Bundle Trust Board Public 2 July 2020

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates

1.2 10:10 - Staff Story

BAME Staff Story
Presented by Lynn Lane and Rex Webb

1.3 Welcome and Apologies

1.4 Declaration of Interests

1.5 10:30 - Minutes of the previous meeting

Minutes attached from meeting held on 4th June 2020
Presented by Nick Marsden
For approval

Draft Public Board mins 4 June 2020.docx

1.6 Matters Arising and Action Log

1.6 Action Log Public Trust Board.docx

1.7 10:35 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:40 - Chief Executive Report

Presented by Cara Charles-Barks
For information

1.8 CEO Board Report July 2020.docx

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:50 - Audit Committee - 17 May

Presented by Paul Kemp
For assurance

2.1 Escalation report from Committee to Board - Audit Committee 17th June 2020.pdf

2.2 10:55 - Trust Management Committee - 17 June

Presented by Cara Charles-Barks
For assurance

2.2 TMC Escalation report July.docx

2.3 11:00 - Clinical Governance Committee - 23 June

Presented by Eiri Jones
For assurance

2.3 Escalation report - from CGCommittee to Board June 2020.docx

2.4 11:05 - Finance and Performance Committee - 23 June

Presented by Paul Miller
For assurance

2.4 Finance and Performance Committee escalation paper 23rd June 2020.docx

2.5 11:10 - Workforce Committee - 25 June

Presented by Michael von Bertlele
For assurance

2.5 MvB Escalation report - Workforce Committee 25 June 2020.docx

2.6 11:15 - Charitable Funds Committee - 18 June

Presented by Nick Marsden
For assurance
To follow

2.6 Escalation report - from Committee to Board template Jan 19.docx

2.7 11:20 - Integrated Performacne Report - M2

Presented by Andy Hyett
For assurance

2.7a 200702 IPR.docx

2.7b IPR July 2020 DRAFT.pdf

3 GOVERNANCE

3.1 11:40 - Accountability Framework

Presented by Andy Hyett
For approval

3.1a AF Board cover sheet July 2020.docx

3.1b DRAFT June 2020 Accountability Framework.docx

3.1c Appendix 1 SFT Accountability Framework 18-19 - directorates to board flowchart.pptx

3.1d Appendix 3 SFT Accountability Framework 18-19 - Directorate Management Committee TOR.docx

3.1e Appendix 4 SFT Accountability Framework 18-19 Agenda Executive Directorate Performance Meetings.docx

3.1f Appendix 2 SFT Accountability Framework DRAFT TMC Terms of Reference 2020.docx

3.2 11:45 - Integrated Governance Framework including Committee Terrms of Reference

Presented by Fiona McNeight
For approval

3.2a Board cover sheet 2020 Integrated Governance Framework.docx

3.2b DRAFT Integrated Governance Framework.docx

3.3 11:50 - Fit and Proper Person

Presented by Fiona McNeight
For approval

3.3a Board cover sheet_Fit and Proper Person Policy.docx

3.3b FPPR Policy draft March 2020_OMB approved June 2020.doc

3.3c Appendix 1 Fit and Proper Person Policy Self-Declaration Form.docx

3.3d Appendix 2 Fit and Proper Person Policy Summary Guidance_Final draft.docx

3.3e Appendix 3 Ratification Checklist_FPPR Policy.doc

3.3f Appendix 4 EIA Fit and Proper Person Policy.doc

4 QUALITY AND RISK

4.1 11:55 - Patient Experience Report - Q4 and Annual Report

Presented by Kat Glaister
For assurance

4.1a Patient Experience Report Q4 19_20 May 2020 final.docx

4.1b CGC Patient Engagement end year report 2019_20 final.docx

5 WORKFORCE

5.1 12:05 - 2019 Staff Survey Results

Presented by Lynn Lane
For approval

5.1 Board staff survey Jun20 update.docx

6 CLOSING BUSINESS

6.1 12:15 - Agreement of Principle Actions and Items for Escalation

6.2 Any Other Business

6.3 12:20 - Public Questions

6.4 12:25 - Date next meeting

6 August 2020

7 RESOLUTION

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

Salisbury NHS Foundation Trust

DRAFT

Minutes of the Public Trust Board meeting held at 11:00am on Thursday 4 June 2020 via Skype in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr Nick Marsden	Chairman
Ms Tania Baker	Non-Executive Director
Mr Paul Kemp	Non-Executive Director
Mr Paul Miller	Non-Executive Director
Ms Eiri Jones	Non-Executive Director
Ms Rakhee Aggarwal	Non-Executive Director
Dr David Buckle	Non-Executive Director
Dr Michael von Bertele	Non-Executive Director
Mrs Cara Charles Barks	Chief Executive Officer
Mr Andy Hyett	Chief Operating Officer
Dr Christine Blanshard	Medical Director
Mrs Lisa Thomas	Director of Finance
Mrs Lynn Lane	Director of OD and People
Ms Lorna Wilkinson	Director of Nursing

In Attendance:

Miss Kylie Nye	Corporate Governance Manager (minutes)
Mr John Mangan	Lead Governor (observer)
Mrs Fiona McNeight	Director of Corporate Governance
Ms Esther Provins	Director of Transformation
Ms Lizzie Swift	Freedom to Speak Up Guardian

ACTION

TB1 4/6/1 OPENING BUSINESS

TB1 4/6/1.1 Welcome and Apologies

N Marsden welcomed everyone to the virtual meeting and noted there were no apologies.

TB1 4/6/1.2 Declarations of Conflicts of Interest

There were no declarations of conflicts of interest pertaining to the agenda.

TB1 4/6/1.3 Minutes of the part 1 (public) Trust Board meeting held on 21 May 2020

The minutes were agreed as an accurate record of the meeting held on 21 May 2020.

TB1 4/6/1.4 Matters Arising and Action Log

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

- Electronic Prescribing Business Case: The Board noted that a seminar had been organised for July. Item closed.

There were no further matters arising.

TB1 4/6/1.5 Register of Attendance

The register was noted.

TB1 4/6/1.6 Chairman's Business

N Marsden provided the following update:

- The last few weeks have been focussed on Chief Executive recruitment. The vacancies were shortlisted on Tuesday and there are currently 5 candidates. It is important to note that the recruitment process is underway in a very different environment with most contact via phone and video conference.

- The final interview is on 17th June and the focus is currently trying to organise meetings between everyone and the focus groups. N Marsden noted that he would be coming into the Trust over the next few weeks to ensure everyone has the opportunity to meet.

- N Marsden thanked everyone for their support and flexibility in relation to the recruitment process and everyone's ongoing contribution to ensure the right candidate is recruited.

TB1 4/6/1.7 Chief Executive's Report

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

- The Trust is currently operating under COVID-19 response financial arrangements, with block contracts in place with key commissioners. The Trust is currently awaiting the next national letter which will outline 'phase 3' of the COVID-19 financial response. C Charles-Barks noted that a further discussion covering key components of the financial situation will take place in Private Board.

- In relation to workforce the Organisational Development and People team are working hard to reset policies to reflect different ways of working. There is also a focus on vulnerable staff and the support available for them.

- COVID-19 patient numbers are low with 4 positive patients in the organisation. The health and well-being of all staff and patients remains the highest priority as we work to increase critical non COVID-19 services and new processes are being put in place to ensure a focus on safety remains.

- On 12th May, the Trust celebrated International Nurses Day and the 200th anniversary of the birth of Florence

Nightingale. On Tuesday 5th May the Trust celebrated International Midwives day and in the year of the nurse and midwife it was particularly important to celebrate this day to say thank you to our amazing nursing and midwifery staff. A full day of activities took place across the Trust to mark this special day.

- The Trust marked Mental Health Awareness week between 18th and 22nd May, to highlight the importance of looking after minds as well as bodies. This year's theme was 'kindness'.

- The weekly 'Clap For Carers' has demonstrated how much the community appreciate what we do and the staff have been really touched by the kind donations of foods and gifts which have been distributed via the Star's Appeal donation hub to staff. To reverse this act of kindness, on the usual Thursday 'Clap For Carers', the Trust instead 'Clapped for the Community'.

- To boost the mental health and wellbeing of patients with spinal injuries at such a difficult time, staff at the centre held a 'Games in the Garden' on Friday 22nd May. This included a range of fun and activities, from bowls to basketball, for patients to enjoy in the safety and tranquillity of Horatio's Garden, ensuring social distancing was in place.

Discussion:

- T Baker referred to the system response to COVID-19 and asked if there was an update. C Charles-Barks explained that the system response to COVID-19 over the next few months will be focussed on national guidance, for example the track and trace scheme. C Charles-Barks noted that a full report will come back on system response to the next Board in July. There is a developing governance structure relating to the reset of services which ranges from GP to outpatients services and looks at maximising digital and workforce opportunities. Additionally, the Acute Hospital Alliance is working together to develop a single system waiting list. C Charles-Barks noted that there is a presentation next week relating to the BSW approach which will be shared with the Board outside of the meeting. It was suggested that COVID-19 recovery progression should be covered in a Board Seminar, or similar session.
  ACTION:CCB **CCB**

- D Buckle asked how effective the Trust's messaging is regarding COVID-19 as messages from the government have not been clear. People are concerned and anxious and this is a complex situation. C Charles-Barks explained that the Trust has been clear about following national guidance and we have additional security guards to ensure social distancing rules are adhered to. C Blanshard explained that there is a weekly newsletter sent to GPs

each week with COVID-19 updates and BSW is doing something similar. The Head of Patient Experience is reviewing how patients are affected by the difference in services and asking how well the Trust is managing this. The public facing website is being constantly updated with relevant information and template letters, consent forms and other methods of communication are under review to ensure the Trust is delivering the correct message to patients.

- L Lane explained that from the outset there has been a comprehensive plan about how the Trust communicates with managers and staff, including the daily updates and paper updates for those who do not have access to PCs. Additionally, there is Occupational Health and wellbeing support, risk assessments on meeting rooms and training rooms and updated signage.

- A Hyett noted that Endoscopy had been asking for patient feedback since restarting the service and the outcome reflects a largely positive experience.

- P Miller queried if there was any early insight into what services might be reconfigured and how this will impact on the campus development. C Charles-Barks explained that the conversations have not yet gone to that level of detail. Prior to COVID-19 the hospital was working with the Nuffield Trust reviewing how the three acute hospitals should work together. The move to an elective Prime Provider Model may also open the door for different conversations in relation to service reconfiguration and this will be on the agenda over the next 2 years.

TB1 4/6/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 4/6/2.1 **Trust Management Committee – 20 May**

C Charles-Barks presented the report, providing a summary of escalation points from Trust Management Committee held on 20 May.

- There were no business cases to approve this month, instead the Divisions were asked to report if there were any hot spots which needed to be escalated to the committee.

- The committee reviewed the Corporate Governance Structure following an Internal Audit of Board Compliance and Reporting in November 2019, which identified areas for further improvement. A revised Board Committee structure is proposed which clearly identifies a divide between delivery and assurance. TMC supported the structure and changes will be put into action over the next few months.

- The committee received a report on the benefits realisation

of business cases formerly approved, namely for Patient Records and Data capture within Children's DAU. Not all benefits of the original business case have been realised and it was not possible to quantify the financial impact that the introduction of this role has had due to a slight reduction in activity over the last 6 months. The financial benefit will be picked up via the Executive performance review process going forward.

Discussion:

- P Kemp noted that throughout the year there will always be changes in volumes of productivity and new business cases should allow the Trust to realise the financial benefits if volumes change. L Thomas noted that the business case process is not at this stage yet, but as guidance changes we are working in different timeframes. C Charles-Barks explained that the challenge is if we are only able to deliver 75% of what the Trust used to, there will be a need to look at workforce configuration. The Trust needs to be in a position where it knows what the cost base is and what capacity is required.

- The Board discussed the Trust's analytical capability and L Thomas explained that improvements were required. In order to mitigate, the Trust is working with the Commissioning Support Unit (CSU) to build modelling capability. P Kemp noted that the Trust's analytical capability required improvement but noted that assurance had been given that we are moving in the right direction.

- P Miller noted that a useful report came out from the Nuffield Trust regarding COVID-19 recovery. P Miller noted he would circulate to NEDs. C Charles-Barks noted that the Trust needed to think about capital plans and how this relates to COVID-19. This will be a strong theme to ensure we are adhering to core principles.

TB1 4/6/2.2 **Finance and Performance Committee – 19 May**

P Miller provided a summary of escalation points from Finance and Performance Committee held on 19 May.

- **COVID-19 from an operational performance and financial perspective** – There was a further update on both the current operational and financial position within the Trust. The Committee's reflections, based on this further update, are that the hospital continues to be in a good place to effectively manage the day-to-day COVID-19 incident going forward.

- **COVID-19 Recovery –** The Trust continues to plan the detail and commence the recovery of non-COVID services within the hospital and the expectation is over time the hospital will see most services reinstated, however there is

likely to be a reduction in inpatient capacity, possibly 5% to 10%, due to social distancing rules.

- **Financial Performance 2020/21** – Following the achievement of the reforecast financial outturn in 2019/20, the Trust was able to achieve a "break even" financial performance in the first month of 2020/21. This was due to the NHS financial arrangements covering the national COVID-19 incident. It is likely that these financial arrangements will have a significant impact on the Trusts finances throughout 2020/21 and further details will be confirmed when formally known.

- **Transformation Programme** – The Trust has taken the opportunity to reflect on the significant number of operational and clinical changes that were implemented during March and April 2020. Following this review the Trusts has comprehensively revised and reset the 2020/21 transformation programme, to ensure that the most valuable changes are kept, consolidated and built upon.

- **IT annual network penetration test** – The outcome of this annual IT test was reported to the Committee and whilst it demonstrated an improvement, there were still significant concerns outstanding. As a consequence the Executive team agreed to prioritise the closing off of risks that it was able to close and would produce a further report, putting the remaining outstanding risks into wider context.

- **Finance and Performance Committee annual effectiveness report** – This report was formally reviewed and supported.

Discussion:

- C Charles-Barks noted that the corporate objectives have been refreshed and they will be closely aligned to the transformation programme. This will come to the Board in July. **ACTION: KH** **KH**
- It was suggested at F&P that the Board Committees receive a Transformation programme update going forward.

TB1 4/6/2.3 Workforce Committee – 28 May

M von Bertele gave a verbal update and the following key points were highlighted:

- The committee noted the hard work of the OD and People Directorate over the last few months.

- The "Best Place to Work" and cultural diagnostic work has been paused whilst managing the COVID-19 pandemic.

- The Committee received the Freedom to Speak Up Guardian report and it is clear that staff are gaining

confidence in FTSU process. A key message from the report is that when concerns are raised via the FTSUG the Trust need to demonstrate that action is being taken so people gain confidence.

- Dave Roberts has been appointed as the new Head of Communications. The Trust need to refocus on strategic corporate communications.

- The Committee approved the Terms of Reference.

- The Committee agreed that as part of the governance review there should be a level of scrutiny on work prior to it reporting to the Workforce Committee. To that end the Committee supported the idea of developing an Organisational Development and People Management Board. N Marsden noted that as part of these discussions the Committee had discussed if the "Workforce Committee" reflected what the meeting discussed. It was agreed that the Workforce Committee would change its name to "People and Culture Committee". *Post Meeting Note - discussions to go back to the Workforce Committee to decide if 'Organisational Development' is added to the title**. ACTION: LL*** **LL**

Discussion:

- L Lane noted that the Trust is relaunching the "Best Place to Work" from 15th June.

- The estates work as a result of an internal review has continued and a number of positive changes have happened at pace. There is still further work to be done but it should be recognised that people are working together more effectively and able to access resources to do their jobs.

- E Jones noted that it would be useful to triangulate the change of the title of the Workforce Committee with the governance structure later in the meeting.

TB1 4/6/2.4 Audit Committee – 3rd June 2020

LT highlighted that the Audit Committee had been moved to mid-June. This has been driven by changes by the government, who have delayed the submission date for all Trusts, and requested by Grant Thornton.

The Board noted that the Audit Committee had been rescheduled for 17th June with a further sub-board meeting to be arranged to sign off the final Annual Report and Accounts.

Decision:
The Board agreed with this approach.

TB1 4/6/2.5 **Integrated Performance Report**

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

- In April, the COVID-19 pandemic has continued to dominate all areas of the organisation. There has been an expected reduction in elective activity which has had an impact on RTT performance, diagnostic and cancer standards.

- Whilst Divisions have been working on reprioritising the waiting list the Trust has incurred 10 52 week breaches as a result of COVID-19.

- The 62 day cancer performance has declined, largely due to Endoscopy services being paused. This will improve as we restart Endoscopy activity.

- ED attendances were down by 40% in April but this did pick up in May. Reduced Bed occupancy has improved both ED and stroke targets. The percentage of patients arriving on the Stroke Unit within 4 hours was 96.2%, the highest figure in the last 18 months.

- The Trust continued to report a high rate of category 2 pressure ulcers in April. Of these, 8 were in 3 critically ill patients associated with COVID-19 nursed prone who developed mucosal lesions in the mouth and nose and the other 16 were across a variety of wards. The Tissue Viability team have trained over a 100 staff in the last month in skin care and will publish an item in the 'React to Red' bulletin.

- Sickness absence rose in April, which was to be expected, driven by an increase in long term absences.

Discussion:

- D Buckle asked about thrombolysis rates and C Blanshard explained that these contribute to SSNAP figures although numbers are small. The time from the event to arrival is longer due to patients coming from different areas.

- The Board discussed those patients who are not attending their appointments at the hospital or ED as they are too concerned about coming into the Trust. C Blanshard explained that those waiting for cancer diagnostics are all being phoned by a consultant to discuss the risks and benefits of attending the site. For those patients shielding the message from the government is quite clear and it is difficult to change the public mind-set. T Baker suggested that the positive patient feedback stories could be used by the media to encourage those who are anxious about coming into the hospital.

- T Baker further queried if the Trust is involved in the national work in relation to COVID-19 mortality, particularly due to the number of deaths in nursing homes in Wiltshire. C Blanshard explained that there were two strands of work to the mortality reviews. Firstly, the 3 acute Medical Directors will share outcomes to share learning and secondly, there will be a national programme to review those who tested positive. However, the guidance has not yet been published. The mortality reviews in relation to community deaths have been discussed at the BSW strategic clinical reference group.

- M von Bertele asked if the Trust has demonstrated patient to patient transmission of COVID-19. C Blanshard explained that the hospital had started early with patient testing but there have been some cases where there was a possibility of hospital acquired infection. L Wilkinson noted that the hospital had an outbreak on one ward in the early stages of the pandemic but this was minimised immediately. L Wilkinson also explained that there is a twice weekly board round and this is reviewed closely.

- M von Bertele asked if the Trust was continuing the upper GI bleed service alongside University Hospital Southampton (UHS). C Blanshard noted that the service is being provided in-house but noted that a full report on the Gastroenterology service is going to CGC in June. C Blanshard did report that there had been no incidents relating to GI bleeding and the opportunity has been taken during the pandemic to improve the pathway.

- R Aggarwal asked how the Trust communicates with the public to ensure ED is used appropriately in the future. A Hyett noted that the Salisbury Walk In centre is commissioned through the Trust and there are regular conversations with them to maximise this opportunity. A Hyett noted that the NHS 111 initiative is crucial in ensuring ED is utilised properly and discussions are live about how this is done. In the last 5 days the Trust's ED attendance figures have crept up and it is important to ensure the right people keep attending.

- E Jones referred to pressure ulcers, and noted her interest to see if our figures reflected national trends. The Board noted that further assurance relating to the management of pressure ulcers was to be presented at June's CGC meeting. E Jones queried if the Trust is capturing any harms from cancer cessation. C Blanshard explained that all breaches are subject to root cause analyses (RCA) which are reported via the cancer board to capture patterns and required improvements. A Hyett agreed and explained that the management teams are monitoring this closely and it is expected that it will take some time to work through the delays.

TB1 4/6/3 **GOVERNANCE**

TB1 4/6/3.1 **Board Assurance Framework and Corporate Risk Register**

F McNeight presented the report providing the Board with the revised Board Assurance Framework and updated Corporate Risk Register. The following key points were noted:

- Since the last update in April there has been a significant change in the risk profile with a number of risk scores decreasing; with 8 extreme risks compared to 12.
- F McNeight is working with K Humphrey, Associate Director of Strategy to align the BAF reporting to the strategy and corporate objectives update.
- Two risks (5972/ 5751) have triggered deep dives and the Head of Risk Management is leading. These will come back to the relevant Board Committee.

Discussion:

- E Jones asked if the risk of delivering the IT improvement plan had realistically reduced. E Provins noted that the original risk related to the remedial plan, which is on plan to deliver and significant improvements have been made. The Digital Strategy element has been delivered and capability has increased due to the significant work done in the last year. In relation to the IT Penetration test, not all the gaps have been closed off but the ongoing work reduced the risk. E.g. unsafe passwords have reduced.
- E Jones noted that it would be helpful to see the outcome of the deep dive on action 5972 (Insufficient organisational development resources to delivery transformational and cultural change) reflecting on change required going forward.
- P Miller noted that the way risk 5972 is described gives the impression that resources is the only limiting factor to cultural change and suggested that there are wider problems. E Provins agreed and will change the wording of the risk **ACTION: EP** **EP**

TB1 4/6/3.2 **Board Governance Structure Review**

F McNeight presented the report which provided a summary of the governance structure review and the recommended outcomes. F McNeight noted that this work had been completed as a result of the Internal Audit of Board and Compliance Reporting in November 2019. The following key points were noted.

- The review highlighted that there is a lack of a defined delivery arm to the organisation, which has manifested itself in blurring the purpose of some of the Board Committees.

- It was found that the Board Committees were functioning with the exception of the Workforce Committee. There is a lack of an oversight delivery group for the organisational development (OD) and people function, with groups reporting directly to the Workforce Committee. There is agreement that a new OD and People Management Board would provide this oversight.

- The purpose and objectives of TMC was unclear as a result of the lack of clarity over the delivery function governance arrangements. Therefore, the TMC terms of reference have been completely revised.

- As discussed earlier in the meeting the title of the workforce Committee can be updated to reflect the discussions and assurance it now receives. The Integrated Governance Framework will be revised.

- C Blanshard and the quality team have been supportive during this review. It is recognised that the committee structure under Clinical Management Board (CMB) is under review and this is subject to change.

Discussion:

- P Kemp noted a minor change to where the Accountable Officer should sit in the organisational structure. This will be amended. **ACTION: KN** **KN**

- E Jones noted that the report was not clear from the outset about the management assurance work. F McNeight explained that the report covers both arms of the organisation, delivery and assurance. It is now clear that TMC has complete oversight of work prior to going to the Board Committees.

- C Charles-Barks reminded the Board that this work has taken a layered approach and is a continuous improvement journey. There is now better alignment and the Trust is now working towards being outstanding as a well-led organisation.

- T Baker queried if there was a separate executive meeting to TMC. C Charles-Barks noted that there is a weekly executive meeting. This is not a formal decision making committee. However, C Charles-Barks agreed that any critical disagreements need to be worked through prior to presenting an agreed perspective as an executive team.

- P Miller supported the suggested changes. However, he observed that committees and management groups are

internally focussed and asked where system meetings fit into the structure. P Kemp noted that these are external meetings with staff appointed as 'ambassadors' to attend and make recommendations however, they do not inform the internal governance arrangements. C Charles-Barks noted that whilst these are external meetings the Trust should recognise that there is a third dimension.

- R Aggarwal noted that she had found the paper really useful but in relation to workforce, she noted that culture is not mentioned. R Aggarwal suggested that cultural change needs to be the ethos and underpinning of governance. E Provins suggested that the best place to pick this up would be through the new OD and People Management Board. However, C Charles-Barks noted this is a wider developmental piece of work. L Lane and A Hyett are working on a development programme for divisions which will pick up the cultural ethos and their role as leaders.

- E Jones noted that CGC is 9 times a year whilst others are held more often. This will be discussed at the next CGC.

Decision:
The Board were happy to support and approve the changes to the governance structure.

TB1 4/6/4 WORKFORCE

TB1 4/6/4.1 Freedom to Speak up Guardian Annual Report

C Charles-Barks provided an update on FTSU work over the past 12 months and highlighted the following key points:

- There has been positive progress by the Trust in terms of their Freedom to Speak Up Programme. In relation to the FTSU Guardian Ambassadors there has been a delay as there was further work required in relation to linking this to other ambassador roles.

- There has been a significant increase to from 21 cases in 2018-19 to 85 cases at the end of this year. This is line with the rest of country and identifies a healthier, transparent culture. Other Trusts are looking to us for guidance and there is also a focus of reviewing the inclusion of those lesser known groups of staff.

- Currently, only 10% of staff returns a feedback form but there has been positive feedback from staff who have raised concerns and are satisfied with the outcome.

- As a result of the FTSU process a number of positive outcomes have occurred, including revised policies and procedures, adjusted rostering, training needs identified, poor behaviours challenged, increased resource, inclusion

issues raised.

Discussion:

- L Swift noted the key achievements in year have been the higher rates of reporting and evidence that the Trust's culture is changing in a positive way.

- L Swift noted she had been working closely with NHSI which has been a positive experience and also working with Jean Scrase to ensure the Trust is adhering to new guidance.

- N Marsden noted the great progress and thanked L Swift for her great work and the comprehensive report.

TB 4/6/5 QUALITY AND RISK

TB 4/6/5.1 Learning from Deaths Report Q4/Annual Report

C Blanshard presented the report providing the Board with the Q4 Learning from Deaths update. The following key points were noted:

- The Medical Examiner system was introduced in April which it is hoped will improve bereavement support going forward.

- In Q4 a majority of deaths were unavoidable and expected. Three deaths were unexpected and subject to serious incident inquiry.

- There has been a multidisciplinary review of 33 patients who died with a fractured neck of femur and an action plan has been agreed for improvements in the pathway.

- A case notes review of the patients who died from gastrointestinal haemorrhage was presented to CGC in February 2020. An action plan is in place to improve the referral and booking process and the acute upper GI pathway. An update will be reported at the next CGC meeting.

- The relative risk of death from acute renal failure has been rising since July 2018 but remains within the expected range. The Mortality Surveillance Group commissioned a review of these deaths which will be reported to the group in June 2020

Discussion:

- D Buckle noted that the report provided a good level of assurance and demonstrated a systematic approach. D Buckle referred to those patients who had been discharged into the community at the start of the COVID pandemic and asked how the Trust could review if any of these patients had died. C Blanshard explained that the SHMI data includes the deaths of all patients within 30 days of

discharge.

- In relation to a review of COVID deaths D Buckle asked if it would give an indication about the source of infection. L Wilkinson noted that the review will indicate if COVID-19 was community or hospital acquired. This can be correlated to how the Trust has cohorted patients and Personal Protective Equipment (PPE) reflecting that national guidance changes frequently. L Wilkinson noted that the situation is very complex and PPE is only part of the infection and prevention controls in place.

- E Jones referred to RIDDOR cases and L Lane explained that there are robust processes in places and any cases are escalated to Health and Safety immediately with immediate action taken. L Wilkinson noted that this is triangulated to the virtual board rounds as they include Occupational Health. R Aggarwal reflected on the report and asked how this then informs learning in terms of quality improvement. C Blanshard provided an explanation and R Aggarwal asked for this to be explicit in the next report. **ACTION: CB** **CB**

- C Charles-Barks asked about the process if patients die of COVID-19 up to 30 days after discharge and if this data is being triangulated. C Blanshard explained that Dr Foster is reviewing mortality to take COVID-19 into account. C Blanshard agreed to review this and how this is captured in real time. **ACTION: CB** **CB**

TB1 4/6/6 **CLOSING BUSINESS**

TB1 4/6/6.1 **Agreement of Principle Actions and Items for Escalation**

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

- The Board agreed to re-name the Workforce Committee.
- The Corporate Objectives will come to July's Board.
- The revised governance framework was agreed with the understanding it is a continuous process and there should be oversight of external factors. N Marsden, C Charles-Barks and F McNeight to discuss outside of the meeting.
- There will be a wider board discussion/seminar session on the transformation programme and system response to COVID.

TB1 4/6/6.2 **Any Other Business**

N Marsden noted that this was L Wilkinson's last meeting. On behalf of the Board he thanked her for her excellent work as Director of Nursing and recognised the great impact she had on the nursing community. N Marsden wished L Wilkinson all the best in her new role.

There was no further business.

TB1 4/6/6.3 **Public Questions**

- J Lisle asked that in relation to culture and transformation work, how the hospital ensures clear communication with the public. N Marsden noted that the Trust needs a review of the Communications Strategy due to the number of changes in the way we interact. C Charles-Barks suggested that the Trust requires a comprehensive reset framework that has representation from across the trust. One piece of work that can incorporate this internally is the "Best Place to Work" which will include conversations about vision and what makes a different and this will be relaunched in mid-June.

- J Mangan reflected that this had been the best meeting he had observed in his time at the Trust. He observed that the Board had answered varied questions that have never been more accurate. J Mangan noted that the communications team had produced an information sheet and then the governors had drafted documents to constituencies which worked well and keeps the Trust's membership informed.

TB1 4/6/6.4 **Date of Next Meeting**

Thursday 2 July 2020, Board Room, Salisbury NHS Foundation Trust

TB1 4/6/7 **RESOLUTION**

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

Salisbury NHS Foundation Trust

Action Log Trust Board Public 2 July 2020

	Agenda item	Assigned to	Deadline	Status
1.7 Chief Executive Report				
192.	TB1 4/6/1.7 - SFT COVID-19 Recovery Session	Charles-Barks, Cara	02/07/2020	Pending
	Explanation action item C Charles-Barks noted that there is a presentation next week relating to the BSW approach which will be shared with the Board outside of the meeting. It was suggested that COVID-19 recovery progression should be covered in a Board Seminar, or similar session.			
2.2 Finance and Performance Committee - 19 May				
193.	TB1 4/6/2.2 Corporate Objectives	Humphrey, Kieran	02/07/2020	Pending
	Explanation action item C Charles-Barks noted that the corporate objectives have been refreshed and they will be closely aligned to transformation programme. This will come to the Board in July			
2.3 Workforce Committee - 28 May				
194.	TB1 4/6/2.3 Workforce Committee	Lane, Lynn	02/07/2020	Pending
	Explanation action item It was agreed that the Workforce Committee would change its name to “People and Culture Committee”. Post Meeting Note - discussions to go back to the Workforce Committee to decide if 'Organisational Development' is added to the title.			
3.2 Board Governance Structure Review				
195.	TB1 4/6/3.2 Board Governance Structure Review	Nye, Kylie	02/07/2020	Completed

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	Explanation action item P Kemp noted a minor change to where the Accountable Officer should sit in the organisational structure. This will be amended.			
5.1 Learning from Deaths Report Q4/Annual Report				
196.	TB 4/6/5.1 - Learning from Deaths Report Q4/Annual Report	Blanshard, Christine	03/09/2020	Pending
	Explanation action item R Aggarwal reflected on the report and asked how this then informs learning in terms of quality improvement. C Blanshard provided an explanation and R Aggarwal asked for this to be explicit in next report			
197.	TB 4/6/5.1 - Learning from Deaths Report Q4/Annual Report	Blanshard, Christine	03/09/2020	Pending
	Explanation action item C Charles-Barks asked about the process if patients die of COVID-19 up to 30 days after discharge and if this data is being triangulated. C Blanshard explained that Dr Foster is reviewing mortality to take COVID-19 into account. C Blanshard agreed to review this and how this is captured in real time.			

Report to:	Trust Board	**Agenda item:**	**1.8**
Date of Meeting:	July 2nd 2020		

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

Recommendation:
The Board are asked to Note the report.

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • **Performance –** update on current performance • **Finance –** update on our financial recovery plan • **Workforce –** update on workforce situation • **COVID-19 response** • **Best Place to Work** • **Volunteers' Week** • **Pride on Parade**

Performance

Following guidance on the second phase of the NHS response to Covid-19, the Trust moved into a recovery mode in May. This involved the restart and recovery of services. The return of routine work is limited by the requirement to adhere to testing, distancing and cleaning regulations, and therefore elective activity levels, although increasing, remain significantly lower than plan (YTD outpatients -18,973, Elective -580 and Day case -2577).

Bed occupancy increased slightly from April, but remained low at 64%. As a positive side effect of this there were zero same sex accommodation breaches, decreased bed moves, and almost zero escalation bed days. All wards were sufficiently staffed for the month, with a reduction in agency spend as a result of lower bed occupancy levels, and overall expenditure on pay in the month a 2.4% reduction on April. The continued decreased levels of elective activity, combined with a reduction in referrals caused further deterioration of RTT (down to 74.6% from 83.0% in April).

Diagnostics improved marginally to 47.2% (46.6% in April). Performance of the cancer standards was mixed, with achievement of the Two Week Wait standard at 94.8%.

There is concern, however, that this is linked to a low rate of referrals. Due to a low number of treatments provided, the 62 day standard performance was 77.8%, some way under the target level of 85%.

Concerns around low volumes of emergency activity remained, but ED attendances increased at 4409 compared to 3139 in April (6209 in May 2019). Subsequently the 4 hour Emergency access standard was met, the first time this has been achieved since August 2019. Stroke and TIA performance remained good, and reassuringly TIA presentations have increased to near pre Covid-19 levels.

Finance

June is third month during which we are operating under Covid-19 Phase 1 financial arrangements, prior to revised guidance taking effect on 1st August. In order to break even the Trust has lodged a claim for a £0.1m retrospective top up against an overall modelled cost base of £45m year to date.

We are expecting confirmation of the revised guidance to be applied from 1st August to be received by 1st July, significant changes are not anticipated.

The month of May saw a number of services stepping back up their capacity for planned care, as well as an increased footfall through A&E, with each service preparing their own standard operating procedures incorporating key considerations such as physical environment and infection control.

Workforce

Although there have been no events this month, we have continued to recruit reducing numbers, by conducting interviews by Skype or Microsoft Teams.

Induction is still continuing also with reduced numbers, only 30 new staff this month, and in compliance with social distancing guidelines. We will need to plan for a return to normal levels of recruiting as we move out of lockdown, as the number of vacancies has correspondingly increased.

In May, the Trust's overall sickness absence rate sharply reduced to 3.95%, still above the 3% target, although 1.20% of this is attributable to COVID, and with managers also reporting an increase in anxiety/stress also related to the pandemic.

Mandatory training has again increased slightly at 90.57%, still above the 85% target, and non-medical appraisals have reduced slightly to 82.02%. Medical appraisals have been suspended by national agreement for the time being until such time as we are beyond the pandemic.

We are very conscious of supporting our staff through this challenging time and in particular ensuring that they feel safe at work. In addition to providing the appropriate levels of PPE, we are also conducting comprehensive risk assessments.

Initially, these will be focussed on our more vulnerable colleagues, for example those over 70, from a BAME background, or with an underlying medical condition and will eventually extend to all staff. We are also trying to alleviate the anxiety of staff by introducing testing as soon as this is available, both antigen (which results show whether you currently have the virus or not) and antibody (which results show whether you have had the virus or not – and may therefore have a degree of immunity).

It is unfortunately not possible to test everyone immediately, so we are working through a programme of antibody testing which will cover all areas by the middle of July. WE are working on a roll out plan for the antigen testing. In addition to these practical measures, we have provided

discounts on food and drink for staff, made chill out rooms available so that staff have somewhere to go to let off steam, and signposted everyone to the national employee assistance helpline. We are seeking new ways of improving staff health and wellbeing through any available initiatives.

COVID-19 response

Following the suspension of routine clinical services, our teams have gone to extraordinary lengths to review and restructure our services to ensure the safety of our patients and our staff.

From Monday 15th June 2020 we implemented new measures on the use of face masks and coverings in hospital in line with national guidance.
As part of the measures, visitors and patients coming to hospital for planned and outpatient care need to wear face coverings when in the hospital setting to reduce the risk of spreading coronavirus to other patients and staff. Staff now also wear facemasks in non-COVID-19 secure settings, such as the main corridors or public areas.

Signage has been updated across the site, including posters and floor markers to encourage the use of masks and face coverings and to enable visitors to adhere to social distancing.

The dedication and professionalism shown by our staff in safely restoring services for patients shone through in the BBC 2 Newsnight Programme's third feature on Salisbury Hospital, which focused on our hospital's road to recovery.

Best Place to Work

The Best Place to Work programme, a cross organisational project to listen to our workforce in order to understand what it feels like to work for the Trust, relaunched in June.

The collected information will support and inform the work of the Trust with an analysis of the current culture and leadership characteristics helping develop the corporate strategy.

While this programme was instigated before COVID-19 it now provides an excellent opportunity to not only assess our overarching culture and values but also to learn from the past 100 days, recognise when things could be done better and ensure we capture the best and embrace the positive.

This will culminate in a proposal back to the Board in September.

Volunteers' Week

At the beginning of June we celebrated Volunteers' Week and said thank you to our amazing hospital volunteers – all are members of our local community who give their time freely to help teams across the hospital. Videos thanking our volunteers were shared across the organisation and images of our volunteers were projected on to the Salisbury City Guildhall.

We are lucky to have over 600 dedicated volunteers who make life that little bit better for so many people in hospital. Although a number of our volunteers are rightly shielding and isolating at home and/or are currently unable to carry out their usual duties, others have continued to support our staff throughout the coronavirus crisis and a number of new volunteers have joined the Trust.

Our volunteers are an integral part of Team Salisbury not just for what they do but how they do it – with enthusiasm, commitment and compassion, they are part of the beating heart of our hospital family.

Pride on Parade

The Trust celebrated Pride month in June, by decking out six of our tugs in the Pride Rainbow colours. The vehicles, which drivers use to deliver and collect and deliver items throughout the hospital, each have their base wrapped in individual colours of the Pride rainbow. The tugs are seen throughout the day by staff and patients across the hospital site and will be a highly visible reminder of Pride.

Cara Charles-Barks
Chief Executive

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	
Date of Meeting:	2nd July 2020		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	17th June 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation

The Trust Board is asked to note the matters below, considered by the Committee in making its recommendation.

The Board is recommended to adopt the Annual Report and Accounts for 2019/20 and sign the Letter of Representation to Grant Thornton

Key Items for Escalation

Internal Audit Annual Report and Head of Internal Audit Opinion

The committee reviewed progress on internal audit work. There was a degree of disappointment that there were five overdue audit actions as at the 31st March, three of which relate to audits undertaken in the 2018/19 financial year. A further four have subsequently gone overdue in the first quarter of the 2020/21 financial year. The Executive committed to a focus on clearing the overdue items as soon as is practical and the Committee will review progress at the next meeting.

The last item of work from the 2019/20 work programme was reported out, with the review of Agency Costs being rated as Low Risk, having only two low priority findings assigned.

The formal Head of Internal Audit opinion was headlined “Generally satisfactory with some improvements required”, which was one step up from last year’s opinion of “Major improvement required”. This change in rating was in recognition that some tangible progress in control matters had been achieved, which was generally agreed by the committee, although there was some discussion at the committee regarding the degree of progress and the need for continuation of trajectory towards a good result.

Annual Report and Accounts

The Annual Report and Accounts were presented to the Committee. The Committee briefly discussed these documents and agreed that they were suitable for recommending for adoption by the Board.

The four main financial statements are appended to this report.

External Audit Opinion

Grant Thornton presented their findings from their audit of the Annual Report and Accounts, together with their formal audit opinion. Grant Thornton's report noted a number of issues encountered whilst undertaking their review and presented a number of recommendations for changes in processes. The Finance Director broadly accepted the findings, although commented that a number of them were rated as a higher priority matter than was considered appropriate by the Finance team.

The Audit Opinion for the accounts was qualified in two areas, which we have been told are common to all NHS Trust accounts for this year.

1. The working processes of the audit team, as dictated by the requirements for safe working during the Covid-19 lockdown, meant that the auditors were unable to properly evidence the inventory counts in the Trust.
2. The valuation of the Trust's fixed assets are subject to material uncertainty due to the macro-economic environment, again largely driven by the impact of the Covid-19 pandemic

The Audit Opinion also draws attention to the overall lack of financial sustainability of the Trust, as noted in the Annual Report. However, there was no audit qualification for this matter, as the Trust does not meet the conditions specifically set by the Department of Health to be considered to be no longer a going concern. As has been discussed at Board before, under all normal circumstances and without this specific government exception, the Trust would not be able to be accounted for as a going concern, in common with many NHS Trusts.

Although not qualifying their overall Audit Opinion regarding the financial sustainability of the Trust, the separate opinion required to be provided in what is generally referred to as the Value for Money assessment is strongly qualified, citing three specific shortfalls.

1. The Trust delivered a net deficit of £14.7m for 2019/20, compared to a planned control total deficit of £9.0m
2. There is an ongoing structural deficit without a robust plan to eliminate it
3. The Trust remains in enforcement undertakings with NHSI (largely as a result of point 2)

There was a degree of friction between the finance team and the external auditors during the audit process, at least some of which should be recognised as being caused by shortcomings in the Trust's management and execution of the work. It has been recommended that there be a round table discussion between the key personnel involved to try to ensure better outcomes next year. Grant Thornton are seeking to claim additional fees for the services they have performed.

Letter of Representation

The Committee reviewed the Letter of Representation proposed by Grant Thornton. This contained only the normal statements that are to be expected in such a document and there were no special representations requested.

The Committee asked the Chief Executive and Finance Director for assurance that the statements in the document were correct and for how they had reviewed and ensured that this was the case. Appropriate assurance was given and the Committee agreed to recommend that the letter be signed on behalf of the Board.

STATEMENT OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2020

	Note	Group 2019/20 £000	Group 2018/19 £000	Trust 2019/20 £000	Trust Restated 2018/19 £000
Revenue from patient care activities	3	**222,621**	210,675	**222,621**	210,675
Other operating revenue	5	**38,106**	37,335	**24,918**	25,098
Operating expenses	7	**(263,885)**	(243,848)	**(252,570)**	(234,236)
OPERATING SURPLUS/ (DEFICIT)		**(3,158)**	4,162	**(5,031)**	1,537
FINANCE COSTS					
Finance income	12	**454**	346	**265**	198
Finance expense	13	**(2,592)**	(2,512)	**(2,592)**	(2,512)
PDC Dividends payable		**(3,037)**	(3,480)	**(3,037)**	(3,480)
NET FINANCE COSTS		**(5,175)**	(5,646)	**(5,364)**	(5,794)
Losses on disposal of assets	17	**(72)**	(11)	**(72)**	(11)
Share of profit/ (loss) of associates/ joint ventures	34	**(15)**	(147)	**(15)**	(147)
Movement in fair value of investment property	22	**-**	-	-	-
Movement in fair value of other investments	18	**(986)**	282	-	-
RETAINED DEFICIT FOR THE YEAR		**(9,406)**	(1,360)	**(10,482)**	(4,415)
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations	17	**(441)**	4,706	**(444)**	4,659
Items that may be reclassified to income and expenditure					
Fair Value gains/ (losses) on Available-for-sale financial investments	18	**-**	-	-	-
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**(9,847)**	3,346	**(10,926)**	244
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**8**	7	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(9,414)**	(1,367)	**(10,482)**	(4,415)
TOTAL		**(9,406)**	(1,360)	**(10,482)**	(4,415)
(b) Total comprehensive income/ (expense) for the year attributable to:					
(i) Minority interest, and		**8**	7	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(9,855)**	3,339	**(10,926)**	244
TOTAL		**(9,847)**	3,346	**(10,926)**	244

The notes on pages 5 to 49 form an integral part of these financial statements.
All revenue and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION
31 MARCH 2020

	Note	Group			Trust		
		31 March 2020	Restated 31 March 2019	Restated 1 April 2018	**31 March 2020**	Restated 31 March 2019	Restated 1 April 2018
		£000	£000	£000	**£000**	£000	£000
NON-CURRENT ASSETS							
Intangible assets	16	**8,828**	8,390	9,899	**8,828**	8,390	9,899
Property, plant and equipment	17	**140,083**	142,250	136,417	**137,635**	139,579	133,647
Investments in subsidiaries	33	**-**	-	-	**5**	5	5
Investments in joint ventures	34	**88**	103	250	**88**	103	250
Investments	18	**6,319**	7,059	6,779	**-**	-	-
Other financial assets	19	**2,299**	2,204	2,123	**4,982**	3,340	3,721
Receivables	21	**649**	-	-	**649**	-	-
Total non-current assets		**158,266**	160,006	155,468	**152,187**	151,417	147,522
CURRENT ASSETS							
Inventories	20	**7,514**	6,770	6,214	**5,892**	4,840	4,807
Receivables	21	**15,575**	23,555	14,726	**13,894**	22,761	14,063
Investments	18	**133**	201	44	**-**	-	-
Other financial assets	19	**-**	-	-	**-**	962	462
Non-current assets held for sale	22	**-**	-	570	**-**	-	570
Cash and cash equivalents	23	**16,145**	12,516	10,370	**9,087**	7,476	7,780
Total current assets		**39,367**	43,042	31,924	**28,873**	36,039	27,682
Total assets		**197,633**	203,048	187,392	**181,060**	187,456	175,204
CURRENT LIABILITIES							
Trade and other payables	24	**(29,191)**	(24,929)	(24,457)	**(27,799)**	(23,439)	(23,269)
Borrowings	25	**(22,784)**	(1,695)	(1,164)	**(22,784)**	(1,695)	(1,164)
Provisions	26	**(198)**	(713)	(292)	**(198)**	(713)	(292)
TOTAL CURRENT LIABILITIES		**(52,173)**	(27,337)	(25,913)	**(50,781)**	(25,847)	(24,725)
TOTAL ASSETS LESS CURRENT LIABILITIES		**145,460**	175,711	161,479	**130,279**	161,609	150,479
NON-CURRENT LIABILITIES							
Borrowings	25	**(20,271)**	(42,897)	(33,306)	**(20,271)**	(42,897)	(33,306)
Provisions	26	**(1,144)**	(275)	(320)	**(1,144)**	(275)	(320)
TOTAL NON CURRENT LIABILITIES		**(21,415)**	(43,172)	(33,626)	**(21,415)**	(43,172)	(33,626)
TOTAL ASSETS EMPLOYED		**124,045**	132,539	127,853	**108,864**	118,437	116,853
FINANCED BY:							
TAXPAYERS' EQUITY							
Minority Interest		**50**	42	35	**-**	-	-
Public dividend capital	35	**58,650**	57,297	55,957	**58,650**	57,297	55,957
Revaluation reserve		**61,193**	61,827	57,168	**61,193**	61,827	57,168
Income and expenditure reserve		**(9,779)**	345	4,530	**(10,979)**	(687)	3,728
Charitable fund reserves	36	**13,931**	13,028	10,163	**-**	-	-
TOTAL TAXPAYERS EQUITY		**124,045**	132,539	127,853	**108,864**	118,437	116,853

The notes on pages 5 to 49 form an integral part of these financial statements.

The financial statements on pages 1 to 49 were approved by the Board on 2020 and signed on its behalf by:

Signed:

Cara Charles-Barks - Chief Executive

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS EQUITY
31 MARCH 2020

	Public dividend capital (PDC)	Restated Income and expenditure reserve	Restated Revaluation reserve	Minority interest	Restated NHS Charitable Funds reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2018 as previously stated	**55,957**	**2,968**	**54,827**	**35**	**14,066**	**127,853**
Prior year adjustment	**-**	**1,562**	**2,341**	**-**	**(3,903)**	**-**
Taxpayers' and Others' Equity at 1 April 2018	**55,957**	**4,530**	**57,168**	**35**	**10,163**	**127,853**
Changes in taxpayers' equity for 2018/19						
Retained surplus/(deficit) for the year	-	(4,389)	-	7	3,022	**(1,360)**
Other recognised gains and losses	-	-	-	-	-	**-**
Net gain/(loss) on revaluation of property plant and equipment	-	-	4,659	-	-	**4,659**
Transfers between reserves	-	-	-	-	-	**-**
Revaluations and impairments - charitable fund assets	-	-	-	-	47	**47**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-	**-**
Other reserve movements	-	204	-	-	(204)	**-**
Public dividend capital received in year	1,340	-	-	-	-	**1,340**
Balance at 31 March 2019	**57,297**	**345**	**61,827**	**42**	**13,028**	**132,539**
Changes in taxpayers' equity for 2019/20						
Retained surplus/(deficit) for the year	-	(10,740)	-	8	1,503	**(9,229)**
Other recognised gains and losses	-	-	-	-	-	**-**
Impairment of property plant and equipment	-	13	(13)	-	-	**-**
Net gain/(loss) on revaluation of property plant and equipment	-	-	(621)	-	-	**(621)**
Transfers between reserves	-	-	-	-	-	**-**
Revaluations and impairments - charitable fund assets	-	-	-	-	3	**3**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-	**-**
Other reserve movements	-	603	-	-	(603)	**-**
Public dividend capital received in year	1,353	-	-	-	-	**1,353**
Balance at 31 March 2020	**58,650**	**(9,779)**	**61,193**	**50**	**13,931**	**124,045**

The notes on pages 5 to 49 form an integral part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

	Note	Group 2020 £000	Group 2019 £000	Trust 2020 £000	Trust 2019 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating surplus/ (deficit)		**(3,158)**	4,162	**(5,031)**	1,537
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	7	**11,204**	9,531	**10,982**	9,074
Impairments	7	**19**	1,203	**19**	1,203
Non-cash donations credited to income		**(606)**	(207)	**(606)**	(207)
(Increase)/ decrease in trade and other receivables	21	**7,776**	(9,042)	**9,012**	(8,952)
(Increase)/ decrease in inventories	20	**(744)**	(556)	**(1,052)**	(33)
Increase/ (decrease) in trade and other payables	24	**4,092**	727	**4,090**	531
Increase/ (decrease) in provisions	26	**353**	375	**(295)**	375
NHS charitable funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		**(400)**	57	**-**	-
Net cash inflow from operating activities		**18,536**	6,250	**17,119**	3,528
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**113**	54	**108**	117
Purchase of financial assets		**-**	-	**-**	-
Payments to acquire property, plant and equipment	17	**(6,683)**	(7,432)	**(6,626)**	(7,307)
Receipts from sale of property, plant and equipment		**-**	466	**-**	466
Payments to acquire intangible assets	16	**(2,436)**	(923)	**(2,436)**	(923)
NHS charitable funds - net cash flows from investing activities		**68**	55	**-**	-
Net cash (outflow) from investing activities		**(8,938)**	(7,780)	**(8,954)**	(7,647)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	35	**1,353**	1,340	**1,353**	1,340
Loan to subsidiary		**-**	-	**(700)**	(500)
Loan repayment received		**-**	-	**115**	462
Movement in loans from the Department of Health and Social Care	25	**(631)**	9,034	**(631)**	9,034
Capital element of finance lease rental payments		**(434)**	(529)	**(434)**	(529)
Capital element of Private Finance Initiative obligations	30	**(468)**	(488)	**(468)**	(488)
Interest paid		**(643)**	(528)	**(643)**	(528)
Interest element of finance lease rental payments		**(24)**	(29)	**(24)**	(29)
Interest element of Private Finance Initiative obligations	30	**(1,928)**	(1,919)	**(1,928)**	(1,919)
PDC dividend paid		**(3,194)**	(3,205)	**(3,194)**	(3,205)
Net cash inflow/ (outflow) from financing		**(5,969)**	3,676	**(6,554)**	3,638
Increase/ (decrease) in cash and cash equivalents		**3,629**	2,146	**1,611**	(481)
Cash and cash equivalents at the beginning of the financial year		**12,516**	10,370	**7,299**	7,780
Cash and cash equivalents at the end of the financial year	23	**16,145**	12,516	**8,910**	7,299

The notes on pages 5 to 49 form an integral part of these financial statements.

CLASSIFICATION: UNRESTRICTED

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	2 July 2020		

Report from: (Committee Name)	**Trust Management Committee (TMC)**		**Committee Meeting Date:**	20 May 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Board Sponsor (presenting):	Cara Charles-Barks, Chief Executive			

Recommendation
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 11 June 2020

Key Items for Escalation

The Trust Management committee took place on 11 June 2020.

The committee received the update on Governance which had previously been approved by the Board.

The committee also noted that the new OD&People Management Board terms of reference had been drafted and approved by the Director of OD&People with meetings commencing from early September.

In order to further strengthen Governance arrangements, from July it was agreed that all committees which report into TMC will have formal escalation reports produced for the committee to receive.

Other items for Escalation:

The committee received a paper on FTSUG Ambassadors which upon review was noted to be lacking detail around costs to implement. The committee therefore agreed that the paper would need to return to the committee with costs included, for them to be able to ensure value for money.

End of report

Salisbury NHS Foundation Trust

Report to:	Trust Board Choose an item.	**Agenda item:**	2.3
Date of Meeting:	23rd June 2020		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	12th May 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones			
Board Sponsor (presenting):	Miss Eiri Jones			

Recommendation

Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 23rd June 2020. The report both provides assurance and identifies areas where further assurance was sought and is required.

