Bundle Trust Board Public 1 May 2025

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
March SOX of the month – Louise Smith, Clinical psychology
March Patient Centred SOX – Coutney Harnett, Acute Medical Unit

1.2 10:10 - Staff Story
Presented by Melanie Whitfield

1.3 Welcome and Apologies
No apologies received

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting held on 6 March 2025
For approval
1.5 Draft Public Board mins 6 March 2025

1.6 Matters Arising and Action Log
1.6 Public Trust Board Action Log

1.7 Public Trust Board Cycle of Business 2025/26
Presented by Fiona McNeight
For approval
1.7a Cover Sheet Trust Board cycle of business
1.7b Draft Public Board Annual Business Cycle 2025-6

1.8 10:35 - Chair's Business
Presented by Ian Green
For information

1.9 10:40 - Chief Executive/Managing Director Report
Presented by Cara Charles Barks / Lisa Thomas
For information
1.9 Chief Executive Report April 2025

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:50 - Integrated Performance Report to include exception reports
Presented by Niall Prosser
For assurance
2.1a IPR Cover Sheet - Trust Board 2025-04 FINAL
2.1b Integrated Performance Report - May 2025

2.2 11:15 - Audit Committee - 20th March
Presented by Richard Holmes
For assurance
2.2 20 March Audit Committee Escalation Report

2.3 11:20 - Finance and Performance - 13 March, 25 March and 29 April
Presented by Debbie Beaven
For assurance
29th April will be a verbal update
2.3 Finance and Performance Escalation Report 13 March 2025 - Extraordinary meeting
2.3 Finance and Performance Escalation Report 25 March 2025

2.4 11:25 - Clinical Governance Committee – 25 March and 29 April
Presented by Anne Stebbings
For assurance
29th April will be a verbal update
2.4 Clinical Governance Committee Escalation Report 25 March 2025

2.5 11:30 - Trust Management Committee – 26 March and 23 April
Presented by Lisa Thomas
For assurance
2.5a TMC escalation report April (March mtg)
2.5b TMC escalation report April (April Meeting)

2.6 11:35 - People and Culture Committee - 27 March and 24 April
Presented by Eiri Jones
For assurance

- 2.6 PCC Escalation Report to Trust Board from March 2025 PCC to May 2025 Trust Board
- 2.6 PCC Escalation Report to Trust Board from April 2025 PCC to May 2025 Trust Board

3 STRATEGY AND DEVELOPMENT

3.1 11:40 - Improving Together Update Report
Presented by Alex Talbott
For assurance

- 3.1a Cover sheet_Improving Together Quarterly Trust Board Report_May 2025
- 3.1b QTB condensed version (May 25) final

3.2 11:50 - Triannual Strategy Deployment Update
Presented by Lisa Thomas
For assurance

- 3.2a Triannual-Strategy-Deployment-Update CoverSheet
- 3.2b Triannual-Strategy-Deployment-Update

3.3 12:00 - Partnerships Stocktake
Presented by Lisa Thomas
For assurance

- 3.3a Partnerships-Stocktake Cover-Sheet
- 3.3b Partnerships v0.4

4 PEOPLE AND CULTURE

4.1 12:10 - National Staff Survey Results
Presented by Melanie Whitfield
For information

- 4.1a Staff Survey Overview. Public Board. Cover Sheet. MW
- 4.1b Staff Survey 2024 - Public Board. May 25

4.2 12:20 - Health and Safety Quarterly Report
Presented by Melanie Whitfield
For information

- 4.2a Health & Safety Report Q3 - Cover sheet
- 4.2b Health and Safety Report Q3 FY25

4.4 12:30 - BREAK

5 QUALITY AND RISK

5.1 13:00 - Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For assurance

- 5.1a Trust Board BAF Report May 2025
- 5.1b Board Assurance Framework May 2025
- 5.1c Corporate Risk Register March 2025
- 5.1d CRR tracker v1 Board Committees March 2025

5.2 13:10 - Incident Reporting ad Risk Report
Presented by Judy Dyos
For assurrance

- 5.2a Q3 risk management report cover sheet
- 5.2b Q3 Risk Management Report

5.3 13:20 - Perinatal Quality Surveillance Report March (February data)
Presented by Vicki Marston / Judy Dyos
For assurance

- 5.3a Front sheet Perinatal Quality Surveillance Report - March (February data)
- 5.3b Perinatal Quality Surveillance Mar 2025 Slides (Feb data)

5.4 13:25 - Perinatal Quality Surveillance Report April (March data)
Presented by Vicki Marston / Judy Dyos
For assurance

5.4a Front sheet Perinatal Quality Surveillance Report - April (March data)
5.4b Perinatal Quality Surveillance April 2025 Slides (March data)

5.5 13:30 - Bi-Annual Midwifery, Maternity & Neonatal Staffing Report March 2025
Presented by Vicki Marston / Judy Dyos
For assurance
5.5a Front Sheet Trust Board Maternity Neonatal Staffing Report March 2025
5.5b Midwifery and Neonatal Nursing Staffing Report March 25

6 GOVERNANCE

6.1.1 13:35 - Annual Review of Directors Interests
Presented by Fiona McNeight
For assurance
6.1.1 Annual Register of Interests Report 2024_25 - Board
6.1.1 Declarations of Interest - Additional Declarations
6.1.1 Declarations of Interest - Board
6.1.1 Declarations of Interest - Budget Holders
6.1.1 Declarations of Interest - Governors
6.1.1 Declarations of Interest - Procurement Staff
6.1.1 Declarations of Interest - Senior Staff 8d+

6.1.2 13:40 - Annual Review of Gifts and Hospitality
Presented by Fiona McNeight
For assurance
6.1.2 Annual Register of Gifts and Hospitality 2024_25
6.1.2a Annual Register of Gifts and Hospitality 2024_25

6.1.3 13:45 - Fit and Proper Persons Annual Assurance
Presented by Fiona McNeight
For assurance
6.1.3 Fit and Proper Persons Annual Assurance

6.2 13:50 - Integrated Accountability and Governance Framework to include Review of Board Committee Terms of Reference
Presented by Fiona McNeight
For discussion
6.2 Integrated Governance and Accountability Cover_Sheet
6.2 Integrated Governance and Accountability Framework March 2025
6.2_Board and Committee Organisational Structure inc quality_governance V1March_2025
6.2a Audit Committee Terms of Reference Dec 24
6.2b CGC Terms of Reference_March 25
6.2c F& P Terms of Reference
6.2d People and Culture Committee Terms of Reference V6 2025
6.2e Remuneration Committee ToR

6.3 13:55 - Annual Review of Constitution
Presented by Fiona McNeight
For approval
6.3a Constitution Cover Sheet - Trust Board 2025
6.3b Draft Constitution 2025

6.4 14:00 - NHSE Self-Certification CoS7 (Continuation of Services) and Training for Governors
Presented by Fiona McNeight
For approval
6.4a Cover Sheet Self Certification 2025
6.4b Self Certification 2025

6.5 14:05 - Joint Committee Terms of Reference and Partnership Agreement
Presented by Cara Charles Barks
For approval
6.5a Cover_Sheet_May 25_BSW Hospitals Group_Partnership Agreement TORsV1.0 (003)
6.5b Project Sapphire - Draft Partnership Agreement v006.3(71688163.15)

7 FINANCIAL AND OPERATIONAL PERFORMANCE

7.1 14:10 - Business Plan 2025/2026
Presented by Niall Prosser
For approval
- 7.1a Public board Annual Plan Update Cover Sheet
- 7.1b SFT business plan 2526 public board april 25

7.2 14:20 - Review of Standing Financial Instructions and Scheme of Delegation
Presented by Mark Ellis
For approval
- 7.2a SFI and SoD review May25 TB
- 7.2b DRAFT - Standing Financial Instructions Mar25
- 7.2c DRAFT - Schemeofdelegation Mar25

7.3 14:25 - Estates Technical Service Update
Presented by Mark Ellis
For assurance
- 7.3a Estates report cover sheet - Board May 2025
- 7.3b Estates Report April - Board

8 CLOSING BUSINESS

8.1 14:35 - Any Other Business

8.2 Agreement of Principal Actions and Items for Escalation

8.3 14:40 - Public Questions

8.4 Date next Public meeting - 3 July 2025

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

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10am on Thursday 6th March 2025, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director (via Teams)
Mark Ellis (ME)	Interim Chief Finance Officer
Lisa Thomas (LT)	Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director
Jon Burwell (JB)	Senior Information Officer
Cara Charles Barks (CCB)	Chief Executive
Kirsty Matthews (KM)	Non-Executive Director
Judy Dyos (JD)	Chief Nursing Officer

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Director of Improvement
Tapiwa Songore (TS)	Head of Corporate Governance (minutes)
Vicki Marston (VM)	Director of Midwifery (items 3.1, 3.2, 3.3, 3.4, 3.5, 3.6 and 3.7)
John O'Keefe (JO'K)	Head of Estates (for agenda item 6.1)
Stuart Henderson (SH)	Deputy Chief Medical Officer (For agenda item 3.9)
Victoria Aldridge (VA)	Head of Patient Experience (For agenda item 1.2)
Russell Edwards (RE)	Commercial Director, The Surgical Consortium
Jess Willetts (JW)	SLT (For agenda item 1.2)
Allan Adlam (AA)	Patient (For agenda item 1.2)

Observers

Jane Podkolinski	Governor
Francis Owen	Governor
Peter Rusell	Governor
Jacques Harte	Governor

Apologies

Duncan Murray (DM)	Chief Medical Officer

ACTION

TB1 OPENING BUSINESS

6/3/1 IG welcomed everyone to the meeting and informed those present that this was a meeting held in public but not a public meeting.

IG also reminded the Board to approach the meeting using the Improving Together Program methodology, the quality improvement used by the Trust in the delivery of change and transformation.

TB1 6/3/1.2 **Presentation of SOX Certificates**

IG informed everyone that the SOX Nominations recognised staff in the organisation for their contribution to the development of the Trust strategy and patient care, and announced the following the SOX nominations:

- January SOX of the month – Adam Parsons, Operational Performance Management and Christopher Mansfield, Cardiology and Stroke Operational Manager
- January Patient Centred SOX – Amalia O'Neill, Leigh Eldridge and the Phlebotomy Department
- February SOX of the month – Scott Gillespie, Old Petrie, Estates and Facilities.
- February Patient Centred SOX – Pearl Lippin, Pitton Ward

IG explained that the nominations were publicly acknowledged at the Board and the Certificates would be presented to the recipients by the members of the Executive Team.

TB1 6/3/1.2 **Patient Story**

JDy introduced the Patient Story, and the Board welcomed AA and JW from the Speech and Language Team (SLT) to the meeting.

AA, supported by JW shared his experience of spending time in hospital after suffering a stroke and then developing aphasia, a communication impairment. AA narrated the impact aphasia had on his life. He was now receiving speech and language therapy from the SLT since being discharged from hospital.

JW reported that there had been a lot of learning for the SLT, and they were looking at ways to improve support to patients with communication impairments and to promote independence. It had been recognised that providing accessible information was important in facilitating person centred care.

The Board asked AA whether he had been able to access other services, and it was noted that he had received support from the clinical psychologist, however there were challenges due to his unusual situation.

The Board asked if there was support in the community for patients who had been discharged from acute settings and CCB reported that this warranted a conversation with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) as it involved partnership working.

The Board thanked AA and the SLT team for sharing the story and welcomed the opportunity to hear from services like SLT. It was acknowledged that receiving feedback from patients was important in developing and shaping services to improve the patient journey and that AA's experience would be useful as a lived experience.

TB1 6/3/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and reported that apologies had been received from DM. SH would be deputising for him and would be joining after his clinic.

TB1 6/3/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

There were no declarations of interest pertaining to the items on the agenda.

IG reported that, although there was no interest involved, EJ as the SID would chair Agenda item 4.4, regarding the appointment of the Joint Chair, and he would leave the room to facilitate a proper discussion. This arrangement had been agreed by the three BSW Chairs.

TB1 6/3/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 9th January and 6th February 2025**

IG presented the minutes from the Public Board meetings held on 9th January and 6th February 2025.

Decision:
The Board **APPROVED** the minutes of the meetings held on 9th January 2025 and 6th February 2025 as a true and correct record.

EJ reported that the Improving Together event in Gloucester had been well received and had been very beneficial.

TB1 6/3/1.6 **Matters Arising and Action Log**

FMc presented the action log and the Board agreed to close the following actions which had been completed

- **TB1 5/12/5.5** Perinatal Culture and Leadership Report.
- **TB1 9/1/2.1** Integrated Performance Report
- **TB1 9/1/3.1** External Well Led Review 6 monthly update on progress -
- **TB1 9/1/5.2** Quarter 2 Learning from Deaths Report

The Board received the following updates;

TB1 3/10/5.2 Estates Technical Service Update –The Board noted that progress had been made however the reporting was still evolving. Action Closed.

TB1 9/1/5.4 Incident Reporting and Risk Report – This action was due in May.

The Board asked whether there was any intelligence on the next CQC well-led inspection. It was noted that the CQC were still developing the framework and were focusing on the system rather that individual Trusts.

TB1 6/3/1.7 **Register of Attendance**

The Board noted the Register of Attendance.

TB1 6/3/1.8 **Chair's Business**

IG reported on the following

- The discussion on the appointment of a Joint Chair and thanked the Council of Governors for the contribution.
- The approach to group working, which would be explored further in the CEO's report.
- The importance of developing a balance between progressing the work on the development of the BSW Group and focusing on the legal responsibility of the Board in providing quality care for the Trust and its patients. There were some challenges to be negotiated in the coming months in designing and shaping the BSW Group and it was inevitable that the Board and the Executive in particular, would feel stretched.

The Board noted the Chair's report.

TB1 6/3/1.9 **Chief Executive's Report**

CCB presented the Chief Executive's Report and highlighted the following key points:

- The leadership changes at NHS England with Jim Mackey replacing Amanda Pritchard as the Chief Executive. The focus for the new Chief Executive was likely to be on recovery of the financial position and performance targets.
- Progress on the development of the BSW Group and the process for the recruitment of the Managing Directors. The interviews were expected in April 2025 and would be designed to ensure staff spent time getting to know the candidates.
- A partner had been identified to provide transitional support for the BSW Group and was expected to start in mid-March 2025.
- Progress on the development of the Joint Committee. Proposals would be coming to the April Board and CCB highlighted the importance of developing a framework that was suitable for the Group to avoid one that was mandated from the centre.
- The development of the Electronic Patients Records system and this would be discussed further on the agenda

LT reported that the Trust had declared a critical incident in the week, related to patient flow and pressures. The Trust had been under pressure for the past 12 to 18 months and this had been made worse by the number of patients waiting for onward care. The incident had been stood down and the Trust was working with system partners to alleviate the pressure and underlying issues.

PC appraised the Board on the progress with the development of the Joint Committee following the meeting with BSW partners. The next phase was gaining agreement on the documents. The Board thanked PC, EJ and RC for engaging with the Group on behalf of the Trust.

Discussion:

The Board welcomed the appointment of a transitional support partner to support the development of the Group and acknowledged the importance of developing a good relationship with them. The Board requested that they be sighted on their proposals and noted that engaging with transitional team was the remit of the Joint Committee. IG informed the Board that the RUH Board were currently dealing with the governance process for the appointment on behalf of the Group.

The Board referred to the critical incident, asked whether the other Trusts were experiencing the same pressures, and it was noted that RUH were experiencing the same type of pressures, however they had not declared a critical incident. It was noted that BSW were experiencing the second worst ambulance pressure in the country and had received mandated support from an Urgent Care Delivery Director and the three MDs would be meeting her to discuss ambulance delays.

The Board sought clarity on the main causes of the pressure and NP reported that the combination of internal and external factors including the No Criteria to Reside (NCTR), processes in emergency care, patients waiting for bedded care in the community. Other factors such as school half term were all contributing to the incident.

The Board asked what the response had been from the community partners, and it was noted that system partners were doing their best to support the Trust, however some of the community and local government partners were experiencing challenges of their own. NP reported that 40 - 60% of the challenges being experienced were within the Trust capability to fix.

The Board asked whether there was any support from the system to shift the NCTR and CCB reported that a Recovery Director had been appointed to influence recovery from within the Trust, focusing on the drivers of the NCTR. Mandated system recovery support on urgent care delivery had also been made available and would be supporting acutes Trusts around urgent care pathways. The combined internal and external focus was expected to alleviate the pressure.

The Board asked whether the risks from system partners had been adequately captured and LT reported that this was being discussed and would be added to the BAF.

The Board noted the measures being taken to address the NCTR and inquired on how long it would take for them to become effective. NP reported that this was a problem nationally and the Improving Together methodology ‘sprint’ had managed to improve pathways around length of stay. The next phase was tackling elements around bedded care requirements, and the Finance and Committee was monitoring progress.

The Board noted the report.

TB1 6/3/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 6/3/2.1 Integrated Performance Report (IPR) (M10 January)

JDy presented the Integrated Performance Report for Month 10 and highlighted the following key points:

- Capacity was high during the period mainly due to the impact of respiratory infections.
- Breakthrough objectives had been static during this period and focus was gaining traction and moving them forward.
- ICU admissions had gone up, but cardiac capacity remained stable.
- An increase in staff sickness absence rate for January, due to the impact of respiratory infections and linked to higher patient admissions.
- Mixed sex breaches were up resulting from the inability to move patients out ICU within the hour once deemed wardable.
- There was a proposal to change the high harm reporting due to time lag and need for data validation each month.
- Cancer and mortality data showed strong performance.

Discussion:

The Board referred to the mixed sex breaches and sought clarity on the processes in place to ensure privacy was maintained. Assurance was provided that most of the breaches were in ICU and the breaches reflected the inability to move patients out of ICU quickly enough. The breaches happened mainly for safety issues especially infection control and were rare outside ICU.

NP informed the Board that despite the challenges in urgent care, the Trust benchmarked very well against the national position. Cancer performance had improved tremendously and the Trust was now in the top quartile mainly due to the Improving Together program. The Board acknowledged that the improved performance came at a cost as reflected in the Trust's finance position and emphasised the importance of evaluating and sustaining the improvement. It was noted that many of the initiatives were now embedding into business as usual.

Despite the challenging environment, the Board commended the Executive for the strong performance, and thanked staff for their hard work. The Board challenged the Executive to strive for even better performance.

The Board noted the report

TB1 6/3/2.2 **Finance and Performance Committee – 28th January and 25th February**

DB presented the report from the Finance and Performance (F&P) Committee meetings held on 28th January and 25th February, and highlighted the following;

- The increased demand which was the main driver of the challenges being experienced and this impacted on the finances.
- The risk emanating from the Community Services Contract and whether this was financed or not.

- The workforce controls and the associated headcount reductions which could potentially impact on quality. The Trust Governors had requested to be kept informed on the impact on quality.
- The Planning Submission for 2025/26 and the challenges with CIPs. The main challenge was on identifying enough programmes and whether there was a realistic opportunity for delivery of the programmes. The Outpatient transformation had been identified as a key component in the delivery of the plan, however there were some challenging targets.
- The Planning submission timetable was challenging as well, and an Extraordinary F&P had been arranged to review the Plan.

Discussion:

The Board sought clarity on the planned deficit for the year and ME reported that the BSW system was targeting a breakeven position, however the system was discussing with the regional team as the final allocation had not yet been decided. BSW had been given an increased allocation which would help the resilience of the cash position.

The Board noted that the risk posed by the workforce controls was being fleshed out both internally and at system level as well and the Group was looking at pragmatic ways of managing the risk. The challenge from the CIPs was being managed effectively and it was recognised that while many of the programmes improved productivity, they were not cash releasing.

The Board noted the report.

TB1 6/3/2.3 **Clinical Governance Committee – 28th January and 25th February**

AS presented the report and the Board noted that the maternity reports later on the agenda had increased the volume of papers, however these were mandatory and required Board attention. The Board also noted that the Badgernet system for maternity had gone live.

Discussion:

The Board sought clarity on the support available for patients with mental health issues and it was noted that this was under the remit of the Chief Medical Officer and various avenues were being considered. IG reported that one of the questions from the Young People Board was whether there was enough support for young people transitioning from young people to adult.

In response to a question on the risk with the adult safeguarding team vacancy, JDY reported that the vacancy was being considered as business critical.

The Board noted the report.

TB1 6/3/2.4 **Trust Management Committee – 22nd January and 26th February**

LT presented the report from the Trust Management Committees – 22nd January and 26th February and reported on the final recommendations

following the car parking engagement. A number of changes were being made and a communication plan for the implementation had been developed.

The Board noted the report.

TB1 6/3/2.5 **People and Culture Committee – 30th January and 27th February**

EJ presented the report and highlighted the following;

- The impact of workforce controls on the ability to deliver both strategic and operational intentions and the quadrangulation required across people, finance, quality and performance.
- The delay in medical e-roster implementation.
- The Guardian of Safe Working report would be coming to the Board.
- The lack of availability for Masks for PPE and change in type of mask, increasing the risk for some staff.
- The Physio gap in occupational health.
- The Gender pay gap report which was on the agenda.

Discussion:

The Board sought clarity on the challenges being faced with masks, and it was noted that this was beyond the Trust's control and had been escalated. Assurance was provided that there were enough masks if masks became mandatory, however there was a cohort that would not have the right fit. Action was being taken to address this. Assurance was also provided that staff were not pressurised to work without PPE.

The Board sought assurance on the Sexual Safety Charter and MW reported that national policy had been adopted and had been launched. Managers had been trained, and more were being identified for training as the policy required. In response to a question on safeguarding, MW provided assurance that there was a robust process for handling safeguarding issues within the Trust.

The Board noted the report.

TB1 6/3/3 **QUALITY AND RISK**

TB1 6/3/3.1 **Women and Newborn Divisional Governance Report**

The Board welcomed VM to present the report providing assurance that quality care and patient safety was being effectively monitored and shared within the Women and Newborn Division, to understand the challenges, improve practice and maintain standards. This was being achieved by providing Divisional teams (MDT) with information required to promote changes in practice and learning from incidents at monthly Divisional Governance meetings. The report had been discussed extensively at the Clinical Governance Committee.

The Board noted the report.

TB1 6/3/3.2 **Maternity Quality and Safety Report Quarter 3**

VM presented the Maternity and Neonatal Quality and Safety Report for Q3 which demonstrated the current position against local and nationally agreed measures to monitor maternity and neonatal safety. The Board noted that

- There were no PMRT cases to review in Q3.
- The 1:1 labour care and supernumerary status of labour ward coordinator was maintained 100% of the time in Q3.
- Executive and Non-Executive safety champions attendance at the Safety Champion meetings.
- Three Stillbirths (Excluding Medical Termination of Pregnancy) Overall rate for last 12 months for SFT was 2.12 per 1000. (National rate 3.9/1000 National ambition 2.5 per 1000).
- Two reportable cases referred to Maternity and Newborn Safety Investigations (MNSI). One case met eligibility for investigation but not referral to ENS in full as first abbreviation (not eligible), the other case was rejected by MNSI
- The report had been discussed extensively at the Clinical Governance Committee.

The Board noted the report.

TB1 6/3/3.3 **Perinatal Quality Surveillance Report January (December data)**

VM presented the monthly Perinatal Quality Surveillance Report providing assurance to the Board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9

The Board noted that for December, the Midwife to birth ratio was 1:22– SFT recommended ratio was 1:24. Activity and births reduced in December contributing to low ratio.142 in December against 190 in October.

The Board noted the report.

TB1 6/3/3.4 **Perinatal Quality Surveillance Report February (January data)**

VM presented the Perinatal Quality Surveillance Report February to provide assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

The CNST Maternity Incentive Scheme required the Board review the report at each meeting.

The Board noted the report.

TB1 6/3/3.5 **Annual Maternity Survey**

VM presented the CQC Maternity Survey for 2024 and the Trust's action plan. The Board noted that the CQC carried out the survey annually for all NHS Trusts providing Maternity services. Women accessing maternity services at SFT in January and February 2024 were selected for the survey and provided responses anonymously. 289 women were included in the survey and 162 responded (56.4%). The Patient Perspective average response rate for all 30 Trusts surveyed was 45%.

SFT maternity department scored in the top 20% of Trusts on ten questions and bottom 20% of Trusts on 12 questions out of 63 questions. Four questions showed at least 10% improvement on the 2023 score, and for no questions the score was worse by 10% or more.

- The top five scores compared nationally were around the areas of
  - Partners being able to stay
  - Induction information
  - Mental health support.

- The bottom five scores were around
  - Care at home after birth
  - Support with Infant feeding.

An action plan to focus on areas to improve on has been coproduced with the Maternity and Neonatal Voices partnership (MNVP) to ensure service user oversight and input into improvements. It was noted that the post labour ward had been previously identified as an area of concern, however there had been a massive improvement in this survey.

The Board noted the report.

TB1 6/3/3.6 **Salisbury NHS Foundation Trust Maternity Self Certification Board Assurance Report for Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme Year 6 January 2025**

VM presented the Trust Maternity Self Certification NHS Resolution Maternity Incentive Scheme, Board Assurance Report for January 2025

The Trust Board had delegated the CEO to sign the declaration form declaring compliance with the ten safety actions for Year 6 of the Scheme, prior, to submission to NHS Resolution.

The Board noted the report.

TB1 6/3/3.7 **CQC Maternity Report**

JDy presented the report from the unannounced CQC inspection carried out on maternity services on 24 September 2024.The CQC inspection report was published on 14 February 2025 and the overall improved rating of Good was achieved. The CQC inspected 15 quality statements across the safe, caring and well-led key questions and combined the scores for those areas with scores from the last inspection to give the overall rating.

The service had been rated as overall ‘Requires Improvement’ in 2021, with a rating of ‘Requires Improvement’ for Safe and ‘Inadequate’ for well-led and a section 29A warning notice issued.

Discussion:

The Board thanked the team for the work done to improve the service and quality for the benefit of patients. The Board also thanked JDy and VM for their leadership.

The Board challenged the team to move on to achieve a rating of outstanding and VM reported that embedding and sustaining the good practice was the key. The Board also noted the importance of improving the culture and acknowledged this had been an area of focus with a lot of money invested in and the improving together program had been crucial in improving the service.

The Board received the report.

TB1 6/3/3.8 **Patient Feedback Report Q3**

JDy presented the Patient Feedback report for Q3. Patient activity across the Trust has increased this quarter and the total number of complaints and concerns has also increased. A total of 110 were logged for Q3, compared with 77 in Q2. A total of 347 comments/enquiries were logged by the PALS team in Q3, this was less than the previous quarter. A total of 257 compliments were recorded on Datix across the Trust (88 more than previous quarter).

For Q3 the top three most prevalent high-level themes for complaints across the Trust were largely the same as those seen in both Q1 and Q2. These were in relation to Patient Care (44%) and Communication (17%). However, Appointments including delays and cancellations was a new theme this quarter (10%).

Discussion:

The Board noted that the other BSW acutes were achieving higher response rates to complaints than SFT and queried whether they had more resources. It was noted that the delays that the Trust experienced were with the divisional teams and PALs were working on ways to expedite the process.

With regards to the quality of the responses, assurance was provided that the Director of Integrated Governance reviewed all the responses, which were then approved by the Managing Director, before they were sent out and the overall quality was improving across the Trust.

The Board noted the report.

TB1 6/3/3.9 **Learning from Deaths Q3**

The Board welcomed SH to present the Learning from Deaths Q3 report providing assurance that the Trust was learning from deaths and making improvements. Trust Boards were required to publish information on deaths, reviews, and investigations through a quarterly report to comply with the national requirements of the Learning from Deaths framework. SH highlighted the following issues;

- The crude mortality increased in December whereas below average numbers had been observed for the previous seven months recorded. Latest SHMI figure for the Trust was 0.96 (12-month period ending in August 2024). This was the lowest recorded figure for some time. According to NHSE this figure was statistically within the expected range for the Trust.

- The Trust mortality process enabled concerns to be escalated by the reviewer, who may then request a secondary (higher level) review.
- The main purpose of the learning from death process was to ensure that clinical teams review all the cases of patients who died under their care.

The Board noted that the report had been discussed at the Clinical Governance Committee and it was also noted that the SHMI was six months behind.

The Board noted the report.

TB1 6/3/4 GOVERNANCE

TB1 6/3/4.1 Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance – deferred from January

NP presented the report to update the Board on the EPRR duties and responsibilities, and a request to sign off the Annual EPRR assurance report as part of the NHSE assurance process

The Board noted that SFT had been rated by NHS Bath and Northeast Somerset, Swindon and Wiltshire Integrated Care Board as 'Fully' compliant for this year. As a Category One responder, the Trust was meeting its civil protection duties under the Civil Contingencies Act (2004). Full compliance meant that arrangements were in place that appropriately addressed all the core standards that the organisation was expected to achieve. The report had been reviewed at Finance and Performance Committee.

Discussion:

The Board acknowledged that it was reassuring to know that the Trust was prepared for any eventuality especially as some incidents were happening in other parts of the world and asked whether exercises were held jointly with other agencies. NP reported that this was the case.

The Board asked whether there was anything being done in preparation for extra ordinary incidents and NP reported that each Trust was part of the Local Resilience Group which mapped out the plans and requirements from each organisation and ensured that organisations were well placed to respond to any situation.

The Board queried whether more money was being used to achieve 100% compliance, and it was noted that this was designed to ensure safety and a high level of preparedness. However, there were opportunities for consolidating activities across the BSW group.

The Board noted the report and approved the recommendation to sign off this Annual EPRR assurance report

TB1 6/3/4.2 Register of Seals

The Board noted the Trust's seal had not been used since the previous report presented to Board on 9th January 2025.

TB1 6/3/4.3 **Board Meeting Schedule Proposal**

FMc presented the report seeking Board approval for the alignment of SFT Board meetings with the BSW Group. Progress had been made towards the Group working and this required meetings to be aligned to ensure efficiency.

The impact of the proposed changes would be to reduce the number of Board meetings to six in the year and the number of seminars to five. There would be no meetings in August. Three joint seminars would be arranged with BSW partners resulting in two local development days.

The GWH Board had considered and approved the proposed changes and RUH were also considering the proposals at their next Board meeting.

Discussion

The Board discussed the proposed changes and acknowledged that developing a common approach reflected the interconnectedness of the governance within the BSW Group. This was key to the development of the Joint Committee and would be the first step in facilitating its structures and systems. However this would have an impact on the work of the Board and Committees, and this required careful management.

It was acknowledged that the joint seminars would increase efficiency when mandatory issues affecting the three Boards were being discussed. The Joint Seminars would also act as important levers for organisational development and relationship building, however there was a potential loss of visibility for the Board.

The Board discussed the proposals and agreed that this was the first stage of an iterative process and there was room for flexibility going forwards. Careful planning focus and discipline would be crucial in improving the governance of the Group.

The Board approved the recommendations to

a) **Reduce the number of Board meetings to six in the year.**
b) **Move full Board (public and private) meetings to alternate months and in the intervening months, hold a Board seminar (x 5) with the opportunity of a private Board as required.**
c) **Two of the seminars will be held locally as Board Development Days, and the other three will be shared with the other Trusts. All Board members across the three hospitals will meet as one.**
d) **There will be no meetings in August.**

TB1 6/3/4.4 **Group Chair Appointment** *(IG left the room and EJ chaired this item)*

EJ introduced the report seeking the Board's support on the recruitment and appointment of a Group Chair for the BSW Group. EJ reported that the Chair's appointment was a remit for the Council of Governors (CoGs), however the Board were being asked to support the process, the development of a job description and person specification for the role. The report would be going to the three Boards and the three COGs.

The Board noted the advantages and disadvantages of a Joint Chair and the national guidance for such appointments. Two options had been proposed for

the recruitment process, for consideration and further development by a Joint Nominations Committee and the recommended option would be going to the meeting of the Council of Governors on 10 March 2025.

The options were as follows;

Option 1

- Open external recruitment process, assume internal candidates short-listed.

Option 2

- Interim appointment, pending completion of external open recruitment process.
- Role ringfenced to current Chairs of Trusts. Applications and interview process. Propose 6-8 months role.

Discussion

The Board noted the proposals and clarity was sought on whether there would be a Vice Chair and a SID. EJ reported that the exact arrangements would be dependent on the Group model, however the anticipation was that there would be three Vice Chairs and three SIDs. Separating the role of Vice Chair and that of the SID would strengthen the Board, however the decision was for the COG to make.

The Board expressed concern on the proposed time commitment for the Joint Chair and it was noted that the expectation was that the Joint Chair would chair all the Board meetings and would be supported by a Vice Chair.

The Board discussed the options and recognised that this was a period of significant and unprecedented change within the NHS and the Trusts required capacity to be able to deliver significant transformation. The Board acknowledged the importance of considering a wider pool of candidates, and it was suggested that there be a third option for consideration, to provide for an interim arrangement given the challenging timescales**.**

MW queried whether any legal advice had been sought and it was noted that the Chairs did not have contracts of employment and as such did not have employment rights however, there was a contractual notice period. It was decided that legal advice be sought in the event that the contracts for the current Chairs were terminated. Given the pace of change and to maintain stability and capacity, the Board advised the COG to consider short term interim arrangements. **MW**

The Board agreed to recommend Option one pending legal advice on the contractual arrangements for the Chairs and advised that the COG to consider interim arrangements.

TB1 6/3/5 PEOPLE AND CULTURE

TB1 6/3/5.1 Gender Pay Gap Report

MW presented the Gender Pay Gap Annual Report & Action Plan for 2024/25. The Board noted that all organisations with 250 or more employees

were required to report annually on their gender pay gap and the report was based on workforce as on 31 March 2024.

The SFT's total workforce was 4,665 employees, comprised of 3,508 female employees (75%) and 1,157 male employees (25%).

The Board noted that the Trust had continued to reduce the Mean hourly gender pay gap. The 2024 data showed that the Trust had a mean hourly pay gap of 15.75% a decrease from the 2023 figure of 16.47%, this has been achieved by an improved proportionality of female staff in the upper quartile of pay.

In 2024 the gender pay gap for the Administration and Clerical staff group had reduced to 15.90% compared to 15.97% (2023) and that for the Medical and Dental group was 10.95% compared to 10.23% (2023)

An action plan had been developed and the People Committee were satisfied that it was robust to support the capacity and capability.

The Board noted the report and approved its publication.

TB1 6/3/6 STRATEGY AND DEVELOPMENT

TB1 6/3/6.1 Estates Strategy

ME introduced the Estates Strategy which had been developed by Exi Design Group, in collaboration with the Trust and the Board welcomed JO'K to co present the report.

The Strategy set out the priority areas for development, reflecting projections on future needs of the Trust campus redevelopment plans. Engagement had been carried out with clinical teams on its development and the report had been discussed at the TMC.

Discussion:

The Board welcomed the development of the Strategy and MW informed the Board that estates had been discussed at the Health and Safety Committee and the Strategy addressed the health and safety concerns of the campus, in terms of the physicality and safety of the environment which had an impact on the morale and motivation of staff.

The Board queried whether the strategy was aligned with the BSW Group Estate and Investments Strategy, and whether the priorities were in accordance with the population needs. ME reported that Strategy was a key component in providing the roadmap outlining the priorities for the population. The work had commenced over 12 months ago and would help shape and inform better Group outcomes. The strategy would be refreshed yearly with feasibility studies conducted. The Board acknowledged the importance being cognisant of what's happening in the community and the clinical pathways being developed in the Group. It was also important to keep sense checking if the right approach had been developed.

The Board noted that the strategy would be helpful in attracting capital to the BSW Group and would help the Group develop a collective understanding of

where the biggest risk lay. CCB informed the Board that she would be encouraging the other partners in the Group to adopt the same approach to inform the Joint Committee capital requirements.

The Board acknowledged the importance of getting the Governance right and agreed that the implementation of the strategy would be monitored by the Finance and Performance Committee. Some elements of the strategy would require the approval of business cases by the Board

.

The Board endorsed the strategy.

TB1 6/3/6.2 **Service Strategy Responses**

LT presented a report outlining the responses from services and specialties to the Trust master strategy and plan, setting out how they would develop their services over the coming years.

The Board noted that in 2023, services and specialty level responses to the Trust strategy were commissioned by the Executive team. This helped in bringing specificity and clarity in how they were delivering on the strategy over the medium and longer term.

Discussion

The Board observed the different ambitions of the various teams, and it was noted that this was still work in progress and the Improving Together methodology would work to address that.

The Board agreed this was a good starting point in outlining the ambitions, however it was important to be conscious of the changes to the NHS landscape and the opportunities for system collaboration in the next 12 -24 months. There was an opportunity to the Trust to have different conversations with the BSW Group, and services should be able to shift and pivot in response.

The Board noted the report

TB1 6/3/6.3 **Strategic Planning Framework Update**

AT presented the proposed the changes to the SPF for 2025/26 for Board approval

The Board noted the proposed changes to the Breakthrough Objectives (18–24-month focus), the Strategic Initiatives (3–5-year horizon), the Vision Metrics (7-10 year) measures and the Process Improvements.

The Board endorsed the changes to the SPF for 2025/26

TB1 6/3/6.4 **Strategy Horizon Extension**

TM presented a report seeking Board approval for a two-year extension to the Trust's 2022-2026 strategy. This would align the strategic timeline across BSW Hospitals Group and presented a significant opportunity for strategic harmonisation across the region as the RUH and GWH had their strategic

horizons ending in 2028. The BSW Integrated Care System Strategy also ran until 2028 and extending the strategy would create alignment across all major healthcare organisations in the region. This synchronisation would facilitate more cohesive planning and implementation of shared priorities.

Discussion

The Board queried whether the refresh had a local focus and CCB reported that the current focus was on stabilising the performance and finances and an overarching strategy was being developed from 2026 to go live in 2027. The strategies would dovetail each other. GWH and RUH had also done the same

The Board asked what would happen to the two years and it was noted that this would de driven by the SPF and would seek to align the priorities to the BSW Group.

The Board approved the proposals for a two-year extension to Trust's 2022-2026 strategy.

TB1 6/3/7 CLOSING BUSINESS

TB1 6/3/7.1 Any Other Business

None

TB1 6/3/7.2 Agreement of Principle Actions and Meeting Reflection

- The Operating Plan for 2025
- The ToRs for the Joint Committee
- Board meeting and Committee schedule including capacity
- Need to have a local focus
- Civility of the Board in undertaking the discussions

The Board noted the volume of papers this and it was agreed this would be discussed at a Board Development session to ensure the balance was right. It was important to be able to specify why papers were coming to the Board.

TB1 6/3/8.3 Public Questions

There were no public questions.

TB1 6/3/8.4 Date of Next Public Meeting

The next Public Trust Board meeting will be held on 1st May 2025.

TB1 6/3/8 RESOLUTION

TB1 6/3/8.1 Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

Contact Kylie Nye, kylie.Sanders1@nhs.net for any issues or feedback

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Godfrey	TB1 9/1/5.4 Incident Reporting and Risk Report	01/05/2025	Judy Dyos (JDy)	Update on Duty of Candour responsibility and improvements to be included in the next quarterly report.		N	4
Trust Board Public	Tapiwa Songore	TB1 6/3/4.4Group Chair Appointment	01/03/2025	Melanie Whifield	legal advice on the contractual arrangements for the Chairs and advised COG	**Completed**	Y	3

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.7
Date of meeting:	1st May 2025		

Report tile:	Public Trust Board Annual Cycle of Business 2025/26			
Status:	Information	Discussion	Assurance	Approval
				✓
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Sasha Godfrey, Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:
The Trust Board is asked to approve the 2025/26 cycle of business for Public Trust Board.

Executive Summary:
The cycle of business has been updated to reflect the new Trust Board meeting schedule. The Trust Board and Committees are asked to review their cycle of business on an annual basis to ensure all participants are prepared in advance and to inform each meeting agenda.

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

Public Trust Board
Annual Business Cycle 2025/26

			Q1			Q2			Q3			Q4		
Item	**Sponsor**	**Author**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
Board Administration			Development Day		Development Day		no meeting		Development Day		Development Day		Development Day	
Opening Business														
Apologies for absence	Chair	Verbal		✓		✓		✓		✓		✓		✓
Declarations of interest	Chair	Verbal		✓		✓		✓		✓		✓		✓
Presentation of SOX certificates	Chair	Verbal		✓		✓		✓		✓		✓		✓
Patient story	Director of Nursing	Various				✓				✓				✓
Staff story	Director of OD & People	Various		✓				✓				✓		
Minutes from the last meeting	Chair	Head of Corporate Governance		✓		✓		✓		✓		✓		✓
Matters arising and action log	Chair	Head of Corporate Governance		✓		✓		✓		✓		✓		✓
Approve next years cycle of business	Chair	Head of Corporate Governance												✓
Register of attendance	Chair	Head of Corporate Governance				✓				✓				✓
Chairman's business	Chair	Verbal		✓		✓		✓		✓		✓		✓
Chief Executive / Managing Director report inc ICS update	Chief Executive	Head of Communications		✓		✓		✓		✓		✓		✓
Assurance and reports of Committees														
Committee escalation reports	Executive Director	NED Chair of Committee		✓		✓		✓		✓		✓		✓
Integrated Performance Report (inc, operational perf, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors		✓		✓		✓		✓		✓		✓
Quality and Risk														
Board Assurance Framework and Corporate Risk Register (aligned with corporate priorities) (Board Committees June, September,January and April)	Chief Nursing Officer	Director of Integrated Governance		✓		✓				✓				✓
Patient Experience Report (CGC June, September, November, February)	Chief Nursing Officer	Head of Complaints				Q4/Annual Report				Q1		Q2		Q3
Quarterly Learning from Deaths Report (CGC June, September, November, February)	Chief Medical Officer	Head of Clinical Effectiveness				Q4/Annual Report				Q1		Q2		Q3
DIPC Report (CGC June, November) July and January confirmed with Fiona McCarthy	Chief Nursing Officer	Lead Nurse Infection Control				✓						✓		
Incident Reporting and Risk Report (CGC June, September, January, March)	Chief Nursing Officer	Head of Risk		Q3		Q4				Q1				Q2
Risk Management Strategy (3 yrly, due 2023, 2026, 2029)	Chief Nursing Officer	Head of Risk				✓								
Annual Maternity Survey (CGC January)	Chief Nursing Officer	Chief Nursing Officer												✓
Quarterly Maternity Quality and Safety Report (CGC June, September, November, February)	Chief Nursing Officer	Chief Nursing Officer				Q4				Q1		Q2		Q3
In-Patient Survey Results (CGC September)	Chief Nursing Officer	Chief Nursing Officer								✓				
Research Annual Report (CGC June)	Chief Medical Officer	Head of R&D						Annual Report						
Strategy and Development														
Green Plan Progress Report (reporting annually to Jan TMC) **Update to be appended to the TMC esacaltion report for information**	Chief Operating Officer	Head of Facilities												✓
Digital Plan Update (Nov F&P)	Chief Digital Officer	Chief Information Officer										✓		
External Well-led Review - 6 monthly update on progress.	Director of Integrated Governance	Action/ workstream Leads				✓						✓		
Improving Together Update Report (Vision Metrics/ SI/ BO) January, May, September	Chief Nurse Officer	Associate Director of Improvement		✓				✓				✓		
Triannual Strategy Deployment Update (January, May September)	Chief Operating Officer	Associate Director of Strategy		✓				✓				✓		
Financial and Operational Performance														
SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR) (F&P July)	Chief Finance Officer	Chief Information Officer						✓						
2025/26 Budget	Chief Finance Officer	Chief Finance Officer		✓										
Standing Financial Instructions	Chief Finance Officer	Chief Finance Officer		✓										
Business Plan 2025/26	Chief Operating Officer	Chief Operating Officer		✓										
Estates Technical Service Update (moved from private Agenda Oct 23) (F&P February, April, July, November)	Director of Estates	Chief Finance Officer		✓				✓				✓		✓
People and Culture														
Nursing and Midwifery Safer Staffing Review (P&C September and March) Separate paper from Maternity	Chief Nursing Officer	Deputy Director of Nursing		✓						✓				
Guardian of Safe Working Annual Report (P&C September)	Chief People Officer	Guardian of Safe Working (RS)								Annual Report				
Equality & Diversity Annual Report - to be included in OD and P annual report in September see below	Chief People Officer	Head of Diversity and Inclusion												
National Staff Survey Results	Chief People Officer	Deputy Directof of OD & People		✓										
Medical Revalidation and Appraisal Annual Report **Including Statement of Compliance** (P&C June)	Chief Medical Officer - Move to July for 2023	Chief Medical Director (Zoe Cole and Mark Pountney)				Annual Report								
Freedom to Speak Up Guardian Annual Report (quarterly to People & Culture Committee (P&C June)	Chief People Officer	FTSUG Lead						✓						
Health & Safety Quarterly Report (**Aligned with ETS reporting**)- TMC bi monthly and Board quarterly (TMC June, September, December, March)	Chief People Officer	Health and Safety Manager		✓		✓				✓		✓		
Education & Development Annual Report - **proposal by MW to merge OD&P reports into one** (P&C July)	Chief People Officer	Associate Director Education, Inclusion, Comms & Engagement						Annual Report						
WRES & WDES (2023 MW confirmed 31st October deadline for sign off)	Chief People Officer							✓						
Gender Pay Gap (P&C January)	Chief People Officer													✓
Medical Education Performance Report (P&C November)	Chief Medical Officer	Director of Medical Education										Annual Report		
Governance														
Annual Report and Accounts (to come to public board once laid to parliament)	Director of Integrated Governance	Director of Integrated Governance/ Head of Corporate Governance						✓						
External Well-Led Review	Director of Integrated Governance	Director of Integrated Governance						✓						
Annual review of Board and Committee effectiveness	Director of Integrated Governance	Director of Integrated Governance						Annual Report						
Annual review of Directors Interests/ Annual Review Fit and Proper Persons Test	Director of Integrated Governance	Director of Integrated Governance/ Head of Corporate Governance		✓										
Integrated Accountability & Governance Framework INCLUDING Review of Board Committee Terms of Reference	Chief Executive	Director of Integrated Governance/ Head of Corporate Governance		✓										
Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance (F&P January)	Chief Operating Officer	EPRR Manager												Annual Report
Register of Seals	Director of Integrated Governance	Director of Integrated Governance				Q1				Q2		Q3		Q4
NHSE Self-Certification (CoS7)	Chief Finance Officer	Director of Integrated Governance		✓										
Annual Review of the Constitution	Chief Executive	Director of Integrated Governance		✓										
Approve Board and Committee dates for next year	Director of Integrated Governance	Head of Corporate Governance						✓						
Closing Business														
Agreement of principal actions	Chair	Verbal		✓		✓		✓		✓		✓		✓
Any Other Business	Chair	Verbal		✓		✓		✓		✓		✓		✓
Public Questions	Chair	Verbal		✓		✓		✓		✓		✓		✓
Date of Next Meeting	Chair	Verbal		✓		✓		✓		✓		✓		✓
Resolution	Chair	Verbal		✓		✓		✓		✓		✓		✓

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of meeting:	1st May 2025		

Report title:	Chief Executive and Managing Director Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Cara Charles-Barks, Chief Executive Officer Lisa Thomas, Managing Director			
Executive Sponsor: (presenting)	Cara Charles-Barks, Chief Executive Officer Lisa Thomas, Managing Director			
Appendices	N/A			

Recommendation:

The Board is asked to receive and note this paper as progress against the local, regional and national agenda.

Executive Summary:

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

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

National

Laying the Foundations for Reform

Sir James Mackey, the new NHS England Chief Executive wrote to Trust and ICB Chairs and Chief Executives on 1st April 2025 setting out priorities for the coming weeks and months. The letter covers an update on 2025/26 planning, next steps on reducing non-patient-facing roles and planned work on the financial regime and NHS operating model.

The governments mandate published in January to reform the NHS lays the foundation for longer-term reform as part of its health mission, focusing on bringing care closer to communities, prioritising prevention over treatment, embracing digital transformation, and embedding financial discipline within the system.

Through the 10 Year Health Plan, the government will focus on 3 strategic shifts, moving care from:

- Hospital to community
- Sickness to prevention
- Analogue to digital
- These shifts will help to:
  - cut waiting times for care
  - reduce the amount of time spent in ill health
  - tackle health inequalities
  - reduce the lives lost to the biggest killers - cancer, cardiovascular disease and suicide
  - make the NHS sustainable in the long term

Among those changes:

We are required to reduce the cost of the current operating model of the NHS

- 50% reduction in NHSE and DHSE staffing by Q3 – Central oversight of the NHS (which has been the remit of NHS England since 2012) will now be reduced in size and move back into the Department of Health in the following 2 years.

- 50% reduction in ICB running and program costs by start of Q3

- 50% reduction in corporate cost growth in providers

- Plans to reduce costs and streamline governance and non-clinical activities.

I appreciate that these are challenging messages, the reason for these changes are that the NHS and BSW are in deficit and need to make changes to move to a more financially sustainable model. There are also clear requirements regarding service offering and delivery of core performance and quality metrics.

I appreciate that this is a challenging time for all of our teams. For providers such as ourselves, there is a significant change in the oversight regime and the expectation regarding delivery, along with a changed consequence regime for non-delivery.

I understand that these times of transition and uncertainty are by nature unsettling. I also want to reassure you that we are already doing good work in terms of the change that's needed for our future NHS. for example leaders of Corporate Services are taking control of what will be best for us and our patients in terms of future service design. Planning has also been underway for a number of months now responding to the asks of the national Guidance issued in January and consistent with creating a bright and sustainable future for the NHS.

As a group we have a great opportunity to learn together, to tackle inequalities in access to services, to work together to remove barriers to good health and provide improved health outcomes for all our communities. Together I believe we can be at the forefront of the transformation that's needed in the NHS, but most importantly we will achieve this by working together.

Updated NHS Standard Contract and Payment Scheme 2025/26

NHS England recently published the 2025/26 NHS Standard Contract which is mandated for use by commissioners for all contract for healthcare services other than primary care. Following the consultation on the 2025/26 NHS Payment Scheme, NHS England are now consulting on further changes to the 2025/26 Contract. The consultation is scheduled to close of Monday, 28th April 2025.

Board Member Appraisal Guidance

NHS England published new Board member appraisal framework on 1st April 2025 which sets out expectations and recommendations in the completion of board member appraisals to ensure a consistent and standard approach to appraisal. The executive team at SFT have adopted this process for the current appraisal round.

Group

Group Development

March and April saw progress in resourcing and governance supporting the establishment of BSW Hospitals Group.

Leadership Team: Managing Directors and Group Chief Transformation and Innovation Officer (Interim)

The recruitment process for our three Managing Director roles saw stakeholder panels and final interviews held in early April. Later in April, Jonathan Hinchcliffe started with us as interim Group Chief Transformation and Innovation Officer. Jonathan brings a wealth of digital experience as well as years of working in a hospital group at Manchester University Hospitals.

Transitional Support Partner

Following a detailed procurement exercise, we have selected an experienced partner, Teneo, to support us in our Group set-up, design and implementation over the next eighteen months. The Teneo team is led by Lucy Thorp and started working with us in late March. Initially, focus will be on detailed planning for our Group design phase – including work on our operating model, leadership structure, corporate services programme and governance and accountability framework.

Partnership Agreement and Joint Committee Establishment.

The working party leading development of our BSW Hospitals Group Partnership Agreement and Terms of Reference (TOR) for a group Joint Committee held further sessions in March, supported by colleagues from our legal advisors Browne

Jacobson. Trust Board review of the draft Partnership Agreement, incorporating TORs for a special purpose Joint Committee is underway. Subject to Board approval, the first meetings will be arranged for 23rd May and 25th June.

Board to Board Development

Following our first Board to Board development day in January, we have agreed to hold three Board to Board development sessions annually, to allow Board members from GWH, RUH and SFT to build and deepen relationships. Sessions are planned in June, October and next February.

Operating Model/ Leadership Structures/ Corporate Services

Work to establish our new operating model began in April, supported by colleagues from Teneo. Corporate services will be an important part of the new operating model. We have re-launched a comprehensive joined-up corporate services programme. A Steering Group with executive leads (Simon Wade & Melanie Whitfield), has been established to oversee the programme, confirming core assumptions and adopting a common framework in response to latest national requirements on NHS provider corporate service workforce.

Governance and Accountability Framework.

Trust governance leads and company secretaries meet weekly and, with Teneo's support, are developing our Group Governance and Accountability Framework, identifying opportunities for collaboration, alignment and avoidance of duplication.

Group Engine Room.

Improving Together and the engine room rhythm is well-established in the Trust; we will establish something similar for the Group to help us align teams around our biggest problems, connecting Teams across the Group. Improving Together leads, Alex Talbot, Emily Beardshall and Rhiannon Hills are helping shape our approach, aiming to establish our Group Engine Room in May.

Shared Electronic Patient Record (EPR)

We are now in the 'Engage' stage which runs through to March 2026. This includes the build, testing and training for EPR. The team are in the building phase, preparing to show that build for the first time from 30th June onwards at Future State Review. Future State Validation will follow in mid-July. Our EPR Joint Committee met on 21st March. The implementation team is well established and following a tender exercise, St Vincent's has recently joined us as EPR Implementation partner.

Managing Directors – Local update

Overall, as outlined in the Integrated Performance Report March was a very busy month operationally. The Trust had a business-critical incident at the start of March due to the high number of patients in hospital on the urgent care pathways waiting longer than we would aspire to be admitted to beds. Colleagues across the Trust worked as a team to de-escalate pressures. The plans for 2025/26 continue to look at how we ensure patients receive timely care in the context of increasing demand.

Staff Survey

The National staff survey results were published and showcased some significant improvements and positive results for SFT. We believe based on some analysis by the health service journal that once again we are the most improved Acute Trust in the country. The survey also showed that Salisbury is ranked first for staff looking forward to going to work and we are in the top quarter of all acute trusts for seven of the nine key indicators of the People Promise – all indicators are in the top half. This is an outstanding result, and I must congratulate

every single member of staff for not just delivering excellent care under pressure but also striving to make our hospital the best place to work.

Divisional restructure

This month the Trust finalised its transition to three clinical Divisions from four, **Medicine', 'Surgery' and 'Family and Specialist Services', plus the Corporate division**. These changes have been made to ensure that the hospital has a leadership structure that can maintain and continue the improvements we have already made and support meeting the challenges of the next five years.

Sexual safety charter

The Trust published the sexual misconduct policy this month underpinning the national NHS England sexual Safety charter which was published last year. This was an important step forward in the Trust ensuring we uphold our values for all staff.

On Call consultation

To effectively manage non-medical services and generate the resilience to deal with situations which may adversely impact our operations on site at night, weekends and during bank holiday periods, SFT has a requirement to maintain an on-call system. Our system is managed through a collective agreement agreed with Staff Side. In partnership with Staff Side colleagues, we have recently reviewed the collective agreement to bring it up to date and address some concerns raised. The consultation was launched in March to seek colleagues views.

Surgical Same Day Emergency Care (SDEC)

In March the Surgical Assessment unit on Britford Ward was reconfigured and renamed as the Surgical SDEC (Same Day Emergency Care). Initially this is a three month trial, the new unit aims to minimise delays in surgical emergency patient pathway, allowing for emergency patients within same day of arrival (avoiding hospital admission) which in turn will improve flow in ED.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	01st May 2025		

Report title:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Niall Prosser, Chief Operating Officer			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Niall Prosser, Chief Operating Officer			
Appendices				

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 12 (March 2025).

Executive Summary:

Breakthrough Objectives

- *Time to First OP Appointment* reduced from 127 to 126 days pushing the lowest point since adoption further down from the baseline of 139 days in April 2023.
- *Productivity* increased slightly from -12% to -12.8% although maintains an improved position overall and a total of 3.3% improvement against the adoption baseline of -16.1% in April 2024.
- *Managing Patient Deterioration* continued its improvement from 48.4% to 49.2% and pushing highest point since adoption further up, a total 2.7% improvement against the baseline of 45.7% in April 2024.
- *Staff Turnover* saw an upturn from 16.7% to 17.9% although also maintains an improved position comparatively and a total 2.5% improvement since adoption and baseline of 20.4% in April 2024.

Alert

- Flow into the hospital continues to be challenged with *Bed Occupancy* remaining high despite a slight reduction from 97.6% to 96.9% average across the month.
- *No Criteria to Reside (NCTR)* also increased again from 88 to 94 against the H2 plan of 64.
- Stroke Care measure of *Motor Minutes per Patient per Day* minutes reduced fractionally from 37 to 36 minutes and remains significantly below the national target of 180 minutes.
- *Income* is below plan year-to-date driven by underperformance in Elective activity impacting on the ERF income, partially offset by overperformance on Day Cases, Non-Elective and Outpatient activity.

Advise

- Despite flow constraints and an increase in *Attendances* to 7,090 the Emergency Department (ED) improved across all metrics:
  - *4-hour Performance* increased from 67.2% to 71%.
  - *Ambulance Handover* time decreased from 30 to 27 minutes average.
  - *Ambulance Handovers >60 minutes* reduced from 138 to 93.
  - *ED 12-hour Breaches (arrival to departure)* decreased from 446 to 428 with the overall proportion of patients *>12 hours in ED* also reduced from 10.5% to 8.7%.
- *Incidents resulting in High Harm* increased from 3.2% to 4.1% of total and continues a worsening trend for the third month in a row.
- *Inpatients undergoing VTE Risk Assessment <24 hours* reduced again from 21.1% to 19.5% and is on a downward trend away from the 95% target.

Assure

- *Referral to Treatment (RTT)* waiting list metrics continued overall improvement:
  - Patients waiting *>65 weeks* reduced from 6 to 0 and we are one of a few Trusts in region to achieve the target.
  - Patients waiting *>52 weeks* increased slightly from 650 to 665 with plans to reduce waits to this level in Q1 being made.
  - Total *RTT Waiting List* reduced marginally from 28,168 to 28,100 with plans to reduce further.
- Diagnostics *DM01 Standard* increased from 83.8% to 84.6% with improvements in the high-volume modalities of Endoscopy and Audiology contributing.
- Cancer performance generally improved and continues to be strong regionally:
  - *28-day Faster Diagnosis Standard (FDS)* reduced slightly from 76.7% to 75.8% and continues just below the target.
  - *62-day Standard* improved from 69.3% to 70.1% although similarly continues close to but below the target.
  - Patients waiting *More than 62 days* for Cancer treatment reduced from 84 to 69 and returns to December levels after January spike.
    Note: Cancer performance reports one month behind, February in this IPR.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

May 2025

(March 2025 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

Flow around the hospital was again challenged in March, however this report will show that performance across the Trust was generally very positive and, in many metrics, improved when compared to the previous year, signaling progress going into the next financial year.

Key indicators of flow constraints, the number of patients with *No Criteria to Reside (NCTR)* increased again to an average of 94 and the adult *Bed Occupancy* levels remaining high at 96.9% with both above targets. Despite these challenges, the Emergency Department (ED) saw performance improve overall in core metrics and beyond. The *4-hour Standard* performance increased to 71% and the *Ambulance Handover* time reduced to 27 minutes on average. The *Temporary Use of Escalation Beds* and *ED Corridor Care* also generally improved, with the former relatively static and continuing an improved position overall at 10, and the latter reducing significantly to 169 patients. The number of *Attendances* into ED increased sharply to 7,090 this highlights the strong performance of the department.

The access related breakthrough objective of *Wait Time to 1st Appointment* further improved its lowest point since launch in April 2023 at 126 days against the target of 87. The number of patients waiting *Longer than 65 weeks* for elective treatment reached the target of zero and SFT is one of only a few Trusts in the region to achieve this and the first within BSW. The aim now is to maintain this position and focus on reducing waits to 52 weeks.

Cancer performance continues to be strong regionally although it was mixed in month. The *28-day Faster Diagnosis Standard (FDS)* reduced to 75.8% whereas the *62-day Standard* improved to 70.1% with both slightly below operational plan targets. The number of patients waiting *More than 62 days* for Cancer treatment reduced significantly to 69 and back to December levels after the January spike. Note: Cancer performance reporting is one month behind, therefore February in this report.

Diagnostics *DM01 Standard* improved again to 84.6% as additional capacity in high volume modalities of Audiology and Endoscopy saw their respective contributions to total position improve. The Stroke Care measure of *Motor Minutes per Patient per Day* reduced fractionally to 36 minutes average and continues below the 180 minutes target.

The quality breakthrough objective of *Managing Patient Deterioration* continued improvement to its highest point at 49.2%. Wider quality metrics were negative and likely impacted by stubbornly high levels of staff sickness and bed occupancy, as *Care Hours per Patient per Day* remained static at a low 7.5 hours, the number of *Incidents resulting in High Harm* increased to 4.1% of the total and the *Infection Control* measures increased to 2 instances of each infection.

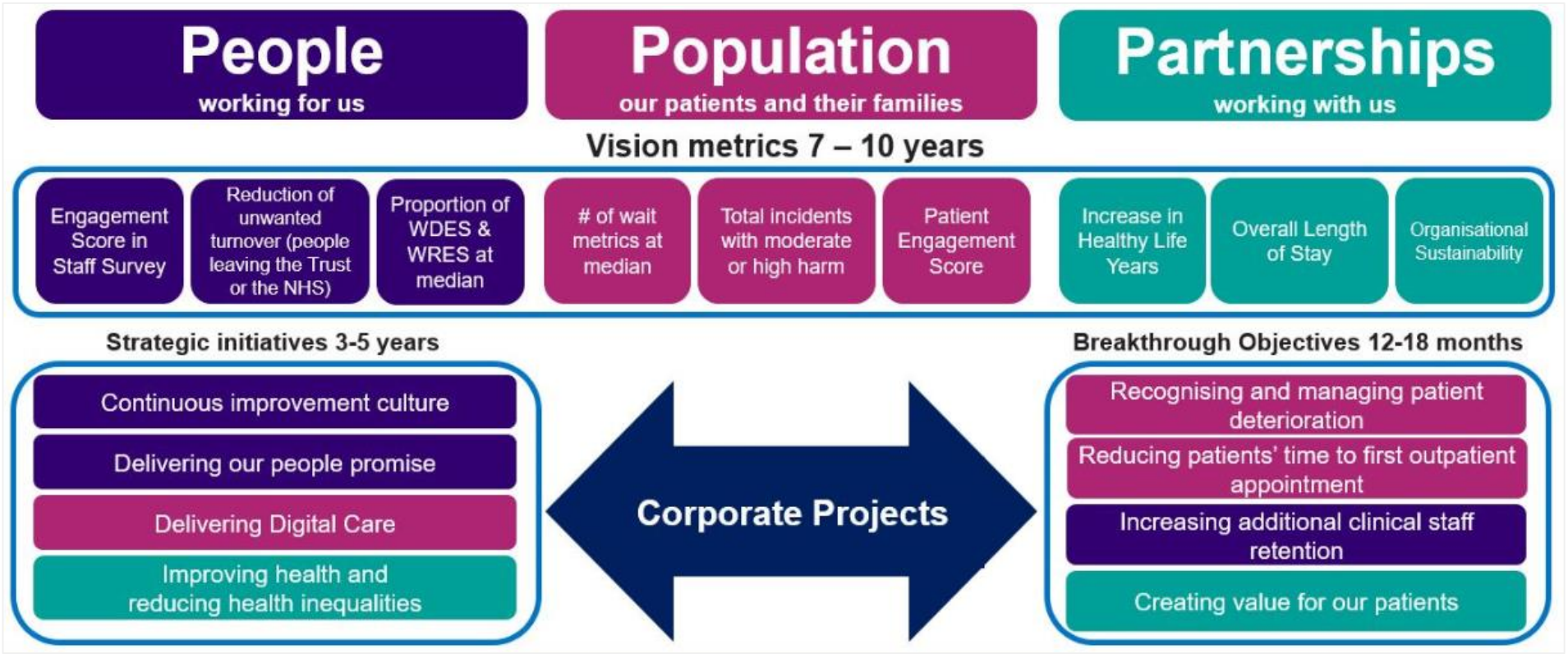
The workforce breakthrough objective of *Staff Turnover* took an upturn to 17.9% although it maintains the overall improved position. Other workforce metrics showed improvement, as *Staff Sickness Absence* dropped back from seasonal high to 3.4% and *Staff Vacancies* dropped further to the lowest point on record at -0.35% which is now reporting that the Trust is above establishment.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* increased to -12.8% although also maintains an overall improved position. The Trust recorded an in-month control total deficit of £2.9m against an original deficit target of £1.1m - an adverse variance of £1.8m. This is adjusted for £1.1m income which is the in-month impact of the £17m. The year-to-date *Elective Recovery Fund (ERF)* performance is currently at 115% against a H2 plan of 115%.

Strategic Priorities

NHS Salisbury NHS Foundation Trust

Our Vision is to provide an outstanding experience for our patients, their families and the people who work for and with us.



What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives. It is divided into three sections: Quality of Care, Access and Outcomes, People and Finance and Use of Resources which contain the following within them:

Key Term	Definition
Breakthrough Objective	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to address worsening performance or celebrate achievement if improving.
Non-Alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

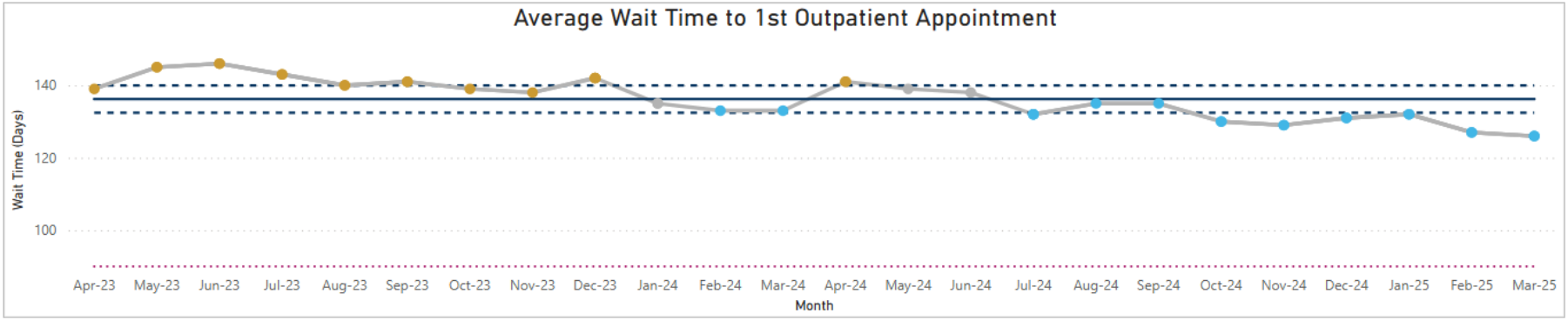
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 139 days (April 2023)**	SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% Referral to Treatment (RTT) 18-week elective treatment target since October 21. A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18-week RTT target at risk. It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Target: ≤90 days Performance: 126 days Position: Special Cause Improvement



Understanding the Performance

Time to first outpatient appointment (TT1OPA) reduced again from 127 to 126 days pushing the lowest point on record further down.

The three focus specialties for 2024/25 have made considerable improvements as comparison to April 2024 evidences (days): Urology (-81) Oral Surgery (-53) and Colorectal (-35).

New focus specialties for 2025/26 are in the process of being selected, with the aim of replicating the success seen in focus areas for this year.

High waiting list specialties (>500 patients) with longest and shortest wait times: Dermatology (287) and ENT (86).

Countermeasure Actions	Due Date
• To establish the required leadership structure to support the TT1OPA work going into the 2025/26 period. This will include an Outpatient Operational Manager and Clinical Lead.	30/04/2025
• Develop an Outpatient Programme to support the delivery of the national Elective Reform targets. This will involve agreeing a strategy and programme of work for addressing TT1OPA waits across the Trust	30/04/2025
• Investigate how Robotic Process Automation could help with PIFU utilisation full process compliance, to increase capacity for New appt slots.	31/03/2025

Risks and Mitigations

- Risk that overall TT1OPA improvements may not be realised due to declining performance in other specialties. Mitigation: Focussed sessions are being set up with declining areas and this is being accounted for in the programme strategy.
- Risk to project delivery if the required Operational and Clinical Leads, and Transformational resource, is not in place. Monitoring during recruitment phase.

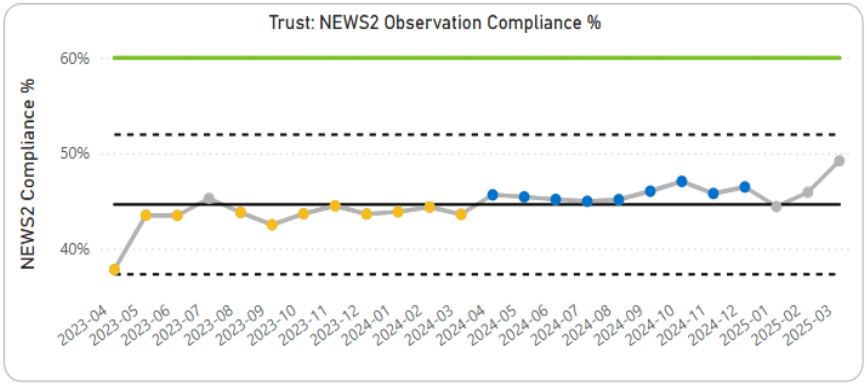
Recognising and Managing Patient Deterioration

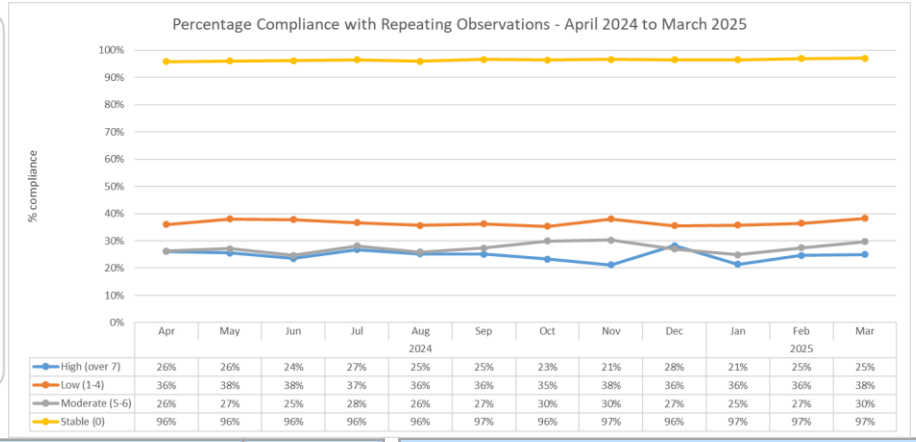
NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 45.7% (April 2024)**	Improving the early recognition of patient deterioration is a multidisciplinary team activity and comprises of three recognised steps – **Record, Recognise and Respond.** The first step is regular measurement and recording of clinical observations and in line with recommendations from the *Royal College of Physicians* and *Academy of Medical Royal Colleges*, frequency of these physiological measures is determined by the NEWS2 score. Monitoring trends in both the patient's physiology and NEWS2 score will provide information to the clinical teams to triage workload and to identify potential patients at risk of deterioration. Our aim is to improve upon the current compliance for the recording of these measures with reductions in both mortality, morbidity and late escalations of care.

Target: ≥60% Performance: 49.2% Position: Common Cause





Understanding the Performance

Frequency of clinical observations is a nationally set standard which is determined by the automatic calculation of the NEWS2 score. Performance in month of 49.2% and highest point. Recent analysis of individual ward data discussed at the *Escalation Workstream* would suggest that frequency is governed by ward routine rather than a response to the NEWS2 score.

The group have now examined the compliance broken down by risk category and identified that there is a 97% compliance with NEWS2 scores of 0 with lower compliance within other risk categories.

The average time for the RN to electronically document decision to escalate (not shown) has decreased this month to 319 minutes. The measure does not consider verbal escalation by the ward team.

Countermeasure Actions

	Due Date
RECORD:	
• Evaluation of patient outcome for those identified at outcomes at the daily huddle.	June 2025
RESPOND:	
• Carry out a baseline audit for response rates to request for assessment.	May 2025
• Matron for Quality and Safety to work collaboratively with AMU, Imber, Spire and Laverstock ward in completing PDSA cycles.	Ongoing

Risks and Mitigations

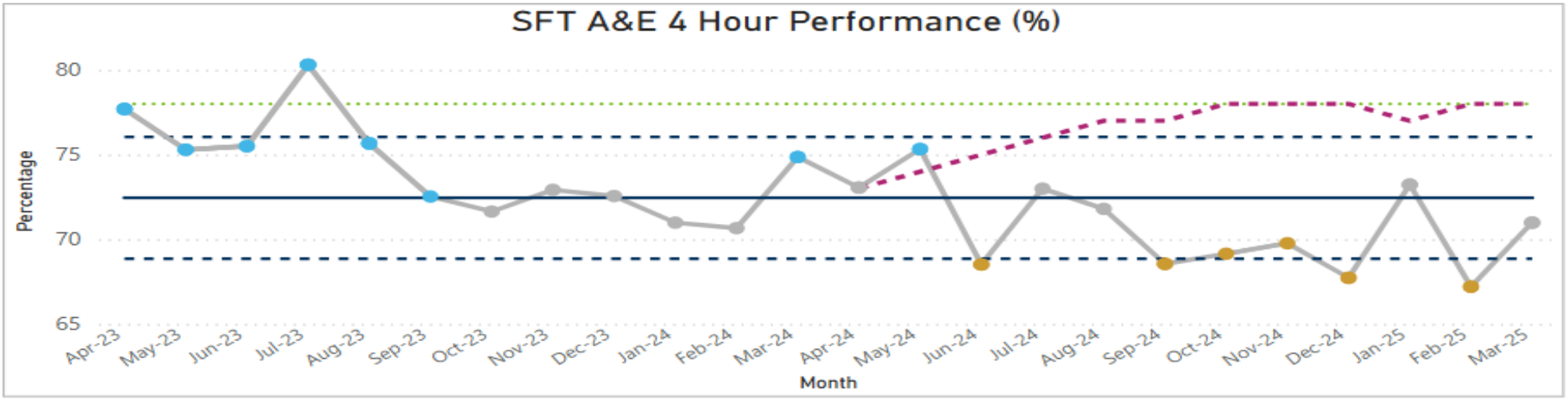
- There is still a risk of unrecognised deterioration which may lead to patient harm. However, whilst we continue to learn and improve, other measures allow us to monitor the risk including:

Positive

- Overall mortality rates remain low.
- Cardiac arrest rates remain low.
- Medical emergency team call are increasing.
- Unplanned admissions to ITU have fallen this month following a reduction in the cases of Influenza A.

Emergency Access 4-hour Standard

Target: ≥78% Performance: 71.0% Position: Common Cause



Understanding the Performance
Overall 4-hour performance increase from 67.2% in February to 71% in March. Type 1 attendances in March saw an increase to 4,905 from 4,263 in February and comparative with March 2024 at 4,969. A decrease is noted in performance in month from the previous year, with an average at 56.4% compared with 61.9% in March 2024. Average time in the department for admitted patients reduced from over 10 hours (603 minutes) to 9.1 hours (550 minutes) and non-admitted patients reduced to under 4 hours (236 minutes) average. With admitted and non-admitted performance following similar trend patterns. SDEC has remained bedded with inpatients nightly, causing a decrease in capacity to pull into when the service resumes the following day. Time to first clinician remains stable.

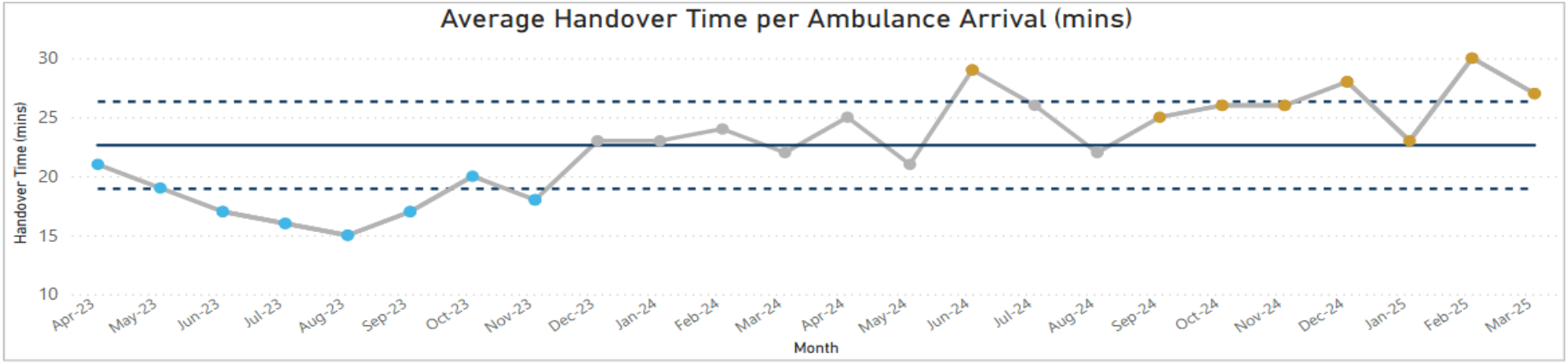
Countermeasure Actions	Due Date
• Successful recruitment for 4 x WTE Consultant posts which will provide stability within the mid shift, essential for the timely assessment of patients and senior leadership across the department.	1.6.25
• ED Trackers have been resolved of their duties to book in ambulances, this task has returned to the reception team. Allowing for the ED Tracker to concentrate on moving the patient forward in their journey.	Ongoing
• SAU began operating an SDEC model which has seen success in its pull model.	Ongoing
• Stop bedding down in SDEC.	May 25

Risks and Mitigations
• Ongoing concern for overcrowding in the department. Mitigations include the move to stop inpatients being bedded in SDEC overnight which may cause initial decrease in performance during a period of adjustment. However longer-term improvements are expected.

Ambulance Handover Delays

Salisbury NHS Foundation Trust

Target: ≤15 mins Performance: 27 mins Position: Special Cause Concern



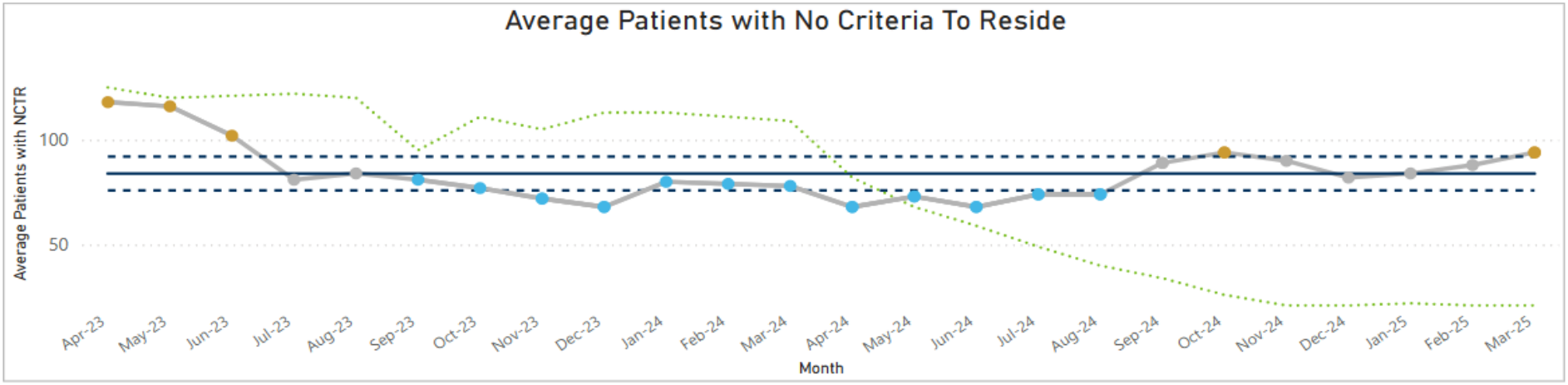
Understanding the Performance	Countermeasure Actions	Due Date
Ambulance handover performance remains consistent at 43.94% achieved within 15minutes, compared with a decrease in February at 37.21% and resuming to the performance seen in January at 43.66%. There has been a slight decrease in the average handover time which sits at 27minutes in March from an average of 30minutes in February. Admitted and Non-admitted performance has fallen throughout the previous 4 weeks. Regarding non-admitted, there have been a few ENP gaps which have either remained unfilled or are backfilled by an SHO who do not always have the required skill set to perform all treatments within minors. Equally, the minors footprint has been reduced since the implementation of the ED corridor being moved into an adjacent area and restricting use of the Minors treatment room. Whilst <15m performance remains below target and average handovers continue an upward trend, the <60m handovers remain extremely positive at 92.7%.	• A RATT NIC role is being implemented from the 14.4.25 whereby increasing the nursing staffing by 50% between the hours of 12:00-22:00. This increase will allow for better co-ordination of the ambulance off loads and the transfer of patients out of the RATT bays into an appropriate area of the department. • Planned move to THP 24/7. Agreed by the SLT, DMT and DCOO. • Not bedding down in SDEC should support pulling GP expected pts out of ED quicker and additionally support reducing LOS	14.4.25 14.4.25 01.5.25

Risks and Mitigations
• Risks associated with the moved to THP 24/7 will be mitigated by the addition of the RATT NIC until 22:00 and the additional consultant recruitment of which the benefits will be seen in the coming months.

Optimising Beds

Salisbury NHS Foundation Trust

Target: ≤25 (5%) Performance: 94 Position: Special Cause Concern



Understanding the Performance

The average number of patients with No Criteria to Reside (NCTR) has risen again for a 4th month, this is being driven by the average increase in delayed Length of Stay (LoS) by 1 day, the time for LoS to NCTR declaration has decreased by 0.5 day.
NCTR was an average of 1.6 days from 1.1 days which has risen in month.
The average overall LoS remains static.

Average bed day delays by pathway:
- P0 – 4.2 days
- P1 – 7.7 days
- P2 – 10.3 days
- P3 – 14.3 days

Note: ED attendances continue to remain high with no decline in conversion rate, hence the number of patients being admitted is also higher.

Countermeasure Actions	Due Date
• Ongoing work to reduce time from NCTR to pathway allocation – Sprint Improvement.	Ended
• Digitisation of Decision to Admit (D2A), awaiting confirmation from provider.	July 25
• Greater use of Hospital at Home (H@H). Agreement for model of care to be ACP lead with consultant oversight.	May 25
• Breamore ward team working to reduce Length of Stay (LoS) and prevent deterioration of patients waiting packages of care.	April 25
• Detailed codes providing details on reasons for delays in discharge.	Ongoing
• Ward flow work that standardises process to link into NCTR group.	Ongoing
• System working to reduce time for NCTR patients to be allocate.	Ongoing
• Identifying the next areas of change to trial – will run a number of trials during Q1/Q2 and look to implement best practice identified by winter.	May 25

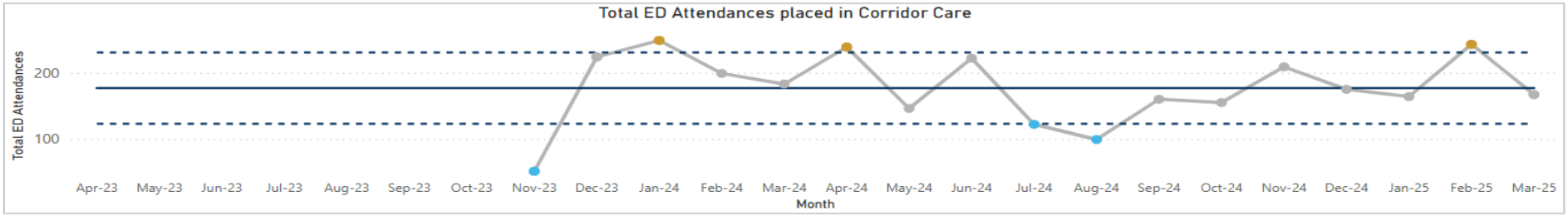
Risks and Mitigations

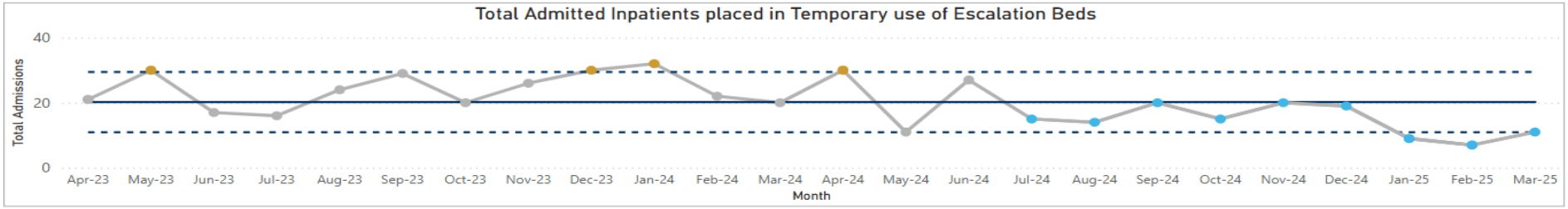
- External conflicts such as reduction in capacity in local authority social care teams and financial constraints.
- Changes to community model.
- Clinical capacity and demand conflicts.
- Clinical engagement.
- Operational pressures.

Use of Temporary Escalation Beds & ED Corridor Care

Salisbury NHS Foundation Trust

Target: 0 Performance: 167 Position: Common Cause





Understanding the Performance

There was a reduction in the number of patients placed in corridor care in month, from 243 in February down to 167 in March. This is distinct progress when considering the flow constraints of NCTR increasing and General and Acute (G&A) beds occupied remain elevated at 96.9% average in March compared to 97.6% in February.

Use of temporary escalation beds increased slightly to 10 however in the context of challenged flow, this is good performance and notably improved overall in comparison to the previous year, with the trend of average positively lower.

Same Day Emergency Care (SDEC) continues to see patients overnight, with plans to address this ongoing.

Countermeasure Actions	Due Date
• Planning for the end SDEC escalation space use continues - plan to effectively use SDEC from morning means it cannot be used overnight as escalation and so planning to accommodate this change is ongoing.	28/04/2025
• Understanding the use of corridor and temporary escalation in the context of attendances and admissions would support the broader understanding of flow and highlight areas of further focus for countermeasures - discussion April 2025 with Informatics and Deputy Chief Operating Officer.	April 2025

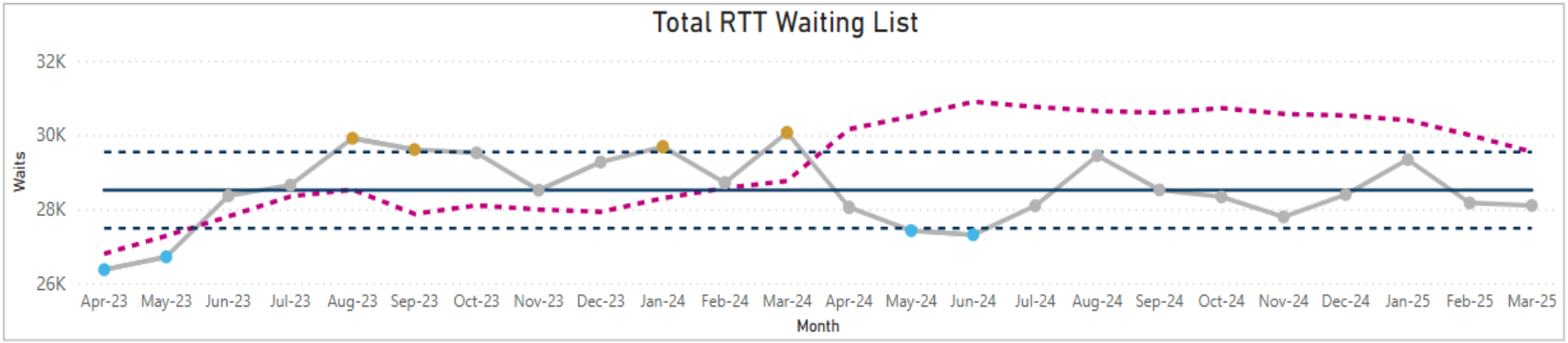
Risks and Mitigations

- Not using SDEC in escalation overnight from 28/04/25 will potentially negatively impact both corridor care and use of temporary escalation in the first instance.

Total Elective Waiting List (Referral to Treatment)

Salisbury NHS Foundation Trust

Target: ≤29,997 Performance: 28,100 Position: Common Cause



	Feb - 24	Mar - 24	Apr -24	May-24	June -24	July -24	Aug -24	Sep -24	Oct -24	Nov -24	Dec -24	Jan-25	Feb-25	Mar-25
Longest Waiting Patient (Weeks)	94	72	68	73	74	79	83	73	74	78	71	74	78	64

Understanding the Performance

Referral to Treatment (RTT) waiting list reduced to 28,100 maintaining its position below the trajectory target of 29,543.

Focused work to reduce long wait times continues and in March resulted in the Trust achieving the national target of zero patients waiting more than 65 weeks. The expectation is to now maintain this and begin driving reduction further down to 52 weeks.

RTT performance will be the focus next year with good progress made already against the minimum 65% target, with the Trust reporting 63.9% in March.

Specialties with notable waiting list change from last month (patients): Oral Surgery (-122) Dermatology (-115) and Trauma and Orthopaedics (+227)

Countermeasure Actions	Due Date
• Work underway to validate all historic patients currently assigned with non-RTT status in the elective waiting list.	Ongoing
• Continue weekly access meeting to focus on reducing long waits of patients in line with new national targets - NHSE planning guidance received 30/01/2025 - of 65% of patients waiting no more than 18 weeks for treatment and only 1% of overall waiting list waiting more than 52 weeks by March 2026.	Ongoing
• Work with Trust CCS software to improve waiting list management by enhancing reports in the system and move to using this for all long waits management.	Ongoing
• This slide will change to demonstrate the RTT position instead of waiting list size.	May 25

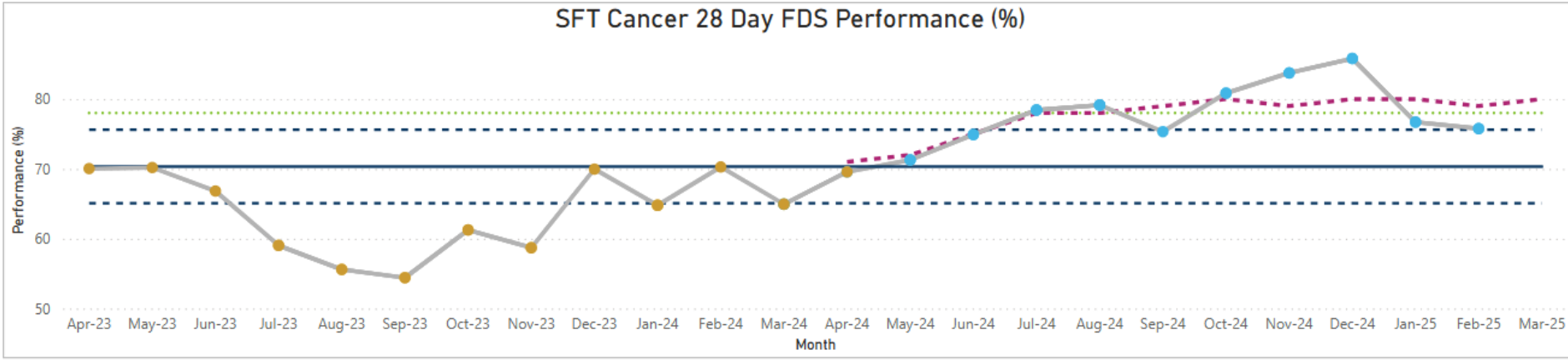
Risks and Mitigations

- Risk of long wait patients having incorrect status (particularly non-RTT) now being addressed through validation – see countermeasure action. Sustainable process introduced to monitor weekly additions to waiting list, with automation of this process through Trust CCS software being explored.
- Capacity constraints in some specialties are a risk to reducing overall waiting list and particularly challenging with regards to national reduction targets - being mitigated through additional capacity arrangements where necessary.
- Weekly Access Meeting continuing with aim of reducing risk of long waiting patients and drive towards national reduction targets.

Cancer 28 Day Faster Diagnosis Standard

NHS Salisbury NHS Foundation Trust

Target: ≥78% Performance: 75.8% Position: Special Cause Improvement:



Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

28-day performance standard was not achieved in M11, with month-end position of 75.8% and under trajectory of 79.06%.

Specialities which remain most challenged in delivering the standard include:

- Lower GI: 53.7% (improvement from 46.7%)
- Haematology: 25% (deterioration from 50%)
- Non-site specific: 37,5% (deterioration from 52%)
- Urology: 28.9% (deterioration from 46.9%)

Breach reasons associated with insufficient diagnostic capacity (both locally and at tertiary centres), patient choice / engagement, diagnostic reporting, letter typing backlogs and pathway complexity.

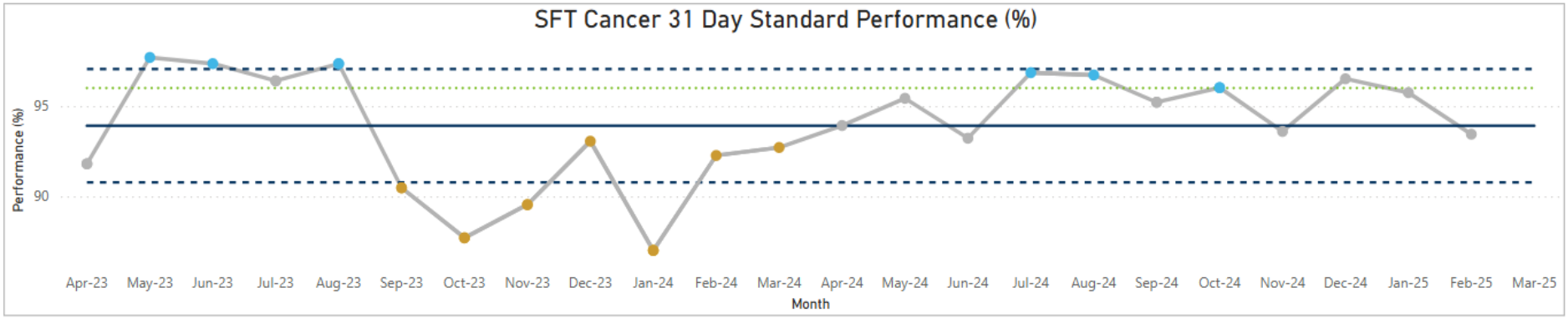
Countermeasure Actions	Due Date
• Maintain regular site-specific 'Faster Diagnosis touch-point' meetings.	Ongoing
• Maintain sufficient breast and skin capacity for first appointments to support overall delivery of FDS.	Weekly via CIG
• Impact of BSW-wide Bowel Cancer Screening pathway alongside 'local' Lower GI FDS remains ongoing; improvements seen in terms of alignment with FDS	Ongoing
• Review / deep dive of non-site-specific pathway delays to identify root cause and improvement action	M2 2025/26

Risks and Mitigations

- Skin pathways reliant on insourcing or WLIs to achieve required capacity to maintain average wait for first appointment under 14 days. 'Super clinics' established from Q4 to support increased capacity. Involvement in SWAG-driven tele-dermatology across BSW.
- Long-term resource within MDT cancer services team remains challenging in terms of capacity. Assistant MDT Co-ordinator recruited to on a fixed-term basis. Impact of long-term sickness detrimentally affecting capacity to escalate.
- Letter typing backlogs identified across multiple tumour sites. Navigators identifying priority letters as needed to support discharge from cancer pathway.
- Further risk to Urology FDS identified following publication of revised CWT guidance. Anticipated 'go live' from July '25; cancer services working with Urology to scope anticipated impact.

Cancer 31 Day Standard

Target: ≥96% Performance: 93.4% Position: Common Cause



Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

31-day performance standard not achieved in M10, with month-end performance of 93.4%. This represented a total of 13 breaches against the 221 patients treated.

Specialties which were unable to meet the standard include:

- Breast: 89.8% (6 breaches of 59 patients)
- Lower GI: 86.7% (2 breaches of 15 patients)
- Gynaecology: 83.3% (1 breach of 6 patients)
- Haematology: 91.7% (1 breach of 12 patients)
- Head & Neck: 50% (2 breaches of 4 patients)
- Upper GI: 90% (1 breach of 10 patients)

Breach reasons associated with insufficient theatre capacity, insufficient oncology capacity, clinical delays, need for prehabilitation, anaesthetic input and lack of timely escalation.

Countermeasure Actions	Due Date
• Maintain routine use of Cancer Escalation policy, ensuring early escalation where a patient is booked to breach.	Ongoing
• Increased visibility of 31-day breach dates within weekly PTL meetings established, with further consideration of awareness and visibility of breach dates within booking teams.	Ongoing

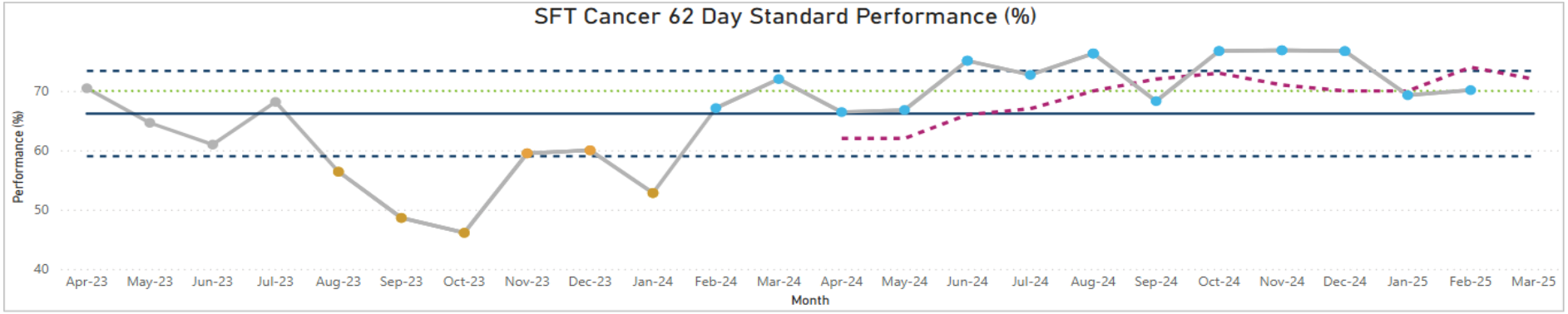
Risks and Mitigations

- Theatre capacity across all tumour sites remains vulnerable to demand and capacity issues. Escalation to Divisional Director level for increased scrutiny. New theatre timetable anticipated from March '25, which outlines plans for required cancer theatre capacity over 25/26.
- Long-term resource within MDT cancer services team remains challenging in terms of capacity. Assistant MDT Co-ordinator posts recruited to on a fixed-term basis; impact to be monitored. Impact of long-term sickness detrimentally affecting capacity to escalate.

Cancer 62 Day Standard

Salisbury NHS Foundation Trust

Target: ≥70% Performance: 70.1% Position: Special Cause Improvement:



Patients waiting over 62 days for treatment	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
	145	117	91	73	76	65	61	69	78	68	55	84	84	69

Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

Improvement in 62-day performance in M11, with submitted position of 70.1%. Data is subject to change upon receipt of post-op histology and confirmed cancer diagnosis treatments recorded after quarterly submission.

134.5 patients treated against the standard in M11, with 34.5 patients breaching 62 days. Specialties which were unable to meet the standard include:

- Lung: 33.3% (6 breaches of 9 patients)
- Upper GI: 56.5% (5 breaches of 11.5 patients)
- Urology: 56.4% (12 breaches of 27.5 patients)

Breach reasons associated with complex pathways, clinical delays, insufficient capacity in diagnostics (PET-CT and Interventional Radiology, as well as pathology reporting turnaround times), oncology and theatres (locally and tertiary centre), patient choice and engagement.

Countermeasure Actions	Due Date
• Sustain robust patient tracking list meetings, with improved resilience and standardisation across all tumour sites.	Ongoing
• Amendment of Cancer Escalation policy complete to support timely escalation of patients booked to breach at Divisional Director-level.	Ongoing

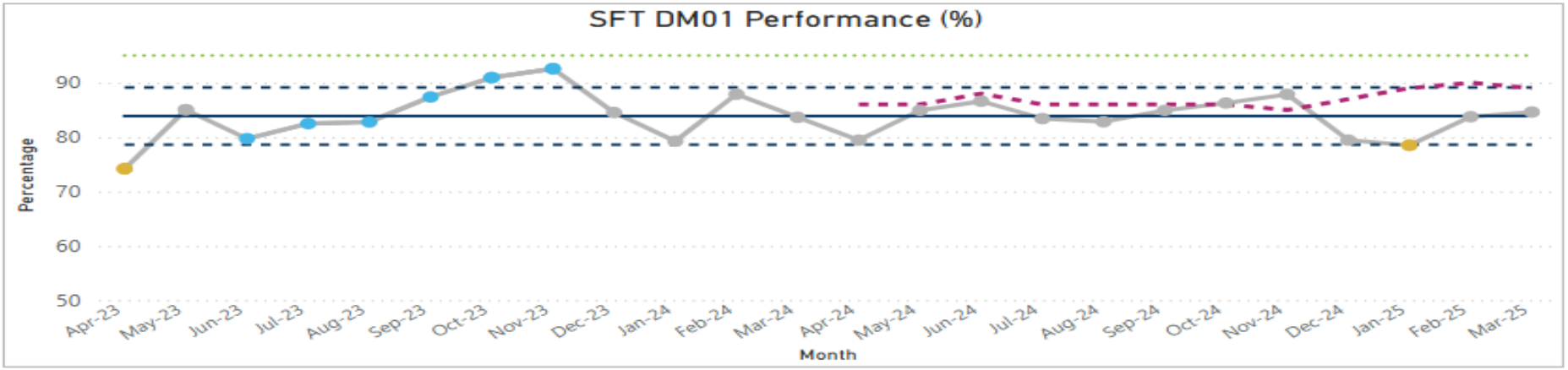
Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62-day compliance will be impacted. Aiming for <6% of PTL size for patients >62 days in their pathway.
- Risk to M11/12 2024/25 and Q1 2025/26 performance identified considering tertiary centre prostate surgery backlog. Ongoing liaison and escalation as required.
- Noted resource within MDT cancer services team remains challenging in terms of long-term capacity.
- Risk of Oncology capacity associated with Aseptics and associated outsourcing, alongside Consultant (UHS) and nursing capacity.
- Cancer escalation policy routinely in use across all tumour sites.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 84.6% Position: Common Cause



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	87.6%	106	Dexa	100%	0	Colonoscopy	50.3%	199	Urodynamics	44.8%	37
CT	90.1%	75	Neurophysiology	100%	0	Gastroscopy	66.8%	86	Cystoscopy	93.9%	4
Ultrasound	90.9%	187	Echo	92.1%	40	Flexi Sigmoid	36.3%	109	Audiology	81.1%	135

Understanding the Performance

Diagnostic performance improved to 84.6% in March from 83.8% in February.

Main contributors to the position were improvements in high volume modalities of Endoscopy, as early impact of insourcing additional capacity began to show, and Audiology as the backlog over 6 weeks reduced.

Outlier modalities are Flexible Sigmoidoscopy - part of the Endoscopy group of sub-specialties for reporting purposes - and Urodynamics, with both remaining around 40% since the beginning of the year despite relatively low total waiting list size. Both will be a focus to improve in Q1.

Countermeasure Actions	Due Date
• Endoscopy insourcing arrangement to be online from M11.	31/03/2025
• Audiology additional starter recruited for March, however a further vacancy will now offset this gain.	31/03/2025
• Continued maximisation of Community Diagnostic Centre (CDC) USS and Echo capacity to a) achieve CDC activity plan and b) recover DM01 position for USS.	Ongoing
• Locum support in Audiology continuing to support reduction of paediatric waiting list.	Ongoing
• Complete review into Endoscopy booking processes with the aim of unlocking improved position overall.	Ongoing

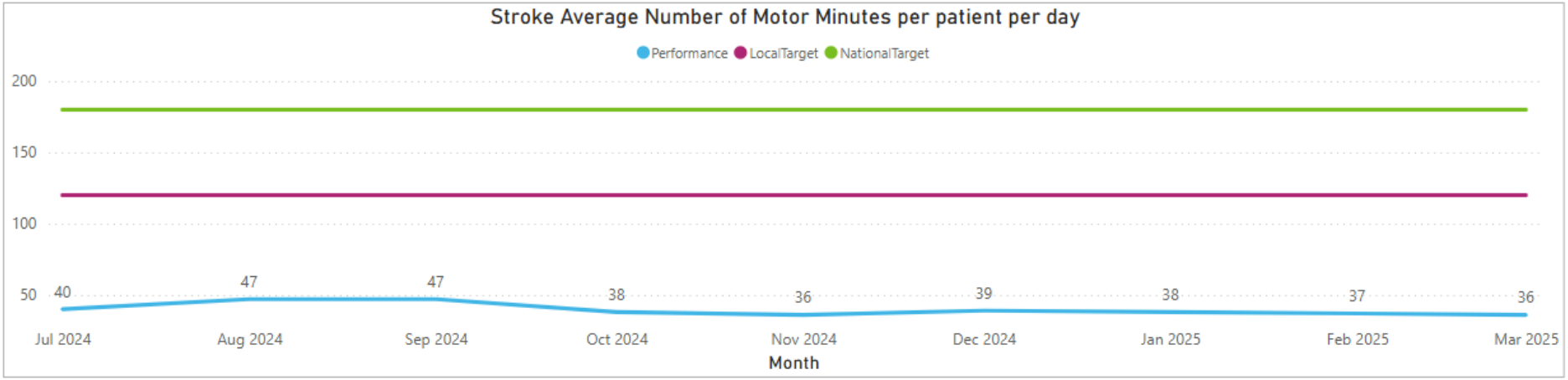
Risks and Mitigations

- Capacity remains reliant on either insourcing or in house overtime to meet demand.
- Audiology remains difficult to recruit to, with one appointment made whilst another vacancy was created, although as evidenced the backlog is reducing

Stroke Care

Salisbury NHS Foundation Trust

Target: ≥180 mins Performance: 36 mins Position: N/A



	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2
SSNAP score	C	C	B	A	B	C	C	C

Understanding the Performance

March demonstrates an average of 36 mins which is a consistent performance since the start of the new guidance and method used to calculate the performance.

Work to optimise therapy activity prior to October has limited the impact on the performance and if measured in the same way as pre-October would have resulted in an increase for those patients requiring motor therapy.

Key themes:

- No of minutes of motor therapy is averaged across all patients requiring **any** duration or level of motor input. This means that at any point up to 30% of patients will be too unstable or have no therapy goals so will lower the average minutes for all patients.
- Previously counted activities are no longer included eg assessments.
- There is still a small gap in captured motor activity from nursing teams and for patients outlying on other wards
- No formal benchmarking has occurred.

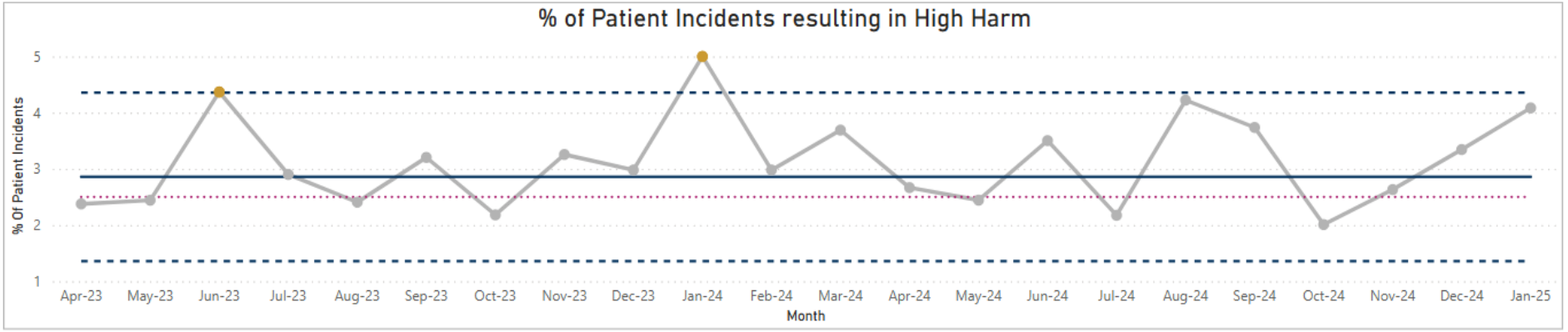
Countermeasure Actions	Due Date
• Further work to optimise uncaptured activity from outlying patients and ward nurses	May 25
• Benchmark performance with local services including methodology for calculating performance.	May 25
• Time in motion and job planning for current team to ensure all available capacity is utilised effectively.	June 25
• Gap analysis between current registered workforce (8.55wte) and new recommendation workforce (13.29) in increased productivity.	June 25
• If optimisation of capacity is achieved, then work up business case for additional staffing.	July 25
• Stroke deep dive at CGC in April	April 25

Risks and Mitigations

- The number of therapy motor minutes provided to patients requiring and able to participate is higher than performance suggest (reduced by averaging across all patients requiring any motor input during stay).
- The mitigation is a redesign of A3 which will include benchmarking and sharing of good practice across Wessex network.
- Team working with original workforce on 10.55 WTE therapists and 15.29 WTE recommended.

Incidents

Target: ≤2.5% Performance: 4.1% Position: Special Cause Improvement



Understanding the Performance
There were 899 total incidents that occurred in January compared to 819 in December. In January: Of those 899 incidents, 736 were incidents relating to patient safety. Of the 736 patient safety incidents; 24 reported moderate harm (an increase of 7 from December) 2 reported major harm (no change from December) and 2 reported catastrophic harm (no change from December). *(There may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively. A patient safety review (PSR) is undertaken for all patient incidents where moderate harm is reported to have potentially occurred)*

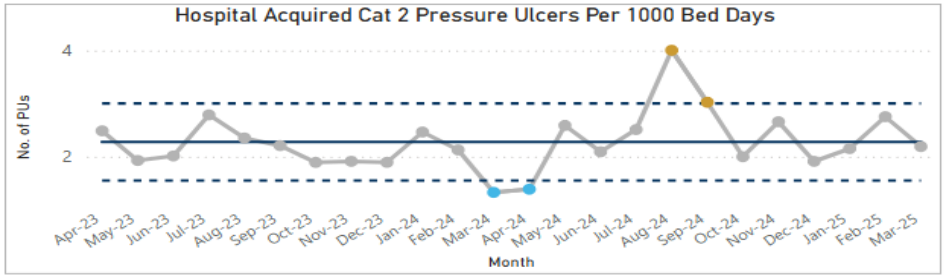
Countermeasure Actions	Due Date
• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required.	Daily
• Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed.	Weekly
• Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients.	Ongoing
• Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue/trend and a patient safety incident investigation (PSII) is indicated.	Ongoing
• Learning from incidents forum.	
• Trusts learning from incidents forum.	Monthly Quarterly

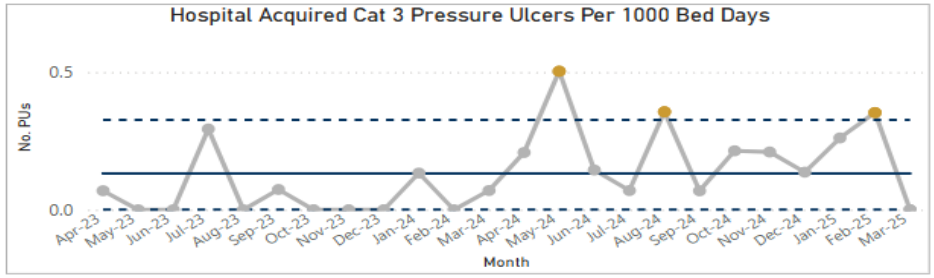
Risks and Mitigations
Learning <u>Theatres</u> • Clearer ring marking on the finger for all finger surgery. Awareness for theatre staff that markings should be visible after draping the patient. <u>Maternity</u> • The labour ward coordinator should be aware, and the paediatric team called for a birth when the CTG is not classified as normal or is difficult to interpret, particularly in a growth restricted baby where wellbeing cannot be assured. • To utilise fetal scalp electrodes (FSE) to accurately record fetal wellbeing to differentiate between fetal and maternal heart rates.

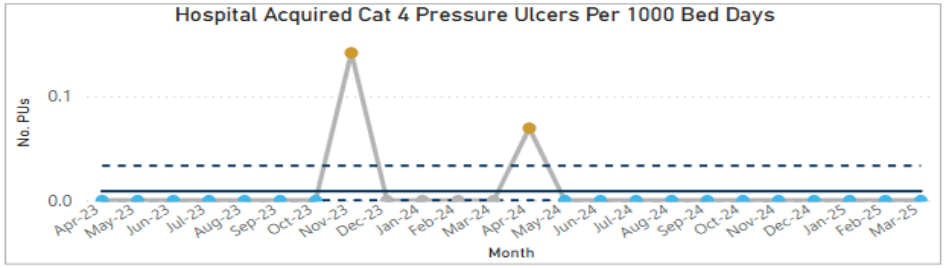
Pressure Ulcers

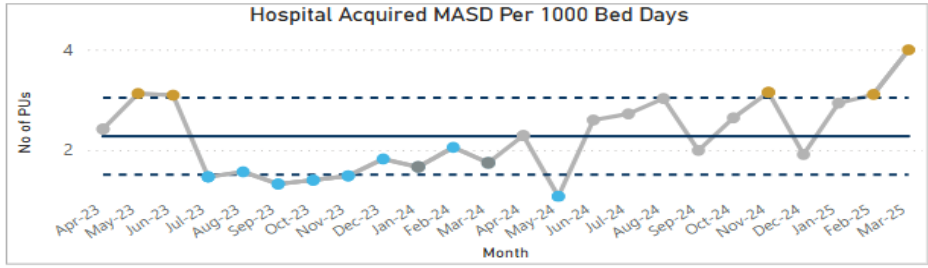
Salisbury NHS Foundation Trust

Target: N/A Performance: 2.19 Position: Common Cause







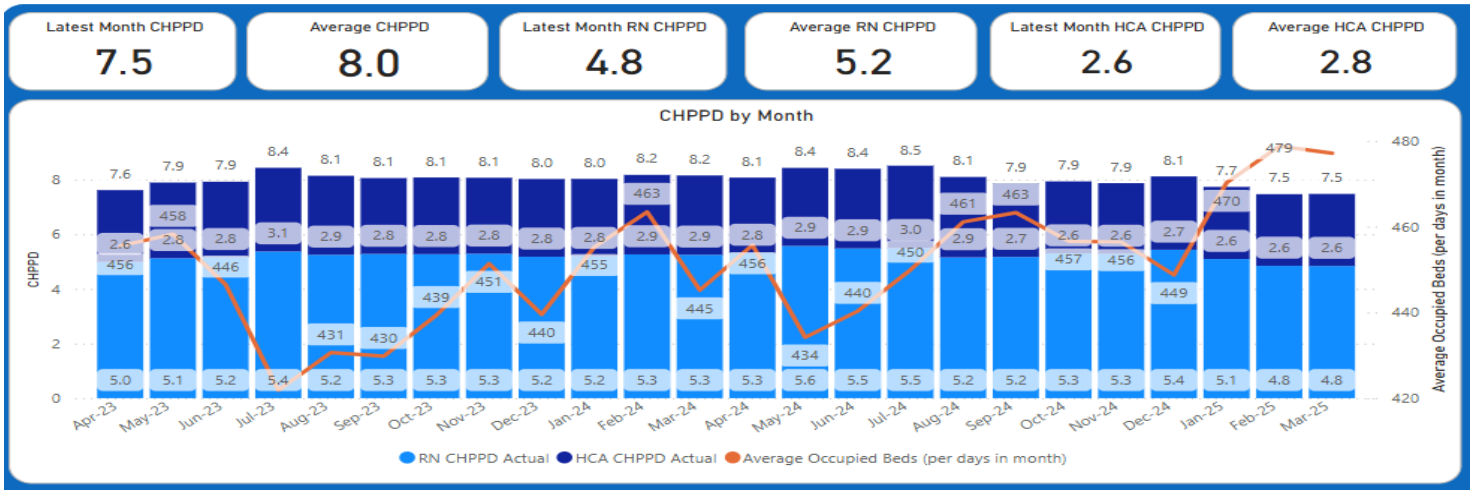


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The number of Pressure Ulcers (PUs) across the Trust has decreased in March (34) when compared to February (44). There is a decrease of category 2 PUs from 39 to 34 this month. We have seen an increase in device related pressure injuries with 6 this month. We have had 0 PU3s this month compared to the 5 we had last month. We have had 0 hospital acquired PU4s this month. The total number of PUs identified on admission was 89. Moisture Associated Skin Damage (MASD) hospital incidence has seen an increase of 62 compared to lasts months 44. The MASD identified on admission was 43.	• Tissue Viability (TV) held a successful study day that was available to all levels of staff throughout the hospital. We saw over 30 members of ward staff attend. • TV have provided shadow shifts to ward link nurses and Students. • The two-month MASD prevention trial on two wards continues until April. • VAC training given with 5 staff members attending and will continue to be offered throughout the year. • Continue to review data for PU and MASD monthly. • TV continue to provide monthly information and updates to the ward link nurses. • Wards to utilise TV link workers to support with wound management and prevention.	March 25 March 25 April 25 March 25 Ongoing Ongoing Ongoing	• Wards to utilise link workers to support with wound case management and prevention of skin tissue injury. • Extraordinary meeting being rearranged rearranged for senior divisional nurses. • MASD incident numbers have increased and being monitored. • The new MASD pathway is in the final stages of review before it is approved and then availabl to the wards.

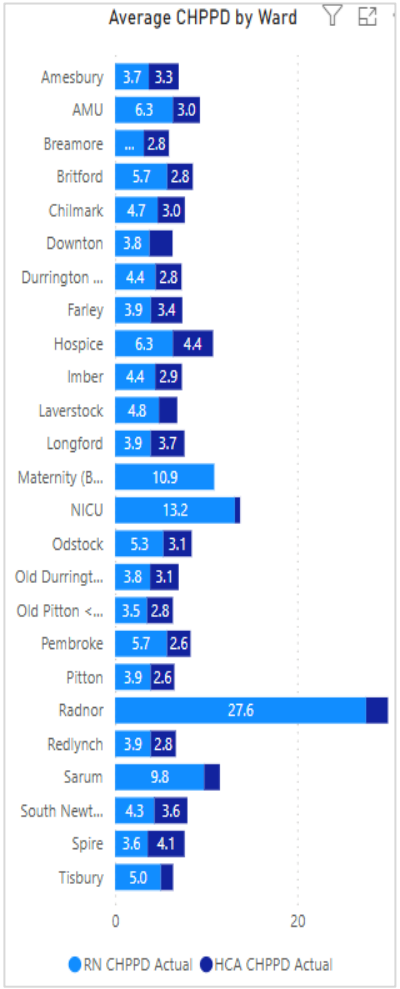
Care Hours per Patient per Day (CHPPD)

NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 7.5 hours Position: N/A



Definition: CHPPD measures the total hours worked by RNs and HCAs divided by the average number of patients at midnight and is nationally reported. Note: There is no national target as is a benchmark to review wards.



Understanding the Performance

CHPPD static at 7.5 and 7.0 when excluding critical care, maternity and NICU, remaining at the lowest position since June 2023 (and significantly lower than rolling average). Average occupied bed days have remained high at 442 (445 last month) which is indicative of ongoing escalation beds and boarding across some areas and 5 patients in SDEC and SAU most nights. High sickness on wards remains a contributing factor.

Fill rate has remained static - with HCA day shifts remaining under 100% due to pay rates for weekday shifts.

Off framework usage in ICU has reduced but should be noted long-term break glass agency for SACT nurses in Pembroke and also within cardiology.

Issues with reporting of temporary staffing being explored so total temp staff spend not clear.

Countermeasure Actions	Due Date
• Twice daily staffing meetings.	Ongoing
• Roster review meetings being held for all wards across March/April - ensuring roster KPI compliance, sickness reviews, temp staff usage reviewd at ward level.	April 25
• Trust wide workstreams commenced for agency reduction and sickness.	Ongoing

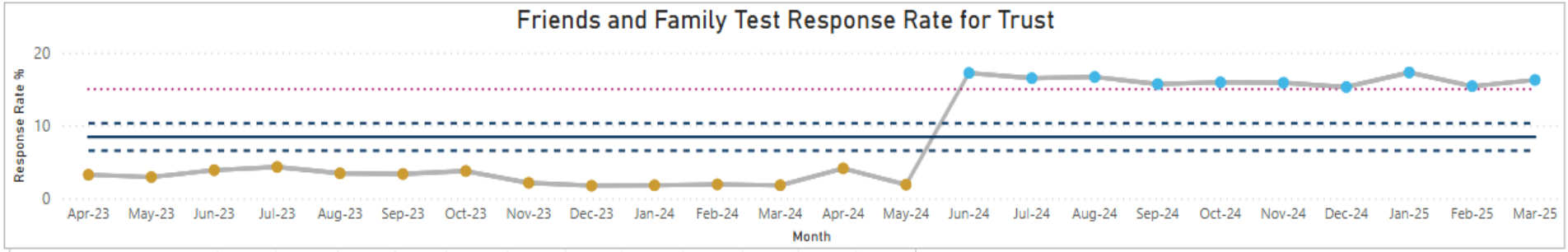
Risks and Mitigations

- Requirement to reduci headcount / temporary staffing (risk).
- On-going demand for RMNs to supporte patients at risk (risk).
- On-going short-term sickness and other absence driving temp staff spend considering low vacancies (risk).
- On-going use of escalation areas (risk).
- HCA vacancy and turnover (risk).
- SW agency collaborative holding agency at capped rates (mitigation).

Friends and Family Test Response Rate

NHS Salisbury NHS Foundation Trust

Target: ≥15% Performance: 16.3% Position: Special Cause Improvement



Response Rate by Area	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
FFT Response Rate - A&E	0.7%	0.6%	20.6%	20.4%	22.0%	20.7%	21.6%	20.6%	21.7%	21.8%	20.0%	19.5%
FFT Response Rate - Day Case	2.1%	2.9%	3.4%	10.8%	11.2%	6.3%	10.3%	8.7%	10.1%	12.3%	9.6%	23.0%
FFT Response Rate - Inpatient	22.3%	18.5%	10.4%	26.3%	31.8%	21.4%	26.0%	24.8%	27.2%	30.2%	19.9%	34.6%
FFT Response Rate - Maternity	0.5%	0.0%	13.7%	9.7%	10.1%	10.3%	9.5%	10.2%	10.4%	10.3%	8.9%	3.5%
FFT Response Rate - Outpatient	1.0%	0.9%	18.3%	16.4%	16.0%	15.8%	15.6%	15.8%	14.5%	16.8%	15.4%	14.5%

Understanding the Performance

Our response rate in March was still recording a maintained improvement since the new digital dashboard and SMS message service went live in June 24. Our response rate was 17% with a satisfaction rate of 94% therefore we met our response rate target but slightly fell short of our satisfaction rate target of 95%. We don't have full l insight on the dissatisfaction at this stage, but we are looking to provide this with future narratives.

Countermeasure Actions	Due Date
• SMS messages are sent to all eligible patients attending our maternity services, Outpatients and ED This has demonstrated a significant improvement to the Trust's response rate. The new online forms have now also gone live and work is underway to advertise these changes through a new poster.	Ongoing
• The installation of the new FFT boards currently in the inpatient areas is currently taking place, with a second phase rollout planned for outpatient areas The patient experience team will be working with individual clinics and services not included in the new hierarchy data structure, to consider alternative data collection methods for informing service Improvements.	Apr 25

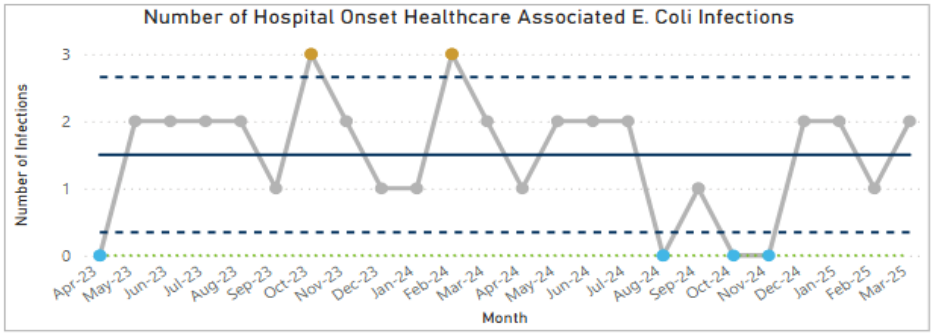
Risks and Mitigations

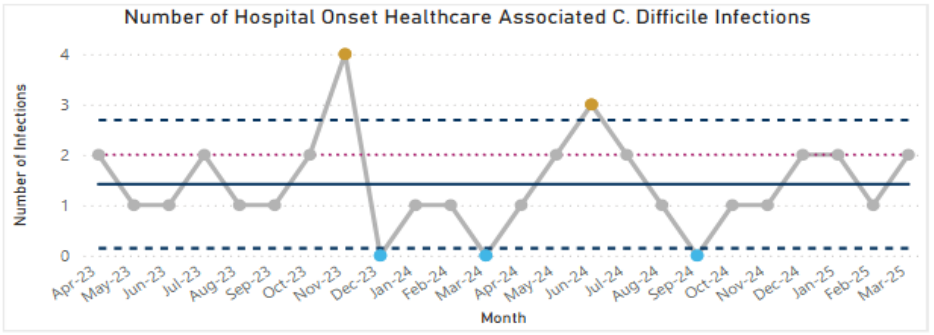
- The new dashboard continues to enable better themes and insight analysis of comments. Going forward we will be able to offer more robust analysis and insights from the feedback received. Implementation of the new system has already demonstrated a successful drive towards the Trust's 15% improving together response rate target set for 2024/25.
- Due to a technical fault in March there may be a lower response rate that anticipated but we are hoping this will rectify in April's figures.

Infection Control

Position: Common Cause

Position: Common Cause





Year	2023-2024	2024-2025
MRSA Bacteraemia Infections: Hospital Onset	0	0
MSSA Bacteraemia Infections: Hospital Onset	10	10

Understanding the Performance

There have been two Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* bacteraemia infections.

There have been no HOHA reportable *MSSA* bacteraemia infections.

For HOHA reportable *C.difficile* cases, there have been two cases, compared to one last month. *(The previously reported periods of increased incidence (PII) of C.difficile for Redlynch Ward; and AFU and Imber Ward continue due to ongoing practice concerns).*

Continued activity of diarrhoea for inpatient areas and has included bay closures on Spire Ward.

Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas / teams to identify good practice and any new learning continues with identified timeframes.	Monthly
• From reviews completed for *C.difficile,* delay in escalation for clinical reviews, documentation, and delay in isolation nursing identified. Divisions continue to monitor areas that have produced action plans and provide updates to the IP&CWG.	Monthly
• Delay in receiving antimicrobial prescribing feedback from Pharmacy Team for incident investigations, which has been followed up with the Deputy DIPC.	Ongoing
• The IPC nursing team continue to undertake targeted ward visits and use educational opportunities for staff.	Ongoing

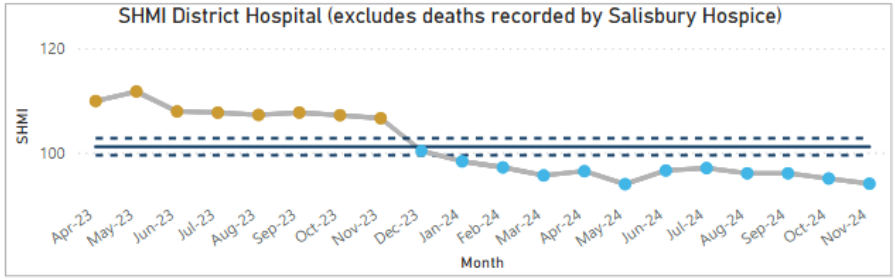
Risks and Mitigations

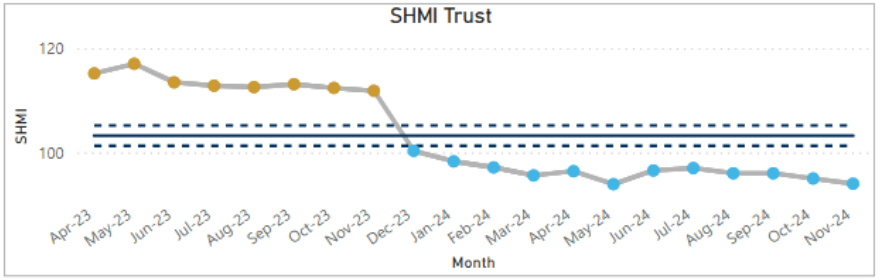
- Increased workload for IPC nursing team members due to unexpected team member absence.
- Underlying risk continues to be potential increase in reportable HCAI with poor patient outcomes. NHS Standard Contract 2024/25: minimising *C.difficile* & Gram-negative BSIs, outlines the threshold levels set by NHSE. For *C.difficile*; the threshold is 21 Healthcare Associated (HA) cases. From 1st April to 31st March, there have been 32 cases (18 HOHA, 14 COHA).
- The Trust has exceeded the threshold set for HA *Pseudomonas aeruginosa* BSIs. Set at 7 cases; there have been 13 cases.
- Replacement of inpatient bed gel holders ongoing by the IPC nursing team but delayed due to other priorities.
- A UKHSA audit reviewed our Data Capture Site entries for reportable healthcare infections with corrective measures agreed to improve and reporting to the IPCWG.

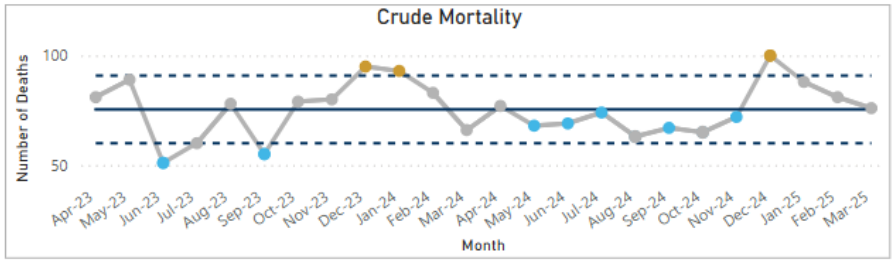
Mortality

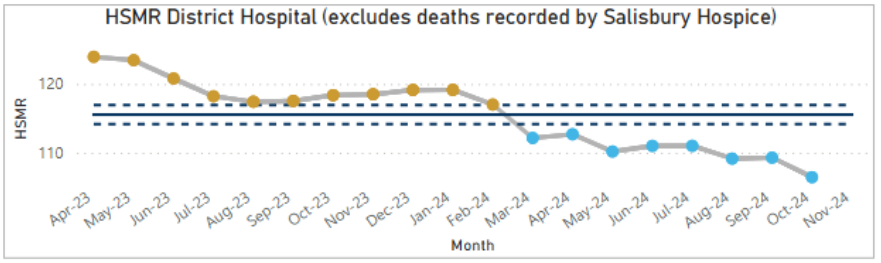
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A









Understanding the Performance

The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in November 2024 is **0.94** and remains statistically within the expected range.

The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in October 2024 for Salisbury District Hospital is **106.4.** This number has continued to improve and moved from statistically higher than expected to within the expected range this month.

A national revision to the methodology for calculating the SHMI came into effect from Dec'23 onwards. *We have recently seen the introduction of the newly remodelled HSMR (HSMR+). The Trust initially saw an upward shift in the data (applied retrospectively), but the overall trajectory remains a downward one.

