Bundle Trust Board Public 14 January 2021

1	OPENING BUSINESS
1.1	10:00 - Presentation of SOX certificates *Presented by Nick Marsden*
1.2	10:05 - Patient Story
1.3	Welcome and Apologies *Apologies received from Peter Collins*
1.4	Declaration of Interests
1.5	10:20 - Minutes of the previous meeting *Minutes from meeting held on 5th November 2020* *For approval* 1.5 Draft Public Board mins 5 November 2020.docx
1.6	Matters Arising and Action Log 1.6 Public Trust Board action log.pdf
1.7	10:25 - Chairman's Business *Presented by Nick Marsden* *For information*
1.8	10:30 - Chief Executive Report *Presented by Stacey Hunter* *For information* 1.8a CEO Board meeting Jan 2021.ppt 1.8b open_letter_CEO_Salisbury_District_Hospital_January_2021.docx 1.8c Acute Hospital Alliance Annual Briefing_Final_Dec_20v1.0.pdf
2	ASSURANCE AND REPORTS OF COMMITTEES
2.1	10:40 - Clinical Governance Committee - 22 December *Presented by Eiri Jones* *For assurance* 2.1 Escalation report - from December CGCommittee to January Board 2021.docx 2.1b - Covid-19 Recovery High Level Update.pptx
2.2	10:45 - Finance and Performance Committee - 22 December *Presented by Paul Miller* *For assurance* 2.2 Public Board - Finance and Performance Committee escalation paper 22nd December 2020.docx
2.3	10:50 - Trust Management Committee - 16 December 2020 *Presented by Stacey Hunter* *For assurance* 2.3 TMC Escalation report December for January Board.docx
2.4	10:55 - Audit Committee - 17 December *Presented by Paul Kemp* *For assurance* 2.4 Escalation report from Committee to Board - Audit Committee 17th Dec 2020 2.docx
2.5	11:00 - Charitable Funds Committee - 17 December *Presented by Nick Marsden* *For assurance* 2.5 Charity committee esclation report 07-01-2021.docx
2.6	11:05 - Integrated Performance Report (M8) *Presented by Lisa Thomas* *For assurance* 2.6a 140121 IPR cover Board.docx 2.6b IPR January v2.pptx
3	STRATEGY AND DEVELOPMENT

3.1 Communication Strategy - deferred

3.2 11:20 - Corporate Priorities Quarterly Review

Presented by Kieran Humphreys
For assurance

3.2a 210114 Corporate Objectives.docx

3.2b Corporate priorities update Jan Board 14.01.21.pdf

4 QUALITY AND RISK

4.1 11:30 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona McNeight
For assurance

4.1a Trust Board BAF Cover sheet January 2021.docx

4.1b BAF v1.2 January 2021_Trust Board.docx

4.1c CRR tracker v19.1_January Board 2021.xlsx

4.1d Draft Corporate Risk Register December 20 v6.4.xlsx

4.2 11:40 - Patient Experience Report

Presented by Judy Dyos
For assurance

4.2 Patient Experience Report Q2 final Nov 2020.docx

4.3 11:50 - Learning from Deaths Report Q2

Presented by Sallie Davies
For assurance

4.3 TB Learning from deaths report Q2 20 21 October 20 FINAL.docx

4.4 12:00 - DIPC Report

Presented by Judy Dyos
For assurance

4.4a Trust Board Summary sheet Annual DIPC Report (2019-20).docx

4.4b DIPC Report 6 monthly update 2020-21 (Draft v.1).doc

4.4.1 12:10 - BREAK

4.5 12:25 - Maternity Ockenden Review

Presentation by Judy Dyos
For discussion

4.5a Board cover sheet template Jan 2019 Ockneden report.docx

4.5b Overview of the Ockenden report.ppt

4.5c SFT Response to Ockenden Report.pdf

4.5d Salisbury Letter to CEOs from SW Regional Chief Midwife.docx

4.6 12:45 - Medical Revalidation and Apraisal Annual Report

Presented by Sallie Davies
For assurance

4.6a Board cover sheet template Jan 2019.docx

4.6b Appraisal and Revalidation_annual-board-report-and-statement-of-compliance 2019.20 (2).docx

4.7 12:50 - Medical Education Performance Report

Presented by Emma Halliwell & Sallie Davies
For assurance

4.7a Committee cover sheet template Jan 2021.docx

4.7b Annual Medical Education Report 2019-2020 v1.pdf

4.7c Survey monkey results - 2019.pdf

5.1 12:55 - Equality and Diversity Annual Report

Presented by Lynn Lane
For approval

5.1a Board cover sheet EDIAnnual report.docx

5.1b SFTEqualityreport2020_v4.pdf

6.1 13:15 - Register of Seals

Presented by Fiona McNeight
For approval

6.1 Register of Seals.docx

6.2 13:20 - Remuneration Committee Terms of Reference

Presented by Fiona McNeight
For approval

6.2a Board cover sheet RemCom ToR January 2021.docx

6.2b Appendix 1_Final Nomination and Remuneration Committee Terms of Reference_November 2020 v1.2_Remcom approved 03122020.docx

6.2c Appendix 2_ Annex_A_NHS_Trust_and_Foundation_Trust_combined_board_summary_pay_data.pdf

6.2d Appendix 3_ NHSI updated_guidance_on_pay_for_VSMs_FINAL.pdf

6.3 13:25 - Constitution

Presented by Fiona McNeight
For approval

6.3a Cover sheet Constitution Trust Board Jan 2021.docx

6.3b Constitution V 2.1 draft Dec 2020.docx

6.4 BREXIT Update Report (deferred to F&P Jan)

7 CLOSING BUSINESS

7.1 13:30 - Agreement of Principle Actions and Items for Escalation

7.2 13:35 - Any Other Business

7.3 13:40 - Public Questions

7.4 Date next meeting

Next Public Trust Board meeting 4th March 2021

8 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

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 5 November 2020 via MS Teams Salisbury NHS Foundation Trust

Present:

Nick Marsden (NM)	Chairman
Tania Baker (TB)	Non-Executive Director
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Michael von Bertele (MvB)	Non-Executive Director
Stacey Hunter (SH)	Chief Executive Officer
Andy Hyett (AH)	Chief Operating Officer
Lisa Thomas (LT)	Director of Finance
Lynn Lane (LL)	Director of OD and People
Judy Dyos (JD)	Director of Nursing

In Attendance:

Kylie Nye (KN)	Corporate Governance Manager (minutes)
Fiona McNeight (FMc)	Director of Corporate Governance
Esther Provins (EP)	Director of Transformation
Kat Glaister (KG)	Head of Patient Experience
John Mangan (JM)	Lead Governor (lead observer)
Peter Kosminsky (PKo)	Governor (observer)
Ali Vandyken (AV)	Divisional Manager Clinical Support and Family Services
Ruth Radley (RR)	Head of Nursing Clinical Support and Family Services
Joanne Harris (JH)	Microbiology, Biomedical Scientist

ACTION

TB1 05/11/01 OPENING BUSINESS

TB1 05/11/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

NM noted the following members of staff who had been awarded a SOX Certificate:

- The Central Booking team, SOX of the month
- Nicole Ridgway, Responsive SOX

NM congratulated the members of staff who had received a SOX award and noted that these would be placed on the notice board and presented to the individuals personally after the current lockdown situation has ended.

TB1 05/11/1.2 Staff Story

Ali Vandyken, Jo Harris and Ruth Radley joined the meeting to present the staff story.

NM noted that Staff Stories help to center thoughts from a staff or patient perspective.

JH provided an update of Pathology services during the pandemic, noting that equipment and resources were a challenge in light of the extremely high demand in testing.

Discussion:

- PM noted the amazing response and innovation from the Pathology team and thanked the wider team for their hard work.
- SH noted it was national Pathology week and thanked the team for their ongoing hard work. SH reminded the Board that despite the ongoing hard work of all staff an outcome of the pandemic is that it puts continued pressure on staff and that Pathology will be expected to do more in the near future. SH asked for thoughts in relation to aggregating and centralising Pathology services. JH noted there has been a drive to centralise but on reflection this is not necessarily the best way of providing services. JH noted that local labs have supported each other and have work well together.
- AH noted that the flexibility of the team has been great, particularly in light of the changing priorities on a daily basis.
- PC noted the step change in the service and noted that from a strategic point of view the Trust need to plan to support the implementation of 7 day lab services.
- DB suggested that the Board should consider how Covid-19 changes clinical practices and centralising services required further consideration. DB acknowledged that SFT has done well with testing compared to other Trusts.
- RA thanked the Pathology team and noted that their personability both operationally and strategically had helped to achieve service delivery
- LL noted she had worked closely the team and noted the fantastic job they had done in the circumstances.
- NM gave his own personal thanks and noted the achievement of the department.

TB1 05/11/1.3 **Welcome and Apologies**

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

NM welcomed Peter Collins, Interim Medical Director, to his first public Trust Board.

TB1 05/11/1.4 **Declarations of Conflicts of Interest**

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

- EJ informed the Board that, whilst not a conflict of interest, she had been appointed as Non-Executive Director at

Homerton University Hospital NHS Foundation Trust.

- RA noted that there were references in the papers to the Blended Nursing degree and the organisation she works for led the procurement and is a provider in SW.
- PC noted that he was on a secondment from University Hospitals of Bristol and Weston NHS Foundation Trust. It was noted that this was not a conflict of interest pertaining to the agenda.

TB1 05/11/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 3rd September 2020**

NM presented the minutes and the following points were noted:

- DB noted that he had made a comment about excess mortality in relation to Covid-19 noting that England is the country with the worst excess mortality. The point made was if this is impacting the Trust's efforts in understanding mortality rates.
- EP noted that there was a sentence at the top of page 10 which did not relate to the discussion she had.
- MvB noted that the Guardian of Safe Working's name is Juliet Barker.

Subject to these amendments the minutes were agreed as an accurate record of the meeting held on 3rd September 2020.

TB1 05/11/1.6 **Matters Arising and Action Log**

NM presented the action log and the following items were noted:

- **TB1 03/09/3.2 Annual review of committee effectiveness** – NM referred to the Board 360 final review session with the 360 assessor and noted that this session would be better facilitated face to face.

- **TB1 3/9/4.1 Health and Safety Annual Report** - It was noted that this had been added to the Audit Committee work plan. Item closed.

There were no further matters arising.

TB1 05/11/1.7 **Chairman's Business**

NM provided the following update:

- NM emphasised the role of Trust Offices in light of the recently announced lockdown. NM noted that one of the key reasons for lockdown is to protect the NHS from being overwhelmed. NM noted the importance of adhering to the rules and explained that all staff have a personal responsibility to do so.
- The Trust have received notification of a return to Incident Level 4 and more guidance is awaited from the centre
- NM acknowledged that there is a backlog of patients who have been unable to be treated over the last few months

and despite the pandemic, the Trust needs to get back to the best possible position in order to provide timely and efficient care.

Discussion:

- AH noted that during November there will be work underway to fix the heating in Trust Offices. AH noted that these are essential works which require urgent repair and therefore a large number of staff will be moving offices for a temporary period or working from home.

TB1 05/11/1.8 **Chief Executive's Report**

S Hunter presented the Chief Executive's report and highlighted the following key points:

- SH noted the dynamic situation the Trust is currently in since writing the CEO report and noted the move to a national response. The Trust is expecting a letter from the centre although this is yet to be received. SH noted that JD was joining a call with the Director of Nursing colleagues in the region to ensure consistency with regards to visiting rules and social distancing. It is recognised that there is variation and a consistent approach has been requested.
- The December deadline for Brexit is fast approaching and AH is leading the preparation and mitigation work in line with NHS Improvement/England and the Department of Health. AH had a call in relation to the EU exit and there are activities to undertake in relation to this, particularly if there is no trade agreement. There is acknowledgment that there will be pressure on areas already under pressure in the Trust.
- SH is taking part in a discussion on 30th November with the South West Regional Director of Commissioning, in relation to setting up a new partnership board and arrangements covering BSW and Dorset ICS for specialist commissioning going forward. This is a priority for us given specialist services and ensuring the population continue to have equal access to specialist services going forward.
- SH gave thanks to all staff for their continued efforts in a very changeable and challenging situation.
- There are a number of communications going out to the wider community noting that the Trust has a small number of Covid-positive patients and patients who have appointments or treatment booked are urged to keep them.

Discussion:

- EJ noted that there is a fine balance between having a grip of business as usual, managing a Level 4 Incident and Brexit. EJ asked if the Trust had any specific concerns regarding the Brexit impact. SH explained that the focus of business continuity largely relates to non-consumables, medical and surgical equipment and medicines. This does reflect the national picture and currently the EU exit risk is

related to the unknown and the response will not start until next year. It was noted that AH is re-escalating the EU exit to the Corporate Risk Register (CRR).
- SH explained that the Trust is currently focused on winter planning, the Covid reset and flu. However, there should also be focus capacity and capability into next year and the future.
- PM referred to specialised commissioning and suggested the Board needs to decide what it wants from the emerging conversations and what would 'good' look like. SH noted that the population will need to access services in Southampton and there needs to be a review of equity and equality of access and of sustainability of access to services. SH noted that the Board will need to focus on this over the next few months.

TB1 05/11/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 05/11/2.1 **Clinical Governance Committee – 27 October 2020**

E Jones presented the report, providing a summary of escalation points from the meeting held on 27th October:

- The new Interim Medical Director, Divisional Director for Medicine and Divisional Head of Nursing for Medicine were welcomed to the Committee.
- The ongoing challenge in relation to theatre restart was discussed and assurance provided that a plan is being implemented to improve staffing levels and use of theatre space for elective and urgent non-Covid19 work. An increase in activity is expected from November 2020 and will be followed up in future committee meetings.
- Further assurance was provided by the Clinical Director for Surgery that the Trust can demonstrate a robust process for reviewing patients on the waiting lists. It was agreed that a quality impact assessment (QIA) and equality impact assessment (EQIA) would be undertaken.
- A very positive presentation was provided by the Cancer Matron in relation to the cancer patient survey. Positive assurance was gained with the Trust performing in the top quartile. It was also positive to note that despite this high performance the team were working on identifying further improvements.
- A 6 month update was presented by surgery and medicine in relation to pressure ulcers. Whilst improvements have been made and widespread training has been rolled out, all agreed that there was more work to do.

Discussion:
- JD noted that the Trust is reviewing every Covid-19 case to ensure there were no instances of cross contamination. There have been none identified so far.
- DB referred to the number of closed theatres and whilst this is a national problem asked if more assurance could be

provided in terms of increasing theatre activity. PC explained that theatre capacity is related to issues that have been highlighted during Covid-19 and is more about staffing than Infection, Prevention and Control. There is a plan going forward to understand the gap in staffing and therefore in the short term the Trust is ensuring the best utilisation of the theatres it can staff and prioritise those patients who need it the most. SH noted that as of Monday no theatres are empty as there are plans to use some of the space for escalation.

TB1 05/11/2.2 **Finance and Performance Committee – 27 October 2020**

P Miller provided a summary of escalation points from the Trust Management Committee:

- The Trust is forecasting overspend of between £3.2m-£4.1m but the big challenge will be in 2021/22. This is because of Covid-19 and the affect on patient pathways and new ways of working which will mean resetting the budgets and ensuring robust systems of financial governance and financial controls that work.
- Referrals and attendances, whilst still lower than pre-Covid, are slowly increasing and there is increasing pressure on Emergency Department (ED) 4 hour performance, which showed reduced performance at 88% in September 2020. These ED activity pressures are compounded by challenges in discharging patients, particularly into Nursing Homes with Covid infections.

Discussion:

- PK noted his concerns relating to the focus on the underlying control processes, particularly in relation to overspend on staffing. LT noted that she was concerned about workforce numbers and the deployment of resources. LT reported that deep dives with the Divisions were scheduled within the next week to look into the allocation of resources. It is acknowledged that financial controls do require strengthening. However, LT noted that Covid does cost more and in responding to the pandemic the Trust will need to do what is necessary whilst also ensuring reasonable and rational decisions are made.

TB1 05/11/2.3 **People and Culture Committee – 29 October 2020**

M Von Bertele provided a verbal summary of escalation points:

- There has been a great effort to listen to our staff and understand their concerns. This includes the annual Staff survey, and over the last 3 months the Best Place to Work has provided the opportunity for staff to give feedback.
- The Committee received the annual report from the Freedom to Speak Up Guardian and it is encouraging to

learn that the Trust have appointed FTSU ambassadors.
- The challenges that the OD and People team current face were summarised.

Discussion:
- LL referred to the challenges that OD&P team face. LL explained that the team is a small team and there are individual and collective challenges in terms of supporting, listening and understanding.
- SH noted that the Trust has listened to staff and the important part of this is the capability to respond. The top priority is to get things right for staff as this ultimately affects quality and care.

TB1 05/11/2.4 **Trust Management Committee – 21 October 2020**

S Hunter presented the report and asked if anyone had any questions.

The Board noted the report.

TB1 05/11/2.5 **Integrated Performance Report**

A Hyett presented the Integrated Performance Report to the Board and noted the following key points:

- The Trust is returning to pre-Covid levels of activity and this is being managed concurrently with the potential challenges faced by the winter period, the EU exit and increasing levels of Covid-19.

Discussion:
- PM asked what the action would be if the Trust is unable discharge into nursing homes. AH explained that there are plans in place and the Trust is working collaboratively with colleagues to provide alternative solutions to manage this if it occurs. PM asked for further positive assurance that these plans are working. AH explained that the Trust has seen a number of patients discharged before midday and the early supported discharge team have been chasing this where appropriate. SH noted that there is a focus on Length of Stay and improving criteria led discharge and disseminating these practices across the weekend to improve the discharge process in the Trust.
- It was discussed that two key problems for the Trust is community and capacity. There are ongoing conversations with partners but it is recognised there is no quick solution. JD explained that in relation to discharge the Trust is working as a system with CCG to work with care homes.
- RA referred to ED (Emergency Department) and the increase in activity and asked what the plans are going forward to resolve ED usage and the continued challenge of

achieving the 4 hour ED target. AH explained that changes to the department are underway in ED due to the space constraints. The Trust continues to work with the walk in centre in Salisbury and there is work underway to establish how this service can be incorporated on site. There is also the 111 first service pilot which will hopefully encourage patients to only come to ED if required. RA noted the importance of focussing on long term planning and the public perception of ED usage.

- EJ noted that the rise in 52 week waiters had been discussed at CGC and F&P and asked for assurance that there is a focus on this. Additionally, EJ noted that there had recently been 2 reported C Difficile cases and asked what the workforce plans were in microbiology to increase the team, and what assurance is there that staff have completed essential training.
- PC referred to the waiting lists process of monitoring patients and noted that the way patients are prioritised means that those waiting the longest are the least urgent.
- JD noted that a newly appointed microbiologist has started in the Trust and has restarted twice weekly antimicrobial ward rounds with pharmacy input.
- In relation to training LL explained that monthly performance review meetings with the divisions scrutinise any challenges in relation to training development and learning, including medical staffing. PC noted that the appraisal process has been made more optional under the requirements of revalidation until 2021 as a result of Covid and the Trust will need to pick up the relevant new training modules in relation to PPE (Personal Protective Equipment) and IPC (Infection, Prevention and Control).

TB1 05/11/3 **QUALITY AND RISK**

TB1 05/11/3.1 **Patient Experience Report Q1**

J Dyos presented the Patient Experience Report and highlighted the key points:

- In Q1 the Trust received 26 complaints in total with the key challenge being producing and sending the responses out in a timely manner.
- The team is working with Health Watch to review complaint responses to learn from process.
- There has been positive feedback on virtual visiting and the ‘message to a loved one’ process. There has also been positive feedback in relation to the Attend Anywhere remote consultations.
- In relation to complaint themes there are trends in relation to unsatisfactory treatment and communication, particularly from doctors. The Trust do feedback to staff and also use the appraisal process and reflective learning.

Discussion:

- SH asked if the complaints and compliments could be triangulated with activity in the report. **ACTION: JD/KG** **JD/KG**
- The Board discussed the themes in relation to communication and PC asked if this is a consequence of shift to virtual appointments or do staff need further training. EJ noted that it was a theme that had been highlighted several times. JD noted that it was about those clinicians under clinical strain ensuring that it does not affect their communication style and this is picked up as part of the feedback process.

TB1 05/11/3.2 **Learning from Deaths Report Q1**

P Collins presented the report which provided assurance that the Trust is learning from deaths and making improvements. The following key points were noted:

- 207 deaths were in Q1 and 96% of these have been reviewed. 2 deaths were unexpected of which one is subject to a serious incident inquiry and the other scrutinised by two Medical Examiners and at the Critical Care mortality and morbidity meeting.
- The Medical Examiner process is established and provides robust process of understanding concerns from bereaved families.
- Weekend HSMR has declined from a peak of 133 in July 19 to 107 in May 20 and is within the expected range
- There is evidence and assurance of a focus on improving the care of patients with an acute upper GI Bleed. It is acknowledged that whilst progress has been made there is more work required.

Discussion:

- The report was discussed and PC noted that he would like the report to provide more of an understanding of learning and how we are putting this learning back into the Trust. EJ noted that alongside this she would like more assurance in relation to Duty of Candour as it should be an important focus. PC noted that he was content to ensure the process is followed and further assurance is given.
- RA referred to how learning is evaluated and noted that the report details the learning that is required but there is no evidence of it. RA Referred to pg.5 which provided details of the death of a patient with a learning disability and it reported that there were “no learning points”. PC noted that there are always learning points and it was agreed that going forward this would be picked up and reviewed in future reports. **ACTION: PC** **PC**
- TB referred to weekend HSMR and asked if the Trust is confident that the hospital is safe at the weekend given the work undertaken. TB further referred to Fracture Neck of Femur (FNoF) and associated mortality and asked if the Trust could focus on more consistent progress. Additionally, TB asked if the Trust is learning as much as it can and

learning at a regional level. PC noted that many Trusts are noting that they have recurrent themes that are not new and there has been a shift of focus to try to develop networks, particularly with the medical examiner and regional medical examiner. PC reported that the organisation does feel safe at the weekend. Often the data focuses people's minds on good governance and progress and making improvements. PC referred to the query relating to FNoF and suggested that there was a requirement for a dedicated hip fracture pathway and this work will be taken forward with the orthopaedic team.

- SH noted that the reasons for the increase and subsequent decrease in weekend HSMR is unclear. SH noted that the more we can understand the data the more assurance is provided. SH noted that in the GIRFT report in relation to orthopaedics the Trust has specific unwarranted variation and therefore improvement is required. SH further asked what the Trust's ambition is in relation to mortality and what has happened to mortality figures of non-Covid patients. The same depth of analysis is required when the data is available.
- PC explained that the report on Covid-19 mortality will be coming to the next board. Due to the lag time in figures the understanding of non-Covid mortality at organisational level will be available in the New Year.
- LT noted that there was an opportunity the Trust had in relation to weekend mortality and the link to primary care at the weekend, particularly end of life care. This was not picked up when weekend HSMR was high but there is an opportunity to take this forward in different way. PC agreed and noted he would pick this up.
- PM noted that nationally the quality of clinical coding has been affected by Covid-19. PC agreed noted the importance

TB1 05/11/3.3 **Quality Improvement Progress Update**

E Provins presented the Quality Improvement Progress Report and introduced Emma Cox, Head of QI.

- EP provided the background and context of the Trust's QI approach to date.
- EC noted the successful progress through 2019/20 and the process of embedding a culture of continuous improvement, particularly throughout the Covid-19 pandemic.
- Key actions and highlights to focus on throughout 2021/22 were summarised.

Discussion:

- PK referred to the future plans and asked why the lead was only EC and EP. EP noted that the Trust does have the support of senior leadership and team leaders but resources to embed new ways of working have been lacking.

- PM referred to the 2021/22 plans and suggested that it might be helpful to review governance arrangements to ensure we do not have any that will impede new ways of working. EP noted that the team have reviewed business planning processes and strategic service review but there is more to do.
- SH thanked EP and EC for their report and noted that embedding a QI approach needs to be a part of response in the Best Place to Work and form part of a complete improvement focus.

TB1 05/11/4 **FINANCIAL AND OPERATIONAL PERFORMANCE**

TB1 05/11/4.1 **Operating Plan 21/22 and Quarterly Review**

L Thomas noted that the guidance for the operating plan guidance has not been released but F&P and the Trust Board will be briefed as appropriate.

TB 05/11/5 **PEOPLE AND CULTURE**

TB 05/11/5.1 **People Plan**

L Lane presented the report and highlighted the following key points:

- The People Plan identifies short term actions required in the remainder of this business year to March 2021, with further actions to be identified and mobilised in 2021/22.
- The NHS was immediately mobilised at System level to respond to the call to action identified in the nine themes of the plan.
- The Trust has been involved in discussions at director level with BSW partners in identifying actions in which SFT will take the lead to contribute to the system response to the plan.
- The plan sets out to build on how we develop inclusion and belonging and how we grow and develop workforce.

Discussion:

- EP noted that the way the report discusses the ways talk about addressing issues this cannot just be done via induction and appraisals. The Executive team need to set a real example to shift the Trust's culture. The first step is acknowledgement which links to the Best Place to Work programme. LL agreed and noted that if the Trust continues to do the same it will get the same outcome.
- PM noted the amount of work that is detailed in the report. He also noted that there was an oversight in the executive summary as it did not mention the People and Culture Committee. LL noted that this would be amended.
- SH thanked LL for the report and asked for clear and specific trajectories that can measure what the Trust/System is trying to achieve. SH appreciated that some

LL

of the actions are long term but detailed trajectories were required to help track what is a very ambitious People Plan. **ACTION: LL**

TB1 05/11/6 **GOVERNANCE**

TB1 05/11/6.1 **Register of Seals**

F McNeight presented the updated register of seals report.

The report was noted.

TB1 05/11/7 **CLOSING BUSINESS**

TB1 05/11/7.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted the following highlights from the meeting:

- Covid-19, winter and the EU exit are going to be challenging in the next few months and the Trust needs to be agile and respond accordingly.
- The focus of the Board in short term needs to be on theatre utilisation as this is vital in providing the best care for patients.
- The actions arising from the QI work and the People Plan. Specific trajectories are required so the Board can monitor progress.

TB1 05/11/7.2 **Any Other Business**

There was no other business

TB1 05/11/7.3 **Public Questions**

J Mangan raised the following points:

- JM observed that the Board discussion had been really useful and informative.
- JM referred to a previous query he had in relation to clinical coding and palliative care and the changes in policy. PC noted he would pick this up outside of the meeting with JM.
- PKo asked for further explanation in relation to the pressure on hospitals and care homes and how this differed from the first lockdown situation.
- PC noted that during the first wave of Covid-19 staff were redeployed as a lot of activity was paused. Over the summer some activity has been restarted and an important balance across the health and social care sector is required. Hospitals are filling up as they normally would at the start of winter and without the mass redeployment that occurred in the first wave of Covid, the usual workforce issues are there.
- SH explained that Covid has highlighted issues that were there before, for example the social care model and

workforce supply require a lot of investment. Whilst this is not a Covid-specific problem the Trust is doing all it can to respond to the usual increases in activity, flu and the pandemic, whilst continuing to catch up on the activity that has been delayed. SH noted that care homes are doing everything they can to protect vulnerable residents but there is a lack of capacity in a model that needs policy and funding.

TB1 05/11/7.4 **Date of Next Meeting**

Thursday 14th January 2021, Board Room, Salisbury NHS Foundation Trust

TB1 05/11/8 **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).

Public Trust Board Action log

Deadline passed.	1
Update required /paper due at next meeting	2
Completed	3
Deadline in future.	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 05/11/3.1	**Patient Experience Report Q1 -** SH asked if the complaints and compliments could be triangulated with activity in the report.	**JD/KG**	04/02/2020	**Next report due Feb 2021**	N	4
TB1 05/11/3.2	**Learning from Deaths Report Q1 -** RA referred to how learning is evaluated and noted that the report details the learning that is required but there is no evidence of it. RA also referred to the deaths where "no learning points" have been identified. It was agreed that this would be picked up and reviewed in future reports.	**PC**	04/02/2020	**Next report due Feb 2021**	N	4
TB 05/11/5.1	**People Plan -** SH thanked LL for the report and asked for clear and specific trajectories that can measure what the Trust/System is trying to achieve.	**LL**	04/02/2020	**Due Feb 2021**	N	4
					N	4
					N	4

NHS
Salisbury
NHS Foundation Trust

Chief Executive Update

Public Board Meeting

Thursday 14th Jan

Stacey Hunter

An outstanding experience for every patient

Content

- National context & priorities
- Regional /BSW ICS
- Local
- Forward look

National Context

- Transition period ended – exited EU
- Incident management arrangements in place for NHS
- No material issues to report at this time
- Provide assurance via F & P against the risks 7 report by exception

- Operating plan for 2021/22 shared on 23rd Dec
- NHSE/I Consultation on Integrating Care – next steps
- Ockenden Review

- COVID – 19 vaccine programme commenced early Dec
- New variant up to 70% more transmissible
- 60 percent increase in hospital admissions
- Boxing Day : 6 week lockdown in England

Regional/BSW

- ICS Designation confirmed
- Acute Hospital Alliance – attached annual briefing
- Pre Christmas focus on reset and recovery
- Post Christmas SW region C-19 growing at one of the highest rates
- COVID vaccination centres
  - Hospital sites
  - Vaccination Centres
  - PCN sites

SFT

- Substantial increase in numbers of people being treated for COVID in hospital
- Almost treble the peak of Wave 1
- Exceptionally challenging for our teams
- Using surge capacity in G/A and Critical Care beds
- Difficult decision re cancelling some elective activity
- Sustaining emergency , urgent, cancer & clinically urgent surgery
- OPEL level 4 on 3 occasions since start of Jan
- Regular CEO all staff briefings
- Executive on call moved to daily with Director presence on site at weekends during this phase
- HWB offer for our colleagues
- Communication to our communities – see open letter attached

SFT cont.

COVID Vaccination

- Hospital Hub started 29th Dec 2020
- Approx. 300 people per day from priority groups inc NHS staff , care home staff and people over 80
- Excellent service with really positive feedback
- Delivering 7/7 from 8am – 8pm

- Recognition and appreciation that colleagues are working tirelessly to support response
- Redeployment to support core ward & clinical areas
- People are tired, dealing with the pandemic for 10 months – feel relentless during the peaks
- Teams doing everything they can to support each other
- Communities

Forward look

- Anticipate the context re COVID remaining challenging for the next 4-6 weeks
- Continue vaccination roll out
- Priority is to continue to support colleagues to respond and provide the safest possible care
- Support
- Communications

NHS
Salisbury
NHS Foundation Trust

An outstanding experience for every patient

Salisbury
NHS Foundation Trust

Salisbury District Hospital
Odstock Road
Salisbury
Wiltshire
SP2 8BJ
Telephone 01722 336262

12/01/2021

Open letter to patients and members of the public

Salisbury District Hospital continues to experience intense pressure

Salisbury District Hospital continues to experience intense pressure as it treats an ever rising number of COVID-19 positive patients. We are now treating over 100 patients that have tested positive - this is over double the number we saw in the first wave and equal to over 25% of all our inpatients. And the number is rising daily. In addition we have now recorded 99 deaths where the patient had tested positive.

To me and all my colleagues at the hospital this data is more than simple numbers, behind every number is a person with a family, friends and neighbours, all of whom are either worried about their loved ones health or are mourning a life cut short.

In order to continue to provide care for those suffering the severe impact of COVID-19 infection and those with other critical conditions, we are having to make changes to the way the hospital works and how we prioritise who we can treat. To that end we are now limiting the number of surgical procedures we undertake. Sadly this means we are having to postpone some operations. We will continue to perform all cancer, high priority, emergency and trauma surgery. By making this difficult decision we can continue to provide professional, compassionate care when it is most needed

We will contact you if your appointment has been postponed. If you do not hear from us please attend as planned.

If you are feeling unwell please contact the NHS by calling 111, your GP or in an emergency 999. Our A&E remains open 24/7 to treat emergencies and the hospital continues to provide critical and urgent care, and of course our maternity team never stop delivering babies.

We've been dealing with this pandemic day in and day out for almost 10 months, it's exhausting, it feels relentless and it has impacted all areas of our lives, both at work and at home. I know that this must be taking its toll on the whole community. That's why it's so important we continue to look out for one another, be kind and support each other wherever we can.

In all parts of the NHS and across partner organisations staff are working through extraordinary times and regularly going above and beyond to care for patients, residents in care homes and numerous other settings. Every day the team at Salisbury Hospital amaze me with their professionalism, compassion and flexibility. As we ask staff across the hospital to work in different ways and in an ever changing environment they consistently step up to

the challenge. My heartfelt thanks goes out to every member of staff and all those that support them at home and in their personal lives.

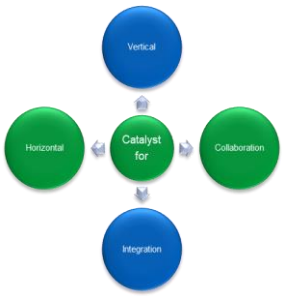
While the situation is serious, the vaccination programme offers real hope that things will begin to get better soon. Across the NHS the vaccination teams are working hard to vaccinate as many of the over 80s, high priority NHS staff and care home workers as quickly as possible. I encourage everyone that receives an invitation from the NHS to be vaccinated to accept. It is through a wide spread and successful vaccination campaign that we will be able to start getting our lives back to normal. However, please do not contact your GP or hospital to ask about the vaccine, the NHS will contact you with an invitation when it is your turn.

With such a rapid rise of COVID-19 in the community, and with such high numbers of patients in our hospital, we must remain extra vigilant and continue to do all we can to protect each other from this new infectious strain. This means limiting the amount of contact we have with other people and adhering to all the lockdown regulations and continue to follow the hands, face and space guidance at work and at home.

Together we can protect our friends and family, beat the virus and eventually get back to normal.

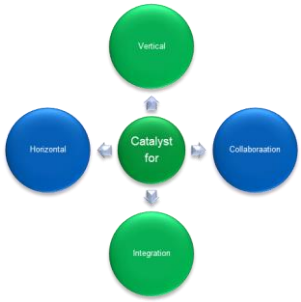
Yours

Stacey Hunter
Chief Executive, Salisbury NHS Foundation Trust



Acute Hospital Alliance Annual Briefing
December 2020

GWH, SFT & RUH working together to deliver better value services for the populations we serve.



Introduction

- Throughout 2020, our Acute Alliance has continued to meet regularly, fostering effective and collaborative working relationships between Great Western Hospital, Salisbury District Hospital, and RUH Bath NHS Foundation Trusts. This 2020 Annual briefing summarises the progress we have made through what has been an extraordinary year for the NHS. The briefing is designed for Boards of Directors, Governors and Management teams, as well as BSW ICS and SW Regional colleagues.

- The Acute Hospitals Alliance (AHA) formed in May 2018 – with the three Trusts signing a partnership to: *'lead discussions between the organisations focused on improving clinical services and closing health, care & financial gaps for the benefit of the population of the BSW STP.'* Through 2018 and 2019 we steadily built relationships and momentum in a range of back-office and clinical collaboration schemes led by members of our Programme Board.

First Quarter 2020: Acute Alliance Stock-take & Refresh

- The leadership of the AHA rotates periodically, and early in 2020 Cara Charles-Barks became Programme SRO; we began a programme stock-take, which saw discussions about the collective ambition for the three Trusts working together in the BSW system. The Programme Board set an ambition to deliver tangible change and to work on difficult issues together.

- **Vertical and Horizontal lenses: Three Streams of Work.** In the context of our developing STP, in early 2020 we deliberately **adopted a Horizontal and Vertical lenses approach.** In either axis we considered that together we can enhance overarching collaborative cohesion, recognising potential gaps, developing joined-up views; and focusing on delivery of small number of impactful changes.

- The AHA Programme is supporting our organisations to **further horizontal collaboration** in clinical and back-office functions, while also underlining the vital role of AHA members in **enabling vertical integration**. The programme is organised in **three complementary streams** of work targeting a range of **efficiency and resilience** opportunities:

  1. AHA Corporate Stream
  2. AHA Recovery/ Next Phase Covid-Response
  3. AHA as Effective BSW Partners.

1. AHA Corporate

- Financial Systems [Procurement, ledger, contracting, costing]
- EPR Alignment
- DGH 5-10 year Strategy – link to AHA Estates development work

2. Recovery/ Next Phase

- Network Prime Provider Model – Shared Elective Capacity - single waiting list;
- AHA Clinical Services support & Mutual Aid
- BSW Critical Care Alliance
- BSW AHA Peer Learning
- AHA Elective Strategy

3. Effective BSW Partners

- AHA Improvement Approach
- ICS & ICA Development;
- Team BSW Specialty [Dermatology, Paediatrics, Histo-pathology]
- BSW Financial Sustainability.
- AHA Improvement Approach

Second Quarter 2020: Covid Wave 1

- April to June saw Covid wave 1. After an initial pause in the majority of AHA activities while programme leads supported local Covid response, the programme adjusted plans to focus on activities that supported recovery as well as enabling reflection on emerging ways of working and patterns of daily operations in communities that had been adopted; the integrated care approach, digital transformation, and pathway redesign had been catalyzed.

- Towards the end of this period as re-start activities began, the risk of **inequality in access to care** between AHA members affecting our BSW population became clear. At the same time nationally, the short and longer-term impact of Covid exacerbating inequality in communities was widely seen. In BSW and the Acute Alliance, we agreed that a focus on reducing inequality and unwarranted variation should be a guiding principle.

Third Quarter 2020: Summer – Building on new patterns of working

- The July to September period saw progress in our clinical and corporate collaborative work.

- **Our BSW Clinical Teams work**, led by Charlotte Forsyth, Medical Director, GWH, is designed to break down organisational silos – encouraging clinical and care teams to design optimal models without historic constraints, potentially building long-lasting resilience in services by creating teams that have a critical mass able to delivery good access to high quality care. Paediatric and Dermatology teams started to meet in September. The team of Paediatrics clinical leads has identified priorities for support and collaborative development over the next six months– including **Day Surgery Recovery** and **Advice and Guidance systems**. Similarly in **Dermatology**, teams have met and identified variation in practice and priorities for joint working and sharing learning. Dedicated BSW CCG programme support for each specialty is in place now to work alongside clinical leads over the next six months. This work is intended to address whole pathways – involving full range of primary and community care opportunities.

- **Network Prime Provider and Single Waiting List MOU**. In September the AHA approved a draft Memorandum of Understanding (MOU) which aims to strengthen the joint working arrangements in BSW and to support the next stage of development of the BSW Partnership. The MOU builds on the existing collaborative work to establish more robust mutual accountability and break down barriers between the separate organisations in BSW. It is intended to be a transparent mechanism to ensure a whole system approach to managing limited capacity against demand. We agreed that we should proceed to implement and test the new working model, adapting it as required.

- **Critical Care Alliance & Mutual Aid.** Andy Hyett, COO at SFT, and Bernie Marden, Medical Director at RUH led a series of sessions bringing together critical care teams from the three Trusts to explore potential for mutual aid. At a critical care workshop held in August, the group discussed metrics for inclusion in a **BSW critical care dashboard**; there was commitment from nursing leads to work more closely together **on recruitment, training and education**; non-clinical inter-hospital transfer and COVID patient cohorting were discussed; and a set of **three Operating Principles** was developed by the team to encourage and support mutual aid.

- **DGH Strategic view**. A series of conversations were held with strategy leads across all three organisations exploring AHA Vision, AHA Remit and associated Governance, identifying opportunities and potential next steps. There was appetite for identifying further opportunities for joint work at scale: for example - Phase 3, sustainability, specialist services, learnings from COVID, business and service planning. It was clear that the DGH strategy should be strongly connected with emerging ICS strategy. AHA member involvement in ICS development System Capability, Population Health & Care Design and System Architecture groups, would help ensure this connection. The Programme Board agreed that leads from the three Trusts would continue

to build DGH Strategic Narrative Development Plan through the remainder of the year**,** in readiness for a **workshop** sessions **in January and March 2021** that would shape the AHA programme for the next phase.

- **AHA Member Estate Development Plans. Aligning Developments and Care Models in BSW.** Our Programme Board discussions highlighted the desire for greater awareness of estates development plans in all three organisations, and the need for core assumptions on our care model to be deliberately embedded within the BSW Integrated Care System.

- **GWH Way Forward Programme**. We had a detailed briefing from Julian Auckland-Lewis, Programme Director, on the GWH Way Forward Programme and Future Health Campus. The current situation and case for change in GWH is driven by a range of factors including significant growth in the local population over past 20 years with further housing expansion planned to 2026. This growing population presents significant chronic disease management and urgent care need. Demand and capacity analysis shows insufficient bed capacity, and insufficient rehabilitation provision – resulting in long length of stay and challenging patient flow, affecting quality and experience, with predictable impact on elective care, and risks to recruitment and retention. The GWH *Way Forward Programme* brings together 3-5 year priorities including: plans for Integrated Front Door; an integrated whole system approach to Urgent and Emergency Care in Swindon & N Wiltshire); supported by detailed demand and capacity modelling (U+EC, Electives, diagnostics & mental health; and land purchase near the hospital.

- **Salisbury Campus Development Programme.** Laurence Arnold, Director in SFT, gave a briefing on the SFT Campus Programme and the associated planned clinical model. We heard about the broad case of need, including the substantial estate-based risks the Trust is seeking to manage. The clinical model underpinning the Campus Development Programme will see a number of priority developments: Redevelopment of day surgery to promote separation of elective and emergency care; development of DGH maternity services, including amidwife-led unit, NICU; an Ambulatory cancer centre; and finally development of Rehabilitation services, including regional and supra-regional services (spinal injuries unit).

- **RUH HIP2 Programme.** Jocelyn Foster, Director of Strategy, introduced AHA members to the RUH HIP2 investment process, summarizing national objectives and planned Strategic Outline Case (SOC) development stages and timeline. The SOC investment vision builds on the RUH ambition of: "*Achieving better outcomes and experiences for service users and families through flexible integrated care using innovations that work*". The RUH team led a workshop session in late September to involve AHA members in shaping the HIP2 Strategic Outline Case. In particular, AHA members discussed care model assumptions and potential back office collaboration opportunities.

- In the course of the three site estates briefings, the AHA Programme Board reflected on funding availability, and how the three Trusts could support each other by working in coordinated manner in the BSW system. In the New Year we plan to work together with BSW colleagues to align care model assumptions. Our procurement team is also actively planning how work together to most effectively support these capital development schemes.

- **Single Electronic Patient Record (EPR) Business Case.** The **AHA Medical Directors** have decided to meet regularly to support identification of emerging areas for alignment, and the progress of AHA clinical projects. In September the team considered the clinical benefits of development of a single EPR:

    - *'In light of developments we have seen over the last two years, looking forward, it is hard to see how working individually as organisations we can realise benefits of a scale anywhere near approaching those that we could achieve by working together. A single EPR would be* ***an essential enabler in developing integrated care system working****…*
    - *Working together would enable our clinical teams, allowing establishment of* ***single standardised pathways****, single waiting lists, with embedded* ***clinical decision-making support****, decreasing*

*unwarranted variation in care. It would allow pooling of resources – virtual BSW specialty clinical workforce – **enhancing our flexibility and resilience**….'*

- The Programme is well resourced, led by Bernie Marden on behalf of the three Trusts, and the business case for a common EPR is scheduled to be completed February 2021.

Final Quarter: AHA and Integrated Care in BSW

- **In light of Covid Wave 2,** the final months of the year saw greater emphasis on resilience, mutual aid, and elective recovery. However, we made good progress with a number of other significant schemes too.

- **Elective Surgery and Critical Care Mutual Aid.** Our Medical Directors and COOs, with BSW System Winter Director came together to discuss opportunities for mutual aid across our three organizations as Covid wave two ramped up; in particular, we plan to work together to enable **timely and equitable access** to elective care – particularly P1 & P2 surgery. At our December Programme Board we approved a paper (*Surgical & Critical Care Mutual Aid between RUH Bath, GWH and Salisbury District Hospital, During Covid-19 Pandemic*) building on the abovementioned series of sessions over the past three months exploring potential for Critical Care mutual aid in BSW.

- **Clinical Services Resilience.** Medical Directors held initial discussions to consider: Areas where collaboration is underway or planned; Clinical Strengths; Areas presenting opportunity to work together / some resilience concerns. As a next step, a framework to enable clinically-led identification of opportunities to work together in the BSW acutes will be created.

- B**SW Orthopaedics Recovery programm**e. Recognising the collective desire to address known challenges in waiting times and inequalities of access across the BSW system, representatives from each Trust have been invited to come together to consider our **adult hip and knee services**, developing a **shared ambition for the future** together and planning for our journey to get there. The team's short-term focus will be on GIRFT variation opportunities; defining what an excellent BSW Orthopaedic service would look like; and then defining how we might best deliver that service in BSW.

- **BSW Ophthalmology services** recovery. Building on the SW Region GIRFT event on 9th November, on 17th November the team agreed to start some **collaborative work** designed to ensure the BSW population's access to **ophthalmology services** is enhanced. Initial planning meetings have been held.

- **Organisational Development and Improvement Methodology**. Our OD and Transformation leads have been exploring improvement methodology and cultural change capability and capacity – with the aim to enhance the three Trusts' ability to drive transformative change and make improvements at scale and pace. The team is developing proposals for further consideration with BSW partners in the early New Year.

- **Financial sustainability**. The AHA Directors of Finance have been helping develop the system financial sustainability programme; achieving financial sustainability will be a core component part of our maturing as a system. The AHA Programme Board has determined that this financial sustainability planning and transformation work must remain a priority for us through the remainder of this financial year and the next.

- **Procurement Collaboration**. Our Procurement Transformation Board has continued to meet monthly and after significant successful delivery over the past two years, has commissioned work to explore **options to deepen collaboration** between the three Trusts.

- **BSW ICS designation and planning next steps for BSW ICS development**. As we near the end of the year we have been supporting development of the BSW ICS by being active aligned partners; encouraging our teams

to think and work across our system. Many Acute Alliance colleagues play important roles BSW ICS Development programme work – enabling us to ensure activities are connected and complement each other.

Next Six Months

- The first half of next year will see us focus on a number of significant schemes.

- We are planning to develop a ***BSW Acute Elective Strategy***. We anticipate the Elective Strategy will support our achievement of the enhanced access, quality and financial sustainability triple aim referenced in the recently published *Integrating Care* consultation document. It will help connect current strands of Acute Alliance and BSW system work, including ***BSW Care Model development*** planned by the BSW Population Health and Care Group – for early 2021; The ***BSW Network Provider and Single Waiting List*** work; Our ***BSW System Recovery*** – including work recently started in Orthopaedics and Ophthalmology, Elective Surgery and Critical Care Mutual Aid; and finally the **Clinical Services Collaboration Framework**, recently begun by the Acute Alliance, building on our recent clinical services strengths and resilience discussions.

- **EPR Business Case.** In February and early March the AHA and Trust Boards will consider next steps in relation to EPR Alignment, and will decide whether to commission a Full Business Case and initiate procurement exercise.

> 2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

- **AHA & Provider Collaboration Approach**. In light of our current programme and planned work, we think we're in a good position to respond positively and quickly to the recently issued **Integrating Care: Next Steps to Building Strong and Effective Integrated Care Systems across England** Consultation Document (Nov 20), with its Provider Collaboratives proposals which envisage provider organisations operating in formal collaborative arrangements and at scale (*see extract in box above*).

- **AHA & DGH Strategy**. In January and March we will hold AHA & DGH Strategy workshops designed to shape our AHA and DGH strategy. We will explore potential for **deepening horizontal collaboration** in back office and clinical services, and will develop our approach to vertical / place-based collaboration. In relation to **Vertical Integration**, the Alliance has an important role in helping with development of our locality Integrated Care Alliances, enabling transformation of pathways**,** developing the role of our acute **organisations as anchor institutions in localities, supporting economic and social regeneration with local authorities**, and critically, leading a change in the **focus of our teams on to population health** and wellbeing.

Conclusion

- It's been a busy year, but one where looking back we can point to real changes having been made in how the three Trusts work together. Learning from each other is becoming our start point. Relationships and behaviours have been central – and looking back over 12 months, have transformed. These strengthened relationships are continuing to develop and will enable further momentum to build in our BSW collaborative working.

- Importantly, there's clear collective ambition to go further as we enter 2021, by shaping better value services – making a difference for the BSW populations we serve.

Acute Hospital Alliance Programme Board Members

GWH	SFT	RUH
• Liam Coleman • Kevin McNamara • Charlotte Forsyth • Simon Wade	• Nick Marsden • Stacey Hunter • Lisa Thomas • Peter Collins	• Alison Ryan • Cara Charles-Barks • Bernie Marden • Libby Walters

Further Information

- For further details, including who is involved in Acute Alliance project work in each organization, please **contact our AHA Virtual Core team which** continues to meet fortnightly to ensure timely progress. The group, comprising leads in each Trust, maintains an overview of progress across the three workstreams.

- **Trust Core Team Leads:** Esther Provins, SFT; Stacey Saunders, GWH; Fiona Bird, RUH; & **Programme Director, Ben Irvine** (ben.irvine@nhs.net).

Dates for the Diary in 2021

Meeting	***Date (2021)***
EPR Programme Boards	Fortnightly from 11th January
AHA Workshop: AHA in BSW	15th January
AHA Programme Board	29th January
AHA Programme Board: *EPR Business Case*	16th February
AHA Programme Board	26th February
AHA Workshop: AHA in BSW	5th March
AHA Programme Board	26th March
AHA Programme Board	30th April
AHA Programme Board	28th May
AHA Programme Board	25th June
AHA Programme Board	30th July
AHA Programme Board	27th August
AHA Programme Board	24th September
AHA Programme Board	29th October
AHA Programme Board	26th November
AHA Programme Board	17th December

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	14th January 2021		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	22nd December 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation
Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 22nd December 2020. The report both provides assurance and identifies areas where further assurance was sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - A further Covid-19 update was provided this month. It was noted that numbers of admissions continue to rise. A further outbreak had occurred and a continued focus on infection prevention and control requirements is in place. An update in relation to forthcoming vaccinations was provided. High risk staff are being offered vaccines through Great Western Hospital and it is likely that a Salisbury centre will be in place in the new year.
  - A presentation in relation to Lessons Learnt from Covid was provided. The presentation is appended for all Board members to have sight.
  - The Medical Director reported that he had received the latest update and information required to respond to the external reviewers of the gastroenterology service. The latest update will be considered further in the January CGC meeting.
  - The Medical Director gave a verbal update in relation to the development of a Clinical Strategy for the Trust. It was noted that this will include a focus on the Trust's role in relation to BSW and Place. He outlined the wide stakeholder work required. A draft is expected at the March 2021 CGC. The committee agreed that this was a positive way forward.
  - An update on progress in relation to Divisional level governance was provided. Some progress was noted for example in relation to management of serious incidents and review against risk registers. Weekly Executive led patient safety summits have commenced. An internal audit report is awaited and this will be considered when available. An update will be provided to CGC mid 2021.
  - The care and quality section of the IPR were discussed. No new issues or risks were raised, noting the impact of the increasing Covid-19 activity. Where there are areas of ongoing challenge, further assurance has been requested. As an

example, a falls update will be presented to the January CGC.

