# Bundle Trust Board Public 2 May 2024

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
*March SOX of the month – Alex Hurley, Theatre Operational Manager*
*March Patient Centred SOX – Sara Wilds, Principal Clinical Physiologist, Neurophysiology*
*April SOX of the month – Jo Chown, Clinical Trials Assistant, Research Department and ICU Team*
*April Patient Centred SOX – Louise Morris, Staff Nurse, Laverstock Ward*

1.2 10:05 - Staff Story
*Presented by Melanie Whitfield*

1.3 10:25 - Welcome and Apologies
*Apologies received from Fiona McNeight and Jon Burwell*

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 Minutes of the previous meeting
*Minutes attached from meeting held on 7 March 2024*
1.5 Draft Public Board mins 7 March 2024

1.6 10:30 - Matters Arising and Action Log
1.6 Trust Board Action Log May 2024

1.7 10:35 - Chair's Business
*Presented by Ian Green*
*For information*

1.8 10:40 - Chief Executive's Report
*Presented by Lisa Thomas*
*For information*
1.8a CEO report March 24
1.8b AHA_Feb24_April24_Briefing_240424_V1.0

2 GOVERNANCE

2.1 10:50 - Annual Review of Constitution
*Presented by Kylie Nye*
*For approval*
2.1a Cover Sheet Constitution Annual Review 2024
2.1b Draft Constitution 2024

2.2 10:55 - Annual Review of Directors Interests
*Presented by Kylie Nye*
*For approval*
2.2a Cover sheet Annual Register of Interests 2024
2.2b 2023 24 Register of Interests Master

2.3 11:00 - Integrated Governance and Accountability Framework (including Board Committee Terms of Reference)
*Presented by Kylie Nye*
*For approval*
2.3a Integrated Governance and Accountability Cover Sheet May 2024
2.3b DRAFT 2024_25 Integrated Governance and Accountability Framework March 2024 V1.2
2.3c Appendix 4 DRAFT Audit Committee Terms of Reference Dec 23 approved at AC
2.3d Appendix 4 DRAFT CGC Terms of Reference March 24 CGC approved 26032024
2.3e Appendix 4 Draft Charitable Funds Committee 2024
2.3f Appendix 4 DRAFT People and Culture Committee Terms of Reference V5 March 2024
2.3g Appendiix 4 F&P Terms of Reference 2024 approved 26032024
2.3h Appendix 4 Remuneration Committee ToR Jan 2024 Remcom approved

2.4 11:05 - Fit and Proper Persons Policy
*Presented by Kylie Nye*
*For approval*

2.4a Fit and Proper Persons Policy Cover Sheet
2.4b DRAFT Fit and Proper Person Policy March 2024 V2
2.4c Policy Checklist March 2024 FPPT

3 ASSURANCE AND REPORTS OF COMMITTEES BY EXCEPTION

3.1 11:10 - Integrated Performance Report to include exception reports
*Presented by Mark Ellis*
*For assurance*
3.1a IPR Cover Sheet - Trust Board 2024-04
3.1b Integrated Performance Report May 24 FINAL

3.2 11:30 - 12th March Charitable Funds Committee
*Presented by Ian Green*
*For assurance*
3.2 Charitable Funds escalation report

3.3 21st March Audit Committee
*Presented by Richard Holmes*
*For assurance*
3.3 240321 Audit Committee Escalation Report - updated

3.4 11:35 - 27th March and 24th April Trust Management Committee
*Presented by Lisa Thomas*
*For assurance*
3.4a TMC esclation report

3.5 11:40 - 26th March and 30th April Clinical Governance Committee
*Presented David Buckle*
*For assurance*
3.5 26 March CGC Escalation Report

3.6 11:45 - 26th March and 30th April Finance and Performance Committee
*Presented by Debbie Beaven*
*For assurance*
3.6 Finance and Performance Escalation Report March 2024

3.7 11:50 - 28th March and 25th April People and Culture Committee
*Presented by Eiri Jones*
*For assurance*
3.7a PCC Escalation Report to Trust Board from PCC March 2024 to Board May 2024
3.7b PCC Escalation Report to Trust Board from PCC April 2024 to Board May 2024. revised
3.7c 20240122-V6 ODP Governance
3.7d EDI appendix

4 FINANCIAL AND OPERATIONAL PERFORMANCE

4.1 11:55 - Estates Technical Service Update Report
*Presented by Mark Ellis*
*For assurance*
4.1 Estates Report April 2024

4.2 12:00 - BREAK - 30 Minutes

5 QUALITY AND RISK

5.1 12:30 - Perinatal Quality Surveillance Report March (February data)
*Presented by Judy Dyos and Vicky Marston*
*For assurance*
5.1a Front sheet Perinatal quality surveillance March (February data)
5.1b Perinatal Quality Surveillance March Slides (Feb Data) (1)

5.2 Perinatal Quality Surveillance Report April (March data)
*Presented by Judy Dyos and Vicky Marston*
*For assurance*
5.2a Front sheet Perinatal quality surveillance April ( March data)
5.2b Peri Qual Surv April 2024 Slides (March Data) - DF

5.3 12:35 - Midwifery and Neonatal Staffing Report March 2024
*Presented by Judy Dyos and Vicky Marston*
*For assurance*

- 5.3a Front Sheet Maternity  Neonatal Staffing Report March 2024 - TRUST BOARD MAY 24
- 5.3b Midwifery and Neonatal Nursing Staffing Report March 24

5.4 12:40 - Annual Maternity Survey (deferred from March)
*Presented by Judy Dyos and Vicky Marston*
*For assurance*

- 5.4a Front sheet for NHS Maternity Survey 2023
- 5.4b Salisbury NHS Foundation Trust full report 2023
- 5.4c - NHS Maternity Survey 2023 Action Plan

5.5 12:45 - Birth Rate Plus Reassessment
*Presented by Judy Dyos and Vicky Marston*
*For assurance*

- 5.5a Recommendation for increase in Midwifery establishment following Birth Rate Plus individualised report publication
- 5.5b BR plus reassesment recomended Midwifery establishment paper

5.6 12:50 - Quarterly Risk Report Card Q3 (deferred from March)
*Presented by Judy Dyos*
*For assurance*

- 5.6a  Q3 Incident and risk report
- 5.6b Q3 RMRC March 2024

6 PEOPLE AND CULTURE

6.1 13:00 - Safe Staffing Six Monthly Update
*Presented by Judy Dyos*
*For assurance*

- 6.1a Trust Board Cover Sheet Safe Staffing Review Update May 2024
- 6.1b Safe Staffing Update April 2024

6.2 13:10 - Health and Safety Report - deferred from March
*Presented by Melanie Whitfield*
*For assurance*

- 6.2a H&S Cover Sheet Board Q3
- 6.2b HS Report Q3

7 STRATEGY AND DEVELOPMENT

7.1 13:20 - Improving Together Quarterly Update Report Q4
*Presented by Peter Collins and Alex Talbott*
*For assurance*

- 7.1 Improving Together Quarterly Trust Board Report_April 2024_Final

7.2 13:30 - Review of Trust Strategy Progress Report
*Presented by Lisa Thomas and Tony Mears*
*For information*

- 7.2 Strategy Update May Board

8 CLOSING BUSINESS

8.1 13:55 - Agreement of Principal Actions and Items for Escalation

8.2 14:00 - Any Other Business

8.3 14:05 - Public Questions

8.4 Date next meeting
*4 July 2024*

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

Salisbury NHS Foundation Trust

**Draft**
**Minutes of the Public Trust Board meeting**
**held at 10:00am on Thursday 7th March 2024, Boardroom/MS Teams**
**Salisbury NHS Foundation Trust**
**Boardroom**

| **Board Members:** | |
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| Ian Green (IG) | Chair |
| Eiri Jones (EJ) | Non-Executive Director |
| Debbie Beaven (DBe) | Non-Executive Director |
| David Buckle (DBu) | Non-Executive Director |
| Tania Baker (TB) | Non-Executive Director |
| Michael von Bertele (MVB) | Non-Executive Director |
| Richard Holmes (RH) | Non-Executive Director |
| Rakhee Aggarwal (RA) | Non-Executive Director (Via Teams) |
| Judy Dyos (JDy) | Chief Nursing Officer |
| Mark Ellis (ME) | Interim Chief Finance Officer |
| Peter Collins (PC) | Chief Medical Office |
| Lisa Thomas (LT) | Interim Chief Executive Officer |
| Niall Prosser (NP) | Interim Chief Operating Officer |
| Melanie Whitfield (MW) | Chief People Officer |
| **In Attendance:** | |
| Kylie Nye (KN) | Head of Corporate Governance (minutes) |
| Fiona McNeight (FMc) | Director of Integrated Governance |
| Jayne Sheppard (JS) | Lead Governor (observer) |
| Jane Podkolinski (JP) | Governor (observer) |
| Frances Owen (FO) | Governor (observer via Teams) |
| Abigail Kingston (AK) | Clinical Director Women and Newborn (item - TB1 7/3/6.5) |
| Luke Curtis (LC) | Lead Cancer Nurse (Item - TB1 7/3/1.2) |
| Victoria Aldridge (VA) | Head of Patient Experience Patient (Item - TB1 7/3/1.2) |
| Peter Tanner | Patient (Item - TB1 7/3/1.2) |

| | | ACTION |
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| **TB1 07/03/1** | **OPENING BUSINESS** | |
| **TB1 7/3/1.1** | **Presentation of SOX (Sharing Outstanding Excellence) Certificates** | |
| | IG noted the following members of staff had been awarded a SOX Certificate and details of the nominations were given:<br><br>**January SOX of the month** – Amanda Chinnock, Whiteparish Ward and Olive Sohan, Will Knibbs and Mathew Hill, AMU<br><br>**January Patient Centred SOX** – Urology Department<br><br>**February SOX of the month** – Philip Ferguson, Waste and Grounds Team and Holly Gillespie and Samantha Amor, Mortuary<br><br>**February Patient Centred SOX** - Glen Garcia and Mary Joseph, Radiology<br><br>IG congratulated all the staff that had been recognised in January and February on behalf of the Board and also thanked all the staff that had been | |

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| | nominated for their hard work and innovation. These staff will receive a SOX award in person. | |
| **TB1 7/3/1.2** | **Patient Story** | |
| | VA introduced Peter Tanner (PT) to the Trust Board who had joined in person to talk through his experience of his cancer care pathway in Salisbury. PT provided a detailed summary of his care from his first diagnosis in 2007 to date, highlighting the good care he had received and the areas of improvement that could have been made to improve his care during this time.<br><br>In his presentation he explained that his experience would have been greatly improved if he had received a detailed care plan, been signalled to the appropriate support groups, and been given a contact card to help communication during the process. Additionally, he noted that further support in terms of financial advice and nutritional support would have been appreciated. PT also noted that blood test results should go to the patient and the GP at the same time.<br><br>PT explained that in terms of the environment in Oncology, the space could be much improved for patients by improving the wall coverings, implementing a water machine, reintroducing printed information leaflets and a brighter waiting area for patients.<br><br>He noted that the areas of his care which had been good included his involvement in the cancer experience group and the support provided and the improvements in urology care which he has seen in the last 16 years. He also noted that the care he had receive from the plastics and burns team in the Trust, due to an unrelated incident, was outstanding, noting the opportunity for shared learning within the Trust.<br><br>PT noted the challenging journey he had been on since his diagnosis, noting that time spent within the Royal Marsden had really highlighted the importance of how an organisation influences how you feel about your care and treatment and the importance of communication. He ended his story noting that whilst improvements have been made at SFT it is the small changes, e.g., brightening up offices and walls that make a huge difference.<br><br>**Discussion:**<br>IG thanked Peter for his candid presentation and a discussion was had with LC regarding the information leaflets. LC noted that as part of the Patient and Public voice group the lack of information packs/ information leaflets has been raised with no funding currently in place. The cancer team is developing a website, going live in mid-March, which will provide more information on side effects etc.<br><br>LC noted that in terms of Oncology, it is acknowledged that the space is not an ideal environment for patients. The team have been working with Art Care to improve the space, although it is noted that there is nowhere for Cancer Nurse Specialists (CNS) to take patients for private discussions. There has also been work on the personalised care strategy which all organisations will sign off in relation to transparent options and consistent care.<br><br>DBu thanked Peter for sharing his experiences with the Board. DBu noted that some of the suggestions are small and could possibly be supported by | |

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| | charitable funds. Additionally, DBu asked PT if he had been pointed in the direction of any cancer support charities, e.g., Prostate Cancer UK PT noted that he had not but had joined some forums in the USA to find out more about possible treatments available.<br><br>PC noted the changes in terms of care delivered at a relatively small District General Hospital (DGH) and community health providers compared to when PT first started his treatment. PT's experience highlights that there is an increasing number of people living with and beyond cancer who may receive a majority of their care within the local community. Whilst SFT may not be able to replicate some treatments at specialist hospitals there should be an ambition about delivering the best possible care locally. PC noted that the environment makes a huge difference and there is a need to understand the patient's point of view to help improve care.<br><br>EJ recognised the great work LC and VA are doing to improve patient's experience. EJ noted the importance of the patient voice in organisational learning.<br><br>The Board thanked PT for his time and he and VA left the meeting. | |
| **TB1 7/3/1.3** | **Welcome and Apologies** | |
| | IG welcomed everyone to the meeting and noted apologies had been received from Jon Burwell, Interim Chief Digital Officer.<br><br>IG welcomed Niall Prosser to his first Trust Board. He joined the Trust as Chief Operating Officer (COO) in early February.<br><br>IG noted the purpose of the meeting, asking members and attendees to be present in the room and reminding them to highlight if they were going to step out during the meeting. | |
| **TB1 7/3/1.4** | **Declarations of Conflicts of Interest** | |
| | There were no declarations of conflict of interest pertaining to the agenda. | |
| **TB1 7/3/1.5** | **Minutes of the Part 1 (Public) Trust Board meeting held on 11th January 2024** | |
| | IG presented the public minutes from 11th January 2024 and the following was noted:<br><br>• EJ noted one correction on page 3/17 regarding the continuity of carer discussion. EJ asked that the wording be updated to note that the formal stance around continuity of carer should be implemented when staffing numbers allow.<br><br>Subject to these amendments, the minutes were agreed as a correct record of the meeting. | |
| **TB1 7/3/1.6** | **Matters Arising and Action Log** | |
| | FMc presented the action log and noted the following key updates: | |

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| | **TB1 07/12/3.2 Digital Plan Update –** The Board noted that this had been incorporated into the digital updates which will go to F&P Committee in March.<br><br>**TB1 11/1/2.2a Standing Financial Instructions (SFIs)** – ME explained that the capital revenue limits are explicit and are summarised in the Capital Control Group terms of reference. **Closed.**<br><br>**TB1 11/1/7.2 Quarterly Learning from Deaths Report –** PC noted that the Q4 report will include more detail on deaths of patients with serious mental health concerns. PC noted that the requested addendum for Q3 had unfortunately been missed in the report but it has been circulated separately. The report will also be circulated to the governors, as suggested.<br><br>It was noted that all other matters arising were either closed or to be considered on a future agenda. | |
| **TB1 7/3/1.7** | **Chair's Business** | |
| | IG noted he had no specific business to highlight. | |
| **TB1 7/3/1.8** | **Chief Executive's Report** | |
| | LT presented her CEO report, taking it as read but highlighting the good news regarding the Nursing Associate Foundation Degree in Salisbury, thanks to a new collaboration between Coventry University Group and Wiltshire College and University Centre.<br><br>**Discussion:**<br>The Board discussed the report, noting the positive steps in terms of operational performance. The target for the 4-hour ED in March is 76%. The team have completed an 'A3' to understand what is required to improve the current position. IG asked how confident the executive team were re ED performance. NP highlighted the national and regional focus on ED performance, noting that there had already been two particularly challenging days in March. However, teams have responded well to the challenge, looking at immediate actions to drive change but also reviewing how the position becomes sustainable. The teams are focusing on a better outcome but using the culture and values driven by the Improving Together methodology, rather than pre-Covid measures.<br><br>The Board discussed the good news stories, with NP highlighting the number of changes teams are identifying as part of a continuous improvement culture e.g., new standard operating procedures for patients who are admitted in ED overnight. The Board also noted that the new ward 'Imber' opens in May and there will be a lot of work to rebalance the rest of hospital to support delivery of the objectives of a new ward. On 1st April a new theatre timetable starts and a lot of preparatory work is underway to ensure this goes as smoothly as possible. JDy reported the positive news that there had been zero falls reported with a moderate/ high level of harm in the last month: a real reflection of the focused improvements underway in the Trust.<br><br>In terms of financial planning the recent news as part of the Budget indicated that the NHS was to receive £2.5bn revenue day to day funding which will | |

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| | cover existing pay awards. There has been £3.4bn allocated for the NHS technology/ digital agenda over the next three years. The Trust will know more in the summer but the commitment to digital is positive in light of the Shared EPR project currently underway. ME noted that none of this additional funding is likely to ease SFT's funding issues for the next financial year.<br><br>The report was noted. | |
| **TB1 7/03/1.9** | **Register of Attendance** | |
| | IG presented the register of attendance, noting that it was positive to see a number of governors attending regularly and this supported their responsibility in holding the non-executive directors to account.<br><br>The register was noted. | |
| **TB1 7/3/2** | **ASSURANCE AND REPORTS OF COMMITTEES** | |
| **TB1 7/3/2.1** | **Integrated Performance Report (IPR) (M9)** | |
| | MW presented the Integrated Performance Report which provided a summary of January 2024 performance metrics and is used to monitor progress towards the Trust's overall vision. MW noted the purpose of the report and highlighted the following key points:<br><br>• Marginal improvement in the time to the first outpatient appointment with recognition given to several departments.<br>• A JDy noted there has been no harm from falls in the reporting period.<br>• Staff availability has been better, with a positive impact seen within clinical teams.<br>• However, bed occupancy has increased, as has the number of patients not meeting the criteria to reside (NCTR), with contributions from surgery and medicine. The number of late discharges has been highlighted during the month.<br>• Emergency Department (ED) performance and handover times have deteriorated, and weekly performance huddles and skill mix reviews have been introduced.<br>• The cancer metrics are concerning, with planned actions in five specialties and a challenging waiting list.<br>• There are a number of watch metrics alerting this month Three alerting metrics (detail and mitigations in detail of IPR).<br><br>**Discussion:**<br>There was a detailed discussion re cancer pathways and the Board discussed waiting times, and the levels of detailed work to improve the trajectory in target areas. The Trust is under Tier two (regional oversight) for cancer performance, with a 62-day cancer backlog. Improvements are being seen in the number of patients waiting over 62 days, but certain pathways like Skin and Colorectal remain challenging. The Trust has instigated a Patient Tracking List (PTL) to ensure focused management of cancer pathways. The Divisions have been reminded to recognise cancer pathways as part of their performance. | |

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| | There is ongoing work with partner hospitals to reinvigorate pathways through the use of community diagnostic centres, hopefully leading to earlier diagnosis. In January, 158 patients were waiting over 62 days, and this number has reduced to 98 in the current month.<br><br>Several concerns were raised, including the number of patient moves within the hospital (over three for some), the risk of harm associated with these moves. Assurance was provided that the Trust is focused on minimising patient moves and improving bed modelling and handover processes.<br><br>EJ noted that concerns with the gynaecology pathway had been raised at F&P and CGC. There was a discussion and the Board noted that during Industrial action, the gynae team can suffer due to challenges in covering maternity. NP reassured the Board that gynaecology performance is a focus and there is currently only one patient waiting over 62 days on the gynae pathway.<br><br>The Board was advised to focus on the trajectories and plans for improvement, particularly in cancer performance, where a deep dive at the F&P committee is planned.<br><br>There were discussions around prioritising actions and objectives, considering resource constraints, and the challenges associated with weekend discharges and the implementation of seven-day services.<br><br>The report was noted. | |
| **TB1 7/3/2.2** | **Clinical Governance Committee – 30th January and 27th February** | |
| | DBu presented the report which provided a summary of escalation points from the meetings held on 30th January and 27th February 2024: He took the reports as read but highlighted the following key points:<br><br>• The mortality reviews are designed to identify clinical variation. The Committee has noted that the recent mortality review to look at our processes was wide ranging, thorough and practical. The team have provided us with advice and recommendations which CGC reviewed and supported. The Committee was satisfied with the response and this has been included in item 6.3.2 on the agenda. IG asked for this to be circulated to the governors *(completed).*<br>• The Committee noted that VTE assessments remain low but the number of patients impacted is similar, suggesting a data collection issue. This is under review.<br><br>The report was noted. | |
| **TB1 7/3/2.3** | **Finance and Performance Committee – 30th January and 27th February** | |
| | DBe presented the report which provided a summary of escalation points from the meetings held on 30th January and 27th February. DBe asked the Board to take the reports as read, highlighted the following key points: | |

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| | • As mentioned in the IPR cancer performance was discussed with a further deep dive requested at the next meeting.<br>• Our performance and run rate have been impacted by industrial action (IA) and our elective capacity, which an impact on CIPs. We are £5.8m off target ytd, with the majority of the shortfall arising in Medicine and Surgery. We are £1m adverse to the H2 forecast, which made no allowance for IA. There is a risk that we will end the year with a deficit in the range of £6m best case to £10m most likely, with a shortfall of £1-2m on CIPs contributing to a worse position, remembering there is no system solution to NCTR, which as a £3m reduction target, although SFT are covering some of that shortfall with overperformance on divisional CIPs.<br>• Coding was discussed as an audit has suggested some improvements. The team have been encouraged to use the Improving Together approach to address the issues from a different perspective.<br><br>The report was noted. | |
| **TB1 7/3/2.4** | **People and Culture Committee – 24 January and 28 February** | |
| | EJ presented the report which provided a summary of escalation points from the meetings held on 25th January and 29th February. EJ asked the Board to take the report as read and noted the following points:<br><br>• Workforce metrics are going in the right direction.<br>• Digital maturity and the impact on other areas was flagged in the latest meeting.<br>• Staff survey feedback has been published and will be discussed later in the meeting.<br><br>**Discussion:**<br>The report was noted. | |
| **TB1 7/3/2.5** | **Trust Management Committee – 24th January and 28th February (to include Annual Green Plan Report)** | |
| | LT presented the report which provided a summary of escalation points from the meetings held on 24th January and 28th February.<br><br>The report was noted. | |
| **TB1 7/3/3** | **FINANCIAL AND OPERATIONAL PERFORMANCE** | |
| **TB1 7/3/3.1** | **Standing Financial Instructions** | |
| | The Board noted the Standing Financial Instructions (SFIs) had been changed to May on the cycle of business. | |
| **TB1 7/3/4** | **GOVERNANCE** | |
| **TB1 7/3/4.1** | **Register of Seals** | |
| | FMc presented the report noting that none of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an | |

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| | interest in the transactions they witnessed.<br><br>The report was noted. | |
| **TB1 7/3/5** | **PEOPLE AND CULTURE** | |
| **TB1 7/3/5.1** | **National Staff Survey Results** | |
| | MW provided a presentation noting that the Staff Survey was now in the public domain. MW provided details noting the significant improvement in comparison to last year's results.<br><br>The slides detailed the positive highlights and the areas of improvement. MW noted she would share the full slide deck after the meeting. It is encouraging to see the Trust has improved against a number of elements of the People Promise.<br><br>Compassionate and Inclusive and Staff Engagement are above average in relation to other acute Trusts. In terms of 'Always learning' it is acknowledged that the Trust does not always deliver against annual appraisal and performance review. There is still some way to go to improve this.<br><br>It is good to noted improvement in the responses from staff re engagement, motivation, coming to work and sense of involvement. It is recognised that there are improvements to be made but the trajectory is going in right direction.<br><br>What is clear from the results is that Black, Asian and Minority Ethnic (BAME) staff have a less positive experience at work than white staff. Further work to understand this data and focus on areas of improvement is required.<br><br>**Discussion:**<br>IG thanked MW for the report noting that he was pleased to see progress in a number of areas and an improved trajectory. However, whilst there has been improvement in the last 12 months IG asked how the Trust will avoid complacency at this stage. EJ noted that the Trust is above average in lots of areas but there are Trusts in a better position and therefore it is a continuous improvement process. There are still very few recommending us a place to work.<br><br>RA asked if there is an opportunity to look at protected characteristics as some staff are obviously feeling less engaged and supported. MW noted that there was a session on Private Board to discuss and at People and Culture Committee.<br><br>MvB asked if the Trust has identified the changes made since last year and tracked if what we did made a difference, i.e., if the effort in the specific areas had an impact. MW explained that each division tracks their progress against those actions and owns those plans for improvement.<br><br>DBe noted that going forward staff retention is a breakthrough objective. However, highlighted the 23% of staff looking for a new job. The Board discussed how this is reviewed from a divisional perspective to look at | |

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| | retention strategies. Nationally, LT noted that staff retention is a focus and the Trust will have to submit a plan in line with best practice.<br><br>RH noted that from initial impression a majority of the results reveal that the Trust is below average on several of the indicators and therefore we should not be complacent about these results despite the significant improvement from last year.<br><br>TB asked if the Trust give divisions steer regarding the areas of focus expected. For example, the Equality, Diversity and Inclusion (EDI) issues should be a prompt given the wider challenges faced. MW noted that HR Business Partners are brief with a breakdown of scores in speciality to allow for focused actions. MW noted that this has led to a focused piece of work on Health Care Assistant (HCA) retention, providing additional pastoral support and running away days and a newsletter to create a sense of 'team'. PC noted that a conversation was led at TMC focusing on the challenges and experience of BAME groups and also on violence and aggression.<br><br>IG referenced the Pulse Survey and how this is used locally. MW explained that this is run quarterly and local questions are added to gain assurance on challenging areas. These are reported back through TMC.<br><br>RA noted that for further assurance in relation to WRES data, a deep dive on actions that have had an impact and what is planned next is required. Divisions understanding this data is positive but there is a 'so what' element and therefore to have sight of actions would be useful. MW explained that further EDI board development sessions are planned as it is clear from the data that BAME staff are less engaged. DBe reflected that overseas staff are more likely to leave and therefore it would be useful to understand from a retention perspective.<br><br>IG summarised that the key outcome from this report reflecting that as this goes out to divisional colleagues, should they be given a steer as to what to focus on? Additionally, there is a wider piece relating to impact of this data and our responsibility as an inclusive employer. The Board EDI sessions and People and Culture Committee will work on this aspect. Strategically, the team need to be looking at the pulse survey to understand current aspirations of staff and how we respond in amore dynamic way.<br><br>The update was noted. | |
| **TB1 7/3/5.2** | **Health and Safety Report** | |
| | The Board noted the Health and Safety Report had been deferred to May. | |
| **TB1 7/3/6** | **QUALITY AND RISK** | |
| **TB1 7/3/6.1** | **Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** | |
| | FMc presented the BAF and CRR which provides the key corporate and strategic risks which challenge the Trust's strategy. The following key points were noted: | |

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| | • It is pleasing to see a positive move since June regarding workforce risks.<br>• The number of risks on the CRR has remained consistent. There has been a reduction of 5 risks with two risks detailed in the report moving to their target score.<br>• There was a discussion regarding financial risks and how they are described and if scores should be reviewed. This will be done for next round of reporting.<br>• There has been a discussion around estates and if the score is reflective of the current position, this will be picked up.<br><br>**Discussion:**<br>The Board discussed, noting there are areas where progress has been made in terms of reducing risk. The next step is ensuring this is sustainable by engaging and assessing risks on a regular basis. The management is risk is live, e.g., staff availability.<br><br>FMc noted that the risks out with tolerance are reflected in the Committee agendas. The internal audit team have joined us and have complimented us on the process and mechanism in which we look at risks.<br><br>IG asked the Board if they were comfortable and felt sighted on all the risks and mitigations. EJ noted that a theme, as highlighted by NHS Providers, is that we are aware of where quick improvement is not expected and how long we will tolerate this for. IG noted all items on agenda are covering these key risks and that the Board is spending time focusing on those key areas.<br><br>DBe agreed but noted her concerns around a worsened situation where the Board cannot tolerate but there is no funding. DBe is not sure of the mechanism around how this would be resolved. IG suggested this was discussed as part of operational planning in the private Board. TB noted that in that situation, the reality of the only option available will be to consider closing services. IG agreed.<br><br>The report was noted. | |
| **TB1 7/3/6.2** | **Patient Experience Report Q2 (deferred from December) and Q3** | |
| | JDy presented the reports which had been discussed at CGC. The patient experience report details our complaints management throughout the two quarters. The number of formal complaints made in Q2 has increased (n~40) when compared with the previous quarter. 35 complaints were formally logged in Q1, however these figures are still significantly lower than those logged in Q4 (n~57) and Q3 of 2022/23 (n~56).<br><br>The Friends and Family response ratings in relation to experience have decreased from 98%-97%, although Q2 saw highest response rate with 2,529 responses.<br><br>JDY highlighted the number of attachments to the report indicating what the teaching programme is and the current improvements being made. | |

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| | The feedback received from audit notes we have a good process but the challenge is completing the work in a timely fashion. The team has really tried to improve patient experience and co-production with patients.<br><br>**Discussion:**<br>IG asked if the Board understand the blocks and barriers to responding to complaints in a timely fashion. The responses have to come from clinical teams who oversee care, this is where the main delay is. FMc noted that the complaint responses have greatly improved with ongoing engagement when there is a delay. The number of reopened complaints has also reduced.<br><br>The report was noted acknowledging it has been discussed at CGC. | |
| **TB1 7/3/6.3** | **Quarterly Learning from Deaths Report Q3** | |
| | PC presented the report, including item TB1 7/3/6.3a noting that it had been through CGC. The following key points were noted:<br><br>• PC noted the downward trend but the importance of the Board and public to recognise the historic nature of reporting due to the 6-month time lag. Whilst we do delay reporting to enable coding teams to be more effective, the delay is largely outside of the Trust's control.<br>• The current approach to reviewing mortality is to amalgamate a number of aspects of Trust governance into one place, including end of life care, statistics relating to mortality, and case reviews of care and to look at the themes and elements of safety which are linked to mortality which comes through PSIRF processes<br>• In terms of the Mortality Insight Visit the recommendations have been received. The Mortality Governance Group received the report and an action plan has been put in place to deliver these recommendations.<br><br>**Discussion:**<br>EJ noted that CGC had asked for further information regarding learning disability deaths which will come back in the Q4 report.<br><br>IG there has been a discussion at the Council of Governors (CoG) due to input from governors around mortality, particularly in the last 6 months. The issue raised was around the transparency of mortality reporting. However, the understanding from the mortality review is that there are no concerns expressed regarding transparency. Our Learning from Deaths Report was commended.<br><br>The Board discussed the issues raised in terms of mortality reporting in the IPR. PC explained that the report follows the improving together methodology and there are no metrics we choose not to disclose. What we have committed to do is work with governors to ensure learning from deaths is more accessible.<br><br>TB noted that the Trust does publish data on actual deaths and this can sometimes be unhelpful and needs to be risk adjusted as it can be misinterpreted. PC agreed noting that further context is required if these are published. | |

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| | TB noted that the mortality review was clearly thorough but she noted her surprise that they commented on lack of engagement with clinical staff. PC recognised that input from a clinical leadership perspective will invoke a better discussion in a mortality review setting. There is now good visibility through dashboards and the new Audit AMAT system. This is about being clear with clinical leadership that it is their responsibility to understand.<br><br>IG summarised that when these issues were raised, concerns were highlighted around the mortality data and the Trust therefore commissioned an independent review. As a result of this. Nothing of serious concern has been flagged by the regional medical director. The recommended actions are in place to help us understand our position and to improve coding and diagnosis. This will be followed up at CGC.<br><br>PC reflected on the fair challenge in relation to reporting, noting that when something is RAG rated red, it is difficult to advise that there is no concern. There is an action going forward to include the NHS England SHMI as this will tell you where you are within the expected limits.<br><br>EJ noted that the mortality deep dive and continuous work is a good example of us continually being curious and being open and transparent.<br><br>TB queried if the Trust will report SHMI at hospital or site and if the plan was to report HSML. PC noted that the team will look at a range of options and decide the best way forward to provide the most transparent and clear reporting.<br><br>The Board discussed if this had been a useful exercise. PC noted that the review had utilised a lot of resource to obtain the assurance requested and wouldn't want this to become the norm. Ideally, review of this nature would be picked up as part of Internal Audit processes.<br><br>IG thanked Peter for his input.<br><br>The report was noted. | |
| **TB1 7/3/6.3a** | **Peer Mortality Report** | |
| | This was discussed as part of item TB1 7/3/6.3. | |
| **TB1 7/3/6.4** | **Quarterly Risk Report Card Q2 – deferred from December** | |
| | JDy presented the report, highlighting that this would be the last report in this format. The next version of the report will be a more data driven slide deck due to come in May. From Q1 23/24 (2519) to Q2 23/24 (2411) there is a 7.8% decrease in the reporting rate.<br><br>In November 2023, the National Reporting and Learning System (NRLS) was replaced by the Learning from Patient Safety Events (LFPSE). Leading up to this, testing was required which meant staff were unable to access Datix and this may therefore have impacted on the decreased reporting.<br><br>The changes in relation to the implementation of PSIRF requires investigators, which will take pressure away from risk team supporting an | |

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| | improved risk management process. There are a large number of risks open which need to be reviewed, operationalised if required and closed.<br><br>**Discussion:**<br>The Board discussed Duty of Candour (DoC) and raised concerns it was only 20% at stage 3. JDy assured the Board that DoC compliance is discussed at the weekly Patient Safety Summit where the executive team have the opportunity to explore any barriers with the divisional teams. PSIRF will ensure that the process is expedited. JDy also noted that the report is misleading as DoC is not always recording in the system. The ethos behind PSIRF is learning and engagement and the new investigators will have this responsibility too.<br><br>The Board noted the Q3 report had been deferred to May. | |
| **TB1 7/3/6.5** | **Maternity & Neonatal Quality and Safety Report Q3** | |
| | This item was taken after TB1 7/3/7.3. AK joined the meeting to present.<br><br>JDy highlighted that SFT's maternity department had been moved into a 'sustainable' status by NHS England. IG noted that it was important for the Board to formally acknowledged this, noting that AK and her colleagues have worked diligently and hard to deliver improvements in a sustainable way. IG also gave thanks to EJ for her Ockenden NED role and JDy as executive lead. AK thanked the Board, noting that the team have been extremely well-supported.<br><br>AK presented the report, including the CNST requirements including the PRMT review detailed within the report and the compliance with the labour ward coordinator being supernumerary and women receiving 1:1 care at 100% compliance.<br><br>AK noted that the executive summary highlighted the key points but there was nothing further to escalate.<br><br>**Discussion**:<br>EJ noted that she is involved in the monthly PRMT reviews and this includes external participants with shared learning and practice.<br><br>The Board noted the PRMT review and the 100% compliance re the labour ward coordinator being supernumerary and women receiving 1:1 care. | |
| **TB1 7/3/6.6** | **Perinatal Quality Surveillance Report January (December data)** | |
| | AK presented the report, noting that the report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme, year 5, Safety Action 9. This had been reviewed at CGC.<br><br>AK noted that the key points were detailed in the executive summary of the report.<br><br>There have been three moderate incidents: | |

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| | • 1 stillbirth at 25.5. No omissions in care noted at initial review, for PMRT review.<br>• 2 third degree tears, no themes noted.<br>• In terms of CNST 9/10 safety actions achieved which is an increased from the 5 achieved last year.<br><br>**Discussion**:<br>PC commended the compliance with training.<br><br>The Board discussed the report noting that the mortality surveillance group ToR include a second look at deaths which happen in neonatal period. We also receive external assurance to ensure the Trust is not missing any themes.<br><br>The report was noted. | |
| **TB1 7/3/6.7** | **Perinatal Quality Surveillance Report February (January data)** | |
| | AK presented the report, noting that the report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme, year 5, Safety Action 9. This had been reviewed at CGC.<br><br>AK detailed the key points included in the executive summary, noting there were no key concerns to highlight.<br><br>The report was noted. | |
| **TB1 7/3/6.8** | **Salisbury NHS Foundation Trust review of Neonatal Death in the Neonatal Unit between 2018-2023** | |
| | AK presented the report, asking Board to note the contents of the report that has been provided in response to the Lucy Letby trial and shows our review of all Neonatal Deaths on the Neonatal Unit over the five years from 2018-2023. The report provides assurance that the Trust is not missing anything in terms of care provision.<br><br>There has been a full and thorough PMRT review and no key themes have been highlighted. In conclusion, the trust has seen a level of neonatal deaths that is within expected parameters for the number of annual births within the trust.<br><br>The report was noted. | |
| **TB1 7/3/6.9** | **Annual Maternity Survey** | |
| | The Board noted the report had been deferred to May. | |
| **TB1 7/3/7** | **CLOSING BUSINESS** | |
| **TB1 7/3/7.1** | **Any Other Business** | |
| | There was no other business. | |

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| **TB1 7/3/7.2** | **Agreement of Principle Actions and Meeting Reflection** | |
| | IG summarised the board's discussion, noting the pertinent topics that had been raised. | |
| **TB1 7/3/7.3** | **Public Questions** | |
| | This item was taken after TB1 7/3/6.4. IG presented the public questions:<br><br>A public question had been sent in which was inappropriate to discuss in a public forum and would be managed outside of the meeting.<br><br>A further question was posed to the meeting and it was acknowledged that this could have been managed as part of an FOI process. The question and response were as follows:<br><br>*As one of Salisbury's largest employers I am sure you are aware, high engagement, enhanced creativity, low absenteeism, improved retention and financial benefits are all signs of a happy workforce. The answer to the questions below (from April 2022 - April 2024) would provide further clarity and context.*<br>*How many patient complaints were received at Salisbury FT?*<br>*How many Salisbury FT staff sick days were taken due to stress?*<br>*How many staff grievance procedures were dealt with by Salisbury FT HR Department?*<br>*What is Salisbury FT staff turn over, permanent and fixed term contracts?*<br>*How many non-disclosures have been signed?*<br><br>**The Trust reply:**<br><br>• **How many patient complaints were received at Salisbury FT?** In April 2022 we received 20 complaints, the numbers peaked later that year at 28 and have been on a continual decline to 5 in February 2024<br>• **How many Salisbury FT staff sick days were taken due to stress?** Total days of sickness absence both short and long term ( over 30 days) was 5808 which has reduced to 5040 in February<br>SFT lost 23,333 days to Stress/Anxiety/Depression/Other Psychiatric Illness in the period April 2022 to January 2024, which accounts for 22.6% of our total sickness.<br>This compares to 26.4% of sickness for this same reason across the NHS as a whole.<br>• **How many staff grievance procedures were dealt with by Salisbury FT HR Department?**<br>Over the course of two years the HR team have received 35 grievances<br>• **What is Salisbury FT staff turn over, permanent and fixed term contracts?**<br>Our turnover rate has increased since april 2022 by 1.2%, though our staff stability index (that is the degree of change in our organisation) has improved from 84.2% to 86.9%)<br>Turnover for permanent staff was 13.34% over the period April 2022 to January 2024. Turnover for staff on fixed term contracts | |

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| | was 25.87%, giving a combined turnover total of 14.13%. Figures exclude trainee doctors in rotation.<br>• **How many non-disclosures have been signed?**<br>22/23 – 2 settlement agreements<br><br>23/24 – 2 settlement agreements | |
| | **Reflection** | |
| | The Board reflected on the meeting and the following was discussed:<br>• The agenda felt light but it was noted a lot of the detailed discussion happens at the Board Committees. The Board noted the importance of the IPR and escalation report.<br>• RA noted that the Board need to look into how we triangulate protected characteristics and their experiences as staff and patients. PC noted the emerging health inequalities group which will look at scope and what does this mean for staff and population.<br>• TB noted that the Board do not spend enough time on strategic issues. IG agreed noting that development time should be used for those strategic issues that are not routinely discussed at Board. | |
| **TB1 7/3/7.4** | **Date of Next Public Meeting** | |
| | The next Public Trust Board meeting will be held on 2nd May 2024, in the Board Room, Salisbury NHS Foundation Trust | |
| **TB1 7/3/8** | **RESOLUTION** | |
| **TB1 7/3/8.1** | Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted). | |

# Master Action Log

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| 1 | Deadline passed, Update required |
| 2 | Progress made, update required at next meeting |
| 3 | Completed |
| 4 | Deadline in future |

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

| Committee | Organiser | Reference Number | Deadline | Owner | Action | Current progress made | Completed Status (Y/N) | RAG Rating |
|---|---|---|---|---|---|---|---|---|
| Trust Board Public | Sasha Grandfield | TB1 07/12/3.2 Digital Plan Update | 26/03/2024 | Jon Burwell, JB | IG referenced the 'project and planned work progress', noting that some have dates and some do not. IG asked for all to have dates for consistency. | **To be incorporate into the digital updates which go to F&P Committee in March. Went to F&P in March.** | Y | 3 |
| Trust Board Public | Sasha Grandfield | TB1 11/1/3.1 Quarterly Strategy Update | 06/06/2024 | Lisa Thomas, LT<br>Tony Mears, TM | The Board discussed how the Trust can demonstrate progress against the actions supporting delivery of the Trust Strategy. LT noted that this can be included in the next update. | **June** | N | 4 |
| Trust Board Public | Sasha Grandfield | TB1 11/1/5.1 Health and Safety Quarterly Report | 04/07/2024 | Melanie Whitfield, MW | EJ noted that some areas of the H&S report links to the issues highlighted in the Estates report. It was agreed that MW would review how the information in each report could be triangulated | **July** | N | 4 |

NHS Salisbury NHS Foundation Trust

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| Report to: | Trust Board (Public) | Agenda item: | 1.8 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report title: | Chief Executive Report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | | | |
| Approval Process: (where has this paper been reviewed and approved): | N/A | | | |
| Prepared by: | Lisa Thomas, interim Chief Executive | | | |
| Executive Sponsor: (presenting) | | | | |
| Appendices | Appendix 1- AHA briefing update | | | |

| Recommendation: |
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| 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: |
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| The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of. |

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

## 1. Population

### Operational Context

The end of March gives us time to reflect the difference our staff have made to many thousands of patients over the last year. The highlights to reflect on include:

- We saw over 277,525 people in outpatients
- We treated 24,178 day case patients.
- 75, 033 attended our ED department
- 28,439 attended our services as an emergency admission.

- We saw an improvement in our overall length of stay as an organisation by one day, thank you to the changes in our SDEC and Acute Frailty services.

- The Number of patients waiting for onwards care (NCTR) reduced by an average of c40 patients, allowing us to treat more planned patients.

- Our quality indicators show continued improvement with significant progress on the number of falls reducing as well as pressure ulcers.

As an organisation our staff survey results have been published showing the most improved organisation in England for 2023. I am delighted the investment in training and development, the move to reduce our vacancies – particularly in nursing, have shown a marked improvement.

Whilst 2023/24 has been a challenging year in the NHS we have so much to be proud of at Salisbury.

### National updates

The NHS Planning guidance was finally published just before Easter. The overall priority remains to be the overall increase in productivity and reducing patient waiting times for planned care.

The key priorities that impact SFT are:

- Maintaining collective focus on quality and safety of services – with specific reference to maternity and neonatal services.

- Improving ambulance response and accident and emergency (A&E) waiting times.

- A reduction in waits of over 65 weeks for elective care and an improvement in core cancer and diagnostic standards.

- Improving staff experience, retention and attendance.

Integrated care boards (ICBs), trusts and primary care providers to work together to plan and deliver a balanced net system financial position. The guidance also sets out a number of key areas where systems are asked to develop longer-term plans. Systems are asked to update their five-year joint forward plans (JFPs) by

June 2024 and set out the steps they will take to better join up care and address the causes of morbidity and premature mortality.

Systems are asked to include workforce plans in their JFPs, outlining their staff and skill requirements to meet the needs of their populations. Systems are also asked to develop long term infrastructure strategies to underpin their JFPs, outlining a shared view of priorities for estates and capital investment. Guidance on developing a 10-year infrastructure strategy has also been published. Systems are asked to support improving provider digital maturity across all sectors, with a focus on deploying and upgrading electronic patient records and the use of the NHS App.

The guidance restates the focus on delivering the urgent and emergency care recovery plan. This includes an ask that a minimum of 78% of patients are seen in A&E within 4 hours in March 2025. NHSE will also operate an incentive scheme (with details to be set out separately), rewarding providers with a Type 1 A&E department achieving the greatest level of improvement and/or delivering 80% against the four-hour target by the end of 2024/25.

NHSE recognises the impact that industrial action has had on the ability to deliver the elective recovery plan. The immediate priority is to eliminate 65-week waits by 30 September 2024, with systems also asked to reduce the overall size of the waiting list. We are also expected to increase productivity by making improvements towards the 85% day case and 85% theatre utilisation expectations, using GIRFT, and moving procedures to the most appropriate settings.

We should also continue to reduce waits for first outpatient appointments. NHSE have also introduced a new metric, measuring the proportion of outpatient attendances that are first or follow up appointments against a nation ambition of 46%. The national objectives for reducing cancer waiting times include improving performance against the 62- day standard to 70% by March 2025. We are also expected to improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025. We should also increase the percentage of patients receiving a diagnostic test within 6 weeks towards the target of 95% by March 2025.

The guidance confirms that the 2024/25 payment system will continue with the activity-based payment model for planned elective activity. Integrated care boards (ICBs) and providers are expected to work together to meet the minimum 2.2% efficiency target and raise productivity levels.

Systems are expected to improve operational and clinical productivity and make best use of the opportunities provided by Getting It Right First Time (GIRFT), the Model Health System and other benchmarking and best practice guidance. Workforce productivity is expected to improve and as a result we should reduce agency spend as a percentage of the total pay bill. Systems should also release efficiency savings through reducing variation, optimising medicines value and complying with best value frameworks. Systems are also asked to develop action plans to improve workforce productivity, using a new tool to identify the rationale for increases in staffing since 2019/20, based on outcomes, safety, quality, or new service models. The full guidance and supporting documents are available on the NHSE website.

**Purdah guidance**: With local elections taking place in May and a general election due to take place before the end of 2025, NHS England Chief Strategy Officer Chris Hopson has written to chairs and chief executive officers across the NHS to remind us of the responsibilities of all colleagues of public bodies during pre-election periods. The pre-election period is designed to avoid the actions of public bodies distracting from or having influence on election campaign.

### Helipad opening

Our new helipad opened in April which thank you to a donation from the HELP appeal ensures we can continue to support Wiltshire Air Ambulance landings in a safe environment, we now have the additional of lights to allow night landings. This is a great development to ensure our rural population can access emergency care at hospitals in a timely way.

### Electronic Patient Record (EPR)

We are in mobilisation stage of planning for replacing our electronic patient record, recruitment into key roles has started and engagement across the organisation is in full mode. The benefits this will bring to both patient care and staff morale in the longer term will be significant.

## 2. Our People

### NHS Pay Matters

It was recently announced that the British Medical Association (BMA) had confirmed acceptance of a revised offer put forward by the government which brings an end to the recent strike action by consultants in England. The revised pay deal will modernise the consultant pay structure by reducing the number of pay points and the time it takes to reach the top. The shortened pay scale will improve inequalities by helping to reduce the gender pay gap in medicine.

The ongoing junior doctor dispute has not been concluded and whilst the BMA announced on 20 March that its junior doctor members have voted to extend their mandate for further industrial action, no details have yet been confirmed regarding any action. The results of the latest ballot provide the BMA with a mandate for both strike action, and a new mandate to take part in action short of strike.

The Hospital Consultants and Specialists Association (HCSA) has however announced a further ballot of its members expected to commence on 29 April to extend its mandate for industrial action in respect of the pay dispute over the pay of doctors-in-training, dentists-in training and locally employed doctors and dentists.

## 3 Our Partnerships

The ongoing financial pressures across the system and the organisation mean that we are forecasting a significant deficit as part of a system next year. This is despite planning to deliver over 5% of cost reductions / income generation through our transformation programme in year.

The real terms funding growth for the NHS for 2024/25 (£2.5bn) is less than 1%, the lowest annual growth for many decades. This is putting considerable strain on the financial forecasts of all organisations for the forthcoming year. Transformation of services, in partnership with health and care colleagues, in a planned, phased and integrated way is required to achieve cost reductions over the scales faced by the Trust and the system. The importance of system wide working, and the development of the local Health and Care Partnerships are fundamental to this.

An update to the work of the Acute Hospitals Alliance (AHA) is included as an appendix, we continue to prioritise a number of workstreams including the EPR. Conversations continue to happen as to how we can work more collaboratively to enact better outcomes for the wider BSW population.

We are continuing to plan for our hospital open day on Saturday 8th June 10.00-15.00 which gives the chance for members of our community to come and see more about what we do at the Trust. It was a great success last year we are hoping for an even greater turnout in June (and better weather!).

**Meeting of Board of Directors**

**Report Summary Sheet**

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| Report Title | Acute Hospital Alliance Briefing, February - April 2024. | | | | | Agenda item | | X |
| Date of meeting | May 2024 | | | | | | | |
| Purpose | Note<br>X | | Agree | | Inform | | Assure | |
| Author, contact for enquiries | Ben Irvine, Programme Director (ben.irvine@nhs.net) | | | | | | | |
| Appendices | Appendix 1. AHA Briefing | | | | | | | |
| This report was reviewed by | • Cara Charles-Barks, CEO RUH, Senior Responsible Owner<br>• Jon Westbrook Acting CEO GWH<br>• Lisa Thomas, Acting CEO SFT | | | | | | | |
| Executive summary | This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) between February and April 2024, as well as a description of priorities for the forthcoming period. The following areas are covered in the briefing:<br>1. Committees in Common, Programme Board & All Trust Executives Group activities<br>2. Programme Reset for 2024-2026 [Acute Sustainability, EPR, BSW Communities Together]<br>3. Governance Update<br>4. Programme Resources, Risks, Communications & Engagement<br><br>The next AHA Board briefing will be issued in June 2024.<br><br>For further information on the AHA Programme please contact Programme Director Ben Irvine (ben.irvine@nhs.net). | | | | | | | |
| Equality Impact Assessment | An AHA Programme Equality Impact Assessment [EIA] has been completed. The EIA is currently being refreshed and will be reviewed and updated regularly as the AHA Programme 2023-26 matures.<br><br>In relation to BSW Communities Together, the tender for Community Services has been the subject of an EIA. As the service model for BSW community services develops proposals will be brought to the AHA with EIAs included. | | | | | | | |
| Public and patient engagement | The AHA Programme Board approved a Communications and Engagement strategy in Q2 2023-24. A refreshed 2024-2025 Communications and Engagement strategy and delivery plan is in draft pending approval. | | | | | | | |

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| | Our AHA Clinical Strategy work is closely linked with the BSW Care Model which has been through a significant public engagement exercise. Service users will be involved in service design activities as the AHA Clinical Strategy is implemented.<br><br>EPR Patient Portal Development is planned as a phase 2 activity post initial go-live. The Trusts will engage via Healthwatch as this element of EPR is implemented. |
| **Recommendation(s)** | To note the AHA Briefing, February-April 2024. |
| **Risk (associated with the proposal / recommendation)** | High ☐ Medium ☐ Low X ☐ N/A ☐ |
| **Key risks** | The development of the BSW AHA is in line with national policy and strategic direction on provider collaboration. The AHA Programme Board, SRO and Programme Director identify and manage risks associated with programme delivery. |
| **Impact on quality** | The AHA maintains a strong focus on quality and patient safety and assumes continuous focus on quality improvement – the Improving Together Programme is one of the AHA's core activities. The AHA Clinical Strategy and Staffing Methodology workstreams are designed to improve clinical service effectiveness, patient experience, and quality. The corporate workstreams aim to deliver value for money, quality, and resilience of corporate services. |
| **Resource implications** | The programme leadership ensures balance in financial contributions between the three Trusts.<br><br>A cost centre has been established at GWH hosting the core AHA budget. |
| **Conflicts of interest** | None known. |
| **This report supports the delivery of the following BSW System Priorities:** | ☒ Improving the Health and Wellbeing of Our Population<br>☒ Developing Sustainable Communities<br>☒ Sustainable Secondary Care Services<br>☒ Transforming Care Across BSW<br>☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan |

Appendix One.

Acute Hospital Alliance, February-April 2024 Briefing

## Introduction

This briefing summarises the activities of the Acute Hospital Alliance (AHA) between February and April 2024, and priorities for the forthcoming period. The following contents are included:

1. Committees in Common, Programme Board & All Trust Executives Group Activities
2. Governance Updates
3. Programme Reset for 2024-2026
4. Delivery of Core Projects (Staffing Methodology)
5. Programme Resources, Risks and Forward Meeting Plan.

## Committees in Common & Programme Board Activities and All Trust Executives Group

- The **Committees in Common (CIC)** sets strategic direction for the AHA. At its meeting on 15th February CIC saw discussion on ***collaborative ambition for the next phase*** of the Programme. This meeting also approved the membership of the Joint Committee to oversee our single EPR Programme. On 13th March CIC members and ICB Chair Stephanie Elsy and CEO Sue Harriman held their latest quarterly meeting. The session focused on ***strategic alignment between AHA and ICB,*** in the context of BSW system financial position. On 19th March, CIC discussed the three main strands of the reset AHA Programme with sponsors and executive leads - Acute Sustainability, EPR Programme, and BSW Communities Together.
- The **AHA Programme Board** oversees programme delivery. The group met virtually on 22nd March, reviewing progress of each of the elements of the ***reset programme for 2024-2026***, as well as programme set-up, creating conditions for success - resources, governance arrangements, communications and engagement.
- The **All Trust Executives Group (ATEG)**, met on 23rd February, receiving a briefing by CEOs on the planned AHA programme reset. The group then held a discussion with leads from Health Innovation West of England (HIWE), regarding opportunities for collaborative work between AHA and HIWE. The ATEG team also convened on 5th March for a workshop focused on embedding Improving Together in the AHA.
- ***Executive Team Coaching Sessions.*** The AHA's executive coaching programme intended to support our collaborative development has continued. The planned coaching sessions with Professional Trios of Executive Leads are progressing with most trios meeting in February, March, or April. The latest of the larger-scale development sessions bringing together the three Executive Teams for an away day in Devizes was held on 19th March.

## 2.0 Governance Update

The period of this report, saw several governance developments related to the AHA and its work in the BSW system. These are listed briefly below:

1. **AHA SRO change**. In late January, Cara Charles-Barks, CEO, RUH, became SRO.
2. **Integrated Care Board Acute Partner Member**. At its meeting on 15th February 2024, the AHA CIC noted the formal nomination of Cara Charles-Barks, CEO RUH, and Acute Hospital Alliance SRO, as the acute sector partner member of the BSW Integrated Care Board.
3. **CEO Sponsor and Executive Lead roles refreshed** as part of Programme Reset. An **Acute Sustainability Programme Board** has been established. Additionally, to support the embedding of **Improving Together** methodology in the AHA, a Task and Finish Group has been established to develop a *Strategic Planning Framework (SPF) for the AHA* - due to be completed in June.
4. **EPR Joint-Committee establishment** has been confirmed following approval by Trust Boards in January Membership was approved by the CIC in February. The **first meeting is planned for 28th May**.
5. A **Digital Steering Committee** has been established to oversee the digital collaboration between the three Trusts, also involving ICB.
6. **Chair roles for key committees.** At the February CIC the following decisions regarding chairing roles were recorded: Chair CIC: Ian Green; Chair EPR Joint Committee: Liam Coleman; Chair Community Bid Joint Committee [if establishment approved by three Boards]: Alison Ryan.

## 3.0 Reset AHA Programme 2024-2026

We know that 2024-25-26 need to be years of action, delivered well and at pace with a focus on a small number of high impact changes. We're conscious of our BSW system's financial position and must use collective opportunities to work better and be more efficient, identifying those things we should not duplicate. Hence, our reset AHA programme has three major strands with three enabling elements. The following sections provide some detail on the three main programmes.

| *Main Programmes:* | *Enabling Elements* |
|---|---|
| 1. Acute Sustainability<br>2. EPR Implementation<br>3. BSW Communities Together | 1. Improving Together Methodology<br>2. Strategic Alignment bw AHA & ICB<br>3. Creating Conditions for Successful Delivery |

### *3.1 Acute Sustainability Programme: Corporate and Clinical Services Collaboration Development*

- *CEO Sponsor: Cara Charles-Barks. Executive Leads: Simon Wade, CFO, GWH; Melanie Whitfield, CPO, SFT; Andrew Hollowood, CMO, RUH.*
- *Objective:* The Acute Sustainability Programme has clinical and corporate service streams of work. Against the background of BSW and Trust financial position, latest national policy, available benchmarking, and best practice guidance, Executive Team professional leads have been asked to identify opportunities to work at scale to enhance service quality, user experience, career pathways and resilience, and improve efficiency and productivity.
- *Recent activities:* The following corporate services have continued developing their collaboration plans: People, Digital, Finance, Estates & Facilities, Capital Projects, Governance & Legal, Communications,

Research & Innovation, Strategy & Planning. Services have identified a significant range of opportunities for collaboration between the Trusts, yielding qualitative and quantitative benefits. Leads have also identified a range of areas for working at greater scale with other collaborative partners in BSW. Discussions with ICB leads on opportunities for collaborative working continued in February and March.

- *Next Steps.* A plan to accelerate AHA-BSW corporate collaboration at scale work is being developed by Executive leads and will be shared widely in May & June.

### *3.2 EPR Alignment Programme*

- *CEO Sponsor:* Jon Westbrook, GWH*; Executive Lead:* Roger Steadman.
- *Objective:* Procurement and deployment of a single EPR platform across the three acute hospitals within BSW. This will support optimisation of care and reduction of unwarranted variation. The Programme aims to improve clinical outcomes and efficiencies and raise digital maturity across the three Trusts.
- *Recent Activities:* The Full Business Case was approved by the NHSE team on 22nd March. Contracts were signed by all parties by 27th March, the associated EPR Collaboration Agreement also signed. Capital funding for 2023-24 has been secured by the Trusts. Implementation / transition stage preparation activities underway, including a series of recruitment fairs to stand up required team to support implementation. Detailed 'as is' process mapping has been completed.
- *Next Steps:* ***Governance and oversight arrangements for implementation phase*** have been developed and are due to be implemented in coming weeks. As reported above, the EPR Joint Committee will hold its first session on 28th May.

### *3.3 BSW Communities Together Response*

- *CEO Sponsor: Lisa Thomas, Trust leads:* C Thompson, J Foster, Laurence, Simon Sethi
- Tender exercise includes most community services across BSW. *Objectives*: to develop long-term sustainable transformation, driven collaboratively through place partners and utilising scale where appropriate. To enable integration opportunities that support our system to deliver improved outcomes for our population, places and neighbourhoods. To establish a dynamic and collaborative approach to community services delivery.
- *Recent Activities:* In February, March, April, the team has been focused on ITN1 stage bid delivery (17th April), including vision, structure, and priorities. Consideration is also being given to bid governance arrangements, risks, resourcing and mobilisation model, and organisational form.
- *Next steps:* Procurement process milestones are set out in table 1 below. There are two phases – first phase unscored, followed by negotiations; ITN2 in July will lead to award decision; 6 months mobilisation to April launch.
- *Governance arrangements for the next phase are in development.* By early May each Trust Board is anticipated to have made decision regarding adoption of a BSW Communities Together Joint Committee, with the specific remit for decision-making on the BSW Community Services bid.

Table 1. Community Services Tender Timelines.

| Stage | Dates |
|---|---|
| ITN1: Outline Proposals released to Bidders | 27/02/2024 |
| Deadline for submission of Bidder clarification questions (CQs) | 12:00 - 05/04/2024 |
| ITN1: Outline Proposals submission closing date | 12:00 - 17/04/2024 |
| Commissioner review of ITN1: Outline Proposals responses | 22/04/2024 to 20/05/2024 |
| Bidder invitations to Meetings | 20/05/2024 |
| Negotiation/feedback meetings on ITN1: Outline Proposals responses | 28/5/24 + 29/05/2024<br>4/6/24 + 05/06/2024<br>18/6/24 + 19/06/2024 |
| Bidder Presentation (prior to ITN2 release) | 03/07/2024 |
| ITN2: Final Bids released to Bidders | 10/07/2024 |
| Deadline for submission of Bidder clarification questions (CQs) | 12:00 - 17/07/2024 |
| ITN2: Final Bids submission closing date. | 12:00 - 25/07/2024 |
| Final Bids evaluation and governance | July/August 2024 |
| Formal award decision communicated to Bidders | September 2024 |
| 10-day standstill period | September/October 2024 |
| Contract mobilisation | October 2024 |
| Contract start | 1/4/25 |

## 4.0 Delivery of Core Projects – Staffing Methodology

Updates on the recent activities and next steps for the ***AHA Staffing Methodology programme*** follow. This stream of work will be incorporated into the new Acute Sustainability programme from May.

### *Staffing Methodology Programme*

- *Executive Leads: Toni Lynch, CNO RUH and Melanie Whitfield CPO in SFT.*
- *Objective:* Project aims to achieve safe staffing levels across the AHA supported by agreed principles and variance, informed by clarity on national standards; to identify best practice and innovation for adoption, encouraging new staff models designed to support delivery of the Clinical Strategy and BSW Care Model; in the context of BSW financial position; to outline a phased risk-based approach where unwarranted variation exists – informing annual planning rounds.
- *Recent Activities:* Leads for Nursing, Midwifery, Healthcare Scientists, Allied Health Professionals and Medical Staffing, are coordinating reviews of respective workforce groups. Initial drafts of reports on Emergency Department nursing staffing and Midwifery staffing across the three Trusts are expected to be completed in May. Reviews of outpatient nursing, neonates, obstetrics, and theatres staffing are planned for 2024-25. The review of Healthcare Scientist professions is planned to complete in Q2.

## 5.1 Programme Resources

The programme is funded by balanced contributions from the three Trusts. CEO sponsors and executive leads are in place for all priority activities. The executive leads for our clinical and corporate services transformation

programmes are working with the Programme Director to ensure sufficient support is available to drive improvements in 2024-2025.

### 5.2 Risks & Issues

A range of risks and issues continue to be managed by the programme team. A risk register is held centrally, risk management responses are reviewed monthly, with significant items being reported to CEOs, Programme Boards and Committees in Common. Availability of sufficient resource to deliver agreed priorities remains the most significant risk to the programme. No new significant risks have emerged in this reporting period.

### 5.4 Communications and Engagement Plan

To support delivery of the reset AHA Programme, a refreshed 2024-2026 A***HA Narrative, Communications and Engagement Strategy and Delivery Plan*** have been developed by programme communications lead Tim Edmonds (GWH).

### 5.3 AHA Forward Meeting Cycle

Table two below sets out the dates of our Committees in Common meetings, EPR Joint Committees, Programme Boards and Clinical Summits for 2024. A detailed meeting planner underpinning this table, provides a clear view of key decision points and milestones and is used by the Programme SRO, Programme Director and the Committees in Common Chair.

Table 2. 2023-2024-2025 Meeting Cycle: Key Dates

Acute Hospital Alliance

**AHA – 2024-2025 Key Meetings Table – For Board Awareness [22/04]**

| Key Meetings | Jan '24 | Feb '24 | March '24 | April '24 | May '24 | June '24 | July '24 | Aug '24 | Sep '24 | Oct '24 | Nov '24 | Dec '24 | Jan '25 | Feb '25 | March '25 | April '25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute Sust... Prog Board | 26th PB | 23rd ATE | 22nd PB | 26th *PB* | 24th PB | 28th *PB* | 26th PB | 23rd *PB* | 27th PB | 25th *PB* | 22nd PB | 20th *PB* | 24th PB | 28th *PB* | 28th PB | 25th *PB* |
| All Execs (f2f 3* PA)*** | | | | | *20th* | *28th* | | | *27th* | | *11th* | | *24th* | | *25th* | |
| Improving Together** WShops x 3/ CI. Summits | | | IT. No 1 05/03 | CI Summit 22nd | | IT. No 2 7th | | | CI Summit 24th | IT. No 3 14th | | | | | | CI Summit TBC |
| CIC | | 15th | | 19th | | 21st | | 16th | | 18th | | 13th | | TBC | | TBC |
| CIC planning | 5th | 2nd | 1st | 5th | 3rd | 7th | 5th | 2nd | 6th | 4th | 1st | 6th | 3rd | 7th | 7th | 4th |
| CIC-ICB 4ly | 30th | | 13th | 30th | | | 30th | | | 29th | | | TBC | | | TBC |
| *BSW Communities - Approvals* | | | | WShop2 2nd | TBC | | TBC | | TBC | | TBC | | TBC | | TBC | |
| *EPR Joint Committee* | | | | | 28 | | 29 | | 30 | | 29 | | 29 | | 24 | May 30 |
| Trust Boards | G: 11th S: 11th R: 10th | G: 1st S:22nd R: 7th | G: 7th S: 7th R: 6th | G: 4th S: 4th R: 3rd | G: 2nd S: 2nd R: 1st | G: 6th S: 20th R: 5th | G: 4th S: 4th R: 3rd | G: 1st S: 8th R: NA | G: 5th S: 5th R: 4th | G: 3rd S: 3rd R: 2nd | G: 7th S: 7th R: 6th | G: 5th S: 5th R: 4th | TBC | TBC | TBC | TBC |
| ICB Board: | 10th | NA | 28th | 17th | 15th | 19th | 18th | 21st | 19th | 16th | 21st | 18th | 23rd | NA | 20th | TBC |

Acute Provider Collaborative in Bath and North East Somerset, Swindon and Wiltshire

Finally, the next AHA Board briefing will be issued in June 2024.

*Close*

*Drafted by Programme Director, Ben Irvine*

*24th April 2024*

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 2.1 |
| Date of meeting: | 2 May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Constitution Annual Review 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | ✓ | | ✓ |
| Approval Process: (where has this paper been reviewed and approved): | | | | |
| Prepared by: | Kylie Nye, Head of Corporate Governance | | | |
| Executive Sponsor: (presenting) | Fiona McNeight, Director of Integrated Governance | | | |

## Recommendation:

The Trust Board is asked to consider and support the amendments to the constitution.

## Executive Summary:

The constitution is reviewed and approved by the Trust Board and Council of Governors on an annual basis. After a review by the governance team, the following amendments have been made:

- Updating Paragraph 1 to reflect the Health and Social Care Act 2022.
- Paragraph 4 - Powers updated to recognise joint committees and the 2006 Act (revised 2022).
- Paragraph 4.5 added as specified in the Health and Care Act 2022.
- Paragraph 17 updated to recognise joint committees.
- Annex 4 updated to reflect changes to 'partnership organisations' in relation to Appointed Governors.
- Annex 8, paragraph 5.9 added to reflect the establishment of Joint Committees and Committee-in Common.

As part of the above changes described above and highlighted on page 25, there is a proposed change to the number of 'partnership organisations' included under the Appointed Governors section. Appointed Governors are representatives of organisations with whom NHS Foundation Trusts have a strong relationship. The Trust has not been able to recruit 6 Appointed Governors in a number of years. Whilst we consistently have a representative from Wiltshire Council and from the military on the Council, other positions have not been filled for some time. Therefore, the proposal is to remove the three Integrated Care Boards (ICBs) from the list and have three partnership organisations to include the military. The other two partnership organisations are to be decided but will have to be approved by the Board and Council of Governors (to align with the NHS Act 2006 - schedule 7).

The updates used to recognise joint committees reflects the same wording used in Great Western Hospitals NHS Foundation Trust (GWH) as they have recently reviewed their constitution.

| 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:** | April 2024 |
| **Approved by:** | Council of Governor's/ Trust Board |
| **Date Approved:** | |
| **Next Due for Revision:** | April 2025 |
| **Date Policy Becomes Live:** | |

| Version No. | Updated By | Updated On | Description of Changes |
|---|---|---|---|
| 1.0 | Director of Corporate Governance | See amendment history below | |
| 1.1 | Director of Corporate Governance | April 2020 | Annex 9 Updated |
| 2.0 | Director of Corporate Governance | October 2020 | Complete revision |
| 2.1 | Corporate Governance Manager/ Membership Manager | December 2020 | Further amendments as per amendment history below agreed at CoG. |
| 2.2 | Head of Corporate Governance | January 2022 | Small amendments to wording to provide consistency in document |
| 2.3 | Head of Corporate Governance | March 2022 | Further small amendments following CoG. |
| 2.4 | Head of Corporate Governance / Membership Manager | January/ February 2023 | Amendments to NED terms of office, nominated governor categories and nominations Committee composition and Annex 4 |
| 2.5 | Head of Corporate Governance | April 2024 | Annual Review - Further amendments reflected in amendment history 2024. |

**CONTENTS:**

**Annex:**



**Amendment history – 2013 to 2023**

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

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

- **2023**
  - Minor formatting updates.
  - Item 32.3 updated to reflect NED terms of office (2 x 3-year terms plus 1 x 2-year term).
  - Annex 4 – Composition of the Appointed Governors updated to reflect the distinction between local authority and partnership organisations.
  - Annex 7 – Item 11.3 updated to include 'external stakeholder' in the composition of future Nominations Committees.
- **2024**
  - Updating para 1 to reflect the Health and Social Care Act 2022.
  - Para 4 – Powers updated to recognise joint committees and the 2006 Act (revised 2022).
  - Para 4.5 added as specified in the Health and Care Act 2022.
  - Para 17 updated to recognise joint committees.
  - Annex 4 updated to reflect changes to 'partnership organisations' in relation to Appointed Governors.
  - Annex 8, para 5.9 added to reflect the establishment of Joint Committees and Committee-in Common.

## 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 and the Health and Social Care Act 2022.

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 The Health and Care Act 2022 has merged "Monitor" and the Trust Development Authority (TDA) into NHS England and removed legal barriers to collaboration and integrated care, ensuring providers adopt greater responsibility for service planning and putting Integrated Care Systems (ICSs) on a statutory footing. ~~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.

4.4 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S5 65Z6 of the 2006 Act.

4.5 In exercising its powers, the Trust will have regard to:

- S.63A of the 2006 Act (revised 2022) (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim";
- 3.7.2 S.63B of the 2006 Act (revised 2022) (duties in relation to climate change).

## Membership and Constituencies

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

4.4.14.5.1 A public constituency

4.4.24.5.2 A staff constituency

## Application for Membership

4.54.6 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.

## 5 Public Constituencies

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

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

5.3 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.

5.4 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.

## 6 Staff Constituencies

6.1 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:

**6.1.1** They are 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

**6.1.2** They have been continuously employed by the Trust under a contract of employment for at least 12 months.

6.2 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.

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

6.4 The Staff Constituency shall be divided into 5 classes of individuals as set out in Annex 2

6.5 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.

## 7 Automatic Membership by default – Staff

7.1 An individual who is:

**7.1.1** Eligible under paragraph 8.1 to become a member of the Staff Constituency, and

**7.1.2** 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.

## 8 Patients' Constituency

There is no Patients' Constituency

## 9 Restrictions on Membership

9.1 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.

9.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any other constituency.

9.3 An individual must be at least 16 years old to become a member of the Trust.

9.4 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.

9.5 A member of the Trust shall inform the Secretary of the Trust of any circumstances which may affect their entitlement to be a member.

9.6 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.

9.7 A member may resign by written notice to the Secretary of the Trust.

## 10 Annual Members' Meeting

10.1 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.

## 11 Council of Governors - Composition

11.1 The Trust is to have a Council of Governors comprising both elected and appointed governors.

11.2 The composition of the Council of Governors is specified in Annex 4.

11.3 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.

11.4 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.

## 12 Council of Governors – Election of Governors

12.1 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.

12.2 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.

12.3 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).

12.4 An election, if contested, shall be by secret ballot.

12.5 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.

## 13 Council of Governors - Tenure

13.1 Subject to 14.5 and 15.2, an elected governor may hold office for a period of up to three years.

13.2 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 nine years in all.

13.3 An appointed governor may hold office for a period of up to three years and may then be re-appointed but shall not hold office for more than nine years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

13.4 A governor may resign by giving notice in writing to the Chair of the Trust.

13.5 In the event of an appointed governor ceasing to hold office, the body appointing him may make a further appointment.

13.6 The limits of nine years in sub-paragraphs 15.2 and 15.3 shall in the case of an elected governor include any time served as an appointed governor, and in the case of an appointed governor include any time served as an elected governor.

## 14 Council of Governors – Disqualification and Termination of Office

14.1 The following may not stand for election or continue as a member of the Council of Governors:

**14.1.1** a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

**14.1.2** 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;

**14.1.3** 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;

**14.1.4** The further persons set out in Annex 6.

14.2 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.

14.3 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:

**14.3.1** the failure was in their opinion due to a reasonable cause or causes, and

**14.3.2** he will be able to, and will, start attending meetings of the Council within such period as they consider reasonable.

14.4 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:

**14.4.1** 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

**14.4.2** 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.

14.5 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.

14.6 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.

14.7 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.

14.8 If a governor who is an employee of the Trust is suspended as an employee as a part of a disciplinary process, the Chair of the Trust may suspend the governor from acting as a governor while the governor remains suspended as an employee.

## 15 Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

15.1 The general duties of the Council of Governors are–

**15.1.1** to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

**15.1.2** to represent the interests of the members of the Trust as a whole and the interests of the public.

15.2 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.

15.3 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.

## 16 Council of Governors – Meetings of Governors

16.1 The Chair of the Trust, that is the Chair of the Board of Directors, or in his absence, the Deputy Chair or, in his absence, the Lead Governor (or Deputy Lead Governor), shall preside at meetings of the Council of Governors.

16.2 Where it is inappropriate by reason of the subject matter of a meeting that it should be chaired by the Chair, the Deputy Chair may preside unless it is also inappropriate that the Deputy Chair preside, in which case the Lead Governor or in his absence the Deputy Lead Governor may preside.

16.3 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.

16.4 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.

16.5 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.

16.6 For the purpose of obtaining information about the Trust's performance of its functions or the ~~directors~~director's 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.

16.7 The Council of Governors may appoint committees consisting wholly ot partly of its members to assist it in carrying out its functions ~~will establish statutory committees to carry out such functions~~ as are required by law and to carry out such functions as the Council specifies.

16.8 The Council of Governors may appoint members to serve on joint committees with the Board of Directors of committees thereof.

16.9 The Council of Governors will establish working groups to carry out such functions as the Council specifies.

16.10 These committees, sub-committees or joint committees may call upon outside advisers to help them in their tasks, provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph will be determined in accordance with para 44 (Dispute Resolution).

## 17 Council of Governors – Standing Orders

17.1 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.

## 18 Council of Governors – Referral to the Panel

18.1 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 –

**18.1.1** to act in accordance with its constitution, or

**18.1.2** to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

18.2 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.

## 19 Council of Governors – Conflicts of Interest of Governors

19.1 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 they~~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.

19.2 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.

## 20 Council of Governors – Travel Expenses

20.1 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.

## 21 Board of Directors – Composition

21.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

21.2 The Board of Directors is to comprise:

**21.2.1** a non-executive Chair

**21.2.2** a maximum of 7 other non-executive directors

**21.2.3** a maximum of 6 executive directors (subject to 23.4 below), to include:

**21.2.4** a Chief Executive who shall be the Accounting officer,

**21.2.5** a Finance Director.

21.3 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.

21.4 The number of non-executive directors including the Chair must always exceed the number of executive directors. At any meeting where there is parity of non-executive and executive directors the Chair, or in his absence the Deputy Chair, shall have a casting vote.

21.5 Only a member of a public constituency or the patients' constituency is eligible for appointment as a non-executive Director.

## 22 Board of Directors – General Duty

22.1 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.

## 23 Board of Directors – Appointment and Removal of Chair and Non-executive Directors

23.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other non-executive directors.

23.2 Removal of the Chair or any other non-executive director shall require the approval of 75% of the members of the Council of Governors.

23.3 The Standing Orders of the Council shall provide for nomination committees to identify appropriate candidates for appointment as Chair and as non-executive directors.

## 24 Board of Directors – Deputy Chair

24.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chair. The Deputy Chair 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.

## 25 Board of Directors – Appointment and Removal of the Chief Executive and Executive Directors

25.1 The non-executive directors shall appoint or remove the Chief Executive.

25.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

25.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

## 26 Board of Directors – Disqualification

26.1 The following may not be appointed or continue as a member of the Board of Directors:

**26.1.1** a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

**26.1.2** 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;

**26.1.3** 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.

**26.1.4** The persons referred in Annex 9.

## 27 Board of Directors – Meetings

27.1 Before holding a meeting the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

27.2 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.

27.3 Meetings of the Board of Directors shall be open to members of the public.

27.4 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

## 28 Board of Directors – Standing Orders

28.1 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.

## 29 Board of Directors – Conflicts of Interest of Directors

29.1 The duties that a director of the Trust has by virtue of being a director include in particular–

**29.1.1** 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;

**29.1.2** 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.

29.2 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.

29.3 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.

29.4 In sub-paragraph 31.1.2 'third party' means a person other than the Trust or a person acting on its behalf.

29.5 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.

29.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

29.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

29.8 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.

29.9 A director need not declare an interest –

**29.9.1** if it cannot be reasonably regarded as likely to give rise to a conflict of interest;

**29.9.2** if, or to the extent that, the directors are already aware of it;

**29.9.3** 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.

## 30 Board of Directors – Remuneration and Terms of Office

30.1 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 Chair and the other non-executive directors.

30.2 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.

30.3 The Chair and other non-executive directors may be appointed for an initial term of up to three years, which may be renewed by the Council for a further term of up to three years, and may be renewed thereafter for a two year term, which will bring the total length of service to eight years. Where a director has served eight years, his appointment may be renewed for a further one year provided that exceptional circumstances exist in relation to the renewal.

## 31 Registers

31.1 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.

31.2 a register of members of the Council of Governors;

31.3 a register of interests of Governors;

31.4 a register of interests of directors;

31.5 and a register of directors.

## 32 Registers – Inspection and Copies

32.1 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.

32.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

**32.2.1** any member of the Rest of England Constituency; or

**32.2.2** any other member of the Trust, if the member so requests.

32.3 So far as the registers are required to be made available:

**32.3.1** They are to be available for inspection free of charge at all reasonable times; and

**32.3.2** A person who requests a copy or extract from the registers is to be provided with a copy or extract.

32.4 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.

## 33 Documents Available for Public Inspection

33.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

**33.1.1** A copy of the current constitution;

**33.1.2** A copy of the latest annual accounts and of any report of the auditor on them; and

**33.1.3** A copy of the latest annual report

33.2 The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:

**33.2.1** 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;

**33.2.2** A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

**33.2.3** A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act;

**33.2.4** A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

**33.2.5** A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

**33.2.6** 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;

**33.2.7** A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

**33.2.8** A copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

**33.2.9** 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;

**33.2.10** A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

33.3 Any person who requests a copy or extract from any of the above documents is to be provided with a copy.

33.4 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.

## 34 Auditor

34.1 The Trust shall have an auditor.

34.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council.

34.3 The auditor must be qualified to act as auditor in accordance with paragraph 23 of schedule 7 to the 2006 Act.

34.4 The auditor shall comply with schedule 10 of the 2006 Act and shall have the rights and powers there set out.

34.5 The Trust shall provide the auditor with every facility and all information which he may reasonably require for the purpose of his functions.

## 35 Audit Committee

35.1 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.

## 36 Accounts

36.1 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.

36.2 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.

36.3 The accounts are to be audited by the Trust's auditor.

36.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

**36.4.1** the accounts;

**36.4.2** the records relating to them; and

**36.4.3** any report of the Auditor on them

36.5 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.

36.6 NHS Improvement may with the approval of the Secretary of State for Health direct the Trust:

**36.6.1** to prepare accounts in respect of such period or periods as may be specified in the direction; and/or

**36.6.2** 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.

36.7 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:

**36.7.1** the methods and principles according to which the annual accounts are to be prepared; and/or

**36.7.2** the content and form of the annual accounts

36.8 The Trust must –

**36.8.1** lay a copy of the annual accounts, and any report of the Auditor on them, before Parliament; and

**36.8.2** 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

36.9 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.

36.10 The functions of the Trust referred to in this paragraph 38 shall be delegated to the accounting officer.

## 37 Annual Report, Forward Plans and Non-NHS work

37.1 The Trust shall prepare an annual report and send it to NHS Improvement.

37.2 The annual report must give:

**37.2.1** 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

**37.2.2** 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

**37.2.3** 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

**37.2.4** information on the remuneration of the directors and on the expenses of the governors and the directors

**37.2.5** any other information that NHS Improvement or requires

37.3 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement

37.4 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

37.5 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.

37.6 Each forward plan must include information about:

**37.6.1** 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

**37.6.2** the income it expects to receive from doing so

37.7 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:

**37.7.1** 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

**37.7.2** notify the directors of the Trust of its determination

37.8 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.

## 38 Presentation of the Annual Accounts and Reports to the Governors and Members

38.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council:

**38.1.1** the annual accounts

**38.1.2** any report of the auditor on them

**38.1.3** the annual report.

38.2 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.

38.3 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.

## 39 Instruments

39.1 The Trust shall have a seal.

39.2 The seal shall not be affixed except under the authority of the Board of Directors

## 40 Amendment of the Constitution

40.1 The Trust may make amendments of its constitution only if –

**40.1.1** more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

**40.1.2** more than half of the members of the Board of Directors of the Trust voting approve the amendments

40.2 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.

40.3 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) –

**40.3.1** at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

**40.3.2** the Trust must give the members an opportunity to vote on whether they approve the amendment

40.4 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.

40.5 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.

## 41 Mergers etc. and Significant Transactions

41.1 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.

41.2 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.

41.3 A 'significant transaction' is a transaction which, if entered into by the Trust:

**41.3.1** 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;

**41.3.2** 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

**41.3.3** 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

**41.3.4** 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;

**41.3.5** would be likely to put at risk the Trust's ability to maintain the minimum required financial risk rating/ continuity of service risk rating

**41.3.6** 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

**41.3.7** 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

41.4 In deciding whether to approve a proposed significant transaction the Council will:

**41.4.1** act in accordance with its judgment of the best interests of the Trust; and

**41.4.2** 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

41.5 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.

41.6 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.

## 42 Indemnity

42.1 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.

## 43 Dispute Resolution

43.1 In the event of a dispute arising between the Board of Directors and the Council, the Chair shall take the advice of the Secretary and such other advice as he sees fit, and he shall confer with the Vice-Chair and the Lead Governor and shall seek to resolve the dispute.

43.2 If the Chair 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.

43.3 If the dispute is not resolved, the Chair 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:<br><br>▪ Beacon<br>▪ Blandford<br>▪ Cranborne Chase<br>▪ Gillingham<br>▪ Hill Forts & Upper Tarrants<br>▪ Shaftesbury Town<br>▪ Stalbridge & Marnhull (Marnhull parish)<br>▪ Sturminster Newton |
| Kennet | The area formerly covered by Kennet District Council comprising the following electoral wards:<br><br>• Bromham, Rowde & Potterne<br>• Devizes East<br>• Devizes North<br>• Devizes & Roundway South<br>• Ludgershall & Perham Down<br>• Pewsey<br>• Pewsey Vale<br>• Roundway<br>• Summerham & Seend<br>• The Lavingtons & Erlestoke<br>• The Collingbournes & Netheravon<br>• Tidworth<br>• Urchfont & The Cannings |

| | |
|---|---|
| New Forest | The following electoral wards within New Forest District Council:<br><br>▪ Downlands & Forest<br>▪ Fordingbridge<br>▪ Forest Northwest<br>▪ Ringwood East & Sopley<br>▪ Ringwood North<br>▪ Ringwood South |
| Salisbury City | The following electoral wards formerly covered by Salisbury District Council:<br><br>• Salisbury Bemerton<br>• Salisbury Fisherton & Bemerton Village<br>• Salisbury Harnham<br>• Salisbury St. Edmund's & Milford<br>• Salisbury St. Francis & Stratford<br>• Salisbury St. Marks & Bishopdown<br>• Salisbury St. Martin's & Cathedral<br>• Salisbury St. Paul's |
| South Wiltshire Rural | The following electoral wards<br><br>• Alderbury & Whiteparish<br>• Amesbury East<br>• Amesbury West<br>• Bourne & Woodford Valley<br>• Bulford, Allington & Figheldean<br>• Downton & Ebble Valley<br>• Durrington & Larkhill<br>• Ethandune<br>• Fovant & Chalke Valley<br>• Laverstock, Ford & Old Sarum<br>• Mere<br>• Nadder & East Knoyle<br>• Redlynch & Landford<br>• Till & Wylye Valley<br>• Tisbury<br>• Warminster Broadway<br>• Warminster Copheap & Wylye<br>• Warminster East<br>• Warminster West<br>• Warminster Without<br>• Westbury East<br>• Westbury North<br>• Westbury West<br>• Wilton & Lower Wylye Valley<br>• Winterslow |

| | |
|---|---|
| East Dorset | The following electoral wards within the area formerly covered by East Dorset District Council:<br><br>• Cranborne & Alderholt<br>• St. Leonards & St. Ives<br>• Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes<br>• Verwood<br>• 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<br>Health Care Assistants (Nursing) |
| **Scientific, Therapeutic and Technical Staff** | Occupational Therapists and Helpers<br>Orthoptists<br>Physiotherapists and Helpers<br>Art/Music/Drama Therapists<br>Speech and Language Therapists and Helpers<br>Psychologists and Psychology Technicians<br>Psychotherapists<br>Medical Physicists and Technicians<br>Pharmacists and Pharmacy Technicians<br>Dental Technicians<br>Operating Department Practitioners<br>Social Workers<br>Chaplains<br>Clinical Scientists<br>Biomedical Scientists and Technical Staff<br>Geneticists and Technicians<br>Audiology Staff<br>Cardiographers and Support Staff |
| **Administrative, Facilities and Managerial Staff** | Ancillary Staff<br>Works and Maintenance Staff<br>Ambulance Staff |
| **Voluntary Staff** | |

1. The minimum number of members of each class shall be 10.
2. The Secretary to the Trust shall assign persons to the classes set out above in accordance with the groups set out by each. In case of any difficulty the Secretary shall have discretion to allocate the person to the class which is in his opinion the most appropriate.
3. The Secretary shall maintain a register of volunteer schemes designated for the purposes of membership of the Trust.
4. A volunteer is a person who carries out functions on behalf of the Trust on a voluntary basis under a scheme on the register referred to in paragraph 4 above.
5. Where a person is eligible to be included both in the volunteers class and another class, the Secretary shall assign the person to that other class.

## ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

## ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

**Public Governors**

**1.** There shall be 15 public governors as set out in Annex 1.

**Staff Governors**

**2.** There shall be 5 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.

**Appointed Governors**

**3.** There shall be 46 appointed governors:

**Local Authority**

**3.1.** As stated in paragraph 9(4) of the Schedule 7 of the 2006 Act, Wiltshire Council may appoint one governor by notice in writing to the chair, signed by the senior executive of the Council. For the avoidance of doubt, the person appointed shall be a councillor of Wiltshire Council.

**Partnership Organisations**

**3.2.** There shall be ~~five~~ three partnership organisations (or successor organisations) who may appoint one governor by notice in writing, signed by the chief executive (or equivalent) of that organisation and delivered to the chair. These partnership organisations are decided by the Board of Directors and Council of Governors. There is currently one partnership organisation as detailed below. The other vacant partnership organisations positions are currently under review.

**3.2.1.** ~~There shall be one governor appointed by Wessex Community Action~~.

3.2.1. There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests.

~~**3.2.2.** Bath and North-East Somerset, Swindon, and Wiltshire (BSW) Integrated Care Board~~

~~**3.2.3.** NHS Dorset Integrated Care Board~~

~~**3.2.4.** Hampshire and Isle of Wight Integrated Care Board~~

## ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

**PART 1: INTERPRETATION**

1. Interpretation

**PART 2: TIMETABLE FOR ELECTION**

2. Timetable
3. Computation of time

**PART 3: RETURNING OFFICER**

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

**PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS**

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

**PART 5: CONTESTED ELECTIONS**

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

*Action to be taken before the poll*

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

*The poll*

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information

**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**

## 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**

## 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 inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote

(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

**PART 6: COUNTING THE VOTES**

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## 41. -[NOT USED]

## 42. Arrangements for counting of the votes

**42.1** The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

**42.2** The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

## 43. The count

**43.1** The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

**43.2** The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

**43.3** The returning officer is to proceed continuously with counting the votes as far as is practicable.

## PP44. Rejected ballot papers and rejected text voting records

**FPP44.1** Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

**FPP44.2** Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

**FPP44.3** A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

**FPP44.4** The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

**FPP44.5** The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

**FPP44.6** Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

**FPP44.7** Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

**FPP448** A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

**FPP44.9** The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

**FPP44.10** The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

## [PARAGRAPHS 45-50 NOT USED]

## FPP51. Equality of votes

**FPP51.1** Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

**PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS**

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## 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 Chair of the NHS Trust, or
  (ii) in any other case, to the Chair 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 Chair 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 Chair 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 Chair 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, Chair 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 Chair) of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two governorships or directorship and governorship;
4. A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected;
5. A person who occupies the same household as an existing governor or a director of the Trust;
6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election, or becomes employed by the Trust;
4. A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor.

## ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(See paragraph 19)

**CONTENTS**

## 1. Introduction

1.1 Paragraph 14 of Schedule 7 to the National Health Service Act 2006 provides that the constitution of an NHS foundation trust must make provision for the practice and procedure of the Council of Governors. The Council made such provision in its standing orders adopted in 2006. Paragraph 3.13 of those orders provided that they might be amended as there set out. At a meeting of the Council on 25 February 2013 in accordance with paragraph 3.13, these standing orders as set out herein were adopted in substitution of those orders.

## 2. Interpretation

2.1 The expressions and terms used herein shall have the same meaning as in the Trust's Constitution.

2.2 'The Constitution' means the constitution of the Trust.

2.3 'The Council' means the Council of Governors.

2.4 A 'motion' means a formal proposition to be considered and voted on at a meeting of the Council.

2.5 An 'item for the agenda' means a matter to be considered at a meeting of the Council.

2.6 'The Secretary' means the person appointed as the Secretary to the Trust.

## 3. Meetings of the Council

3.1 Paragraph 18.3 of the Constitution provides that meetings of the Council shall be open to members of the public but that the public may be excluded as there set out.

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chair 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 Chair 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 Chair 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 Chair 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 Chair 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 Chair of the meeting.

4.8 Save where the Chair 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 Chair 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 Chair 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 Chair 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 Chair 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 Chair 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 Chair, 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
- 1 external stakeholder

11.3 For the appointment of non-executive directors, the Nominations Committee shall consist of:

- the Chair (or, at the Chair's request the Deputy Chair)
- 2 public governors
- 1 staff governor
- 1 appointed governor
- the Chief Executive
- 1 external stakeholder

11.4 When the formation of a Nomination committee is required the Secretary shall:

11.4.1 ask governors to put themselves forward as members within 10 days of his request, and if more governors put themselves forward than are places for particular categories of governor shall conduct an election or elections for each category with each governor having one vote in respect of each governor place on the committee.

11.4.2 In the case of a nomination for Chair 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 Chair 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 Chair or the Deputy Chair;
- 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 Chair;
- 17.1.3 to communicate regularly with the Chair, 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 Chair;
- 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 Chair, the Chair 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 Chair 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 Chair 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 Chair. 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 Chair, 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 Chair;

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 Chair 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.

### 5.9 Joint Committees

Joint committees may be established by the Trust, by joining together with one or more other trusts, consisting of wholly or partly of the Chair and Directors of the Trust or other health service bodies, or of Directors of the Trust with non-directors of other health bodies in question.

Any Committee-in-Common or Joint Committee established under standing orders may, subject to such directions or guidance as may be given by NHS England or the Trust or any other health bodies in question, appoint sub-committees consisting wholly or partly of directors sitting on the Committee or Joint Committee (whether or not they are directors of the other health bodies in question) or wholly of persons who are not directors of the other health bodies in question provided that the Trust is always represented by an Executive Director (or deputy nominated by the Executive Director) on such Committees, Joint Committees or sub committees.

# 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 or joint 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 AND SIGNATURE 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, Chair or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the Chair) 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.

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 2.2 |
| Date of meeting: | 2 May 2024 | | |

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|---|---|---|---|---|
| Report tile: | 2024 Annual Review of Directors Interests | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | ✓ | | | ✓ |
| Approval Process: (where has this paper been reviewed and approved): | | | | |
| Prepared by: | Kylie Nye, Head of Corporate Governance | | | |
| Executive Sponsor: (presenting) | Fiona McNeight, Director of Integrated Governance | | | |
| Appendices (list if applicable): | Annual Register of Interests (Directors and all band 8d and above or equivalent staff) | | | |

## Recommendation:

To review, note and approve the annual Register of Interests as of April 2024.

## Executive Summary:

There is a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. In 2020 it was agreed that the annual requirement would extend to all decision-making staff, described as those at band 8d and above or equivalent.

The corporate governance team have reviewed any positive declaration and any agreed action is documented on the register. The Senior Independent Director has also had sight of the register of interests. No concerns have been raised as part of this process.

A proactive review of the Declaration of Interests processes in 2023 by the Trust's Counter Fraud specialists at KPMG identified several recommendations to improve compliance and to improve how the Trust utilises this data effectively.

In 2021/22, improvements made on the previous process resulted in an improved compliance rate of 60%. In 2022/23 the Trust achieved 53% compliance, rated as amber. There is no recommended threshold to move compliance to a green rating. However, there is a suggested compliance level of 80% to achieve this. Ongoing actions to improve compliance have been put in place and are discussed and reviewed at the Audit Committee. This year the return rate (as of 22nd April 2024) is **71.5%** (a 18.5% increase on the previous year). Those who haven't responded have been contacted individually and this has yielded an improved response to previous years.

Compliance with this process is reported as part of the Counter Fraud Annual Risk Assessment submission. An update on the actions set by our Local Counter Fraud Specialist will report to the Audit Committee in June. As part of these actions, it was suggested that all procurement staff should have to declare on an annual basis. This has been trialled for this year's process and has had a positive response.

Salisbury NHS Foundation Trust

This report has historically included the Fit and Proper Persons return. Due to the new requirements around FPPT, this will be completed later in the year, with a report submitted to Board to align with the requirement for the chair's submission to NHSE.

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

# Salisbury NHS Foundation Trust Register of Interests 2023/24

**Includes: All decision making staff, agenda for change band 8D and above or equivalent.**

| Name | Job Title | Company | Position | Action / Notes |
|---|---|---|---|---|
| Greg Pearson | Gynacology Consultant | Wessex Gynacology and Wellbeing | Director | No action - signed by department lead |
| | | N/A | Partner works at the Trust | No Action |
| Serap Mellor | Consultant Surgeon | Dermahealth LTD | Director / Owner | No action - signed by department lead |
| | | New Hall | Private Practice | No action - signed by department lead |
| Ian Crowley | Deputy Chief People Officer | Nil return | Nil return | No action - signed by department lead |
| Anna Aertssen | Consultant Surgeon | Nil return | Nil return | Nil return |
| Catherine Thompson | Consultant in Respiratory Medicine | Nil return | Nil return | Nil return |
| Gurdip Shergill | Orthopaedic Consultant | Shergill Orthopaedics Ltd | Director | no action |
| | | New Hall | Private Practice | no action |
| Natalia Roszkowski | Consultant Radiologist | Nil return | Nil return | Nil return |
| Russell Mellor | Consultant Elderly Medicine | Nil return | Nil return | Nil return |
| Rob Ritchie | Consult Urologist | Nil return | Nil return | Nil return |
| Emma Halliwell | Director of Medical Education and Consultant Anaesthetist | Nil return | Nil return | Nil return |
| Claire Page | Consultant | HEE Wessex | Educational facilitator | no action |
| G Richard Smith | Consultant Rheumatology | Dr G R Smith Ltd | Co-director | no action |
| | | Salisbury OPL | Consultant Rheumatologist | no action |
| | | SIMP Salisbury | Consultant Rheumatologist | no action |
| | | KEMH (Falklands) | Visiting Consultant | no action |
| Sergio Nabais De Araujo | Consultant Cardiologist | Daichi Sankyo | Speaker fees | no action |
| | | TMLEP | Medico legal expert | no action |
| | | Self employed private practice | Cardiologist | no action |
| Richard Harrison | Consultant | Ambu | un-remunerated connection | no action |
| | | N/A | Son works for KP Health | No action - signed by department lead |
| Robert Padwick | Consultant Colorectal and General Surgeon | Nil return | Nil return | no action |
| Tracey Farnon | Consultant Paedatarician | Nil return | Nil return | No action - signed by department lead |
| Graham Lloyd-Jones | Consultant Radiologist | Radiology Masterclass Ltd | Director | no action |
| | | FDI World Dental Federation | Advisor | no action |
| Ian Robinson | Head of Facilities | nil return | nil return | nil return |
| Sebastian Gray | Paediatric Consultant | BSW ICS | CYP Asthma Lead | No action - signed by department lead |
| Damian James Mayo | Consultant General Surgeon | New Hall | Consultant | no action |
| Richard Cole | Consultant Plastic Surgeon | Nil return | Nil return | no action |
| Stephen Veitch | Consultant Orthopaedic Surgeon | SW Veitch Orthopaedics Ltd | Director | nil return |
| Michael Hughes | Consultant Radiologist | University Hospital Southampton | Radiologist | no action |
| Laura Findlay | Consultant UGI ang General Surgeon | Nil return | Nil return | nil return |
| Alistair Morton | Consultant Oral Surgeon | | Nil return | nil return |
| James Brewin | Urology Consultant | | Director | no action |
| | | New Hall | Consultant | signed by department lead |
| Alastair Raynes | Chief Pharmacist | Nil return | Nil return | no action |
| Effie Grand | Consultant Haematologist | Nil return | Nil return | no action |
| Elisa Porretta | Consultant in Stroke Medicine | Nil return | Nil return | no action |
| Jonathan Arnott | Consultant Radiologist | New Hall | Consultant | no action |
| Jonathan Quayle | Consultant Orthopaedic Surgeon | New Hall | Independent practitioner | no action |
| James Barr | Consultant Anaesthetist | New Hall | Anaesthetist | no action |
| John O'Keeffe | Head of Estates | Nil return | Nil return | No action - signed by department lead |
| Katherine Backhouse | Consultant Obstetrian and Gynnaecologist | Nil return | Nil return | no action |
| Peta Coulson-Smith | Locum Consultant Paediatrician | University of Southampton | Principal Teaching Fellow | no action |
| Stuart Henderson | Consultant Physician | Nil return | Nil return | no action |
| Sarah Needle | Divisional Director of Operations, Medicine | Nil return | Nil return | no action |
| Ben Siggers | Consultant Anaesthetist | Nil return | Nil return | no action |
| Neil Wickham | Consultant | Nil return | Nil return | no action |
| Helen Iveson | Consultant in Sexual Health | Nil return | Nil return | no action |
| Alice Veitch | Consultant Radiology | SW Veitch Orthopaedics Ltd | Spouse is Director | no action |
| | | SDH Radiology Private Practice | Consultant | no action |
| Melissa Davies | Consultant Urologist | Wessex Urology Ltd | Director | no action |
| Philippa Ridley | Paediatric Consultant | Nil return | Nil return | Nil return |
| Paul Russell | Consultant Medical Microbiology and Virology | Nil return | Nil return | Nil return |
| Pippa Caygill | Consultant Urologist | Nil return | Nil return | Nil return |
| Roger Humphry | Ophthalmology Consultant | Nil return | Nil return | Nil return |
| Stephen Davies | ED Consultant | Nil return | Nil return | Nil return |
| Roanne Fiddes | Consultant Breast Surgeon | Nil return | Nil return | Nil return |
| Sarah Bartram | Consultant Rheumatologist | Nil return | Nil return | Nil return |
| Alexandra Crick | Consultant Plastic and Reconstructive Surgeon | Nil return | Nil return | Nil return |
| Christopher Pandya | Consultant Acute Medicine | Nil return | Nil return | Nil return |
| Ian Cook | Consultant Pathologist | New Hall | Consultant | No action - signed by department lead |
| Lynn Fenner | Consultant Anaesthetics | Nil return | Nil return | Nil return |
| Mark Wills | Consultant Radiology | Nil return | Nil return | Nil return |
| Peter Ellis | Emergency Consultant | Nil return | Nil return | Nil return |
| Phil Pettit | Orthopaedic Consultant | PN Orthopaedics Ltd | Director | no action |
| | | New Hall | Consultant | no action |
| Sally Bugg | Haematology Consultant | Nil return | Nil return | Nil return |
| Alistair Smith | Haematology Consultant | Nil return | Nil return | Nil return |
| Andrew Nash | Consultant Anaesthetist | ANA Medical Services Ltd | Director | no action |
| | | Newhall via Public Limited company | Consultant anaesthetist | no action |
| | | | Wife shareholder in public limited company | no action |
| James Haslam | Consultant anaesthetist | Critical Care Medicine Ltd | Director | signed by department lead |
| | | | Wife shareholder in Critical Care Medicine | no action |
| | | Newhall | Consultant Anaesthetist | signed by department lead |
| James Milnthorpe | Consultant Haematologist | Nil return | Nil return | Nil return |
| Mark Wills | Consultant Radiologist | Nil return | Nil return | Nil return |
| Stuart Verdin | Consultant | Newhall | Consultant | No action - signed by department lead |
| Tim Burge | Consultant Plastic Surgery | Medico-legal reporting | Self employed (since 1996) | no action |
| Temitayo Gandon | Paediatric Consultant | Nil return | Nil return | Nil return |
| Tracey Parker | Consultant Haematologist | Nil return | Nil return | Nil return |
| Victoria Brown | Consultant Surgeon | Nil return | Nil return | Nil return |
| Matthew Flynn | Consultant Histopathologist | Flynn-Lees Consulting Ltd | Director, Partner also director of same company | signed by department lead |
| | | HM Coroner | Consultant Histopathologist | signed by department lead |
| | | Salisbury Pathology Services | Consultant Histopathologist | signed by department lead |
| Ann Barton | Consultant Physician | Nil return | Nil return | Nil return |

| | | | | |
|---|---|---|---|---|
| Kush Duggal | Consultant Anaesthetist | Nil return | Nil return | Nil return |
| Alex Talbott | Associate Director of Improvement | Nil return | Nil return | Nil return |
| Charlotte Atkinson | Consultant O&G | Nil return | Nil return | Nil return |
| Jessica Savage | Consultant Plastic Surgeon | Nil return | Nil return | Nil return |
| Melanie Halliday | GP Clinical Assistant - Breast Surgery | Salisbury Medical Practice | GP (Salaried) | no action |
| Abigail Kingston | Consultant O&G | Salisbury Gynaecology Ltd | Consultant O&G | no action |
| Saboor Ghauri | Consultant Medical/General Surgery | Nil return | Nil return | no action |
| Hannah Boyd | Divisional Director of Operations, Women and New Born | Nil return | Nil return | no action |
| Adam Hughes | ED Consultant | Nil return | Nil return | no action |
| Polly Ford | Consultant Gynaecologist | Fertility and Gynaecology Limited | Director | no action |
| | | Complete Fertility | Consultant in Reproductive Medicine | no action |
| | | Nuffield Health Bournemouth | Counsultant Gynaecologist | no action |
| Xanthia Holmwood | Consultant Anaethetics | Nil return | Nil return | Nil return |
| Kate Thompson | Consultant Physician | Nil return | Nil return | Nil return |
| Andrew James | Financial Controller | The League of Friends of Salisbury Hospital | Treasurer and Trustee | no action |
| Annalise McNair | Consultant Orthodontist | Inspire Orthodontics | Owner | no action |
| Carmen Carroll | Consultant Geriatrician | Nil return | Nil return | Nil return |
| Jo Baden Fuller | Consultant Obstetrician and Gynaecologist | Nil return | Nil return | Nil return |
| Nola Lloyd | Consultant Plastics and Burns | Nil return | Nil return | Nil return |
| Angshuman Rick Panigrahi | Consultant Histopathologist | HM Coroner | | no action |
| | | Ramsay Healthcare UK | | no action |
| Lee Grimes | Consultant Haematologist | Jersey District Hospital | Locum Consultant Haematologist | no action |
| Max Johnston | Consultant Urologist | University Hospital Southampton | Consultant Urologist | signed by department lead |
| Susana Bull | Speciality Doctor | Nil return | Nil return | Nil return |
| Shree-eesh Waydia | Emergency Medicine Consultant | Nil return | Nil return | Nil return |
| Temitayo Gandon | Paediatric Consultant | Nil return | Nil return | Nil return |
| Susan Hergarty | Consultant Radiologist | AXON DIAGNOSTICS | Flexible radiology reporting contract (started 15/09/2023) | This company provides outsourced reporting services to Salisbury Hospital. I undertake reporting for other hospitals only and have no influence on the choice of this company for Salisbury reporting |
| | | New Hall | Consultant radiologist (since 2001) Private work | No action |
| Michael Brockbank | ENT Consultant | Nil return | Nil return | No action |
| Paul Flanagan | Consultant Microbiologist | Nil return | Nil return | No action |
| Aarti Umranikar | Consultant in Reproductive Medicine | Springbanks Medical | Part Ownership (with partner) | No action |
| Jonathan Cullis | Consultant Haematologist | Cress UK | Trustee | No action |
| | | Coombe Bissett & Homington Parochial Church Council | Member | No action |
| Matthew Wakefield | Consultant Surgery/ Opthalmology | Eye Surgery Limited | Director | Private practice is either conducted entirely separately to Trust activities or any performed on site is arranged via the SFT private practice office. |
| | | MWNH Limited | Director | no action |
| | | Independent Health Group (IHG) | Practising privileges | no action |
| | | Medcentres Plus | Practising privileges | no action |
| | | BSW ICB | Ophthalmology Lead Clinician (1PA) | no action |
| Angie Ansell | Deputy Chief Nurse | Nil return | Nil return | Nil return |
| Natasha Cartwright | Consultant Emergency Department | Nil return | Nil return | Nil return |
| Graham Branagan | Consultant Surgeon | G & PB Ltd | Director | no action |
| | | New Hall | Private Practice | no action |
| Claire Solly | Consultant Anaesthetist | nil return | nil return | nil return |
| Clare Raubusch | Consultant Biomedical Scientist | nil return | nil return | nil return |
| Lina Serhal | Locum Rheumatology Consultant | Basingstoke and North Hampshire Hospital | Senior Associate Specialist Rheumatology | no action |
| Martin Cook | Consultant Anaesthetist | KMPC Medical Ltd | Director | no action |
| | | Salisbury Cathedral | Photographer | no action |
| | | New Hall | Private Practice | no action |
| Susan Lewis | Consultant Cardiologist | Nill return | Nill return | Nil return |
| Ginette Phippen | Deputy Divisioanl Clinical Director (CSFS) | Nil return | Nil return | Nil return |
| Toby Black | Consultant Physician | Nil return | Nil return | Nil return |
| Jane Dickinson | Deputy Chief Operating Officer | Nil return | Nil return | Nil return |
| Niki Meston | Consultant Chemical Pathologist | Nil return | Nil return | Nil return |
| James Lawrence | Consultant Physician | Nil return | Nil return | Nil return |
| Sian Evans | Respitatory Consultant | Nil return | Nil return | Nil return |
| Carl Taylor | Consultant Paediatrician | Nil return | Nil return | Nil return |
| Caroline McGuiness | Consultant Plastics and Reconstructive Surgery | Nil return | Nil return | Nil return |
| Amira Moussa | Oral Surgery | The Oral Surgery Ltd | Oral Surgeon | signed by department lead |
| Daniell Bagg | Acute Physician | Nil return | Nil return | Nil return |
| Samuel Leach | Consultant Radiologist | Consultant Radiologist | Ramsey Healthcare | no action |
| Maqbool Jaffer | Consultant Anaesthetist | Maqbool Jaffer Ltd | Director | no action |
| Annabel Harris | ED Consultant | Nil return | Nil return | Nil return |
| Rachel Oaten | ED Consultant | ACOs Medical Ltd | Director | no action |
| | | Qualsafe Ltd | Clinical Reviewer | no action |
| | | SECAMB NHS Trust | CMO | no action |
| | | EMAS NHS Trust | Strategic Medical Advisor (on call only) | no action |
| | | North Bristol NHS Trust | Trauma Team Leader (Bank) | no action |
| Fiona Hyett | Deputy Chief Nurse | Nil return | Nil return | Nil return |
| Martin Smith | Consultant Endocrinologist | Director | Salisbury Endocrinology Medical Partnership Ltd | no action |
| Susan Hegarty | Consultant Radiologist | Consultant Radiologist | New Hall and Axon Teleradiology | no action |
| Ross Cruickshank | Consultant Anaesthetist | Director | Private Practice - wife is also a director | no action |
| Robin Alcock | Consultant Radiologist | Nil return | Nil return | Nil return |
| Heba Hassan | Locum Consultant Paediatrician | Nil return | Nil return | Nil return |
| Ian Wright | Consultant Anaesthetist | Nil return | Nil return | Nil return |
| Jonny Drayson | Consultant Geriatrician and general physician | Nil return | Nil return | Nil return |
| Laszlo Zavori | ED Consultant | Nil return | Nil return | Nil return |
| Layth Alsaffar | Consultant Microbiologist | 19-22 Summerseat Owners Limited | Director | no action |
| | | BioFix Limited | Director | no action |
| | | Portsmouth QAH | Consulant Microbiologist | signed by department lead |
| Louise Gamble | Consultant Haematologist | Nil return | Nil return | Nil return |
| Lynne-Marie Abbott | Interim Deputy Director of Finance | Director | Odstock Medical | no action |
| | | Director | Chewvale Limited | signed by department lead |
| Mary Pedley-Duncalfe | Paediatric Consultant | Nil return | Nil return | Nil return |
| Nicola Finneran | Consultant Acute Physician | Nil return | Nil return | Nil return |
| Ali Murtaza Samar | General Surgeon | Nil return | Nil return | Nil return |
| Sarah Cook | Consultant Radiology | Nil return | Nil return | Nil return |
| Sathish Jayagopal | Plastic Surgery | Nil return | Nil return | Nil return |
| Mark Wills | Consultant Radiologist | Nil return | Nil return | Nil return |
| Mary Bussell | Consultant Orthodontist | Nil return | Nil return | Nil return |
| Tom Jackson | Consultant Cardiologist | Nil return | Nil return | Nil return |
| Uma Thakur | Consultant Ophthalmologist | Nil return | Nil return | Nil return |
| Vicki Marston | Director of Midwifery | Nil return | Nil return | Nil return |

| | | | | |
|---|---|---|---|---|
| Benita Florence | Locum Consultant in Emergency Medicine | Nil return | Nil return | Nil return |
| Christina Cox | Lead Clinician Anaesthetics | Nil return | Nil return | Nil return |
| Christopher Couzens | Consultant in Anaesthetics | CAS Medical Services Limited | Director | no action |
| | | New Hall Hospital | Consultant |Anaesthetist | no action |
| Diana Slade-Sharman | Consultant Plastic Surgeon | Nil return | Nil return | Nil return |
| Gavin McCoubrey | Consultant Plastic Surgeon | Sarum Road Hospital, Winchester | Consultant Plastic Surgeon | no action |
| | | Spire Southampton | Consultant Plastic Surgeon | no action |
| | | Nuffield Health Bournemouth | Consultant Plastic Surgeon | no action |
| Graeme Kerr | Consultant Histopathologist | Nil return | Nil return | Nil return |
| Duncan Wood | Consultant Clinical Scientist, Head of Department | Odstock Medical Ltd | Shareholder and Board member | signed by CMO/ no action |
| Hannah Rickard | Consultant Obstetrician and Gynaecologist | New Hall Hospital | Director | signed by department lead |
| Ian Jenkins | Consultant in Anaesthesia | New Hall Hospital | Private Practice | no action |
| Jessica Steele | Consultant Plastic Surgeon | Nil return | Nil return | Nil return |
| Jim Baird | Consultant Childrens Outpatients | Nil return | Nil return | Nil return |
| Mohammed El-saghir | Urology Consultant | New Hall | Private Practice | no action |
| Nicola Bell | Consultant Radiologist | Nil return | Nil return | Nil return |
| Nicola Jones | Oral and Maxilofacial Surgery | Nil return | Nil return | Nil return |
| Orla Baird | Speciality Doctor | Nil return | Nil return | Nil return |
| Rebecca Exton | Consultant Plastic Surgeon | Nil return | Nil return | Nil return |
| Simon Sleight | Consultant General Surgeon | Nil return | Nil return | Nil return |
| Tony Mears | Associate Director of Strategy | Nil return | Nil return | Nil return |
| Yasser Shahata | Locul Consultant Gastroenterology | Nil return | Nil return | Nil return |
| Alister Campbell | Consultant Urologist | RALP Campbell Ltd | Director | no action |
| | | University Hospital Southampton | Honorary Consultant | no action |
| | | New Hall | Consultant Urologist | no action |
| Anne Goggin | Consultant in Palliative Medicine | Nil return | Nil return | Nil return |
| Belinda Cornforth | Consultant Anaesthetist | Nil return | Nil return | Nil return |
| Bushra Awan | Consultant Radiologist | Nil return | Nil return | Nil return |
| Julie Onslow | Consultant Anaesthetist | Nil return | Nil return | Nil return |
| Simon Williams | Consultant Anaesthetist | SPW Medical Ltd | Providing anaesthetic services at New Hall Hospital | no action |
| Jonathan Linton | Consultant Anaesthetist | Independent practitioner at New Hall Hospital | Anaesthetist | no action |
| Rashi Arora | Consultant Ophthalmologist | Stars Appeal | Charity Trek (no position of authority) | no action |
| Sarah Jane Pestell | Counsellor, Salisbury Fertility Centre | Nil return | Nil return | Nil return |
| William Garrett | Consultant Anaesthetist | Nil return | Nil return | signed by department head |
| James Wigley | Consutant Anaesthetist | New Hall Hospital | Consultant Anaesthetist | no action |
| Greg Pearson | Consultant Obs and Gynae | Wessex Gynacology and Wellbeing | Nil return | Nil return |
| James (Hugo) Powell | Elderly Medicine Consultant | Nil return | Nil return | Nil return |
| Sarah Asshton | ED Consultant | Nil return | Nil return | Nil return |
| Stephen Jukes | Consultant in Anaesthetics and Intensive Care | Nil return | Nil return | Nil return |
| Swarna Guttikonda | Consultant Gynaecologist | Nil return | Nil return | Nil return |
| Syed Hussain | Specialist Anaesthetist | Nil return | Nil return | Nil return |
| Victoria Smith | Consultant Dermatologist | Nil return | Nil return | Nil return |
| Laurence Arnold | Programme Director | Sterile Supplies Ltd | SFT Representative on Sterile Supplies Ltd | Signed by LT |
| Alison Vandyken | | Medical Technology for NHS Supply Chain | Husband (Steve Vandyken) is the Director of Medical Technology for NHS Supply Chain (NHSSC) with direct responsibility for a number of national framework agreements supplying medical devices and consumables. SFT has contractual arrangements in place with a variety of suppliers via the aforementioned framework agreements. | Contract renewal will be managed by the Procurement Team @ SFT, with input from the relevant clinical and operational teams.<br><br>Any recommendation reports pertaining to these framework agreements will be approved by other members of the Surgery DMT to avoid any direct involvement by myself that could be construed as a conflict of interest. |
| | Divisional Director of Operations | | | |
| Jon Burwell | Interim Chief Information Officer | Nil return | Nil return | nil return |
| Duncan Murray | Deputy Chief Medical Officer | DM Clinical and Professional Services Ltd | Director / Joint owner/ Spouse is a joint owner | no action |
| | | New Hall Hospital | Private work - Clinical anaesthesia services | no action |
| Nick Evans | Consultant Spinal Orthopaedic Surgeon | New Hall Hospital | Non-contracted NHS Work | no action |
| Ben Browne | Head of Clinical Effectiveness/ Associate Medical Director | East Cowes Surgery, Isle of Wight | GP (1 session per week) | Signed by line manager - no action |
| Paul Stephens | Clinical Director Surgery | Nil return | Nil return | Nil return |
| Gemma Simons | Consultant Spinal Unit | Solent NHS Trust | Contracted 5 PAs (from Nov 2022) | Signed by line manager - no action |
| Katharine Johnson | Consultant Radiologist | Southampton General Hospital | Contracted 5 PAs (from Feb 2020) Consultant Radiologist | Signed by line manager - no action |
| | | Heart Lung Health | Clinical Private Practice Consultant Radiologist - approx 1PA | Signed by line manager - no action |
| Ivor Vanhegan | Consultant Trauma and Orthopaedics | New Hall Hospital | Self employed consultant (from Oct 2022) | no action |
| Diran Padiachy | Consultant Elderly Medicine | Nil return | Nil return | Nil return |
| Rowena Staples | Paediatric Consultant | Nil return | Nil return | Nil return |
| Hazel Woodland | Consultant Gastroenterologist and Hepatologist | Nil return | Nil return | Nil return |
| Ben Templer | Consultant Histopathologist | Nil return | Nil return | Nil return |
| Tina Giannopoulou | Cosultant Ophthalmologist | Nil return | Nil return | Nil return |
| Rosalind Penny | Associate Director of OD and Leadership | People Dynamics Limited | Owner | no action |
| | | Witlshire College/ Coventry Partnership | Daughter is an employee of Wiltshire College who are part of the Coventry partnership that I am involved in. | no action |
| Pippa Baker | Palliative Medicine Consultant | Nil return | Nil return | Nil return |
| Eunan Tiernan | Consultant in Burns and Plastics | New hall Hospital (not employed by them) | Consultant started in 2023. | no action |
| Sophie Geany-Moloney | Consultant Gynaecologist | Nil return | Nil return | Nil return |
| Julian Hemming | Consultant Microbiologist | Nil return | Nil return | Nil return |
| Mark Szymankiewicz | Consultant Colorectal and General Surgeon | SWIFTSS (surgical teams working in Africa for safer surgery | Trustee | no action |
| | | The Ruth Grace Foundation | Trustee | no action |
| | | Hereford Muheza Salisbury Link | Trustee | no action |
| | | University of Winchester | Lecturer (ad hoc) | no action |
| Andy Agobar | Consultant Surgeon | Nil return | Nil return | Nil return |
| Rayyan Pervez | Radiologist | New Hall | Radiologist (started May 2022) | no action |

# Salisbury NHS Foundation Trust Register of Interests 2023/24

**Includes: Trust Board / Directors**

| Name | Job Title | Company | Position | Action / Notes |
|---|---|---|---|---|
| Mark Ellis | Director of Finance | Nil return | Nil return | No action |
| Melanie Whitfield | Chief People Officer | Nil return | Nil return | No action |
| Fiona McNeight | Director of Integrated Governance | Nil return | Nil return | No action |
| Peter Collins | Chief Medical Officer | Orchestra Live | Trustee | No action |
| Lisa Thomas | Chief Operating Officer | Sterile Services Ltd (SSL) | Director | No action |
| | | Healthcare Storage Solutions Ltd | Director | No action |
| | | My Trust Co Ltd | Director | No action |
| | | Salisbury Trading Ltd (STL) | Director | No action |
| | | Dauntsey Academy Primary School | Governor | No action |
| Judy Dyos | Chief Nursing Officer | Nil return | Nil return | No action |
| Michael Von Bertele | Non-Executive Director | Grenadenburg Consulting | Owner / Director | No action |
| | | Trayned Insight | Director | No action |
| | | Aspen Medical | Non-Executive Director | No action |
| | | ULTROX | Director | No action |
| | | Ultra-Genetics Ltd | Director | No action |
| | | Ministry of Defence: Army HQ | Chairman of Appeal Body for employment related complaints | No action |
| David Buckle | Non-Executive Director | Society for Assistance of Medical Families | President | No action |
| | | East and North Hertfordshire NHS Hospital Trust | Non-Executive Director | No action |
| | | Crohn's and Colitis UK | Trustee | No action |
| | | Stroke Association | Vice President | No action |
| Tania Baker | Non-Executive Director | Nil return | Nil return | No action |
| Rakhee Aggarwal | Non-Executive Director | Nil return | Nil return | No action |
| Eiri (Margaret) Jones | Non-Executive Director | EJP ltd. | Director | No action |
| | | Dorset County Hospital | Clinical Non-Executive Director/ Deputy Chair | |
| Ian Green | Chair (Non-Executive Director) | Cruisaid | Director | No action |
| | | Accession Homes | Director | No action |
| | | NHS Wales Joint Commissioning Committee | Chair | No action |
| | | South Central Ambulance NHS FT | NED | No action |
| Richard Holmes | Non-Executive Director | The Wallscourt Foundation (Charity in connection with University of West England) | Trustee | no action |
| Debbie Beaven | Non-Executive Director | Boundless | NED | No action |
| | | Community Forest Trust | Trustee | No action |
| | | Leap Confronting Conflict | Trustee | No action |
| | | Newbury Building Society | NED | No action |
| Niall Prosser | Chief Operating Officer | Nil return | Nil return | no action |
| Richard Holmes | Non-Executive Director | nil return | Nil return | no action |

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 2.3 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report tile: | Integrated Governance and Accountability Framework 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | ✓ | | | ✓ |
| Approval Process: (where has this paper been reviewed and approved): | TMC 24 April 2024 | | | |
| Prepared by: | Fiona McNeight, Director of Integrated Governance<br>Kylie Nye, Head of Corporate Governance | | | |
| Executive Sponsor: (presenting) | Fiona McNeight, Director of Integrated Governance | | | |
| Appendices | Appendix 1 Board Committee Summary<br>Appendix 2 Trust Committee Governance Structure<br>Appendix 3 Committee Effectiveness Template<br>Appendix 4 Board Committee Terms of Reference | | | |

## Recommendation:

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

## Executive Summary:

In 2023, as part of the Trust Improving Together Programme and a review of the operating framework at both Trust, Division and Specialty level and to align to the recently published NHS Oversight Framework, the Trust Accountability Framework, and Integrated Governance Framework ('the framework') was merged to create one document.