Key Items for Escalation

- As with last month's meeting the committee covered a comprehensive agenda with several key quality topics returning for discussion and to provide an update on progress and assurance.
- The meeting commenced with welcoming Ms Judy Dyos, the new Interim Director of Nursing.
- It was noted that no Governor observer was on the teams call. The Chair agreed to make contact with the relevant Governor to discuss any issues.
- An annual self-assessment of the effectiveness of the CGC was presented and discussed. The annual lookback was presented by Paul Miller as he had chaired most of the meetings in 2019-20. The forward look was presented by Eiri Jones. Key matters to escalate to Board include:
    - The report provided assurance that the CGC was complying with its duties as set out in the Terms of Reference. It also noted the challenge in relation to Non Executive attendance earlier in the year. This had been resolved with the appointment of new Non Executives and the co-opting of the Chair as a member for 2020-21.
    - The Terms of Reference had been reviewed and changes proposed. Key changes included increasing the number of meetings to 12 a year in line with the Finance and Performance Committee and to include the Chief Executive as a member.
    - A forward plan had been agreed to include high priority and priority areas, recognising that some of these may change in line with post Covid-19 resetting.
- The Safety and Experience elements of the Integrated Performance Report were presented and considered. Good focus and assurance continues to be provided in

relation to safety during the current pandemic though delays in access to the stroke ward from the Emergency Department (ED) were noted due to ED pressures. Of positive note, it was reported that the TIA clinic has returned to near normal numbers. The number of Covid-19 patients continue to reduce and work has commenced to identify any hospital acquired infections. All Covid-19 deaths are being reviewed by the mortality surveillance group. It was noted that the number of pressure ulcers have reduced this month with no Grade 3 or 4s reported. Whilst complaint numbers were small, it was noted that the 2 main themes were 'appointment system – procedures' and 'unsatisfactory care'. A further theme was 'communication'. These will be explored in detail at a further CGC meeting.

- Along with the annual review of the CGC, an annual Clinical Governance report was presented. This outlined all the activity delivered over the past 12 months and included the changes to directorate governance which will become embedded in the new divisional structures.
- Following concern in relation to the increase in pressure ulcers over the past 12 months, a presentation was requested to provide assurance in terms of the root causes and actions taken. Two Heads of Nursing and the Tissue Viability Nurse presented. It was noted that there were several contributory factors under the themes of: lack of knowledge, delays in care and inaccurate identification / documentation. Actions had and were being taken in relation to these issues including the training of more than 100 individuals recently. Reminders in relation to professional accountability and responsibility have also been emphasised. Whilst it was noted that pressure ulcer numbers have reduced in the current report, this needs to be kept under consideration of this committee. An update will planned into the annual cycle of business currently underway.
- A detailed Serious Incident compliance report was presented (outstanding reports and quarter 4 report). This was separated into the three new divisions and cancer. Confirmation that issues identified are now linked with the risk register was provided. The committee raised the concern and were not assured that incidents were being managed in a timely way thus leaving the potential for the harm to be repeated. The committee requested further assurance in relation to timeliness of completing plans as many had long delays in completing with completion dates being extended more than once. There was also little evidence of learning from when things had gone wrong. It was also questioned as to how the Clinical Management Board (CMB) was managing its oversight of serious incidents. Further work was requested with an update to come back to CGC in the near future.
- Feedback was provided from the recent virtual cancer summit (a follow on from the September 2019 summit) to review the progress against the actions agreed following a cluster of serious incidents in 2018-19. Four task and finish groups had been established to undertake work in relation to outstanding issues in the following areas: appointments, outcome forms, reviews of investigations and MDT meetings. An internal audit review was also undertaken of the cancer pathway. Good progress was noted with further work needed in relation to outcome process for clinics and also responding to results. Both of these issues continue to be addressed. A further update will be provided in 6 months. For assurance, 2 cancer serious incident investigations were commissioned in 2019/20 with none to date this year.
- An update was provided in relation to progress of actions based on the risks identified in the Gastroenterology service. It was noted that the new structures under the leadership of surgery was positive and that this was expected to have a positive impact on the workforce risk. Assurance was provided that mitigating actions were also working well. A review of progress against the plan developed to meet the recommendations made by the Royal College was provided. It was also noted that as non-emergency endoscopy services were suspended during Covid-19, this had enabled rapid progress to be made in terms of improvement actions. As there were some remaining actions, a further update was requested in three months. Assurance was also provided that the CQC have been kept informed in relation to this risk.

- A report in relation to the Transformation Programme was presented. This outlined how the Trust Transformation Programme will support the quality agenda in services through paperless working and quality improvement methodology. It was noted that more work is required on specific outcome / delivery dates. The report was welcomed and will become a regular report.
- A detailed end of year report was provided in relation to patient and public experience and involvement. It was noted that the team had been working differently during the pandemic though the focus had continued on listening to and involving patients. Progress was noted in relation to the three themes of communication, working together and outstanding care. Priorities for 2020-21 have also been planned and these will be reviewed in the annual work programme for CGC.
- The following Quarter 4 reports were presented: Risk Management, Patient Experience, Safeguarding Adults and Children. A key issue emerging from the children's safeguarding report during Covid-19 was the increase in the number of 11-15 year olds reporting domestic abuse. The Trust is working with safeguarding partners in relation to this.
- Minutes from CMB and CRG were received. Further assurance is being sought in relation to the timely management of serious incidents. It was also requested that escalation reports are provided to the CGC from these meetings.

Two key themes to be raised at Board are: IT solutions required in some areas discussed in this committee and workforce solutions in some areas discussed in this committee. The second issue relates to decisions that were expected in the postponed workforce summit.

CLASSIFICATION:

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	2 July 2020		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	23rd June 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance Committee meeting of the 23rd June 2020

Items for Escalation to Board
MRI recommendation report – The Trust Board has previously approved the award of a tender for the Stars Appeal financed MRI scanner, this further tender recommendation report was for an additional NHS funded replacement MRI, which would result in two new static MRI scanners be available on the Salisbury Hospital site during the early part of 2021. The recommendation in this paper to award the tender was supported by the committee. **Integrated performance and finance reports as at 31st May 2020 –** both reports were received and noted the key issues were (a) despite covid-19 the Trusts operational performance is satisfactory against the measured targets and (b) the Trust continues to financially break even, as at month two, as a consequence of the current interim NHS finance regime. The key issue is what happens to performance when activity increases as non-covid NHS services resume and the current interim NHS financial regime ends, particularly going into the next financial year 2021/22. **Transformation update** – following the resetting of the Trusts transformation plan for 2020/21, which was reported to the committee and the Trust Board in May 2020, the committee received the first update report. It was noted that the reporting format and performance indicators were still in development, however the update report did give assurance that there was oversight of the new transformation programme and the associated governance arrangements were in place. In addition this report highlight that a proposal to award a new Microsoft Office contract (based on national NHS negotiations)

would be going straight to the Trust Board in July 2020, because of the timescale of negotiations.

Covid-19 recovery update– The Trust continues to plan the detail and commence the recovery of non-covid services within the hospital and the expectation is over time the hospital will see most services reinstated. A key element of this recovery are the production and approval of detailed standard operating procedures (SOP's) for all aspects of the Trusts services. These SOP's will also enable the Trust to improve its planning process and help us match activity to capacity and available resources.

Proposal for critical care surge in capacity – the Trust have developed three capital schemes to help us manage any future surge in critical care capacity. These schemes would not increase capacity in themselves, but instead would enable a more flexible response, thereby protecting non-covid activity in the hospital. The intention is to submit these capital schemes for external central NHS funding. If these bids were not successful, then a separate set of business cases would need to be produced and formally approved, if the intention was to reset the Trusts 2020/21 capital programme to accommodate them.

Purchase of (PPE respiratory) hoods – The recommendation to purchase 150 units at a cost of £89,000 (excluding VAT) was supported by the committee.

Campus development – the committee received a detailed report and noted the following;

(a) The proposed programme approach to manage the campus scheme including broad timelines
(b) The intent to undertake some engagement on the scheme during the latter part of the summer
(c) The proposed principles for a revised partnership agreement
(d) An outline of high level draft funding mechanisms to finance any possible upfront planning and design costs

Finally the committee approved an extension to the existing partnership agreement with Salutem until the Trust Board meeting on the 3rd September 2020, on the condition that it did not commit the Trust to any additional costs, above and beyond the funding already approved by the Trust Board.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	25th June 2020nd		

Report from: (Committee Name)	Workforce Committee		**Committee Meeting Date:**	25th June 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele; Non-Executive Director			
Board Sponsor (presenting):	Michael von Bertele; Non-Executive Director			

Recommendation
The Trust Board are asked to note the items escalated from the Workforce Committee meeting held on Thursday 25th June 2020.

Key Items for Escalation

1. The Committee discussed the name and purpose of the committee following approval of ToRs at last week's Board Meeting and decided to change the name to "People and Culture Committee." It was noted that assurance of the various strands of Organisational Development is an important function of the committee but it was agreed that OD is a part of the process by which our people are supported and developed, rather than the end state we wish to achieve.

2. The committee is expected to conduct a review of its own effectiveness annually, but in light of the critical observations made in the PwC audit of committees it was agreed that it would be appropriate to report on the changes and improvements made since that report was published.

   a. A new board, the OD and People Management Board has been formed to coordinate and manage much of the transactional activity that was being reported and discussed at the Workforce Committee. It will be chaired by the director of OD and People. This will elevate the sights of the committee to more strategic matters. ToRs for the new board will be published in due course.
   b. Frequency of meetings has been increased to 10 per year, reducing the number of items to be considered at each committee.
   c. Production, quality and timeliness of papers for the committee have been much improved under oversight of the new Director of OD and People.

3. Work on "The Best Place to Work," that was paused at the start of the COVID-19 pandemic, has been kick started and rapid progress has been made on the first phase, consulting with staff and understanding their concerns and aspirations. This will inform development of the strategy that will in turn guide work on developing the leadership within

the Trust to deliver the improvements that will provide continually improving care to our patients.

4. The Committee received the first outline report on progress in the Transformation Programme that brings together the multiple strands of work underway across the Trust. This includes a number of projects under the Quality Improvement project and the Committee noted good progress in training of the QI Coaches who are essential to the delivery of a large number of discrete change projects.

5. Within the Integrated Perfomance Report the Committee noted relatively poor compliance with mandatory training in some areas and agreed to revisit the target and how it might be achieved.

6. The Perfomance Report also highlighted a significant fall in sickness absence that has almost halved in the past month, in large part as a result of excellent coordination between line managers, HR Business partners, and a strengthened Occupational Health team. This has been a remarkable achievement in the face of heightened anxiety and uncertainty

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:			

Report from: (Committee Name)	Charitable Funds Committee		**Committee Meeting Date:**	18th June 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Lisa Thomas, Director of Finance			
Board Sponsor (presenting):	Nick Marsden, Chair			

Recommendation
The Trust Board are asked to note the items escalated from the charitable Funds Committee meeting held on 18 June 2020

Key Items for Escalation
• The Committee welcomed the appointment of new the investment, planning and policy manager for the Charity and an outline of the work completed to date. • The Terms of reference were approved • The head of fundraising report highlighted the increase in physical gifts to the charity in the peak of the Covid -19 pandemic and the committee noted the generosity of local people and business was overwhelming. • The 2018/19 Accounts issues have now been resolved and the audit completed • New funding requests were supported for Vicon Motion and ENT department processor. • Support for the £1.7m funding raised for the MRI scanner being utilised for the cardiac scanner as well as equipping/installing the NHS funded MRI scanner, with Stars Appeal branding to be in both areas.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.7
Date of Meeting:	02 July 2020		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Felicity Anscombe, Information Services Manager Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

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

Executive Summary:
Following guidance on the second phase of the NHS response to Covid-19, the Trust moved into a recovery mode in May. This involved the restart and recovery of services. The return of routine work is limited by the requirement to adhere to testing, distancing and cleaning regulations, and therefore elective activity levels, although increasing, remain significantly lower than plan (YTD outpatients -18,973, Elective -580 and Daycase -2577). Bed occupancy increased slightly from April, but remained low at 64%. As a positive side effect of this there were zero same sex accommodation breaches, decreased bed moves, and almost zero escalation bed days. All wards were sufficiently staffed for the month, with a reduction in agency spend as a result of lower bed occupancy levels, and overall expenditure on pay in the month a 2.4% reduction on April. Sickness levels have significantly reduced to 3.95%, with non Covid-19 related sickness (2.75%) under the Trust target of 3%. Mandatory training levels have increased slightly, with increased IT access from home helping achievement of this. These workforce metrics are now shown as SPC charts in this report. The continued decreased levels of elective activity, combined with a reduction in referrals caused further deterioration of RTT (down to 74.6% from 83.0% in April). Diagnostics improved marginally to 47.2% (46.6% in April). Performance of the cancer standards was mixed, with achievement of the Two Week Wait standard at 94.8%. There is concern, however, that this is linked to a low rate of referrals. Due to a low number of treatments

provided, the 62 day standard performance was 77.8%, some way under the target level of 85%.

Concerns around low volumes of emergency activity remained, but ED attendances increased at 4409 compared to 3139 in April (6209 in May 2019). Subsequently the 4 hour Emergency access standard was met, the first time this has been achieved since August 2019. Stroke and TIA performance remained good, and reassuringly TIA presentations have increased to near pre Covid-19 levels.

The block contracts and 'top-up' payment received as part of the Covid-19 response were not quite enough to cover the baseline costs of the Trust, with a claim for a £0.1m retrospective top up required. This is inclusive of the recognised £0.3m per month 'shortfall' in the top up methodology caused by the instruction from NHSE&I not to invoice for provider-to-provider genetics tests.

Pressure Ulcers have seen an improvement, notably in level 2 ulcers which reduced to almost target (15) level at 16. Additional education has been provided, and results of a cluster review and an improvement plan are expected at the June Clinical Governance Committee. Further work is expected to be undertaken as a result of this review.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

July 2020

(data for May 2020)

An outstanding experience for every patient

Summary

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Structure of Report

Performance against our Strategic and Enabling Objectives

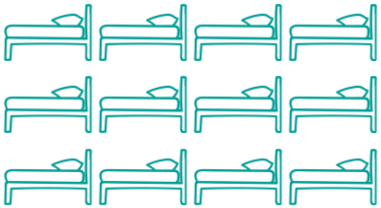
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
May 2020

Salisbury NHS Foundation Trust

There were **2,375** Non-Elective Admissions to the Trust

We carried out **95** elective procedures & **747** day cases



47.2% ↑ of patients received a diagnostic test within **6 weeks**

Emergency (4hr) Performance
95.0% ↑
(Target trajectory: 95%)

We delivered **11,467** outpatient attendances cases (-8,435 vs plan)

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

Our income was **£21,166k** (£714k over plan)

1070 patients arrived by Ambulance

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

RTT 18 Week Performance:
74.6% ↓
Total Waiting List: **15,055** ↓

20.4% ↓ of discharges were completed before 12:00

Our overall vacancy rate was **4.32%** ↑

Reading a Statistical Process Control (SPC) Chart

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

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

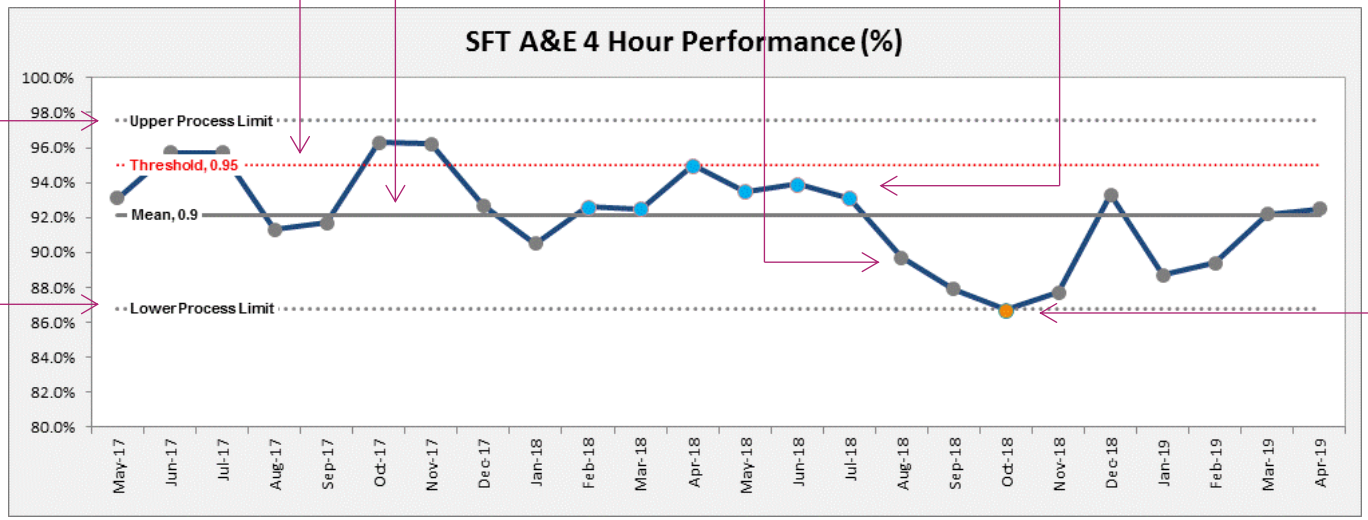
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

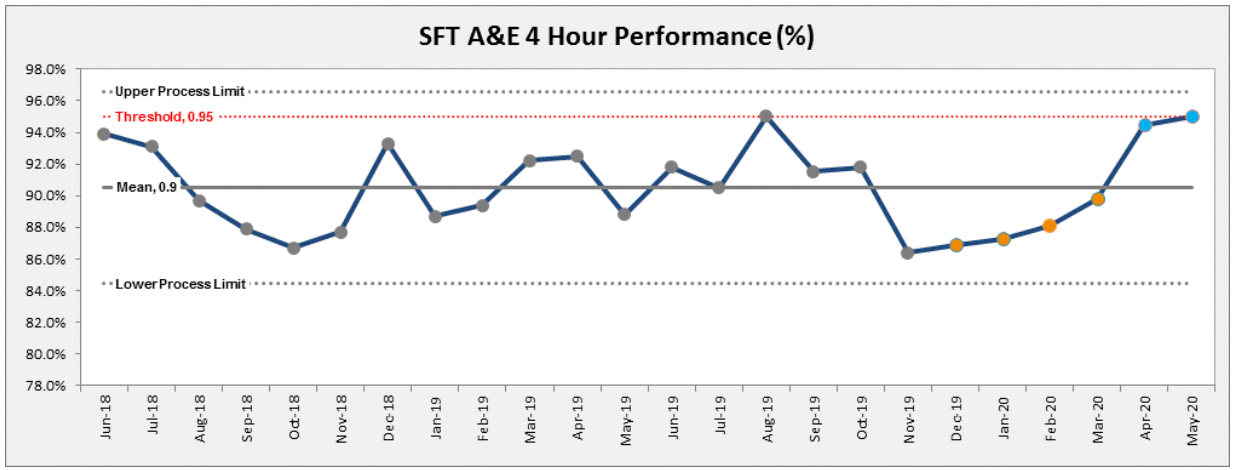
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

Emergency Access (4hr) Standard Target 95% / Trajectory 96.6%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	95.0%
Attendances:	4409
12 Hour Breaches:	0
ED Conversion Rate:	32.7%

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

In M2, the Trust achieved the 95% 4hr Emergency Access target for the first time since August 2019.

Attendances down 24% on M2 2019 due to reduction in footfall owing to Covid-19 and paediatric patients being diverted direct to paeds team.

Attendances up by 25% from M1 with minors footfall particularly returning to usual levels.

ED time to triage and time to treatment for all areas maintained within KPIs.

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

Works have been agreed to increase number of side rooms available in ED – planned completion date mid July. This supports plans for de-escalation of RAZ or increased requirement for infection control beds over winter.

Review of minors service – including opening hours, staffing etc. Extended clinical hours for ENPs to commence in June to extend opening hours from 8pm-10pm and bolster number of clinical staff during the day.

Risks to delivery and mitigations

Space and social distancing restraints. Waiting areas for patients in both ED majors and ED minors (based in fracture clinic). Division. Space allocation and recovery group to review longer term plan for this service.

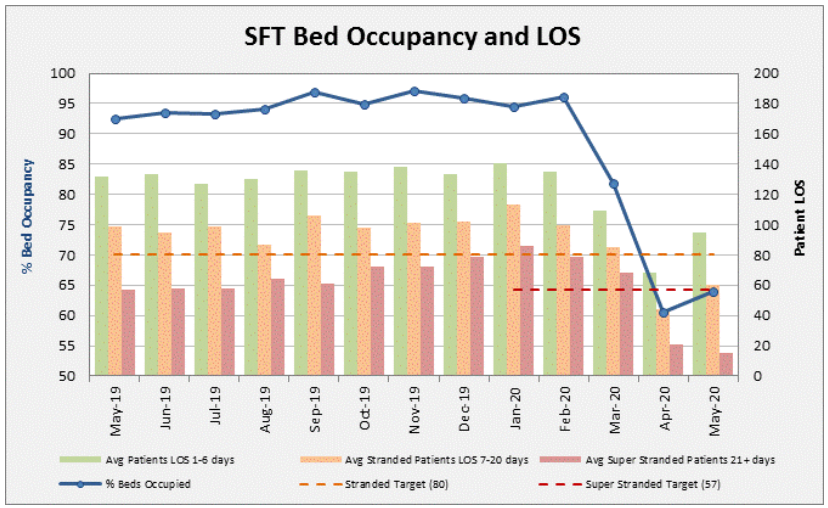
Extending minors stretches ED experienced nursing staff throughout ED. This is reducing ability to provide navigator shift. Majors triage nurse now responsible for safety in ED waiting room. Currently managing to keep time to triage comfortably below 15 mins for majors patients. Close monitoring of this KPI ongoing.

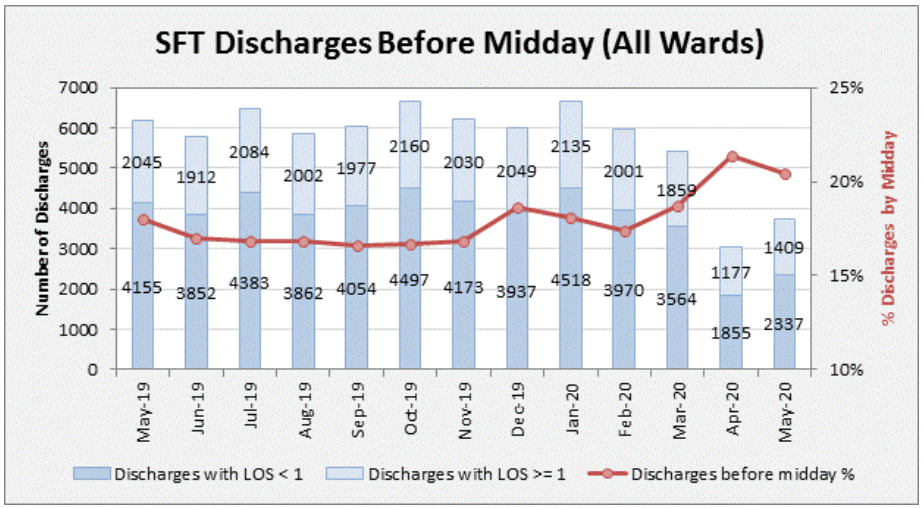
Statistical Process Control Chart Key:

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

Patient Flow and Discharge

Are We Effective?





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

M2 shows a small increase in patients with LOS <6 days and those with LOS >7 days. This reflects the increase in attendances as patients become more comfortable with coming in to the hospital and primary care becomes more accessible.

Discharges before midday shows an increase from the previous month but numbers are still below average.

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

RCU now working differently; 10 Farley beds on the right hand side are now for Category A + patients and under the Respiratory team. The remaining 20 Farley beds are for co-horting and isolating Category B patients and is under the AMU team. Spire ward is continuing to be used for co-horting purposes and is under the elderly team.

There is no separate RCU doctor rota now but is covered by usual Gen Med on call arrangements.

Risks to delivery and mitigations

Increase in Gen Med patients continuing and a return to normal levels of attendance in ED. Capacity currently sufficient but social distancing between patients will put further pressure on beds if demand increases significantly.

Possible second wave will mean that the RCU will have a staggered approach and flex up and down within the Farley/Spire template as necessary and remain there for the foreseeable.

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

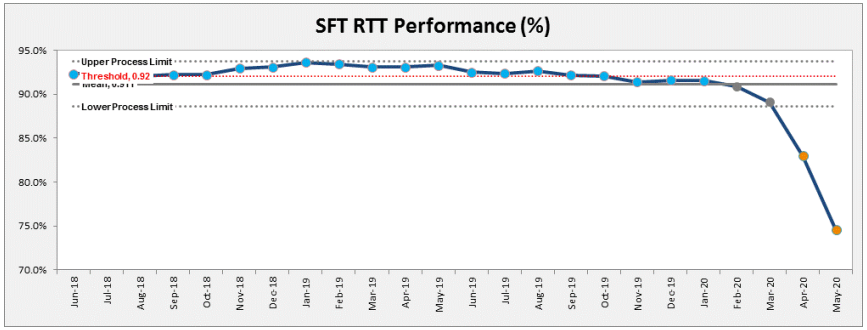
Total WL	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Dorset CCG (11J)	2,845	2,871	2,889	2,882	2,834	2,856	2,825	2,605	2,593	2,448	2,268	2,128
West Hampshire CCG (11A)	1,690	1,743	1,695	1,682	1,655	1,614	1,606	1,544	1,550	1,512	1,424	1,333
BSW (92G)	10,718	10,630	10,809	10,900	11,050	11,130	11,018	10,840	10,577	10,297	9,672	9,095
Other CCGs	2,498	2,732	2,800	2,822	2,729	2,718	2,747	2,643	2,722	2,667	2,594	2,499
Trust Total	**17,751**	**17,976**	**18,193**	**18,286**	**18,268**	**18,318**	**18,196**	**17,632**	**17,442**	**16,924**	**15,958**	**15,055**

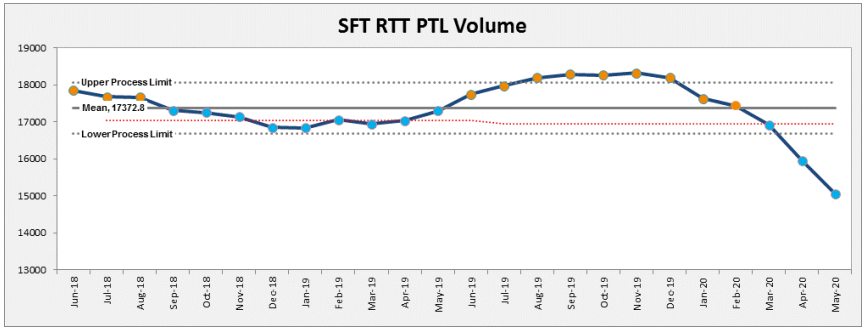
Data Quality Rating:

Performance Latest Month: 74.6%

PTL Volume: 15,055

52 Week Breaches: 35





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

Overall RTT performance fell further in May due to the continued impact of elective cancellations and limitations due to Covid-19. This has been further impacted by the level of routine referrals continuing to be below those in the pre-Covid period. Now referral pathways have reopened, we hope to see referrals increase, which will lead to a slight improvement on RTT performance although the effects of this will be limited by capacity constraints in theatres and outpatients and also influenced by how quickly referral rates move towards those previously seen .

The focus this month has continued to be validating the PTL to ensure accuracy and also to support the continuation of the PTL size being below target. This can be seen in the April position where the end of month PTL size was 966 under target and in May which has ended at 903 below target.

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

The approach remains to continue with as much elective outpatient activity as possible using virtual solutions, both video and telephone, and enhanced advice and guidance referral triage and treatment pathways. Outpatient recovery plans are being put in place for a controlled increase in face-to-face activity which started in late May, where clinically necessary, and these will also support continued, and where possible increased, use of virtual solutions.

Urgent and cancer surgical activity continues to be undertaken and elective recovery theatre lists are now running for several specialties and cases also continue to be transferred to Newhall, if clinically suitable to be undertaken there, and where there is available capacity. Work is currently being undertaken to increase the usage of this capacity.

The clinical triage of the full surgery PTL undertaken by the clinical teams based on the national priority levels and the specialty best practice guidance continues to form the basis of the Theatre Recovery Plan which started in mid-May and has now expanded to three all day lists in the day surgery unit.

All new outpatient demand currently held by each specialty is being monitored and the overviews produced have been used to model capacity required to clear backlogs. A clinical triage of those waiting has also been undertaken to ensure bookings are made in order of clinical priority.

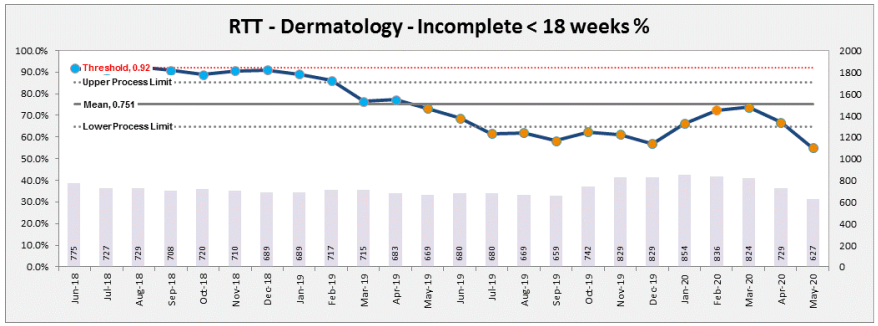
Risks to delivery and mitigations

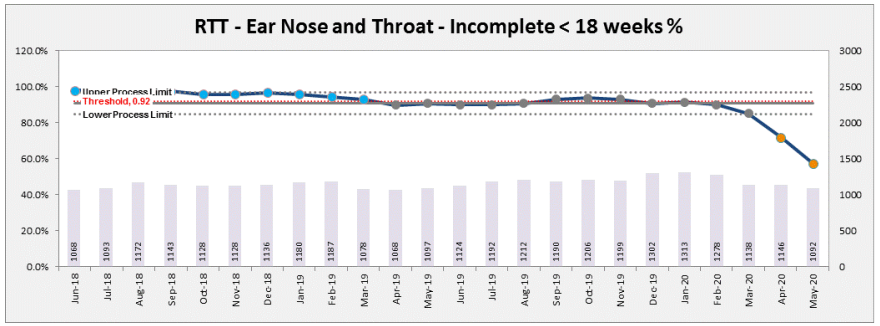
Continued risk of not achieving the performance standard in coming months due to the continued impact of the pandemic which has exacerbated the impact of previous capacity pressures.

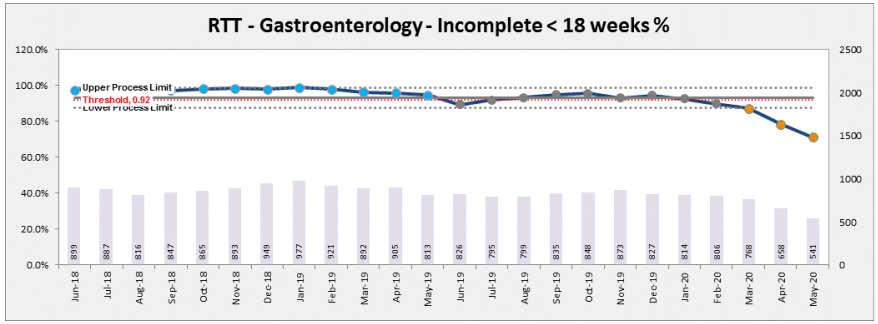
Validation of outpatient PTL, follow up waiting lists and surgery PTL have all been undertaken during the pandemic period to confirm accuracy and also to ensure that all recovery plans are based on clinical priority of patients.

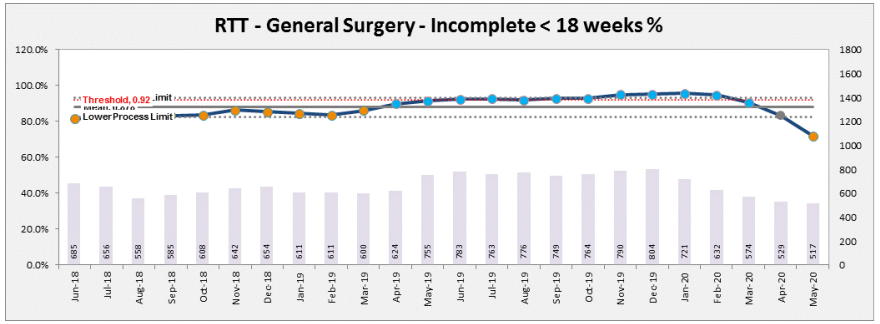
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

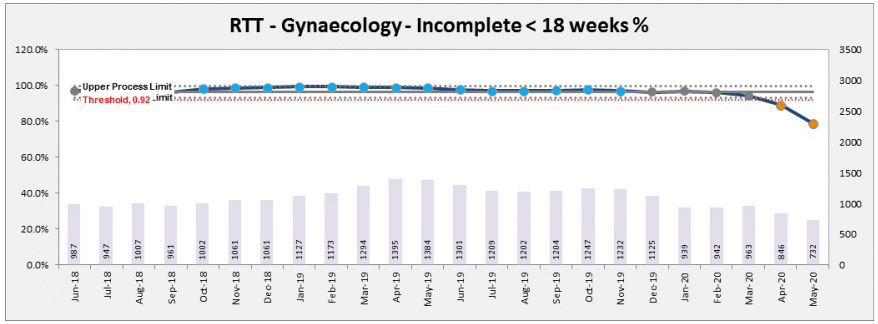
National Key Performance Indicators

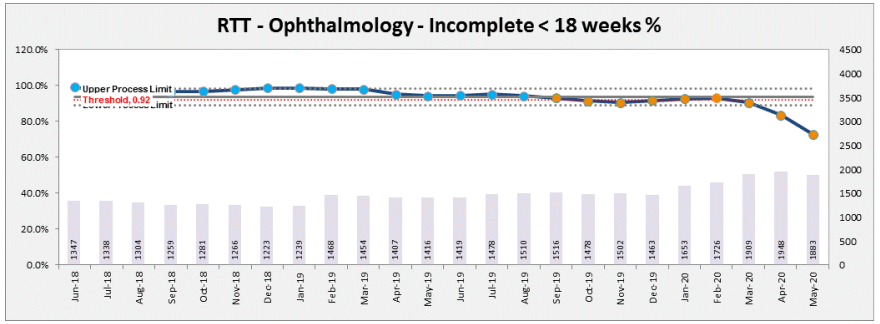






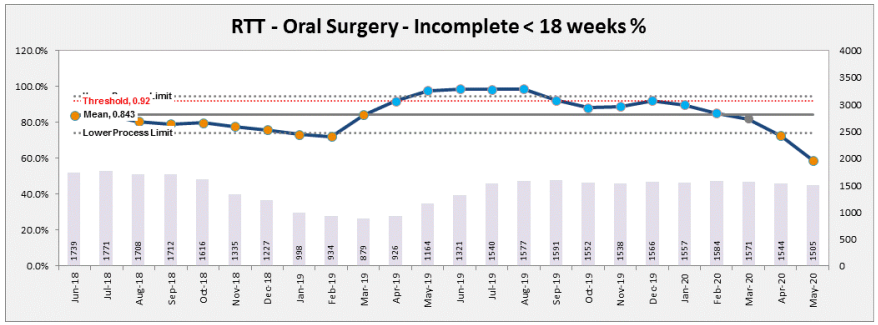


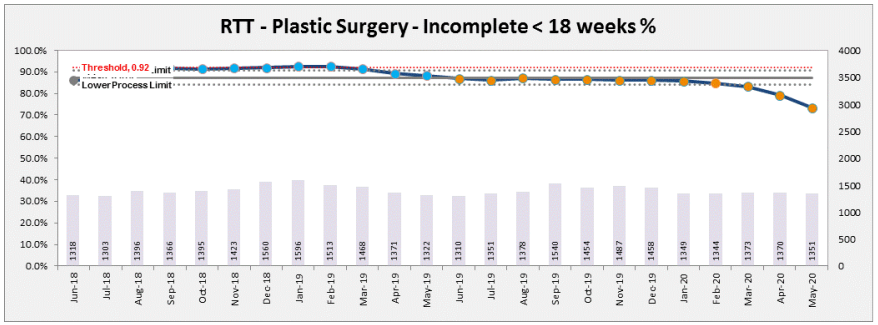


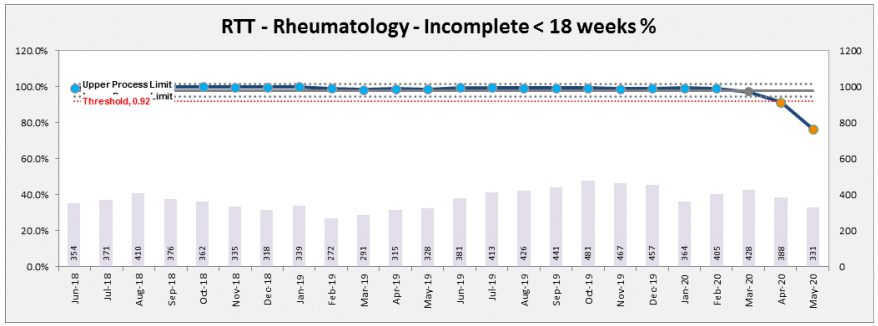


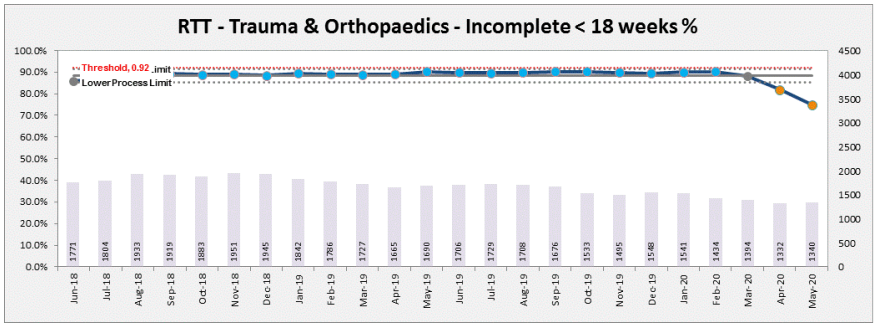
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

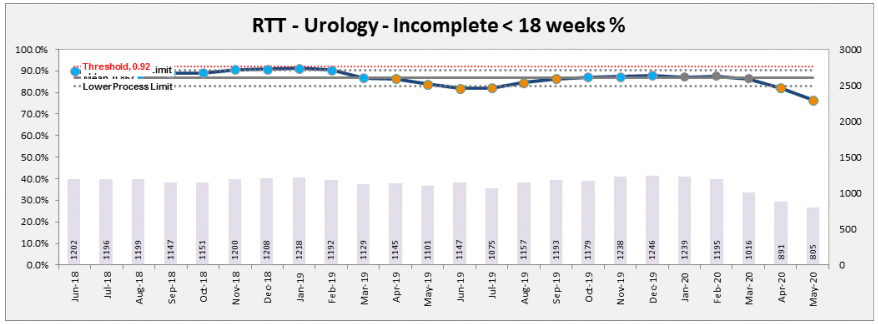
National Key Performance Indicators

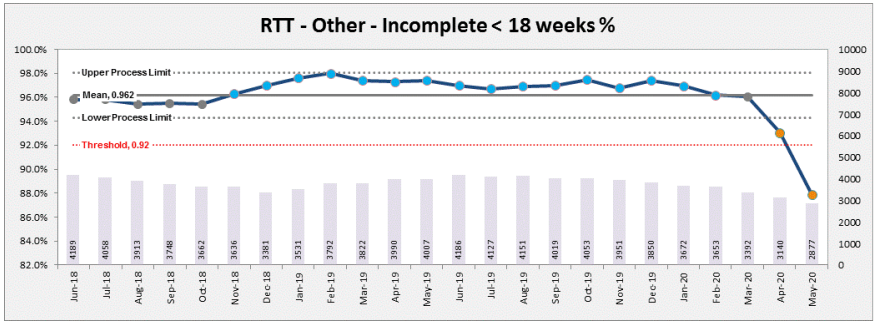






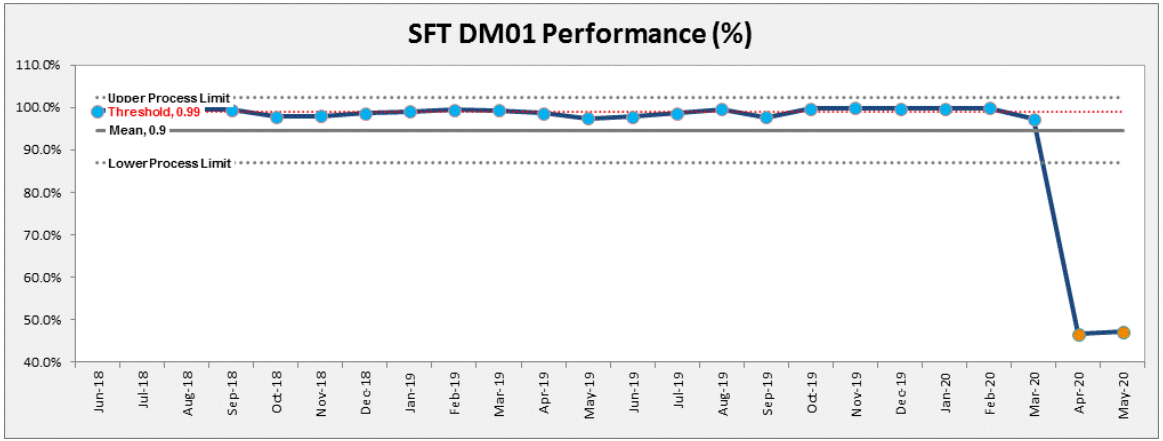






Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	47.2%
Waiting List Volume:	2,894
6 Week Breaches:	1,529
Diagnostics Performed:	3,440

Background, actions being taken and risks and mitigations

Performance standard in month has not be achieved as a direct impact of Covid-19. June projections confirm that the target is not achievable for M3, however, there is an expectation of improvement following the re-start of capacity constrained routine activity across multiple specialties and modalities.

Endoscopy

121 confirmed in month breaches, all attributable to Covid-19

Radiology

948 confirmed in month breaches, all attributable to Covid-19

Radiology Reporting

Go live of the second provider for outsourced reporting remains on hold. IT remain in dialogue with the provider to resolve, but timescales for completion remain unknown. Reduced activity has positively impacted on the number of outstanding scans for reporting so the risk of this service not being available at this time is mitigated against.

Audiology

0 confirmed in month breaches.

Cardiology

265 confirmed in month breaches, all attributable to Covid-19

Neurophysiology

195 in month breaches, all attributable to Covid-19

Cancer 2 Week Wait Performance Target 93%

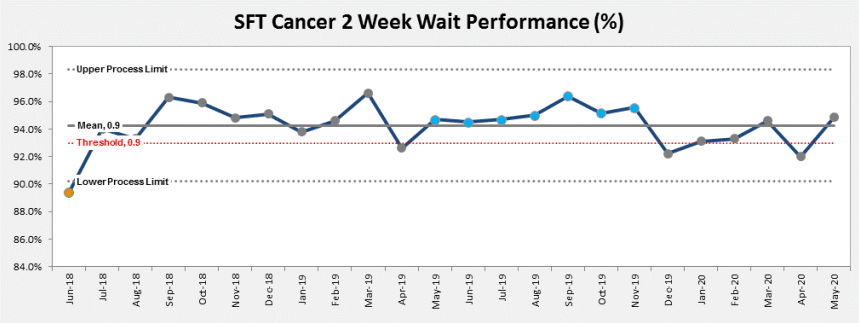
National Key Performance Indicators

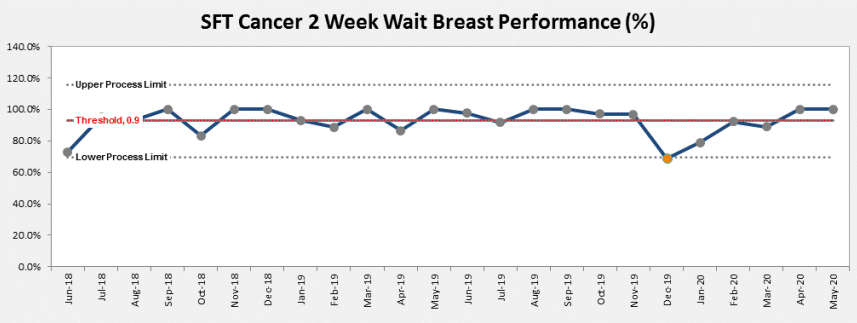
Performance Latest Month:

Two Week Wait Standard: 94.8%

Two Week Wait Breast Standard: 100%

Data Quality Rating:





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

M2 achieved for 2ww standard in light of reduced referral numbers and revised Cancer Waiting Times (CWT) guidance around triage and telephone appointments during Covid-19.

Significant reduction in 2ww referrals as a result of Covid-19.

2ww breast symptomatic performance standard achieved, though again very few referrals and therefore denominator low.

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

Revised PTL format in place from June 2020. More proactive response and more timely reporting and escalation to Delivery Group on a weekly basis.

Weekly cancer ops meetings to be re-instated to focus on 2ww appointments and clinic capacity.

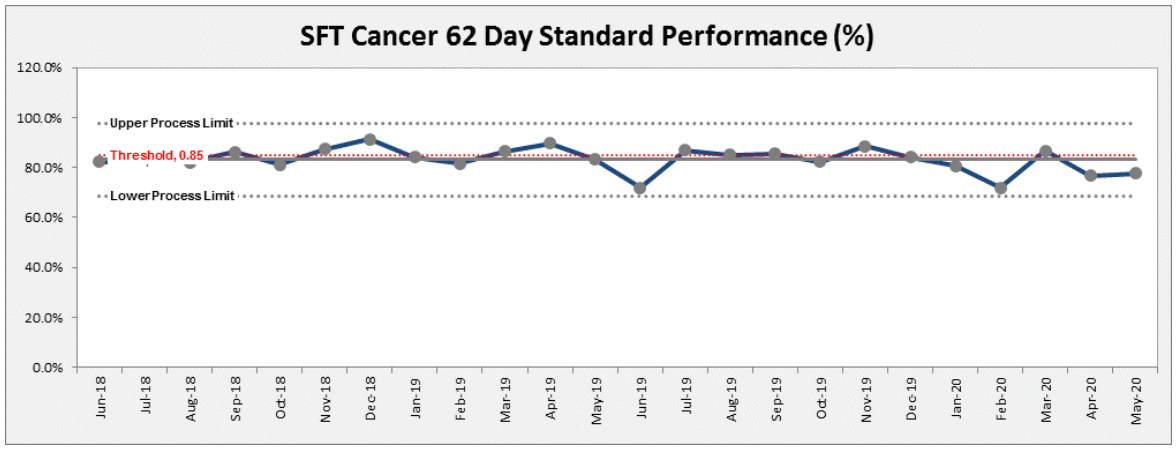
Risks to delivery and mitigations

Diagnostic backlog is likely to significantly effect our ability to achieve the 2ww standard going forward once the revised CWT version 11 guidance is implemented. Work remains ongoing to book these patients in, though it is evident that patient choice and fear is likely to impact service delivery for a significant period of time.

Working closely with CCG and clinical leads around options available to provide assurance to patients that it is safe to attend hospital.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard: 77.8%

62 Day Screening: 0 patients

Risks to delivery and mitigations

M2 validated 62 day performance of 77.78%, with a total of 8 breaches. Deterioration in performance as a result of reduction in treatments performed (linked to diagnostic backlog in endoscopy particularly) and therefore smaller denominator.

Concerns around future performance as a result of Covid-19. Service is currently focussing primarily on longest waiters and overall PTL backlog, though it is evident that patient choice is impacting service delivery significantly. Performance is likely to be compromised whilst backlog is worked through based on clinical prioritisation.

Screening services postponed during Covid-19, therefore standard is currently not applicable.

Statistical Process Control Chart Key:

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

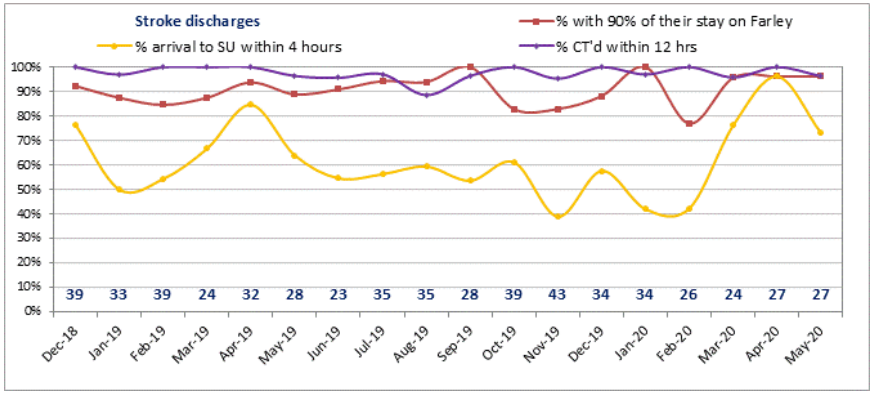
Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20	B	B	B	

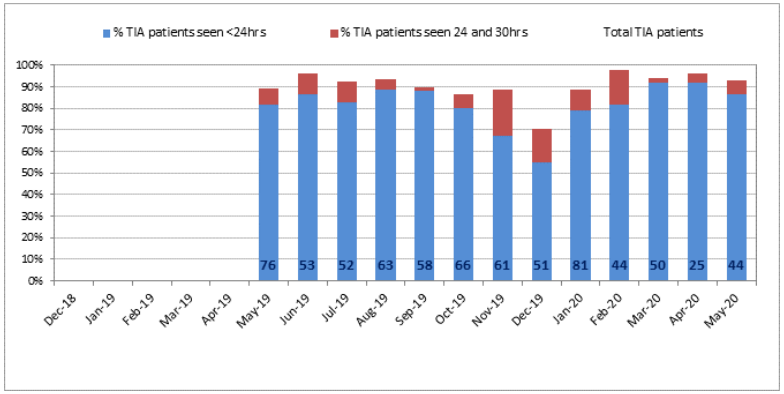
Data Quality Rating:

% Arrival on SU <4 hours: 73.1%

% CT'd < 12 hours: 96.3%

% TIA Seen < 24 hours: 96.2%





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

The stroke unit remains relocated on Laverstock ward as part of the Covid-19 plans. Almost 60% of stroke patients had a CT within 1 hour and the door to needle time for patients suitable for thrombolysis was 97 minutes. Fewer patients reached the stroke unit in 4 hours: 5 patients were affected by delays in ED - waiting for medical review (2), leaving ED just before 4 hours (2) and waiting for a bed (1). 2 inpatients with a stroke reached the unit after 4 hours. There were five stroke deaths in May – slightly higher than expected.

Q4 SSNAP audit score is expected by the end of July and is most likely to remain at B

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

In respect of the Covid-19 emergency, the stroke and TIA emergency stroke services are open as 'business as usual' with cross-cover arrangements regionally for TIA clinics 7/7 and thrombolysis 24/7. The service is following the NHSE Covid-19 response stroke specialty guidance.

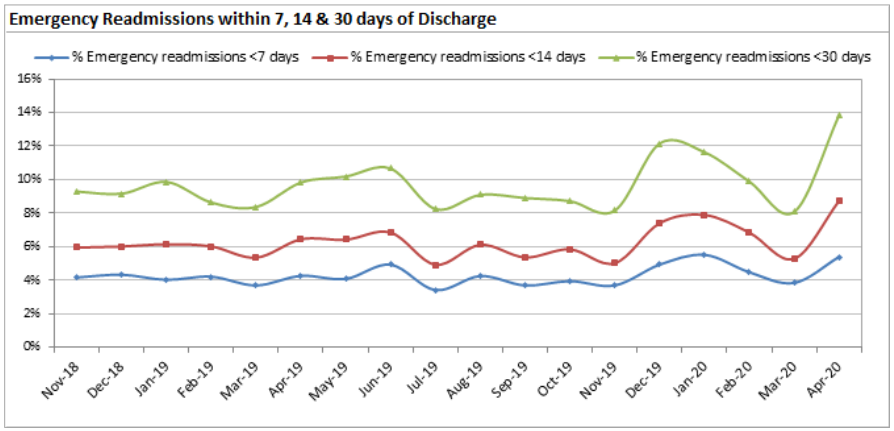
As part of the Covid-19 arrangements, the stroke unit has acted as a hyper-acute unit with patients who require rehabilitation discharged to community hospitals or 'discharge to assess' at home with therapy provision in the community. This model has replaced the early supported discharge (ESD) stroke team during the Covid-19 emergency and is working well.