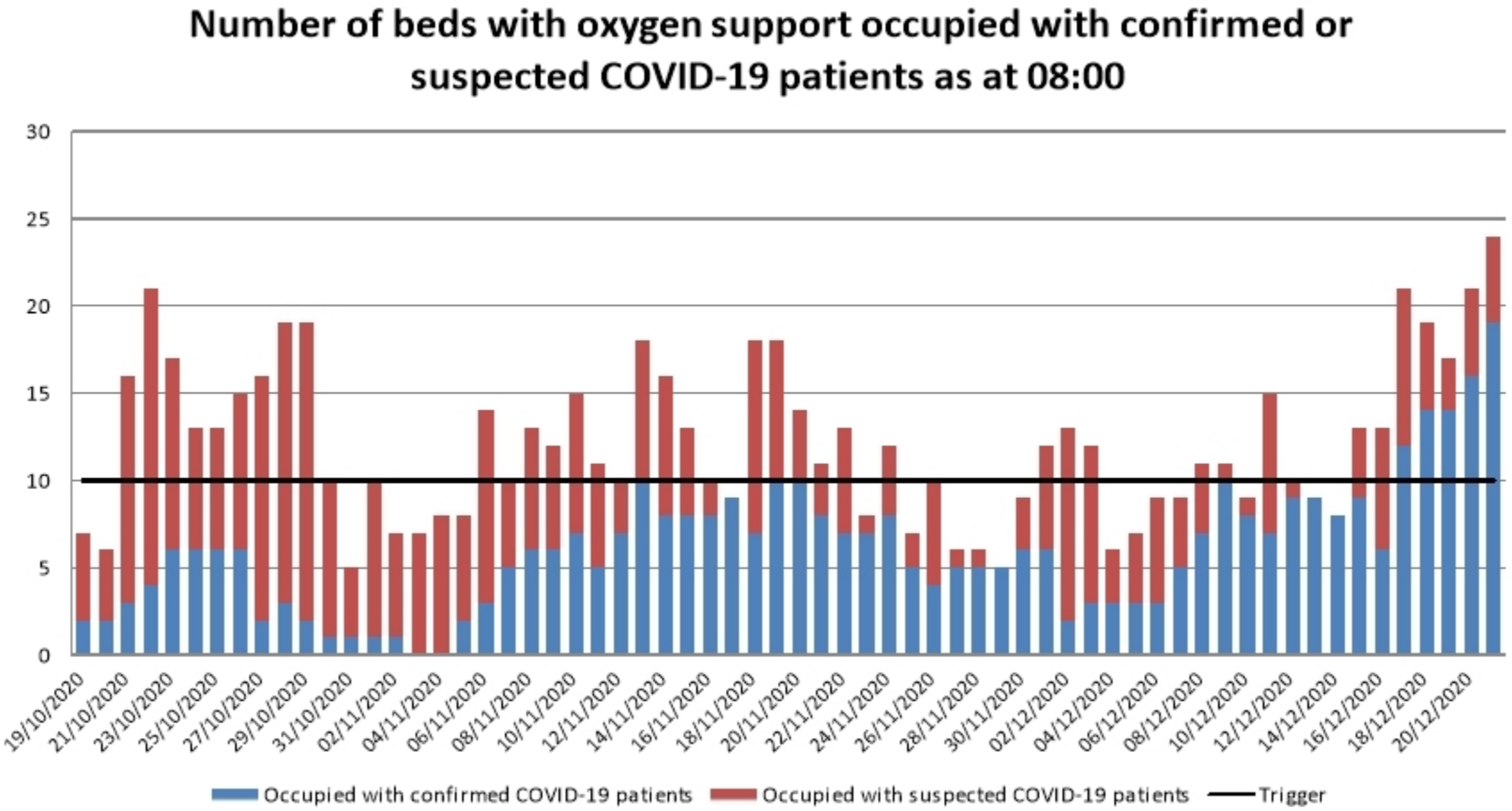
- Reports were received and discussed in relation to Quality Impact Assessments and the Quality Account 6 month review. It was positive to note that the QIA tool is being used more in connection with quality improvement and transformation work. The impact of Covid-19 on some of the Quality Account priorities was noted. Some actions have been paused whilst others will continue into a future year. Positively, the increased partnership working due to Covid-19 has been of benefit.
- A cancer improvement plan update was provided with assurance received in relation to the benefits of some of the improvements. Having previously identified that the original plan to roll out e-outcomes would take 2 years, this has now been changed to achieve roll out in 6 months. It was noted that this will reduce the current risk. Additional improvements include flagging cancer follow up patients on the Lorenzo system, thus reducing the risk of 'lost to follow up'. Controls have also been improved with the development of a new monthly report looking back at cancer follow ups. A review of the diagnostics policy is also planned. Assurance was provided that non Covid-19 patients continue to be prioritised as per national guidance.
- A first report from the mental health strategy group was presented. This provided an opportunity for enhanced scrutiny for this cohort of patients (adults and children). Mental health services are provided to us as a Trust through various partnership arrangements. A detailed discussion took place in relation to how this work could be developed and improved to provide robust assurance. Further work will take place with a review on progress to come back to CGC at a date to be confirmed. Consideration will be given to any risk and this will be aligned with the risk register and BAF where relevant.
- An update was provided in relation to NatSSips and LocSSips (safer systems work). Limited assurance is currently available and it was agreed that this is not as advanced as it should be and that further work is required in this area. This will be addressed through the CMB. It was also noted that strong clinical leadership is required. The Medical Director is addressing this. Further assurance will be provided at the end of Q4.
- An update in relation to GIRFT was provided. It was noted that most of the work has been paused by the national team during 2020 due to Covid-19. This has given the Trust time to review progress. In order to embed fully, GIRFT is now a standing agenda item at Divisional meetings. A recent pathology report demonstrated positive findings for the Trust. Regular updates will be provided to CGC to gain assurance that learning and improvement is taking place.
- The 7 day working deferred from the November 2020 meeting was presented. This provided assurance that improvements had been achieved since September 2019. It was also noted that whilst meeting the minimum is the requirement, there is an appetite to have higher aspirations. This will link into the Clinical Strategy alongside transformation of services.
- The 6 month audit reports (national and local) demonstrated good clinical engagement and that the Trust is generally performing better than expected.
- The External Enquiries and External Agency visits was presented and noted.
- The Q2 patient experience report confirmed that themes remain similar to previous reports, noting that some complaints were in relation to the impact of Covid-19.
- The harms review letter from the Regional Medical Director was noted. The internal process in place (previously escalated to the Board) provides robust assurance in relation to harms review.

COVID update –key points

- New outbreak declared in RSU
- Increase in COVID admissions in last week
- Roll –out of staff testing (lateral flow)
  3112 staff testing
- On-site COVID-19 vaccination plans in train for end of December

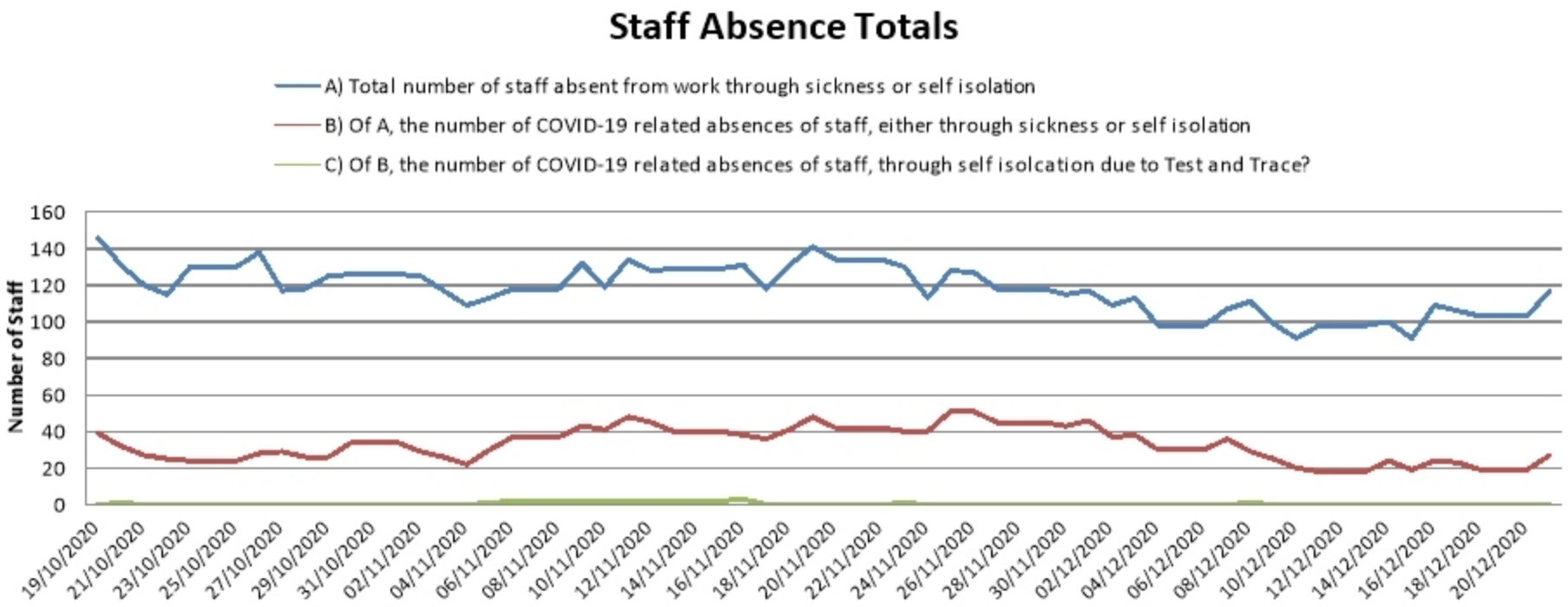
An outstanding experience

for every patient

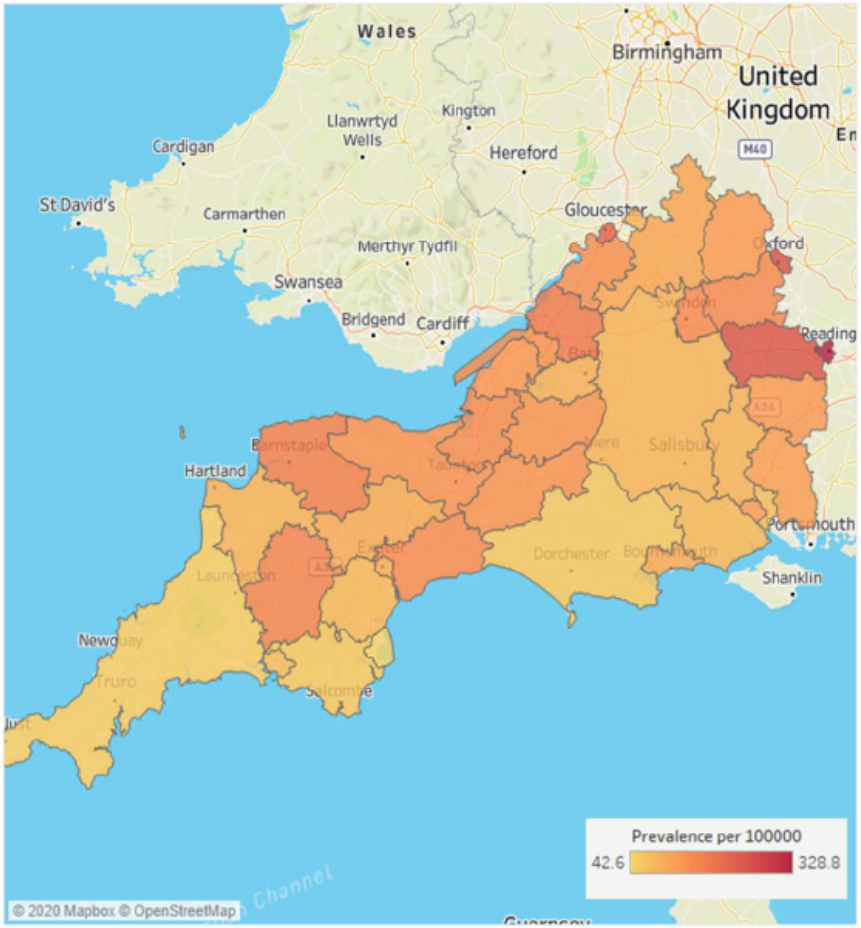


An outstanding experience

for every patient



Lower Tier Local Authority
Prevalence per 100000 7 day rate and Total cases in 7 days
9 December 2020 to 15 December 2020



Reading	328.8
Oxford	247.3
West Berkshire	243.0
Gloucester	222.3
South Gloucestershire	181.3
North Devon	171.9
West Devon	163.1
Swindon	154.8
Vale of White Horse	154.4
East Devon	153.8
Sedgemoor	151.0
Stroud	143.4
Somerset West and Taunton	142.5
Bristol, City of	141.8
South Somerset	141.4
Mendip	139.3
North Somerset	136.7
Southampton	131.1
Basingstoke and Deane	128.0
West Oxfordshire	125.6
Winchester	120.9
Cotswold	110.2
Bournemouth, Christchurch and Poole	108.3
Mid Devon	108.1
Exeter	104.3
Bath and North East Somerset	97.8
Test Valley	92.7
Torridge	92.3
Cheltenham	91.1
Wiltshire	90.2
Teignbridge	86.5
New Forest	85.5
Plymouth	78.6
Eastleigh	75.6
South Hams	63.2
Dorset	61.6
Cornwall and Isles of Scilly	53.4
Torbay	42.6

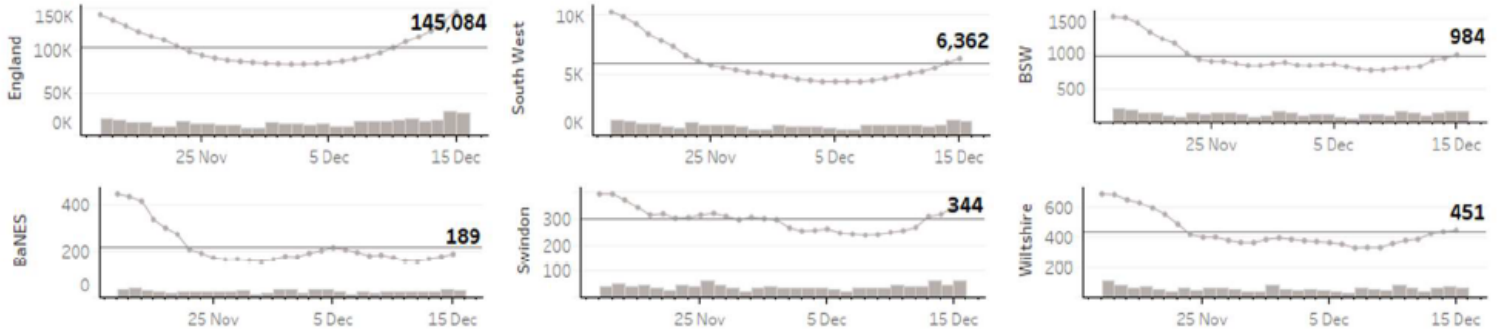
NHS Bath and North East Somerset, Swindon and Wiltshire CCG

Cases and Prevalence

Data shown are cases by specimen date and because these are incomplete for the most recent dates, the period represented is the seven days ending 5 days before todays date. Inline with how its reported on the Gov.UK website.

Number of cases in the last 7 days (Line Graph) & Daily cases (Bar Graph)

15 December 2020



Rate of cases in the last 7 days per 100,000

	01 Dec	02 Dec	03 Dec	04 Dec	05 Dec	06 Dec	07 Dec	08 Dec	09 Dec	10 Dec	11 Dec	12 Dec	13 Dec	14 Dec	15 Dec
England	174.67	173.58	171.05	172.11	168.47	171.47	186.40	189.28	196.34	205.31	218.24	223.75	237.70	269.49	287.15
South West	100.90	97.80	94.60	91.53	88.24	88.22	93.14	93.87	95.30	99.10	101.57	102.71	108.00	121.12	128.09
Bath and North East Somerset	92.61	91.58	99.85	105.55	111.75	107.61	101.92	93.65	95.72	90.02	81.75	80.19	86.40	92.09	97.78
Swindon	133.67	120.17	114.77	115.67	118.37	111.16	109.36	107.56	108.46	112.51	115.22	121.07	139.07	142.67	154.82
Wiltshire	79.80	77.80	76.00	75.00	73.60	71.60	66.80	67.40	67.20	72.40	76.40	78.00	85.60	88.20	90.20
Bournemouth, Christchurch and Poole	74.12	69.06	67.03	65.01	63.24	64.00	64.00	66.02	67.54	70.07	79.43	86.26	91.32	98.90	108.26
Bristol, City of	150.42	139.63	140.92	129.05	127.11	119.56	114.59	124.30	120.20	115.67	117.18	120.64	128.84	138.55	141.79
Cornwall and Isles of Scilly	25.28	25.63	25.81	23.88	22.65	21.77	19.14	18.43	18.43	21.07	26.16	30.72	34.41	44.07	53.37
Dorset	41.21	40.69	39.63	38.84	39.63	41.21	41.48	43.06	44.65	44.12	44.65	46.23	50.20	59.44	61.56
Devon	77.27	76.90	76.90	75.65	75.65	73.78	74.90	72.04	76.90	80.64	86.74	88.61	97.09	105.56	117.53
Gloucestershire	100.77	96.38	90.73	93.08	94.81	101.56	105.48	114.12	121.81	132.64	135.62	134.05	140.17	146.45	146.29
North Somerset	127.88	126.95	118.58	113.46	114.39	118.58	119.51	126.95	123.23	126.02	129.27	125.55	116.72	134.85	136.71
Plymouth	61.43	60.66	54.94	46.55	48.45	59.14	60.28	59.14	62.95	67.15	68.68	69.82	65.24	71.73	78.60
Somerset	85.91	85.38	85.38	85.20	84.13	86.09	89.11	91.96	98.54	105.30	112.77	118.64	125.04	138.56	143.36
South Gloucestershire	151.88	137.15	133.99	132.59	136.80	132.24	133.29	134.69	147.67	153.63	155.39	160.30	166.26	172.58	181.34
Torbay	50.64	46.97	41.10	36.69	33.02	35.23	33.02	36.69	35.96	35.96	39.63	40.36	36.69	41.83	42.56

Data Source: https://coronavirus-staging.data.gov.uk/details/about-data

COVID-19 Capacity Thresholds and Triggers

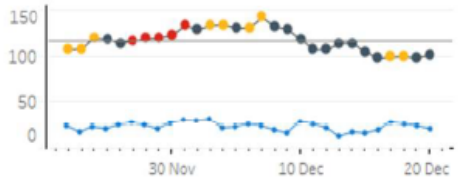
System/Locality
BSW

OPEL Status

	10 Dec	11 Dec	12 Dec	13 Dec	14 Dec	15 Dec	16 Dec	17 Dec	18 Dec	19 Dec	20 Dec
GWH	3	3	3	3	3	3	3	3	3	3	3
RUH	4	4	4	4	4	4	4	4	4	4	4
SFT	3	3	3	3	3	3	3	3	3	3	3

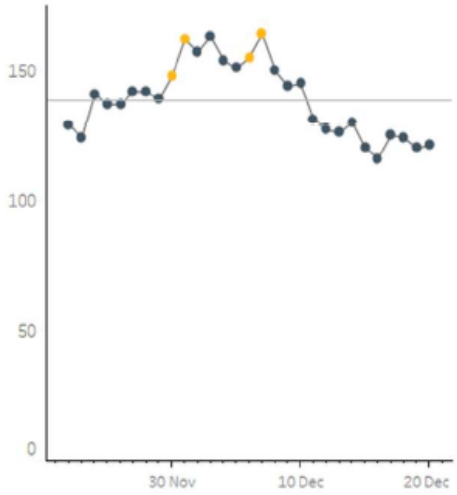
Total No of confirmed COVID cases (Acute) 20 Dec **102**

Total No of suspected COVID cases (Acute) 20 Dec 19

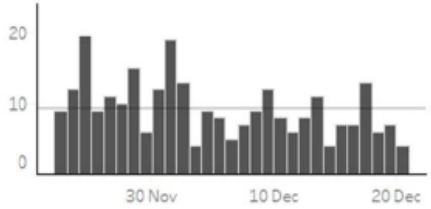


Confirmed & Suspected COVID Cases (Acute) 20 Dec **121**

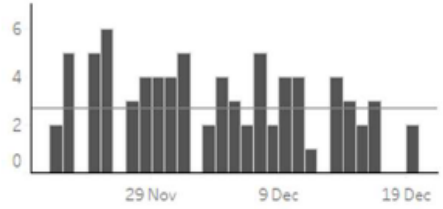
% COVID Bed Base 5% 5-10% 10-15% >15%
No of Beds



Inpatients diagnosed with COVID 20 Dec **4**



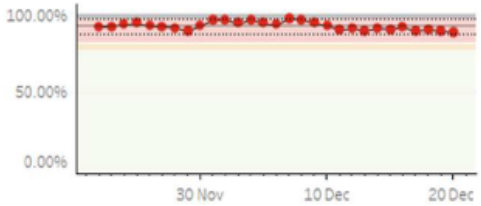
No of Deaths from COVID 19 Dec **2**



Total No of patients in ITU 20 Dec **31**

Total No of confirmed COVID patients in ITU 20 Dec **11**

Acute Bed Occupancy 20 Dec **87.76%**



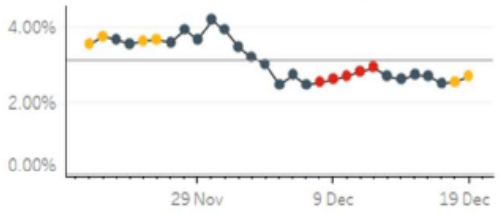
NHS Bath and North East Somerset, Swindon and Wiltshire CCG

COVID-19 Capacity Thresholds and Triggers

System/Locality
BSW

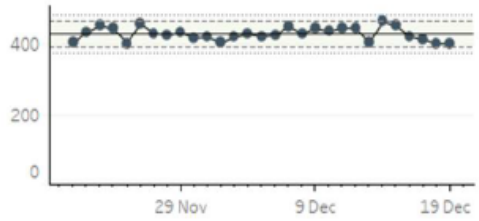
Primary Care COVID Activity per 1000 Population 17 Dec **0.31**

111 - COVID Cases as a % of all cases 19 Dec **2.70%**



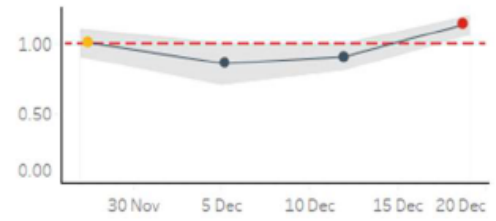
COVID Infections in Care Homes 20 Dec **1.08%**

ED Attendances (Type 1) 19 Dec **402**

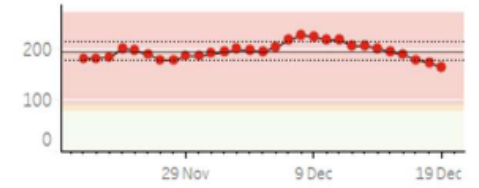


SWAST - Resource Hours Lost 19 Dec **30.79**

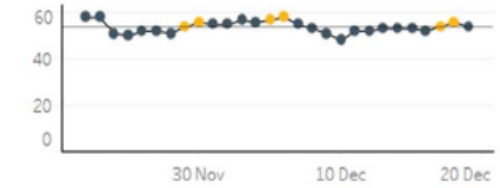
Latest R Value (South West) 19 Dec **1.05 - 1.20**



Super-Stranded (Acute) 19 Dec **164**

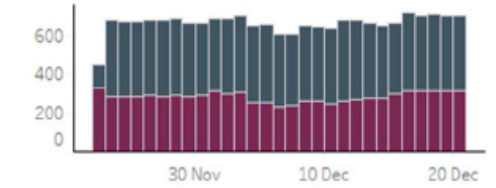


Super Stranded (Community) 19 Dec **54**



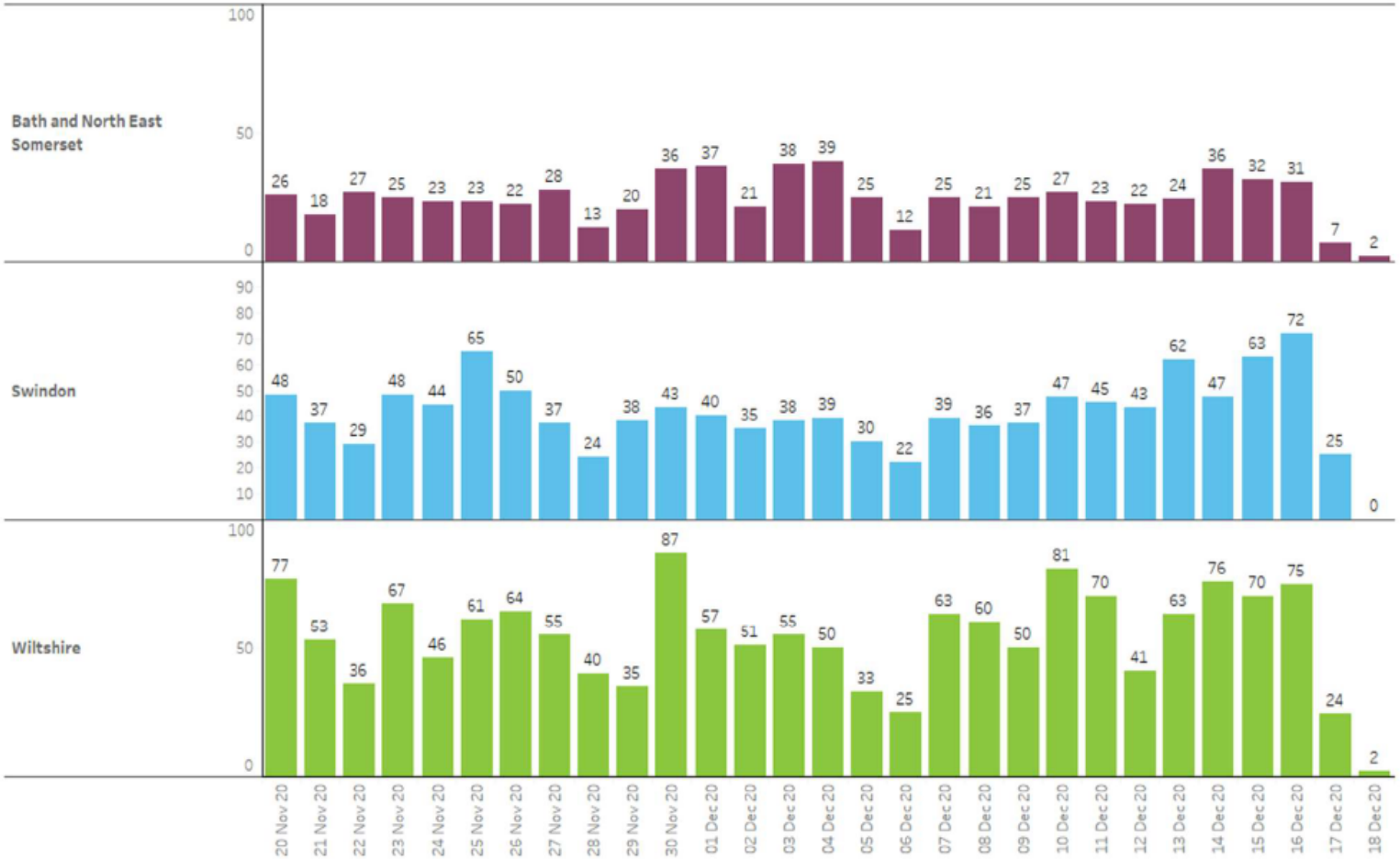
Staff absent (Acute) 20 Dec **700**

COVID-19 related absence (Acute) **315**



Number of cases in the last 28 days by specimen date

Note there is a time lag of around ~5 days for complete recording of this case data.



Bath and North East Somerset, Swindon and Wiltshire CCG

CLASSIFICATION:

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.2
Date of Meeting:	14 January 2021		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	22nd December 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 (F&P) Committee meeting of the 22nd December 2020

Items for Escalation to Board
Integrated performance report as at 30th November 2020 – Whilst in absolute terms the Trusts performance is below expected targets, in relative terms the Trust benchmarks reasonably well with its peers. However there were two specific areas of concerns (a) **Cancer 2 week** wait which has decreased to 76% with a key pressure being Breast Cancer referrals, which account for 108 out of 225 breaches and (b) **elective activity** where there is an increase in patients waiting over 52 weeks i.e. at month 7 the trajectory was 196 but the actual performance was 298. Further the number of 52 week waiters are expected to increase as winter progresses, which will create a strategic and operational challenge for both the Trust and the new Bath, Swindon and Wiltshire (BSW) Integrated Care System (ICS) going forward into 2021/22. **Covid-19 Recovery High Level Plan Update** - This update reflected the tremendous amount of work all staff have done during 2020 and also to prepare going forward into 2021 to manage the second wave. The committee requested a verbal update of how the Trust would manage over the Christmas and New Year period, in particular how the Trust would manage an increase in inpatient admissions. Following a detailed and comprehensive response, the committee was assured that plans were in place to manage an increase in admissions. However these plans, if required, would come at the cost of elective work (see above) as something would have to give to accommodate any significant escalation in covid-19 inpatient activity. **Estates Transformation Update** – The committee had previously requested a report to provide assurance that issues raised in the January 2020 estates review have been

addressed. At this meeting a detailed paper was presented and discussed and whilst not all issues and concerns have been closed off, the committee were assured that significant progress had been made. However the key issue to address going forward is to recruit to a sustainable leadership model in early 2021, which may or may not involve other partner organisations in the BSW ICS.

Integrated Care System (ICS) finance sustainability proposal – The committee received a detailed paper on the background to the financial challenges facing the Bath, Swindon and Wiltshire (BSW) ICS i.e. an estimated underlying deficit of £70m. Further the committee discussed and agreed a recommendation to establish a process and finance a resource, that would enable a BSW financial sustainability plan to be produced by April 2021.

Vaccination at scale – the committee received two papers relating to a covid-19 population vaccination programme that the Trust would be directly supporting in January 2021. The first paper outlined financial arrangement and the second requested a change in the Trusts standing financial instructions (SFI's) to enable the swift mobilization of this vaccination programme. The committee noted the first and with regard to the second the committee recommended to the Chairman that he approve the change to the SFI's on behalf of the Trust Board.

South Six Pathology Laboratory Information Management System (LIMS) – The Trust is a member of a pathology network, known as the "South Six". It was raised under any other business, that the Trust has been provisionally offered £1.3m to proceed with a joint LIMS IT procurement. However our estimate of the cost of a LIMS procurement is £1.7m, therefore if we proceed there could be a shortfall of £400k, which would have to be funded out of the Trusts 2021/22 capital programme. This offer was noted as were the timescales of acceptance and it was agreed to discuss this further at the Trust Board/Finance and Performance Committee in January 2021.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	14 January 2021		

Report from:	Trust Management Committee (TMC)		**Committee Meeting Date:**	15 December 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 15th December 2020.

Executive Summary:
The Trust Management Committee met on 15th December 2020 and the following outlines the key points for the Board to note. The Board should note that TMC had proactively reduced the time available for the meeting to 60 minutes to recognise the impact operational challenges are having on senior leaders' capacity. The meeting only considered exceptions arising from the standing reports it receives. • The committee received a report it had requested on the implementation plan for E outcomes. The request asked for options to speed up the roll out of e outcomes for all specialities which was projected to take up to 2 years. Given there are patient safety risks that will be reduced via this approach this time frame isn't acceptable. The paper outlined 3 options and following discussions the committee agreed to support option 3 which achieves roll out in 6-9 months and requires circa 30k investment. . • The committee noted that performance in the Emergency Department had deteriorated, however it was noted that the Trust is maintaining their upper quartile ranking within the region and nationally. The reduction in performance is associated with the measures in place to safely manage COVID and responding to mutual aid requests from other BSW providers. The team were thanked for their ongoing commitment and hard work.

- The committee further noted that in relation to Infection, Prevention and Control there have been a number of C-Diff cases and there have been challenges in isolating cases alongside Covid-19 patients. It was noted that the C-Diff cases are unrelated and whilst the teams are doing all they can to release side rooms in the quickest way possible when required, there are increasing competing priorities for these rooms given COVID -19.

- The committee noted the context re the numbers of patients with COVID-19 in hospital was increasing, albeit wasn't material in respect of our ability to absorb this whilst continuing other urgent and elective activity. It was recognised that staff are working incredibly hard and flexibly to achieve this. The CEO is doing regular all staff meetings re COVID via teams to ensure colleagues have access to the information they need re the situation. These are well attended and supplement the information our communications team continue to provide via their daily bulletin.

The committee also noted that the January meeting will be used for the Annual Strategy Review.

End of Report

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

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	14th January 2021		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	17th December 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.

Key Items for Escalation

Programme Management Deep Dive

Management gave a presentation on the Programme Management process, essentially stepping forward from the 2018 Lorenzo "lessons learnt" exercise to the current position. In summary, it was clear that progress had been made, but that there was still some way to travel before the disciplines and techniques of programme management were effectively embedded within the Trust's management and control processes. Some of the remaining open areas were in fairly basic areas, such as the lack of clear definitions as to what was a project or programme for which varying degrees of programme management techniques were to be applied. As part of the presentation, a timetable for the next key deliverables was presented, which covered a period up to April 2021.

There was a good discussion amongst the Committee and the management team. Amongst other matters, the Committee encouraged the team to try to develop some commonality of approach across the BSW network.

The Committee asked for a further update on progress at the July 2021 meeting.

Internal Audit Report

Generally good progress continues to be made, but it was noted that four action items from the 2019/20 programme and three from the current year programme were overdue. The committee were told that these items were being addressed.

External Audit Planning

Given the challenges encountered in completing the 2019/20 year end audit, the Committee were keen to be able to review a plan for the upcoming 2020/21 exercise at the December meeting. Unfortunately, none was presented. This was partially

due to late delivery of planning milestones by NHSI, but this was not accepted as being the only reason for the deficiency.

By the next scheduled Audit Committee meeting in March, the interim audit will be complete and it will too late to challenge the planning assumptions. The committee therefore asked the DoF to arrange a special meeting in January to review the plan for the year-end audit.

Counter Fraud Report

The Committee received the regular progress report from the Local Counter Fraud Officer. Progress was shown in several of the small number of open fraud investigations, but one in particular was of particular concern to the Committee.

An employee was challenged and subsequently admitted stealing drugs from the pharmacy. The admitted thefts were of serious, but not formally controlled, drugs. However, the investigation also showed the possibility of thefts of controlled drugs. Unfortunately, the reconciliation processes within the pharmacy systems were not sufficiently robust to allow this to be proven. In parallel with this investigation, it was noted that the annual PWC internal audit of key controls had also identified some potential weaknesses in pharmacy control processes. Both the counter-fraud and PWC exercises were still in progress, but the matter was of sufficient concern that the committee were unhappy with a deferral of the matter to the March meeting and asked the DoF to circulate an update in January, with the potential for committee members to discuss further when it meets to review the external audit plan.

Consultant Job Planning

Peter Collins gave the Committee an update and his views on the process from the perspective of a new Medical Director. The Committee were presented with an outline plan to deliver a robust job planning approach and were assured that the process was getting appropriate attention.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	13th January 2021		

Report from: (Committee Name)	Charitable Funds Committee		**Committee Meeting Date:**	17th December 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 17th December 2020

Key Items for Escalation
• The committee approved the annual accounts and received the external audit findings following the annual audit. Key points to note included; the VAT status of the charity was now concluded following external professional advice. A prior period adjustment was included which related to removal of the medical trials income and its associated expenditure. Material uncertainty was raised regarding property valuations, which reflects Covid and the uncertainty of impact on valuations. • The committee approved a new balance scorecard approach to investment decisions, making decision making more transparent for all applicants. • Terms of reference were agreed for a new investment committee which would be the governance route for approvals. • The committee approved a governance structure to continue the improvements in oversight and direction of the Stars Appeal, this included additional resource to strengthen the management team and communications.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	14 January 2021		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

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

Executive Summary:
A second National lockdown period was enforced during M8 slowing the rate of Covid-19 infection and hospital admissions. Similarly to the first lockdown period, a reduction was seen in the number of ED attendances, Stroke admissions and TIA attendances. Nevertheless challenges were seen in ED with spikes in attendances in the evening, and ED performance remained static at 89.8%, overall attendances were slightly lower than M7. Increasing bed occupancy and challenges in flow to the Respiratory Care Unit due to increasing Covid-19 prevalence affected the ability to move patients swiftly through the department and into the hospital. Capacity constraints were exacerbated by the number of discharges by midday being low at 15.52%, the lowest levels achieved this year. Sickness absence reduced to 3.13% (3.72% in M7) although within that Covid-19 related absence has increased from 0.27% to 0.42% reflecting the continued pressures from Covid-19. Flow issues also affected the number of patients reaching the Stroke unit quickly, with 38% reaching the unit within 4 hours, and 41% receiving a CT within one hour (target 50%). In an effort to improve access the dedicated Stroke Assessment bed has been reinstated. The number of pressure ulcers increased to 30 (25 in M7), however improvements were seen in some of the hotspot areas identified in medicine. An increase was noted this month in the surgical division; root cause work is underway to identify any failings or improvements.

Elective and Daycase activity levels increased slightly, although did not meet the trajectory levels submitted to NHSE/I as part of the Phase 3 recovery plan. The Elective Incentive Scheme income reduction has been assessed at £494k but not included within the position per instruction from NHSE/I. Outpatient activity continues to perform above trajectory submitted to NHSE/I.

RTT performance slightly improved due to increasing activity in daycases and outpatients. The number of patients waiting over 52 weeks increased in M8 by 43 to a total backlog of 338. The forecast position for M8 was a backlog of 226. The increase in backlog is in part due to decreased theatre capacity, and also partly due to patients requesting to wait due to concerns around Covid-19.

Recovery of the Diagnostic standard continues to improve with 94.1% (92.7% in M7) of patients receiving their diagnostic procedure within 6 weeks. 177 of the 212 breaches were in Cardiology diagnostics, an increased level of referrals is increasing pressure on the service.

The Cancer Two Week Wait performance has decreased to 76.11% in M8, the lowest performance to date in 2020-21. Pressure on the Breast referrals is a big factor in this (108 of 225 breaches). An increase in referrals following Breast awareness month, and space constraints in enabling social distancing requirements are impacting on available capacity. Capacity is expected to increase from January.

The Trust has now submitted a formal M07-12 forecast to NHSEI for the remainder of 2020/21; however for the purposes of continuity reporting for the remainder of the financial year will track performance against both the original 2020/21 plan, and the forecast as submitted. In November the Trust has reported a modest YTD deficit of £0.1m, however this represents an improvement on both the original M07 plan and the Phase 3 forecast.

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

January 2021

(data for November 2020)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

A second National lockdown period was enforced during M8 slowing the rate of Covid-19 infection and hospital admissions. Similarly to the first lockdown period, a reduction was seen in the number of ED attendances, Stroke admissions and TIA attendances. Nevertheless challenges were seen in ED with spikes in attendances in the evening, and ED performance remained static at 89.8%, with attendances slightly lower than M7. Increasing bed occupancy and challenges in flow to the Respiratory Care Unit due to increasing Covid-19 prevalence affected the ability to move patients swiftly through the department and into the hospital. Capacity constraints were exacerbated by the number of discharges by midday being low at 15.52%, the lowest levels achieved this year.

Flow issues also affected the number of patients reaching the Stroke unit quickly, with 38% reaching the unit within 4 hours, and 41% receiving a CT within one hour (target 50%). In an effort to improve access the dedicated Stroke Assessment bed has been reinstated.

Elective and Daycase activity levels increased slightly, although did not meet the trajectory levels submitted to NHSE/I as part of the Phase 3 recovery plan. The Elective Incentive Scheme income reduction has been assessed at £494k but not included within the position per instruction from NHSE/I.

RTT performance slightly improved due to increasing activity in daycases and outpatients. However, the number of patients waiting over 52 weeks increased in M8 by 43 to a total backlog of 338. The forecast position for M8 was a backlog of 226. The increase in backlog is in part due to decreased theatre capacity, and also partly due to patients requesting to wait due to concerns around Covid-19. Outpatient activity continues to perform above trajectory submitted to NHSE/I.

Performance against the Diagnostic standard continues to improve with 94.1% (92.7% in M7) of patients receiving their diagnostic procedure within 6 weeks. 177 of the 212 breaches were in Cardiology diagnostics, an increased level of referrals is increasing pressure on the service.

The Cancer Two Week Wait performance has decreased to 76.11% in M8, the lowest performance to date in 2020-21. Pressure on the Breast referrals is a big factor in this (108 of 225 breaches). An increase in referrals following Breast awareness month, and space constraints in enabling social distancing requirements are impacting on available capacity. Capacity is expected to increase from January.

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
November 2020

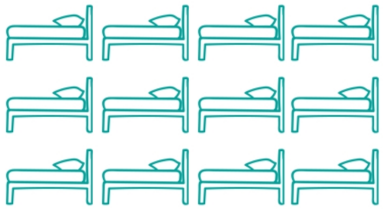
NHS Salisbury NHS Foundation Trust

There were **2,541** Non-Elective Admissions to the Trust

We delivered **19,289** outpatient attendances, **xx%** through video or telephone appointments

We met **2 out of 7** Cancer treatment standards

We carried out **286** elective procedures & **1,672** day cases



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

RTT 18 Week Performance:
73.63% ↑

Total Waiting List: **17,392** ↑

94.1% ↑ of patients received a diagnostic test within **6 weeks**

Our income was **£23,265k** (£1,161k over plan)

15.9% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance
89.8% ↓
(Target trajectory: 95%)

56 patients stayed in hospital for longer than 21 days

Our overall vacancy rate was
0.70% ↓

Reading a Statistical Process Control (SPC) Chart

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

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

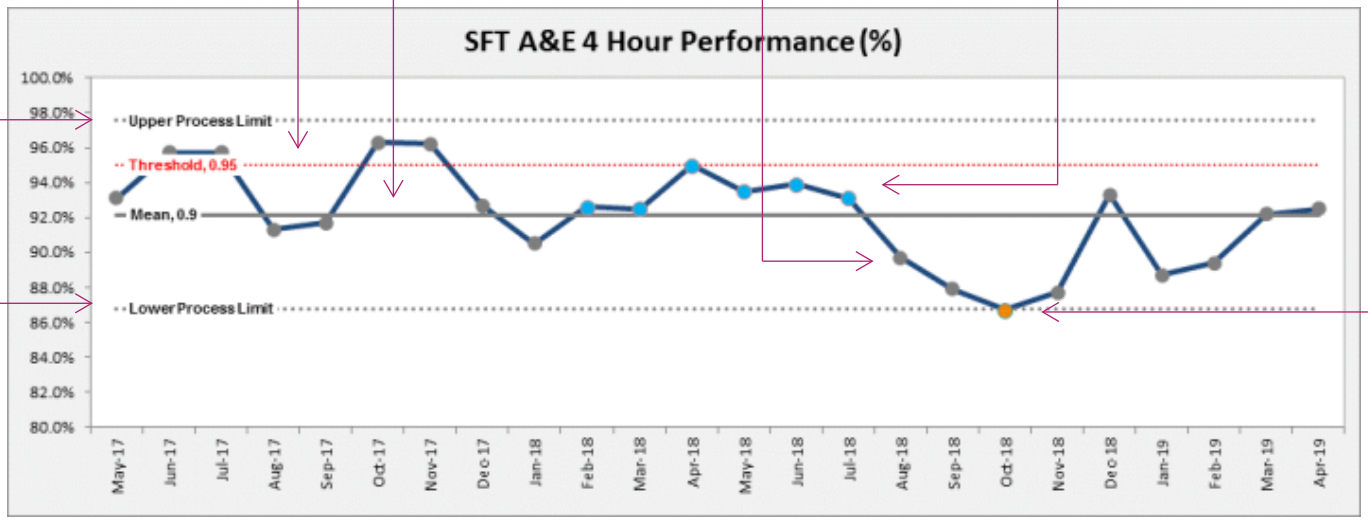
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

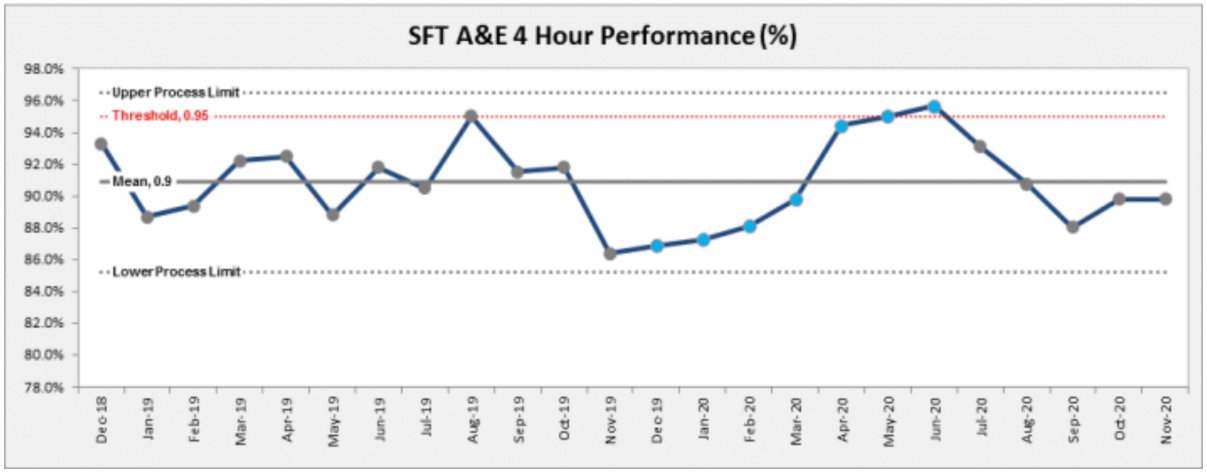
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	89.8%
Attendances:	4409
12 Hour Breaches:	0
ED Conversion Rate:	32.6%

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

M8 lower attendances in ED as compared with M8 of 19/20 (1,564 fewer attendances this year). A reduction in attendances from M7 20/21 is also noted (409 fewer attendances) and may be attributable to the second national lockdown period

There is an improvement in performance from 86.39% in M8 19/20 to 89.8% in M8 20/21. Performance compared to M7 remains exactly the same at 89.8%.

Sharp spikes in attendances post 6pm for majors patients continuing to put pressure on later half of the day.

Average times to assessment and average times for treatment for the most unwell (resus) patients reduced from 9.9mins to 9.1mins and 43.6mins to 38.1 mins respectively with no breaches of the related 15 and 60 minute standards across the month for this group of patients.

Workforce gaps in junior, middle and Consultant tiers continue, mitigated by Locum cover where possible, although are worsening into M9 and M10

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

Temporary cubicle solutions are in place in majors – permanent arrangement is due for installation by end of Q3 – this will serve to increase flexibility for managing infection control issues.

Substantive Consultant appointment achieved in month, start date confirmed for February 2021.

Returning Consultant from employment break expected M11

Increase in Registrar level cover expected M11.

Bolstering of junior and middle grade rotas with appropriate rota cover continues as BAU.

Risks to delivery and mitigations

Pathways for Covid-19 positive (Cat A) patients dependent on flow to RCU. This has improved during the latter part of M8 but must be retained so as not to cause risks to safety, flow or performance in ED.

Gaps in medical workforce in particular night registrar gaps throughout M9 and M10 due to gaps in rota and staff absence. Constant attempts to cover with locums are being made but some gaps will likely remain. All Consultant shifts for M9 are covered and do not anticipate issues in M10 for the Consultant rota. Registrar situation improves from M11 onwards.

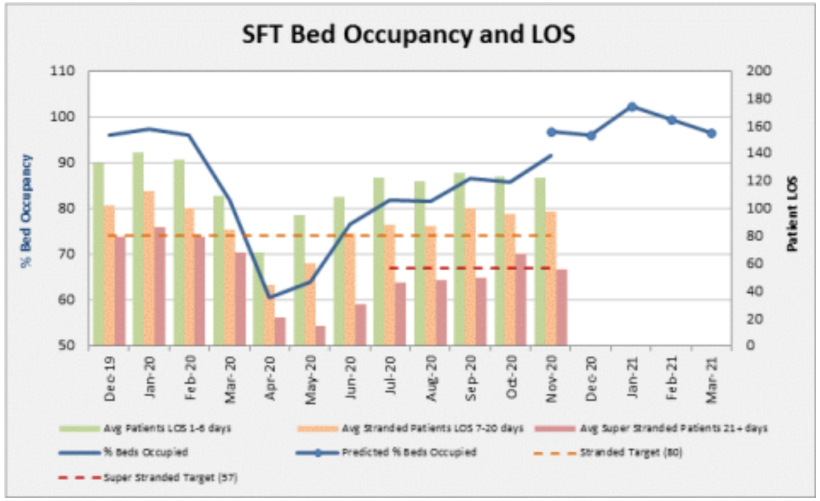
Nursing gaps on the rota and reduced nursing skill mix continues to create risk. Reliant on staff support from other areas and some bank shift uptake but since return to school this has been variable.

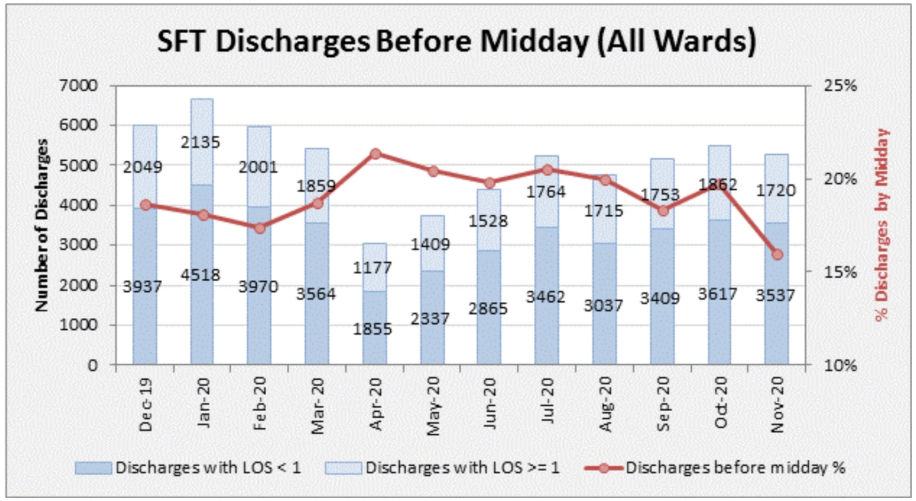
Statistical Process Control Chart Key:

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

Patient Flow and Discharge

Are We Effective?





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

Bed occupancy continued to climb in November although below the predicted level, and there was a slight decrease in the group of 21 day+ patients, showing as on target. Both other LOS groups remained steady. Of note as an influencing factor is the Stroke unit recommencing rehabilitation on site, extending the stay of patients in this group particularly.

There has been a drop in the number of discharges before midday, even below pre Covid-19 levels. This may be an indicator of staff ability in rising admissions to prioritise early discharge given the numbers of patients needing reviews which may not be possible in the morning.

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

Expert panel is established for 14 day+ and an escalation route for internal issues is established within divisions supporting an expedited journey.

Criteria Led Discharge has been introduced on pilot wards and is starting to demonstrate an opportunity for pre noon and weekend discharge but this acknowledged to be in it's infancy. Once established and proved as effective, a rollout across adult inpatients is planned.

The Wiltshire system recognises a higher proportion of patients requiring complex discharge planning that are outside of the criteria for the discharge to assess model and who remain in hospital for assessment to establish a safe discharge plan. This is being explored but currently presents as an anomaly that appears to be without an obvious explanation. Patient information regarding discharge will be refreshed across wards to support the message around discharge as soon as is practical.

Criteria to reside advice will be provided to support ward and board rounds in December and January – this is nationally required information daily and is designed to support decision making, and flagging areas of service both internally and externally that require attention.

Risks to delivery and mitigations

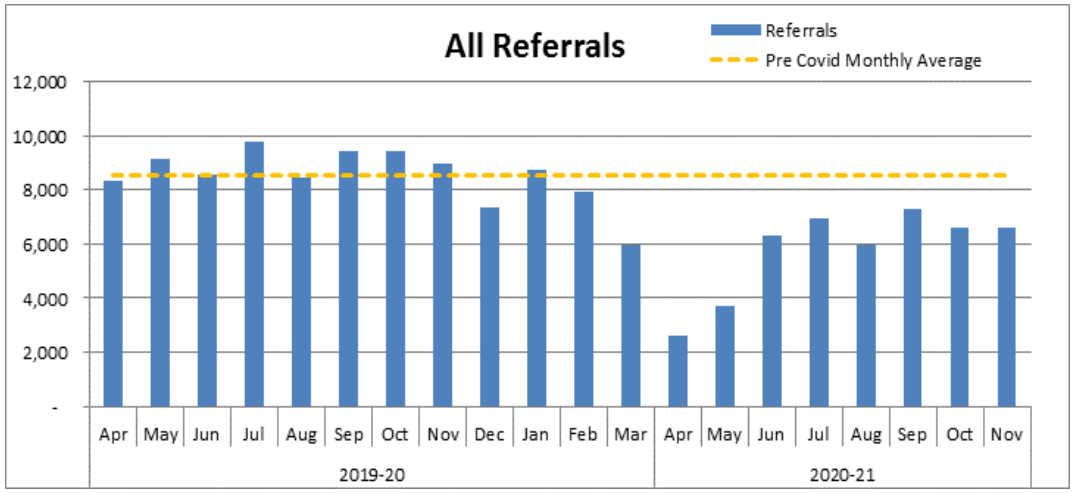
Criteria Led Discharge in pilot areas requires a demonstrable impact that may not be available until January at least as confidence in professionals grows.

