Bundle Trust Board Public 5 March 2020

1 OPENING BUSINESS

1.1 10:00 - Presented of SOX Certificates

Presented by Nick Marsden

1.2 10:10 - Patient and Staff Story

1.3 10:20 - Welcome and Apologies

No apologies received

1.4 Declaration of Interests

1.5 Minutes of the previous meeting

Minutes of Public Trust Board held on 6th February
Presented by Nick Marsden

1.5 Draft Public Board mins 6 February 2020.docx

1.6 Matters Arising and Action Log

Presented by Nick Marsden

1.6 Public Trust Board Action Log.docx

1.7 Register of Attendance

Presented by Nick Marsden

Register of Attendance - Public Board 2019-20.docx

1.8 10:25 - Chairman's Business

Presented by Nick Marsden

1.9 10:30 - Chief Executive Report

Presented by Cara Charles-Barks
For information

1.9 CEO Board Report March 2020.docx

2 ASSURANCE AND COMMITTEE REPORTS

2.1 10:40 - Trust Management Committee - 19 February

Presented by Cara Charles-Barks
for assurance

2.1 TMC Escalation report March 2020.docx

2.2 10:45 - Finance and Performance Committee - 25 February

Presented by Paul Miller
For assurance

Finance and Performance Committee escalation paper 25th February 2020.docx

2.3 10:50 - Clinical Governance Committee - 25 February

Presented by Eiri Jones
For assurance

2.3 Escalation report - from CGC Feb 2020.docx

2.4 10:55 - Workforce Committee - 27 February

Presented by Michael von Bertele
For assurance

2.4 Escalation report - Workforce Committee.docx

2.5 11:00 - Integrated Performance Report

Presented by Lisa Thomas
For assurance

2.5a 200305 IPR.docx

2.5b IPR March 2020 Final.pdf

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 11:20 - PLACE Update

Presented by Andy Hyett
For approval

3.1 PLACE Report - 2019.docx

4 WORKFORCE

4.1 11:30 - Skill Mix Review

Presented by Lorna Wilkinson
for assurance

4.1a Board Skill Mix Review Front sheet Feb 2020.docx

4.1b Skill mix review Final Board Feb 2020.docx

4.1c Appendix 1 National Quality Board Expectations for Safe Staffing.docx

4.1d Copy of Appendix 2 Compliance NQB Guidance.pdf

4.1e Copy of Appendix 3 Ward Staffing Ratios (3).pdf

4.1.a Materrnity and Neonatal Staffing Report

Presented by Lorna Wilkinson
For assurance

4.1ia Board cover sheet - maternity and neonatal.docx

4.1ib Maternity Neonatal staffing report with Appendix final version 6 to send to LW.docx

5 GOVERNANCE

5.1 11:40 - Well Led Action Plan

Presented by Cara Charles-Barks
For assurance

5.1a Well-Led Board Progress Report February 2020.docx

5.1b Well-Led action plan_revised August 2019 FINALv4_updated December 2019.pdf

5.2 11:45 - Constitution

Presented by Nick Marsden
For approval

5.2a Board cover sheet-constitution change March 2020.docx

5.2b Constitution March 2020 v1.1Draft.docx

6 Closing Business

6.1 Agreement of Principle Actions and Items for Escalation

6.2 Any Other Business

6.3 11:50 - Public Questions

6.4 Date next meeting

Next Public meeting 2nd April 2020

7 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 6 February 2020 in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr N Marsden	Chairman
Mrs Cara Charles Barks	Chief Executive Officer
Mr Andy Hyett	Chief Operating Officer
Dr C Blanshard	Medical Director
Mrs L Thomas	Director of Finance
Ms L Wilkinson	Director of Nursing
Mr Andy Hyett	Non-Executive Director
Ms T Baker	Non-Executive Director
Mr P Kemp	Non-Executive Director
Ms R Credidio	Non-Executive Director
Mr P Miller	Non-Executive Director
Ms E Jones	Non-Executive Director
Ms R Aggarwal	Non-Executive Director
Dr D Buckle	Non-Executive Director

In Attendance:

Kylie Nye	Corporate Governance Manager (minutes)
John Mangan	Lead Governor (observer)
Sir Raymond Jack	Public Governor (observer)
Fiona McNeight	Director of Corporate Governance
Esther Provins	Director of Transformation
Kat Glaister	Head of Patient Experience

ACTION

TB1 06/02/1 OPENING BUSINESS

TB1 06/02/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

N Marsden presented January's SOX awards to Amy Tiller, Alex Beck and Chris Anderson and thanked them for their commitment and hard work.

TB1 06/2/1.2 Patient Story

LW presented the patient story which related to a patient's experience using the Trust's Hematology and Cancer services

Discussion:

- NM referred to the number of services within the Trust, this specific patient had utilised and the great service he had received in every department. LW noted that his condition is very rare with only 200 cases reported in the UK each year and it was positive that the patient was assured by the

networking aspect of his care. LW reported that this particular patient has expressed an interest in continuing to work with the hospital to pass on his experiences and help staff use this for future learning.

- L Thomas referred to the point raised regarding the car parking, when patients are unexpectedly admitted and their car may still be parked on-site. L Thomas noted that at times of high anxiety patients should not be worried about parking, or being charged. A Hyett explained that there is a process for those who are admitted with their car still on site but suggested he take this back to his teams to reiterate the process.
- P Miller noted that part of this patient's good experience was the individual and integrated care he got as a cancer patient. P Miller noted that the patient had specifically mentioned the helpful phone number he had been given if he had any questions or concerns. P Miller suggested that all patients should receive this care, not just those on cancer pathways.
- D Buckle noted the positive experience the patient had in relation to waiting times for both diagnostic and clinic appointments.
- E Jones noted that this story is a good example for learning as the practices discussed can easily be disseminated across the hospital. E Jones noted that this was a great example of patient-centered care and asked if the Trust had a library of other stories used for learning. L Wilkinson explained that patient stories are used for learning across the Trust, particularly in staff meetings. K Glaister reported that from October 2020 onwards there will be a private portal on the Trust's website which will be used for staff learning and reflection.
- T Baker noted that the story had highlighted how complex some patient pathways are and how much the NHS expects their staff to do. LW noted that the pathway described in this story was not unusual and it is common for patients to utlilise a number of services across the Trust.
- LW highlighted the importance of this patient having a key worker and the difference it made to his care. EP agreed that the patient felt supported and confident, even with a rare disease.

TB1 06/2/1.3 **Welcome and Apologies**

Apologies were received from.

- Michael von Bertele, Non-Executive Director
- Lynn Lane, Interim Director of OD and People

N Marsden welcomed the Trust's newly appointed Non-Executive Directors, Dr David Buckle and Rakhee Aggarwal to the meeting.

TB1 06/2/1.4 **Declarations of Conflicts of Interest**

There were no declarations of conflicts pertaining to the agenda.

TB1 06/2/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 9 January 2020**

The minutes were agreed as an accurate record of the meeting held on 9 January 2020.

TB1 06/2/1.6 **Matters Arising and Action Log**

N Marsden presented the action log and the following items were noted:

- **Action 151 RTT Performance** - AH noted that a recovery plan would be coming to March's meeting. **ACTION: AH** **AH**
- **Action 152 SPC Charts –** AH noted that there is an issue with the IT software which is causing some discrepancies in the SPC charts. There is work ongoing to try and resolve the issue and an update will come back to the next meeting. **ACTION: AH** **AH**
- **Action 153 Safety and Effectiveness of Services at the Weekend.** The Board noted that a quarterly update would be coming to the Board. Item closed.

There were no further matters arising.

TB1 06/2/1.7 **Chairman's Business**

N Marsden reported that the Trust has been focusing on developing its operational plans for 2020/21 after the guidance was published on 30th January by NHS Improvement/NHS England. N Marsden further reported that the publication of the People Plan is expected to be very soon, which will influence the Trust's strategic plans.

Discussion:

- P Miller queried if there had been any further updates regarding the STP. N Marsden noted that there had recently been a BSW STP Sponsoring Board chaired by S Elsy and the meeting had provided focus and progress had been made. PM asked that now the governance is established, is there any scope to involve Executives and Non-Executive Directors to be involved in these meetings to help move towards an Integrated Care System (ICS) by 2021. C Charles-Barks noted that the challenge is the variation in ICS models as there are currently only 11 established in the country.
  C Charles-Barks explained that she is planning to meet Tracey Cox, chief executive of BSW STP, to discuss and try and progress this work. What is critical is the quality of relationships with our partners and establishing what roles each provider will take to establish a system of care that best serves the population.
- T Baker asked if place-based systems had been considered

in the newly published planning guidance. C Charles-Barks explained that this work is moving forward through the Trust's work with the Primary Care Networks. Additionally, the Trust has applied for support from NHS Providers with a workshop scheduled for March to look at what Integrated Care will mean locally.

TB1 06/2/1.8 **Chief Executive's Report**

C Charles-Barks presented the Chief Executive's report and highlighted the following key points:

- The Trust continued to be under considerable pressure over the Christmas period and continues to experience challenges with the emergency pathway as a result. Despite these challenges and not achieving the 4 hour ED standard, the hospital was in the top 15% of best performing Trusts in the country in relation to this target.
- The Trust's financial position remains challenging and the revised forecast means the Trust will not be in receipt of any further sustainability funding in 2019/20. The Trust is focused on financial control in order to ensure we begin 2020/21 on a stronger footing.
- In relation to workforce the Trust is focused on "hard to recruit" consultant and Allied Health Professional posts to reduce expenditure on costly locum staff. In terms of wider workforce planning, the Acute Alliance Network have been reviewing some longer term solutions and have proposed initiating virtual leadership networks to help the delivery of services across the region.
- The flu vaccine uptake has been really positive with 76% of frontline staff having now had their flu jab. Flu nurses are visiting areas directly and peer vaccinators are available to vaccinate staff in and out of hours.
- 2020 is the International Year of the Nurse and the Midwife which is a great opportunity to celebrate and say thank you to the Trust's nurses and midwives who display commitment, care and compassion every day. There will be a number of activities planned in 2020 to celebrate this special year.
- The Trust recently received a visit from Olivia Colman and Josh O'Connor, who had taken time off of filming "The Crown" nearby at Wilton House. They met staff and patients as they visited the Breast Cancer Unit, Pembroke Unit and Neonatal Unit, all of which have benefitted from generous funding via the Stars Appeal.
- C Charles-Barks provided an update on the STP and reported that Dr Andrew Girdher has been successfully voted as the new clinical chair for the merged BaNES, Swindon and Wiltshire (BSW) CCG. His new role starts on 1st April 2020, when the three existing CCGs formally merge but work is already underway to shape this role and develop priorities to focus on.
- On 16th January, the BSW CCGs approved a proposal to improve and modernise maternity services across the region.

The proposals will provide more choices for birth to more women and we build a strong foundation on which to enhance continuity of care. This will mean that more women can see the same midwife or small team of midwives before, during and after labour.

TB1 06/2/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 06/2/2.1 **Trust Management Committee Report – 27 January**

C Charles-Barks presented the report, providing a summary of escalation points from TMC held on 27th January.

- The Committee received the 2020/21 operational plans of the directorates of Medicine, Surgery, MSK and Child Support and Family Services.
- The directorate's plans were well received with clear structured deliverables on what needs to be achieved. The directorates agreed to review how the digital strategy could help inform their plans going forward into 2020/21.
- The biggest challenge will be balancing strategic priorities with financial sustainability.

Discussion:

- E Jones referred to the recent high occupancy challenges the Trust has faced and asked how realistic the plans will be in helping with this issue. L Thomas explained that the Trust's focus is balancing what is achievable with the Trust's capacity and financial situation and therefore developing realistic plans going forward.
- P Miller noted that clinical engagement is vital in the operational plan and asked if TMC meetings were working efficiently and allowing for clinical engagement with the management team. C Charles-Barks explained there is further work required to improve TMC to ensure it is an efficient and useful meeting.

TB1 06/2/2.2 **Finance and Performance Committee Report – 4 February**

P Miller presented the report providing a summary of escalation points from CGC held on 4 February.

- The Committee endorsed the Financial Sustainability Strategy and this will go to February's Board for final approval.
- The Trust is forecasting a £15m Control Total Deficit, which is £6.1m more than that original plan
- The Committee received a brief report on the 2020/21 Operational Planning guidance which was only published on 30th January. A more detailed presentation went to Board on 6th February.
- The Committee reviewed the BAF and CRR and it will be updated accordingly.

TB1 06/2/2.3 **Clinical Governance Committee – 4 February**

P Miller presented the report, providing a summary of escalation points from Clinical Governance Committee held on 4 February

- The Committee received a paper regarding the National Patient Safety Strategy and the actions to take the work forward. It was noted that there are risks against the delivery of this strategy, most notably due to the Trust's digital infrastructure constraints.
- C Blanshard provided a verbal update on the initial feedback from the Royal College of Physician Invited Service Review of Gastroenterology services. A full report and action plan will come to a future meeting.
- The Committee received an update on AMU flow and bed management. It is clear that ED and AMU have good processes in place and that patient flow is largely constrained due to issues further along the patient pathway. The discussion highlighted the issues relating to the lack of general medicine clinicians, which is a national problem.
- The Committee reviewed the BAF and it was agreed that Cancer and the risks surrounding this service should be added to the CRR.
- LW provided an update on the Coronavirus (COVID-19) ; assuring the Committee that the Trust has robust plans in place should the situation escalate further.

TB1 06/2/2.4 **Workforce Committee – 23 January**

M von Bertele presented the report, providing a summary of escalation points from Workforce Committee held on 23rd January.

- There was a discussion regarding the risks associated with culture change in the organisation and the Committee noted that a bigger piece of work in relation to listening to staff is coming to March's Workforce Committee.
- A majority of consultant's job plans have not been signed off and the impact of this in relation to operational and financial planning was discussed. This is being discussed at TMC and a follow up paper will come to March's Committee with progress on agreed actions.
- The recommendation for FTSUG Ambassadors was supported but not approved. It was suggested that further work was required to identify established ambassadors e.g. Dignity at Work, and identify their connections across the Trust to try and establish the role of the FTSU Ambassador. Following this work, a recommendation report will come to March's meeting

Discussion:

- C Charles-Barks noted the importance of the Trust developing the FTSU Ambassador posts but not wanting duplication in relation to other posts in the Trust.
- P Kemp noted that the Trust Board should monitor job plans similarly to when staff appraisals were not performing. P Kemp suggested that the Board monitor job plan sign off as part of the IPR until the issue has been resolved. C Charles-Barks noted that she was monitoring this closely and had asked for a trajectory of sign off between now and March 2020. A Hyett explained that there are complexities but work is underway to ensure the job plans are signed off as a priority.

TB1 06/2/2.5 **Board Assurance Framework and Corporate Risk Register**

F McNeight presented the report asking the Board to consider and approve the revised Board Assurance Framework (BAF). The following key points were noted:

- Following an increase of the risk profile noted in the last report presented to Board in December 2019; there has been a full review and rationalisation of all corporate risks. This was undertaken by the Executive Directors and subsequently informed the Strategic Planning Board Seminar Session in January.
- Discussions have taken place regarding which risks should be further investigated and this has led to the development of criteria to initiate a deep dive or review. F McNeight explained that using the criteria proposed would initiate one deep dive this month and two next month. F McNeight noted that a deep dive template is being produced but asked the Board to initially consider the proposed criteria.

Discussion:

- P Kemp noted that the concern with the scorings is the unrealistic target if a risk has been at a high score for a number of months. P Kemp asked if a risk has been a 16 for 12 months, is a target of 6 correct.
- L Wilkinson explained that the concern wasn't the gap in the scores but is where the Board has not had a collective understanding of the underlying problem when a risk has been on the register for some time. There could be a number of controls in place and work underway that is not on the register or has not had an impact.
- T Baker noted her concerns about an automatic trigger for further investigation as this could cause duplication in work. C Charles-Barks noted that there is an opportunity to develop this oversight at the Trust Management Committee.
- R Credidio referred to the risk relating to cyber ware and asked that be added as a separate risk to the other IT risks in the Trust.

Decision:

- The Board agreed to the proposed criteria to escalate risks to a further deep dive. F McNeight and L Wilkinson will review this closely.
- The risk relating to cyber ware will be added as a separate risk on the register**. ACTION: FMc/EP**

TB1 06/2/2.6 **Integrated Performance Report**

C Blanshard presented the Integrated Performance Report to the Board and the following key points were noted.

- The Trust continues to feel the impact of winter pressure whilst also maintaining the four hour ED performance above the national average for December.
- There was an improvement in discharges before midday and whilst bed occupancy fell during December, the longer term trend for this and Delayed Transfers of Care (DTOC) is one of sustained increase. Inpatients being moved, escalation bed days and Mixed Sex (Non-Clinical) breaches have also remained high. External reviews of the Trust's emergency pathways and patient flow have identified a number of areas of improvement which is a focus.
- Referral to Treatment (RTT) performance has remained a concern due to the downward trend in performance, particularly in Dermatology and Plastics.
- There has been progress as part of the Theatres productivity programme which saw an 8% increase in activity in December.
- Despite issues with a CT scanner, the Trust has maintained its Diagnostic waiting time performance. The underlying problems with the CT scanner are under investigation.
- There has been a notable increase in category 3 and 4 pressure ulcers and work is underway to identify learning and improvement practices.
- Weekend HSMR has stabilised. An improvement plan relating to risk of mortality in gastrointestinal haemorrhage is being presented to CGC in February.
- There was a peak in the number of leavers in February and further validation on this is required. Staff sickness remains relatively static and there have been new consultant appointments in Urology and Upper GI.

Discussion:

- P Miller referred to the drop in 2 week wait cancer performance over Christmas and asked what the cause of this was. AH explained that December saw a drop in referrals causing the denominator to fall. A small number of the breaches were also patient choice and all those who chose not to come in over the Christmas period, were seen in the first clinic in January.
- E Jones referred to the workforce gaps highlighted in Microbiology and asked if this had been mitigated. L Wilkinson noted that one of the substantive Microbiologists

has returned to work and there is also a locum working in the department. Whilst this mitigates the immediate workforce risks, L Wilkinson noted there is a substantive gap.

- E Jones asked for further assurance in relation to C Diff. rounds and inspections. L Wilkinson explained that C Diff rounds occur and are robustly managed but they are not always carried out by the consultant to ensure their time is used efficiently.
- The Board discussed the waiting list, which had dropped slightly during December. However, the trend is still on an upwards trajectory, particularly in certain departments. T Baker asked what was being done in Dermatology to manage the patients waiting for appointments and the workforce gaps. C Blanshard noted that there a number of solutions to mitigate the workforce gaps in Dermatology; upskill the nursing staff, combine clinics so those patients who need Rheumatology and Dermatology are seen at the same time, properly validate referrals as some could be managed by primary care and there are also options for tele-dermatology. It is recognised that some of these are short term and some are longer term solutions.
- R Credidio referred to the Trust's turnover in December and asked if the Executive team were sighted on the reasons for leaving. L Wilkinson noted that the Trust was sighted on all the leavers and reported that all nursing staff who had left in December had been replaced. L Wilkinson further explained that there had been a few members of staff who were part of a "retire and return" process.

TB1 06/2/3 **QUALITY AND RISK**

TB1 06/2/3.1 **Learning from Deaths Report**

C Blanshard presented the report and noted that it had been received and discussed at CGC. The following key points were noted:

- A Medical Examiner system will be introduced this year to strengthen the support of bereaved families and drive improvements in the investigation and reporting of deaths.
- Belinda Cornforth has agreed to take up the role of Lead Medical Examiner and by the end of February 2020 5 Medical Examiners will be fully trained. A Medical Examiners' Officer job description has been written and is to be submitted this month for a banding decision.
- In Q3, 3 deaths were unexpected, of which 2 are subject to a serious incident inquiry and the other a clinical review. The key theme arising in Q3 was the ability to recognise a dying patient and the importance of early discussions about ceilings of care to avoid unnecessary treatment.
- A case notes review of a new relative risk of gastrointestinal haemorrhage took place in Q2 and will be reported to CGC on 25th February.

Discussion:

- D Buckle thanked C Blanshard for the report and noted that the report provided real assurance and it was positive to see the introduction of the Medical Examiner Role. D Buckle highlighted the importance of end of life care and the impact that this has on patient experience. D Buckle asked for a summary of the recent improvements relating to weekend HSMR and C Blanshard provided him with a brief summary.
- R Aggarwal referred to weekend HSMR and queried what percentage of people who present at the weekend have mental health problems and what training is provided for staff. C Blanshard explained that the review of weekend HSMR found no trend in relation to people with mental health problems or learning disabilities. L Wilkinson explained that training could be improved. The Trust have joined an improvement programme via AHSN to upskill the workforce in relation to mental health.
- E Jones referred to the recent report relating to East Kent Hospitals NHS Trust and the cases currently being investigated in relation to preventable baby deaths. E Jones highlighted the importance of the Trust using the learning from this event to improve Maternity services. L Wilkinson noted that a report would be coming to CGC, triangulating this with the Trust's Maternity Improvement Plan. **ACTION: LW** **LW**

TB1 6/2/4 **GOVERNANCE**

TB1 06/2/4.1 **Constitution**

F McNeight presented the report and noted that due to a review of the existing constituencies after being unable to recruit to a governor post after two elections the proposed changes to the constitution have been made:

- The insertion of the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency;
- The deletion of West Wiltshire as a constituency;
- The number of governors for the South Wiltshire Rural constituency be increased from five to six governors.

These changes were proposed to the Council of Governors meeting in November 2019 and were approved by the full Council.

Decision:

- The Board approved the changes to the constitution.

TB1 06/2/4.2 **Board Evaluation**

F McNeight presented her report. The following key points were highlighted:

- The NHS FT Code of Governance sets out the requirements

that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and committees and individual directors.

- At the August 2019 Trust Board meeting the Board agreed that the following evidence should inform the Board evaluation; facilitated 360 review, board member questionnaire, Board member self-assessment against the Good Governance Maturity Matrix, Annual Report 2019/19 overview of performance and a review of Board papers.
- The evidence so far demonstrates that the Board is operating to a satisfactory standard with a higher level of maturity in relation to Board governance, probity and reputation and quality performance.
- There are a number of areas highlighted which could inform further Board development which F McNeight asked the Board to consider and discuss.

Discussion:

- C Charles Barks referred to the 8 areas of development highlighted in the report and asked what the Board thought were the top 3 priorities to focus on.
- The Board discussed the areas of development and it was agreed that the 3 key priorities should be:
  - Ensuring that the Board operates strategically and that it focuses time on issues that only it can consider, and that the balance of assurance activities and driving improvement is correct.
  - Ensuring appropriate succession planning for key Board members and that Board members are appraised and inducted effectively.
  - Ensuring strong partnership arrangements which include communicating more proactively with key stakeholders and taking account of these views.
- T Baker suggested that instead of consistently discussing strategy at the end of the Board day perhaps it would be useful to have that discussion in the morning.

TB1 06/2/4.3 **EPRR Report**

AH presented the report asking the Board to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to sign off this annual EPRR assurance report as part of the NHSI/E assurance process.

AH reported that the Trust's status for EPRR compliance has been rated by Wiltshire CCG and NHSI/E as fully compliant for the third consecutive year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).

Discussion:

- PM referred to section 8. Identified Gaps in EPRR Portfolio and Next Steps and noted that the dates were very broad. AH noted these dates would be reviewed and updated: **ACTION: AH** **AH**

Decision:

- The Board approved the EPRR annual assurance report.

TB1 06/2/4.4 **Remuneration Committee Terms of Reference**

F McNeight presented the Remuneration, Nominations and Appointments Committee Terms of Reference which required Trust Board approval.

F McNeight explained that the Terms of Reference were new and had been approved by the Remuneration Committee on 5th December.

Discussion:

- R Credidio suggested that there should be a comment in the Terms of Reference regarding the cultural setting of the organisation. The Board agreed this should be added. **ACTION: FMc** **FMc**

Decision:

- Subject to this minor addition the Board approved the Terms of Reference.

TB1 06/2/4.5 **2020 Cycle of Business**

F McNeight presented the Trust Board 2020 Cycle of Business for the Board to note.

Discussion:

- PM asked if there should be a regular system/STP update coming to the Board. LT noted that from March onwards a new paper would be coming to the Board regarding the system plan. It was agreed this would be added to the cycle of business. **ACTION: KN** **KN**
- AH reminded the Board that some of the dates are subject to change as they are dependent on national timelines.

TB1 06/2/5 **CLOSING BUSINESS**

TB1 06/2/5.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted that the key points of escalation from this Board meeting were:

- The 2020/21 Operating Planning process and the overarching themes relating to this including, sustained performance, financial sustainability whilst ensuring the Trust is deliver safe and effective care. N Marsden noted that an update on the planning process would be discussed in the private meeting.

TB1 06/2/5.2 **Any Other Business**

There was no other business.

TB1 06/2/5.3 **Public Questions**

J Mangan raised a concern regarding clinicians not automatically copying letters to patients when sending a letter to other clinicians and GPs. J Mangan stated that every patient should have access to their own letters. A Hyett explained that some years ago these letters were automatically copied to every patient but there were patients who did not wish to receive them.

E Provins explained that the Trust is no longer able to charge for access to medical record so any patient can request access without charge. E Provins further noted that providing a system where all letters are copied to patients would be difficult as there are several separate IT systems running across the hospital. The Board agreed that is something to take into account when the Trust is reviewing how its IT systems can be improved.

J Mangan noted that some clinicians do ensure their letters are copied to patients and explained the benefits of patients being well informed about their care. D Buckle noted that the Trust receives hundreds of Subject Access Requests a year and this could be a consequence of not routinely sending letters to patients. D Buckle noted that copying all letters to patients is sometimes for work for clinicians because the language used has to be carefully considered. However, this work is outweighed by the huge benefit this has to patients. C Blanshard explained that all recent evidence suggests that a majority of patients would like to see these letters and would prefer if it was written directly to them.

TB1 06/2/5.4 **Date of Next Meeting**

Thursday 5 March 2020, Board Room, Salisbury NHS Foundation Trust

TB1 06/2/6 **RESOLUTION**

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

Trust Board Public 5 March Action Log

List of action items Trust Board Public 5 March

Agenda item		Assigned to	Deadline	Status
1.6 Matters Arising and Action Log				
155.	Action 151 RTT Performance	Hyett, Andy	05/03/2020	Pending
	Explanation action item AH noted that a recovery plan would be coming to March's meeting.			
156.	Action 152 - SPC Charts	Hyett, Andy	05/03/2020	Pending
	Explanation action item AH noted that there is an issue with the IT software which is causing some discrepancies in the SPC charts. There is work ongoing to try and resolve the issue and an update will come back to the next meeting.			
2.5 Board Assurance Framework and Corporate Risk Register				
157.	TB1 06/2/2.5 Board Assurance Framework	McNeight, Fiona Provins, Esther	05/03/2020	Completed
	Explanation action item The risk relating to cyber ware will be added as a separate risk on the register.			
3.1 Learning from Deaths Report				
158.	Learning - East Kent Hospitals NHS Foundation Trust	Wilkinson, Lorna	31/03/2020	Pending
	Explanation action item E Jones highlighted the importance of the Trust using the learning from this event to improve Maternity services. L Wilkinson noted that a report would be coming to CGC, triangulating this with the Trust's Maternity Improvement Plan.			
4.3 EPRR Report				
159.	TB1 06/2/4.3 EPRR Report	Hyett, Andy	05/03/2020	Pending

	Explanation action item PM referred to section 8: Identified Gaps in EPRR Portfolio and Next Steps and noted that the dates were very broad. AH noted these dates would be reviewed and updated.			
4.4 Remuneration Committee terms of Reference				
160.	TB1 06/2/4.4 Remuneration Committee Terms of Reference	McNeight, Fiona	05/03/2020	Completed
	Explanation action item R Credidio suggested that there should be a comment in the Terms of Reference regarding the cultural setting of the organisation.			
4.5 2020 Cycle of business				
161.	TB1 06/2/4.5	Nye, Kylie	05/03/2020	Completed
	Explanation action item PM asked if there should be a regular system/STP update coming to the Board. LT noted that from March onwards a new paper would be coming to the Board regarding the system plan. It was agreed this would be added to the cycle of business.			

Register of Attendance – Public Board 2019/20

	4 April	23 May	6 June	4 July	1 August	5 September	3 October	7 November	5 December	9 January	6 February	5 March	attendance rate
Nick Marsden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		11/11
Tania Baker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		11/11
Michael von Bertele	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	X		9/11
Paul Kemp	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		11/11
Jane Reid	X[1]	X[1]	X[1]	X[1]	✓	✓	✓	✓					4/8
Rachel Credidio	✓	✓	✓	X	X	✓	✓	✓	X	✓	✓		8/11
Paul Miller	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓		10/11
Cara Charles-Barks	✓	✓	✓	X	✓	✓	✓	X	✓	✓	✓		9/11
Christine Blanshard	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓		10/11
Lisa Thomas	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓		10/11
Andy Hyett	✓	X	✓	X	✓	✓	✓	X	✓	✓	✓		8/11
Lorna Wilkinson	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓		10/11
Paul Hargreaves	✓	X	✓	X[1]	X	✓							3/6
Lynn Lane								✓	✓	✓	X		3/4
Eiri Jones										✓	✓		2/2
Rakhee Aggarwal											✓		1/1
David Buckle											✓		1/1

Governor Observer													
Raymond Jack	✓	✓			✓						✓		
John Mangan			✓	✓		✓	✓	✓	✓	✓			

Attended - ✓

Apologies – X

X[1] – authorised absence

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	**1.9**
Date of Meeting:	5 March 2020		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	Yes			
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	None			

Recommendation:
The Board is asked to Note the report

Executive Summary:
This is the 3nd Board report for 2020 and provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • Performance – update on current performance • Finance – update on our financial recovery plan • Workforce – update on workforce situation • Trust Planning and Response to COVID-19 • NHS Staff Survey Results • LGBT+ History Month •

Performance

The Trust saw 87.3% of patients within 4 hours during January, which was a slight improvement on our performance during December. Our frontline staff provide the very best, safe care that they can under difficult circumstances and our operational managers and support staff continue to work hard to manage the situation.

There have been a total of 19 C.difficile cases to date, which significantly exceeds the upper limit of nine cases. However, 11 of these are classed as community onset healthcare associated. In January, one case was successfully appealed by Wiltshire CCG for no lapses in care, taking the total number of successful appeals to six. We continue to regularly brief NHSI and CCGs and no further action is currently needed.

Finance

Our year to date financial position at the end of January is an NHSE&I control total deficit of £12.2m, this a slight shortfall on our revised financial forecast that has been submitted to the regulators and culminates in a £6.1m shortfall versus plan by the end of the financial year.

Our workforce costs we higher than we had expected, with the cost of more beds opened that we had planned for adding to the cost of the time taken prepare newly recruited nurses from overseas for roles on the wards.

We have now received the NHS operating guidance for 2020/21and are working with internal departments and external system partners to ensure we have robust plans in place to deliver the required performance standards, while also stabilising the Trust's financial position.

Workforce

We held an HCA recruitment event where 60 potential applicants attended career evening, 30 applied, and 27 were offered positions. There were 26 passes of the OSCE, enabling overseas nurses to gain their PINs and work at Band 5, taking up vacancies on the wards.

Two representatives from the Trust went to Nigeria with Southampton University as part of the pilot project to recruit candidates to the PG Dip course. The course will commence in January 2021 and placements will be provided by the Trust.

In January, the Trust's overall sickness absence rate increased to 4.14%, above the 3% target, with long term absence decreasing and short term absence increasing this month. Although this is above our internal target, it compares favourably with the other Acute Trusts in our STP.

Mandatory training improved slightly at 89%, and above the 85% target, and medical and non-medical appraisals continue to improve whilst remaining below their respective targets, at 84% for non-medical and over 86% for medical.

Trust Planning and Response to COVID-19

The NHS and Public Health England (PHE) are extremely well prepared for outbreaks of new infectious diseases. The NHS has put in place measures to ensure the safety of all patients and NHS staff while also ensuring services are available to the public as normal.

As a hospital, we are well prepared for dealing with the infections and we have been following national guidance and working closely with the Clinical Commissioning Group and system partners.

The Trust has fulfilled the nationally set requirements for providing an NHS 111 Priority Assessment Pod.

Testing of suspected coronavirus cases is carried out in line with strict regulations.

NHS Staff Survey Results

This year's annual staff survey results have been published and we are pleased that the response rate of 54% is significantly up on last year's 39%. It is the continued contribution from staff that will

help the Trust deliver the outstanding experience for all that we aim for.

The key findings show that the Trust scored:

- Above the national average for eight of the eleven key survey themes (in 2018 the Trust was above average for eight of ten themes.)
- Improved compared to last year in six themes and remained the same in five and there were no deteriorations
- average for two themes and below the national average for one theme (Quality of Care).

The Trust is reviewing the detail of the survey results and will be engaging with all our existing staff groups and management teams in order to create an action plan to address the one key theme that is below average and other areas that could be improved.

Culture and Leadership Programme

The Trust is also undertaking a programme of work to ensure that the Hospital is ***The Best Place to Work.***

In November 2019, an Organisational Development culture “change team” was formed and is currently working with NHS Improvement on a Culture and Leadership Programme. The programme is launching a diagnostic and listening phase to truly understand the culture of our hospital – warts and all – which will then help the Board develop plans for the future.

As part of this listening and diagnostic phase there will be a number of short focus groups. These will take place during March and April and we are encouraging all teams and departments to get involved.

LGBT+ History Month

Throughout February we proudly flew the rainbow flag at the hospital, in support of LGBT+ History Month. The month offers an opportunity to reflect on the struggle for equality and a chance to celebrate and recognise our differences.

A flag-raising ceremony was held on the Hospital's Green which was attended by senior management from the hospital, staff and partners from the community including Mayor Cllr John Walsh, Very Reverend Nick Papadopulos, Dean of Salisbury, Colonel Alison Farmer, 243 (The Wessex) Field Hospital, Inspector Pete Sparrow, Wiltshire Police and Paul Kealey, Division Head, DSTL Cyber and Information Systems.

CLASSIFICATION: UNRESTRICTED

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	05 March 2020		

Report from: (Committee Name)	**Trust Management Committee (TMC)**		**Committee Meeting Date:**	19 February 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Board Sponsor (presenting):	Cara Charles-Barks, Chief Executive			

Recommendation
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 19 February 2020

Key Items for Escalation

The Trust Management considered the following business cases:

- **Third Haem CNS Post -** This business case was approved following second review.
- **Endoscopy Business Case** –This business case was not approved and will form part of our Workforce summit in March and April
- **Medical Records Storage Solution -**This business case was not approved and will form part of our Workforce Summit in March and April
- **Dietetic Service Provision -** This business case was not approved and will form part of our Workforce Summit in March and April

Other items for Escalation:

The Committee reviewed the Car Park Strategy and following debate amongst the committee, the decision was taken for the strategy to be discussed at Directorate level for further views on the proposal with an updated paper to be brought back to committee.

The committee also noted that performance against the 4 hour target was 87.3 % in January with Year to Date currently at 90.3%, with an RTT score of 91.5%.

End of report

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	5 March 2020		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	25th February 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance Committee meeting of the 25th February 2020

Items for Escalation to Board
Trauma and Orthopaedics (T&O) deep dive – There was a presentation at the committee on T&O performance, which is a key reason behind the Trusts failure to achieve the 2019/20 income target, as a consequence of lower than expected activity. The specific reasons behind the under performance are numerous, however with hindsight all were potentially knowable and management mitigations could have been implemented earlier. As consequence future management arrangements are likely to be strengthened, a remedial action plan (with key dates) is being finalised and the activity plans for 2020/21 are receiving additional operational scrutiny. **Financial and Operational performance 2019/20** – The Trust continues to face challenges in maintaining hospital flow, particularly as a consequence of delayed transfers of care (an average of over 40 beds in January). This is resulting in bed occupancy remaining high (over 93% in month) and in four hour A&E performance being behind plan at 87.3%. As a consequence Trusts finances also remain under significant pressure and the Trusts financial performance in January 2020 was an overspend of £1.7m, which was £200k greater than our Q3 reforecast. However the Trust is still aiming to achieve our revised 2019/20 forecast year end overspend of £15m, made up of our original agreed control total deficit of £8.9m and a Q3 revision of an additional £6.1m.

Operational Plan 2020/21 – The process of pulling together next years Operational plan continues within the Trust, with the aim of bringing the final plan to the Trust Board meeting on the 2nd April 2020. It is too early to make any detailed comments, however at present the planning gap to achieve next years' financial control total is circa £14m. Of which only £6.2m of CIP plans have been identified, £4.3m of which have quality impact assessments in place.

Informatics improvement report and digital strategy – The committee received these reports and noted that progress was being made but the previously identified risks remain and the Trusts risk register score was not likely to be reduced down in value.

Wessex Regional Genetics Laboratory, Illumina contract – the committee recommended to the Chairman to take "Chairman's action" and approve this contract valued at £1.6m (over 3 years) so it could commence on the 1st March 2020. The Chairman would then report this action to the Trust Board on the 5th March 2020.

2019/20 capital programme, purchase of additional endoscopes – the committee agreed to recommend to the Trust Boar, the acceptance of a capital business case to purchase 10 scopes to the value of £489k, to be funded out of slippage on the 2019/20 capital programme.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	5th March 2020		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	25th February 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Miss Eiri Jones, Non-Executive Director			
Board Sponsor (presenting):	Miss Eiri Jones, Non-Executive Director			

Recommendation

The Trust Board are asked to note the items escalated from the Clinical Governance Committee meeting held on 25th February 2020.

Key Items for Escalation

The Safety and Experience elements of the Integrated Performance Report were presented and considered.

- Discussion covered the current issues and risks which are well recognised (Pressure ulcers, C. Diff and ED experience). All have actions to mitigate.
- Stroke services were discussed. SSNAP is currently graded as B and is expected to remain at this level for quarters 2 and 3.
- The Medical Director reported that a Never Event had been reported in February. This will be reviewed in March CGC though assurance was provided that the patient had not suffered harm.

The Children and Young People National Survey report was received and discussed. The Trust performs well in this area. Two areas to address involve the environment. A plan to improve experience in the DSU is underway. The Trust has received a letter from the Chief Inspector of Hospitals praising the Trust regarding it's CYP survey.

Quarterly reports were received for Patient Experience, Safeguarding Children and Adults.

- All provided areas of positive assurance.
- Matters to escalate for Patient Experience: Response rate for 25 days remains low.
- Matters to escalate for CYP safeguarding: information sharing from partners and service provision for young people with substance abuse. The Trust has escalated appropriately to the lead agency.
- Matter to escalate for adult safeguarding is the change to Deprivation of Liberty

requirements from October 2020. A Board workshop will be provided.

Human Tissue Authority. Assurance was provided that the Trust expects to maintain its license for both areas that HTA license is required for.

Research and Development report. Again the Trust is a high performer.

- Matter to escalate: Due to cessation of several high volume studies, without new studies to replace, the Trust's funding will be reduced. The risks associated with this have a clear plan.

GI bleed mortality. A detailed report was received and well discussed. Areas of learning have been identified and further support is underway from the British Society of Gastroenterology. A plan has been developed with medical leadership in place.

- Matters to escalate: The need to embed the care bundle, an ongoing serious incident investigation, workforce gaps and a request from the committee that the action plan be reviewed in relation to delivery dates. An update will come back to the Committee 3 months.

Minutes from the Clinical Business meeting and Clinical Risk Group provided good assurance in relation to the presentations of audits and management of incidents. Good clinical attendance was noted at both meetings.

A discussion was held in relation to the Trust's preparedness for Covid19. Assurance was provided to the Committee that robust plans were in place.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	5th March 2020		

Report from: (Committee Name)	Workforce Committee		**Committee Meeting Date:**	27th March 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael Von-Bertele; Non-Executive Director			
Board Sponsor (presenting):	Michael Von-Bertele; Non-Executive Director			

Recommendation
The Trust Board are asked to note the items escalated from the Workforce Committee meeting held on Thursday 27th February 2020.

Key Items for Escalation

The Committee discussed the following key points:

- The committee received the report from the Guardian of Safe Working and noted a specific concern raised by trainees working at weekends. They expressed a sense of uncertainty about lines of support and direction. Work is in hand to understand and rectify this.
- The committee received an update on progress to develop use of the ESR. The committee agreed to support the direction of travel and progress to phase 3 of this important work that will underpin improvements in many aspects of management of our people.
- The committee received an update on the development of the temporary staffing model and agreed that it makes sense to develop the model based on a hub and spoke construct. They asked for assurance that a mechanism for ensuring compliance with application of all necessary and mandated standards would be described in the proposal.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	06 March 2020		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Kieran Humphrey, Associate Director of Strategy Felicity Anscombe, Information Services Manager			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

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

Executive Summary:
While there was some improvement in performance against the Emergency Access (4hr) target, the Trust continued to feel the impact of winter pressure – performance was closer to the national average for December (87.3% vs 85.3% nationally). Escalation capacity remained open throughout January and the number of cancelled operations remained the same as December 2019. December's improvement in discharges before 1200 was not maintained and this must remain an area of focus to improve overall patient flow. The upward trend for beds occupied by DTOCs has continued and remains significantly above the agreed trajectory. This makes planning the appropriate non-elective capacity in 2020-21 challenging, with the Trust expected to achieve a reduction to 92% bed occupancy (the Trust achieved 94.4% in January). Despite the continued demand pressures, reductions were achieved on mixed sex breaches and escalation capacity open vs December's performance. Positive progress was made in reducing the Trust's elective waiting list by nearly 500 patients in January after growth throughout the year to date. Baseline performance for 2020-21 will, however, be taken from the list size as at 31 January 2020, so this improvement will be required to be maintained. This improved position is also reflected in a slight stabilisation of the performance trends in the most challenged specialties (dermatology, ENT, plastics). The progress on the theatre productivity programme has not been maintained in January and the Surgical Directorate has undertaken a detailed review of performance to address this.