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

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

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

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

**DRAFT**

# Accountability and Integrated Governance Framework

## March 2024

| | |
|---|---|
| Version | V 1.2 |
| Author | Fiona McNeight, Director of Integrated Governance<br>Niall Prosser, Chief Operating Officer |

**CONTENTS** **Page No.**

## 1. Background

1.1. The Integrated Governance and Accountability Framework (IGAF) provides a coherent package of information to support ways of working, decision making, degrees of autonomy, accountabilities and assurance and reporting requirements.

## 2. Purpose

2.1. The purpose of the Integrated Governance and Accountability Framework is to ensure that Salisbury NHS Foundation Trust has sufficient mechanisms in place to monitor and drive delivery of the Trust's strategy and resultant operational plans during 2024 and beyond. This framework takes account of the Trust's requirement to comply and adopt best practice from the following:

- NHS Oversight Framework (updated 2 November 2023)
- Trust Provider Licence
- Trust Constitution
- NHS Standard Contract
- NHS Code of Governance
- Care Quality Commission

2.2. The framework also takes account of the establishment of the BSW Integrated Care System on 1 July 2022, and collaborative arrangements at system level including the Trust's role in the Acute Hospital Alliance (AHA). The framework aims to outline proportionate and effective oversight arrangements of Trust-led care within this system

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

## 3. NHS oversight

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

| Theme | Aim |
|---|---|
| Quality of care, access, and outcomes | To continuously improve care quality, helping to create the safest, highest quality health and care service |
| Finance and use of resources | For the Trust to balance its finances and improve its productivity |

| | |
|---|---|
| Preventing ill-health and reducing inequalities | To support prevention programmes to help people to stay healthy and support more accurate assessment of health inequalities and unmet needs of the local population |
| People | To be a responsive and flexible employer and address current workforce pressures |
| Leadership and capability | To build leadership and improvement capability to deliver sustainable services |
| Local Strategic priorities | The Trust is part of the ICB and the planning process. The ICB strategy has been published "Our Integrated Care Strategy – BSW Together" Our Integrated Care strategy - BSW Together |

3.2. Our strategy includes each of these themes and ensures they are actively worked throughout the year.

## 4. NHS England Monitoring

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

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

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

## 5. Governance

5.1. Integrated Governance is how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to

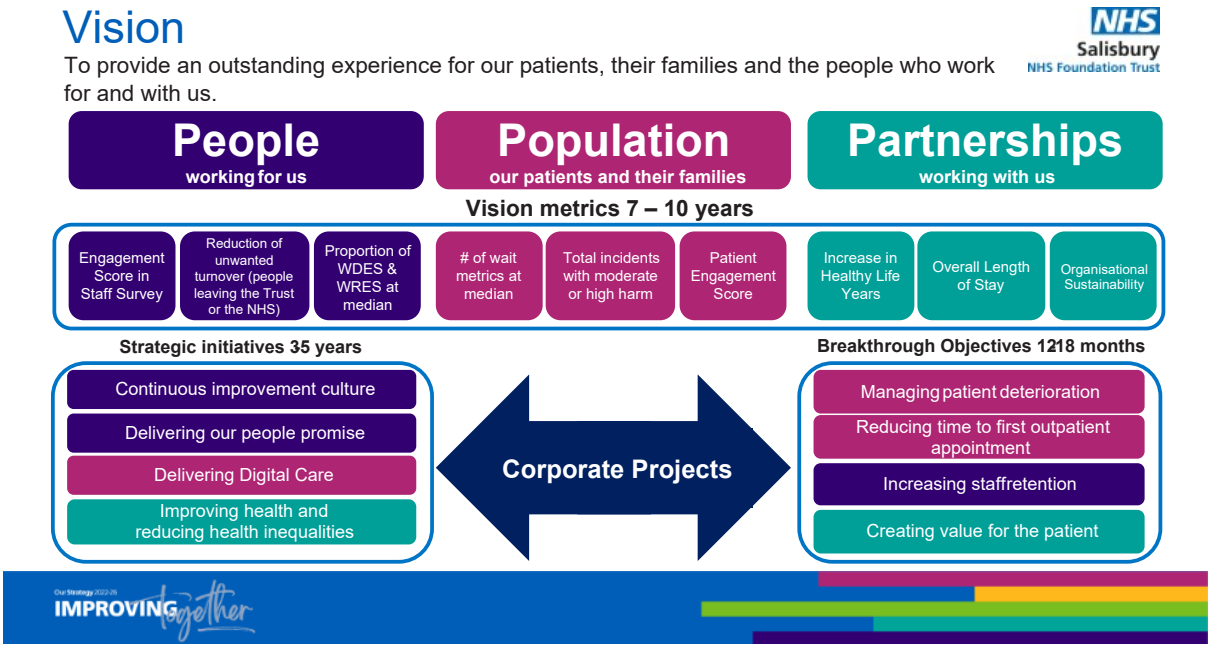
support the delivery of our vision, “To provide an outstanding experience for our patients, their families and the people who work for and with us” through our operational management system. It promotes an organisation that is well managed, cost effective and has a skilled and motivated workforce.

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

## 6. Strategic Domains

6.1. The Trust’s strategic domains are set out in its 2022-26 strategy. Improving Together, our operational management system (OMS), underpins the delivery of these by aligning our focus from Board to ward and enabling teams to continually improve their daily work. The strategic domains are:


6.2. Our Strategic Planning Framework (SPF) sets out our long, medium and short term strategic foci. The Executive reviews performance against this monthly in what is known as the Engine Room. The Engine Room is where the escalations and successes from the OMS rise to from the organisation.



## 7. Scope of the Framework for Integrated Governance

### *7.1.* ***Corporate Governance***

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

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

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

### 7.2. ***Financial Governance***

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

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

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

### *7.4.* ***Clinical Governance***

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

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

7.4.3 The Maternity and Neonatal Governance Framework 2023 details the local arrangements for implementation of trust processes and/or standalone arrangements for the management and reduction of risk within maternity and neonatal services. Maternity and Neonatal Governance Framework 2023

(microguide.global)

7.5. ***Demonstrating Quality***

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

*7.6.* ***Continuous Improvement***

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

7.6.2. The Improving Together Programme is focused on continuous improvement and is predicated on the development of a coaching culture. This programme supports staff in undertaking tasks that really add value and empowers them to make improvements at a local level. It recognises the highest level of expertise, often is the lowest level of authority and seeks to train people with that expertise in the skills and behaviours needed for continuous improvement to thrive. The approach is intended to ensure everyone has the time, space, and responsibility to be curious about processes, consider how priorities can be achieved and have freedom to test new ways of working. As part of this programme a modular training programme has commenced for all staff, which is being rolled out in a phased approach over the next 4 years.

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

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

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

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

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

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

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

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

8.2. The Board ensures a balanced focus on all aspects of its business. Further to this:

- The Integrated Governance Framework ensures the Board and its committees are structured effectively and properly constituted.
- The Board will ensure it promotes a culture where patients are at the centre; staff learn from experience; and the Trust engages with patients, the public and partners to develop services for the future.
- Board business cycles will be clearly set out with actions implemented.
- The Board will ensure codes of conduct are upheld and the public service values of accountability, probity, and openness in the conduct of business are maintained.
- Board members will receive appropriate induction and ongoing training and development to ensure they can undertake their responsibilities effectively and appropriately.

## 9. **Charitable Trustees**

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

## 10. **Annual Governance Statement**

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

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

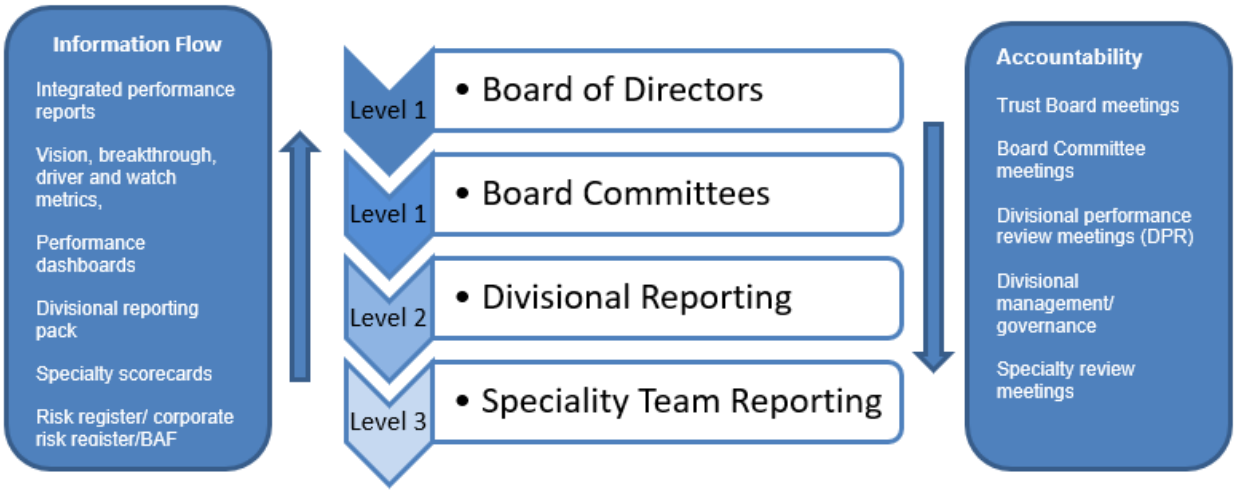
## 11. **Internal performance Framework**

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

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

11.2. Through the use of Improving Together the measurement of performance is directly linked to achieving the Trust strategy (2022-26). It ensures we plan and embed new ways of working alongside achieving tangible progress for our ambitions and aims.

The main strands of performance reporting within SFT are:




11.3. **Board of Directors**

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

*11.4.* ***Accountability***

| Level 1: SFT Trust Board | | |
|---|---|---|
| **Committee** | **Membership** | **Principal Reporting Documents** |
| **Trust Board** | All directors | Corporate Strategy.<br>Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management.<br>Performance Reports – quality, workforce, operations, finance.<br>Board Committee escalation reports<br>Customer Care and Legal Reports. |

| | | |
|---|---|---|
| **Board Committees** | Non-Executive Directors, CEO Lead Executives | Presentation on key performance information, including detailed information and actions on any key business targets currently being failed.<br>Scrutiny of the Trust's commercial holdings.<br>Scrutiny and assurance regarding risks and adequacy of actions.<br>Escalation actions from Divisional Performance Reviews (by exception). |

*11.5.* ***Information***

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

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

11.6. **Committees of the Board**

11.6.1. There are four key board assurance committees in addition to a Remuneration and Nomination Committee. An outline of each committee responsibilities and core functions are set out in Appendix 1 and the overall Trust Committee Assurance Map in Appendix 2.

- Audit Committee
- Clinical Governance Committee
- Finance & Performance Committee
- People and Culture Committee

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

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

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

12. **Divisional Reporting**

*12.1.* ***Accountability***

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

12.1.2. The objective of the Divisional Performance Reviews is to review the performance of each Division in relation to an agreed suite of key metrics, ensuring both compliance and continual improvement. The reviews will also provide a forum for Divisions to discuss issues and challenges facing services with Executive Directors and agree solutions in partnership as well as an opportunity to share and celebrate success and good practice.

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

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

*13.* ***Information***

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

14. **Divisional Management**

*14.1.* ***Accountability***

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

*14.2.* ***Information***

The Divisions have access to Power BI with a range of dashboards to support quality/performance/finance and workforce metrics (specialty/divisional/specific

resource metrics e.g., Theatres/outpatients). These are used to underpin performance at specialty level.

| Committee | Membership | Principal Reporting Documents |
|---|---|---|
| **Divisional Management Committees** | Divisional Management Committee, HR and Finance Business Partners | Divisional performance dashboard Individual dashboards, locally held performance information, and divisional risk register. |
| **Divisional Governance Committees** | | Team/specialty goals and measures Improvement as set out in the Trust's Quality/performance/finance and workforce objectives |

### *14.3. Specialty Reporting*

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

### 14.4. Escalation

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

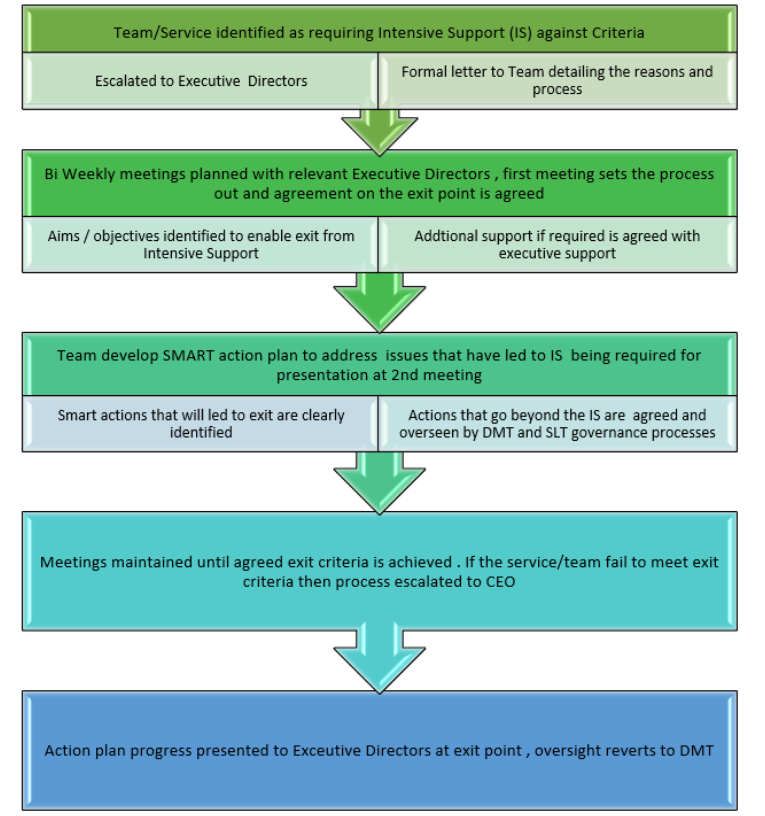
| Stage | Intervention |
|---|---|
| Enhanced diagnostic | • Ensure root cause analysis addressed<br>• Remedial action plans in place<br>• Utilisation of improving together tools (Go See, Improvement Huddles, A3 thinking) |
| Enhanced Oversight | • Increased reporting<br>• Consideration of external/peer review<br>• Comprehensive action plans with clear metrics for improvement. |
| | • Bespoke mandated support |

| Stage | Intervention |
|---|---|
| Intensive Support | • Executive oversight |
| CEO escalation | • Meeting with CEO regularly<br>• Capacity and Capability review<br>• Identification of any longer term structural and strategic issues which must be addressed. |

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

14.5. **Intensive Support**

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




14.5.1. The focus of the meetings is to ensure actions are being taken promptly, required improvements are being made and that the actions prioritise the key areas of

concern. The meetings will also enable the Executives to identify and action any additional support or help required, to ensure standards can be improved and sustained. At any stage of escalation, all parties will agree the criteria that must be met for the Division to exit any mandated support. Specific arrangements will need to be agreed in each situation to ensure appropriate governance and oversight.

15. **Corporate Departments**

**This will be reviewed once content of DPR agreed.**

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

16. **Public Accountability**

16.1. **Council of Governors**

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

## 17. Collaborative Working and Partnerships

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

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

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

17.2. As part of the move towards more collaborative working the Trust is also part of the Acute Hospital Alliance (AHA) with Great Western Hospital and Royal United Hospitals (RUH) Bath NHS Foundation Trusts. The AHA is focused on improving clinical services and closing the gaps in relation to health and care inequalities

and finance to benefit the population of BSW. The acute providers have formed a Committee in Common (CIC) which is responsible for leading the development of the AHA programme and the workstreams in accordance with the Principles of Collaboration; and setting the overall strategic direction in order to deliver the AHA programme. The local place-based Wiltshire Integrated Care Alliance is also a clear focus for the executive team and clinical leaders.

**Version control**

| | | | | |
|---|---|---|---|---|
| **Document Title** | **Integrated Governance and Accountability Framework 2024/25** | | | |
| **Date Issued/Approved:** | TBC | | | |
| **Date Valid From:** | May 2023 | | | |
| **Date Valid To:** | April 2024 | | | |
| **Division / Department responsible (author/owner):** | Chief Operating Officer | | | |
| **Executive Director responsible for Policy:** | Chief Operating Officer | | | |
| **Date revised:** | March 2024 | | | |
| **Approval route (names of committees)/consultation:** | Chief Operating Officer in consultation with Trust Board | | | |
| **Publication Location (refer to Policy on Policies – Approvals and Ratification):** | Internet & Intranet | x | Intranet Only | |
| **Related Documents** | Listed Appendices | | | |

**Version Control Table**

| Date | Version No. | Summary of Changes | Changes made by (name and job title) |
|---|---|---|---|
| **18/03/22** | **V1** | **Draft document – joint Integrated Governance and Accountability Framework** | **Lisa Thomas, Chief Operating Officer<br>Fiona McNeight, Director of Integrated Governance<br>Kylie Nye, Head of Corporate Governance** |
| **March 2023** | **V1.1** | **Annual Review** | **Lisa Thomas, Chief Operating Officer<br>Fiona McNeight, Director of Integrated Governance** |

| | | | |
|---|---|---|---|
| | | | **Kylie Nye, Head of Corporate Governance** |
| **March 2024** | **V1.2** | **Annual review, incorporating additional narrative re improving together and updates to diagram.** | **Lisa Thomas, Chief Operating Officer**<br>**Fiona McNeight, Director of Integrated Governance**<br>**Kylie Nye, Head of Corporate Governance**<br>**Alex Talbott, Director of Improvement**<br>**Tony Mears, Associate Director of Strategy** |

# Appendix 1: Board Committees

## BOARD COMMITTEES

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

### Level 1: Assurance Committees of the Board

### Audit Committee

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

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

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

*Principal functions:*

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

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

### Clinical Governance Committee

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

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

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

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

*Principal functions:*

To provide assurance to the Board on:

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

**Finance & Performance Committee**

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

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

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

**People and Culture Committee**

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

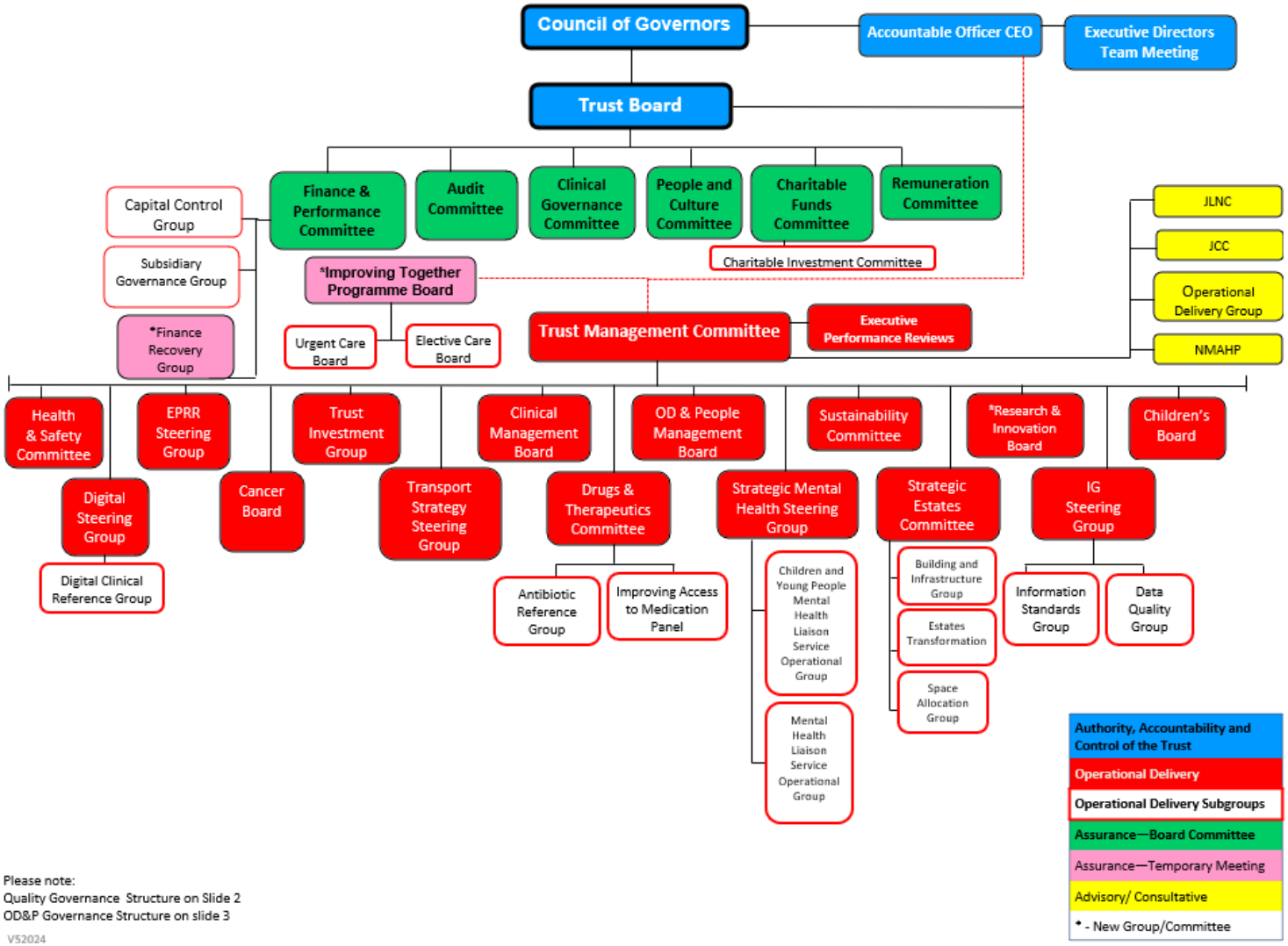
- ensuring the mechanisms are in place to support the development of compassionate and inclusive leadership capacity and capability within the Trust
- the development and design of the workforce, to ensure that the Trust has productive staff, with the skills, competencies, and information to meet the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

*Principal functions:*

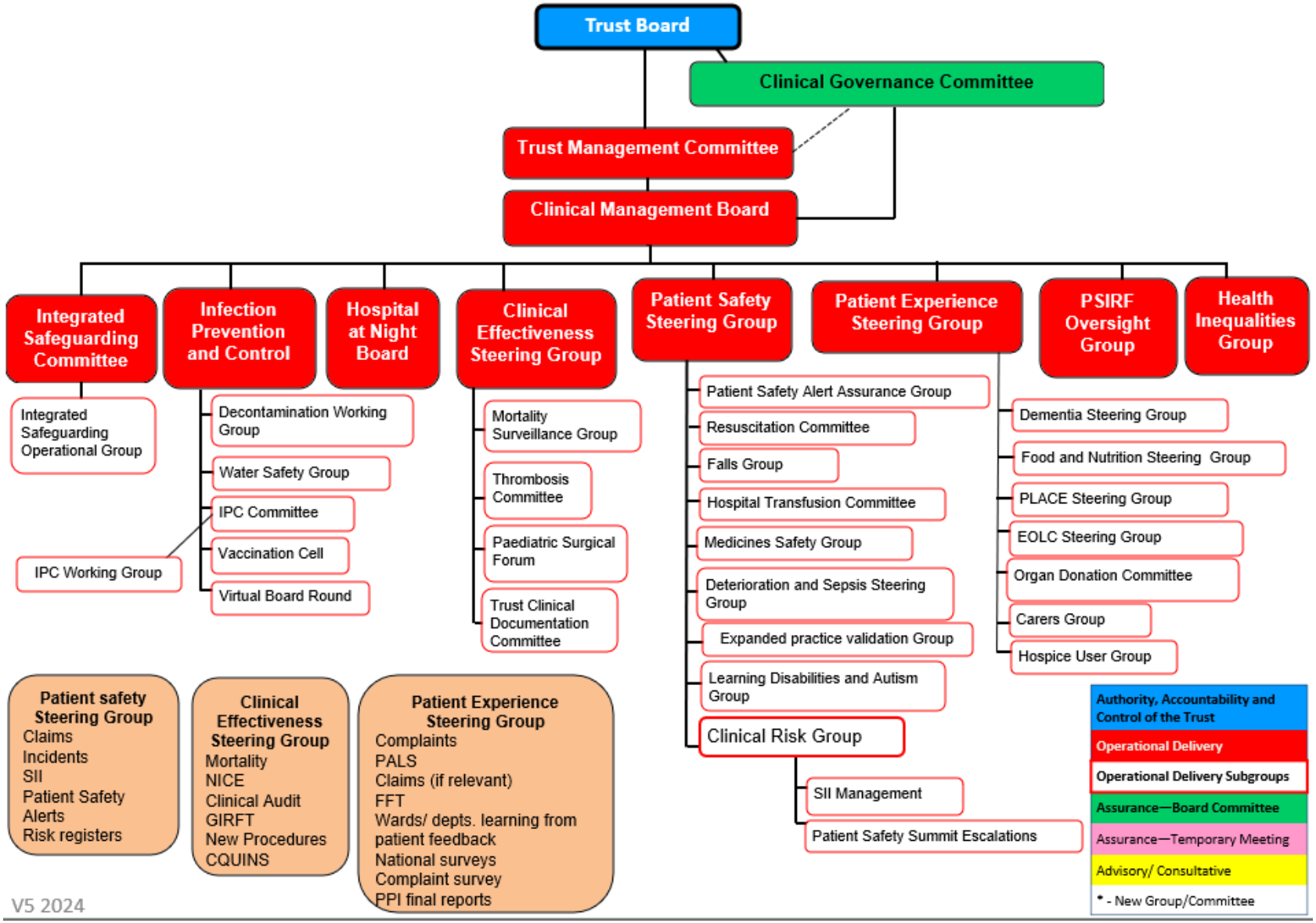
To provide assurance on:

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

**Appendix 2 - Committee Trust Committee Assurance Map -** *NB: This is a live working document and is currently under review*

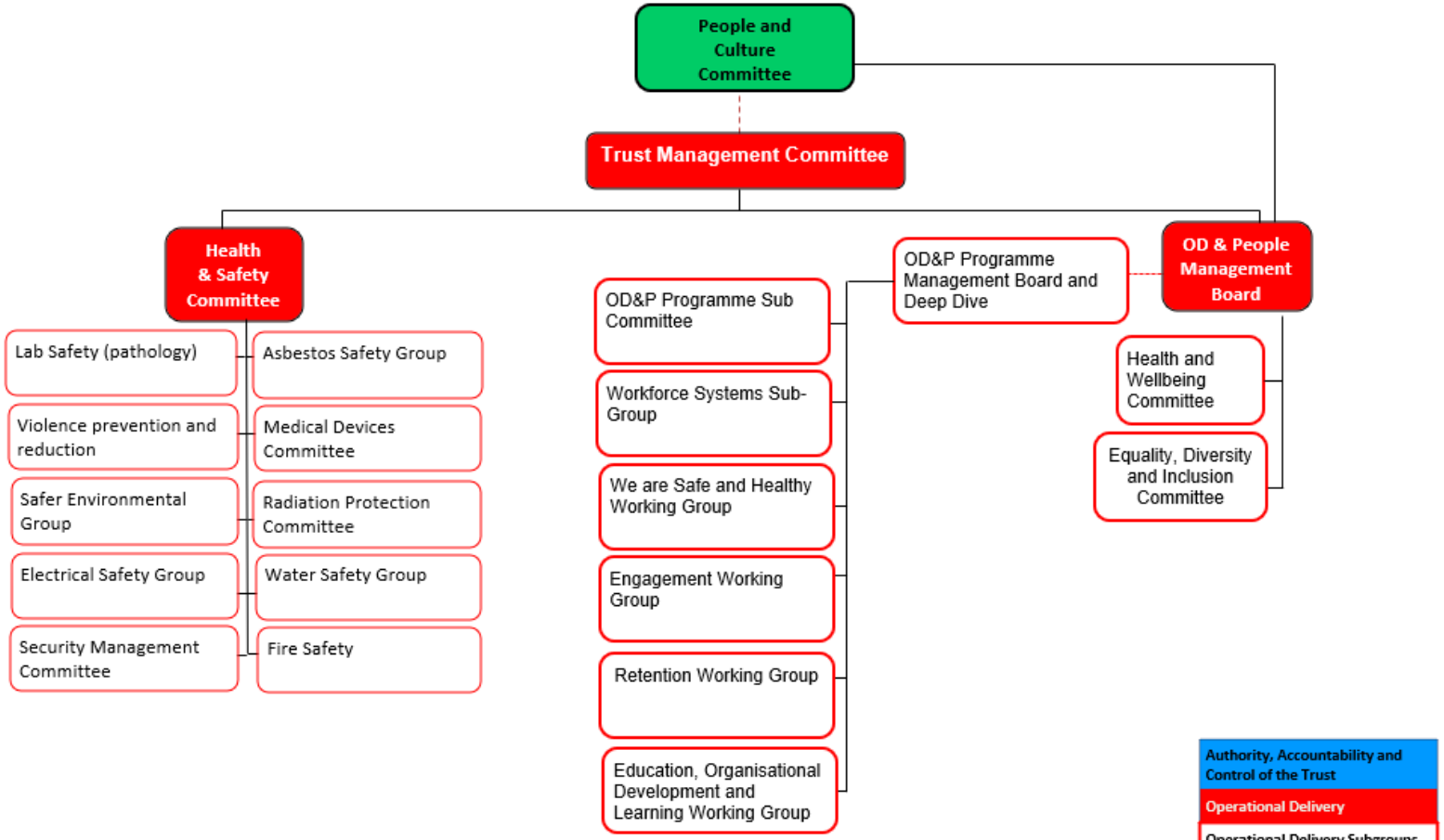


# Quality Governance Structure




V5 2024

# Organisational Development and People Structure




V5 2024

## Appendix 3 – Salisbury NHS Foundation Trust Committee Effectiveness Template

| Governance | | | |
|---|---|---|---|
| # | Statement | Answer | Comments |
| 1 | The committee has written terms of reference that adequately and realistically define the committee's role and that have been reviewed annually. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 2 | The Committee has an annual cycle of business which is annually reviewed. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 3 | The meeting is always quorate and the attendance log is regularly received and noted at the meeting. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 4 | Decisions and actions are implemented in line with the required timescale. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| **Committee Effectiveness** | | | |
| # | Statement | Answer | Comments |
| 5 | The work of the committee is triangulated appropriately with the work of other committees. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 6 | The committee has met its responsibilities/ objectives as outlined in the terms of reference. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |

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| 7 | The committee receives timely assurances from sub-groups and departments who deliver key committee-relevant functions | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |
| 8 | The agenda is aligned to the key risks and priorities of the organisation. | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |
| 9 | The committee has oversight of key risks, safety issues and any gaps in control. | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |
| 10 | The quality of committee papers received allows committee members to perform their roles effectively. | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |
| 11 | The committee provides a written summary report of its meeting to the Board. | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |
| 12 | The committee has given sufficient focus to each of the areas of responsibility outlined in the Terms of Reference. | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |
| 13 | The committee met as per the committee schedule. (Provide comment on: were meetings cancelled? / Were there extraordinary meetings?) | Strongly Agree Agree Neutral Disagree Strongly Disagree Not Applicable | |

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| 14 | The committee's remit is appropriate and manageable within the allocated time of the meeting. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 15 | The committee has appropriately referred items for oversight to another committee. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 16 | The standard work in relation to the Improving Together methodology been effectively implemented into the Committee e.g., purpose, check-in, and reflection? | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| **Leadership** | | | |
| # | Statement | Answer | Comments |
| 16 | Committee meetings are chaired effectively | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| 17 | The committee chair has a positive impact on the performance of the committee. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |
| **Engagement** | | | |
| # | Statement | Answer | Comments |
| 18 | Members and attendees have the opportunity to engage in committee discussion and challenge effectively. | Strongly Agree<br>Agree<br>Neutral Disagree<br>Strongly Disagree Not Applicable | |

Comments

Please enter any comments you have about this

NHS
Salisbury
NHS Foundation Trust

# Audit Committee Terms of Reference

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of version** | **Version number** | **Type of Revision Major/minor** | **Description of Revisions** | **Author** |
| April 2018 | 1 | Approved version | Approved by the Trust Board of Directors | |
| February 2019 | 2 | Major | All sections revised | Director of Corporate Governance |
| March 2020 | 2.1 | Minor | Annual Revision | Director of Corporate Governance |
| March 2021 | 2.2 | Nil changes | Annual Revision | Director of Corporate Governance |
| Dec 2021 | 2.3 | Nil changes | Annual Revision | Director of Integrated Governance |
| Dec 2022 | 2.4 | Minor change | Annual Revision – title change | Director of Integrated Governance |
| Dec 2023 | 2.5 | Minor change | Annual revision – addition to purpose | Director of Integrated Governance |

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|---|---|
| **Date Adopted** | December 2023 |
| **Review Frequency** | Annual |
| **Terms of Reference Drafting** | Director of Integrated Governance |
| **Review and Approval** | Audit Committee |
| **Adoption and ratification of changes** | Board of Directors |

## 1) Purpose and function

The purpose and function of the Committee is to:

1.1. The Audit Committee has overall responsibility for the establishment and maintenance of an effective system of integrated governance, risk management and internal control that supports the achievement of the Trust's strategic objectives.

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

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

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

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

## 2) Authority

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

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

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

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

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

## 3. Membership and Attendance

### Membership

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

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

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

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

**Quorum**

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

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

**Attendance**

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

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

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

### 4.1 Financial reporting

The Committee shall:

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

### 4.2 Governance, Risk Management and Internal Control

The Committee shall:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
b) Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
c) Review the Trust's processes to establish and maintain an effective Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements.
d) Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security as required by the NHS Counter Fraud Authority
e) Receive assurance from Internal Audit, External Audit, Directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

### 4.3 Internal Audit and Counter Fraud

The Committee shall:

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

### 4.4 External Audit

The Committee shall:

a) In conjunction with the Chief Finance Officer, consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor.
b) Work with the Chief Finance Officer and the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall

investigate the issues leading to this, and make any associated recommendations to the Council of Governors.

c) Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts.
d) Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted.
e) Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work.
f) Meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit.
g) Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, and the impact on the audit fee.
h) Review all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

**4.5 Other Board Assurance Functions**

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

**5). Reporting and Accountability**

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

## 6) Conduct of Business

### Administration

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

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

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

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

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

Notice of meetings

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

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

Salisbury NHS Foundation Trust

# Clinical Governance Committee

## Terms of Reference

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of version** | **Version number** | **Type of Revision Major/minor** | **Description of Revisions** | **Author** |
| April 2018 | 1 | Approved version | Approved by the Trust Board of Directors | |
| March 2019 | 2 | Major | All sections revised | Director of Corporate Governance |
| May 2020 | 3 | Minor | Annual review | Corporate Governance Manager |
| March 2021 | 3.1 | Minor | Annual Review | Corporate Governance Manager |
| March 2022 | 3.2 | Minor | Annual Review | Director of Integrated Governance – updates made by PA |
| March 2023 & April 2023 | 3.3 | Minor addition of health inequalities oversight | Annual Review | Director of Integrated Governance |
| March 2024 | 3.4 | Minor | Annual Review | Director of Integrated Governance |

| | |
|---|---|
| **Date Adopted** | |
| **Review Frequency** | Annual |
| **Terms of Reference Drafting** | Director of Integrated Governance |
| **Review and Approval** | CGC 26/03/2024 |
| **Adoption and ratification** | Trust Board |

## 1. Purpose

1.1. The Committee has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board and the Chief Executive that high quality care is provided to patients throughout the Trust.

## 2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee (the Committee).

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

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

2.4. The Committee is authorized to monitor, scrutinize and where appropriate, investigate any quality activity considered to be within its terms of reference.

## 3. Membership and Attendance

### Membership

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

- Three Non-Executive Directors
- Chief Medical Officer, Chief Nursing Officer (joint Lead executive)
- Chief Operating Officer

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

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

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

### Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members and at least one of the joint lead Executives.

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

### Attendance

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

- Any nominated deputy attending in place of a designated Committee member.
- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.
- The PA to the Chief Nursing Officer and Chief Medical Officer will act as Secretary to the Committee.
- Governor observer(s)

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

Regular Attendees
Chair
Associate Chief Medical Officer/Head of Clinical Effectiveness
Head of Compliance
Head of Risk Management
Head of Patient Experience
Head of Patient Safety
Director of Integrated Governance
Deputy Chief Nursing Officer
Deputy Chief Nursing Officer
EA to Chief Medical Officer and Chief Nursing Officer (Minutes)

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

4.1. The function of the Committee is to ensure:

4.1.1. That the Board establishes and maintains compliance with health care standards including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission and statutory regulators of health care professionals (including NHS Improvement).

4.1.2. Provision of assurance that high quality care is provided to patients throughout the Trust, actively engaging with patients, staff and other key stakeholders as appropriate.

4.1.3. There is clear accountability for quality of care throughout the Trust including but not restricted to, systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate

4.1.4. Support for the Trust's approach to continuous quality improvement through the Improving Together methodology.

4.1.5. Consideration of the clinical risks to the Trust's ability to achieve high quality care and continuous quality improvement through review of the Care and Innovation sections of the Board Assurance Framework

4.1.6. To consider the implications of wider changes in NHS policy and governance within the committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaboratives including BSW Acute Alliance.

4.2. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

### 4.2.1. Development and Review

- Agree the annual quality plan (quality account priorities) and monitor progress**.**
- Extend the Boards monitoring and scrutiny of the standards of quality, compliance, and performance of Trust services.
- Make recommendations to the Board on opportunities for improvement in the quality of services.
- Support and encourage quality improvement where opportunities are identified.
- Working in conjunction with the Audit Committee, People and Committee and Finance and Performance Committee, cross-referencing data and

ensuring alignment of the Board assurances derived from the activities of each committee.

- Review the Trust's Annual Quality Report and Account prior to submission to the Trust's Board of Directors for approval.
- Monitor the status of the Trust's quality objectives as set out in the Annual Plan
- Review the Integrated Performance Report Quality and Care section prior to inclusion in the Board Integrated Performance Report Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust.
- Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, and patient safety.
- Provide oversight of relevant Internal Audit recommendations as directed by the Audit Committee
- Understanding inequalities in access to health or outcomes for individuals within our population and devising strategies to tackle inequalities when where they exist.

### 4.2.2. Review of Trust activity in assigned area

**Patient Safety:**

- Agree the annual safety priorities and monitor progress.
- Ensure risks to patients are minimised through application of a comprehensive risk management system in accordance with the risk management strategy. Identify areas of significant risk, set priorities and agree actions using the Assurance Framework and Corporate Risk Register process.
- Monitor and review the clinical risks in the Assurance Framework and corporate risk register as per the risk management strategy and policy.
- Assure that there are processes in place that safeguard adults and children within the trust and review the annual safeguarding adult and children's reports prior to submission to Trust Board
- Receive and review bi-annual reports from the Director of Infection Prevention and Control

**Clinical Effectiveness / Clinical Outcomes:**

- Ensure that care is based on evidence of best practice and national guidance.
- Assure the implementation of all new procedures and technologies according to Trust policies
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.
- Review the Annual Clinical Audit plan and receive a bi-annual report on progress with the plan.

**Patient Experience:**

Assure that the Trust has reliable, real time, up to date information about what it is like to be a patient experiencing care in this hospital, to identify areas for improvement and ensure that these improvements are made. This will be provided through a comprehensive patient engagement programme. This will be achieved through:

- Review of the patient experience quarterly report
- Agree the annual patient experience/engagement plan and monitor progress.

- Receipt of reports regarding patient experience and engagement and review the results and outcomes of local and national patient surveys

**Learning:**

- Commitment to strengthen learning across the organization aligned with continuous improvement and improve patient safety, experience and outcomes.
- Ensure the Trust is outward looking and incorporates learning and recommendations from external bodies into practice with mechanisms to monitor their delivery.
- Request reports to monitor against action plans arising from Serious Incidents, complaints and Never Events to ensure Trust-wide learning.

### 4.2.3. Policy monitoring and review

Ensure the research programme and governance framework is implemented and monitored.

## 5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the PA to the Chief Nursing Officer and Chief Medical Officer whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

The Committee chair will provide an escalation report to the Board of Directors following each meeting, in the public session where possible; agreed with the Committee Chair.

**Frequency**

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

5.3. Meetings will be held 9 times per year, with additional meetings where necessary.

**Notice of meetings**

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

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

**Reporting**

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

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

5.8. Reporting arrangements into the Committee from Sub-Committees

5.9. The Clinical Management Board will continue to report to the Trust Management Committee, and its Escalation Report (Minutes) will be submitted to the Clinical Governance Committee for assurance.

## 6. Review

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

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

6.3. These terms of reference were approved by the Clinical Governance Committee with amendments on

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NHS Foundation Trust

# Charitable Funds Committee Terms of Reference

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

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

| **Document Change Control** | | | | |
|---|---|---|---|---|
| **Date of version** | **Version number** | **Type of Revision Major/minor** | **Description of Revisions** | **Author** |
| August 2018 | 1 | Approved version | Approved by the Trust Board of Directors | |
| March 2019 | 2 | Minor | Added role of secretary to the Committee | Director of Corporate Governance |
| December 2020 | 2.1 | Minor | Membership and Administration | Investment Planning and Policy Manager |
| March 2022 | 2.2 | Minor | Review of TOR addition of Head of PALS to attend. | Executive Services Manager |
| April 2024 | 2.3 | Minor | Minor review circulated outside of Committee – full review once Charitable Strategy reviewed. | Head of Corporate Governance |

| | |
|---|---|
| **Date Adopted** | |
| **Review Frequency** | Annual |
| **Terms of Reference Drafting** | Investment Planning and Policy Manager |
| **Review and Approval** | Charitable Funds Committee |
| **Adoption and ratification** | Trust Board |

## 1. Purpose

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

## 2. The committee is established to:

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

2.2. Determining an investment strategy and arrangements for the investment of funds which are not immediately required for use.

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

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

## 3. Authority

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

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

3.3. The Committee is authorised to:

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

## 4. Membership and Attendance

### Membership

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

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

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

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

### Quorum

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

### Attendance (non-voting members)

4.5. Meetings of the Committee shall be attended by:

- Senior Responsible Officer for the Charity
- Financial Controller or Financial Accountant
- Director of Integrated Governance
- Representative from the Fundraising Team
- Staff representation – in the form of representatives from the Charity Ambassador board
- Community representation – in the form of the Chairman for the Fundraising Committee which is external to the Trust

### Attendance by Other Trustees

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

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

## 5. Roles and Responsibilities

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

### Assurance

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

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

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

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

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

### Investments

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

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

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

### Fundraising

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

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

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

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

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

## 6. Conduct of Business

### Administration

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

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

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

6.4. The Executive Assistant to the Chief Finance Officer will act as the role of secretary to the Committee.

### Frequency

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

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

### Notice of meetings

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

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

### Reporting

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

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

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

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

## 7. Review

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

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

# People and Culture Committee Terms of Reference

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of version** | **Version number** | **Type of Revision Major/minor** | **Description of Revisions** | **Author** |
| April 2018 | 1 | Approved version | Approved by the Trust Board of Directors | |
| February 2019 | 2 | Major | All sections revised | Director of Corporate Governance |
| May 2020 | 3 | | Annual Revision | Corporate Governance Manager |
| March 2021 | 3.1 | Minor | Annual Revision | Corporate Governance Manager |
| January 2022 | 3.2 | Minor | Annual Revision | PA to Chief People Officer |
| January 2023 | 3.3 | Minor | Annual Revision | Head of Corporate Governance |
| Apr 23 | 3.4 | Minor | Annual Revision agreed at P&CC | Deputy Chief People Officer |
| March 2024 | 3.5 | Minor | Annual Revision | Head of Corporate Governance / Chief People Officer |

| | |
|---|---|
| **Date Adopted** | 28th March 2024 |
| **Review Frequency** | Annual |
| **Terms of Reference Drafting** | Head of Corporate Governance |
| **Review and Approval** | People and Culture Committee |
| **Adoption and ratification** | Trust Board |

## 1. Purpose and Function

1.1 The purpose of the Committee is twofold, firstly the provision of assurance for all national workforce actions and secondly to ensure the Trust has a workforce strategy in place which recognises the importance of all the people who work within the Trust, supporting the recruitment and retention of sufficient people with the necessary knowledge, skills, and experience to deliver the Trust strategy including its clinical and other operational objectives. Specifically:

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

1.1 To achieve this, the Committee shall:

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

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

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

## 2. Authority

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

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

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

## 3. Membership and Attendance

### Membership

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

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

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

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

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

### Quorum

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

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

### Attendance

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

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

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

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

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

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

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

4.3 Oversight of the delivery of the people plan and associated policy management.

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

4.5 Oversight of the development and delivery of the Long-Term People Plan, the people aspects of the Clinical Strategy and their contribution to the Trust strategy.

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

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

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

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

4.10 Maintaining oversight of the Trust's employment related equality, diversity and inclusion agenda, including assurance of Gender Pay Gap, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) annual reports. Champion the Trust's position as an equitable employer encouraging and maintaining progress against both our strategic commitment and public sector duties.

4.11 To provide oversight of the management and delivery of education and training within the Trust.

## 5. Conduct of Business

### Administration

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

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

- Agreement of agendas with Chair and attendees and collation of papers.
- Taking the minutes.
- Keeping a record of actions, matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues/areas.

- Provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

### Frequency

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

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

### Notice of meetings

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

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

### Reporting

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

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

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

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

- Organisational Development and People Management Board.

## 6. Review

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

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

6.3 These terms of reference were approved by the People and Culture Committee with amendments on 28th March 2024 and ratified by the Board of Directors on **{Insert date}.**

NHS
Salisbury
NHS Foundation Trust

# Finance & Performance Committee

## Terms of Reference

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of version** | **Version number** | **Type of Revision Major/minor** | **Description of Revisions** | **Author** |
| April 2018 | 1 | Approved version | Approved by the Trust Board of Directors | |
| February 2019 | 2 | Major | All sections revised | Director of Corporate Governance |
| Nov 2019 | 3 | Minor | Added delegated authority limits | Corporate Governance Manager |
| May 2020 | 4 | Minor | Annual Review | Corporate Governance Manager |
| March 2021 | 4.1 | Minor | Annual Review | Corporate Governance Manager |
| March 2022 | 4.2 | Minor | Annual Review | Head of Corporate Governance |
| Feb 2023 | 4.3 | Minor | Annual Review | Head of Corporate Governance |
| Feb 2024 | 4.4 | Minor | Annual Review | Head of Corporate Governance |

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

## 1. Purpose

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

## 2. Authority

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

## 3. Membership and Attendance

### Membership

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

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

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

### Quorum

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

### Attendance

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

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

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

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

## 4. Roles and responsibilities

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

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

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

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

### 4.3.1. Reporting

Utilising an 'Alert, Advise, Assurance' approach, reports will be received by the Committee to:

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

### 4.3.2. Financial and Operational performance management

- To undertake high-level, exception-based monitoring of the delivery of operational and financial performance to ensure that the Trust is operating in line with its annual business plan objectives and, where not, satisfy itself that appropriate action is being taken by Executive Directors.

- To take an overview of the Trust's performance against financial and performance objectives as aligned to the Improving Together programme, ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

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

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

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

4.3.3. **Income and Contracts management**

- Review the Trust contracting approach with key commissioners

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

- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

- Consider material opportunities to grow new commercial income streams and market share of existing services.

4.3.4. **Annual Trust planning cycle**

- To consider the Trust's medium and long-term financial strategy, in relation to both revenue and capital.

- To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of divisional business plans, including workforce plans, aligned to the Trust's vision metrics, strategic initiatives, and breakthrough objectives as part of Improving Together.

- Consider proposals for Commercial and Business Development activities in accordance with Standing Financial instructions.
    - The Finance and Performance Committee has delegated authority to approve revenue business cases from **£250k - £750k**.
    - The Committee has delegated authority to approve capital business cases from **£500k - £750k.**

- Review the annual CIP plans to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.

- Receive benchmarking and other information (for example from GIRFT and Model Hospital) to assess Trust productivity and ensure targeting or efficiency programmes.

- Review the Trust procurement strategy, systems, and arrangements for obtaining best value. Monitor progress against the NHS standards of Procurement within the Trust.

- To consider the implications of wider changes in NHS policy and governance within the committee's remit including (but not limited to) the development of Integrated Care Boards (ICB), NHSE regulatory oversight and developments of provider collaboratives including BSW Acute Alliance.

4.3.5. **Capital management**

- Review the strategic five-year capital programme and the annual capital budgets and recommend as appropriate to the Board of Directors.

- To consider the financial proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Approve capital business cases in accordance with the Trust's Detailed Scheme of Delegation (DSoD).

4.3.6. **Treasury management**

- To review the cash position of the Trust and the related treasury management policies of the Trust.

- Review Trust finance applications including loan applications.

4.3.7. **Risk Management**

- The Committee shall ensure the Trust has robust financial and operational risk management systems and processes in place.

- To regularly review the Board Assurance Framework (BAF) and risk profile in accordance with the agreed risk appetite and risk tolerance levels.

4.3.8. **Subsidiary Governance**

- The Committee will receive and review regular updates on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company (known as a related company/entity).

- The Committee will ensure the Trust has a clear strategy for the use and development of subsidiary and related companies/entities.

- To maintain a clear view of the subsidiary level risk profile and the operational, reputational, and financial exposure across the group profile.

- Ensuring the Trust has a clear governance framework and structure for oversight of any related company/entity.

4.3.9 **Digital**

- To review the Digital Strategy and gain assurance on the Trust's digital programmes of work, to scrutinise delivery and achievement of key milestones.

- Receive regular Senior Information Risk Owner (SIRO) reports to have oversight of areas of improved compliance and areas of concern with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

- To have oversight on progress of the Trust's annual Data Security and Protection Toolkit (DPST) submission.

- To gain assurance on the progress and effectiveness of the Trust's cyber security activities.

**4.3.10 Other**

- To review any matters referred to this committee by the Board of Directors.

- To make arrangements as necessary to ensure that all Board members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.

- To notify the Audit Committee of any statutory reporting concerns or system weaknesses identified.

## 5. Conduct of Business

**Administration**

5.1. The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:
- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas.

**Frequency**

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

5.3. Meetings will be held at least nine times per year, with additional meetings stood up where agreed triggers have deemed it appropriate to do so.

**Notice of meetings**

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

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

**Reporting**

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

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board via an escalation report. The

Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

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

## 6. Review

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

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

6.3. These terms of reference were reviewed and approved by Trust Board on {insert date}

NHS
Salisbury
NHS Foundation Trust

# Remuneration, Nominations and Appointments Committee

## Terms of Reference

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of version** | **Version number** | **Type of Revision Major/minor** | **Description of Revisions** | **Author** |
| September 2019 | 1 | New ToR | | Director of Corporate Governance |
| November 2020 | 1.1 | Minor | Updates to membership and attendance sections and minor formatting | Director of Corporate Governance |
| March 2022 | 1.2 | Minor | | Head of Corporate Governance |
| May 2023 | 1.3 | Major | Complete review | Director of Integrated Governance/ Non- Executive Director |
| January 2024 | 1.4 | Minor | Change to membership and quoracy | Director of Integrated Governance |

| | |
|---|---|
| **Date Adopted** | |
| **Review Frequency** | Annual |
| **Terms of Reference Drafting** | Director of Integrated Governance |
| **Review and Approval** | Approved Jan 2024 |
| **Adoption and ratification** | Trust Board |

## 1. Purpose

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

## 2. Authority

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

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

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

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

## 3. Membership and Attendance

### Membership

3.1. Members of the Committee are appointed by the Board and will be made of all Non-Executive Directors, one of which will be the SFT Chair.

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

3.3. The Committee will be chaired by one of the Non-Executive Directors. In the absence of the nominated Chair, another Non-Executive Director will chair the meeting.

### Attendance

3.4. Members of the Committee are expected to attend meetings.

3.5. At the invitation of the Committee, the Chief People Officer and/or the Chief Executive Officer will attend to advise the Committee but will not attend for discussions about their own remuneration and terms of service.

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

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

### Quorum

3.8. The quorum for meetings and necessary for the transaction of business is five non-executives including the Committee Chair and Trust Chair.

3.9. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

### Secretary

3.10. The Director of Integrated Governance or their nominee will act as secretary to the Committee.

## 4. Duties

### 4.1. Appointments

The Committee will:

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

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

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

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

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

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

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

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

### 4.2. Remuneration

The Committee will:

4.2.1. Determine and agree with the Board the framework and policy for the remuneration of SFT Chief Executive Officer and Executive Directors. In determining such policy, consider all factors which it deems necessary including relevant legal and regulatory requirements, and other best practice as appropriate. The objective of such policy shall be to ensure that SFT'S Chief Executive Officer and Executive Directors, are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation.

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

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

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

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

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

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

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

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

## 5. Executive termination payments

5.1. Approve any policies relating to early termination payments. Approve termination payments (including contractual payments such as redundancy or early retirement provisions as well as other payments) for Executive Directors. In doing so the Committee will ensure that any payments are fair, failure is not rewarded and the duty to mitigate loss is fully considered. Payments exceeding £100,000 will require subsequent Board approval.

## 6. Conduct of Business

### Administration

6.1. The Director of Integrated Governance or their nominee will act as secretary to the Committee. The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

6.2. Any member of the Committee can ask for an extraordinary meeting to be convened to meet business needs.

### Frequency

6.3. The Committee will be held quarterly and at such other times as the Chair of the Committee shall require.

### Notice of meetings

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

### Reporting

6.5. The Committee's Chair will report formally to the Board, in the private session, on its proceedings after each meeting.

6.6. The Committee will make whatever recommendations to the Board it deems appropriate in any area within its remit where action or improvement is required.

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

## 7. Review

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

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board Public | Agenda item: | 2.4 |
| Date of meeting: | 2 May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Fit and Proper Person Policy | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | | x |
| Approval Process: (where has this paper been reviewed and approved): | Consultation with OD&P and Corporate Governance<br><br>TMC 24 April | | | |
| Prepared by: | Kylie Nye, Head of Corporate Governance<br>Fiona McNeight, Director of Integrated Governance | | | |
| Executive Sponsor: (presenting) | Fiona McNeight, Director of Integrated Governance | | | |
| Appendices | Fit and Proper Person Policy<br>Policy checklist | | | |

## Recommendation:

The Board is asked to review the updated Fit and Proper Person Policy and approve.

## Executive Summary:

In August 2023, NHS England published an updated Fit and Proper Person test (FPPT) framework with a purpose to strengthen and reinforce individual accountability and transparency for Board members, enhancing the quality of leadership in the NHS. The framework was developed in response to the Kark Review (2019) of the FPPT and also takes into account the CQC requirements - Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out statutory requirements. The new guidance has highlighted several new requirements as part of the FPPT, including:

- New standard board member reference for all new board appointments. To also be created when any board member leaves (regardless of whether they have another NHS Board role) and should be sought by employing organisation.
- ESR will be used to store FPPT related information. CQC will be able to access for inspection.
- No public facing register proposed.
- Full FPPT for all new appointments, board member moves to new board role in current organisation and annually thereafter.
- Annual declaration by board members will continue.
- Increased accountability of the Chair to effectively implement FPPT.
- Annual appraisals should feed into the FPPT annual assessment and make use of the NHS Leadership Competency Framework.
- New Board appraisal framework being developed incorporating the Leadership Competency Framework.
- Senior Independent Director responsible for ensuring the Chair is meeting FPPT.

- Quality assurance through CQC well led reviews and NHSE oversight through annual submission to Regional Directors. Trust to internally audit controls in place every 3 years including sample testing.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the FPPR.

The expectation outlined was that elements of the framework would be enacted from 30 Sept 2023, with full implementation by 31 March 2024. The Corporate Governance team has utilised the comprehensive guidance published last year to update the Trust's Fit and Proper Persons Policy to ensure the appropriate processes are in place to adhere to the new requirements. As part of this work, we have aligned our policy with our acute system partners in the AHA.

The Corporate Governance team is currently working with OD&P to establish each department's responsibilities when new directors are appointed and will be confirmed in the coming weeks (this specifically relates to Appendix B).

| 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 | x |
| Other (please describe): | |

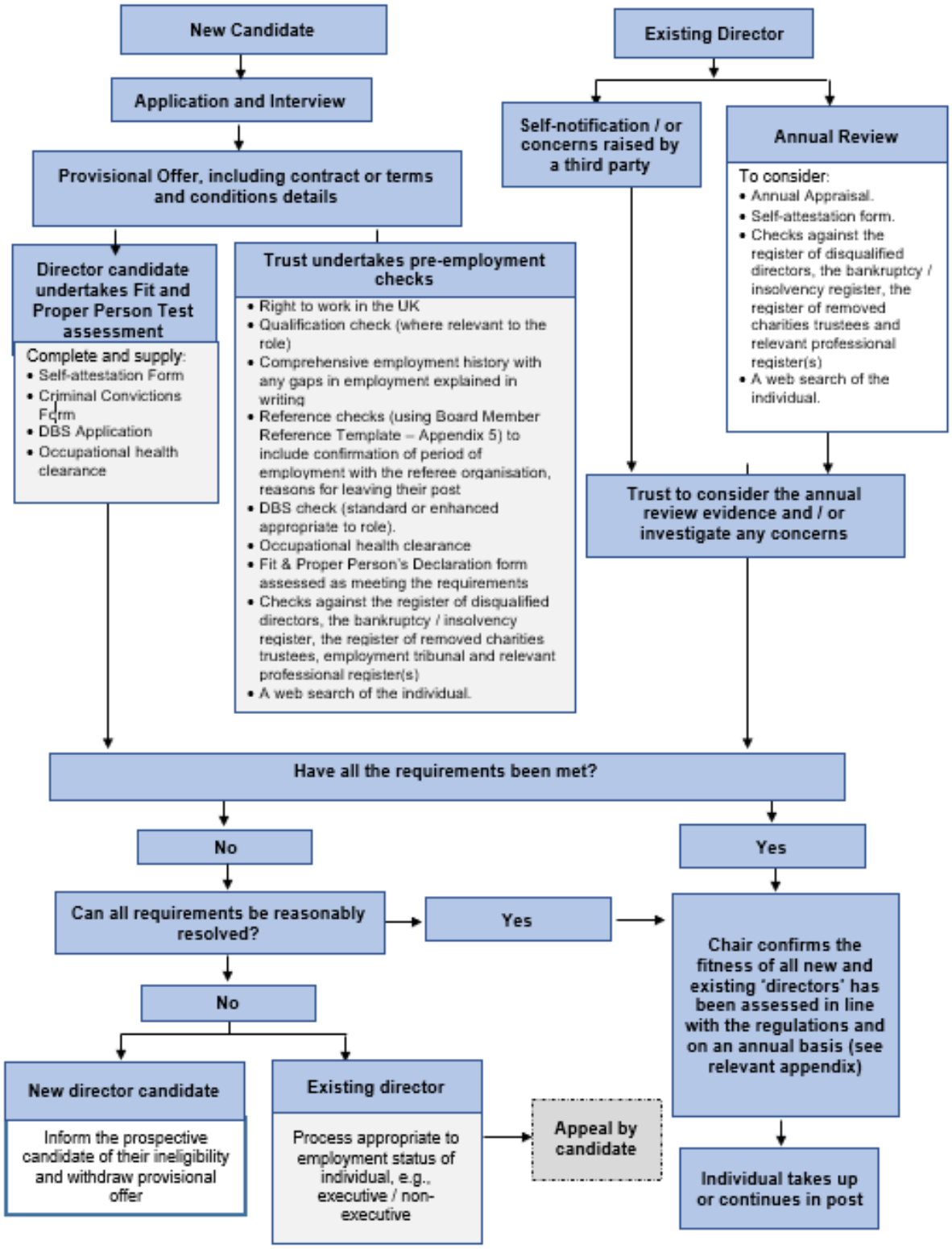
# Fit and Proper Person Requirement (FPPR) Policy

| Version No. | Updated By | Updated On | Description of Changes |
|---|---|---|---|
| 1 | Director of Corporate Governance | March 2020 | New policy |
| 1.1 | Head of Corporate Governance | July 2023 | Review of Policy<br>New QRG<br>New format |
| 2 | Director of Integrated Governance | March 2024 | Major revision based on latest National guidance and policy alignment across the AHA |

**Contents:**

## 1. QUICK REFERENCE GUIDE

### Fit and Proper Person Test Process



## 2. INTRODUCTION

**2.1.** The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into effect for NHS Providers on 27 November 2014 requiring directors to be fit and proper persons (Regulation 5).

**2.2.** Regulation 5 establishes a statutory requirement on all NHS providers not to appoint, or have in place, an individual as a Director (Executive or Non-Executive), or "performing the functions of, or functions equivalent or similar to the functions of a director" unless they satisfy the requirements as set out in the Regulations (Regulation 5(2)).

**2.3.** In January 2018, the Care Quality Commission (CQC) published updated guidance for providers on compliance with Regulation 5. Whilst there have been no changes to the regulation, the guidance provided more detail and clarity on the CQC's expectations of providers in implementing the regulation, particularly in respect to determining misconduct and mismanagement.

**2.4.** The FPP test is integrated into the CQC registration requirements and the regulatory and inspection approach.

**2.5.** The legislation also articulates the expectation that where an individual no longer meets these requirements, the Trust must take appropriate and proportionate action to ensure that the office or position in question is held by an individual who meets such requirements and, if appropriate, inform the appropriate regulator. The CQC recognises that a Trust may not have access to all relevant information about a person, or that false or misleading information may be supplied to them. However, they expect Trusts to demonstrate due diligence in carrying out checks and that they have made every reasonable effort to assure themselves about an individual by all means available to them.

**2.6.** A new Fit and Proper Person Test Framework was published by NHS England in August 2023. This policy reflects the latest requirements.

## 3. PURPOSE

**3.1.** The purpose of this document is to provide the policy and procedures by which Salisbury NHS Foundation Trust (SFT) will support its commitment to the fit and proper person requirements (FPPR), and to ensuring it is not managed or controlled by individuals who present an unacceptable risk either to the Trust or to the people receiving services; that SFT Directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.

**3.2.** The purpose of the Regulation is to ensure that all board level appointments at NHS bodies carrying on a regulated activity are held responsible for the overall quality and safety of the care provided, for making sure the care meets the existing regulations and effective requirements of the Health and Social Care Act, and that providers and directors can be held to account. Services must be safe, effective, caring, responsive and well-led.

## 4. SCOPE

**4.1.** This policy applies to all directors whether executive, non-executive, permanent, interim, deputy or associate directors, irrespective of their voting rights. The requirement does not apply to the Council of Governors. Although

it is for SFT to determine which individuals fall within its scope, the CQC will take a view on how effectively SFT has discharged its responsibility. However, the CQC will not undertake the fit and proper person's test of a director or determine what is serious mismanagement or misconduct[1].

## 5. DUTIES AND RESPONSIBILITIES

| Role | Responsibilities |
|---|---|
| Trust Chair | • The Chair is ultimately responsible to discharge the requirement placed upon the Trust to ensure that all directors meet the requirements of the Fit and Proper Persons Test and do not meet any of the 'unfit' criteria. The Chair is also subject to the requirements of the test. The Chair is responsible for taking the necessary action to ensure existing directors who no longer meet the regulations of the FPPR (i.e., are deemed 'unfit') do not continue in their role |
| Senior Independent Director (SID) | • Annually, the senior independent director (SID) will review and ensure that the Trust Chair is meeting the requirements of the FPPT.<br>• Undertaking any investigations into any concerns raised about the Trust Chair (supported by the Chief People Officer and/or Company Secretary) |
| Chief Executive Officer (CEO) | • Overseeing the outcome of the FPPT for all the Executive Directors |
| Chief People Officer (CPO) | • Jointly overseeing the implementation of the FPPT policy<br>• Ensuring any FPPT undertaken on appointment comply with the process detailed in this policy, bringing non-compliance to the attention of the Chair and/or Senior Independent Director [SID] (as appropriate)<br>• Supporting the Chair and/or SID with any investigations<br>• Ensuring that all appropriate documentation is completed, stored and available for inspection upon request |
| Director of Integrated Governance /supported by Head of Corporate Governance | • Jointly overseeing the implementation of the FPPT<br>• Maintaining the Directors' register of interests including annual updates<br>• Ensuring the annual FPPT declarations are undertaken, recorded and evidenced on ESR and on individual files<br>• Ensuring annual submissions are made to NHSE<br>• Confirming compliance with the policy in the Trust's annual report<br>• Providing advice and support to the Trust Board and Council of Governors in respect of the administration of and compliance with the FPPT<br>• Preparing annual reports for consideration by the appropriate Committee as part of the appraisal process<br>• Identifying any changes to the Regulations or guidance, recommending to the Remuneration Committee and Council of |

| | |
|---|---|
| | Governors' Nominations & Remunerations Committee the appropriate policy amendments |
| Remuneration Committee | • Ensuring ongoing compliance on the application of FPPT in relation to Executive Directors (including the Chief Executive (CEO)) via annual performance appraisals. |
| Nominations Committee | • Ensuring ongoing compliance on the application of FPPT in relation to Non-Executive Directors (NEDs) including the Chair via the annual performance appraisal. |
| Directors (individuals who fall within the policy) | • Providing consent to the required checks as described in this policy<br>• Signing the declaration that they are a fit and proper person on appointment and on an annual basis<br>• Providing evidence of their qualifications, experience, and identity documents on appointment or on request to confirm the competencies relevant to the position<br>• Identifying any issues that may affect their ability to meet the statutory requirements on appointment and bringing any issues on an ongoing basis to the CEO (for Executive Directors) and the Chair (for NEDs). The Chair will raise any issues with the Lead Governor as appropriate |
| Staff | • Raising any concerns via appropriate Trust policies and procedures, for example through the Freedom to Speak Up – Raising Concerns Policy. |
| NHS Regional Director | • Oversight role covering elements of:<br>– appointment and initial Fit & Proper Person Test arrangements<br>– receiving of the annual Fit & Proper Person Test submissions forms<br>– where required, in relation to disputes and appeals. |

## 6. DEFINITIONS

### 6.1. Director

A Board Director of the Trust

### 6.2. Deputy/Associate Director

A direct report of a Board Director

### 6.3. Non-Executive Director

A Non-Executive Director is a member of the Board of Directors of the Trust who is not a member of the Trust Executive Group.

### 6.4. Fit and Proper

Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 sets out the criteria that a director must meet on appointment, and on an ongoing basis:

- be of good character
- have the qualifications, competence, skills, and experience necessary for the relevant office or position or the work for which they are employed

- be able, by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed
- not have been responsible for, contributed to of facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity)
- not be 'unfit' by reason of matters set out in paragraph 4.2.2 below.

**6.5. The 'Unfit Person Test' and considerations relating to 'Good Character'**

6.5.1. Schedule 4 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (**see Appendix A**) describes the unfit person test (part 1) and matters to be considered relating to 'good character' (part 2). Its purpose is to ensure that the Trust is not managed or controlled by individuals who present an unacceptable risk to the organisation or to patients.

6.5.2. Under Schedule 4, Part 1, a director is deemed unfit if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period applies under a debt relief order, which applies under prat VIIA (debt relief orders) of the Insolvency Act 1986(1).
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

6.5.3. In determining whether an individual is of good character, consideration will be given to Schedule 4, Part 2:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and /or
- Whether the person has been erased, removed, or struck off a register of professionals maintained by a regulator of health or social care work professionals.

6.5.4. The document Regulation 5: Fit and proper persons: directors released by the Care Quality Commission in 2018 provides additional guidance to help providers interpret and implement the regulation. This guidance will be taken into account by the Trust

in reviewing an individual's compliance with the Fit and Proper Person Test. The document outlines:

- Definitions of misconduct and mismanagement and when proven misconduct or mismanagement should be assessed as 'serious'
- Factors to consider around concerns regarding serious misconduct or mismanagement
- Features that would normally be associated with 'good character' and factors to consider when assessing 'good character'

### 6.6. Determining Misconduct and Mismanagement

Determining whether there has been serious misconduct or mismanagement is a matter for the Trust and should be managed in line with the Trust's Disciplinary Policy and Procedure. The Trust recognises that context is paramount. When considering mismanagement and misconduct the Trust needs to consider these in relation to; the services the Trust provides, the role of the individual and the possible impact on the Trust or confidence in its ability to carry out its mandate and fulfil its duties in the public interest.

### 6.7. Mismanagement

Mismanagement means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of managers falls below any reasonable standard of competent management. The following are a non-exhaustive list of examples of behaviour that may amount to mismanagement:

- Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it is correct.
- Failing to interpret data in an appropriate way.
- Suppressing reports where findings may be compromising for the organisation.
- Failing to have an effective system in place to protect staff who have raised concerns.
- Failing to learn from incidents, complaints or when things go wrong.
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies or accepted practices.
- Continued failure to develop and manage business, financial or clinical plans.
- Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual, over the interests of people who use a service, staff, or the public; or
- Failing to implement quality, safety and/or process improvements in a timely way, where there are recommendations or where the need is obvious.

### 6.8. Misconduct

6.8.1. The following non-exhaustive list of examples is likely to amount to serious misconduct:

- Disrespect in the workplace
- Failing to comply with lawful instructions.
- Breach of confidentiality.
- fraud or theft.

- any criminal offence (other than minor motoring offences) such as assault; sexual harassment of staff; bullying; victimisation of staff who raise legitimate concerns.

6.8.2. Any conduct that can be characterised as dishonesty, including:

- Deliberately transmitting information to a public authority or to any other person, which is known to be false.
- Submitting or providing false references or inaccurate or misleading information on a CV.
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues.

## 7. PROCESS

### 7.1. New Director Appointments

7.1.1. All appointments will be subject to the individual satisfactorily meeting the Fit and Proper Person Test prior to confirmation of offer of employment/office. An agreed sign-off process with all relevant checks **(Appendix B)** will be carried out prior to final checking by the Trust Chair or nominated deputy and conditional offer. This will include completion, by the individual, of a self-attestation (**Appendix C**). All offers must be conditional on meeting the statutory requirements.

7.1.2. Where a senior level post or interim is sourced by an agency or executive search company, the agency will be made aware of the Trust's Fit and Proper Person Test process and must confirm that they have undertaken the necessary checks; compliance will be confirmed by the Trust.

7.1.3. Disclosure & Barring Service checks - Where the position and role of the director meets the eligibility criteria, a Disclosure & Barring Service check will be undertaken in accordance with the Trust's Employment Check Policy & Procedure.

7.1.4. Disqualification - A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will immediately disqualify that person from the proposed appointment.

7.1.5. Ineligibility of candidates - If the candidate fails to show that they meet the Fit and Proper Person Test as outlined in 6.4 above, the Trust will withdraw the provisional offer of employment.

### 7.2. Joint appointments across different NHS organisations

7.2.1. For joint appointments across different NHS organisations, the full Fit and Proper Person Test would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the Chair of the other contracting NHS organisation to ensure that the Board member is fit and proper to perform both roles.

7.2.2. The host/employing NHS organisation will then provide a 'letter of confirmation' to the other contracting NHS organisation to confirm that the

Board member in question has met the requirements of the Fit and Proper Person Test.

7.2.3. The Chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the Fit and Proper Person test assessment of the board member.

7.2.4. For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a Chair or Non-Executive Director) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the Fit and Proper Person Test.

7.2.5. If the Fit and Proper Person assessment at one organisation finds an individual not to be a Fit and Proper Person, the Chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not a Fit and Proper Person at the other organisation.

### 7.3. Existing Directors: Annual Review Process

7.3.1. The Trust is responsible for ensuring that relevant individuals continue to meet the Fit and Proper Person Test. This shall be done through an annual review which will be aligned with appraisal dates to ensure that outcomes are available for reference at individual appraisals. Documentation will include:

- Completion of the self-attestation form (**Appendix C**) by the individual Annual checks against the disqualified directors register, the bankruptcy and insolvency register, the removed charity trustees register and relevant professional registers.
- The Chair will review and sign (**Appendix D**) to confirm that the annual checks have been completed and that the person continues to meet the Fit and Proper Person Test. Confirmation of compliance will be declared in the Trust's Annual Report.

### 7.4. Existing Directors: Responsive Review Process

7.4.1. Circumstances may arise where concerns are raised about the Fit and Proper Person status of an individual, either by self-notification, or as a result of concerns raised by a third party. Should this occur then a review should take place outside of the normal testing schedule.

### 7.5. Existing Directors: Action required via Annual / Responsive review Process

7.5.1. If an individual is deemed competent but does not hold relevant qualifications, there should be a documented explanation, approved by the Chair, as to why the individual in question is deemed fit to be appointed as a Board member, or fit to continue in role if they are an existing Board member. This should be recorded in the annual return to the NHS England Regional Director.

7.5.2. If an individual is deemed unfit (they failed the Fit and Proper Person Test) for a particular reason (other than qualifications) but the NHS

organisation appoints them or allows them to continue their current employment as a Board member. In such circumstances there should be a documented explanation as to why the Board member is unfit and the mitigations taken, which is approved by the Chair. This should be submitted to the relevant NHS England Regional Director for review, either as part of the annual Fit and Proper Person Test submission for the NHS organisation, or on an ad hoc basis as a case arises.

7.5.3. If an individual is deemed to no longer meet the Fit and Proper Persons Test (either through the annual review process, or via a responsive review), the Chair will be notified and is responsible for making an informed decision regarding the course of action to be followed.

### 7.6. Dispute Resolution

7.6.1. ***Data and information***

Where a Board member identifies an issue with data held about them in relation to the Fit and Proper Person Test, they should request a review which should be conducted in accordance with local policies in the first instance. Where this does not lead to a satisfactory resolution for the Board member, the following options are available:

- For NHS England-appointed Board members (NHS Trust Chairs and Non-Executive Directors and Integrated Care Board Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For Chairs not appointed by NHS England – a further request for review can be made to the Senior Independent Director or Deputy Chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other Board members (including NHS England-appointed Board members, and Chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
    - referring the matter to the Information Commissioner's Office
    - taking the matter to an employment tribunal (for executive director roles only)
    - instigating civil proceedings.

*7.6.2.* ***Outcome of Fit and Proper Person Test assessment***

Where a Board member disagrees with the outcome of the Fit and Proper Person Test assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed Board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
    - Where this results in a Board member being terminated from their appointed role, a Board Member Reference must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
    - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

At any point, employees have the right to take the matter to an Employment Tribunal.

### 7.7. Personal Data

7.7.1. Personal data for Board members relating to the Fit and Proper Person Test assessment will be retained in local record systems and on the NHS Electronic Staff Record.

7.7.2. Fit and Proper Person Test outcomes must be entered onto Electronic Staff Record so that an Electronic Staff Record Fit and Proper Person Test Dashboard can reviewed by the Chair. Once satisfied, the Chair must update and sign off each Board member on Electronic Staff Record.

7.7.3. An annual submission form (**Appendix E**) will be generated for Chair sign off and submitted to the NHS England Regional Director, where the NHS England Fit and Proper Person test central team will collate records from NHSE regions.

### 7.8. Board Member Reference Request

7.8.1. NHS organisations will need to request Board member references (**Appendix F**), and store information relating to these references so that it is available for future checks; and use it to support the full Fit and Proper Person test assessment on initial appointment.

7.8.2. NHS organisations should maintain complete and accurate Board member references at the point where the Board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and Board member references should be retained locally on Electronic Staff Record.

7.8.3. Board member references will apply as part of the Fit and Proper Person test assessment when there are new Board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

- New appointments that have been promoted within an NHS organisation.
- Existing Board members at one NHS organisation who move to another NHS organisation in the role of a board member.
- Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.
- Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

### 7.9. Breaches of the Regulation

7.9.1. The regulation is breached if the Trust has in place someone who does not satisfy the FPPT. Evidence of this could be if:

- A Director is unfit on a ‘mandatory’ ground, such as a relevant un-discharged conviction or bankruptcy.
- The Trust does not have a proper process in place to enable it to make the robust assessments required by the FPPT.

- On receipt of information about a director's fitness, a decision is reached on the fitness of the Director that is not in the range of decisions that a reasonable person would make.
- A Director has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England, would be a regulated activity.

7.9.2. An offence contrary to the Fraud Act 2006 may be committed if an employee provides false documentation, references, or experience in relation to pre-employment checks. Any such suspected conduct will be investigated in accordance with the Trust's Resolution Policy and will also be referred to the Local Counter Fraud Specialist, potentially resulting in a full investigation, appropriate disciplinary action and/or prosecution. Where it is found non-compliance constitutes a criminal offence, it will be subject to a criminal investigation and sanction as appropriate.

7.9.3. If fraud is suspected in relation to this policy, please report to the Trust's Local Counter Fraud Specialist as follows:

**The Local Counter Fraud Specialist**
**Tel: 07392861672**
**Email: Isabel.Turner@kpmg.co.uk**

or by calling the NHS Counter Fraud Authority (NHSCFA) FREE 24 hour confidential fraud reporting hotline on 0800 028 4060 or report via the online reporting form: https://cfa.nhs.uk/report-fraud. Please refer to the Trust's Fraud and Corruption Policy for further details.

### 7.10. Training requirements

7.10.1. Training will be provided by the Corporate Governance Team to Executive / Non-Executive Directors around the declarations to be made.

## 8. MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF THIS POLICY

**8.1.** An annual review of compliance against all of the elements defined within this policy will be presented to the Board of Directors.

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements |
|---|---|---|---|---|
| Fit and Proper Persons tests undertaken for newly appointed Directors | Chief People Officer | Audit of personal files to ensure the pre-employment checks (including FPPT) have been undertaken for all new Director appointees. | On appointment | Trust Chair / Chief Executive |

| | | | | |
|---|---|---|---|---|
| Annual Fit and Proper Persons test declarations completed by existing Directors. | Director of Integrated Governance / Head of Corporate Governance | Audit of personal files to ensure the annual fit and proper persons declarations have been completed by existing Directors. | Annually | Trust Chair / Chief Executive |

## 9. REFERENCES AND FURTHER READING

Equality Act 2010
Safeguarding Vulnerable Groups Act 2008
Care Quality Commission – Regulation 5: Fit and proper persons: directors (2018)
The Health and Social Care Act (Regulated Activities) Regulations 2014
NHS Employers Employment Check standards
Insolvency Act 1986
Police Act 1997
Fit and Proper Persons Regulations in the NHS – What do providers need to know? (NHS Providers).
NHS England Fit and Proper Person Test Framework for board members (August 2023).

## 10. EQUALITY IMPACT ASSESSMENT FOR POLICIES

**10.1.** Salisbury NHS Foundation Trust aims to design and implement services and policies that meet the diverse needs of its services, population and workforce, ensuring that none are placed at a disadvantage over others.

***10.2.*** *This document has been assessed against the Trust's Equality Impact Assessment Tool. This document has been assessed as not relevant to the duty.*

## 11. RATIFICATION CHECKLIST

| | |
|---|---|
| **Post Holder /Author Responsible for Policy:** | Fiona McNeight<br>Director of Integrated Governance/<br>Kylie Nye Head of Corporate Governance |
| **Date Written:** | July 2023 |
| **Date Reviewed:** | March 2024 |
| **Approved By:** | |
| **Ratified by:** | |
| **Next Due for Review:** | March 2026 |

**12. APPENDICES**

# Appendix A: Regulation 5 – Schedule 3: Information required in respect of persons employed or appointed for the purposes of a regulated activity

**1.** Proof of identity including a recent photograph.

**2.** Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(**1**), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(**2**).

**3.** Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

**4.** Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to—
(a) health or social care, or
(b) children or vulnerable adults.

**5.** Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.

**6.** In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

**7.** A full employment history, together with a satisfactory written explanation of any gaps in employment.

**8.** Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

**9.** For the purposes of this Schedule—
(a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;
(b) "satisfactory" means satisfactory in the opinion of the Commission;
(c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

# Appendix B: Fit and Proper Person Test checklist

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **First name** | ✓ | ✓ | ✓ | x – unless change | ✓ | ✓ | Application and recruitment process. | **Recruitment team to populate Electronic Staff Record.**<br><br>For NHS-to-NHS moves via Electronic Staff Record / Inter-Authority Transfer/ NHS Jobs.<br><br>For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency. | |
| **Second name/surname** | ✓ | ✓ | ✓ | x – unless change | ✓ | ✓ | | | |
| **Organisation**<br><br>(ie current employer) | ✓ | x | ✓ | N/A | ✓ | ✓ | | | |
| **Staff group** | ✓ | x | ✓ | x – unless change | ✓ | ✓ | | | |
| **Job title**<br><br>Current Job Description | ✓ | ✓ | ✓ | x – unless change | ✓ | ✓ | | | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **Occupation code** | ✓ | x | ✓ | x – unless change | ✓ | ✓ | | | |
| **Position title** | ✓ | x | ✓ | x – unless change | ✓ | ✓ | | | |
| **Employment history**<br><br>Including:<br>• job titles<br>• organisations/ departments<br>• dates and role descriptions<br>• gaps in employment | ✓ | x | ✓ | x | ✓ | ✓ | Application and recruitment process, CV, etc. | Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained.<br><br>The period for which information should be recorded is for local determination, taking into account relevance to the person and the role.<br><br>It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly. | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **Training and development** | ✓ | ✓ | ✓ | ✓ | ✓ | * | Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification.<br><br>Annually updated records of training and development completed/ongoing progress. | * NED recruitment often refers to a particular skillset/experience preferred, e.g. clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration.<br><br>At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role.<br><br>For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role.<br><br>It is suggested that key qualifications required for the role and noted in the person specification (e.g. professional qualifications) and dates are recorded however far back that may be. | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly. | |
| **References**<br><br>Available references from previous employers | ✓ | ✓ | ✓ | x | ✓ | ✓ | Recruitment process | Including references where the individual resigned or retired from a previous role | |
| **Last appraisal and date** | ✓ | ✓ | ✓ | ✓ | ✓ | * | Recruitment process and annual update following appraisal | * For Non-Executive Directors, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required. | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **Disciplinary findings**<br><br>That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Reference request (question on the new Board Member Reference).<br><br>Electronic Staff Record (high level)/ local case management system as appropriate. | The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to Fit and Proper Person Test.<br><br>This question is applicable to board members recruited both from inside and outside the NHS. | |
| **Grievance** against the board member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Whistleblowing claim(s) against the board member | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| Behaviour not in accordance with organisational values and behaviours or related local policies | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| Type of Disclosure and Barring Service disclosed | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Electronic Staff Record and DBS response. | Frequency and level of Disclosure and Barring Service in accordance with local policy for board members. Check annually whether the Disclosure and Barring Service needs to be reapplied for.<br><br>Maintain a confidential local file note on any matters applicable to Fit and Proper Person Test where a finding from the Disclosure and Barring Service needed further discussion with the board member and the resulting conclusion and any actions taken/required. | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| Date Disclosure and Barring Service received | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Electronic Staff Record | | |
| Date of medical clearance* (including confirmation of OHA) | ✓ | x | ✓ | x – unless change | ✓ | ✓ | Local arrangements | | |
| Date of professional register check (eg membership of professional bodies) | ✓ | x | ✓ | ✓ | ✓ | x | E.g. NMC, GMC, accountancy bodies. | | |
| Insolvency check | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Bankruptcy and Insolvency register | Keep a screenshot of check as local evidence of check completed. | |
| Disqualified Directors Register check | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Companies House | | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **Disqualification from being a charity trustee check** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Charities Commission | | |
| **Employment Tribunal Judgement check** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Employment Tribunal Decisions | | |
| **Social media check** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Various – Google, Facebook, Instagram, etc. | | |
| **Self-attestation form signed** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Template self-attestation form | | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **Sign-off by Chair/Chief Executive** | ✓ | x | ✓ | ✓ | ✓ | ✓ | Electronic Staff Record | Includes free text to conclude in Electronic Staff Record fit and proper or not. Any mitigations should be evidence locally. | |
| **Other templates to be completed** | | | | | | | | | |
| **Board Member Reference** | ✓ | ✓ | x | x | ✓ | ✓ | Template BMR | To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest. | |
| **Letter of Confirmation** | x | ✓ | ✓ | ✓ | ✓ | ✓ | Template | For joint appointments only | |

| Fit and Proper Person Test Area | Record in Electronic Staff Record | Local evidence folder | Recruitment Test | Annual Test | Executive Director | Non-Executive Director | Source | Notes | Responsibility HR/ corporate governance |
|---|---|---|---|---|---|---|---|---|---|
| **Annual Submission Form** | x | ✓ | ✓ | ✓ | ✓ | ✓ | Template | Annual summary to Regional Director | |
| **Privacy Notice** | x | ✓ | x | x | ✓ | ✓ | Template | Board members should be made aware of the proposed use of their data for Fit and Proper Person Test | |
| **Settlement Agreements** | x | ✓ | ✓ | ✓ | ✓ | ✓ | Board member reference at recruitment and any other information that comes to light on an ongoing basis. | Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses. | |

## APPENDIX C – SFT FPPT SELF ATTESTATION FORM

# New starter/Annual NHS FPPT self-attestation

Every board member should complete the template annually and this attestation should be submitted to the Corporate Governance team on behalf of the chair.

**Fit and Proper Person Test annual/new starter self-attestation**

**Salisbury NHS Foundation Trust**

I declare that I am a fit and proper person to carry out my role. I:

am of good character

have the qualifications, competence, skills and experience which are necessary for me to carry out my duties

where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals

am capable by reason of health of properly performing tasks which are intrinsic to the position

am not prohibited from holding office (eg directors disqualification order)

within the last five years:

- I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
- been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
- nor is on any 'barred' list.

have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

| | |
|---|---|
| Name and job title/role: | |
| Professional registrations held (ref no): | |
| Date of DBS check/re-check (ref no): | |
| Signature: | |

| | |
|---|---|
| Date of last appraisal, by whom: | |
| Signature of board member: | |
| Date of signature of board member: | |
| **For chair to complete** | |
| Signature of chair to confirm receipt: | |
| Date of signature of chair: | |

# APPENDIX D: Fit and Proper Persons Requirement – Annual Checklist for existing Directors

| | |
|---|---|
| **Name** | |
| **Position** | |

| Item | Checked by (Initials) | Any relevant information to note |
|---|---|---|
| Fit and Proper Persons Requirement self-declaration signed and returned (appendix c) | | |
| Disqualified Directors Check | | *(date to be noted)* |
| Bankruptcy & insolvency check | | *(date to be noted)* |
| Removed Charity Trustees check | | *(date to be noted)* |
| Financial Conduct Authority<br>*where individual has worked for an organisation regulated by the Financial Conduct Authority (FCA)* | | *(date to be noted)* |
| Employees Tribunal | | *(date to be noted)* |
| Where appropriate, relevant professional registers | | |
| Web search results | | |

I confirm that the above checks have been undertaken and I am satisfied the individual named above is assessed to be a "fit and proper person" to continue in their appointed role.

| **Trust Chair** | **Name** | **Signature** | **Date** |
|---|---|---|---|
| | | | |

# APPENDIX E – ANNUAL NHS FPPT SUBMISSION REPORTING TEMPLATE

| NAME OF ORGANISATION | NAME OF CHAIR | FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST: |
|---|---|---|
| | | |

## Part 1: FPPT outcome for board members including starters and leavers in period

| Name | Date of appointment | Position | Confirmed as fit and proper? | | Leavers only | |
|---|---|---|---|---|---|---|
| | | | Yes/No | Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed | Date of leaving and reason | Board member reference completed and retained? Yes/No |
| | | | | | | |
| | | | | | | |

***Add additional lines as needed***

## Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

| Reviewer / inspector | Date | Outcome | Outline of key actions required | Date actions completed |
|---|---|---|---|---|
| CQC | | | | |
| Other, eg internal audit, review board, etc. | | | | |
| | | | | |
| | | | | |

***Add additional lines as needed***

## Part 3: Declarations

| DECLARATION FOR [name of organisation] [year] | | | | |
|---|---|---|---|---|
| **For the SID/deputy chair to complete:** | | | | |
| FPPT for the chair (as board member) | Completed by (role) | Name | Date | Fit and proper? Yes/No |
| | | | | |
| **For the chair to complete:** | | | | |
| Have all board members been tested and concluded as being fit and proper? | Yes/No | If 'no', provide detail: | | |
| | | | | |
| Are any issues arising from the FPPT being managed for any board member who is considered fit and proper? | Yes/No | If 'yes', provide detail: | | |
| | | | | |
| *As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.* | | | | |
| Chair signature: | | | | |

| | |
|---|---|
| Date signed: | |
| **For the regional director to complete:** | |
| Name: | |
| Signature: | |
| Date: | |

# APPENDIX F – BOARD MEMBER REFERENCE TEMPLATE

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

**Re: [applicant's name] - [ref. number] – [Board Member position]**

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

## Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.

Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

| | |
|---|---|
| **1. Name of the applicant (1)** | |
| **2. National Insurance number or date of birth** | |

**3. Please confirm employment start and termination dates in each previous role**

*A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)*

*B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)*

Job Title:

From:

To:

Job Title

From:

To:

Job Title:

From:

To:

Job Title:

From:

To:

Job Title:

From:

| | | |
|---|---|---|
| To: | | |
| **4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):**<br>*(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)* | | |
| | | |
| **5. Please confirm Applicant remuneration in current role** (*this question only applies to Executive Director board positions applied for)* | Starting: | Current: |
| **6. Please confirm all Learning and Development undertaken during employment:**<br>*(this question only applies to Executive Director board positions applied for)* | | |
| | | |
| **7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes?**<br>***(only applicable if being requested after a conditional offer of employment)*** | Days Absent: | Absence Episodes: |
| **8. Confirmation of reason for leaving:** | | |

| | | |
|---|---|---|
| | | |
| | | |
| **9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS)**<br>(This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board) | | |
| **Date DBS check was last completed.** | Date | |
| **Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)** | Level | |
| **If an enhanced with barred list check was undertaken, please indicate which barred list this applies to** | Adults □<br>Children □<br>Both □ | |
| **10. Did the check return any information that required further investigation?** | Yes □ | No □ |
| If yes, please provide a summary of any follow up actions that need to/are still being actioned: | | |
| **11. Please confirm if all annual appraisals have been undertaken and completed** | Yes □ | No □ |

| | | |
|---|---|---|
| (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board) | | |
| Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals: | | |
| **12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)?**<br><br>(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position) | Yes □ | No □ |
| If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions: | | |
| **13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to:**<br>• **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS**<br>• **Dishonesty**<br>• **Bullying**<br>• **Discrimination, harassment, or victimisation** | Yes □ | No □ |

| | | |
|---|---|---|
| • **Sexual harassment**<br>• **Suppression of speaking up**<br>• **Accumulative misconduct**<br><br>(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position) | | |

If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:

**14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)**

**Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)**

**The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**

**15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.**

Referee name (please print): …….. Signature: ……

Referee Position Held:

| | |
|---|---|
| Email address: | Telephone number: |
| Date: | |

**Data Protection:**

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Checklist for Approval and Ratification Boards Procedural Documents

NHS Salisbury NHS Foundation Trust

**Policy Name: Fit and Proper Persons Policy**

**Action Requested: Ratification by TMC**

| | | Yes/No/ N/A | Comments |
|---|---|---|---|
| **1** | **Format & Layout** | | |
| | Has a quick reference guide been included? | x | |
| | Is the procedural document clearly set out and free from spelling errors? | x | |
| | Is the key information displayed at the beginning of the procedural document? | x | |
| | Have the appendices been saved as separate documents?<br>Please ensure that PDFs are not included in published documents as they do not meet The Web Content Accessibility Guidelines (known as WCAG 2.1) | x | |
| **2** | **Additional assessments** | | |
| | Does the procedural document have the following:<br>• Equality Impact Assessment (for 'Must Do' policy only)<br>• An Approved Privacy Impact Assessment (if you implementing a new system or service, or changing the way you work)<br>If yes, attach for the Ratifying committee to review | x<br>N/A | |
| **3** | **Title and Rationale** | | |
| | Is the title clear and unambiguous? | x | |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | x | |
| | Are reasons for development of the document stated? | x | |
| **4** | **Development Process** | | |
| | Who has been involved in the development of the procedural document?<br>• Head of Corporate Governance<br>• Director of Integrated Governance<br>• Deputy Chief People Officer<br>• Associate Director of HR Operations | | |
| | For procedural documents that detail training needs or specifications have these been agreed with the Education Department? | N/A | |
| **5** | **Content** | | |
| | Is the objective of the document and intended outcomes clear? | x | |
| | Is the target population clear and unambiguous? | x | |
| | Are the statements clear and unambiguous? | x | |
| **6** | **Evidence Base** | | |

| | | Yes/No/ N/A | Comments |
|---|---|---|---|
| | Are key references cited? | x | |
| | Are supporting documents referenced? | x | |
| **7** | **Local Approval** | | |
| | Has DTC approval been given (for clinical documents including drugs) Yes ☐ No ☐ Not applicable x | | |
| | Which Governance Committee/Group has approved the procedural document:<br>Asking for TMC approval – will then report to Board for final ratification as it is a Trust Wide Policy | | |
| | If appropriate have the joint OD and People/staff side committee (or equivalent) approved the document? | N/A | |
| **8** | **Dissemination** | | |
| | What is the implementation Plan: Once approved, comms to affected staff will be delivered. | | |
| | Who (job title/name) will review this document: Kylie Nye, Head of Corporate Governance / Fiona McNeight, Director of Integrated Governance | | |
| **9** | **Document Control** | | |
| | Does the document include version details? | x | |
| **10** | **Process to monitor compliance and effectiveness** | | |
| | Are there measurable standards to support the monitoring of compliance with and effectiveness of, the document? | x | |
| **11** | **MicroGuide** | | |
| | Is this document new or replaces an existing document?<br>If a replacement, what does it replace? | new ❑ replacement x<br>The existing fit and proper persons policy. | |
| | For new procedural documents please state where on MicroGuide this document should be placed<br>Guide Name: N/A Subheading name: | | |
| **12** | **Review Date** | | |
| | When will this procedural document be reviewed: 1 year ☐ 3 years X 5 years ☐ | | |

| **Post Holder responsible for the Policy/Document Approval** | | | |
|---|---|---|---|
| The Post Holder (procedural document owner/author) should sign here to confirm their approval of the document and their authority for its submission to the Board | | | |
| Name | Kylie Nye | Date: | 14/03/2024 |
| Signature | *Kylie Nye* | | |

| **Board/Committee Ratification** | | | |
|---|---|---|---|
| If the committee is happy to ratify the approval of this document, the minutes should reflect this. Chair of the board/committee should sign and date it here. Document owner to maintain this signed approval form in their records | | | |
| Name | | Date | |
| Signature | | | |

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| 3eport to: | Trust Board (Public) | Agenda item: | 3.1 |
| Date of meeting: | 02nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Integrated Performance Report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | Yes | |
| Approval Process: (where has this paper been reviewed and approved): | Niall Prosser, Chief Operating Officer | | | |
| Prepared by: | Adam Parsons, Operational Performance Lead | | | |
| Executive Sponsor: (presenting) | Mark Ellis, Chief Finance Officer | | | |

## Recommendation:

The Trust Management Committee are asked to note the Trust's operational performance for Month 12 (March 2024).