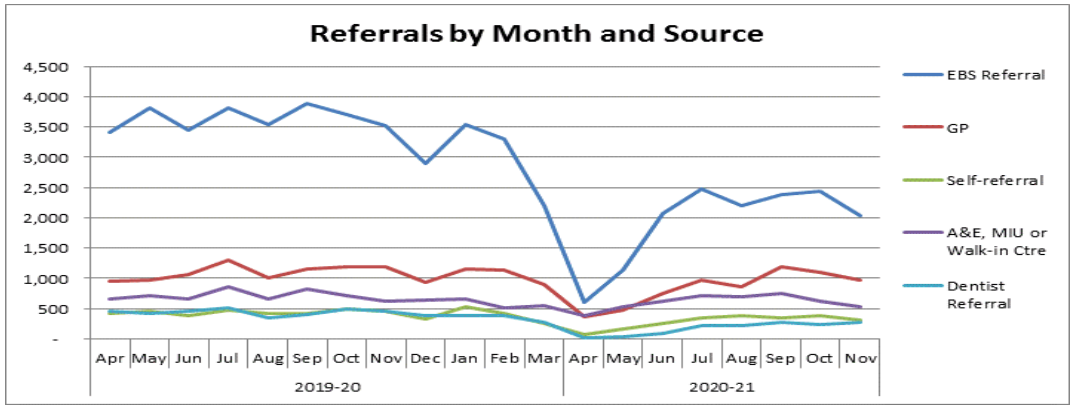
Staffing over Winter with additional implications of Covid-19 may impact on both internal and partner capacity to facilitate discharge leading to longer patient journeys

A surge in Covid-19 or other winter complications meaning higher than expected occupancy will continue to put strain on patient flow.

Referrals

Additional Supporting Information





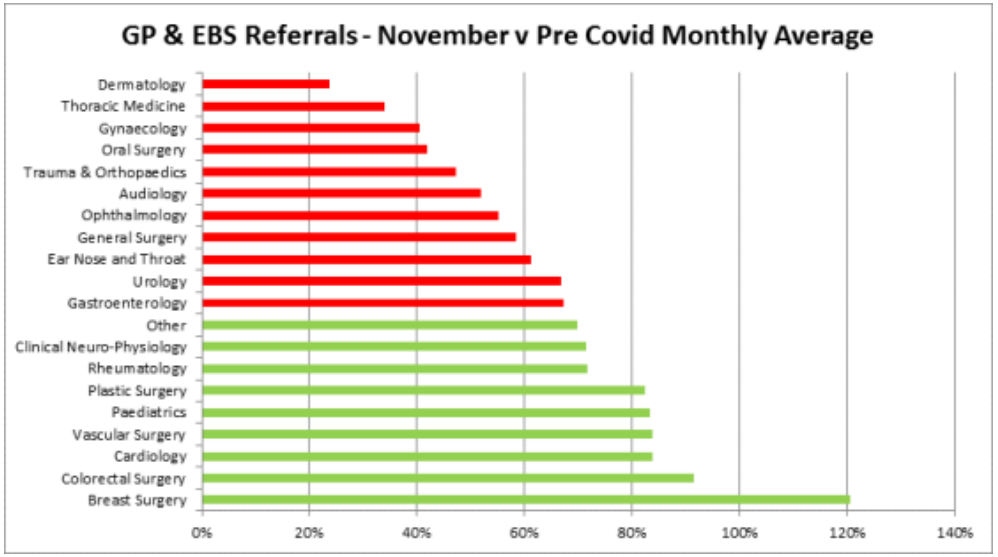
Comments

Referral levels had increased through Q2, but now appear to have plateaued at a level lower than seen pre Covid-19. Referrals through the Electronic Referral System dropped in November, which may be linked to the second lockdown period. Dentistry referrals have been slow to recover following the first lockdown period, and although still low increased slightly in November.

Referrals

Additional Supporting Information

Specialty	November	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Breast Surgery	271	225	121%
Colorectal Surgery	262	287	91%
Cardiology	212	253	84%
Vascular Surgery	48	57	84%
Paediatrics	142	170	83%
Plastic Surgery	242	294	82%
Rheumatology	121	169	72%
Clinical Neuro-Physiology	93	130	72%
Other	413	591	70%
Gastroenterology	110	164	67%
Urology	161	241	67%
Ear Nose and Throat	185	303	61%
General Surgery	50	86	58%
Ophthalmology	227	412	55%
Audiology	160	309	52%
Trauma & Orthopaedics	86	182	47%
Oral Surgery	22	52	42%
Gynaecology	123	304	40%
Thoracic Medicine	35	103	34%
Dermatology	44	186	24%

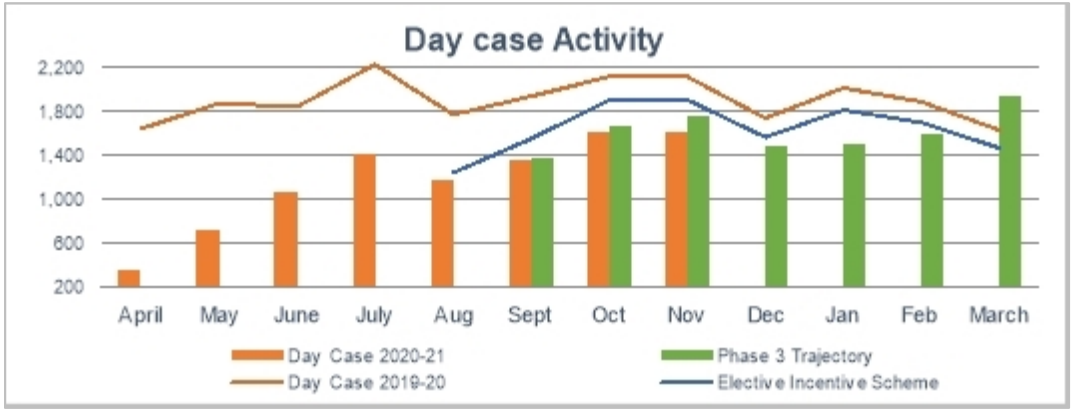


Comments

Although referral levels overall remain lower than pre Covid-19 levels, Breast surgery has seen a big increase in referrals in November. This is related to a Breast Awareness campaign in October, and an increase in referrals that are sent without the GP physically examining the patient.

Activity recovery – Day case (target 80%)

Are We Effective?



Specialty	Division	Nov 20 activity	Phase 3 Plan - Nov 20	Variance	% of Nov 2019
Ophthalmology	Surgery	86	134	-48	43%
General Surgery	Surgery	220	262	-42	86%
General Medicine	Medicine	38	78	-40	51%
Colorectal Surgery	Surgery	76	110	-34	60%
ENT	Surgery	19	51	-32	33%
Dermatology	Surgery	6	15	-9	120%
Gynaecology	CSFS	26	34	-8	51%
Interventional Radiology	CSFS	2	10	-8	11%
Respiratory Medicine	Medicine	9	15	-6	50%
Rheumatology	Surgery	83	88	-5	79%
Upper Gastrointestinal Surgery	Surgery	0	2	-2	0%
Breast Surgery	Surgery	12	13	-1	171%
Neurology	Medicine	15	16	-1	75%
Obstetrics	CSFS	4	5	-1	0%
Geriatric Medicine	Medicine	6	5	1	0%
Paediatrics	CSFS	6	5	1	0%
Cardiology	Medicine	106	100	6	89%
Urology	Surgery	137	130	7	107%
Oral Surgery	Surgery	58	48	10	69%
Plastic Surgery	Surgery	283	269	14	139%
Gastroenterology	Surgery	383	366	17	67%
Spinal Surgery	Surgery	19	0	19	271%
Trauma & Orthopaedics	Surgery	23	2	21	55%
		1618	**1757**	**-139**	**77%**

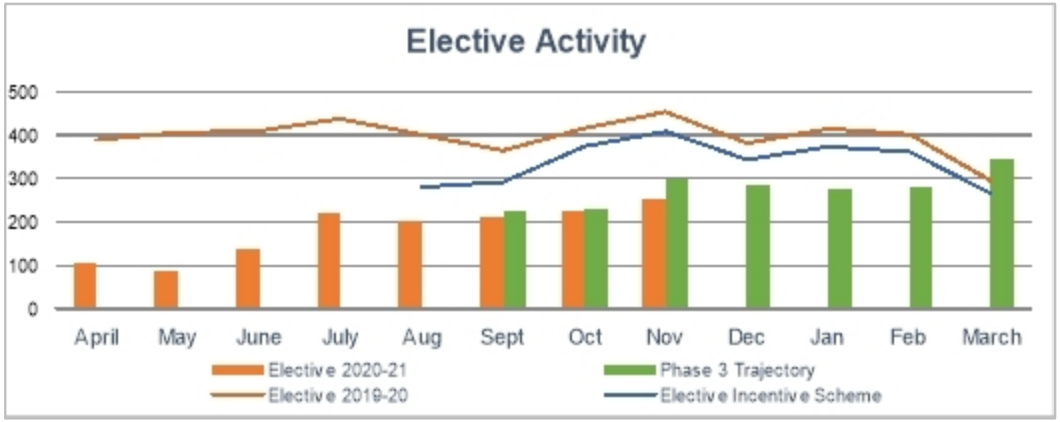
Daycase activity in M8 was increased from M7 (1618 in M8, compared to 1603 in M7) but the gap between activity and the Phase 3 trajectory submitted to NHSE/I has widened slightly and in M8 there was a shortfall of 139.

Theatre space continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month. Outsourcing to New Hall continues in Trauma & Orthopaedics, Plastics, Spinal and Ophthalmology.

New Hall activity is not included within SFT numbers. ENT and Oral Surgery remain challenging to increase with proportionally higher numbers of aerosol generating procedures.

Activity recovery – Electives (target 80%)

Are We Effective?

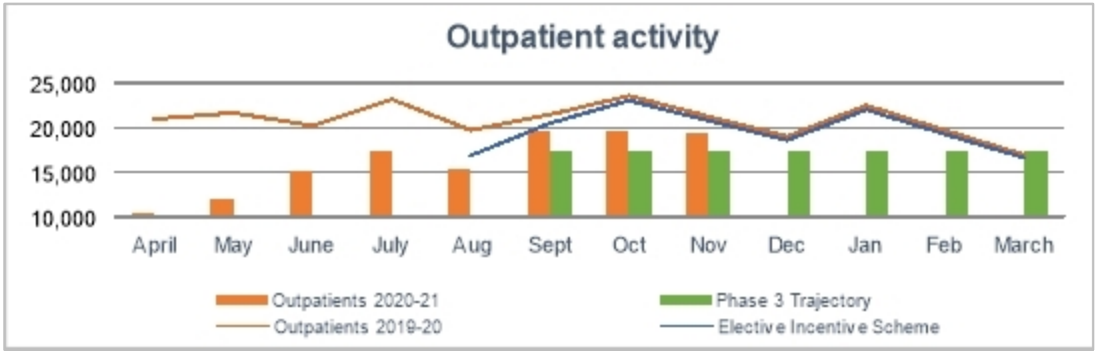


Specialty	Division	Nov 20 activity	Phase 3 Plan - Nov 20	Variance	% of Nov 2019
Trauma & Orthopaedics	Surgery	18	50	-32	17%
Plastic Surgery	Surgery	48	63	-15	62%
ENT	Surgery	14	25	-11	70%
Oral Surgery	Surgery	2	9	-7	20%
Urology	Surgery	45	52	-7	69%
Gynaecology	CSFS	12	16	-4	57%
Colorectal Surgery	Surgery	22	25	-3	85%
Obstetrics	CSFS		1	-1	0%
Maxillo-Facial Surgery	Surgery	0	1	-1	0%
Rheumatology	Surgery		1	-1	0%
Spinal Surgery	Surgery	2	1	1	11%
Breast Surgery	Surgery	15	14	1	68%
Cardiology	Medicine	7	5	2	50%
Ophthalmology	Surgery	2		2	50%
Medical Oncology	Medicine	3		3	0%
Paediatrics	CSFS	4	1	3	200%
Clinical Haematology	Medicine	8	5	3	160%
General Surgery	Surgery	24	20	4	100%
General Medicine	Medicine	9	4	5	129%
Interventional Radiology	CSFS	8	2	6	800%
Gastroenterology	Surgery	9	1	8	180%
		253	297	-44	58%

- Elective activity was slightly higher in M8 than M7, however the trajectory submitted to NHSE/I predicted a higher increase than was achieved. 253 electives were performed against a trajectory of 297, resulting in a shortfall of 44 against plan.
- The two specialties with the highest variance from plan were Trauma & Orthopaedics and Plastic Surgery, both of these specialties are outsourcing activity to New Hall which is not included in the SFT activity numbers.
- ENT, Urology, Plastic Surgery and Trauma & Orthopaedics were all planned to increase elective activity in M9, however this was not achieved due theatre lists continuing to be allocated on clinical prioritisation, which means that specialities with lower levels of urgent patients will recover activity levels more slowly – ENT, Gynaecology and Urology were affected by this in November.

Activity recovery – Outpatients (target 100%)

Are We Effective?



Specialty	Nov 20 activity	Phase 3 Plan - Nov 20	Variance	% of Nov 2019
Respiratory Medicine	583	1058	-475	88%
Trauma & Orthopaedics	1272	1694	-422	78%
Paediatrics	641	945	-304	77%
Endocrinology	459	713	-254	190%
Cardiology	617	758	-141	101%
ENT	652	771	-119	89%
Orthodontics	214	299	-85	78%
Other		37	-37	0%
General Surgery	215	252	-37	83%
Chemical Pathology		36	-36	0%
General Medicine	68	91	-23	67%
Vascular Surgery	182	198	-16	83%
Maxillo-Facial Surgery	31	41	-10	47%
Transient Ischaemic Attack	36	41	-5	60%
Anticoagulant Service	86	90	-4	91%
Interventional Radiology	65	63	2	107%
Clinical Psychology	113	108	5	81%
Breast Surgery	417	411	6	92%
Clinical Oncology	79	73	6	111%
Pain Management	23	16	7	35%
Neurophysiology	115	108	7	90%
Ophthalmology	2078	2069	9	83%
Clinical Haematology	430	413	17	119%
Clinical Physiology	44	27	17	60%
Occupational Therapy	30	10	20	158%
Gastroenterology	357	336	21	147%
Paediatric Trauma And Orthopaedics	31		31	79%
Gynaecology	676	644	33	93%
Paediatric Burns Care	35		35	97%
Upper Gastrointestinal Surgery	36		36	144%
Respiratory Physiology	36		36	46%
Medical Oncology	414	376	38	108%
Paediatric Ear Nose And Throat	38		38	52%
Physiotherapy	43		43	52%
Hepatology	48		48	66%
Geriatric Medicine	198	142	56	98%
Orthotics	507	450	57	107%
Oral Surgery	572	514	58	69%
Gynaecological Oncology	61		61	109%
GUM	553	450	103	109%
Clinical Cardiac Physiology	296	185	111	241%
Rheumatology	1012	900	112	121%
Burns Care	124		124	118%
Urology	761	631	130	78%
Colorectal Surgery	607	473	134	97%
Dermatology	692	543	149	89%
Spinal Surgery	155	0	155	68%
Orthoptics	164		164	92%
Spinal Injuries	189		189	112%
Diabetic Medicine	271		271	108%
Plastic Surgery	2054	1423	631	97%
Audiology	771		771	76%
Total	**19289**	**17409**	**1880**	**91%**

Outpatient activity levels for M8 exceeded the forecast Phase 3 trajectory submitted to NHSE/I but although the plan was met, outpatient activity remains slightly lower than pre Covid-19 levels with November 2020 activity being 91% of November 2019's.

Specialties with fewer Covid-19 related constraints can be seen to have fully recovered with activity for some being well over 100% of last November's.

With increased numbers of appointments being undertaken virtually, the level of outpatient procedures has reduced.

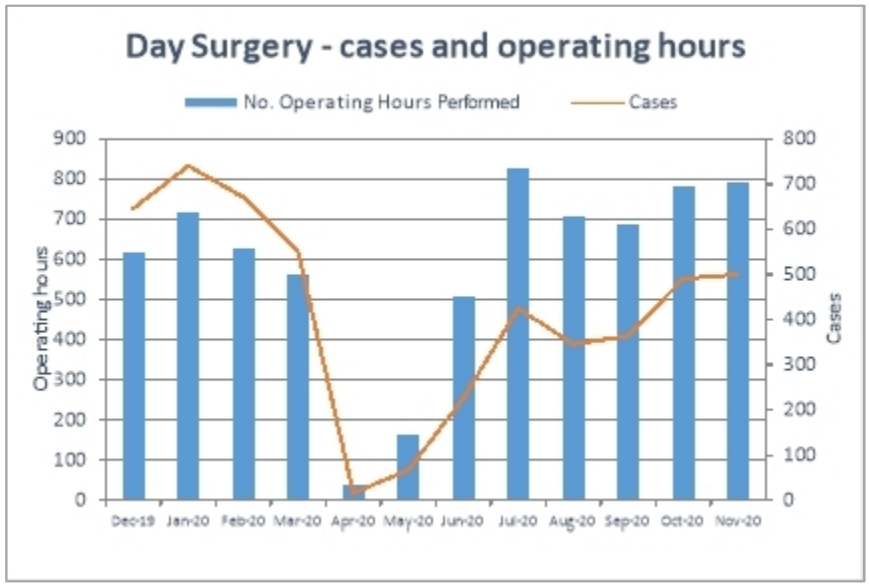
An air change solution for ENT & Oral Surgery outpatient department has been identified, and is expected to be in place during Q4, with activity expected to rise following this.

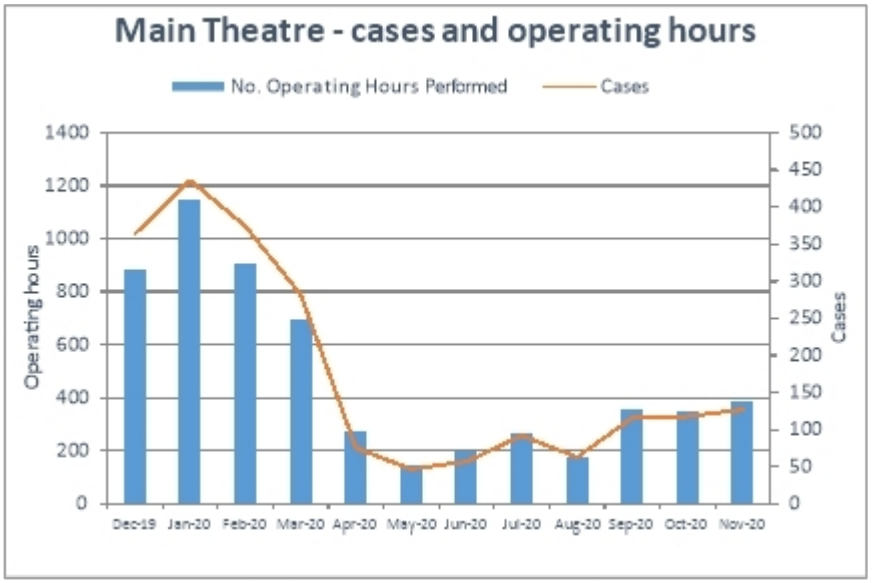
Space constraints across outpatient department continue to be a challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics. The modular build expected in mid-Q4 will increase the number of patients that can be safely seen.

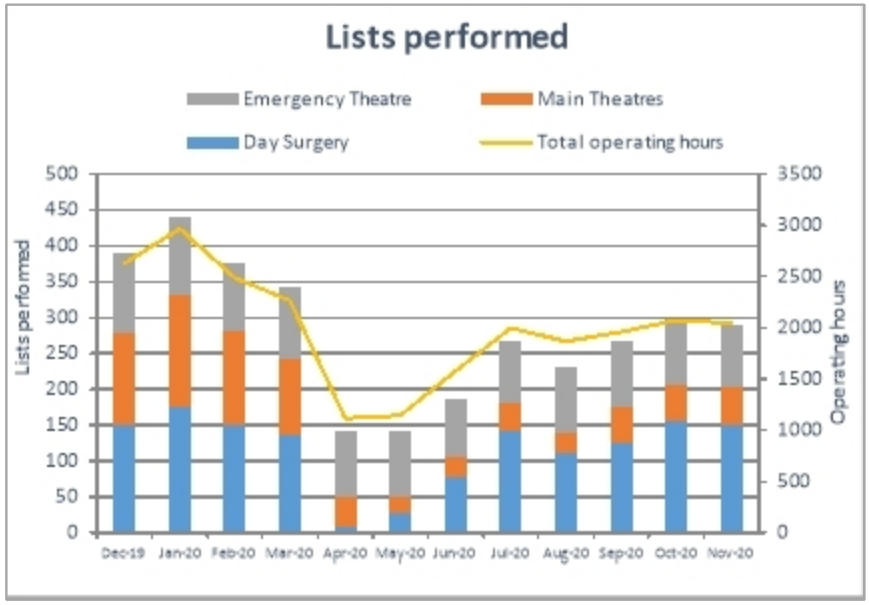
Virtual appointments are working well in some specialties with Gastroenterology seeing the majority of their outpatients virtually. Urology and Colorectal surgery are also seeing good use of virtual appointments.

Activity recovery - Theatres

Additional Supporting Information







Theatre activity was slightly higher in both daycase and main theatres.

Theatre activity was expected to increase in November with the opening of two further Main Theatres, which was partially achieved.

Challenges remain around staffing, sickness levels, agency fill and recruitment. Covid related absence remains a difficult issue to mitigate. Theatre staff payment incentive was approved and started in November.

Flexibility around juggling elective and non elective lists has minimised short notice cancellations.

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

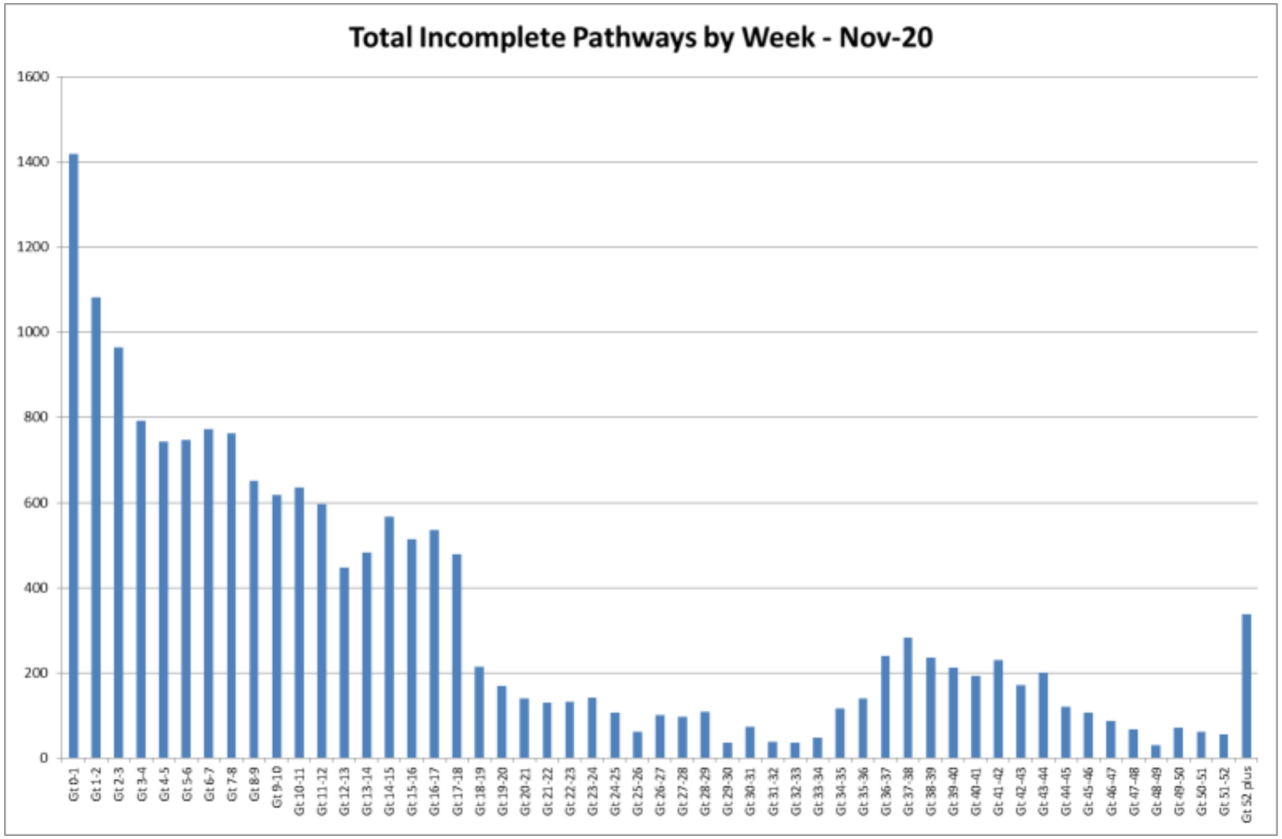
National Key Performance Indicators

Top 5 lowest 18 week performance

Specialty	WL Total	Total <18 weeks	% <18 weeks
Dermatology	419	173	41.3%
Ophthalmology	1957	1033	52.8%
Ear, Nose & Throat (ENT)	1494	867	58.0%
Oral Surgery	1497	900	60.1%
Plastic Surgery	1259	795	63.1%

Top 5 largest 18 week breach backlog

Specialty	WL Total	Total 18 wk breaches	% <18 weeks
Ophthalmology	1957	924	52.8%
Ear, Nose & Throat (ENT)	1494	627	58.0%
Oral Surgery	1497	597	60.1%
Plastic Surgery	1259	464	63.1%
Other	3234	461	85.7%



RTT performance continued to improve in November at 73.63% (69.9% in M7). This is due to increased activity especially in outpatients and day cases.

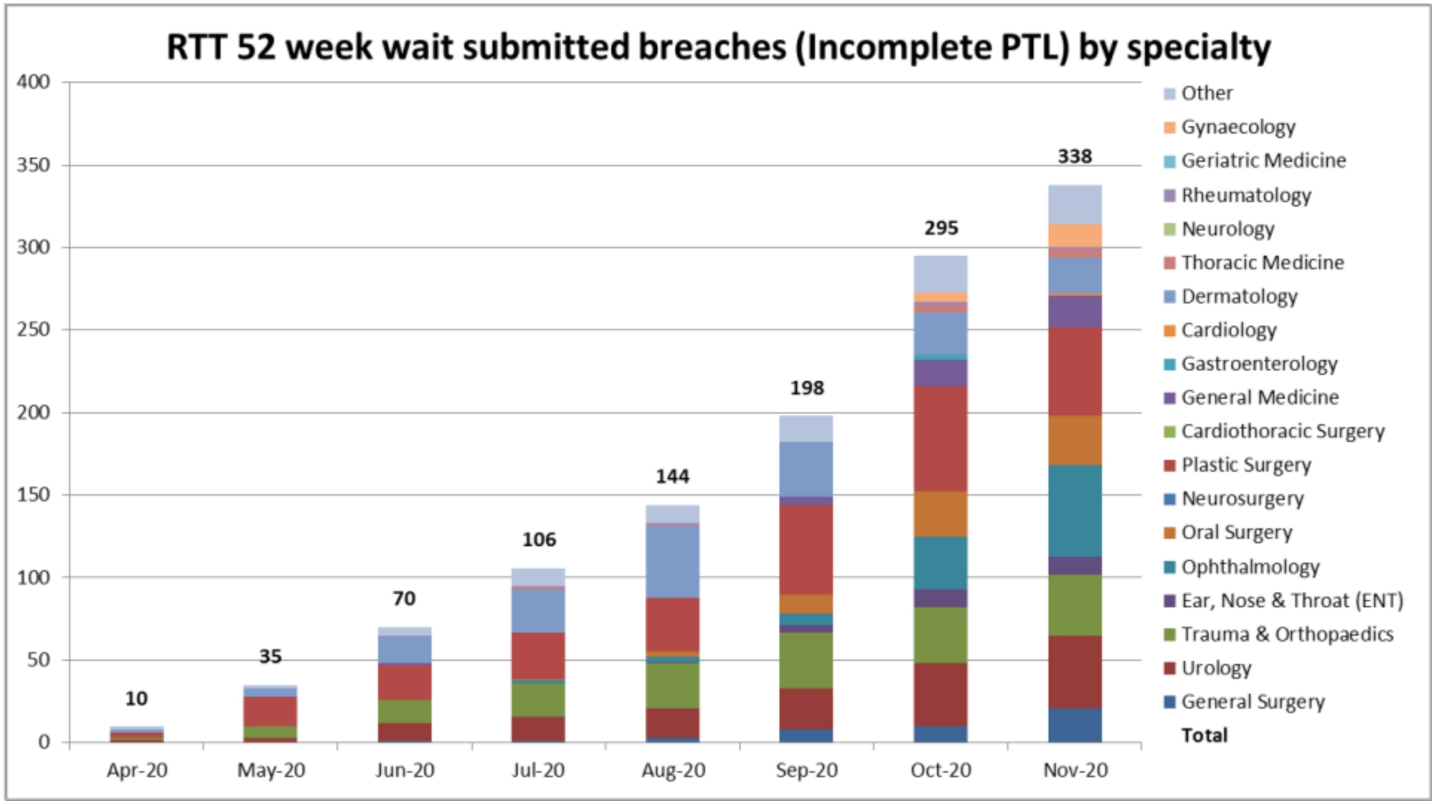
As part of the support work for areas with the poorest compliance, and largest volumes, the Surgical DMT are focussing on Ophthalmology reviewing options to increase their outpatient capacity options including possible outsourcing solutions and increased use of peripheral sites.

Additionally the air change solutions now identified for ENT and Oral Surgery, which will be installed during Q4, will improve their capacity but improvement will be limited until these are in place.

Work on Dermatology productivity continues and additional minor operation capacity continues to be organised including Saturday outpatient and surgical lists and Locum cover for one week every month has been reinstated which will provide additional outpatient capacity from December.

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

National Key Performance Indicators



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

Treatment function	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	% change from previous month
Urology	2	3	11	15	18	25	38	30	52%
Plastic Surgery	3	18	21	28	33	54	64	25	19%
Trauma & Orthopaedics	1	7	14	20	27	34	34	23	0%
Dermatology	2	5	16	26	43	33	26	20	-21%
Other	2	2	5	11	11	16	22	15	38%

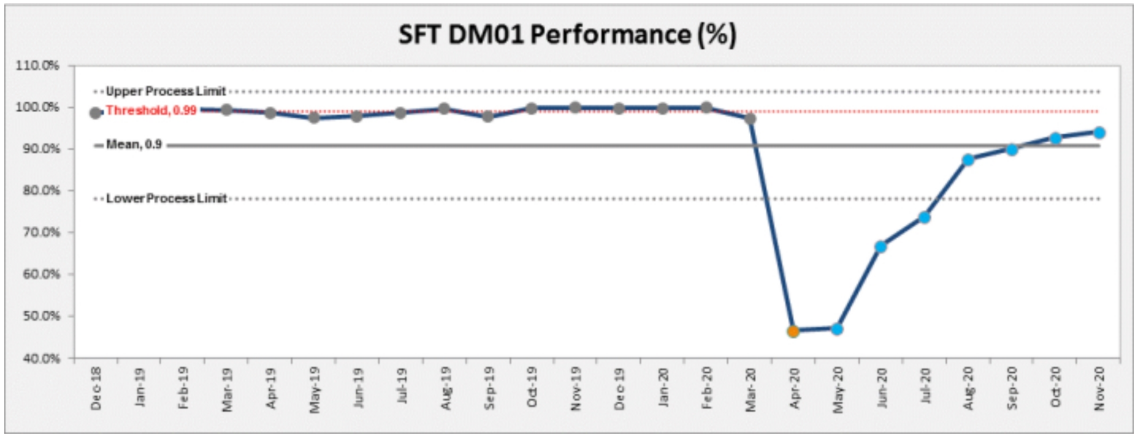
The number of patients waiting longer than 52 weeks has grown by 43 patients to a total of 338. Of these 35 are patients who have requested to pause their pathway due to Covid-19 concerns.

As part of the phase 3 activity assumptions the Trust forecast that the number of over 52 week patients would grow every month until the end of 2020-21. The forecast position for M8 was 226 patients over 52 weeks.

Theatre capacity continues to be allocated on the basis of clinical priority and then longest waiters. Space constraints in outpatient areas are resulting in long wait times for some first appointments especially in ENT and Ophthalmology.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	94.1%
Waiting List Volume:	3591
6 Week Breaches:	212
Diagnostics Performed:	6534

Background, actions being taken and risks and mitigations
Performance standard in month has not been achieved as a direct impact of Covid-19. December projections confirm that the target is not achievable for M9 owing to an increased referral rate for Cardiology Diagnostics and unplanned downtime of Mobile MRI's both onsite at SFT and at Newhall Hospital. Further progress against wait times has improved for the majority of diagnostics, Cardiology being the exception. Clarity is being sought around access to MRI and CT capacity @ Newhall from January 2021 onwards, reflecting contract negotiations currently taking place between BSW and Ramsay

Endoscopy
5 confirmed in month breaches, all attributable to Covid-19.

Radiology (Inc. DEXA)
20 confirmed in month breaches, all attributable to Covid-19.

Radiology Reporting
Go live of second provider live from 08-12-2020. Reduced activity continues to have positive impact on the number of outstanding reports, so the risk to the service is being mitigated against. Interventional Radiology remain the exception, owing to reduced functionality in the work station located at the Royal Bournemouth and Christchurch Hospital (RBCH). SFT IT supporting with resolution.

Audiology
9 confirmed in month breaches, all attributable to Covid-19.

Cardiology
177 confirmed in month breaches. This is a direct result of an increasing referral rate. Total activity reported for the month, reflects continuous improvement, the Specialty will review and rebase the recovery trajectory.

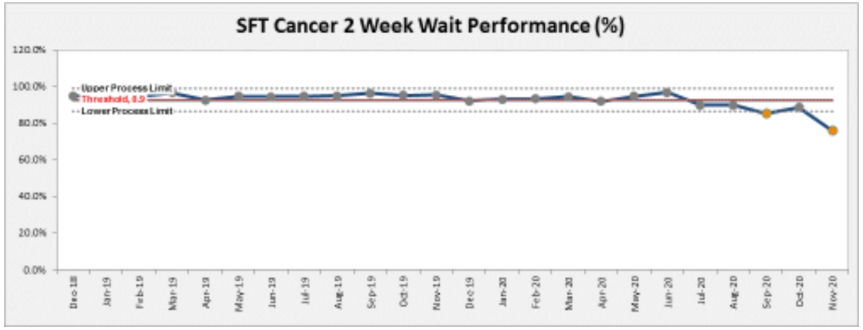
Neurophysiology
1 confirmed in month breach, attributable to Covid-19.

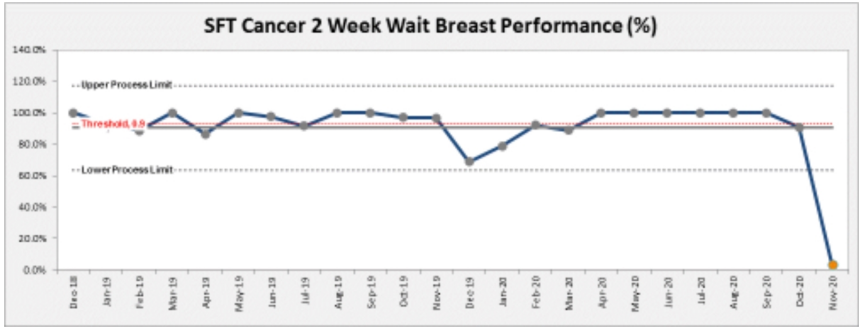
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	76.11%	717/942	225 (29 patient choice)
Two Week Wait Breast Symptomatic Standard:	3.28%	2/61	59

Data Quality Rating:





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

Two week wait standard now achieved for M8 (942 patients seen in total; 717 seen within target; 225 breaches). This is due to a variety of reasons including:

- Face to face outpatient capacity (108 breaches, 106 of which were related to breast one stop clinic capacity constraints);
- Patient choice (29 breaches);
- Late receipt of qFIT result (34 breaches);
- GP delay (22 breaches);
- Endoscopy capacity (8 breaches);
- Radiology capacity (7 breaches);
- Admin delay (10 breaches);
- COVID-related delay (5 breaches);
- Other (2 breaches)

Breast symptomatic two week wait performance standard not achieved for M8 (61 patients seen in total; 59 breaches); increase in denominator compared to previous months following audit of referral routes and increase in referrals due to breast awareness month (October 2020). Delays again associated with breast one stop clinic capacity.

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

Booking teams continue to prioritise cancer pathways, though ongoing concerns related to patient choice remain; this is likely to impact on service delivery for a significant period of time.

Significant challenge within breast service due to increase in referrals following breast awareness month in October 2020, and a number of patients who are referred without having a physical examination from their GP. This increase in demand is then exacerbated by reduced capacity due to social distancing restrictions. A fifth one stop clinic is due to commence from January 2021, with plans to complete a full business case to secure longer term funding.

Weekly PTL meetings in place, which look to mitigate against any upcoming breaches. This then enables cancer services to work with the relevant team to expedite where possible. Use of cancer escalation process reinvigorated to reduce unnecessary delays.

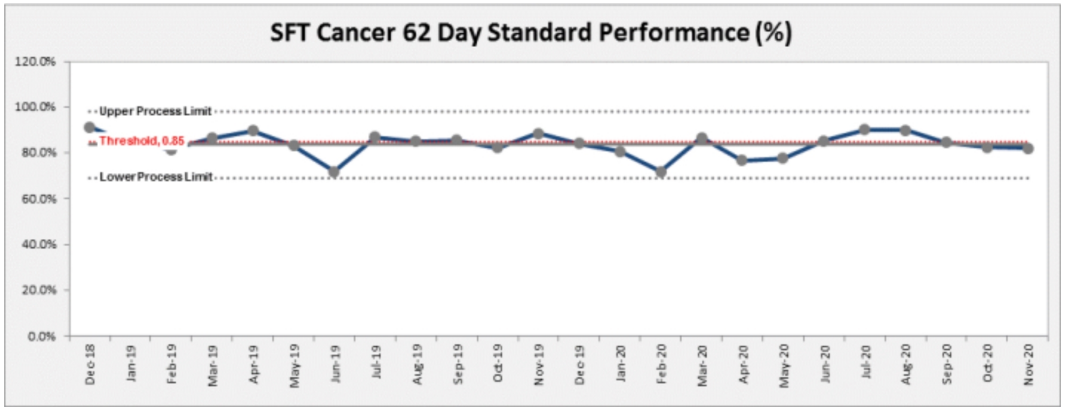
Risks to delivery and mitigations

Diagnostic capacity is likely to significantly affect out ability to achieve the two week wait standard going forward, particularly with services with well established straight to test pathways in place.

The SWAG cancer alliance has confirmed that secondary care will be unable to book or perform diagnostic tests without the completion of a qFIT; this should be completed by the patient prior to referral though there is a risk that as this is not mandated, that patient pathways will be significantly delayed. Cancer services continue to work closely with the colorectal team and CCG around the impact of this.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month	Performance	Num/Den
62 Day Standard:	82.14%	69/84
62 Day Screening:	50%	1/2

Risks to delivery and mitigations

Month 8 62 day performance of 82.14% (84 patients treated in total; 69 within target; 15 breaches). Breach reasons predominantly as a result of complex diagnostic pathways, patient choice and clinical delays.

Four 104 day breaches reported in November following treatment:

1 x Haematology; delayed transfer from head & neck team

1 x Upper GI; clinical delay

1 x Colorectal; complex diagnostic pathway and delays at tertiary centre to commence treatment

1 x Head & Neck; complex diagnostic pathway and delays at tertiary centre to commence treatment

Future performance continues to remain fragile. Cancer services and DMT continue to focus on long waiters and the overall PTL backlog (patients waiting over 62 days); this continues to show improvement. Weekly cancer action group to be established to maintain DMT oversight of cancer care delivery.

Month 8 62 day screening performance standard not achieved (2 patients treated in total; 1 breach). Breach associated with complex diagnostics across two tumour sites to identify primary.

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:

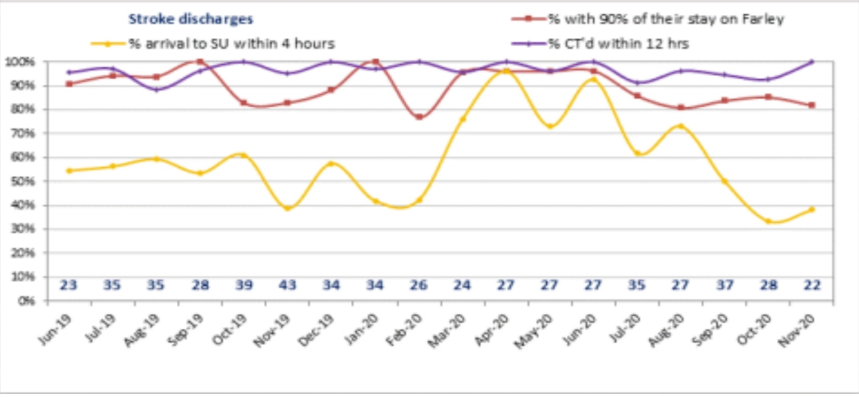
Year	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported		

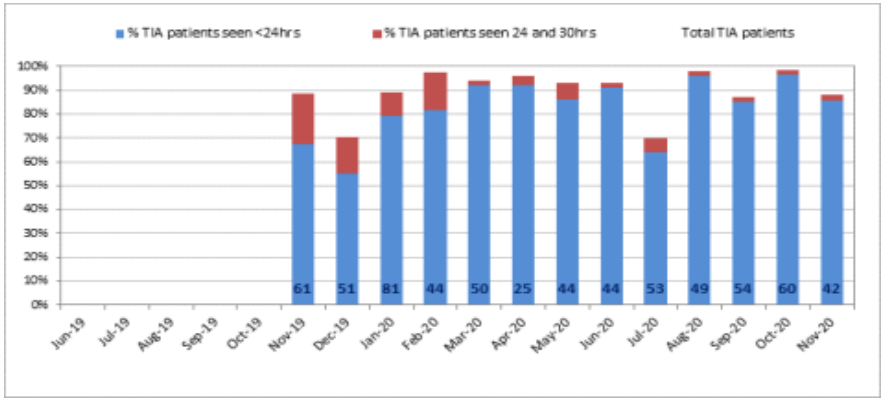
Data Quality Rating:

% Arrival on SU <4 hours: 38.1%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 85.7%





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

A reduction in the number of stroke admissions as a result of the national lockdown. The reduction was seen nationally, particularly of patients with transient or mild symptoms who chose not to attend hospital. 41% of stroke patients had a CT within 1 hour (target 50%) reflecting the number of patients arriving out of hours and increased pressure on ED. Patients reaching the stroke unit within 4 hours remained at a low level (38%) affecting 13 patients. Delays were due to waiting for a diagnostic (3), waiting for first/speciality doctor (2), in ED >4 hours (2), admitted to AMU/SSEU (2), 2 inpatient strokes and late referral /waiting for a bed (2). 1 (4.5%) stroke death within 7 days – lower than expected (10%) and 2 (9%) stroke deaths within 30 days – lower than expected (17%). 82% of patients spent 90% of their time on the stroke unit exceeding the national target (80%). 61% of eligible patients accessed the Early Supported Discharge (ESD) service exceeding the national target (40%).

A reduction in the number of patients presenting with a TIA due to the national lockdown. TIA performance reduced to 86% – affected 6 patients. These were due to full or no clinics available (4) and 2 late GP referrals (seen by the out of hours service or late in the day and patients not referred until the following day).

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

The Stroke Unit now has 30 beds available for stroke patients across Laverstock (acute) and Breamore (rehabilitation) wards. The assessment bed has been re-instated enabling GP direct admissions and transfers out of ED within 4 hours of arrival and is expected to improve the time to the stroke unit.

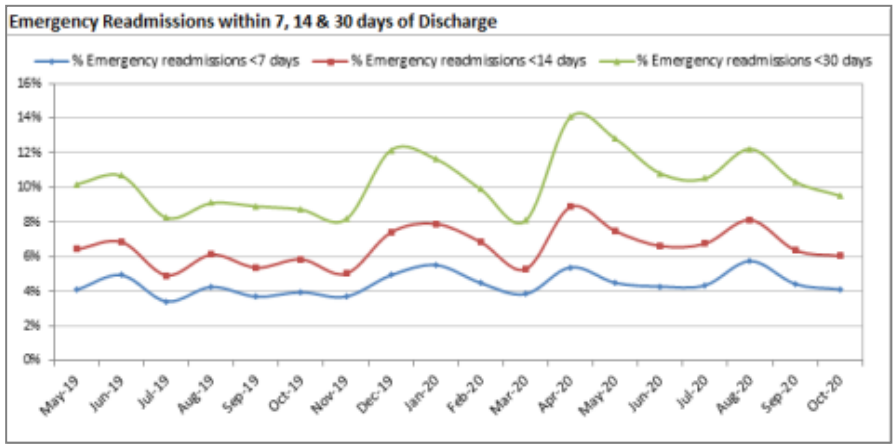
Risks to delivery and mitigations

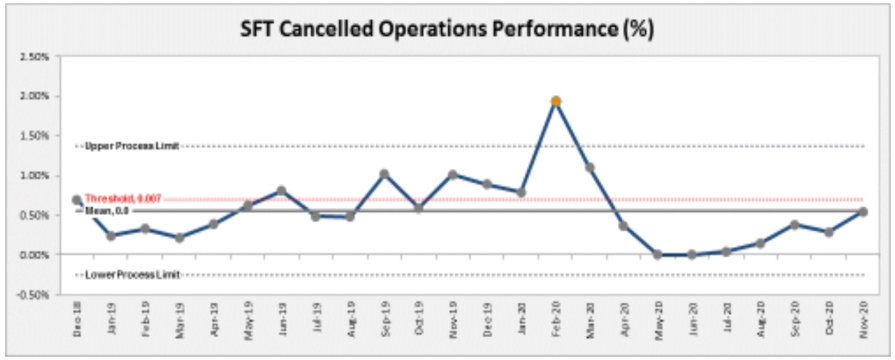
The assessment bed for GP direct admissions/transfers from ED within 4 hours is sometimes used for bed capacity, mitigated by proactive bed management by the clinical site team and stroke team.

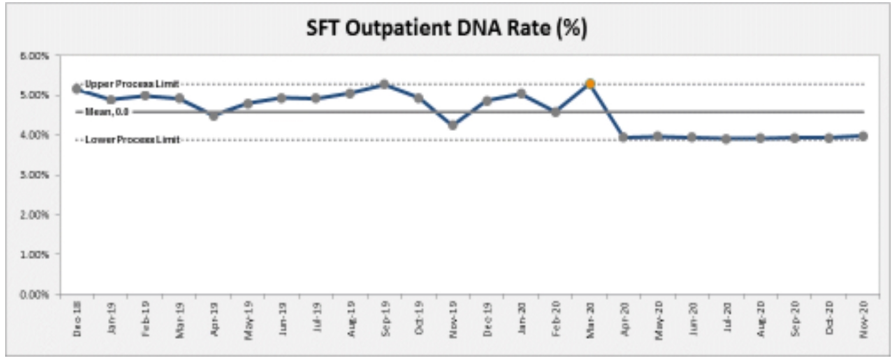
Reduced stroke admissions and TIA attendances. Public health messaging planned that hospitals are open for business as usual and are safe for patients to attend.

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.

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		

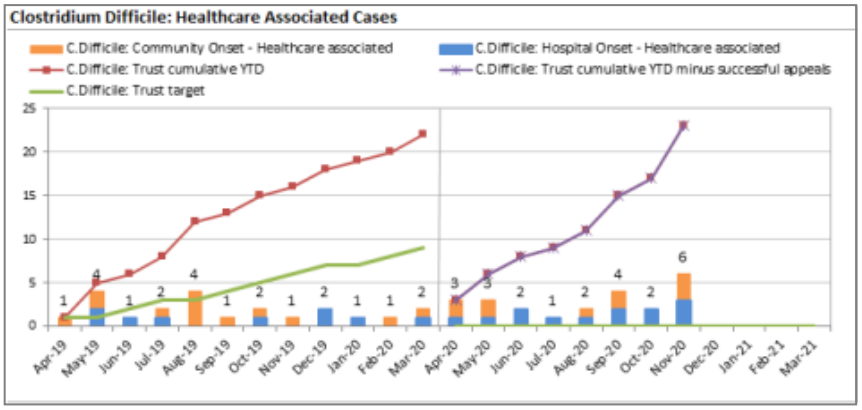
Infection Control

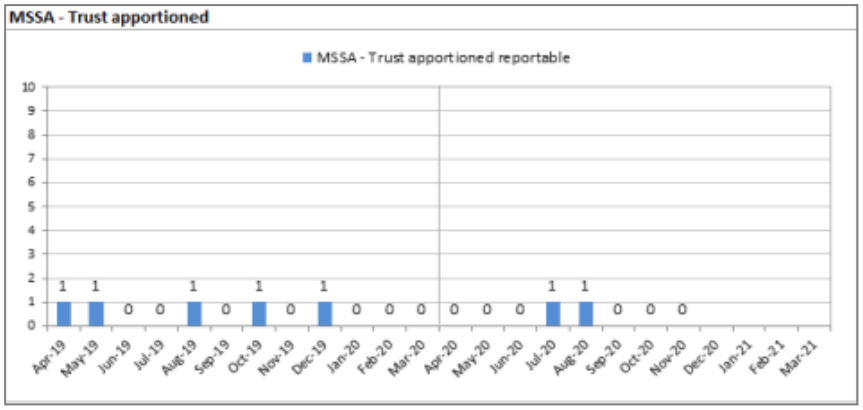
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
Cases Appealed	0	0	0	0	0	0	0	0	0	0
Successful Appeals	2	0	0	0	0	0	0	0	0	0

MRSA	2019-20	2020-21
Trust Apportioned	0	1





Summary and Action

PHE has not set a C.Difficile upper limit for hospital onset healthcare associated and community onset healthcare associated cases. The Trust has not submitted any cases for appeal to the CCG for no lapses in care.

3 hospital onset healthcare associated C.difficile cases in November:

- A patient admitted due to congestive cardiac failure was being isolated on Whiteparish Ward, having been transferred from a bay on Tisbury CCU. The patient had recent antibiotics for cellulitis. The case is currently under investigation.
- A patient on Spire Ward who had previously been identified as C.difficile positive in July, and had been under the care of the Pembroke Team. A sample was obtained at the request of the clinicians. The case is currently under investigation.
- A patient on the Stroke Unit, who transferred to a sideroom on Odstock Ward. The case is currently under investigation.

3 community onset healthcare associated cases . 2 patients had samples sent via GP surgeries and 1 child who attended the Children's Day Assessment Unit who was C.difficile positive on two previous occasions. Additional information has been requested from the paediatric team in relation to the decision to retest.