The Trust has maintained its performance against the diagnostic waiting time standard, delivering 99.7% of diagnostic tests within 6 weeks in January.

Although the deterioration in month in 2 week wait and 2 week wait (breast) cancer performance has not fully corrected, the Trust expects to meet this standard in Q4.

Delivery of the 62 Day Cancer Standard in Q4 is, however, at risk with deteriorating performance in January. Action is being taken by individual case to ensure treatment is expedited.

Improvements in weekend HSMR have been sustained for 3 consecutive months and learning is being embedded from recent mortality cluster reviews. However, a further increase in reported category 3 and 4 pressure ulcers has been observed, prompting a revised pathway for highest risk patients.

The Trust's in month control total deficit (£1.7m) is £0.2m greater than forecast expectations shared with NHSE/I. Pay expenditure remains a primary area of concern, with overseas nursing recruitment not converting as quickly as planned to substantive, rostered posts. Other financial risks remain as per Q3, being productivity and in house capacity within Endoscopy. Although the Trust has achieved 84% delivery of its CIP programme YTD, the key issues above put the delivery of the 2019/20 financial forecast at significant risk. In response the Trust is deploying plans including acceleration of the rate of qualification for overseas nurses joining the Trust, refining a business case for future Endoscopy capacity and putting recovery actions in place for high yield CIP programmes – especially theatre utilisation.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

March 2020

(data for January 2020)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

While there was some improvement in performance against the Emergency Access (4hr) target, the Trust continued to feel the impact of winter pressure – performance was closer to the national average for December (87.3% vs 85.3% nationally). Escalation capacity remained open throughout January and the number of cancelled operations remained the same as December 2019. December's improvement in discharges before 1200 was not maintained and this must remain an area of focus to improve overall patient flow. The upward trend for beds occupied by DTOCs has continued and remains significantly above the agreed trajectory. This makes planning the appropriate non-elective capacity in 2020-21 challenging, with the Trust expected to achieve a reduction to 92% bed occupancy (the Trust achieved 94.4% in January). Despite the continued demand pressures, reductions were achieved on mixed sex breaches and escalation capacity open vs December's performance.

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Structure of Report

Performance against our Strategic and Enabling Objectives

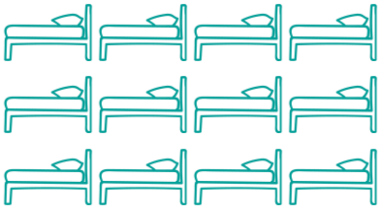
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
January 2020

Salisbury NHS Foundation Trust

There were **3,172** Non-Elective Admissions to the Trust

We carried out **505** elective procedures & **2,169** day cases



99.7% ↑ of patients received a diagnostic test within **6 weeks**

Emergency (4hr) Performance
87.3% ↑
(Target trajectory: 95.1%)

We delivered **22,168** outpatient attendances cases (-1,060) vs plan)

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

Our income was **£20,900k** (£36k over plan)

1,408 patients arrived by Ambulance

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

RTT 18 Week Performance:
91.5% →
Total Waiting List: **17,632** ↓

18.2% ↓ of discharges were completed before 12:00

Our overall vacancy rate was
2.48% ↓

Reading a Statistical Process Control (SPC) Chart

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

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

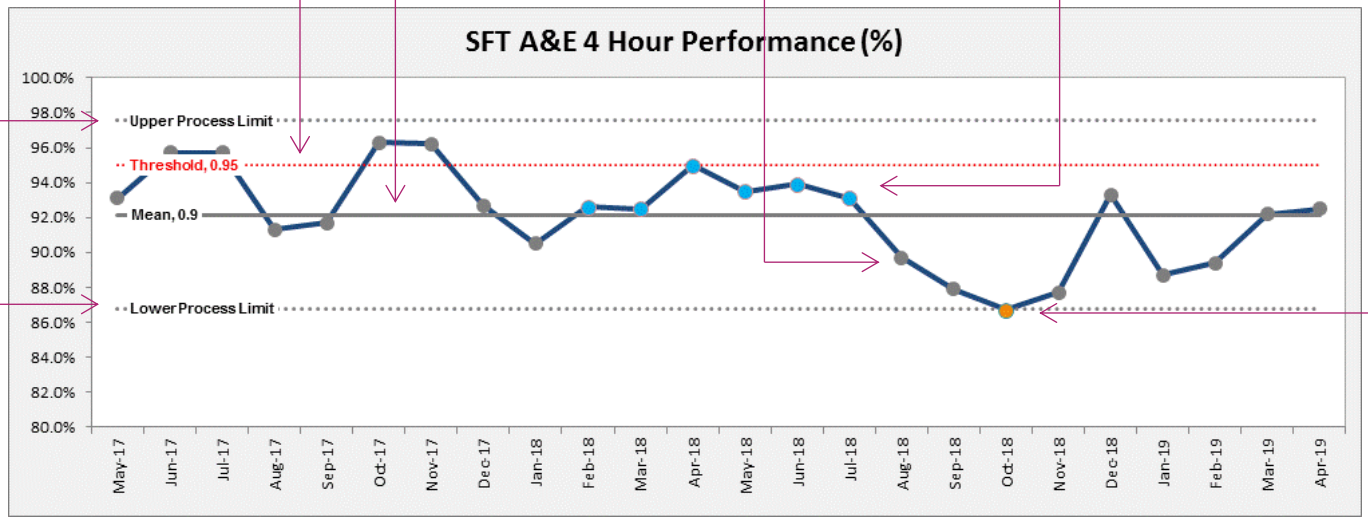
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points above the Mean or one point greater than the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points below the Mean or one point less than the lower limit



Statistical Process Control Chart Key:

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

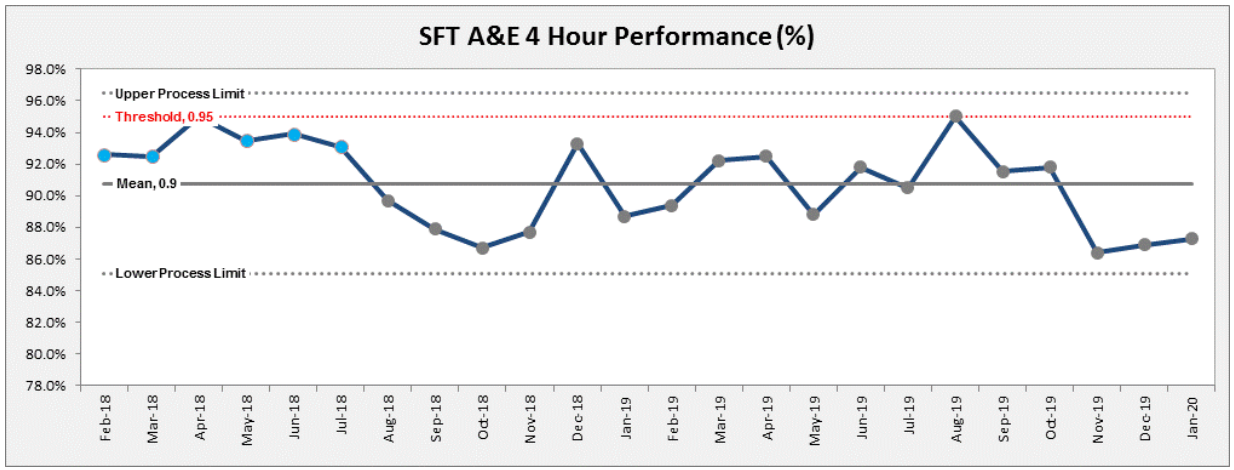
Salisbury NHS Foundation Trust

Part 1: Operational Performance

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Emergency Access (4hr) Standard Target 95% / Trajectory 95.1%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	87.3%
Attendances:	5992
12 Hour Breaches:	0
ED Conversion Rate:	29.6%

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

M10 saw a slight improvement on 4 hr performance compared to M9. There was a slight reduction in overall attendance numbers although an increase in conversion rate, suggestive of increased acuity of patient. M10 saw an improvement in ambulance conveyance performance with 8 patients waiting more than 1 hr for handover (16 in M9).

Medical workforce vacancies are persisting with locum requirements necessary to ensure cover. Rates of pay escalated for registrar level cover to ensure critical out of hours shifts are covered.

Medical Admissions to AMU for M10 were at highest numbers on record for the Unit with a highest day of 71 admissions (average take = 36).

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

Staffing - Ongoing recruitment for medical workforce gaps. DMT to also outline future workforce gaps in junior team due to contract changes in August 2020 and present to Executive Team.

Leadership – Finalisation of Consultant job plans and rota to take effect from April 2020 (delays to software) to ensure core coverage and consistency in shift patterns.

Flow – reinstate work with ED as part of RSG programme to ensure plans from Q3 are completed (single assessment form, OPAL development etc.)

Risks to delivery and mitigations

Peak hours or days of high attendance volumes (beyond average of 130 per day).

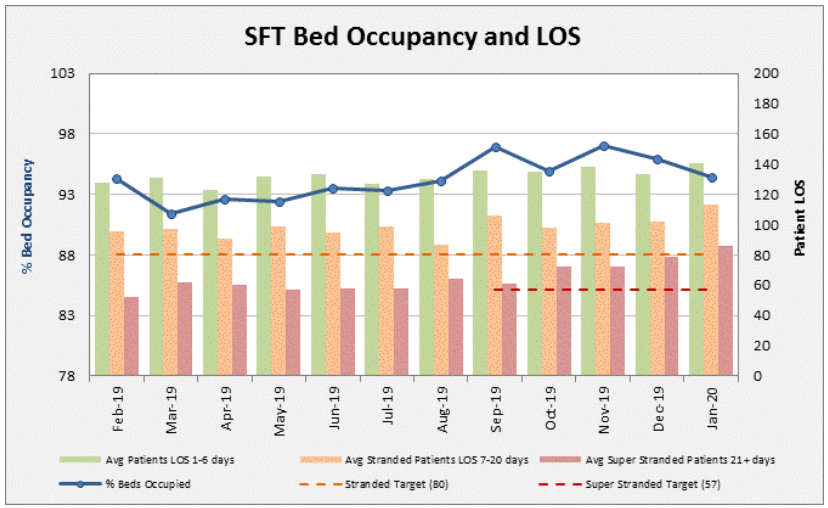
Persisting gaps in Medical Workforce rotas (requiring adhoc locum cover). Risk of gaps not filling. This is mitigated through rota management of ED rota Administrator and escalation to DMT where necessary.

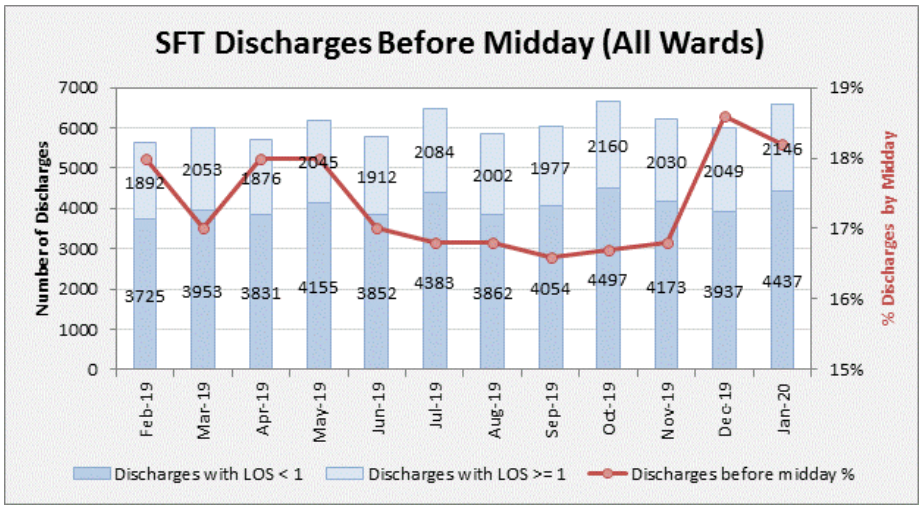
Inflated locum rates in neighbouring Trusts making it challenging to 'compete' for filling of locum shifts. This has been escalated to Exec Team for approval of escalated rates at SFT and discussion with neighbouring Trusts.

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

Patient Flow and Discharge

Are We Effective?





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

Against a backdrop of record number of medical take in M10, a continued improvement in number of patients with LOS of < 24 hours was achieved in AMU, as well as the number of patients with < 48 hours and < 72 hours LOS. AMU Consultant Workforce stabilised (albeit with Locum cover) in M10, providing better consistency of cover and increased senior clinical presence.

Stranded, super stranded and DTOC numbers increased in M10.

Weekend senior Consultant presence present within Medicine to support winter pressures, supporting weekend discharges ensuring weekend discharge rates can be sustained (circa 20%) during time of pressure.

Medical Outlier numbers remaining stable throughout M10 with limited escalation into DSU.

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

Laverstock Ward, 26 escalation beds is expected to remain open for M11 and M12.

Expert Panel weekly reviewing 14+ days LOS patients.

Continued delivery of the Patient Flow improvement programmes.

Risks to delivery and mitigations

Sustained demand at the front door continues.

Operational pressures for SFT and partners preventing regular attendance at expert panel by Matrons.

Continued focus on pre-noon discharges.

Delayed Transfer of Care (DToC) Bed Days

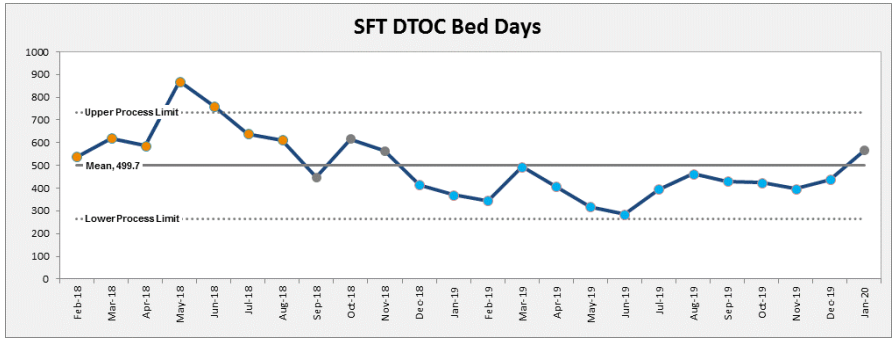
National Key Performance Indicators

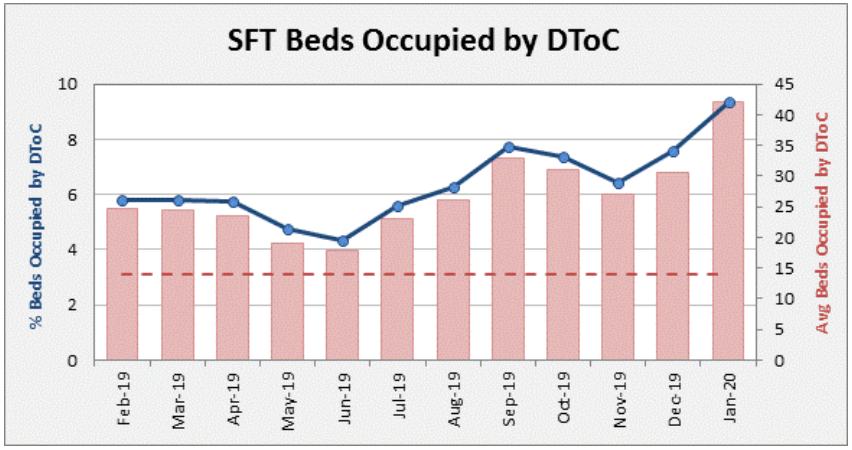
Performance Latest Month:

Data Quality Rating:

Days Lost to DToC: 161 NHS + 386 SS

DToC Patients (last Thursday of month snapshot): 27





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

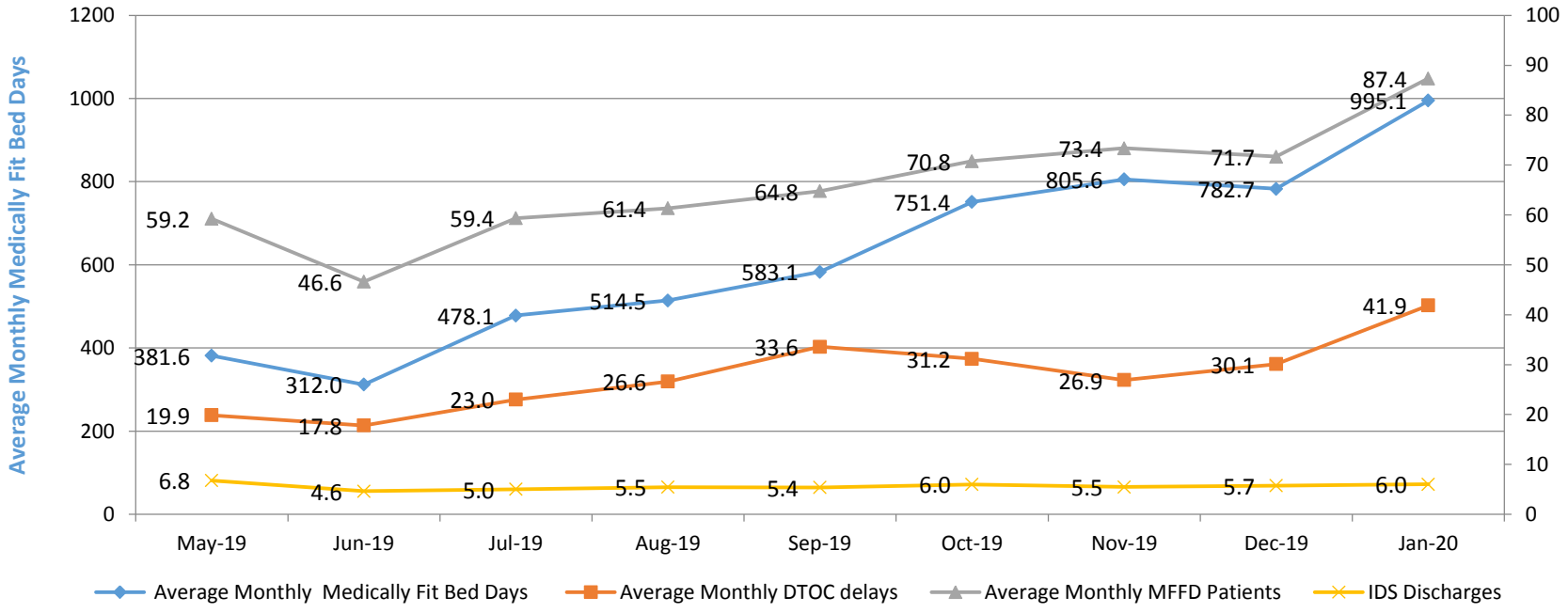
The DTOC bed and occupied bed day both as predicted rose during January to the highest position over the past 12 months. This picture clearly illustrates a system under pressure from the acute across through partners services (see next slide) .

Overall January was a challenging month for achieving complex discharges despite additional support from Order of Saint Johns Care Trust beds commissioned to support Wiltshire flow. Home first discharges remained a source of unmet demand despite the additional resource and work is underway to support by using additional home care and therapy support for community teams. Placements continue to also be challenging and work continues with Wiltshire Council to improve communication and feedback.

Escalation calls continued throughout January with Wiltshire CCG support to challenge the system and expert panel has continued to examine opportunities with wards and partners to expedite internal and external actions to achieve flow.

Delayed Transfer of Care (DToC) compared to MFFD Bed Days

National Key Performance Indicators



January saw a jump in the number of medically fit bed days, number of medically fit patients and number of DTOC. The number of partner and IDS supported discharges remained steady but under the aim of 10 per day. Overall this demonstrates the symptoms of a system under pressure, from the acute setting and across into partner services. Infection control issues reduced this month in the acute Trust, but an additional challenge was infection control related closures in Wiltshire community hospitals and care homes which contributed to additional delays and lack of out of hospital capacity.

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

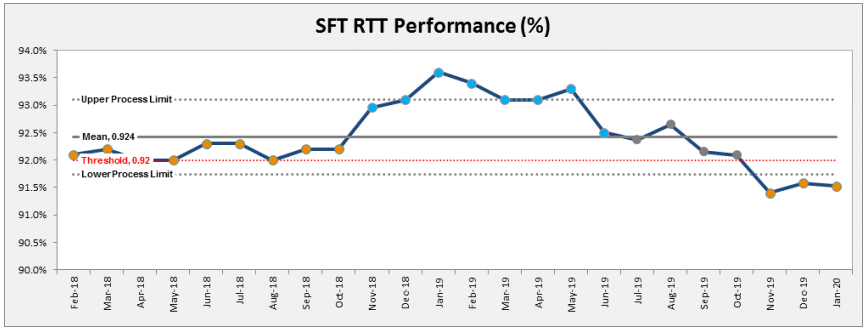
Total WL	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Dorset CCG (11J)	2,762	2,760	2,771	2,832	2,845	2,871	2,889	2,882	2,834	2,856	2,825	2,605
West Hampshire CCG (11A)	1,696	1,748	1,638	1,667	1,690	1,743	1,695	1,682	1,655	1,614	1,606	1,544
Wiltshire CCG (99N)	10,500	10,328	10,540	10,478	10,718	10,630	10,809	10,900	11,050	11,130	11,018	10,840
Other CCGs	2,105	2,113	2,083	2,323	2,498	2,732	2,800	2,822	2,729	2,718	2,747	2,643
Trust Total	**17,063**	**16,949**	**17,032**	**17,300**	**17,751**	**17,976**	**18,193**	**18,286**	**18,268**	**18,318**	**18,196**	**17,632**

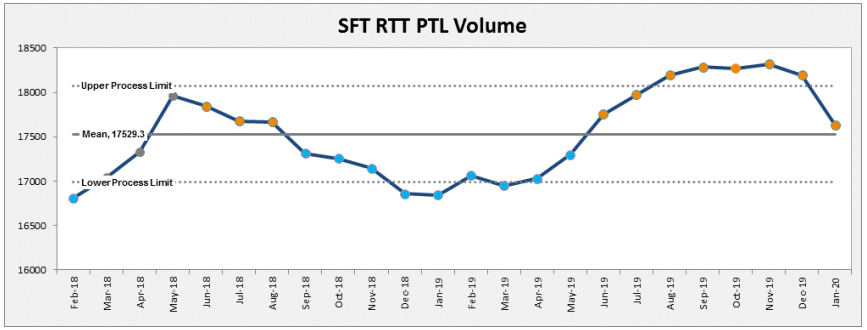
Data Quality Rating:

Performance Latest Month: 91.5%

PTL Volume: 17,632

52 Week Breaches: 0





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

Overall RTT Performance remained just under 92% in January.

The main cause of this failure to achieve the performance standard remains the high volume of long waiting patients in Dermatology and Plastic Surgery. Capacity pressures in Dermatology have resulted in long first appointment wait times with high volumes of patients booked between 40 – 50 weeks whereas the high volume of long waiters in Plastic Surgery are due to capacity pressures for surgery.

Long first appointment wait times are also seen in Respiratory, 38 weeks, and Gastroenterology, 31 weeks, and Glaucoma first appointment wait times remain at 25 weeks. A high volume of long waiters are also seen in Oral Surgery due to capacity issues for surgery and ENT did not achieve the performance standard in January but is expected to continue to recover.

The overall PTL is predicted to remain above target but focussed work resulted in a drop of around 560 from December.

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

ENT: Changes to the referral pathway for ENT has seen first appointment wait times reduce to 24 weeks. Further RTT recovery expected from Feb onwards due to putting flexible rota in place to help equalise surgical waiting lists.

Ophthalmology: Has now recovered with the RTT target being achieved this month and elective activity now above plan.

Urology: New consultant started in February but due to long term sickness recovery trajectory has lengthened.

Dermatology: Capacity work continues and there are no further patients booked in excess of 52 weeks. Work is ongoing to expedite those booked between 30 – 40 weeks.

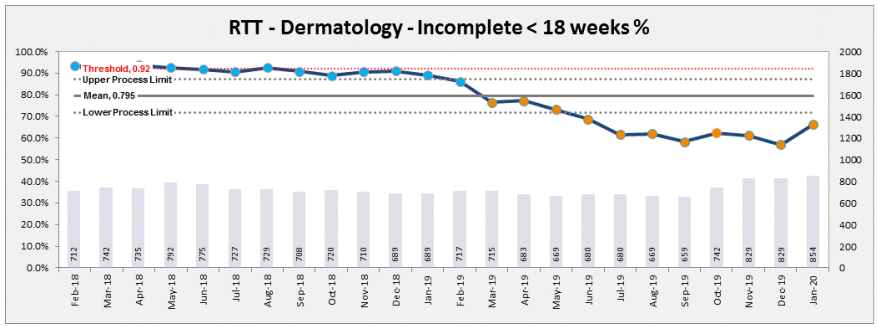
Risks to delivery and mitigations

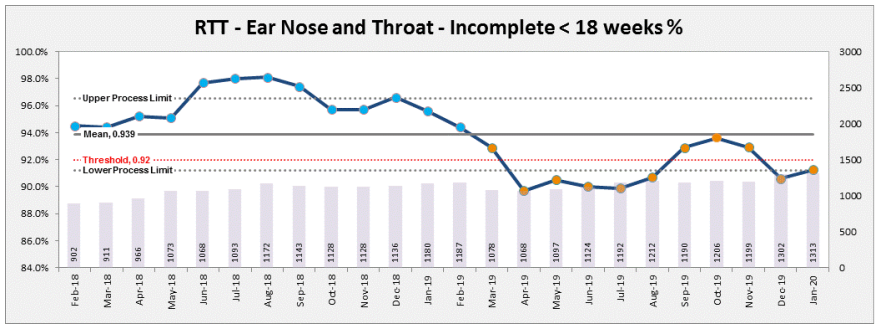
Continued risk of not achieving performance standard for February due to lack of capacity and high volumes of long waiters.

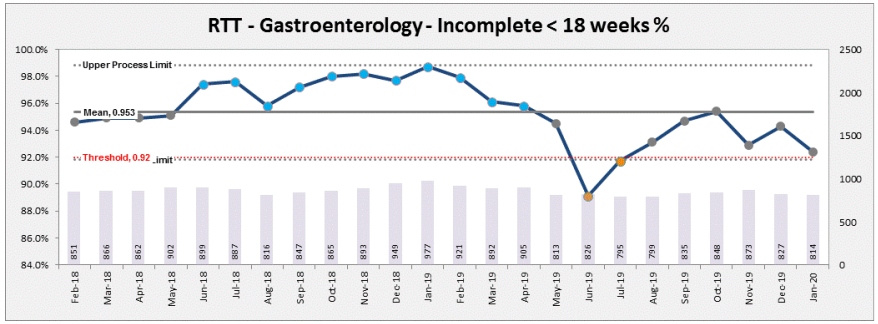
Impact of non-elective demand and bed capacity over the winter. The mitigation is that elective capacity is reviewed daily against bed capacity and mapped against discharges in the Trust.

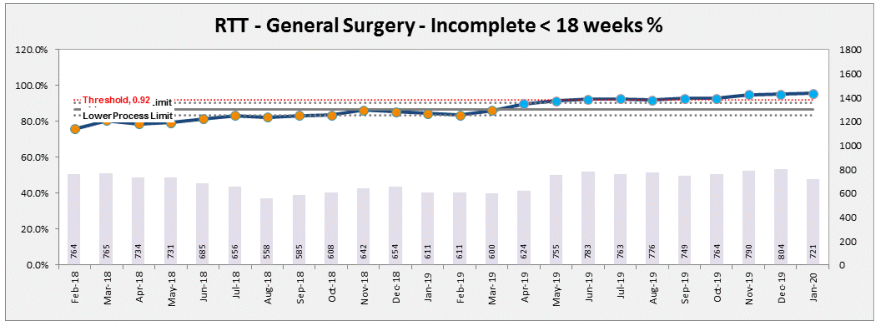
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

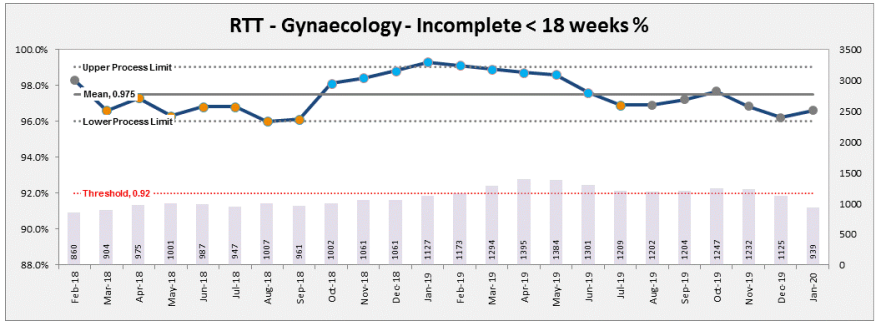
National Key Performance Indicators

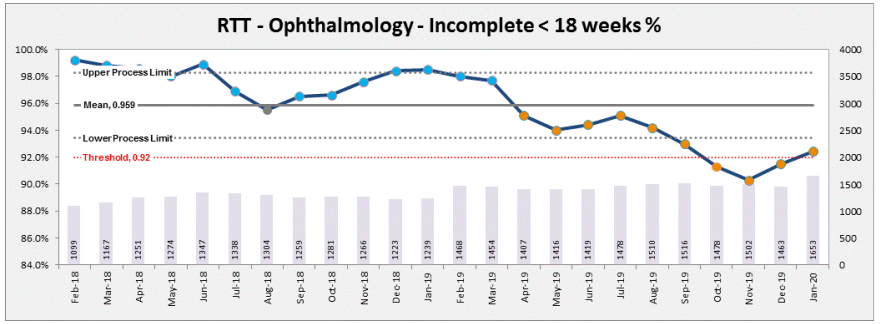






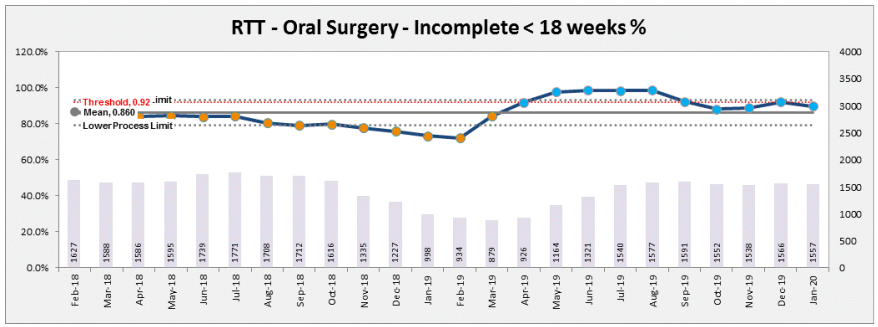


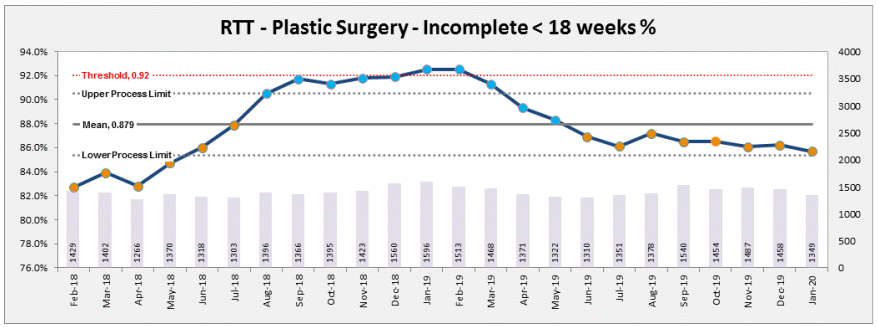


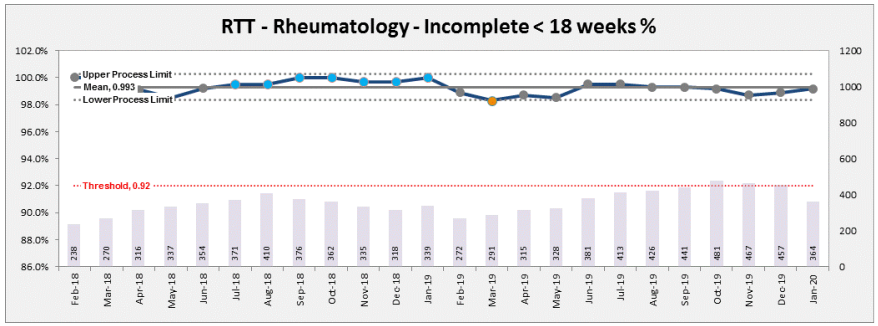


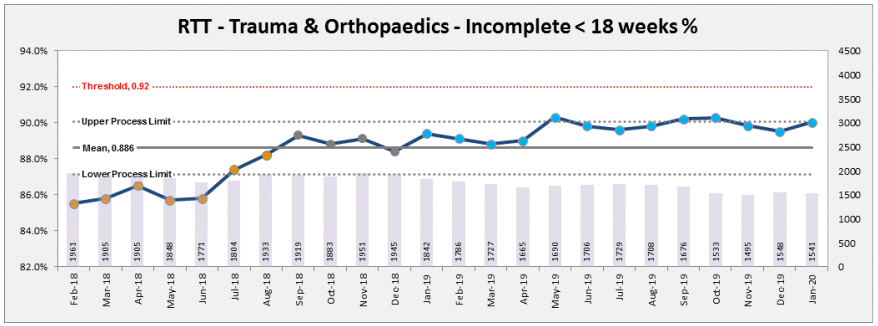
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

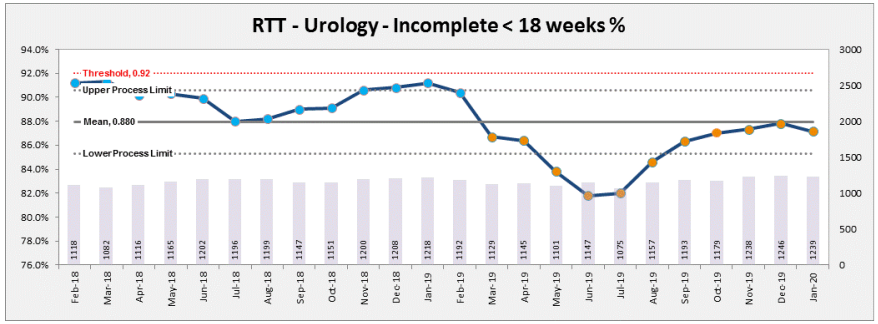
National Key Performance Indicators

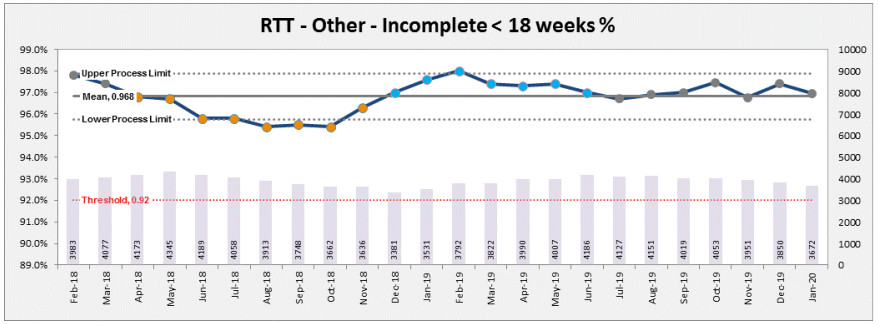






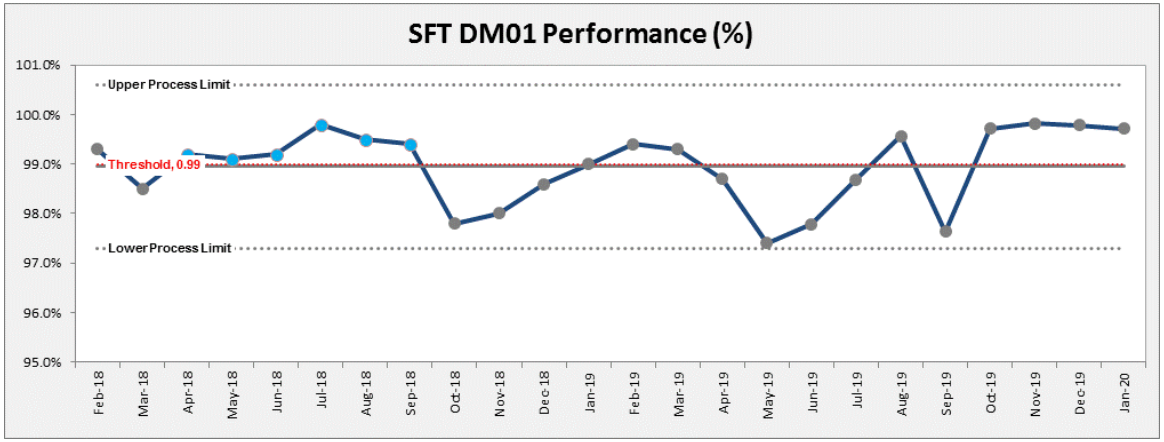






Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	99.7%
Waiting List Volume:	3,805
6 Week Breaches:	11
Diagnostics Performed:	7,857

Background, actions being taken and risks and mitigations

Performance standard in month achieved, with 11 in month breaches recorded for M10. February projections suggest no concerns in achievement of target for M11, however this is reliant on additional sessions taking place for CT, to absorb lost capacity following CT1 fault.

Endoscopy

6 confirmed in month breaches for M10.

Radiology

4 confirmed in month breaches for M10.

Radiology Reporting

Go live of the second provider for outsourced reporting on hold, further instruction from IT pending.

Audiology

1 confirmed in month breach for M10.

Cardiology

0 in month breaches for M10.

Cancer 2 Week Wait Performance Target 93%

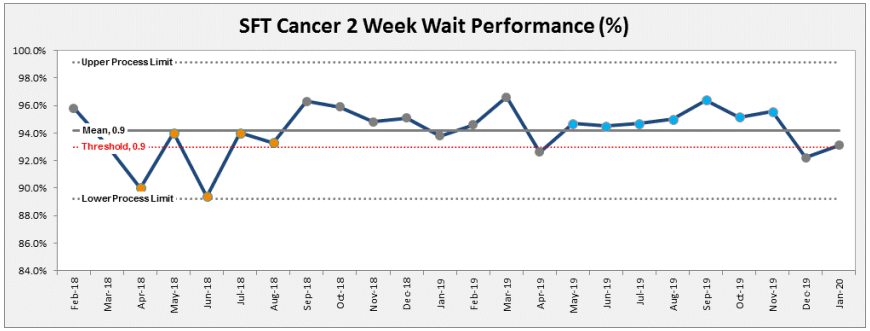
National Key Performance Indicators

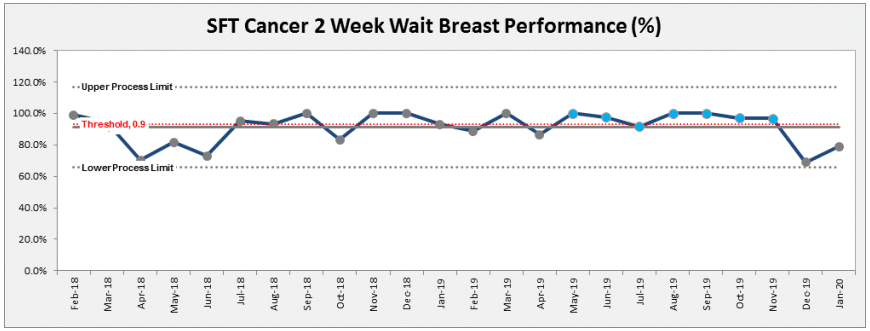
Performance Latest Month:

Two Week Wait Standard: 93.1%

Two Week Wait Breast Standard: 78.9%

Data Quality Rating:





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

M10 achieved for 2WW standard but not for breast symptomatic. Breast symptomatic breaches based only on patient choice – capacity issues from M9 resolved.

Expecting 2WW for Q4 to be achieved.

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

Weekly cancer ops meetings continue to monitor performance and identify issues that require resolution.

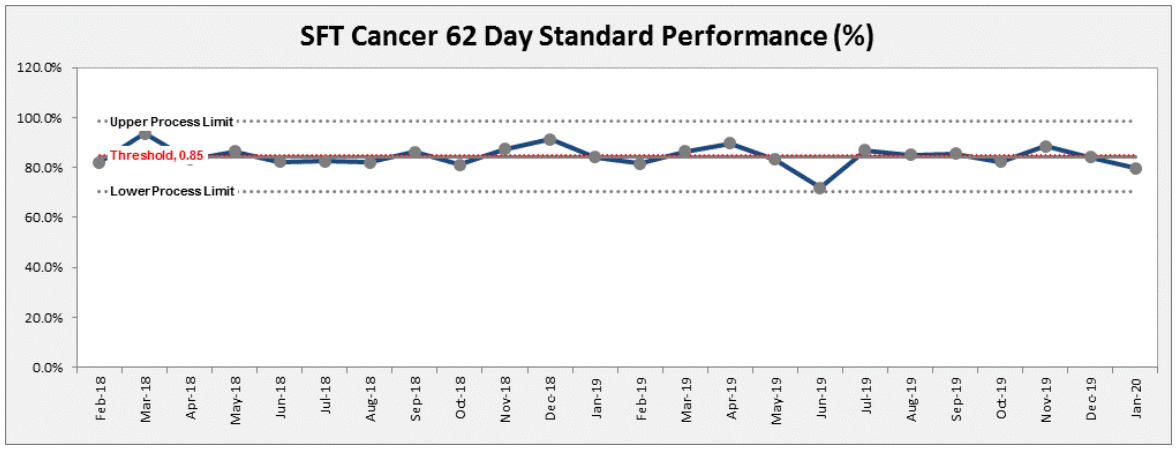
Risks to delivery and mitigations

Radiology support for one stop breast clinics (Surgery Directorate working with CSFS Directorate as and when capacity is required to meet demand).