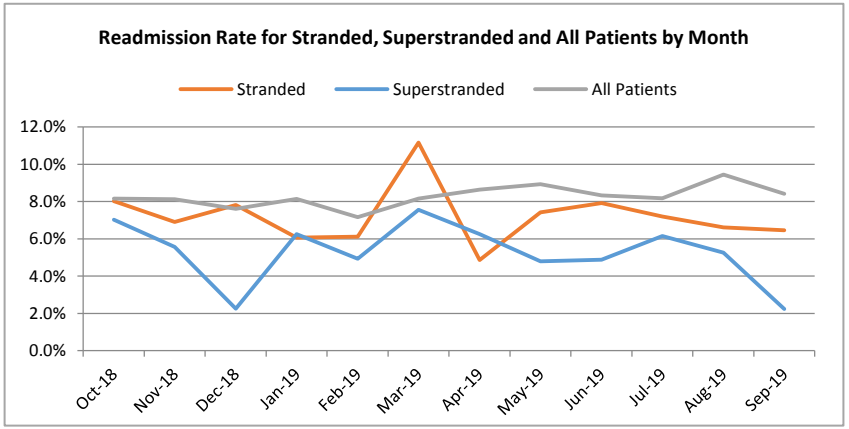
Risks to delivery and mitigations

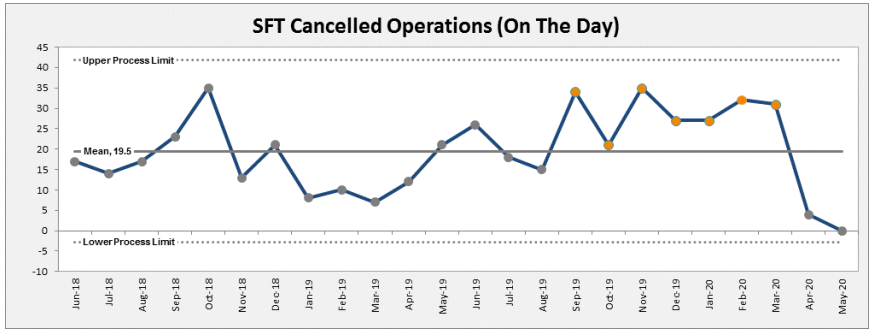
The national concern that patients with a stroke are not presenting to hospital due to fears about Covid-19 is borne out by our data. The average number of stroke admissions reduced from 35.2 (Dec 19 – Feb 20) to 21.3 (March – May 20). However, a significant increase in the number of TIA patients attending clinic within 24 hours to near normal levels – 44 in May compared to 25 in April. This hopefully indicates successful public health messaging and communication with GPs.

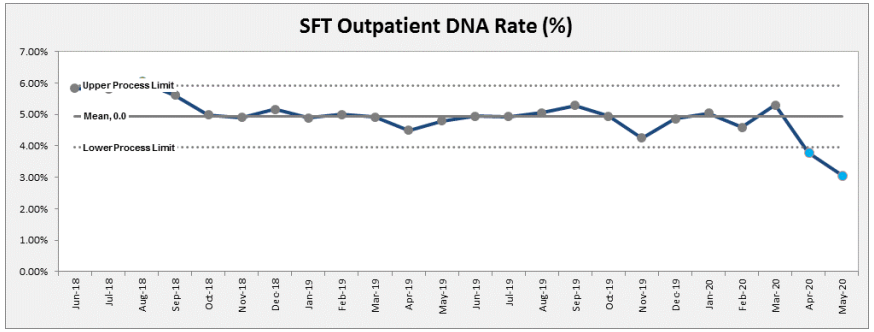
Other Measures

Are We Effective?









To note, the outpatient DNA rate measurement was changed by the PMO OP Transformation Board in April 2020 to remove a filter that excluded a set of OP clinics. By removing the filter the number of attendances has gone up, and therefore the DNA rate has dropped.

Salisbury NHS Foundation Trust

Part 2: Our Care

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

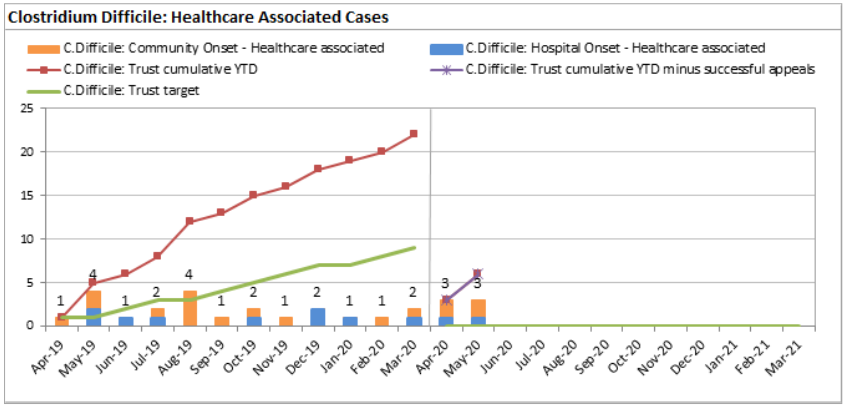
Infection Control

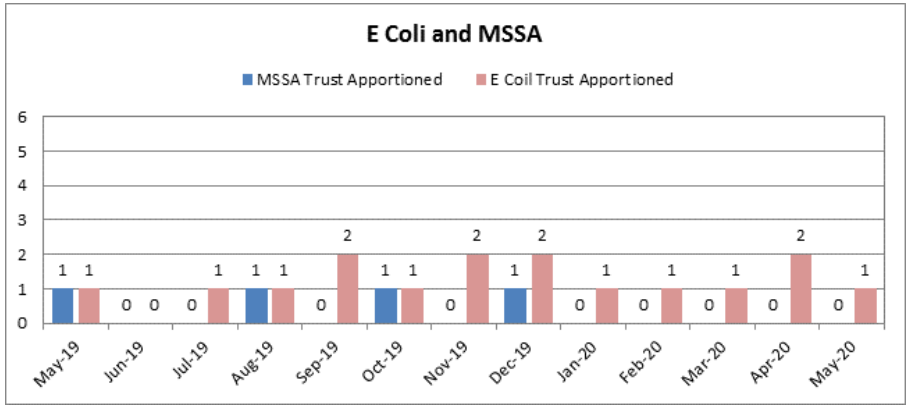
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Cases Appealed	0	7	0	0	0	1	0	0	0	0
Successful Appeals	0	5	0	0	0	1	2	0	0	0

MRSA	2019-20	2020-21
Trust Apportioned	0	1





Summary and Action

PHE have not yet set a C.Difficile upper limit for hospital onset health care associated and community onset healthcare associated cases.

In May, 1 hospital onset health care associated case of C.difficile of a patient on a medical ward who remains Covid-19 positive. The case is currently under investigation with further information awaited before consideration of whether the case is suitable for appeal to the CCG for no lapses in care. Two community onset healthcare associated cases of patients who had an inpatient stay within 30 days of discharge. Both cases are under investigation.

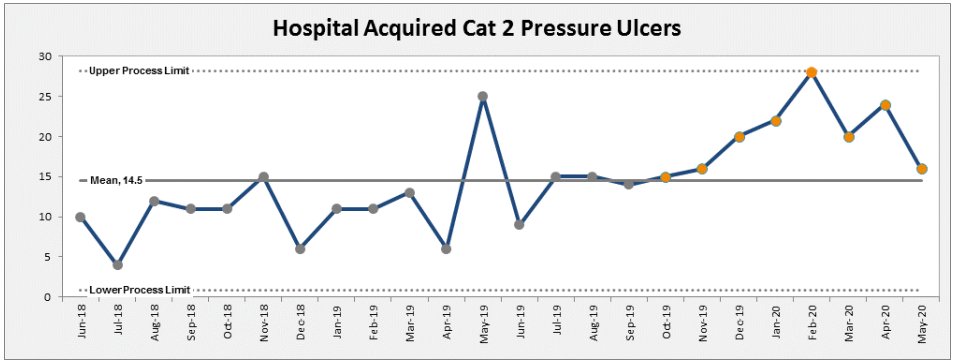
One Trust apportioned E Coli bacteraemia - the source of infection was identified as lower urinary tract of a patient with a complex history and complications post gastrojejunostomy.

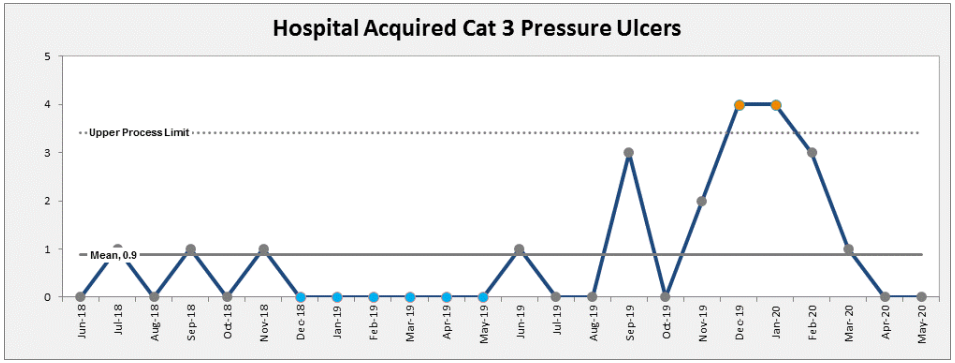
In respect of the Covid-19 emergency, the number of positive cases has reduced significantly over the last month and is consistently less than five. The Trust continues to deal effectively with suspected and actual cases. Regular meetings take place throughout the week to ensure national guidance is implemented. A Covid-19 clinical reference group meets twice a week to consider the clinical response to the pandemic, restarting non-Covid services and associated risks and makes recommendations to the recovery cell. For the last three weeks we have been reporting the dates of positive swabs in relation to admission date to enable PHE to identify possible hospital acquired infection – all of our new cases so far have been community onset.

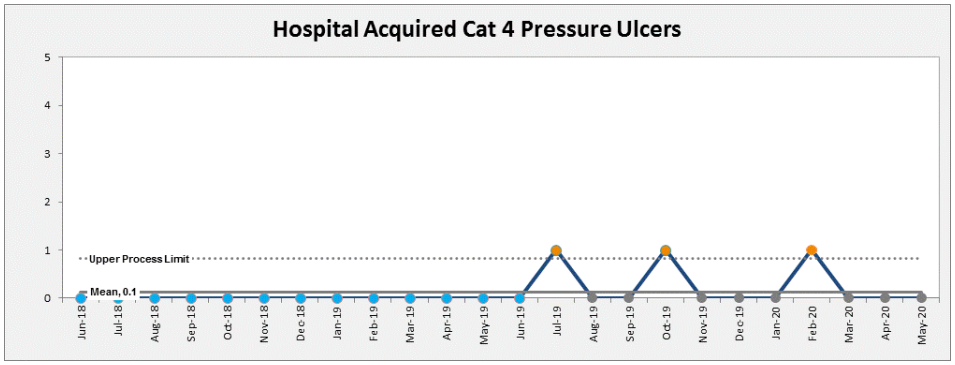
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1
Pressure Ulcers	1.05	1.10	1.22	1.73	1.90

Summary and Action

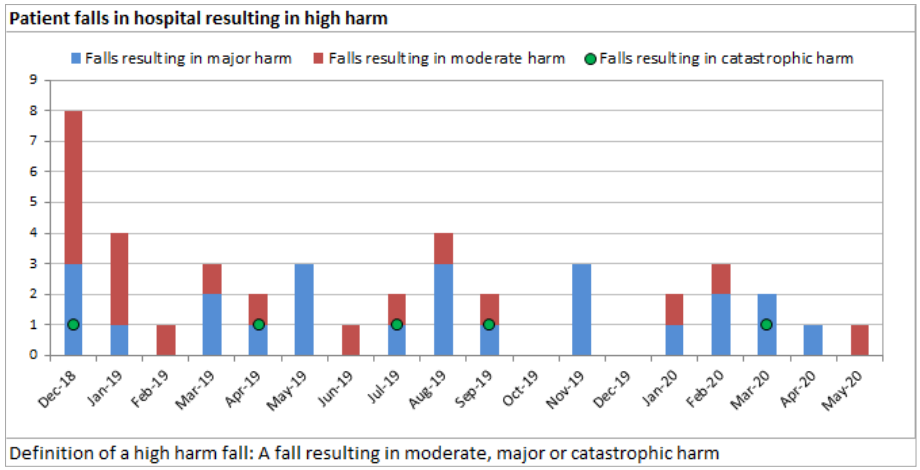
There were no category 3 or 4 pressure ulcers in May and a reduction in the number of category 2 pressure ulcers to 16 across a range of wards. In total, 130 staff received education in the recognition, assessment and care planning of pressure ulcers over the last 2 months. An increase in the number of pressure ulcers reported on admission was noted in May as a result of education and improved assessment and care planning. The quality improvement projects to reduce pressure ulcers are focused on AMU and theatres.

The cluster review and improvement plan is to be reported to the Clinical Governance Committee in June by the Heads of Nursing. The review has highlighted a concern regarding baseline knowledge and education in our nursing staff on prevention of pressure damage. It is too early to conclude any impact.

National guidance has been issued on preventing pressure ulcers in response to proning patients with Covid-19 infection.

Patient Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1
Patient Falls	0.16	0.20	0.07	0.17	0.13

Summary and Action

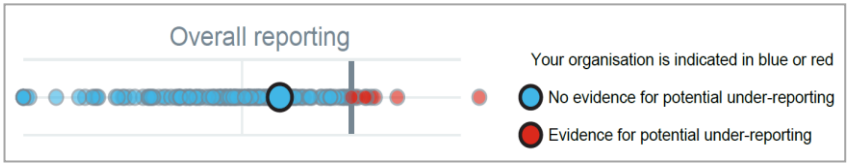
In May, 1 fall resulting in moderate harm of a patient who fell and fractured his wrist, managed conservatively. The case is currently under investigation.

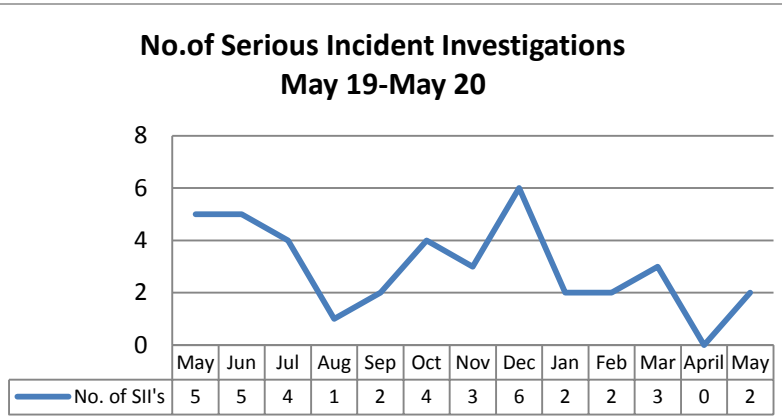
Incidents

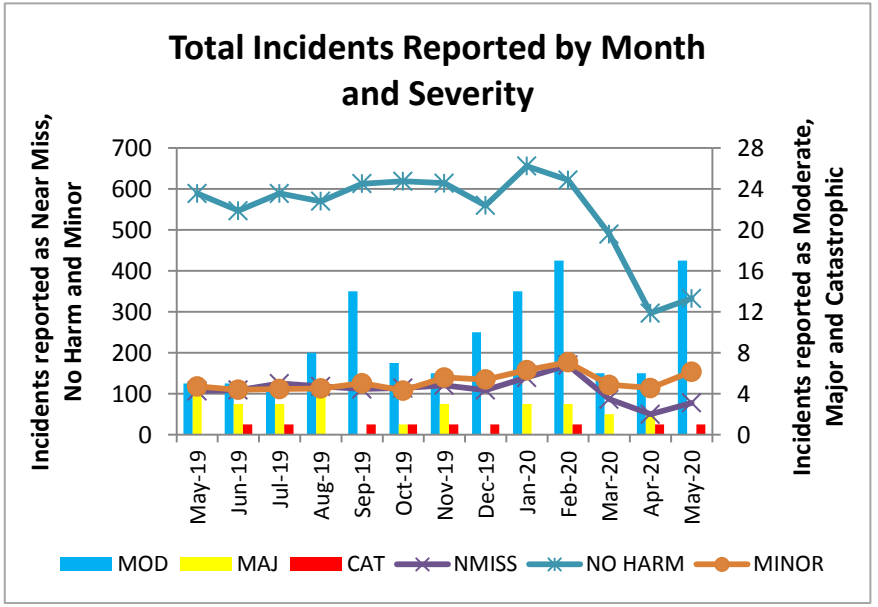
Are We Safe?

Year	2019-20	2020-21
Never Events	2	0

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







Summary and Action

There were 2 new commissioned serious incidents in May. These were a term stillbirth in maternity and a potential delay in receiving an MRI for cord compression with a further delay in transferring to UHS.

The maternity thematic review of SIs from 2019 has now been concluded and an overarching safety improvement plan has been completed, this will now be monitored through the Clinical Risk Group.

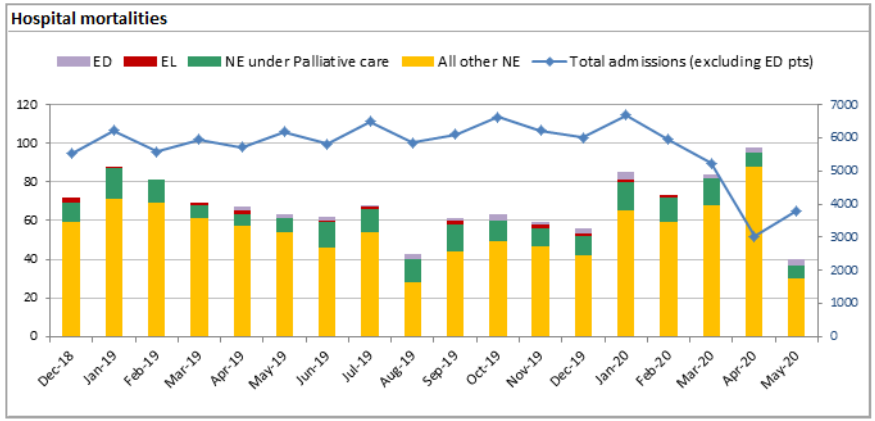
The pressure ulcer cluster review and improvement plan was approved at the Clinical Risk Group and will be presented to Clinical Governance Committee in June. A quality improvement project is being arranged to support the ongoing work with the pressure ulcer improvement plan.

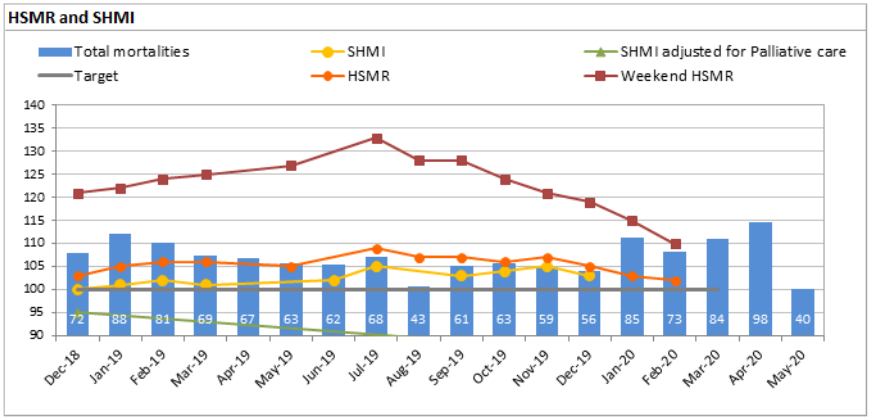
The Cancer Risk Summit follow up meeting went ahead in May as a virtual meeting with 20 members of staff in attendance. The Task and Finish groups presented the progress of their individual work streams and the outcome of the risk summit will be reported at CGC.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected. The weekend HSMR has decreased again and is within the expected range.

Total deaths associated with Covid-19 are 55 (10 June) patients with a positive swab. 69% were men, the majority over 80 with underlying health conditions and the cause of death recorded as Covid-19 pneumonia. A total of 9 (10 June) patients had a negative swab but Covid-19 was recorded on their medical cause of death certificate.

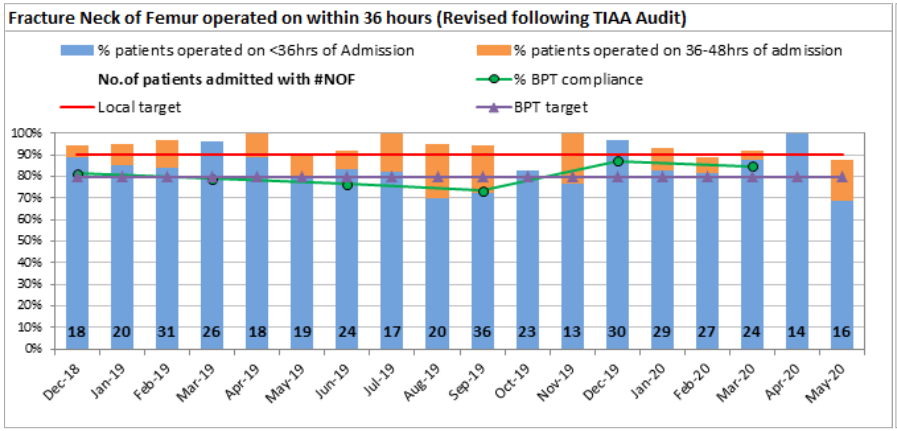
The Mortality Surveillance Group has started to review deaths from Covid-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate, and if patients required ventilation, received it. This will be reported to the Mortality Surveillance Group in September 2020.

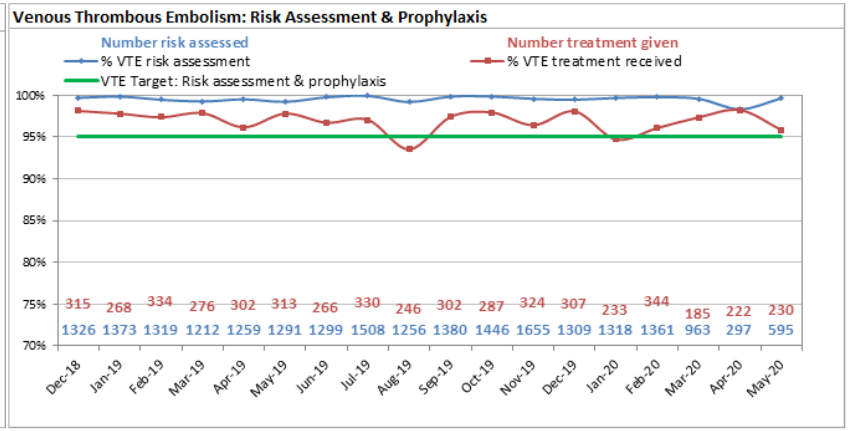
The Specialist Palliative Care Team and bereavement service are contacting all relatives whose loved ones died during the Covid emergency to ascertain their wellbeing, listen to and respond to concerns, offer support and signposting to other organisations.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

In May, 5 patients did not receive hip surgery for a fractured neck of femur within 36 hours whilst waiting for medical review or stabilisation – raised APTT (2) and high INR (1). 2 patients waited for theatre space and both received surgery at 43 hours after admission.

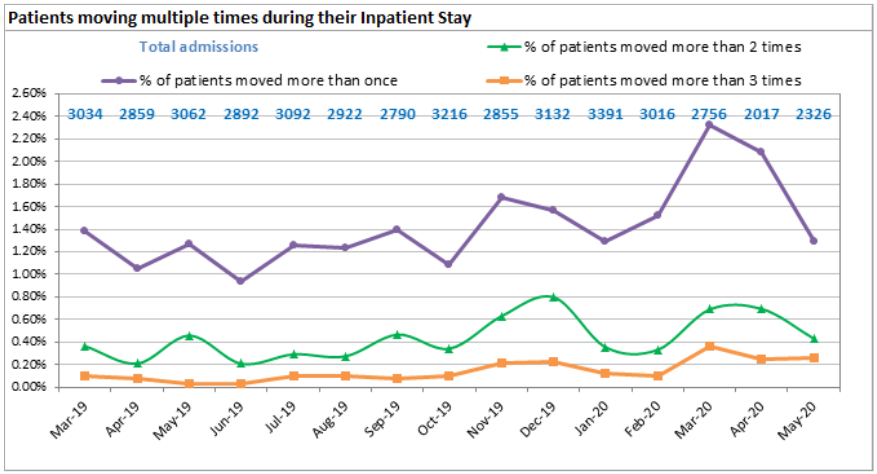
NHSE and NHSI suspended reporting of VTE assessment and prophylaxis in Q1 20/21 but the Trust continued to report a high level of performance to provide assurance on the quality of care.

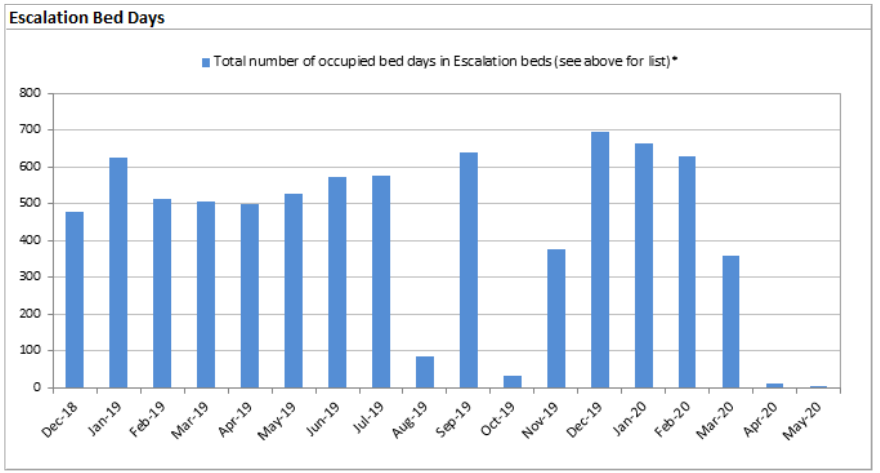
Patient Experience

Are We Safe?

Last 12 months	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Bed Occupancy %	93.5	93.3	94.1	96.9	94.9	97.1	95.9	94.4	96.1	81.8	60.5	64.0

Data Quality Rating:





Summary and Action

No escalation bed capacity was opened in May as bed occupancy was low at 64%. The percentage of multiple ward moves significantly decreased as co-horting for Covid -19/suspected Covid was established and fewer Covid-19 patients were admitted.

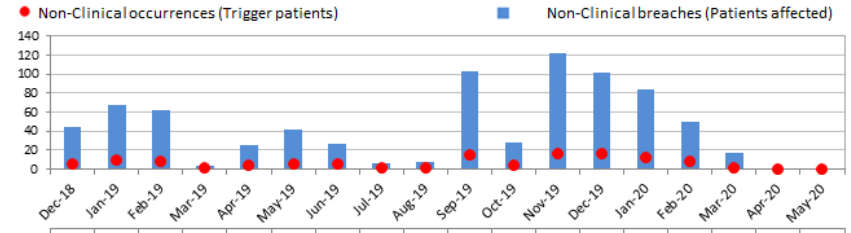
The national policy changed on 10 May to 'Stay alert, control the virus, save lives', as social distancing and hand hygiene reduced the R rate and have been effective in maintaining sufficient critical care capacity in the hospital.

Patient Experience

Are We Safe?

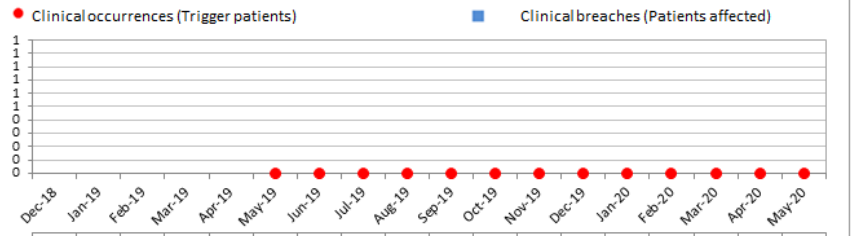
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
■	45	67	62	3	26	42	27	7	8	103	28	122	102	84	50	17	0	0
●	5	10	9	1	4	6	5	1	1	15	4	17	16	13	8	2	0	0

Delivering Same Sex Accommodation - Clinical



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

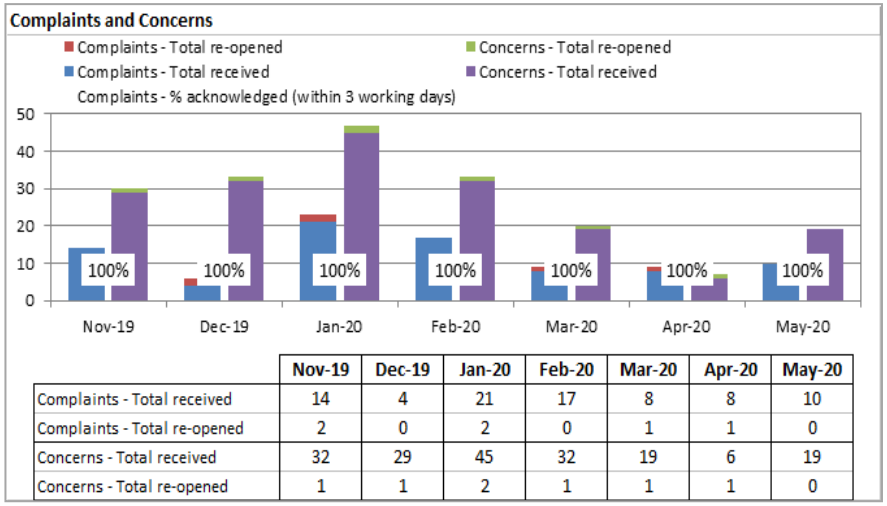
Summary and Action

No reported mixed sex accommodation breaches in May. The impact of managing the Covid-19 emergency has seen a reduction in the number of trollies in AMU from 10 to 6 so that social distancing is maintained along with the Trust wide reduced bed occupancy rate which has enabled patients to be moved quickly to downstream wards thereby avoiding any breaches. We anticipate there will be very few, if any, mixed sex accommodation breaches for the foreseeable future.

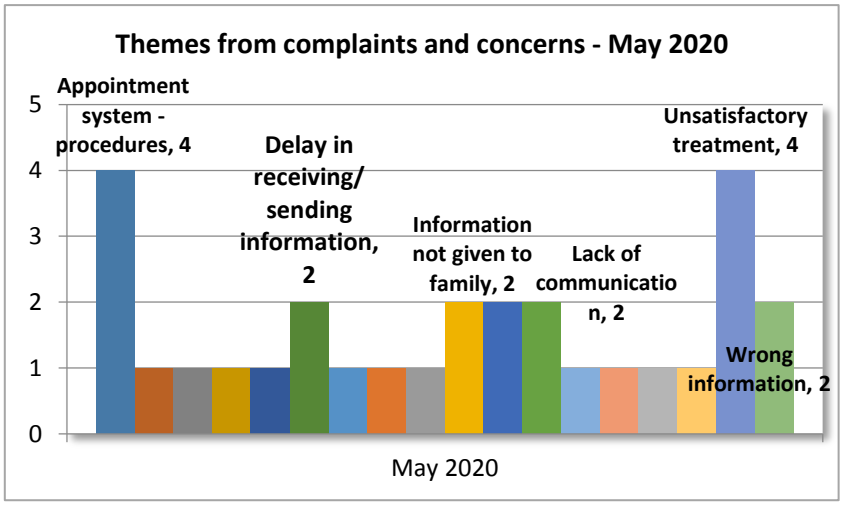
Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

Data Quality Rating:



	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Complaints - Total received	14	4	21	17	8	8	10
Complaints - Total re-opened	2	0	2	0	1	1	0
Concerns - Total received	32	29	45	32	19	6	19
Concerns - Total re-opened	1	1	2	1	1	1	0



Summary and Actions:

The top 2 themes of complaints and concerns in May 2020 are 'Appointment systems – procedures' and 'Unsatisfactory care'.

In addition, there are a significant number of concerns and complaints regarding 'communication' be it, delays in receiving information, lack of communication or wrong information being offered to patients and families.

May 2020 - Actions from closed complaints:

ED has engaged in multiple discussions reflecting on their interactions with the patient, the mental health team and with each other; in order to make positive changes to practice.

The importance of checking patients regularly has been discussed with the team on Downton ward and consideration has been given to increasing staffing levels at night.

To enhance communication between patients and staff, yellow name badges have been ordered for the Ophthalmology clinicians so that patients can easily read the names. In addition, the Ophthalmology department has implemented a process in order to efficiently address patient's enquiries regarding appointments.

Part 3: Our People

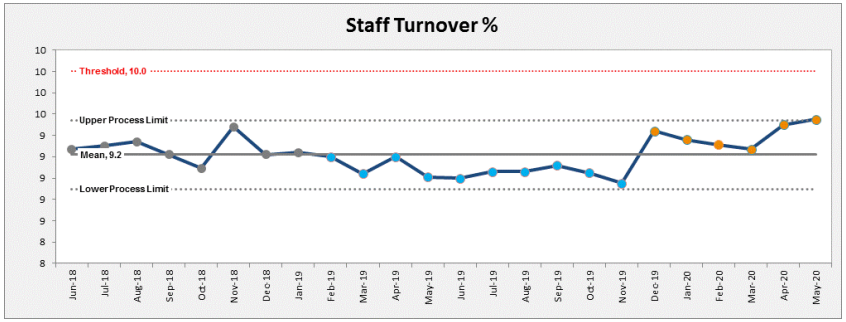
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

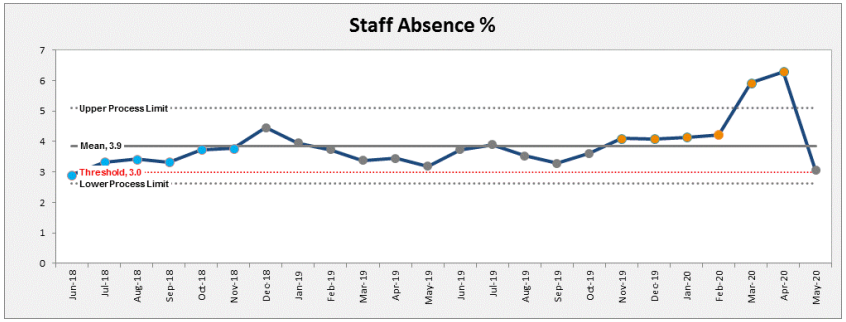
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	May '20		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	409.9	15.2
Nursing	950.5	982.2	(31.8)
HCAs	412.1	482.9	(70.8)
Other Clinical Staff	619.3	606.7	12.7
Infrastructure Staff	1,227.9	1,207.2	20.7
TOTAL	**3,634.8**	**3,688.9**	**(54.0)**





Summary and Action

During May the total number of leavers reduced to 21 in total. We saw a reduction in starters falling to 30, as a result of a slowdown in recruitment activity, controlled induction, as a direct result of Covid-19 restrictions. Our turnover stands at 9.55% this month, and remains under the target of 10%.

During the month, the Trust welcomed a total of 40 students who have signed up to the workforce to boost capacity as part of special arrangements in place to deal with Covid-19. We also had 16 OSCE nurses sign up to the temporary register who are now operating at Band 5 level.

Sickness absence has significantly reduced to 3.95%, the lowest so far this year. Non-Covid-19 sickness accounts for 2.75% of the absences, and 1.20% relate to Covid-19. Therefore if Covid-19 related sickness is discounted, the Trust would be below the KPI target level of 3%. This change demonstrates the considerable work that has gone into supporting staff with sickness absence issues.

However, managers anecdotally have reported increased levels of anxiety in relation to Covid-19, linked to individuals' personal circumstances, concern for their family members, schooling, etc. We therefore need to ensure that we continue to support our staff as much as possible with our wide ranging health and wellbeing initiatives.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

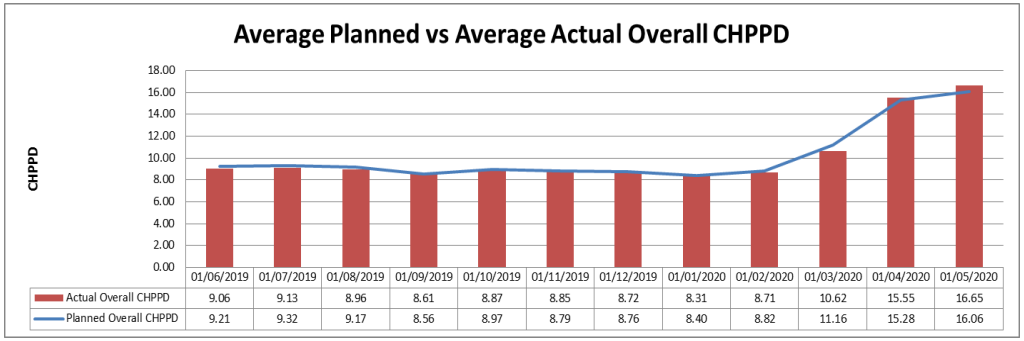
Table 1 – May-20

Day	RN	HCA
Total Planned Hours	35679	18370
Total Actual Hours	38138	18935
Fill Rate (%)	107%	103%

Night	RN	HCA
Total Planned Hours	27223	11474
Total Actual Hours	27865	12277
Fill Rate (%)	102%	107%

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

Table 2



	01/06/2019	01/07/2019	01/08/2019	01/09/2019	01/10/2019	01/11/2019	01/12/2019	01/01/2020	01/02/2020	01/03/2020	01/04/2020	01/05/2020
Actual Overall CHPPD	9.06	9.13	8.96	8.61	8.87	8.85	8.72	8.31	8.71	10.62	15.55	16.65
Planned Overall CHPPD	9.21	9.32	9.17	8.56	8.97	8.79	8.76	8.40	8.82	11.16	15.28	16.06

Summary and Action

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

Aggregated Trust data appears to show a sharp increase in both planned and actual staffing levels, however on further analysis this is skewed by the number of ward and bed closures, staff who have been redeployed and staffing templates set to manage high numbers of Covid-19 patients that was not realised. The sharp increase in April and May is dues to the impact of Covid-19. Both planned and actual patient numbers are taken from the count at midnight, thus there is not the expected gap between planned and actual staffing levels you would expect to see with the number of empty beds. Due to the flaws with the data the divisional level graphs have been removed.

Zero wards flagged red (internal rating) this month. All wards had sufficient staff for the numbers of patients admitted, with bed occupancy for the first half of the month remained low and staffing templates set for normal bed occupancy and a significant focus was placed on reducing temporary staffing with zero agency for the month of May.

The skill mix of RN:HCA has improved with RN 68% /HCA 32%. The broad recommendation is 65%:35%. For April and May the RN and HCA levels both sit slightly above 100% - due to both significant reduction in RN vacancy levels, several wards remaining closed with staff redeployed and reduction in demand for enhanced care requiring additional staff.

At the time of completing this report bank and agency spend for nursing is not available. The expectation is for the expenditure on agency to have significantly reduced across May with zero expenditure for agency across the wards.

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

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

Training

There has been a 1% increase in training compliance up to 90.57% this month and Divisions are reporting that the increase over the past 2/3 months is due to individuals being able to complete their MLE at home or by accessing it at work in quieter times which they cannot normally do.

Nevertheless, there is still reduced compliance in some areas for specific subjects including GDPR, Hand Hygiene and Safeguarding. Business Partners have been asked to focus on these specific subjects when engaging with their DMTs and wider teams.

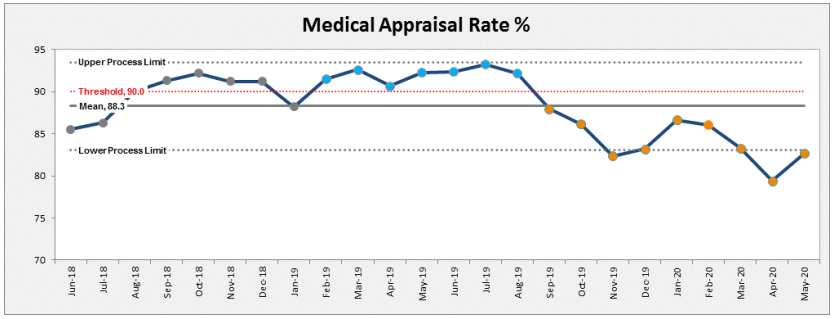
Non Medical Appraisals

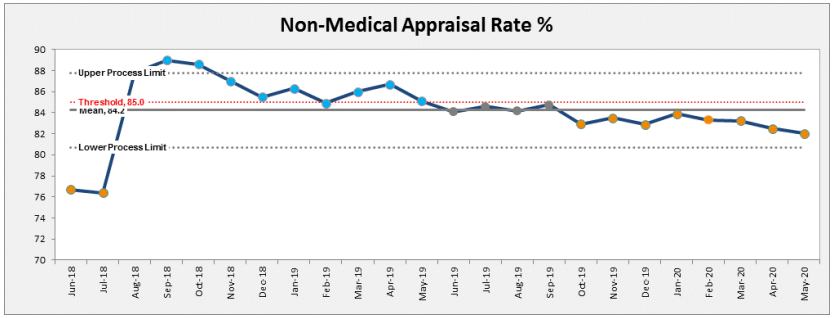
A very marginal decrease in appraisal compliance of 0.44% to 82.02% means that we continue to be below the Trust target level of 85%. The capacity and opportunity to conduct appraisals has been affected by sickness and absence which is Covid-19 related, compounded by the ability to do so whilst adhering to safety guidelines for social distancing.

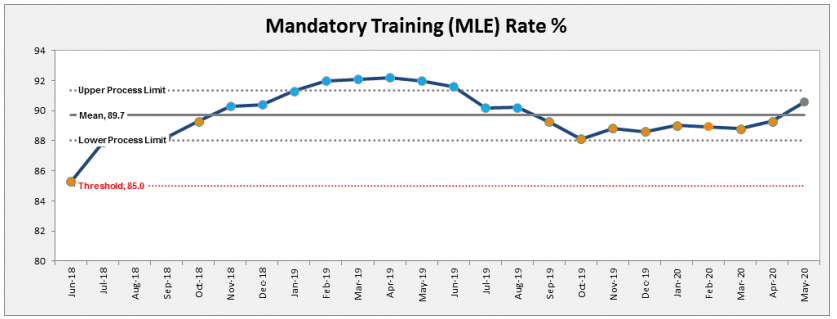
Business Partners and Advisors are working with the operational teams to identify those staff that have out of date appraisals and helping managers work through alternatives to the usual face to face meeting, e.g.. Telephone, Microsoft Teams, etc.

Medical Appraisals

As reported last month, medical appraisals have been “suspended” for the time being, although we are continuing to encourage them to take place within timeframe. The compliance rate has actually increased from 79.42% in April to 82.67% in May.



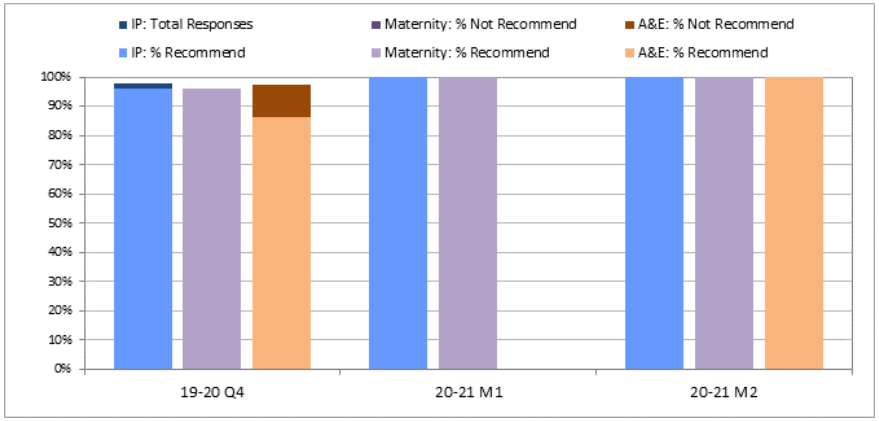




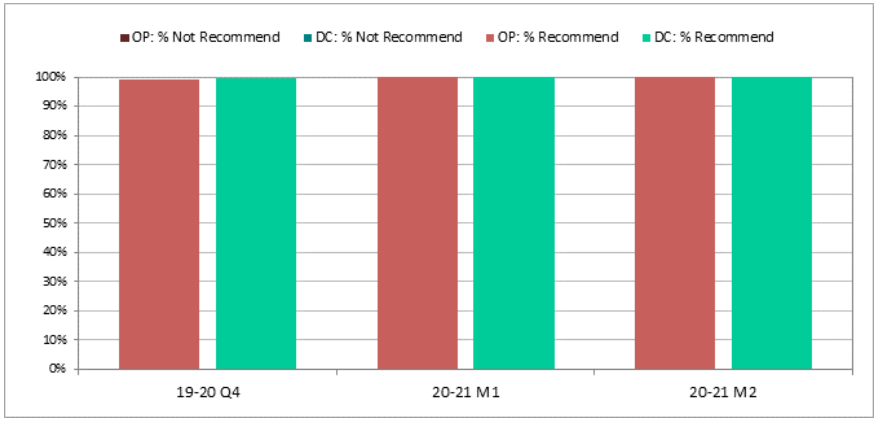
Friends and Family Test – Patients and Staff

Use of Resources

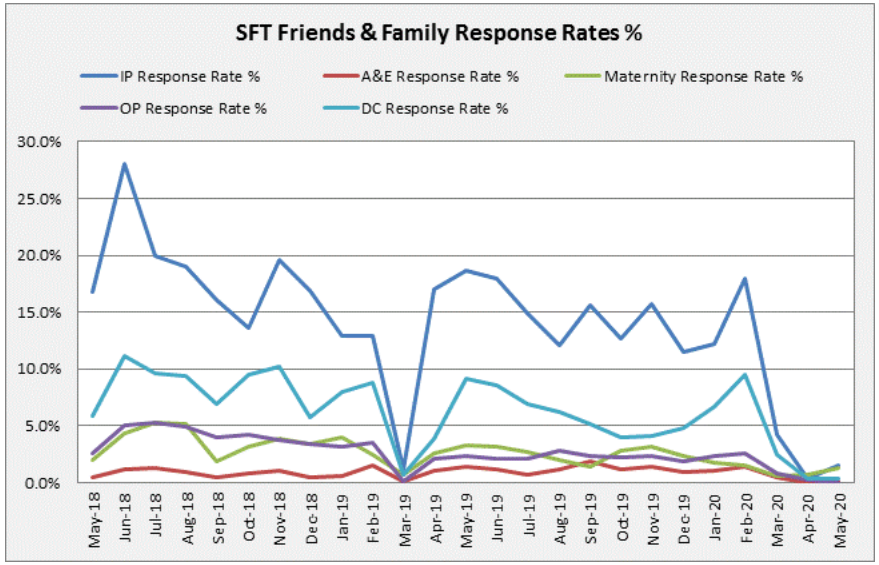
Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase

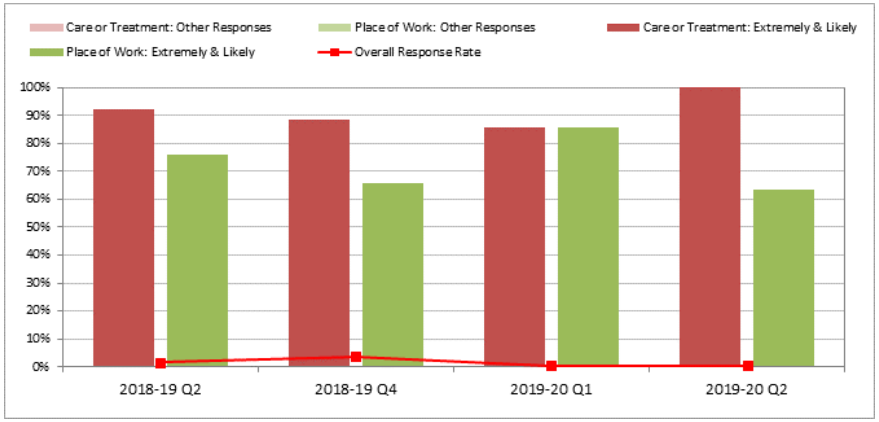


SFT Friends & Family Response Rates %



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

Staff Responses: Place of Work and Place of Care



In May 20 - 27 responses in total.

- 2 ED patients.
- 13 inpatients , 7 maternity patients, 4 day cases and 1 outpatient – all extremely likely & likely to recommend the service to their family and friends..

Part 4: Use of Resources

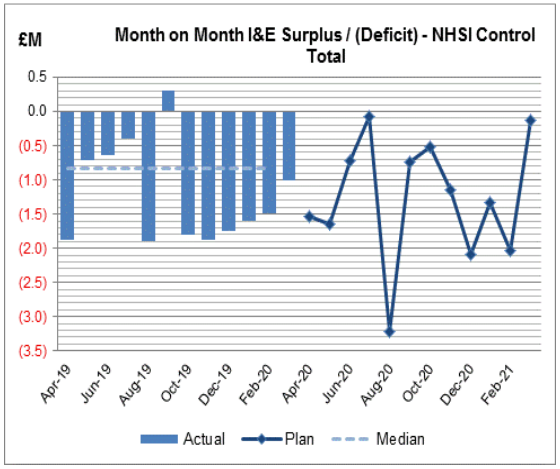
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	May '20 In Mth			May '20 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	17,278	17,386	108	34,458	34,698	240	208,163
Other Clinical Income	758	1,834	1,076	1,719	4,260	2,541	12,789
Other Income (excl Donations)	2,416	1,945	(471)	4,832	4,205	(627)	28,992
Total income	**20,452**	**21,166**	**714**	**41,009**	**43,164**	**2,155**	**249,944**
Operating Expenditure							
Pay	(13,636)	(14,002)	(366)	(27,273)	(28,354)	(1,081)	(163,634)
Non Pay	(7,012)	(5,830)	1,182	(14,024)	(12,139)	1,885	(84,050)
Total Expenditure	**(20,648)**	**(19,832)**	**816**	**(41,297)**	**(40,493)**	**804**	**(247,684)**
EBITDA	**(196)**	**1,333**	**1,529**	**(288)**	**2,671**	**2,959**	**2,260**
Financing Costs (incl Depreciation)	(1,449)	(1,334)	115	(2,898)	(2,671)	227	(17,474)
NHSI Control Total	**(1,645)**	**(0)**	**1,645**	**(3,186)**	**(0)**	**3,186**	**(15,214)**
Add: impact of donated assets	*44*	*(66)*	*(110)*	*(4)*	*(66)*	*(62)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: PSF & FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(1,601)***	***(67)***	***1,534***	***(3,190)***	***(67)***	***3,123***	***(13,588)***



Variation and Action

For the purposes of financial reporting during the Phase 1 Covid-19 response the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £1.6m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed.

The block contracts and 'top-up' payment received as part of the Covid-19 response were not quite enough to cover the baseline costs of the Trust, with a claim for a £0.1m retrospective top up lodged by the cost. This is inclusive of the recognised £0.3m per month 'shortfall' in the top up methodology caused by the instruction from NHSE&I not to invoice for provider-to-provider genetics tests.

As anticipated, both Pay and Non Pay expenditure showed modest reduction in the period as the peak of Covid-19 related demand passed. It is anticipated that this will now begin to rise against of SOPs for routine activity are approved, although it should be noted that social distancing and deep clean arrangements mean that previous levels of productivity will not be reached. Discussions on how to reflect this is system contractual arrangements are on going at a national and regional level.