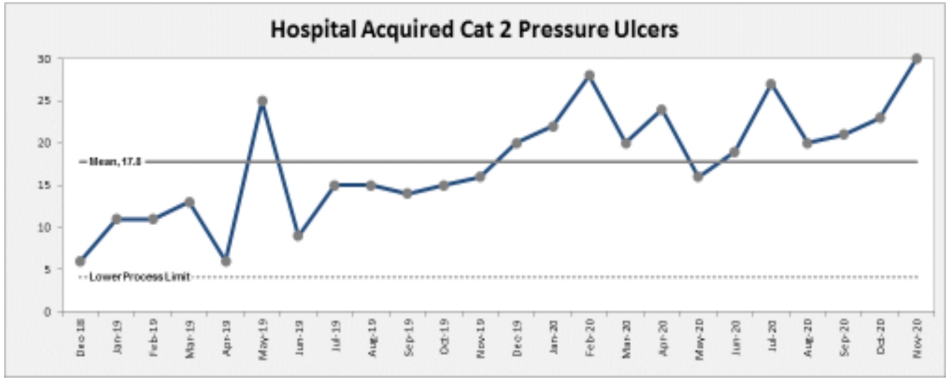
Outcome of investigations/learning from hospital onset healthcare associated cases not previously reported in October:

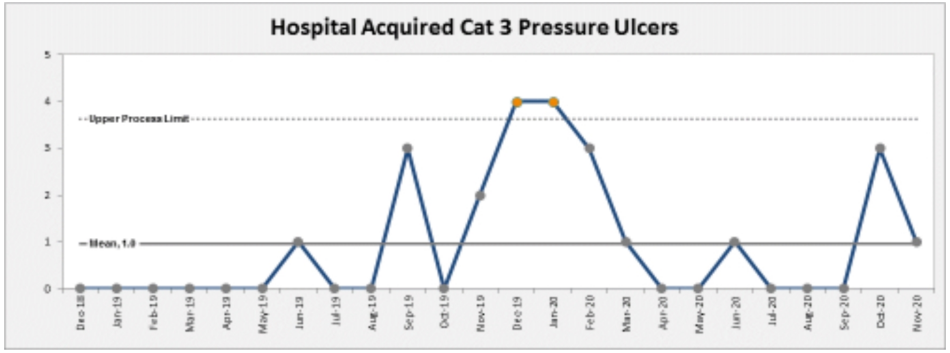
- A patient who was being isolated on Pitton Ward admitted to Redlynch Ward for alcohol detoxification and electrolyte replacement who had a history of chronic diarrhoea. Initially, symptoms were assessed to be secondary to his underlying condition, but a sample was requested when symptoms persisted and the patient transferred to Pitton ward. No concerns about anti-microbial prescribing. Case yet to be presented at the Share and Learn group meeting.
- A patient on Downton Ward with a complex history, and was admitted generally unwell with urinary retention, infection and haematuria having recently been discharged from New Hall Hospital. A CT scan undertaken showed thickening of the sigmoid colon, which could have been related to colitis, a lesion or may have been caused by C.difficile. No concerns about anti-microbial prescribing. Learning: the requirement to close the bay where the patient had been nursed on receipt of the positive result.

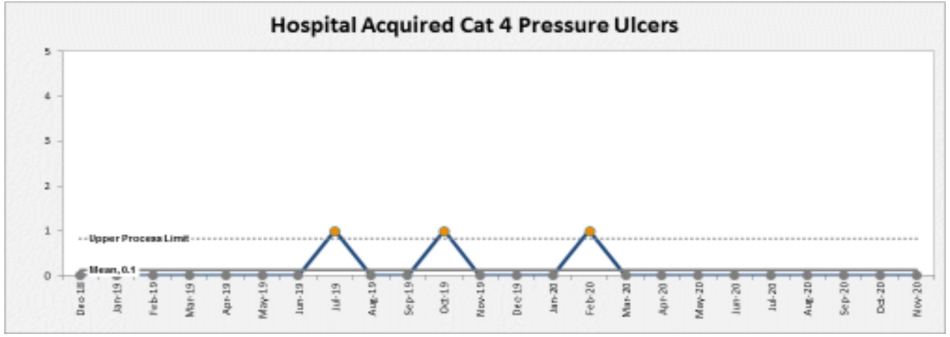
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2
Pressure Ulcers	1.10	1.22	1.73	2.27	1.92

Summary and Action

The number of category 2 pressure ulcers increased (30), particularly in the Surgical Division (14). Share and learn meetings are yet to be held to understand the root cause. Pitton ward reported a positive reduction in the number of category 2 pressure ulcers (0) following a change in two elements of care - the breakfast routine and safety brief has released time to provide basic nursing care and the handover process is more in-depth. The AMU pressure ulcer quality improvement project planned 'Plan Do See Act' cycle is still planned and has been taken on by the interim Senior Nurse.

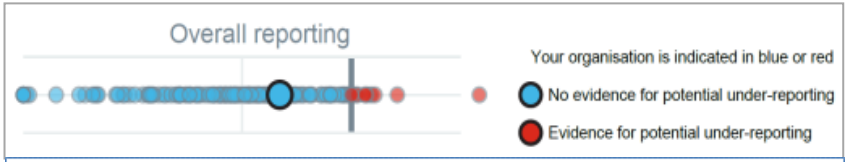
In November, one category 3 pressure ulcer of a patient on Redlynch ward. A serious incident inquiry of a cluster of three category 3 pressure ulcers of patients in 3 different medical wards in October is ongoing. A theme has emerged of patients able to independently mobilise and self-care often spend long periods in one position increasing the risk of pressure damage. Two new skin bundles are proposed 1) patients at risk and at moderate risk of pressure damage – a daily skin check with questions to prompt staff to undertake it and 2) patients at high and very high risk of pressure damage – a turn regime has been added to the bundle. The plan is to undertake a 'Plan Do See Act' cycle in the Medical Division. Education of link nurses is a key part of the improvement plan.

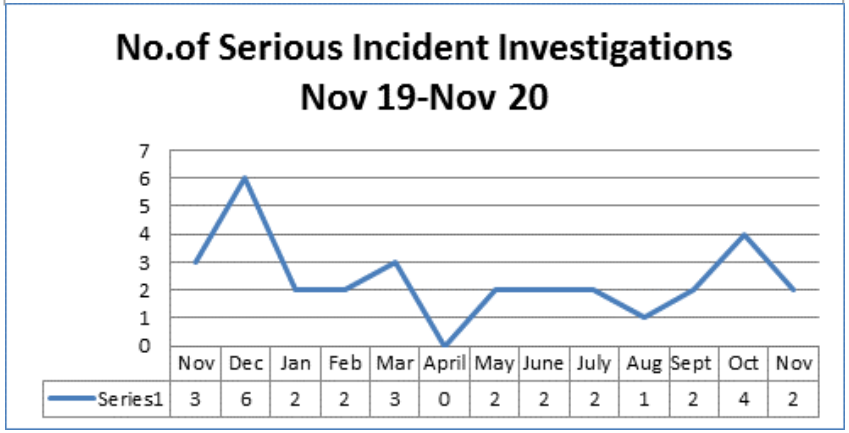
Incidents

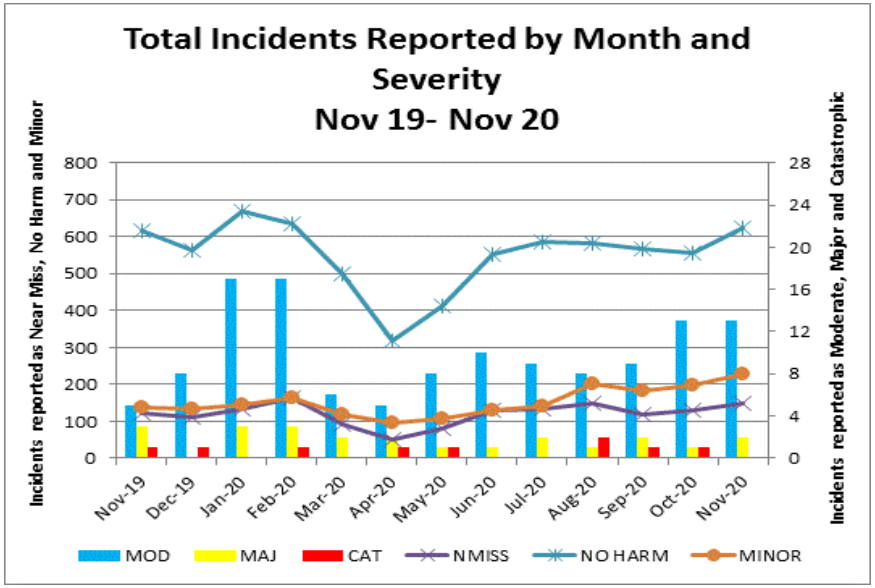
Are We Safe?

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

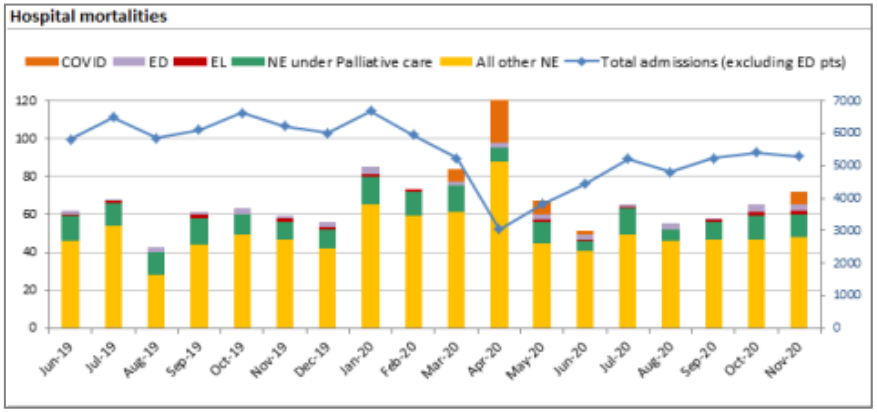
2 serious Incident investigations commissioned in November:

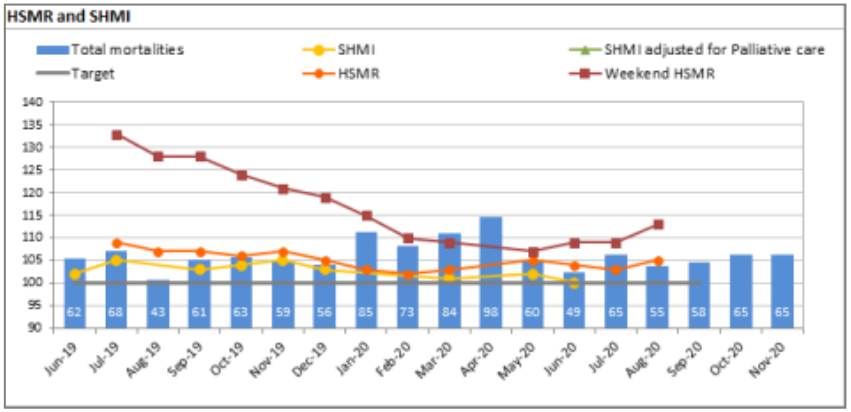
- Hypoglycaemic patient who required an ITU admission after a prolonged period of hypoglycaemia resulted in catastrophic harm.
- A paediatric medication incident resulting in major harm transferred to PICU at the University Hospital Southampton

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected to August 20. The weekend HSMR has increased again and remains within the expected range.

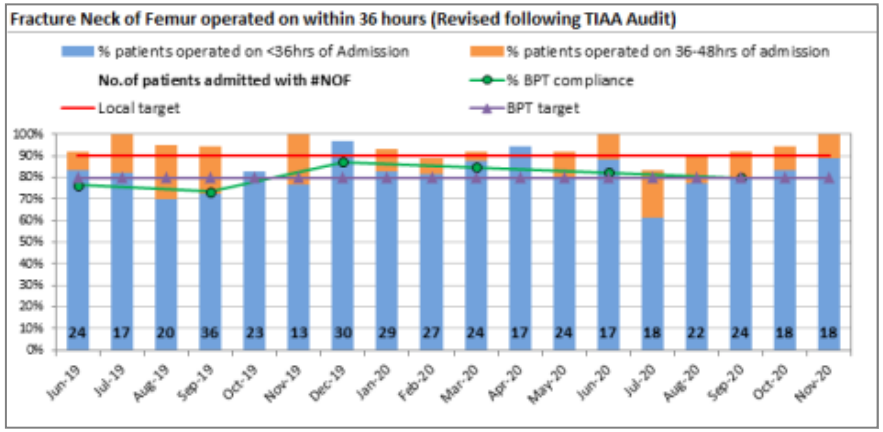
7 deaths in November associated with Covid-19. 5 cases were community onset. 2 cases were hospital-onset indeterminate healthcare associated, of which 1 patient tested negative twice before testing positive on day 5 with a high clinical suspicion of Covid-19 on admission. The other patient tested negative on the day of admission before testing positive on day 6 with a high clinical suspicion of Covid-19 on admission.

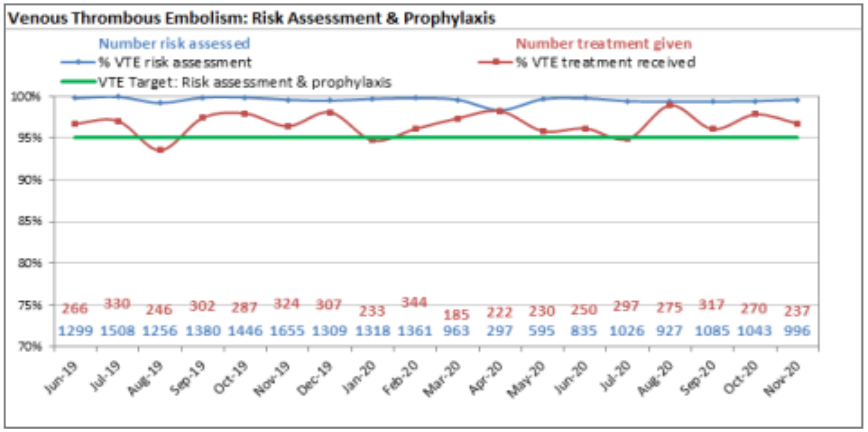
The chair of the Mortality Surveillance Group reported the review of deaths from Covid-19 at the Clinical Governance Committee in November 20. The Committee were assured that risks associated with nosocomial transmission have been reduced with measures already put in place. It was agreed that the Duty of Candour should apply to the cases classified by the NHSE classification of hospital-onset definite (9 cases) and probable (5 cases) healthcare associated cases.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

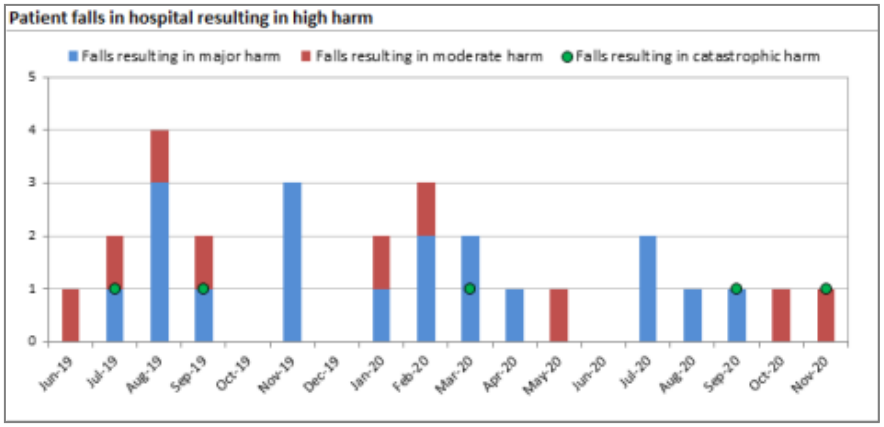
In November, 3 patients did not receive hip surgery for a fractured neck of femur within 36 hours waiting for theatre space.

- 1 patient had surgery at 37 hours had post-operative delirium and was successfully treated for a hospital acquired lower respiratory tract infection and discharged when back to baseline on day 26.
- 1 patient had surgery at 46 hours having initially not given consent for surgery and was, therefore, not listed for surgery. The patient changed his mind and gave consent 17 hours later. Cardiac conditions were optimised prior to surgery and the patient discharged at baseline on day 49.
- 1 patient waited for 49 hours before surgery and had a post-operative ileus and acute kidney injury both treated successfully. Discharged to a community hospital for rehabilitation at day 35.

The Trust continued to report good performance in VTE risk assessment and prophylaxis. NHSE&I notified the Trust on 29 September that due to the continued impact of Covid-19 and the ongoing need to release capacity across the NHS to support the response, a pause on VTE data collection and publication will continue until March 2021.

Patient Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2
Patient Falls	0.20	0.07	0.17	0.08	0.11

Summary and Action

In November, 2 falls resulting in harm:

- A patient fell and suffered a catastrophic head injury with an acute on chronic cerebral haemorrhage.
- A patient admitted with a fractured neck of femur, had a further fall as an inpatient and fractured her wrist resulting in moderate harm which was treated with a back slab.

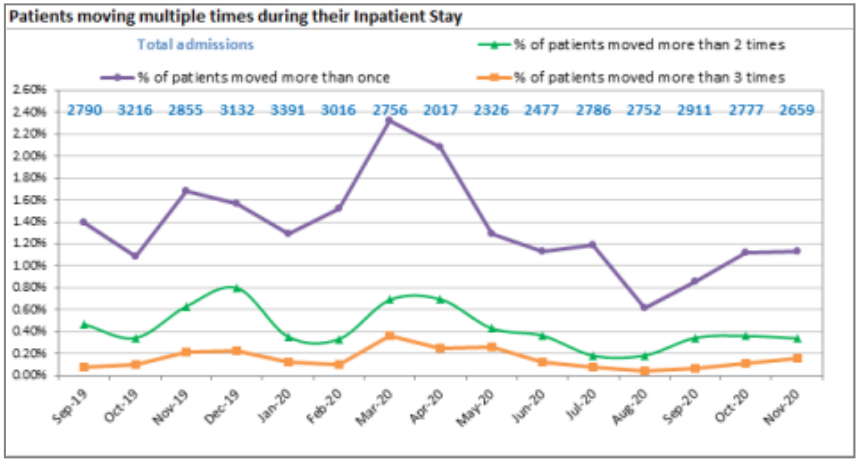
A Trust wide falls improvement plan with aggregated learning from SWARMs and serious incident inquiries is in place. The number of high harm falls has reduced over the last 5 years.

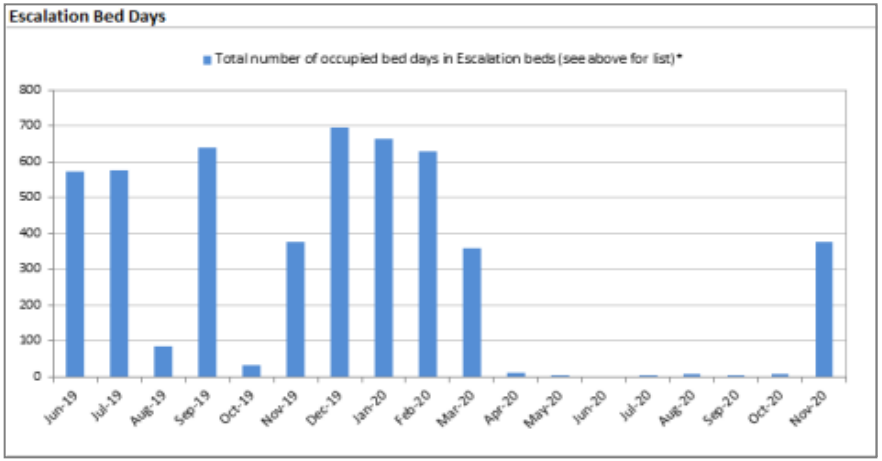
Patient Experience

Are We Safe?

Last 12 months	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep20	Oct 20	Nov 20
Bed Occupancy %	95.9	94.4	96.1	81.8	60.5	64.0	76.4	81.7	81.5	86.6	85.7	91.5

Data Quality Rating:





Summary and Action

Significant increase in escalation bed capacity in November as bed occupancy increased to 91.5% and the number of patients admitted with Covid-19 increased with the need for social distancing. The percentage of multiple ward moves remained static.

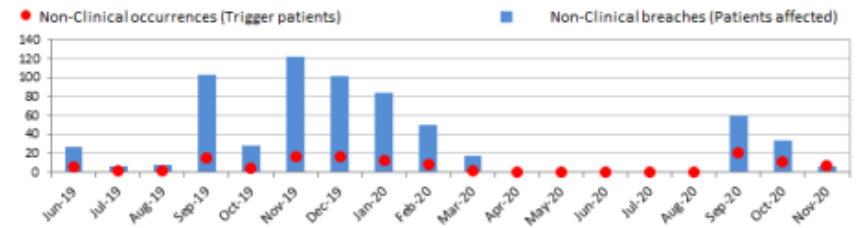
The Medicine Division supported by the PMO are leading a piece of work to increase the percentage of patients discharged by midday to meet the 33% standard and implement criteria led discharge.

Patient Experience

Are We Safe?

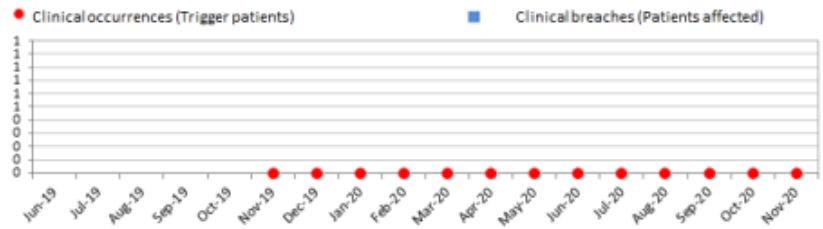
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
■	27	7	8	103	28	122	102	84	50	17	0	0	0	0	0	59	33	7
●	5	1	1	15	4	17	16	13	8	2	0	0	0	0	0	20	11	7

Delivering Same Sex Accommodation - Clinical



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-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

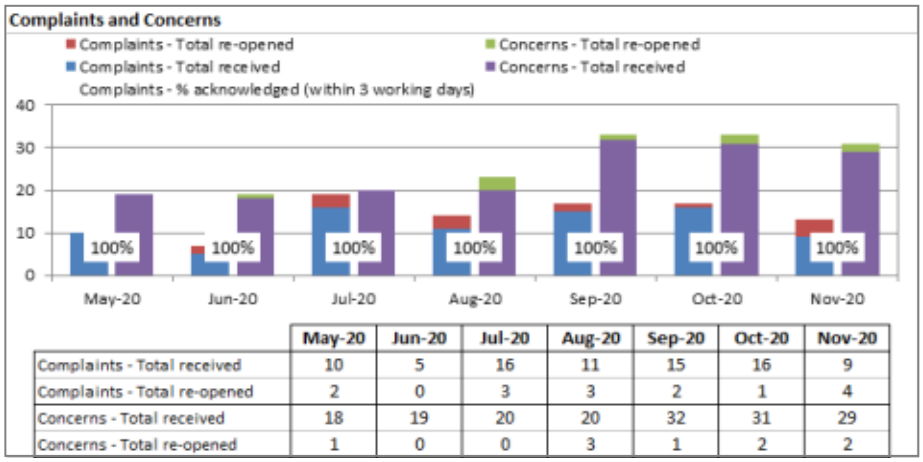
7 occurrences of non-clinical mixed sex accommodation breaches in November affecting 7 patients in Radnor ward (Critical Care) and all resolved within 24 hours. Privacy and dignity was maintained in the individual bed space. These were patients who were not able to be transferred out to a general ward within 4 hours of the decision that the patient was fit to be moved. Potential discharges from Radnor ward are raised at the twice daily bed meeting.

There were no non-clinical mixed sex accommodation breaches on any of the general wards.

NHSE&I notified the Trust on 29 September that due to the continued impact of Covid-19 and the ongoing need to release capacity across the NHS to support the response, a pause on mixed sex accommodation data collection and publication will continue until March 2021.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Complaints - Total received	10	5	16	11	15	16	9
Complaints - Total re-opened	2	0	3	3	2	1	4
Concerns - Total received	18	19	20	20	32	31	29
Concerns - Total re-opened	1	0	0	3	1	2	2

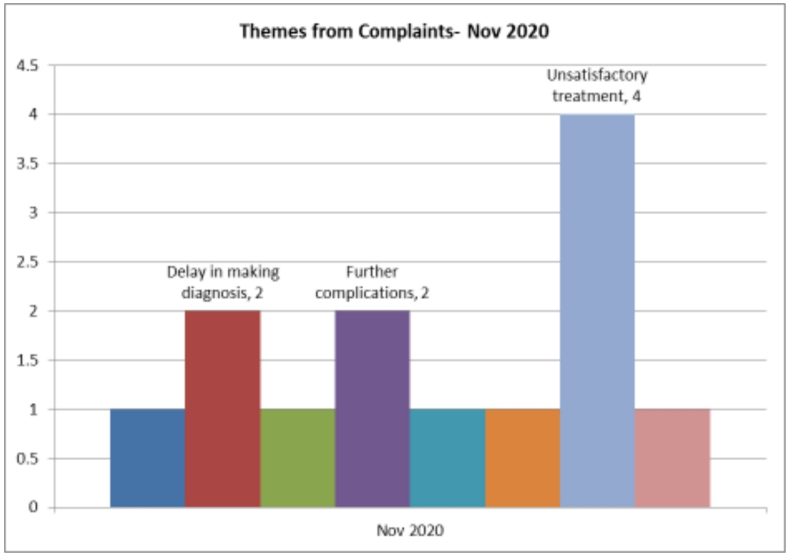
Summary and Actions:

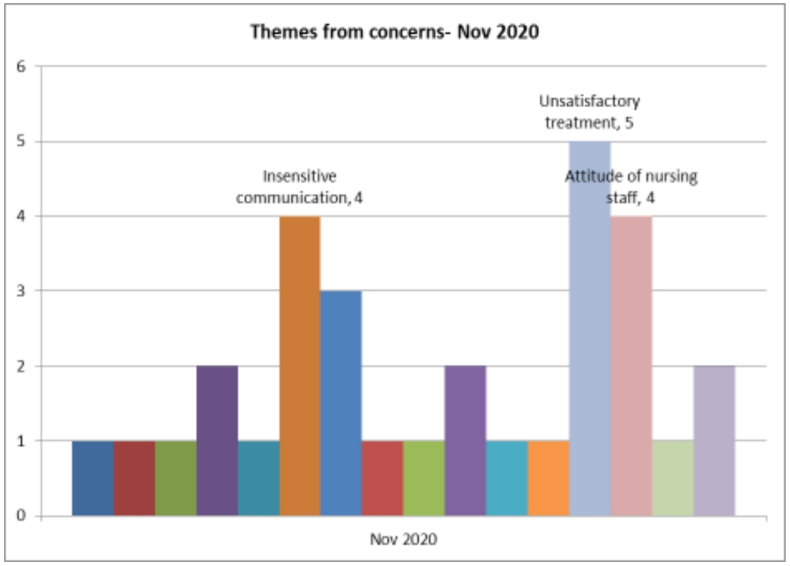
Main theme from both complaints and concerns is unsatisfactory treatment.

Examples of actions from closed complaints include:

- Downton ward: All staff are aware of the issues pertaining to poor communication and the need to speak to families on discharge. Staff member cited in the complaint has engaged in assisted reflection.
- Maternity Services: The community midwifery team have taken this opportunity to learn and develop their practice. They have stated that they will in future explore with mothers further if they express concerns and adjust the plan of care according to the mother's requests.
- ED: Increase clinician's awareness of ectopic pregnancy through:
  - Teaching in terms of a case discussion.
  - Incorporation of key learnings into the trainee's induction.
  - Discussion at senior clinicians' department governance meeting.
  - Case will be discussed at the relevant quarter's M&M meeting.

Data Quality Rating:





Part 3: Our People

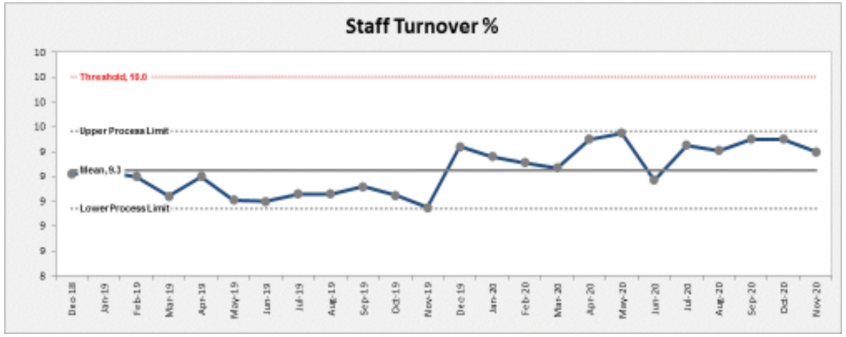
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

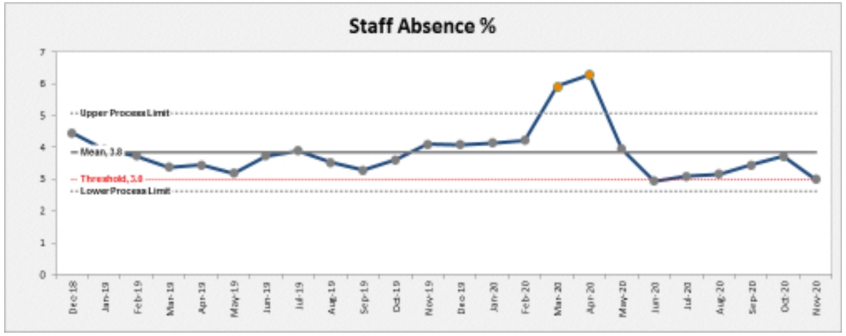
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Nov '20		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	430.4	(5.3)
Nursing	950.5	1,056.9	(106.4)
HCAs	412.1	467.8	(55.8)
Other Clinical Staff	619.3	649.3	(30.0)
Infrastructure Staff	1,227.9	1,298.4	(70.5)
TOTAL	**3,634.8**	**3,902.8**	**(267.9)**





Summary and Action

During November, there were 59 starters, which is the highest number since January. 21 people left the Trust and turnover is slightly down, as is the vacancy rate now below 1% with vacancies at 23.97 the lowest it has been in 2020.

A total of 68 vacancies were advertised during the month, representing WTE of 98.47, an increase of 27 over the same month last year. 73 offers of employment were made, including 12 Health Care Assistants. Ten nurses arrived from overseas during the month in two cohorts and were supported through their quarantine period by our recruitment team, their ward managers and members of the BAME network group.

Radiography have been approved to over-recruit Band 5 Radiographers. They also now have a Clinical Educator in post and working well which will enhance the opportunity to create apprenticeships and implement "grow our own" strategies. We are also working on overseas recruitment in this area in conjunction with Yeovil. We are interviewing a candidate for the consultant Histopathologist on 16th December.

Sickness absence in November is slightly down on previous months at 3.55%, reflecting the decrease in long term sickness absence. Covid-19 related absence accounts for 0.42% of this and all other absences make up the majority proportion of 3.13%.

There are in all 23 long term sickness cases being managed, in conjunction with Occupational Health, and with a view to returning people to work where possible. There has been one Ill Health Retirement during the month.

Short term sickness absence is slightly increased and there are a total of 53 cases being managed via the attendance Management Policy in Stages 2-4. Business Partners are working closely with managers to ensure that individuals receive required support to enable them to remain in work.

All three Clinical Divisions have anxiety, stress & depression as their top reason for absence, whilst in Facilities the top reason is MSK. These two absence reasons are consistently in the top three and we are focussing our wellbeing strategy on these issues. We are currently advertising for a psychological wellbeing practitioner and working on ways to switch our physiotherapy service from reactive casework to proactive prevention.

Workforce – Nursing and Care

% Fill of Registered Nurse/HealthCare Assistant Shifts

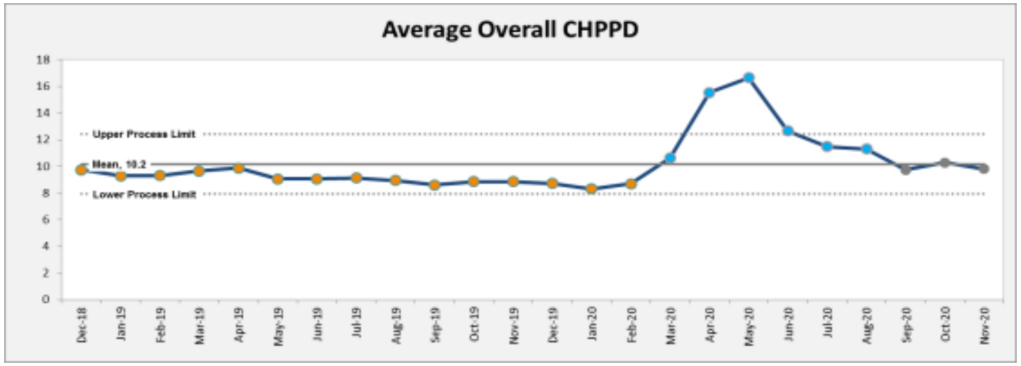
Table 1 – November Data

Day	RN	HCA
Total Planned Hours	36410	20617
Total Actual Hours	38718	17352
Fill Rate (%)	106%	84%

Night	RN	HCA
Total Planned Hours	24430	12637
Total Actual Hours	27484	12635
Fill Rate (%)	112%	99%

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

Table 2



Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for November. 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.) The graph on the right shows the average overall CHPPD across all wards and the impact of bed closures for Covid-19 can be clearly seen from April – as services start to realign to 'normal' then CHPPD can be seen to have returned to previous levels and plateaued.

Table 1 shows the overall planned vs actual fill rate for November. Overall the RN and HCA rate is broadly similar to last - the fill rate on days has decreased as demand has increased starting to be seen in the requirements for additional staff for enhanced care which is slowly increasing and pockets of HCA vacancies (national requirement to be at zero HCA vacancies post Covid-19). All wards had sufficient staff for the numbers of patients admitted, with staffing templates remain set for normal bed occupancy and a slow return to normal bed occupancy is starting to be seen. Twice daily staffing meetings continue to provide review of actual staffing requirements and ensuring staff are redeployed before temporary staffing use approved. There are virtually zero RN vacancies at RN level across the wards. The skill mix of RN:HCA has remained fairly consistent with last month with RN 69% /HCA 31%. The broad recommendation is 65%:35%.

2019/20 saw an overall nursing underspend. At the end of M8 (2020/21) there is a £981k overspend, which is a £140k deterioration on last month. Agency spend has increased to £39k of which £18k is in surgery (attributable to vacancies in theatres and Covid-19 escalation in critical care) and £18k in Sarum (related to RMN special for a child) and a £2k spend in medicine. Whilst some high risk / shielding staff have returned to their clinical departments, some remain in non-clinical or extended leave ahead of maternity roles impacting on spend. In addition there is still additional pressure from areas requiring additional staffing due to Covid-19 e.g. ED RAZ, RCU.
Deep dives into nursing workforce spend been held with surgery and medicine and a paper has been presented to F&P, with work in progress to align establishments.

Nurse Sensitive Indicators no specific concerns at present, increases in NSI's can be associated with suboptimal staffing. Trust wide programme for pressure ulcers improvement as previously reported continues.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

The compliance rate for MaST is down slightly at 92.13% although still above our 90% target. Main subjects of non-compliance are (again) Hand Hygiene and safeguarding.

Staff this month have reported the availability of hand hygiene courses to have been a contributory factor, and the transition to Windows 10 to have created issues in accessing MLE.

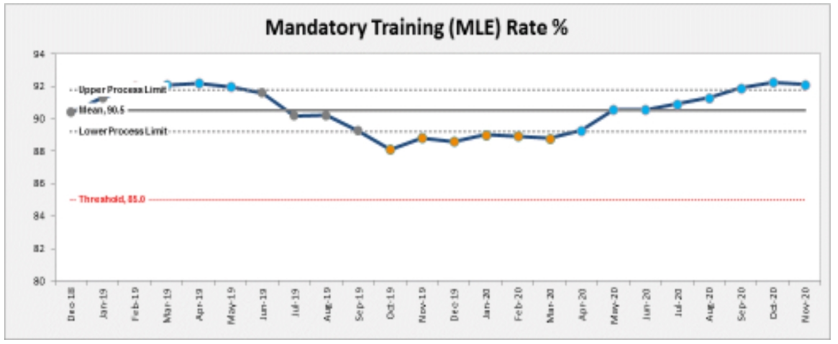
It would also appear that lower compliance rates occur where there is higher incidence of sickness, not only because individuals themselves are absent due to sickness and non-compliant with training, but colleagues who are covering the sickness do not have time to complete their MLE.

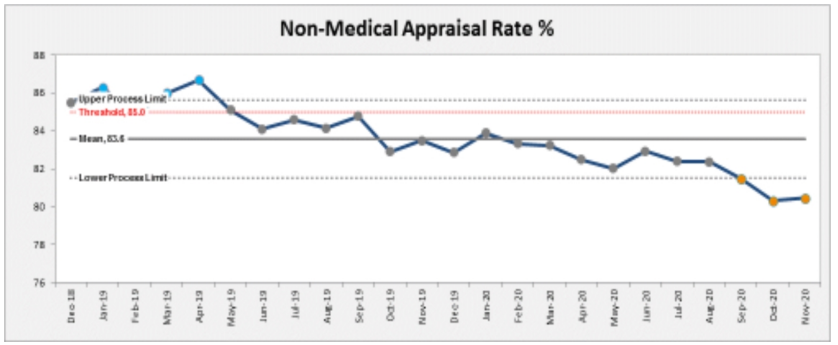
Business Partners regularly share the individual details of non-compliance with the managers so that they can be followed up and supported to complete required training.

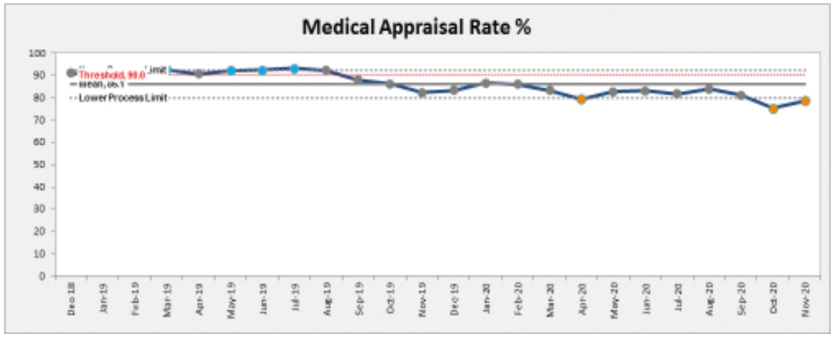
Non-medical appraisals are slightly improved at 80.46%, although still below the target of 85%. Estates and Facilities have the best compliance rate at 92.5% which is attributable to robust management within their teams. Medicine appears to be struggling with the lowest compliance rate of 78.79% and over 150 people out of date on their appraisals.

Whilst it is challenging to identify the specific reasons for this level of compliance, anecdotally it seems to be related to issues around social distancing, being able to access suitable rooms to accommodate the meeting, and people being absent due to sickness or self-isolating.

During October and November, we carried out appraisal refresher training to focus managers on the quality of the appraisal conversation, which was identified as an issue in the 2019 Staff Survey.







Feedback from Friends and Family test

What was good about your experience?

November 2020

"Staff friendly and kept me informed as to what was happening and when. Everything was done to make me feel relaxed and comfortable. Was a good experience"

"Everyone was kind, caring and gave lots of information. They explained what was going to happen and how I would feel. They made me feel relaxed"

"The sensitivity and compassion of staff. Clear information and expertise of the procedure"

The doctor performing and staff in the room were so chatting and calming. They talking me through the whole thing. Best one yet"

"The staff on all shifts during my 13 day stay were very kind, caring, professional and extremely supportive. I cannot express my gratitude sufficiently to them all. How lucky Salisbury Trust is to have such a dedicated team"

"I had a complicated C-section. The care was excellent. Kept in labour ward for 24hrs with round the clock care for me and baby"

"Very thorough assessment and all my questions were answered by all. I also felt safe thanks to thorough COVID safety measures"

"Being able to choose colours and making the nurses laugh"

"Watching the staff communicate with other staff and to patients was reassuring"

"Totally committed caring staff. We should all be proud of our NHS. Such wonderful people"

"Staff took the trouble to explain what was to happen and why. They connected at a human level"

"I was scared, but staff were very friendly"

Friends and Family Test – Patients and Staff

Use of Resources

In April, NHSE advised Trusts to cease collecting paper-based Friends and Family Test cards due to health and safety concerns. Updated guidance was released in June and following approval of a local standard operating procedure the Trust recommenced the use of paper-based Friends and Family Test cards with the new questions. The Trust will restart reporting in December 2020.

The staff Friends and Family test was also suspended this year due to Covid-19.

In September, the Best Place to Work discovery phase report was published which describes the experience of our workforce. The aim was to understand the culture and the 'way we do things around here' as these shape the behaviour of everyone in the organisation and directly affects the quality of care they provide.

The discovery work acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. The Board discussed the recommendations at its meeting in October 2020. It was agreed a further seminar session should be held to review and prioritise the 20 recommendations. This is scheduled to take place at the beginning of December. The Board also agreed a co-creation approach whereby sessions with staff are scheduled to obtain their views on the areas that should be prioritised from the 20 recommendations.

Part 4: Use of Resources

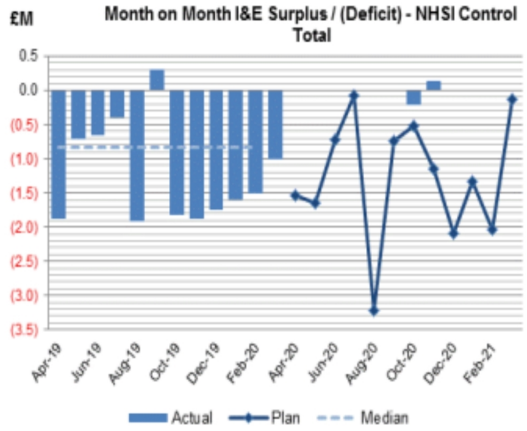
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Nov '20 In Mth			Nov '20 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	17,663	20,247	2,584	140,897	144,684	3,787	220,952
Other Clinical Income	871	544	(327)	6,942	16,675	9,733	0
Other Income (excl Donations)	2,416	2,475	59	19,328	17,485	(1,843)	28,992
Total income	**20,950**	**23,265**	**2,315**	**167,167**	**178,843**	**11,676**	**249,944**
Operating Expenditure							
Pay	(13,635)	(14,519)	(884)	(109,089)	(113,735)	(4,646)	(163,634)
Non Pay	(7,001)	(7,279)	(278)	(56,069)	(54,191)	1,878	(84,050)
Total Expenditure	**(20,636)**	**(21,797)**	**(1,161)**	**(165,158)**	**(167,927)**	**(2,769)**	**(247,684)**
EBITDA	**314**	**1,468**	**1,154**	**2,009**	**10,916**	**8,907**	**2,260**
Financing Costs (incl Depreciation)	(1,462)	(1,344)	118	(11,627)	(11,005)	622	(17,474)
NHSI Control Total	**(1,148)**	**124**	**1,272**	**(9,618)**	**(87)**	**9,530**	**(15,214)**
Add: impact of donated assets	*(48)*	*(66)*	*(18)*	*(92)*	*(485)*	*(393)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(1,196)***	***58***	***1,253***	***(9,710)***	***(573)***	***9,137***	***(13,588)***



Variation and Action

While the Trust continues to report against the original 2020/21 plan as a baseline for continuity reasons, a focus has shifted to the delivery of the Phase 3 forecast set out in page 7.

The plan had assumed a deficit of £1.1m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. Performance against the original plan is summarised in the table above. The Trust's improved performance against this target is due to the increase in funding made available to NHS providers in 2020/21.

Notable is the increase in Pay costs versus those planned, with the temporary cessation of cost releasing efficiency schemes (although productivity schemes remain core to the phase 3 recovery). Pay costs directly related to Covid-19 now stand at £3.8m YTD.

Although Depreciation is currently less than that originally planned (plans to implement IFRS 16 were deferred), on going work on the Trust's critical infrastructure means asset lives are under review and this is likely to result in increased charges from December 2020.

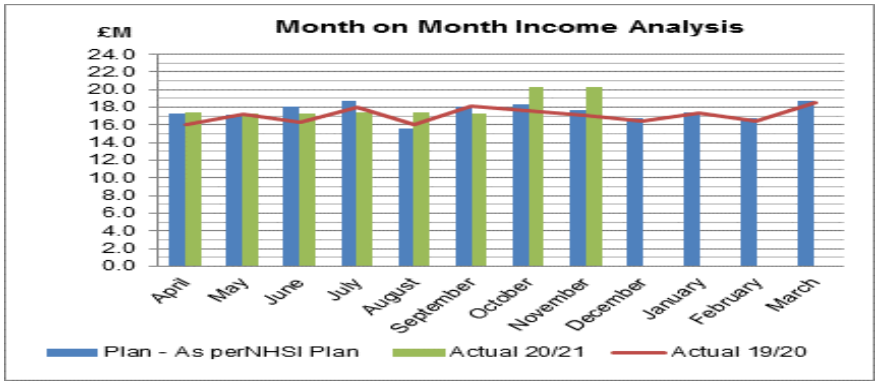
The Elective Incentive Scheme income reduction has been assessed at £494k but not included within the position per instruction from NHSEI.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Nov '20 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	6,291	5,343	(948)
Day Case	11,614	6,872	(4,742)
Elective inpatients	12,300	4,064	(8,236)
Excluded Drugs & Devices (inc Lucentis)	12,858	11,230	(1,628)
Non Elective inpatients	41,760	35,926	(5,834)
Other	33,970	67,339	33,369
Outpatients	22,104	13,910	(8,194)
TOTAL	**140,897**	**144,684**	**3,787**



SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s	Phase 3 Forecast (YTD) £000s	Phase 3 FC Var (YTD) £000s
BSW CCG	78,443	83,286	4,843	83,286	-
Dorset CCG	16,033	16,563	530	16,563	-
West Hampshire CCG	11,522	11,484	(38)	11,484	-
Specialist Services	21,868	21,492	(376)	21,621	(129)
Other	13,031	11,859	(1,172)	11,436	423
TOTAL	**140,897**	**144,684**	**3,787**	**144,390**	**294**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	48,970	31,705	(17,265)	46,871	(15,166)
Day case	15,361	9,300	(6,061)	15,501	(6,201)
Elective	3,259	1,445	(1,814)	3,297	(1,852)
Non Elective	21,311	17,039	(4,272)	17,758	(719)
Outpatients	171,782	128,645	(43,137)	171,737	(43,092)

Variation and Action

Activity in November has increased above October across all of the main points of delivery with the exception of A&E, Non Elective and Outpatients. The most significant increases by specialty are Urology, Plastic Surgery, Gastroenterology and Cardiology Day cases and Plastic Surgery, Breast Surgery, Trauma and Orthopaedics and Interventional Radiology Elective spells.

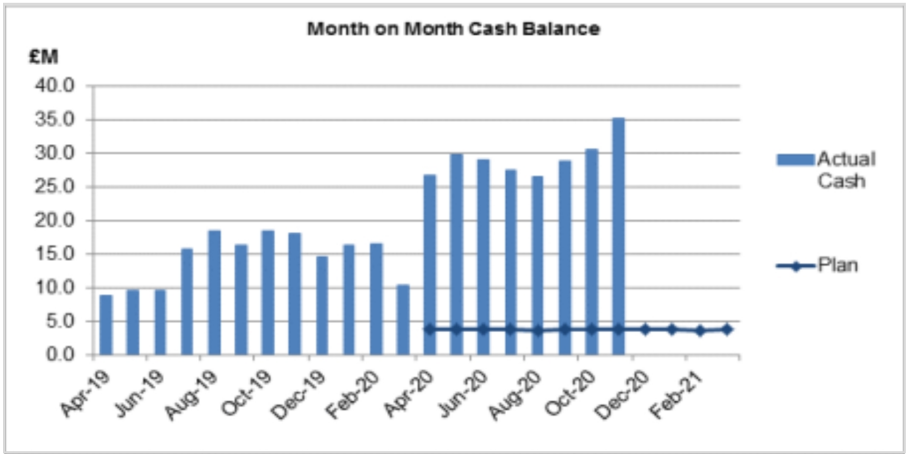
Covid-19 response contractual payment values with main commissioners were based on the Month 9 agreement of Balances (from a provider perspective), adjusted by 2.8% for inflationary pressures. From October onwards, Top up and Covid-19 funding will now be received from BSW CCG c£2.5m per month. Over the first eight months of the year underlying activity has been valued at less than the agreed block by £37,909k (26%), owing to the temporary cessation of non-urgent planned work and phased recovery response. The November adjustment has increased by £327k mainly due to the reduction in Non Elective activity levels in month. The November Elective Incentive scheme has been assessed at a reduction of c£193k (c£301k in October) but not included within the position per instruction from NHSEI.

The variance to the Phase 3 forecast is due to High cost drugs that sit outside of the block arrangements predominantly Specialist services and Cancer drugs fund.

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.

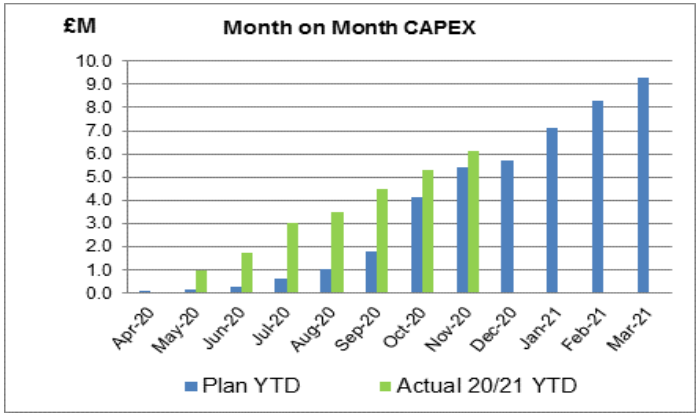
Payments on account in advance up until 31st December 2020 have been received. New guidance has indicated these payments will continue for the remainder of the financial year, with the clawback potentially due to take place in March 2021. Core block payments for months 7-12 will be at a lower level than for the first 6 months due to the Phase 3 contracting guidance but these will be supplemented by further funding from within the STP system. The cash flow position will continue to be closely monitored to ensure any potential shortfalls are identified.

The Trust received £5,211k of its additional capital fund allocations in the month contributing to the improved cash position. These funds will be spent in the coming months.

Borrowings have previously included £21m of working capital loans. These were repaid In September and funding was returned to the Trust simultaneously as Public Dividend Capital .

Capital Expenditure Position

	Annual	Nov '20 YTD		
	Plan	Plan	Actual	Variance
Schemes	**£000s**	**£000s**	**£000s**	£000s
Building schemes	850	500	53	447
Building projects	2,600	1,050	1,050	0
IM&T	2,600	1,050	2,271	(1,221)
Medical Equipment	2,778	1,050	738	312
Other	449	298	298	0
Addition: Critical Infrastructure Fund	3,455	721	259	462
Addition: Covid 19	4,711	778	1,402	(624)
TOTAL	**17,443**	**5,447**	**6,071**	**(462)**



Summary and Action

Delays in capital works at the end of 2019/20, including those due to the Covid-19 response, 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 the first three months of 2020-21. The most material element falls in IT, where the Microsoft environment replacement project phases out Windows 7.

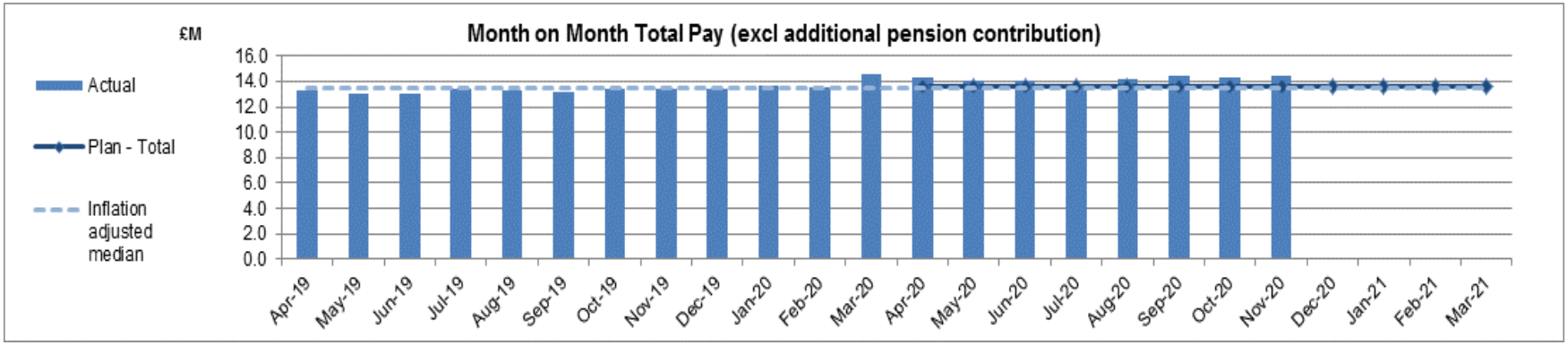
In addition to the Critical Infrastructure Fund of £3.455m and various Covid-19 schemes totalling £4.354m reported in previous months, the Trust has been notified of further funding of £1.188m for an Electronic Prescribing and Medicines Administration (EPMA) system. The EPMA funds are due to be received in January 2021. Plans are underway to ensure schemes are fully developed, with the necessary resources in place, to complete these projects in 2020-21. All schemes will be funded through additional Public Dividend Capital.