Standard of referrals from GPs for patients on Colorectal pathway – lacking in information to be able to triage straight to test. This will result in some patients being triaged to OPD, increasing time in pathway. This has been escalated to CCG/NHSI who have informed us that we cannot delay a patient's OPA pending chasing adequate referral data from their GP. Being unable to triage direct to test may have a consequential impact on 62 day delivery.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard:	79.7%
62 Day Standard (without shared care):	77.4%
62 Day Screening:	93.8%

Risks to delivery and mitigations

M10 current position of 79.7% awaits final validation by DMT of breached patients to ensure data quality and accuracy of reporting. Anticipate that 62 day position for M10 will continue to be under 85% on completion of this due to high number of breached patients in starting position.

There is a risk to delivery of 62 day for Q4 due to low performance in M10.

Scrutiny is being given to the PTL by the cancer management team and potential breaches are being managed on a case by case basis to prevent them contributing to the position and to ensure patients are being treated as quickly as possible for their cancer diagnosis.

Improvement work within the prostate pathway continues. Consideration to focused prostate PTL to be given as this is the area of Urology most likely to be impacted by longer waiting times and complex pathways.

Improvement in Head and Neck pathways required and is underway. Loss of experienced CNS in this area although post recruited into. Pathways are complex and often combined with UHS which can prolong diagnostics. Discussions with UHS occurring to agree on joint actions that can be taken to improve waiting times and performance.

Statistical Process Control Chart Key:

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

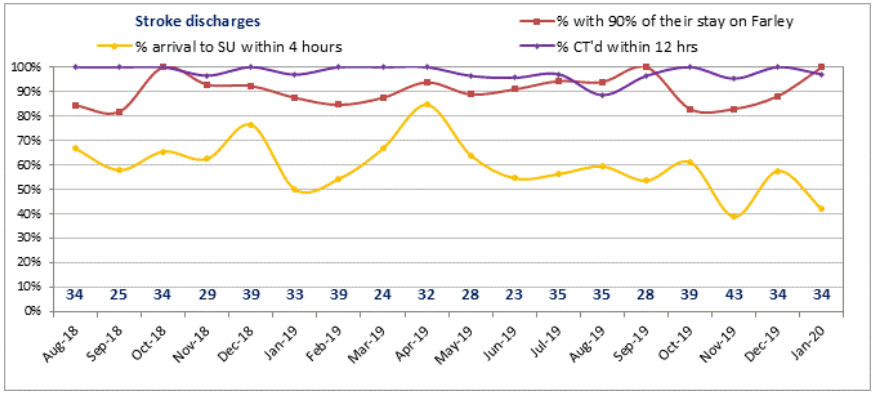
Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20	B	B		

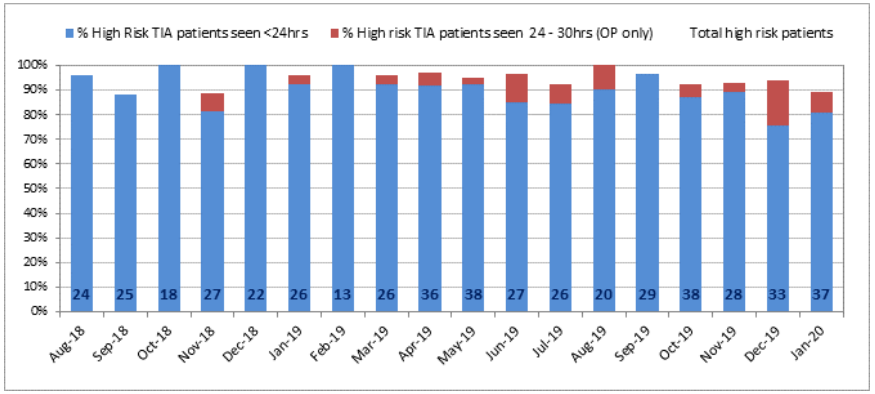
Data Quality Rating:

% Arrival on SU <4 hours: 41.9%

% CT'd < 12 hours: 97.1%

% High Risk TIA Seen < 24 hours: 81.1%





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

The further reduction of patients reaching the stroke unit within 4 hrs reflected ED and bed pressures - delays were waiting for a stroke bed (8), waiting to see a doctor in ED (2), remained in ED > 4 hrs (3), unstable exceptions (3), waiting for porters (1), move to AMU (1), diagnostic (1) & speciality doctor (1).

Only 81% of high risk TIA patients were able to been seen within 24 hours due to a number of full clinics.

Q2 SSNAP audit score sustained at a B. Q3 SNNAP score expected in March/April 20.

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

The Stroke Unit trialled the nurse practitioner role for 12 days between 09:00 – 17:00 in December. The nurse met potential stroke patients on admission to ED and the Stroke Unit. He expedited the initial scan, assessments and transfer to the Stroke Unit. The outcome of the trial is to be presented to the Medicine DMC for consideration of a business case.

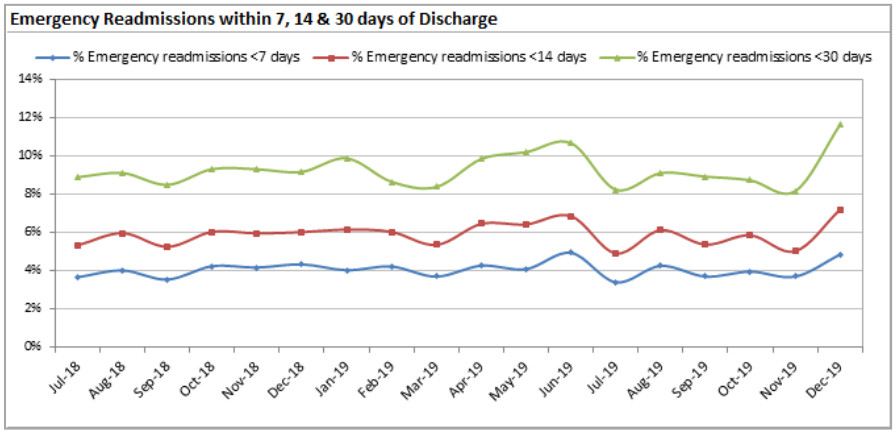
The increased funding for speech and language therapists in the stroke unit has improved performance and the SSNAP score is expected to reach an A in Q4.

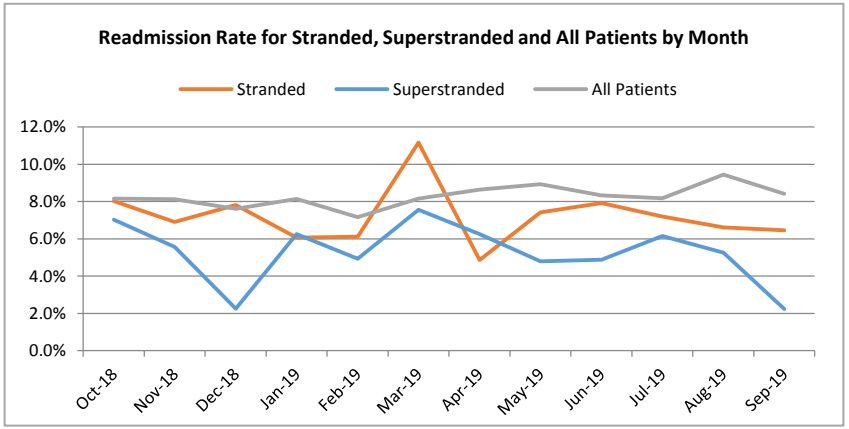
Risks to delivery and mitigations

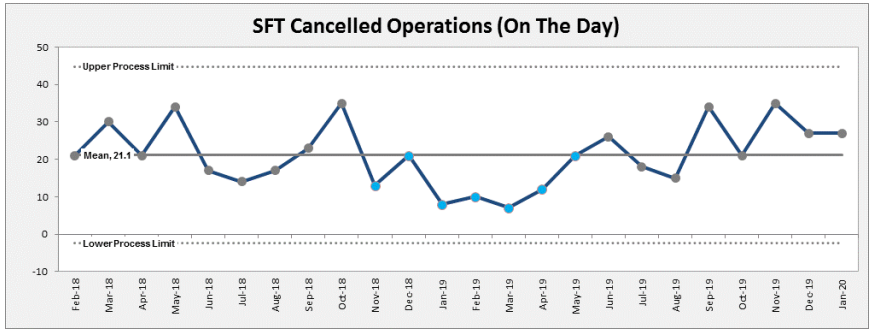
Ability to fund the nurse practitioner role and provide a consistent service 7/7.

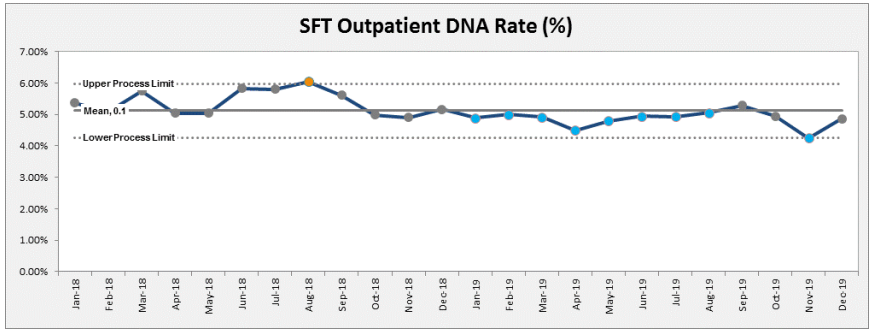
Other Measures

Are We Effective?









Salisbury NHS Foundation Trust

Part 2: Our Care

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

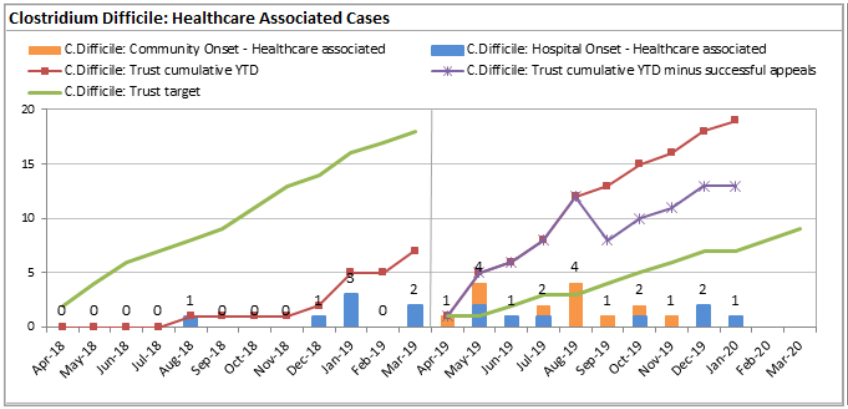
Infection Control

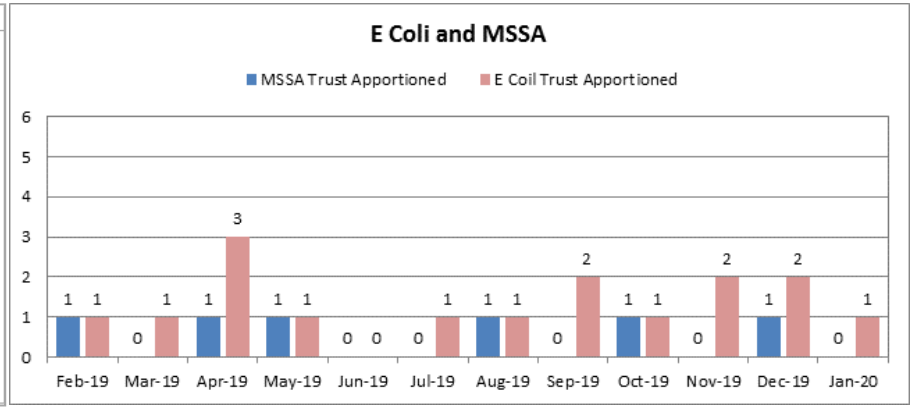
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20
Cases Appealed	0	0	0	0	0	7	0	0	0	1
Successful Appeals	0	0	0	0	0	5	0	0	0	1

MRSA	2018-19	2019-20
Trust Apportioned	3	0





Summary and Action

C.Difficile cases have now significantly exceeded the upper limit of 9 cases with 1 hospital onset healthcare associated case reported in January. This case is currently being investigated.

Year to date, 8 of the 19 cases are hospital onset with the remaining 11 cases classed as community onset healthcare associated. In January, 1 case was successfully submitted to Wiltshire CCG for no lapses in care taking the total number of successful appeals to 6. The outcome of 2 cases submitted to West Hampshire CCG in October are still awaited following the submission of additional information. NHSI and the CCGs are regularly briefed on this issue with no further action currently.

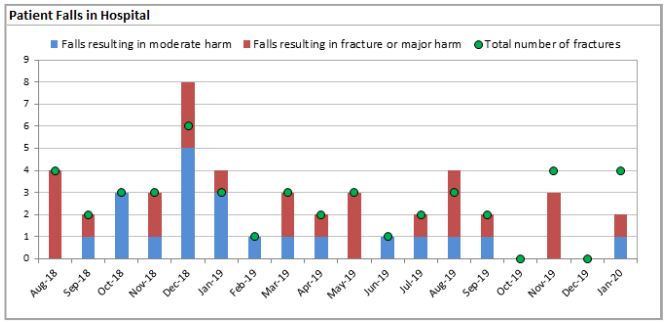
One Trust apportioned E Coli bacteraemia from a likely chest infection of a patient with chronic lung disease and a complex medical history. The case was considered unavoidable due to the patient's underlying condition.

The Trust continues to benchmark positively. For Q2 (most recent data available) the Trust had the lowest rate of both C. Difficile and E Coli bacteraemias when benchmarked across all acute trusts in the South West (PHE data).

A robust infection prevention and control programme of work is in place and reports to Board twice per year.

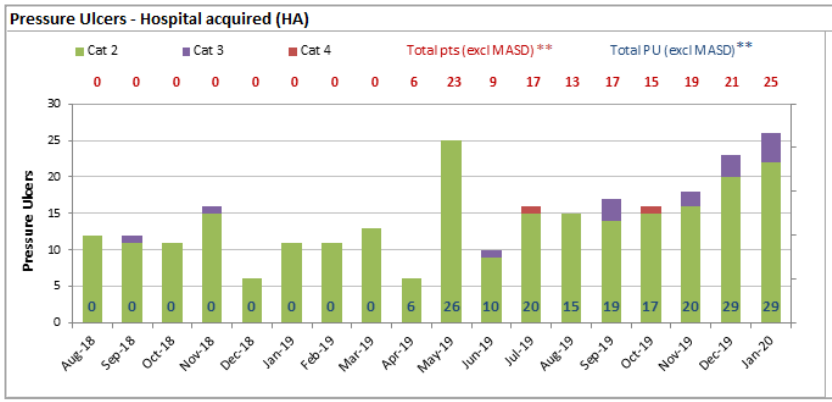
Pressure Ulcers / Falls

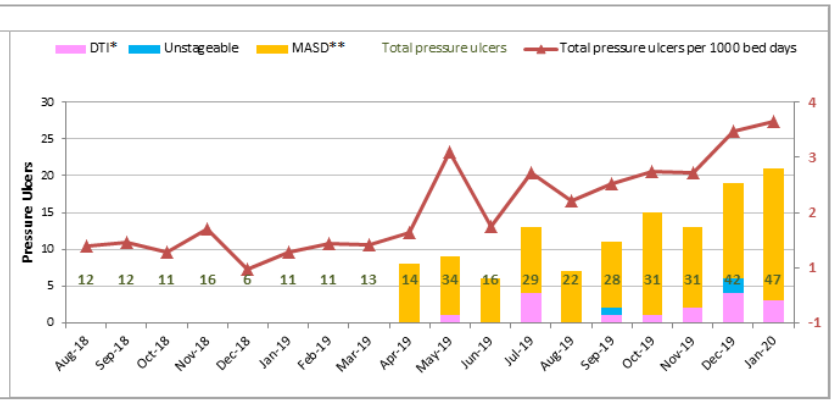
Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2018-19 Q4	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4
Pressure Ulcers	0.88	1.05	1.10	1.22	1.47
Patient Falls	0.20	0.16	0.20	0.07	0.13





Summary and Action

A further increase in the number of category 2 pressure ulcers consistent with the national picture and changes in reporting in 19/20. However, of concern, is 4 more category 3 pressure ulcers reported in January across a range of wards. Total year to date of category 3 pressure ulcers is 13 and category 4 pressure ulcers is 2.

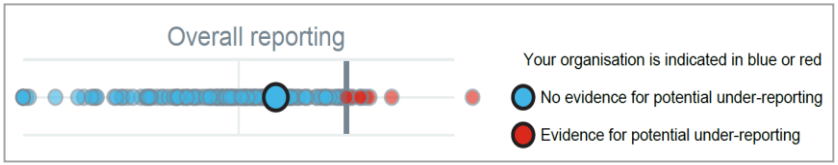
Several Directorate deep dive meetings have been held with key staff to evaluate themes and root causes. An emerging theme is the number of patients admitted who are malnourished and the time taken for a review by a dietician. This has prompted an adjustment to the pathway for high and very high risk patients so that high protein supplements and vitamins are started on admission before the patient is assessed by the dietician. The review found that less than 10% of malnourished patients are referred to the dietician (1.0 wte dietician for the whole Trust). A new numerical validated risk assessment tool 'Purpose T' is to be tested over the next 2 months on Pitton ward to ensure that appropriate plans are in place for high and very high risk patients. A Trust wide recovery plan will be signed off and overseen by the Nursing and Midwifery Forum and presented to the CCG Quality leads in April 2020.

In January, 4 falls resulting in fractures - 1 fall resulted in major harm (fractured hip), 1 fall resulted in moderate harm (fractured elbow) and 2 resulted in minor harm (fractured pubic rami). A patient safety facilitator commenced one day a week to provide education and support improvement work.

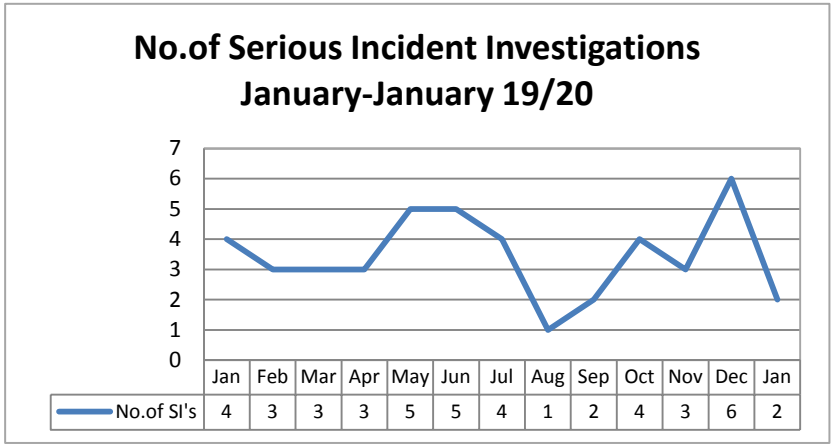
Incidents

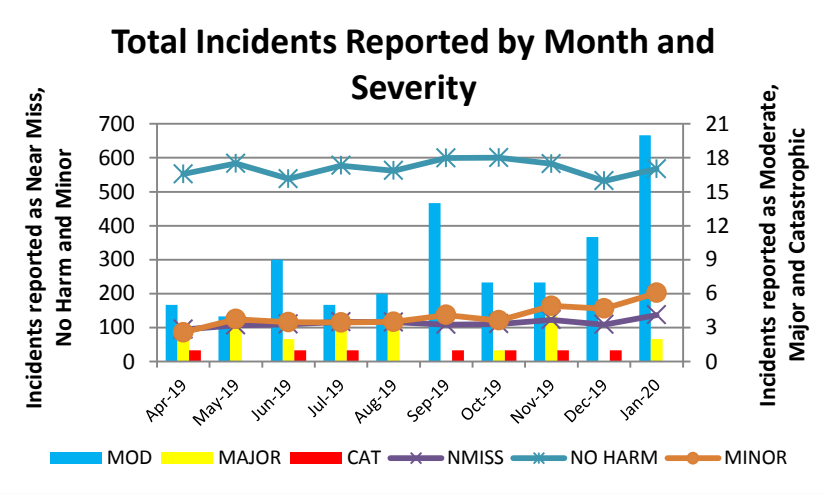
Are We Safe?

Year	2018-19	2019-20
Never Events	3	1



Information from NRLS benchmarks SFT in regard to reporting of incidents and reflects a positive reporting culture.





Summary and Action

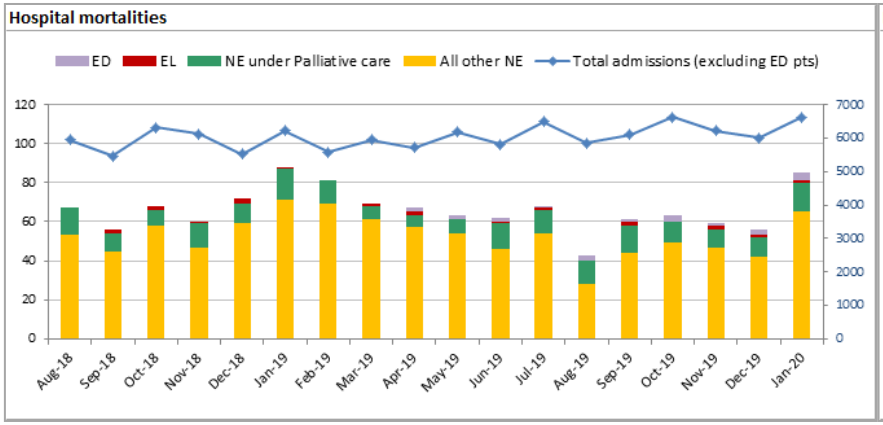
There were 2 new commissioned serious incidents in January -a safeguarding incident and an unexpected death. Work is in progress reviewing and aggregating the key contributory factors for the reported pressure ulcers and ensuring the recommendations are in one Trust wide recovery plan.

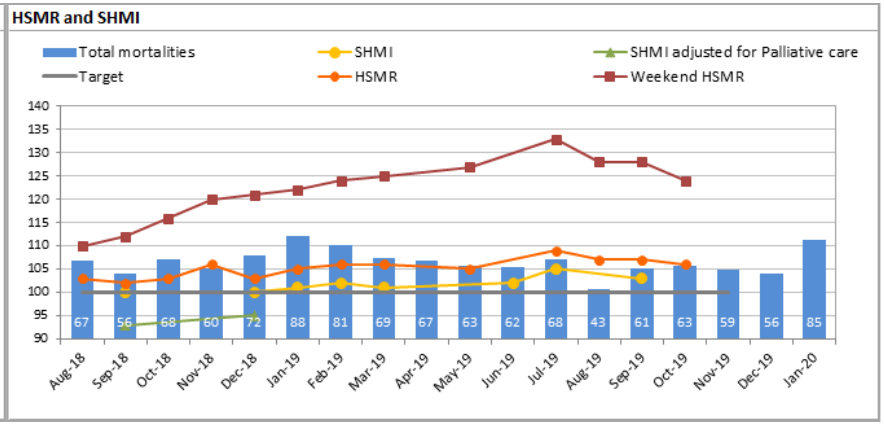
Arrangements are underway for the upcoming follow up to the Cancer Risk Summit scheduled to take place on 29 April 2020.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR overall has decreased and is as expected. The weekend HSMR trend has decreased again due to a considerable fall in observed mortality in August 19 and a decrease in the crude rate for weekend mortality since May 2019. The Board received an update on the progress of the action plan to improve the safety and effectiveness of services at a weekend in January 20. Improvements have been made by increasing resources for frailty services in the Trust and community at weekends and some improvements in comorbidity identification and palliative care coding.

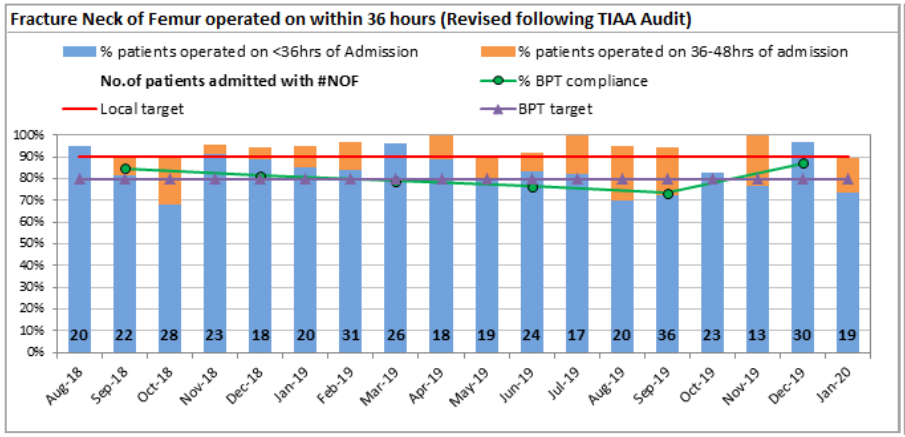
A review of 33 patients who died following a hip fracture was completed in October 19. Care was generally good but there was potential for improvement in the pathway and root cause analysis will be undertaken for all patients not meeting best practice standards. The report was presented to the Clinical Governance Committee on 4 February 2020.

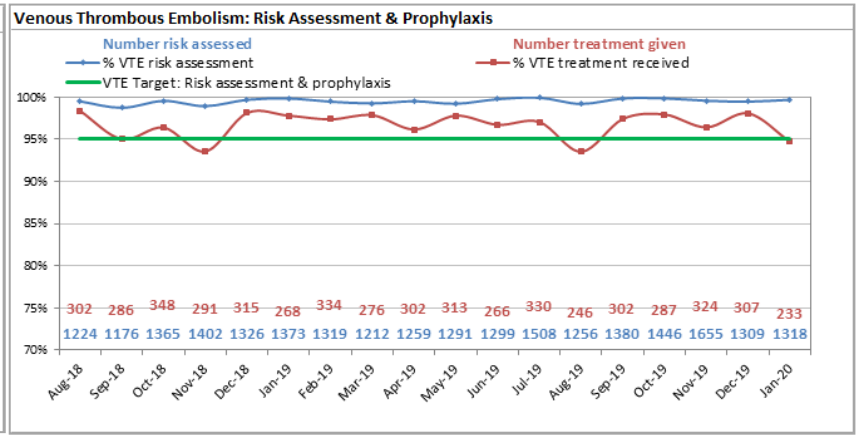
A review of 18 patients who died following a gastrointestinal haemorrhage took place in October identifying themes and improvements needed in the pathway. The British Society of Gastroenterology acute upper GI bleed care bundle is being implemented and the report was presented to the Clinical Governance Committee on 25 February 2020.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

In January, 4 patients did not receive hip surgery for a fractured neck of femur within 36 hours due to waiting for theatre space (2), theatre kit not clean (1) and waiting stabilisation due to a high INR (1). The orthopaedic nurse specialists introduced a root cause analysis to examine delays in Q3 and now present themes to the joint orthopaedic and anaesthetic clinical governance meeting.

The review of 33 patients who died with a fractured neck of femur completed in October 2019 was discussed at the joint orthopaedic and anaesthetic governance meeting in February. The action plan was agreed to improve:

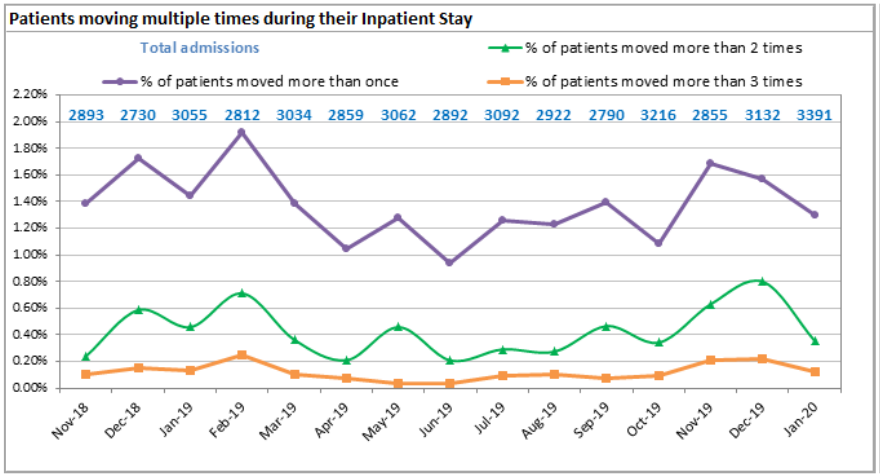
- Frailty scoring
- Pre-operative analgesia
- Time to theatre within 36 hours
- Time to consultant review within 14 hours of admission
- Falls prevention
- A continued focus on root cause analysis to identify the reason patients did not receive best practice standards

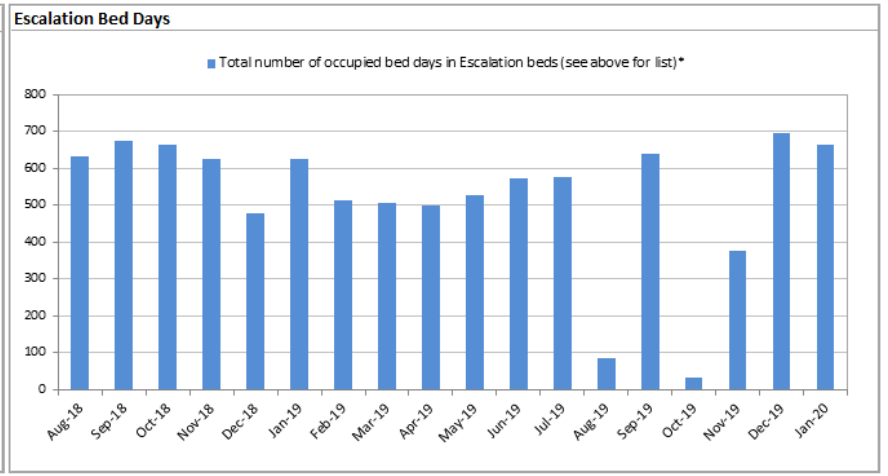
Patient Experience

Are We Safe?

Last 12 months	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20
Bed Occupancy %	94.4	91.4	92.6	92.5	93.5	93.3	94.1	96.9	94.9	97.1	95.9	94.4

Data Quality Rating:





Summary and Action

Escalation bed capacity remained at a high level in January as did the number of multiple ward moves. The Trust was in OPEL 4 status on 6 occasions. The number of delayed transfer of care, stranded and super stranded patients are all above our internal targets and discharges before midday were below target. Wiltshire, West Hampshire and Dorset CCG quality leads undertook a walk round on Laverstock ward (escalation ward) on 14 February and were assured that patients were receiving safe, high quality care. One recommendation for improvement was made - the need for a ward pharmacist. This is included in the winter plan but has not been recruited to.

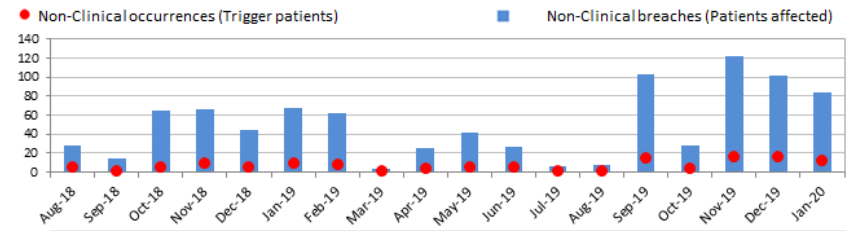
The 'Ready Steady Go' patient flow improvement work continues with a focus on increasing the number of patients discharged before midday and with multi-agency partners to decrease the number of delayed transfer of care, stranded and super stranded patients.

Patient Experience

Are We Safe?

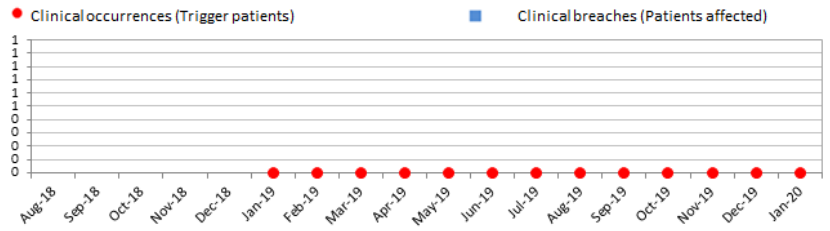
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
■	28	14	65	66	45	67	62	3	26	42	27	7	8	103	28	122	102	84
●	5	1	5	10	5	10	9	1	4	6	5	1	1	15	4	17	16	13

Delivering Same Sex Accommodation - Clinical



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

The reported mixed sex accommodation breaches in January occurred in our assessment areas only, 79 patients were affected on 11 occasions on AMU and 5 patients were affected on SAU on 2 occasions. All were resolved within 24 hours. The Trust was in OPEL 4 status on 6 occasions. There were no breaches on any of the wards.

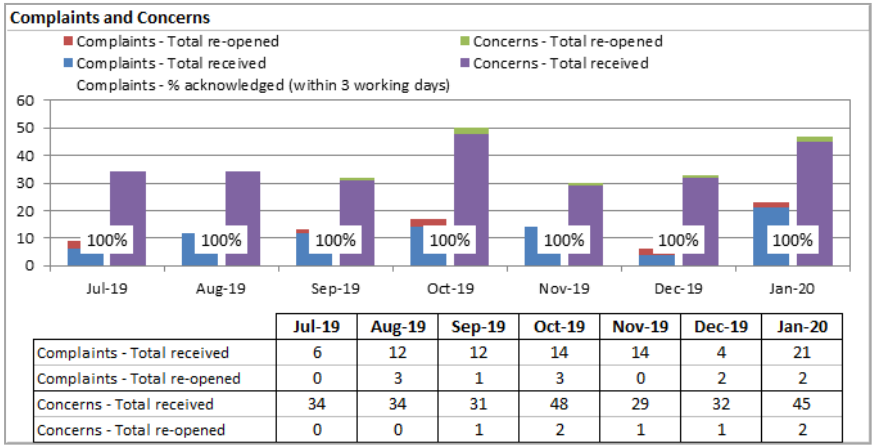
Privacy and dignity is maintained during these times with the use of quick screens and identification of separate bathroom facilities.

The Deputy Director of Nursing met with Wiltshire and West Hampshire CCG quality leads to agree a proposal for reporting in accordance with the new guidance. This will be formally submitted to the CCGs in February.

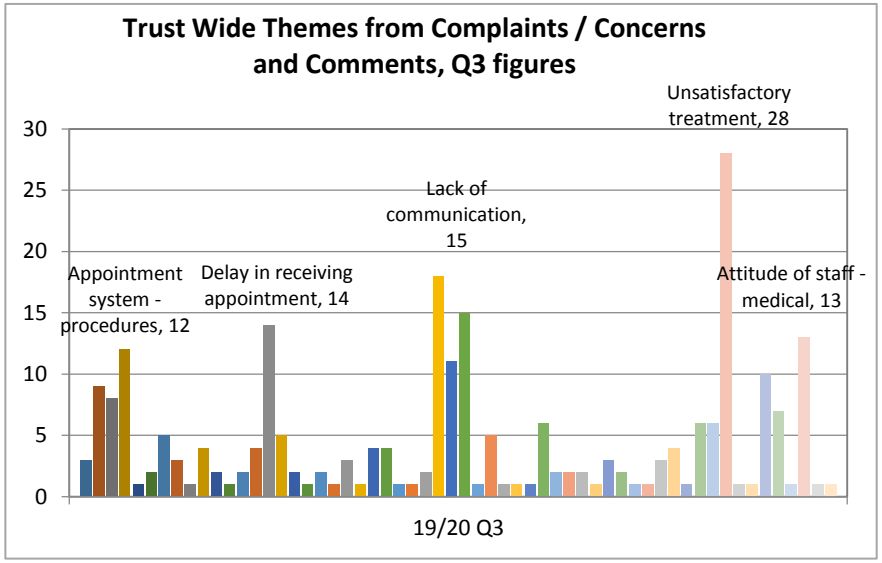
Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

Data Quality Rating:



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Complaints - Total received	6	12	12	14	14	4	21
Complaints - Total re-opened	0	3	1	3	0	2	2
Concerns - Total received	34	34	31	48	29	32	45
Concerns - Total re-opened	0	0	1	2	1	1	2



Summary and Actions

Top 5 themes of complaints/ concerns and comment in Q3:

- Unsatisfactory treatment
- Lack of communication
- Delay in receiving appointments
- Attitude of medical staff
- Appointment system - procedures

Examples of actions from recent complaints:

In order to reduce the likelihood of paper outcome forms being lost in transit from the clinic to Central Booking, plans are in place to convert this to an electronic process.

Reminder to staff of property policy. Sharing of complaints with staff to ensure they appreciate the impact of care on patients and relatives.

Review of specific documentation areas to make it 'Easy to do well'. This is led through 'documentation meeting' and 'Share and learn'. It has led to new post falls check list, handover proforma review and currently review of skin bundles.

Part 3: Our People

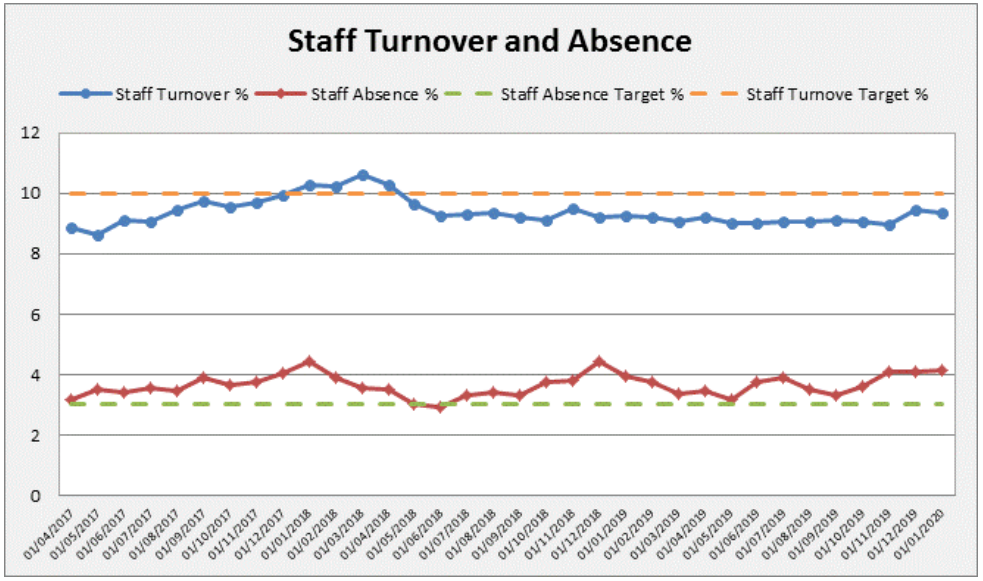
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Jan '20		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	567.9	565.8	2.1
Nursing	1,102.7	971.9	130.8
HCAs	411.8	534.5	(122.7)
Other Clinical Staff	482.9	522.2	(39.3)
Infrastructure Staff	1,004.4	1,033.4	1.0
TOTAL	**3,569.5**	**3,597.7**	**(28.1)**



Summary and Action

Staff turnover is down in January to 9.36% well below target of 10%. There was a much more normal 27 leavers, more than balanced out by 69 new starters. During the month, there has been good progress in most areas on the "hard to recruit" (mainly medical and AHP) posts, with interviews being held or scheduled and alternative plans being developed in the event that all attempts at recruitment fail.

Staff sickness absence increased again to 4.14%, and is now over 4% for the third month consecutively, reflecting an upturn in short term absence whilst long term sickness absence has decreased. Whilst well over our internal target of 3%, this nevertheless compares favourably with other Acute Hospitals in our STP. The group with the highest level of sickness absence is additional clinical services, which encompasses Health Care Assistants and who feature consistently in this position. People Advisors and Occupational Health Advisors are working together to support managers in enabling staff to return to work well and sooner.

Across the Trust, although the highest level of sickness absence is related to anxiety/stress/depression, this is not true of all staff groups or of all Directorates. For example, the highest level of absence in Estates and Facilities is caused by MSK issues, with anxiety etc third, whilst in Surgery the top three reasons for absence were other MSK, Cough/Cold/Flu and Gastro. In Medicine, there were at least two cases of planned surgery and an outbreak of Norovirus on two wards. Both individual and strategic interventions to manage attendance therefore need to be flexed according to the reasons and the environment.