Income & Activity Delivered by Point of Delivery

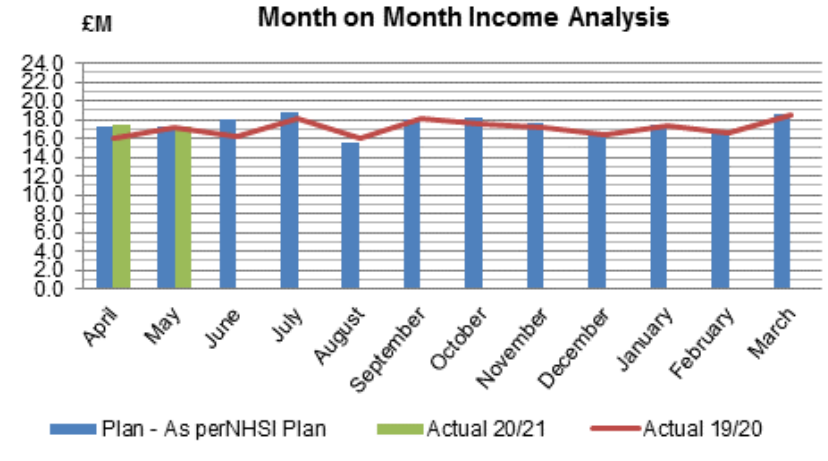
Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	May '20 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	1,558	1,110	(448)
Day Case	2,762	724	(2,038)
Elective inpatients	2,925	508	(2,417)
Excluded Drugs & Devices (inc Lucentis)	3,175	2,550	(625)
Non Elective inpatients	10,440	7,252	(3,188)
Other	5,256	2,480	(2,776)
Outpatients	8,342	20,074	11,732
TOTAL	**34,458**	**34,698**	**240**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	19,159	19,385	226
Dorset CCG	3,905	4,141	236
West Hampshire CCG	2,810	2,871	61
Specialist Services	5,403	5,405	2
Other	3,181	2,896	(285)
TOTAL	**34,458**	**34,698**	**240**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance		Last Year Actuals	Variance against last year
A&E	12,150	7,269	(4,881)		11,587	(4,318)
Day case	3,653	1,076	(2,577)		3,515	(2,439)
Elective	775	195	(580)		795	(600)
Non Elective	5,295	3,630	(1,665)		4,399	(769)
Outpatients	40,850	21,877	(18,973)		42,594	(20,717)



Variation and Action

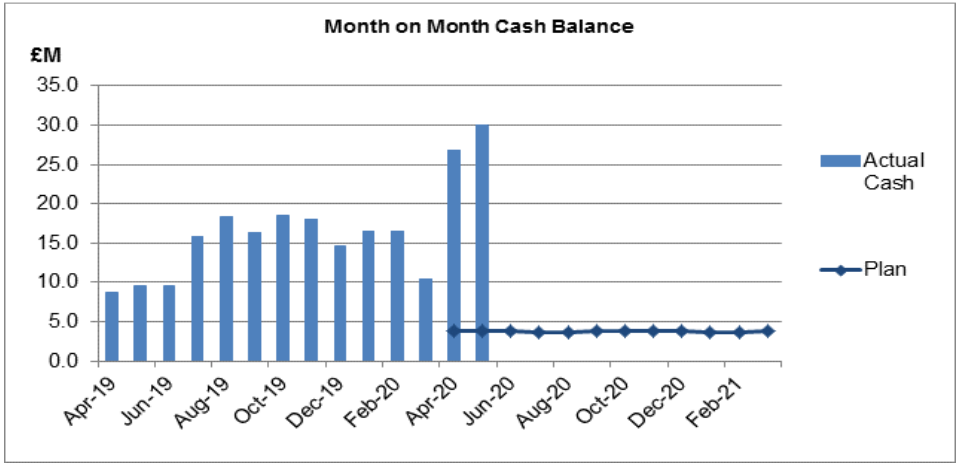
Activity dropped substantially from historic baselines in April and during May A&E, Day cases, Non Elective, Outpatient and Radiology has increased above April levels. The increase by specialty is Gastroenterology and Colorectal Surgery within Day cases, General Medicine and Obstetrics within Non Elective and Plastic Surgery, ENT and Gynaecology within Outpatients.

Contracts with main payment values with main commissioners have been based on Month 9 agreement of Balances (from a provider perspective), adjusted by 2.803% for inflationary pressures. An adjustment of £13,508k is included within the position to match the income to the payments. The May adjustment has reduced by £1.1m due to increased activity levels.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



Covid-19 response contractual arrangements are designed to ensure that there is sufficient cash in NHS providers to respond appropriately to clinical and operational challenges.

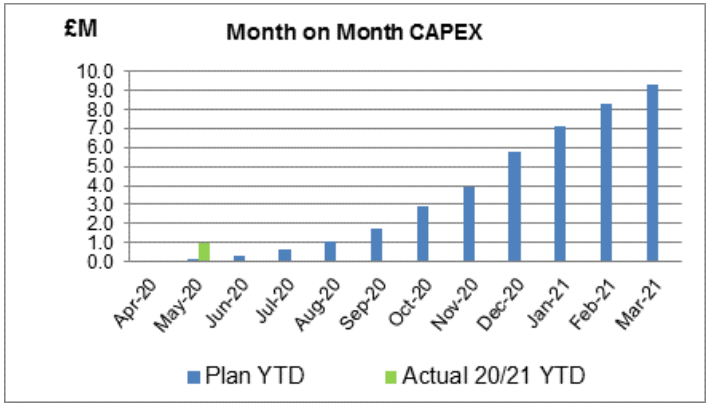
Payments on account in advance up until 31st July 2020 have been agreed and received. Plans for the next phase have yet to be communicated - this brings with it risk as at present there is no certainty around any payment in July, although balances are currently sufficient to return to a payment in arrears arrangement.

The deadline for communication by NHSE&I of arrangements for contractual payments post-31 July is 1 July 2020.

Borrowings had included £23m of working capital loans due for repayment by 31 March 2021. The Trust has now received confirmation that these have been converted to PDC on 1 April 2020.

Capital Expenditure Position

Schemes	Annual Plan £000s	May '20 Plan £000s	May '20 Actual £000s	May '20 Variance £000s
Building schemes	850	0	69	(69)
Building projects	2,600	30	4	26
IM&T	2,600	30	765	(735)
Medical Equipment	2,778	30	49	(19)
Other	449	74	75	(1)
TOTAL	**9,277**	**164**	**962**	**(798)**



Summary and Action

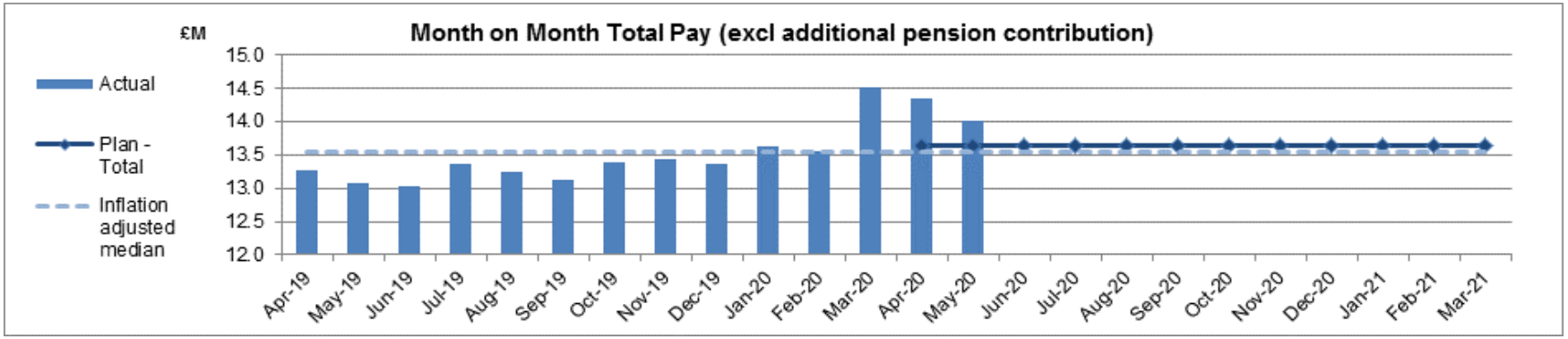
Delays in capital works at the end of 2019/20, including those due to the Covid-19 response, has meant slippage into 2020/21. While agreed items were brought forward to offset a proportion of this slippage, the final 2019/20 outturn was c£900k short of that initially planned for. This has inevitably affected the phasing of the plan as the delays to committed spend has mostly been incurred in April and May 2020. The most material element falls in IT, where the Microsoft environment replacement project phases out Windows 7.

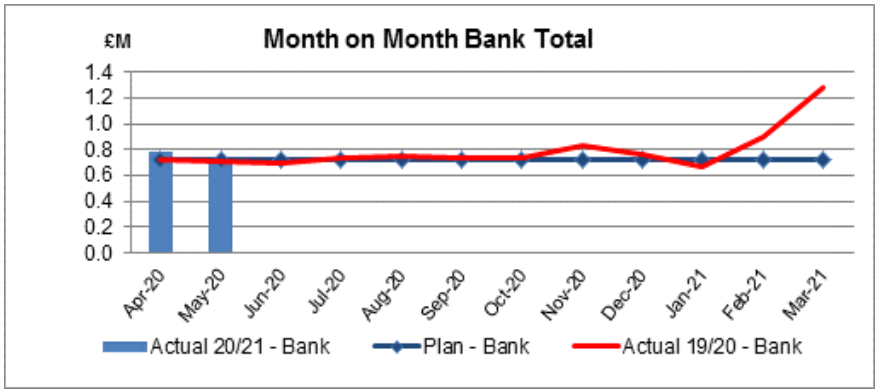
The Trust has also had c£800k of medical and IT equipment funded directly in 2020/21 as part of the Covid-19 response.

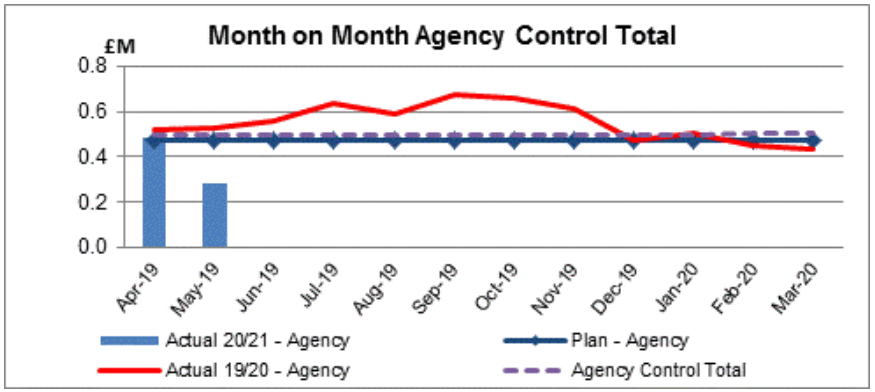
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

The overall expenditure on pay in the month of £14.0m represent a 2.4% reduction on April, mostly owing to agency usage dropping to virtually zero in the period. This represents a £366k overspend versus plan for the period, although it should be noted that this is inclusive of a £339k efficiency target.

During this period c£900k of additional/redeployed shifts were worked by the substantive workforce in response to Covid-19, two thirds of it by the Nursing, and Support to Nursing work force, the resources required to achieve this we made available by the closure of Elective capacity, the costs were therefore mostly offset by reductions in business as usual costs. c£100k related to additional medical shifts.

Sickness and self isolation due to Covid-19 remains high, although steady reduction could be observed throughout May.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	02 July 2020		

Report Title:	Accountability Framework			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Andy Hyett, Chief Operating Officer			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):	Appendix 1 – Division's to Board Flowchart Appendix 2 – Trust Management Committee Terms of Reference Appendix 3 – Divisional Management Committee Terms of Reference Appendix 4 – Executive Performance Review Meeting Agenda			

Recommendation:
The Board is asked to approve changes following the annual review of the Trust's Accountability Framework.

Executive Summary:
The Accountability Framework has been reviewed in conjunction with the Integrated Governance Framework. Key changes have been aligned with the revised Divisional structure and changes to the monitoring of corporate service performance.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐

Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

Salisbury NHS Foundation Trust

Accountability Framework

2020/21

June 2020

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Appendix 1 – Division's to Board Flowchart

Appendix 2 – Trust Management Committee Terms of Reference

Appendix 3 – Divisional Management Committee Terms of Reference

Appendix 4 – Executive Performance Review Meeting Agenda

PURPOSE

The purpose of the Accountability Framework is to ensure that Salisbury NHS Foundation Trust has sufficient mechanisms in place to monitor and drive delivery of the Trust's strategic and operational plans during 2020 and beyond.

The Accountability Framework pulls together, in one place, the Trust's business as usual performance, including delivery against its contracts and transformational programmes including Cost Improvement Plans (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) plans and Commissions for Quality and Innovation (CQUIN) schemes.

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

The Accountability Framework has been designed to align as closely as possible with the NHS Improvement Oversight Framework. This framework reflects the requirements of the Care Quality Commission (CQC), Financial sustainability/stability, performance management and improvement capability. It will ensure that as an organisation we are pro-active in providing assurance to our regulators.

There are five themes to the Accountability Framework (these match the themes defined in the Oversight Framework) each set out below:

Theme	Aim
Quality of care (safe, effective, caring, responsive)	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
Operational performance	To maintain and improve performance against core standards
Strategic change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build leadership and improvement capability to deliver sustainable services

PERFORMANCE FRAMEWORK

The performance function will oversee the delivery of all elements of Trust performance throughout the year, including service performance and quality of care, linked to the delivery of the Trust's Transformational and Financial plans. No one element of the Trust's business plan can be assessed in isolation.

The Performance Framework sets out the metrics that each directorate will be held accountable against, these metrics will be taken from the Trust's Operational Plan, individual directorate plans and will include all national and contractual requirements.

The dashboard is based on the five themes that will be used as part of the overall assessment of performance at a directorate and organisational level.

To mirror the Oversight Framework the Trust is using the segmentation methodology and for each theme there will be an assessment:

Segment	Description of support needs
1 Maximum autonomy	No actual support needs identified across the 5 themes
2 Targeted support	Support needed in one or more of the 5 themes
3 Mandated support	Significant support needs
4 Special measures	Very serious/complex issues

Below is the summary of the five themes with the information used and the triggers that will highlight issues or concerns.

Theme	Information used	Triggers
Quality of care (safe, effective, caring, responsive)	• CQC information • Quality information • 7 day services	• CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the key questions for - 'Safe' - 'Caring' - 'Effective' - 'Responsive' • CQC warning notices relating to the divisional core areas • Any other material concerns identified through, or relevant to, CQC's monitoring process, such as civil or criminal cases raised or raising concerns information • Concerns arising from trends in Quality Indicators • Failure to deliver against agreed commitments regarding the four priority standards for seven- day hospital services • Any other material concerns about a providers quality of care arising from intelligence gathered
Finance and use of resources	• A monthly finance score (Trust level) • A use of resources assessment (where available) • Other relevant information on financial performance, operational productivity and whether a Division is making optimal use of its resources	• Poor levels of overall financial performance, such as monthly finance score of 4 or 3 (at Trust level) • A use of resources rating of 'inadequate' or 'requires improvement' (at Trust level) • Any other material concerns about a Division's finances or use of resources
Operational performance	- NHS Constitution standards • A&E waiting times • Referral to treatment times • Cancer treatment times	• Failure to meet any operational performance standard for at least two consecutive months • Other factors (eg a significant deterioration in a single month or multiple potential support needs across standards and/or other themes) indicate the need to get involved before two months have elapsed • Any other material concerns about a Division's operational performance

Strategic change	• Extent to which Division's and departments are working with partners to address local challenges and to improve services for patients • Division's contribution to developing, agreeing and delivering the objectives of sustainability and transformation partnerships (STPs) • Nature of Division's relationships with local partners, their role in any agreed service transformation plans and how far these plans have been implemented	• Material concerns about support for the local transformation agenda, including (where relevant) new care models and devolution
Leadership and improvement capability (well-led)	**Effective Boards and Governance:** • CQC well led inspections and outcomes of developmental well-led reviews where these generate material concerns relating to directorates • Information from third parties eg Healthwatch, MPs, complaints, whistleblowers, coroners' reports • Staff/patient surveys • Level of Divisional management team turnover • Organisational health indicators • Delivering Workforce Race Equality Standards (WRES) **Continuous improvement capability:** • Assessments of learning, improvement and innovation within well-led reviews undertaken by CQC or in developmental reviews using the well-led framework **Use of data:** • Adoption of measurement-for-improvement approach	• CQC 'inadequate' or 'requires improvement' assessment against 'well-led' in relevant core areas • Concerns arising from trends in Divisional health indicators • Other material concerns about a Division's governance, leadership and improvement capability

Quality of Care

The following metrics will constitute the metrics that the Trust will use to establish the quality of care provided by the Trust.

	Measure	Type	Frequency	Source
	Written Complaints - rate	Caring	Quarterly	HSCIC (publicly available)
	Staff Friends and Family Test Percentage Recommended - Care	Caring	Quarterly	NHSE (publicly available)
	Never events	Safe	Monthly	NHSE (publicly available)
	Serious Incidents count	Safe	Monthly	StEIS
	Potential under-reporting of patient safety incidents	Safe	Monthly	NRLS (publicly available)
	Central Alerting System (CAS) alerts outstanding	Safe	Monthly	NRLS (publicly available)
	Mixed Sex Accommodation Breaches	Caring	Monthly	NHSE (publicly available)
	Inpatient Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	A&E Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	Emergency c-section rate	Safe	Monthly	HES
	CQC Inpatient Survey	Organisational Health	Annual	CQC (publicly available)
	Maternity Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
	Percentage of new harms	Safe	Monthly	NHSE (publicly available)
	VTE Risk Assessment	Safe	Quarterly	NHSE (publicly available)
*	*Clostridium Difficile* - variance from plan	Safe	Monthly	PHE (publicly available)
	Clostridium Difficile - infection rate	Safe	Monthly	PHE (publicly available)
*	MRSA bacteraemias	Safe	Monthly	PHE (publicly available)
	Hospital Standardised Mortality Ratio (DFI)	Effective	Quarterly	DFI
	Summary Hospital Mortality Indicator	Effective	Quarterly	HSCIC (publicly available)
	Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	Effective	Monthly	HES

	MSSA bacteraemias	Safe	Monthly 12 month rolling	PHE
	E Coli bacteraemias	Safe	Monthly 12 month rolling	PHE
	Total number of deaths & total number of admissions	Safe	Monthly 12 month rolling	Local

The Quality of Care is underpinned by the production of performance packs to provide the Executive Directors (via Executive Performance Review Meetings) and ultimately the Board with a clear line of sight on current performance. The information available is reviewed and amended annually to ensure it captures all required metrics.

*Well Led performance indicators

Workforce Metrics (organisational health indicators)

	Measure	Type	Frequency	Source
*	Staff sickness	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
*	Staff turnover	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
	Proportion of Temporary Staff	Organisational Health	Quarterly	FT return

*Well Led performance indicators

Operational Performance

Standard	Frequency	Standard
Acute and specialist providers		
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	92%

All cancers – maximum 62-day wait for first treatment from:	Monthly	
a) Urgent GP referral for suspected cancer		85%
b) NHS cancer screening service referral		90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%
Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:	Quarterly	
a) Who have a diagnosis of dementia or delirium or to whom case finding is applied		90%
b) Who, if identified as potentially having dementia or delirium, are appropriately assessed and		90%
c) Where the outcome was positive or inconclusive, are referred on to specialist services		90%

Monthly performance packs will be produced which outline current performance against plan or set targets. Divisions will be expected to respond to any concerns or risks highlighted within the performance reports to the Executive Performance Review meetings. Any additional assurance sought by way of recovery plans or increased monitoring of specific measures will be overseen by the performance function and monitored through the weekly performance meeting.

Financial Performance

The financial metrics show the Trust's financial sustainability, efficiency and controls relating to high profile policy imperatives such as agency staffing, capital expenditure and the overall financial performance of the Trust.

The scoring mechanism for the metrics mirror the Oversight framework and scoring from 4 (poorest) to 1 (best). A score of 3 or 4 will trigger a concern with NHS Improvement and trigger potential or mandated support.

Trust Level Finance Metrics

Area	Metric	Definition
Financial sustainability	Capital service capacity	Degree to which the provider's generated income covers its financial obligations
	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
Financial efficiency	Income and expenditure (I&E) margin	I&E surplus or deficit / total revenue
Financial controls	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to Year-to-date plan I&E margin (surplus/deficit) on a control total basis
	Agency spend	Distance from provider's cap

Directorate level finance metrics

Metric	Considerations
Revenue	Spend versus budget for pay and non pay
Income	Income in line with contracts and production plan
Cost Improvement Plans	Delivery against cost improvement trajectories and plans

Use of Resources Assessments

NHS Improvement's Use of Resources assessments aim to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. NHS Improvement will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are and how efficiently they use their workforce, clinical and operational services to deliver high quality care for patients. NHS Improvement will introduce Use of Resources assessments alongside the CQC's new inspection approach from autumn 2017.

Use of resources area	Key lines of enquiry (KLOEs)	Initial metrics
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?	- Pre-procedure non-elective bed days - Pre-procedure elective bed days - Emergency readmissions (30days) - Did not attend (DNA) rate
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?	• Staff retention rate • Sickness absence rate • Pay cost per weighted activity unit (WAU) • Doctors cost per WAU • Nurses cost per WAU • Allied health professionals cost per WAU (community adjusted)
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?	• Top 10 medicines – percentage delivery of savings target • Overall cost per test
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?	• Non-pay cost per WAU • Finance cost per £100 million turnover • Human resources cost per £100 million turnover • Procurement Process Efficiency and Price Performance Score • Estates cost per square metre
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?	• Capital service capacity • Liquidity (days) • Income and expenditure margin • Distance from financial plan • Agency spend

NHS IMPROVEMENT MONITORING

NHS Improvement 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.

Summary of information requirements for monitoring

	In-year	Annual/ less frequently	By exception[1]
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 1)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance and use of resources	Monthly returns	Annual operational plans Information relating to Use of Resources (UoR) assessments	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Quarterly/monthly/weekly operational performance information (see Appendix 3)		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of sustainability and transformation plans Progress of any new care models, devolution plans	Sustainability and transformation plans	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[2] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and patient surveys Third-party information with governance implications[2]	Findings of well-led reviews and developmental well-led reviews Third-party information with governance implications[2]

[1]Providers are also expected to notify NHS Improvement of any other material changes in performance or risks that fall outside routine monitoring

[2]eg reports from quality surveillance groups (QSGs), General Medical council, ombudsman, CCGs, Healthwatch England, NHS Digital, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges

Support needs and segment descriptions

The support offered by NHS Improvement will be Trust specific but is defined below:

Description of support needs	Level of support offered	Segment
No actual support needs identified across our five themes. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider will support providers in other segments.	**Universal**	**1 (Maximum autonomy)**
Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed.	**Universal** **+ Targeted** support as agreed with the provider to address issues identified and help move the provider to Segment 1	**2 (Targeted support)**
The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts), but is not in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to address specific issues and help move the provider to segment 2 or 1	**3 Mandated support)**
The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to minimise the time the provider is in special measures	**4 (Special measures)**

LOCAL ASSESSMENT CRITERIA

Division's will be assigned an overall RAG rating based on performance against the domains of quality, operational, financial and workforce performance as well as delivery of the Divisional operational plan.

Overall Performance Ratings and Oversight Model

Individual domain ratings will then be aggregated to provide an overall rating for the Division. The proposed criteria for the overall ratings are shown in the overall performance ratings and oversight model on page 14. The criteria for assigning the overall RAG rating is not limited to the reasons shown, discretionary decisions regarding ratings may be made in agreement at the Executive Performance Review Meetings should they feel that either increased or lesser scrutiny would be more appropriate.

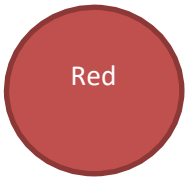
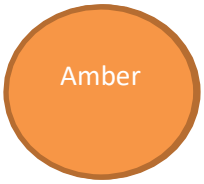
RAG ratings will be routinely reported to the Trust Management Committee to ensure that appropriate scrutiny is given to the most significant areas of risk.

The 'Overall Performance Ratings and Oversight model' below sets out how the Trust Board, Finance and Performance Committee, Trust Management Committee, and the Executive Performance Review Meetings will hold Division's to account for delivery in a consistent and transparent way. The oversight arrangements are directly linked to the Performance Framework, as outlined above.

The overall Divisional rating will determine the regularity of performance review meetings and other escalation meetings. These Divisional Performance Review meetings will take place routinely, however for those directorates rated red or amber that require additional intervention of support, increased oversight will be established.

Preparatory work for each of these meetings will be required and the Information Team will work to standardise the documentation as much as possible. This will ensure consistency in the way in which performance is reviewed across the organisation and will align reporting requirements across multiple meetings. This will minimise the amount of time taken by directorates assessing data, re-focussing efforts on ensuring sufficient plans are in place to address areas of under-performance.

Overall Performance Ratings and Oversight Model:

RAG rating	Definitions	Oversight requirement
	• 3 or more domains are rated red • 2 or more domains are rated red and considerable risks to other areas of performance have been identified • Division is forecasting significant variances to plan at year end and there is not sufficient confidence in recovery trajectories	➢ Weekly performance challenge meetings ➢ Weekly submission of recovery trajectories and progress ➢ Presentation of recovery plan at Trust Management Committee and monthly update on recovery ➢ Further assurance to the Finance & Performance Committee may be required ➢ Dedicated project support as relevant
	• 1 or more domain is rated red • 3 or more domains are rated amber • 2 or more domains are rated amber and risks to other areas of performance have been identified • Division is forecasting moderate variance to plan at year end, however there is confidence in recovery trajectories	➢ Agreed trajectories for improvement ➢ DMT Monitoring weekly ➢ Monthly Executive Performance Review Meetings
	• No more than 2 domains are rated amber, which indicates small variance to plan • There are no significant risks to delivery identified • Robust recovery trajectories are in place for any variance to plan	➢ Monthly Executive Performance Review meetings ➢ Agreement regarding resource and support required to enable delivery

ESCALATION

The overall RAG rating for each directorate will act as the trigger for any additional support or escalation. For Division's who are rated 'Amber' or 'Red' and/or have failed to deliver any improvements for a sustained period of time, additional interventions may be enacted to support the return of performance to acceptable levels.

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

Additional interventions will normally take the form of intensive support. Depending upon the issues causing concern this may be department specific, ward specific, or, across the directorate. Exec Directors will be allocated based on the areas of concern. At the initial meeting the scope and focus will be agreed along with the KPI's for success. More serious measures, such as removal of delegated directorate budgets, should there be significant deterioration in performance which does not appear recoverable will also exist, though it is expected that such measures would only be implemented in extreme circumstances. Through the use of agreed KPI's, the point at which intensive support will cease shall be set and agreed early on.

GOVERNANCE

Throughout this document the term Division is used to describe the following clinical and corporate directorates;

- Surgery
- Medicine
- Clinical Support and Family Services

Monthly Executive Performance Review meetings will take place with each of the above Divisions. Once in Quarters 1 and 3, Executive Performance Review meetings will be Chaired by the CEO. All Division's will receive a RAG rating and escalation will be the same for Division's as outlined on page 14.

CORPORATE DEPARTMENTS

Additional information to support the Governance process is provided in the attached Appendices;

- Appendix 1 - Division to Board flow chart
- Appendix 2 - Trust Management Committee Terms of Reference
- Appendix 3 - Divisional Management Committee Terms of Reference
- Appendix 4 - Executive Performance Meeting Agenda

Performance of Corporate Services will be monitored by the relevant Director and assurance provided to the Chief Executive Officer. Where the Chief Executive Officer is not satisfied with performance, they will ask the Chief Operating Officer to commence intensive support with the area. This will be led by two Executive Directors and progress will be reported via the standard escalation reports.

Version control

Document Title	Accountability Framework 2019/20			
Date Issued/Approved:				
Date Valid From:	4 April 2018			
Date Valid To:	31 March 2021			
Directorate / Department responsible (author/owner):	Chief Operating Officer			
Brief summary of contents	This document provides a framework for how the Trust will maintain and manage its performance and focuses on the accountability relationship between the Executive and the management of the three Division's that are subject to performance review meetings.			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2019 December 2019 June 2020			
Approval route (names of committees)/consultation:	Chief Operating Officer in consultation with Trust Board			
Name and Post Title of additional signatories	Not Required			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet		Intranet Only	x
Document Library Folder/ Folder	Standing Financial Instructions & Orders			
Links to key external standards	• NHS Improvement Single Oversight Framework November 2017 • NHS Improvement and Care Quality Commission Use of Resources: Assessment Framework August 2017			

Related Documents	Integrated Governance Framework April 2018
Training Need Identified?	No

version Control Table

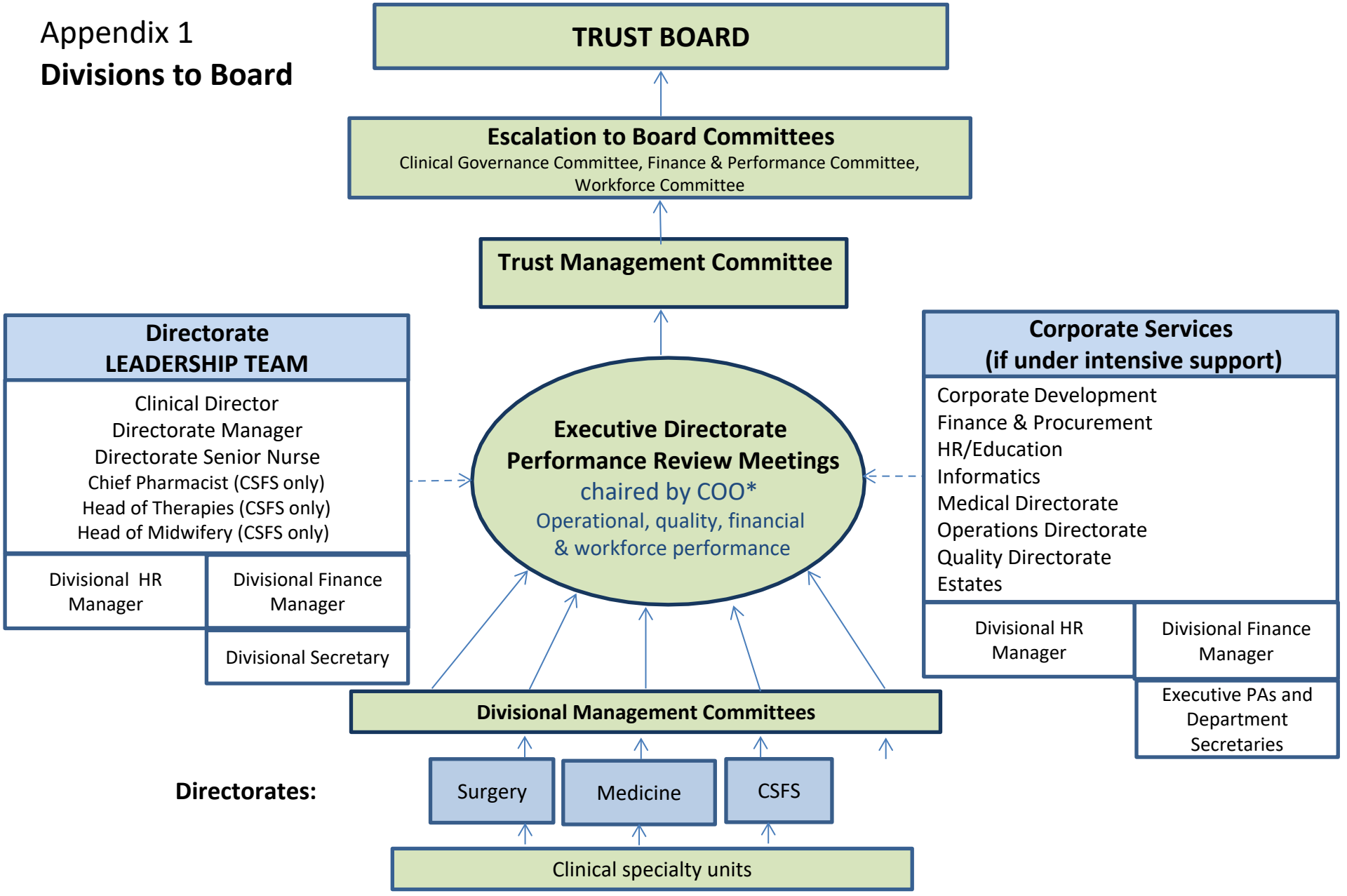
Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
03/02/18	V1.0	Draft document	Andy Hyett, Chief Operating Officer
28/02/18	V1.1	Draft document	Andy Hyett, Chief Operating Officer
15/03/18	V1.2	Final version	Andy Hyett, Chief Operating Officer
15/03/18	V2.1	Draft annual review of document updated to reflect NHS Improvement Single Oversight Framework November 2017	Andy Hyett, Chief Operating Officer
29/03/18	V2.2	Ongoing annual review of document, including updates to document appendices	Andy Hyett, Chief Operating Officer
04/04/18	V2.3	Ongoing annual review of document, including incorporation of key lines of enquiry from CQC & NHSI Use of Resources Assessment Framework August 2017	Andy Hyett, Chief Operating Officer
05/04/18	V2.4	Ongoing annual review of document and supporting appendices	Andy Hyett, Chief Operating Officer
09/04/18	V2.5	Draft document – presented to Board. Approved with need to further update key metrics	Andy Hyett, Chief Operating Officer
22/05/18	V2.6	Final document – updated key quality of care and operational performance metrics for presentation to Finance & Performance Committee	Andy Hyett, Chief Operating Officer
04/04/19	V2.7	Draft document – presented to Board.	Andy Hyett, Chief Operating Officer
03/12/19	V2.8	Draft document	Andy Hyett, Chief Operating Officer
25/06/20	V2.9	Draft document	Andy Hyett, Chief Operating officer

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

Appendix 1

Divisions to Board



* Executive Directorate Performance Review meetings attended by Chief Operating Officer, Director of Finance, Director of Nursing, Medical Director, Director of Organisational Development and People to provide support, oversight and challenge to the directorate leadership team regarding delivery against all requirements in preparation for providing assurance to the Trust Management Committee

Appendix 3

DIVISIONAL MANAGEMENT COMMITTEE
TERMS OF REFERENCE

1. Formation of this Committee

The Divisional Management Committees role is to consider key strategic and managerial issues within the Division and to ensure that performance is in line with agreed objectives.

2. Role

The Division will function as a decision making body in line with its delegated authority. It will provide effective and proactive leadership to the Division and ensure that robust governance arrangements are in place and high quality care is consistently delivered. It will provide information and assurances to the Board via meetings with the Chief Operating Officer (COO).

3. Membership of the Divisional Management Committee

The committee shall be comprised of Division members as follows:

- Clinical Director (CD)
- Divisional Director of Operations (Surgery & Medicine only)
- Divisional Manager (DM)
- Divisional Head of Nursing
- Chief Pharmacist (CSFS only)
- Head of Therapies (Medicine only)
- Head of Midwifery (CSFS only)
- Divisional Finance Manager
- Divisional Human Resources Manager
- Speciality Lead Clinicians
- Ward Sisters
- Heads of departments

It is expected that all members will attend at least 75% of meetings of the committee. An annual attendance report will be submitted to the COO for information and action as required.

4. Chair of the Divisional Management Committee

The chair of the Divisional Management Committee shall be the Clinical Director, with the Divisional Director of Operations (Surgery & Medicine only) for CSFS this will be the Divisional Manager adopting the role of Vice Chair.

5. Quorum

The quorum shall be the chair or vice chair, and at least 50% of the other representation.

6. Meetings

The Divisional Management Committee shall meet monthly. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7. Attendance at meetings

Other employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that employee.

8. Notice of meetings

Meetings of the committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the committee not less than five working days before the date of the meeting.

9. Agenda and action points

The agenda and action points of all meetings of the board shall be produced in the standard agreed format of the Trust and kept by the Divisional Administration Team.

10. Reporting arrangements

The Divisional Management Committee has a direct reporting line to the Trust Management Committee. Assurance responsibility is delegated to the Chief Operating officer who along with the Medical Director, Director of Nursing, Director of Finance and Director of Organisational Development & People will meet with the Divisional Management team in line with the Accountability Framework.

11. Responsibilities of the Divisional Management Committee

The Divisional Management Committee is responsible for providing information and assurances to the COO that the Division is safely managing all issues relating to the strategic objectives of the Division and the Trust. In addition it has responsibility to:

11.1 based on the Trust strategy and emerging risks develop an annual directorate operational plan to form part of the Trust's operational plan

11.2 identify any risks which may prevent the achievement of the work plan and ensure that they are assessed, placed on the Divisional Risk Register and the action plan is monitored

11.3 evaluate its own membership and performance on at least an annual basis

11.4 provide assurance to the Trust Board via meetings with COO and other executive Directors as outlined in the Accountability Framework

11.5 review and monitor the Division against its Operating Plan

11.6 review and monitor the Quality Metrics on at least a quarterly basis.

11.7 escalate any significant issues that impact on the corporate objectives

12. Administration

The Committee shall be supported administratively by the Divisional Administration Team who will agree the agenda with the chair, produce all necessary papers, produce and distribute minutes and action points, and generally provide support to the chair and members of the Committee.

Appendix 4

Executive Performance Review Meeting

Agenda

1. **Welcome and apologies**
2. **Minutes of the last meeting**
3. **Action log review**
4. **Performance Overview**
5. **Key Issues**
6. **Data dashboards**
7. **Quality performance (to include Directorate Governance meeting minutes)**
8. **Operational performance**
9. **Financial performance**
10. **Workforce performance**
11. **Performance against Directorate Operational Plan**
12. **Risk Register Review**
13. **Key issues for escalation**
14. **External Visits**
15. **RAG rating**

Salisbury NHS Foundation Trust

Trust Management Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
March 2020	1.1	Major Revision	All sections revised	Corporate Governance Manager

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Corporate Governance Manager
Review and Approval	Trust Management Committee
Adoption and ratification	Board of Directors

1. Purpose

1.1. The Committee is established by the Chief Executive as the senior executive committee of Salisbury NHS Foundation Trust.

1.2. The Trust Management Committee is responsible for the coordination and operational management of the system of internal control and for the management of the achievement of the Trust's objectives as agreed by the Board of Directors.

1.3. It is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accounting Officer.

2. Authority

2.1. The Chief Executive has established an executive committee to be known as the Trust Management Committee (TMC).

2.2. The Trust Management Committee is accountable to the Board of Directors through the Chief Executive for the operational management of the Trust and delivery of objectives agreed by the Board.

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Chief Executive and shall consist of:

- Chief Executive
- Medical Director
- Chief Operating Officer
- Director of Finance
- Director of Organisational Development and People
- Director of Nursing
- Director of Transformation
- Directorate Managers
- Clinical Directors
- Chief Information Officer

3.2. Each Clinical Director or Executive Director may nominate a deputy to attend in their place if they are unable to attend. Other attendees may attend at the discretion of the Chair in support of specific agenda items.

Quorum

3.3. The quorum necessary for the transaction of business shall be half of members including at least two Executive Directors and at least one representative from the Directorate Management Teams.

4. Roles and Responsibilities

Strategy and Business Planning

4.1. Support the development of the Trust Annual Plan, including policy direction, revenue and capital finance and play a key role in developing and implementing the overall strategy of the Trust;

4.2. Clear recommendations to the Trust Board on key strategic and operational decisions which are retained by the Board;

4.3. To ensure effective arrangements are in place to manage key partnerships and stakeholder engagement;

4.4. Maintain the Board Assurance Framework, reviewing and mitigating gaps in evidence and assurance to align with and support the Trust's objectives.

4.5. To determine business cases for approval which require investment of £20k - £250k and ensure that approved business cases are reviewed within the agreed time-frame.

Operational, Quality and Performance

4.6. Ensuring collective and individual responsibility and accountability for delivering operations, required performance and addressing current and emerging risk to maintaining successful delivery;

4.7. Develop and monitor the implementation of plans to improve the efficiency, effectiveness, quality and safety of services;

4.8. Clear decision making in accordance with the decision making framework on a timely basis and subsequent communication as appropriate;

4.9. The monthly Integrated Performance Report will be circulated for information.

4.10. Receive assurance and have oversight of Care Quality Commission (CQC) preparedness and to ensure subsequent actions are effectively embedded.

Governance and Risk

4.11. Monitor the management of organisational risk;

4.12. Receive and review the Corporate Risk Register and manage actions to effectively mitigate risks;

4.13. Receive assurance that both the clinical and non-clinical Register of External Visits and Accreditations is maintained and that the outcome of these visits has been appropriately actioned;

4.14. Monitor the Register of Gifts, Interests and Hospitality.

Procedural Documents in line with the Policy for Policies

4.15. Review and approve procedural documents, including strategies, policies, protocols and procedures;

4.16. Monitor and provide updates for the schedule of Matters Arising and ensure agreed actions are appropriately and promptly completed.

Receive Reports from the following sub-groups*

4.17. Clinical Management Board (CMB)

Operational Management Board (OMB)

Trust Investment Group (TIG)

Transformation Board

Strategic Estates Committee

Health and Safety Committee

Executive Performance Reviews

Information Governance Steering Group (IGSG)

Digital Steering Group (DSG)

Organisational Development and People Management Board

*Frequency of reporting to be dictated by the Committee's annual business cycle.

5. Conduct of Business

Administration

5.1. The Committee shall be supported administratively by the Executive Services Manager, whose duties in this respect will include:

- Agreement of agendas with Chair and attendees and collation of papers;
- Taking the minutes;
- Maintain a record of matters arising and track the progress of actions delegated for action by the committee;
- Provision of an escalation report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

5.2. It is the responsibility of the author to produce the paper and any supporting documents in the correct format. Papers not in the correct format will be sent back to the author for amendment.

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Meetings will be held once a month.

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. Agenda template attached as Appendix A. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

5.5. Late papers are unacceptable and will only be added to the meeting papers after the deadline if permission has been given by the Chair of that meeting.

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. Formal 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 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.

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

5.10. The Committee will report to the Board of Directors after six months on its effectiveness in meeting responsibilities as reflected within this Terms of Reference.

5.11. The Committee will receive minutes for information from the sub-groups listed under point 4.13 and from the following advisory groups:

Joint Local Negotiating Committee (JLNC)

Joint Consultative Committee (JCC)

Operational Delivery Group

Nursing, Midwifery and Allied Health Professionals Forum (NMAHP)

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.

Appendix A

NHS Salisbury NHS Foundation Trust

Agenda Template
Trust Management Committee
Date, Time
Room

Timings	1	Opening Business	To present	Purpose	Verbal/ Enc.
	1.1	Welcome and apologies:	CCB	Noting	
	1.2	Minutes of the previous TMC meeting held on **DATE**	CCB	Approval	Enc
	1.3	Matters Arising and action log	All	Discussion	Enc
	2	**Urgent Business**			
	2.1	Hot spots/ Feedback from frontline visits			
	4	**Sub-Group Exception Reports**			
	4.1				
	5	**Operational, Quality and Performance**			
	5.1	Integrated Performance Report		Information	
	5.2	Quality, Clinical and Patient Issues		Information	
	5.3	Finance Report		Information	
	5.4	Workforce and Organisational Development Issues		Information	
	6	**Strategy and Partnerships**			
	6.1				
	7	**Business and Commercial**			
	7.1				
	8	**Governance and Risk**			
	8.1				
	9	**Minutes for Information**			
	9.1				
	10	**Closing Business**			

	10.1	Agreement of principal actions / Items for Escalation			
	10.2	Any Other Business			
	10.3	**Date of next meeting:**			

Agenda and papers circulated to:

Committee members:
Chief Executive
Medical Director
Chief Operating Officer
Director of Finance
Director of OD and People
Director of Transformation
Director of Nursing
Clinical Director, Surgery
Clinical Director, Medicine
Clinical Director, CSFS
Clinical Director MSK
Directorate Manager, Surgery
Directorate Manager, Medicine
Directorate Manager, CSFS
Directorate Manager, MSK
Chief Information Officer

Regular Attendees
Director of Corporate Governance
Deputy Director of Finance
Associate Director of Strategy
Executive Services Manager (minutes)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	02 July 2020		

Report Title:	**Integrated Governance Framework**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Fiona McNeight, Director of Corporate Governance Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Integrated Governance Framework – July 2020			

Recommendation:

The Trust Board is asked to approve the revised Integrated Governance Framework and the Board Committee's Terms of Reference.

Approve the CEO as a member of Finance and Performance, Clinical Governance and People and Culture Committees (as agreed at the June CGC meeting).

Approve the Mental Health Strategy Committee reporting to TMC.

Executive Summary:

Following a review of the Trust's Integrated Governance Framework a number of changes have been made to bring the document up to date.

Amendments include the following:

- Minor amendments have been made as a result of the Internal Audit of Board Compliance and Reporting in November 2019. These include changes to Appendices 1,2 & 3 and a complete revision of TMC terms of reference, which have been included.
- The Strategy Committee has been removed as this is now covered at the private Trust Board. A strategy session is included as a standard agenda item each month.
- The name of Workforce Committee has changed to People and Culture Committee to better reflect the business of the meeting.

- The CEO will now be a member of Finance and Performance, Clinical Governance and People and Culture Committees with an expected 70% attendance for each Committee. This was agreed at the June Clinical Governance Committee to ensure equity of attendance across the assurance committees (currently only a member of F&P).

- During 2019/20 the Directorate Management Teams were restructured and are now called Divisional Management Teams; this is reflected in the report. Additionally, the Divisional Management Governance was strengthened and the Divisional Management Committee standard agenda was reviewed to ensure effective governance and quality assurance.

- All Board Committee Terms of Reference have been to their respective Committee's and have been reviewed, updated and recommended for approval. The document now includes Charitable Funds Committee and Remuneration Committee Terms of Reference.

- The Mental Health Strategy Committee has not featured in the agreed structure. It is proposed that this committee reports to TMC and the TMC terms of reference and the committee structure will be updated if this is approved.

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

Salisbury
NHS Foundation Trust

INTEGRATED GOVERNANCE FRAMEWORK

July 2020

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1. INTRODUCTION

Integrated Governance is the means by which the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of the delivery of "an outstanding experience for every patient", by an organisation that is well managed, cost effective and has a skilled and motivated workforce.

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 particular reference to the provision of quality services.

This document is underpinned by the Accountability Framework which specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focussing across the breadth of quality, operations, finance and workforce.

2. STRATEGIC OBJECTIVES

The Trust's strategic objectives are set out in its 2018-20 strategy. Underpinning delivery of these objectives, there is a business planning process. The corporate goals are:

Local Services - Our aim is to meet the needs of the local population by developing new and improved ways of working which always put the patient at the centre of all that we do.

Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population – more than 11 million across Southern England for the Spinal Centre and over three million for patients across Wessex for burns and plastics, cleft lip and palate, genomics and specialist rehabilitation services.

Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of the Trust.

Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm.

People - We will make SFT an outstanding place to work where everyone feels

valued, supported and engaged and are able to develop as individuals and as teams.

Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources.

3. SCOPE OF THE FRAMEWORK FOR INTEGRATED GOVERNANCE

Integrated Governance is based on the understanding that all elements of governance are important and they should not be managed in silos. To achieve focused decision-making and deliver strategic objectives, the Board considers all aspects of accountability in the round. This framework sets out the principal strands of governance and describes how Salisbury FT arrangements bring these together.

4 ELEMENTS OF GOVERNANCE

4.1 Corporate Governance

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.

4.2 Financial Governance

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).

Standing Orders and Standing Financial Instructions

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

4.3 Clinical Governance

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.

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.

Demonstrating Quality

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 national framework, Data Security and Protection Toolkit, CQC standards and the Trust's performance monitoring framework.

4.4 Risk Management Strategy & Board Assurance Framework

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

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.

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

The Board Assurance Framework is reported to the Trust Board at quarterly public meetings, with a detailed review undertaken in advance by the assurance

committees.

4.5 The Role of the Trust Board

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

It will ensure a balanced focus on all aspects of its business.

Further to this:

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

Charitable Trustees

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 6.

4.6 Annual Governance Statement

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.

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.

5. INTEGRATED GOVERNANCE FRAMEWORK

The following describes the Trust's Integrated Performance Management Framework.

Committee	Membership	Principal Reporting Documents
Level 1: SFT Trust Board		
Trust Board	All directors	Corporate Strategy Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management Performance Reports – quality, workforce, operations, finance Board Committee supporting information Customer Care and Legal Reports
Board Committees	Non-Executive Directors, CEO and 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)
		

Level 2: Review of Divisional Management		
Executive Performance Review Meetings	Lead Executives Divisional Management Team HR and Finance Business Partners	Detailed performance dashboard for Division Division commentary Risk Registers Other issues by exception
		
Level 3: Divisional management		
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 Annual Quality Account Annual CQUIN indicators Patient Safety Clinical Effectiveness Patient Experience
		
Level 4: Specialty / Service Line		
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
		
Level 5: Team / Individual		
Ward and clinical area	Specialty Director, and Service Lead,	Ward trigger tools and dashboards, budget review and

reviews	with Ward Sister or equivalent	other specific governance indicators
Individual performance management arrangements (non-medical)	Individual line manager	Agree objectives Appraisal and appraisal documentation

6. 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. A number of meetings and processes support the Board in its role.

Level 1: Assurance Committees of the Board

6.1 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

6.2 Clinical Governance Committee

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

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

The Committee provides assurance to the Board, through ensuring the supporting processes are embedded and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

Principal functions:

To provide assurance to the Board on:

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

6.3 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 Programme

- Operational performance

6.4 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 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;
- Organisational Development and Change Management.

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

6.5 Subsidiary Governance Committee

The Subsidiary Governance Committee was established late 2018 to provide assurance to the Board of Directors on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company. Meetings commenced in early 2019.

Principal Functions:

- Oversight of the subsidiary level risk profile and exposure

- Ensuring a governance framework and structure for oversight of any related company/entity

6.6 Remuneration and Nominations Committee Committee

The purpose of the Remuneration Committee is to ensure there is a fair and transparent procedure for developing and maintaining policy on executive remuneration and for setting the remuneration packages of individual Directors.

Specifically, the Committee will make decisions, on behalf of the Board, on the appropriate remuneration and terms of service for the Chief Executive, Executive Directors within the remit of the Remuneration Committee, including:

- all aspects of salary, including any performance related/bonus elements;
- arrangements for termination of employment and other contractual terms;
- monitor and evaluate the performance of the Chief Executive and Executive Directors;
- succession planning

6.7 Level 2 – Review of Divisional Management

Executive Performance Review Meetings are held monthly with the clinical Divisions, consisting of three executive directors and each Divisional Management Team to review performance across quality, finance, operations, and workforce. In 2019 the reviews were extended to also include Corporate Functions.

Further detail is given in the Accountability Framework.

Level 3: Divisional Arrangements

6.8 Divisional Clinical Governance Arrangements

The Trust manages the delivery of its services through a divisional structure with each accountable for its contribution to the Trust's strategic objectives and integrated business plan. Authority to act is set out in the Trust's Scheme of Delegation and Accountability Framework as appropriate to each individual post or generic staff group.

There are also specific corporate functions in place to support the Divisions to achieve their objectives and to provide assurance to the Trust Board in its performance management role. These include: finance; human resources; quality; operations, and informatics.

6.9 Divisional Management Committees

Each division is led and managed by a Divisional Management Team, made up of the Clinical Director, Divisional Manager and Divisional Senior Nurse.

This Divisional Management Committee (DMC) is supported by Lead Clinicians, operational managers, and the corporate functions such as HR and Finance. For the Facilities Directorate, this is the Head of Service and General Managers.

The Divisional Management Committee is responsible for providing leadership within the clinical divisions. They ensure the Trust delivers an outstanding experience for every patient, which represents best value and includes working with partner organisations to deliver innovative models of care.

Divisional Management Committees, together with Specialty Leads, have specific roles and responsibilities to ensure that the care and treatment provided to patients meets with the Care Quality Commission's standards.

Each Division will have governance arrangements appropriate to their services as set out in the Accountability Framework.

6.10 Level 4: Quality Assurance within Divisions

The Divisions have in place arrangements for quality governance that is accountable, through the DMC and Divisional Governance Committee and escalation via the Executive Performance Meetings to the executive team.

Divisional Governance Committees will be held monthly. Standard Terms of Reference can be found in the Accountability Framework.

The scope of matters covered by Divisional Governance Committee agendas will include:

- Development of team/specialty quality goals and measures
- Areas designated for improvement as set out in the Trust's Annual Quality Account
- Achievement of indicators defined in the annual CQUIN payment framework.

Core Standard Items

- Divisional Governance Agenda / Specialty Risk Register
- New Serious Incidents Commissioned
- Triangulation of quality intelligence relating to safety, experience and outcomes
- New Trust policies / guidelines for noting
- Quality Impact assessments for Cost Improvement Plans

Patient Safety:

- SI management
- Incident analysis and learning
- Claims analysis and learning
- Safety Alert notifications and progress against compliance
- Progress against patient safety initiatives/work programmes
- Safety walkabouts – progress against any identified actions

Clinical Effectiveness:

- Compliance with clinical audit plan (National and local audits)
- Compliance with NICE and NICE Quality Standards
- New Divisional Policies / guidelines for sign off
- External visits / NCEPOD / inspections
- Outcome data (e.g. Dr Foster, PROMs, Mortality & Morbidity lessons learned)
- GIRFT outcomes and action plan compliance
- Information Governance compliance

Patient Experience:

- Progress against patient and public involvement projects/initiatives
- Complaint, PALS, SOX, patient feedback and plaudit analysis and learning
- Progress against improvement action plan
- Progress against CQC action plan/preparedness
- Quality improvement initiatives/programmes of work

All of the above to include:

- The monitoring of progress against associated action plans.
- Monitor progress with current quality initiatives.
- Provide a forum for continuous improvement and development.
- The DMC will ensure that clinical specialties have relevant supporting/ parallel working arrangements.

Executive and Committees

6.12 Accounting Officer – Chief Executive

Under the Accounting Officer Memorandum, the Chief Executive is responsible for the stewardship of all the resources entrusted to the Trust. This role also carries extensive delegated authority from the Trust Board for the delivery of the Trust's services.

6.13 Trust Management Committee

The Trust Management Committee (TMC) comprises the Executive Directors, Clinical Directors, and Divisional Managers and is the senior Executive committee. The purpose of TMC is to support the Chief Executive in ensuring the delivery of Trust services, meeting required financial, organisational and governance requirements.

As a result of an Internal Audit of Board Compliance and Reporting a piece of work addressing the Trust's governance structure has been undertaken. As part of this work the TMC terms of reference were completely revised, which helped to set out clear lines of reporting and escalation up to Executive Directors and Senior Management

The revised Terms of Reference can be found in Appendix 5.