## Executive Summary:

**Breakthrough Objectives**

- *Wait to First OP Appointment* was static at 128 days and remains at lowest point since March 2023. The Access Meeting is having a positive impact on this, achieving the long wait reduction to meet national target of zero patients waiting >78 weeks by the end of March. In addition, the aim to minimise those waiting >65 weeks ended with only 9 patients.
- Flow through the Trust improved and is reflected in *Bed Occupancy* reduction from 101.5% to 98% supported by the decrease in patients with *No Criteria to Reside (NCTR)* from 85.5 to 73 daily average. The Trust is finalising plans for 2024/25 with a reduction of NCTR to 5-10% of our core bed base.
- Reducing patient harm measured through *Falls* increased to 6.6 per 1,000 bed days however is below the improvement target again and finishes the year with an outstanding 8 months achievement of this.
- Staff Availability measured by *Agency Spend* reduced sharply to 3.8% from 4.5% and is again only fractionally above the target.

**Deteriorating Performance**

- Cancer remains under national monitoring with the Trust in tier 2 Cancer oversight for our current *62-day backlog* position. Performance against this metric improved again for the second consecutive month, with a sharp reduction in the backlog from 145 to 117 patients and is forecast to be close to the target of 78 by the end of March 2024. Positive improvement was seen across all pathway metrics in month:
  - *28-day Faster Diagnosis Standard (FDS)* from 65.2% to 73.8%
  - *31-day Standard* from 87.8% to 92.4%
  - *62-day Standard* from 53.2% to 66.2%

  Note: Cancer data is one month behind, reporting February in this IPR.
- Stroke *4-hour Standard* performance was static at 30% performance however this extends the negative trend since November 2023 and has room for improvement, despite being a better comparative position than the previous year. Time to CT scan fell for the second month with 40% of stroke patients receiving this within an hour.

- Diagnostics *6-week Standard (DM01)* was slightly below plan of 87.9% at 83.6%. Although this is also a good starting point as substantially better than the comparative 69% achieved the previous year.

**Alerting Metrics**

- The Emergency Department (ED) improved performance across all metrics despite highest attendances in over 6 years at 7,411. The *4-hour Standard* increased after recent decline to 74.9% and *Ambulance Handovers* reduced to 22 minutes average. Service model changes of Rapid Assessment Treatment and Triage (RATT) and more recently utilising Short-Stay Emergency Unit (SSEU) as a Clinical Decisions Unit (CDU) have contributed to commendable performance.
- The number of *Complaints Closed within Agreed Timescale* and *High Harm Falls* fluctuate as proven this month at 28% and 4 respectively.

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

# Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

## March 2024

# Summary

# March 2024

Salisbury NHS Foundation Trust

This month saw the Trust make positive improvements across a range of metrics. Bed Occupancy and patients with No Criteria to Reside (NCTR) continued their reduction to 98% and 73 daily average respectively, and the Overall Length of Stay (LoS) of patients also improved to 8.8 days. All of these are noticeably better than the comparative month last year (109.8% / 156 average / 9.6 days) and more significantly, the overall position across last year, indicating potential for a promising year ahead.

As a result of the improvements described above, the Trust only entered the highest level of escalation (OPEL 4) on 3 days in the month and this had a direct impact on supporting the Emergency Department (ED), as whilst seeing the highest number of attendances in at least 6 years at 7,411 the Trust 4-hour standard performance improved to 74.9%. Ambulance Handovers also improved to 22 minutes average, with the number of Handovers 60+ minutes reducing remarkably to 57 from 91 in the previous month.

Cancer performance remains under national monitoring with the Trust in Tier 2 Cancer oversight for our 62-day patient backlog position. Performance against this metric improved again for the second consecutive month, with a sharp reduction in the backlog from 145 to 117 patients and is forecast to be close to the target of 78 by the end of March 2024. Performance across the service improved resulting from additional capacity, notably the 28-day Faster Diagnosis Standard (FDS) increasing to highest position in over a year from 65.2% to 73.8% and close to the target. The 31-day Standard improved from 87.8% to 92.4% and 62-day Standard from 53.2% to 66.2% in what was a good month. Note: Cancer reports a month behind, February in this IPR.

Even with the reduced working days resulting from the bank holiday, the breakthrough objective of Wait Time to 1st Appointment was able to remain static at 128 days - remaining the lowest point since March 2023 - although the Total Referral to Treatment (RTT) Waiting List increased to 30,063. Focus through the Access Meeting was to reduce long waiting patients to meet national targets, and the Trust ended the year achieving the most important, by having zero patients waiting longer than 78 weeks for treatment. The next target was to minimise those waiting more than 65 weeks and the Trust ended the year with only 9 patients. This will continue and drive towards reducing the wait time for patients to less than 52 weeks by this time next year.

Diagnostics 6-week Standard (DM01) achieved 83.6% against a target of 85% although this is a 14% improvement on the Trust position 12 months ago.

Quality related metrics were varied, with highlights being the number of Pressure Ulcers reducing to lowest point since September 2022 at 1.33 per 1,000 bed days and the number of patients who Moved Bed More Than Once reducing in line with improved flow to the lowest point in a year at 2.25%. The breakthrough objective of Reducing Falls increased to 6.6 per 1,000 bed days although remains below the improvement target of 7 and leaves the annual position of 8 months attainment of this target. Nursing Care Hours per Patient Day (CHPPD) was static at 8 hours and continues to position the Trust in the lowest quarter nationally, providing room for improvement.

Wider workforce metrics remained positive, with the Staff Vacancy Rate commendably sustaining improvement trend to extend the lowest point on record at 1.6%. The breakthrough objective of staffing availability measured by Agency Spend reduced sharply to 3.8% and is again only fractionally above the target, similar to Staff Absence which continued improvement for the third month to 3.36%. Staff Turnover was static at 13.7% to round out a brilliant year of workforce improvement.

Finance reported a monthly control total surplus of £8.9m against an original deficit target of £0.2m - a favourable variance of £8.7m. The annual control total position was an underlying deficit of £8.675m, which is a small deficit of £135k, when the additional £2m Elective Recovery Fund (ERF), £2.2m NHS England funds and £4.34m historic Clinical Commissioning Group (CCG) surplus are accounted for.

# Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

NHS Salisbury NHS Foundation Trust

**People**
working for us

**Population**
our patients and their families

**Partnerships**
working with us

## Vision metrics 7 – 10 years

- Engagement Score in Staff Survey
- Reduction of unwanted turnover (people leaving the Trust or the NHS)
- Proportion of WDES & WRES at median
- # of wait metrics at median
- Total incidents with moderate or high harm
- Patient Engagement Score
- Increase in Healthy Life Years
- Overall Length of Stay
- Matrix Measure

### Strategic initiatives 3-5 years

- Continuous improvement culture
- Delivering our people promise
- Delivering Digital Care
- Improving health and reducing health inequalities

**Corporate Projects**

### Breakthrough Objectives 12-18 months

- Reducing Falls
- Reducing time to first outpatient appointment
- Staff Availability
- Bed Occupancy

# What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

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

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

# Business Rules - Driver Metrics

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

# Business Rules - Watch Metrics

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

# Business Rules - Statutory/Mandatory Metrics

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

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

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

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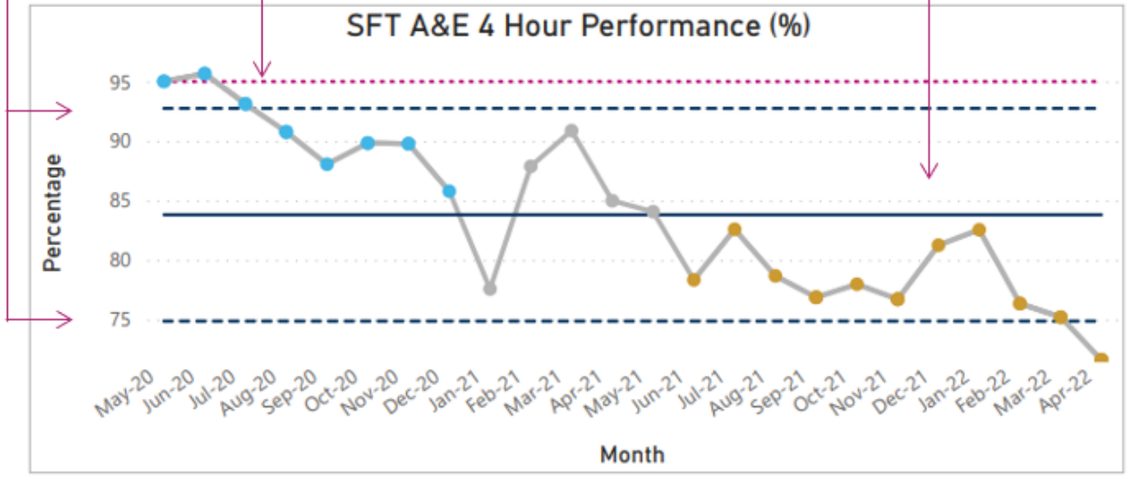
# Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset




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

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

**Grey** markers show normal behaviour with no significant cause for variation

# Part 1: Quality of Care, Access and Outcomes

## Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

**Our Priorities**

**Population**

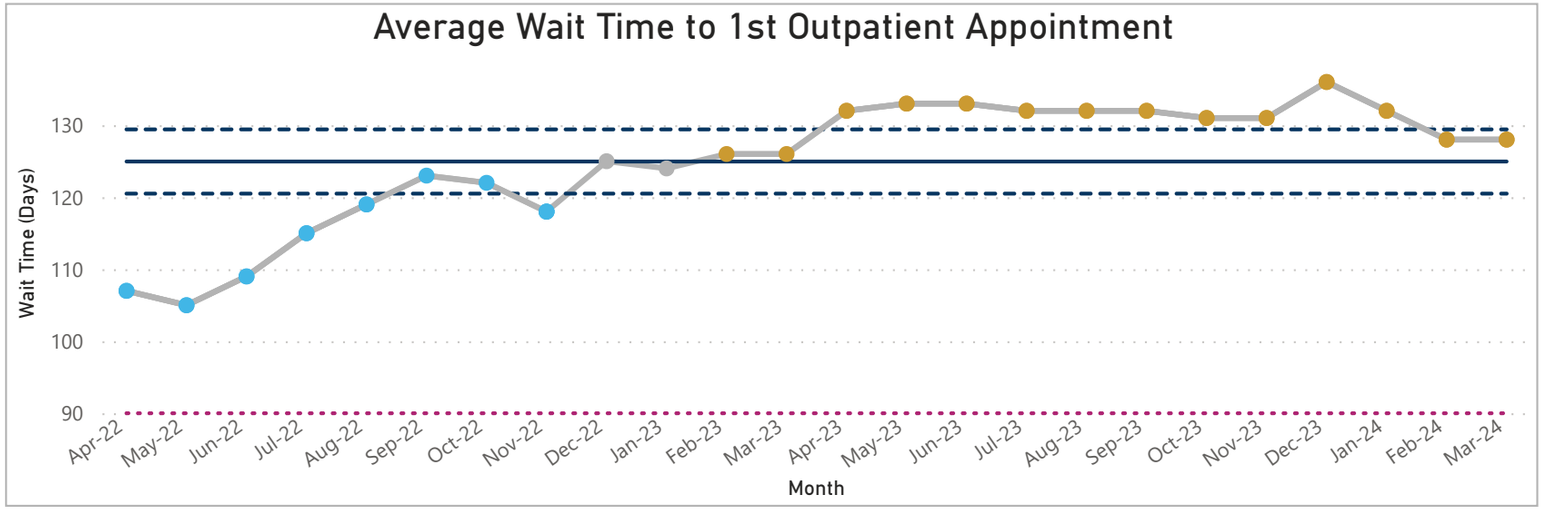
**Partnerships**

**People**

# Reducing Patient Waiting Times

## Target 87 days

Breakthrough Objective




### We are driving this measure because...

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

A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18 week RTT target at risk.
It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

### Understanding the performance

Wait time to 1st appointment performance was static at 128 days for a second consecutive month, maintaining the improved position since December and holding the lowest position since March 2023.

Contributing specialties of note to overall time and monthly change were as follows:
- Oral Surgery - Increase of 10 days
- Plastic Surgery - Increase of 8 days
- Gastroenterology - Reduction of 6 days
- Ear Nose and Throat (ENT) - Reduction of 13 days

And Divisional level contribution as follows:
- Clinical Support and Family Sevices (CSFS) - Increase of 5 day (115.5)
- Women and Newborn (W&NB) - Reduction of 0.5 days (136.9)
- Surgery - Static (133.5)
- Medicine - Reduction of 0.3 days (109.5)

Weekly Access Meeting now in place with representation from all Divisions. Primarily focusing on delivering the national long waits reduction targets with a consequential positive impact on all wait times, suppoting a downward trend in performance.

### Actions (SMART)

- Introduction of Outpatient Improvement Group.
- Increase in Urgent referrals have been noted and internal analysis has been undertaken to identify variation in individual practice referral behaviours - comms plan and targeted practice visits to be arranged.
- Planned Care Board to continue to focus on a further three specialities: General Surgery, Gynaecology and Respiratory to drive reduction improvement.
- Trust progress against long waiting patients including those awaiting 1st Appointment to continue to be monitored weekly and to be reported to the CEO and COO via weekly summary updates.
- Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients via new Access Meeting.
- Capacity and Demand support to Gynaecology concluded, Plastics and Respiratory in progress.
- Further rollout of specialty huddles to contribute to reduction in Time to 1st OP Appointment - as seen in Plastics and ENT - in line with Improving Together approach.

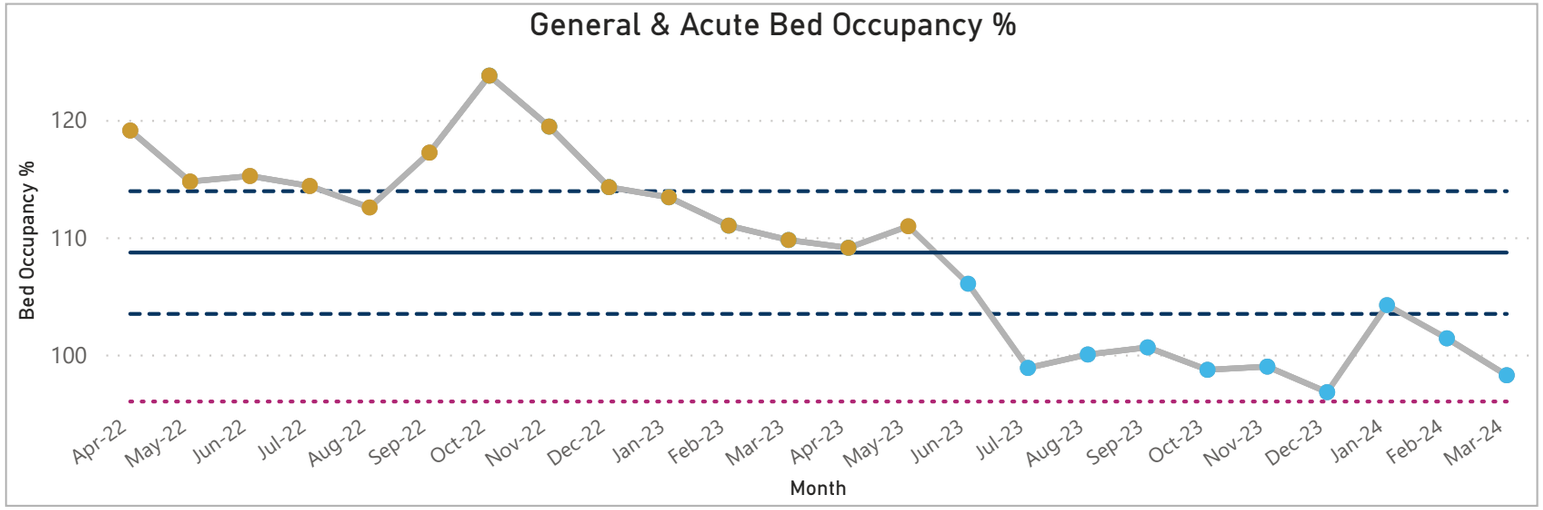
### Risks and Mitigations

- Limitations continue in relation to the Trusts ability to comprehensively map demand and capacity, however the Performance team are supporting this work with the Divisions and specialities.
- Risk of any future IA and potential impact.
- Weekly Access Meeting now in place to reduce risk of long waiters and drive towards national reduction targets.
- Continued growth in demand against challenges to recruit to some positions is a risk.

# Optimising Beds

**Target 92%**

Breakthrough Objective




## We are driving this measure because…

Bed occupancy is used as a driver metric as it is closely linked to length of stay.

Lower bed occupancy generally is associated to optimised clinical practice and lower lengths of stay, the combination of the two are known to demonstrate good outcomes and patient experience. An additional positive consequence is also lower temporary staffing costs.

## Understanding the performance

Bed occupancy has dropped in March for the second consecutive month to 98%.

The Emergency Department (ED) attendances reached an all time high for SFT with Type 1 at just under 5,000. Acute Medical unit (AMU) also saw its highest number of referals at over 1,300.

ED conversion rate was 26% which is similar to March 2023 although reattendance rates within 30 days has reduced very slightly. Ambulance arrivals as a % of overall attendances remain static at 27% vs 72% self presenting.

Overall Length of Stay (LoS) has seen a decrease in month by 0.5 day, seen across medicine and surgery, in both elective and non-elective pathways; this is approximately 2.5 days shorter than in March 2023.

No Criteria to Reside (NCTR) lost bed days has increased significantly in March, especially in the P2 and P3 pathways

The discharge pattern across 24 hours remains unchanged.
Weekend discharges have increased to 19% in March from 14% in February, with the actual numbers discharged at weekends also increasing. 88% of discharges are Pathway 0 (non-complex), up from 85% in February.

## Actions (SMART)

- Improving Together work continues across the divisions. Surgery have identified a focus on Trauma and Orthopaedic pathways for LoS reduction for both Non-Elective (NEL) and elective patients.
- Improvement huddle has been started Laverstock ward.
- NCTR workstream being established internally and with partners to focus on reducing NCTR patients to 10%.
- Electronic Discharges (EDS) not being done in a timely manner and causing discharges on the day to fall through is becoming a theme and needs an Improving Together A3.
- Ward reconfiguration plan being worked through that will support more efficient working.

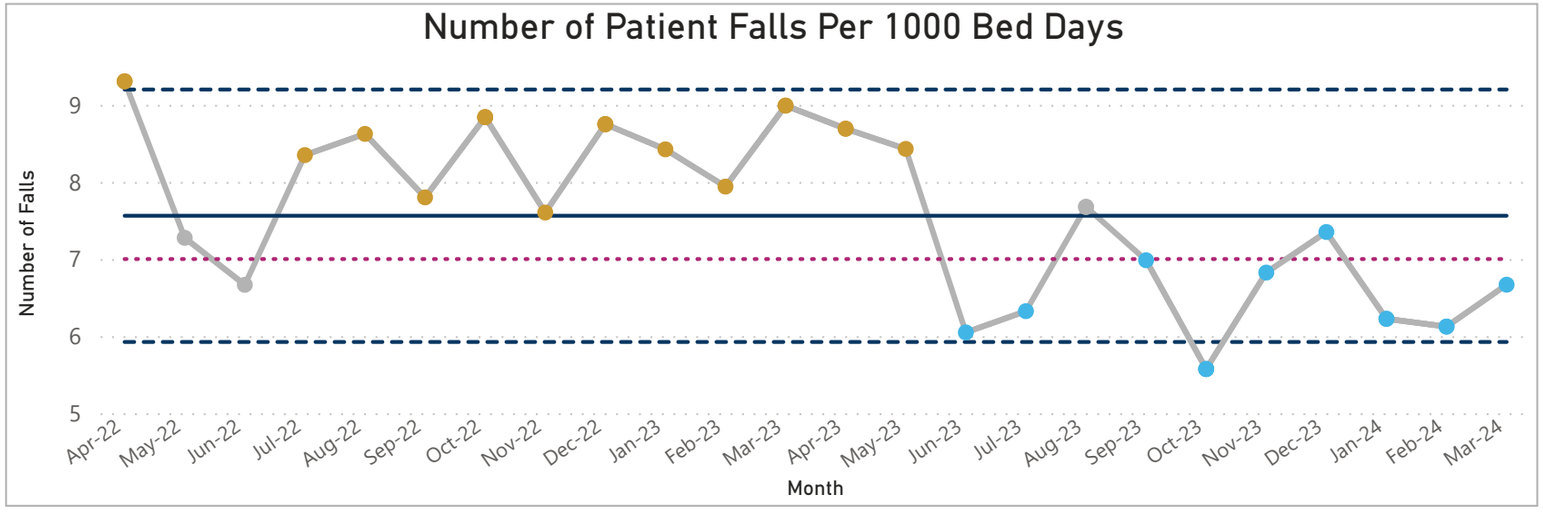
## Risks and Mitigations

- An increase in Infection Prevention Control challenges such as COVID or other will impact the ability to keep escalation areas closed. IPC will also impact staff available to work.
- Ongoing operational challenges related to capacity are expected to vary over the winter months.
- Ongoing industrial action from various professional groups and unions reduces staff capacity to focus on the QI work

# Reducing Patient Harm

## Target 7

Breakthrough Objective




We are driving this measure because...

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

### Understanding the performance

The falls per 1,000 bed days was below target of 7 at 6.66 for March. The figure for the quarter is 6.3 per 1000 bed days, a 29% decrease on quarter 4 last year (2022/23).

The falls with moderate and above harm are again variable with 0 reported in February but 5 reported in March. However, for the quater there has been a decrease of 38% from 2022/23 quarter 4.

In March there were 3 falls with moderate harm and 2 with major harm. All of the falls were investigated and presented to the Patient Safety Summit, with none commissioned for further investigation.

### Actions (SMART)

- Targeted training in high reporting areas, mainly within the Medicine division.
- Emergency Department (ED) "Think yellow" campaign planning launch in May. The patients will be risk assessed and be given a yellow blanket as an indicator of a high risk patient.
- Redlynch, Spire and Farley wards will all be concentrating on establishing "Bay watch" to their areas embedding the concept by June 2024.
- Following deep dives and audit, a theme in all areas has been highlighted: Risk assessments are mainly timely, however approximately 80% of these are inaccurate, hence interventions are not instigated. It has not been established how to project manage this at the time of writing.
- 54 crash mats have been delivered to all inpatient areas.

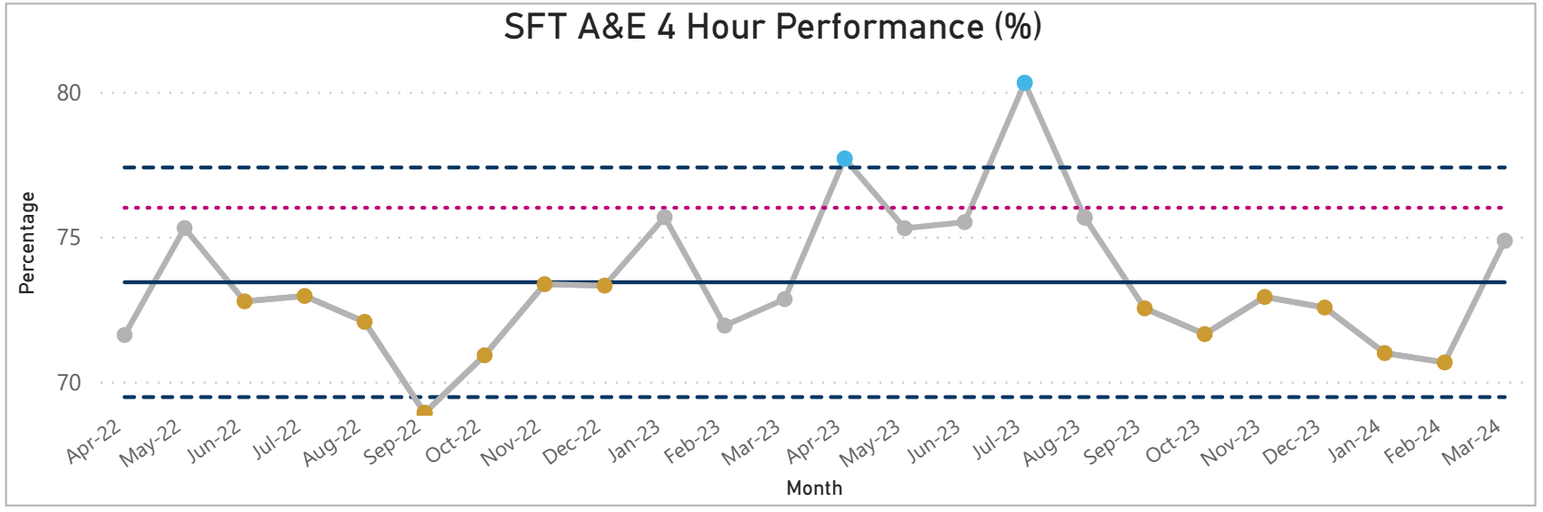
### Risks and Mitigations

- The maternity leave cover of 15 hours per week at band 6 has not been recruited to and has been re-advertised. This has had an impact on the falls reduction service.
- The falls workstream has poor attendance, especially from inpatient nursing staff. This will be re launched as a priority for divisions.
- The need for patients to mobilise as much as possible to assist reducing Length of Stay (LoS) continues as a risk to potential falls.

# Emergency Access (4hr) Standard

**Target 76%**

National Key Performance Indicators




| | |
|---|---|
| Performance Latest Month: | 74.9% |
| Attendances: | 7411 |
| >12 hrs in ED Breaches: | 29 |

## Understanding the performance

4-hour standard saw a significant upturn in performance to 74.9% despite record number of attendances in M12 of 7,144 which is an increase of 13.96% from M11 attendances of 6,269. In comparison with attendances against the same period last year this was an increase of 19.72% (1,177 attendances). This performance was supported by short-term additonal resource and the Trust wil now explore how this can be maintained.

Triage Category 1 & 2 patients, which are patients requiring Resuscitation level care, remained fairly static for M12 at 498 patients compared with 489 in M10.

M12 saw type 1 attendances of 4,956 which is an average of 159.87 patients a day compared with 147.62 in M11. This is an average of beyond 40 patients a day against what the Trust is staffed to see. M12 is now the 11th consecutive month of demand exceeding this capacity.

There were no confirmed (validated) 12-hour breaches in M12 which is great to report as this contributes to patient safety and a better experience for patients.

Admitted 4-hour performance saw a huge shift of 9.98% to 30.56% which is the best performance since July 2023 and attributable to the trial of using 4 cubicles on Short-Stay Emergency Unit (SSEU) to allow for a Clinical Decisions Unit (CDU).

Average time to initial assessment slipped further in M12 to 35.97 minutes from 34.95 minutes in M11 which again is indicative of the higher number of attendances and demand outstripping capacity.

## Actions (SMART)

- Weekly 4-hour performance huddles involving all Specialties discussing previous weeks performance and areas for improvement.
- The 2023/24 skill mix review is awaiting formal confirmation of funding to ensure there are adequate staff with the correct skills, staffing the correct areas.
- Exploration of a Minors booked appointment system to allow for patients attending evenings and overnight to be discharged and return the following day.
- Ring-fence of 4 spaces on SSEU to allow for a CDU approach for patients awaiting test results/periods of observation to continue.
- Business Case in development to support increase in Advanced Clinical Practitioner (ACP) numbers.

Investment secured for an additional 2 junior doctor posts next year.

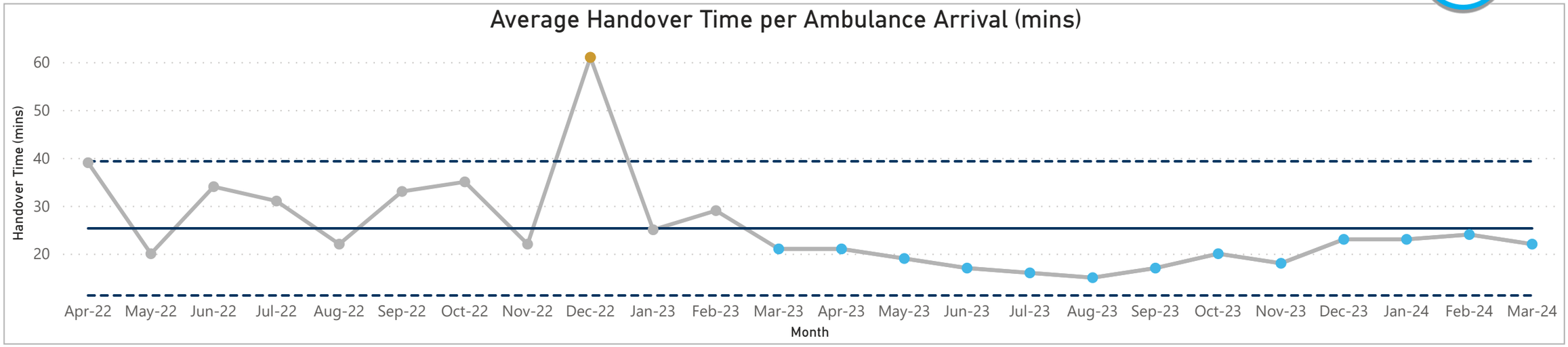
- Rapide Assessment Treat and Triage / Ambulatory Care (RATT/RAMBO) service model is continually under review.

## Risks and Mitigations

- Timely flow out of the Emergency Department (ED) continues to impact 4-hour and 12-hour standard performance targets with high bed occupancy levels across the Trust. 2 Improving Together A3s produced for both Admitted & Non-admitted performance and further investigative work is ongoing.
- Improving Together A3 under development to explore reasons for non-Admitted breaches. There is increased focus as these breaches should be within EDs ability to reduce.
- Using SSEU as a CDU has see an increased conversion rate however this will be offset by a reduction in LOS and a positive impact on the 4hr performance. This is only successful if there is the capacity to keep these areas as true short-stay areas i.e., awaiting transport, awaiting results etc.

# Ambulance Handover Delays

National Key Performance Indicators




## Understanding the performance

Average attendances by ambulance in M12 remained high at 42.77 compared with 42.72 daily in M11 which again is an increase of 15.50% from 2023 (1148 in 2023 to 1326 in 2024).

The ability to maintain the ambulance performance well above the national average is as a direct result of close working with South Western Ambulance Service Trust (SWAST) and Rapid Assessment Treatment and Triage (RATT) being embedded within the department.

RATT has enabled the department to continue to perform despite challenging flow out and into the Trust. However, RATT has also seen some delays when ambulances arrive in clusters due to there only being 2 spaces and process taking 15-30 minutes.

## Actions (SMART)

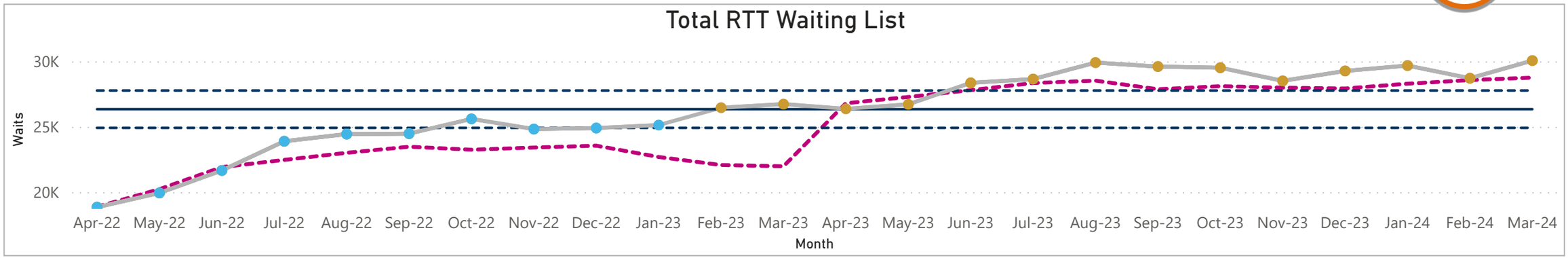
- Monthly meetings with the SWAST team are taking place improving collaborative working between teams.
- Review undertaken of RATT flow with SWAST to mitigate handover delays when RATT full when ambulances arrive in quick succession led to ringfencing chair spaces for fit to sit patients which has had a positive effect despite the continuing high number of attendances.

## Risks and Mitigations

- The RATT (Rapid Assessment Treat and Triage) continues.
- There has been an increase in Cat 4 conveyances and there will be some work working with SWAST team around investigating alternative routes.
- There is currently ongoing work with Informatics looking into the validity of ambulance data as not all data sources match. Informatics are working with SWAST to be able to access and use their data set from the new XCAD handover process.

# Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators




| Month | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Longest Waiting Patient (Weeks) | 76 | 75 | 76 | 77 | 243 | 200 | 194 | 153 | 139 | 110 | 94 | 72 |

## Understanding the performance

The waiting list increased in month to 30,063 and is now at the highest point on record. However, the focus through the Access Meeting of reducing long wait times to meet national targets for end of March 2024 was successful:

- Zero patients waiting >78 weeks (result 0)
- Minimise patients waiting >65 weeks (result 9)

The performance team are working with Divisional operational managers through the Access Meeting to make annual plans to reduce this, whilst also driving to meet future national long wait reduction targets.

## Actions (SMART)

- The Trust is on track to meet NHSE long wait reduction target of zero patients waiting longer than 78 weeks and is also forecasting no more than 20 patients waiting longer than 65 weeks by the end of March 2024.

A number of actions are planned to continue through March including:

- Adoption of GIRFT Further / Faster principles for three key specialties via Planned Care Board, General Surgery, Respiratory and Gynaecology, to include clinical engagement.
- Ongoing Breast DIEP waiting list reduction, with trajectory for clearance to NHS target level by March 2024 - on target.
- Plastics insourcing in place to support both Cancer performance and 65 week wait clearance.
- Preparation for new ward (Imber) opening and expanded Theatre timetable from April will support increase of surgical activity and in turn reduce waiting list.

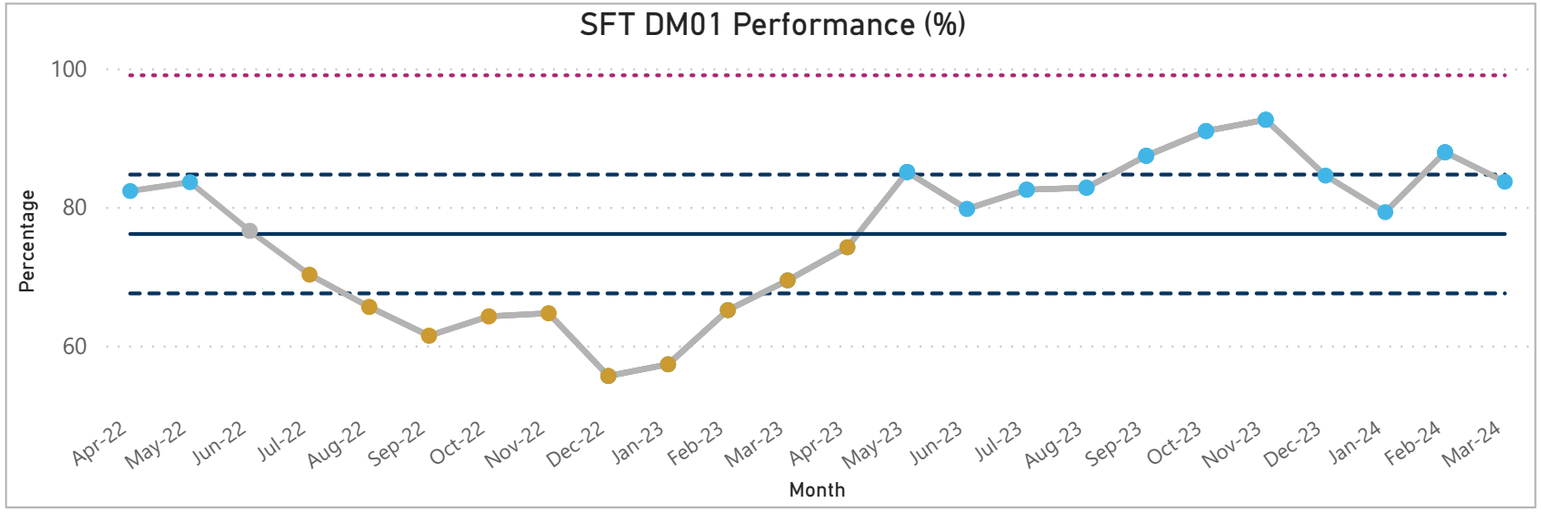
## Risks and Mitigations

- The risk of lost capacity owing to any future IA remains. Whilst mitigations are in place to support safety for those most clinically urgent patients, it is unlikely that the volume of activity affected cannot be entirely mitigated, and many plans have now been stretched beyond that for which they were designed with the ongoing elevated risk to the 65 week wait clearance for year end.
- Weekly Access Meeting now in place to reduce risk of long waiters and continue drive towards national reduction targets.
- Support into operational teams to enhance level of focus on the non-admitted pathways, through further Outpatient Department (OPD) workshops and weekly huddles in line with Improving Together methodology to continue.

# Diagnostic Wait Times Performance (DM01)

**Target 99%**

National Key Performance Indicators




Performance Latest Month: 83.6%

Diagnostic Activity: 8340

| | Performance | Breaches | | Performance | Breaches |
|---|---|---|---|---|---|
| MRI | 79.1% | 204 | CT | 99.9% | 1 |
| US | 83.0% | 396 | DEXA | 91.7% | 21 |
| Audio | 81.8% | 124 | Cardio | 67.0% | 212 |
| Neuro | 100.0% | 0 | Colon | 81.7% | 44 |
| Flexi Sig | 76.1% | 26 | Gastro | 87.5% | 33 |

## Understanding the performance

DM01 performance reduced in M12 to 83.65% from 87.9% in M11. The number of patients impacted by waiting more than 6 weeks for their diagnostic test increased from 755 breaches in M11 to 1,061 patients in M12. As a result, overall waiting list size has increased from 6,240 to 6,489.

Breach numbers increased across all modalities with the exception of Cardiology Echo (and CT), summary as follows:

- MRI - 204 breaches (88 in M11)
- CT - 1 breach (0 in M11)
- USS - 396 breaches (227 in M11)
- Audiology - 124 breaches (100 in M11)
- Cardiology Echo - 212 breaches (253 in M11)
- Endoscopy - 103 breaches (95 in M11)

Activity across all modalities was higher in M12, with the exception on Endoscopy and a small decrease in CT but, of note, there is currently one substantive CT scanner out of action due to the replacement project underway.

## Actions (SMART)

- Maximise CDC capacity for MRI for the second week online from M1.
- Continue work to resolve CT contrast issue with CDC mobile (currently only able to scan non-contrast due to anaphylaxis risk) to maximise capacity and bring second week per month back online from June.
- Continue with overtime and internal Waiting List Initiative (WLI) work for Audiology and Echo to reduce numbers of breaches.
- Review 2024/25 planning trajectory for final submission late April.

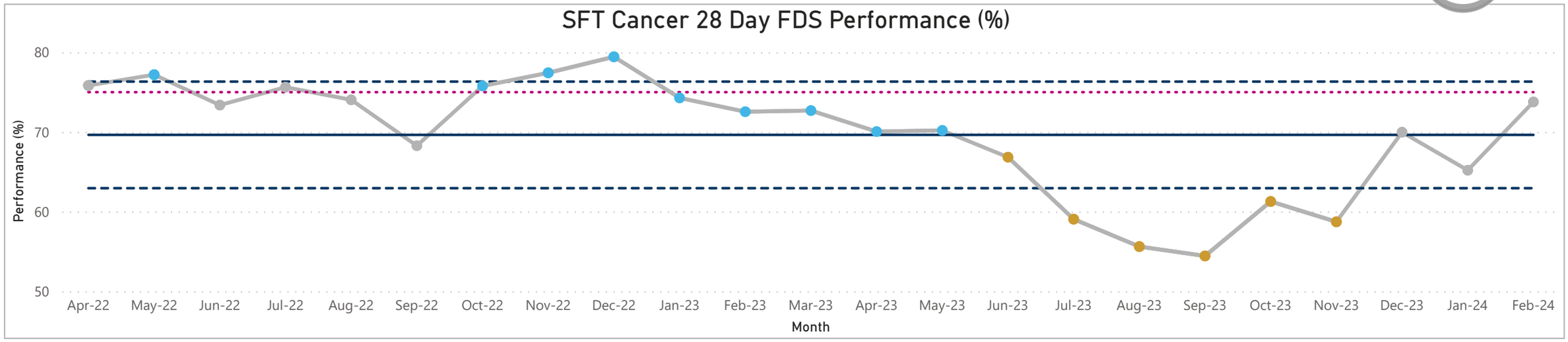
## Risks and Mitigations

- M11 performance for USS was highly dependent on internal overtime and insourcing provision. This is expected to reduce in M1 of 24/25 du to reduced staff appetite to work increased hours and a minimum number of scans being provided by the insource provider.
- CT Scanner replacement project is underway, mitigated in part by a mobile scanner on site but unable to scan all types of routine DM01 work through the mobile and so waiting list is growing.
- MRI waiting list is growing, in particular Cardiac MRI which is challenging to create additional capacity for. Exploring outsourcing options and additional lists inhouse. Second week of MRI provision also online with CDC from M1 24/25.

# Cancer 28 Day Faster Diagnosis Standard Performance

**Target 75%**

National Key Performance Indicators




*Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.*

## Understanding the performance

28-day performance improved in M11, reporting a position of 71.7%, the highest position at SFT for over 12 months. Whilst this remains below the national standard of 75% there were a number of specialties that reported a position above target and these were:

- Breast - 94.7%
- Head and Neck - 76.1%
- Lung - 90.5%
- Upper GI - 86.2%
- Gynaecology continuing to improve their performance, reporting 72.1% and close to target

Specialties that did not achieve the 75% standard are:

- Lower GI - 38.7%
- Haematology - 22.2%
- Skin - 69.0%
- Urology - 54.9%

Capacity for a first appointment in Skin was compromised in M11 which resulted in first seen waits of >28 days late in the month, impacting the 28-day position for specialty and Trust.

Lower GI continues to be challenged by historical pathways that had delays at first assessment and diagnostic, although this is steadily improving and M12 onwards is expected to be above 40% as a minimum.

## Actions (SMART)

- Maintain daily oversight patient tracking meetings in Lower GI and Skin services led by operational manager.
- Restoration of sufficient first appointment capacity for skin to ensure delivery of the skin 28-day position at > 85% (to support overall Trust delivery at >77% from 2024/25)
- Data analysis for Best Practice Timed Pathway priorities to confirm Lower GI and Urology (prostate) likely as key areas of improvement focus.
- Some further improvements in early part of Head & Neck pathway which may support earlier transfer to Haematology patient where Lymphoma is the likely diagnosis.

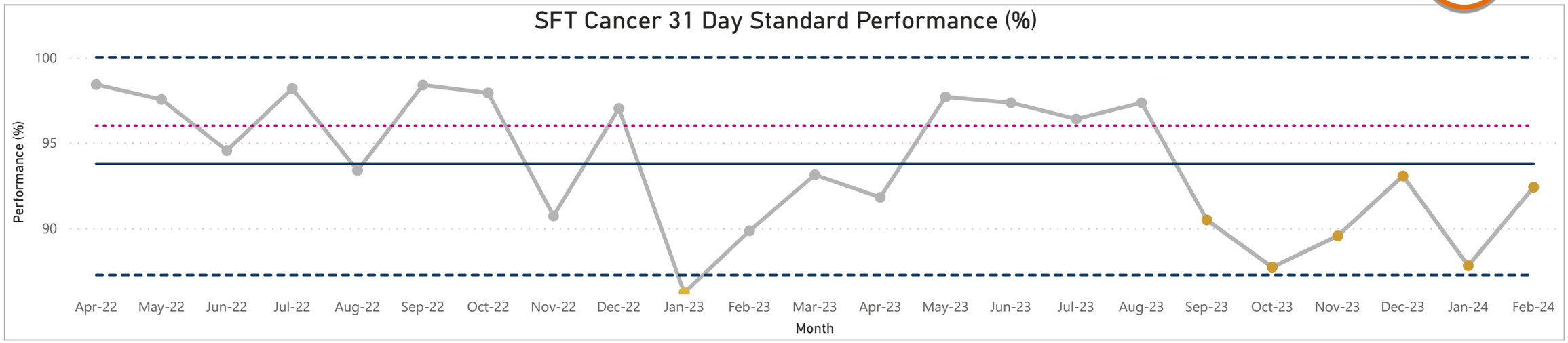
## Risks and Mitigations

- Skin service remains vulnerable to demand and capacity issues - daily oversight meetings and early warning on first seen waits through cancer improvement group are acting as an alert for improved responsiveness.
- Resource within MDT cancer services team remains challenging in terms of team numbers but also with regards to skills and expertise. New cancer services manager working with team to improve data collection processes.
- Urology service remains vulnerable to CNS workforce absence and also to first seen waits being close or sometimes greater than 14 days.

# Cancer 31 Day Standard Performance

**Target 96%**

National Key Performance Indicators




*Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.*

## Understanding the performance

31-day performance improved in M11 to 92.1%. This represented 14 breaches of the 177 patients treated.

All specialties achieved > 93% performance with the exception of the following:

- Skin - 81.3% - 9 patients not treated within 31 days of DTT
- Head and Neck - 60% - 2 patients not treated within 31 days of DTT
- Lower GI - 90.9% - 1 patient not treated within 31 days of DTT

As with 28-day performance, the Skin position was challenged by reduced capacity to meet demand and this was impacted within the minor ops capacity of the pathway as well as first appointment.

## Actions (SMART)

- Maintain daily oversight patient tracking meetings in Skin services led by operational manager.
- Restoration of sufficient minor ops capacity for skin to ensure delivery of the 31-day waiting time
- Early escalation to bookings where patients are booked beyond 31-day target

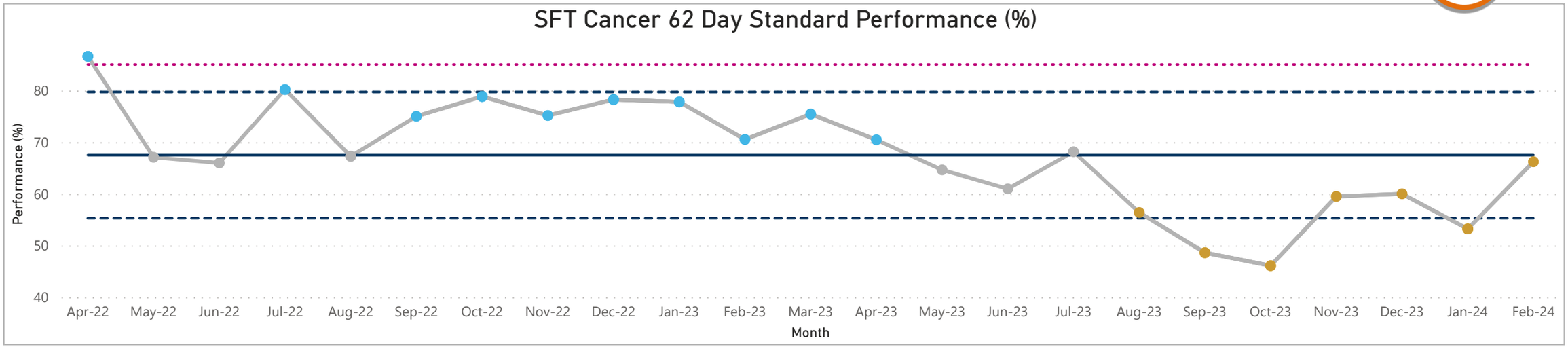
## Risks and Mitigations

- Skin service remains vulnerable to demand and capacity issues - daily oversight meetings and early warning on first seen waits through cancer improvement group are acting as an alert for improved responsiveness.

# Cancer 62 Day Standard Performance

**Target 85%**

National Key Performance Indicators




*Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.*

## Understanding the performance

62-day performance for M11 for SFT is now reported at 66.7%, increasing on the submitted position due to post-op histologies and confirmed cancer diagnosis treatments recorded after the monthly submission. Data will be updated within quarterly submission and this represents an increase in 62-day performance for SFT compared to M10.

75 patients were treated against the 62-day target in M11 and 25 patients did not meet the target.

Only Skin delivered >85%, reporting a position of 93%.

Specialty performance summary as follows:
- Breast - 3 out of 13 breaches, 76.9%
- Lower GI - 4 out of 4 breaches, 0%
- Gynaecology - 1 out of 2 breaches, 50%
- Haematology - 3 out of 4 breaches, 25%
- Head and Neck - 3.5 out of 5.5 breaches, 36.4%
- Lung - 0.5 out of 1.5 breaches, 66.7%
- Upper GI - 2 out of 3 breaches, 33.3%
- Urology - 6.5 out of 20.5 breaches, 66.3%

## Actions (SMART)

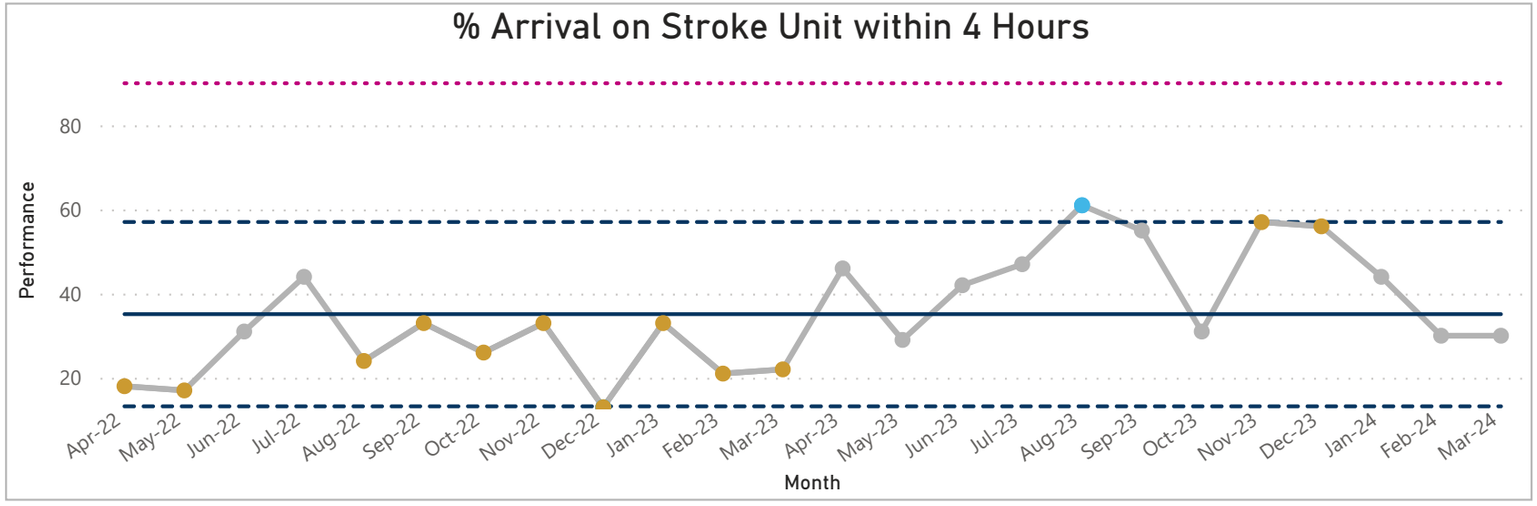
- Continue/sustain robust patient tracking list meetings, improving their resilience and ensuring weekly meetings are happening
- Best Practice Timed Pathway focus for improvement in the 28-day performance will have subsequent positive impact on 62-day.
- Surgery Divsion adopting 62-day driver metric as part of their key 24/25 improving together priorities.
- Early escalation of potential breaches to avoid breaches occuring a few days after target

## Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62-day % compliance will be impacted. Aiming for < 6.8% of PTL size to be for patients over 62 days in their pathway. Will set specialty targets to remain within these levels to support reduced numbers of patients being treated and reported beyond 62 days in their pathway.

# Stroke Care

National Key Performance Indicators




**SSNAP Case Ascertainment Grade**

Highest Level = Grade A
Lowest Level = Grade E

| Fyear | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2022-2023 | D | C | C | C |
| 2023-2024 | B | A | B | |

## Understanding the performance

M12 performance (based on discharged patients) was 30% and remains the same as M11. Out of the 30 patients discharged in M12, 20 patients were admitted to the Stroke Unit (SU) outside of the 4-hour target.

The Improving together 4-hour performance metric monthly admission target is 70%. M12 end performance for admissions was 60%.

Based on the above data and meetings to identify root causes, several key themes have been identified. Combining both admitted and discharged patients:

- 2 waiting first doctor and both out of hours (OOH).
- 8 waiting specialist doctor r/v (4 OOH 2 had non-specific stroke symptoms).
- 2 waiting bed capacity.
- 2 inpatient strokes delaying transfers.
- 2 admitted to Acute Medical Unit (AMU) first.
- 3 delayed referrals to SU.

## Actions (SMART)

Countermeasures for the root causes identified include:

- Education of Stroke targets and SOP - Stroke unit to present at the ED band 7 study day (17th April) to explain the importance of SSNAP and our BPT targets. This was an area identified during meetings with the ED matron as not being fully understood by ED staff.
- Education of Stroke targets and SOP - Thrombolysis training will be held on the 15th May as part of the ED band 6 SIM training day. This will also have emphasis on the SSNAP and BPT to ensure a larger proportion of ED staff will have more of an understanding of Stroke Unit targets.
- Communication During OOH – During the presentation to ED Band 7 on 17th April, an emphasis will be placed on following the SOP and its effect on improving performance, especially with patients out of hours.
- Communication in and between ED and Stroke – Service Manager to arrange a meeting with the ED matron and senior nursing staff to discuss root causes of delays in specialist doctor reviews.

## Risks and Mitigations

- Due to the high number of out of hours patients this month this is had a negative impact on our specialist assessments which in turn delays diagnosis and has an impact on the Stroke Unit 4-hour performance.
- Discharges before midday have been a drive metric, however due to high acuity across the Trust, and issues surrounding EDS' being prepared, Stroke Unit average LOS remains at 19 days. Work is continuing as part of the improving together methodology, with a particular focus on actions to improve EDSs'.

# Maternity

Are We Safe?

| 01/03/2024 | <- Reporting Month (Input the first of the REPORTING month) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | RAG rating | | | | | | | | | |
| SFT Assurance Dashboard | Guidance | Standard | RAG Target 2021-22 Q4 | Red | Green | Improvement Direction | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Rolling 6m average |
| Perinatal Morbidity and Mortality (M&M) | Number of late fetal losses (22+0 to 23+6 weeks excl TOP) | | | NA | >= 2 | = 0 | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of stillbirths (> = 24 weeks excl TOP) | | | NA | NA | NA | Down | 0 | 2 | 1 | 0 | 1 | 0 | 1 |
| | Number of stillbirths (> = 24 weeks excl TOP) per 1,000 Live (reg) Births (Rolling 12 month average) | NHSE (2023) | 3.9 per 1000 live births | NA | >= 3.9 | < 3.9 | Down | 2.1 | 3.0 | 3.5 | 2.4 | 3.0 | 2.5 | NA |
| | Number of Neonatal deaths < 24 weeks (including MTOPs) for 0-28 days | | | NA | NA | NA | Down | 0 | 0 | 0 | 2 | 0 | 0 | NA |
| | Number of Neonatal deaths >= 24 weeks for 0-28 days | | | NA | NA | NA | Down | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| | Number of neonatal deaths >= 24 weeks: 0-28 days per 1,000 Live (Reg) Births (Rolling 12 month average) | MBRACEUK (2021 | 1.6 per 1000 live births >= 24 wks | NA | >= 1.6 | < 1.6 | Down | 1.0 | 1.0 | 0.0 | 0.0 | 1.1 | 1.1 | NA |
| | Medical termination over 24 +0 registered | | | NA | NA | NA | Down | 0 | 0 | 1 | 0 | 0 | 0 | 0.17 |
| Maternal M&M | Number of Maternal Deaths | | | NA | NA | NA | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Maternal Deaths per 100,000 Maternal Deaths | ONS | 9.1 per 100,000 women who delivered | NA | >= 9.2 | <= 9 | Down | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Number of women requiring admission to ITU | 6 month SFT rolling | | NA | >= 2 | = 0 | Down | 1 | 0 | 0 | 0 | 0 | 0 | 0.2 |
| Insight | Datix incidence SII | 6 month SFT rolling | | 0 | >= 1 | = 0 | Down | 0 | 0 | 0 | 0 | 1 | 0 | 0.2 |
| | HSIB referrals | 6 month SFT rolling | | 0 | >= 1 | = 0 | Down | 1 | 0 | 0 | 0 | 0 | 1 | 0.3 |
| | HSIB/NHSR/CQC or other organisation with a concern or request | 6 month SFT rolling | | 0 | >= 1 | = 0 | Down | 0 | 1 | 0 | 0 | 0 | 0 | 0.2 |
| | Coroner Reg 28 made directly to trust | 6 month SFT rolling | | 0 | >= 1 | = 0 | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Workforce | Obstetric cover - labour ward | RCOG guidence | | 40 | <= 39 | >= 40 | Up | 40 | 40 | 40 | 40 | 40 | 40 | 40 |
| | Midwife to Birth ratio | RCM;NHSR;BR + | 1:26 | 1:28 | >= 1:28 | <= 1:26 | Down | 1:35 | 1:28 | 1:32 | 1:25 | 1:27 | 1:30 | NA |
| | Midwifery vacancy rate (black= over establishment; red = under establishment ) | | | NA | >= 1 | NA | Down | 15.7 | 13.9 | 14.0 | 12.0 | 11.6 | 12.1 | NA |
| | Provision of 1 to 1 care in established labour (%) | NICE, RCM, MIS | 100% | 100 | <= 94 | >= 100 | Up | 100 | 100 | 100 | 100 | 100 | 100 | NA |
| | Datix relating to workforce | 6 month SFT rolling | | NA | >= 2 | = 0 | Down | 0 | 0 | 1 | 0 | 0 | 4 | 0.83333 |
| | Compliance with supernumery status of the LW coordinator - % | NICE;RCM;NHSR | 100% rostered | 100 | <= 94 | >= 100 | Up | 100 | 100 | 100 | 100 | 100 | 100 | NA |
| | Numbers of times maternity unit on divert | 6 month SFT rolling | | NA | >= 2 | = 0 | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Involvement | Service user feedback : Number of Compliments | 6 month SFT rolling | | 12 | NA | >= 12 | Up | 3 | 1 | 0 | 35 | 25 | 11 | 13 |
| | Service user feedback : Number of Complaints | 6 month SFT rolling | | NA | NA | NA | Down | 0 | 2 | 0 | 0 | 2 | 0 | 0.7 |
| | Number of SOX | 6 month SFT rolling | | 4 | NA | >= 4 | Up | 6 | 0 | 4 | 9 | 3 | 5 | 5 |

## Understanding the performance

Perinatal loss data: This data now reflects the rolling 12-month average per 1000 births in addition to number of stillbirths and neonatal deaths.

Midwife to birth ratio remains above SFT individualized recommended rate of 1:26, despite this 1:1 care in labour maintained.

4 Datix' relating to workforce. All investigated by respective areas as relate to Obstetric, anaesthetic and midwifery staffing, respectively.
1 Healthcare Safety Investigation Branch (HSIB) referral triaged and accepted by Maternity and Neonatal Safety Investigation (MNSI). Investigation in early stages and ongoing.

## Actions (SMART)

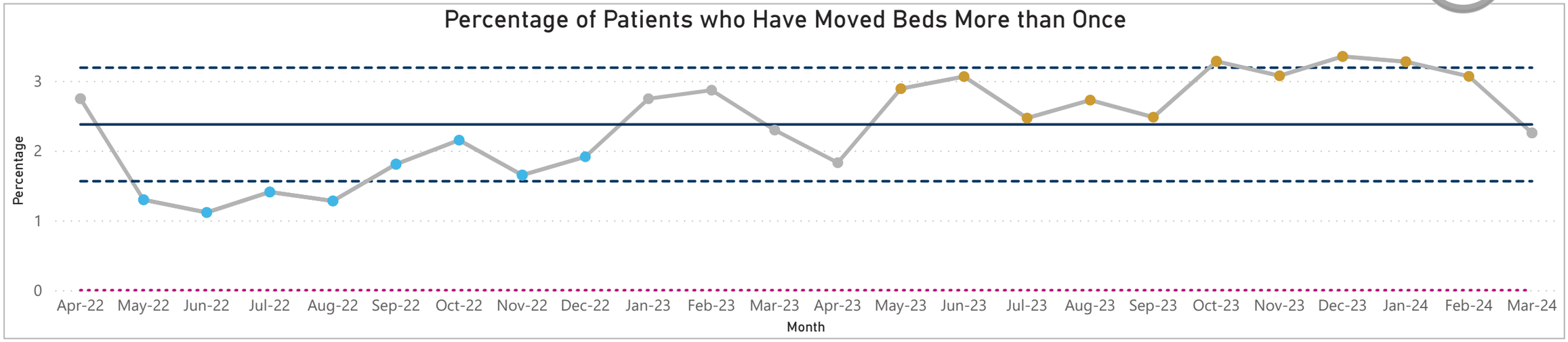
- Targeted recruitment drive in place with welcome incentive.
One new Band 6 Midwife commenced in post.
- Two International Midwives are still awaiting Nursing and Midwifery Council (NMC) PINs.

## Risks and Mitigations

- Midwifery staffing remains a risk and active recruitment is seeing an ongoing reduction in vacancy rate.
- Escalation policy followed to ensure one to one and safe care maintained.
- Maternity care assistants supporting with non-midwifery care.
- Registered nurses employed within maternity services, supporting with non-midwifery specific roles, e.g., working alongside midwives in postnatal care.
- Midwife to birth ratio increased this month due to increased birth rate.

# Patients Who Have Moved Beds More Than Once

Are We Safe?




## Understanding the performance

There has been a significant improvement in M12 in the percentage of patients moved more than once in comparison to M11, although this remains above the target. The reduction in overall bed occupancy aligns and will have contributed to this performance. There continues to be a drive to ensure that ward teams are identifying the patients who have had more than one move.

Increased number of escalation beds open has a direct impact on patient moves, length of stay and experience. There has been a rise in number of medical patients being placed within the surgical template to create acute medical capacity, which increases the moves per patient figure.

A reconfiguration of wards and areas included in the metric has been completed to accurately reflect the number of patients moves within the bed base.

## Actions (SMART)

- Meeting with informatics to review the wards included to trigger the metric, ensuring we are capturing the information accurately. There will be a report added to pull the patient level information which can then be used to improve the number of patients moves and patient experience. Informatics reviewing the target for this metric.
- Work with the divisional nursing teams to ensure teams are aware of the information around how many times a patient has been moved per stay and continued efforts for this to be considered when backfilling any escalation areas.
- Work with clinical teams in admission areas for the early identification and triage of patients to speciality, to ensure the correct patient placement from the point of admission.

Expert panel continues to allow for the identification of these patients and to promote awareness at ward level which feeds into the site team.

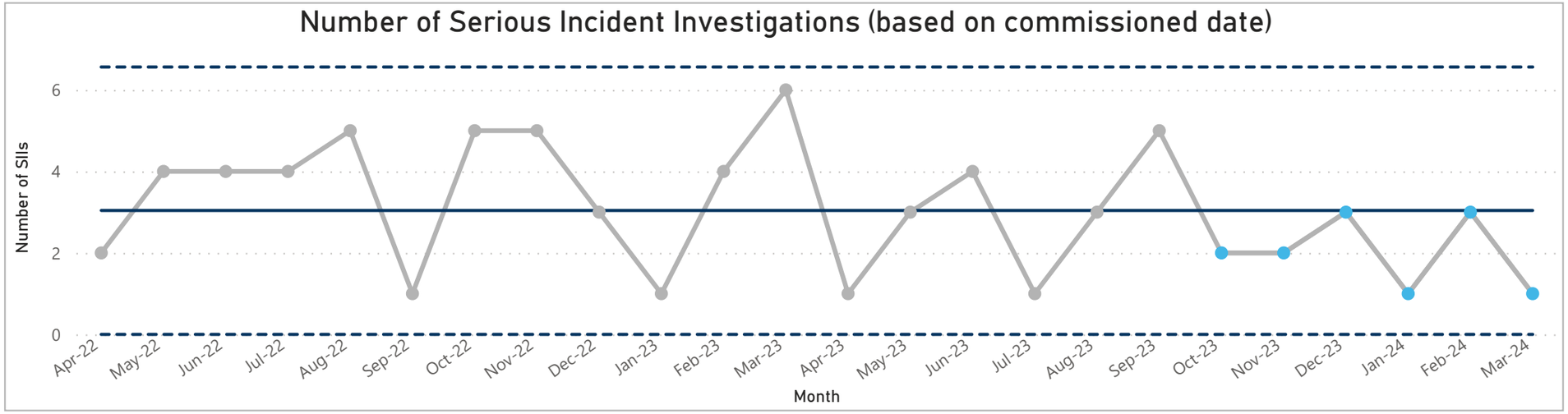
- Work with community services and the Transfer of Care Hub continues to enhance the service and aims to achieve a downward trend in the number of NC2R numbers.
- The opening of new ward (Imber) will allow rebasing of Trust beds and this work is underway to support reduction in bed moves.

## Risks and Mitigations

- Drive to improve number of complex discharges with system partners to improve flow from the Trust, TOCH steering group implemented to enhance this.
- Ongoing work with informatics regarding target setting.
- Education at ward level, through expert panel and the site team, aims to mitigate the increase in number of moves per patient.
- Increase in the use of escalation areas to minimise the risk within our front door areas will have an impact on the number of moves per patient.
- Mitigations are in place to from each division, a requirement to have a list of appropriate names to move to the escalation areas, who have not been moved more than once.

# Incidents

Are We Safe?




| Fyear | Never Events |
|---|---|
| 2022-2023 | 0 |
| 2023-2024 | 4 |

## Understanding the performance

In March, two incidents were presented at Patient Safety Summit where it was agreed that they met the requirement for a Patient Safety Incident Investigation (PSII) as per our Patient Safety Incident Response Plan:

Unexpected level of risk:
• PSII03 (Datix ID 162304: Surgery Division – Loss of a degree of sight.

National requirement (but locally-led):
• PSII04 (Datix ID 164043): Surgery Division - Never event, wrong site biopsy taken.

## Actions (SMART)

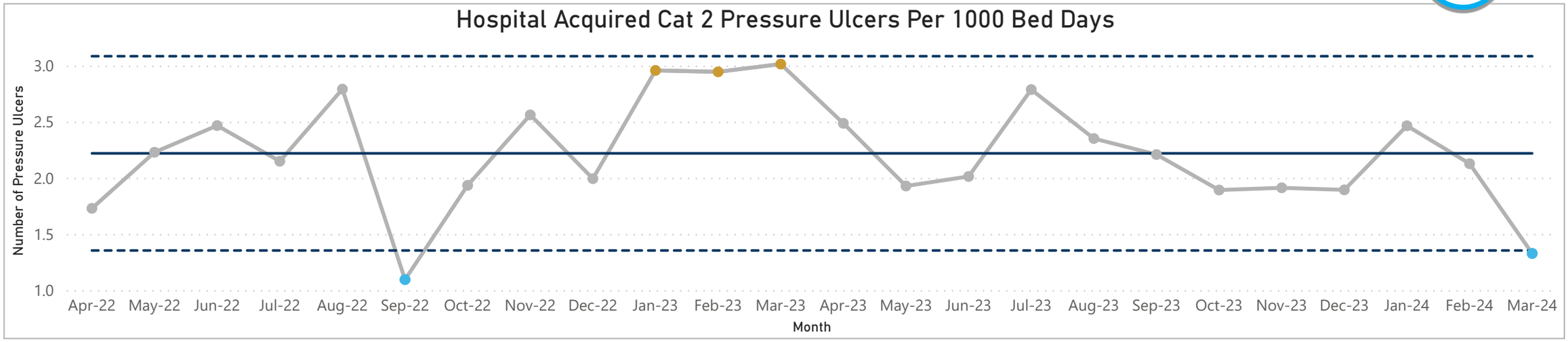
• Undertake PSII incident investigation in accordance with national Patient Safety Incident Response Framework (PSIRF) plan and policy.
• Ensure internal reporting of incidents through PSIRF established.

## Risks and Mitigations

• When an incident is discovered, all employees have a responsibility to ensure immediate action is taken to reduce further risk, maintain safety and ensure that their own safety is not compromised.
• Line managers should be informed immediately if there are ongoing concerns and further risks to safety that require management and escalation.

# Pressure Ulcers

Are We Safe?




## Understanding the performance

There has been a decrease in Pressure Ulcers (PUs) to 34 from 37 and a decrease of Moisture Associated Skin Damage (MASD) to 25 from 28 in March compared to February.

There has been 1 hospital acquired category 3 PU and no category 4 PUs in March. Deep tissue injury numbers remain the same and we have seen an increase in unstageable PUs (from 1 to 7) in comparison to February.

## Actions (SMART)

- Following a review of incontinence products, a MASD pathway will be produced.
- There are no national targets for pressure ulcers or MASD. The Trust will need to identify its own targets. Lead Tissue Viability Nurse (TVN) to continue to work with informatics over the next month.
- Review of how Hospital acquired pressure ulcer numbers are reported i.e. what is included. Lead TVN to continue to work with informatics over the next month.
- PURPOSE T screening tool continues to be reviewed by TV and the Transformation and Informatics Team.
- Tissue viability held a Link nurse study day this month and continue to carry out weekly education sessions for all new health care and over sea employees in the Trust.

## Risks and Mitigations

Risks

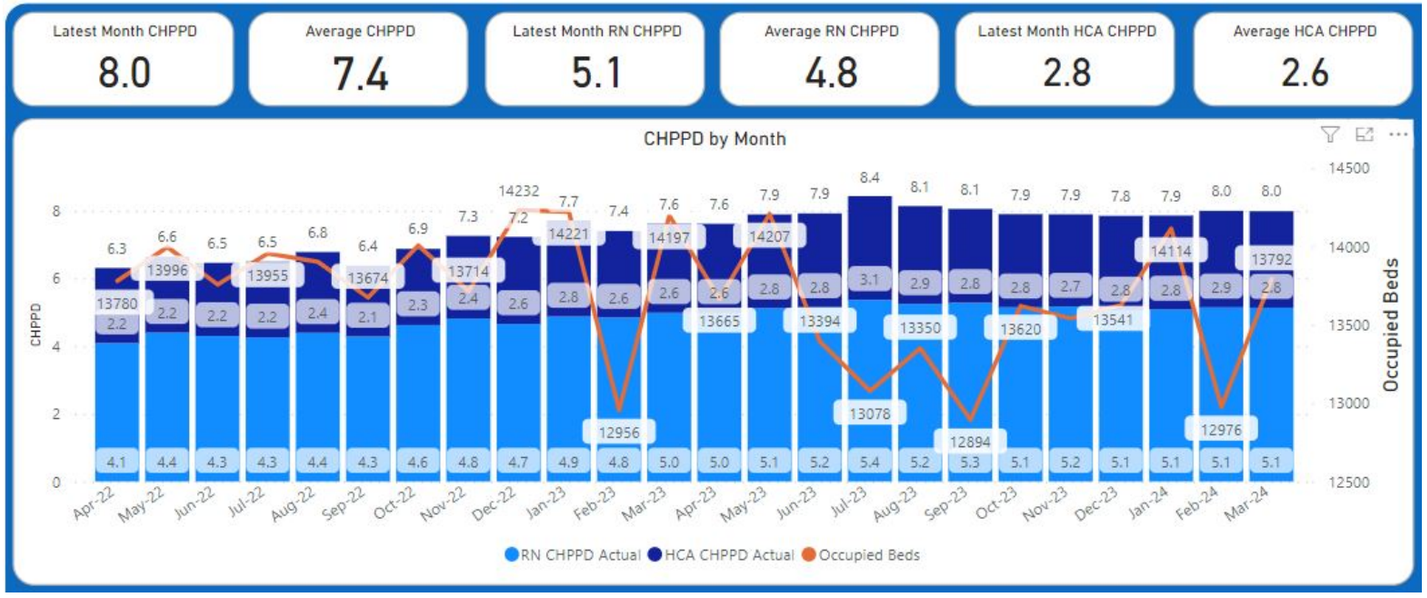
- Tissue viability outpatient service still has no Consultant for clinics or for surgery.
- The Trust still has not received the correct number off the Repose foot protectors that were ordered.
- Pressure ulcer risk documentation in ED missing screening tool. We are awaiting feedback from PSS.

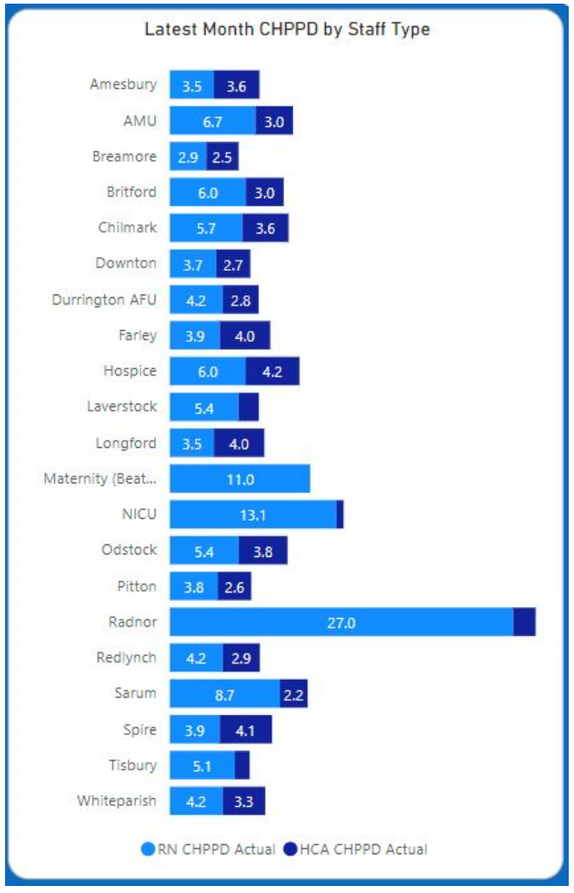
Mitigations

- We continue to review the hospitals incontinence products.
- Procurement have been notified regarding the outstanding delivery of Repose foot protectors.
- New pressure ulcer recommendations have identified a standardised care pathway for pressure ulcer prevention and management. Tissue Viability continue to work on the changes to risk assessment and care plans.
- The new aSSKINg Care Plan (for patients at risk of pressure ulcers) has been sent to the printers and will be available mid-April.
- ED continue to use the Braden risk assessment tool as a A4 poster while documentation is reviewed.
- The Q4 SEQUIN audit for pressure ulcers finished at the end of March and is under review for the outcome.

# Nurse Staff Fill Rate

Are We Safe?




## Understanding the performance

CHPPD (Care Hours per Patient Day) measures the total hours worked by Registered Nurses (RNs) and Healthcare Assistants (HCAs) divided by the average number of patients at midnight – and is nationally reported.

CHPPD 8.0 in month (same as last month) and 7.4 when excluding critical care and maternity excluded. Of note in month CHPPD in hospice high at 10.0 Sarum CHPPD remains high at 11.96 - reflective of number of empty beds in February in paeds.

CHPPD has continued to show steady improvement over time which is reflective of the improvement in vacancies.

December 2023 data shows SFT to have lowest CHPPD in the ICB and 2nd lowest in the region (8.01 against national average of 9.93).

## Actions (SMART)

- Safer Nursing Care Tool (SNCT) training commencing in April to remaining wards.
- Ward assistant project moved into divisions, remain unfunded.

IEN pass rate – data on improvement shared at WCP and will be presented regionally in April.

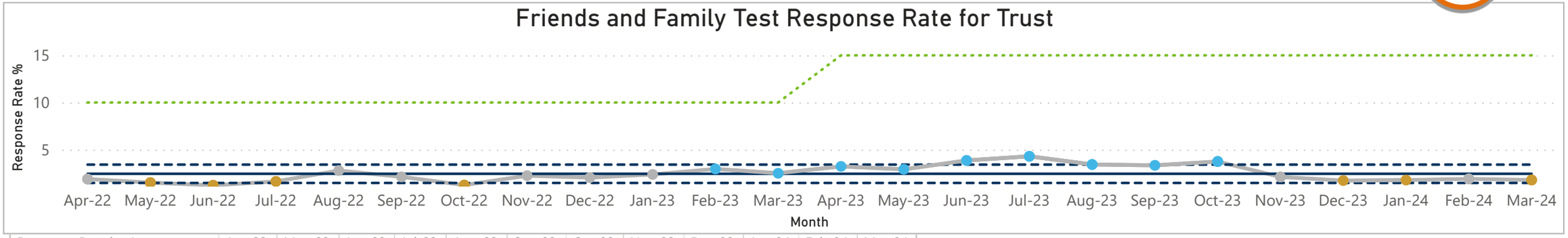
- Business cases for RNDA, Nurse associate to RN business cases approved in principle but being taken to system financial recovery group – remains with exec team with no update.
- Trailers now been offered from UKHSA –awaiting delivery date.
- Weekly forward review of staffing meeting implemented and Safe Staffing SOP being updated in line with partner organisations.
- Agency spend on nursing whilst up on February holding strong position of reduced spend in ward areas – main areas of spend specialist areas: Theatres, ED, ICU and Paediatrics.

## Risks and Mitigations

- Output from annual skill mix review still not in budgets resulting in additional temp staffing spend (risk).
- Requirement to reduce headcount to 2022/23 staffing (risk).
- Ongoing turnover for HCAs and RNs exceeds starters (risk).
- Increase demand for patients requiring RMN support (risk).
- Increased demand for additional nursing in ED to provide corridor nurse for ED – additional 5.5wte per week for corridor nursing (risk).
- Increased demand for nursing due to high numbers of escalation bed areas open means that there has been increase in bank and agency expenditure – still being seen in April (risk).
- Domestic and international recruitment campaigns (mitigation).
- OD&P led work on retention, turnover and inclusion (mitigation and risk).

# Friends and Family Test Response Rate

Our Care




| Response Rate by Area | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FFT Response Rate - A&E | 0.6% | 0.6% | 0.8% | 1.1% | 0.8% | 0.6% | 1.0% | 0.6% | 0.9% | 0.7% | 0.5% | 0.5% |
| FFT Response Rate - Day Case | 3.4% | 4.2% | 6.4% | 6.6% | 3.5% | 5.8% | 4.1% | 2.4% | 2.5% | 3.1% | 3.2% | 3.3% |
| FFT Response Rate - Inpatient | 14.5% | 12.9% | 17.1% | 28.4% | 20.5% | 33.7% | 24.0% | 17.2% | 10.2% | 19.1% | 19.7% | 17.2% |
| FFT Response Rate - Maternity | 0.0% | 0.5% | 0.0% | 0.0% | 0.9% | 1.0% | 2.9% | 0.9% | 0.5% | 3.8% | 0.0% | 3.0% |
| FFT Response Rate - Outpatient | 2.5% | 2.3% | 2.6% | 2.2% | 2.2% | 2.1% | 2.3% | 1.3% | 1.1% | 0.9% | 1.0% | 0.8% |

## Understanding the performance

March Friends and Family Test (FFT) showed a slight reduction in performance to 1.8%.

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

Negative feedback should be reviewed by the ward / area regularly and formal reporting bi-annual is provided by PALS, to the Patient Experience Steering Group.

FFT response figures have largely increased since ecording began, and staff are still being encouraged and reminded to offer FFT through the PALS outreach services. This remains the sole method of obtaining responses and this will mean inevitable fluctuations in activity.

Cards have gone to all areas and offer free postage. Gender options have also now been extended in line with national guidance.

## Actions (SMART)

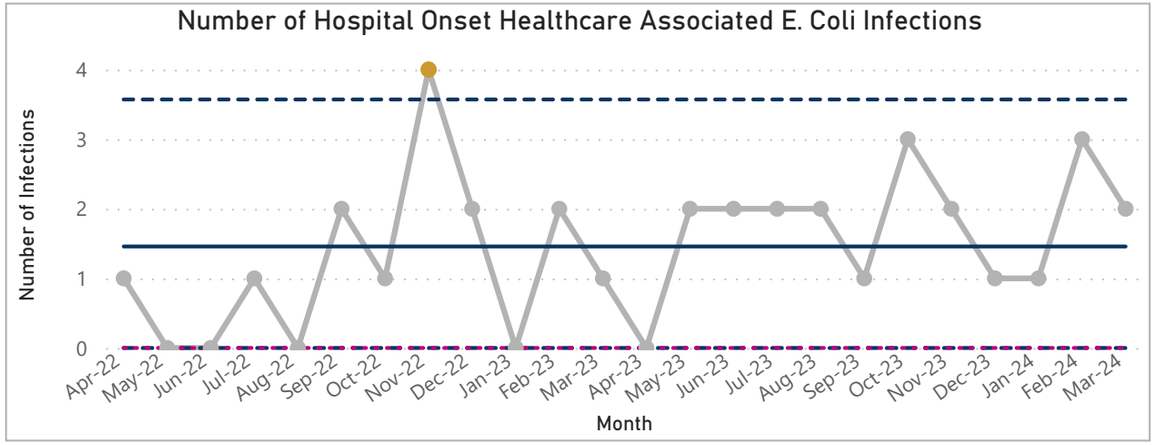
• Delay in the rollout of digital provider was taken in November 2022, postponing this until early 2024.
• This solution would facilitate an SMS option in a bid to increase responses rates, particularly in Outpatient areas and ED. It would also meet accessibility requirements with a new online form and digital dashboard.
• Interim actions were taken to develop the digital dashboard in the interim. This will be loaded with retrospective data to allow insight and analysis of FFT comments. This will not have any impact on response rates.
• Concentrated efforts to promote adoption of FFT has been communicated via PALS
• Outreach visits, helping to demonstrate to staff the importance of promoting this to patients as a way to hearing their views and gathering feedback on their services.

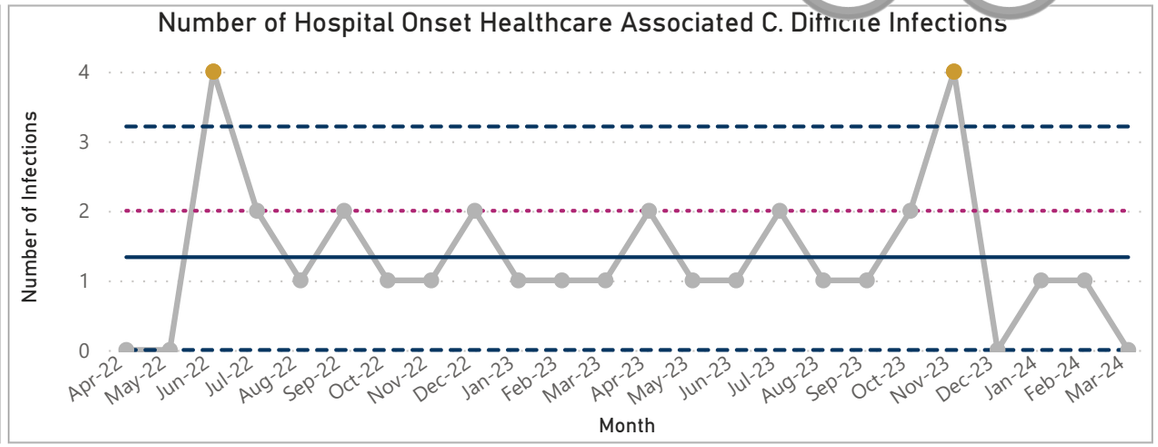
## Risks and Mitigations

• We anticipate that the new dashboard will further increase this as we will be in a position to draw themes and insights from these comments. We are currently working with the new digital provider on the data analysis dashboard and we hope to be in a position to analyse and theme comments showcasing these through the
Divisional Governance structures and Patient Experience reports.
• These mitigations are unlikely to have any impact on response rates but will significantly improve our data quality and therefore the insights we draw from this feedback. We hope to have the dashboard populated and begin extractions soon, we then plan to introduce this reporting within the Patient Experience Reporting.
• Manual entering of data is a known risk to the data collection and entry, this delay in response input cannot be mitigated until the new digital provider is fully adopted where these gaps can be supplemented with a courier service collection and data entry services, which they also provide.

# Infection Control

Are We Safe?




## Understanding the performance

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

However, we have exceeded set trajectories for reportable healthcare associated C.difficile cases for 2023/24 (total now 23 cases against a target baseline set of no more than 22 cases). There have been two hospital onset healthcare associated MSSA bacteraemia infections this month.

The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and use educational opportunities with different staff groups.

| Year | 2022-2023 | 2023-2024 |
|---|---|---|
| MSSA Bacteraemia Infections: Hospital Onset | 10 | 10 |
| MRSA Bacteraemia Infections: Hospital Onset | 0 | 0 |

## Actions (SMART)

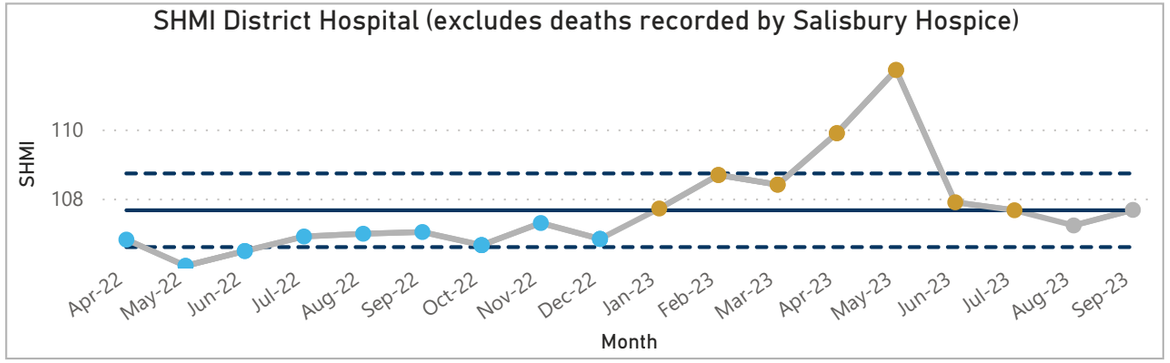
• Completion of required case investigations by clinical areas to identify good practice and any new learning continues. SFT IP&C team facilitate this process so that areas can take ownership and progress any actions or identified learning (including sharing good practice).
From the reviews completed, lapses in care continue to be identified. The divisions continue to monitor those areas that have produced action plans.
• Involvement with the newly formed BSW ICS HCAI and IP&M collaborative workstream. Feedback from the sessions is shared at the SFT IPCWG. A BSW IPC End to End Post Infection Review meeting has been undertaken this month, with each acute provider presenting and sharing learning.

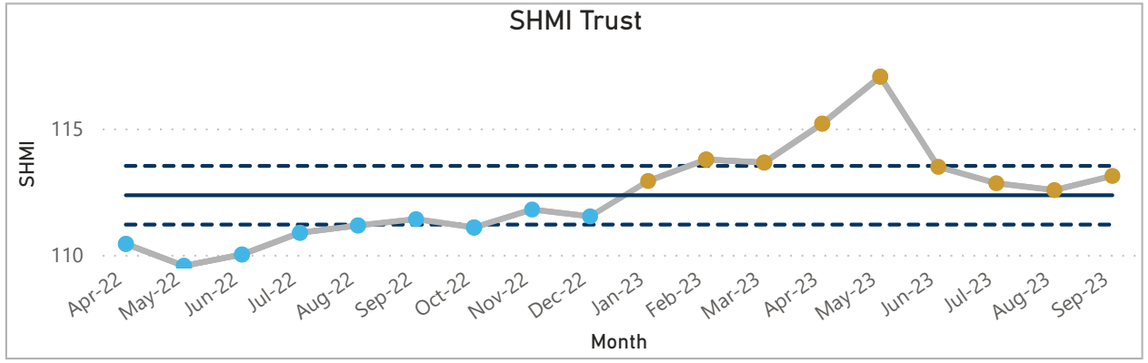
## Risks and Mitigations

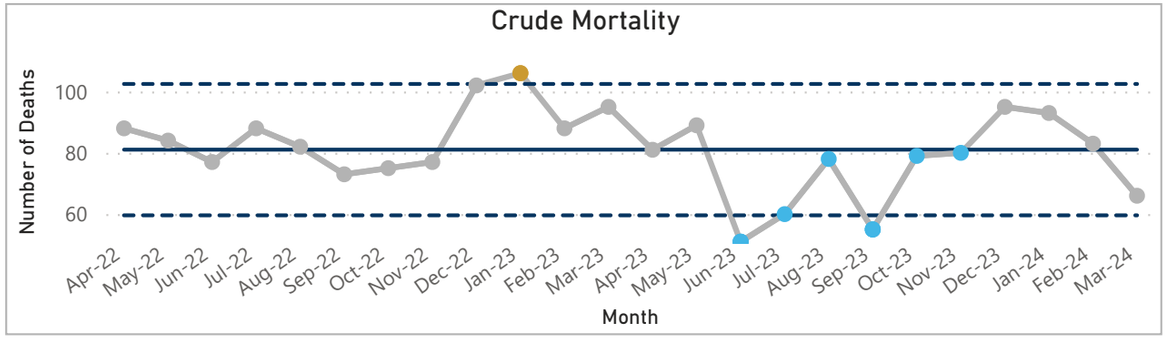
• No identified progress reported by the medical division for roll out of alternative hand hygiene assessment method.
Band 6 nurse continues progressing through their orientation programme.
• Clinical workload for IPC nursing team continues to have an impact on ability to progress other HCAI prevention work e.g. policy reviews/development, and innovation activities.
• An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. (Of note: Trust trajectories for 2024/25 yet to be published).

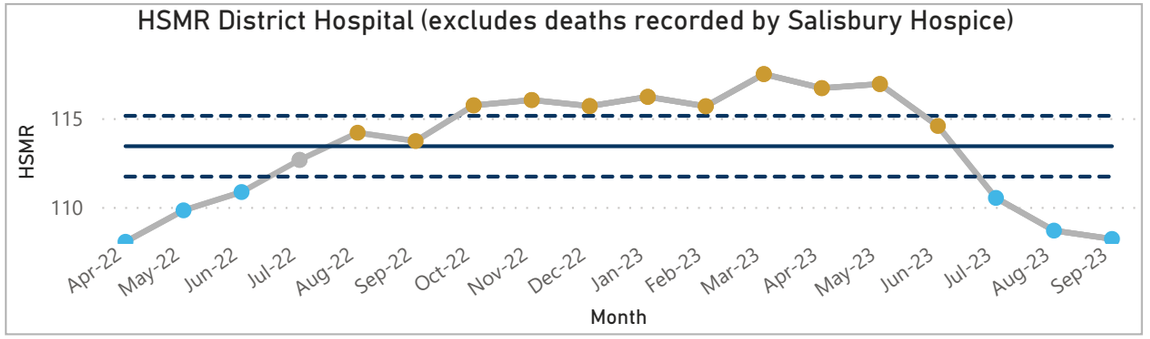
# Mortality

Are We Safe?




## Understanding the performance

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

The Summary Hospital-level Mortality Indicator (SHMI) for the 12 month rolling period ending in September 2023 for Salisbury District Hospital is 1.0767.

The Hospital Standardised Mortality Ratio (HSMR) for the 12 month rolling period ending in September 2023 for Salisbury District Hospital is 108.2 (99.7-117.3). This is within the expected range and a change in banding from statistically higher than expected.

## Actions (SMART)

• The latest mortality data is now being represented using SPC charts (see above). This is a change from using tables to present the SHMI/HSRM figures and is consistent with how data is elsewhere presented throughout the IPR report. The Trust has recently seen a positive reduction in both the SHMI and HSMR figures. This may in part be due to the lower crude mortality rates observed during this same time period last year and we will therefore be seeking sustained improvements in our position and opportunities to learn from the data with the support of our partners at Telstra Health UK (Dr Foster). • The Trust received formal feedback from a Board requested mortality insight visit in February 2024, and this included some positive feedback and also areas for further development and learning. A list of 28 actions have been developed and are being progressed, with assurances being sought via the Trust's Mortality Surveillance Group. • A Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) wide mortality group has recently been established to help consider shared opportunities for improvement across our wider population. A separate regional group is also being established to focus more specifically on 'coding,' which was an improvement area identified from the visit. For instance the need for us to improve our depth of coding, recording of comordbidities, and link between our coders and clinicians.

## Risks and Mitigations

• The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend in order to help us to interpret
and analyse our mortality data and identify variations in specific disease groups.
• Where alerts are generated, these are discussed and a further review of the patient's records may be undertaken.

# Watch Metrics: Alerting

Quality of Care, Access and Outcomes

| Metric | Two Months Ago | Last Month | This Month | Improvement Target | National Target | Variation | Variation Detail | Target Met This Month? | Consecutive Months Target Failed |
|---|---|---|---|---|---|---|---|---|---|
| Ambulance Handovers 60+ mins | 94 | 91 | 57 | | 0 | | Special Cause Improving - Run Below Mean | X | 36 |
| Cancer 2 Week Wait Performance | 48.9% | 64.5% | 71.8% | | 93% | | Special Cause Concerning - Run Below Mean | X | 36 |
| Cancer Patients waiting > 62 days | 158 | 145 | 117 | 83 | | | Common Cause Variation | X | 3 |
| Complaints Closed within agreed timescale % | 48.0% | 57.0% | 28.0% | 90.0% | | | Special Cause Improving - Run Above Mean | X | 36 |
| ED 12 Hour Breaches (Arrival to Departure) | 42 | 33 | 29 | | 0 | | Special Cause Improving - Run Below Mean | X | 36 |
| ED Attendances | 6549 | 6269 | 7411 | | | | Special Cause Concerning - Above Upper Control Limit | | |
| Inpatients Undergoing VTE Risk Assessment within 24hrs % | 26.6% | 40.3% | 39.8% | | 95% | | Special Cause Improving - Above Upper Control Limit | X | 36 |
| Number of High Harm Falls in Hospital | 4 | 1 | 5 | 0 | 0 | | Common Cause Variation | X | 19 |
| RTT Incomplete Pathways: Total 52 week waits | 919 | 919 | 1033 | 690 | 0 | | Special Cause Concerning - Above Upper Control Limit | X | 15 |
| RTT Incomplete Pathways: Total 65 week waits | 195 | 119 | 9 | 0 | 0 | | Special Cause Improving - Below Lower Control Limit | X | 7 |
| Stroke patients receiving a CT scan within one hour of arrival | 56.0% | 53.0% | 40.0% | | 50% | | Common Cause Variation | X | 1 |

# Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

## Understanding the performance

Metrics that are alerting this month due to improvement are Ambulance handover delays over 60 minutes, the number of patients spending over 12 hours in the Emergency Department and the number of patients waiting over 65 weeks for elective treatment.

Cancer Two Week Wait performance continues to run below the mean, but has improved for the last 2 months as a result of improvements in the Skin and Lower GI tumour site pathways, however there has been a deterioration in waiting times for the Breast pathway linked to an unexpected higher than average referral wait over Winter.

ED attendances continue to alert due to the high volume, with attendances in March were the highest recorded to date, with large increases in both Type 1 (main ED department) and Type 3 (Walk in Centre).

The number of patients waiting over 52 weeks for treatment remains above plan due to disruption in year from Industrial Action, however only 9 patients waited over 65 weeks at the end of March, very narrowly missing the target of 0.

The number of High Harm falls in month increased to 4 but remains within common cause variation. Also within common cause variation is the proportion of Stroke patients receiving a CT scan within one hour of arrival. Whilst this is within common variation it is a third month of reducing performance so requires close monitoring. Further detail around improving Stroke standards is earlier in this report on the Stroke care page.

## Actions (SMART)

- Cancer performance remains a focus with the Trust still in Tiering level 2. There has been considerable improvements which require sustaining over the longer term. There have been improvements in Lower GI and Skin, the biggest contributor is now the Breast service due to increased referrals from Decmber to March. 7 additional clinics have been undertaken and the first wait has reduced to less than 20 days which reduces the impact upon the standards in the latter part of the pathway.
- The Trust has submitted a plan to get to zero 52 week patients by March 2025. Additonal theatre and ward capacity comes online in month 1 and 2 with an increased level of elective, daycase and outpatient activity acoss the 24/25 in comparison to 23/24.
- Out of hours arrivals has been identified as a factor in Stroke performance which results in slower diagnosis and arrival on the Stroke Unit. Education and communication in ED is being targeted with sessions arranged with ED in April.

## Risks and Mitigations

- Risk of ongoing Industrial Action into 2024/25 and impact on elective activity.
- Volatility in demand for some services – the Skin service and Ultrasound in particular have seen peaks in referrals rates. Close monitoring through daily cancer huddles and radiology weekly waiting list meeting.
- High occupancy levels remain challenging and provide poor flow into the hospital from the Emergency Department. New ward (Imber) opening in Q1 will increase capacity and expanded Theatre timetable from April will support increase of surgical activity and in turn reduce waiting list.

# Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

| Metric | Two Months Ago | Last Month | This Month | Improvement Target | National Target | Variation | Variation Detail | Target Met This Month? | Consecutive Months Target Failed |
|---|---|---|---|---|---|---|---|---|---|
| Average Patients with No Criteria to Reside | 88 | 85 | 73 | 109 | | | Special Cause Improving - Below Lower Control Limit | ✓ | 0 |
| Diagnostics Activity | 7978 | 7988 | 8340 | 6908 | | | Special Cause Improving - Above Upper Control Limit | ✓ | 0 |
| Mixed Sex Accommodation Breaches | 20 | 31 | 0 | 0 | 0 | | Common Cause Variation | ✓ | 0 |
| Neonatal Deaths Per 1000 Live Births | 0 | 7 | 0 | | 0 | | Common Cause Variation | ✓ | 0 |
| Pressure Ulcers Hospital Acquired Cat 2 | 37 | 29 | 19 | | | | Special Cause Improving - Below Lower Control Limit | | |
| Pressure Ulcers Hospital Acquired Cat 3 | 2 | 0 | 1 | | | | Common Cause Variation | | |
| Pressure Ulcers Hospital Acquired Cat 4 | 0 | 0 | 0 | | | | Common Cause Variation | | |
| Proportion of patients spending more than 12 hours in an emergency department | 0.9% | 0.8% | 0.6% | | | | Special Cause Improving - Run Below Mean | | |
| RTT Incomplete Pathways: Total 78 week waits | 21 | 18 | 0 | 0 | 0 | | Special Cause Improving - Below Lower Control Limit | ✓ | 0 |
| Stillbirths Per 1000 Total Births | 0 | 7 | 0 | | | | Common Cause Variation | | |
| Total Incidents (All Grading) per 1000 Bed Days | 58 | 57 | 51 | | | | Common Cause Variation | | |
| Total Incidents Resulting in High Harm (Mod/Maj/Cat) % | 5.6% | 2.8% | 3.4% | | | | Common Cause Variation | | |
| Total Number of Complaints Received | 14 | 17 | 12 | | | | Common Cause Variation | | |
| Total Number of Compliments Received | 43 | 91 | 79 | | | | Common Cause Variation | | |

# Part 2: People

## Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

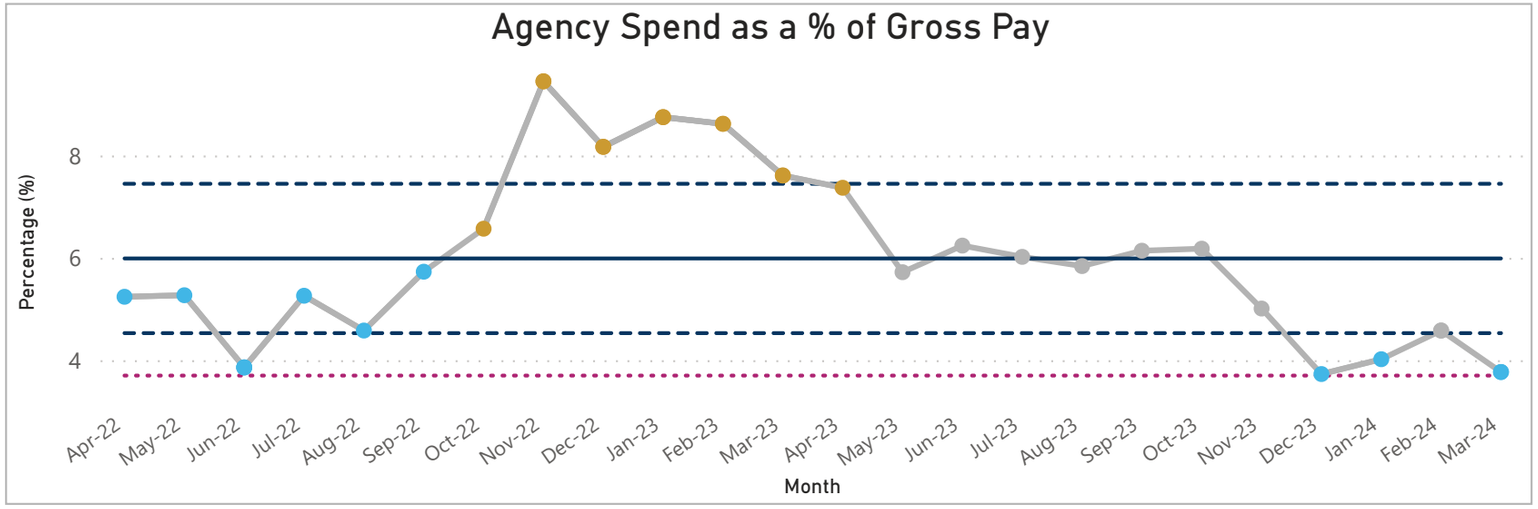
Partnerships

People

# Staffing Availability

**Target 3.7%**

Breakthrough Objective




## We are driving this measure because...

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

## Understanding the performance

Agency spend has fallen back to 3.77% this month, in line with Dec 23 and Jan 24 figures which broadly meet the target measure. Actual Agency spend was £615K down from £788K last month. In this period bank spend rose to £1,730K, the highest Bank spend this FY, this increase was generated within the Nursing and Medical staff groups.

Nursing agency spend also rose by £47K this month. The increase against both bank and agency is down to a combination of an increase in operational pressures and the easter leave period which saw raised level of unavailability across the nursing staff group. Nursing agency spend remains below the 12 month average, representing 40% of Agency cost. At £254K Medical represented 41% of the total spend.

Elderly Medicine, Respiratory and Stroke were the highest agency spenders, with Bank increases most prominent in ED, Theatres and AMU, reflecting operational pressures.

## Actions (SMART)

- Temporary Staffing Grip and Control. Grip and control of Temp staffing continues to affect temp staffing numbers, with an overall reduction in spend in the last 3 months. There has also been a shift of use from more expensive agency cover to cheaper bank cover for a number of shifts. Further work continues to better manage medical spend and to align agency rates across the region.
- Bank Staff: Bank shift numbers have increased with improved availability of qualified staff. Nurse and HCA staff recruitment remains live.
- Temporary Staffing Work is ongoing to align off cap rates at a regional level which will reduce nursing agency costs. The recent move to a new contract provider for medical agency staffing is still bedding in and should enable a reduced spend on framework agency use in the coming months.

## Risks and Mitigations

Corporate Risk – Sustainable Workforce

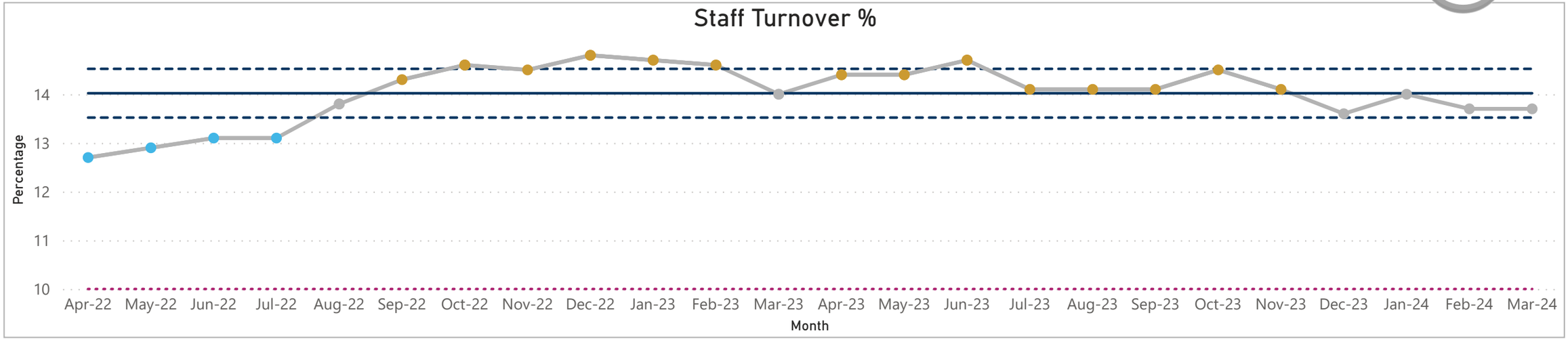
Mitigations:

- Line Managers insufficiently trained to support people promise and absence management initiatives – Leaders training now established at 2 levels, with management training interventions designed and in place.
- Temporary staffing 5 point plan seeks to address weaknesses in the process and controls of temp staffing, as well as managing Agency costs through increasing Bank staff numbers and a negotiation of improved contracts with agency providers.

# Workforce - Turnover

**Target 10%**

People




## Understanding the performance

The 12-month rolling turnover measure is 13.7% for the second month running and has remained below the average 14% figure for this quarter. Staff numbers increased this month by 2.33 FTE overall, with a total of 57 staff (44.82 FTE) leaving the Trust. The impact of increased scrutiny through workforce control panels has reduced overall inflow this month.

The corporate area has the best turnover numbers, at 12.30% close to the interim target. Women and New Born remains the worst performing division at 15.36%. Across the various staff groups, Nursing sits at 10.8%, Medical and Dental at 8.53%. Additional Clinical services have dropped by a single percentage point, but remain the worst performing staff group at over 20%.

Amongst the 57 leavers, 15 left due to retirement, this is a significantly higher proportion than previous months, likely due to this month being tax year-end.

## Actions (SMART)

- Training and further education to improve exit conversations within the Additional Clinical Services group of staff will support further work across the Trust to better investigate the negative reasons for leaving and target these areas to mitigate negative reasons for leaving the Trust.
- The national retention toolkit has been released and actions assessed against this toolkit to support line managers with a particular focus on those in their first 2 years of service and under 30. This work is complemented by 100 day and 1-year sessions for staff organised by OD&P. Specific actions against the Additional Clinical Services cohort are being developed
- Wellbeing survey data is being analysed and actions will be discussed at the next Health and Wellbeing Committee in December.

## Risks and Mitigations

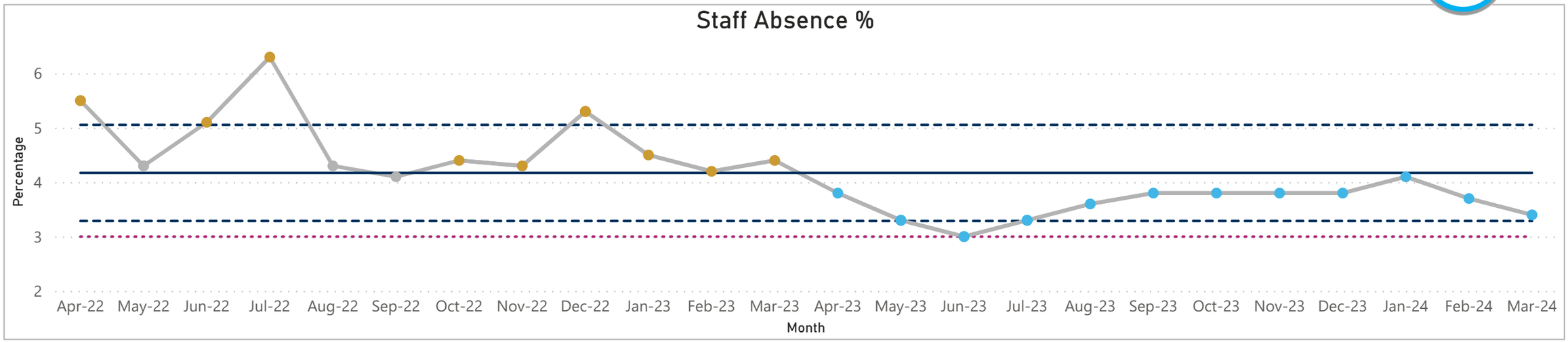
Corporate Risk – Sustainable Workforce.