Countermeasure Actions	Due Date
• All actions related to the previous NHSE mortality insight visit have now been completed and/or closed. Our mortality metrics used for benchmarking against national figures (HSMR/SHMI) have continued to show improvements.	Ongoing / Bi-Monthly
• The number of primary mortality reviews (SJRs) being undertaken across the Trust is increasing and the Trust's online mortality system is capturing thematic learning and actions.	Ongoing / Bi-Monthly
• The online mortality system to support learning from deaths was launched in March last year. Activity has been centred on improving reporting outputs from the mortality reviews. A new training guide for staff and a supporting video have recently been produced and disseminated.	Ongoing / Bi-Monthly

Risks and Mitigations

- The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend to help us to interpret and analyse our mortality data and identify variations in specific disease groups.
- Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	68	138	93		0		Common Cause Variation	X	48
Beds Occupied %	97.0%	97.6%	96.9%	96.0%	92%		Common Cause Variation	X	3
Complaints Closed within agreed timescale %	60.0%	42.0%	53.0%	85.0%			Common Cause Variation	X	48
ED 12 Hour Breaches (Arrival to Departure)	349	446	428		0		Special Cause Concerning - Above Upper Control Limit	X	48
Inpatients Undergoing VTE Risk Assessment within 24hrs %	28.2%	21.1%	19.5%		95%		Special Cause Concerning - Below Lower Control Limit	X	48
Mixed Sex Accommodation Breaches	53	68	14	0	0		Common Cause Variation	X	48
Number of High Harm Falls in Hospital	4	3	3	0	0		Common Cause Variation	X	10
Pressure Ulcers Hospital Acquired Cat 2 - Device Related	3	0	6	0			Common Cause Variation	X	1
Pressure Ulcers Hospital Acquired Cat 4 - Device Related	0	0	0	0			Special Cause Concerning - Above Upper Control Limit	✓	0
Proportion of patients spending more than 12 hours in an emergency department	7.8%	10.5%	8.7%				Special Cause Concerning - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	674	650	665	0	0		Special Cause Improving - Below Lower Control Limit	X	48

Watch Metrics: Alerting

NHS Salisbury

Quality of Care, Access and Outcomes

Understanding the Performance

Continued pressure on flow remains evident in the alerting metrics with Ambulance Handovers more than 60 minutes, the number and proportion of patients spending longer than 12 hours in the Emergency Department all reducing slightly in comparison to February, but the trend position remaining above upper control limits or in common cause. Bed occupancy also remains high at around 97%.

The number of patients waiting longer than 52 weeks remains in an improving position and for the first month there were zero patients waiting longer than 65 weeks.

Countermeasure Actions

- The work to reduce the number of patients in the hospital that no longer meet the criteria to reside is essential to reducing occupancy levels and improving flow – the improvement sprint work continues with partners, whilst the average number of patients has increased this month, the average number of bed days associated with the delays has improved which could be offsetting an increase in the number of patients unable to be discharged without additional needs.
- Successful consultant recruitment in ED and further expansion of SDEC (same day emergency care) services will provide additional support to the Emergency Department.

Risk and Mitigations

- There have been significant increases this year in both ED attendances and non-elective admissions, if this growth continues then flow levels will remain challenged. Capacity of community services and local authority services to be able to both mitigate growth in attendances/admissions and also support onward discharge requirements remains a concern, particularly with the persistent levels of NCTR seen in the recent months.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Diagnostics Activity	8741	7972	8090	0			Common Cause Variation	✓	0
ED Attendances	6545	6123	7090				Common Cause Variation		
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	90.3%	83.7%	88.7%				Special Cause Improving - Above Upper Control Limit		
Pressure Ulcers Hospital Acquired Cat 3 - Device Related	1	0	0	0			Common Cause Variation	✓	0
RTT Incomplete Pathways: Total 65 week waits	8	6	0	0	0		Special Cause Improving - Below Lower Control Limit	✓	0
RTT Incomplete Pathways: Total 78 week waits	0	1	0	0	0		Special Cause Improving - Below Lower Control Limit	✓	0
Stroke patients receiving a CT scan within one hour of arrival	65.0%	46.0%	67.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	59	62	63				Common Cause Variation		
Total Number of Complaints Received	17	19	21				Common Cause Variation		
Total Number of Compliments Received	43	35	75				Common Cause Variation		
Total Patient Falls per 1000 Bed Days	6.66	6.46	6.23	7			Common Cause Variation	✓	0
Trust 30 day Emergency Readmission Rate	12.0%	11.3%	10.6%				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

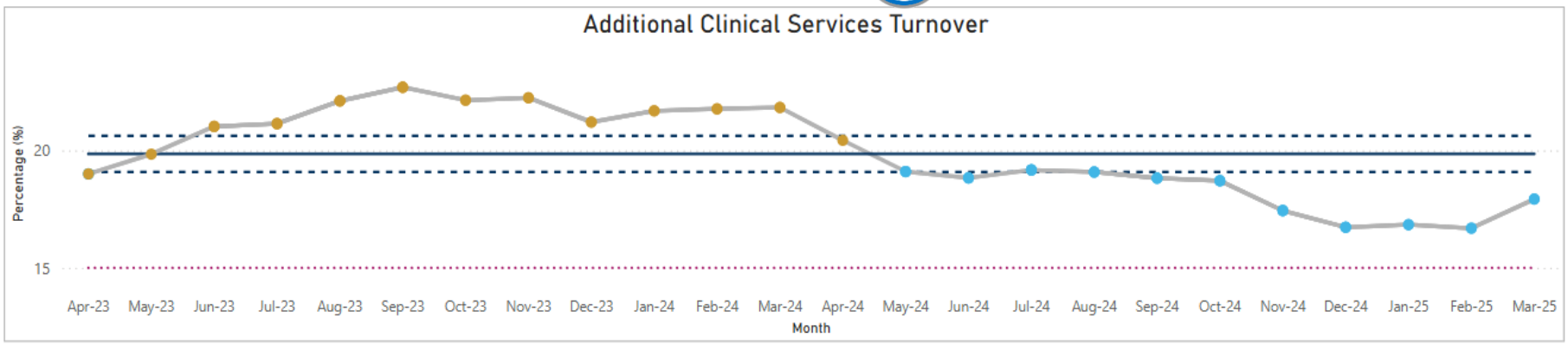
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

We are driving this measure because…	The breakthrough is on Retention – focus on Healthcare Assistants (HCA) turnover. HCAs have the highest turnover of any staff group at circa 21%. The breakthrough objective is to improve this to a target of 15% turnover by March 2025. SFT currently measures the highest turnover areas by staff group (HCA), length of service and Age of Leavers.
Baseline: 20.4% (April 2024)	We have developed an A3 approach to focus on improving retention in this staff group due to the significant impact this turnover has on direct patient care. This will enable more direct patient care hours due to more available HCAs working each shift.

Target: ≤15% Performance: 17.9% Position: Special Cause Improvement



Understanding the Performance

ACS turnover increased to 17.93% M12 (16.7% in M11), therefore missing the breakthrough target (15%).

This remains the highest turnover staff group, equating to 10.3 WTE leavers in month.

- 7.2 WTE had 2 years' service or less.
- 3.0 WTE were u-25 years old.

Leavers reasons:

- 3.71 WTE Other / not known
- 2.6 WTE Work / life balance
- 1.8 WTE Relocation
- 1.24 WTE Retirement
- 0.6 WTE Dismissal (Capability)
- 0.4 WTE Dismissal (SOSR)

SFT turnover overall is up slightly to 12.32%, still under the 13% target.

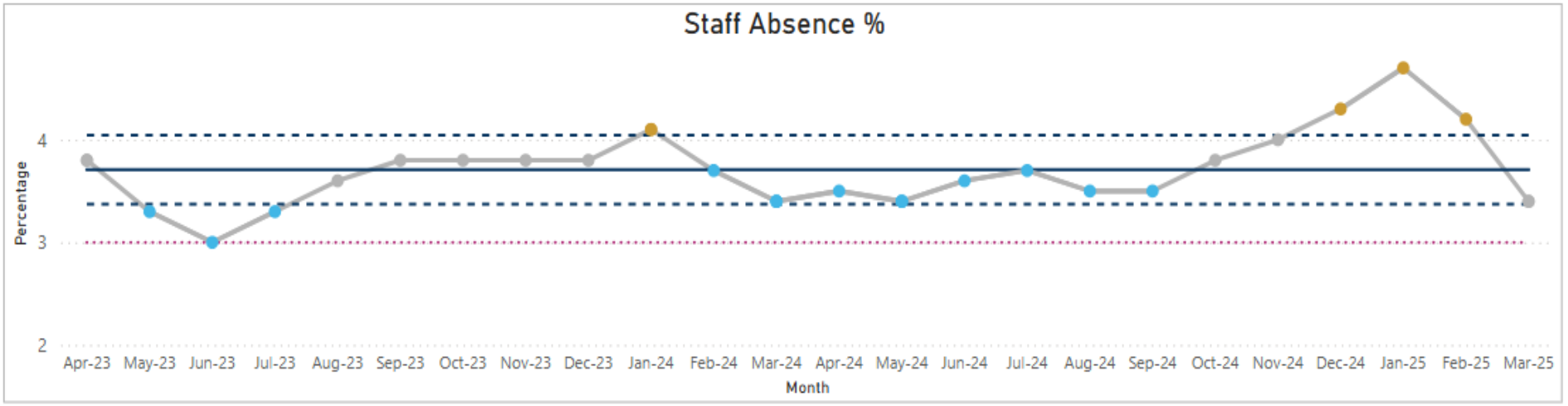
Countermeasure Actions	Due Date
• R&R retention leads delivering exit interviews to improve leavers data.	Ongoing
• Review of current recruitment processes. Slight delay due to resourcing issues.	Q4 2024-25
Countermeasures under review and will be refreshed from Q1, as current list is now BAU. These will focus on triangulation of high turnover, high vacancy, short length of service and identify if leavers exit the role or the NHS entirely.	April 2025

Risks and Mitigations

- New to care staff identified on appointment and provided additional support.
- Care certificate completion rates up to 99%.
- Insufficient leavers data to plan actions. HCA R&R team working to develop this.
- HCA role not sufficiently understood by applicants. Educational/informative HCA Vlogs now part of attraction/recruitment process.
- High attrition of staff in first 12 months of appointment.
- HCA opportunities not well understood by line managers and staff.

Sickness Absence

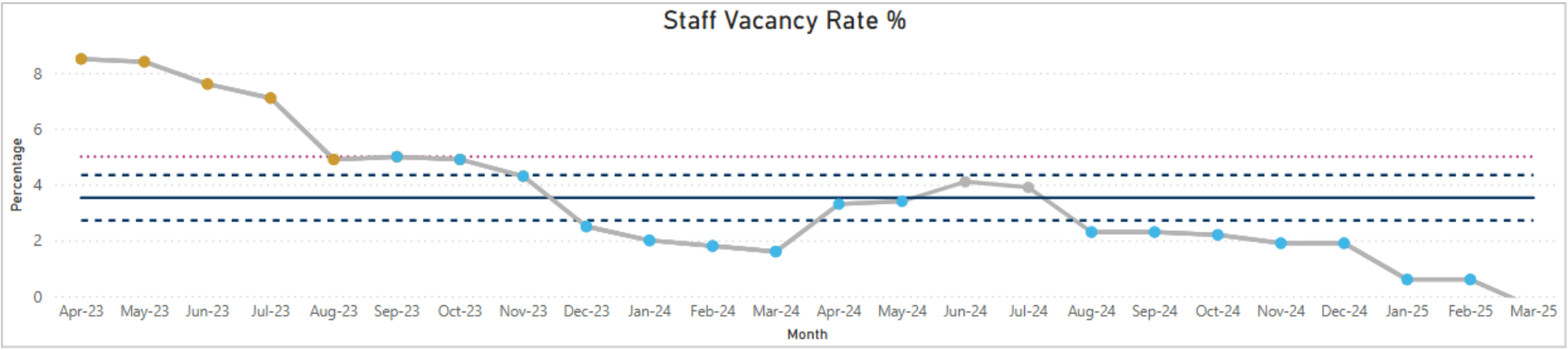
Target: ≤3% Performance: 3.4% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Sickness absence has dropped by over 0.8% from 4.23% in M11 to 3.24% M12 (lowest this financial year). The highest absence rate in month is again Anxiety / Stress / Depression, accounting for c25% of all absence. Colds, Gastrointestinal and MSK make the top 4 absence reasons. W&NB and Surgery remain the highest contributors at 5.13% and 4.15% respectively. Corporate, CSFS and EFM are 3% or less. Additional clinical services remain the highest contributing staff group at 4.94% (5.96% in M11) and Nursing and Midwifery 4.21% (5.21% in M11). Sickness accounted for 4,371 FTE days lost (4,855 FTE in M11), with a broad 60 / 40 split of long-term vs short-term sickness – highlighting the recent increase in STS has subsided.	• Line Manager (LM) training on Absence Management policy and actions seeking to deliver training opportunities for all by year end. Sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy). • Reduction of violence and aggression on wards and in ED / AMU, seeking to prevent physical injury and reduce cases of workplace stress and anxiety. 'No excuse for abuse' campaign and training interventions planned each month. • Deep dive of EFM absence causation to generate mitigation actions. Main volume / % absence is within Housekeeping. Newly appointed HRA for Corporate will begin deep dive into Top 50 absentees.	Complete /Ongoing Complete /Ongoing Complete /Ongoing	• Availability of instructors and advisers to support training interventions and workplace support to LM. Staff are being trained and recruited to fill vacancies in current team. • Availability of LM to attend training. • The ER team has filled all HRA roles as of January, but this currently remains a risk until new starters are established in post. There are still significant vacancies in other HR roles.

Vacancies

Target: ≤5% Performance: -0.35% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
M12 vacancies are at minus 0.35% (+0.27% in M11), so technically reporting that the overall Trust headcount is above establishment. Noteworthy that this is the NET position, so some teams are above and some below funded establishment. The highest contributing staff group is infrastructure staff, where there are a total of 113 WTE vacancies (108 in M11). The highest vacancy rates amongst clinical divisions sit within Surgery - Theatres, particularly HCA (38.71%) & B5 ODP (56.85%), noting B5 RGN is 21.41% over establishment. (GWH) Procurement 10.74 WTE (24.75%) are highest Corporate team. HCA vacancies are 78.12 WTE (72.06 in M11), with 11.75 WTE in Elderly Medicine (Breamore, Durrington, Imber, Pitton & Spire). M12 vacancy information as reported to ICS, which includes subsidiaries and hosted services show a total of 52 FTE (66 in M11), a vacancy rate of 1.21%.	• Targeted support to the identified hard to recruit roles, seeking to support attraction campaigns to fill these post which generate high agency back fill costs. • Confirmation that vacancies identified as greater than 10% align accurately to team structures to ensure that attraction campaigns are focused on the areas of most need. Further work required to prioritise these areas in line with patient safety / service delivery and to support Trust headcount management. • Workforce control process being reviewed following new ICB guidance.	Ongoing Ongoing April/May 25	• DMT and HRBPs working to design and develop attraction packages for hard to recruit roles. • Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through ineffective recruitment and on-boarding processes Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations. This includes ED&I monitoring, Recruiting manager training and development of job personas.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	85.5%	85.5%	77.9%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	48
Non-Medical Appraisal Rate %	69.3%	69.3%	72.0%		90%		Common Cause Variation	X	48
Staffing Availability	3.1%	3.6%	3.8%	3.7%			Special Cause Improving - Run Below Mean	X	1

Watch Metrics: Alerting Narrative

Salisbury NHS Foundation Trust

People

Understanding the Performance

Due to Information Systems failure between Kalidus and Power BI there is no M11 updated Mandatory training data at the time of producing this report. This was not available for M10 either. This has been resolved and figures have been corrected on the system, including removal of leavers from the database resulting in a cleaner set of data being reported. Mandatory training for M12 is showing below target at 77.9% completion rate across the Trust. The best performing area was Estates & Facilities with 93% completion. The lowest contributors are Corporate at 71% and Medicine at 77%. The 90% target has not been met for since January 2023. The application of significant oversight from management teams remains the most effective action to increase compliance.

Medical appraisals improved "in month" and is 90%. The number of "out of date" appraisals has decreased from 76 to 58, with the number out of date by >3months decreasing from 43 to 38.

Non-medical appraisals rates have improved to 72% (69.2% M11). This is >8% worse than the previous March. This equates to over 900 appraisals being 'out of date'. The main contributors to poor appraisal rates across the Trust are Corporate at 55.7% (248 out of date) and CSFS at 71.8% (222 out of date).

Countermeasure Actions

- Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.
- Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months. A working group is established to review and improve the process to enable higher completion rates. A trial of focussed support has been implemented in OD&P directorate in Q4.
- The review/project to overhaul non-medical appraisals is also looking to link to talent management, and CPD required for colleagues across SFT. This is part of the OD&L steering group for monthly review and update.

Risk and Mitigations

- Loss of Trust in the accuracy and useability of the MLE system may deter staff from completing mandatory training. Work is ongoing to improve accuracy and design course content which is easy to understand and use.
- Inability to release staff to enable MLE completion is frequently cited as the main blocker to success.
- Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers.
- Management time to enable appraisal completion is frequently cited as the main blocker to success.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	89.0%	88.7%	90.0%	90.0%			Common Cause Variation	✓	0
Staff Turnover (Trust overall)	12.3%	12.2%	12.3%	13.0%			Special Cause Improving - Below Lower Control Limit	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

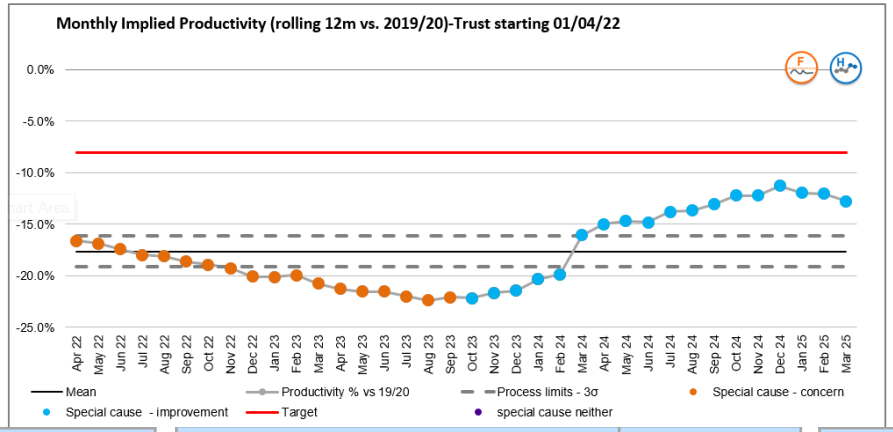
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -16.1% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services have the opportunity to affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: ≤-8% Performance: -12.8% Position: Special Cause Improvement



Understanding the Performance

M12 higher non-pay costs driven by in tariff drugs, IT licences, income backed project, and one-off education costs, have not been fully mitigated by increased Day cases and Non-elective activity, with a 0.72% deterioration in the rolling 12-month delivery.

There is an improvement of 3.3% delivery since March due to cost increases being mitigated by Day cases, Outpatient First and Non-Elective + 1-day activity increases.

Calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate for implied Productivity % as a comparator to 2019/20.

Countermeasure Actions	Due Date
• FRG task and finish group operating on alternate fortnight basis to review headcount above March 23 levels.	Ongoing
• Modernisation and consistency of admin processes.	Ongoing
• Corporate transformation and redesign.	May 25

Risks and Mitigations

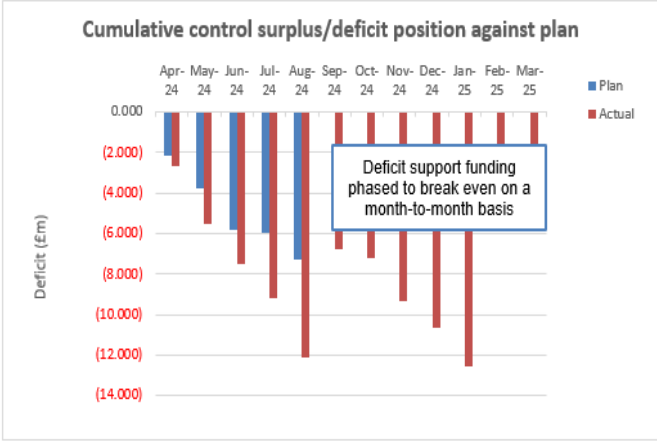
- The Finance Recovery Group and ERF / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

	March '25 In Month			March '25 YTD			24-25
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	26,642	27,541	899	319,474	326,471	6,997	319,525
Other Clinical Income	850	1,729	879	10,846	14,642	3,796	10,795
Other Income (excl Donations)	3,270	19,567	16,297	39,359	55,831	16,472	39,359
Total income	**30,762**	**48,837**	**18,075**	**369,679**	**396,943**	**27,264**	**369,679**
Operating Expenditure							
Pay	(20,392)	(36,864)	(16,472)	(246,855)	(268,969)	(22,114)	(246,855)
Non Pay	(9,620)	(13,401)	(3,781)	(117,175)	(129,043)	(11,868)	(117,175)
Total Expenditure	**(30,012)**	**(50,266)**	**(20,254)**	**(364,030)**	**(398,013)**	**(33,983)**	**(364,030)**
EBITDA	**750**	**(1,429)**	**(2,179)**	**5,649**	**(1,069)**	**(6,718)**	**5,649**
Financing Costs (incl Depreciation)	(1,890)	(1,525)	365	(22,654)	(21,449)	1,205	(22,654)
NHSI Control Total	**(1,140)**	**(2,954)**	**(1,814)**	**(17,005)**	**(22,518)**	**(5,513)**	**(17,005)**
Deficit Support Funding	1,140	1,140		17,005	17,005		17,005
Reported Position		**(1,814)**	**(1,814)**	**(0)**	**(5,513)**	**(5,513)**	



Understanding the Performance

The financial plan submitted to NHS England on 12 June shows a £17m deficit position for the year and includes an efficiency requirement of £21.1m. £17m non recurrent deficit support has been funded from October with £10.2m non recurrent BSW funding in February.

The Trust recorded an in-month control total deficit of £2.9m against an original deficit target of £1.1m - an adverse variance of £1.8m. This is adjusted for £1.1m income which is the in month impact of the £17m.

Pay costs include the technical adjustments required by the Department of Health and Social Care for the NHS pension adjustment of £15.228m. The underlying position was an increase of £0.2m. Non pay costs increased due year end stock levels, central assessments of outstanding costs, drugs costs due to additional clinical activity which are not income backed, IT licences and, income backed or one off, project and education costs .

Countermeasure Actions

- Financial recovery group (FRG) was established in April 23, as a sub-committee of the Finance and Performance committee, to provide monthly scrutiny and support to the savings programme. The workforce FRG was established in July 24 to provide additional scrutiny on the deployed workforce.

Due Date

Risks and Mitigations

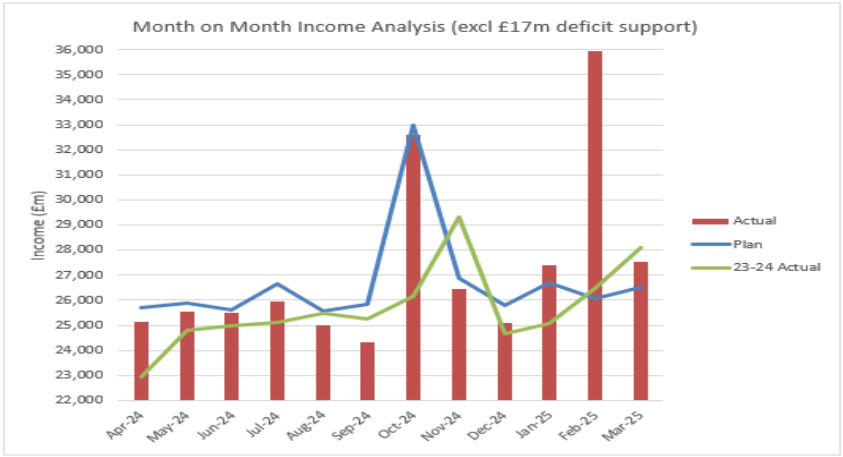
- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and recruitment.
- The Trust's £21.1m efficiency savings plan includes more than 40% non-recurrent delivery and signals a risk into 25/26.

Income and Activity Delivered by Point of Delivery

Target: N/A Performance: N/A Position: N/A

Income by Point of Delivery (PoD) for all commissioners	March Year to Date (YTD)		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	12,291	13,138	847
Day Case	26,601	26,956	355
Elective inpatients	22,154	17,053	(5,101)
Excluded Drugs & Devices (inc Lucentis)	27,828	29,450	1,622
Non Elective inpatients	82,875	83,964	1,089
Other	102,329	109,371	7,042
Outpatients	45,396	46,539	1,143
TOTAL	319,474	326,471	6,997

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	207,652	218,411	10,759
Dorset ICB	31,385	30,067	(1,318)
Hampshire, Southampton & IOW ICB	28,225	26,923	(1,302)
Specialist Services	43,429	48,735	5,306
Other	8,783	2,335	(6,448)
TOTAL	319,474	326,471	6,997



	Activity YTD			Activity Last Year Actuals	Variance last year
	Plan	Actuals	Variance		
A&E	73,787	78,594	4,807	75,033	3,561
Day case	28,191	27,378	(813)	24,178	3,200
Elective	4,744	3,659	(1,085)	3,274	385
Non Elective	28,536	30,823	2,287	28,439	2,384
Outpatients	293,980	304,107	10,127	277,525	26,582

Understanding the Performance

The Trust level performance is driven by BSW support funding and Specialised commissioning ERF over performance offset by lower Elective Inpatients and Outpatient First attendances impacting on the ERF income, partially offset by overperformance on Day case income and Outpatient Procedures, underperformance on Community diagnostics activity, prior year funding which will not be received and overperformance above the block high-cost drugs and devices and diagnostics plan for BSW.
There is underperformance across all the main commissioners except for Specialised commissioning due to ERF and high-cost drugs and devices over performance and BSW support funding.

Activity across the main points of delivery was higher in March than in February.

Countermeasure Actions

- The 2024/25 ICB and NHS England contracts are now signed.
- 2025/26 contracts are expected to be signed by the end of May 25.

Due Date

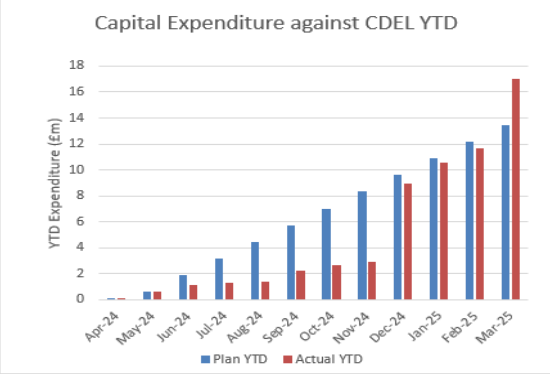
Risks and Mitigations

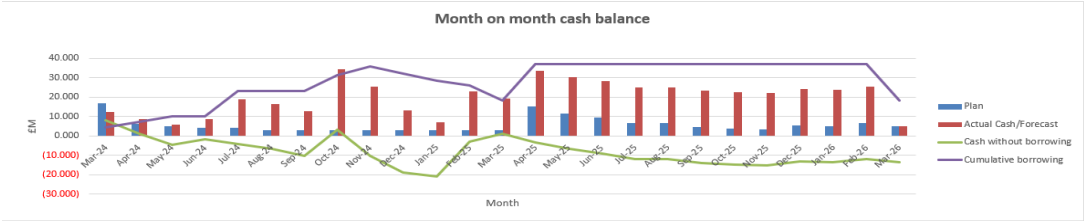
- Additional 25/26 NHS England Standard contract consultation issued. This closes on 28th April with changes to the contract activity management provisions and requirement for agreement of robust Indicative activity plans consulted on.
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements.

Cash Position and Capital Programme

Target: N/A Performance: N/A Position: N/A

	Closing Balance March 2024 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	7,520	(434)
Debtors	24,999	19,291	(5,708)
Cash	28,891	22,530	(6,361)
TOTAL CURRENT ASSETS	**61,844**	**49,341**	**(12,503)**
Creditors	(58,026)	(49,082)	8,944
Borrowings	(641)	(1,391)	(750)
Provisions	(474)	(590)	(116)
TOTAL CURRENT LIABILITIES	**(59,141)**	**(51,063)**	**8,078**
TOTAL WORKING CAPITAL	**2,703**	**(1,722)**	**(4,425)**





Schemes	Annual Plan £000s	March '25 YTD Plan £000s	March '25 YTD Actual £000s	March '25 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,609	3,609	2,748	(861)
Building projects	2,682	2,682	9,308	6,626
Fire schemes	500	500	469	(31)
IM&T	6,264	6,264	3,480	(2,784)
Medical Equipment	393	393	581	188
Non Medical equipment			400	400
Total CDEL schemes	**13,448**	**13,448**	**16,986**	**3,538**
National Funding				
Shared EPR - national element	2,731	2,731	2,731	
Digital Pathology & LIMS	837	837	635	(202)
Community Diagnostic Centre	1,306	1,306	872	(434)
CIR Funding	761	761	760	
PDC Regional re-allocation	525	525	523	(2)
Elective care centre	1,500	1,500	1,500	
Total National Funding	**7,660**	**7,660**	**7,021**	**(639)**
IFRS 16 Leases				
Medical Equipment	1,800	1,800	1,245	(555)
Vehicles and transport	850	850	360	(490)
All other leases including property	350	350	639	289
Total IFRS 16 Leases	**3,000**	**3,000**	**2,244**	**(756)**
GRAND TOTAL	**24,108**	**24,108**	**26,251**	**2,143**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £24.0m driven by the South Newton site purchase, EPR, Elective care centre, Imber ward, SDEC and Chimney flues.

The cash balance at the end of Month 12 was £22.5m, £19.4m above the planned level of £3.1m. The improvement is due to payments relating to the non-recurrent deficit support and BSW support funding.

Countermeasure Actions

- BSW ICB has paid two month's contract payments in April to mitigate any requirements for PDC support in 25/26.

Due Date

Risks and Mitigations

- The aging estate, medical equipment and digital modernisation means that the Trust's capital requirements are more than resources.
- The Trust seeks to mitigate the constraint of available system capital by proactively bidding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.

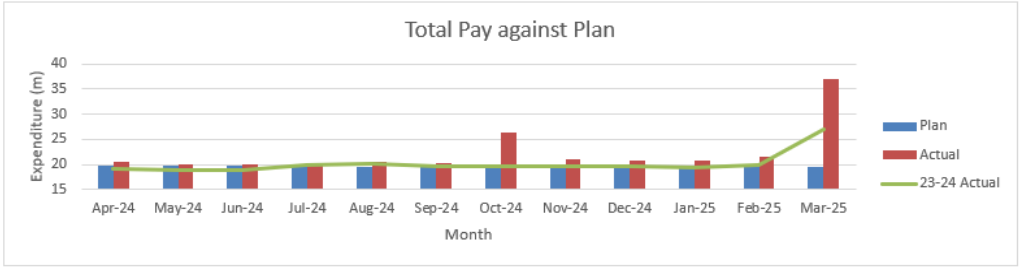
Workforce and Agency Spend

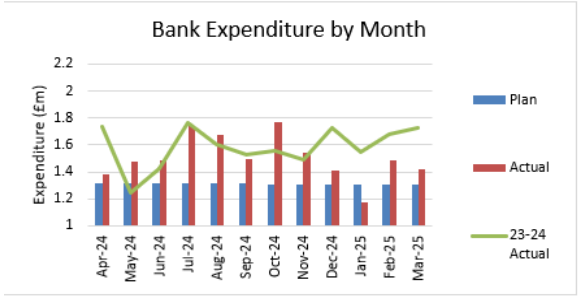
Salisbury NHS Foundation Trust

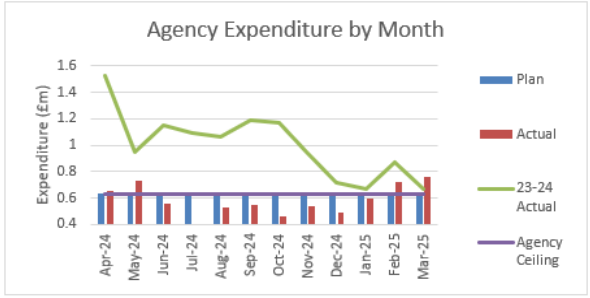
Target: N/A Performance: N/A Position: N/A

	March '25 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	222,396	243,013	(20,617)
Pay - Bank	16,196	18,046	(1,850)
Pay - Agency	7,543	6,905	638
Other (eg apprenticeship levy)	720	1,006	(286)
TOTAL	**246,855**	**268,969**	**(22,114)**
Medical Staff	63,111	72,144	(9,033)
Nursing	67,571	66,759	813
Support to Nursing	23,888	20,525	3,363
Other Clinical Staff	33,504	33,546	(42)
Infrastructure staff	58,415	59,761	(1,346)
Other (eg apprenticeship levy)	365	16,235	(15,870)
TOTAL	**246,855**	**268,969**	**(22,114)**

	March '25 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	535.1	569.95	34.8
Nursing	1,191.6	1,356.64	165.0
Support to Nursing	433.7	561.14	127.4
Other Clinical Staff	808.1	657.82	(150.3)
Infrastructure staff	1,340.5	1,464.15	123.7
TOTAL	**4,309.0**	**4,609.7**	**300.7**







Understanding the Performance

Pay costs include the technical adjustments required by the Department of Health and Social Care for the NHS pension adjustment of £15.228m. The underlying position was an increase of £0.2m which includes changes to the annual leave assessment at year end and central pay provisions, including but not limited to, clinicians pensions and employment issues and staff capitalisations.

The pay savings target was £13.5m against which achieved pay savings were £7.9m - an adverse variance of £5.6m, with £1.8m recurrent delivery.

There is an over-establishment of 301 WTE against the 4,309 WTE Workforce trajectory with the over-establishment across all Pay categories apart from Other Clinical Staff.

Countermeasure Actions	Due Date
• Trust-wide and Division workforce control panels in place since November 23.	Ongoing
• Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients).	Ongoing

Risks and Mitigations

- Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although it is likely that the Trust will require both due to operational pressures.
- Enhanced bank rates have been introduced for January to March.

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Business Rules – Driver Metrics

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

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

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

Appendix

Reading a Statistical Process Control (SPC) Chart

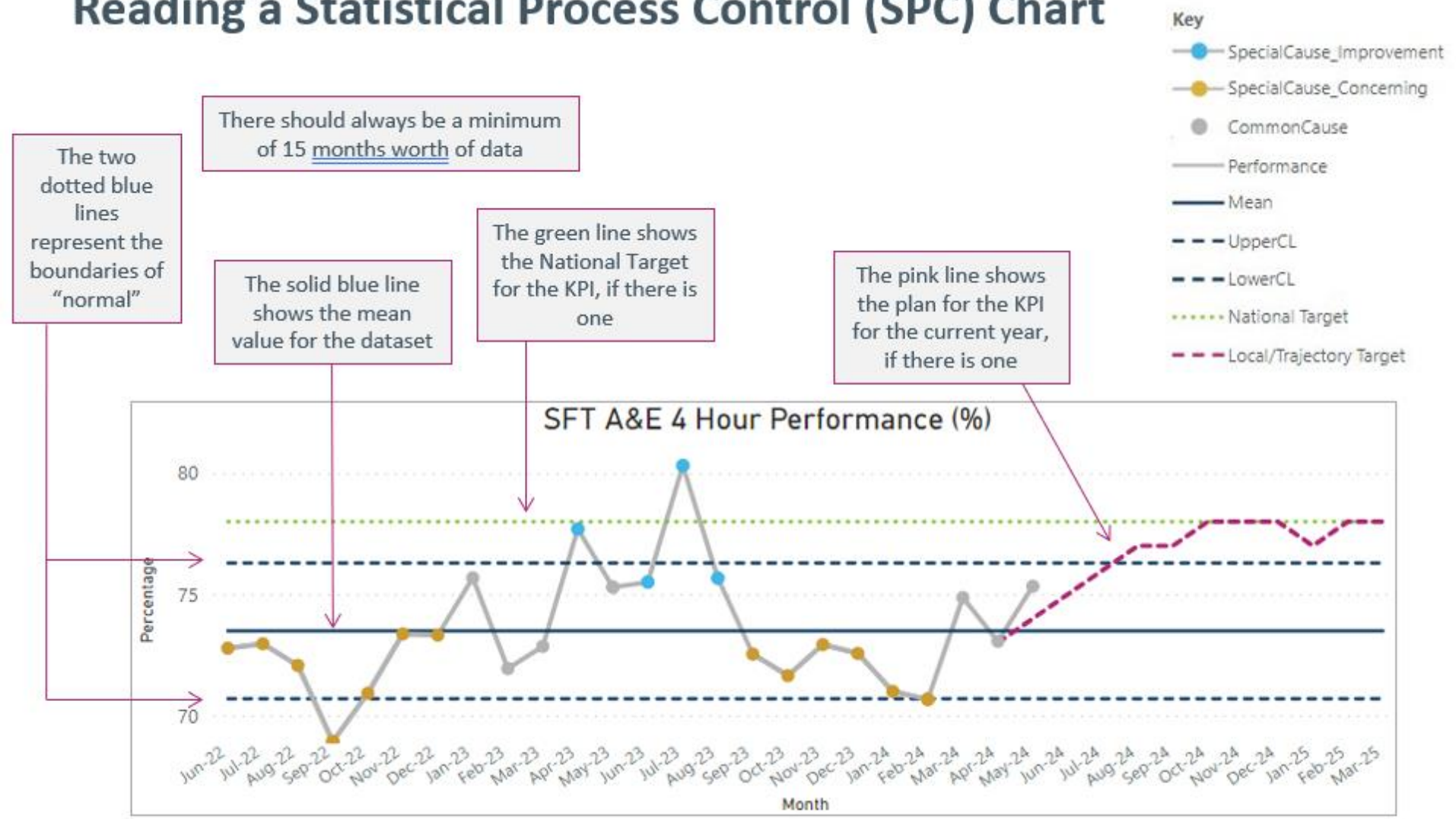
There should always be a minimum of 15 months worth of data

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

The solid blue line shows the mean value for the dataset

The green line shows the National Target for the KPI, if there is one

The pink line shows the plan for the KPI for the current year, if there is one



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	1 May 2025		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	20 March 2025
Status:	Information	Discussion	Assurance	Approval
Prepared by:	Richard Holmes (Audit Committee Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- The Committee received a deep dive into the Vacancy Control Process at Trust and BSW System level, and noted that the BSW Workforce Plan System Meeting (WPSM) established to review recruitment requests across the three Trusts has no non-clinical representation. Clinical functions are represented at the meeting at CMO/CNO level. Outside of and without explicit approval of the BSW WPSM, SFT through its own vacancy control process has approved and recruited non-clinical staff based on its own risk-based reviews – eg a Water Safety Officer. The Committee noted the potential impact on morale as a result of staff having the perception that the System values Clinical staff over Operational staff.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The fieldwork for the final External Audit is commencing. The Committee reviewed progress to implement process improvements following the last year-end audit and, notwithstanding the retirement of the Financial Controller Andy James, the teams are ready to support the External Auditors with full files of information in line with schedule dates.
- The External Auditors will be presenting their report on Value for Money, and are very likely to be noting a significant weakness in this area. As last year, any such opinion may well be based on the challenges to the financial sustainability of the Trust, and the high ongoing maintenance backlog, but this year may well also be including reference to the EPR, noting that it is in its early stages of implementation and that programme issues have already been identified.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The Committee agreed to complete the enhanced Review of Committee effectiveness, and agreed that external attendees of the meeting should be encouraged to complete the review as well.
- The Committee received the Internal Audit Progress report and was pleased to note that no management actions were overdue.
- The Board reviewed three Internal Audit Reports, all of which received assurance in line with management expectations. Only one high level priority 1 significant weakness was raised associated with the process for raising and approving ad-hoc shifts for locums. An action plan to address this by

October 2025 is in place and will be reviewed for implementation effectiveness by the People and Culture Committee later in the year.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- The Committee received and reviewed the current Board Assurance Framework, and in particular the consequences of reviewing the approach to evaluating Risk Appetite recently agreed by the Board. A number of risks are now being reported as out of tolerance. The Committee is considering how to increase its oversight of Clinical and other risk areas in conjunction with the Director of Integrated Governance and Internal Auditors. The Committee concluded and recommended to the Board that the process of review and update continues to be effective.
- The Trust's delegated limits within the Trust's SFIs require formal review at least every two years, previously having been reviewed and approved in March 2023. Any changes to the SFIs must be approved by Trust Board on recommendation by the Audit Committee. Having reviewed the minor changes proposed, primarily as a result of the new Group structure, the Audit Committee recommends that the existing delegated approval limits of the CEO are mapped across to the Managing Director, that accountabilities of the CEO remain unchanged and that the SFIs as presented to the meeting are approved by the Board. The changes also include a clarification on the financial threshold for the completion of procurement recommendation reports.
- The Committee approved the Internal Audit Plan for 2025/26, supporting and noting a number of joint audits across the three Group Trusts.
- Similarly, the Committee approved the Counter Fraud Plan for 2025/26.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
	1st May 2025		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	13 March 2025
Status:	Information	Discussion	Assurance	Approval
				x
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- Cumulative risk of plan given system and NHSE changes and disruption – added to BAF

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **Seeking further assurance**
  - To understand pace and scale we would like to see the monthly build of CIPs in plan to receive regular reports as we monitor against this phasing
  - There is a degree of dependency on the HCRG schedule of activity to help manage demand, discharge patients earlier and to increase community capacity and services, in order that we can achieve some of the improvements in productivity and NCTR. F&P seek to have regular updates on their progress through the engagement that Lisa and Niall have in various forums.
  - We seek more detail on the actions from the NCTR sprint and their timing and impact, particularly focussing on what is "our responsibility" (up to the point of the discharge ready date).
  - Quality impacts of plan and CIPs to be presented to Committees as they are developed further
  - Triangulation – we will want to see regular assessment as plans develop further

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation, or action that the Committee considers to be outstanding.

- We have a compliant plan
- It is a breakeven plan with a trajectory towards sustainable finances
- It sets out plans to achieve performance targets set nationally – many are already being achieved
- The Executive team believe that the plan outlines the pathways for what is possible, and recognises the risk given the scale and pace

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- **25/26 Plan** – Final plan approved, on behalf of Board, for submission with a request to distinguish clearly between SFT and system enablers for the delivery of the plan.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
	1st May 2025		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	25 March 2025
Status:	Information	Discussion	Assurance	Approval
				x
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- A **POSITIVE** alert that we will end the year on forecast, having maintained our forecast position for some time now, showing good financial control and engagement. Whilst we were not able to deliver the full £5.6m savings relating to NCTR we will end the year with approx. £17m-£17.5m of savings against our plan of £21m, which is quite some achievement. Next year's CIPs target is £20.9m, with 40% of scheme with a clear route to delivery, 40% with developing routes and approx. 20% with no clear route yet.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **Chief Financial Officers' Report**
  - We received verbal confirmation that we had submitted a compliant plan for 25/26 and there is a reasonable level of confidence, at system level, that SFT can deliver their plan. However, with BSW needing to reduce WTE significantly and with £80m of savings in the plan the level of risk may lead to great oversight as the focus on provider performance increases.
  - There was a challenge on how we will get the debt of nearly £3m paid by STL to the Trust, which led to a discussion around the commercial future of STL. We had assurance that STL is competitive and is strong on quality and recent losses were due to unsustainable pricing by one particular competitor. With the guidance around the "arm's length" arrangements with commercial entities the ownership structure will be considered together with the commercial strategy. There will be a report back on what level of performance is needed and for how long to settle the SFT debt.
  - There will be 2 helpful Internal Audit reports this year, relating to some challenges raised at the Committee; Benefits realisation and MLE – the later supporting evidence of cyber training compliance.
- **Stroke Performance** – not yet seeing signs of improvement, but there will be a deep dive at CGC in April.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation, or action that the Committee considers to be outstanding.

- **NCTR –** We received another update on the progress being made and despite there being a spike in February (>100) the levels are back down again now – the reflection here was that spikes are around holiday periods, and these should not be a surprise so better planning is needed. Our time to referral to hub has reduced to <24 hours, the quality of information provided is improving to help with appropriate onward care provision, and the e-whiteboard testing is imminent with go live expected in June. Work is being done on mapping patient transport pathways too. We heard that councils can't afford any more beds for pathway 2 so more work is needed to shift patients to pathway 1. There is some hope of evolving the virtual ward/ hospital at home model to be another level in reducing NCTR. Overall, although the progress is slow, we are assured that the right actions are being taken, collaboration and objectives are aligned and there is a determination to make a difference.
- **IPR –** Although a number of metrics were reported as alerting in the month, overall, we took assurance that these measures were improving again and that actions were being appropriately focussed to continue the improvement journey. Cancer performance was negatively impacted by Christmas (data one month behind) but is now recovering to its previous position. RTT work continues to improve performance with coordination and delivery resulting in better utilisation of clinical rooms and rolling out improving together to all specialities (from 4 to 20). The focus in April is outpatient improvements, cancer performance and maintaining DM01.
- **Digital Quarterly Report and SIRO Report** – Overall these were assuring reports. We heard Badgernet implementation is going well, but that there is some potential tension on deadlines between EPR and pathology LIMS with the emphasis being on the EPR deadline being the most important for SFT. The level of training compliance needs to improve so "chasing" continues to get to the 85% target.
- **Campus Update** – We had assurance that if we receive the funds for the £6m Safety fund that the chimneys will be a priority (this is one of our highest estate risks, which is being mitigated through regular surveys).

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- **Primary Care Minor Injuries and Illness Unit – Contract –** A contract extension for a year was approved (running from 1 April 2025), during which time we hope to receive £7m ICB funding for a new unit, with conditions that it is spent by March 2026.
- **Campus update** – Approval was given to proceed with the covenant negotiations with Salutum, despite the challenges regarding the Charity's ownership of the land, which is complicating negotiations. Salutum have agreed to their less preferred option on the basis that we get the collaboration agreement signed by the end of June.

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	1st May 2025		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	25/3/25
Status:	Information	Discussion	Assurance	Approval
	X		x	
Prepared by:	Anne Stebbing			
Non-Executive Presenting:	Anne Stebbing, Chair			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- Two improvement notices have been received following a planned CQC inspection of the Trust's implementation of IRMER (ionising radiation) regulations. Immediate actions to correct these have been taken and further actions are planned. An update will come to the next CGC. The committee noted that the full report from the inspection had now also been received, and much good practice had also been noted.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- CGC received the perinatal Surveillance Report and noted the greater stability in staffing numbers over recent reports, along with meeting the required standards for 1:1 care and supernumerary leader.
- CGC noted the number of pressure ulcers reported in the IPR and discussed the actions being taken to help reduce this. The measures provide partial assurance and CGC will continue to monitor the situation closely
- CGC noted that compliance with due of candour is improving and that the number of risks without actions to mitigate continues to reduce
- The CMO drew CGC attention to data from the National Joint Registry, (NJR), continuing to show that SFT is an outlier for revision hip replacement. This had been noted several years ago and an internal review suggested it may relate to the use of metal-on-metal hip replacements. It is unclear whether recent data is still affected by this practice which ceased some years ago. The CMO will update CGC once more data and clarification is received from the NJR.
- CGC questioned how well it is sighted on the clinical governance of the specialist services and has asked the executive to consider how best assurance might be provided around the diverse specialist services.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

• CGC approved its Cycle of business for 2025/2026 (subject to small amendments, including updating the divisions reporting their governance, following the changes to divisional structure. • CGC has reviewed its Terms of Reference. Many comments had been received prior to the meeting. The director of Integrated Governance will circulate a clean final version for approval by members via email, prior to the updated version going to the Trust Board for approval.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	1st May 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	26/03/2025
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- The Children's quality and safety board (CQSB) raised concern that the move to the new shared EPR would lose connection for patient medications that come via GP connect – and that this was only an issue for SFT so needed raising in the EPR governance structures.
- Workforce control process is having an impact on both morale and concern of delays impacting delivery of services or improvement plans.
- Intensive support process is happening in Fertility services and Plastics services.
- Digital oversight in the form of Digital steering group has been cancelled due to poor diary availability, this has now been moved to a different day of the week going forward.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- Financial position was updated showing the Trust expected to hit the revised total agreed with the system.
- Policies update was given at the committee showing significant progress

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- . The Committee received an update on the Health and Safety Committees work, which highted work on prevention of violence and aggression, update on the steps taken by the Fit Testing team due to supply of masks being restricted and update on the work to reduce the use of Tugs within the hospital to reduce noise.

- Cancer performance for 28 days was the best in the Southwest so showcased the improvements made in cancer oversight.
- Divisional restructure process is underway and progressing well.
- TMC annual effectiveness report was received and approved alongside the annual workplan.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- Access to rest facilities for resident doctors standard operating procedure

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	1st May 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	25/04/2025
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- VTE metric has changed for external reporting from within 24 hours of admission to 14 hours, Clinical management board are considering the change and the impact on reporting.
- Workforce controls continue to be an escalation from Divisional teams in lowering morale and impacting service change.
- The Trust received an CQC IMER inspection improvement notice which an action plan has been developed.
- There is a backlog on triage process for some electronic approvals, Surgery DMT is completing a Quality Impact assessment to remove triage steps to improve the process times.
- The pathology LIMs programme is being rephased due to resourcing pressures with a new go live of Sept 2025.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The Committee received a quarterly report from facilities which celebrated the recycling centre being shortlisted for the health estates facilities management association award. Updated the ANPR car parking processes and improvements. Discussions took place on the need to improve the use of clean mail to save money and the bleep audit process to reduce inconsistencies in bleep reporting.

- Improving Together report was considered highlighting the continued progress against the strategic initiative.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The Committee received the results of the PLACE audit where 7/8 dimensions had an improved score. Plans were in place to support improvement in the other dimension (organisational food) where the score had remained static.
- TIG process for benefits realisation is underway
- A report on the annual declarations of interest register was considered, and annual register of gifts and hospitality
- The integrated governance and accountability framework was approved.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
- The committee considered a case for voice recognition, this was agreed to be escalated to the group for a BSW Hospitals solution. • A case for frailty advanced practitioners was approved, this formed part of the SDEC plan and is within the financial plan for 2025/26 and underpins the improvements required for bed reduction.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.6
Date of meeting:	1st May 2025		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	27th March 2025
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- Deep dive on the MLE system identified that there is significant work to do in the short, medium and long term to meet the needs of the organisation. Whilst the committee was not fully assured at this point, a plan is in place with further updates to be provided on an ongoing basis. Feedback will be provided to both CGC and Audit committees
- BAF discussion confirmed high risk areas of digital and workforce whilst also noting the new MLE issue. Workforce risk updated and out with tolerance
- The strategic workforce plan under development now needs a radical rethink based on changing national expectations about WTE reductions (circa 200 WTE for 2025-26). Also awaiting 10 year plan. This will be discussed further in the June committee

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The following items were presented and discussed at this month's meeting:
  - MLE (as alert)
  - Consultant Pay Progression new process
  - BAF (as alert)
  - Strategic workforce plan (as alert)
  - Operational Plan (workforce) due for submission on day of meeting
  - People Promise update, noting progress across most areas
  - The IPR report – noting the risk to meeting Breakthrough objective (BTO). Other metrics positive
  - Staff Survey (see assure)
  - Car parking survey feedback noting positive process whilst acknowledging not everyone happy with outcome
  - Organisational Development and People (OD&P) management Board escalation report

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The meeting was quorate
- Positive workforce metrics in IPR (apart from BTO as advise above)

- Positive Staff Survey results demonstrating further improvement
- Fit Testing masks issue resolved
- Good discussion was held and the principles of Improving Together followed
- Positive feedback from Governors present

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• None

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.6
Date of meeting:	1st May 2025		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	24th April 2025
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- Continuing concern discussed re the challenge of reducing workforce (WTE) with increasing demand, financial challenges and maintaining quality whilst meeting national initiatives. This will be a key discussion in the June committee
- Gaps in occupational health services – physiotherapist and counselling roles

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The following items were presented and discussed at this month's meeting:
  - Terms of Reference – finalised will go to Board in June
  - Key Performance Indicators (KPIs) for the Organisational Development and Performance (OD&P) teams were presented. Good performance in most areas with only 4 out with target. Ongoing challenging areas include: digitalisation of personnel records, occupational health roles, MLE data and some policies
  - People operational projects, noting good progress in all despite the workforce gaps in the team
  - Audit and Fraud Report action plans update – further update provided noting good progress on actions with most closed and others projected to meet due dates
  - The IPR report – noting the Breakthrough objective (BTO) wasn't met for 2024-25 and would continue into this financial year alongside the new BTO of appraisals. The MLE data is lower than previous but following work with the Business Intelligence team was a more accurate position. As reported to the last Board, a project is underway with short-, medium- and long-term plans in relation to capturing staff training data. A response has been sent to the Chair of Clinical Governance committee following her request for assurance from PCC
  - Mental Health First Aider report
  - Health and Safety report noting good monitoring of performance metrics. Assurance was provided in relation to the Fit Testing risks and ongoing compliance. Violence and Aggression continues to be challenging
  - WRES and WDES action plan (2023-4 data) report, noting a new network Chair, improvement from previous year, Trust performing above national average however noting that there is still

a difference between these staff groups and others. Bullying and Harassment continues to be an issue as is staff self-reporting a disability ○ Organisational Development and People (OD&P) management Board escalation report, noting several policies not approved. Further assurance sought for next meeting
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• The meeting was quorate • Good discussion was held and the principles of Improving Together followed • Strong focus on DBS to support safe care • Good practice noted in KPIs, audit actions, Mental Health First Aiders, Health and Safety, Grievance Policy focussed around PSIRF requirement of Just and Restorative Culture

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• None

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	1 May 2025		

Report title:	Improving Together Quarterly Report (FYE 2024/25 and focus Q1/2)			
Status:	Information	Discussion	Assurance	Approval
			✓	
Prepared by:	Emma Cox, Head of Continuous Improvement and Coach House Alex Talbott, Director of Improvement			
Executive Presenting:	Alex Talbott, Director of Improvement			
Appendices (if necessary)				

Executive Summary:

This report reviews the 24/25 financial year as well as identifying the focus areas for Q1 and Q2 of the new financial year.

During the last year, Improving Together has continued to embed and mature across all levels at SFT: Executives, Divisions, Specialities and Teams. This is evidenced through the self-assessments undertaken by each layer of the management system. In addition, the Trust's overall NHS Impact self-assessment shows growing maturity in five of the twenty-two assessment areas.

The number of driver metrics aligned to the SPF continues to grow across the specialities and teams, demonstrating the deepening connection with the Trust strategy. To continue to further develop and mature the Operational Management System (OMS) the introduction of corporate Divisional Performance Reviews (DPPs) is a key milestone. Following an extensive period of learning and mapping of corporate services, this work has made positive progress and the proposed approach will be tested during Q1 and Q2.

The leadership behaviours that underpin Improving Together continue to be crucial in helping us build and embed a culture of continuous improvement. The positive 2024 staff survey results demonstrate the significant impact and influence this work has had to date.

The importance of working collaboratively continues to gain momentum. Across BSW Hospital Group, a Group level SPF is now in place, our Coach House teams have established working groups to share and learn from each other to harmonise our approaches. We have also established an industry partnership with Chemring Countermeasures. Internally, collaboration across our Senior Leads in Coach House, Transformation and OD&L has been established.

A review of the next steps listed in January 2025's quarterly update shows:

1. Successful recruitment of the second round of rotational roles to the Coach House. Three roles have been successfully recruited to.
2. Proposal for external partnership working to be developed in preparation for presenting to Execs during Q4.
   A partnership proposal with Chemring Countermeasures was agreed at the Improving Together Board, which will receive regular updates on the benefits of the partnership.

3. Continue to routinely share stories of improvement being realised across the organisation by our teams.
   The routine communication of celebrations and successes continues.
4. Increase collaborative working across the Senior Leadership Teams of Coach House, OD&L and Transformation Colleagues as part of the Centre of Excellence/Change Forum concept.
   Established monthly meetings across the three teams Senior Leaders is now in place with collaborative working to test the approach and learning as a result.
5. Further review training material of Improver Standard with OD&L colleagues to improve the training experience and ensure up to date material available for all attendees.
   Continued collaborative working across both teams is in place, with further meetings scheduled to review material during Q1.
6. Continue to improve the maturity of our OMS by increasing the number of PRMs and improvement huddles that are introduced and sustained over time.
   The Coach House continue to train and coach teams in introducing improvement huddles and PRM's within set timeframes after attending training.
7. Review and further align the maturity assessment scoring, with a focus on leadership behaviours, increasing the number of responses received and introducing peer-to-peer constructure challenge.
   This continues to be an area of focus and priority throughout Q1 and Q2, recognising there has been minimal progress on this since the last board report.
8. Continue to plan and implement the review of the SPF and our breakthrough objectives in line with business planning and the formation of the Group SPF.
   The BSW Hospitals Group has agreed a group SPF.
9. Develop and identify an improved process mapping offer which can be rolled-out across the whole organisation.
   An test of change project is underway in Orthopaedic theatres to look at reducing turnaround times between cases. This will help train our theatres teams in the process focused approach. In addition, the development of our process mapping training offer from Coach House has also been completed.
10. Develop our first iteration of a Corporate Division Performance Review (DPR)
    Extensive learning from others and mapping has been undertaken with the first scorecard agreement and associated DPR to be in place by the end of Q1.

Below we have used the Alert, Assure, Advise approach to help inform the Board of our levels of assurance in the deployment and development of Improving Together at SFT.

There is an identified set of next steps for Q1 and 2 noted at the end of report to build on the work that has already commenced.

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- None escalated from Improving Together Board.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- There are a reported 53 active improvement huddles post improver standard training, an increase from our position in December 2024. This remains lower than we would like, however, there is also

an improved understanding that teams are actively using other tools i.e. A3 and reporting the use of such tools will help provide a more rounded view.

- The Communication Managers role with responsibility for Improving Together communications remains vacant. The communications team with support from the coach House continue to ensure that there is a regular celebration of improvements achieved across the organisation.
- Increasing and improving how we routinely include patients, families and carers continues to score low in the NHS Impact assessment.
- The number of maturity assessments results returned is low at speciality and team level, therefore improving the processes and support available is necessary to improve this position.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- Utilisation of the Improver Standard training and increasing attendances to scheduled masterclasses remains strong, with a strong pipeline and prioritisation of bookings into 2025. Feedback on the training remains consistently positive.
- The OMS continues to mature and deepen across all levels of the organisations and across clinical and corporate services, this is as a result of achieving key milestones in the workstream roadmaps, continuing to align drivers to the SPF and aligning our corporate resources to the Trust Strategy.
- The Staff Survey Results of 2024 show a continued strong set of results against the four key questions used to measure the impact of improving together, with SFT outperforming most Trusts in these four areas.
- The continued embedding of our leadership behaviours framework, targeted support, training offer and investment to the OD&L team to support the development and embedding of a culture of continuous improvement has demonstrated improvement in all aspects of the people promise elements – through the 2024 staff survey results.
- In the last quarter SFT have hosted two more visits from NHS Trust board members looking to learn from how we have deployed and benefited from Improving Together.

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

Salisbury NHS Foundation Trust

Improving Together Quarterly Roadmap Progress Report – May 2025

This quarterly progress report reflects the outcomes in the nine workstreams overseen by the monthly Improving Together Board. It also includes updates on additional areas of work that align to embedding a culture of continuous improvement at SFT.

Reporting in January 2025, identified the following areas of focus:

1. **Training and Support**
   Achievement against the training trajectory of 100% of teams trained to Improver Standard remains on track (Q2 of 2026/2027). The pipeline of prioritised teams to training continues to remain strong across the whole training offer. Improved processes to provide focused ongoing coaching support, via the Coach House, will be adopted during Q1-2 to further strengthen maturity of the methodology alongside sustained and embedded ways of working.
   Reviewing and aligning training content across RUH/GWH/SFT to ensure consistent messages are cascaded will be overseen by the Heads of Coach House, in addition to linking up newly trained teams service leads to encourage wider collaboration, where appropriate and helpful.
   Strengthening our use of process mapping through deployment of training approaches to improve skills in teams and challenge assumptions remains a focus.

2. **Celebrating Successes and Improvements**
   The 2024 Staff Survey results have shown a strong set of results and improvements against all four key questions (see appendix 1) – SFT has improved faster across all four metrics than the average and top performance data points. These show we are beginning to embed a culture of continuous improvement at SFT and place us in the top quartile nationally.

   Equipping our leaders, with skills and mindset to shape and lead teams to be creative and innovative is being recognised through the continued embedding of the Trust's Leadership Behaviours Framework. The investment into the OD&L team has helped deliver significant impact across the seven elements of the people promise.

   Green shows an improvement, Amber no movement and Red a decline from the 2023 results.

Survey Area	SFT
Compassionate Culture	7.16
Compassionate Leadership	7.19
Autonomy & Control	7.20
Development	6.55
Teamwork	6.75
Line Management	7.03
Motivation	7.25

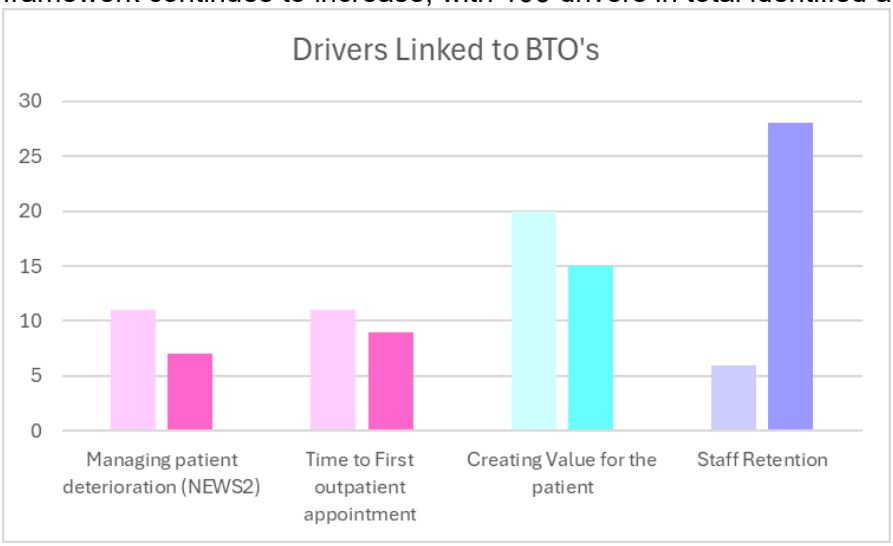
   Regular and routine sharing of successes achieved across the organisation is now embedded within our corporate communication team and is recognised as a valuable approach to disseminate the benefits being realised within teams. Opportunities to

extend and expand those achievements across BSW need to be realised and adopted to establish greater impact, sustainability and improved performance.

3. **Operational Management System (OMS) Maturity**
The OMS provides strategic focus to the organisation and cascades up and down from Board to division, speciality and team and back again.

Further development in mapping out future approaches to deploy corporate performance review meetings is a key milestone in aligning all areas of the organisation with the improving together methodology. Corporate scorecard agreements and performance review will commence in Q1 with identified corporate services.

Alignment of drivers being chosen and focused on that align to the strategic planning framework continues to increase, with 106 drivers in total identified as shown below:



Number of drivers aligned to each breakthrough objective. Coloured by Vision Domain, with lighter columns relating to Team drivers and darker columns Specialty drivers.

Divisions, specialities and teams continue to engage in self-assessing their maturity aligned to the Shingo principles of align, enable and improve. There has been limited progress on this since the last board report, however, through the creation of a driver within the Coach House at a senior team level progress is expected during Q1 and 2. The limited progress has not directly impacted the embedding of a culture of continuous improvement, as the work to adopt the methodology has continued. However, greater focus from our teams on using the self-assessment to guide their development will help accelerate the embedding of Improving Together as the way we work.

Our approach to supporting programmes and projects via a centralised corporate resource continues to be overseen by the Corporate Projects Prioritisation Group (CPPG) and discussed at the monthly engine room. As the OMS continues to mature, re-aligning 70% of its corporate projects to delivery of strategic initiatives will be necessary over the next year. The benefits being realised through corporate services is made available in appendix 2 with development of a structured benefits realisation approach being established throughout Q1 and 2.

Improving Together Quarterly Roadmap Progress Report – May 2025

4. Collaborative Working

There has been an increasing amount of wider system collaborative working during the last reporting period and areas of improved collaboration have been referenced throughout this report.

The development and approval of a BSW Hospitals Group Strategic Planning Framework (appendix 3) marks a significant step in adopting the improving together methodology at Group. The associated monthly Engine Room routines to support adoption and review are now being developed for roll out from June.

Internal collaborative working and development of a Centre of Excellence, across Coach House, OD&L and Transformation teams is gaining momentum with Senior Leaders of those team developing that shared vision and future approach to fully utilise their skills in supporting and managing change across SFT.

5. Identified Next Steps

The following have been identified as key areas of focus between May – September and align to our reporting progress in this report.

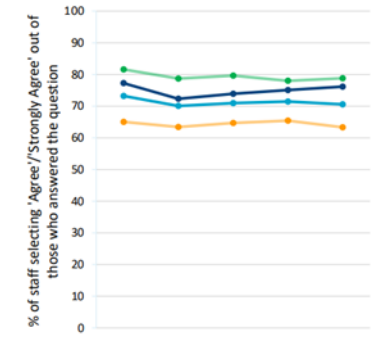
- Move to a triannual reporting cadence of May, Sep and Jan to fit the new Trust Board rhythm.
- Establish a robust benefits realisation approach to capture further benefits as a result of embedding Improving Together methodology
- Further analysis of the staff survey results to aid in the strategic alignment of which teams we train, coach and support over 25/26
- Continue to routinely share stories of improvement being realised across the organisation by our teams.
- Review our training material for Improver Standard with OD&L and Group colleagues to improve the training experience.
- Share regular good news stories of clinical lead and wider consultant involvement in Improving Together to encourage further engagement across teams.
- Establish next steps for external partnership working with Chemring Countermeasures.
- Continue to improve the maturity of our OMS by increasing the number of PRMs and improvement huddles that are introduced and sustained over time.
- Review and further align the maturity assessment scoring, with a focus on leadership behaviours, increasing the number of responses received and introducing peer-to-peer constructure challenge. In addition, review maturity assessments across RUH and GWH and consider shared assessment tool/approach.
- Review the approach to initiating Corporate scorecard agreements and performance review meetings, identifying areas of improvement as a result.

Salisbury NHS Foundation Trust

Improving Together Quarterly Roadmap Progress Report – May 2025

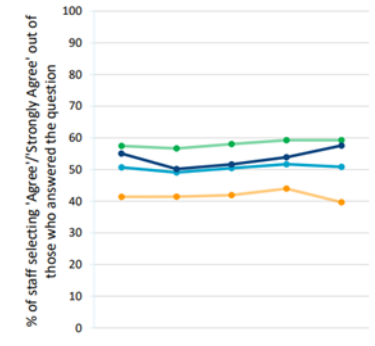
Appendix 1 – 2024 Staff Survey Results

Q3d I am able to make suggestions to improve the work of my team / department.



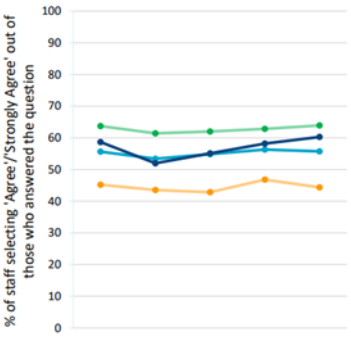
	2020	2021	2022	2023	2024
Your org	77.26%	72.33%	73.89%	75.11%	76.15%
Best result	81.61%	78.70%	79.64%	78.01%	78.83%
Average result	73.23%	70.08%	70.96%	71.46%	70.60%
Worst result	65.06%	63.41%	64.71%	65.42%	63.34%
Responses	2041	1851	1854	2246	2634

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



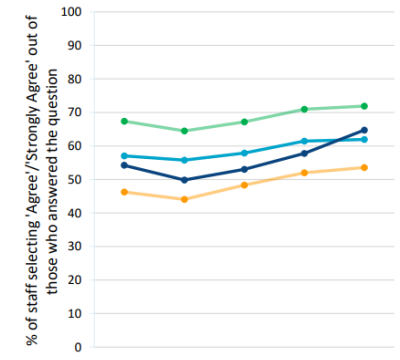
	2020	2021	2022	2023	2024
Your org	55.02%	50.17%	51.61%	53.89%	57.57%
Best result	57.43%	56.64%	58.05%	59.27%	59.25%
Average result	50.68%	49.08%	50.44%	51.68%	50.81%
Worst result	41.35%	41.40%	41.91%	43.96%	39.67%
Responses	2039	1851	1858	2249	2637

Q3f I am able to make improvements happen in my area of work.



	2020	2021	2022	2023	2024
Your org	58.65%	51.98%	55.08%	58.18%	60.28%
Best result	63.70%	61.43%	61.98%	62.83%	63.91%
Average result	55.64%	53.40%	54.86%	56.31%	55.73%
Worst result	45.19%	43.51%	42.83%	46.80%	44.36%
Responses	2032	1845	1856	2245	2633

Q7b The team I work in often meets to discuss the team's effectiveness.



	2020	2021	2022	2023	2024
Your org	54.22%	49.85%	53.05%	57.79%	64.75%
Best result	67.38%	64.49%	67.16%	70.97%	71.90%
Average result	57.06%	55.78%	57.87%	61.46%	61.94%
Worst result	46.26%	44.06%	48.33%	52.00%	53.58%
Responses	2039	1835	1857	2249	2638

Salisbury NHS Foundation Trust

Improving Together Quarterly Roadmap Progress Report – May 2025

Appendix 2

Some of the benefits delivered through the project delivery system;
(supported by the Trust wide Transformation Team)

Urgent Emergency Care projects: Links to Creating value for the patient breakthrough objective

Medical SDEC Bed Day Cost avoidance since go live on 27/03/23 to 31/03/24 - £760,000 From March 2024 to February 2025 Year on year savings £75,000 in bed day cost avoidance. Total £835,000

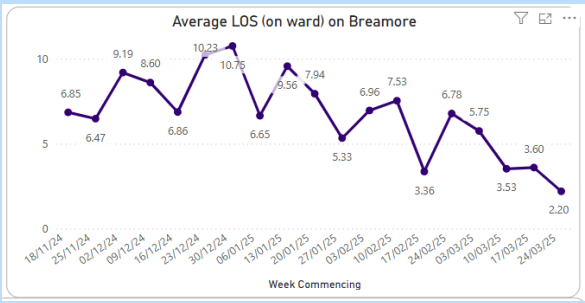
Zero-day length of stay for medical admission Pre SDEC 20.3% now running at 30.0% - **50% improvement** maintained. - SDEC zero-day LoS 46.4%

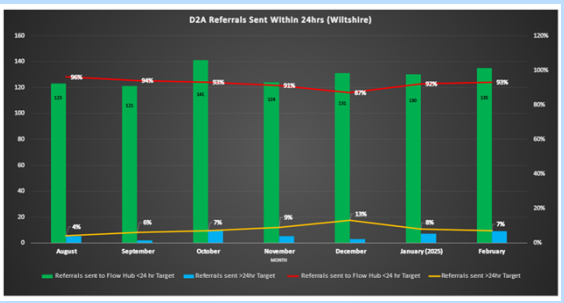
AFU Bed Day Cost avoidance August 2023 - July 2024 - £2,803,437. From August 2024 to January 2025 Year on year savings £356,909 in bed day cost avoidance. Total £3,160,346. **Average length of stay reduction maintained at 4 days.**

Expansion of Medical SDEC to include 2 in/out assessment rooms resulting in reduced average LoS, increased % 0-day LoS, reduced number of NEL admissions

Total Bed Day Saving across AMU and AFU - £3,995,346

Non Criteria to Reside (NCTR): Links to Creating value for the patient breakthrough objective - The NCTR programme has been in flight since July 2024. The Driver metric for the Systems and Processes element of the programme has been to review the Discharge To Assess process (D2A). The programme has sustained delivery of its driver metric to have **90% of D2A referrals completed and presented to the Care Transfer Hub within 24 hours of patient being declared NCTR.** This has been achieved through Improved and sustained engagement, communications and relationships between internal clinical, discharge teams and our System partners**.** Through the corporate estates project delivering environmental Improvements and the use of Improving Together methodology, Breamore Unit has seen a **significant decrease their patient LoS and de-conditioning**





Planned Care projects: Breakthrough objective – Time to First Outpatients -Vision Metric timely access to care

Review of booking processes & reducing Time to First OPA

Since April 24, the Trust has made a **10.4% improvement in TT1OPA wait times** (from 141.9 in Apr 24, to 127.1 in Feb 25.

To align to our principle of inch wide, mile deep we have focussed the current work on improving TT1OPA performance within **Oral Surgery, Colorectal and Urology** specialties. These services have made significant improvement from April 24, through the implementation of focussed countermeasures:

The coordination and collaboration of outpatient work both within the Trust, and as a system has been improved. Further opportunities for improving the internal processes within the booking pathway which are being further scoped and may include the implementation of RPA and other digital solutions may help to support improvement in these areas. The project is also under review to understand how a greater alignment to the elective reform changes can be delivered at a Trust and BSW System level.

Colorectal 34.9% improvement: 124.6 days in Apr 24 to 81.1 days in Feb 25
Urology 38.8% improvement: 177.7 days in Apr 24 to 108.8 days in Feb 25
Oral 32.3% improvement: 160.5 days in Apr 24 to 108.6 days in Feb 25

Salisbury NHS Foundation Trust

Improving Together Quarterly Roadmap Progress Report – May 2025

Planned Care projects: Breakthrough objective – Time to First Outpatients -Vision Metric timely access to care

Digitalisation of clinic letters (outpatient) - Improved Efficiency -In the first three weeks, the Cardiology team (proof of concept) recorded a **time saving of 306 minutes.** 6 specialities have reported a **reduction in manual tasks** associated with letter production, allowing them focus on other important work. improved identification of address errors resulting in more patients receiving their letters.

→ **Cost savings**- 3,301 letters sent to patients digitally. Achieved an average read rate of 70% within 7 days, resulting in a cost savings of **£1,424.98** (excluding printing costs)

Planned Care projects: Breakthrough objective – Time to First Outpatients -Vision Metric timely access to care

Dr Doctor digital assessments - 12 Digital Assessments deployed and project now in BAU.

Key benefits delivered:

- **Respiratory Sleep Assessment Clinic**: Weekly administrative **reduction from 0.5-1 day per week to ~20 mins**, (distribution and triaging of assessments).
- **Plastics Scar Management Clinic**: Improved clinic efficiency
- **Pre-Op Health Screening Questionnaire**: Compliance with NHSE requirements of assessing patients when they are added to a surgical waiting list, enabling Patient Modifiable Risk Factors to be reviewed and earlier pre-operative screening to be completed. **Increase** in the pool of Green patients who are medically fit for surgery.
- **Pre-Op Surgical Waiting List Validation**: Compliance with NHSE requirements of validating patients for their waiting list and health status every 3-months. Within the first 6-months, 2% of patients have been requested to be removed from the waiting list.
- **Spinal Annual Review**: Administrative time has **reduced from ~5 mins to ~1 min per patient**. This equates to around ~9.75 hours of saved administrative time so far for distributing assessments. Completion rate since moving to a digital system has more than doubled, to 60%, enabling greater compliance with nationally mandated audit requirements.
- **Paediatric Diabetes Virtual Upload Clinic**: increase in clinic efficiency - service looking at potential to increase the clinic to twice weekly

→ **13,558 forms have been assigned to 8,854 patients with an average completion rate of 70.2%.** Individual outpatient services are seeing completion rates up to 83%.

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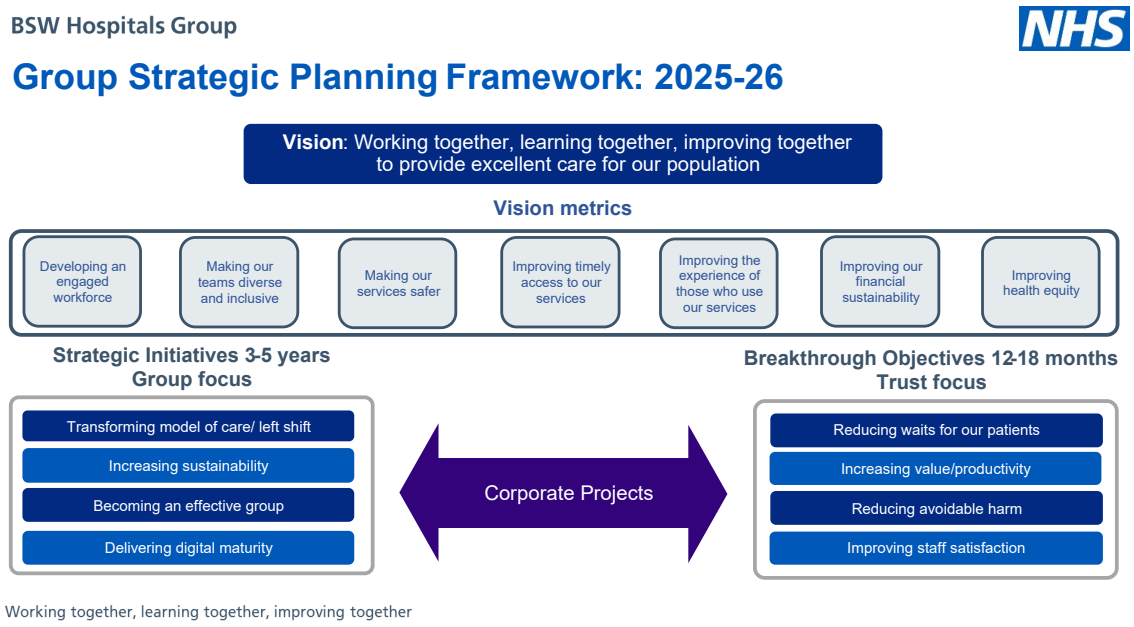
Improving Together Quarterly Roadmap Progress Report – May 2025

Appendix 3 – Group Strategic Planning Framework



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of meeting:	1st May 2025		

Report title:	Triannual Strategy Deployment Update			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Executive Directors			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Lisa Thomas, Managing Director			

Recommendation:

1) The Board is asked to note the report and progress against our Vision Metrics and Strategic Initiatives.
2) The Board is asked to take assurance in the process standard work surrounding our strategy deployment.

Executive Summary:

The Trust continues to make positive progress against its 2022-2026 strategy and long-term vision, with improvements observed across most Vision Metrics and strategic initiatives.

The Triannual Strategy Deployment Update demonstrates that we are making significant progress against the Trust's Strategic Planning Framework (SPF), which focuses on three key areas: People, Population, and Partnerships.

The SPF is structured across time horizons, with Vision Metrics (7-10 year timeframe), Strategic Initiatives (3-5 years), and Breakthrough Objectives (18-24 months). Each element has assigned executive sponsorship, responsible leads, and contributing forums ensuring clear accountability and governance.

People

The Trust is making positive progress against its people-focused metrics. Staff engagement has increased to 7.09 in 2024, outperforming the falling national average. Staff retention has improved with turnover rates declining, supported by initiatives like the Breakthrough Objective targeting Additional Clinical Services staff turnover. The Trust is also developing comprehensive strategies to ensure equitable treatment, with a new quarterly EDI Steering Group established.

The Strategic Initiative to embed a continuous improvement culture is yielding results, with 105 teams now trained in Improving Together methodology, demonstrating improved performance against key staff survey questions. The sustainable workforce initiative is addressing critical gaps through strategic workforce planning, talent management, and focused retention efforts.

Population

The Trust is tackling wait times through UEC and Planned Care Board actions, including the expansion of Same Day Emergency Care. Patient harm reduction is being addressed through multiple workstreams, including falls reduction, pressure ulcer prevention, and the timelines of deteriorating patient observations. Patient engagement has improved significantly with Friends and Family Test response rates consistently above target, work is underway to define a metric that encompasses more our patient engagement as a result.

Digital care transformation is progressing, with preparations for Electronic Patient Record implementation in October 2026, alongside other enabling technologies to improve clinical pathways.

Partnerships

The partnerships pillar includes our work on reducing health inequalities, with specific projects targeting areas like paediatric 'not brought' rates and improved access for CORE20 communities. Length of stay reductions are being achieved through initiatives like the Acute Frailty Unit, which has cut stays from 17 days to under 5 days.

Organisational sustainability efforts include addressing backlog maintenance and developing the 10-year campus masterplan. A new Strategic Initiative on *Designing services to meet population needs* has been established to address demographic shifts, particularly Wiltshire's significantly ageing population.

Significance for Board

This update is important for the Board for several reasons:

- Strategic Alignment: It demonstrates how all levels of the organisation are aligned to deliver the Trust's vision of providing an outstanding experience for patients, families, and staff.
- Accountability and Governance: The clear ownership structure with executive sponsors, responsible leads, and contributing forums ensures proper oversight of strategy implementation.
- Demonstrable Progress: Metrics show tangible improvements across multiple domains, from staff engagement to patient outcomes.
- Forward Planning: The timeframes provide clear expectations of when benefits will be realised, helping the Board understand the maturity of different initiatives.

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

NHS
Salisbury
NHS Foundation Trust

Triannual Strategy Deployment Update

The organisation's strategy is overseen through the Strategic Planning Framework (SPF). It has three areas of focus - People, Population and Partnerships - all with assigned **Vision Metrics** which allow the organisation to track progress over a 7-10 year timeframe. Flowing from these are our:

Strategic Initiatives, which are programmes of work we consider 'must do, can't fail' for our vision to be achieved; these deliver over a 3 –5 year timeframe and flow from multiple Vision Metrics.

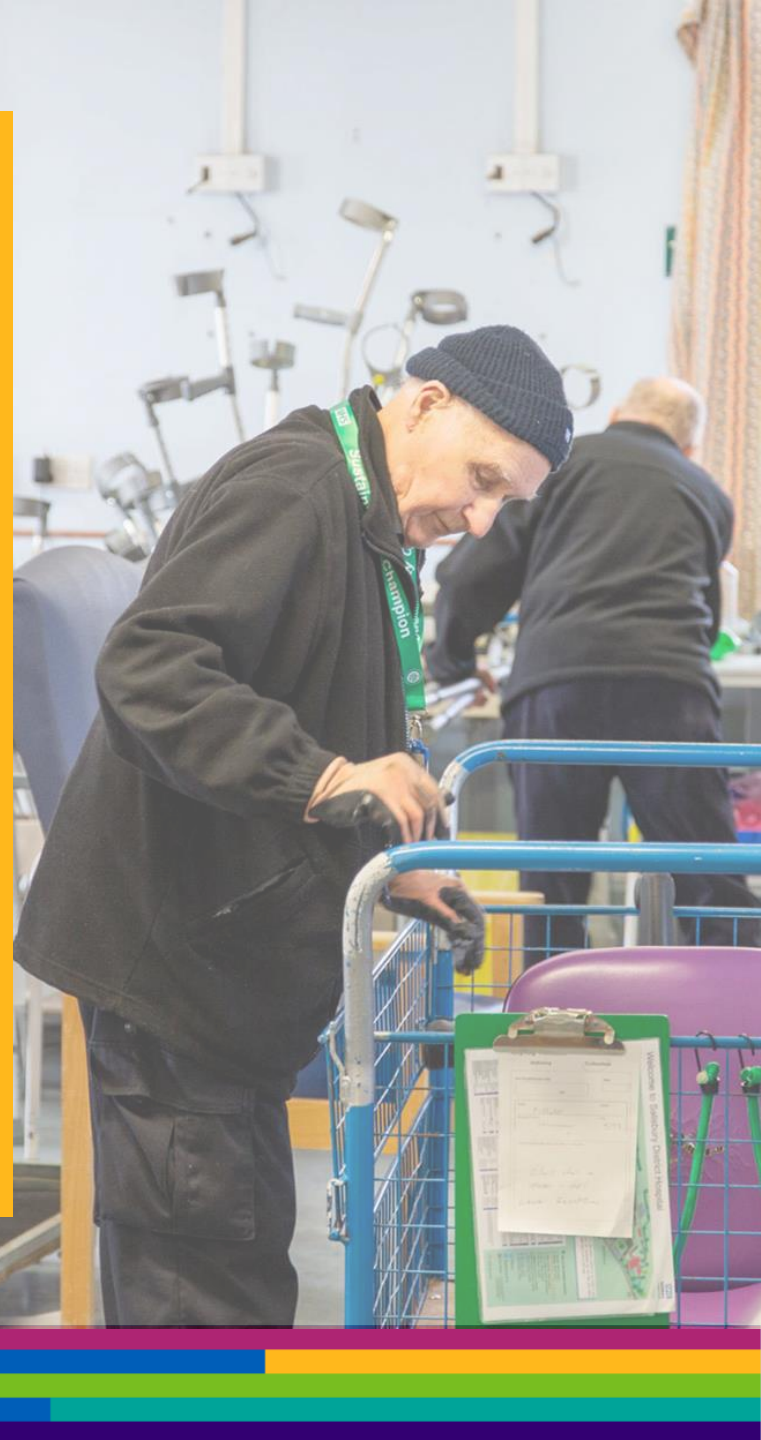
Breakthrough Objectives, which are programmes of work taking place over 18-24 months driving at key areas of improvement. Each Breakthrough Objective is the top (trust wide) contributor to a Vision Metric. I.e., the most significant (current) cause of moderate or high harm is inadequately managing patient deterioration. Progress against these is covered in the IPR.

This paper is an outline of progress against our **Vision Metrics** and **Strategic Initiatives** as the principal means by which we track the delivery of our vision over the medium and long-term.

These are each 'sponsored' by an executive, and executive scrutiny takes place monthly in the Engine Room, chaired by the Managing Director and with each executive, the associate director of strategy, and the heads of transformation and coach house present.

To lead the work each vision metric and strategic initiative has a responsible lead and a forum providing support to iterate the A3. These leads and forums are supported through 'clinics', led by the associate director of strategy and the head of coach house, which help with A3 iteration, strategic alignment, and provide a peer support network.

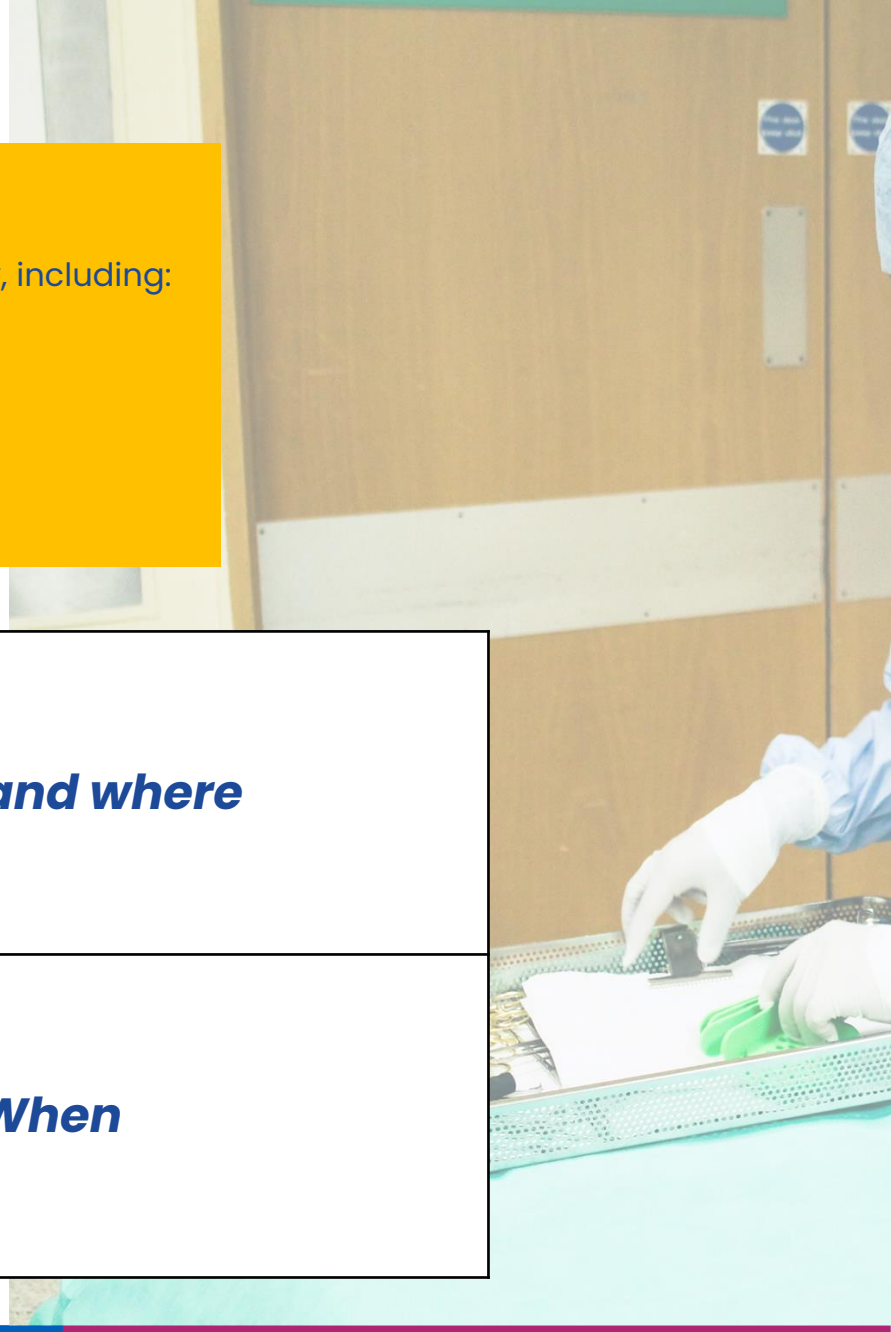
The content within the following slides is not exhaustive, but demonstrates the progress against each aspect of our strategy at the Trust-wide level.



Purpose

This paper aims to provide assurance to board that we are making progress against our strategy, including:

- How we're **measuring** our progress
- **What** we're doing to deliver progress
- **Who** is doing it and **where** that work takes place
- **When** we will expect to see benefit



Report format

Metric	***Who and where***
TITLE	
What	***When***

Strategic Planning Framework 2025-26

Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reducing Health Inequalities
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

- Embedding our culture of continuous improvement
- Developing a sustainable workforce
- Delivering digital care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients

Strategic Planning Framework Ownership

		Executive Sponsor	Responsible Lead(S)	Contributing Forum(s)
Vision Metrics	Increasing staff engagement	Chief People Officer	Associate Director, Communications	Engagement Working Group & OD&P Management Board
	Increasing staff retention	Chief People Officer	Associate Director, Operational HR	Retention Steering Group
	Staff are treated equitably	Chief People Officer	Associate Director, Culture, OD & Learning	Dedicated working group
	Reducing wait times	Chief Operating Officer	Deputy Chief Medical Officer	No dedicated working group, captured in Planned Care Board and UEC Board.
	Reducing patient harm	Chief Nursing Officer	Head, Risk Management	Dedicated working group
	Our population help improve our services	Chief Nursing Officer	Head, Patient Experience Deputy Chief Nursing Officer	Patient Experience Steering Group
	Reducing Health Inequalities	Chief Medical Officer	Associate Medical Director, Health Inequalities	Health Inequalities Operations Group Wiltshire Health Inequalities Group Dedicated working group
	Reducing overall length of stay	Chief Operating Officer	Deputy Chief Medical Officer	No dedicated working group, captured in Planned Care Board and UEC Board.
	Organisational Sustainability	Chief Finance Officer	Associate Director, Finance & Associate Director, Strategy	Dedicated working group
Strategic Initiatives	Embedding our culture of continuous improvement	Director of Improvement	Head of Coach House	Dedicated working group
	Developing a sustainable workforce	Chief People Officer	Deputy Chief People Officer	Dedicated working group
	Delivering digital care to improve pathways	Chief Information Officer	Chief Information Officer	Digital Steering Group
	Designing services to meet population needs	Chief Operating Officer	Associate Director, Strategy Programme Director, Strategic Projects	Under formation

People

working for us

Vision

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Population
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Breakthrough Objectives 18-24 months

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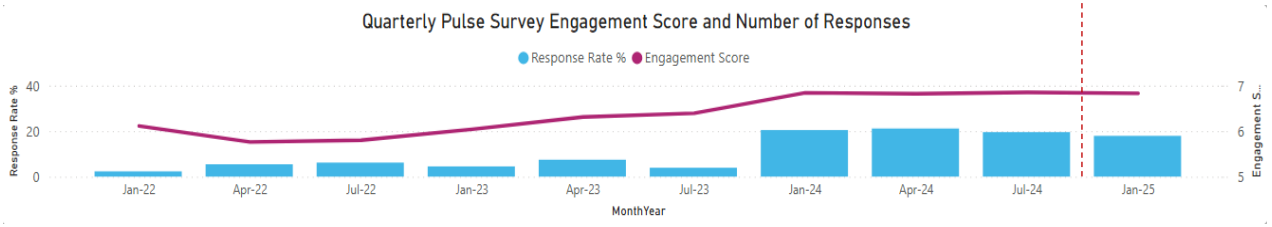
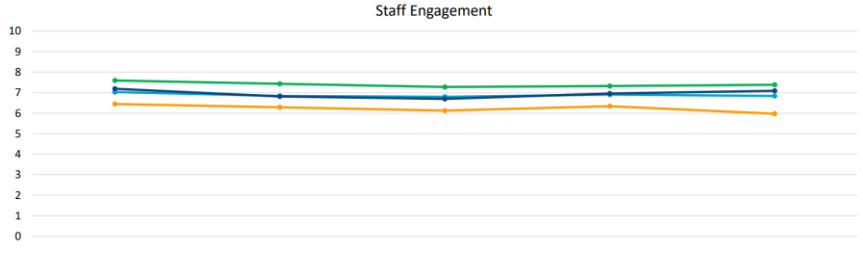
Last report to board





	2020	2021	2022	2023	2024
Your org	7.19	6.82	6.70	6.96	7.09
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	2041	1858	1859	2254	2640

2024 increase to 7.09
Above a falling national average

Who & Where

The engagement vision metric is overseen by the Associate Director Communications, Engagement & Community Relations.

The AD CECR Chairs the Engagement Working Group.

The working group reports to the OD&P Management Board.

Increasing staff engagement

What

The engagement score is made up of questions that assess staff advocacy, involvement and motivation.

A core measure within these questions is staff likelihood to recommend SFT as a place to work and for treatment.

Due to positive progress over the past 2 years the goal is moving towards being the numerical scores being top quartile not just the national ranking.

We have focussed work on delivering the 7 elements of the People Promise – with a focus on listening to the workforce, rewarding and recognising staff, delivering improved wellbeing, developing line management skills and creating an inclusive, equitable and compassionate workplace.

When

2025/26

Building momentum behind recent results to generate further engagement.

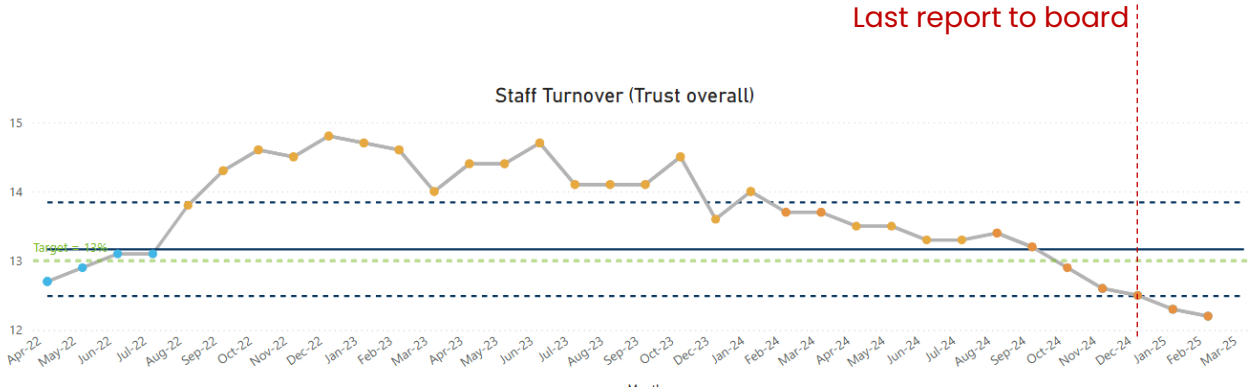
2026/27

SFT scoring in the top quartile nationally.

2027/28

Ranked top quartile for all People Promise elements and Morale and Engagement.

Reduced number of outlier engagement scoring depts. by 50% from 2024 figure.



Who & Where

The Retention Steering group meets monthly to review current workforce availability context (focussing on turnover, sickness absence and vacancy data). This also reviews progress against the current three focussed workstreams:

- Breakthrough Objective – Additional Clinical Services staff turnover
- 'We work Flexibly' People promise focus – Flexible working group
- Overhauling recruitment project – currently phase two of project focussing on improving ED&I elements of recruitment practice.

Retention Steering group (chaired by AD for HR Ops)
Flexi working group (chaired by HR BP Medicine)

The escalation report following each monthly Retention group meeting is presented at:

- OD&P management board
- People & Culture Committee

Increasing staff retention

What

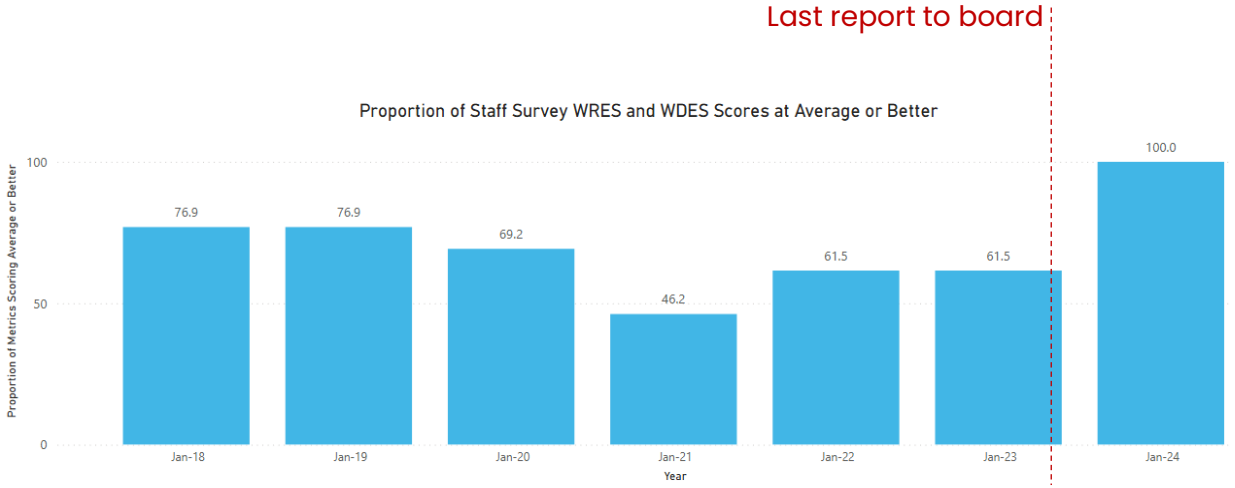
Most action addressing this Vision Metric since 2022 has been through trust-wide breakthrough objectives. Overall Trust Turnover had a target of 13% for 2024/25, the Breakthrough objective (BTO) for 2024/25 targeted the top contributing factor, which was turnover in the Additional Clinical Services staff cohort..

The BTO set an improvement target of reducing from 21% to 15% in 2024/25. Counter measures to support the BTO include:

1) Focus on improving Care certificate compliance amongst HCAs (progress from 25% April 2024- 99% March 2025)
2) Introduction of HCA Preceptorship to improve support and induction available
3) Overhaul of recruitment and onboarding including improved attraction material, more line manager involvement in selection process and introduction of shadow shifts/buddying for new to care staff

When

2025/26	*2026/27*	*2027/28*
BTO achieved @ 15% Trust Turnover <12%	Improved retention rates Reduced 'leavers' from the NHS Focus on next highest staff group for turnover	Trust turnover rates </= 10%



Who & Where

Executive sponsorship for this programme is provided by the Chief People Officer (CPO). Strategic leadership and delivery responsibility are shared between the Associate Director of Organisational Development, Learning and Culture, and the Head of Inclusion, Health and Wellbeing.

To strengthen governance and oversight, a new quarterly Equality, Diversity and Inclusion (EDI) Steering Group has been established, with its inaugural meeting held on 20 May 2025. This group is chaired by the CPO and includes a broad membership of key stakeholders, including executives and heads of service. Its purpose is to oversee, challenge and guide the delivery of our strategic EDI Long-Term Plan 2024–2027, as well as the NHS EDI Improvement Six High Impact Actions (HIAs). In parallel, work is underway to develop A3 planning tools to support and accelerate the implementation of EDI priorities at an operational level.

Staff are treated equitably

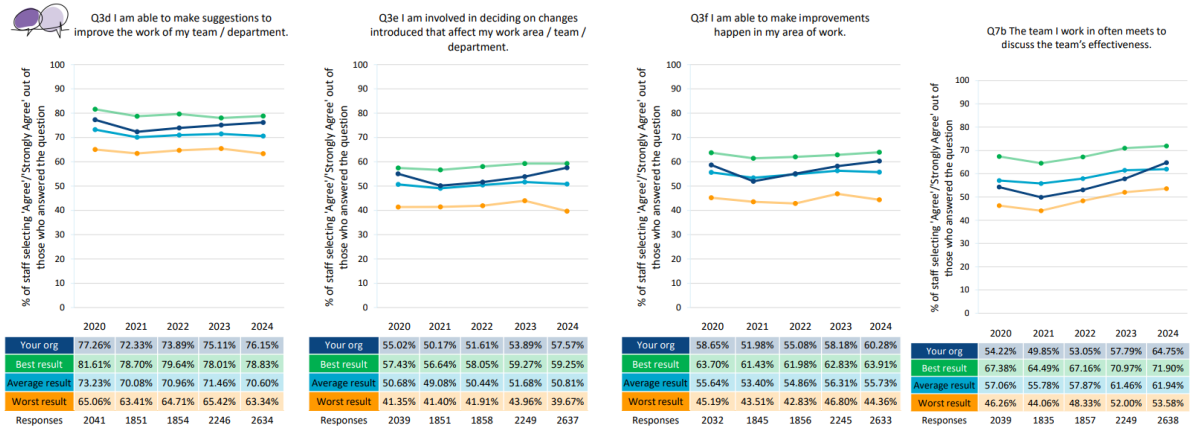
What

Equitable treatment for all staff is the essential foundation upon which genuine inclusion and belonging are built, supported by a strong commitment to staff health and wellbeing so that everyone can thrive at SFT. To achieve this, we are:

- Operationalising the NHS EDI Improvement Plan's Six High Impact Actions as core strategic objectives guiding our approach to inclusion and wellbeing.
- Operationalising the specific 2025/26 activities in our EDI Long-Term Plan (2024-2027).
- Strengthening the development, reach, and impact of our seven staff networks.
- Regularly raising awareness and celebrating significant events and achievements from our annual inclusion and wellbeing calendar.
- Developing a comprehensive Health and Wellbeing Strategy for 2025-2027.
- Developing a Men's Health Strategy to support the Men's Health staff network and health inequalities.
- Developing a Women's Health Strategy to address access and health inequalities.

When

2025/26	*2026/27*	*2027/28*
Improved ESR % of staff self-declaring disability compared to the staff survey. Health & Wellbeing strategy published.	Improved metrics associated with bullying and harassment of our BME and disabled staff.	All staff experience equitable treatment.



	2020	2021	2022	2023	2024
Your org	77.26%	72.33%	73.89%	75.11%	76.15%
Best result	81.61%	78.70%	79.64%	78.01%	78.83%
Average result	73.23%	70.08%	70.96%	71.46%	70.60%
Worst result	65.06%	63.41%	64.71%	65.42%	63.34%
Responses	2041	1851	1854	2246	2634

	2020	2021	2022	2023	2024
Your org	55.02%	50.17%	51.61%	53.89%	57.57%
Best result	57.43%	56.64%	58.05%	59.27%	59.25%
Average result	50.68%	49.08%	50.44%	51.68%	50.81%
Worst result	41.35%	41.40%	41.91%	43.96%	39.67%
Responses	2039	1851	1858	2249	2637

	2020	2021	2022	2023	2024
Your org	58.65%	51.98%	55.08%	58.18%	60.28%
Best result	63.70%	61.43%	61.98%	62.83%	63.91%
Average result	55.64%	53.40%	54.86%	56.31%	55.73%
Worst result	45.19%	43.51%	42.83%	46.80%	44.36%
Responses	2032	1845	1856	2245	2633

	2020	2021	2022	2023	2024
Your org	54.22%	49.85%	53.05%	57.79%	64.75%
Best result	67.38%	64.49%	67.16%	70.97%	71.90%
Average result	57.06%	55.78%	57.87%	61.46%	61.94%
Worst result	46.26%	44.06%	48.33%	52.00%	53.58%
Responses	2039	1835	1857	2249	2638

SFT Trust position showing continued improvement since 2021 against four key questions – demonstrating that SFT is changing faster and further than other Trusts who are/are not adopting operational excellence approaches.

Who & Where

Exec Owner: Director of Improvement, with Head of Coach House and Continuous Improvement providing leadership support.

- Trust Wide Oversight: Monthly Improving Together Board (Trust wide roll out of nine workstreams)
- Working Group: Monthly Dedicated Multi-disciplinary Team SI A3 review this specific A3)
- Supporting Group: Monthly Strategic Initiative Clinic Meeting (Trust wide)

In addition, the Transformation and Coach House teams have identified 'drivers' that are actively being worked on, using improving together methodology to improve performance. These are monitored through:

- Monthly Senior Leadership Team (Transformation and Coach House) Performance Review Meeting
- Monthly Team (Transformation and Coach House) Performance Review Meeting

Trust wide deployment is through a change in culture being embedded as a result of the training offer. Our Leadership Behaviours – socialised to 1290 staff and Improving Together (Improver Standard) to 105 teams who are now able to actively use A3's and improvement huddles to drive improvement locally.

Embedding our culture of continuous improvement

What

- Building our capacity to improve individuals and the organisation by training staff to use tools, that will improve behaviours and embed new routines.
- Aligning our vision and the SPF so that it is understood and repeated across the organisation using visual management, dissemination in training and regular conversations.
- A workforce that can describe and understand the importance of Improving Together and our leadership behaviours through self-reflection, feedback, observations and increased visibility and awareness.
- Staff understand and describe the Trusts visions and strategy and their individual contribution to delivery using the tools taught and through improved effective questions/coaching conversations.
- Staff survey results continue to report increasing scores against the four identified questions (Q3d,3e,3f, 7b) because of continued roll-out and embedding of tools, methodology and conversations.
- Increasing patient involvement in identifying and sharing ideas and opportunities for improvement through a skilled workforce.

When

2025/26

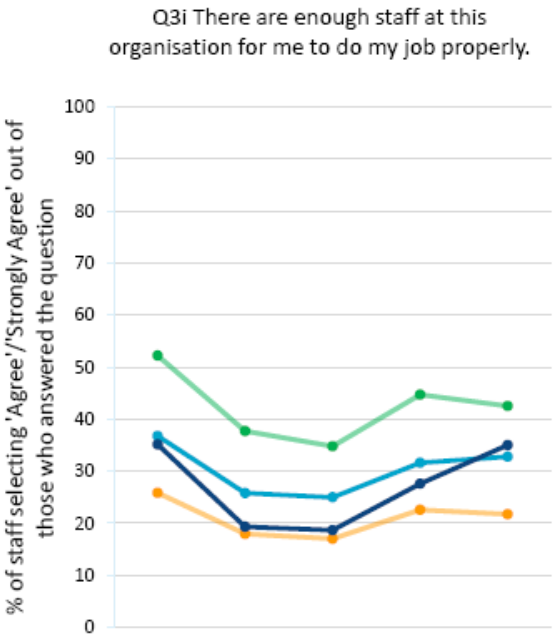
- Further develop our leadership behaviour framework and embed as part of recruitment, appraisal and talent programmes
- Create a programme approach to deploying SI's and which is routinely reviewed

2026/27

- Train 100% in improver standard by July 2026
- SFT is in the top decile for staff survey results in Q's 3d,3e,3f,7b.
- Embed self-led maturity assessment across all levels of the organisation (division/speciality/ team)

2027/28

- Transformational Coaching leadership style for improvement is embedded across all levels of the organisation
- Maturing the daily management system to realise greater depth and pace of improvement.



	2020	2021	2022	2023	2024
Your org	35.13%	19.32%	18.65%	27.57%	34.99%
Best result	52.21%	37.72%	34.78%	44.71%	42.52%
Average result	36.76%	25.80%	24.95%	31.62%	32.77%
Worst result	25.83%	17.92%	17.00%	22.55%	21.73%
Responses	2034	1855	1855	2248	2634

Who & Where

The Chief People Officer providers executive sponsorship to this strategic initiative with the Deputy Chief People Officer providing leadership to deliver against identified countermeasures.

They are supported by the insights of the Workforce Systems Strategic Steering Group, and the four Working Groups chaired by OD&P Associate Directors which manage people promise initiatives against all seven elements of the people promise

The A3, and associated work that should move the metric, is overseen by the OD&P Management Board, and assured through the People and Culture Committee.

Across the Trust work to support organisational design within individual services is supported by HR Business partners for each Division.

Developing a sustainable workforce

What

Analysis demonstrates that we have insufficient knowledge and skills to develop a sustainable workforce which meets the needs of the Trust in the next 5 years. Therefore, there is a risk that SFT will be unable to provide the care and support to patients that is required in the future. To address this risk, four principle workstreams are underway:

- Cross-trust strategic workforce planning to develop a viable long-term workforce plan, which identifies staff roles, embraces new skillsets and identifies the training requirements to support staff development.
- Advancing our talent management approach to develop capability internally.
- The retention focussed breakthrough objective, given its role as the top contributor to the retention Vision Metric.
- Refreshing our EDI long term plan with a focus on identified areas of concern, and the furthering of our 'we all belong' Vision Metric understanding.

When

2025/26

Improved metrics associated with our Engagement and retention vision metrics.

Improved line management skills training

Talent management plan initiated.

2026/27

Realised improvements in our retention position following breakthrough objective impact.

Correlation of long term workforce plan initiatives and training requirements starts

2027/28

All associated metrics in the top quartile nationally ('enough staff', retention, WDES & WRES)

Population

our patients and their families

Vision

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working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
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- Reducing patient harm
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- Organisational Sustainability

Strategic initiatives 3-5 years

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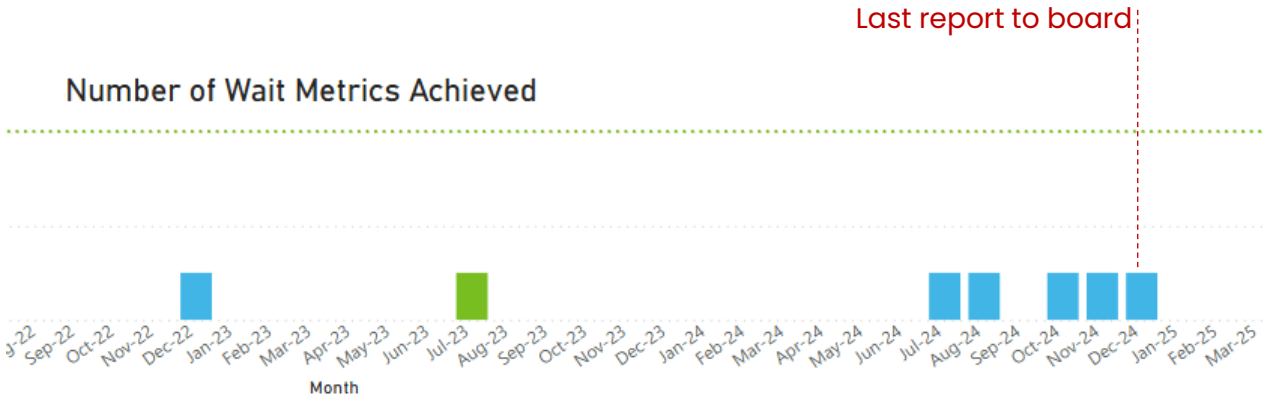
Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients



The graph shows a colour coded block for each wait metric (ED4h, DM01, 28d and 62d) target achieved in month.

Reducing wait times

Who & Where

While this A3 has no specific working group, planned care board covers much of the work.

However, improvements in estate, workforce and digital e.g. RPA will positively impact our performance which aren't covered in this meeting but escalate through other routes and the vision metric lead (Deputy Chief Medical Officer) is given sight of those escalations.

What

UEC Board are taking actions to improve ED4h performance, including the expansion of SDEC in both scope and scale (move to 7-day service and standing up of frailty SDEC).

DM01 is currently being achieved but improved utilisation of the CDC through the year will help further improvements in performance.

By Q2 we are establishing an outpatient operational group that will be responsible for all aspects of OPD e.g. estates, process, pathways, and booking. With improvements to follow.

Theatres - we've now created a perioperative journey group that links pre-op, central booking and theatres into one team. Theis will improve theatre utilisation and reduce elective waits.

When

2025/26

UEC Board improvement work impact on 4hr performance.

Outpatient transformation.

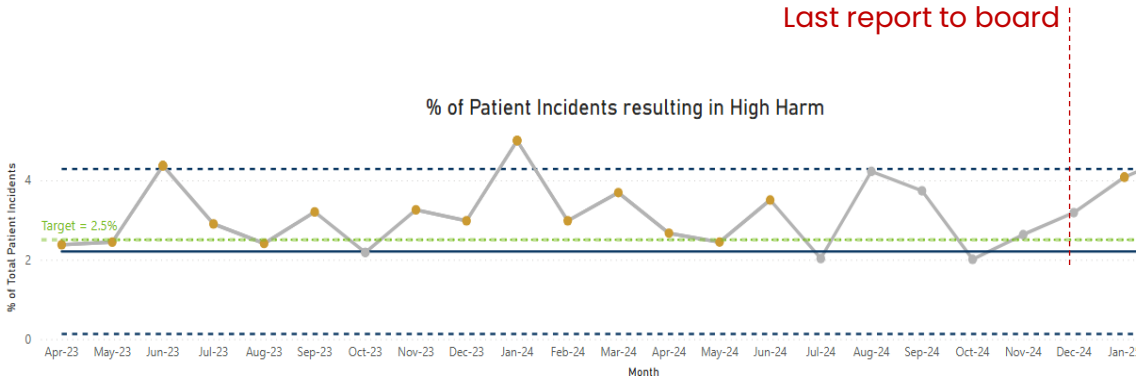
Theatre utilisation and waits work impact.

2026/27

Benefits of outpatient transformation fully felt, i.e. productivity improvements through standardised templates.

2027/28

Return to constitutional standards.



Who & Where

- Breakthrough Objective receives executive oversight at the Engine Room and is worked on within divisions
- Patient Safety Summit (chaired by Head of Risk Management)
- Patient Safety Steering group (chaired by Head of Patient Safety)
- Patient Safety Oversight group (chaired by Consultant Anaesthetist/Clinical Scientist)
- Learning from incidents forum (chaired by Heads of Nursing)
- The Vision Metric working group consists of the Chief Nursing Officer, Deputy Chief Nurse, Head of Risk management, and the Head of Patient Safety.

Reducing patient harm

What

The key element which underpins this priority is staff having a proactive approach to patient safety which includes staff feeling supported to speak out and openly report incidents and concerns which impacts on effective delivery of care.

To address this, we are:

- Using our 'Managing Patient Deterioration' Breakthrough Objective to reduce harm through recording, recognising and responding to patient deterioration.
- Multidisciplinary falls workstream to reduce the number of high harm falls whilst inpatients in our care.
- Pressure Ulcer A3 to reduce patients sustaining pressure damage whilst inpatients in our care.
- Communication workstream to ensure a structured transfer of care that is right each time.

When

2025/26

Breakthrough Objective in year impact.

Falls reduction by 10% by April '26.

Transfer of care handover improvements by April '26.

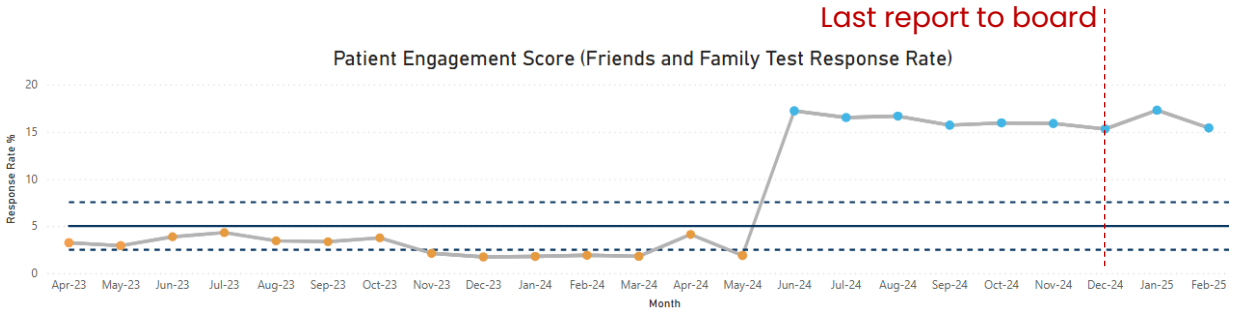
2026/27

EPR implementation will deliver higher data fidelity and model pathways.

BSW clinical group in place to manage pathway development.

2027/28

30% reduction in pressure damage by April '28.



While FFT provides part of the picture, and is our largest means of collating feedback, further metrics are under developing focussed on tracking our increasing patient involvement in service design.

Who & Where

The Chief Nursing Officer providers executive sponsorship to this vision metric with the Head of Patient Experience, and Deputy Chief Nurse, providing leadership to the A3. They are supported by the insights of

Work is underway across the organisation beyond the vision metric leadership and A3 iteration forums, for example:

- Cancer services are increasing targeted patient engagement, i.e. through outreach to our traveller population.
- The Stoma, Parkinsons, and learning disability groups are maturing.
- We have matured to a place where each specialty has patients available to engage with on service design. PALS continue to help facilitate 'how' those patients are brought in to that work.

Our population help improve our services

What

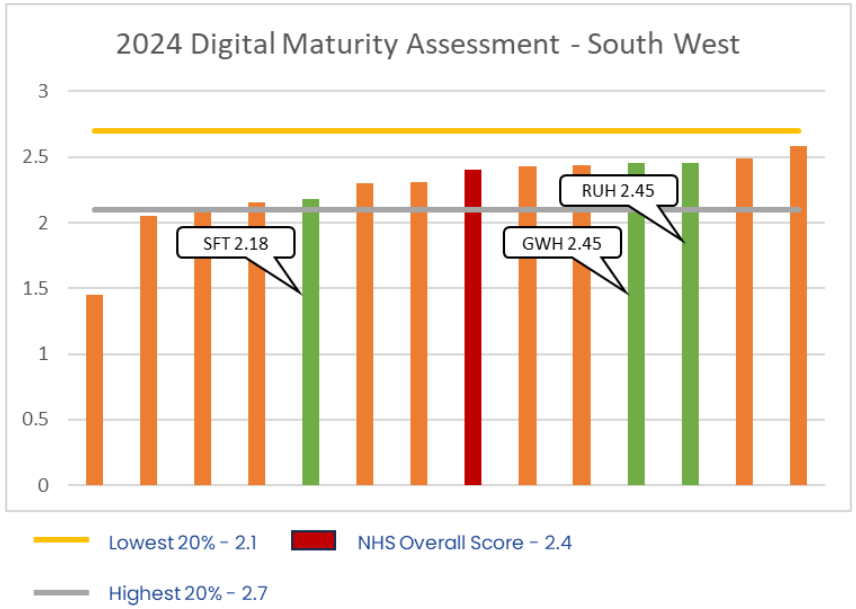
Key pillars of work affecting the metric have included the digitisation of the process, ensuring a more visible PALS presence around the estate, and the establishment of quarterly meetings to pull together all of the activity impacting how our population can improve our services.

Specifics include:

- Replacement of FFT signage and consideration of a PALS presence in the main entrance of the hospital.
- Improvements to the SFT website and showcasing patient led initiatives internally through divisional updates and patient stories to Board.
- Increased inclusion of patients in service redesign, such as in the new strategic initiative 'Designing services to meet population needs'.

When

2025/26	*2026/27*	*2027/28*
FFT response rate >17%. 95% rated good or very good. Increase patient involvement through service design panels.	Centralised co-ordination of patient engagement in service design. Clear process for measuring patient engagement with designing services.	No service redesign or pathway development will take place without patient involvement.



Metric #2: Bi-Annual pulse score
Q. "I have a good overall experience when using technology and business intelligence tools in my place of work." (agree or fully agree)

July 2024: 49.1%

Agreed to be included each January and July in pulse survey to ensure consistency.

Who & Where

The Trust's digital agenda is overseen through Digital Steering Group (DSG) which chaired by the Chief Medical Officer, has executive members plus a range of digital team and wider members.

The Corporate Project Prioritisation Group (CPPG), prioritises new requests that require resourcing with all divisions represented, Digital Steering Group

Digital Leadership ensures delivery of overarching requirements across the digital portfolio including effective digital governance and risk management below DSG. The Chief Digital Officer is also a member of the ICS Digital Board.

Digital Clinical Leadership in place to support engagement and drive the use of technology and data to enable change.

EPR Governance in place with Board EPR sub-committee with executive leads from each Trust as members. Key executive and senior leads for the Trust sit on the wider EPR governance below this including EPR Programme Board and Clinical Design Authority. A local EPR Delivery Group (chaired by Deputy Chief Operating Officer) and Executive EPR Oversight Group (chaired by interim Managing Director) looks to ensure local activities are delivered on time.

Delivering digital care to improve pathways

What

Key activities to support improvement of digital maturity include:

- Implementation of the Shared EPR and optimisation post go live. Post Go Live optimisation includes key clinical pathway redesign across the hospitals group.
- Implementation of complementary systems to the EPR, supporting sharing of information and improved clinical pathways. i.e. BadgerNet Neonates and GP ICS Order Comms.
- Implement and embed an improved digital engagement and digital literacy model across the Trust.
- Increase the availability of end user devices and networked medical devices to ensure staff can function in a paperless fashion and implement improved network capability as a key enabler.
- Implementation of a Hospitals Group Digital function to ensure we have the resilience and right structures to support the future needs of digital and analytics.

When

2025/26	*2026/27*	*2027/28*
EPR engagement and digital literacy plans implementation. Roll out Phase 1 network improvement and end user devices. Implement Group Digital Function.	EPR Implementation October 2026. Refresh of Group and local Digital Plans.	Clinical Pathways redesign using EPR. Phase 2 of network improvement programme. Implementation of GP ICE Order Comms. BadgerNet Neonates.

Partnerships

working with us

Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reducing Health Inequalities
- Reducing overall length of stay
- Organisational Sustainability

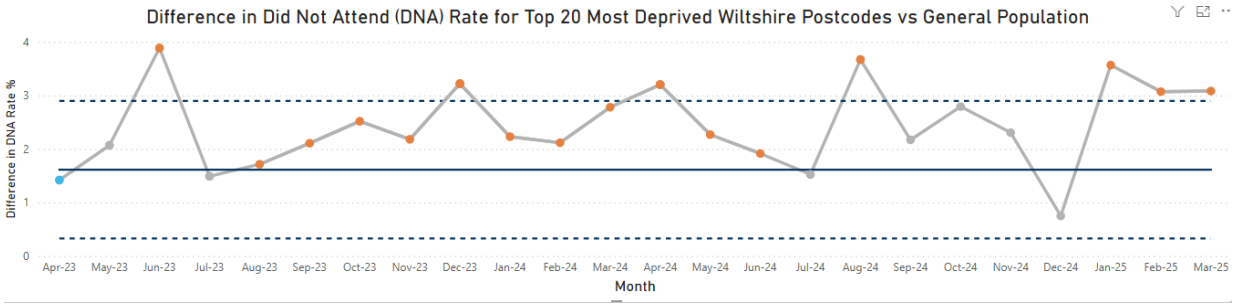
Strategic initiatives 3-5 years

- Embedding our culture of continuous improvement
- Developing a sustainable workforce
- Delivering digital care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients



Who & Where

The iteration of the A3 takes place quarterly within the internal A3 development group. This is made up of the Chief Medical Officer, Associate Medical Director for Health Inequalities, Associate Director of Strategy, and a Wiltshire Council Public Health Consultant.

The WHIG meets monthly and the below working groups report to it.

- The SFT Health Inequalities Ops Group, which meets monthly and is chaired by the Deputy Chief Operating Officer with representation from across the divisions.
- The 5 clinical specialties that make up the CORE20PLUS**5** model chaired by respective clinical leads for those specialties

NEW

Reducing Health Inequalities

The WHIG reports to CMB, BSW Inequalities Steering Group, and to Wiltshire Council H&W Board quarterly.

What

With health inequalities covering both health*care* inequalities (largely a function of access) and health inequalities in the population we have chosen to focus most of our organisational effort on healthcare inequalities where we can have the most impact. We will continue to influence forums for broader health inequality work such as the Wiltshire Health Inequalities Group (WHIG) and their efforts in broader public health.

We have completed projects internally and externally such as the improvement sprint which resulted in a 30% reduction in time LDAN patients wait for care. Externally we have leveraged system funds to improve the diet of local children, and in 2025/26 will have live projects on paediatric DNA rates and cancer screening.

When

2025/26

Paediatric 'not brough' (DNA) reduction project.

Cardiology pathway inequity investigation.

Impact on families of military personnel.

2026/27

Impact of U5 Health project in target LSOAs – i.e. dental.

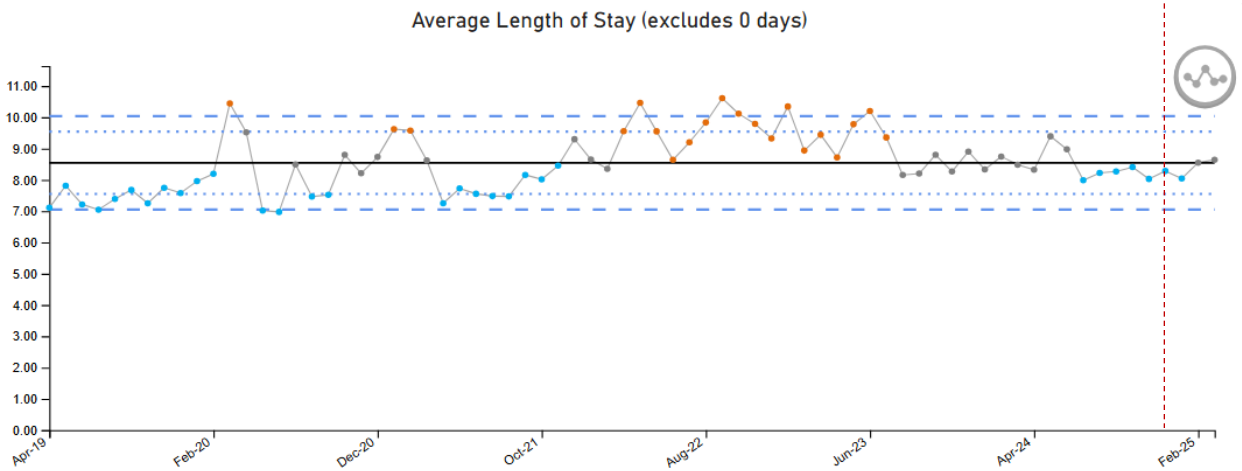
Support to BSW work with PLUS group access to care.

2027/28

Embedded impact of Ops group policy / SOP changes.

EPR pathway design opportunities and protected characteristic flagging.

Last report to board



Who & Where

- No dedicated forum and working group, draws on aspects of work from planned care board and UEC board.
- Shared EPR model pathways will have a positive impact on LoS and that work is underway within the programme and will be escalated through Digital Steering Group.
- Work with HCRG on flow takes place at both executive and working level bi-lateral engagement.
- Work to improve LoS on the wards is taking place using our Improving Together methodology and by empowering local teams to make the changes that will have a local impact.

Reducing overall length of stay

What

Several workstreams across the organisation will impact on our LoS position:

NCTR – We have positive Impact data from the introduction of AFU and the work on Breamore.

SDEC expansion will take more 1+ day LoS spells down to 0-day LoS, this is slated for Q2/3 2025/26 and includes both expansion to 7 days and specialty expansions (Surgery and frailty).

Acute Frailty Unit (AFU) has resulted in significant reduction in LoS (17 days to sub-5) and is maintaining this performance. The frailty team have been working on hospital at home (H@H) with HCRG with the aim of facilitating earlier discharge.

Broader work with **HCRG** as they take on the community services contract will target reducing LoS beyond NCTR through flow-out improvements.

When

2025/26

HCRG community services transformation is part of system plan to reduce NEL demand by 3.6%.

SDEC expansion will make immediate impact.

2026/27

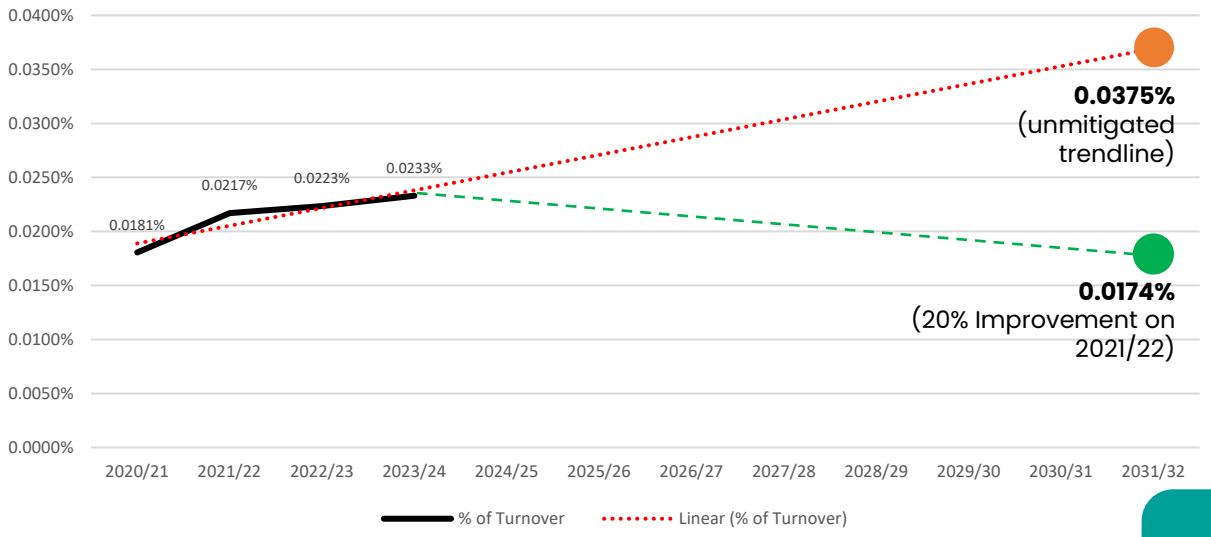
Maintained performance realised, in light of increasing demand, a positive outcome of our interventions.

2027/28

Realisation of integrated neighbourhood teams and left shift will result in fitter patients and better flow.

EPR model pathway deployment.

METRIC: Estates maintenance backlog per m2 as a percentage of Trust turnover



Who & Where

- The Value Breakthrough Objective receives executive oversight at the Engine Room and is worked on within divisions thanks to 38 individual drivers. There are also 3 Trust-wide deployable resource tickets allocated to the work. The Vision Metric executive sponsor is the Chief Financial Officer, and the responsible leads are the associate directors of finance and strategy.
- Further contributions to, and scrutiny of, the relevant work takes place at:
  - Financial Recovery Group
  - Strategic Capital Committee
  - Sustainability Committee
- The Vision Metric working group consists of:
  - Chief Finance Officer (Executive Sponsor)
  - Associate Director of Strategy (Responsible Lead)
  - Associate Director of Finance (Responsible Lead)
  - Programme Director
  - Head of Facilities (and sustainability lead for the Trust)

Organisational Sustainability

What

The key elements which underpin this priority include: financial sustainability, having an infrastructure that reflects the needs of a modern hospital (including environmental sustainability), and our role as an anchor institution. To address these we are:

- Driving short term change through our 'Creating Value for our Patients' Breakthrough Objective.
- Addressing backlog maintenance through specific programmes of work (DSU, Spinal, Maternity) in line with our 10-year campus masterplan.
- Progressing our decarbonisation work.

When

2025/26

Breakthrough Objective 10% improvement in productivity.

Continued addressing of backlog maintenance.

2026/27

Medium term DSU replacement plan online.