This governance review identified all groups and committees in operation, providing transparency of the meeting structure. Further work continues on the meeting structure to streamline the lines of escalation and reporting. This can be found in Appendix 3.

Public accountability

6.14 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 membership to the Trust Board.

Board Appointments

6.15 Nominations Committees

The non-executive directors are appointed by the Council of Governors and a Nominations Committee that is run jointly with the Board, oversees the appointments process. Executive Directors are appointed by a committee of the non-executive directors and the Chief Executive. The Chief Executive is appointed by the non-executive directors, and the appointment is subject to approval by the Council of Governors.

7. GOVERNANCE SUPPORT ARRANGEMENTS

Quality Directorate

The Quality Directorate provides trust-wide guidance, facilitation & support for the

following elements of the integrated governance agenda, linked to Divisions:

- Collecting and storing evidence to support external assessments and preparing submissions to the CQC and NHS Resolve.
- Monitoring compliance with NICE guidelines and standards, alerts and other national frameworks.
- Producing the Trust's annual Quality Account
- Practice development associated with Patient Safety.
- CQUINs and clinical audit element of the annual contract.
- Risk management, including operational and corporate risk registers.
- Serious, critical and other Incident investigation and reporting.
- Aggregating learning from Incidents, Complaints, PALs, Claims, Mortality Review, Inquests and Regulation 28 letters.
- Monitoring and reporting with National Institute of Health Research and clinical Research Network high level objectives'
- Customer Care: Complaints and PALs
- Clinical audit programme
- Mortality review processes
- Administering the CAS process

The Trust's CQC registration is overseen by the Head of Corporate Governance.

8. SUSTAINABILITY & TRANSFORMATION PARTNERSHIP

The Trust is part of the Bath & North East Somerset, Swindon and Wiltshire Sustainability Partnership. Under its emergent plan the agencies that comprise the partnership are working to address five priorities:

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

The Trust Board will receive periodic updates on progress being made through the partnership.

9. MONITORING AND REPORTING PROCESS

The Trust Board monitors the delivery of this framework primarily through reports to the Board from the following committees:

- Audit

- Finance & Performance
- Clinical Governance
- People and Culture
- Subsidiary Governance

In addition, reports will be received from internal and external audit, and other regulatory bodies to provide independent assurance to the Board.

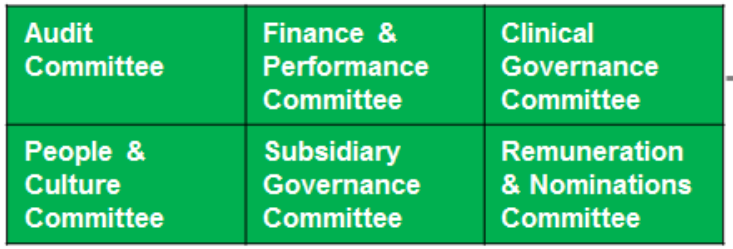
All committees receive reports and regular monitoring information as set out in each committee's work plan. This covers all principal strands of governance as part of the Trust-wide assurance framework.

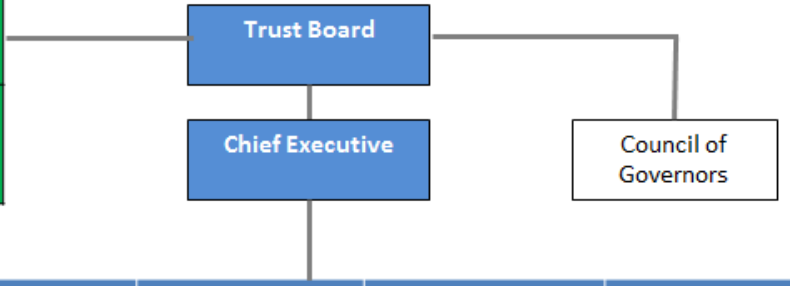
Appendix 1: Overview of Assurance Committees that report to Trust Board

Audit	Finance & Performance	Clinical Governance	People and Culture	Subsidiary Governance
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 concems	To provide assurance and scrutinise high level operational and finance related matters, providing assurance to Board regarding reported results and compliance with NHSI requirements, in particular: • Financial strategy, policy, management and reporting • Performance management and reporting • Service improvement and change management • Monitoring cost improvement programme • Operational performance	To provide assurance on: • Patient safety • Clinical effectiveness • Patient experience • Service improvement and change management	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 & professional development • Recruitment & retention • Staff engagement • Change management • Occupational therapy & counselling services • Service improvement and change	To provide assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company: • Oversight of the subsidiary level risk profile and exposure • Ensuring a governance framework and structure for oversight of any related company/entity

NB: Committee reporting comprises an Escalation Report prepared by the Chairman of the committee and Lead Executive, and is supported by the minutes presented to the Trust Board.

Appendix 2 – Committee structure and accountability of direct reports to Chief Executive





Medical Director (Executive)	Director of Nursing (Executive)	Chief Operating Officer (Executive)	Director of Finance (Executive)	Director of People & OD (Executive)	Director of Transformation	Director of Corporate Governance
Themes Professional leadership Responsible Officer (Medical Appraisal) Clinical Effectiveness Caldicott Guardian Mortality Reviews Research Medical Education	**Themes** Nursing, Midwifery, Therapy workforce Patient Safety Patient experience Risk management Litigation Customer Care Adult and children's safeguarding DIPC	**Themes** Operation Performance Facilities Medical Equipment Emergency planning	**Themes** Financial Recovery Plan Contracting Procurement Financial Control Trust-owned companies Capital control Site development	**Themes** Organisational development Education Equalities Occupational Health Volunteers	**Themes** Cost improvement planning Informatics Information governance Policy planning SIRO	**Themes** Corporate Governance Well-Led Board Assurance Framework Board and Committee business and standards Integrated Governance Framework Foundation Trust Governors and members function

Note: Executive Directors are Board level positions

APPENDIX 2 CONTINUED: ACCOUNTABILITY OF DIRECT REPORTS TO THE CHIEF EXECUTIVE

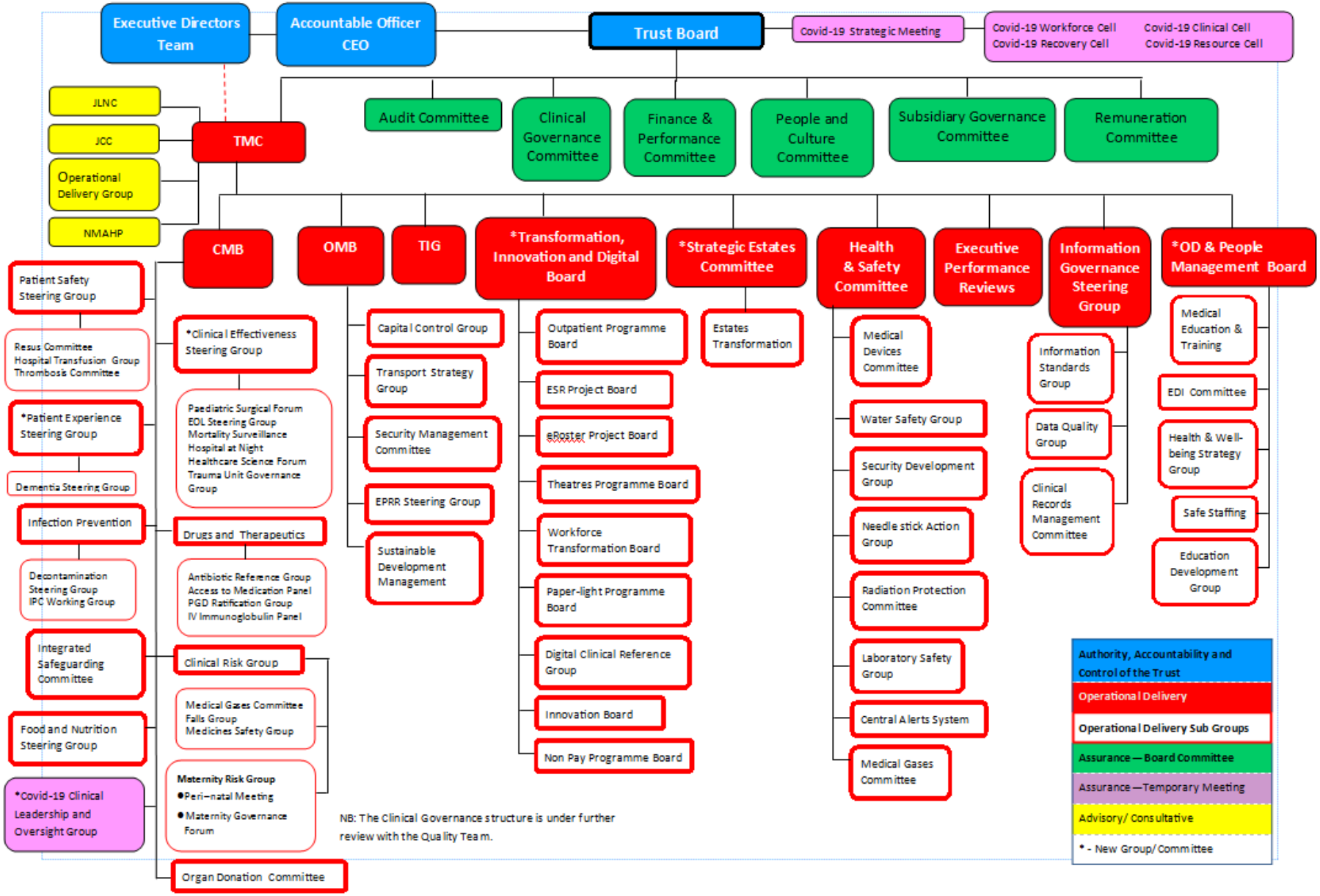
Note: Executive Directors are Board level positions

	Lead for Board Objective
Chief Executive Officer	Delivery of strategic and corporate objectives Working across the wider health and social care system Financial Recovery Plan Accounting Officer for Annual Governance Statement Executive governance arrangements Corporate governance – policies and compliance Board Assurance Framework
Chief Operating Officer (Executive Director)	Clinical Divisions and Facilities Service delivery; transformation and improvement Change management/CIP programme Performance delivery of divisions Accountable Officer for emergency planning and business continuity Medical Equipment Security Management Estates Hard Facilities Management
Medical Director (Executive Director)	Professional leadership – medical Responsible Officer (Medical Appraisal) Clinical Effectiveness Quality Account (joint with Director of Nursing) Caldicott Guardian Mortality reviews Clinical audit and effectiveness Medical-legal matters Research and Development Medical Education QIA approval (joint with Director of Nursing) Medicines Management Joint management of the Quality Directorate (with Director of Nursing) Chief Knowledge Officer

Director of Nursing (Executive Director)	Professional lead – nursing, midwifery, therapists Patient Safety Patient Experience Quality Account (joint with MD) Joint management of the Quality Directorate with Medical Director Risk management Infection, prevention and control (DIPC) Safeguarding adults and children Legal Services CQC lead (liaison and reporting) QIA approval (joint with Medical Director) CQUIN and Quality Schedule negotiation
Director of Finance (Executive Director)	Financial Recovery Plan Financial planning and performance Financial management and accounting Audit and counter fraud Performance management Oversight Capital planning and management Commissioning and Contracting Payroll Procurement Charitable Trustees Trust-owned companies and Wholly Owned Subsidiary project Wiltshire Health & Care Estate strategy and management Trust Strategy and business planning GP relationships Commercial – tenders co-ordination
Director of People & Organisational Development (Executive Director)	Human resources Health & Safety Learning, Training and development Equality and diversity (staff, patient and public) Corporate Communications Volunteers Chaplaincy Fire Safety Occupational Health Employment law Staff involvement Radiological Protection lead

Director of Transformation	Chief Information Officer Chief Clinical Information Officer Information Governance and records management Informatics Senior information risk owner (SIRO)
Director of Corporate Governance	Corporate Governance Well-Led Board Assurance Framework Board and Committee business and standards Integrated Governance Framework Foundation Trust Governors and members function

APPENDIX 3 – Salisbury Hospital NHS Foundation Trust Organisation Committee Assurance Map



APPENDIX 4 – ANNUAL REVIEW OF COMMITTEES

In devising their annual reviews, committees are requested to follow the template set out here

1. Conduct of business throughout the year

- Committee membership and any changes
- Frequency of meetings and register of attendances
- Administration arrangements
- Reports to Board

2. Terms of Reference

- Delivery against terms of reference and work programme
- Key decisions or recommendations
- Key risks identified and mitigations
- Key issues managed or escalated to board
- Any changes made or requested to the Terms of Reference

3. Future plans

- Areas of focus for the coming year

4. Timings of reviews

- Committees to review their effectiveness in Quarter 1 each year.

A report providing an overview of the outcomes of this process will be presented to the Board at their meeting in public in August each year.

APPENDIX 5 – TRUST MANAGEMENT COMMITTEE TERMS OF REFERENCE

Trust Management Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
March 2020	1.1	Major Revision	All sections revised	Corporate Governance Manager

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Corporate Governance Manager
Review and Approval	Trust Management Committee
Adoption and ratification	Board of Directors

1) Purpose

1. The Committee is established by the Chief Executive as the senior executive committee of Salisbury NHS Foundation Trust.
2. The Trust Management Committee is responsible for the coordination and operational management of the system of internal control and for the management of the achievement of the Trust's objectives as agreed by the Board of Directors.
3. It is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accounting Officer.

2) Authority

1. The Chief Executive has established an executive committee to be known as the Trust Management Committee (TMC).

2. The Trust Management Committee is accountable to the Board of Directors through the Chief Executive for the operational management of the Trust and delivery of objectives agreed by the Board.

3) Membership and Attendance

Membership

1. The Committee shall be appointed by the Chief Executive and shall consist of:
   - Chief Executive
   - Medical Director
   - Chief Operating Officer
   - Director of Finance
   - Director of Organisational Development and People
   - Director of Nursing
   - Director of Transformation
   - Divisional Managers
   - Clinical Directors
   - Chief Information Officer

2. Each Clinical Director or Executive Director may nominate a deputy to attend in their place if they are unable to attend. Other attendees may attend at the discretion of the Chair in support of specific agenda items.

Quorum

3. The quorum necessary for the transaction of business shall be half of members including at least two Executive Directors and at least one representative from the Divisional Management Teams.

4) Roles and Responsibilities

Strategy and Business Planning

1. Support the development of the Trust Annual Plan, including policy direction, revenue and capital finance and play a key role in developing and implementing the overall strategy of the Trust;
2. Clear recommendations to the Trust Board on key strategic and operational decisions which are retained by the Board;
3. To ensure effective arrangements are in place to manage key partnerships and stakeholder engagement;
4. Maintain the Board Assurance Framework, reviewing and mitigating gaps in evidence and assurance to align with and support the Trust's objectives.
5. To determine business cases for approval which require investment of £20k - £250k and ensure that approved business cases are reviewed within the agreed time-frame.

Operational, Quality and Performance

6. Ensuring collective and individual responsibility and accountability for delivering operations, required performance and addressing current and emerging risk to maintaining successful delivery;
7. Develop and monitor the implementation of plans to improve the efficiency, effectiveness, quality and safety of services;
8. Clear decision making in accordance with the decision making framework on a timely basis and subsequent communication as appropriate;
9. The monthly Integrated Performance Report will be circulated for information.
10. Receive assurance and have oversight of Care Quality Commission (CQC) preparedness and to ensure subsequent actions are effectively embedded.

Governance and Risk

11. Monitor the management of organisational risk;
12. Receive and review the Corporate Risk Register and manage actions to effectively mitigate risks;
13. Receive assurance that both the clinical and non-clinical Register of External Visits and Accreditations is maintained and that the outcome of these visits has been appropriately actioned;
14. Monitor the Register of Gifts, Interests and Hospitality.

Procedural Documents in line with the Policy for Policies

15. Review and approve procedural documents, including strategies, policies, protocols and procedures;
16. Monitor and provide updates for the schedule of Matters Arising and ensure agreed actions are appropriately and promptly completed.

Receive Reports from the following sub-groups*

17. Clinical Management Board (CMB)

    Operational Management Board (OMB)

    Trust Investment Group (TIG)

    Transformation Board

    Strategic Estates Committee

    Health and Safety Committee

    Executive Performance Reviews

    Information Governance Steering Group (IGSG)

    Digital Steering Group (DSG)

    Organisational Development and People Management Board

*Frequency of reporting to be dictated by the Committee's annual business cycle.

5) Conduct of Business

Administration

1. The Committee shall be supported administratively by the Executive Services Manager, whose duties in this respect will include:

   - Agreement of agendas with Chair and attendees and collation of papers;
   - Taking the minutes;
   - Maintain a record of matters arising and track the progress of actions delegated for action by the committee;
   - Provision of an escalation report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

2. It is the responsibility of the author to produce the paper and any supporting documents in the correct format. Papers not in the correct format will be sent back to the author for amendment.
3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Meetings will be held once a month.

Notice of meetings

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. Late papers are unacceptable and will only be added to the meeting papers after the deadline if permission has been given by the Chair of that meeting.
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

7. Formal minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.
9. The Committee will report to the Board of Directors annually on the performance of its duties as reflected within its Terms of Reference.
10. The Committee will report to the Board of Directors after six months on its effectiveness in meeting responsibilities as reflected within this Terms of Reference.
11. The Committee will receive minutes for information from the sub-groups listed under point 4.13 and from the following advisory groups:

    Joint Local Negotiating Committee (JLNC)

    Joint Consultative Committee (JCC)

    Operational Delivery Group

    Nursing, Midwifery and Allied Health Professionals Forum (NMAHP)

6) Review

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.

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.

APPENDIX 6 – BOARD COMMITTEE TERMS OF REFERENCE

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

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

1) Purpose

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

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. 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.
3. The Committee may take any legal or other professional advice with regard to the financial performance of the Trust as necessary.
4. The Committee is authorized 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

1. The Committee shall be appointed by the Board of Directors and shall consist of:
    - Three non-Executive Directors
    - Director of Finance (Lead Executive)
    - Director of Transformation
    - Chief Executive
    - Chief Operating Officer
    - Director of O.D. & People
2. A Non-Executive Director shall be appointed as Chair of the Committee.
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.

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

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

Attendance

7. Meetings of the Committee shall normally be attended by:
    - Core members defined in para 1 above
    - Deputy Director of Finance
    - Other directors and other staff by invitation
    - Governor observer
8. The Director of Corporate Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.
9. Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4) Roles and responsibilities

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

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

The duties of the committee can be categorised as follows:

Reporting

- To oversee the ongoing development of the Integrated Performance Report.
- To seek assurance that the measures incorporated in the Board report meet the requirements of external stakeholders.
- To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support operational management of the organisation.

- Monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.

- To review in detail via a deep dive any major performance variations, in order to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.

- To consider changes to the Trust reporting requirements under any new regulatory arrangements.

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 (including delivery of recovery and transformation plans) ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

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

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

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

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.

Annual Trust planning cycle

- To consider the Trust's medium & 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, linked to the Trust's Corporate Objectives.

- To ensure that the Trust has an appropriate Recovery and Transformation Programme in place and provide Board level oversight of its delivery

- Consider proposals for Commercial and Business Development activities in accordance with Standing Financial instructions. The Finance and Performance Committee has delegated authority to approve revenue business cases from £250k - £500k. The Committee has delegated authority to approve capital business cases from £300k - £750k.

- Review the process for developing the transformation plan and for the oversight and delivery of the programme within the Trust. Consider and recommend any major transformation programmes that the Trust should undertake.

- Review the annual CIP and transformation plan 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 Carter metrics) 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.

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).

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.

Risk Management

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

Other

- To review any matter 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

1. The Corporate Governance Manager shall be Secretary to the Committee
2. The Committee shall be supported administratively by the Corporate Governance Manager, 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 in conjunction with the Committee Chair.

Frequency

3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
4. Meetings will be held at least twelve times per year, with additional meetings where necessary.

Notice of meetings

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
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

7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
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. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.
9. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6) Review

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.
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.
3. These terms of reference were reviewed and approved by Trust Board on {INSERT DATE}

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

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1) Purpose

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

2) Authority

1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee (the Committee).
2. The Committee is a standing committee of the Board of Directors (the Board).
3. A non-executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference
4. The Committee is authorized to monitor, scrutinize and where appropriate, investigate any quality activity considered to be within its terms of reference

3) Membership and Attendance

Membership

1. The Committee shall be appointed by the Board of Directors and shall consist of:
    - Three Non-Executive Directors
    - Medical Director, Director of Nursing (joint Lead executive)
    - Chief Operating Officer
2. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.
3. A Non-Executive Director shall be appointed as Chair of the Committee.
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

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

Attendance

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

- Any nominated deputy attending in place of a designated Committee member.
- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.
- The PA to the Director of Nursing and Medical Director will act as Secretary to the Committee.
- Governor observer
- The Director of Corporate Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

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

1. The function of the Committee is to ensure:

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

ii) 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.

iii) 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

iv) Support for the Trust's objective to strive for continuous quality improvement and outcomes, through the Care and Innovation objectives.

v) 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

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

i) Development and Review

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

ii) Review of Trust activity in assigned area

Patient Safety:

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

Clinical Effectiveness / Clinical Outcomes:

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

Patient Experience:

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

- Review of the patient experience quarterly report
- Agree the annual patient experience/engagement plan and monitor progress.
- Receipt of reports regarding patient experience and engagement and review the results and outcomes of local and national patient surveys

Learning:

- 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.

iii) Policy monitoring and review

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

5) Conduct of Business

Administration

1. The PA to the Director of Nursing and Medical Director shall be Secretary to the Committee
2. The Committee shall be supported administratively by the PA to the Director of Nursing and Medical Director whose duties in this respect will include:

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

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

Frequency

3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
4. Meetings will be held 12 times per year, with additional meetings where necessary.

Notice of meetings

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
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

7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
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. 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.
9. Reporting arrangements into the Committee from Sub-Committees

The following groups and committees report to the Clinical Governance Committee:

- Clinical Management Board (Minutes and raising concerns)
- Infection Prevention and Control Committee (Minutes and raising concerns)
- Clinical Risk Group (Minutes and raising concerns)
- Children and Young People's Quality & Safety Board (Minutes and raising concerns)
- Integrated Safeguarding Committee (Minutes and raising concerns) NB: quarterly reports presented to the CGC.

6) Review

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.

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.

4. These terms of reference were approved by the Clinical Governance Committee with amendments and ratified by the Board of Directors on {INSERT DATE}

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	Major	Annual Revision	Corporate Governance Manager

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1) Purpose and function

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

    - That the Trust has a clear understanding of its strategic workforce needs and that plans are in place to deliver these;
    - That the Board receive assurance that all legislative and regulatory requirements relating to the workforce are met;
    - That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented.

2. To achieve this, the Committee shall:
    - Support the development and monitoring of a workforce strategy
    - Champion workforce issues ensuring adequate oversight of all workforce areas by the Board.

3. The Committee shall discharge this function on behalf of the Board of Directors by:
    - Monitoring key workforce metrics to ensure that the expected standards are being delivered
    - Receiving reports to provide assurance around compliance with legislation and regulations
    - Considering workforce plans and improvement plans on behalf of the Board

2) Authority

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. The Committee is a standing committee of the Board of Directors (the Board).
3. The Committee is a Non-Executive Committee and has no Executive powers.

3) Membership and Attendance

Membership

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

    - Two Non-Executive Directors
    - Director of Organisational Development (OD) & People (Lead Executive)
    - Medical Director
    - Director of Nursing
    - Director of Transformation

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

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

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

Attendance

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

- Deputy Director of OD & People
- Associate Director of Education, Inclusion, Communication and Engagement
- Director of Medical Education
- Deputy Director of Nursing

And others by invitation

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

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

1. Oversee progress on the development and delivery of workforce, OD and cultural change strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives.
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.
3. Oversight of the delivery of the HR operating plan and associated policy management.
4. Maintaining oversight of the business of the newly developed 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.
5. Oversight of the development and delivery of the People Strategy and the people aspect of the Clinical Strategy

6. Monitor effectiveness of compliance with local and National staff surveys and the implementation of action plans to deliver against identified areas of concern.
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.
8. Oversee the implementation of Internal Audit recommendations as directed by the Audit Committee
9. To receive and review quarterly and annual reports of the Guardian of Safe Working on the Board's behalf.
10. To receive and review quarterly reports of the Freedom to Speak up Guardian, including an annual report.
11. To receive and review Safe Staffing reports to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the needs of patients and service users.
12. Maintaining oversight of the Trust's employment related equality, diversity and inclusion agenda. To receive and review the minutes of the Equality and Diversity Committee.

5) Conduct of Business

Administration

1. The PA to the Director of OD and People shall be Secretary to the Committee
2. The Committee shall be supported administratively by the PA to the Director of OD and People 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

3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
4. Meetings will be held at least nine times per year, with additional meetings where necessary

Notice of meetings

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

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

7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
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.
9. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.
10. The Committee will receive, for oversight and information, the minutes of the following committees:

- Medical Education and Training Committee
- Diversity and Inclusion Committee
- Health and Safety Committee
- JCC
- JNC
- Safe Staffing Steering Group
- Organisational Development and People Management Board

6) Review

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.

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.

3. These terms of reference were approved by the People and Culture Committee with amendments on and ratified by the Board of Directors on {INSERT DATE}.

Audit Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	Director of Corporate Governance
March 2020	2.1	Minor	Annual Revision	Director of Corporate Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate 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. 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
2. Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes
3. Review the effectiveness of the Trust's internal audit and external audit function; and
4. 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.
5. Report to the Board as to how it is discharging its responsibilities as a Committee

2) Authority

1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee.
2. The Committee is a standing committee of the Board of Directors (the Board).
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.
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.
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

1. The Committee shall be appointed by the Board of Directors and shall consist of four Non-Executive Directors, with at least one of whom shall have recent and relevant financial experience.
2. A Non-Executive Director shall be appointed as Chair of the Committee.
3. The Chairman of the Board of Directors shall not be a member of the Committee.
4. The Chair of the Committee shall not be the Senior Independent Director of the Board of Directors.

Quorum

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

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

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

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

4.1 Financial reporting

The Committee shall:

a) Ensure the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain
b) Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement, focusing in particular on:
    - Any changes in accounting policies and practices
    - Major judgmental areas
    - Value for Money considerations
    - Significant adjustments arising from the audit
    - The going concern basis

- Compliance with accounting standards
- Major risks to the Trust

c) Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust.
d) Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements)
e) Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of both the Trust Executive and the External Auditor
f) Review the clarity of disclosure in the Trust's financial reports and the context within which statements are made
g) The Committee Chair shall report formally to the Board on its proceedings after each meeting on all escalation matters
h) The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

4.2 Governance, Risk Management and Internal Control

The Committee shall:

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

4.3 Internal Audit and Counter Fraud

The Committee shall:

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

4.4 External Audit

The Committee shall:

a) In conjunction with the Director of Finance, 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 Director of Finance and the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors
c) Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts
d) Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted
e) Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work
f) Meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit

g) Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, and the impact on the audit fee
h) Review all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

4.5 Other Board Assurance Functions

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

5). Reporting and Accountability

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

f) The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year
g) The Committee shall review its own terms of reference annually.

6) Conduct of Business

Administration

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

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

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

Enabling the development and training of Committee members

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

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

Notice of meetings

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

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

Subsidiary Governance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1.0	Major	Drafted	Director of Corporate Governance
Jan 2019	1.0	Minor	Minor amendments agreed at the first meeting	Director of Corporate Governance
May 2020	1.1	Minor	Annual Revision	Director of Corporate Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Finance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose

The Committee is established to provide the Board of Directors with assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company (known as related company/entity).

2. The committee is established to:

- Ensure that where the Trust has an interest, or shareholding, the Trust has appropriate oversight and governance

3. Authority

3.1. The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Subsidiary Governance Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

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

3.3. The Committee is authorised to:

- Perform any of the activities within its terms of reference;
- Obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- Consider and make recommendations to the Board of Directors any and all items of which they should be aware to fulfil their responsibility

4. Membership and Attendance

Membership

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

- Non-Executive Directors
- Independent Chairman of OML and STL
- Director of Finance
- Director of Organisational Development and People.

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

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

Quorum

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

Attendance (non-voting members)

4.4. Meetings of the Committee shall be attended by:

- Director of Corporate Governance
- Specialist expertise as required

Attendance by Other Trustees

4.5. Any member of the Board of Directors can attend.

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

5. Roles and Responsibilities

The duties of the Committee can be categorised as follows:

5.1. Ensuring the Trust has a clear strategy for the use and development of subsidiary and related companies/entities.

5.2. Maintaining a clear view of the subsidiary level risk profile and exposure (operational, reputational and financial) across the group profile.

5.3. Ensuring the Trust has a clear governance framework and structure for oversight of any related company/entity. This framework will ensure:

- That any related company/entity identifies and evaluates all potential commercial opportunities in line with its agreed strategy.
- That any related company/entity complies with its relevant industry regulatory framework.
- That the related company/entity achieves the planned financial and operational performance levels.
- That the related company/entity has due regard for the issue of public accountability in the context of ethical responsibilities, corporate and social responsibility, statutes and other regulations e.g. tax.
- That the related company/entity has appropriate governance mechanisms in place (including SFI's, business planning process).

- The process for appointing the senior leadership team (Managing Director, Non-Executive Directors).

6. Conduct of Business

Administration

The Director of Corporate Governance is a member of the committee and has corporate responsibility for:

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

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

6.3. Identifying an officer to undertake the role of secretary.

Frequency

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

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

Notice of meetings

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

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

Reporting

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

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

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

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

7. Review

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

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

Charitable Funds Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Minor	Added role of secretary to the Committee	Director of Corporate Governance
June 2020	2.1	Minor	Annual Revision	Director of Corporate Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose

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

1.2. 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.

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

2. The committee is established to:

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

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

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

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

3. Authority

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

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

3.3. The Committee is authorised to:

- Perform any of the activities within its terms of reference;

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

4. Membership and Attendance

Membership

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

3 Non-Executive Directors
2 Executive Directors, of which one is the Director of Finance (lead Executive)

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

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

Quorum

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

Attendance

4.5. Meetings of the Committee shall be attended by:

- Associate Director of Strategy
- Financial Controller or Financial Accountant
- Director of Corporate Governance
- Representative from the Fundraising Team
- Fund Manager (as defined in Standing Financial Instructions)

Attendance by Others

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

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

5. Roles and Responsibilities

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

Assurance

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

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

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

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

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

Investments

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

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

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

Fundraising

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

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

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

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

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

6. Conduct of Business

Administration

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

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

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

6.4. The Director of Corporate Governance will act as the role of secretary to the Committee.

Frequency

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

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

Notice of meetings

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

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

Reporting

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

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

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

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

7. Review

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

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

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
May 2020	1.1	Minor	Annual Revision	Director of Corporate Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Rem com 4th June 2020
Adoption and ratification	Trust Board

1) Purpose

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

2. When appointing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

2) Authority

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. 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.
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.
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

1. The membership of the Committee shall consist of:

- The Trust Chair
- The other Non-Executive Directors
- And in addition, when appointing Executive Directors (other than the Chief Executive), the Chief Executive.

2. The Trust Chair shall chair the Committee
3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair.

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

Quorum

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

Attendance

3.6 Only members of the Committee have the right to attend the meetings

3.7 At the invitation of the Committee, meetings may be attended by the Director of OD & People

Secretary

3.8 The Director of Corporate Governance shall be secretary to the Committee

4) Duties

4.1 Appointments

The Committee will:

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

4.1.2 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account 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 candidates to fill posts within its remit as and when they arise.

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

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

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

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

4.2 Remuneration

The Committee will:

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

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

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

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

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

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

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

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

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

5) Conduct of Business

Administration

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

Frequency

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

Notice of meetings

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

Reporting

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

6 Review

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

Appendix 7: Version control

Document Title	Integrated Governance Framework			
Date Issued/Approved:	TBC 2nd July 2020			
Date Valid From:	2nd July 2020			
Date Valid To:	1st July 2021			
Division / Department responsible (author/owner):	Director of Corporate Governance			
Brief summary of contents	Description of the integrated governance operated within the Trust. It is designed to ensure the delivery of high quality patient focussed care from an organisation that is well managed, cost effective and has a well-trained and motivated work force.			
Executive Director responsible for Policy:	Chief Executive			
Date revised:	24 June 2020			
Approval route (names of committees)/consultation:	Trust Board			
Name and Post Title of additional signatories	Not Required			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet		Intranet Only	x
Document Library Folder/ Folder	Constitution			

Links to key external standards	Well-Led Framework
Related Documents:	Accountability Framework Constitution Standing Orders Standing Financial Instructions Scheme of Delegation
Training Need Identified?	No

Version Control Table

Date	**Version No**	**Summary of Changes**	**Changes Made by** *(Name and Job Title)*
1 March 2017	V1.0	Initial Issue	David Seabrooke Head of Corporate Governance
1 April 2017	V2.0	Completed version	David Seabrooke Head of Corporate Governance
8 August 2017	V 3.0-	Amended Exec responsibilities from away awayday – appendix 4	David Seabrooke Head of Corporate Governance
16 November 2017	V v4.0	Minor amendments to exec responsibilities and introduction of OETB	David Seabrooke Head of Corporate Governance
22 January 2018	V 5.0	Introduction of Trust Management Committee and Strategy Committee	David Seabrooke Head of Corporate Governance
20 February	V 5.1	Minor updates and clarifications; addition of Charitable Trustees	David Seabrooke Head of Corporate Governance
19 March 2018	V5.2	Comments by CEO and DoN Attendance at Strategy C'ttee Removed Exec Oversight of Directorates (previously extracted from Accountability Framework) and individual extract of Terms	David Seabrooke Head of Corporate Governance

		of Reference of Trust Management Team Proposed removal of committee memberships Added review of committees Added Nominations Committees	
26 March 2019	V6.0	Document updated to reflect changes to Board Committees including introduction of a Subsidiary Governance Committee, update to accountabilities of direct reports to the chief executive and condensing of content to remove duplication	Fiona McNeight Director of Corporate Governance
2 July 2020	V6.1	Document updated to reflect the changes as a result of the Internal Audit of Board Compliance and Reporting in November 2019. The Strategy Committee has been removed. The Workforce Committee's name has been changed to People and Culture Committee. Charitable Funds Committee and Remuneration Committee Terms of Reference added. Directorates are now called Divisions. The Divisional Governance Committee remit has been strengthened.	Fiona McNeight Director of Corporate Governance

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This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.3
Date of Meeting:	02 July 2020		

Report Title:	Fit and Proper Person Policy			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Appendix 1: Fit and Proper Person Policy Self-Declaration Form Appendix 2: Fit and Proper Person Policy Summary Guidance Appendix 3: Ratification Checklist Appendix 4: Equality Impact Assessment			

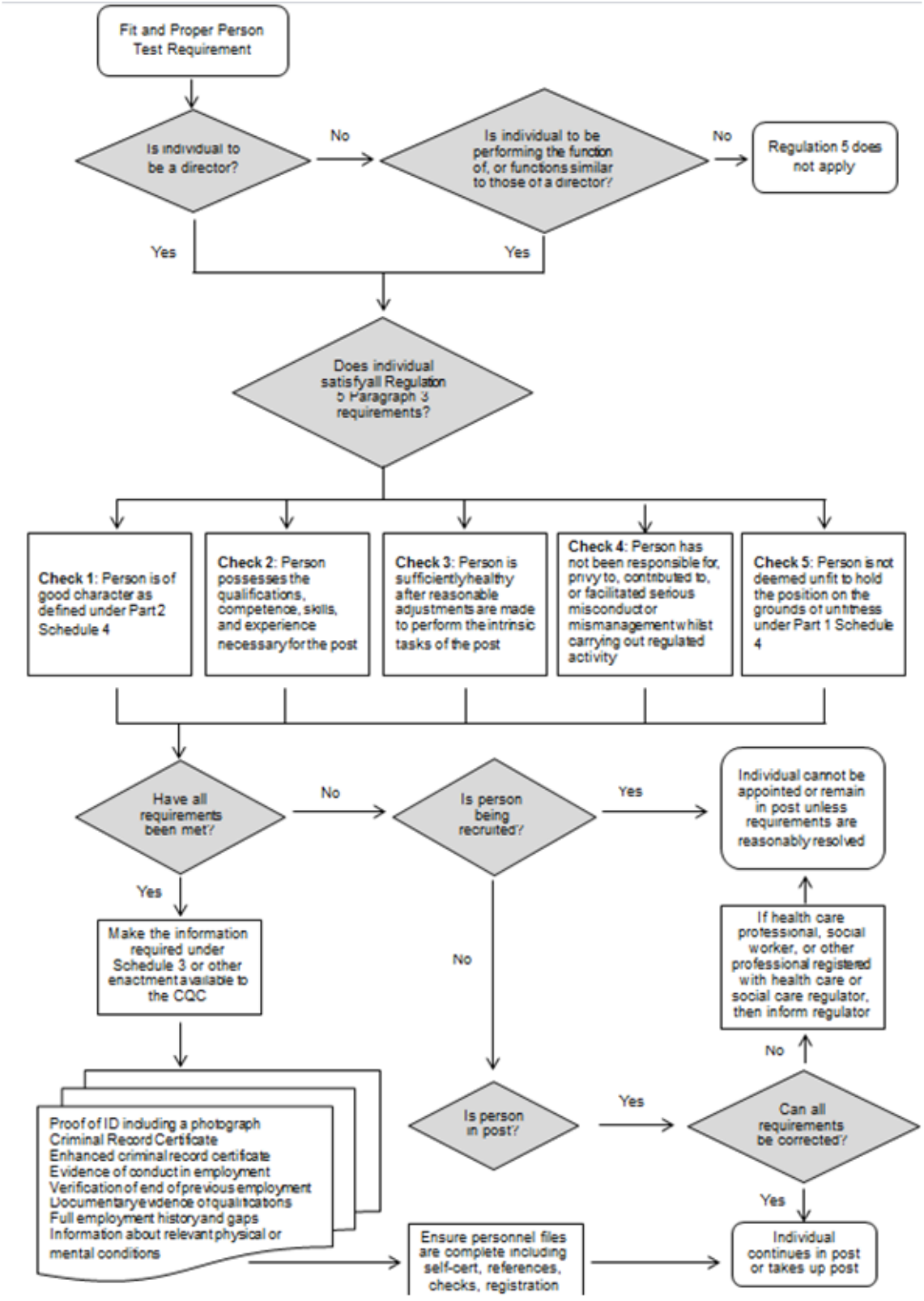
Recommendation:
The Board to ratify the Fit and Proper Person Policy

Executive Summary:
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into effect for NHS Providers on 27 November 2014 requiring directors to be fit and proper persons (Regulation 5). Regulation 5 establishes a statutory requirement on all NHS providers not to appoint, or have in place, an individual as a Director (Executive or Non-Executive), or "performing the functions of, or functions equivalent or similar to the functions of a Director" unless they satisfy the requirements as set out in the Regulations (Regulation 5(2)). In January 2018, the Care Quality Commission (CQC) published updated guidance for providers on compliance with Regulation 5. Whilst there have been no changes to the regulation, the guidance provided more detail and clarity on the CQC's expectations of providers in implementing the regulation, particularly in respect to determining misconduct and mismanagement. The FPP test is integrated into the CQC registration requirements and the regulatory and inspection approach. The Trust did not have a policy; this is a new policy. The policy was approved at Operational Management Board on 16th June 2020. The Board is asked to ratify the policy given it predominantly affects them.

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

Fit and Proper Person Requirement (FPPR) Policy (non-clinical policy)

1. Quick reference guide



Policy: Fit and Proper Person Policy
Version No 1
Author: Director of Corporate Governance
Review Date TBC

2. Introduction

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

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

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

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

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

Version details (should follow the introduction)

Version No.	Updated By	Updated On	Description of Changes
1	Director of Corporate Governance	March 2020	New policy

3. Purpose

The purpose of this document is to provide the policy and procedures by which Salisbury NHS Foundation Trust (SFT) will support its commitment to the fit and proper person requirements (FPPR), and to ensuring it is not managed or controlled by individuals who present an unacceptable risk either to the Trust or to the people receiving services; that SFT Directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.
The purpose of the Regulation is to ensure that all board level appointments at NHS bodies carrying on a regulated activity are held responsible for the overall quality and safety of the care provided, for making sure the care meets the existing regulations and effective requirements of the Health and Social Care Act, and that providers and directors can be held to account. Services must be safe, effective, caring, responsive and well-led.

4. Scope

This policy applies to all directors whether executive, non-executive, permanent, interim, deputy or associate directors; irrespective of their voting rights. The requirement does not apply to the Council of Governors. Although it is for SFT to determine which individuals fall within its scope, the CQC will take a view on how effectively SFT has discharged its responsibility. However, the CQC will not undertake the fit and proper person's test of a director, or determine what is serious mismanagement or misconduct[1]

5. Duties and responsibilities

5.1 Trust Board of Directors

Is responsible for:

- Approving this policy and subsequent amendments

5.2 Director of Corporate Governance

Is responsible for:

- Keeping this policy and its procedural requirements updated in accordance with regulatory guidance and best practice
- Arranging for existing and prospective directors to make the necessary annual declarations
- Notifying all directors that they are responsible for informing the Trust if they have reason to believe that they no longer meet the fit and proper person standard
- Assessing and reviewing the fitness of directors every 3 years
- Making the information required by Regulation 5 or other enactments available for CQC inspection
- Retaining the Fit and Proper Persons documentation
- Ensuring the relevant information is retained for each director in accordance with the Regulation 5 requirements within their personal files, held in Trust Headquarters.
- Ensuring the checks outlined in 7.1.2 are completed.

5.3 Recruitment Team

Is responsible for:

- Ensuring the relevant pre-employment checks are carried out satisfactorily, and including the NHS Employment Check Standards as required

5.4 Head of Resourcing

Is responsible for:

- Ensuring checks and procedures to implement the regulatory requirements are followed.
- Updating the contracts of employment and related relevant employment and recruitment policies to reflect the requirements of this policy.

6. Definitions

Director

A Board Director of the Trust

Deputy/Associate Director

A direct report of a Board Director

Non-Executive Director

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

Fit and Proper

Directors must satisfy all the requirements set out in Regulation 5(3) and be declared fit and proper persons. Individuals must be of good character, have the necessary qualifications, competence, skills and experience for the relevant office or position for which they are employed; have the appropriate level of physical and mental fitness [1] have not been responsible for or privy to any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity, and not be deemed unfit under the Regulation provisions.

Unfit

In accordance with schedule 4 part 1 of the 2014 Regulations, a person is deemed “unfit” if:

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

Good Character

In accordance with Schedule 4 Part 2 of the 2014 Regulations, the Trust (via the Chair) will take into consideration, in determining whether an individual is of good character, whether he or she:

- Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence;

- Has been erased, removed, or struck off a register of professionals maintained by a regulator of health care or social work professionals.

1 i.e. the individual is capable by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed

Determining Misconduct and Mismanagement

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

Mismanagement

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

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

Misconduct

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

- Disrespect in the work place
- Failing to comply with lawful instructions
- Breach of confidentiality;
- fraud or theft;
- any criminal offence (other than minor motoring offences) such as assault; sexual harassment of staff; bullying; victimisation of staff who raise legitimate concerns;

Any conduct that can be characterised as dishonesty, including:

- Deliberately transmitting information to a public authority or to any other person, which is known to be false;
- Submitting or providing false references or inaccurate or misleading information on a CV;

- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process;
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues;

All relevant post holders are obliged to complete a declaration form (Appendix 1) on appointment in accordance with paragraph 7.1 below, and, where already appointed, an annual FPPR declaration in accordance with paragraph 7.2 below. This declaration will be retained on the individual's personal file by the Director of Corporate Governance. Where concerns are raised about a Director's fitness (whether such matters are self-declared, or of which the Trust becomes aware via other means), the Trust shall investigate the issue in accordance with paragraphs 7.1 to 7.3 below, and shall (where the individual is determined not to be fit, in consequence of that investigation):

(a) take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets the requirements of the 2014 Regulations, and
(b) if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the relevant regulator.

7. Process

7.1 Process for new appointments

7.1.1. Pre and post-employment checks will be completed in line with the Trust Policy. These include the following:

- Proof of identity;
- DBS check to the level required by the role;
- Occupational Health Clearance as relevant to the role;
- Evidence of the right to work in the UK;
- A check of employment history and two references one of which must be the most recent employer. A minimum of three years continuous employment including details of any gaps in service need to be validated.
- Qualifications/registration applicable to role.

7.1.2. In addition, the following registers will be checked:

- Disqualified directors
- Bankruptcy and insolvency
- Removed Charity Trustees
- A web search of the individual.

7.1.3. All new appointments into the relevant posts need to complete a FPPR Declaration form (Appendix 1). This form and summary guidance (Appendix 2) will be sent as part of the pre-employment documentation.

7.1.4. The Trust will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent'. However, there is no time limit for considering serious misconduct or responsibility for failure in a previous role. In consideration of any instances of serious misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC.

7.1.5. The Chair of the appointments panel for Board members will be responsible for ensuring compliance supported by the Director of Corporate Governance and Director of Organisational Development and People. A detailed checklist will be completed and will be retained on the director's personal file for the purposes of audit by CQC). For non-Board members (i.e. Associate Director and

those with 'Director' in their job title and who report to an Executive Director) covered by this policy, the Recruitment Team will ensure that all appropriate checks are undertaken and recorded via Trac. The only additional check required for non-Board member is the FPPR declaration form.

A copy of all FPPR forms will be retained centrally by the Director of Corporate Governance.

7.1.6. The Council of Governors is responsible for the appointment and removal of the Chair and the Non-Executive Directors, drawing on the recommendations of the Council of Governors' Appointments Committee. In respect of Executive Directors, this responsibility will be discharged by the Board of Directors' Nomination and Remuneration Committee which is responsible for the appointment and removal of the Executive Directors. Any appointment to a relevant post will take into account the Trust's obligations under the Regulations.

7.1.7. Where the Trust deems that the individual who is to be appointed is of good character notwithstanding the presence of a matter outlined in Schedule 4, Part 2 of the Regulations (Good Character), the reasons will be recorded in the minutes of the relevant meeting: i.e. the Board of Directors' Nomination and Remuneration Committee (in the case of Executive Directors) or the Council of Governors and the Council of Governors' Appointments Committee (in the case of the NEDs) and the information about the decision will be made available. The appointment process will include an evaluation against the Trust's values, and any relevant external guidance. External advice will be sought as necessary.

7.1.8. Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

7.1.9. The Trust will carry out employment checks (so far as reasonably practicable) on a candidate's qualifications and employment records.

7.10. Where the Trust considers that an individual can be appointed to a role based on their qualification, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timescale any such discussions or recommendations will be recorded in the minutes of the Appointments Committee or Nomination and Remuneration Committee, as applicable. Any discussion, recommendation or decision must also be recorded in the minutes.

7.11. If the Director has a physical or mental disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Where a physical or mental health concern is identified the appointment will be subject to clearance by Occupational Health as part of the pre-appointment process. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded in the minutes of the Appointments Committee or Nomination and Remuneration Committee, as applicable.

7.12. The Chair will be notified of any issues of non-compliance and is responsible for making an informed decision on the course of action to be followed with regard to the appointment of the executive and non-executive directors.

7.2 Process for considering on-going fitness

7.21 The Trust shall regularly review the fitness of directors to ensure that they remain fit for the role they are in. Annually, there will be a requirement for all Executive and Non-Executive Directors, to complete a further form of declaration confirming that they continue to be a fit and proper person. Confirmation of compliance will be published in the Trust's Annual Report.

7.22. The process for assurance includes a check of personal files to ensure there is a complete employment history and where there are any gaps or omissions the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration the individual will be asked to produce the original for inspection and verification.

7.23. The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust's values and behaviour standard including the leadership behaviour expected. The Chief Executive will be responsible for appraising the Executive Directors. The Chair will be responsible for appraising the Non-Executive Directors. The Chief Executive will be appraised by the Chair. The Chair will be appraised through the agreed appraisal process that includes feedback from Governors, Non-Executive Directors and Executive Directors, lead by the Senior Independent Director.

Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust using the Fit and Proper Persons Requirement Disclosure Form (Appendix 1). For Board directors, the Fit and Proper Persons Requirement Disclosure Form for existing post holders will be considered by the Chair and Director of Corporate Governance. The annual consideration will include other matters raised in the year. An annual statement will be filed onto the personal file.

7.3 Action to consider for concerns about an individual's continued FPPR compliance

7.3.1 Where matters are raised (whether in the course of new appointments, or annual declarations made under paragraphs 7.1.1 or 7.1.2, or other matters that come to the Trust's attention in other ways) that cause concerns relating to an individual being fit and proper to carry out their role, the Chair will address this in the most appropriate, relevant and proportionate way on a case by case basis. In consideration of any potential misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC. Where it is necessary to investigate or take action, the Trust's current capability or disciplinary processes will apply. There may be occasions where the Trust would contact NHS Improvement/England for advice or to discuss a case directly.

7.3.2. The Trust reserves the right to suspend an Executive and Non-Executive Director, or restrict them from duties on full pay / adjusted pay (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

7.3.3. Should there be sufficient evidence to support a conclusion that the individual is not or is no longer fit and proper, then the Trust shall take such action that is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements. As such, the Trust may terminate the appointment of the Executive / Non-Executive Director with immediate effect, in line with the Trust's Disciplinary Policy.

7.3.4. Where an individual who is registered with a professional regulator (GMC, NMC etc.) no longer meets the FPPR the Trust must also inform the relevant regulator.

7.4 Record of information and supply to the CQC

7.4.1 The Trust may make available information to the CQC relating to an individual's compliance with the requirements of the 2014 Regulations, and in particular, shall maintain a record of (and may make available), in respect of each Director:

- Proof of identity including a recent photograph.

- Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997, a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request).

- Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

- Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to —
  (a) health or social care, or
  (b) children or vulnerable adults.

- Where the Director has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why their employment in that position ended.

- In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

- A full employment history, together with a satisfactory written explanation of any gaps in employment.

- Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

7.4.2 Where the Trust is required under any enactment to maintain information which is relevant to the individual, this must also be available to be supplied to CQC.

7.5 Board of Directors / Council of Governors Assurance

7.5.1 The Council of Governors' Appointments Committee or the Board of Directors' Nomination and Remuneration Committee, depending on type of appointment, will receive a report to confirm the outcome of the annual FPPR checking process. The committees will also receive reports regarding new appointments. The Chair is the responsible officer for ensuring compliance for new starters. A summary of compliance will appear in the Trust's Annual Report.

7.6 Training requirements

7.6.1 Training will be provided by the Corporate Governance Team to Executive / Non-Executive Directors around the declarations to be made.

8. Monitoring Compliance With and the Effectiveness of this policy

An annual review of compliance against all of the elements defined within this policy will be presented to the Board of Directors.

Objective	Evidence	Method	Frequency	Responsible	Committee
To ensure the Trust is in compliance with CQC regulation 5	Documentation to evidence appropriate checks being carried out (relevant certificates; proof of identification; and so on)	Collection of documentation to evidence checks on appointment of directors/those with equivalent responsibilities	On appointment of candidate.	Head of Resourcing and Director of Corporate Governance	Trust Board
The implementation of the policy is in compliance with relevant CQC regulations.	Evidence of review/approval of proposed revisions by authorising group.	Review of Policy on an annual basis to ensure CQC compliance – as well as that policy is fit for purpose.	Annual Review Note: this is not conducted quarterly as it can only be conducted on appointment of a candidate	Director of Corporate Governance	Trust Board

9. References

Regulation 5 Fit and Proper Persons: Directors and Regulation 20 Duty of Candour, Guidance for NHS Bodies, Care Quality Commission November 2014.

Guidance for Providers on Meeting the Regulations, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended), Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended), Care Quality Commission February 2015.

Regulation 5 Fit and Proper Persons: Directors, Information for NHS Bodies, Care Quality Commission March 2015.

Regulation 5 Fit and Proper Persons: Directors, Information for providers of Adult Social Care, Primary Medical and Dental Care, and independent Healthcare, Care Quality Commission March 2015.

Regulation 5: Fit and Proper Persons: Directors – Guidance for Providers and CQC inspectors – January 2018

NHS Employment Check Standards revised July 2013.

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers 'Criminal Record and Barring Checks' dated July 2013.

NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers ‘Work Health Assessments’ dated 2013.

National Clinical Assessment Service 'Protocol for Reviewing Health Professional Alert Notices' dated April 2013.

National Clinical Assessment Service 'NCAS Operational Protocol: Issue of Health Professional Alert Notices' dated April 2013.

NHS Employers 'Identity Checks' dated July 2013.

NHS Employers 'Right to Work Checks' dated June 2014.

Equality Impact Assessment for policies

10. Equality Impact Assessment for policies

Salisbury NHS Foundation Trust aims to design and implement services and policies that meet the diverse needs of its services, population and workforce, ensuring that none are placed at a disadvantage over others

This document has been assessed against the Trust’s Equality Impact Assessment Tool. This document has been assessed as not relevant to the duty.