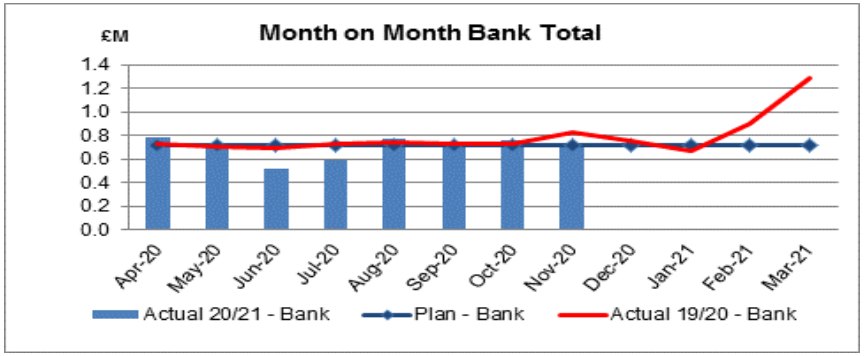
As a result of the considerable additional funding allocated to the Trust in the year, substantial funds still remain to be spent in order to achieve a balanced capital position for 2020-21. Although it is considered the majority of these funds can be spent, potential slippage of circa £4.2m has been identified. A draft capital programme for 2020-21 has been compiled and some schemes have been approved by the Finance and Performance Committee for bring forward into the current year to cover the slippage. The Trust's Scheme of Delegation will be adhered to when considering any additional schemes for bring forward from next year's draft programme.

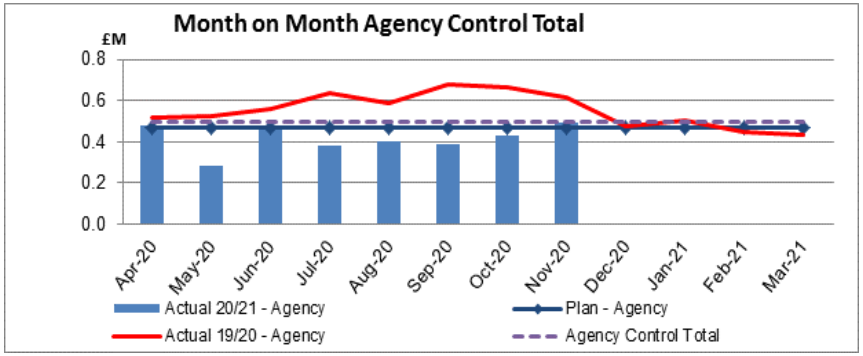
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure increased by £0.2m, or 1.4%. The main driver for this was an increase in medical staff expenditure of £141k, the cause of this increase was a combination of demand and an amendment to Clinical Excellence Award assumptions. In terms of the demand, there has been and increase in the use of agency consultants, both in the emergency admission pathway (Elderly Care), and within Endocrinology and Cardiology (the latter did benefit from a 30% upturn in the number of day case procedures completed).
Previous periods had seen a sharp increase in the level of agency ODPs used within theatres, while this remains about M01-06 run rate there has been a 30% month on month drop. This reflects the lack of availability of this particular work force and remains a key barrier to opening more theatre capacity .

Sickness absence due to Covid-19 and self isolation has reduced in month 8. Total sickness absence was 3.55% for the month, and Covid-19 represented 11.7% of the total.
The costs directly driven by the Covid-19 response have now reached £3.8m, 64% of which relates to additional hours worked by the Trust's existing workforce. Covid-19 response costs continue to reduce as redeployed clinical staff return to their normal areas of work, however the residual cost of streamed patient pathways and protected capacity remain, this leads to a requirement to maintain (and staff) an increased bed footprint to achieve the same level of patient flow.

In addition to these directly reported costs, analysis has been undertaken on the reduced availability of rostered staff (caused by a variety of reasons including sickness, self-isolation, shielding etc.), this now stands at c30%, Trust 2020/21 budgeted assumptions had been 19%. The Trust's strong recruitment position means that despite this reduction in availability, there have been sufficient temporary staffing availability to ensure this has not translated to an increase in unfiled shifts (this does however lead to increased costs).

The Trust's contracted WTE continues to rise, 29 WTE of this relates to the laundry subsidiary; 26 WTE has been driven by additional bed capacity during November, this capacity had been forecast from December; additional posts have also been added to the clinical support services in order to under pin the response to winter and Covid-19.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	14 January 2021		

Report Title:	Corporate Objectives 2020-21			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance & Capacity manager			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the progress against the Corporate Objectives

Executive Summary:
The approach to corporate priority setting was reset in Q1 following the first wave of Covid-19 to ensure that any initiatives support the recovery and transformation required as a result of the Covid-19 pandemic. Executive Directors reassessed priorities to ensure they met this requirement, with acknowledgement that as a Trust we would need to be responsive to developing pressures or national requirements should the circumstances of the pandemic change. A small number of priorities that contributed to the Trust's strategy and assisted in recovering from Covid-19 were identified, with monitoring of progress through the relevant Board Committees, and a quarterly updates to Trust Board.

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

Corporate Objectives 2020-21

Q3 Update

14 January 2021

An outstanding experience for every patient

Summary

- Board approved revised corporate priorities for the remainder of 2020-21 in July 2020, with a focus on COVID-19 recovery
- Relevant Board Committees and Programme Boards have oversight on delivery of specific objectives, with Board being updated quarterly on progress – this is the first quarterly update.
- The Integrated Performance Report continues to evolve to regularly demonstrate performance against corporate priorities.
- The NHS Phase 3 planning requirements further underpins the Trust's priorities.

Corporate Objectives 2020-21

Sustainable recovery from Covid-19 through effective partnership working

Care

How:

1. Implement national patient safety strategy
2. Agree a Quality Assurance Framework incorporating ward accreditation & a ward performance review process
3. Ensure that service delivery during the COVID-19 recovery phase is supportive of changing staff & patient needs.

Target Measures:

- Patient Safety strategy implementation plan agreed with time lines for delivery signed off
- 2 Pilot wards undertaken first full ward accreditation and 100% of wards have undertaken first Ward Performance Review
- Review of IPC Covid-19 BAF with Trust Board signoff. Target 90 % compliance with KLoE

People

How:

Best Place to Work programme

Target Measures:

Staff survey:

- 65% response rate
- Equality, Diversity & Inclusion score 9.4
- Health & Well Being score 6.5
- Staff engagement score 7.5

Specialist

How:

Refresh clinical strategy

Target Measure:

- Strategy approved by CGC, & implementation plan agreed.

Local

How:

Develop with partners initiatives to ensure patients do not stay in hospital any longer than they need.

Target Measures:

- Achieve average of 30% discharges before 1200
- Reduce Super Stranded Patients to 14%

Innovation

How:

No Going Back programme - Embed the use of virtual outpatient appointments

Measure:

- 60% of outpatient appointments carried out virtually

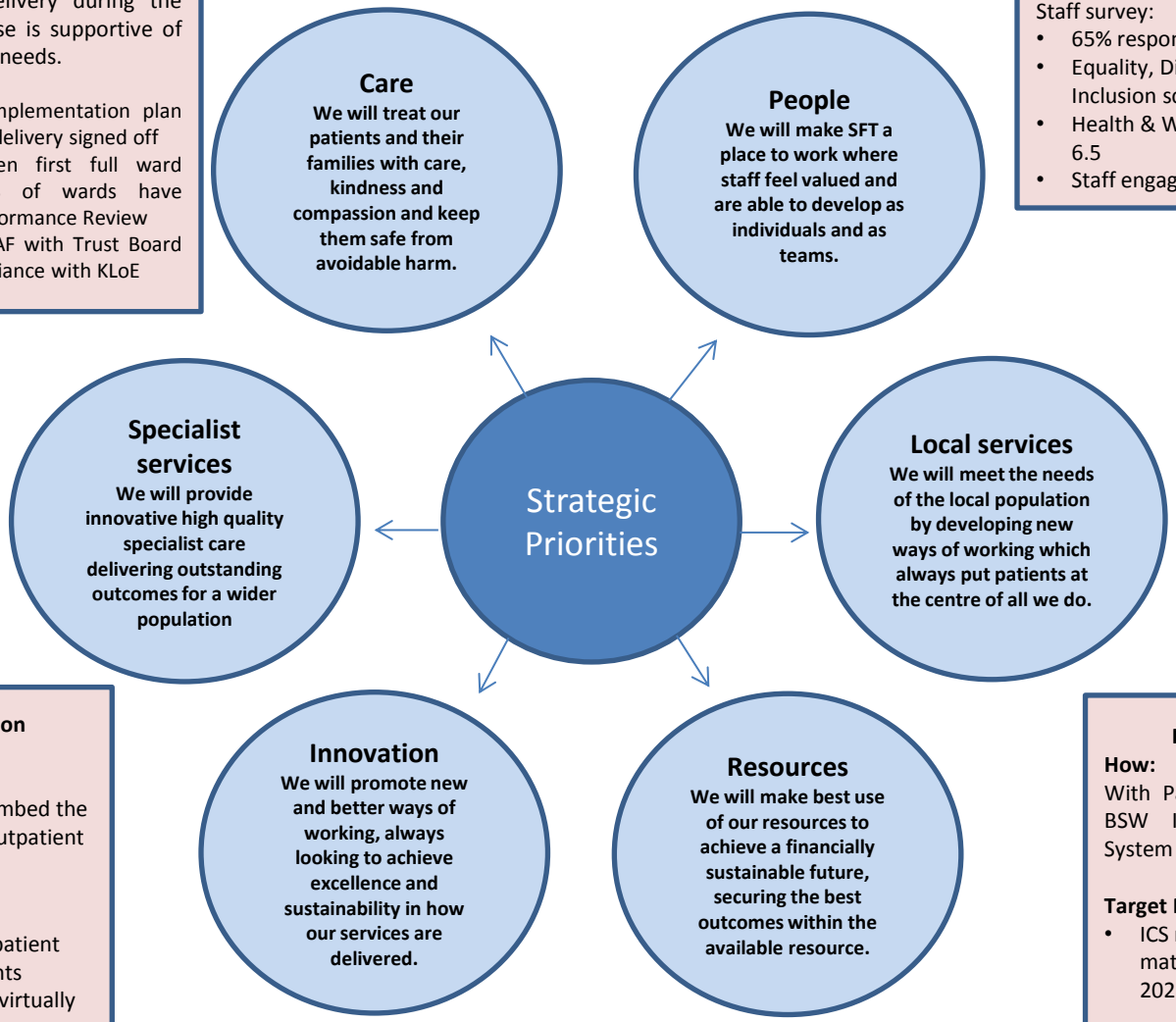
Resources

How:

With Partners, develop BSW Integrated Care System

Target Measure:

- ICS rated as maturing by Apr 2021



Local - Discharges before midday and super stranded patients

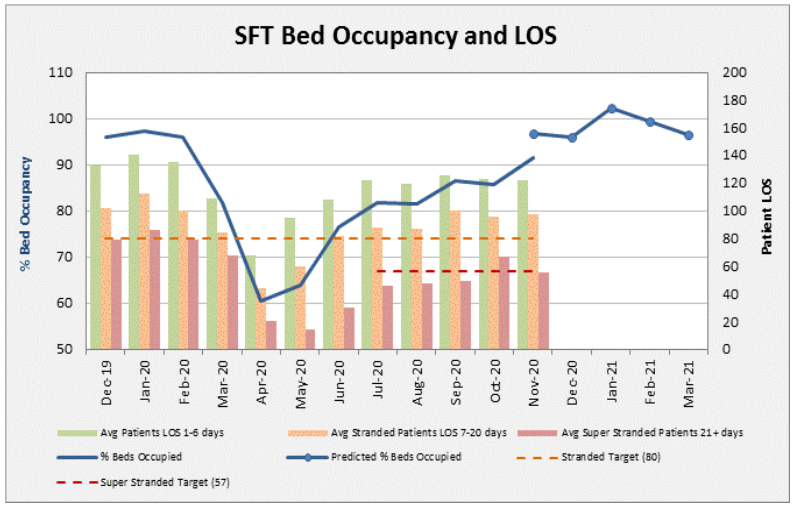
Exec sponsor: Andy Hyett

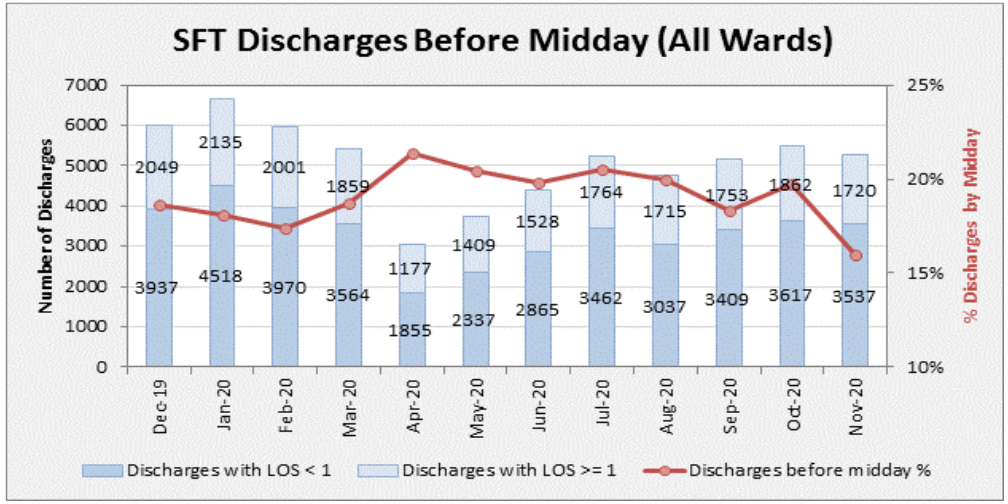
Programme aims & key deliverables

To provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay. Prolonged stays in hospital are bad for patients, especially for those who are frail or elderly.

Key highlights / challenges

- Criteria led discharge trial commenced on 2 wards 2nd Dec. Chief Registrar leading.
- TTO audit run across all wards w/c 7/12, results to be analyzed and feedback January.
- Paper re risks/benefits of moving whiteboard location to be presented by end January.
- Draft Criteria led Discharge document circulated.
- Wards agreed to adopt QI methodology and initial engagement sessions arranged.
- Site team recommenced prompting midday discharges, needs further embedding.
- Explore with Durrington ward the good practice evidenced by transport audit (this is on hold due to Covid-19 prevalence).
- Radiology audit to commence end of January 21.





Success measures (tbc)	How measured	Baseline	Target	Nov Actual
1. % discharges before midday	Lorenzo	17.9%	33%	15.52%
2. Number of 'super stranded' patients (% of occupied beds)	Lorenzo	17.6%	14%	19.4% (59 of 304)

Data source patient flow scorecard

Specialist – Clinical Strategy Refresh

Exec sponsor: Peter Collins

Programme aims & key deliverables

In line with wider corporate strategy review, the Clinical Strategy will be refreshed, approved by Clinical Governance Committee and aligned with the requirements of the recovery programme from COVID-19.

Alignment with BSW Health and Care Strategies and Long Term Plan, including the themes of ageing well, improved mental health and services for people with learning disabilities.

Prioritisation of the Integration of SFT Acute services with the wider neighborhood, place and ICS services across South Wiltshire and BSW.

Key highlights / challenges

- The framework and direction of travel for the renewed Clinical and Corporate Strategies has been established and considered by Board in November 2021.
- The refresh of SFT strategies is aligned and assisted by the designation of BSW as an Integrated Care System and the integration of our services with our partner organisations and clinical networks is a key theme in SFT's strategic direction. Our future relationship with RUH and GWH as part of an Acute Hospital Alliance will also underpin this.
- The clinical strategy is taking form through consultation with Clinical Directors and wider Trust staff to include planning for future population health needs – with a core service offer building from:
    - Integrated Frailty
    - New front door models of care
    - Imaging and Diagnostics
    - Mental health support
    - General surgical services
    - Chronic disease management
- Wider consultation and engagement with SFT teams and partners is underway, including Trust-wide workshops in January 2021. The strategy refresh remains on target to be progressed throughout Q4 2020-21.

Success measures	How measured	Baseline	Target
Approval of Phase 3 Covid-19 response and plans	NHSI approval	N/A	Complete
Implementation plan for revised clinical strategy approved through CGC.	CGC approval	N/A	March 2021

Best place to work

Exec sponsor: Lynn Lane

Programme aims & key deliverables

The purpose of the programme is to discover, design and deliver a range of activities developed by NHS Improvement, to enable organisations to embed compassionate and inclusive leadership cultures.

- Phase 1: Discovery and Diagnostics concludes end of July. Board report on findings from Phase 1 due in October 2020.
- Feedback Loop back to staff following Discovery Phase - week commencing week commencing 24th August.
- Collation, analysis and review of Discovery and Diagnostic Phase results , aligned to Strategic and Corporate Objectives - mid September 2020.
- Report to Board on Phase 1 and recommended next steps for Phase 2 – October 2020.
- Phase 2: Design will be informed by Phase 1 findings and proposed action plan considered by the Board. Phase 2 due to commence from November 2020 with repurposed vision and values.
- Phase 3: Delivery will commence in March 2021 as a rolling programme of events into 2021/22.

Key highlights / challenges

- Project leads established to monitor and manage delivery and risks. Chaired by Ass. Director of Education, Inclusion, Communication and Engagement reporting into CEO and OD and People Director.
- Full report presented to (Private) Board in October. The Board agreed a co-creation approach whereby sessions with staff are scheduled to get their views on what they would prioritise from the recommendations. This work is underway. Second engagement event scheduled for 22nd January.
- Board development day scheduled for Jan 12th 2021 postponed. Risk to commencement of Phase 2 following board consideration of the impact of COVID-19.
- Our implementation plan will need to dovetail into agreed OD interventions across BSW.
- External facilitator leading the Board development day will support the work agreed for the implementation plan.
- Risk to delivery of phase 3 as phase 2 is delayed.

Success measures (tbc)	How measured	Baseline	Target	Nov Actual
Phase 1: Discovery phase completion using 6 NHSi tools: 1. Patient experience 2. Culture focus groups 3. Leadership Behaviour Survey 4. Culture and Outcomes Dashboard 5. Board Interviews 6. Leadership Workforce Analysis	Synthesis: bring together the results of the diagnostic tools/resources	Engagement with staff from all levels (Bands 2-9) and directorates across the Trust to achieve 60% engagement	September 2020	Phase 1 complete.
Phase 2: Design phase completion using NHSI tools	Design agreed by Trust board and implementation plan approved.	Agree priorities from the recommendations at board development day influenced by priorities of Trust staff.	April 2021	Trust board development day postponed
Staff Survey Response Rate	Staff Survey	54.0 % (2019)	60%	54.2% (2020)
Health and Wellbeing	Staff Survey	6.1 (2019)	6.5	Results available Feb/March 2021
Equality, Diversity & Inclusion	Staff Survey	9.2 (2019)	9.4	Results available Feb/March 2021
Staff Engagement	Staff Survey	7.2 (2019)	7.5	Results available Feb/March 2021

Care – Patient safety and IPC

Exec sponsor: Judy Dyos

Programme aims

1. Implement national patient safety strategy
2. Agree a Quality Assurance Framework incorporating ward accreditation & a ward performance review process
3. Ensure that service delivery during the COVID-19 recovery phase is supportive of changing staff & patient needs.

Key deliverables:

- Patient Safety strategy implementation plan agreed with time lines for delivery signed off
- 2 Pilot wards undertaken first full ward accreditation and 100% of wards have undertaken first Ward Performance Review
- Review of IPC Covid-19 BAF with Trust Board signoff. Target 90 % compliance with key lines of enquiry

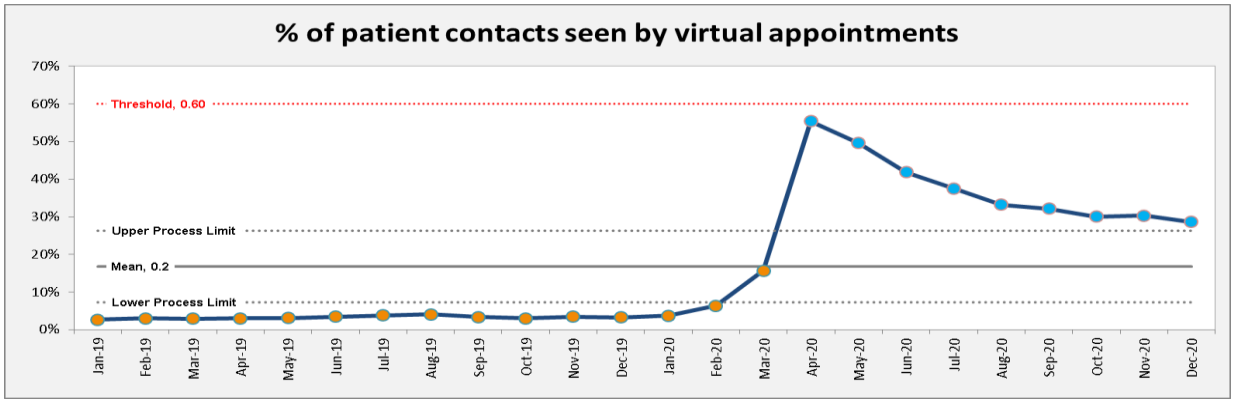
Key highlights / challenges

- A new patient safety meeting will be piloted from January leading to a patient safety report to clinical management board, . Following this a patient safety strategy will be developed by the end of March.
- 100% of ward performance reviews have been completed.
- The IPC Covid-19 BAF has been completed and reviewed at Board performance reviews.
- Anti-microbial ward round re-commenced
- Ward accreditation dashboard in development

Success measures	Target
1, 2 pilot wards undertaken full ward accreditation	2 by March 2021
2, 100% of wards to have undertaken first Ward Performance Review	Complete
3, Compliance with IPC Covid key lines of enquiry	90% compliance

Outpatients Transformation Programme measures – December 2020

Exec sponsor: Esther Provins

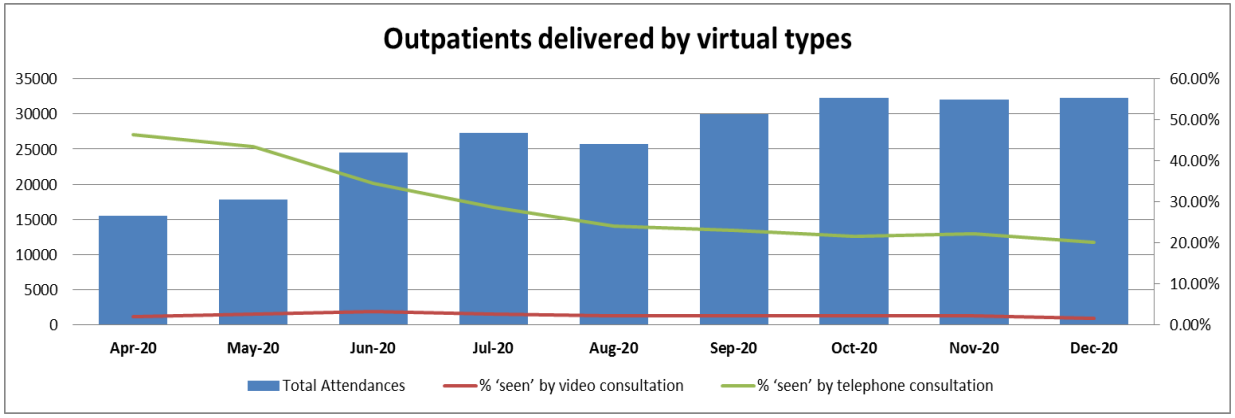


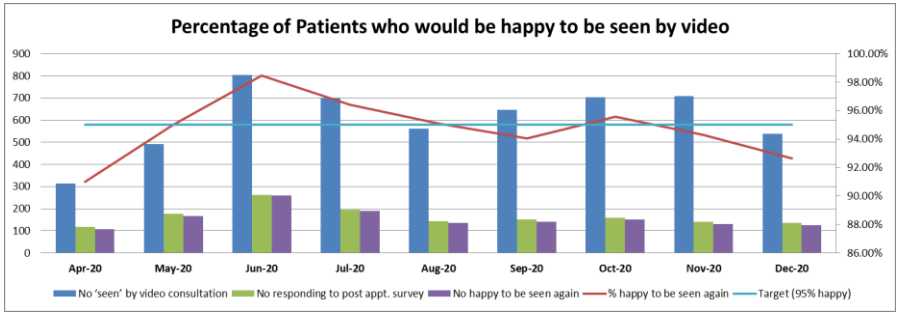
The current SFT position against the 60% Trust target, for December is 28.63%. This target measures the percentage of virtual OP appointments against all OP activity, and does not account for specialties that may not be appropriate for virtual (e.g. diagnostics). This reflects the national data provision, which includes all activity.

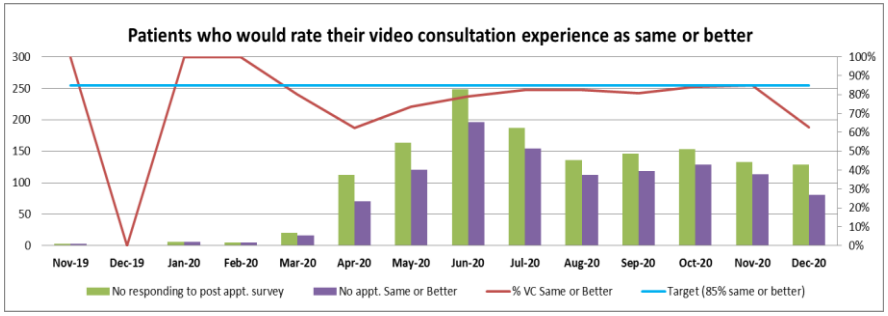
With increasing Covid-19 pressures operational and clinical capacity to engage with further implementation of virtual clinics has been a challenge. Further review is required to identify which clinics are suitable for virtual, which clinics can default to virtual and a review of those clinics that are currently not conducting any virtual appointments.

Space continues to be a challenge, modular structure expected to be available from end of Feb 21. Specific training for clinical staff in conducting Outpatient appointments virtually is currently being scoped, which will also help with clinical engagement.

Furthermore, there is a system wide piece of work currently taking place to procure a virtual solution across BSW for March 21-22, which is being funded nationally. This procurement will mean that trusts will be using the same system regardless of geographical location, decreasing variation in experience for patients across BSW







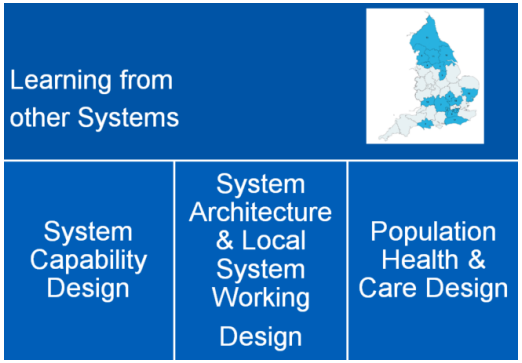
Resources – Developing our Integrated Care System

Exec sponsor: Lisa Thomas

Programme aims

- Develop system capabilities across BSW to perform role as Integrated Care System, co-ordinating transformation activity and system performance at system, place and neighbourhood level.

Key deliverables – to demonstrate maturity through:



- Streamlined commissioning arrangements
- Development of full shared care record
- System Phase 3 plans (and beyond)
- Capital and Estates Plans
- System leadership model
- System-wide governance arrangements.

Key highlights / challenges

- BSW achieved designation as an ICS from NHSE/I on 4 December 2020.
- The ICS continues to develop programmes around its 5 key priorities:
  - to improve the health and wellbeing of our population
  - reduce health and care inequalities
  - improve the quality and experience of care for those receiving and those delivering it
  - ensure workforce development and wellbeing
  - make the best use of resources
- The BSW programme board has approved a financial sustainability plan to address the underlying deficit position – SFT leading this work.
- BSW is engaged with the further legislative and governance frameworks within which ICSs will operate.
- Further alignment of SFT and BSW strategies and priorities continues – particularly using population health management as a data tool for planning
- The Acute Hospital Alliance is driving forward programmes related to elective care, shared functions and BSW-wide pathway reform.

Success measures	Target
1, BSW draft ICS submission	Complete
2, BSW final submission	Complete
3, NHSE/I determine designation of system as ICS	Complete

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	14 January 2021		

Report Title:	Board Assurance Framework and Corporate Risk Register Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x	x	
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	Board Assurance Framework v1.2 January 2021 (draft) Draft Corporate Risk Register December 2020 v6.4 Draft Summary CRR tracker v19.1 January 2021			

Recommendation:

The Trust Board are asked to review, discuss and make any updates to the following:

- Board Assurance Framework (BAF)
- The Corporate Risk Register (CRR)
- The Corporate Risk Tracker

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current risks
- Review the corporate risk register to ensure that it accurately reflects the corporate risks and related actions with particular attention to mitigating actions, risk score and residual risk score.
- Review the principle risks and any associated gaps in control or assurance identified against the delivery of the strategic priorities and review delivery of associated actions
- Review the gaps in control and assurance against delivery of the 2020/21 corporate objectives and review associated actions to address these gaps

Executive Summary:

Summary

The Trust risk profile has seen a significant shift since the last report in September. There is one new risk regarding the EU Exit which has replaced the existing risk relating to a potential no deal reflected within the documentation. A number of other risks are emerging and will inform the BAF and CRR being presented to the Board Committees later in January. These include risks in relation to outbreaks, impact from the redeployment of staff

to support the current Covid response, flow and achievement of virtual outpatient appointments.

The Trust is below our current target for % virtual outpatient appointments; currently at 32% against a target of 60%. The national target is 25% of all appointments and 60% of all follow up appointments (SFT 34%). The challenge in respect of follow up appointments has been an increase in number of patients needing a face to face appointment following the first lockdown.

Barriers to improvement are:

- Operational and clinical capacity to develop standard protocols for which clinics are suitable for virtual, and which can be virtual by default
- Personal preferences regarding use of video, and human factor issues.

Actions planned over the next 3 months, also in support of the current wave of the pandemic are:

- A structured ground up review to establish all clinics that are suitable for virtual and all clinics that can be virtual by default
- Delivery of training for clinical staff in conducting virtual appointments
- Offering patients choice regarding type of appointment

The Interim Medical Director has reviewed all risks for which he is Executive Lead. Changes will be reflected in the next update to the Board Committees in January.

Extreme risks

- 6212 (Local) - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm (Score 15).
- 6654 (Local) - The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance (Score 15).
- 6471 (Resources) - Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services (Score 15)
- 5751 (Local) - Risk of patient harm caused by a delayed discharge from hospital (Score 15).

New risks

- 6731 (Resources) - This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach. (Score 6).

Risks removed

- 6690 (Resources) - Risk of disruption in the supply chain for consumables and drugs and in the ability to deliver capital programmes due to delay to deliveries due to a potential no-deal EU Exit (Score 15). This risk has been replaced with risk 6731 above.

Risks with an increased score

- 5751 (Local) - Risk of patient harm caused by a delayed discharge from hospital (Score 12 to 15).

Risks with a decreased score

- 6247 (Resources) - Risks associated with critical plant and building infrastructure that may result in utility or system failure (Score 20 to 12)
- 6470 (Resources) - Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged resulting in the Trust having to take emergency measures (Score 12 to 9)

Deep Dive

The Board approved the criteria for the initiation of a deep dive of a risk on the corporate risk register in February 2020. The criteria is set out below:

- A corporate risk of 16 and above for a period of 6 months will initiate a deep dive
- A corporate risk score <16 unchanged for 12 months will initiate a deep dive
- An escalating risk score over a 3 month period will initiate a Board Committee discussion

The following risk triggered a deep dive as this has been scored at 15 for over 6 months and although not meeting the exact criteria, is deemed to require further review.

- Risk 6212 (Local) - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm (Score 15)

The Interim Medical Director is currently reviewing this risk which may be subject to change.

Risk 6471 has also triggered a deep dive as this has been scored at 15 since March 2020. The Director of Finance is reviewing this risk and this will be reported back to Board Committees in January 2021.

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	☒

Board Assurance Framework

Incorporating the revised Corporate Objectives for 2020/21

2020/21

Trust Vision: An Outstanding Experience for Every Patient

V1.2 January 2021

Delivery of our vision and the strategic objectives is underpinned by our Trust Values and Behaviours: Patient Centred and Safe, Professional, Responsive, and Friendly. A drive to be 'outstanding every time.' It is also recognised (as illustrated above) that woven throughout the delivery of the strategy is the need to successfully develop and work across partnerships and collaborations which is why the Corporate Risk Register highlights both internal and external risks to delivery of our objectives.

Strategic Priorities

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

Board Assurance Framework – Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/ systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Internal Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2: semi-independent Assurance** For example – Non-Executive Director walk arounds, Internal Audits **Level 3 External Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

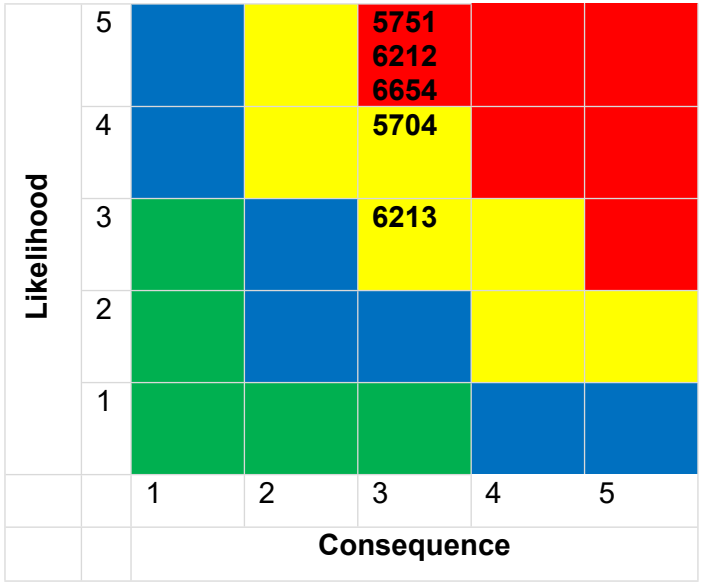
	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

Strategic Priority: 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.

Executive Lead: **Chief Operating Officer** **Reporting Committee:** **Finance & Performance Committee**

Distribution of Corporate Risks for Local Services



5704 – Inability to provide a full gastroenterology service due to a lack of medical staff capacity
5751 – Patient safety risk due to high numbers of delayed transfers of care due to lack of community capacity
6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked.
6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm.
6654 - The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance

Linked risks

5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.(Innovation)
6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care (Care)
5966 - Risk of compromised services due to hub and spoke model (Care)

Principle Internal Risk: Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population	
Key Controls	**Assurance on Controls**
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO) • Workforce plans	• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group
Principle External Risk: Managing the complexity of relationships with our partners to lead and share our joint strategy plans for a place based integrated care system	
Monitoring information	**Areas of influence**
• Integrated Performance Report – impact on metrics • Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard) • STP Operational Plan	• Requested improvement trajectories for decreased attendances and delayed transfers of care • STP Executive Board (CEO) • STP Sponsorship Board (CEO and Chair) • Wiltshire Integration Board (CEO) • Stakeholder meetings / engagement • Acute Hospital Alliance

2020/21 Corporate Objectives – Local Services

Objective	Target Measures
Develop with partners initiatives to ensure patients do not stay in hospital any longer than they need.	• Achieve average of 30% discharges before 1200 • Reduce Super Stranded Patients to 14%

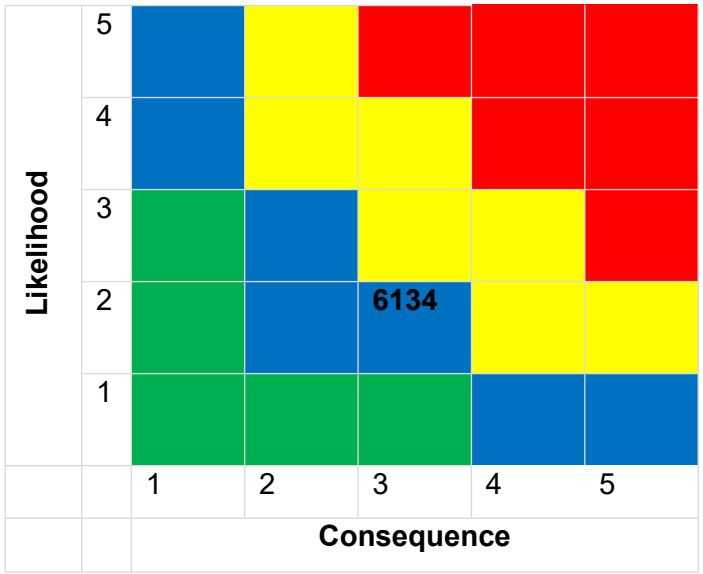
Gaps in Control/Assurance	Action	Deadline	Lead
Local Authority adopting a change to the approval process for packages of care (GC)	Chief Operating Officer to liaise with the CCG *October update: Process change adopted. Lack of assurance due to increasing numbers of medically fit stranded patients. Action closed. New action below*	Review 30/09/2020 *Reviewed – action closed*	Chief Operating Officer
	Discharge workstream with new project lead to meet weekly to drive improvements in discharge pathways	31/12/2020 In place – action complete	Chief Operating Officer
Community capacity being directed to areas with Covid-19 peaks (GC)	No internal action		

Strategic Priority: Specialist Services

We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Executive Lead: **Chief Operating Officer** **Reporting Committee:** **Finance & Performance Committee**

Distribution of Corporate Risks for Specialist Services



6134 – Financial and workforce risk as a result of NHS England Specialist Commissioners driving centralisation of genetics and genomics clinical testing into fewer laboratories resulting in laboratory testing unlikely to be provided at the Trust in the longer term

Nov 20 NB: Wider risk being considered regarding tertiary services

Principle Internal Risk: Risk of balancing delivery of services that are 'outstanding' against the risk of economies of scale and cost effectiveness	
Key Controls	**Assurance on Controls**
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board • COO Delivery Group • Genomics Consortium Board • Established performance monitoring and accountability framework • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO)	• Integrated Performance Report • Specialist Services dashboards • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group

Principle External Risk: National drive and policy regarding further centralisation	
Monitoring information	**Areas of influence**
• Integrated Performance Report	• Plastics network

2020/21 Corporate Objectives – Specialist Services

Objective	Target Measures
Refresh the clinical strategy	• Strategy approved by CGC, and implementation plan agreed.

Gaps in Control/Assurance	Action	Deadline	Lead
Current strategy does not reflect changes in service delivery as a result of: • Working towards the BSW ICS • Covid pandemic and recovery phase • Shift in national priorities	Refresh of the Clinical Strategy to reflect changes and Phase 3 proposals	~~30.10.2020~~ Revise date 31/3/2021 *Interim update to CGC in December 20 – update provided to CGC*	Medical Director

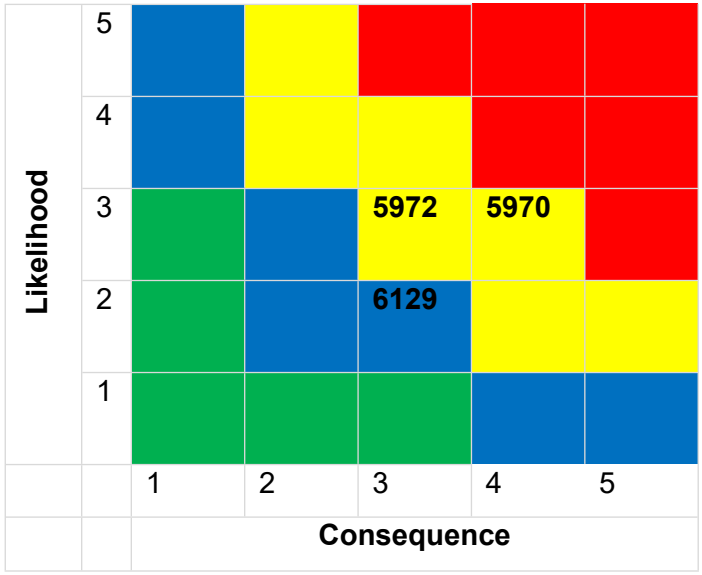
Strategic Priority: Innovation

We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: **Director of Transformation**

Reporting Committee: **Clinical Governance Committee**

Distribution of Corporate Risks for Innovation



5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff

5972 – Risk that improvement and transformation is not delivered in a timely manner

6129 - Risk of the non-delivery of the IT Improvement Plan

Principle Internal Risk: Risk of a lack of capability and capacity to deliver innovation	
Key Controls	**Assurance on Controls**
• Transformation, Innovation and Digital Board • QI Operational plan and improvement strategy • QI Steering Group • People and Culture Committee • Clinical Governance Committee • Research Governance Framework • F&P Committee • Trust Board • IT Improvement Plan • Digital Strategy Implementation Plan • Shared Acute Alliance EPR Progamme Board • BSW system capability workstream • Joint Acute Alliance improvement approach	• Model Hospital benchmarking • NIHR Wessex compliance reports • QI KPIs to evaluate success • Staff survey • Committee effectiveness review • Internal reports to F&P Committee, Trust Board and CGC • Executive performance reviews • EPR programme reports and plan • BSW system capability reports • Acute Alliance reports

Principle External Risk: Risk of indecisiveness/fluidity in National policy and best practice	
Monitoring information	**Areas of influence**
• NHS Provider briefings • NHS Improvement briefings • NHS England briefings • Research networks	• Consultation on National policy • Representation on policy groups where appropriate • Contract negotiation

2020/21 Corporate Objectives – Innovation

Objective	Target Measures
No Going Back programme - Embed the use of virtual outpatient appointments	• 60% of outpatient appointments carried out virtually

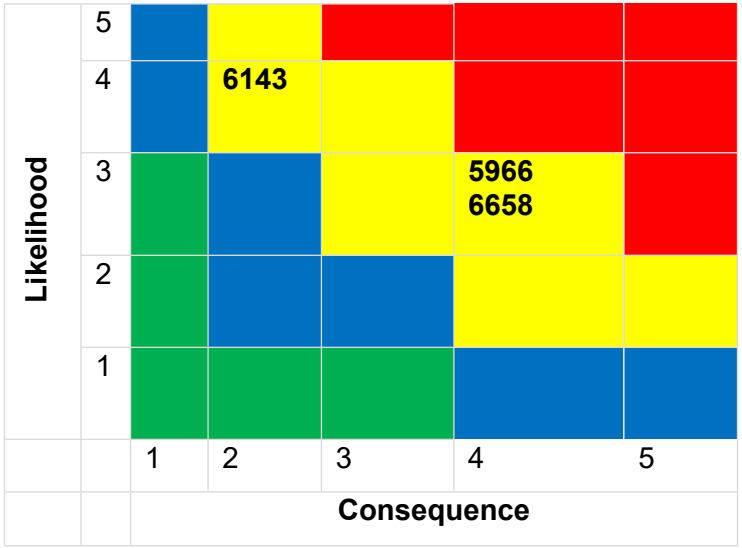
Gaps in Control/Assurance	Action	Deadline	Lead
Reduction in virtual appointments since April (36% in September, 29% in December 2020) (GA) Phase 3 recovery plan performance against target: • 25% of all appointments carried out virtually – SFT Dec 29% • 60% of all follow-ups carried out virtually – SFT Dec, 31%	Delivery of Phase 3 recovery actions to increase the use of virtual appointments *October update: Additional actions below to address compliance*	Review 31/10/2020 *Review complete* Review 31/12/2020	Director of Transformation
	Increase oversight and accountability of the percentage of virtual appointments through Executive Performance Reviews	Commencing October 2020	Chief Operating Officer
	Increase clinical engagement targeting challenged areas by Deputy Medical Director	Commencing October 2020	Deputy Medical Director
	Adoption of National Service Redesign Best Practice. *Action replaced with the below (Dec 2020):* Ground up review to establish all clinics that are suitable for virtual and all clinics that can be virtual by default	~~31/12/2020~~ 31/03/2021	Deputy Medical Director/Clinical Leads/ Director of Transformation
	Delivery of training for clinical staff to conduct virtual appointments	31/03/2021	Deputy Medical Director/ Director of Transformation
	Offer patient choice regarding type of appointment	31/03/2021	Deputy Medical Director/Clinical Leads/ Director of Transformation

Strategic Priority: Care

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

Executive Lead: **Medical Director and Director of Nursing** **Reporting Committee:** **Clinical Governance Committee**

Distribution of Corporate Risks for Care



5966 – Risk of compromised services due to hub and spoke model
6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care
6658 - Maternity service inability to complete serious incident actions within expected timeframes leading to concerns regarding failure to embed learning. Further concerns have been raised via the FTSUG in relation to cultural behaviours

Linked Risks
6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked (Local)
6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm (Local)
5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Local)
5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Local)

Principle Internal Risk: Insufficient resources (skilled staff and infrastructure) to deliver safe effective care	
Key Controls	**Assurance on Controls**
• Integrated Governance Framework • Accountability Framework • Clinical and HR policies and procedures • Workforce plan • Clinical Governance Committee • Clinical Management Board • People and Culture Committee • Divisional Performance Meetings • Contract Quality Review Meeting / contractual monitoring • Annual audit programme (national and local) • GIRFT Programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Infection Control Board Assurance Framework • Learning from Deaths Policy • Appraisal and revalidation of doctors	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime – last inspection report March 2018 • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review completed March 18 • Internal Audit report on morbidity and mortality meetings • CQC peer review process • GIRFT reports and action plans • Annual appraisal quality assurance review

Principle External Risk: National initiatives may be unsuitable to deliver high quality care to the population of a small rural DGH	
Monitoring information	**Areas of influence**
• Integrated performance report – impact on metrics • National Policy – horizon scanning • Commissioning/decommissioning of services	• STP Boards and sub-groups • NHS Rural Hospitals Alliance • Clinical senates and networks • NHSE Specialist Commissioning • Local MPs

2020/21 Corporate Objectives – Care

Objective	Target Measures
1. Implement the National Patient Safety Strategy 2. Agree a Quality Assurance Framework incorporating ward accreditation and ward performance review process 3. Ensure that service delivery during the COVID-19 recovery phase is supportive of changing staff and patient needs.	• Patient Safety Strategy implementation plan agreed with time lines for delivery signed off • 2 Pilot wards undertaken first full ward accreditation and 100% of wards have undertaken first Ward Performance Review • Review of IPC Covid-19 BAF with Trust Board signoff. Target 90 % compliance with KLoE

Gaps in Control/Assurance	Action	Deadline	Lead
Lack of ward accreditation system (GC)	Development of a ward accreditation system	31/03/2021	Director of Nursing
Lack of a clinical summary dashboard (GC)	Development of a clinical summary dashboard	~~31/12/2020~~ Review 31/03/2021 *Delay due to Covid. Work in progress. Ward performance review data pack in place as an interim solution*	Director of Nursing
External estates review identified inadequate ventilation standards (GA)	Executive lead task and finish group to oversee delivery of the estates action plan	Commenced – in place	Chief Operating Officer
	Quotes for critical areas requested by Chief Operating Officer *October update: Action closed. All critical risks mitigated and reviewed on a regular basis by Execs and F&P Committee*	Review 30/09/2020 Complete	
	Appoint additional 0.3wte microbiologist	30/09/2020 Complete – in post	
Non-compliance with Constitutional standards (GA)	Weekly monitoring of recovery through the Delivery group	Elective recovery being managed through Phase 3 recovery plan which is reported to F&P and	Chief Operating Officer

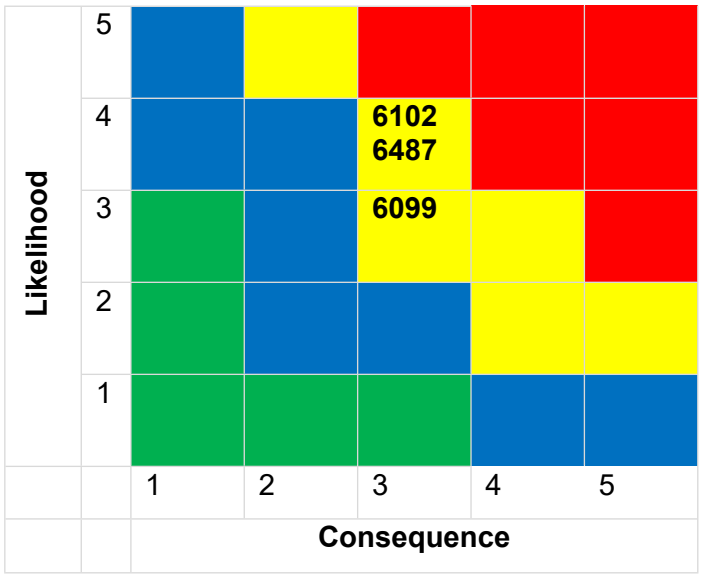
Gaps in Control/Assurance	Action	Deadline	Lead
		Board	
Infection Prevention Board Assurance Framework non-compliance regarding anti-microbial stewardship (GA)	Re-commencement of anti-microbial ward rounds	30/09/2020 Complete – re-started	Director of Nursing

Strategic Priority: People

We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: **Director of Organisational Development and People** **Reporting Committee:** **People and Culture Committee**

Distribution of Corporate Risks for People



6099 - Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services.
6102 - Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service.
6487 - Risk of not being able to safely staff ward areas, ED and Critical Care as a result of the potential second wave of Covid-19

Principle Internal Risk: Risk that the Trust will be unable to recruit and sustain an engaged and effective workforce	
Key Controls	**Assurance on Controls**
• People and Culture Committee • OD & People Management Board • Health and Wellbeing strategy Board (from 19/7) • HR Policies • Directorate Performance meetings • People strategy Delivery Board • Safer Staffing Group • Equality, Diversity and Inclusion Committee (launch 29 July) • Health and Safety Committee • Freedom to Speak Up Guardians • JCC Staff Side Meeting • JLNC Committee (medical staff) • Vacancy control group • People Plan • Best Place To Work Programme	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • Integrated Performance Report at Board • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report • Health and safety annual report • Guardian of safe working report • Volunteers annual report • Monthly Workforce Dashboard at EWC • Executive Safety Walks

Principle External Risk: Risk that the local authority priorities for housing, retail and leisure results in Salisbury not being a place to work for your people	
Monitoring information	**Areas of influence**
• Integrated performance report – impact on workforce KPIs	Member of Wiltshire workforce group (local place based care, part of ICS)

2020/21 Corporate Objectives – People

Objective	Target Measures
• Best Place To Work Programme	Staff survey: • 65% response rate • Equality, Diversity and Inclusion score 9.4 • Health and Well-being score 6.5 • Staff engagement score 7.5

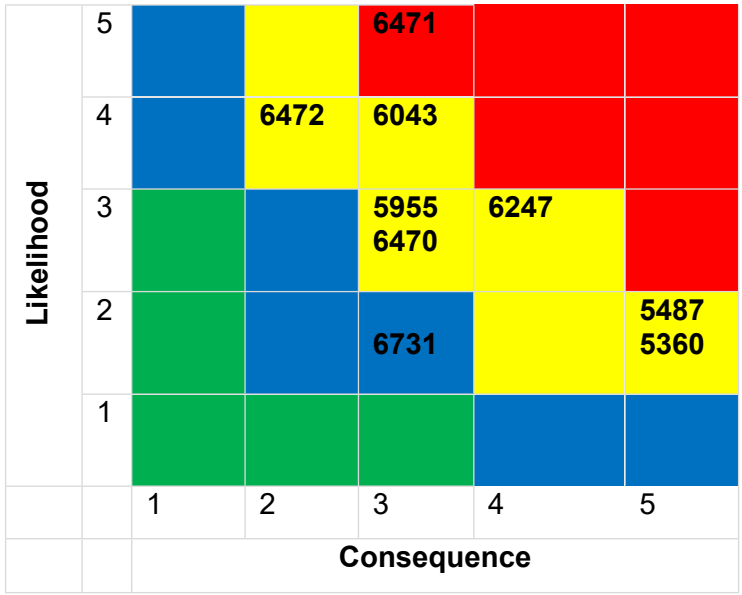
Gaps in Control/Assurance	Action	Deadline	Lead
No current identified gaps in control or assurance			

Strategic Priority: Resources

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

Executive Lead: **Director of Finance** **Reporting Committee:** **Finance & Performance Committee**

Distribution of Corporate Risks for Resources



5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
5955 - Insufficient robust management control processes
6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT
6247 - Risks associated with critical plant and building infrastructure that may result in utility or system failure.
5360 - Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss.
6472 – Risk of not delivering key objectives aligned to operational, activity and workforce plans in year due to Covid-19 and the final elements of the 2020/21 planning round not being completed in line with national guidance.
6470 – Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged.
6471 – Shortfall in funding available for capital programme with potential risk to safety and availability of buildings and equipment to deliver services.
6731 - This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach.