Spinal refurbishment and reprovision.

2027/28

Estates master plan roadmap actions such as maternity improvements.

As a new strategic initiative the metric is to be determined. Current candidates to show the right progress include ED attendances per 100,000 of population, hospital readmission rates, as well as acute and primary care caseload relative to population size.

A clear metric will be in place ahead of the next report to Board in Autumn 2025.

Who & Where

Executive sponsorship is provided by the Chief Operating Officer, with the responsible leads for the programme of work being split between the associate director of strategy and the associate director of strategic projects. At the time of writing these three individuals are Niall Prosser, Tony Mears, and Jane Dickinson.

While the workshop to define the problem statement casts a wide stakeholder net, a more focussed group will exist to drive forward the work, the composition of which will follow A3 development over the summer of 2025.

NEW

Designing services to meet population needs

What

As a new strategic initiative the methodological process is underway to refine the problem statement, apply an appropriate metric, build a team to iterate the programme of work, and define by when benefits will be realised.

A workshop with representatives from primary and community care, system colleagues, public health, and internal SFT colleagues – is planned for Tuesday 20th May 2025, to iterate the problem statement and begin root cause analysis.

What is clear is that our services must change to meet the demographic shifts in our population, including the outsized demand in population growth affected by long term conditions and Wiltshire's (nationally significant) ageing population.

When

2025/26	*2026/27*	*2027/28*
Initiative defined with clear problem statement, metric, root cause analysis and programme of work stood up. Early pathway redesign opportunities identified.	Clear programme of work to innovation across our services, including realising left shift and associated service change.	Clear evidence of services redesigned to meet the changing needs of our changing population..

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.3
Date of meeting:	1st May 2025		

Report title:	Partnerships Stocktake			
Status:	Information	Discussion	Assurance	Approval
		X	X	
Approval Process: (where has this paper been reviewed and approved):	Executive Directors			
Prepared by:	Tony Mears - Associate Director, Strategy			
Executive Sponsor: (presenting)	Lisa Thomas - Managing Director			

Recommendation:

It is recommended that the Board:

- **Note** the various partnerships relevant to the delivery of outstanding care and delivery of our strategy.
- **Note** the partnership landscape, including legacy networks and potential future changes.
- **Be assured** that the organisation's partnership working is appropriate, and continuing to develop, in the pursuit of delivering our vision and strategy.

Executive Summary:

The stocktake examines Salisbury NHS Foundation Trust's (SFT) partnership work, which forms one of the three pillars of our strategic planning framework alongside People and Population. The paper presents analysis of SFT's current partnership landscape and outlines development areas to enhance collaborative working.

The purpose of the paper is to provide information and assurance to Board regarding the partnership working undertaken by the Trust in pursuit of strategy deployment. Including where we are learning and areas for development.

The Trust recognises that no organisation can deliver high-quality care in isolation. Partnerships touch every aspect of hospital operations, from patients arriving via ambulance to those awaiting onward packages of care. The strategic planning framework measures partnership success through three vision metrics: reducing health inequities, reducing length of stay, and enhancing organisational sustainability.

The paper categorises SFT's partnerships into three tiers based on their criticality and impact on vision delivery:

Vital partnerships: requiring significant investment of executive time and organisational capacity

Influential partnerships: requiring structured engagement and senior representation

Nurture partnerships: requiring relationship development

Key healthcare delivery partners include BSW Group (RUH and GWH), BSW Integrated Care Board, HCRG (community services provider), Oracle (EPR provider), primary care, social care, and SWAST (ambulance service).

The paper evaluates partnership quality across six domains: strategic alignment, shared governance, operational integration, financial alignment, shared learning, and sustainability dependency.

Learning from specific partnership examples - including shared plastics services with University Hospital Southampton, primary care collaboration, no-criteria-to-reside patient management, and the Acute Hospital Alliance; has highlighted that successful partnerships require strategic alignment, shared decision-making, operational integration, and financial alignment.

The Trust's Board Assurance Framework includes four partnership domain risks, including financial deficits (BAF 9), establishing effective ICS partnerships (BAF 10), achieving transformation requirements (BAF 11), and preventing performance deterioration (BAF 12).

Moving forward, SFT will:

- Further refine its partnership gap analysis
- Continue developing shared services and governance structures
- Investigate partnership opportunities through the Group model
- Consider geographic public service changes impacting partnerships
- Advance discussions with Southern Counties Pathology Network partners

The paper concludes that SFT's ability to deliver outstanding care is fundamentally linked to partnership quality. Success depends on meaningful collaboration across the Integrated Care System and beyond, with progress measured through the three partnership vision metrics.

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

Partnerships Stocktake

Introduction and purpose

Partnerships are critical to the delivery of our vision. No organisation can provide the calibre of care to which we aspire in isolation. As such, 'partnerships' is one of the three strategic domains present within our strategy and our strategic planning framework.

This paper is for discussion and assurance – its **purpose** is to set out:

1. Our partnership working and strategy,
2. Our existing partnership landscape and quality,
3. Learning from our partnership working to date,
4. How partnership working impacts our risks, and
5. How the organisation needs to develop to deliver partnership working of the nature required to achieve our vision.

While the paper will draw-in partnerships adjacent to the delivery of our care, it is principally the partnerships affecting the end-to-end pathway of our patient cohort that will be addressed – those organisations and bodies which directly impact the care we provide and the patients to whom we provide it.

Why do our partnerships matter? Far from being something done 'out there', our partnership work touches every aspect of care in our hospital. From those arriving by ambulance, to the patients waiting for an onward package of care. Partnership working is delivered not just by executive colleagues, but by the site team, by primary care liaison, and by clinicians. Our partnerships not only let us amplify our impact beyond our walls, but deeply affect the care we are able to give within them.

1. Our Partnership Working & Strategy

Our strategy[1] sets out that the Trust recognises working through partnerships is essential to transform and integrate services effectively. The principal focus is healthcare organisations across our integrated care system and 'place' (Wiltshire).

Given the SFT strategy publication date (Summer 2022) it focuses on our Acute Hospital Alliance with Royal United Hospitals Bath and Great Western Hospitals Swindon, which we have now matured into our Group model. We have set out specifically in the strategy to explore a

[1] ourstrategy_2022-2026.pdf

shared elective programme to optimise planned care resources, virtual clinics across specialties, aligning Electronic Patient Records (now alive through our shared EPR programme), sharing corporate services, and standardising service improvements.

The strategy also emphasises the importance of integrated care services across Wiltshire, particularly for transforming urgent care and services for older people. The strategy also committed us to financial sustainability and working in a system-wide way to deliver it. Including ambitions to work with partners on inefficiencies, duplication, and integration.

The strategy makes clear that partnership working is fundamental to addressing future healthcare challenges and delivering the Trust's vision of providing an outstanding experience for our patients, their families, and the people who work for and with us.

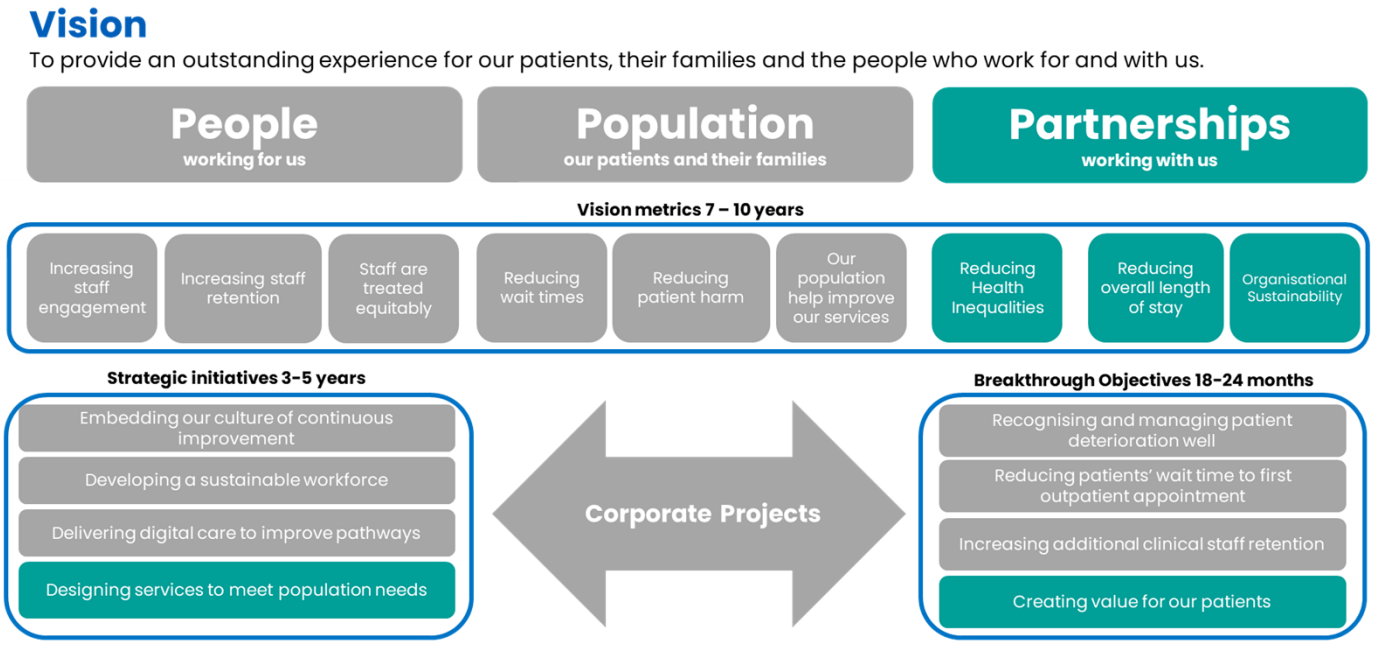


***Figure 1**: The partnership domain of our Strategic Planning Framework*

As a consequence 'partnerships' are one of the three key pillars of our strategic planning framework. We measure our partnership working contribution to our vision in three ways:

- How much we reduce health inequity
- The length of stay of our patients, and
- How sustainable our organisation is.

These are the three partnership domain vision metrics, and more detail is available in the triannual strategy update (item 3.2 of this meeting).

We also have a strategic initiative (must do, can't fail package of work over a 3-5 year time horizon) to design services to meet population needs, as well as our breakthrough objective to

create value for our patients, which we measure through an implied productivity metric (more information in the IPR paper for this meeting, item 2.1).

NHS England, as well as health focussed think tanks, have issued guidance on partnership working and what it should mean to those organisations providing care in, with, and on behalf of the NHS.

- **NHS England** have outlined in statutory guidance[2] the position on working with people and communities to improve care – placing this as both a legal and strategic imperative for NHS trusts. The guidance sets out that effective community partnership delivers clear benefits: better service change decisions, reduced legal risks, improved safety and performance, and more effective addressing of health inequalities. When combined with both the Fuller stocktake[3], Hewitt review[4], and Lord Darzi's review[5] of the NHS, the call to action on effective partnership working is clear.

- **The Kings Fund** have published extensively on partnership working across the health sector, particularly on the nature of power in those relationships[6]. Their analysis examines how power operates in health and care partnerships, focusing on relationships between NHS organisations, local authorities, and voluntary sector partners. Power is presented as a property of relationships rather than a finite resource, with partnerships struggling to transform traditional hierarchies. Four key themes emerge:
    - role expectations (where senior leaders and statutory organisations often dominate)
    - funding imbalances (where money holders wield disproportionate influence)
    - community engagement (where professionals make decisions without meaningful public input), and
    - language (where terminology can reinforce inequalities).

  For NHS trusts, and SFT in particular given the challenges of caring for an ageing rural population with pockets of deprivation, this highlights the need to examine how institutional practices reinforce power imbalances and to develop more equal partnerships.

[2] NHS England » Working in partnership with people and communities: statutory guidance
[3] NHS England » Next steps for integrating primary care: Fuller stocktake report
[4] The Hewitt Review: an independent review of integrated care systems - GOV.UK
[5] Independent investigation of the NHS in England - GOV.UK
[6] Transforming Power Relationships In Partnership Working | The King's Fund

- **NHS Confederation**'s 'systems for change' report[7] sets out that trusts should actively build relationships with VCSE organisations, particularly grassroots groups in diverse communities. They highlight the role Acute trusts can play as anchor institutions by adopting employment charters, paying real living wages, and purchasing from local suppliers. Resources should be shared strategically (facilities, vehicles, levy funding) as demonstrated by the Bristol, North Somerset, South Gloucestershire Apprenticeship Levy Bank, and success metrics should balance quantitative outcomes with qualitative measures of community impact. The shift towards place-based working requires trusts to adapt their strategic approach to community and non-traditional healthcare partnerships to drive new value.

- The **United Nations** has 17 sustainable development goals (SDGs)[8]. Goal 17 is 'Partnerships for the Goals'. It is the only cross-functional SDG, there is not a 'finance for the goals', or 'leadership for the goals'. The criticality of partnership formation and working is recognised at the most macro level for its ability to unlock previously perennial and intransigent problems. To quote directly from the goal:

  To build a better world, we need to be supportive, empathetic, inventive, passionate, and above all, cooperative.

There are many types of partnerships relevant to the healthcare sector. These include university relationships, research partnerships, commercial and subsidiary relationships – and while these will be noted the principal focus of this paper is on the partnerships through which we directly impact the health and wellbeing of our population. We must also recognise that partnership working often requires time to fully embed and while our attention is naturally drawn to operational and performance pressures, much of this work requires us to consider the longer time horizons present within our strategy. This also requires Board to consider which aspects of partnership working may form part of Group, rather than Trust, responsibility. Patient-pathway-affecting partnerships are likely to form part of core SFT business and as such this is the focus of this paper.

2. Our Partnership Landscape

SFT operates across a broad rural geography delivering DGH services at district and place, as well as regional and supra-regional services covering populations of millions. To do this we rely

[7] Systems for Change: a whole-system approach | NHS Confederation
[8] THE 17 GOALS | Sustainable Development

on partnerships with local authorities, other NHS organisations, different types of care provider, and digital systems.

Our partnerships exist within a web of organisations. Our system partnership working includes acute providers, primary care, social and community care, local authorities, ambulance, universities, private companies, regional networks, and national regulator sponsorship relationships.

Annex A sets out who our key partners are, what type of organisation they represent, what impact they have on us and what we deliver together, and how we engage and work together.

Our partnership landscape is also subject to future change. In addition to potential amends to the geography of integrated care systems, MHCLG published their white paper on devolution[9] in December will impact on how we work with public health, and how we work across the boundaries of public services relevant to our population. The White Paper sets out a policy shift that affects the geographical boundaries of integrated care systems.

"Over the long term, the government is announcing an ambition to align public service boundaries, including job centres, police, probation, fire, health services and Strategic and Local Authorities".

At the time of writing the *places* comprising BSW are all aligned to the emergence of different Strategic Authorities.

As much as our partnerships may be affected by future shifts, we continue to feel the influence of historic networks, particularly clinically. The Wessex geography comprising what is currently Hampshire, Dorset, South Wiltshire, and parts of Somerset provides clinical networking and development to teams across cancer, haematology, stroke, imaging, pathology, rehabilitation, burns, plastics, neurology, cardiology, paediatric, diabetes, palliative and end of live, respiratory, and trauma services.

We must maintain constancy of purpose on our vision and strategy as these partnership tectonics shift around us. A historic strength of SFT has been our ability to work in partnership with a variety of organisations spanning a range of geographies be that NHSE regions, Wessex clinical networks, or our integrated care system. This has been further strengthened by our move to Group.

Our partnerships can be considered across three categories:

[9] English Devolution White Paper - GOV.UK

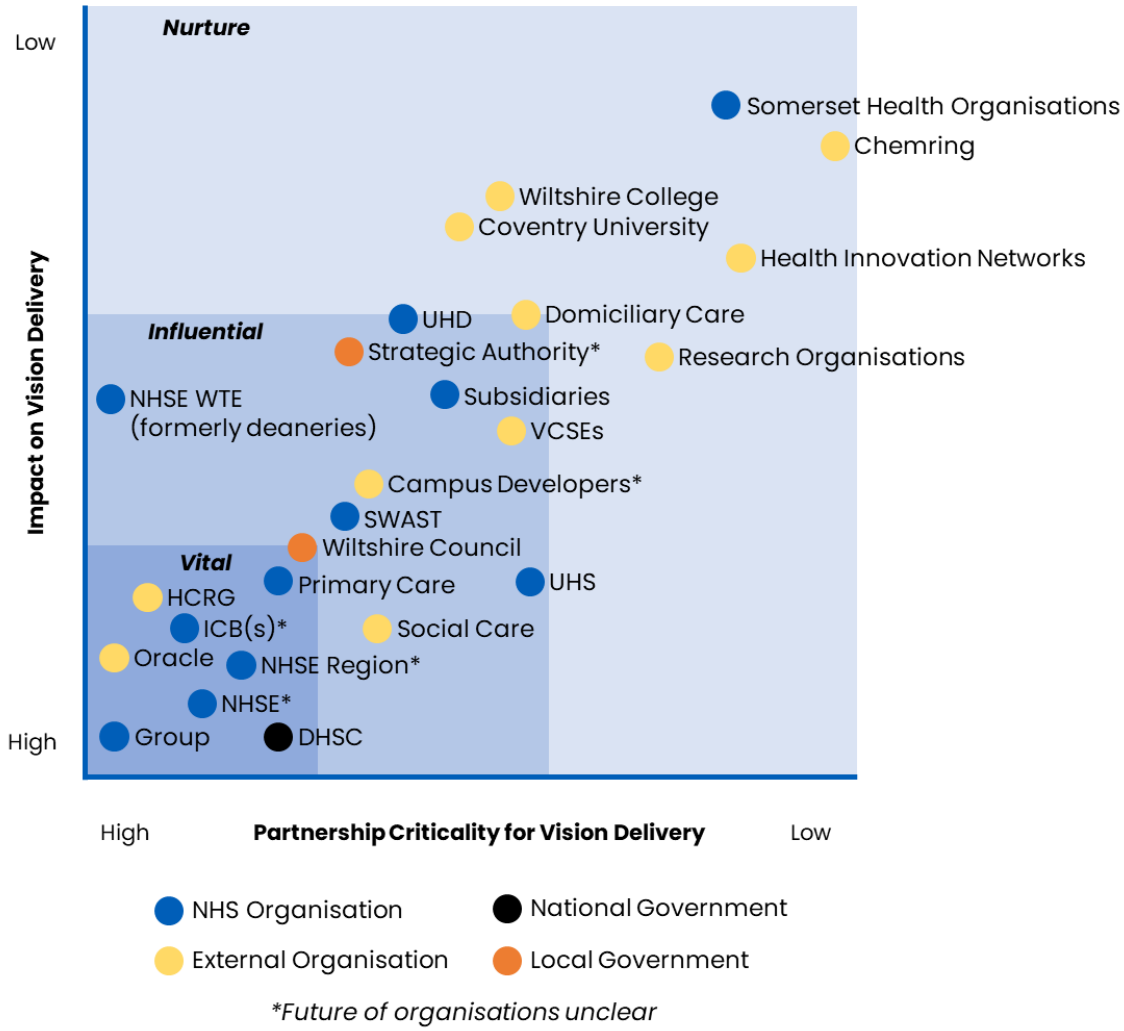
- **Vital**: these score at least 8/10 regarding both their impact on the delivery of our vision and their criticality to delivering the vision. They are partnerships we need to be strong and effective and are worth significant investment on the part of the organisation such as regular executive time and joint project working.

- **Influential**: these score between 4-7/10 on impact and criticality. They are organisations which have significant influence over aspects of our vision delivery and require a structured plan of engagement including senior engagement and a presence in relevant forums, i.e. Wiltshire Council's Health & Wellbeing Board.

- **Nurture**: these partners score 1-4 regarding impact and criticality, they are important partners with whom we should develop and further our relationships.

The scoring in the following charts are indicative only and intended to form the starting point of more detailed analysis and validation of our partnership working.

***Figure 2**: Partner organisations arranged by their criticality to vision delivery and impact upon vision delivery, and colour coded by the type of organisation.*



**Future of organisations unclear*

While **figure 2** sets out the totality of our organisational partnership landscape, there is a subset which represent our partners in **delivering** our healthcare services. **Figure 3** removes our non-healthcare direct delivery partnerships and shows the same categorisation of our partners.

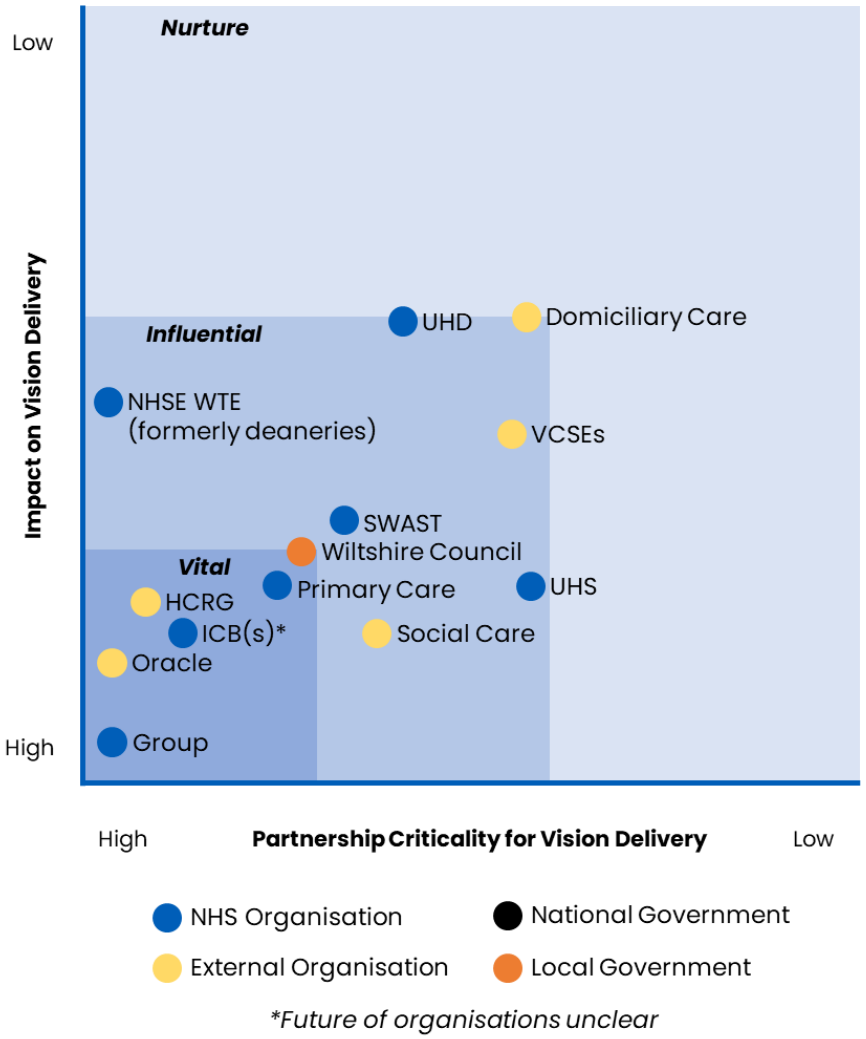


***Figure 3**: Healthcare delivery partner organisations arranged by their criticality to vision delivery and impact upon vision delivery, and colour coded by the type of organisation.*

In addition to the criticality to, and impact on, the delivery of our vision we must consider the quality of our existing partnerships. Partnership quality can be assessed against six domains:

- **Strategic alignment** refers to how closely we share a vision and objectives, the compatibility of our organisational strategy, and if we have identified mutual benefits to partnership working.

- **Shared governance and leadership** looks to the quality of any joint decision making, clarity of leadership structures, how well those structures understand one another, and if we have clear risk sharing arrangements.
- **Operational integration** means how well we have integrated pathways, shared processes, shared roles, and joint teams where appropriate.
- **Financial alignment** is a consideration of how aligned our financial incentives are, the transparency of resource allocation, shared investment goals, and collective accountability.
- **Shared learning and improvement** refers to the extent we have a joint approach to improvement, systems for shared learning, opportunities to collaborate, and the capacity to test and scale new models of care.
- **Sustainability dependency** scores the reliance of SFT and the organisation to one another for future organisational sustainability.

The below table scores each of these criteria for each of the organisations in ***figure 3***. As with the above partnership mapping, these scores are indicative only ahead of further validation with our partners.

Table 1 - Partnership Quality

Healthcare delivery partner organisations scored against the contributing criteria to partnership quality.

Organisation	Strategic Alignment (1-5)	Shared Governance & Leadership (1-5)	Operational Integration (1-5)	Financial Alignment (1-5)	Shared Learning & Improvement (1-5)	Sustainability Dependency (1-5)	TOTAL (30)
Group	5	4	3	5	5	4	**26**
BSW ICB	5	3	3	5	3	3	**22**
HCRG	4	1	4	3	2	4	**16**
Oracle	4	1	5	4	3	3	**20**
Primary Care	3	1	2	2	3	4	**15**

Organisation	Strategic Alignment (1-5)	Shared Governance & Leadership (1-5)	Operational Integration (1-5)	Financial Alignment (1-5)	Shared Learning & Improvement (1-5)	Sustainability Dependency (1-5)	TOTAL (30)
Social Care	2	1	4	2	3	4	**16**
Wiltshire Council	3	2	2	2	2	3	**14**
SWAST	3	2	4	2	2	3	**16**
VCSEs	2	1	2	1	1	2	**9**
UHS	2	2	2	3	2	3	**14**
UHD	2	1	2	2	2	1	**10**
Domiciliary Care	1	1	1	1	1	3	**8**

Other methodologies are available for determining partnership quality, Kanter's partnership equation for instance could allow us to more deeply assess and compare partnership quality. This can be expressed as:

$PQ = V + I + P$

Where:

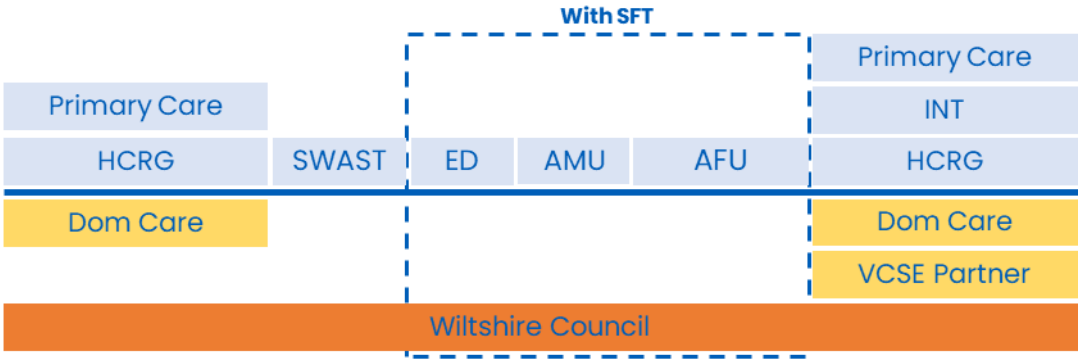
- PQ = Partnership Quotient
- V = Value (mutual benefit created)
- I = Integration (connections between organisations)
- P = Process (governance mechanisms)

The equation establishes that successful partnerships depend on creating mutual value, establishing meaningful integration, and developing effective processes.

In the context of a specific pathway, Frailty, for example, partnerships manifest in the end-to-end care experience of a patient. The quality of our partnership working with SWAST, local

domiciliary care, our VCSE partners such as Silver Salisbury[10] or Age UK[11], and primary care are critical to the onward care of our patients and preventing them from needing high acuity interventions in future.

Figure 4: *Sample frailty end-to-end patient pathway.*



3. Learning from our partnerships

SFT has been working in partnership for the entirety of its organisational existence, from that there is learning regarding what has gone well and what we might do differently in future. From this learning we can begin to distil the criteria for success. This section draws out some key learning points from our partnership working.

Shared plastics service

Over recent years increasing demands have been placed on the SFT plastics service through demographic shifts and growth across both our and UHS' population. These changes outpaced the mechanisms in the SLAs for reimbursement and left the clinical teams over capacity, and our financial position under stress.

In recent months SFT and UHS teams have been working together to define a new shared service, appropriate payment mechanisms, and the governance arrangements that will keep the new service nimble in the face of a shifting context. Through shared demand and capacity planning, and building the business case together, the relationships across the organisations have improved and we are closer to a far more effective arrangement.

The example has taught us that we cannot rely on static SLAs to keep up with an evolving situation, and that working through shared organisational problems by pooling resource builds more trust, solution credibility, and service resilience.

[10] Community Engagement | Silver Salisbury | Salisbury
[11] Welcome to Age UK Wiltshire

Primary care

To create an environment of shared understanding and open dialogue, regular meetings of senior clinical leaders from primary care, secondary care and partner organisations are held. This quarterly meeting attended by the local PCN Clinical Directors, hospital clinical leadership as well as the LMC and BSW ICB allows current issues to be discussed and agreed actions taken. SFT has resourced this partnership working through an Associate Medical Director with responsibility for clinical aspects of this interface, as wells as a GP Liaison Manager responsible for operational matters.

This closer partnership working has created two-way communication resulting in multiple improvements to patient care. This has included projects such as the implementation of template clinical letters and their electronic transmission to GPs allowing for more efficient use of resources on both sides and faster, more accurate information sharing to ensure patients receive correct timely care. In addition, SFT and Primary Care partners lobbied successfully for improvements to the current Advice and Guidance system to reduce the need for GPs to re-refer following specialist clinical advice, speeding up patients access to care.

No criteria to reside

Over the last two years SFT has been challenged by flow out of hospital due to a range of complex issues across the system. This has been compounded by internal variation in ward and discharge process and shifts in how the site and flow team work with our external partners. The complexity of our partnership working has manifested in the development of our shared understanding regarding what is within SFT's gift to fix internally, how we should influence external partners, and how we mitigate for factors beyond our control such as demographic growth or a population with higher acuity and complex co-morbidity.

The learning from working with ICB, local authority, and community care providers has shown us that traditional levers of control are ineffective when seeking to tackle problems spanning multiple organisations. It has taught us that we must work collaboratively across the entire pathway, from preventative measures to community capacity, in order to create the patient experience we all want to see.

Acute Hospital Alliance

Our AHA formed in 2021, and forms a key part of our strategy, with the aim of sharing best practice, developing our services, supporting each other in busy periods, and pursuing joint projects such as a shared EPR. As this relationship has matured into Group, and we have had opportunities to closely collaborate on the future of care (such as the integrated community care bid), we have learned where we can all be stronger by working in partnership.

While our duplicated governance processes as an AHA pre-group offered learning about the pace we can move at on decisions, we have also been able to evolve our shared understanding of the left shift required in care. Our long standing shared procurement service has taught us the benefits of centralised corporate functions and we will be deploying the best of that learning as we seek to rise to the current financial challenges and opportunities to do more together in driving both high quality care and value for the taxpayer.

Conditions for success

With these in mind we can consider what the conditions for success are. We have clearly moved beyond a competitive NHS provider landscape with leadership behaviour cultures reliant on pulling levers of control to deliver change – and into a collaborative professional world of system working and influencing.

The same domains by which we measured the quality of our partnerships in **table 1** are applicable and present in the partnerships where we have seen the most success. Where we have strategic alignment, shared decision making, operational integration, financial alignment, shared approaches to learning and improvement, and a need for each other to thrive – this is then when our partnership working delivers the positive results we have seen in developing shared services, deepening primary care trust and interface improvements, reducing our NCTR numbers, and our Group.

Areas for development

Across our partnership working we nevertheless have gaps that require further development and focus. These are:

- Whether we have sufficient dedicated capacity for partnership development and how much of this capacity should be a function of Trust or Group working.

- How we govern our partnership working and provide the appropriate levels of regularised assurance to Board and appropriate sub-board forums.

- How we involve patients and communities more closely in organisational partnership development.

- How we have clearer ownership and oversight of partnership working within the management structures of the organisation.

4. Partnerships and our risks

A reason to work in partnership is to help us mitigate our risks, particularly those influenced by external factors that therefore necessitate partnership working. The Board Assurance Framework (BAF) is segmented by the three domains of our strategy – People, Population, and Partnerships. This final element includes BAF risks 9-12 and highlights the key role our partnership working plays in managing Trust-wide risk.

This section sets out each of our partnership domain risks within the BAF, who are key partners are and how they impact the risk, how we resource our partnership working, what that resource is doing, and our success criteria for that work.

BAF	Risk Title	Who are our key partners?	How do they impact us?	How do we resource this partnership?	What are we doing?	Success criteria
9	An irreversible inability to reduce the scale of financial deficit	•DHSC •NHSE •BSW ICB	Through tariff and other financial mechanisms, the income received and oversight of spend.	Executive level engagement in regional and national fora.	Working at system and region to ensure commissioning reflects cost base where possible. Leveraging national CEO forums to influence policy.	Ability to influence national policy and decision making. Organisational sustainability Vision Metric.
10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	•BSW ICB •BSW ICP •HCRG •Wiltshire Council •VCSE Community •Social Care •Public Health •Primary Care	Demand on our services and flow into and out of hospital.	Specific teams and the development of new models of care such as integrated neighbourhood teams. Senior representation in critical forums such as Health and Wellbeing Board and the ICA.	Standing up of the new strategic initiative focussed on service design. Leveraging place-based forums to influence demand management and out of hospital capacity.	LoS Vision Metric. Reducing wait times Vision Metric. Reducing health inequalities Vision Metric.

BAF	Risk Title	Who are our key partners?	How do they impact us?	How do we resource this partnership?	What are we doing?	Success criteria
11	Risk of not achieving the transformation requirements at the pace required to deliver the 2025/26 plan	•Wiltshire Council •HCRG	Demand reduction from system partners in the plan (4.4% to 1.4%) Flow out of hospital improvement through the ICBC contract with HCRG.	Senior representation in critical forums such as Health and Wellbeing Board and the ICA.	Working with HCRG and Wiltshire Council to ensure existing performance improves and new pathways are designed with plan delivery at their heart.	LoS Vision Metric. Reducing wait times Vision Metric.
12	Risk of sustained deterioration across key performance metrics (new risk)	•Primary Care •HCRG •Wiltshire Council	As BAF 11 with addition of referral patterns from primary care.	AS BAF 10 and 11, plus a dedicated primary care liaison group.	Leveraging working level forums to drive improvement including through improvement sprints and our new strategic initiative.	LoS Vision Metric. Reducing wait times Vision Metric.

5. Partnership Working Development

To achieve our vision, we have resourced partnership working throughout the organisation. Senior leaders within the organisation have devoted capacity to working within system forums to collectively move forward care for our population and align our strategic ambitions. To continue developing we will:

- Further refine our partnership gap analysis including in non-pathway related partnership areas such as research, innovation, commercial, and improvement (i.e. our shared lean methodology work with Chemring Countermeasures[12]).

- Continue to develop shared services and governance structures that work for our patients and our population, building on the shared plastics service work with UHS to strengthen our tertiary cancer partnerships.

[12] Chemring Countermeasures UK – Chemring Group PLC

- Investigate further partnership working opportunities as a result of group, including how SFT can benefit from existing relationships the RUH and GWH have, i.e. with Bath Spa University.

- Give further consideration to the partnerships and relationships necessary for SFT to continue work on delivering our vision in the context of geographic public service changes around us such as potential ICB footprint changes and the emergence of strategic authorities[13].

- Continue to advance our discussions with partners in the Southern Counties Pathology Network.

In addition to these smaller next steps we have committed to a new Strategic Initiative in the partnership domain of our strategy – 'Designing services to meet population needs'. This programmatic package of work, lead by the Chief Operating Officer, will allow us to further resource our partnership working with primary and community care to deliver on the left shift, integrated neighbourhood working, and leverage the transformation set out in the ICBC tender won by HCRG.

We will measure our effectiveness through the three partnership vision metrics:

- Reducing health inequalities
- Reducing overall length of stay
- Enhancing organisational sustainability.

Conclusion

The above has set out for discussion and assurance:

1. Our partnership working and strategy,
2. Our existing partnership landscape and quality,
3. Learning from our partnership working to date,
4. How partnership working impacts our risks, and
5. How the organisation needs to develop to deliver partnership working of the nature required to achieve our vision.

[13] English Devolution White Paper - GOV.UK

Our ability to deliver outstanding care is fundamentally linked to the strength and quality of our partnerships, we cannot achieve our vision in isolation - our success depends on meaningful collaboration with our partners across the ICS and beyond. We will focus on three next steps:

- Strengthen our highest-impact partnerships, particularly with the Group, BSW ICB, and HCRG, through deliberate investment of executive time and joint initiatives.

- Address gaps in our partnership quality, especially in shared governance, operational integration, and financial alignment where appropriate.

- Continue to progress our new Strategic Initiative 'Designing services to meet population needs' through the planned A3 development session with external partners scheduled in May 2025.

By measuring our impact through our vision metrics - reducing health inequalities, decreasing length of stay, and enhancing organisational sustainability - we can ensure these partnerships translate into tangible benefits for our patients. Effective partnership working is not simply a strategic priority; it is the essential foundation upon which we will build an outstanding experience for our patients, their families, and the people who work for and with us.

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ANNEX A – OUR PARTNERS

Who are our key partners? What type of organisation they represent? What impact they have on us and what we deliver together? and how we engage and work together?

Group

- Royal Unity Hospitals Bath (RUH) and Great Western Hospitals Swindon (GWH) are acute health providers and district general hospitals.
- Together we represent the acute provision within BSW ICB and have significant strategic alignment, a shared OMS and improvement approach, collective responsibility for the majority of NHS spend within the ICB, and deliver a range of corporate and clinical services together including shared EPR.
- Pre-group our engagement was through the Acute Hospital Alliance (AHA) and committee in common structures, this has matured into our Group function with shared CEO and work underway to define what other aspects of our work are harmonised.

BSW ICB

- Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board is the statutory body responsible for planning and commissioning health services within our geography.
- Together we arrive at the annual plan for the system and design/delivery services for our population. Until recent changes the ICB had also been responsible for performance managing SFT.
- SFT has representation on the ICB Board, and in numerous other ICB convened forums including but not limited to Population Health Board, the Integrated Care Alliance, System Workforce Control, and other clinical and corporate engagement forums.

NHSE Regional Team

- The NHSE regional team is the principal oversight mechanism for national performance management of our integrated care system and SFT.
- We report our organisational performance and financial position to region, and engage with them on other aspects of our work such as talent development programmes and primary care provision.
- Most regional engagement, particularly pertaining to annual planning and performance management, is conducted at the executive level.

NHSE

- NHS England is the principal commissioner of healthcare services in England and is an executive agency of the Department of Health and Social Care. In addition to commissioning it also sets a range of policy and strategy, as well as delivering digital programmes and leadership development for the NHS nationally.
- NHSE, in tandem with other parts of central government, issue our annual planning guidance and intervene in the event the organisation falls into distress.
- Direct engagement with NHSE is limited, however several executives have networks of influence connecting them to national peers.

DHSC

- The Department of Health and Social Care is a ministerial department of His Majesty's Government responsible for supporting and advising minsters, setting strategic direction on global and domestic health, acting as guardians of health and care legislation and regulation, and are the accountable body to Parliament.
- The policy direction and budgetary allocations governed by DHSC have a significant impact in our approach to care, including the value of tariff and strategic direction such as the major conditions strategy. Ministerial decisions can radically alter the healthcare landscape such as through the formation of integrated care systems
- Direct engagement with NHSE is limited, however several executives and deputies have networks of influence connecting them to departmental peers.

HCRG

- HCRG are a private healthcare provider holding the contract to provide community services in BSW from 2025 to 2034. Taking over this role in Wiltshire from Wiltshire Health and Care.
- The services provided by HCRG are those in the patient pathway often before and after those in our care. Their community nursing packages of care are often the provision our patients go on to receive (Pathway 2). They have a critical role to play in both demand management on our services and on flow out of hospital.
- Those responsible for the operational management of the hospital have weekly meetings with HCRG leadership and we engage with them in other forums such as the Integrated Care Alliance (ICA), Wiltshire Council's Health and Wellbeing Board, and Neighbourhood Collaboratives Steering Group.

Oracle

- Oracle are a provider of digital services including electronic patient records. Their 'Cerner' platform is a widely used EPR in the (acute) English NHS and is the EPR which BSW Hospitals Group are in the process of deploying.
- Together we are delivering the rollout of a shared EPR across our Group, this will touch on every clinical and non-clinical part of our work – offering huge opportunity to increase our digital maturity and improve our pathways. As such this partnership is a critical enabler to our Strategic Initiative *Delivering digital care to improve pathways*.
- To deliver this together have a programme board and clinical representation from the organisation embedded within the Programme.

Primary Care

- 'Primary care' covers general practice and the primary care networks to which several practices belong. Often described as the front door of the NHS, general practice is the principal referrer to our services and represents continuity of care for our patients.
- Primary care feels demand growth just as keenly as acute providers, it is also a key player in how we manage demand on acute services and in how we deliver a left shift of services and the prevention agenda. Primary care seeks advice and guidance from acute clinicians and relationships, as across the country, vary in depth and efficacy.
- We have a primary care forum with representation from the local GPs and PCNs in South Wiltshire, including the military. We also engage in forums with primary care representation across the system including Wiltshire Council's Health & Wellbeing Board.

Wiltshire Council (excl. Social Care)

- Wiltshire Council is a unitary authority responsible for all local government services in Wiltshire, they combine the functions of all other forms of local government with the exception of parish councils. They hold responsibility for public health and other services which impact on the wider determinants of health.
- Council decisions regarding public health budgets and the role of council leadership within the integrated care systems both have a big impact on the planning of healthcare provision across the system.
- We send senior representation to Wiltshire Council's health and wellbeing board, chaired by the leader of the council, and engage in other system forums such as the ICA.

Social Care

- Social Care is a function of Wiltshire Council responsible for the provision of all social care services in Wiltshire.
- This includes transfers of care, delays to which can significantly impact on our NCTR position; and the packages of care that our patients go on to receive which can also affect their chances of readmission. From April 2025 Wiltshire Council are responsible for all pathway 1 discharges.
- Social care teams are embedded with the integrated discharge team at the hospital and operational colleagues work with social care colleagues daily to influence positive outcomes for our patients.

Southern Counties Pathology Network (SCPN)

- SCPN is a collection of acute providers brought together by NHSE to explore the harmonisation and amalgamation of pathology services. Those providers are University Hospitals Southampton NHS Foundation Tryst, University Hospitals Dorset, Portsmouth Hospitals University NHS Foundation Trust, Isle of Wight NHS Foundation Trust, and Hampshire Hospitals NHS Foundation Trust. It spans two NHS regions, three ICBs, and five acute providers.
- The network has no formal control over SFTs services but the NHSE directive to form and deepen networks providers an imperative to explore if all the benefits of integration have been delivered or some remain. The impact on our pathology offer, the cost of delivering the service, and the recruitment and retention of staff are all affected by our approach to the network.
- Monthly programme meetings are resourced by the Trust at the executive level and we continue to work with SCPN partners to iterate the business case for an appropriate level of integration.

SWAST

- South West Ambulance Service NHS Foundation Trust provide ambulance services across the South West. They are the principal conveyor of emergency ambulances to SFT.
- SWAST impact SFT through the handover of patients into the emergency department. Together we have kept the handover wait times amongst the best in the region.
- SWAST participate in daily ICB convened operational calls and are in daily contact with operational teams at SFT including our hospital ambulance liaison officer (halo). We also engage with SWAST at system and place such as at the ICB and in more localised forums such as the Neighbourhood Collaboratives Steering Group.

University Hospitals Southampton (UHS)

- UHS are a provider of acute healthcare services and the principal tertiary referral centre for our patients. They are also the local major trauma centre.
- We refer cancer patients to UHS for specific treatments not provided by SFT, provide plastic surgery services to UHS, participate in the SCPN together, and other clinical relationships such as the urology network. Our impact on one another revolve around financial flows for services, and on the health and timely treatment of our population. We also share a workforce geography.
- In 2025/26 we are forming our partnership board consisting of CMOs, COOs, and strategy directors. This will collect the various partnership work strands and provide the opportunity for executive steer to the development of our various shared workstreams.

University Hospitals Dorset (UHD)

- UHD are a provider of acute healthcare services and a major trauma centre.
- Our pathways are not integrated with UHD as they are with UHS, however we are partners in SCPN and will share a health geography if Strategic Authorities form as planned. We also share a workforce geography.
- Our formalised engagement is through the SCPN programme board – other ad hoc partnership working forums form as necessary.

NHSE Workforce, Training & Education (Formerly Deaneries)

- NHSE WTE, formerly the clinical deaneries oversee postgraduate medical education, manage the recruitment and placement of resident doctors, ensure quality training environments in trusts, and conduct assessments and progression reviews for doctors.
- Without this function of NHSE WTE (recruitment and placement of doctors) we would be unable to adequately staff our resident doctor rotas within the organisation.
- NHSE WTE allocate doctors to SFT representing a proportion of the total doctors in training across the Wessex region in line with our post schedules (broadly equivalent to SLAs).

Wholly Owned Subsidiaries

- Our wholly owned subsidiaries (WOS) include the laundry and Odstock Medical. These organisations deliver value to SFT without being a part of the organisation. They operate as distinct legal structures but are owned by SFT as the sole shareholder.
- Our WOS deliver income and VAT benefits to us, and in some cases (such as the laundry) provide services to the Trust.
- Executives retain seats on the Boards of the subsidiaries and through these influence the onward partnerships of the WOS.

Strategic Authority

- These are tiers of local authority above unitary authorities. Examples include the greater London and greater Manchester authorities – they are usually, but not always, led by a mayor. The 2024 MHCLG devolution white paper mandates their formation across all of England by the end of the parliament. Wiltshire, Dorset, Bournemouth, and Somerset councils have expressed their interest to secure this level of devolution for a 'Heart of Wessex' Strategic Authority.
- Given they do not yet exist our partnership work is not underway, however our consideration of impact is underway. This layer of local authority will likely include some aspect of public health responsibility, and there is likely to be a formal partnership role with ICBs.
- We will seek to participate in appropriate forums when they emerge.

VCSE Organisations

- Voluntary, Community, and Social Enterprise organisations deliver a broad range of services to our patients. Examples include Silver Salisbury, Age UK, and Mind.
- The services provided by VCSE organisations are credited with keeping patients fit and well in the community, reducing demand on acutes.
- As we engage more with neighbourhood working, where VCSE organisations are a core part of the model, we will be able to work in closer partnership to leverage our differing capabilities for the benefit of our patients, such as through more preventative interventions drawing on acute clinical advice.

Research Organisations

- Research organisations are either academic or private in nature and represent an opportunity for both income and access to the latest treatments and approaches for our patients.
- Research organisations positively impact trust finance, often require access to clinical space, and also play a role in the delivery of care relevant to their studies.
- Research partnership work is led by the research team who have a stated aim of growing our research activity. The relationships are transactional, however this may change as we mature university partnerships as part of our Group work.

Domiciliary Care

- Domiciliary care providers are not a part of the public sector healthcare provision market and are for-profit entities. There are more than 100 in Wiltshire, and it is challenging to engage with the sector overall because of this.
- The impact of better local domiciliary care has been shown to reduce demand on hospitals and readmission – in some geographies, such as Northumbria, NHS trusts have set up their own domiciliary care providers to deliver the service and reduce pressure on acute services. We currently do not have partnerships with domiciliary care.
- We do not currently work with domiciliary care providers.

Health Innovation Networks

- HINs, formerly Academic Health Science Networks, are partially publicly funded and partially funded through income and subscription. They are regional and the once covering our geography is 'Wessex HIN'. They provide specialist evaluation, innovation adoption, and research services.
- The impact HINs have on trusts is variable, and ours is principally through ad hoc support provided to us when we adopt technologies through the national 'Medtech Funding Mandate'.
- There is opportunity to work more closely together in adopting proven innovation from elsewhere.

Coventry University

- Coventry University are an degree awarding academic institution that has partnerships with a range of hospitals beyond its geography nationally.
- With a focus on nurse training alongside local education delivery partners Coventry are helping SFT to grow and improve the pipeline of nursing talent.
- We have bi-monthly meetings with both Coventry University and Wiltshire College to progress the partnership work.

Wiltshire College

- Wiltshire College is a local degree awarding further education institution, and are education partners to the Trust alongside Coventry University.
- Our work with the college is focussed on our nursing pipeline, but there are additional opportunities being explored via our anchor institution work drawing in examples from the South West anchor partnership network – this includes broader career opportunity engagement for young people to address vacancy rates.
- We have regular engagement with Wiltshire College as part of the Coventry partnership work.

Chemring

- Chemring Countermeasures are a local military hardware supplier, largely focussed on defensive measures for aircraft. They use a similar, Lean, operational management system with improvement at its core.
- We have forged a partnership with Chemring to explore how we can learn from each other's improvement approaches and translate learning from another context into ours.
- The partnership work is nascent, but in addition to presenting at each other's programme boards for improvement further bi-lateral meetings are planned between organisational improvement teams.

----- PAPER ENDS -----

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	1st May 2025		

Report title:	Overview of National Staff Survey 2024 (NSS)			
Status:	Information	Discussion	Assurance	Approval
	X	X		
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Dave Roberts Associate Director Communications Engagement and Community Relations			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Trust Board are asked to note the overall continued improving progress of the Trust National Staff Survey Results.

Colleagues are invited to explore further the extent of our ambition to achieve the top 25% in at least one of the seven elements of the People Promise

Executive Summary:

- SFT has the highest score among all Acute Trusts in England for staff looking forward to coming to work @ 62%
- Staff would recommend SFT as a place to work has increased by 7% to 67%
- All elements of staff engagement (vision metric) and morale have increased.
- All elements of retention have improved (vision metric)
- Both Team working and Line Management scores have improved to above average
- Appraisals have improved slightly on last year to 0.03 below average.
- For the second year running SFT is the most improved Acute Trust.

Responses in the NSS 2024 at an organisational level indicate continuous improvement across all People Promise elements so that after three years we have achieved above average against all seven elements

Response rates from Additional Clinical Services and Nursing and Midwifery have significantly improved, alongside those of Medical and Dental and so offering a more representative score for the Trust as a whole.

NSS 2024 indicates declining scores for:
staff experiencing physical violence from patients, family members and the public
staff experiencing MSK problems caused by work
the organisation offering challenging work, and
enjoying working with their team.

It is worth noting that the fall in enjoying working with colleagues in the NSS is supported by a small decrease in the complimentary January Pulse Survey for staff feeling colleagues were kind to each other and kind to new starters.

Recommendation:

In light of our exceeding our 2024 target - we were in the upper quartile ranking of trusts for 7 out of 9 areas, and upper half for remainder, which far exceeds our ambition to reach at least one upper quartile ranking by 2025.

We aspire to be in the top 25% of at least one elements of the People Promise in 2025 noting 'Recognised and rewarded', 'Team' and 'Engagement' were within 0.03 points of top 25% scores for 2024.

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

Salisbury NHS Foundation Trust

Staff Survey 2023 – 2024

Public Trust Board: 1st May 2025

Melanie Whitfield: Chief People Officer

SFT Strategic Planning Framework: 2025-26

Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

NHS Salisbury NHS Foundation Trust

People working for us

Population our patients and their families

Partnerships working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reduced inequity in Healthy Life Years
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

- Maintain continuous improvement culture
- Developing a sustainable workforce
- Delivering Digital Care to improve pathways
- Designing services to meet population needs

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients

Three years of improvement

Salisbury
NHS Foundation Trust

People Promise at a glance

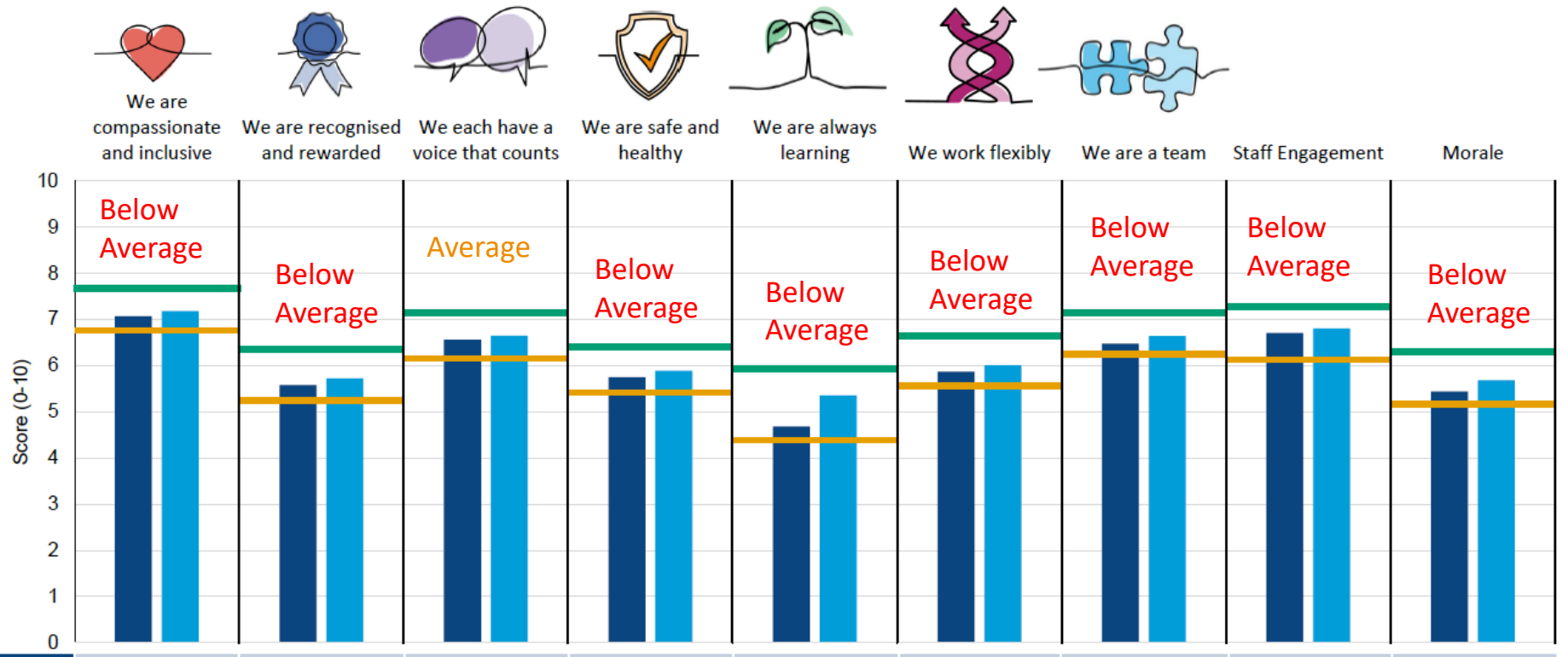
Overview of Survey results 2022

NHS Salisbury NHS Foundation Trust

People Promise Elements and Themes: Overview

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.1	5.6	6.6	5.8	4.7	5.9	6.5	6.7	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1857	1855	1842	1846	1763	1846	1855	1859	1859

2022 saw a decline in scores for SFT bringing us to exactly average in one area, voice that counts and below average in the rest

Always learning and Morale were of particular concern.

People Promise at a glance

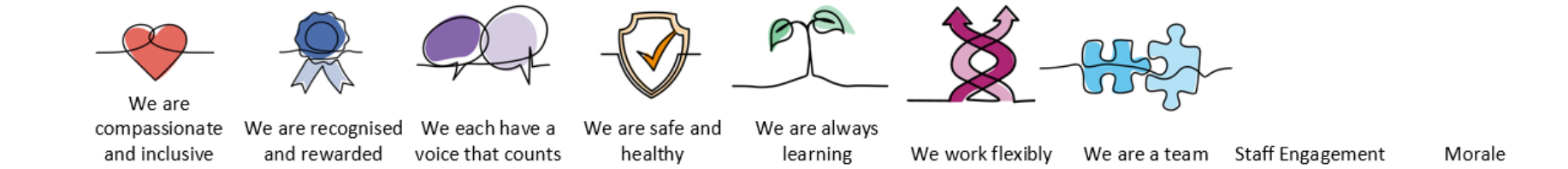
Overview of Survey results 2023

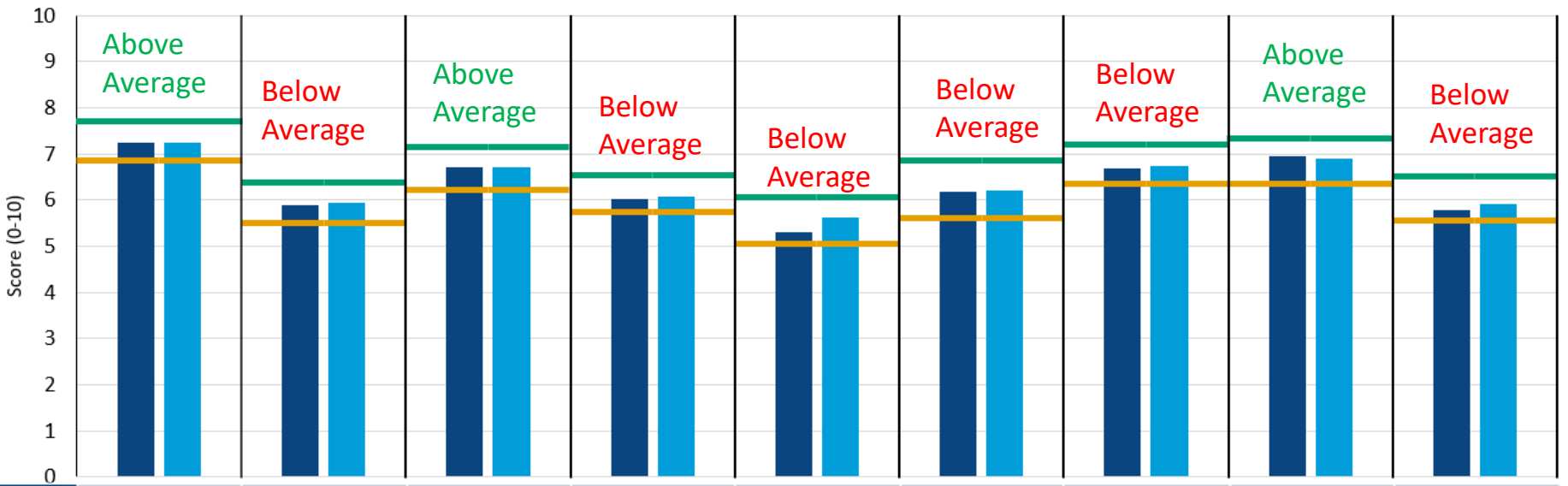
NHS Salisbury NHS Foundation Trust

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.





	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.25	5.88	6.72	6.02	5.32	6.17	6.68	6.96	5.79
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2254	2252	2223	2228	2137	2239	2247	2254	2255

According to HSJ SFT is the 'most improved' Trust in the 2023 survey.

All of our scores have improved to bring us above average in three elements. Always Learning still of concern.

People Promise at a glance

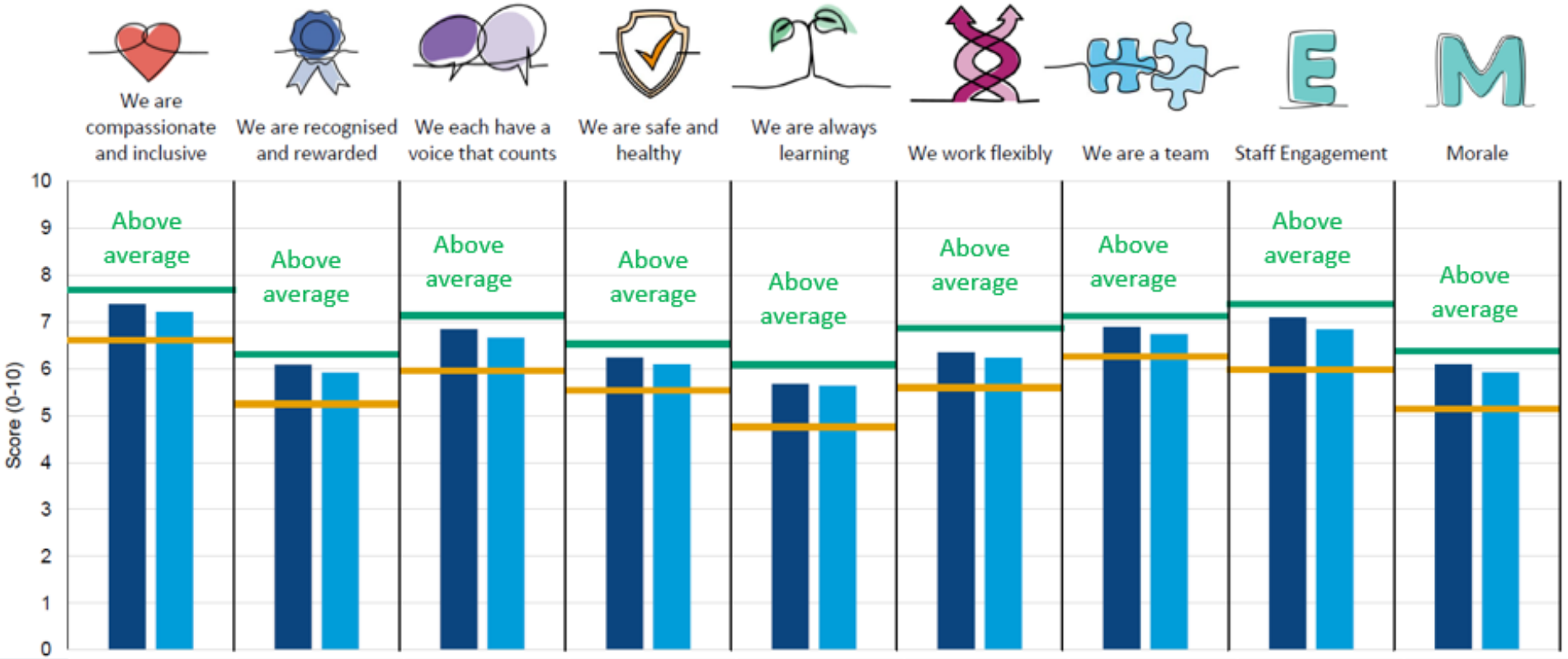
Overview of Survey results 2024

NHS Salisbury NHS Foundation Trust

People Promise elements and themes: Overview

Survey Coordination Centre NHS

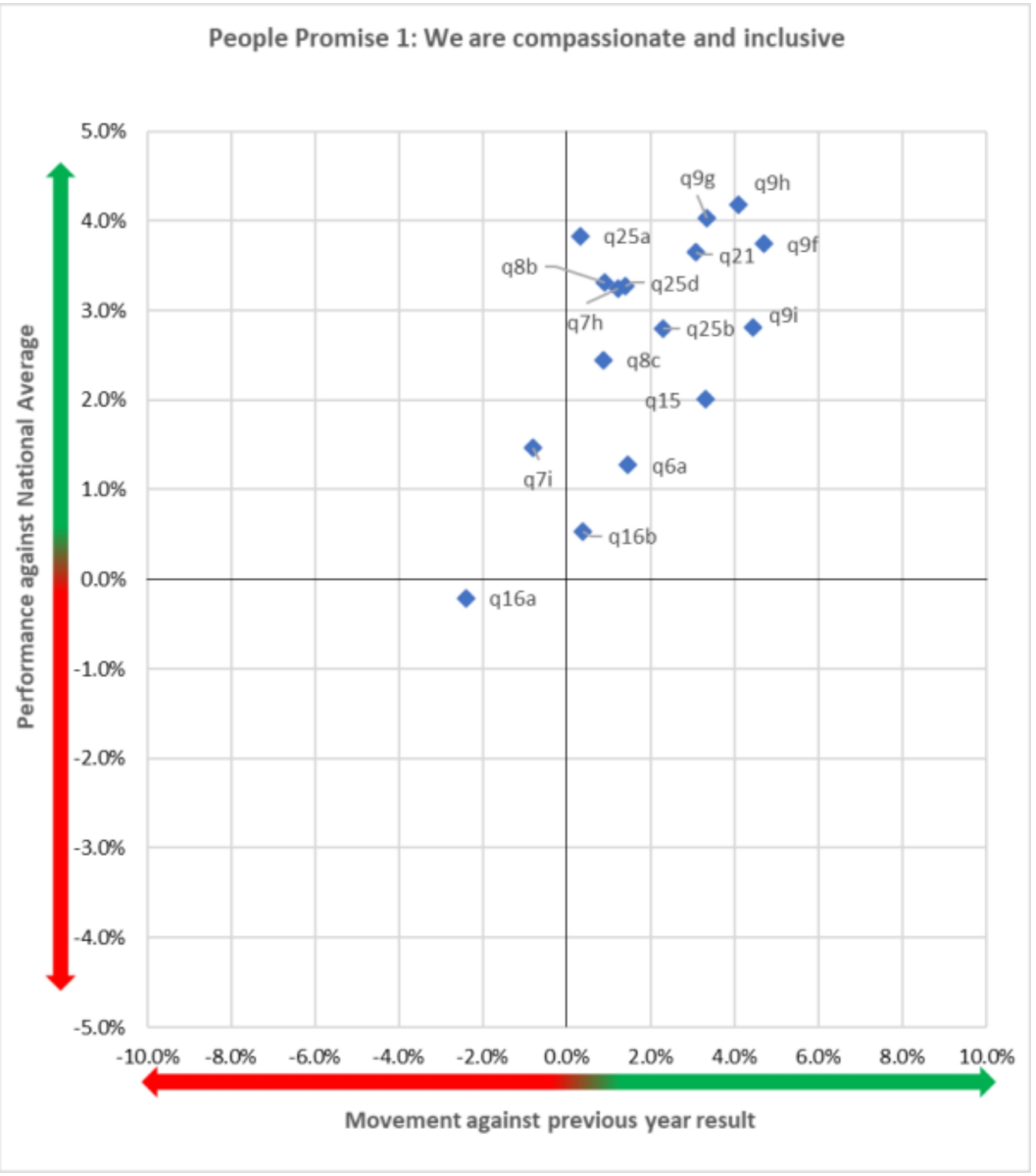
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.38	6.09	6.85	6.24	5.67	6.35	6.89	7.09	6.09
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	2639	2637	2613	2622	2505	2626	2637	2640	2640

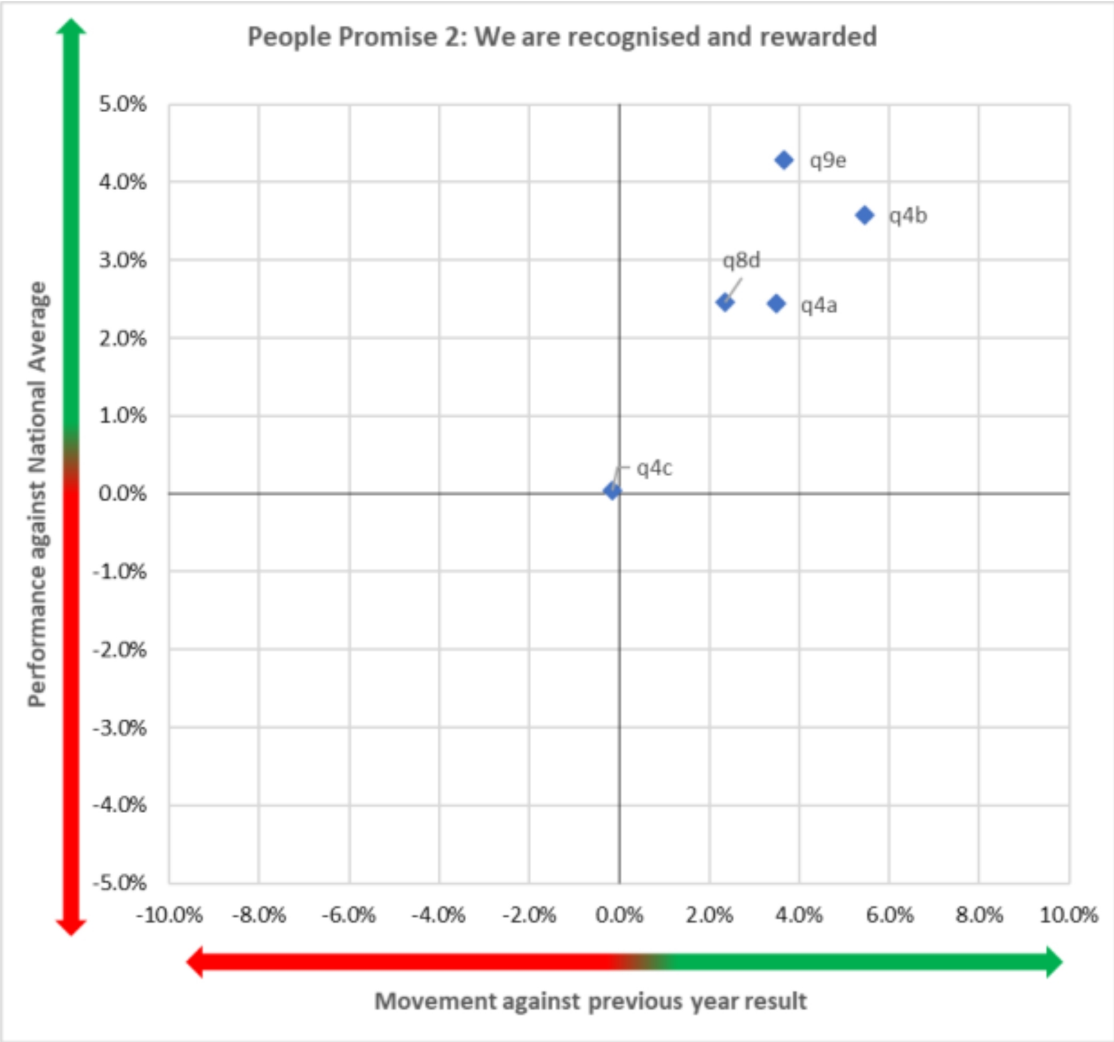
According to HSJ SFT is the 'most improved' Trust in the 2024 survey, for the second year running.

All of our scores have improved to bring us above average in all elements.



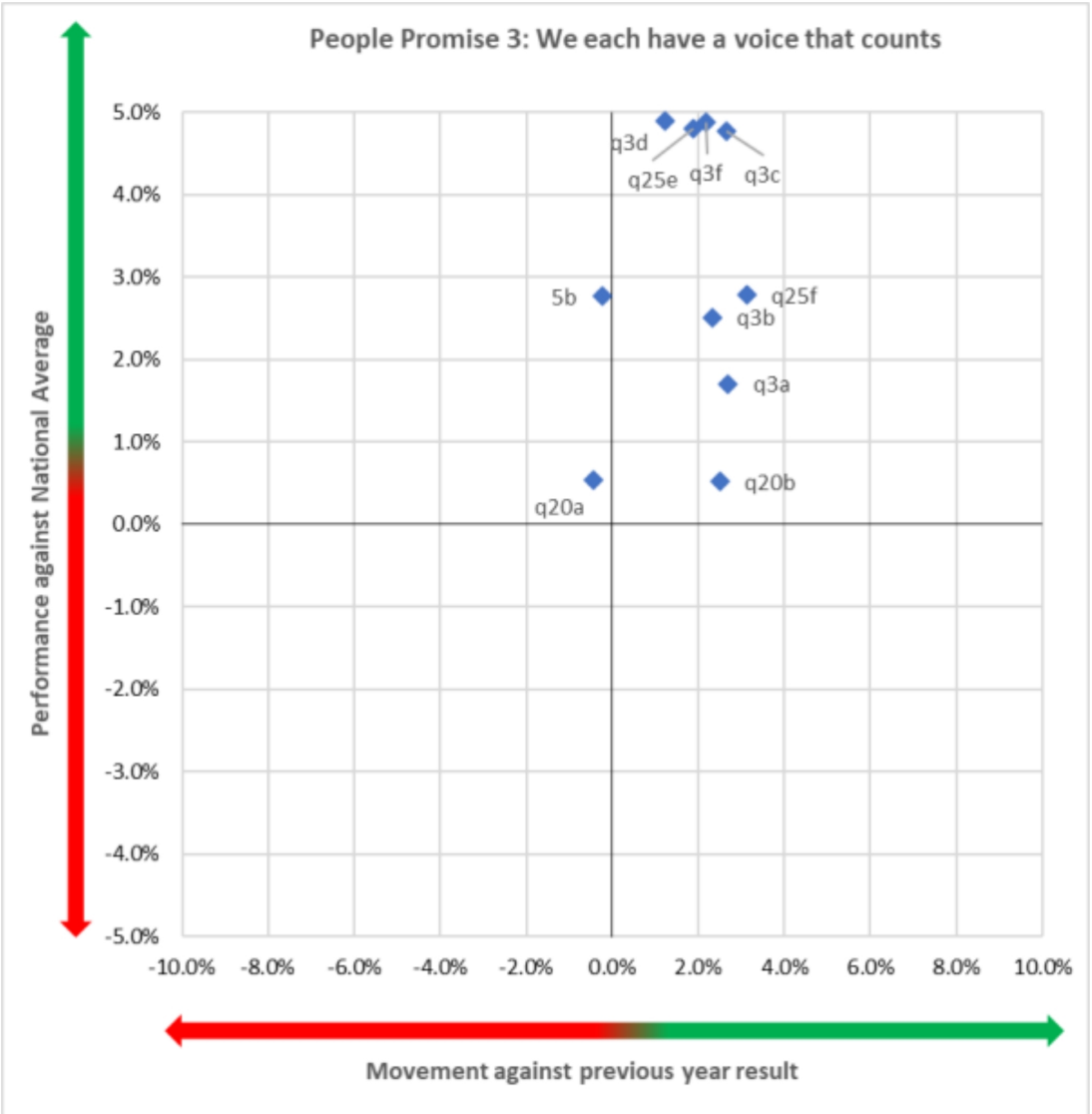
People Promise 1
We are compassionate and inclusive

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q6a	Feel my role makes a difference to patients/service users	89.2%	1.5%	87.9%	1.3%
q7h	Feel valued by my team	72.5%	1.2%	69.3%	3.2%
q7i	Feel a strong personal attachment to my team	64.9%	-0.8%	63.5%	1.5%
q8b	Colleagues are understanding and kind to one another	72.5%	0.9%	69.2%	3.3%
q8c	Colleagues are polite and treat each other with respect	72.8%	0.9%	70.3%	2.4%
q9f	Immediate manager works with me to understand problems	72.7%	4.7%	69.0%	3.7%
q9g	Immediate manager listens to challenges I face	75.5%	3.3%	71.4%	4.0%
q9h	Immediate manager cares about my concerns	74.4%	4.1%	70.2%	4.2%
q9i	Immediate manager helps me with problems I face	69.8%	4.4%	67.0%	2.8%
q15	Organisation acts fairly: career progression	59.0%	3.3%	57.0%	2.0%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	91.1%	-2.4%	91.3%	-0.2%
q16b	Not experienced discrimination from manager/team leader or other colleagues	91.5%	0.4%	91.0%	0.5%
q21	Feel organisation respects individual differences	74.4%	3.1%	70.7%	3.7%
q25a	Care of patients/service users is organisation's top priority	76.3%	0.3%	72.5%	3.8%
q25b	Organisation acts on concerns raised by patients/service users	71.4%	2.3%	68.6%	2.8%
q25c	Would recommend organisation as place to work	66.9%	6.6%	59.1%	7.8%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	64.8%	1.4%	61.6%	3.3%



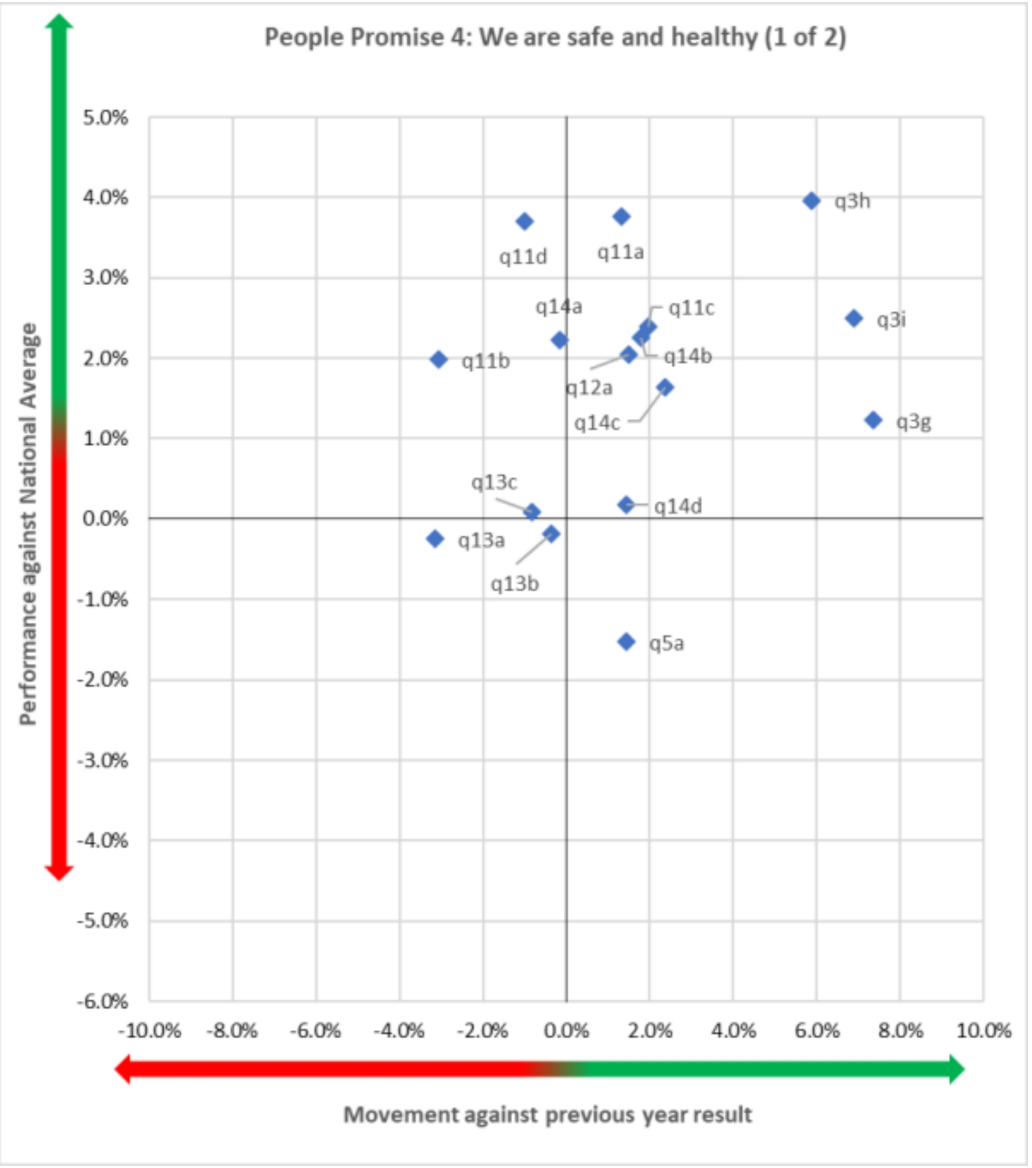
People Promise 2
We are recognised and rewarded

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q8d	Colleagues show appreciation to one another	68.9%	2.3%	66.4%	2.5%
q4a	Satisfied with recognition for good work	55.5%	3.5%	53.1%	2.4%
q4b	Satisfied with extent organisation values my work	47.1%	5.5%	43.5%	3.6%
q4c	Satisfied with level of pay	31.7%	-0.1%	31.7%	0.0%
q9e	Immediate manager values my work	76.1%	3.7%	71.8%	4.3%



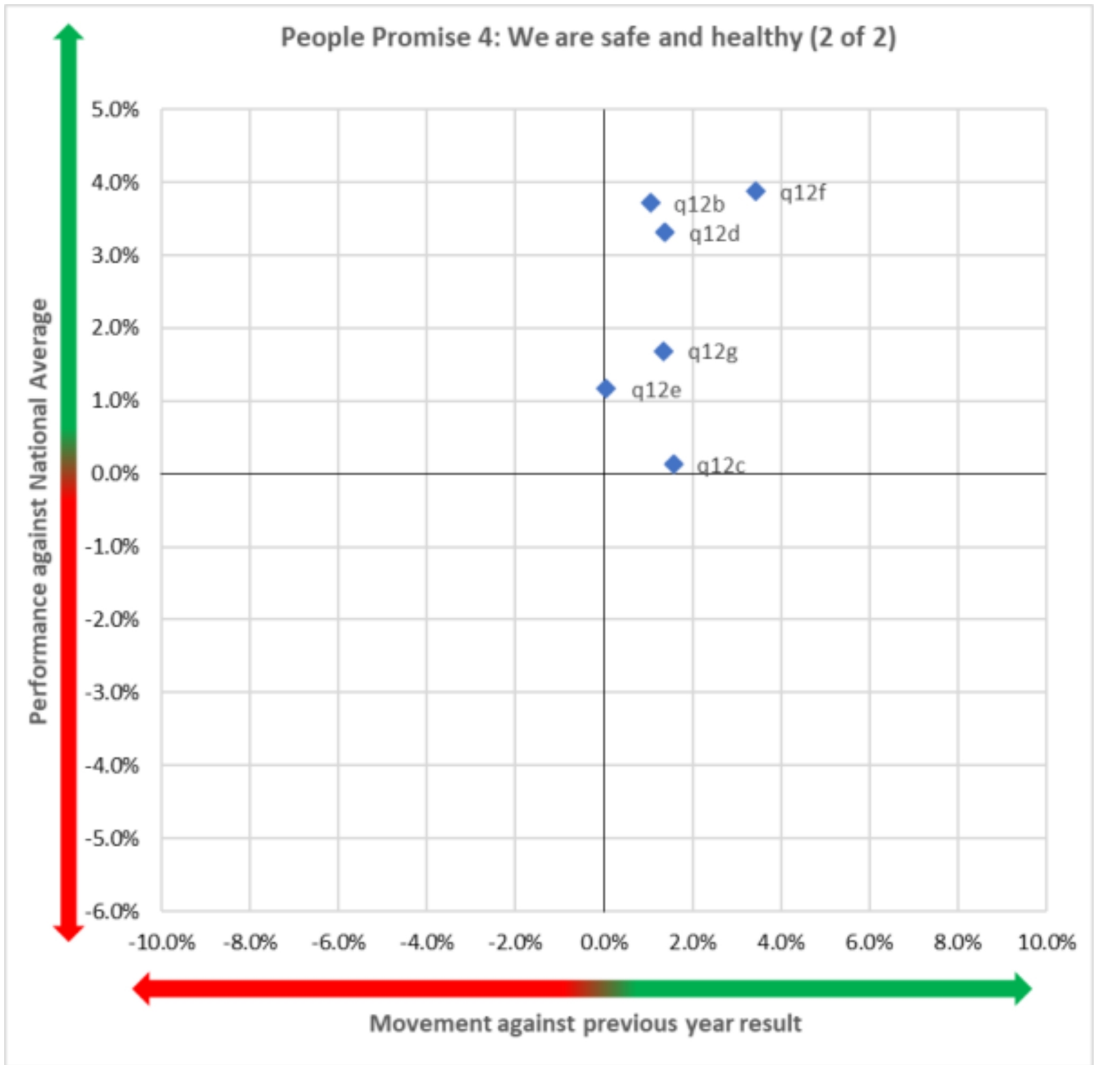
People Promise 3
We each have a voice that counts

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q3a	Always know what work responsibilities are	88.3%	2.7%	86.6%	1.7%
q3b	Feel trusted to do my job	92.7%	2.3%	90.2%	2.5%
q3c	Opportunities to show initiative frequently in my role	78.2%	2.6%	73.4%	4.8%
q3d	Able to make suggestions to improve the work of my team/dept	76.1%	1.2%	71.2%	4.9%
q3e	Involved in deciding changes that affect work	57.4%	3.9%	50.4%	7.0%
q3f	Able to make improvements happen in my area of work	60.1%	2.2%	55.2%	4.9%
5b	Have a choice in deciding how to do my work	55.0%	-0.2%	52.2%	2.8%
q20a	Would feel secure raising concerns about unsafe clinical practice	70.5%	-0.4%	70.0%	0.5%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	55.7%	2.5%	55.1%	0.5%
q25e	Feel safe to speak up about anything that concerns me in this organisation	65.4%	1.9%	60.5%	4.8%
q25f	Feel organisation would address any concerns I raised	50.7%	3.1%	48.0%	2.8%



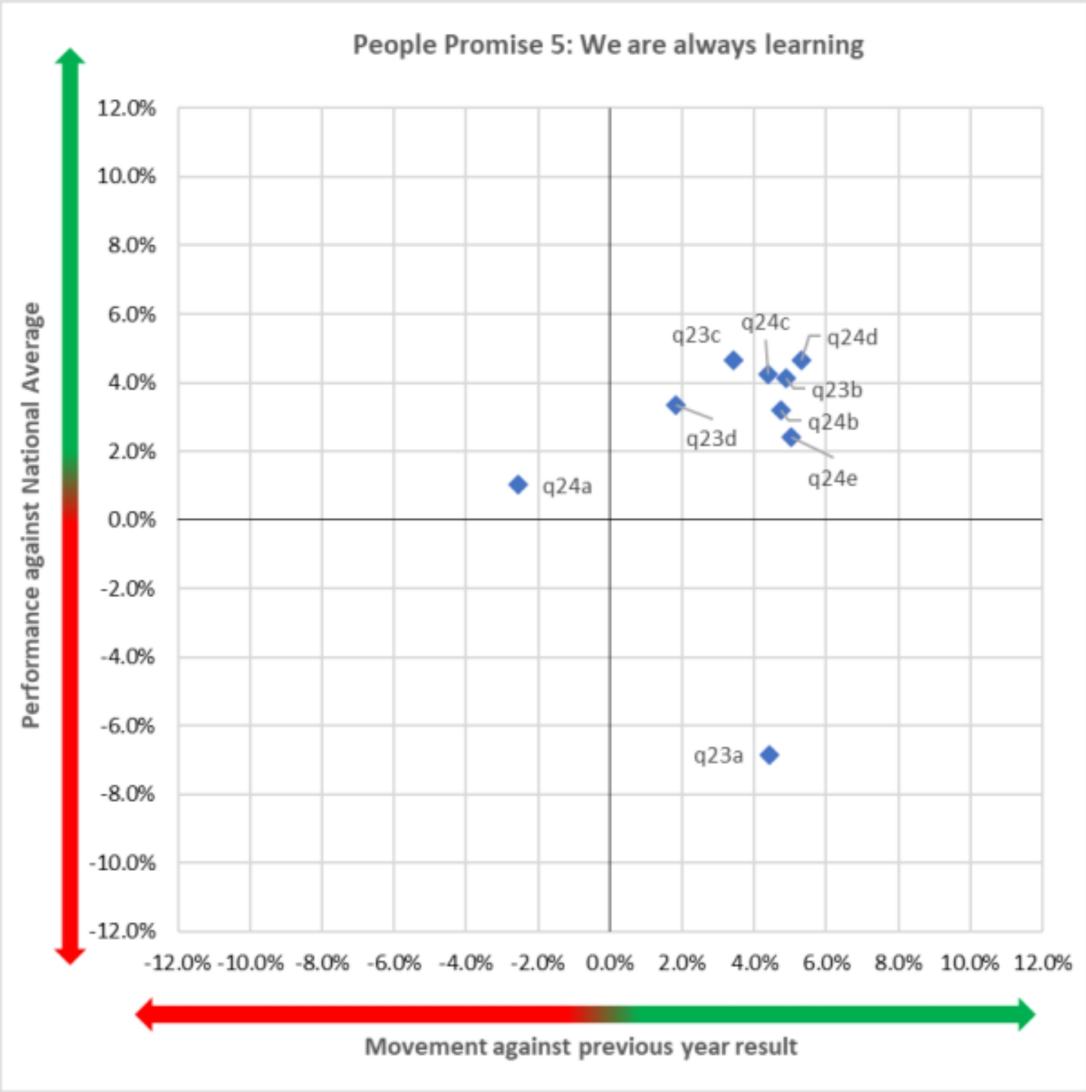
People Promise 4
We are safe and healthy (1 of 2)

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q11a	Organisation takes positive action on health and well-being	58.6%	1.3%	54.9%	3.8%
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	72.4%	-3.1%	70.4%	2.0%
q11c	In last 12 months, have not felt unwell due to work related stress	61.5%	2.0%	59.1%	2.4%
q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	48.9%	-1.0%	45.2%	3.7%
q12a	Never/rarely find work emotionally exhausting	25.0%	1.5%	23.0%	2.0%
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	85.5%	-3.2%	85.7%	-0.2%
q13b	Not experienced physical violence from managers	98.9%	-0.4%	99.1%	-0.2%
q13c	Not experienced physical violence from other colleagues	98.1%	-0.8%	98.0%	0.1%
q13d	Last experience of physical violence reported	75.7%	10.7%	71.4%	4.2%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	77.8%	-0.2%	75.6%	2.2%
q14b	Not experienced harassment, bullying or abuse from managers	92.5%	1.8%	90.3%	2.3%
q14c	Not experienced harassment, bullying or abuse from other colleagues	83.3%	2.4%	81.7%	1.6%
q14d	Last experience of harassment/bullying/abuse reported	52.7%	1.4%	52.5%	0.2%
q3g	Able to meet conflicting demands on my time at work	48.7%	7.3%	47.5%	1.2%
q3h	Have adequate materials, supplies and equipment to do my work	60.7%	5.9%	56.8%	4.0%
q3i	Enough staff at organisation to do my job properly	35.4%	6.9%	32.9%	2.5%
q5a	Have realistic time pressures	24.5%	1.4%	26.1%	-1.5%



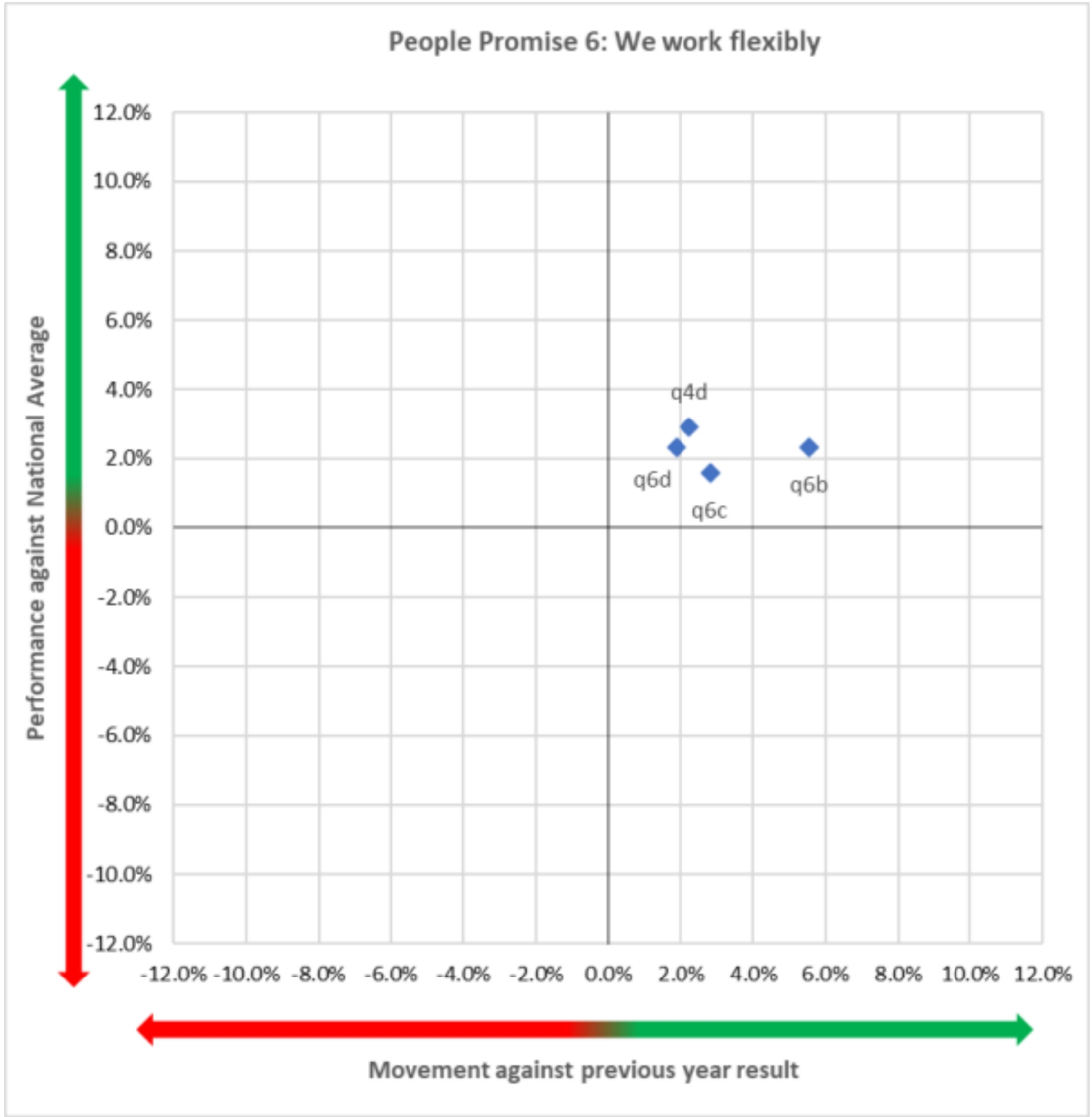
People Promise 4
We are safe and healthy (2 of 2)

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q12b	Never/rarely feel burnt out because of work	34.1%	1.0%	30.4%	3.7%
q12c	Never/rarely frustrated by work	22.3%	1.6%	22.2%	0.1%
q12d	Never/rarely exhausted by the thought of another day/shift at work	40.1%	1.4%	36.8%	3.3%
q12e	Never/rarely worn out at the end of work	20.2%	0.1%	19.0%	1.2%
q12f	Never/rarely feel every working hour is tiring	54.3%	3.4%	50.4%	3.9%
q12g	Never/rarely lack energy for family and friends	37.1%	1.4%	35.4%	1.7%



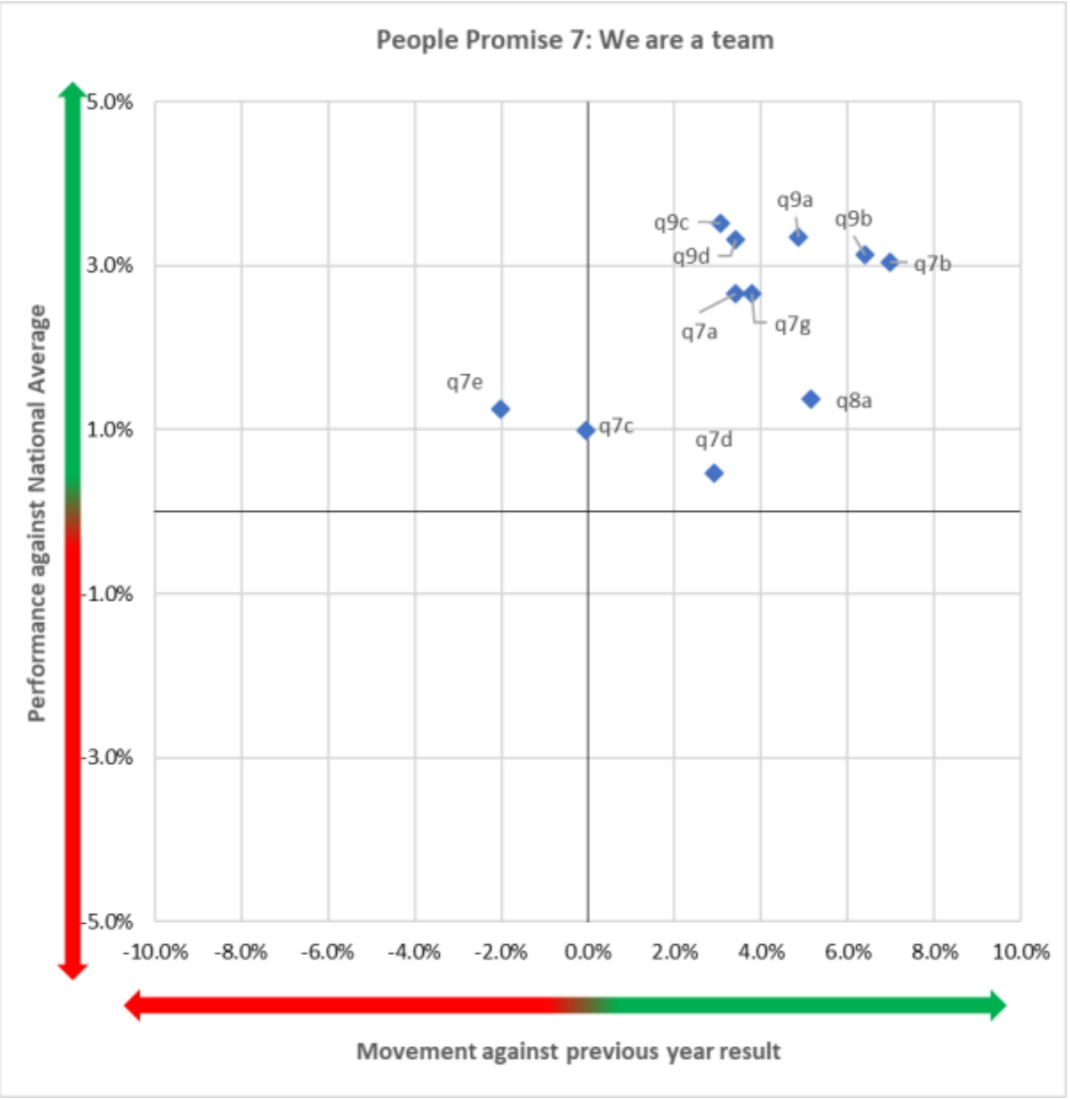
People Promise 5
We are always learning

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q23a	Received appraisal in the past 12 months	77.1%	4.4%	83.9%	-6.8%
q23b	Appraisal helped me improve how I do my job	30.5%	4.9%	26.3%	4.1%
q23c	Appraisal helped me agree clear objectives for my work	40.2%	3.4%	35.5%	4.7%
q23d	Appraisal left me feeling organisation values my work	36.9%	1.8%	33.6%	3.3%
q24a	Organisation offers me challenging work	69.4%	-2.6%	68.4%	1.0%
q24b	There are opportunities for me to develop my career in this organisation	56.8%	4.8%	53.6%	3.2%
q24c	Have opportunities to improve my knowledge and skills	73.6%	4.4%	69.3%	4.2%
q24d	Feel supported to develop my potential	61.1%	5.3%	56.5%	4.6%
q24e	Able to access the right learning and development opportunities when I need to	62.4%	5.0%	60.0%	2.4%



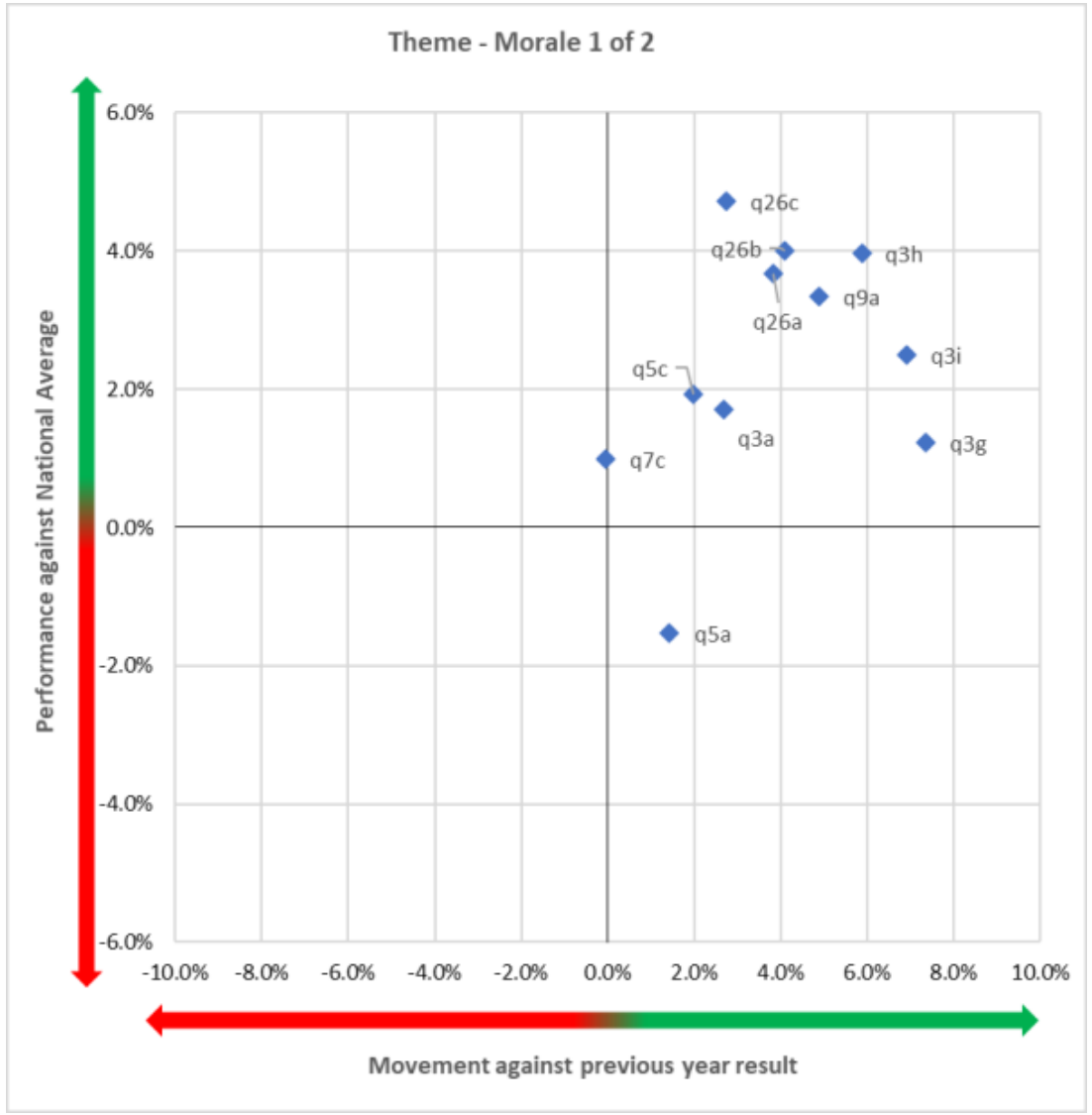
People Promise 6
We work flexibly

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q4d	Satisfied with opportunities for flexible working patterns	58.9%	2.2%	56.0%	2.9%
q6b	Organisation is committed to helping balance work and home life	50.9%	5.6%	48.6%	2.3%
q6c	Achieve a good balance between work and home life	57.4%	2.8%	55.9%	1.6%
q6d	Can approach immediate manager to talk openly about flexible working	72.2%	1.9%	69.9%	2.3%



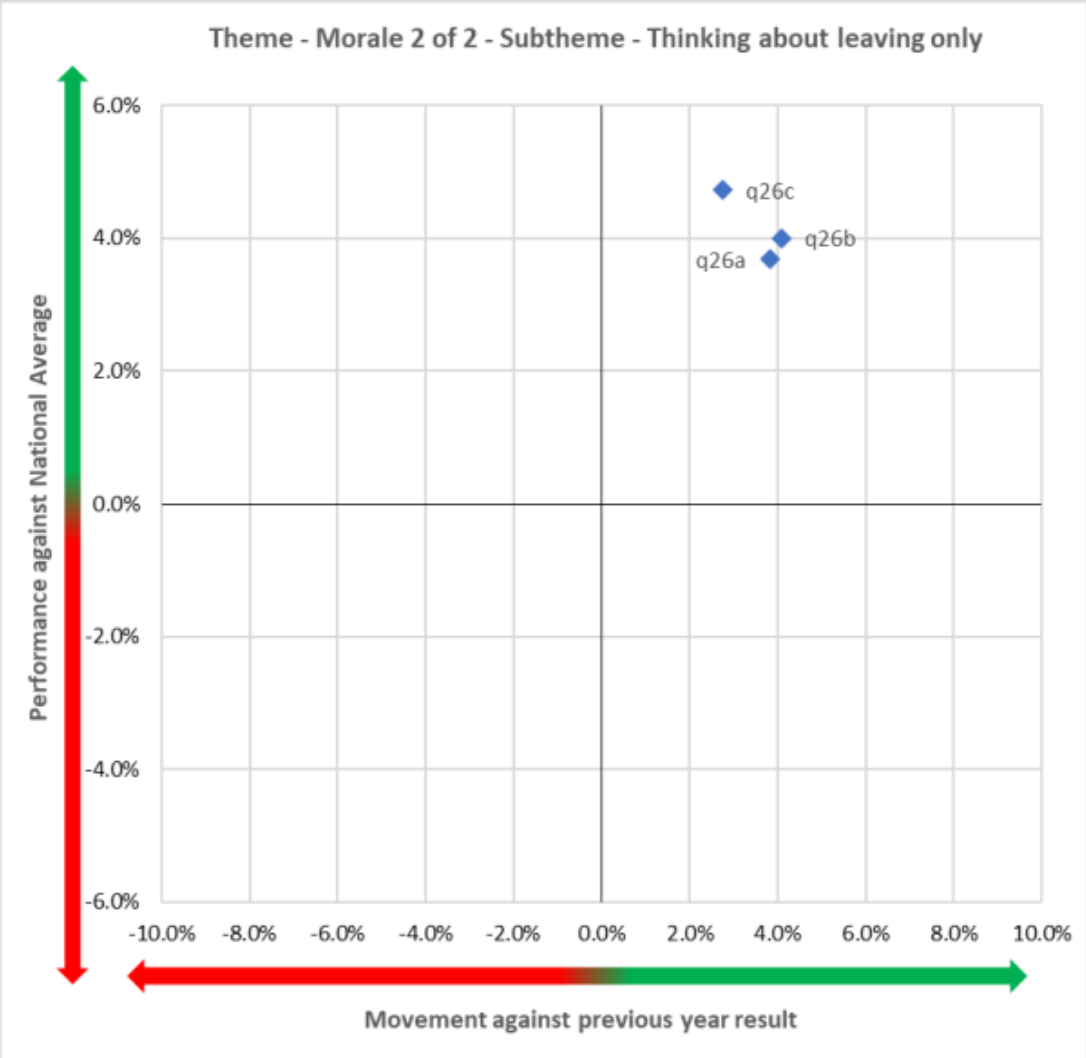
People Promise 7
We are a team

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q8a	Teams within the organisation work well together to achieve objectives	55.2%	5.2%	53.8%	1.4%
q9a	Immediate manager encourages me at work	75.3%	4.9%	72.0%	3.3%
q9b	Immediate manager gives clear feedback on my work	68.2%	6.4%	65.1%	3.1%
q9c	Immediate manager asks for my opinion before making decisions that affect my work	62.4%	3.1%	58.9%	3.5%
q9d	Immediate manager takes a positive interest in my health & well-being	73.5%	3.4%	70.2%	3.3%
q7a	Team members have a set of shared objectives	75.7%	3.4%	73.1%	2.7%
q7b	Team members often meet to discuss the team's effectiveness	64.7%	7.0%	61.7%	3.0%
q7c	Receive the respect I deserve from my colleagues at work	71.3%	-0.1%	70.3%	1.0%
q7d	Team members understand each other's roles	71.5%	2.9%	71.0%	0.5%
q7e	Enjoy working with colleagues in team	81.4%	-2.0%	80.2%	1.2%
q7f	Team has enough freedom in how to do its work	63.8%	3.8%	58.5%	5.3%
q7g	Team deals with disagreements constructively	58.5%	3.8%	55.9%	2.7%



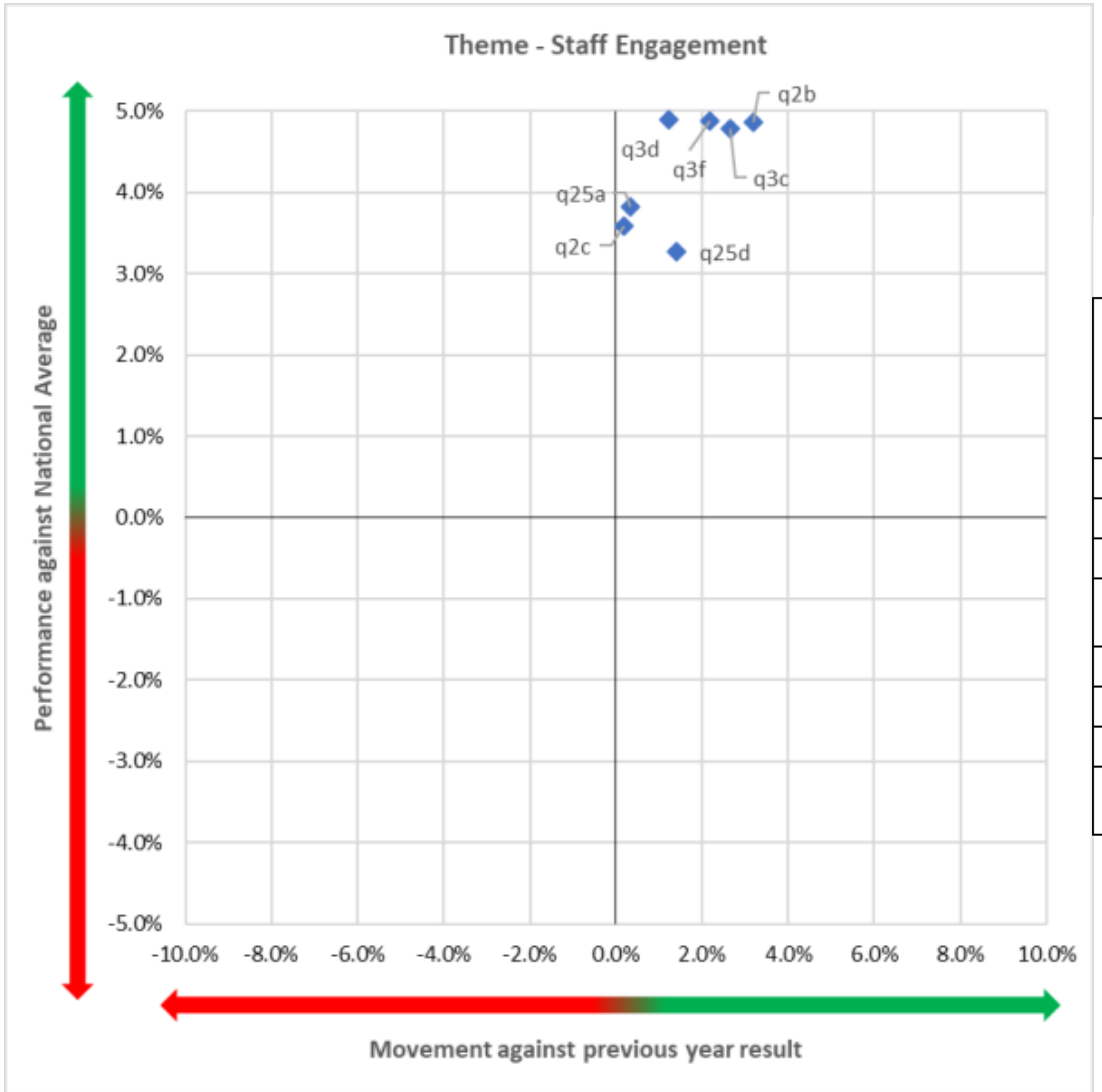
Theme - Morale
1 of 2

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q3a	Always know what work responsibilities are	88.3%	2.7%	86.6%	1.7%
q3e	Involved in deciding changes that affect work	57.4%	3.9%	50.4%	7.0%
q3g	Able to meet conflicting demands on my time at work	48.7%	7.3%	47.5%	1.2%
q3h	Have adequate materials, supplies and equipment to do my work	60.7%	5.9%	56.8%	4.0%
q3i	Enough staff at organisation to do my job properly	35.4%	6.9%	32.9%	2.5%
q5a	Have realistic time pressures	24.5%	1.4%	26.1%	-1.5%
q5c	Relationships at work are unstrained	48.2%	2.0%	46.2%	1.9%
q7c	Receive the respect I deserve from my colleagues at work	71.3%	-0.1%	70.3%	1.0%
q9a	Immediate manager encourages me at work	75.3%	4.9%	72.0%	3.3%
q26a	I don't often think about leaving this organisation	47.0%	3.8%	43.4%	3.7%
q26b	I am unlikely to look for a job at a new organisation in the next 12 months	55.5%	4.1%	51.5%	4.0%
q26c	I am not planning on leaving this organisation	61.4%	2.7%	56.7%	4.7%



Theme - Morale (2 of 2)
Subtheme - Thinking about leaving only

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q26a	I don't often think about leaving this organisation	47.0%	3.8%	43.4%	3.7%
q26b	I am unlikely to look for a job at a new organisation in the next 12 months	55.5%	4.1%	51.5%	4.0%
q26c	I am not planning on leaving this organisation	61.4%	2.7%	56.7%	4.7%



Theme - Staff Engagement

		Actual Score	Vs Last Year	Picker Average	Vs Picker Ave
q2a	Often/always look forward to going to work	61.6%	3.9%	54.3%	7.3%
q2b	Often/always enthusiastic about my job	73.3%	3.2%	68.4%	4.9%
q2c	Time often/always passes quickly when I am working	75.2%	0.2%	71.6%	3.6%
q3c	Opportunities to show initiative frequently in my role	78.2%	2.6%	73.4%	4.8%
q3d	Able to make suggestions to improve the work of my team/dept	76.1%	1.2%	71.2%	4.9%
q3f	Able to make improvements happen in my area of work	60.1%	2.2%	55.2%	4.9%
q25a	Care of patients/service users is organisation's top priority	76.3%	0.3%	72.5%	3.8%
q25c	Would recommend organisation as place to work	66.9%	6.6%	59.1%	7.8%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	64.8%	1.4%	61.6%	3.3%

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Exceeding ambition

2024 NHS Staff Survey results against our ambitions

As at March 2025

Salisbury NHS Foundation Trust

2024 response rate 59.1%, 2644 individuals (response rate 2023 54%, 2022 48%. Median rate 49%)

We aspire to be in the upper quartile for at least one score in the 2025 NHS Staff survey against our 10-year ambition of reaching the upper quartile for all scores

For more information on the National Staff Survey and these results, please visit *https://www.nhsstaffsurveys.com/results/local-results/*

We are compassionate and inclusive

2022 7.1 (average 7.2 best 7.7)

2023 7.26 (avg 7.2 best 7.7) ✓MET

2024 7.38 (avg 7.21 best 7.69)✓MET

2025 ambition 7.4 to 7.6

2026 ambition 7.5 to 7.7

We are recognised and rewarded

2022 5.6 (average 5.7 best 6.4)

2023 5.88 (avg 5.9 best 6.4) ✓MET

2024 6.09 (avg 5.92 best 6..30) ✓MET

2025 ambition 6.1 to 6.3

2026 ambition 6.2 to 6.4

We each have a voice that counts

2022 6.6 (average 6.6 best 7.1)

2023 6.72 (avg 6.7 best 7.2) ✓MET

2024 6.85 (avg 6.67 best 7.14) ✓MET

By 2025 ambition 6.9 – 7.1

By 2026 ambition 7.0 – 7.2

We are safe and healthy

2022 5.8 (average 5.9 best 6.4)

2023 6.02 (avg 6.1 best 6.6) ✓MET

2024 6.24 (avg 6.09 best 6.53) ✓MET

2025 ambition 6.3 to 6.5

2026 ambition 6.4 to 6.6

We are always learning

2022 4.7 (average 5.4 best 5.9)

2023 5.32 (avg 5.6 best 6.1) x NOT MET

2024 5.67 (avg 5.64 best 6.09) ✓MET

2025 ambition 5.7 to 5.9

2026 ambition 5.8 to 6.0

We work flexibly

2022 5.9 (average 6.0 best 6.6)

2023 6.17 (avg 6.2 best 6.9) ✓MET

2024 6.35 (avg 6.24 best 6.86) ✓MET

2025 ambition 6.4 to 6.6

2026 ambition 6.5 to 6.7

We are a team

2022 6.5 (average 6.6 best 7.1)

2023 6.68 (avg 6.6 best 7.2) ✓MET

2024 6.89 (aim 6.7 to 6.9)) ✓MET

2025 ambition 6.9 to 7.1

2026 ambition 7.0 to 7.2

Staff Engagement

2022 6.7 (average 6.8 best 7.3)

2023 6.96 (avg 6.9 best 7.3) ✓MET

2024 7.09 (aim 7.0 to 7.2)) ✓MET

2025 ambition 7.1 to 7.3

2026 ambition 7.2 to 7.4

Morale

2022 5.4 (average 5.7 best 6.3)

2023 5.79 (avg 5.9 best 6.5) ✓MET

2024 6.09 (aim 5.8 to 6.0)) ✓MET

2025 ambition 6.1 to 6.3

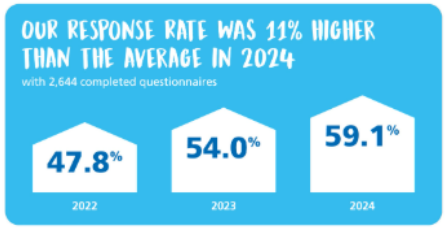
2026 ambition 6.2 to 6.4

2024 ambitions: We exceeded our ambitions in relation to 'Morale' (6.09 vs 5.8 to 6.0 ambition) and 'Always learning' (5.67 vs 5.4 to 5.6 ambition). We met all our other 2024 ambitions bringing us to above average in all 9 areas compared to on or above average for 3 in 2023 and 1 in 2022.

Ranking history: In 2023 and 2024 SFT has ranked as the most improved acute trust.

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

NHS Staff Survey Results 2024



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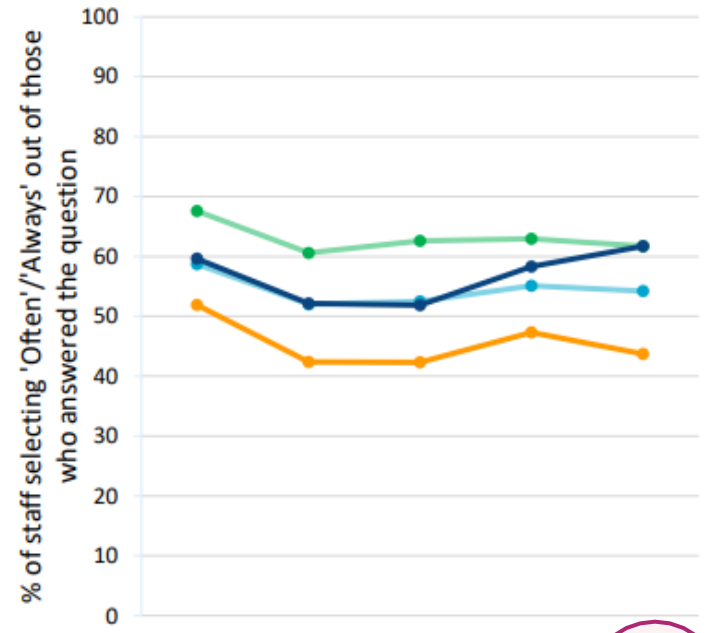
Q2a I look forward to going to work.



	2020	2021	2022	2023	2024
Your org	59.60%	52.13%	51.85%	58.32%	61.70%
Best result	67.56%	60.59%	62.57%	62.91%	61.70%
Average result	58.70%	52.01%	52.47%	55.07%	54.19%
Worst result	51.87%	42.39%	42.30%	47.30%	43.71%
Responses	2048	1868	1848	2248	2626

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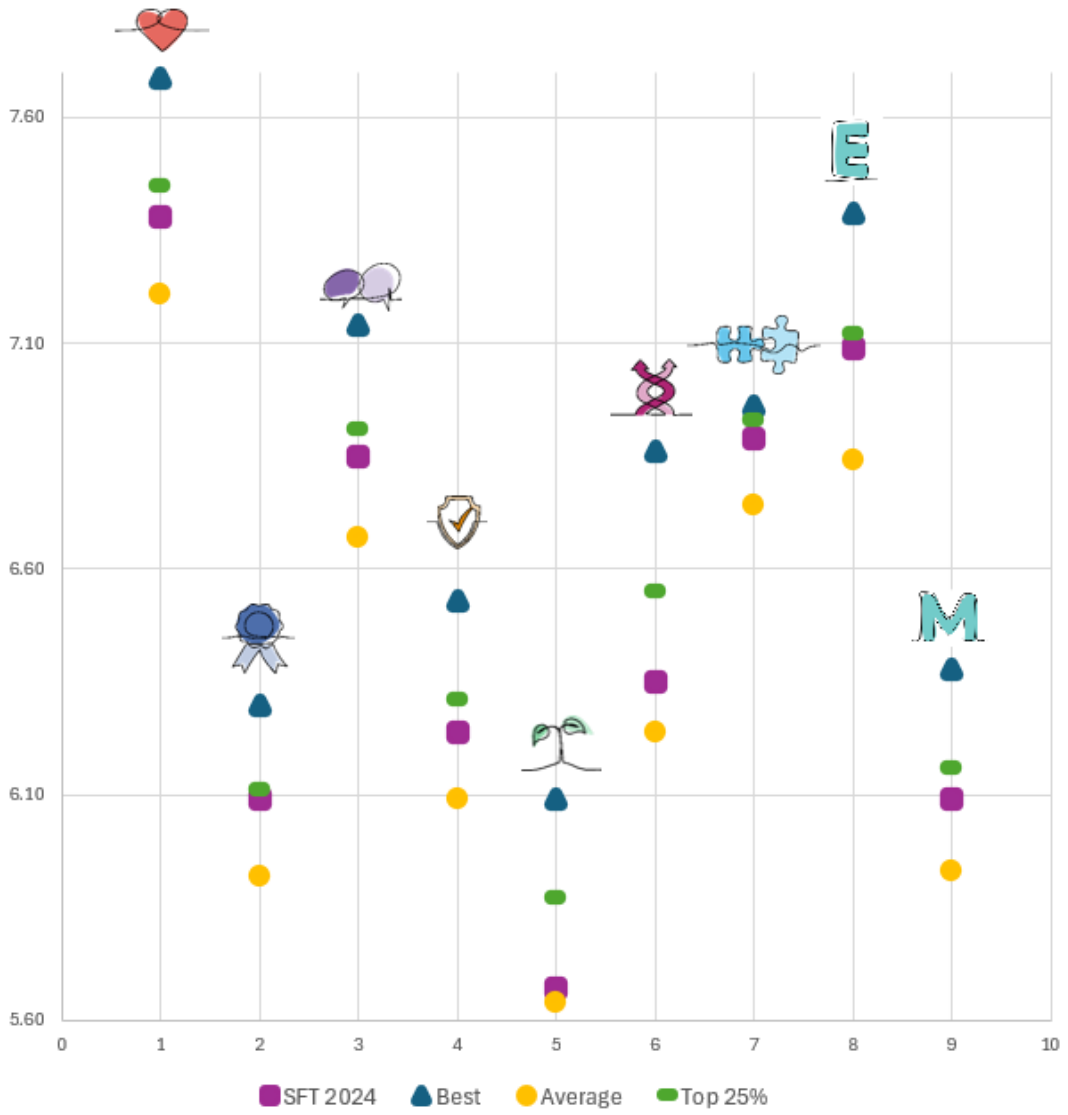
More to do – new ambition

April 2025

Ambition to reach the upper quartile

Scores 2024 Staff Survey scores against average, top 25% and best

We aspire to reach the top 25% in at least one area in the 2025 survey



- We **exceeded our score ambitions** in relation to 'Morale' (5.8 to 6.0) and 'Always learning' (5.4 to 5.6)
- We **met** all our other 2024 score ambitions bringing us to above average in all 9 areas compared to 3 in 2023
- 'Recognised and rewarded', 'Team' and 'Engagement' were **within 0.03 points of top 25% scores**
- We were in the **upper quartile ranking** of trusts for 7 out of 9 areas, and upper half for remainder.
- This far **exceeds our ambition** to reach at least one upper quartile ranking by 2025

People Promise Area	Score Gap (to reach top 25% scores)	Ranking (out of 123 trusts)	Quartile
We are compassionate and inclusive	0.07	26th	✓ Upper quartile
We are recognised and rewarded	0.02	24th	✓ Upper quartile
We each have a voice that counts	0.06	23rd	✓ Upper quartile
We are safe and healthy	0.07	25th	✓ Upper quartile
We are always learning	0.20	56th	• Upper half
We work flexibly	0.20	37th	• Upper half
We are a team	0.03	27th	✓ Upper quartile
Staff engagement	0.03	18th	✓ Upper quartile
Morale	0.07	25th	✓ Upper quartile

We are recognised and rewarded

NHS England

CERTIFICATE OF RECOGNITION AWARDED TO

Salisbury NHS Foundation Trust

With thanks and in acknowledgement of your achievement in improving the experience and engagement of colleagues within your organisation.

Em Wilkinson-Brice — *15th April 2025*

Em Wilkinson-Brice, Director for Staff
Experience and Leadership Development
NHS England

Living the People Promise

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of meeting:	1 May 2025		

Report title:	Health and Safety Q3 Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process: (where has this paper been reviewed and approved):	H&S Committee, Trust Management Committee and People & Culture Committee			
Prepared by:	Troy Ready – Health and Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			
BAF Risk link				

Recommendation:

The Trust Board is asked to note for information the continued H&S performance, the work undertaken across the Trust to improve the management of violence and aggression and the ongoing work to reduce the internal movement of tugs along Maternity Hill.

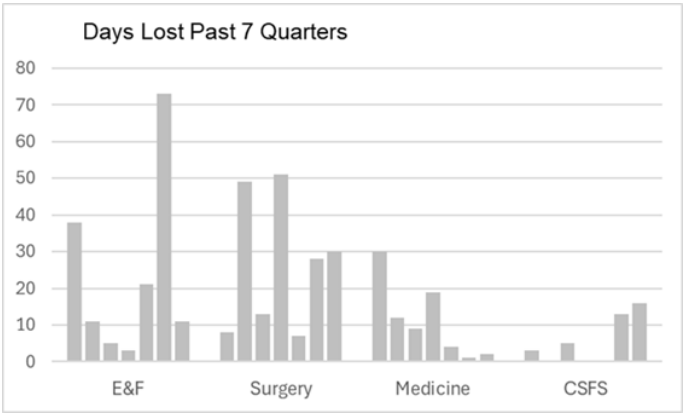
The Trust Board is also asked to note for assurance the steps taken by the Fit Testing Team to ensure the ongoing availability of Filtering Facepiece Protection level 3 (FFP3) masks and steps taken to improve fit test compliance by ward.

Executive Summary:

Performance Results

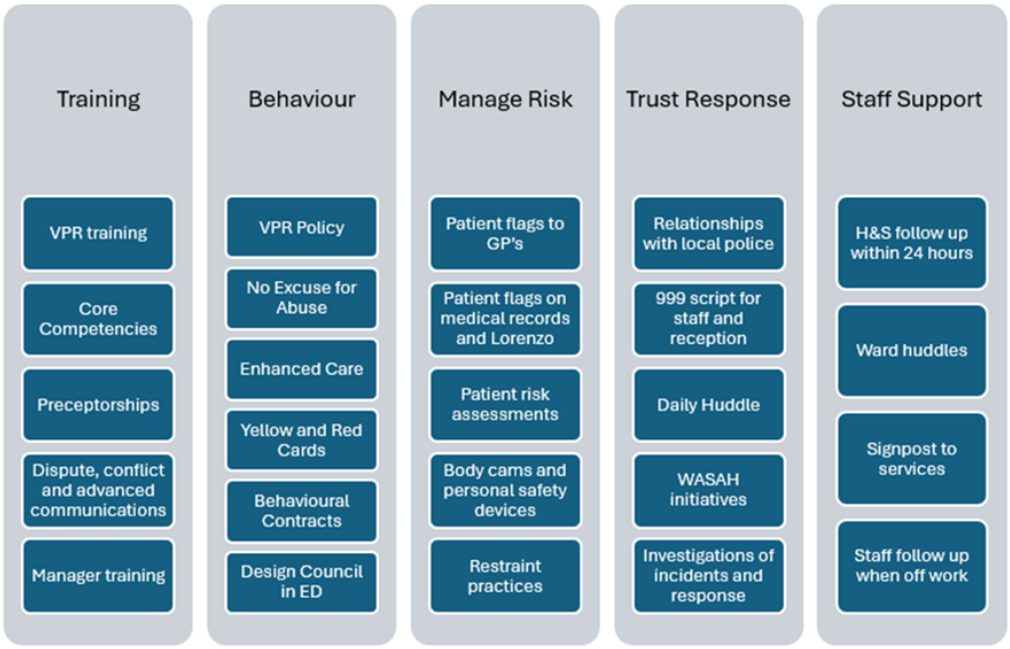
Part of the Trust H&S management system is a requirement to develop performance measures and provide quarterly reports. There has been a standardized collation of data for the past 7 quarters that allows an improved understanding of longer term trends, overall performance and emerging risks.

Over the past 7 quarters, the Trust averages 8 lost time injuries and 70 days lost each quarter due to reported workplace injuries. Q3 saw an increase in lost time injuries (9) but a reduction in the amount of time lost (59) compared against this average. Performance reporting shows relatively low injury rates and therefore 1 injury can skew results significantly. The diagram below shows the days lost per quarter by Division and the impact seen by each spike is the result of 1 or 2 injuries in a quarter. It also shows that these 1 or 2 injuries are generally managed back to work before the next quarter demonstrating effective post injury management to enable a return to work.



Managing Violence and Aggression

As noted in previous reports, violence and aggression continues to be the most reported injury, incident or near miss. And as noted previously incidents are the result of antisocial behaviour, mental health and confusion / delirium. The Trust continues to take significant steps to reduce the risk of violence and aggression, respond to patients and the ongoing support of staff. An overview of the actions taken by the trust to manage violence and aggression is seen in the diagram below.



Managing the Internal Movement of Tugs

As noted in previous reports, consultation with departments that use tugs continued in Q3. Several risks regarding the state of the roads were identified at keys points that could likely cause injury to tug operators and works have commenced to rectify these areas. Work also continues to explore alternative moving equipment required to reduce the risk of manual handling injuries. There are various options available to assist with moving equipment across the Trust but steep gradients on Maternity Hill mean the devices typical used are not suitable. Alternatives are available and are being explored as a replacement to the use of tugs.

Fit Testing

Fit test bookings moved to MLE (Learn) in mid-2024 to streamline the booking process and to measure overall compliance by ward. Doing so proved to be a timely action because the Alpha Solway mask (called the 3030) fitted to the majority of staff was removed from circulation by the supplier and replaced with a similar mask, that did not have the same pass rates. Compliance reports have been distributed to departments to increase overall compliance rates for fit testing in Q4 and the Fit Test Team has increased

the number of appointments by reducing fit test appointment times and undertaking tests in departments to improve compliance rates.

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

HEALTH AND SAFETY PERFORMANCE REPORT

FY25 - QUARTER 3

Salisbury NHS Foundation Trust

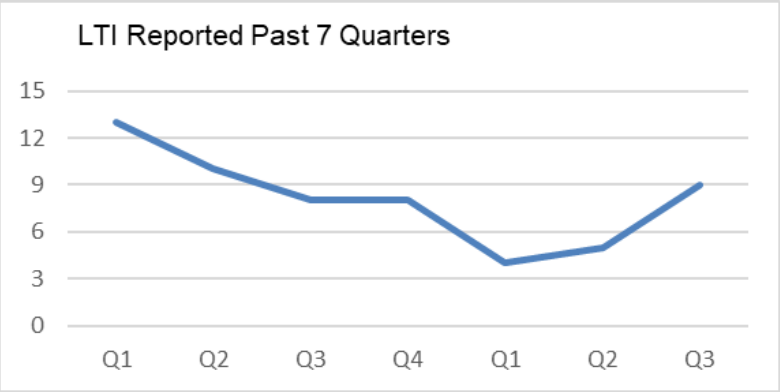
1. Performance Measures

Overall performance when viewed against historical performance by quarter looks relatively stable in Q3. The tables below show that whilst quarter by quarter performance does vary widely, the overall performance over the past 7 quarters looks stable. Q3 performance is on par with these historic averages.