11. Appendices

Appendix 1: FPPR Declaration Form
Appendix 2: FPPR Summary Guidance

Post Holder /Author Responsible for Policy:	Fiona McNeight Director of Corporate Governance
Date Written:	31 December 2019
Approved By:	
Ratified by:	
Next Due for Review:	

CONFIDENTIAL WHEN COMPLETE

Salisbury NHS Foundation Trust

Guidance for providers

How to meet Regulation 5: Fit and proper persons: directors

You can view the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 via this link:
http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents

Regulations 5 and 20 came into force for NHS bodies on 27 November 2014

The position for which you have applied/currently hold is subject to Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (the Regulations"). The Regulations requires that Salisbury Hospital NHS Foundation Trust (the "Trust") must not appoint, or have in place, a) an individual as a director of the Trust, or b) performing the functions of, or functions equivalent or similar to the functions of a director, without being satisfied that the individual is a fit and proper person to hold such a position.

The Trust aims to promote equality of opportunity and is committed to treating all applicants for positions and existing staff fairly and on merit regardless of race, disability, age, gender, gender re-assignment, religion or belief, sexual orientation, pregnancy or maternity, marriage or civil partnership.

The information that you provide in this declaration form will be processed in accordance with the General Data Protection Regulation and Data Protection Act 2018. It will be used for the purpose of determining your application for the position for which you have applied or assessment of your suitability to continue in your current role. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud. Any information provided during your application/continued employment shall be processed and retained in accordance with the Trust's Privacy Statement (see below).

Directors to self-declare that they are compliant with the requirements of the regulations:

5—(1) This regulation applies where a service provider is a health service body.
(2) Unless the individual satisfies all the requirements set out in paragraph **(3),** the service provider must not appoint or have in place an individual—
(a) as a **director** of the service provider, or
(b) performing the functions of, or functions equivalent or similar to the functions of, such a director.

(3) The requirements referred to in paragraph (2) are that—
(a) the individual is of **good character**,
(b) the individual has the **qualifications, competence, skills and experience** which are necessary for the relevant office or position or the work for which they are employed,

(c) the individual is able by reason of their **health**, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
(d) the individual has not been **responsible for, been privy to**, contributed to or facilitated any **serious misconduct or mismanagement** (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

(4) In assessing an individual's character for the purposes of paragraph (3) (a), the matters considered must include those listed in Part 2 of Schedule 4.

(5) The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or (b)—
(a) the information specified in Schedule 3, and
(b) such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.

(6) Where an individual who holds an office or position referred to in paragraph (2) (a) or (b) no longer meets the requirements in paragraph (3), the service provider must—

(a) take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
(b) if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

SCHEDULE 4 Good character and unfit person tests

PART 1 Unfit person test

Please respond to the following questions by indicating your response by circling Yes or No

1. The person is an undischarged **bankrupt** or a person whose estate has had sequestration awarded in respect of it and who has not been discharged. **Yes/No**
2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland. **Yes/No**
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986. **Yes/No**
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it. **Yes/No**
5. The person is included in the children's **barred** list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland. **Yes/No**
6. The person is **prohibited** from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment. **Yes/No**

PART 2 Good character

7. Whether the person has been **convicted** in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

8. Whether the person has been erased, removed or **struck-off** a register of professionals maintained by a regulator of health care or social work professionals.

Please choose one option below.

☐ **I confirm that I MEET the Fit & Proper Persons and Good Character requirements set out above.**

☐ **I confirm that I DO NOT MEET the Fit & Proper Persons and Good Character requirements set out above. If you have chosen this option, please provide details in the box below.**

Declaration Privacy Statement

As an employee or applicant for employment by the Trust, your personal information is processed (created, stored and transmitted) in a variety of paper and electronic formats by the Trust in accordance with the provisions of current data protection law. The General Data Protection Regulation (GDPR) Article 6, paragraph 1b) – *processing is necessary for the performance of a contract to which the data subject is a party…..* is the lawful basis for using your data.

Personal data includes that relating to ethnic origin, health, disability, religious belief, sexual orientation, genetic and biometric data and gender identity. You will have been asked to provide personal sensitive information during the recruitment process. The Trust is obliged to seek this information from staff but it is not compulsory for staff to provide responses. Access to and the sharing of this information is controlled very carefully. When reporting on personal sensitive information only aggregate data is presented so that an individual's data is protected.

For more information about how your personal information is collected, used, stored and shared please visit our website:
http://www.salisbury.nhs.uk/InformationForStaff/YourInformation.aspx

There is a legal obligation on the Trust as employer, (see Article 10 of GDPR) to provide information regarding the commission of offences, or alleged commission of any offence, or any proceedings for any offence committed, the disposal of proceedings, or the sentence of any courts of any such proceedings.

The Trust will not retain this Declaration Form for longer than is necessary accordance with the NHS Code of Practice: Records Management. Your completed form will be kept securely and in confidence. Access to the information contained within the Form will be restricted to designated persons within the Trust who are authorised to view it as a necessary part of their work. It may also need to be disclosed to the Care Quality Commission (CQC) or, where applicable your Professional Regulator.

In signing the Declaration below you are explicitly consenting for the data you provide to be processed in the manner described above.

I hereby consent to the information provided in this Declaration Form being used by Salisbury Hospital NHS Foundation Trust for the purpose of ensuring that I meet the Fit and Proper Persons Requirements and for enquiries in relation to the prevention and detection of fraud.

I hereby confirm that the information I have provided in this Declaration Form is correct and complete. I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may ultimately result in the withdrawal of an offer of employment or my dismissal, and I may be liable to prosecution.

In addition to completing this questionnaire I understand I must also make the Trust aware as soon as practicable of any incident or circumstances which may impact on my position and provide details of the issue to the Director of Corporate Governance so that this can be considered by the Trust.

Should you wish to withdraw your consent at any time after completing this Declaration Form, or you have any enquiries relating to the information required in this form, please contact the Recruitment Team.

Signed……..

Name ……..

Position / Position applying for
…….

Date…….

PLEASE COMPLETE, SIGN AND FORWARD A HARD COPY OF THE DECLARATION FORM IN AN ENVELOPE MARKED ‘CONFIDENTIAL’ FOR THE ATTENTION OF THE DIRECTOR OF CORPORATE GOVERNANCE.

Salisbury NHS Foundation Trust

Procedural Check 1: Good Character

Key Document References:

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers 'Criminal Record and Barring Checks' dated July 2013.

NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

Regulatory Requirement.

Individuals are to be of good character (Regulation 5(3)(a)) with regard to (Schedule 4 Part 2):

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Compliance with CQC Guidance: Policy

Salisbury NHS Foundation Trust (SFT) policy is that it will maintain robust processes and continuous assessment to:

- Make sure that all available information is gathered to confirm the directors' good character, on appointment and thereafter annually through declarations.

- Take account of the individuals' honesty, trustworthiness, reliability and respectfulness as part of their temperament, character and empathies.

- Confirm that individuals have not been complicit with significant care failures and none of the definitions of unfitness should apply.

- Take appropriate and timely action to investigate and rectify instances where information is discovered that an individual is not of good character after a person has taken up their role. This will include:

    - Taking action as soon as possible to minimise harm or potential harm to people receiving services.
    - Evidencing any reasons for any delays that any reasonable trust would avoid.

  Regard may be had to when convictions and bankruptcies are considered 'spent'

Employment of Individuals with Previous Character Issues.

Where SFT deems an individual to be suitable for employment, after checks have identified that individual as being convicted of an offence, and/or removed from the register of professional health or social care regulators, the following action will be taken:

- The reasons are to be recorded.

  The information regarding the decisions is to be made available to those that are required to know.

Responsibilities

The Head of Resourcing and Director of Corporate Governance will jointly ensure that the data sources, to comply with the regulatory requirement as listed in section 13 are collected as part of the recruitment process.

Procedure for Conducting the Checks

- All applicants will be required to provide a self-disclosure on their criminal history.
- Once the individual has been offered the role, a DBS check will be undertaken. If the individual has indicated on their application that they have worked outside of England, one of the region specific service checks will be completed.
- A check of the registers of relevant professional bodies will be completed to confirm registration and any conditions/restrictions which may have been applied. Where this is not publicly accessible, the individual will be asked to provide proof of registration.
- A review will be undertaken of publicly available information on the other listed organisation's websites, which will include searching for the individual's name within the websites.

Procedure for Recording and Retaining the Check Information

- Copies of all documents and, where possible, searches made, will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

Procedural Check 2: Qualifications, Competence, Skills & Experience

Key Document References

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

Regulatory Requirement

Individuals are to have the necessary qualifications, competence, skills and experience required for their office or position (Regulation 5(3)(b)).

Compliance with CQC Guidance: Policy

SFT policy is that:

- All specific qualifications deemed necessary for a role will be made clear as part of job specifications and contracts. Only individuals who meet the requirements will be employed.

- SFT will assess and check all individuals hold the required qualifications competence, skills and experience, including the requirement to be registered with a professional regulator, the appropriate communication and leadership skills, and evidence of a caring and compassionate nature as required.

- SFT will apply best practice guidelines addressing value-based recruitment, and in conducting regular appraisal and development of individuals.

- SFT will take the appropriate disciplinary action including dismissal of directors if required.

Developing Competence

Where SFT consider that an individual can be appointed to a role based on their qualifications, skill and experience, with the expectation that they will develop specific competence to undertake the role within a specified timeframe, the Trust will record that fact and monitor the progress and development of the individual.

Best Practice

SFT will ensure that it applies best practice in accordance with the CQC expectation that providers be aware of the various guidelines, and to have implemented procedures in line with best practice, and the seven principles of public life (the Nolan Principles).

Responsibilities

- The Head of Resourcing will ensure that the data sources, to comply with the regulatory requirement, are collected as part of the recruitment process.

Procedure for conducting checks

- All applicants will be required to submit an application form which includes details of the applicants work and training history, details of at least two referees, one of whom should be the individual's current or last line manager.

- Where gaps are listed in the individual's employment history these should be challenged by the appointing manager and an explanation sought.

- Copies of any academic and/or professional qualifications, which are used as the basis for selecting the candidate, should be requested. Only originals should be accepted as evidence of award.

- The Trust will also undertake a check through a third party background checking service to ensure that the academic and/or professional qualifications presented are genuine.

Procedure for Recording and Retaining the Check Information

- Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

Procedural Check 3: Health

Key Document References:

NHS Employers 'Work Health Assessments' dated July 2013.

Regulatory Requirement.

Individuals are to be able by reason of their health, after reasonable adjustments have been made, of properly performing those tasks which are intrinsic to the office or position for which they are appointed, or to the work for which they are employed (Regulation 5(3)(c)).

Compliance with CQC Guidance: Policy

SFT policy is that those people in positions of control must be appropriately physically and mentally fit in accordance with their role, and after making reasonable adjustments, to enable individuals to carry out their responsibilities with regard to sustaining the management function. This must be in line with the provisions of the Equality Act 2010.

Responsibilities

- The Head of Resourcing will ensure that the data sources, to comply with the regulatory requirement, are collected as part of the recruitment process.

Procedure for Conducting the Checks

- Once the individual has been offered the role, they will be asked to submit an occupational health assessment to identify whether they have a health condition or disability which may require an adjustment to the workplace.

- If the occupational health assessment indicates that further assessment is required, then this will be commissioned by the Head of Resourcing.

Procedural Check 4: Misconduct or Mismanagement

Key Document References

National Clinical Assessment Service 'Protocol for Reviewing Health Professional Alert Notices' dated April 2013.

National Clinical Assessment Service 'NCAS Operational Protocol: Issue of Health Professional Alert Notices' dated April 2013.

Regulatory Requirement

Individuals must not at any time in their career have been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity. Individuals should not have been complicit with significant care failures.

Serious Misconduct or Mismanagement

- Misconduct or mismanagement means behaviour that would constitute a breach of any legislation or enactment that the CQC deems relevant to meeting these regulations or their component parts.

- 'Serious misconduct' might be expected to include assault, fraud and theft, breaches of health and safety regulations, intoxication while on duty, any breach of confidentiality, disobedience of lawful and reasonable instruction, and disrespect in the workplace.

- Where these actions take place, the individual concerned is to be subject to SFT disciplinary procedure under the Disciplinary Policy and the details retained on the personnel files.

- Mismanagement might be expected to indicate that a director has dealt with responsibilities badly or carelessly, by mismanaging funds and / or not adhering to recognised practice, of following guidance, or processes within which an individual is meant to work.

- Where these actions take place, the individual concerned is to be subject to SFT disciplinary procedure under the Disciplinary Policy and the details retained on the personnel files.

- 'Responsible for, contributed to, or facilitated' means there is evidence that a person has intentionally, or through neglect, behaved in a manner that would be considered to be, or would have led to serious misconduct or mismanagement.

- 'Privy to' means that there is evidence that could lead the provider to reasonably conclude that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.

Collective Responsibility:

- Where individuals are implicated in a breach of health and safety requirements, or other statutory duty or contractual responsibility due to how the management team organised and managed activities, SFT will seek to establish what role the individual played in the breach. If the breach is attributable to the individuals conduct, CQC will expect that SFT will find them unfit.

Policy

SFT policy is to investigate any allegations that individuals may have been party to misconduct or mismanagement as defined within Regulation 5. The appropriate action will be taken to ensure that no harm comes to staff or patients, and where appropriate the individual concerned, if in post, will be suspended in accordance with the Trust's disciplinary policy whilst the investigation takes place.

Responsibilities

- The Head of Recruitment and Director of Corporate Governance will jointly ensure that the data sources, to comply with the regulatory requirement as listed in section 16.5, are collected as part of the recruitment process.

Procedure for Conducting the Checks

- All applicants will be required to submit an application form which includes details of the applicants work and training history, details of at least two referees, one of whom should be the individual's current or last line manager.

- The references will be requested and considered by the recruiting manager to consider if there are any issues which may require any further investigation.

Procedure for Recording and Retaining the Check Information

- Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

Procedural Check 5: Grounds of Unfitness

Regulatory Requirement:

- SFT must seek all available information to assure itself that directors do not meet any elements of the unfit person test (Schedule 4 Part 1). This includes whether the person is:

- An undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

- Subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

- A person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

- A person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

- Included in the children's barred list or the adults barred list maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

- Prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment such as the Companies Act 2006 and the Charities (Protection and Social Investment) Act 2016.

CQC Guidance

- Only individuals acting in a role that falls within the definition of a regulated activity as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the DBS. Where providers deem the individual is suitable despite not meeting the characteristics required, the reasons must be recorded and information about the decision made available to those that need to be aware. It is for the provider to

regularly review the fitness of directors to ensure they remain fit for their role and to investigate concerns in a timely manner.

Responsibilities

- The Director of Corporate Governance will ensure that the data sources, to comply with the regulatory requirements are collected as part of the recruitment process.

Procedure for Conducting Checks

- The various registers and sources of information will be reviewed for the details of the individuals.

Procedure for Recording and Retaining the Check Information

- Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

Checklist for Approval and Ratification Boards Procedural Documents

NHS Salisbury NHS Foundation Trust

Policy Name: Fit and Proper Person Requirement

Action Requested: Ratification by OMB ☐ CMB ☐ other: Trust Board

		Yes/No/ Unsure	Comments
1	**Format & Layout**		
	Has a quick reference guide been included?	Y	
	Is the procedural document clearly set out and free from spelling errors?	Y	
	Is the key information displayed at the beginning of the procedural document?	Y	
	Are the appendices separate (if an appendix is a form is it in an editable format)? List appendices here: Appendix 1: FPPR Self- Declaration Form Appendix 2: FPPR Summary Guidance	Y	
2	**Additional assessments**		
	Does the procedural document have the following: • Equality Impact Assessment (for 'Must Do' policy only) • An Approved Privacy Impact Assessment (if you implementing a new system or service, or changing the way you work) If yes, ensure these are attached for the Board to review	Y N	
3	**Title and Rationale**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
	Are reasons for development of the document stated?	Y	
	Development Process		
	Who has been involved in the development of the procedural document? Head of Resourcing Deputy Director of OD & People Board Members		

		Yes/No/ Unsure	Comments
4	**Content**		
	Is the objective of the document and intended outcomes clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the statements clear and unambiguous?	Y	
5	**Evidence Base**		
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6	**Local Approval**		
	Has DTC approval been given (for clinical documents) Yes ☐ No ☐ Not applicable ×		
	Which Committee/Group has approved the procedural document: Name: OMB Date: June 2020		
	If appropriate have the joint OD and People/staff side committee (or equivalent) approved the document?	Yes – reviewed. No impact on members	
7	**Dissemination and Implementation**		
	What is the implementation Plan: Publish on Microguide. Process only impacts a discreet number of staff and process managed centrally by the Corporate Governance Team		
	Who (job title/name) will review this document: Director of Corporate Governance		
	Where on MicroGuide should this document be published: Guide Name: Subheading name:		
8	**Document Control**		
	Does the document include version details?	Y	
9	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards to support the monitoring of compliance with and effectiveness of, the document?	Y	
10	**Review Date**		
	When will this procedural document be reviewed: 1 year ☐ 3 years Π other:		

Post Holder responsible for the Policy/Document Approval

The Post Holder (procedural document owner/author) should sign here to confirm their approval of the document and their authority for its submission to the Board

Name	Fiona McNeight	Date:	25/06/2020
Signature			

		Yes/No/ Unsure	Comments
	Board/Committee Ratification		
If the committee is happy to ratify the approval of this document, the minutes should reflect this. Chair of the board/committee should sign and date it here. Document owner to maintain this signed approval form in their records			
	Name	Date	
	Signature		

Race	Disability	Gender	Sexual Orientation	Religion	Age

EQUALITY IMPACT ASSESSMENT
Stage 1. Screening

FORM A

Name of activity:	Fit and Proper Persons Policy	Date:	26.06.2020
Name of person responsible for the activity:	Fiona McNeight, Director of Corporate Governance	Directorate:	Corporate services
Names of people undertaking screening:	Fiona McNeight, Director of Corporate Governance	Department:	Corporate Governance
Briefly describe the purpose of the activity:	To set out the requirements to meet the Fit and Proper Persons requirement (Regulation 5, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014		
Who will benefit from this activity?	Patients, visitors and staff		

	Yes	No	Please give details
1. Could or does the activity affect one or more of the equality groups in a different way to others?		✓	The policy applies equally to all individuals within the scope of the policy
2. Could or do different equality groups have different needs in relation to the policy?		✓	
3. Does the policy actually or potentially hinder equality of opportunity?		✓	
4. Does the policy actually or potentially contribute to equality of opportunity?		✓	
5. Does the policy offer opportunities to promote equality?	✓		There are set requirements for compliance which is applied equally to all individuals within the scope of the policy
6. Does the policy offer opportunities to promote positive relations?	✓		The policy is ensuring that the Trust is not managed or controlled by individuals who present an unacceptable risk either to the Trust or to the people receiving services; that SFT Directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.

Does this activity/policy require further impact assessment, action or amendment?	**No**	(if yes, please complete FORM B)

Please state in your policy documentation that it has been equality impact assessed and include your completed screening form (FORM A) as an appendix.

Screening form completed by: F McNeight	When will the policy and screening be reviewed? Each time the policy is reviewed

Race	Disability	Gender	Sexual Orientation	Religion	Age

Race	Disability	Gender	Sexual Orientation	Religion	Age

Please forward a copy of your policy/activity document and completed screening form (FORM A) to pamela.permalloo-bass@salisbury.nhs.uk

EQUALITY IMPACT ASSESSMENT
Stage 2
Full Assessment and Action Plan

FORM B

ACTION	RESPONSE	BY WHEN
What changes or actions do you propose to eradicate or minimise the adverse impact of this activity on the identified group(s)?		
How do you intend to communicate with and involve the appropriate group(s)?		
What are the resource implications of the involvement activities?		
Briefly describe the outcome of your involvement activity.		
Has the involvement activity changed your proposals for eradicating or minimising the adverse impact of this activity? If yes, please give details.		
Are there any resource implications for your proposed amendments.		
How will your actions and proposals be monitored to ensure success?		
What is the date of the next review?		
Signature of lead manager		
Date full assessment completed		

Completed screening and (if appropriate) full impact assessment forms should be included with documentation related to the activity and as an Appendix for formal papers. A copy should be sent to Equality and Diversity Manager for monitoring and publication (pamela.permalloo-bass@salisbury.nhs.uk)

Report to:	Trust Board (Public)	**Agenda item:**	4.1a
Date of Meeting:	02 July 2020		

Report Title:	Q4 Patient Experience Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Katrina Glaister, Head of Patient Experience			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing			
Appendices (list if applicable):	1. SOX Poster presented to national conference 2. Complaints and concerns over the past 10 years 3. Demographics of those who have made a complaint this year			

Recommendation:
The Board is asked to note this report.

Executive Summary:

This report provides a report of activity for Q4 2019/20 and an overview of the year in relation to complaints and the opportunities for learning and service change. Some key changes are highlighted below:

- In view of the new variable response times, this report now reports on complaints closed within the quarter
- Complaints continue to show a slight downward trend.
- 100% of complaints were acknowledged within 3 working days.
- In Q4 55% of closed cases were responded to within the agreed time scales. This is comparable with Q3's figures.
- Actions for previous quarters are displayed. All bar one action for Q2 have been closed. All Q1 actions are now closed
- Lost property has been a theme recently and whilst lost property is now managed by PALS the process had not formally been defined. A new policy that more clearly outlines the roles and responsibilities for found and reclaimed property has been ratified in Q4
- There has been a marked reduction in reopened complaints over the past 5 years which is thought to be due to an increase in face-to-face local resolution meetings, and the level of scrutiny given to the complaint investigations and subsequent responses.
- Reopened concerns show an upward trend. Additional training on concern investigations and writing a good response letter is being brought in for 2020/21.
- Health Watch published a national report on complaints in Q4. Key improvement actions for PALS

are detailed.

- The PPI update is available in a separate report showing progress against our engagement strategy
- At the end of March 2020, NHSE and NHSI wrote to all NHS providers to ask them to 'pause' new and ongoing complaints investigations, to allow providers to concentrate on front-line duties and responsiveness to coronavirus (COVID-19). In addition, the PHSO will not be accepting new health complaints or progress existing ones where this requires contact with the health service or clinical advisers.

This report provides assurance that the Trust is responding and acting appropriately to patient feedback and assurance of patient and public involvement in service co-design and improvement.

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

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints from patients and demonstrate that learning and actions are taken to improve services in response to feedback.

To provide assurance of patient and public involvement in service co-design and improvement.

Background

Patient experience is defined as "the sum of all interactions, shaped by an organisation's culture that influence patient perceptions across the continuum of care."[1] Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative, including learning from feedback, transparency and honesty when healthcare goes wrong. This report provides some evidence of the patient experience feedback and activities in relation to self-improvement based on that feedback.

Making a complaint takes courage. Patients fear that speaking up could affect their care, but we are clear that this is not the case and welcome complaints as a means to improve our services.

The Trust takes concerns and complaints seriously. They are an important opportunity for us to learn and improve. Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where complaints are welcomed and learnt from.

Actions taken since last report

- Following feedback from patients that the PALS office was difficult to find; additional signage has been placed within the hospital.

Actions going forward

- The PALS team have been found a new home in offices close to Day Surgery and plans to move in Q1. This will make PALS more visible and accessible for visitors.

1. 'Pause' on new and existing complaint investigations

At the end of March 2020, NHS England and NHS Improvement wrote to all NHS providers to ask them to 'pause' new and ongoing complaints investigations, to allow providers to concentrate on front-line duties and responsiveness to coronavirus (COVID-19). The initial 'pause' period was recommended to be for three months; with immediate effect.

During this period, complaints and concerns will be acknowledged, logged on Datix and triaged for any immediate issues of patient safety; in this event immediate action will be taken. All complaints are concerns are sent to the relevant division but they do not have to respond until the 'pause' is over if they do not have capacity within the team. All complaints/concerns will then remain open unless a local resolution can be achieved, or the complainant chooses to withdraw their complaint. Currently most complaints and concerns are being responded to as normal.

2. Sharing Outstanding Excellence (SOX)

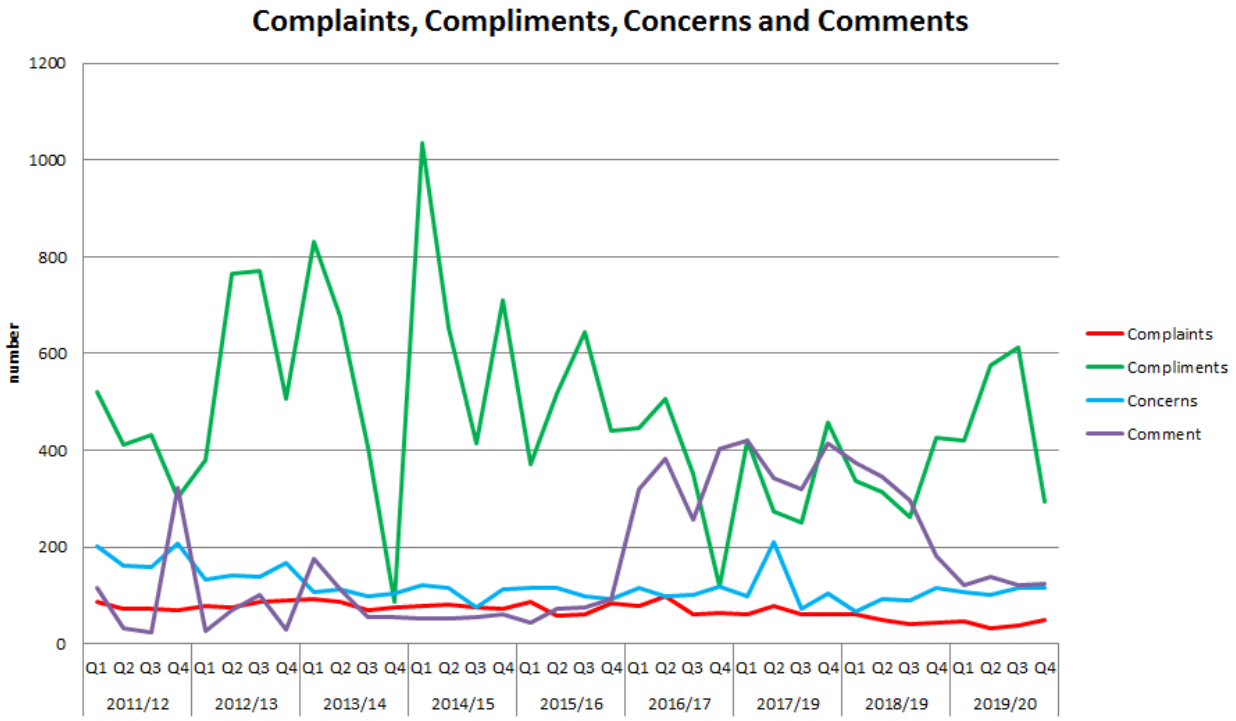
There is growing awareness nationwide that since complaints are a small minority compared to other PALS feedback, learning from what goes well in a Trust is as important as learning from complaints. In this Trust, a positive report is known as a SOX.

As can be seen from the graph below, 'Team Work', 'Patient Centred' and 'Patient Safety' continue to be the most frequently occurring themes.

A poster displaying a qualitative analysis of words from emails associated with SOX nominations (along with a preliminary exploration of words used in SOX forms sent by patients) was presented at a national conference in Q4 (see appendix 1).

3. Complaints

The graph overleaf shows the numbers of complaints, compliments, concerns and comments over time. Complaints show a slight downward trend.



Complaint themes Q4

	CSFS	Transformation & IM&T	Medicine	MSK	Surgery	totals
Admission cancelled / postponed	0	0	0	0	1	1
Appointment postponed	0	0	0	1	0	1
Appointment system - procedures	0	0	0	1	1	2
Clinical Treatment - Medicine	0	0	2	0	0	2
Correct diagnosis not made	0	0	1	1	0	2
Data protection	0	1	0	0	0	1
Delay in making diagnosis	1	0	2	1	0	4
Delay in receiving appointment	0	0	0	0	1	1
Delay in receiving treatment	0	0	0	0	1	1
Delay in receiving/sending information	0	0	1	0	0	1
Discharge procedures	0	0	0	2	0	2
Drug Error	0	0	1	0	0	1
Falls	0	0	1	0	1	2
Further complications	0	0	0	1	2	3
Inappropriate treatment	1	0	0	0	0	1
Infection risk	0	0	0	0	1	1
Information not given to patient	0	0	1	0	0	1
Insensitive communication	0	0	1	0	0	1
Lack of Care	0	0	0	0	1	1
Lack of communication	0	0	0	1	1	2
Lack of equipment/aids/appliances	0	0	0	1	0	1
Neglect	0	0	1	0	0	1
Pain management	0	0	0	1	0	1
Unsatisfactory arrangements	0	0	1	0	0	1
Unsatisfactory Outcome	0	0	0	1	0	1
Unsatisfactory treatment	4	0	1	0	2	7

Wrong information	1	0	1	0	0	2
Attitude of staff - admin	0	0	1	0	0	1
Attitude of staff - medical	1	0	1	1	0	3

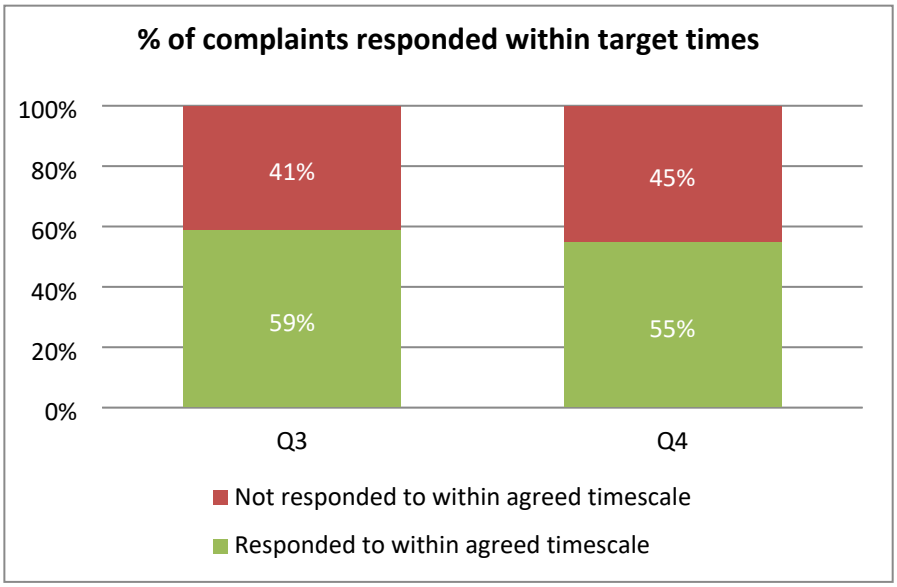
In Q4 the Trust treated 17,837 people as inpatients, day cases and regular day attendees. Another 15,789 people were seen in the Emergency Department (includes the walk-in clinic) and 33,569 as outpatients. 49 complaints were received which is 0.073% of the number of patients treated.

294 compliments were received across the Trust in Q4. Those sent directly to the Chief Executive or PALS are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment/national patient survey/RTF/FFT the PALS team complete a SOX which is sent to the individual and their line manager.

Timeliness of response

100% of complaints were acknowledged within 3 working days.

Graph to show the percentage of complaints responded to within the agreed timescale; over the previous two quarters.



In Q4 55% of closed cases were responded to within the agreed time scales. This is comparable with Q3's figures. Comparison over a greater period of time cannot be made due the implementation of variable response times in Q3.

In this quarter we have seen an increase of 23% in compliance with responses being sent to those complainants who have agreed to a 25 working day timescale. However we have seen a reduction in responses being sent to complainants within 40 working days.

Of the complaints where 60 working days was agreed with the complainant, only 20% were responded to within the given target time. However, these cases are complex and require a level of scrutiny which can only be obtained through clinical/local or SI investigations.

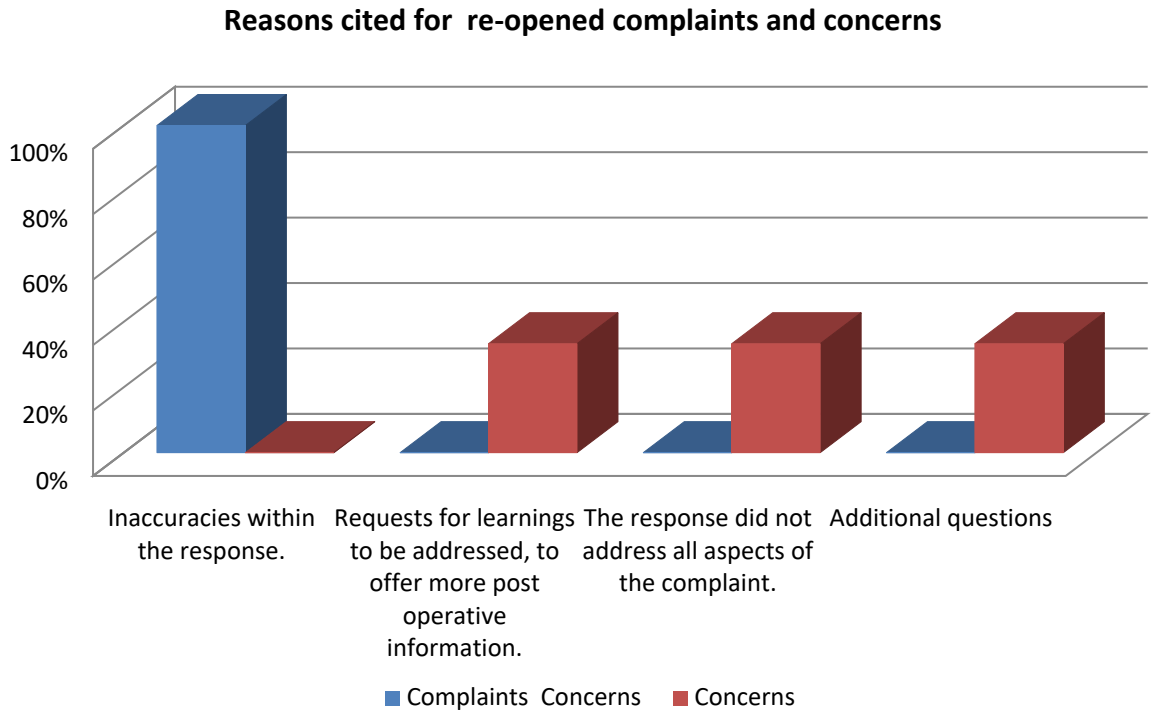
Please see the individual directorate's reports for more compliance data.

Reopened complaints

There were 3 reopened complaints and 3 reopened concerns in Q4:

In all the reopened complaints the reason cited was that there were inaccuracies within the response letter. In one case a request was made for priority to be given to the complainant if additional surgery was considered clinically necessary.

There appears to be no particular themes as to why concerns were reopened. In one case the response did not fully address all the complainant's concerns, and there was a request for additional information.



However, there has been a marked reduction in reopened complaints over the past 5 years which is thought to be due to an increase in face-to-face local resolution meetings, and the level of scrutiny given to the complaint investigations and subsequent responses.

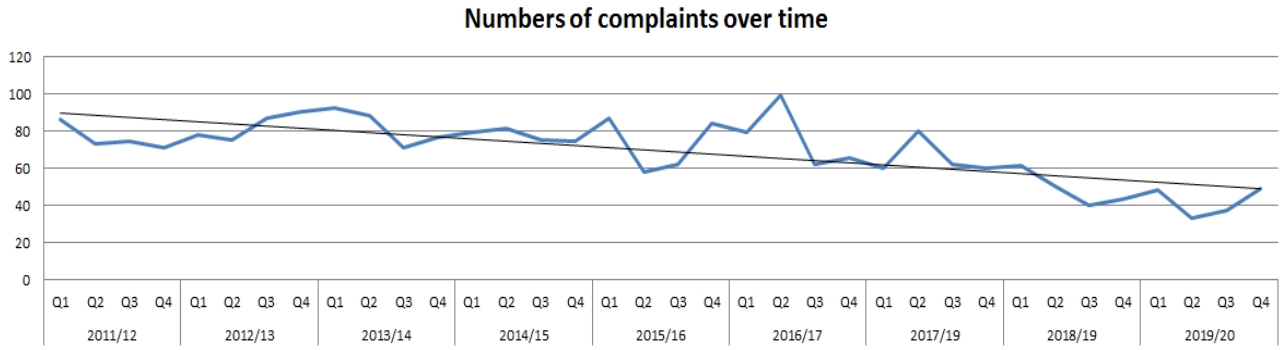
Whilst the rate for complaints that are reopened has reduced over time; the same cannot be said for concerns. Different staff respond to concerns than do for complaints and this may be one reason for the difference between complaints and concerns. Additional training will be offered in 2020/21. Please refer to Appendix 2 for a breakdown of the trends over the past 5 years.

The total number of concerns, comments and enquiries received by the team in Q4 was 354. 85% of these were closed within 10 working days.

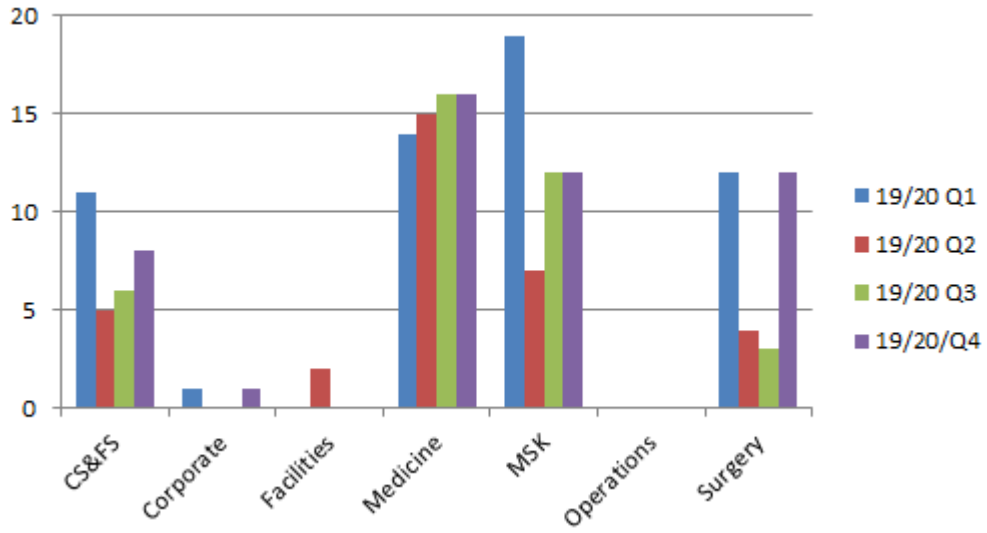
Concerns, comments and enquiries – when are they closed?		
	Number	**%**
Not yet closed	11	3%
0-10 working days	301	85%
11-24 working days	20	6%
25 +working days	22	6%
Total	**354**	

See individual directorate reports for the maximum length of time a complainant waited for a response this quarter.

4. Complaints by directorate



The following graph shows the number of complaints by directorate over the last financial year.



Clinical Support and Family Services

	Q4 2018-19	Q3 2019-20	Q4 2019-20
Complaints	3	6	8
Concerns	16	21	10
Compliments	96	70	42
Re-opened complaints	0	2	0
% closed complaints responded to within agreed timescale	33%	50%	42%
Complaints closed in this quarter	-	1	7
% concerns responded to within 25 working days	-	52%	56%

- There were 8 complaints raised in quarter 4 with no particular themes seen.
- No complaint meetings were held in this quarter.
- 42% of closed complaints were responded to within the agreed timescale. Delays were due to relevant staff being on annual leave and the complexity of the issues that were raised.
- 10 concerns were raised in quarter 4 with Radiology receiving the most (n=4). The main theme is 'unsatisfactory treatment'.
- The PALS department received 15 comments and enquiries for CSFS in Quarter 4 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 9113 and of this number 0.08% raised a complaint.
- 4 action plans are outstanding from 1st April 2019 and the directorate have been chased for these.

Themes and actions from concerns and complaints closed in this quarter

Q4 themes		
Department/Ward	**Topic**	**Actions**
		Updated 15th April 2020
Radiology	Unsatisfactory treatment	**(1+3)** Confirmed CT/MRI & NM review and action plan completed and in daily use **(4)** External training session very well attended by range of Radiology staff with full engagement and suggested actions – communications improvements to be monitored by SMT over next 3 months. **(5)** No progress due to IT resource pressures. On Risk register

		Other actions underway: **6)** Review of Radiology signage and information on display (working with ArtCare to ensure dementia compliant) **7)** New Operational Lead Radiographer revising all outstanding Risks and supporting Leads with training gaps and quality concerns
Feedback on actions from the previous quarter's themes **Q3 themes**		
Department/Ward	**Topic**	**Actions**
Postnatal	Unsatisfactory care & treatment	The complainant received a refund of half of the cost of the amenity room; as financial redress. A robust cleaning schedule has now been established. Complaint training sessions will be included in the Maternity Care Assistants mandatory training. This will ensure that they have an increased awareness of Trust's values and behaviours by using storytelling as a way to share the impact of poor patient care. Staff cited in the complaints were asked to reflect on how their communications can directly affect the patients' experience.
Q2 themes		
Radiology – **Unsatisfactory treatment and care and lack of relevant information given to patients.**	(1) Review of information given to patients within CT/MRI &N/M. Both written and verbal. (2) Ensure that patients can here through intercoms. If no response then enter room when safe to speak to patient directly. (3) Patient information written to ensure clear understanding of aftercare following extravasation of contrast. (4) Planning Communication training for February governance from outside Trust. (5) Working with IT to see if MRI safety questionnaire can be completed electronically.	Updated 8th January 2020 **(1) + (3)** CT/MRI & NM Leads have been asked to confirm review has been completed and action plan initiated at Radiology SMT 14th Jan. Should these be outstanding, Radiology Service Manager will take ownership and drive to conclusion by end of February **(2)** This has been completed. New patient headphones were purchased November 2019. Radiographers aware of need to ensure patient response and understanding throughout examination **(4)** External trainer has been booked and will give presentation to all available Radiology staff at Clinical Governance 7th February **(5)** No definitive answer from IT. MRI Lead to contact IT again, and to involve the new Clinical Liaison for Radiology
Q1& 2 themes	All actions have been completed	

Compliments
42 compliments were received in quarter 4, the breakdown is as follows:

Bowel screening = 10, Endoscopy = 2, Labour ward = 1, Maternity = 22, Radiology = 5, SALT = 2.

MSK Directorate

	Q4 2018-19	Q3 2019-20	Q4 2019-20
Complaints	6	12	11
Concerns	22	30	22
Compliments	14	58	
Re-opened complaints	7	1	2
% closed complaints responded to within agreed timescale	33%	50%	64%
Complaints closed in this quarter	6	6	8
% closed concerns responded to within 25 working days	33%	52%	52%

- The Orthopaedics specialty received the most complaints with 6 this quarter, the areas being Amesbury Suite (n = 2), Chilmark Suite (n = 2) and Orthopaedics (n = 2). The main theme of these complaints was 'discharge procedures'.
- 2 concern meetings were held in this quarter; both had resolution at the meeting with actions now completed.
- There were 22 concerns raised in Quarter 4. Orthopaedics received the most with 9 with the main theme being unsatisfactory treatment (2 concerns). Longford Ward received 4 concerns with themes of nursing care and nursing staff (n=2), assistance not given (n=1) and delay in receiving treatment (n=1)
- The PALS department received 25 comments and enquiries for MSK in Quarter 4 which were investigated, managed and responded to by the team.
- The longest complaint outstanding was due on 20th November 2019 and a holding letter was sent on 16th December. There has been no further explanation for the delay from the DMT.
- Total activity within the directorate was 13,856 and of this number 0.08% raised a complaint.
- The Complaints Co-ordinator is waiting for 16 outstanding action plans from closed complaints since 1st April 2019 for the MSK directorate.

Themes and actions from concerns and complaints closed in this quarter

Q4 themes		
Department/Ward	**Themes**	**Actions**
Laser Clinic and Orthopaedic department	Lack of capacity; resulting in delayed and cancelled appointments.	Laser clinic has experienced some service delivery issues; which the team are working to resolve. There is a programme of training ongoing, and it is anticipated that in the near future they will have two fully trained members of the nursing staff, in the dermatology/plastics team. It is hope this will increase the capacity of the laser clinic; thus reducing the need for the service to reschedule patient's appointments. **Orthopaedic department:** Patients are allocated follow up appointments as appropriate based on clinical priority; unfortunately over the summer, patients were waiting longer than initially indicated due to capacity issues. Details of this case will be shared with the relevant teams and any lessons learnt.
Orthopaedic/ and Orthopaedic Outpatients	Lack of/ or miscommunication.	Miscommunication regarding treatment plan. Plan of care has been agreed with patient. Misinformation received regarding preoperative testing; which was unfortunately due to human error. This has been addressed with both the booking and

		administration teams in Central Booking. A crib card to remind staff of the timings regarding the validity of pre ops and bloods and swabs for various specialties has been produced and circulated to the teams. Plans are in place to amend the letter template for orthopaedic operations to include further information about the timeframes for pre op bloods and swabs.
Ward department **Amesbury ward and Plastic department.**	**Themes** Medication errors.	**Amesbury:** Issues raised within the complaint has been shared with the team; informally through team meetings and via the safety briefings**.** **Plastic department:** Consultant met with patient and concerns resolved Amesbury: Apologies given regarding the omission of insulin. More education regarding the management of patient with diabetic is required. Training sessions will be undertaken.
Feedback on actions from the previous quarter's themes **Q3 themes**		
Department/Ward - Orthopaedics Department	**Actions** Learning regarding communication has been shared with the team where appropriate.	
Q2 (2019/20) themes	**Actions**	**Updates**
Dermatology – delay in receiving appointment	Ensure communication is clear with patients in order to manage their expectations. DMT action plan being developed as a result of the Skin Summit.	Action Plan forms part of the Intensive Support action plan which has now been shared with the Executive Team. As a result of actions already put in place the longest wait has decreased from 83 weeks at 16th December, to 63 weeks at 9th January. The length continues to decrease and it is expected that all appointments will be booked to take place within 45 weeks by September 2020.
Q1 (2019/20) Themes	**Actions**	**Updates**
Orthodontics (OMFS)	Clinician behaviour	JW/AMc met with locum consultant. Agreed action plan and review progress - complete
T & O	Clinical treatment	Reviewed cases for themes – no themes identified
Q1 actions	Completed.	
Q2 actions	Complete (pending clarification on one outstanding action).	

Compliments
13 compliments were received in Quarter 4, the breakdown is as follows:
Odstock Ward = 11, Plastics Outpatients = 2

Medicine Directorate

	Q 4 2018-19	Q 3 2019-20	Q 4 2019-20
Complaints	23	16	16
Concerns	27	32	38
Compliments	82	292	169
Re-opened complaints	4	0	0
% closed complaints responded to within agreed timescale	17%	55%	56%
Complaints closed in this quarter	-	9	16
% concerns responded to within 25 working days	-	75%	90%

- The Emergency Department received the most complaints with 6 this quarter. The main theme of these complaints was incorrect diagnosis.
- 4 complaint meetings were held in this quarter.
- 56% of closed complaints were responded to within the agreed timescale. Some of these delays were down to the complexity of the concerns raised and the arranging of meetings.
- There were 38 concerns raised in Quarter 3. The Emergency Department received the most (n = 9). The main theme was unsatisfactory treatment.
- The PALS department received 47 comments and enquiries for Medicine in Quarter 4 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 19015 and of this number 0.08% raised a complaint.
- The Complaints Co-ordinator is waiting for 19 outstanding action plans from closed complaints since 1st April 2019 for the Medicine directorate.

Themes and actions from concerns and complaints closed in this quarter

Q4 themes		
Department/Ward	**Topic**	**Action**
Emergency Department	Incorrect diagnosis and unsatisfactory treatment.	Commitment to regular Junior Doctor teaching programme – weekly in house training has been in place and consistent for several months. Work on ED strategy to place staff learning and development at the centre
Feedback on actions from the previous quarter's themes		
Q3 (2019/20) themes	**Actions**	**Updates**
Emergency Department Unsatisfactory treatment, misdiagnosis and communication.	1:1 with individuals in receipt of 3 complaints relating to attitude and behaviour. Changes to Senior meet structure to prioritise discussion of complaints and sharing learning x1 per month. Case reviews with staff to identify learning and ensure shared throughout the ward staff. Spire have increased their band 6 numbers (vacancies filled) and therefore presence on the ward with band 7	These 1:1 sessions have been taking place but we have had comparably fewer complaints about attitude and behaviour in this quarter. Unfortunately we have not been having regular seniors meetings over winter and now into COVID-19 crisis therefore we have created new folders for sharing learning from individual complaints in staff coffee rooms.

AMU and Spire ward Unsatisfactory care and treatment.	ensuring she is visible each day. Sharing of complaints with staff to ensure they appreciate impact of care on patients and relatives. Review of specific documentation areas to make it 'Easy to do well'. This is led through 'documentation meeting' and 'Share and learn'. It has led to new post-falls check list, handover proforma review and currently review of skin bundles. Reminder to staff of property policy.	
Q2 (2019/20) themes	**Actions**	**Updates**
Emergency Department **Unsatisfactory Clinical treatment and attitude of medical staff.**	To share complaints at next M&M and discuss how we can best manage complaints relating to unsatisfactory treatment.	Changes to senior meeting structure to bring discussion about complaints and sharing learning to monthly.
Q1&2 themes	All actions have been completed	

Compliments

169 compliments were received in Quarter 4, the breakdown is as follows:

AMU = 11, Cardiology = 1, Durrington = 14, Emergency Department = 6, Farley = 30, Hospice = 38, Pembroke = 14, Redlynch = 4, Spire = 10, Tisbury = 30

Surgical Directorate

	Q4 2018-19	Q3 2019-20	Q4 2019-20
Complaints	8	2	12
Concerns	35	27	27
Compliments	218	190	74
Re-opened Complaints & Concerns	2	6	1
% closed complaints responded to within agreed timescale	25%	0%	83%
Complaints closed in this quarter	-	2	6
% closed concerns responded to within 25 working days	-	71%	83%

- There were 12 complaints received this quarter with Downton ward and Urology receiving 3 each. There were no evident themes.
- There were no complaint meetings held in this quarter.
- There were 27 concerns raised in Quarter 4. The Central Booking department received the most with 9. The main theme is 'appointment system procedures'.
- There was 1 concern re-opened in Quarter 4 due to the complainant wanting further clarification.
- The PALS department received 34 comments and enquiries for Surgery in Quarter 4 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 13694 and of this number 0.08% raised a complaint.
- The Complaints Co-ordinator is waiting for 1 outstanding action plan from closed complaints since 1st April 2019 for the Surgery directorate. This has been chased.

Themes and actions from concerns and complaints closed in this quarter

Q4 themes of complaints and concerns		
Department/Ward	**Topic**	**Actions**
Division-wide	Delay in receiving appointment Operation delayed	Capacity pressures are being addressed in several ways including: • Running extra lists whenever possible, • The setting up of a monthly diary meeting to flex consultant job plans to try and ensure cross cover to minimise the loss of theatre capacity due to leave. • Work is also ongoing to move LA injection procedures from theatre to the Outpatient Department setting to create additional capacity. • Development of nurse led service for LA injections, to facilitate further consultant theatre time. • The Urology consultant team has also been expanded to increase capacity with one consultant starting last year and another having started In February 2020. • In all cases apologies were offered and appointments rearranged were appropriate.
It has been acknowledge that of the closed complaints and concerns this quarter, 53.8% (21) of cases highlighted concerns regarding delayed appointments or surgical procedures. Of those 21 cases, 47% (10) were in relation to appointments or procedures generated by Central Booking. Central Booking is responsible for booking over 88,000 appointments and theatre admissions each month. As stated, within Q4, 10 complaints/concerns where assigned to Central Booking and of these, only 5 identified system procedure issues; equating to 1.8% of contacts made by Central Booking. This demonstrates a small minority. However, all cases have been sent to the Central booking Manager, and learning is shared with the relevant booking teams.		
Q3 themes		
Department/Ward	**Topic**	**Actions**
Urology General Surgery Central Booking	Delay in receiving appointment Operation delayed Delay in receiving Treatment Appointment postponed Appointment system procedures	Delays in operations and receiving appointments are around capacity and demand issues which are being monitored weekly at the Executive Delivery Group meetings and within Booking Teams and DMT. Errors in appointment procedures are small but have been discussed with Central Booking Manager and Booking Teams.
Q 1&2 themes	All completed	

Compliments

66 compliments were received in Quarter 4, the breakdown is as follows:

Amesbury = 11, General surgery = 1, Breast surgery = 1, Britford = 19 & 4 SOX, DSU = 1 & 1 SOX, Downton = 17 & 3 SOX, Radnor = 11, Theatres = 2, Urology = 2.

5. Parliamentary and Health Service Ombudsman (PHSO)

In this quarter, 4 ‘information requests’ from the Ombudsman were received. However, during the COVID-19 pandemic the PHSO have decided that they should not place additional burden on the NHS and are therefore currently not accepting new health service complaints nor progressing existing ones where contact with the NHS is required.