Linked Risks
5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff (Innovation)

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities	
Key Controls	**Assurance on Controls**
• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • Transformation Board • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan • Acute Alliance Programme Board • Local urgent and planned care boards	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement

Principle External Risk: Risk of a lack of available and qualified clinical resource	
Monitoring information	**Areas of influence**
• Workforce Committee • HEE Board reporting • NHSI Board reporting	

2020/21 Corporate Objectives – Resources

Objective	Target Measures
With Partners, develop BSW Integrated Care System	• ICS rated as maturing by April 2021

Gaps in Control/Assurance	Action	Deadline	Lead
Lack of National guidance on finance regime for 2020/21 M6+ and future years	No internal action		
Unclear guidance beyond this financial year making planning for 2021/22 challenging	No internal action		
Increased spending in 2020/21 in response to Covid-19 and Phase 3 recovery	To ensure control totals agreed for 2020/21 for Divisions and monitoring in place	November 2020 Action complete	Director of finance

Corporate Risk Register Summary - January Board 2021 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Nov-19	Jan-20	Mar-20	May-20	Jul-20	Sep-20	Nov-20	Dec-20	Target
Risk Detail				Score Trend									
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													
5704	Inability to provide a full gastroenterology service due to a lack of medical staff capacity	Medical Director	31-Jan-19	16	16	16	16	16	12	12	12	12	12
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	16	16	16	16	12	12	15	15	12
6654	The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance	Chief Operating Officer	02-Sep-20	15						15	15	15	9
6213	Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked	Medical Director	06-Mar-20	12			12	9	9	9	9	9	6
6212	Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm	Medical Director	06-Mar-20	15			15	15	15	15	15	15	9
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population													
6134	Financial and workforce risk as a result of NHS England Specialist Commissioners driving centralisation of genetics and genomics clinical testing into fewer laboratories resulting in laboratory testing unlikely to be provided at the Trust in the longer term	Medical Director	02-Jan-20	16		16	16	16	16	6	6	6	6
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered													

5970	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Director of Transformation	23-Aug-19	16	16	16	16	12	12	12	12	12	9
6129	Risk of the non-delivery of the IT Improvement Plan (incorporating clinical risk)	Director of Transformation	19-Dec-19	20		9	9	6	6	6	6	6	6
5972	Risk that improvement and transformation is not delivered in a timely manner	Director of Transformation	23-Aug-19	16	16	16	16	16	9	9	9	9	6

Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm														
6143	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Medical Director	02-Jan-20	16		16	16	12	8	8	8	8	6
6658	Maternity service inability to complete serious incident actions within expected timeframes leading to concerns regarding failure to embed learning. Further concerns have been raised via the FTSUG in relation to cultural behaviours	Director of Nursing	08-Sep-20	16						12	12	12	4
5966	Risk of compromised services due to hub and spoke model	Medical Director	20-Aug-19	12	15	12	9	12	12	12	12	12	9
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams														
6099	Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services	Director of OD&People	14-Feb-20	12			12	12	9	9	9	9	9
6102	Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service	Director of OD&People	14-Feb-20	16			16	16	12	12	12	12	9
6487	Risk of not being able to safely staff ward areas, ED and Critical Care as a result of the potential second wave of Covid-19	Director of Nursing	04-Jun-20	12					12	12	12	12	6
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources														
5487	The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation	Director of Finance	26-Nov-18	12	9	6	6	10	10	10	10	10	6
6690	Risk of disruption in the supply chain for consumables and drugs and in the ability to deliver capital programmes due to delay to deliveries due to a potential no-deal EU Exit **(Removed Nov 20; replaced with 6731)**	Chief Operating Officer	20-Oct-20								12		6

6731	This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach. The worst case planning assumptions the flow rate through the straits could reduce to 60 -80%. **(New risk)**	Chief Operating Officer	19-Nov-20										6	1
5955	Insufficient organisation wide robust management control procedures	Director of Finance	13-Aug-19	15	15	15	15	12	12	9	9	9	9
6247	Risks associated with critical plant and building infrastructure that may result in utility or system failure	Chief Operating Officer	16-Mar-20	12			12	12	12	20	12	12	8
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Director of Transformation	11-Feb-20	15			15	10	10	10	10	10	6
6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Director of Finance	25-Oct-19	12	12	12	12	12	12	12	12	12	6
6472	Due to Covid-19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year	Director of Finance	26-May-20	12				12	12	8	8	8	8
6470	Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged resulting in the Trust having to take emergency measures	Director of Finance	26-May-20	12				12	12	12	9	9	9
6471	Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services	Director of Finance	26-May-20	15				15	15	15	15	15	8

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Corporate Risk Register
December 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6129	Transformation & IM&T	Information Technology	19/12/2019	Trusts Objectives	20	There is a risk that the Trust does not deliver the IT Improvement Plan, which may result in compromised patient care, inaccurate reporting, loss of IT systems, financial and reputational loss, and breaches to data regulations (e.g. GDPR)	Do not expect it to happen again but it is possible	Moderate	6	Develop and produce monthly update and highlight report	16/01/2020	02/03/2020	Burwell, Jonathan	Executive Director Meeting	31/12/2020	6	Innovation	Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	20/12/2019
										Complete internal service delivery model review (desktop exercise)	16/01/2020	02/03/2020	Burwell, Jonathan								
										Procure support to deliver a service delivery model review of hot spots, including options appraisal and recommendations	13/01/2020	21/02/2020	Provins, Esther								
										Executive team review and decision on recommendations arising from external service delivery review	21/02/2020	21/02/2020	Provins, Esther								
										Board seminar to appraise Board of Directors as to agreed way forward regarding IT Service Delivery Models.	05/03/2020	02/03/2020	Provins, Esther								
										Add in to digital update in April 2020 next steps from the service model review informed by on the recommendations from PWC and linked to key elements of IT improvement plan.	10/05/2020	07/05/2020	Burwell, Jonathan								
										pwc final assurance review to be completed.	31/12/2020		Burwell, Jonathan								
6134	Clinical Support and Family Services	Genetics	20/12/2019	Trustwide risk assessment	16	NHS England Specialist Commissioners are driving centralisation of genetics and genomics clinical testing into fewer laboratories and this means it is unlikely that laboratory testing services can be provided at SFT in the longer term. This is a financial risk for the Trust and a Workforce Risk.	Do not expect it to happen again but it is possible	Moderate	6	Work with UHS to centralise genomic testing in Wessex.	31/03/2021		Collins, Peter	Trust Board	01/01/2021	6	Specialist Services	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	02/10/2020
										Devise a business plan required to mitigate the financial risk.	31/03/2021		Collins, Peter								
6731	Operations Directorate	Trustwide	19/11/2020	Trustwide risk assessment	8	This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach. The worst case planning assumptions the flow rate through the straits could reduce to 60 -80%.	Do not expect it to happen again but it is possible	Moderate	6	D20 - will be a standing agenda item on the IMT daily meetings D20 - information from central and national teams is being cascaded through the SFT SPOC, which is monitored 7/7 08.00 - 20.00 UK GOV D20 alerts have been subscribed to by TM, and this if received are cascaded to the D20 group The D20 group can be stood up as a separate entity if required	29/01/2021		Merrifield, Tracey	Covid 19 SCG (Strategic Coordination Group)	20/01/2020	1	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	19/11/2020

Corporate Risk Register
December 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6472	Finance and Procurement	Trustwide	24/05/2020	COVID-19/Coronavirus, Financial management	12	Due to Covid 19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year.	Do not expect it to happen again but it is possible	Major	8	Ensure revised corporate Objectives are completed linked to restart	31/07/2020	09/11/2020	Thomas, Lisa	Trust Board	31/12/2020	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	26/05/2020
6143	Quality Directorate	Trustwide	20/12/2019	Trustwide risk assessment	16	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Do not expect it to happen again but it is possible	Major	8	Weekend safety and effectiveness action plan reported to Board on a quarterly basis.	01/04/2020	28/04/2020	Blanshard, Dr Christine (Inactive User)	Trust Board	30/10/2020	6	Care	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	02/01/2020
										Report containing triangulation of all relevant information and associated action plan to be submitted to Clinical Governance Committee.	30/06/2020	07/07/2020	Blanshard, Dr Christine (Inactive User)								
										Reinstate the weekend working Task and Finish Group.	31/03/2021		Collins, Peter								
6099	Organisational Development and People	All clinical areas	06/12/2019	Other assurance not listed	12	Risk of not being able to recruit to posts identified as hard to recruit. Risk is that they will remain hard to fill with the result that we are forced to continue costly Agency/Locum support and/or outsourcing and/or discontinue services.	May recur occasionally	Moderate	9	Head of Resourcing to focus further time on Recruitment issues and to feedback to Deputy Director of OD and People	28/02/2020	03/02/2020	Holt, Sharon	Executive Workforce Committee	31/12/2020	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Holt, Sharon	14/02/2020
										Review and update of Directorate action plans to be undertaken monthly with Head of Resourcing, BP's, DM's and CD's. This includes planning for 2020/2021.	30/06/2020	06/07/2020	Holt, Sharon								
										Follow up with Lead Clinicians possible leads for specific vacant posts and provide support as required.	30/06/2020	06/07/2020	Holt, Sharon								
										Business case for funding for marketing and branding expertise to be resubmitted to TIG.	30/10/2020	11/11/2020	Holt, Sharon								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6213	Medicine	Cancer Services	21/02/2020	Specialty Risk assessment	12	As a result of having three systems involved in the cancer pathway that are not contextually linked (Lorenzo, ERS and Somerset), there is a risk that patient could be missed or delayed, resulting in patient harm.	May recur occasionally	Moderate	9	Carry out an Investigation to confirm current position (take 10 patients randomly from breast and urology to compare the date stamps across eRS, Lorenzo, Somerset and the data warehouse)	31/12/2019	31/12/2019	Burwell, Jonathan	Trust Board	31/10/2020	6	Local Services (Care)	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	06/03/2020
										Management actions agreed in response to pwc audit report.	06/03/2020	05/03/2020	Blanshard, Dr Christine (Inactive User)								
										Management action from pwc audit: Cancer services will be reviewing random samples of patients on a monthly basis (alongside existing Lorenzo/SCR audit) to assess pathway across eRS, Lorenzo and SCR	30/04/2020	28/04/2020	Scutt, Emilia								
										Management action from pwc audit: Task and Finish Group in place to review opportunities around electronic outcome forms from a Trust-wide (not just cancer) perspective.	30/09/2020		Burwell, Jonathan								
										Management action from pwc audit: Follow up Risk Summit scheduled for 29/04/2020 to review overall progress	01/06/2020	07/07/2020	Blanshard, Dr Christine (Inactive User)								
										Management action from pwc audit: Raise awareness to the Trust Board of the workarounds currently in place and the associated risks; this will enable the Board to make an informed cost/benefit assessment of improving the systems in place.	30/06/2020	07/07/2020	Blanshard, Dr Christine (Inactive User)								
										Management action from pwc audit: Cancer services are in the process of constructing a policy that which outlines clear data quality requirements for recording the referral to treatment data on the Trusts systems to ensure accuracy and completeness of the data and make it readily available to staff.	30/09/2020		Scutt, Emilia								
										Central booking team to have reduced the un-outcome patients to zero by the end of June.	31/07/2020		Critchley, Jennifer								
										Add an alert to every patient's Lorenzo record who has been diagnosed with cancer since 2015. (The intention is that cancer services will be adding these alerts and follow up codes to Lorenzo on a monthly basis going forward. They will be able to audit against this to ensure patients are not missed.)	31/12/2020		Scutt, Emilia								
										Add a follow up code to every cancer patient's Lorenzo record, linked to their original referral. (The intention is that cancer services will be adding these alerts and follow up codes to Lorenzo on a monthly basis going forward. They will be able to audit against this to ensure patients are not missed.)	31/12/2020		Scutt, Emilia								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	May recur occasionally	Moderate	9	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/12/2020	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	13/08/2019
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa								
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly								
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020		Thomas, Lisa								
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan								
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy								
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew (Inactive								
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020		Burwell, Jonathan								
										Full review of standard operating procedures including adherence	31/12/2020		Scott, Andy								
										Full implementation of IT general controls framework	31/12/2020		Scott, Andy								
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan								
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Riesk Register
5972	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	As a result of deeply rooted historic ways of working, resistance to change and the absence of a mature continuous improvement culture, there is a risk that improvement and transformation is not delivered in a timely manner. This may result in poor quality services, reputational damage, financial impact, ineffectiveness, an inability to attract and retain high quality staff and non-delivery of strategic and or corporate priorities.	May recur occasionally	Moderate	9	Review of role and purpose of Innovation Committee; develop a clear approach for innovation	13/12/2019	21/02/2020	Provins, Esther	Trust Board	31/12/2020	6	Innovation (Resources)	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Director of Transformation	Provins, Esther	23/08/2019
										Introduce a Dragon's Den event to inspire, promote and reward innovation	30/07/2020	19/08/2020	Provins, Esther								
										Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther								
										Review effectiveness of Quality Improvement plan.	01/06/2020	19/08/2020	Provins, Esther								
										Implement Quality Improvement plan (see also risk 6138).	31/03/2021		Provins, Esther								
										Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther								
										Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/12/2020		Provins, Esther								
										Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	28/08/2020	03/09/2020	Hyett, Andy								
										Escalate discussions with system partners regarding levels of DToCs. *Action covered by Corporate Risk 5751. Please see risk 5751*	31/12/2019	04/03/2020	Hyett, Andy								
										Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	28/08/2020	19/08/2020	Provins, Esther								
										Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020	21/02/2020	Provins, Esther								
										Undertake a CIP assurance exercise for 19/20	11/01/2020	21/02/2020	Provins, Esther								
										Delivery of Best Place to Work programme.	29/01/2021		Lane, Lynn								
										Delivery of phase 1 of NHS Improvement Cultural Leadership Programme.	31/07/2020	18/08/2020	Lane, Lynn								
										Delivery of 20/21 Transformation Priorities.	31/03/2021		Provins, Esther								

Corporate Risk Register
December 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6470	Finance and Procurement	Trustwide	24/05/2020	COVID-19/Coronavirus, Financial management	12	There is financial uncertainty for the year 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures. The guidance is currently issued to July 2020, beyond this it is unclear as to how the Trust will be funded.	May recur occasionally	Moderate	9	cash flow forecast to ensure cash flow risk monitored closely	30/06/2020	17/06/2020	Ellis, Mark	Finance and Performance Committee	31/12/2020	9	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	26/05/2020
5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob (Inactive User)	Information Governance Steering Group	31/12/2020	6	Resources	Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	11/02/2020
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob (Inactive User)								
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan								
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen								
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen								
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen								
										Windows 10 migration complete	31/12/2020		Arnold, Jon								
										Cyber essentials plus accreditation achieved	30/06/2021		Carman, Mr Stephen								
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan								
										Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen								
										ATP to be installed on Servers	31/12/2020		Gibson, Richard								
										External CORS review to be undertake to support progress review	30/11/2020		Burwell, Jonathan								
										Test implementation of IT Health Assurance Dashboard	30/11/2020		Burwell, Jonathan								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5487	Finance and Procurement	Finance Department	26/07/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation. Covid 19 places increased uncertainty with changes in demand impacting on subsidiary cash flows.	Will undoubtedly recur, possibly frequently	Minor	10	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	21/12/2018	19/12/2018	Thomas, Lisa	Finance and Performance Committee	31/12/2020	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	16/10/2018
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	31/01/2020	18/02/2020	Thomas, Lisa								
										Subsidiary companies to recruit or establish suitable qualified financial support.	31/03/2020	24/05/2020	Thomas, Lisa								
										- Issue of Subsidiary performance challenges in light of COVID 19 raised to NHSI/E for clarification of treatment	15/07/2020	26/08/2020	Ellis, Mark								
5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	The inability to provide a full gastroenterology service due to a lack of medical and nursing staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed. See also linked Risk 5644 (CSFS Gastroenterology Risk).	Will probably recur, but is not a persistent issue	Moderate	12	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	Intensive Support Meeting	31/10/2020	12	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	31/01/2019
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa								
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali								
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali								
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew								
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy								
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy								
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy								
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart								
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine (Inactive								
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy								
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy								
										To recruit medical and nursing staff for the GI Unit.	31/12/2020		Lane, Lynn								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6043	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	12	The lack of a national clear model for small rural DGH services places future strategic planning uncertain at SFT. The funding regime and clinical models of care as advocated by royal college guidelines are built around average Trusts. SFT is more geographically challenged and smaller than an average DGH which in turn places its future as an independent Trust at risk which could limit and damage service provision to the local population.	Will probably recur, but is not a persistent issue	Moderate	12	Nuffield Trust are visiting SFT in January 2020 to assess and offer help on development of the South Wiltshire Urgent Care Model.	28/02/2020	18/02/2020	Hyett, Andy	Trust Board	31/12/2020	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	25/10/2019
										Development of system plans for sustainability of NHS elective care	31/03/2020	24/05/2020	Humphrey, Kieran								
										Trust part of BSW drivers of the deficit work to ascertain the financial issues in BSW, of which size and geography will be identified.	31/07/2020	26/08/2020	Thomas, Lisa								
										work with BSW to develop Financial sustainability plan for BSW to be agreed by March 2021	31/03/2021		Thomas, Lisa								
5966	Medicine	Trustwide	20/08/2019	Trustwide risk assessment	12	Services which are provided to the trust by another provider on a networked or hub-and-spoke arrangement can be compromised if the provider runs into operational or workforce difficulties. It is likely that services will be withdrawn from our site as they consolidate at the hub. Examples are vascular, interventional radiology, clinical oncology, medical oncology, renal medicine, neurology and various paediatric specialties.	Will probably recur, but is not a persistent issue	Moderate	12	Interventional Radiology: Work with commissioners to secure service provision with another provider.	30/11/2019	31/12/2019	Vandyken, Mrs Ali	Trust Board	31/08/2020	9	Care	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	21/08/2019
										Oncology: Develop additional joint working and new posts. update 06/05/20 - collaborative work with UHS continuing and they have been very supportive during COVID. We are currently not considering any joint posts but this may change as we ease out of COVID and head in to the recovery phase. We have an update meeting with UHS on 07/05/20.	01/09/2020		Clarke, Lisa								
										Vascular: Set up a vascular network meeting.	30/09/2019	25/10/2019	Murray, Dr Duncan								
										Renal: Signed Service Level Agreement with Portsmouth for provision of renal services.	31/10/2019	25/10/2019	Clarke, Lisa								
										Continued meetings every two weeks with UHS. Dr Shablak's planned sabbatical to go to Qatar has been postponed until November due to COVID, so will work here until end Oct. Proposal to cover Dr Shablak's absence with two SpRs but one of those has now got a permanent role. Will update again after next UHS update.	01/09/2020		Barrett, Mrs Jessica								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5970	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	May recur occasionally	Major	12	Development of an IT improvement plan which includes staffing, communications, infrastructure, governance and any outstanding pen test/audit actions.	22/11/2019	11/12/2019	Provins, Esther	Finance and Performance Committee	31/12/2020	9	Innovation	Finance and Performance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	23/08/2019
										Set up monthly executive performance reviews.	30/09/2019	31/10/2019	Provins, Esther								
										Completion of internal audit action plans and penetration test action plans.	31/12/2019	02/03/2020	Burwell, Jonathan								
										To complete the review and proposal for improving our capacity to do business change.	30/06/2020	18/06/2020	Provins, Esther								
										Agree long term direction of the EPR and short/medium term investment.	15/07/2020	19/08/2020	Burwell, Jonathan								
										Develop, agree and implement a new range of informatics service standards	19/05/2020	19/06/2020	Burwell, Jonathan								
										Conclude work to agree and commence implementation of a robust and fit for purpose service delivery model	29/03/2020	28/04/2020	Burwell, Jonathan								
										Develop and implement a communications and engagement plan aligned to digital strategy	15/01/2020	02/03/2020	Burwell, Jonathan								
										Evolve current change management approach, ensuring it is comprehensive, clinically led	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement an Informatics team development programme	30/06/2020	01/08/2020	Burwell, Jonathan								
										Strengthen clinical leadership in informatics by reaffirming priorities for CCIOs and appointing to CNIO roles	31/12/2020		Provins, Esther								
										Embed information analysts into directorate management teams	31/01/2021		Burwell, Jonathan								
										Informatics staff to undertake relevant customer service training	30/09/2020	23/10/2020	Burwell, Jonathan								
										Work with BSW to agree a shared EPR approach.	30/11/2020		Provins, Esther								
										Recruitment of Lead Information Business Partner	30/11/2020		Burwell, Jonathan								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6247	Estates	Estates	10/03/2020	Directorate risk assessment	12	As a result of a comprehensive external review of the Estates function it has been identified that the Trust has significant risks associated with critical plant and building infrastructure, that may result in utility or system failure. Including: Water ingress leading to a loss of building use. Failure to maintain critical plant leading to failure of systems e.g. nurse call, ventilation, power, gas, water, lifts and pressure systems. Failure to ensure compliance with mandatory training, leading to an inability to maintain plant. Lack of appropriately trained staff to undertake preventative maintenance. In ability to complete mandatory returns or compliance checks/reporting. Failure to mitigate these risks may result in the loss of buildings and services/utilities, for clinical functions.	May recur occasionally	Major	12	The Estates Transformation Steering Group has been formed with an action plan detailed to mitigate these risks.	01/09/2020	18/08/2020	Lane, Lynn	Executive Director Meeting	01/12/2020	8	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	16/03/2020
										Work through action plan to address health and safety breaches identified in the Critical Plant Survey.	31/12/2020		Frith, Gerry								
										Completion of actions arising from the independent Estates review (Cammies Report). The delivery of these objectives are managed via the Estates Transformation Board.	31/12/2020		Frith, Gerry								
										A plan for investment needs to be identified to address remaining concerns highlighted in the critical plant survey in July 2020.	31/12/2020		Frith, Gerry								
										As a result of the May 2020 review, a plan for investment to reduce the Trusts back log of maintenance is required.	31/12/2020		Frith, Gerry								
										Capital Prioritisation Group to prioritise funds for Estates.	01/04/2021		Thomas, Lisa								
6102	Organisational Development and People	Trustwide	06/12/2019	Other assurance not listed	16	Risk of being unable to fill Medical Workforce Gaps which may include posts identified as hard to fill. Risk is that they will remain hard to fill with the result that we are forced to continue costly Agency/Locum support and/or outsourcing and/or discontinue services	Will probably recur, but is not a persistent issue	Moderate	12	Head of Resourcing to focus time on Medical Recruitment issues and to feedback to Deputy Director of OD and People	31/01/2020	03/02/2020	Holt, Sharon	Executive Workforce Committee	31/12/2020	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Holt, Sharon	14/02/2020
										Lead Clinicians to follow up with potential recruitment leads for specific posts	30/06/2020	06/07/2020	Holt, Sharon								
										Hard to recruit plans to be routinely updated with Head of Resourcing, BP's, CD's and DM's	31/12/2020	06/07/2020	Holt, Sharon								
										Attendance at Doctors Job Fair (29 February 2020). To report back on success of event and any actions required.	31/03/2020	26/05/2020	Holt, Sharon								
										Review of current recruitment process to ensure efficient and conducted in timely manner to mitigate against the potential loss of candidates applying for positions.	29/02/2020	26/05/2020	Holt, Sharon								
										Successful recruitment to Medical Workforce Manager post.	31/10/2020		Craine, Sarah								
										Paper to be submitted to Executive Team on possible Trust incentives to be offered/applied to Medical vacant posts.	01/02/2021		Holt, Sharon								

Corporate Risk Register
December 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6487	Quality Directorate	Trustwide	04/06/2020	COVID-19/Coronavirus	12	As a result of the potential second wave of the Covid-19 pandemic there is a risk that the Trust will not be able to safely staff ward areas, Emergency Department and Critical Care. Not being able to safely staff these areas may result in patient harm, staff undertaking duties for which they are not fully prepared and poor patient experience.	Will probably recur, but is not a persistent issue	Moderate	12	Agree rebased staffing levels for ICU and RCU.	30/11/2020		Hyett, Fiona	Trust Board	01/01/2021	6	People (Care)	Trust Board (Corporate Risk Register)	Director of Nursing	Hyett, Fiona	10/07/2020
										Continue recruitment of nursing staff.	01/09/2020	30/10/2020	Holt, Sharon								
										Ongoing upskilling of the nursing workforce.	31/12/2020		Hyett, Fiona								
										Continuation of the returning workforce and paid student placement programmes.	14/08/2020	10/07/2020	Hyett, Fiona								
										Twice daily staffing review using safe care and roster data.	30/09/2020	10/07/2020	Hyett, Fiona								
										Work with Exec Director of OD&P regarding management of shielding staff.	30/09/2020	03/11/2020	Dyos, Judy								
										Review of Covid Risk Assessment process in light of new guidance.	31/12/2020		Lane, Lynn								
6658	Clinical Support and Family Services	Maternity Administration	08/09/2020	Specialty Risk assessment	16	Nationally maternity services have been an area for concern and review . Within this Trust a higher number of Serious incidents have been noted and the maternity team have struggled to complete actions plans within expected timeframes leading to concerns that there has been a failure to embedded lessons learned. Further concerns have arisen via the Freedom to speak up guardian in relation to cultural behaviours.	May recur occasionally	Major	12	Externally led Cultural review to be undertaken reviewing key Terms of reference related to culture and behaviours	30/11/2020		Lane, Lynn	Trust Board	15/12/2020	4	Care	Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	08/09/2020
										Externally led Clinical review to be undertaken reviewing key Terms of reference related to key clinical processes, SII management and maternity governance .	31/10/2020	03/11/2020	Dyos, Judy								
										Intensive executive support and SII exit meetings to be expedited	30/11/2020		Provins, Esther								
										Executive Director of Nursing to attend monthly CNST meeting	30/09/2020	24/09/2020	Dyos, Judy								
										Improvement programme to be developed based on external clinical review findings.	31/01/2021		Dyos, Judy								

Corporate Risk Register
December 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6654	Operations Directorate	Trustwide	02/09/2020	COVID-19/Coronavirus, National guidance	15	The impact on service delivery as a result of Covid 19 and the subsequent infection control requirements impacting on the ability of the Trust to recover activity to pre-Covid Levels. The consequence of not achieving this would be delay to treatments, impact to quality of care and impact on performance.	Will undoubtedly recur, possibly frequently	Moderate	15	Delivery of Phase 3 action plan.	31/01/2021		Hyett, Andy	Trust Board	01/12/2020	9	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	02/09/2020
										Short term pay incentives for Theatre staff.	01/11/2020		Dyos, Judy								
										Managing Estates priorities and risk mitigation.	01/04/2021		Hyett, Andy								
6471	Finance and Procurement	Trustwide	24/05/2020	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	Raise issue of capital funding for strategic replacement of key estate with regional director of FInance	31/07/2020	26/08/2020	Thomas, Lisa	Trust Board	31/12/2020	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	26/05/2020
										In response to critical infrastructure review need to prioritise capital spending plan for next 5 years to address concerns.	30/10/2020		Robinson, Ian								
										Escalate risks to estate through NHSI capital funding route, with a view to source funding for replacement day surgery as a minimum	31/12/2020		Thomas, Lisa								
6212	Medicine	Trustwide	21/02/2020	Service Delivery Plan, Specialty Risk assessment	15	As a result of not receiving a follow up appointment in the required time-frame, there is a risk that patients with cancer (e.g. melanoma patients) will experience clinical deterioration in between follow-up appointments which may result in patient mis-management, disease progression, limited treatment options and patient harm. Examples- Cancer, Opthalmology and Dermatology (particularly melanoma patients not being seen at 3 month intervals). See also closed risks 4107 and 5421.	Will undoubtedly recur, possibly frequently	Moderate	15	Development of new Lorenzo flag for patients whose follow-up appointments should not be slipped.	30/06/2020	02/09/2020	Insull, Victoria	Directorate Management Team Meeting	30/10/2020	9	Local Services (Care)	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	06/03/2020
										Develop telephone and virtual clinics to increase clinic capacity.	01/12/2020	25/08/2020	Arnett, Louise								
										Develop and roll-out a system for recording outcome forms electronically.	31/12/2020		Provins, Esther								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	16	Risk of patient harm caused by a delayed discharge from hospital. This risk is caused by lack of capacity within the community and delay in internal processes within the hospital.	Will undoubtedly recur, possibly frequently	Moderate	15	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	01/12/2020	12	Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	11/03/2019
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy								
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy								
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy								
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy								
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy								
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy								
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy								
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy								
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy								
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy								
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy								
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy								
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy								
										Action plan to be developed for 2021 by Urgent Care Board.	01/11/2020		Hyett, Andy								
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy								

v6.4	Rating (initial)	Rating (current)	Rating (Target)	v6.3	Rating (initial)	Rating (current)	Rating (Target)	
5360	15	10	6	5360	15	10	6	0
5487	12	10	6	5487	12	10	6	0
5704	16	12	12	5704	16	12	12	0
5751	16	15	12	5751	16	15	12	0
5955	15	9	9	5955	15	9	9	0
5966	12	12	9	5966	12	12	9	0
5970	16	12	9	5970	16	12	9	0
5972	16	9	6	5972	16	9	6	0
6043	12	12	6	6043	12	12	6	0
6099	12	9	9	6099	12	9	9	0
6102	16	12	9	6102	16	12	9	0
6129	20	6	6	6129	20	6	6	0
6134	16	6	6	6134	16	6	6	0
6143	16	8	6	6143	16	8	6	0
6212	15	15	9	6212	15	15	9	0
6213	12	9	6	6213	12	9	6	0
6247	12	12	8	6247	12	12	8	0
6470	12	9	9	6470	12	9	9	0
6471	15	15	8	6471	15	15	8	0
6472	12	8	8	6472	12	8	8	0
6487	12	12	6	6487	12	12	6	0
6654	15	15	9	6654	15	15	9	0
6658	16	12	4	6658	16	12	4	0
6731	8	6	1					Added
				6690	12	12	6	Removed

Initial Score Change	Current Score change	Target Score Change
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	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	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0

v6.3	Rating (initial)	Rating (current)	Rating (Target)
5360	15	10	6
5487	12	10	6
5704	16	12	12
5751	16	15	12
5955	15	9	9
5966	12	12	9
5970	16	12	9
5972	16	9	6
6043	12	12	6
6099	12	9	9
6102	16	12	9
6129	20	6	6
6134	16	6	6
6143	16	8	6
6212	15	15	9
6213	12	9	6
6247	12	12	8
6470	12	9	9
6471	15	15	8
6472	12	8	8
6487	12	12	6
6654	15	15	9
6658	16	12	4
6690	12	12	6

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	14 January 2021		

Report Title:	Q2 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):				

Recommendation:
The Board is asked to note this report.

Executive Summary:

This report provides a report of activity for Q2 2020/21 in relation to complaints and the opportunities for learning and service change. Some key changes are highlighted below:

- The PALS team have been found a new home in offices close to The Green Entrance and hopes to move in Q3. This will make PALS more visible and accessible for visitors.
- The main theme of complaints this quarter across the clinical divisions was 'attitude of medical staff'. The second theme is appointments (our procedures, delays) and this theme is one that is seen in the concerns raised in Q2
- Issues to do with appointments remain a significant theme seen in concerns
- With the relaxation in visitor restrictions have seen an increase in the number of complaint meetings offered and held. Seven complaint meetings were held in Q2.
- Most FFT responses are positive (very good or good). The additional free text question is providing a number of valuable topics for improvement
- The cancer survey 2019 (published June 2020) demonstrated very positive findings with the Trust being (positive) outliers for six questions.

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 going forward

- The PALS team have been found a new home in offices close to The Green Entrance and hopes to move in Q3. This will make PALS more visible and accessible for visitors.

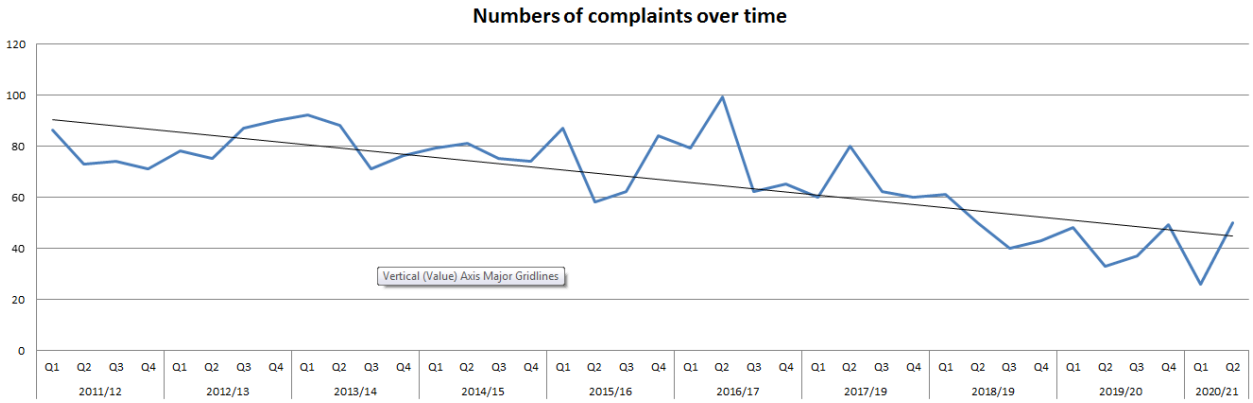
1. Sharing Outstanding Excellence (SOX)

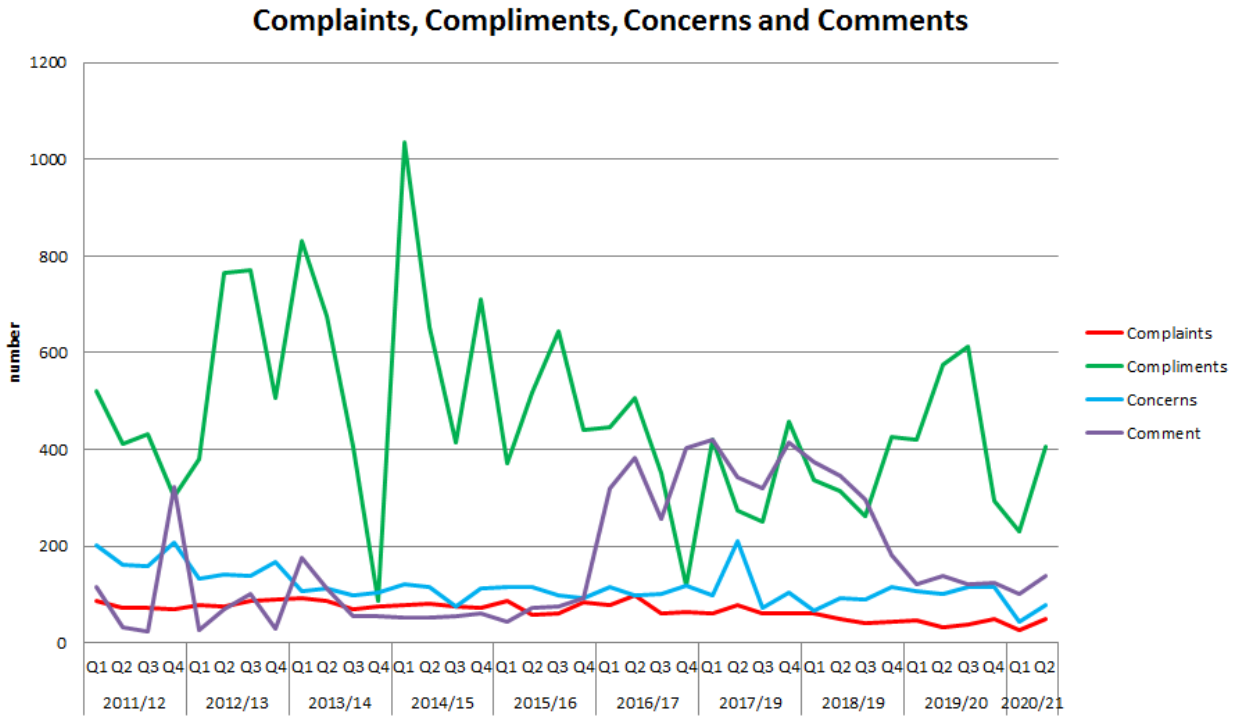
There is growing awareness nationwide that since complaints are a small minority compared to other PALS feedback, learning from what goes well in a Trust is as important as learning from complaints. In this Trust, a positive report is known as a SOX.

The PALS team (and patient representatives going forward) review all the SOX nominations and chose a selection to go forward to the Trust Board where recipients receive a certificate.

2. Complaints

The graph overleaf shows the numbers of complaints, compliments, concerns and comments over time. Below you can see that complaints continue to show a slight downward trend.





Complaint themes Q2

	CSFS	Medicine	Surgery	Trustwide	total
Appointment system - procedures	0	0	2	0	2
Clinical Treatment - Obstetrics and Gynaecology	3	0	0	0	3
Correct diagnosis not made	1	3	0	0	4
Delay in making diagnosis	1	1	2	0	4
Delay in receiving appointment	0	2	1	0	3
Delay in receiving treatment	0	1	1	0	2
Discharge procedures	0	1	0	0	1
Drug Error	0	1	0	0	1
Early discharge	0	1	2	0	3
Falls	0	3	0	0	3
Further complications	0	0	2	0	2
Insensitive communication	0	1	0	0	1
Lack of Care	0	0	1	0	1
Lack of communication	0	0	1	0	1
Meal not available	0	0	1	0	1
Neglect	1	1	0	0	2
Operation delayed following admission	1	0	0	0	1
Pain management	0	0	1	0	1
Patient Confidentiality	1	0	0	0	1
Unsatisfactory treatment	1	1	2	1	5
Wrong information	1	0	0	0	1
Attitude of nursing staff	0	1	0	0	1
Attitude of staff - medical	2	2	2	0	6
Total	12	19	18	1	50

In Q2 the Trust treated 26,455 people as inpatients, day cases and regular day attendees. Another 28,487 people were seen in the Emergency Department (includes the walk-in clinic) and 40,455 as outpatients (this excluded telephone calls). 50 complaints were received which is 0.052% of the number of patients treated.

407 compliments were received across the Trust in Q2. Those sent directly to the Chief Executive, PALS or via the SOX inbox 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.

Concerns, comments and enquiries closed within 10 working days of receipt.

A total of 348 comments, concerns and enquiries were logged by PALS this quarter. Of this number 87.3% were closed within 0 -10 days.

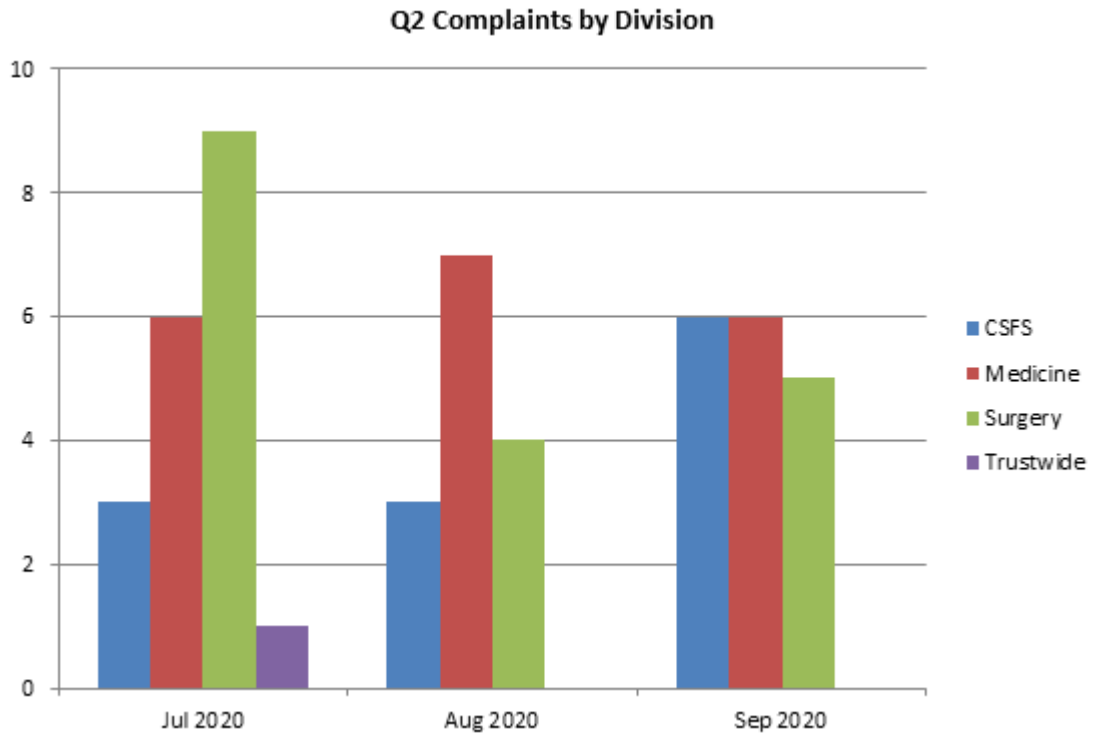
Concerns, enquiries and comments - closed within 10 working days	No.	%
Not yet closed	20	5.75
0-10 working days	304	87.36
11-24 working days	10	2.87
25+working days	14	4.02
Total	**348**	

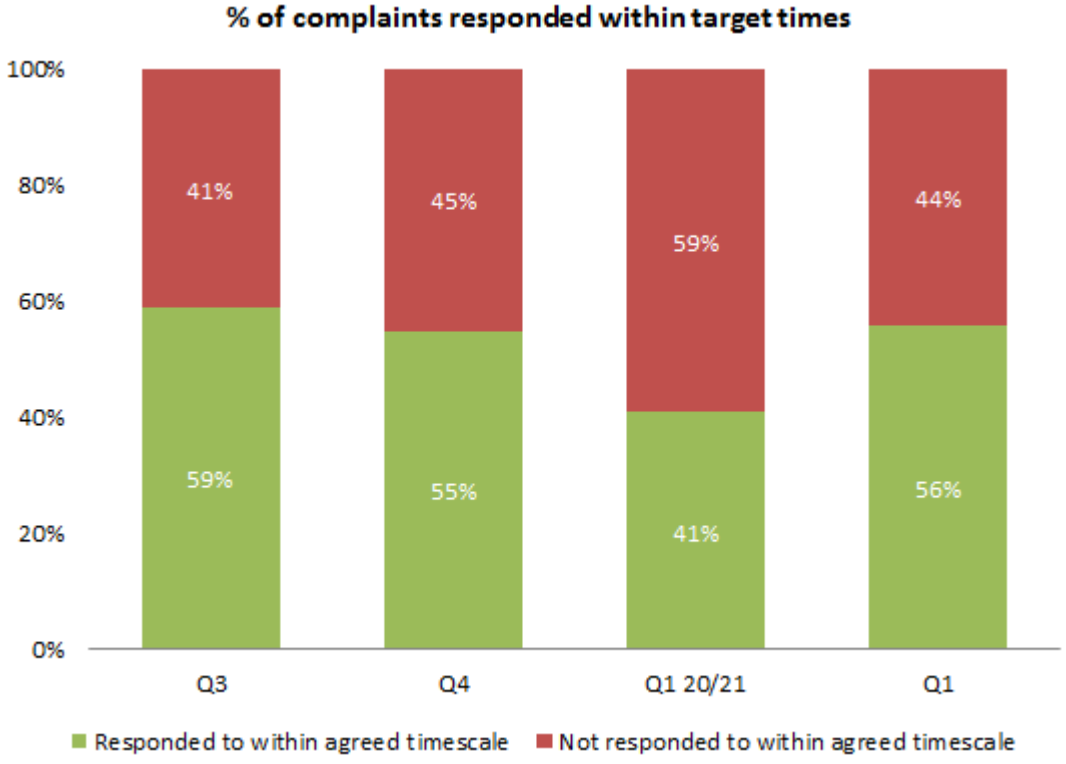
The main theme of complaints this quarter across the clinical divisions was 'attitude of medical staff'. The second theme is appointments (our procedures, delays) and this theme is one that is seen in the concerns raised in Q2.

Concern themes Q2

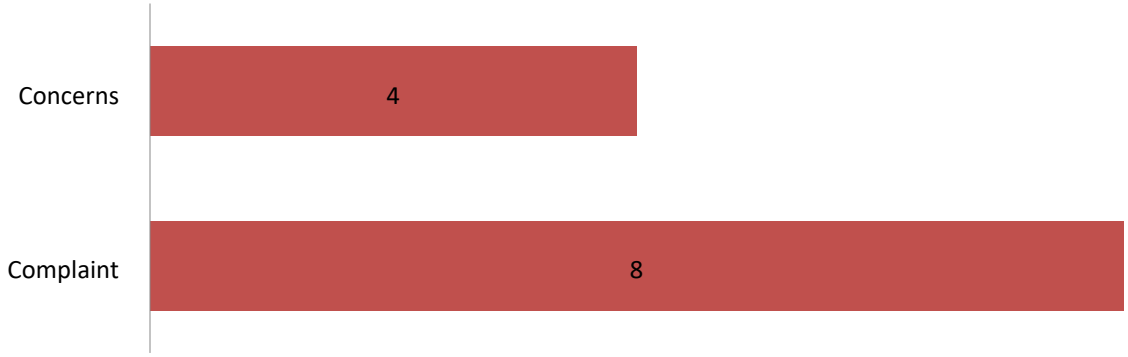
	CSFS	Facilities	Medicine	Quality	Surgery	totals
Appointment date required	0	0	0	0	4	4
Appointment postponed	0	0	0	0	1	1
Appointment system - procedures	2	0	0	0	3	5
Assistance not given	0	0	0	0	1	1
Clinical Treatment - Surgical	0	0	0	0	3	3
Clinical Treatment - ED	0	0	2	0	0	2
Clinical Treatment - Medicine	0	0	2	0	0	2
Clinical Treatment - Paediatrics	1	0	0	0	0	1
Correct diagnosis not made	0	0	0	0	1	1
Covid-19	0	0	1	1	3	5
Damaged Property	0	0	0	0	1	1
Delay in receiving appointment	0	0	1	0	2	3
Delay in receiving treatment	1	0	1	0	5	7
Discharge procedures	0	0	1	0	0	1
Drug Error	0	0	1	0	0	1
Early discharge	0	0	2	0	0	2
Falls	0	0	1	0	0	1
Further complications	0	0	1	0	2	3
Incorrect medical records	0	0	1	0	0	1
Information not given to family	0	0	1	0	0	1
Insensitive communication	0	0	2	0	0	2
Lack of communication	2	0	2	0	4	8
Opening times	0	0	1	0	0	1
Operation cancelled following admission	0	0	0	0	1	1
Operation delayed	0	0	0	0	2	2

Pain management	0	0	0	0	1	1
Unsatisfactory arrangements	0	0	3	0	1	4
Unsatisfactory treatment	2	0	6	0	0	8
Wrong information	0	0	0	0	1	1
Attitude of nursing staff	0	0	1	0	0	1
Attitude of staff - admin	0	0	2	0	0	2
Attitude of staff - medical	0	0	0	0	1	1
Attitude of staff - other	0	1	0	0	0	1
total	8	1	32	1	37	79





Number of reopened concerns and complaints in Q2 20/21



The reasons cited for complaints and concerns being reopened remain the same as for previous quarters. Many complainants feel that not all the issues they raised were addressed fully within the response or they believed that the explanation or opinions offered differed from their own experiences.

PALS are waiting for a response from Facilities for one concern (initially raised in January 2020) that has not yet been closed.

With the relaxation in visitor restrictions have seen an increase in the number of complaint meetings offered and held. Seven complaint meetings were held in Q2.

3. Complaints by directorate

Clinical Support and Family Services

	Q2 2019-20	Q1 2019-20	Q2 2020-21
Complaints	5	1	12
Concerns	14	3	7
Compliments	96	32	32
Re-opened complaints	1	1	4
% closed complaints responded to within agreed timescale	40%	0%	12%
Complaints closed in this quarter	-	3	8
% concerns responded to within 25 working days	-	100%	75%

- There were 12 complaints raised in Q2 with Gynaecology receiving the most (n=4). The main theme was unsatisfactory clinical treatment.
- 4 complaints were re-opened in Q2 due to either the complainant disagreeing with what was said in the final response letter or feeling that not all of their questions had been answered satisfactorily.
- 8 complaints were closed in Q2; with only 1 being responded to within the agreed timescale. The delays were due to the directorate awaiting statements from relevant doctors and staff members.
- 7 concerns were raised in Q2 across the directorate with no particular themes noted.
- The PALS department received 20 comments and enquiries for CSFS in Quarter 2 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 8025 and of this number 0.1% raised a complaint.
- There are no action plans outstanding from the division.

Themes and actions from concerns and complaints closed in this quarter

Q2 themes		
Department	**Themes**	**Actions**
Gynaecology	Unsatisfactory clinical treatment	Clinical Lead will be reviewing the previous 12 months of concerns and complaints relating to Gynaecology. Themes and learnings to be presented to CSFS DMT.
Q1 themes – there were no identified themes in Q1		

Compliments

CSFS received 32 compliments in Q2; the breakdown is as follows:

Bowel Screening =5, Gynae =1, Labour =1, Maternity =1, Pathology =1, Pharmacy =1, Radiology =4, SALT =1 and Sarum ward =17.

Medicine division

	Q2 2019-20	Q1 2019-20	Q2 20-21
Complaints	15	16	19
Concerns	39	25	31
Compliments	308	116	126
Re-opened complaints	0	1	4
% closed complaints responded to within agreed timescale	80%	54%	79%
Complaints closed in this quarter	-	11	19
% concerns responded to within 25 working days	-	75%	88%

- The Emergency Department received the most complaints (n = 8), the main theme being discharge procedures and incorrect diagnosis.
- 19 complaints were closed in Q2 and of these 16 were responded to within the agreed timescale. The Medicine Division have done really well in regards to closed concerns and complaints in Q2 by responding to them within the agreed timescale. The compliance against agreed timescales has therefore increased significantly from the previous quarter.
- 4 complaints were re-opened in Q2, which is an increase from previous quarters. The reason for these being re-opened were due to the complainants feeling their answers were not satisfactorily answered. The complainants have been offered a meeting to discuss their outstanding concerns..
- There were 31 concerns raised in Quarter 2. The Emergency Department received the most with 10, the theme being insensitive communication and attitude of staff. AMU received 5 concerns with no particular theme.
- The PALS department received 52 comments and enquiries for Medicine in Quarter 2 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 27554 and of this number 0.06% raised a complaint.
- The Complaints Co-ordinator is waiting for 6 outstanding action plans from closed complaints since 1st April 2019 for the Medicine directorate. These have been chased.

Themes and actions from concerns and complaints closed in this quarter

Q2 20-21 themes		
Department/Ward	**Topic**	**Action**
Emergency Department	Unsatisfactory discharge procedures.	Continued work to ensure the all patients have an ED discharge summary and that all junior doctors ask for a senior review prior to discharging patients.
	Incorrect diagnosis made.	Each complaint is reviewed by a clinician to ascertain if a diagnosis has been missed or simply perceived to have been missed. If there are learning needs the consultants have been
	Insensitive communication	

	Attitude of nursing and admin staff	reviewing the pathways and ensuring that all staff are aware of the learning from the complaint. During this difficult time we have had several issues with communication – complex, new processes for patients, regular changes to staff workloads etc. It has undoubtedly raised the number of dissatisfied customers in ED and for a lot of staff has been the most challenging time of their career. We have dealt with these complaints on an individual basis with each member of staff taking time to reflect on attitudes and behaviours and how this could be improved upon whilst recognising the processes which have created patient unrest – Planned changes to waiting areas, navigation around department should help reduce confusion and support staff with irate patients.
Feedback on actions from the previous quarter's themes		
Q1 (2020/21)		
Emergency Department Unsatisfactory treatment	Prompt telephone contact with complainants. Work within the department with setting professional behaviours and encouraging civility, compassion etc. Focus on education and training of staff - increased SIM activity which includes communication of difficult news to patients and relatives. Development of a new junior doctor rota pattern to include dedicated time for learning and development	This has been a real challenge since COVID. We have tried to have prompt contact but in reality complaints have fallen quite out of date. We have displayed posters with House Rules and reminders to be kind etc.
Farley RCU Unsatisfactory treatment and communication	Many of these concerns are around the problems highlighted because of Covid-19 and the lack of visiting by relatives. A white board has been set up in the office on RCU to record all conversations with families and should be completed at least once during the day. There has been a general theme around communication throughout medicine as a whole. Also Farley/RCU, Spire and Laverstock are setting up communication sessions for staff especially around end of life issues. 1 has taken place more to be announced	This is ongoing with commitment to ongoing SIM training and the new rota has been launched and we are seeing protected SPA time for junior docs as well as our senior doctors happen regularly There are still ongoing challenges with regards to the lack of visitors due to the COVID restrictions. The Medical wards are trialling new handover sheets to better communication between staff and relatives.