When the new Head of Health and Wellbeing starts in April, we plan to increase the strategic interventions and shift the emphasis towards wellbeing in order to improve the health (and attendance) of the largest number of people possible.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

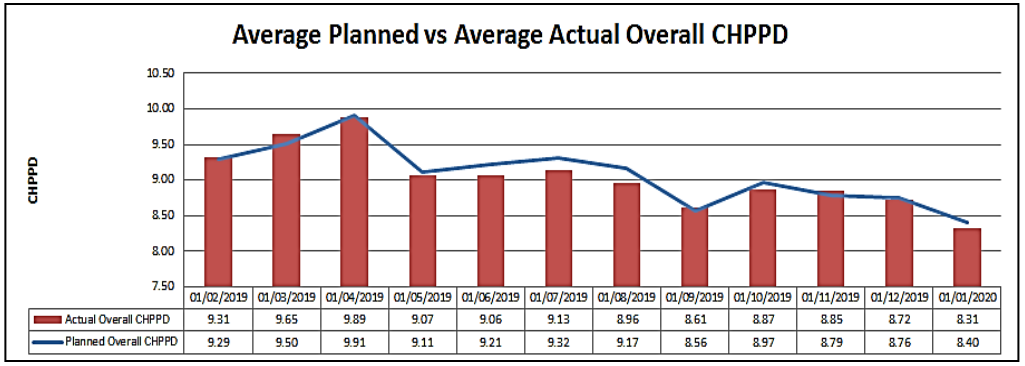
Table 1

Day	RN	HCA
Total Planned Hours	38266	20740
Total Actual Hours	36397	20678
Fill Rate (%)	95%	100%

Night	RN	HCA
Total Planned Hours	25331	12683
Total Actual Hours	25368	15022
Fill Rate (%)	100%	118%

Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend

Table 2



Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for January. The graph on the right shows planned vs actual Care Hours per Patient Day at Trust level, with graphs on subsequent pages showing split by Directorate. (CHPPD is a simple calculation dividing the number of actual nursing/midwifery (both registered an unregistered) hours available on a ward per 24hour period by the number of patients on the ward that day It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.)

Aggregated Trust data appears to show a decline in both planned and actual, however on further analysis this is skewed by the inclusion of very specialist areas whose planned and actual demand varies considerably namely Radnor, Maternity, NICU and Sarum. When these are excluded this levels out and shows a more even graph (see next slide). Graphs showing directorate level data are included for information.

There are no wards flagging Red (internal ratings) for this reporting month except Radnor for NA day staffing levels. This is due to very small numbers which distorts and exaggerates the figures.

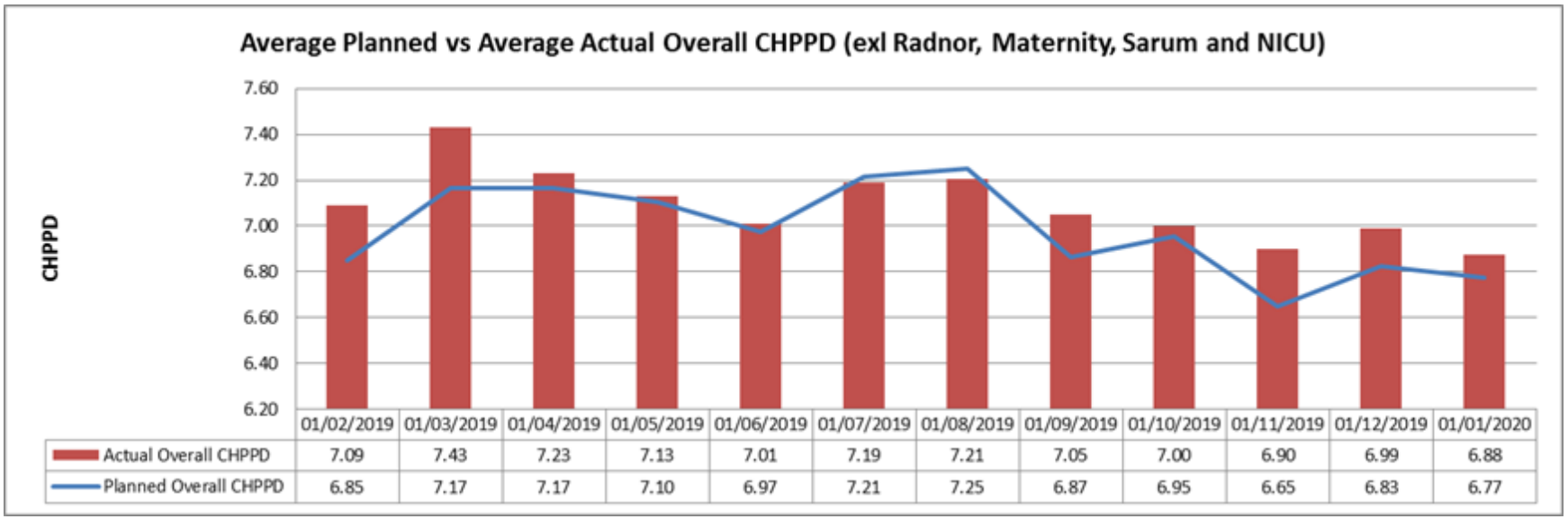
The skill mix of RN:HCA remains unchanged since November 2019 with RN 63% /HCA 37%. The broad recommendation is 65%:35%. The gap between overstaffing of HCA and RN understaffing remains controlled and for a second reporting month evidences continued restraint with HCA staffing levels for day shifts reduced further by 1% to 100% and RN levels remaining at 95%. RN night shifts are covered to 100% ensuring this period is well staffed at a time when other staff groups are not readily available (to support unfilled gaps) unlike day shifts.

Agency spend in January was up on the previous month, which reflects the opening of additional capacity areas, however is still significantly down on the same time period as last year. Overall nursing budgets remains underspent, though again there has been slight deterioration compared to the previous month which is due to the overseas pipeline and escalation capacity.

With regards to Nurse Sensitive Indicators there is concern regarding the increase seen in category 3 and 4 pressure ulcers. Trust wide review of practice and recovery programme underway and early themes are being identified. Increases in NSI's can be associated with suboptimal staffing levels, this is the only indicator currently flagging for us, and requires further investigation into underlying causes before a link can be made.

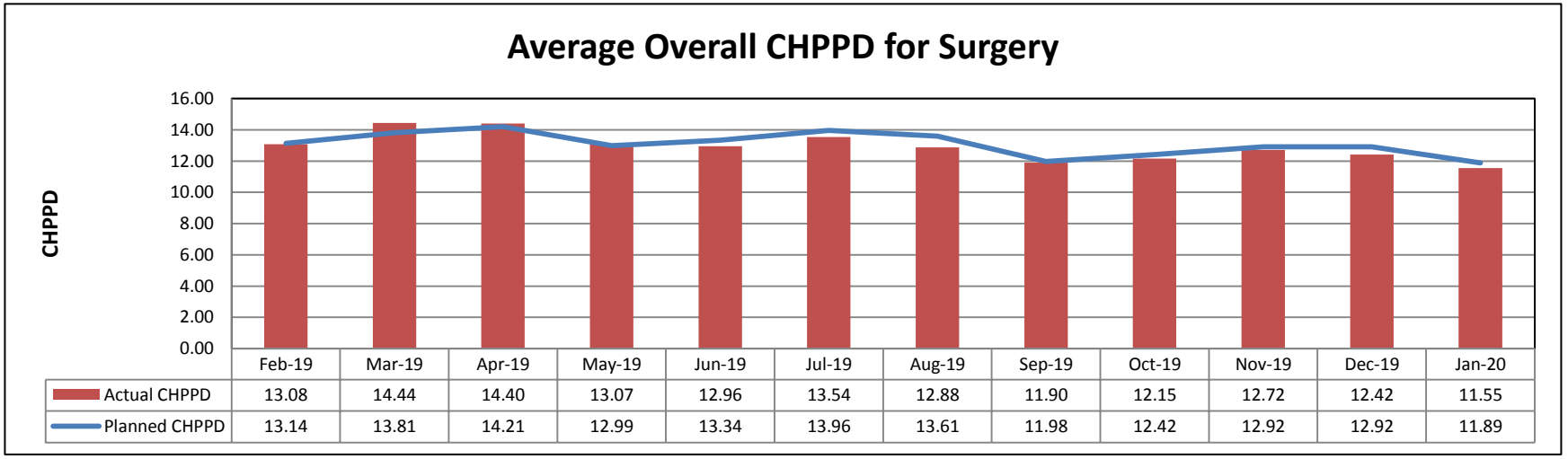
Workforce – Nursing and Care

Use of Resources



	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019	01/07/2019	01/08/2019	01/09/2019	01/10/2019	01/11/2019	01/12/2019	01/01/2020
Actual Overall CHPPD	7.09	7.43	7.23	7.13	7.01	7.19	7.21	7.05	7.00	6.90	6.99	6.88
Planned Overall CHPPD	6.85	7.17	7.17	7.10	6.97	7.21	7.25	6.87	6.95	6.65	6.83	6.77

Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend by Directorate



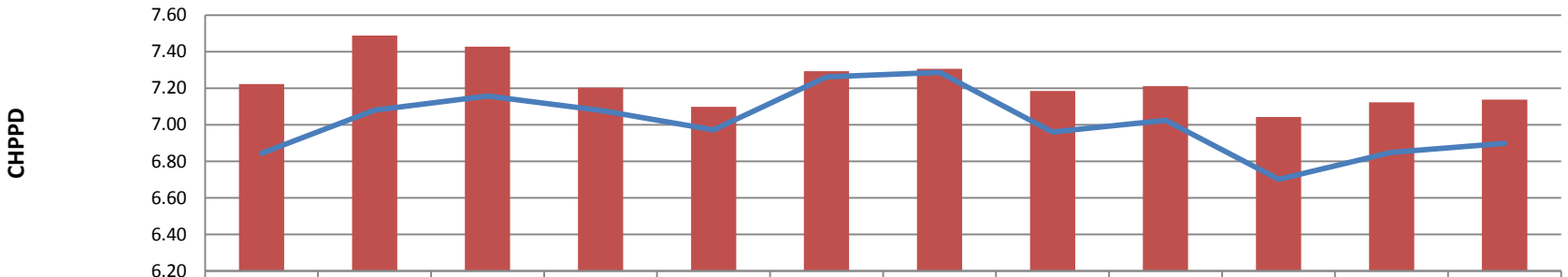
	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Actual CHPPD	13.08	14.44	14.40	13.07	12.96	13.54	12.88	11.90	12.15	12.72	12.42	11.55
Planned CHPPD	13.14	13.81	14.21	12.99	13.34	13.96	13.61	11.98	12.42	12.92	12.92	11.89

Workforce – Nursing and Care

Use of Resources

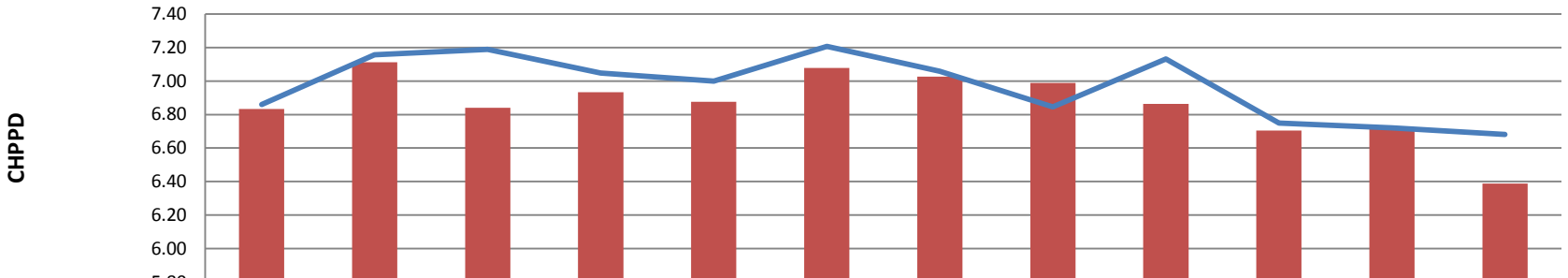
Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend by Directorate

Average Overall CHPPD for Medicine



	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Actual CHPPD	7.22	7.49	7.43	7.20	7.10	7.29	7.31	7.18	7.21	7.04	7.12	7.14
Planned CHPPD	6.84	7.08	7.16	7.08	6.97	7.26	7.29	6.96	7.02	6.70	6.85	6.90

Average Overall CHPPD for MSK

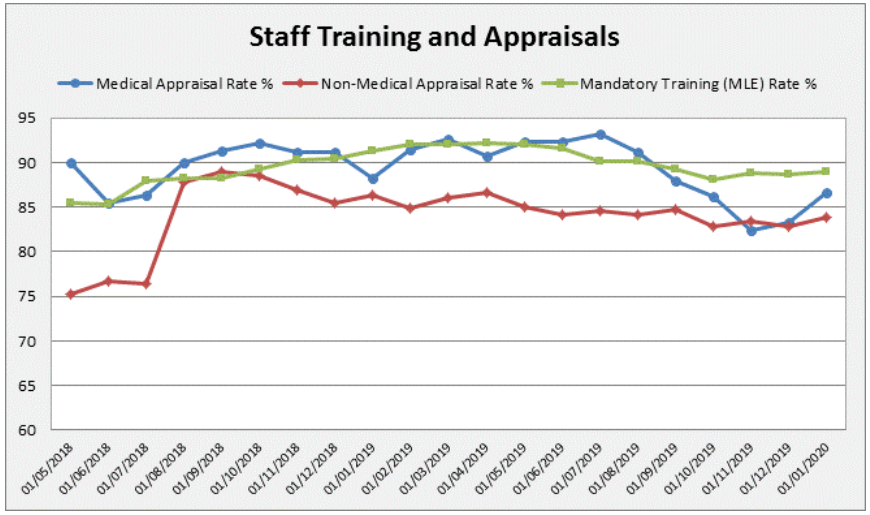


	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Actual CHPPD	6.83	7.11	6.84	6.93	6.88	7.08	7.03	6.99	6.86	6.71	6.72	6.39
Planned CHPPD	6.86	7.16	7.19	7.05	7.00	7.21	7.06	6.85	7.13	6.75	6.72	6.68

Workforce – Staff Training and Appraisals

Use of Resources

Salisbury NHS Foundation Trust Workforce Dashboard			
	Training	Appraisal	
	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend			
Month Trend	↓	↑	↓
Target	85.00%	90.00%	85.00%
Apr-19	92.19%	90.65%	86.70%
May-19	91.99%	92.31%	85.05%
Jun-19	91.60%	92.42%	84.08%
Jul-19	90.20%	93.25%	84.59%
Aug-19	90.22%	92.19%	84.15%
Sep-19	89.27%	87.95%	84.77%
Oct-19	88.12%	86.17%	82.91%
Nov-19	88.84%	82.38%	83.49%
Dec-19	88.61%	83.21%	82.87%
Totals	90.12%	88.95%	84.29%



Summary and Action

Training

Mandatory and Statutory training compliance rates continue to improve at over 89% against a target of 85%. Hot topics – in terms of low compliance – appear to be GDPR, Safeguarding Level 2, and Hand Hygiene. There are no particular location or staff group hot spots, although it is noted that Corporate are no better than the clinical directorates.

Non Medical Appraisals

Compliance rates continue to improve to almost 84% against a target of 85%, with the lowest rate in Corporate Directorates, followed by MSK. People Advisors are working with the MSK Directorate to diagnose the issues at work here so that remedial action can be taken. We have agreed a similar approach for Corporate directorates.

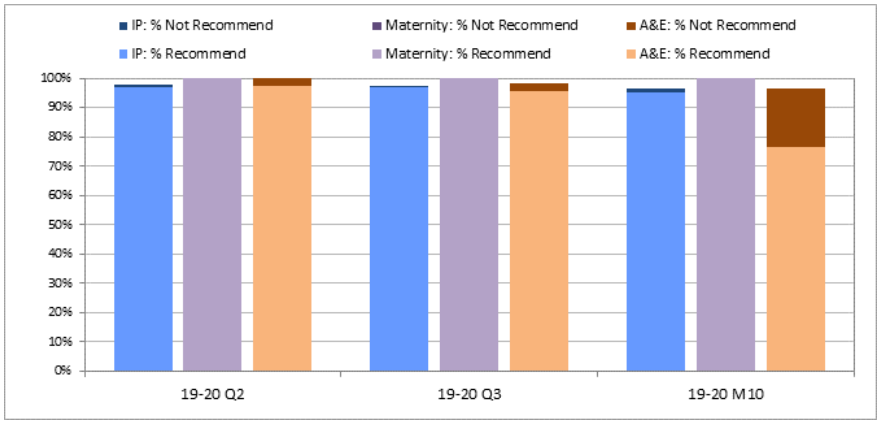
Medical Appraisals

Continuing to improve compliance now over 86% against a target of 90%. Clinical Directors are working closely with Education and appraisers on scheduling, sign off and other issues, to improve compliance and bring back to green before the end of March 2020.

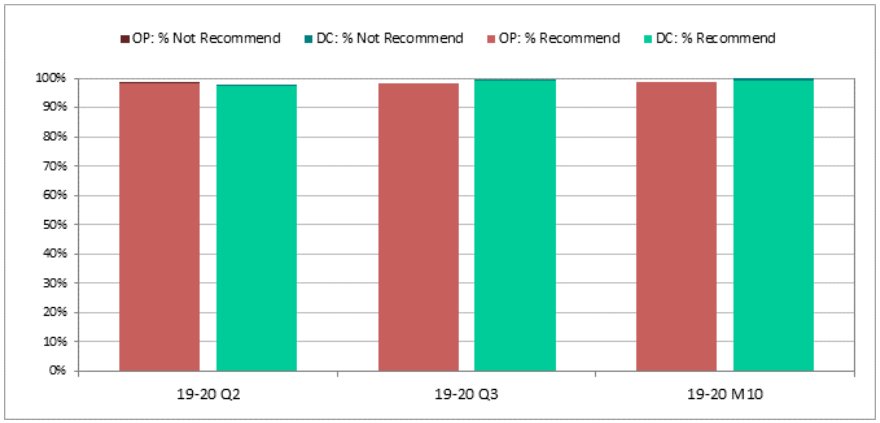
Friends and Family Test – Patients and Staff

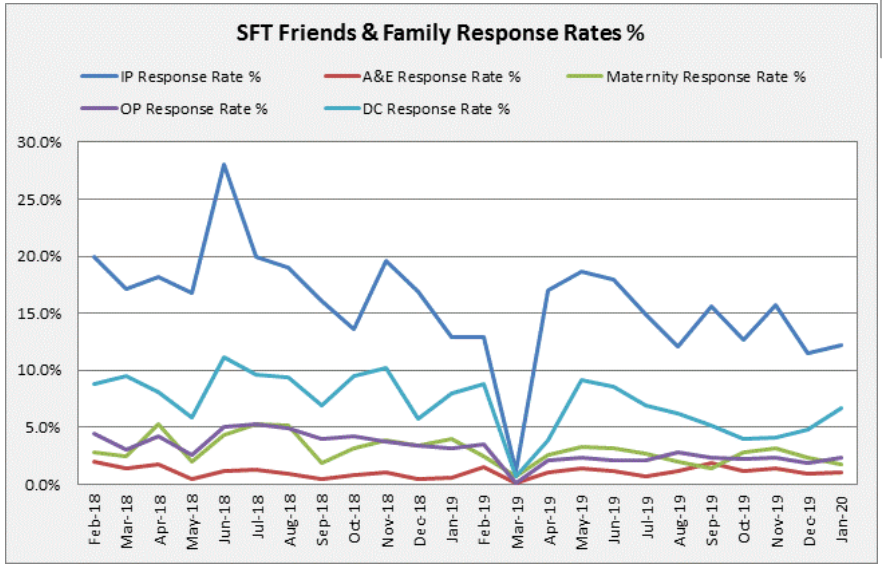
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



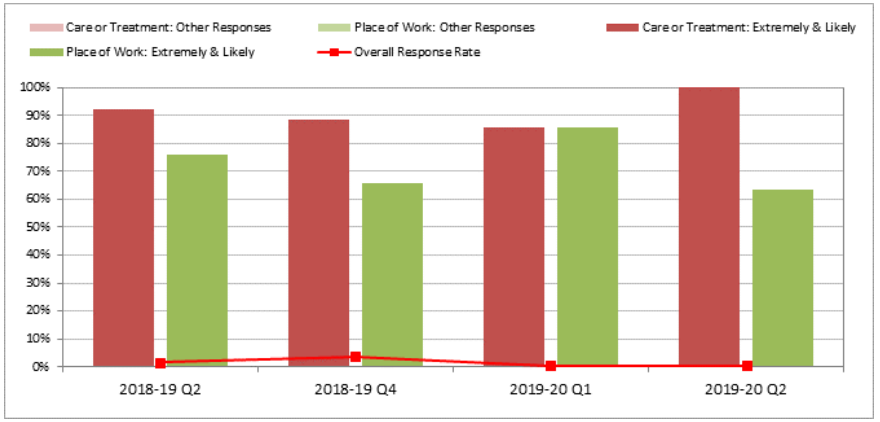
Patient Responses: Outpatient and Daycase





There was an issue in March 2019 whereby responses were input into the wrong FFT website and were unable to be retrieved, hence the low response rate for one month.

Staff Responses: Place of Work and Place of Care



January - **FFT A&E -** 6/30 patients said 'extremely unlikely to recommend'. The 6 comments related to the time patient's waited to be seen in ED.

Part 4: Use of Resources

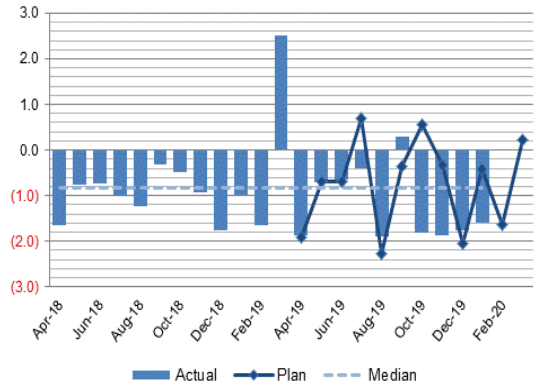
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Jan '20 In Mth			Jan '20 YTD			2019/20
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	17,726	17,374	(352)	173,329	170,098	(3,231)	208,163
Other Clinical Income	779	807	28	7,761	8,541	780	9,322
Other Income (excl Donations)	2,359	2,719	360	23,474	24,417	943	28,307
Total income	**20,864**	**20,900**	**36**	**204,564**	**203,056**	**(1,508)**	**245,792**
Operating Expenditure							
Pay	(13,046)	(13,673)	(591)	(130,967)	(132,923)	(1,956)	(157,326)
Non Pay	(6,799)	(7,488)	(689)	(66,758)	(68,522)	(1,764)	(80,163)
Total Expenditure	**(19,845)**	**(21,124)**	**(1,279)**	**(197,725)**	**(201,445)**	**(3,720)**	**(237,489)**
EBITDA	**1,019**	**(224)**	**(1,243)**	**6,839**	**1,611**	**(5,228)**	**8,303**
Financing Costs (incl Depreciation)	(1,430)	(1,367)	63	(14,297)	(13,840)	475	(17,157)
NHSI Control Total	**(411)**	**(1,592)**	**(1,181)**	**(7,458)**	**(12,230)**	**(4,772)**	**(8,854)**
Add: impact of donated assets	105	195	90	1,050	(28)	(1,078)	1,260
Add: Impairments	0	0	0	0	0	0	0
Add: Central MRET	174	173	(1)	1,737	1,736	(1)	2,082
Add: PSF & FRF	790	0	(790)	5,191	2,544	(2,647)	6,772
Surplus/(Deficit)	***658***	***(1,223)***	***(1,881)***	***520***	***(7,978)***	***(8,498)***	***1,260***



Variation and Action

The in month NHSI control total deficit of £1.7m is £0.2m greater than forecast expectations as shared with NHSE&I. Pay expenditure remains an area of concern. One-off bonuses in the laundry subsidiary and overseas nursing recruits moving into substantive rosters have contributed to this specifically in January.

The decision to open additional medical bed capacity was taken in early December, in order to allow for the more effective management of emergency patient flow, this capacity had initially been planned for two months and expected to be utilised in quarter 4. The revised forecast assumes these beds will be open for the remainder of the financial year.

The Trust is in the process of recruiting intakes of overseas nurses, an exercise with upfront costs but a payback period of approximately 9 months per nurse due to the upfront costs of c£10k per appointment and 12 weeks' supernumerary time. The number of passes in January was lower than anticipated, and this has had a knock on impact on the rate of reduction in ward temporary staffing costs.

Capacity constraints are leading to sustained costs associated with outsourced healthcare in order to maintain performance, driven by both increased demand (Endoscopy), and shortfall in capacity due to key hard to fill vacancies (Pathology, Radiology).

Income & Activity Delivered by Point of Delivery

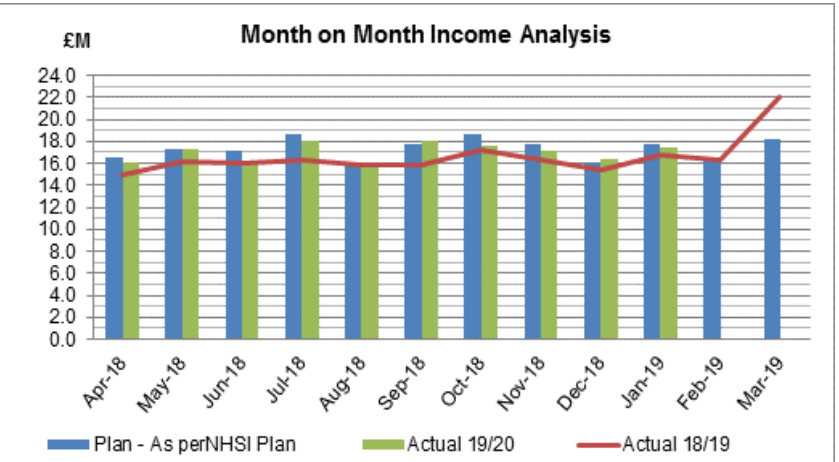
Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Jan '20 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	7,436	7,474	38
Elective inpatients	15,874	14,846	(1,028)
Day Case	14,801	14,254	(547)
Non Elective inpatients	47,753	45,922	(1,831)
Obstetrics	5,284	5,080	(204)
Outpatients	27,902	26,953	(949)
Excluded Drugs & Devices (inc Lucentis)	14,425	15,122	697
Other	39,854	40,447	593
TOTAL	**173,329**	**170,098**	**(3,231)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	93,294	93,332	38
Dorset CCG	19,881	19,928	47
West Hampshire CCG	13,816	13,905	89
Specialist Services	26,501	26,023	(478)
Other	19,837	16,910	(2,927)
TOTAL	**173,329**	**170,098**	**(3,231)**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance		Last Year Actuals	Variance against last year
Elective	4,482	4,104	(378)		4,292	(188)
Day case	18,762	19,287	525		18,127	1,160
Non Elective	23,657	22,813	(844)		21,694	1,119
Outpatients	221,710	213,071	(8,639)		211,942	1,129
A&E	58,232	58,420	188		56,282	2,138



Variation and Action

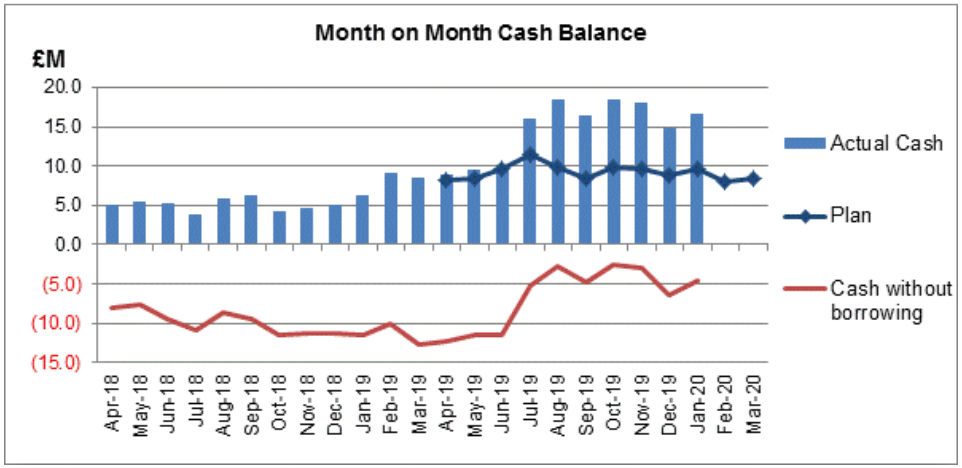
Income to date is £170,098k, £3,231k below plan and an under performance of £352k in January. Income has under performed on all points of delivery year to date with the exception of A&E, Excluded drugs and devices and Other. Cardiology Day cases are 221 cases and £342k below plan year to date with activity below plan in month and Orthopaedics Day cases are 132 cases and £355k below plan with a deterioration of 10 cases in month. Urology and Ophthalmology Day case activity is above plan due to recent Consultant appointments. Elective Orthopaedics are now 227 spells below the year to date plan of 1,068 which is a deterioration of 28 cases in month. The Non Elective position year to date position is driven by a combination of under performance on spells, mainly within Trauma and Orthopaedics, Plastic Surgery and Cardiology, and excess bed days activity. The Outpatients position is driven by underperformance notably within Dermatology and Plastic Surgery due to Consultant vacancies.

An adjustment of +£961k is included to reflect the blended approach, +£721k for Wiltshire CCG (£1,106k Month 9) and +£240k for West Hampshire CCG (£237k Month 9), due to under performance on the non elective element of the contract. An adjustment of +£288k is included to increase income to reflect the under performance on the Dorset managed contract at Month 10 (£187k Month 9). An adjustment of +£816k is included to increase income to reflect the minimum income guarantee with Wiltshire CCG at Month 10 (£964k at Month 9). The total impact is £2,065k within the income position (£2,494k Month 9).

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



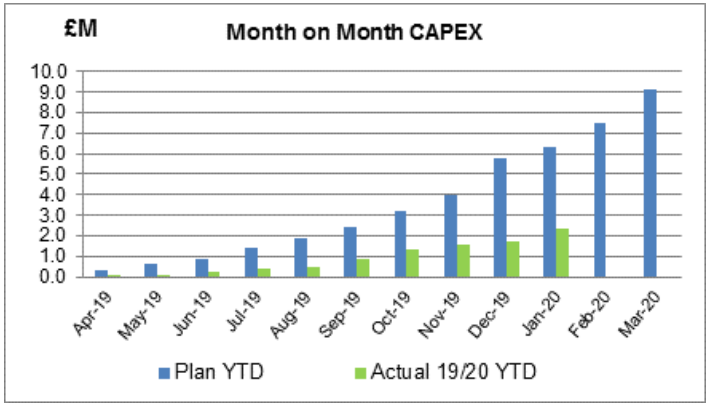
Cash remains higher than planned, primarily due to limited expenditure on the capital programme to date and the receipt of MRET and Health Education England payments in advance for the quarter to 31 March 2020. Capital spend is due to increase considerably in the last two months of the year and will include Board approved schemes brought forward from 2020-21.

Borrowings include £11m of working capital loans due for repayment by 31 January 2021. The Trust will request these are reissued as it will not have the funds to repay them. The plan had assumed they will be reissued and hence they have remained in long term borrowings. The Trust is expecting updated guidance on the treatment of these loans moving forward to be included alongside the 2020/21 operating guidance.

The cash flow will continue to be closely monitored during the remainder of 2019-20 and into next year to ensure funds are available when required, although no additional borrowing is anticipated in this year.

Capital Expenditure Position

Schemes	Annual Plan £000s	Jan '20 Plan £000s	Jan '20 Actual £000s	Jan '20 Variance £000s
Building schemes	700	350	0	350
Building projects	1,814	1,340	566	774
IM&T	3,540	2,400	468	1,932
Medical Equipment	2,650	1,860	970	890
Other	420	350	350	0
TOTAL	**9,124**	**6,300**	**2,354**	**3,946**



Summary and Action

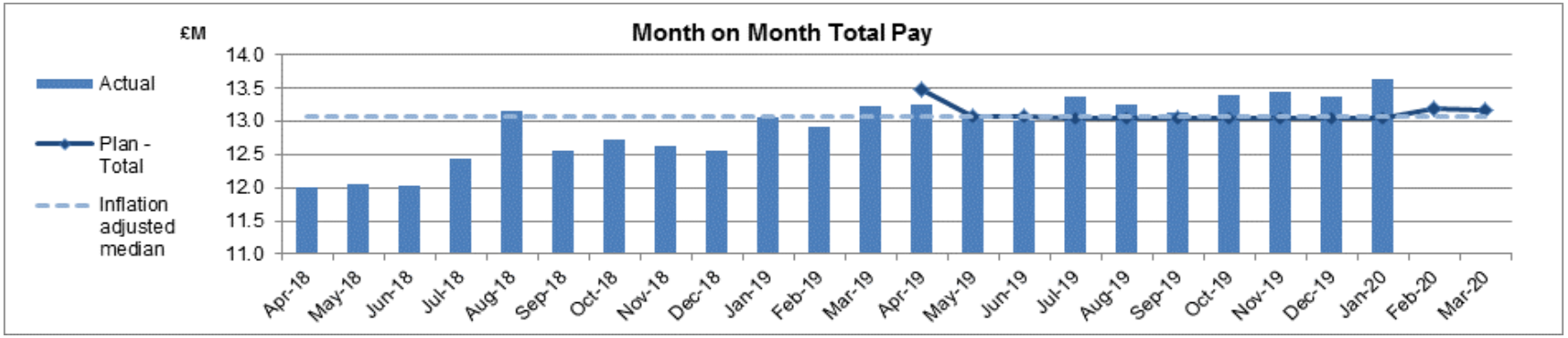
The Trust is primarily financing its capital spend in 2019-20 through depreciation. Additional national initiative public dividend capital funding of £1,348k is due to be received for various schemes, including a second MRI Scanner. £188k of this funding was drawn down by the end of January 2020, with the remainder receivable during February.

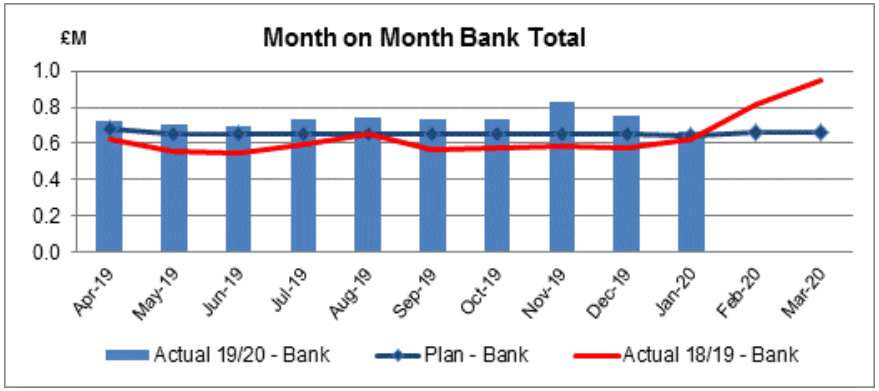
The Trust remains a considerable way behind the original plan for the year. Action has been taken to bring forward schemes, originally scheduled for 2020-21 into the current year to ensure the total expenditure included in the plan is met. Requisitions and purchase orders are being closely reviewed against each scheme to ensure the forecast spend will be achieved. Assurances have also been sought that these schemes can be completed by the end of the financial year. It is anticipated expenditure will increase considerably in February although lead times mean that the bulk of spend will not go through until March 2020. The Capital Control Group continues to closely monitor the forecast outturn and take any additional steps required within its terms of reference to ensure the capital plan is achieved for the year.

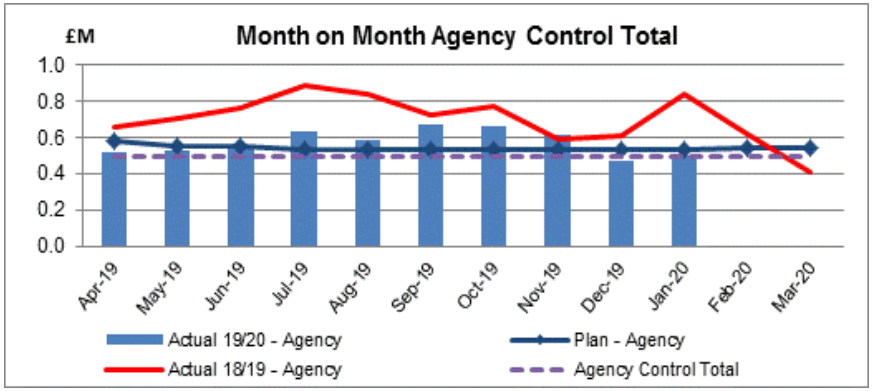
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure of £13,637k in January is £591k greater than planned and crucially £250k greater than forecast.

A decision was taken to open escalation bed capacity in early December in order to allow for more effective management of emergency patient flow, the Trust has received an allocation of winter pressures funding to cover the costs of these additional 26 beds. As previously reported, the Trust has c50-60 newly recruited overseas nurses who are currently acting in a largely supernumerary capacity while working towards their official registration. Although the long term benefits of this strategy may be seen in the reductions in temporary staffing, the rate at which this cohort are moving into substantive, rostered positions is behind forecast expectations.

STL, the Trust's laundry subsidiary, made bonus payments to its workforce in accordance with their non-AfC contracts to the value of £132k in the period.

Agency premium for the period is estimated at c£170k, roughly half of which relates to medical staffing groups due to difficulties filling vacancies and rota gaps. Gastroenterology, Acute Medicine, Elderly Care, and Pathology account for the vast majority of the medical agency spend.

Efficiency – Better Care at Lower Cost

Efficiency:

Use of Resources

Position							
	Annual	Jan '20			YTD		
Directorate	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	2,192	191	104	(87)	1,809	1,056	(753)
Musculo Skeletal	1,385	128	129	1	1,120	846	(274)
Surgery	1,728	149	118	(31)	1,430	1,112	(308)
Clinical Support & Family Services	1,965	184	150	(34)	1,598	1,437	(161)
Corporate Services	1,730	137	144	7	1,354	1,618	264
Strategic	1,000	164	74	(90)	672	623	(49)
TOTAL	**10,000**	**954**	**720**	**(234)**	**7,983**	**6,702**	**(1,281)**

Position							
	Annual	Jan '20			YTD		
Scheme	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	1,068	89	430	(59)	890	167	(723)
Workforce	1,001	83	90	6	834	804	(29)
Diagnostics	600	42	42	(33)	450	417	(33)
Patient Flow	825	69	0	(69)	688	138	(550)
Outpatients	500	56	56	0	389	389	0
Non-Pay Procurement	1,494	138	152	14	1,220	1,272	52
Medicines Optimisation - Drugs	500	83	19	(65)	333	234	(99)
Clinical Directorate Plans	2,634	255	222	(33)	2,117	1,961	(156)
Corporate Directorate Plans	1,378	106	110	4	1,063	1,320	257
TOTAL	**10,000**	**954**	**720**	**(234)**	**7,983**	**6,702**	**(1,281)**

Summary and Action

The Trust has reported CIP delivery of £720k (75%) in January 2019, taking the year to date delivery to 84%.

Delivery against the theatres programme has reduced from the 2019/20 high of £44k reported in M09, although there remains a general upward trend in the utilisation of lists.

The in month Diagnostics underdelivery is set to continue for the remainder of the year, as assumptions for £100k savings related to the Histology lot of the Southern Counties Pathology consortium (formerly 'South 6') managed service contract procurement will now not be realised.

The patient flow programme has once again not met its financial target. The Trust has needed to flex into and out of escalation capacity in order to maintain flow through its emergency admission pathways. Escalation had not been planned for until M11, with the associated excess cost assumed in the baseline plan identified as opportunity for savings in the Patient Flow programme (as supported by the 2019/20 bed model).

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	05 March 2020		

Report Title:	Patient Led Assessment of the Care Environment (PLACE) Report for 2019.			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	**x**
Prepared by:	Ian Robinson, Operations Director Estates and Facilities			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):	1. 2019 PLACE Results - by Domain 2. 2019 Ward/Department PLACE Scores 3. 2019 PLACE Results – Organisation and National Averages 4. 2019 PLACE Action Plan			

Recommendation:
This report identifies how the Trust discharged its obligation to complete the 2019 NHSE/I Patient Led Assessment of the Care Environment (PLACE), to note the 2019 PLACE scores and the action plan prepared to address key areas identified for improvement.

Executive Summary:
In 2013, the Patient Environment Action Team (PEAT) environmental assessments were replaced by Patient Led Assessments of the Care Environment (PLACE). Hospitals and hospices (in England) with 10 or more beds, proving NHS funded care are encouraged to participate; in 2019 all NHS Trusts (in England) undertook a PLACE assessment. During 2019 NHSI/E undertook a review of the PLACE process and criteria, this extensive review resulted in around 400 changes, we were advised by NHSE/I that the 2019 results will not be comparable with previous PLACE results. On 18th October (2019) five PLACE teams completed the assessment, measuring patient food services, cleanliness, privacy and dignity and wellbeing, condition, appearance and maintenance, Dementia and Disability standards, using criteria set by NHSI/E. During the year cleanliness and the standard of maintenance, condition and appearance, are monitored by the Matrons group and the standard and scope of food services for patients, by the Food and Nutrition Steering Group. The assessment identified a number of areas for improvement, an action plan to improve on the 2019 PLACE scores is provided.

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

Introduction

In 2013 the Patient Environment Action Team (PEAT) programme was replaced by the Patient-Led Assessment of the Care Environment (PLACE) the key changes being:

1. Membership of assessment teams must meet specified criteria (patients representing 50% of each team)
2. A revised scoring process to include Fail (<80%), Qualified Pass (80-99%) and Pass (100%).
3. Revised assessment questions.

The assessment focuses on the environment (e.g. maintenance, appearance and signage) in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. In 2015 the assessment criteria was extended to include Dementia standards and in 2016 standards measuring the extent to which the environment supports those with a disability, were added.

On October 24th 2018 we were advised that NHSE/I plan to review the PLACE programme to ensure the collection remains fit for purpose, this led to a delay in the 2019 PLACE collection from January to September. As the changes have been extensive (c400), we were advised by NHSE/I that the 2019 results will not be comparable with previous PLACE results.