- Improved toolkits to support Line Managers to deliver appraisals and other conversations have been delivered.
- Divisional Staff Survey Action Plans.
- Line Manager Training interventions.

# Workforce - Sickness

**Target 3%**

People




## Understanding the performance

Sickness absence has maintained a downward trend in 2024, down a further 0.37 points to 3.36%, below the long-term mean and trending towards the target of 3%. Corporate and CSFS are below target this month at 2.25 and 2.67% respectively, and all divisions are below 4%, with women and new-born the highest at 3.99%

Additional clinical services (4.94%) remain the staff group with the highest absence rate, which has risen on last month's figure.

Sickness accounted for 4110 FTE days lost to the Trust, of which 2860 were for short term absence. Long term absence fell further this month to 1250 FTE days, a positive trend compared to nearly 600 more days lost in the same quarter last year. Key reasons for absence remain Anxiety/Stress/Depression (29%), Cold/Cough/Flu (19%) and Gastrointestinal (9%).

## Actions (SMART)

- Absence Management: A second round of staff briefings is underway to explain the implementation and policy relating to reasonable adjustments, aimed at getting staff with long term sickness back to work. These interventions are having an effect as long term sickness numbers are reducing.
- The prevention of violence and aggression within the Trust remains a focus, seeking to prevent physical injury, but also aiming to reduce cases of workplace stress and anxiety for those working in high prevalence situations. Comms advertising the no excuse for abuse campaign have been approved for the ED.
- The first 2 of a series of training interventions for ward staff have been very well received by those released to attend.

## Risks and Mitigations

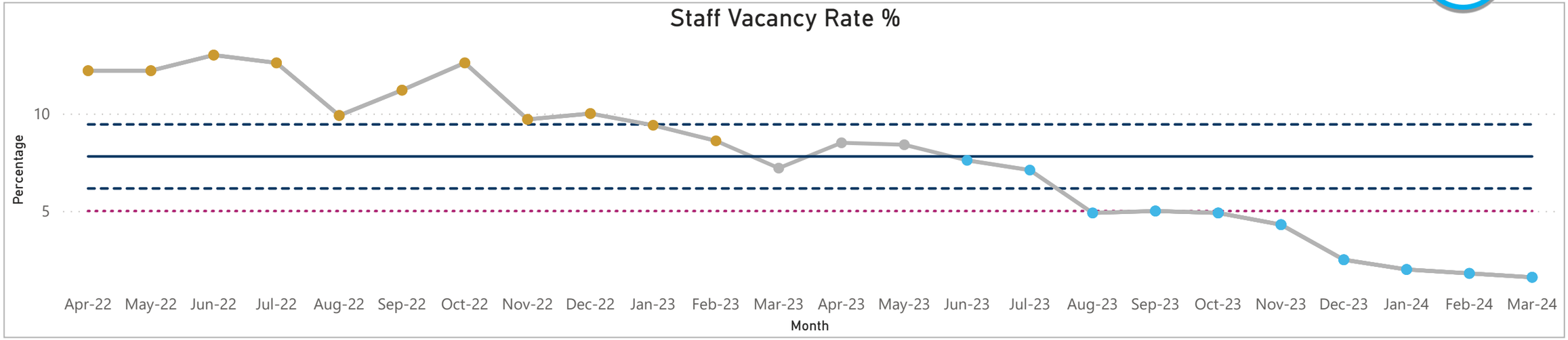
Corporate Risk – Sustainable Workforce

- The HRA team has been reduced by 50% (4 FTE) due to promotion, resignation and maternity leave – this will generate a short-term impact on outputs for the Team. An additional staff member has been recruited which has mitigated some element of this risk.

# Workforce - Vacancies

Target 5%

People




## Understanding the performance

The Trust's net vacancy position has fallen again this month to 1.62%, a net 65 FTE. This is well below the 5% target for the Trust.

Highest vacancy rates remain in theatres, although vacancies have halved in the last 6 months, representing good progress.

A small number of vacancies in hard to recruit medical posts, including Gastro and Dermatology continue to impact on medical agency and bank rates.

## Actions (SMART)

• Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team
• The focus of Advertisement campaigns remains Theatres, The Emergency Department, Maternity, HCAs and Housekeeping.
Recent activity has also focussed on delivery of additional bank staff for nursing and HCA. A campaign has also been launched to attract consultant staff in hard to recruit posts.
• A business case has been agreed to support return to practice for nurses. Business cases to support degree apprenticeships for nursing and to enable additional training to allow those overseas staff with nursing qualifications to practice in the UK are pending decisions at system level.

## Risks and Mitigations

Corporate Risk – Sustainable Workforce
• Resourcing Plans delivered.
• Implementation of PWC 'overhauling recruitment'. recommendations to generate more efficient processes.
Recruitment campaigns are being refreshed.
• Communication of single version of recruiting picture across the Trust.
• Creation of career pathways and improved career structures to better advertise roles and opportunities.

# Watch Metrics: Alerting

People

| Metric | Two Months Ago | Last Month | This Month | Improvement Target | National Target | Variation | Variation Detail | Target Met This Month? | Consecutive Months Target Failed |
|---|---|---|---|---|---|---|---|---|---|
| Mandatory Training Rate % | 86.2% | 87.2% | 86.3% | 90.0% | 85% |  | Special Cause Concerning - Below Lower Control Limit | X | 14 |
| Medical Appraisal Rate % | 86.5% | 87.8% | 88.6% | 90.0% | |  | Common Cause Variation | X | 7 |
| Non-Medical Appraisal Rate % | 80.3% | 79.9% | 80.5% | 86.0% | |  | Special Cause Improving - Above Upper Control Limit | X | 36 |

# Watch Metrics: Alerting Narrative

People

## Understanding the performance

There has been little movement in the mandatory training picture for the last few months, sitting at an average of 86.6%. In Mar the rate was 86.3%. Only quality and facilities are above the 90% improvement target, with Women and Newborn and Corporate divisions the lowest achievement rates at 82% each, below the national 85% target.

Medical appraisal rates measure 88.6% this month. This represents a gradual upward trend over the 6 months since Oct 23 when rates were at 82.7% against the target of 90%. 40 medical appraisals are showing as out of date for greater than 3 months.

Non-Medical appraisals increased above 80% again this month at 80.5%, remaining below the improvement target of 86%. The corporate division is the worst performing area at 73.5% completion rate

## Actions (SMART)

• Mandatory Training: A review of Mandatory training requirements will seek to better understand the mandated training environment and the time required to complete training – this review will then seek to implement any changes to the provision and need for statutory and mandatory training in different roles and professions. The review will report in Jul 24.
• Non-Medical Appraisals: Instructions on how to record appraisals on ESR have been published and training offered to line managers to support data capture. The ESR support team remain available to support line managers with uploading appraisal data into ESR. Monthly reconciliation of appraisals with line managers by business partners is also having a positive effect.

## Risks and Mitigations

Corporate Risk - Sustainable Workforce.
• Corporate Risk – MLE accuracy: Ongoing work to identify and establish accuracy within compliance rates on the Trust MLE system.
• Retention Mitigations – People Promise Projects, Appraisal Project, Development and Delivery of Leadership Training Modules for line managers.

# Part 3: Finance and Use of Resources

## Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

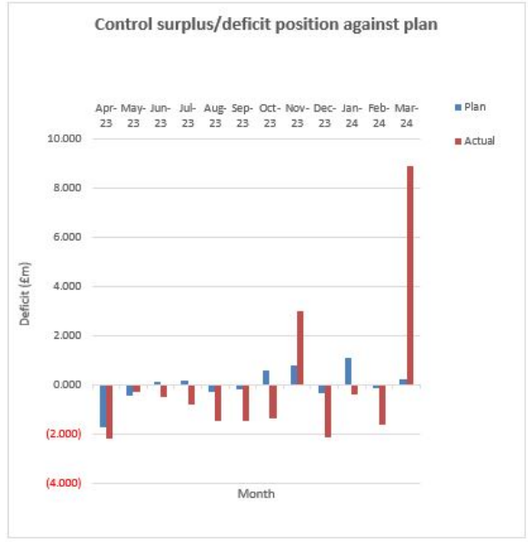
People

# Income and Expenditure

**Income & Expenditure:**

Finance and Use of Resources

| | March '24 In Month | | | March '24 YTD | | | 23-24 |
|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s |
| **Operating Income** | | | | | | | |
| NHS Clinical income | 22,756 | 32,415 | 9,659 | 290,195 | 312,613 | 22,418 | 275,490 |
| Other Clinical Income | 803 | 1,825 | 1,022 | 9,471 | 15,414 | 5,943 | 9,478 |
| Other Income (excl Donations) | 5,372 | 13,839 | 8,467 | 44,923 | 50,074 | 5,151 | 59,621 |
| **Total income** | **28,931** | **48,080** | **19,149** | **344,589** | **378,101** | **33,513** | **344,589** |
| **Operating Expenditure** | | | | | | | |
| Pay | (17,638) | (27,024) | (9,386) | (212,809) | (241,717) | (28,908) | (212,809) |
| Non Pay | (9,463) | (10,879) | (1,416) | (112,722) | (116,168) | (3,446) | (112,722) |
| **Total Expenditure** | **(27,101)** | **(37,903)** | **(10,802)** | **(325,531)** | **(357,884)** | **(32,354)** | **(325,531)** |
| | | | | | | | |
| **EBITDA** | **1,830** | **10,176** | **8,346** | **19,058** | **20,217** | **1,159** | **19,058** |
| Financing Costs (incl Depreciation) | (1,590) | (1,249) | 341 | (19,058) | (20,352) | (1,294) | (19,058) |
| **NHSE Control Total** | **240** | **8,927** | **8,687** | **0** | **(135)** | **(135)** | **0** |




## Understanding the performance

In month 12 the Trust recorded an in month control total surplus of £8.9m against an original deficit target of £0.2m - a favourable variance of £8.7m. The YTD control total position was an underlying deficit of £8.675m, which is a small deficit of £135k, when the additional £2m Elective Recovery Fund (ERF), £2.2m NHS England funds and £4.34m historic Clinical Commissioning Group (CCG) surplus are taken into account.

Pay costs include the technical adjustments required by the Department of Health and Social Care for the NHS pension adjustment of £9.148m. The underlying position was a reduction of £0.4m which includes changes to the annual leave assessment at year end and central pay provisions, including but not limited to, clinicians pensions and employment issues. Non pay costs increased due to the impact of year end stock levels, central assessments of outstanding costs and drugs costs due to additional clinical activity which are not income backed.

## Actions (SMART)

• The 2023/24 plan includes an efficiency requirement of £15.3m and the Financial recovery group was established in April, as a sub committee of the Finance and Performance committee, to provide scrutiny and support to the savings programme.

## Risks and Mitigations

• Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working. • Delivery of productivity increases which are contingent on both length of stay reductions and the recruitment of staff. • The Trust's forecast of £15.3m efficiency savings includes more than 29% non recurrent delivery and signals a risk into 2024/25.

# Income & Activity Delivered by Point of Delivery

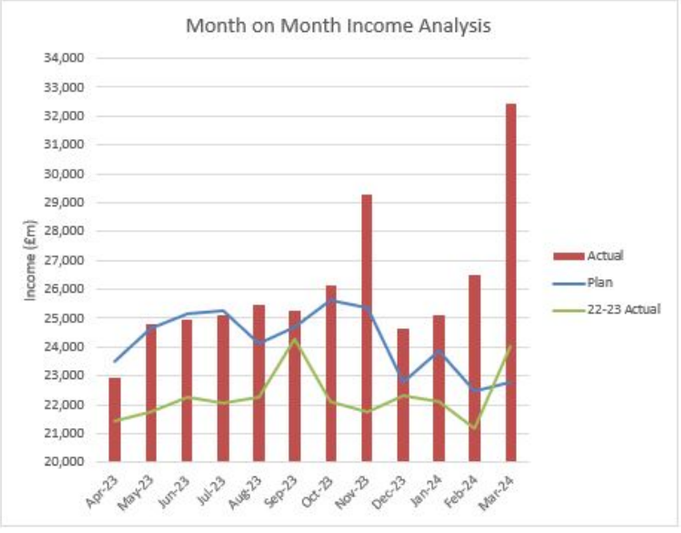
**Clinical Income:**

Finance and Use of Resources

| Income by Point of Delivery (PoD) for all commissioners | March Year to Date (YTD) Plan (YTD) £000s | Actual (YTD) £000s | Variance (YTD) £000s |
|---|---|---|---|
| A&E | 10,711 | 11,915 | 1,204 |
| Day Case | 22,172 | 21,718 | (454) |
| Elective inpatients | 14,320 | 14,677 | 357 |
| Excluded Drugs & Devices (inc Lucentis) | 24,070 | 27,401 | 3,331 |
| Non Elective inpatients | 79,133 | 76,612 | (2,521) |
| Other | 103,444 | 119,406 | 15,962 |
| Outpatients | 36,345 | 40,884 | 4,539 |
| TOTAL | 290,195 | 312,613 | 22,418 |

| SLA Income Performance of Trusts main NHS commissioners | Contract Plan (YTD) £000s | Actual (YTD) £000s | Variance (YTD) £000s |
|---|---|---|---|
| BSW ICB | 176,355 | 193,282 | 16,927 |
| Dorset ICB | 29,369 | 29,819 | 450 |
| Hampshire, Southampton & IOW ICB | 25,156 | 25,173 | 17 |
| Specialist Services | 40,385 | 45,709 | 5,324 |
| Other | 18,930 | 18,630 | (300) |
| TOTAL | 290,195 | 312,613 | 22,418 |

| | Activity YTD Plan | Actuals | Variance | Activity Last Year Actuals | Variance last year |
|---|---|---|---|---|---|
| A&E | 73,900 | 75,033 | 1,133 | 72,327 | 2,706 |
| Day case | 23,583 | 24,178 | 595 | 22,394 | 1,784 |
| Elective | 3,302 | 3,274 | (28) | 3,261 | 13 |
| Non Elective | 27,566 | 28,439 | 873 | 26,840 | 1,599 |
| Outpatients | 250,607 | 277,525 | 26,918 | 254,523 | 23,002 |




## Understanding the performance

The Clinical income position is above plan year to date due to BSW ICB overperformance which includes the system risk share, draw down of historic CCG surplus, Industrial action funding, funding for the financing charges of nationally funded capital schemes and overperformance on ERF points of delivery, Advice & Guidance and Radiology, with Other variable reduced by £1.0m for the risk share impact. Specialist services is over performing on Drugs and devices, Dorset ICB overperformance continues on High cost drugs and devices, Radiology and Advice and guidance with Hampshire ICB continuing to under perform on Day case activity.

The level of uncoded day cases and inpatient spells is 10% in February and 93% in March at the time the activity was taken for reporting purposes. January's activity was fully coded at the SUS submission.

Activity was higher in March than February across all the main points of delivery with the exception of Outpatients activity.

## Actions (SMART)

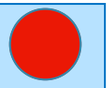
• The NHS England contracts have been signed by all parties and the ICB contract is agreed but awaiting final signatures by both parties.

## Risks and Mitigations

• The impact of IA has constrained the elective programme and management capacity to improve productivity. No further IA is anticipated in March. • All commissioner contracts, excluding BSW ICB, now require 99% of 2019/20 Elective activity levels. The Trust is mitigating the impact by maximising activity recording opportunities and contract negotiations on the year end forecast outturn.

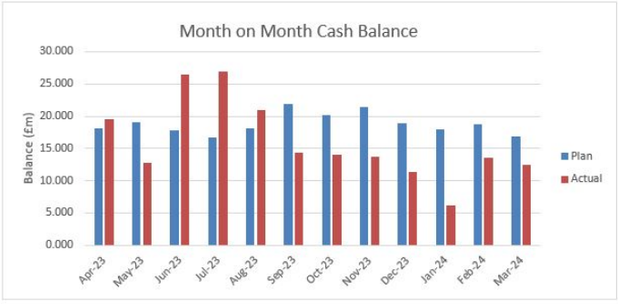
# Cash Position & Capital Programme

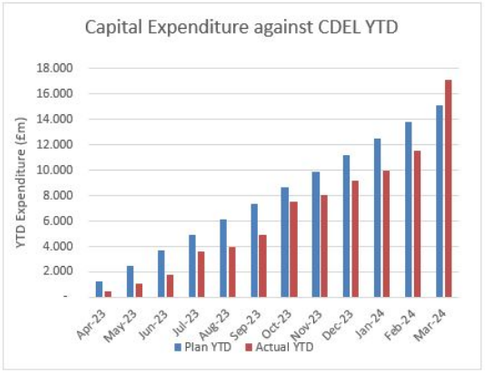
**Capital Spend:** 

**Cash & Working:** 

Finance and Use of Resources

| | Closing Balance March 2023 £000s | Current Month Balance £000s | Actual In Year Movement £000s |
|---|---|---|---|
| Inventories (Stock) | 7,954 | 8,629 | 675 |
| Debtors | 24,999 | 38,043 | 13,044 |
| Cash | 28,891 | 12,440 | (16,451) |
| **TOTAL CURRENT ASSETS** | **61,844** | **59,112** | **(2,732)** |
| Creditors | (58,026) | (58,481) | (455) |
| Borrowings | (641) | (631) | 10 |
| Provisions | (474) | (445) | 29 |
| **TOTAL CURRENT LIABILITIES** | **(59,141)** | **(59,557)** | **(416)** |
| **TOTAL WORKING CAPITAL** | **2,703** | **(445)** | **(3,148)** |




| Payables age profile | Total Payables £'000 | 0-30 days £'000 | 31-60 days £'000 | 61-90 days £'000 | 90+ days £'000 |
|---|---|---|---|---|---|
| Mar-24 | **11,372** | 10,854 | 168 | 84 | 266 |
| Feb-24 | **12,839** | 11,548 | 318 | 566 | 407 |
| Jan-24 | **8,523** | 7,017 | 849 | 190 | 467 |
| *Movement vs prev mth* | *(1,468)* | *(694)* | *(151)* | *(482)* | *(141)* |

| Schemes | Annual Plan £000s | March '24 YTD Plan £000s | March '24 YTD Actual £000s | March '24 YTD Variance £000s |
|---|---|---|---|---|
| **CDEL Schemes** | | | | |
| Building schemes CIR | 2,785 | 2,785 | 2,965 | (180) |
| Building projects | 6,201 | 6,201 | 6,311 | (110) |
| IM&T | 3,432 | 3,432 | 3,480 | (48) |
| Medical Equipment | 2,698 | 2,698 | 2,724 | (26) |
| GWH CDEL | 400 | 400 | 0 | 400 |
| **Total CDEL schemes** | **15,516** | **15,516** | **15,480** | **36** |
| **National Funding** | | | | |
| New Elective Ward TIF | 11,952 | 11,952 | 11,952 | 0 |
| Salix Decarbonisation | 10,005 | 10,005 | 10,005 | 0 |
| Shared EPR - national element | 2,106 | 2,106 | 2,106 | 0 |
| Digital Pathology & LIMS | 1,553 | 1,553 | 1,553 | 0 |
| Cyber Improvement | 16 | 16 | 16 | 0 |
| Community Diagnostic Centre | 605 | 605 | 426 | 179 |
| Medical Equipment Diagnostics | 26 | 26 | 20 | 6 |
| Mental Health UEC | 30 | 30 | 30 | 0 |
| National Endoscopy programme | 149 | 149 | 149 | 0 |
| **Total National Funding** | **26,442** | **26,442** | **26,257** | **185** |
| **GWH transaction** | | | | |
| Medical Equipment - Surgical robot | | | **1,431** | **(1,431)** |
| **GRAND TOTAL** | **41,958** | **41,958** | **43,168** | **(1,210)** |

## Understanding the performance

Capital expenditure on both CDEL and nationally funded projects increased markedly in month 12 as projects came to completion in line with the forecast. Total expenditure on CDEL schemes was £36k under plan for the year, taking into account agreed additional system allocations and spend on nationally funded projects was £185k under plan.

Cash reserves remain below plan despite the receipt of additional payments from NHS E in month 11 and the Revenue support of £4.3m in March.

## Actions (SMART)

• NHS England provided £4.3m revenue support in March. The Trust has requested £3m support to be paid on 22 April 2024. This is on the basis that the Trust will maintain the NHSE approved minimum cash balance of £1.1m for the remainder of 2024/25.

## Risks and Mitigations

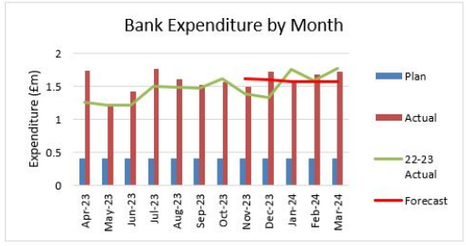
• Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

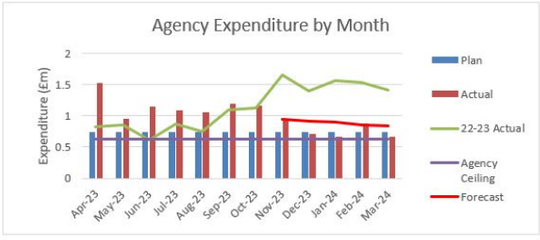
• The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of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

# Workforce and Agency Spend

Pay:

Finance and Use of Resources


| | March '24 YTD Plan £000s | March '24 YTD Actual £000s | March '24 YTD Variance £000s |
|---|---|---|---|
| Pay - In Post | 198,024 | 209,736 | (11,711) |
| Pay - Bank | 5,090 | 19,041 | (13,951) |
| Pay - Agency | 9,151 | 12,015 | (2,863) |
| Other (eg apprenticeship levy) | | 925 | (925) |
| **TOTAL** | **212,265** | **241,717** | **(29,451)** |
| Medical Staff | 55,859 | 62,507 | (6,648) |
| Nursing | 55,631 | 61,895 | (6,265) |
| Support to Nursing | 15,216 | 21,232 | (6,016) |
| Other Clinical Staff | 30,096 | 30,756 | (660) |
| Infrastructure staff | 55,463 | 55,252 | 211 |
| Other (eg apprenticeship levy) | | 10,074 | (10,074) |
| **TOTAL** | **212,265** | **241,717** | **(29,452)** |

| | March '24 Y' Baseline Plan WTE | March '24 YTD Plan WTEs | March '24 YTD Actual WTEs | March '24 YTD Variance WTEs |
|---|---|---|---|---|
| Medical Staff | 501.02 | 461.7 | 530.42 | 68.7 |
| Nursing | 1,162.21 | 1,150.2 | 1,253.43 | 103.2 |
| Support to Nursing | 533.74 | 521.7 | 654.21 | 132.5 |
| Other Clinical Staff | 658.70 | 643.4 | 661.25 | 17.8 |
| Infrastructure staff | 1,543.34 | 1,500.8 | 1,431.68 | (69.1) |
| **TOTAL** | **4,399.0** | **4,277.8** | **4,531.0** | **253.2** |

## Understanding the performance

Pay costs in month include the technical adjustments required by the Department of Health and Social Care for the NHS pension adjustment of £9.148m. The underlying position was a reduction due to capitalisation of pay costs, changes to the annual leave assessment at year end and central pay provisions, including but not limited to, clinicians pensions and employment issues.
Bank costs increased by £188k and Agency costs reduced by £198k.

The full year pay savings target was £10.5m against which total achieved pay savings were £5.6m - an adverse variance of £5.0m, with £2.7m recurrent delivery and £2.9m mainly relating to non-recurrent savings from vacancies.

An increase in substantive staff of 15 WTE with a 1% vacancy rate mainly within Consultants (14%). The level of unfilled shifts remained constant at 0% in March but there were gaps across Consultants, AHP, Scientific & Technical and NHS Infrastructure staff groups.

## Actions (SMART)

• Detailed actions on the response to the Trust's workforce challenges are set out in the People section of the IPR. These focus on establishment, recruitment, staff availability, temporary staffing and sickness.

## Risks and Mitigations

• Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although in the short term it is likely that the Trust will require both.

# Data Sources: Narrative and Breakthrough Objectives

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Breakthrough Objective | Beds Occupied % | Lorenzo via Trust Data Warehouse | Niall Prosser | Medium |
| Breakthrough Objective | Staffing Availability | Oracle | Melanie Whitfield | High |
| Breakthrough Objective | Total Patient Falls per 1000 Bed Days | DATIX Team | Judy Dyos | High |
| Breakthrough Objective | Wait time to first OPA (non-admitted) | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Narrative | Average Ambulance Handover Time | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Narrative | C Difficile Hospital onset Healthcare associated | Infection Control Team | Judy Dyos | High |
| Narrative | Cancer 28 Day Faster Diagnosis Standard | Cancer Services | Niall Prosser | High |
| Narrative | Cancer 31 Day Performance Overall | Cancer Services | Niall Prosser | High |
| Narrative | Cancer 62 Day Standard Performance | Cancer Services | Niall Prosser | High |
| Narrative | Cat 2 Pressure Ulcers per 1000 Bed Days | Tissue Viability team | Judy Dyos | High |
| Narrative | DM01 Performance | Trust Data Warehouse | Niall Prosser | High |
| Narrative | E Coli Hospital onset Healthcare associated | Infection Control Team | Judy Dyos | High |
| Narrative | ED 4 Hour Performance | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Narrative | Friends and Family Test Response Rate - All Trust | Trust Data Warehouse | Judy Dyos | High |
| Narrative | Patients moved more than once % | Lorenzo via Trust Data Warehouse | Judy Dyos | High |
| Narrative | Serious Incident Investigations | DATIX | Judy Dyos | High |
| Narrative | Staff Sickness Absence % | Health Roster | Melanie Whitfield | High |
| Narrative | Staff Turnover | ESR | Melanie Whitfield | High |
| Narrative | Stroke: % Arrival on Stroke Unit within 4 hours | Stroke Team | Peter Collins | Medium |
| Narrative | Total Waiting List | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Narrative | Vacancies | ESR | Melanie Whitfield | High |

# Data Sources: Watch Metrics (1)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Watch | Ambulance Handovers 60+ mins | SWAST AR119 report | Niall Prosser | High |
| Watch | Average Patients with No Criteria to Reside | e-whiteboards via Trust Data Warehouse | Niall Prosser | Medium |
| Watch | ED 12 Hour Breaches (Arrival to Departure) | Lorenzo via Trust Data Warehouse | Niall Prosser | Medium |
| Watch | ED Attendances | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Watch | MSSA Bacteraemia Infections: Hospital Onset | Infection Control Team | Judy Dyos | High |
| Watch | RTT Incomplete Pathways: Total 52 week waits | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Watch | RTT Incomplete Pathways: Total 78 week waits | Lorenzo via Trust Data Warehouse | Niall Prosser | High |
| Watch | Stroke patients receiving a CT scan within one hour of arrival | Stroke Team | Peter Collins | Medium |

# Data Sources: Watch Metrics (2)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Watch | Inpatients Undergoing VTE Risk Assessment within 24hrs % | Lorenzo via Trust Data Warehouse | Peter Collins | High |
| Watch | Mandatory Training Rate % | MLE | Melanie Whitfield | High |
| Watch | Medical Appraisal Rate % | ESR | Melanie Whitfield | High |
| Watch | Mixed Sex Accommodation Breaches | Site Team | Judy Dyos | Low |
| Watch | Neonatal Deaths Per 1000 Live Births | E3 via Trust Data Warehouse | Peter Collins | High |
| Watch | Non-Medical Appraisal Rate % | ESR | Melanie Whitfield | High |
| Watch | Number of High Harm Falls in Hospital | DATIX | Judy Dyos | High |
| Watch | Pressure Ulcers Hospital Acquired Cat 2 | Tissue Viability team | Judy Dyos | High |
| Watch | Pressure Ulcers Hospital Acquired Cat 3 | Tissue Viability team | Judy Dyos | High |
| Watch | Pressure Ulcers Hospital Acquired Cat 4 | Tissue Viability team | Judy Dyos | High |
| Watch | Stillbirths Per 1000 Total Births | E3 via Trust Data Warehouse | Peter Collins | High |
| Watch | Total Incidents (All Grading) per 1000 Bed Days | DATIX | Judy Dyos | High |
| Watch | Total Incidents Resulting in High Harm (Mod/Maj/Cat) % | DATIX | Judy Dyos | High |
| Watch | Total Number of Complaints Received | PALS Team | Judy Dyos | High |
| Watch | Total Number of Compliments Received | PALS Team | Judy Dyos | High |

# Data Sources: Other Metrics (1)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Day HCA | Health Roster | Melanie Whitfield | High |
| Other | Day RN | Health Roster | Melanie Whitfield | High |
| Other | Night HCA | Health Roster | Melanie Whitfield | High |
| Other | Night RN | Health Roster | Melanie Whitfield | High |

# Data Sources: Other Metrics (2)

Understand the Data

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

# Data Sources: Other Metrics (3)

Understand the Data

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

# Data Sources: Other Metrics (4)

Understand the Data

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

# Data Sources: Other Metrics (5)

Understand the Data

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

# Data Sources: Other Metrics (6)

Understand the Data

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

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.2 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report from (Committee Name): | Charitable Funds committee | | Committee Meeting Date: | 12th March 2024 |
| Status: | Information | Discussion | Assurance | Approval |
| | x | | x | |
| Prepared by: | Ian Green | | | |
| Non-Executive Presenting: | Ian Green | | | |
| Appendices (if necessary) | | | | |

| **Key discussion points and matters to be escalated from the meeting:** |
|---|
| **ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.** |
| • Nothing to report |
| **ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.** |
| • Charity remains financially secure with a balance sheet of £14.9 million<br>• Committee approved the charity budget for 2024/25<br>• Committee received a presentation on the development of a cancer centre for the Trust. It was agreed that Trust support would be required before approaching the charity for funding. |
| **ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.** |
| • Committee received an update on the framework for evaluation and monitoring which intends to provide greater assurance on assessing the impact of the charity's grants. |

| **Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.** |
|---|
| • The committee approved funding for specialist equipment to support the opening of additional theatre lists and improve outcomes for patients. |

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

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.3 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report from (Committee Name): | Audit Committee | | Committee Meeting Date: | 21 March 2024 |
| Status: | Information | Discussion | Assurance | Approval |
| | X | | X | |
| Prepared by: | Richard Holmes (Audit Committee Chair) | | | |
| Non-Executive Presenting: | Richard Holmes | | | |
| Appendices (if necessary) | None | | | |

**Key discussion points and matters to be escalated from the meeting:**

**ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.**

- The Committee received an Internal Audit Report in respect of Data Quality – Cancer Wait Times, assessed as Partial Assurance (Amber/Red), in line with Management expectations. This report confirmed previous management advice to the Board and its Committees that inaccurate data records in the Somerset Cancer Register (the methodology tool used to capture and calculate SFT Cancer Wait times) had impacted recording and management reporting of performance. Whilst inaccurate recording is the primary direct impact, potential indirect impacts on management decision making are obvious, with a consequential impact on patient pathway management. The COO confirmed the recent appointment of a new Cancer Services Manager who would assume responsibility for the delivery of the corrective and preventative actions over the next six months under his direction, but noted that delivery of the Faster Diagnosis Standard timescales will remain challenging.

**ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.**

- The ongoing programme of Internal Audits continues. The considered rating of the overall Core Financial Controls audit presented to the Committee was determined as 'Substantial Assurance (Amber/Green), however the Internal Auditors took the unusual step of pulling out Fixed Asset assurance separately, which was assessed as 'Partial Assurance' (Amber/Red). This was less than management prediction, driven by inaccuracies identified within the data held in the fixed asset register (FAR) and improvements required in the monitoring and approval of asset disposals and variances from the capital plan. The committee sought assurance from the CFO, and were assured, that a programme of work to complete the improvements had been commenced and would be completed prior to the Year End, such that Fixed Asset information would be correctly stated in the Annual Accounts. Additionally, a programme of ongoing management oversight to ensure the Fixed Asset process was appropriately operating into the future would be undertaken; the Committee will receive a further update at its September meeting.

NHS Salisbury NHS Foundation Trust

**ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.**

- With the Year End only days away, the Committee received assurance from the CFO and the External Auditors that no concerns had so far been raised about either the process or the content of the year end audit, about the financial controls in place, or about the management judgements likely to be made during the year end analysis and reporting of financial results for 2023/24.
- The Audit Committee was presented with a Deep Dive from the Procurement Director regarding inventory management processes and controls around managing stock and stock valuation across the Hospital. Stock is categorised into two; Point of Care stock – tracked against individual patients – eg implants, and Top-Up stock – fast moving general consumable items. Whilst there is always stock loss in any inventory management system, the Committee was assured that the control environment is improving and the level of stock loss and write offs is decreasing, to a level of 3.5% in 2023/24.
- Following a previous deep dive, the Committee received an update on the status of International Nurse Recruitment, and was pleased to note significant improvements in the overall position. The additional learning and pastoral support now given to newly appointed International Nurses has resulted in substantial increase in first time OSCE pass rates, and reduced time between arrival at SFT and joining the band 5 clinical numbers. This is very encouraging, and the Committee encouraged the team to socialise its success wider.
- The Committee received assurance from further Internal Audit and Counter Fraud Audits reports and plans presented at the meeting.

**Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.**

- The Committee received and noted regular reports regarding Stock write-off and Payroll overpayments. Values are all within normal business expectations.

| 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

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.4 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report title: | TMC escalation report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | | | |
| Approval Process: (where has this paper been reviewed and approved): | N/A | | | |
| Prepared by: | Lisa Thomas, Chief Executive | | | |
| Executive Sponsor: (presenting) | Lisa Thomas, Chief Executive | | | |
| Appendices | N/A | | | |

| Recommendation: |
|---|
| The Board is asked to note the report |

| Executive Summary: |
|---|

The Trust management Committee was held on the 24th April the key points to note were

**Assure**

- Divisions presented analysis of staff survey feedback and focus areas for action for 2024/25/ Learning was shared and a follow up progress review scheduled for Sept.
- The committee considered and approved the Integrated governance and Accountability Framework.
- The committee considered and approved the fit and proper persons policy.

**Alert**

- An update was provided on the national standards for healthcare cleanliness, where the Trust is not fully compliant with national standards predominately due to workforce and recruitment challenges. The Committee agreed to a phased approach in line with a recruitment and training plan.
- The committee reviewed the number of out of date policies, there are still a number outstanding with actions taken by all departments to update.

**Advise**

- The 2024/25 bed configuration plan was shared and approved at TMC. The aim was to right size the wards between medical and surgical beds, align ambitions for reduction of NCTR patients and ensure delivery of planned care activity levels. The discussion also aligned to revisit the bed escalation framework and ensure safer staffing levels were reviewed if material changes to patients were identified on individual wards.
- The committee signed off an invest to save case on Reporting radiographers, which would reduce the level of outsource reporting and offer new opportunities to upskill staff. This would now be taken to the system wide investment group for approval.
- The Committee received an update on out of hours mental health provision by AWP and the implications of the changes to the right person right care agenda. The committee was assured of the processes and would monitor any impact.

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

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.5 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report from (Committee Name): | Clinical Governance Committee | | Committee Meeting Date: | 26 March 2024 |
| Status: | Information | Discussion | Assurance | Approval |
| | | | x | |
| Prepared by: | David Buckle, Non-Executive Director | | | |
| Non-Executive Presenting: | David Buckle, Non-Executive Director | | | |
| Appendices (if necessary) | | | | |

**Key discussion points and matters to be escalated from the meeting:**

**ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.**

- **Nil**

**ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.**

- **IPR; It was noted that this was the first month with no fall documented for a year .VTE assessment was at 40% and this required further monitoring. A never event had occurred and CGC had requested a follow up report after investigation.**
- **CGC received a quarterly risk and PSIRF compliance report for Q3**
- **A health Inequalities update was discussed.**
- **Bi-annual Midwifery, Maternity and Neonatal Staffing report provided on going detail and assurance**
- **March Perinatal Quality Safety Report was received.**
- **CMB escalation report provided a summary of key issues**

**ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.**

- **Strategic Planning Framework was discussed and provided assurance on breakthrough objectives progress.**
- **Gastroenterology service update provided encouraging assurance but the clinical service risk is long term and CGC will consider further follow up .**
- **Annual Maternity Survey gives evidence-based assurance and the team is clear on what areas require action and improvement**
- **Surgical Site infection review. The Trust had been a statistical outlier but CGC was assured that action was being taken which was consistent with NICE and GIRFT. Patients were not seen to be at unnecessary risk.**

| Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board. |
|---|
| • Nil |

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

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.6 |
| Date of meeting: | 2 May 2024 | | |

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|---|---|---|---|---|
| Report from (Committee Name): | Finance & Performance Committee | | Committee Meeting Date: | 26 March 2024 |
| Status: | Information | Discussion | Assurance | Approval |
| | | | x | |
| Prepared by: | Debbie Beaven – Chair of Finance & Performance Committee | | | |
| Non-Executive Presenting: | Debbie Beaven | | | |
| Appendices (if necessary) | none | | | |

**Key discussion points and matters to be escalated from the meeting:**

**ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.**

- **Cancer –** The Trust remains in tier 2 Cancer oversight for our current 62-day backlog position (note: the backlog has halved since January). Additional capacity is in place and the position continues to reduce in line with trajectory with a projected financial year end position of 78 patients. Positive improvement was also seen in the 2 week wait metric, however, all national pathway metrics deteriorated in month. The Committee received a deep dive with a spotlight on Skin and lower GI. Teams are running "daily touch points" supporting planning and pathway improvements with an expectation that unnecessary steps in pathways will be removed, referencing best practice seen in other trusts, and with the agreement of the MDT to come it will be embedded. The hope is that we come out of tiering in April 2024.

- **Financial outturn –** The position remains complex, challenging and off-plan. Despite being very clear on the level of risk to this year's plan during the planning and submission phase (this time last year), regular communications about forecasts and challenges, our position doesn't seem to have resonated in the system. The Committee positively acknowledges the efficiency levels achieved in the trust (a +1.6% favourable movement in the NHSE productivity measure since M07 and some of the best reported year on year performance: +2.3% vs a national average of +0.9%), which shows we are doing the right things. Together with the significant level of CIPs delivered, beyond anything achieved before, there is good progress being made. This, however, continues to be eroded by the ongoing high level of costs of NCTR and the growth in non-elective activity.

  We expect to end the year with approx £8.9m deficit, before an additional £2m ERF income allocation. At this level there could be a "claw back" into next year of circa £2.2m to £6.9m, adding to the already high level of risk in the proposed plan.

- **Operational Planning 24/25 –** significant pressure is cascading through the system to increase our CIPs and reduce the plan deficit further. In the context of the risk of "claw back" (see above), the Committee feels extremely concerned about committing to any further reductions in costs. In its assessment, signing up to a plan that, despite diligent and concerted effort, is highly unlikely to be delivered in the next 12 months is not advisable.

There was a discussion around Board integrity and good governance, considering how we bridge the gap from agreeing to the level of risk already in our current and stretching plan submission and potential acquiesce to a further stretched financial plan, and there was a consensus that it feels a step too far. The conclusion of the committee was that it didn't feel comfortable recommending the plan to the Board, and it, therefore, asks the Board, whether , in good faith and governance, the Board can accept a further stretch to the plan. The Committee also suggests to the Board, that we seek an opportunity to share our concerns with the ICB Board in the hope that a way forward can be found without significant operational or financial consequences.

**ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.**

- **Stroke** – the position has deteriorated again, mirroring delays in ED. The Committee has asked for a deep dive into cause and effect in the next few months.
- **Bed Occupancy -** This breakthrough objective reduced from 104% to 101.5%, with the majority impact being from SDEC, together with a slight decrease of patients with No Criteria to Reside (NCTR) from 88 to 85.5 daily average. The Trust is finalising plans for 2024/25 with a reduction of NCTR to 10% of our core bed base (45 beds).

**ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.**

- **DM01** improved as expected resulting from additional capacity in place, from 79.2% to 87.9% and is now on track to meet the 85% target by the end of March 2024.
- **Reducing patient harm** measured through Falls decreased again to 6.1 per 1,000 bed days and now has an outstanding record of only two occasions in the last 9 months that the target of 65 weeks has not been achieved.
- **National waiting list reduction** - target of zero patients waiting >78 weeks by the end of March 2024 - the Trust is on track to achieve this.
- **Digital –** programmes are being managed effectively with the majority running to plan. A gap in budget reporting was identified and, although verbal assurance was given that projects are managed to budget. We hope to have spend to budget reported in future.

**Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.**

- **Hearing Aids and Consumables** procurement contract for 4 years, is recommended to Board for approval.

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

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.7 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report from (Committee Name): | People and Culture Committee | | Committee Meeting Date: | 28th March 2024 |
| Status: | Information | Discussion | Assurance | Approval |
| | √ | | √ | |
| Prepared by: | Miss Eiri Jones, NED, Chair People and Culture Committee | | | |
| Non-Executive Presenting: | Miss Eiri Jones, NED, Chair People and Culture Committee | | | |
| Appendices (if necessary) | | | | |

**Key discussion points and matters to be escalated from the meeting:**

**ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.**

- No areas to Alert this month

**ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.**

- The following items were presented and discussed at this month's meeting:
  - Annual review of Terms of Reference
  - Workplan sign off
  - Chapter 4, Part 2 of NHS Long Term Workforce plan – reform and working and training differently
  - People Promise and an Exemplar Site update (see Assure section below)
  - People promise sub committees. Work to analyse and develop actions for improvement is underway. The actions will be linked to either the new breakthrough objective or to watch metrics
  - Themes from Hearing It and actions. Appreciative Inquiry methodology is being used
  - Integrated Performance Report (IPR) (see Assure section below)
  - Staff Survey results Protected Characteristics
  - OD&P Management Board escalation report

**ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.**

- The committee used Improving Together methodology in the meeting and this will continue through future meetings
- Positive feedback was received from the national team in terms of the breadth of progress made during the second year as an Exemplar site
- Strong performance continues in relation to workforce metrics. Vacancies are in an excellent position at 1.8% and sickness absence at 3.7%. Nursing temporary staffing spend was at lowest level for 12 months (though agency spend overall up this month). There is good understanding of the data in relation to the additional spend

| Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board. |
|---|
| • As part of the annual review of the committee, the Terms of Reference were discussed and approved with minor changes<br>• The annual workplan for 2024-25 was approved |

| 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

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.7 |
| Date of meeting: | 2nd May 2024 | | |

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|---|---|---|---|---|
| Report from (Committee Name): | People and Culture Committee | | Committee Meeting Date: | 25th April 2024 |
| Status: | Information | Discussion | Assurance | Approval |
| | √ | | √ | |
| Prepared by: | Miss Eiri Jones, NED, Chair People and Culture Committee | | | |
| Non-Executive Presenting: | Miss Eiri Jones, NED, Chair People and Culture Committee | | | |
| Appendices (if necessary) | 1. OD&P Governance map<br>2. EDI projects | | | |

**Key discussion points and matters to be escalated from the meeting:**

**ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.**

- The committee received an update on the flash submission in relation to 2024/25 strategic workforce plan. The committee heard that the plan addressed the required reduction in whole time equivalents linked to the reduction in beds and reduction in use of temporary staffing. The plan has risks which the committee will continue to review through the year. The committee felt the Board should be made aware of the risks involved noting that both clinical Executives were sighted on this. High level detail of the reductions will be shared with the Board by the Chief People Officer.

To note: Committee members and Governors both noted that these are tough and challenging times in relation to workforce in the NHS with the Governors stating they understand the pressures the Trust is facing.

**ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.**

- The following items were presented and discussed at this month's meeting:
  - Strategic workforce planning (see Alert section)
  - OD and People service level agreement and key performance indicators performance report. There has been good performance in most metrics over the past 12 months. Where KPIs haven't been achieved, plans are in place to address these. This topic also included a discussion about the revised governance for OD&P (Appendix 1)
  - Strategic workforce systems steering group (The electronic system used by the Trust). The ongoing management of vacancies, absence management and turnover will continue through business-as-usual operational arrangements. Ongoing focus in on temporary staffing spend and rolling out e-rostering for the medical workforce.
  - Audit and fraud report update (see Assure below)
  - Integrated Performance Report (IPR) (see Assure below)
  - OD&P Management Board escalation report
  - EDI Long term plan. The elements of the plan have been identified into projects. These projects will be developed with key outcomes identified and the committee will receive

updates at intervals through the year. The relevant appendix from the report is attached for all Board members to be sighted
- The committee were informed that the Acute Health Care Alliance (AHA) are progressing collaboration work across corporate services.
- The committee were informed of the suite of national people policies that will be launched throughout the year, and
- The committee were briefed on the resourcing issue in the OD&P Employer Relations team, a team that is critical to the support of staff.

To note: The annual review of committee effectiveness was deferred to June, in line with other subcommittees and to use the new approach that has been developed.

**ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.**

- Flash report for workforce planning has been submitted by the due date.
- The one open audit report action has a timeline to complete for the end of July. This timeline extension was approved through the Trust formal process.
- Strong performance continues in relation to workforce metrics with ongoing reduction in agency spend. Vacancies are in an excellent position and where there continue to be challenges, there is a strong focus on this built on understanding of the data (e.g., theatre vacancies)

**Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.**

- No decisions or approvals were required from the committee in this meeting

| 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): | |

# OD&P Governance

Trust Management Committee (Approvals)

People and Culture Committee (Assurance) — EJ

SLT — Operational Updates weekly, Planning Monthly

IC / ST — Escalation Report (Achievements, Impact, Next Steps)

Highlight Report (Pj Milestones, Impact, Risks) — IC

MW. — OD&P Performance Management Board — Apr, Jul, Oct, Jan

OD&P Prog Management Board and Deep Dive — MW. — Jun, Sep, Nov, Feb, Mar

Escalation Report — Health and Safety Committee

Escalation Report — EDI Committee

Dashboard Performance against KPIs — ADs

Highlight Report (Pj Milestones, Impact, Risks) — ADs

Medicine DMT

Surgical DMT

CSFS DMT

Women and NewBorn

DR — Comms and Eng H2A — AD HR Ops H2A — MR

IC — DCPO H2A — AD OD&L H2A — RP

SLA/KPIs

Pj Boards

IC — OD&P Prog Sub Ctte

IC — WF Systems SG

IC — We are Safe and Healthy WG

DR — Engagement WG (Voice that Counts, Reward and Recognition)

MR — Retention WG (We work flexibly)

RP IC — Education and OD&L WG (Compassionate and Inclusive, We are a team, Always Learning)

Workforce Systems Working Group (Staff Availability WF Systems - ESR, E-Roster, Digital)

Health Intelligence Wellbeing CI Pjs

Reward and recognition Ambassadors Staff Council Snap Comms SaLI Continuous Improvement

Overhauling recruitment Turnover Absence Management Policies Flexible Working

OD&L Culture

Education

Escalation Report — Health and Wellbeing Committee

Week 4 Thur 1000-1200

Week 3 Tues am

Week 1 Various

Carers network

Ability network

Race network

LGBTQ+ network

Women's network

Veteran's network

Faith network

JCC

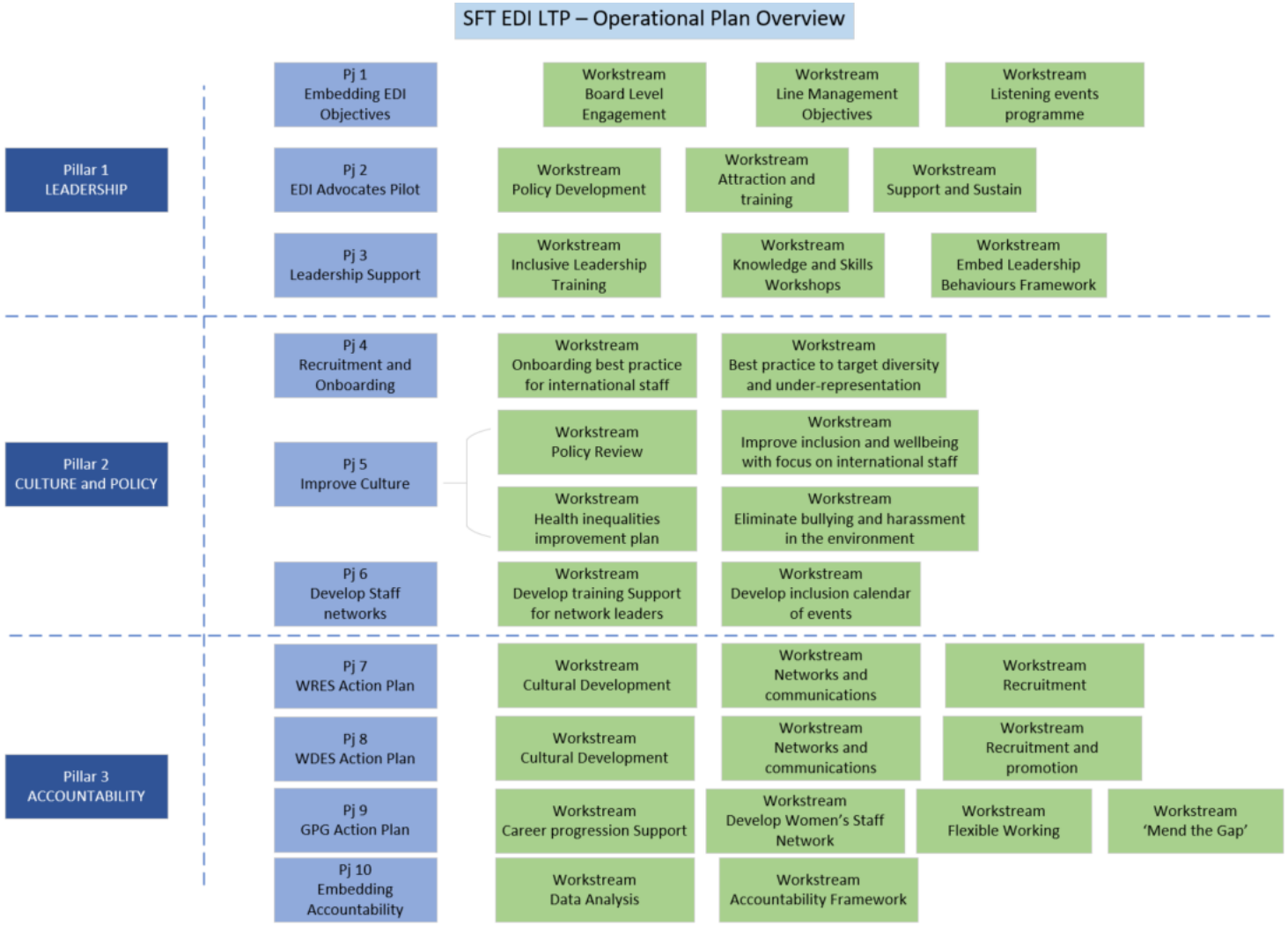
JLNC

OD&P MB Role: Perf Man | Prog Man | No meet

Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar

Salisbury
NHS Foundation Trust

## Appendix G



NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 4.1 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Estates Department Quarterly Update – April 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | | x | |
| Approval Process: (where has this paper been reviewed and approved): | | | | |
| Prepared by: | John O'Keeffe – Head of Estates<br>Edmund Ellert – Head of Estates Capital<br>Tom Sneddon – Interim Deputy Head of Estates | | | |
| Executive Sponsor: (presenting) | Mark Ellis – Chief Financial Officer | | | |
| Appendices | Appendix A – Estates Report April 2024 | | | |

## Recommendation:

Trust Board is asked to note the content of the paper summarising the work of the Estates Department, consisting of Estates Technical Services (ETS) and Capital Projects teams during the last quarter, including current and ongoing risk positions.

## Executive Summary:

Director of Estates no longer in post, Head of Estates standing in.

Staff position improving, one vacancy which is currently being held due to financial situation.

Our work on compliance and estates risks continues to reduce volume and classification of risks. We now have one extreme risk (Estates CAFM System) and twelve high risks remaining, which have continued beyond our target of the end of financial year due to funding (implementation of a new CAFM system) and volume of works. We are now targeting closure and removal of the high risks by August 2024 by means of mitigating and reducing risks so that only medium and low remain. At this stage we will cease reporting and continue as business as normal.

Overall, we have now reduced the total number of estates risks from 383 to 130.

| | | Extreme | | High | | Moderate | | Low | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **This Period** | **Remaining** (by **Current** Risk Score) | 1 | ↓ | 12 | ↓ | 112 | ↑ | 5 | ↓ | 130 | ↓ |
| **Previous Period** | **Remaining** (by **Current** Risk Score) | 3 | | 104 | | 61 | | 7 | | 175 | |

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and also returning to the market to tender for replacement.

Our MLE compliance remains at 89% mainly due to hand hygiene training dates availability but this will be addressed during April/May, and we are confident our compliance rates will move back to the very high levels previously sustained.

Our department appraisal rates are currently 87%

The capital team have successfully delivered the 23/24 capital plan with a CDEL allocation of £9.275m. Total works delivered exceeded £30m as the two externally funded projects drew-down all monies by year-end, including £12m for creation of the new 24 bed Ward and £10m Salix funding contributing to the decarbonisation of the Trust estate.

The decarbonisation project is progressing well with the final connections shortly to be made. Final commissioning has been delayed from the end of March to July due to electrical infrastructure issues.

Progress on the new Estates strategy has slipped due to challenges around staff engagement. The engagement requirements have been re-planned however, target completion for the project has slipped from end March to May 2024.

The new Imber Ward progress has slowed with a revised target handover in May, with first patients June 2024, subject to agreement on accepting the building on generator power. There have been ongoing risks around the design and subsequent construction of the new HV substation compound, which is also accommodating heat pumps from the decarbonisation project. The capital team has been working closely with the contractor, with the HV connections anticipated early May. This date is after the target completion and mitigations to maintain program are to commission the building services using temporary power supplies with a generator now in place.

Replacement of CT 1 & 2 Scanners will be delayed due to structural engineers determining the floor slab unable to take the weight of the new heavier scanners. Mitigation works identified and currently being worked through.

Work now begins on the 2024/25 CDEL allocation of £6.7 million.

The Head of Estates has concerns on the potential impact of the Trust financial position with the requirement for CIP targets and the headcount challenge directly impacting on the work that has taken place over the last three years to address the historic challenges and issues. However, we are working with colleagues to overcome this.

| Board Assurance Framework – Strategic Priorities | Select as applicable: |
|---|---|
| Population: Improving the health and well-being of the population we serve | x |
| Partnerships: Working through partnerships to transform and integrate our services | x |
| People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work | x |
| Other (please describe): Long term strategic and sustainable benefits for the SFT campus, supporting the effective delivery of health services. | x |

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## Appendix A – Estates Report – April 2024

### 1.0 Introduction

This is a quarterly update to Trust Board for activity within the Estates Technical Services (ETS) and Capital Project teams from 1st Jan 2024 – 31st March 2024.

### 2.0 Staff

Our staffing levels have improved again since the last report. We have recruited to the Senior Estates Officer position and the shared Energy Officer This will provide more internal resources and continue to allow a reduction in the use of external contractors.

We continue meetings with our people business partner and recruitment team to discuss vacancies which currently stand at 1 WTE role. We attend the Weekly Divisional Workforce Control Panel (Corporate) meetings as required to discuss and manage vacancies appropriately.

Our latest staff position is below.

| March 2024 | No. | Notes |
|---|---|---|
| Estates Posts | 38.5 | Includes vacancies. |
| Vacancies | 1 | B2 Mechanical Assistant. ***On hold due to Trust financial position.*** |
| Sub Total | 37.5 | |
| | | |
| Bank Staff | 3 | 2 x Flushers<br>1 x Admin |
| Estates Officer Operations | 1 | Agency Cover |

Our MLE compliance remains at 86%. Whilst our compliance position remains high, there has been a reduction in several mandatory training areas, many are the result of training now becoming due. Staff are being reminded the importance of mandatory training and supported to undertake their training in reasonable time.

Availability of hand hygiene training has recently improved, and we are booking staff onto the training as well as training a member of our staff as an assessor to address this, our largest compliance issue.

Estates mandatory training includes requirement for our staff to complete Level 2 Safeguarding and Life Support training courses. We are checking the relevance of this to our staff and discussing with the MLE team. (Note: Estates staff already complete Level 1 Safeguarding training).

## Top Level by Training Title

| KEY: | 0-79% | 80-84% | 85-100% |
|---|---|---|---|

Report database last refreshed on 16/04/2024 at 03:37:04

| Training Title | Number complete | Number incomplete | Number in target group | Compliance |
|---|---|---|---|---|
| Adult Basic Life Support 122014 | 1 | | 1 | 100% |
| Equality and Diversity 122014 | 37 | | 37 | 100% |
| Fire Safety 122014 | 33 | 4 | 37 | 89% |
| Hand Hygiene Assessment 122014 | 23 | 14 | 37 | 62% |
| Infection Control 122014 | 35 | 2 | 37 | 95% |
| Information Governance 122014 | 33 | 4 | 37 | 89% |
| Moving and Handling 122014 | 34 | 3 | 37 | 92% |
| Prevent - 122014 | 35 | 2 | 37 | 95% |
| Safeguarding Adults Level 2 - 122014 | 2 | 1 | 3 | 67% |
| Safeguarding Children Level 1 122014 | 28 | 2 | 30 | 93% |
| Safeguarding Children Level 2 122014 | 0 | 1 | 1 | % |
| **Overall:** | **261** | **33** | **294** | 89% |

### 3.0 Compliance

We continue our trajectory of closing and mitigating risks from the Estates compliance report. The table below indicates we are now reduced to one (1) extreme risk, although as previously highlighted some of our mitigation actions do transfer risks into lower rating categories as we work toward concluding them. There has also been a further reduction of nineteen (19) high risks and eight (8) overall closures in this period. We have seen an overall reduction in risks and continue toward our year end trajectory which was to close all extreme and the majority of high risks and convert the remaining moderate and low risks to *business as usual*, with closure of the compliance report. However, some high risks will remain until late 2024.

| | | Extreme | High | Moderate | Low | Total |
|---|---|---|---|---|---|---|
| **Initial Risks** | **Initial Risks** | 286 | 95 | 2 | 0 | 383 |
| | **Closed** (by **Initial** Risk Score) | 181 | 71 | 1 | 0 | 253 |
| | **Remaining** (by **Initial** Risk Score) | 105 | 24 | 1 | 0 | 130 |
| **Risk Changed/Moved** | **Risk Mitigated** (+/-) due to mitigation in place | -285 | -83 | 110 | 5 | -253 |
| **This Period** | **Added** in this reporting period. | 0 | 0 | 0 | 0 | 0 |
| | **Remaining** (by **Current** Risk Score) | 1 | 12 | 112 | 5 | 130 |
| **At last report** | **Remaining (by Current Risk Score) at last report** | 3 | 104 | 61 | 7 | 175 |
| | **Change during reporting period** | -2 | -92 | 51 | -2 | -45 |

We have extracted the final extreme and high risks from the compliance report to the table below and provided a narrative previously.

| ID | Source of Risk Data | Risk |
|---|---|---|
| | | |
| 197 | PAM Audit | Estates and Facilities Operational Management/ Maintenance: CAFM and PPM regime's inadequate |

**Risk 197**

Estates CAFM system not fit for purpose – **1x risk**

Update to last report: The bids received on the CAFM procurement have been assessed and moderated. Concerto came out as the preferred platform. The recommendation report has been shared to seek the capital funding to implement the platform with the preference to place orders and start within this Financial year. Work is also being done now the cost is understood how to absorb the ongoing cost into the Estates budget. A full business case is required and we are currently working on that.

The implementation cost that is required for this year is £64,500, with an ongoing annual cost of £65,000. The procurement is tested for a 7-year contract.

Salisbury NHS Foundation Trust

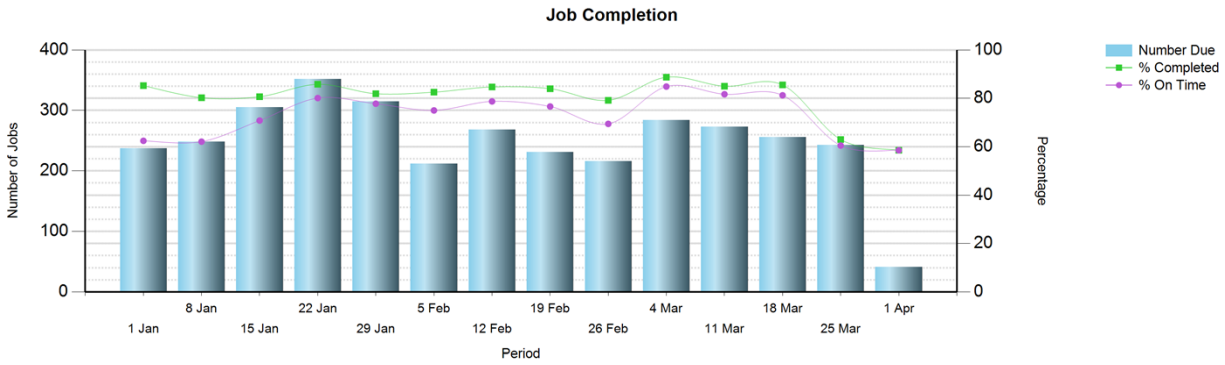
Although we are on track to close or mitigate the bulk of the high-risk actions, there are twelve actions that will still be outstanding until mid 2024 . They are:

| ID | Source of Risk Data | Risk | Update |
|---|---|---|---|
| 16 | AE Audit | Switchgear not worked or inspected periodically | With the fixed-wiring testing yet to be completed, a separate preventive maintenance (PPM) regime has been created and is underway to thermal image all switchgear for assurance of correct operation. This will allow the risk of the action to be brought down until the fixed-wiring testing is complete, at which point the action can be closed.<br>**Closure Target – August 2024** |
| 56 | AE Audit | Fire Damper maintenance | With the survey work now finished and remediation of faulty dampers in progress, completion of the action is anticipated by August 2024, barring budgetary constraints.<br>**Closure Target – August 2024** |
| 87 | Other | HTM 06-23 Periodic Inspection and Testing - New contract in place, but not yet used, last undertaken 2013, reports of outstanding C1 and C2 from then | Fixed wiring testing is complete in the residence's south and most central areas. While some testing has begun in the north block, approximately 30% of the site remains untested. This will be completed within the current financial year, as progress awaits confirmation of the capital budget allocation.<br>Additionally, any code FL, C1, or C2 remediation is being addressed as encountered.<br>**Closure Target – August 2024** |
| 106 | Other | 32-09 Hot Water Cylinders - No Practice in place | Progress on this action has been delayed due to higher-risk actions taking priority. The preventive maintenance plan (PPM) is currently being developed and implemented, however, resource availability for its execution depends on estates operations capacity.<br>**Closure Target – August 2024** |
| 134 | Other | 102-04 Window Restrictors - No Practice in place | We encountered issues with the survey contractor due to inaccurate reporting and inconsistencies in their findings. The contractor has agreed to revisit the site commencing the week of April 22nd to address any outstanding problems. Upon completion, remediation of identified non-compliances will be undertaken.<br>**Closure Target – August 2024** |
| 147 | Other | HTM 06-18 Busbar System and Cables - No annual non-intrusive checks or 10 yearly full service taken place | The primary method for identifying and mitigating risk was the fixed wiring inspection. Due to delays with the inspection, a temporary reporting form has been implemented for ETS electrical staff. This ongoing measure allows them to report on the condition of equipment and identify any non-compliances. Once all busbars have been inspected, either through the estates PPM task or the fixed wiring inspection, this action will be closed.<br>**Closure Target – August 2024** |
| 150 | Other | 44-08 Electrical Installation – Generally - No practice in place - RCD and AFDD | Pending completion of fixed wiring inspection - see ID 87<br>**Closure Target – August 2024** |

| | | | |
|---|---|---|---|
| 151 | Other | 44-09 Three Phase Circuits - No practice in place - RCD and AFDD | Pending completion of fixed wiring inspection - see ID 87<br>**Closure Target – August 2024** |
| 161 | Other | HTM 02-20 Oxygen Systems - No Risk Assessment carried out on Oxygen system with yearly review | The newly appointed Senior Estates Officer (Mechanical) is tasked with completing this within the next quarter.<br>**Closure Target – July 2024** |
| 215 | PAM Audit | Medical Gas Systems/Resilience, Emergency & Business Continuity Planning: BCP / Procedure to be developed | Due to resource limitations and prioritization of higher-risk actions, completion of this task has been deferred to the next quarter.<br>**Closure Target – July 2024** |
| 371 | AE Audit | RP Water not adequately trained in pool specific safety | Training is pending confirmation of the new fiscal year budget and available funds.<br>**Closure Target – August 2024** |
| 380 | AE Audit | The asbestos register is not a live document. Hard copies are currently placed around the site who those who are aware can review. A copy of the 2019 Register is present on the Trust Server. | Significant risk remains due to the lack of a suitable platform for external access to the asbestos register, despite vast improvements in asbestos management and register dissemination. Implementation of the new CAFM platform will address this limitation and allow for closure of this action (See ID 197 in the extreme risk section above).<br>**Mitigation target – May 2024**<br>**Closure Target – TBA** |

### 4.0 Estates Maintenance

The data for January 2024 – March 2024 is shown below. (Data is shown for full month activity).




This quarter

**Job Type Summary**

| | Due | Cancelled | Completed | On Time |
|---|---|---|---|---|
| ECO | 231 | 0 | 225 | 198 |
| HELPDESK | 2053 | 26 | 1738 | 1621 |
| PPM | 1197 | 13 | 891 | 766 |
| **Total** | **3481** | **39** | **2854** | **2585** |

Previous quarter

**Job Type Summary**

| | Due | Cancelled | Completed | On Time |
|---|---|---|---|---|
| ECO | 178 | 0 | 177 | 175 |
| HELPDESK | 1959 | 20 | 1663 | 1491 |
| PPM | 1201 | 1 | 980 | 848 |
| REMEDIAL | 1 | 0 | 1 | 1 |
| **Total** | **3339** | **21** | **2821** | **2515** |

The data shows a continued high volume of helpdesk jobs raised (logged calls for maintenance actions across the estate) although data for planned maintenance (PPM) and Helpdesk are consistent with previous 3-month reporting periods The data shows we carry out more reactive than planned works and we should be aiming for the opposite situation.

During this period the number of emergency call outs was 231. As with previous report periods, some analysis of the increased numbers is in progress, although given the estates backlog continues to increase at a rate faster than it can be reduced, the failure rate of the estate is equally likely to increase particularly whilst the Trust resources to maintain the estate remain constant or potentially reduce.

## 5.0 Capital Delivery

The capital team have successfully delivered the 23/24 capital plan with a CDEL allocation of £9.275m. Total works delivered exceeded £30m as the two externally funded projects drew-down all monies by year-end, including £12m for creation of the new 24 bed Ward and £10m Salix funding contributing to the decarbonisation of the Trust estate.

### Imber Ward

BAM as main contractor delivering the new Ward have encountered many challenges since starting on site early in 2023.

The substation compound area remains the highest risk element of the project, specifically connection to the HV mains electric supply. The contractor is still unable to confirm a final connection date from SSE (the district network operator) to provide mains power, as delays with infrastructure works associated with enabling the HV connection have prevented SSE from entering into legal agreements.

The contractor is therefore currently reporting a 6-week delay to sectional completion of the 24 bed ward due to issues surrounding electrical work, with the planned date for handover of the ward now scheduled for 20th May, with patient access in early June, although this assumes temporary power is acceptable. If the Trust decides temporary power isn't an option, Imber Ward wouldn't open to patients until late June/early July following a period of fitting equipment, cleaning and clinical staff becoming familiar with their new environment.

Whilst a temporary generator can be provided to commission the building with a standby generator as resilience, there will be an approximate period of between one week to 10 days of commissioning required once the HV connection has been made during which the building will have intermittent power provision, so patients would need to be moved out. The Trust is under no contractual obligation to accept accommodation on temporary power, so needs to decide whether the proposal from the contractor is acceptable. A full assessment of a diesel generator running close to the Ward, with the permanent standby generator providing resilience, needs to be thoroughly assessed.

We have received legal opinion that the delay to handover is the responsibility of the main contractor, including the liability for all associated costs, as well as the levy of damages which will accrue on a weekly basis. There is a fear that if the Trust accepts handover of the Ward on temporary power, the contractor loses any sense of urgency to establish the permanent mains supply. There are also reputational considerations of delaying handover to mid-summer as the Trust has reported Imber Ward will open to patients in Spring 2024. Although there are reasons why the Trust might not wish to take possession of the ward on temporary power, it has to consider the clinical impact, so medical and surgical divisions are assessing whether the need to increase inpatient numbers is such that the Trust accepts handover on temporary power, this will be the deciding factor, the decision for which is needed by early May.

The date of practical completion including the external cladding and landscaping therefore slips, as this can only be achieved once mains electrical supply has been established, so is currently unknown.

### Salix decarbonisation

As part of the £10m Salix funded decarbonisation scheme, various net zero carbon works have been carried-out across the estate. Photo voltaic panels have been installed on numerous roofs, with the south facing roofs of SDH North the last to be completed. Replacement windows and insulation have been installed to Odstock Leisure Centre and the Spinal Unit, where air source heat pumps are being commissioned with additional units serving the energy centre. The Trust's 12% capital contribution to the Salix funding is commissioning a geothermal feasibility study; unfortunately the main

contractor GT Energy and the Trust have been unable to secure the consent of landowners for seismic surveys to be undertaken within the proposed timeframe, so the study won't be complete until midway through this financial year.

**Estates Strategy**

The consultant team appointed to undertake the Estates Strategy have made good progress, although engagement with clinical divisions has been compromised by the lack of availability of staff causing a slight delay to circulation of the final report. Completion of the report is now expected by the end of May 2024; as a consequence, there was a variation of £7,350 to cover additional costs with £12,500 funding slipping in this financial year.

**Multi-flue Chimneys**

We have previously reported the age of the energy centre chimneys and associated risks, with a requirement for replacements. The current decarbonisation project reduces the number of gas fired boilers in operation on the estate and this also reduces the number of boiler flues. It is hoped there will only be a need for a single chimney rather than the two currently in situ. Mitigations are in place to regularly monitor the condition of the chimneys and we have undertaken non-destructive testing to gain further data on the condition of the chimneys. We are looking to appoint a specialist consultant to provide further advice on the design of the chimneys and alternative options which may potentially extend their life before re-tendering for the full replacement, taking into consideration the challenges of future capital availability. Funding has been agreed within our 24/25 allocation.

**Replacement of CT1 & CT2 scanners**

The Trust has taken delivery of CT1 & CT2 scanners ensuring these could be signed-off within 23/24 year-end spend, although these are both being stored within containers until the enabling works have been completed. Structural strengthening works are required to the Level 3 floor slab as the weight of modern scanners is in excess of those the building was designed to accommodate, so we are liaising with the PFI. Once CT2 scanner has been successfully installed, the Radiology team will require a couple of months before they're able to consider the commencement of CT1 enabling works.

**24/25 Capital Allocation**

The following funding has been allocated to the Building and Infrastructure Group:

| **CDEL** | £'000's |
|---|---|
| Imber Ward | £1,500 |
| Energy Centre Flues | £1,219 |
| CDEL Salix – seismic studies | £930 |
| CT building works | £404 |
| Installation of Fluoroscopy C Arm | £200 |
| Other <£100k | £180 |
| Lift Refurbishment | £700 |
| Fire compartmentation | £300 |
| Other <£300k | £1,358 |
| **Total BIG** | **£6,791** |

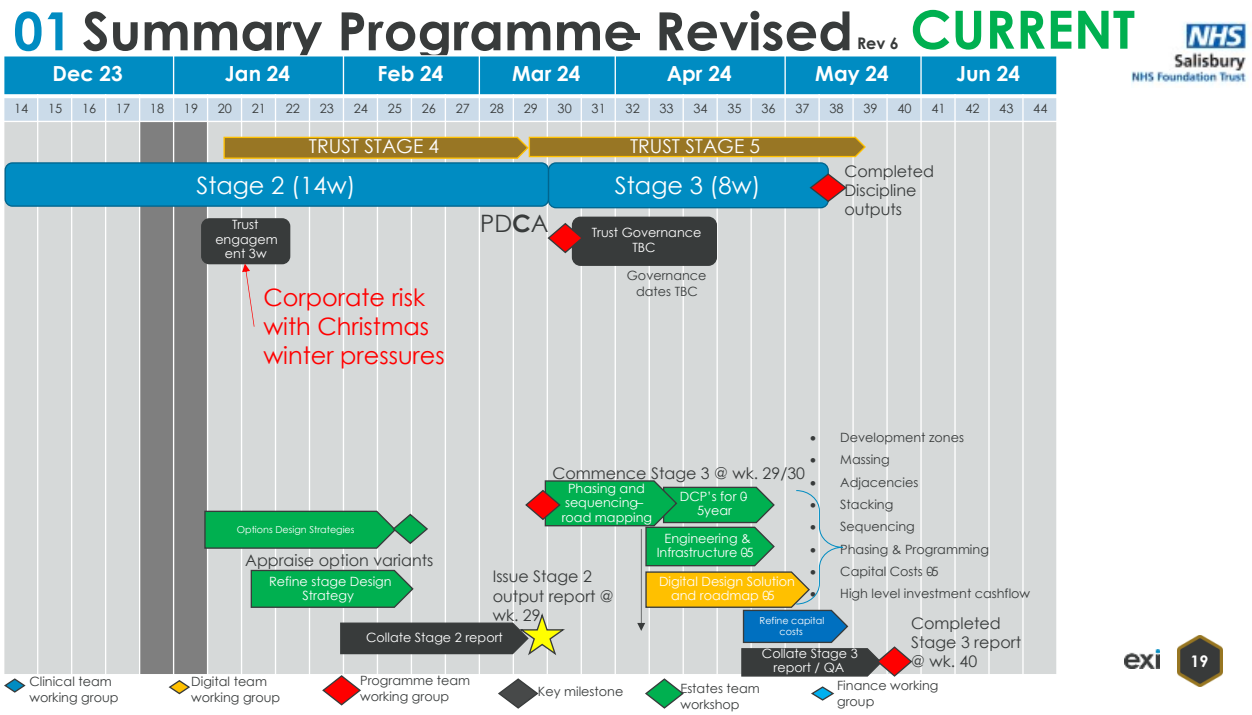
| **National Funding** | £'000's |
|---|---|
| Community Diagnostic Centre | £1,306 |
| **Total BIG** | **£1,306** |

Capital availability has become highly constrained following the system-wide commitment to invest in the EPR system. Whilst our requirements for 5-year (and beyond) capital investment is well documented (and tabled regularly via the relevant committees) we expect a reduced investment for 2024-27 and a resulting very high demand for capital allocation in the years following. Given the continued pressures from IT and Medical Equipment investment we expect the Trust

risks to increase with some difficult decisions lay ahead regarding allocation of capital and our ability to maintain a safe estate.

In response to a reduction of estates capital over the next 3-years, consideration is being given to resource requirements and wholesale review of capital project systems and processes to improve the delivery of capital allocations, year-on-year. We are currently undertaking additional diligence on the planning and forecasting of our estates backlog works, to ensure transparency of the backlog program alongside the 5-year capital program.

*Estates Strategy programme*




## 6.0 Governance and Risks

As noted previously the BSW commitment to invest in the EPR system over the next 3-years has resulted in significantly reduced capital availability. Whilst our requirements for 5-year (and beyond) capital investment are now well documented (and tabled regularly via the relevant committees) we expect a combination of reduced investment for 2024-2027 and a resulting very high demand for capital allocation in 2027-28, alongside IT and Medical Equipment requirements, to increase the Trust risks further and the backlog maintenance position to worsen.

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and also returning to the market to tender for replacement.

New risks identified within this report.

| | Risk | Action |
|---|---|---|
| | Potential reduction in funding and staffing will reduce the Estates service to the position it was in prior to the Cammies report. | When the final financial/staffing position is known put mitigations in place to reduce the impact and monitor regularly |

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 5.1 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –February 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | x | x | |
| Approval Process: (where has this paper been reviewed and approved): | Agreed by DMT 20.03.2024<br>Divisional Governance 21.03.2024<br>Clinical Governance Committee 26th March 2024 | | | |
| Prepared by: | Vicki Marston –Director of Midwifery and Neonatal Services | | | |
| Executive Sponsor: (presenting) | Judy Dyos - Chief Nursing Officer | | | |

## Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

## Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for February 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

**Summary**:

**Staffing:**

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.
- Vacancies and maternity leave mitigated by bank usage.
- Midwife to birth ratio 1:27 – SFT recommended ratio 1:26

- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

**Incidences reported as moderate.**

- 5 Incidences reported as moderate.
  - Neonatal Deaths of one twin with known congenital anomaly, palliative care received.
  - Stillbirth at 36 weeks
  - 3 term admissions to Neonatal Unit – all for review via ATAIN

**PMRT**

- One review 34.6 Stillbirth of baby. PMRT Grading of care A and A

**Training**

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December. Work continues to improve compliance with other mandatory training.

**Service user and staff feedback**

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS

**National Guidance**

- CNST compliance 9 out of 10
- Work ongoing to improve compliance with Ockenden 2022 IEA, new meetings set up monthly to provide targeted support and improve compliance with the actions. Good progress with closure of actions in February.

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

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# Perinatal Quality Surveillance
*February 2024*

Maternity and Neonatal Unit

**Salisbury Foundation Hospital**

# Safe: Maternity & Neonatal Workforce (workforce lead)

| | Target | Threshold | | | Dec 23 | Jan 24 | FEB '24 | Comment |
|---|---|---|---|---|---|---|---|---|
| | | Green | Amber | Red | | | | |
| Midwife to birth ratio | 1:26 | 1:26 | | >1:26 | 1:32 | 1:25 | 1:27 | Active recruitment continues |
| Compliance with supernumerary Status of LW Coordinator % | 0 | 0 | | >1 | 100% | 100% | 100% | |
| 1:1 care not provided | 0 | 0 | | >1 | 0 | 0 | 0 | |
| Confidence factor in BirthRate+ recording | 60% | >60% | | <50% | | 80% | 79.89 | Percentage of possible episodes for which data was recorded. Audit commended December 23 |
| Daily multidisciplinary team ward round | 90% | >90% | | <80% | 100% | 100% | 100% | |
| Consultant non-attendance when clinically indicated (in line with RCOG guidance) | 0 | 0 | | >1 | 0 | 0 | 0 | |

NHS Salisbury NHS Foundation Trust

| Impact (biggest > smallest) | Concern | Cause | Countermeasure /Action (completed last month) | Owner |
|---|---|---|---|---|
| 1 | Shortage of Band 6 Midwives nationally leading to difficulty in recruitment of experienced midwives | National shortage and unit size not attractive to midwives already in post elsewhere | Grow our own – early interviews for student midwives to recruit as band 5's with recognition that after 12 months they will move to band 6and over time will contribute to a more stable workforce | DOM |
| 2 | Recruitment of MW's | Multifaceted however focus on lack of development opportunities due to unit size | Introduction of rotational development programme to specialist roles | DOM |
| 3 | Recruitment of Consultants | Not enough sub-speciality Obstetrics due to unit size | AJK to hold meeting with Maternal Medicine Network to discuss options for Obstetric Consultant opportunities | Clinical director |

Table 1. Total WTE vacancy and availability to work - by role

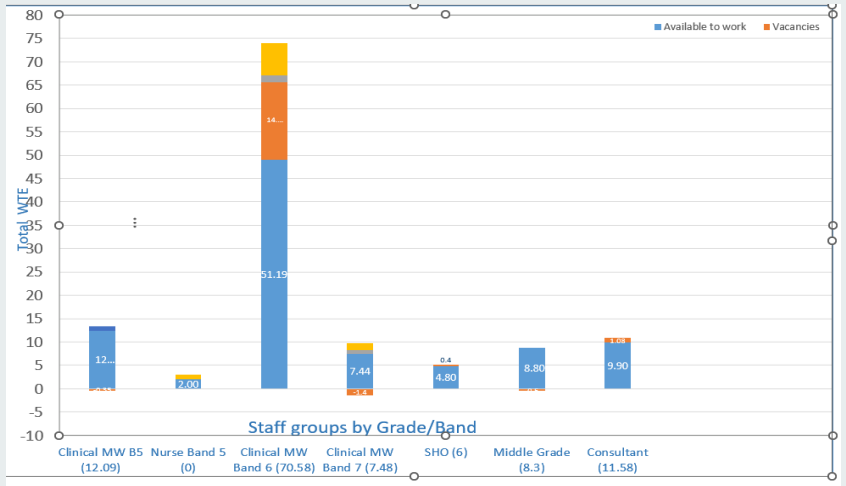
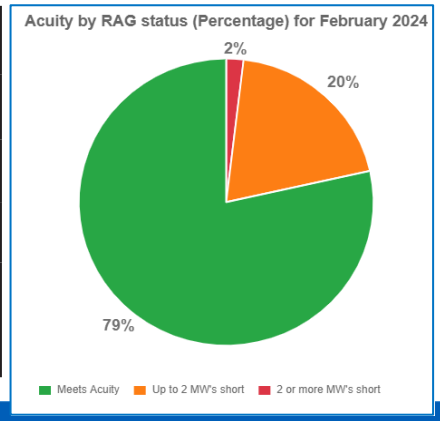



Table 2. Average midwife shift fill rates

| | | Nov 23 | Dec 23 | Jan 24 |
|---|---|---|---|---|
| Midwives | Day | 88.8 % | 90.7 % | 94.2 % |
| | Night | 96.5. 8% | 94.6 % | 93.5 % |
| MCA/MSWs | Day | TBC | TBC | TBC |
| | Night | TBC | TBC | TBC |

Table 3. Acuity by RAG vs staffing data




**Is the standard of care being delivered?**

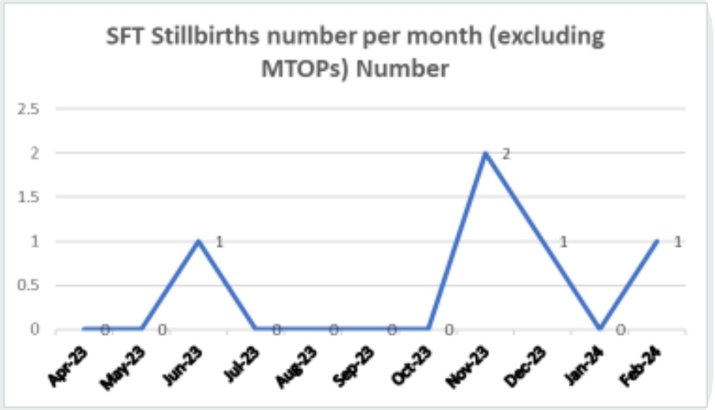
- Supernumerary Labour Ward coordinator status achieved 100% time
- The Midwife to Birth ratio increased slightly in February due to Increased births/long term sickness.

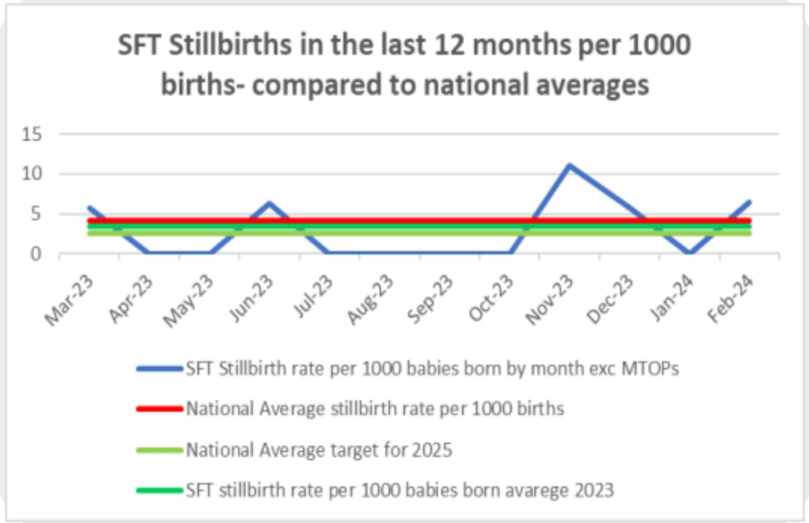
**What are the top contributors for under/over-achievement?**

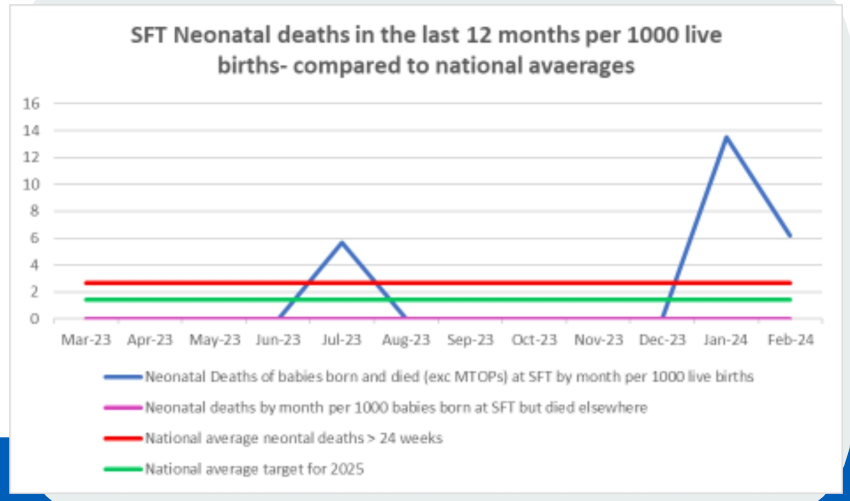
- Vacancy rate
- Maternity leave/long term sickness.
- Challenges in recruiting midwives

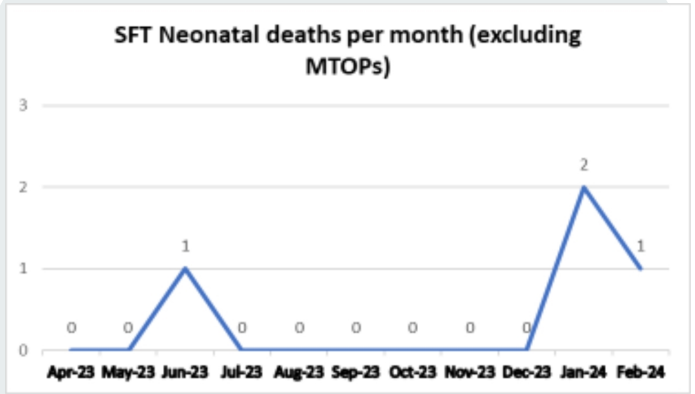
# Safe:- Perinatal Mortality Review Tool (PMRT) (Bereavement midwife)

NHS Salisbury NHS Foundation Trust




- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is MIS Safety Action 1 for year 5. A quarterly update paper is shared with the board.
- Stillbirth and neonatal death rates are excluding MTOP's
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Still birth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- Perinatal deaths for February 2024 :
  1 neonatal death of one twin at 32 weeks, this baby had a known congenital heart condition and received palliative care
  1 antenatal stillbirth at 36 weeks

**PMRT Action Plans for Salisbury Foundation Trust – February 2024 reviews**

| PMRT case ID | Issue text | Action plan text | Person responsible | Target date |
|---|---|---|---|---|
| 90642 | No Issues identified that generated an action | | | |

## PMRT grading of care – Key

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

| Case Ref | Date | Category | Incident | Outcome/Learning/Actions | HSIB Reference | SI? Reference |
|---|---|---|---|---|---|---|
| PMRT: 90642<br><br>Datix 161129 | 24/11/2023 | Unavoidable death | Stillbirth of baby at 34+6 weeks. | Cause of death-High grade fetal vascular malperfusion with fetal growth restriction<br><br>PMRT grading of care- A and A<br><br>**Actions**<br>No issues raised that generate actions | NA | NA |

# Incidents

Salisbury NHS Foundation Trust

## New Cases for February 24

| Case Ref (Datix) | Date | Category | Incident | | MNSI Reference | SI? Reference |
|---|---|---|---|---|---|---|
| **163161** | 1/2/24 | Moderate | Baby born transferred out to a tertiary unit. (MCDA Twins) Duplicate Datix: 163163 Neonatal death. (Expected) | | | |
| 163122 | 4/2/24 | Moderate | IUD at 36/40 in low risk woman | | | |
| 163208 | 7/2/24 | Moderate | Term admission with APGAR of 6 at 5 minutes | | | |
| 163396 | 13/2/24 | Moderate | Term admission with APGAR of 5 at 5 minutes | Delay with review due to team availability, CTG trace not reflective of low APGAR at 5 minutes, likely issue with transitioning | | |
| **163526** | 18/2/24 | Moderate | Pathological CTG, meconium, term admission with APGAR of 6 at 5 minutes | To be reviewed | | |

# Ongoing maternity and neonatal reviews

NHS
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## Ongoing Maternity and Neonatal Reviews

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions |
|---|---|---|---|---|
| 155892 | 18/5/23 | Moderate Harm | Unexpected admission to neonatal unit | Shared decision making and escalation training, as well as introduction of updated CTG stickers that give improved information on appropriate actions required. For exit 11/3/24 |
| 156305 | 2/6/23 | Moderate | Uncrossmatchable blood - antibodies | Draft: Develop a system for handover of care for high-risk women expected on LW.<br>Improve communication between lab and community midwife and add antibodies as risk factor on PPH risk assessment tool. For exit 11/3/24 |
| 156497 | 9/6/23 | Never event | Retained swab | Draft: Options to be explored around possibility of purchasing swabs that enable a physical barrier to prevent swabs being left in a cavity.<br>a)Revise the Accountable Items, Swab, Instrument and Sharps Count Policy to ensure this is clearly articulated and the associated flow chart is amended in line with this.<br>b)When revising the policy strengthen action 5.2.2 to reiterate the expectation for clear and timely communication of the swab count prior to closure of a body cavity<br>c)Ensure these changes are communicated to all staff within the operating and 'pseudo' operating departments where this policy has relevance.<br>To review and revise the SOP for Opening a Second Obstetric Theatre and link it to the Obstetric Theatre Operational Policy<br>To include into the current maternity records audit a question on whether there is documented evidence that the need for translation services has been considered on the Delivery Suite for women for whom English is not their first language.<br>The Trust should use a second WHO checklist when a separate and distinct operation is required even if the patient has not left the operating room<br>To support junior medical, midwifery nursing staff by anticipating where unusually pressured situations may arise for example in situations of family conflict, personal / professional boundaries / knowledge / power dynamics. Draft expected imminently |

# Ongoing maternity and neonatal reviews (continued)

NHS Salisbury NHS Foundation Trust

## Ongoing Maternity and Neonatal Reviews

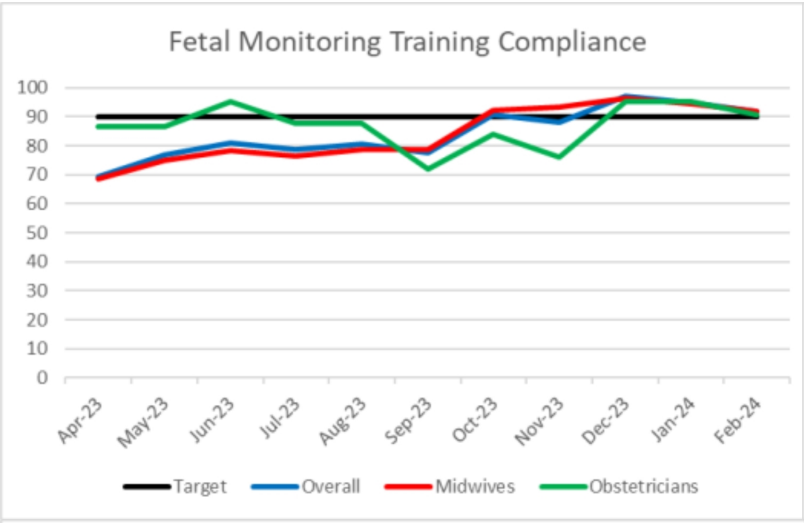
| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions |
|---|---|---|---|---|
| 157595 | 8/8/23 | Moderate Harm | 3B tear, tailing growth and mode of birth | Not ready. Draft chase and expected 13/3/24 |
| 157555 | 8/1/23 | Moderate Harm | Term admission | Amend induction of labour guideline AND fetal monitoring guidelines such that both unequivocally state to continue fetal monitoring at minimum 6 hourly intervals. Clarification of whether women partway through induction need evening Obs ward round review as only intrapartum are currently mandated for this. Draft chased. |
| 158301 | 8/12/23 | Moderate harm | Term Admission, required cooling at tertiary unit | Actions currently being discussed. Report share planned for 14/3/24 |
| 158202 | 8/8/23 | Moderate harm | Eclamptic seizure at home, admitted to ED - GA | Draft actions: Update pathway and explore options for documentation of administration and escalation. Implementation of case huddles in complex patients with clear SBAR handovers. Clinical teams to be notified and included in future sim scenarios. Awaiting CRG date |
| 158066 | 31/7/23 | Moderate Harm | PE at 15/40, missed opportunity for LMWH | A failsafe should be introduced to be implemented between appointments with different clinics/specialties to avoid missed appointments and to aid follow up. Appojntment letters should be clearer and terminolgy changed to make it more obvious if a woman is required to see a doctor. High risk VTE women where VTE prophylaxis should br prescribed before 12 weeks should have a timely obstetric consultant appointment in clinic. Awaiting final report |
| 159341 | 19/9/23 | Moderate harm | PPH at home, guidance not followed | Awaiting final comments from draft |
| 161025 | 19/11/23 | Moderate Harm | Eclamptic seizure | Still to hold panel following issues with identifying chair |

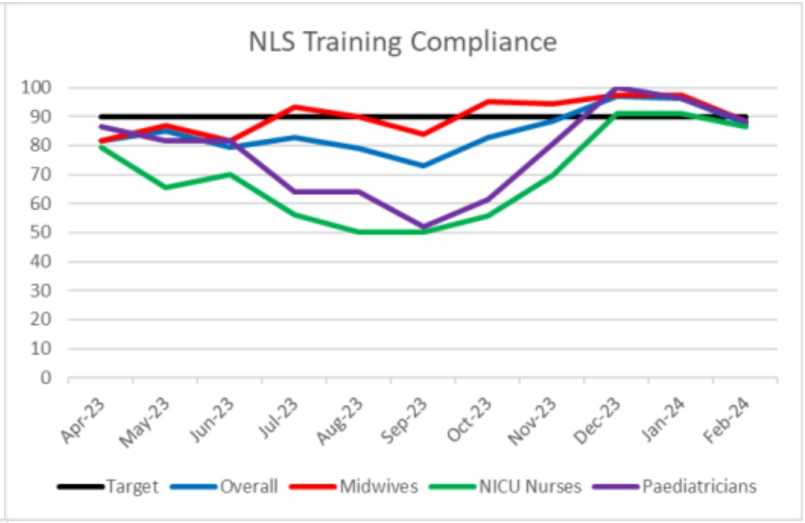
# Responsive

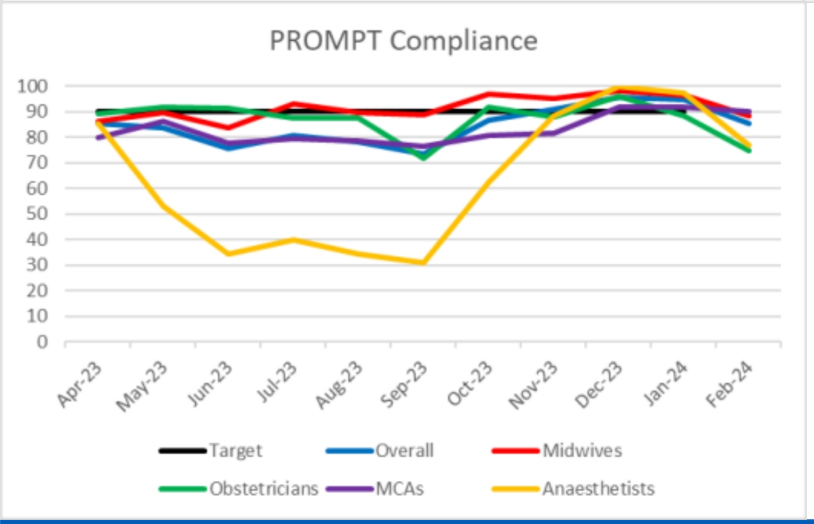
Salisbury NHS Foundation Trust

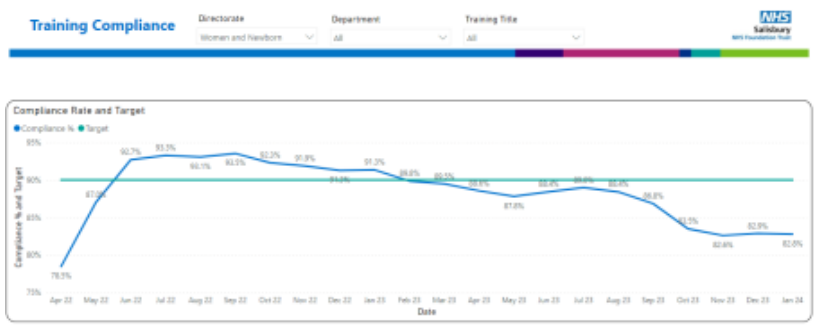
| MNVP Service User Feedback (Feb 24) | Safety Champions Staff Feedback |
|---|---|
| **Key Achievements & Positive Feedback:** No new updated from the MNVP.<br><br>**Positive feedback received for NNU RE Teamwork:**<br>**Whilst the team were caring for an extremely sick baby, X, XX and XXX ensured smooth running of the unit. Caring for all the other babies & parents and meeting their needs.**<br>**This was XX's third shift on the unit, so this was awesome. X had come in for a few hours to support the unit but ended up staying until early evening to support XX and the unit. I will be forever grateful to the team in supporting the unit at a difficult time.**<br><br>**Identified Areas of Improvements:**<br>Explore support that we could be offered to families to who limited or no childcare to attend their USS appointments.<br><br>**Next Steps for Progressions:**<br>• Continue roll out of personalised care plan training<br>• Complete actions from 15 steps.<br>• Work ongoing to improve the outcome for women within are ethnic minoritised communities (further Local audit to be conducted) | **Key points raised:** No meeting in Feb 24<br><br>**Items for escalation:** n/a<br><br>**Next Steps for Progressions:** n/a |
| **Compliments & Complaints** | **Friends & Family Survey** |
| 25 compliment logged in Feb 24 . 3 SOX<br><br>***"XX was informative, kind, realistic and supportive towards the planning of my birth and went through my previous concerns.***<br>***I think I probably spent well over my time slot with her and she kindly saw me face to face rather then a phone call and I felt the positive birth service really did provide me with a positive experience and would like to share that as I appreciate as a member of staff at SDH the positive comments are not always communicated so much".*** | **Key Achievements:**<br>No FFT returns in Feb 24<br><br>**Identified Areas of Improvements:**<br>Further exploration is required to support military families (who have limited access to childcare) to attend their USS appointments. |

# Well-led – Training (Education Midwife)




**Training**

CNST requirements for >90% training compliance in all staff groups for NLS, fetal monitoring and PROMPT training achieved in December 2023.

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

**Countermeasures/action:**

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring.

**Risks:**

- Ongoing medical industrial action has already impacted training in January 2024.
- Influx of new MDT staff in September /October /November.
- Booking of training rooms availability – rooms booked for 2024 in advance but there have been changes to these bookings at short notice impacting training time
- Anaesthetic conflicts of priorities to attend training.

# Compliance to National Guidance

Table 1. Ockenden 2022

| OCKENDEN 2022 | | Immediate and Essential Action | Number of actions under each heading rated | | | |
|---|---|---|---|---|---|---|
| | | | RED | AMBER | AWAITING CLOSURE | GREEN |
| Mar-24 | 1 | Workforce Planning and Sustainability | 0 | 2 | 0 | 5 |
| | 2 | Safe Staffing | 0 | 4 | 0 | 6 |
| | 3 | Escalation and Accountability | 0 | 1 | 0 | 4 |
| | 4 | Clinical Governance - Leadership | 0 | 2 | 0 | 5 |
| | 5 | Clinical Governance - Incident Investigation and Complaints | 0 | 2 | 0 | 5 |
| | 6 | Learning from Maternal Deaths | 0 | 0 | 0 | 2 |
| | 7 | Multidisciplinary Learning | 0 | 2 | 0 | 5 |
| | 8 | Complex Antenatal Care | 0 | 4 | 0 | 1 |
| | 9 | Preterm Birth | 1 | 3 | 0 | 0 |
| | 10 | Labour and Birth | 0 | 4 | 0 | 2 |
| | 11 | Obstetric Anaesthesia | 0 | 7 | 0 | 0 |
| | 12 | Postnatal Care | 0 | 3 | 0 | 1 |
| | 13 | Bereavement Care | 0 | 3 | 0 | 1 |
| | 14 | Neonatal Care | 0 | 1 | 0 | 5 |
| | 15 | Supporting Families | 0 | 3 | 0 | 0 |
| | | | 1 | 41 | 0 | 42 |

## Ockenden Report

**Key Achievements:**

- Review of meetings and actions.

**Next Steps for Progressions:**

- Adopting new methodology to ensure progress of actions

Table 2. CNST Maternity Incentive Scheme – Year 5 submission

| Are we well led? | NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024 | | | |
|---|---|---|---|---|
| | | Description | Yr 5 Submission | Comment | Current Assessment |
| | 1 | **Perinatal Mortality Review Tool** using to required standard for all perinatal deaths | Compliant | All Standards Met | |
| | 2 | **Maternity Services Data Set** submission to required standard | Compliant | All Standards Met | |
| | 3 | **Transitional Care Data Set** minimise separation to mothers and babies | Compliant | All Standards Met | |
| | 4 | **Clinical Workforce Planning** effective system | Compliant | All Standards Met | |
| | 5 | **Midwifery Workforce Planning** | Compliant | All Standards Met | |
| | 6 | **Saving Babies Lives Care Bundle V3** compliance with all elements | Non Compliant | New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable. | |
| | 7 | **Service User Involvement and co-Production** | Compliant | All Standards Met | |
| | 8 | **Multidisciplinary Training** | Compliant | All Standards Met | |
| | 9 | **Board Assurance** Board to Ward to Board | Compliant | All Standards Met | |
| | 10 | **HSIB and EN Reporting** | Compliant | All Standards Met | |
| | | Person Centred & Safe | Professional | Responsive | Friendly | Progressive |

## Maternity Incentive Scheme (CNST) Year 5

**Key Achievements:**

- 9/10 declared for CNST

**Next Steps for Progressions:**

- Action plan created and submitted to NHSR to secure roles to support compliance for SBL

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 5.2 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –March 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | x | x | |
| Approval Process: (where has this paper been reviewed and approved): | Divisional Governance 19.4.2024<br>Clinical Governance Committee 30th April 2024 | | | |
| Prepared by: | Vicki Marston –Director of Midwifery and Neonatal Services | | | |
| Executive Sponsor: (presenting) | Judy Dyos - Chief Nursing Officer | | | |

## Recommendation:

The committee are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

## Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for March 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

**Summary**:

**Staffing:**

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.
- Midwife to birth ratio 1:30 – SFT recommended ratio 1:26 – reflective of Midwifery vacancies.
- 1:1 care in labour achieved at all times

- Supernumerary status of labour ward maintained 100% time.

**Incidences reported as moderate.**

- 5 Incidences reported as moderate.
  - 1 Massive Obstetric Haemorrhage 1700ML.
  - 2 x 3b perineal tears
  - 2 x term admissions to Neonatal Unit – all for review via ATAIN

**PMRT**

- One review 26 Stillbirth of baby. PMRT Grading of care A and B

**Training**

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December. Work continues to improve compliance with other mandatory training.

**Service user and staff feedback**

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS

**National Guidance**

- CNST compliance 9 out of 10
- Work ongoing to improve compliance with Ockenden 2022 IEA, new meetings set up monthly to provide targeted support and improve compliance with the actions. Good progress with closure of actions in February.

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

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# Perinatal Quality Surveillance

*April 2024 (March data)*

Maternity and Neonatal Unit

**Salisbury Foundation Hospital**

# Safe: Maternity & Neonatal Workforce (workforce lead)

Salisbury NHS Foundation Trust

| | Target | Threshold | | | Jan 24 | Feb 24 | Mar 24 | Comment |
|---|---|---|---|---|---|---|---|---|
| | | Green | Amber | Red | | | | |
| Midwife to birth ratio | 1:28 | 1:28 | | >1:26 | 1:25 | 1:27 | 1:30 | Active recruitment continues. 3 MW to start In April. |
| Compliance with supernumerary Status of LW Coordinator % | 0 | 0 | | >1 | 100% | 100% | 100% | |
| 1:1 care not provided | 0 | 0 | | >1 | 0 | 0 | 0 | |
| Confidence factor in BirthRate+ recording | 60% | >60% | | <50% | 80% | 79.89 | 41.67% | Percentage of possible episodes for which data was recorded. Audit commended December 23 |
| Consultant presence on LW (hours/week) | 40 | 40 | | | 40 | 40 | 40 | |
| Daily multidisciplinary team ward round | 90% | >90% | | <80% | 100% | 100% | 100% | |
| Consultant non-attendance when clinically indicated (in line with RCOG guidance) | 0 | 0 | | >1 | 0 | 0 | 0 | |

| Impact (biggest > smallest) | Concern | Cause | Countermeasure | Owner | Due Date | Status |
|---|---|---|---|---|---|---|
| 1. | Recruitment and Retention of Midwives | Multifaceted however focus on lack of development opportunities due to Unit size | Introduction of a rotational development programme to specialist roles | VM and SL | Feb 2024 | In progress |
| 2. | Recruitment of consultants | Not enough sub-speciality Obstetrics due to unit size | AJK to hold meeting with Maternal Medicine Network to discuss options for Obstetric consultant opportunities. Review of medical staffing model due in January 2024 | AJK | Jan 2024 | Complete |
| 3. | Line Manager Structure/engagement | Structure and organisation chart unclear meaning divisional staff are not always clear who to link into for support. | Review of line management structure and reporting lines. Review process of induction and introduction to line managers. | JW and VM | June 24 | In progress |

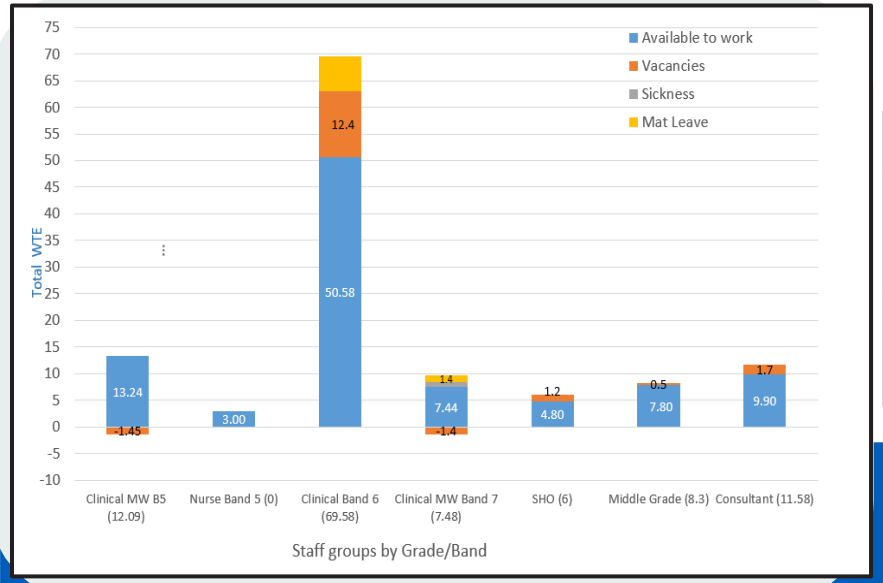
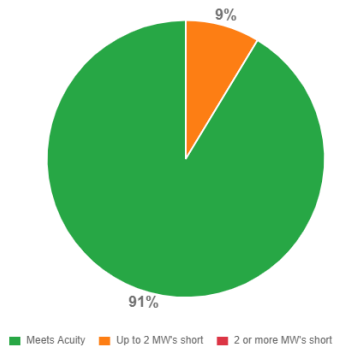



Table 2. Average midwife shift fill rates

| | | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|
| Midwives | Day | 95.3 % | 95.2 % | 94.2 % |
| | Night | 93.5 % | 97.8 % | 97.9 % |
| MCA/MSWs | Day | 84.2 % | 93.6 % | 97% |
| | Night | 86.7 % | 87.2 % | 98.4 % |

Table 3. Acuity by RAG vs staffing data




**Is the standard of care being delivered?**

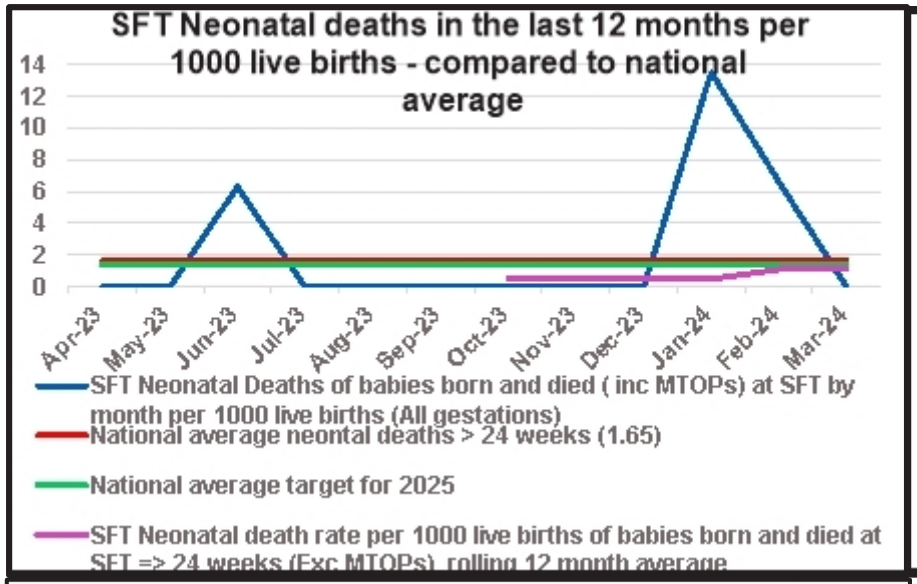
- Supernumerary Labour Ward coordinator status achieved 100% time
- The Midwife to Birth ratio increased in March due to Increased births/long term sickness.