Compliments

AMU=17, Durrington=12, ED=9, Haematology=1, Hospice=38, Pembroke=11, Pitton=8, Spire=23, Stroke=20, Tisbury=21 and Whiteparish=18.

Surgical Division

	Q2 2019-2020		Q1 2020-21	Q2 2020-21
	Surgery	MSK	Surgery	Surgery
Complaints	4	8	8	18
Concerns	23	21	10	37
Compliments	95	29	64	165
Re-opened Complaints & Concerns	2	1	3	5
% closed complaints responded to within agreed timescale	25%	75%	28%	36%
Complaints closed in this quarter	-	-	18	11
% closed concerns responded to within 25 working days	-	-	37%	41%

- There were 18 complaints received this quarter with Endoscopy having the most (n=3). The Endoscopy complaints were about Communication & Care; Patient Unhappy with Treatment; and Attitude of Consultant.
- There were 4 complaints about Delayed Diagnosis/Treatment across 4 specialities. There were 4 complainants who were unhappy with Inpatient Care across 3 specialities (2 were for the Spinal Treatment Centre). Three complaints about Communication across 3 specialities.
- There were 2 complaint meetings held in this quarter.
- There were 37 concerns raised in Quarter 2. Central Booking and Orthopaedics received the most with 7 each (one was a joint Central Booking/Orthopaedics case). Ophthalmology received 6 concerns.
- Four of the Central Booking cases involved appointment delays/restrictions due to COVID-19. Three of the Orthopaedic concerns were due to appointment/operation delays due to COVID-19.
- The main themes for concerns were; appointment/operation delays due to COVID-19, with 12 cases across 7 specialities; and 'unhappy with treatment', with 8 cases across 5 specialities.
- There were 5 concerns re-opened in Quarter 2 (one was re-opened twice). Three are still open and a meeting is being arranged for the fourth.
- The main themes for the 11 complaints closed in Q2 were; communication & discharge (n=2) and delay in making diagnosis (n=2).
- The main themes for the 19 concerns closed in Q2 were; appointment/operation delays due to COVID-19 (n=10) across 7 specialities; problems with communication (n=7) across 6 specialities; and unhappy with treatment (n=4) across 4 different specialities.
- The PALS department received 70 comments and enquiries for Surgery in Quarter 2 which were investigated, managed and responded to by the team.
- Total activity within the Division was 18,252 and of this number 0.1% raised a complaint.
- There is one action plan outstanding (8258) from closed complaints since 1st April 2020 for the Surgery Division. The actions have taken place but the dates are required to complete the action plan – DMT will forward to PALS and will be reported in Q3.

Themes and actions from concerns and complaints closed in this quarter:

Q2 2020-2021 themes Department/Ward	Topic	Action
Endoscopy	Communication & Care	Case will be discussed at the next Clinical Governance Session by the Band 6 Nursing Team on 19/11/2020.
Endoscopy	Attitude of Consultant	The doctor was providing services under the outsourced 18 Week Support contract. Case was highlighted to their Head of Governance & Risk, who liaised with doctor involved and provided written response assuring they will remind staff of importance

		of communication; summarise experience on learning log to aid reflection; and monitor complaints and feedback for this clinician over the next 3 months.
Endoscopy	Unhappy with Treatment	No action identified as the procedures were followed correctly.
Spinal Treatment Centre	Unhappy with Inpatient Care	No action identified on one case as we followed correct procedures. The other case is still being investigated due to staff sickness and is subject to an SII
Central Booking	Appointment Delays/Restrictions due to COVID-19	All outpatient and elective procedure waiting lists have been triaged by the specialty consultants and activity is taking place based on clinical priority. The Division is utilising telephone and video facilities for outpatient appointments where possible and clinically appropriate, and this supports activity taking place that would otherwise not be possible due to restrictions such as social distancing
Orthopaedics	Appointment/Operation Delays due to COVID-19	All outpatient and elective procedure waiting lists have been triaged by the specialty consultants and activity is taking place based on clinical priority. The Division is utilising telephone and video facilities for outpatient appointments where possible and clinically appropriate, and this supports activity taking place that would otherwise not be possible due to restrictions such as social distancing.

Q4 2019/20 themes and updates		
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. **Update Q1 2020:** The training plan is in progress. Activity in the laser clinic was put on hold as part of the Trust's response to the pandemic, and has not yet restarted. **Update Q2 2020:** Restarting of Laser activity has now been signed off. **Orthopaedic Department:** Patients are allocated follow up appointments as appropriate based on clinical priority; unfortunately over Q4, patients were waiting longer than initially indicated due to capacity issues. Details of this case has been shared with the relevant teams and lessons learnt. **Update Q2 2020:** All appointments on the waiting list have been triaged by consultants as part of the overall Trust response to the COVID-19 pandemic. Appointments are being booked based on clinical priority, using virtual medium, where possible.
Orthopaedic and Orthopaedic	Lack of information or	Miscommunication regarding treatment plan. Plan of care has been agreed with patient.

Outpatients	miscommunication	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. **Update Q1 2020:** Changes to template letters currently on hold due to COVID-19 as we are not currently able to undertake any routine orthopaedic procedures and several main theatres have been repurposed for the COVID-19 escalation. **Update Q2 2020:** We are sending orthopaedic patients to New Hall hospital and are working through the highest priority patients first as per the guidelines given to us by NHS England, these patients are being booked and pre-opted by New Hall who will be sending their own letters to these patients, therefore our template letters have not yet been changed for orthopaedic patients.
Amesbury Ward and Plastic Department.	Medication errors	Amesbury: Issues raised within the complaint have been shared with the team informally through team meetings and via the safety briefings. Amesbury: Apologies given regarding the omission of insulin. More education regarding the management of patient with diabetes is required. Training sessions will be undertaken. **Update Q1 2020:** Confirmation of training course dates to be confirmed within the next report. **Update Q2 2020:** There is Trust wide insulin training which is mandatory for RNs to complete.
Q3 2019/20 themes and updates		
Central Booking	Appointment Dates: Central Booking unable to book appointments in time due to capacity pressures in clinical areas meaning there aren't appointments available.	This is ongoing. Capacity issues are escalated to the department heads of the areas involved and discussed regularly to clinically triage those waiting and add extra clinics and appointments wherever possible. Due to the COVID-19 pandemic all outpatient and elective procedure waiting lists have been triaged by the specialty consultants and activity is taking place based on clinical priority. The Division is utilising telephone and video facilities for outpatient appointments where possible and clinically appropriate, and this supports activity taking place that would otherwise not be possible due to restrictions such as social distancing.

Compliments

165 compliments were received in Quarter 2, the breakdown is as follows:

Britford Ward = 32, Radnor Ward =27, Downton Ward = 26, Endoscopy = 19, Amesbury Suite = 18, Odstock Ward = 17, ENT = 5, Orthopaedics = 4, OMFS = 3, DSU = 4, Urology = 2, Rheumatology = 2, Central Booking = 2, Breast Team = 1, General Surgery = 1, Laser = 1, Plastic O/P = 1,

4. Parliamentary and Health Service Ombudsman (PHSO)

There were two closures in Q2. One complaint was not upheld by the Ombudsman and the other was partially upheld.

- The Ombudsman's feedback in regards to the partially upheld complaint was that although they acknowledged that there were no failings in the care of the patient, they highlighted a concern around the capacity assessment.
  A working party has been tasked with reviewing the Ombudsman's recommendations. Any learning will be cascaded and actions implemented across the Trust.

There were no new Ombudsman's cases reported this quarter.

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.

5. Trust wide feedback

Patients surveyed

A total of 512 patients provided feedback during the quarter through the Friends and Family Test (FFT). This is up from 296 in the last quarter. The number is increasing as we are encouraging areas to start displaying the FFT feedback forms again.

Friends and Family Test

Please note new question:

"**Thinking about…**" (**Britford Ward** for example) **"Overall, how was your experience of our service?"**

The possible responses are:

- ❑Very good
- ❑Good
- ❑Neither good nor poor
- ❑Poor
- ❑Very poor
- ❑Don't know

In addition to the new question there are two new free text boxes for patients to give specific feedback:

- What was good about your experience?
- Please tell us about anything we could have done better?

Responses for the quarter are set out in the table below.

		Rating											
	Total Responses Received	Very good		Good		Neither Good nor poor		Poor		Very poor		Don't know	
Day Case	67	65	98%	1	1%	0	-	1	1%	0		0	-
ED	12	4	33%	2	17%	1	8%	3	25%	2	17%	0	-
Inpatients	271	229	84.5%	39	14%	0	-	1	0.5%	2	1%	0	-
Maternity	26	23	88%	2	8%	1	4%	0	-	0		0	-
Outpatients	136	34	94%	1	3%	0	-	0	-	1	3%	0	-

Some feedback received this quarter

<u>What was good about your experience?</u>

- Good experience all round. Staff efficient, friendly and had time for patients concerns offering a listening ear and a professional expertise.
- Friendly and helpful staff. No problem was too much trouble. Felt very safe and informed at all times and post op toast was fabulous.
- My appreciation of phone calls during lockdown to tell you your service to detail. Thank you for your special care and assurance. Gives me peace of mind. Wonderful work. Please keep going. Thank you.
- Came in having everything, noise, chaos, waits, needles - ended up overwhelmed by your kindness, cheerfulness and sense of duty and reassuring extra work to protect us all.
- We had fantastic care. Nothing was ever too much trouble, despite the CV19 situation. Feel very lucky SDH is our local hospital
- For a large hospital it has the atmosphere of a small intimate caring environment. So important when patients are admitted nervous and worried. 10 out 10.

What could we have done better?

- Whilst waiting, try to keep me updated, as being on my own my mind began to wonder 'what if'!
- Lengthy discharge after being encouraged to wash and dress at 8am then sat waiting and feeling tired after surgery at 3pm. Yesterday still waiting at 1pm!
- Very hesitant to criticise but the surgical team could have given a more explanation of the procedure and set better expectations around the possibility of a patient putting up a fight on the way under and the way back. It would have been good to have updates post surgery, to have been less rushed and to have waited until I wasn't dealing with a distressed child. I appreciate the current challenges, the additional pressures and that probably came at the end of a long and under resourced shift.
- Very surprised, when seated and waiting next to water station that a member of staff came right next to me with no mask. When I commented he gave no reply. I was very concerned as I have to shield at home.
- Car parking charges should be reduced or free for patients. Even worse when you are told to come back for another appointment. It's too expensive.
- The only negative was being moved at 11.45pm to a different ward. That was inconsiderate and probably not necessary. However this was not a decision taken by the ward staff, but by an anonymous manager.

Patient and Public Involvement – National surveys

National Cancer Patient Experience Survey 2019 – published June 2020

The survey provides a '**snap shot**' of patients' experience of the whole cancer pathway (from visiting the GP pre-diagnosis, referral to secondary care, diagnostics and treatments and any related follow-up/support care received)

The 2019 survey involved 143 NHS Trusts. Out of 111,366 people, 67,858 people responded to the survey, yielding a response rate of 61%.

Locally the response rate was above that seen nationally at 69%.

The results for Salisbury NHS Foundation Trust were extremely positive in many areas but some aspects of care still require improvement and each specialist MDT at is developing an action plan.

The following questions are included in phase 1 of the Cancer Dashboard developed by Public Health England and NHS England:

- Q61. Patients' average rating of care was 8.7 (scale 0-10, 10 being top score)
- Q18. 79% Patient definitely involved as much as they wanted in decisions about care and treatment
- Q19. 91% Patient given the name of a CNS who would support them through their treatment
- Q20. 87% Patient found it very or quite easy to contact their CNS
- Q39. 94% Patient always felt they were treated with respect and dignity while in hospital
- Q41. 95% Hospital staff told patient who to contact if worried about condition or treatment after leaving hospital
- Q55. 59% General practice staff definitely did everything they could to support patient during treatment

Questions outside the expected range

In all bar one question the responses that fell outside the expected range far exceeded the national average.

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q23. Hospital staff discussed or gave information about the impact cancer could have on day to day activities	**90%**	79%	89%	**84%**
Q24. Hospital staff gave information on getting financial help or possible benefits	**75%**	54%	71%	**63%**
Q39. Patient always felt they were treated with respect and dignity while in hospital	**94%**	82%	94%	**88%**
Q52. Patient definitely given enough support from health or social services during treatment	**64%**	43%	61%	**52%**
Q53. Patient definitely given enough support from health or social services after treatment	**65%**	33%	57%	**45%**
Q57. Patient given a care plan	**44%**	32%	44%	**38%**

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q36. Patient always given enough privacy when discussing condition or treatment	**78%**	78%	91%	**85%**

The full report can be downloaded here: https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-Trust-Salisbury-NHS-Foundation-Trust-RNZ.pdf

Urgent and Emergency Care Survey 2020

This has been delayed due to the pandemic. The sample is being drawn inQ3 for patients treated in September.

Adult inpatient survey 2020

Work commences November 2020

Children and Young Persons Survey 2020

Work commences November 2020

Maternity Survey 2020

Again, this has been delayed and will commence in February 2021

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.

6. Health Watch Wiltshire feedback

Regular meetings are held between PALS and Health Watch Wiltshire and any feedback they receive about this hospital is shared with us.

7. Translation and Interpretation

The Procurement team have been working with PALS on a new tender for the interpretation and translation (Inc. BSL) managed service. The idea is that a 'one stop' service will be provided (BSL, video, telephone, face-to-face and translation of written material) .This piece of work has been done in conjunction with the other organisations in our STP. The invitation to respond to the tender has now been sent out and closes mid Q3.

In Q2 we saw a £506 spend for BSL.

8. Patient Stories

Patient stories are taken to every public Board meeting. The Trust's website is due for complete re-design (published as planned in October 2020) and will include a private section where patient stories can be posted for staff to access for individual/team learning.

9. NHS Digital

NHS Digital has suspended both the KO41a secondary care and KO41b primary care collections for Q4 2019-20 and Q1 2020-21 but have begun retrospectively collecting data from secondary care.

- 2019-20 Q4 (Jan-Mar) data will be collected from 7 September 2020 – 9 October 2020
- 2020-21 Q1 (Apr-Jun) and Q2 (Jul-Sep) data will be collected from 12 October 2020 – 20 November 2020

They aim to publish the 2019-20 Q4 data in November 2020 and the 2020-21 Q1 and Q2 data in January 2021.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

10. Patient and public involvement (PPI)

New website

The hospital's website has been launched. Patients and the general public have been involved at all stages of the development and a feedback facility has been made available now that the website is live. Comments received thus far have been very positive. Accessibility has also been tested with Mencap with positive feedback given on the functionality of the website.

Patient information app

The beta version of the hospital's patient information app has been tested and feedback has been very positive. It is hoped that the app will go live in Q3.

Low Risk Birthing Unit

An online meeting platform was used to meet with Mums to discuss design and décor of the birthing unit. Sessions were advertised on social media platforms and shared by the local breastfeeding support group and the Maternity Voices Partnership. A variety of engagement methods were offered by Artcare including a pack with a Dulux paint catalogue enclosed that was posted out to interested women.

Salisbury City Almshouses

Following a concern that was raised regarding an elderly patient resident in a warden-controlled flat managed by Salisbury City Almshouses a meeting with the hospital's Head of Integrated Discharge, Head of Patient Experience, the Trustees of Salisbury City Almshouses and a warden. The main topic of discussion was the lack of information they were given due to Information Governance constraints. A way forward was discussed and an information sharing agreement is being drafted.

Veteran/Armed Forces focus groups

PALS joined an online meeting with Alabare with the view to holding a focus group for Veterans as a 'Seldom Heard Voice'. It was decided this wasn't the best way to gather feedback from this group but Alabare are now aware that, as an organisation, we are very happy to listen and act on feedback.

Paediatric Diabetes peer review

Three families were involved in the paediatric peer review and a feedback session was held with PALS at the end of the event. The families all welcomed the chance to talk about their experiences and reflected on the value of being able to hear other families' experience. All the families had positive things to say about the paediatric diabetes team as a whole, and felt that their (very diverse) needs were met.

Cancer services video

As a result of reports that patients were too frightened to attend the hospital PALS worked with the Communication Team and Pembroke Unit to record a video designed to encourage patients to attend. The video is available here: https://youtu.be/_0z3fl4Ltpo.

PALS are working with communication teams across the STP to create additional resources for patients.

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

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

11. Social media

NHS Website feedback

There were six items of feedback posted on the NHS Website in Q2. Four were positive (Emergency Department, Gynaecology, ENT and inpatient ward) the others were negative (Emergency Department and inpatient general surgery)

An example of a positive comment:

This is my second experience at this department and feeling nervous the two nurses were very quick to reassure and talk to me taking my mind off the procedure. The second visit was exactly the same and just wanted to say a very big Thank you for being such caring people. The lovely cup of tea was very nice too and a well needed one. Thank you again all of you from the start at reception right through to the consultant. (gynaecology)

An example of a negative comment:

Nurses on Chilmark ward were cold, unapproachable and made me (and the two other ladies in the ward) feel like we were an inconvenience. Attended for Laparoscopic Hysterectomy on 17th Aug and was required to stay overnight. The only nurse who showed any compassion was the night nurse. The first day shift nurse wouldn't even look you in the eye-she looked like she was 18 and really didn't want to be there. The next day shift Nurse- never even got her name, was cold, too busy to respond to any question - if you dared to ask anything she would cut you off and say "I'm doing something!" Every time! She gave no assistance to moving, getting out of bed, Nothing. She gave no advice or instructions for discharge either, just appeared at 7pm and said "ok you can go home now!". Another lady who had abdominal hysterectomy was also sent home after one night!! The other lady was just completely ignored. We were just told to go and had to walk the entire length of the main hospital with no assistance and lifts out of order. I've heard lots of great things about SDH but I'm afraid to say the only good thing was the surgery. The ward staff were shockingly bad, no bedside manner or caring ability came across at all- sure they did what they needed to, but with no interaction or assistance and certainly no friendliness. Such a shame....

All feedback is responded to via the NHS Website and those that leave negative feedback are given the contact details for PALS. All feedback (positive and negative) is shared with the relevant divisions.

All feedback is available here: https://www.nhs.uk/services/hospital/salisbury-district-hospital/P1700/ratings-and-reviews

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.3
Date of Meeting:	14 January 2021		

Report Title:	Q2 Learning from Deaths 2020 - 2021			
Status:	Information	Discussion	Assurance	Approval
			✓	
Prepared by:	Dr Belinda Cornforth, Consultant Anaesthetist, Chair of the Mortality Surveillance Group Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Sallie Davies, Deputy Medical Director			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard Q2 2020/21 Appendix 2 - Learning from deaths action plan. Appendix 3 – Mortality dashboard explanation of terms			

Recommendation:

Recommendation – assurance that the Trust is learning from deaths and making improvements.

The Clinical Governance Committee were assured that the Trust is learning from deaths at its meeting in November 2020.

Executive Summary:

The report highlights how the Trust has learnt from deaths and outcomes in 20/21 and work that needs to be done to improve further. The progress of the Medical Examiner system is set out and the support of bereaved relatives and carers. The Q2 mortality dashboard shows the number of deaths and outcome of reviews. The majority of deaths were unavoidable and expected. 2 deaths were unexpected of which one was reported to the Coroner and the other scrutinised by a Medical Examiner.

Over the coronavirus pandemic period, when the Trust was compared with a peer group of Trusts that had a similar cohort and number of COVID-19 spells, HSMR is within the expected range.

Weekend HSMR started to decline from a peak of 133.8 in July 19 to 107 in May 20 but has subsequently risen to 109.2 and remains within the expected range. A weekend working group was set up in January 20 to improve the safety and effectiveness of services at the weekend but was put on hold due to the COVID-19 emergency. The plan is to re-establish the group in Q3 20/21. An NHS 7 Day Services survey in September 20 shows the Trust met the 90% standard for time to consultant review along with a significant improvement in the proportion of patients who needed a daily review at the weekend received it.

A review of 65 deaths of patients who died from COVID was completed and this showed that learning from experience and research saw the introduction of new treatments and management. The risk of nosocomial transmission was mitigated by changes in testing, retesting and patient placement. To date in the 2nd wave, of the 3 deaths all were community onset with no outbreaks in the hospital.

Board Assurance Framework – Strategic Priorities	
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	☐

Q2 2020/2021 Learning from Deaths report

1. Purpose

To comply with the national requirements of the learning from deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

A system of Medical Examiners was introduced in April 2020 to strengthen the support of bereaved families and drive improvements in the investigation and reporting of deaths.

3. Learning and outcomes in 20/21

Trust wide:

- A review of 65 deaths of patients who died from COVID – learning from experience and research saw the introduction of new treatments and management. The risk of nosocomial transmission was mitigated by changes in testing, retesting and patient placement – see section 7.0. To date in the 2nd wave, of the 3 deaths, all were community onset with no outbreaks in the hospital.
- Deterioration and sepsis – improvements seen in screening and the administration of antibiotics in the Emergency Department and inpatients. However, this year compliance across the Trust has decreased. Our Suspicion of Sepsis dashboard shows decreased survival over this period. The Working Group needs to be re-engerised with a new medical lead.
- Serious incident inquires – learning shared with relevant teams and compliance is now monitored by the Clinical Risk Group following recognition of repeated themes. More work is required.
- End of life care - learning of the importance of staff education. Improved recognition of dying patients, increased use of the personalised care framework and improvements in the care of the bereaved – bereavement survey and contact with the majority of relatives of patients who died during the first wave of the pandemic showed positive feedback.

Department/teams:

- A review of 33 hip fracture deaths identified improvements needed in frailty scoring, pre-operative analgesia, time to theatre within 36 hours and falls prevention. The review was discussed at a well attended joint Orthopaedic and Anaesthetic mortality and morbidity meeting. Actions completed. Hip fracture HSMR is on a downward trajectory – see figure 15 and best practice tariff is over 80%.
- A review of 18 patients who died following a gastrointestinal haemorrhage identified improvements needed in referral and booking processes, use of the acute upper GI bleed care bundle, continuity of care by the GI team and improved governance around learning from deaths. The review was discussed at an Endoscopy User Group and GI team mortality and morbidity meeting. Actions completed. GI bleed HSMR is as expected – see figure 16.
- The stroke team introduced a monthly multi-disciplinary mortality review meeting in June 20 to share learning with the wider team and improve communication with families especially around the 'uncertain recovery period' and transition from active treatment to palliative care. Inpatient mortality at 7 and 30 days reduced from 19/20 and is well below the national upper limit.
- The maternity services introduced a Perinatal Mortality Review Tool to identify learning across the whole patient pathway. CTG interpretation was identified as a theme. Learning shared at the perinatal mortality review meeting. CTG training levels improved and a Fetal Surveillance Midwife appointed to support midwives and doctors in practice.

Individual level:

- Individual case discussion with doctors and nurses to enable reflection on practice.
- Quarterly Mortality Matters bulletins – outline learning achieved and case vignettes, published on the intranet. http://intranet/website/staff/publications/mortalitymatters/index.asp
- Medical Examiner case discussion with trainees – feedback from the trainees is a learning opportunity.

4. Medical Examiners (ME)

The new ME system was introduced in April 20 to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The system was established by August 2020 and the following is now in place:

- Dr Stephen Jukes is the Lead Medical Examiner and Dr Belinda Cornforth remains the chair of the Mortality Surveillance Group to ensure independence between the two roles.
- In August, 7 MEs started to scrutinise acute hospital deaths. The process for scrutinising Hospice and Emergency Department deaths is the next stage and expected to be in place by February 21.
- The Qualified Attending Physicians (junior doctors) are given an appointment to hold a face to face discussion of each case with an ME to agree the medical certificate of cause of death (MCCD). The ME then discusses the cause of death with the bereaved relatives and gives them an opportunity to voice any concerns about care. Straightforward issues are dealt with immediately and followed up with clinical teams and feedback given to bereaved relatives.
- Two Medical Examiners' Officers (MEO) started in July. Their role is to support the MEs and if delegated, the MEOs have a discussion with bereaved relatives about the MCCD and any concerns about care. The MEO's follow up concerns and report to the ME and feedback to bereaved relatives.
- The MEs decide whether the case requires a structured judgement review by another senior doctor to ensure learning is shared across the organisation.
- A summary of our data is submitted to the regional ME. It is anticipated that we will be required to submit data to the national ME IT system if and when it is available.
- A local network of MEs exists to share learning and provide an independent review facility if needed.
- The Clinical Governance core session in July 20 was well attended by consultants on the Medical Examiner role.
- Learning has centred on establishing the ME system and adjusting processes over the Q2. In August, 22 (40%) acute hospital deaths were scrutinised by an ME and in September 43 (74%).

5. Working with bereaved families

In April 20, the 'Your Views Matter' bereavement survey was put on hold during COVID due to visiting restrictions. In July/August 20, the Specialist Palliative Care Team telephoned the majority of families of patients who had died during the pandemic to listen and support the bereaved as well as to give them the opportunity to raise concerns. The majority appreciated the call and many commented on the excellent care and the support they received from the staff. 8 people commented on negative aspects of care, usually around poor communication.

In September 20, the bereavement survey was adapted to acknowledge the pandemic and the effect it may have had on visiting restrictions and end of life care. In November 2020, the survey will be sent to a nominated member of all bereaved families one month after their loved one's death. A leaflet offering advice and support with local and national support details will be included with the survey. A separate condolence card continued to be sent by the ward on behalf of the Trust 3 weeks after the death.

When the family are contacted by a Medical Examiner to ask if they have any concerns or questions about their loved one's care. If concerns are raised, the family are sent the survey immediately, so any themes and learning can be addressed quickly. If the initial concerns warrant immediate investigation families are signposted to PALS who contact them directly.

The bereavement survey also includes a question to ask about the family's experience of the Medical Examiner Role and whether they felt able to raise concerns either before or after death. The feedback is used to improve practice.

6. Mortality dashboard, learning, themes and actions

In Q2 20/21, 178 deaths occurred in the Trust. The total includes patients who died in the Emergency Department and the Hospice. Of these, 164 (92%) deaths were screened. In August, the Medical Examiners started to scrutinise deaths and by the end of September 65 (57%) deaths had been scrutinised. There were no deaths of patients who tested positive for COVID. In Q2 20/21, 1 death was possibly avoidable and 3 had slight evidence of avoidability.

7. Review of deaths of patient with COVID-19 and learning

On 11 March 20, the World Health Organisation declared a COVID-19 pandemic and a national lockdown was imposed on 23 March 20. During this time guidance received from Public Health England was used to develop our own response. This advice changed rapidly on a weekly, and even daily basis in response to this unprecedented event.

65 deaths attributed to COVID were reviewed to establish whether patients were involved in decisions about their care, were escalated to ICU, whether they would benefit from ventilation and, if so, whether they received it. Our findings indicated care was provided in accordance with NICE critical care guidance and adapted as new learning emerged from clinical experience and research.

However, it became evident that a number of patients may have acquired COVID in hospital as a result of nosocomial transmission. At this point, in liaison with the Medical Director the focus of the review switched to tracking where patients were placed and their contacts. Hospital onset was presumed to have definitely occurred if the first positive specimen collection date was 15 days or more after admission. National guidance at the point the patient was admitted was compared to our local standard operating procedures as part of the COVID-19 response. This showed the Trust followed national guidance as evidenced in our COVID response plan.

Interpreting the COVID-19 test results was challenging as the accuracy may have varied depending upon the site and quality of the sample. It is recognised that the COVID-19 test is only 70% reliable and therefore interpretation was considered alongside the clinical presentation of the patient. Overall, the reviewers concluded that 4 cases could be defined as hospital-onset definite healthcare associated cases as the patients had been admitted prior to the pandemic declaration without COVID-19 symptoms and had a significant length of stay. It was difficult to be certain where or from whom the patients may have acquired COVID-19, but they had been admitted for other reasons and the incubation period was consistent with exposure to the virus.

Since the end of April 20, the likelihood of nosocomial transmission has been reduced with measures already put in place (testing and re-testing all new admissions, pre-admission testing of elective admissions, reduced turnaround times of test results, increased testing of healthcare workers, wearing face masks, risk stratification prior to ward placement and twice weekly virtual board rounds). At the outset of this review all these were areas of concern. However, at the point of report publication it can be confirmed that processes have been put in place to mitigate the risk and that evaluation of the effectiveness of these measures will be assessed from deaths occurring in the 2nd wave. Although measures have been put in place to mitigate the risks that were identified in the first wave, it is recognised that the environment cannot be a 100% secure due to the nature of a highly contagious and mutating virus.

The review will be reported to the Clinical Governance Committee in November 2020.

8. CUSUM alerts

15 new CUSUM alerts raised in Q2 20/21:

- Viral infection (COVID deaths) - a total of 12 CUSUM alerts. In March 20, 1 CUSUM alert occurred of 4 cases observed compared to 0.1 expected, relative risk 2675. In April and May 20, 11 CUSUM alerts of 37 cases observed compared to 2.2 expected, relative risk 1798. CUSUM alerts arose because a viral infection is considered to be a low risk diagnosis group. The Mortality Surveillance Group investigated all these deaths and the learning generated is set out in section 6.
- Inflammatory disease of female pelvic organs – 1 case observed compared to 0.1 expected, relative risk 1896. Cause of death related to diverticular disease. No iatrogenic events contributed to the death. No learning points.
- Secondary malignancies – 19 cases compared to 12.2 expected, relative risk 155. Agenda item at the November Mortality Surveillance Group to decide if this alert should be investigated.
- Cancer of pancreas – 13 cases compared to 8 expected, relative risk 162. Agenda item at the November Mortality Surveillance Group to decide if this alert should be investigated.

9. Death following a planned admission to hospital

In Q2 20/21, 2 deaths of patients following a planned admission:

- A 74 year old man admitted for a cardiac diagnostic angiogram which showed severe triple vessel disease requiring a coronary artery bypass graft. Hypotensive post procedure from a possible reaction to contrast. Significant drop in haemoglobin following a gastrointestinal bleed requiring a blood transfusion. Escalated to ICU but ongoing ECG changes and deterioration. Death definitely not avoidable. No learning points.
- An 81 year old woman with myelodysplasia progressed to acute leukaemia admitted from the Nunton Unit with diarrhoea and fever. Treated for sepsis and disseminated intravascular coagulation but despite active treatment continued to deteriorate. A palliative approach with symptom relief was agreed in discussion with the family. Death definitely not avoidable. No learning points.

10. Unexpected deaths

In Q2, there were 2 unexpected deaths:

1. A 55 year old woman referred by her GP on a Friday with a suspected pulmonary embolism. The patient arrived on Saturday morning and shortly after arrival had a cardiac arrest. Prolonged resuscitation and thrombolysis given. The delay in arrival at hospital may have had impact on the outcome. Case referred to the Coroner.
2. A 74 year old man admitted for a cardiac diagnostic angiogram which showed severe triple vessel disease requiring a coronary artery bypass graft. Hypotensive post procedure from a possible reaction to contrast. Significant drop in haemoglobin following a gastrointestinal bleed requiring a blood transfusion. Escalated to ICU care but ongoing ECG changes and deterioration. Death definitely not avoidable. No learning points

11. Stillbirths, neonatal deaths and child deaths

In Q2 20/21:

- 1 stillbirth ?at term of a concealed pregnancy of a woman with a profound learning disability. Subject to a police investigation.
- 1 neonatal death - a live birth at 22 weeks but sadly the baby died of extreme prematurity
- 1 neonatal death at 31 weeks subject to a serious incident inquiry (SII 375).
- No child deaths.

12. Patients with a learning disability

In Q2, 1 patient with a learning disability died in September. The case will be reviewed and reported in the Q3 20/21 report. The case will also be reported to the LeDeR programme.

In Q1 20/21, 1 patient with a learning disability died in April 20:

- A 58 year old man with neurofibromatosis, epilepsy, hydrocephalus and a shunt in situ. Admitted with difficulty in breathing, reduced oxygen saturations and reduced consciousness. Negative COVID test. He continued to deteriorate during his admission despite active treatment. End of life care was recognised and care provided on the personalised care framework. Death definitely not avoidable. No learning points.

The case was reported to the LeDeR programme.

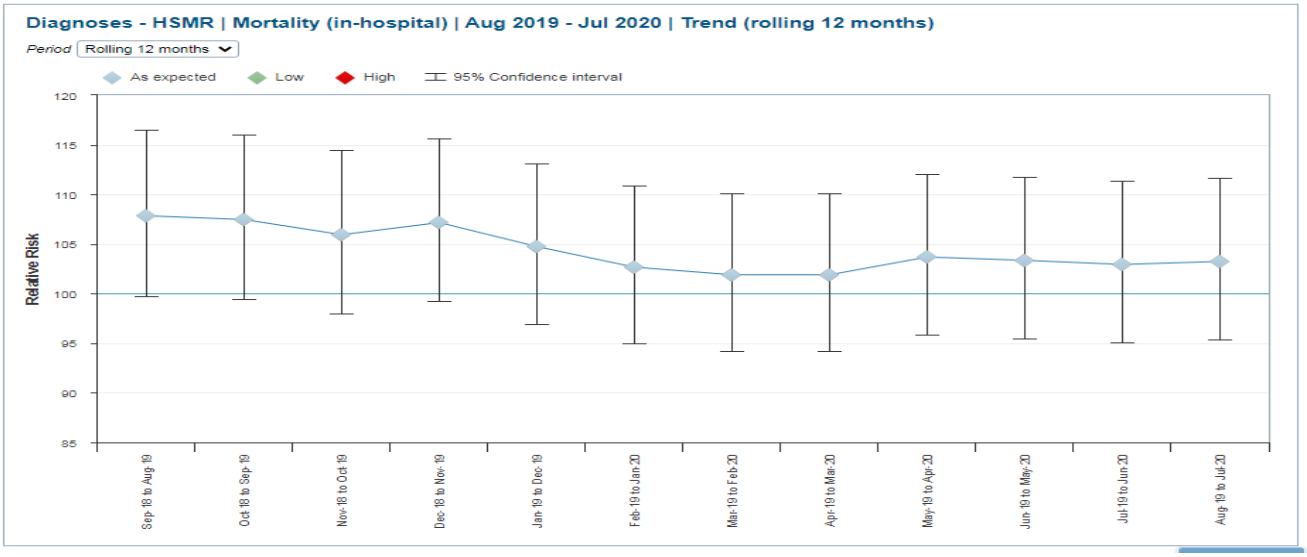
13. Patients with a serious mental illness

In Q2, 3 patients with a serious mental illness died in August 20:

- A 68 year old woman with a history of schizophrenia and severe COPD. Admitted with shortness of breath and treated for an exacerbation of COPD. The patient was reluctant to receive regular treatments such as nebuliser and continued to smoke as an inpatient. Acute deterioration with severe type 2 respiratory failure. In agreement with the patient and family a decision was made to provide palliative care and the patient died peacefully. Death definitely not avoidable.
- A 75 year old woman with bi-polar and depressive disorder developed aspiration pneumonia whilst an inpatient at Fountain's Way, Hospital. Admitted to ICU for respiratory support but despite optimal treatment developed severe respiratory failure and died. Death definitely not avoidable.
- An 82 year old man with severe depression and multiple cardiac comorbidities unsuitable for a valve replacement. Following admission he was detained under the Mental Health Act Section 2 having made a serious attempt to take his own life at home and became psychotic. He was transferred to Fountains Way Hospital for treatment and re-admitted to this hospital 11 days later following deterioration with abdominal pain and vomiting. A DNARCPR was in place. He continued to deteriorate and died 12 hours after admission. Death definitely not avoidable. No learning points.

14. HSMR rolling 12 month trend to July 2020

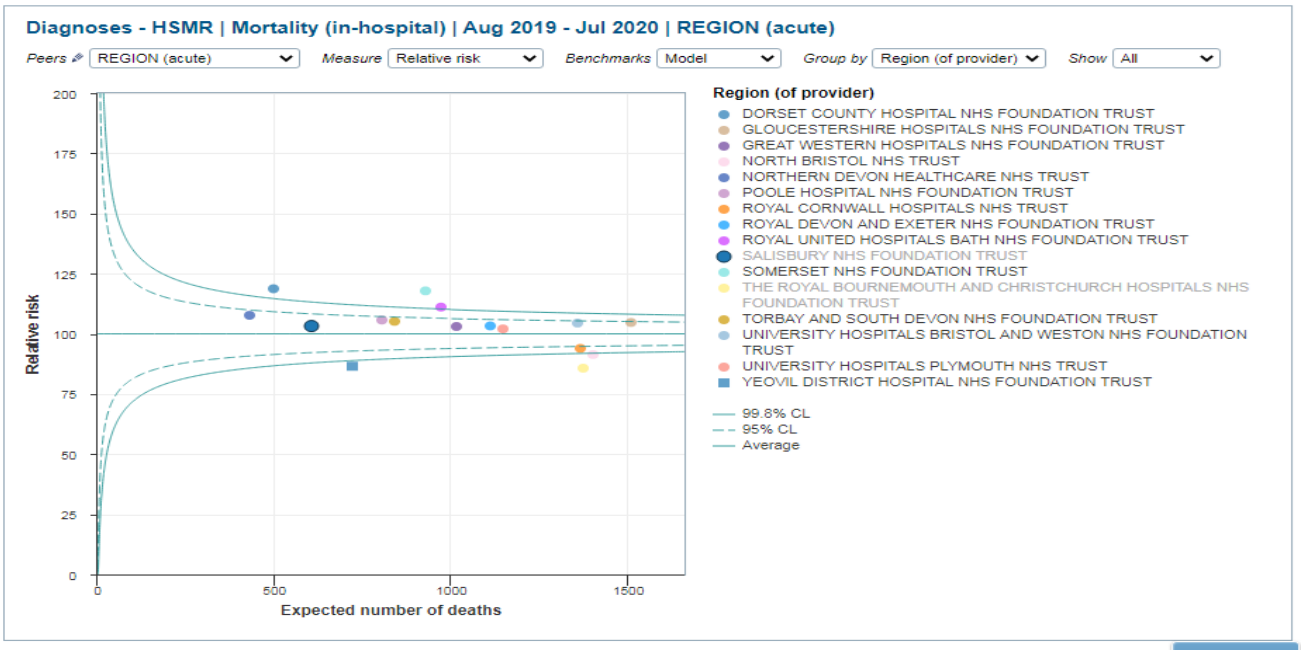
Figure 1: HSMR relative risk of all diagnoses Aug 19 – July 20



HSMR is 103.2 and is as expected over the last 12 month rolling period to July 20.

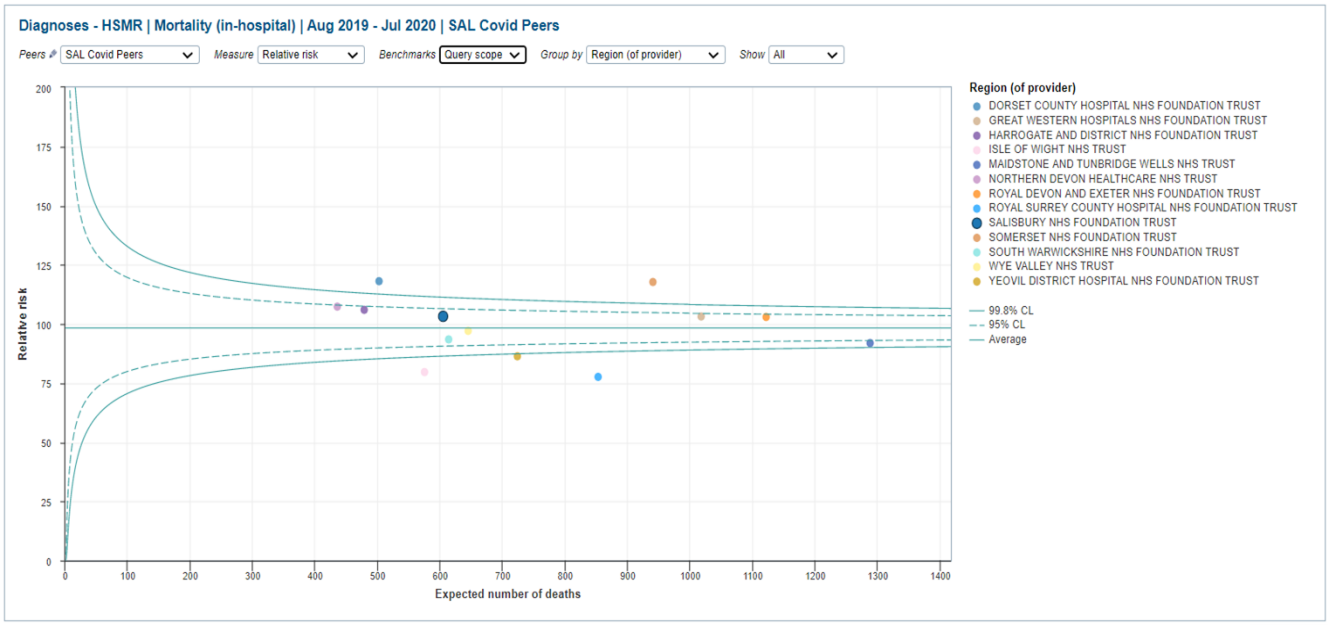
15. Mortality (in-hospital) regional peer comparison Aug 19 – July 20

Figure 2: Mortality (in-hospital) regional peer comparison Aug 19 – July 20



HSMR regional peer comparison shows the Trust is one of 9 acute Trusts with an HSMR within the expected range. Three Trusts have an HSMR that is statistically significantly higher than expected.

Figure 3: Mortality (in hospital) benchmarked with COVID-19 peers

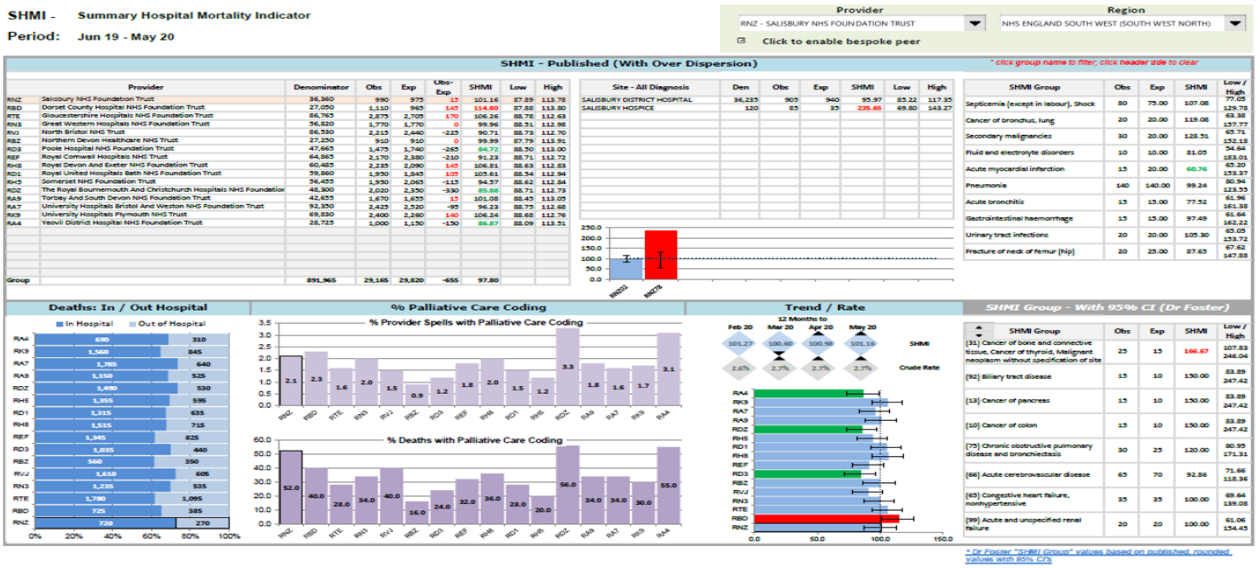


Over the coronavirus pandemic period, when the Trust is compared with a peer group of Trusts that had a similar cohort and numbers of COVID-19 spells and similar baseline capacity, the Trust sits comfortably within the funnel plot.

16. SHMI June 2019 – May 2020

SHMI is 101.16 within the expected range to May 2020 and when adjusted for palliative care is 89.37. When comparing SHMI by site Salisbury District Hospital is 95.97 and Salisbury Hospice is 235.65. When compared with regional peers the Trust has a SHMI within the expected range.

Figure 4: SHMI regional peer comparison June 2019 – May 2020



17. Comorbidity and palliative care profile 20/21

Trends in comorbidity coding have shown an improvement since the Q1 20/21 report in the Trust's Charlson comorbidity upper quartile rate for the HSMR basket from 20.7% in Q1 to 21.5% in Q2 and an improvement as an index of national from 83 in Q1 to 86 in Q2. This means the proportion of a Trust's HSMR spells are where the Charlson comorbidity score for the primary diagnosis episode is in the national upper quartile for that diagnosis and admission type (the observed value). The expected value is the equivalent proportion nationally (100).

It was noted in the Q1 report that SFT had a lower than average number of secondary diagnosis codes overall. In response, the Clinical Coding Department undertook an audit and made a number of improvements. A further audit took place in Q2 based on Dr Foster's diagnosis group, highest numbers under the P25 centile with no Charlson comorbidities and those recorded outside of the first 14 codes. So far, abdominal hernia, acute stroke, anal and rectal conditions, biliary tract disease and pneumonia have been examined. COPD and bronchiectasis and other upper respiratory disease will also be reviewed. The audit will be reported to the Information Standards Group on 16 December 20.

Figure 5: Trend in comorbidity profile

Comorbidity Profile

Organisation: **SALISBURY NHS FOUNDATION TRUST**

Report Date: **26 October 2020**

	2017/18	2018/19	2019/20	2020/21
Upper-quartile comorbidity	24.5%	24.2%	23.3%	21.5%
as index of national (100)	98	97	94	86

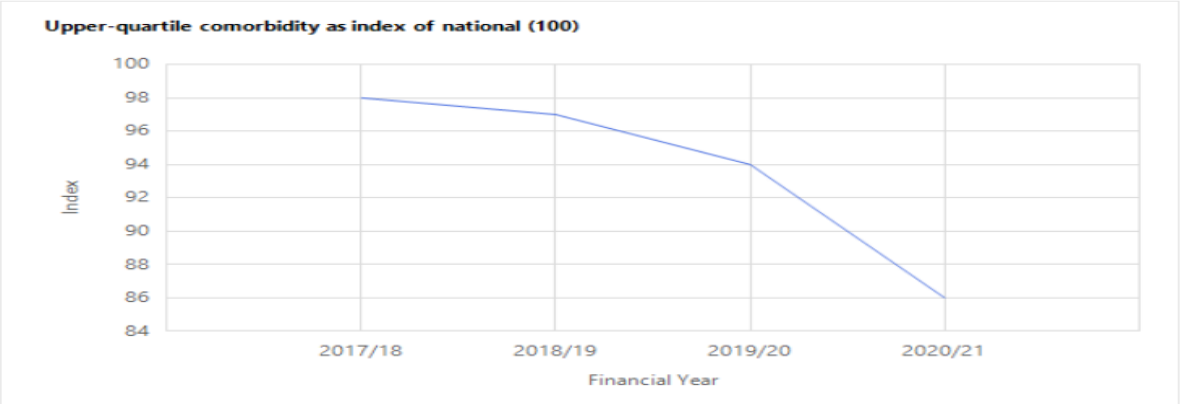
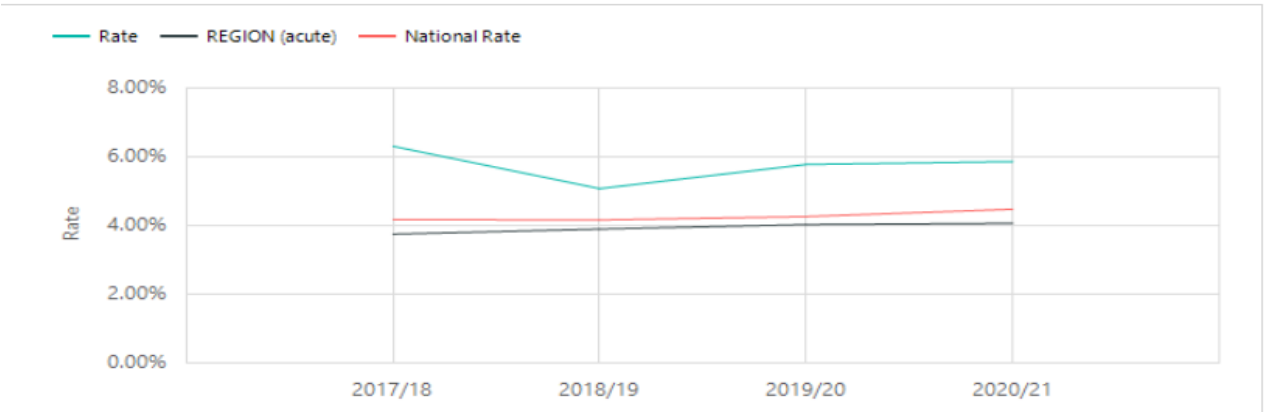


Figure 6: Trend in palliative care profile

Organisation: **Salisbury NHS Foundation Trust** *Report Date:* **26 October 2020**

Basket: **Diagnoses - HSMR** *Peer group:* **REGION (acute)**

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2017/18	9,773	616	6.30%	4.17%	3.75%
2018/19	9,972	506	5.07%	4.16%	3.90%
2019/20	10,720	619	5.77%	4.26%	4.03%
2020/21	2,885	169	5.86%	4.47%	4.07%



The trend in the Trust's palliative care coding rate for non-elective spells in 20/21 I is 5.86% and remains higher than the national rate of 4.47% and peer group rate of 4.07%.

18. Weekday/weekend HSMR

Figure 7 shows the non-elective weekday HSMR is 99.8 and weekend HSMR is 109.1 to July 20 having reduced from a peak of 133.8 in July 2019. Both are within the expected range. It should be noted that Saturday HSMR is 100.9 and Sunday HSMR is 116.9. Both are within the expected range.