Lost Time Injuries

The number of lost time injuries increase in Q2. A trend that continued in Q3. Over the past 7 quarters the Trust reports an average of 8 lost time injuries a quarter. Q3 saw 9 reported

The table below shows the average number of lost time injuries across the Trust by quarter and the average for each Division (with more than 1 injury reported) over the past 7 quarters.



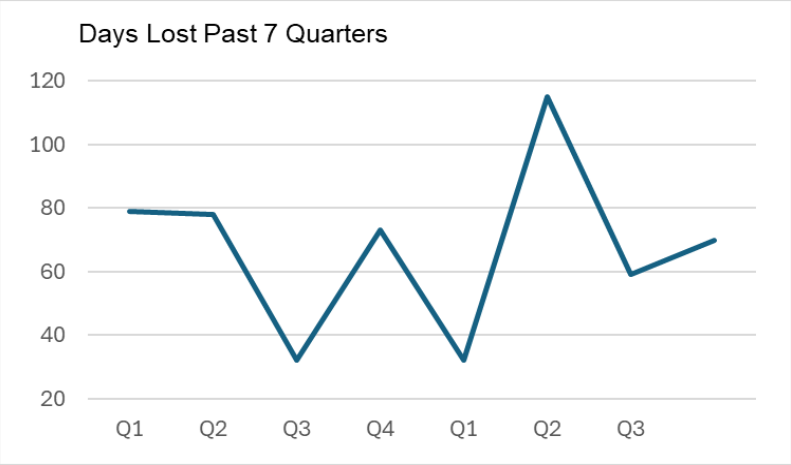
Division	Quarterly Average
E&F	1.8
Surgery	3.8
Medicine	2.4
CSFS	2

Q3 performance is broadly in line with these historic averages. It should be noted that 8 of the 9 injuries that resulted in lost time were reported as musculoskeletal injuries from manual handling and 3 were an exacerbation of a preexisting injury.

Time Lost

Days lost vary widely by quarter with an average of 70 days lost per quarter. Once again, Q3 performance is broadly reflective of this average with 59 days lost.

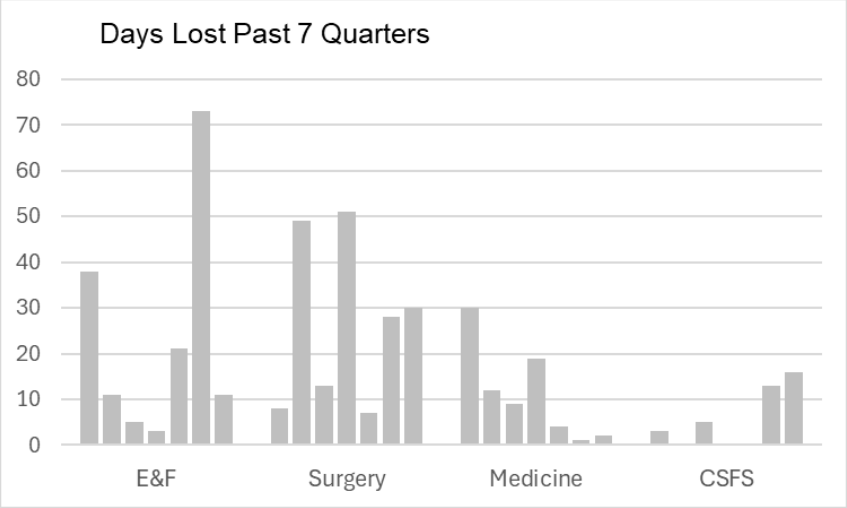
The table below shows the average number of days lost across the Trust by quarter and the average for each Division (where there was more than 1 episode of lost time) over the past 7 quarters.



Division	Quarterly Average
E&F	23
Surgery	27
Medicine	11
CSFS	9

Further analysis of injury data however shows each peak is often the result of 1 or 2 injuries within a division. It is encouraging to note:

1. All staff who reported a lost time injury in Q1 and Q2 have returned to work.
2. Half of the time lost in Q3 was the result of 2 staff members who sustained a RIDDOR reportable injury late in Q2 and have returned to work at the time of reporting.
3. The average time lost for work related injuries reported in Q3 was 3 days.
4. YTD days lost equate to 0.01% of all hours worked and the population of staff injured at work is less than 0.5% of the workforce.



Injury Classification by Division

Division	Incidents reported	No Harm	Minor Harm	Moderate Harm	Serious Harm
Corporate	5	3	2	-	-
CSFS	82	42	33	7	-
Estates and Facilities	34	24	3	3	1
Medicine	97	49	45	3	-
Surgery	86	54	25	4	-
W&N	5	3	2	-	-

Injury and Frequency Rates

Injury and Frequency Rates by Division										
	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	RIDDOR	YTD
Estates & Facilities	11	105	3	4	15	6.8	4.2	13	-	1
Surgery	30	65	4	8	5.2	3.5	2.9	2.1	1	3
Medicine	2	7	2	5	3.2	2.7	0.3	0.3	-	-
W&N	-	-	-	-	-	-	-		-	-
CSFS	16	29	-	4	-	2.7	2.7	1.2	2	4
Corporate	-	-	-	-	-	-	-		-	-
Total	**59**	**206**	**9**	**21**	**3.2**	**2.5**	**1.6**	**1.8**	**3**	**8**

Definitions:
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive
Near Miss is an incident that did not result in harm to staff.

Analysis and Commentary

Despite quarter-by-quarter fluctuations in time lost and injuries, the fluctuations are the result of a small cohort of staff who sustain an injury at work. A small increase in the number of injuries reported has a significant impact on quarterly performance. A broader look at performance over the past 18 months shows relatively stable performance results with consistent or slight improvements in injury rates.

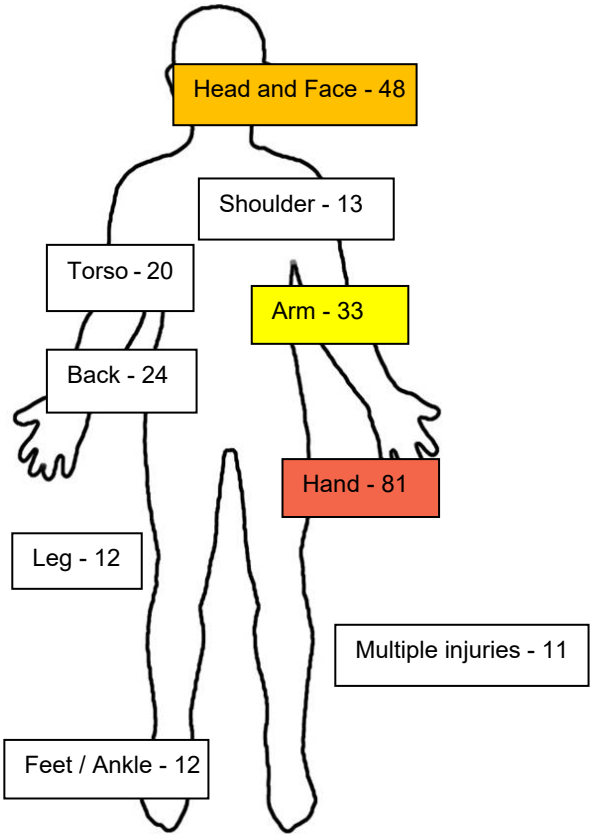
The Injury Classification by Division table shows, despite the increased reports in injuries and incidents year on year, the frequency of moderate injuries is low and therefore the time taken to return to work continues to fall where there is early engagement to support staff off work.

2. Injury Statistics
Compared to this time last year:

- There is improved classification of incident classifications and opportunities to identify trends,
- Manual handling injuries remain steady,
- There is an increase in sharps injuries and slips and trips, and
- There is an increase in violence and aggression that remains the most reported incident.

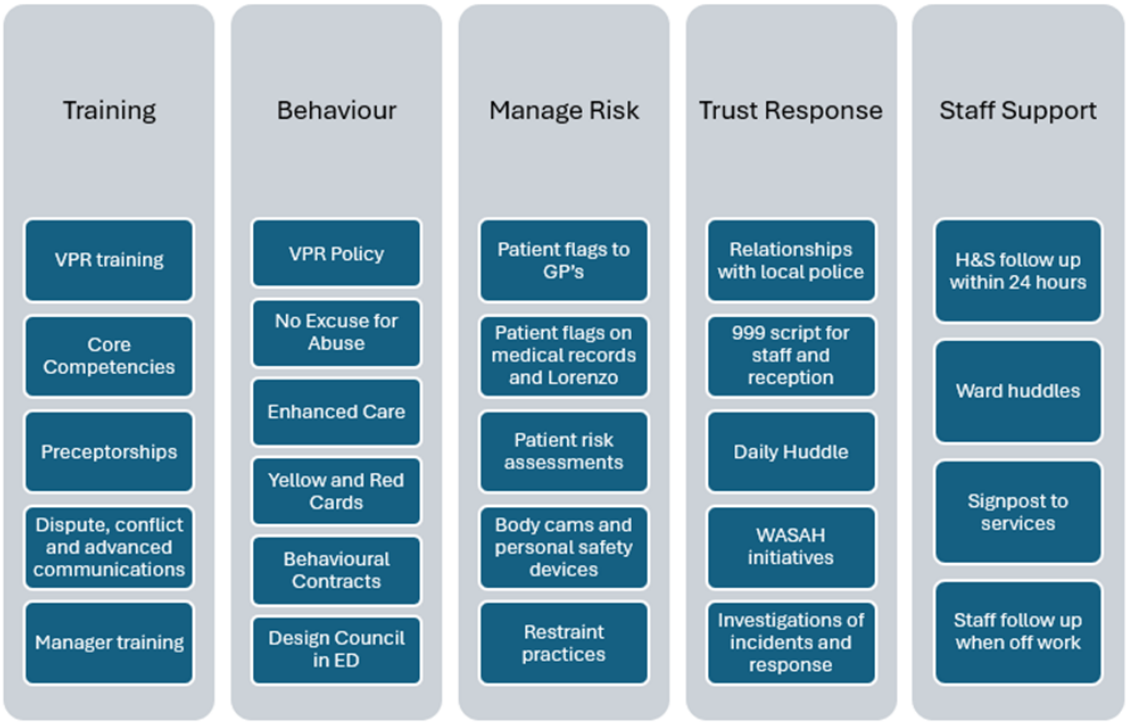
Datix Reports by Type	Q3		YTD	
	FY24	FY25	FY24	FY25
Violence and aggression	38	66	84	152
• Antisocial behaviour		23		52
• Violence and Aggression – mental health		19		46
• Violence and Aggression – confusion and delirium		24		54
Manual handling	11	11	25	31
Struck an object	-	4	4	11
Near miss	30	24	41	70
Damage, broken equipment and Infrastructure failure		10		27
Slip and trips and falls	11	15	22	47
Struck by a moving object	4	1	15	16
Other	1	2	7	12
Exposure to sharps	5	16	14	45
Biological exposure (inc incorrect waste disposal)		10		17
Radiation exposure		3	2	5
Electrical exposure				1
Chemical exposure	1	2	5	4
Lacerations	1	5	2	13
Total	**102**	**172**	**221**	**451**

2.1 Injuries by Body Location



3. Managing Violence and Aggression

Over the past 18 months there has been significant number of steps taken to reduce the risk of violence and aggression and improve the support offered to staff exposed to violence and aggression. There are tools and resources available to support managers who are expected to provide the initial response to, and support for, violence and aggression.



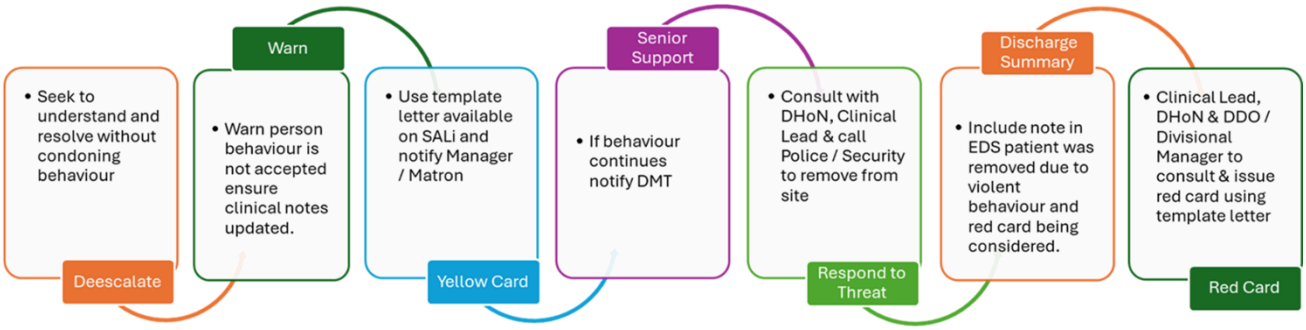
But as with all new processes, there are some areas to improve that are being actioned by the H&S team and the Violence Prevention and Reduction Working Group. These include:

Red and Yellow Cards

It should be noted the management of an immediate threat to the safety of staff does not require a patient or individual to be issued with a red card to be removed from the Trust. Staff can utilise security and 999 to manage this threat where appropriate to do so.

Datix fields have been updated to include reference to yellow and red cards with dates of issue, and for review, with a report template created on Datix to identify who has been issued with cards and when they are due to be reviewed. The Violence Prevention and Reduction Working Group will act as a review point to rescind yellow and red cards by including this report as a standard agenda item for discussion. Staff who issued a card will be notified by the Chair of the Violence Prevention Group of an expiry date and the patient / GP will be notified by a standard response letter available on SALi.

The process of issuing yellow and red cards has been outlined in the below diagram. Template letters are available, to notify patients and GP's, are available on SALi and will be included in training packages being developed for staff.



But where a red card is being considered, the need for consultation to determine if a red card is appropriate or not must be undertaken by the Clinical Lead, DHoN and Operations Lead and may in most circumstances be agreed after a patient has been discharged.

Information is shared with the GP through a template letter but there is a need to communicate to the GP in a timely manner. The most appropriate action is to include a note in the electronic discharge summary that the patient was removed from the Trust due to violence and aggression and the Trust is considering a decision to issue a red card.

Supporting staff

A number of breakfast seminars have been listed on MLE, and scheduled throughout the year, to introduce ward leaders to investigating health and safety related injuries and responding to and managing injuries. One element of this session is the immediate response to staff exposed to violence and aggression and the expected actions to be taken by ward leaders such as huddles and the ongoing support for staff if off work.

4. Reducing the Internal Movement of Tugs

As noted in the previous H&S report, a detailed paper outlining the use, users, approved routes of travel and directions of travel for tugs was agreed by the H&S Committee.

The consultation period has begun and a number of concerns have been raised by some managers. Specifically, the impact walking will have on service delivery and the conditions of access points and some road areas. These issues continue to be worked through with the H&S Manager and Departments.

There is however a need for the Trust to consider purchasing a number of pedestrian operated tugs that are used to tow cages and trolleys that eliminates the manual handling risk that comes with moving equipment unaided. Such tugs are already used by Theatres to move surgical flight boxes and the Supply Chain Team to move supplies throughout the hospital.

Action
Continue consultation period and explore provision of pedestrian operated tugs that are used to tow cages and trolleys. Such tugs are already used by Theatres to move surgical flight boxes and the Supply Chain Team to move supplies throughout the hospital.

5. Auditing, Ward Inspections and Risk Assessments
During Q3, the H&S team conducted an external audit of the Bath Swindon and Wiltshire Integrated Care Board (BSW ICB). The Trust H&S team has signed a commercial agreement with the BSW ICB, who approached the H&S Manager, with a request to become the competent person to advise the BSW ICB on matters affecting H&S. During November the H&S team met with the Associate Director of Estates, who is tasked with H&S management, to audit 3 of the 4 BSW ICB offices.

An audit schedule for Q3 and Q4 has been developed and approved by the H&S Committee for the first half of the 2025 FY. The first areas to be audited will include the Wessex Rehabilitation Workshop in January and the Odstock Health and Fitness Centre in February and Pharmacy in March. Inspections of wards are due to commence earlier in the new year.

6. Lone Working Policy
There are a number of departments that have staff working remotely either in a patient home, in a satellite space or in isolation. Some departments have local procedures to manage the risk of lone working but tit was recognised a Trust policy on the management of risks to the H&S of staff in this situation did not exist.

Such a policy is now being developed for review and comment by the H&S Committee in Q4.

7. Fit Testing
Fit test bookings moved to MLE (Learn) in mid-2024 to streamline the booking process and to measure overall compliance by wards.

As noted in Q2, the Alpha Solway mask (**3030**) fitted to the majority of staff was removed from circulation by the supplier and replaced with a similar mask. Assurances from the manufacturer suggested pass rates would be similar to the previous mask yet showed otherwise and an alternative mask was sourced. Compliance under NHS guidance states staff are compliant if fitted to 2 masks and retested every 2 years but to address increased demand to fit test staff who no longer have access to an FFP3 mask, the fit test team has prioritised testing for staff new to the Trust or previously fitted to the mask no longer available and not staff who have been fit tested to a mask that remains available within the Trust. The fit test team has increased the amount of testing spots available and test to 1 mask whilst this backlog of non compliant individuals are fit tested.

A compliance report shows the level of fit test compliance by ward where the 303 was available and now that the 3030 is not available. As noted, there are some wards affected by the change in mask, whilst other wards had overall poor compliance. This report has been distributed to departments and divisional managers and work is underway to increase overall compliance rates for fit testing in Q4.

Q3					
Department	with 3030 mask	without 3030 mask	Department	with 3030 mask	without 3030 mask
Radnor	64%	53%	Downton	33%	14%
Amesbury	49%	22%	Sarum	38%	25%
AMU	53%	20%	Whiteparish	63%	28%
Chilmark	67%	40%	Pitton	33%	10%
Laverstock	69%	22%	Longford	63%	33%
Spire	56%	25%	Redlynch	46%	30%
Imber	60%	30%	Maternity	39%	18%
Odstock	65%	40%	Sexual health	78%	26%
Tisbury	73%	43%	Hospice	43%	32%
Farley	31%	6%	NICU	52%	24%
Durrington	49%	20%	Pembroke	75%	35%
Britford	38%	13%	ED	54%	31%
Breamore	63%	43%	Bank	18%	10%

8. Trust Risk Register

Risks reported in Q2, with an element of H&S and a risk score of 8 or above remain in Q3

- 7 risks relate to the risk of violence and d the risk to the H&S of staff. As noted above, there has been a considerable number of actions developed and agreed by the VP&RWG but the risk to the H&S of staff remains given the unpredictable nature of patients with mental health issues, dementia, confusion and delirium or antisocial tendencies.
- 30 relate to the quality of the buildings, areas in need of repair, outstanding maintenance work or the insufficient funding to conduct maintenance activities or lack of desk / office space. These risks have a H&S element but are reported through to the F&P Committee and to the Board to discuss the resources required to manage these risks. The H&S Manager continues to schedule quarterly risk reviews with the Head, and Deputy Head, of Estates to review high or long standing risks on the Trust Risk Register.

Risks of particular note are outlined below.

HEALTH AND SAFETY PERFORMANCE REPORT

FY25 - QUARTER 3

NHS Salisbury NHS Foundation Trust

Risk ID	Rating	Description	Action
7931	16	Theatres electrical power is reliant upon extension leads that are not supported by UPS	Extension leads are being used for surgical equipment due to insufficient sockets and are not protected by IPS/UPS sockets. This compromises the reliability and safety of critical healthcare infrastructure. A fortnightly inspection continues to be carried out by the estates, medical devices and theatres teams whilst the UPS/IPS protected socket project is being explored.
7932	16	Wyle house electrical earth failure poses a risk to staff in accommodation should worn and frayed electrical equipment be used.	The cabling installed during construction is breaking down. A Project Manager has been nominated to manage a replacement project and current mitigation has been to replace metal items such as faceplates and light fixtures with plastic ones to eliminate conductive risks.
7917	15	Fire risk in main theatres due to the volume of goods stored in theatre corridors	Simple but effective actions have been taken to reduce the risk such as practice evacuations, clearer evacuation plans and practice evacuations and removal of racking adjacent to isolation valves, but the volume of equipment continues to expand and theatre trays wrapped in paper offer an ongoing source of fuel should a fire start. After a walk through with the MD and Fire Officer, a review of storage and availability of storage areas away from theatres has been commenced to reduce congestion in the corridors.
3184	12	Insufficient staff and funding of the ETS program to conduct planned and scheduled maintenance	Paper to be submitted to the H&S Committee in Q3 will be submitted in Q4, but many of the risks regarding insufficient funding are reported through to the F&P Committee.

Report written by
Troy Ready
Health and Safety Manager
January 2025

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	1 May 2025		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices:	Board Assurance Framework May 2025 Summary CRR Tracker v1 March 2025 Corporate Risk Register March 2025			

Recommendation:

Trust Board are asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- Risk Appetite

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out of tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.

Executive Summary:

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

The risk appetite was approved by the Board in October 2024. This was a significant process change which included adoption of new risk types, risk definitions and risk appetite. This has been applied to each risk within the BAF and CRR. The Trust has moved from an open risk appetite to a more cautious approach to risk which has markedly impacted the status of risks out of tolerance and is reflected within the BAF and

CRR dashboards. This was acknowledged by the Board Committees and Trust Board when presented in November 2024 and January 2025 respectively. This is subject to ongoing review.

The strategic risk profile has not changed significantly since last reported. Despite 4 corporate risks having reduction in scores, these risks are still out of tolerance given their applied risk appetites. The risk profile is reflective of the significant risks the Trust is facing as we enter 2025/26 relating to the financial position, risk to delivery of the 2025/26 Operational Plan given the scale and pace of transformation required, the estate and digital resilience.

There are 12 strategic risks, with one new risk (BAF 11) relating to the scale and pace of the transformation required to deliver the 2025/26 Plan. There have been no changes to the risk scores.

There are 11 BAF risks out of tolerance. Whilst not unexpected with a move to a much more cautious risk appetite, this is subject to ongoing review.

There are 20 risks on the CRR, unchanged since the last report. There is one new risk and one risk was de-escalated. The corporate risk profile is reflective of the key challenges relating to the financial position, workforce sustainability, the estate and operational challenges relating to demand and capacity. There are 17 risks out of tolerance although 5 risks have reduced scores.

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement. The application of the new risk appetite approved by the Board in October 2024 has resulted in 28 risks out of tolerance across the BAF and CRR. This is subject to ongoing review. The current risk profile reflects the operational, financial and workforce challenges which ultimately have potential to impact the quality of care provision.

Feedback from the Board Committees in March 2025

The Committees acknowledged the overall shift in risks out of tolerance and that the Board had set a more averse risk appetite given the complexity of the NHS currently. The general understanding was that over the coming year, there may be more risks moving out of tolerance recognising the National NHS landscape. The financial performance drives the Finance and Performance Committee agenda and is discussed in depth and the financial risks are well understood. The significant reduction in the risk score relating to access to CT perfusion (CRR 8250) was noted at Clinical Governance Committee. The Committee also acknowledged the strengthening of the workforce risk and increase in risk score relating to the workforce controls (CRR 7472) and the potential to impact on patient safety as a result of potential workforce gaps. The Trust Management Committee discussed BAF risk 1 and the slippage in the Electronic Patient Record Programme. The score has subsequently been increased to 15 from 12.

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

Salisbury NHS Foundation Trust

Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report

Purpose

1.1 The purpose of the report is to provide an updated BAF and CRR providing all relevant information to the Board and Board Committees on the risks to achievement of the strategic objectives and their management.

2 Background

2.1 The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. The provision of healthcare involves risks and being assured is a major factor in successfully controlling risk.

3 Summary Strategic Risk Profile

3.1 Overall summary

The risk appetite was approved by the Board in October 2024. This was a significant process change which included adoption of new risk types, risk definitions and risk appetite. This has been applied to each risk within the BAF and CRR. The Trust has moved from an open risk appetite to a more cautious approach to risk which has markedly impacted the status of risks out of tolerance and is reflected within the BAF and CRR dashboards. This was acknowledged by the Board Committees and Trust Board when presented in November 2024 and January 2025 respectively. This is subject to ongoing review.

The strategic risk profile has not changed significantly since last reported. Despite 4 corporate risks having reduction in scores, these risks are still out of tolerance given their applied risk appetites. The risk profile is reflective of the significant risks the Trust is facing as we enter 2025/26 relating to the financial position, risk to delivery of the 2025/26 Operational Plan given the scale and pace of transformation required, the estate and digital resilience.

3.2 BAF summary

There are 12 strategic risks, with one new risk (BAF 11) relating to the scale and pace of the transformation required to deliver the 2025/26 Plan. There have been no changes to the risk scores.

3.3 BAF Risks Out with Tolerance

There are 11 BAF risks out of tolerance. Whilst not unexpected with a move to a much more cautious risk appetite, this is subject to ongoing review.

3.4 CRR summary

There are 20 risks on the CRR, unchanged since the last report. There is one new risk and one risk was de-escalated. The corporate risk profile is reflective of the key challenges relating to the financial position, workforce sustainability, the estate and operational challenges relating to demand and capacity.

There are 17 corporate risks out of tolerance although 5 risks have reduced scores.

New risks since December 2024:

There is 1 new risk:

- Risk 8334 (People): The Education Administration team have identified data quality issues within the SFT on-line learning platform (Kallidus Learn MLE) that means the reporting of Trust compliance to the core Mandatory & Statutory training (MaST) subjects is inconsistent and lack assurance as to it accuracy across the 11 core subjects (Score 12).

Risks removed:

- Risk 7090 (Population): Overall colonoscopy capacity provided by the sites is lower than was planned/required in the current year. SDH is delivering the requirement RUH and GWH are not. The service is not delivering the standard of 2 weeks of appointment to first offered diagnostic test and surveillance patients are not being seen. This risk has been de-escalated to the Surgery Divisional risk register.

Risks with an increased score:

- Risk 7472 (People): As a consequence of a challenging financial position plus additional workforce controls, we may not be able to replace/recruit or train staff to key positions. To achieve an improved optimisation of workforce and commensurate reduction financially and in WTE, there is a need to reconfigure services and roles. Vacancies may compromise service delivery and safety. Score 12 to 15. The score has been increased to reflect the increased workforce controls and current financial position.

Risks with a decreased score:

- Risk 5751 (Population): Risk of patient harm caused by a delayed discharge from hospital. Score 20 to 16.
- Risk 8102 (Population): Current vacancy rate in Central Booking 9.5wte. Current theatre utilisation is not meeting Trust KPIs (approx 70-90 theatre slots not booked per week). Risk of patient harm due to significant backlog of referrals which are triaged but not transferred to Lorenzo. Risk to delay of patient follow up due to backlog of e-outcome forms. Score 20 to 10. Current score reflects improvements in staffing.
- Risk 8250 (Population): Lack of 24/7 access to CT perfusion and CT angiography for patients with acute ischaemic stroke there is a risk that patients will not be able to receive life changing treatment as per national guidance. Score 20 to 12.
- Risk 7308 (Partnerships): The financial plan for 2025/26 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Score 20 to 15.

4 Summary

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement. The application of the new risk appetite approved by the Board in October 2024 has resulted in 28 risks out of tolerance across the BAF and CRR. This is subject to ongoing review. The current risk profile reflects the operational, financial and workforce challenges which ultimately have potential to impact the quality of care provision.

5 Recommendations

5.1 The Trust Management Committee is asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework
- Corporate Risk Register
- The risk appetite

Specifically, the Committee is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out of tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Fiona McNeight
Director of Integrated Governance

Salisbury NHS Foundation Trust

Our Vision is to provide an outstanding experience for our patients, their families and the people who work for and with us.

Board Assurance Framework
May 2025

Fiona McNeight

Director of Integrated Governance

Board Assurance Framework

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

Trust Values

The core values and behaviours to support the achievement of the Trust vision:

Strategic Priorities

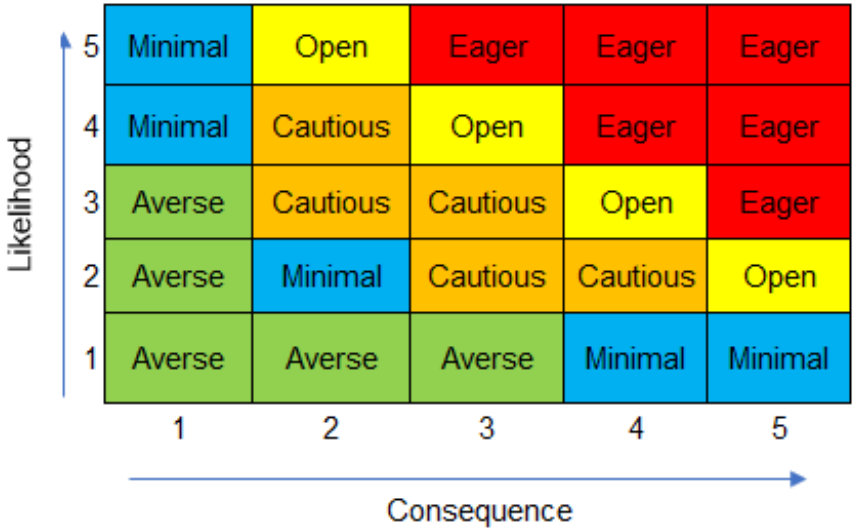
Risk Matrix

Risk Matrix					
Likelihood/ Frequency ↓	Consequence/Impact →				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	Moderate 5	High 10	Significant 15	Significant 20	Significant 25
4 Likely	Moderate 4	High 8	High 12	Significant 16	Significant 20
3 Possible	Low 3	Moderate 6	High 9	High 12	Significant 15
2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Risk Tolerance Scores	Risk Appetite Level
15+	Eager
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Risk Tolerance	
within tolerance	
outwith tolerance	

Risk Appetite



Averse — Avoidance of risk and uncertainty is key objective

Minimal — Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Cautious — Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Open — Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Eager — Willing to be innovative and take on a very high level of risk but only in the right circumstances

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Mar-25	Target	Risk Type	Risk Appetite	Risk tolerance
	Risk Detail		Score Trend													
POPULATION - Improving the health and wellbeing of the population we serve																
BAF 1	Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trusts operating model	Chief Finance Officer	12						12	12	12	16	6	Operational	Cautious	
BAF 2	Due to the size of our catchment population there is a risk that some services are not sustainable	Chief Medical Officer	15	10	10	10	10	12	12	12	8	8	8	Clinical	Minimal	
BAF 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff	Chief Digital Officer	16	12	12	12	12	12	12	12	12	12	9	Operational	Cautious	
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Finance Officer / Director of estates	12	16	16	16	16	16	16	16	16	16	12	Operational	Cautious	
BAF 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.	Chief Digital Officer	20							20	20	20	15	Operational	Cautious	
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20	20	20	16	16	16	12	12	12	12	9	Clinical	Minimal	
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work																
BAF 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.	Managing Director	16						16	16	12	12	8	Workforce	Cautious	
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20	20	20	16	16	12	12	12	12	12	9	Workforce	Cautious	

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Mar-25	Target	Risk Type	Risk Appetite	Risk tolerance
PARTNERSHIPS - Working through partnerships to transform and integrate our services																
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12	16	16	16	16	16	16	20	20	20	9	Financial	Cautious	
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Managing Director/ Chief Operating Officer	9	9	9	9	9	9	9	9	9	9	6	External	Cautious	
BAF 11	Risk of not achieving the transformation requirements at the pace required to deliver the 2025/26 plan	Managing Director	16									16	9	Financial	Cautious	
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16	16	16	12	12	12	12	12	12	12	9	Clinical	Minimal	

Risk Score Key
Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

	Within tolerance
	Out of tolerance

BAF Risk 1	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic and financial benefits not being realised including and impact the delivery of the Trust future operating model.
Strategic Priority	People, Population, Partnership
Linked Corporate Risks	
Executive Lead	Chief Financial Officer
Lead Committee	Finance and Performance
Risk Type	Operational
Risk Appetite / tolerance	Cautious

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	Mar 25		Target Score
12				12	12 3Lx4C	12 3Lx4C	16 4Lx4C		6 2Lx3C

Context

Becoming a digitally mature organisation with a fit for purpose, integrated Electronic Patient Record (EPR) is a key enabler of the Trust's strategy. The EPR business case articulates the range of anticipated clinical, strategic and financial benefits expected to be achieved through transformation in part driven by the implementation of the EPR. This includes the reduction of duplication and waste as well as the ability to improve access and reduce variability in outcomes across the BSW Acute Hospital Alliance.

Deployment of a common EPR across three acute Trusts is a complex technical and change management process, requiring significant acquisition of skills within our existing workforce and through new recruitment. The level of change both in pathways and culture to maximise the potential of the Shared EPR. Given the multifaceted nature of the programme and the wide range of strategic plans the EPR will enable, the risk that delay or ineffective delivery is substantial.

Controls

- BSW shared EPR programme board in place.
- Joint Committee established to oversee EPR programme at AHA level. Both meet monthly.
- Monthly EPR Delivery Group (CDO/CCIO led) established, with EPR Oversight Group (MD led) to oversee delivery of local actions, any emerging risks/mitigations and impact of wider change.
- SFT board level engagement in all key aspects of EPR delivery.
- Delivery partnership with Oracle Health.
- Weekly EPR Programme Team meeting with workstream leads
- Delivery partners in areas such as Data Migration in place. St Vincent's critical friend role in place.

Assurance

- Joint committee governance reporting to three boards within AHA
- Phased deployment plan with project milestones overseen by programme board, escalating to joint committee
- NHSE oversight of EPR programme progress and gateways with assurance reviews
- Berkeley independent assurance
- Internal Audits for local Audit Committee assurance

Progress

What is going well/ Future Opportunities?

Implementation oversight governance agreed including NED led Joint Committee meeting bi-monthly.
Resourcing for the programme including local and central team established.
First "align" gateway passed in November 2024 with a few areas work in progress, remediation actions largely complete.
Localisation phase underway.
Requirement to consolidation EPR impacted digital teams across group by June 2025.

What are the current challenges including future risks?

Score moved from 12 to 16 given delays in completion of data collection workbooks and the care identity service 2 integration with the Shared EPR. Plan expected to see a c.2 month delay (see point 5 below). Risk score will reduce once assurance is provided on mitigating further delay.

1. Digital transformation has a legacy reputational issue within SFT
2. Significant change programme delivery already occurring with SFT and the Hospitals Group
3. Current financial and operating context could jeopardise acquisition of key skills or individuals
4. Release and backfill of key clinical staff
5. Delivery of programme on time and budget.
6. Lorenzo end of life with limited supplier development to resolve issues identified and comply with Information Standard Notices.

How are these challenges being managed?

1. Strong executive oversight at all levels of digital governance, increased leadership briefings to be embedded by Apr 25.
2. Strengthened digital clinical leadership capacity, recruit Group CSO role, EPR programme integrated with Improving Together continuous improvement methodology at Hospitals Group and organisational level, oversight of quantum of change through MD led group.
3. Recruitment report reviewed weekly at workforce control panel to remove delays
4. Targeted engagement on recruitment with Divisions, approach for monitoring backfill impact to be agreed between CFOs and CPOs
5. EPR Programme Director in post, EPR governance manages risk portfolio, St Vincent's critical friend role commenced. Rephasing of plan underway.
6. National escalation on any severe incidents/requirements, monthly supplier engagement to influence development priorities

BAF Risk 2	Due to the size of our catchment population there is a risk that some services are not sustainable		
Strategic Priority	Population		
Linked Corporate Risks	8188, 5704		
Executive Lead	Chief Medical Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	**Risk Appetite / tolerance**	**Minimal**

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25		Target Score
15	10	10	12	12	12 3Lx4C	8 2Lx4C	8 2Lx4C		8 2x4

Context

Increasing public professional and regulatory requirements resulting in increasing specialisation which is resource intensive and difficult to provide in a Trust of this size.

Sustainable services is a clear priority for BSW ICB and the Trust strategy.

The Group model provides opportunities for strengthening fragile services that are critical to the sustainability of the Trust to be identified through the development of the Group Strategic Planning Framework (SPF)

This risk links with BAF risk 7 given the challenges to recruitment and retention of staff in these fragile services.

Controls

Work has been initiated at BSW Hospitals Group level to develop an approach to transformation and rationalisation of services in line with NHS Planning Guidance.

Development of service 5 year strategies aligned to SFT and BSW Hospital Group Strategic Planning Frameworks.

Assurance

Sustained and/or improving performance metrics

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
The requirement of health and Care legislation to actively collaborate affords an opportunity to redesign services to ensure delivery for the population of BSW as a whole which may be impacted by the developing Group Model with transitional support in place.	1. Pace of change required for large scale reconfiguration. 2. Cultural change required to deliver service benefit through collaborative transformation.	1. Development of Group Model effectiveness with transitional support.

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks	7472		
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	Risk Appetite / tolerance	Cautious

Risk Score 2024/25

Initial Score	Jan 23	Jun 23	Sep 23	Jan 24	Jun 24	Sept 24	Dec 24	Mar 25		Target Score
16	12	12	12	12	12	12 3Lx4C	12 3Lx4C	12 3Lx4C		9 3Lx3C

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.
As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks a slower response to identified clinical or operational risks and requirements, meaning the Trust will be accepting a higher level of associated risk until programmes can be completed/systems introduced. The Trust also may not be able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Current score remains at 12, recognising Trust financial position increases risk associated with sufficient funding to deliver wider elements of the Digital Plan.

Controls

- Monthly Digital Steering Group in place with robust digital governance below this, including programme governance.
- Comprehensive clinical digital leadership in place.
- Digital Innovation Network launched to increase digital profile including digital champions and digital superusers to support change and ownership, further maturing expected with EPR
- Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
- Joint CDO, CIO & Deputy CIO across SFT & GWH.

Assurance

- Monthly Digital Steering Group minutes.
- Regular Digital Plan updates to Board sub-committees.
- Annual board Digital Plan update
- Regular minutes from BSW shared EPR programme board with updated governance being set up.
- Rolling cyber desktop exercises results
- Fortnightly risk review meetings in place

Progress

What is going well/ Future Opportunities?

Opportunity to build resilience across Hospitals Group across the Digital structures, building on Corporate Services Review work in Nov 23, seeking to progress this in Q1 2025/26.

Annual planning for 2025/26 expected to provide a single list of those agreed digitally enabling transformation/digital projects, opportunity to have sight of this across the group once.

What are the current challenges including future risks?

1. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised.
2. Some digital programmes are behind original plans.
3. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
4. Clinical engagement is limited due to operational pressures.
5. Recruitment and retention of Coding and Business Intelligence skills
6. Clinical Safety Officer role currently vacant and not sufficient for Hospital Group working.

How are these challenges being managed?

1. Prioritisation of programmes through Corporate Projects Prioritisation Group to ensure the change agenda is realistic and QIAs completed for those unfunded or de-prioritised programmes.
2. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
3. Seeking opportunities for national funding to support programmes.
4. Shared EPR leads identified to champion and engage with wider peers, mangers comms pack for EPR being rolled out in Apr 25.
5. External coding support agreed at risk for 2025/26 with wider business case awaiting approval with ICB. Hospital Group digital service development work expected to provide the direct resolution to Business Intelligence leadership risk.
6. CCIO and CNIO holding CSO responsibilities whilst ICS CSO recruited to

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks	7734, 6229		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	Risk Appetite/Tolerance	Cautious

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	May 24	Sept 24	Dec 24	March 25		Target Score
12	16	16	16	16	16 4Lx4C	16 4Lx4C	16 4Lx4C		12 3Lx4C

Context

SFT has a substantial estates backlog (£78m – 2024) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.
Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long-term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond) but require significant investment to achieve.

Controls

6 Facet survey of the whole site completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Last annual update May 2024 Quarterly estates reporting to Trust Board.
Annual capital plan reviewed via Strategic Capital committee.
Internal audit on compliance reporting completed in 2024 and recommendations currently being followed through.

Assurance

Significant improvements in estates governance and risk management introduced including the 10 year capital programme compiled, with investment forecasts for estates backlog and a 5 year plan for year on year spend.
Estates compliance status clearly recorded. Majority of targets achieved. One extreme risk outstanding, most highs reduced. Continued progress to mitigate and conclude compliance actions Mid 2025 before moving to business as usual.

Progress

What is going well /Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Estates strategy renewal, mobilised with target completion March 2025
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years. Geothermal exploration.
- Seed funding allocated for DSU replacement
- Bid of circa £5m submitted to National Estates Safety Fund

What are the current challenges including future risks?

1. Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
2. Competing demands for Trust capital each year.
3. Reduction in revenue funding will impact on ability to maintain and repair existing infrastructure.
4. Estates backlog value (£78m) is not actual cost to deliver Likely value £140m
5. Limited electrical infrastructure on campus impacting future redevelopment opportunities
6. Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
7. Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases
8. Day surgery unit remains Trust highest priority.
9. Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
10. Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
11. National targeted resources do not address key resilience issues
12. Patient environment quality being compromised e.g., spinal unit
13. Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

1,2 - Categorisation & prioritisation of Trust capital. Review and prioritisation within Trust framework alongside digital, medical equipment
1,8- Continued lobbying for major service developments – DSU
3- The frequency of maintenance is adjusted where possible, trying to ensure statutory requirements and best practice are maintained, this can result in increased issues at a later date and increased cost pressures.
6 - Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
9 - Investigations into strategic partnership models to allow development and investment of the estate.
7,9,10 - Continued review of poor-quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
10 - Increased scrutiny of estate requests via space management committee. Management of space utilisation 'creep'.
12 - Estate's strategy mobilised
11 - Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
13 - Board paper planned to present options for on-site residential accommodation

BAF Risk 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks	Nil		
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/25

Initial Score	Jun 23	Sep 23	Jan 24	Jun 24	Sep 24	Dec 24	Mar 25		Target Score
20					20 4Lx5C	20 4Lx5C	20 4Lx5C		15 3Lx5C

Context

The Global cyber position is a continuous evolving picture with new threats on a daily basis, therefore the inherent risk to the NHS remains high. The impact of a cyber attack is wide reaching, disrupting clinical care and operational delivery, increasing the risk of reputational damage and legal challenge due to the risk of data availability and loss. A cyber attack will impact whether it is directly against the Trust or indirectly against a partner or third-party supplier.

The Trust has a range of controls and processes in place, engaging with national, regional and local peers to provide a networked approach to cyber security. However, a cyber attack can commence very easily, and it is impossible to have complete cover. Recent cyber events highlight that the healthcare supply chain is an increasingly targeted area.

The NHS has released a new cyber strategy for healthcare to help ensure organisations maintain good cyber posture, protect as one and focus on staff awareness and development as this is often an attack vector.

Given this is an inherent risk, the expectation is that this risk will always be out of tolerance.

Controls

- Local cyber security team in place
- Digital Steering Group oversight of cyber plans
- Modern and secure cyber security technologies including VPN, antivirus, bitsight, endpoint protection, medical equipment, IoT, modern firewalls, etc
- Security patching controls
- Multifactor authentication on NHS Mail
- Cyber awareness programme and phishing feedback/retraining
- Member of ICB TDA Cyber Group and National forums including Cyber Associates Network and Executives Forum
- Close engagement with NHSE regional cyber lead

Assurance

- Weekly tech group minutes,
- Replacement programme – unsupported servers
- Monitoring of Infrastructure downtime
- IT Health Assurance Dashboard oversight
- Quarterly cyber report to FIDC
- Annual Data Security and Protection Toolkit (DSPT) internal audit and penetration testing
- Data, Security and Protection Toolkit submission with annual internal audit assessment as part of this
- Cyber awareness plan
- Phishing testing
- Annual cyber framework reviewed at Trust Board

Progress

What is going well/ Future Opportunities?

Trust met DSPT standards for 2024/25.

Good coverage of cyber toolsets to monitor the Trust and respond to cyber events.

The Trust has a high Bitsight score showing good internet facing cyber posture.

Opportunity for closer ICS working and national funding through ICS wide procurements.

Approval of ICS wide cyber lead agreed by ICB, recruitment being finalised.

What are the current challenges including future risks?

1. Improvement required in Cyber Security Preparedness, in particular stronger planning for business continuity for longer term cyber attack.
2. Trust is required to expand Multi-Factor Authentication (MFA) in line with national policy.
3. Alignment of cyber security controls and policies across ICS will enable improved support in the event of a cyber attack.
4. Supplier controls and oversight requires enhancement given recent cyber attacks

How are these challenges being managed?

1. Review of existing and planned system business continuity for extended outages and for systems which are shared across the region/clinical networks to ensure business continuity plans are fit for purpose. Starting with new Pathology LIMS.
2. MFA improvement plan underway to provide assurance of application MFA compliance ahead of June 2025 CAF (new DSPT) deadline.
3. Softcat cyber gap analysis for all ICS partners completed in Feb 2025, proposed action plan being finalised.
4. Engaging with existing suppliers to clarify the current position on sub-contractors/dependant suppliers, assurance of supplier penetration testing and preparedness with support from ICS procurement team.

BAF Risk 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.		
Strategic Priority	People		
Linked Corporate Risks	7308		
Executive Lead	Managing Director		
Lead Committee	Board of Directors		
Risk Type	Workforce	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/25									
Initial Score	June 24	Sept 24	Dec 24	March 25					Target score
16	16	16 4Lx4C	12 3Lx 4C	12 3Lx 4C					8 2Lx4C

Context	Controls	Assurance
The Executive team will have three interim roles (MD, COO, CFO) which can limit stability of leadership in year. There is a delay to substantive recruitment due to uncertainty on future governance arrangements in the group, the uncertainty could also lead to further attrition of key roles. The level of change in National policy and expectations, system transformation plans and move towards group working bares a significant impact on resources and capacity. There are a number of strategic objectives which will render significant leadership capacity including replacement EPR and financial recovery which dilutes capacity on BAU improvements. Changes in executive team can mean loss of organisational knowledge and experience which in the short term can slow progress or risk delivery which impacts on the reputation of the organisation.	Board oversight of key metrics through IPR BSW Hospitals Group Joint Committee on EPR to ensure oversight and shared delivery. Interim mitigation plans enacted for all roles Remuneration committee for oversight of performance. Succession planning in place	- Engine room oversight of breakthrough metrics/strategic initiatives and vision metrics to focus on delivery and risks which is demonstrating slow, steady progress in the achievement of our objectives.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Interim roles predominately held by SFT substantive employees maintaining organisational knowledge. Recruitment plans underway to commence MD Q1 2025. CMO role now substantive recruited	• Uncertainty about group governance structures leading to further attrition in key roles. • Attracting high calibre candidates in context of uncertainty as group governance develops.	- Regular executive team development . - Recruitment process planning underway - Board oversight of risks and strategic programme

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.										
Strategic Priority	**People**			**Risk Score 2024/25**							
Linked Corporate Risks	7472, 8102, 5704, 8188			Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25		Target Score
Executive Lead	Chief People Officer												
Lead Committee	People and Culture Committee			20	16	16	12	12	12 3Lx4C	12 3Lx4C	12 3Lx4C		12 3Lx4C
Risk Type	Workforce	**Risk Appetite / tolerance**	**Cautious**										

Context	Controls	Assurance
Quarterly pulse survey continues to show a maintained position against all elements of the People Promise. National Staff Survey shows an improved position across all elements 7% uplift in engagement and lead Trust for "looking forward to coming to work" There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, golden handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme' has been successful. These initiatives are now subject to authorisation by the ICB further to increased financial and workforce controls. Financial target includes a WTE reduction of 220wte which has remained off track all year. This year's breakthrough objective is to increase staff retention/reduce turnover of HCAs from 20% to 15% (current position at month 9 is 16%). Alongside a revised Trust all staff turnover of 13%. On-going challenge to attract Consultant medical workforce in specific specialties (links to BAF risk 2) and major cause of Agency spend Recognition of the need to improve transparency of career pathways and access to continuous professional development (CPD). Focus of the newly appointed Associate Director for Leadership, Culture and Education .	Weekly Workforce Control Panel overseeing vacancies Financial recovery workforce –group now meet fortnightly International RN and Midwife recruitment HCA recruitment and retention facilitator in post Staff retention remains a breakthrough objective with clear focus Active update and review of all people policies which are being written and implemented in support of a just and restorative culture. Workstreams for all 7 elements of the People Promise benchmarked against staff survey. Monthly and quarterly governance schedule established. Established leadership development programme plus launch of the people management skills modular programme Overhauled recruitment process; emphasis on high impact actions People Promise Manager retained with an extended portfolio to include widening participation IPR metrics monthly reporting	Improved vacancy position as a result of attraction incentives; less than 1% - the lowest ever Completion rate of the National Staff Survey is 59.1% (National average is 48.6%) Maximum take up on the leadership development, wellbeing and appraisal training courses Time to hire recruitment process – significant reduction to 35 days Sickness absence Trust average 4% - higher on wards/ nursing staff Turnover c 13%

Progress

What is going well/ Future Opportunities?	What are the current challenges/future risks?	How are these challenges being managed?
Leadership including clinical leads first introduced this year with good uptake. Leadership engagement – practical support including investment and participation Head of Education leading improvement projects e.g. increasing apprenticeships/Safe Learning Environment Charter Development of a strategic workforce plan. NHS Ambassadors and take up of work experience in the Trust Data preparation and focus on workforce controls	1. Increasing retention and reducing turnover 2. Line managers capacity & capability to manage exit interviews and complete appraisals 3. Non-Medical Appraisal compliance – slow improvement 4. Manager's capacity to manage staff wellbeing and career development due to operational pressures. 5. Lack of Strategic workforce planner 6. HCA retention 7. Increasing ward-based absence	1. A comprehensive improvement programme against all 7 elements of the People Promise and focus on breakthrough objective (turnover). 2. Approach to appraisal & career conversation part of talent and succession planning launch. Soft launch of c18 modules for Line managers, formal launch of required core modules April 25 (Licence to Manage). 3. Improving line manager training. 4. As per 2. 5. Outstanding – post to be considered at WCP 6. Breakthrough objective for 24/25 7. Detailed breakdown of absence data to be shared with ward leads

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.		
Strategic Priority	Population		
Linked Corporate Risks	7573, 8260, 5751, 8250		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	**Risk Appetite / tolerance**	Minimal

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25		Target score
20	16	16	16	12	12 3Lx4C	12 3Lx4C	12 3Lx4C		9 3Lx3C

Context

Our operational context remains challenging with demand for Urgent and Emergency services currently outstripping our capacity and this is consistently meaning patients are waiting for treatment longer than the national constitutional standard, which can also lead to substandard care.

Demand within urgent care continues to grow at 10% year on year which is leading to the continued use of escalation capacity and putting undesired pressure on clinical services which is compromising efficiency and effectiveness of the operational flow and compromises patient care.

The underlying constraint is insufficient capacity in respect of the skilled workforce required alongside system wide change to respond to an ageing population . The ongoing level of patients in the hospital who are medically fit for discharge impact on available beds to see and treat planned care patients.

Controls

BSW system support to identify / enhance out of hospital offering and capacity such as virtual ward and care co-ordination centre in place. Further productivity improvements in SFT, Urgent Care, introduced new ways of working within SDEC / frailty model / ED etc

Increasing SFT capacity through opening of Imber ward.

Utilisation of escalation capacity and outsourcing when required.

Assurance

BSW Virtual ward and care co-ordination centre in place reducing demand on SFT beds and admissions
SDEC model reducing bed occupancy requirements for SFT
Acute Frailty model started August 23 – decreased LOS
Overall bed escalation and bed occupancy has decreased since Q4 2022/23.

Progress

What is going well/ Future Opportunities?

Improvement plan developed and range of system/ sft groups to help reduce NC2R to 9% of bed base during 25/26.

The Trust opened Imber ward in June 24 which will support increasing bed capacity, enabling further improvements to elective and non-elective flow.

Urgent care and flow board identifying further improvements that can support flow e.g. weekend working and expanding SDEC

What are the current challenges including future risks?

1. Relatively high NCTR bed occupancy limiting available bed capacity.
2. Continued escalation into DSU compromising surgery rates and enhanced paycosts
3. On going workforce challenges within a number of specialities. Eg frailty team.
4. Continued growth in NEL demand that is higher than forecast/planned.
5. Ageing estate is limiting productivity opportunities.

How are these challenges being managed?

1. BSW and SFT specific work programme on reducing NC2R as percentage of bed base. Aiming for 14% during 24/25.
2. Urgent care Board to oversee transformation programme. Rebasing of the hospital capacity to enable and support improved functionality of key flow components ie reintroducing a discharge lounge.
3. Dedicated work within people committee to support recruitment into hard to recruit posts.

BAF Risk 9	SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability		
Strategic Priority	Partnership		
Linked Corporate Risks	7472, 6857, 7308		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Financial	Risk Appetite / tolerance	Cautious

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	Mar 25			Target Score
12	16	16	16	16	20 5Lx4C	20 5Lx4C	20 5Lx4C			9 3Lx3C

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led to a reducing cash balance, in turn constraining its ability to invest in capital programmes.

Continued pressure on urgent case pathways and agency pressures driven by hard to recruit posts have led to this position deteriorating leading to a requirement for cash support, and due to the financial pressure across the NHS the availability of cash support is increasingly uncertain. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.

Although BSW is likely to agree a break-even plan for 2025/26 with cash-back deficit support, delivery will require a cash releasing savings programme of 5%.

Controls

ICB engaged in supporting SFT cash position through phasing of contractual payments.
Finance & Performance Committee oversight of cash position with escalation to Board.
Agreement of annual financial plan including cash requirements.
Escalation to ICB and engagement in NHSE revenue support process.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on maximising the clinical outputs of the Trust while maximising the input resource required.
Enhanced BSW recruitment and investment controls

Assurance

External audit value for money assessment.

Monthly reporting on performance and forecast through Financial Recovery Group, escalated to Finance and Performance Committee.

Cash flow forecasting included in Finance and Performance Committee reporting.

Reporting of improved productivity as demonstrated by Creating value for the patient: Improving productivity breakthrough objective measurement

Third party assessment on financial plans and efficiency programme undertaken with BSW

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maintain ERF delivery through a reduced cost base. BSW hospital group transformation programme to commence with implementation partners procured. Acute services transformation director appointed. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	1. Delivering CIP plans against identified opportunity in context of significant operational challenges. 2. Increasing proportion of savings programme will have to be delivered through clinical service transformation. 3. Adequate cash reserves to service capital programme 4. Medium term financial outlook is uncertain 5. Long term capital programme needs to be assessed against available CDEL and additional funding sources. 6. BSW transformation programme immature and not fully developed.	1. Improving together programme improving a structured approach to change. 2. Working with ICS to develop BSW sustainability programme. 3. Engagement in capital cash support programme 4. BSW mid-term plan under development 5. Trust and BSW strategic capital groups developing prioritisation. 6. BSW-wide oversight through System Recovery Group, chaired by BSW ICB CEO. 10 programmes of work established. Transformation director appointed.

BAF Risk 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.										
Strategic Priority	**Partnership**			**Risk Score 2024/25**							
Linked Corporate Risks	Nil			Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25		Target Score
Executive Lead	Managing Director/Chief Operating Officer												
Lead Committee	Finance and Performance			9	9	9	9	9	9 3Lx3C	9 3Lx3C	9 3Lx3C		6 2Lx3C
Risk Type	External	**Risk Appetite / tolerance**	Cautious										

Context	Controls	Assurance
The Integrated Care Board continues to develop and respond to changing national guidance on role and functions. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery. As the ICB develops further, there remains a need to focus on place. New guidance for local Authority on the establishment of strategic authorities and what impact will that have for NHS joint working. Without partnership working within Wiltshire, one of SFT's strategic aims of integrating care and partnership working is compromised leading to disjointed services for patients. The community services contract has now gone live which offers both an opportunity and presents a challenge to the integration of services for SFT.	ICB and Wiltshire PLACE with SFT representation Established AHA with SFT representation SFT executive representation within ICS workstreams	Community services delivery plan published

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
New Community services tender creates an opportunity for a reset. Wiltshire Council have relaunched the aging well board.	1. Place based working still in infancy, further work to progress placed based strategy for integrated care. 2. Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups. 3. New partner for SFT with HCRG winning community tender and establishing new models of care. 4. Ongoing challenges to reduce patients waiting for onwards care and working with Local Authority colleagues to improve pathways and length of stay.	1. The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS. 2. Exec team members developing relationships with professional colleagues, attending stakeholder events. 3. Community service programme board being established.

BAF Risk 11	Risk of not achieving the transformation requirements at the pace required to deliver the 2025/26 plan.		
Strategic Priority	Partnership		
Linked Corporate Risks	7308		
Executive Lead	Managing Director		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite / tolerance**	**Minimal**

Risk Score 2024/25

Initial Score	March 2025								Target score
16	16								9 3Lx3C

Context

There is a risk the Trust does not have the capacity or capability to deliver the transformation required to meet the national planning guidance leading to reputational failure and risk of regulatory action.

The Trust is part of a group and ICS which has significant transformation priorities including reducing financial deficit, improving urgent care pathways and improving RTT performance. The scale and pace of change is significant.

There are significant layers of transformation required to achieve the performance, quality and financial targets including implementing system and group transformation programmes for urgent and planned care, internal change programmes to SFT to improve outpatients, length of stay and corporate services improvements. This also sits alongside the change in Electronic Patient record roll out.

Controls

Trust SPF
Planned care and urgent Care boards for transformation
BSW Delivery groups monitoring performance delivery.

Trust reports performance against agreed trajectories within the IPR.

EPR governance and oversight in Joint committee and programme boards.

Assurance

Limited assurance at present until plan initiated in 2025/26

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
• Trust SPF in place to guide transformation priorities alongside with CPPG process to ensure resources aligned. • Trust submitted compliant plan for 2025/26 but with key identified risks.	• Delivery groups across the system in infancy and establishing change programmes which may delay significant change e.g., reduction in demand management impacting on bed closures. • Group SPF in infancy so risk priorities may not be aligned and increase resource requirements.	• Group support in place to improve governance and oversight and alignment of priorities. • Group Board Assurance Framework to be developed to provide oversight of strategic risk at Group level

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	**Population**		
Linked Corporate Risks	5751, 7573, 8250, 8260		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	**Risk Appetite / tolerance**	**Minimal**

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24	March 25		Target score
16	12	12	12	12	12 3Lx4C	12 3Lx4C	12 3Lx4C		9 3Lx3C

Context

There is a risk that all performance targets (Cancer, Planned Care, Diagnostic targets, Urgent Care standards) are not improving in line with the agreed trajectories or meeting the requirements of the national planning guidance due to significant gaps in workforce, continued NEL pressure, issues in discharging NC2R pts and increase in demand.

There remains risk of regulatory action if the Trusts fails to meet agreed access targets.

Controls

Planned care and urgent Care boards for transformation
BSW Planned Care Board and Elective Recovery group
Delivery group monitors performance weekly
Cancer improvement group

Assurance

Trust reports performance against agreed trajectories within the IPR.

52/65 week performance is on trajectory although delivery will be tight in certain specialities.

Outsourcing arrangement for additional capacity in Radiology which has improved DMO1 performance significantly in Ultrasound, MRI and CT.

Annual planning includes demand and capacity planning

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
DM01 improved during 24/25 Q2& Q3 with additional capacity and focused recovery. Have eliminated all pts waiting over 78 weeks and almost completely eliminated 65 week wait The Trusts cancer performance has significantly improved during 24/25 and is anticipated to remain above the national target level. Launching additional outpatient transformation work.	1. Number of Patients referred for planned treatment is increasing; 2. Significant issue with Plastic breast reconstruction services due to Consultant capacity. 3. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients.	1. Improved governance processes for oversight of performance (delivery group. Cancer improvement group). New process standard work in place from January 2024. 2. Planned Care and Urgent Care SFT Boards in place to support transformation – focus on outpatient in Q4. 3. BSW Urgent care and Planned care boards well established to help support delivery.

ID	Directorate	Opened	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework link (AF Risk Ref)	Executive Lead	Risk Owner	Date Escalated to Corporate Risk	Controls in Place	Gaps in Control	Assurance on Controls	Gaps in Assurance
5955	Finance and Procurement	13/08/2019	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Do not expect it to happen again but it is possible	Moderate	6	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/05/2025	6	Population	Director of Finance	Ellis, Mark	13/08/2019	SFI's standard operating procedures corporate policies (e.g. HR) Governance assurance map risk register Leadership development programme in place Regular finance training provided for budget holders	-Education and training on management of risk across the organisation.	-Low levels of reported Fraud -low volume of litigation -head of internal audit opinion -Infrequent high risk audit findings -Internal audit reports highlighting weaknesses in controls and processes. (Auditors are assured by responsiveness of recomendations)	N/A
								Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa										
								Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly										
								Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa										
								Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan										
								Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy										
								Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew										
								All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan										
								Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy										
								Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy										
								Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan										
								Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan										
								Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan										
								Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan										
								Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan										
								Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark										
								Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023	29/12/2023	Ellis, Mark										
								Financial management responsibilities reflected in managers 'appraisal process	30/06/2024	05/06/2024	Ellis, Mark										
7078	Transformation & IM&T	12/10/2021	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the BSW hospitals group. This could result in the Trust not being able to improve performance (quality, people, operational & financial) as far as it could have if the programme had stayed on track.	Do not expect it to happen again but it is possible	Moderate	6	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	01/09/2025	6	People	Director of Transformation	Talbott, Alex	13/10/2021	Responsibility for delivery sitting with Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by Managing Director. Reporting will include progress against the October 2024 to March 2026 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes. 03/09/24: Coach House beginning to track if improvement huddles are active and supporting teams to set up their performance review meetings. 03/03/25: Process in place through maturity self assessments to ensure performance review meetings at specialty and team level are rolling out and going ahead. Updated 03/03/25	05/06/24: Process confirmation of the routine use of Improving Together tools such as the improvement huddle boards and divisional weekly driver meetings. This is beginning to be picked up in Divisional Performance Review meetings and the Executive huddle. 03/03/25: Current gap remains in relation to assurance that this is happening on a weekly basis.	- Monthly reviews in preparation for the Improving Together Programme Board between the Director of Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. 05/06/24: Any off-track workstreams have known and owned actions in place to bring them back on-track. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives including progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects. -Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. 05/06/24: - Review and monitoring of training place utilisation on a weekly and monthly basis by the Coach House team. - Quarterly maturity self-assessment by the divisional management teams 03/09/24: Starting to be able to describe how many active huddles and PRMs we have. updated 03/03/2025	Behind trajectory of Improver Advanced training - 05/06/24: new training approach using masterclasses now in place to mitigate this - 03/09/24: It has been difficult to bring staff to this new set of classes. Attendance remains below optimal utilisation. 03/03/25: Attendance is rising in the masterclasses but still not optimal. 05/06/24: Process confirmation of the quarterly maturity self-assessment by the divisional management teams - who and how do we review the rationale and accuracy of the self-assessment. 03/03/25- Maturity self assessment by the divisional management teams now includes a peer review step. This is a new initiative and will be re-assessed in May 25. updated 03/03/25
								SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma										
								Executive to agree new road map by end of July.	31/07/2022	31/10/2022	Provins, Esther										
								Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter										
								Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma										
								Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023	06/10/2023	Cox, Emma										
								Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023	02/01/2024	Cox, Emma										
								Review of training delivery approach and programme in order to bring the Trust back on trajectory. This includes learning from the past year of training delivery within current structure	29/02/2024	05/06/2024	Cox, Emma										
								Develop and deliver the next Improving Together sustainability roadmap session on 15th July 2024 to map out the next 18 months of the programme (October 2024 to March 2026).	16/07/2024	03/09/2024	Talbott, Alex										
								Socialise and develop the October 2024 to March 2026 roadmap with the deputies, divisions and corporate leads. Develop the workstreams in more detail with the leads and their respective executive sponsors so that come October we can manage against each workstream via the Improving Together Board.	30/09/2024	02/12/2024	Talbott, Alex										
6857	Finance and Procurement	12/03/2021	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	Will probably recur, but is not a persistent issue	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Departmental Team meeting	30/06/2025	8	Partnerships	Director of Finance	Ellis, Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems between purchasing and paying training to all staff on induction	Standard operating procedures across the Whole Trust inconsistently applied	Counter Fraud reports budget monitoring reports fraud investigations low level reporting	investigative fraud allegations show sporadic gaps in procedures.
								Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa										
8054	Chief Executive	09/04/2024	9	As a result of out of date policies, there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	May recur occasionally	Moderate	9	Meeting with all Divisional Management Teams to agree policy management framework	28/06/2024	10/12/2024	Nye, Kylie	Trust Management Committee	30/05/2025	6		Director of Integrated Governance	McNeight, Fiona	09/04/2024	Oversight of policy compliance reported to Trust management Committee. Dedicated resource in some divisions (W&NB specifically) providing oversight of compliance Named authors for each policy. Policy compliance report from Eolas Microguide transitioned to new Eolas system with improved	Consistent ownership and oversight of policy management across all divisions. Capacity of policy owners to review and update the policy and system	Improving picture of compliance with out of date policies No reported incidents relating to out of date policies	Guideline compliance requires further oversight
								Draft a new policy management framework	28/06/2024	10/12/2024	Nye, Kylie										
								Policy Summit to be held 3rd September	30/09/2024	10/12/2024	McNeight, Fiona										
								Compliance report to be presented to TMC now Microguide transitioned to Eolas	31/03/2025		McNeight, Fiona										
7573	Operations Directorate	16/01/2023	15	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology & boarded beds) has an impact on patient safety and experience due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	May recur occasionally	Moderate	9	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	Trust Board	31/05/2025	9	Population	Chief Operating Officer	Prosser, Niall	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce whiteparish ward closed to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
								expansion of SDEC for surgery Gynae specialities to further prevent admissions and need for beds	29/12/2023	15/01/2024	Thomas, Lisa										
								work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023	15/01/2024	Thomas, Lisa										
								finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023	15/01/2024	Thomas, Lisa										
								expansion of SDEC for surgery, AMU and Frailty. As funded by business plan. to further prevent admissions and need for beds	29/07/2025		Prosser, Niall										

8102	Surgery	23/05/2024	20	Current vacancy in rate in Central Booking 9.5WTE with a further 2.5WTE due to leave the department in the next four weeks. Current theatre utilisation is not meeting Trust KPI's with approximately 70 - 90 theatre slots not booked each week, this will increase due to pending resignations. There is a risk of patient harm due to a significant backlog of referral which have triaged but have not been transferred from eRS to Lorenzo. There is also a delay to patient follow up due to a further significant backlog of e-outcome forms meaning patients are not being added to follow up access plans in a timely manner. The staff are taking between 50 - 150 calls a day (depending on role) which adds an additional pressure and is blocking them from booking and processing urgent referrals. This may result in a loss of confidence from our clinical teams and patients.	Do not expect it to happen again but it is possible	Catastrophic	10	Review and revision of current operational structure, to ensure fit for future state, including career progression opportunities, to support recruitment and retention. Support provided by OD&P specialist	30/09/2024	16/10/2024	Critchley, Jennifer	Trust Board	31/05/2025	12		Chief Operating Officer	Critchley, Jennifer		2 bank staff have been approved by WCP to help with eRS transfers. Secretariat team are supporting with booking forms and e-outcome forms wherever possible but this is not keeping on top of the backlog as minimal hours across the week. DMT initiative has taken place whereby senior managers were present in Central Booking W/C 13/05/24. Processes have been updated where clinical buy in supports - for example moving over to electronic triage.	Further bank staff required to increase establishment until successful recruitment has taken place. Band matching exercise needs to be finalised to boost staff morale and reinstate faith and confidence in management team.	Proposal to revise current structure, including roles and responsibilities supported by Exec 2/7. Working with OD&P specialist to redefine JD's and career progression structure. Recruitment Team to support with appropriate advertising campaign in recognition of the criticality of these roles. Recruitment Team to support with identifying external agency solution to support in short term	Approx 70 - 90 theatre slots unbooked each week. Approx 7000 follow up access plans to be added to Lorenzo, currently on e-outcome form report, this is across all specialties / divisions with some particular areas of concern requiring a focused tie period to catch up, this will be achievable with the support of bank staff. Approx 1500 routine referrals to be transferred from eRS to Lorenzo access plans
									Short term mitigation to be agreed for either bank or external agency support. Recruitment team to approach external agencies to scope options to coincide with conclusion of bank support post college/university summer holidays.	31/01/2025	14/03/2025	Critchley, Jennifer											
8174	Surgery	30/07/2024	10	A national review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A regional assessment of SFT services has identified a high risk of potential harm and mandated a detailed review of @200 cases from	Do not expect it to happen again but it is possible	Catastrophic	10	Service doing retrospective harm review, consistent with NHSE incident requirements.	31/03/2025	07/03/2025	Smith, Rory	Clinical Governance Committee	31/05/2025	5	Population	Chief Medical Officer	Murray, Dr Duncan	30/07/2024	National agreed process for review is being coordinated by NHS England and BSW ICS well engaged leadership team in audiology have been recognized by the initial review visit and the service is felt to	Department have identified that it will take time and resources to attain national accreditation Extra resource may be required to complete historic reviews in a timely fashion (this is being supported by NHSE)	Initial review identified a good culture of improving and ownership of the issues within the department Clinical Governance Committee is sighted on the risk and has requested regular updates	until the retrospective review is complete the extent of any harm will not be known
								Awaiting NHSE report	31/03/2025		Smith, Rory										
8188	Surgery	08/08/2024	12	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one	May recur occasionally	Major	12	Intensive support for GI services	31/12/2024	17/03/2025	Dyos, Judy	Directorate Management Team Meeting	31/07/2025	9	Population	Chief Medical Officer	Murray, Dr Duncan	09/08/2024	1. Clinicians in Southampton offer ad hoc support for complex cases that should be performed in tertiary units, and more clinically urgent cases that cannot wait to the next scheduled SFT session	1. The arrangement with UHS is ad hoc, reliant on good will and not supported by an SLA 2. Attempts at substantive recruitment to SFT posts have failed, and multiple options to provide more resilient and	1. Outcomes from the procedure that are performed at SFT (approx 115 per year) are satisfactory compared to regulatory standards	1. Recent complaint and related incident report 2. Informal concerns raised by service users (referring gastroenterologists) 3. Discussions with respected external expert opinions
								Surgery DMT to conclude discussions with GWH around mutual aid, requesting executive support as required.	31/07/2025		Insull, Victoria										
8250	Medicine	26/11/2024	20	Current national guidance requires acute stroke units to have access to enhanced neuro-imaging assessments for patients with acute ischaemic stroke 24/7. Patients are required to have an available slot for imaging within an hour from arrival at hospital. This includes provision of CT angiography and CT profusion 24 hours per day.	May recur occasionally	Major	12	Business case submitted to TMC and escalated to ICB. ICB investment committee rejected request but now escalated back to MDs meeting for further guidance on next steps.	23/12/2024	14/03/2025	Needle, Sarah	Directorate Management Team Meeting	31/05/2025	6		Chief Operating Officer	Barrett, Mrs Jessica	03/12/2024	The Trust current sends patients to Southampton for mechanical thrombectomy. 14/03/2025: Trust has now agreed to proceed with the recruitment of the posts.	There is currently a business case in development which would include recruitment and training which would ensure provision of CT angiography and CT profusion to the required national standard.	There are currently no incident or complaint forms linked to this issue.	a Recent audit of data relating to advanced imaging indicated that there would be likely 69 patients per year who would be eligible for reperfusion treatments if national guidance was met.
								Recruitment of necessary team to enable expansion	30/06/2025		Needle, Sarah										
8344	Organisational Development and People	10/03/2025	16	The Education Administration team have identified data quality issues within the SFT on-line learning platform (Kallidus Learn MLE) that means the reporting of Trust compliance to the core Mandatory & Statutory training (MaST) subjects is inconsistent and lack assurance as to it accuracy across the 11 core subjects. This has the consequence of the Trust being unable to assure themselves on the compliance of core MaST across all staff groups with a risk that: 1.non-compliant staff may be treating our patients without up-to-date	Will probably recur, but is not a persistent issue	Moderate	12	Data quality review and data corrected for accuracy within safeguarding training	08/04/2025		Mulshaw, Cris	Directorate Management Team Meeting	30/04/2025	4		Director of Organisational Development and People	Mulshaw, Cris	13/03/2025	Education have instigated an Improvement Plan, using A3 thinking, to work through the series of Data quality issues identified by the MLE team now in place. These can be summarised as: 1. Data quality - within the system there are issues with duplicate accounts, accounts with no line manager, un-enabled accounts, excessive number of groups. These all impact the accuracy of the reporting data.	Current resources available to correct the MLE system to ensure data accuracy are insufficient in terms of capacity and in terms of expertise. The team is currently developing their knowledge and expertise in manipulating the system. Kallidus (the provider) have a help desk academy that supports them. Their focus is divided with manning the MLE helpdesk - responding to daily queries & issues from staff.	Data quality can be shown to be improving in the following areas - i. reducing accounts with no manager / reduction in duplicate accounts ii. progress on adapting of reporting through new linked Power BI reporting tool. iii. Issues or dual accreditation within Safeguarding modules being addressed - reporting numbers improving	At current progress: a) an assured Division level report on MaST compliance will be available week end 14th March. b) Safeguarding data will have been cleansed by 15 April 2025 c) Account data re duplicates and line managers will be rationalised by 15 April 2025
								Reconcile ESR data against Kallidus data to confirm inaccuracies and establish processes for maintaining accuracy	22/04/2025		Mulshaw, Cris										
								Secure funding to achieve Kallidus support to manage corrections and correctly establish system processes	30/05/2025		Mulshaw, Cris										
7807		16/08/2023	20	As a result of a lack of community and acute mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. This also impacts on staff morale and staff retention.	Will probably recur, but is not a persistent issue	Moderate	12	Agree an approval algorithm for mental health 1 to 1 support with AWP.	28/02/2024	24/02/2025	Osman, Laura	Trust Board	01/07/2025	9	Populaten	Chief Medical Officer	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. Use of agency RMNs. As required Meetings with key agency to discuss current patients and plans to mitigate risk. Risk Assessments and care planning in conjunction with AWP	Availability of adult mental health beds and tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge. 02/09/24: Out of hours cover provision is at arm's length. Recent changes to this service not fully embedded and impact of changes not yet understood.	Recent audit 28/05/24 demonstrated improved compliance with Mental Health Act. 02/09/24: Operational KPIs of MHLS consistently good.	Long length of stay for mental health patients requiring community or MH inpatient facilities. Increase number of incidents reported in relation to mental health patients (alongside increase in patient load and acuity). 28/05/24: Recent audit identified variability in meeting the requirements as set out in the Mental Health Act regarding
								Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/03/2024	21/11/2024	Murray, Dr Duncan										
								Meeting to improve governance structures and assurance processes regarding Mental Health groups	31/07/2025		Murray, Dr Duncan										
7946	Transformation & IM&T	02/01/2024	12	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work, delaying the start of new work and spend more corporate resource time than budgeted.	Will probably recur, but is not a persistent issue	Moderate	12	Training refresher on project documentation in the transformation team	29/03/2024	05/06/2024	Arnett, Louise	Directorate Management Team Meeting	01/09/2025	9	Population	Director of Transformation	Talbott, Alex	02/01/2024	05/05/24: Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery 03/09/24: Annual review of transformation workplan and resource alignment in conjunction with business planning round started in Sept/Oct 2024. Corporate Deep Dive 25/11/24: Align and connect resource planning with business planning for 2025/26 03/03/25: Transformation team has a driver in their performance review meeting, focused on project delivery and use of budgeted resources. This is reviewed on a monthly basis and worked on weekly.	Capacity and capability to deliver to time 03/09/24: A routinely used standardised approach to scoping and scheduling projects with robust SRO engagement with the timeline (i.e. we have the standard, but do we use it routinely?) Corporate Deep Dive 25/11/24: Capacity to demand mismatch for resource allocation to top contributing projects for achieving the organisation's plan. 03/03/25: There is a risk that Corporate Projects may be prioritised and started outside of a multi-portfolio review. This gap in control can lead to too much change going on at once. updated: 03/03/25	Good knowledge of transformation programmes and projects underway 05/05/24: Monthly review of on/off-track to project/programme plan at Transformation team Performance Review Meeting. 03/09/24: Increasing use of standard scoping and project documentation across the Transformation team is increasing accuracy of timelines and what's needed to achieve them. Corporate Deep Dive 25/11/24: Seeing a longer-term view (6-12 months) of which projects are coming down the pipeline than before. 03/03/25: Agreed as correct/current.	Programme slippage remains in some projects started before the introduction of the new standards. Sub-standard documentation. 03/03/25: Agreed as correct/current.
								Support provided to the Project Managers to practise and develop their knowledge of the Programme Management Industry Standard (PMIS) as all new projects and programmes are stood up. Peer review to be used to highlight best practise and share learning.	31/10/2024	25/10/2024	Lewis, Neil										
								Action agreed at CPPG November 2024 : Review through future CPPG agenda item where project work has started prior to formal prioritisation and filtering / or emerged outside of annual business planning to ascertain whether we could have been more effective in our approach. This learning will help understand any change needed to CPPGs role and remit - or whether a change in organisational practice is needed	31/01/2025	25/02/2025	Arnett, Louise										
								Action agreed at CPPG November 2024: To sense check that projects prioritised under an SI or BTO can show the link back as a countermeasure in the relevant A3 and CPPG to take a harder line in wanting to see that evidence and linkage when reviewing new work	31/01/2025	25/02/2025	Ellis, Mark										
								Transformation Team to explore "resourcing" which is emerging as the top contributor to projects currently being off track. This requires a deeper understanding of the root causes and identification of countermeasures to address potential improvements	28/02/2025	04/03/2025	Arnett, Louise										
								Transformation Team to explore improving through a new driver metric the scoping phase to include the following countermeasures Countermeasures: 1. Agree a set of criteria for what our scoping standards are. 2. Complete a deep dive of our historical and current projects to establish how these align to the agreed scoping standards.	30/06/2025		Arnett, Louise										
								Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa										
								Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa										
								Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali										
								Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali										
								Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew										
								Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy										
								Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy										
								Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy										
								Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart										
								Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine										
								Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy										

5704	Surgery	31/01/2019	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	May recur occasionally	Major	12	New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy	Intensive Support Meeting	31/05/2025	8	Population	Chief Medical Officer	Murray, Dr Duncan	31/01/2019	unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service October 23 - continued support from executive team for improvements with fortnightly assurance meetings. Partnerships with local GP in place and due to commence Nov 23 supporting with specific clinical pathways. 02/09/24: Further recruitment of fixed-term consultant gastroenterologists; currently only one ID Medical employed at SFT.	May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce October 23 - business case in progress with Southampton hospital to increase support for ERCP / IBD services June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. 02/09/24: Resignation of fixed-term gastroenterologist and subsequent threatened resignation of single substantive gastroenterologist (current clinical lead).	oversight and assessment of current service performance. Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier. October 23 - Reduction in long waiters for both gastro and endoscopy through focussed attention on waiting lists 30/05:Current substantive Gastroenterologist as clinical lead for service. 02/09/24: Access times for first outpatient appointments in several sub-specialties have improved significantly. No increase in complaints for service. Regular audit of ERCP outcomes compliant with national benchmarking.	No service specific concerns identified currently. New consultants are uncovering new risks as they explore the service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control August 23 - as June update. All subject to ongoing work overseen by Deputy CMO 02/09/24: Internal concerns being voiced by team members around quality, capacity and cultural issues within the team.
								To recruit medical and nursing staff for the GI Unit	28/02/2025	17/03/2025	Insull, Victoria												
								Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham												
								Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham												
								Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael												
								Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael												
								Develop joint governance meeting between medicine and surgery	31/08/2023	20/11/2023	East, Rachael												
								Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul												
								CMO to report outcome of GI services review once complete.	30/09/2024	02/09/2024	Murray, Dr Duncan												
								Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael												
								Intensive support meetings to commence fortnightly from 24th July.	24/07/2023	17/08/2023	East, Rachael												
								GI Unit enhanced support programme ongoing to identify strategic aims for 24/25 to address stats and service	28/06/2024	28/06/2024	Insull, Victoria												
								02/09/24: GI services to be put into intensive support	06/09/2024	21/11/2024	Murray, Dr Duncan												
								Exec intensive support programme for GI Unit stood up - lead by Judy Dyos. Actions related to priority areas of cultural behaviours and collaborative working, safety specifically related to ERCP provision, and plan to ensure service has long term sustainability being progressed through this.	31/01/2025	17/03/2025	Insull, Victoria												
								To work through the action plan generated by the Executive Intensive Support programme.	31/10/2025		Insull, Victoria												
7734	Finance and Procurement	16/06/2023	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	2024/25 medical equipment brought into 2023/24 as backfill against estates program slippage.	31/03/2024	05/06/2024	Ellis, Mark	Finance and Performance Committee	30/06/2025	8	Resources	Director of Finance	Ellis, Mark	21/09/2023	- capital control group prioritises capital programme - monitor Datix incident reporting related to infrastructure and equipment.	- financial constraints on ability to address whole scale estate risk. - unclear regional/national process for emergency capital bids 21/11/24: High cost and high priority EPR programme underway - arising pressures may impact other programmes. 07/03/25: Slippage in the EPR programme, additional	- incident reporting highlighting areas of concern - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps	21/11/24:Availability of cash to service capital programme. - increasing level of maintenance required - increasing number of incidents of operational disruption particularly in day surgery 21/11/24: Uncertainty of reporting in latter years of EPR programme.
								24/25 Capital monitoring in place. Ongoing processes. Board reporting continues, including specific updates on digital & estates.	31/12/2024	21/11/2024	Ellis, Mark												
								25/26 Capital prioritisation and planning underway	31/05/2025		Ellis, Mark												
								Capital cash support request submitted to NHSE	31/03/2025	07/03/2025	Ellis, Mark												
7308	Finance and Procurement	19/04/2022	15	The financial plan for 2025/26 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Cash balances have depleted with NHSE instructing that cash must be managed within the system. In the event of under-delivery of savings plans the constraint of capital expenditure will need to be considered. updated 07/03/25	Will undoubtedly recur, possibly frequently	Moderate	15	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	Finance and Performance Committee	30/06/2025	9	Partnerships	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting -- monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2024/25 based on internal assumptions - Deficit support funding agreed. - Weekly agency usage monitoring - Fortnightly financial recovery group chaired by CEO - Enhanced vacancy control and temporary staffing process - System investment triple lock 02/09/2024: Medical rate card went live in August 2024.	- Delivery of 5% CIP dependent on external action - Uncertain impact of winter pressures, staffing gaps, and unintended effects of increased vacancy control.	2024/25 efficiency plan delivered £17 million. Improving Together methodology being used to underpin 25/26 programme. Continued upward trajectory in Trust productivity calculation. Theatre utilisation in the top quartile 02/09/2024: Downward trend in nursing bank and agency - continued reduction in UEC length of stay.	Ongoing agency bookings - particularly hard to recruit to medical posts. Pay overspend Opportunity identified for 5% savings programme but detailed plan yet to be worked up. Continued UEC growth outstripping planning assumptions and putting pressure on ability to reduce bed base.
								Divisions asked to identify full CIP and or productivity plans to ensure they manage within Budget for 2022/23	29/07/2022	11/10/2022	Thomas, Lisa												
								Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark												
								Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark												
								Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie												
								3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023	29/12/2023	Ellis, Mark												
								Identification of additional savings opportunities managed through Divisions with oversight from FRG.	31/12/2024	07/03/2025	Ellis, Mark												
								Organisation wide communications strategy for financial recovery	30/09/2024	21/11/2024	Ellis, Mark												
								Work on 25/26 savings targets and plans.	30/06/2025		Ellis, Mark												
								Refresh of financial recovery group standard work. Aligned with SPF.	30/06/2025		Ellis, Mark												
7472	Organisational Development and People	12/10/2022	16	As a consequence of a challenging financial position plus additional workforce controls, we may not be able to replace / recruit or train staff to key positions. To achieve an improved optimisation of workforce and commensurate reduction financially and in WTE , there is a need to reconfigure services and roles, and both current operational pressures and capacity/ capability of people managers is limited in this area of OD Vacancies may compromise service and safety, staff been asked to cover for vacancies in the team may chose to leave , sickness absence in the remaining workforce may continue to increase and none essential development training maybe restricted to accommodate only essential clinical skills training. Updated 06/03/2025	Will undoubtedly recur, possibly frequently	Moderate	15	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024	12/06/2024	Crowley, Ian	Trust Board	01/09/2025	9	People	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels Breakthrough objective - turnover - people promise improvement projects Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations. Weekly divisional and trust workforce control panels -recent addition of weekly ICB vacancy control panel Monthly financial recovery - workforce - include oversight vacancies and bank and agency. First 90 day and 1 year anniversary feedback events. Hearing it campaign. We have a specialist interim involved in resource planning and strategic workforce management. Quarterly nursing safe staffing meetings. Nursing skills mix bi-annual reviews. Monthly Organisation Development, Culture and Learning working Group providing oversight of training - MDT approach Absence data oversight in DPRs plus IPR Regular formal reporting against all elements of the People Promise. Updated 03/03/25	Limited resources to deliver the NHS Widening participation agenda. Line management confidence to manage absence and grievance procedures. Insufficient wellbeing and career conversations. Line managers failing to regularly conduct appraisals and failure to follow resignation processes - including exit interviews. Reviewed 03/03/25	Improving KPIs for vacancy rate, time to hire. Monthly IPR provides oversight of sickness absence and turnover which includes monitoring reasons for leaving. 22/08: Lowest vacancy rate and time to hire than we have ever had. 20/11 - no changes 03/03/25: Now 0.8% vacancy rate and 35 day time-to-hire. Positive trend on quarterly pulse surve, plus continuing improved scores across all elements of the people promise across the national staff survey across 2023/24.	Number of days absence/time lost due to short intermittent periods of absence being effectively managed within wards. Improving control and effective management of temporary staffing numbers - documentation gaps in medical and nursing workforce. 22/08: Limited meaningful data from exit interviews Updated 03/03/25
								Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian												
								Movers and leavers project delivered.	31/12/2024		Crowley, Ian												
								People Promise actions for this year to be delivered.	31/03/2024	12/06/2024	Crowley, Ian												
								Health and Well-being plan delivered.	30/09/2023	17/09/2023	Crowley, Ian												
								Exit and appraisal policy review and application.	31/03/2024	12/06/2024	Whitfield, Melanie												
								12/06: Ongoing delivery of all elements of the People Promise.	31/01/2025	03/03/2025	Whitfield, Melanie												
								12/06: Conclude the line management skills build pilot in July and launch trustwide.	30/09/2024	22/08/2024	Crowley, Ian												
								Disaggregate turnover and absence data in IPR to highlight hotspots and tailor appropriate actions	31/12/2024	03/03/2025	Crowley, Ian												
								Execs to visit ward areas with high sickness absence (Go and See) to provide overight and support	30/04/2025		Dyos, Judy												
8260	Medicine	06/12/2024	15	The planning guidance stipulated that for 25/26 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2026, with further improvement in 2024/25. SFT signed up to 78%. Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with a No Criteria to Reside, the Trust has been unable to meet the nationally agreed targets.	Will undoubtedly recur, possibly frequently	Moderate	15	Medical SDEC expansion & GP Assessment area development	01/12/2025		Bagg, Danielle	Trust Management Committee	31/05/2025	8		Chief Operating Officer	Prosser, Niall	06/12/2024	OPEL Card and escalation plans in place Daily capacity meetings x 4 Silver bleep holders and Matron of the day in place for the Divisions Wait 75 actions implemented to support flow when at risk of ambulance holds over 75 minutes EDEL levels within ED Escalation plans in place to flex ED and Wards when needed to support flow UEC Board in place to support improvements in UEC pathway Medical SDEC in place with plans to expand over next 12 months Surgical SDEC plan in place for January Frailty SDEC commenced and more support at Front door from Frailty team Implementation of Virtual wards NCTR working group in place - Breamore ward in place for	Further redirection in ED to external partners ie No alternatives in working hours Out of hours- significant gaps in community pharmacy GP collective action Inability to control demand Medical staffing to meet demand in ED	Reductions in LOS for medicine Increase in 0 Day LOS Data that supports increased demand Shortages in professional groups	Performance is below target Higher numbers of patients with NCTR than anticipated
								Dischargе initiative across Medicine	31/12/2024	10/12/2024	Needle, Sarah												
								NCTR working group as part of UEC Board	01/05/2025		Dickinson, Jane												
								Ward Processes working group as part of UEC board	02/06/2025		Bagg, Danielle												
								Streaming in ED	02/06/2025		Garrett, Neil												
								Reconfiguration of ED to support more RATT space and in/out assessment space	12/12/2024	14/03/2025	Garrett, Neil												
				There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the	oredy sibly ty	te		Safeguarding lead monitoring DOLS activity & training levels	07/07/2025		Cobham, Gill	ed ing tee			on	of ge	dy		MCA and safeguarding training in place Safeguarding lead monitors training levels and reports to	Training numbers is lower than we want it to be . Documentation poor	Reporting of data regarding mental capacity and safeguarding to ISC, CMB and onwards CGC	

8264		10/12/2024	15	Mental Capacity Assessment(MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally staff releasing for the MCA and safeguarding training is a challenge for	Will undoubt recur, pos frequent	Modera	15	Recruitment to post to focus solely on training delivery	31/07/2025		Dyos, Judy	Integrate Safeguar Committ	31/07/2025	9	Populati	Director Nursing	Dyos, Ju	08/12/2024	CGC Week day oversight of all incidents in previous 24 hrs. with safeguarding input. Audits regarding mental capacity assessments.	Documentation poor Reports from dementia lead that staff not practicing least restrictive options	Safeguarding leads monitoring on weekly basis Weekly patients safety look's at all moderates and above. Risk team monitor for high volume low harm themes for low harm, no harm	Training data , numbers failing Incident review data
								Safeguarding lead undertaking documentation audits	31/07/2025		Cobham, Gill											
5751	Operations Directorate	11/03/2019	15	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by capacity/resource constraints in out of hospital care. 02/09/24: Failure to reduce NC2R is leading to increased bed occupancy and delaying continued financial recovery.	Will probably recur, but is not a persistent issue	Major	16	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	31/05/2025	12	Populaten	Chief Operating Officer	Prosser, Niall	11/03/2019	Site and Flow meetings 3x a day. Specific medicine ward level discharge meeting Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews all patients with LoS over 7 days with CTR. Monthly urgent care board which the COO attends. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality Improved use of e-Whiteboards on wards. 02/09/24: Working groups with BSW system to improve discharge process and capacity. Experienced subject matter experts - focussed on work to resolve current issues. 14/03/2025: Trust has implemented improvement sprint which is helping to improve processes and reduce the length of time between patients being non critieria to reside and being ready for discharge	Reporting of timelines in patients journeys challenging with current IT systems. - capacity gap in Council for domiciliary care which means significant shortage of available care hours. 02/09/24: Complexity in pathway management is leading to delays in discharge.	02/09/24: Monthly reporting of number of patients waiting for discharge & pathways is well understood.	Understanding of discharge process at ward level (nursing and medical) is inconsistent. Use of e-whiteboards although improved is still inconsistent with no training delivered to new starters. 02/09/24: Understanding headline number in place but further work required to truly understand reasons for delays.
								Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy												
								Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy												
								Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy												
								Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy												
								Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy												
								Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy												
								All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy												
								Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy												
								CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy												
								COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy												
								System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy												
								COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy												
								Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy												
								Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy												
								Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy												
								Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy												
								Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy												
								Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran												
								Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy												
								Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul												
								Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa												
								Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa												
								Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa												
								Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma												
								SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023	15/01/2024	Thomas, Lisa												
								Further engagement with system partners to understand their actions	25/09/2024	19/11/2024	Cavill, Emma												
								02/09/24: Established A3 approach - Support delivery of NC2R challenges & joint system working group implementation.	31/05/2025		Prosser, Niall												
								Launching multi-agency dedicated team for 12 weeks to undertake further A3 thinking within pathway 1 and interface delay challenges.	31/03/2025		Prosser, Niall												
6229	Surgery	04/03/2020	12	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous roof leaks and delayed/cancelled	Will probably possibly frequent	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	st Board	31/05/2025	4	ulation	Chief erating officer	Keeffe, ohn	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations.	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding.	None Constant lobbying being undertaken to attempt to secure funding	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020).

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Jan-24	Jun-24	Sep-24	Dec-24	Mar-25	Target	Risk Type	Risk Appetite/ Tolerance
	Risk Detail			Score Trend								
POPULATION - Improving the health and wellbeing of the population we serve												
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	15	12	16	12	12	8	Workforce supply	Cautious
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	15	15	15	20	16	12	Capacity planning	Cautious
5955	Insufficient organisation wide robust management control procedures. **Risk tolerated**	Chief Finance Officer	13-Aug-19	15	9	6	6	6	6	6	Legal & Governance	Averse
7946	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work.	Director of Transformation	02-Jan-24	12	12	12	12	12	12	9	Research, innovation and development	Open
6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12	20	20	20	20	20	4	Estates / Physical assets	Cautious

7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20	12	9	9	9	9	9	Capacity planning	Cautious
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	Chief Medical Officer	16-Aug-23	20	15	15	12	12	12	9	Patient safety & outcomes	Minimal
8102	Current vacancy rate in Central Booking 9.5wte. Current theatre utilisation is not meeting Trust KPIs (approx 70-90 theatre slots not booked per week). Risk of patient harm due to significant backlog of referrals which are triaged but not transferred to Lorenzo. Risk to delay of patient follow up due to backlog of e-outcome forms. **Risk tolerated**	Chief Operating Officer	01-Nov-24	20				20	10	12	Workforce supply	Cautious
8250	Lack of 24/7 access to CT perfusion and CT angiography for patients with acute ischaemic stroke there is a risk that patients will not be able to receive life changing treatment as per national guidance.	Chief Operating Officer	03-Dec-24	20				20	12	6	Patient safety & outcomes	Minimal

8264	There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the Mental Capacity Assessment (MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally staff releasing for the MCA and safeguarding training is a challenge for clinical staff.	Chief Nursing Officer	10-Dec-24	15				15	15	9	Workforce performance	Cautious
8260	The planning guidance stipulated that for 2025/26 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments, with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2026. SFT signed up to 78%. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with NCTR, the Trust has been unable to meet the nationally agreed targets (including ambulance response times)	Chief Operating Officer	06-Dec-24	15				15	15	8	Patient safety & outcomes	Minimal

8188	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one session for ERCP per week, with no cover for annual leave. On its own this arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention before the next available list. Therefore some patients will not get timely intervention, with acute inpatients suffering deterioration in their condition possibly resulting in worsening organ failure, and outpatients waiting longer, resulting in a poor experience and possibly developing complications while waiting.	Chief Medical Officer	08-Aug-24	12			12	12	12	9	Workforce supply	Cautious
8174	A National review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A Regional assessment of SFT services has identified a high risk of potential harm and mandated a review of c200 cases from 2017 to date. There is a risk that the review could discover significant harm to children and this could result in reputational and litigation risk in the future.	Chief Medical Officer	30-Jul-24	10			10	10	10	5	Patient safety and outcomes	Minimal
8054	As a result of out of date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	Director of Integrated Governance	09-Apr-24	9		9	9	9	9	6	Legal and governance	Averse

People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work												
7472	As a consequence of a challenging financial position plus additional workforce controls, we may not be able to replace/recruit or train staff to key positions. To achieve an improved optimisation of workforce and commensurate reduction financially and in WTE, there is a need to reconfigure services and roles. Vacancies may compromise service delivery and safety.	Chief People Officer	12-Oct-22	16	12	12	9	12	15	9	Workforce retention	Cautious
8334	The Education Administration team have identified data quality issues within the SFT on-line learning platform (Kallidus Learn MLE) that means the reporting of Trust compliance to the core Mandatory & Statutory training (MaST) subjects is inconsistent and lack assurance as to it accuracy across the 11 core subjects.	Chief People Officer	13-Mar-25	16					12	4	Information Governance	Cautious
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines **Risk tolerated**	Director of Improvement	13-Oct-21	12	9	9	6	6	6	6	Research, innovation and development	Open
PARTNERSHIPS - Working through partnerships to transform and integrate our services												
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	8	8	8	8	8	8	Counter-fraud	Averse
7734	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Chief Finance Officer	16-Jun-23	15	15	15	15	15	15	8	Revenue funding & cash management	Cautious

7308	The financial plan for 2025/26 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside	Chief Finance Officer	12-Mar-21	15	20	20	20	20	15	9	Financial Management	Cautious

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Risk Appetite

	Outwith tolerance
	Within tolerance

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	1st May 2025		

Report title:	Q3 Risk Management Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board 19/02/2025 Clinical Governance Committee 25/03/2025			
Prepared by:	Louise Jones- Head of Risk Management			
Executive Sponsor: (presenting)	Judy Dyos- Chief Nursing Officer			
BAF Risk link				

Recommendation:

The report aims to provide an overview of risk management activity in Quarter 3

Executive Summary:

- **LFPSE**

  SFT harm data is now available to access via the NHSE LFPSE data portal. There is a discrepancy between patient safety incident data collected from Datix and those that are on the LFPSE data dashboard. This discrepancy is a consequence of a number of factors, almost exclusively outside of our control:

  1. When we update an incident on Datix, there is a delay for this to appear on LFPSE (updates overnight). Furthermore, if the event type of the incident is altered, Datix would duplicate the incident on LFPSE. This has since been fixed and does not occur on the Datix version we are using.
  2. LFPSE will sometimes return an incomprehensible error message when an incident fails to upload, we have worked alongside Datix to make sense of these error messages and have reduced the factors that cause these errors.
  3. The patient harm grading captured by LFPSE cannot be directly auto populated using Datix harm grading process (due to technical limitations) this means these harm gradings need to be manually aligned – we have aligned this data from April 24 to date and we have developed a process to ensure these discrepancies are aligned on a weekly basis.
  4. There have been a series of ‘down days’ where LFPSE failed to receive any data, this was a national issue and meant those affected would need to manually re-send incidents that were reported in these periods.

- **Risk Registers**

  There have been 15 risks escalated from Departmental level Risk Register to Divisional Risk Register in Q3:

Medicine – 2
Lack of documentation for CRM alert-based management.
Neuro-Imaging Access Not Within National Guidelines

Surgery – 7
Risk of DSU - Estate Infrastructure failure
Overdue Ophthalmology Follow Ups
Spinal urology patients on routine elective waiting lists
Diabetes foot clinic
Inability to provide 24hr CCOT cover
There is a risk of deterioration in condition leading to patient harm due to delayed access to ERCP
Risk of increase length of stay for orthopaedic trauma due to Therapy staffing

CSFS – 6
Future provision of CT lung biopsies
No IT system for notification of urgent, unexpected and significant Radiology findings
Reduced MLA staffing in Laboratory Medicine impacting on service delivery and staff wellbeing.
Lack of pharmacy clinical service - impact on discharges, medicines reconciliation
Lack of clinical pharmacy service at weekends
Delays in reporting referral laboratory results in Laboratory Medicine

- There have been 0 risks escalated from Divisional Risk Register to Corporate Risk Register in Q3.

- The Trust has upgraded to the latest version of Datix to remain compliant with NHSE's LFPSE requirements. This was the first upgrade performed by the I.T department since RLDatix retracted their assistance with upgrades. This went efficiently with minimal disruption to the Trust.

- Data from Q1 & Q2 has shown significant improvement in Duty of Candour compliance overall. Stage 1 at 98%, Stage 2 at 93% & Stage 3 at 80%. Work is continuing in supporting the wards.

- Of the 2700 incidents reported in Q3, 69 (2.55%) of these were reported as moderate or above harm compared with 3.24% of incidents in Q2 and 3.08% in Q1.

- The second round of 'Matron Deep Dives' have been commenced in Q3 to review all department level risks. This is facilitating standardisation across the Divisions in reviewing their ward/department risks. The Matron Deep Dives are providing an opportunity to enhance learning & education around risk registers.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	
Partnerships: Working through partnerships to transform and integrate our services	

People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	
Other (please describe):	

Salisbury NHS Foundation Trust

(Insert Title)

Purpose

1.1 State the purpose of the report.

2 Background

2.1 Provide sufficient background to inform the reader of the history to the content of the paper and prepare them for the recommendation.

3 Use headings to separate the report

3.1 Complete the report using appropriate headings and sections.

3.2 Link your report to the Trust's Strategy or Assurance Framework as appropriate

4 Summary

4.1 Summarise the content and bring report to a close.

5 Recommendations

5.1 State the recommendation to the group [This should mirror the recommendation on the covering paper]

[Insert name of author(s)]
[Insert Job title of author(s)]

Risk Management Report

Salisbury NHS Foundation Trust

Quarter Three (October, November, December 2024)

Louise Jones

Overview

This report has been written by the Risk Management team for SFT to detail the current trust position in relation to the following:

- Annual Review of Datix

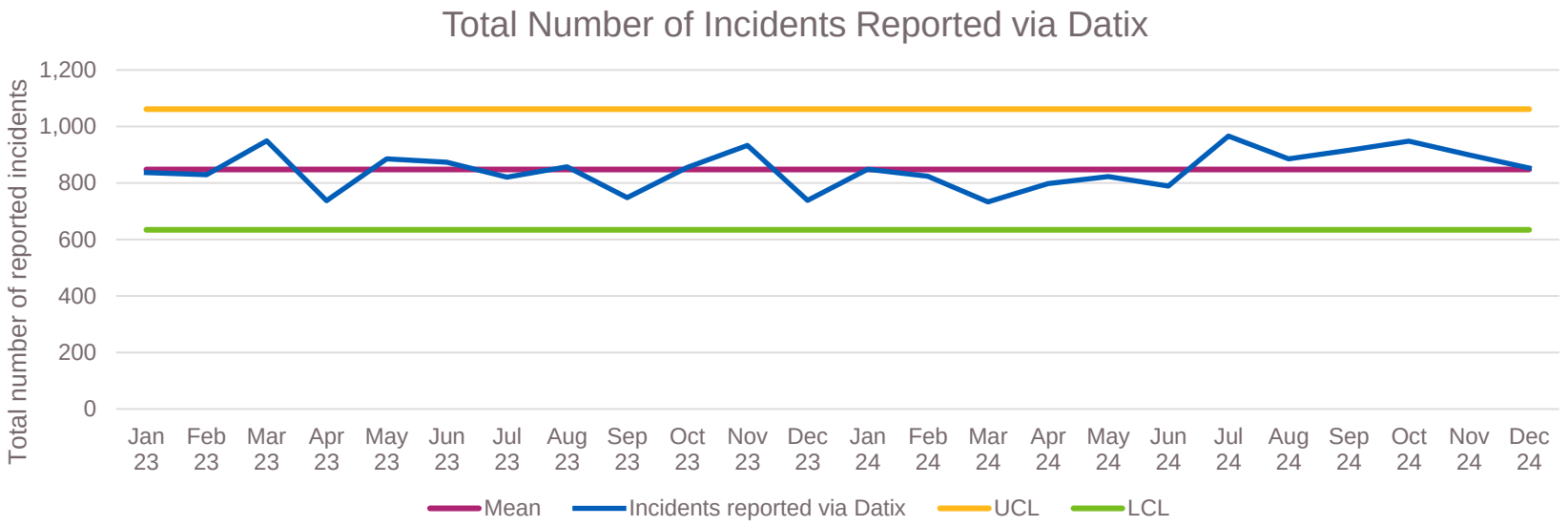
Q3 Data

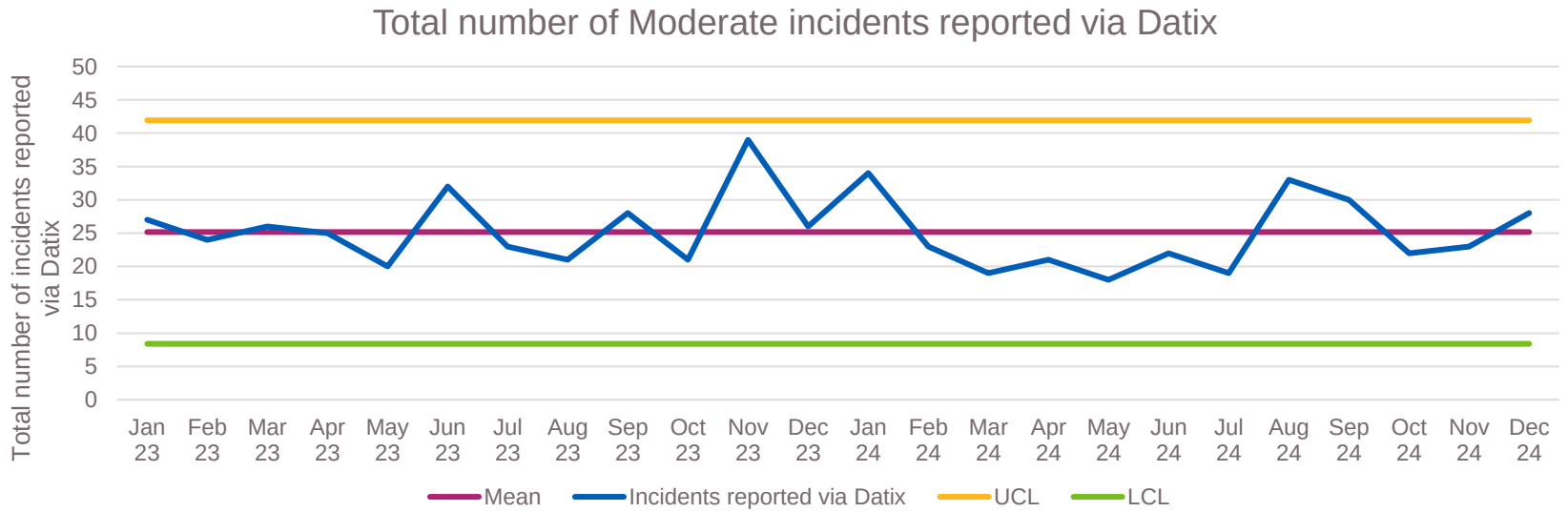
- Total number of Datixes Reported in Q3
- Total Q3 Datixes by Category
- Breakdown of Moderate reported Datixes in Q3
- Outstanding Serious Incident Investigations (SII) and Clinical reviews (CR) in Q3
- Never Events
- SII/CR Action Compliance and Deep Dives
- Risk Registers
- Duty of Candour (DoC)

NHS
Salisbury
NHS Foundation Trust

Annual Review of Datix
Dec 2023 – Dec 2024

Incident Reporting Overall Profile





Salisbury NHS Foundation Trust

The SPC charts show that our reporting culture has remained consistent throughout the last financial year. The number of moderate Datix reports had decreased during the end of Q3 and compared to the same quarter last year, we have seen a reduction in the number of reported high harm incidents. There continues to be additional vigilance and discussion for each high harm incident that is reported at the morning Datix incident huddle.

There has been an increased number of Datix reports submitted noted around diabetes management in ED, As flow has become more challenged and patients are waiting longer in ED, the ask of the clinical teams both nursing and medical has shifted significantly. Our systems are challenged to sustain good quality care in that environment.
In addition, issues relating to discharge processes across some medical wards.

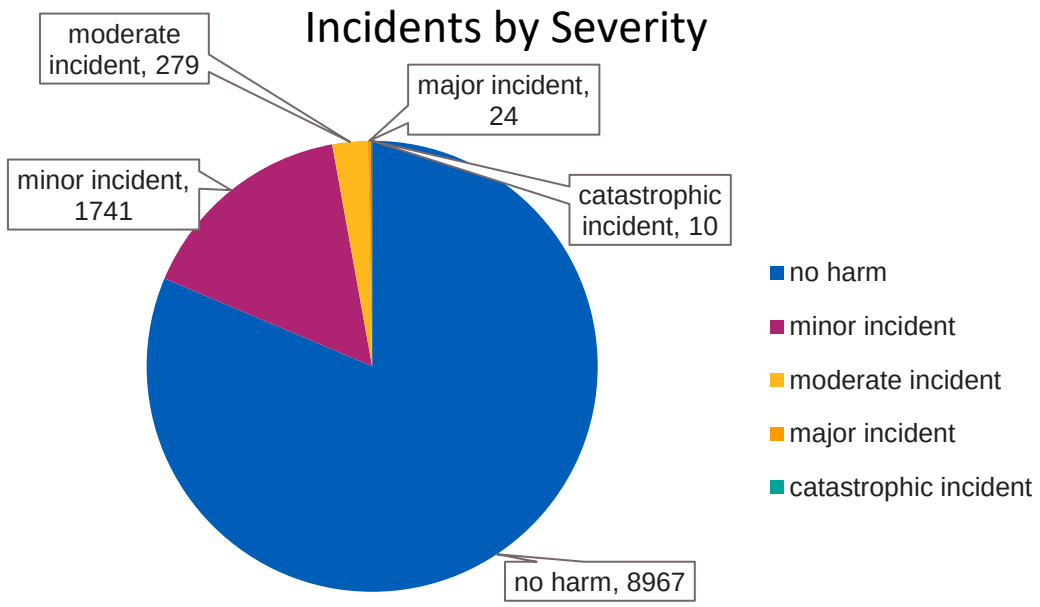
SFT harm data is now available to access via the NHSE LFPSE data portal. There is a moderate discrepancy between patient safety incident data collected from Datix and those that are on the LFPSE data dashboard. The patient harm grading captured by LFPSE cannot be directly auto populated using Datix harm grading process (due to technical limitations) this means these harm gradings need to be manually aligned – we have aligned this data from April 24 to date and we have developed a process to ensure these discrepancies are aligned on a weekly basis.

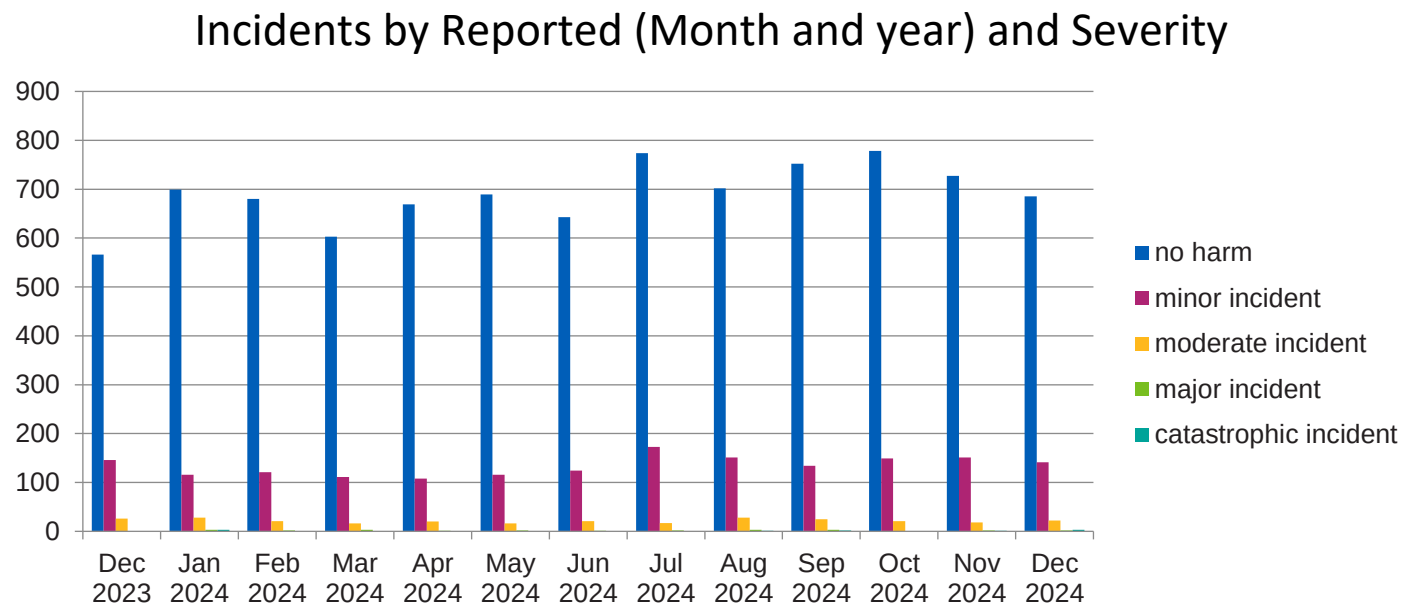
Total Annual Incidents Overview

From December 2023 to December 2024 there were 11021 incidents reported. Each moderate and above case is scrutinised through the weekly patient safety summit with executive oversight and agreement of further review, if necessary, in line with our PSIRF Policy and Plan. The overall average of moderate harm has increased over the last 12 months.

NHS Salisbury NHS Foundation Trust

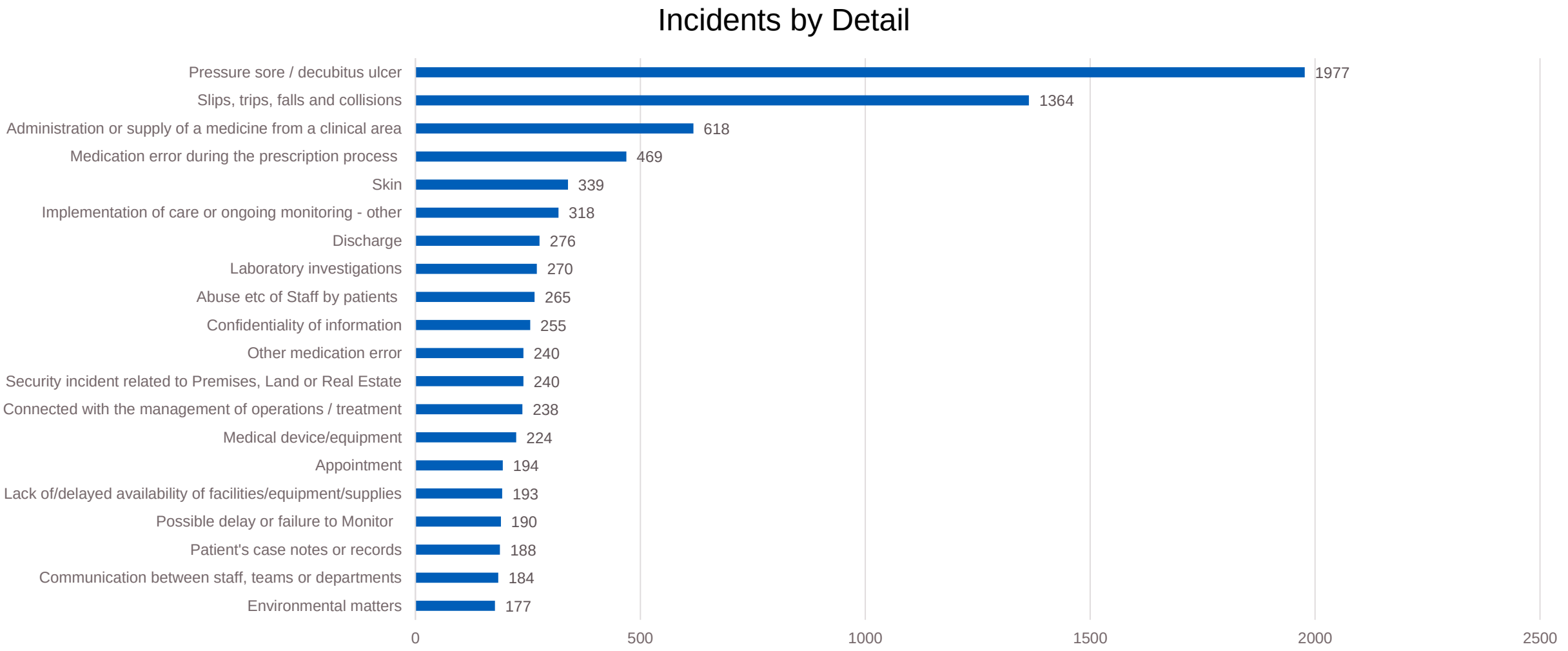
	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Total
no harm	566	699	680	603	669	689	643	774	702	752	778	727	685	8967
minor incident	146	116	121	111	108	116	124	173	151	134	149	151	141	1741
moderate incident	26	28	21	16	20	16	21	17	28	25	21	18	22	279
major incident	0	3	2	3	1	2	1	2	3	3	0	2	2	24
catastrophic incident	0	3	0	0	0	0	0	0	1	2	0	1	3	10
Total	738	849	824	733	798	823	789	966	885	916	948	899	853	11021





Total Annual Incidents top 20 by Category

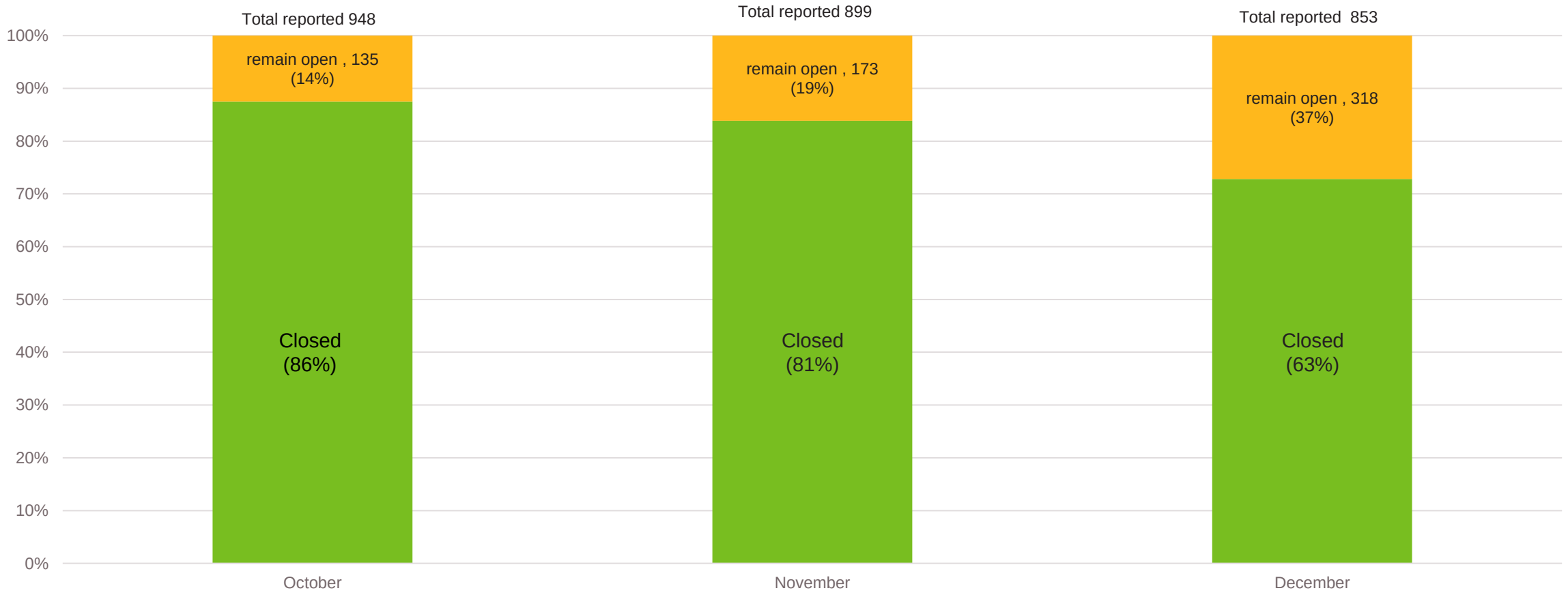
Salisbury NHS Foundation Trust



Quarter 3 Datix Reported (Oct, Nov, Dec 2024)

Total Reported Incidents in Q3

In Q3 there were a total of 2700 Datix reported, a decrease of 76 in comparison to Q2 where 2776 were reported, the below table breaks this down by month and the number of incidents that have been investigated and closed.



(data correct as of 13/01/2024)

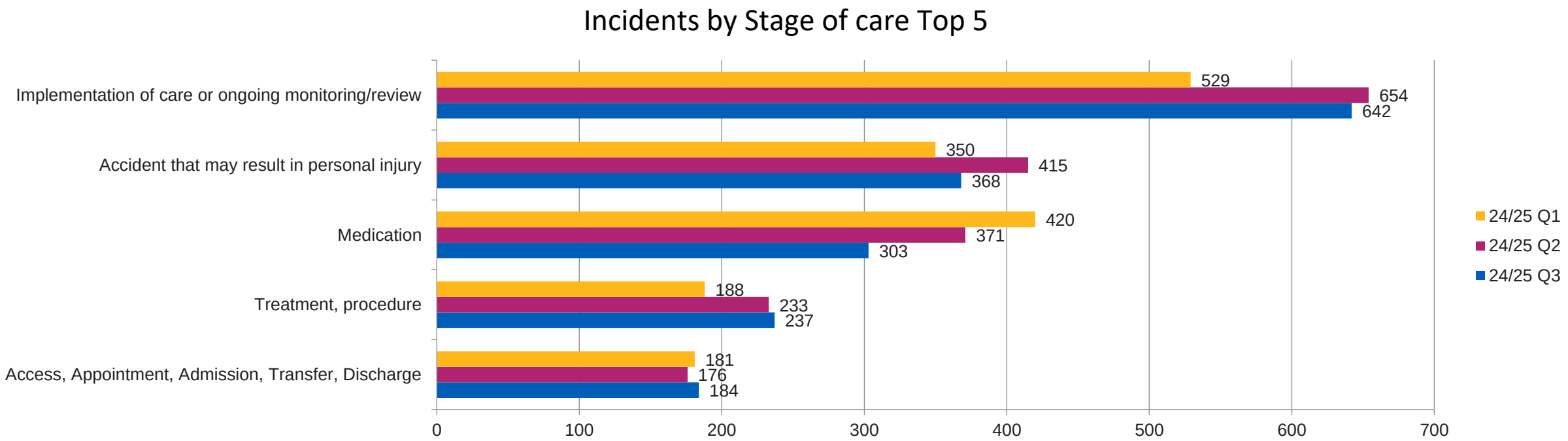
Total Q3 Datix reported by Category

Similarly to the Annual picture, the highest reported type of Datix in Q3 is implementation of care or ongoing monitoring/review

There are several ongoing workstreams and breakthrough objectives that are in place to focus on the areas identified in the data, these include:

- Recognising the deteriorating patient (Breakthrough objective 24/25)
- Pressure damage reduction
- IPC working group
- Falls Working group
- VTE working group
- Medication management
- Communication working group

These workstreams all feed into the patient safety steering group on a quarterly basis for ongoing monitoring and updates.



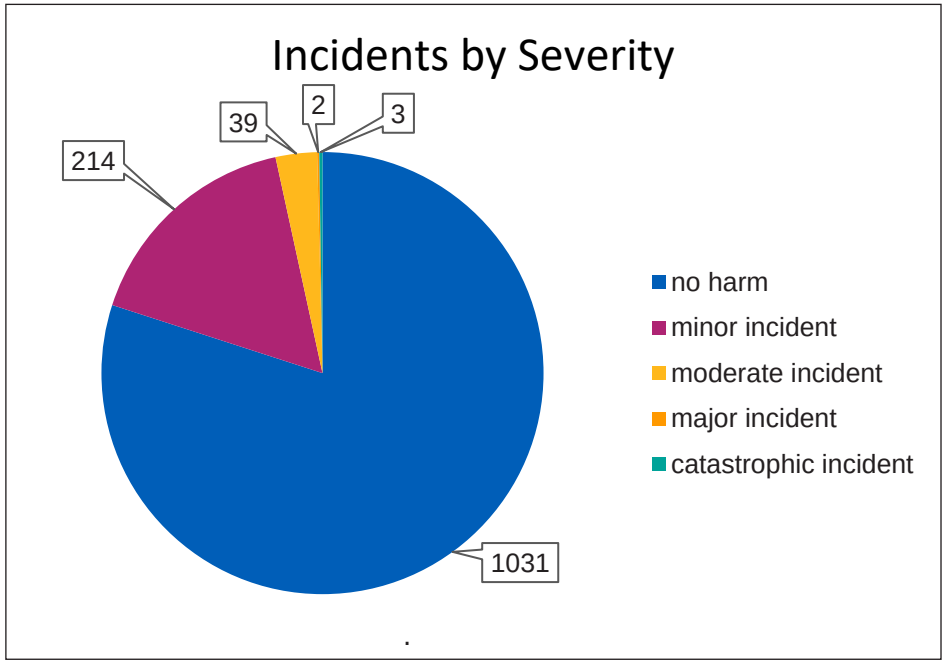
Breakdown of Q3 (October 24 – December 24)

(data correct as of 06/01/2024)

Medicine Division

	Oct 2024	Nov 2024	Dec 2024	Total
no harm	366	359	306	1031
minor incident	72	77	65	214
moderate incident	11	12	16	39
major incident	0	0	2	2
catastrophic incident	0	1	2	3
Total	449	449	391	1289

In total 1289 datix reports were submitted in Medicine during Q3.



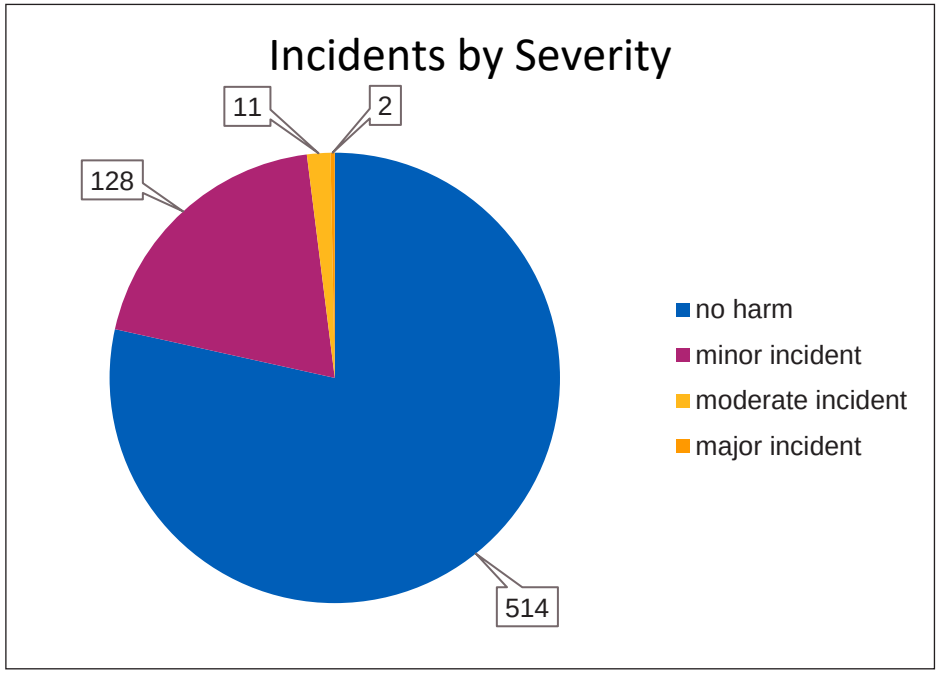
Breakdown of Q3 (October 24 – December 24)

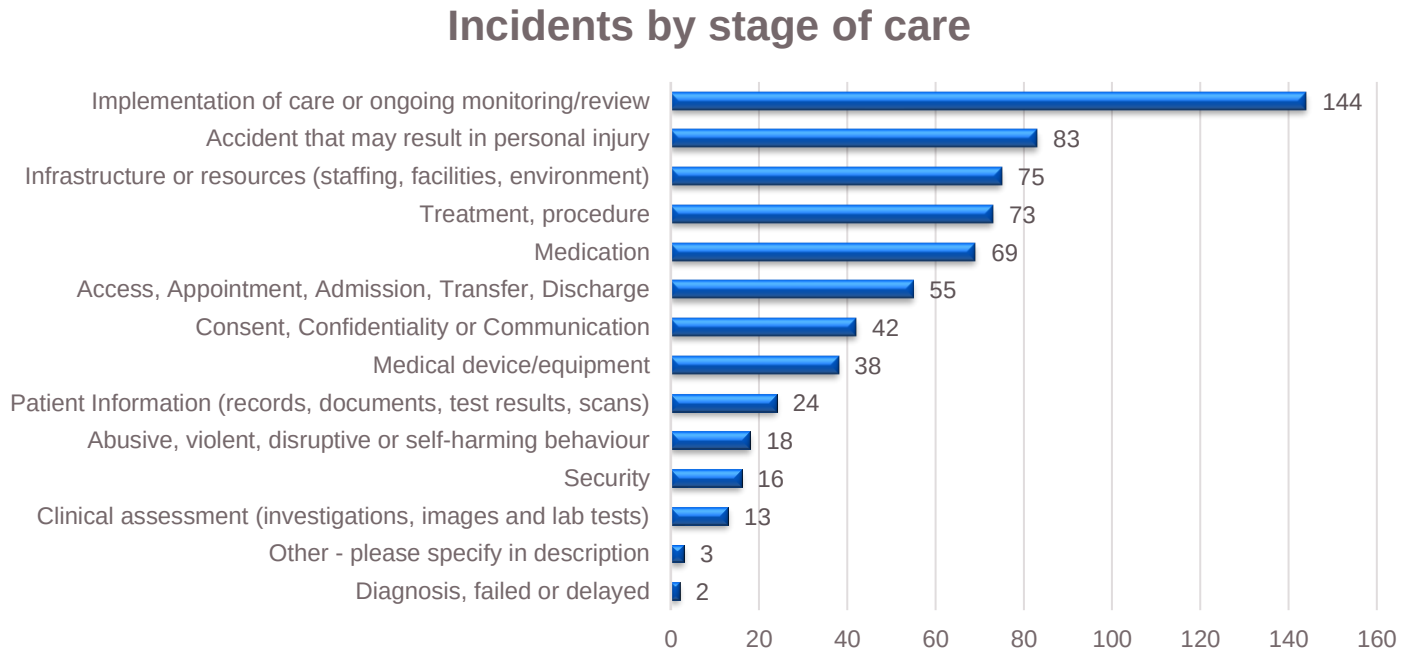
(data correct as of 06/01/2024)

Surgery Division

	Oct 2024	Nov 2024	Dec 2024	Total
no harm	183	182	149	514
minor incident	45	51	32	128
moderate incident	4	4	3	11
major incident	1	1	0	2
Total	233	238	184	655

In total 655 datix reports were submitted in Surgery during Q3.