Completed actions

- Lost property has been a theme over this year and whilst lost property is now managed by PALS the process had not formally been defined. A new policy that more clearly outlines the roles and responsibilities for found and reclaimed property has was ratified in Q4.

For the first time the PHSO has published data about their recommendations for upheld and partially upheld cases. They have also published a data table of complaints received, assessed and investigated about NHS Organisations. This data will be published every quarter alongside their existing health complaints statistics report.

6. Trust wide feedback

This quarter three Friends and Family Test responses named a member of staff in negative feedback (Breamore, Surgical Admissions Lounge and ED). The feedback was shared immediately with the senior leads who have taken the issue forward with the staff concerned.

PATIENTS SURVEYED

A total of 2,548 patients provided feedback during the quarter through national patient surveys, real-time feedback (eRTF) and the Friends and Family Test (FFT). This is less than the previous quarter (Q2 – 3,486). The decrease is across all areas of feedback.

REAL-TIME FEEDBACK

PATIENTS SURVEYED

A total of 2,135 patients provided feedback during the quarter through real-time feedback (eRTF) and the Friends and Family Test (FFT). This is less than the previous quarter (Q3 – 2,548).

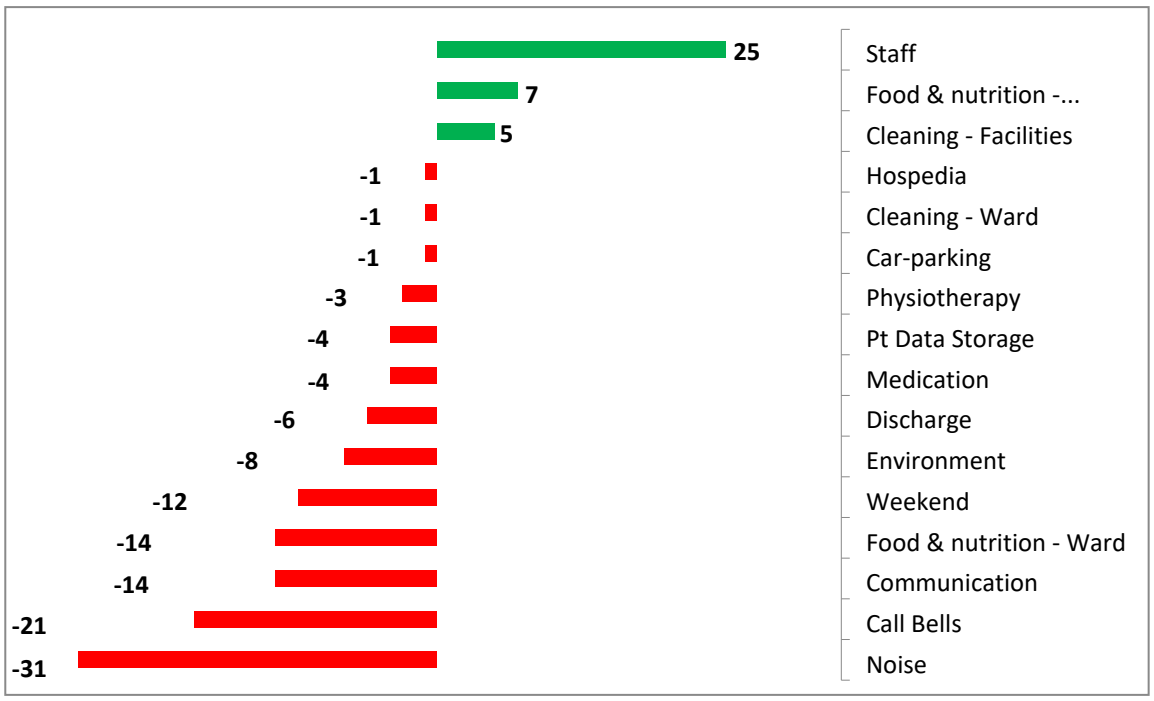
eRTF was stopped in the first week of March due to coronavirus. There are no national patient surveys running during this time.

REAL-TIME FEEDBACK

INPATIENTS

"I have been very impressed with the care I have had here and with the patience shown to patients with dementia."

A total of 143 inpatients were surveyed in the quarter. They made 126 positive comments and shared 169 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.



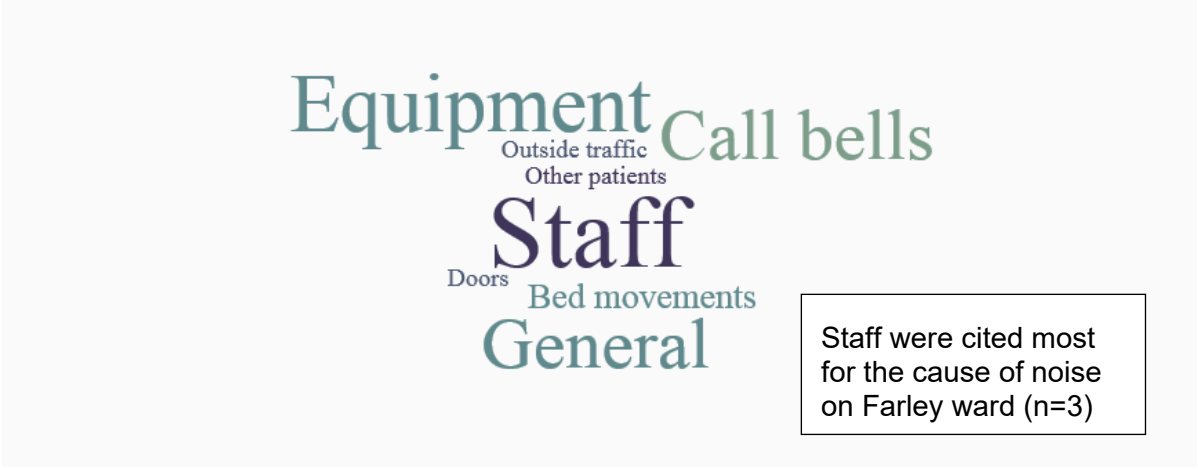
The largest area of positive comments related to staff (51 positive against 26 negative).

The main areas of concern were noise, call bells and communication.

Noise

Three positive and 34 negative comments were made regarding noise.

"It was very noisy from staff talking all night."



Staff were cited most for the cause of noise on Farley ward (n=3)

Call Bells

Three positive and 24 negative comments were made regarding response to call bells.

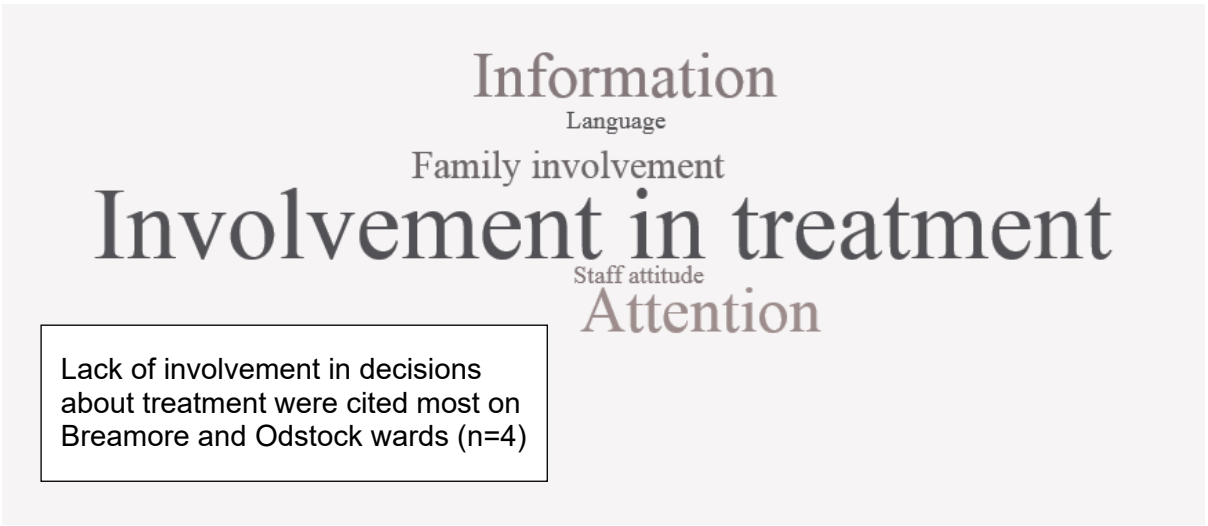
"I do not always get attention when I need it. The staff are under great pressure at times."

Busy staff were cited most on Amesbury & Farley wards (n=6)

Communication

Five positive and 19 negative comments were made regarding communication.

"I am not disappointed with the staff's professionalism but would like to be more involved in plans for my care and treatment."

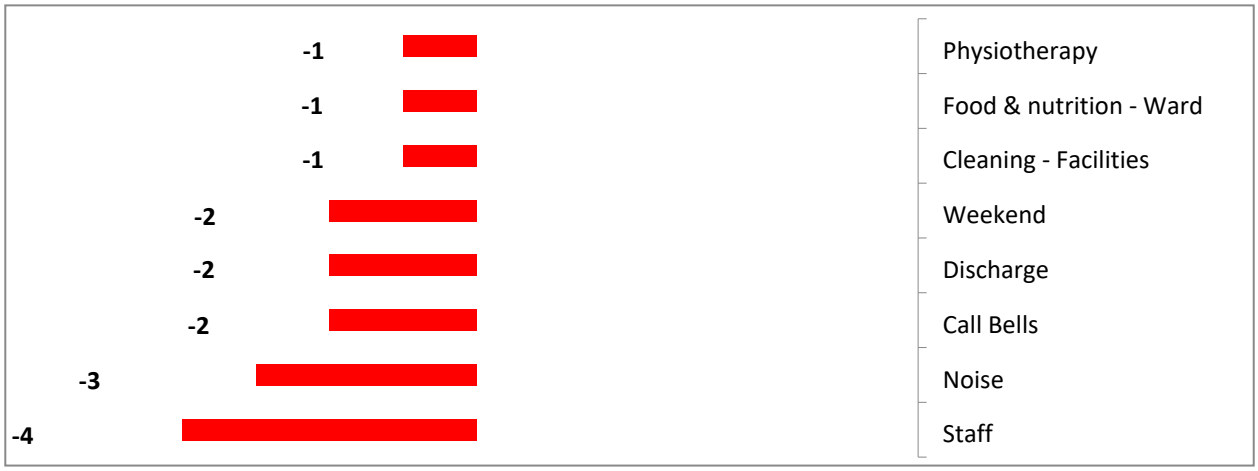


Lack of involvement in decisions about treatment were cited most on Breamore and Odstock wards (n=4)

SPINAL

"I do like the curries and stuff."

A total of 5 patients were surveyed in the quarter. They made 2 positive comments and shared 19 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.



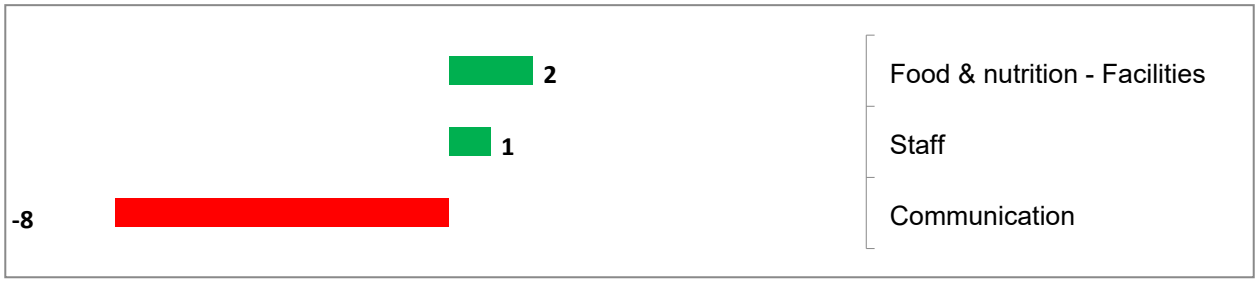
The main area of concern was staff (0 positive against 4 negative).

"I saw my main doctor last week and I do not know when I will see them again. It is important to me that I see my doctor regularly as I feel they do not know me. The ward doctors are brilliant but they are not in charge of my care."

MATERNITY

"Everyone is lovely here."

Nine new mothers were surveyed in the quarter. They made 5 positive comments and 11 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.



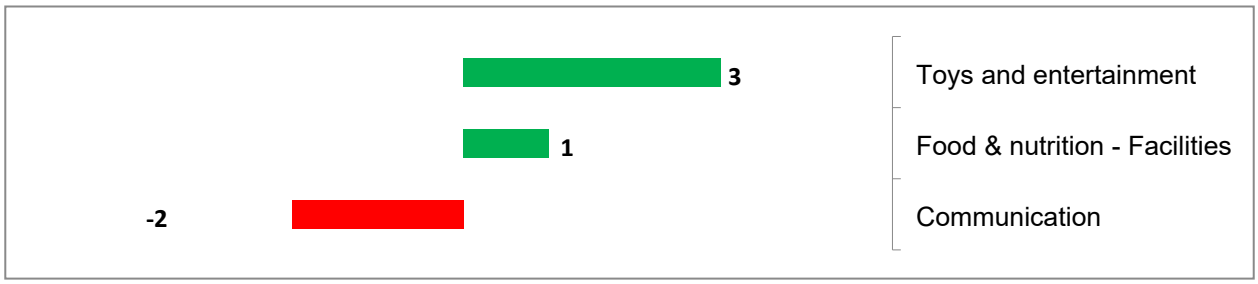
The main area of concern related to communication (0 positive against 8 negative).

"I was not involved in decision-making until the last week when I spoke to my midwife and she told me that it was my right to choose. That was when I saw the consultant who agreed that I would have a caesarean due to the complications I have had."

PAEDIATRICS

"The welcome we received when we came here was brilliant."

A total of 9 adults or carers and 3 children were surveyed during the period. They made 8 positive comments and shared 5 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.



The only area of concern related to communication (1 positive against 3 negative).

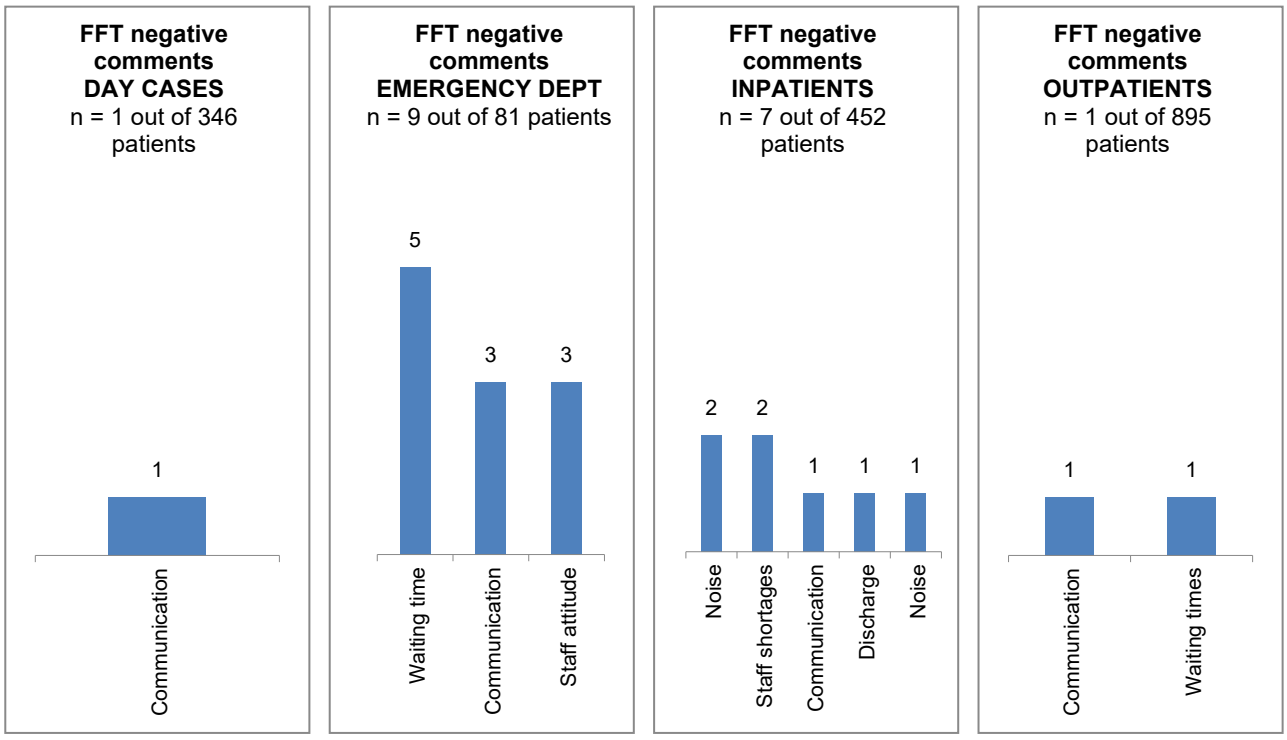
"Communication between the ward and Theatres was bad after my child's accident. We were waiting for him to go to Theatres at 13:00 hrs and as time went on, no-one told us anything until I asked. They called down to Theatres and we were told that the op was postponed until the next day."

FRIENDS AND FAMILY TEST

Responses for the quarter are set out in the table below.

		Rating											
	Total Responses Received	Extremely Likely		Likely		Neither likely nor unlikely		Unlikely		Extremely Unlikely		Don't know	
Day Case	346	329	95%	15	4%	1	0.5%	0		1	0.5%	0	
Emer Dept	81	68	84%	2	2.5%	2	2.5%	0		9	11%	0	
Inpatients	452	406	90%	28	6%	11	2.5%	3	0.6%	3	0.6%	1	0.2%
Maternity	25	22	88%	2	8%	1	4%	0		0		0	
Outpatients	895	859	96%	28	3%	5	0.6%	0		1	0.1%	2	0.2%

Comments made between January and March by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below.



The numbers are too low to identify any main areas of concern.

PATIENT AND PUBLIC INVOLVEMENT – NATIONAL SURVEYS

No national survey results were published within the reporting period.

INPATIENT SURVEY (IP) 2019

Fieldwork on the national inpatient survey 2019 ended on 10 January 2020. The results will be published in the summer of 2020.

MATERNITY SURVEY 2020

Initial work on the national maternity survey 2020 commenced in March but in early April a decision was taken by the Care Quality Commission, in consultation with NHS England and NHS Improvement, to stop the survey for the following reasons:-

1) There was evidence that the sampling process was seriously compromised as a considerable number of Trusts had raised concerns about being unable to meet sampling deadlines, and a small number of Trusts had withdrawn altogether. Due to the expectation at that time that the outbreak would worsen over the coming weeks and peak in early summer, it was unlikely to be possible to extend the sampling period to a time in the near future when NHS services would be under less pressure.

2) The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, which came into force on 26 March, required people to stay at home, except for very limited purposes. There was concern about encouraging respondents to return the paper questionnaire as this would require them to leave their homes to do so.

3) Wider government measures to combat the outbreak, such as the closure of business premises, social distancing and push to homeworking, were anticipated to compromise the mailing, receipt, and processing of questionnaires during the fieldwork period (20 April to 25 August). Problems in these areas were likely to have a negative impact on the consistency of survey methodology and damage data quality which, in turn, would have a significant impact on the trustworthiness and value of survey results.

4) The survey was due to sample women who gave birth under the care of an NHS Trust in February 2020. While questions on antenatal care and labour were likely to have asked women to reflect on maternity care before the health service was majorly impacted by the outbreak, questions on postnatal care were likely to have asked respondents to reflect on their care while the health service was under severe pressure. Survey results from this section of the questionnaire, which focus on care in the eight weeks after birth, were therefore unlikely to have been straightforwardly comparable with the results from previous years.

ACTION TAKEN ON AREAS OF CONCERN

Wards, the Emergency Department and Maternity, have action plans in place to address the main areas of concern in their location. Progress is monitored via the Trust's Matrons Monitoring Group and is overseen by the Clinical Management Board.

7. Health Watch Wiltshire feedback

Regular meetings are held between PALS and Health Watch Wiltshire.

A focus group for patients who had made a complaint and had been unhappy with their response had been planned for Q4 but was cancelled due to social distancing measures for COVID-19. Healthwatch have agreed to telephone those people who had planned to attend and we are awaiting their report.

The COVID-19 outbreak has resulted in changes to way that Health Watch work, with much of their planned public engagement and visits to services paused and a greater focus on providing advice to the public and supporting the local response to the pandemic. They have started a fortnightly report that highlights what they are hearing from local people and identifies any gaps. In the first report they published the account of one patient's experience with Salisbury NHS Foundation Trust:

Care given at Salisbury District Hospital at the beginning of the outbreak was fantastic. Arrangements were made and supplies of all necessary drugs and equipment was rapid to say the least, as I was more at risk of catching something in hospital. Both the Respiratory department and Rheumatology department are only ever a phone call away. I have been assured that I am to contact them if I become unwell or have any concerns.

8. Translation and Interpretation

This quarter's most frequently used languages for face-to-face interpretation (used on 25 occasions):

- Polish 25% Arabic 12.5% Nepalese 8.4%

Total spend for face-to-face interpreting this quarter = £4602.24

The areas where interpretation was used most often are:

- Endoscopy = 25% Children's Outpatients = 12% Urology 8%

British Sign Language was used on 14 occasions this quarter with a total spend of £1805.15

The **total spend for 2019/20** is:

Face-to-face interpretation: £25352.75
British Sign Language: £8995.80
Translation (of documents): £586.22
Overall total: £34934.80

The Procurement team are working on a new tender for Translation Services and an update on progress will be presented here in due course.

9. Patient Stories

Patient stories are taken to every public Board meeting. The Trust's website is due for complete re-design (due for completion in October 2020) and will include a private section where patient stories can be posted for staff to access for individual/team learning.

10. NHS Digital

As the health and care system continues to respond to the Covid-19 pandemic, NHS Digital is adjusting key data services activity. This is partly to create additional capacity to support national planning and delivery through the provision of new collections and analysis to support the Covid-19 response, and partly to ease the pressure on NHS staff completing these returns. NHS Digital have therefore suspended both the KO41a secondary care and KO41b primary care collections for Q4 2019-20 and Q1 2020-21.

Q3 data (2019-20) is available here https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2019-20-quarter-3-ns

11. Patient and public involvement (PPI)

Please see separate end of year update against our engagement strategy priorities.

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

The PPI toolkit is available here: https://viewer.microguide.global/guide/1000000334#content,1df17a5a-25ee-4524-ab5e-96031930d247

12. Social media

NHS Website feedback

There were eight items of feedback posted on the NHS Website. All were positive (7 scored their interaction with the hospital as five stars and one as four stars).

Areas complemented were:

- ED (received four positive comments)
- Oral Surgery (received two positive comments)
- Breamore
- Eye Clinic

The only negative element within one feedback surrounded the patient's observation that other patients were not using the hand sanitiser provided.

An example of feedback from the ED is:

This morning my 11 year old Granddaughter and I visited the A&E department to review her damaged small finger. Absolutely everyone we had contact with, reception, initial assessment, xray and finally the lead nurse who reviewed the xray and agreed next steps, there empathy and professionalism was excellent. Thank you all so much.

Other Social Media for Q4

There were 18 tweets where the Trust was tagged. 18 of these were positive and one was neutral.

There were 36 new reviews of the hospital on Facebook. 36 were positive and 3 were negative.

> An example of a positive review is:
>
> *The staff are beyond fabulous. Kind and caring and so understanding of a frightened teenager. Thank you*
>
> Cold food, attitude of medical staff and poor mental health provision feature in the negative reviews

25 comments were made in response to posts that we made on Facebook and additionally 66 people posted 'thank you'. Of the 25 comments only 3 were negative and there is no particular theme.

An example of a negative comment is:

> *I have just walked through into the hospital and had to go. Go to the reception to ask where the nearest hand wash was which was on level 3 down the corridor that is disgraceful.*

14 new Facebook messages were received this quarter. 11 were positive and 3 negative. The only theme in the negative messages was 'social distancing' (one was a comment on a photograph that had been posted and the other referenced the number of staff standing close together smoking).

13. Shifting the mindset: a closer look at NHS complaints (Healthwatch)

The Francis Report in 2013 made it clear that the processes for dealing with complaints should be a priority for the NHS and that learning should be implemented and shared with the public. A recent report by Healthwatch explored whether complaints processes had improved and whether learning was now made public.

In January 2020 Healthwatch searched the websites for the 149 NHS Acute Trusts in England and examined each organisation's complaint reports in detail.

Key findings:

- Local reporting on complaints is inconsistent and inaccessible
- All hospital trusts are reporting to NHS Digital on the numbers of complaints they receive; however, only a minority of trusts report any more meaningful data at a local level.

- Staff are not empowered to communicate with the public on complaints
- All hospitals must produce an annual statutory complaints report but they are only required to make it available to people upon request. Yet we found that hospital complaints staff were often not aware of the reports or who could access them.
- Reporting focuses on counting complaints, not demonstrating learning
- Only 38% of trusts make public any information on the changes they've made in response to complaints. Much of this reporting is still only high-level, telling us little detail about what has changed and only stating that "improvements were made".

Issue	Action	By who and by when
All Patient experience reports are published on our website but are not easy to find.	Create additional link to published patient experience reports and publish on the PALS page of the website	Head of Patient Experience June 2020
Demographic details of who have made a complaint have not been included in patient experience reports	Add demographic details as a matter of routine to all patient experience reports	See this report for details for 2019-20 (appendix 3)
4 in 5 people that Healthwatch spoke to report that seeing details of other people's complaints would encourage them to make their own voice heard in future	Explore how an increased level of detail could be added to the patient experience reports. See Maidstone and Tunbridge Wells NHS Trust https://www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/complaints-stories/	For discussion at Board
Staff are not aware of patient experience reports or know how to access them	Add a link to each published Patient Experience Report and include with the Complaints and Risk Newsletter. Advertise publication of reports via Pulse	Head of Complaints June 2020
The PHSO's report, Learning from Mistakes, July 2016, reiterated that training and accrediting sufficient investigators is crucial to improve learning from investigations.	Additional training to be set up including investigating complaints and writing an effective response letter	Head of Complaints in progress
We do not make it clear in our patient experience report that we have a welcoming approach to complaints	Add a statement to all our patient experience reports	See page 3
To improve public confidence in the complaints system we should communicate our learning from complaints through 'you said, we did' boards	All PALS Noticeboards to be kept up to date and changes made as a result of a complaint or concern to be added to the relevant ward's board	PPI Lead and Head of Complaints Ongoing
To deliver sustained improvement on complaint response times	Our data shows that the 40 day response time is more achievable and we have had no negative feedback on the extended time frame. To explore increasing the 'green' 25-day timescale to 40 days.	Head of Complaints

Appendix 1

SOX
Sharing Outstanding Excellence

NHS
Salisbury
NHS Foundation Trust

What can we learn about the impact of words used in excellence reporting?

Katrina Glaister, Head of Patient Experience
sft.sox@nhs.net @kat_glaister @SOXatSalisbury

You never know when a moment and a few sincere words can have an impact on a life Zig Ziglar

Excellence reporting at Salisbury District Hospital (known as SOX) started in 2016 and has become an established part of working life in the hospital with excellence reporting coming from and going to all parts of the organisation (and beyond). This poster presents our learning from two aspects:

1. Once a SOX is received it is emailed out to the nominee, their line manager and the person who nominated them. There are often email responses and the words staff used offer an insight into the impact of excellence reporting.
2. Increasingly excellence reports are being written by patients and it is suggested here that the words patients use gives us an understanding of what 'excellence' is in the eyes of those on the receiving end of care.

Emails from staff

129 emails from staff who received a SOX and 157 emails from line managers of 'excellent' staff have been received to-date and were analysed. Key words were extracted and used to create a word cloud.

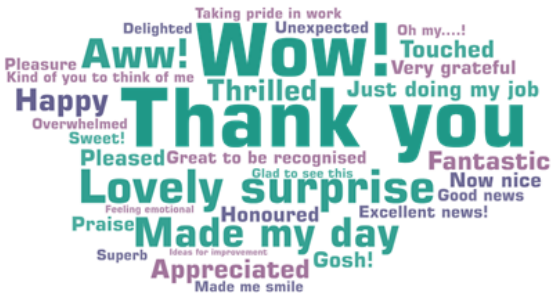
Nominated staff

The words they used in their emails are powerful and undeniably positive.

That the SOX was unexpected is a clear theme from the email responses. A typical example is *'I was surprised and touched that my line manager was so appreciative of my efforts'*

Other findings

11% of staff made reference to 'using' their SOX (examples being in their appraisal and professional portfolios). Others forwarded the SOX to other team members as they felt that they too should have been named. Some staff (5%) reported they were 'just doing their job' however, in the eyes of the person nominating them they were doing it excellently (and, arguably, better than others).



Excellence reports from patients

In the NHS there are eight domains defined as critical to a 'good' patient experience, including respect, information and communication, physical comfort, emotional support, and access to care[1]. The literature suggests that traditional patient-completed questionnaires paint a limited and optimistic picture[2] and their usefulness and value are questioned[3]. However, we have adopted a Safety-II perspective to the patient feedback, arguing here that analysis of the words they use when reporting excellence can be examined with another, more positive mind-set. 104 reports of excellence from patients, carers and family members have been received at Salisbury District Hospital over the last two years. Whilst some of the words used can be matched to the 8 domains cited as key to patient experience; not all can be. We believe that, over time, examining the words used will help clarify further exactly what is an excellent patient experience. Through us then using an appreciative inquiry approach to explore themes will help drive further improvements.

Line managers of 'excellent' staff

The emails all (100%) clearly show the line managers' appreciation of the nominated staff member but 4% also showed their appreciation for the person that took the time to report the excellence. Whilst most line managers echoed the sentiment of the SOX, 4% used their email to add additional (positive) feedback for the staff member; in essence providing a second SOX.

Other findings

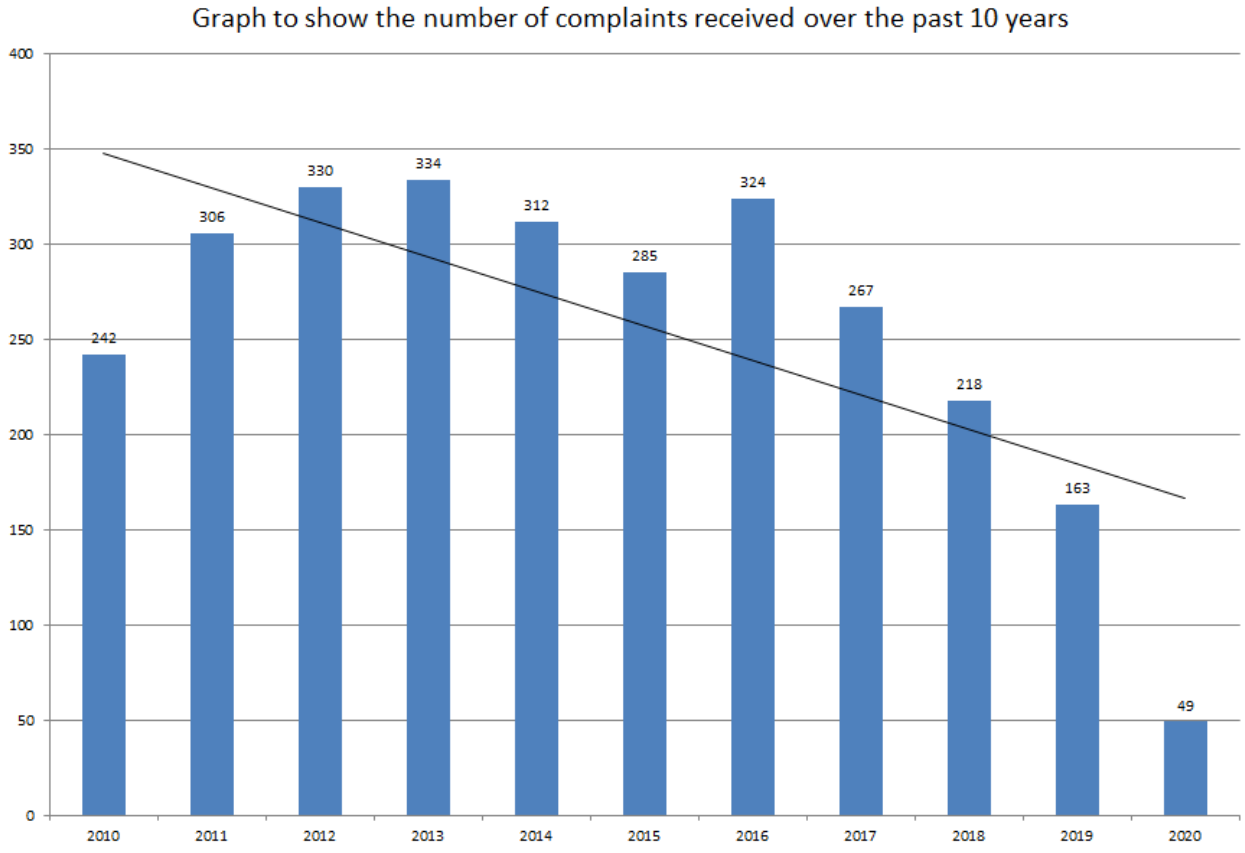
A key theme that emerged from the emails was 'learning and sharing' where 10% of line managers reported how the SOX would be used within the team - for example being discussed at the next team meeting and SOX forms being displayed on notice boards. An example is '*Many thanks ..... it just highlights to me how much of a positive impact sharing our experiences has.'*

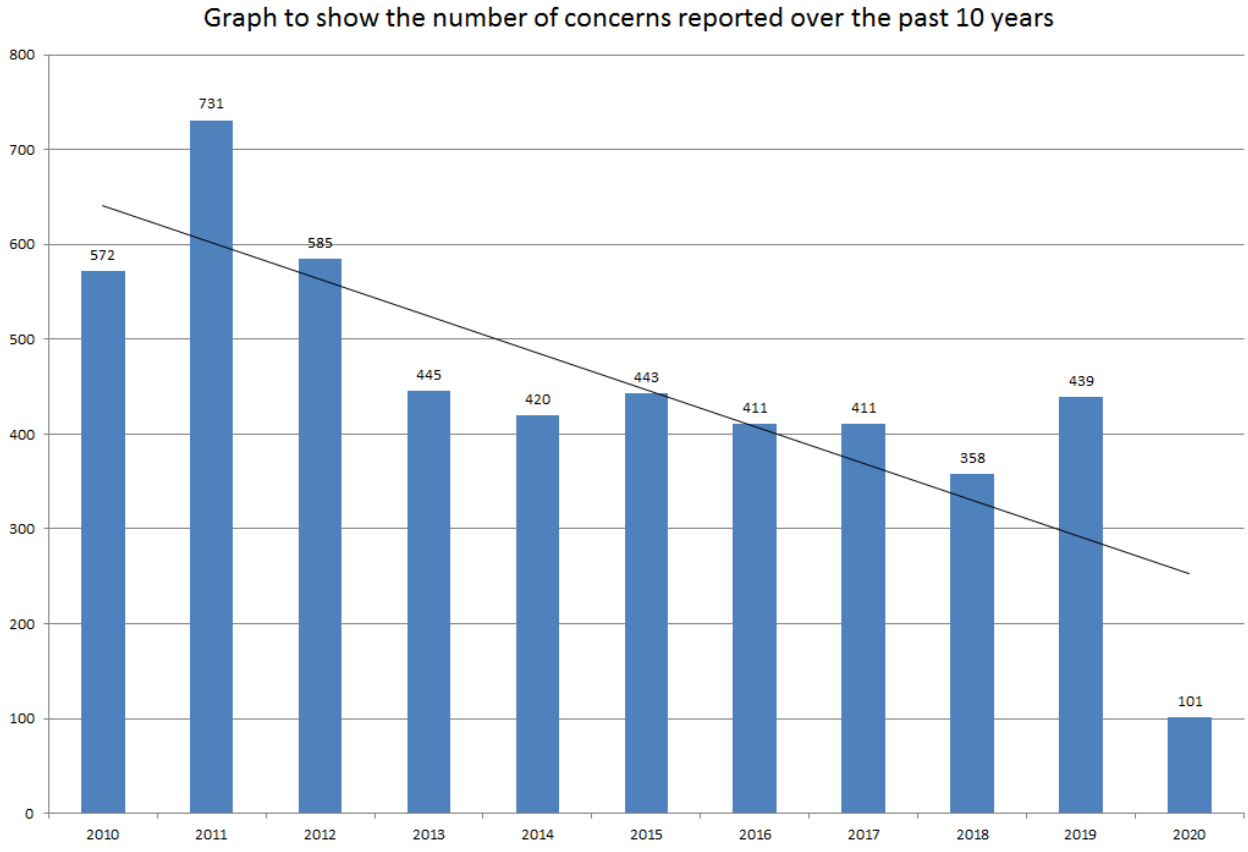
Being treated with 'care' and kindness, along with the professionalism of those treating them are words that appear most frequently.

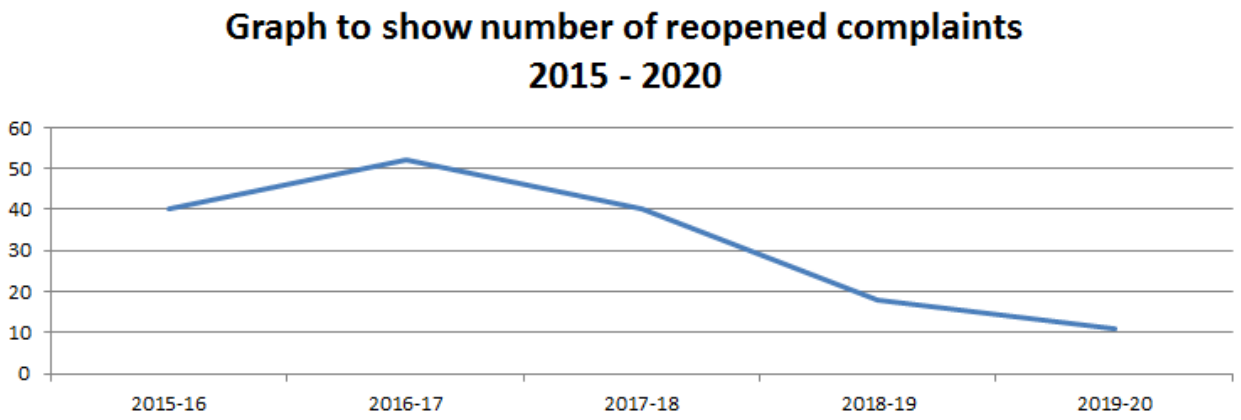
References:

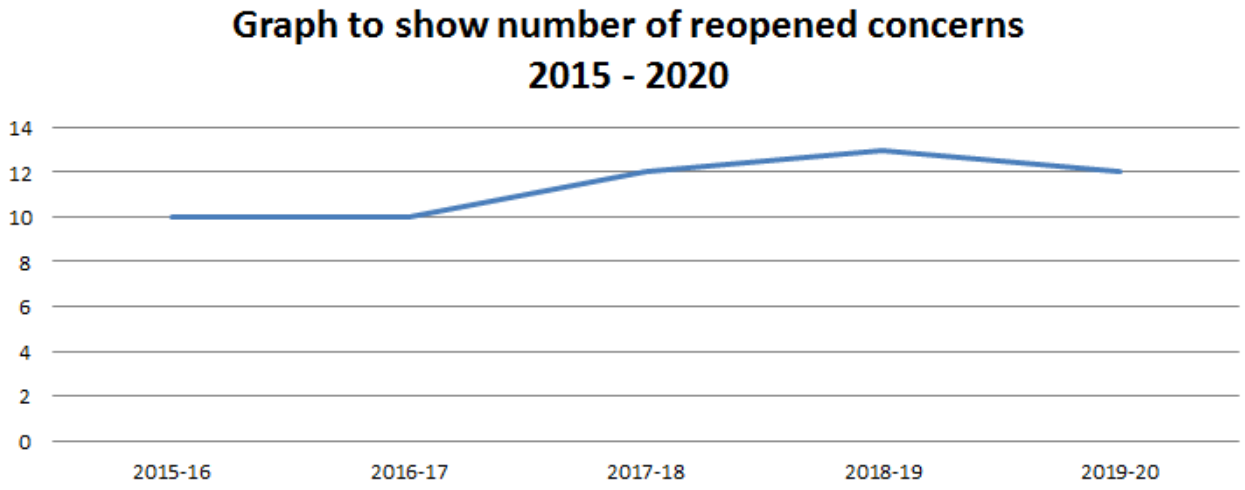
1. Department of Health,. 2012. NHS patient experience framework. Department of Health. Gateway Ref No 17273
2. Jenkinson C, Coulter A, Bruster S, *et al* Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care *Quality and Safety in Health Care* 2002;**11**:335-339.
3. Ahmed F, Burt J & Roland M. Measuring Patient Experience: Concepts and Methods. *Patient* **7**, 235–241 (2014) doi:10.1007/s40271-014-0060-5

Appendix 2 – look back at complaints and concern numbers of the years

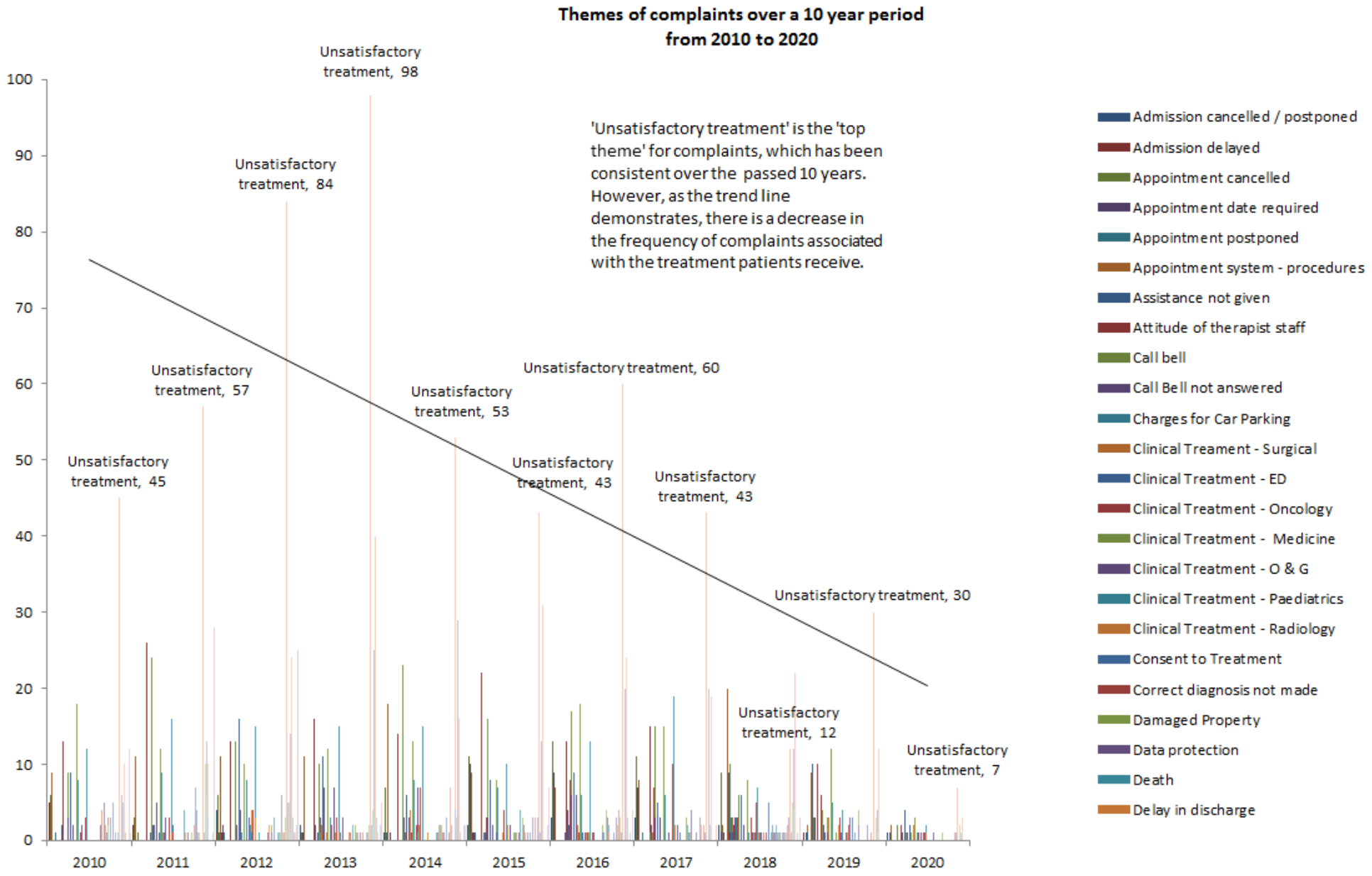


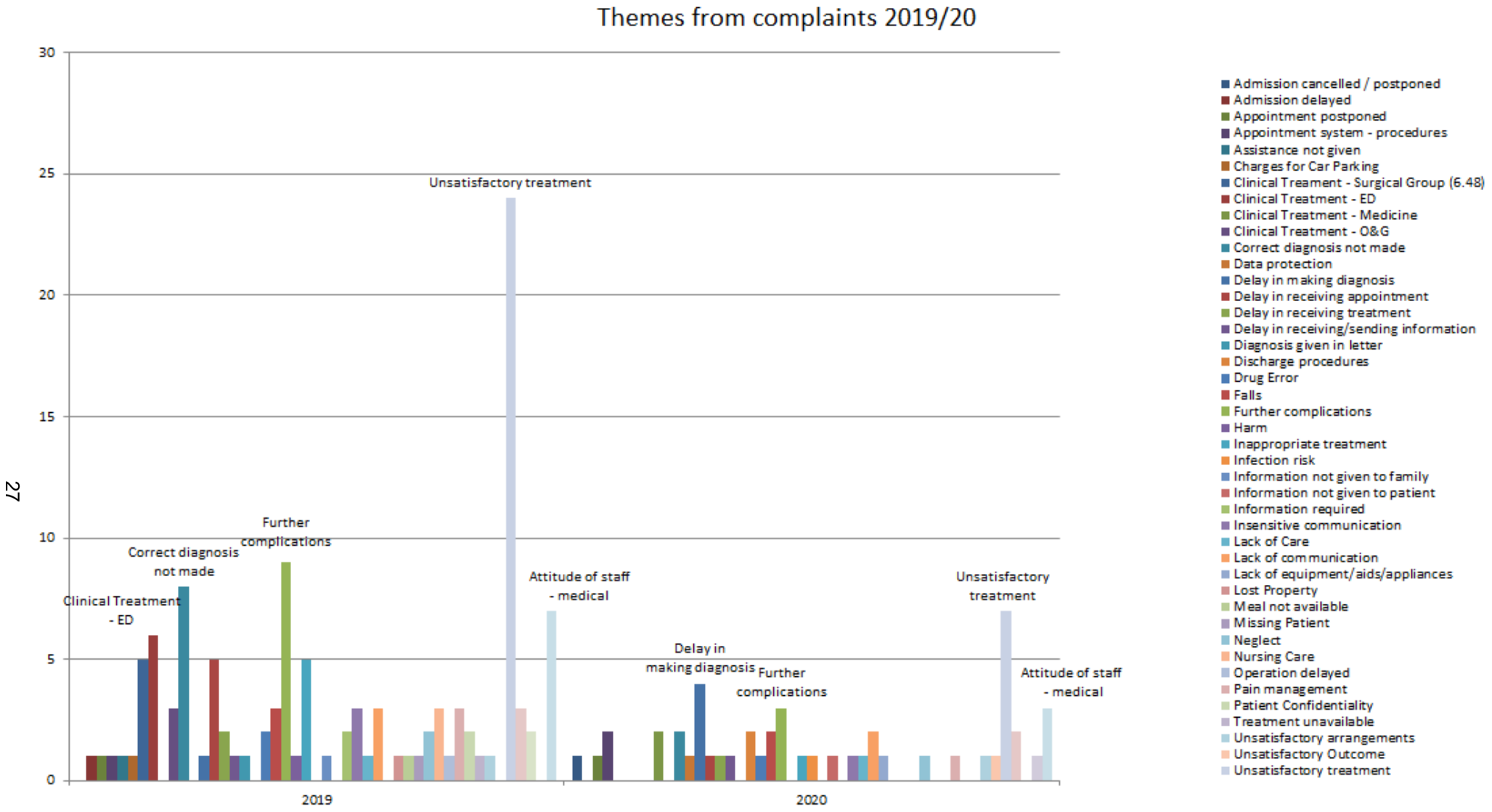


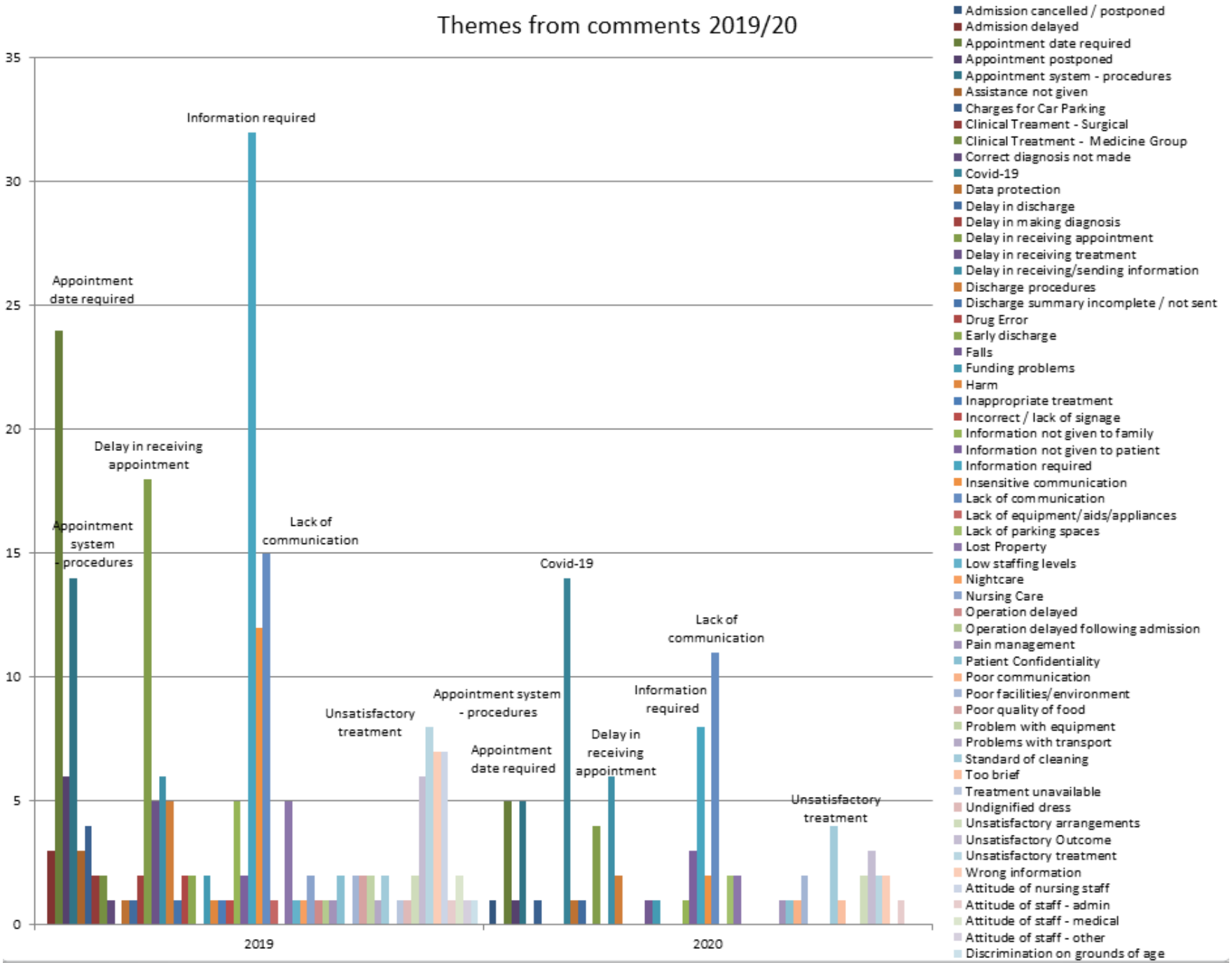


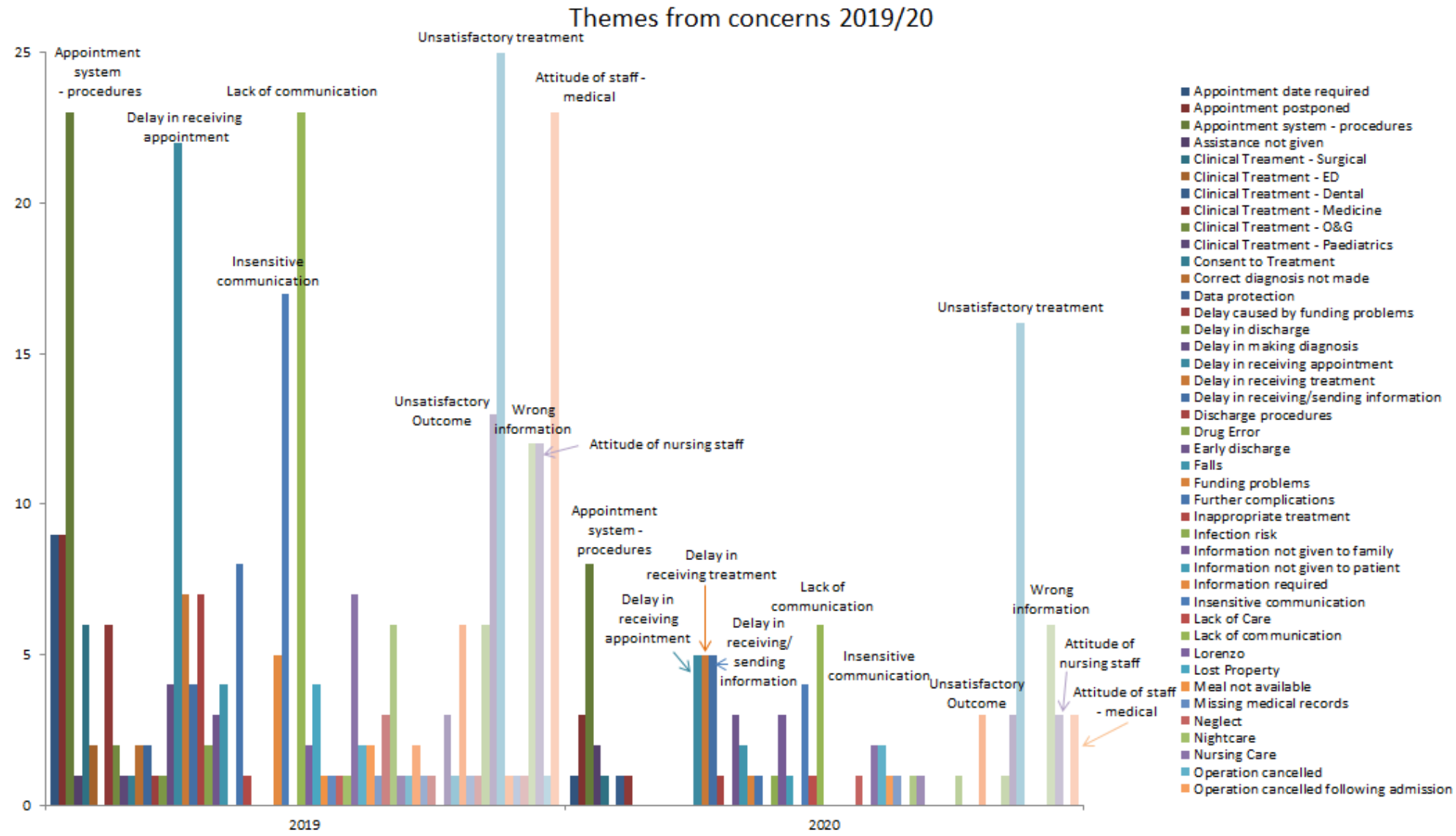


Whilst the rate for complaints that are reopened has reduced over time; the same cannot be said for concerns. Different staff groups are involved in writing response letters for concerns and the letters do not get the same level of scrutiny as complaint responses do. Additional training to help staff investigate and respond to concerns will be offered in 2020/21.