PLACE Criteria

The PLACE assessment criteria are set by NHSE/I and apply to all hospitals and hospices in England, with 10 or more beds, proving NHS funded care in both NHS and private/independent sectors.

On Friday 18th October 2019, the Trust was assessed in accordance with these criteria:

- 25% of inpatient wards or 10, whichever is the greater (10 wards were assessed)
- 25% of all other space (this included 5 outpatient departments and the ED)
- Food Assessment to be undertaken, 1 for each 6 wards (or part) (4 food assessments were completed)

In accordance with the PLACE criteria, different wards and departments are assessed each year. PLACE results reflect the buildings/environments assessed, which can be significantly different from the environments assessed in the previous year. As a result of the 2019 PLACE review were are advised that the 2019 results are not be comparable with previous PLACE results.

2019 PLACE Assessment

In preparation for the formal PLACE assessment around 50 mini PLACE audits were undertaken during the year (2018/19). Mini PLACE assessments focus on cleanliness, condition and appearance and linen and are led by the Housekeeping team supported by Foundation Trust Governors, the Infection and Prevention and Control team (IPC), ward/department and Estates Technical Services (ETS) representatives. The outcomes from these assessments are reported via the monthly Matrons meeting.

A PLACE training event for Trust staff and Patient Assessors planning to participate in the 2019 assessment was held on Monday 30th September.

In accordance with PLACE assessment criteria and following formal notice the Trusts PLACE assessment was undertaken on Friday 18th October 2019. Foundation Trust members, Patient Representatives and members of Health watch joined Trust staff in undertaking the assessment.

In accordance with the PLACE criteria 10 Wards (including 4 food assessments) and 25% of the Trusts patient environment, was assessed.

In addition to public areas (including toilets), entrances, lifts, stairwells, car parks and external areas the following patient areas were assessed (department/ward scores are provided in appendix 2):

1. Cardiac Suite
2. Oncology Outpatients
3. Children's Outpatients
4. Pembroke Suite

5. Sexual Health
6. Emergency Department

Wards/Units:

1. Amesbury
2. Hospice
3. NICU
4. Odstock
5. Pembroke
6. Pitton
7. Radnor
8. Redlynch
9. Sarum
10. Spire

Food Assessments were undertaken on the following wards:

1. Laverstock
2. Britford
3. Downton
4. Odstock

2019 PLACE Scores

The 2019 PLACE scores were published by NHSI/E on 30th January 2020.

	2019 National average score*	2019 Trust score*
Cleanliness	98.6%	96.7%
Food & Hydration	92.2%	91.4%
Privacy, Dignity & Wellbeing	86.1%	85.8%
Condition, Maintenance & appearance	96.4%	97.5%
Dementia	80.7%	79.5%
Disability	82.5%	75.5%

**Scores are rounded to one decimal place.*

Summary of National Results

- 1,144 assessments were undertaken by 261 organisations.
- All eligible NHS Trusts participated in the 2019 PLACE assessment, 214 in total (81.7% of participants) and 47 (18.3% of participants) voluntary, independent or private sector providers.

Action Plan

The assessment identified a number of areas for improvement, an action plan to improve on the 2019 PLACE scores is provided in appendix 4.

The cleanliness issues identified have been addressed by the Housekeeping team and maintenance concerns have been shared and are being actioned by the PFI and ETS teams.

Areas of concern around food and food services are being reviewed and actioned (as appropriate) by the Trusts Food and Nutrition Steering Group.

The PLACE action plan will be shared and discussed at the Matrons monthly monitoring meeting.

Conclusion
The Trusts PLACE assessment was undertaken robustly and in accordance with the criteria set by NHS Digital (on behalf of NHSI/E), the Trust received a set of results the PLACE team recognised as reflecting the standards achieved on the day of inspection.

As part of the PLACE process, Patient Assessors are asked to provide a statement that summarises their view of the Trusts performance. The 2019 Patient Assessors statement was as follows:

External window cleaning and ledge cleaning should be done more frequently, suggested at least 6-9 monthly

Very high standards of cleaning inside the wards and clinical areas. Stairwells and corridors were dusty.
There are some exceptional outside areas but other areas over to the car park and the enclosed areas between old and new buildings needs substantially more care.

Exceptional standards of food in all areas and well served and well received by patients.

Other comments
Memory room in Spire ward is exceptional and well used and appreciated by patients. It would be good to extend it to other wards.

We were all impressed by the very supportive and professional care by all the staff at all levels throughout the hospital. Team work is clear evidence from nurse in charge to the cleaner.

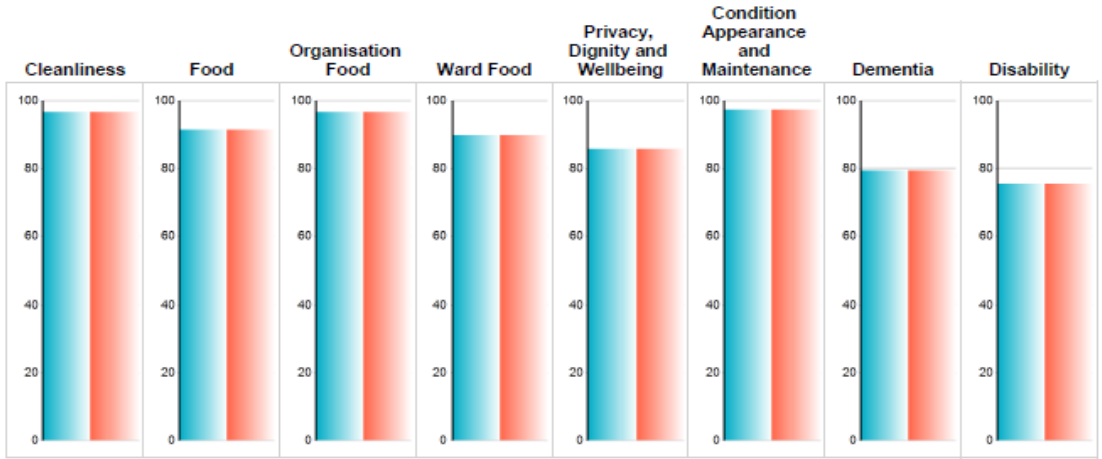
One patient said: 'It's like being in a hotel'.

To note, window cleaning (within clinical areas) is completed every 6 months.
The frequency of cleaning is in line with National Standards and is risk based, with corridors and stairwells receiving less frequent cleaning than clinical areas.

Ian Robinson
Operations Director - Estates & Facilities
February 2020

Appendix 1
2019 PLACE Results - by Domain

SALISBURY DISTRICT HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2066.0000	360.0000	87.0000	273.0000	451.3333	846.0000	588.0000	391.0000
Available Score (Actual)	2136.0000	394.0000	90.0000	304.0000	526.0000	868.0000	740.0000	518.0000
Site Score	96.72%	91.37%	96.67%	89.80%	85.80%	97.47%	79.46%	75.48%
Organisation Average	96.72%	91.37%	96.67%	89.80%	85.80%	97.47%	79.46%	75.48%

Appendix 2
2019 Ward/Department PLACE Scores

Ward Type: A&E/Minor Injuries Units

Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability
Emergency Department	91.82%		71.43%	98.08%	45.83%	29.41%

Ward Type: Food

Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability
Britford		86.36%			80.00%	83.33%
Downton		94.29%			80.00%	100.00%
Laverstock		81.43%			80.00%	83.33%
Odstock		97.37%			80.00%	100.00%

Ward Type: Out-Patient Areas

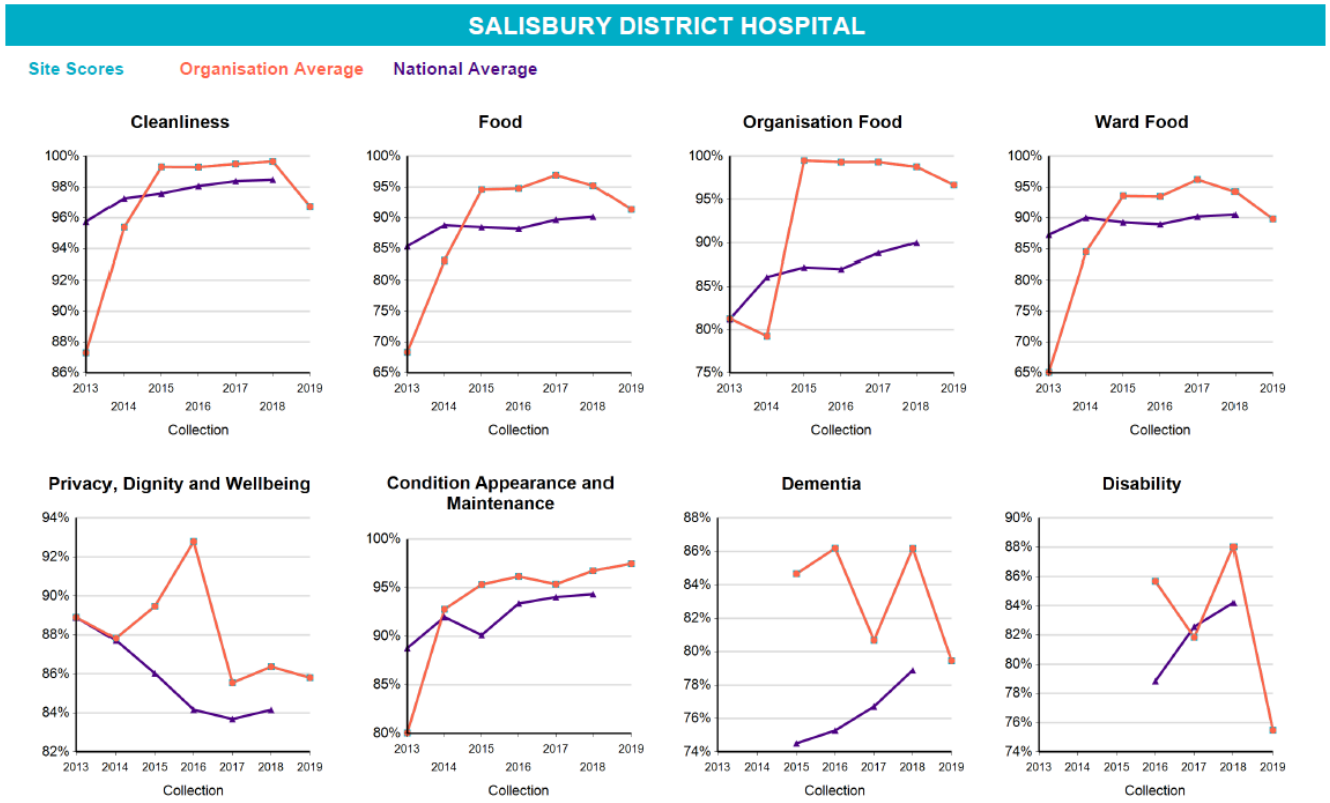
Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability
Cardiac Suite	100.00%		100.00%	100.00%	85.71%	93.33%
Oncology Outpatients	100.00%		100.00%	100.00%	90.91%	87.50%
Paediatric Outpatients	98.25%		100.00%	95.83%	100.00%	100.00%
Pembroke Suite	100.00%		60.00%	100.00%	50.00%	40.00%
Sexual HeaLTH	98.25%		77.78%	100.00%	90.48%	86.67%

Ward Type: The Ward Assessment - Acute and Community Hospitals

Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	First Impression	Final Impression		Comments
Amesbury	73.53%		70.59%	79.63%	37.50%	42.86%	Not Very Confident	Not Very Confident		Remained not very confident - felt worse on completion but not enough to move to not at all confident Felt if visiting family would be very disappointed - did not feel upbeat or motivating Ward very tired, would benefit from input of ArtCare to brighten and lift the ward.

Hospice	100.00%		95.00%	100.00%	92.59%	86.67%	Very Confident	Very Confident	⇨	Beautiful area with many personal touches, not in the least clinical, The area was spotlessly clean and a home from home environment with beautiful views over the gardens and fields. We all felt very privileged to of been able to visit this area.
NICU	100.00%		76.47%	98.15%	75.00%	100.00%	Confident	Very Confident	⇧	
Odstock	100.00%		90.00%	98.15%	85.19%	80.00%	Confident	Very Confident	⇧	
Pembroke	100.00%		83.33%	100.00%	74.07%	60.00%	Very Confident	Very Confident	⇨	Really nicely refurbished ward Very welcoming Clean and bright, no nasty smells Beautiful artwork Heard good interaction/engagement with patients
Pitton	99.32%		95.00%	98.15%	88.89%	86.67%	Very Confident	Very Confident	⇨	Good cleaning standards
Radnor	100.00%		61.11%	100.00%	88.89%	83.33%	Very Confident	Very Confident	⇨	
Redlynch	93.15%		85.00%	100.00%	85.19%	80.00%	Very Confident	Very Confident	⇨	
Sarum	99.33%		94.44%	96.30%	100.00%	100.00%	Confident	Very Confident	⇧	
Spire	97.33%		90.00%	100.00%	70.37%	53.33%	Confident	Confident	⇨	

Appendix 3
2019 PLACE Results – Organisation and National Averages



Appendix 4

2019 PLACE Action Plan
The PLACE assessment identified improvements required in the following areas:

	Domain	Issue	Action	Status
1.	Cleanliness	Some lighting in communal areas - dusty	Clean and review cleaning schedules	Cleaning completed
2.	Cleanliness	A number of bedside TV's found to be dusty	Clean and review cleaning schedules	Cleaning completed
3.	Cleanliness	Tops of notice boards and ventilation grills - within communal areas - dusty	Clean and review cleaning schedules	Cleaning completed
4.	Cleanliness	Some bed space curtain tracks dusty	Clean and review cleaning schedules	Cleaning completed
5.	Cleanliness	Some internal glazing (communal areas and wards), dirty	Clean and review cleaning schedules	Cleaning completed
6.	Cleanliness	Radiators/Heating panel and pipes – a number found to be clean on the outside but dusty behind	Clean and review cleaning schedules – review staff training.	Cleaning completed
7.	Cleanliness	Low level surfaces – some found to be dusty around fire extinguishers, under bed frames, some over bed tables and window sills	Clean and review cleaning schedules – highlight to cleaning staff	Cleaning completed
8.	Cleanliness	Some marks on walls	Clean and review cleaning schedules	Cleaning completed
9.	Cleanliness	Visible marks on mirrors	Clean and review cleaning schedules	Cleaning completed
10.	Access	Not all corridors have hand rails	To be reviewed as part of the Trusts refurbishment/capital programme.	
11.	Access	Not all reception areas are fitted with a hearing loop	To be reviewed	
12.	Privacy, Dignity and Wellbeing	A Trust wide access audit has not been completed	Plan to complete an audit in 2020	-
13.	Privacy, Dignity and Wellbeing	A Changing Places toilet is not provided	Plans and funding are in place to deliver this in 2020	
14.	Privacy, Dignity and Wellbeing /Disability	Insufficient outdoor seating	Review outdoor seating close to entrances	
15.	Privacy, Dignity and Wellbeing	Toilets and bathrooms are not all for single sex use – with appropriate signage	To be reviewed as part of the Trusts refurbishment programme.	-
16.	Privacy, Dignity and Wellbeing	Not all patients have access to a lockable cupboard for personal belongings	To be reviewed	
17.	Privacy, Dignity and Wellbeing	A separate treatment room is not available on all wards	To be reviewed as part of the Trusts refurbishment programme.	-
18.	Dementia	Not all toilet doors are painted in a single distinctive colour	Included within the Trusts painting and refurbishment programme.	
19.	Dementia /Disability	Not all slopes are clearly marked	Included within the Trusts painting programme.	
20.	Dementia	Toilet seats, flush handles	Included within the Trusts	

		and hand rails are not in a contrasting colour from the walls/floor	refurbishment programme.	
21.	Dementia	Not all patient areas displayed points of interest/Artwork	Escalated to ArtCare for Review	
22.	Dementia	Not all areas use colour to enhance patients co-ordination	To be reviewed as part of the Trusts refurbishment and repainting programme.	
23.	Dementia	Not all areas promoted a less clinical feel	To be reviewed as part of the Trusts refurbishment/redevelopment programme.	
24.	Dementia /Disability	Lighting – dimmer switches not fitted	To be reviewed as part of the Trusts refurbishment programme.	
25.	Dementia-Friendly	The correct day and date is not clearly visible from each bed space	To be reviewed	
26.	Dementia-Friendly	A large accurate and silent clock (18inch/45cm in diameter) is not visible in all patient areas	To be reviewed	
27.	Dementia-Friendly	Not all signs for staff have been moved from eyesight level	To be reviewed as part of the Trusts refurbishment programme/signage review.	
28.	Dementia-Friendly	Not all flooring is consistent, matt and non-reflective	To be reviewed as part of the Trusts refurbishment programme.	
29.	Dementia-Friendly	Not all toilet/bathroom door signage includes pictures	To be reviewed as part of the Trusts refurbishment programme/signage review	
30.	Dementia-Friendly	Some hot/cold indicators missing from taps	Escalated	Completed
31.	Ward Social Spaces	Not all wards have a day room or social space	To be reviewed as part of the Trusts refurbishment/redevelopment programme.	
32.	Ward Social Spaces	Not all patient areas provide different styles/types (including heights) of seating	To be reviewed	
33.	Condition /Appearance	Floors within patient areas show signs of wear	To be reviewed as part of the Trusts refurbishment programme.	
34.	Condition /Appearance	Areas of internal decoration require attention	To be reviewed as part of the painting programme and the Trusts refurbishment programme.	
35.	Condition /Appearance & Maintenance	Broken taps and light cords identified	Escalated	Completed
36.	Condition, Appearance and Maintenance /Disability	External signage obstructed by vegetation and require cleaning	Escalated	Completed
37.	Condition, Appearance	Shower not draining	Escalated	Completed

	and Maintenance			
38.	General Tidiness	Items found in corridors and bathrooms	Escalated	Raised during PLACE visits and at Matrons
39.	Food	Not all wards provided an area away from the bed space to eat meals	To be reviewed as part of the Trusts refurbishment/development programme.	-
40.	Food	Not all patients were made ready (including the opportunity to wash their hands), prior to meals being served	Escalated to Food and Nutrition Steering Group for review/action	Reviewed as part of the unannounced mealtime audits
41.	Food	Patient areas were not always made ready (items moved away) prior to the meals being served.	Escalated to Food and Nutrition Steering Group for review/action	Reviewed as part of the unannounced mealtime audits

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	05 March 2020		

Report Title:	Nursing Skill Mix Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	X
Prepared by:	Fiona Hyett, Deputy Director of Nursing			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Appendix 1 – NQB Expectations Appendix 2 – Compliance NQB Guidance Appendix 3 – Ward Staffing Ratios			

Recommendation:

The recommendations from the annual nursing staffing skill mix review are:

- To note the findings of the full ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
  - SFT nursing establishments are set to achieve an average of 1:5 – 1:7 registered to patients across the majority of wards during the day
  - Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing including Developing Workforce Safeguards.
- To note the requirement to implement Safer Nursing Care tool to provide additional assurance that nurse staffing levels are safe.
- To continue momentum on actions to fill vacancies and improve retention to continue the reduction on the reliance on high cost agency. This year it will include a specific project on flexible rostering, which the Trust are piloting with Allocate Healthroster.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To agree the additional investment into staffing of total cost £541,412 although some of this is offset by run rate (see table 2) which will be prioritised through the planned workforce summits

Executive Summary:
The annual nursing skill mix report is presented to Trust Board, as per the requirement of the National Quality Board (2013;2016) and Workforce Safeguards (2018) expectations for Boards to ensure themselves of safe staffing. The report details the methodology, findings, risk assessment and recommendations arising from the 6 monthly ward staffing review undertaken during the summer of 2019. Maternity workforce review is subject to a separate paper. The report outlines SFT's progress in meeting the recommendations from the National Quality Board for Safe Staffing, and includes a detailed summary of progress to date. The report is presented in full as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board of all aspects of the 6-monthly staffing reviews, and includes a statement from the Director of Nursing on the safety and sustainability of nurse staffing as required in Developing Workforce Safeguards guidance. Current workforce establishments are safe and sustainable, a huge amount of work has gone into the recruitment programme for Registered Nurses and the vacancy rate has dropped significantly since the last review. It is important to note however, that skill mix and establishment requirements are dynamic and we must be responsive to the changing complexity and acuity of our case mix, and where further investment is supported in the attached paper, this is the underlying reason. This is also the reason for recommending that the Safer Nursing Care Tool is deployed as a validated tool to track nursing demand over time and changes to case mix to test the majority of areas listed. The paper has been discussed at Trust Management Committee (TMC), who approved the recommendations but requested the proposed investment is put forward to the internal workforce summit in April to be prioritised alongside all other workforce requirements. Subsequent to TMC concern was raised that staffing levels on Durrington ward needed increasing ahead of a full business case requirement for a frailty unit and therefore an additional RN has been requested, and is included in the costs outlined below.

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

1. Purpose

1.1 The purpose of this paper is to report the outcomes of the 6 monthly review of ward staffing nursing establishments. This full review forms part of the Trust's approach to the systematic review of staffing resources to ensure safe staffing levels meet patient care needs.

1.2 The paper focuses specifically on a review of in-patient ward areas, intensive care, and Emergency Department (ED), Spinal Unit and Children's service.
Theatres and Out-patients have been subject to separate reviews.

1.3 A separate report focussing on midwifery needs to be reviewed alongside this paper following review by Birthrate+.

1.4 The report fulfils expectation 1 and 2 of the NQB requirements[1,2] for trusts in relation to safe nurse staffing, and the most recent guidance Developing Workforce Safeguards[3] which requires Boards to be fully sighted on the staffing requirements.

2. Specific Detail

2.1 Ward staffing review methodology

2.1.1 In 2012 SFT established a systematic, evidence-based and triangulated methodological approach to reviewing ward staffing levels on a 6-monthly basis and taking proposals for changes to establishment to Board to be approved and implemented via budget setting process. The aim of this process is to provide safe, competent and fit for purpose staffing to ensure delivery of efficient, effective and high quality care.

2.1.2 This process has been adapted to include a full annual skill mix review presented to Board in February, followed up by an update review 6months later to ensure plans are still appropriate and to review the impact of any investment. The last full review went to Board in February 2019 followed by an update in August 2019.

2.1.3 The approach taken for the full skill mix review utilises the following methodologies:

- Safecare module of Allocate as a proxy for Shelford Safer Nursing Care Tool.
- Care Hours per Patient Day
- Professional judgement
- Peer group validation
- Benchmarking and review of national guidance
- Review of e-rostering data
- Review of ward nurse sensitive indicator data
- Review of HR indicators and finance metrics
- INSIGHTs data (from Allocate E-Roster data)

2.2 National Guidance

2.2.1 In 2013 as part of the response to the Francis Enquiry[4] the National Quality Board (NQB) published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This guidance was refreshed, and broadened to include all staff groups and re-issued in July 2016 to include the need to focus on safe, sustainable and productive staffing. The expectations outlined in this guide are presented in Appendix 1.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability -- report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.2.2 These expectations are fulfilled in part by this review and the detailed action plan (Appendix 2) which shows assessment and progress against the 37 recommendations that make up the 3 over-arching recommendations. This assessment shows SFT to be fully compliant with 33 recommendations (compared to 31 last year), with on-going action required against 4 and of these two have progressed to partial completion.

2.2.3 There is now available a suite of improvement resources developed and designed to support the approved NQB guidance on safe, sustainable and productive staffing. The resources applicable to the Trust are:

- In-patient Wards for Adult Acute Hospitals - is aimed at wards that provide overnight care for adult in-patients and excludes intensive care, high dependency, acute admissions and assessment units.
- Urgent and Emergency Care
- Maternity Services
- Children's Services
- Deployment of nursing associates in secondary care

These resources have been included within the process for the skill mix reviews and assessing compliance against them.

2.2.4 In July 2014 NICE published clinical guideline 1: Safe Staffing for nursing in adult in-patient wards in acute hospitals.[5] This guideline is made up of 38 recommendations. The Trust remains compliant with these guidelines.

2.2.5 In October 2018 NHSI published 'Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing'. The document moves forward from the NQB Guidance as described above and from April 2019 NHSI will assess Trusts compliance with the 'triangulated approach to deciding staffing requirements described in the NQB guidance – the Trust is compliant with this through the staffing review process.
The Trust is also required to include a specific workforce statement in its annual governance statement.

2.2.6 In January 2018 the NQB published an additional resource 'An improvement resource for the deployment of nursing associates in secondary care'.[6] The Trust remains compliant with the recommendations, the deployment of Nursing Associates has not resulted in a substantial change to the RN establishment (a full QIA would need to be undertaken if this approach changed).
The guidance indicates that Care Hours Per Patient Day (CHPPD) needs to be reported separately for Nursing Associates, this requirement will be met with a planned e-rostering update early 2020.

2.3 6 monthly Ward Staffing Review

2.3.1 The full review was carried out with each ward during Q3, reviewing the data from September 2018 – August 2019. The reviews were attended by the ward sister, Head of Nursing and/or Matron and Deputy Director of Nursing. Business partners and finance managers were invited to attend. The same triangulated methodology was used as in previous reviews – review of nurse sensitive indicators, HR and finance metrics, headroom data, nurse-patient ratios, Safecare data and professional judgement.

2.3.2 The detailed spreadsheets with ward by ward findings are included in Appendix 3. This provides detailed information on the current establishment levels for each ward and vacancies at time of ward reviews; registered to unregistered ratios; nurse to patient ratios by registered and total nurse staffing by shift; nurse sensitive quality and HR outcome data and detailing acuity and dependency information from the Safe Care Tool reviewed by ward.

2.3.3 <u>Nurse to patient ratios by registered and total nursing</u>

- The ward establishments allow for registered nurse to adult patient ratios during the day across SFT to range from 1:4 to 1:8 depending on specialty and overall staffing model. The ratios are an improvement from last year due to additional staffing being approved on Amesbury (orthopaedic surgery). In some areas where there has been active implementation of the band 4 role these ratios can vary on specific shifts, although the underlying establishment ratio has not been altered. These ratios are set against establishment and can regularly increase when wards are not fully established.

- Planned staffing ratios at night require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. Ratios range from 1:5 to 1:12; all areas with higher ratios have been reviewed to ensure the registered nurse ratio is appropriate for the acuity of the ward and is offset by higher total staff to patient ratios.

- Appendix 4 gives a summary of ratios by ward

2.3.4 <u>Registered to unregistered ratios</u>

- The wards have been reviewed against the benchmark of 60:40 registered to unregistered ratios as the planned model of care.

- Overall the Trusts registered to unregistered workforce meets the planned 60:40 ratio and the majority of wards are at this level.

- Several wards have actively implemented the use of Band 4's (elderly care and orthopaedics) and the ratios have been reviewed as registered: band 4: unregistered. This will be further supported when we are able to report CHPPD for the Nursing

Associate role. The band 4 role continues to be developed as part of models of care and utilisation of the role continues to be a theme for review for each skill mix review to identify further opportunities, particularly linked to the development of apprenticeships nationally and providing a career development route for unregistered staff.
The Trust was part of the national pilot for the nursing associate role and the first cohort completed in April 2019. A second cohort of Nursing Associates and Assistant Practitioners commenced in March 2019. A candidate from the first cohort has secured a place on an exciting national leadership programme for Nursing Associates.
There are ward areas where the acuity and intensity of patients has increased and treatment and medication regimes are complex and so an overall reduction in registered to unregistered ratios would not be appropriate to maintain safe staffing levels. Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes.

- A few wards are significantly above the 60:40 ratios and this tends to be where the intensity of patient needs requires a higher ratio of registered staff (intensive care, cancer care, cardiology, Acute Medical Unit).

2.3.5 Assessment against SafeCare Tool

- The Safe Care tool (acuity/dependency model) has been used to review the staffing. This is integrated into the Healthcare roster system and provides information on the acuity/dependency levels and corresponding staffing levels on a real-time basis. When predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the specialty and number of beds. The data is reviewed at each skill mix review as well as being used to review staffing levels on a daily basis.
- Analysis of SafeCare data is included within the reviews
- The Deputy DoN has undertaken a Safe Staffing fellowship and through this programme it has become clear there is a need to undertake a more formal assessment of staffing levels using Shelford Safer Nursing Care Tool (this is different to SafeCare within Allocate). Next year (2020/21) the Trust will undertake a minimum of 2 assessments, each for 20 days to triangulate with the annual skill mix review. This will ensure meeting the requirement to assess staffing levels using an evidence-based tool.
- In line with the NHSI Developing Workforce Safeguards, licences have been obtained from Imperial Innovations to allow the use of the Shelford Safer Nursing Care Tool.[7]

2.3.6 Allowance for additional headroom requirements and supervisory ward leader

- All areas have 19% budgeted funding allocated to allow for additional headroom requirements arising from non-direct care time ie annual leave, study leave, sick leave (parental leave is excluded and held centrally). Review of the actual headroom for each ward continues to demonstrate that 19% is insufficient and the Trust is an outlier compared to its peers. Data from the e-rostering system overall would indicate on average 23% excluding parental leave is generally required (and is comparable to peers).
- The consequence of this is the necessity to use temporary staffing over and above ward staffing establishments which challenges budget management and is less efficient and can cause wards to overspend despite good budgetary management.
- The Trust continues to run a supervisory model for ward sisters/charge nurses, in which they are given 0.8wte of their working week for this, with 0.2wte clinically

rostered into numbers. In this review the amount of supervisory time ward leaders were able to take had improved due to the improved vacancy position with a range from 45-98%. Surgery have Ward Secretary post which has proved successful in releasing ward sisters from administrative duties, and other areas such as MSK have started to roll this out from within budget.

In summary from the evidence gained through the staffing reviews the assessment is that broadly we have staffing levels that can be seen to be safe. The skill mix review undertaken last year rightly cited vacancies as the biggest risk to achieving safe levels of nurse staffing. Recruitment, alongside focused nurse retention activity has significantly reduced the vacancy gap. This is to be commended whilst not losing focus on either of these activities within a very challenging environment locally and nationally.

Outlined below is the detail by directorate which articulates where there are opportunities on efficiency, effectiveness and patient experience

2.3.7 Specific Directorate Themes

Medicine Directorate:

Staffing overall in the medical directorate has seen an improvement in vacancy rates on last year due to the international nurse recruitment, areas such as the Emergency Department have welcomed overseas and preceptorship nurses for the first time.

Whilst the clinical areas report an increase in the acuity and dependency of patients, the introduction of the Safer Nursing Care tool will be helpful to triangulate this professional judgement alongside nurse sensitive indicators. Many areas whilst seeing an improvement in staffing vacancies do have a junior skill mix and this may be contributing to areas requesting an increase in staffing.

The ward areas requesting an increase in their staffing that the directorate would support at this review include the Hospice, Farley, Durrington, and Spire. In addition the Emergency Department however it is recommended that this is subject to separate business cases as the staffing requests are related to changes in the functioning and flow of the department.

The hospice have uplifted a band 5 to band 6 to allow them 1.6wte band 6 to ensure provision of senior support across seven days. In addition they are requesting to uplift a band 2 to a band 4 and develop a nursing associate role to support the night shift. At night the team are isolated and it is not uncommon for 1 RN to be consumed by care for 1 patient leaving 1 RN to manage high number of controlled drugs and syringe drivers – development of the Nursing Associate role in this area would enable this to be managed. During the 2year training period this would be at a Band 3.

Farley ward requested a number of additions of these the DMT would support an additional band 5 at night. A Stroke nurse staffing working party (2013) looking at hyperacute, acute and rehabilitation patient groups suggested 2.9wte per bed for hyperacute and 1.35 wte acute numbers, with no guidance for rehabilitation. The addition of a band 5 at night to support with hyperacute and acute patients would move us closer to this standard and also provide cover for thrombolysis when required. Currently if a patient requires thrombolysis then an additional member of staff is booked via temporary staff (up to and including Thornbury), although not all attributable to this the ward's current expenditure on enhanced care YTD is £65k. If acuity was low, then this nurse would be pulled to cover gaps in other

areas. It should be recognised that this is guidance and not evidence-based, and will need to be reviewed as part of the implementation of the Safer Nursing Care tool.

Spire ward requested additional HCA staff due to the high numbers of patients requiring enhanced care which results in additional staffing. A request was also made for a discharge co-ordinator role. An additional HCA on nights is supported, though this could be used flexibly across the 24-hr period where the need is highest. In addition new ways of working are being implemented including more holistic use of therapy and health care assistants and additional training to support patients with mental health needs. The discharge role is not directly related to safe staffing and needs to be explored by the Directorate management team.

Durrington have requested additional staff to support the development of a frailty unit, again it is recommended that staffing will be reviewed as part of a business case. Subsequent to this review, concern has been raised from across professional groups that on the RN staffing levels on the ward and it is recommended that an additional RN be added to the early shift, but that a business case is still required for the frailty unit.

The Emergency department (ED) are seeking to increase their staffing in the paediatric area to ensure compliance with the Standards for Children and Young People in Emergency Care (2012) which requires children to be nursed in separate area to adults and by paediatric nurses, many smaller EDs find it challenging to comply with this. The plan for paediatric staffing is a business case to improve the structure of paediatric nursing with a vision that any child presenting to the department will be cared for in a dedicated paediatric area, with the appropriate environment, equipment and paediatric trained staff.
In addition to address the concerns raised by CQC, ED are working creatively to review the use and flow through SSEU which would see the area managed in a more ambulatory approach which would impact on the staffing requirement. Both of these ambitions are subject to separate business cases which will be presented through Trust Management Committee.

Several wards within the medicine directorate have made requests for additional staffing based on professional judgement of the ward leader, the directorate assess that current staffing levels are safe and these areas will continue to be monitored and evaluated across the coming year.
Areas of note include:

- Redlynch – the development of a new combined Gastro intestinal unit is being considered and any impact on ward staffing will be reviewed as part of this development.
- AMU requested the 5th registered nurse on night duty to be substantiated, this is part of escalation when ambulatory is used for patients overnight and is supported via temporary staffing. On-going analysis is required to assess number of times the unit is in escalation and how the 'Ready Steady Go' programme impacts positively on patient flow through 2020. This area being used for escalation causes issues for patient flow the following day and is the prime area for mixed sex breaches occurring due to utilisation for escalated patients.
- Pembroke and Tisbury both requested additional HCA's but these are not supported without analysis through use of SNCT.

Musculo-Skeletal Directorate:
The past 12 months has seen the directorate benefit from the Trust wide approach to recruitment and retention, and the directorate have developed creative opportunities such as rotational posts through orthopaedics, plastic and burns and spinal rehabilitation. Wards have proactively engaged with recruitment events and are now (January 2020) on the verge of becoming fully established.

The most significant turnaround has been on Odstock ward which now have a fully established and settled team. Issues of junior skill mix have been addressed through the use of specialist nurses, medical staff and directorate support in the training and upskilling of the staff to meet the specialist needs of the wards.

The Spinal Centre continues to transform with the tendering and award of contract to Holton Lee to provide 8 off site progression beds. It is anticipated this initiative will go live in 2020 and see a corresponding reduction in on-site beds by x6. In anticipation of this launch, the two spinal centre wards (Avon and Tamar) combined to form Longford ward and projected recruitment and reduction in beds would see the ward become fully established in 2020. Staffing numbers and shift allocation have been set using 12 months' worth of safe care data to inform anticipated requirements, resulting in no further request for uplift or increase in staffing numbers made.

With the previous staffing increase for Amesbury (B5 late and B2 night) available staffing numbers and acuity are balanced, and no further requests are made.

Nursing staff on Chilmark have requested a review of their shift pattern to adopt long days. This consultation has concluded and long shifts will be implemented. The MSK Directorate team are working with the service leads to explore what wte can be realised from this process and subsequently be redirected to the address the request for an additional B2 late and B5 night shift. Evaluation of the move to a long day staffing pattern will be reviewed as the evidence base for long days is mixed.

Surgical Directorate:
There will be no significant registered nurse vacancy in the directorate at the end of the financial year. Recruitment of overseas nurses has contributed significantly to this. ITU has also successfully recruited overseas nurses and student nurses into substantive posts for the first time.
In the skill mix reviews the Surgical Admissions Unit on Britford, Breamore and Downton all identified a case to increase their nursing establishment. For the surgical directorate the priority would be:

Surgical Admissions Unit
In the autumn the Surgical Head of Nursing along with the Britford ward leader identified the need for an increase of 1 B5 late shift and slight extension of hours to match the pattern of demand across the day. There has been a steady increase in the numbers of patients attending for assessment, observation and treatment resulting in either discharge home or admission into the hospital. Since the inception of SAU the attendances have significantly increased, including a number of patients who are brought back to the unit for review post discharge but the workforce has not changed in line with this. There are times when patient care has been compromised; there have been delays in providing medication on time, and observations being carried out on time, with general overcrowding being experienced within

the footprint. GP referrals include more complex patients resulting in a requirement for more nursing time for assessment, observation and treatment. This has had an impact on morale as staff have been unable to take a break at times due to there being only 1 Registered Nurse working in this area. An additional RN was agreed therefore by DMT to cover the late shift with extended hours to match patient footfall. This means that there are 2 RNs working at peak times during the middle to latter half of the day. This is making a significant difference to patient experience and staff morale with a reduction in clinical tasks being delayed and therefore assessment and care delivered in a timely manner. We are requesting to make this a substantive position to continue to ensure patient safety in this busy assessment area and to support staff who work there.

Breamore – Short Stay Surgical Unit
Requested an increase of 1 B5 or B4 day shift. There has been an increase in the activity of patients being admitted and discharged through the 4 chairs on Breamore; this is an average of 12-14 patients per day. This is in addition to the existing work load to care for 20 short stay surgical patients on the ward. The nurse in charge is required to take 6-8 patients on the early and late shift, in addition to coordinating other staff and dealing with day to day running of the ward and supporting the discharge of patients through chairs. This impacts the quality of care for patients as drug rounds are disturbed, observations and administration of IV medication are delayed. There have been patient complaints relating to the discharge process and the time it takes to discharge patients. An advantage of the use of these 4 chairs is to improve patient flow as patients are not being held in recovery to wait for beds on the main wards. As a consequence of this surgery is not being delayed as anaesthetists do not have to wait for space to become available in recovery for their patients. This ensures that patients are able to have their surgery on the day and they are not cancelled due to running out of theatre time. It is recommended that a band 4 post be implemented covering a shift spanning 10-7pm.

Downton
Requested increase of an RN on the late shift and an HCA on the twilight shift.
The additional band 5 nurse on the late shift would allow for a nurse in charge who is not allocated patients to support and coordinate staff and deal with the daily routine of running the ward. The case mix of patients on the ward has changed as more medical patients are allocated to Downton and this increased during the winter months.
A band 2 twilight nurse is also requested as this would help provide nursing support due to increased dependency of medical patients. It is recommended that this case of need is reviewed as part of the undertaking of the Safer Nursing Care tool rollout to assess the acuity and dependency of the patients.

Clinical Support and Family Services – Paediatrics
Overall the staffing establishment remains appropriate for Sarum; however the last year has seen an increased level of long-term sickness that has impacted upon the ability to work within the RCN (2013) Safer Staffing Guidance for Children and Young People at times of high acuity and/or additional short-term sickness. This has resulted in reliance on bank and agency paediatric trained nurses to ensure that safe level of staffing are maintained on the ward and that recommended staffing ratios are maintained (i.e. 1 nurse: 2 HDU patients). Adherence to the RCN Safer Staffing model continues to help ensure an appropriate staffing level on Sarum, however the outreach post continues to be pulled into staffing numbers at times of high acuity and/or high patient numbers to ensure patient safety and avoid the use of costly paediatric agency staff. This has resulted in challenges for

ensuring appropriately skilled paediatric nurses are available for children attending Day Surgery Unit (where outreach were intended to also support).

In February 2019, the paediatric nurse recruited to DSU left and since then the post has remained unfilled despite the post being offered to 2 successful candidates on two separate occasions, but both withdrew. The RCN (2013) guidance states that a paediatric trained nurse must be available at all times when children are admitted for Day Case Surgery. In order to mitigate this risk and ensure that paediatric operations are not cancelled on DSU, an agreement was made that the paediatric outreach nurse will support DSU with paediatric patients whenever possible. This is agreed on a weekly basis but, due to the unforeseen nature of paediatrics, sometimes, at short notice, the outreach nurse is unable to support DSU. In these circumstances, following a review of bank options with the sisters from Sarum and NICU ward, a paediatric agency nurse may be requested on work on DSU. At the time of finalising this report the Paediatric post on DSU had been recruited to and the post holder is due to commence in March 2020. The Directorate are aware of the need to ensure that this post holder feels part of the paediatric team to avoid a single point of failure scenario in the future, the Head of Nursing CSFS is working closely on this. It is also to be noted that there has been intensive work to ensure that the DSU staff undergo their paediatric competencies and during the Christmas break when lists were down some of the DSU staff were redeployed to Sarum to expedite this.

Paediatric staffing continues to be a challenge within the Emergency department. A business case has been written by the ED matron and ED Lead Paediatric Consultant. This outlines various options to address the limited availability of paediatric trained nurses within ED. No decisions have been made as of yet to the outcome of this business case, which is being led by the medicine directorate with support from the CSFS Head of Nursing in her additional role as trust lead of care of children.

2.4 Trust wide risks and issues considered in the review

2.4.1 Increasing patient acuity/dependency

The development of services and changing demographic of the population continues to result in an evidenced increase in the complexity, acuity and dependency of the patients admitted into the general wards.
Information on the acuity and dependency of patients, including enhanced care needs is available to be reviewed via the SafeCare functionality in Healthroster and is used in real time as part of the daily staffing meetings. This information is also used in the 6 monthly reviews as part of the professional judgement assessment. More robust data will become available on this through the implementation of Shelford Safer Nursing Care tool.