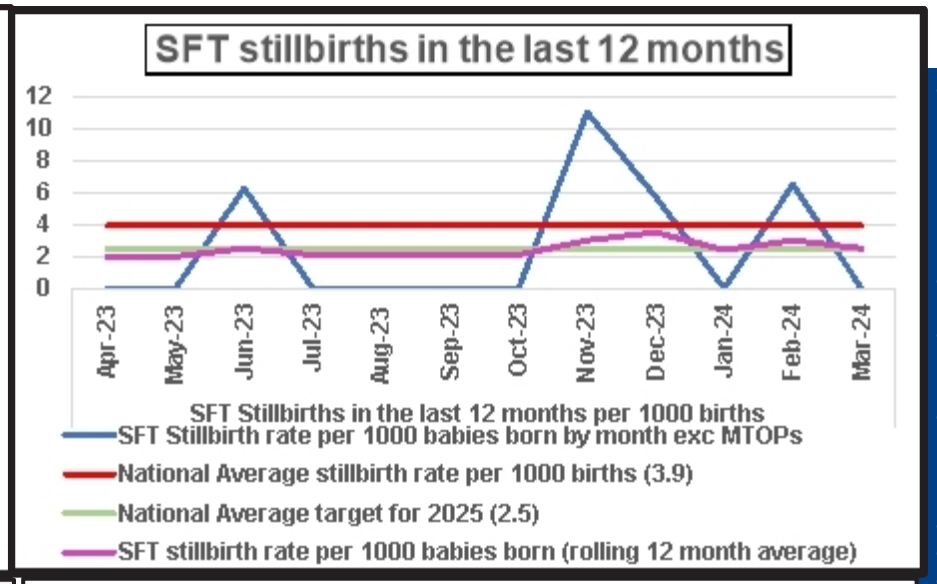
**What are the top contributors for under/over-achievement?**

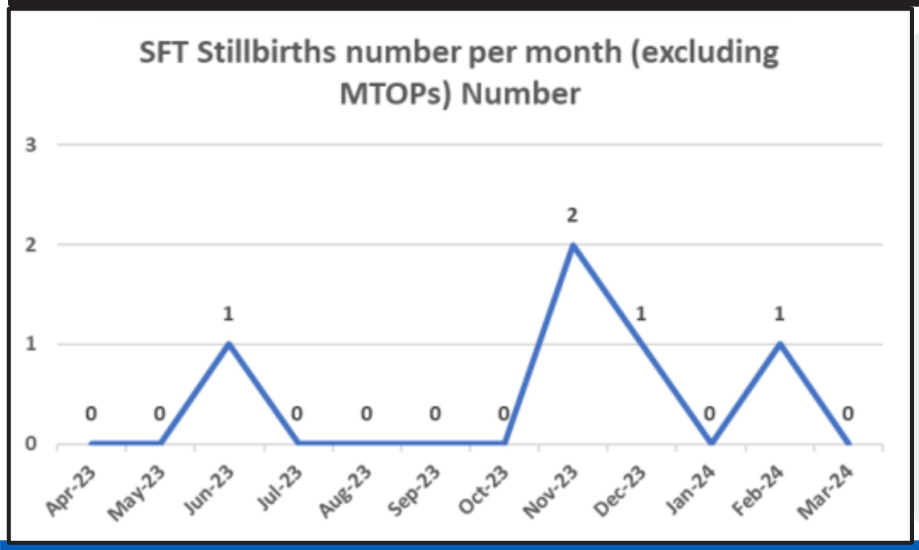
- Vacancy rate
- Maternity leave/long term sickness.
- Challenges in recruiting midwives

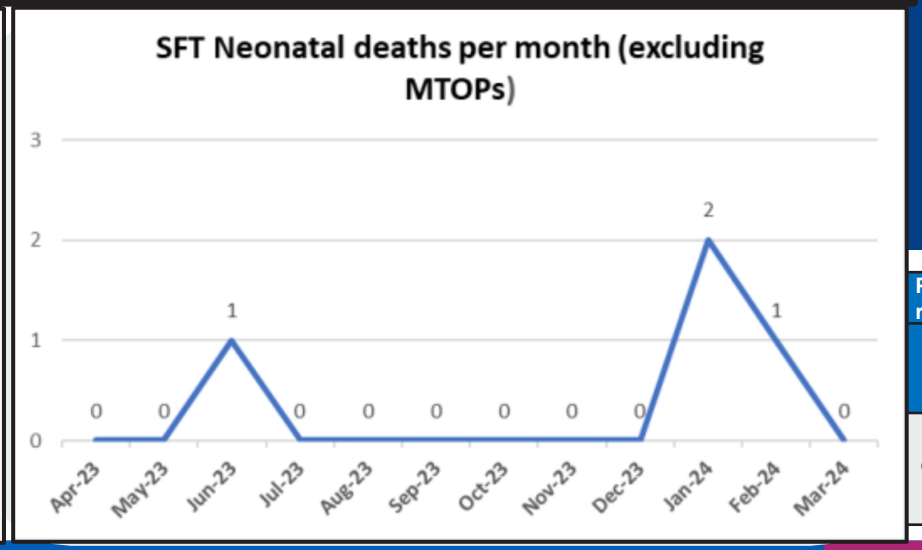
# Safe: Perinatal Mortality Review Tool (PMRT) (Bereavement midwife)

Salisbury NHS Foundation Trust




- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is MIS Safety Action 1 for year 5. A quarterly update paper is shared with the board. The national data figures have been changed this month to a-line with MBRRACE data rather than ONS data.
- Stillbirth and neonatal death rates are excluding MTOP's
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Still birth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- Perinatal deaths for March 2024 :
- One miscarriage at 19+4 weeks gestation
- One miscarriage at 20+1 weeks gestation
- Selective reduction of one multiple at 16 weeks delivered with live twin at 37 weeks

**PMRT Action Plans for Salisbury Foundation Trust – March 2024 reviews**

| PMRT case ID | Issue text | Action plan text | Person responsible | Target date |
|---|---|---|---|---|
| 91012 | There were no issues with care found that generated an action. | | | |

## PMRT grading of care – Key

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

| Case Ref | Date | Category | Incident | Outcome/Learning/Actions | HSIB Reference | SI? Reference |
|---|---|---|---|---|---|---|
| PMRT: 91012<br><br>Datix 237392 | 22/12/2023 | Unavoidable death | Stillbirth of baby at 26 weeks. | Cause of death-Severe growth restriction due to placental insufficiency<br><br>PMRT grading of care- A and B<br><br>**Actions**<br>No actions were generated from this review.<br>Issues had been addressed prior to the meeting. | NA | NA |

# Incidents

NHS Salisbury NHS Foundation Trust

**New cases for March 24**

| Case Ref (Datix) | Date | Category | Incident | | MNSI Reference | SI? Reference |
|---|---|---|---|---|---|---|
| **163965** | 6/3/24 | Moderate | MOH 1.7L following difficult extraction at ELCS. Baby admitted to NICU for observation, APGAR 5 @ 5 | Review planned 5/4/24, delay due to sickness and annual leave in team | | |
| 163960 | 6/3/24 | Moderate | 3b tear following forceps delivery | No care omissions | | |
| 163957 | 5/3/24 | Moderate | 3b tear following svd in pool; | No care omissions | | |
| 163944 | 4/3/24 | Moderate | Term baby admitted to NICU and transferred out to tertiary unit for cooling. Initial blood gas <7.0 | Under MNSI | MI-036889 | |
| 164285 | 19/3/24 | Moderate | Unexpected term admission | As yet unreviewed, to obtain notes | | |

# Ongoing maternity and neonatal reviews

NHS
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## Ongoing Maternity and Neonatal Reviews

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions |
|---|---|---|---|---|
| 155892 | 18/5/23 | Moderate Harm | Unexpected admission to neonatal unit | Shared decision making and escalation training, as well as introduction of updated CTG stickers that give improved information on appropriate actions required. Has been through exit |
| 156305 | 2/6/23 | Moderate | Uncross matchable blood - antibodies | Draft: Develop a system for handover of care for high-risk women expected on LW.<br>Improve communication between lab and community midwife and add antibodies as risk factor on PPH risk assessment tool. Has been through exit |
| 156497 | 9/6/23 | Never event | Retained swab | Draft: Options to be explored around possibility of purchasing swabs that enable a physical barrier to prevent swabs being left in a cavity.<br>a)Revise the Accountable Items, Swab, Instrument and Sharps Count Policy to ensure this is clearly articulated and the associated flow chart is amended in line with this.<br>b)When revising the policy strengthen action 5.2.2 to reiterate the expectation for clear and timely communication of the swab count prior to closure of a body cavity<br>c)Ensure these changes are communicated to all staff within the operating and 'pseudo' operating departments where this policy has relevance.<br>To review and revise the SOP for Opening a Second Obstetric Theatre and link it to the Obstetric Theatre Operational Policy<br>To include into the current maternity records audit a question on whether there is documented evidence that the need for translation services has been considered on the Delivery Suite for women for whom English is not their first language.<br>The Trust should use a second WHO checklist when a separate and distinct operation is required even if the patient has not left the operating room<br>To support junior medical, midwifery nursing staff by anticipating where unusually pressured situations may arise for example in situations of family conflict, personal / professional boundaries / knowledge / power dynamics. Draft expected imminently. Still in writing – escalated to Risk |

# Ongoing maternity and neonatal reviews (continued)

NHS Salisbury NHS Foundation Trust

## Ongoing Maternity and Neonatal Reviews

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions |
|---|---|---|---|---|
| 157595 | 8/8/23 | Moderate Harm | 3B tear, tailing growth and mode of birth | Not ready. Draft chase and expected 13/3/24. Report in writing |
| 157555 | 8/1/23 | Moderate Harm | Term admission | Amend induction of labour guideline AND fetal monitoring guidelines such that both unequivocally state to continue fetal monitoring at minimum 6 hourly intervals. Clarification of whether women partway through induction need evening Obs ward round review as only intrapartum are currently mandated for this. Draft chased, still in writing |
| 158301 | 8/12/23 | Moderate harm | Term Admission, required cooling at tertiary unit | Action planning in progress |
| 158202 | 8/8/23 | Moderate harm | Eclamptic seizure at home, admitted to ED - GA | Draft actions: Update pathway and explore options for documentation of administration and escalation. Implementation of case huddles in complex patients with clear SBAR handovers. Clinical teams to be notified and included in future sim scenarios. Out for actual accuracy |
| 158066 | 31/7/23 | Moderate Harm | PE at 15/40, missed opportunity for LMWH | A failsafe should be introduced to be implemented between appointments with different clinics/specialties to avoid missed appointments and to aid follow up. Appointment letters should be clearer and terminology changed to make it more obvious if a woman is required to see a doctor. High risk VTE women where VTE prophylaxis should br prescribed before 12 weeks should have a timely obstetric consultant appointment in clinic. Report out for factual accuracy |
| 159341 | 19/9/23 | Moderate harm | PPH at home, guidance not followed | Report out for factual accuracy |
| 161025 | 19/11/23 | Moderate Harm | Eclamptic seizure | Panel held 19/3/24 - draft in progress |

# Responsive

Salisbury NHS Foundation Trust

## MNVP Service User Feedback (March 24)

**Key Achievements & Positive Feedback:**

MNVP survey Sept 23-Jan 24 and MNVP Survey Feb 24 are now available and out to the relevant Matrons for comment.

Example of the Positive feedback received includes:

- Parents report positive personalised care from the obstetricians suggesting growth scan/ high risk care no longer needed.
- A number of women shared positive feedback for the birth reflection service- they felt it helped them to process what happened during labour.
- Parent education sessions were informative

**Identified Areas of Improvements:**

**feeling listened to - compassionate care**

The main theme throughout this months feedback is around families feeling like the care they've received is not compassionate or personalised and that they have not been listened to.
Parents feel as though they aren't being given choices, that their opinions aren't valid and that HCP's know what's best. Whether this is lack of conversation in antenatal appointments, wishes on birth plans not being acknowledged or being given pain relief when asking

**Next Steps for Progressions:**

- Continue roll out of personalised care plan training
- Complete actions from 15 steps.
- Work ongoing to improve the outcome for women within are ethnic minoritised communities (further Local audit to be conducted)
- Continue to promote the Pains relief in labour parent educational classes.

## Safety Champions Staff Feedback

**Key points raised:** Meeting in March 24.

**Items for escalation:** Funding to support a Safety champion's notice board in all clinical area.

**Next Steps for Progressions:**

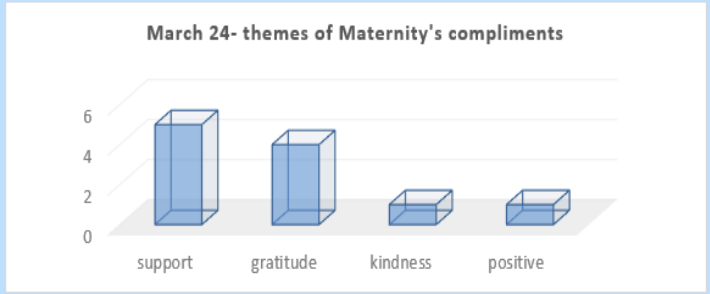
Real time audit on women's experience of the care on the postnatal ward.

## Compliments & Complaints

11 Compliment logged in March 24. 5 SOX in March

*"We will never forget your dedicated work & support that helped us through this unforgettable journey".*

**No complaints logged in March 24**




## Friends & Family Survey

**Key Achievements:**

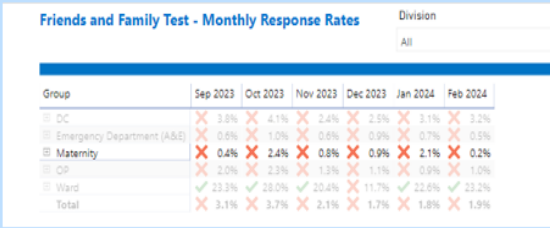
7 FFT responses in March 23

6 of which were in relation to postnatal care, and 1 in respect to the infant feeding team.

All feedback were positive, with a score: very good.

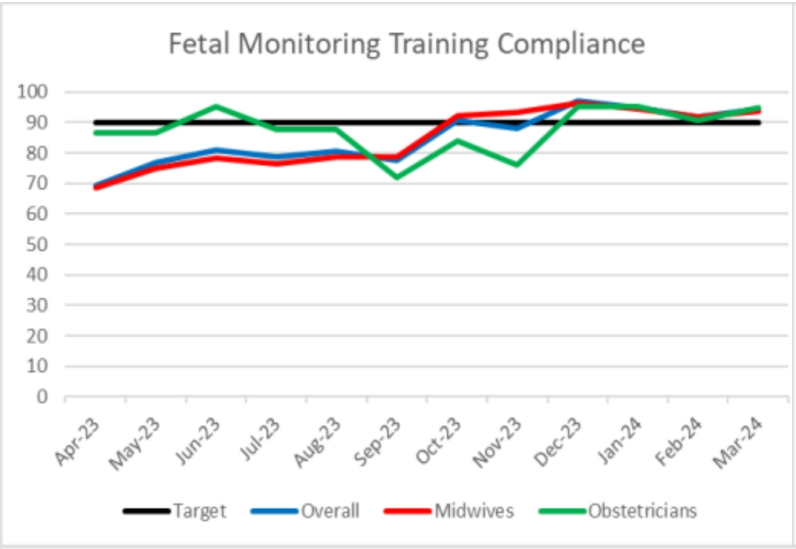
*"All the staff are lovely and have been incredibly knowledgeable, helpful, reassuring and kind. We could not have been looked after better". Postnatal feedback*

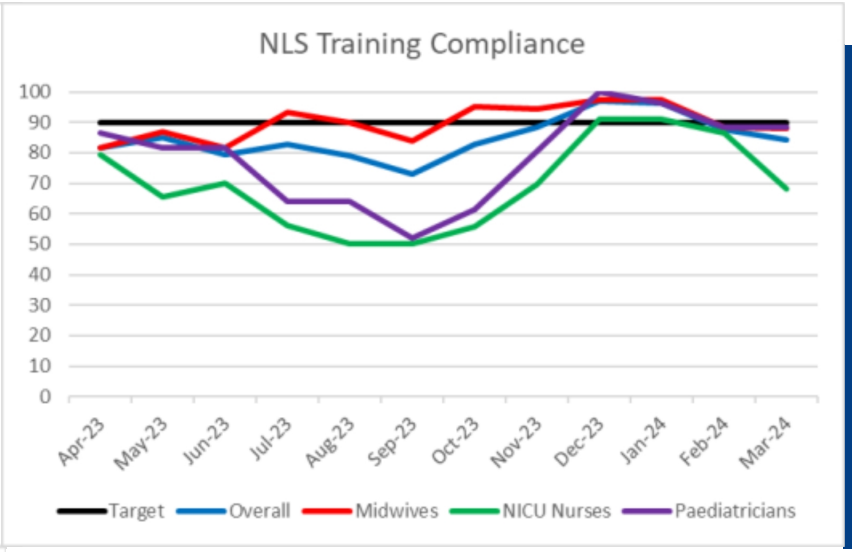
*"Wonderfully kind and empathetic ladies who quickly put myself and baby at ease. We felt like we were in knowledgeable hands and that we weren't alone in our struggles". IFT*

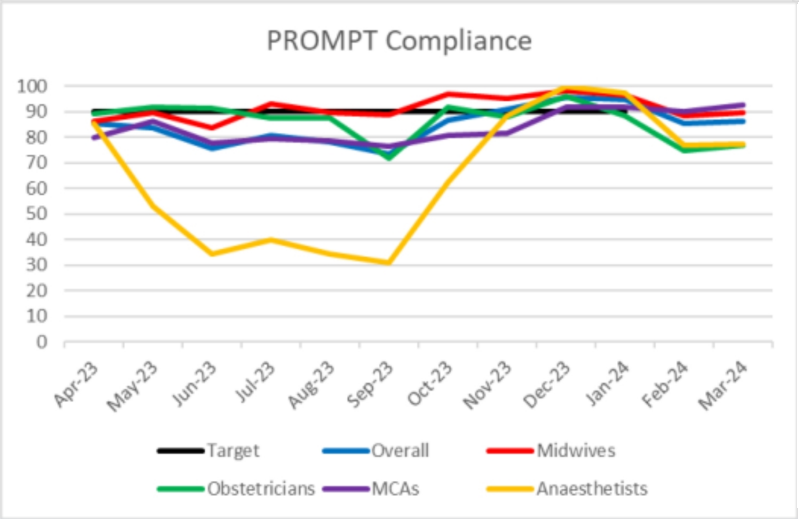


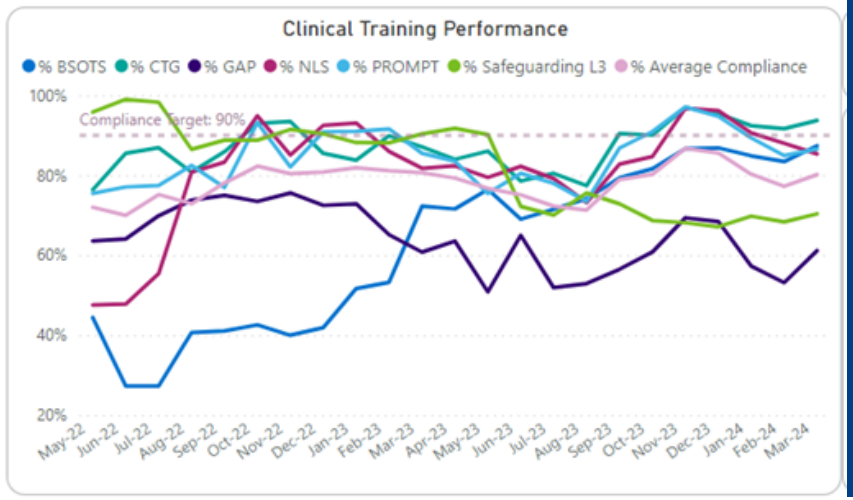
# Well-led Training (Education Midwife)

Salisbury NHS Foundation Trust




**Training**

CNST requirements for >90% training compliance in all staff groups for NLS, fetal monitoring and PROMPT training achieved in December 2023.

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

**Countermeasures/action:**

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring.

**Risks:**

- Ongoing medical industrial action has already impacted training in January 2024.
- Influx of new MDT staff in September /October /November.
- Booking of training rooms availability – rooms booked for 2024 in advance but there have been changes to these bookings at short notice impacting training time
- Anaesthetic conflicts of priorities to attend training.

# Compliance to National Guidance

Table 1. Ockenden 2022

| OCKENDEN 2022 | | Immediate and Essential Action | Number of actions under each heading rated | | | |
|---|---|---|---|---|---|---|
| | | | RED | AMBER | AWAITING CLOSURE | GREEN |
| Mar-24 | 1 | Workforce Planning and Sustainability | 0 | 2 | 0 | 5 |
| | 2 | Safe Staffing | 0 | 4 | 0 | 6 |
| | 3 | Escalation and Accountability | 0 | 1 | 0 | 4 |
| | 4 | Clinical Governance - Leadership | 0 | 2 | 0 | 5 |
| | 5 | Clinical Governance - Incident Investigation and Complaints | 0 | 2 | 0 | 5 |
| | 6 | Learning from Maternal Deaths | 0 | 0 | 0 | 2 |
| | 7 | Multidisciplinary Learning | 0 | 2 | 0 | 5 |
| | 8 | Complex Antenatal Care | 0 | 4 | 0 | 1 |
| | 9 | Preterm Birth | 1 | 3 | 0 | 0 |
| | 10 | Labour and Birth | 0 | 4 | 0 | 2 |
| | 11 | Obstetric Anaesthesia | 0 | 7 | 0 | 0 |
| | 12 | Postnatal Care | 0 | 3 | 0 | 1 |
| | 13 | Bereavement Care | 0 | 3 | 0 | 1 |
| | 14 | Neonatal Care | 0 | 1 | 0 | 5 |
| | 15 | Supporting Families | 0 | 3 | 0 | 0 |

## Ockenden Report

**Key Achievements:**

- Review of meetings and actions.

**Next Steps for Progressions:**

- Adopting new methodology to ensure progress of actions

Table 2. CNST Maternity Incentive Scheme – Year 5 submission

| NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024 | | | | | |
|---|---|---|---|---|---|
| | | Description | Yr 5 Submission | Comment | Current Assessment |
| Are we well led? | 1 | **Perinatal Mortality Review Tool** using to required standard for all perinatal deaths | Compliant | All Standards Met | |
| | 2 | **Maternity Services Data Set** submission to required standard | Compliant | All Standards Met | |
| | 3 | **Transitional Care Data Set** minimise separation to mothers and babies | Compliant | All Standards Met | |
| | 4 | **Clinical Workforce Planning** effective system | Compliant | All Standards Met | |
| | 5 | **Midwifery Workforce Planning** | Compliant | All Standards Met | |
| | 6 | **Saving Babies Lives Care Bundle V3** compliance with all elements | Non Compliant | New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable. | |
| | 7 | **Service User Involvement and co-Production** | Compliant | All Standards Met | |
| | 8 | **Multidisciplinary Training** | Compliant | All Standards Met | |
| | 9 | **Board Assurance** Board to Ward to Board | Compliant | All Standards Met | |
| | 10 | **HSIB and EN Reporting** | Compliant | All Standards Met | |
| Person Centred & Safe | Professional | Responsive | Friendly | Progressive | |

## Maternity Incentive Scheme (CNST) Year 5

**Key Achievements:**

- 9/10 declared for CNST

**Next Steps for Progressions:**

- Action plan created and submitted to NHSR to secure roles to support compliance for SBL

# Themes - OASI

**Figure 1. Local 3rd and 4th degree tear (OASI) rates at Salisbury**

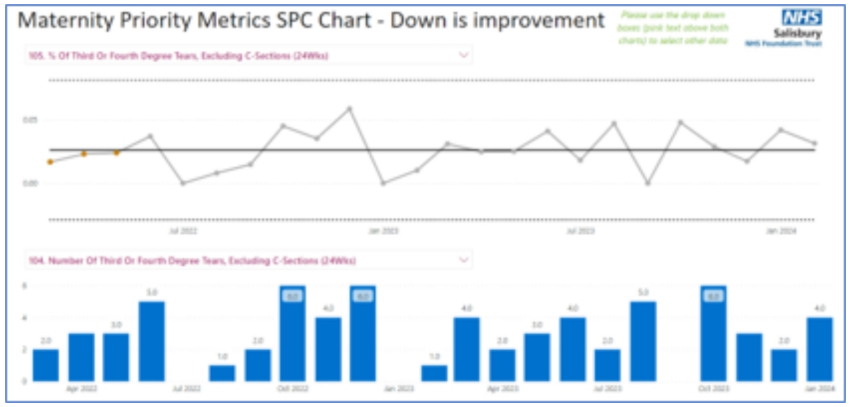
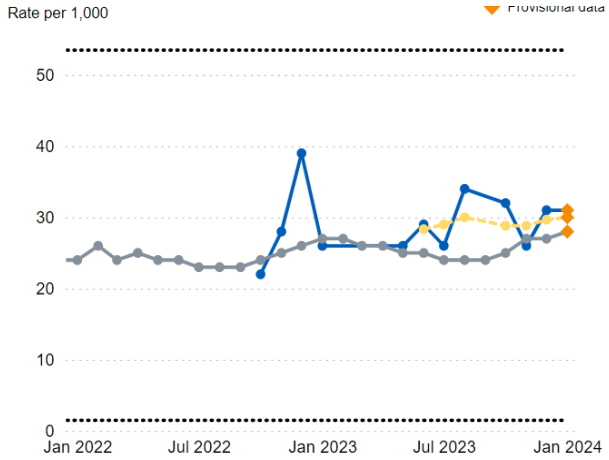



**Figure 2. Local OASI rates (blue), Trust tolling average (yellow) versus National OASI rate (grey)**




## Theme – Raised 3rd & 4th Degree tear rates

Figure 1 represents local rates & figure 2 benchmarks local rates, Trust rolling average and national rates. This demonstrates that Salisbury's rate and rolling average is higher than the national rate. Updated to include most up to date available data.

**Countermeasures:**

Q&S team undertaking a thematic review of cluster cases in the last quarter during March. Pelvic Health Midwife in post. OASI care bundle is now included on the annual training day (from Jan '24).

**Figure 3 Post Partum Haemorrhage (PPH) >1500mls at Salisbury**

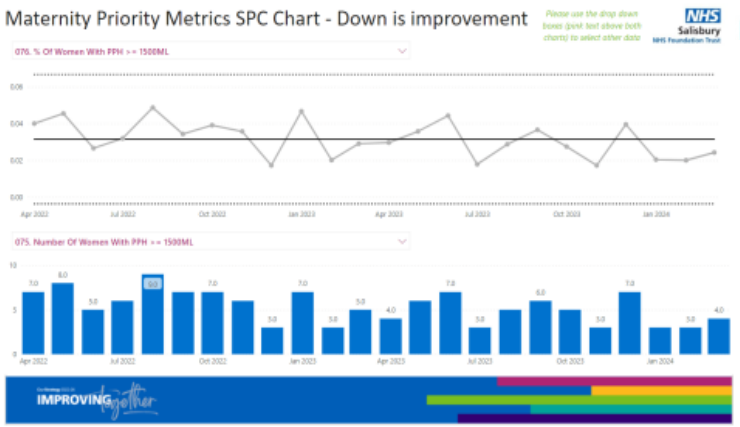
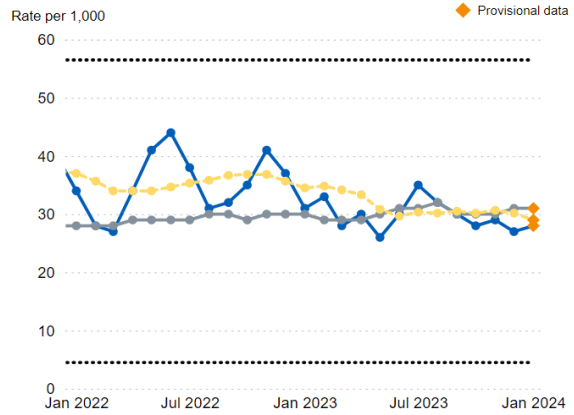



**Figure 4. PPH >1500mls Trust rates (blue), Trust tolling average (yellow), National OASI rate (grey)**




## Theme – Previously raised PPH rates (2023)

PPH rates have been raised previously and a thematic review took place in December 2023 identifying that PPH risk assessments are being completed in all cases (as per current audit data). This review also generated some actions around fluid balance and third stage management. There has been a steady rate through Jan, Feb and March with no marked increase. The Trust rate is currently below that of the national average.

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 5.3 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Maternity and Neonatal bi-annual Staffing report – March 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | Yes | | Yes | |
| Approval Process: (where has this paper been reviewed and approved): | Approved by Women and Newborn Divisional Management Team 20.03.24.<br>Divisional Governance 21.03.2024<br>Clinical Governance Committee 26th March 2024 | | | |
| Prepared by: | Vicki Marston - Director of Maternity and Neonatal Services | | | |
| Executive Sponsor: (presenting) | Judy Dyos - Chief Nursing officer | | | |

## Recommendation:

The Trust Board are asked to note the contents of this report which has been provided for information and assurance processes.

To recognise that this report does not show compliance with our latest birthrate plus report which was confirmed and published post this report being written.
To note that we are no longer compliant with Safety Action 5 CNST due to the changes in the most recent BR plus report and the recommended increases in funded midwifery establishment.

In order to demonstrate compliance with the Maternity Incentive scheme the committee is asked to note the specific expectations in relation to demonstrating effective midwifery workforce planning as detailed in the report.

To acknowledge that reports will be following with birth rate plus and BAPM establishment recommendations for both Midwifery and Neonatal Nursing staffing establishments to ensure that at SFT we are compliant with both.

## Executive Summary:

This report provides a bi-annual Midwifery staffing report as per Maternity Incentive Scheme (Year 5) – Safety Action 5 recommendation and requirement.

It also includes a bi-annual staffing report relating to the neonatal nursing workforce.

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For the Trust Board to note and minute the following required standards as set out in the report:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed –
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. **Non-compliant due to Birth rate plus 2024 individualised SFT report being published post this report being written.**
c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
d) All women in active labour receive one-to-one midwifery care.
e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

To note vacancy levels and recruitment challenges and plans in place to mitigate against this by use of escalation policy.

In addition to note the challenges and mitigations in Midwifery staffing over the 6-month period this covers, and to acknowledge that the required standards as set out above have been met and are evidenced in the report.

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

# BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT March 2024

## 1. Purpose

**The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from September 2023 to March 2024. This is a requirement of the NHSLA Maternity Incentive Scheme and relates to Safety Action 5**

## 2. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 5, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning.
To provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, this paper provides staffing data on Midwifery and Neonatal Nursing Staffing. The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as

calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

## 3.Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents.

## 4. Birthrate Plus Workforce Planning and staffing levels.

A formal Birth Rate Plus assessment was completed in 2019, with a recalculation of workforce in 2021, this is the staffing model we are currently budgeted to and working within.

A repeat assessment was carried out through October to December 2023, as per NICE (2017) national recommendation for repeat assessment timeframes, which reviewed the acuity of women who used maternity services. The report from this assessment has been received in draft, once the completed report has been received it will be presented to Trust Board to escalate any changes required within Midwifery establishment and action planning around this**.**

The current midwifery establishment at SFT was calculated using a midwife/birth ratio of 1:26 as recommended by the SFT Birthrate Plus® report in December 2019. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the

safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data detailing risk and acuity of inpatients on Labour Ward 4 hourly, and Postnatal 6 hourly. This gives us up to date feedback on the level of safe staffing against the acuity and activity of the day. The tool also measures by exception where 1:1 care is not possible for labouring women, and when the labour ward coordinator is not able to maintain supernumerary status.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments. It was recognised that the figures of current clinical establishment presented to Birthrate Plus® in Summer 2019 that informed the report published in December 2019, included some non-clinical roles within the variance report, and was therefore, inaccurate in this calculation and subsequent recommendations.

Following liaison with Birthrate Plus® in May 2021 and a recalculation of the service requirements using 2019 clinical data, Birthrate Plus® recalculated our staffing requirements. Table 1 is the updated report from Birthrate Plus® May 2021.

Birth-rate plus recommendation May 2021

| | |
|---|---|
| Total Births | **2193** |
| **Core Hospital Services** | |
| Delivery Suite | 33.86 |
| | |
| Postnatal Ward | 20.95 |
| | |
| Maternity DAU | 7.56 |
| | |
| Community Inc. Homebirth provision | 27.83 |
| | |
| **Total Clinical wte** Band 3-7 | **90.15** |
| | |

Our substantive funded establishment reflects the birthrate plus recommendation for staffing levels. However, recruiting to our funded establishment has been challenging over recent months and maintaining staffing levels is a constant challenge.

This has been escalated to Board level and is being managed accordingly, as detailed later in the report.

We recognise that there is a need to balance the junior workforce with experienced staff and in particular the recruitment into senior Band 6 positions is a challenge for Salisbury. Although challenges in recruitment are not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors to recruitment challenges.

The concept of flexible working across the maternity pathway, rather than having fixed areas of working, as an alternative approach to providing maternity care, is being piloted to aid recruitment. We have adapted to look at several varying processes to attract staff, including supporting return to practice midwives, financial incentives, and varying contracts. From a flexible working perspective, we have trialed an increase in requesting for staff, stepping out of the policy dictating numbers of request and doubling them to allow staff more opportunity to balance work and home life. This has been well-received by staff and supports our work around retention.

Our collaborative work with Gloucester and GWH to recruit international midwives has been successful, we have 7 international midwives working within the service now. Five are working at band 5 having completed their OSCE and received their NMC Pin, the remaining 2 midwives have passed OSCE process and are awaiting NMC registration. We also have 2 Maternity care assistants who have started a Midwifery apprenticeship and one nurse who has commence a nurse to midwife conversion course. Exploring all options for recruitment is enabling us to draw form a variety of sources, as well as supporting recruitment of individuals with valuable experience in other areas of the NHS.

## 1. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient ward areas by month.

| | Day qualified %<br>Fill rates. | Night qualified %<br>Fill rates |
|---|---|---|
| September 2023 | 87.75 % | 96.02% |
| October 2023 | 82.01% | 93.26% |
| November 2023 | 88.8% | 96.5% |
| December 2023 | 90.76% | 94.66% |
| January 2024 | 94.28% | 93.56% |
| February 2024 | 95.2% | 97.7% |

Maternity leave has been consistently high amongst midwives and as of February 2024 we have 8.31 WTE midwives on maternity leave which does put further pressure on fill rates.

When staffing is less than optimum, the following measures are taken in line with the Maternity Department escalation policy:

- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Support of Maternity and Neonatal Duty Manager Day and night as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Recruitment of nurses to the maternity Services.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and staff are feeling the pressure of vacancies. It is recognised that although staff have undertaken Bank work to close day to day gaps this is not a sustainable long-term solution.

From a pastoral support perspective, we have a retention Professional Midwifery advocate (PMA) in post and have recently received LMNS money to support funding a retention lead for MSW. The PMA post has proved valuable in supporting staff and understanding the reasons they may be

considering leaving the service and helping them to find solutions to remaining with us i.e., flexible working for example.

## 5. Midwife to Birth Ratio

Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:26. Following review of individualised data this takes into account anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This rate is reached via calculations between monthly birth numbers and available numbers of midwives. The ratios are analysed monthly and are affected by fluctuating birth numbers and variations in establishment month to month.

The table outlines the real time monthly birth to midwife ratio for the past 6 months.

| Month | September 23 | October 23 | November 23 | December 23 | January 24 | February 24 |
|---|---|---|---|---|---|---|
| Midwife to birth ratio | 1:29 | 1:35 | 1:28 | 1:32 | 1:25 | 1:26 |

## 6. Specialist Midwives

Birth Rate Plus recommends a percentage of the total establishment are not included in the clinical numbers. This percentage is tailored to units considering size, acuity and whether units are multi-centered. These roles include management positions and specialist midwives. These roles include Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Birth Environment Lead, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons amongst others.

Since our assessment in 2019/21 birthrate plus has been reviewing the standard percentage and is adapting it depending on unit size, recognizing that the national ask is the same despite the number of births and therefore smaller units may expect to require a higher percentage of non-clinical. They have indicated that the percentage applicable to SFT is likely to move upwards in our next assessment.

## 7. Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool is used in the intrapartum areas and in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition, admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward coordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

## 8. Supernumerary Labour Ward Coordinator

One of the safety standards mandated by CNST is the need to have a supernumerary Labour Ward Coordinator leading on every Labour Ward 24-hours a day. We have ensured that our rostering reflects this requirement. The Birthrate Plus acuity tool monitors this every 4 hours. It also takes into account risk factors, acuity and dependency of women, environmental factors and skill mix enabling the co-ordinator to flex staffing to the need of the service within a shift by redirecting staff and prioritising care. A detailed escalation policy also ensures the coordinator retains this supernumerary status enabling oversight of activity. Supernumerary status of the coordinator was maintained 100% of the measured occasions in the 6 months this report relates to.

The following table outlines the compliance against this action by month:

| | Number of days per month | Number of shifts per month | Compliance |
|---|---|---|---|
| **September 23** | 30 | 60 | 100% |
| **October 23** | 31 | 62 | 100% |
| **November 23** | 30 | 60 | 100% |
| **December 23** | 31 | 62 | 100% |
| **January 23** | 31 | 62 | 100% |
| **February 23** | 29 | 58 | 100% |

## 9. One to One care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward coordinator to follow the course of actions within the acuity tool and the escalation policy. These may be clinical, or management actions taken.

The following table outlines compliance with provision of 1:1 care by Month.

| | September 23 | October 23 | November 23 | December 23 | January 24 | February 24 |
|---|---|---|---|---|---|---|
| **Birth Centre** | 100% | 100% | 100% | 100% | 100% | 100% |
| **Labour Ward** | 100% | 100% | 100% | 100% | 100% | 100% |

## 10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events for the 6-month period from 1st September 2023 to 29th February 2024. Out of 896 data admissions (confidence factor of 82% recorded) there were 13 red flags entered onto the system with the reasons detailed below:

**Number & % of Red Flags Recorded**

From 01/09/2023 to 30/11/2023

| | | | |
|---|---|---|---|
| RF1 | Delayed or cancelled time critical activity<br>e.g Delay EL LSCS >4 hours | 3 | 33% |
| RF2 | Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)<br>e.g waiting for suturing >60 mins | 0 | 0% |
| RF3 | Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) | 0 | 0% |
| RF4 | Delay of more than 30 minutes in providing pain relief | 0 | 0% |
| RF5 | Delay of 30 minutes or more between presentation and triage | 0 | 0% |
| RF6 | Full clinical examination not carried out when presenting in labour | 0 | 0% |
| RF7 | Delay of 2 hours or more between admission for induction and beginning of process | 6 | 67% |
| RF8 | Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) | 0 | 0% |
| RF9 | Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0% |
| RF10 | Supernumerary status of labour ward coordinator not achieved | 0 | 0% |
| | Total | 9 | |

**Number & % of Red Flags Recorded**

From 01/12/2023 to 29/02/2024

| | | | |
|---|---|---|---|
| RF1 | Delayed or cancelled time critical activity<br>e.g Delay EL LSCS >4 hours | 4 | 100% |
| RF2 | Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)<br>e.g waiting for suturing >60 mins | 0 | 0% |
| RF3 | Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) | 0 | 0% |
| RF4 | Delay of more than 30 minutes in providing pain relief | 0 | 0% |
| RF5 | Delay of 30 minutes or more between presentation and triage | 0 | 0% |
| RF6 | Full clinical examination not carried out when presenting in labour | 0 | 0% |
| RF7 | Delay of 2 hours or more between admission for induction and beginning of process | 0 | 0% |
| RF8 | Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) | 0 | 0% |
| RF9 | Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0% |
| RF10 | Supernumerary status of labour ward coordinator not achieved | 0 | 0% |
| | Total | 4 | |

Each red flag is recorded on the acuity tool and reported via datix, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

## 11. Safety and Overview

For the service to demonstrate safe staffing on a daily basis the Maternity Duty Manager plays a fundamental role in responding to the constant changing clinical situations within maternity, both in the building and in the community environment. The Duty Manager is available to provide a 24/7 support to the Maternity and Neonatal Service, providing a helicopter view across all areas and maintaining safety at every level. The Maternity Duty Manager rota is covered by Band 7 and Band 8 midwifery leaders and provides visible responsive leadership to Maternity and Neonatal Services.

Maternity Services continue to report missed breaks via Datix and when the coordinator is unable to maintain their supernumerary status. At such a time the involvement of the Duty Manager and use of the Maternity Escalation Policy ensures oversight and transparency when staffing and incidents occur. Additionally, Red Flag reporting is discussed monthly at the Maternity Risk meeting, with any themes being fed into the Trust Clinical Risk Group.

Staffing is discussed at Maternity Risk monthly, forms part of the Executive Performance Review monthly meetings (as an Improving together divisional driver) and is discussed with the Board level Safety Champions monthly. In addition, it is reported to Trust Board and LMNS Board via its inclusion in the Perinatal Quality slide set, which is presented to both boards monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges.

## 12. Risks

Delivery of Continuity of Carer Model

In February 2016 Better Births, the report of the National Maternity Review, set out the Five Year Forward View for NHS Maternity Services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be Continuity of Carer to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. When moving towards the continuity model, it is recognised nationally that this will require an increased number of midwives as opposed to the traditional working model and in Salisbury a pilot study for Continuity of Carer at SFT ended in March 2021 due to concerns around entire midwifery workforce skill mix and vacancy rates. This decision was supported by the Ockenden report (2022) when there was clear guidance published to NHS Trusts advising that if adequate staffing levels were not in place, then continuity of carer should be immediately paused until full establishment of staff was reached. With our vacancy rates we have followed this advice and paused our rollout of continuity at present.

The table below demonstrates the required staffing levels needed to achieve Continuity of Carer using SFT data and staffing establishment figures.

It is clear within the report that to develop Continuity of Carer to 35% of women the service requires the establishment of 90.16 WTE clinical midwives to be fully recruited into, and with the current vacancy rate this is not currently feasible.

Continuity of Carer modelling from Birthrate Plus® report (May 2021)

| SALISBURY NHS TRUST | 24% uplift | Version date: 13/05/2021 | | DRAFT | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL BIRTHS | 2193 | **The figures are an indication only and should be reviewed as more caseload teams are set up.** The staffing totals assume the annual births, community exports and imports remain as in the baseline and there are no other changes to services. The CoC staffing is based on a caseload ratio of 36 cases to 1wte. Factored into core staffing is that 20% of CoC women will require care from core staff on D/S and that 90% of women will require transfer to the p/n ward for maternal and/or fetal reasons. The % may reduce as CoC becomes established. It is advisable to consider minimum staffing on D/S and Maternity Ward as higher % of women are allocated to a CoC team. | | | | | | | | | |
| TOTAL COMMUNITY CASES | 2756 | | | | | | | | | | |
| ELIGIBLE FOR COC | 2023 | | | | | | | | | | |
| Minimum Staffing 24/7 x 1 m/w | **Baseline exc CoC** | *Core Staffing Nos. per Shift* | **CoC 20%** | *Core Staffing Nos. per Shift* | **CoC 35%** | *Core Staffing Nos. per Shift* | **CoC 51%** | *Core Staffing Nos. per Shift* | **CoC 75%** | *Core Staffing Nos. per Shift* | **CoC 100%** | *Core Staffing Nos. per Shift* |
| *5.56* | | | | | | | | | | | | |
| **Core Hospital Services** | | | | | | | | | | | | |
| Delivery Suite | 33.86 | *6.09* | 30.85 | *5.55* | 27.86 | *5.01* | 24.67 | *4.44* | 19.88 | *3.58* | 14.90 | *2.68* |
| Maternity Ward | 20.95 | *3.77* | 20.91 | *3.76* | 20.27 | *3.65* | 19.59 | *3.52* | 18.58 | *3.34* | 17.52 | *3.15* |
| OPD/MAU | 7.96 | | 7.96 | | 7.96 | | 7.96 | | 7.96 | | 7.96 | |
| **Core Community** | 25.45 | | 21.99 | | 18.75 | | 15.29 | | 10.10 | | 4.70 | |
| **Home births** | 2.38 | | | | | | | | | | | |
| **Caseload Teams** *includes home births* | 0.00 | | 11.24 | | 19.67 | | 28.66 | | 42.15 | | 56.19 | |
| **Total Clinical wte** PN Band 3s to Band 7/8s | **90.60** | | **92.94** | | **94.51** | | **96.17** | | **98.67** | | **101.28** | |
| **Variance from BR+ baseline in CLINICAL WTE** | 0.00 | | 2.35 | | 3.91 | | 5.57 | | 8.07 | | 10.68 | |
| Incremental Variance in Clinical wte | | | 2.35 | | 1.56 | | 1.67 | | 2.50 | | 2.60 | |
| **TOTAL CLINICAL, SPECIALIST, MANAGEMENT WTE** | **98.75** | | **101.31** | | **103.01** | | **104.83** | | **107.55** | | **110.39** | |
| **Variance from BR+ baseline in TOTAL WTE** | | | **2.56** | | **4.26** | | **3.52** | | **4.54** | | **5.56** | |

## 13.0 **Neonatal nursing staffing**

To meet safety action 4 of the Maternity Incentive Scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards and the Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The nursing workforce review was completed in September 2023 using the Workforce calculator seen below. This demonstrates that the unit is not compliant to the BAPM standards and requires additional nursing workforce. The requirement would be an additional 0.77wte registered nurse and 2.09wte non-registered nurse. There are mitigations in place for increasing the number of nurses who are QIS trained, 1.45wte are in training currently. An action plan to review neonatal staffing was shared at Trust Board January 2024, and a paper is currently in progress. However, it is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month.

| | FUNDED September 23 | IN POST September 23 | Calculated requirement (from tool) | Variance |
|---|---|---|---|---|
| **Total direct care nurses** | **21.69** | **20.48** | **24.55** | **2.86** |
| **Total registered nurses (band 5 and above)** | **20.89** | **19.88** | **21.66** | **0.77** |
| **of which QIS** | **13.65** | **13.65** | **15.16** | **1.51** |
| **Total Non QIS** | **7.24** | **6.23** | **6.50** | **-0.74** |
| **Total Non Reg** | **0.80** | **0.60** | **2.89** | **2.09** |
| **% REGISTERED NURSES QIS QUALIFIED** | | **68.7%** | **70.0%** | |

## 13. Conclusion and Next Steps

The paper demonstrates the current staffing establishment in the maternity service, challenges, risks, and mitigations in place. The ongoing work to recruit and retain is key to the long-term staffing within the service.

Next steps are detailed:

- Continue with the recruitment campaign work utilising all options available to the Trust for recruitment and retention incentives.
- Utilise Bank and Agency staff.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.
- Continue with retention work and input from PMA to support staff.
- Continued consideration of any exit interview themes and actions associated with them.
- Review of completed Birth rate plus report in full and establishment to reflect recommendations.

## 14. Recommendations

It is recommended that the Board note the contents of the report and formally record in the Trust Board minutes the compliance to those metrics requiring noting as evidence for CNST compliance.

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 5.4 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | NHS Maternity Survey 2023 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | x | |
| Approval Process: (where has this paper been reviewed and approved): | Safety Champions – Action Plan – 21.11.23<br><br>Maternity Risk and Governance – Action Plan – 01.12.23<br><br>Divisional Governance<br>- Action Plan – 22.02.24<br>- Action Plan & Benchmark Report 21.03.24<br>- Clinical Governance Committee 26th March 24 | | | |
| Prepared by: | Alison Lambert (Family Experience Midwife)<br>Presented By Vicki Marston DoM | | | |
| Executive Sponsor: (presenting) | Judy Dyos | | | |
| Appendices | • Action plan: Maternity Survey 2023- Coproduced with the MNVP<br>• NHS Maternity Services Survey 2023 Benchmark Report | | | |

## Recommendation:

The Trust board is asked to note progress and the continued focus from Maternity Services on:

- Postnatal care
- Sharing relevant information regarding the induction of labor (IOL) process, and options available to women.
- Introduction of the personalized care model
- Reducing delays in discharge from the postnatal ward.
- Hosting listening events to establish women's experiences of their pregnancy journey.
- Continue to build on signposting women to mental health services.
- Review support offered to women in response to infant feeding.

## Executive Summary:

This survey looks at the experiences of 25,515 women and pregnant people, across 121 NHS trusts, who gave birth in February 2023 (and January 2023 for smaller trusts).

Questionnaires were sent out between April and August 2023; responses were received from 170 (59%) people at Salisbury NHS Foundation Trust. The average response rate for all 31 Trusts surveyed was 47%.

**3** questions showed **at least 10% improvement** on the 2022 score, and for **0 questions** the score was **worse by 10%** or more.

- **Labour and birth**

  **Patient Response 8.2 / out of10**
  **Compared with other trusts About the same**

- **Staff caring for you**

  **Patient Response 8.4 / out of10**
  **Compared with other trusts About the same**

- **Care in hospital after the birth**

  **Patient Response 6.8 / out of10**
  **Compared with other trusts About the same**

The Trust were in the top 20% for six questions around the following areas:

- Choice and being listened too antenatally.
- Not being left alone when worried during labour.
- Confidence and trust in midwives after going home.

The Trust were in the bottom 20% for seven questions around the following areas:

- Feeding in Hospital (action: The IFT offer a feeding service six days a week (including bank holidays) and work is ongoing to raise awareness of the national infant feeding helplines
- Mental Health and changes that might be experienced. (action: MNVP to host an online listening event on: families experience of perinatal mental health support).
- Visiting times (action: as from March 23, there is no restrictions place on visiting for birth partners).
- Being treated with kindness and being given information on the ward after birth (action: The PMA lead intends to work with staff on the Behavioural Charter with the focus on kindness and compassionate communication with staff and patients).

An comprehensive action plan has been devised and is being monitored and worked to, to enable continued improvements.

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

# NHS Maternity Services Survey 2023 Benchmark Report

Salisbury NHS Foundation Trust

# Contents

# Background and methodology

**This section includes:**

- explanation of the NHS Patient Survey Programme
- information on the 2023 Maternity Survey
- a description of key terms used in this report
- navigating the report

# Background and methodology

## The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2023 Maternity Survey will be the tenth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

## The 2023 Maternity Survey

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 63,271 people who used maternity services were invited to participate in the survey across 121 NHS trusts.

Completed responses were received from 25,515 maternity service users, an adjusted response rate of 41%.

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2023. If there were fewer than 300 people within an NHS trust who gave birth in February 2023, then births from January were included.

In larger trusts, all eligible individuals from ethnic minority backgrounds, who had a live birth between 1 and 31 January and 1 and 31 March 2023 were invited to participate. A full list of eligibility criteria can be found in the survey sampling instructions.

Fieldwork took place between May and August 2023.

## Trend data

In 2021, the Maternity Survey transitioned from a solely paper based methodology to both paper and online. This dual approach was continued in 2022 and 2023.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2022 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2022 data.

## Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

# Background and methodology (continued)

## Antenatal and Postnatal data

The Maternity Survey is split into three sections that ask questions about:

- antenatal care
- labour and birth
- postnatal care

It is possible that some maternity service users may have experienced these stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 121 NHS trusts that took part in the survey.

Trusts were asked to carry out an “attribution exercise”, where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2023, 121 of the 121 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

## Limitations of this approach

Data is provided voluntarily. In 2023, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

# Key terms used in this report

## The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

## Standardisation

Demographic characteristics, such as age can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in profiles between trusts. For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity service users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

## Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10 (except for questions B3 and D8). A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive, and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C3). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

## Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

## Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to). This is to prevent individual responses being identifiable.

## Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

# Using the survey results

## Navigating this report

This report is split into **five** sections:

**1. Background and methodology** – provides information about the survey programme, how the survey is run and how to interpret the data.

**2. Headline results** – includes key trust-level findings relating to the service user who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.

**3. Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/ or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.

**4. Trends over time** – includes your trust's mean score for each evaluative question in the survey. This is either shown as a historical trend chart or a significance test table, depending on the availability of longitudinal data.

Where possible, significance testing compares the mean score for your trust in 2022 to your 2023 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.

**Historical trends** are presented where data is available, and questions remain comparable for your trust. Trends are presented only where there are at least five data points available to plot on the chart. Historical trend charts show the mean score for your trust by year, so that you can see if your trust has made improvements over time. They also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not.

**Significance test tables** are presented where there are less than 5 data points available, and questions remain comparable between 2022 and 2023.

**5. Appendix** – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

# Using the survey results (continued)

## How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

### Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: http://www.cqc.org.uk/maternitysurvey
- National and trust-level data for all trusts who took part in the 2023 Maternity Survey: https://nhssurveys.org/surveys/survey/04-maternity/year/2023. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors services: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

# Headline results

**This section includes:**

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

# Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

**288** invited to take part

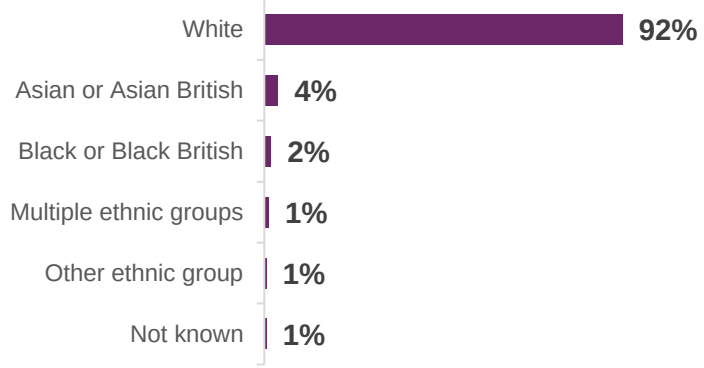
**170** completed

**59%** response rate

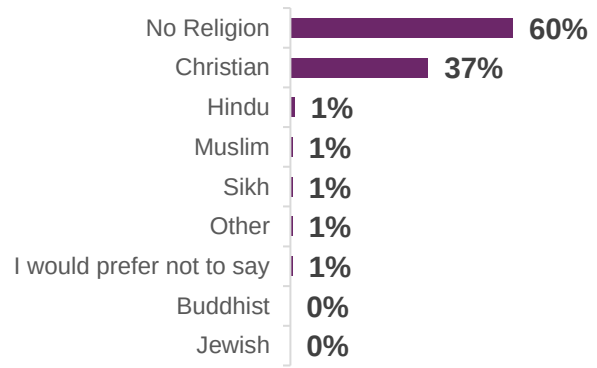
41% average trust response rate

61% response rate for your trust for 2022

## ETHNICITY

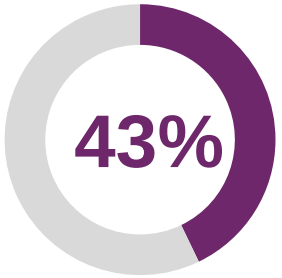



## RELIGION




## PARITY

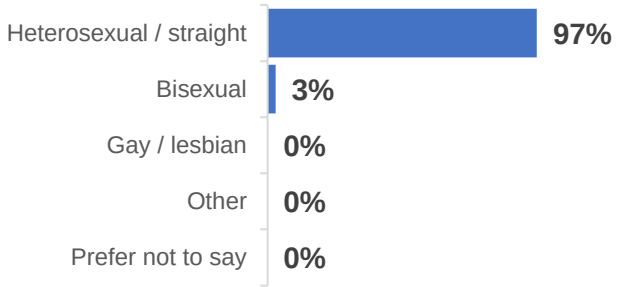
How many babies have you given birth to before this pregnancy?



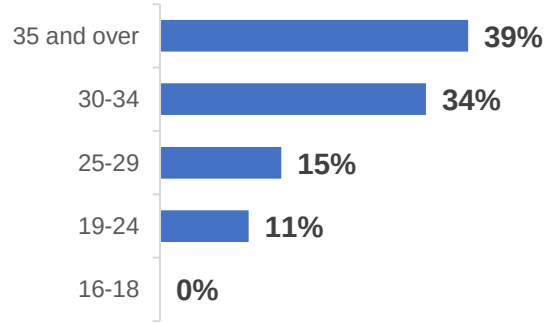

of respondents gave birth to **their first baby.**

## SEXUALITY

Which of the following best describes how you think of yourself?




## AGE

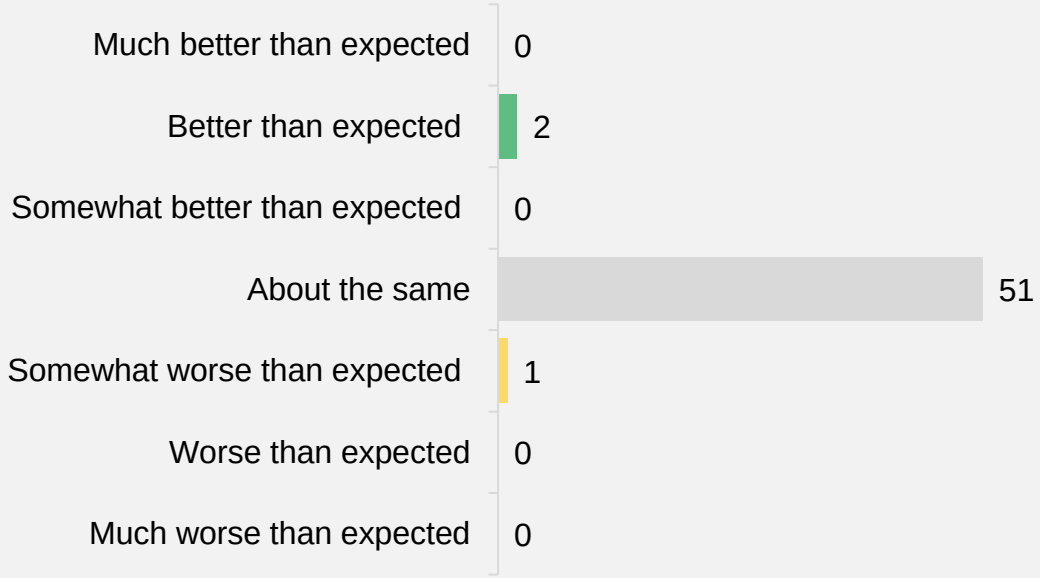



Please note that demographic information is unweighted.

# Summary of findings for your trust

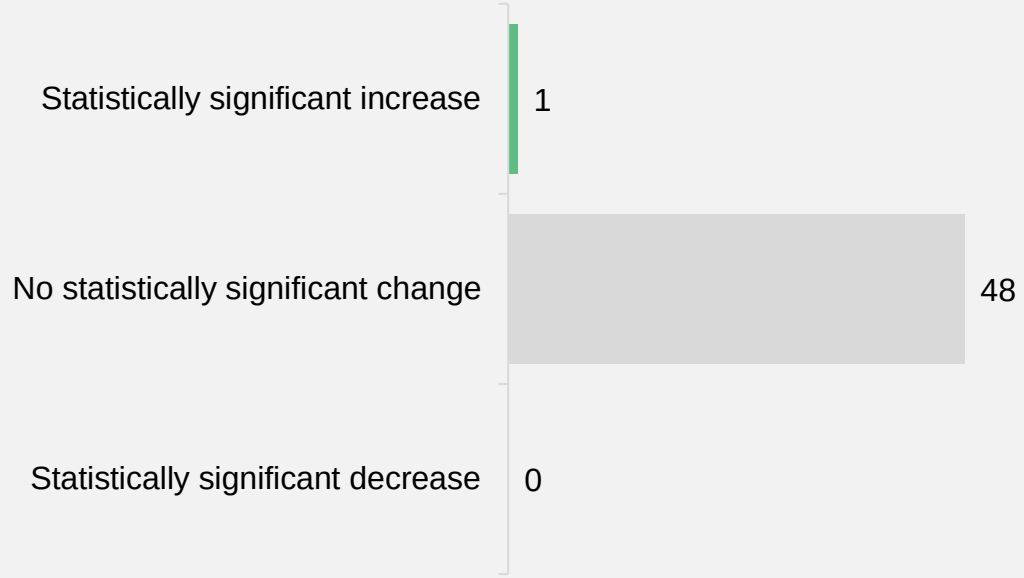
## Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.




## Comparison with results from 2022

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2022 results.




For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

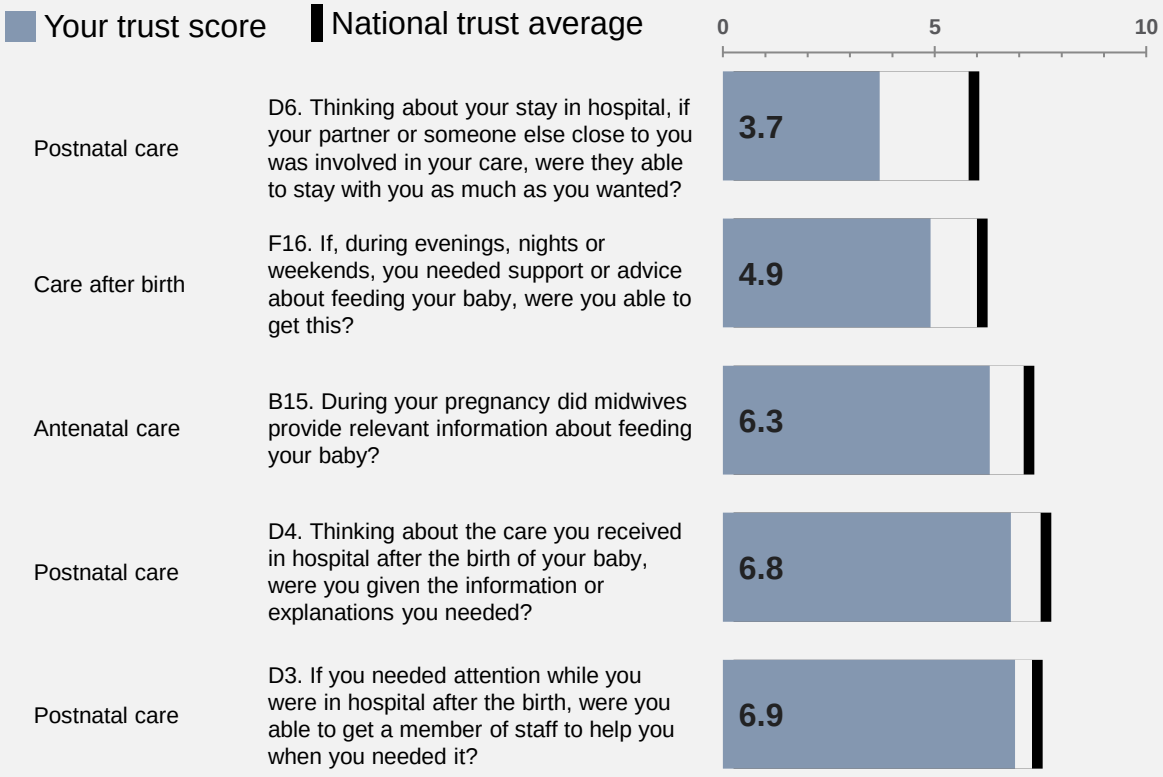
# Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

**Top five scores** (compared with average trust score across England)


**Bottom five scores** (compared with average trust score across England)



# Benchmarking

**This section includes:**

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts
- for more guidance on interpreting these graphs, please refer to the appendix

# Benchmarking

# Antenatal care

NHS

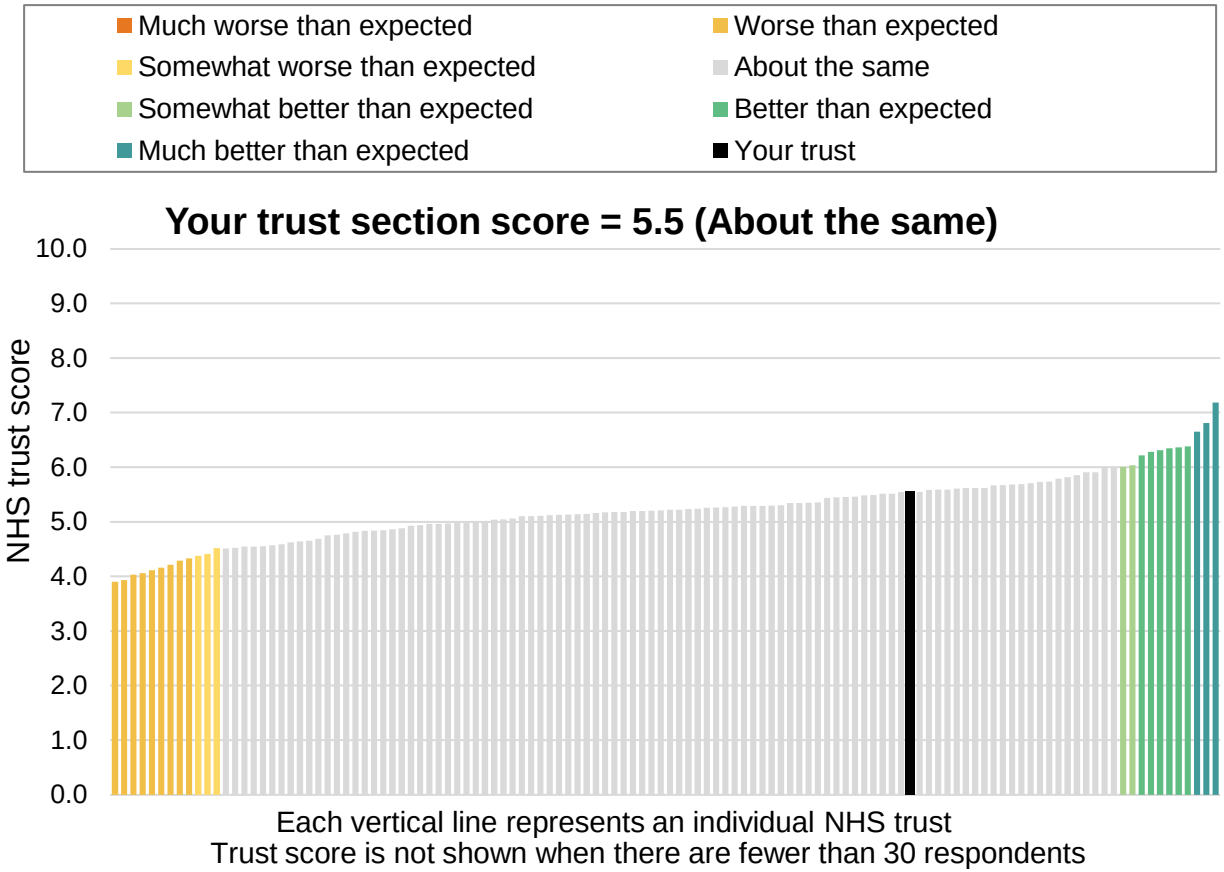
Care Quality Commission

Ipsos

# The start of your care during pregnancy

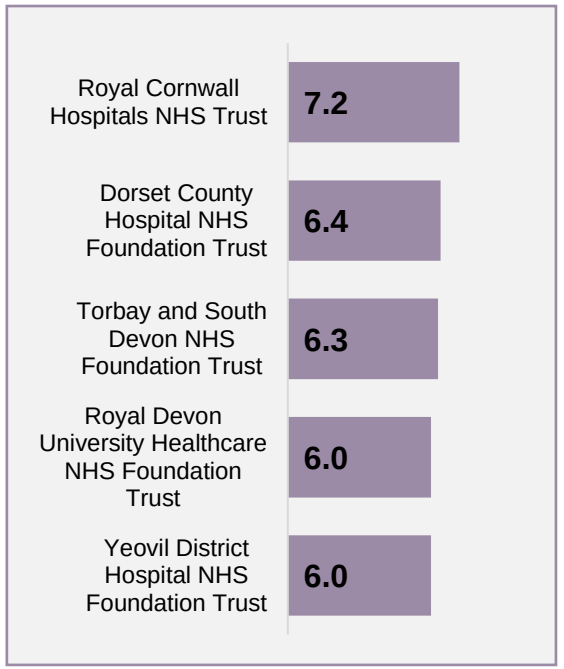
## Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

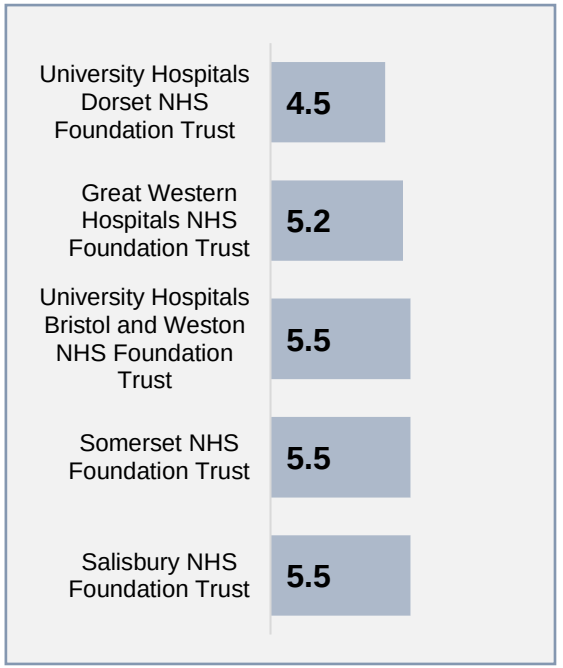



## Comparison with other trusts within your region

### Trusts with the highest scores



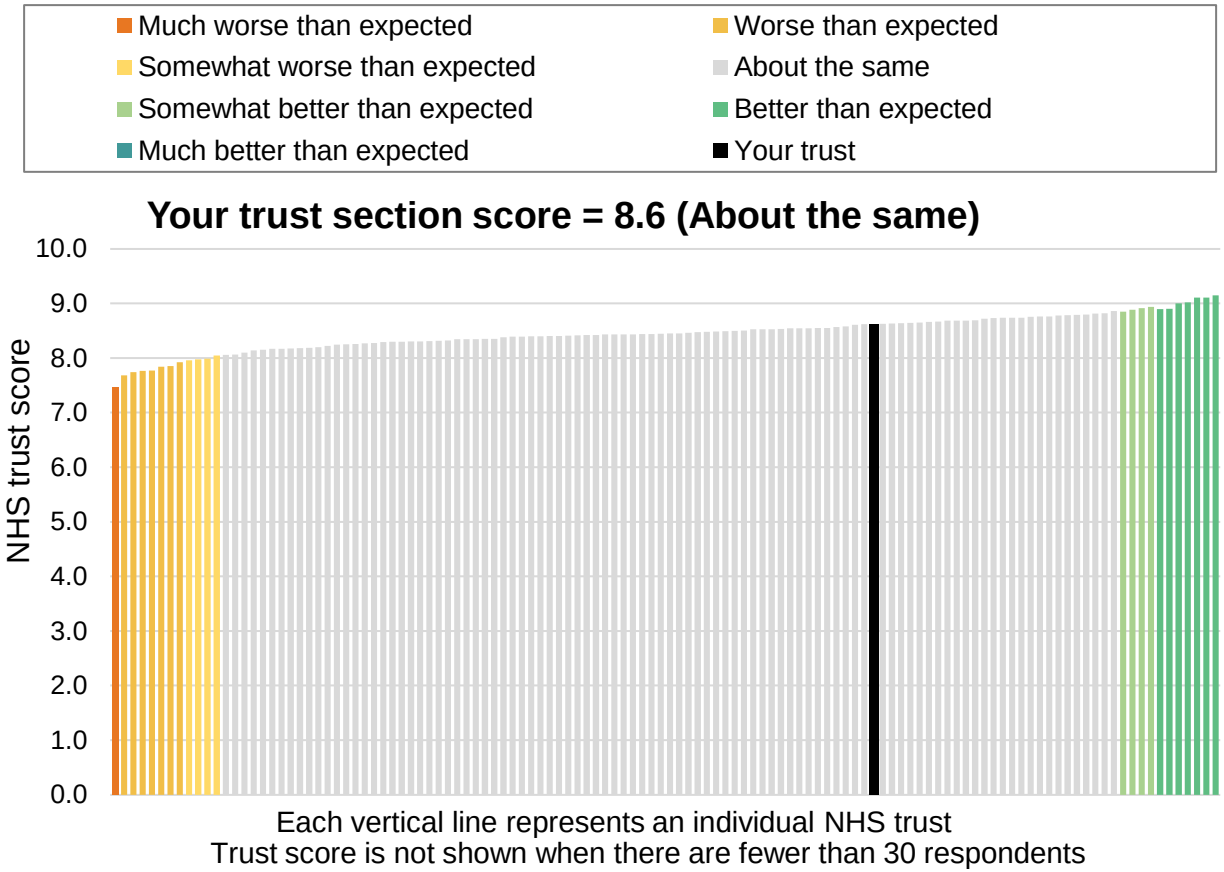

### Trusts with the lowest scores



# Antenatal check-ups

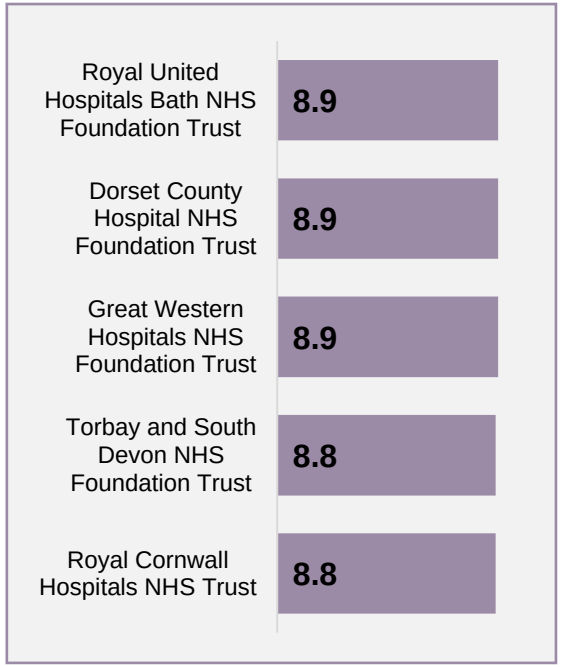
## Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B7 to B10. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

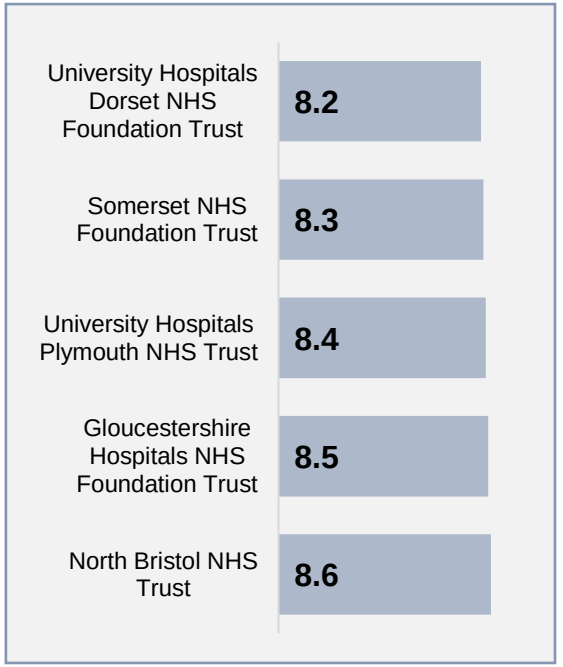



## Comparison with other trusts within your region

### Trusts with the highest scores




### Trusts with the lowest scores



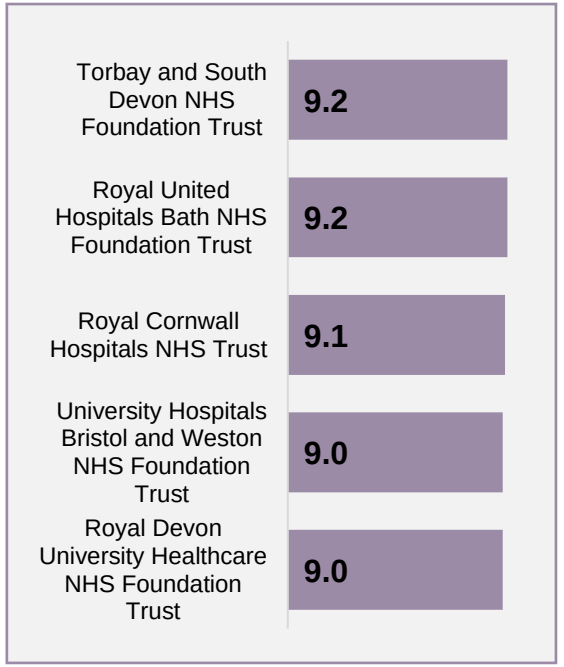
# During your pregnancy

## Section score

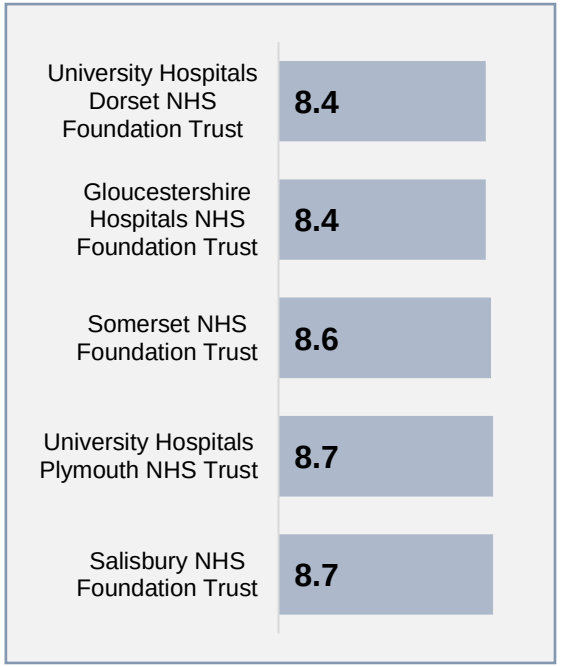
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B11 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.


## Comparison with other trusts within your region

### Trusts with the highest scores

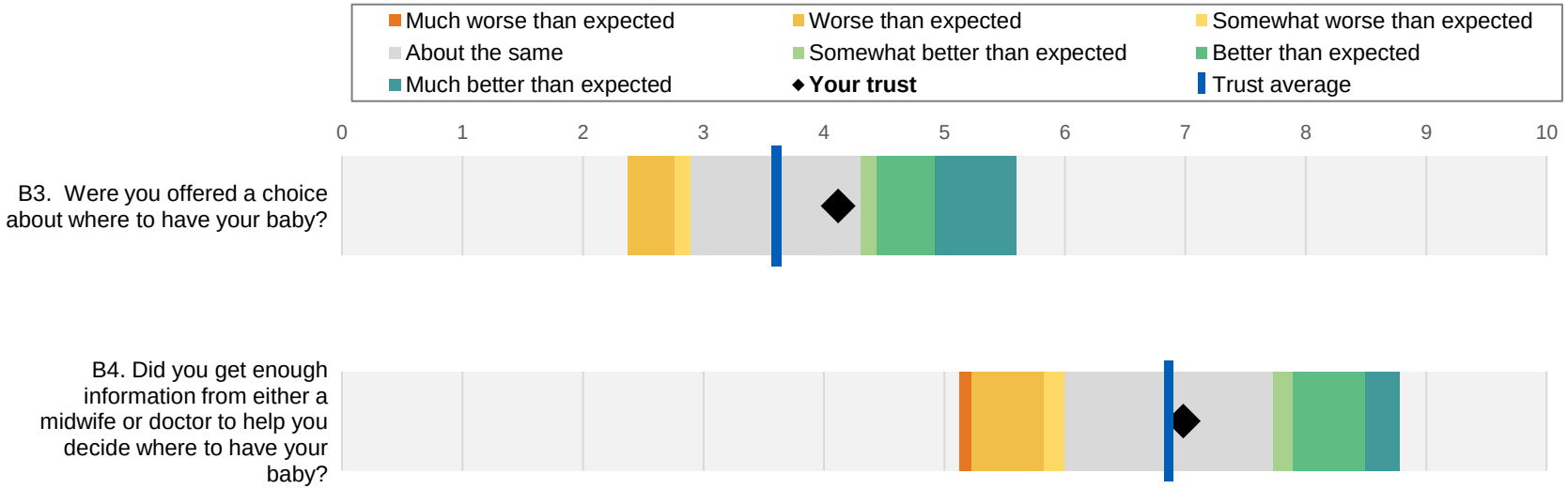



### Trusts with the lowest scores



# Benchmarking - Antenatal care

## Question scores: Start of your pregnancy

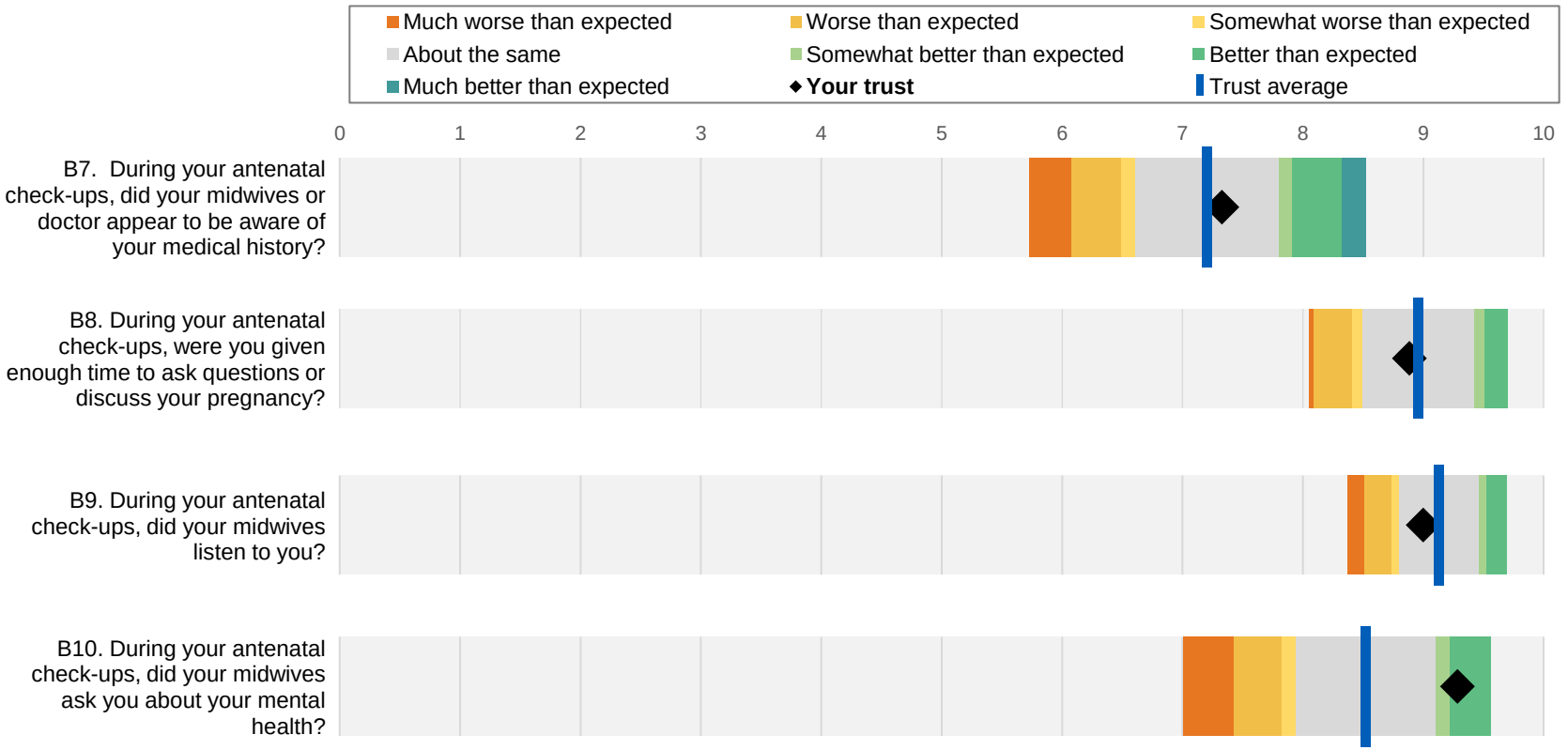



| | | All trusts in England | | |
|---|---|---|---|---|
| Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| 134 | 4.1 | 3.6 | 2.4 | 5.6 |
| 149 | 7.0 | 6.9 | 5.1 | 8.8 |

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Antenatal care (continued)

## Question scores: Antenatal check-ups




| | | | All trusts in England | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| About the same | 155 | 7.3 | 7.2 | 5.7 | 8.5 |
| About the same | 156 | 8.9 | 9.0 | 8.1 | 9.7 |
| About the same | 156 | 9.0 | 9.1 | 8.4 | 9.7 |
| Better | 156 | 9.3 | 8.5 | 7.0 | 9.6 |

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Antenatal care (continued)

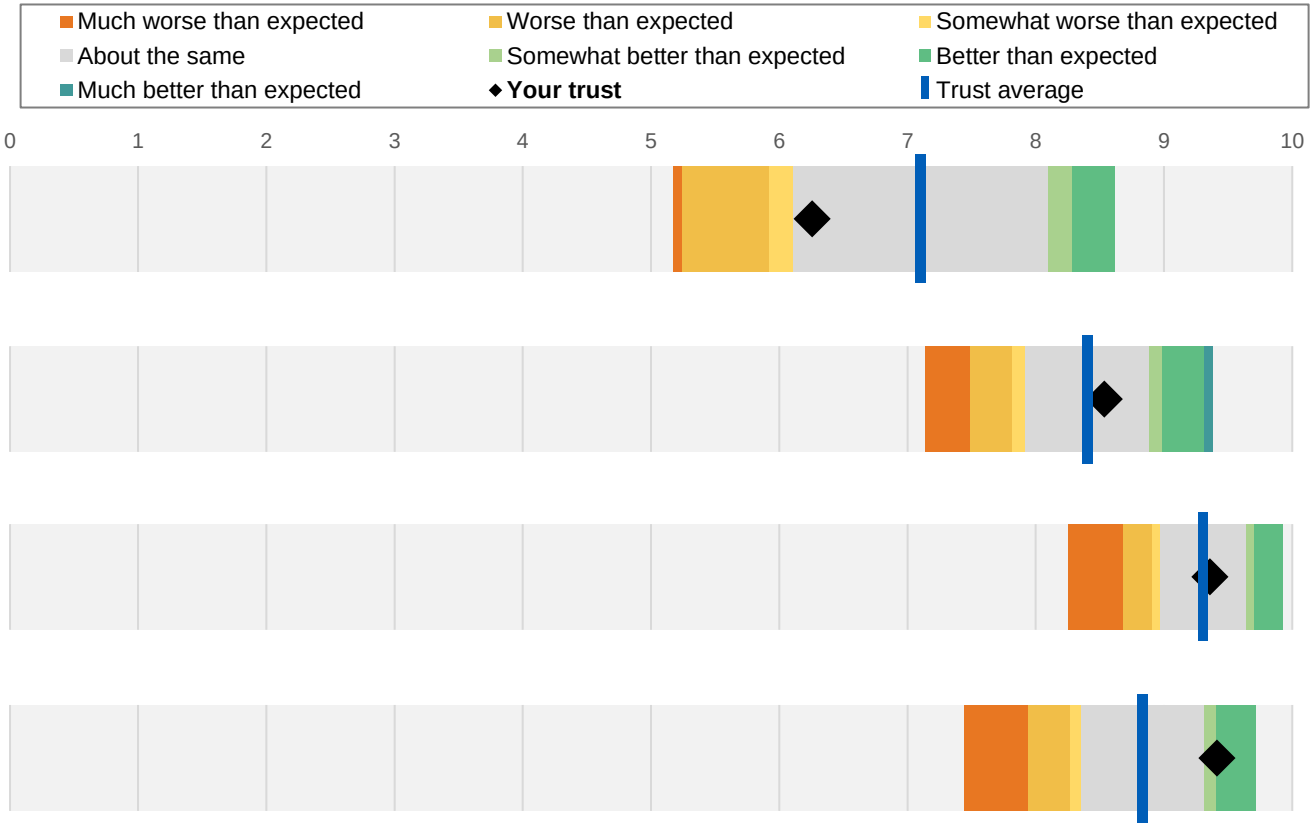
## Question scores: During your pregnancy


| | | All trusts in England | | | | |
|---|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score | |
| B11. Were you given enough support for your mental health during your pregnancy? | 107 | 9.1 | 8.8 | 7.6 | 9.7 | About the same |
| B12. During your pregnancy, if you contacted a midwifery team, were you given the help you needed? | 149 | 8.7 | 8.4 | 7.1 | 9.3 | About the same |
| B13. Thinking about your antenatal care, were you spoken to in a way you could understand? | 156 | 9.4 | 9.4 | 8.8 | 9.9 | About the same |
| B14. Thinking about your antenatal care, were you involved in decisions about your care? | 153 | 9.0 | 8.9 | 8.2 | 9.6 | About the same |

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Antenatal care (continued)

## Question scores: During your pregnancy




| | | | All trusts in England | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| B15. During your pregnancy did midwives provide relevant information about feeding your baby? | 151 | 6.3 | 7.1 | 5.2 | 8.6 |
| B16. Did you have confidence and trust in the staff caring for you during your antenatal care? | 156 | 8.5 | 8.4 | 7.1 | 9.4 |
| B17. Thinking about your antenatal care, were you treated with respect and dignity? | 156 | 9.4 | 9.3 | 8.3 | 9.9 |
| B18. If you raised a concern during your antenatal care, did you feel that it was taken seriously? | 106 | 9.4 | 8.8 | 7.4 | 9.7 |

About the same

About the same

About the same

Better

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking

# Labour and birth

NHS

CareQuality Commission

Ipsos

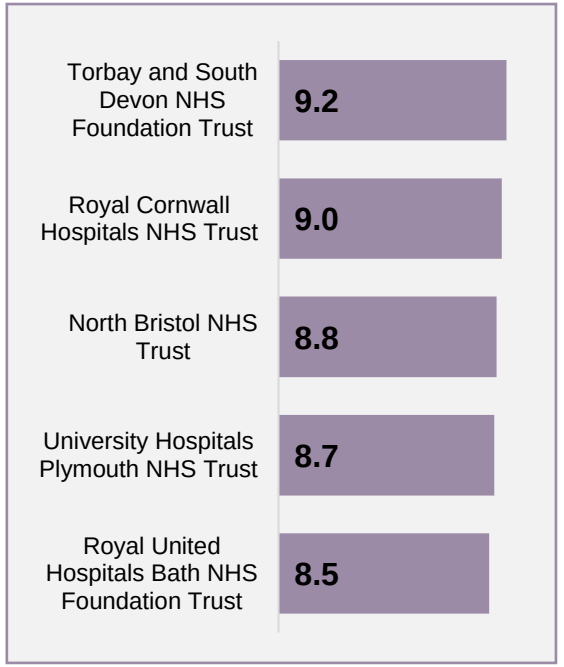
# Your labour and birth

## Section score

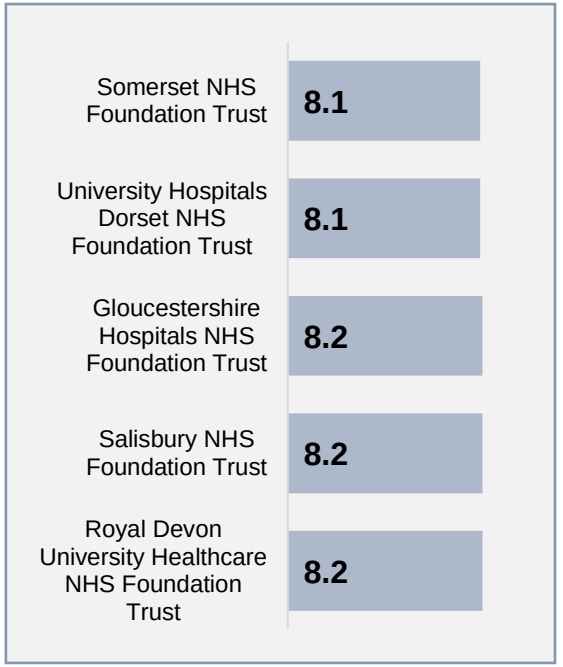
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.


## Comparison with other trusts within your region

### Trusts with the highest scores




### Trusts with the lowest scores

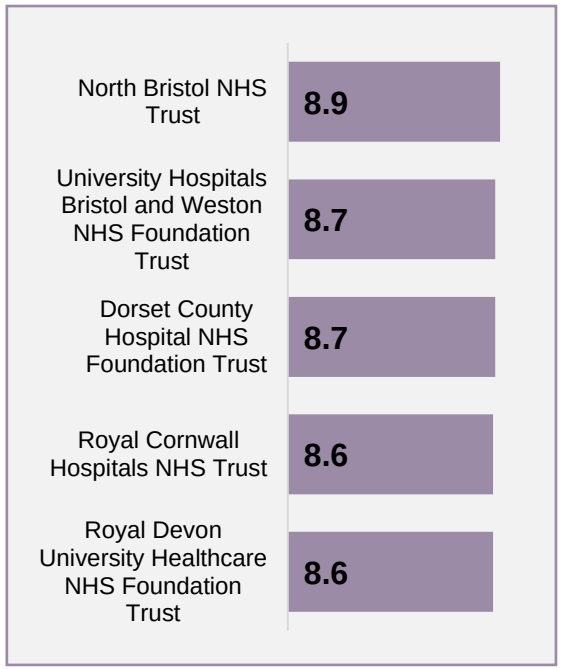


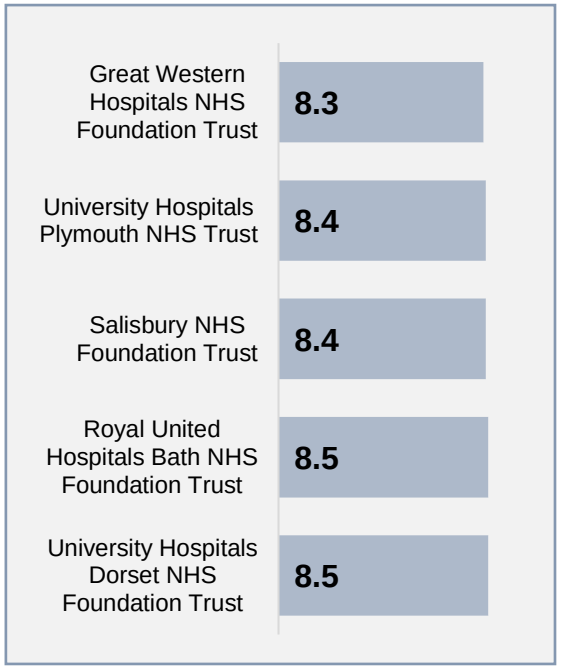
# Staff caring for you

## Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 and C12 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.