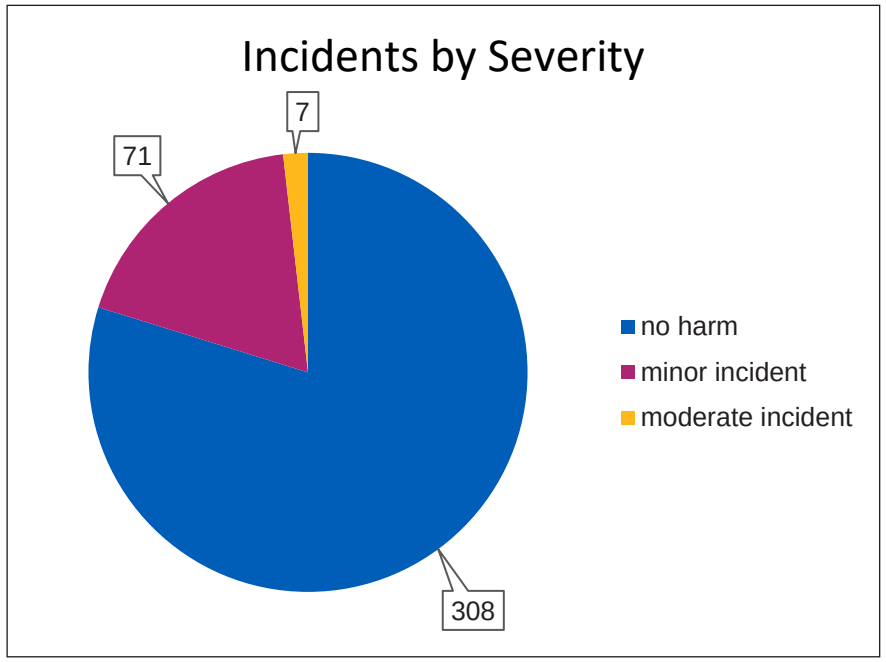
Breakdown of Q3 (October 24 – December 24)

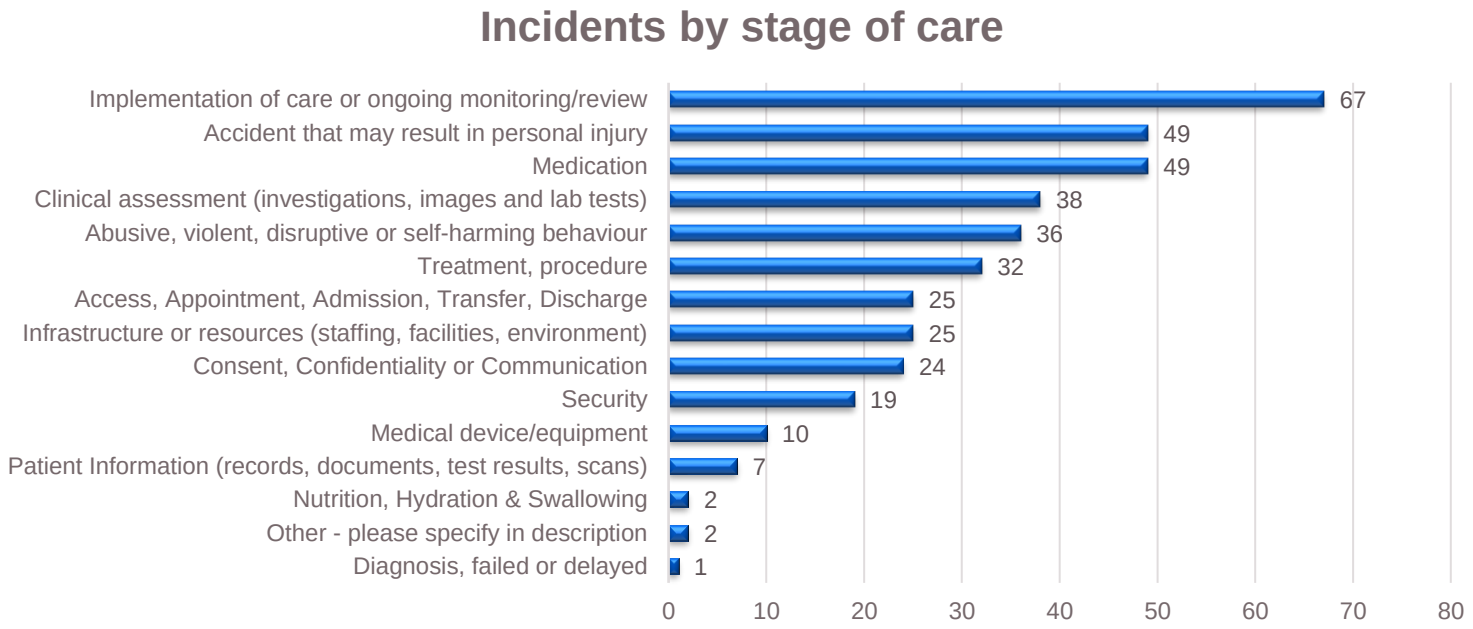
(data correct as of 06/01/2024)

Clinical Support and Family Services Division

	Oct 2024	Nov 2024	Dec 2024	Total
no harm	107	109	92	308
minor incident	28	16	27	71
moderate incident	2	2	3	7
Total	137	127	122	386

In total 386 datix reports were submitted in CSFS during Q3.





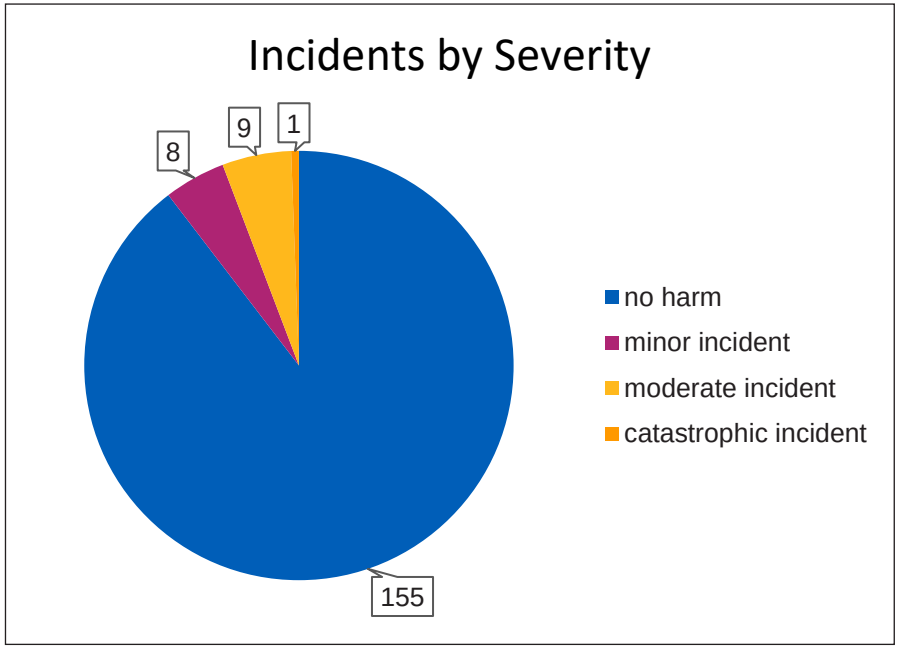
Breakdown of Q3 (October 24 – December 24)

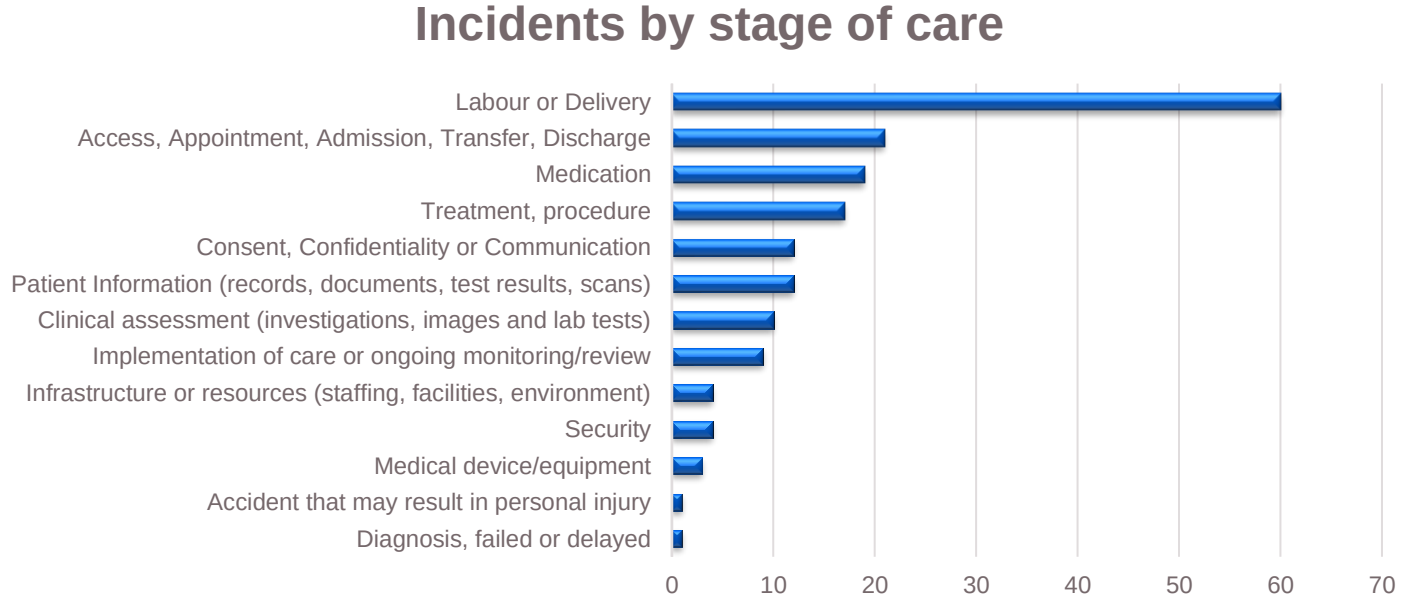
(data correct as of 06/01/2024)

Women and Newborn Division

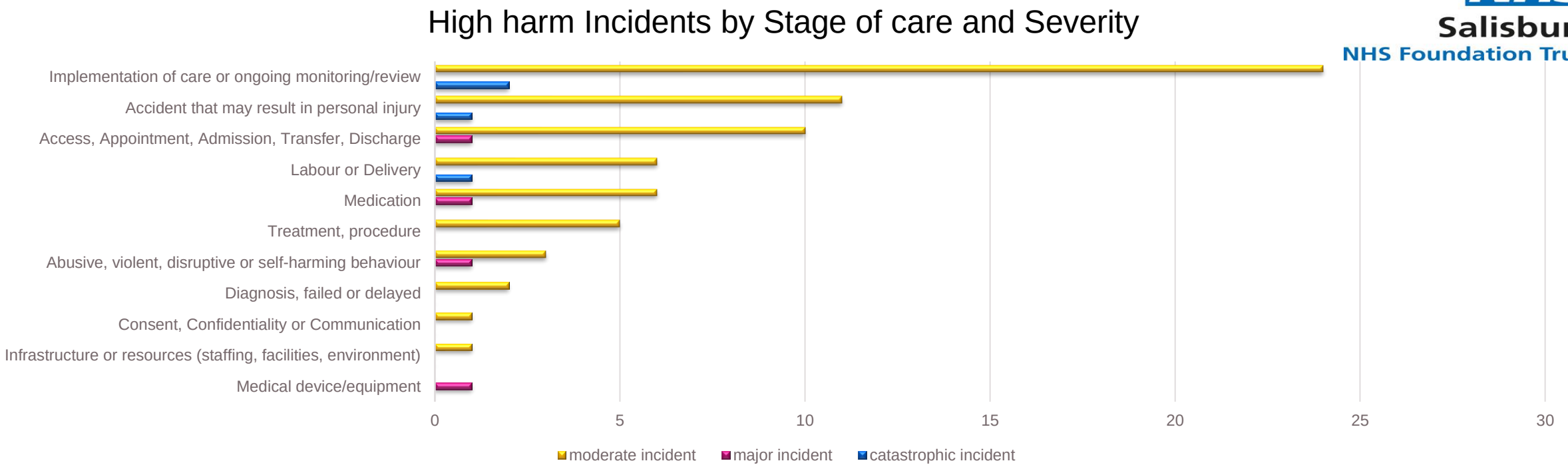
	Oct 2024	Nov 2024	Dec 2024	Total
no harm	61	56	37	154
minor incident	2	3	2	7
moderate incident	4	2	5	11
catastrophic incident	0	0	1	1
Total	67	61	45	173

In total 173 datix reports were submitted in the Women and newborn division during Q3.





Breakdown of all Moderate and above harm incidents in Q3



Of the 2700 incidents reported in Q3, 69 of these were moderate or above harm.

	Q1	Q2	Q3
Percentage of incidents with high harm	3.08%	3.24%	2.55%

This will look slightly different to the IPR data as these figures include all reported incidents on Datix not just patient safety incidents.

Patient Safety Incident Investigation (PSII) and Clinical Review (CR) updates

Work has continued to complete outstanding SII/CRs.

All Serious Incidents and Clinical Reviews are now complete and being shared with the patients involved.

In Q2- 3 PSIIs were commenced:

July PSII 7 – Wrong route medication (Never Event)
July PSII 8 – Discharge process (Local priority)
Sept PSII 9- Unexpected death (National priority)

In Q3- …. PSIIs have commenced:

Nov – PSII 10 - catastrophic fall with C spine fracture (National priority)
MNSI case - Intrauterine death 40/40 (National priority)

In Q3 …. Thematic review

ED diabetic care thematic review - currently sat with division for action plan development

Risk Registers and Duty of Candour

Divisional and Service Level Risk Registers

NHS Salisbury NHS Foundation Trust

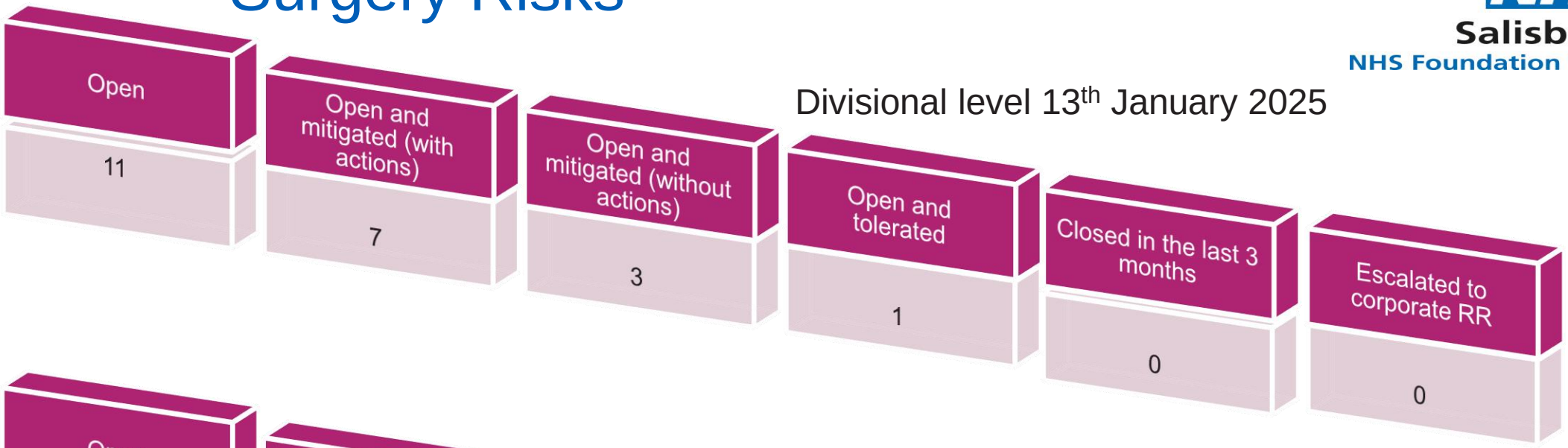
The Mini Deep Dives that review all service level risks continued to be rolled out across the divisions, the focus was CSFS in Q3. these deep dives support standardisation and education for the service level teams across the trust and continues to raise awareness of new risks, risks that are increasing in score and risks that require closure.

The following slides show the service level and divisional level risk registers in Surgery, Medicine and CSFS.

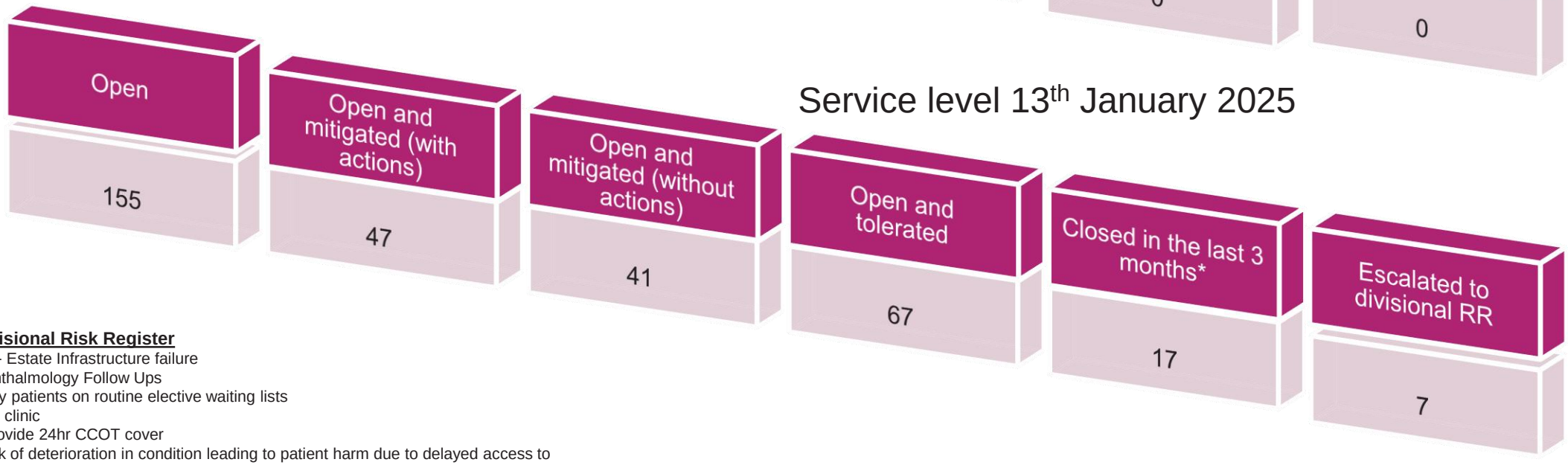
Surgery Risks

Salisbury NHS Foundation Trust

Divisional level 13th January 2025



Service level 13th January 2025



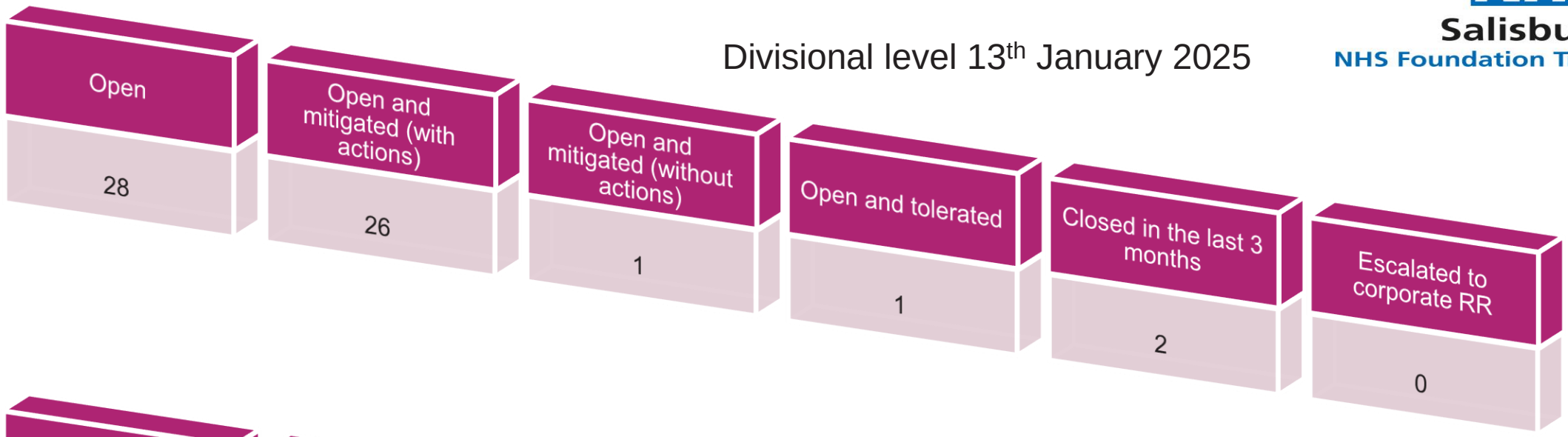
Escalated to Divisional Risk Register

- Risk of DSU - Estate Infrastructure failure
- Overdue Ophthalmology Follow Ups
- Spinal urology patients on routine elective waiting lists
- Diabetes foot clinic
- Inability to provide 24hr CCOT cover
- There is a risk of deterioration in condition leading to patient harm due to delayed access to ERCP
- Risk of increase length of stay for orthopaedic trauma due to Therapy staffing

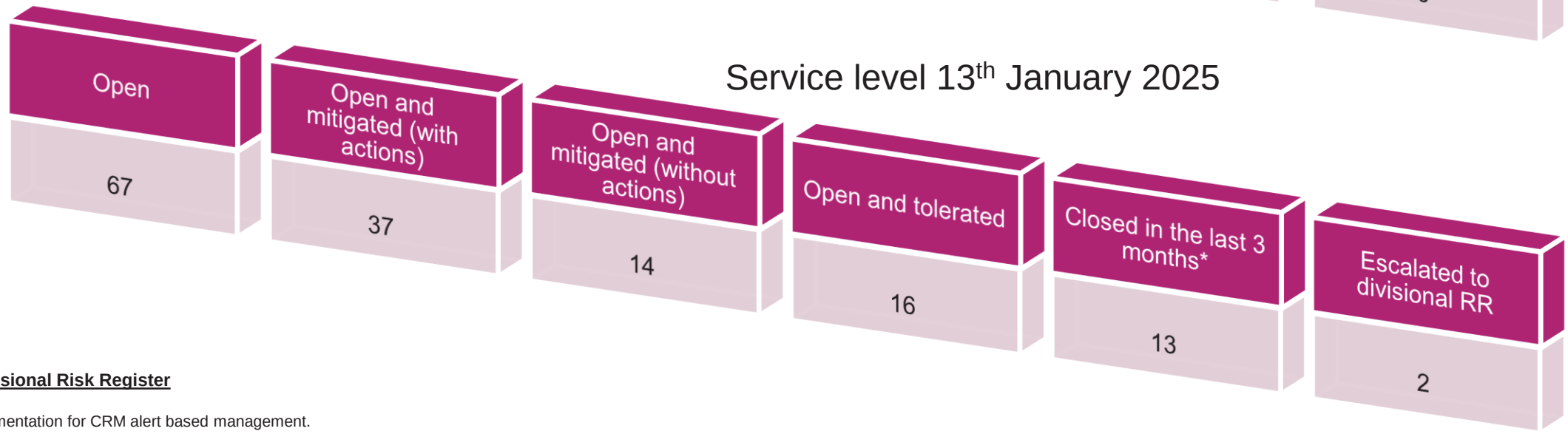
Medicine Risks

Salisbury NHS Foundation Trust

Divisional level 13th January 2025



Service level 13th January 2025



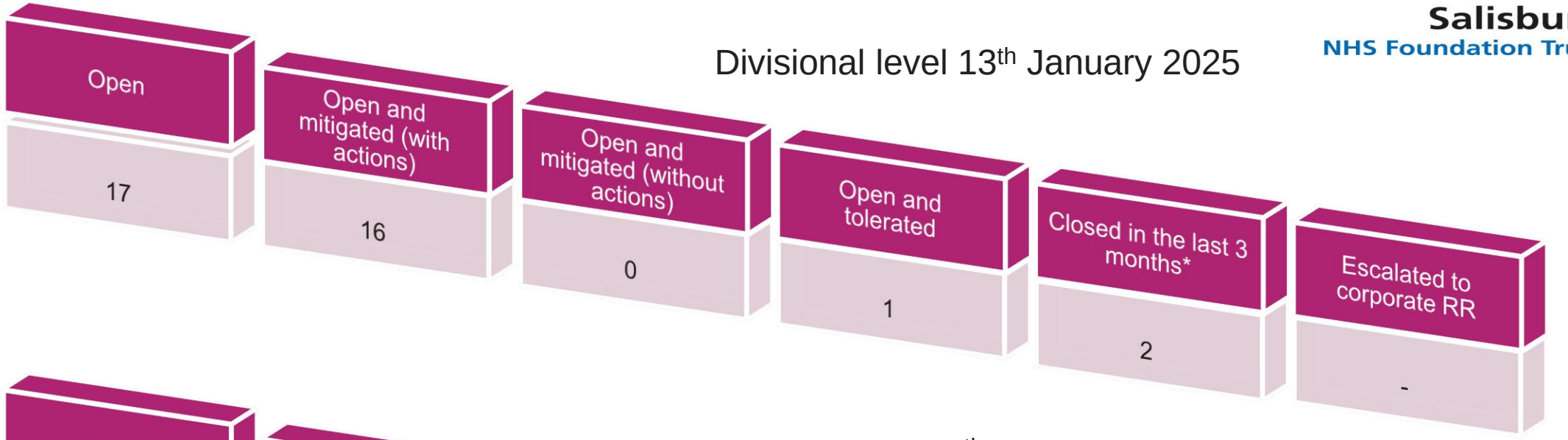
Escalated to Divisional Risk Register

- Lack of documentation for CRM alert based management.
- Neuro-Imaging Access Not Within National Guidelines

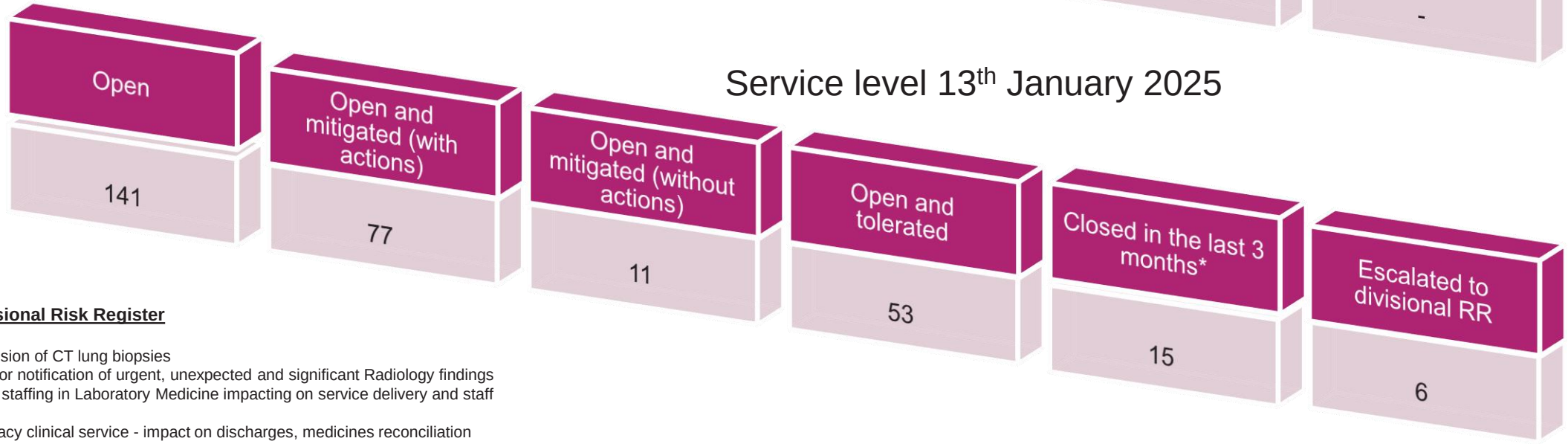
CSFS Risks

Salisbury NHS Foundation Trust

Divisional level 13th January 2025



Service level 13th January 2025



Escalated to Divisional Risk Register

- No future provision of CT lung biopsies
- No IT system for notification of urgent, unexpected and significant Radiology findings
- Reduced MLA staffing in Laboratory Medicine impacting on service delivery and staff wellbeing.
- Lack of pharmacy clinical service - impact on discharges, medicines reconciliation
- Lack of clinical pharmacy service at weekends
- Delays in reporting referral laboratory results in Laboratory Medicine

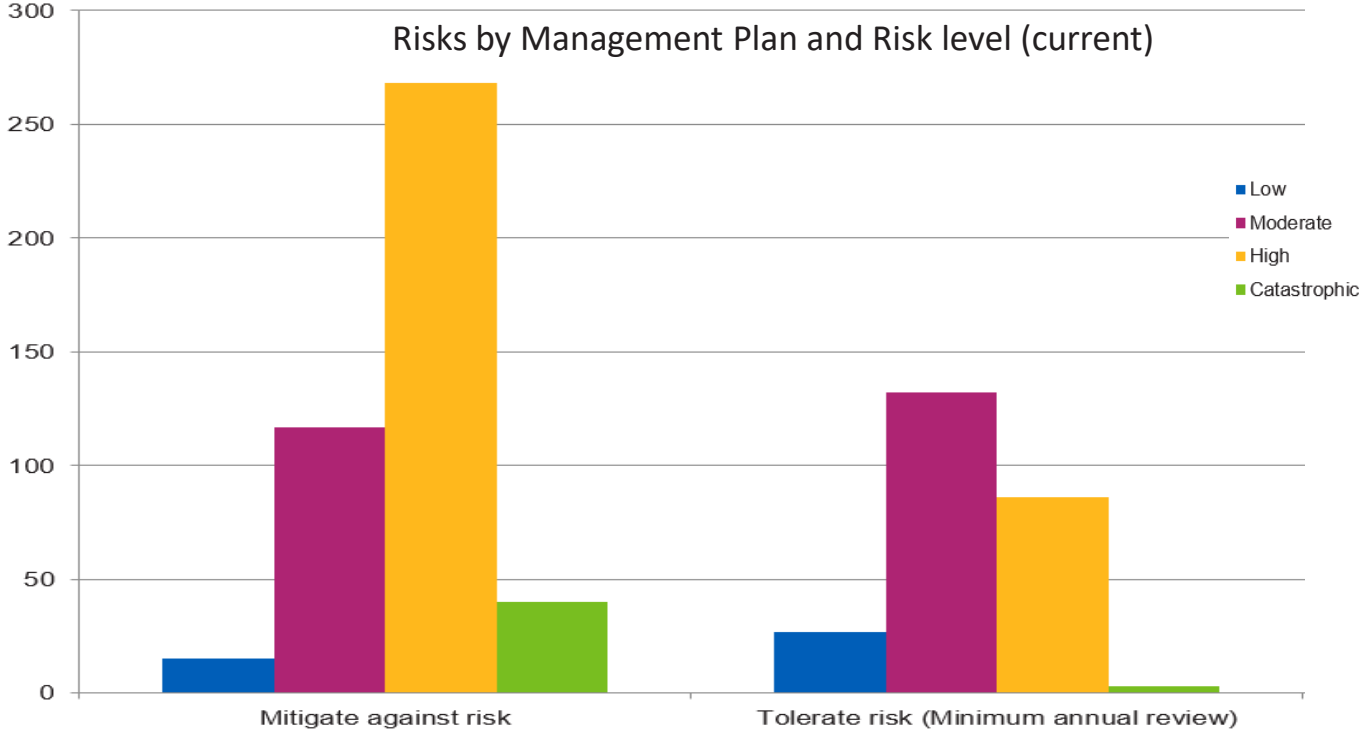
Trust wide Risk Registers

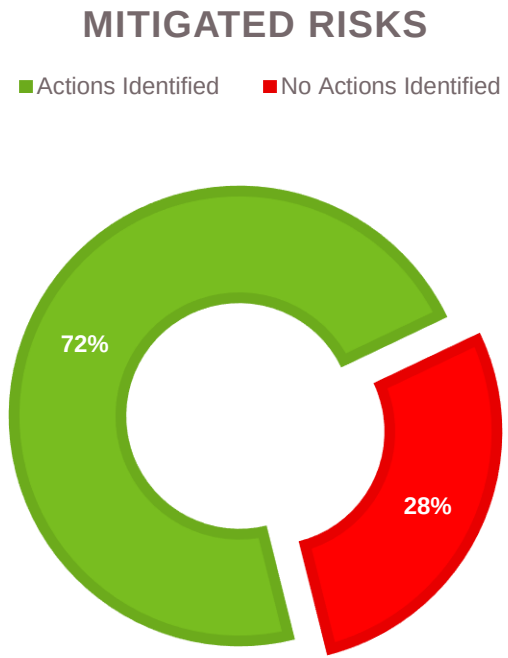
As of 15th January 2025, there are 694 open risks throughout the Trust compared with 704 in Q2, of these 248 (250 in Q2) are being tolerated while 440 (447 in Q2) are being mitigated.

Of the 440 (447 in Q2) mitigated risks, 124 (132 in Q2) of these still do not have actions, work continues to address this with the risk owners.

Continued focus on education around mitigated risks and the requirement for actions to be in place. There has been some improvement, but further support is necessary.

	Q1	Q2	Q3
New Risks	-	11	53
Closed Risks (Service Level)	86	96	73
Closed Risks (Divisional Level)	4	17	5

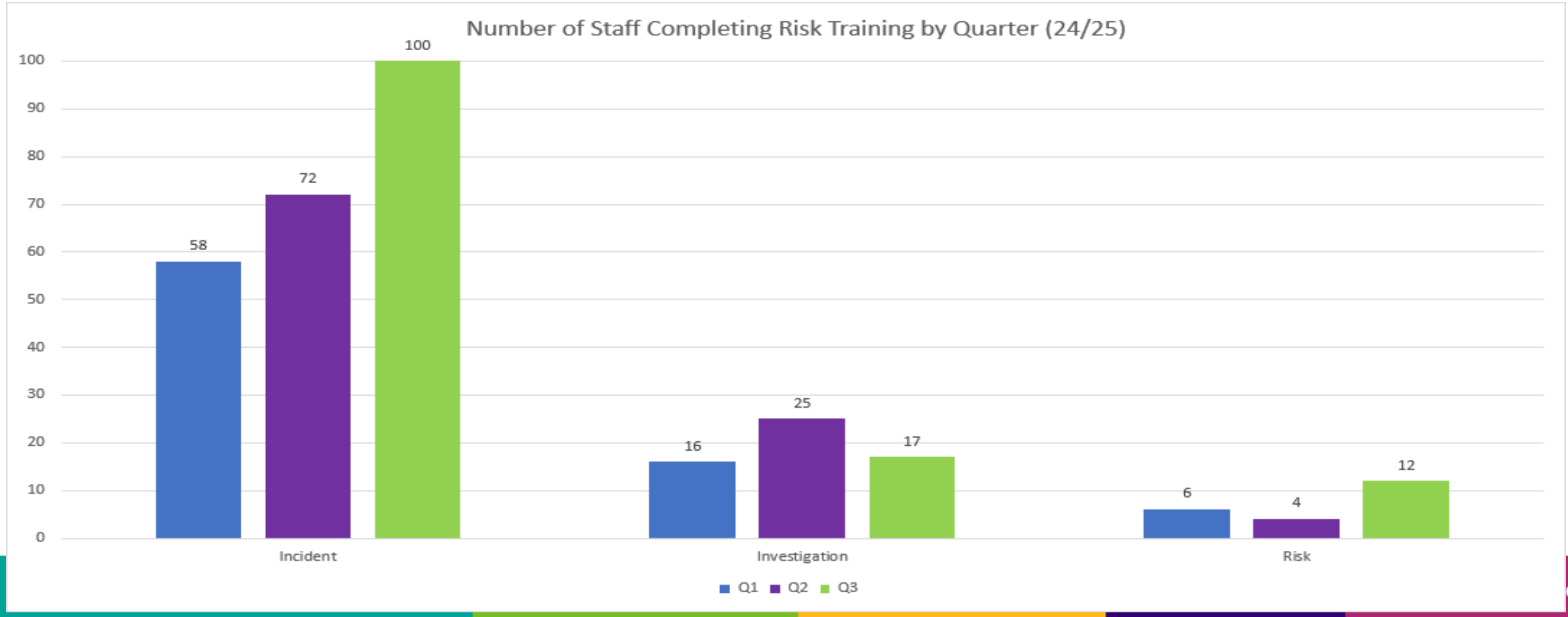




Risk Management Training

The Risk Management team provide training to staff who are responsible for their area's incidents and risk registers.

- The incident training is part of the Trust induction
- The investigation training is provided twice monthly and is a requirement before staff can log into Datix to investigate an incident.
- The risk register training is housed on MLE.
- In addition, the Risk Management team provide ad hoc training alongside this for specific area manager needs.



Duty of Candour (DoC) Part 1

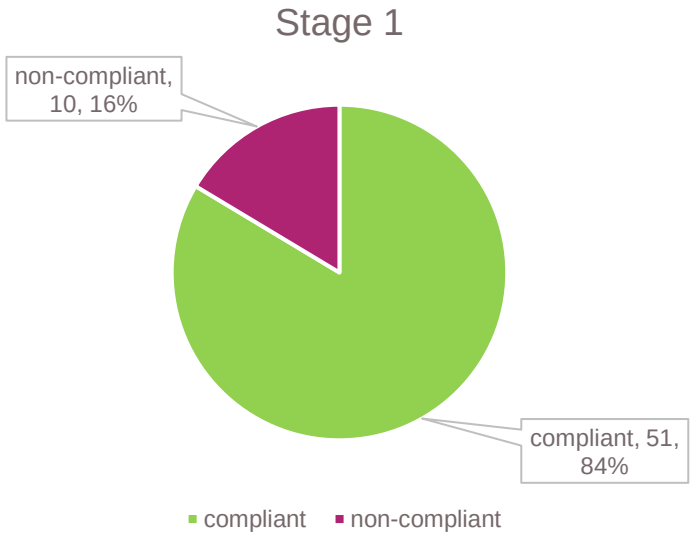
Salisbury NHS Foundation Trust

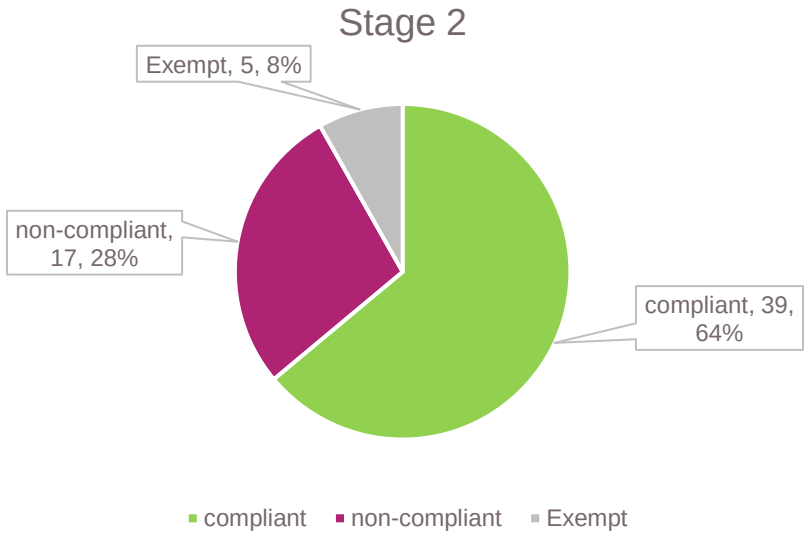
Q3 DoC Compliance to date (as of 14/01/2025)

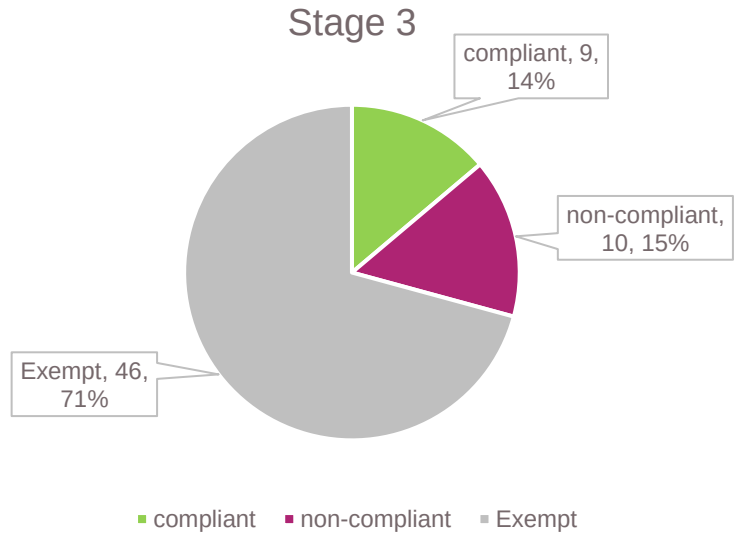
Duty of candour is a three-stage process that requires an apology for any incident reported as moderate or above. This is broken down into the following stages:
Stage 1 – verbal apology
Stage 2 -following the verbal apology with a letter outlining what was said in the apology.
Stage 3- an opportunity to share the findings of the incident/review.
It is a requirement that the above is captured on our Datix system to evidence that stage 1, 2 and 3 has occurred as currently this is how the Trust compliance is reported.

All DoC is discussed at the weekly Patient Safety Summit to keep track of compliance. The charts below reflect compliance in all 3 of Duty of Candour stages.

Compliance has reduced in quarter 3 despite the continued drive of education & awareness. In quarter 4 the Patient Safety Oversight Group (PSOG) will be commencing which will provide an opportunity to strengthen the quality of the reports so they can be shared sooner. There is also additional education being cascaded to support with the completion of PSRs by the Patient Safety Team.



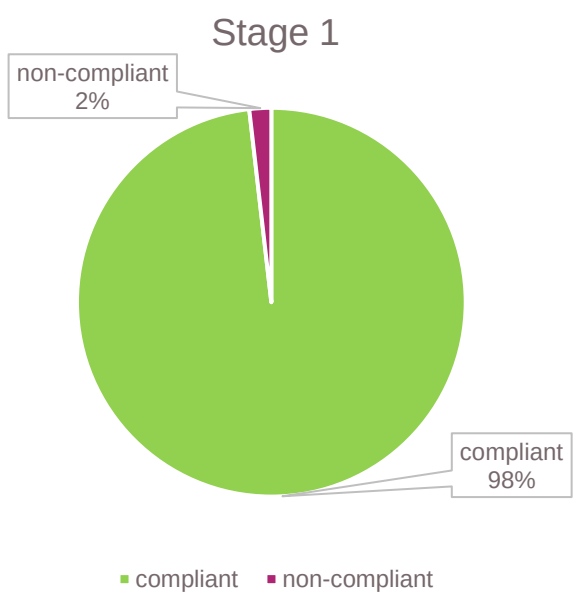


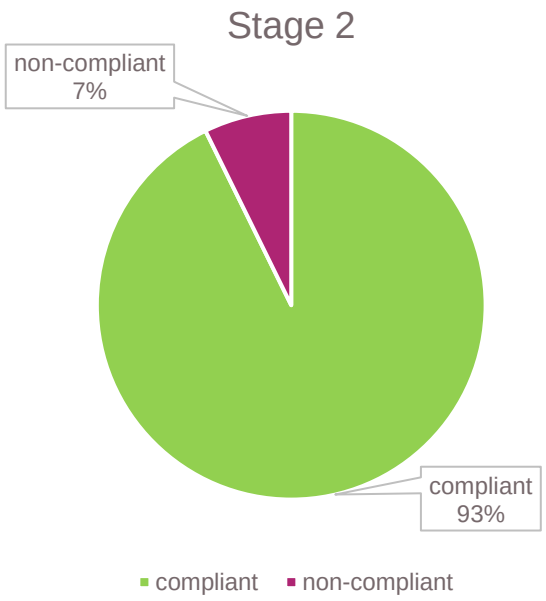


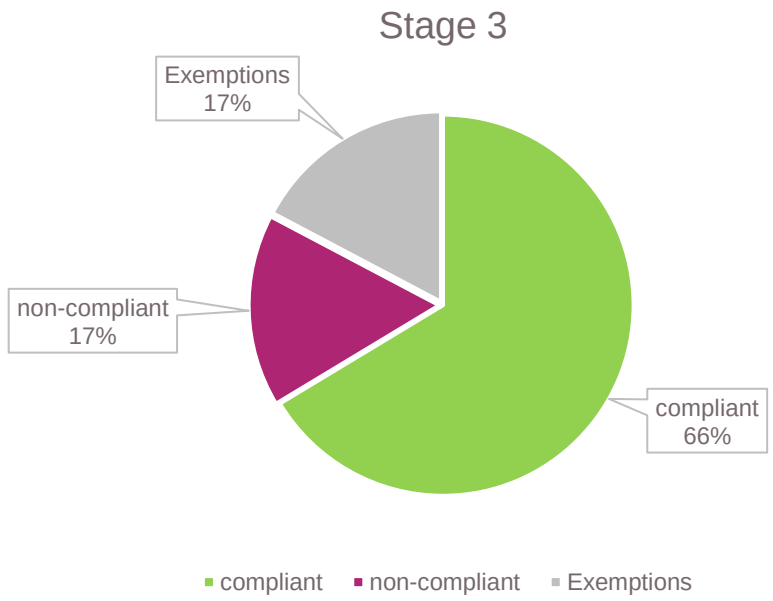
Duty of Candour (DoC) Part 2

Salisbury NHS Foundation Trust

Q1&2 DoC Compliance to date (as of 14/01/2025)







In Conclusion…

NHS Salisbury NHS Foundation Trust

- The Trust has upgraded to the latest version of Datix to remain compliant with NHSE's LFPSE requirements. This was the first upgrade performed by the I.T department since RLDatix retracted their assistance with upgrades. This went efficiently with minimal disruption to the Trust.

- There has been several Datix reporting form optimisations to improve the reporting experience and ensure our reporting culture remains high. Although the form remains lengthy due to mandatory LFPSE fields, the general feedback remains positive.

- SFT harm data is now available to access via the NHSE LFPSE data portal. This outlined a discrepancy in data between Datix incident severity grading and LFPSE data. Work is being done to reconcile this data and sustain aligned gradings going forward.

- There have been 15 risks escalated from service level to Divisional in Q3: Medicine – 2, Surgery – 7, CSFS – 6.

- There have been 0 escalated from Divisional risk register to Corporate risk register in Q3.

- Data from Q1 & Q2 has shown significant improvement in duty and candour compliance overall. Stage at 98%, stage 2 at 93% & stage 3 at 80%. Work is continuing in supporting the wards.

- Of the 2700 incidents reported in Q3, 69 of these were moderate or above harm which is an average 2.55% of incidents compared with 3.24% of incidents in Q2 and 3.08% in Q1.

- The second round of 'Matron Deep Dives' have been commenced in Q3 to review all department level risks. This is facilitating standardisation across the Divisions in reviewing their ward/department risks. The Matron Deep Dives are providing an opportunity to enhance learning & education around risk registers.

- Collaboration with Clinical Psychology & OD&P has enabled us to implement a staff wellbeing section within Datix to gather data to ensure the impact on staff is recognised and appropriate help is signposted.

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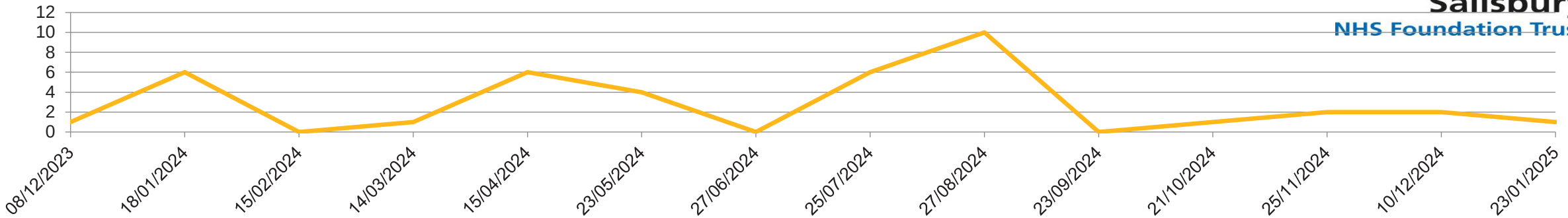
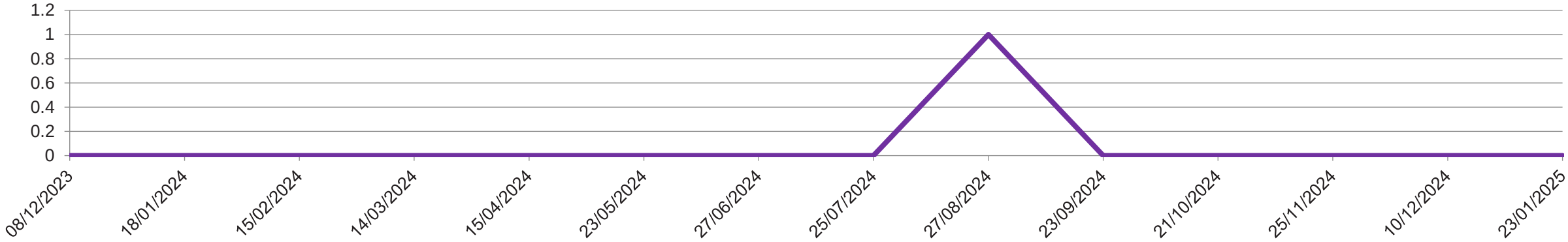
Appendices

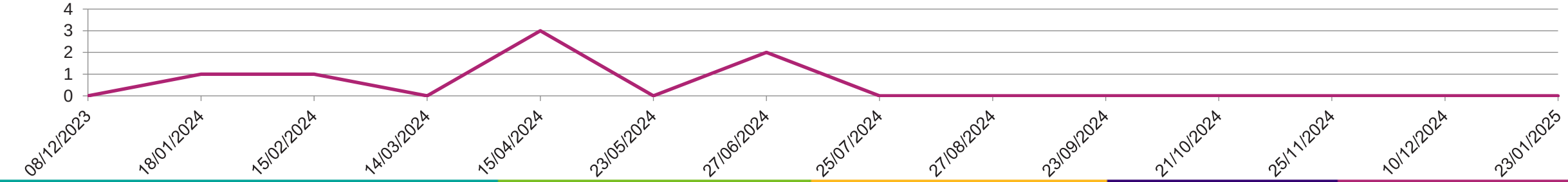
Surgery: Number of Risks in the Status of 'New Risk Awaiting DMT Review' for Over 28 Days



Medicine: Number of Risks in the Status of 'New Risk Awaiting DMT Review' for Over 28 Days



CSFS: Number of Risks in the Status of 'New Risk Awaiting DMT Review' for Over 28 Days



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	1st May 2025		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services – **March 2025 (February 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Maternity Governance 14.03.2025 CGC 25 March 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for February 2025.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Midwife to birth ratio 1:23– SFT recommended ratio 1:24.
- 1:1 care in labour achieved 100% of time
- Supernumerary status of labour ward maintained 100% time.

- Business case being written to propose increase in Neonatal Nurses and Medical staffing to achieve BAPM compliance
- BAPM compliance significantly reduced due to increased acuity and specific clinical need on NICU in February

PMRT

- 1 stillbirth in February
- 0 Neonatal death in February

- 1 PMRT case for review in February -Graded B and B
  - **B** - The review group identified care issues which they considered would have made no difference to the outcome for the baby
  - **B** - The review group identified care issues which they considered would have made no difference to the outcome for the mother

Incidents reported as moderate.

- 8 Incidents reported as moderate or above, relate to 7 care incidents. (1 x Catastrophic and 1x severe both relate to same case)

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champions, you said/We did boards updated monthly on wards.

Compliance to National Standards

- Three-year delivery plan – focus on action and compliance in this final year
- Work continues to improve compliance to Saving Babies Lives v3 in line with projected trajectory. Submission to LMNS in February, awaiting feedback

Themes

- PPH>1500ml thematic review. Noted higher incidences of women from global majority (30%) despite this group representing 12% of maternity service users.
- Plan to continue to focus on demographic and inequalities when reviewing incidences and themes.

Litigation Scorecard

- Evidence provided (slide 15) that the Trust's claims scorecard is reviewed alongside incident and complaint data. The Scorecard data is used to agree targeted interventions aimed at improving patient safety.

Board Assurance Framework – Strategic Priorities	Select as applicable:

Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe):	

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Perinatal Quality Surveillance

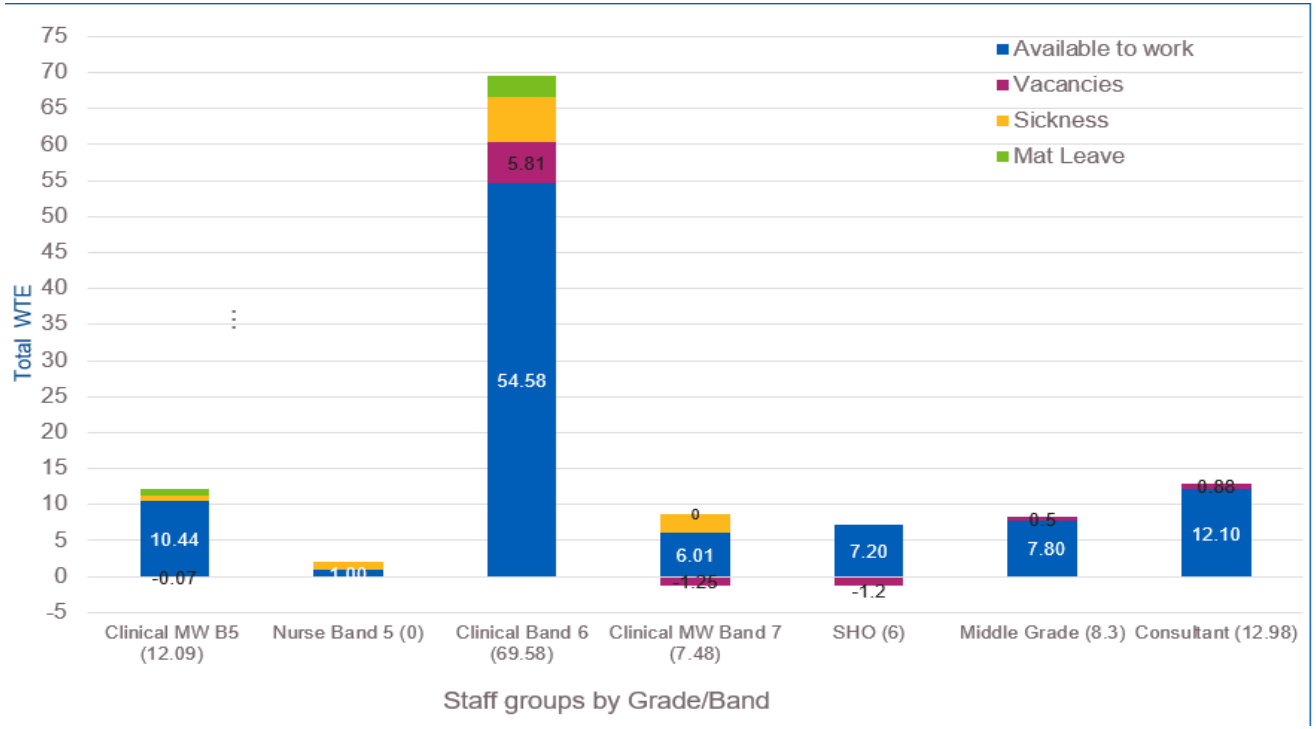
March 2025 (February Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Staffing vs acuity ratio was very positive this month showing 93% of the time there were required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show a decrease due to increased levels of short and long-term sickness.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this with new starters this month.

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Nov '24	Dec '24	Jan '25	Feb '25
Midwives	Day	99.4%	93.7%	98.3%	97.1%
	Night	96.7%	96.9%	97.5%	94.6%
MCA/MSWs	Day	85.3%	80.8%	86.5%	87%
	Night	93%	89.6%	94.4%	94%
NNU Nurses	Day	97.04%	90.8%	88.7%	79.9%
NNU Nurses	Night	99	93.8%	95.8%	84%

Countermeasures / Action (completed last month)	Owner
MCA recruitment	Workforce lead/HOM
NNU Band 6 recruitment	HOM

Countermeasures / Action (planned this month)	Owner
Review of sickness absence management compliance.	HOM

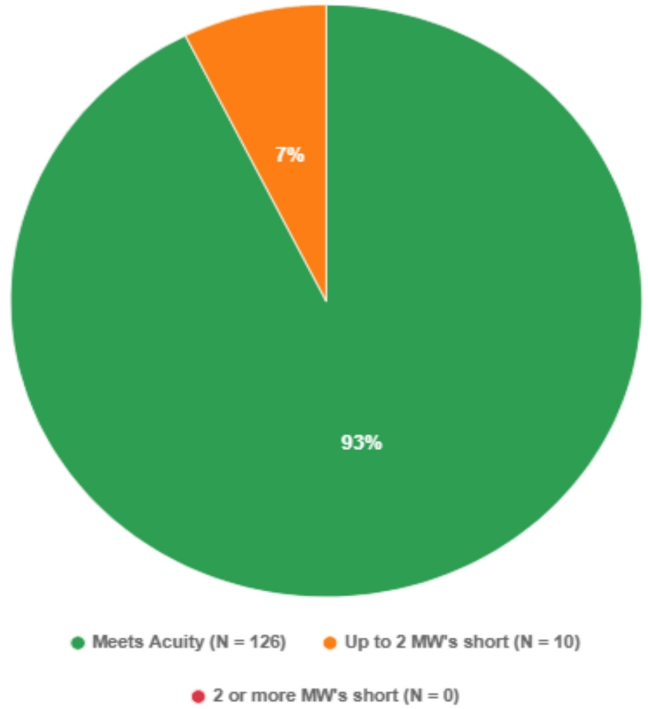
Safe: Maternity & Neonatal Workforce (cont)

	Target	Threshold		Dec '24	Jan '25	Feb '25	Comment
		Green	Red				
Midwife to birth ratio	1:24	1:24	>1:24	1::22	1:25	1:23	Ratio decreased this month due to a reduction in expected births and acuity..
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	84.4%	86.02%	76.7%	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		60	60	60	Consultant presence on Labour ward recently amended to align with Ockenden requirements.
Neonatal shifts staffed to BAPM standards	100%	>90	<90	84%	95.1%	50%	Recruitment plan in place to support BAPM standards compliance.
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	

Is the standard of care being delivered?
- Supernumerary Labour Ward coordinator status achieved 100% time.
- 1:1 care in labour achieved 100% of time.

What are the top contributors for under/over-achievement?
- The Midwife to Birth ratio decreased this month due to reduction in expected birth numbers.

Graph 1. Acuity by RAG vs staffing data:

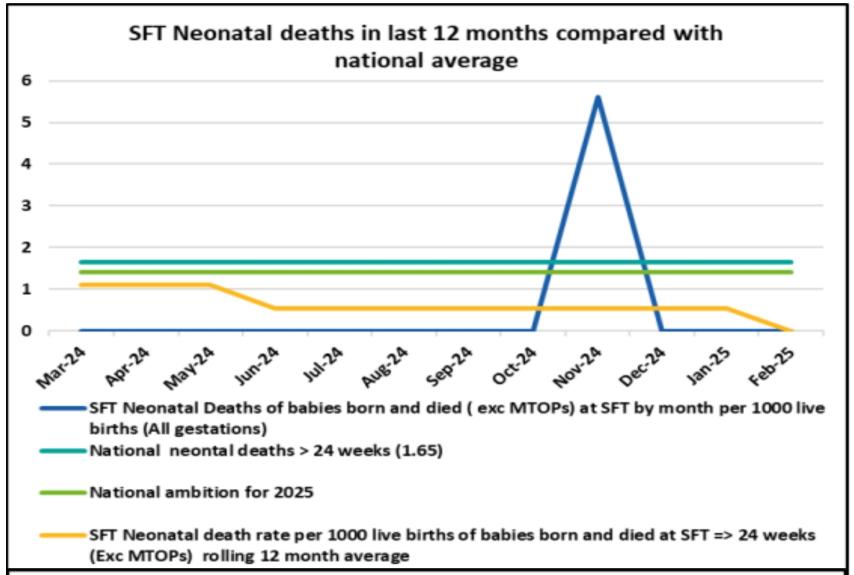


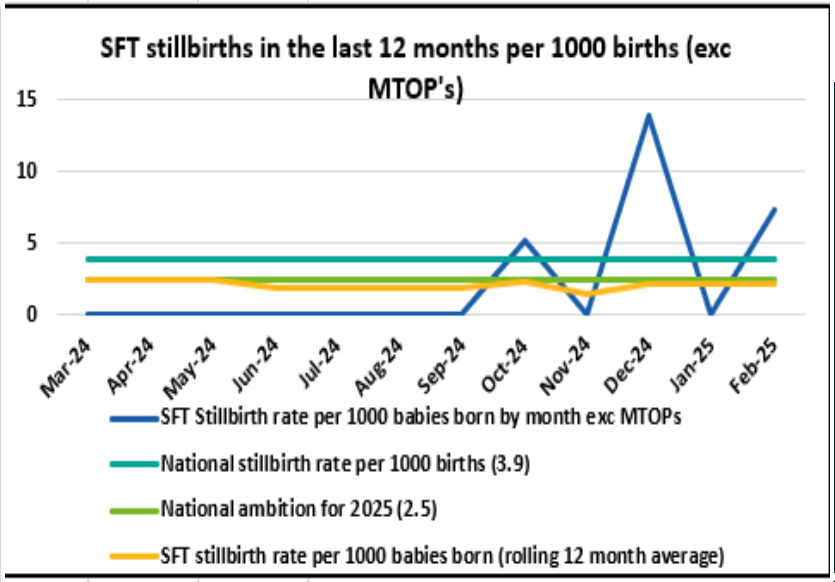
Countermeasures / Action (completed last month)	Owner
NNU Nurse Band 6 recruitment	HOM

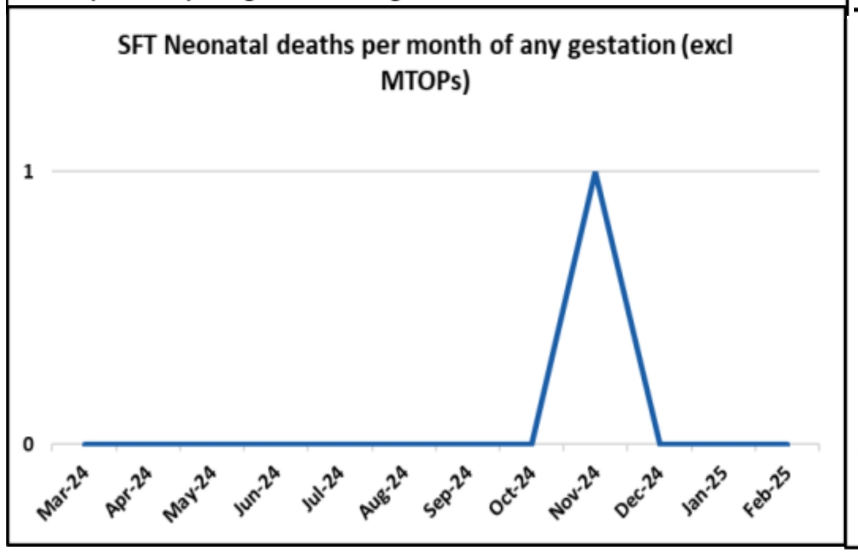
Countermeasures / Action (planned this month)	Owner
NNU Nurse Band 5 recruitment	HOM

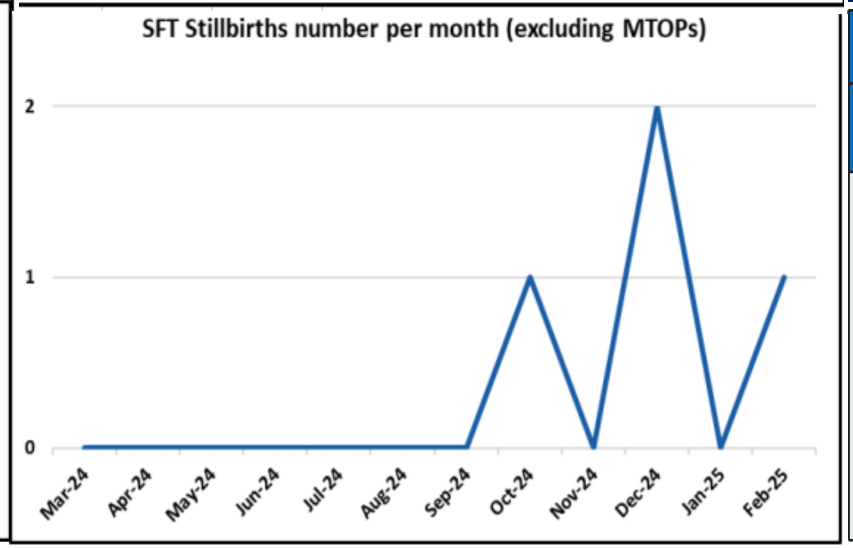
Safe: Perinatal Mortality Review Tool (PMRT)

Salisbury NHS Foundation Trust









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There was 1 perinatal loss in February >12 weeks.
- 32+6 week stillbirth.

PMRT Action Plans for Salisbury Foundation Trust – January 2025 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
96493/1	Stillbirth 26+3	-Ensure DV asked and PHQ and GAD scores completed. -Use of partograms will now be covered with Badgernet. -Add CMV and Toxo to bloods and ensure added to test group set. -Educate staff on Kleihauer requests	S.Thompson and CLA	30/4/25

PMRT grading of care – Key

Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
Case: 96493/1	Review: 7/2/25	B B	Stillbirth 25/40	- Ensure DV asked and PHQ and GAD scores completed. - Use of partograms will now be covered with Badgernet. - Add CMV and Toxo to bloods and ensure added to test group set. - Educate staff on Kleihauer requests.	N/A	N/A

INCIDENTS: Moderate Incidents and PSRs

Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (DATIX)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
173513	04/02/25	Moderate	Sepsis, LSCS & ITU admission	PSR Part 1 presented, for MDT & Part 2	**N**		
173673	07/02/25	Moderate	Term Admission	PSR Part 1 presented, for MDT & Part 2	**N**		
173909	14/02/25	Moderate	Term Admission	HIE grade 2, referred to MNSI	**N**	**Y**	
173968	17/02/25	Severe	IUD, Abruption and MOH	PSR Part 1 presented	**N**		
174219	17/02/25	Catastrophic	Ambulance Delay and IUD	Linked to 173968 Datix above for SWAST Investigation	**N**		
174101	20/02/25	Moderate	Term Admission	Pending review			
174224	24/02/25	Moderate	Term Admission	Pending review			
174350	26/02/25	Moderate	Term Admission	Pending review			

PSRs Presented

Datix Number	Presentation Date	Incident Summary	Actions	Part 2 or PSII?
173513	07/02/25	Sepsis / ITU	• Awaiting meeting date with A&E Matron to understand processes and pathways. • MDT review needed.	Part 2 to be written
172472	07/02/25	NICU Admission (Unknown Gestation)	• Presented to PSS as a PSR Part 1 due to meeting criteria for poor cord gases. • No omission in care identified.	Case closed
173909	13/02/25	Term Admission to NICU	• Difficult birth extraction during surgery. • Referred to MNSI – currently triaging.	MSNI

INCIDENTS: Investigation update

NHS Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date	Category	Incident	Outcome/Learning/Actions
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Feedback provided on draft report. Awaiting final report.
MNSI 163944	04/03/2024	Moderate	Baby transferred to tertiary unit for cooling	Final report received and met with family. **Next steps:** Action plan drafted, for review by DMT and to PSOG group (for approval).

Responsive – Patient Experience

NHS Salisbury NHS Foundation Trust

MNVP Service User Feedback

Positive Themes:

- Great consistency of antenatal midwife appointments (parents felt well looked after).
- Reassuring care from DAU.

Areas for improvement:

- Continuity of consultant care.
- More consistent information for GDM (Birth Centre access/ General information & assistance for management).

Complaints and Concerns

Complaints received	Summary / themes
2	Unhappy with aspects of intrapartum and postnatal care
	Unhappy with antenatal and postnatal advice given.

Concerns received	Summary / themes
0	N/A

Safety Champions

Concerns from staff	Action
Support for staff in antenatal clinic with Badgernet roll out.	An extra resident doctor will be available in antenatal clinic to support with patient flow plus a specialist BadgerNet floor walker to support

Items for escalation.....

1. Nil

You said, we did...

'Delays in getting hold of amnihooks and delivery packs.'

'Issues have now been resolved. Amnihook procurement as a result of national delivery issues '

Friends and Family Test

Response rate	% Positive	% Negative
9%	92.8%	4.7%

Top 3 themes	
Positive	**Negative**
• Staff attitudes (23) • Implementation of care (15) • Environment (14)	• Environment (3) • Implementation of care (3) • waiting times (3)

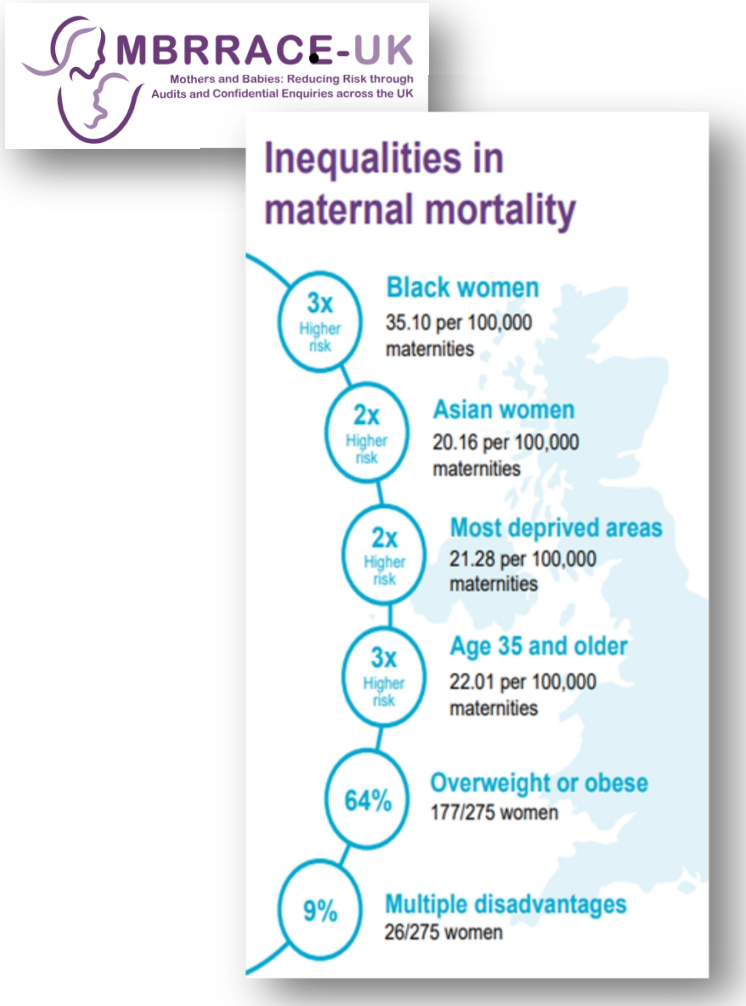
Service User Compliments

- **10 compliments reported on Datix in February for NNU and maternity services**

Compliments - top themes	Numbers received
Gratitude	3
Support	3
Care	2

Health Inequalities – Priorities

NHS Salisbury NHS Foundation Trust



Listening events: Eligibility under the ARAP/ Afghan refugee community.

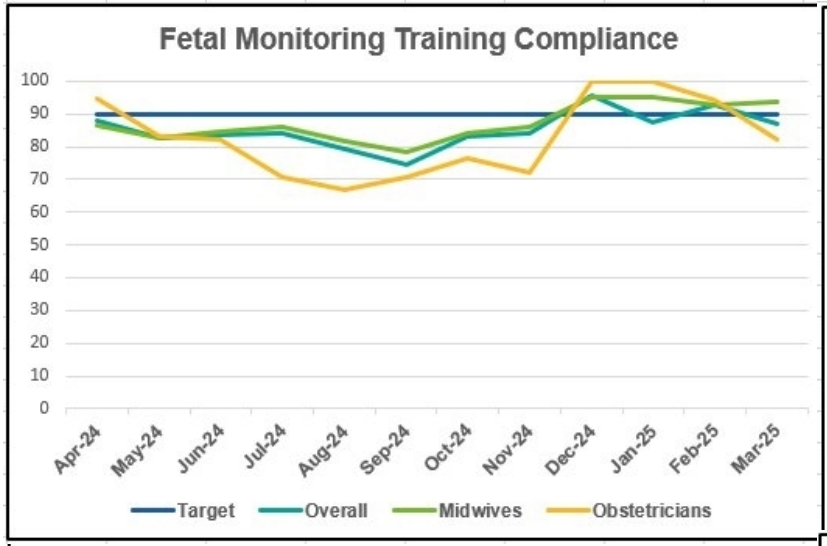
Ongoing Projects: Work is ongoing to establish a pathway to enable all Community Hubs to offer in-person parent education classes.

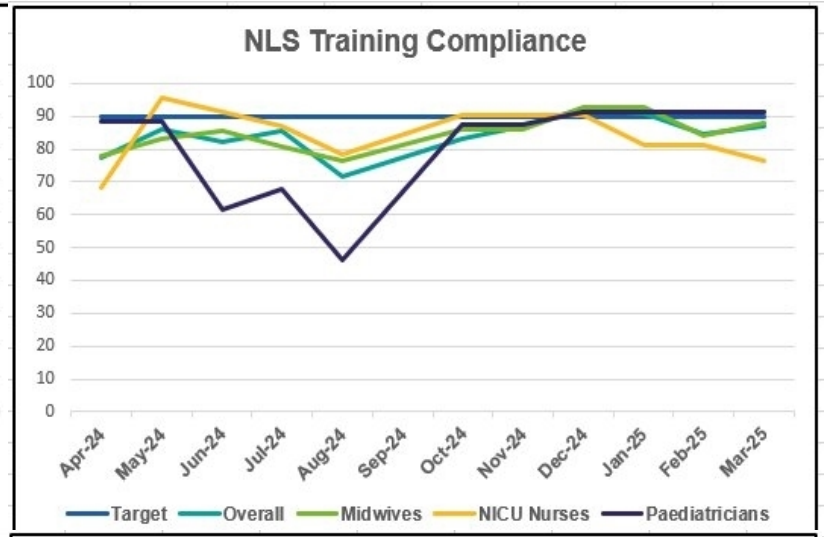
Equality Data: Work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for summer 2025. This will support targeted activities and bench-marking against national MBRRACE data .

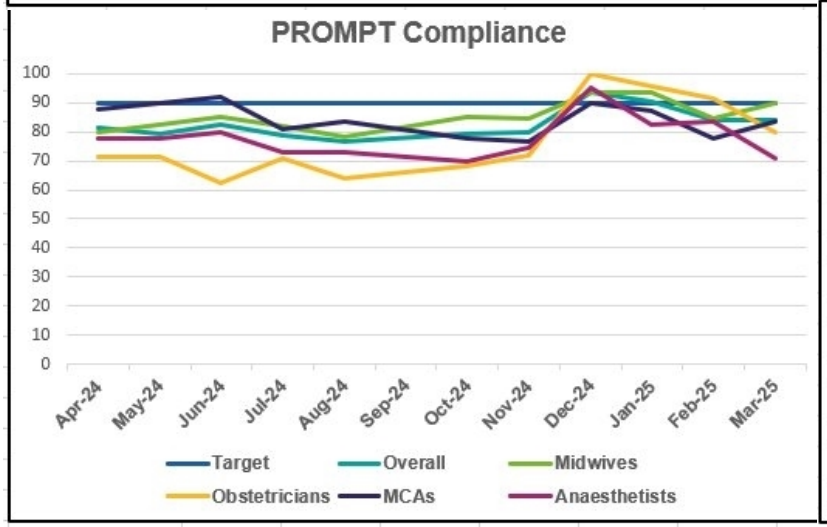
Translation service: Translation tool bar functionality to be implemented on the Trust's website.

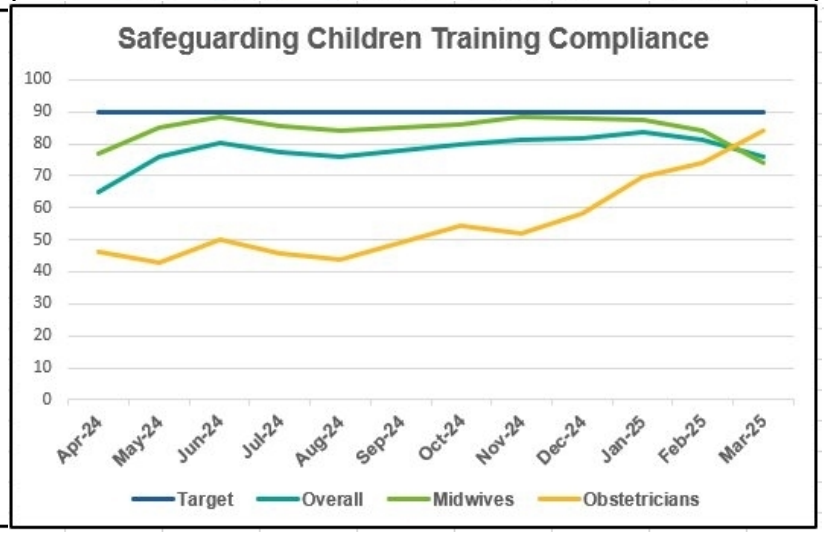
We continue to explore 'at the point of contact' translation services. We hope to purchase 10 'Pocketalk' translation devices (following positive feedback from trials undertaken in Nottingham and Southampton primary care). Steady progress has been made, and it is hoped we will roll out the device in March/ April 2025. The SOP and related documentation is to be submitted for approval during March's Maternity Risk Governance meeting.

Well-led: Training









Training

Updated training plan commenced in 2025 to meet the Core Competency Framework Version 2 (CCFv2) requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Anaesthetics planning to send staff on every PROMPT date evenly throughout 2025 (to maintain compliance rather than see drop-off over summer as in 2024) - some staff booked on did not attend in February.
- Additional SG Children sessions being planned within maternity to maintain compliance in 2025 (limited dates available with Trust SG team).

Risks:

- MDT attendance (obstetric) at all PROMPT and fetal monitoring training is a challenge and has dropped below the 90% compliance required. All obstetricians continue to be booked to attend these study days.
- Obstetric engagement with eLearning requirements of SBL is a challenge and has been escalated with a plan to provide face-to-face sessions.

Compliance to National Guidance (1)

CNST Maternity Incentive Scheme (Year 6)

	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
Are we well led?		Description	Yr 5 Submission	Comment	Current Assessment
	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
	4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
	5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Compliant	Met best endeavours of improvement	
	7	**Service User Involvement and co-Production**	Compliant	All Standards Met	
	8	**Multidisciplinary Training**	Compliant	All Standards Met	
	9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
	10	**HSIB and EN Reporting**	Compliant	All Standards Met	

Maternity Incentive Scheme (CNST)

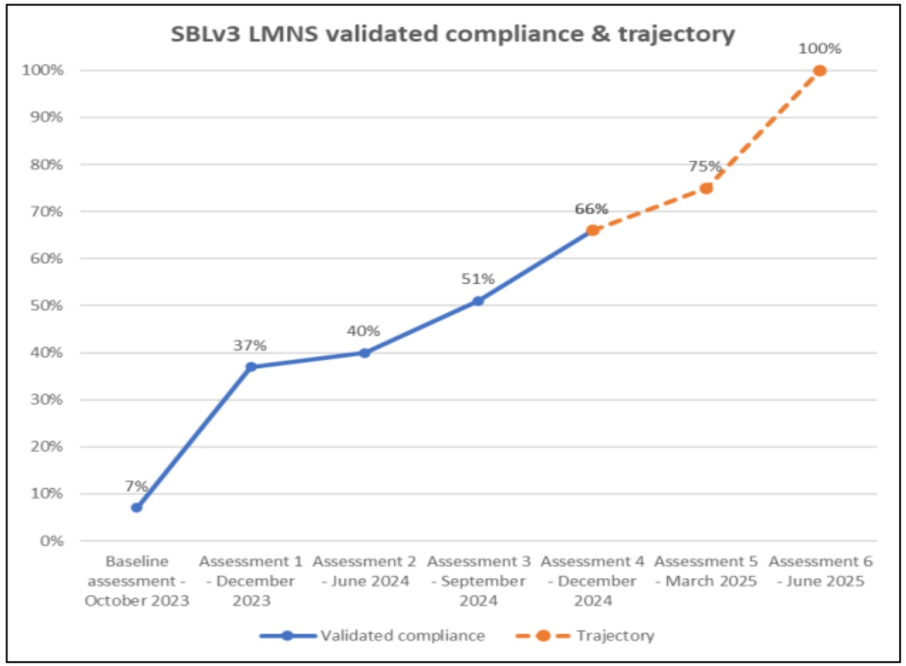
Key Achievements:

- Trust Board supported declaring 10 out of 10 compliance.

Next steps for progression:

- Continue to focus on completion of SBL and await guidance for MIS Year 7.

Saving Babies Lives v3



Saving Babies Lives v3

Key Achievements:

- SFT have achieved 66% compliance from the recent November 2024 submission.
- Latest submission uploaded 20/02/25.

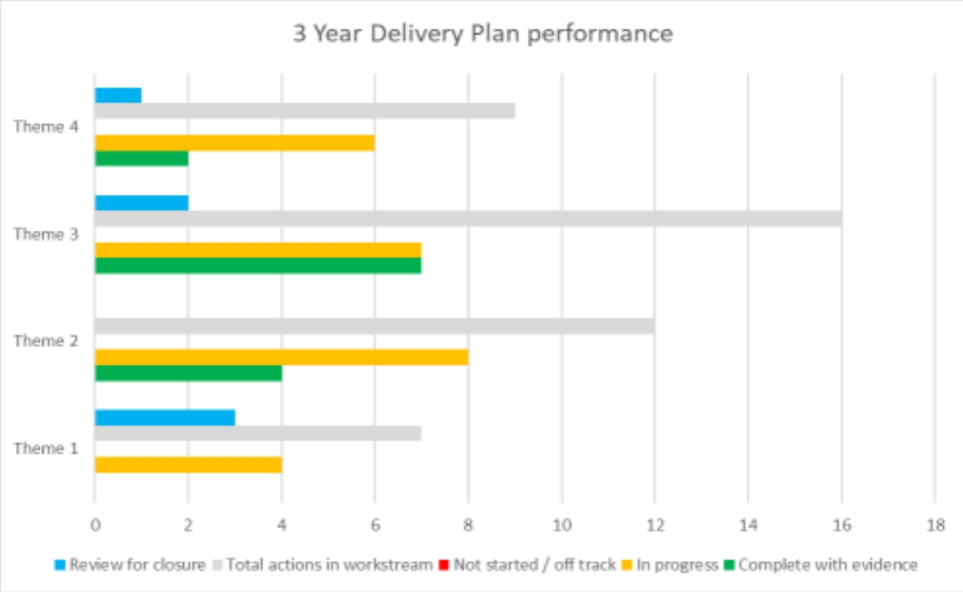
Next steps for progression:

- Currently awaiting LMNS feedback.

Compliance to National Guidance (2)

Salisbury NHS Foundation Trust

3 Year Delivery Plan



3-Year Delivery Plan

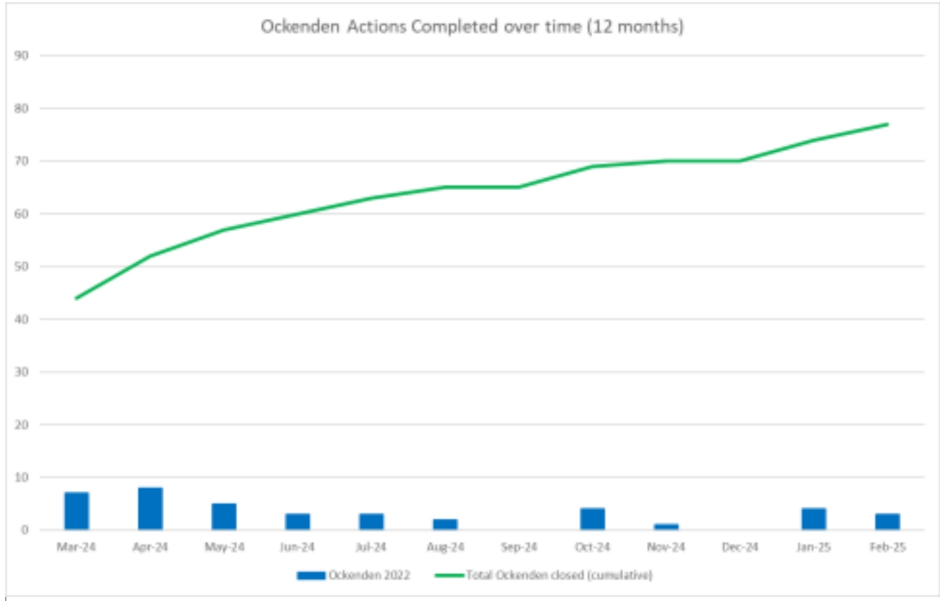
Key Achievements:

- Of the 44 actions; 26 are in progress and no concerns identified. The remaining 18 have been completed.

Next steps for progression:

- Continue to meet with action holders.
- Provide evidence of completed actions.

Ockenden 2022



Ockenden 2022

- **Key achievements:** 3 further actions closed in February, with just 7 remaining open.
- **Next steps for progression:** Ongoing work continues around labour ward coordinator leadership education, succession planning gap analysis and leadership development training, maternity self-assessment, centralised CTG monitoring and anaesthetic documentation.

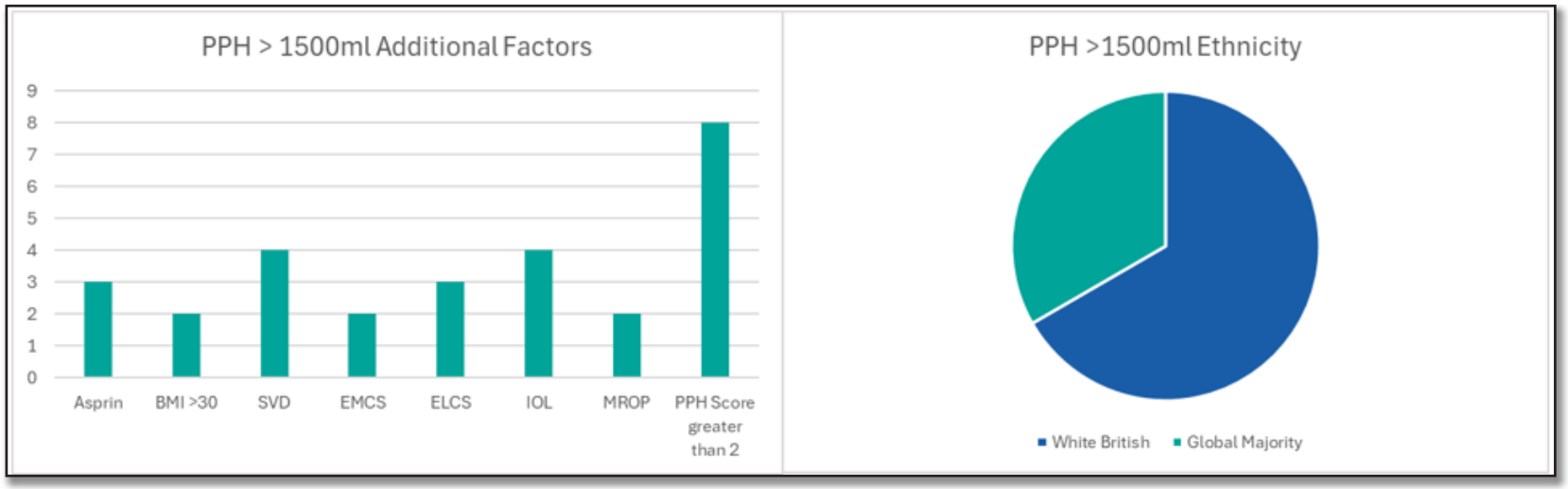
OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Feb-25	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	1	0	4
	9	Preterm Birth	0	0	0	4
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	0	0	4
	13	Bereavement Care	0	0	0	4
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	7	0	↑ 78

Themes

Including PSIRF 'continuous audits' & DATIX

Salisbury NHS Foundation Trust

PPH >1500ml



Results:

- 9 cases identified in February 2025.
- 30% of the women who experienced postpartum hemorrhage (PPH) over 1500ml were from the Global Majority, despite this group representing only 12% of the maternity service users.
- A PPH score greater than 2 was present in 8 out of the 9 women.

Actions:

- All cases have been incorporated into the ongoing rolling audit within W&NB for continuous data collection. A comprehensive thematic review is scheduled for the spring, which will enable a thorough analysis and facilitate enhanced data collection using the new governance-approved Datix proformas. These proformas capture additional details including: ethnicity, social deprivation areas and emerging trends.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

- The Perinatal Quad continue to use the action plan produced following the SCORE Survey, to prioritise their workstreams
- The Quad are aiming to organise a staff event in the spring, with a focus on OD&L, Wellbeing and celebrating Maternity & Neonatal services, following the feedback from the staff survey completed at the end of 2024 – look out for an invite!

Actions in progress:

- Following the culture and leadership work, the Neonatal nurses now attend the huddle on Sarum to ensure all clinical areas are aware of which Neonatal medical staff are on duty – helping with communication and collaboration across teams
- The "team of the shift" model continues to be used, to have a team check-in and support each other on shift.
- Members of staff offered 'Cultural conversations' training from NHSE to support the Quad work in responding to, and discussing with, staff about cultural and safety issues.

Litigation Scorecard

(Present March, June, Sept, Dec)

NHS Salisbury NHS Foundation Trust

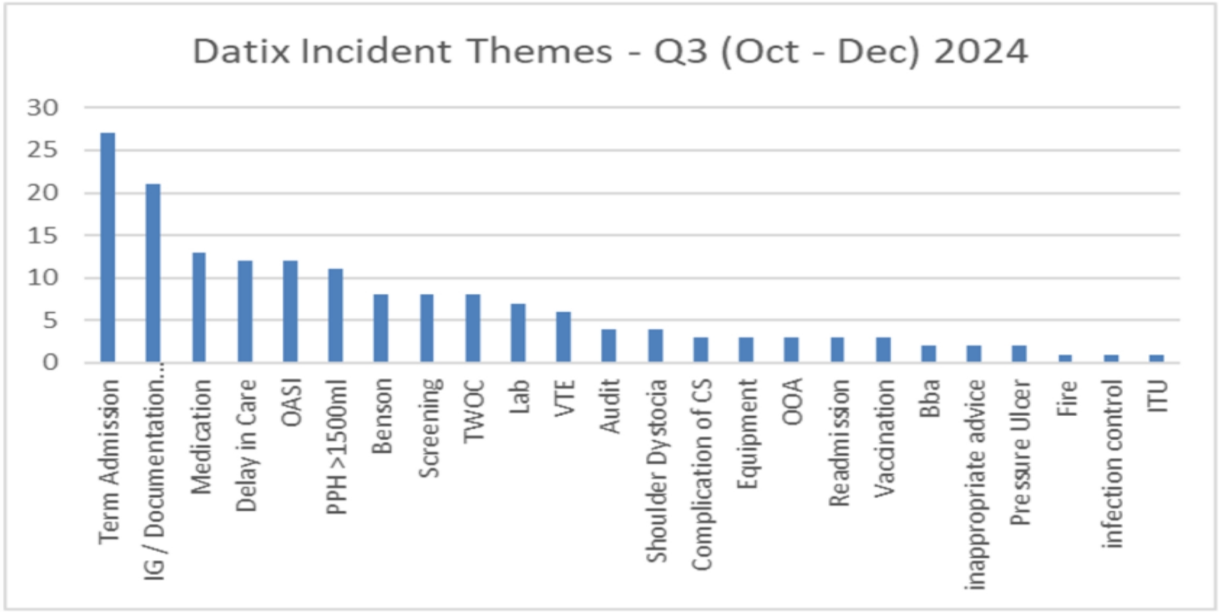
Scorecard summary (April 2014 – March 2024)

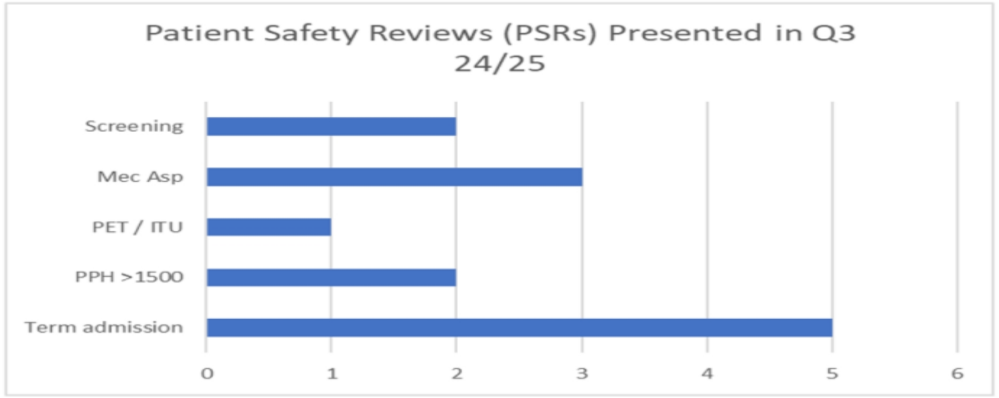
Top Causes by Value	Top Injuries by Value
• Bacterial Infection • Fail / Delay Treatment • Medication Error • Intra-Op Problems • Fail to warn —informed consent • Unexpected Death	• Failure / Delay Diagnosis • Failure to respond to abnormal FH • Failure to recog. complications • Birth Defects
Top Causes by Volume	**Top Injuries by Volume**
• Fail / Delay Diagnosis • Fail / Delay Treatment • Fail to act on abnormal test results • Incorrect injection site • Medication Error • Inadequate Nursing Care	• Perineal Trauma • Fail / Delay Treatment • Fail to recog. complications • Fail to warn —informed consent • Fail to follow up —arrangements • Fail to diagnose PET

Low to High Value

Low to High Volume

Q3 Incidents





Q3 Complaints

3 complaints received:

- Bladder management
- Labour care and the immediate postnatal period
- Management and communications during instrumental birth.

***Maternity Incentive Scheme (MIS) - SA9: Quarterly review of litigation scorecard alongside incident and complaint data*

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.4
Date of meeting:	1st May 2025		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –**April 2025 (March 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Maternity Governance 11.04.2025 Maternity and Neonatal Assurance committee 18.4.2025 Clinical Governance Committee 29th April 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 7 – Safety Action 9.

Year 7 was launched on 28.4.2025.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly.

The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for March 2025.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Midwife to birth ratio 1:27– SFT recommended ratio 1:24.
- 1:1 care in labour achieved 100% of time
- Supernumerary status of labour ward maintained 100% time.
- Business case being written to propose increase in Neonatal Nurses and Medical staffing to achieve BAPM compliance
- BAPM compliance significantly reduced due to increased acuity and specific clinical need to accommodate care for twins on NICU in March

PMRT:

- 0 stillbirth in March
- 0 Neonatal death in March
- No PMRT review in March as none due

Incidents reported as moderate:

- 14 Incidents reported as moderate or above as of end March 2025. Immediate review complete, but more detailed review not yet complete due to access to notes and new Badgernet system causing delay in review.
- Likely that re-classification will occur for some upon MDT review.

Service user and staff feedback:

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champions. You said/We did boards updated monthly on wards.
    - Emergency proformas relocated due to escalation around their location.
    - Translation Toolbar on trust website and it's use escalated
    - Neonatal staff vacancies and sickness
    - Challenge with embedding Badgernet and additional time required to support this.

Compliance to National Standards:

- Three-year delivery plan – focus on action and compliance in this final year
- Work continues to improve compliance to Saving Baies Lives in line with projected trajectory. Submission to LMNS in February 73% compliant – agreed actions to improve.

Themes:

- Term admissions to neonatal unit – new proforma designed to support standardised approach to reviews.
- Plan to continue to focus on demographic and inequalities when reviewing incidences and themes.

Perinatal Culture and Leadership Programme:

- Action plan around score survey and culture work continues.

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

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance

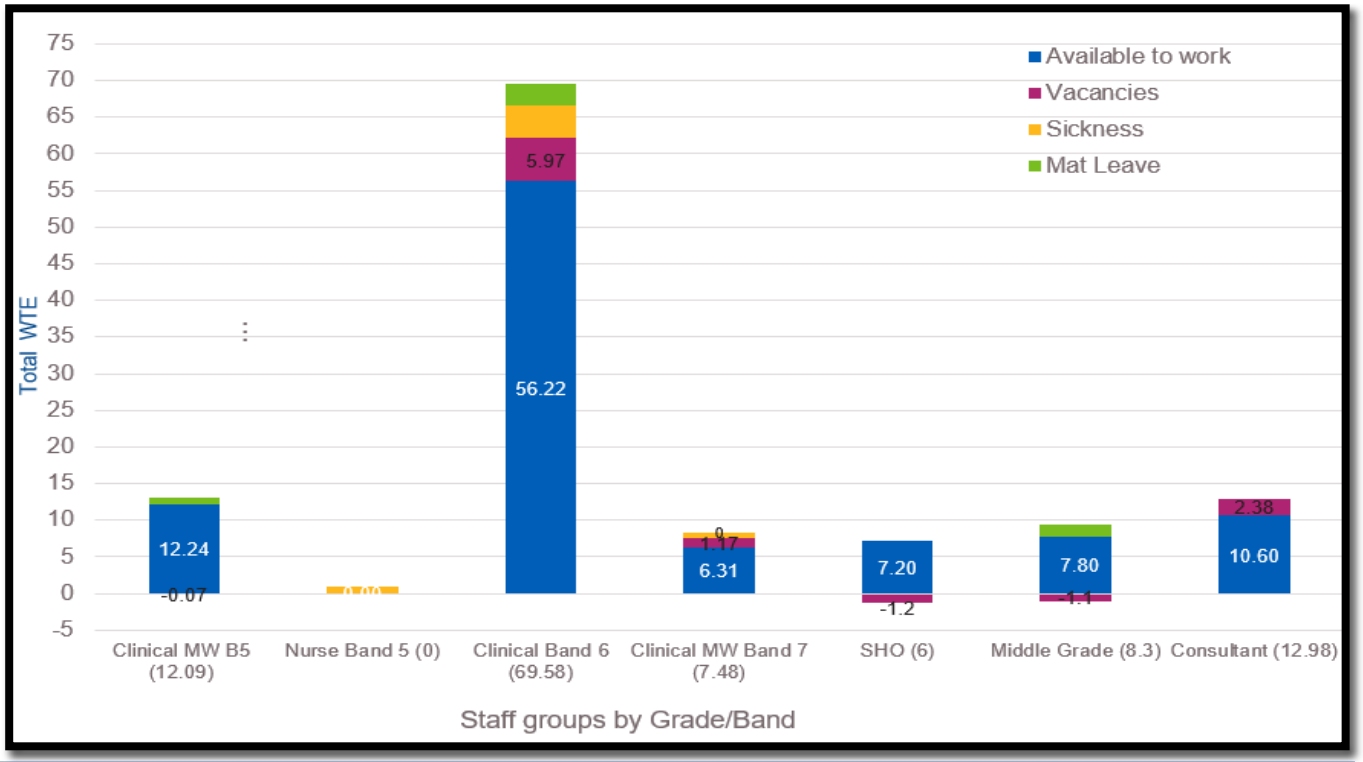
April 2025 (March Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Staffing vs acuity ratio was very positive this month showing 93% compliance of required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show a decrease due to increased levels of short and long-term sickness.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this with new starters this month.

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Jan '25	Feb '25	Mar '25
Midwives	Day	98.3%	97.1%	91.4%
	Night	97.5%	94.6%	96.7%
MCA / MSWs	Day	86.5%	87%	83.07%
	Night	94.4%	94.0%	83.9%
NNU Nurses	Day	88.7%	79.9%	95.2%
NNU Nurses	Night	95.8%	84%	98.7%

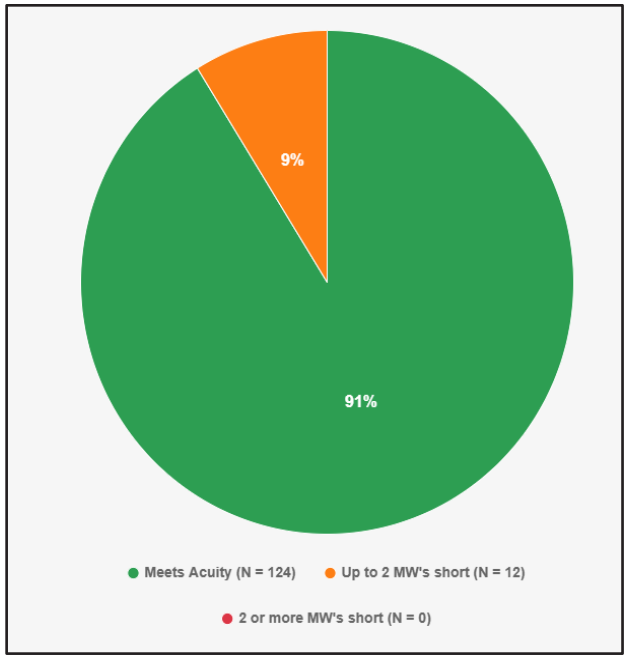
Countermeasures / Action (completed last month)	Owner
MCA recruitment	Workforce lead/ HOM
NNU Band 6 recruitment	HOM

Countermeasures / Action (planned this month)	Owner
Review of sickness absence management compliance.	HOM

Safe: Maternity & Neonatal Workforce (cont)

	Target	Threshold		Jan '25	Feb '25	Mar '25	Comment
		Green	Red				
Midwife to birth ratio	1:24	1:24	>1:24	1:25	1:23	1:27	Ratio decreased this month due to an increase in births and acuity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	86.02%	76.7%	73.12%	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		60	60	60	Consultant presence on Labour ward recently amended to align with Ockenden requirements.
Neonatal shifts staffed to BAPM standards	100%	>90	<90	95.1%	50%	61.29%	Recruitment plan in place to support BAPM standards compliance.
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	

Graph 1. Acuity by RAG vs staffing data:



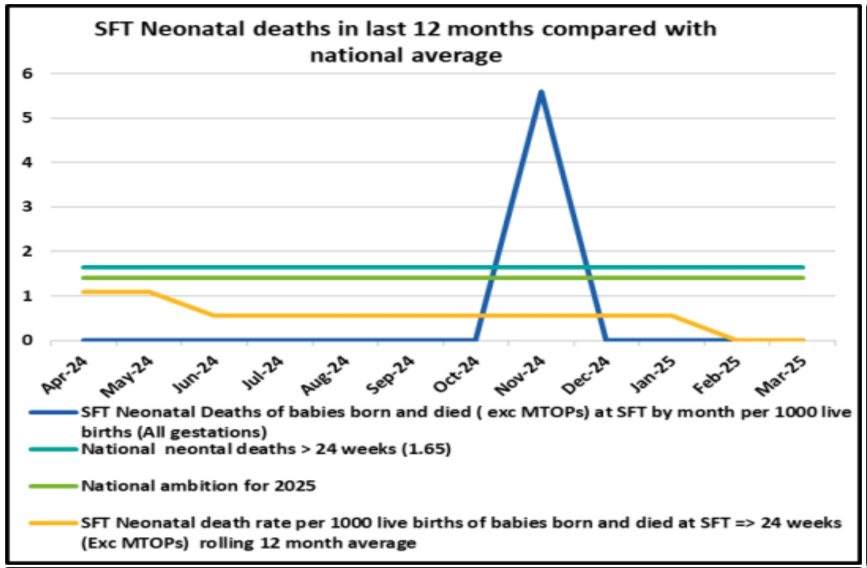
Is the standard of care being delivered?
- Supernumerary Labour Ward coordinator status achieved 100% time.
- 1:1 care in labour achieved 100% of time.

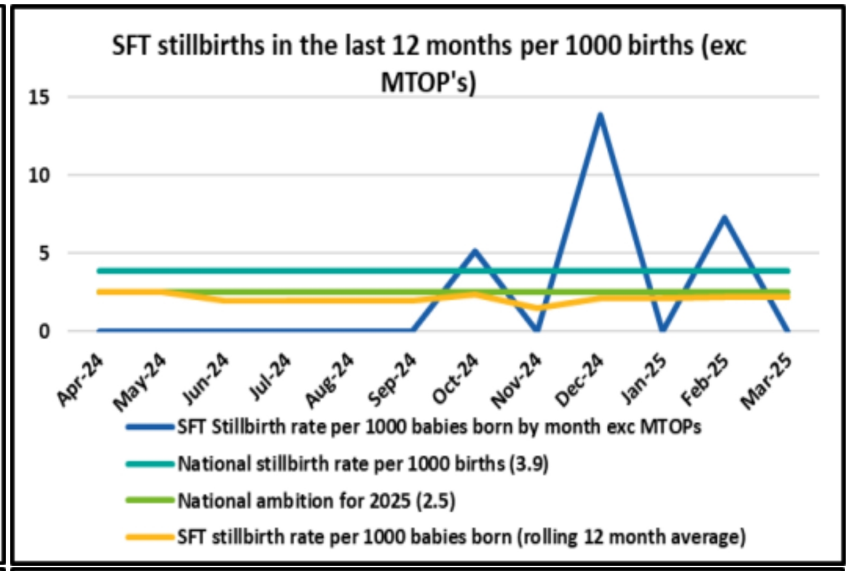
What are the top contributors for under/over-achievement?
- The Midwife to Birth ratio increased this month due to high accuity and births.

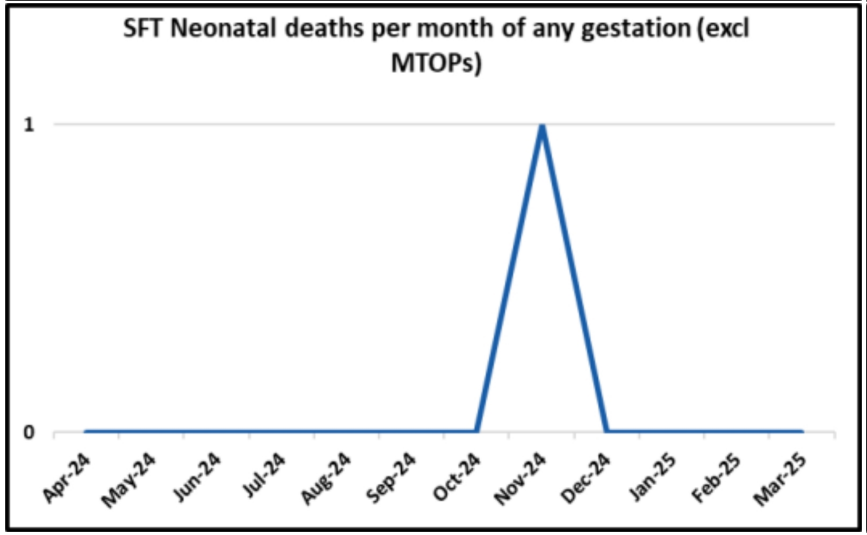
Countermeasures / Action (completed last month)	Owner
NNU Nurse Band 6 recruitment	HOM

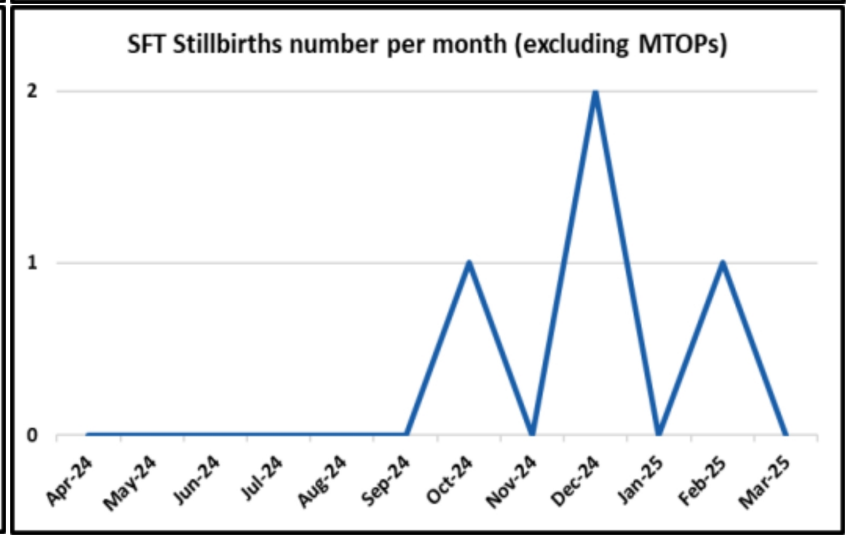
Countermeasures / Action (planned this month)	Owner
NNU Nurse Band 5 recruitment	HOM

Safe: Perinatal Mortality Review Tool (PMRT)









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There was 3 perinatal loss in March >12 weeks.
- 17 and 16+5 week miscarriage, 23+1 MTOP.

PMRT Action Plans for Salisbury Foundation Trust – March 2025 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
		No PMRT reviews in March 2025		

PMRT grading of care – Key

NHS Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
				No PMRT reviews in March 2025.		

INCIDENTS: Moderate Incidents and PSRs

NHS Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (DATIX)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
174396	01/03/25	Moderate	29/40 IUT to London	Awaiting Paediatric input - ?PSR	**N**		
174569	06/03/25	Moderate	PPH 1500ml	Awaiting Obstetric input – for PSR 1	**N**		
174567	06/03/25	Moderate	OASI	For PSR P1 – awaiting obstetric input	**N**		
174951	17/03/25	Moderate	Term Admission to NICU	Awaiting Dr response as documentation missing – for PSR 1	**N**		
174997	24/03/25	Moderate	PPH 2500ml	Awaiting notes for review	**N**		
175112	24/03/25	Moderate	OASI	Awaiting notes for review	**N**		
175131	24/03/25	Moderate	PPH 1900ml	Awaiting notes for review	**N**		
175159	25/03/25	Moderate	Shoulder Dystocia	Awaiting notes for review	**N**		
175349	30/03/25	Moderate	Drug error	Awaiting notes for review	**N**		
175340	27/03/25	Moderate	Term Admission to NICU	Awaiting notes for review	**N**		
175305	28/03/25	Moderate	Shoulder Dystocia	Awaiting notes for review	**N**		
175332	31/03/25	Moderate	PPH 1900ml	Awaiting notes for review	**N**		
175357	29/03/25	Moderate	PPH 2000ml	Awaiting notes for review	**N**		
175356	31/03/25	Moderate	EMCS following failed trial of instrumental	Awaiting notes for review	**N**		

INCIDENTS: Investigation update

NHS Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

	Date	Category	Incident	Outcome/Learning/Actions	
	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Feedback provided on draft report. Awaiting final report.	

PSR's Submitted

	Incident Date	Category	Incident	Outcome
	25/02/25	Moderate	Term Admission following EMCS cat 3, hyperstimulation, scar pain	For PSR 2 – in draft
	24/02/25	Major	EMCS, IUD and 8L MOH	Closed – awaiting SWAST report
	30/12/24	Moderate	Term Admission	Closed – with actions around escalation, holistic approach to CTG interpretation for risk factors
	2/7/24	Moderate	Process mapping for uterine septum, EMCS & 1.8L MOH	Closed, actions in progress for new guidelines and electronic records

Responsive – Patient Experience

NHS Salisbury NHS Foundation Trust

MNVP Service User Feedback

Positive Themes:

- Great consistency of antenatal midwife appointments (parents felt well looked after).
- Reassuring care from DAU.

Areas for improvement:

- Continuity of consultant care.
- More consistent information for GDM (Birth Centre access/ General information & assistance for management).

Complaints and Concerns

Complaints received	Summary / themes
2	Unhappy with aspects of their postnatal care
	Readmission to the NNU

Concerns received	Summary / themes
1	Attitude of nursing staff

Safety Champions

Concerns from staff	Action
• ***'Blinds in Labour Ward rooms are not black out blinds and there are often bugs in them.'*** • ***Concerns also raised around poor Labour ward décor by staff in Non-Executive walkaround.***	Labour Ward has been assigned a project manager to improve general décor and flooring of Labour Ward.

Friends and Family Test

- **As Maternity Services moved to BadgerNet in February, this has had an impact on FFT maternity reporting during March.**
- **The new data warehouse is due to go live in April and, until then, there will be limited data flowing in from BadgerNet. Therefore, no FFT was reported in March 2025.**

Response rate	% Positive	0% Negative
0	0	0

Service User Compliments

- **7 compliments reported on Datix in March for NNU and maternity services.**

Compliments - top themes	Numbers received
Gratitude	2
Kindness	1
Exceptional	1

Items for escalation...

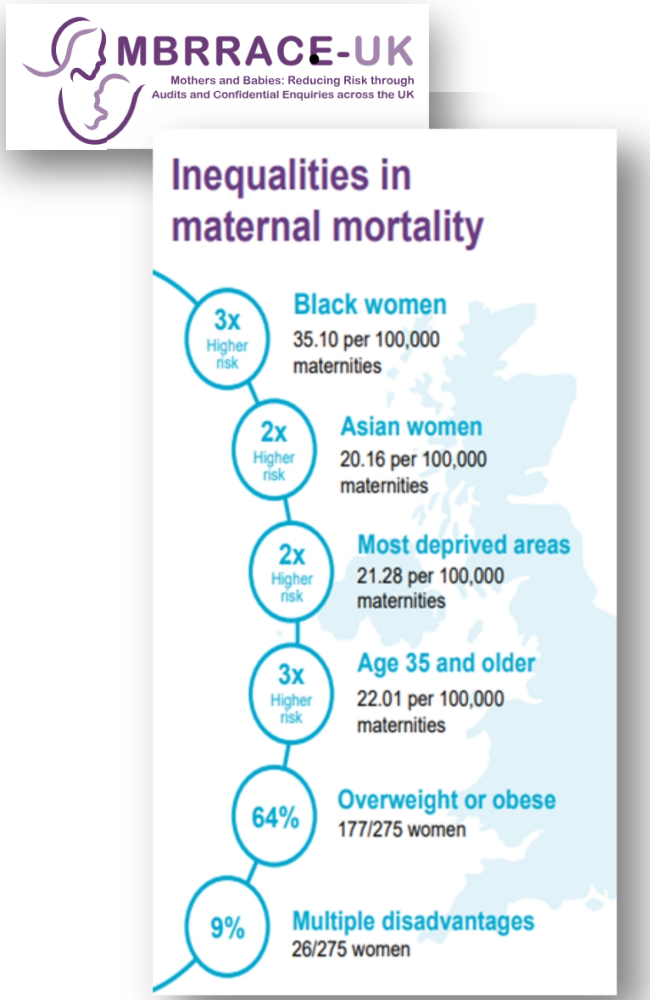
1. Labour ward décor
2. Translation toolbar on Trust website
3. Additional BadgerNet support for community midwives
4. Neonatal staff challenges

You said, we did...

'Difficulty locating emergency proformas on Labour ward.'

Proformas have now been relocated and now easily visible/accessible in all the Labour ward rooms.

Health Inequalities – Priorities



Listening events: No listening events held in March.

Ongoing Projects: Work is ongoing to establish a pathway to enable all Community Hubs to offer in-person parent education classes.

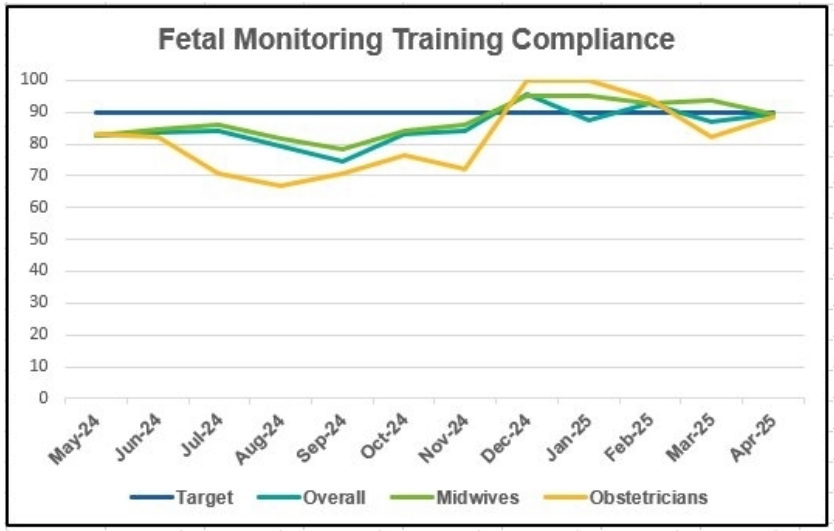
Equality Data: Work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for summer 2025. This will support targeted activities and bench-marking against national MBRRACE data .

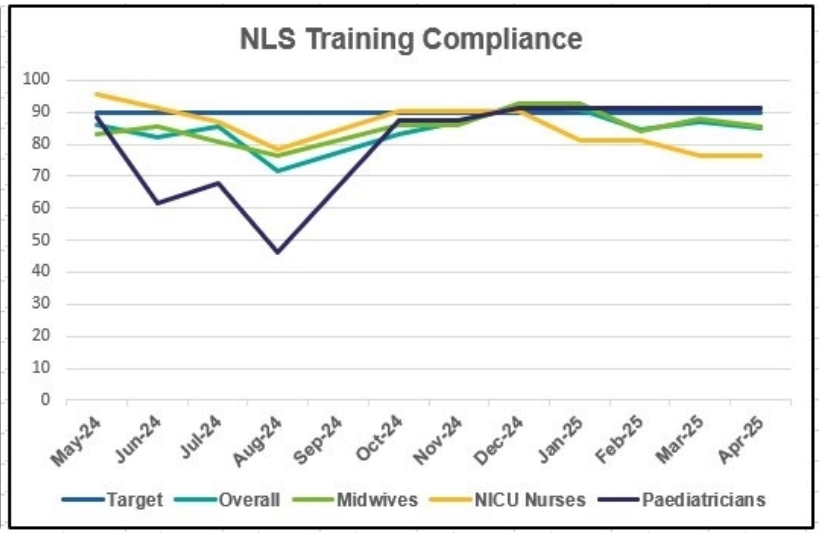
Translation service:

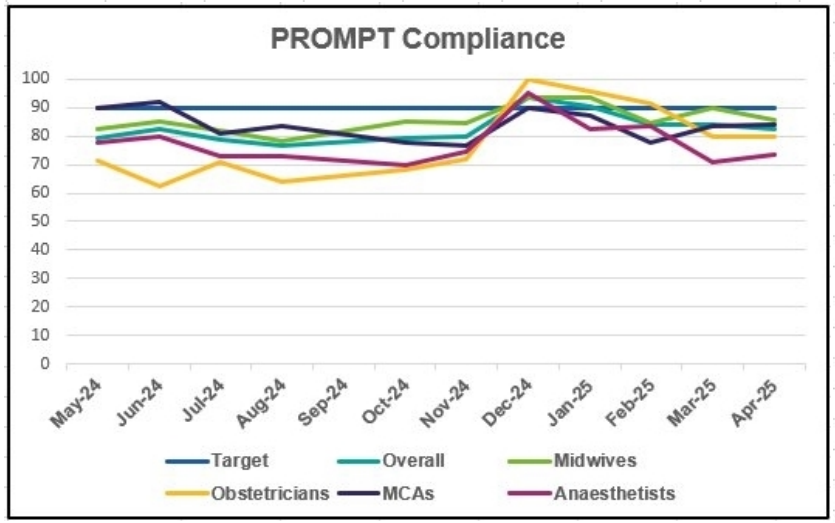
- Renewed emphasis has been placed on the implementation of the Translation toolbar on the Trust's website. The Translation toolbar is on the risk register. A hazard workshop is to be scheduled for April.

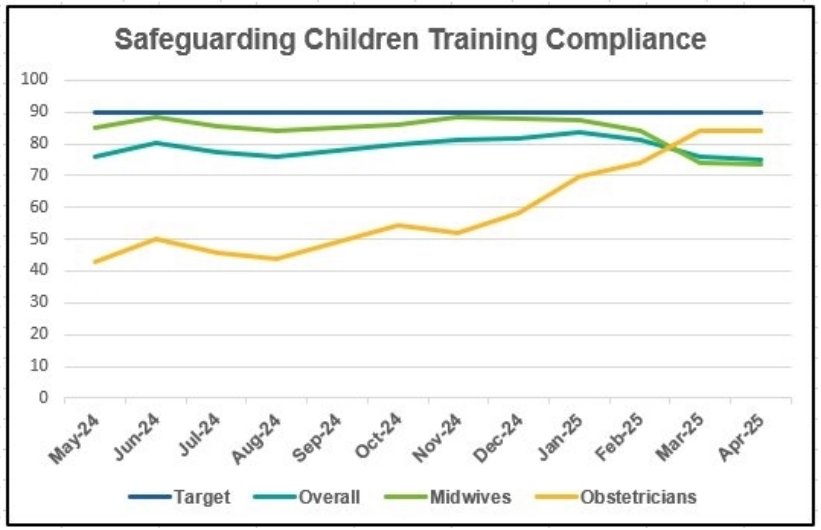
- Implementation of Pocketalk: Steady progress has been made, and it is hoped we will roll out the device in April 2025. The SOP and related documentation were approved at Maternity Risk Governance meeting. CSA and Hazard Log has been approved in principle by the CSO. Further conversation is needed to establish the next steps in the Governance process, as it is anticipated that the project will need approval from the Digital Steering Group.

Well-led: Training









Training

Updated training plan commenced in 2025 to meet the Core Competency Framework Version 2 (CCFv2) requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/ action:

- Anaesthetics planning to send staff on every PROMPT date evenly throughout 2025 (to maintain compliance rather than see drop-off over summer as in 2024) - all anaesthetists booked for March attended.
- Additional SG Children sessions being planned within maternity to maintain compliance in 2025 (limited dates available with Trust SG team). All out-of-date midwives are now booked onto training this year.

Risks:

- MDT attendance (obstetric) at all PROMPT and fetal monitoring training is a challenge and has dropped below the 90% compliance required. All obstetricians continue to be booked to attend these study days.
- Obstetric face-to-face SBL Elements training has been incorporated into rotating obstetricians' induction programmes.

Compliance to National Guidance (1)

Salisbury NHS Foundation Trust

CNST Maternity Incentive Scheme (Year 6)

		NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
		Description	Yr 5 Submission	Comment	Current Assessment
Are we well led?	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
	4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
	5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Compliant	Met best endeavours of improvement	
	7	**Service User Involvement and co-Production**	Compliant	All Standards Met	
	8	**Multidisciplinary Training**	Compliant	All Standards Met	
	9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
	10	**HSIB and EN Reporting**	Compliant	All Standards Met	

Maternity Incentive Scheme (CNST)

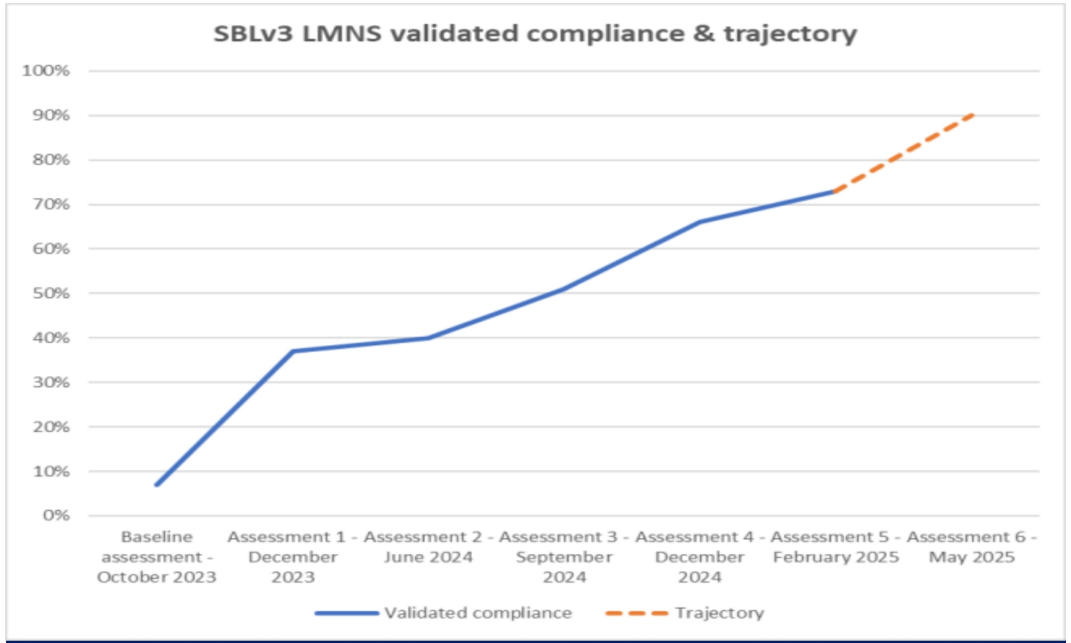
Key Achievements:

- NHSR confirmed 10 out of 10 compliance for MIS Year 6.

Next steps:

- Review of guidance for MIS Year 7, in progress, released 2nd April 2025.
- MIS Year 7 Launch event scheduled 28th April 2025 – update to be provided.

Saving Babies Lives v3



Saving Babies Lives v3

Key Achievements:

- SFT have achieved 73% compliance with our February 2025 submission.

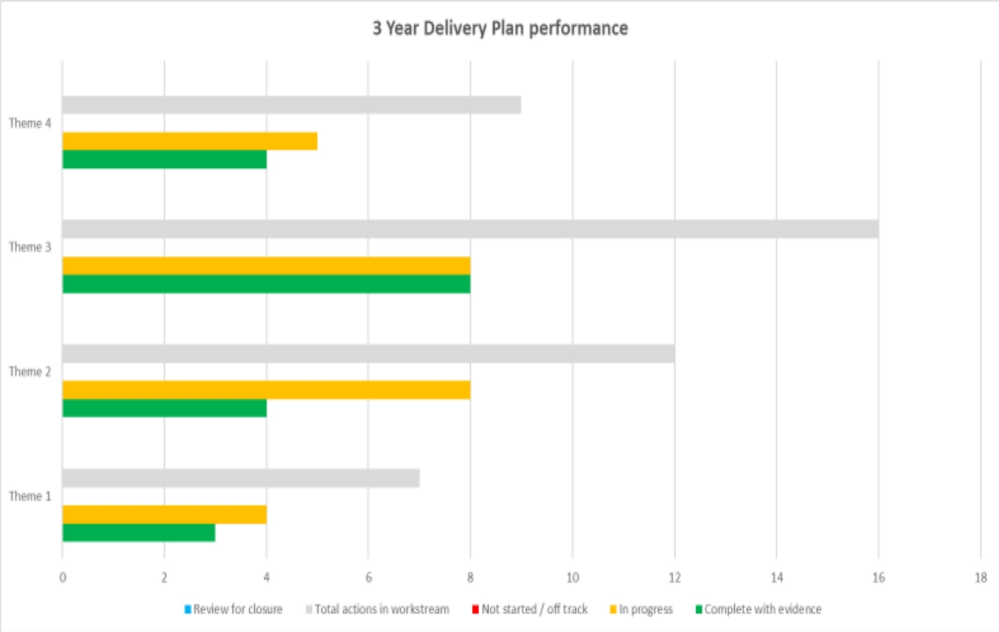
Next steps for progression:

- Action holders are currently collating data for Q4 2024-25 ready or submission in May.

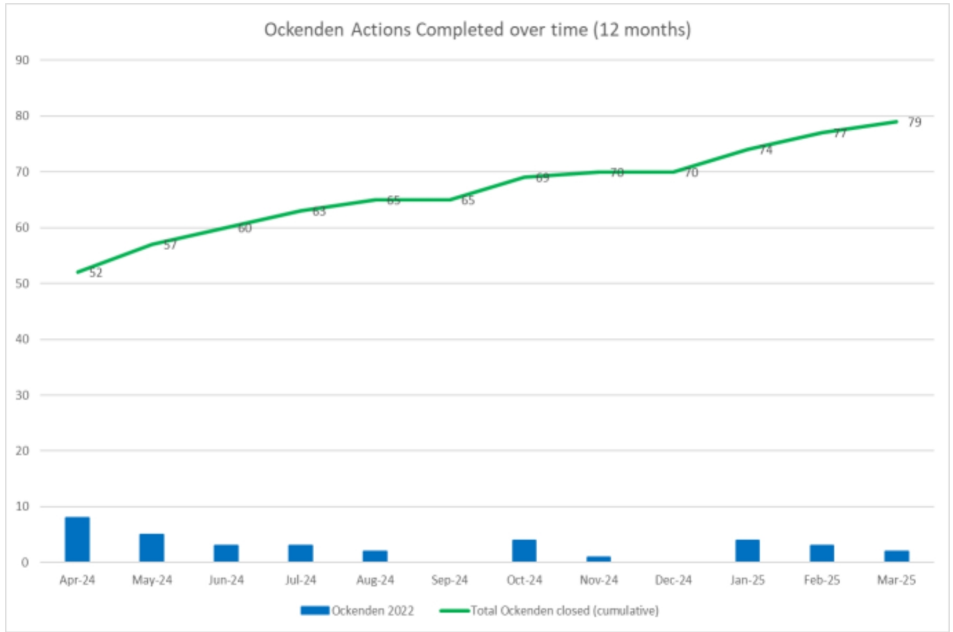
Compliance to National Guidance (2)

Salisbury NHS Foundation Trust

3 Year Delivery Plan



Ockenden 2022



Ockenden 2022

- **Key achievements:** 2 actions closed in March, with just 5 remaining open.
- **Next steps for progression:** Remaining 5 Ockenden actions will now be monitored in monthly MIG meetings due to noted improvement.

3-Year Delivery Plan

Key Achievements:

- Of the 44 actions; 20 are in progress and no concerns identified.
- The remaining 24 have been completed.

Next steps for progression:

- Continue to meet with action holders.
- Provide evidence of completed actions for sign off at MIG

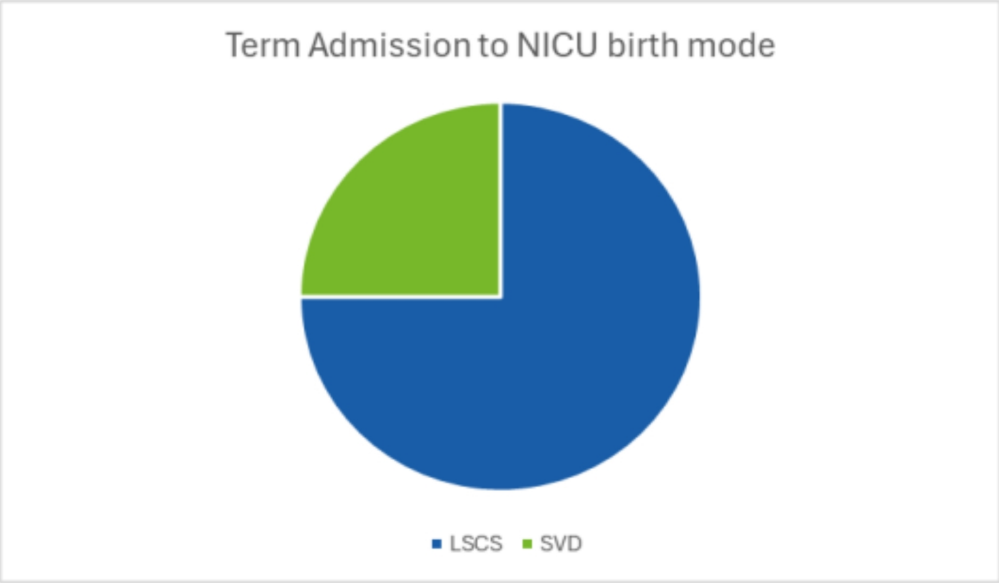
OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Mar-25	1	Workforce Planning and Sustainability	0	1	0	6
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	0	0	5
	9	Preterm Birth	0	0	0	4
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	0	0	4
	13	Bereavement Care	0	0	0	4
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	5	0	80

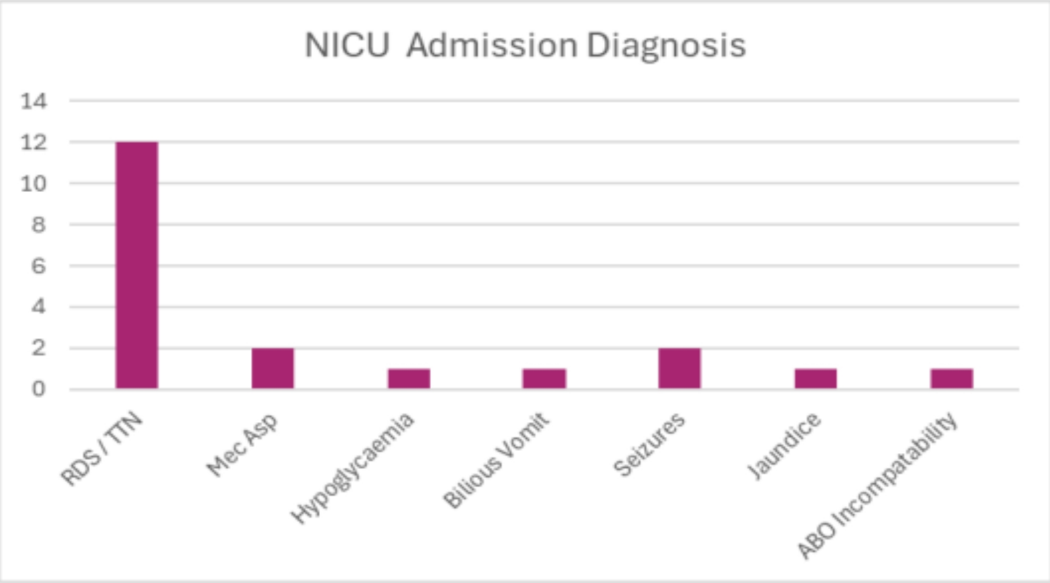
Themes

Including PSIRF 'continuous audits' & DATIX

Salisbury NHS Foundation Trust

Term Admission to NICU January – March 2025





Results:

- 20 babies were admitted to NICU between January and March 2025.
- Birth modes were: SVD 5, ELCS 9, EMCS 6.