Consideration needs to be given to nurse sensitive indicators which are part of the triangulation when reviewing nurse staffing levels. Overall, nurse sensitive indicators have been seen to be good, however there is currently an increase in Grade 3 pressure ulcers which is of concern. A thematic review is being undertaken to identify key learning points. The burden of the increase in numbers of new staff and a dilute skill mix needs to be taken into consideration and the impact of this will not be seen until the next skill mix review.

2.4.2 Increasing enhanced care needs

The Trust continues to incur expenditure for patients requiring additional nursing care support due to their enhanced care needs. Year to date there has been £360k spend on

enhanced care, of which £241k is in medicine, £98k MSK and £11k surgery. Medicine and surgery are down on last year and MSK has seen an increase, £68k being due to one patient housed during the closure of Glenside and for which the Trust received funding. When this £68k is removed there has been £40k less expenditure year to date, compared to 2018/19. A SOP has been developed and the risk assessment tool updated as part of the on-going work to improve the quality of enhanced care. As the Trust continues to see an improvement in vacancies and over-recruitment in some areas then focus needs to be on rostering to areas of peak demand and channelling temporary bank staff for any required additional staffing.

2.4.3 Vacancies and temporary staffing

Nationally RN vacancies remain high, it is estimated there are about 40-50,000 vacancies across the country. Due to the success of both retention project and international nurse recruitment programme Salisbury is bucking this trend and RN vacancies across the wards have significantly improved since the last review. As of November 2019 there are 115wte RN vacancies, however, there are approximately 80 wte overseas nurses undertaking their transition programme thus the real vacancy position is approximately 30, with several further cohorts due to arrive.

Triangulation of information on vacancies, temporary staffing usage and actions to reduce are reviewed via the Safe Staffing group. Again as of November 2019 nurse agency expenditure is £1,300,000 lower than last year, and overall nursing budgets are £760k underspent. It is acknowledged that there has been a cost pressure in year due to the overseas pipeline being more successful than anticipated due to changes at a national level with requirements set by NMC.

The Trust has participated in cohort 4 of the RN retention programme, and has a series of workstreams in place. Over the year turnover for RNs has reduced from 16.5% (June 2018) to 10.9% (May 2019). The key workstreams are career pathways, flexible rostering, breakfast club for managers and a review of current policies. The Trust has commenced on an improvement programme with Allocate which will see 2 wards pilot self-rostering as part of a wider piece of work on improving flexibility for staff.

Focused recruitment campaigns continue for HealthCare Assistants to increase the numbers of substantive staff with the intention of eliminating agency expenditure in this area. The Trust has been noted to be an outlier for retention of NA's and this has been reviewed as part of the NHSi retention programme.

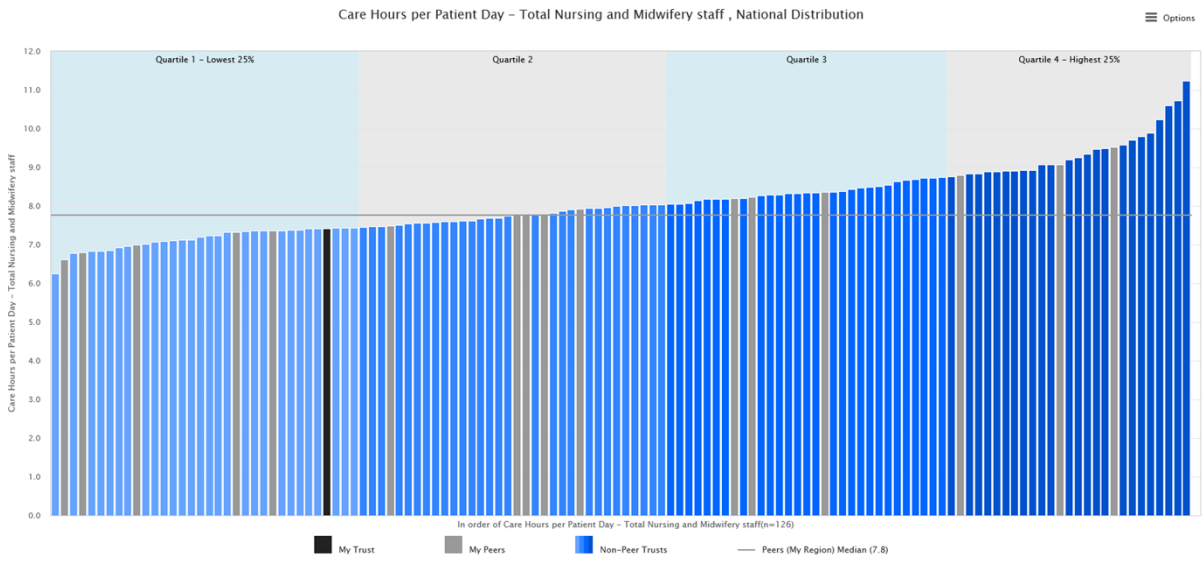
2.4.4 Care Hours per Patient Day (CHPPD)

The national reporting requirements for safe staffing has changed from the planned vs actual hours' methodology to reporting on care hours per patient day. This metric provides a single comparable metric for recording and reporting nursing and care staff deployment. It's a simple calculation which divides the number of actual nursing /midwifery (registered and non-registered) hours available on the ward per day by the number of patients on the ward at midnight. It represents the average number of hours that are nominally available to each patient that day.

Within model hospital comparisons can be seen at both ward and trust level, however caution is required as the specific configuration of services in any organisation determines the level of staffing required. The data in the model hospital provides the opportunity to review staffing levels through another lens, ask questions and challenge and evaluate whether staffing levels are safe.

As previously highlighted going forward Nursing Associates (but not Assistant Practitioners) will be shown separately to RNs and HCAs.

The graph below is taken from Model hospital, SFT whilst not the lowest appears is in the lowest quartile (data Nov 19):



3. Conclusions

A significant improvement has been made with recruitment and retention over the last year with benefits to the experience of both our staff and patients. However, this brings with it a high proportion of the workforce who are adjusting to a new place/country of work and the support requirements that this entails. There will also follow a requirement to focus much more on the on-going agency spend to understand the gaps in workforce from a safe staffing perspective to understand what is driving this temporary spend (even though reducing).

Nursing continues to demonstrate effectiveness in deploying workforce efficiently as seen in both INSIGHTs data which is reviewed monthly at Safe Staffing Group and an overall underspend in nursing expenditure, including over £1m reduction in agency spend ytd.

Good progress has been made against ensuring nursing continues to meet the requirements of the national publications on nurse staffing, and the responsibilities in Developing Workforce Safeguards.

SafeCare CHPPD data has shown some areas to require additional investment which is supported when triangulated with professional judgement and these are identified as recommendations within this paper. However, it is noted the requirement to undertake a formal review in 2020 using the Safer Nursing Care tool in a systematic way.

Overall quality of care continues to be maintained according to reportable nurse sensitive indicators despite the challenging environment of increasing acuity and dependency and some changes to the definitions of some of the measures such as pressure ulcers and clostridium difficile alongside the noted concern of the increase in grade 3 pressure ulcers.

The Director of Nursing on acceptance of the recommendations considers the nurse staffing model to be safe, effective and sustainable and reflective of current levels of acuity and dependency – this will be subject to an annual review.

4. Recommendations

- To note the findings of the full ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
    - SFT nursing establishments are set to achieve an average of 1:5 – 1:7 registered to patients across the majority of wards during the day
    - Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing including Developing Workforce Safeguards.
- To note the requirement to implement Safer Nursing Care tool to provide additional assurance that nurse staffing levels are safe.
- To continue momentum on actions to fill vacancies and reduce retention to continue the reduction on the reliance on high cost agency. This year it will include a specific project on flexible rostering, which the Trust are piloting with Allocate Healthroster.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To agree the additional investment into staffing as outlined in table 2 below, noting some is offset by runrate and work pattern review:

Table 1

Areas Identified in Skill Mix Review	**£ amount**	**Comments**
MEDICINE		
Hospice: Uplift B5 to B6 Uplift B2 to B4	 £9,280 £3,780	Supported
Farley: 1 x B5 Night shift (2.55wte) 1 x B2 Night shift (2.55wte) 1 x B2 Late shift (1.66wte)	 £99,288 £74,505 £48,501	 Supported Not supported at this review Not supported at this review *Both require further review following SNCT*
Tisbury: 1 x B2 Night shift (2.55wte)	 £74,505	 Not supported at this review *Requires further consideration following SNCT*
Redlynch: 1 x B5 Day shift (2.55wte) 1 x B2 Night shift (2.55wte)	 £85,116 £74,505	 Not supported at this review *Requires further consideration following SNCT*
Durrington 1 x B5 Day shift (2.55wte)	 £85,116	 Supported 1 x RN on early shift so £55,409 cost *Requires further consideration* ***following SNCT and in conjunction with AFU business case***
AMU: 1 x B5 Night shift (2.55wte)	 £99,288	 Not supported at this review – but will require funding when in escalation
Spire: 2 x B2 Day Shift (5.1wte) 2 x B2 Night Shift (5.1wte)	 £120,335 £149,010	 Supported x 1 HCA on night shift so £74,505 cost *Requires further consideration following SNCT*
Pembroke: 1 x B2 Early shift (1.33wte)	 £31,381	 Not supported at this review
ED: 1 x B5 Paed Nurse (2.55wte) 1 x B7 Paed Sister (1wte) 1 x B4 Day Shift (2.55wte) 1 x B4 Night Shift (2.55wte)	 £85,116 £51,227 £75,924 £87,639	 All posts subject to separate business cases
SURGERY		
Britford: 1 x B5 Late shift (1.66wte) 3hrs per day B5 (0.6wte)	 £55,409 £20,027	 Supported
Breamore: 1 x B5 (or 4) Day shift (2.55wte)	 £85,116 (£75,924)	 Supported at band 4
Downton: 1 x B5 Late Shift (1.66wte) 1 x B2 Twilight shift (1.33wte)	 £55,409 £38,060	 Not supported at this review *Requires further consideration following SNCT*
MUSCULO-SKELETAL		
Chilmark: 1 x B2 Late Shift (1.66wte) 1 x B5 Night Shift (2.55wte)	 £48,501 £99,288	 Supported with costs covered by change in shift patters

Table 2

Proposed Investment for 2020/21 **Areas supported**	**£ amount**	**Comments**
MEDICINE		
Hospice: Uplift B5 to B6 Uplift B2 to B4	 £9,280 £3,780	Supported with B5-B6 change in current run rate
Farley: 1 x B5 Night shift (2.55wte)	£99,288	Supported, and post to be used flexibly across Medicine footprint
Spire: 1 x B2 Night Shift (2.55 wte)	£74,505	Supported x 1 HCA on night shift with expectation of offset in enhanced care costs
Durrington: 1 x B5 Early Shift	£55,409	Supported pending Acute Frailty Unit business case
SURGERY		
Britford (SAU): 1 x B5 Late shift (1.66wte) 3hrs per day B5 (0.6wte)	 £55,409 £20,027	Supported and in current run rate
Breamore: 1 x B5 (or 4) Day shift (2.55wte)	 £85,116 (£75,924)	Supported at band 4
MUSCULO-SKELETAL		
Chilmark: 1 x B2 Late Shift (1.66wte) 1 x B5 Night Shift (2.55wte)	 £48,501 £99,288	Supported with costs covered by change in shift patters
TOTAL (Supported Costs):	£541,412	NB: Chilmark costs are offset by implemented changes to shift patterns, so total costs are **£393,623** Of this Britford costs have been in runrate this year and Spire costs expected to be offset by reduction on specials expenditure leaving **£243,682**.

References

1. National Quality Board. How to ensure the right people, with the right skills, are in the right place and the right time: A guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013.

2. National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: London: NQB. 2016.

3. NHS improvement. *Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing*. NHSi. 2018

4. Francis R. Independent Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London: The Stationary Office, 2013.

5. National Institute for Health and Care Excellence (NICE). *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE 2014. Available from https://www.nice.org.uk/guidance/sg1/resources

6. National Quality Board. Safe, sustainable and productive staffing. An improvement resource for the deployment of nursing associates in secondary care. NQB. 2019.

7. The Shelford Group. Safer Nursing Care Tool; Implementation Resource Pack 2014.

National Quality Board Expectations for Safe Staffing
Safe, Sustainable and Productive Staffing (July 2016)

Expectation 1: Right Staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six 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. Safe staffing is a fundamental part of good quality care, and the CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.
Expectation 2: Right Skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services and there is a staffing resource that reflects a multi-professional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.
Expectation 3: Right Place and Time	Boards should ensures staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at Board, if concerns arise. Directors of Nursing, Medical Directors, Directors of Finance and Directors of Workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

	Descriptor	No	Recommendation	Current measures in place	Assessed SFT rating C-compliant A-actions required	Identified actions required	Timescale	Lead
Expectation 1: Right Staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six 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. Safe staffing is a fundamental part of good quality care, and the CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	**1.1 Evidence-based Workforce Planning**						
		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource	Triangulated approach to skill mix reviews well embedded. Shelford SNCT used and embedded in SafeCare as part of e-rostering. NICE guidance systematically reviewed	C	Continue with current approach and further develop use fof CHPPD and SafeCare	Complete	DDoN
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and enable benchmarking with peers	All tools used as recommended	C	Continue to monitor use of SafeCare to ensure no local modification	Complete	DDoN/E-roster lead
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave eg sickness, parental leave, annual leave, training and supervisions	Headroom 19%. Uplift reviewed at each skill mix review. Wards budgeted at out-turn so makes some provision.	PC	Change to establishment headroom to be agreed by DoF / DoN	Paritially Complete	DoN/DoF
		1.2 Professional Judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6-monthly staffing reviews which are face to face meetings with Ward Lead, DSN and Deputy DoN. Range of indicators including quality, HR, finance and ratios are reviewed alongside professional judgement	C	Continue with current approach and further develop use fof CHPPD and SafeCare	Complete	DDoN/DSNs/ Ward Leads
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing to reflect changesin case mix, acuity/dependency and activity.	Professional judgement used as part of twice daily staffing meetings.	C	Continue with current approach and further develop use fof CHPPD and SafeCare	Complete	DDoN/DSNs
		1.3 Compare Staffing with Peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Benchmarking with peers via INSIGHTs. Data being entered into Model Hospital	C	Next review will include data from Model Hospital	Complete	DDoN
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides the context for differences in staffing mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design and patient acuity and dependency	All considered as part of systematic staffing reviews	C	Continue with current approach and horizon scan for further opportunities	Complete	DDoN
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparitive data on staffing and skill mix with other efficiency and quality metrics eg for acute inpatients, the model hospital dashboard will include CHPPD	Quality/HR/finance indicators reviewed at Skill Mix reviews. Data entered into Model Hospital but needs further focus on analysing data	c	Continue to work with Allocate and NHSi on Heatmap work looking at CHPPD metrics - complete	Complete	DDoN/E-roster lead
	Boards should ensure clinical leaders and managers are appropriately dveloped and supported to deliver high quality efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive serv ices. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an idenified need or skill gap.	**2.1 Mandatory training, development and education**						
		2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated appoach outlined in the document.	All frontline leaders skilled to manage staffing agenda, roster masterclasses, and training for new ward leaders. Recent NHSi work on heatmaps shows good roster management	C	Continue to maintain competence, skill and knowledge through on-going masterclasses and staffing reviews	Complete	DDoN/E-roster lead/DSN
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.	19% headroom allowance (excluding maternity leave). Rosters show average of around 23% needed (excluding maternity leave). Ward leads get 4/5 days supervisory allocated but only taking approx 50% due to staffing pressures	PC	Continue through skill mix reviews to demonstrate need for additional headroom. Continue to review supervisory time. Continue roll out of CLIP model to support students	On-going - DoF and DoN to agree any change to headroom	DDoN/E-roster lead/DSNs/Ed ucation team

Expectation 2: Right Skills		2.1.3	Those with line mangement responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals and support to revalidate and maintain professional registration.	JDs articulate management responsibilities, compliance with appraisals and training monitored. All staff successfully revalidated so far	C	Continue to keep oversight of JDs and continue to monitor compliance through HR metrics and skill mix reviews	Complete	DDoN/DSNs/HR
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisations training and development strategy, which also aligns with Health Education England's quality framework.	Training needs analysis completed at ward level, further work required to bring this into comprehensive trust approach	PC	Work with HR and L&D to agree approach. Forms part of People Strategy	On-going	HRD/Head of L&D
		2.1.5	The organisation develops its staff skills, underpinned by knowledge and understanding of public health and prevention, and supports behaviour change work with patients, including self-care, well-being and an ethos of patients as partners in care	Implementing MECC and Health Coaching with nurse specialists	C	Continue to implement	On-going	DDON/Patient safety lead
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	QI approach throughout the organisation being established. Working across boundaries much more developed within Thearpy working	C	Identify areas where this should be prioritised and piloted such as OPAL QI methodology being rolled out	On-going	Head of Transformation
		2.1.7	The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	Ward sisters have 80% allocated supervisory time. Ward sister development sessions run quarterly. Intensive support programmes run where concerns regarding leadership of clinical area	C		Complete	DDoN/DSNs
		2.2 Working as a multiprofesssional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clincial duties and decisions about patient care	Involved in national pilot of Nursing Associate roles, utilising APs, reviewing options such as pharmacy techs delivering medicines, ward administrator in place in surgery and looking to implement ward housekeeper role	C	Continue to review all opportunities for delivering workforce differently	Complete	DDoN/DSNs/Education
		2.2.2	The organisation recognises the unique contributution of nurses, midwives and care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity as shown in the literature	Strong evidence for staff pursuing extended roles as part of skill and service reviews	C	Continue to expose opportunities for new ways of working within the MDT	Complete	
		2.2.3	The organsiation works collaboratively with others in the local health and social care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries	Evidence through introduction of models such as OPEL and ESD	C	Continue to seek out opportunities to work collaboratively with other professions and sectors	Complete	
		2.3 Recruitment and retention						
		2.2.1	The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	Strong equality and diversity lead in the organisation, with compliance monitored through separate subgroup. Deputy DoN sits on this group	C	Separate Equality & Diversity plan, reported through to Board	Complete	E&D lead/Director of HR
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid the over reliance on temporary workforce	Full recruitment strategy for nursing in place. Safe Staffing Group established - review all associated data and agrees actions	C	Further work required on retention of staff - part of NHSi Collaborative	On-going	Deputy DdoN/Deputy DHR

		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	This is an area where we could improve knowledge on the issue. Approaches to retention and development tend to be localised	C	Addressed through retention workstream	Complete	DDoHR
Expectation 3: Right place and time	Boards shoule ensure staff are deployed in ways that ensure patients receive the right care, firsts time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at Board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the orgnaisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	**3.1 Productive working and eliminating waste**						
		3.1.1	The organisation uses 'lean' working principles such as the productive ward, as a way of eliminating waste	Transformation/PMO incorporates lean techniques	C	Continue to ensure lean techniues are used as part of system transformation	Complete	PMO
		3.1.2	The organisation uses pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queuing	Incorporated into service redesign eg reprovision of AMU, RACE etc	C		Complete	PMO
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources	Staff are employed to be fully flexible (skills and competence allowing), skills being incorporated into rostering system, daily staffing reviews ensure staffing allocated to acuity and dependency	C	Continue to review as part of daily staffing meetings	Complete	DDoN/DSNs
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff	Staff are employed to be fully flexible (skills and competence allowing), skills being incorporated into rostering system, daily staffing reviews ensure staffing allocated to acuity and dependency	C	Continue to review as part of daily staffing meetings	Complete	DDoN/DSNs
		3.1.5	The organsiation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing wasted time is a key priority.	Included in the methodology for skill mix reviews eg looking at how other roles can be incorporated into ward based nursing	C	Continue with current approach	Complete	DDoN/DSNs
		3.1.6	Systems for manageing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed	Clear escalation process for managing staffing risks. Red flag reporting in place. Monthly staffing report to Board inlcuding mitigation	C	Contnue with current processes and monitor trends with staffing risks	Complete	DDoN/DSNs/Risk
		3.2 Efficient deployment and flexibility						
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	All ward/dept leaders involved in 6-monthly skill mix rievews and the setting of establishment levels and reviewing rostering templates. Six monthly check and challenge meetings	C	Continue with current approach, ensure all new ward leaders are given training as part of induction	Complete	DDoN/E-roster/DSNs
		3.2.2	Clinical capacity and skill mix aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow	Clinical specialty, acuity and dependency via SafeCare and pathways included as part of systematic skill mix reviews	C	Continue with current approach and ensure staffing requirements feed into site reconfiguration	Complete	DDoN/DSNs
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs	Twice daily staffing meetings that use SafeCare which compares actual and required, and linked to site requirements	C	Continue with current approach	Complete	DDoN/DSNs
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are award of the steps to tkiae where capacity problems cannot be resolved	Twice daily staffing meetings, escalation policy for unresolved staffing issues. Temporary staffing escalation policy sits alongside	C	Continue with current approach and review escalation procedures to ensure remain fit for purpose	Complete	DDoN/DSNs/Site
		3.2.5	Meaningful application of effective e-rostering polices is evident, and the organisation uses available best practice from NHSi Employers and the Carter Review Rostering Good Practice Guidance (2016)	Best practice guidance used and included in rostering policy. Twice yearly check and challenge meetings for all wards. INSIGHTs measures effectivenss via KPIs. NHSi heatmap work complete - showing best in class rosters	C	Continue with current approach and remain aware of future guidance	Complete	DDoN/E-roster lead
		3.3 Efficient employment, minimising agency use						

		3.3.1	The annual strategic staffing assessment gives boards a clear medium term view of the likely temporary staffing requirements. It also ensures discussion takes place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency) as reflected by NHSi Improvement Guide.	Twice yearly staffing review, includes review of vacancies and HR metrics to focus on substantive fill. Effective in-house bank. Robust relationship with procurement and agencies. Weekly and monthly reporting on temp spend. Clear links to recruitment strategy	C	Continue to maximise all opportunities to reduce agency spend	Complete	DDoN/DSNs/E-rostering/HR
		3.3.2	The organisation is effectively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplemenetary guidance and timescales	Continued focus on agency spend, tiering system to apply caps, process for break glass	C	Continue with all actions to reduce temporary staffing spend, increase bank use and ensure safe staffing	Complete	DDoN/DSNs
		3.3.3	The organisations work plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population	Good engagement with STP workforce group led by Director of OD and People	C	Continue to work with the STP as well as Wessex workforce groups to ensure plans are built around a population base	On-going	DOD&P
		3.3.4	The organisation works closely with commissioners and with Health Education England and submit the workforce plans they develop as part of the STP, using th defined process to inform supply and demand modelling	as above	C	a/a	On-going	a/a
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable services.	Annual review of all clinical placements, utilising hub and spoke model, new initiatives with specialist nurses as hub. Quality reviews with University. Introducing CLIP model.	C	Continue to review all options for clinical placements	Complete	DDoN/Education

Ward	Directorate	Specialty	Beds	RN			Ratios		
				E	L	N	E	L	N
AMU	Medicine	Medical Assessment Unit	19 beds + 10 assessment trolleys	6	6	4(5)	3.1	3.1	4.8
Durrington	Medicine	Acute Frailty Unit	21	3	3	2	7	7	10.5
Farley	Medicine	Stroke	30	5	5	3	6	6	10
Pembroke	Medicine	Oncology	10	2	2	2	6	6	6
Pitton	Medicine	Respiratory	27	5	5	4	5.4	5.4	6.7
Redlynch	Medicine	Gastroenterology	27	4	4	3	6.7	6.7	9.0
Spire	Medicine	Elderly	30	4	4	3	7.5	7.5	10.0
Tisbury	Medicine	Cardiology	23 inc 5 CCU	6	6	4	3.8	3.8	5.8
Whiteparish	Medicine	Endocrinology	23	4	3	2	5.7	7.6	11.5
Hospice	Medicine	Palliative Care	10	2	2	2	5	5	5
Amesbury	MSK	Elective Ortho	32	4	4	3	8	8	10.6
Chilmark	MSK	Trauma	24	4	3	2	6	8	12.0
Odstock	MSK	Burns and Plastics	17	4	3	3	4	5.6	5.6
Longford	MSK	Spinal (inc respiratory)	42	7	6	5	6	7	8.4
Breamore	Surgery	23-hr stay Surgery	20	3	3	2	6.6	6.6	10
Britford	Surgery	General Surgery with high care	20 + 6 assessment	5	4	3	4	5	6.6
Downton	Surgery	General Surgery	24	4	3	2	6	8	12
Radnor (ICU)	Surgery	Intensive Care	10	routinely, staffing needs to reflect levels of care L3 1:1,					
Sarum	CSFS	Paediatrics	14 (can increase)	3	3	3			

NB ratios are based on planned staffing establishment vs bed numbers. The ratios can increase if shifts not filled, decrease if empty beds on ward

The ratios are pre any agreed skill mix changes approved by Board

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1a
Date of Meeting:	05 March 2020		

Report Title:	Midwifery and Neonatal Nursing Skill Mix Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	X
Prepared by:	Fiona Coker – Head of Midwifery			
Executive Sponsor (presenting):	Lorna Wilkinson – Director of Nursing			
Appendices (list if applicable):	Appendix 1 - Midwife to Birth Ratio Appendix 2 – Birthrate Plus Report December 2019 Appendix 3 - 1:1 Care in Labour			

Recommendation:

The Board are asked:

- To note the initiatives and the on- going progress in recruitment of midwives and neonatal nurses.
- Note the current maternity staffing and challenges with maternity leave and acuity
- To be aware of the dynamic nature in maternity services, driven by national drivers (Better Births/Continuity of Carer), local drivers (alongside midwife led unit progressing) and increasing complexity which will continue to require an evolving workforce model
- For the board to support the recommendations from the recent birth rate plus assessment being worked up in further detail to submit to the workforce summit. The Birth-rate+ assessment has identified a shortfall of 5.48 posts (total cost circa £250k across clinical and non-clinical roles)
  The recommendations of the Birth rate plus assessment have been considered, alongside the recent concerns around incidents reported and therefore the priority and first stage of investment requested is for a triage midwife (cost of £140,923).

Executive Summary:

The annual nursing skill mix report is presented to Trust Board, as per the requirement of the National Quality Board (2013;2016) and Workforce Safeguards (2018) expectations for Boards to ensure themselves of safe staffing. This paper is provided as assurance to Board that the staffing model within maternity and neonatal services is safe and sustainable.

Maternity
Recruitment and retention activity continues in both areas and it is highlighted that sickness and maternity leave does pose a challenge to the operational delivery of staffing levels on a day to day basis. The Head of Midwifery is working closely with the Directorate Management team and HR Business partners on this.
Midwifery and Maternity services are subject to national strategic drivers for change in improving safety and outcomes and this will require a new model of working. It is anticipated that this will result in further analysis and workforce investment required as a result of implementation of caseload working linked to Better Births, and more locally the introduction of an alongside Midwifery led unit.
Our quality metrics currently are positive with assurance around 1:1 care in labour, midwife to birth ratios, and the feedback we receive from women about the service through the national survey
The service has undergone a Birth Rate Plus review of skill mix and case load and the report from December 2019 is attached as an appendix. It is recommended that the shortfall in midwives (5.48) identified by this review is worked up in detail for the upcoming workforce summits but as a priority we are proposing investment in a senior triage midwife to carry out telephone assessments and advice across the Day Assessment Unit (DAU) and Labour ward. This is a function identified as a result of learning from Serious Incidents in 2018 and the current remodelling of pathways into DAU.

Neonatal
The Neonatal Unit has reduced both vacancies and turnover and we perform well in the number of nurses with specialist neonatal training (78%)
Quality outcomes in this area remain positive

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

Midwifery staffing report January 2020
Report from: Fiona Coker- Head of Maternity and Neonatal Service

1. Purpose

The maternity workforce is reviewed utilising National published responses to maternity staffing:

- Safer Childbirth: Minimum standards for the organisation and the delivery of care in labour (RCOG, RCM 2007, NICE2019).
- Birth rate Plus (Salisbury assessment 2019).
- National Quality Board (2018). Safe, sustainable and productive staffing - An improvement resource for maternity services
- National Maternity Review: - 'Better Births' (2016) – A five year forward view for maternity care.

Maternity Workforce Strategy- Transforming the Maternity Workforce HEE. March 2017 **The maternity management team reviews the service and workforce in line with the recommendations and standards outlined in the above documents on a monthly basis and staffing is reviewed through the '*Safer staffing*' committee.**

2. Maternity Services staffing review methodology

2.1 The Salisbury maternity services have a budgeted establishment of 86.86 WTE (including the Head of Maternity). Under the Birth-rate plus methodology 9% of this should be in non-clinical roles such as leadership, management and specialist roles such as Breastfeeding specialists and Antenatal and Newborn screening teams, safeguarding.
NICE 2019 recommends a midwife to birth ratio of 1:25 for a DGH service. We are not currently meeting this new ratio. (See appendix 1).The ratios are analysed monthly and are affected by fluctuating birth numbers. Following the original Birth rate plus assessment in 2015 there was investment of 10 WTE registered midwives, there has been a subsequent assessment by birth rate plus in summer 2019. The report recommends a further 5.4 WTE midwives are required. This is due to the amended NICE recommendations of midwife to birth ratio, and the continually increasing complexities of women accessing maternity services, especially through the antenatal services. The current birth rate plus assessment for 2019 is included in appendix 2.

Nationally and locally there has been a fall in birth numbers over the last 2 years and whilst this has enabled the service to meet recommended ratios at times this has resulted in a drop in clinical income. However the acuity of women is creeping upwards and this has resulted in longer lengths of stay for women with complications in the antenatal period.

2.2 Non-registered staff are utilised both in the hospital and community as appropriate. **However it is difficult to utilise staff in bands 2 and 3 as their input is restricted to basic postnatal care or postnatal screening only.** There is good uptake from the maternity care assistant bank cohort and rosters are filled with staff working flexibly.

2.3 The NICE clinical standard (55) dictates that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a trainee midwife under direct supervision. This is audited monthly (appendix 3) and demonstrates excellent compliance as the care of labouring women is always the priority and escalation is utilised when needed to ensure this.

2.4 National Quality Board (2018). *Safe, sustainable and productive staffing*. An improvement resource for maternity services. This guidance outlines the expectation of the 'Better Births- A five year forward view' agenda and is helpful in terms of the 'Continuity of Carer' element of the service that all maternity services are working towards. Continuity for 20% of women throughout the complete

pregnancy, birth, and post-partum period was mandated for March 2019 and a figure of 35% is required for March 2020. The 13 month continuity pilot ended in November 2019, the original team of midwives providing continuity of care continues and as of March 2019 we met 12.7% compliance. This does not benchmark too negatively against other Trusts as the struggle has been universal. This has proved popular with women and we are aspiring to improve this percentage. 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. A project midwife funded by the LMS, came into post April 2019 for 18 months to assist with workforce planning for change which will be subject to a business case. There is a current consultation process in place with the overall aim of meeting this National standard in March 2021.

One of the safety standards mandated is the need to have a 'supernumery leader' on every delivery suite shift. This has been reinforced and continues to be implemented at SFT and is recognised as an absolutely essential element to ensure safety with an increasingly junior workforce.

2.5 Recruitment has been variable in the last 6 months and we recognise that there is a need to balance the junior workforce with experienced staff and these are a little harder to come by. The vacancy rate currently sits at 4.27 WTE out of an establishment of 86.86 WTE as of January 2020. These vacancies have been mitigated by a lower birth rate and the use of bank staff ensuring safety and adequate 1:1 care in labour provision. This vacancy rate does not include the recommendation from the birth rate plus assessment in summer 2019 which recommends a further 5.4 WTE of midwives.

The service has focused on turnover the last 12 months.
The maternity service continues to be an area where there are high numbers of staff on maternity leave. This has been an increasing issue throughout the previous 18 months and is predicted to continue to be above the national average throughout 2020. It has consistently been above 4 WTE and at times as high as 9 WTE. Absence has been problematic with an overall rate of 8% amongst registered staff and 10% within the non-registered. These percentages are impacted by long term sickness in a small proportion of the workforce. The service is working closely with Occupational health and with HR and all staff are on the appropriate processes within the Management of Attendance policy
Last year this was mitigated by permission from the board to over recruit by 5 WTE. In fact, this resulted in 'recruiting to turnover' but it did mean that there was no reliance on agency staff. This has once again been agreed at board.
The maternity quality indicators have remained stable in the last 6 months despite turnover. As an acute service, activity is difficult to predict so a robust escalation policy is in place within maternity which is heavily reliant on the community workforce and this has impacted on the willingness of staff to work in the community model

It has been recognised that over the past 12 months, there has been an increase in the number of SIIs within the maternity services, with a significant number sitting within the ante natal service. This has prompted an analysis of the care provision offered and it is evident that a core of experienced, consistent midwives is required to ensure a safe service where safe, evidenced care is given to these high risk women. An area flagged as a concern has been the triaging process across the service. In the day assessment unit the phone calls from women and GPs/other health practitioners is a constant distraction and calls are taken in a busy office which has been identified as a contributory factor to the stress of working in this area, it also carries patient safety concerns. Equally on the Labour Ward – calls from women at home are constant throughout the shift and mean that the coordinator is split between having clinical responsibility and oversight of the women on labour ward as well as those calling in. Again these calls are taken within the main office and are subject to many distractions. This highlights that triaging of women into the service is not dedicated to an area or role, has the potential to significantly impact on safety in the antenatal and intrapartum areas and is inconsistent at present. It is therefore recommended that this is reviewed as a priority and consideration of calls going through a triage midwife in a dedicated area is implemented to cover times of peak demand.

2.6 There continues to be an evidenced increase in women with medical and social complexities and in addition the antenatal surveillance arising from the 'GAP' programme has identified an increase in the number of 'small for gestational age babies. This has led to a significant rise in the acuity, particularly the induction of labour numbers within the service. The activity, acuity and dependency are regularly analysed as the staffing need is not just about birth numbers. Maternity utilises an evidence based acuity tool (Birth rate plus) and this is measured every 4 hours within the labour ward on every shift. However there has been no means to identify the acuity within the postnatal area and the service aims to address this with the Post-natal acuity tool that will be offered as part of the new 'Birth rate' assessment.

2.7 The department has commenced work within the Maternity and Neonatal Safety Collaborative. As part of this national initiative the department has undertaken a 'culture survey.' This has demonstrated that there is work to be done to improve the team work and this forms part of the Maternity Improvement Plan. Turnover, and in particular retention, needs constant attention. Nationally there is an expectation that Professional Midwifery Advocates (PMAs) are in post. This is to provide clinical restorative supervision and alongside the leadership team, this team will aim to enhance morale and enhance the value that staff feel they have; there are now 4 PMAs in post totalling 60 hours per month, these hours are currently worked additionally to their substantive work.

3. Challenges:

3.1 The maternity department staffing is complex, with 6 rotas in place and staff often working between several of the areas. Transparency on this has improved since the introduction of electronic rostering

3.2 In the 2016 National Maternity Review 'Better Births' (NHS England 2016) was published outlining expectations for a five year forward vision for maternity services. Within the vision document a model of case loading midwifery is recommended across all services with the aim of providing continuity of care throughout pregnancy, intrapartum and postnatal period, delivered within midwifery teams of 4-6. Considerable additional midwifery resource of approximately 10 WTE will be required if the service does adopt a fully case loading team model of midwifery as recommended within 'Better Births'. The development of this model is still being worked through and would be subject to a business case.

3.3 The Department has seen an increase in activity and risk through the day assessment unit. There have been some Serious Incidents relating to this which has resulted in a full review of the area and the need for a dedicated triage midwife has been identified in order to stream calls away from those directly delivering care. . Triage is not formalised across the department and currently falls to the labour ward coordinator and in DAU to the Registered Midwife on duty. By staffing a dedicated triage service across these two areas the leader on labour ward is enabled to focus on supporting the intrapartum activity and workforce, similarly, the midwife on DAU can focus on assessing arriving women and carrying out any reviews/interventions required. The triage midwife may be categorised as a 'non-clinical' role as it is not directly patient facing

3.4 The workforce is overall now much more junior from an experience perspective. It is therefore increasingly important that the lead midwife on labour ward is case load free and able to coordinate the unit giving advice and support where needed.

3.5 The numbers of births through the service in 2018-19 was 2217, a slight increase in the number predicted. The numbers for 2019-20 are similar. There is uncertainty about the repatriation of troops and families. The expectation is that this will lead to approximately additional 200 births over the next 18 months. The number of women booking to birth at SFT is analysed monthly and the risks associated with those bookings. The data suggests that the number of high risk women continues to rise which highlights the need to understand acuity.

3.6 The maternity bank staff numbers have remained steady over the last 12 months and the majority of the bank contingent is contracted staff who will when possible work additional hours. There has been no use of agency in maternity since January 2018.

3.7 The department has been awarded CCG money to construct a Midwifery-led birth unit (MLU) within the existing footprint. Plans are in place with an aim for this work to be completed by December 2020. This is a positive step for choice for women and will support any contingency in capacity needed when the military repatriation is completed. Leadership and support staff will be the main staffing requirements for this new venture. This will be a change and so will be addressed through a business case.

4. Strategies in place for maintaining recruitment and retention of staff

4.1 The following strategies are being utilised to maintain the recruitment and retention across the maternity workforce:

- Early advert to capture newly qualified 'home grown' staff- This resulted in successful recruitment of 5 newly qualified staff who started in October 2019
- Support from the board to recruit to turnover to manage vacancies and to cover maternity leave to remove the need to resort to agency staff
- Monthly assessment of staffing and effective forecasting.
- The introduction of PMAs who will enhance the clinical support needed for the junior staff.

5.0 Recommendations

- To note the initiatives and the on- going progress in recruitment.
- Note the current maternity staffing and challenges with maternity leave and acuity
- To be aware of the dynamic nature in maternity services, driven by national drivers (Better Births/Continuity of Carer), local drivers (alongside midwife led unit progressing) and increasing complexity which will continue to require an evolving workforce model
- For the board to support the recommendations from the recent birth rate plus assessment being worked up in further detail to submit to the workforce summit. The Birth-rate+ assessment has identified a shortfall of 5.48 posts (total cost circa £250k across clinical and non-clinical roles) The recommendations of the Birth rate plus assessment have been considered, alongside the recent concerns around SIIs and the priority and first stage of investment requested is for a triage midwife (see below).

Birth-rate+ Recommendations	**£ amount**	**Rationale**
2.55 wte Registered Midwife Band 6	£140,923.20	The priority area under consideration is maternity DAU, as currently this is the area of highest risk and in particular, telephone triage. The Triage would initially operate alongside DAU as a 12 hour shift 7 days a week. Local intelligence indicates this is when the majority of non-labouring telephone activity occurs. The DAU activity transfers to labour ward at night and weekends and unscheduled antenatal activity tends to be lower at night.
Total	£140,923.20	

Neonatal Staffing

1. **Purpose**

- The review has been undertaken utilising National published recommendations for Neonatal staffing:
- British Association of Perinatal Medicine (BAPM) June 2018
- National Quality Board (2016). Safe, sustainable and productive staffing - An improvement resource for neonatal care Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time- Safe, sustainable and productive staffing.
- National Institute for Health and Care Excellence (NICE) quality standard (QS4) for neonatal specialist care (2010),

The senior neonatal nurse and the head of maternity and neonatal services reviews the service and workforce in line with the recommendations and standards outlined in the above documents on a monthly basis.

2. **Neonatal Services staffing review methodology**

2.1 A neonatal nursing workforce review was undertaken in 2016 following a reduction in cots in line with activity and was implemented in November 2016. The department has been in escalation on 18 days from June 2019 to December 2019. The service has had higher acuity against plan in the first quarter of 2019 because of a rise in the number of Intensive care babies. This increase did not exceed the cot occupancy on the neonatal unit and was successfully mitigated by NICU staff, Maternity staff and the use of bank nurses. The second quarter was due to the unit being over capacity with special care infants which was mitigated in the same way.

2.2 All units within the local Neonatal network are utilising a recognised acuity tool (Badger) which enables staff to consider the staffing, capacity and activity in real time and activate escalation when necessary. The senior nurse produces a monthly acuity report to there is clarity around activity.

2.3 Within the staffing numbers 70% of RNs are expected to be Qualified in speciality (QIS) and the unit is currently at 78%. This is an improvement from 68% in December 2018. The service has recruited 1 WTE nurse who is experienced, but not QIS trained.. There will be one more 0.92 WTE on the training this year (2020). The QIS training has come out of the university set-up and will be delivered by the neonatal network with the backing of Health Education England (HEE). Salisbury has been asked to deliver some QIS content on a regular basis which has been agreed by the Head of Maternity & Neonatal Manger. This process will reduce the ongoing cost to Salisbury in securing QIS places in the future. QIS training may require some backfill to enable staff to complete the qualification but this has been, and will continue to be managed successfully with experienced nurse bank.

3 **Challenges**:

- Key challenges within the neonatal unit have been short term sickness which has been over 3% on average in the first 6 months of the year. To mitigate against this, and maternity leave, the department is recruited to 115% (within the 19% headroom). This enables some readjusting when sickness does occur, and flexibility across post-natal and Sarum when the paediatric service goes into escalation. This reduces the need for agency staff.

- There is a national initiative (ATAIN) to reduce the number of babies admitted to a neonatal service. This demands a transitional care provision which was developed within SFT in 2018 and the neonatal nurses are providing an outreach service to the postnatal ward for transitional care babies.
- The service has a rotational post (1.0WTE) with the children's service to enable newly qualified registered children's nurses to gain experience and confidence in both areas.
- At present there are some gaps in the rota created by maternity leave (2WTE) and 0.6WTE on long term sick.