## Comparison with other trusts within your region

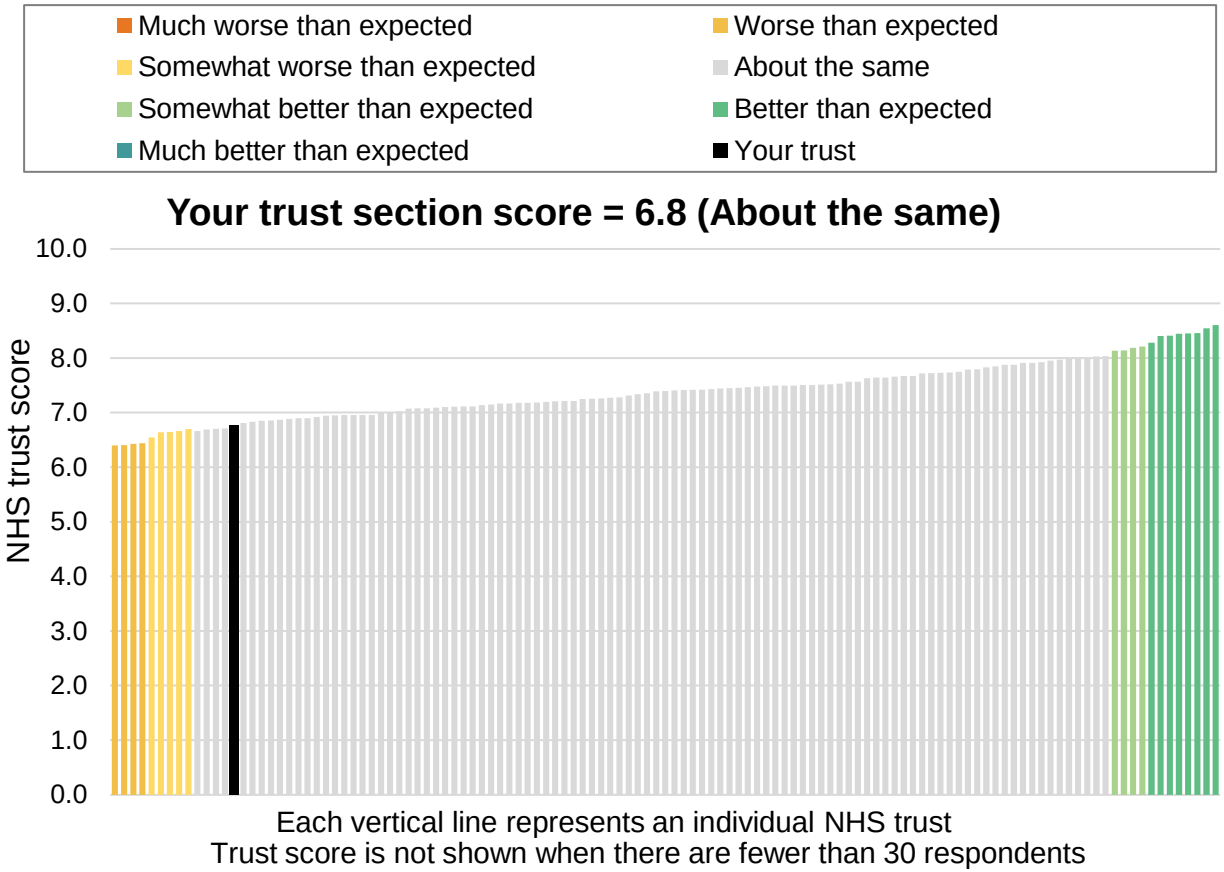


# Care in the ward after birth

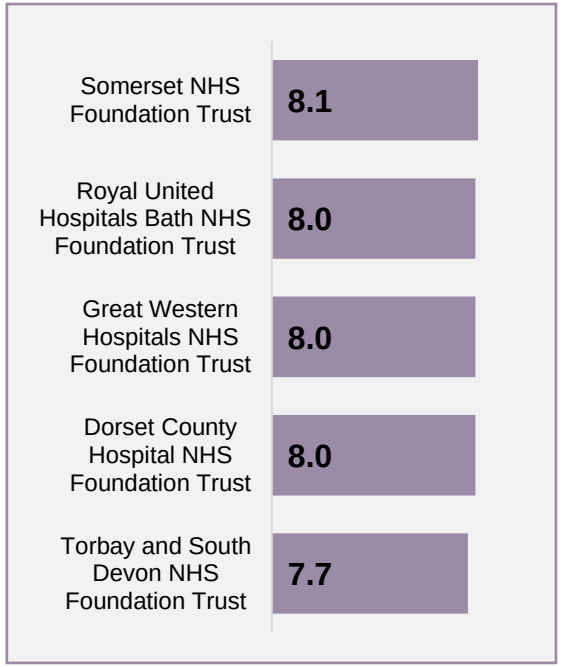
## Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, ‘care in the ward after birth’ is calculated from questions D2 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The ‘expected range’ analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

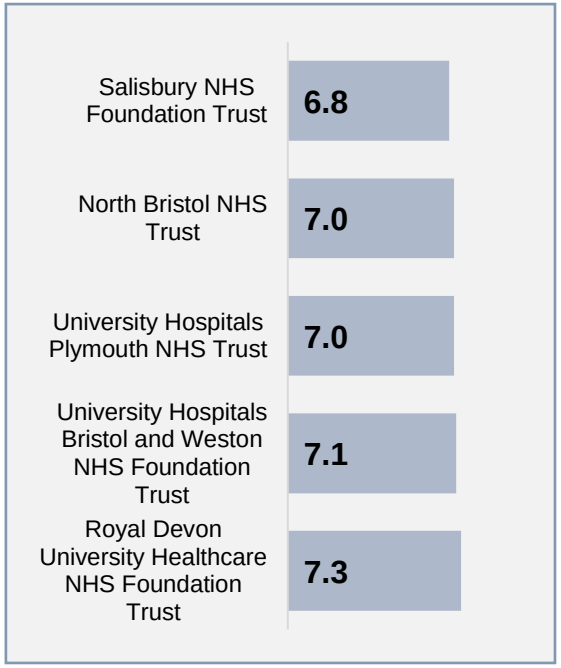



## Comparison with other trusts within your region

### Trusts with the highest scores

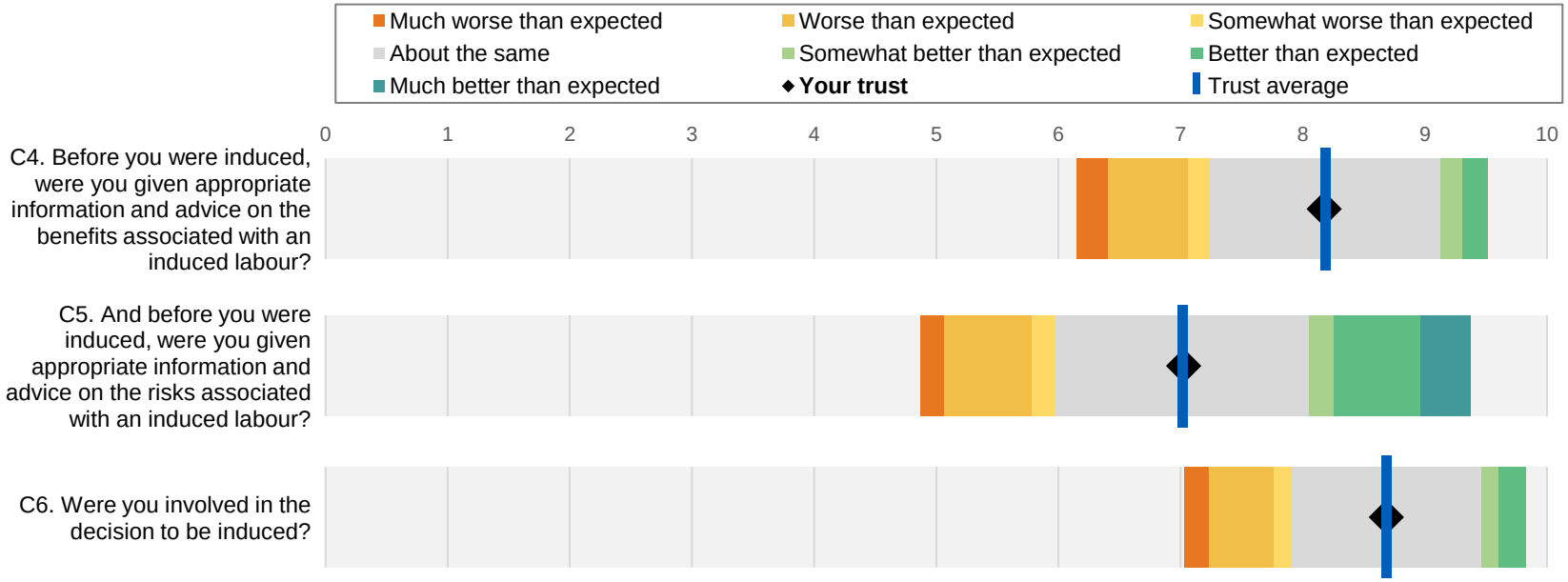



### Trusts with the lowest scores



# Benchmarking - Labour and birth

## Question scores: Your labour and birth

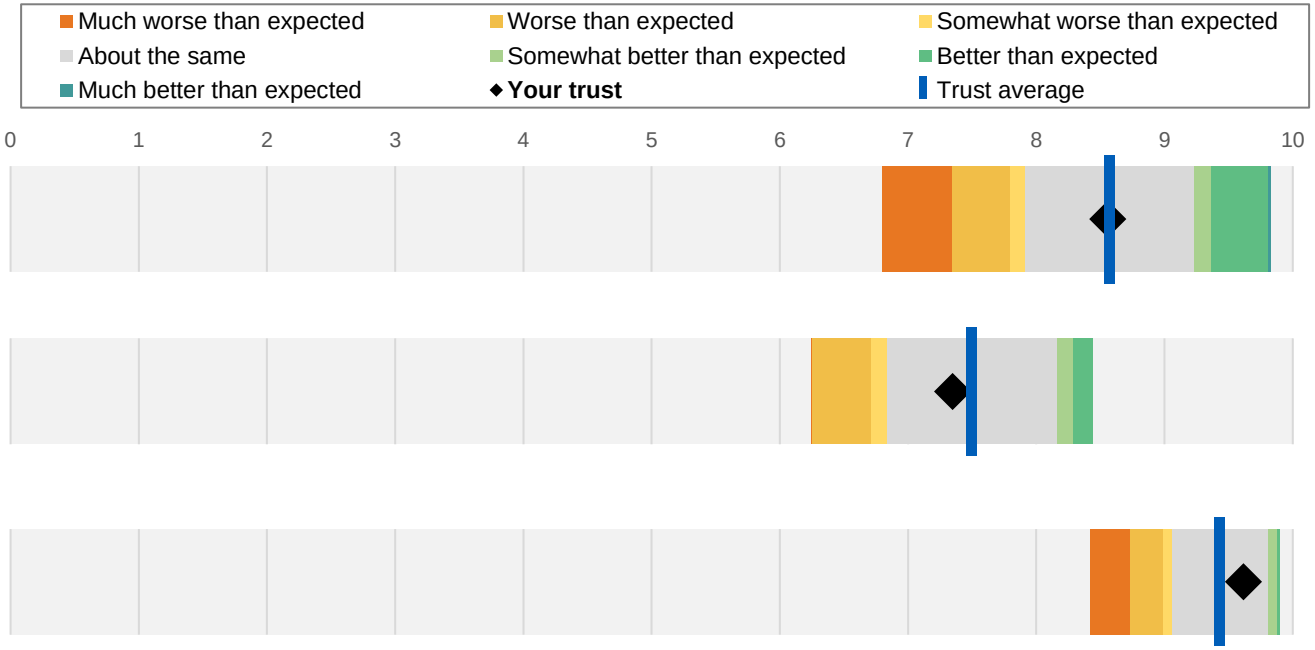



| | | | All trusts in England | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| About the same | 60 | 8.2 | 8.2 | 6.1 | 9.5 |
| About the same | 60 | 7.0 | 7.0 | 4.9 | 9.4 |
| About the same | 60 | 8.7 | 8.7 | 7.0 | 9.8 |

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Labour and birth (continued)

## Question scores: Your labour and birth




| | | All trusts in England | | | | |
|---|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score | |
| C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital? | 112 | 8.6 | 8.6 | 6.8 | 9.8 | About the same |
| C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth? | 133 | 7.3 | 7.5 | 6.2 | 8.4 | About the same |
| C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted? | 163 | 9.6 | 9.4 | 8.4 | 9.9 | About the same |

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Labour and birth (continued)

## Question scores: Staff caring for you

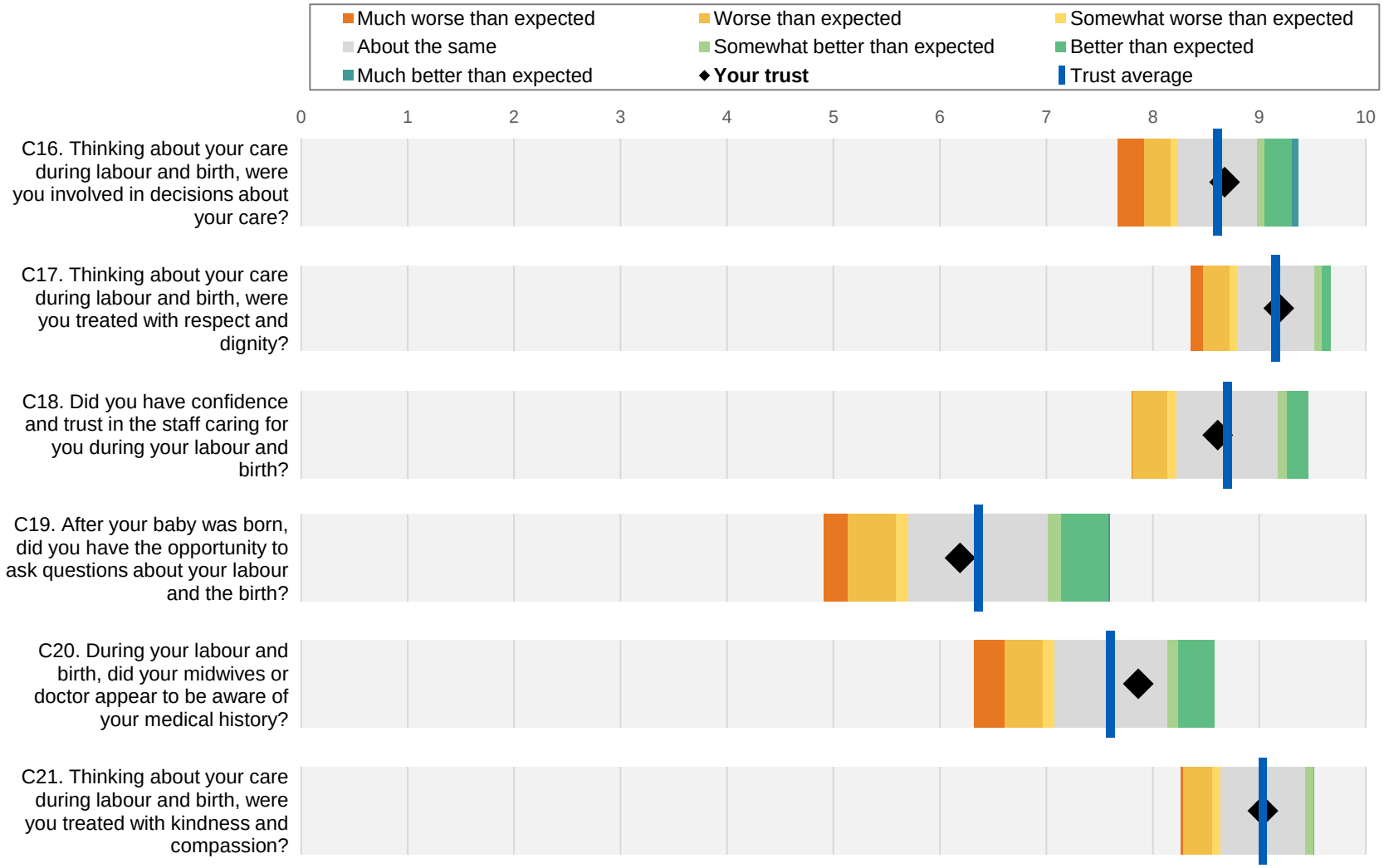

| | | All trusts in England | | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| C10. Did the staff treating and examining you introduce themselves? | 164 | 9.1 | 9.1 | 8.5 | 9.7 |
| C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? | 168 | 7.8 | 7.5 | 6.1 | 8.8 |
| C13. If you raised a concern during labour and birth, did you feel that it was taken seriously? | 102 | 8.2 | 8.1 | 7.0 | 9.3 |
| C14. During labour and birth, were you able to get a member of staff to help you when you needed it? | 165 | 8.6 | 8.6 | 7.6 | 9.3 |
| C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand? | 168 | 9.4 | 9.3 | 8.8 | 9.8 |

About the same

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Labour and birth (continued)

## Question scores: Staff caring for you



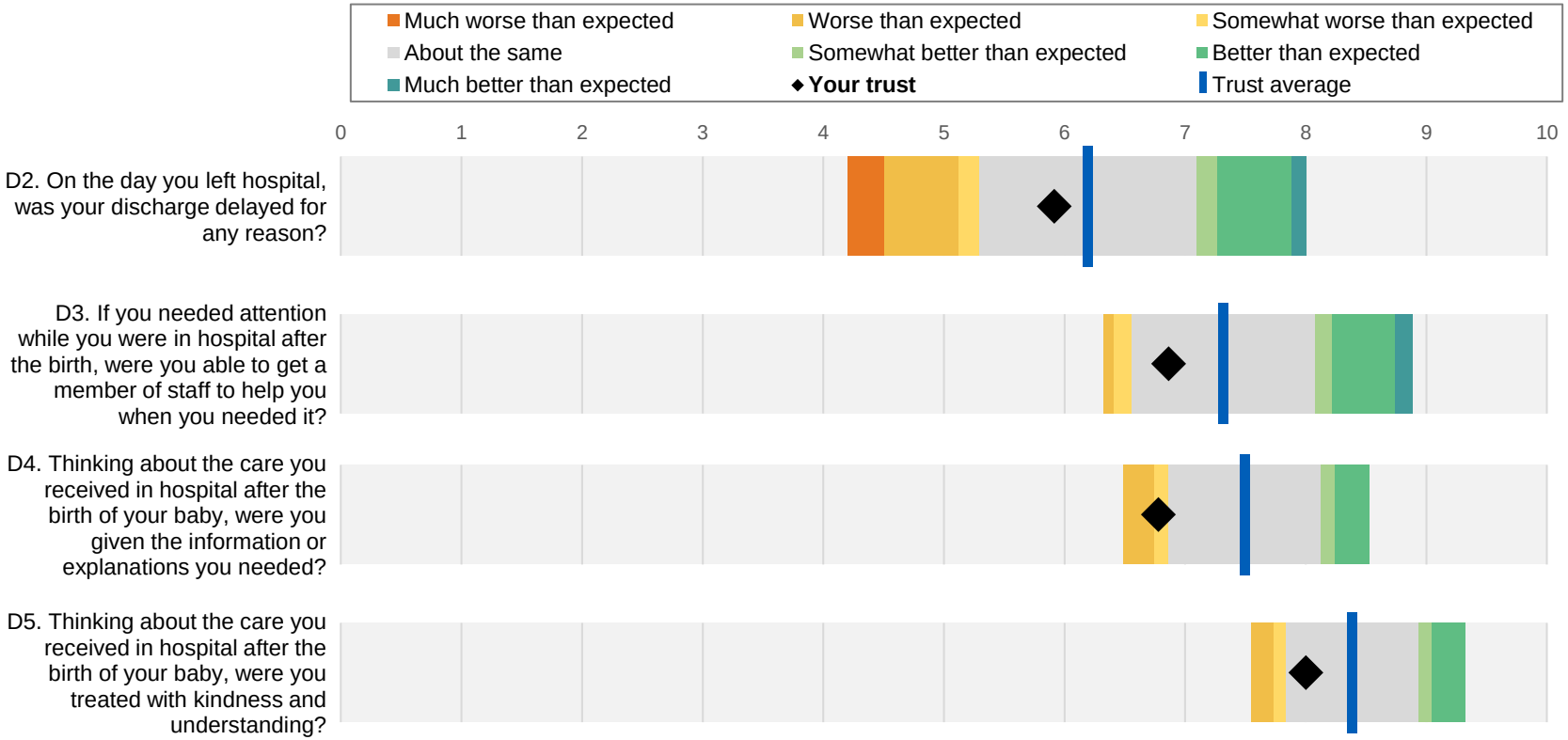

| | | | All trusts in England | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| C16. Thinking about your care during labour and birth, were you involved in decisions about your care? | 168 | 8.7 | 8.6 | 7.7 | 9.4 |
| C17. Thinking about your care during labour and birth, were you treated with respect and dignity? | 168 | 9.2 | 9.2 | 8.4 | 9.7 |
| C18. Did you have confidence and trust in the staff caring for you during your labour and birth? | 167 | 8.6 | 8.7 | 7.8 | 9.5 |
| C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth? | 143 | 6.2 | 6.4 | 4.9 | 7.6 |
| C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history? | 150 | 7.9 | 7.6 | 6.3 | 8.6 |
| C21. Thinking about your care during labour and birth, were you treated with kindness and compassion? | 168 | 9.0 | 9.0 | 8.3 | 9.5 |

About the same

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Labour and birth (continued)

## Question scores: Care in the ward after birth

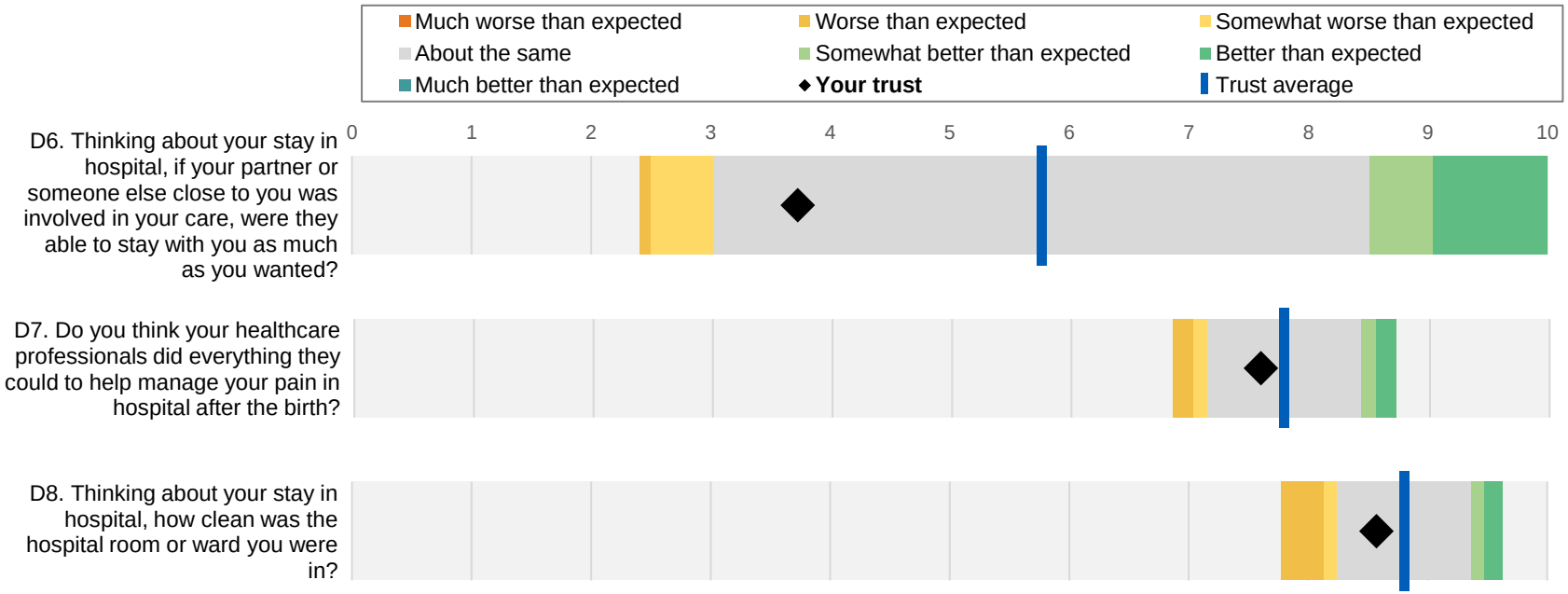



| | | | All trusts in England | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| About the same | 162 | 5.9 | 6.2 | 4.2 | 8.0 |
| About the same | 148 | 6.9 | 7.3 | 6.3 | 8.9 |
| Somewhat worse | 161 | 6.8 | 7.5 | 6.5 | 8.5 |
| About the same | 162 | 8.0 | 8.4 | 7.5 | 9.3 |

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Labour and birth (continued)

## Question scores: Care in the ward after birth




| | | | All trusts in England | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? | 155 | 3.7 | 5.8 | 2.4 | 10.0 |
| D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth? | 147 | 7.6 | 7.8 | 6.8 | 8.7 |
| D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in? | 161 | 8.6 | 8.8 | 7.8 | 9.6 |

About the same

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking

# Postnatal care

NHS

Care Quality Commission

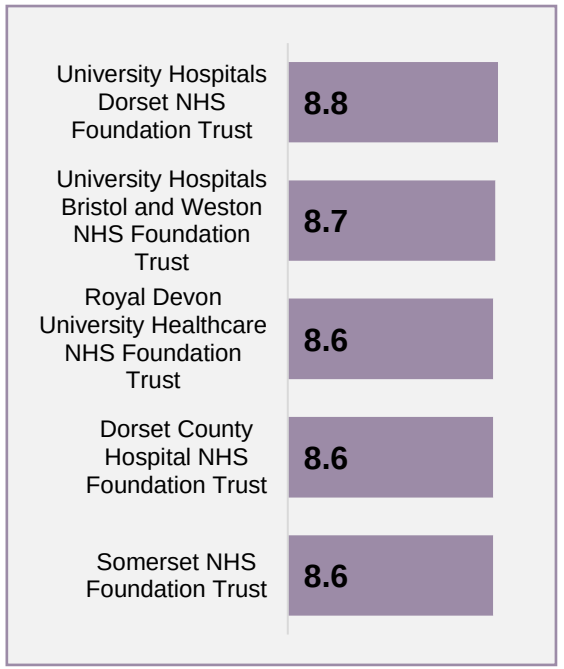
Ipsos

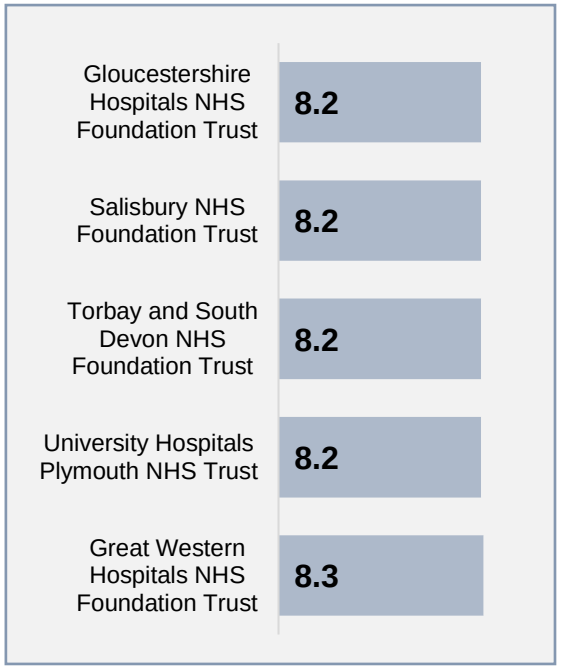
# Feeding your baby

## Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.


## Comparison with other trusts within your region



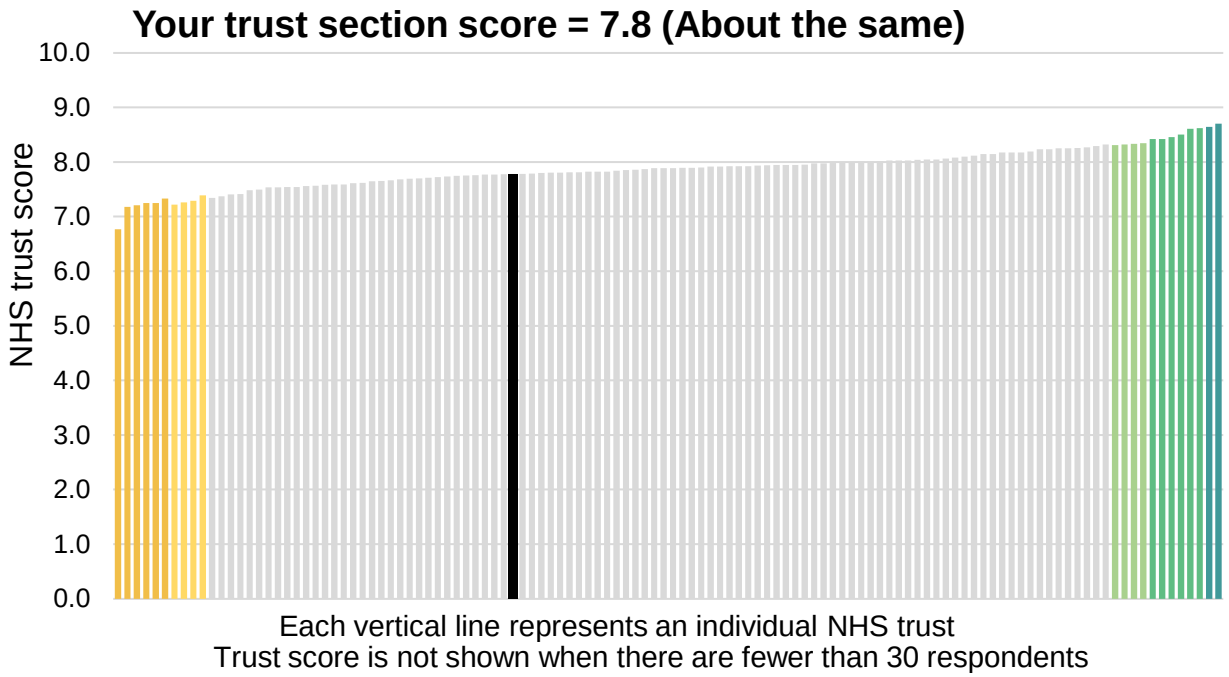



# Care at home after birth

## Section score

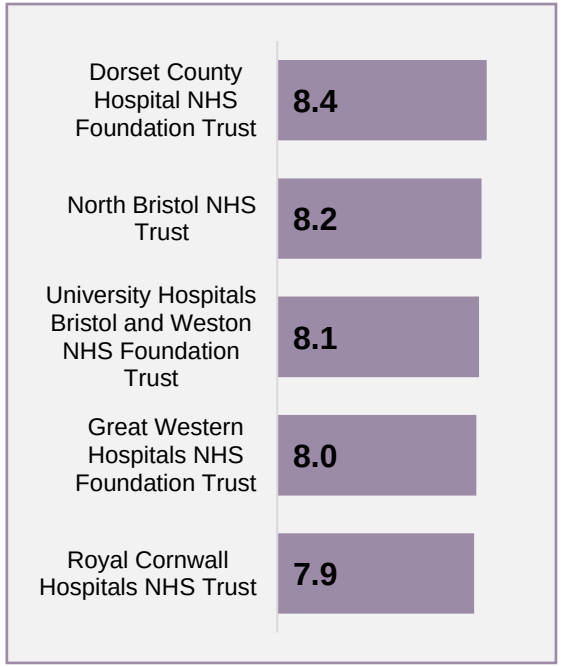
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F5 to F9 and F11 to F17. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust

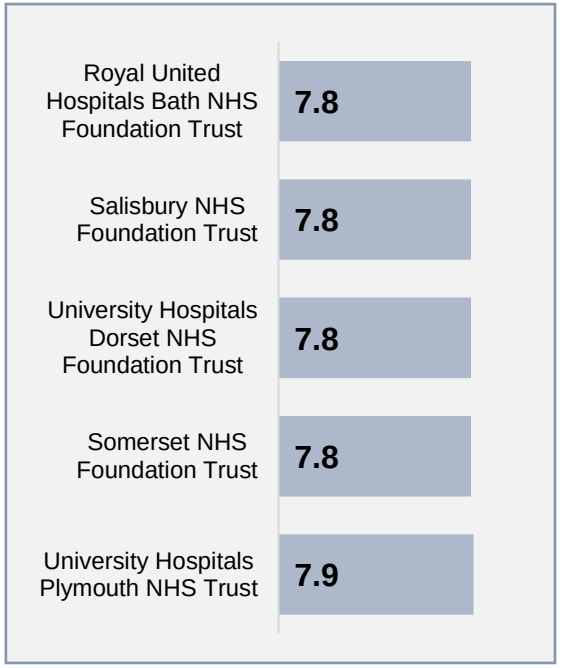



## Comparison with other trusts within your region

### Trusts with the highest scores

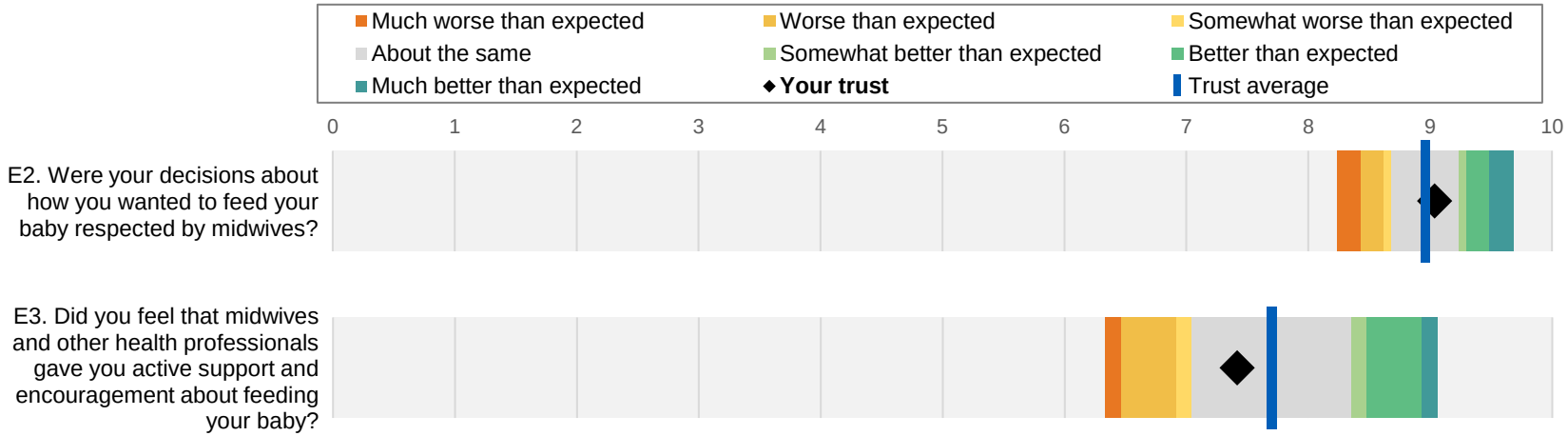



### Trusts with the lowest scores



# Benchmarking - Postnatal care

## Question scores: Feeding your baby




| | | All trusts in England | | |
|---|---|---|---|---|
| Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| E2. Were your decisions about how you wanted to feed your baby respected by midwives? | | | | |
| 157 | 9.0 | 9.0 | 8.2 | 9.7 |
| E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby? | | | | |
| 148 | 7.4 | 7.7 | 6.3 | 9.1 |

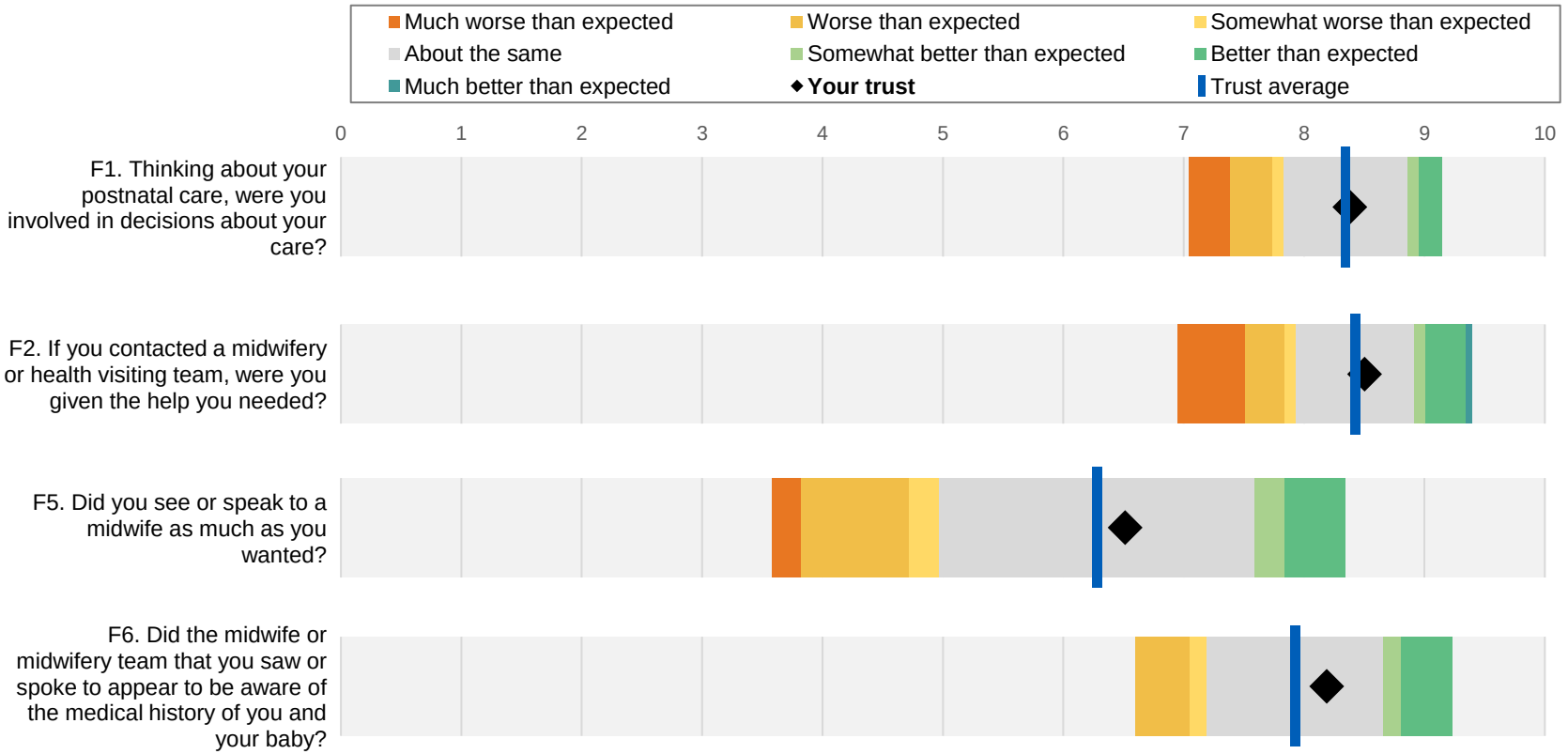
About the same

About the same

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Postnatal care (continued)

## Question scores: Care at home after birth




| | Number of respondents (your trust) | Your trust score | All trusts in England: Trust average score | All trusts in England: Lowest score | All trusts in England: Highest score |
|---|---|---|---|---|---|
| F1. Thinking about your postnatal care, were you involved in decisions about your care? | 151 | 8.4 | 8.3 | 7.0 | 9.1 |
| F2. If you contacted a midwifery or health visiting team, were you given the help you needed? | 130 | 8.5 | 8.4 | 6.9 | 9.4 |
| F5. Did you see or speak to a midwife as much as you wanted? | 145 | 6.5 | 6.3 | 3.6 | 8.3 |
| F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby? | 125 | 8.2 | 7.9 | 6.6 | 9.2 |

About the same

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Postnatal care (continued)

## Question scores: Care at home after birth

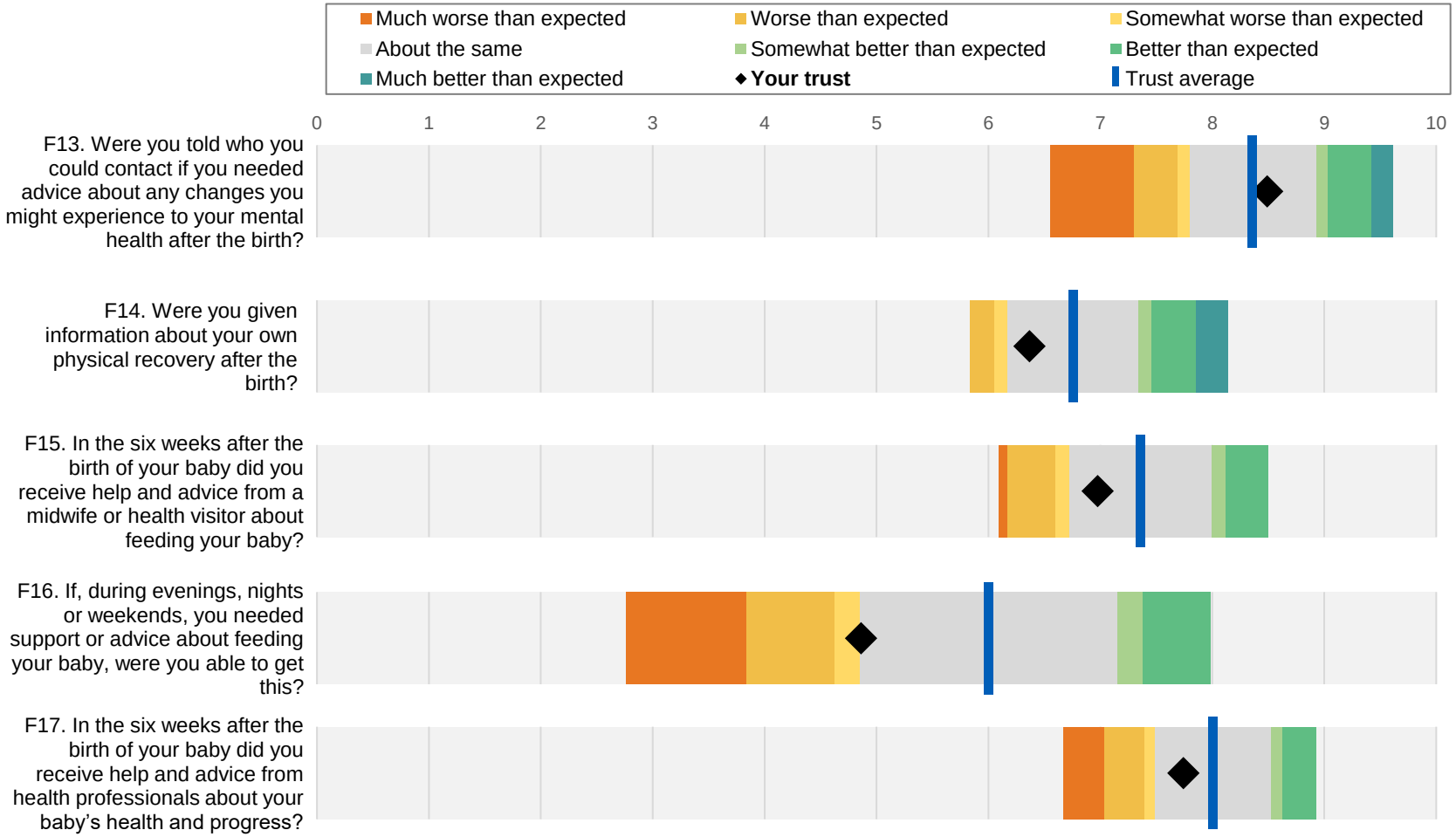

| | | All trusts in England | | | |
|---|---|---|---|---|---|
| | Number of respondents (your trust) | Your trust score | Trust average score | Lowest score | Highest score |
| F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you? | 145 | 8.9 | 8.7 | 7.8 | 9.6 |
| F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice? | 138 | 8.7 | 8.5 | 7.4 | 9.5 |
| F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home? | 145 | 8.6 | 8.4 | 7.5 | 9.2 |
| F11. Did a midwife or health visitor ask you about your mental health? | 153 | 9.7 | 9.7 | 8.8 | 10.0 |
| F12. Were you given information about any changes you might experience to your mental health after having your baby? | 150 | 7.1 | 7.4 | 6.2 | 8.3 |

About the same

Trust score is not shown when there are fewer than 30 respondents.

# Benchmarking - Postnatal care (continued)

## Question scores: Care at home after birth




| | Number of respondents (your trust) | Your trust score | All trusts in England: Trust average score | All trusts in England: Lowest score | All trusts in England: Highest score |
|---|---|---|---|---|---|
| F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth? | 131 | 8.5 | 8.4 | 6.6 | 9.6 |
| F14. Were you given information about your own physical recovery after the birth? | 151 | 6.4 | 6.8 | 5.8 | 8.1 |
| F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby? | 134 | 7.0 | 7.4 | 6.1 | 8.5 |
| F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this? | 56 | 4.9 | 6.0 | 2.8 | 8.0 |
| F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress? | 140 | 7.7 | 8.0 | 6.7 | 8.9 |

Trust score is not shown when there are fewer than 30 respondents.

# Trends over time

**This section includes:**

- your mean trust score for each evaluative question in the survey. This is the average of all scores that maternity service users from your trust provided in their survey response
- where comparable data is available over at least the past five surveys, the trend charts show the mean score for your trust by year. This allows you to see if your trust has made improvements over time
- they also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not
- where consistent data are not available for at least the past five surveys statistical significance testing has been carried out against the 2022 survey results for each relevant question
- for more guidance on interpreting these graphs, please see the next slide

NHS

CareQuality Commission

Ipsos

# Trends over time

The following section presents comparisons with previous survey results. Statistically significant differences in the trust mean score between 2022 and 2023 are highlighted to show where there is meaningful change between years.

**Historical trend charts are presented when there are at least five data points available** to plot on the chart. Five data points may not be available due to:

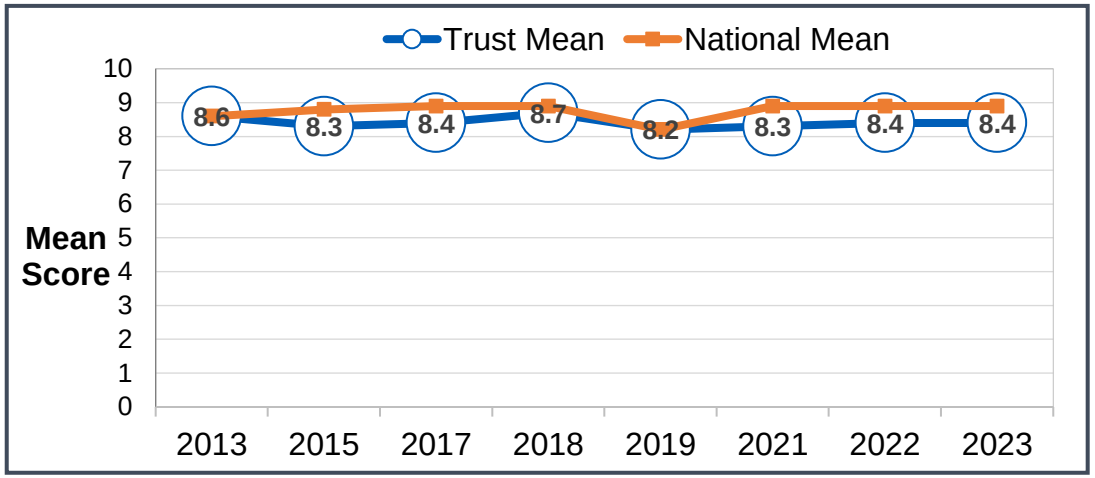
- changes to the questionnaire mean that a question is no longer comparable over time;
- organisational changes which impact comparability of results over time; or,
- historical errors with sampling or issues with fieldwork which impact comparability.

Statistically significant differences in the trust mean score between 2022 and 2023 are highlighted. These are carried out using a two sample t-test. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a filled green circle, and significant decreases are in red.

**Where comparable data is not available, statistical significance test tables are provided.** Statistically significant changes in your trust score between 2022 and 2023 are shown in the far right column 'Change from 2022 survey', significant increases are indicated with a green arrow and significant decreases are indicated with a red arrow.

The following questions were new or changed for 2023 and therefore are not included in this section: B18, C4, C8, C21 and D7.

## Historical trend chart example




## Significance test table example

| | | 2023 Trust Score | 2022 Trust Score | No. of respondents | Change from 2022 survey |
|---|---|---|---|---|---|
| **The start of your care in pregnancy** | | | | | |
| B4. | Did you get enough information from either a midwife or doctor to help you decide where to have your baby? | 4.3 | 7.1 | 178 | ▼ |

# Trends over time

# Antenatal care

# Trends over time - Antenatal care

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |
|---|---|---|---|---|---|---|

| | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|
| **The start of your care in pregnancy** | | | | | |
| B3. | Were you offered a choice about where to have your baby? | 4.1 | 3.4 | 134 | |
| B4. | Did you get enough information from either a midwife or doctor to help you decide where to have your baby? | 7.0 | 6.4 | 149 | |
| B7. | During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history? | 7.3 | 7.0 | 155 | |

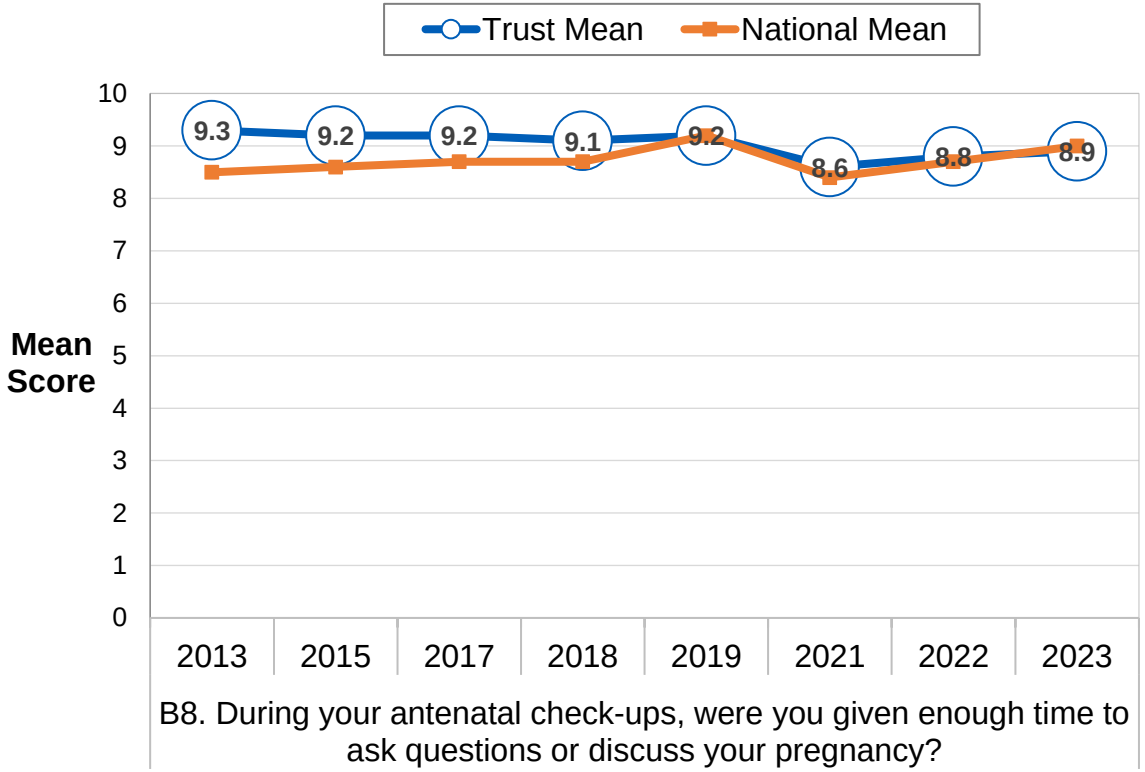
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

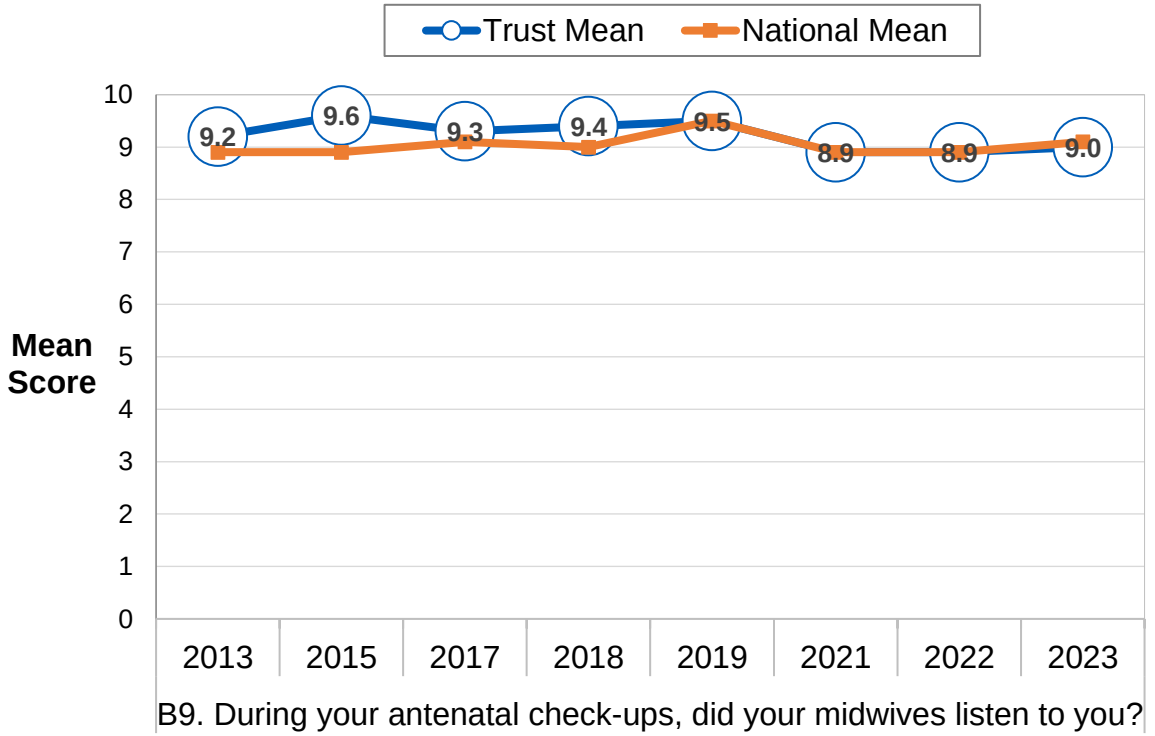
# Trends over time - Antenatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Antenatal check-ups




B8. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?




B9. During your antenatal check-ups, did your midwives listen to you?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|
| **Antenatal check-ups** | | | | | | | | | | |
| B10. During your antenatal check-ups, did your midwives ask you about your mental health? | | | | | | | 9.3 | 9.0 | 156 | |

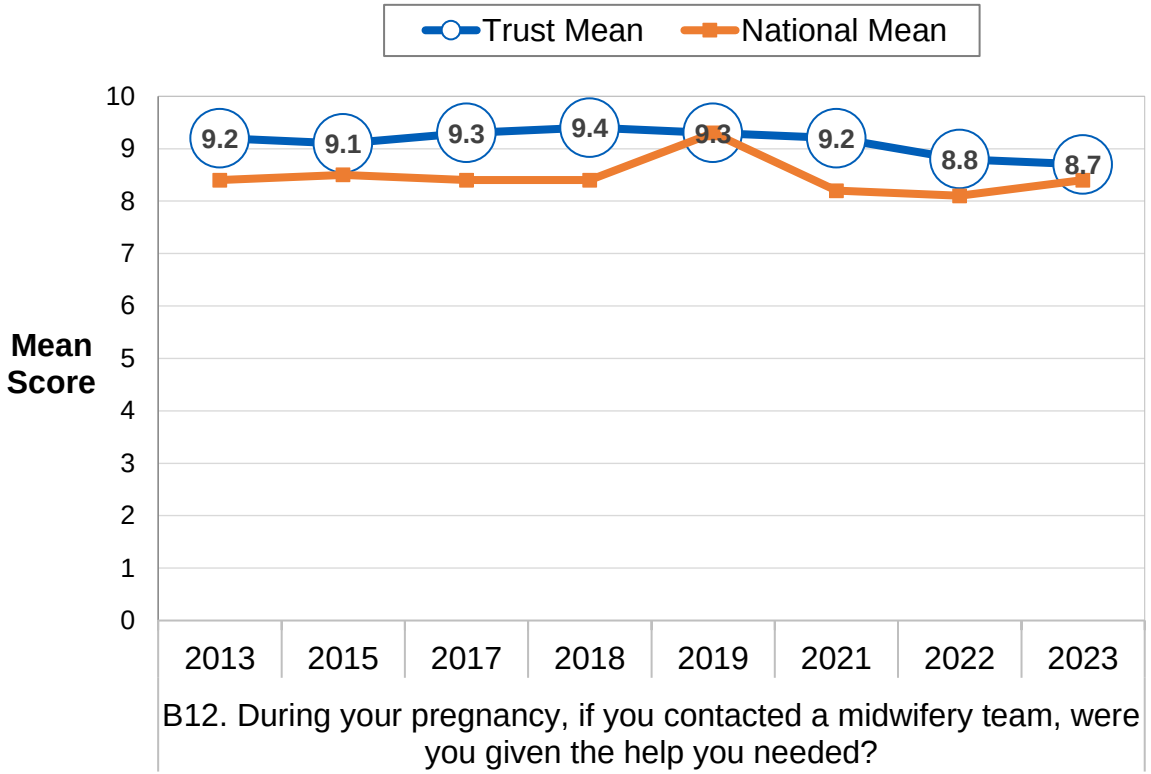
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

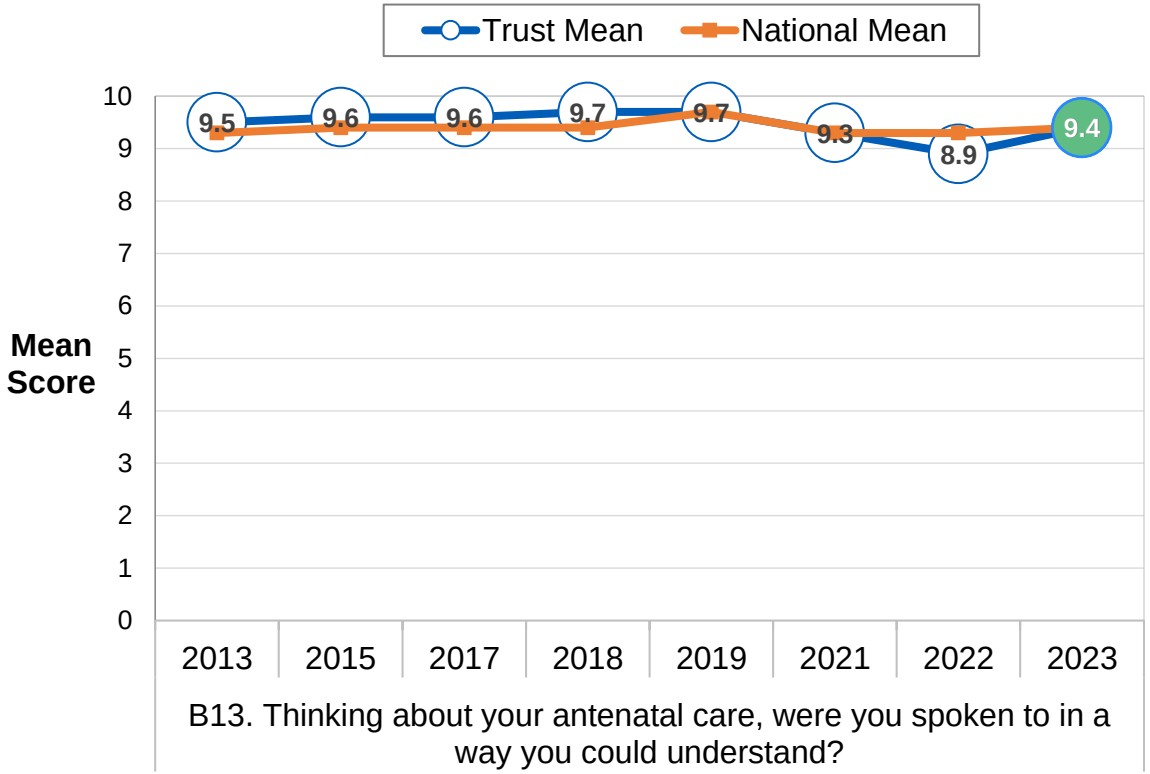
# Trends over time - Antenatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## During your pregnancy




B12. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?




B13. Thinking about your antenatal care, were you spoken to in a way you could understand?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |
|---|---|---|---|---|---|---|

| | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|
| **During your pregnancy** | | | | | |
| B11. | Were you given enough support for your mental health during your pregnancy? | 9.1 | 8.8 | 107 | |
| B14. | Thinking about your antenatal care, were you involved in decisions about your care? | 9.0 | 8.8 | 153 | |
| B15. | During your pregnancy did midwives provide relevant information about feeding your baby? | 6.3 | 6.4 | 151 | |
| B16. | Did you have confidence and trust in the staff caring for you during your antenatal care? | 8.5 | 8.1 | 156 | |
| B17. | Thinking about your antenatal care, were you treated with respect and dignity? | 9.4 | 9.0 | 156 | |

▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

# Trends over time

# Labour and birth

# Trends over time - Labour and birth

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Your labour and birth** | | | | | | | | | | | |
| C5. | And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour? | | | | | | | 7.0 | 6.5 | 60 | |
| C6. | Were you involved in the decision to be induced? | | | | | | | 8.7 | 8.5 | 60 | |

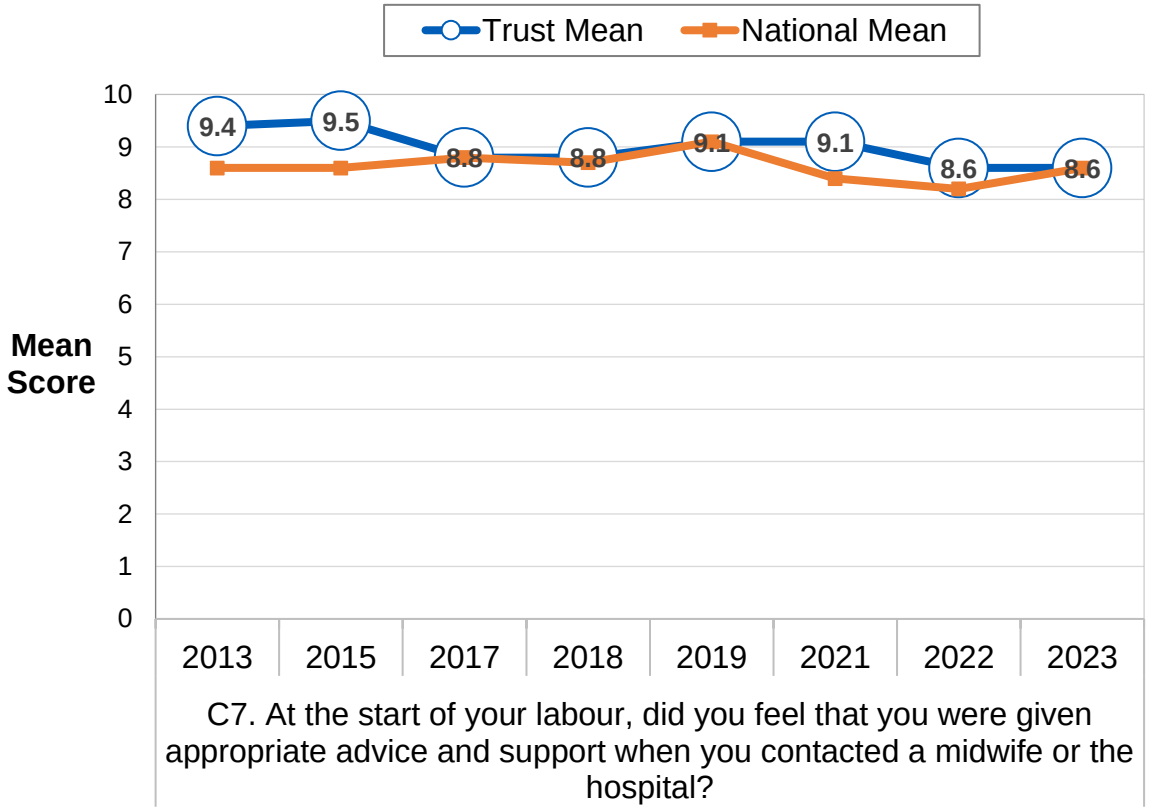
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

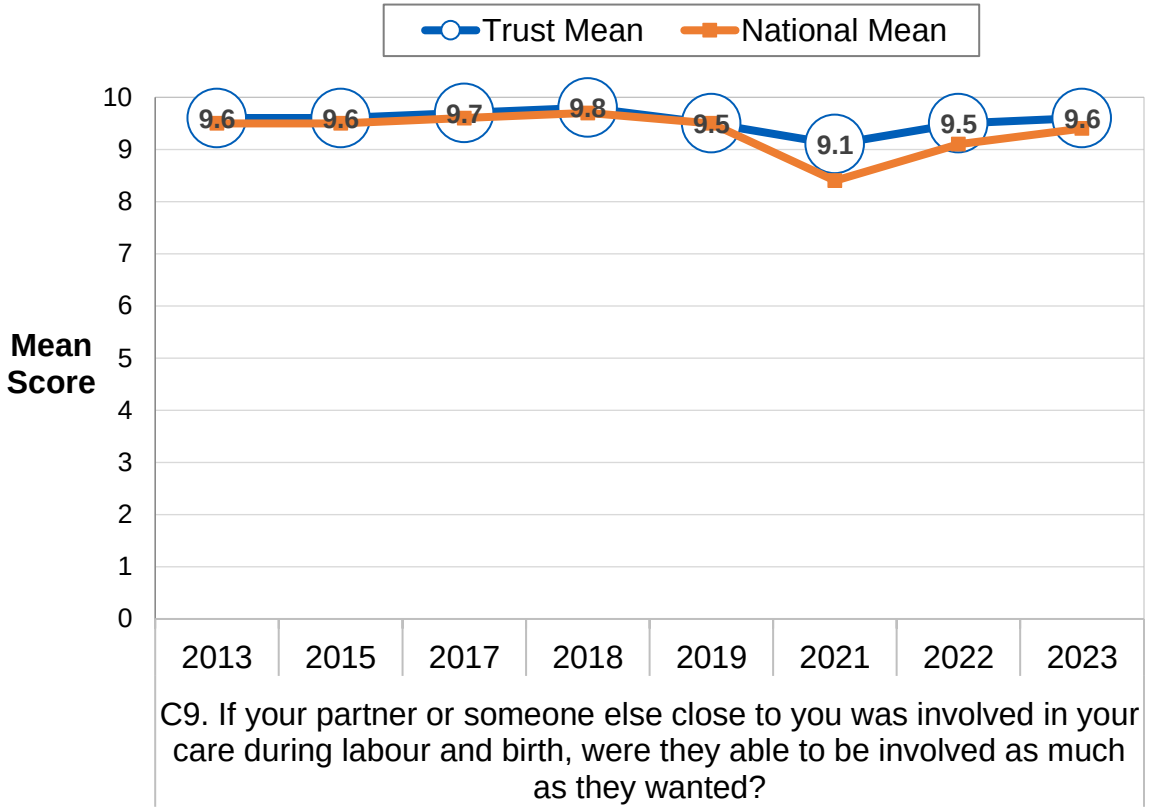
# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Your labour and birth




C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?




C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

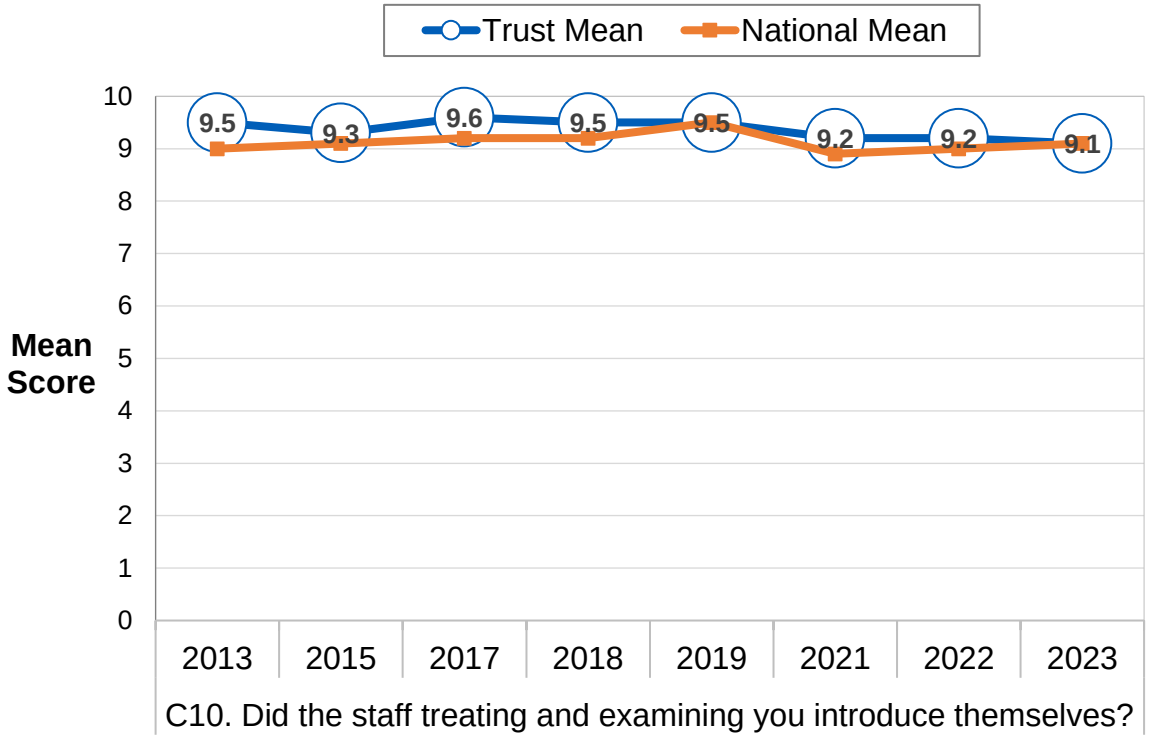
*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

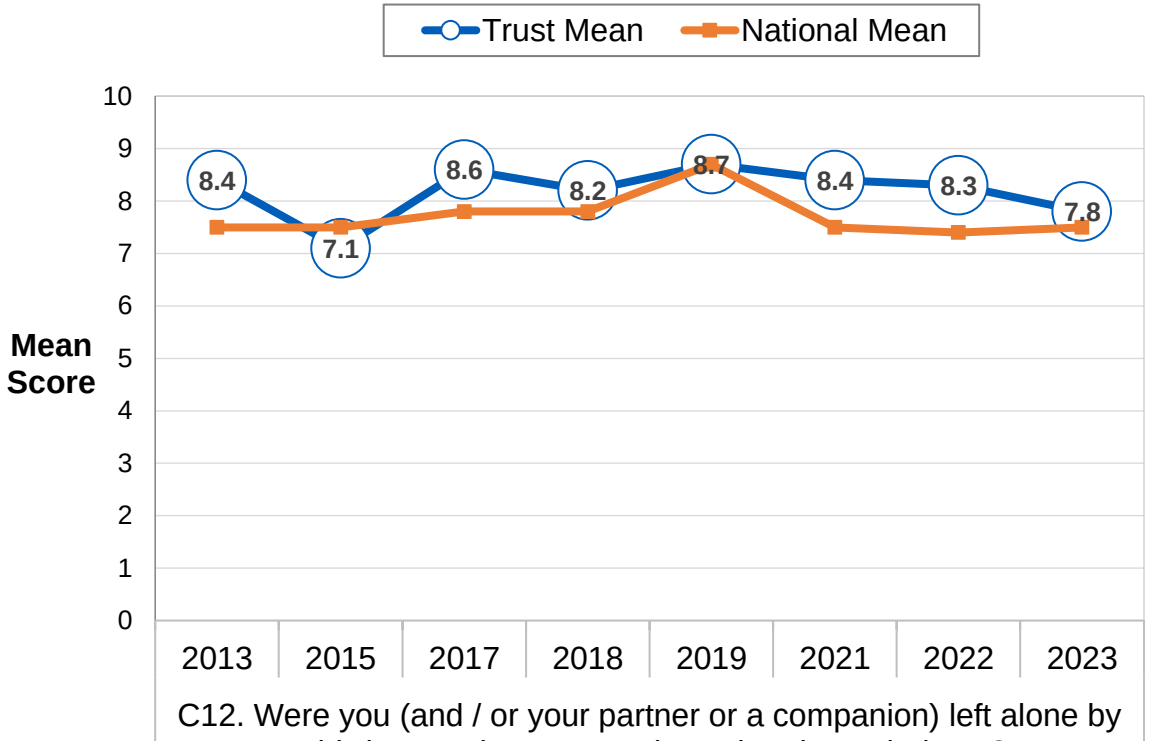
# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Staff caring for you




C10. Did the staff treating and examining you introduce themselves?




C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

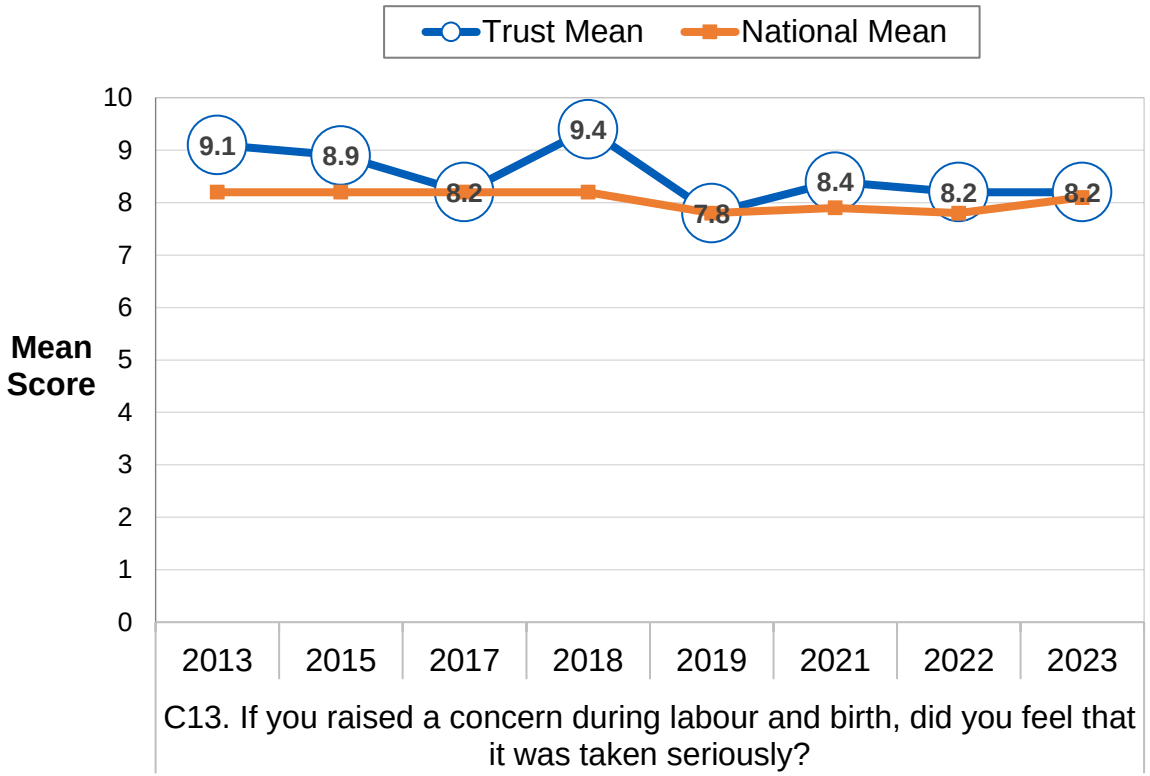
*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

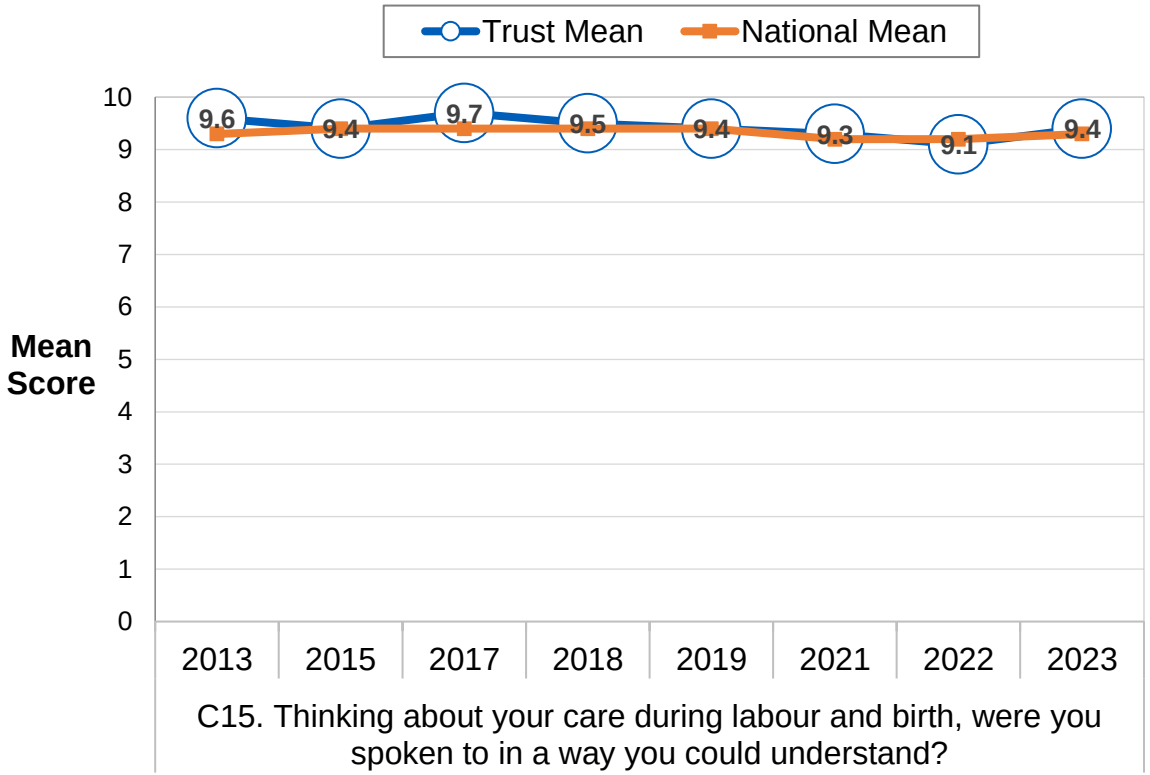
# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Staff caring for you




C13. If you raised a concern during labour and birth, did you feel that it was taken seriously?




C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff caring for you** | | | | | | | | | | | |
| C14. | During labour and birth, were you able to get a member of staff to help you when you needed it? | | | | | | | 8.6 | 8.9 | 165 | |
| C16. | Thinking about your care during labour and birth, were you involved in decisions about your care? | | | | | | | 8.7 | 8.6 | 168 | |

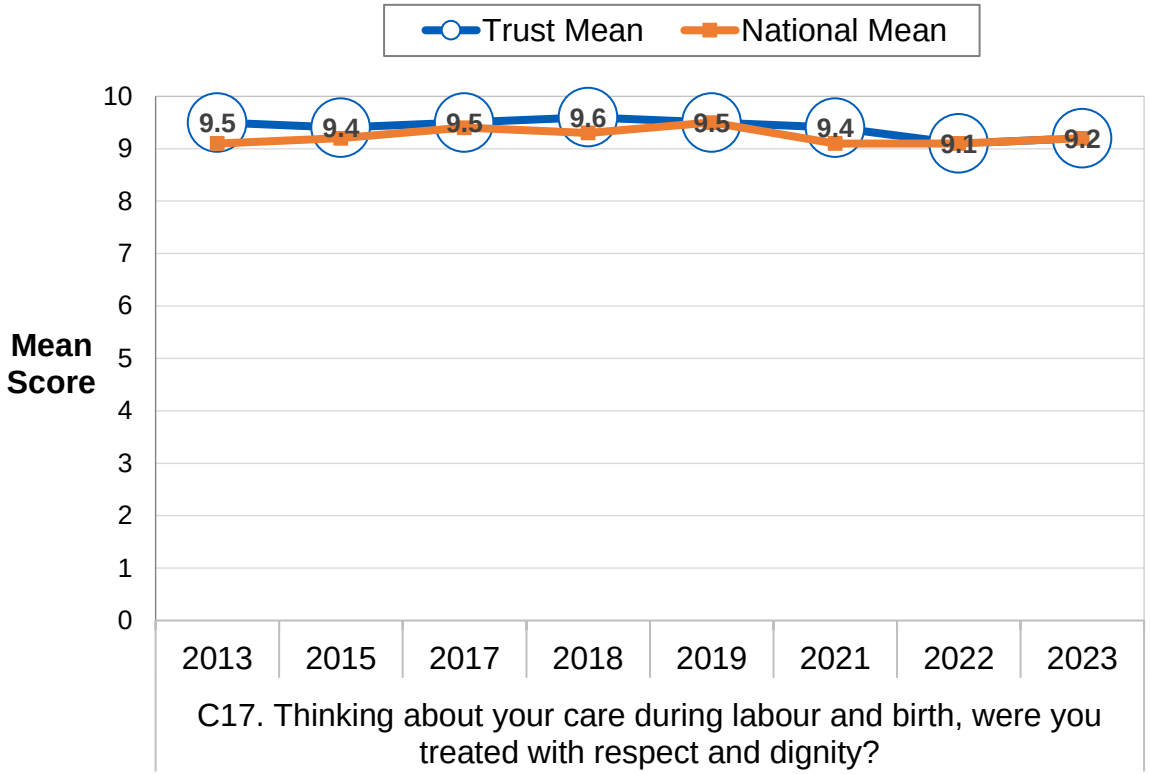
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

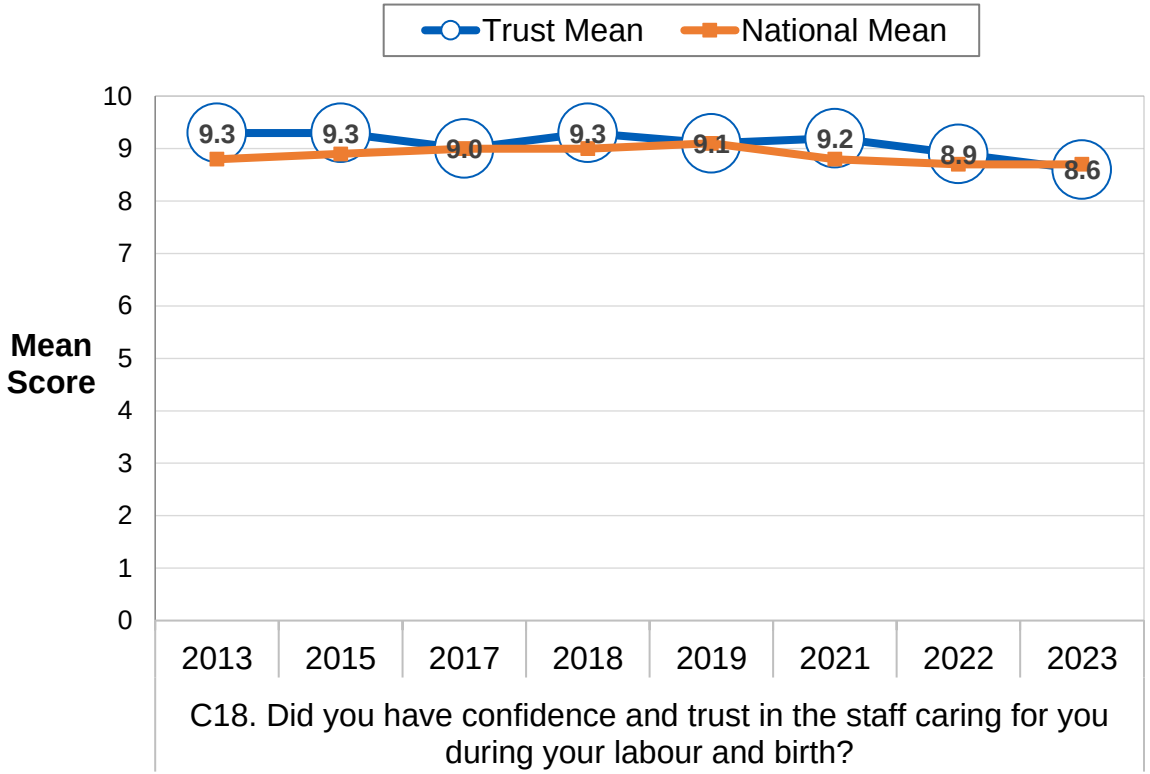
# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Staff caring for you




C17. Thinking about your care during labour and birth, were you treated with respect and dignity?




C18. Did you have confidence and trust in the staff caring for you during your labour and birth?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff caring for you** | | | | | | | | | | | |
| C19. | After your baby was born, did you have the opportunity to ask questions about your labour and the birth? | | | | | | | 6.2 | 6.5 | 143 | |
| C20. | During your labour and birth, did your midwives or doctor appear to be aware of your medical history? | | | | | | | 7.9 | 7.7 | 150 | |

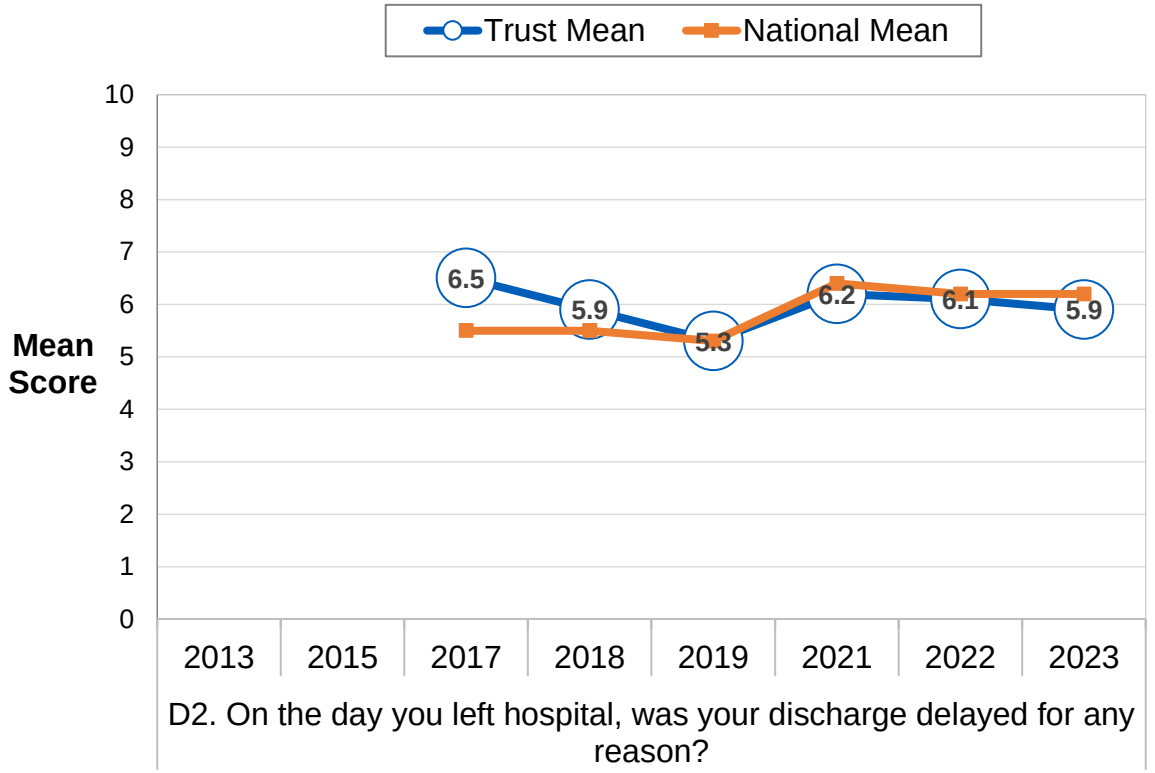
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care in the ward after birth




***Please note:*** *no data available for some years*

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|
| **Care in the ward after birth** | | | | | | | | | | |
| D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it? | | | | | | | 6.9 | 7.3 | 148 | |

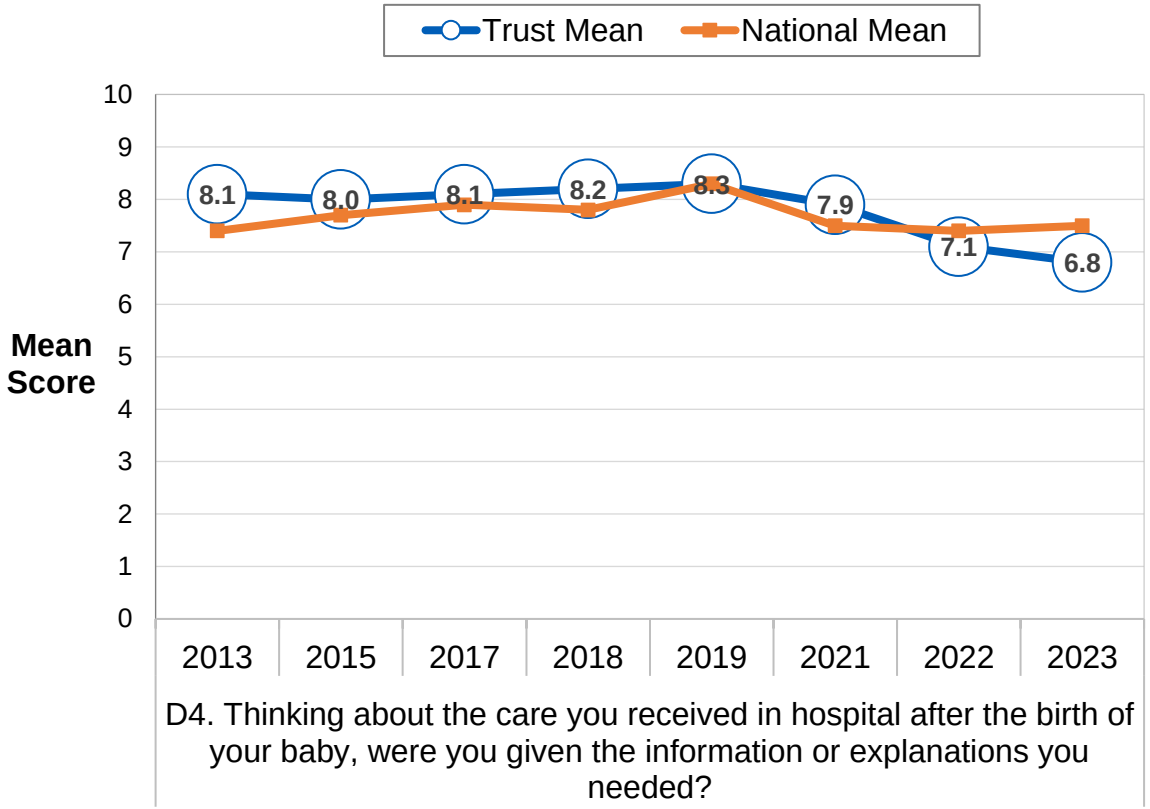
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

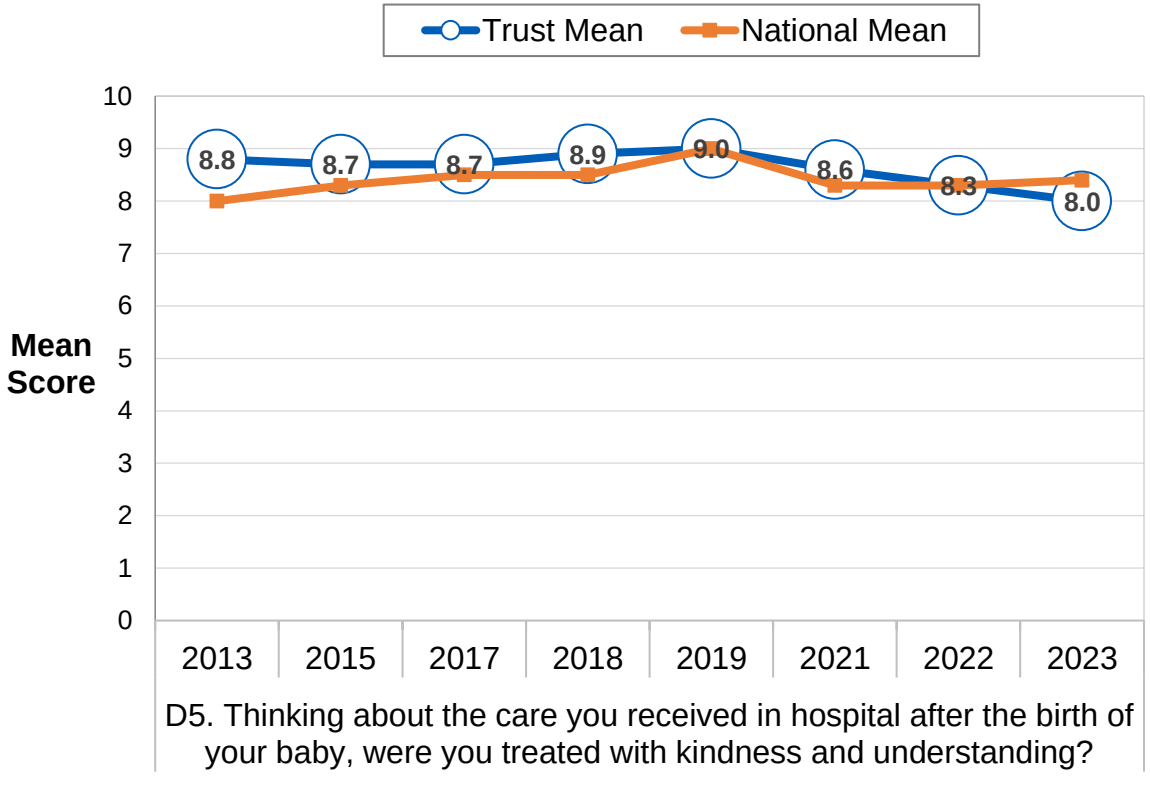
# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care in the ward after birth




D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?




D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

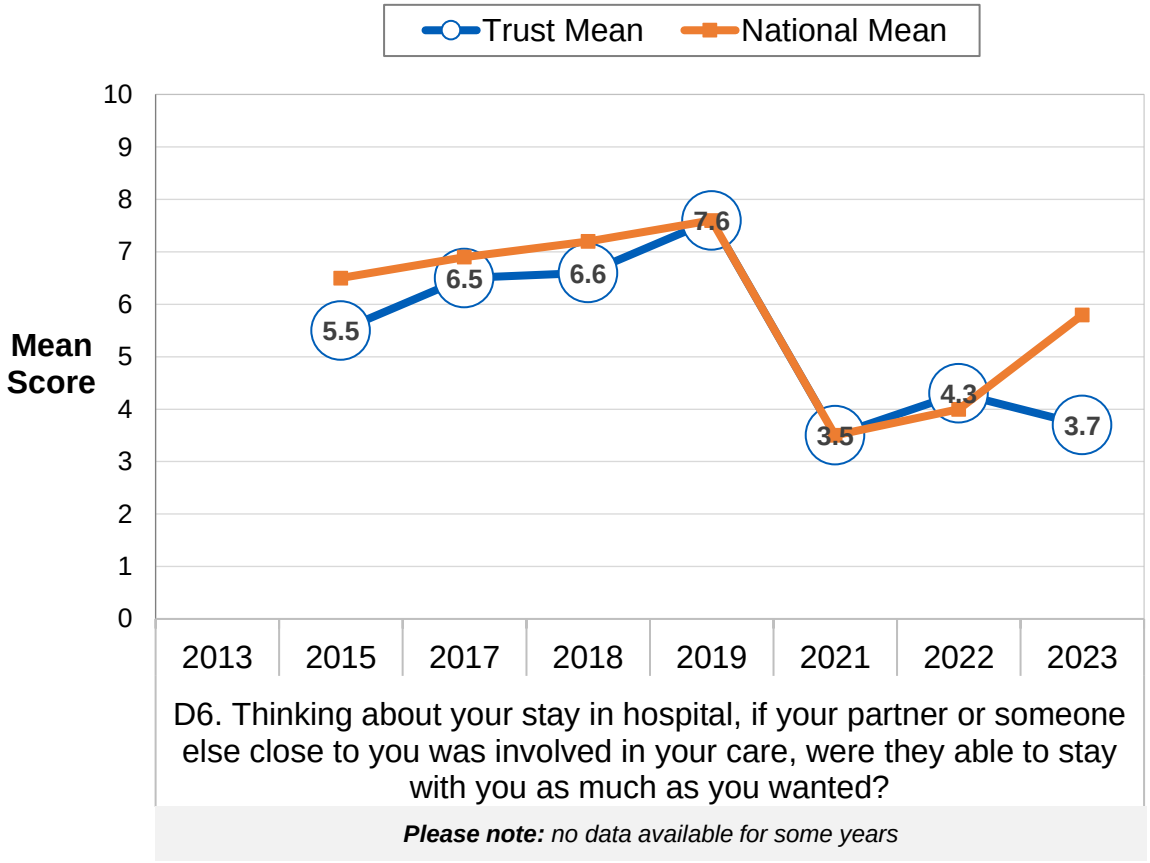
*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

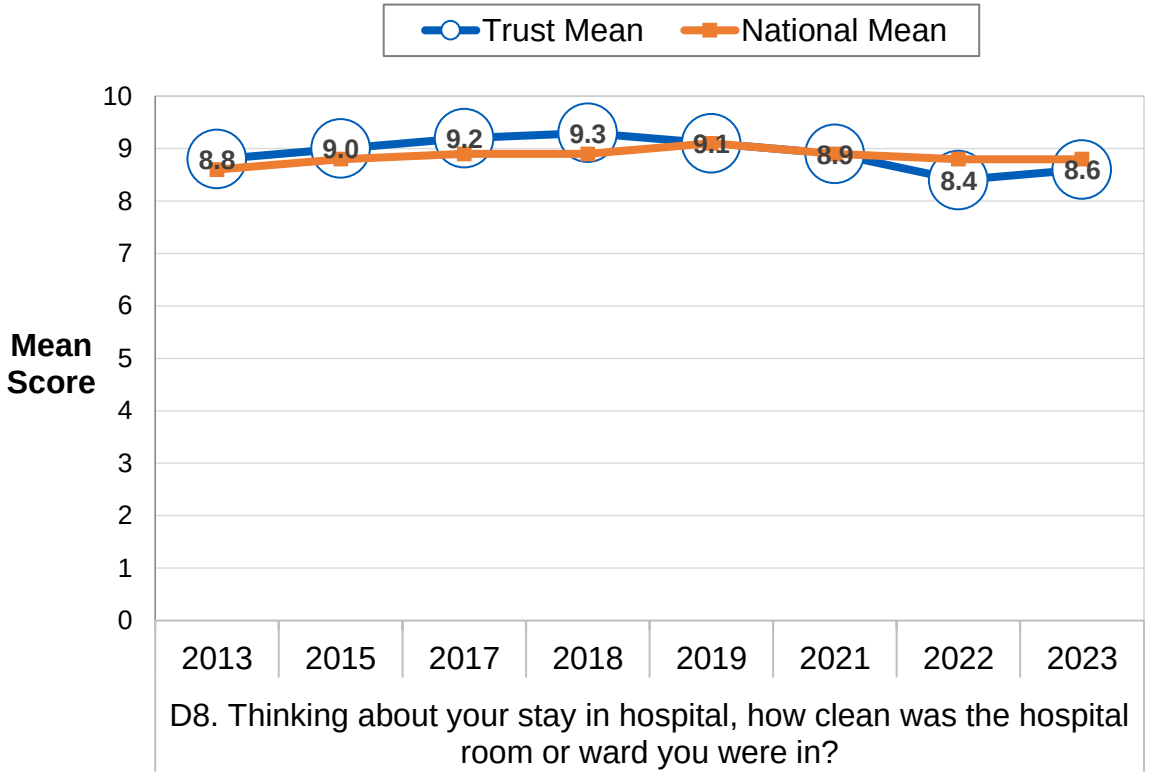
# Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care in the ward after birth




D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?




D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

***Please note:*** *no data available for some years*

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

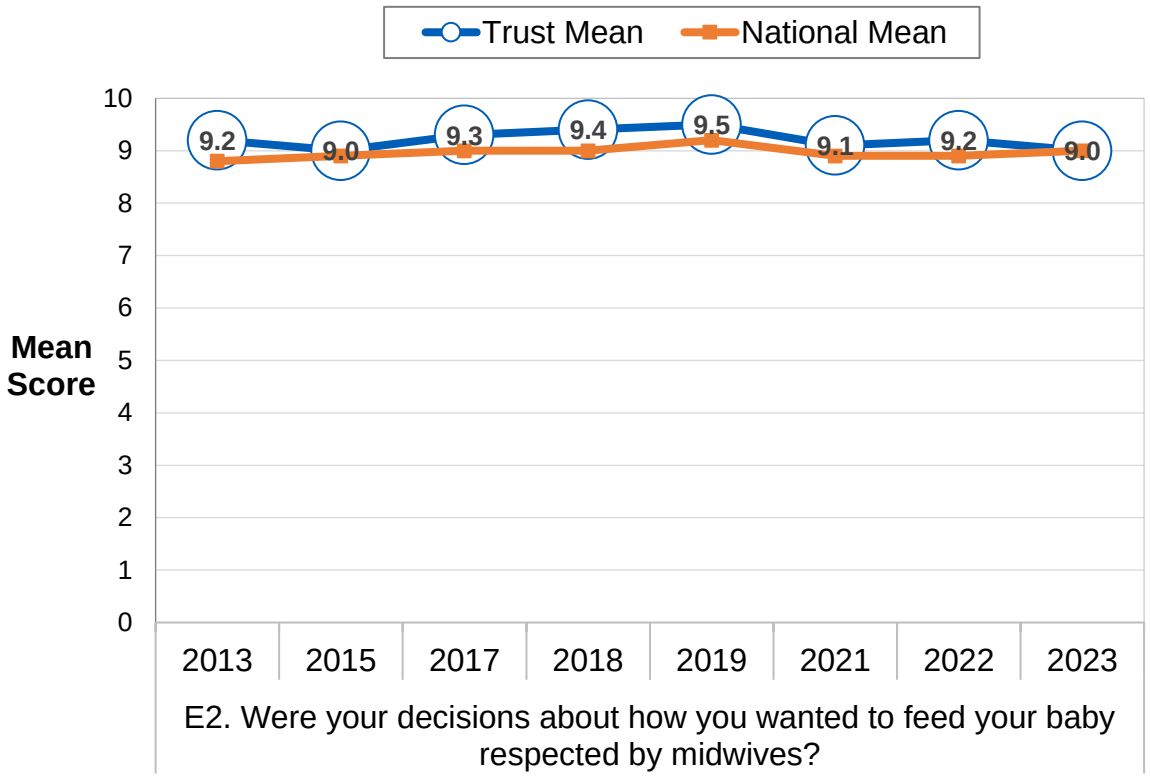
# Trends over time

# Postnatal care

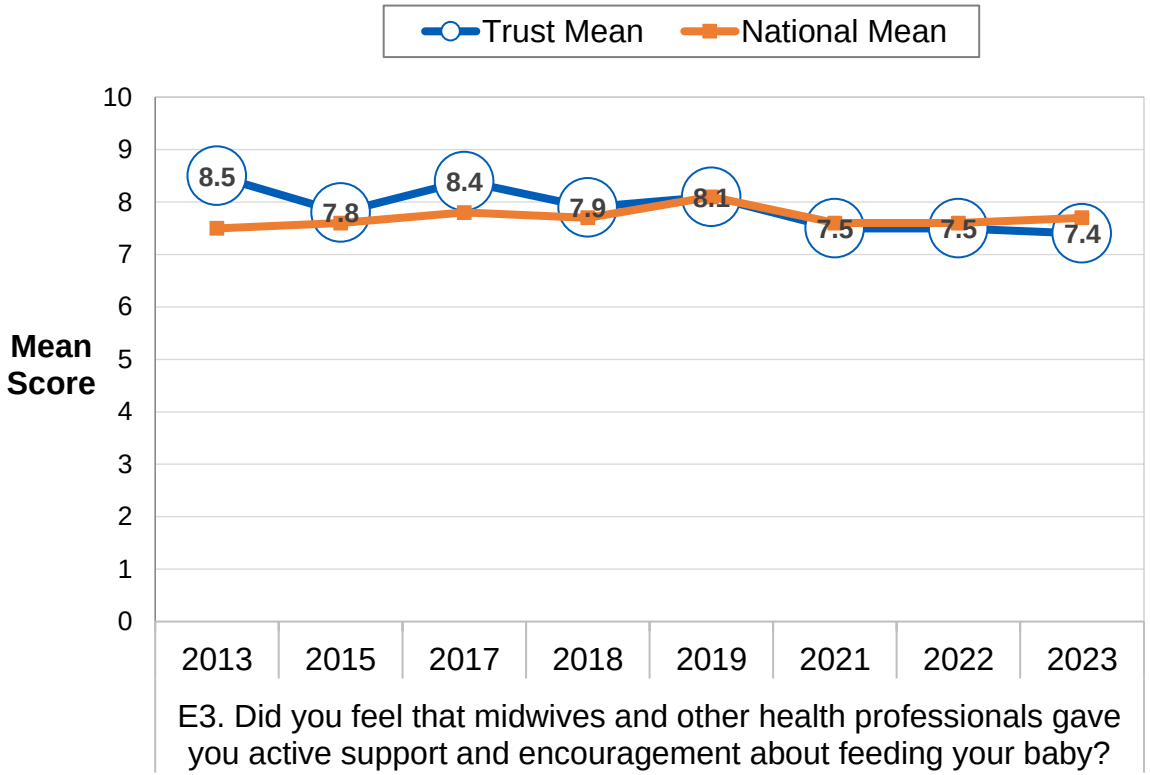
# Trends over time - Postnatal care

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Feeding your baby




E2. Were your decisions about how you wanted to feed your baby respected by midwives?




E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|
| **Care at home after the birth** | | | | | | | | | | |
| F1. | Thinking about your postnatal care, were you involved in decisions about your care? | | | | | | 8.4 | 8.3 | 151 | |
| F2. | If you contacted a midwifery or health visiting team, were you given the help you needed? | | | | | | 8.5 | 8.5 | 130 | |

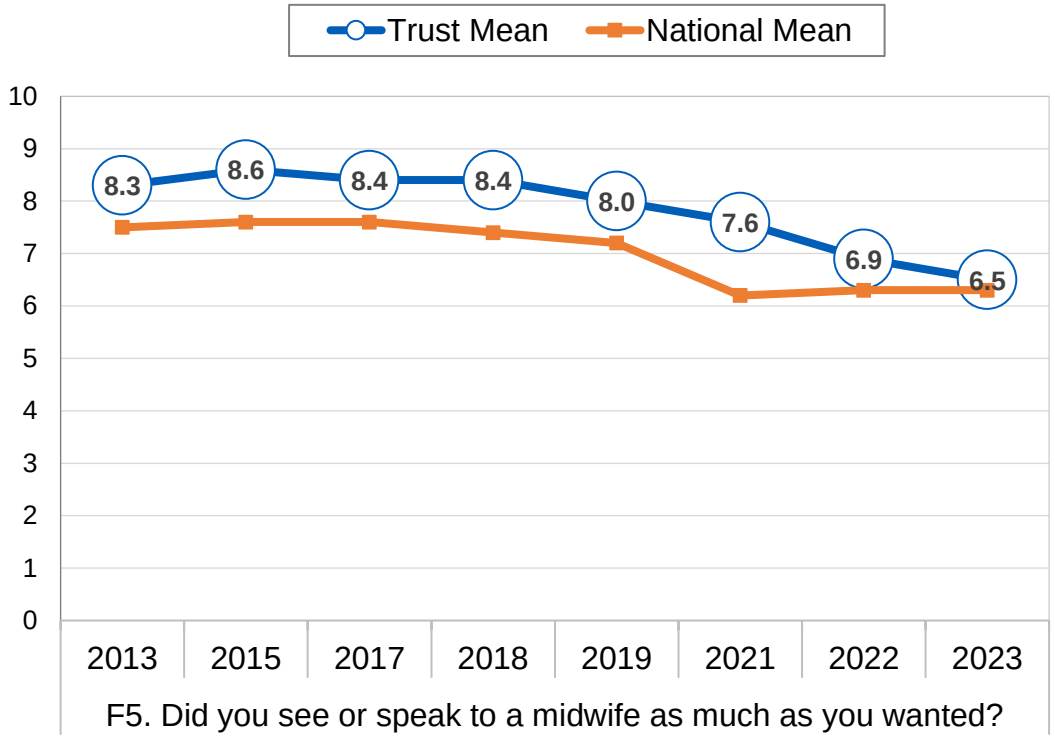
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

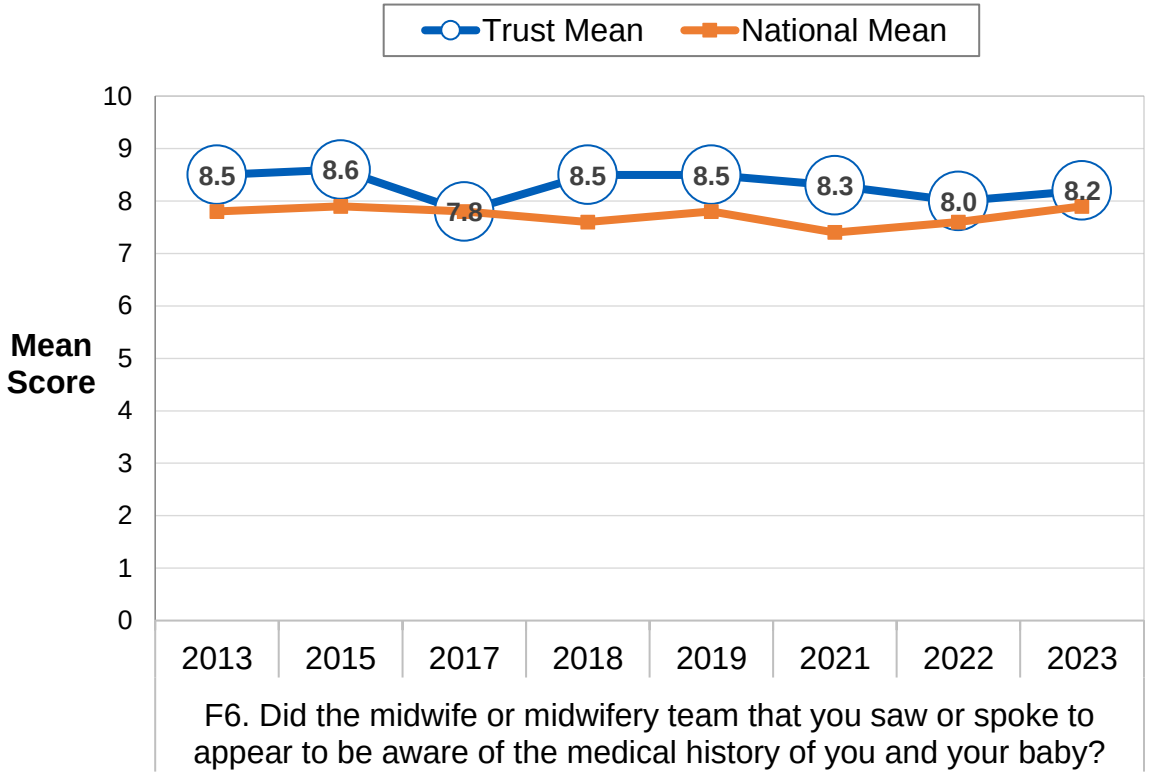
# Trends over time – Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care at home after the birth




F5. Did you see or speak to a midwife as much as you wanted?




F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

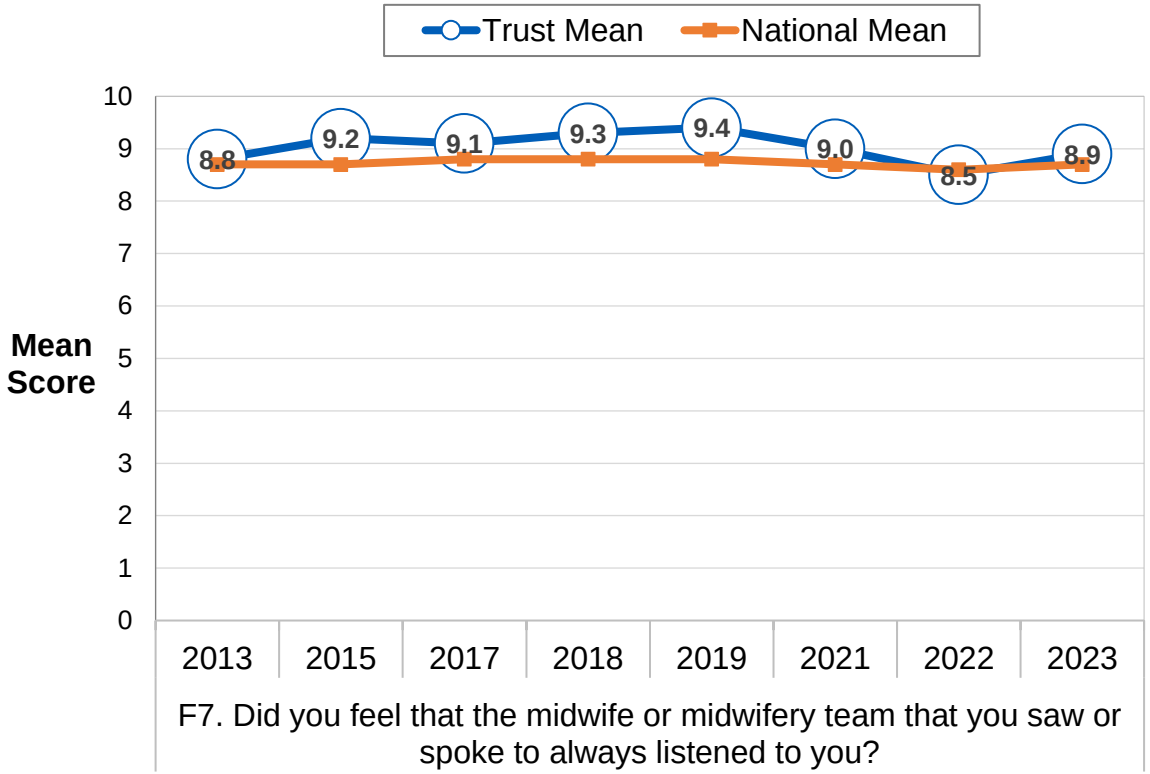
*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

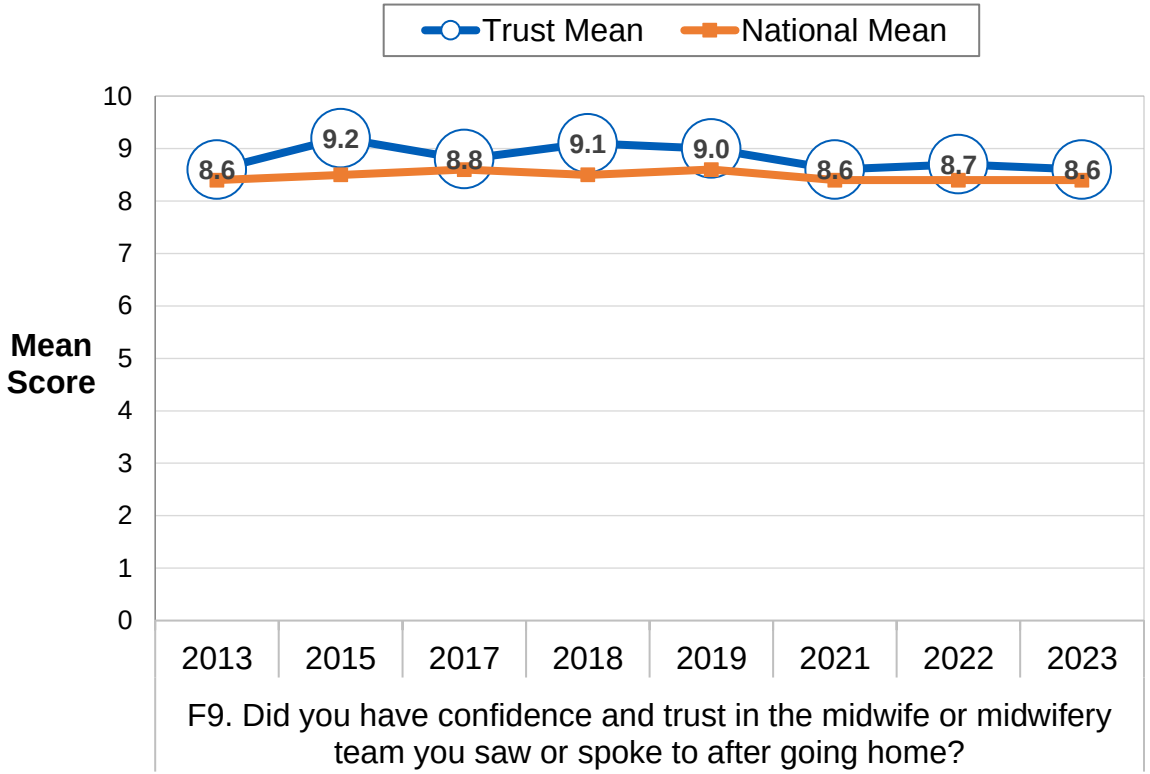
# Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care at home after the birth




F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?