Actions:

- All cases have been incorporated into the ongoing rolling audit within W&NB for continuous data collection.
- A comprehensive thematic review is scheduled for the spring, which will enable a thorough analysis.
- An Unexpected Neonatal Admission Datix Incident Review Proforma is proposed for approval at Maternity Governance meeting in April. This will ensure a standardised approach for reviewing care in line with the Trust PSIRP and will capture additional details including ethnicity, social deprivation areas and emerging trends.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

- The Perinatal Quad continue to use the action plan produced following the SCORE Survey, to prioritise their workstreams
- Staff event scheduled Friday 25th April 2025; with a focus on OD&L, Wellbeing, opportunity to learn what we are doing as a quad and celebrating Maternity & Neonatal services, following the feedback from the staff survey completed at the end of 2024 .

Actions in progress:

- The "team of the shift" model continues to be used, to have a team check-in and support each other on shift.
- Members of staff offered 'MOMENTS' training from Wessex Health Innovation Network to support the Quad work in responding to, and discussing with, staff about cultural and safety issues.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.5
Date of meeting:	1st May 2025		

Report tile:	Maternity and Neonatal Bi-Annual Staffing report – March 2025			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Approved by Women and Newborn Divisional Management Team 14th March 2025. Maternity Governance 14th March 2025 Clinical Governance Committee 25th March 2025			
Prepared by:	Vicki Marston - Director of Maternity and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing officer			

Recommendation:

The Trust Board are asked to note the contents of this report which has been provided for information and assurance processes.

In order to demonstrate compliance with the CNST Maternity Incentive Scheme Year 7 (launched 28.4.25) the Committee is asked to note the specific expectations in relation to demonstrating effective Midwifery and Neonatal workforce planning as detailed in the report.

Executive Summary:

This report provides a bi-annual Midwifery and Neonatal staffing report as per Maternity Incentive Scheme (Year 6) – Safety Action 5 recommendation and requirement.

The Committee are asked to note and minute the following required standards as set out in the report to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme.
The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as

calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year six reporting period.

To note vacancy levels and recruitment challenges and plans in place to mitigate against this by use of escalation policy.

To note the agreement from Trust Board for the recommended uplift of 3.27 WTE Midwives, to note this is now in budget.

To note the increased demand on Maternity and Neonatal Services from an assurance and quality and safety perspective and to recognise that the national ask of each maternity unit is the same despite the number of births, and therefore smaller units may require a higher percentage of non-clinical staff.

To note that an action plan to review neonatal staffing was shared at Trust Board February 2025, when CNST evidence was shared, and a business case is being written to support an increase of medical and non-medical staff. Whilst it is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month, we have a consistent current shortfall in Neonatal staffing against activity.

In addition to note the challenges and mitigations in Midwifery staffing over the 6-month period this covers, and to acknowledge that the required standards as set out above have been met and are evidenced in the report

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

BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT March 2025

1. Purpose

The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from September 2024 to February 2025. This is a requirement of the CNST Maternity Incentive Scheme and relates to Safety Action 5.

2. Background

It is a requirement, that as NHS providers. we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment, to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 6, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning.

To provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, this paper provides staffing data on Midwifery and Neonatal Nursing Staffing. The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year six reporting period.

3.Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents.

4. Birthrate Plus Workforce Planning and staffing levels.

A formal **Birthrate Plus®** assessment was carried out through October to December 2023, as per NICE (2017) national recommendation for repeat assessment timeframes, which reviewed the acuity of women who used maternity services. It was formally reported in February 2024; recommended changes to Midwifery establishment were presented to and accepted by Trust board on 2nd May 2024. It included an uplift of the midwifery establishment by 3.27WTE Band 6 Midwives.

The current midwifery establishment at SFT is calculated using a midwife/birth ratio of 1:24 as recommended by the SFT Birthrate Plus® report in February 2024. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data

detailing risk and acuity of inpatients on Labour Ward 4 hourly, and Beatrice Ward 6 hourly. This gives up to date feedback on the level of safe staffing against the acuity and activity of the day. The tool also measures, by exception, where 1:1 care is not possible for labouring women, and when the labour ward coordinator is not able to maintain supernumerary status.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments. Table 1 shows the recommendations from Birthrate Plus® February 2024 for clinical midwifery staffing.

Birthrate Plus® recommended clinical WTEs - February 2024

Total Births	**2200**
Core Hospital Services	
Delivery Suite	31.86
Antenatal/postnatal Ward	24.52
Outpatient Services	2.79
Maternity DAU	6.48
Community Inc. Homebirth provision	27.63
Total Clinical wte Band 3-7	**93.28**

Historically recruiting to our funded establishment has been challenging, however there has been improved recruitment over recent months which has ensured more consistent staffing levels. There are still a number of midwifery vacancies (at the time of writing this is at 5.87 WTE + the 3.27TWE which has been added to budget) which fluctuate from month to month.

There is continued recognition that there is a need to balance the junior workforce with

experienced staff and in particular the recruitment into senior Band 6 positions is a challenge for Salisbury. Although challenges in recruitment are not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors to recruitment challenges.

The concept of flexible working across the maternity pathway, rather than having fixed areas of working, as an alternative approach to providing maternity care, is being piloted to aid recruitment. There has been adaptation around recruitment to look at varying processes to attract staff, including supporting return to practice midwives, financial incentives, and varying contracts. From a flexible working perspective, an increase in requesting for staff has been trialed, stepping out of the policy dictating numbers of requests and doubling them to allow staff more opportunity to balance work and home life. This has been well-received by staff and supports work around retention.

Collaborative work with Gloucester and GWH to recruit international midwives has been very successful, we have 6 international midwives working within the service now all of whom are now Band 6 midwives. There are also have 4 Maternity care assistants who are undertaking a Midwifery apprenticeship and one nurse who has commenced a nurse to midwife conversion course. Exploring all options for recruitment is enabling SFT to draw form a variety of sources, as well as supporting recruitment of individuals with valuable experience in other areas of the NHS.

1. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient ward areas by month.

	Day qualified % Fill rates.	Night qualified % Fill rates
September 2024	97.6%	96.8%
October 2024	93.9%	96.5%
November 2024	99.4%	96.7%
December 2024	93.7%	96.9%
January 2025	98.3%	97.5%
February 2025	97.1%	94.6%

Maternity leave has been consistently high amongst midwives. In September 2024 we had 4.42

WTE midwives on maternity leave, dropping to 3.94WTE in February 2025 - this does put further pressure on fill rates.

When staffing is less than optimum, the following measures are taken in line with the Maternity Department escalation policy:

- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Support of Maternity and Neonatal Duty Manager Day and night as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity and Neonatal services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Recruitment of nurses to the maternity services.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

5. Midwife to Birth Ratio

Birthrate Plus® has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:24. The recommended ratio takes into account anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This rate is reached via calculations between monthly birth numbers and available numbers of midwives. The ratios are analysed monthly and are affected by fluctuating birth numbers and variations in establishment month to month.

The table below outlines the real time monthly birth to midwife ratio for the past 6 months.

Month	September 24	October 24	November 24	December 24	January 25	February 25
Midwife to birth ratio	1:30	1:30	1:27	1:22	1:25	1:23

6. Specialist Midwives

Birthrate Plus® recommends a percentage of the total midwifery establishment is not included in the clinical numbers. This percentage is tailored to units considering size, acuity and whether units are multi-centered. These roles include management positions and specialist midwives. Some roles deemed out of scope are the Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons amongst others.

Birthrate Plus® has a standard percentage of roles deemed out of scope and adapts it depending on unit size, recognising that the national ask of each maternity unit is the same despite the number of births, and therefore smaller units may require a higher percentage of non-clinical staff. This was reflected in our most recent Birthrate Plus® assessment outcome where the suggested numbers of specialist midwife roles increased from it's current substantive establishment by 1.59 WTE.

7. Birthrate Plus® Live Acuity Tool

The Birthrate Plus® Live Acuity Tool is used in the intrapartum and the other maternity inpatient areas. It is a tool for midwives to assess their 'real time' workload determined by the number of women needing care, and their condition during admission, labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birthrate Plus®.

The Birthrate Plus® classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward coordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women including the requirement of achieving the one-to-one care in labour standard for all women and increased ratios of midwifery time for women in the higher need categories. This provides an assessment on admission, of where a woman fits within the identified Birthrate Plus® categories and alerts midwives when events during labour move her into a higher category and increased need of midwifery support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on '*Safe Midwifery Staffing for Maternity Settings'* necessary for the

determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

8. Supernumerary Labour Ward Coordinator

One of the safety standards mandated by CNST is the need to have a supernumerary Labour Ward Coordinator leading on every Labour Ward 24-hours a day; SFT have ensured that rostering reflects this requirement. The Birthrate Plus® acuity tool monitors this every 4 hours. It also takes into account risk factors, acuity and dependency of women, environmental factors and skill mix, enabling the co-ordinator to flex staffing to the need of the service within a shift, by redirecting staff and prioritising care. A detailed escalation policy also ensures the coordinator retains this supernumerary status enabling oversight of activity. Supernumerary status of the coordinator was maintained 100% of the measured occasions in the 6 months this report relates to.

The following table outlines the compliance against this action by month:

	Number of days per month	Number of shifts per month	Compliance
September 24	30	60	100%
October 24	31	62	100%
November 24	30	60	100%
December 24	31	62	100%
January 25	31	62	100%
February 25	28	56	100%

9. One to One care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward coordinator to follow the course of actions within the acuity tool and the

escalation policy depending on the situation.

The following table outlines compliance with provision of 1:1 care by Month.

	September 24	October 24	November 24	December 24	January 25	February 25
Birth Centre	100%	100%	100%	100%	100%	100%
Labour Ward	100%	100%	100%	100%	100%	100%

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birthrate Plus® acuity tool.

The following tables demonstrate red flag events for the 6-month period from 1st September 2024 to 28th February 2025. Out of 1092 data admissions (confidence factor of 83% recorded) there were 3 red flags entered onto the system with the reasons detailed below:

Number of Red Flags recorded

01/09/2024 to 28/02/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	3	100%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of 30 minutes or more between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Supernumerary status of labour ward coordinator not achieved	0	0%
TOTAL		3	

*The % is rounded to nearest whole number

Each red flag is recorded on the acuity tool and reported via datix, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

11. Safety and Overview

For the service to demonstrate safe staffing on a daily basis, the Maternity and Neonatal Duty Manager plays a fundamental role in responding to the constant changing clinical situations within maternity services, both in the building and in the community environment. The Duty Manager is available to provide 24/7 support to the Maternity and Neonatal Service, providing a helicopter view across all areas and maintaining safety at every level. The Maternity Duty Manager rota is covered by Band 7 and Band 8 midwifery leaders on a two tier rota (one band 7 and one band 8 on call 24/7) and provides visible responsive leadership to Maternity and Neonatal Services.

Maternity Services continue to report missed breaks via Datix and when the coordinator is unable to maintain their supernumerary status. At such a time the involvement of the Duty Manager and use of the Maternity Escalation Policy ensures oversight and transparency when staffing and incidents occur. Additionally, Red Flag reporting is discussed monthly at the Maternity Risk and Governance meeting, with any themes reported to the Trust Clinical Risk Group via the perinatal quality slides.

Staffing is discussed at the monthly Maternity Risk and Governance meeting; forms part of the Executive Performance Review monthly meetings (as an Improving together divisional driver) and is discussed with the Board level Safety Champions monthly. In addition, it is reported to Trust Board and LMNS Board via its inclusion in the perinatal quality slide set, which is presented to both boards monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges.

12. Risks

Delivery of Continuity of Carer Model

In February 2016 the report *'Better Births'*, set out the Five Year Forward View for NHS Maternity Services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be midwifery Continuity of Carer teams in place, to ensure safe care based on a relationship of mutual trust and respect, in line with the woman's decisions. In 2022 there was clear guidance published to NHS Trusts advising that if adequate staffing levels were not in place, then continuity of carer teams should be immediately paused until full establishment of staff was reached. With SFTs vacancy rates and predicted junior workforce this advice was followed and rollout of continuity of carer paused.

13.0 **Neonatal nursing staffing**

To meet safety action 4 of the Maternity Incentive Scheme, the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards. The Trust is required to formally record in the Trust Board minutes compliance to BAPM Nurse staffing standards annually, using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The nursing workforce review was completed in February 2025 using the Workforce calculator seen below. This demonstrates that the unit is partially compliant to the BAPM standards being over funded for registered nurses but underfunded for non-registered nurses. The requirement would be an additional 2.09 wte non-registered nurse. There are mitigations in place for increasing the number of nurses who are QIS trained, 0.92wte are in training currently, with 2.0 WTE to commence this year. A business case has now been drafted to support an increase of non-registered staff. However, it is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month.

	FUNDED February 25	**IN POST February 25**	**Calculated requirement (from BAPM tool)**	**Variance (between BAPM requirement and funded)**
Total direct care nurses	**24.09**	**21.03**	**24.55**	**0.46**
Total registered nurses (band 5 and above)	**23.29**	**20.23**	**21.66**	**-1.63**
of which QIS	**13.65**	**14.27**	**15.16**	**1.51**
Total Non QIS	**9.64**	**8.11**	**6.50**	**-3.14**
Total Non Reg	**0.80**	**0.80**	**2.89**	**2.09**
% REGISTERED NURSES QIS QUALIFIED		**71%**	**70%**	

13. Conclusion and Next Steps

The paper demonstrates the current staffing establishment in the maternity service, challenges, risks, and mitigations in place. The ongoing work to recruit and retain is key to the long-term staffing within the service.

Next steps are detailed:

- Continue to recruit to turnover and focus on retaining staff utilising all options available to the Trust for recruitment and retention
- Utilise Bank and Agency staff when required.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.
- Continue with retention work and input from the PMA team to support staff.
- Continued consideration of any exit interview themes and actions associated with them.

14. Recommendations

It is recommended that the Board note the contents of the report and formally record in the Trust Board minutes the compliance to those metrics requiring noting as evidence for CNST compliance.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	1st May 2025		

Report tile:	2024/25 Annual Review of Directors Interests			
Status:	Information	Discussion	Assurance	Approval
	✓			✓
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Christina Steele, EA to Managing Director and Chair			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Annual Register of Interests (Directors and all band 8d and above or equivalent staff, Procurement staff and Budget Holders Band 8a and above)			

Recommendation:

To review, note and approve the annual Register of Interests as of April 2025.

Executive Summary:

There is a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. In 2020 it was agreed that the annual requirement would extend to all decision-making staff at band 8d and above or equivalent. In 2024, following recommendations in the Counter Fraud: Conflicts of Interest report, it was agreed to expand the scope of the annual requirement to band 8a budget holders.

In 2021/22, improvements made on the previous process resulted in an improved compliance rate of 60%.
In 2022/23 the Trust achieved 53% compliance.
In 2023/24 the Trust achieved 71.5% compliance.
This year the return rate (as of 17/04/2025) is **99%** (an increase of 27.5% on the previous year).

Compliance with this process is reported as part of the Counter Fraud Annual Risk Assessment submission. An update on the actions set by our Local Counter Fraud Specialist will report to the Audit Committee.

The Corporate Governance team had a return of 99% (481 of 486) declaration of interest forms. 31% (151) made a positive return, of which 87% (131) were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict. The further 13% were reviewed by the Corporate Governance Team and no concerns were noted. In addition, a further 160 declaration forms were submitted by staff across a range of specialities and job roles, which did not fall within the annual return criteria. 73% (117) made a positive return, of which 100% were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict.

98% (243) of Band 8d+ submitted their declarations of interest form, 49% declared a possible conflict of interest with 84% reviewed and countersigned by their line manager or appropriate senior person, stating no conflict.

100% (110) of Procurement staff submitted their declarations of interest form. In addition, a further 26 declarations were made as new staff joined the team, bringing the total returns to 136. 8% of procurement staff declared a possible conflict of interest, all of which were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict. Any member of staff within procurement, who has declared an interest, would be excluded from any procurement process where a conflict of interest has been acknowledged.

100% (17) of the Board submitted their declarations of interest form, 59% declared a possible conflict of interest, all of which were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict. The Board declarations were reviewed by the Senior Independent Director (SID) and no concerns were raised. Board declarations will be published on the Trust website. In addition to the annual declaration, all Board members declare any conflict of interest at the beginning of all Board and Board Committee meetings, for any relevant agenda item.

100% (18) of Governors submitted their declarations of interest form and only one Governor declared a possible conflict of interest. The Director of Integrated Governance reviewed the declaration and no concerns were noted.

100% (93) of Budget Holders Band 8a+ submitted their declarations of interest form, 15% declared a possible conflict of interest, of which all but one were reviewed and countersigned by their line manager or appropriate senior person, stating no conflict.

A total of 22 staff were excluded from the figures as they had either left the Trust, could not be found on the system, were on maternity leave or were on long term sick during this process. This includes twelve 8d+ staff, five Procurement staff, one Governor and four budget holders.

A recent counter fraud review identified a lack of declarations of secondary employment. Following internal communications to the organisation, several additional declarations were submitted. These are included within the 160 additional declarations which did not fall within the annual return criteria.

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

Additional Declarations

Assignment Number	Title	First Name	Last Name	Email	Job Title	Company	Position	Action/Notes
	Dr	Amira	Moussa		SAS Grade, Oral Surgery	My Dentist	Oral Surgery	
		Benjamin	Crouch		Gym Instructor	Nil return	Nil return	
		Chris	Webb		Leisure Assistant	Nil return	Nil return	
		Katy	Darrington		Gym Supervisor	Nil return	Nil return	
		Marcia	Gould Hocking		Executive Assistant	Salisbury City Council	Mayoress for Salisbury; husband is Wiltshire County Councillor and Mayor	
						Wiltshire Air Ambulance	Fundraising for the Air Ambulance	
		Summer	Venning		Leisure Assistant	Nil return	Nil return	
		Thomas	Smartt		Gym Instructor	Nil return	Nil return	
		Glaiza	Contreras		Anticoag and Thrombosis Nurse	Nil return	Nil return	
		Mark	Richards		Maxillofacial Laboratory	Nil return	Nil return	
		Harriet	Boston		Speech and Language Therapist		Private Paed Speech and Lanaguage Therapist	
		Penny	Scott		Speech and Language Therapist	Own Private Practice	SLT	
		Laura	Barclay		Matron CCOT	Mr & Mrs T Sumner	Dog Handler	
		Sadie	Loveridge		Cleaning Assistant	Self Employed	Childminder	
		Paula	Cubley		Medical Secretary	SFT	Bank Typing	
		Abigail	Hooper		Speech and Language Therapist - Bank	Hampshire and IOW Healthcare NHS Foundation Trust	Speech and Language Therapist	
		Jessica	Evans		Clinical Trials Practitioner	HCRG Care Group	Bank Nurse	
						Salisbury NHS Foundation Trust	Bank Nurse	
		Anna	Williams		Colorectal Cancer Pathway Navigator	Dr Susie Lewis	Private Secretary	
		Rachel	Jones		Volunteer Coordinator	Siteform Trucks	Transport Manager Partner is owner/director	
		Kieran	Castle		Specialist Radiology Department Assistant	Dorset and Wiltshire Fire and Rescue Service	Firefighter	
		Nadine	Crook		Speech and Language Therapist	Say Aphasia (Charity)	Local Group Facilitatior	
		Joanna	Youdan		Senior Improvement Practitioner	Salisbury NHS Foundation Trust	Bank RN	
		Martin	Cunningham		Medical Devices Technician	Salisbury NHS Foundation Trust	Staff Nurse - Bank	
		Lucy	Banham		Chief Pharmacy Technician	Orange Grover Fostercare	Foster Carer	
		Diane	Graham		Admin Lead Rheumatology	Dr R Smith & A Coy	Secretary	
		Rebecca	Stonell		Lead Tech for Antimicrobials	Tim Walter (Norma Farrelly Catering)	Waitress	
						Rebecca Green Catering	Waitress	
						Victoria Blashford - Smell Catering	Waitress	
		Joanne	Thomas		Vascular CNS	Jo Thomas Coaching Ltd	Director & Health Coach	
		Zita	Jappy		Staff Nurse	Salisbury NHS Foundation Trust	Theatre Staff Anaesthetic Practitioner	
		Suzanne	Bailey		Vascular CNS	First Aid Training Company	Owner	
		Janet	Eguia		Clinical Nurse Specialist - Inflammatory Bowel Disease	18 Week Support	Endoscopy Nurse	
		Jason	Gambold		Medical Devices Technician / Medical Devices Workstream Lead	Salisbury NHS Foundation Trust	Band AB3 VOIP Facilities	
		Elaine	Bowden		Administrator - Maternity	S/E	Arts & Crafts & Reiki	
		Charlotte	Draper		Vascular/ Lymphoedema Nurse Specialist	Salisbury NHS Foundation Trust	Bank Band 7 for Vascular	
		Emma	Twine		Antenatal Clinic Lead Midwife	Somek & Associates	Midwife Expert Witness	
						Somek & Associates	Associate Trainer	
						Somertset Foundation Trust	Applying for Bank Midwife post	
						Indemnity Insurance	Antenatal and postnatal care via the RCN - Midwife	
		Anne	Perrier		Legal Assistant	Salisbury NHS Foundation Trust	PT Ward Clerk	
						Salisbury NHS Foundation Trust	Bank Contract	
		Alex	Beck		Clinical Specialist Physiotherapist	Salisbury Rugby Football Club	Physiotherapist	
						Self Employed (pitch sided & school clinic cover)	Physiotherapist	
		Rebecca	Murphy		Advanced Dietetic Practitioner	BDA- PENG Group	Clinical Update Course Tutor	
						University of Winchester	Guest Lecturer	
						AECC	Guest Lecturer	
						Circle Health	Dietitian	
		Remelita	Lucina		Healthcare Assistant	Barchester Healthcare, Milford House Care Home	Carer	
						Salisbury NHS Foundation Trust	Bank Band 2 Healthcare Assistant	

		Amy	Hibbs		Urology Nurse Practitioner	Salisbury NHS Foundation Trust	Bank - Registered Nurse	Signed by Line Manager
		Lizzie	Sexton		Labour Ward Co-Ordinator	Quoris Consultant Ltd	Director	Signed by Line Manager
						Curo (Albian) Housing Association	Husband is NED	
						Quoris Consultant Ltd	Company Secretary	
		Charlotte	Wood		Midwife	Webineer Ltd - Computer Facilities Management	Director. Spouse owns company.	Signed by senior member - Line Manager absent.
		Katie	Gaimster		ST4 Obstetrics and Gynaecology	Nil return	Nil return	
		Zoë	Townend		Chief Audiologist	Salisbury NHS Foundation Trust	Bank Chief Audiologist	Signed by Line Manager
		Elaine	Deeks		Central Booking Co-Ordinator	A Box of Tricks Ltd	Director, owner and shareholder	Signed by Line Manager
		Tim	Kershaw		IM&T Specialist / Technical Engineer	John Lewis	Supermarket Assistant	Signed by Line Manager
		Katherine	Seymour		Clinical Trials Assistant	Salisbury Hospital	Nursing Assistant - Urology	Signed by Line Manager
		Estrela	Pinto		Clinical Educator Endoscopy	18 Week Support	Staff Nurse - Agency	Signed by Line Manager
		Bonnie	Randall		Neonatal Nurse	Godolphin School	School Nurse	Signed by Line Manager
		Kate	Jenkins (Outhwaite)		Consultant Clinical Psychologist	UHS	Clinical Psychologist	Signed by Line Manager
						Self Employed	Director, Owner and Clinical Psychologist - Providing adult ADHD assessments and staff wellbieng consultancy to corporate settings	
		Priyanka	Sharma		Sister (Radnor) & Medical Device Trainer (MDMS)	Nil return	Nil return	
		Jessica	Hitchenson		Clinical Specialist Occupational Therapist	Salisbury NHS Foundation Trust	Clinical Specialist OT - Bank	Signed by Line Manager
		Timhar	Hadjail		Prostate Cancer (CNS)	Salisbury NHS Foundation Trust	RN Bank	Signed by Line Manager
		Rachael	Shortman		Medical Device Trainer	Salisbury NHS Foundation Trust	Bank ODP	Signed by Line Manager
		Tanya	Angel		Stoma Clinical Nurse Specialist	Self Employed	Yoga Instructor	Signed by Line Manager
		Deborah	Rowland		Nursing Assistant	State21	Director	Signed by Line Manager
		Conrado	Laguna		Charge Nurse	Nil return	Nil return	
		Jasmin	Schwender		Senior Sister	IV Healthcare Ltd	Registered Nurse	Signed by Line Manager
		Emily	Abanco		Clinical Nurse Lead	Nil return	Nil return	
		Clare	Penny		Senior Sister	18 Week Support	Staff Nurse	Signed by Line Manager
		Charis	Bradshaw		Trainee Clinical Endoscopist Colorectal CNS	Nurse Plus	Nurse - Agency	Signed by Line Manager
		Leah	Cordova		Clinical Endoscopist	18 Week Support	Nurse in Charge	Signed by Line Manager
						Salisury NHS Foundation Trust	Bank - Nurse in Charge	
		Jeffrey	Cambil		Specialist Radiographer	Ramsay Healthcare	Bank Radiographer	Signed by Line Manager
		Hayley	Rowell		Operational Manager	Mr M Geyer	Med Secretary	Signed by Line Manager
		Katherine	Woodall		Clinical Lead of Paediatric Audiology	Salisbury NHS Foundation Trust	Band - Band 7 Audiologist	Signed by Line Manager
		Sophia	Strong-Sheldrake		Swimming Teacher	Nil return	Nil return	
		Marcia	McCarthy		Endoscopy Senior Nursing Assistant	18 Week Support	Health Care Assistant	Signed by Line Manager
		Sarah	Watson		Senior Sister	Nil return	Nil return	
		Lesley Jane	Moore		Hospice Receptionist	Salisbury NHS Foundation Trust	Bank Receptionist	Signed by Line Manager
		Molly	Say		Medical Secretary	Nil return	Nil return	
		Alison Jane	Clarke		Senior Administrator	Salisbury NHS Foundation Trust	Bank Admin	Signed by Line Manager
		Emma	Rutherford		Medical Secretary	Salisbury NHS Foundation Trust	Bank Medical Secretary	Signed by Line Manager
		Rebecca	Mitchell		Vascular CNS	Nil return	Nil return	Signed by Line Manager
		Chris	Wilton		Operational Manager	Stonehenge CrossFit	Fitness Trader (Sole Trader)	Signed by Line Manager
		Lijo	Joy		Clinical Trial Practitioner	Asheralyna Ltd	Director	Signed by Line Manager
		Katherine	Jenkins		Midwife	Salisbury NHS Foundation Trust	Bank Midwife	Signed by Line Manager
		Kat Marie	Brawn		Support Booking Coordinator	Wiltshire Creative	Bar Staff	Signed by Line Manager
		Abigail	Howard		Central Booking Co-Ordinator	Salisbury Rugby Football Club	Clubhouse Staff	Signed by Line Manager
		Helen	Whatsley		Senior Sister	Nil return	Nil return	Signed by Line Manager
		Tiffany	Hayden		Senior Sister	Nil return	Nil return	Signed by Line Manager
		Essie	Griffett		Senior Sister	Nil return	Nil return	Signed by Line Manager
		Suzy	Rainbow		Senior Sister	Nil return	Nil return	Signed by Line Manager
		Laura	Stott		Medical Secretary	Polly Ford, Consultant Gynaecologist	Private Medical Secretary	Signed by Line Manager
		Kevin	Francis		Housekeeper	Salisbury NHS Foundation Trust	Bank Housekeeping	Signed by Line Manager
		Ken	Francis		Cleaner	Salisbury NHS Foundation Trust	Bank	Signed by Line Manager
		Rusu Radu	Stefan		Cleaner	Salisbury NHS Foundation Trust	Bank Cleaner	Signed by Line Manager
		Alexandra	Feca		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Saifon	Grout Smith		Cleaning Assistant	Chokdee Ltd	Waitress	Signed by Line Manager
		John	Knight		Cleaning Assistant		Wife works in NHS as in clinical administration/auditing.	Signed by Line Manager
		George	Popa		Cleaning Operative	Naim Audio	Quality Inspector	Signed by Line Manager

						Salisbury NHS Foundation Trust	Bank	Signed by Line Manager
		Nikki	Merritt		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank	Signed by Line Manager
		Beata	Wrzosek		Cleaning Operative	Wiltshire Council		Signed by Line Manager
		Rotchana	Thomas		Cleaning Assistant	Mydentist	Practice	Signed by Line Manager
		Kwanta	Renault		Cleaning Assistant	La Pasisienne Restaurant	Kitchen Assistant	Signed by Line Manager
		Jonathan	Taylor		Cleaner	Wiltshire Police	Evidential Property	Signed by Line Manager
		Stefan	Pop		Cleaning Assistant	Wagamama	Chef	Signed by Line Manager
		Shaheda	Begum		Housekeeping Staff	AWP	Administrator	Signed by Line Manager
		Paul	Larcombe		Cleaning Operative	Salisbury NHS Foundation Trust	Stockman	Signed by Line Manager
		Rajkumar	Ghoorun		Cleaning Assistant	Salisbury NHS Foundation Trust	Theatres ODO	Signed by Line Manager
						Salisbury NHS Foundation Trust	Bank Ward Clerk	Signed by Line Manager
						Salisbury NHS Foundation Trust	Bank Security	Signed by Line Manager
		Sanju	Rana		Cleaning Assistant	Gurkha Welfare Trust	Finance & Assistant	Signed by Line Manager
		Nike	Sobowale		Cleaning Assistant	Dohatech Health Science	Healthcare Assistant	Signed by Line Manager
		Mark	Morgan		Cleaning Assistant	KGB South West	Cleaning Supervisor	Signed by Line Manager
		Fabian	Monsaluo		Housekeeper	Fabian Monsaluo	Bank Housekeeper	Signed by Line Manager
		Deepanjali	Raithapa		Cleaning Assistant	Salisbury NHS Foundation Trust		Signed by Line Manager
		Lucy	Gales		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Zoe	Arden		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaner	Signed by Line Manager
		Francis	Obiri-Korang		Cleaning Assistant	Goldcrest Security	Security Officer	Signed by Line Manager
		William	Sanger		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Lopes	Maria Do Carmo		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Housekeeping	Signed by Line Manager
		Florina	Ologeanu		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Daniel	Downham		Cleaning Operative	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Agnieszka	Godlewska		Cleaner	Salisbury NHS Foundation Trust	Bank Cleaner	Signed by Line Manager
		Charlotte	Johnson		Administrator	Salisbury NHS Foundation Trust	Bank Administrator	Signed by Line Manager
		Shannon	Creasey		Spinal Injuries Booking Co-Ordinator	Salisbury NHS Foundation Trust	Bank Housekeeper	Signed by Line Manager
		Tracey	Miller		Ward Clerk	Salisbury NHS Foundation Trust	Cleaning Assistant	Signed by Line Manager
		Melanie	De Weymarn		Cancer Therapy Team Co-Ordinator	Self Employed	Companion/Helper	Signed by Line Manager
		Jacqueline	Convey		Community Palliative Care Nurse		Several family members work within the Trust but she does not directly supervise or be supervised by them.	Signed by Line Manager
						Oak Haven Hospice Trust	Bank - Community CNS	
		Simon	Wickes		CBT Therapist	Capita Infer	Examination/Test Development	Signed by Line Manager
		Lucian	Gaca		Cleaning Supervisor	Salisbury NHS Foundation Trust	Bank Cleaning Supervisor	Signed by Line Manager
		Jacqui	Daniels		Supervisor/ Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Housekeeping	Signed by Line Manager
		Shirley	Down		Housekeeping Supervisor	Salisbury NHS Foundation Trust	Bank Housekeeping	Signed by Line Manager
		Patryk	Brzezinskin		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaner	Signed by Line Manager
		Alison	Crook		MCA	Salisbury NHS Foundation Trust	Bank MCA	Signed by Line Manager
		Sandra	Ellis		Cleaning Operative	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Annemarie	Miller		Housekeeping Supervisor	Salisbury NHS Foundation Trust	Bank Housekeeping Supervisor	Signed by Line Manager
		Moniua	Kania		Cleaning Assistant	DOC Cleaning Ltd	Cleaner	Signed by Line Manager
		Panladda	Ingleson		Cleaner	Salisbury NHS Foundation Trust	Bank	Signed by Line Manager
		Andreea	Malita		Cleaning Assistant	ACS Salisbury Ltd	Director & Owner	Signed by Line Manager
						Salisbury NHS Foundation Trust	Bank Cleaning Assistant	
		Muyideem	Kassim		Cleaner	Salisbury NHS Foundation Trust	Bank Cleaner	Signed by Line Manager
		Qin	Li		Cleaner	Sarum College	Kitchen Assistant	Signed by Line Manager
		Julie	Varney		Cleaning Operative	Salisbury NHS Foundation Trust	Bank Cleaning Operative	Signed by Line Manager
		Ioulia	Trousmei		Cleaning Assistant	Salisbury NHS Foundation Trust	Bank Cleaning Assistant	Signed by Line Manager
		Karen	Scott		Cleaning Supervisor	Sarum St Pauls Primary School	Teaching Assistant	Signed by Line Manager
						Salisbury NHS Foundation Trust	Bank	
		Teodor	Strugariu		Cleaning Assistant	Salisbury NHS Foundation Trust	Portering & Housekeeping Bank	Signed by Line Manager
		Marvalyn	Scott		Cleaning Assistant	Compass	Cleaning Assistant	Signed by Line Manager
		Sebastian	Olivier		Bookings Coordinator	Esso Fuel Station	Sales Assistant	Signed by Line Manager
						Salisbury Odstock Health and Fitness	Fitness Consultant	
		Nicole Louise	Read		Staff Nurse	Dorset County Hospital	Bank Nurse	Signed by Line Manager
		Domiandor	De Castro		Clinical Audit & QI Facilitator	NHS Professionals, Univerity Hospital Southampton	Critical Care Nurse	Signed by Line Manager
Total Required Declarations (Not including 'Other')	486							
Declared	131							
Nil Return	330							

Board

Assignment Number	Title	First Name	Last Name	Email	Job Title	Company	Position	Action/Notes
	Ms.	Rakhee	Aggarwal		Non Executive Director	Nil return	Nil return	
	Mrs.	Deborah	Beaven		Non Executive Director	Newbury Bulding Society	Non Executive Director	Signed by Line Manager
						Boundless	Non Executive Director	
						Community Forest Trust	Trustee	
						Leap - Confronting Conflict	Trustee	
	Dr	Paul	Cain		Non Executive Director	Avant Health Ltd	Director. Wife is also a Director	Signed by Line Manager
		Cara	Charles-Barks		Chief Executive Officer	Great Western Hospitals, Royal United Hospitals and Salisbury Foundation Trusts	Group CEO	Signed by Chair
						NHS Quest, a Leadership and Development Provider.	Chair	
						243 (Wessex) Multi-Role Medical Regiment, part of the Army Reserve Medical Services	Appointed Honorary Colonel	
						Faculty of Health and Applied Sciences at the University of the West of England	Professor	
	Mrs.	Judy	Dyos		Chief Nursing Officer	Nil return	Nil return	
	Mr.	Mark	Ellis		Chief Finance Officer	STL - SFT's Laundry Subsidiary	Director	Signed by Line Manager
						SSL - SFT's Sterile Services JV	Director	
	Mr.	Ian	Green		Chair	Somerset Care Ltd	NED	
						The Drawing Room Ltd	Director	
						PrideWide	Trustee	
						Estuary Housing Association	Chair	
						NHS Wales Joint Commissioning Committee	Chair	
						South Central Ambulance NHS FT	NED	
						Patient Safety Commissioner Advisory Group	Member	
						Health and Social Care LGBT Leaders Network	Vice Chair	
	Mr.	Richard	Holmes		Non Executive Director	Nil return	Nil return	
	Miss	Margaret	Jones		Non Executive Director	EJP LTD	Director, Owner and shareholder	Signed by Line Manager
						Dorset County Hospital	Deputy Chair	
						Dorset Healthcare	NED	
	Ms.	Kirsty	Matthews		Non Executive Director	DFN Project SEARCH	CEO	Signed by Line Manager
	Mrs.	Fiona	McNeight		Director of Integrated Governance	Nil return	Nil return	
	Dr	Duncan	Murray		Chief Medical Officer	DM Clinical and Professional Services Ltd	Director. Wife is also a Director.	
	Mr.	Niall	Prosser		Chief Operating Officer	Nil return	Nil return	
	Miss	Margaret	Stebbing		Non Executive Director	Hampshire Hospitals NHS FT	Consultant Surgeon	Signed by Chair
	Mr.	Alexander	Talbott		Director of Improvement	Nil return	Nil return	
	Mrs.	Lisa	Thomas		Managing Director	Dauntsey Academy Primary School	Governor	Signed by Chair
	Mrs.	Melanie	Whitfield		Chief People Officer	Nil return	Nil return	

Total	17
Declared	10
Nil Return	7
Received/Awaiting Info/ LM Signing	0
Left Trust / Unable to find	0

Total Returns	17
Percentage Returned	100.00%

Budget Holders

Assignment Number	Title	First Name	Last Name	Email	Job Title	Company	Position	Action/Notes
		ROSARIA	AIELLO		Aseptic Services Accountable Pharmacist	Nil return	Nil return	
		VICTORIA	ALDRIDGE		Head of Patient Experience	Nil return	Nil return	
		ISOBEL	ALI		Service Manager, Diagnostics		Family Members working in the Trust, Mother, Step Mother, Sister and Brother In Law	Signed by Line Manager
		LOUISE	ARNETT		Head of Transformation Resourcing	Nil return	Nil return	
		JENNY	BAILLIE		Laboratory Manager Histopathology	Self-employed Mohs BMS	Biomedical scientist	Signed by Line Manager
		JESSICA	BARRETT		Divisional Manager	Nil return	Nil return	
		KATHERINE	BARRIO		Head of Midwifery & Neonatal Services	Nil return	Nil return	
		LORRAINE	BATIN		Consultant	Nil return	Nil return	
		THOMAS	BEAUMONT		Head of Radiology	The Health and Care Professions Council	Registration Assessor and Visitor	Signed by Line Manager
		HELEN	BENFIELD		Divisional Head of Nursing - Medicine	Nil return	Nil return	
		VANESSA	BETTS		Lead Respiratory Nurse	Nil return	Nil return	
		MICHELLE	BOUCHER		Lead Stome Care Clinical Nurse Specialist	Nil return	Nil return	
		CLAIRE	BRATTLE		Simulation Manager	Nil return	Nil return	
		BEN	BROWNE		Associate Medical Director	East Cowes Medical Centre	GP	Signed by Line Manager
		SONENI	BUHALI		Lead Sonographer	Hampshire Hospitals NHS Foundation Trust	Bank Sonographer	Signed by Line Manager
		COLLETTE	BYELONG		DHON, Surgery	Nil return	Nil return	
		EMILY	CARTER		Head of Information, Informatics	Nil return	Nil return	
		EMMA	COX		Head of Continuous Improvement & Coach House	Nil return	Nil return	
		MANDY	CRIPPS		South West Adult Spinal Cord Injury Network Manager	Nil return	Nil return	
		STEVEN	CROOK		Consultant	OML	Shareholder, & Employee - Quality and Regulatory Manager	Signed by Line Manager
		LUKE	CURTIS		Lead Cancer Nurse	Nil return	Nil return	
		PAULA	DAWSON		Lead End of Life Nurse	Nil return	Nil return	
		GARY	DAWSON		Head of Theatre Services	Nil return	Nil return	
		CHAMPIKA	DONA		Head of Nursing, Surgery	Nil return	Nil return	
		GEOFFREY	DUNNING					On Long Term Sickness
		RACHAEL	EAST		Deputy Divisional Manager	Nil return	Nil return	
		JENNIFER	EVANS		Theatre Matron	Nil return	Nil return	
		DEBBIE	FISHLOCK		Resuscitation Manager	Self Employed	Training Consultant	Signed by Line Manager
		PAUL	FREEMAN		General Manager, Support Services	Nil return	Nil return	
		BEVERLEY	GRANFIELD		Patient Flow Matron	Nil return	Nil return	
		JOANNE	HARRIS		Microbiology Lab Manager	Nil return	Nil return	
		MEGAN	HAWTHORN					On Maternity Leave
		ALISON	HEMMING		Outpatient Matron	Nil return	Nil return	
		SANDY	HIGDON		Health Records and Clinical Coding Manager	Nil return	Nil return	
		LISA	HIRST		Head of Service, SaLT	Nil return	Nil return	
		SHARON	HOLT		Head of Resourcing	Nil return	Nil return	
		ALEXANDRA	HURLEY		Matron	Nil return	Nil return	
		VICTORIA	INSULL		Deputy Divisional Manager	Nil return	Nil return	
		LOUISE	JONES		Head of Risk	Nil return	Nil return	
		CARRIE	JONES		Matron	Nil return	Nil return	
		TUMI	KAMINSKAS		Head of Research	Limited Company	Managing Director	No action required.
		LIZ	KIMBER		Matron Outpatient Services	Nil return	Nil return	
		SHARIFAH	KIYEGGA		Lead Vascular Scientist	Royal Bournemouth Hospital	Locum Vascular Scientist	Signed by Line Manager
		JUDITH	LEACH		Head of Legal	Nil return	Nil return	
		CARL	LEWIN		Head of OD & Leadership	Nil return	Nil return	
		ANNA	LONG		Cardiovascular Service Manager	Nil return	Nil return	
		EMMA	LUNN		Urodynamic Lead Practitioner	Nil return	Nil return	
		AFRODITI	MAVROMYTI		Matron for Surgery	Nil return	Nil return	
		FIONA	MCCARTHY		Lead Nurse, Infection Prevention & Control	Nil return	Nil return	
		JANE	MCGUIRE		Lead Achocardiographer	Nil return	Nil return	
		NICOLA	MCQUAID		Anticoagulation & Thrombosis Nurse Consultant	Nil return	Nil return	
		HELEN	MORELAND		Lead CNS	Nil return	Nil return	

		EMMA	MOULD		Named Nurse Safeguarding Children	Nil return	Nil return	
		CRISPIAN	MULSHAW		Head of Education	Nil return	Nil return	
		ARDESHIR	NASARWANJI		Service Manager	Nil return	Nil return	
		ANUSHKA	NATARAJAN		Blood Transfusion Lab Manager	Nil return	Nil return	
		BEN	OAKLEIGH					Left Trust December 2024
		LAURA	OSMAN		Divisional Head of Nursing - Medicine	Nil return	Nil return	
		ALLISON	PEEBLES		Head of Therapies and Dietetics	Nil return	Nil return	
		MATTHEW	PETRY		Bichemistry Lab Manager	Nil return	Nil return	
		LEE	PHILLIPS		Head of Pathology	Nil return	Nil return	
		ANDY JOHN	PHILLIPS		Deputy Divisional Manager	Nil return	Nil return	
		CHLOE	PONSFORD		Service Manager	Nil return	Nil return	
		LAUREN	PROSSER		Clinical Specialist Sonographer	Health Science University	Locum Sonographer	Signed by Line Manager
		KERRY	RANDALL		Gynaecology Matron	Nil return	Nil return	
		KATIE	RANSBY		Divisional Head of Nursing, Surgery	Nil return	Nil return	
		TROY	READY		Health and Safety Manager	Nil return	Nil return	
		CHARLOTTE	REVELL		Senior Nurse ACP	Nil return	Nil return	
		MARK	RICHARDS		Manager Maxillofacial Lab	Nil return	Nil return	
		DAVID	ROBERTS		Associate Director Communications Engagement and Community Relations	Morgan Roberts Ltd	Director and Owner	Signed by Line Manager
						Army Widow Association	Trustee	
						Institute of Health Visiting	Trustee	
							Wife is employed by Salisbury Catherdral - Director of External Relations	
						Serve On Ltd	Training Assistant	
		REBECCA	ROBERTS		Inpatient Matron for Maternity	Nil return	Nil return	
		MARK	ROBINSON		AD HR Operations	Nil return	Nil return	
		ANDREA	ROBSON		Paediatric Matron & Trust Leader for CYP	Nil return	Nil return	
		MEGAN	ROBSON		Advanced Clinical Practitioner	Salisbury and South Wilts Physiotherapy	Occupational Therapist	Signed by Line Manager
		JO	ROWNTREE		Head of Occupational Health	Nil return	Nil return	
		EMILY	RUDD		Matron for Critical Care Services	Nil return	Nil return	
		MICHELLE	SADLER		General Manager, Facilities Admin	Nil return	Nil return	
		SARAH	SCADDEN		Blood Sciences Manager	Nil return	Nil return	
		EMILIA	SCUTT		Cancer Services Manager	Nil return	Nil return	
		PEDRO	SERRA		Divisional Matron Medicine	Nil return	Nil return	
		JAYNE	SHEPPARD		DHON, CSFS & Governor	Nil return	Nil return	
		RORY	SMITH		Head of Audiology	Aurium Audiology Ltd	Director and Owner	Signed by Line Manager
		NICOLA	SUMMERILL		Spinal Matron	Nil return	Nil return	
		FIONA	TALBOT		Clinical Lead Physio	Nil return	Nil return	
		PAUL	TAYLOR		Consultant	Odstock Medical Limited	Clinical Director and Shareholder	Signed by Line Manager
		ANDREA	TAYLOR		Principal Clinical Scientist	Nil return	Nil return	
		JANE ELIZABETH	TEMBLETT		Speciality Manager	Stable LTD	Director Husband is Joint Director	Signed by Line Manager
		ANDY	THOMAS		Interim Head of CIU	Nil return	Nil return	
		KELLY	TYRIE		Matron for Critical Care Services	Nil return	Nil return	
		CLAIRE	UZZELL		Principal Orthotist	Nil return	Nil return	
		MIGUEL	VASCONCELOS		Matron	Nil return	Nil return	
		Rob	Walker					Left Trust December 2024
		CATHERINE	WHITMARSH		Clinical Lead, Spinal Unit	Nil return	Nil return	
		KATHARINE	WILCOCKS		Service Lead, Orthopaedic Therapy	Nil return	Nil return	
		SARA	WILDS		Neurophysiology Service Lead	Nil return	Nil return	
		KELLY	WILKINS		Divisional Matron Medicine	Nil return	Nil return	
		EMMA	WOODLAND		Head of Embryology & Lab Manager	Nil return	Nil return	

Total	93
Declared	14
Nil Return	78
Received/Awaiting Info/ LM Signing	1
Left Trust / Unable to find	4
Total Returns	93

Governors

First Name	Last Name	Email	Job Title	Company	Position	Action/Notes
Kevin	Arnold		Public Governor	Nil return	Nil return	
Joanna	Bennett		Public Governor	Nil return	Nil return	
Mark	Brewin		Staff Governor	Nil return	Nil return	
Barry	Bull		Public Governor	Nil return	Nil return	
Pauline	Church		Nominated Governor	Paloma Lily Wiltshire Council	Owner Wiltshire Councillor for Wilton	
Frank	Cunnane		Public Governor	Nil return	Nil return	
Benita	Florence		Staff Governor	Nil return	Nil return	Contract ended December 2024
Jason	Goodchild Maj		Nominated Governor	Nil return	Nil return	
Jacqueline	Hartas		Public Governor	Nil return	Nil return	
William	Holmes		Public Governor	Nil return	Nil return	
Peter	Kosminsky		Public Governor	Nil return	Nil return	
Frances	Owen		Public Governor	Nil return	Nil return	
Jane	Podkolinski		Staff Governor	Nil return	Nil return	
Salil	Ray-Chowdhury		Public Governor	Nil return	Nil return	
Andrew	Rhind-Tutt		Public Governor	Nil return	Nil return	
Paul	Russell		Staff Governor	Nil return	Nil return	
Peter	Russell		Public Governor	Nil return	Nil return	
Susan	Snoxall		Public Governor	Nil return	Nil return	
Sara	Willan		Public Governor	Nil return	Nil return	

Total	18
Declared	1
Nil Return	17
Received/Awaiting Info/ LM Signing	0
Left Trust / Unable to find	1

Total Returns	18
Percentage Returned	100.00%

Procurement Staff

Assignment Number	Title	First Name	Last Name	Email	Job Title	Company	Position	Action/Notes
	Mr.	Babatunde	Adeniyi		Head of Procurement & Contract Management	Nil return	Nil return	
	Mr.	Christopher	Bailey		Supply Chain Coordinator	Nil return	Nil return	
	Mrs.	Sylwia	Bajek		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	James	Baker		Supply Chain Assistant	Nil return	Nil return	
	Mrs.	Beth	Bartholomew		Deputy Head of Sourcing	QE Facilities	Cousin is the Managing Director of QE Facilities Limited, which is a framework used throughout the ICS to procure goods/services.	Signed by Line Manager
	Mrs.	Janet	Bartlett		Senior Supply Chain Co-Ordinator	Nil return		
	Mr.	Paul	Brierley		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Paul	Broomfield		Head Storeman	Nil return	Nil return	
	Mrs.	Alison	Brunt		Stores Coordinator	Nil return	Nil return	
	Mr.	Justin	Calayan		Supply Chain Coordinator	Nil return	Nil return	
	Miss	Amanda	Caswell		Materials Management Officer	Nil return	Nil return	
	Mrs.	Evelyn	Chalk		Commercial Client Procurement Manager	Nil return	Nil return	
	Mrs.	Christine	Chambers		Procurement Manager	Nil return	Nil return	
	Mr.	Jonathan	Chapman		Procurement Manager	Nil return	Nil return	
	Mr.	Stefanos	Christoforidis		Head of Supply Chain	Nil return	Nil return	
	Mr.	Franklin	Colomer		Supply Chain Coordinator	Nil return	Nil return	
	Mrs.	Sharon	Cousins		ICS P2P Manager	HCRG	Daughter will be an employee of HCRG from 16/09/2024.	Signed by Line Manager
						The Health Business and Technical Park	Contractor for Salisbury NHS Foundation Trust.	
	Mr.	Michael	Craddock		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Andrew	Davies		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Simon	Dennis		Head of Commercial	Nil return	Nil return	
	Mrs.	Emily	Dixon		Invoice and No-Po Manager	Nil return	Nil return	
	Mr.	Sid	Dring		Senior Procurement Analyst	Nil return	Nil return	
	Mr.	Rene	Dulog		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Deepesh	luvalikkal Balakrishna		Supply Chain Coordinator	Nil return	Nil return	
	Mrs.	Alison	English		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Ryan	Evans		Senior Sourcing Manager	Nil return	Nil return	
	Ms.	Ogheneovo	Ezeh		Contract Buyer	Nil return	Nil return	
	Mrs.	Joie	Feria		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Ronnie	Fernandez		Surgical Kitting Assistant	Nil return	Nil return	
	Mr.	Aldrin	Fonseka		Senior Transactional Buyer	Nil return	Nil return	
	Mr.	Roger	Fussell					Email not found
	Miss	Lindsay	Gamlin		Procurement Manager	Nil return	Nil return	
		Shantanu	Gavhane		Procurment Manager	Nil return	Nil return	
	Mr.	William	Gibbons		Procurement Analyst	Nil return	Nil return	
	Mr.	Vinicius	Godoi de Castro		Supply Chain Coordinator	Nil return	Nil return	
	Mrs.	Sarah	Goodchild		Procurement Manager	Nil return	Nil return	
	Mr.	Oliver	Gould		Supply Chain Coordinator	Nil return	Nil return	
	Miss	Marlena	Gulaj		Procurement Systems and Data Analyst	Nil return	Nil return	
	Mr.	Callum	Haines		Supply Chain Supervisor	Nil return		
	Mr.	Martyn	Hale		Supplies Coordinator	Nil return	Nil return	
	Ms.	Elizabeth	Hamilton		Procurement Graduate Trainee	Nil return	Nil return	
	Ms.	Yvonne	Harvey		Maternial Management Officer	Nil return	Nil return	
	Mrs.	Karen	Harwood		Supply Chain Assistant	Nil return	Nil return	
	Mrs.	Louise	Hatch		GWH Transaction Procurement Manager	Nil return	Nil return	
	Mr.	Simon	Head		Procurement Systems and Analytics Manager	Nil return	Nil return	
	Mr.	Michael	Hedges		Supply Chain	Nil return	Nil return	
	Mr.	Rocel	Hernandez		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Kittiphong	Hiranyaphan		Purchase to Pay Administrator	Nil return	Nil return	
	Ms.	Jennifer	Hykin		Head of Operational Procurement	Nil return	Nil return	
	Mr.	Alexander	Ilbury-Holliday		Supply Chain Manager	Nil return	Nil return	
	Mrs.	Mariana	Ionescu		Supply Chain Supervisor for Wards	Nil return	Nil return	
	Mr.	Jason	Jarmin		Supply Chain Assistant	Nil return	Nil return	
	Miss	Maham	Jawwad		Procurement Specialist	Nil return	Nil return	
	Mr.	Nathan	Jefferd		Surgical Kitting Lead	Nil return	Nil return	
	Mr.	Nicholas	Jeffery		Surgical Kitting	Nil return	Nil return	

	Mrs.	Sharon	Jennings		Senior Procurement Manager	Nil return	Nil return	
	Mr.	Milan	John		Purchasing Assistant	Nil return	Nil return	
	Mr.	Steve	Kelly		Team Leader	Nil return	Nil return	
	Mr.	Roger	Knowlson		Store Coordinator	Nil return	Nil return	
	Ms.	Lok	Leung		Purchase to Pay Administrator	Nil return	Nil return	
	Mr.	Christopher	Lund		Deputy Supply Chain Manager	Nil return	Nil return	
	Miss	Shannon	Mahoney		Purchasing Buyer	Nil return	Nil return	
	Miss	Clementine	Maitland		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Antu	Mathew		Purchasing & Suppy Chain Coordinator	Nil return	Nil return	
	Mr.	Joshua	Mayfield		Supply Chain Coordinator	Nil return	Nil return	
	Mrs.	Katie	McKernan		Supply Chain Coordinator	Nil return	Nil return	
	Dr	Lucia	Mihok		Head of Capital Procurement and Equipping	SIC 68209Letter and Operating Real Estate	Director/ Owner	
	Mr.	John	Miles		Supply Chain Coordinator	Nil return	Nil return	
	Mrs.	Cheryl	Miranda		Supply Chain Supervisor	Nil return	Nil return	
	Mr.	Regino	Morales		Supply Chain Coordinator	Nil return	Nil return	
	Miss	Stacey	Moreton		Supply Chain Supervisor	Nil return	Nil return	
	Mr.	Eduardo	MORGILLO		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Joe	Murray					
	Mrs.	Shaila	Nafees		Procurement Administrator	Nil return	Nil return	
	Mr.	Adam	Nicholass		Supply Chain Manager	Nil return	Nil return	
	Mr.	Danny	O'Callaghan		Deputy Supply Chain Manager	Nil return	Nil return	
	Mrs.	Heather	O'Callaghan		Supply Chain Supervisor	Nil return	Nil return	
	Mrs.	Karen	Ody		Senior Clinical Procurement Specialist Nurse	Nil return	Nil return	
	Mr.	Amit	Ohri		Procurement Graduate Trainee	Nil return	Nil return	
		Sarah	Ogungbe		Senior Procurement Management	Nil return	Nil return	
	Mr.	Samuel	Olajire		Procurement Specialist	Nil return	Nil return	
	Mr.	Olusola mathew	Olanrewaju		Purchase to Pay Administrator	Nil return	Nil return	
	Mrs.	Anita	Otvos		Assistant Supply Chain Analyst	Nil return	Nil return	
	Mr.	Shalmon	Panketh Joy		Procurement Specialist	Nil return	Nil return	
	Mr.	William	Pearcey		Purchasing & Systems Assistant	Nil return	Nil return	
	Mr.	Jonathan	Phillips		Supply Chain Assistant	Nil return	Nil return	
	Mr.	Michael	Philpott					Left Trust
	Mr.	Kevin	Pomroy		Materials Management	Nil return		
	Mrs.	Shelley	Pragnell		Senior Transactional Buyer	Nil return	Nil return	
	Mr.	Chris	Prosser		Supply Chain Supervisor	Nil return	Nil return	
	Mr.	Henry	Prudden		Procurement Manager	Nil return	Nil return	
	Mr.	Andrew	Quinn		Senior Procurement Manager	Nil return	Nil return	
	Mr.	James	Quinnell		Supply Chain Assistant	Nil return	Nil return	
	Mr.	A B M Hamidur	Rahman		Senior Procurement Manager	Supply Chain Talent Jaguar Land Rover, Dyson and Rolls Royce	Sole Director Contractor Procurement Consultant	Signed by Line Manager
	Mr.	Jake	Rattue		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Oliver	Rogers		Stores Assistant	Nil return	Nil return	
	Mr.	Alan	Roy		Purchasing Assistant - Capital	Nil return	Nil return	
	Mr.	Naveen	Sadagopan Pitchumar		Contracts Buyer	Nil return	Nil return	
	Miss	Lavanya	Sasupally		Procurmeent Specialist	Nil return	Nil return	
	Mr.	Sam	Saunders		Supply Chain Manager	Nil return	Nil return	
	Mr.	Rishabh	Sharma		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Luke	Sharman		Supply Chain Analyst	Nil return	Nil return	
	Mr.	Christopher	Thomas					Left Trust
	Mr.	Cyril	Thomas		Capital Contracts Buyer	Nil return	Nil return	
	Mr.	Tomy	Thomas		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Ben	Thompson		Supply Chain Manager	Nil return	Nil return	
	Mr.	Von Ryan	Venzon		Supply Chain Coordinator	Nil return	Nil return	
	Mr.	Kevin	Waite		Material Management Coordinator	Nil return	Nil return	
	Mr.	Robert	Webb		Director of Procurement & Commercial Services	Siemens Financial Services	Sister in Law (Penny Pinnock) works as financial manager for leasing services to the NHS	Signed by Line Manager (Mark Ellis)
	Mrs.	Kelly	Willoughby		Deputy Director of Procurement	Nil return	Nil return	
	Mr.	Richard	Witt		Storeman	Nil return	Nil return	
	Miss	Clare	Witt-Bartlett		Supply Chain Coordinator	Nil return	Nil return	
	Miss	Gabriela	Wysocka					Left Trust
	Mrs.	Catherine	Yeo		Clinical Procurement Specialist Nurse	Nil return	Nil return	

28437357	Mrs.	Zhimei	Zhai	zhimei.zhai@nhs.net	Procurement System Assistant	Husband works within Salisbury NHS Foundation Trust Radiology Department	Nil return	
		Jacqueline	Flook		Personal Assistant	Nil return	Nil return	
		Bukola	Ajoke Adjikpe		P2P Administrator - Bank	Nil return	Nil return	
		Elizabeth	Liversage		Interim Procurement Transformation Specialist	Nil return	Nil return	
		Steve	Novetsky		Procurement Interim	Nil return	Nil return	
		Angela	Morais		Operations Transaction Buyer	Nil return	Nil return	
		Carolyn	Cope		Ops Team Procurement	Nil return	Nil return	
		Ella	Liversage		Transactional Buyer		Mother-in-law Liz Liversage works in the trust as an interim Procurement Transformation Specialist.	Email confirmation received to confirm reviewed by Line Manager
						Self Employed	Actor under 'Ella Dunlop'	
		Debbie	Parin		Interim Clinical Category Specialist	Nil return	Nil return	
		Fiona	Mobbs		Procurement Department Admin Support	Your Stylist In A Box Ltd	Director & Owner	Signed by Line Manager
						My Stylist In A Box Ltd	Director & Owner	
						Your Colour & Style	Soletrader	
						Personal Poet Fiona	Soletrader	
						Jane Slarth Charity	Volunteer	
						Peter Symonds College	Exam Invigilator	
		Lidiya	Walton		Interim Procurement Manager	Director/Owner of own company		Signed by Line Manager
		Yasin	Virani		Commercial Programme Manager	Nil return	Nil return	
		Mark	Hilton		Bank Administrator	Nil return	Nil return	
		Martin	Brown		Supply Team - Theatres	Nil return	Nil return	
		Oliaitan	Oyedokun		Clerical Bank	The Bridge Youth Project	Youth Worker	Signed by Line Manager
		Sada	Zeb		Transactional Buyer	Nil return	Nil return	
		Gerard	Sheehan		Clinical Procurement Specialist Nurse	Nil return	Nil return	
		Shelley	Tisanjoh		Dep Head of Sourcing	Nil return	Nil return	
		Justin	Thomas		Transactional Buyer	Nil return	Nil return	
		Raimund	Koppel		Procurement Consultant	RK Procurement Specialists LTD	Director , owner and shareholder	Signed by Line Manager
		Kevin	Varghese		Transactional Buyer	Nil return	Nil return	
		Kingsley	Okite		Contract Buyer	Nil return	Nil return	
		Ryan	Markwick		Senior Transactional Buyer	Nil return	Nil return	
		Bridgette	Morrison		Supply Chain Coordinator	Nil return		
		Donna	West		Supply Chain Coordinator	Nil return		
		Martin	Brown		Supply Chain Assistant	Nil return	Nil return	
		Jose	Ganotisi		Supply Chain Assistant	Nil return	Nil return	

Total	110
Declared	6
Nil Return	104
Received/Awaiting Info/ LM Signing	0
Left Trust / Unable to find	5

Total Returns	110
Percentage Returned	100.00%

Senior Staff - 8d (or equivalent) and above

Assignment Number	Title	First Name	Last Name	Email	Job Title	Company	Position	
	Dr	Syed	Abbas		Consultant	New Hall Hospital	Consultant Anaesthetist	Signed by Line Manager
	Miss	Lynne-Marie	Abbott		Deputy Director of Finance	Chewvale Ltd	Director	Signed by Line Manager
						Odstock Medical Ltd	Director	
	Dr	Yasser	Abdelhalim Shahata		Consultant	Nil return	Nil return	
	Dr	Deena	Abdel-Satir					Email address unknown
	Miss	Anna	Aertssen		Consultant	Nil return	Nil return	
	Dr	Hayder	Agha		Consultant	Hampshire Clinic, Basingstoke	Consultant in Rehabilitation Medicine	Signed by Line Manager
	Mr.	Andrew	Agombar		Consultant	Nil return	Nil return	
	Dr	Robin	Alcock		Consultant		Spouse is Purchasing Assistant in Procurement	Signed by Line Manager
						Salisbury NHS Foundation Trust	Consultant Radiologist - Private Practice	
	Dr	Dalia	Allam		Consultant	Nil return	Nil return	
	Dr	Layth	Alsaffar		Consultant	Biofix Ltd	Director and Shareholder	Signed by Line Manager
						Summerseat Owners Ltd	Director	
						Portsmouth Hospitals Trust	Infection Control Doctor and Decontamination Lead	
	Dr	Christopher	Anderson		Consultant		Designated person for safeguarding Downton Baptist Church	Signed by Line Manager
	Mrs.	Angela	Ansell		Deputy Chief Nursing Officer	Nil return	Nil return	
	Mr.	Laurence	Arnold		Programme Director	Sterile Supplies Ltd	On the Board	Signed by Line Manager
							Partner employed by Amplity company providing services to pharmaceutical organisations	
						Amesbury Redevelopment Partnership (ARP)	Partner has a share in company who own property in Amesbury, part of which may potentially be leased by the Trust.	
	Dr	Jonathan	Arnott		Consultant	New Hall Hospital	Self Employed part of Radiology Group	Signed by Line Manager
	Dr	Rashi	Arora		Consultant	Nil return	Nil return	
	Dr	Sarah	Assheton		Consultant	Nil return	Nil return	
	Dr	Charlotte	Atkinson		Consultant	Nil return	Nil return	
	Dr	Nwe	Aung		Consultant	Nil return	Nil return	
	Dr	Bushra	Awan					Left Trust November 24
	Dr	Katharine	Backhouse		Consultant	Nil return	Nil return	
	Dr	Danielle	Bagg		Consultant	Nil return	Nil return	
	Mr.	James	Baird		Consultant	Nil return	Nil return	
	Dr	Philippa	Baker		Consultant	Nil return	Nil return	
	Mr.	Surendra	Bandi		Consultant	Private Limited Company	Co-Director, Owner and Shareholder Wife & daughters co-directors	Signed by Line Manager
							President of British Association of Spinal Cord Injuries	
	Mr.	Guy	Barham		Spinal Surgeon	Wessex Medical & Surgical Services LTD	Director Wife is co-director	No action required.
	Dr	Juliet	Barker		Consultant	Nil return	Nil return	
	Mr.	James	Barr		Consultant	New Hall Hospital	Anaesthetist	No action required.
	Dr	Anna	Barton		Consultant	Nil return	Nil return	
	Dr	Sarah	Bartram		Consultant	Nil return	Nil return	
	Dr	Nicola	Bell		Consultant	Nil return	Nil return	
	Dr	Toby	Black		Consultant	Nil return	Nil return	
	Miss	Amanda	Bond		Consultant	Salisbury Gallbladder Surgery LTD	Director	
						Salisbury Hospital Foundation Charity	No specific title within this charity for managing this trust to provide members of Salisbury Hospital staff with funds from training opportunities. More details via intranet link.	Signed by CD
	Mr.	Richard	Booth		Consultant	Croydon NHS Trust	Honorary Consultant	Signed by Line Manager
	Dr	Julia	Bowditch		Consultant	Bowditch Medical Ltd	Director	No action required.
						New Hall Hospital	Consultant Anaesthetist	
	Mrs.	Hannah	Boyd		W&N DDO	Nil return	Nil return	
	Dr	Robert	Boyd		Consultant	Robert Boyd Limited	Director Wife also Director	No action required.

						New Hall Hospital	Consultant	
	Mr.	Graham	Branagan		Consultant	G&PB Ltd	Director, Owner, Shareholder. Wife is co-director.	Signed by Line Manager
						BWS Grammer School	Chair of Governors	
						G&PB Ltd	Consultant Surgeon	
	Mr.	James	Brewin		Consultant	Sarum Urology Ltd	Director, Part Owner and Marjoity Shareholder.	Signed by Line Manager
	Dr	Carl	Broadbridge		Consultant	Salisbury Hospice	Trustee	No action required.
						New Hall Hospital	Consultant Anaesthetist	
	Miss	Victoria	Brown		Consultant	Nil return	Nil return	
	Dr	Sally	Bugg		Consultant	Nil return	Nil return	
	Dr	Timothy	Burge		Consultant	Clifton Plastic Surgery	Secondary Employment - Medico Legal Consultant	Signed by Line Manager
	Mr.	Jonathan	Burwell		Consultant	Nil return	Nil return	
	Dr	Harriet	Bush		Consultant	Nil return	Nil return	
	Dr	Lucy	Bushby		Consultant	Nil return	Nil return	
	Mrs.	Mary	Bussell		Consultant	Nil return	Nil return	
	Mr.	Colin	Campbell		Consultant	RALP Ltd	Director	Signed by Line Manager
						UHS	Honorary Consultant Urologist	
	Dr	Carmen	Carroll		Consultant	Nil return	Nil return	
	Dr	Natasha	Cartwright		Consultant	Nil return	Nil return	
	Miss	Phillippa	Caygill		Consultant	Nil return	Nil return	
	Dr	Simon	Claridge		Consultant	Self Employed	Doctor	Signed by Line Manager
	Mrs.	Lisa	Clarke		DDO - CSFS	Nil return	Nil return	
	Dr	Michael	Clynes		Consultant	Clynes Medical Ltd	Director Spouse has majority shareholdings	Signed by Line Manager
						Eden Clinical	Locum Rheumatology Consultant	
	Dr	Zoe	Cole		Divisional Medical Director & Consultant Rheumatologist	Nil return	Nil return	
	Mr.	Richard	Cole		Consultant	Self Employed	Plastic Surgery	Signed by CD
	Dr	Ian	Cook		Consultant	Ramsay Health	Consultant	Signed by Line Manager
	Dr	Martin	Cook		Consultant	KPMC Medical Ltd	Director - Wife also Director	Signed by Line Manager
						Salisbury Cathedral	Photographer	
						New Hall Hospital	Consultant Anaesthetist	
	Dr	Sarah	Cook		Consultant	Nil return	Nil return	
	Dr	Simon	Cooper		Consultant	Nil return	Nil return	
	Dr	Belinda	Cornforth		Consultant	Property LLP	Joint Director	No action required.
						Limited Company Property Investments	Joint Director	
						Hartley Orthopaedics	Joint Director	
	Dr	Peta	Coulson-Smith		Consultant	Nil return	Nil return	
	Dr	Suzanne	Coulter		Consultant	RC/SC Anaesthesia	Joint Director	Approved by Line Manager
	Dr	Christopher	Couzens		Consultant	CAS Medical Services Limited	Director	Signed by Line Manager
						Salisbury Anaesthetic Group - New Hall Hospital	Consultant Anaesthetist	
	Dr	Christina	Cox					Retiring end of March 25, hasn't been in worked since end of summer 24.
	Dr	Aisling	Coy		Consultant	Purple Medical Limited	Director, 33% shareholder,	Signed by Line Manager
						Consultant Connect A&G	Rheumatology Consultant	
						New Hall Hospital	Rheumatology Consultant	
	Dr	Alexandra	Crick		Consultant	Nil return	Nil return	
	Mr.	Ian	Crowley		Consultant	Nil return	Nil return	
	Dr	Ross	Cruickshank		Consultant	Ltd Company	Director - Private Practice Wife is joint Director	Signed by Paul Stephens
						Fordingbridge Rugby Football Club	Coach	
						Ramsay New Hall Hopsital	Consultant Anaesthetist	
	Dr	Jonathan	Cullis		Medical Examiner	CRESS Charity	Trustee	Signed by Line Manager
						Coombe Bissett and Homington Parochial Church Council	Member	
	Mr.	Harshad	Dabke		Consultant	Orthopaedic Plastic Spinal Surgeons LLP	Treasurer & Member	No action required.
						Self Employed	Consultant	
	Miss	Melissa	Davies		Consultant	Wessex Urology LTD	Director	Signed by Line Manager
						Ramsay Health	Consultant Urologist	
	Dr	Stephen	Davies		Consultant	Nil return	Nil return	
	Mr.	Simon	Dennis		Consultant	New Hall Hospital	Private Practice	Signed by Line Manager
						Simon Dennis ENT Ltd	Director	
	Dr	Ajit	Dhillon		Consultant	Nil return	Nil return	
	Mrs.	Jane	Dickinson		Deputy DDO	Nil return	Nil return	

	Dr	Philip	Donnison		Consultant Anaesthetist	PD Anaesthetics Ltd	Director	Signed by Line Manager
	Mr.	Ian	Downie					
	Dr	Jonathan	Drayson		Consultant	Nil return	Nil return	
	Dr	Kush	Duggal					
	Dr	Harriet	Edgar		Consultant	Nil return	Nil return	
	Dr	Peter	Ellis		Consultant	Nil return	Nil return	
	Mr.	Ahmed	Elmorsy		Consultant	New Hall Hospital	Self employed - Consultant with admission right	Signed by CD
	Mr.	Mohammed	Elsaghir					
	Dr	Sian	Evans		Consultant	Nil return	Nil return	
	Mr.	Nicholas	Evans		Consultant	Nick Evans Spinal Surgery Limited	Director, & majority shareholder. Wife is also a shareholder	Signed by Line Manager
						Ramsay Healthcare (NHS Work)	Spinal Surgeon	
	Miss	Rebecca	Exton					
	Dr	Yazmin	Faiza		Consultant	Nil return	Nil return	
	Miss	Nefer	Fallico		Consultant	N Fallico Ltd	Director and Owner	
							Private Consultant Plastic Surgeon	
	Dr	Tracey	Farnon		Consultant	23rd Salisbury Scout Group	Treasurer	Signed by Line Manager
	Dr	Lynn	Fenner		Consultant	Nil return	Nil return	
	Miss	Roanne	Fiddes		Consultant	Nil return	Nil return	
	Miss	Laura	Findlay		Consultant	Nil return	Nil return	
	Dr	Nicola	Finneran		Consultant	Nil return	Nil return	
	Dr	Paul	Flanagan		Consultant	Nil return	Nil return	
	Dr	Benita	Florence			Nil return	Nil return	
	Dr	Matthew	Flynn		Consultant	Flynn-Lees Consulting Ltd	Director, owner and shareholder. Partner also a Director.	Signed by Line Manager
						HM Coroner	Autopsy Pathologist	
						New Hall - Private Dental Clinics	Through Flynn-Lees Consulting Ltd	
	Dr	Polly	Ford		Consultant	Fertility and Gynaecology Limited	Director, owner, shareholder.	Signed by Line Manager
						Complete Fertility	Consultant in Reproductive Medicine	
						Ferring Pharmaceuticals	Sponsorship of attendance at Conferences / Professional Meetings including travel, conference fees and accommodation. Received speaker fees.	
						Nuffield Health Bournemouth	Consultant Gynaecologist - Private	
	Dr	Louise	Gamble		Consultant	Nil return	Nil return	
	Dr	Temitayo	Gandon		Consultant	Nil return	Nil return	
	Dr	Neil	Garrett		Consultant	Nil return	Nil return	
	Dr	William	Garrett		Consultant	Self Employed	Consultant Anaesthetist	Signed by Line Manager
	Mr.	Abdus	Ghauri		Consultant	Nil return	Nil return	
	Dr	Konstantina	Giannopoulou		Consultant	Nil return	Nil return	
	Dr	Elizabeth	Goggin		Consultant	Nil return	Nil return	
	Dr	Effie	Grand		Consultant	local Cancer rresearch UK (CRUK) Fundraising Group	President	No action required.
	Dr	Sebastian	Gray		Consultant	Re-Palm Health	Director	Signed by Line Manager
						BSW ICB	Clinical Advisor	
	Dr	Lee	Grimes		Consultant	Jersey General Hospital	Locum Haematologist	Signed by Line Manager
	Dr	Swarna	Guttikonda		Consultant	Nil return	Nil return	
	Dr	Emma	Halliwell		Consultant	Nil return	Nil return	
	Mr.	Naeem	Haq		Consultant	MWNH	Director & Part Owner Colleague Co -Owner	
						Sarum Eye Clinic Ltd	Director & Part Owner Spouse is Director	
						Ramsey UK, Sarum Eye Clinic	Consultant Ophthalmologist	
	Dr	Helen	Hardy		Consultant	Nil return	Nil return	
	Dr	Annabel	Harris		Consultant	NHS England South West Commissioning Group	GP Appraiser	Signed by Line Manager
						Wessex Appraisal Service	Appraiser	
	Dr	Richard	Harrison		Consultant		SD-on does sessional work as Clinical Governance lead for an in-reach company - KPI Health	Signed by Line Manager
						AMBU	Honorary Advisor - Resigned	

	Dr	James	Haslam		Consultant	Critical Care Medicine Limited	Director Wife is Shareholder	
						Ramsay Health	Consultant Anaesthetist	
						Limited Company	Self Employed Contractor	
	Dr	Heba	Hassan		Consultant	Nil return	Nil return	
	Ms.	Ann	Hawkins		Consultant	NAPS Womens Health Charity	Trustee	Signed by Line Manager
						Hormone Health	Associate - Private Work	
	Dr	Helen	Hayward		Consultant	Nil return	Nil return	
	Dr	Susan	Hegarty		Locum Consultant Radiologist	AXON	Adhoc Radiology Reporting	Signed by Line Manager
						New Hall Hospital	Private Practice	
	Dr	Julian	Hemming		Consultant	Nil return	Nil return	
	Dr	Stuart	Henderson		Consultant	Nil return	Nil return	
	Dr	Mary	Hennebry		Consultant	Captiosus Consulting Ltd	Director (since 2022)	No change since 2022 form
	Mr.	Ryan	Higgin		Consultant	RH Orthopaedics Ltd	Director, Owner and Shareholder	No action required.
						OPSS LLP	Member	
	Dr	Jeremy	Hill		Consultant	Nil return	Nil return	
	Dr	Makoko	Hlahane		Consultant	Nil return	Nil return	
	Dr	Alexandra	Hogan		Consultant	University Hospital Southampton	Professor	Signed by Line Manager
						UCL Great Ormond Street Institure of Child Health	Research Associate	
	Dr	Xantha	Holmwood		Consultant	Nil return	Nil return	
	Mr.	Nigel	Horlock		Consultant	Private Practice Partnership	Director Wife is partner in the practice.	No action required.
	Dr	Christopher	Horne		Doctor	Portsmouth Hospitals Trust	Locum Consultant	Signed by Line Manager
	Mrs.	Nicola	Howells		Associate Director of OD, Culture and Learning	Self-Employed	Driving Instruction and Career Coaching	No action required.
	Dr	Adam	Hughes		Consultant	Nil return	Nil return	
	Dr	Michael	Hughes		Consultant	University Hospital Southampton	Consultant Radiologist	Signed by Line Manager
						New Hall Hospital	Self Employed - Consultant Radiologist	
	Mr.	Roger	Humphry		Consultant	Nil return	Nil return	
	Dr	Simon	Hunter		Consultant	Nil return	Nil return	
	Mrs.	Fiona	Hyett		Deputy Chief Nursing Officer	Nil return	Nil return	
	Dr	Helen	Iveson		Consultant	Nil return	Nil return	
	Dr	Thomas	Jackson		Consultant	Nil return	Nil return	
	Mr.	Neal	Jacobs		Orthopaedic Surgeon	Salisbury Medical Solutions Ltd	Director and Owner. Wife is a Director	Signed by Line Manager
						OPSS LLP	Member	
						Salisbury Medical Solutions Ltd	Wife is a local GP.	
						New Hall Hospital	Consultant	
						Spire Southampton Hospital	Consultant	
	Dr	Maqbool	Jaffer		Consultant	Maqbool Jaffer Ltd	Director	Signed by Line Manager
							Private Clinical Practice	
	Mr.	Andrew	James		Financial Controller	Salisbury Hospital League of Friends	Treasurer	Signed by Line Manager
	Dr	Ian	Jenkins		Consultant	Nil return	Nil return	
	Mr.	Maxmillian	Johnston		Consultant	Prviate Medical Work Ltd Companies	Director, Shareholder and wife holds similar positions.	Signed by Line Manager
						Prviate Medical Work Ltd Companies	Consultant	
	Dr	Stephen	Jukes		Consultant	Ramsay Health Care UK	Consultant Anaesthetist	Signed by Line Manager
	Dr	Graeme	Kerr		Consultant	Nil return	Nil return	
	Miss	Abigail	Kingston		Consultant & CD for W&N	New Hall Hospital	Private Practitioner in O&G	Signed by Line Manager
	Dr	Heena	Kithany		Consultant	Nil return	Nil return	
	Dr	Katarzyna	Konieczny		Consultant	Nil return	Nil return	
	Mr.	Jayanth	Kunjur					
	Dr	James	Lawrence		Consultant	Nil return	Nil return	
	Dr	Samuel	Leach		Consultant	New Hall Hospital	Consultant Radiologist	
	Dr	Susan	Lewis		Consultant	New Hall Hospital	Private Work	Signed by Line Manager
						Salisbury NHS Foundation Trust	Private Work	
	Dr	Karinya	Lewis		Consultant	IHG	Consultant Surgeon	Signed by department lead
	Dr	Jonathan	Linton		Consultant	New Hall Hospital	Consultant Anaesthetist - Self Employed	Signed by Line Manager
	Dr	Nola	Lloyd		Consultant	Nil return	Nil return	
	Dr	Graham	Lloyd-Jones		Consultant	Radiology Masterclass Ltd	Director, part owner, shareholder. Spouse is also part owner/shareholder.	Signed by Line Manager
						Self Employed	Consultant Radiologist	

	Dr	Gavin	Lockhart		Head of Clinical Psychology, Consultant Psychologist	NHS England	Assistant Director, Mental Helath, Learning Disabilities, Autism and SEND	Signed by Line Manager
						Self-employed	Consultant Clinical Psychologist	
	Dr	Dominic	Macleod		Consultant	Nil return	Nil return	
	Dr	Konstantinos	Marinakis		Consultant	Lymington Hospital	ENT Consultant	
						KVM ENT Services	ENT Consultant	
	Mrs.	Victoria	Marston		Director of Midwifery	Nil return	Nil return	
	Dr	Aram	Mashoof Fard		Consultant	Private Practice	Adhoc writing Medical/Medicolegal reports	Signed by Line Manager
	Mr.	Shahid	Masood		Consultant	Ramsay Health Care UK	Consultant Plastic Surgeon	Signed by Line Manager
	Mr.	Damian	Mayo		Consultant	Nil return	Nil return	
	Mr.	Gavin	McCoubrey		Consultant	University Hospital Southampton	Honorary Consultant	Signed by Line Manager
						Spire Southampton Hospital	Private Practice	
	Miss	Caroline	McGuiness		Consultant	Orthoaedic LLP	Director	
						Caroline McGuiness Private Practice	Owner & Private Practitioner	
	Miss	Annalise	McNair			Inspire Orthodontics	Owner and Lead Orthodontist	No action required.
	Mr.	Tony	Mears		Associate Director, Strategy	Nil return	Nil return	
	Dr	Rohan	Mehta		Consultant	Mehta Respiratory Ltd	Director & Consultant Physician	Signed by Line Manager
	Dr	Russell	Mellor		Consultant	Nil return	Nil return	
	Dr	Serap	Mellor		Consultant	Dermahealth	Director & Private Practice	Signed by Line Manager
	Dr	Ashfaque	Memon					
	Dr	Nicola	Meston		Consultant	Nil return	Nil return	
	Dr	James	Milnthorpe		Consultant	Nil return	Nil return	
	Dr	Sophie	Moloney-Geany		Consultant	Nil return	Nil return	
	Dr	Clare	Morden		Consultant	Vantage Event Medicine – Event company specialising in Motorsport – since July 2024	Medical Director	No action required.
						HeartBeatz UK – teaching CPR to chil	Chair	
						European Resuscitation Council	Representative of Permanent Members	
						FIA Girls on Track	Ambassador	
	Dr	Andrew	Morris					
	Dr	Georgina	Morris		Consultant	Sexual Health Dermatology Special Interest Group	Chair	Signed by Line Manager
	Mr.	Alistair	Morton		Consultant	Nil return	Nil return	
	Dr	Sergio	Nabais De Araujo		Consultant	TMLEP	Medico-legal expert	Signed by Line Manager (In 2024, no changes)
						Self Employed Private Practice	Consultant Cardiologist	
	Dr	Kashif	Naeem		Consultant	Salisbury NHS Foundation Trust	Private - Consyultant Cardiologist	Signed by Line Manager
	Dr	Andrew	Nash		Consultant	ANA Medical Services Ltd	Director	Signed by Line Manager
						New Hall Hospital	Consultant	
	Miss	Sarah	Needle		DDO Medicine	Spire Hospital	Husband is Hospital Director	Signed by Line Manager
	Dr	Gail	Ng		Consultant	Nil return	Nil return	
	Mr.	Marios	Nicolaou					
	Dr	Rachel	Oaten		Consultant	ACOS Medical	Director	Signed by Line Manager
						East Midlands Ambulance	Strategic Medical Advisor	
						North Bristol Hospital (Southmead)	Trauma Team Leader	
	Mr.	John	O'Keeffe		Head of Estates	Nil return	Nil return	
	Dr	Julie	Onslow		Consultant	Nil return	Nil return	
	Dr	Dirandiran	Padiachy		Consultant	Nil return	Nil return	
	Mr.	Robert	Padwick		Consultant	Nil return	Nil return	

10876649	Dr	Claire	Page	cpage2@nhs.net	Consultant		2-3 x per year I facilitate on the Deanery Induction Course for Educational Supervisors. I do this on days that I do not work or during annual leave and am consequently paid by HEE Wessex £500 per day. I have facilitated on 3 courses in the last 12 months: 08/01/2024, 22/07/2024 and 11/11/2024. Being a trained facilitator on this course has allowed the Refresher Training to be delivered at the Trust to Educational Supervisors as only recognised facilitators may do this. I have facilitated one Refresher course at the trust this year (April 2024 - April 2025) for which I received £600 as the course was held on a morning that I was not due to work (payment authorised by Dr. Emma Halliwell - Director of Medical Education).	No action required.
	Dr	Christopher	Pandya		Consultant	Nil return	Nil return	
	Dr	Angshuman	Panigrahi		Consultant	HM Coroner (Wiltshire)	Undertake Coroner postmortems	Signed by Line Manager
						Ramsay Health Care UK	Report private cases	
	Dr	Tracey	Parker-Foo			Nil return	Nil return	
	Dr	Amit	Patel		Consultant	Nil return	Nil return	
	Dr	Katherine	Peace		Consultant	KPMC Medical Ltd	Director & Owner	Signed by Line Manager
						New Hall Hospital	Radiology Consultant	
						SFT Radiology Dept	In house private practice - Radiology Consultant	
	Dr	Amy	Pearce		Consultant	Nil return	Nil return	
	Dr	Gregory	Pearson		Consultant	Wessex Gynaecology & Wellbeing Ltd	Director Wife, Mother and Daughter have shares.	Signed by Line Manager
						Liberal Democrats	Member	
						Cricle Sarum Road Winchester	Private & NHS Practice - Consultant Gynaecologist	
						Practice Plus Devizes	Private & NHS Practice - Consultant Gynaecologist	
	Dr	Mary	Pedley		Consultant	Nil return	Nil return	
	Dr	Rayyan	Pervez					Left Trust November 24
	Ms.	Sarah	Pestell		Counsellor/Psychotherapist	Private Practice	Counselling	Signed by Line Manager
	Dr	Katrina	Pettit		Consultant	Nil return	Nil return	
	Mr.	Philip	Pettit		Consultant	Nil return	Nil return	Long term sick, but no conflicts.
	Mrs.	Ginette	Phippen		Divisional Medical Director		Chair of national Cleft Development Group including oversight of national cleft database (Crane)	Signed by Line Manager
	Dr	Elisa	Porretta		Consultant	Nil return	Nil return	
	Dr	James	Powell		Consultant	Nil return	Nil return	
	Mr.	Jonathan	Quayle		Consultant	New Hall Hospital	Independent Practitioner	Signed by Line Manager
	Miss	Clare	Raubusch		Consultant	Nil return	Nil return	
	Mr.	Alastair	Raynes		Chief Pharmacist	Nil return	Nil return	
	Dr	Hannah	Rickard		Consultant	Hannah Richard Medical Ltd	Director	Signed by Line Manager
						New Hall Hospital	NHS - Consultant Gynaecologist	
						New Hall Hospital	Private - Consultant Gynaecologist	
	Dr	Benjamin	Rickett					Email no longer valid
	Dr	Philippa	Ridley		Consultant	Nil return	Nil return	
	Mr.	Robert	Ritchie		Consultant	University Hospital Southampton	Consultant Urologist	Paid for by SFT through a service level agreement.
	Mr.	Ian	Robinson		Head of Facilities	Nil return	Nil return	
	Dr	Raina	Rodrigues		Consultant	The Academy of Aesthetic Excellence Limited (UK)	Medical Director and 50% Shareholder. Oher 50% shares owned by husband.	Signed by Line Manager
						Aesthetic Virtue Limited(Malta)	Medical Director and 100% owner	
						Aesthetic Holdings Limited	Medical Director and 100% owner	
						The Academy of Aesthetic Excellence Limited (UK)	Plastic Surgeon	
	Dr	Natalia	Roszkowski		Consultant	Nil return	Nil return	

	Dr	Paul	Russell		Consultant	Army	Reservist Medical Officer	
	Mr	Sridhar	Sampalli		Associate Specialist	SRS Orthopaedics	Director	Signed by Line Manager
						BMA Salisbury Division	Chair Person	
						Orthoplastics	Chair	
						LLP	Practitioner	
						New Hall Hospital	Practicing priviledges	
						Salisbury Hospital ADHDC Private Work	Orthopaedic Surgeon	
	Miss	Jessica	Savage		Consultant	Nil return	Nil return	
	Dr	Lina	Serhal					Left Trust February 2025
	Dr	Bhavisha	Shah		Consultant	Nil return	Nil return	
	Dr	Khalid	Shamel		Consultant	Nil return	Nil return	
	Mr.	Gurdip	Shergill		Consultant	Shergill Orthopaedics LTD	Director, Owner and shareholder	Signed by Line Manager
						New Hall Hospital	Orthopaedic Consultant	
	Dr	Ben	Siggers		Consultant	Siggers Medical Ltd	Director	Signed by Line Manager
						Hampshire and Isle of Wight Air Ambulance	Consultant (under Service Level agreement between SFT and University Hospitals Southampton Trust.)	
						South Central Ambulance Service Trust	Medical Incident Advisor	
						New Hall Hospital	Self Employed Consultant Anaesthetist - Siggers Medical Ltd	
	Dr	Gemma	Simons		Consultant	Hampshire & Isle of Wight Healthcare NHS FT	Consultant Physical and Rehabilitation	Signed by Line Manager
	Dr	Manas	Sinha		Consultant	Olima Medical Ltd	Director	Approved by Line Manager
	Mrs.	Diana	Slade-Sharman		Consultant	Slade-Sharman Ltd	Owner	Signed by Line Manager
						New Hall Hospital	Plastic Surgeon	
	Mr.	Simon	Sleight		Consultant	Nil return	Nil return	
	Dr	Alistair	Smith		Consultant	Nil return	Nil return	
	Dr	Victoria	Smith		Consultant	Nil return	Nil return	
	Dr	Martin	Smith		Consultant	Salisbury Endocrinology Medical Partnership PLC	Private Medical Practice	
	Dr	George	Smith		Consultant	Dr G R Smith Ltd	Co-Director Wife is Co-Director Son is paid employee	No action required.
						INSPIRE	Trustee	
						STARS	Ambassador	
						BSR Heberdents Committee	Trustee	
						Eli Lilly, UCB, Medac, Janssen	Have spoken at conferences & meetings sponsored by these Pharma companies.	
						KEMH	Consultant Rheumatologist	
						Private Practice - Salisbury & SIMP	Consultant Rheumatologist	
						New Hall Hospital	Consultant Rheumatologist	
	Dr	Claire	Solly		Consultant	New Hall Hospital	Consultant Anaesthetist	Signed by Line Manager
	Dr	Rowena	Staples		Consultant		Husband is Director of a Limited Company	Signed by Line Manager
	Miss	Jessica	Steele		Consultant	Nil return	Nil return	
	Mr.	Paul	Stephens		Consultant & CD for Surgery	Nil return	Nil return	
	Mr.	Mark	Szymankiewicz		Consultant	SWIFTSS	Trustee	Signed by Line Manager
						The Ruth Grace Foundation	Trustee	
						Hereford Muheza Salisbury Link	Trustee	
						University of Winchester	Visiting Lecturer	
	Dr	Stephen	Taylor		Consultant	Nil return	Nil return	
	Dr	Robert	Templer		Doctor	Nil return	Nil return	
	Dr	Uma	Thakur		Consultant	Ophthotech Limited	Director	No action required.
							Hasband has company which makes NHS apps for other Trusts.	
						Ramsay Health	Consultant	
	Dr	Catherine	Thompson		Consultant	Nil return	Nil return	
	Dr	Kate	Thompson		Consultant	Nil return	Nil return	
	Mr.	Eunan	Tiernan		Consultant	Self Employed at New Hall	Consultant	Signed by CD
	Dr	Aarti	Umranikar		Consultant	Private Ltd Company	Joint Director	Signed by Line Manager
						TFP The Fertility Partnership	Consultant in Reproductive Medicine	
	Dr	Leonidas	Vachtsevanos					
	Dr	Alexander	Van Heerden		Consultant	RAF	Sqn Leader 4626	No action required.

						Med 247	Contractor	
	Mrs.	Alison	Vandyken		DDO - Surgery	Nil return	Nil return	
	Mr.	Ivor	Vanhegan		Consultant	Nil return	Nil return	
	Dr	Alice	Veitch		Consultant	SW Veitch Orthopaedics Ltd	Shareholder	Signed by Line Manager
						Odstock Group Radiology	Occasional private cases	
	Mr.	Stephen	Veitch		Consultant	SW Veitch Orthopaedics Ltd	Owner & Private Work	Signed by Line Manager
						Orthopaedic Plastic Spinal Service	Member	
						New Hall Hospital	Consultant	
	Mr.	Stuart	Verdin		Consultant	Private Medical Business Sole Trader	Owner	Signed by Line Manager
						New Hall Hospital	Consultant - Not contracted	
	Dr	Matthew	Wakefield		Consultant	Matthew Wakefield Eye Surgery Ltd	Director Wife is also Director	Signed by Paul Stephen (CD to Surgery), Joint Director is Line Manager
						MWNH	Director & Co-Owner	
						Independent Health Group	Practising Priviledges & Clinical Pathway Development Lead	
						Medcentres Plus	Practicing priviledges	
						BSW ICB	Ophthalmology Lead Clinician	
	Dr	Shree-eesh	Waydia		Consultant	Nil return	Nil return	
	Dr	Timothy	Wells		Consultant	T.A.N.T Medical Ltd	Private Practice run through T.A.N.T	No action required.
							Paid to Chair Education Evening Symposiums (Astra Zeneca)	
						AVIVA	Chief Cardiology Officer	
	Dr	Susan	Wheatley					Email not found
	Mr.	Neil	Wickham		Consultant	Nil return	Nil return	
	Dr	James	Wigley		Consultant	New Hall Hospital	Consultant Anaesthetist	Signed by
	Dr	Simon	Williams		Consultant	Nil return	Nil return	
	Dr	Mark	Wills		Consultant	New Hall Hospital	Consultant Radiologist	Signed by Line Manager
	Dr	Duncan	Wood		Consultant Clinical Scientist, Head of CSE	Odstock Medical Ltd	B Shareholder	Signed by Line Manager
						OML	As of 1st August 2024, he no longer work for OML (prior to 1/8/24 0.2 WTE of his employment contract was cross-charged to OML).	
	Dr	Hazel	Woodland		Consultant	Nil return	Nil return	
	Dr	Ian	Wright		Consultant	Nil return	Nil return	
	Dr	Laszlo	Zavori					Left the Trust

Total	248
Declared	100
Nil Return	124
Received/Awaiting Info/ LM Signing	19
Left Trust / Unable to find	12
Total Returns	243
Percentage Returned	97.98%

Report to:	Trust Board (Public)	Agenda item:	6.1.2
Date of meeting:	1 May 2025		

Report tile:	2024/25 Annual Review of Gifts and Hospitality			
Status:	Information	Discussion	Assurance	Approval
	✓		✓	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Christina Steele, EA to Managing Director and Chair			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Annual Register of Gifts and Hospitality			

Recommendation:
To note the annual Register of Gifts and Hospitality for 2024/25.

Executive Summary:
In line with the Trust Conflicts of Interest Policy, staff should not accept gifts or hospitality that may affect, or be seen to affect, their professional judgement. Gifts valued at over £50 should be declared and discussed with a line manager. Meals or refreshments valued between £25 and £75 may be accepted but must be declared. During 2024/25, a total of nine declarations were submitted to the Corporate Governance Team, with an estimated combined value of £48,445. Each declaration was reviewed in consultation with the respective employee's line manager, and no issues or concerns were identified.

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

2024/25 Register of Gifts

Date	Name	Post	Declaration	Accepted/ Declined	Amount/ Value (£)
26/06/2024	Fiona Mobbs	Procurement Department Administration Support	AdviseInc gave 24 hardback A5 lined notebooks and pens to the Procurement department. Salisbury Hospital already use AdviseInc as a tool for our Supply Chain product management systems, so it is not an inducement to use them. We would find it useful to issue them to Procurement staff who require an A5 notebook.	Accepted - signed by Rob Webb	Each notebook and pen set is valued at £5, so total value is £120.
18/04/2024	Paul Russell	Private Patient Manager	Invited to Regimental dinner by Colonel Bhabutta of Defence Primary Healthcare as a thank you for rhe work I have done with military locally	Accepted.	Unknown
04/11/2024	Amy Ciecura	Junior Sister, Imber War	£50 Amazon Voucher posted to ward. Advice sought from Dave Cates - donor name added to database and money to be used for patient engagement resources	Accepted but donated to ward fund via charitable funds. Signed by manager Norma Noyce.	£50
28/05/2024	Jane Temblett	Specialty Manager, Spinal	Annual Guttman conference hosted by Salisbury SCIC on 20th and 21st June 2024 at the stones hotel, salisbury. Delegates anticipate to attend for specialty meetings on 20th June. Gala dinner on-site (paid for by delegates) Full day conference on 21st June. Refreshments will be rpovided by the venue during the two days which will be paid for by sponsorship monies received. There is also live entertainment at the gala dinner paid for from sponsorship monies. There are a total of 9 sponsors who have cumulatively sponsored a total sum of £47,000 inc VAT.	Accepted - Invoices created by procurement for all sponsors - signed by Lisa Clarke, Divisional Manager for CSFS.	£47,000

18/10/2024	Rachel Harrison	AHP Lead for the SCI Network	I have been invited to a Spinal Injuries Association Ball on 7th November in London as a guest of CFG Law. This will include overnight accommodation in the same hotel. This will be a good opportunity for networking which forms part of my role	Accepted - Catherine Whitmarsh signed form. She advised This is a charitable event that will provide very valuable opportunities to network with national colleagues and charities which is an important aspect of her role as lead AHP in the Spinal Cord Injuries regional network. I fully support this on that basis.	Unknown.
28/08/2024	Simon Dennis	Head of Commercial, procurement and commercial services	Attendance and speaking at European Economic Form in Poland 2-5 Sept 2024. Full details on form. In conjunction with Coventry University who are covering all attendance costs - flights, accomodation meals.	Accepted - signed by Rob Webb	Estimated £750
29/10/2024	Tracy Harris	HCA IMBER Ward	I received £10 in a thank you card from a patients relative I was caring for. I was u sure what to do with the money so I asked Amy the sister in charge on my shift. I've held on to the £10 and will donate it to the stars appeal.	Received in a thank-you so unable to decline. Has been donated to the stars appeal.	£10
23/12/2024	Sarah Phillips	Transactional Finance Assistant	A supplier who I deal with on a weekly basis have gifted me a Irish Cream Gift Set.	Retained the gift. Form signed by Andy James. 'Considered pragmatic solution is to allow her to retain gift, confirmed in discussion between financial controller and Deputy Director of Finance.'	£20

03/01/2025	John Itter	Senior Technician Medical Device	Having assisted manufacturer perform vital field corrective measures on anaesthetic machines over a two-day weekend. Having assisted Draeger we ensured that all machines were updated and no risk to patient harm and no cancellation to surgical lists affected. Draeger grateful for assistance and work achieved to allow them to complete works ahead of schedule. Draeger would like to donate £495.00 to a charity of my nomination.	Donation to charity. Charity number is 305937 the 10th Salisbury Scout Group - Signed by Alex Sims 'This is a generous offer by one of our Suppliers following the hard work by John to support an urgent FSN. I support the offer and have spoken to John about the offer and have consulted the Policy in regards to donations and gifts. I have also consulted with my line Manager Duncan Wood for awareness.'	£495

Report to:	Trust Board (Public)	Agenda item:	6.1.3
Date of meeting:	1 May 2025		

Report tile:	Fit and Proper Persons Annual Assurance			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Tapiwa Songore, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices				

Recommendation:
The Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2024/2025 and that all Board members satisfy the requirements.

Executive Summary:
The purpose of this paper is to provide annual assurance that all Board Directors remain fit and proper for their roles, and meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

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

1.0 Introduction

In accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test' (FPPT).

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations from the Kark Review, NHS England developed the FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023 and the Trust Board approved its Fit and Persons Policy in May 2024.

The policy requires a full FPPT to be completed;

a) on appointment, and
b) annually for existing directors.

The annual self-declaration process is undertaken at the start of each new financial year and the results of the annual self-declaration are recorded on the Electronic Staff Record (ESR). The scope for the policy is specified as '*All executive and non-executive directors of the Board, including permanent, interim, and associate positions, irrespective of their voting rights'*

2.0 Fit and Proper Person: New Appointment and Annual Assurance Checks

All current directors have been subject to the following checks.

a) DBS checks;
b) Search of insolvency and bankruptcy register,
c) Search of Companies House register to ensure that no board member is disqualified as a Director,
d) Search of the Charity Commission's Register of Removed Trustees,
e) Web/social media search,
f) Satisfactory completion of the self-declaration.

3.0 Outcome of the Annual Fit and Proper Persons Checks

All Directors of the Trust Board satisfy the requirements and the outcome of the FPPT checks has been saved on each personal file and uploaded onto ESR. All Directors completed the Fit and Proper Persons Test Self Declaration Form and these will be reviewed by the Trust Chair in preparation for the Regional submission.

Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues to the attention of the Director of Integrated Governance or the Trust Chair.

4.0 Conclusion

All Directors of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

5.0 Recommendations

The Board is asked to note that the FPPT has been conducted for the period 2024/2025 and that all Board members satisfy the requirements.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	1 May 2025		

Report tile:	Integrated Governance and Accountability Framework (IGAF) 2025			
Status:	Information	Discussion	Assurance	Approval
		✓		
Approval Process: (where has this paper been reviewed and approved):	Executive Directors Meeting TMC			
Prepared by:	Tapiwa Songore, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices	Appendix 1 Trust Governance Structure charts Appendix 2 Committee Terms of Reference			

Recommendation:
The Board is asked to approve the IGAF.

Executive Summary:
The IGAF outlines the mechanisms in place to monitor and drive the delivery of the Trust's strategic and operational plans. It also sets out how the Trust adopts and complies with requirements of the NHS Oversight Framework, Provider Licence, Trust's constitution, NHS Standard Contract, NHS Code of Governance, and the Care Quality Commission. The framework takes into the account the Trust's involvement as part of the BSW Integrated Care system and new collaborative arrangements at system level. The IGAF has been updated to reflect current arrangements, and further changes will be made as the BSW Group Governance structure evolves. The document will also be amended to incorporate the NHS Performance Assessment Framework which will be replace the Oversight framework. NHSE is set to publish the new framework at the end of Q1.

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

DRAFT

Integrated Governance and Accountability Framework (IGAF)March 2025

Version	V 1.4
Author	Fiona McNeight, Director of Integrated Governance Niall Prosser, Chief Operating Officer

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Appendix 1 - Board Committees Summary
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Appendix 3 - Committee Effectiveness Review Template
Appendix 4 – Board Committee Terms of Reference (attached separately)

1. Background

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

2. Purpose

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

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

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

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

3. NHS oversight (This section will be refreshed when NHSE publishes the new NHS Performance Assessment Framework expected in Q1)

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

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

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

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

4. **NHS England Monitoring** This section will be refreshed when NHSE publishes the new NHS Performance Assessment Framework expected in Q1

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

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

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

5. **Governance**

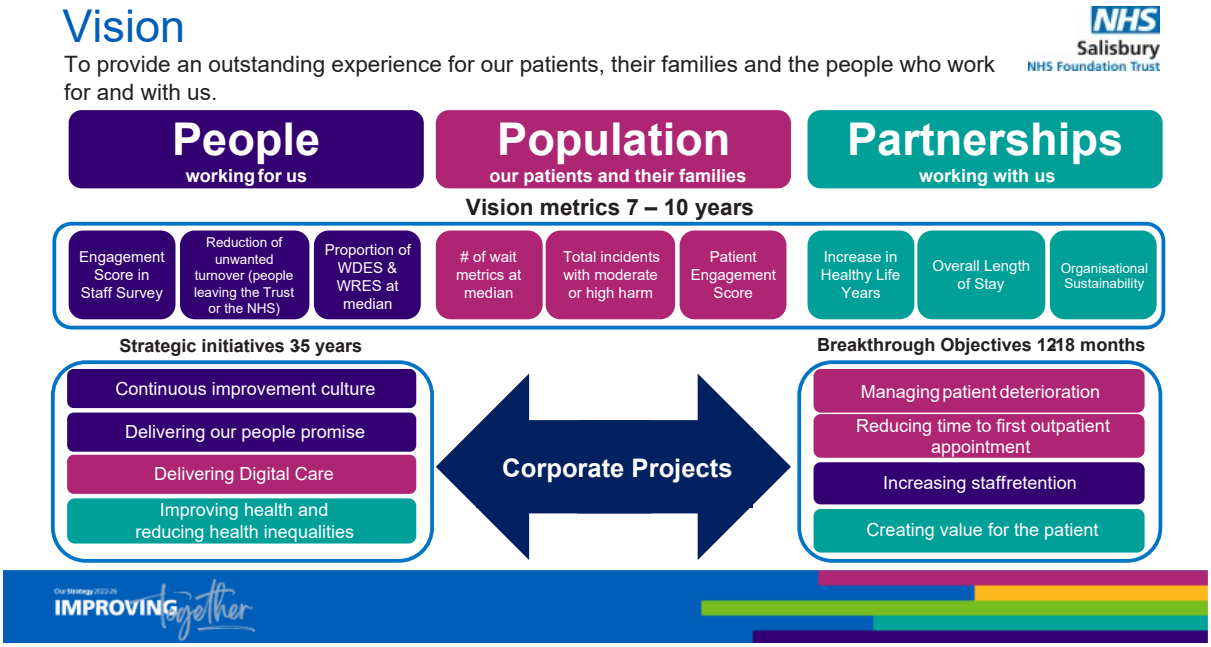
5.1. Integrated Governance is how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives safety and quality of service and in which they relate to patients and carers, the wider community and other stakeholders.. The framework is designed to support the delivery of our vision, "To provide an outstanding experience for our patients, their families and the people who work for and with us" through our operational management system. It promotes an organisation that is well managed, cost effective and has a skilled and motivated workforce.

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

6. Strategic Domains

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

6.2. Our Strategic Planning Framework (SPF) sets out our long, medium and short



term strategic foci. The Executive reviews performance against this monthly in what is known as the Engine Room. The Engine Room is where the escalations and successes from the OMS rise to from the organisation.

7. Scope of the Framework for Integrated Governance

7.1. Corporate Governance

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

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

7.1.3. As a Foundation Trust, the organisation is. required to completes an annual self-certification that confirms eligibility to hold an NHS Provider licence.

7.2. *Financial Governance*

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

7.3. *Standing Orders and Standing Financial Instructions*

7.3.1. The Trust Standing Orders regulate the way in which the proceedings and business of the Board is conducted, and Standing Financial Instructions provide the framework for the financial conduct of the Trust. This includes guidance on delegation limits and procurement rules.

7.4. Clinical Governance

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

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

7.4.3 The Maternity and Neonatal Governance Framework 2023 details the local

arrangements for implementation of trust processes and/or standalone arrangements for the management and reduction of risk within maternity and neonatal services. Maternity and Neonatal Governance Framework 2023 (microguide.global)

7.5. ***Demonstrating Quality***

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

7.6. ***Continuous Improvement***

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

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

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

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

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

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

7.7.3. The Board is responsible for the Board Assurance framework, but the Audit Committee undertakes scrutiny and review of the process, to provide assurance to the Board, supported by the three assuring committees: Clinical Governance

Committee, Finance & Performance Committee, People and Culture Committee together with the Trust Management Committee.

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

8. The Role of the Trust Board

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

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

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

9. Charitable Trustees

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

10. Annual Governance Statement

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

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

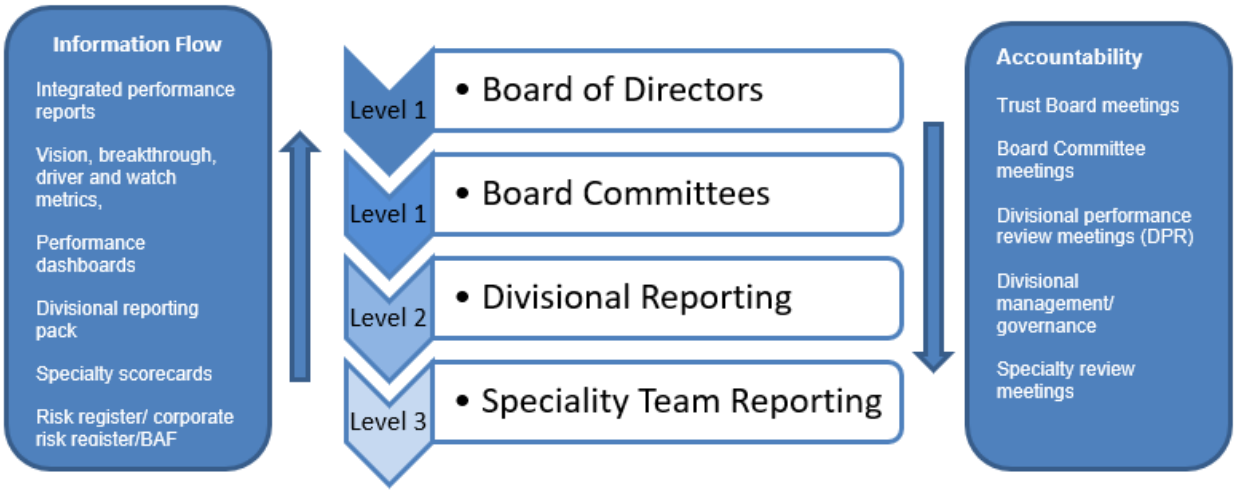
11. Internal performance Framework

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

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

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

The main strands of performance reporting within SFT are:



11.3. **Board of Directors**

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

11.4. Accountability

Level 1: SFT Trust Board		
Committee	**Membership**	**Principal Reporting Documents**
Trust Board	All directors	Corporate Strategy. Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management. Performance Reports – quality, workforce,

		operations, finance. Board Committee escalation reports Customer Care and Legal Reports.
Board Committees	Non-Executive Directors, CEO Lead Executives	Presentation on key performance information, including detailed information and actions on any key business targets currently being failed. Scrutiny of the Trust's commercial holdings. Scrutiny and assurance regarding risks and adequacy of actions. Escalation actions from Divisional Performance Reviews (by exception).

11.5. ***Information***

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

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

11.6. **Committees of the Board**

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

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

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

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

11.6.4. Each committee will undertake an annual review of their performance against the terms of reference.

12. **Divisional Reporting**

12.1. ***Accountability***

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

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

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

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

13. **Information**

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

14. **Divisional Management**

14.1. ***Accountability***

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

14.2. ***Information***

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

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

14.3. Specialty Reporting

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

14.4. Escalation

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

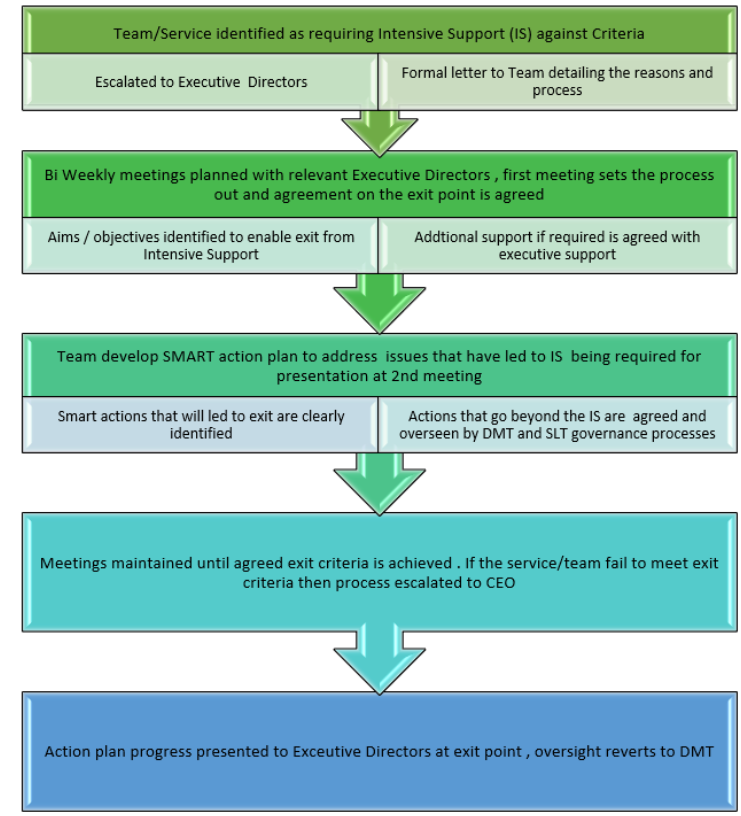
Stage	Intervention
Enhanced diagnostic	• Ensure root cause analysis addressed • Remedial action plans in place • Utilisation of improving together tools (Go See, Improvement Huddles, A3 thinking)
Enhanced Oversight	• Increased reporting • Consideration of external/peer review • Comprehensive action plans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

Stage	Intervention
Intensive Support	• Bespoke mandated support • Executive oversight
CEO escalation	• Meeting with CEO regularly • Capacity and Capability review • Identification of any longer term structural and strategic issues which must be addressed.

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

14.5. **Intensive Support**

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



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

15. **Corporate Departments**

This will be reviewed once content of DPR agreed.

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

16. **Public Accountability**

16.1. **Council of Governors**

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

17. Collaborative Working and Partnerships

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

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

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

17.2. As part of the move towards more collaborative working the Trust is working towards a Group structure with Great Western Hospital and Royal United Hospitals (RUH) Bath NHS Foundation Trusts. The Group is focused on improving clinical services and closing the gaps in relation to health and care inequalities and finance to benefit the population of BSW. The Governance Structure is still being developed, and a Group Chef Executive has been appointed. Arrangements for the appointment of a Joint Chair are being finalised.

Version control

Document Title	**Integrated Governance and Accountability Framework 2024/25**			
Date Issued/Approved:	TBC			
Date Valid From:	May 2024			
Date Valid To:	April 2025			
Division / Department responsible (author/owner):	Chief Operating Officer			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2025			
Approval route (names of committees)/consultation:	Chief Operating Officer in consultation with TMC			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	x	Intranet Only	
Related Documents	Listed Appendices			

Version Control Table

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

March 2023	**V1.1**	**Annual Review**	**Lisa Thomas, Chief Operating Officer** **Fiona McNeight, Director of Integrated Governance** **Kylie Nye, Head of Corporate Governance**
March 2024	**V1.2**	**Annual review, incorporating additional narrative re improving together and updates to diagram.**	**Lisa Thomas, Chief Operating Officer** **Fiona McNeight, Director of Integrated Governance** **Kylie Nye, Head of Corporate Governance** **Alex Talbott, Director of Improvement** **Tony Mears, Associate Director of Strategy**
April 2025		**Annual review** **- updating the Committee ToRs and the structure charts** **- More info regarding the BSW Group structure and the NHS Performance Assessment Framework will be included**	**Fiona McNeight, Director of Integrated Governance** **Tapiwa Songore, Head of Corporate Governance**

Appendix 1: Board Committees

BOARD COMMITTEES

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

Level 1: Assurance Committees of the Board

Audit Committee

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

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

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

Principal functions:

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

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

- Raising Concerns

Clinical Governance Committee

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

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

The Committee provides assurance to the Board, through ensuring the supporting processes are embedded and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

Principal functions:

To provide assurance to the Board on:

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

Finance & Performance Committee

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

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

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

People and Culture Committee

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

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

Principal functions:

To provide assurance on:

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

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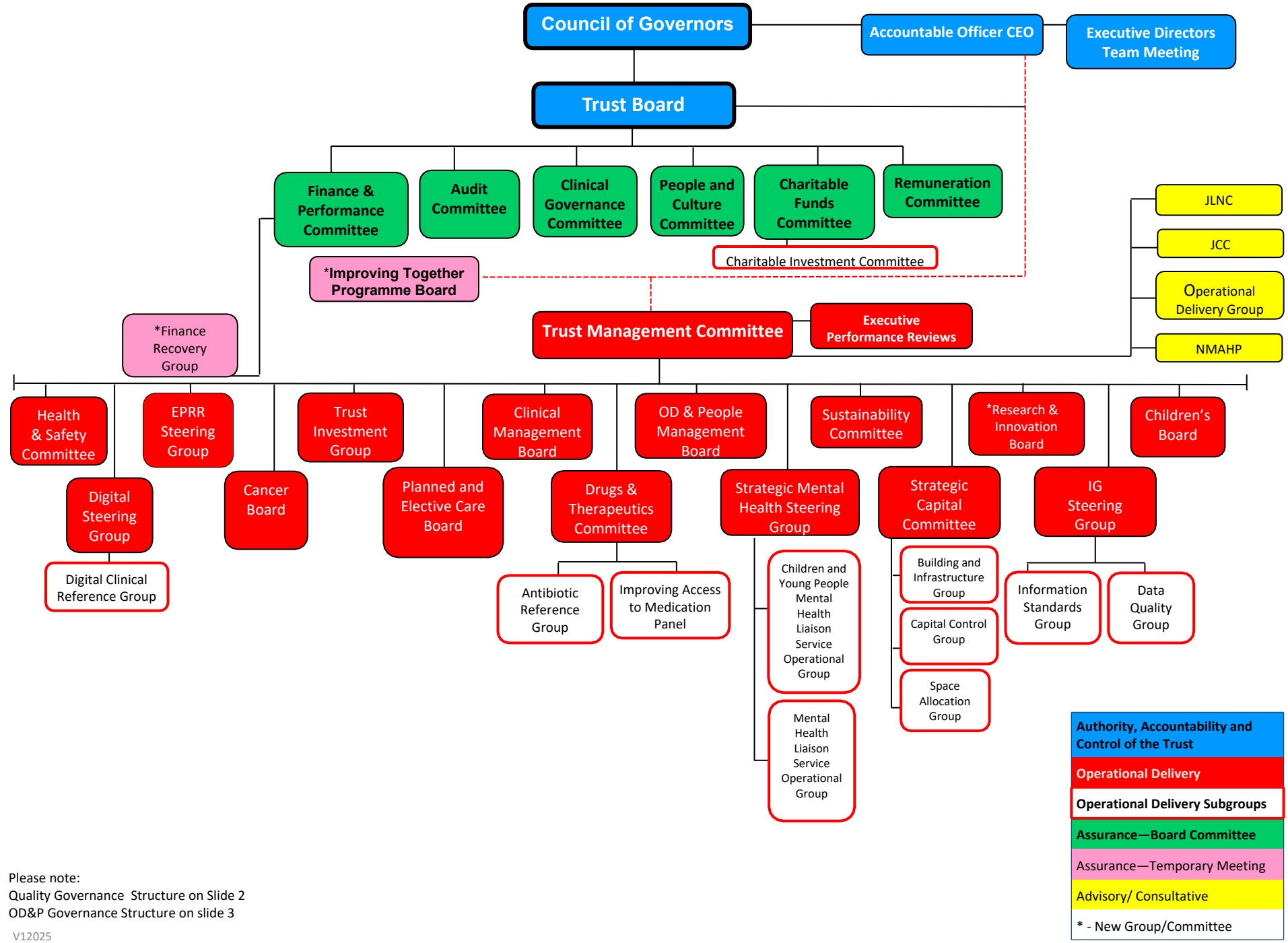
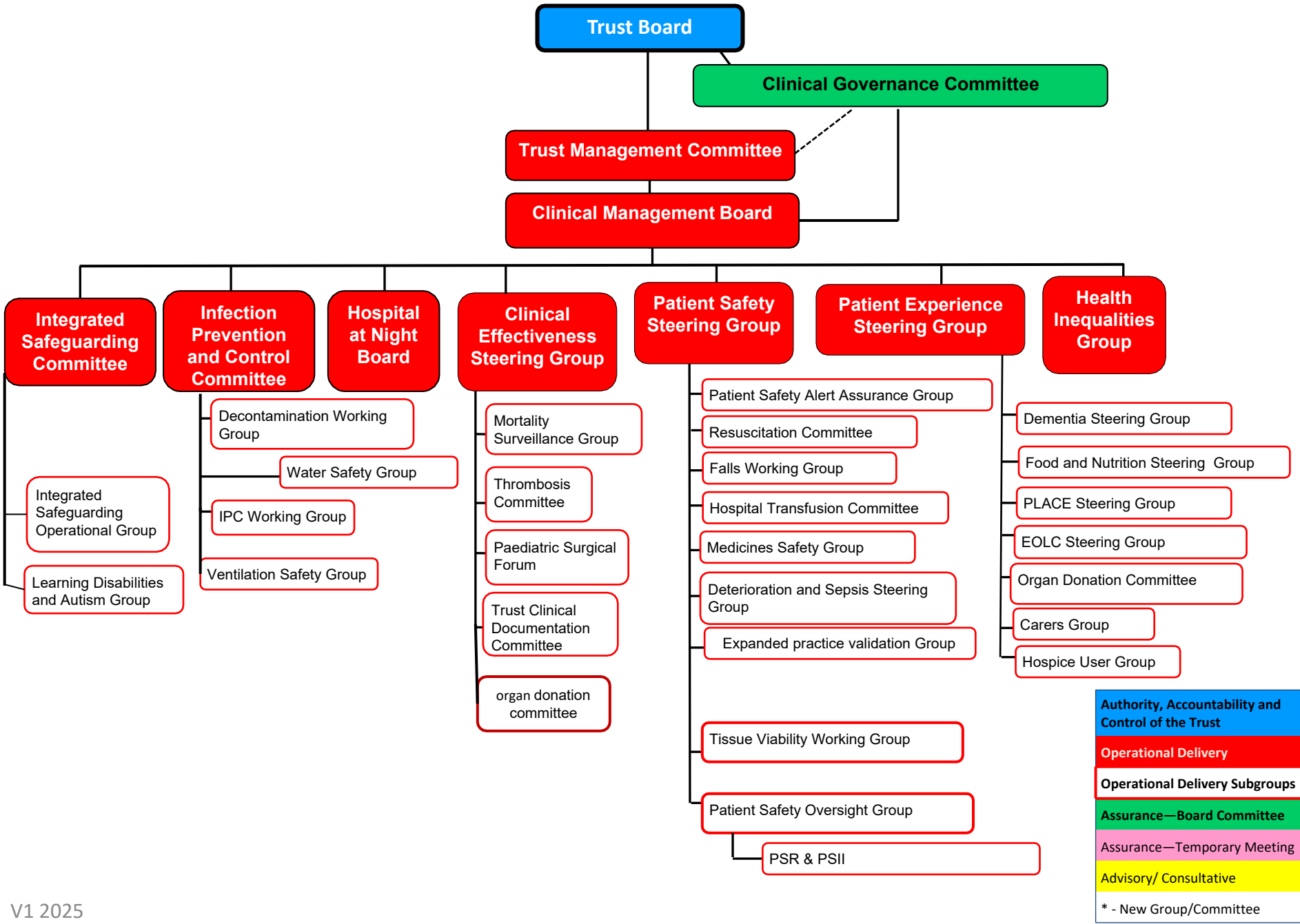


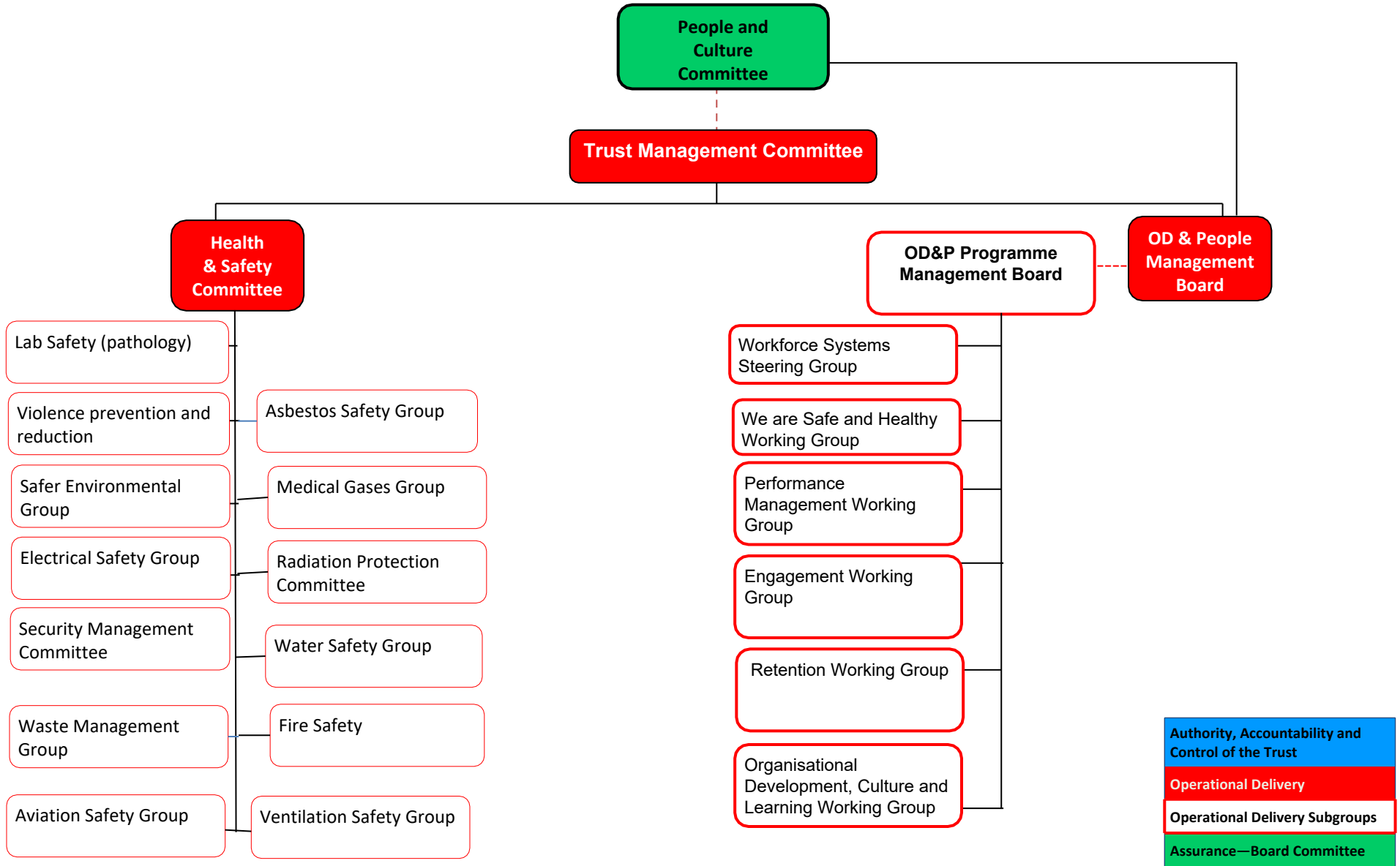
Please note:
Quality Governance Structure on Slide 2
OD&P Governance Structure on slide 3

V12025

Quality Governance Structure



Organisational Development and People Structure



V1 2025

NHS
Salisbury
NHS Foundation Trust

Audit Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
March 2020	2.1	Minor	Annual Revision	Director of Corporate Governance
March 2021	2.2	Nil changes	Annual Revision	Director of Corporate Governance
Dec 2021	2.3	Nil changes	Annual Revision	Director of Integrated Governance
Dec 2022	2.4	Minor change	Annual Revision – title change	Director of Integrated Governance
Dec 2023	2.5	Minor change	Annual revision – addition to purpose	Director of Integrated Governance
Dec 2024	3	Major	Aligned to NHS Audit Committee Handbook	Director of Integrated Governance

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

1) Purpose and function

The purpose and function of the Committee is to:

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

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

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

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

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

2) Authority

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

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

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

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

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

3. Membership and Attendance

Membership

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

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

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

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

Quorum

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

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

Attendance

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

- The Managing Director should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.
- The Chief Finance Officer, or a nominated Deputy
- Representatives from the External (Appointed) Auditors, Internal Auditors and Counter Fraud Specialist.
- The Director of Integrated Governance, or nominated deputy, will act as Secretary to the Committee and will therefore attend all meetings
- Financial Controller
- Others by invitation – this may include executive sponsors in the case of audit reports and/or other Executive Directors/managers when discussing areas of risk or operation
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.
- The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist (where they do not report elsewhere)

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

4.1 Financial reporting

The Committee shall:

a) Ensure the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain.
b) The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the annual governance statement and other disclosures relevant to the terms of reference of the committee
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.
- The going concern basis
- Compliance with accounting standards
- Value for Money considerations
- Major risks to the Trust

c) Review the consistency of, and changes to, accounting policies both on a year-on-year basis and across the Trust.
d) Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements)..

e) Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of both the Trust Executive and the External Auditor.
f) Review the clarity of disclosure in the Trust's financial reports and the context within which statements are made.
g) The Committee Chair shall report formally to the Board on its proceedings after each meeting on all escalation matters.
h) The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

4.2 Governance, Risk Management and Internal Control

The Committee shall:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
b) Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
c) Review the Trust's processes to establish and maintain an effective Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements.
d) Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence and work related to counter fraud and security as required by the NHS Counter Fraud Authority
e) Receive assurance from Internal Audit, External Audit, Directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.
f) As part of its integrated approach, the committee will have effective relationships with other key committees (for example, Clinical Governance Committee) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

4.3 Internal Audit and Counter Fraud

The Committee shall:

a) Ensure that there is an effective Internal Audit function that meets the aspirations of the Trust's Executive, *Government Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors.
b) Review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
c) Review promptly all reports on the Trust from the Internal and External Auditors, review and monitor the Executive Management's responsiveness to the findings and recommendations of reports and ensure coordination between Internal and External Auditors to assist the Executive to optimise use of audit resource.
d) Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee.
e) Conduct a review of the Executive's use of internal audit and counter fraud consultancy resources, including an assessment of the effectiveness of these services.

f) Ensure the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

4.4 External Audit

The Committee shall:

a) In conjunction with the Chief Finance Officer, consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor.
b) Work with the Chief Finance Officer and the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors.
c) Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts.
d) Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted.
e) Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work.
f) Meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit.
g) Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, and the impact on the audit fee.
h) Review all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

4.5 Other Board Assurance Functions

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

4.6 System for raising concerns

The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

4.7 Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence*, *NHS code of governance* and the fit and proper persons' test.

The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

5.0 Accountability and reporting

The committee shall report to the board on how it discharges its responsibilities.

The minutes of the committee's meetings shall be formally recorded by the secretary and available for the board if required. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board or require executive action through the Trust escalation report.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

The audit committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

6) Conduct of Business

Administration

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

b) Duties in this respect will include:

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

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

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

Notice of meetings

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

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

g) These terms of reference were reviewed and approved by Trust Board on 1 May 2025

Salisbury NHS Foundation Trust

Clinical Governance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3	Minor	Annual review	Corporate Governance Manager
March 2021	3.1	Minor	Annual Review	Corporate Governance Manager
March 2022	3.2	Minor	Annual Review	Director of Integrated Governance – updates made by EA
March 2023 & April 2023	3.3	Minor addition of health inequalities oversight	Annual Review	Director of Integrated Governance
March 2024	3.4		Annual Review	Director of Integrated Governance
March 2025	3.5	Minor amendments	Annual Review	Director of Integrated Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	CGC 29/03/2025
Adoption and ratification	Trust Board

1. Purpose

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

2. Authority

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

2.2. The Committee is a standing committee of the Board.

2.3. The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

3. Membership and Attendance

Membership

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

- Three Non-Executive Directors
- Chief Medical Officer, Chief Nursing Officer (joint lead executive)
- Chief Operating Officer
- The Managing Director

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

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

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

Quorum

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

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

Attendance

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

- Any nominated deputy attending in place of a designated committee member.
- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.

- The EA to the Chief Nursing Officer and Chief Medical Officer will act as Secretary to the Committee.
- Governor observer(s).
- The Director of Integrated Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

Regular Attendees
Associate Medical Director/Head of Clinical Effectiveness
Head of Compliance
Head of Risk Management
Head of Patient Experience
Head of Patient Safety
Deputy Chief Nursing Officer x2
Deputy Chief Medical Officer x2

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

4.1. The function of the Committee is to ensure:

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

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

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

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

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

4.1.6. To consider the implications of wider changes in NHS policy and governance within the Committee's remit.

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

4.2.1. Development and Review

- Agree the annual quality account priorities and monitor progress**.**
- Extend the Boards monitoring and scrutiny of the standards of quality, compliance, and performance of Trust services.
- Make recommendations to the Board on opportunities for improvement in the quality of services.
- Support and encourage quality improvement where opportunities are identified.
- Working in conjunction with the Audit Committee, People and Culture Committee and Finance and Performance Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each committee.
- Review the Trust's Annual Quality Report and Account prior to submission to the Trust's Board of Directors for approval.