4. Strategies in place for maintaining recruitment and retention of staff

4.1 The following strategies are being utilised to maintain the recruitment and retention across the maternity workforce:

- 1 staff member undertaking QIS training. Strong investment into QIS training that is now paying dividends (78% of staff with QIS – Highest in the Wessex network)
- Recruited into headroom to allow flexibility within a specialist service to cover maternity leave/sickness resulting in minimal need to resort to agency staff
- Monthly assessment of staffing and effective forecasting.

5.0 Recommendations

- To note the improvements and the on- going progress in recruitment.
- To note and continue to support the plan to maintain the current staffing to manage maternity leave and sickness.

Midwife to Birth ratio APPENDIX 1

Midwives to Births Ratio
(excluding HOM & non clinical time)

Month	Midwives Establishment	Reg Births (E3)	Non Reg Births (E3)	Total Births	Midwife to Birth ratio (rounded)	not rounded	12 Month average
Jun-18	76.21	187	4	191	1:30	30.07	30.3
Jul-18	76.21	176	2	178	1:28	28.03	30.1
Aug-18	76.21	198	0	198	1:31	31.18	30.3
Sep-18	76.21	180	2	182	1:29	28.66	29.9
Oct-18	76.56	194	2	196	1:31	30.72	30.1
Nov-18	76.56	166	3	169	1:26	26.49	29.5
Dec-18	78.56	160	2	162	1:25	24.75	29.2
Jan-19	79.56	184	3	187	1:28	28.21	29.0
Feb-19	79.56	164	1	165	1:25	24.89	28.7
Mar-19	79.56	185	2	187	1:28	28.21	28.7
Apr-19	79.56	162	4	166	1:25	25.04	28.4
May-19	79.96	204	1	205	1:31	30.77	28.1
Jun-19	79.96	167	2	169	1:25	25.36	27.7
Jul-19	79.96	204	3	207	1:31	31.07	27.9
Aug-19	80.16	181	3	184	1:28	27.54	27.6
Sep-19	80.16	196	3	199	1:30	29.79	27.7
Oct-19	80.16	203	0	203	1:30	30.39	27.7
Nov-19	80.16	164	0	164	1:25	24.55	27.5
Dec-19	80.16	183	1	184	1:28	27.54	27.8
Jan-20	80.16	184	3	187	1:28	27.99	27.8

<=1:28
>1:28-<1:35
>=1:35

Notes:
Since Jan 2017 ratio is based on midwife establishment minus non clinical percentage as recommended by Birthrate Plus
(from Oct 2018 actual establishment has exceeded budget to manage Maternity lead cover)
Total Births sourced from E3 reports
Ratios are rounded to nearest integer

BIRTHRATE PLUS®

MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

Salisbury Hospital NHS Trust

Final REPORT –December 2019

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Of course birth outcomes are not influenced by staff numbers alone. Nevertheless a recognised and well-used tool like BR+ is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition BR+ caters for the various models of providing care, such as traditional, community based teams and caseload working. It is sensitive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Any maternity unit and service must be able to assess its staffing needs using a tried and tested system of workforce planning. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs, and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones. The assessment does not yet have scope to make recommendations about continuity models.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff have been applied.

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence based guidelines, on-going monitoring and audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Wards provide care to 'normal' uncomplicated postnatal women needing basic midwifery care, which is often over-shadowed by other women who are more complex cases. This may result in insufficient time being spent with such women who may require considerable assistance with breast feeding and general care of their baby.

The encouragement of early transfer home does mean that the level of midwifery input during their hospital stay is considerable, in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and midwifery support roles. Women and babies are often being seen more in a clinic environment with less contacts at home. However reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Increasingly midwives are undertaking the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have an impact on community resources in two ways. Some women receive ante and postnatal care from their "home" maternity service, but give birth in another. Because these count as extra to the workload related to that recorded in relation to the annual births of a unit they have been termed as "imported" cross border" cases. Salisbury Hospital provides intrapartum care to 170 women and some degree of immediate postnatal to women from another maternity service, but "export" their community care. Adjustments to midwifery establishments have been made to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss so the total number of postnatal women is less than antenatal. Salisbury Hospital similar to most maternity services book approximately 262 women and then have no further contact with the midwife.

SUMMARY: RESULTS/FINDINGS

Salisbury Hospital & Local Community

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 19% for annual, sick & study leave allowance and 15% for travel in community. *A detailed summary is included on page 7.*

The overall clinical establishment for total of 2193 births at Salisbury Hospital is summarised as follows:

[a] Hospital Services	59.80 wte
[b] Community Services	26.10 wte
TOTAL CLINICAL WTE	**85.90 wte**
[c] Additional non-clinical midwifery 9%	7.73 wte

Discussion of Findings

1. The main factor in the results is the casemix based on 3 months' data from May-July 2019 collected using the BR+ scoring system and validated by the Birthrate Plus Team to ensure data quality was 100%.

2. Within the methodology are national standards which include the minimum standard of 1 midwife to 1 woman for care in the labour, delivery and an additional % m/w increase is applied to Categories III (20%); IV (30% & V (40%). Community antenatal care is based on NICE guidance, as is postnatal care with allocation of average midwife hours for the women to cover their standards a/n & p/n assessments, Parent Education, socio-economic issues and all clinical needs.

3. The annual births are based on 2193 as below:
    - 2112 in Delivery Suite and Obstetric Theatres
    - 81 at Home or BBAs in community

4. The casemix is unique to each individual unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making (*see appendix 1 for Birthrate scoresheet)*.

5. The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Suite and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.

Salisbury Hospital	**Cat I**	**Cat II**	**Cat III**	**Cat IV**	**Cat V**
Casemix	8.1%	13.5%	17.1%	24.7%	36.6%

6 The Casemix indicates that 21.6% of births are in the lower categories I & II with 78.4% in the moderate to high categories, of which 61.3% are in IV & V. Key contributory factors include obesity, Postpartum Haemorrhage, Massive Obstetric Haemorrhage, Prelabour Rupture of membranes (requiring augmentation and IV antibiotics) method of delivery and vulnerability with specific reference to mental health issues. Of the 55 maternity units in England who have undertaken a BR+ assessment from 2015 to 2017, the average % of women in Categories IV & V is 56% ranging from 41 to 69%. Salisbury Hospital at 61.3% is above the average, indicating that a higher % of the population require more clinical input.

7 Category V at 36.6% includes emergency CS, and women with obstetric/medical problems, such as increased diabetes, obesity related problems, mental health and high incidence of complex safeguarding issues

8 The women in Category IV at 24.7% are those having an elective CS or epidural for pain relief with a normal birth. Women with low birth weight/preterm babies; high-risk inductions of labour and PPH fall into this group.

9 Category III women (17.1%) have moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries as well as normal births with continuous fetal monitoring fall into this group.

10 The Casemix in categories III to V wil have the greatest impact on the workload and also for postnatal care on the ward.

11 Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. Ante Natal admissions (595) many of whom are high risk-antenatal cases requiring a period of one to one care.

12 Some additional non-birth activity is caring for women who have a fetal loss prior to 24 weeks gestation (n = 18). On average, there are 18 escorted transfers from Salisbury Hospital to another obstetric unit usually for neonatal reasons.

13 All maternity units have significant antenatal activity that is both planned and unplanned cases and often the latter equate to the actual number of women delivering in the service. Maternity units deal with this activity in a variety of ways, such as via DAU and delivery suite. Staffing has been based on annual episodes of 5160 in DAU and 2120 in Delivery Suite.

14 The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital and used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters. Many babies require additional observation and monitoring in postnatal wards (n=224). There were 52 PN re-admissions which create additional workload and this is factored into the staffing requirements.

15 Midwives now carry out more of the NIPE checks on the postnatal ward which was previously performed by the paediatric team requiring additional resources from the Midwifery team.

16 Induction of labour takes place on the delivery suite the annual total of 906 will be fewer women as some may receive more than one dose of prostin/propess. As with many maternity units there has been a significant increase in the number of women requiring induction of labour as part of the ‘Each Baby Counts’ safety agenda.

17 Outpatient Clinic services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service and will heavily depend on the obstetric specialities provided, complexity of women, etc.

18 The community cases are based on those women birthing in Salisbury Hospital and having all ante & postnatal community care locally plus any women, who may birth in neighbouring units, but belong to the local CCG area. The total number of community cases is 2675, excluding home births, whilst 170 women are transferred to neighbouring Trusts for their community care, there are an additional 90 women who receive ante and postnatal care having birthed in neighbouring hospitals and another 100 who receive post natal care only.

19 There are approximately 260 women who will see a midwife in early pregnancy as per NICE Antenatal Guidelines and the 'Early Contact' recommendation, but do not progress further with their pregnancy. An average 2 hours of midwifery time is allocated to these women.

20 A skill mix adjustment of 95/3% can be applied to the clinical total of 85.90 wte and local community where an average of 3% of the total clinical wte can be competent and qualified support staff usually being Bands 3 & 4 [See Appendix 2]. This equates to 2.58 wte support staff giving postnatal care in community.

21 The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs.

22 The total clinical establishment of 85.90wte does not include the following roles:

- Head of Midwifery & Matrons with additional hours for team leaders to participate in strategic planning & wider Trust business.
- Clinical Governance role
- Time for Baby Friendly Initiative, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
- Additional hours for antenatal screening over & above the time provided in actual clinics
- Coordination for such work as Safeguarding Children

23 The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2016. It is a local decision as to the % increase, for e.g. addition of 9% equates to 7.73 wte. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties.

24 **The Total Clinical & Non-Clinical wte is 93.63wte. Of this total, 2.58wte can be suitably qualified support staff replacing midwifery hours in postnatal care only in the community and 91.07wte midwives proving clinical care and management roles.**

Comparison of Birthrate Plus® staffing totals with Current Funded Establishment based on above dataset

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles and skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff can be applied.

The table below outlines the comparison of Birthrate Plus® results with current funded establishments based on above data and results.

The BR+ clinical staffing is 85.90wte comprising midwives and 2.10 postnatal MSWs Band 3s

The non-clinical midwifery staffing is based on applying 9% to the clinical establishment equates to 7.73wte.

The clinical wte has been adjusted with 97% as RMs at 83.32wte and 3% as MSWs in the community supporting postnatal care at 2.58wte. This is an appropriate skill mix for maternity services with around 2000 births or less where it is essential to have adequate midwives in hospital due to the 'peaks and troughs' of activity on delivery suite. Working with an adjustment of RMs for MSWs on the maternity ward will reduce flexible rostering needed to staff intrapartum services.

Applying the 97/3 skill mix indicates a shortfall of 2.589 wte midwives and 0.48wte MSWs to 'top up' community services – total of 3.07wte.

Of the non-clinical staff, there is a shortfall of 2.33 wte, resulting in a total deficit of 5.40wte clinical and non-clinical staffing.

Salisbury NHS Trust Draft 19/12/2019			
	RMs	**MSWs**	**Bands 5- 7**
Current Total Clinical	79.33	2.10	**83.03**
Contribution from Specialist MWs	1.60		
Total Current Funded	**80.93**	**2.10**	**83.03**
BR+ Clinical wte			**85.90**
Skill Mix Adjustment (97/3)	83.32	2.58	

Variance +/-	2.59	-0.48	
TOTAL CLINICAL VARIANCE			**-2.87**
	BR+	Current	**Variance**
NON CLINICAL (9%)	7.73	5.40	**-2.33**
OVERALL VARIANCE			**-5.40**

SUMMARY of DATA & REQUIRED WTE for

SALISBURY NHS TRUST

First draft 11/11/2019

Data collected May - July 2019

Total births in service **2193**

CASEMIX

	Cat I	Cat II	Cat III	Cat IV	Cat V
% Casemix	8.1	13.5	17.1	24.7	36.6

		Annual No.	Required WTE	
DELIVERY SUITE				
Births		2112	24.24	**24.24**
Other DS Activity				
	Category X	*2120*	1.49	**8.26**
	Ante Natal Cases	*595*	4.33	
	Category R	*165*	0.58	
	Escorted Transfers OUT	*18*	0.07	
	Non-viables	*18*	0.21	
	Inductions	*906*	1.59	
MATERNITY WARD				
Postnatal Care	Postnatal women	*2112*	17.74	**19.66**
	Postnatal Re-admissions	*52*	0.26	
	NIPE	*490*	0.23	
	Extra Care Babies	*224*	1.42	
OUTPATIENT SERVICES				
Antenatal Clinics	Sonography		0.80	**1.95**
	Obstetric Clinics		1.15	
Maternity Assessment Unit		*5160*	5.39	**5.39**
Parent Education			0.29	**0.29**
COMMUNITY SERVICE	Home Births	*81*	2.23	**26.10**
	Community Cases	*2675*	23.44	
	Community Bookings ONLY	*260*	0.33	
	NIPE	*210*	0.10	
			85.90	

CLINICAL MIDWIFERY WTE REQUIRED **85.90**

Additional non-clinical midwifery wte @ 9% 7.73

Using ratios of births/cases to midwife wte for projecting staffing establishments

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will take into account an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

In addition, a % is added (8/10%) to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 112 cases to 1 wte is the correct ratio to apply. To use the 1:26 ratio will overestimate the staffing as this covers all ante, intra and postnatal care.

Example; A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 26 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

Midwife Ratios based on above data and results
The ratios below are based on the BR+® dataset, national standards with the BR+ methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

Ratios:

- Home births — 36 births to 1 wte
- Delivery Suite births (all hospital care) — 35 births to 1 wte
- Ante & Postnatal Community care only — 114 cases to 1 wte
  Community imports only receive postnatal care so affects ratio
- Overall ratio for **all** births — 26 births to 1 wte

Note: The overall ratio for Salisbury Hospital of 26 births to 1wte equates to the often-cited ratio of 28 or 29.5 births to 1 wte, but they are not directly comparable for the above local factors. The latter ratios are based on extensive data from Birthrate Plus studies and whilst published so seen as 'up to date', more recent studies in the past 3 years are indicating that these ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the

antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.
Inductions of labour with prostaglandins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

APPENDIX 2

MATERNITY SUPPORT WORKERS/CARE ASSISTANTS

Due to changes in skill mix with the increasing use of support staff with a formal qualification in maternity services, there is a need to distinguish between those that can replace midwife hours, and other staff that support the midwife in care of women and their babies. Maternity Support Workers (MSW) refers to those support workers with a formal qualification such as Level 3 NVQ or Nursery Nurse, and who can replace midwife hours. The Maternity Care Assistant (MCA) is used to denote the more basic grade of support worker who supports the midwife. In all clinical areas the use of Care Assistants greatly aids the provision of maternity care, by releasing midwifery staff to be client, rather than ward centered.

Skill Mix Rationale

It is important to distinguish between the situations where support staff assist the midwife and where he/she replaces the midwife.

Birthrate Plus® (1996) makes it clear the ward and clinic staffing levels for midwives are based upon the premise that they are supported by MCA and clerical staff and these staff needs are assessed on a shift by shift basis.

The decision about the percentage of midwife time, which might be replaced, by MSW time must be that of the local service managers.

Antenatal care: As this calls for midwife skills so it is not recommended to replace the midwives with an MSW, but units should ensure that midwives are well supported by clerical and MCA staff.

Intrapartum care: Birthrate Plus® does not recommend any replacement of midwife time by MSW time. To do so would undermine the basic quality standard of one to one care throughout labour plus the increased % of midwife time required for high needs categories.

Postnatal care in Hospital: Many services now suggest 20 - 25% of midwife time can be replaced by MSW input. Once a local decision has been made, the calculations of wte staff for each ward can readily be adjusted.

Postnatal Care in Community: Many services now suggest that 25% of midwife time can be replaced by MSW time. This would allow for full assessment and planning of care by the midwife, with a minimum of three visits and additional visits being undertaken by the MSW working under the direction of the midwife in charge of each woman's care.

Based on adjustments made by other maternity units, an average of 10% of the clinical total wte can be competent and qualified support staff usually being Bands 3 & 4. However this may vary based on the size of unit, where smaller units may have a skill mix of around 5%.

The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs.

Note: In addition, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies, but are in addition to the calculated clinical establishments. To assess the requirement of Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision. For example, 2 per shift on D/S at all times inclusive of the leave allowance.

References:

Ante Natal Care for Uncomplicated Pregnancies NICE 2017 CG62 *https://www.nice.org.uk/Guidance/CG62*

Better Births a five year forward view for Maternity care https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board 2013)

Kings Fund 2011 Staffing in Maternity Units: getting the right people in the right place at the right time (King's Fund 2011)

RCOG 2007 Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour (RCOG 2007)

RCOG 2015 'Each Baby Counts' https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/ebc-2015-report/

Royal College of Midwives 2015 State of Maternity Services https://www.rcm.org.uk/briefings-and-reports

Royal College of Midwives 2016 Guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings

Royal College of Midwives 2016 'Getting the Midwifery Workforce Right' *https://www.rcm.org.uk/sites/default/files/Getting%20the%20Midwifery%20Workforce%20Right%20A5%2024pp_2_1.pdf*

Safe Midwifery Staffing for Maternity Settings NICE 2015 NG4 www.nice.org.uk/guidance/ng4

APPENDIX 3

SALISBURY NHS FOUNDATION TRUST

1:1 Midwifery Care in labour Audit
2019-2020 Q3 report

Conducted by Alison Lambert

1.0 Introduction

This report is the result of an audit undertaken to demonstrate our 1:1 midwifery care in labour as a result of actions arisen from the CQC inspection.

2.0 Background

The RCOG Safer Births report (2007) recommends that women should not, in principle, be left alone during or just after labour. It is an expectation that women are offered 1:1 midwifery care in labour.

3.0 Aim

- To ascertain compliance with the standard that 1:1 midwifery care in labour is achieved.
- To ascertain compliance with the standard and ensure appropriate action is taken in the event that 1:1 midwifery care is not achieved consistently.

4.0 Audit standards

4.1. 1:1 midwifery care should be offered to all women during labour**.**

5.0 Methodology:

Prior to January 2016, data demonstrating our 1:1 care in labour figures were limited and somewhat unreliable. Work was undertaken to incorporate an additional field within the Maternity E3 database system. This field was entered within the delivery segment, which the delivering midwife completes to reflect whether she was able to provide 1:1 care. This data is pulled on a monthly basis. In the event that this field is left incomplete or in the cases where it was identified that 1:1 was not achieved, a manual retrospective review of the intrapartum records is undertaken to ensure accuracy of data.

Where it has been identified that 1:1 midwifery care was not achieve in active labour, these cases will be retained for reviewed.

Since the introduction of this method of data collection, compliance to the standards has been between 99=100%.

6.0 Exclusion:

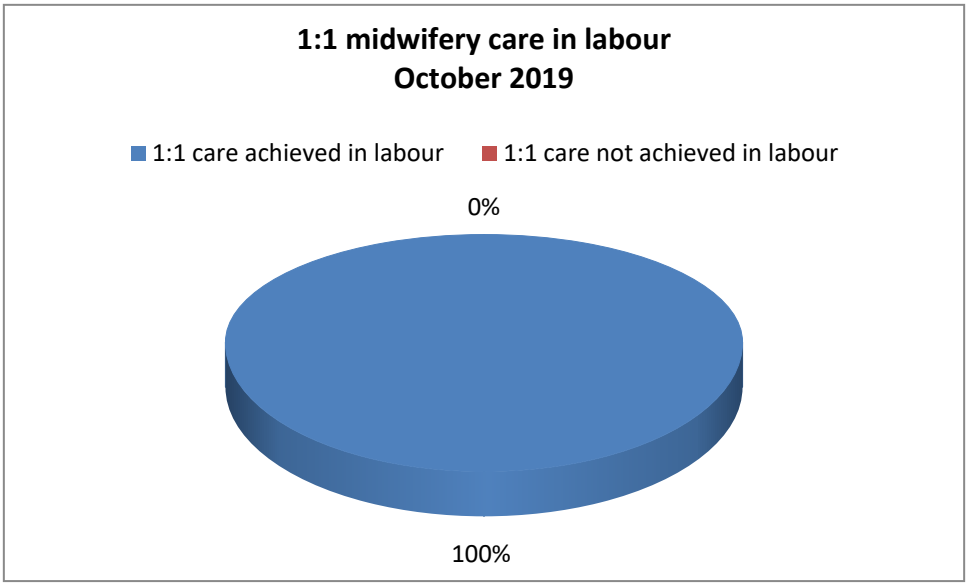
Cases excluded from the audit:

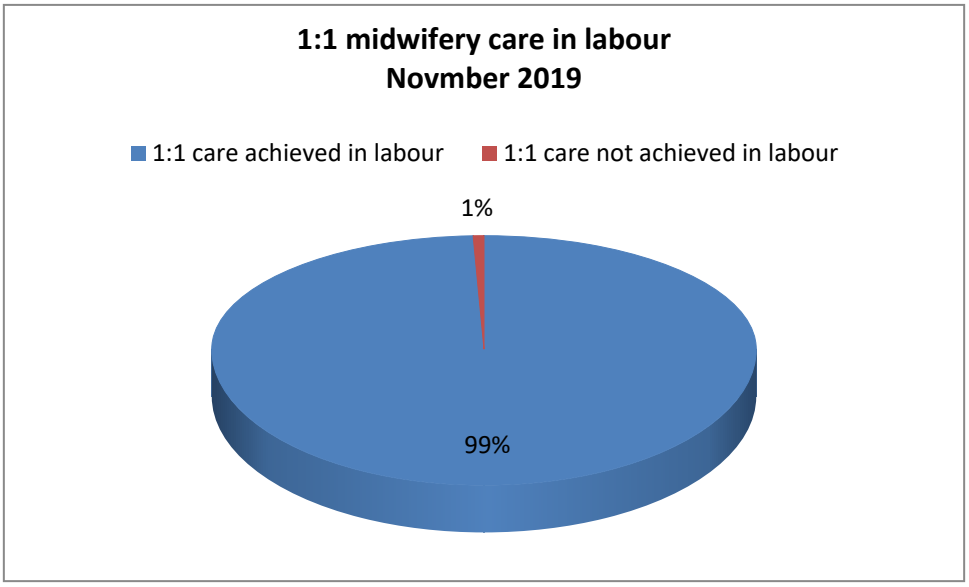
- Early miscarriages
- Born before Arrival (BBA)
- EM LSCS performed in the A/N period

- All ELLSCS

7.0 Audit results:

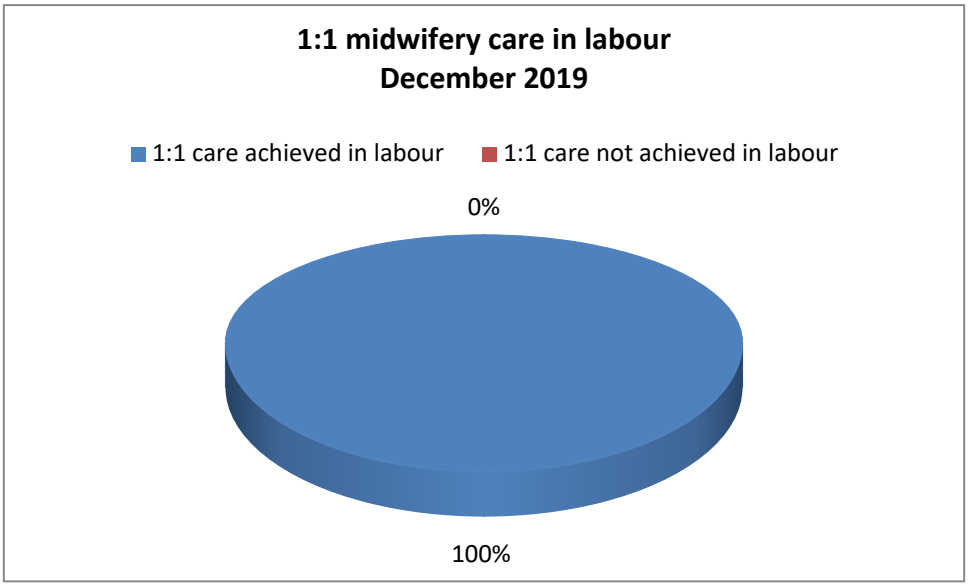
October 2019	November 2019	December 2019	**Q3**
159/159=100%	130/131= 99.2%	160/160=100%	**449/450=99.7%**





Details of the cases where 1:1 care was not achieved:
G3 P1 39 +5 weeks, high risk pregnancy; due to polyhydramnios. Admitted to BLW with a precipitant labour; total length of labour 3 hours 18 minutes. No episodes of intrapartum

care documented within the maternity records. From reviewing Datix, it would seem that the acuity on the labour ward was high; all beds occupied, with a further 2 women expected.

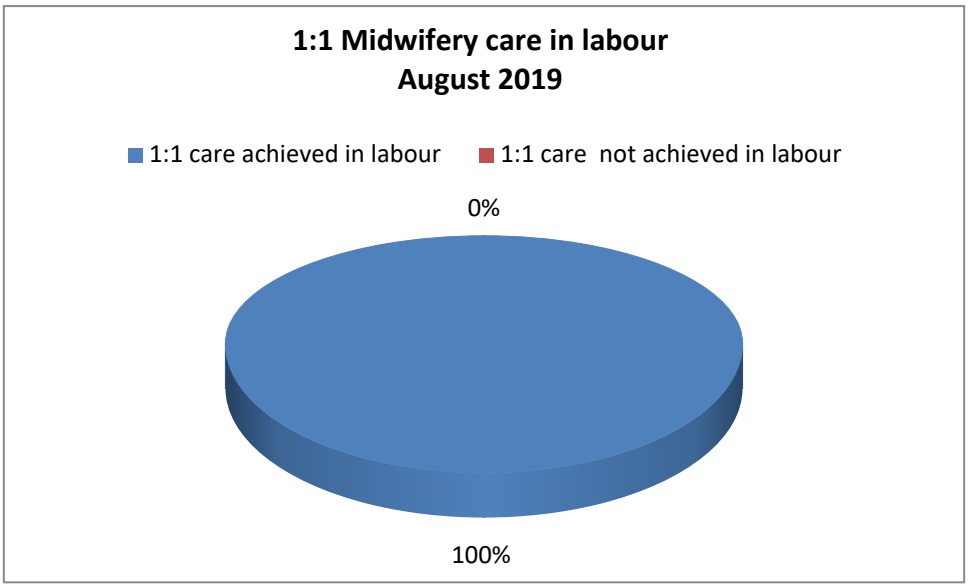


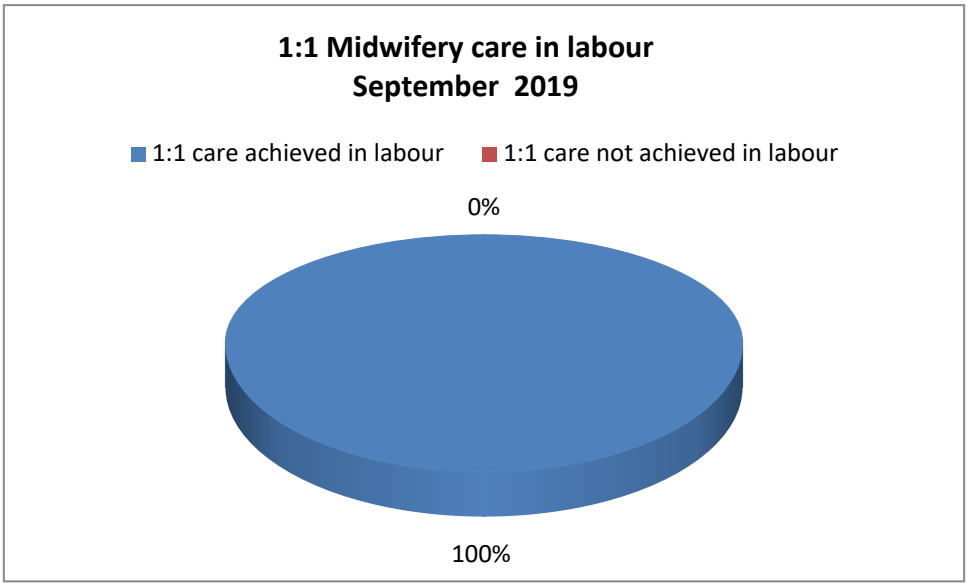
8.0 Discussion:

In Q3, 1:1 care in labour was achieved in 99.7% of cases.

9.0 Actions

No	Action	By who, by when	Evidence	RAG
1	No actions required			Green





8.0 Discussion:

In Q2, 1:1 care in labour was achieved in 100% of cases.

9.0 Actions

No	Action	By who, by when	Evidence	RAG
1	No actions required			Green

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	05 March 2020		

Report Title:	Well-Led Action Plan Progress Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	Appendix 1: Well-led action plan			

Recommendation:
The Board to note the contents of the report.

Executive Summary:
The Trust commissioned an external review of the Well-Led Framework by Deloitte and 32 recommendations were identified in the report provided in May 2018. An action plan was subsequently implemented and a number of actions were progressed, with regular oversight by the Executive Team through reports to the weekly Executive meeting. The Care Quality Commission (CQC) undertook a Well-Led inspection in December 2018 and initial feedback from this provided a further focus on improvement actions required. This provided an opportune time to review the current action plan and summarise progress which resulted in creation of a new plan to progress over the next 12 months. Summary of progress over the last 12 months against the updated plan is detailed within the report and themed under key headings used within the existing plan. Significant progress has been made to date against the plan across all domains, with a continued focus for further improvement. There are 47 actions within the well-led action plan. 34 actions are complete. 10 are still within target date. 3 are overdue.

The 3 overdue actions:

- Introduction of directorate governance meetings – these have been introduced however; they are not fully embedded with some further advanced than others.
- Introduction of forecasting into committee and Board reporting – there has been significant work on the Integrated Performance Report, which has been completely revised in terms of format and content. Financial forecasting is embedded and there is now a focus on forecasting for the other performance metrics. This work is on-going acknowledging the significant progress to date.
- Business case review process – the process has been revised including a revised benefits realisation template. This is being presented to Audit Committee in March.

The plan will be reviewed at the end of March 2020 and any further improvements required against the Well-Led Framework will inform a new plan for 2020/21 which will be presented to Trust Board in May 2020.

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

1 Purpose

1.1 The purpose of this report is to provide assurance to the Board on progress against the Well-Led action plan.

2 Background

2.1 The Trust commissioned an external review of the Well-Led Framework by Deloitte and 32 recommendations were identified in the report provided in May 2018. An action plan was subsequently implemented and a number of actions were progressed, with regular oversight by the Executive Team through reports to the weekly Executive meeting.

The Care Quality Commission (CQC) undertook a Well-Led inspection in December 2018 and initial feedback from this provided a further focus on improvement actions required. This provided an opportune time to review the current action plan and summarise progress which resulted in creation of a new plan to progress over the next 12 months.

Summary of progress over the last 12 months against the updated plan is detailed below and themed under key headings used within the existing action plan.

3 Progress

3.1 **Leadership Capacity and Capability**
The Clinical Directorate re-structure consultation is currently underway, lead by the Chief Operating Officer.

There has been a continued focus on Board development which has included individual and team coaching facilitated by NHSI for Executives Directors. On site NHS Provider facilitated Board development sessions have been provided covering Effective Challenge and Report Writing; extended to Directorate Management Teams. This will continue into 2020/21 with regular seminar days, Board development days and Executive away days; external facilitation and coaching is on-going.

Significant progress has been made against the leadership development actions within the plan. A leadership development paper will be presented to the Workforce Committee in March 2020. This will outline an ambitious suite of leadership development and management programmes proposed to launch in Q1 of 2020/21.

The trust approach to talent management will be further developed in line with the activity above:

- To define competencies for all levels of leadership, and a talent process
- To improve the annual training needs analysis process, and in future years ensure a close connection with succession planning/talent management and organisational transformation needs.

Publication of the NHS ‘People Plan’ remains pending. It is expected based on the interim people plan that leadership development and culture will feature strongly in the final publication. Once published, the Trust plans will be developed to both build on the strong foundation being built and to adjust/iterate the direction of travel as required.

An update against the delivery of the action plan is outlined below:

Phase 1	
Objective	Update
Design and deliver an initial module for Clinical Leaders and offer to all CLs and selected other leaders during the next 6 months	Senior Clinical Leadership Programme now in place. • Bespoke 2-day programme for senior clinical leaders (clinical leads, heads of profession etc.). • Provided for 5 cohorts and a new cohort is due to start in March. • Now been opened up to matrons. Feedback has been extremely positive.
Launch Senior Leadership Engagement forum.	Bi-monthly leadership forum now ongoing providing masterclasses on a range of topics. Each session sponsored by two executives.
Revised coaching programme to be offered to 60% of exec team, PBPs and deputies	On-going
Establish the offering and level of participation in Leadership apprenticeships	Range of apprenticeships offered and tracked centrally: • Team Leader / Supervisor Level 3 • Business Administration Level 3 • Associate Project Manager Level 4 • Operations / Department Manager Level 5 • Chartered Manager Degree Level 6 • Senior Leader Master's Degree Apprenticeship Level 7 • Hospitality Manager Level 4 • Facilities Management Supervisor Level 3
Complete selection of Leadership L7 candidates to commence programme in Q1 2019/20	Completed
Phase 2	
Extend coaching offer to all leaders	Highly regarded ‘Coach to lead’ programme now delivered, accredited with the NHS Leadership Academy. The coaching faculty continue to be supported/supervised and options for further expanding the faculty are being considered, linked to psychometrics, 360 and utilization of the apprenticeship levy.
Develop values based appraisal framework	Values included within appraisals. Training is provided for appraisers that focuses on good practice for appraisal conversations.

In 2019/20 SFT staff have been able to access the following leadership development opportunities:

Coach to lead	Highly regarded programme delivering within SFT, accredited with the NHS Leadership Academy
Appraisals	Short course upskilling managers to conduct high quality appraisal conversations.
Senior Clinical Leadership Programme	Bespoke 2-day programme for senior clinical leaders (clinical leads, heads of profession etc.).
Apprenticeships	Team Leader / Supervisor Level 3 Business Administration Level 3 Associate Project Manager Level 4 Operations / Department Manager Level 5 Chartered Manager Degree Level 6 Senior Leader Master's Degree Apprenticeship Level 7 Hospitality Manager Level 4 Facilities Management Supervisor Level 3
Bi-monthly leadership forum	Masterclasses on a range of topics, sessions sponsored by executives.
Monthly line manager's breakfast/ support sessions	Varied topics presented and discussed to support line managers.
Leadership Academy programmes and masterclasses	National and regional opportunities available for staff to access, (some national offers are restricted due to cost).

The paper being presented to Workforce Committee in March will outline offers for a range of staff groups and levels of seniority. The focus will be upon providing programmes that:

- Support staff in formal, and informal, leadership roles to live and display compassionate collective leadership.
- Support staff to display excellence in management practices; supporting staff engagement and wellbeing, patient-centred processes and behaviours, high performing teams, value for money working practices and innovation.
- Provide learning of optimal utility through purposeful use of case studies, stories, internal/external guest speakers and on-the-job application.
- Enhance internal communities and build sustaining networks within and across staff groups.
- Are aligned to, and actively support, achievement of all key trust objectives.
- Support staff engagement, recruitment and retention by providing a feeling of being valued, developed and able to utilise new skills.
- Support succession planning / a 'talent pipeline' for key roles such as ward, directorate and team leadership and management roles.

The vision is to ensure that all programmes at all levels incorporate 'golden threads' of:
a) living the trust values and
b) a shared 'leadership' ethos for what it means to be a leader at the Trust.

The following are also being explored/planned:

- Development opportunities for the Trust's most senior leaders with a programme associated with the re-structuring. It is likely this will utilise some external expertise.
- Establishment of a Deputies Forum: External facilitation will be utilised to engage with deputies to agree a programme of appropriate professional development.

Coaching and mentoring

Objective	Update
Extend coaching offer to all leaders	Coach to lead training available to embed coaching skills into daily practice. Apprenticeship route being explored to expand coaching faculty.
Coaching of the executive (NHSI)	Ongoing
Develop the capacity to support Action Learning sets to support the introduction of project activity as part of leadership programmes	To be integrated into leadership development programmes.

Talent management

Objective	Update
Formal introduction of a Personal Development Planning section into the appraisal process	PDP is incorporated into the online appraisal process. This will be reviewed in line with: • ESR phase 2 rollout • Talent management / Passport to progression
Develop values based appraisal framework	In place.
Training for all staff in how to make the most of the appraisal process	Training is in place to support line managers in undertaking a high quality appraisal conversation.
Design and implement a Talent Management Process	Work is ongoing linked with the above.
Develop passport to progression (defining the framework and skills levels that will be required at key leadership levels within the organisation)	Work is ongoing linked with the above.
Strengthen links between TNA, Appraisal, Talent Management data and participation in development activity	Paper taken to Education Development Group in Feb 20 outlining a proposed approach and timescales.

Plans are in place to further build the leadership capacity and capability at all levels of the organisation. Developments will continue in advance of the publication of the 'People Plan', adjusting the Trust's approach as required.

3.2 Vision and Strategy

The Trust has now reached the midpoint of its 2018-22 Corporate Strategy. A quarterly review process has been put in place (September 2019) to ensure that the Executive Team, relevant Board Committees and the Trust Board can assess progress on the delivery of the Trust's strategic priorities. At the review in December 2019, the Trust Board agreed to:

a) Update its Corporate Strategy to reflect the progress made against the current strategy and the priorities set out in the NHS and BSW Long Term Plans.
b) Review the prioritisation of the corporate objectives to ensure that those which are most likely to deliver significant contributions to the Trust's strategic objectives are prioritised and form the focus for operational planning for 2020/21. The renewed priorities shall be supported by a robust and consistent project management process.
c) Expand the Trust's core vision to include the ambition to deliver an outstanding experience for both patients and staff. This proposal will be underpinned by a wide consultation in April 2020 and form part of the formal review of the current Trust strategy.

The process of enacting these recommendations is now underway and is aligned in particular with the implementation of the BSW Long Term Plan and the 2020/21 Operational Planning processes.

The Associate Director of Strategy commenced their position in March 2019. The focus of the postholder has been to establish a clear link between corporate and clinical strategy, the delivery of corporate operational plans and strategic service review. To achieve this, the following has been undertaken with monthly updating of the Trust Board:

- Strategy Development session as a Trust Executive Away Day on 2 May 2019. This established corporate objectives to support delivery of the Trust's strategic priorities and set out the Trust's plans to support the development of an integrated local health and care economy.
- Alignment of the Corporate Strategy, key operational priorities and the Board Assurance Framework – to ensure that the Board and Executive team are focussed on an agreed set of corporate priorities.
- Alignment of Corporate and Clinical Strategy to service operational planning – including the establishment of consistent processes for Strategic Service Review. Directorate Operational Plans are structured to respond to the priorities set out in the Clinical Strategy.
- An assessment of the strength of the Trust's partnerships and key stakeholders to deliver Trust strategy and local integration (July 2019)
- Active involvement in the development of the BSW Long Term Plan, including Board sessions in August and November 2019
- Engagement of the Trust Board in the development of a place based Integrated Care System – setting the strategy for the Trust's role (February 2020)
- The Trust has facilitated 2 sessions with key stakeholders in the development of a South Wiltshire Integrated Care System (in September 2019 and March 2020). The March 2020 workshop will be facilitated with the engagement of NHS Providers and the Local Government Association Peer Support offer.
- Integrated Performance Report: The Trust Board, Workforce Committee, Finance and Performance Committee and Clinical Governance Committee now receive (from June 2019), a consistent format for performance reporting which is structured to

reflect the Trust strategic priorities and reflects NHSI 'Making Data Count' guidance and support.

Strategy Committee

A paper was taken to Trust Board in June 2019 recommending the dissolution of the Strategy Committee to allow implementation of an alternative model that allows the Trust Board and Executive to better fulfil their roles in setting the strategic direction of the organisation. The committee has been replaced with a dedicated Board seminar session, monthly as part of the Private Board agenda, which is facilitated by the Associate Director of Strategy and/or Director of Finance to enable the Board to be updated on implementation of Trust and system strategy and plans and seek the views of the Board in setting future strategy.

Financial Sustainability Strategy

The Trust undertook a development programme resulting in the approval of a financial sustainability strategy at Trust Board in February 2020. This sets out the steps that the Trust will take, organisationally and with partners to achieve financial sustainability over the period of the BSW Long Term Plan. The Trust is developing an implementation plan for the strategy in Q4 2019/20.

3.3 **Culture**

Freedom to Speak Up Guardian (FTSUG)

In response to the 2018 CQC visit, the Trust's FTSUG worked collaboratively with NHSI to develop an action plan. These recommendations have been reviewed at board sub-committees at quarterly intervals, and the FTSUG continues to maintain contact with NHSI to ensure that the recommendations are delivered within the agreed timescales.

Included in these recommendations was the refreshing and publication of the Raising Concerns Policy which was completed in August 2019. Another of the recommendations was the Board attending a training session that included FTSU and Equality, Diversity and Inclusion (EDI); with very positive feedback. A Communications Plan is currently being developed to continue to raise awareness.

The FTSUG has commenced another 12 month peer supervision/action learning set with the London FTSUG network as it has proven to be very beneficial to both the Guardian and the organisation. NHS Providers has published a blog produced by this group to start to raise awareness of what it is like to be a Guardian and how organisations can support this important piece of work.

FTSU and EDI continue to align their work together to look at different minority groups and the additional barriers they face when speaking up. The FTSUG is developing a training package with support from the Education Department in line with National Guardian Office and NHSI/E guidelines. The FTSUG and EDI Leads deliver face to face training to approximately 100 members of staff per month. The FTSUG meets all new starters, and attends departmental and team meetings. With the role becoming more visible, there has been a significant increase in staff raising concerns through FTSUG.