F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Care at home after the birth** | | | | | | | | | | | |
| F8. | Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice? | | | | | | | 8.7 | 8.5 | 138 | |
| F11. | Did a midwife or health visitor ask you about your mental health? | | | | | | | 9.7 | 9.9 | 153 | |
| F12. | Were you given information about any changes you might experience to your mental health after having your baby? | | | | | | | 7.1 | 7.3 | 150 | |

▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

# Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected | | 2023 Trust Score | 2022 Trust Score | No. of respondents in 2023 | Change from 2022 survey |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Care at home after the birth** | | | | | | | | | | | |
| F13. | Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth? | | | | | | | 8.5 | 8.0 | 131 | |
| F14. | Were you given information about your own physical recovery after the birth? | | | | | | | 6.4 | 7.0 | 151 | |

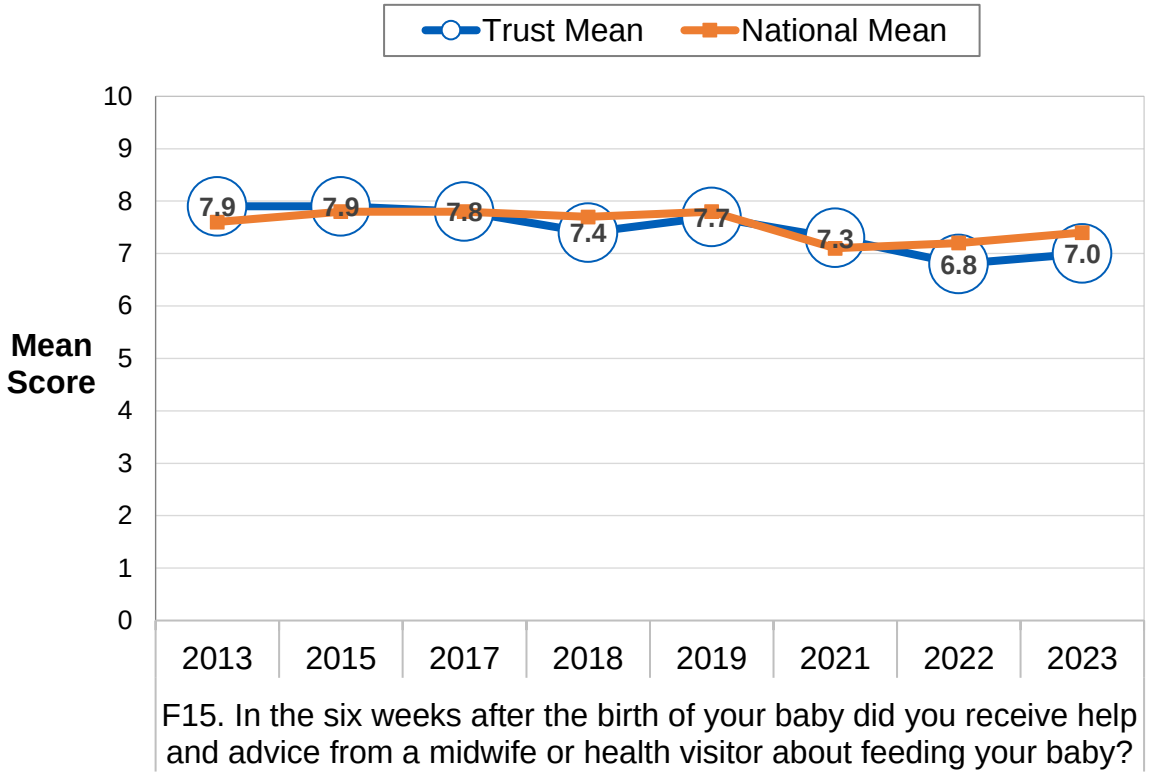
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

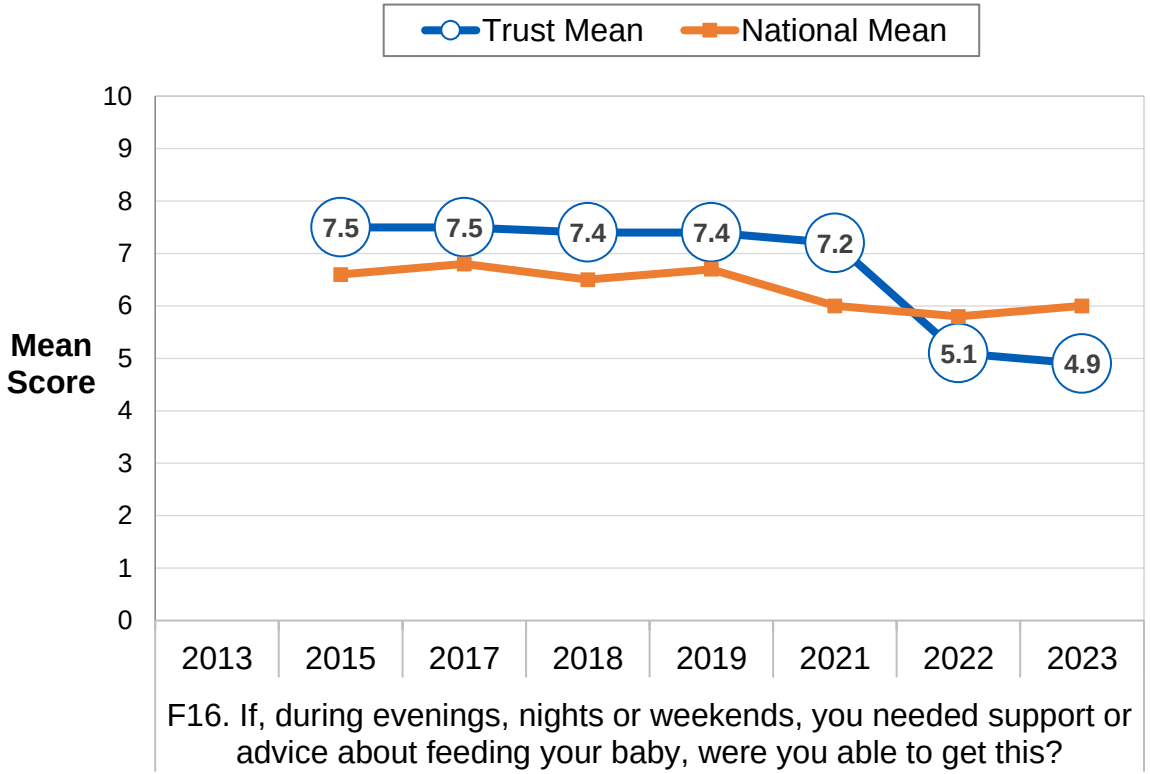
# Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care at home after the birth




F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?




F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

***Please note:*** *no data available for some years*

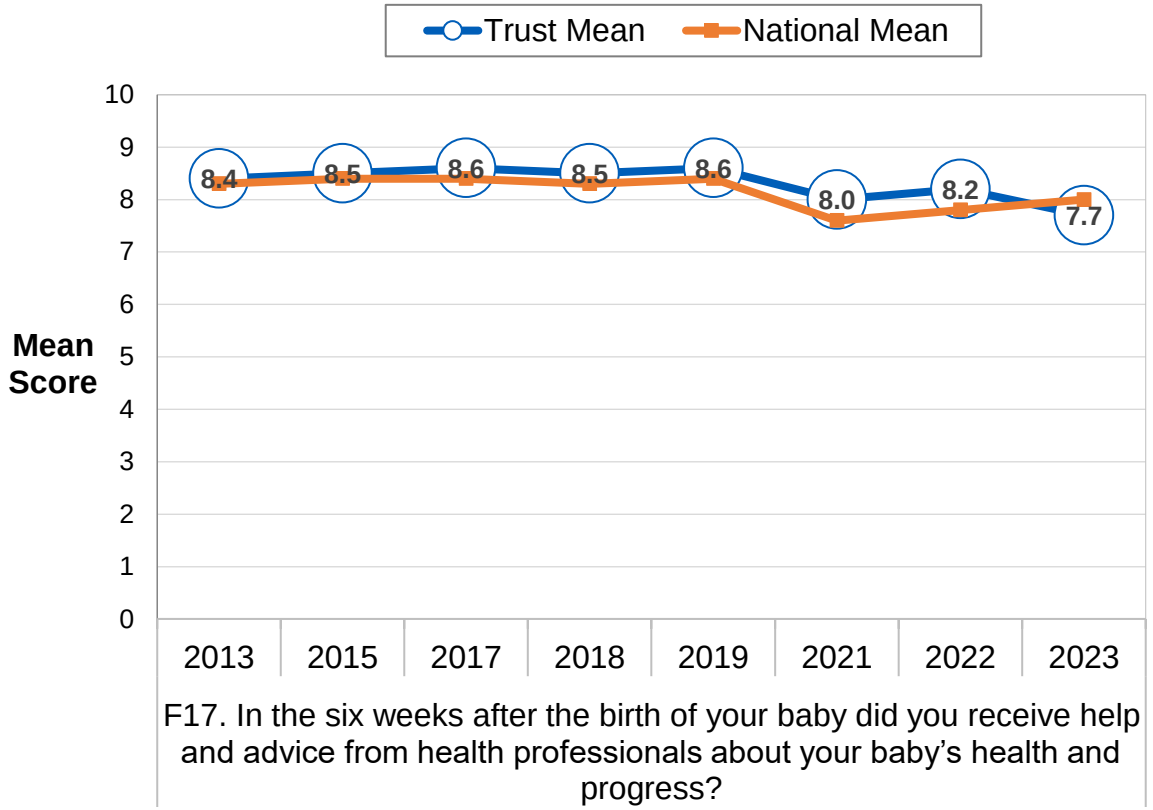
*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

## Care at home after the birth




F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?

*This shows a significant increase in the trust mean for this question for 2023 compared to 2022*

*This shows a significant decrease in the trust mean for this question for 2023 compared to 2022*

# Appendix

# Comparison to other trusts

The questions at which your trust has performed worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

| Much worse than expected | Worse than expected |
|---|---|
| • Your trust has not performed “much worse than expected” for any questions. | • Your trust has not performed “worse than expected” for any questions. |

# Comparison to other trusts

The questions at which your trust has performed somewhat better or worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

| Somewhat worse than expected | Somewhat better than expected |
|---|---|
| • D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? | • Your trust has not performed “somewhat better than expected” for any questions. |

# Comparison to other trusts

The questions at which your trust has performed better compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

| Better than expected | Much better than expected |
|---|---|
| • B10. During your antenatal check-ups, did your midwives ask you about your mental health?<br>• B18. If you raised a concern during your antenatal care, did you feel that it was taken seriously? | • Your trust has not performed “much better than expected” for any questions. |

# NHS Maternity Survey 2023

## Results for Salisbury NHS Foundation Trust

### Where maternity service users' experience is best

- ✓ During antenatal check-ups, service users being asked about their mental health by midwives.
- ✓ Maternity service users feeling that if they raised a concern during their antenatal care it was taken seriously.
- ✓ Maternity service users being offered a choice about where to have their baby during their antenatal care.
- ✓ Maternity service users being given enough support for their mental health during pregnancy.
- ✓ During pregnancy, maternity service users receiving the help they needed when they contacted a midwifery team.

### Where maternity service users' experience could improve

- Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- Midwives providing service users with relevant information, during their pregnancy, about feeding their baby.
- Maternity service users being given the information or explanations they needed while in hospital after the birth.
- Maternity service users being able to get a member of staff to help when they needed it while in hospital after the birth.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where maternity service users experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where maternity service users experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

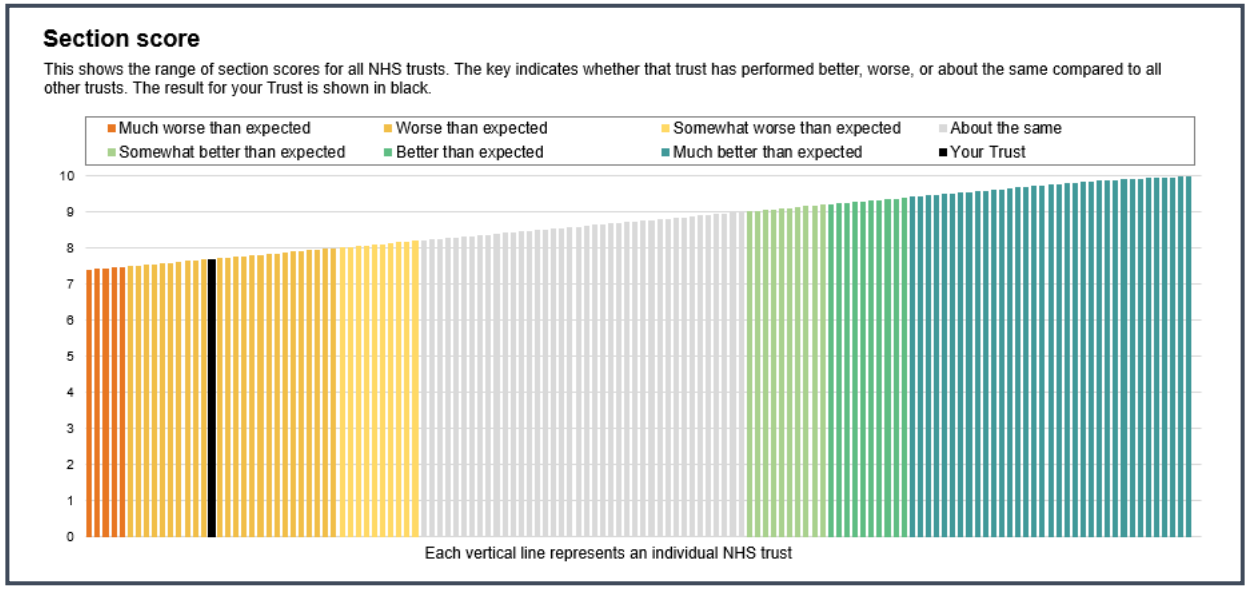
This survey looked at the experiences of individuals in maternity care who gave birth between January and March 2023 at Salisbury NHS Foundation Trust. Between May and August 2023, a questionnaire was sent to 288 individuals. Responses were received from 170 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

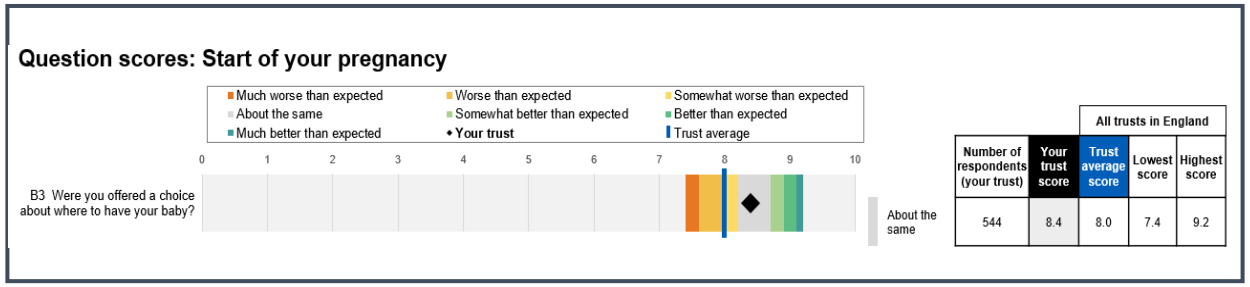
# How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.



# How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Please note, the benchmark bandings were updated for the 2021 survey to provide a greater level of granularity in the expected range score. The 2023 survey uses the same approach.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

# An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the experience of people who use maternity services could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

**Calculating an individual respondent's score**

The following provides an example for the scoring system applied for each respondent. For question B7 "During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of the people who use maternity services experiences.

**Calculating the trust score for each question**

The weighting mean score for each trust, for each question, is calculated by dividing the sum of the weighting scores for a question by the weighted sum of all eligible respondents to the question for each trust. Weighting is explained further in the quality and methodology report.

**Calculating the section score**

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

# For further information

Please contact the Coordination Centre for Mixed Methods at Ipsos.

MaternityCoordination@ipsos.com

| Action Plan: Maternity survey 2023 Coproduced with the MNVP | Date Created | 18/10/23 |
|---|---|---|

| | | | |
|---|---|---|---|
| **Plan Owner :** | **Alison Lambert (Family Experience Midwife)** | **Date last updated : (and version no)** | 7.12.23 |
| **Core implementation Group :** | **WNB Division Senior Management Team.** | **Next review due by - Group / Committee : Date :** | **Patient Experience Steering Group Safety Champions** |

**Links to key documents** – NHS Maternity Survey 2023 Benchmark Report

MAT23_Preliminary Report_RNZ_Salisbu

Salisbury NHS Foundation Trust fu

| Question text | Action<br>What specific actions will be taken to address the issue(s) | # | National Comparisons | Lead by: | Achieve by: | Progress update / notes | Status |
|---|---|---|---|---|---|---|---|
| **1.1 Antenatal care** | | | | | | | |
| Advice and information offered RE Birth Choices. | Signpost women at booking to the NHSE information leaflet – 'Where to have your baby'. A link to this leaflet will be added to the information offered to women at booking.<br><br>NHSE-your-choice-where-to-have-baby-first-baby-sept2018.pdf (assets.nhs.uk) | B3-1 B4 | Middle 60% | Family Experience Midwife / Transformation Lead | Jan 24 | Update Jan 24 The information leaflet is available on the Maternity website and have been shared with the community teams throughout the annual study day. | |
| Prior knowledge of the woman's / birth persons medical history. | A (local) comparative survey to establish the thoughts from both staff and women/ pregnant people, on whether we have enough information available in ANC on the patient's prior medical history. | B7 | Middle 60% | Family Experience Midwife | March 24 | Pending. Realtime audit to be completed in March 24 | |
| Respectful communications RE IOL | The recent Personalize care planning session, presented at Clinical Governance on 17/11/23 has highlighted the challenges Consultants/Obstetricians encounter when | Free Text | / | Transformation midwife | Dec 23 | Pending. Update March 23 : the clinical governance sessions completed in Nov 23.<br><br>Local statistics for differences | |

| Status tracking | | |
|---|---|---|
| Complete | Green | G |
| On plan | Blue | B |
| Risks slippage | Amber | A |
| Barriers – not achieved | Red | R |

| Question text | Action<br>What specific actions will be taken to address the issue(s) | # | National Comparisons | Lead by: | Achieve by: | Progress update / notes | Status |
|---|---|---|---|---|---|---|---|
| | counselling women for an IOL, within the time allocated for ANC appointments.<br><br>The IOL leaflet is set to be redesigned to reflect the advantages and disadvantages of all procedures available. It is hoped that this will provide women with information necessary in order to facilitate a more targeted and personalised conversation about the suggested method of IOL. | | | | | between OASI/assisted birth/PPH rate for 2023 for IOL versus spontaneous labour have been obtained. The next step is to draft the leaflet, circulate for approval and share with the MNVP for comments | |
| Information provided to parents in the antenatal period regarding infant feeding. | A variety of Infant feeding support groups Monday through to Thursday. Details can be found on the maternity Website in the feeding Padlet as well. | B15 | Bottom 20% | IFT | Nov 23 | Completed<br>Family Experience 20th July 23.odp | |
| 1.2. Labour and Birth | | | | | | | |
| Information provided to women on the risks and benefits of an induction of labour | Circulation of the new IOL leaflet | C5 | Middle 60% | Transformation Midwife | Dec 23 | Pending- to be drafted | |
| Prior knowledge of the woman's medical history | A (local) comparative survey to establish the thoughts from both staff and women/ pregnant people, on whether we have enough information available in ANC on the patient's prior medical history. | C20 | Middle 60% | Family Experience Midwife. | March 24 | Pending | |
| Continuity of consultant care | Information to be update on the maternity is website RE to increase women awareness and expectations around the AN appointments schedule and whom they can expect to see. | Free Text | / | Family Experience midwife | Nov 23 | Completed<br>action RE named consultant.docx | |

| Status tracking | | |
|---|---|---|
| Complete | Green | G |
| On plan | Blue | B |
| Risks slippage | Amber | A |
| Barriers – not achieved | Red | R |

| Question text | Action<br>What specific actions will be taken to address the issue(s) | # | National Comparisons | Lead by: | Achieve by: | Progress update / notes | Status |
|---|---|---|---|---|---|---|---|
| Personalize care planning | Personalize care planning to be the subject of a multidisciplinary discussion | Free Text | / | Clinical Lead for Quality and Safety | 17/11/23 | Completed  Quarterley Maternity Governan | |
| Opportunity provided for women to ask questions about their labour. | Transformation approach to the review of the birth reflection/ listening services | C19 Free Text | Middle 60% | Family Experience Midwife<br><br>Transformation Lead | Jan 24 | Pending Update March 24 :<br>It is anticipated that the clinical band 7's will have capacity to support the clinic, following a period of training. It is hoped that this will reduce the waiting times to this service | |
| Advice offered to women RE supporting women to manage their pain during labour and birth | Ensure that all labour rooms have a pain relief guide | C8 | Middle 60% | In patient Matron | Nov 23 | Completed. All rooms have a QR code | |
| | Poster to be displayed in all labour rooms, signposting women to the 'pain relief in labour' section of the maternity website https://www.salisbury.nhs.uk/wards-departments/departments/maternity/your-labour-birth/pain-relief/ | | | Family Experience midwife | Jan 24 | Completed 31/10/23 | |
| | **2024 -New action:** Introduction of parent education sessions on pain relief options in labour. | | | Anaesthetic lead form Maternity | Jan 24 | Completed Jan 24  **Pain relief parented session.docx** | |
| **1.3 postnatal care** | | | | | | | |
| Delayed postnatal discharge | Action to be implemented in response to the postnatal experience survey 23, results. | D2 | Middle 60% | In patient Matron Family Experience Midwife | Dec 23 |  S2023033 Postnatal pt exp responses 20 Completed | |

| Status tracking | | |
|---|---|---|
| Complete | Green | G |
| On plan | Blue | B |
| Risks slippage | Amber | A |
| Barriers – not achieved | Red | R |

| Question text | Action<br>What specific actions will be taken to address the issue(s) | # | National Comparisons | Lead by: | Achieve by: | Progress update / notes | Status |
|---|---|---|---|---|---|---|---|
| | Workstream to be undertaken on the timelessness of the NIPE | | | In patient Matron | Feb 24 | Re introduction of the NIPE clinic. | |
| | Dedicated pharmacist for the postnatal ward, will ensure timeliness of women's 'take home' medications being dispensed | | | | Oct 23 | Completed | |
| Restrictions on birth partner's visiting times | Birth partners are welcome to stay overnight on the Postnatal ward- no restriction on visiting | D6-1 and D6-2 D6-3 | Middle 60% And Bottom 20% | Inpatient matron | March 23 | Completed March 23 | |
| Support and advice offered in a timely manner. | Focus of postnatal education will be on providing kind and compassionate care | D3<br><br>D5 | Middle 60%<br><br>Bottom 205 | Postnatal ward manager | June 24 | Pending. Update March 24<br>The PMA lead intends to work with staff on the Behavioural Charter with the focus on kindness and compassionate communication with staff and patients. | |
| | MNVP to host an online listening event on:<br>• families experience on the postnatal ward. | | | MNVP Lead | TBC | Completed: Included in the Conversation 15 - programme for 2024 | |
| Postnatal information | A sticker to be added to the 'red book' with QR codes signposting women to information on pain relief postpartum, co sleeping and mental health support. | D4 **Free text** | Bottom 20% | Family Experience midwife | Dec 23 | Pending: Update March 24. Not all women get a red book upon discharge, therefore an alternative solution was sought. It is anticipated that women will receive a paper envelope on discharge which will contain all relevant postnatal information in the form of QR codes. This envelope is with the printing company for quotation. | |
| 1.4 Feeding your baby | | | | | | | |

| Status tracking | | |
|---|---|---|
| Complete | Green | G |
| On plan | Blue | B |
| Risks slippage | Amber | A |
| Barriers – not achieved | Red | R |

| Question text | Action<br>What specific actions will be taken to address the issue(s) | # | National Comparisons | Lead by: | Achieve by: | Progress update / notes | Status |
|---|---|---|---|---|---|---|---|
| Support and encouragement offered to parents about infant feeding | IFT to explore ways they can support women during their time on the postnatal ward.<br>The IFT intends to offer Baby friendly education sessions to staff on the ward. | E3 **Free text** | Bottom 20% | Infant feeding team | Dec 23 | Completed: staff assessment undertaken | |
| | Appointment of a New Maternity Care assistant within the infant feeding team. It is anticipated that they will be ward based. | | | | Jan 24 | Completed | |
| | MNVP to host an online listening event on:<br>• families experience on feeding support , with a focus on postnatal and the IFT , aspects of antenatal education, postnatal ward and community support | | | MNVP Lead | TBC | Completed: Included in the Conversation 15 - programme for 2024 | |
| 1.5 Care after birth | | | | | | | |
| Information offered to women on the changes they might experience to their mental health after having their baby | 'Wellbeing After Baby Course' available to women residing in Wiltshire | F12 | Bottom 20% | AWP Wiltshire Talking Therapies | Nov 23 | Pending | |
| | MNVP to host an online listening event on:<br>• families experience of perinatal mental health support | | | MNVP Lead and Family Experience Midwife | TBC | Completed: Included in the Conversation 15 - programme for 2024 | |
| | Information on the role of the Maternity's Psychological Health team will be displayed on the postnatal and toilet doors. | | | Psychological health midwife | Dec 23 | Pending | |
| Out of hours, Infant feeding support | To raise awareness of the national helplines and apps such as ANYA that offer great infant feeding support. The IFT offer a feeding service six days a week (including bank holidays) | F16 | Bottom 20% | IFT | Jan 24 | Completed- information can be found on the feeding Padlet https://padlet.com/jacquelyndalley/salisbury-infant-feeding-information- | |

| Status tracking | | |
|---|---|---|
| Complete | Green | G |
| On plan | Blue | B |
| Risks slippage | Amber | A |
| Barriers – not achieved | Red | R |

| Question text | Action<br>What specific actions will be taken to address the issue(s) | # | National Comparisons | Lead by: | Achieve by: | Progress update / notes | Status |
|---|---|---|---|---|---|---|---|
| | | | | | | f0no6u47p0ewtnan | |
| Flexibility of location RE PN check ups | All women should be offered a home visit<br><br>following discharge | Free text | | Comm Teams | Nov 23 | Completed | |
| Continued support offered to parents six weeks postpartum: consideration given to:<br>Access to health care professionals, advice RE babies' health and progress together with infant feeding advice. | MNVP lead to share survey results with Health visiting teams | F15 And F17 | Middle 60% | MNVP lead | Jan 24 | Completed 16/11/23 | |
| Comments from the Free Text RE primary care service to be shared with the Health Visitor coordinator | MNVP Lead to share the results of the National Maternity Patient Survey 23 with the primary care team | Free text | / | MNVP Lead | Jan 24 | Completed | |
| To celebrate the department's success, all positive feedback will be shared with the department and those individuals sited in the free text | Positive feedback to be shared with the wards/ areas and individual's sited in the free text | Free text | / | Family Experience midwife | Nov 23 | Completed | |

| **Measures of success - How will we know the issue(s) have been addressed?** | |
|---|---|
| **Monitoring method** (e.g. audit, spot check, document produced): | **What issues / action in the plan does this cover?** |

| Status tracking | | |
|---|---|---|
| Complete | Green | G |
| On plan | Blue | B |
| Risks slippage | Amber | A |
| Barriers – not achieved | Red | R |

| | |
|---|---|
| CQC survey | **All** |

| Status tracking | | |
|---|---|---|
| Complete | **Green** | G |
| On plan | **Blue** | B |
| Risks slippage | **Amber** | A |
| Barriers – not achieved | **Red** | R |

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 5.5 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Recommendation for increase in Midwifery establishment following Birth Rate-Plus individualised report publication. | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | Yes | | Yes | |
| Approval Process: (where has this paper been reviewed and approved): | Approved by Women and Newborn Divisional Management Team 23.4.24.<br>CGC 30th April 2024 | | | |
| Prepared by: | Vicki Marston - Director of Maternity and Neonatal Services | | | |
| Executive Sponsor: (presenting) | Judy Dyos - Chief Nursing officer | | | |

## Recommendation:

The Trust Board are asked to agree the recommendation of this paper for an uplift in Midwifery staffing establishment from 104 WE to 107.27 WTE Midwives.

This will allow SFT to provide the recommended Midwife to birth ratio of 1:23, which is not achievable currently.

In order to maintain compliance with the Maternity Incentive scheme, Trust Boards are required to demonstrate a funded establishment in line with birthrate plus recommendations, without uplift of establishment SFT will be non-complaint with Safety action 5 and thus overall non-compliant.

## Executive Summary:

Birthrate plus is a framework for midwifery workforce planning. It is based upon an understanding of the total midwifery time required to care women on a minimum standard of providing one to one midwifery care throughout established labour.

A birthrate plus assessment was funded by the LMNS for SFT Maternity services in late 2023, as per approach taken at RUH and GWH. A case mix was produced by BR plus based on clinical indicators for each birth in the assessment period and the number of midwife hours per patient/client category. Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and post-natal care of women and babies in community birthing either in the local hospital or neighbouring ones.

Birth Rate plus has calculated that locally, in line with nationally, the acuity and complexity of women continues to increased with higher rates of medical co-morbidities. Rates of caesarean section and inductions – combined with other factors such as a wide geographical area and safeguarding cases have led to an establishment being recommended which requires an increase of 3.27 WTE clinical midwives.

The report recommends that the current SFT Midwifery vacancy is not adequate for provision of care to our population and therefore the recommendation is that the Trust Board agree to the uplift in establishment from 104 WTE to 107.27 WTE.

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

# Recommendation for increase in Midwifery establishment following Birth Rate-Plus individualised report publication.

## Purpose of the Report

The purpose of this report is to provide the Trust Board with information and recommendations from the Birth-rate Plus (BR+) assessment which was reported to Salisbury NHS Foundation Trust in 2024.

## Recommendations

The Trust Board is asked to note that we no longer have a funded midwifery establishment inline with the Birthrate plus recommended establishment and would require an uplift of 3.27 WTE Midwives to meet the activity and acuity for women in the population that we serve as recommended in our individualised assessment.

This will ensure our midwife to birth ratio can be met and that we are complaint with CNST Maternity Incentive Scheme Safety Action 6.

## Background

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. The nationally recognised and utilised assessment of this is individualised birthrate plus assessments.

Salisbury NHS Foundation Trust (SFT) commissioned a full Birthrate Plus (BR+) midwifery workforce assessment in 2023. The assessment utilised maternity services activity data from the preceding twelve-month period (2022/23) with the final report providing information and

the recommended midwifery workforce requirements for maternity services at SFT based on the number of births and including the acuity and complexity of all women and babies accessing the service.

Initial and Final Ockenden Independent Maternity Review Reports (2020,2022) mandates all providers of maternity services in England and Wales to ensure safe levels of midwifery and maternity staffing by undertaking a midwifery workforce review using a recognised safe staffing methodology.

BirthRate Plus (BR+) is the sole midwifery workforce planning and real time staffing acuity tool currently. It the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments. Validated methodology to support the delivery of safe high quality maternity care is required by the NHS Resolution (NHSR) CNST Maternity Incentive Scheme (MIS). BR+ is also the only nationally recognised midwifery workforce tool endorsed by the Royal College of Midwives (RCM), Royal College of Obstetrics and Gynaecology (RCOG), National Institute for Clinical Excellence (NICE) and the Care Quality Commission (CQC).

In addition, the CNST Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning.

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

It is recommended that Birth Rate Plus assessment is carried out a minimum of 3 yearly and Midwifery establishment is set against this.

Our current Budgeted establishment is set inline with the 2019 report recommendations.

## Current position

A Birthrate plus assessment was carried out in Autumn 2023. This was later than the per NICE national recommendation for repeat assessment timeframes. Activity and the acuity of women who used maternity services in addition to a consideration of individual geography, community areas, rates of intervention and risk of population, areas of deprivation and safeguarding all impacted on the results of this individualised review. The full report from this assessment has now been received.

Having reviewed individualised SFT data, Birth rate plus has recommended an uplift in Midwifery establishment from 104 WTE to 107.27 WTE.

| Current funded Clinical, Specialist and Management WTE | Birthrate plus recommended WTE following 2023 reassessment | Variance WTE |
|---|---|---|
| 104.00 | 107.27 | -3.27 |

Following the BR+ assessment which evaluated information reflecting the complexity of women and their babies accessing maternity services at SFT, the required midwife to birth ratio was increased from 1:26 to 1:23. This reflects the increased acuity of the intrapartum case mix which has the greatest influence on midwifery establishment recommendations. This acuity has increased since the last full BR+ assessment undertaken in 2019 and reflects the rise incomplexity during pregnancy, birth and postnatally locally, this is mirrored nationally.

The revised ratio recommended aligns with the midwife to birth ratios across BSW. A commitment to increase establishment inline with birthrate plus would enable this midwife to birth ratio to be achieved. At present we are unable to provide a service in line with this ratio.

The cost of increasing midwifery establishment by 3.27 Mid-point Band 6 midwives would be = £155,092

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## Recommendation.

It is recommended that Midwifery establishment is increased inline with the report recommendations by 3.27 WTE. This will ensure compliance with MIS and allow midwife to birth ratios that offer the safest and most appropriate ratios of midwifery staff recommended care to women and families.

NHS Salisbury NHS Foundation Trust

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| **Report to:** | Trust Board (Public) | **Agenda item:** | 5.6 |
| **Date of Meeting:** | 01 May 2024 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Q3 Incident reporting and risk report | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | x | |
| **Approval Process** (where has this paper been reviewed and approved) | CMB via email<br>CGC 26 March 2024 | | | |
| **Prepared by:** | Kim Melborne, Risk Lead<br>Judy Dyos, Chief Nursing Officer | | | |
| **Executive Sponsor** (presenting): | Judy Dyos, Chief Nursing Officer | | | |
| **Appendices** (list if applicable): | | | | |

| **Recommendation:** |
|---|
| The report aims to inform the committee of the process and data related to incident reporting and the management of the risk registers over the Q3 period of 2023. |

| **Executive Summary:** |
|---|
| This is the first version of a revamped Incident and Risk Register report to the Committee. The aim of the report is to provide data in a more accessible format.<br><br>Initially the report provides the overarching data for incident reporting over a 12-month period moving to the data for Q3. The report then provides the risk register information and the plans to resolve outstanding risks held at service level that require review.<br><br>Due to the number of SI investigations, clinical reviews, the roll out of PSIRF and LEPSE the risk team had huge demand upon them, this has led to reduced oversight in risk registers and outstanding SI actions. As both PSIRF and LEPSE embed, the team has undertaken a review and agreed new ways of working which will allow focused work on incident reporting and the risk registers, especially at service level.<br><br>Assurance<br>• All Datix incidents undergo a robust quality check to ensure accuracy of reporting utilising a Standard operating procedure process to reduce unwarranted variation.<br>• The data shows that incident reporting has remains consistent throughout the last year, there has been a spike in moderate incidents in June 2023 however this may be due to reclassification of incidents.<br>• Themes and trends continue to be analysed and moving forward will form the intelligence for the yearly PSIRF plan. There are several workstreams (e.g., Deteriorating patient |

and pressure ulcer working group) in the Trust which look at the current top categories of reported incidents.

- For Q3 there were 2491 incidents reported throughout the Trust, only 3.6% of these were moderate or above harm. These incidents continue to be scrutinised through the Weekly Patient Summit with executive oversight.

Alerting

- The Risk Management Team will be working collaboratively with the divisional teams to thematically cluster all the 175 open actions and consider closure if an improvement workstream is already in place.
- There are a high number of open risks at service level that require review, a targeted piece of work is now being undertaken with risk team members assigned to divisional teams. A more prescriptive process has been put in place to assist divisional colleagues.
- Duty of candour compliance has been challenging due to the length of time reporting takes but the move to Patient Safety Reviews (PSR) under PSIRF should help to resolve this.

Advising

- The risk team has cleared a significant backlog of quality control checks on incident reporting in recent weeks.
- There were 7 Serious Incident Inquires and 12 Clinical Reviews Commissions in Q3 with common themes being: delay in treatment, delay in diagnosis and failure to follow up.

| **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) -** | ☐ |

# Risk Management Report

Salisbury NHS Foundation Trust

Quarter Three (Oct, Nov and Dec 2023)

Kim Melbourne

# Overview

This report has been written by the Risk Management Team for SFT to detail the current Trust position in relation to the following:

Annual data
- Incident Reporting Overall Profile
- Total Annual moderate/Severe Incidents
- Total Annual Incidents by Category
- Breakdown of Annual data (Dec 22 – Dec 23)

Q3 Data
- Total Reported Incidents in Q3
- Total Q3 Incidents by Category
- Breakdown of Moderate incidents in Q3
- Serious Incident Investigations (SII) and Clinical reviews (CR) in Q3
- SII/CR Action Compliance and Deep Dives
- Risk Registers
- Duty of Candour (DoC)

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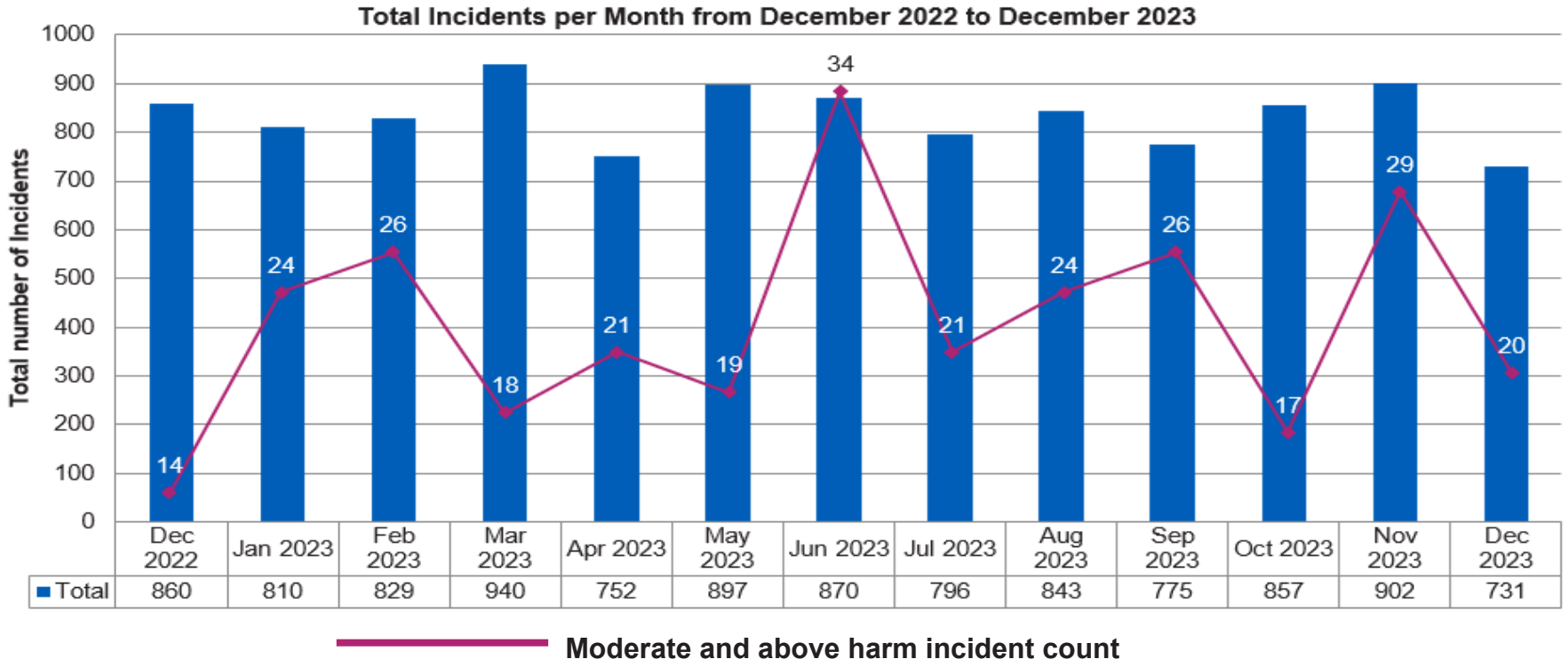
# Annual Review of Incidents 2022 - 2023

# Incident Reporting Overall Profile

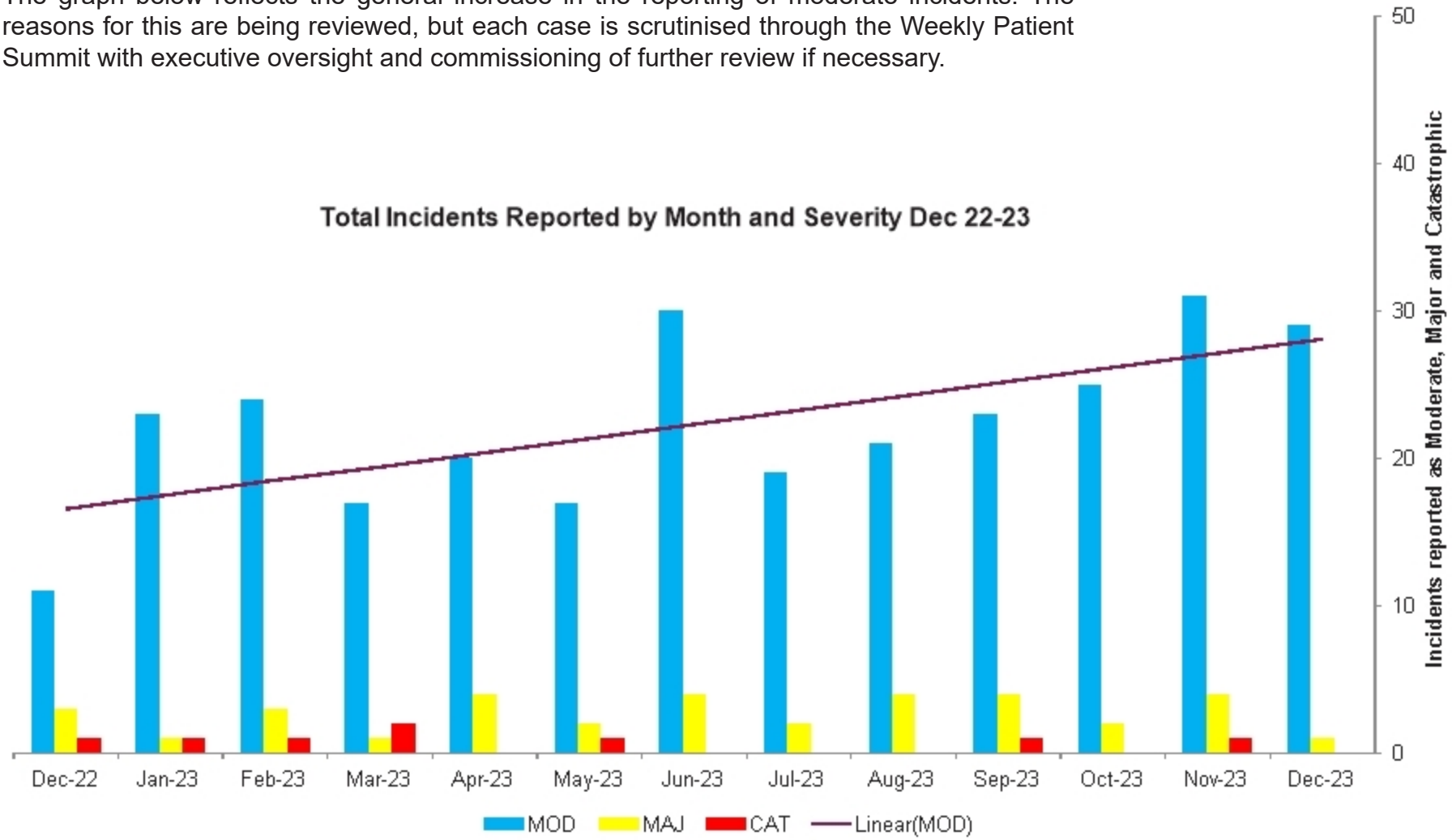
In December, the Trust switched to the Learning From Patient Safety Events (LFPSE) system for reporting our patient safety incidents to the national platform, this has replaced the National Reporting Learning System (NRLS). Datix remains the system in place for reporting events. The graph below shows that our reporting culture has remained consistent throughout the last 12 months. The full extent of the impact of the LFPSE system will become evident at the end of Q4, with a hope that reporting increases with awareness.



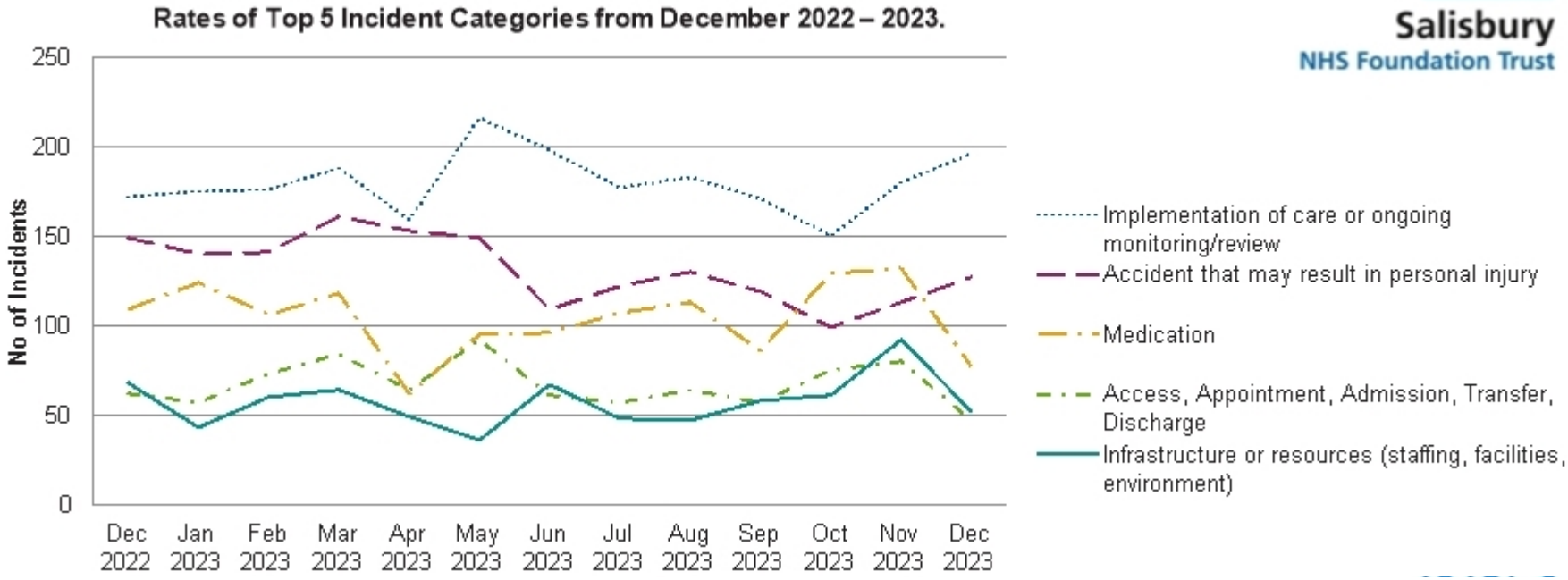

There is an increase in the number of moderate incidents in June 2023 there were several Maternity incidents that were reclassified from no harm to moderate in June which would account for the spike.

# Total Annual Moderate/Severe Incidents

The graph below reflects the general increase in the reporting of moderate incidents. The reasons for this are being reviewed, but each case is scrutinised through the Weekly Patient Summit with executive oversight and commissioning of further review if necessary.



# Total Annual Incidents by Category




The above run chart demonstrates 13 months of reported incidents and will be further broken down into quarter 3 later in the report.

The highest reported incident type is implementation of care or ongoing monitoring/review, this includes all reported pressure ulcers. The following slides will breakdown each incident category.

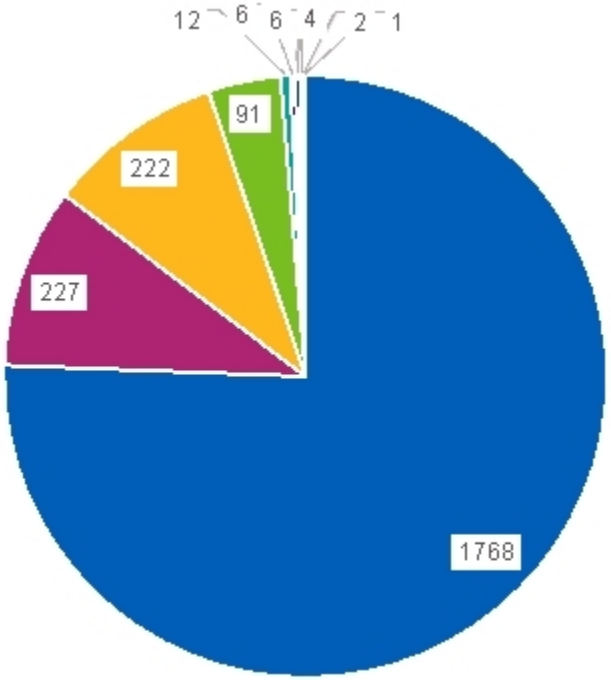
There are several ongoing workstreams and breakthrough objectives that are In place that include:

- The Deteriorating Patient
- Pressure Ulcers
- IPC working group
- Falls Working group
- VTE working group

# Breakdown of Annual data (Dec 22 – Dec 23)

## Implementation of care or ongoing monitoring (2,339)

Salisbury NHS Foundation Trust




- Pressure sore / decubitus ulcer 1768
- Possible delay or failure to Monitor 227
- Implementation of care or ongoing monitoring - other 222
- Infection control 91
- Inadequate maintenance of fluids 12
- Slips, trips, falls and collisions 6
- Patient complains of inadequate pain management 6
- 24-hour monitoring of "at risk" mental patients 4
- Other medication error 2
- Pulmonary embolism postoperatively 1

This chart shows implementation of care broken down into subcategories, the highest being pressure ulcers, 588 of these were present on admission to hospital and 613 were hospital acquired. The TV Team undertake a more in-depth review and cleanse the number formally reported via the IPR. Numbers reduce as staff reporting may be duplicated as patient moves through services and may include tissue damage that is not pressure related such as vascular issues (e.g. leg ulcers). The Trust has a workstream for pressure ulcers implementing a new assessment form and charting processes

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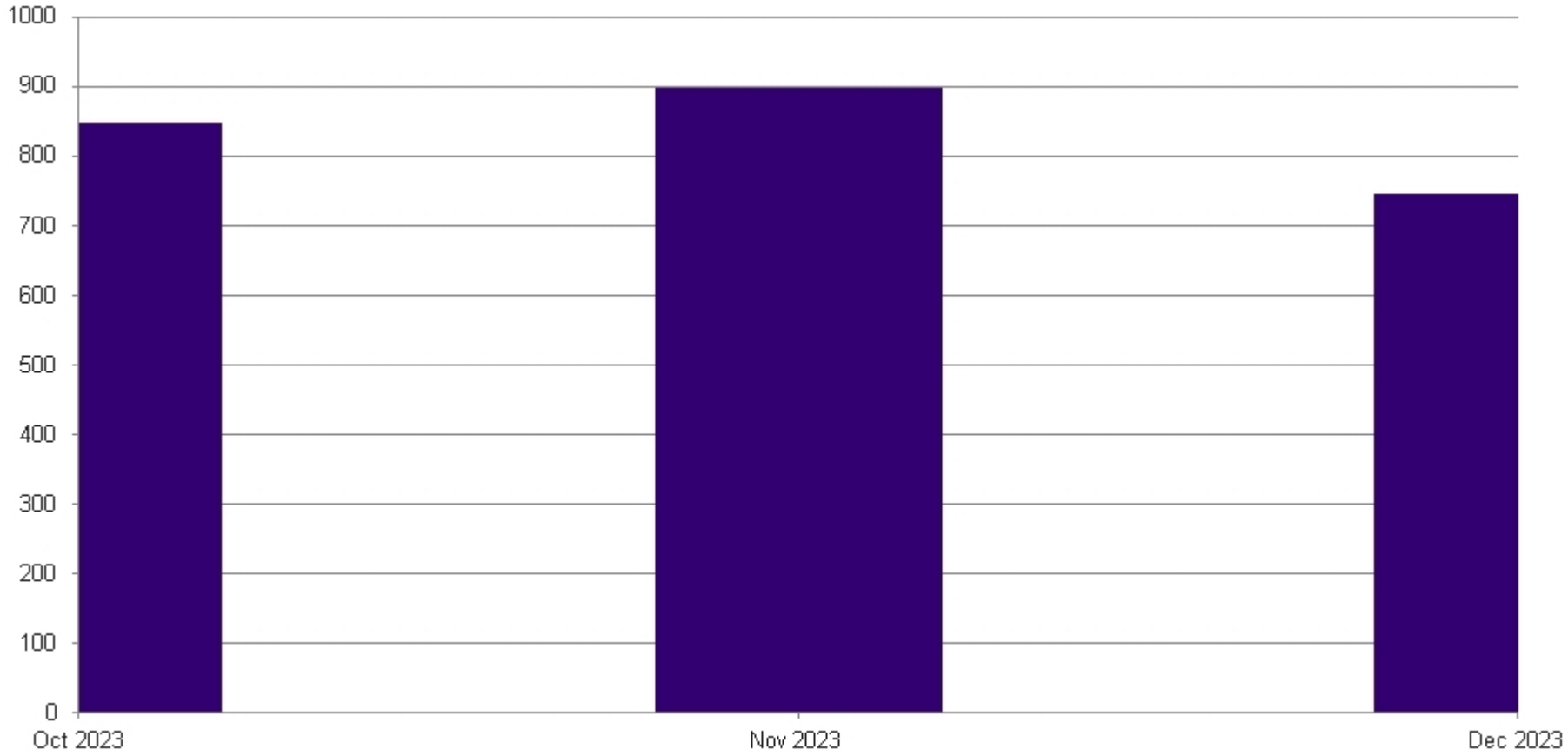
# Quarter 3 Incidents (Oct, Nov, Dec 2023)

# Total Reported Incidents in Q3

Salisbury NHS Foundation Trust

In quarter 3 there were a total of 2491 incidents reported, the below table breaks this down by month.
December numbers are lower than the previous months, this could be attributed the usual decrease in reported incidents through the Christmas period. This is commonly seen in the summer holiday period.

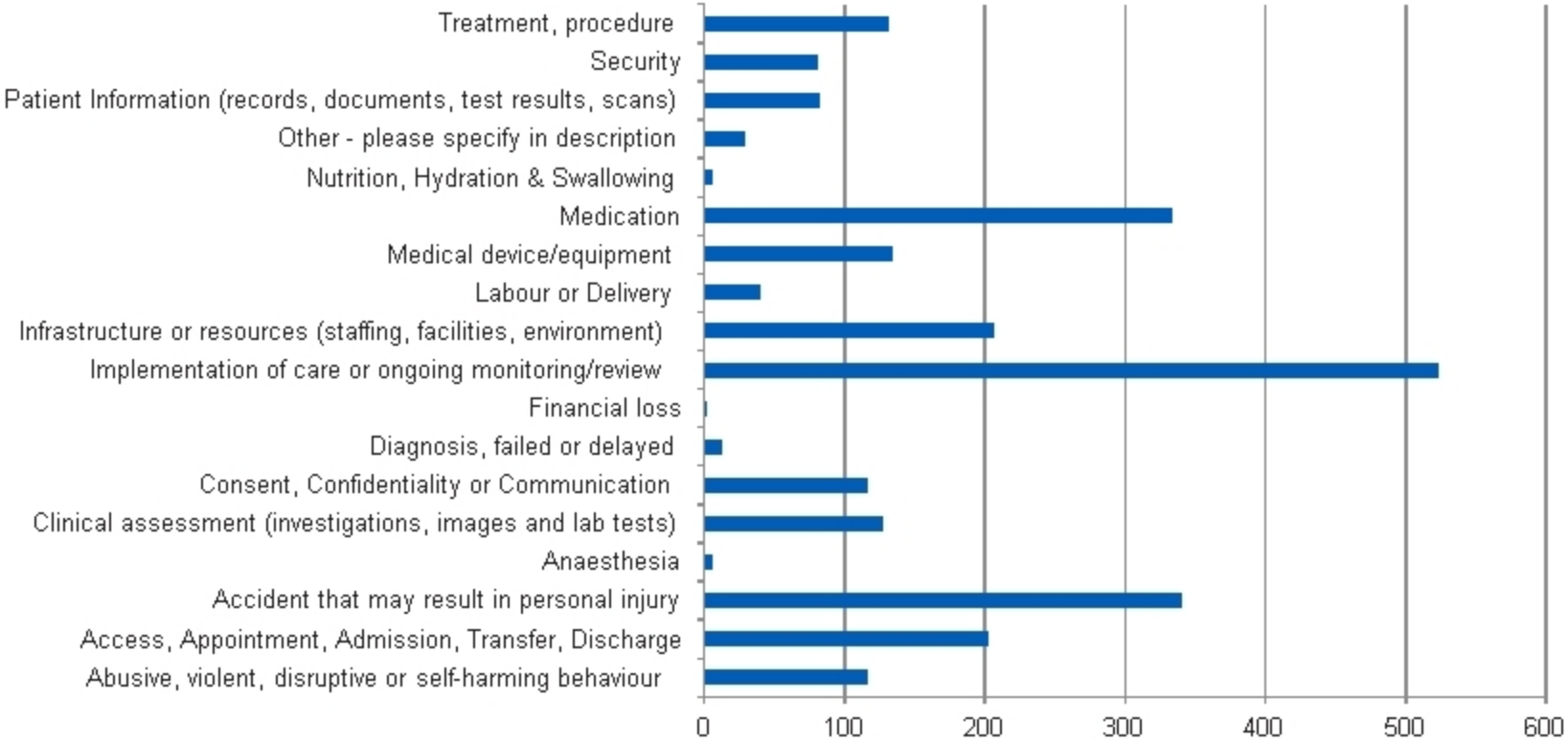


# Total Q3 Incidents by Category

Similarly to the annual picture,  the highest reported incident type in Q3 is implementation of care or ongoing monitoring/review.

There are several ongoing workstreams and breakthrough objectives in place to focus on the areas identified in the data, these include:

- Recognising the deteriorating patient (Breakthrough objective 24/25)
- Pressure damage reduction
- IPC working group
- Falls Working group (Breakthrough objective 23/24)
- VTE working group
- Medication management

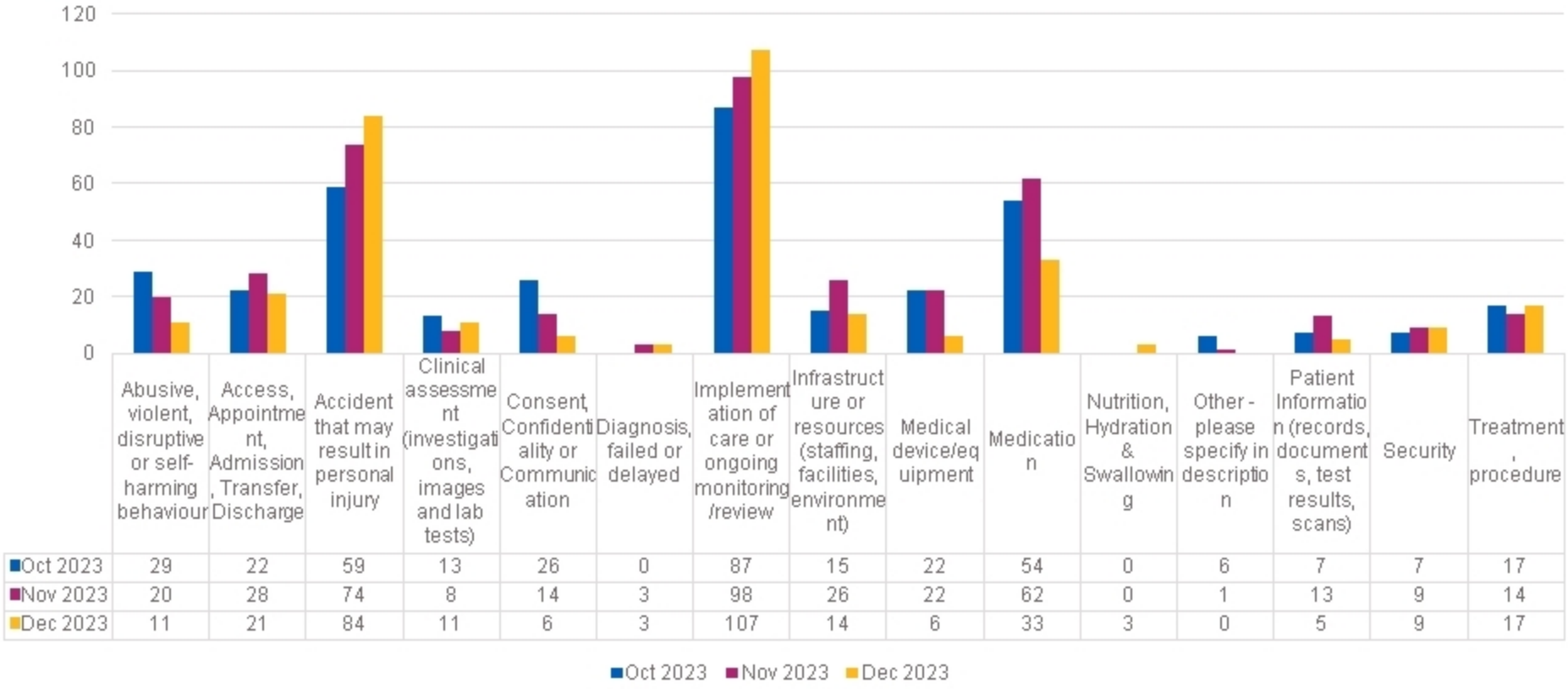


# Breakdown of Q3 (Oct 23 – Dec 23)

## Medicine Divisional Themes and Trends

Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the medicine division for Quarter 3.



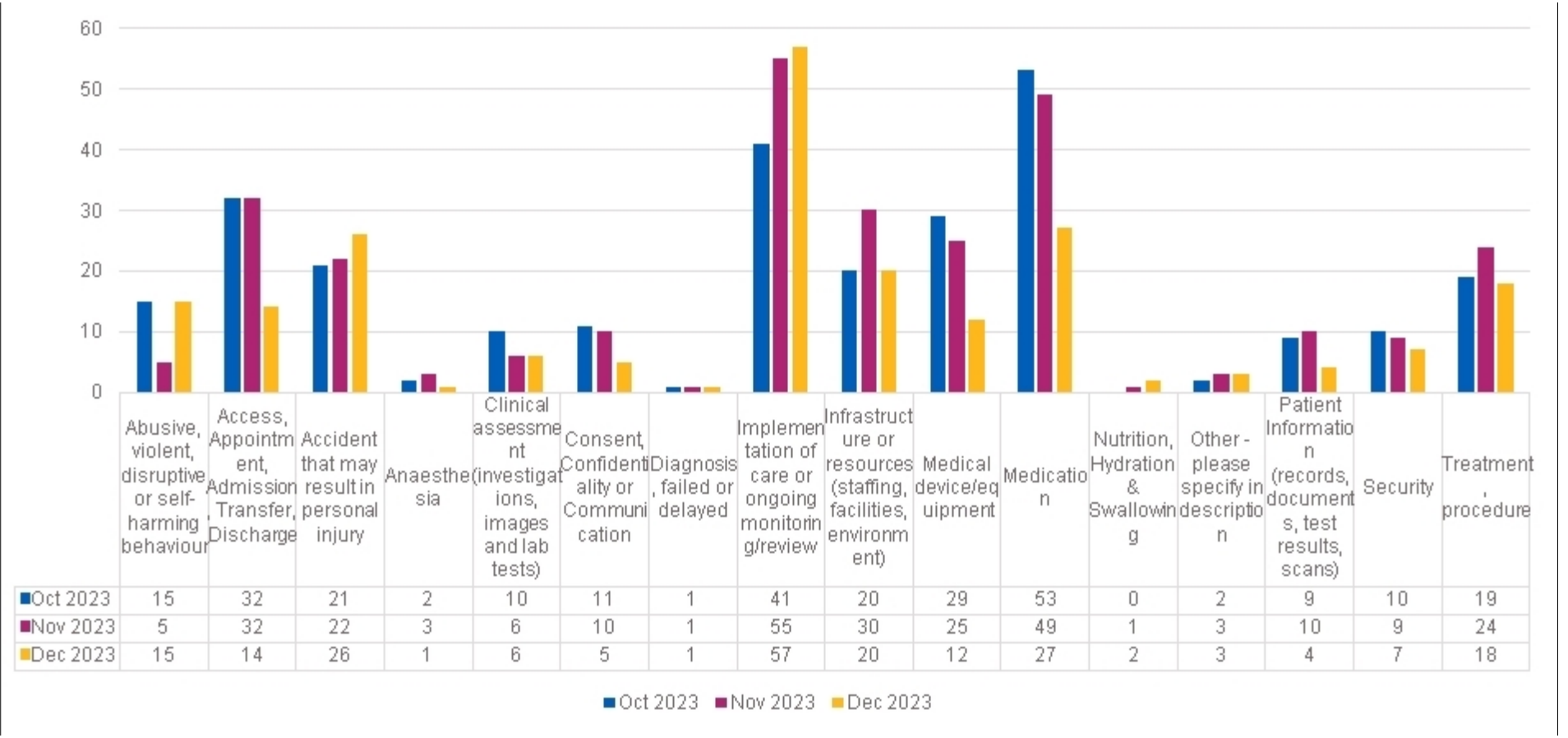

| | Abusive, violent, disruptive or self-harming behaviour | Access, Appointment, Admission, Transfer, Discharge | Accident that may result in personal injury | Clinical assessment (investigations, images and lab tests) | Consent, Confidentiality or Communication | Diagnosis, failed or delayed | Implementation of care or ongoing monitoring /review | Infrastructure or resources (staffing, facilities, environment) | Medical device/equipment | Medication | Nutrition, Hydration & Swallowing | Other - please specify in description | Patient Information (records, documents, test results, scans) | Security | Treatment, procedure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oct 2023 | 29 | 22 | 59 | 13 | 26 | 0 | 87 | 15 | 22 | 54 | 0 | 6 | 7 | 7 | 17 |
| Nov 2023 | 20 | 28 | 74 | 8 | 14 | 3 | 98 | 26 | 22 | 62 | 0 | 1 | 13 | 9 | 14 |
| Dec 2023 | 11 | 21 | 84 | 11 | 6 | 3 | 107 | 14 | 6 | 33 | 3 | 0 | 5 | 9 | 17 |

# Breakdown of Q3 (Oct 23 – Dec 23)

## Surgery Divisional Themes and Trends

NHS Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the surgery division for Quarter 3.



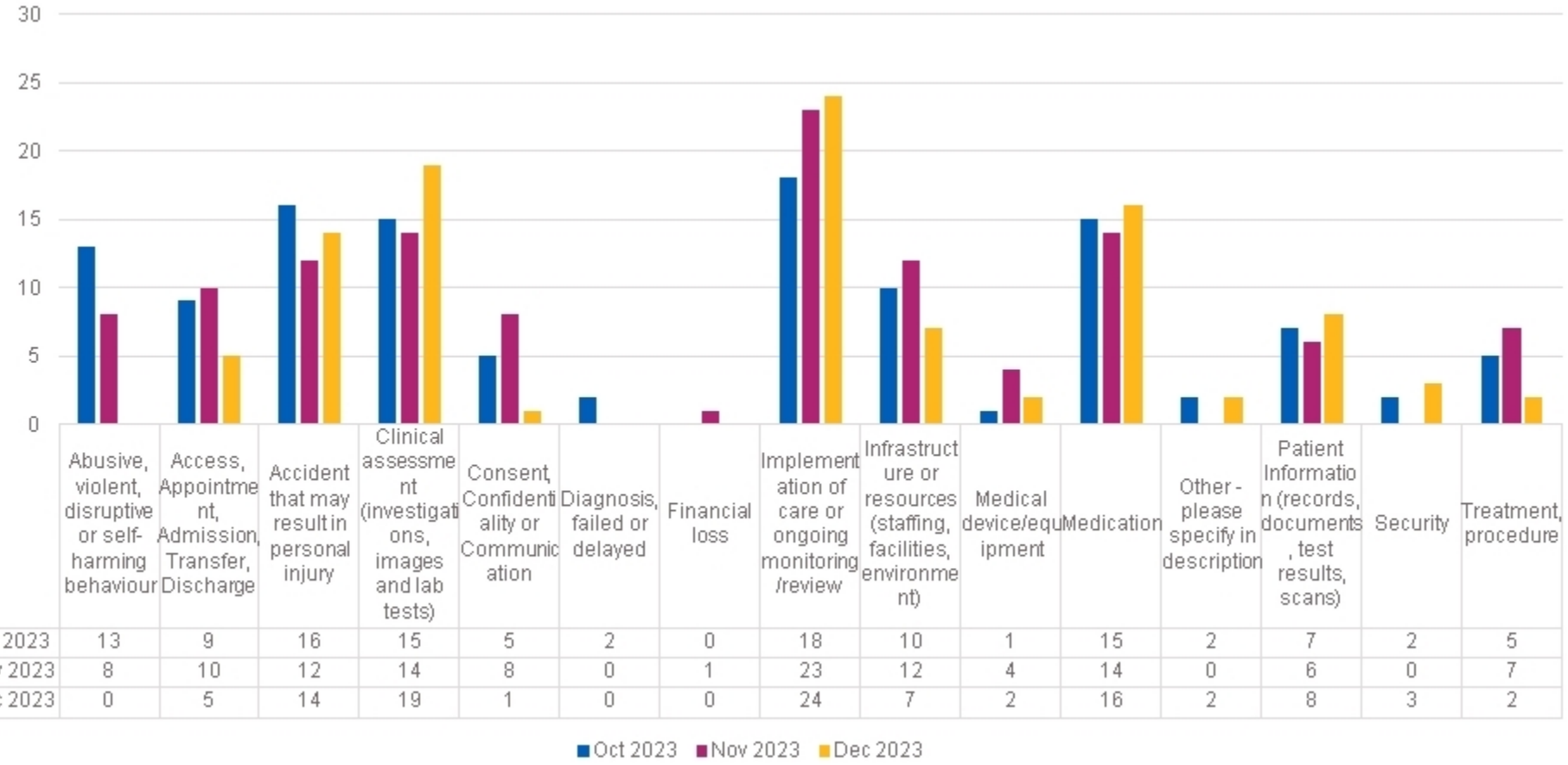

| | Abusive, violent, disruptive or self-harming behaviour | Access, Appointment, Admission, Transfer, Discharge | Accident that may result in personal injury | Anaesthesia | Clinical assessment (investigations, images and lab tests) | Consent, Confidentiality or Communication | Diagnosis, failed or delayed | Implementation of care or ongoing monitoring/review | Infrastructure or resources (staffing, facilities, environment) | Medical device/equipment | Medication | Nutrition, Hydration & Swallowing | Other - please specify in description | Patient Information (records, documents, test results, scans) | Security | Treatment, procedure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oct 2023 | 15 | 32 | 21 | 2 | 10 | 11 | 1 | 41 | 20 | 29 | 53 | 0 | 2 | 9 | 10 | 19 |
| Nov 2023 | 5 | 32 | 22 | 3 | 6 | 10 | 1 | 55 | 30 | 25 | 49 | 1 | 3 | 10 | 9 | 24 |
| Dec 2023 | 15 | 14 | 26 | 1 | 6 | 5 | 1 | 57 | 20 | 12 | 27 | 2 | 3 | 4 | 7 | 18 |

# Breakdown of Q3 (Oct 23 – Dec 23)

## CSFS Divisional Themes and Trends

Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the CSFS division for Quarter 3.



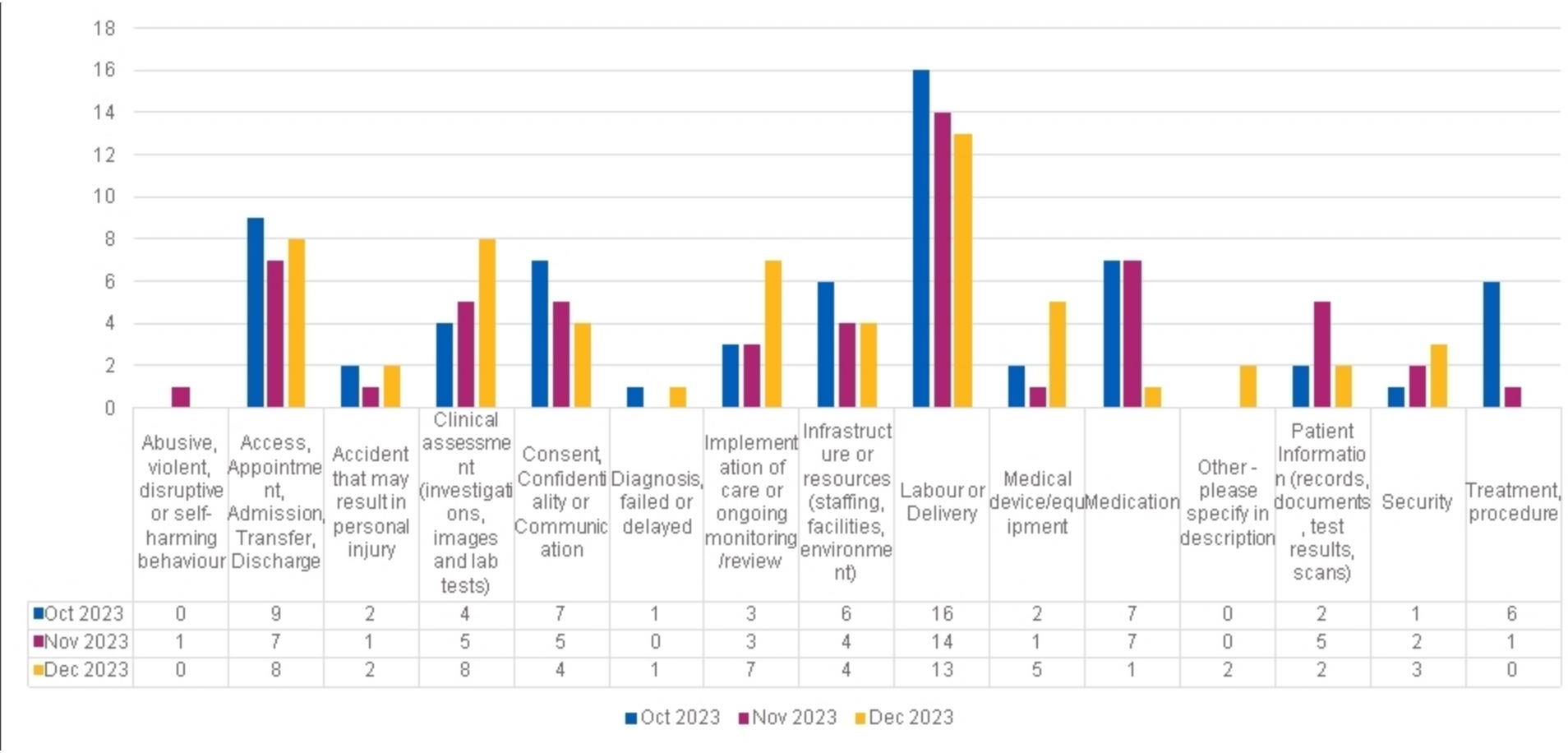

| | Abusive, violent, disruptive or self-harming behaviour | Access, Appointment, Admission, Transfer, Discharge | Accident that may result in personal injury | Clinical assessment (investigations, images and lab tests) | Consent, Confidentiality or Communication | Diagnosis, failed or delayed | Financial loss | Implementation of care or ongoing monitoring /review | Infrastructure or resources (staffing, facilities, environment) | Medical device/equipment | Medication | Other - please specify in description | Patient Information (records, documents, test results, scans) | Security | Treatment, procedure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oct 2023 | 13 | 9 | 16 | 15 | 5 | 2 | 0 | 18 | 10 | 1 | 15 | 2 | 7 | 2 | 5 |
| Nov 2023 | 8 | 10 | 12 | 14 | 8 | 0 | 1 | 23 | 12 | 4 | 14 | 0 | 6 | 0 | 7 |
| Dec 2023 | 0 | 5 | 14 | 19 | 1 | 0 | 0 | 24 | 7 | 2 | 16 | 2 | 8 | 3 | 2 |

# Breakdown of Q3 (Oct 23 – Dec 23)

Salisbury NHS Foundation Trust

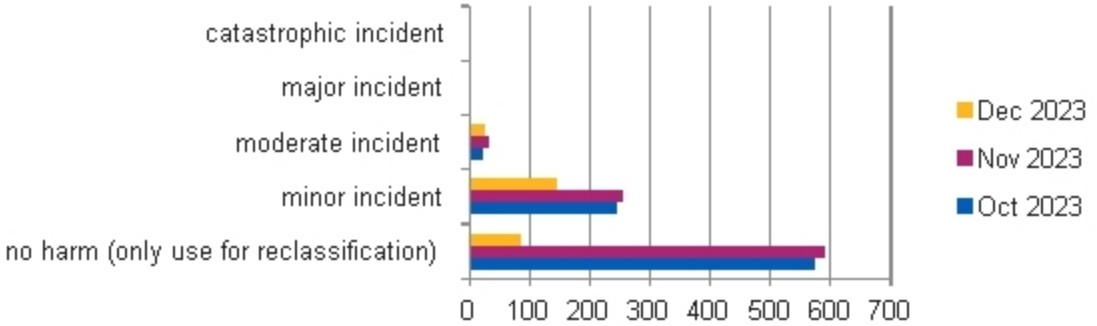
## WNB Divisional Themes and Trends

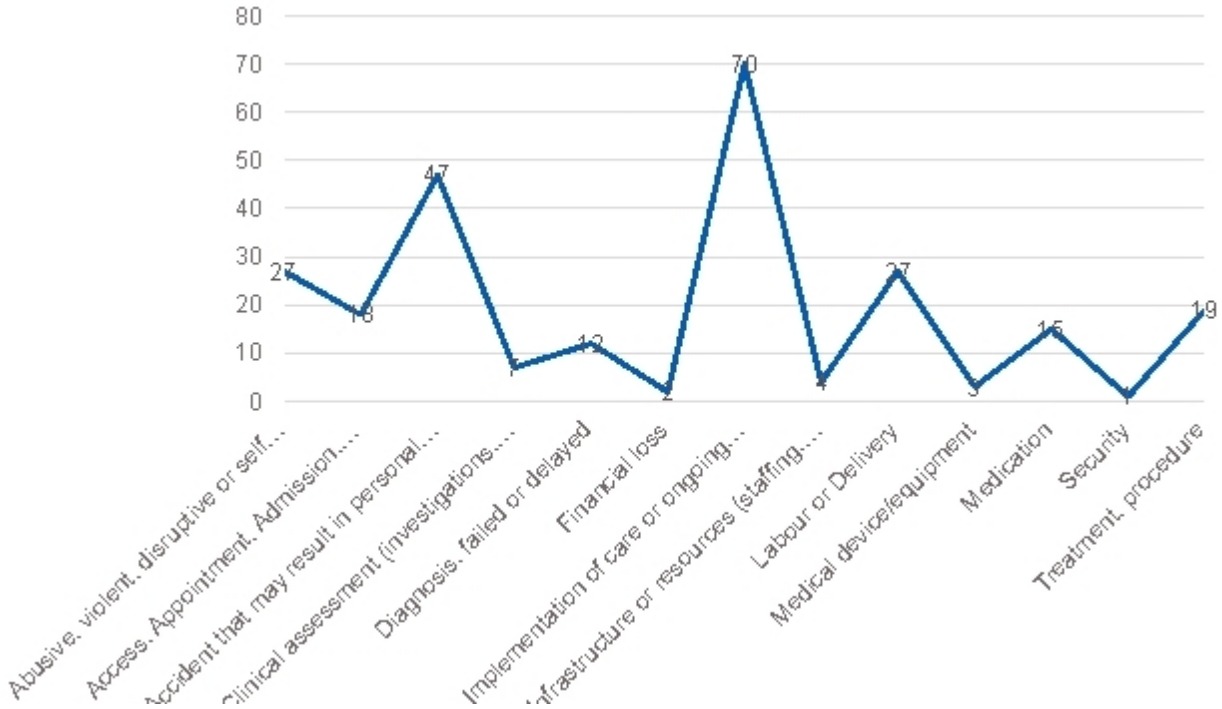
This chart shows the themes and trends of incidents in the women and new-born division for Quarter 3.




| | Abusive, violent, disruptive or self-harming behaviour | Access, Appointment, Admission, Transfer, Discharge | Accident that may result in personal injury | Clinical assessment (investigations, images and lab tests) | Consent, Confidentiality or Communication | Diagnosis, failed or delayed | Implementation of care or ongoing monitoring /review | Infrastructure or resources (staffing, facilities, environment) | Labour or Delivery | Medical device/equipment | Medication | Other - please specify in description | Patient Information (records, documents, test results, scans) | Security | Treatment, procedure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oct 2023 | 0 | 9 | 2 | 4 | 7 | 1 | 3 | 6 | 16 | 2 | 7 | 0 | 2 | 1 | 6 |
| Nov 2023 | 1 | 7 | 1 | 5 | 5 | 0 | 3 | 4 | 14 | 1 | 7 | 0 | 5 | 2 | 1 |
| Dec 2023 | 0 | 8 | 2 | 8 | 4 | 1 | 7 | 4 | 13 | 5 | 1 | 2 | 2 | 3 | 0 |

# Breakdown of Moderate incidents in Q3




Of the 2491 incidents reported, only 90 of these were moderate or above harm which is on average 3.6% of incidents.

This separates the moderate and above incidents into categories, the next slide will break this down further.

# Continued Breakdown of Moderate incidents in Q3

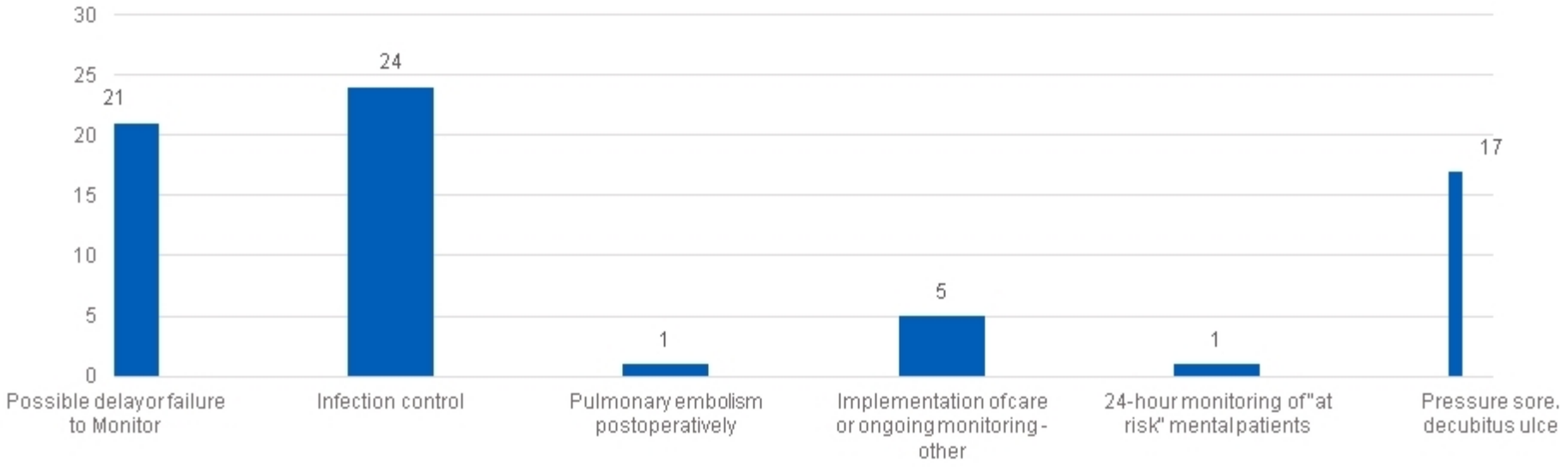
Salisbury NHS Foundation Trust

The highest reported moderate incident category is Implementation of care or ongoing monitoring, the graph below breaks this down into subtypes of the incident.

Infection control is the most common moderate incident that is reported, The IPC team work to national reporting standards and we benchmark well against other trusts.

Delay or failure to monitor is an area of focus for the trust currently and is one of our breakthrough objectives.

Pressure sores have been a focus of ours for some time, ongoing work includes; the TVN lead is bringing in a new aSSKINg bundle for the assessment of patient skin and there is new body maps being introduced throughout the trust.



# Serious Incident Investigations (SII) and Clinical reviews (CR) in Q3

NHS Salisbury Foundation Trust

**2023/24**

**Quarter Three**

**7 SII's & 12 CR's**

**13 Moderate**

CR 599 – WNB – Community MOH

CR 600 – Med – Missed Fracture

CR 601 – Med – Delay to treatment

SII 603 – Med – Delay to treatment

CR 604 – Med – Incorrect Anti-coag dosage

CR 605 – Med – Delay to treatment

CR 606 – CSFS – Failure to Follow Up

CR 607 – Surg – Delay to follow up

CR 608 – Surg – Failure to treatment and handover

CR 612 – Med – Overdose

CR 613 – WNB – Eclamptic fit

SII 615 – Surg – Water plant Breakdown

SII 616 – CSFS – Undiagnosed Melenoma

**3 Major**

CR 602 – CSFS – Inappropriate Transfer

CR 609 – med – stroke call unavailability

SII 611 – Surg – Delayed Diagnosis

**3 Catastrophic**

SII 598 - Med – AMU Discharge Process.

SII 610 – Med – NEWS2 not actioned

SII 614 – Med – Deteriorating patient

There was a decrease in commissioning of reviews in December 2023, this is due to the transition over to PSIRF and the focus on only commissioning SII's.

The common themes are:

- Failure to recognise and escalate deteriorating patient (Breakthrough Objective)
- Delay to treatment /follow up (Theme to be addressed in PSIRF framework)
- Medication error (local priority subject identified by PSIRF analysis with related workstream)

# SII/CR Action Compliance and Deep Dives

NHS Salisbury NHS Foundation Trust

As this table shows, there are currently 175 outstanding actions across the 4 clinical divisions.

| Directorate | Open actions |
|---|---|
| CSFS | 9 |
| Medicine | 89 |
| Surgery | 45 |
| Women and Newborn | 32 |

Moving forward the Risk Management Team will be working collaboratively with the divisional teams to thematically cluster all the 175 open actions and consider closure if an improvement workstream is already in place. A high number of actions have been actioned but as per good practice the risk team will not close them until all evidence is submitted.

Traditionally we aim to hold a deep dive meeting for each clinical division every 3 months. The Divisional Management Teams, Executives and Risk Management attend to go through their Risk Registers and Compliance with open actions.

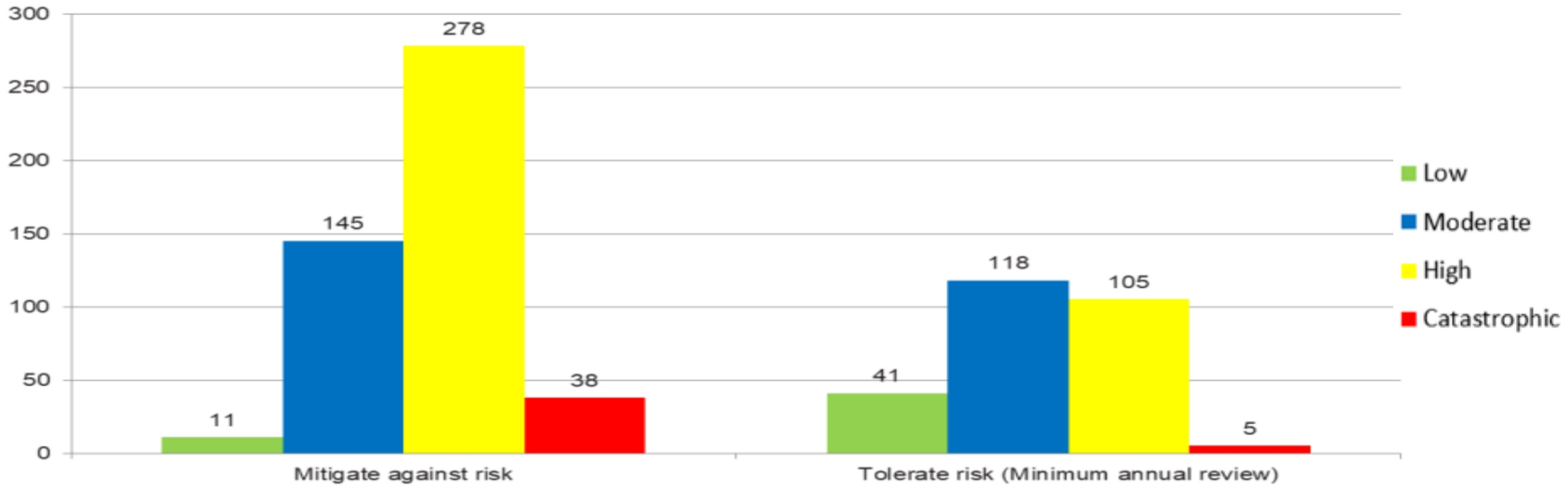
NHS
Salisbury
NHS Foundation Trust

# Risk Registers

# Divisional and Service Level Risk Registers

Salisbury NHS Foundation Trust

- As of March 2024, there are 741 open risks throughout the trust, of these 269 are being tolerated while 472 are being mitigated.
- The risk team aim to run quarterly deep dives into the divisional risk registers with the CNO and CMO but there is less robustness about the processes being undertaken at service level, this has been reviewed in an external audit by KPMG and we await the outcomes but to note targeted work is planned .
- Following the approval of the Trust risk management strategy the risk team have assigned a staff member to each division to assist them with management of the risk register at a service level. They are providing a more detailed process of review to aid the divisional teams. This will clarify the steps in the review process including how to assess the score, the time frames and the mitigating actions.



# Duty of Candour (DoC)

Salisbury NHS Foundation Trust

Duty of candour is a three-stage process that requires initial information sharing of any moderate or above incident review. Stage 2 is that a letter to the person that has been involved detailing the review work and this needs to be uploaded to Datix to be counted in the percentage data, the final stage is the sharing of the review outcomes. The length of time it taking to undertake those reviews impacts the stage 3, the move to PSIRF and the use of Patient Safety Reviews will speed up all aspects of this and should positively impact the DOC processes

A DoC tracker has been incorporated into the weekly Patient Safety Summit meeting which keeps track of compliance. The table outlines a significant increase in stage 1 and 2 DoC being completed since its implementation.

This will in the future be added to the Deep Dive agendas in place of the current SII/CR action tracker which will eventually dissolve due to PSIRF, the work the Risk team are doing to distribute the actions into the existing workstreams will support this.

| Q3 (Oct-Dec 2023) | | |
|---|---|---|
| | Compliance against total cases | Compliance Percentage |
| Stage 1 compliance | 43/56 | 77.00% |
| Stage 2 compliance | 35/55 | 64.00% |
| Stage 3 compliance | 24/55 | 44.00% |

# In Conclusion…

NHS Salisbury NHS Foundation Trust

- All Datix incidents undergo a robust quality check to ensure accuracy of reporting utilising  a Standard operating procedure process to reduce unwarranted variation.
- The data shows that Incident reporting has remains consistent throughout the last year, there has been a spike in moderate incidents in June 2023 however this may be due to reclassification of incidents.
- Themes and trends continue to be analysed and moving forward will form the intelligence for the yearly PSIRF plan. There are several workstreams (e.g. deteriorating patient and pressure ulcer working group) in the trust which look at the current top categories of reported incidents.
- For quarter 3 there were 2491 incidents reported throughout the Trust, only 3.6% of these were moderate or above harm. These incidents continue to be scrutinised through the weekly patient summit with executive oversight.
- There were 7 Serious Incident Inquires and 12 Clinical Reviews commissions in Q3 with common themes being: delay in treatment, delay in diagnosis and failure to follow up. The SII/CR compliance reports are being reviewed and the Risk Management Team will be working collaboratively with the divisional teams to thematically cluster all the 175 open actions and consider closure if an improvement workstream is already in place.

# Next Steps…

Salisbury NHS Foundation Trust

Injuries to staff are now escalated and fed into the Violence and Aggression Working Group.

LFPSE have not released the national data for 2023 at the time of writing, therefore we are not able to benchmark our stats currently however in Q4 we hope to be able to present this data.

The Risk management team will be continuing to look at themes and trends of the daily Datix that are submitted, this will be fed back into the Learning from Incidents Forum or each division and inform the annual PSIRF plan.

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 6.1 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Bi-Annual Safe Staffing: Six monthly update | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | | x | |
| Approval Process: (where has this paper been reviewed and approved): | Safe Staffing Board | | | |
| Prepared by: | Fiona Hyett, Deputy Chief Nurse | | | |
| Executive Sponsor: (presenting) | Judy Dyos, Chief Nurse | | | |
| Appendices | Nil | | | |

## Recommendation:

Trust Board is asked to review and note the six monthly update safe staffing review. The paper provides an update on progress of implementation of the recommendations from the full safe staffing review (Sept 2023), of the current nurse staffing position reviewed as per the requirement of NHS guidance Developing Workforce Safeguards and NQB guidance for safer staffing.

It is recognised that there was a significant funding request at a time of financial challenge and so the recommendations for investment were stratified into those most urgent based on risk and that a focus on reducing additional staffing requirements would in part fund the required investment to deliver safe staffing levels. At the time of the 6-monthly update the red-rated recommendations for increased staffing had not been implemented at ward level thus it has not been possible to recruit into these posts or review the impact on outcomes.

## Executive Summary:

The six-monthly safe staffing update has focused on implementation of the recommendations from the full review and provides an overview of the nursing position in relation to 6 key metrics which are reviewed monthly at the Safe Staffing Board, an overall improvement has been seen across these metrics.

During the period of the review (September 2023-March 2024) there has been a continued improvement in nurse staffing levels in terms of reduction in vacancy levels and a reduction on temporary staffing spend. It should be noted that the recruitment has been heavily reliant on international and newly qualified nurses leading to a more dilute skill mix as these nurses need time to adjust to NHS way of working.

Other factors which have continued to impact on safe staffing levels include operational capacity demands impacting both the front door (Emergency Dept/AMU and downstream wards), and high levels of staff sickness at ward level.

Corporate risk register ID 7039, which was initially logged when safe staffing levels could not be guaranteed has now been reduced to a rating of 12, following the improvement in vacancy levels and staff unavailability.

It should be noted that Care Hours per Patient Day (CHPPD) which whilst alone cannot be seen as a measure of quality and safety has improved from a low figure of 5.7 in September 2022 to 8.01 in January 2024. Current figures are

artificially inflated by some areas being over their RN/HCA complement as the staff have been employed in preparation for the opening of Imber Ward.

There is an on-going impact in the numbers of patients admitted who require RMN or general enhanced care support to meet their needs which increased the numbers of staff required in some wards on a day to day basis. An SOP has been implemented to ensure this demand is supported by effective assessment of enhanced care needs and a changed process for the authorization of the creation of additional duties in excess of ward establishments has been implemented.

The full implementation of the Safer Nursing Care Tool has commenced which will ensure that future safe staffing reviews will have evidence-based data to support establishment setting in line with NQB and NICE guidance and ensure nursing meets all elements of Workforce Safeguards.

The Board is also asked to note the on-going collaborative work across the Acute Health Alliance which is now focused on ED, CNS, theatres and out-patient staffing.

The Board is asked to note the report which has been reviewed at Clinical Governance Committee through the lens of quality and patient safety.

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

Trust Board May 2024

| | |
|---|---|
| **Title** | Nurse Safe Staffing Review Update |
| **Meeting Date** | May 2024 |
| **Executive Sponsor** | Judy Dyos – Chief Nursing Officer |
| **Author** | Fiona Hyett - Deputy Chief Nursing Officer |

## 1.0 Background

This report provides an update on the full annual safe staffing review that took place in August 2023 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 safe staffing review was presented to Trust Board in September 2023. 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. The full staffing review that took place in September took into consideration initial recommendations from the Acute Health Alliance workforce review – headroom (fully achieved) and minimum ratio of 1:7.
At the time of this mid-review the recommendations rag-rated red, provisionally agreed at Board have not yet been implemented due to financial considerations, there were other staffing recommendations rated amber and green which were not approved and which are likely to require funding in the next full review.

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

- Update and review of recommendations from 2023 skill mix review (whilst red-rated approved at Board have not at time of report been implemented into budgets)
- Overview of key nursing metrics to assure the workforce is deployed efficiently and effectively, supporting delivery of levels of attainment.
- Care Hours Per Patient Day summary
- Continued work within Acute Health Alliance in nursing workforce

## 2.0 Review of Previous Recommendations

In August 2023 a total of £1,950,465 additional funding to support changes to ward establishment was requested, which following review and prioritisation £1,190141 was presented and approved in principle by Board subject to budget setting process and cycle. The table below summarises the requests approved to go into budget setting for 2024/25.

| WARD | Recommendation | Rationale | COST |
|---|---|---|---|
| **AMU** | Uplift 3wte from B5-B6 | 2 x B6 per shift to support SDEC | £36,050 |
| **ED** | 5.3wte B5 RN | Additional triage (ECIST) | £263,316 |
| | 2.5wte B3 HCA | RCEM/ECIST | £92,680 |
| | 2wte B4 Nurs Ass | ED NA funding recieved | £78,762 |
| **Farley** | Uplift 2.6wte B5-B6 | 24/7 B6 cover – 4hr target | £31,243 |
| **Laverstock** | Increase by 1B5 RN day and night (5.3wte) | Unfunded beds and achieve 1:6 ration resp beds | £263,316 |
| **Spire** | 2.6wte B5 RN nights | Meet ratio of 1:7 (currently 1:10) – quality concerns on ward | £129,714 |
| **Amesbury** | 2.6wte B5 RN nights | Meet ratio of 1:7 (currently 1:10) | £129,714 |
| **Britford** | Uplift 0.5wte B5 to B6 | Support 7-day leadership SAU | £6,008 |
| **Downton** | 2.6wte B5 RN nights | Meet ratio of 1:7 (currently 1:10) | £129,714 |
| **Sarum** | Uplift 2.6wte B5 to B6 | Support senior cover at night | £31,243 |
| | | **TOTAL** | **£1,191,760** |

*Extract from 2023 Skill Mix review, costings correct at the time of Board report September 2023.*

Given the budget setting process for 2024/25 is ongoing, these recommendations are yet to be implemented and therefore impact fully realised.

Other recommendations:
*Implementation of Safer Nursing Care Tool* – in Nov 23 6 ward areas undertook first data collection and ED completed second full review. Training is fully underway for remaining wards who will undertake first data collection in June 24 giving first data snapshot for next full safe staffing review.

*Sustain improvement in vacancy and focus on retention to decrease temporary staffing spend* – excellent progress has been made in this area. RN vacancies have reduced significantly in wards, however, this has been reliant on international recruitment market and average length of service for international nurses is approximately 2yrs so on-going focus needs to be maintained on retention and recruitment. Current turnover rates above 10% (10% for RNs and 20% for HCAs) also drives need for continued focus.
Nurse agency spend has reduced significantly in both volume and rate paid but high sickness and absence rates (average 6%), and ongoing use of escalation areas which whilst funded are not recruited to impact on further reduction in temporary staffing spend.

*Reducing additional duties to offset the funding required* – on-going focus continues in this area. Initial work has ensured correct reasons utilised for the booking of staff over and above ward templates, a weekly forward planning/review meeting has been implemented providing challenge and oversight. Enhanced care requirements for some patients continues to be high in some ward areas.

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

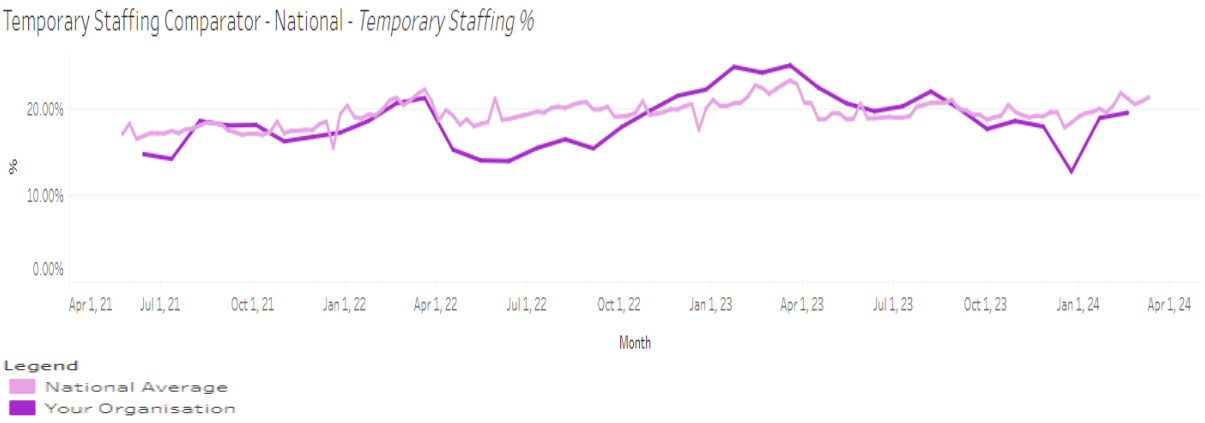
The Safe Staffing Board monitors seven core KPIs to assess the efficient and effective use of the nursing workforce against establishment (the report is also shared with divisions and HR/finance

business partners). In addition to this monitoring, the Safe Staffing Matron regularly supports and proactively engages with leads and services at risk of deterioration and puts measures in place to make improvements with stakeholders.

- **Temporary staff** - % of temporary staff used on rosters
- **Approvals** – % of rosters fully 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

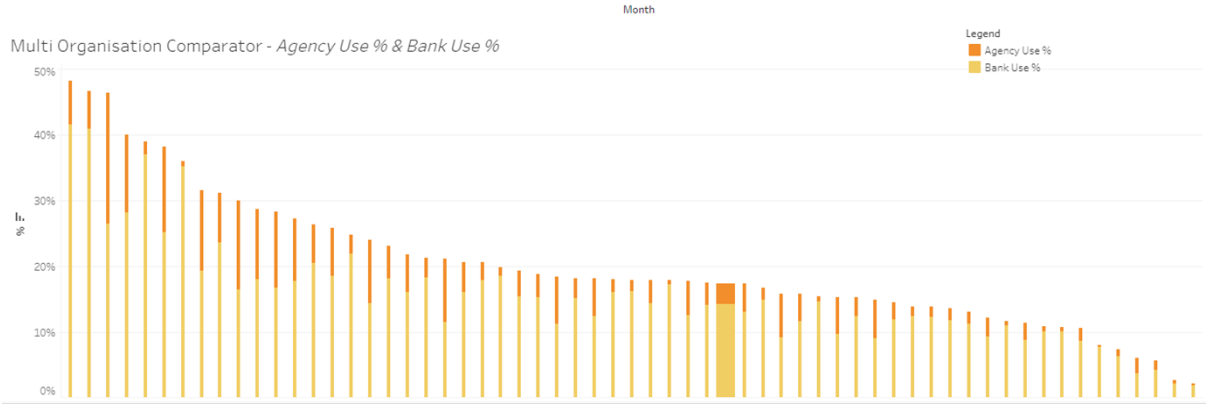
These metrics are viewable via an additional portal (Insights) from rostering supplier RLDatix (formerly Allocate), which provides a view of our performance internally as a Trust, with ability to read data and comparisons at both ward/dept level as well as against other Trusts (who use the software) 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 and narrative has been provided for each metric.

### 3.1 Temporary staffing



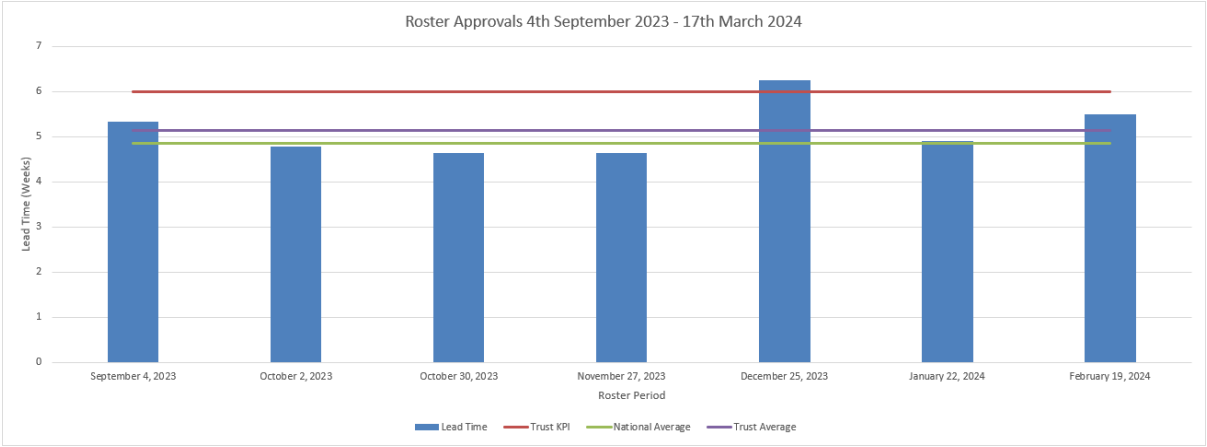

Following a peak in Q4 2022/23 the usage of temporary staffing can be seen to be on a downward trajectory, due to a reduction in vacancies alongside increased control measures. When benchmarked against other Trusts of a similar size we have been under the national average for a period of 5-months. This has translated into nursing considerably reducing its financial spend on agency staff. Drivers for on-going use are predominantly in the specialist areas (ED, ICU, Paeds, Theatres) with additional capacity beds, RMN requirements and short notice sickness being main factors at ward level.

The graph below shows our split between bank and agency (14% and 3% respectively of total nursing spend) for the past six months and how we compare to other Trusts, which is a position that has improved in the last year:



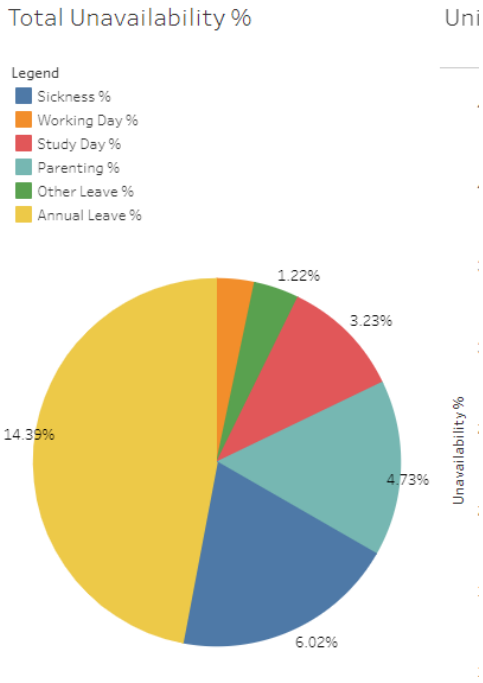

Analysis of temporary staffing usage shows that proportionately equal numbers or RN and HCA shifts are covered and across the week there is an equal spread of shifts going out to bank across the days of the week, with a slight peak on Sundays. Night shifts and weekends have a better fill rate due to the higher rates of pay offered.

### 3.2 Roster Approvals




Approval lead time Sept 2023 to March 2024 was an average of 5.2 weeks against a KPI of 6 weeks in advance, but higher than national average of 4.8. The 6 week lead time has been proven to have a positive effect on other metrics such as reducing sickness levels and temporary staff use as well as qualitative measures such as improved staff satisfaction and wellbeing.
In March 2024 Safe Staffing Board approved a change to an 8-week lead time, which supports additional time for rosters to be produced and approved to support better delivery against the 6-week KPI.

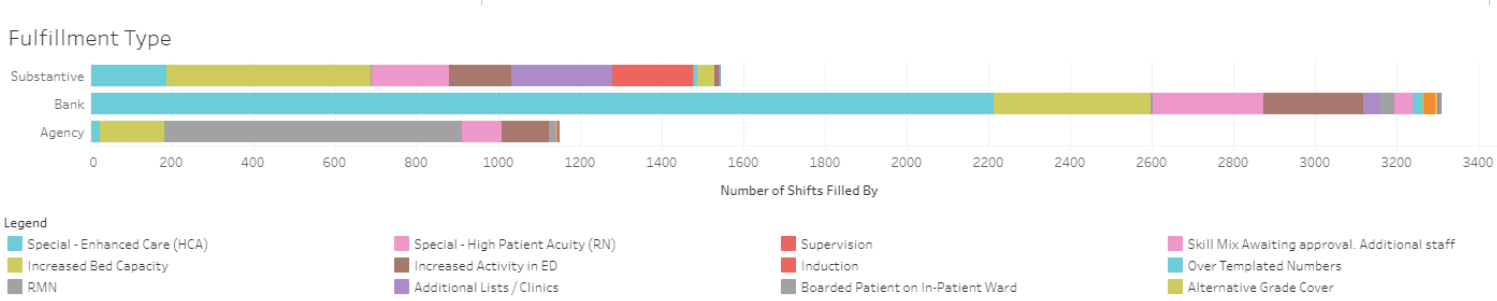
### 3.3 Unavailability (Headroom)




Staff unavailability between Sept 23 and March 24 was 30.6% (including parenting) and 25.87% (excluding parenting) against a Trust headroom of 27% and 24% respectively. Compared to last year this is an improved position
Unavailability is made up of annual leave, sickness, study leave, working days and other leave (emergency, birthday, carers etc).
All parameters are within the tolerated percentages except sickness which is at an average of 6%.