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

4.2.2. Review of Trust activity in assigned area

Patient Safety:

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

Clinical Effectiveness / Clinical Outcomes:

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

Patient Experience:

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

- Review of the Patient Experience Quarterly Report
- Agree the Annual Patient Experience/Engagement Plan and monitor progress.
- Receipt of reports regarding patient experience and engagement and review the results and outcomes of local and national patient surveys

Learning:

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

4.2.3. Policy monitoring and review

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

5. Conduct of Business

Administration

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

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

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

Frequency

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

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

Notice of meetings

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

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

Reporting

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

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

Reporting arrangements into the Committee from Sub-Committees

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

6. Review

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

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

6.3. These terms of reference were approved by the Board on 1 May 2025

NHS Salisbury NHS Foundation Trust

Finance & Performance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
Nov 2019	3	Minor	Added delegated authority limits	Corporate Governance Manager
May 2020	4	Minor	Annual Review	Corporate Governance Manager
March 2021	4.1	Minor	Annual Review	Corporate Governance Manager
March 2022	4.2	Minor	Annual Review	Head of Corporate Governance
Feb 2023	4.3	Minor	Annual Review	Head of Corporate Governance
Feb 2024	4.4	Minor	Annual Review	Head of Corporate Governance
Feb 2025	4.5	Minor	Annual Review	Head of Corporate Governance

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

1. Purpose

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

2. Authority

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

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:
- Three non-Executive Directors
- Chief Finance Officer (Lead executive)
- Managing Director
- Chief Operating Officer

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

Quorum

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

Attendance

3.7. Meetings of the Committee shall normally be attended by:
- Core members defined in para 3.1 above
- Chief People Officer
-
- Deputy Chief Finance Officer, Other Directors, and other staff by invitation
- Governor observer(s)

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

4. Roles and responsibilities

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

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

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

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

4.3.1. Reporting

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

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

4.3.2. Financial and Operational performance management

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

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

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

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

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

4.3.3. **Income and Contracts management**

- Review the Trust contracting approach with key commissioners

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

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

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

4.3.4. **Annual Trust planning cycle**

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

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

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

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

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

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

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

4.3.5. **Capital Management**

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

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

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

4.3.6. **Treasury Management**

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

- Review Trust finance applications including loan applications.

4.3.7. **Risk Management**

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

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

4.3.8. **Subsidiary Governance**

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

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

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

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

4.3.9 **Digital**

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

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

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

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

4.3.10 Other

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

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

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

5. Conduct of Business

Administration

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

Frequency

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

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

Notice of meetings

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

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

Reporting

5.6. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board via an escalation report. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.
5.8. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.
6.2. As part of this assessment, the Committee shall consider whether it receives adequate and appropriate support in fulfilment of its role and whether its current workload is manageable.
6.3. These terms of reference were reviewed and approved by Trust Board on 1 May 2025

People and Culture Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3		Annual Revision	Corporate Governance Manager
March 2021	3.1	Minor	Annual Revision	Corporate Governance Manager
January 2022	3.2	Minor	Annual Revision	PA to Chief People Officer
January 2023	3.3	Minor	Annual Revision	Head of Corporate Governance
Apr 23	3.4	Minor	Annual Revision agreed at P&CC	Deputy Chief People Officer
March 2024	3.5	Minor	Annual Revision	Head of Corporate Governance / Chief People Officer
October 2024	3.7	Minor		EA to Chief People Officer
January 2025	3.7 4.5	Minor	Annual revision	EA to Chief People Officer

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

1. Purpose and Function

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

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

1.1 To achieve this, the Committee shall:

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

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

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

2. Authority

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

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

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

3. Membership and Attendance

Membership

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

- Three Non-Executive Directors
- Chief People Officer (Lead Executive)
- Chief Medical Officer
- Chief Nursing Officer
- Director of Improvement
- Managing Director

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

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

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

Quorum

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

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

Attendance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Conduct of Business

Administration

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

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

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

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

Frequency

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

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

Notice of meetings

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

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

Reporting

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

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

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

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

- Organisational Development and People Management Board.

6. Review

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

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

6.3 These terms of reference were approved by the People and Culture Committee with amendments on 28th March 2025 and ratified by the Board of Directors on 1 May 2025.

NHS
Salisbury
NHS Foundation Trust

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance
November 2020	1.1	Minor	Updates to membership and attendance sections and minor formatting	Director of Corporate Governance
March 2022	1.2	Minor		Head of Corporate Governance
May 2023	1.3	Major	Complete review	Director of Integrated Governance/ Non- Executive Director
April 2025	1.4	Minor	Change to quoracy	Director of Integrated Governance

Date Adopted	~~7th April~~
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	Remcom Approved JAN 2024
Adoption and ratification	Trust Board

1. Purpose

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

2. Authority

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

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

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

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

3. Membership and Attendance

Membership

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

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

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

Attendance

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

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

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

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

3.8. Quorum

3.9. The quorum for meetings and necessary for the transaction of business is four non-executive directors and either the Committee Chair or the Trust Chair.

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

Secretary

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

4. Duties

4.1. Appointments

The Committee will:

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

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

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

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

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

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

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

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

4.2. Remuneration

The Committee will:

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

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

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

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

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

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

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

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

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

5. Executive termination payments

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

6. Conduct of Business

Administration

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

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

Frequency

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

Notice of meetings

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

Reporting

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

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

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

7. Review

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (public)	Agenda item:	6.3
Date of meeting:	1st May 2025		

Report title:	Annual Review of Trust Constitution			
Status:	Information	Discussion	Assurance	Approval
				Yes
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Isabel Cardoso, Membership Manager			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices				

Recommendation:

Trust Board are asked to:

- Approve the amendments endorsed by the Council of Governors on 10 March 2025 (highlighted in yellow in the attached document); and
- Consider and approve the additional amendment to Annex 9. If approved by the Board, this one further amendment will need to be approved by the Council of Governors in May.

Executive Summary:

Brief Summary:
Following the Council of Governors meeting on 20 May 2024, where proposed amendments to the Constitution were not approved, it was agreed to reconvene the Governors Constitution Group to review and refine all proposed changes.

The Constitution Group met on several occasions, with input from Fiona McNeight, Director of Integrated Governance and Kyle Sanders, Head of Corporate Governance to provide context. Unfortunately, consensus on the amendments was not achieved at the 25 November 2025 Council of Governors meeting. As a result, the Council resolved to establish a working group composed of Non-Executive Directors (NEDs) and Governors to review and reach agreement on the amendments.

This Constitution Working Group, consisting of two NEDs, Governors, Deputy Lead Governor Peter Russell, and Director of Integrated Governance Fiona McNeight, met and reached agreement on the majority of the amendments. Three points were agreed in principle but required further discussion.

The revised Constitution was presented to the Council of Governors on 10 March 2025 and after thorough discussion, all amendments were approved. It was noted that the Constitution remains a live document and can be reviewed as necessary.

Subsequently, a further amendment was proposed for Annex 9 – Additional Provisions – Directors – DISQUALIFICATION, specifically point 3, to include an exception where a Board member is appointed to a joint role within a group structure.

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

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

Post Holder Responsible for Policy:	Director of Integrated Governance
Directorate Responsible for Policy:	Chief Executive's
Contact Details:	Ext: 2774
Date Written:	2005
Date Revised:	April 2024
Approved by:	Council of Governor's/ Trust Board
Date Approved:	
Next Due for Revision:	April 2025 (Annual Review)
Date Document Becomes Live:	

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

Introduction

Salisbury NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the three organisations and wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB)

In line with current legislation all three trusts remain as individual statutory organisations with individual constitutions. Therefore, for the purposes of this document references to the chief executive will remain singular and not 'joint' or 'group'.

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Amendment History:

Year	Amendment
2014	• The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
2016	• Amendment of paragraph 37 of the Constitution was approved by the Board of Directors on 29 February 2016 and by the Council of Governors on 11 April 2016. • The new Model Election Rules were issued by the former Foundation Trust Network (NHS Providers) in August 2014 and formally adopted by the trust on 29 February/11 April 2016 • Amendment of paragraph 16 of the Council's standing orders was approved by the Council on 16 May 2016
2018	• April 2018 minor amendments to Board Standing Orders • Addition of Standing Financial Instructions – approved February 2018
2019	• Amendment of Annex 1 to a) insert the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency; (b) delete West Wiltshire as a constituency; (c) increase the number of governors for the South Wiltshire Rural Constituency from 5 to 6. – approved November 2019
2020	• Annex 8 Standing Orders of the Board of Directors has been completely revised and is included as an appendix to the Constitution. • The wards and constituencies have been updated. This includes merging West Wiltshire into South Wiltshire Rural. North Dorset and East Dorset constituencies have also been updated based on the electoral ward. • Within Annex 2 the Hotel and Property Class in the Staff Constituency is merged with the Clerical, Administrative and Managerial staff class. The name has been amended to "Administrative, Facilities and Managerial". • The unused paragraphs have been removed and the document renumbered and reformatted to reflect this.
2021	• Wiltshire Clinical Commissioning Group (CCG) is now called Bath and North-East Somerset, Swindon and Wiltshire (BSW)
2022	• Amendments to Annex 6 and Annex 9 to update Governor and Board disqualification criteria. • Document renumbered.
2023	• Minor formatting updates. • Item 32.3 updated to reflect NED terms of office (2 x 3-year terms plus 1 x 2-year term). • Annex 4 – Composition of the Appointed Governors updated to reflect the distinction between local authority and partnership organisations. • Annex 7 – Item 11.3 updated to include 'external stakeholder' in the composition of future Nominations Committees
2025	• Updating para 1 to reflect the Health and Social Care Act 2022. • Para 4 – Powers updated to recognise joint committees and the 2006 Act (revised 2022). • Para 4.5 added as specified in the Health and Care Act 2022. • Para 17 updated to recognise joint committees. • Annex 4 updated to reflect changes to 'partnership organisations' in relation to Appointed Governors. • Annex 8, para 5.9 added to reflect the establishment of Joint Committees and Committee-in Common. • Para 14.5 – the wording around Governor elections has been further clarified • Para 21 – Board Composition has been updated and aligns with Great Western Hospitals NHS Foundation Trust. • Para 23 – updated to include the associate NED reference. • Para 25 – Updated to reflect the Fit and Proper Persons (FPPR) regulations. • Para 26 – new section added reflecting the latest Code of Governance relating to the appointment and removal of the Company Secretary.

	• Para 31 – Updated wording for terms of office for Chair and Non-Executive Directors to reflect the latest Code of Governance. Ultimately, any decision to extend a NED term of office beyond 6 years should be subject to rigorous review. • Para 42 – The wording around significant transactions has been strengthened following feedback from the Council of Governors • Annex 9 – updated wording to reflect an exception to board membership

1. Interpretation and definitions

1.1 Unless otherwise stated, words or expressions used in this constitution have the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022.

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

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

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

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, updated in the 2012 Health and Social Care Act and the 2022 Health and Care Act.

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

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

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

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

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

5. Membership and constituencies

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

5.1.1 A public constituency

5.1.2 A staff constituency

6. Application for membership

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

7. Public Constituency

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

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

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

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

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

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

9. Automatic Membership by default – Staff

9.1 An individual who is:

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

9.1.2 invited by the Trust to become a member of the Staff Constituency, shall become a member of the Staff Constituency and in the appropriate staff class without an application being made, unless they inform the Trust that they do not wish to do so.

10. Patients' Constituency

There is no Patients' Constituency

11. Restrictions on Membership

11.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.

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

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

11.4 An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.

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

11.6 Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.

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

12. Annual Members' Meeting

12.1 The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public. This should be held no later than 30th September.

13. Council of Governors – Composition

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

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

13.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.

13.4 No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

14. Council of Governors – Election of Governors

14.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.

14.2 The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).

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

14.5 Where membership of the Council of Governors ceases within 12 months of election, public and staff governors shall be replaced by the candidate in the same constituency and class with the next highest number of votes at the last election. If the vacancy cannot be filled by this method the Trust will commence another election process at the earliest opportunity, in accordance with the Model Election Rules

15. Council of Governors – Tenure

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

15.2 An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than nine years in all.

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

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

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

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

16. Council of Governors – Disqualification and Termination of Office

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

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

16.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

16.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

16.1.4 The further persons set out in Annex 6.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

16.3 If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

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

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

16.4 A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

16.4.1 acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or

16.4.2 failed to declare a material interest pursuant to paragraph 21 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

16.5 Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 16.3 and 16.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

16.6 In the event of a notice being given under sub-paragraph 16.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's ability to remain a governor (other than those set out in paragraphs 16.3 and 16.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

16.7 A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

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

17. Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

17.1 The general duties of the Council of Governors are–

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

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

17.2 The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

17.3 The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

18. Council of Governors – Meetings of Governors

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

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

18.3 Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

18.4 The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

18.5 The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

18.6 For the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18.7 The Council of Governors may appoint committees consisting wholly or partly of its members to assist it in carrying out its functions as are required by law and to carry out such functions as the Council specifies.

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

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

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

19. Council of Governors – Standing Orders

19.1 The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

20. Council of Governors – Referral to the Panel

20.1 In this paragraph the Panel means a panel of persons appointed by NHS England to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

20.1.1 to act in accordance with its constitution, or

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

20.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

21. Council of Governors – Conflicts of Interest of Governors

21.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.2 For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

22. Council of Governors – Travel Expenses

22.1 The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

23. Board of Directors – Composition

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

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chair

23.2.2 a minimum of 5 other non-executive directors

23.2.3 a minimum of 5 executive directors to include:

23.2.4 One of the Executive Directors shall be the Chief Executive.

23.2.5 The Chief Executive shall be the Accounting Officer.

23.2.6 One of the Executive Directors shall be the Chief Finance Officer

23.2.7 One of the Executive Directors shall be the Managing Director

23.3 One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

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

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

24. Board of Directors – General Duty

24.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors – Appointment and removal of Chair and Non-Executive Directors, including Associate Non-Executive Directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other non-executive directors, including Associate Non-Executive Directors.

25.2 Removal of the Chair or any other non-executive director, including Associate Non-Executive Directors shall require the approval of 75% of the members of the Council of Governors (in person or virtual attendance).

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

26. Board of Directors – Deputy Chair

26.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chair. The Deputy Chair shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

27. Board of Directors – Appointment and removal of the Chief Executive and Executive Directors

27.1 The non-executive directors shall appoint or remove the Chief Executive. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

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

27.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

28. Board of Directors – appointment and removal of the Company Secretary

28.1 The whole Board shall appoint or remove the Company Secretary (Director of Corporate Governance)

29. Board of Directors – Disqualification

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

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

29.1.2 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.

29.1.3 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.

29.1.4 The persons referred in Annex 9.

30. Board of Directors – Meetings

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

30.2 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.

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

30.4 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.

31. Board of Directors – Standing orders

31.1 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.

32. Board of Directors – Conflicts of Interest of Directors

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

32.1.1 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.

32.1.2 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.

32.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

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

32.5 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.

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

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

32.8 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.

32.9 A director need not declare an interest –

32.9.1 if it cannot be reasonably regarded as likely to give rise to a conflict of interest.

32.9.2 if, or to the extent that, the directors are already aware of it.

32.9.3 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.

33. Board of Directors – Remuneration and Terms of Office

33.1 The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

33.2 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.

33.3 The Chair and other non-executive directors should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years for a valid reason and should be subject to rigorous review which may be renewed by the Council. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

34. Registers

34.1 The Trust shall have a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.

34.2 a register of members of the Council of Governors.

34.3 a register of interests of Governors.

34.4 a register of interests of directors.
34.5 and a register of directors.

35. Registers – Inspection and copies

35.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.
35.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:
- **35.2.1** any member of the Rest of England Constituency; or
- **35.2.2** any other member of the Trust if the member so requests.

35.3 So far as the registers are required to be made available:
- **35.3.1** They are to be available for inspection free of charge at all reasonable times; and
- **35.3.2** A person who requests a copy or extract from the registers is to be provided with a copy or extract.

35.4 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.

36. Documents available for public inspection

36.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
- **36.1.1** A copy of the current constitution.
- **36.1.2** A copy of the latest annual accounts and of any report of the auditor on them; and
- **36.1.3** A copy of the latest annual report

36.2 The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:
- **36.2.1** 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.
- **36.2.2** A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
- **36.2.3** A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act.
- **36.2.4** A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
- **36.2.5** A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.
- **36.2.6** 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.
- **36.2.7** A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
- **36.2.8** A copy of any final report published under section 65I (administrator's final report) of the 2006 Act.
- **36.2.9** 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.
- **36.2.10** A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

36.3 Any person who requests a copy or extract from any of the above documents is to be provided with a copy.
36.4 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.

37. Auditor

37.1 The Trust shall have an auditor.

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

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

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

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

38. Audit Committee

38.1 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.

39. Accounts

39.1 The Trust must keep proper accounts in such form as NHS England may with the approval of the Treasury direct and proper records in relation to those accounts.

39.2 NHS England 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.

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

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

- **39.4.1** the accounts.
- **39.4.2** the records relating to them; and
- **39.4.3** any report of the Auditor on them

39.5 The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State for Health direct.

39.6 NHS England may with the approval of the Secretary of State for Health direct the Trust:

- **39.6.1** to prepare accounts in respect of such period or periods as may be specified in the direction; and/or
- **39.6.2** that any accounts prepared by it by virtue of sub-paragraph 38.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

39.7 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 NHS England with the approval of the Secretary of State for Health as to:

- **39.7.1** the methods and principles according to which the annual accounts are to be prepared; and/or
- **39.7.2** the content and form of the annual accounts

39.8 The Trust must –

- **39.8.1** lay a copy of the annual accounts, and any report of the Auditor on them, before Parliament; and
- **39.8.2** send copies of the annual accounts, and any report of the Auditor on them to NHS England within such a period as NHS England may direct

39.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 38.6 above and a copy of any report of the Auditor to NHS England within such a period as NHS England may direct.

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

40. Annual Report, Forward Plans and Non-NHS work

40.1 The Trust shall prepare an annual report and send it to NHS England.

40.2 The annual report must give:

40.2.1 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.

40.2.2 information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 18.5 here of

40.2.3 information on the corporation's policy on pay and on the work of the committee established under paragraph 32(2) hereof and such other procedures as the corporation has on pay.

40.2.4 information on the remuneration of the directors and on the expenses of the governors and the directors

40.2.5 any other information that NHS England or requires.

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

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

40.5 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.

40.6 Each forward plan must include information about:

40.6.1 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

40.6.2 the income it expects to receive from doing so.

40.7 Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 39.6.1, the Council of Governors must:

40.7.1 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

40.7.2 notify the directors of the Trust of its determination.

40.8 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.

41. Presentation of the Annual Accounts and Reports to the Governors and Members

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

41.1.1 the annual accounts

41.1.2 any report of the auditor on them

41.1.3 the annual report.

41.2 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.

41.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

42. Instruments

42.1 The Trust shall have a seal.

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

43. Amendment of the Constitution

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

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

43.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.

43.2 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

43.3 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) –

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

43.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

43.4 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.

43.5 Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England'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.

44. Mergers etc. and Significant Transactions

44.1 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.

44.2 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. The threshold for a significant transaction differs depending upon whether the transaction relates to UK or non-UK healthcare investment or disinvestment.

44.3 A Significant Transaction is a transaction deemed to be high risk and will include Statutory Transactions, (as set out in clause 44.1), and a transaction which the Trust's Finance Director, reporting to the Board, determines is covered by ANY of the following:

44.3.1 Assets, (i.e. the gross assets of the proposed transaction divided by the gross assets of the Trust), will exceed or be reduced by 10% or more

44.3.2 Income, (i.e. the income of the proposed transaction divided by the operating income of the Trust), will exceed or be reduced by 10%, or more

44.3.3 Any transaction that might lead to the Trust breaching its licence conditions

44.3.4 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.

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

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

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

44.4.2 have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail.

44.5 If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council's discussion of the transaction for and against approval shall be recorded in the minutes.

44.6 The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust's income or capital in the previous year.

45. Indemnity

45.1 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.

46. Dispute Resolution

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

46.2 If the Chair is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

46.3 If the dispute is not resolved, the Chair may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area formerly covered by North Dorset District Council, comprising the following electoral wards: ▪ Beacon ▪ Blandford ▪ Cranborne Chase ▪ Gillingham ▪ Hill Forts & Upper Tarrants ▪ Shaftesbury Town ▪ Stalbridge & Marnhull (Marnhull parish) ▪ Sturminster Newton
Kennet	The area formerly covered by Kennet District Council comprising the following electoral wards: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings
New Forest	The following electoral wards within New Forest District Council: ▪ Downlands & Forest ▪ Fordingbridge ▪ Forest Northwest ▪ Ringwood East & Sopley ▪ Ringwood North ▪ Ringwood South
Salisbury City	The following electoral wards formerly covered by

	Salisbury District Council: • Salisbury Bemerton • Salisbury Fisherton & Bemerton Village • Salisbury Harnham • Salisbury St. Edmund's & Milford • Salisbury St. Francis & Stratford • Salisbury St. Marks & Bishopdown • Salisbury St. Martin's & Cathedral • Salisbury St. Paul's
South Wiltshire Rural	The following electoral wards • Alderbury & Whiteparish • Amesbury East • Amesbury West • Bourne & Woodford Valley • Bulford, Allington & Figheldean • Downton & Ebble Valley • Durrington & Larkhill • Ethandune • Fovant & Chalke Valley • Laverstock, Ford & Old Sarum • Mere • Nadder & East Knoyle • Redlynch & Landford • Till & Wylye Valley • Tisbury • Warminster Broadway • Warminster Copheap & Wylye • Warminster East • Warminster West • Warminster Without • Westbury East • Westbury North • Westbury West • Wilton & Lower Wylye Valley • Winterslow
East Dorset	The following electoral wards within the area formerly covered by East Dorset District Council: • Cranborne & Alderholt • St. Leonards & St. Ives • Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes • Verwood • West Moors & Three Legged Cross
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 6)

The Staff Constituency is divided into 5 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUBGROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries Health Care Assistants (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers Orthoptists Physiotherapists and Helpers Art/Music/Drama Therapists Speech and Language Therapists and Helpers Psychologists and Psychology Technicians Psychotherapists Medical Physicists and Technicians Pharmacists and Pharmacy Technicians Dental Technicians Operating Department Practitioners Social Workers Chaplains Clinical Scientists Biomedical Scientists and Technical Staff Geneticists and Technicians Audiology Staff Cardiographers and Support Staff
Administrative, Facilities and Managerial Staff	Ancillary Staff Works and Maintenance Staff Ambulance Staff
Voluntary Staff	

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

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

Public Governors

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

Staff Governors

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

Appointed Governors

3. There shall be 4 appointed governors:

- **Local Authority**

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

- **Partnership Organisations**

3.2 There shall be a maximum of five partnership organisations (or successor organisations) who may appoint one governor by notice in writing, signed by the chief executive (or equivalent) of that organisation and delivered to the chair. These partnership organisations are decided by the Board of Directors and Council of Governors.

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

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

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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

PART 5: CONTESTED ELECTIONS

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

Action to be taken before the poll

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

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone

35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES
41- [NOT USED]
42. Arrangements for counting of the votes
43. The count
FPP44. Rejected ballot papers and rejected text voting records
[45-50 NOT USED]
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

67. Secrecy

68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

- **"*2006 Act*"** means the National Health Service Act 2006;
- "***corporation***" means the public benefit corporation subject to this constitution;
- **"*council of governors*"** means the council of governors of the corporation;
- **"*declaration of identity*"** has the meaning set out in rule 21.1;
- **"*election*"** means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;
- "*e-voting*" means voting using either the internet, telephone or text message;
- "*e-voting information*" has the meaning set out in rule 24.2;
- "*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);
- "*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
- "*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.
- "*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;
- "*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;
- "*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;
- "*numerical voting code*" has the meaning set out in rule 64.2(b)
- "*polling website*" has the meaning set out in rule 26.1;
- "*postal voting information*" has the meaning set out in rule 24.1;
- "*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;
- "*telephone voting facility*" has the meaning set out in rule 26.2;

- "*telephone voting record*" has the meaning set out in rule 26.5 (d);
- "*text message voting facility*" has the meaning set out in rule 26.3;
- "*text voting record*" has the meaning set out in rule 26.6 (d);
- "*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
- "*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;
- "*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,
- "*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

a) a Saturday or Sunday;
b) Christmas day, Good Friday, or a bank holiday, or
c) a day appointed for public thanksgiving or mourning, shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.
4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:
(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:
a) the constituency, or class within a constituency, for which the election is being held,
b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
c) the details of any nomination committee that has been established by the corporation,
d) the address and times at which nomination forms may be obtained;
e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
f) the date and time by which any notice of withdrawal must be received by the returning officer
g) the contact details of the returning officer
h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

a) is to supply any member of the corporation with a nomination form, and

b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

a) full name,

b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

a) any financial interest that the candidate has in the corporation, and

b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

a) they wish to stand as a candidate,

b) their declaration of interests as required under rule 11, is true and correct, and

c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

a) decides that the candidate is not eligible to stand,

b) decides that the nomination form is invalid,

c) receives satisfactory proof that the candidate has died, or

d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

b) that the paper does not contain the candidate's particulars, as required by rule 10;

c) that the paper does not contain a declaration of the interests of the candidate, as required

by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.
19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.
19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.
19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.
19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
   i. configured in accordance with these rules; and
   ii. will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system.
b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
   i. configured in accordance with these rules; and
   ii. will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system.
c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
   i. configured in accordance with these rules; and
   ii. will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.
20.2 Every ballot paper must specify:

a) the name of the corporation,
b) the constituency, or class within a constituency, for which the election is being held,
c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.
20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

a) that the voter is the person:
   i. to whom the ballot paper was addressed, and/or

ii. to whom the voter ID number contained within the e-voting information was allocated,

b) that he or she has not marked or returned any other voting information in the election, and

c) he particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

a) a postal address; and,

b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

a) the name of the corporation,

b) the constituency, or class within a constituency, for which the election is being held,

c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

g) the address for return of the ballot papers,

h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located.

i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

k) the date and time of the close of the poll,

l) the address and final dates for applications for replacement voting information, and

m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice

of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

a) a ballot paper and ballot paper envelope,
b) the ID declaration form (if required),
c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
d) a covering envelope.

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

a) instructions on how to vote and how to make a declaration of identity (if required),
b) the voter's voter ID number,
c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

a) only be sent postal voting information; or
b) only be sent e-voting information; or
c) be sent both postal voting information and e-voting information.

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

a) the address for return of the ballot paper printed on it, and
b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

a) the completed ID declaration form if required, and
b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election, then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election, then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election, then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

a) require a voter to:
   i. enter his or her voter ID number; and
   ii. where the election is for a public or patient constituency, make a declaration of identity;
   in order to be able to cast his or her vote;
b) specify:
   i. the name of the corporation,
   ii. the constituency, or class within a constituency, for which the election is being held,
   iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
   iv. the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
   v. instructions on how to vote and how to make a declaration of identity,
   vi. the date and time of the close of the poll, and
   vii. the contact details of the returning officer.
c) prevent a voter from voting for more candidates than he or she is entitled to at the election.
d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
   i. the voter's voter ID number.
   ii. the voter's declaration of identity (where required).
   iii. the candidate or candidates for whom the voter has voted; and
   iv. the date and time of the voter's vote,
e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and
f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

a) require a voter to
   i. enter his or her voter ID number in order to be able to cast his or her vote; and
   ii. where the election is for a public or patient constituency, make a declaration of identity.
b) specify:
   i. the name of the corporation,
   ii. the constituency, or class within a constituency, for which the election is being held,
   iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
   iv. instructions on how to vote and how to make a declaration of identity,
   v. the date and time of the close of the poll, and
   vi. the contact details of the returning officer.
c) prevent a voter from voting for more candidates than he or she is entitled to at the election.
d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
   i. the voter's voter ID number.
   ii. the voter's declaration of identity (where required).
   iii. the candidate or candidates for whom the voter has voted; and
   iv. the date and time of the voter's vote
e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this.
f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

a) require a voter to:
   i. provide his or her voter ID number; and
   ii. where the election is for a public or patient constituency, make a declaration of identity;
   in order to be able to cast his or her vote;
b) prevent a voter from voting for more candidates than he or she is entitled to at the election;
c) create a record ("text voting record") that is stored in the text messaging voting system in

respect of each vote cast by a voter by text message that comprises of:

i. the voter's voter ID number;
ii. the voter's declaration of identity (where required);
iii. the candidate or candidates for whom the voter has voted; and
iv. the date and time of the voter's vote

d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.
28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.
29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.
29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

a) is satisfied as to the voter's identity; and
b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

a) the name of the voter, and
b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.
29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.
29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity**.**
29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes")**:**

a) the name of the voter, and
b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

a) is satisfied as to the voter's identity,
b) has no reason to doubt that the voter did not receive the original voting information,
c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

a) the name of the voter
b) the details of the unique identifier of the replacement ballot paper, if applicable, and
c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

a) the name of the voter,
b) the unique identifier of any replacement ballot paper issued under this rule;
c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote**.**

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

a) a covering envelope, or

b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

a) the candidate for whom a voter has voted, or

b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

a) put the ID declaration form if required in a separate packet, and

b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

a) mark the ballot paper “disqualified”,

b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

b) record the voter ID number on the internet voting record, telephone voting record or text

voting record (as applicable) in the list of disqualified documents; and
c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:
a) mark the ID declaration form "disqualified",
b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
b) mark as "disqualified" all other votes that were cast using the relevant voter ID number.

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
a) mark the ballot paper "disqualified",
b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents.
d) place the document or documents in a separate packet; and
e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
a) the disqualified documents, together with the list of disqualified documents inside it,
b) the ID declaration forms, if required,
c) the list of spoilt ballot papers and the list of spoilt text message votes,
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.

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

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**.**

FPP44.8 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 Chair of the NHS Trust, or
   ii. in any other case, to the Chair of the corporation; and
c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

a) the total number of votes given for each candidate (whether elected or not), and
b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

a) declare the candidate or candidates remaining validly nominated to be elected,
b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and
c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

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54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
b) the ballot papers and text voting records endorsed with “rejected in part”,
c) the rejected ballot papers and text voting records, and
d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

a) the disqualified documents, with the list of disqualified documents inside it,
b) the list of spoilt ballot papers and the list of spoilt text message votes,
c) the list of lost ballot documents, and
d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

a) its contents,

b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

a) any voting documents are received by the returning officer after the close of the poll, or
b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

a) the inspection of, or the opening of any sealed packet containing –
   i. any rejected ballot papers, including ballot papers rejected in part,
   ii. any rejected text voting records, including text voting records rejected in part,
   iii. any disqualified documents, or the list of disqualified documents,
   iv. any counted ballot papers, internet voting records, telephone voting records or text voting records, or
   v. the list of eligible voters, or
b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

a) persons,
b) time,
c) place and mode of inspection,
d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

a) in giving its consent, and
b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

i. that his or her vote was given, and
ii. that NHS England has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

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) account 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 Chair of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS England (previously Monitor) under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

a) personal expenses,
b) travelling expenses, and expenses incurred while living away from home, and
c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

a) compile and distribute such information about the candidates, and
b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

a) objective, balanced and fair,
b) equivalent in size and content for all candidates,
c) compiled and distributed in consultation with all of the candidates standing for election, and
d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

a) a statement submitted by the candidate of no more than 250 words,
b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the

purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS England (previously 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 NHS England (previously 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. NHS England (previously Monitor) will refer the application to the independent election arbitration panel appointed by NHS England (previously 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 NHS England (previously Monitor) shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

a) the returning officer,

b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

i. the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

ii. the unique identifier on any ballot paper,

iii. the voter ID number allocated to any voter,
iv. the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

a) a member of the corporation,
b) an employee of the corporation,
c) a director of the corporation, or
d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

a) the delivery of the documents in rule 24, or
b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 16)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the laws of England and/or Wales.
3. A person who is a director of the Trust, Chair or chief executive of another NHS Foundation Trust or NHS Trust; However, a governor (other than the lead governor) may be a governor or non-executive director (other than Chair) of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two governorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected.
5. A person who occupies the same household as an existing governor or a director of the Trust.
6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election or becomes employed by the Trust.
7. A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor.

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

(See paragraph 19)

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1. Introduction

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

2. Interpretation

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

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

2.3 'The Council' means the Council of Governors.

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

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

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

3. Meetings of the Council

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

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chair and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given

3.3 If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4 Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5 Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. Agenda Items and Motions

4.1 Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chair and the Lead Governor.

4.2 A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second the motion and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chair of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3 A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the Chair of the meeting.

4.4 No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chair of the Trust.

4.5 The proposer of a motion shall propose it and shall have a right to speak before a vote is taken.

4.6 During the consideration of a motion a governor may move:

4.6.1 an amendment to the motion;

4.6.2 that the consideration of motion be adjourned to a subsequent meeting;

4.6.3 that the motion be summarily dismissed and the meeting to proceed to the next business;

4.6.4 that the motion be voted on immediately.

4.7 No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the Chair of the meeting.

4.8 Save where the Chair of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. Quorum

5.1 No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. Relevance and Concision

6.1 Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2 The Chair of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3 In any matter relating to the interpretation of the Constitution and Standing Orders the Chair of the meeting shall consider the advice of the Secretary.

7. Voting

7.1 Save where it is otherwise provided by the constitution, or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2 In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3 At the discretion of the Chair of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4 Save in the case of a secret paper ballot, if at least one third of the governor's present request, the voting for and against of each governor shall be minuted.

7.5 If a governor requests, his vote shall be minuted.

7.6 No one may vote unless physically present: there shall be no votes by proxy.

8. Minutes

8.1 Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting.

8.2 The minutes shall record the names of those attending.

9. Suspension of Standing Orders

9.1 Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the Chair of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2 A decision to suspend standing orders shall be recorded in the minutes.

9.3 A separate record of matters while the orders were suspended shall be made and shall be provided to the governors with the minutes.

10. Committees

10.1 The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2 The powers of the Council may be delegated to a committee for a specific purpose if the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3 The powers of the Council shall be exercised in general meeting.

10.4 The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5 Meetings of the Council's committees, sub-committees and working groups shall be private.

Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. Nominations Committee

11.1 Paragraph 27 of the Constitution provides for the appointment and removal of the Chair of the Trust and the other non-executive directors by the Council. Paragraph 27.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2 For the appointment of the Chair, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director
- 1 external stakeholder

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

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

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

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

11.4.2 In the case of a nomination for Chair invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5 If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. Declarations and Register of Interests

12.1 Paragraph 21 of the Constitution provides for declarations of interest. It states:

- **21.1** *If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.*
- **21.2.** *For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question***.**

12.2 Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3 If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4 Subject to the exceptions below, material interests include:

12.4.1 any directorship of a company;

12.4.2 any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3 any interest in an organisation providing health and social care services to the National Health Service;
12.4.4 a position of authority in a charity or voluntary organisation in the field of health and social care;
12.4.5 any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter before the Council fairly.

12.5 The exceptions are:
12.5.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;
12.5.2 an employment contract with the Trust held by a staff governor;
12.5.3 an employment contract held with the appointing body by an appointed governor;

12.6 If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7 The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting

12.8 The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9 If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the Chair of the meeting shall rule on the question having taken the advice of the Secretary.

12.10 A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11 A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 16.4 of the Constitution.

13. Code of Conduct

13.1 Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders and shall at all times comply with the Code.

14. Confidentiality

14.1 It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2 Governors must keep secure all confidential matter recorded on paper or electronically and must ensure that their NHS mail and forum details are not disclosed.

14.3 Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4 The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5 A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the information has entered the public domain.

14.6 Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. Expenses

15.1 Paragraph 22 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2 Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3 The total of the expenses paid to governors will be published in the Annual Report.

16. Lead and Deputy Lead Governor's Appointment

16.1 The Lead Governor and the Deputy Lead Governor must be elected governors. A staff

governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. Lead Governor and Deputy Lead Governor – Roles

17.1 The role of the Lead Governor is:

17.1.1 to chair meetings of the Council which cannot for any reason be chaired by the Chair or the Deputy Chair;

17.1.2 to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chair;

17.1.3 to communicate regularly with the Chair, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4 to be a point of contact for NHS England when appropriate;

17.1.5 to provide input into the appraisal of the Chair;
17.1.6 to take an active role in the activities of the Council;
17.1.7 to be a point of contact for governors when they have concerns;

17.2 The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. Lead and Deputy Lead Governors – Vote of No Confidence

18.1 If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chair, the Chair shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2 The Chair will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting.

18.3 The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4 At the meeting the Chair will present the reasons for the motion, and it will be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5 A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governor's present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6 A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. Directors' Attendance

19.1 Paragraph 18.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2 The attendance of a director pursuant to paragraph 18.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chair. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. Forward Plan

20.1 Paragraph 39.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2 The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3 The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting.

21. Amendment of Standing Orders

21.1 Paragraph 19.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX 7.1

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;
2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;
3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;
4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;
5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;
6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;
7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;
8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;
9. Recognise that the Trust is a non-political organisation.
10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;
11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;
12. Comply with the Council's Standing Orders;
13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;
14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    a) advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    b) any request by the media for comment should be forwarded to the Trust's press officer;
    c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer rather than responding himself;
    d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;
15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness:

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity:

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity:

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability:

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness:

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty:

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership:

Holders of public office should promote and support these principles by leadership and example

Governor's undertaking

I,_____, of ,
undertake as a Governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed:_____ Date:_____

ANNEX 8 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(see paragraph 30)

1. Interpretations and Definitions

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3. Any expression to which a meaning is given in the Health and Social Care Act 2012, or any legislation or any regulations made under this Act, shall have the same meaning in these standing orders and in addition:

1.3.1 **"Accounting officer"** means the person responsible and accountable for funds trusted to the Trust. The Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, this shall be the Chief Executive;

1.3.2 **"Board"** means the Board of Directors, consisting of the Chair, the independent non-executive directors and the executive directors;

1.3.3 **"Audit Committee"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework;

1.3.4 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

1.3.5 **"Committee"** means a committee or sub-committee appointed by the Trust;

1.3.6 **"Committee Members"** shall be persons formally appointed by the Trust to sit on or to chair specific committees;

1.3.7 **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

1.3.8 **"Council"** means the Council of Governors, formally constituted in accordance with the constitution and presided over by the Chair;

1.3.9 **"Director of Finance"** means the chief financial officer of the Trust;

1.3.10 **"Executive Director"** means a member of the board who is an officer of the Trust;

1.3.11 **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting;

1.3.12 **"Nominated Officer"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

1.3.13 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

1.3.14 **"SFIs"** means standing financial instructions;

1.3.15 **"SOs"** means Standing Orders.

1.3.16 **"Trust"** means Salisbury NHS Foundation Trust

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP AND ROLE OF MEMBERS

2.1 Composition of the Board of Directors

The composition of the Board of Directors shall be in accordance with paragraph 23 of the Constitution.

2.2 Role of Members of the Board of Directors

The Board of Directors will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal members. Their role will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. The Director of Finance shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may; however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair

The Chair shall be responsible for the operation of the Board of Directors and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of employment and with these Standing Orders.

The Chair shall take responsibility either directly, or indirectly, for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

The Chair shall work in close conjunction with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the discussion and ultimate resolutions.

Senior Independent Director

The Board of Directors should in consultation with the Council of Governors, appoint a Non-Executive Director to be the Senior Independent Director. Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another Non-Executive Director as Senior Independent Director.

2.3 Corporate role of the Board of Directors.

2.3.1 All business shall be conducted in the name of the Trust.

2.3.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3.3 The powers of the Trust established under statute shall be exercised by the Board except as otherwise provided for under Section 4 of this annex.

2.3.4 The Board has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the

'Schedule of Matters reserved to the Board' and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 Admission of the Public and the Press

3.1.1 The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.1.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.2 Observers at Board Meetings

3.2.1 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.2.2 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

3.3 Calling of Meetings

3.3.1 Ordinary meetings of the Board shall be held at such times and places as the Board determines. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board of Directors so resolves for special reasons.

3.3.2 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

3.4.1 Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear days before the meeting.

3.4.2 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.10 below

3.4.3 Agendas will normally be sent to members of the Board seven calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than five clear days before the meeting, save in emergency.

3.4.4 Before any meeting of the Board which is to be held in public, a public notice of the

time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

3.5 Agendas and supporting papers

3.5.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.7 Chair of Meeting

3.7.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he/she is present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, then the remaining non-executive directors present shall choose which non-executive director shall preside.

3.8 Notices of Motion

3.8.1 A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 12 clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chair shall include in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. This Standing Order 3.8.1 shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda.

3.8.2 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8.3 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Motions – procedure at and during meetings

3.9.1 Who may propose?

A motion may be proposed by the Chair or any Director present at the meeting. Such motion must also be seconded by another Director.

3.9.2 Contents of Motions

The Chair may (at his discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.8, other than a motion relating to:

(a) the reception of a report;
(b) consideration of any item of business before the Trust Board;
(c) the accuracy of minutes;
(d) that the Board proceed to next business;
(e) that the Board adjourn;
(f) that the question be now put.

3.9.3 Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.9.4 Rights of reply to motions

Amendments: The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9.5 Motions Once Under Debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put;
- that a Director be not further heard;
- a motion resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.10 Emergency Motions

Subject to the agreement of the Chair and SO 3.9 above, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.11 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matter shall be final.

3.12 Voting

3.12.1 Save as provided in SO 3.15 Suspension of Standing Orders, every question at a

meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.12.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.12.4 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.14 Quorum

3.14.1 The quorum of a meeting will be at least half of the whole number of members of the Board of Directors (including at least one Non-Executive Director and one Executive Director).

3.14.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.14.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.15 Suspension of Standing Orders

3.15.1 Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present votes in favour of suspension.

3.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.15.4 No formal business may be transacted while Standing Orders are suspended.

3.15.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.16 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.6 Scheme of Delegation

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Discharge of the Direct Accountability

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by NHS England), the Board of Directors may appoint committees of the Trust

5.2 Applicability of Standing Orders and Standing Financial Instructions to committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of Powers

The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.5

Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6 Approval of appointments to committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.8 Committees established by the Board of Directors

The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the

Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

5.9 Joint Committees

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

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Disclosure of Interests

The Constitution, the 2006 Act and the Foundation Trust Code of Governance requires Board Directors to declare interests which are relevant and material to the NHS board of which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 Declaring interests

6.3.1 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.3.2 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.3.3 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.3.4 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.

6.3.5 Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3.6 This standing order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

6.4 Register of Interests

6.4.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will

include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.4.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.4.4 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their respective Directors for clarification.

6.5 Exclusion of Chair and Members in proceedings on account of pecuniary interests

6.5.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.5.2 The Board of Directors may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.5.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.5.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 6.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7 STANDARDS OF BUSINESS CONDUCT POLICY

7.1 All staff and members must comply with the Trust's Standards of Business Conduct, the Regulatory Framework and the National guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4 Canvassing of and Recommendations by, Directors in Relation to Appointments

7.4.1 Canvassing of Directors of the Trust or of any Committee or joint committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 7 shall be included in application forms or otherwise brought to the attention of candidates.

7.4.2 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 7 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 Relatives of Directors or Officers

7.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

7.5.2 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.5.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

8.2 Sealing of Documents

8.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Trust Secretary; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly.

(The report shall contain details of the seal number, a description of the document and the date of sealing).

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

ANNEX 9 – Additional Provisions - Directors – DISQUALIFICATION

(See Paragraph 28)

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

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, Chair or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the Chair) may be a non-executive director or a governor of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two directorships or directorship and governorship. With exception to when a Board member is appointed to a joint role within a group structure
4. A person whose physical or mental wellbeing is such that their ability to act as a director of the Trust is materially affected.
5. A person who occupies the same household as an existing director of the Trust or a governor.
6. A person who has had their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list and, due to the reasons(s) for such removal, they are considered by the Trust to be unsuitable to be a Director.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.4
Date of meeting:	1 May 2025		

Report tile:	Self-Certifications CoS7 (Continuation of Services) and Training for Governors			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Tapiwa Songore, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices	Appendix 1 – Evidence of compliance, risk and mitigations.			

Recommendation:
The Board is asked to review the evidence provided including the risks and mitigations, and self-certify that the Trust is compliant with the conditions of the Provider Licence

Executive Summary:
The Trust is required to self-certify on an annual basis, as to whether they have: • The required resources available if providing commissioner requested services (CRS) (condition CoS7) • Provided Governors with the necessary training. This report provides the Board with assurance that the Trust is complying with the NHS Provider Licence conditions above, and the evidence to support the self-certification is outlined in Appendix 1. The CEO and chair will be required to sign the self-certification and publish on the Trust's website.

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

Continuity of Services condition 7 – Availability of Resources				
		Evidence	**Risks**	**Mitigating Actions**
1	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate	N/A	N/A	N/A
or	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. **Proposed Response:** **Confirmed**	• The Trust Trust's Financial Plan for 2025/26 set out details of the resource requirements and efficiencies required. • Improvement plans are in place to deliver the required savings • The Annual Accounts have been prepared on a going-concern basis.	• The delivery of the financial plan for 2025/26 is predicated on the delivery of a cash releasing savings target of 5% and a CIP total of £20.9m. • The level of cultural change required for delivery in the areas of identified opportunities • The pace and scale required and the impact of the quality of service given the operational pressures • The risk of non-delivery of schemes within the wider system, which could impact on the delivery of the Trust's plan.	• The key risks to financial, clinical and operational sustainability have been identified and are being effectively monitored and managed with appropriate escalation in place • Risks to the delivery of the Trust's strategic goals are regularly reviewed and managed through the Board Assurance Framework. • The delivery against key performance metrics is reported to the Board monthly through the Integrated Performance dashboard • The Trust and other NHS and social care providers are working collaboratively to address the issues of demand and activity on a collective basis • The Trust has agreed contracts in place with commissioners for the provision of services

Training of Governors				
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. **Proposed Response: Confirmed**	• Induction and mandatory training Programme • Governor development days • Governor observers on all Board and Board Committees • Informal Governor and NED meetings • Attendance at external training events • Governor self-assessment to review training requirements. • Participate on Trust led working groups	N/A	N/A

Report to:	Trust Board (Public)	Agenda item:	6.5
Date of Meeting:	1 May 2025		

Title of Report:	**BSW Hospitals Group Partnership Agreement and Joint Committee Terms of Reference**
Status:	**For approval**
Board Sponsor:	**Cara Charles-Barks, Chief Executive**
Author:	**Ben Irvine, Programme Director, BSW Hospitals Group**
Appendices	**BSW Hospitals Group Partnership Agreement and Terms of Reference.**

1. Executive Summary of the Report

- In accordance with the Board of Directors' decision in September 2024 to form a Group, in January 2025 Trusts nominated non-executive and executive directors to join a working party to develop Terms of Reference for our BSW Hospitals Group Joint Committee. The working party has been supported by legal advisors Browne Jacobson, who have helped other groups across the NHS develop their governance arrangements. The team has completed a ***Partnership Agreement***, incorporating ***Terms of Reference for a Joint Committee***.

  The document was reviewed in private Boards in April. In response to those Board discussions a few updates have been made to text:

  - Provision for attendance of deputies has been included, in the event of absence of a member [refer s5.4].
  - The binding nature of decisions of the Joint Committee in relation to Joint Functions is clarified [refer s8.4]
  - Reference is included to duties introduced by the Health and Care Act 2022 on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. [refer s10.3]
  - In the event of the Joint Committee establishing a committee to oversee a tranche of work, that committee may include members who are not voting members of the Joint Committee [refer s17.3].
  - Finally, the cycle of business for the Joint Committee will include a review after six months of operation.

  The updated version of the *BSW Hospitals Group Partnership Agreement*, incorporating *Terms of Reference for a Joint Committee* is presented for Board consideration and approval.

2.	Recommendations (Approve)

In accordance with Board of Directors' decision in September 2024 to form a Group it recommended that the Board of Directors:

1) Approve the BSW Hospitals Group Partnership Agreement, agreeing
    1) Five Joint Functions - set out in Schedule 3 (Page 22)
    2) Terms of Reference of a special purpose Joint Committee – set out in Schedule 5 (Page 58)
2) Approve the execution of the Partnership Agreement by 9th May.
3) Request that the Chair and Chief Executive nominate members of the Joint Committee.
4) Establish the BSW Hospitals Group Joint Committee in May.

3.	Legal / Regulatory Implications

In policy terms the Partnership Agreement and Joint Committee, are designed to support delivery of greater collaboration between providers, enabling delivery of benefits of working at scale in service of BSW population.

The Partnership Agreement and Joint Committee TORs have been drafted with support of legal advisors Browne Jacobson. The documents are based on model content. The Trusts have developed the Partnership Agreement for the purpose of collaborating as a Group including exercising their powers under s65Z5 and s65Z6 of the NHS Act (2022) to agree and establish joint working and delegation arrangements.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The Partnership Agreement and Terms of Reference are designed to support the Trust and Group to address risks associated with service delivery, performance and financial sustainability, through collaborative activities.

5.	Resources Implications (Financial / staffing)

The Partnership Agreement and Terms of Reference are designed to support delivery of benefits identified in the 2024 Case for Collaboration.

6.	Equality and Diversity

An Equality and Health Inequalities Assessment in relation to BSW Hospitals Group Development Programme was completed in July and August 2024.

7.	References to previous reports/Next steps

This report addresses one of the recommendations approved by the Board of Directors in September 2024, to establish a Group Joint Committee. The previous draft of the *Partnership Agreement and Terms of Reference* was considered by the Board of Directors in April 2025.

Next steps

- 1-8th May. SFT, RUH and GWH Board review and consideration of recommendations.
- Nomination by Trust Chairs and Chief Executive of Members of the Joint Committee.
- 9th May. Signing / Execution of Partnership Agreement
- 23rd May. First meeting of Joint Committee.

8.	Freedom of Information

The report is Public.

Date **2025**

Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Partnership Agreement

for the purpose of establishing Hospital Group Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions

DRAFT

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
23 Feb 2025	001B	BSW Programme Team updates
17 Mar 2025	002	Working party updates from 3 March meeting and marked up copies of version 001B
20 Mar 2025	003	Browne Jacobson LLP
26 Mar 2025	004	Feedback incorporated from Board Members re membership, quorum and decision-making.
27 Mar 2025	005	Working party updates from 27 March included: Draft for Board consideration.
14 Apr 2025	006	Updated following review by all three Trust Boards.

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This Agreement is made between the Parties on

PART A – PARTIES

The Parties to this Agreement are

(1) Great Western Hospitals NHS Foundation Trust of Marlborough Road, Swindon, SN36BB (**GWH**)
(2) Royal United Hospitals Bath NHS Foundation Trust of Combe Park, Bath, BA1 3NG (**RUH**) and
(3) Salisbury NHS Foundation Trust of Salisbury District Hospital, Odstock Road, Salisbury, Wiltshire, SP2 8BJ (**SFT**)

Each a Trust and together the Trusts

PART B – BACKGROUND

A. The Background to this Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1

B. GWH is constituted as an NHSFT in accordance with its constitution dated November 2023

C. RUH is constituted as an NHSFT in accordance with its constitution dated 2022

D. SFT is constituted as an NHSFT in accordance with its constitution dated January 2023

E. Each Trust must exercise its Functions in accordance with its respective Governance and having regard to Guidance.

F. The Trusts have worked together collaboratively since 2018 as the Acute Hospital Alliance (AHA) in Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS). The Trusts have formalised this relationship through Committees in Common made up of the Chief Executive, Managing Directors and Chairs.

G. In May / June 2024 the Boards received the Case for Collaboration report which set out recommendations for the collaborative leadership, governance, and development of the Trusts as a group. In July and September 2024 the Boards formally approved eight recommendations developed in light of the Case for Collaboration report.

H. In October 2024 the Trusts implemented recommendation 1 by appointing Cara Charles-Barks as Joint Chief Executive.

I. The Trusts now wish to work together to deliver high quality care to our population more effectively and efficiently. In a climate with increasing financial constraints and demand, a group structure is seen as an appropriate way to do that and future initiatives will include, but are not limited to, the remaining recommendations set out in Schedule 9.

J. Accordingly, the Trusts intend to exercise their powers under sections 65Z5 and 65Z6 of the NHSA to establish and implement joint working and delegation arrangements as set out in this Agreement and to establish a joint committee to exercise Joint Functions.

K. The Trusts accordingly intend that the arrangements set out in this Agreement will supersede and replace their current committees in common arrangements.

L. The Trusts intend to agree to data sharing, access to records and mutual operation of all Joint Functions including human resources and joint line management arrangements to facilitate the exercise of Joint Functions.

M. The Trusts have agreed that the BSW Hospitals Group Joint Committee should exercise Joint Functions but not Reserved Functions.

PART C – OPERATIVE PROVISIONS

1 Definitions and interpretation

This Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1.

2 Purpose of this Agreement

The Trusts have entered this Agreement for the purpose of collaborating as a Group including exercising their powers under s65Z5 and s65Z6 of the NHSA to agree and establish joint working and delegation arrangements.

3 **Creating an Environment for Success**

3.1 The Trusts will:

3.1.1 Work as a Group with pace and agility.

3.1.2 Work collectively to enable provision of seamless services to the population, prioritising resources to provide maximum healthcare benefit, ensuring that patient experience and outcomes are reflected in discussions and decisions.

3.1.3 Communicate frequently, comprehensively and with transparency using multiple channels to reach all patients, staff and partners. Staff will be enabled to relay in clear and simple terms why the group matters to patients and staff.

3.1.4 Actively seek to build trust between themselves and all partners.

3.1.5 Adopt the principle of doing together once what can beneficially be done as a group, allowing the Trusts to deliver that which can only be done locally.

3.1.6 Share learning across the Group as a core behaviour.

3.1.7 Agree a timely definition of the Operating Model which provides clarity and certainty and, once agreed, provide strong and consistent support.

3.1.8 Appoint a highest quality leadership team and provide them strong and consistent support to thrive.

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3.1.9 Empower the BSW Hospitals Group Joint Committee which will include the Joint Chief Executive, a Chief Nursing Officer, Chief Medical Officer, Chief Finance Officer, Chief People Officer, Chief Operating Officer, and Director of Estates and Facilities, Managing Director of each Trust, agreed joint Executive Director roles (Chief Strategy Officer and Chief Information and Technology Officer), Joint Chair and a majority of voting NEDs

3.1.10 Ensure the demands on capacity of Non-Executive Directors and Executive Directors are practical, so will review frequency, length and remit of Board committee meetings as the BSW Hospitals Group Joint Committee and other group-level fora emerge.

3.1.11 Establish an annual programme of work that provides focus, clear deliverables and quick wins.

3.1.12 Through the BSW Hospitals Group Joint Committee, be responsible for Group strategy development in accordance with the Group Strategy Framework.

4 Commencement and duration

4.1 The Agreement shall take effect from the Commencement Date and will continue in full force and effect until terminated in accordance with the terms of this Agreement and, in particular but without limitation, in accordance with Clause 19.

4.2 No termination of the Agreement by any of the Trusts shall take effect within the period of three years from the Joint Chair Commencement Date.

5 No merger, acquisition or dissolution

5.1 The Trusts shall remain independent, sovereign organisations constituted in accordance with the NHSA and their respective constitutions.

5.2 Nothing in this Agreement commits the Trusts or is intended to commit them to undertake or apply for merger, acquisition or dissolution or any other transaction whose outcome would be the establishment of a single organisation as successor to any of them.

5.3 Each of the Trusts shall continue at all times to maintain its own individual governance, registrations, licences, memberships, committees and other arrangements that it may be required to maintain or hold by Law, Direction or Guidance including:

5.3.1 Standing Orders, Standing Financial Instructions and Scheme of Delegation

5.3.2 CQC registration

5.3.3 NHS provider licence

5.3.4 ICO registration

5.3.5 NHSR Schemes membership

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5.3.6 Remuneration Committee

5.3.7 Audit Committee

5.3.8 Meetings that the Trusts' Boards must each hold in accordance with Schedule 7.

6 **Capacity and capability**

6.1 The Trusts shall together use their best endeavours to support their leadership capacity and capability:

6.1.1 To focus not on doing more but doing the things only the Trusts can do.

6.1.2 To work in partnership between the Trusts and with others – collaborating as inter-dependent parts of the BSW Hospitals Group and BSW Integrated Care System.

6.1.3 To focus on what the Trusts can do to deliver improvements in the services they provide to the BSW population.

6.2 The Trusts shall together use their best endeavours to improve their leadership capacity and capability through:

6.2.1 The 'golden thread' of working together, learning together, improving together – cultural change.

6.2.2 Maximising the opportunity to transform and work differently that coming together as a Group gives them.

6.2.3 Listening to and delivering through front-line teams based on clear priorities, using an 'Improving Together' approach.

7 **Trust Board Appointments**

7.1 Voting NEDs of each Trust shall continue to be appointed by its CoG in accordance with its Constitution.

7.2 Voting EDs of each Trust shall continue to be appointed by its Remuneration Committee:

7.3 Each Trust shall (in compliance with its Constitution) continue to maintain a functioning Board comprising Voting NEDs (including the Chair) and Voting EDs whose numbers will be neither less nor more than the number of Voting NEDs and Voting EDs prescribed by its Constitution.

7.4 For the purpose of developing Group Operating Model and Governance arrangements the Trusts including their Councils of Governors shall cooperate to appoint Joint Directors where the BSW Hospitals Group Joint Committee recommends that they should do so.

8 **Appointment of Joint Committee**

8.1 The Trusts shall establish a special purpose Joint Committee to be known as the BSW Hospitals Group Joint Committee.

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8.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust.

8.3 The BSW Hospitals Group Joint Committee membership (including the number of members, and balance between EDs and NEDs) shall be agreed by each Trust.

8.4 The BSW Hospitals Group Joint Committee ToR shall be substantially in the form set out in Schedule 5 and shall include the provisions set out in Clause 8.5.

8.5 The provisions referred to in Clause 8.4 are:

8.5.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members of the BSW Hospitals Group Joint Committee during their terms of office

8.5.2 The Trusts may agree in writing to appoint Non-Voting Directors and/or other individuals to be voting members of the BSW Hospitals Group Joint Committee

8.5.3 The Trusts and BSW Hospitals Group Joint Committee shall have Committees in accordance with Clause 12

8.5.4 The BSW Hospitals Group Joint Committee shall exercise the Joint Functions

8.5.5 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the BSW Hospitals Group Joint Committee.

9 Joint Exercise of Functions

9.1 Subject to Clause 9.2 the Trusts agree that:

9.1.1 They shall jointly exercise their Joint Functions

9.1.2 If the BSW Hospitals Group Joint Committee appoints a Committee in accordance with Clause 12, then the BSW Hospitals Group Joint Committee may authorise the Committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the Committee in its ToR.

9.1.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or the Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

9.2 Subject to Clause 8.5.5, the Trusts agree that they, the BSW Hospitals Group Joint Committee and their Committees, directors and officers shall always comply with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising Joint Functions.

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10 **Workforce**

10.1 Each Trust shall continue to employ its own workforces

10.2 The Trusts intend that in the exercise of their joint working arrangements, members of one Trust's workforce may be line managed by duly authorised officers of one or more of the Trusts.

11 **Exercise of Reserved Functions**

11.1 The Trusts shall continue to exercise separately their Reserved Functions.

11.2 The Trusts agree that the BSW Hospitals Group Joint Committee shall not at any time exercise their Reserved Functions.

12 **Appointment of Committees and Committees in Common**

12.1 The BSW Hospitals Group Joint Committee shall have the following Committees (sub-committees to the Joint Committee):

- Electronic Patient Record (EPR) Committee
- Financial Sustainability Committee
- Group Development, Strategy & Planning Committee

12.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more Committees additional to those set out in Clause 12.1.

12.3 The voting members of a Committee of the BSW Hospitals Group Joint Committee may comprise or include individuals who are or are not voting members of the BSW Hospitals Group Joint Committee.

12.4 For the purpose of assisting the exercise of their Mandatory Reserved Functions the Trusts may appoint Committees in Common.

12.5 Without prejudice to the generality of Clause 12.4, the Boards of each of the Trusts (acting as independent, sovereign bodies) may consider and (if agreed by each Board) arrange for their like for like committees to operate together as Committees in Common.

12.6 For illustrative purposes an organogram of the Trusts' Committees structure as at the Commencement Date is set out in Schedule 6.

13 **Operating Principles**

13.1 The Trusts shall exercise their Functions having regard to best practice in effective collaborative and system leadership, adopting the operating principles set out in Clause 13.2, and further commitments set out in Clause 13.3.

13.2 The operating principles referred to in Clause 13.1 are:

13.2.1 Create value for the population

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13.2.2 Create constancy of purpose

13.2.3 Think systematically

13.2.4 Lead with humility

13.2.5 Respect every individual

13.3 In addition, the Trusts together commit to:

13.3.1 Develop a shared purpose and vision for the population we serve

13.3.2 Ensure frequent personal contact to build understanding and trust

13.3.3 Surface and resolve conflicts, not letting them fester

13.3.4 Work collectively for the long-term

13.3.5 Behave altruistically towards partners

13.3.6 An open book approach to information to build understanding and trust.

13.3.7 Be facilitative, enabling and pace setting in their role as System leaders.

14 Benefits

14.1 The Trusts shall exercise their Functions having regard to unlocking benefits set out in Clause 14.2. The benefits of group formation and approach to measurement and evaluation of those benefits will be set out in detail in **BSW Hospitals Group Business Case** and **Return on Investment plan**, which will be developed alongside the **Group Operating Model** and **Governance and Accountability Framework**.

14.2 The benefits referred to in Clause 14.1 are:

14.2.1 Together we will make the best use of collective resources available to us to support the population we serve. Our decisions will be judged by their ability to make best use of resources for Group in BSW, working to deliver the BSW Integrated Care Partnership strategy.

14.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

14.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group for the BSW population. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts.

14.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers Trusts opportunity to remain as stand-alone local organisations focused on needs of population within the support structure of a group.

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14.2.5 A group model offers a range of benefits for staff, including increased service resilience, enhanced career development and specialization opportunities. It also offers the ability to work within a wider network of professionals, spreading learning, improving training and development provision, freeing-up capacity by reducing duplication.

15 **Organisational development**

The Trusts will develop and adopt a shared organisational development programme.

16 **Resourcing the BSW Hospitals Group Joint Committee**

The Trusts shall be jointly responsible for resourcing the BSW Hospitals Group Joint Committee.

17 **Pooled Fund**

17.1 The Trusts may enter arrangements for the Trusts themselves or the BSW Hospitals Group Joint Committee to establish and maintain a Pooled Fund.

17.2 Arrangements for any Pooled Fund must be on terms set out in a Pooled Fund Agreement.

18 **Variation**

18.1 Except as set out in Clause 18.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of each Trust's Board.

18.2 The Scheme for Trust Board Appointments set out in Schedule 8, the Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date set out in Schedule 6 and the Recommendations set out in Schedule 9 are intended to be illustrative only and may be updated by resolution of the BSW Hospitals Group Joint Committee without the requirement for Variation set out in Clause 18.1.

19 **Termination**

19.1 The Trusts acknowledge and confirm that, save in accordance with this Clause 19, none of them shall be entitled to terminate this Agreement.

19.2 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach (whether material or otherwise) of any provision of this Agreement by the other.

19.3 The Trusts acknowledge and confirm that they have considered and understood the position set out at Clause 19.2 above and that the provisions of Clause 4.2 (and Clause 24 in relation to the Dispute Resolution Procedure) shall apply in the event of any breach of this Agreement.

19.4 Subject to Clause 4.2 , a Trust may only terminate this Agreement by giving Notice of Termination specifying a minimum notice period that expires on the next 31 March which is not less than six months before the third anniversary of

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the Joint Chair Commencement Date if it expires on the third anniversary of the Joint Chair Commencement Date or (if it expires on a date after the third anniversary of the Joint Chair Commencement Date) twelve (12) months from the date the notice of termination is served. The notice period may be shorter where agreed in writing by the other Trusts.

20 **Consequences of termination**

20.1 On or pending termination of this Agreement, the Trusts will agree an Exit Plan to ensure that the services provided by any Trust are not destabilised. The Trusts shall use best endeavours to agree the Exit Plan no less than six (6) months prior to termination of this Agreement

20.2 For a reasonable period before and after termination of this Agreement the Trusts shall co-operate fully with one another and ensure that the Exit Plan provides for continuity of services and a smooth transition of Trust Boards whilst avoiding any inconvenience or risk to the health and safety of the Trusts' service users, employees or members of the public.

20.3 This Clause 20 shall continue in full force and effect on or after termination of this Agreement.

21 **Data sharing and confidentiality**

Each Trust undertakes that it shall not at any time during the period for which this Agreement applies, and for a period of five years after termination of this Agreement, disclose to any person any Confidential Information concerning or in connection with the other Trust or this Agreement except as permitted by Schedule 7.

22 **No partnership**

Except as expressly provided in this Agreement, nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between the Trusts, constitute one Trust the agent of another Trust, nor authorise a Trust to make or enter any commitments for or on behalf of another Trust.

23 **Notices**

23.1 A notice given under this Agreement:

23.1.1 Will be in writing in the English language

23.1.2 Will be sent to the intended recipient by email to the following address or such other address as the Party has notified for the purposes of this clause:

(a) For GWH, the Chief Executive Officer of GWH in post at the time of the notice

(b) For RUH, the Chief Executive Officer of RUH in post at the time of the notice

(c) For SFT, the Chief Executive Officer of SFT in post at the time of the notice

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23.2 Any notice or other communication given to a Trust under or in connection with the Agreement shall be in writing, addressed to the authorised representatives at the Trust's principal place of business or such other address as that Trust may have specified to the other Trusts in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or email.

23.3 A notice or other communication shall be deemed to have been received:

23.3.1 If delivered personally, when left at the address referred to in Clause 23.2; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Business Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by fax, one (1) Business Day after transmission.

23.3.2 If delivered by email, immediately on sending provided it is correctly addressed or if deemed receipt is not within business hours (meaning prior to 5.30 pm and excluding weekends and public holidays in England), then it will be deemed to have been received at 9.00 am on the next day that is not a weekend or a public holiday in England.

23.4 The provisions of this Clause 23 shall not apply to the service of any proceedings or other documents in any legal action.

24 **Dispute Resolution**

24.1 In accordance with Clauses 4.2 and 19 regarding termination of the Agreement, the Trusts agree to this dispute resolution process.

24.2 In a case where it has not been possible or appropriate to seek to resolve any dispute informally, a Trust shall promptly serve on the other Trusts a Notice (a 'Dispute Notice') of any dispute or claim or any potential dispute or claim in relation to this Agreement or its operation (each a 'Dispute') when it arises.

24.3 A Dispute Notice must contain a particularised account of the Dispute and the resolution sought.

24.4 In the first instance the Chair(s) shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts.

24.5 If the Dispute cannot be resolved by the Chair(s) within ten (10) Working Days of the Dispute being referred to it, the Dispute shall be referred to the ICB Chair.

24.6 The ICB Chair will consider and reach a position on the Dispute which, in the view of the ICB Chair, is the most consistent with the principles set out in this Agreement.

24.7 If a Trust does not agree with the position reached by the ICB Chair, it may within ten (10) Working Days of receiving notice of the ICB Chair position, refer the Dispute to an independent facilitator.

24.8 Where it has not been possible or appropriate to seek to resolve any dispute informally, if the Trusts consider doing so appropriate before or instead of

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making a referral to the ICB under Clause 24.5, they may refer the Dispute to an independent facilitator.

24.9 If the Trusts are unable to agree on an independent facilitator or the terms of their appointment within seven (7) Working Days of any Trust serving details of a suggested independent facilitator on the others, any Trust shall then be entitled to request NHS England to appoint an appropriately experienced and reputable independent facilitator and for NHS England to agree with the terms of appointment.

24.10 The independent facilitator shall act on the following basis:

24.10.1 The independent facilitator shall decide the procedure to be followed in the determination and shall be requested to make their determination within thirty (30) Working Days of their appointment or as soon as reasonably practicable thereafter. The Trusts shall assist and provide the documentation that the independent facilitator requires for the purpose of the determination

24.10.2 The determination process shall be conducted in private and shall be confidential

24.10.3 The independent facilitator shall have its costs and disbursements met by the Trusts.

24.11 The Trusts recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Trust.

24.12 In the case of dispute between the Boards leading to consideration of termination, Clauses 3.2 and 3.3 determine the timescale and Clause 18 in respect of notification of termination.

25 **Other general provisions**

25.1 Each Trust shall (at its own expense) promptly execute and deliver such documents, perform such acts and do such things as the other Trust may reasonably require from time to time for the purpose of giving full effect to this Agreement.

25.2 Each Trust will bear its own costs of negotiating and entering into this Agreement.

25.3 This Agreement is personal to each of the Trusts who shall not assign, transfer, mortgage, charge, declare a trust of, or deal in any other manner with any of its rights and obligations under this Agreement without the prior written consent of the other Trusts.

25.4 This Agreement (together with the documents referred to in it) constitutes the entire agreement between the Trusts and supersedes and extinguishes all previous discussions, correspondence, negotiations, drafts, agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

25.5 No failure or delay by a Trust to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or

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remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy. A waiver of any right or remedy under this Agreement or by law is only effective if it is in writing.

25.6 Except as expressly provided in this Agreement, the rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

25.7 If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this Clause shall not affect the validity and enforceability of the rest of this Agreement.

25.8 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

25.9 No one other than a party to this Agreement shall have any right to enforce any of its terms.

25.10 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

25.11 Each Trust irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

The Trusts have executed this Agreement as set out below on the date stated at the beginning of it.

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PART D – SCHEDULES

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Schedule 1 – Definitions and Interpretation

1 In this Agreement capitalised words and expressions shall have the meanings given to them as follows:

Word or expression	**Meaning**
Agreement	This partnership agreement (including its Schedules) which sets out arrangements for the purpose the Trusts exercising their Functions jointly
Arrangements for delegation and joint exercise of statutory functions	NHS England Guidance *Arrangements for delegation and joint exercise of statutory functions – Guidance for integrated care boards, NHS trusts and foundation trusts* dated 27 March 2023 (Publication approval reference: PRN00346)
Audit Committee	A Committee that each of the Trusts must appoint in accordance with NHS England's *Code of governance for NHS provider trusts* (2022) to ensure that it operates effectively and meets its statutory and strategic objectives, and to provide it with assurance that this is the case
CEO	A Voting ED who is the Chief Executive Officer of one or more of the Trusts
Chair	A Voting NED who is the Chair of one or more of the Trusts
Commencement Date	[DATE]
Committee	A committee or subcommittee of one of the Trusts or a subcommittee of a joint committee (including the BSW Hospitals Group Joint Committee)
CiC or Committees in Common	Arrangements between the Trusts to appoint like for like Committees with the same or equivalent terms of reference and

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Word or expression	Meaning
	memberships so that they may meet simultaneously with shared agenda and minutes
Conditions for Success	the conditions for success set out in Clause 3
CoG	Council of Governors
CQC	Care Quality Commission
Constitution	The constitution of an NHSFT that has been approved by its Board of Directors and CoG and is in force at the relevant time of their respective decision-making and exercise of functions
Direction	A direction to a Trust that the Secretary of State or NHS England may issue in the exercise of their respective functions under Legislation
Director	A NED or an ED of one or more of the Trusts
ED or Executive Director	an executive director who may be Voting ED or a Non-Voting ED
Exit Plan	A plan for the transition of any affected services and required changes to the Trust Boards on the termination of this Agreement to include: (i) details of the affected services; (ii) details of service users and/or user groups affected; (iii) the joint working arrangements and jointly exercised functions that will need to continue to ensure continuity of services and how these will be transitioned into separate arrangements for each Trust; (iv) the intended timescales for the Exit Plan
Functions	All the duties and/or powers of the Trusts under the NHSA or their constitutions or any other legislation or otherwise conferred by any other source whatsoever

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Word or expression	**Meaning**
Governance	A Trust's Constitution, Standing Orders and Schedule 7
Group	The Trusts jointly working together as a hospitals' group in accordance with this Agreement
Group Strategy Framework	The group strategy framework set out in Schedule 2
Guidance	Any statutory guidance of the Secretary of State or NHS England to NHS bodies comprising or including NHS trusts (for example *Arrangements for delegation and joint exercise of statutory functions*) or other non-statutory guidance that the Trusts must have regard to in accordance with their NHS provider licence
Joint Chair Commencement Date	The date of commencement in post of the Joint Chair
Joint Committee	A joint committee that the Trusts have agreed to establish under section 65Z6 of the NHSA to exercise Joint Functions in accordance with the BSW Hospitals Group Joint Committee ToR
Joint Committee ToR	ToR of the BSW Hospitals Group Joint Committee
Joint Functions	Any Functions which the Trusts agree are jointly exercisable by them in accordance with Schedule 3
Legislation	An Act of Parliament (for example the NHSA) or statutory instrument (for example the NHSM&P Regulations)
Mandatory Reserved Functions	Any Reserved Functions that the Trusts may not delegate and/or exercise jointly under Legislation or Guidance

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Word or expression	Meaning
NED or Non-Executive Director	A non-executive director who may be Voting NED or a Non-Voting NED
NHSA	National Health Service Act 2006
NHSFT	NHS foundation trust within the meaning of section 30 of the NHSA
NHSR Schemes	The indemnity schemes known as the Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and Property Expenses which the Secretary of State has established under the NHSA and which are managed on her behalf by NHS Resolution
Non-Voting ED	An Executive Director who is not a Voting Director
Non-Voting NED	A Non-Executive Director who is not a Voting Director
Notice of Termination	Notice in writing from one Trust to the other Trust to terminate this Agreement in accordance with Clause 19
Pooled Fund	A fund to be made up of payments received in accordance with arrangements between the Trusts that must be set out in a Pooled Fund Agreement and out of which payments may be made in accordance with the arrangements towards expenditure incurred in the exercise of Joint Functions
Pooled Fund Agreement	An agreement in writing between the Trusts for the establishment of a Pooled Fund in accordance with section 65Z6 of the NHSA
Remuneration Committee	A Committee that each Trust must appoint whose responsibilities include functions under paragraphs 17(3), 17(4) and 18(2) of Schedule 7:

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Word or expression	Meaning
	• (The CEO not being a member of it) to appoint the Trust's CEO and to determine the remuneration and terms of service of the CEO and other executive directors and • (The CEO being a member of it) to appoint the other executive directors
Reserved Functions	Any Functions that are not Joint Functions
Schedule 7	Schedule 7 of the NHSA unless it is intended to refer to Schedule 7 of this Agreement
Secretary of State	Secretary of State for Health and Social Care
Standing Orders	The standing orders of each of the Trust's board of directors and/or the standing orders of its CoG that the Trust is required to adopt by its Constitution for the regulation of their proceedings and business
ToR	Terms of reference
UK GDPR	Has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.
Variation	A variation of this Agreement in accordance with Clause 18
Voting Director	A Voting ED or a Voting NED
Voting ED	A Director who is an executive director of one of the Trusts within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NEDs and (except for the CEO's appointment) the CEO in accordance with the NHSFT's Constitution

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Word or expression	Meaning
Voting NED	A Director who is a non-executive director of one of the Trusts within the meaning of paragraph 16 of Schedule 7 and has been appointed by the Trust's CoG in accordance with its Constitution
Working Day	A day (other than a Saturday, Sunday or public holiday) when banks in London are open for business.

2 Any reference to the exercise by the Trusts of Joint Functions shall be interpreted to include any exercise of Joint Functions by the BSW Hospitals Group Joint Committee or a Committee of it on behalf of the Trusts.

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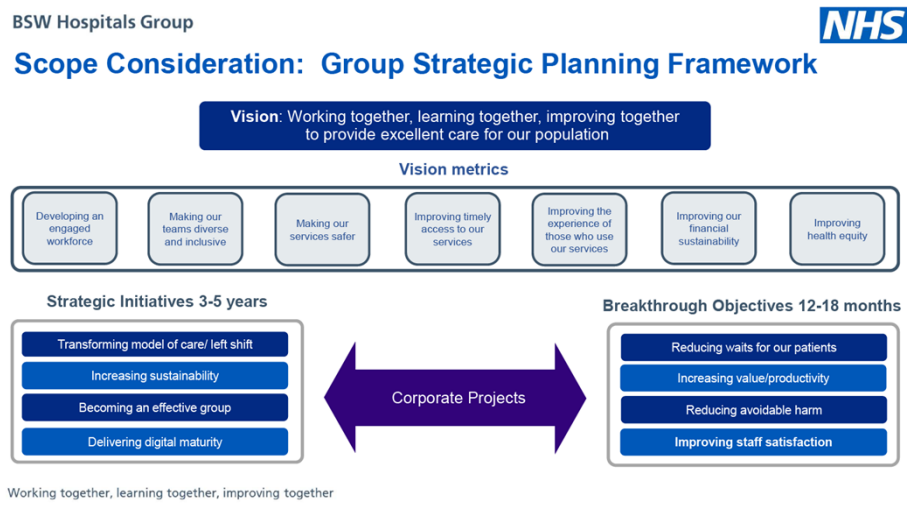
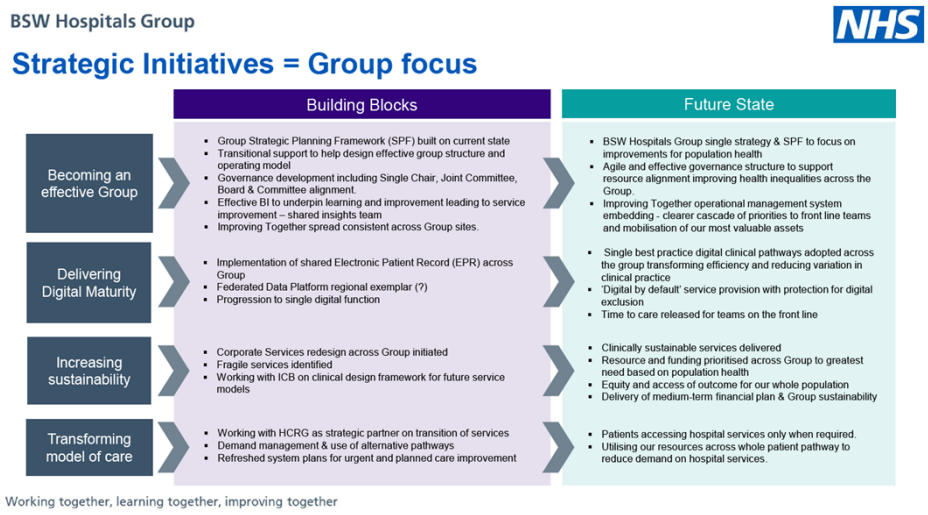
Schedule 2 Group Strategy Framework

Part 1 - Strategic Planning Framework



Part 2 – Group Focus



Part 3 – Trust Focus

BSW Hospitals Group

NHS

Breakthrough objectives = Trust focus

	Building Blocks	Future State
Reducing waits for our patients	▪ 5% increase RTT performance through focus on theatre productivity, outpatient efficiency and GIRFT opportunities at individual sites. ▪ BSW single waiting list to identify opportunities for collaboration and reduced IS usage. ▪ Urgent care improvements including Ambulance handover times and ED overcrowding, NCTR.	▪ Increase in planned care undertaken by the NHS. ▪ Maximisation of planned care capacity across the group. ▪ Aligned bed capacity to demand to optimise occupancy and flow.
Increasing productivity	▪ Increased Trust productivity depending on local opportunity: ▪ Planned – improvement in: theatre utilisation, outpatients' diagnostics, using additional intelligence of FDP. Opportunities relevant to site. ▪ Urgent care: SDEC, Frailty pathways, NCTR process improvements, out of hospital pathways. ▪ Maximise CDC assets across Group for faster diagnostics.	▪ More patients seen and treated through existing resources through reduced unwarranted variation. ▪ Proactive sharing of best practice and learning across the group maximising the learning e.g. GWH Theatres.
Reducing avoidable harm	▪ Top contributor at site specific to reducing harm – e.g. pressure ulcers, falls, deteriorating patient. ▪ Breakthrough aligned at Trust site to teams to enable front line mobilisation and contribution.	▪ Proactive sharing of best practice and learning across the group maximising the learning e.g. RUH Maternity.
Improving staff satisfaction	▪ Focus on staff survey outcomes and top contributors at each Trust.	▪ Group development opportunities – leadership training. ▪ Values driven organisations.

Working together, learning together, improving together

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Schedule 3 – Joint Functions

1 Subject to paragraph 2:

1.1 Joint Functions are any Functions relating to any of the matters set out in paragraph 3 below.

1.2 Joint Functions may additionally include any or all Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 4 below (excluding references to legislation that is applicable to or in force in Wales only) which the Trusts agree by Variation should be Joint Functions.

2 Joint Functions may not at any time include Mandatory Reserved Functions.

3 The matters referred to in paragraph 1.1 are:

3.1 Group Strategy & Planning Framework

- Development, approval and delivery of overarching Group Strategy and associated specialist development and delivery plans, including Group Clinical, Workforce, Financial Sustainability, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital Plans.
- Development, approval and delivery of Group Strategic Planning Framework and Annual Group-wide Plan.
- Oversight of delivery of Group Strategic Initiatives.
- Management of risk to delivery of Group Strategy

3.2 Transforming our Model of Care for the BSW Population we Serve - Clinical Services Organisation/ Pathways/ Design

- Development of Group **clinical services framework for the collective population we serve** with associated decision-making processes.
- **Approval** of service/pathway/treatment configuration changes across the Group.

3.3 Financial Sustainability - Use of Resources

- Setting and delivery of Group Financial Recovery and long-term Group financial sustainability.
- Capital Programme. Development and approval of capital investment programme for the Group ensuring we attract capital into BSW to address priorities.
- Capital Programme. Development and approval of capital limits for each Trust within the group to be delegated.

3.4 Group Mobilisation & Development

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- Oversight of Group Mobilisation & Development. Approval of Group Operating Model, including Accountability Framework and associated Integrated Performance Reporting.
- Oversight of delivery of the Case for Collaboration and emerging agreed priorities. Includes programme oversight of 10x workstreams from case for collaboration – with details, phasing and resourcing agreed in Group annual plan.
- Group Development - Corporate Services – Define objectives, shape and structure of Group corporate services transformation. Approve resourcing of programme.

3.5 Achieving Digital Maturity

- EPR Programme – Oversight of Implementation. Approval of new Benefits Profile. Approval of proposals for new Budget.
- Group Digital transformation programme – implementation [x-refer 3.1]

4 The table referred to in paragraph 1.2 is as follows:

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation 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) An NHS foundation trust may also carry on activities other than those mentioned in subsection (2) for the purpose of making additional income available in order better to carry on its principal purpose.	ANCILLARY FUNCTION	Yes
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.	COMMISSIONING	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) "The purposes of the NHS foundation trust" means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).	ANCILLARY FUNCTION	Yes
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust	CORPORATE	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	established under section 25, to the regulator for the dissolution of the trusts and the establishment of a new NHS foundation trust. (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust, and (d) be accompanied by a copy of the proposed constitution of the new trust (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken. (11) On the grant of the application, the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.		
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B.	CORPORATE	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken. (4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.		
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England;	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.		
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section "relevant body" means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.	CORPORATE	Yes
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B);	CORPORATE	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.		
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.	ANCILLARY FUNCTION	Yes
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements for the purpose of assessing and managing risks posed by relevant sexual	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	and violent offenders &c, the responsible authority i.e. the chief officer of police, the local probation board for that area or (if there is no local probation board for that area) a relevant provider of probation services and the Minister of the Crown exercising functions in relation to prisons, acting jointly must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by those persons of their relevant functions. NHS trusts are included among persons in sub-s (6)(h).		
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act i.e. relating to provision of care and support services and services designed to promote well-being and independence; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.		
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or (b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.	ANCILLARY FUNCTION	Yes
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State are— (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies which includes NHS Trusts by ss(1) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.		
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners which includes NHS Trusts by ss(4)(e); and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) not reproduced here are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	must co-operate with the authority in the making of arrangements under this section.		
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund as defined by ss(7).	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 see lines above applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c) must make arrangements for ensuring that–	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.		
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation which includes NHS trusts by s13 that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations which includes NHS Trusts by s13 must have regard to guidance published by the SoS by ss(1) under this section.	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code on additional learning needs issued by the Welsh Ministers by ss(1)]— (h) an NHS trust;	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body which includes an NHS Trust by s99(1) under this section, the NHS body must consider whether there is a relevant treatment or service as defined by ss(6) that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.	COMMISSIONING	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) which includes an NHS Trust, in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs. (3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.	REGULATORY	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part.	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. ss(4) specifies the contents of the report.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body i.e. the Welsh Ministers and SCW, by s176(1) must, in the exercise of its relevant functions, seek to co-operate with a relevant authority which includes, by s177(1)(e) an NHS Trust if the regulatory body thinks such co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or (c) thinks that such co-operation would have an adverse effect on its functions.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	action. "Public bodies", by section 6, includes NHS Trusts.		
Counter-terrorism and Security Act 2016, s26	(1) A specified authority which includes, by Schedule 6, and NHS Trust must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners which include NHS Trusts by Schedule 7 of a panel i.e. a panel established by a LA by s36 must, so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police and local authorities in the carrying out of their functions in connection with section 36.	CORPORATE	Yes
Counter-terrorism and Security Act 2016, s38	By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act i.e. the public sector equality duty of the Equality Act 2010. See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of continues as to charges to be made in respect of particular items See further reg 6 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of continues as to charges to be made in respect of particular items See further reg 7 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if— (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision	COMMISSIONING	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.		
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) a charge for such amount for glasses and contact lenses as determined by the SoS, the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. See further reg 10(2) for requirements on issuing a voucher	COMMISSIONING	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area, and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and	ANCILLARY FUNCTION	Yes

DRAFT

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).		
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance, provide that local authority with information about the care and support it provides in the local authority's area.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales— (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of	ANCILLARY FUNCTION	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer as defined by ss(4) of the responsible authority as defined by ss(3)— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.		
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) which includes an NHS Trust to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. Subject to ss(3) which provides that a person is not required to provide documents, records or other	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	information under subsection (1) if the person is prohibited from providing them by any enactment or other rule of law.		
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements with a view to promoting the matters specified in ss(3) to promote co-operation between— (a) the local authority, (b) each of the authority's relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority's area with needs for care and support, or (ii) adults within the authority's area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources;	COMMISSIONING	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) establish and maintain a pooled fund defined at ss(7); (c) share information with each other.		
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority must, in exercising their functions under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes an NHS Trust in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes an NHS Trust provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions.	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) includes an NHS Trust must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes NHS Trusts in the exercise of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes NHS Trusts provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would—	REGULATORY	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible, and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part— (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a	ANCILLARY FUNCTIONS	Yes

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	request under subsection (1) must give the authority that made the request written reasons for the decision.		
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) including at ss(1)(l) NHS Trusts must have regard to the Code of Practice issued by the SoS pursuant to ss(1) in exercising their functions under this Part.	ANCILLARY FUNCTIONS	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

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Schedule 4 Mandatory Reserved Functions

1 Mandatory Reserved Functions are any Functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are Functions that NHS England has categorised as not 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in paragraph 2 below.

2 The table referred to in paragraph 1 is as follows:

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Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) 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 corporation must take such steps as are necessary as a result.	CORPORATE	**No**
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	**No**
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	**No**

Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	**No**
Section 43 NHS Act 2006	(3D) An NHS foundation trust which 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 the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	**No**
Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	**No**
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	**No**
Section 51A NHS Act 2006	(1) An NHS foundation trust may enter into 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. (2) "Significant transaction" means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	**No**

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Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	**No**
Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	**No**
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	**No**
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	**No**
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a) to establish, or to participate in, a domestic homicide review as defined by ss(1).	ANCILLARY FUNCTION	**No**

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Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	**No**
Policing and Crime Act 2017, s1	(1) A collaboration agreement as defined by ss(3) may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. See further sections 3 and 4 regarding collaboration agreements	CORPORATE	**No**
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	**No**
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	**No**
Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.	CORPORATE	**No**

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Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. See further regs 5(2) onwards and reg 6 for requirements as to publication.	CORPORATE	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	**No**
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	**No**

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Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	**No**
Mental Health Act 1983	Refers to entire Act.	REGULATORY	**No**
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	**No**
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	**No**
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	**No**

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Schedule 5 BSW Hospitals Group Joint Committee ToR

Terms of Reference for a special purpose joint committee (the BSW Hospitals Group Joint Committee) between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
27 Mar 2025	002	Browne Jacobson LLP
14 Apr 2025	003	Browne Jacobson LLP

1 Introduction

1.1 The BSW Hospitals Group Joint Committee is a statutory joint committee of the boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury Hospital NHS Foundation Trust (the Trusts) who have established it under section 65Z6 of the National Health Service Act 2006 to exercise Joint Functions in accordance with the Partnership Agreement entered into by the Trusts dated [DN: INSERT DATE] (the Partnership Agreement).

1.2 As set out in the Partnership Agreement, the BSW Hospitals Group Joint Committee will oversee the plan for closer collaboration, the subsequent delivery programme, and development of the proposed Group model. The shared narrative for the Group is as follows:

1.2.1 Together we will make the best use of collective resources available to us. Our decisions will be judged by their ability to make best use of resources for the population in BSW.

1.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

1.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts, including with our Place-based, network and tertiary partners.

1.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers real opportunity to remain as stand-alone local organisation focused on needs of population within the support structure of a group.

1.2.5 Risk: We will develop collective approach to risk and address differences between local and group risk appetite when they emerge.

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1.3 In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trust Boards have agreed are Joint Functions in accordance with the Partnership Agreement.

2 Authority & Accountabilities

2.1 The BSW Hospitals Group Joint Committee is authorised by the Boards to exercise the Joint Functions.

2.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust Board for the exercise of the Joint Functions and shall at all times comply with the Partnership Agreement and NHS England guidance when exercising Joint Functions.

2.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or each Trust jointly and severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.4 The BSW Hospitals Group Joint Committee is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The BSW Hospitals Group Joint Committee shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of the Public Services.

3 Reporting Arrangements

3.1 The minutes of Joint Committee meetings shall be formally recorded and submitted to each Trust's Board.

3.2 The BSW Hospitals Group Joint Committee shall provide regular update reports to each Trust's Board on the activities of the BSW Hospitals Group Joint Committee in accordance with a single reporting schedule agreed by the Trust Boards.

4 Membership

4.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members (Members) of the BSW Hospitals Group Joint Committee during their terms of office.

4.2 Each Trust shall appoint the following Members, who may be Voting Director or Non-Voting Directors:

4.2.1 Chair, Vice Chair and three other Voting NEDs nominated in writing by the Trust's Chair

4.2.2 Chief Executive Officer, Managing Director and two other EDs nominated in writing by the Trust's Chair and Chief Executive Officer.

4.2.3 All joint Executive Director roles created by the Trusts.

4.3 The Trusts shall ensure that in appointing the EDs in accordance with paragraph 4.2.2 the membership of the BSW Hospitals Group Joint Committee shall include a Chief Nursing Officer, a Chief Medical Officer, a Chief Finance Officer, a Chief People Officer, a Chief Operating Officer, and a Director of Estates and Facilities. The role of these EDs shall be to bring their portfolio expertise to the decisions of the BSW Hospitals Group Joint Committee in the interests of the Group.

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4.4 It is acknowledged that the role of the Members shall be to make decisions in the interests of the Group rather than to represent the views of their individual Trusts.

Commented [RH1]: Browne Jacobson comment: I have suggested separating this provision out so that it is a standalone provision that applies to all members of the Joint Committee rather than just the EDs.

4.5 The Trusts may agree in writing to vary these Terms of Reference to amend the number of Members of the BSW Hospitals Group Joint Committee provided that:

4.5.1 Each Trust appoints the same number of Members

4.5.2 The Chair and Chief Executive Officer are Members

4.5.3 The Chair and other Voting NED Members outnumber the ED Members.

4.6 Additionally, the Trusts may agree in writing to vary these Terms of Reference to permit them to appoint Non-Voting Directors of the Trusts to be Members of the BSW Hospitals Group Joint Committee.

4.7 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a Member.

4.8 A Member's initial term of appointment to the BSW Hospitals Group Joint Committee shall be up to three years, or the end of their term of appointment as a Director of a Trust, whichever is the earlier. A Member's may be reappointed by their Trust in accordance with paragraph 4.2 for further terms.

5 Attendance

5.1 The Trust Secretary of one of the Trusts will attend as required to ensure that the BSW Hospitals Group Joint Committee business is transacted as per this Terms of Reference, the Partnership Agreement, the Trusts' Standing Orders and documents referred to in them.

5.2 With the consent of the BSW Hospitals Group Joint Committee Chair, other persons may be invited to attend and contribute to meetings of the BSW Hospitals Group Joint Committee but not take part in making decisions.

5.3 In line with the Trusts' Standing Orders, Members must attend at least half the BSW Hospitals Group Joint Committee's meetings annually. Any failure of a Member to meet this attendance requirement shall be considered as part of that individual's Annual Review and Appraisal process.

5.4 Subject to paragraph 5.3 and the prior agreement of the Chair, each Trust may nominate a deputy to attend a meeting of the BSW Hospitals Group Joint Committee in the event of a Member's absence. For Members appointed under paragraph 4.2.1 the deputy shall be a Voting NED nominated by the Chair of the relevant Trust. For Members appointed under paragraph 4.2.2 the deputy shall be an ED or senior director nominated by the Chair and Chief Executive of the relevant Trust. For Members appointed under paragraph 4.2.3 the deputy shall be an ED or senior director nominated by the Chief Executive. A deputy shall be formally nominated with the same rights and privileges as the Member for whom they are deputising.

6 Chair

6.1 The Joint Chair of the Trusts, if present, shall preside at any meeting of the BSW Hospitals Group Joint Committee or, if the Joint Chair is absent, the Deputy Chair of the BSW Hospitals Group Joint Committee shall preside. If the Deputy Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Deputy Chair.

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6.2 Pending the appointment of a Joint Chair of the Trusts, the current Chairs of the Trusts shall agree between them who shall chair meetings of the BSW Hospitals Group Joint Committee (where possible rotating between them) and any reference in these terms of reference to 'Joint Chair' shall (where the context requires) be construed as the Trust Chair who presides at a meeting.

7 Quorum

7.1 No business shall be transacted at a meeting of the BSW Hospitals Group Joint Committee unless:

7.1.1 At least half the Members of the BSW Hospitals Group Joint Committee are present

7.1.2 At least half of the Members present are Voting NEDs

7.1.3 The Members present include (in addition to the Joint Chair) at least two EDs of each of the Trusts (who in the case of a joint director may be the same person) and at least two Voting NEDs of each of the Trusts (who in the case of a joint director may be the same person).

8 Decision making

8.1 The BSW Hospitals Group Joint Committee will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all Members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst Members.

8.2 If the BSW Hospitals Group Joint Committee is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

8.2.1 A special majority of not less than two thirds of the Members present and voting are in favour, and

8.2.2 The Members in favour include more than half of the Members from each Trust.

8.3 Each Member of the BSW Hospitals Group Joint Committee shall have one vote except in the event that prior to the appointment of the Joint Chair an individual is appointed as the Chair of two of the Trusts but not the other, in which case they shall be treated as if they were separate individuals and entitled to cast a vote on behalf of each Trust to which they are appointed.

8.4 The decisions of the BSW Hospitals Group Joint Committee (which for the avoidance of doubt extend only to decisions in respect of the Joint Functions) are binding on each of the Trusts.

9 Admission of the public to meetings

9.1 Meetings of the BSW Hospitals Group Joint Committee shall be held in in private.

9.2 But the BSW Hospitals Group Joint Committee may, by resolution, permit the public to attend a meeting to observe (whether during the whole or part of the proceedings).

10 Managing Conflicts of Interest

10.1 Each Member of the BSW Hospitals Group Joint Committee must abide by all policies of the Trust of which she or he is a director or officer in relation to conflicts of interest.

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10.2 At the first meeting of the BSW Hospitals Group Joint Committee, the BSW Hospitals Group Joint Committee will select a chair ("Joint Committee Chair") from amongst the members who are Trust Chairs. A Deputy-Chair will also be selected. Once a joint chair for the Trusts is appointed, he or she shall become the BSW Hospitals Group Joint Committee Chair and the incumbent Joint Committee Chair (if not the joint chair) shall immediately hand over.

10.3 The Trusts acknowledge that sections 63A and 223L to 223N of the NHSA (as introduced by the Health and Care Act 2022) impose duties on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. In the light of these duties, there should be few occasions where the interests of the Trusts are not aligned and directors of each Trust must have regard to the wider impact of their decisions on the other Trusts and seek to cooperate with the other Trusts in exercising their functions.

11 Administrative Support

The Chief Executive Officer shall nominate a Trust Secretary to arrange provision of administrative support to the BSW Hospitals Group Joint Committee.

12 Annual Workplan

The BSW Hospitals Group Joint Committee will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.

13 Frequency of Meetings

13.1 Ordinary meetings of the BSW Hospitals Group Joint Committee shall be held not less than six times a year and shall be coordinated with the cycle of Board meeting of the Trusts.

13.2 Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

13.3 Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

14 Papers Publication

All papers will be published using the available electronic Board paper system. Publication of papers will be seven working days before meetings. A progress report of outstanding/pending Joint Committee actions will be presented to each meeting of the BSW Hospitals Group Joint Committee.

15 Routines, Behaviours and Standards

15.1 The BSW Hospitals Group Joint Committee will implement the following routines and behaviours, in order to enable a safe, inclusive and trusting environment, where teams build and maintain effective relationships:

15.1.1 Develop a shared purpose and vision for the population we serve

15.1.2 Ensure frequent personal contact to build understanding and trust

15.1.3 Surface and resolve conflicts, not letting them fester

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15.1.4 Work collectively for the long-term

15.1.5 Behave altruistically towards partners

15.1.6 An open book approach to information to build understanding and trust.

15.1.7 Be facilitative, enabling and pace setting in their role as System leaders.

15.2 The BSW Hospitals Group Joint Committee shall comply with the following standards:

15.2.1 NHSE Code of Governance for NHS provider trusts

15.2.2 NHSE Risk Assessment Framework

15.2.3 NHSE Annual Planning Guidance

15.2.4 The Health NHS Board – Principles of Good Governance

15.2.5 Corporate Governance – Principles of Public Life (GP01)

15.2.6 King's Fund: The Practice of Collaborative Leadership: across health and care services

15.3 The BSW Hospitals Group Joint Committee shall work to the following principles:

15.3.1 Create value for the population

15.3.2 Create constancy of purpose

15.3.3 Think systematically

15.3.4 Lead with humility

15.3.5 Respect every individual

16 Standard Agenda

16.1 Agendas will be built around the BSW Hospitals Group Joint Committee annual workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year:

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Group Strategy

16.1.5 Performance, Transformation and Benefits Realisation

16.1.6 Reports of committees of the BSW Hospitals Group Joint Committee

16.1.7 Self-assessment of the BSW Hospitals Group Joint Committee's effectiveness

16.1.8 Review of the BSW Joint Hospitals Group Committee's terms of reference

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16.1.9 Regular reports to the Trust Boards

16.1.10 Other items as per agreed cycle of business

17 Committees

17.1 The BSW Hospitals Group Joint Committee shall have the following committees (sub-committees to the Joint Committee):

17.1.1 The EPR Committee

17.1.2 Financial Sustainability

17.1.3 Group Development, Strategy & Planning

17.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more additional committees.

17.3 The voting members of a committee of the BSW Hospitals Group Joint Committee may may comprise or include individuals who are or are not voting Members of the BSW Hospitals Group Joint Committee.

17.4 The BSW Hospitals Group Joint Committee may authorise a committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the committee in its ToR.

18 Amendment

These terms of reference may only be amended by variation agreed by resolution of each of the Trust Boards save that the Chair and Chief Executive of each of the Trusts may agree a non-material variation that they may reasonably consider to be necessary for the purpose of remedying any obvious error or omission in the terms of reference.

Date approved:

Date of review:

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Annex to BSW Hospitals Group Joint Committee Terms of Reference

Functions Delegated by each of the Boards of GWH, RUH and SFT – Roles & responsibilities

	Role of the Joint Committee	Role of the Trust Boards
	1. Group Strategy & Planning	
Strategy		
1	Development and approval of BSW Hospitals Group Strategy. The Joint Committee determines the strategic direction, ensuring that collective BSW population interests are paramount.	Responsible for development and delivery of local operational plans aligned to and reinforcing *Group Strategy and Specialist Delivery* Plans.
2	Development and approval of *Specialist Delivery Plans* underpinning Group Strategy; Finance, People, Clinical, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital plans, in accordance with relevant system plans or strategies.	
Planning		
1	Development, approval and delivery of *Group Strategic Planning Framework* and *Annual Group-wide Plan*, reflecting planning guidance and Group Strategy. Set strategic goals and key objectives for upcoming year. Oversee budgeting process, reviewing and consolidating budgets at Group level. Oversight of delivery of *Group Strategic Initiatives.*	Development and delivery of the Trust operational plan aligned to Group objectives.
2	Approval of the overall Group Programme Budget - developing a plan that determines the financial contribution, and pooling of resources to meet financial challenges.	Delivery of the Trust operational plan, incorporating Group programme budget requirements.
3	Development of a Group Board Assurance Framework and Risk Management Framework.	Board Assurance Frameworks and risk management processes will remain in place for each Trust. Enable standardisation and consistency in a controlled and managed approach as determined by the Joint Committee.
4	Review and identification of the risks associated with the delivery of *Group Strategy and Group Annual Plan*.	
	2. Transforming Models of Care for the Population we Serve	
1	Development and approval of a *Group Clinical Services Framework* for the collective population we serve and associated decision-making processes.	Actively engage in co-creation and implementation of the Group Clinical Services Framework.

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2	Approval of service/pathway/treatment configuration changes across the Group	
	3. Financial Sustainability – Use of Resources	
1	Sets and delivers Group financial recovery and long-term Group financial sustainability.	Responsible for developing and delivering financial plans as determined by the Group Programme Budget. Manage operational budgets.
2	Approval of new capital investment programme for the Group	Responsible for implementing local capital investment plans.
3	Approval of capital limits for each Trust within the Group.	Identifies local priorities for investment within the delegated limit.
	4. Group Mobilisation & Development	
1	Approval of *Group Operating Model*, *Accountability Framework* and associated *Integrated Performance Reporting*.	Works within the Group governance structure and accountability framework to deliver services ensuring that local governance aligns with group governance.
2	Oversight of delivery of the BSW Hospitals Group Case for Collaboration and emerging agreed priorities. Includes programme oversight of workstreams from case for collaboration – with details, phasing and resourcing agreed in *Annual Group-wide Plan*.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight. Delivery of change locally with Partners. Participates in group mobilisation and development workstreams.
3	Defines objectives, shape and structure of Group Corporate Services transformation. Approval of programme resourcing.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight.
4	Identification and approval of any further opportunities in support of Group Strategy.	Actively identify further opportunities to maximise economies at scale.
	5. Achieving Digital Maturity	
1	Responsible for the strategic oversight of successful delivery of the EPR Programme [via EPR Joint Committee activity]. Approves proposals for new budget and new benefits profile.	Ensures local delivery plans in place and appropriate relevant engagement for successful implementation.
2	Identifies, approves and implements digital transformation initiatives across the Group structure, as described in *Group Digital Delivery plan* [refer 1,2].	Ensures local IT infrastructure supports Group-wide strategy. Ensures local delivery plans in place and appropriate relevant engagement for successful implementation

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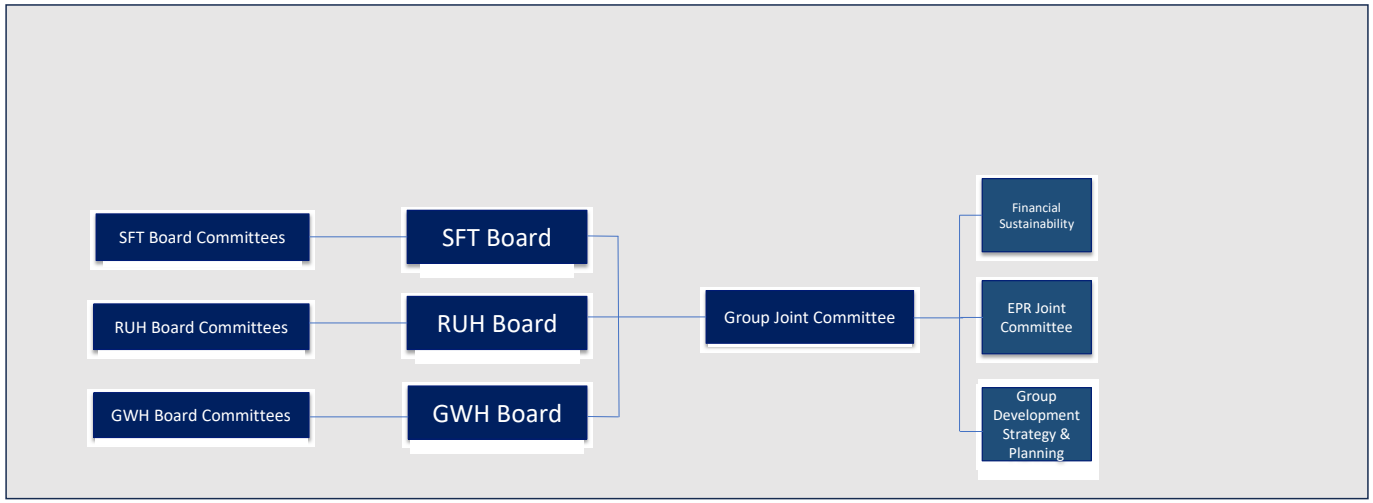
Schedule 6 Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date

BSW Hospitals Group – Organogram



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

Schedule 7 Data sharing and confidentiality

Part A: Confidentiality

1 In this Schedule "Confidential Information" means: all information, whether written or oral (however recorded), provided by one Trust (the Disclosing Trust) to the other Trusts (Receiving Trust(s)) and which (i) is known by the Receiving Trust(s) to be confidential; (ii) is marked as or stated to be confidential; or (iii) ought reasonably to be considered by the Receiving Trust(s) to be confidential.

2 The Trusts may disclose Confidential Information:

2.1 to their employees, agents or consultants who need to know such information for the purpose of discharging their obligations under this Agreement if they ensure that their employees, agents, or consultants to whom they disclose Confidential Information comply with this Schedule 7 and

2.2 as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

3 The Trusts will not use each other's Confidential Information for any purpose other than to comply with this Agreement.

4 The Trusts acknowledge that they are subject to legal duties under the FOIA and EIR which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

5 If a Trust receives a Request for Information (as defined in FOIA) or a request under regulation 5(1) of EIR (each, a Request) about their collaboration arrangements or the BSW Hospitals Group Joint Committee, prior to any disclosure of information to which an exemption to FOIA or EIR (as the case may be) may apply (Potentially Exempt Information) and recognising fully that the decision whether and what to disclose is for the Trust receiving the Request:

5.1 Notify the other Trusts of such Request

5.2 Consider any representations made by the other Trusts in relation to the Request and any possible exemptions and

5.3 Consult with the other Trusts in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question.

6 Each Trust agrees that it will promptly inform the other Trusts of any media enquiries which it receives in relation to the collaboration arrangements. The Trusts will work co-operatively to agree a joint response to any media enquiries received in relation to the collaboration arrangements.

Part B: Independent Data Controllers

7 The Trusts shall, and shall procure that any of its staff and its other employees, agents and sub-contractors involved in the processing of Relevant Personal Data under this Agreement ("Personnel") shall, in connection with this Agreement and the transactions

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and activities contemplated by it, comply with their obligations under Data Protection Legislation and this Schedule 7.

8 For the purposes of the Data Protection Legislation each Trust shall be an independent Data Controller of any Relevant Personal Data created in connection with the conduct or performance of this Agreement.

9 Each Trust shall implement and maintain appropriate technical and organisational measures (including, but not limited to, [encryption and password protection]), when transferring and/or processing Relevant Personal Data, to preserve the confidentiality, integrity, availability and resilience of Relevant Personal Data and prevent any unlawful processing or disclosure or damage, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects.

10 Each Trust shall notify the other Trusts without undue delay, and in any event within 48 hours of becoming aware of:

10.1 a Personal Data Breach where the breach has affected or could have affected the Relevant Personal Data;

10.2 a breach of technical and organisational security measures or any Data Protection Legislation where the breach has affected or could have affected the Relevant Personal Data;

10.3 an enquiry from the Information Commissioner's Office about the Relevant Personal Data; or

10.4 a request from a Data Subject exercising any of their rights under Chapter III UK GPDR in respect of the Relevant Personal Data (a "Data Subject Rights Request").

Each Trust agrees to keep the other Trusts regularly updated as to how the handling of such breach, enquiry or request.

11 Each Trust shall provide reasonable assistance to the other Trusts in ensuring compliance with its obligations under the Data Protection Legislation with respect of Personal Data Breach notifications and a Trust shall not make such notification without first consulting the other Trusts wherever possible.

12 Each Trust shall, as soon as reasonably practicable taking into account the nature of the processing provide reasonable assistance to the other Trusts, where that Trust has received:

12.1 a Data Subject Rights Request;

12.2 an enquiry from the Information Commissioner's Office about the Relevant Personal Data;

12.3 a complaint or request relating obligations served under the Data Protection Legislation which relates to the processing of Relevant Personal Data by any Trust; or

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12.4 any other communication directly relating to the processing of any Relevant Personal Data created in connection with the conduct or performance of this Agreement in relation to such requests.

Wherever possible, no Trust shall not disclose, release, amend, delete or block any Relevant Personal Data in response to a Data Subject Rights Request or respond to such a request, complaint or communication without first consulting the other Trusts. Each Trust will bear their own costs in complying with their respective obligations under this Schedule 7.

13 Each Trust shall:

13.1 ensure that only those Personnel who need to have access to the Relevant Personal Data are granted such access and only for the purposes of performing their respective obligations under this Agreement;

13.2 take all reasonable steps to ensure the reliability of its Personnel;

13.3 ensure that all Personnel have completed training in Data Protection Legislation and in the care and handling of the Relevant Personal Data;

13.4 ensure that all Personnel are informed of the confidential nature of the Relevant Personal Data and are subject to appropriate contractual obligations of confidentiality; and

13.5 ensure that all Personnel comply with the obligations set out in this Schedule 7.

14 During the term and upon the termination of this Agreement, each Trust shall ensure that all Relevant Personal Data held by it shall be up-to-date and accurate.

15 Where transferring the Relevant Personal Data to the other Trusts or to a third party, each Trust shall:

15.1 ensure that such transfer is compliant with all applicable laws;

15.2 make such transfer in a secure manner; and

15.3 take all reasonable steps, at its own cost, to provide the Relevant Personal Data in a usable and compatible format.

16 Where transferring the Personal Data to a third party, each Trust shall enter into appropriate arrangements with all third parties containing written contractual obligations concerning the Relevant Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this Schedule 7 and where applicable, compliant with Article 26 or 28 UK GDPR.

17 No Trust shall transfer any Relevant Personal Data outside the UK unless the transferor ensures that:

17.1 the transfer is to a country approved under the applicable Data Protection Legislation as providing adequate protection;

17.2 there are appropriate safeguards in place, such as the Standard Contractual Clauses, pursuant to the applicable Data Protection Legislation; or

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17.3 one of the derogations for specific situations in the applicable Data Protection Legislation applies to the transfer.

18 Each Trust shall retain Relevant Personal Data in a form which permits identification of Data Subjects for no longer than is necessary for the purposes for which it processes the Personal Data, as per its obligations under the Data Protection Legislation. Each Trust shall securely delete Relevant Personal Data which cannot be lawfully retained in accordance with Data Protection Legislation and good industry practice.

19 In this Schedule 7 the terms "Personal Data", "Processing", "Processor", "Controller", "Personal Data Breach" and "Data Subject" shall have the meanings ascribed to them under Data Protection Legislation, and the terms "Process" "Processes" and "Processed" shall be construed accordingly.

Part C: Joint Controller Status and Allocation of Responsibilities

20 With respect to personal data under Joint Control of the Trusts, as set out in Paragraph Schedule 725 below ("Shared Personal Data"), the Trusts envisage that they shall each be a Data Controller in respect of that Shared Personal Data in accordance with the terms of this Part C of Schedule 7 (Joint Controller Agreement) in replacement of Part B of Schedule 7. Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Shared Personal Data as Data Controllers.

21 The Trusts agree that the information governance team(s) of each Trust:

21.1 are the exclusive point of contact for Data Subjects and is responsible for using best endeavours to comply with the UK GDPR regarding the exercise by Data Subjects of their rights under the UK GDPR;

21.2 shall direct Data Subjects to the Data Protection Officer(s) or suitable alternative in connection with the exercise of their rights as Data Subjects and for any enquiries concerning their Shared Personal Data or privacy;

21.3 are responsible for the Trusts' compliance with all duties to provide information to Data Subjects under Articles 13 and 14 of the UK GDPR;

21.4 are responsible for ensuring the informed consent of Data Subjects, in accordance with the UK GDPR, for Processing in connection with the Joint Functions where consent is the relevant legal basis for that Processing; and

21.5 shall make available to Data Subjects the essence of this Part C of Schedule 7 (and notify them of any changes to it) concerning the allocation of responsibilities as Joint Controller and its role as exclusive point of contact, the Trusts having used their best endeavours to agree the terms of that essence. This must be outlined relevant privacy policies (which must be readily available by hyperlink or otherwise on all of its public facing services and marketing).

22 Notwithstanding the terms of Paragraph 21, the Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of all Trusts

23 The Trusts each undertake that they shall:

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23.1 report to the other Trusts every quarter on:

23.1.1 the volume of Data Subject Access Request (or purported Data Subject Access Requests) from Data Subjects (or third parties on their behalf);

23.1.2 the volume of requests from Data Subjects (or third parties on their behalf) to rectify, block or erase any Shared Personal Data;

23.1.3 any other requests, complaints or communications from Data Subjects (or third parties on their behalf) relating to the other Trusts' obligations under applicable Data Protection Legislation;

23.1.4 any communications from the Information Commissioner or any other regulatory authority in connection with Shared Personal Data; and

23.1.5 any requests from any third-party for disclosure of Shared Personal Data where compliance with such request is required or purported to be required by Law,

that it has received in relation to the exercise of the Joint Functions under this Agreement during that period;

23.2 notify each other immediately if it receives any Data Subject Request, complaint or communication made as referred to in Paragraphs 23.1.1 to 23.1.5. For the avoidance of doubt, this clause 23.2 does not apply to requests, complaints or communications made about the general operations of the Trusts as a whole;

23.3 provide the other Trusts with full cooperation and assistance in relation to any request, complaint or communication made as referred to in Paragraphs 21 and 23.1.1 to 23.1.5 to enable the other Trusts to comply with the relevant timescales set out in the Data Protection Legislation;

23.4 not disclose or transfer the Shared Personal Data to any third-party unless necessary for the provision of the Joint Functions and, for any disclosure or transfer of Shared Personal Data to any third-party, (save where such disclosure or transfer is specifically authorised under this Agreement or is required by Law) that disclosure or transfer of Shared Personal Data is otherwise considered to be lawful processing of that Shared Personal Data in accordance with Article 6 of the UK GDPR. For the avoidance of doubt, the third-party to which Shared Personal Data is transferred must be subject to equivalent obligations which are no less onerous than those set out in this Part C of Schedule 7

23.5 request from the Data Subject only the minimum information necessary to provide the Joint Functions and treat such extracted information as Confidential Information;

23.6 ensure that at all times it has in place appropriate technical and organisational measures to guard against unauthorised or unlawful Processing of the Shared Personal Data and/or accidental loss, destruction or damage to the Shared Personal Data and unauthorised or unlawful disclosure of or access to the Shared Personal Data;

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23.7 use best endeavours to ensure the reliability and integrity of any of its Personnel who have access to the Shared Personal Data and ensure that its Personnel:

23.7.1 are aware of and comply with their duties under this Part C of Schedule 7 (Joint Controller Agreement) and those in respect of Confidential Information;

23.7.2 are informed of the confidential nature of the Shared Personal Data, are subject to appropriate obligations of confidentiality and do not publish, disclose or divulge any of the Shared Personal Data to any third-party where that Trust would not be permitted to do so;

23.7.3 have undergone adequate training in the use, care, protection and handling of Shared Personal Data as required by the applicable Data Protection Legislation;

23.8 ensure that it has in place appropriate technical and organisational measures as appropriate to protect against a personal data breach having taken account of the:

23.8.1 nature of the data to be protected;

23.8.2 harm that might result from a personal data breach;

23.8.3 state of technological development; and

23.8.4 cost of implementing any measures;

23.9 ensure that it has the capability (whether technological or otherwise), to the extent required by Data Protection Legislation, to provide or correct or delete at the request of a Data Subject all the Shared Personal Data relating to that Data Subject that the party holds; and

23.10 ensure that it notifies the other Trusts as soon as it becomes aware of a personal data breach.

24 Each Joint Controller shall use best endeavours to assist the other Controllers to comply with any obligations under applicable Data Protection Legislation and shall not perform its obligations under this Part C of Schedule 7 in such a way as to cause the other Joint Controllers to breach any of its obligations under applicable Data Protection Legislation to the extent it is aware, or ought reasonably to have been aware, that the same would be a breach of such obligations.

Shared Personal Data

25 All Trusts shall document and keep a register of types of Shared Personal Data that will be shared between the Trusts during the Term. This register will be coordinated by the Information Governance team(s).

Data Protection Breach

26 Without prejudice to Paragraph 27, each Trust shall notify the other Trusts without undue delay, and in any event within 48 hours, upon becoming aware of any personal

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data breach or circumstances that are likely to give rise to a personal data breach, providing the other Trusts and their advisors with:

26.1 sufficient information and in a timescale which allows the other Trusts to meet any obligations to report a personal data breach under the Data Protection Legislation;

26.2 all reasonable assistance, including:

26.2.1 co-operation with the other Trusts and the Information Commissioner investigating the personal data breach and its cause, containing and recovering the compromised Shared Personal Data and compliance with the applicable guidance;

26.2.2 co-operation with the other Trusts including using such best endeavours as are directed by the Trusts to assist in the investigation, mitigation and remediation of a personal data breach;

26.2.3 co-ordination with the other Trusts regarding the management of public relations and public statements relating to the personal data breach; and/or

26.2.4 providing the other Trusts and to the extent instructed by the other Trusts to do so, and/or the Information Commissioner investigating the personal data breach, with complete information relating to the personal data breach, including, without limitation, the information set out in Paragraph 27.

27 Each Trust shall use best endeavours to restore, re-constitute and/or reconstruct any Shared Personal Data where it has lost, damaged, destroyed, altered or corrupted as a result of a personal data breach which is the fault of that Trust as if it was that Trust's own data at its own cost with all possible speed and shall provide the other Trusts with all reasonable assistance in respect of any such personal data breach, including providing the other Trusts, as soon as possible and within 48 hours of the personal data breach relating to the personal data breach, in particular:

27.1 the nature of the personal data breach;

27.2 the nature of Shared Personal Data affected;

27.3 the categories and number of Data Subjects concerned;

27.4 the name and contact details of the joint Data Protection Officer or other relevant contact from whom more information may be obtained;

27.5 measures taken or proposed to be taken to address the personal data breach; and

27.6 describe the likely consequences of the personal data breach.

Impact Assessments

28 The Trusts shall:

28.1 provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed

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information and assessments in relation to Processing operations, risks and measures); and

28.2 maintain full and complete records of all Processing carried out in respect of the Shared Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Liabilities for Data Protection Breach

29 If financial penalties are imposed by the Information Commissioner on a Trust for a personal data breach ("Financial Penalties") then the following shall occur:

29.1 if in the view of the Information Commissioner, one Trust (Trust A) is responsible for the personal data breach, in that it is caused as a result of the actions or inaction of Trust A, its employees, agents, contractors (other than the other Trust) or systems and procedures controlled by Trust A, then Trust A shall be responsible for the payment of such Financial Penalties. In this case, Trust A will conduct an internal audit and engage at its reasonable cost when necessary, an independent third-party to conduct an audit of any such personal data breach. The other Trusts shall provide to Trust A and its third-party investigators and auditors, on request and at Trust A's reasonable cost, full cooperation and access to conduct a thorough audit of such personal data breach;

29.2 if no view as to responsibility is expressed by the Information Commissioner, then the Trusts shall work together to investigate the relevant personal data breach and allocate responsibility for any Financial Penalties as outlined above, or by agreement to split any financial penalties equally if no responsibility for the personal data breach can be apportioned.

29.3 If a Trust is the defendant in a legal claim brought before a court of competent jurisdiction ("Court") by a third-party in respect of a personal data breach, then unless the Trusts otherwise agree, the Trust that is determined by the final decision of the court to be responsible for the personal data breach shall be liable for the losses arising from such personal data breach. Where one or more Trusts are liable, the liability will be apportioned between the Trusts in accordance with the decision of the Court.

29.4 In respect of any losses, cost claims or expenses incurred by a Trust as a result of a personal data breach (the "Claim Losses"):

29.4.1 if a Trust is responsible for the relevant personal data breach, then that Trust shall be responsible for the Claim Losses;

29.4.2 if responsibility for the relevant personal data breach is unclear, then the Trusts shall be responsible for the Claim Losses equally.

30 Nothing in either Paragraph 28 or Paragraph 29 shall preclude the Trusts reaching any other agreement, including by way of compromise with a third-party complainant or claimant, as to the apportionment of financial responsibility for any Claim Losses as a result of a personal data breach, having regard to all the circumstances of the personal data breach and the legal and financial obligations of the Trusts.

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Termination

31 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part C of Schedule 7 in accordance with Clause 19 (Termination).

Sub-Processing

32 In respect of any Processing of Shared Personal Data performed by a third-party on behalf of a Trust, that Trust shall:

32.1 carry out adequate due diligence on such third-party to ensure that it is capable of providing the level of protection for the Shared Personal Data as is required by this Agreement, and provide evidence of such due diligence to the other Trusts where reasonably requested; and

32.2 ensure that a suitable agreement is in place with the third-party as required under applicable Data Protection Legislation.

Data Retention

33 The Trusts agree to erase Shared Personal Data from any computers, storage devices and storage media that are to be retained as soon as practicable after it has ceased to be necessary for them to retain such Shared Personal Data under applicable Data Protection Legislation and their privacy policy (save to the extent (and for the limited period) that such information needs to be retained by the Trust for statutory compliance purposes or as otherwise required by this Agreement), and taking all further actions as may be necessary to ensure its compliance with Data Protection Legislation and its privacy policy.

Part D: Controller to Processor Agreement

Allocation of responsibilities

34 With respect to personal data under Control of one of the Trusts, as set out in Paragraph 37 below ("Personal Data"), the Trusts envisage that for the purpose of the Data Protection Legislation that they shall, at times, each serve as the Controller and the others as the Processors in respect of that Personal Data in accordance with the terms of this Part D of Schedule 7 (Controller to Processer Agreement) in replacement of paragraphs Part B of Schedule 7 (Data Protection).

35 Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Personal Data in their respective roles as Controller and Processor.

36 The Controller retains control of the Personal Data and remains responsible for its compliance obligations under the Data Protection Legislation, including but not limited to, providing any required notices and obtaining any required consents, and for the written processing instructions it gives to the Processor.

37 A record will be maintained by all Trusts to detail the subject matter, duration, nature and purpose of the processing and the Personal Data categories and Data Subject types in respect of which a Trust will serve as the Processor and may process the Personal Data to fulfil the Joint Functions.

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38 The Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of the Trusts

39 The Processor will only process the Personal Data to the extent, and in such a manner, as is necessary for the exercise of the Joint Functions in accordance with the Controller's written instructions. The Processor will not process the Personal Data for any other purpose or in a way that does not comply with this Agreement or the Data Protection Legislation. The Processor must promptly notify the Controller if, in its opinion, the Controller's instructions do not comply with the Data Protection Legislation.

40 The Processor must comply promptly with any Controller written instructions requiring the Processor to amend, transfer, delete or otherwise process the Personal Data, or to stop, mitigate or remedy any unauthorised processing.

41 The Processor will maintain the confidentiality of the Personal Data and will not disclose the Personal Data to third-parties unless the Controller or this Agreement specifically authorises the disclosure, or as required by domestic law, court or regulator (including the Commissioner). If a domestic law, court or regulator (including the Commissioner) requires the Processor to process or disclose the Personal Data to a third-party, the Processor must first inform the Controller of such legal or regulatory requirement and give the Controller an opportunity to object or challenge the requirement, unless the domestic law prohibits the giving of such notice.

42 The Processor will reasonably assist the Controller, at no additional cost to the Controller, with meeting the Controller's compliance obligations under the Data Protection Legislation, taking into account the nature of the Processor's processing and the information available to the Processor, including in relation to Data Subject rights, data protection impact assessments and reporting to and consulting with the Commissioner under the Data Protection Legislation.

43 The Processor (and any subcontractor) must not transfer or otherwise process the Personal Data outside the UK without obtaining the Controller's prior written consent.

44 The Processor may not authorise any third party or subcontractor to process the Personal Data without the agreement of the Controller. The Trusts agree that the Processor will be deemed by them to control legally any Personal Data controlled practically by or in the possession of its subcontractors.

45 The Processor must, at no additional cost to the Controller, take such technical and organisational measures as may be appropriate, and promptly provide such information to the Controller as the Controller may reasonably require, to enable the Controller to comply with:

45.1 the rights of Data Subjects under the Data Protection Legislation, including, but not limited to, subject access rights, the rights to rectify, port and erase personal data, object to the processing and automated processing of personal data, and restrict the processing of personal data; and

45.2 information or assessment notices served on the Controller by the Commissioner under the Data Protection Legislation.

46 The Processor must notify the Controller immediately in writing if it receives any complaint, notice or communication that relates directly or indirectly to the processing of the Personal Data or to either party's compliance with the Data Protection Legislation.

47 The Processor must notify the Controller within 7 days if it receives a request from a Data Subject for access to their Personal Data or to exercise any of their other rights under the Data Protection Legislation.

48 The Processor will give the Controller, at no additional cost to the Controller, its full co-operation and assistance in responding to any complaint, notice, communication or Data Subject request.

49 The Processor must not disclose the Personal Data to any Data Subject or to a third-party other than in accordance with the Controller's written instructions, or as required by domestic law.

50 The Processor must at all times implement appropriate technical and organisational measures against accidental, unauthorised or unlawful processing, access, copying, modification, reproduction, display or distribution of the Personal Data, and against accidental or unlawful loss, destruction, alteration, disclosure or damage of Personal Data.

51 The Processor must implement such measures to ensure a level of security appropriate to the risk involved, including as appropriate:

51.1 the pseudonymisation and encryption of personal data;

51.2 the ability to ensure the ongoing confidentiality, integrity, availability and resilience of processing systems and services;

51.3 the ability to restore the availability and access to personal data in a timely manner in the event of a physical or technical incident; and

51.4 a process for regularly testing, assessing and evaluating the effectiveness of the security measures.

52 The Processor will ensure that all of its employees:

52.1 are informed of the confidential nature of the Personal Data and are bound by written confidentiality obligations and use restrictions in respect of the Personal Data;

52.2 have undertaken training on the Data Protection Legislation and how it relates to their handling of the Personal Data and how it applies to their particular duties; and

52.3 are aware both of the Processor's duties and their personal duties and obligations under the Data Protection Legislation and this Agreement.

Breaches

53 The Processor will within 48 hours and in any event without undue delay notify the Controller in writing if it becomes aware of:

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53.1 the loss, unintended destruction or damage, corruption, or unusability of part or all of the Personal Data. The Processor will restore such Personal Data at its own expense as soon as possible.

53.2 any accidental, unauthorised or unlawful processing of the Personal Data; or

53.3 any Personal Data Breach.

54 Where the Processor becomes aware of the matters set out in Paragraph 53 above, it will, without undue delay, also provide the Controller with the following written information:

54.1 description of the nature of the matters set out in Paragraph 53, including the categories of in-scope Personal Data and approximate number of both Data Subjects and the Personal Data records concerned;

54.2 the likely consequences; and

54.3 a description of the measures taken or proposed to be taken to address the matters set out in Paragraph 53, including measures to mitigate its possible adverse effects.

55 Immediately following any accidental, unauthorised or unlawful Personal Data processing or Personal Data Breach, the Trusts will co-ordinate with each other to investigate the matter. Further, the Processor will reasonably co-operate with the Controller at no additional cost to the Controller, in the Controller's handling of the matter, including but not limited to:

55.1 assisting with any investigation;

55.2 providing the Controller with physical access to any facilities and operations affected;

55.3 facilitating interviews with the Processor's employees, former employees and others involved in the matter including, but not limited to, its officers and directors;

55.4 making available all relevant records, logs, files, data reporting and other materials required to comply with all Data Protection Legislation or as otherwise reasonably required by the Controller; and

55.5 taking reasonable and prompt steps to mitigate the effects and to minimise any damage resulting from the Personal Data Breach or accidental, unauthorised or unlawful Personal Data processing.

56 The Processor will not inform any third-party of any accidental, unauthorised or unlawful processing of all or part of the Personal Data and/or a Personal Data Breach without first obtaining the Controller's written consent, except when required to do so by domestic law.

57 The Processor agrees that the Controller has the sole right to determine:

57.1 whether to provide notice of the accidental, unauthorised or unlawful processing and/or the Personal Data Breach to any Data Subjects, the Commissioner, other in-scope regulators, law enforcement agencies or others,

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as required by law or regulation or in the Controller's discretion, including the contents and delivery method of the notice; and

57.2 whether to offer any type of remedy to affected Data Subjects, including the nature and extent of such remedy.

58 The Processor will cover all reasonable expenses associated with the performance of the obligations under Paragraphs 53 to 55 unless the matter arose from the Controller's specific written instructions, negligence, wilful default or breach of this Agreement, in which case the Controller will cover all reasonable expenses.

59 The Processor will also reimburse the Controller for actual reasonable expenses that the Controller incurs when responding to an incident of accidental, unauthorised or unlawful processing and/or a Personal Data Breach to the extent that the Processor caused such, including all costs of notice and any remedy as set out in Paragraph 57.

Warranties

60 Each Trust warrants and represents that, in acting as Processor:

60.1 its employees, subcontractors, agents and any other person or persons accessing the Personal Data on its behalf are reliable and trustworthy and have received the required training on the Data Protection Legislation;

60.2 it and anyone operating on its behalf will process the Personal Data in compliance with the Data Protection Legislation and other laws, enactments, regulations, orders, standards and other similar instruments;

60.3 it has no reason to believe that the Data Protection Legislation prevents it from providing any of the Joint Functions; and

60.4 considering the current technology environment and implementation costs, it will take appropriate technical and organisational measures to prevent the accidental, unauthorised or unlawful processing of Personal Data and the loss or damage to, the Personal Data, and ensure a level of security appropriate to:

60.4.1 the harm that might result from such accidental, unauthorised or unlawful processing and loss or damage;

60.4.2 the nature of the Personal Data protected; and

60.4.3 comply with all applicable Data Protection Legislation and its information and security policies.

61 Each Trust warrants and represents that in acting as Controller, the Processor's expected use of the Personal Data for the Joint Functions and as specifically instructed by the Controller will comply with the Data Protection Legislation.

Impact assessment

62 The Trusts shall:

62.1 provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed information and assessments in relation to Processing operations, risks and measures); and

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62.2 maintain full and complete records of all Processing carried out in respect of the Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Termination

63 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part D of Schedule 7 in accordance with Clause 19 (Termination).

Data retention

64 At the Controller's request, the Processor will give the Controller, or a third-party nominated in writing by the Controller, a copy of or access to all or part of the Personal Data in its possession or control in the format and on the media reasonably specified by the Controller.