Equality, Diversity and Inclusion (EDI)

The Trust Equality Report 2019 presented to the Workforce Committee in November 2019, covers the progress made on the Trust equality journey over the past twelve months. This includes the re-establishment and development of staff networks, the development of EDI Induction Training and the development of face-to-face EDI and

FTSUG Training. During the year 1058 members of staff and volunteers took part in some form of EDI training.

The report also contains references to a number of other reports:

- The Gender Pay Gap Report 2019
- The Workforce Race Equality Standard Report 2019
- The Workforce Disability Equality Standard Report 2019

These reports provide a detailed analysis of the data supplied by the Trust to the national programs; containing a number of recommendations for action which are being considered by the EDI Committee. The EDI Committee chaired by one of the NEDs was also re-established during the year.

The Equality Report 2019 details a number of future influencing factors which will have an effect of the Trusts approach to equality, diversity and inclusion over the next twelve months.

The reports demonstrate that there has been significant progress against this agenda since the CQC inspection in December 2018.

3.4 **Roles and Responsibilities**

Directorate Governance meetings have been established to strengthen governance arrangements and escalation of risk within the Directorates and from specialty level. Standard Terms of Reference and agenda items have been produced to support the Directorates and achieve consistency of approach. The agenda template was reviewed in January 2020 by the Director of Corporate Governance and Director of Nursing to simplify the agenda and establish core items to be covered at each meeting. There has been variability across the Directorates in respect of implementation and adoption. A review of the effectiveness of these meetings is currently underway and will be reported to the Clinical Governance Committee in March 2020.

The Corporate Governance Function has provided increased scrutiny over the reporting to Trust Board with the review of Board and Board Committee work plans, Terms of Reference and revision of reporting templates to strengthen the governance arrangements over the last 18 months. An electronic Board Administration solution, iBabs, has been successfully implemented which has significantly improved timely access and availability of papers and reduction in printing costs.

A Board Governance and Compliance audit was undertaken as part of the Internal Audit work plan in November 2019 which identified further areas for improvement particularly in relation to a committee organigram to ensure appropriate reporting and escalation routes, committee discipline in relation to timeliness and quality of papers, consistency of Non-Executive Director challenge, functionality of the Workforce Committee and operating effectiveness of the Executive Performance Reviews. Actions are currently being delivered to strengthen all these areas.

The Head of Corporate Governance has provided scrutiny over a number of corporate processes to strengthen the governance arrangements, for example, the declaration of interests and declaration of hospitality and gifts process. A revised policy has been ratified and declaration register is published. In addition, increased oversight of the Council of Governors meetings, agendas and work plans has been established.

3.5 **Risk Management**

The patient safety agenda is very much being guided by the recently published National Patient Safety Strategy which is informing Trusts on the expectations going forward.

Embedding the concepts of the Strategy is reliant on both National and Local actions.

Nationally these centre around:

- Developing a patient safety curriculum, a safety specialist network, Replacing NRLS and STEIS, implementing the new Patient Safety Incident Response Framework (PSIRF) and the Patient Safety Partners Framework and developing technical solutions to Never Events.

Locally the Trust will need to:

- Establish the Medical examiner role
- Consider how there is monitoring of the Safety culture
- Move to the new national reporting system in quarter 4 2020/21
- Identify PSIRF leads in the local system
- Identify a patient safety specialist
- Training and support to all staff having access by 2023
- Deliver on national safety priorities
- Annually review of the balance of resources for investigation versus resources for improvement
- Reporting against key milestones/providing assurance

On-going monitoring against delivery of the strategy requirements will be via the Clinical Governance Committee

3.6 **Accurate Information**

The Integrated Performance Report (IPR) has been completely revised in collaboration with data owners. The financial forecasting process is established with monthly reporting to Finance and Performance Committee and quarterly reporting to Board. With the support of NHS Improvement's Making Data Count team and resources, the Trust is increasingly making use of Statistical Process Control to identify performance trends, understand the impact of action taken, and forecast how performance might trend in the future. This has been particularly effective in looking at elective waiting time performance (RTT) where Trust Board and Committees are now able to see 24 month trend data, by specialty, so that future performance trends can be predicted and action taken to address future performance.

With support of South Central and West Commissioning Support Unit, the Trust has also made use of a demand and capacity planning tool specifically for planning its winter capacity. This assisted in forecasting future bed base requirements and the impact of actions on average Length of Stay and the Trust's Delayed Transfers of Care rate and volume.

There is a continued focus on refining the content of the IPR, in particular increasing the use of forecasting information.

The business case process has been reviewed to include an updated benefits realisation template; to be presented to Audit Committee in March 2020.

Data quality oversight and assurance processes have been strengthened over the last year, with a revised data quality policy and a new Information Standards Group now in place. The role of the Information Standards Group is to provide assurance that the Trust has effective controls in place regarding adherence to information standards, data quality policy, reconciliation between SUS and SLAM and clinical coding. A new application providing automated data quality notifications has been built and is due to go live shortly, this will automatically alert users when data quality errors exist and enable timely correction. All core KPIs used by the Trust in Board reporting, along with metrics regularly reported are now scored against the Trust's Data Quality Assurance Framework. Work is shortly due to commence to introduce the NHS Digital Data Quality Assurance Self-Assessment.

3.7 **Engagement**

Staff Engagement
The communications department have begun to implement the corporate communications strategy agreed by the Board in May 2019.

The current headline projects include:

- Business case drafted for a sustainable communications team
- New website Board established and have met. Initial site shared with project board and Executives with user experience at heart of the project. Delivery deadline by September 2020.
- Close involvement with the Organisational Development Culture and Leadership programme
- Strengthened relationship with Radio Odstock
- Florence 200 and Year of the Nurse and Midwife with a number of projects planned
- Annual General Meeting (AGM) presentation slides rebranded and video vox pops were included to help improve staff engagement. A video summary of the AGM has been produced.
- New branding introduced to key corporate documentation during 2019 e.g. annual review, operational plan, staff benefits booklet. Corporate photography style developed and image bank now in place.
- Communications Mailbox introduced in 2019 to better manage and track requests made to the Communications Team. The Team currently manage on average 130 requests a month. The next steps are to develop communications toolkits to empower staff to deliver their own campaigns (for example to support awareness days).
- In direct response to staff feedback changes were made to Staff Broadcast emails from March 2019. The focus was to restrict the numerous and varying quality of all staff emails, averaging 35 emails a week, with over 150 individuals in the organisation being able to send an email to all 4,500 staff. A supporting Standard Operating Procedure has been developed for out of hours broadcasts.
- The 'Pulse' newsletter was introduced to combine messages into one centralised communication and a regular rhythm of internal communications has been implemented.

Challenges to on-going delivery of the strategy link to resources within the Communications Team and recent changes associated with this.

Patient Engagement

Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative, including learning from feedback, transparency and honesty when healthcare goes wrong.

A detailed quarterly Patient Experience Report is presented to the Clinical Governance Committee providing assurance that the Trust is accessing feedback on patient experience, responding appropriately to complaints from patients and can demonstrate that learning and actions are taken to improve services in response to feedback and assurance of patient and public involvement in service co-design and improvement.

Progress to date includes:

- A complaints/risk newsletter has been produced and shared with teams. This will be produced quarterly to share learning Trust-wide.
- A variable complaint response time set out in the Complaint Handling Policy, went live on 1 August 2019. The impact has shown a significant (38.5% in Q2) increase in compliance to complaint responses being sent out within the timescale agreed with the complainant.
- The PALS complaint coordinators have initiated weekly ward rounds with the aim of facilitating real-time and prompt resolution to concerns patients may disclose; preventing concerns escalating to more formal complaints. The initial feedback from the ward staff has been positive.
- The PPI toolkit has been updated and published on MicroGuide.
- The PALS team have been relocated to Admin Block 29. A short-stay parking space has been made available for visitors which has facilitated access to the team.

3.8 **Improvement and Innovation**

In April 2019 the Board approved ‘Our Strategy for Improvement’ and associated Quality Improvement implementation plan. The aim of the strategy and associated plan is to make ‘making improvements’ an intrinsic part of everyone’s job, every day, in every part of the organisation. It aims to provide the right support, tools, techniques and environment to empower staff to act at the top of their game and take ownership for improving things within their control.

In support of this aim, the following has been delivered to date:

- A common Trust-wide quality improvement methodology has been adopted.
- A virtual academy has been launched, providing all staff with access to tools and techniques to support quality improvement initiatives.
- The first cohort of quality improvement coaches have graduated, taking newly learned tools and techniques back to their areas of work, and to support others.
- A Dragons Den initiative to encourage and support innovation has launched, with the first major event in April 2020.
- A quality improvement steering group comprising Q practitioners is well established, providing support and guidance to the programme.

QI is not a quick fix but a continued process requiring a sustained focus over a period of time, and therefore it is still very early days for benefit to be evidenced. The Trust is on track to deliver against plans this year, although not without some challenges that mainly relate to staff capacity constraints for quality improvement work. Plans are in place to address these challenges by embedding a quality

improvement way of working into day to day activities (such as team and directorate meetings, 1:1 conversations) rather than it being seen as a separate additional piece of work. Feedback from staff has been overwhelmingly positive to date, and good engagement from staff is being seen.

4 Summary

4.1 Significant progress has been made to date against the plan across all domains, with a continued focus for further improvement.

There are 47 actions within the well-led action plan. 34 actions are complete. 10 are still within target date. 3 are overdue

The 3 overdue actions:

- Introduction of directorate governance meetings – these have been introduced however; they are not fully embedded with some further advanced than others.
- Introduction of forecasting into committee and Board reporting – there has been significant work on the Integrated Performance Report, which has been completely revised in terms of format and content. Financial forecasting is embedded and there is now a focus on forecasting for the other performance metrics. This work is on-going acknowledging the significant progress to date.
- Business case review process – the process has been revised including a revised benefits realisation template. This is being presented to Audit Committee in March.

The plan will be reviewed at the end of March 2020 and any further improvements required against the Well-Led Framework will inform a new plan for 2020/21 which will be presented to Trust Board in May 2020.

5 Recommendations

5.1 The Board are recommended to note the significant progress made over the last 12 months against the well-led action plan.

Fiona McNeight
Director of Corporate Governance

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Theme	Action	Outcome	Deadline	Lead
Board Development	On-going development program with the organisational coach	NED and Board constructive challenge at Board	Commenced and on-going	CCB
	On-going team and individual coaching for the Executive Team		Commenced and on-going	CCB
	NED development through NHS Provider sessions		30/04/2020	FMc
Leadership development and strategy	Delivery of the Trust Leadership and Development Strategy	Strengthened leadership capability	April 2018 - March 2020	JS/PH
	Clinical Leadership Development Program		31/03/2019 Commenced. 1st cohort completed	JS/PH
	Senior Leaders Forum		28/02/2018 Commenced	PH
	Talent Management Program		31/03/2020	JS/PH

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Theme	Action	Outcome	Deadline	Lead
Ensure confidence in Estates Strategy	Estates Strategy to be presented at March Trust Board	Estates Strategy developed which meets all H&S requirements	31/03/2019 Presented at March Board - further changes required 01/07/2019 On July Board agenda for approval - Board approved	LA
Ensure the Trust can demonstrate and is meeting H&S requirements	NHSI self-assessment and gap analysis to be presented to Finance & Performance Committee in May 2019 and assurance to Trust Board in June 2019	Gap analysis complete and improvement plan agreed	~~30/06/2019~~ ~~30.09.2019~~ ~~30.11.2019~~ **Revised date 31/01/2020** External Consultant reviewing Estates. Paper going to TMC in September outlining proposals **October update:** Review not yet finalised. **December update:** On agenda for Private Trust Board January 2020 **Jan 2020 update:** Report presented to Private Board. Future monitoring via Workforce Committee with Director of OD&People as independent Chair to oversight group	AH
	Delivery of action plan following NHSI self- assessment	Compliance with NHSI requirements	~~30/09/2019~~ Review 31/05/2020 TBC following completion of review	AH
Clinical Strategy	Review clinical strategy and ensure aligned to NHS Long Term Plan and aligned to BSW clinical strategy	Clinical Strategy fully aligned to Long Term Plan and BSW Strategy	21/03/2019 Complete	CB
	Ratification by Trust Board	Ratified Strategy with monitoring of delivery through Strategy Committee	04/04/2019 Complete	CB
Strategy Committee	Ensure programme management approach to enable alignment of digital, workforce, estates and clinical strategy	All key strategies are aligned and support delivery of the Trust objectives	01/04/2019 Initial phase of work completed to align key strategies. Strategy day planned for Exec Away Day 2/5/19 followed by Board Development Day in June. Action closed and further actions to be drafted following discussions at Board	LT

KLOE 3. Is there a culture of high quality, sustainable care?

Theme	Action	Outcome	Deadline	Lead
Review of Freedom to Speak Up Guardian arrangements to reflect best practice National guidance	Development of Equality & Diversity Strategy	E&D objectives identified and programme of work implemented to deliver	31/03/2019 Agreed by Board. Included in Annual Report	PH
	Development of Freedom to Speak Up Guardian (FTSUG) proposal	FTSUG arrangements reflect best practice	31/03/2019 Agreed by Board. Included in Annual Report	PH
	Drafted Corporate Communication Strategy paper to April Board	New Corporate Communication Strategy for the Trust	~~30/04/2019~~ 31/05/2019 Presented to WFC April - further work required 06/06/2019 Board approved strategy	PH
	Exec workshop on Freedom to Speak Up Guardian/ E&D	Behaviour change to improve diversity and equality	05/09/2019 Complete	PH
Equality and Diversity	Equality and Diversity programme established initially to include BAME, EU staff, Disability and LGBTI	Cross reference EDI strategy and action plan	**As per action plan** **January 2020 update:** New EDI Committee re-launched. Oversight of deliverables will be through this Committee	PH
	WRES action plan and objectives to be agreed with staff			PH

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Theme	Action	Outcome	Deadline	Lead
Corporate Governance Framework	Revision of the Integrated Governance Framework to increase governance guidance to directorates and services to improve consistency while ensuring that key governance items are considered at every level. This guidance should make reference to attendees, agendas, reporting templates and approach to performance review	Consistent approach to governance across the organisation	31/03/2019 Framework revised and approved at Board April 2019	FMc
	Introduce Directorate Governance meetings	Consistency of reporting and oversight of key governance items	~~31/03/2019~~ ~~01/07/2019~~ update - all committees established although require further work to fully embed **December update:** DoN picking up with Medicine Directorate **Jan 2020 update:** Revised agenda template. Review of effectiveness of committees going to March CGC	FMc /DMTs
	Internal Audit of Directorate Governance meetings (risk management focus)	External assurance	31/03/2020 Completed as part of the Board Reporting and Compliance Audit November 2019	FMc/Internal Audit
The Executive team should continue to review and develop the approach to EPRMs, particularly in relation to the quality of reporting, focus of meetings on key risks and ensuring that the meetings are given adequate time and prominence to cover the high risk areas in sufficient detail.	Review consistency of approach and adoption of Accountability Framework through internal audit programme	Consistent approach and compliance with the Accountability Framework	30/04/2019 Included in Internal Audit Plan	FMc
	Internal Audit review of meetings and application of Accountability Framework	External assurance of compliance	31/03/2020	FMc/Internal Audit
	Roll-out to Corporate Functions **Jan 2020 update: Process reviewed after 12 months. Corporate area performance to be managed via 1:1s with CEO and Exec Directors. CEO will request intensive support process is commennced as required.**	Complete performance oversight	31/05/2019 Corporate functions now included in performance review	AH
	Performance review escalation reports to TMC require review to include assurance against actions to address identified risks and ensure RAG rating rflects the identified risks	Assurance re mitigation of risk	30/09/2019 All RAG ratings agreed by the subject matter Executive Director and escalation points agreed at the end of each meeting and associated assurances	AH

	TMC minutes to accurately reflect discussion of items for escalation and any associated actions	Improved governance and assurance	30/09/2019 Report is now a separate agenda item and minuted accordingly	KN
	Review of executive attendance at EPRs	Executive commitment to the process Annual review process	31/10/2019 Annual review completed by the Director of Corporate Governance. Meetings for 2020 scheduled with requirement for all executives to attend	AH
	Review of content of EPRs to ensure consistency of provided information and the potential to move to a centrally provided information pack	Consistent approach and compliance with the Accountability Framework	31/03/2020	AH
	EPR action logs or meeting minutes to clearly identify rationale for extended deadlines	Improved governance and assurance	30/09/2019 Complete	AH
	EPR minutes to include when a person arrives late or leaves early	Improved governance and assurance	30/09/2019 Complete	AH

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Theme	Action	Outcome	Deadline	Lead
Risk management training (including serious incidents)	Undertake TNA for risk training	Tailor made training following TNA outcome	30/09/2019 TNA completed. To be presented at CRG for discussion prior to operationalising	LW

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Theme	Action	Outcome	Deadline	Lead
Production of an Integrated Performance Report which is sufficiently detailed, accessible and clearly identifies variations and/or a need for change or improvement	Workshop in February 2019 with data owners	Clear understanding of rationale for changes to IPR, understanding of constraints regarding information flows and capacity	28/02/2019 Complete	EP
	Proposed new IPR for review by Board members	Draft revised IPR for consultation (2 weeks)	~~12/04/2019~~ 30/06/2019 01/07/2019 Approach agreed by Private Board in June. Full revised IPR to public Board in July	EP/FMc
	Revised draft IPR to Board meeting 6th June 2019	Introduction of new IPR	~~06/06/2019~~ 31/07/2019	EP/FMc
Improving digital capability (Digital strategy) and Information Management	Present to Trust Board in March	Ratified Digital Strategy	31/03/2019 Complete	JB/EP
	Delivery of implementation plan	Strategy supporting delivery of corporate objectives	Review 31/03/2020	JB
CIP and QIA reporting to Board	Strengthening the QIA review process following go live	Oversight and assurance on scheme impact	30/09/2019 Process of review strengthened with 6 monthly review. Full review undertaken as part of PMO perfect week governance deep dive	LW/L.Arnett

Production and use of data which can provide intelligent forecasting for the future and to drive commissioning decisions	Introduction of forecasting into Committees and Board reporting	Better decision making	06/06/2019 **Dec 19 update:** Financial forecasting process established with monthly reporting to F&P and quarterly reporting to Board. With the support of NHS Improvement's Making Data Count team and resources, the Trust is increasingly making use of Statistical Process Control to identify performance trends, understand the impact of action taken, and forecast how performance might trend in the future. This has been particularly effective in looking at elective waiting time performance (RTT) where Trust Board and Committees are now able to see 24 month trend data, by specialty, so that future performance trends can be predicted and action taken to address future performance. With support of South Central and West Commissioning Support Unit, the Trust has also made use of a demand and capacity planning tool specifically for planning its winter capacity. This assisted in forecasting future bed base requirements and the impact of actions on average Length of Stay and the Trust's Delayed Transfers of Care rate and volume.	KH
Post implementation review processes for business cases	Review of revised process effectiveness	To realise the benefits of all approved business cases	~~31/07/2019~~ 31/03/2020 Revised process including updated benefits realisation template going to Execs on 13/01/2020 then Audit Committee in March 2020	ME

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality, sustainable services?

Theme	Action	Outcome	Deadline	Lead
Patient engagement	Ratification of revised Patient Engagement Strategy	Systematic approach to patient engagement	30/06/2019 Strategy ratified at CMB	KG
	Commence delivery of strategy subject to Board approval		31/03/2020	KG
	Re-write of the patient engagement toolkit		31/07/2019 Completed - revised and published on Microguide	KG
Staff engagement	A 'mixed economy' approach: - digital - face to face - surveys (exit/joiners) - staff led interest groups	Systematic approach to staff engagement	31/03/2020	JM/PH
Corporate communications	Corporate Communications Strategy to Trust Board in April 2019	Strategy ratified by Board	~~30/04/2019~~ 31/05/2019 Strategy approved	JMcG
	Implementation plan to be developed	Corporate communications and engagement aligned with the Trust's objectives	**July 19 update:** business planning process underway; the results of which will determine what is included in the implementation plan and for when activities are scheduled **October update:** Working matrix in use for work planning, updated on daily basis. Action complete: implementation plan completed and in use	JMcG

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

Theme	Action	Outcome	Deadline	Lead
Quality improvement	QI Strategy to be developed and presented to the Trust Board in March 2019	Structured and embedded approach to quality improvement	31/03/2019 Presented and agreed at April Board	EP
	Delivery of 2019/20 implementation plan post strategy ratification		31/03/2020	EP

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	05 March 2020		

Report Title:	Proposed changes to the Constitution			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Nick Marsden, Chairman			
Appendices (list if applicable):	Appendix 1: Constitution February 2020 v1.1			

Recommendation:
It is recommended that the Board approve the suggested change to the Constitution

Executive Summary:
Section 33, in particular 33.1.4, of the Constitution states:

33. BOARD OF DIRECTORS – DISQUALIFICATION

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

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

33.1.2. 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;

33.1.3. 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.

33.1.4. The persons referred in Annex 9.

Annex 9, in particular, point 4 states:

ANNEX 9 – ADDITIONAL PROVISIONS - DIRECTORS – DISQUALIFICATION

(See Paragraph 33)

The following may not be appointed or continue as a director:

1. All board appointments are subject to compliance with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014
2. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
3. A person who is disqualified from being a company director under the law of England and/or Wales.
4. A person who is a governor of the Trust, or a governor, director, chairman or chief executive of another NHS Foundation trust or NHS trust.
5. A person who is incapable by reason of mental disorder or illness or injury of managing his property and affairs.
6. A person who occupies the same household as an existing director of the Trust or a governor.

With the recent recruitment of Non-Executive Directors (NED), one of whom is a NED in another NHS Trust, there has been discussion with the Deputy Lead Governor and governors forming part of the appointments committee whether this restriction is still appropriate in the current NHS climate and in light of other foundation and NHS Trusts employing NEDs who work in other trusts to share expertise and experience.

There is agreement that Annex 9, point 4, should be amended to:

> A person who is a governor of the Trust, or a governor, director, chairman or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the chairman) may be a non-executive director (other than the chairman) 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.

If Board approval is obtained, approval will be sought by the Council of Governors at the next meeting on 18 May 2020. Approval by both Board and the Council of Governors is required for the change to the Constitution to be adopted.

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

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

CONTENTS

- Standing Financial Instructions
- Scheme of Delegation

Amendment history – 2013 to 2019

- The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
- 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.
- April 2018 minor amendments to Board Standing Orders
- Addition of Standing Financial Instructions – approved February 2018
- 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.

1. INTERPRETATION AND DEFINITIONS

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

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

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

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

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

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

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

2. NAME

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

3. PRINCIPAL PURPOSE

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

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

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

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

3.3.2. the promotion and protection of public health.

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

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

4. POWERS

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

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

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

5. Membership and Constituencies

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

5.1.1. A public constituency

5.1.2. A staff constituency

6. Application for Membership

6.1. An individual who is eligible to become a member of the Trust shall become a member on his application to the Trust to become a member.

7. Public Constituencies

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

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

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

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

8. Staff Constituency

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

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

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

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

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

8.4. The Staff Constituency shall be divided into 6 classes of individuals as set out in Annex 2

8.5. The minimum number of members in each class of the Staff Constituency is specified in Annex 2, and if the number of members in a class does not equal or exceed the minimum number that class shall not be treated as a class for the purpose of electing governors.

9. AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF

9.1. An individual who is:

9.1.1. eligible to become a member of the Staff Constituency, and

9.1.2. invited by the Trust to become a member of the Staff Constituency,

shall become a member of the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10. PATIENTS' CONSTITUENCY

There is no Patients' Constituency.

11. PARAGRAPH 11 IS NOT USED

12. RESTRICTIONS ON MEMBERSHIP

12.1. 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.

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

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

12.4. 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.

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

12.6. 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.

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

13. ANNUAL MEMBERS' MEETING

13.1. The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public.

14. COUNCIL OF GOVERNORS – COMPOSITION

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

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

14.3. 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.

14.4. 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.

15. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

15.1. 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.

15.2. 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.

15.3. 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).

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

15.5. 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.

16. COUNCIL OF GOVERNORS – TENURE

16.1. Subject to 15.5 and 16.2, an elected governor may hold office for a period of up to 3 years.

16.2. An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than 9 years in all.

16.3. An appointed governor may hold office for a period of up to 3 years and may then be re-appointed but shall not hold office for more than 9 years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

16.4. A governor may resign by giving notice in writing to the Chairman of the Trust.

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

16.6. The limits of 9 years in sub-paragraphs 16.2 and 16.3 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.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND TERMINATION OF OFFICE

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

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

17.1.2. 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;

17.1.3. 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;

17.1.4. The further persons set out in Annex 6.

17.2. 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.

17.3. 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:

17.3.1. the failure was in their opinion due to a reasonable cause or causes, and

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

17.4. 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:

17.4.1. 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

17.4.2. failed to declare a material interest pursuant to paragraph 22 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

17.5. 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 17.3 and 17.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

17.6. In the event of a notice being given under sub-paragraph 17.3 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 17.3 and 17.4 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.

17.7. 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.

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

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS, EQUIPPING GOVERNORS, LEAD GOVERNOR & DEPUTY LEAD GOVERNOR

18.1. The general duties of the Council of Governors are–

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

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

18.2. 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.

18.3. 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.

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

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

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

19.3. 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.

19.4. 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.

19.5. 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.

19.6. For the purpose of obtaining information about the Trust's performance of its functions or the directors performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

19.7. The Council of Governors will establish statutory committees to carry out such functions as are required by law and to carry out such functions as the Council specifies.

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

20. COUNCIL OF GOVERNORS – STANDING ORDERS

20.1. 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.

21. COUNCIL OF GOVERNORS – REFERRAL TO THE PANEL

21.1. In this paragraph the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

21.1.1. to act in accordance with its constitution, or

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

21.2. 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.

22. COUNCIL OF GOVERNORS – CONFLICTS OF INTEREST OF GOVERNORS

22.1. 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.

22.2. 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.

23. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

23.1. 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.

24. PARAGRAPH 24 IS NOT USED

25. BOARD OF DIRECTORS – COMPOSITION

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

25.2. The Board of Directors is to comprise:

25.2.1. a non-executive Chairman

25.2.2. a maximum of 7 other non-executive directors

25.2.3. a maximum of 6 executive directors (subject to 25.4 below), to include:

25.2.3.1. a Chief Executive who shall be the Accounting officer,

25.2.3.2. a Finance Director.

25.3. 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.

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

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

26. BOARD OF DIRECTORS – GENERAL DUTY

26.1. 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.

27. PARAGRAPH 27 IS NOT USED

28. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIRMAN AND NON-EXECUTIVE DIRECTORS

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

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

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

29. PARAGRAPH 29 IS NOT USED

30. BOARD OF DIRECTORS – DEPUTY CHAIRMAN

30.1. After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chairman. The Deputy Chairman shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

31. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS

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

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

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

32. PARAGRAPH 32 IS NOT USED

33. BOARD OF DIRECTORS – DISQUALIFICATION

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

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

33.1.2. 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;

33.1.3. 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.

33.1.4. The persons referred in Annex 9.

34. BOARD OF DIRECTORS – MEETINGS

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

34.2. 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.

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

34.4. 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.

35. BOARD OF DIRECTORS – STANDING ORDERS

35.1. 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.

36. BOARD OF DIRECTORS – CONFLICTS OF INTEREST OF DIRECTORS

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

36.1.1. 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;

36.1.2. 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.

36.2. The duty referred to in sub-paragraph 36.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.3. The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.4. In sub-paragraph 36.1.2 'third party' means a person other than the Trust or a person acting on its behalf.

36.5. 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.

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

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

36.8. 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.

36.9. A director need not declare an interest –

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

36.9.2. if, or to the extent that, the directors are already aware of it;

36.9.3. 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.

37. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

37.1. The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

37.2. 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.

37.3. The Chairman and other non-executive directors may be appointed for initial terms of up to 4 years, which may be renewed by the Council for a further term of up to 4 years, and may be renewed thereafter for such term, if any, as will bring the total length of service to 8 years. Where a director has served 8 years, his appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal.

38. REGISTERS

38.1. 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.

38.2. a register of members of the Council of Governors;

38.3. a register of interests of Governors;

38.3.1. a register of directors; and

38.3.2. a register of interests of directors.

39. PARAGRAPH 39 IS NOT USED

40. REGISTERS – INSPECTION AND COPIES

40.1. The Trust shall make the registers specified in paragraph 38 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.

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

40.2.1. any member of the Patients' Constituency; or

40.2.2. any other member of the Trust, if the member so requests.

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

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

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

40.4. 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.

41. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

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

41.1.1. A copy of the current constitution;

41.1.2. A copy of the latest annual accounts and of any report of the auditor on them; and

41.1.3. A copy of the latest annual report.

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

41.2.1. 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;

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

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

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

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

41.2.6. 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;

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

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

41.2.9. 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;

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

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

41.4. 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.

42. AUDITOR

42.1. The Trust shall have an auditor.

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

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

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

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

43. AUDIT COMMITTEE

43.1. 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.

44. ACCOUNTS

44.1. The Trust must keep proper accounts in such form as Monitor may with the approval of the Treasury direct and proper records in relation to those accounts.

44.2. Monitor 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.

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

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

44.4.1. the accounts;

44.4.2. the records relating to them; and

44.4.3. any report of the Auditor on them.

44.5. The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as Monitor may with the approval of the Secretary of State for Health direct.

44.6. Monitor may with the approval of the Secretary of State for Health direct the Trust:

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

44.6.2. that any accounts prepared by it by virtue of sub-paragraph 44.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

44.7. 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:

44.7.1. the methods and principles according to which the annual accounts are to be prepared; and/or

44.7.2. the content and form of the annual accounts

44.8. The Trust must –

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

44.8.2. send copies of the annual accounts, and any report of the Auditor on them to Monitor within such a period as Monitor may direct

44.9. The Trust must send a copy of any accounts prepared by virtue of paragraph 44.6 above and a copy of any report of the Auditor to Monitor within such a period as Monitor may direct.

44.10. The functions of the Trust referred to in this paragraph 44 shall be delegated to the accounting officer.

45. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

45.1. The Trust shall prepare an annual report and send it to Monitor.

45.2. The annual report must give:

45.2.1. 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.

45.2.2. 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 19.5 hereof.

45.2.3. information on the corporation's policy on pay and on the work of the committee established under paragraph 37(2) hereof and such other procedures as the corporation has on pay.

45.2.4. information on the remuneration of the directors and on the expenses of the governors and the directors

45.2.5. any other information that Monitor requires

45.3. he Trust shall give information as to its forward planning in respect of each financial year to Monitor

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

45.5. 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.

45.6. Each forward plan must include information about:

45.6.1. 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

45.6.2. the income it expects to receive from doing so.

45.7. Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 45.6.1, the Council of Governors must:

45.7.1. 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

45.7.2. notify the directors of the Trust of its determination.

45.8. 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.

46. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

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

46.1.1. the annual accounts

46.1.2. any report of the auditor on them

46.1.3. the annual report.

46.2. 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.

46.3. The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. INSTRUMENTS

47.1. The Trust shall have a seal.

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

48. AMENDMENT OF THE CONSTITUTION

48.1. The Trust may make amendments of its constitution only if –

48.1.1. more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

48.1.2. more than half of the members of the Board of Directors of the Trust voting approve the amendments.

48.2. Amendments made under paragraph 48.1 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.

48.3. 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) –

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

48.3.2. the Trust must give the members an opportunity to vote on whether they approve the amendment.

48.4. 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.

48.5. Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor'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.

49. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

49.1. 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.

49.2. 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.

49.3. A ‘significant transaction’ is a transaction which, if entered into by the Trust:

49.3.1. 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;

49.3.2. 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;

49.3.3. 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.

49.3.4. 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;

49.3.5. would be likely to put at risk the Trust’s ability to maintain the minimum required financial risk rating/ continuity of service risk rating

49.4. Not used

49.4.1. Where it might reasonably be considered that a transaction falls within paragraph 49.3 the Board shall inform the Council of the transaction at the earliest opportunity.

49.4.2. 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.

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

49.5.1. act in accordance with its judgment of the best interests of the Trust; and

49.5.2. 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.

49.6. 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.

49.7. 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.

50. INDEMNITY

50.1. 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.

51. DISPUTE RESOLUTION

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

51.2. If the Chairman is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

51.3. If the dispute is not resolved, the Chairman may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 - THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area covered by North Dorset District Council, comprising the following electoral wards: ▪ Blandford Damory Down ▪ Blandford Hilltop ▪ Blandford Old Town ▪ Blandford St Leonards ▪ Blandford Station ▪ Bourton & District ▪ Cranborne Chase ▪ Gillingham Lodbourne ▪ Gillingham Town ▪ Hillforts ▪ Milton ▪ Motcombe ▪ Marnhull ▪ Portman ▪ Riversdale ▪ The Beacon ▪ Shaftesbury Underhill ▪ Shaftesbury Central ▪ Shaftesbury Grosvenor ▪ Shaftesbury Christy's ▪ Stour Valley ▪ The Stours ▪ The Lower Tarrants ▪ Wyke
Kennet	The area formerly covered by Kennet District Council comprising the following electoral divisions: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down

	• Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings
New Forest	The following wards within New Forest District Council: ▪ Downlands & Forest ▪ Fordingbridge ▪ Forest North West ▪ Ringwood North ▪ Ringwood South ▪ Ringwood East & Sopley
Salisbury City	The following electoral divisions formerly covered by Salisbury District Council: • Bemerton • Fisherton & Bemerton Village • Harnham • St. Paul's • St. Francis & Stratford • St. Marks & Bishopdown • St. Edmund's & Milford • St. Martin's & Cathedral
South Wiltshire Rural	The following electoral divisions • Alderbury & Whiteparish • Amesbury West • Amesbury East • Bourne & Woodford Valley • Bulford, Allington & Figheldean • Durrington & Larkhill • Downton & Ebble Valley • Ethandune • Fovant & Chalke Valley • Laverstock, Ford & Old Sarum • Mere • Nadder & East Knoyle • Redlynch & Landford • Till & Wylye Valley • Tisbury • Warminster Copheap & Wylye • Warminster East • Warminster West • Warminster Broadway • Warminster Without • Westbury West • Westbury North

	• Westbury East • Wilton & Lower Wylye Valley • Winterslow
East Dorset	The following electoral wards within the area covered by East Dorset District Council: • Alderholt • Crane • Handley Vale • Holt • Newton • St. Leonards & St. Ives East • St. Leonards & St. Ives West • Three Legged [Cross] & Potterne • Verwood Dewlands • Verwood Stephen's Castle • West Moors
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 6 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUB GROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries
	Health Care Support Workers (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers
	Orthoptists
	Physiotherapists and Helpers
	Art/Music/Drama Therapists
	Speech and Language Therapists and Helpers
	Psychologists and Psychology Technicians
	Psychotherapists
	Medical Physicists and Technicians
	Pharmacists and Pharmacy Technicians
	Dental Technicians
	Operating Department Practitioners
	Social Workers
	Chaplains
	Clinical Scientists
	Biomedical Scientists and Technical Staff
	Geneticists and Technicians
	Audiology Staff
	Cardiographers and Support Staff
Hotel and Property Staff	Ancillary Staff
	Works and Maintenance Staff
	Ambulance Staff
Clerical, Administrative and Managerial 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 14.

1. There shall be 15 public governors as set out in Annex 1.
2. There shall be 6 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.
3. Wiltshire Council may appoint one governor by notice in writing signed by the senior executive of the Council.
4. There shall be one governor appointed by Wessex Community Action.
5. The following Clinical Commissioning Groups may each appoint one governor.
    a. Wiltshire
    b. Dorset
    c. West Hampshire
6. There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 15]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

PART 12: MISCELLANEOUS

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.

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.

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.

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.

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:
    1. (i) configured in accordance with these rules; and
    2. (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

3.

(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;
(d) 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
(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.

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]

Notes

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

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,
(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.

41-[NOT USED]

42. Arrangements for counting of the votes

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

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

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

43. The count

43.1 The returning officer is to:

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

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

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

PP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

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

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

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

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

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

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

FPP44.4 The returning officer is to:

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

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

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

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

FPP44.6 Any text voting record:

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

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

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

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

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

is not to be rejected for such reason (either wholly or in respect of that vote) if

an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

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

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

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

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

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

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

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he or she has declared elected:
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
    (ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –
  (i) any rejected ballot papers, including ballot papers rejected in part,
  (ii) any rejected text voting records, including text voting records rejected in part,
  (iii) any disqualified documents, or the list of disqualified documents,
  (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
  (v) the list of eligible voters, or

4. (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.

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.

FPP59.3 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) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

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

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

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.

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.

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 17)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation;

2. A person who is disqualified from being a company director under the laws of England and/or Wales;

3. A person who is a director of the Trust, or a governor, director, Chairman or chief executive of another NHS Foundation Trust or NHS Trust;

4. A person who is incapable by reason of mental disorder or illness or injury of managing his property and affairs;

5. A person who occupies the same household as an existing governor or a director of the Trust;

6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election, or becomes employed by the Trust

7. A person who has been removed from any list prepared under Part II of the National Health Service Act 1977, or has been removed from a list maintained pursuant to regulations made under section 28X of that Act, and has not been reinstated.

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

(See paragraph 20)

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

3.2. The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given.

3.3. If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4. Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5. Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. AGENDA ITEMS AND MOTIONS

4.1. Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor.

4.2. A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second

the motion, and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chairman of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3. A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the chairman of the meeting.

4.4. No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chairman of the Trust.

4.5. The proposer of a motion shall propose it and shall have a right to speak before a vote is taken.

4.6. During the consideration of a motion a governor may move:
- 4.6.1. an amendment to the motion;
- 4.6.2. that the consideration of motion be adjourned to a subsequent meeting;
- 4.6.3. that the motion be summarily dismissed and the meeting to proceed to the next business;
- 4.6.4. that the motion be voted on immediately.

4.7. No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the chairman of the meeting.

4.8 Save where the chairman of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. QUORUM

5.1. No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. RELEVANCE AND CONCISION

6.1. Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2. The chairman of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3. In any matter relating to the interpretation of the Constitution and Standing Orders the chairman of the meeting shall consider the advice of the Secretary.

7. VOTING

7.1. Save where it is otherwise provided by the constitution or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2. In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3. At the discretion of the chairman of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4. Save in the case of a secret paper ballot, if at least one third of the governors present request, the voting for and against of each governor shall be minuted.

7.5. If a governor requests, his vote shall be minuted.

7.6. No one may vote unless physically present: there shall be no votes by proxy.

8. MINUTES

8.1. Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting and signed by the chairman of that meeting.

8.2. The minutes shall record the names of those attending.

9. SUSPENSION OF STANDING ORDERS

9.1. Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the chairman of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2. A decision to suspend standing orders shall be recorded in the minutes.

9.3. A separate record of matters while the orders were suspended shall be made, and shall be provided to the governors with the minutes.

10. COMMITTEES

10.1. The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2. The powers of the Council may be delegated to a committee for a specific purpose if the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3. The powers of the Council shall be exercised in general meeting.

10.4. The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5. Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. NOMINATION COMMITTEES

11.1. Paragraph 28 of the Constitution provides for the appointment and removal of the Chairman of the Trust and the other non-executive directors by the Council. Paragraph 28.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2. For the appointment of the Chairman, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director

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

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

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

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

11.4.2. In the case of a nomination for Chairman invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5. If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. DECLARATIONS AND REGISTER OF INTERESTS

12.1. Paragraph 22 of the Constitution provides for declarations of interest. It states:

22.1 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.

22.2. For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

12.2. Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3. If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4. Subject to the exceptions below, material interests include:

12.4.1. any directorship of a company;

12.4.2. any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3. any interest in an organisation providing health and social care services to the National Health Service;

12.4.4. a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5. any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter

before the Council fairly.

12.5. The exceptions are:

12.5.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2. an employment contract with the Trust held by a staff governor;

12.5.3. an employment contract held with the appointing body by an appointed governor;

12.6. If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7. The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

12.8. The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9. If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the chairman of the meeting shall rule on the question having taken the advice of the Secretary.

12.10. A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11. A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 17.4 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 23 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2. Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3. The total of the expenses paid to governors will be published in the Annual Report.

16. LEAD AND DEPUTY LEAD GOVERNOR'S APPOINTMENT

16.1. The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR - ROLES

17.1. The role of the Lead Governor is:

17.1.1. to chair meetings of the Council which cannot for any reason be chaired by the Chairman or the Deputy Chairman;

17.1.2. to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chairman;

17.1.3. to communicate regularly with the Chairman, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4. to be a point of contact for Monitor when appropriate;

17.1.5. to provide input into the appraisal of the Chairman;

17.1.6. to take an active role in the activities of the Council;

17.1.7. to be a point of contact for governors when they have concerns;

17.2. The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. LEAD AND DEPUTY LEAD GOVERNORS - VOTE OF NO CONFIDENCE

18.1. If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chairman, the Chairman shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2. The Chairman will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting.

18.3. The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4. At the meeting the Chairman will present the reasons for the motion and it will

be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5. A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governors 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 19.6 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 19.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chairman. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. FORWARD PLAN

20.1. Paragraph 45.5 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 20.1 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

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) before making any statement for publication in the media a governor should take the 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 9 – ADDITIONAL PROVISIONS - DIRECTORS – DISQUALIFICATION

(See Paragraph 33)

The following may not be appointed or continue as a director:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, chairman or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the chairman) may be a non-executive director (other than the chairman) 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 who is incapable by reason of mental disorder or illness or injury of managing his property and affairs.
5. A person who occupies the same household as an existing director of the Trust or a governor.