### 3.4 Additional Duties

Additional duties are shifts that are added to the rosters above the establishment template. Reasons vary from legitimate reasons, such as high patient acuity, seasonal pressures and enhanced care, to avoidable reasons, such as using up staff hours & staff requests.
The most common reasons for additional duties in the last 6 months have been HCA specials for enhanced care, increased/unfunded bed capacity (Laverstock, Breamore) corridor nursing in ED and RMN's.
In the last 6 months 3.62% of all duties were additional – 1558wte (58,427hours). The majority were filled with substantive staff or bank as per graph below.

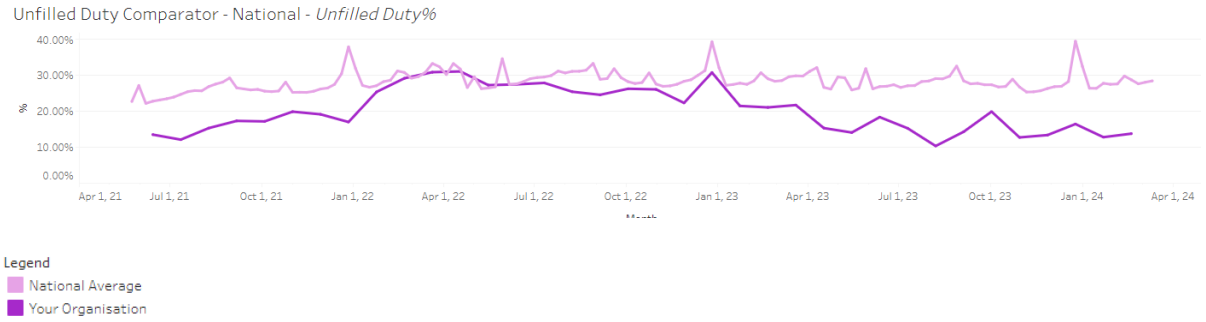



70wte (926 shifts /10,387 hrs) were used for RMNs to support patients with mental health needs. This is reliant on agency workers. The last 6months has seen a reduction in the number of RMNs required.

An SOP was introduced in November 23 for the management of additional duties to provide oversight at a minimum of matron level and a weekly forward planning review meeting has been embedded which includes all additional duties being reported on and reviewed by Dep CNO and Safe Staffing matron. There has been a slight increase seen as rostering practices are being corrected meaning staff are no longer given supernumerary shifts but are in correct additional shifts.

### 3.5 Unfilled duties

Average unfilled duties from Sept 23 -March 24 was 13.24%, significantly under the national average and a 10% decrease on last years report. These are shifts that are required but not filled by either substantive or temporary staff or are shifts that are not required but not cancelled back from a roster. There has been focused attention at the twice daily staffing calls to cancel back shifts that are not required and decrease is result of good housekeeping processes by the Dep CNO and Safe Staffing matron. The introduction of Allocation on Arrival incentive has supported increase in fill rate but comes at a premium cost.




### 3.6 Hours Balance

Average hours balance between Sept 2023 and March 2024 was 2.22% (improvement on last year). 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%.
In comparison to other Trusts we are in the lowest quartile demonstrating good control over hours balances. Monthly analysis of this at Safe Staffing steering group confirms this and often the % with poor compliance that affect our figure are non ward based areas included in our overall trust %. Ward areas have good control and is part of the scrutiny required when signing off a roster.

## 4.0 Care Hours Per Patient Day (CHPPD)

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.

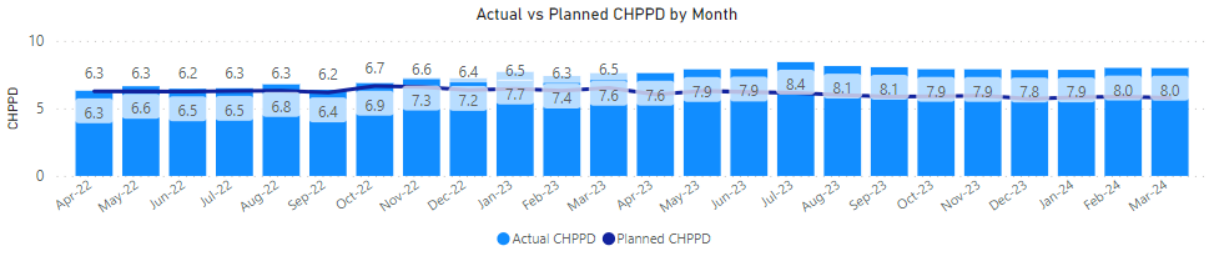
CHPPD data is designed to offer a picture of how staff are deployed and how productively, comparing a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals.

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 full 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 are not included eg 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 Trust has started to embed the use of Safer Nursing Care Tool (see section 5.0) which will ensure that the required CHPPD is set appropriately in ward establishments.

Planned CHPPD represents what staffing level 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 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. Equally if more staff are required (such as additional duties) then the actual can be over the planned hours.

The graph below shows actual vs planned combined CHPPD, with actual moving closer to planned over recent months. 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.




### 4.1 CHPPD by ward for selected months

CHPPD should not be used to compare wards against wards, but rather to show a trend in an individual ward over time. The table below shows each ward across an 18-month period.

| | | Aug-22 | | | Feb-23 | | | Mar-24 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ward** | **Specialty** | **RN** | **HCA** | **Total** | **RN** | **HCA** | **Total** | **RN** | **HCA** | **Total** |
| AMU | Gen Med | 4.65 | 2.41 | 7.06 | 5.3 | 2.5 | 7.4 | 6.81 | 3.07 | 9.88 |
| Breamore | Gen Med | 2.37 | 2.19 | 4.56 | 2.6 | 2.4 | 6.6 | 3.62 | 2.19 | 5.81 |
| Durrington | Gen Med | 2.71 | 2.26 | 4.96 | 3.1 | 2.7 | 6.9 | 4.01 | 2.77 | 6.78 |
| Farley | Stroke | 3.1 | 2.07 | 5.28 | 3.8 | 2.6 | 6.1 | 3.82 | 3.46 | 7.28 |
| Laverstock | Resp medicine | 2.94 | 1.85 | 4.79 | 3.8 | 2 | 5.4 | 4.81 | 2.1 | 6.91 |
| Pembroke | Oncology | 5.97 | 1.93 | 7.9 | 6.4 | 2.4 | 9.1 | Missing on national database | | |
| Pitton | Geriatric Med | 2.5 | 2.25 | 4.75 | 3 | 2.4 | 6.6 | 3.57 | 2.58 | 6.15 |
| Redlynch | Gastroentero logy | 2.61 | 2.15 | 4.76 | 3.1 | 2.3 | 5.5 | 3.44 | 2.83 | 6.27 |
| Spire | Geriatric Med | 2.65 | 2.98 | 5.64 | 2.9 | 3.4 | 6 | 3.37 | 3.97 | 7.34 |
| Tisbury | Cardiology | 3.77 | 1.04 | 4.82 | 4.5 | 1.2 | 5.6 | 5.43 | 1.71 | 7.14 |
| Whiteparish | Gen medicine | 2.88 | 2.37 | 5.25 | 3.4 | 2.4 | 5.8 | 4.22 | 2.96 | 7.18 |
| Amesbury | T&O | 2.81 | 3.12 | 5.94 | 3.2 | 2.9 | 7 | 3.31 | 3.48 | 6.79 |
| Britford | Gen Surgery | 5.53 | 3.06 | 8.59 | 5.9 | 2.9 | 8.9 | 6.09 | 3.27 | 9.36 |
| Chilmark | T+O/Elective | 3.24 | 2.43 | 5.67 | 3.1 | 2.4 | 6.4 | 5.02 | 3.34 | 8.36 |
| Downton | Gen Surgery | 3.29 | 2.58 | 5.87 | 3.6 | 2.8 | 6.6 | 3.62 | 2.66 | 6.28 |
| Radnor | Critical care | 24.68 | 1.14 | 25.82 | 28.3 | 2 | 32.5 | 29.58 | 2.6 | 32.18 |
| Odstock | Plastic & Burns | 4.73 | 3.06 | 7.79 | 4.9 | 2.8 | 7.9 | 5.57 | 3.6 | 9.17 |
| Longford | Spinal | 4.42 | 3.81 | 8.24 | 4.4 | 3.8 | 9.4 | 4.17 | 3.88 | 8.05 |
| Hospice | Palliative | 6.09 | 3.15 | 9.24 | 6.3 | 3.8 | 9.8 | 6.03 | 4.93 | 10.96 |
| Sarum | Paediatrics | 11.94 | 1.74 | 13.68 | 10 | 2.3 | 12.9 | 10 | 1.62 | 11.62 |
| Maternity | Obstetrics | 9.41 | 1.83 | 11.23 | 9.1 | 2 | 9.4 | 10.24 | 0 | 10.24 |
| NICU | Neonatology | 10.35 | n/a | 10.35 | 13.2 | n/a | 10.2 | 10.68 | n/a | 10.68 |

*Data sourced from NHSE NHS England » Care hours per patient day (CHPPD) data*

### 4.2 Peer Comparison

The table below shows comparison of CHPPD across the ICB – a reasonable comparator as the Trusts are similar in size:

| | June 2022 | | | December 2022 | | | Dec 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | SFT | RUH | GWH | SFT | RUH | GWH | SFT | RUH | GWH |
| RN/RM | 4.28 | 4.74 | 4.06 | 4.78 | 4.93 | 4.5 | 5.16 | 5.63 | 4.97 |
| HCA | 2.04 | 2.98 | 3.32 | 2.64 | 2.96 | 3.26 | 2.85 | 2.83 | 3.69 |
| Overall | 6.32 | 7.91 | 8.03 | 7.43 | 8.12 | 7.94 | 8.01 | 8.67 | 8.83 |

Data extracted from NHS England » Care hours per patient day (CHPPD) data

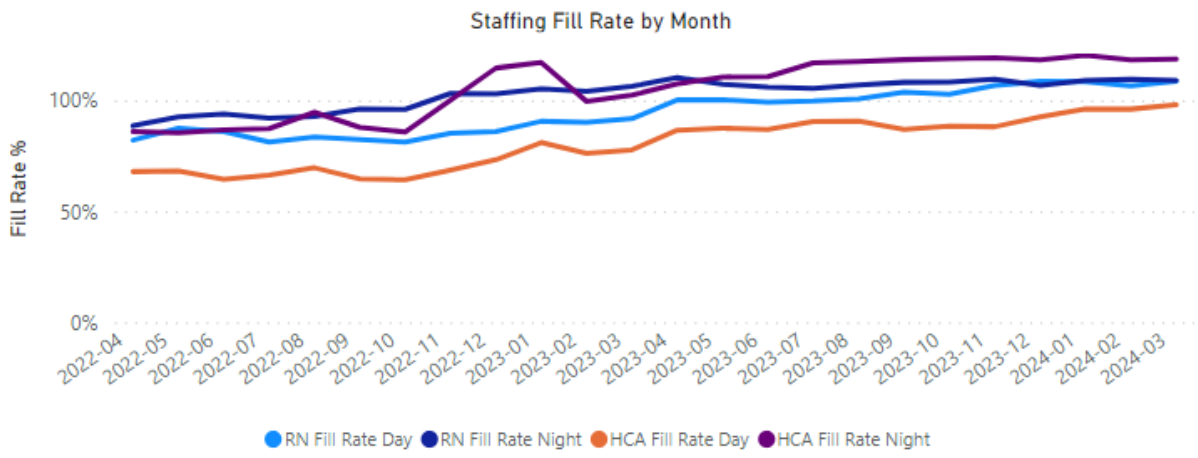
Whilst CHPPD is a useful comparator with other organisations, some caution should be applied as the total number of ITU services and similar high nurse/patient ratios (where CHPPD rates are

consistently much higher) can influence overall data, whereas comparing similar services will be more beneficial. National comparators should be avoided as they are disproportionately impacted by large acute Trusts and specialty hospitals.

### 4.3 Fill Rates

Fill rates were previously reported to Trust Board monthly via the IPR. 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.

Fill rates can be seen to be improving, particularly in HCAs where there has been a focused recruitment campaign, and the use of Allocation on Arrival incentive which is particularly popular amongst HCA staff.




## 5.0 Safer Nursing Care Tool (SNCT)

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. The Safer Nursing Care Tool (SNCT) is currently the only tool to have been endorsed by NICE.

In November 2023 the Trust started to implement the rollout of SNCT across all wards and the Emergency Department. Data collection will be taken across 2 months each year as a minimum (June and November). This has been supported by a refreshed training programme to ensure that data collection is completed by fully trained senior staff in line with SNCT guidance and licence.
A first data set was completed across a selection of 6 wards plus Sarum and ED (for ED this was the second full data collection). The remaining wards which will undertake their first data collection in June 2024, ensuring a data set is available for the full safe staffing review in the summer months. For the majority of wards there will only be one data set and in line with the tool no amendments should be made to establishments based on 1 dataset but it will give an indication of safety of staffing levels.

SafeCare (tool within E-roster) is a daily deployment tool used to support daily staffing decisions based on patient acuity and dependency in the moment whereas SNCT is used to provide a robust review of highest acuity/dependency score in preceding 24hrs and should be carried out a minimum of 2 times per year to understand base establishment for a clinical area.

Since the last report SafeCare has been fully re-implemented into the twice daily staffing meetings as provides supported evidence for decisions on staff allocation on the day. Work is on-going through the Safe Staffing Matron to ensure accurate scoring of the acuity and dependency level of patients.

## 6.0 Acute Health Alliance

The CNO and DCNOs for the three acute Trusts continue to work together to drive a consistent approach to nurse staffing across the ICS. The current agreed areas of focus are:

- **Emergency Department nursing** (initial benchmarking and paper completed)
- **Theatre /Perioperative Care** - The review will consider national staffing guidance from the Association of Perioperative Practice, skill mix and innovative approaches to addressing the national shortage of ODPs and theatre nurses in the context of elective recovery.
- **CNS** - Specialist nurses or nurses taking on extended, enhanced or specialist knowledge and skills have expanded widely in the last 5-10 years and the benefits to patient pathways and experience are well documented. The review will including a standard process for job planning, ensuring they are maximising the clinical impact and not undertaking admin or other tasks that could be undertaken by others.
- **Out-patient nursing**- With the transition to non bed based care and more ambulatory care, the traditional out patient model has transformed in recent years. There has also been an expansion of non registered roles and the development of other new and innovative roles. The review of outpatient staffing models will assist with ensuring that the knowledge and skills required for new roles are fit for purpose and cost effective.

## 7.0 Safe Staffing approach

Daily ward staffing numbers have seen a significant improvement over the past six months. Staff sickness (average 6% but higher in some clinical areas) and turnover (10% RNs and 20% HCAs) need continued attention.
Nurse staffing remains a corporate risk (ID 7039) although the risk score has been reduced from 15 to 12, recognising the improvements that have been made but which need to be sustained.

To ensure oversight of staffing resources across the Trust three times per day staffing meetings are held. The re-introduction of the Safe Staffing matron has ensured delivery of training to wards on acuity/dependency scoring, appropriate use of professional judgement and red flags.

Nursing has seen a significant decrease in its temporary staffing spend and has eradicated the use of off-framework agency for 5months. The reduction in agency should support delivery of better outcomes to patients through having an increase in substantive workforce but the current workforce has a very junior skill mix with a high number of new international nurses and newly-qualified nurses, with recent evidence indicating it takes approximately 2-years to embed within the NHS. The Deputy CNO is co-chairing a regional group which will ensure agency rates are reduced to capped rates across the region

## 8.0 Summary and Recommendations

The Board is asked to:

- To note the findings of the 6 monthly safe staffing update in alignment with the requirements from Developing Workforce Safeguards
- To note 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 2024.
- To note the on-going improvement in rate of CHPPD and fill rates as result of focused and sustained recruitment campaigns.
- To note the commencement of 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.

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Public Trust Board | Agenda item: | 6.2 |
| Date of meeting: | 2 May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Health and Safety Report – Q3 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | X | | X | |
| Approval Process: (where has this paper been reviewed and approved): | Health and Safety Committee | | | |
| Prepared by: | Troy Ready – Health and Safety Manager | | | |
| Executive Sponsor: (presenting) | Melanie Whitfield – Chief People Officer | | | |

## Recommendation:

The Public Trust Board is asked to note the escalation report from the February H&S Committee. There are no items to alert the Board to from Q3.

## Executive Summary:

Highlights from the H&S report are seen below:

**Advise**

Work continues to finalise the Trust strategy on reducing and preventing violence. The Design Council toolkit to reduce violence and aggression through improved communication and signposting in ED is close to being agreed and campaign materials are being developed to roll out the No Excuse for Abuse Campaign (after a delay in staff members stepping forward to have their images included in posters being developed).

Training on reducing and managing the risk of violence and aggression commenced in January with feedback being very positive. Staff found the content relevant, practical and offered practical solutions to managing patients who are at risk of becoming violent and aggressive. Courses are scheduled each month and are fully subscribed up to May. Courses have been funded for the remainder of 2024 and will be booked in the coming weeks.

**Assure**

There has been continued progress in the management of H&S during Q3 and continued downward trends in both the number of time lost injuries, and the amount of time lost. Highlights include:

- Lost time injuries fell 20% - noting this was a modest reduction from 10 in Q2 to 8 in Q3.
- Lost time injuries as a frequency of days worked is tracking 24% lower (from 3.9 in Q2 to 3.0 in Q3),
- The number of days lost due to work related injuries fell from 78 days in Q2 to 38 days in Q3. 32 of these days were the result of injuries reported in Q3. The remaining 6 days lost were due to injuries sustained prior to Q3. This suggests staff absent due to work related injuries are not long term absentees and return to work relatively soon after an injury. Days lost as a frequency of days worked across the Trust also continues to fall from 2.3 in Q2 to 1.1 in Q3.

Scheduled audits are completed, task analysis are completed as scheduled and staff injuries continue to be investigated by the H&S team to better understand causation and corrective actions.

**Alert**

There are no items that require escalation to the Board this quarter.

| 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 | X |
| Other (please describe): | |

# HEALTH AND SAFETY PERFORMANCE REPORT

# QUARTER 3

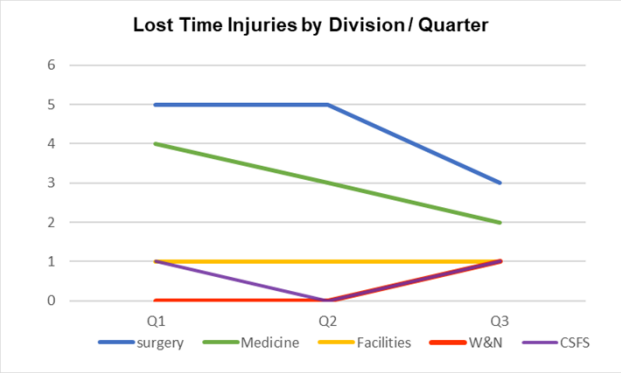
Salisbury NHS Foundation Trust

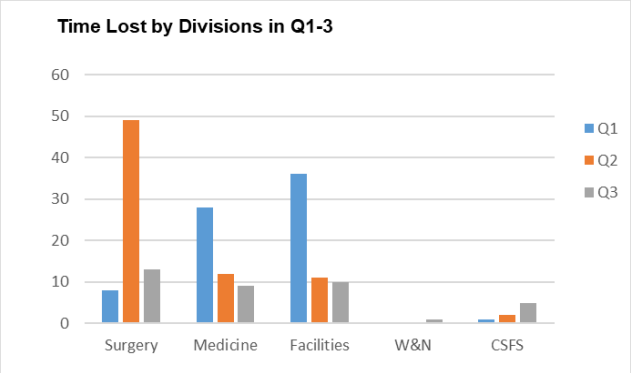
## 1. Report Summary

There has been continued progress in the management of H&S during the year and a continued downward trend in the amount of time lost and the frequency of lost time injuries. Highlights of which include:

- The number of lost time injuries fell 20% from 10 in Q2, to 8 in Q3.
- The number of days lost due to work related injuries fell 52% from 78 days in (Q2) to 38 days (Q3). 86% of time lost was the result of injuries reported in Q3.14% of time lost (5 days) was the result of injuries sustained prior to Q3. And all staff, responsible for the 14% of time lost reported prior to Q3, have returned to work at the time of reporting.
- LTIFR is tracking 24% lower from 3.9 (Q2) to 3.0 (Q3), and
- LTFR remains steady at 2.3 (Q2) to 1.1 (Q3).
- Manual handling injuries were consistent between Q2 and Q3 with no specific Division standing out, and no common trends readily identifiable.

Whilst there is only 9 months' worth of data, there is a continued flat or downward trend across most Divisions as seen in the diagrams below.




It should be noted how overall injury numbers, by Division, are all relatively low and even modest increases have a significant impact on comparable injury frequency rates. As seen above, the largest drop in lost time injuries is seen in Medicine and Surgery, but in real terms this is 2 fewer lost time injuries for each Division when compared to Q1.

A potentially more positive conclusion to draw on the overall reduction in lost time is due, in part, to the timely intervention of the H&S team when a Datix report is submitted. Following up Datix reports to ensure staff are OK is a key pastoral function in ensuring somebody stays at work, and where necessary signposting for intervention, treatment or follow up. Early interaction is known to ensure a timely treatment and return to work. The next step will be to better understand how injuries occur through improved investigations.

## 2. Health and Safety Performance Q3

The following report provides performance against objectives, describes the nature of injuries reported in past 9 months of the financial year and actions to be taken during Q4.

## 2.1 Injury Statistics

| Number of Injuries by Type | Q1 | Q2 | Q3 | YTD |
|---|---|---|---|---|
| | 61 | 58 | 102 | 221 |
| Violence and aggression | 25 | 21 | 38 | 84 |
| Manual handling | 3 | 11 | 11 | 25 |
| Near miss | - | 11 | 30 | 41 |
| Slip and trips | 6 | 5 | 11 | 22 |
| Struck by a moving object | 8 | 3 | 4 | 15 |
| Exposure to sharps | 2 | 6 | 5 | 14 |
| Struck an object | 2 | 2 | - | 4 |
| Chemical | 3 | 1 | 1 | 5 |
| Heat / Cold Exposure | - | 2 | 1 | 3 |
| Fall | - | 2 | - | 2 |
| Other | 1 | 1 | - | 2 |
| Radiation | 2 | - | - | 2 |
| Laceration | 1 | - | 1 | 2 |

Q3 saw an increase in:

- The overall number of incidents, near misses and injuries reported. Q3 saw a 75% increase in safety related Datix reports on Q2. Encouragingly, this did not result in an increase in the amount of time lost, an increase in lost time injuries or reportable injuries (RIDDOR's) to the Health and Safety Executive (HSE).
- As noted in the 202/23 H&S Annual Review slips and trips were more prevalent during dark, wet and windy weather. Q3 saw an increase in the numbers of slips, trips and slips due in outdoor conditions during November and December. Slips and trips were not the result of housekeeping, wet floors or factors that can be reasonably controlled by the Trust but outdoor conditions.
- Near misses, predominantly related to verbal aggression towards staff continues from previous quarters. There is a slight rise in incivility between staff members but again no clear patterns emerge from Datix analysis.

## 2.2 Actions from Q2 Report

### 2.2.1 Understanding Controlled Falls

The Q2 H&S Report identified an action for the H&S Manager to consult with the medical and surgical divisions to determine if there is an increase in falls and the practice of controlled falls to avoid injury to patients. As noted widely across the Trust, there has been a significant reduction in falls across the Trust and where 'controlled falls' were reported in Q2 there was no such trend reported in Q3. Herein lies part of the problem with the limited trend analysis available. Drawing conclusions, or actions, on a quarter by quarter basis without historical data, does not help distinguish long term trends that point to structural gaps in the management of H&S between short term trends that may be cyclical or anomalous.

### 2.2.2 Manual Handling Training on Longford Ward

The Annual H&S Report identified manual handling injuries on the spinal unit as an outlier to the overall Trust manual handling performance. The H&S Manager undertook an audit of Longford Ward to understand manual handling practices and the management of H&S. An action identified was to develop local spinal manual handling competency training.

During Q3, manual handling key workers developed a local ward competency to meet the nuanced manual handling specific to spinal patients and commenced rolling this out to new starters and staff returning to work after absences.

### 2.2.3 Manual Handling Assessment in Theatres

During Q3 the H&S Manager observed spinal and orthopaedic surgery (specifically hip and knee surgery) to understand manual handling risks to theatre staff and ensure a detailed risk assessment was conducted. This was in response to the number of manual handling injuries identified in theatres from 2022/23. A risk assessment was completed and provided to the Theatre Matrons and after discussions with the orthopaedic surgeon, the H&S Manager will explore the potential to develop equipment to help alleviate manual handling efforts required by the surgical team when performing replacement surgery and has consulted with nursing staff to consider rostering support staff to assist with manual handling where bariatric patients are being operated on.

### 2.2.4 Noise Testing and Reduction

During Q2, it was noted the Trust owned cages that evidenced metal rubbing on metal and created noise greater than 85dBA. The H&S Team in consultation with the Portering Team applied self joining rubber tape to contact points on a number of trolleys owned by the Trust, and at first glance has reduced the level of noise significantly without increasing the risk of manual handling injuries. However, as effective as this change is, the cages are in such a poor state of repair that many welds have broken and need to be repaired.

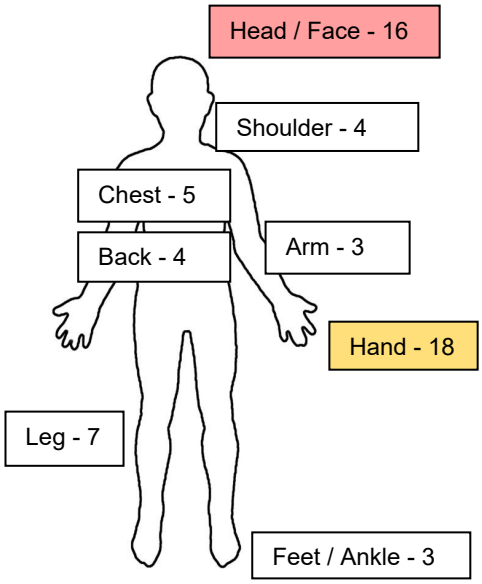
| **Action for Q4** |
|---|
| Members of the Estates Team plan to complete welding certificates during Q4 and will need equipment to practice welding on. These cages have been earmarked as items for the ETS team to practice on and are subsequently expected to reduce the level of noise created by Trust owned cages.<br><br>Peak noise levels were recorded when tugs towed 3 trolleys, cages or bins. Noise levels are significantly reduced when tugs limit cages / trolleys / bins being towed to 2. The H&S team will consult with the Facilities Team to understand the impact reducing the number of cages from 3 to 2 will have on departments. |

### 2.3 Injury Performance Measures

| **Injury and Frequency Rates by Division** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Days Lost | YTD | LTI | YTD | LTIFR | YTD | LTFR | YTD | Near Miss | YTD | RIDDOR | YTD |
| **Estates & Facilities** | 5 | 54 | 1 | 4 | 6.2 | 2.4 | 2.3 | 8.6 | 1 | 4 | - | 2 |
| **Surgery** | 13 | 70 | 3 | 13 | 4.1 | 5.9 | 1.3 | 2.4 | 9 | 12 | - | 1 |
| **Medicine** | 9 | 51 | 2 | 9 | 3.6 | 5.6 | 1.2 | 2.4 | 15 | 17 | - | 1 |
| **W&N** | 1 | 1 | 1 | 1 | 6.9 | 2.3 | 0.5 | 0.2 | 1 | 1 | - | - |
| **CSFS** | 5 | 8 | 1 | 2 | 1.7 | 1.2 | 0.6 | 0.3 | 4 | 7 | 1 | 1 |
| **Corporate** | - | 6 | | 1 | - | 3.1 | - | 0.3 | - | - | - | - |
| **Total** | **38** | **190** | **8** | **30** | **3.0** | **3.9** | **1.1** | **1.8** | **30** | **11** | **1** | **5** |

**Definitions:**
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive
Near Miss is an incident that did not result in harm to staff.

### 2.4 Injuries by Body Location




### 2.5 Injury Analysis

Injuries to the face and hands remain the most prevalent. The majority of which result from being struck in the face, or being pinched, scratched and even bitten on the hands.

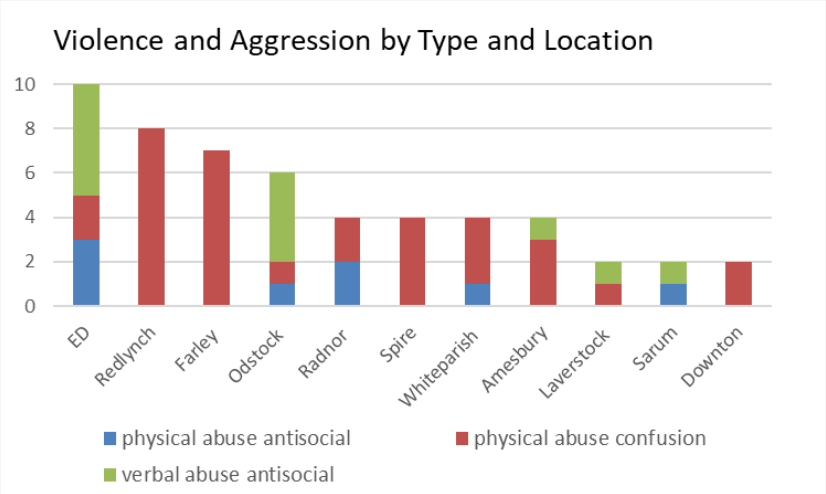
Yet, it remains surprising how small the number of injuries to the back, shoulders and arms remain. This is a testiment to the amount of work put into reducing manual handling and those injuries to shoulder and backs that are typically associated with manual handling in hospitals.

#### 2.5.1 Violence and Aggression

Patterns to violence and aggression are becoming clearer as more data is received and assessed. Trends can be defined as:

a. Physical abuse to staff who are pinched, scratched, bitten, kicked or struck in the face when providing care to confused patients.
b. Verbal abuse from patients, relatives, and next of kin with capacity. Verbal abuse associated with confused patients is almost always followed by acts of physical aggression.
c. Physically violence towards staff as a result of antisocial behaviour that may include drug use or young adults admitted with behavioural diagnosis.

The number of Departments who reported violence aggression in Q3 are seen in the diagram below




The following Departments reported 1 incident of verbal abuse:

- Durrington
- Theatres
- Maternity
- Tisbury
- Orthotics

Whilst Pitton and Durrington both reported 1 incident of physical abuse by a confused patient.

The Violence Prevention and Reduction Working Group continues taking steps to finalise the Trust wide approach to managing violence and aggression. Whilst the plan continues to be consulted on, expanded and is expected to be finalised in Q4, there are a number of actions that have been implemented in Q3. These are:

### 3.2.1 External Training

The first sessions of the externally facilitated violence prevention and breakaway training were developed, scheduled, published and filled. With the first courses completed in the third week of January with further courses fully booked for February, April and May.

- Day one was delivered to HCA's, Band 4 staff and OSCE nurses who work with confused and delirous patients across medicine and surgical wards
- Day two was delivered to senior nurses from AMU, Sarum and Radnor wards exposed to anitsocial behaviour.

### 3.2.2 Violence Prevention and Reduction Policy

The Violence Prevention and Reduction Policy is still in DRAFT and is expected to be finalised and made available on SaLi in Q4.

### 3.2.3 No Excuse for Abuse

There has been a delay in the development of the No Excuse for Abuse Posters. The feedback regarding the initiative has been very positive, and there was much engagement after the campaign was highlighted in the daily communication and CEO Start of the Week communications, but there is a reluctance for people to have photos taken as part of the campaign. Despite ongoing consultation with an array of staff groups, no one is willing to agree to participate and it is unlikely minority groups would be represented.

| **Recommendation** |
| --- |
| It is recommended the Trust utilise a number of stock images to use for images and posters. The Trust has been reluctant to use such images in the past. |
| **Actions for Q4** |
| • Publish No Excuse for Abuse Posters and consider use across the Trust given wide support for the campaign.<br>• Make decision on adopting Design Council tools in ED<br>• Finalise the Violence Prevention and Reduction Policy |

## 4. H&S Team – Divisional Attachment

The H&S Team has developed an informal response structure divided into clinical and non clinical divisions. The H&S Team will look to formalise this structure for Q1 of the 24/25 FY with H&S Advisors assigned to Divisions. Each Advisor will then be expected to work closer with departments on inspections, risk assessments, investigations and injury management, as opposed to sharing activities across the Trust.

Each H&S Advisor will develop a schedule of divisional inspections, actions from investigations, risk assessments and other H&S activities that can be reported to each Division. Doing so would give each Division greater visibility of actions and activity Moreso, would provide stronger engagement with subject matter experts such as the Manual Handling Lead and Infection Prevention and is a key step in increasing the maturity of H&S management across the Trust.

It is envisaged H&S Advisors will be divided into:

1. Surgery, Medicine, Women and Newborns and Sarum Ward, and
2. Estates, Facilities, CSFS (exc Sarum Ward) and Corporate Divisions.

## 5. Further Hazard Management

### 5.1 Nitrous Oxide ($N_2O$) Exposure Testing Update

As noted in Q2, and in response to the NHSE publication on the risk to long term exposure to low levels of $N_2O$ the H&S Team in consultation with Medical Gases Group and Chief Pharmacist have identified a cohort of staff using $N_2O$ and agreed on a testing regime that includes but is not limited to Maternity, Theatres, Endoscopy Suite and ED Minors. An assessment of the risk of exposure to nitrous oxide during Q3 determined there is no need to undertake testing of staff in minors or the plaster clinic.

The Health and Safety Executive (HSE) published exposure rates at 100 parts per million (ppm) over a period of 24 hours that is averaged over 8 hours. This is known as a time weighted average (TWA). There is no minimum peak exposure rate published by the HSE. The following results were recorded:

Day Surgery Recovery
Testing was undertaken in Day Surgery Recovery in response to staff concerns about potential exposure to Entonox from patients recovering post surgery. 3 days of testing did not detect any nitrous oxide from expired air in recovery.

Day Surgery Theatre
Testing was conducted with a consultant anaesthetist administering $N_2O$ for paediatric surgery. The time weighted average was calculated at 8ppm. Further testing is being conducted to determine if similar results are recorded and to determine if subsequent testing is required.

Midwifery
Testing was conducted on 6 midwives nurses during December and January. Results vary considerably with time weighted average exposure results all within the TWA exposure limit of 100ppm with a range between 9ppm and 76ppm. Exposure surveillance will continue in Q4.

Endoscopy
Endoscopy has yet to commence testing but discussions with Senior Sister in Endoscopy suggest Entonox is used daily and frequently as more patients seek to avoid the recovery times associated with sedation. Testing will commence in Endoscopy in Q4.

### 5.2 Road Leading to Lower Spinal Car Park

During the last week of December there was a planned increase in construction work in, and around, the junction that is Sarum Ward entrance, medical / surgical outpatients, Respiratory outpatients and gynaecology areas. Work included the installation of solar panels, installation of new boilers in the Clarendon Building and ongoing construction of the new ward by three different contractors.

The risk of pedestrians, and visitor vehicles, being in potential close proximity to moving construction vehicles was identified, and the decision was made to restrict the movement of patient vehicles within the area. Barriers were erected to close the road and a Banksman was engaged to manage the flow of traffic to ensure the safety of staff, patients and visitors, by limiting access to vehicles that are dropping off patients with severely restricted mobility only.

There has been a significant reduction in the number of vehicles in the area, and Departments affected have been consulted with and made aware of the potential for disruption caused to patients and relatives. But importantly, the risk of injury to staff, patients and visitors has been significantly reduced and continues to be monitored by the H&S Team.

**Report written by**

Troy Ready

Health and Safety Manager

January 2024

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 7.1 |
| Date of meeting: | 02 May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Improving Together Quarterly Roadmap Progress Report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | Yes | Yes | Yes | No |
| Approval Process: (where has this paper been reviewed and approved): | Improving Together Board | | | |
| Prepared by: | Alex Talbott, Associate Director of Improvement<br>Emma Cox, Head of Continuous Improvement and Coach House<br>Louise Arnett, Head of Transformation Resourcing | | | |
| Executive Sponsor: | Peter Collins, Chief Medical Officer | | | |

## Recommendation:

**Assure** – This report is to assure the Trust Board of our progress against the programme roadmap and of the benefits being realised from deploying Improving Together across the Trust.

## Executive Summary:

As we move into 24/25 we are seeing Improving Together's spread across the organisation with increasing momentum. The annual update of the Strategic Planning Framework and divisional scorecards for 24/25 has generated a new wave of focus and alignment to our priorities across the Trust. Thanks to the increasing number of trained specialities and teams we are now starting to have more teams actively working on the breakthrough objectives via the drivers they set. This additional capacity to focus on improvements at team, speciality and divisional levels will enable us to accelerate the delivery of benefits across the Trust in 24/25.

To support this spread and acceleration of Improving Together a 24 strong group of senior leaders are studying the principles and behaviours that underpin a culture of continuous improvement. Their engagement in this work by practicing the behaviours across their spheres of influence is already helping link up cross-divisional workstreams as they seek to align, enable and improve.

Alongside the development of our leaders we have also been improving our processes for prioritising our corporate resources via our Corporate Projects Prioritisation Group (CPPG). Deploying our resources well enables our teams to deliver benefits further and faster in strategically prioritised areas. In the last quarter this has enabled the Maternity team to enter the sustainability phase of the Maternity Safety Support Programme, implemented digital patient letters which will save £100k and through the introduction of Cinapsis advice and guidance system avoided 4,500 outpatient appointment referrals.

| |
|---|
| The evidence presented here shows a maturing use and understanding of Improving Together across teams, divisions and executives. This is increasing the impact Improving Together is having and will have in 24/25. We are confident we can assure the Board the deployment of Improving Together is on-track against the roadmap. |

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

Salisbury NHS Foundation Trust

# Improving Together Quarterly Roadmap Progress Report

## 1 Purpose

This paper provides evidence of how the Trust is progressing against the agreed roadmap. It also sets out the benefits being delivered by teams using Improving Together to continuously improve their services for our people, population and partnerships.

## 2 Confirmation of our confidence in giving assurance on Improving Together's deployment

The evidence shows maturing use and understanding across teams, specialities, divisions and executives and growing impact of use as benefits are realised. We are confident we can assure the Board the deployment of Improving Together is on-track against the roadmap.

## 3 18-month programme roadmap: Workstream updates

As of April 2024 all workstreams are on track. Changes in executive leadership roles and the prioritisation of the community services tender have meant the Executive and Board Leadership Behaviours and Strategy Deployment and Transformation workstreams have been re-scheduled to adapt to the changes in our organisation's leadership team and priorities.

The current roadmap finishes in September 2024.To prepare for the next 18 month period, October 2024 to March 2026, we will run the next Improving Together road mapping session in July 2024.

## 4 Training numbers achieved to date

The numbers of teams, specialities and leaders trained is on-track against our training trajectory (see appendix 2).

### 4.1 Map of teams trained across the divisions

The table below highlights the numbers of teams of leaders and teams trained, by division/directorate. It shows the percentage of the overall teams trained to date.

| Division/ Directorate | Total number of teams | Leaders Trained | Teams trained at Improver Standard |
|---|---|---|---|
| CSFS | 39 | 14 | 3 (7%) |
| Medicine | 25 | 9 | 15 (60%) |
| Surgery | 35 | 12 | 14 (40%) |
| WNB | 9 | 3 | 5 (55%) |
| Quality | 11 | 1 | 4 (36%) |
| Corporate | 52 | 18 | 10 (19%) |
| **Trust Total** | **171 (100%)** | **57 (33%)** | **51 (29%)** |

Across the Trust there is a 'conversion rate' of 29% from training to active use of an improvement huddle. There are 15 active huddles from the 51 teams trained at Improver Standard level. This insight is a large part of why we have re-developed our training and coaching approach to ensure training leads to the use of a huddle and a monthly Performance Meeting Review (PRM).

## 4.2 Catalysis Academy – coaching for Improvement

All 24 senior leaders from across the clinical and corporate divisions are being coached via the Catalysis Academy. This course is helping those colleagues to grow their understanding of the principles and behaviours drive a culture of continuous improvement. Engagement in the work has been good with new practice and approaches to the way in which people work developing through reflection in the sessions and from the coursework. Each person is working on their Personal Development A3, which helps them focus on an opportunity to improve the way in which they lead and work. This work is supporting the development of a group of leaders who are confident and able to cascade, teach and coach Improving Together to their teams.

Early impacts have been the ability for the group to practise their use of coaching questions and go & sees. The conversations have catalysed the creation of cross-division process standard work for speciality scorecard sessions and the resulting performance review meetings.

## 4.3 Training trajectory forward view

Following a training review by the Coach House and presentation at Programme Board, a new training structure is in place to support the roll out (appendix 1). The introduction of 'Introducing It' a 90-minute overview of 'Why we are doing Improving Together' is open to all and will be launched to all new staff in May 2024. Increased focus and support post-training will now be scheduled to teams by the Coach House, including the introduction and setting up of improvement huddles and PRMs – both of which are critical to the success and sustainability of the Operational Management System (OMS).

The table and charts in appendix 2 set out the training trajectory for Improver Standard, Advanced and Leader and forward projection through to end of Q1 of 24/25.

Using our strategic filter the Head of Coach House and Divisional Directors of Operations have prioritised teams for Improving Together training. Teams have been booked through to December 2024, those identified are key contributors to divisional drivers and the Trust's breakthrough objectives.

## 5 Maturity in the use of improving together methodology

The maturity self-assessment represents a structured reflection on where our teams are strongest and where we should focus our energies to develop our understanding and use of the Improving Together approach.

Throughout the course of 23/24 FY, there has been an improvement across all divisions in their overall maturity in Improving Together.

This month sees the introduction of team maturity self-assessments and data available to demonstrate the maturity of teams who have been trained through Improver Standard and Improver Advanced. This team maturity self-assessment aligns the tool to the framework and uses the same maturity scoring as for divisions. The roll out of the team maturity assessment has been managed by the Coach House team, this will now be included and incorporated into the Improver Standard training to help raise awareness and expectation within teams from the start of their training journey.

The Coach House are now developing a speciality layer maturity assessment, it is anticipated that self-assessment scores will be included in the next quarterly Trust Board report.

| Key | |
|---|---|
| Level 0 - Not started | Level 3 – Maturing |
| Level 1 – Aware | Level 4 - Mastering |
| Level 2 – Developing | |

| Tool | Execs (April 24) | Divisions (April 24) | Frontline (April 24) |
|---|---|---|---|
| Scorecard | 3 | 4 | 2 |
| Golden thread | 3 | 3 | N/A |
| Monthly routines (Performance/Executive Review Meeting + A3 Summary) | 3 | 2 | 1 |
| Weekly Routines (Weekly Driver meetings, Go & See), | 3 | 3 | N/A |
| Daily routines (Improvement Huddles, Performance and improvement boards) | N/A | N/A | 2 |
| Process and Leader Standard Work | 2 | 3 | 2 |
| Process Confirmation | 2 | 3 | 1 |
| Structured Conversation | 1 | 2 | 1 |
| DPR | 3 | 3 | N/A |
| SLT PRM | N/A | 2 | 1 |
| PRM | N/A | N/A | 1 |
| A3 | 2 | 3 | 2 |
| Leadership behaviours | 3 | 3 | 1 |

**Key areas to note from the divisions' self-assessments:**

- A continued focus and awareness of leadership behaviours and coaching, aligned to the Trust leadership behaviours continues to be developed.
- Continued development of A3's and A3 thinking.
- Acknowledgement process standard work is now consistently used in divisional settings.
- Increased use of structured conversations through divisional meetings and 1:1's.

**Key areas of focus to support maturity in Q1:**

- Increasing the number of speciality layer scorecard agreements and speciality level PRM's.
- Increasing the number of Go and Sees, specifically improving the scheduling, clarity of purpose and documentation of them.
- Strengthen the use and frequency of driver meetings to support maturity of the OMS.

## 6 Benefits realisation of using Improving Together

### Breakthrough Objectives

Through use of the Improving Together Methodology:

The **Falls breakthrough objective** has delivered a 34.7% improvement in the last 12 months reducing falls from 8.99 (March 23) to 6.67 (March 24) below its target of 7 falls per 1,000 bed days. This significant improvement has been sustained since June 23 and allows for a new breakthrough objective to become the focus of improvement in 2024/25. Improvements that have been introduced include 'bay watch' and improving multi-disciplinary working. The use of the improvement huddles that involve the whole team, encourages junior staff to have a say and make improvements. While the performance boards have helped teams better understand their performance and measure their successes.

The **staff availability breakthrough objective** has reduced agency spend against a percentage of gross pay in the last 12 months from 7.37% (April 23) to 3.77% (March 24). This equates to an improvement in agency spend from £1.3m in April 23 – to £683k in March 24. This improvement allows this breakthrough objective to move to focusing to the retention of additional healthcare staff in 2024/25.

The **Bed Occupancy breakthrough objective** has delivered a 12% improvement in bed occupancy in the last 12 months from 110% bed occupancy in March 23 down to 98% in March 24. This brings bed occupancy close to the local 96% target. Focused work will continue under the leadership of the Urgent Emergency Care Board – supported by a number of corporate projects into 2024/25. A new breakthrough objective focusing on creating value for the patient through productivity improvements is being introduced for 24/25, which aligns to the organisational sustainability vision metric.

The **Time to first Outpatient breakthrough objective** has seen a plateauing of the average time to first appointment and has not yet made the overall improvement expected of this area of focus. This will therefore continue into 2024/25 with refreshed cross-divisional focus through A3 workshops and an outpatients transformation group as a sub-set of Planned Care Board. Individual specialities have, however, seen some good improvement – particularly through improvement huddles introduced and supported by the Transformation Team and Coach House.

- **Cardiology**. An improvement in time to first outpatient appointment has been realised of 40% in the combined cardiology routine clinic. A new process for ex-inpatients has been launched resulting in no delays and improved patient care as follow-up appointments are not lost. Improved working relationships within the speciality has resulted in the booking of appointments, investigations and procedures running more smoothly and has increased understanding of services. Further improvements are due to launch in May 2024 to further improve the experience for patients.
- **Gynaecology** reviewed data to identify the top contributors to increased outpatient wait times. This identified the menopause and vulval skin clinic as their top contributing clinics. Through the use of improvement huddles and go and sees patients are now not waiting as long for initial and follow up appointments. Staff are engaged in the improvements that are noticeable and matter. Further cascading of this approach to other clinics is also now being considered.

Gynae Outpatient Activity

**Waiting time for New Patients reduced** from 16 to 10 months from May-Sept 2023

**Waiting time for F/U Patients reduced** from 12 to 10 months over the same period

**Number of patients awaiting a F/U reduced** from 311 to 63 over the same period

Gynae Outpatient Activity

**Waiting time for New Patients reduced** from 16 to 10 months from May-Sept 2023

**Waiting time for F/U Patients reduced** from 12 to 10 months over the same period

**Number of patients awaiting a F/U reduced** from 311 to 63 over the same period

**Staff Survey**

The latest staff survey score (appendix 3) has noticed an improvement across three core questions relating to making improvements in my team/department (Question 3d, 3e and 3f) these align directly to the strategic initiative of developing a culture of continuous improvement and reviewing the data from 2021 against those three questions demonstrate the following:

- Question 3d – An improvement of 2.72% with a further 5.65% required to match the 'best' score
- Question 3e – An improvement of 7.72% with a further 1.36% required to match the 'best' score. This is our greatest improvement across all the questions in this section, 'empowering' our teams to work on the improvements that matter to them is at the heart of Improving Together and the data would suggest that there has been a positive and significant shift change. It is critical this empowerment message continues to be communicated and heard by all staff.
- Question 3f – An improvement of 6.1% with a further 4.65% required to match the 'best' score.

**The use of improvement tools**

***Go and See*** - Improved collaboration and partnership working across teams, specifically through the use of Go and See to listen and learn. Colleagues are learning about the use of improvement huddles and how this tool can be used in their area. In addition, asking effective questions through go and see will impact positively on the coaching culture that underpins Improving Together.

***A3 thinking*** - The use of A3 thinking across the Trust has continued to increase. As a result, improved benefits of getting to the 'root cause' means improvements made are those which are having greatest benefit and impact. Areas that have adopted A3 thinking outside of formal training through the Coach House vary across corporate and clinical areas (e.g. SMILE oral healthcare, enhanced care and procurement).

**Benefits delivered through the Project Delivery System (PDS) and corporate projects**

The core function of the PDS is to support, through the prioritisation and deployment of corporate resources, projects which help deliver benefit in our strategic initiatives and breakthrough objectives – balanced with any externally mandated changes which are must dos; and those projects raised which relate to patient safety.

The average number of Trust-wide corporate projects supported is 26 – in the last 6 months we have prioritised 9 new projects and closed 10 projects. Prioritisation is through the monthly Corporate Projects Prioritisation Group (CPPG) with monitoring of delivery through a monthly Executive-led engine room. The focus in the Engine Room is on projects reporting off-track through use of a standard work process. Projects reporting off-track for three consecutive months have a deep dive with Exec led actions to facilitate unblocking of barriers to delivery, where possible.

Some of the benefits delivered are outlined below;

NHS Salisbury NHS Foundation Trust

**Urgent Emergency Care projects: Bed occupancy Breakthrough objective - timely access to care**

**In the last 12 months**

**Zero-day length of stay for medical admissions - 37.9% improvement** [pre-SDEC 20.3% now running at 28%]

**Acute Frailty Unit average length of stay reduced by 11 days - 68.8% improvement** [from 16 days down to 5 days]

**Emergency Department time to triage 33.3% improvement (reduction of 17 minutes) -** [51 minutes to 34 minutes].

% of patients in ED <4 hours improved by **11.8%** [59% to 66%]

**52.1% reduction in time from arrival to SAU – 373 minutes improvement** [715 minutes down to 342 minutes] and a **65.5% improvement in the average time to see first clinician** [581 to 200 mins]

Total Bed Day Saving across AMU and AFU - **£2,349,058**

69% routine requests resulted in "advice only" contributing to approx **4474 avoided OP appointments**

39% of urgent requests resulted in "advice only" contributing to approx **64 avoided urgent care attendances**

A typical trust can expect to avoid approximately 1,700 low value procedures or appointments

anticipated annual saving of **£100,019**

**Planned Care projects: Breakthrough objective – Time to First Outpatients - timely access to care in the last 12 months**

**219% increase in the number of requests for advice from GPs** through the Cinapsis Advice & Guidance system [from 2032 requests in 22/23 -to 6484 in 23/24]

**Dr Doctor digital assessments -** enables the reduction of surgical waiting lists using a 3-monthly waiting list validation assessment – an average of 5% waiting list reduction (data analytics from DrDoctor warehouse).

**Dr Doctor digitisation of letters on track to** reduce our use of paper letters by 60% resulting in 142,888 digitised letters yearly

**Patient safety projects:**

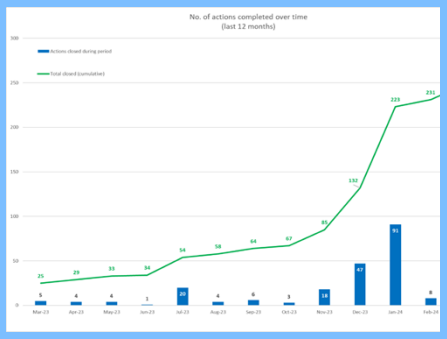
**Delivery of AMaT mortality system**

New system for managing clinical audits, NICE guidance (Phase 1, 25th Sept 23) and mortality reviews (Phase 2, 25th March 24) rolled out for Trust-wide use.

Estimated reduction of 75% of inefficient use of administrative resource re-invested to support key audit activities e.g. improved support for LocSSIP/NatSSIPs work, increased direct support to divisions.

**Mandated time sensitive projects: Maternity Safety Support Programme (MSSP) – increase compliance with NHSE requirements to support exit**

An increase in improvement to **62% compliance** (n.249 requirements) from 6% compliance (n. 25 requirements). With a stepped increase in compliance following deployment of Project Management resource in November 2023.




**Projects Supporting Strategic Initiatives: Digital Care**

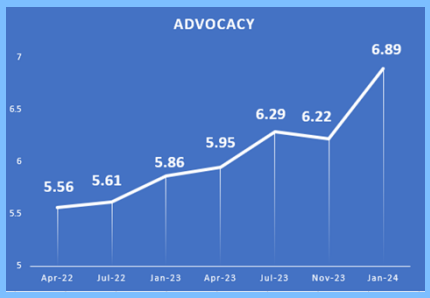
**Server Refresh: 392 servers out of 426 (92%) have been decommissioned** through the decommissioning process. Each server decommissioned increases our cyber-security and patient safety, whilst enhancing the user experience through increased performance and resilience.

**Discharges into Lorenzo** – 30 wards have now moved from the EDS system to Lorenzo for discharges. This delivers improved medication management and reduced transcription errors, supporting improved patient safety and reduced use of multiple applications. This change meets the Transfer of Care Standards set out by NHS Digital

**Robotic Process Automation:** successfully identified processes to be automated that would cover initial investment of the RPA PoC phase of £100,072 split equally over two years

**Projects Supporting Strategic Initiatives: Delivering our People promise**

We are monitoring the Advocacy Score in the Pulse and NHS Surveys for our People Promise Programme of work with a view to return to our pre-2020 position of at least average for our benchmark group by the 2025 survey



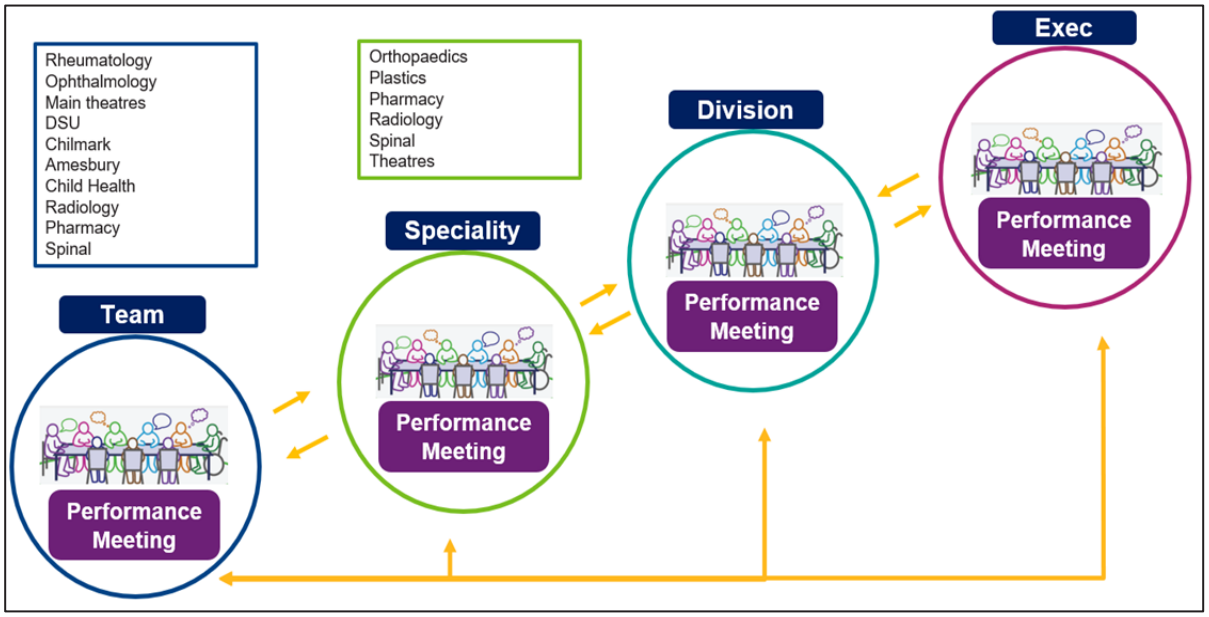

Since 2022 we have seen a 23.9% increase in our advocacy score

In relation to the NHS Staff Survey - In March 2024, HSJ reported SFT as the most improved Acute Trust with a 9.8% in-year change.

## Rotational Roles

The rotational roles in the Coach House are now all in post, with a breadth of skills, knowledge and experience. Individuals have been recruited from the CSFS and Surgery divisions. The knowledge share out into teams/divisions was a key requirement of the business case, further discussion with the DDOs has identified priority focus areas and alignment to their drivers (see below).

Rotational colleagues will support teams/specialities across ***Surgery*** and ***CSFS*** as outlined below:



In addition, the rotational coach house team will prioritise and focus efforts on supporting the divisions to develop and embedding the OMS through the introduction of performance review meetings (PRMs).

Monthly 1:1's between those rotational roles and DDO's are now in place to regularly review progress and achievements and unlock any challenges or gaps in knowledge and training.

## 7 AHA update and Catalysis CEO Summit

Improving Together is our shared improvement management system across the Acute Hospital Alliance (AHA). Work is now underway to develop the AHA's Strategic Planning Framework (SPF), which will help form the golden thread between the three Trusts' SPFs and the ICB's strategy.

In recognition of the work we are doing across the provider collaborative the Catalysis CEO Summit is set to be hosted at Salisbury Hospital in October 2024. This is further evidence of how the work we are doing with Improving Together is starting to gain traction and the attention of UK and international leaders in cultures of continuous improvement and management systems.

## 8 Next steps

To support the growing momentum behind Improving Together at a Trust and AHA level we will work on the following next steps:

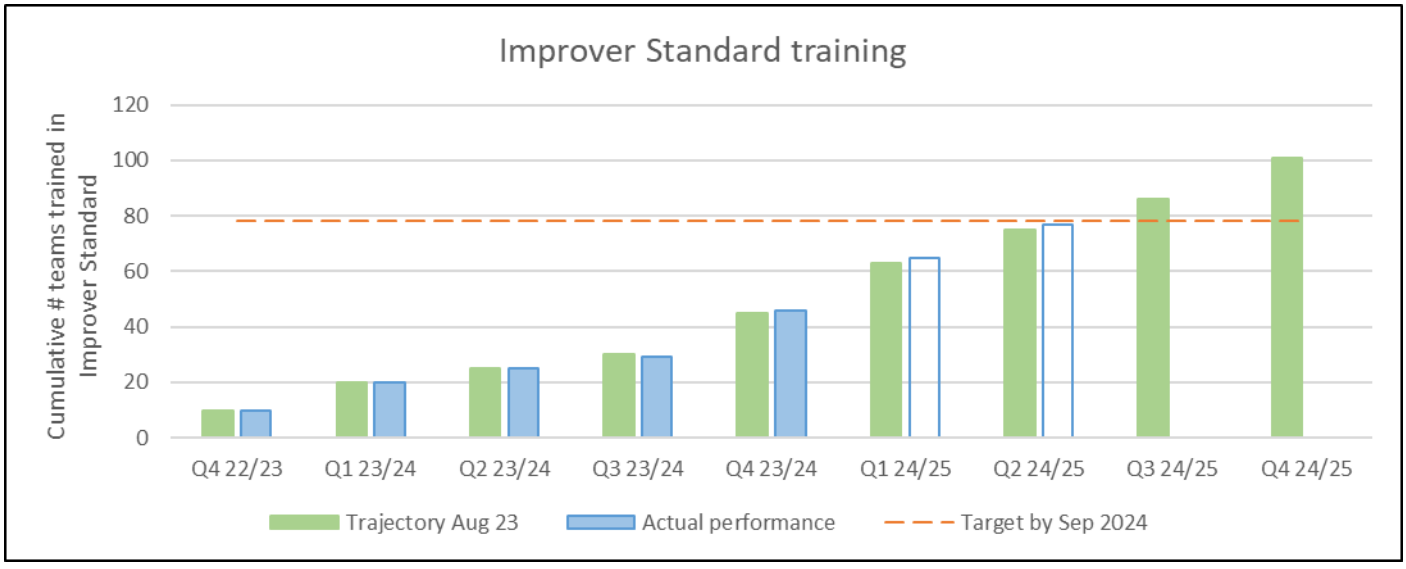
1. Build out and resource via CPPG our programme of improvement for 24/25
2. Focus on connecting the Operational Management System up by coaching and supporting scorecard agreements and instigating the routines of daily/weekly improvement huddles and monthly performance review meetings for every team trained in 24/25
3. Work on ways to further align our OD&L and Improving Together training programmes
4. Work with our AHA and system colleagues to develop an AHA Strategic Planning Framework
5. Roadmap the next phase (October 2024 to March 2026) of Improving Together at SFT to ensure we sustain and continue to deepen our us of the approach.

Salisbury NHS Foundation Trust

**Appendix 1**

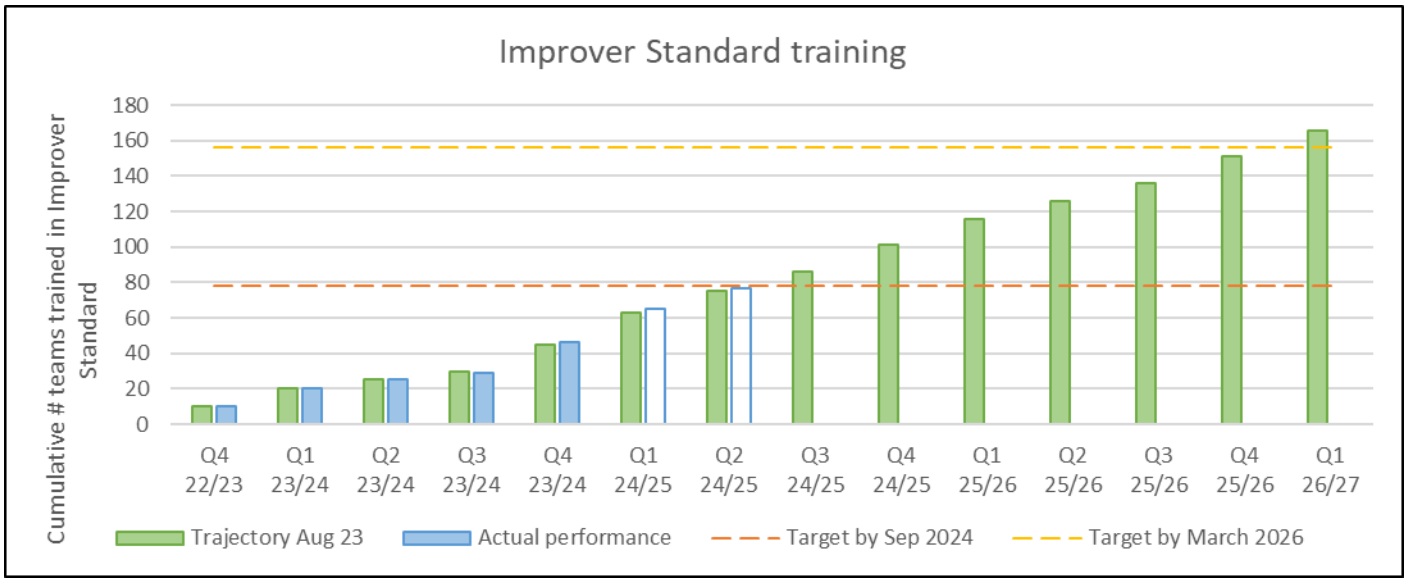

**Appendix 2: Training trajectories through to 2028**

The following charts show the performance against the roadmap trajectory for each course (the unfilled bars reflect our projected performance for the next two quarters).

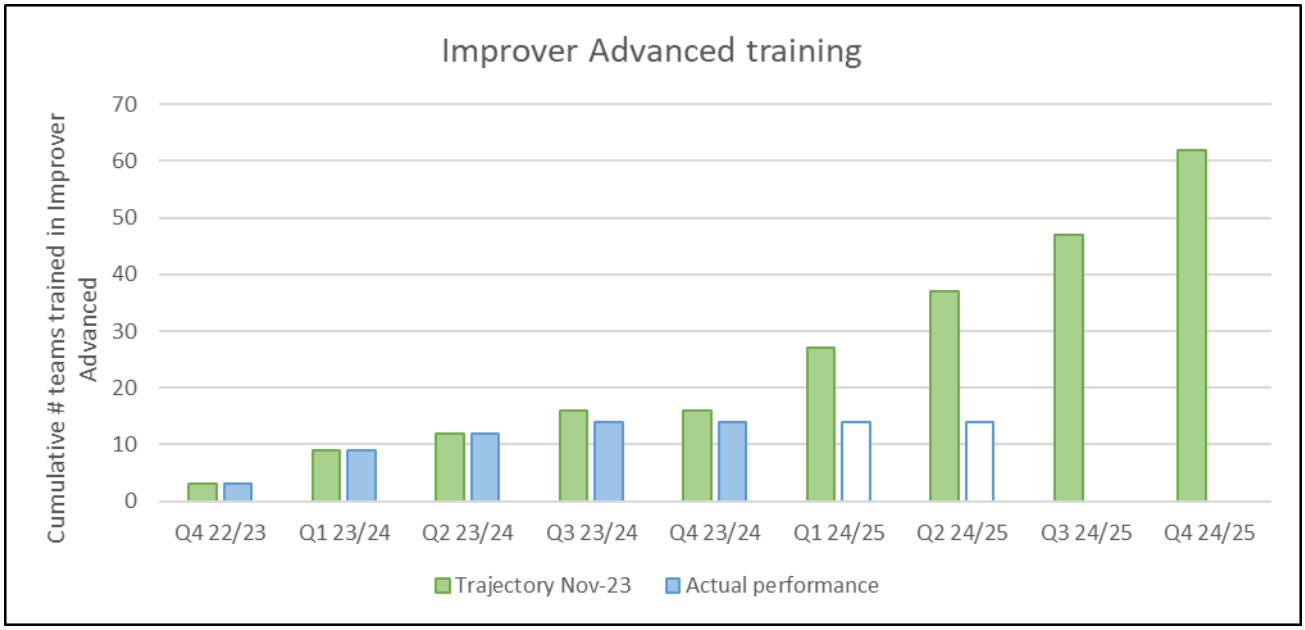



The forecast outturn for September 2024 is 77 teams trained, which is on-track with our trajectory.

The number of teams at baseline is 156, however, as our understanding of speciality and team structures improves, the current number of teams stands at 168 (50% of that figure is 84 – an increase of 6 teams). This trajectory is on target for achievement by Q3.

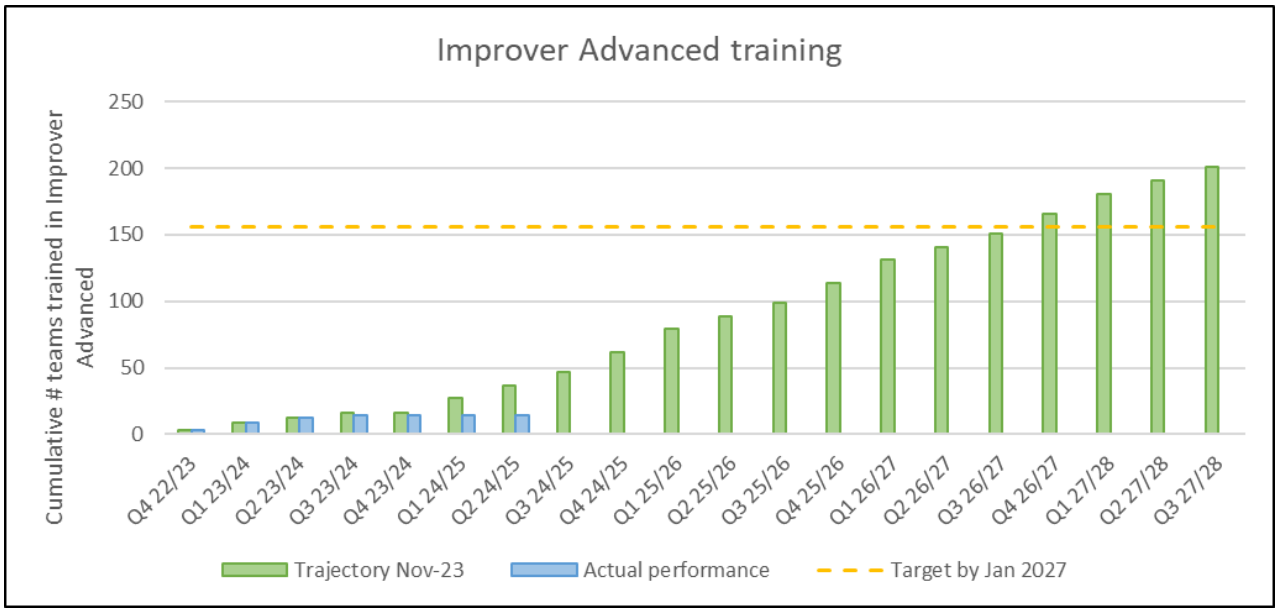


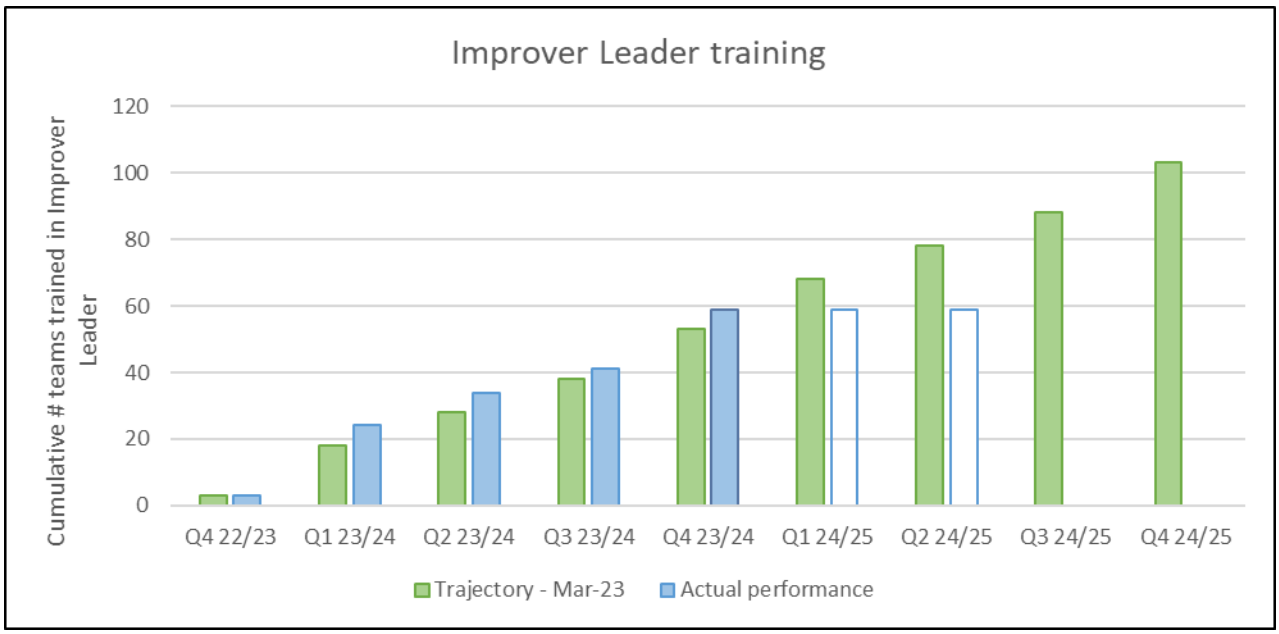

The current trajectory is for representatives of 100% of teams to have attended Improver Standard by end of Quarter 1, 2026.




The delivery of Improver Advanced training has been reviewed as part of the wider training review undertaken by the Coach House.

Delivery of Improver Advanced will now be focused on scorecard agreement and performance review meetings through masterclass delivery. The training trajectory presented remains on target, of 100% by Q4 of 26/27. The first masterclass due for delivery in May and monthly thereafter.




Improver Leader training remains on track for overall numbers. This course is for leaders of teams and specialties, with a particular focus on teams who are undertaking the Improver Standard training. Representatives from 17 teams were trained during Q3 23/24.

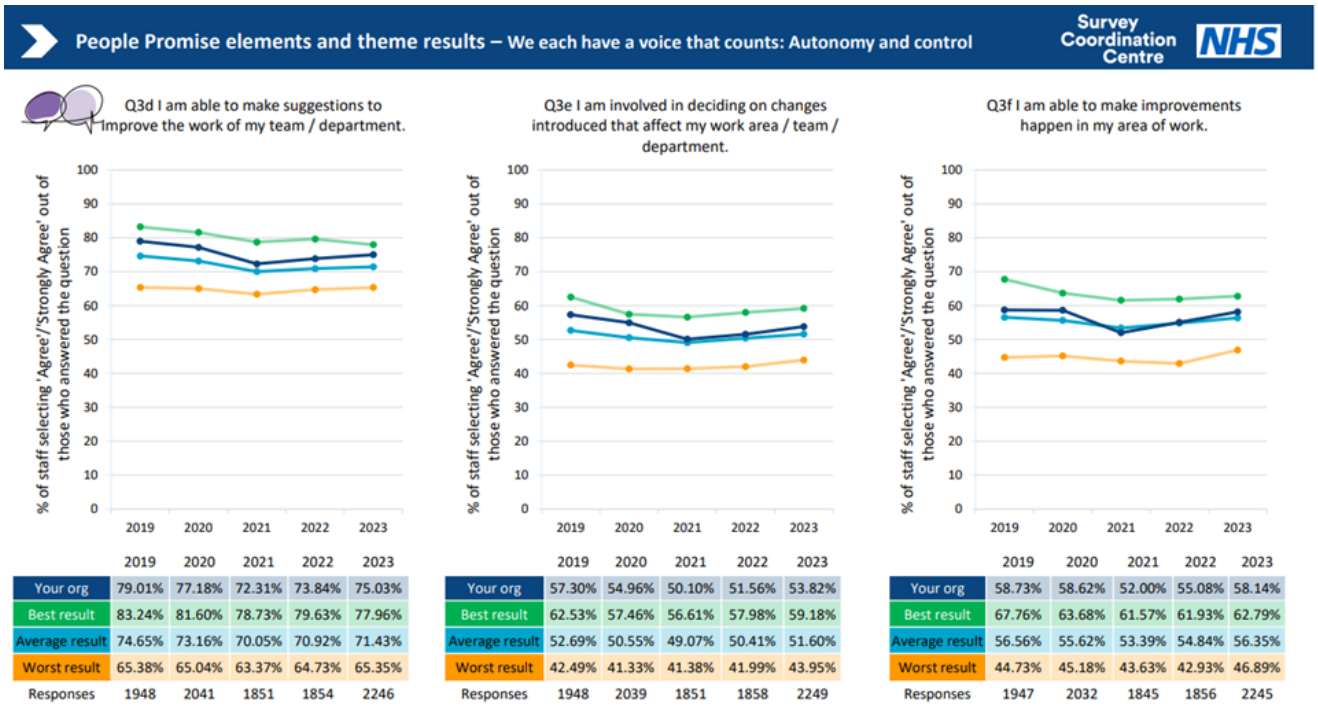
We had a target of training 16 speciality triumvirates in Improver Leader by the end of March 2024 (there are 43 specialities in total across the Trust). A total of 14 specialties have been fully trained (all three of the triumvirate trained), with 32 specialties (74% of the total number of specialities) having at least two members of the triumvirate trained.

Due to changes in speciality tri roles and staff sickness (nursing and clinical lead roles), the Coach House are now actively scheduling in time for those individuals to attend training via Improver Leader, with a further 5 specialities in attendance in May to improve the total number of speciality tri's trained.

| | Number of the triumvirate trained (out of 3) | | | |
|---|---|---|---|---|
| **Specialty tris trained to date** | **3/3** | **2/3** | **1/3** | **0/3** |
| Medicine division | 3 | 4 | 1 | 0 |
| Surgery division | 2 | 11 | 6 | 0 |
| CSFS division | 6 | 2 | 1 | 3* |
| Women & Newborn division | 3 | 1 | 0 | 0 |
| **Total** | **14** | **18** | **8** | **3** |

*these are smaller specialties, with a single specialty lead, rather than a triumvirate

## **Appendix 3:** Staff Survey




| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 79.01% | 77.18% | 72.31% | 73.84% | 75.03% |
| Best result | 83.24% | 81.60% | 78.73% | 79.63% | 77.96% |
| Average result | 74.65% | 73.16% | 70.05% | 70.92% | 71.43% |
| Worst result | 65.38% | 65.04% | 63.37% | 64.73% | 65.35% |
| Responses | 1948 | 2041 | 1851 | 1854 | 2246 |

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 57.30% | 54.96% | 50.10% | 51.56% | 53.82% |
| Best result | 62.53% | 57.46% | 56.61% | 57.98% | 59.18% |
| Average result | 52.69% | 50.55% | 49.07% | 50.41% | 51.60% |
| Worst result | 42.49% | 41.33% | 41.38% | 41.99% | 43.95% |
| Responses | 1948 | 2039 | 1851 | 1858 | 2249 |

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 58.73% | 58.62% | 52.00% | 55.08% | 58.14% |
| Best result | 67.76% | 63.68% | 61.57% | 61.93% | 62.79% |
| Average result | 56.56% | 55.62% | 53.39% | 54.84% | 56.35% |
| Worst result | 44.73% | 45.18% | 43.63% | 42.93% | 46.89% |
| Responses | 1947 | 2032 | 1845 | 1856 | 2245 |

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Board of Directors (Public) | Agenda item: | 7.2 |
| Date of meeting: | 2nd May 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Strategy Update | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | | | |
| Approval Process: (where has this paper been reviewed and approved): | N/A | | | |
| Prepared by: | Tony Mears, Associate Director of Strategy | | | |
| Executive Sponsor: (presenting) | Lisa Thomas, Chief Executive | | | |
| Appendices | N/A | | | |

## Recommendation:

The Board is asked to note the report

## Executive Summary:

This paper is an update on the actions progressed to deliver the Trust strategy under the 3 Pillars- Population, People and Partnership.

The Trust uses a strategic Planning Framework (SPF) to oversee the delivery of the strategy. To ensure the strategy is progressing the SPF identifies 9 metrics to monitor to oversee delivery, these are the vision metrics.

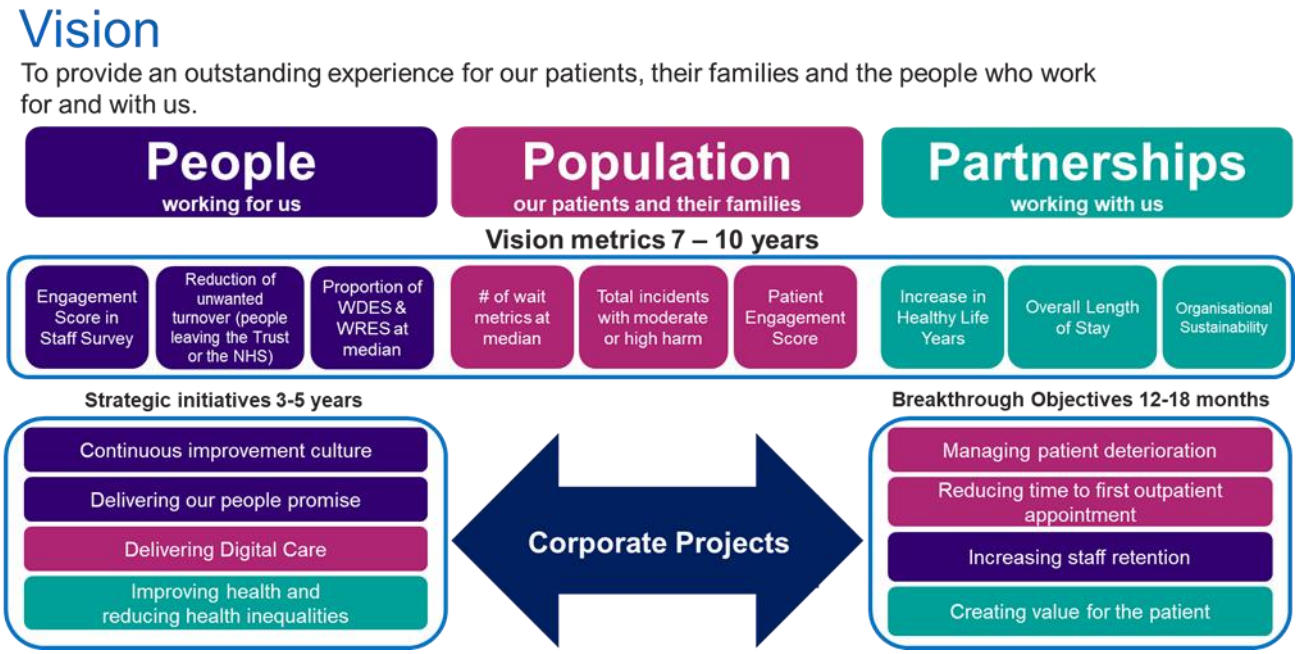
The paper shows progress in most of the vision metrics, there are a number where metrics and monitoring is immature e.g.(increase in health life years), however progress in terms of input actions are outlined for the Board to consider.

The most significant risk to delivery of the five year strategy is the financial sustainability of the organisation and the need to work with system partners to develop a financial plan that ensures services can be delivered within a sustainable resourcing plan.

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

## Introduction

The Organisation's strategy is overseen through the Strategic Planning Framework (SPF), the three areas of focus People, Population and Partnerships all have assigned vision metrics which allow the organisation to track progress over a longer time frame.




To complement the vision metrics the Trust also has strategic initiatives which are programmes which deliver over a 3 –5 year framework.

This paper is an outline of progress against our vision metrics as well as to update the Board on any wider strategic issues which may impact our direction or delivery.

## Vision Metrics

1. **Population**

The focus of the population pillar is to improve the health and wellbeing of the local population. This underpins a focus on good quality patient care and improving on how services are shaped and developed through public engagement.

Progress is measured through a combination of metrics:

- A combined metric looking at ED performance, Cancer performance, Diagnostic standard DM01 and 18 week RTT performance.
- Reducing patient harm
- Patient engagement score.

The combined performance metric is a way to measure whether patients are receiving timely access to care covering both planned and emergency care. The immediate challenges to recover waiting times even four years on from the Covid Pandemic remains a central focus for the Trust. The recognition eighteen months ago that ward capacity was a limiting factor to meeting the longer- term plan to reduce waiting times has been addressed with Imber ward opening June 2024 giving much needed capacity to reduce planned care waits.

The longer-term strategic aim of replacing the day surgery unit is not only about addressing infrastructure risks, but also creating an environment which will maximise efficiency and opportunities to reduce waiting times. The ability to attract national capital funding remains a significant challenge. The Campus redevelopment programme which DSU is a significant part, remains a focus and working is ongoing with regular updates to Board. Alternative funding models are being explored with a view to explore with regional colleagues any potential avenues to progress the programme. The age and environment of the estate remain a significant risk and is reflected in the BAF.

Looking forward the population facing SFT is ageing with more over 70's and increase in the prevalence of dementia. Therefore, the models of care will need to change to meet a frail elderly population with co-morbidities. The Trust is leading the bid for BSW Community services which is directly in response to recognising integrated services are the only way to mitigate further demand. Without changing the way health and care is delivered in BSW both additional workforce and estate would be required to meet increased demand, which is unaffordable and unsustainable.

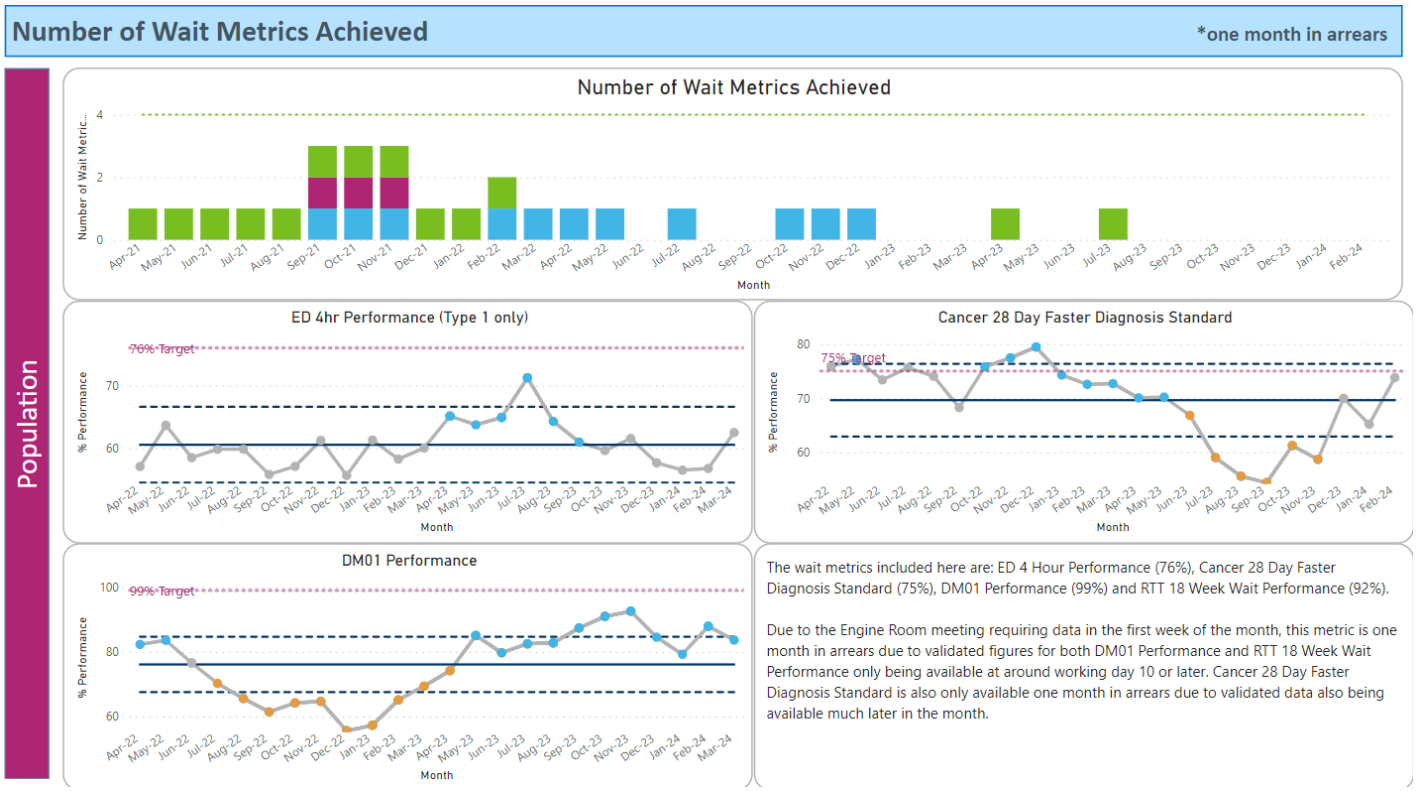
The Board will receive a separate briefing on the progress and anticipated benefits/risks in undertaking such a significant change in service model. The contract award is over seven years which reflects the level of transformation required to improve and integrated services and move resources to preventative care.

In terms of progress against vision metrics in the last twelve months, steady progress has been made.

Diagnostics (DM01) has improved considerably, this will continue to develop in coming months although predominately through capacity increases. The Trust is part of the Community Diagnostics Centre (CDC), where an increase in diagnostics capacity in the community will improve cancer diagnostic rates in the local population. The Trust is an integral part of providing the service and working with primary care to ensure timely access. Operational logistical challenges have slowed progress in establishing CT and MRI capacity in the community in the last six months although these are being resolved to establish services at Central Health Clinic. In the longer term the establishment of CDC capacity will help improve outcomes for the local population and help reduce acute demand.

Cancer performance has struggled under an increase in demand as overall waiting times for services have increased. Short term capacity funded through the South West Cancer Alliance and national access to ringfenced cancer funding have supported rapid capacity increases to improve the skin pathway. In the medium term the focus on diagnostics and improved networked pathways will improve outcomes. The Trust will need to continue to develop pathways with University Hospital Southampton but also will look to what opportunities across the AHA may present, particularly any sub specialisation.

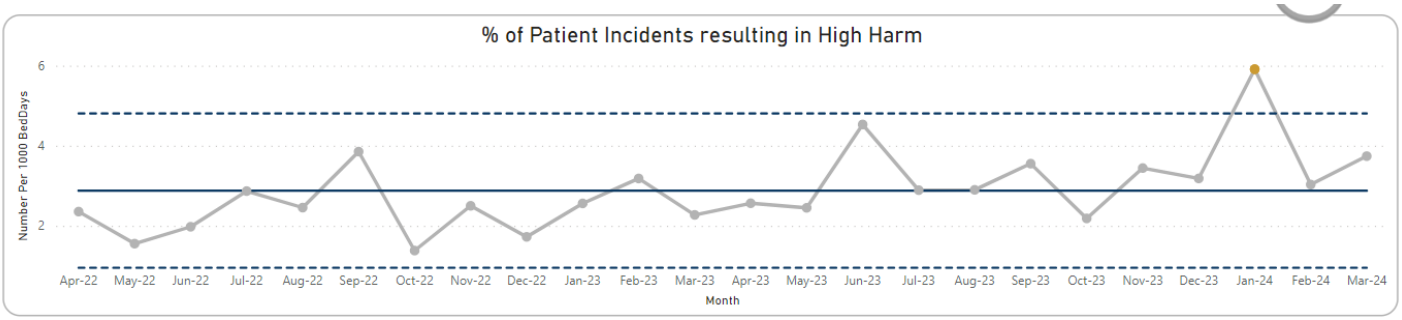
RTT waiting times remain well in excess of 18 weeks. The Trust has reduced the number of over 65 weeks and is working towards reducing 52 week waits but reducing the waits will be a multi year recovery programme. As outlined already in the paper the medium term focus will be on ensuring access to diagnostics, improving theatre environment to maximise experience and efficiency.




## Patient harm

The focus on quality improvement is largely outlined in the quality accounts which illustrate the range of improvements for the last year. The metric used to monitor the vision metric is patient incidents resulting in high harm. The in -year breakthrough objective linked was reducing patient falls, where progress has been significant.

The vision metric below shows no significant statistical change in performance.

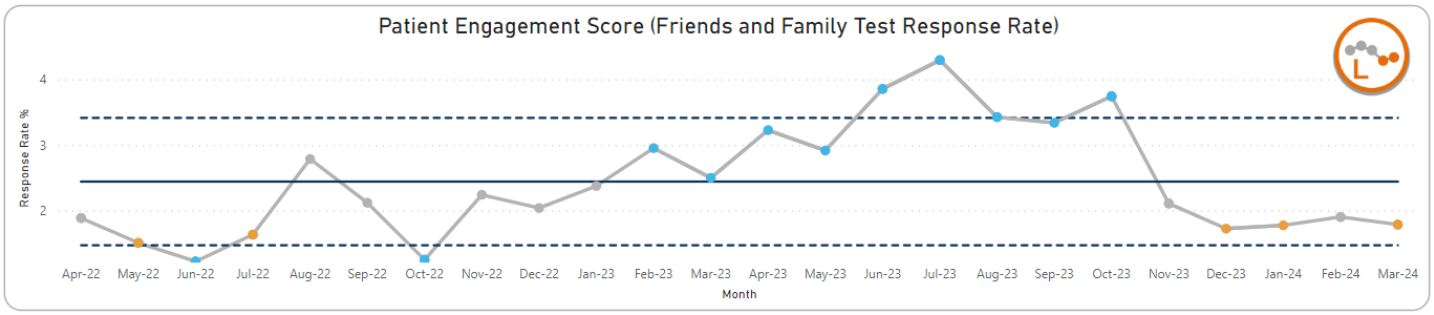


To achieve improvement in the medium term a significant driver of performance is linked to the People pillar, ensuring the organisation has the right workforce roles who are appropriately trained. Themes like ensuring a dementia strategy to reflect the aging population and likely rise in patients with dementia is being reviewed as part of the specialty five year plans.

**Patient Engagement Score**

The Trust had identified a need to improve patient engagement to develop services that are responsive to the population need. The most objective way to measure engagement has been through Friends and Family Test (FFT). The FFT however, it is not accessible enough (main feedback is from inpatient wards only), impacting response rates and does not have the capability to provide insightful data despite being the Trust's current largest source of regular, live feedback.

The PALs team have been developing a strategy effectively improving patient co-production over the last twelve months. Regular progress has been reported through the clinical governance committee. Whilst the FFT remains the best way to measure progress it is not the only on emphasis for the team and doesn't reflect the progress made.




**2) Partnerships**

The partnership work has centred around the Acute Hospital Alliance (AHA) in recent months and examining the opportunities to collaborate further. Now all three hospitals are further on in their development with improving together, the work programme is focused on developing a strategic Planning Framework (SPF) for the AHA to use as the overall framework for joint working. The challenges of ensuring the AHA collective strategy is responsive to the overall ICS strategy published last year, whilst also reflective of the three individual organisations focus is challenging. However it is anticipated this will be completed by the end of Quarter 1 in 2024/25, broadly all three organisations as expected have very similar themes and aims.

Whilst this work is underway there are three immediate priorities we have focused on as an AHA, are 1) The development of the joint Electronic Record (EPR), 2) the development of the community services tender and 3) maximising productivity opportunities across the AHA (in particular to respond to the financial challenges). It is anticipated these projects will be reviewed from at SFT perspective to be future strategic initiatives to ensure they are embedded in the SFT management framework.

The Trust continues to work in partnership at Place with a number of partners. The ICB are mid-way through a consultation in line with a national imperative to reduce staffing levels by 30%. The implications for this are not fully understood yet, but it is anticipated the ICB will not have the same level of resource to invest in Place to support joint working. This presents both a risk and an opportunity for the Trust to develop place based delivery partners to ensure the shared aim of integration moves forward.

The importance of our tertiary networks with University Hospitals Southampton remains central to delivering high quality services. UHS have approached us in a more formal way to develop a programme of joint working to delivery share priorities. There are obvious operational benefits of continuing to improve services and access for our patients (oncology, plastics, cancer pathways in particular urology and respiratory) but in addition there are opportunities to improve SFT's scale of planned care services. UHS have been clear in their intent to focus on specialist work and would like in principle to move non specialist to other providers. As we develop and improve our theatre efficiency this would provide an opportunity to address our financial challenges and provide more services local to the patient.

The Trust remains in the South Six pathology network which is working through business case options for collaboration. There has been a clear NHSE directive towards establishing networked provision to reduce costs and improve efficiency. Conversations continue on the best model for collaboration, with SFT making clear there is minimal appetite for a separate legal entity. In the most recent conversations in April, this position has been echoed by the other NHS Trusts. All remain committed to identifying more effective and efficient ways of working but in a more collaborative partnership approach.

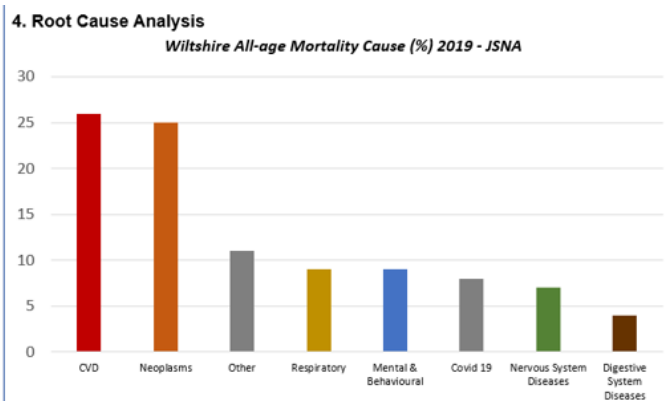
The metrics monitored for progress against our Partnership pillar are:

- Increase in healthy life years
- Overall length of stay
- Organisational sustainability.

**Increase in healthy life years**

The ability to monitor this metric at the Trust is still being developed. The majority of the information which underpins this metric currently sits within the system population health working group. There are a number of system working groups underpinning the programme to influence the wider determinants of health. The Wiltshire Local alliance is developing an operational plan to focus on all partners on operational changes which when themed together will contribute to improving a prevention metric, e.g. access paediatric dentistry.

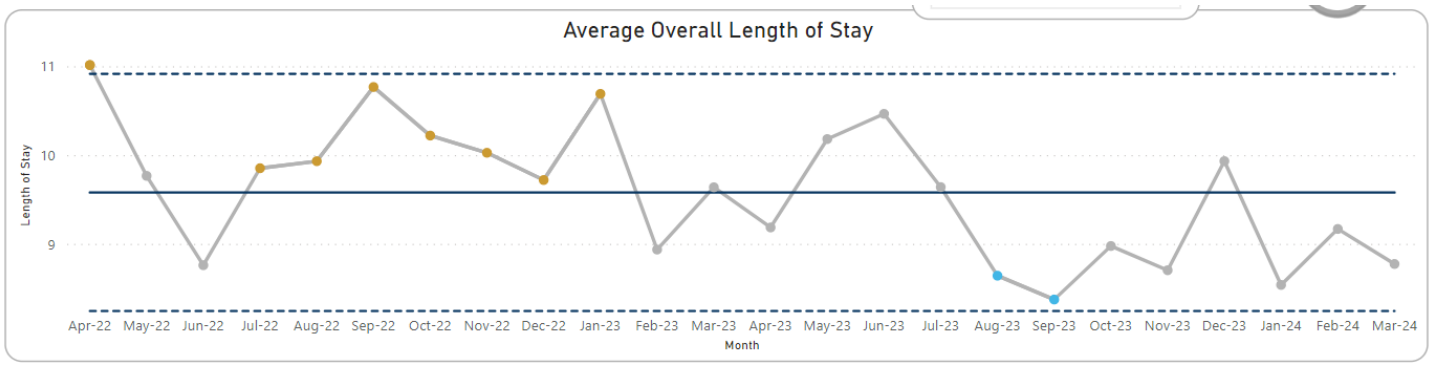
The A3 developed shows cardiovascular disease (CVD) as the top contributor to mortality for Wiltshire. The next steps being developed include focusing on the actions SFT can take to help improve CVD, for example reducing DNA rates for cardiology outpatients which are higher for people from the most socially disadvantaged postcodes.




## Overall Length of stay

The focus on length of stay recognises there has been an increase in length of stay over the last four years with patients not achieving optimum pathways from both a patient experience and outcome basis. With patients waiting for onward care (no criteria to reside NCTR) increasing from c40 in 2019/20 to over 125 in January 2023. To improve integrated care and ensure patients return to their usual place of residence the Trust has been working closely with partners to improve pathways.

In the last year this has meant the length of stay has reduced by 1 day across the whole Trust. This has been driven through Trust wide initiatives such as Same Day Emergency Care (SDEC) and Acute Frailty Unit. The system work has focused on increasing capacity to support patients in their own homes with a move away from bedded capacity (move to increase pathway 1 and reduce pathway 2). This has enabled a reduction in NCTR closer to 70 on average. This has had a significant impact on flow and capacity. The plans for 2024/25 continue to focus on this metric with an aim of reducing NCTR to being maximum of 10% of occupied beds (stretch target of 5%). Therefore it is anticipated the overall length of stay will continue to fall in the year to come.




## Organisational Sustainability

The key elements which underpin this priority include : financial sustainability, having an infrastructure that reflects the needs of a modern hospital (including environmental sustainability) and our role as an anchor institution.  The metric used to measure our progress is our deficit as a percentage of turnover.

Our progress to date has been predominately on a one-year financial plan in line with the NHS planning guidance. Whilst the Trust submitted a medium term financial plan as part of the ICS submission, work both as a single organisation and as a wider system is immature in relation to developing a system wide transformation plan. A working group has been established across the system which meets fortnightly on the back of the recent planning round, to develop a three-year financial recovery plan. The underpinning assumptions at a system level is to address the expected future demand include a move of resources from secondary care to prevention and out of hospital provision. The Community services tender is a key milestone in the strategic plan of the system.

In conjunction with the work undertaken at system level the Trust is starting to develop a longer-term financial recovery plan, however capacity to date has limited progress. An outline plan with timescales will be developed by the end of quarter one, and prioritising progress will be important to achieving progress against this metric.

2. **People**

Recognising the workforce of SFT is paramount to delivering safe and effective care it is a central pillar to the organisation's strategy. The national people plan was published in 2020, and subsequently the People Plan which both outlined the expectations of NHS organisations to ensure the NHS has a compassionate, inclusive and positive culture for staff. The SFT strategy basically reflects the national ambition with focus on specific improvements for the SFT workforce.

The People and Culture Committee oversee delivery of the People strategy with regular updates to Board.

To measure progress 3 vision metrics are being monitored:

- Engagement score in the staff survey
- Reduction in turnover
- Proportion of WDES and WRES at median

The latest staff survey shows improvement in the engagement scores as outlined below

**Staff Engagement**

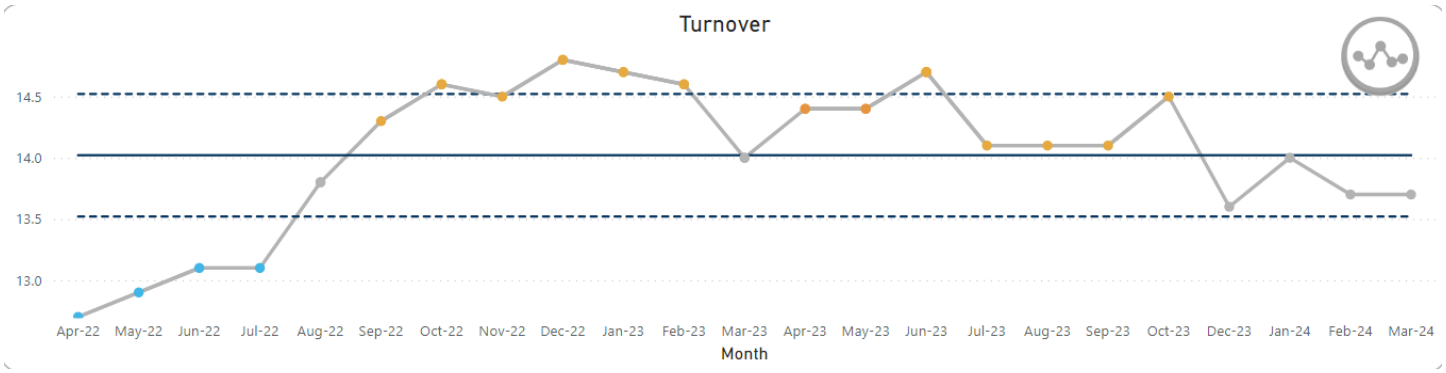
| | | Picker Avg. 2023 n = 217954 | SFT 2023 n = 2265 | SFT 2022 n = 1861 | SFT 2021 n = 1881 |
|---|---|---|---|---|---|
| **Motivation** | | | | | |
| q2a | Often/always look forward to going to work | 55.6% ↑ | 57.7% ↑ | 51.9% | 52.2% |
| q2b | Often/always enthusiastic about my job | 69.6% ✓ | 70.1% ↑ | 65.6% | 66.1% |
| q2c | Time often/always passes quickly when I am working | 73.0% ↑ | 75.0% ✓ | 74.5% | 74.0% |
| **Involvement** | | | | | |
| q3c | Opportunities to show initiative frequently in my role | 74.5% ✓ | 75.5% ✓ | 73.9% | 74.3% |
| q3d | Able to make suggestions to improve the work of my team/dept | 72.3% ↑ | 74.8% ✓ | 73.9% | 72.1% |
| q3f | Able to make improvements happen in my area of work | 56.1% ✓ | 57.9% ✓ | 55.2% | 52.0% |
| **Advocacy** | | | | | |
| q25a | Care of patients/service users is organisation's top priority | 74.2% ↑ | 76.0% ✓ | 70.3% | 75.5% |
| q25c | Would recommend organisation as place to work | 60.4% | 60.3% ↑ | 51.2% | 56.9% |
| q25d | If friend/relative needed treatment would be happy with standard of care provided by organisation | 62.6% ✓ | 63.4% ↑ | 56.4% | 68.6% |

↑ = statistically significant increase ✓ = absolute % increase

This shows significant improvement and progress against the strategy. More in depth conversations have taken place in both the People and Culture Committee and the wider Board of Directors examining the survey results in more detail.

### Reducing unwanted turnover

The metric for turnover shows some improvement particularly the last quarter of 2023/24. This remains a focus for 2024/25 particularly focused on HCA roles and overall staff under 30 who have much higher turnover rates relative to the wider workforce.




### Proportion of staff survey scores at median for - Workforce Disability workforce standard (WDES) and Race Equality workforce standard (WRES)

The recent staff survey results show limited progress against the WRES and WDES standards compared to the overall improvement in staff survey results:

Respondents with a disability had a lower score across all People Promise, Morale and Engagement areas.

| Disability (q31a) | Comparator (Organisation Overall) | Yes | No |
|---|---|---|---|
| Description | n = 2265 | n = 520 | n = 1697 |
| We are compassionate and inclusive | 7.3 | 6.9 | 7.4 |
| We are recognised and rewarded | 5.9 | 5.3 | 6.1 |
| We each have a voice that counts | 6.7 | 6.2 | 6.9 |
| We are safe and healthy | 6.1 | 5.4 | 6.3 |
| We are always learning | 5.3 | 4.8 | 5.5 |
| We work flexibly | 6.2 | 5.7 | 6.4 |
| We are a team | 6.7 | 6.2 | 6.8 |
| Staff Engagement | 6.9 | 6.5 | 7.1 |
| Morale | 5.8 | 5.3 | 6.0 |

Ethnicity - People Promise, Staff Engagement and Morale Scores

The ethnic group with the most positive People Promise, Morale and Engagement scores was "Pakistani", followed by "Any Other Asian background" and "Indian". The ethnic groups with the least positive scores were "Irish", and "Any other ethnic background". A table showing ethnicity of trust staff is shown on the next slide.

| Ethnicity (q28) | Comparator (Organisation Overall) | English / Welsh / Scottish / Northern Irish / | Irish | Any other White background | Any other Mixed / Multiple ethnic background | Indian | Pakistani | Chinese | Any other Asian background | African | Any other ethnic background(please specify) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | n = 2265 | n = 1687 | n = 16 | n = 121 | n = 14 | n = 178 | n = 13 | n = 13 | n = 82 | n = 58 | n = 18 |
| We are compassionate and inclusive | 7.3 | 7.3 | 6.8 | 7.2 | 7.9 | 7.4 | 8.1 | 7.2 | 7.4 | 7.0 | 6.9 |
| We are recognised and rewarded | 5.9 | 5.8 | 5.7 | 6.0 | 6.2 | 6.2 | 6.5 | 6.1 | 6.2 | 6.0 | 5.1 |
| We each have a voice that counts | 6.7 | 6.7 | 6.4 | 6.8 | 7.0 | 7.1 | 7.3 | 6.6 | 6.9 | 6.5 | 6.1 |
| We are safe and healthy | 6.1 | 6.0 | 5.9 | 6.0 | 6.3 | 6.4 | 6.8 | 6.0 | 6.3 | 5.8 | 5.7 |
| We are always learning | 5.3 | 5.2 | 4.6 | 5.6 | 4.3 | 6.1 | 6.5 | 6.0 | 6.2 | 5.5 | 5.1 |
| We work flexibly | 6.2 | 6.2 | 5.3 | 6.2 | 5.2 | 6.4 | 6.7 | 5.6 | 6.7 | 5.8 | 4.6 |
| We are a team | 6.7 | 6.6 | 6.2 | 6.6 | 7.1 | 7.1 | 7.6 | 7.1 | 7.2 | 6.7 | 6.4 |
| Staff Engagement | 6.9 | 6.9 | 6.5 | 7.0 | 7.1 | 7.6 | 7.7 | 6.9 | 7.4 | 7.1 | 6.5 |
| Morale | 5.8 | 5.8 | 5.4 | 5.9 | 6.0 | 6.1 | 7.0 | 5.5 | 6.4 | 5.8 | 5.3 |

Discussions on next step on EDI continue to be a feature of the board development programme and reflect the workplans already shared by the Chief People Officer, further actions will be developed to ensure progress continues in respect of creating an inclusive culture for all.

## Conclusion

Overall the Trust is making positive progress in implementing its five year strategy. A number of the vision metrics show positive progress and those less well developed have action plans to ensure metrics become embedded. Oversight of progress by the executive team is through the engine room and regular updates will be provided to Board.

The next steps include:

- Finalising monitoring and data collection for all nine vision metrics for oversight in the Engine room.
- Align the progress against the vision metrics with the BAF to ensure risks to delivery are well articulated and understood.
- Develop a financial recovery plan in conjunction with the system to ensure delivery of the sustainability metric.