Themes of complaints over a 10 year period from 2010 to 2020
'Unsatisfactory treatment' is the 'top theme' for complaints, which has been consistent over the passed 10 years. However, as the trend line demonstrates, there is a decrease in the frequency of complaints associated with the treatment patients receive.
Unsatisfactory treatment, 45
Unsatisfactory treatment, 57
Unsatisfactory treatment, 84
Unsatisfactory treatment, 98
Unsatisfactory treatment, 53
Unsatisfactory treatment, 60
Unsatisfactory treatment, 43
Unsatisfactory treatment, 43
Unsatisfactory treatment, 30
Unsatisfactory treatment, 12
Unsatisfactory treatment, 7
100
90
80
70
60
50
40
30
20
10
0
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Admission cancelled / postponed
Admission delayed
Appointment cancelled
Appointment date required
Appointment postponed
Appointment system - procedures
Assistance not given
Attitude of therapist staff
Call bell
Call Bell not answered
Charges for Car Parking
Clinical Treament - Surgical
Clinical Treatment - ED
Clinical Treatment - Oncology
Clinical Treatment - Medicine
Clinical Treatment - O & G
Clinical Treatment - Paediatrics
Clinical Treatment - Radiology
Consent to Treatment
Correct diagnosis not made
Damaged Property
Data protection
Death
Delay in discharge


Themes from complaints 2019/20
30
25
20
15
10
5
0
Unsatisfactory treatment
Further complications
Correct diagnosis not made
Clinical Treatment - ED
Attitude of staff - medical
Delay in making diagnosis
Further complications
Unsatisfactory treatment
Attitude of staff - medical
2019
2020
Admission cancelled / postponed
Admission delayed
Appointment postponed
Appointment system - procedures
Assistance not given
Charges for Car Parking
Clinical Treament - Surgical Group (6.48)
Clinical Treatment - ED
Clinical Treatment - Medicine
Clinical Treatment - O&G
Correct diagnosis not made
Data protection
Delay in making diagnosis
Delay in receiving appointment
Delay in receiving treatment
Delay in receiving/sending information
Diagnosis given in letter
Discharge procedures
Drug Error
Falls
Further complications
Harm
Inappropriate treatment
Infection risk
Information not given to family
Information not given to patient
Information required
Insensitive communication
Lack of Care
Lack of communication
Lack of equipment/aids/appliances
Lost Property
Meal not available
Missing Patient
Neglect
Nursing Care
Operation delayed
Pain management
Patient Confidentiality
Treatment unavailable
Unsatisfactory arrangements
Unsatisfactory Outcome
Unsatisfactory treatment


Themes from comments 2019/20
35
30
25
20
15
10
5
0
2019
2020
Information required
Appointment date required
Delay in receiving appointment
Appointment system - procedures
Lack of communication
Unsatisfactory treatment
Appointment system - procedures
Appointment date required
Covid-19
Delay in receiving appointment
Information required
Lack of communication
Unsatisfactory treatment
Admission cancelled / postponed
Admission delayed
Appointment date required
Appointment postponed
Appointment system - procedures
Assistance not given
Charges for Car Parking
Clinical Treament - Surgical
Clinical Treatment - Medicine Group
Correct diagnosis not made
Covid-19
Data protection
Delay in discharge
Delay in making diagnosis
Delay in receiving appointment
Delay in receiving treatment
Delay in receiving/sending information
Discharge procedures
Discharge summary incomplete / not sent
Drug Error
Early discharge
Falls
Funding problems
Harm
Inappropriate treatment
Incorrect / lack of signage
Information not given to family
Information not given to patient
Information required
Insensitive communication
Lack of communication
Lack of equipment/aids/appliances
Lack of parking spaces
Lost Property
Low staffing levels
Nightcare
Nursing Care
Operation delayed
Operation delayed following admission
Pain management
Patient Confidentiality
Poor communication
Poor facilities/environment
Poor quality of food
Problem with equipment
Problems with transport
Standard of cleaning
Too brief
Treatment unavailable
Undignified dress
Unsatisfactory arrangements
Unsatisfactory Outcome
Unsatisfactory treatment
Wrong information
Attitude of nursing staff
Attitude of staff - admin
Attitude of staff - medical
Attitude of staff - other
Discrimination on grounds of age


Themes from concerns 2019/20
25
20
15
10
5
0
2019
2020
Appointment system - procedures
Delay in receiving appointment
Lack of communication
Insensitive communication
Unsatisfactory treatment
Attitude of staff - medical
Unsatisfactory Outcome
Wrong information
Attitude of nursing staff
Appointment system - procedures
Delay in receiving treatment
Delay in receiving appointment
Delay in receiving/ sending information
Lack of communication
Insensitive communication
Unsatisfactory treatment
Unsatisfactory Outcome
Wrong information
Attitude of nursing staff
Attitude of staff - medical
Appointment date required
Appointment postponed
Appointment system - procedures
Assistance not given
Clinical Treament - Surgical
Clinical Treatment - ED
Clinical Treatment - Dental
Clinical Treatment - Medicine
Clinical Treatment - O&G
Clinical Treatment - Paediatrics
Consent to Treatment
Correct diagnosis not made
Data protection
Delay caused by funding problems
Delay in discharge
Delay in making diagnosis
Delay in receiving appointment
Delay in receiving treatment
Delay in receiving/sending information
Discharge procedures
Drug Error
Early discharge
Falls
Funding problems
Further complications
Inappropriate treatment
Infection risk
Information not given to family
Information not given to patient
Information required
Insensitive communication
Lack of Care
Lack of communication
Lorenzo
Lost Property
Meal not available
Missing medical records
Neglect
Nightcare
Nursing Care
Operation cancelled
Operation cancelled following admission

Appendix 3 – demographics

Chart to show the age of patients making a complaint (2019/20)

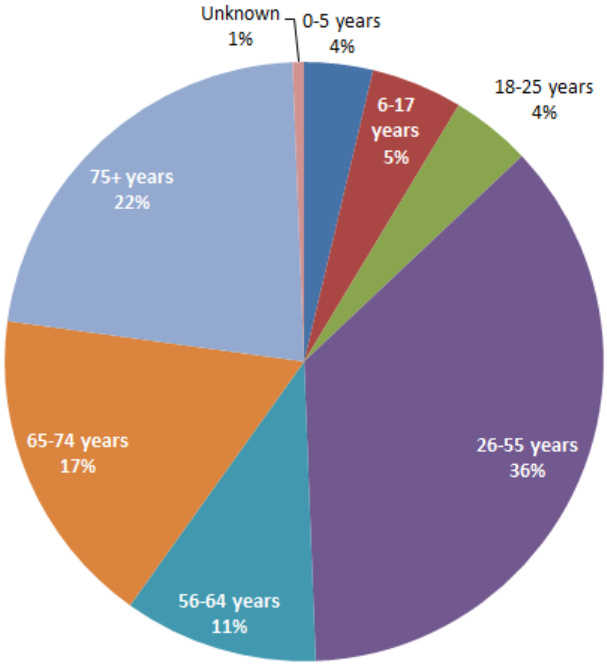


Chart to show the gender of patients who have made a complaint (2019/20)

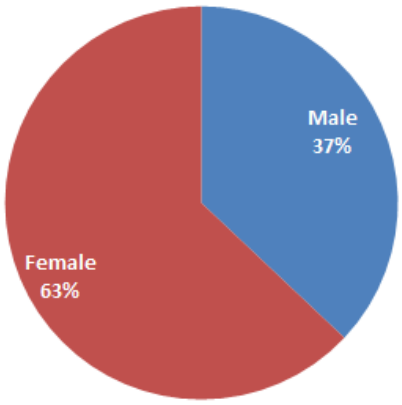
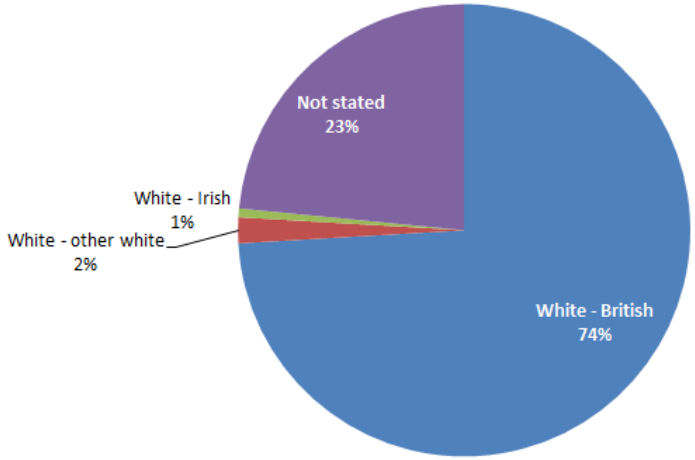


Chart to show the ethnicity of patients making a complaint (2019/20)



Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1b
Date of Meeting:	02 July 2020		

Report Title:	Patient and Public Experience and Involvement Progress on our Priorities – July 2019 (end of year update)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
Prepared by:	Katrina Glaister, Head of Patient Experience			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing			
Appendices (list if applicable):	Patient and Public Experience – strategy			

Recommendation:
The Board is asked to note this report.

Executive Summary:

This report provides end of year update of report of progress against our Patient and Public Experience and Involvement Priorities:

1. **Communication**

We want to build on the work that has already taken place and improve the way we listen to and communicate with our patients their families and their carers

2. **Working together**

We want to review patient experience (positive and negative) and learn from it so we can improve our services and how people are involved

3. **Outstanding care**

We want our patients, their families and carers to have an outstanding experience first time and every time they come into contact with our staff

Updates and progress on existing work is presented; along with the initiatives that are planned for 2020/21.

Engagement with patients/the public at all levels of the Engagement Ladder are evidenced.

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

Patient and Public Experience and Involvement
Progress on our Priorities 2019 - 2020

Our priorities 2019 - 2022

The priorities for 2019 – 2022 were discussed and agreed with patients, the local Health Watch Manager, Health Watch patient representatives and an NHS England Patient Engagement Fellow and are set out within the Patient/Public Engagement Strategy and published on our website.

Whilst there is some good evidence that patients are involved across the Trust; the involvement tends to sit on the bottom rungs of the engagement ladder (see appendix 1). It is our aim to demonstrate engagement at all levels of the engagement ladder.

Therefore we need to continue:

- Actively considering the role of patients/public and opportunities for involvement in planning all our work (including service improvement work)
- Involving people in ways that are meaningful to them as well as us; including encouraging them taking the lead
- Including as diverse a range of voices as possible
- Supporting the people we involve, being clear about what we are asking of them and what they can expect of us.

Each initiative is marked with the level it meets (level 1, 2, 3 or 4) according to the engagement ladder.

1. Communication

We want to build on the work that has already taken place and improve the way we listen to and communicate with our patients their families and their carers

In 2019/20:

Proactively capturing the experiences of our patients (level 3)

Patient Stories are heard at the Public Board meeting on alternate months. These stories have been recorded and are shard with clinical teams. Going forward to 2020/21 the stories will be added to a page on our intranet along with a tool for reflection that can be used by individuals/teams.

The process for sharing stories that the Trust has in place has been shown to increase equality in access to the Board. This has been shared at an International Conference where our process and the way we hear stories generated much interest.
https://www.artsinhealth.wales/programme.html

Learning from Serious Incident Incidents (level 3)

The daughter of a woman who died from sepsis has been attending the hospital at monthly education sessions run by the Critical Care Outreach Team. Her story has now been

captured digitally so that she does not now have to attend in person to recount it. This story has also been shared with the Board.

Due to the increased number of serious incidents across the organisation linked to cancer pathways a Risk Summit was held in September 2019. This was an opportunity to explore and discuss the themes and trends that have been highlighted and provide fresh solutions. Emotional stories from two patients with a delayed/missed diagnosis of cancer opened the Summit.

Communicating learning from complaints (level 1)

Feedback from complainants unhappy with our response to their complaint show that not having a formal mechanism to share learning is hampering our being able to demonstrate that learning is shared beyond the particular clinical/non-clinical team involved in the complaint. A newsletter is now sent to the clinical teams every quarter. The newsletter includes themes and key learning from complaints and incidents.

Information for relatives when a loved one is admitted to ITU (COVID-19) (level 2)

The Intensive Care Team within the Trust created an information leaflet for relatives/NOK of critically ill patients admitted to intensive care with COVID19. Because of the potential for restricted visiting (or no visitors) the team wanted to provide people with written information as a back up to the conversations they planned to have with relatives either over the phone or face-to-face. Members of the public were asked to review the content of the leaflet firstly to see if they felt such a leaflet would be useful and secondly in terms of the language used. The only anxiety raised by the volunteers was that the letter was given to relatives without the face-to-face/telephone conversation. Otherwise the letter was universally welcomed. The letter was amended in the light of their feedback and has now been published for nationwide use by The Intensive Care Society. https://www.ics.ac.uk/ICS/ICS/Pdfs/COVID-19/Guide_to_patient_care_on_ICU_for_families_and_relatives.aspx

Translating feedback into actions

Twice a year we work with a multidisciplinary group of staff from each ward to review and theme any negative feedback received via real time feedback, complaints and the inpatient survey. The ward team put actions in place with the aim that the themes will not recur next time around.

Improvement work on two frequently occurring themes cold food (trust-wide) and lack of entertainment for children (Sarum) have resulted in positive improvements in patient experience

- Wards that deliver food course by course no longer see any negative comments regarding food temperature
- An advert on our Facebook page for play volunteers resulted in 3 new volunteers who now work alongside the ward team and provide additional play time activities.

Communicating all our feedback channels

PALS moved office from the Nunton Unit to Admin Block 29 in Q3. A short-stay, free car parking space was made available for visitors. Whilst patients//relatives managed to find their way to the new office its location was not ideal. In Q1 2020/21 PALS will move to an office close to the Day Surgery Unit and proposed site for the new MRI scanner. This should make it much easier for patients/relatives to visit us and increase our overall accessibility/visibility.

A Governor noted that the hospital's website gave clear advice on how to make a complaint but there was no guidance on how a member of the public/patient could send a compliment. A link to the SOX (Sharing Outstanding Excellence) form has been added and patients are now using this facility and the dedicated email address to send positive feedback.

Compliments received via real time feedback and inpatient surveys are now sent to the relevant individual/team in a SOX.

Customer Care boards (Level 1)

Customer Care boards on wards have been updated to reflect the changes to the department name and contact details. We have worked with wards to personalise the boards and ensure that the information given is relevant to patients and their visitors.

National inpatient survey (Level 2)

The 2018 survey (published 2019) results showed that we had had a significant decrease in a positive response to the question 'During your hospital stay, were you ever asked to give your views on the quality of your care?' We spoke to Trusts who scored higher on this question to see what we can do to improve responses to this question in the 2019 survey. One patient we spoke to suggested there was a disconnect between the questions we ask as part of real time feedback and the ward-based questions asked as part of Perfect Ward app and the question in the survey which refers to 'quality of care'. Those speaking to patients have been asked to alter how they ask the question and say that the questions they would like to ask are about 'quality of care'.

We also scored poorly on the question 'Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?' We have explored how other Trusts advertise their complaint process to improve responses to this question. The one difference between how they do it and how it is done here is that their PALS office is sited in a patient-accessible area.

New complaint posters have been designed, printed and distributed to all patient areas.

The hospital website (level 4)

The hospital's website is being developed and the new version will be launched in Q3 2020/21. Patient representatives are key members of the website steering group and their views/ideas are shaping the design of the website. Patients and visitors will be asked to give their feedback on the new design and functionality in Q1 2020/21 (although this may be delayed due to the need for social distancing). The new beta version of the website can be made available without the need to access a Trust computer so testing could potentially be done remotely.

Table talker (level 3)

A multidisciplinary team have been working with PALS this year to develop a 'table talker' to promote patients and their relatives to ask questions of staff regarding plans for the discharge from hospital. This has been shared with and shaped by patients/members of the general public who have helped us design the table talker and have translated the clinical language used into patient-friendly accessible language. The table talker was piloted in September 2019

We had hoped to speak to patients and families about the initiative after the table talkers were put out on display, however, all the table talkers had disappeared when we next visited the ward.

The plan is to try this initiative with another ward. If feedback is positive the plan is to roll this out Trust-wide and publish the work on the Academy of Fabulous Stuff NHS website.

Improving how patient information is made available electronically (level 3)

For many years all our patient information has been published internally and on our website. The way that the information has been structured is not patient-friendly; although attempts have been made to improve the index. MicroGuide (an app with additional web-view) is the new home for all our clinical and non-clinical information and all procedural documents have been moved there.

A workshop with patients/families and staff was held in July 2019. The patients and family members were very supportive of an app-based solution and were happy to help us design the look and feel of the app going forward.

The app was due to be released to us in Q4 but there has been a delay and will therefore go live in Q1 20/21

All patient information is read and commented on by a panel of volunteers. Going forward this interaction will be electronic rather than paper-based.

Vision Coach (level 1/2)

A pilot for a new patient support app which has been designed specifically for those living with diabetic macular oedema (DMO) has been set up. The programme, called Vision Coach, is fully funded and supported by Bayer, and the pilot will run initially for 6 months. Vision coach helps patients take charge of their DMO including:

- Reviewing treatment plans
- Setting goals and tracking your progress
- Accessing eyesight scores
- Managing appointments

The pilot is running from April 2020 and will be formally evaluated.

Communication passport

The Patient Safety Lead from NHS England/NHS Improvement asked us to speak to some patients/patient groups with a view to gaining feedback on the function and accessibility of a new communication passport that they had developed. Wiltshire Sight, Mencap and the Speech and Language Team at the Trust were involved in the review. All felt that our existing in-house passports worked better and were more accessible than the new passport. A particular strength of ours was that it had been co-designed with patients. The feedback was sent to NHSE/I along with our passports for their review.

2. Working together

We want to review patient experience (positive and negative) and learn from it so we can improve our services and how people are involved

In 2019/20:

Reaching out and working in partnership with our patients (level 2)

A PALS out-reach clinic has been running at Salisbury Medical Practice since April 2019. A member of the team attended every month and was available to speak with patients/general public, signpost and deal with any queries about the hospital.

A number of focus groups and workshops with patients/carers/families have been held (see appendix 3). Reports on the findings have been written up and actions taken as appropriate. The reports are shared with all of the group's participants.

There is a patient/governor on the Food and Nutrition Steering Group and the Signage Group. The patients' voices shape the agenda and the groups' work streams. For example the maps that are now displayed on the lecterns in the carparks have been designed with patients and the final designs were tested with patients. The version currently published is the one that patients/visitors preferred one.

Carers Café (Level 2)

Our Carers Cafés are held each week and is managed by 2 volunteers. On average 3 carers make use of the café each week. Issues that have been brought to the café include:

- staff not recognising that the carer is an expert in the care of the patient
- not listening to carers

- Timing of Parkinson's disease medication
- Lack of involvement in the discharge process

A signposting service is also provided. A tablet donated by Carers Support Wiltshire is available for carers to look up and download relevant literature.

Veterans (Level 3)

A special Armed Forces Carers Café was held in honour of Armed forces week and another for Remembrance Day in November 2019. The Defence medical welfare service (DMWS) were in attendance along with the British legion and the regular Carers café volunteers. The DMWS try to attend weekly and gain a lot of their referrals this way. They are based in the Hospital part of the week. They are beginning to work closely with PALS to build a relationship that will be of benefit to any Veterans, serving soldiers and their families.

Working with outside agencies including Help for Heroes, Alabare and the Defence Medical Welfare Service we have helped patients who have come in to the hospital as an emergency and have had no clothes or toiletries with them. Along with Blesma (the Armed Forces charity that supports limbless veterans) we have been supporting families of patients at a time when contact is limited and ensuring their concerns are being received and fed back to the relevant teams and more importantly that they are listened too and supported.

Wessex Cancer Trust 'What now…'

A focus group was held to talk about the closure of the Wessex Cancer Trust and how this will have affected patients and the wider community. Past members of Wessex Cancer Trust are running the group from the Salisbury Medical Practice whilst there is room availability and time but the feeling of those present at the focus group is that they would very much appreciate help from the Hospital if it were on offer. There are many successful centres that could be looked at for guidance including Jane Scarfe House in Romsey. The ideal would be that the local community could access classes, sessions, cafes and chats, holistic treatments and counselling. The focus group discussed a change of name, location, press and social media support.

Each of the members felt they would have benefited from being offered this support at different stages in their journey from diagnosis right up to a year on therefore a central accessible place with good internet presence would be welcomed by the local community.

The Trust's cancer nurses are sending out a survey to the wider patient/general public population and an action plan will be developed going forwards.

Campus redesign (level 4)

A campus redevelopment workshop was held with local stakeholders and patients at the City Hall in July 2019. The workshop was facilitated by PALS and ArtCare and a creative approach to the workshop was taken; resulting in an entertaining and engaging afternoon with great suggestions as to how health and wellbeing could be improved in the development of the site going forward. Posters displaying the results of the workshop have been drawn up and will be shared going forwards (see appendix 5).

Spinal unit re-design (level 4/5)

The spinal Unit redesign initiative has had patient engagement at all stages; including a patient taking an active role in deciding which architect should be chosen. The project team (with strong patient involvement) is now working together to come up with a service design plan which will feed into the re-design work.

Learning from deaths (level 2)

An audit has demonstrated significant improvement in end of life care throughout the organisation since 2014. Improvements have been seen around the number of patients who

received specialist support by the end of life care team or hospital palliative care team (52% vs 38% nationally) and an improvement in the percentage of patients who had the opportunity to be involved in discussions about their care (30% vs 20% nationally). A 'Your views matter' survey on was completed in July 2019 and an EOLC bereavement service started at the same time. Condolence cards and helpful information are now sent 3 weeks after a death. The Bereavement Survey had a slow start but the number of people responding has picked up and we now have feedback from 48 families. Positive feedback and learning points are shared with the relevant areas.

Dementia Care (level 4)

The Dementia Steering Group meets quarterly and provides leadership and expert advice drawing from a wide range of representatives from the local community. This partnership working is essential to the delivery of dementia care within Salisbury hospital as part the National Dementia Strategy and the Wiltshire Dementia Strategy. The group monitors training compliance, the use of the delirium care bundle and the use of blue wrist bands for people with cognitive issues. The group actively supports the use of 'stay with volunteers' who provide therapeutic social engagement and interaction for those patients who have no family/visitors. Carers and Health Watch Wiltshire are active participants of the steering group who drive the improvement agenda.

2019/20 saw the opening of the memory café on Level 2. This initiative was funded by the League of Friends. Social interactions with others patients can help reduce loneliness, depression and feelings of isolation. Additionally involvement in creative, meaningful activities, such as the Magic Table can improve health & well-being. Feedback from patients and staff has been very positive.

Carers Group (level 4)

Salisbury Hospital works in close partnership with Carer's Support Wiltshire to ensure that hospital services are developed to support carers in their caring responsibility. The group promotes the health and independence of carers; ensuring they are involved during the cared for person's stay in hospital, and in particular, in planning for discharge from hospital. The group have refreshed the Memorandum of Understanding and have surveyed around 150 local carers in doing so.

The group have kindly offered to write the content for the carers pages on our website (due for launch in Q3 2020/21)

3. Outstanding care

We want our patients, their families and carers to have an outstanding experience first time and every time they come into contact with our staff

In 2019/20:

Public and Patient Initiatives (PPI) (Levels 1 - 4)

We are supporting a number of patient and public involvement initiatives at department level and providing areas with the tools to carry out their projects. Recently we have been offering an extra level of support by way of our facilitation skills and time; helping them gather feedback via a variety of methods including focus groups, surveying patients, taking forward actions and becoming ambassadors for Trust wide campaigns.

A directory of users who have said that they wish to be involved in helping us improve patient experience has been pulled together.

Treat me well (level 4)

Salisbury NHS Foundation Trust is now one of Mencap's 14 'Treat me well' target areas for England. Not only will this allow Mencap to support us in our campaign but we will be included in their evaluation and report on the national campaign. A learning disability/autism strategy has been drafted and items in this year's work plan include:

- Identify and share the location of quiet spaces for patients/carers to use
- Introduce noise reducing headphones
- Plan, build and register our Changes Room toilet

The working group has good representation from Mencap and service users/family members and they are driving the improvement work.

Eat, Drink, Move

'Eat Drink Move' supports health, well-being and recovery and aims to maintain functional capacity as far as possible during a hospital admission. Following its launch, an engagement event was held on Spire Ward in June 2019. Feedback showed that offering the day room as a social room for relevant patients to attend for social events/mealtimes would be welcomed. All of the patients who attended appeared to enjoy the experience in their own way. One enjoyed observing and eating throughout the entire session, another joined in with singing once the music started.

- Relatives we spoke to felt really involved in their relative's care and in the plan for their care.
- All of the patients we spoke to felt they were offered enough to eat and drink.

This project is on hold until there is regular staffing has been found to allow lunch clubs to take place and mobility volunteers are a regular feature on the ward. From there we will be gathering further feedback.

Responding to children/family feedback

1. Following a collaborative planning day with Wiltshire creative and representatives from the community, a patient engagement project was identified. A mental health signposting card for relevant young people and their parents/carers would be offered to act as a bridge between discharge and follow up/referral. We are working with a patient and his parents to create this card along with ward staff, medical team, the safeguarding team, community staff and local charities.

   A Focus group was held with students from Wiltshire College. Feedback was positive as well as constructive and a follow up meeting with the project team is needed to decide on next steps before further design and focus groups will take place. Salisbury Sixth Form College and another Wiltshire college group have expressed an interest in helping with this. Initial feedback was that the proposed QR code was rather 'old fashioned' and not as easy to access as we had thought. A very simple web address would be far more accessible with an app being the ideal solution.

2. Following a regular review of real time feedback, an action was formulated and request was put to members of the local community to see if anyone would like to be a play volunteer. The suggestion was that they could run regular sessions involving crafting, storytime, singing etc; whatever they would like to bring to the schedule based on their own creative talents. We had 3 respondents and these volunteers are now working on Sarum and offering regular activities on the ward.

The experiences of patients with urinary stomas (level 3)

Research has shown that whilst the needs of patients with a colostomy are well understood by healthcare professionals; the needs of patients with a urostomy as less so. A focus group was held in June 2019 with 8 patients and 2 carers.

Key learning that emerged was that specialist wards (surgical) were very knowledgeable but if patients were admitted as an emergency to another ward; healthcare professionals' knowledge was not as good. The need for a central emergency store holding urostomy equipment was suggested. This is because urinary sepsis is a frequent cause for admission to hospital in this group and patients often did not have time or were too unwell to pick up their supplies.

The group particularly highlighted the need for all public toilets in the Trust to be stoma friendly (to have a shelf, hook on the back of the door and a mirror at waist level). The report has been written and was shared with the participants.

As a direct action the bathroom facilities on Britford and Downton Ward have been made stoma friendly. Urostomy patients and Stoma UK worked with the teams to get this work done. Out of hours supplies have been made more accessible/visible for all staff to access and stoma kits bags are now kept on Britford and Downton in case patients are admitted as an emergency and do not bring supplies in with them..

Rehabilitation (level 4)

Twice-yearly focus groups/workshops have been held with patients being cared for at Wessex Rehabilitation Centre. The first group resulted in a patient story being presented to the Board. The focus groups were felt to be valuable by those present and the staff that received the feedback. As well as praising the service, patients were honest about their thoughts and feelings about the services available to them and in defining what matters to them.

Patients asked for a closed Facebook group to be set up so that they could stay in contact with the Centre and offer peer support. This went live in Q4. Feedback from patients on this initiative has been very positive

Patient initiated follow up (PIFU) (Level 1)

Research has shown that having a regular outpatient follow up does not help to prevent patients' conditions returning or identify new problems. In fact, many people find that follow up visits to the hospital cause a lot of unnecessary anxiety. Patient initiated follow up allows patients to contact us when they want an appointment. PIFU appointments have been available in a limited number of specialties within the Trust but the Outpatient Transformation Programme believed that they could be offered in an increased number of specialties. A multiprofessional group of staff came together to review the current PIFU pathway and discuss ways to improve the patients' experience. This working group has:

- Written new information about PIFU for our website,
- Written a new patient information sheet template (to be amended for each specialty). The aim of this is to help patients know what signs or symptoms they should be aware of and when to arrange a PIFU appointment
- As a result of patient feedback a new PIFU card has been designed. This will be given to all patients on a PIFU pathway and provide contact details.
- Written a SOP for PIFU

This work reports into the Outpatient Transformation Programme.

Attend anywhere (level 1)

Following the launch of attend anywhere appointments in paediatrics, we followed up the trial appointments of patients with a call to the parents to gather feedback on the service. All

feedback was really positive with everyone siting reduction in stress, time and money saved and ability to relax in own surroundings as the main benefits. Appointments are now being rolled out in a variety of other specialities and we have offered to carry on gathering feedback verbally where relevant/welcomed.

Comment from a clinician:

'It was good to see people attending my appointment with a cup a tea, a few pets were involved, and because parents and children are both sharing the same screen (and sofa) – it feels as though they have an equal voice and are equally present in a way which you sometimes don't even get when they are sat in the room. The quality of the interaction between parents and their children is completely different when they are relaxed and in their own home - and this really helps me foster a 'team' approach to decision making'.

Feedback from a patient:

The patient's daughter, son and husband have to attend the hospital regularly and have a way to travel so the money saved on petrol costs is huge – likewise parking costs mount up (£12 recently). She loves the idea of using her phone as she can move to a private area outside as currently her mother-in-law lives with them and happily listens to all her conversations which she then recounts to her neighbours.

NICE Quality Standard – patient experience in adult NHS Services

This quality standard covers improving the quality of the patient experience for people who use adult NHS services. It describes high-quality care in priority areas for improvement. The quality standard was first published in 2012 and at this time the Trust self-assessment reported us as compliant with all elements. In July 2019 this quality standard was updated. Some statements were merged or had wording amended and so the Standard was sent out to the Directorate Management Teams for their assessment on their current status.

The statements that make up this Standard are:

- People using adult NHS services are treated with empathy, dignity and respect.
- People using adult NHS services understand the roles of healthcare professionals involved in their care and know how to contact them about their ongoing healthcare needs.
- People using adult NHS services experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
- People using adult NHS services experience care and treatment that is tailored to their needs and preferences.
- People using adult NHS services have their preferences for sharing information with their family members and carers established, respected and reviewed throughout their care.
- People using adult NHS services are supported in shared decision making.

All Directorate Leads confirmed that they remain compliant with all the statements.

Transition to adult services

The paediatric diabetes team are working on a project to make their transition to adult services (from paeds) as good as it can be – This is a national QI project which will take place from Q4 19/20 to Q2 20/21. They are working collaboratively with patients/ parents/ carers on this and have linked into Wiltshire Young Health Watch for their help with this.

PALS – identified work for 2020/21

Patient experience resources

We have had permission to set up a Patient and Public Involvement website. The design has been mapped out and sent to IT. The website will host and signpost additional resources for staff carrying out PPI projects, report on completed projects and also allow patients/pubic to contact us if they want to be involved. The website is on hold whist the Trust's website is redeveloped but it is hoped that this can be done in 20/21. The PPI toolkit on the Intranet has been reviewed and published on MicroGuide https://viewer.microguide.global/guide/1000000334#content,1df17a5a-25ee-4524-ab5e-96031930d247.

Patient Experience Improvement Framework

This framework enables organisations to carry out an organisation-wide diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes. Five elements of the self-assessment tool were worked on at a multiprofessional workshop with patient representatives in Q2. An action plan will be drawn up against the identified gaps. An additional workshop for the remaining elements of the Framework will be led by NHS England later on in 2020/21.

Patient letters

Appointment letters are sent from this hospital but the appointment itself can be held in a number of different community hospitals. Because the letters are all printed with our logo and address at the top; the fact that the appointment is not at the hospital can be difficult to spot. The Governors have had many reports of patients arriving at the hospital when their appointment was elsewhere and are continuing their work to make the letters clearer; with an emphasis on the clinic location this time.

Real time feedback

We are exploring a different way of capturing real time feedback; using the PerfectWard app. Adding the data to the app will allow the ward leaders to see the results in real time and gives us an easier way to report the data. The downside is that any comments added to the app are not exported within any reports so we will alter the questions to give yes/no answers so that we can better track trends.

Friends and Family Test

The Friends and Family test has been running since 2013 and NHS England have collected 60 million pieces of feedback. On average 9 out of 10 people say they would recommend the service they used to friends and family.

However, since the launch of the initiative many people have identified areas where the question does not work as well as it could (including the question itself) and in response NHS England planned to launched a new question in April 2020 (now delayed due to COVID-19). The requirement for the question having to be given to patients within48 hours of their appointment will go, as will the fixed 'touchpoints' within maternity.

To save paper and printing costs when departments run out of their existing stock of FFT cards we have not been ordering replacements but photocopying small batches on A5 paper to tide us over. There is no information from NHSE yet as to when the new question will be implemented. All data submission has been temporarily suspended.

In the old friends and family test there was simply one question asking patients to give the reason as to why they would (or wouldn't) recommend a department/ward. The new FFT question asks patients to explain what went well and what did not go so well during their visit

to the hospital. It is hoped that analysis of the feedback will provide us with additional data as to how we can improve the patient's experience.

Outpatient Transformation Programme

The Outpatients Transformation Programme aims to redesign outpatient pathways and our outpatient services; taking a patient-centered, co-creation approach. Clinical staff, GPs, local CCGs are involved in the Programme Board. Patient involvement will be key in testing, designing and shaping the changes. Health Watch volunteers have said they would be very interested in helping us. Patients from the eight clinical specialties (ophthalmology, urology, dermatology, rheumatology, trauma & orthopaedics, paediatrics, gastroenterology and respiratory) will be identified by the clinical teams and will work with the Programme Board/PALS.

Training in complaint handling

Links to nationally available complaint handling computer-based learning have been made via our MLE. The four modules are relevant to all healthcare professionals:

- Valuing feedback and complaints
- Encouraging feedback and using it
- The NHS complaints and feedback process
- The value of apology.

PALS will run training workshops every quarter and make changes according to staff feedback.

New 'Using patient feedback for service improvement' workshops are planned for 20/21.

Low Risk Birthing Unit

Two focus groups were held with patients in Q4 19/20 (twice-monthly focus groups were planned from March but have had to be cancelled due to social distancing/non-essential travel requirements). An electronic survey has been published and shared with local maternity/breastfeeding groups. Working with ArtCare PALS will take what we have heard forward to the design phase. A number of women/family members have contacted PALS to say that they would like to continue to be involved in the project and they will be invited to help us with the design and fitting out of the Unit which will take place in Q2/3 2020/21.

Always Events – noise at night

Always Events® are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system". PALS and three ward leaders attending NHSE training on this improvement methodology with a plan to explore patients' experience of noise at night. Data collection had been planned for Q4 but will start once all the wards are open and visiting allowed.

Appendix 1

NHS Engagement Ladder

Core to the Patient and Public Engagement Strategy is a cultural shift from 'doing to' to 'working with' our patients and local community.

The Engagement Ladder is a model promoted by NHS England which shows the steps that staff can take to make their engagement with patients and members of the public more meaningful.

Appendix 2 - Focus groups held

Topic	Date
Eat Drink Move	June 2019
Urostomy	June 2019
Wessex Rehabilitation Centre	June 2019
Moving on after cancer	July 2019
Patient Information App	July 2019
Low Risk Birthing Unit	Feb 2020
Low Risk Birthing Unit	Feb 2020
Complaints (with Healthwatch)	March 2020 (cancelled)

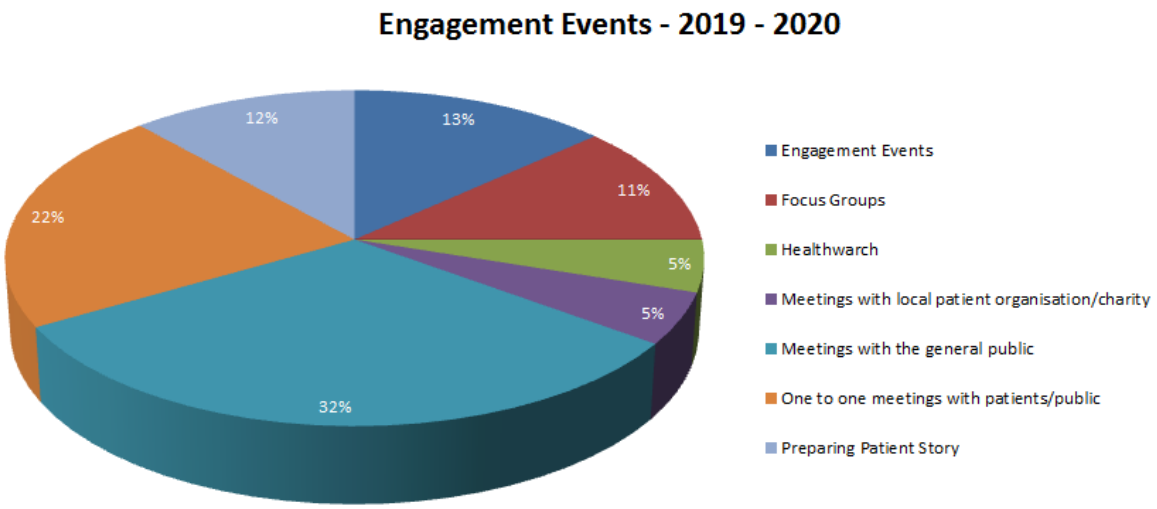
Appendix 3 - PALS - Public and patient involvement initiatives planned for 20/21

Other initiatives in the

Title	Lead
Farley Stroke Unit – environment and communication	PALS
Outpatient Department environment	Alison Hemming/PALS
Carers experience audit	Helen Dowse
Removal of teeth prevention clinic feedback	Gemma Burrows
Laser clinic patients focus group (TBC)	Tom Lister

Parkinson's patient/carer feedback	Emily Scotney
Spinal Bowel prep	Mel Williams
Rapid assessment clinic for IBD patients	Mark Adamson
Nurse led prostate clinic	Cheryl Daniels
Head and neck cancer	John Battersby
Spinal unit engagement project	Penny Calvert
Trust website focus groups	PALS
Vision coach app	Ophthalmology
Postnatal contraception feedback	Maternity
Paediatric constipation and FES focus group	H Chapple
Attend Anywhere feedback from staff and families re Virtual Visits	PALS
Menopause clinic feedback and focus group	Gynaecology

Appendix 4 – chart showing engagement activities



Appendix 5 – poster presentations around the campus redevelopment

NHS Salisbury NHS Foundation Trust

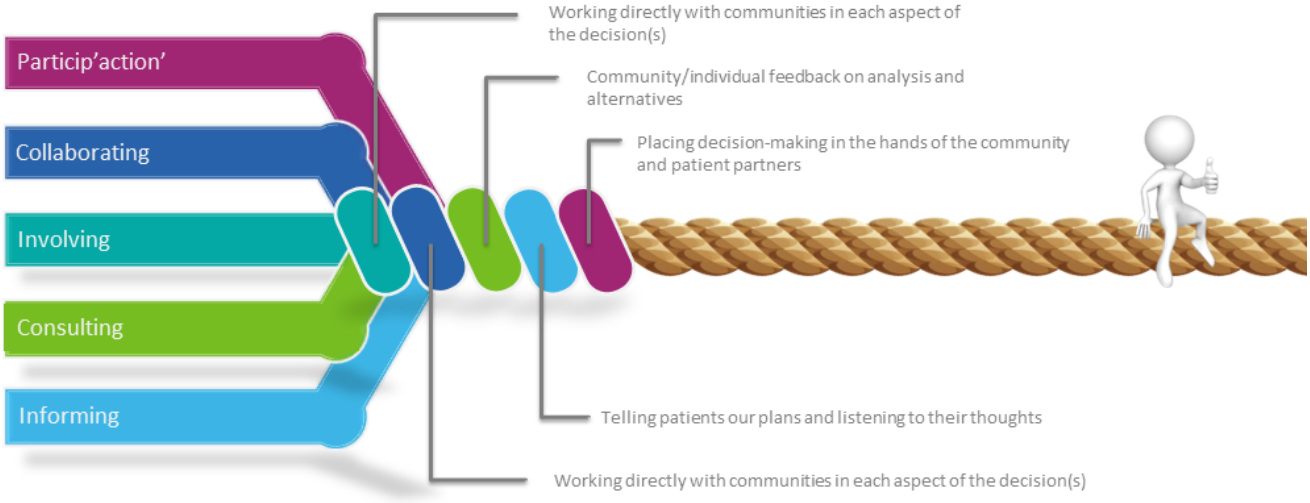
Engaging Patients in the Campus Redevelopment

We believe business is built on relationships, and building them is our business

Katrina Glaister, Head of Patient Experience

Patients have a unique 'front door' experience; their perspective on care at the hospital and their thoughts on our 'shop window' can guide us towards what works and what does not work. Listening to their insight into the 'caring environment' tells us what causes stress and what feels routine (or outstanding). 'Patient' includes: patients, users, families, caregivers, clients, third sector partners and the public (not forgetting the traditionally 'hard to reach' groups such as extremes of age and armed forces). We refer to engaged patients as "Patient Partners."

There are many different ways in which patients can participate in health – depending on their personal circumstances and interest. The Ladder of Engagement and Participation' is a widely recognised model for understanding different forms and degrees of patient and public involvement. Patient activity on every step of the ladder is valuable, although participation becomes more meaningful at the top of the ladder. Our approach is to weave all the strands together into one rope, building on, analysing and sharing at each stage; and in so doing so we create engagement that is inherently stronger than a collection of single and parallel strands.



NHS Salisbury NHS Foundation Trust

Exploring health and wellbeing – a recipe for a healthier Salisbury

We believe business is built on relationships, and building them is our business

Katrina Glaister, Head of Patient Experience

We asked participants:

- What does health mean to you?
- What does wellbeing mean to you and then explored health and wellbeing in more detail

What do you already do to improve your own health/wellbeing?

Talking to friends, family, colleagues
Following advice + proactive self help (attend screening appointments)
Seek further advice - pharmacy and online
Exercise – walking, gym, Pilates, Zumba, yoga , swimming
Healthy diet and drinking water
Sleep
Making time to relax – holidays, socialising
Extra curricular activities
Strategies to reduce stress
Laughter
Clubs – knitting, volunteering
Online – bridge & games
Horse racing

How easy is it?

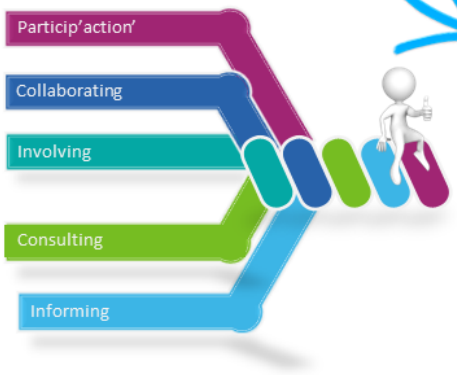
It's tricky but it is better to try to help myself first
Not easy – food especially chocolate and sweet things
One off really easy – to keep it up is really hard!

Are there any barriers?

Yes! knowing where to look and where do I start
Time (mentioned by everyone)
Eating healthily is expensive (money)
Other priorities - work/life balance
Getting an appointment with my GP is difficult
Disconnected from friends and communities (and being alone)
Motivation

Recipe for a healthier Salisbury .... What would you add to the hospital site to support positive changes to your health and wellbeing?

Signage in the hospital (colour coded + footprints)
Monorail!?
Cycle paths
A+E in a better position
Better designed car parks
Yoga studios for 'walking wounded'
Gardens growing edible food
Self-help groups for mental health
Information centre + Information points
Exercise park, exercise classes
Knitting and crochet volunteers to visit patients
Hair dresser, beauty + barber, massage, nail bar
Solar panels
Picnic areas
Demolish the whole thing and start again!
Electric golf buggies to get to far flung departments
Education/rehabilitation rooms
'One stop' support services
Music
Holographic helpers in corridors
Plants and water features, trees + green spaces
Transport links (free bus)
Links with schools
Community health linked into the hospital
Food – café run by catering students
Good mobile signal and connectivity
Digital display screens
Social prescribing
Artwork
Healthy working environment / light / sunshine



Next steps?

- Take forward the themes and ideas for improvement and share at future workshops.
- Co-create a future for SDH that puts health and wellbeing at its centre – for staff, patients and visitors

Many thanks to...

- The members of the public that took time to share their creative ideas around health and wellbeing
- The many organisations and local charities who likewise took time to share their positive ideas for the future of Salisbury District Hospital.

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	02 July 2020		

Report Title:	Staff Survey 2019 action plan			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		X		X
Prepared by:	Glennis Toms, Deputy Director of OD & People			
Executive Sponsor (presenting):	Lynn Lane, Director of OD & People			
Appendices (list if applicable):	Appendix A – Areas of Concern Questions			

Recommendation:
That the Board supports the actions taken so far in addressing the results of the 2019 Staff Survey. A detailed Action Plan is being developed alongside of the Best Place to Work initiative.

Executive Summary:
The results in summary were brought to the Board in February 2020. They showed that the Trust achieved above average scores in eight of the eleven theme areas, at average in two and below average in just one. Over half of the workforce, our highest ever of 54%, responded to the Survey last year which was a significant improvement on the previous year of 39%. The areas of concern – those scoring only average or below – are as follows: • Quality of Care – although higher than last year by 0.1% is still the same amount below average • Team Working – scored average and the same as last year • Quality of Appraisals – Scored average and 0.1% higher than last year. In engaging with teams across the Trust to aid in the action planning from these results (including DMTs, all EDI groups, Senior Leadership Forum, Staff Engagement Group, and JCC), we have asked that they focus on these three areas of concern. In addition, we recognise the need to integrate the results and actions with the diagnostic phase of the Best Place to Work Programme.

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

1. Introduction

The results in summary were brought to the Board in February 2020. They showed that the Trust achieved above average scores in eight of the eleven theme areas, at average in two and below average in just one.

Over half of the workforce, our highest ever of 54%, responded to the Survey last year which was a significant improvement on the previous year of 39%.

2. Results and Action Planning

It is recognised that work could be done across all of the themes, including those eight in which the Trust is scoring above average, but it is believed that whilst we have areas which are only at or below average, these should be the areas of our focus.

The three areas of concern – those scoring only average or below – are as follows:

- Quality of Care – although higher than last year by 0.1% is still the same amount below average
- Team Working – scored average and the same as last year
- Quality of Appraisals – Scored average and 0.1% higher than last year.

In engaging with teams across the Trust to aid in the action planning from these results (including DMTs, all EDI groups, Senior Leadership Forum, Staff Engagement Group, and JCC), we have asked that they focus on these three areas of concern. In addition, we recognise the need to integrate the results and actions with the diagnostic phase of the Best Place to Work Programme.

3. Areas of Concern

The questions related to these three themes are detailed in Appendix A.

3.1. The Quality of Care theme is comprised of three questions, and the one causing most concern relates to the individual's role making a difference to patients. The scores for this question have steadily declined since 2016.

We know that the highest responding group of staff in 2019 was Nurses and Midwives and the second largest group was Admin and Clerical. It is possible that

the Admin and Clerical group responses may have skewed the results for this question. It will be very useful to explore this question further in the Focus Groups arranged for the BP2W programme.

3.2. The Team Working theme has only two questions, both of which have declining scores, which would appear to indicate that there is insufficient focus on the formal aspects of team working. Anecdotally, however, it would appear that informal team working is mainly effective across the Trust.

3.3. The Quality of Appraisals theme consists of four questions which are showing variable trends.

We know, for example, that there are issues with the appraisal recording platform currently in use in the Trust and that this does not always facilitate a quality conversation. The current appraisal compliance rate is over 80% and the numbers reporting having had an appraisal are good.

The action plan will include “quality appraisal conversations” training, and link to the ESR Optimisation Plan to migrate appraisal recording from SPIDA to ESR.

4. Recommendation

That the Board supports the actions taken so far in addressing the results of the 2019 Staff Survey. A detailed Action Plan is being developed alongside of the Best Place to Work initiative.

Appendix A

1.1. The Quality of Care theme is comprised of three questions:

1.1.1. *I am satisfied with the quality of care I give to patients/service users:* since 2016, this question has reduced from almost 85% to the current 79.5%, which is a very marginal increase on last year's 79.1%.

1.1.2. *I feel that my role makes a difference to patients/service users:* since a high of 92.5% in 2016, this score has declined each year to it's current level of 88.7%.

1.1.3. *I am able to deliver the care I aspire to:* since 2016, this element has reduced from almost 70% to 63% in 2017 & 2018, with an upswing in 2019 to 67.3%.

1.2. The Team Working theme has only two questions:

1.2.1. *The team I work in has a set of shared objectives:* from a score of 74.5% in 2018, this has reduced to 71.5% in 2019.

1.2.2. *The team I work in often meets to discuss the team's effectiveness:* from a high of 63.5% in 2015, this has declined in the intervening years to a current score of 56.7%.

1.3. The Quality of Appraisals theme consists of four questions:

1.3.1. *It helped me to improve how I do my job:* in the last five years, this score has improved from 22.7% to the 2019 score of 23.1%, but with a marked dip in 2018 to 21.3%.

1.3.2. *It helped me agree clear objectives for my work:* from a high of 43.1% in 2015, this has decreased to only 38.1%.

1.3.3. *It left me feeling that my work is valued by my organisation:* from a score of 35% in 2015, this score reduced over 2016 and 2017 but then recovered to it's current 36.7%.

1.3.4. *The values of my organisation were discussed as part of the appraisal process:* from the 2015 score of 36.7% the 2019 score is lower at 33.6% but with a marked recovery over the low point in 2017 of 29.6%.