65 On termination of this Agreement for any reason, the Processor will securely delete or destroy or, if directed in writing by the Controller, return and not retain, all or any of the Personal Data related to this Agreement in its possession or control, only.

66 If any law, regulation, or government or regulatory body requires the Processor to retain any documents, materials or Personal Data that the Processor would otherwise be required to return or destroy, it will notify the Controller in writing of that retention requirement, giving details of the documents, materials or Personal Data that it must retain, the legal basis for such retention, and establishing a specific timeline for deletion or destruction once the retention requirement ends.

67 The Processor will certify in writing to the Controller that it has deleted or destroyed the Personal Data within 28 days after it completes the deletion or destruction.

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Schedule 8 Scheme for Trust Board Appointments

Organisational Development Plan: to develop in Q1 2025-2026

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Schedule 9 Recommendations

Recommendations approved by Boards [July/ September 2024].

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NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	13/03/25		

Report title:	SFT Business Plan 2025-26 sign off			
Status:	Information	Discussion	Assurance	Approval
	X	X		X
Approval Process: (where has this paper been reviewed and approved):	All Executives (18th February) Finance and Performance Committee – (8th March)			
Prepared by:	Niall Prosser, Chief Operating Officer Mark Ellis, Chief Finance Officer Lynne Abbott, Deputy Chief Finance Officer Ian Crowley, Deputy Chief People Officer Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Niall Prosser, Chief Operating Officer			

Recommendation:

Trust Board are asked to approve the Trusts annual business plan for 25/26

Executive Summary:

The plan is a build on the work undertaken during 24/25, in which the Trust delivered significant improvements;

- Met national cancer performance targets, eliminated all patients waiting over 65 weeks and delivered 5% improvement in overall RTT performance
- Good rating for CQC in maternity
- Most improved Trust for staff survey
- Most improved trust for productivity within the south west

This has been delivered by;

- Focus on using Improving Together to drive local performance and change
- A focus on productivity within the hospital, with successes such as theatre productivity being top quartile
- Maintaining gains achieved within quality standards and people promise throughout the hospital
- 25/26 plan focuses on taking the productivity and performance gains and either maintaining (theatre activity and productivity) or building on further (outpatient transformation / digitalization of processes).

This years plan is anticipated to deliver;

- A route to break even. Within this the CIP requirement is circa 5%. Within the CIP delivery (£20m needed – identified £17.5m with identified risk) – plan highlights current risk intervals
    - Will close the identified NHSE productivity opportunity over 24/25 and 25/26.
    - Will lead to the closure of beds during 25/26
    - Will lead to reduction in the Trusts wte
- The plan also ensures that the Trust delivers the key headline access targets during 25/26, including delivering further 5% improvement in RTT, delivery of caner targets and getting the 4hr target to 78%.
- The plan will also ensure that the Trust continues to deliver its improvements within Maternity and other safety measures.

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

NHS
Salisbury
NHS Foundation Trust

SFT Business Plan 2025-26

Final plan

Our Strategy 2022-26

IMPROVING together

Executive Summary

Summary

- The plan is a build on the work undertaken during 24/25, in which the Trust delivered significant improvements;
    - Meet national cancer performance targets and eliminated all pts waiting over 65 weeks and delivered 5% improvement in overall RTT performance
    - Good rating for CQC in maternity
    - Most improved Trust for staff survey
    - Most improved trust for productivity within the south west
    - Circa £5m deficit
- This has been delivered by;
    - Focus on using Improving Together to drive local performance and change
    - A focus on productivity within the hospital, with successes such as theatre productivity being top quartile
    - Maintaining gains achieved within quality standards and people promise throughout the hospital
- 25/26 plan focuses on taking the productivity and performance gains and either maintaining (theatre activity and productivity) or building on further (outpatient transformation / digitalization of processes).
- Plan delivers a route to break even. Within this the CIP requirement is circa 5%. Risk within CIP delivery (£20m needed – identified £17.5m but high risk) – plan highlights current risk intervals
    - Will close the identified NHSE productivity opportunity over 24/25 and 25/26.
    - Will lead to the closure of beds during 25/26
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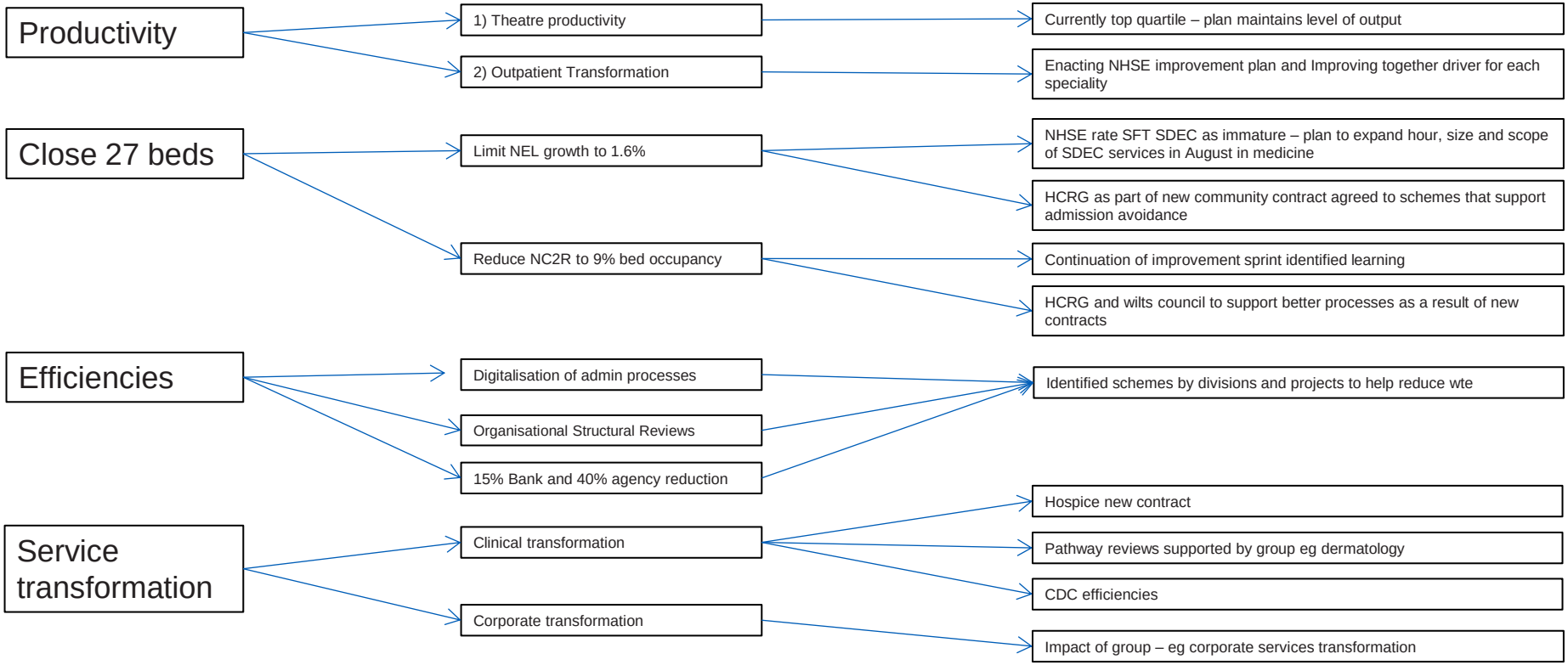
- The plan also ensures that the Trust delivers the key headline access targets during 25/26, including delivering further 5% improvement in RTT, delivery of caner targets and getting the 4hr target to 78%.
- The plan will also ensure that the Trust continues to deliver its improvements within Maternity and other safety measures.

What the plan delivers

Operating plan requirements	Success measure	SFT
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26	
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)	
Maintain our collective focus on the overall quality and safety of services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three-year delivery plan'	Maternity / NICU
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	

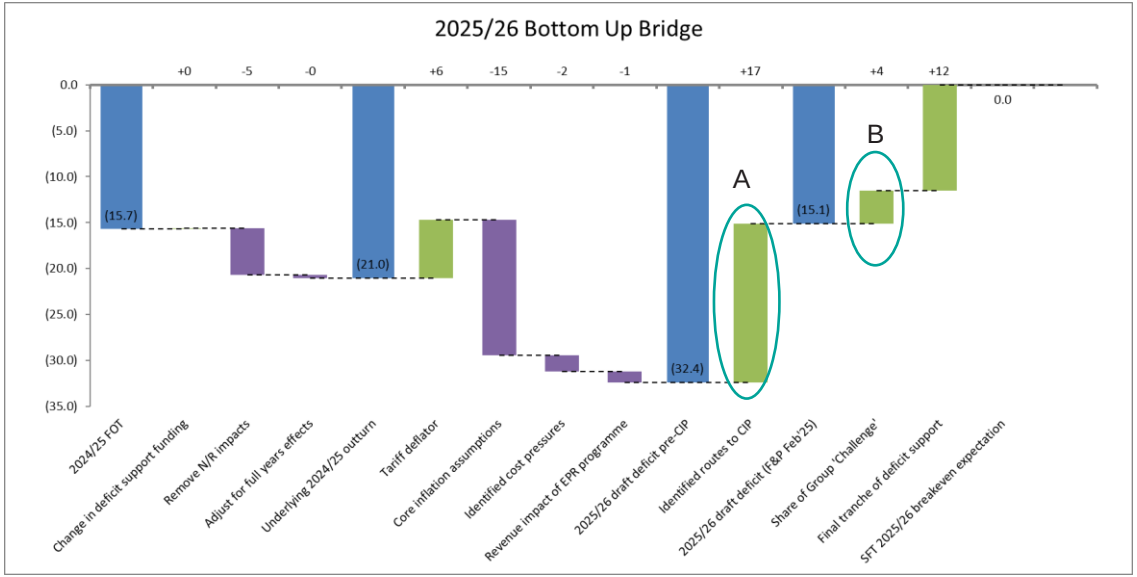
Delivering the plan summary;



Financial Position

2025/26 Bottom Up Bridge

Ref	Bridging items	£'m
	2024/25 FOT	**(15.7)**
1	Change in deficit support funding	0.1
2	Remove N/R impacts	(5.1)
3	Adjust for full years effects	(0.3)
	Underlying 2024/25 outturn	**(21.0)**
4	Tariff deflator	6.3
5	Core inflation assumptions	(14.7)
6	Identified cost pressures	(1.8)
7	Revenue impact of EPR programme	(1.2)
	2025/26 draft deficit pre-CIP	**(32.4)**
8	Identified routes to CIP	17.3
	2025/26 draft deficit (F&P Feb'25)	**(15.1)**
9	Share of Group 'Challenge'	3.6
10	Final tranche of deficit support	11.5
	SFT 2025/26 breakeven expectation	**0.0**



A – Baseline plan underpinned by targeted areas of CIP opportunity

B – Plan based on 'share' of group efficiency requirement in route to BSW breakeven

Full deficit support funding now included bringing SFT to breakeven

SOCI 2025/26

	24/25 Actual £'m	25/26 Q1 Plan £'m	25/26 Q2 Plan £'m	25/26 Q3 Plan £'m	25/26 Q4 Plan £'m	25/26 TOTAL £'m
Operating Income						
NHS Clinical income	343.5	89.7	87.5	87.3	87.0	351.5
Other Clinical Income	14.6	4.2	4.8	4.8	4.7	18.5
Other Income (excl Donations)	55.8	10.0	10.0	10.1	10.1	40.2
Total income	**413.9**	**103.9**	**102.3**	**102.2**	**101.8**	**410.2**
Operating Expenditure						
Pay	(269.0)	(65.9)	(65.1)	(64.9)	(64.7)	(260.6)
Non Pay	(129.0)	(32.3)	(31.4)	(31.6)	(31.3)	(126.6)
Total Expenditure	**(398.0)**	**(98.2)**	**(96.5)**	**(96.5)**	**(96.0)**	**(387.2)**
EBITDA	**15.9**	**5.7**	**5.8**	**5.7**	**5.8**	**23.0**
Financing Costs (incl Depreciation)	(21.4)	(5.7)	(5.8)	(5.7)	(5.8)	(23.0)
NHSE Control Total	**(5.5)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

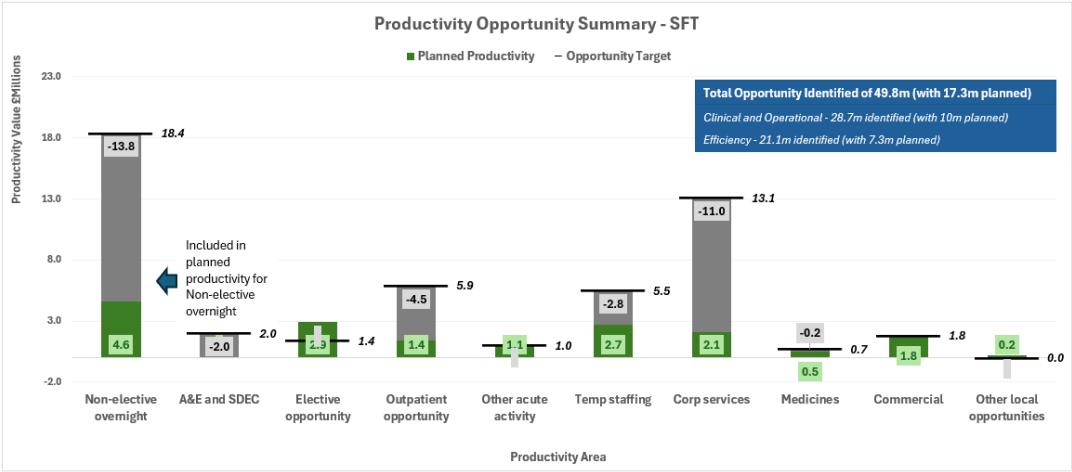
Included within SOCI:

Deficit support funding	31.0	12.2	8.9	8.4	8.7	38.2

Identified route to CIP		3.0	4.5	4.8	5.0	17.3
Share of Group 'challenge'			0.8	1.2	1.6	3.6
Total CIP included		**3.0**	**5.3**	**6.0**	**6.6**	**20.9**

Phasing revised for Seasonal Utilities costs, pay adjustments to reflect triangulation with workforce WTE, deficit support funding reflects BSW agreements and phased to reflect a breakeven plan with activity delivery phasing updated to reflect operational issues

How does this compare to expectations?



NATIONAL PRODUCTIVITY DATA:

System Name	Inflation adj. expenditure	Cost weighted activity	Implied productivity growth
DEVON	3.0%	11.3%	8.0%
GLOUCS	2.2%	7.2%	4.8%
BSW	2.9%	7.5%	4.4%
CORNWALL	3.6%	8.1%	4.3%
SOMERSET	3.3%	5.9%	2.5%
BNSSG	3.9%	6.3%	2.3%
DORSET	4.4%	6.7%	2.2%
SW Region	3.4%	7.9%	4.4%
National	**3.6%**	**6.1%**	**2.4%**
Salisbury	2.1%	10.9%	8.6%
GWH	3.7%	7.2%	3.3%
RUH	2.9%	5.8%	2.8%

NHSE have published Productivity & Efficiency packs with a 'comply or explain' mantra. This set out a route to c£50m of opportunity, in considering this figure it is important to not the basis of the figures:

1. 23/24 national cost collection
2. 23/24 corporate services benchmarking
3. M08 24/25 workforce returns

The mapping to the left set out SFT CIP plans against the published opportunity.

SFT delivery:

@M08 SFT productivity improvement vs 2023/24 @8.6%, valued at c£34m

Vs national improvement of 2.4% relative improvement of 6.2%, valued at c£25m

Current 2024/25 CIP @ £15m therefore SFT driving at having closed £41m-£50m (82-100%) of total efficiency and productivity challenge by end of 2025/26.

2025/26 Risks and Mitigations

Risks	£'m
Diagnostics	1.0
ERF	3.0
High cost drugs & devices	1.0
NEL Demand	5.9
South Newton	0.5
Hospice funding	0.5
Total Risks	**11.9**

Mitigations	£'m
Additional efficiencies	2.0
Total Mitigations	**2.0**
Net Risk	**9.9**

Comments
BSW Fixed Diagnostics & growth
Spinal ERF, UEC growth impact on Elective pathways
BSW Fixed HCDD & growth
Impact would be against ward closure and temporary staffing
Negotiations to close £1.1m funding gap with HCRG and Hospice charity
Opportunities to mitigate Unidentified efficiencies to be identified through planning process and oversight

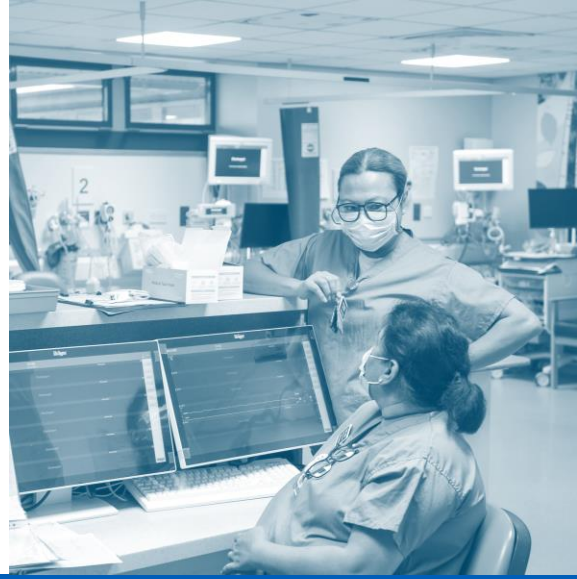
Understanding the plan

Planning Assumptions driving pre-mitigated plan

Assumptions within the plan	SFT
A&E growth – 2 year average	4.4%
NEL growth – 2 year average	4.6%
BSW agreed demand management impact	(3.0%)
Mitigated NEL growth	**1.4%**
LOS reduction assumption	0.5 days
NC2R% target	9%
NC2R beds released (Jan starting position of 82)	**42**
G&A beds – pre CIP	442
Escalation beds – pre CIP	28

Activity : Key Points of Delivery pre mitigations

	19/20 Activity	24/25 FOT Activity	25/26 Draft Plan Activity	25/26 Plan vs 24/25 Activity	25/26 Plan vs 19/20 Activity
A&E (All Types)	71,071	82,994	84,164	101%	
Advice and Guidance	1,922	10,959	10,954	100%	
Day cases	23,853	27,780	29,145	105%	122%
Electives	4,815	3,802	4,214	111%	88%
Non Electives	25,241	29,851	30,280	101%	
Outpatient First	76,084	97,192	102,377	105%	135%
Outpatient Procedures	68,062	81,073	82,754	102%	122%
Outpatient Follow ups	151,182	170,925	172,510	101%	



A&E and NEL: 1.4% A&E growth and 1.6% NEL growth assumed with triangulation to bed model and LOS/NC2R programmes.

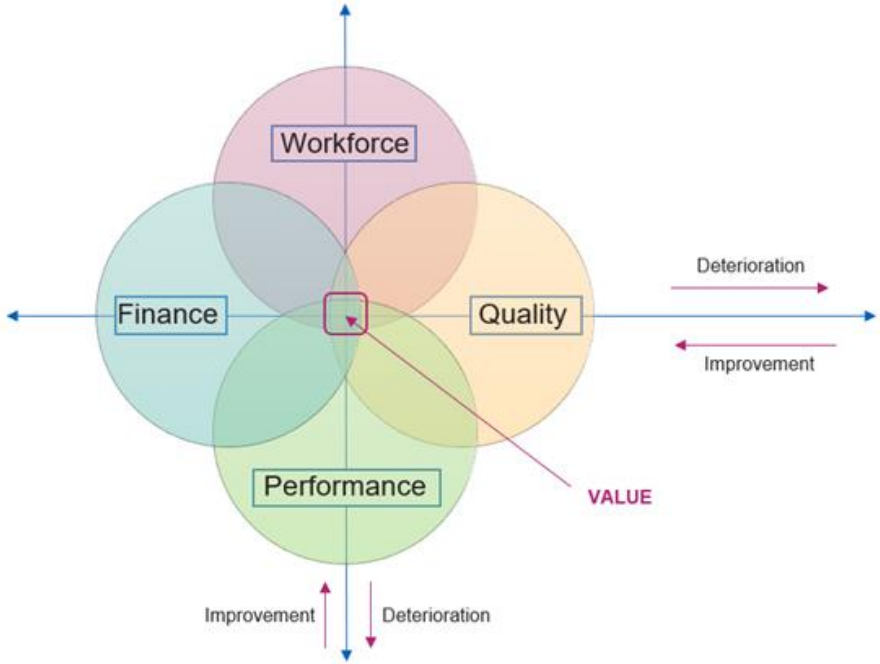
DC and EL: Plans heavily driven by Surgery planning with combined volumes in line with 24/25 and Sulis Elective Orthopaedic centre. Theatre productivity opportunities in the context of current activity run rates, realistic performance thresholds, Theatres planned downtime and Day surgery funding requirements have been reviewed.

Outpatients First and Procedures: 105% / 102% respectively, opportunities through SEOC, Advice and Guidance and clinic template changes.

Outpatients Follow ups: Opportunities for reductions through risk stratification, use of PIFU and Advice and Guidance are under review.

Delivering the CIP

Approach to delivery savings and efficiencies 25/26



In December 24 the Trust board reviewed the Trusts approach to delivering the collective plan. This was through a paper called "finding the balance".

The graph on the right demonstrates on how the Trust is attempting to build the collective plan.

The key issue is the identification of tactical CIPs being developed alongside exercise to understand financial/productivity benefits of Breakthrough objectives and Divisional Driver Metrics to mitigate under delivery of £17.3m identified and unidentified system challenge (assumed SFT share £3.6m)

Identified route to delivering the CIP requirement

Category	CIP: Green rated	CIP: Amber rated	CIP: Red rated	CIP: Total
Agency, Bank and other Workforce controls	1.56	3.36		4.92
Bed rationalisation - SDEC	2.98	1.08		4.05
Bed rationalisation - ICU		0.68		0.68
Elective/OP Activity	1.60	1.96		3.56
Medicines Management	0.50	0.00		0.50
Service redesign - Hospice	0.53	0.53		1.05
Estates & Facilities	0.20	0.02		0.23
Divisional programmes of work	0.52	0.00		0.52
Better Buying/Procurement	0.84	0.96		1.80
Group efficiencies		0.00	3.60	3.60
	8.72	**8.59**	**3.60**	**20.90**
	42%	*41%*	*17%*	

	Q1	Q2	Q3	Q4	FY	
Deficit support funding	11.6	10.7	10.4	10.9	43.5	
Identified route to CIP	2.6	4.5	4.8	5.4	17.3	4.2%
Share of Group 'challenge'	0.4	0.8	1.2	1.2	3.6	0.9%
Total CIP included	**3.0**	**5.3**	**6.0**	**6.6**	**20.9**	**5.1%**

Identified CIP delivery overview

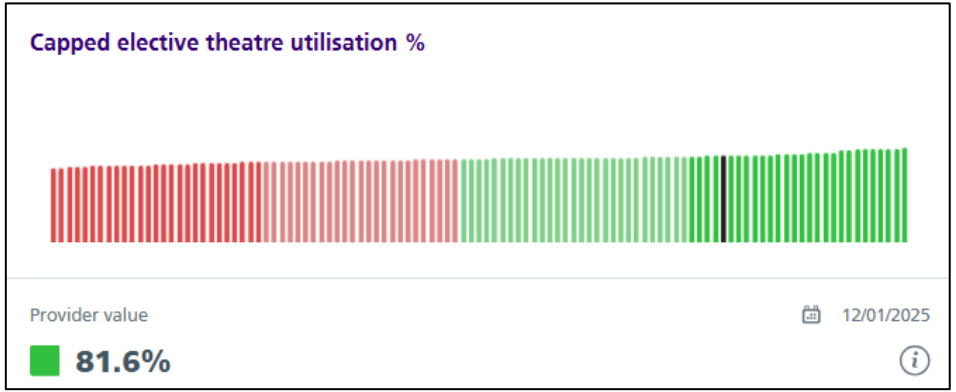
	Efficiency Schemes (FY Total)				
Num		**Planning assumption to support delivery**	**Link to the SPF**	**Delivery forum**	**Risks associated with delivery**
1	Agency, Bank & Other Workforce controls	Bed Closure – linked to NEL growth of 1.4% and NC2R reducing to 9% Corporate services review. Review of administration / digital solutions / span of control.	Strategic initiative – developing sustainable workforce	Workforce Control Panel Workforce FRG	Agency reduction assumes reduction in high cost agency individuals Significant workforce change required and needs support from digital colleagues to enable.
2	Bed rationalisation	Bed Closure – linked to NEL growth of 1.4% and NC2R reducing to 9% Closing two ITU beds	Medicine Driver measure	Urgent Care board	Requires support from external partners to help reduce NC2R and limit. Specific nature of the support is being defined.
3	Better Buying / Procurement (excl Drugs)				
4	Clinical Coding		Strategic initiative – Delivering Digital care to improve pathways	Digital Steering Group	
5	Elective Recovery (including outpatient transformation)	ERF delivery of 125% compared to 19/20	Outpatient Transformation Surgery driver measure	Planned Care Board	Required to maintain level of current theatre outpatient and undertake outpatient transformation.
6	Estates & Facilities	Not investing in improving cleaning of non clinical non patient areas	Facilities driver measure	Facilities management board	Trust would be remain non-compliant.
7	Medicines Management / Drugs		CSFS driver measure		
8	NCTR/Escalation	Bed Closure – linked to NEL growth of 1.4% and NC2R reducing to 9%	Medicine Driver measure	Urgent Care board	Requires support from external partners to help reduce NC2R and limit. Specific nature of the support is being defined.
9	Service redesign		Strategic initiative – Designing services to meet population		Launching new workstream, risk around speed of implementation.

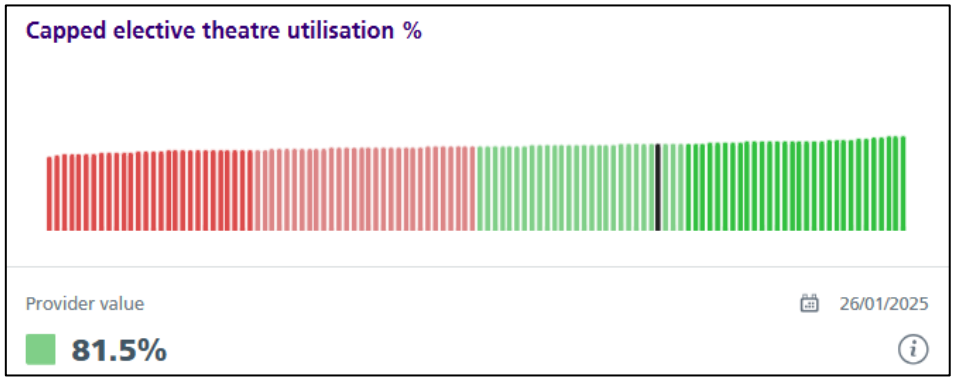
Delivering the Plan

Delivering Productivity

Theatre productivity

- During 24/25 the Trust launched its theatre productivity programme. This helped the Trust move from bottom quartile on model hospital to now top quartile.
- The group continues to meet and is using improving together to continue to work through its top contributors that are causing challenges
- This includes;
    - Theatre list uptake – through team based job plans aiming for 90% list uptake
    - Reducing on the day cancellations
    - Converting rooms into procedure rooms releasing main theatres
- The activity plan assumes the Trust maintains its Q3 and Q4 levels of activity during 25/26.
- The theatre productivity activity is required to deliver the RTT trajectory.





Outpatient productivity

Graph 1

Salisbury Hospital

Outpatient visit 14/10/24 - areas for improvement

NHS Salisbury NHS Foundation Trust

1. Owing to the number of separate outpatient departments across the Trust estate, with no easy solution to change this, it is essential that outpatient estate is shared across services as 'lack of space' was quoted as a barrier to delivering additional outpatient capacity. Therefore, the Trust should implement a single digital outpatient room booking system. The regional team witnessed a lot of unused clinic space on their visit despite being told by several staff that there was not enough room to see patients.
2. Whilst it is recognised that there is a positive culture in the separate outpatient departments visited, these departments appeared well staffed and may benchmark higher in cost to run when compared to a single multi-specialty outpatient department.
3. There is no obvious use of patient self-check in kiosks or outpatient tracking modules. Again, this will lead to higher staff cost in running outpatient services. Modern technology may be difficult to deploy and make effective due to the number of separate modular outpatient departments.
4. The Trust is aware of, but has not yet engaged fully, in the Further Faster checklists for outpatients and this needs to be taken up as a priority. The services we met during the visit did not appear to be engaged with the Further Faster work.
5. There is no single operational leadership or management role for outpatient services. The Trust would benefit from having a single outpatient operational or improvement manager. This individual could not only support the deputy medical director in their work trying to reduce the wait for 1st OP appointment but could drive further improvement and standardisation of process.
6. In some specialties, there were outpatient teams but no medical staff to run the clinics, this is not good use of both estate or support staff resource. The trust may want to consider more use of specialist nurses/AHPs to deliver services such as dermatology.

8

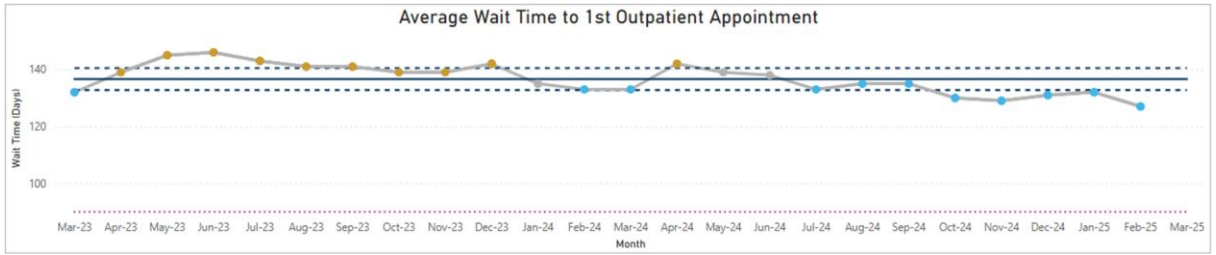
SFTs outpatient improvement plan focuses on two different methods;

- Creation of a central outpatient function focused. This team will aim to focus on the lessons learnt from NHSE review and implement improvements at the Trust level (graph 1)

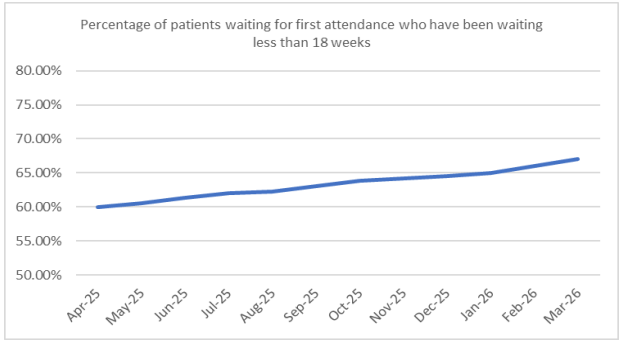
- During 24/25 the Trust used programme support for 4 specialities. These areas delivered significant reduction in time to first outpatient appointment. During 24/25 this will be expanded into each speciality. (graph 2).

The Trust is anticipating seeing improvements in its time to first outpatient and a reduction in the number of patients waiting over 18 weeks for their first appointment. (graph 3)

Graph 2



Graph 3



Closing 27 beds

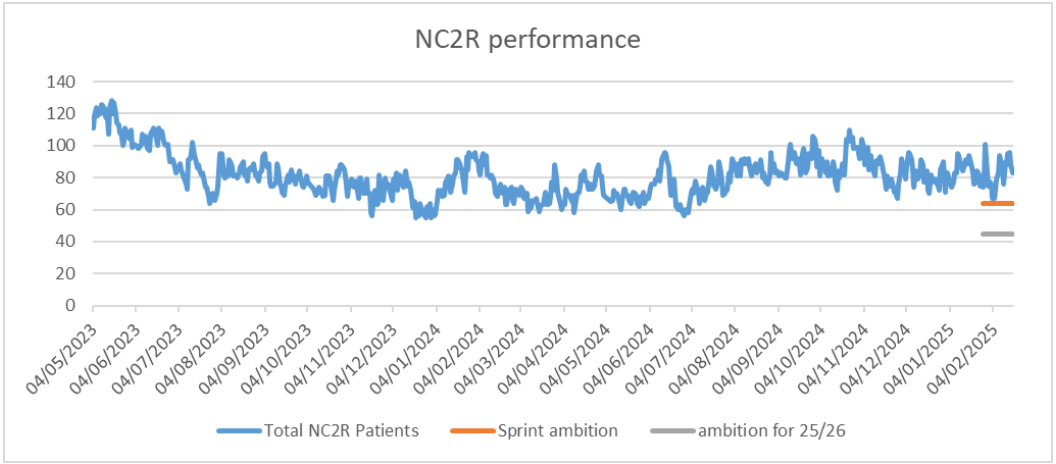
Getting NC2R to no more than 9% of bed base

SFT are working with BSW on the NC2R improvement sprint. The ambition is to get to no more than 40 pts.

The improvement sprint has identified a series of counter measures, a number of which havent been fully implemented during 24/25. These include;

- Electronic D2A discharge form
- Refined care diaries which are being rolled out
- Review roles within the wards to better manage pathways
- Revised community transfer of care hub model
- Training and education of ward based teams
- Daily escalation calls

Additionally new community provider will support shifting in ways of working and capacity to support.



Additional plans to limit NC2R activity;

- New community contract and wiltshire council new services starting in April 25,
- Dedicated focus on frailty pathways across BSW. SFT also working on further developing its own frailty services. These aim to prevent patients needing to be admitting.
- The Trust will also introduce a second NC2R ward, which is proven to support preventing pts decondition and reduce LOS

Limiting NEL growth to 1.4%

NHS Salisbury NHS Foundation Trust

Maturity score (0-2: Early Maturity; 3-5: Progressing Maturity)

	Bournemouth	Poole	Dorchester	Salisbury	Bath
Acute frailty	5	5	1	2	3
Surgical SDEC	2	2	2	1	2
Medical SDEC	2	2	3	2	2

Integrated UEC peer review and maturity self-assessment (needs Futures access)

- In October 24 NHSE undertook assessment of SDEC services and rated SFT as early maturity. It highlighted the areas to support becoming more mature. Key highlights included there was a need to expand space utilised and needed to extend hours.
- The Trust focus is to further implement the recommendations within this assessment and therefore the plan includes;
  - 3 x AMU consultants, expansion of nursing cover and frailty ACPs
  - Expansion of SDEC space within AMU and SAU
- ICB leading on additional actions
  - Community contract for HCRG limits growth – the Trust is working with HCRG to implement transformation to prevent attendance and admission
  - Emerging plans are focused on frailty and urgent care pathways

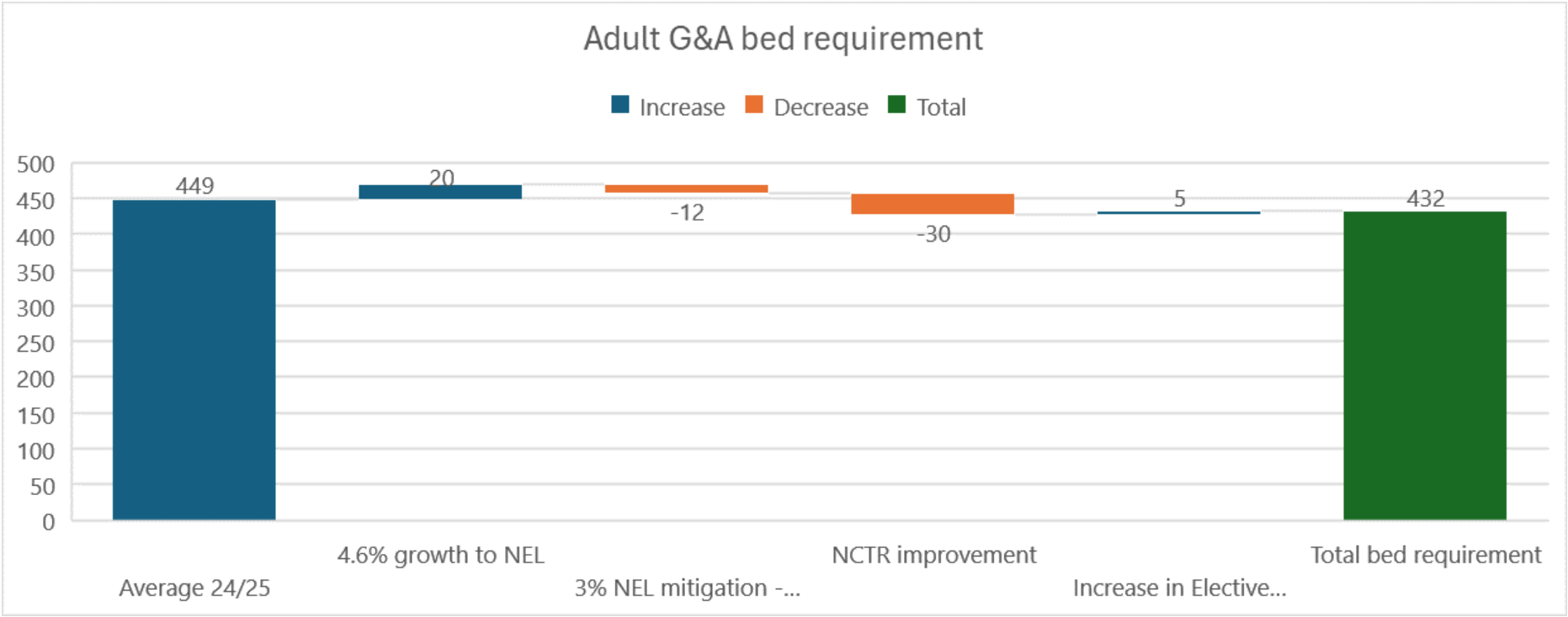
- As a result of these schemes the Trust has sufficient confidence to plan on a NEL admitted growth of only 1.4%

Emerging bed plan

number	scenario description	Core demand with growth excluding NC2R	NC2R pts	total bed requirement	core beds	variance
1	1.4% growth (95% bed occupancy) - no change in NC2R	366	80	446	437	-9
2	1.4% growth (97% bed occupancy) - no change in NC2R	358	80	438	437	-1
3	4.4% growth (95% bed occupancy) - no change in NC2R	378	80	458	437	-21
4	8% growth (95% bed occupancy) - no change in NC2R	392	80	472	437	-35
5	**1.4% growth (95% bed occupancy) - NC2R reduces to 9%**	**361**	**45**	**406**	**437**	**31**
6	1.4% growth (97% bed occupancy) - NC2R reduces to 9%	353	45	398	437	39
7	4.4% growth (95% bed occupancy) - NC2R reduces to 9%	373	45	418	437	19
8	8% growth (95% bed occupancy) - NC2R reduces to 9%	387	45	432	437	5

- Scenario's are based on an average bed requirement over the year so there will be seasonal swing to it that could increase the requirement by as much as 20 or so.
- Assuming 95% occupancy expect option 1b which is 97%
- Length of stay at average seen this year from Apr – Jan.
- The reduced LOS compared to 23/24 releases 12 beds for the same activity
- Above is yearly average, seasonal / monthly variance needs to be modelled
- Core bed base has decreased from 445 to 437 as beds converted in surgery into additional SDEC capacity

Bed summary


Adult G&A bed requirement
Increase
Decrease
Total
500
450
400
350
300
250
200
150
100
50
0
449
20
-12
-30
5
432
Average 24/25
4.6% growth to NEL
3% NEL mitigation -...
NCTR improvement
Increase in Elective...
Total bed requirement

Workforce efficiencies

Workforce reduction

Workforce reductions are achieved through a combination of:

- Corporate Services review (including admin and clerical review) and vacancy management.
- A 15% reduction of Bank staffing, aligned with corporate and divisional reviews, a reduction of bank shifts for non-clinical areas and improved absence management.
- A 40% reduction of Agency Costs achieved through a reduction in Medical Agency spend through recruitment of hard to recruit posts specialist medical posts, and increased efficiency of the use of specialist agency staff.

Workforce Control measures are managed through 2 mechanisms:

- Workforce Control Panel: WCP meets weekly as is chaired by CPO. The WCP seeks to enable Trust activity whilst providing oversight and governance over:
  - The outcome of Divisional Workforce Control Panels, noting QIA for those roles held and further review of those roles recommended for recruitment / projected reduction.
  - Oversight and authorisation to recruit all new and replacement clinical roles, including those required for approval at ICB VCP
  - The oversight and agreement to submit cases in support of regrading of roles, extensions to fixed term contracts and additional payments for recruitment or retention purposes for forward ratification at ICB VCP
  - Authorisation of business cases in support of recruitment to nonclinical roles – by exception
  - Oversight of Temporary Staffing Controls- for example, no bank usage where over funded establishment / no agency where fill rate would be greater than 90%

- Workforce Financial Recovery Group. Meets monthly, chaired by CPO to manage:
  - Current staffing and vacancy situation against Trust workforce WTE establishment
  - Effective management of temporary resources – Fixed Term Contracts (FTC) / secondments / projected Bank and Agency reductions.
  - Impact on organisational design, service efficiencies
  - Administration review – management of change / projected reduction

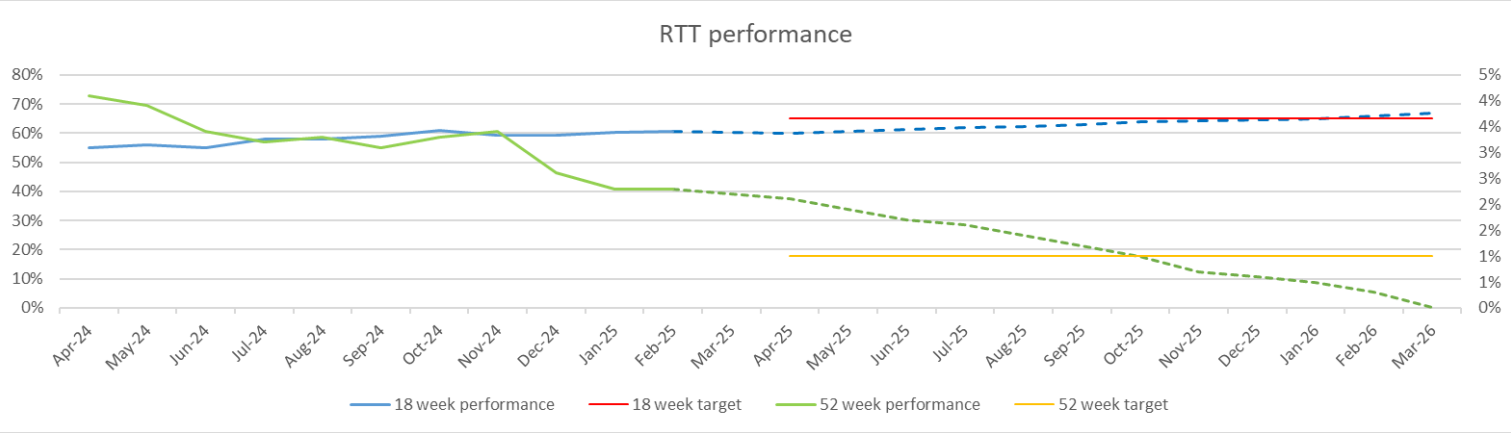
Performance outcome

Performance – RTT

NHS Salisbury NHS Foundation Trust

Ambition

- Increase RTT % within 18 weeks to minimum 64.2%
- Less than 1% of waiting list waiting over 52 weeks
- Increase % of patients waiting over 18 weeks for First OPA to minimum 67%



SFTs RTT trajectory is built on;

- Maintaining the current RTT improvement run rate. This is driven by the continued focus on theatre productivity.
- Continued focus on the long waiters and clearing the number of patients waiting over 52 weeks
- Utilising the outpatient transformation programme to help reduce the waits for first outpatient appointments.

The performance will be delivered by the planned care board and delivery group.

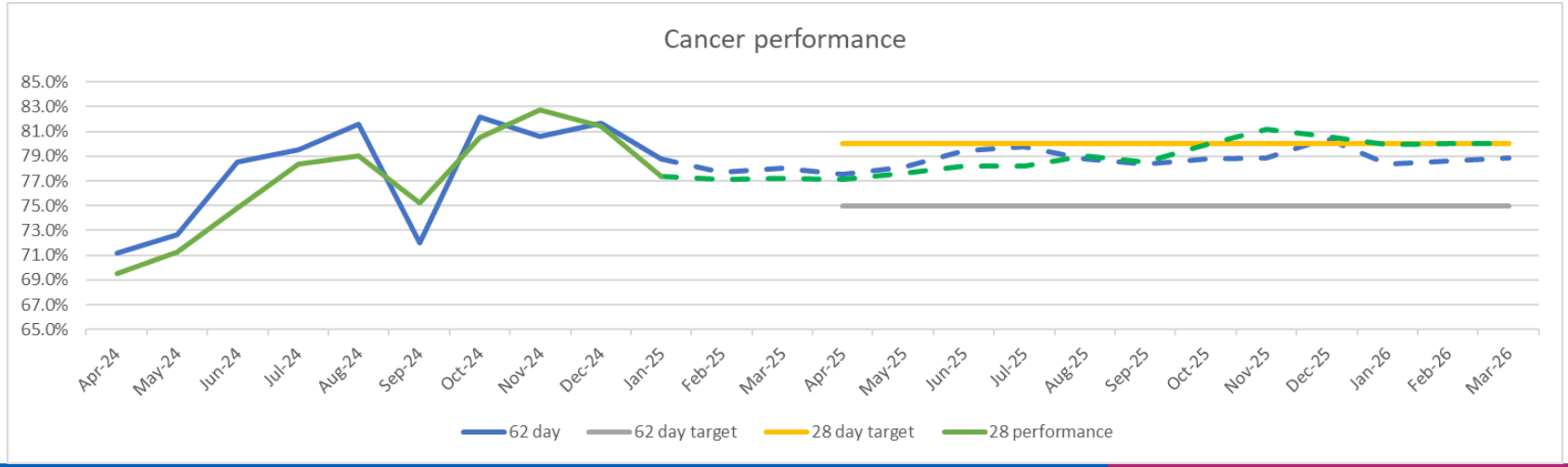
Performance – Cancer

The Trust has, during 24/25 seen significant improvement in its cancer performance. This has been delivered through a focus on implementing national best practice timed pathways and ensuring robust demand and capacity plans are in place. Additionally, through the new speciality managers there is greater micromanagement of patient's pathways.

The Trust is forecasting that it can maintain its performance during 25/26 with some improvement in the 28 day position as endoscopy direct access comes online.

Ambition

Achieve 80% of patients receiving a diagnosis within 28 days
75% receiving treatment within 62 days

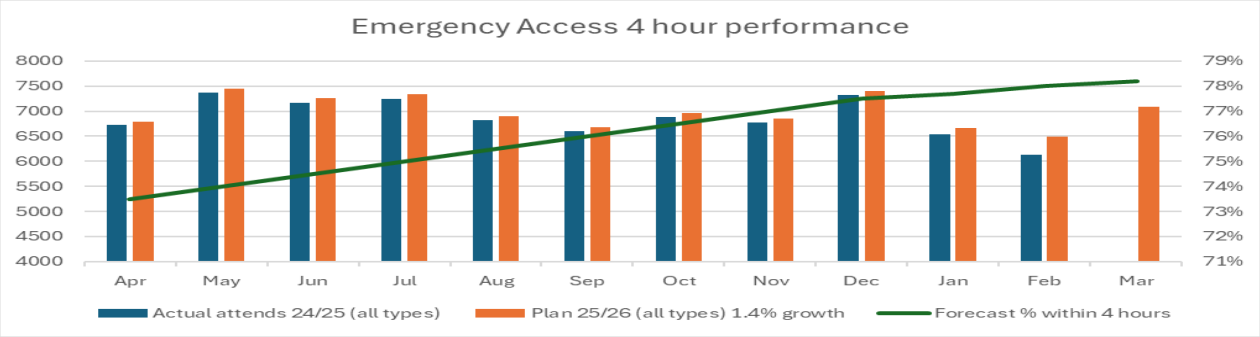


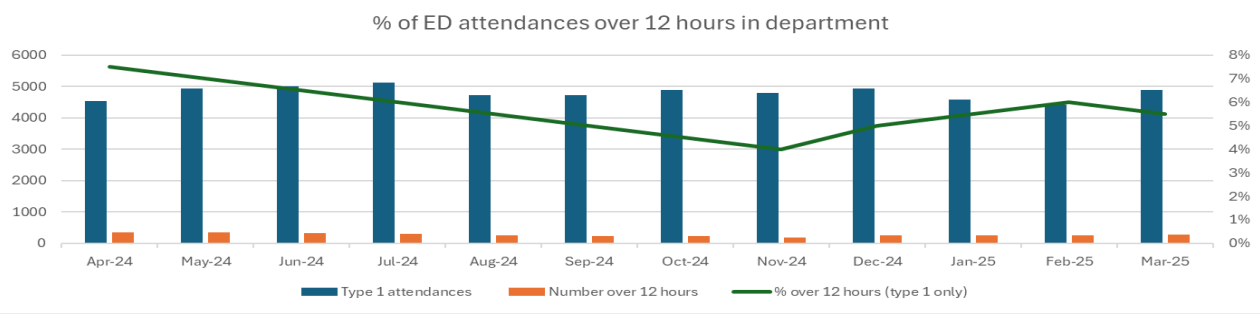
Performance – Emergency Access

NHS Salisbury NHS Foundation Trust

Ambition

Increase performance against the 4 hour standard to 78%
Reduce the proportion of patients spending longer than 12 hours in the ED (no specific target other than reduce)





Assumes growth in attendances mitigated to 1.4%

Reduction in >12 hours to 5.5% (Jan 25 – 8%)

Quality metrics

Quality

NHS Salisbury NHS Foundation Trust

Preventing people from dying prematurely (SHMI)

- Continue to be in line with expected levels relative to national comparators.
- Monitored by the Trust mortality lead and through the Trust's bi-monthly Mortality Surveillance Group, and mortality dashboard.
- Learning from medical examiners shared via leaning forums.

Enhancing quality of life for people with long term conditions

- This section is related to mental health services and admission to acute wards where the Crisis Resolution Home Treatment Team were gate keepers. As these are not commissioned at Salisbury NHS Foundation Trust, there are no indicators to report.

Helping people to recover from episodes of ill health or following injury

- Patient reported outcome measures will continue to be collected and reported appropriately.
- Expansion of SDEC, AFU, and Integrated Discharge Service to deliver appropriate care
- Tertiary and local focus on outcomes for rehabilitation services

Ensuring people have a positive experience of care

- Work is planned to improve across a range of areas, including: discharge process and follow up, communication, staffing levels, food and drink, noise, and facilities. The Trust has also launched 'real time feedback'.
- Most improved inpatient experience report nationally
- Positive relationship with service user groups such as Maternity Voices Partners to inform co production activities

Treating and caring for people in a safe environment and protecting them from avoidable harm

- Addressed by our strategic planning framework vision metric relating to Harm this has resulted in frontline improvement work on falls, medicines, patient deterioration, and pressure injury. Reducing harm will continue to be a Trust wide focus.
- Weekly patient safety meetings reviewing all moderate Datix reports and shared learning processes embedded across the trust

Board Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.		
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.		
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.		
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.		Plan is built in keeping with the finding the balance paper that came to board in November. EQIA process reviewed and adapted to meet the needs of the planning guidance
The organisation's plan was developed with appropriate input from and engagement with system partners.		

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.		
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.		
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.		
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.		Route to delivery has been identified.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.2
Date of meeting:	1 May 2025		

Report tile:	Review of Standing Financial Instructions and Scheme of Delegation			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	Audit Committee, March 2025			
Prepared by:	Mark Ellis, Chief Finance Officer			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer			

Recommendation:

It is requested that the Board approves formalising the delegation of approval limits from the Chief Executive to the Managing Director, as previously agreed by the Trust Board, and notes the clarification on the completion of procurement recommendation reports. The proposals will then be put to the Trust Board for full and final approval.

Executive Summary:

The Trust's delegated limit require formal review at least every two years, the last such review approved by Trust Board was undertaken in March 2023. Any changes to the SFIs must be approved by Trust Board on recommendation by the Audit Committee.

AS previously supported by Trust Board, the recommendation is that the existing delegated approval limits of the CEO are mapped across to the Managing Director. Accountabilities of the CEO remain unchanged.

The changes also include a clarification on the financial threshold for the completion of procurement recommendation reports. This update formally closes a management action agreed as part of the internal audit process.

All other amendments are cosmetic.

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

Purpose

1.1 The purpose of this report is to brief the Committee on the review of the Trust's Standing Financial Instructions and Scheme of Delegation, recommending amendments as appropriate.

2 Background

2.1 The Trust's Standing Financial Instructions (SFIs) have been in place since 1st December 2017. The SFIs are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs should be reviewed for effectiveness and appropriateness on a regular basis, the last such review of the Trust's SFIs was March 2023.

2.3 Where the Board does elect to set delegated limits, the Chief Executive Officer remains ultimately accountable to the Board as Accountable Officer, retaining overall responsibility for the Trust's activities. All delegated powers can be re-assumed by the CEO should the need arise.

2.4 Delegated limits set out in the SFIs and Scheme of Delegation (SoD) are aligned with partners in the BSW hospital group where appropriate.

3 Cosmetic changes

3.1 Updates have been made to the following titles:

i. NHS England & Improvement has been updated to NHS England
ii. Director of Finance (DoF) has been updated to Chief Finance Officer (CFO) in the Scheme of Delegation
iii. Director of Nursing has been updated to Chief Nursing Officer in the Scheme of Delegation
iv. Director of Organisational Development and People has been updated to Chief People Officer in the Scheme of Delegation

4 Managing Director delegated limits

4.1 SFT formally apponted a shared Chief Executive Officer (CEO) with Royal United Hospitals Bath NHS Foundation Trust and Great Western NHS Foundation Trust in Q3 2024/25, and in doing so established the role of Managing Director (MD).

4.2 In Q3 2024/25 Trust Board approved a delegation of duties from the CEO to the MD in order to allow efficient and effective management at a leval level.

4.2 Although the Chief Executive Officer retains all accountabilities set out in the Constitution and the Standing Orders, in order to maintain the day to day operation of the organisations, it is recommended that the delegated approvals limits of the Chief Executive as set out in the table below are formally mapped across to the Managing Director post:

	SFI ref	Description
1	3.1.8	In year revenue approvals (<£250k)
2	9.3.5	Approval of staff payments in advance
3	12.2.1	In year capital approvals (<£500k)
4	12.6.3	Approval of property purchases, licences, or leases (<£200k)
5	12.6.6	Signing of contracts to acquire property
6	14.1.5	Approval of disposal of assets (<£200k)
7	14.2.6	To be informed by CFO of losses that may be material (as well as CEO)
8	19.3	Authorisation of destruction of records before specified guidance limits
9	21.1.2	Approval of individual damages payments (<£500k)
10	22.3	Approval of our of court employment tribunal settlements (<100k)

5 Procurement recommendation report clarification

5.1 A recent internal audit on the BSW group Procurement service highlighted an area of ambiguity on the requirement for a recommendation report in the event of the specified number of quatations/tenders not being met where the market engagement has been conducted. Section 7.12 of the SFIs has therefore been made explicit that a recommendation report is not required for any procurement under £25,000 excluding VAT.

6 Recommendation

There are no material recommended changes to the Trust's SFIs at this time. All amendments are included in the attached SFI document with tracked changes. It is recommended that the following amendments are reflected in the document:

1	Update of job titles (cosmetic)	Throughout SoD document
2	Update of organisational titles (cosmetic)	Throughout SFI document
3	Creation of delegated limits for the Managing Director post as set out in the table in section 4.2 of this paper. The recommendation of this option is contingent on Board approval of moving to a shared leadership structure.	Per table in section 4.2
4	Clarification on requirement for recommendation reports	Section 7.12

Salisbury
NHS Foundation Trust

Standing Financial Instructions

Version:	**Audit Committee ~~March 2023~~March 2025**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	
Signature of authorising Committee:	
Ratification Committee (Category 1 documents):	
Date of Ratification (Category 1 documents):	
Signature of ratifying Committee Group/Chair (Category 1 documents):	
Lead Job Title of originator/author:	**Chief Finance Officer**
Name of responsible committee/individual:	**Mark Ellis**
Date issued:	
Review date:	
Target audience:	**All Directorates**
Key words:	**Trust powers; Trust Board; Chairman; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Directorates**
Consultation:	**Audit Committee** **Executive Directors**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**55**
Type of document:	

Standing Financial Instructions

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STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Salisbury NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st June 2006, following authorisation by "~~NHS England & Improvement~~NHS England", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS England ~~& Improvement~~, which this document represents).

1.1.3 The Single Oversight Framework details how NHS England ~~& Improvement~~ oversees and supports all NHS Trusts. Additional financial guidance is included in The Audit Code for NHS Foundation Trusts, and the Department of Health Group Accounting Manual (DoHSC GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors.

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Finance Officer, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Trust Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Chief Finance Officer (CFO)

1.2.4 The Chief Executive and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Trust Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

1.2.7 Although remaining ultimately accountable, the Chief Executive will delegate all day-to-day operational responsibilities to the Managing Director, as set out in these Standing Financial Instructions and the Scheme of Delegation.

The Chief Finance Officer

1.2.~~8~~7 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

Board of Directors and Employees

1.2.9~~8~~ All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS England ~~& Improvement~~, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.10~~9~~ Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.11~~0~~ For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

Emergency Powers

1.2.12~~1~~ The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

1.2.13~~2~~ The process on utilising Emergency Powers, detailing required documentation, is set out in Annex 4.

2. AUDIT

2.1 Chief Finance Officer

2.1.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by ~~NHS England & Improvement~~NHS England's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets ~~NHS England & Improvement~~NHS England's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DoHSC, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Annual Governance Statement" and also provides assurances to the Audit Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

2.1.2 The CFO and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access during normal working hours to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DoHSC;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.2.4 The Head of Internal Audit or equivalent title, will normally attend Audit Committee meetings and has a right of access to Audit Committee members, the Chairman and Chief Executive.

2.2.5 The reporting system for internal audit shall be agreed between the CFO, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DoHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee.

2.3.2 The Audit Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.3.6 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the CFO is required to authorise expenditure.

2.3.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and CFO shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to NHS Counter Fraud Agency's standards.

2.4.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Agency anti- crime Standards.

2.4.4 The LCFS shall report to the CFO and shall work with staff in NHS Counter Fraud Agency, in accordance with the NHS Counter Fraud Agency anti-crime Standards, the anti-fraud manual and NHS Counter Fraud Agency's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Counter Fraud Agency.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit Committee.

2.4.8 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Counter Fraud Agency .

2.4.9 The Trust will report annually on how it has met the standards set by NHS Counter Fraud Agency in relation to anti-fraud, bribery and corruption work and the CFO shall sign-off the annual self-review and authorise its submission to NHS Counter Fraud Agency. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHS England's standards.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHS England Violence Prevention and Reduction Standard.

2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management

2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD). who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Trust Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in patient care activity, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by ~~NHS England & Improvement~~NHS England (~~NHSE&I~~NHSE).

3.1.2 The annual plan must be approved by the Trust Board and submitted to ~~NHSE&I~~NHSE in accordance with their requirements.

3.1.3 All executive directors, directorate management teams and corporate service managers shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

3.1.4 The CFO will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Trust Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with patient care activity and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks and mitigating actions;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

3.1.5 The Trust Business Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.6 The CFO shall monitor financial performance against budget, and report to the Finance and Performance Committee and Trust Board of Directors.

3.1.7 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.8 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to forecast will be made in year for those that are subsequently approved. Table 1 sets outs the delegated limits for the approval of business cases:

'In year' revenue value	Authorisation to approve
<£25k	Division Management Team
£25k to <£250k	Trust Management Committee Chief Executive Managing Director
£250k to <£750k	Finance and Performance Committee
>£750k	Trust Board

Table 1

3.1.9 The CFO has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the CFO, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

e) Achievement of planned levels of service;

f) Authority to exercise virements.

g) The provision of regular reports.

3.2.2 Except where otherwise approved by the Chief Executive, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

3.2.4 Non-recurring budgets shall be agreed by the Chief Executive or the CFO and should not be used to finance recurring expenditure without their authority in writing.

3.2.5 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.6 Clinical Directors or Service Leads, who are responsible for 'trading activities' must ensure the integrity and supply of information to other users. Price increases in such departments should be monitored by the CFO to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

3.3.1 The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Finance & Performance Committee and Trust Board of Directors in a form approved by the Trust Board of Directors containing sufficient information to allow the Finance & Performance and the Trust Board of Directors to ascertain the financial performance of the Trust. This may include the following:

i) Income and expenditure to date, showing trends and the forecast year-end position;

ii) Workforce spend and WTEs;

iii) NHS commissioner's contractual performance to date;

iv) Movements in working capital (including cash);

v) Capital project spend and projected outturn against plan;

vi) Explanations of any material variances from budget;

vii) Details of any corrective action where necessary and the Chief Executive's and/or CFO's view of whether such actions are sufficient to correct the situation;

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, workload and manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget-holder must account to their Directorate Management Team or line manager for the overspending and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

3.3.3 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Trust's Vacancy Control Panel, other than medical and nursing staff provided for within the budgeted workforce establishment.

3.3.4 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with ~~NHS England & Improvement~~NHS England's Single Oversight Framework, finance and use of resources metrics.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The CFO on behalf of the Chief Executive, will ensure that the appropriate monitoring forms and returns are submitted to ~~NHSE&I~~NHSE in accordance with the national annual timetable. The performance figures to the Trust Board of Directors should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as ~~NHS England & Improvement~~NHS England and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by ~~NHS England & Improvement~~NHS England as to their technical accounting content and information/data shown therein, before submission to ~~NHS England & Improvement~~NHS England.

4.2 The Chief Executive will prepare the Annual Report in accordance with the guidance in the DoHSC Group Accounting Manual.

4.3 The Chief Nursing Officer will prepare the Annual Quality Report in the format prescribed by ~~NHS England & Improvement~~NHS England /Care Quality Commission and in accordance with the DoHSC Group Accounting Manual. The Quality Report presents a balanced picture of the Foundation Trust's performance over the financial year and up to the agreed submission date.

4.4 The Trust's Annual Report, Annual Accounts and financial returns to ~~NHS England & Improvement~~NHS England and Annual Quality Report must be audited by the external auditor in accordance with appropriate international auditing standard, where relevant.

4.5 The Annual Report, Accounts and Quality Report (including the auditor's report), shall be approved by the Board of Directors after review by the Audit Committee. The Clinical Governance Committee will also review the Quality Report prior to its submission to the Audit Committee.

4.6 The Annual Report, Accounts and Quality Report (including the auditor's report) is submitted to ~~NHS England & Improvement~~NHS England (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.7 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.8 The Chief Executive, Chairman and CFO, as appropriate, will sign the various documentation relating to the Annual Report, Annual Accounts and financial returns to ~~NHS England & Improvement~~NHS England and Annual Quality Report on behalf of the Trust Board.

4.9 Where a subsidiary is owned or partially owned by the Trust in a manner to require consolidation under the requirements of IFRS then the annual accounts of the subsidiary will be completed as a part of undertaking the consolidated accounts for the Trust. Should the Trust be involved with an Associate Company the results will be reported in line with recognised accounting requirements.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The CFO will review the banking needs of the Trust at regular intervals to ensure they reflect current business patterns and represent value for money.

5.1.3 The Trust Board will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made, or there is a right of set-off with another account held with that bank;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

f) Monitoring compliance with ~~NHS England & Improvement~~NHS England or DoHSC guidance on the level of cleared funds;

g) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit, if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the "Payment by Results" ("PbR") financial regime determined by the DoHSC where applicable.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Responsibility for arranging the level of property rentals, and for reviewing rental and other charges regularly shall rest upon the Chief Finance Officer who shall take into account independent professional advice on matters of valuation. The Chief Finance Officer shall be consulted about the pricing of goods and services offered for sale.

6.2.3 All Employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Financial Controller
£10,001 to £100,000	CFO
£100,000 plus	~~Audit~~ Finance & Performance Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit Committee should be presented to the Trust board for information.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The Chief Finance Officer shall be responsible for the arrangements for security and issue of bulk stocks of cheques.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the CFO.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed “declarations of indemnity” must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 14 Disposals and Condemnations, Losses and Special Payments).

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

Table 2

Contract Value (Excl VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 - Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage

of the procurement process.

Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method and authorisation).

The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

7.3 Placing Contracts

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 3 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 3.

Table 3

Contract Value (Excluding VAT)	Recommendation Report Requirement	Authorisation To Place or sign Contract
<£10,000 (Inclusive of zero nominal value)	No	Deputy Director of Procurement
£10,000 < £25,000	Recommendation report required only if contract has not be awarded to the most economically advantageous offer	Deputy Director of Procurement
£25,000 < £100,000	Yes	Deputy Director of Procurement
£100,000 < £350,000	Yes	Director of Procurement
£350,000 < £750,000	Yes	Chief Finance Officer
£750,000 < £1,500,000	Yes	Finance Committee
>£1,500,000	Yes	Trust Board/Chairman

The Chief Finance Officer, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

7.4 Electronic Tendering

All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal.

All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.12 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

7.5 Manual Tendering – General Exception Rules

No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.6 Receipt, Safe Custody and Record of Formal Tenders submitted manually

All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

The appropriate officer shall designate an officer or officers, not from the

originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.7.

7.7 Opening Formal Tenders

As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

Every tender received shall be stamped with the date of opening and if manually opened they shall be initialed by two of those present at the opening.

A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record, where a manual process has been conducted.

Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialed by two of those present at the opening.

A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

7.8 Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Finance Officer, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

Tenders received after the due time and date may be considered only if the Chief Finance Officer or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Finance Officer, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Chief Finance Officer or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.8.

Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Finance Officer.

Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.10 below).

All tenders should be treated as confidential and should be retained for inspection.

7.9 Extensions to Contract

In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

7.10 Quotation & Tendering Procedures

Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2 and will involve procurement department in line with Table 2.

Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

No tender shall be considered which bears any mark or name indicating the sender.

Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2

Tender lists for building and engineering works will be compiled in conjunction with the Director of Estates from “Construction line” the Trust’s approved list of Contractors.

Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Chief Finance Officer for further instructions.

The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

Quotation/tenders will be completed accordance with these SFIs.

Adjudication must be made in accordance with SFI 7.8 recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2).

All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 2.

7.11 Quotation & Tendering Procedures Summary - Contracts

Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

No Pre Qualifications stages should be conducted in accordance with Public Contract Regulations
Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 2 in specified in SFI 7.2.

Quotations/ tenders will be issued in accordance with these SFI’s and shall

incorporate standard NHS Terms and Conditions of Contract.

After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.8.

A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Table 2 in SFI 7.3 according to delegated limits.

All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee on a six monthly basis highlighting all waivers over £10,000 in line with STA's approved by the Chief Finance Officer.

All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations.

All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source To Contract System. Any exceptions to this are at the discretion of the Director of Procurement.

7.12 Waiving or Variation of Competitive Tendering/Quotation Procedure

Signed Contracts will be required for all Single Tender Action waivers over £25,000.

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required. A recommendation report is not required for procurements under £25,000 excluding VAT.

Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value out in in SFI 7.2 Table 2

b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with

c. The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (eg/ change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor

d. The expenditure relates to agency pay however internal governance and authorisation will apply

e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health

f. A direct award to a supplier on a national or regional framework is

permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with SFI 7.3 Table 2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. The requirement is to attend a seminar, conference or similar unique event

h. A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement but the nominated Officer must still ensure value for money

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Trust Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by ~~NHS England & Improvement~~NHS England are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

(a) Costing and pricing (in accordance with Payment by Results) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff. Any local price should be at least equal to the appropriate cost of the service being provided.

8.1.7 Any local changes in the counting and coding of patient activity will need to be notified to the CFO prior to implementation

8.1.8 The CFO shall produce regular reports detailing actual and forecast income.

8.1.9 The CFO shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

Annex
8.1.10 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs

and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where SFT is a competing body)

8.3.1 Where SFT participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Directorate Management Team	**Trust Management Committe**	**Finance & Performance Committee**	**Trust Board**
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£5m	<£15m	>£15m
Annual value	£20k pa	<£1m pa	>£1m<£5m pa	>£5m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to Executive Directors for noting.

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration Committee

9.1.1 The Trust Board shall establish a Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and most Senior Manager Posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director Posts above the salary of the Prime Minister (currently circa £150k) must be referred to ~~NHS England & Improvement~~NHS England and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Workforce Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees

after consultation with their Human Resources Manager and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off payroll engagements must be approved by the CFO prior to contract signature.

9.2.3 Each employee shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be submitted to the Chief Finance Officer at the earliest opportunity.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the intranet.

9.2.6 A "Notification of Termination" form and such other documents as the Chief Finance Officer may require, shall be completed and forwarded to the payroll department immediately upon the date of; an employee's resignation, retirement, or termination, being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Payroll Manager shall be informed immediately.

9.2.7 Changes forms covering an Employee's Personal Details i.e. Name, Address or Job Details shall be completed and forwarded to the payroll department immediately upon the Manager becoming aware of the change.

9.2.8 The Trust Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its Managing Implications of Organisational Change Policy.

9.2.11 The Trust must seek approval from ~~NHS England & Improvement~~NHS England before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

9.3.1 The Chief Finance Officer shall be responsible for the final determination of monetary pay, (including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts), the proper compilation of the payroll and for payments made. No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the Chief Finance Officer.

9.3.2 All pay sheets, and other pay records including travel expense claim forms supported by vouchers/receipts where appropriate, shall be in a form approved by the Chief Finance Officer (manual or electronic) and shall be certified and submitted in accordance with his/her instructions.

9.3.3 The Chief Finance Officer shall determine the dates on which salaries and wages shall be paid.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed otherwise by the Chief Finance Officer.

9.3.5 Payment shall not be made in advance of the pay dates determined as in 9.3.3 above except where prior approval has been obtained from the Chief Executive, Managing Director, Chief Finance Officer (or duly appointed representative) or the Chief People Officer. In such cases the payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 Where the Trust HR Policies so allow, loans may be made to staff and recovered in accordance with arrangements that the Chief Finance Officer and Chief People Officer shall determine jointly.

9.3.7 The Chief Finance Officer shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours. Any claims over 3 months old will need to be approved by the CFO.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Finance Officer will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Chief Finance Officer will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition. Only for agreed goods and services (i.e. agency staff and utilities) should a good or service be obtained without a purchase order.

10.3.3 The CFO or if delegated, the Financial Controller, shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.4 The CFO will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are

evidenced;

- In the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.5 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.6 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the Chief Executive;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

e) Petty cash records are maintained in a form as determined by the CFO;

f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and

g) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the CFO who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Where managers are unsure of the VAT status of any particular transaction advice will be provided from the Finance Department.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within ~~NHS England & Improvement~~NHS England's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Trust Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 Any application for an increase in public dividend capital on behalf of the Trust shall only be made by the Chief Finance Officer or their nominated representative and will be notified to the Trust Board or the Finance and Performance Committee on the Board's behalf.

11.2.2 The Trust will comply with the guidance on dividend payments contained in the DoHSC Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 Investment of cash on a short or long term basis shall be in accordance with the Trust's Treasury Management Policy as approved from time to time by the Finance and Performance Committee. The Chief Finance Officer shall compile and regularly review the Trust's Treasury Management Policy and advise the Finance and Performance Committee of any necessary changes.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Trust Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by ~~NHS England & Improvement~~NHS England and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Finance and Performance Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of

investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Finance and Performance Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Strategic Capital Committee (SCC) chaired by the Chief Finance Officer to oversee its allocation of capital investment. The CFO will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The SCC will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The CFO shall establish systems to ensure that approved capital schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The financial performance of the Capital Programme shall be reported to the Trust Board on a monthly basis with fuller details of the larger schemes on a quarterly basis.

12.2 Approval of Capital Business Cases

12.2.1 Approval of Capital Business Cases will be as follows:

Table 4

Capital Plan	***Approval to proceed, or changes to previously approved Capital.***	**Forum**
N/A	<£20k	Buildings & Infrastructure Group, Medical Devices Management Committee, IT Capital Group
N/A	<£100k	CapCG (SCC informed via minutes)
N/A	£100k to <£350k	Strategic Capital Committee Chief Finance Officer
N/A	£350k to <£500k	TMC Chief Executive Managing Director
N/A	£500k to <£750k	Finance and Performance Committee
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	£750k+ Any proposed major scheme within FT compliance arrangements	Trust Board

Any proposed major scheme within FT compliance arrangements	Any proposed major scheme within FT compliance arrangements	~~NHS England & Improvement~~NHS England

Where a capital scheme is approved within the annual capital plan, full and final approval to proceed is still required as set out in the delegated limits in table 4.

Approvals for capital projects over £350k, will be itemised in a schedule to Trust Board on a quarterly basis.

Programme allocations within Capital Plan	**Group/ individual responsible for approval**
Building and Works	The Building and Infrastructure Group
Medical Equipment	Medical Devices Committee
Information Systems	Information Systems Steering Group

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Investment Group for approval or review prior to request for approval by the Finance and Performance Committee or Trust Board if required.

12.4 Asset Registers

12.4.1 The CFO is responsible for the maintenance of registers to record capital fixed assets. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The CFO shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

12) a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. This procedure shall make provision for:

12) ~~a)~~ Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for Equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £200,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £200,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £200,000 each (excluding VAT) may be authorised by the Chief Executive or Managing Director, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive or Managing Director.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £100,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets requires the approval of ~~NHS England & Improvement~~NHS England.

12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework requires the approval of ~~NHS England & Improvement~~NHS England.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £200,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net reliable value. Inventory shall be controlled on a First in First out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; and the control of fuel oil the Head of Estates.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Logistics Manager wherever practicable; stocks should be marked as Health Service property.

13.1.4 The CFO, in conjunction with the Associate Director of Procurement, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.7 The Director of Procurement shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net reliable value. The write down shall be approved by the CFO and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Director of Procurement shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice or the assistance of the Procurement department where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued between £100,001 - £200,000k (higher of either market value or net book value) must be approved by the Chief Executive or Managing Director.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DoHSC Group Accounting Manual and prepare a register.

14.2.2 The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See the Trust's Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Fraud, Bribery and Corruption Policy.

14.2.4 The CFO is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHS Counter Fraud Agency.

14.2.5 The Directorate or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive and Managing Director in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Senior Information Risk Owner (SIRO), supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Informatics Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

It will be at the discretion of the Chief Information Officer whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The CFO will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), and is responsible for the management of funds it holds on trust. For the purposes of these SFI's the Trust Board members shall be termed Trustees. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust with the exception that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and be made only with the approval of the Fund Manager appointed by the Trustees or the Trustees themselves. This section covers those instructions which are specific to the management and governance of funds held on trust.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The CFO has primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.2 Administration of Charitable Funds

17.2.1 The CFO shall:

a) Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust Board as Trustees of charitable funds. These shall be maintained in accordance with legislative requirements and any directions from the Charity Commission.

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within designated or restricted accounts in accordance with charity law;

e) Periodically review the funds, rationalise funds within statutory guidelines, and report changes to the Salisbury District Hospital Charitable Fund Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals to the Salisbury District Hospital Charitable Fund Committee at their quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Salisbury Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising and Incoming Funds

17.3.1 All gifts, donations and proceeds of fund raising activities are the responsibility of the Trustees and shall be handed immediately to the CFO to be banked in the Charitable Funds bank account.

17.3.2 All gifts accepted shall be receipted and held in the name of the Trustees and administered in accordance with the Trustees' policies, subject to the terms of specific trusts. As the Trustees can accept gifts only for all or any purposes relating to the Health Service, managers shall, in cases of doubt, or where there are material revenue expenditure implications, consult the CFO before accepting gifts.

17.3.3 The CFO shall advise the Trustees on the financial implications of any proposal for fund raising activities which may be initiated, sponsored or approved.

17.3.4 The CFO shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. All correspondence concerning legacies shall be dealt with on behalf of the Trustees by the CFO who alone shall be empowered to provide an executor a good discharge.

17.4 Investments and Investment Income

17.4.1 The Trustees shall be responsible for:

a) Appointing investments advisors to manage investments and provide relevant investment advice on these. Charitable funds shall be invested in a manner to maximize medium term value,

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

17.4.2 The CFO will allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Expenditure from any Charitable Fund shall be conditional upon the item being within the terms of the appropriate trust, the procedures approved by the Trustees and sufficient funds being available.

17.5.2 Day to day management of individual expenditure is delegated to Fund Managers who shall not enter into any transaction which will result in any fund under their control becoming overdrawn without first obtaining authorisation in writing from the CFO.

17.5.3 The CFO shall act on behalf of the Trustees in ensuring that all expenditure incurred is in accordance with the purposes identified by the donor.

17.5.4 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.5 A connected multiple orders could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.6 **Levels of Authority**

No expenditure can take place without the approval of the following:

£	**Orders can only be processed once the following people give their authority**
Up to £10,000	The Fund Manager
Over £10,000	The Fund Manager + The Salisbury District Hospital Charitable Funds Committee (reported to the Trust Board)

17.5.7 Where charitable fund expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.6 Asset Management

17.6.1 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure.

17.6.3 The Charity shall not be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The CFO will be responsible for updating an annual risk register for

agreement by the Salisbury District Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. Public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. Breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's Conflicts of Interest Policy. This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Head of Corporate Governance for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Conflicts of Interest and Freedom to Speak Up: Raising Concerns policies, available via the intranet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with ~~NHS England & Improvement~~NHS England / DoHSC guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	~~Director~~ Head of Estates
Building & Engineering Contracts	~~Director~~ Head of Estates & Director of Procurement
Estate Maintenance Contracts	~~Director~~ Head of Estates & Director of Procurement
Maintenance Contracts	Director of Procurement
Commissioner Contracts	Chief Finance Officer
Contracts for goods and services other than the above	Director Procurement

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Director of Procurement for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest ~~NHS England & Improvement~~NHS England / DoHSC guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive, Managing Director, or CFO. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control

cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /~~NHS England & Improvement~~NHS England guidance.

20.2 Insurance

20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Financial Controller shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.2.3 The Financial Controller shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Financial Controller shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3 Clinical Risk Management/CNST

20.3.1 The Chief Nursing Officer shall:

a) Provide a central point of contact within the Trust for NHSLA/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution (formerly NHS Litigation Authority)/Claims Handler considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the trust within the excess of £3k will be notified to the Head of Litigation and Insurance Services for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the Salisbury NHS Foundation Trust as the defendant.

Up to £100k NHSLA/Claims handler ——— Head of Litigation

£100k-£250k NHSLA/Claims handler ——— Chief Nursing Officer

£250k-£500k NHSLA/Claims handler ——— Chief Executive and Managing Director

>£500k NHSLA/Claims handler ——— Trust Board

The DoHSC must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made contrary to legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Salisbury NHS Foundation Trust the act provides that SFT is exempt from repaying their "own" costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Chief People Officer.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Chief People Officer and the CFO. In certain cases, additional approval should be sought from ~~NHS England & Improvement~~NHS England and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Chief People Officer advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £30,000	Chief People Officer
£30,001 to £100,000	Chief Executive and Managing Director
£100,000 plus	Trust Board

22.4 ~~NHS England & Improvement~~NHS England must be consulted before making any special payments that are novel, contentious or repercussive. The Chief People Officer, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against/contrary to legal advice must be approved by the Trust Board.

23. WHOLLY OWNED SUBSIDIARIES

23.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

24. RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, 'Attributing the costs of health and social care research and development' (AcoRD DH2012) using the national costing guidance/templates. Excess treatment costs should be submitted to CRN:Wessex for funding.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 The Standing Orders and other sections of the SFIs apply equally to the undertaking of research and this includes declaration of interests, security of assets, budgetary control, purchasing and contracting, charitable funds, and the section on casual gifts, hospitality and commercial sponsorship.

24.5 The submission of grant applications to support research shall be signed by the Chief Finance Officer or designated representative.

24.6 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

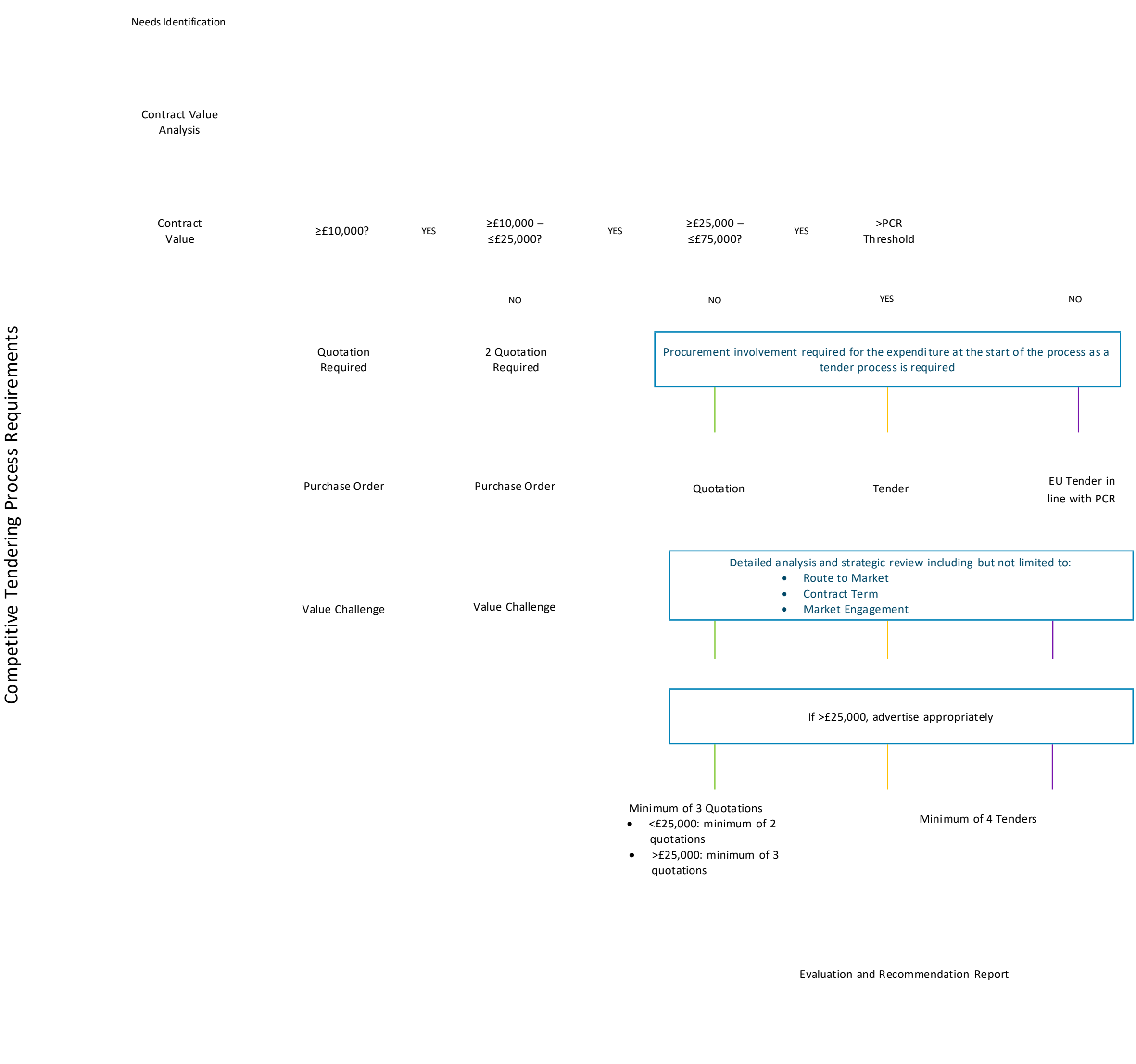
24.7 The principles governing probity and public accountability shall apply equally to work undertaken through research.

Annex 1

Authorisation Levels For Electronic Requisitioning System

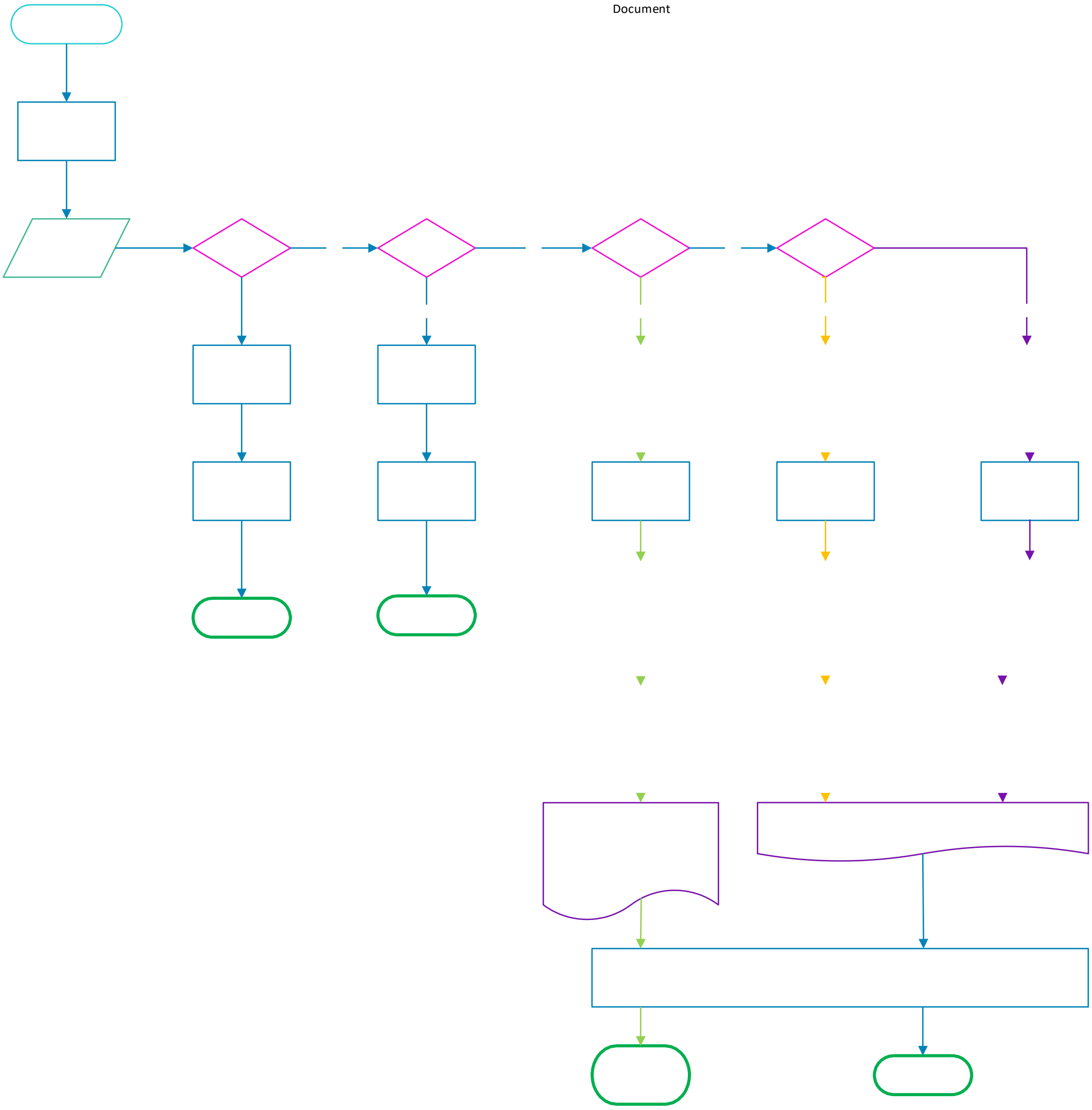
Hierarchy	Abbreviated	iProc Function	Role	Indicative Band for Responsibility	Financial Approval Authority Limit (Financial approval limits are gross (including tax) based on value of transaction)	Non PO Invoice Approval Hierarchy	R12 Invoice Approval Position
Level 1	L1R	Requisitioner	Any	Preferably Band 2 or 3 (several per sub service)	£0	No	RNZ_INVOICE_APPROVER_0000000
Level 2	L2A	Approver	Band 5 if A&C or Band 6 if clin	Band 5 / 6	£1,000	Yes	RNZ_INVOICE_APPROVER_0001000
Level 3	L3A	Approver	Ward Lead or Sub-Service Ma	Band 7	£2,500	Yes	RNZ_INVOICE_APPROVER_0002500
Level 4	L4A	Approver	Head of Service or Clinical Le	Band 8a+ or Clinical Lead	£5,000	Yes	RNZ_INVOICE_APPROVER_0005000
Level 5	L5A	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£9,999	Only for escalation	RNZ_INVOICE_APPROVER_0009999
Level 5A	L5AA	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£10,000	Only for escalation	RNZ_INVOICE_APPROVER_0010000
Level 6	L6A	Approver	Divisional Director of Operations (DDO)	Band 8d or 9	£25,000	Only for escalation	RNZ_INVOICE_APPROVER_0025000
Level 7	L7A	Approver	Deputy Director of Finance / Financial Controller/Director of Procurement		£50,000	Only for escalation	RNZ_INVOICE_APPROVER_0050000
Level 8	L8A	Approver	Chief Operating Officer / Director of Nursing / Medicial Director / Director of OD&P		£100,000	Only for escalation	RNZ_INVOICE_APPROVER_0100000
Level 9	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Level U	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Procurement authority to process pre-authorised orders							
		Approver	Director of Procurement		£350,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000
		Approver	Deputy Director of Procurement		£50,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000

Annex 2 Tendering & Contracting Procedures (where SFT is the procuring body)



Contract Approval Document

Contract Signed



Annex 3

Contracting for Income - Financial Limits

NON NHS
All limits **exclude** Value Added Tax where applicable.

Lifetime Contract value	**Approval**
Up to £20,000 (Inclusive of zero nominal value)	**Deputy** Chief Finance Officer**/Director of Procurement**
£20,000 to < £300,000	CFO
£300,000 to <£1.5million	**CEO**
£1.5m +	**Trust Board**

Lifetime Contract value (NHS)
Service Level Agreements
Up to £100,000,000 Director of Finance
Over £100,000,000 Chief Executive and Managing Director

Annex 4

Emergency Powers (Chair's Action)

1. A recommendation to utilise Emergency Powers must be made by the Chief Executive (or ~~Deputy Chief Executive~~Managing Director) if responsibilities have been delegated) by email to the Chair and at least two other Non-Executive Directors.

2. The request must include the justification for the recommendation, and the reasons for the need to override normal governance procedures.

3. Agreement to proceed is contingent on the approval of CEO, Chair, and at least two Non-Executive Directors. Evidence of the approval must be recorded (email records are sufficient).

4. The exercise of emergency powers shall be reported to the next formal meeting of the Board in public or private (as appropriate) for ratification.

5. Utilising Emergency Powers does not remove the need to subject the recommendation to Trust governance procedures. Business cases, recommendation reports, and any other paper falling within the scope of the Scheme of Delegation should still be reviewed in the forums and committees as set out in the SFIs as a matter of good practice and to ensure risks, mitigations, and benefits have been appropriately explored and challenged.

6. A schedule of decision taken under Emergency Powers should be presented to Audit Committee on a quarterly basis. This schedule should include the reasons for the escalation, as set out in (2.).

Salisbury
NHS Foundation Trust

Schedule of Decisions Reserved to the Board and the Scheme of Delegation

Introduction

1. The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. This document sets out the powers reserved to the Board and those that the Board has delegated.
2. The Board remains accountable for all of its functions; even those delegated to the Chair, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
3. All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee of the Board shall be exercised on behalf of the Board by the Chief Executive or another executive director.
4. The Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligations. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that targets are met.
5. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. Whilst the detailed responsibility can be further delegated the Chief Executive remains accountable for that responsibility to Board. All powers delegated can be re-assumed by him/her should the need arise.
6. The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.
7. In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Deputy Chief Executive Officer or in his/her absence by the Executive Director who is formally acting-up as Chief Executive. Formal acting-up status shall be confirmed in writing by either the Chief Executive or the Chair.
8. The Scheme of Delegation is reviewed annually.
9. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

Schedule of Decisions Reserved to the Board

SFI Ref	Decision reserved to the Board
1.2.1	• Formulate the financial strategy • Approve budgets • Define and approve essential features of important procedures and financial systems • Define delegated responsibilities.
3.1.2	Approve the Annual Business Plan

4.5	Approve Annual Report and Accounts including the auditor's report.
5.1.3	Approve the opening of new bank accounts.
7.3	Authorise contracts with Suppliers which exceed £1.5m.
8.1.1	Regularly review and maintain capacity and capability to provide mandatory goods and services per the terms of the licence.
9.1.1	Establish a Remuneration Committee.
10.1.1	Approve the level of non-pay expenditure.
11.1.3	Approve application for a loan/overdraft.
11.1.5	Approve all long-term borrowing.
11.3.3	Approve investments made in forming/acquiring an interest in bodies corporate.
12.1.1	Establish a Capital Control Group.
12.1.3	Approve the Annual Capital Plan.
12.2.2	Approve all capital business cases above £750,000
12.6.2	Approve Estate Strategy and acquisition of property (freehold & lease) over £200,000.
12.6.8	Approve disposal of property over £100,000.
12.6.10 & 12.6.11	Seek approval from NHS ~~Improvement~~ England for the disposal of protected assets and major disinvestments.
12.6.12	Approve the granting of property leases where the annual value is in excess of £200,000.
16.1	Provide safe custody for money and other personal property of patients.

Decisions/Duties delegated by the Board to Committees

Committee	Duties delegated by the Board
Audit Committee	See Terms of Reference (available from Head of Corporate Governance). In addition: SFI 11.3.2 Set investment policy. Oversee all investment transactions. Approve treasury policy. SFI 11.3.4 Approve short term investment vehicle.
Remuneration Committee	See Terms of Reference (available from Director of Corporate Governance)
Salisbury District Hospital Charitable Fund Committee	See Terms of Reference (available from Director of Corporate Governance)

Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities / Duties Delegated
1.1.8	Audit Committee	Referring action or ratification of any non-compliance with SFIs. Also need to be disclosed to the ~~DOF~~CFO.
1.2.6 & 1.2.9	Chief Executive	Ensuring that all members of the Board and employees of the Trust understand their responsibilities within SFIs.

1.2.7	~~DOF~~CFO	• Ensuring that SFIs are appropriate and up to date • Implementing the Trust's financial policies • Maintaining an effective system of internal financial control • Maintaining records of financial transactions • Providing financial advice to Board and employees.
1.2.8 & 1.2.9	All directors, staff and contractors	Security of Trust property, avoiding loss, exercising economy and efficiency in the use of resources, and conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation.
2.1.1	~~DOF~~CFO	• Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. • Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards. • Ensuring that an annual internal audit report is prepared for the consideration of the Audit and Assurance Committee.
2.2.2	Head of Internal Audit	Reviewing, appraising and reporting upon compliance with established policies and procedures such as the Audit Code.
2.3	Chief Executive / Audit Committee	Ensure that an external auditor is appointed in compliance with the constitution and that they comply with the Audit Code. Ensure that the Council of Governors are aware as appropriate.
2.4	Chief Executive / ~~DOF~~CFO	Ensure compliance with the directions on NHS fraud and corruption. Appoint a Local Counter Fraud Specialist and consult with him/her as to the involvement of the police in cases of fraud and corruption.
2.5	Chief Executive	Control and coordinate security management. Appoint a Local Security Management Specialist.
3.1.1	Chief Executive	Submit to the Board the Annual Trust Business Plan which takes into account financial targets and forecast limits of available resources.
3.1.4	~~DOF~~CFO	Prepare and submit an annual budget.
3.1.6	~~DOF~~CFO	Monitor financial performance against budget and report to Board.
3.1.8	Chief Executive / Managing Director	Approve business cases up to £250,000.
3.1.8	Finance and Performance Committee	Approve business cases up to £750~~50~~0,000
3.1.9	~~DOF~~CFO	Ensure that adequate training is delivered to budget holders to help them manage successfully.
3.2.1	Budget holders	The management of a budget to permit performance of a defined range of activities.

3.3	~~DOF~~CFO	Devise and maintain systems of budgetary control including monthly reports to Board containing sufficient information to ascertain financial performance.
3.3.4	Chief Executive	Identify and implement cost improvement programmes.
3.5.1	Chief Executive/ ~~DOF~~CFO	Appropriate monitoring forms and returns are submitted to Monitor.
4.1	~~DOF~~CFO	Prepare annual financial accounts and returns ensuring that they comply with current guidelines.
4.2	Chief Executive	Prepare an Annual Report.
4.3	Director of Nursing	Prepare the Annual Quality Account.
4.6	~~DOF~~CFO	Submit the annual report and accounts to NHS Improvements.
4.8	Chief Executive & Chair	Sign the Statement of Directors' Responsibilities in Respect of the Quality Report.
5.1.1 & 5.4.1	~~DOF~~CFO	Advise on and manage the Trust's banking arrangements ensuring that these are reviewed regularly.
5.1.2	~~DOF~~CFO	Review banking arrangements.
5.2.2	~~DOF~~CFO	Managing the Trust's Government Banking Service (GBS) bank account, establishing non-exchequer bank accounts, ensuring funds stay in credit unless arrangements have been made,
5.3	~~DOF~~CFO	Prepare detailed instructions of the operation of GBS accounts and advise the Trust's bankers of the conditions under which accounts will be operated.
6.1	~~DOF~~CFO	Design and maintain income systems.
6.2.2	~~DOF~~CFO	Approve and review the level of all fees and charges.
6.2.3	All Staff	Inform the ~~DOF~~CFO of income arising from transactions which they have initiated.
6.3.1	~~DOF~~CFO	Take appropriate recovery action on all debts.
6.4	~~DOF~~CFO	Provide the required documents for recording cash, cheques and negotiable instruments, and ensure adequate system and procedures for handling cash etc.

7	Chief Executive	Arrangements for tenders where SFT is the procuring body.
7.8	~~Director of Finance~~Chief Finance Officer	Report the acceptance of any late tenders to the Board.
7.11	~~DOF~~CFO	Report all waiving of variation of competitive tendering/quotation procedures to Audit Committee.
8	Chief Executive	Arrangements for contracts re provision of services.
9.2.1	Budget holder	Recruit to vacancies provided that this is within the establishment.
9.4.1	~~DOF~~CFO	Final determination of pay.
10.1.1	~~DOF~~CFO	Determine level of delegation of non-pay expenditure to budget managers.
10.2	~~DOF~~CFO	Set out the list of managers and their limits for requisitioning goods and services.
10.3.3	~~DOF~~CFO	Prompt payment of accounts and claims.
10.3.4	~~DOF~~CFO	Recommend the thresholds for quotations or tenders and prepare procedural instructions, ensure prompt payment and maintain a system for managing all amounts payable.
11.3.5 – 11.3.7	~~DOF~~CFO	Determine the investments required and ensure that policies and procedures are drawn up for their operation and maintenance.
12.4.1	~~DOF~~CFO	Maintain registers of assets.
12.4.2	~~DOF~~CFO	Prepare procedural instructions in disposal of assets.
12.4.5	~~DOF~~CFO	Approve procedures for reconciling fixed asset accounts to fixed asset register.
12.5.1	Chief Executive	Establish procedures for the control of fixed assets.
12.5.2 & 12.5.3	~~DOF~~CFO	Approve asset control procedures and manage process.
12.6.2	Chief Executive / Managing Director~~Chief~~	Approve acquisition of property up to £500,000.

13.1.2	~~DOF~~CFO	Systems of control for stores and stocks.
13.1.4 - 13.1.5	~~DOF~~CFO	Establish procedures for the management of stores and stocks.
14.1	~~DOF~~CFO	Establish processes for disposals and condemnations.
14.2	~~DOF~~CFO	Maintain a register of condemnations, losses and special payments, prepare a fraud response plan, and take appropriate actions for any losses, condemnations and special payments.
15.1.1	Senior Information Risk Owner	Devise and implement procedures to safeguard the Trust's data, programs and computer hardware, have regard to the Data Protection Act 1984, ensure adequate controls over data entry, processing, storage etc.
15.1.2 – 15.1.5	~~DOF~~CFO	Ensure that financial systems are appropriately procured and tested; ensure that there are adequate controls in operation in place.
16.1.3	~~DOF~~CFO	Arrangements for the administration of patient property.
17	~~DOF~~CFO	Ensure that the charitable funds are appropriately administered and managed.
17.2.1	~~DOF~~CFO	Prepare the Charity's annual accounts for audit and authorise transactions of funds between investment vehicles.
18.1	Chief Executive	Ensure all staff are aware of the behaviour expected of all staff as set out in the Conflict of Interests Policy.
19	Chief Executive	Maintain archives for all records, information and data.
20.1	Chief Executive	Ensure that the Trust has a risk management policy and procedures and that these are monitored.
20.2.1	~~DOF~~CFO	Review membership of the Non-Clinical Risk Pooling Scheme and other insurance arrangements.
20.2.2 – 20.2.5	~~DOF~~CFO	Liaise with insurance brokers; ensure timely reporting of incidents, losses and submission of claims against the third party liability scheme and insurance provision.
20.3	~~Director of Nursing~~Chief Nursing Officer	Manage claims on NHSLA and report activity to Board.
21	Chief Executive	Managing claims from staff, patients and the public.
22	Chief Executive	Managing Employment Tribunals.

23	Wholly owned subsidiary	Manage governance process.

Other issues to be delegated

10. Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	~~Director of IM&T~~Chief Information Officer
Health and Safety Arrangements	~~Director of Organisational Development and People~~Chief People Officer
Terms and conditions for non-AfC staff	Chief Executive provided this is in line with the AfC terms and conditions

11. This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within his/her Directorate. He/she should produce a scheme of delegation for matters within his/her Directorate. In particular the scheme of delegation should include how the directorate budget and procedures for approval of expenditure are delegated.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.3
Date of meeting:	1st May 2025		

Report tile:	Estates Report – April 2025			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	John O'Keeffe – Head of Estates.			
Executive Sponsor: (presenting)	Mark Ellis - Chief Financial Officer.			
Appendices	Appendix A – Estates Report April 2025 Appendix B - Backlog Infrastructure Risks Appendix C – Board Assurance Framework Risks Appendix D – KPI Report April 2025 Appendix E – Estates & Health and Safety Risk Review March 2025			

Recommendation:

Trust Board is asked to note the content of the paper summarising the work of the Estates Department, consisting of Estates Technical Services (ETS) and Capital Projects teams during the last quarter covering the period January 2025 – March 2025 including current and ongoing risk positions.

Executive Summary:

Staff position 3.6 vacancies, (9%) 2 in progress and 1.6 positions on hold (0.6 at Trust level, **1 at BSW level**) until justified as required.

Our work on Estates compliance and risks continues to reduce both the volume and classification of risks. We now have one extreme risk (Estates CAFM System) and three high risks remaining, which have continued beyond our target of the end of the 2023/24 financial year due to volume of works. We are now targeting closure and removal of the high risks by late 2025 by means of mitigating and reducing risks so that only medium and low remain. At this stage we will cease reporting and continue as business as normal.

Overall, we have now reduced the total number of estates self-identified risks from 383 to 114. (- 269)

		Extreme		High		Moderate		Low		Total	
This Period	**Remaining** (by **Current** Risk Score)	**1**	⟺	**3**	-3 ↓	**105**	+1 ↑	**5**	⟺	**114**	-2 ↓
Previous Period	**Remaining** (by **Current** Risk Score)	**1**		**6**		**104**		**5**		**116**	

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and also returning to the market to tender for reduction/replacement.

We cannot report on our MLE compliance due to data issues at system level, but we are normally around 90%, we are confident our compliance rates will remain in this area.

Our department appraisal rates have increased from 54% to 67% but we continue to aim for 80%.

Estates have started the Improving Together journey with the senior team having completed both the Introducing It and one day Improver Leader sessions and a multidisciplinary team completing the two-day Improver Standard in November 2024. The rest of the department have commenced training and improvement huddles are taking place twice a week.

The capital team were originally allocated £6.791m of CDEL in 24/25. This has increased to £8.2m due to EPR slippage and successful national bids; as well as going some way to reduce the backlog maintenance position, it provided budgets to conclude The Elizabeth Building/Imber Ward as well as the decarbonisation project, including the geothermal feasibility.

Further details of the major schemes are contained within appendix A.

Estates CAFM System – an order has been placed with our preferred supplier, and the project implementation team has held an introductory meeting to begin the phased implementation process, which is expected to last 12-18 months. This will remove the one outstanding extreme risk.

Work continues to identify risks and ensure mitigations are in place for both Backlog Maintenance and Board Assurance Frameworks. We are co-ordinating more at Group and BSW level to ensure we maximise our opportunities.

We have had the opportunity to bid at short notice for national funding related to estates critical infrastructure safety as a group from a pot of £11.7m, SFT have submitted bids for £5.8m, if successful this will go towards reducing our critical infrastructure backlog maintenance position which sits around £14m (full cost).

Safety Group KPI's - While the majority of the KPI's show that the specialist areas are being maintained and monitored within limits, there are areas that are not performing as well as they could and while this appears to be caused by an under resourced compliment of staff along with priority being given to carrying out reactive requests as opposed to planned, we will be investigating further using both root cause analysis and A3 thinking to determine the best way to proceed. As an interim measure resource will be diverted and additional labour brought in for critical works.

Estates & Health and Safety Risk Review - Work continues in conjunction with the Health and Safety Manager to address and reduce Estates related risks on the Trust risk register and identify specific risks that require escalation.

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

Appendix A – Estates Report – April 2025

1.0 Introduction

This is a quarterly update to Trust Board for activity within the Estates Technical Services (ETS) and Capital Project teams from 1st January 2025 – 31st March 2025.

2.0 Staff

We have recruited to a multi skilled position. We have had a carpenter resign due to financial reasons. We currently have to bring in some bank/contractor support to ensure we meet minimum statutory requirements. Our aim is to maintain a core team of internal resources and therefore reduce our requirement to use external contractors, who are approximately twice as expensive.

We continue meetings with our people business partner and recruitment team to discuss vacancies which currently stand at 3.6 WTE role. We attend the Weekly Divisional Workforce Control Panel (Corporate) meetings as required to discuss and manage vacancies appropriately. **Although funded and approved posts are now being refused at BSW level.**

Our latest staff position is below.

April 2025	**No.**	**Notes**
Estates Posts	**40.1**	**Includes vacancies.**
Vacancies (9%)	**3.6**	**B5 Mechanical Multi Water** **B4 Multi skilled Carpenter (Post Vacant 21/2/25)** **B4 Mechanical Craft Person** **B3 Accommodation Craft Person (0.6)**
In Post	**36.5**	
Bank Staff	5	2 x Flushers 1 x Admin 2 x Carpentry
		Vacancy
Senior Team	3	0
Technical	6.5	0
Operations	2	0
Admin	5	0
Mechanical	11.6	**2.6 = 22%**
Electrical	6	0
Building	6	**1 = 17%**

Vacant Post refused at ICB level
Vacant Post refused at Trust level
Vacant Post live on Trac
Vacant Post New

We cannot report on our MLE compliance due to data issues at system level, but we are normally around 90%, we are confident our percentages will remain in this area.

3.0 Compliance

We continue our trajectory of closing and mitigating risks from the Estates compliance report. The table below indicates we are now reduced to one (1) extreme risk, although as previously highlighted some of our mitigation actions do transfer risks into lower rating categories as we work toward concluding them. **There has also been a further reduction of three (3) high risk and two (2) overall closures in this period**. We have seen an overall reduction in risks and continue toward our target which was to close all extreme and the majority of high risks while converting the remaining moderate and low risks to business as usual, which will follow by the closure of the compliance report. However, some risks intended for closure or mitigation last year will now fall into the 2025-2026 finical year.

		Extreme	High	Moderate	Low	Total
Initial Risks	**Initial Risks**	286	95	2	0	383
	Closed (by **Initial** Risk Score)	192	74	1	0	267
	Remaining (by **Initial** Risk Score)	94	21	1	0	116
Risk Changed/Moved	**Risk Mitigated** (+/-) due to mitigation in place	-285	-92	103	5	-269
This Period	**Added** in this reporting period.	0	0	0	0	0
	Remaining (by **Current** Risk Score)	**1**	**3**	**105**	**5**	**114**
At last report	**Remaining (by Current Risk Score) at last report**	**1**	**6**	**104**	**5**	**116**
	Change during reporting period	**0**	**-3**	**+1**	**0**	**-2**

We have extracted the final extreme and high risks from the compliance report to the table below and provided a narrative.

ID	Source of Risk Data	Risk
197	PAM Audit	Estates and Facilities Operational Management/ Maintenance: CAFM and PPM regime's inadequate

Risk 197

Estates CAFM system not fit for purpose – **1x risk**

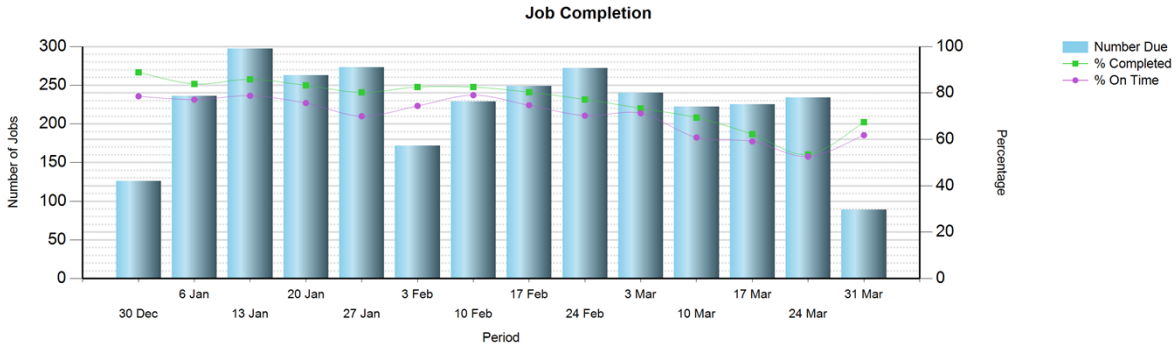
Update to previous reports: The CAFM contract has been awarded to Concerto. The initial project launch meeting took place on February 18, 2025, and work has started on core data gathering. Full system implementation is expected to take 12 months. While the rollout program hasn't yet been finalised with the contractor, we anticipate the core CAFM module, which tracks asset compliance and workforce management, will be in place within six months of this report.

Although we are on track to close or mitigate the bulk of the high-risk actions, there are three connected actions that are still outstanding and now will complete in the 2025-2026 financial year. They are:

ID	Source of Risk Data	Risk	Update
87	Other	HTM 06-23 Periodic Inspection and Testing - New contract in place, but not yet used, last undertaken 2013, reports of outstanding C1 and C2 from then	The capital project for this work was delayed to Q4 of the 2024-2025 financial year. This has pushed the overall project completion into the 2025-2026 financial year. As a result, the plan to use slippage budget could not be utilised this year to meet the March 2025 completion target. The project program is currently under review, and a procurement exercise will be required to address the risk to completion. **Closure Target – December 2025**
150	Other	44-08 Electrical Installation – Generally - No practice in place - RCD and AFDD	Pending completion of fixed wiring inspection - see ID 87
151	Other	44-09 Three Phase Circuits - No practice in place - RCD and AFDD	Pending completion of fixed wiring inspection - see ID 87

4.0 Estates Maintenance

The data for Jan 2025 – March 2025 is shown below. (Data is shown for full month activity).



This quarter

Job Type Summary

	Due	Cancelled	Completed	On Time
ECO	202	0	201	199
HELPDESK	1766	25	1294	1240
PPM	1159	12	904	769
Total	3127	37	2399	2208

Previous quarter

Job Type Summary

	Due	Cancelled	Completed	On Time
ECO	192	0	191	182
HELPDESK	1980	32	1248	522
PPM	1161	35	772	134
Total	**3333**	**67**	**2211**	**838**

The data shows a continued high volume of helpdesk jobs raised (logged calls for maintenance actions across the estate) although data for planned maintenance (PPM) and Helpdesk are consistent with previous 3-month reporting periods The data shows we carry out more reactive than planned works and we should be aiming for the opposite situation.

What is known is that we are carrying out more manual processes relating to the helpdesk, this is shown by a severe drop in works completed and completed on time as admin staff are manually printing tickets, trades staff are writing actions on the tickets and then admin staff collate and manually upload in the system. The new CAFM system will resolve this.

During this period the number of emergency call outs was 202 a slight increase. As with previous report periods, some analysis of the numbers is in progress, although given the estates backlog continues to increase at a rate faster than it can be reduced, the failure rate of the estate is equally likely to increase particularly whilst the Trust resources to maintain the estate remain constant or potentially reduce.

5.0 Capital Delivery

At the start of 24/25, the Estates capital team were allocated £6,791,000 of CDEL; having secured public dividend capital (PDC) for critical infrastructure works (CIR) as well as utilising EPR slippage, the current capital spend for Estates is £8,246,061.

EPR slippage: £475,000
PDC/CIR: £980,061
Electrical Infrastructure: £98,500
Lifts: £388,161
Fire doors: £23,400
Fire alarm upgrades and compartmentation: £250,000
SDEC (infusions): £120,000
ED ramp: £100,000

The capital allocation for 25/26 has yet to be confirmed, but in addition to CDEL, the team will expect to be awarded a share of the estates safety fund. With regard external funding, SFT has been awarded £5.4m seed funding for year one of a three-year delivery of the Elective Care Centre (replacement of Day Surgery Unit), as well as bidding for £7m for the co-location of an Urgent Treatment Centre in Salisbury. If successful with all funding bids, the team will need to restructure to deliver expectations.

Imber Ward

The final account was agreed with the main contractor before Christmas with all finances reconciled. The project remains in the 12 months defects period until July when the final certificate can be issued to the contractor marking the end of the project. A post project evaluation session has been held and responses provided to NHSE. The reprovision of the garden for NICU is now complete.

Salix decarbonisation

The £10m decarbonisation works undertaken by Asset+ have been accepted by Salix and all monies drawn-down. Electrical infrastructure issues prevent commissioning of the air source heat pumps, so this element of the works remains incomplete, but is the only work outstanding. The Trust's 12% capital contribution to the Salix funding went towards commissioning a geothermal feasibility study; the supplier GT Energy has completed their report and issued a financial offer to the Trust for the supply of heat. The Trust has appointed design consultants to undertake the feasibility of a district heat network (DHN) that will supply hot water to specific energy centres around site. The capex of the DHN impacts the financial offer from GT Energy, as does the ability of the Trust to secure external funding from the Green Heat Network; the offer from GT Energy is based on the Trust receiving a grant from the government funding agency. The team are preparing a business case taking into account all costs that affect the heat price.

Estates Strategy

The Estates Strategy has been approved by the board.

Multi-flue Chimneys

The multi-flue chimneys in the main energy centre have stability issues and are identified on the estates risk register, work associated with the long-term replacement, as well as short, to medium term strengthening is taking place. The decarbonisation project and potential geothermal will reduce the reliance on gas-fired boilers required on the estate, thereby reducing the number of boiler flues. Regular monitoring of the condition of the chimneys is ongoing and a consultant has prepared a report assessing the merits of extending the life of each chimney by lowering the height, as well as the potential removal of one chimney. Currently there is a procurement exercise taking place for enhanced monitoring. Cost estimates have been provided and an application for funding is included within the estates safety fund bid.

Replacement of CT1 & CT2 scanners

Structural strengthening works were required for the replacement of both CT1 & CT2 scanners due to the increased weight. Both scanners have now been commissioned and are operational.

Replacement of Lifts 3 & 4

The Trust has appointed a lift contractor to replace existing hydraulic lifts 3 & 4 with electric units which should be more reliable. Although both lifts 3 & 4 were programmed to be installed by the end of the financial year (2024/5), this hasn't been possible due to various issues with the contractor and their supply chain. One lift (Nr 4) has been taken out of action and strip-out of the existing lift has commenced. RJ Lifts delivered both lifts to the Trust by the end of the financial year, this allowed 90% of the contract value to be invoiced, with 10% rolling into this year. The Trust was successful in securing NHSE critical infrastructure risk funding of £388,161 towards the lift installations, these monies needed to be spent by 31st March 2025. Funding the replacement of lifts 1 & 2 is included in our application for estates safety funding.

Critical Infrastructure Risk Funding (CIR)

As well as securing £388,161 of NHSE critical infrastructure risk funding towards the lift installations, the Trust has secured additional funding of £98,500 towards electrical infrastructure, £23,400 towards fire doors and £250,000 towards fire alarm upgrades and compartmentation. The Trust has completed a memorandum of understanding that all monies will be spent by 31st March 2025.

Public Dividend Capital (PDC)

In addition to CIR funding, the Trust has also secured additional NHSE funding of £120,000 for same day emergency care (SDEC) which contributes towards a new infusions area, furthermore £100,000 has been awarded for the resurfacing of the ambulance deck on the ramp in front of ED

National Energy Efficiency Scheme (NEEF)

The Trust was unsuccessful in it's bid to secure £845k of external funding available through the NEEF scheme; however, slippage from EPR and various other schemes has enabled the Trust to raise a PO with Asset+ for that value to enable the purchase of photo voltaic panels, LED lighting and replacement windows, some of which were installed before year-end. These assets will greatly assist the Trusts pathway towards being net zero carbon.

24/25 Capital Allocation

The following funding has been allocated to the Building and Infrastructure Group:

CDEL	£'000's
Imber Ward	£1,500
Energy Centre Flues	£1,219
CDEL Salix – seismic studies	£930
CT building works	£404
Installation of Fluoroscopy C Arm	£200
Other <£100k	£180
Lift Refurbishment	£700
Fire compartmentation	£300
Other <£300k	£1,358
Sub-total	**£6,791**
EPR slippage	£475
Public Dividend Capital (PDC)	£980
Total BIG	**£8,246**

National Funding	£'000's
Community Diagnostic Centre	£1,306
Total BIG	**£1,306**

6.0 Governance and Risks

As noted previously the BSW commitment to invest in the EPR system over the next 3-years has resulted in significantly reduced capital availability. Whilst our requirements for 5-year (and beyond) capital investment are now well documented (and tabled regularly via the relevant committees) we expect a combination of reduced investment for 2024-2027 and a resulting very high demand for capital allocation in 2027-28, alongside IT and Medical Equipment requirements, to increase the Trust risks further and the backlog maintenance position to worsen.

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and returning to the market to tender for replacement.

We cannot currently assure Board and the Trust Duty Holders that we are carrying out our statutory and mandatory tasks, that they are recorded correctly or able to report with conviction that the task are complete due to the failings of the Estates CAFM system. This will be addressed with the new system when implemented and functional which has started with phase one due in six months which will reduce the risk greatly.

New risks identified within this report.

	Risk	**Action**
	See appendix C for existing risks currently being investigated.	

Appendix B - Backlog Infrastructure Risks

Key Risks and Mitigation

1) Fire Safety – compartmentation, doors, emergency lighting.

   The Estates Capital CDEL allocation managed by the Building and Infrastructure group has a 5-year plan to address the highest risks regarding fire safety, ventilation and fixed wiring infrastructure.
   A programme of inspections, repair and replacement is underway along with local mitigation plans in place with regard to fire safety with enhanced evacuation procedures moving beyond the normal one fire compartment barrier to two. Torches in place of emergency lighting. Training encouraged

2) Ventilation – Air handling units serving theatres in use 20+ years, beyond end-of-life.

   Ventilation all critical areas have annual verification in place and in house staff trained on routine maintenance. High level risks raised at IPCC and Ventilation Safety group. Planned replacement underway.

3) Electrical infrastructure – beyond service life and untested.

   A 3–5-year programme of electrical testing and remedial works is underway.

4) Asbestos containing materials (ACMs) within service areas – risk to Estates/IT staff and contractors.

   New asbestos safety hub online with policies, procedures and SOP's – management of risk improving.

5) Lifts – beyond service life, frequent breakdowns and entrapments. Impact on patient movement.

   5-year plan implemented to replace lifts, two per year currently (first two of which were planned to be replaced in 24/25 but have slipped slightly)

6) Roofs – old, damaged, poorly insulated.

   Currently roofs are patch repaired where practicable, whole roof replacement linked to future estates strategy and the wish to vacate some 1940's buildings.

7) Aged estate and equipment, prone to unexpected failures.

   A budget of £200k has been allocated within our capital plan, which is prioritised for addressing in year reactive replacement in the event of total failure.

Appendix C – Board Assurance Framework Risks

Key Risks and Mitigation

1) Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year

The Estates Capital CDEL allocation managed by the Building and Infrastructure group has a 5-year plan to address the highest perceived risks particularly regarding fire safety, ventilation and fixed wiring infrastructure.

2) Competing demands for Trust capital each year. Estates / Medical devices / Informatics

The remaining funding is prioritised using a risk-based method to ensure it is utilised in the appropriate areas

3) Reduction in revenue funding will impact on ability to maintain and repair existing infrastructure.

The frequency of maintenance is adjusted where possible, trying to ensure statutory requirements and best practice are maintained, this can result in increased issues at a later date and increased cost pressures.

4) Estates backlog value (£78m) is not actual cost to deliver Likely value £140m

The reported backlog value is cost of product, it does not include fees, labour and VAT it is generally accepted the cost to carry out the works is base plus 80% plus there are normally additional associated works to allow backlog items to be replaced. This is factored into prioritisation and reporting

5) Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases

The new estates strategy will attempt to plan a way to invest in line with our clinical strategy and allow backlog to reduce significantly – subject to capital funding availability.

6) Day surgery unit remains Trust highest priority, with no firm funding source available.

DSU, currently we have a number of specialist contractors on standby to enable a fast response to the main ongoing issue which is roof leaks which have disruptive effect on the buildings use. The Trust continues to promote the priority need to replace DSU and is currently reviewing the business case. Operational teams have developed contingency plans and Estates continue to react to problems as they arise. Seed funding has been allocated , this will allow detail design to take place.

7) Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.

The six facet survey undertaken in 2021 along with the recent estates strategy has enabled us to identify the areas of concern and work towards managing them with our current CDEL and a long-term plan to refurbish or replace.

8) Trust ‘space’ is in high demand and appetite to remove poor quality buildings challenged with space use.

The Trust Space Allocation Committee works to try and provide the space required to enable the trust to operate effectively. Challenges remain in changing working practices - the use of hot desks and room booking is increasing, whilst long-term options are covered in the estates strategy.

9) National targeted resources do not address key resilience issues

We continue to identify, bid and lobby for external funding

10) Patient environment quality being compromised e.g., spinal unit

We work with clinical teams to identify substandard areas and enhance where possible

11) Quality of on-site residential accommodation poor with little investment

It has been agreed that the Trust will go out to the market to secure a partner(s) to deliver a plan for the future development of keyworker and student accommodation across the site. This will include both refurbishment of existing accommodation, replacement of accommodation and the expansion of the numbers of units on site. . A complex legal and procurement route with difficulty being clear on what will be acceptable to national bodies has limited progress, but work is ongoing. Until then minor maintenance/refurbishments are completed when funding allows

12) Limited electrical infrastructure on campus impacting future redevelopment opportunities

The electrical infrastructure has been surveyed to identify all limitations and discussions are currently underway with the District Network Operator (DNO) and independent providers to explore options to increase the capacity available, but this could take years. The increase in solar pv systems on site will help reduce our reliance on DNO supplies but are weather dependent. We are exploring options with third party suppliers regarding solar farm connectivity. We are sector leading with exploration of geothermal possibilities and if successful this will reduce our requirement for electrical supplies and also contribute to our decarbonisation requirement. We are in discussions with the DNO who currently own our high voltage network after we sold it off in the early 2000's to purchase it back. This will give us different options to manage and connect external supplies.

13) Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.

We are in partnership with the Carbon Energy Fund and will continue to explore options and funding to enable us to decarbonise.

Appendix D – Estates Safety Group KPI Report April 2025

Internal audit reported that Estates compliance metrics for health and safety regulatory requirements were not clearly reported through governance structures and one of the recommendations was that we should report core KPIs within the quarterly reports. This appendix covers off the recommendation and shows a summary position from the last quarterly Estates safety groups. These are still being developed and may change over time as the safety groups challenge the tasks and compliance standards. Any areas that are amber and red are actively worked on while green are monitored. What can be seen is that in the areas that require action it appears the primary cause is an under resourced compliment of staff along with priority being given to carrying out reactive requests as opposed to planned, we are working to understand and reverse this trend.

1.0 Introduction

This is a quarterly update summarising the key performance indicators relating to the Estates safety groups as recommended by internal audit.

2.0 Asbestos Safety Group

The Asbestos Safety Group (ASG) is established to provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to manage asbestos on site.

		Q4 2024	Q1 2025
Asbestos Safety Group			
Completion of Annual Surveys		X	48%
Training (ETS Staff 'Duty to Manage')		X	94%
Training (ETS Staff 'Asbestos Awareness')		X	68%
Training APs		X	YES
Policy in Date		X	YES

First set of KPI's from the ASG, work in progress to address annual surveys and training which should see improvement for next report.

3.0 Electrical Safety Group

The Electrical Safety Group (ESG) is established to provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to provide safe electrical systems at Salisbury NHS Foundation Trust.

		Q4 2024	Q1 2025
Electrical Safety Group			
EICR		60%	65%
Portable Appliance Testing		100%	100%
Emergency Lighting Monthly		100%	100%
Emergency Lighting Annual		100%	100%
Generator weekly test		100%	100%
CP Training		100%	100%
Lightning Protection test		100%	100%
IPS/UPS 6 monthly test		100%	100%

EICR – Electrical installation condition report – This is a 5-year rolling programme that is in its 4th year, we expect to be in a green position by mid 2025

It is encouraging to see most indicators are at 100%

4.0 Fire Safety Group

To provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to manage all fire related systems, processes and procedures.

		Q4 2024	Q1 2025
Fire Safety Group			
Staff Trust wide compliant with fire face-to-face training.		21%	26%
Fire doors surveyed within the last 12 months.		10%	1%
Extinguishers serviced and in date.		99%	99%
Fire detection serviced within the last 12 months		98%	98%
Fire Risk Assessments complete		99%	99%
Fire Risk Assessments in date		87%	90%
Policy in date		YES	YES

Face to face training - This is the New mandatory training that was instigated on MLE in January 2024, after a slow uptake we are progressing in the right direction and expect to see a month-on-month increase.

Fire door surveys – this was scheduled to be carried out in house but a shortage of staff and more resources being spent on reactive works meant that planned works slipped. The teams have been reminded of the need to carry out planned maintenance and if critical contract support will be used. Contractors are being brought in to carry this out and the % will increase.

Fire risk assessments in date. This has been brough back in house and the % is increasing with an expectation we will be green by the next report.

5.0 Safer Environment Group (Confined Spaces, Lifts, Pressure systems, Working at Height)

The Safer Environment Group (SEG) is established to provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to manage Pressure Systems, Lifts, Working at Height and Confined Spaces on site.

		Q4 2024	Q1 2025
Safer Environment Group			
Pressure Systems			
Completion of visual inspections		50-75%	50-75%
Completion of working inspections		50-75%	50-75%
Completion of thorough inspections		50-75%	50-75%
Training (AP)		YES	YES
Training (CP)		NO	NO
Policy in date		YES	YES
Lifts			
Annual Insurance Inspections		75-100%	75- 100%
Monthly PPM (Contractor)		50-75%	75- 100%
Weekly PPM (Estates)		75-100%	75- 100%
Training (AP)		75-100%	75- 100%
Training – Lift Wardens		75-100%	75- 100%
Policy in date		YES	YES
Confined Spaces			
Annual Maintenance of Monitoring Equipment		NO	YES
6M AP Audit of signage / control measures		NO	YES
Training (AP)		NO	YES
Permits issued for entry		YES	YES
Policy in date		YES	YES
Working at Height			
Annual checks of fixed and portable ladders		75-100%	75- 100%
Management of W@H with PTW		YES	YES
Training (AP)		YES	YES
Training (CP)		NO	YES
Policy in date		YES	YES

Completion of visual, working, and thorough inspections. Recently appointed a member of staff to work solely on pressure systems in conjunction with the external inspector to increase the number of inspections completed, this is progressing well.

Training (CP) pressure – we currently do not have the expertise in house to carry out this role, we use external contractors when required which is not frequent.

Monthly PPM (Contractor) lifts – back on track since previous report

Annual Maintenance of Monitoring Equipment – back on track since previous report

6M AP Audit of signage / control measures – AP recently appointed now green

Training (CP) working at height – training completed.

6.0 Ventilation Safety Group

The Ventilation Safety Group (VSG) is established to provide both the Infection Prevention & Control Committee and Health & Safety Committee and subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to minimise the risk of harm and infection from ventilation systems.

		Q4 2024	Q1 2025
Ventilation Safety Group			
Critical ventilation Annual maintenance		75- 100%	90%
Theatre ventilation Annual verification		75- 100%	100%
Critical ventilation Quarterly maintenance		<50%	55%
UCV Theatre Biannual maintenance		75- 100%	100%
LEV inspection and Tests		75- 100%	100%
General ventilation maintenance		50-75%	50%
General ventilation Biannual maintenance		<50%	20%
Training (AP)		75- 100%	100%
Training (CP)		50-75%	75%
Policy in date		YES	YES

Critical ventilation Quarterly maintenance, General ventilation maintenance & General ventilation Biannual maintenance – A shortage of staff and more resources being spent on reactive works meant that planned works slipped. The teams have been reminded of the need to carry out planned maintenance and if critical contract support will be used. The new CAFM system should prevent this happening again with its reporting feature. We are actively working on solutions to increase the percentages.
Training (CP) one staff member trained , others identified and training booked, expect to be green mid-2025, contractor support brought in if required.

7.0 Water Safety Group

The Water Safety Group (WSG) is established to provide both the Infection Prevention & Control Committee and Health & Safety Committee and subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to minimise the risk of harm and infection from water used by patients, staff and visitors associated with waterborne pathogens.

		Q4 2024	Q1 2025	Q2 2025
Water Safety Group				
Annual Tank Inspection		100%	100%	100%
Shower Head / Hose (Quarterly)		90%	90%	100%
Monthly temperature checks		60%	60%	70%
TMV Maintenance		40%	40%	65%
Legionella Sampling		<50%	50%	50%
Pseudomonas Sampling (6 monthly)		100%	50%	100%
Flushing of low use outlets (LUO)		86%	84%	80%
RA Actions (completion)		44%	57%	70%

Monthly temperature checks, A shortage of staff and more resources being spent on reactive works meant that planned works have slipped. The teams have been reminded of the need to carry out planned maintenance.

TMV Maintenance, A shortage of staff and more resources being spent on reactive works meant that planned works have slipped. The teams have been reminded of the need to carry out planned maintenance and if critical contract support will be used. We are bringing in contract support to bring this and the new CAFM system should prevent this happening again with its reporting features.

8.0 Summary

While the majority of the safety group KPI's show that the specialist areas are being maintained and monitored within limits, there are areas that are not performing as well as they could and while this appears to be caused by an under resourced compliment of staff along with priority being given to carrying out reactive requests as opposed to planned, we will be investigating further using both root cause analysis and A3 thinking to determine the best way to proceed. As an interim measure resource will be diverted and additional labour brought in for critical works. It is planned that KPI's will be one of the departments driver measures.

Appendix E – Estates & Health and Safety Risk Review March 2025

1.0 Introduction

This is an update of the monthly coordination meeting between Estates and Health and Safety where we review the Trust Risk Register and move forward outstanding items – January 2025.

2.0 Overview

Monthly the Health and Safety Manager meets with the Head and Deputy Head of Estates to review the Trust risk register. Discussions are held on high or long-standing items and actions agreed as to the best way to resolve or reduce the risk, including determining those that need to be highlighted at the Health and Safety Committee.

3.0 Risks reviewed.

Risk ID	Rating	Description	Action
7931	16	Theatres electrical power insufficient	Paper to H&S Committee
7932	16	Wyle house electrical earth failure	Paper to H&S Committee
8030	12	Poor working environment Dietetics office	Go and See to be arranged

4.0 Summary.

Work continues to address and reduce Estates related risks on the Trust risk register and identify specific risks that require escalation.