Figure 7: HSMR weekday/weekend admission Aug 2019 – July 20

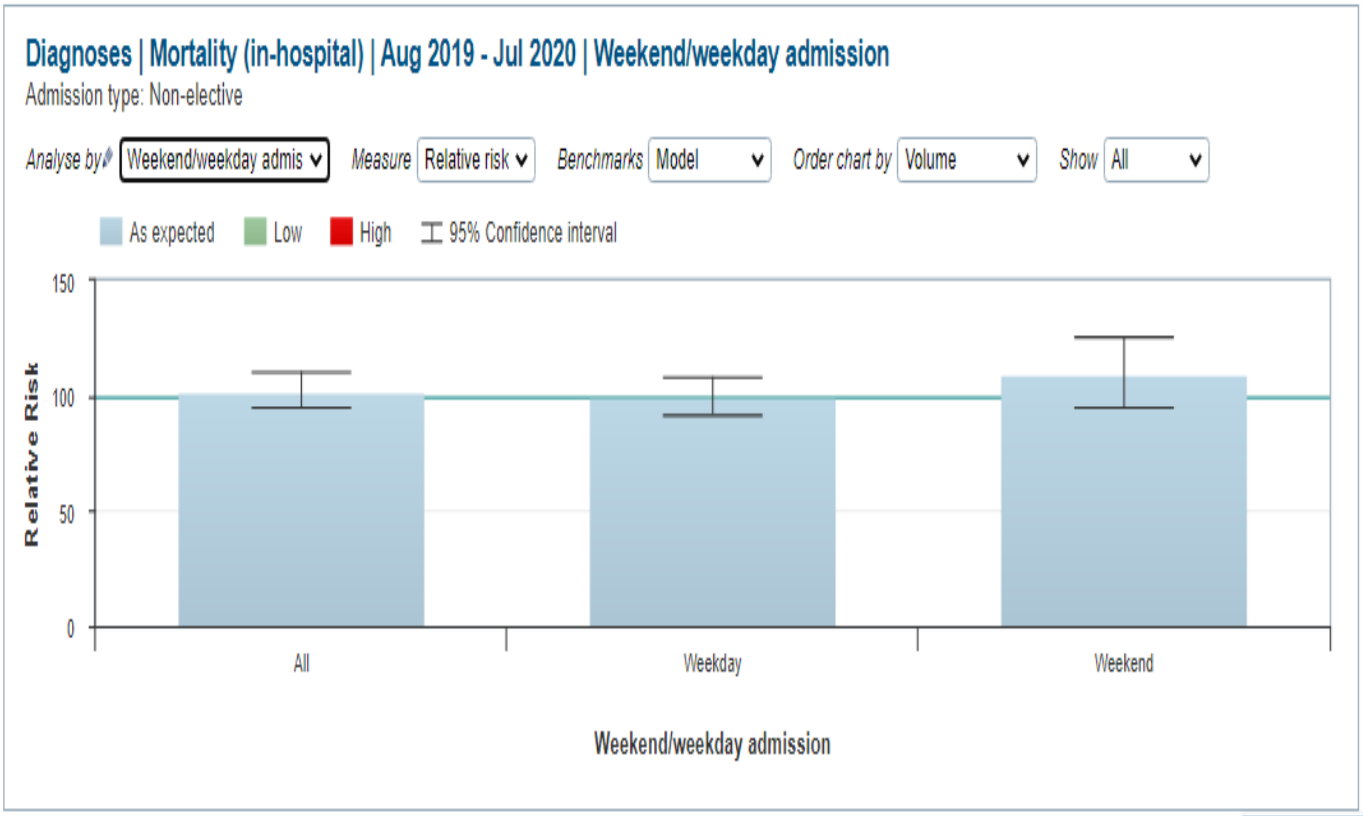
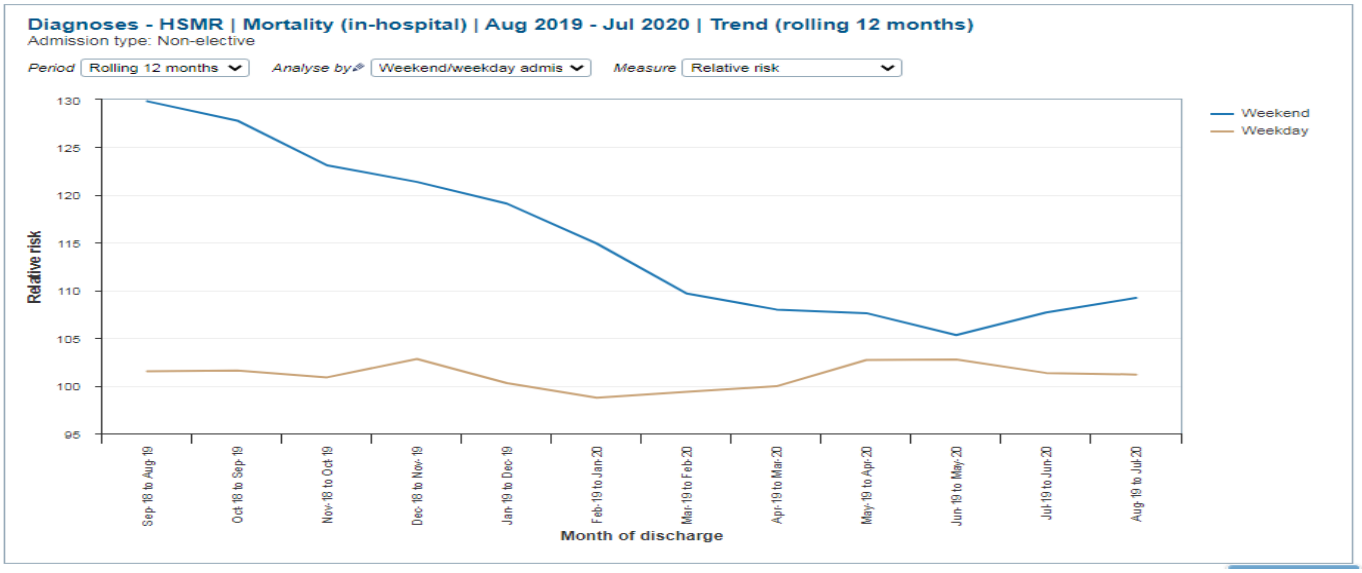


Figure 8: Rolling 12 month trend in emergency weekend and weekday Aug 19 – July 20



The emergency weekend HSMR trend started to decline from a peak of 133.8 in July 19 to 107 in May 20 but has subsequently risen to 109.2 and remains within the expected range. The reduction in weekend HSMR is due to a combination of a decrease in the crude mortality rate and an increase in the expected mortality rate.

A weekend quality improvement group was set up in January 20 which included the Chief Registrar and 3 doctors in training with the aim of improvng the management of the workload at weekends, particularly on a Sunday. The group was put on hold due to the COVID-19 emergency and this needs be re-established in Q3 20/21 contingent on the impact of a 2nd wave of COVID-19. Improvements progressed so far have been the weekend handover and a pilot of a Critical Care Outreach Team co-ordinator on a Sunday from 2 – 10 pm to triage and allocate the workload. Feedback from doctors in training was positive.

An NHS 7 Day Services survey in September 20 showed that 95% of patients at a weekend received an assessment by a consultant within 14 hours of admission compared to 81% in September 2019. A significant improvement in the proportion of patients who needed a daily review at the weekend who received it at 97% compared to 77% in September 19. The improvement was considered to be a change in the weekend physicians rota which removed the ward cover consultant and replaced it with a hybrid model where patients were seen by the person with the right level of seniority.

19. Deaths in high risk diagnosis groups (Aug 19 – July 20)

The Mortality Surveillance Group monitors a 12 month rolling trend in the relative risk for 8 high risk diagnosis groups

Figure 9: Trend in relative risk for septicaemia (except in labour)

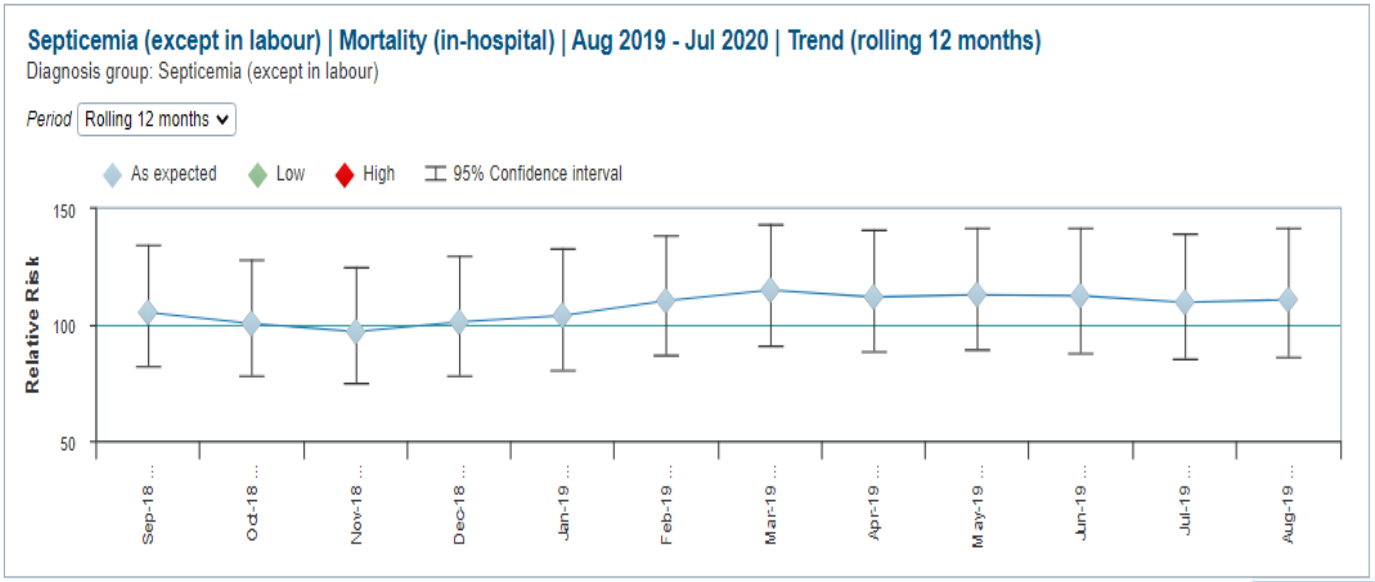


Figure 10: Trend in relative risk for pneumonia

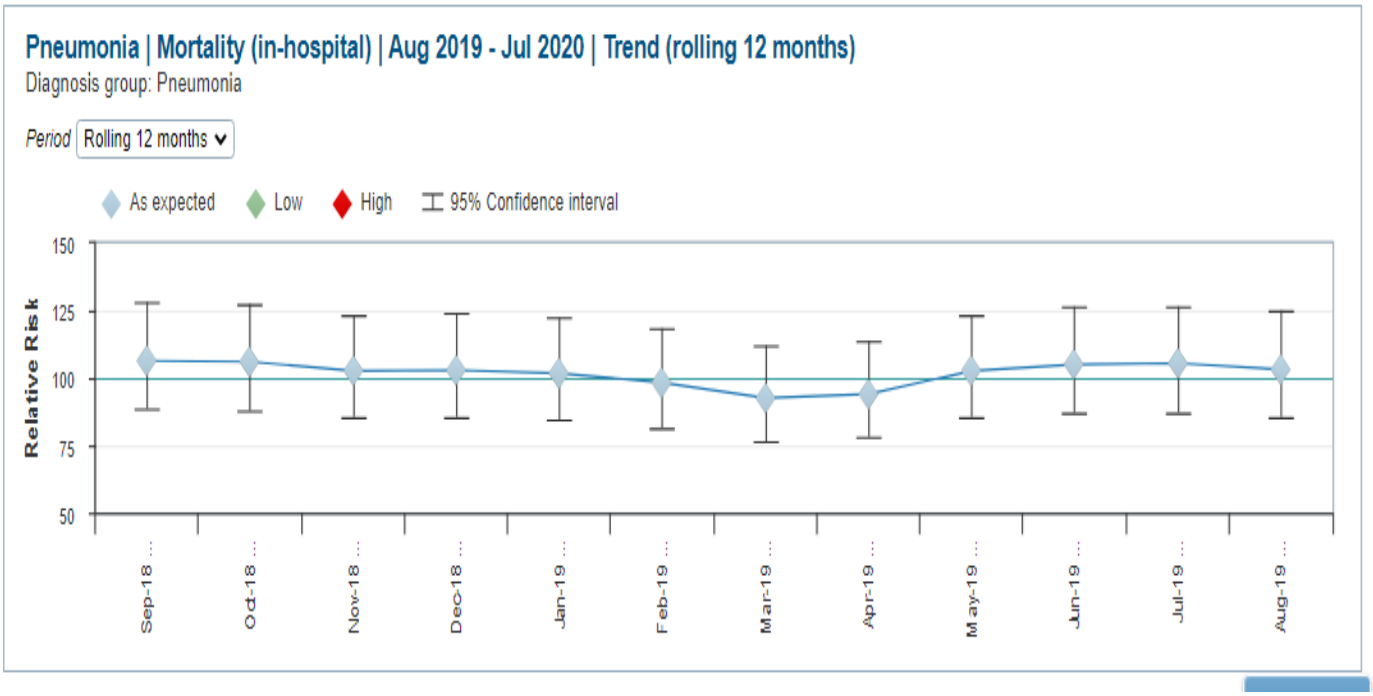


Figure 11: Trend in relative risk for acute cerebrovascular disease

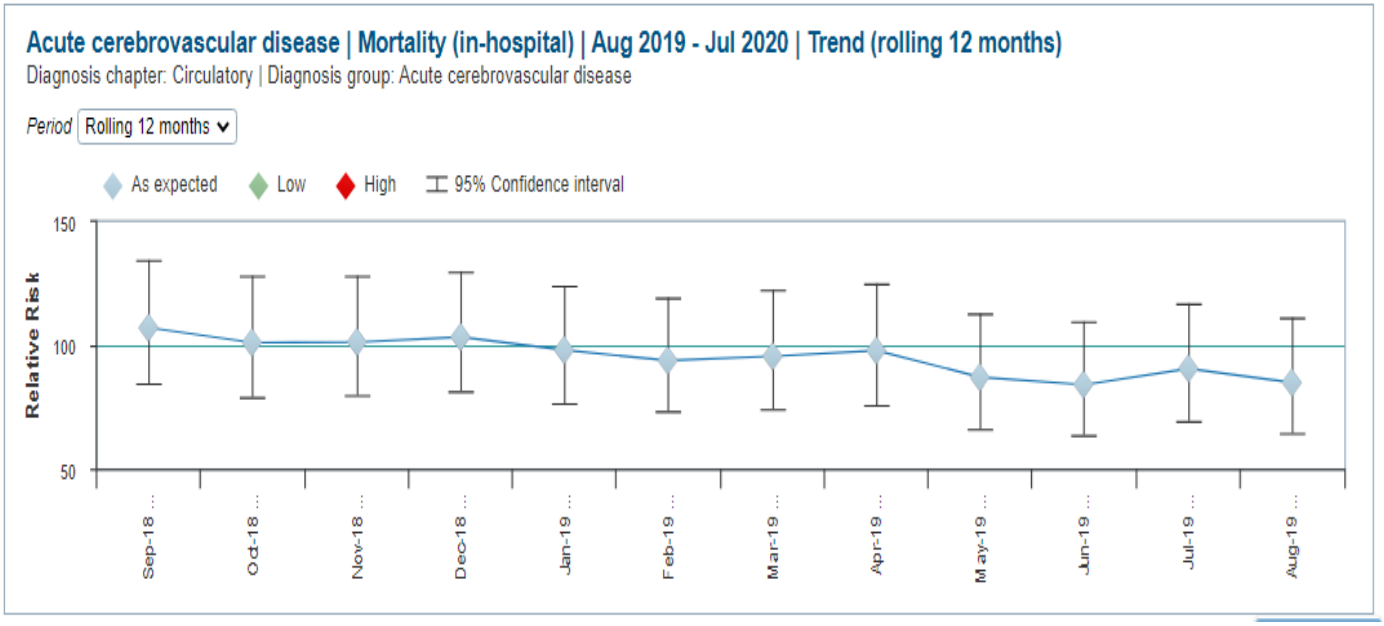


Figure 12: Trend in relative risk for acute myocardial infarction

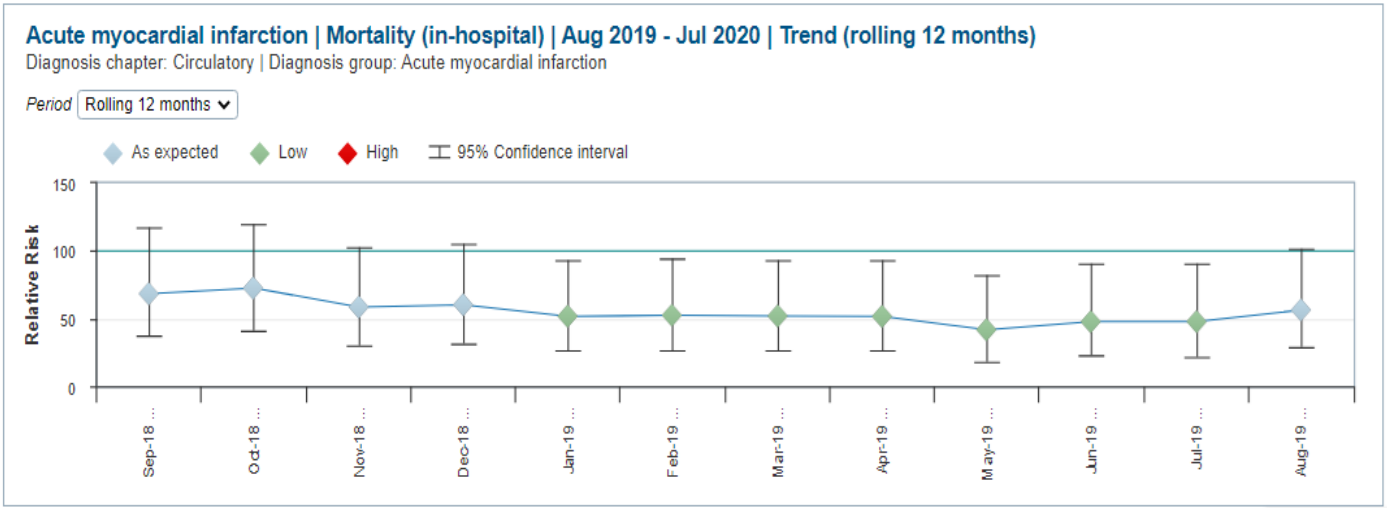


Figure 13: Trend in relative risk for congestive heart failure

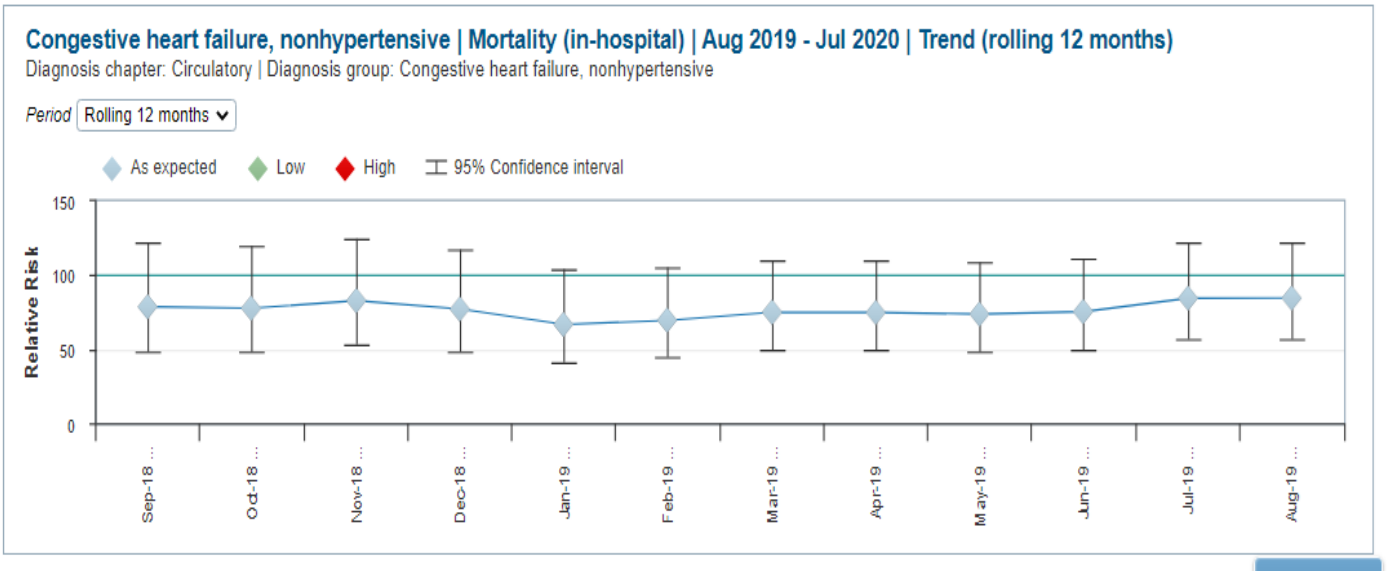
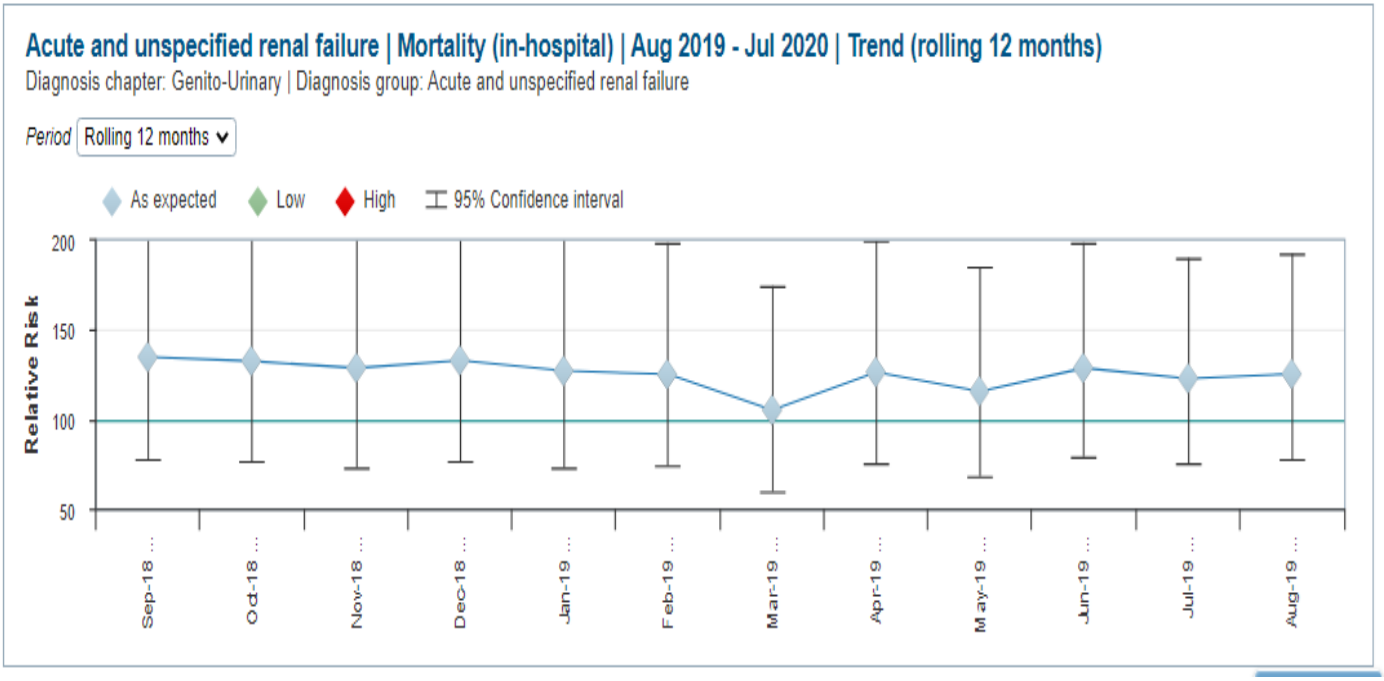


Figure 14: Trend in relative risk for acute and unspecified renal failure



The relative risk of death from acute renal failure had been rising since July 2018 but remains within the expected range. The Mortality Surveillance Group received a report on a case notes review of 15 deaths of patients admitted to hospital between November 2018 and October 2019.

The report concluded that 86% (12/14) of patients had acute kidney injury on admission to hospital and despite initial treatment only 1 patient's renal function improved. Although, the cause of the acute kidney injury was felt to be pre-renal in nature, no urinalysis was carried out to confirm this hypothesis or determine the urgency of the medical treatment plan. There were significant gaps in the monitoring and accuracy of fluid balance therefore treatment evaluation and early detection was delayed. Sepsis screening was missed in 2 cases and specimen results were not reviewed which may represent a missed opportunity to review antibiotic therapy. It is recognised however that changing antibiotic therapy may not have changed the overall outcome. Despite these omissions, all patients had significant co-morbidities which would account for the increased mortality rate in this group.

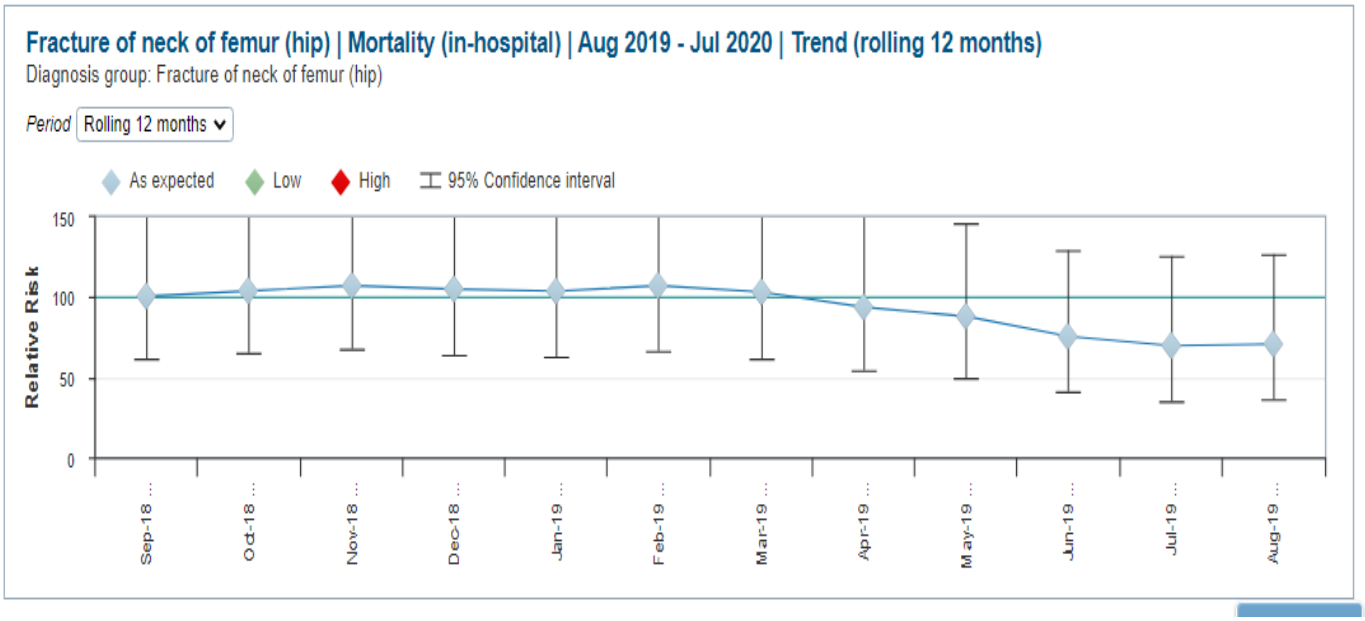
Two patients, developed iatrogenic acute kidney injury following contrast administration which may have contributed to a destabilisation of their pre-existing comorbidities and thus to their death. One patient had a missed diagnosis of acute kidney injury and was discharged but readmitted the same day.

Action plan:

1. Review the Trust guidelines for the management of metabolic acidosis
2. Obtain an update on the implementation of NHSI (2019) alert 'resources to support safe and timely management of hyperkalaemia'
3. Improve the compliance with accurate fluid balance monitoring
4. Ensure all patients admitted to hospital with acute kidney injury or those that develop the disease have a urinalysis undertaken as part of the screening process.
5. Evaluation of the use of the acute kidney injury care bundle.
6. Evaluate the follow up monitoring of patients who have received IV contrast as an inpatient

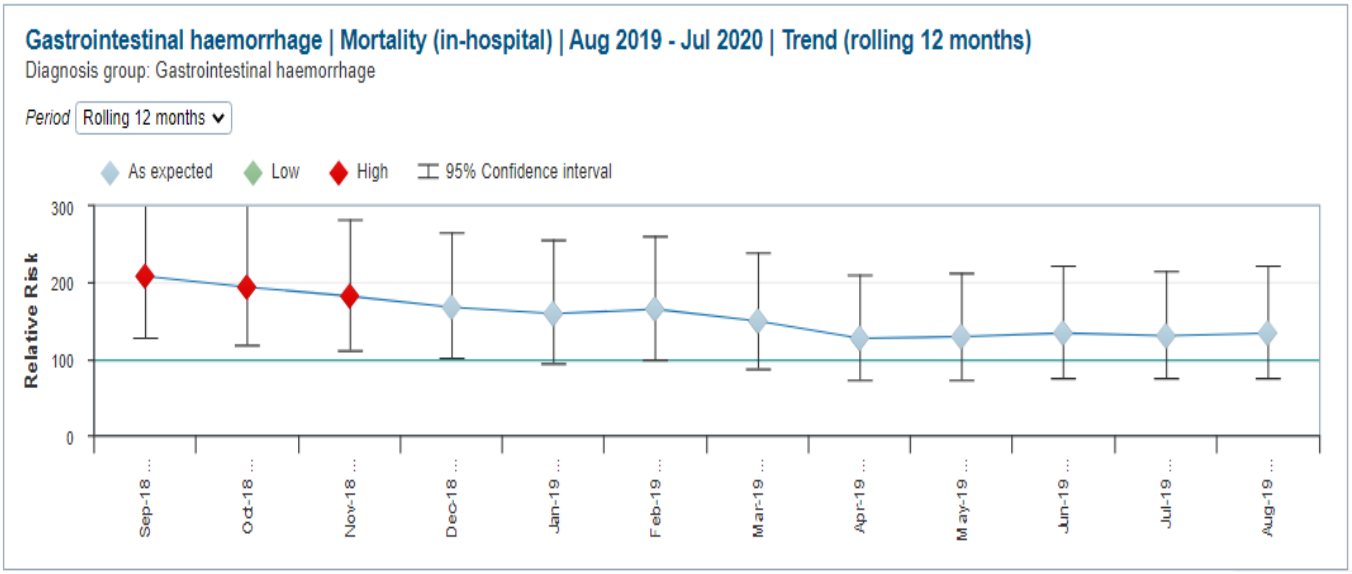
An update on progress of the acute kidney injury action plan will be presented to the Mortality Surveillance Group in February 21.

Figure 15: Trend in relative risk for fracture of neck of femur



A multi-disciplinary review of 33 patients who died with a fractured neck of femur was undertaken in October 2019. Since then, there has been an increase in the use of local analgesia blocks (FICBs) to national levels to March 20 reducing the need for opioids and a more consistent performance in time to theatre within 36 hours. The action plan was completed by September 20. Hip fracture HSMR is on a downward trajectory.

Figure 16: Trend in relative risk for gastrointestinal haemorrhage



A multidisciplinary review of 18 patients who died following a gastrointestinal haemorrhage was completed in December 19. An overall update on the progress of the action plan was reported to the Clinical Governance Committee in September 2020 in the context of the Royal College of Physicians invited review which took place in January 20. In respect of the actions from the review of deaths, the action plan has been completed apart from consultant gastroenterologists still needing to be released from the general internal medicine inpatient work to fully establish the new GI unit arrangements. The timeline for completion is contingent upon recruitment. Formation of a GI Unit took place in May 20, led by a Consultant Colorectal surgeon who continues to report progress quarterly to the Clinical Governance Committee.

20. Summary

The report highlights how the Trust has learnt from deaths and outcomes in 20/21 and the work that needs to be done to improve further. The progress of the Medical Examiner system is set out and the support of bereaved relatives and carers. The Q2 mortality dashboard shows the number of deaths and outcome of reviews. The majority of deaths were unavoidable and expected. 2 deaths were unexpected of which one was reported to the Coroner and the other scrutinised by a Medical Examiner.

Over the coronavirus pandemic period, when the Trust was compared with a peer group of Trusts that had a similar cohort and number of COVID-19 spells, the Trust is within the expected range.

Weekend HSMR started to decline from a peak of 133.8 in July 19 to 107 in May 20 but has subsequently risen to 109.2 and remains within the expected range. A weekend working group was set up in January 20 to improve the safety and effectiveness of services at the weekend but was put on hold due to the COVID-19 emergency. The plan is to re-establish the group in Q3 20/21. An NHS 7 Day Services survey in September 20 shows the Trust met the 90% standard for time to consultant review along with a significant improvement in the proportion of patients who needed a daily review at the weekend received it.

A review of 65 deaths of patients who died from COVID was completed and this showed that learning from experience and research saw the introduction of new treatments and management. The risk of nosocomial transmission was mitigated by changes in testing, retesting and patient placement. To date in the 2nd wave, of the 3 deaths all were community onset with no outbreaks in the hospital.

21. Recommendation

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Dr Belinda Cornforth, Consultant Anaesthetist
Chair of the Mortality Surveillance Group

Claire Gorzanski,
Head of Clinical Effectiveness,

16 November 2020

Appendix 1 **SALISBURY NHS FOUNDATION TRUST - MORTALITY DASHBOARD 2020/2021**

	Apr 20	May 20	Jun 20	Q1	Jul 20	Aug20	Sep 20	Q2	Oct 20	Nov 20	Dec 20	Q3	Jan 21	Feb 21	Mar 21	Q4	Total
Deaths	98	60	49	**207**	65	55	58	**178**									**385**
1st screen	94	56	48	**198**	63	47	54	**164**									**362**
% 1st screen	96%	93%	98%	**96%**	97%	85%	93%	**92%**									**94%**
Medical Examiner (ME) scrutiny						22	43	**65**									**65**
% ME scrutiny						40%	74%	**57%**									**57%**
Case reviews (SJR)	54	16	10	**80**	11	0	0	**11**									**91**
% case reviews	55%	27%	20%	**39%**	17%	0%	0%	**6%**									**24%**
COVID deaths	41	7	3	**51**	0	0	0	**0**									**51**
Deaths with Hogan score 1	89	58	47	**194**	65	54	55	**174**									**368**
Deaths with Hogan score 2 - 3	7	2	2	**11**	0	1	3	**4**									**15**
Deaths with Hogan score 4 - 6	2	0	0	**2**	0	0	0	**0**									**2**
Learning points	13	4	2	**19**	0	2	4	**6**									**25**
Family/carer concerns	1	6	5	**12**	0	2	3	**5**									**17**
CUSUM alerts	1	0	0	**1**	1	13	1	**15**									**16**
CUSUM investigated	0	0	0	**0**	1	12	0	**13**									**13**
Deaths investigated as an SII	1	1	0	**2**	0	0	1	**1**									**3**
SIIs graded as catastrophic	0	0	0	**0**	0	0	1	**1**									**1**
Death following an elective admission	0	1	1	**2**	1	0	1	**2**									**4**
Unexpected death	1	1	0	**2**	2	0	0	**2**									**4**

Stillbirth	1	1	0	**2**	0	0	1	1									**3**
Neonatal death	1	0	0	**1**	0	2	0	2									**3**
Child death	0	0	0	**0**	0	0	0	**0**									**0**
Learning disability deaths	1	0	0	**1**	0	0	1	**1**									**2**
Reported to LeDeR programme	1	0	0	**0**	0	0	0	**0**									**0**
Serious mental illness	0	0	0	**0**	0	3	0	**3**									**3**
Maternal deaths	0	0	0	**0**	0	0	0	**0**									**0**

Note explanatory notes in appendix 3 * 2 cases will be reported to the LeDeR programme when reviews completed.

MORTALITY DASHBOARD THEMES AND ACTIONS 2020/2021 **Appendix 2**

No	Learning points	Action point	By whom	By when	Update 28/10/2020	Status
1	Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form)	Work programme to be developed with planned implementation by 31/3/2021	BSW CCG and Resuscitation Committee	31/03/21	The national version 3 was published in August 20. BSW CCG will be leading the introduction of ReSPECT with support from SFT's Resuscitation Officer and Resuscitation Committee.	
2.	Learning arising from the COVID death review in Q1 & Q2 20/21	Evaluate the effectiveness of the actions already taken from the review of patients who die from COVID in the 2nd wave.	Divisonal Management Teams	30/12/20	The review of deaths of patients with COVID-19 will be presented to the Clinical Governance Committee in November 20.	

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

1. Deaths – the number of adult, child and young people deaths in the hospital including the Emergency Department and the Hospice.

2. 1st screen - the number and proportion of deaths screened by medical staff to decide whether they need a full case review.

3. Medical Examiner scrutiny – the number and proportion of deaths scrutinised by a Medical Examiner. Medical Examiners are senior medical doctors who review deaths and are trained in the legal and clinical elements of the death certification processes. The purpose of the Medical Examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased and to improve the quality of death certification.

4. Case review - the number and proportion of deaths subject to a full case review using the structured judgement review method. Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. This is why the data is not comparable.

5. COVID deaths – the number of patients who died in hospital who tested positive for COVID.

6. Deaths with a Hogan score* of 1 – 3. The scores are defined as: 1) Definitely not avoidable 2) Slight evidence of avoidability 3) Possibly avoidable but not very likely less than 50/50.

7. Deaths with a Hogan score* of 4 – 6. The scores are defined as 4) Probably avoidable more than 50/50. 5) Strong evidence of avoidability 6) Definitely avoidable. NHSI guidance ‘Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading the reader’.

8. Learning points – the number of issues identified from reviews and investigation (including examples of good practice). The main purpose of this initiative is to promote learning and improve how Trusts support and engage with families and carers of those who die in our care.

9. Family/carer concerns – the number of concerns raised by families and carers that have been considered when determining whether or not to review or investigate a death. All families are offered support from our bereavement service and involved in investigations where relevant.

10. CUSUM (or cumulative sum) alerts - are statistical quality control measures which alert the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group. Each death in a CUSUM alert is usually subject to a full case review to promote learning and improvement.

11. Deaths investigated as a SII (serious incident inquiry) - the number of deaths investigated as a serious incident inquiry and graded as catastrophic.

12. Deaths following a planned admission – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had progressive disease and were admitted to hospital for symptom control or a procedure to relieve their symptoms.

13. Unexpected deaths – of patients who were not expected to die during their admission to hospital are subject to a full case review.

14. Stillbirth – is a baby that is born dead after 24 completed weeks of pregnancy.

15. Neonatal death – is the death of a live born baby during the first 28 days after birth.

16. Child death – the death of a child up to the age of 18. All unexpected child deaths are reviewed by the Wiltshire and Swindon Child Death Overview Panel.

17. Learning disability deaths – all patients with a learning disability aged 4 to 74 years who die in hospital. The Trust reports all these deaths to the LeDeR programme.

18. LeDeR programme – Learning Disabilities Mortality review programme hosted by the University of Bristol aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. The programme reviews the deaths of people with learning disabilities.

19. Serious mental illness – all patients who die in hospital with a serious mental illness.

20. Maternal deaths – is the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal deaths are rare events.

References

*Hogan H et al, 2015 Avoidability of hospital deaths and association with hospital wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351 https://www.bmj.com/content/351/bmj.h3239

NHS Improvement, July 2017. Implementing the learning from deaths framework: key requirements for Trust Boards. NHS Improvement, London.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.4
Date of Meeting:	14 January 2021		

Report Title:	Director of Infection Prevention & Control (DIPC) 6 monthly Report for 2019/20			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy, Senior Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing and DIPC			
Appendices (list if applicable):	Included within the report			

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

Executive Summary:

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Director of Nursing.

The DIPC Reports together with the monthly Key Quality Performance Indicators Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this six monthly update DIPC Report is to inform the Trust Board of the progress made against the 2020/21 Annual Action Plan (Appendix A), to reduce healthcare

associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced an exceptionally challenging six months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic

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

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

6 MONTHLY REPORT

April 2020 – September 2020

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

November 2020 (Draft v.1)

CONTENTS **PAGE**

APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Director of Nursing.

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this six monthly update DIPC Report is to inform the Trust Board of the progress made against the 2020/21 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced an exceptionally challenging six months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2020/21 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix B).

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control Team (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 3 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG

- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Facilities directorate regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g. NHS Improvement (NHSi), within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, 2015), and the Health Protection Agency HCAI Operational Guidance & Standards (2012), Health Protection Agency now Public Health England (PHE) from 1st April 2013.

During quarters 1 and 2 of 2020/21, the Trust has had **no** declared internal outbreaks of:

- Viral gastroenteritis (Norovirus)
- *Clostridioides difficile* (*C.difficile*)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the PHE website: https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators (CSC), with additional written documentation provided to support staff in the ongoing management of these patients.

5.1 Coronavirus (Wuhan CoV)

On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province in China. On 12th

January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. The virus is referred to as SARS-CoV-2, and on 11th February, WHO named the syndrome caused by this novel coronavirus COVID-19. The source of the outbreak has not yet been determined. According to current evidence, it is primarily transmitted between people through respiratory droplets and contact routes. Airborne transmission is possible in specific settings in which procedures or support treatments that generate aerosols are performed. The first cases were confirmed in the United Kingdom (UK) at the end of January 2020 and WHO declared a pandemic on 11th March 2020.

From January 2020, the Trust initiated emergency planning and resilience response measures utilising significant PHE guidance and updates published as the situation continued to evolve. This included the identification of emergency assessment/triage areas, respiratory assessment zones and care areas, testing programme and PPE practice management. The Trust has followed established Emergency Preparedness, Resilience and Response (EPRR) protocols which include the instigation of strategy planning and Incident Management Team (IMT) meetings, with key personnel to agree actions and develop iRespond cards across the directorates and disciplines. This work has remained ongoing into quarters 1 and 2 of 2020/21.

The IPC team has continued to provide representation within the various identified workstreams, which has included Incident Management Team (IMT), Clinical Review Group, Workforce, Recovery, Personal Protective Equipment (PPE) and Virtual Board Round. (*Of note: in relation to PPE supplies, the Trust worked exceptionally hard to ensure adequate stock levels of the required standard were maintained).*

An IPC 'Task and Finish' Group was set up to provide a forum to review and action the continual changes to the IPC guidance published by PHE related to COVID-19. The group has representation from all clinical divisions as well as Corporate, Estates and Facilities. Key achievements of the group have included providing evidence to populate the IPC Board Assurance Framework (BAF) document (version 1.3); Outbreak Management Framework/Policy and process agreement; reviewing and final agreement for use of portable fans in clinical environments Standard Operating Procedure (SOP) and risk assessment document; patient visiting protocol and related risk assessment documentation; review of risk assessments for COVID secure workplaces, with adaptations (where possible) of the environments and feedback of national learning.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends.

It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by Public Health England (PHE).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During quarter 1 of 2020/21, there has been one hospital onset MRSA bacteraemia case identified for an inpatient on the haematology/oncology ward (during April). Key learning included the development of a local competency booklet for peripherally inserted central catheters/lines (PICC), continuing monitoring and assessment of all invasive devices by staff and maintaining the required care documentation e.g. consistent recording of visual infusion phlebitis (VIP) scores.

The Trust's MRSA hospital onset case target for 2020/21 is zero.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During quarters 1 and 2 of 2020/21, there have been two hospital onset MSSA bacteraemia cases. Of these unrelated cases, the sources of infection were identified as:

- Skin or soft tissue (one case)
- Lower respiratory tract (one case).

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset.

6.3 Gram-negative organism bloodstream infections (GNBSIs)

The increase in gram negative organism bacteraemia infections is a national concern. Mandatory surveillance of *Escherichia coli* (E.coli), *Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias has been introduced by the Department of Health (DH). This reporting at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work is undertaken by the ICNs. A national action plan 'Tackling antimicrobial resistance 2019 –2024' (January 2019) advises that work should continue to healthcare associated GNBSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021/22 with a full 50% reduction by 2023/24. The latest statistics show the Trust is heading in the right direction to achieve this.

6.3.1 *Escherichia coli (E.coli)*

Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the nine hospital onset cases identified during quarters 1 and 2 of 2020/21, one was unknown or unclear source of infection and the remaining eight cases had a source of infection identified. Of these unrelated eight cases, the sources of infection were:

- Hepatobiliary (one case)
- Lower urinary tract (four cases)
- Gastrointestinal or intra-abdominal collection (three cases).

Of note: two of these E.coli bacteraemia cases were also identified to be Extended Spectrum Beta-Lactamase (ESBL) producing organisms and one bacteraemia case had a second organism identified (Klebsiella spp.).

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, the ICNs are working collaboratively with the relevant CCGs who are leading on achieving this Quality Premium guidance.

6.3.2 *Klebsiella sp.* and *Pseudomonas aeruginosa*

During quarters 1 and 2 of 2020/21, there have been a total of one hospital onset *Klebsiella spp.* bacteraemia cases and three hospital onset *Pseudomonas aeruginosa* bacteraemia cases.

Of note: the Klebsiella spp. bacteraemia case sample also identified E.coli organism (as detailed in section 6.3.1).

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis

6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to PHE. For 2019/20, changes were made to the *C.difficile* reporting algorithm. This included the addition of a prior healthcare exposure element for community onset cases, and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20, the *C.difficile* case objective set for the Trust by NHSi and NHS England (NHSE) was no more than 9 healthcare associated reportable cases. This was a 50% reduction on the previous year's limit. These objectives have been set using the Trust data from 1st April 2018 to 31st December 2018. For 2020/21, no C.difficile case objectives have been set for the Trust. Guidance for testing and reporting *C.difficile* cases remains unchanged and the safety and care of patients remains our concern and priority.

Unfortunately, during quarters 1 and 2 of 2020/21, the Trust has reported 15 healthcare associated *C.difficile* cases to PHE, of which 7 cases were community onset and 8 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is led by the ICNs to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs undertake a case review for the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

Due to the COVID-19 pandemic workload, no healthcare associated *C.difficile* cases have been identified for submission to the relevant CCGs for the Appeals Process Panel.

From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning included improvements required for the use of the Diarrhoea Pathway, completion of stool charts and related documentation; and sampling of symptomatic patients.

During quarters 1 and 2 of 2020/21, the ICNs have completed additional investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

6.4.1 Periods of increased incidence of *C.difficile*

As previously reported for 2018/19 (February 2019), the PII for Pembroke Ward was extended to include the suite facility. The required incident investigations were completed with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant senior staff including HoN and Matrons. At the request of the IPCWG, ribotyping and enhanced fingerprinting service results were reviewed by the ICD with final reporting to the DIPC. No outbreak was declared retrospectively and a meeting has been scheduled during quarter 3 of 2020/21 with the Pembroke Unit team to formally feedback all the *C.difficile* ribotyping results, revisit shared learning and close the PII of *C.difficile.*

Please see Appendix C for the Infection Prevention & Control 'Dashboard' of 2020/21 for further detail.

6.4.2 Notification of intention to review financial sanctions and sampling rates from 2020/21

The faecal sampling and *C.difficile* infection testing rates for all NHS providers will be reviewed to determine how they compare, especially for similar institutions. PHE already collects Laboratory data on such sampling and testing rates on a quarterly basis. PHE are aware that workload variation between Laboratories will affect *C.difficile* infection testing rates, e.g. the proportion of all faecal samples received that originates from the community as opposed to from hospitalised patients.

Preliminary analyses of the data already submitted to the PHE DCS system shows marked workload variations between Laboratories, which need to be explained/addressed to minimise the risk of ascertainment bias on *C.difficile* infection rates. Failure to diagnose *C.difficile* infection raises the possibility of poor outcomes for patients and missed opportunities for control. There will be a particular focus on providers with high *C.difficile* infection rates but low sampling/testing rates relative to their peers. The option to review financial sanctions and the current lapses in care process will be undertaken ahead of objective setting for 2020/21.

There has been no further update received for the Trust regarding this.

6.5 Surgical Site Infection Surveillance (SSIS)
The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved.

The Trust complies with this annual requirement to undertake SSIS. Surveillance was commenced at the beginning of quarter 2 of 2020/21 for total knee replacement (TKR) surgery. However, due to the current COVID-19 pandemic, all elective TKR surgery was being undertaken at a local private hospital. Therefore, following discussions and agreement with the divisional team, the surveillance category was changed to the repair of fractured neck of femur (NOF). Data collection for this category of surgery will continue into quarter 3 of 2020/21 to ensure that an appropriate cohort of cases is attained.

Formal reports outlining progress with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel. From the data collected during quarter 2 of 2020/21, there were no identified deep infections for this active surveillance category. Data will be entered onto the national database and submitted for reconciliation within the required time frame set by PHE.

6.6 MRSA screening
The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For quarters 1 and 2 of 2020/21, the Trust compliance rates for MRSA emergency screening ranged from 84.33% - 97.89%. For MRSA elective screening, 100% and 66.67% compliance was recorded. However, it must be acknowledged that the number of elective patients within the two cohorts were exceptionally small.

Outcomes of any follow up of actions undertaken by the clinical divisions are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health (DH) guidance published in 2015, and continues following further review by the Trust.

6.7 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections (BSIs) in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, report updates have been provided by PHE and cascaded to the area leads.

6.8 Private Healthcare Information Network (PHIN)
The Trust is now mandated to report externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is

externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data reviewed and provided by the ICNs, there have been no externally reportable infection alert organisms identified for this patient group.

7. HAND HYGIENE

Fifty two areas (including wards and departments) across the three clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the divisions to take the necessary action.

Due to the COVID-19 pandemic, there have been no audits completed by the external auditor during quarters 1 and 2 of 2020/21. However, the clinical divisions have been undertaking cross auditing within their areas and specialities to further validate the audit process.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and also following removal of gloves. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed by the clinical areas the overall average compliance rate for quarters 1 and 2 of 2020/21 ranges from 63.08% - 100%. It should be noted, there has been a higher rate of non-completion/non-return of audits from areas during quarters 1 and 2 of 2020/212. This has reduced the overall average compliance score for these areas.

The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures being monitored by the IPCWG, DMTs and Matrons Monitoring Group (MMG) now the Patient Led Assessment in the Clinical Environment (PLACE) Steering Group.

8. ANTIBIOTIC STEWARDSHIP

Quarter 1 of 2020/21 was challenging initially for the Antimicrobial Reference Group (ARG) due to COVID-19 restrictions and reduced staffing. However, as of July 2020, we have recruited a new consultant microbiologist and consequently, started a weekly antimicrobial ward round. This has had a positive impact in promoting antimicrobial stewardship through reviews of all intravenous antibiotics prescriptions. To date, this has resulted in stopping inappropriate intravenous antibiotics prescriptions in 8.8% of prescriptions reviewed. 10.9% of intravenous antibiotics prescriptions have been switched to oral, which has direct impact on length of inpatient stay, and financial savings.

8.1 Commissioning for Quality and Innovations (CQUINs) for 2020/21

All CQUINs are currently on hold however, we continue to collect data as per the 2019/20 CQUIN to help maintain good practice in the diagnosis of urinary tract infections; albeit in older patients. Initial results from quarter 1 of 2020/21 showed a compliance of 47%. This was down compared to 61% and 51% from quarter 4 of 2019/20 and annual average of 2019/20 respectively. The

decrease in compliance can be attributed to changes in what had been standard practice on the acute admissions wards due to pressures from the COVID-19 pandemic.

8.2 Total antibiotic consumption

We have recently appointed a new Lead Antimicrobial and Risk Pharmacist. Due to this and staff shortages, the data on our total antibiotics consumption is outstanding, but this will be included in the next report.

8.3 Action plan for 2020/21

The CQUINs for 2020/21 are currently on hold due to the COVID-19 pandemic. The lower urinary tract infections (UTIs) CQUIN will be extended to include all patients over 16 years with a diagnosis of UTI, including upper, lower and catheter-associated UTI. We are already making plans as to how to tackle this CQUIN.

9. AUDIT

The ICNs have not undertaken any formal policy audit during quarters 1 and 2 of 2020/21, but have been actively involved in supporting identified clinical areas to complete the *'Perfect Ward' Application'* infection prevention and control inspections. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. *(Of note: these inspections include policy practice standards as part of audit criteria).*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via MMG meetings (now the PLACE Steering Group). (Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas).

Please see Appendix D for further details, the results show an improving direction and continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Mean compliance scores for quarters 1 and 2 of 2020/21 were 77% for staff completion of hand hygiene assessments and 92.5% for staff completion for IPC computer based learning (CBL) package.

The drop in hand hygiene assessment compliance may be attributed to the access opportunities during both quarters due to the COVID-19 pandemic. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their divisional areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. These include core induction sessions in addition to specific topic requests. The facilitation of learning has also involved members of staff shadowing of the ICNs in addition to the monthly scheduled Infection Control Link Professional (ICLP) meetings. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Progress on actions from quarters 1 and 2 of 2020/21

Progress on actions from some of the bigger projects was affected during quarter 1 due to the COVID-19 pandemic and re-prioritisation of work but some progress has been made in quarter 2.

We continue to explore transferring our Trophon devices to a managed service contract but recently have identified an alternative device which may suit some clinical areas better due to faster processing times. We need to assess the feasibility of both systems before being able to confirm the contract. Both systems would provide an automated process with reliable validation of efficacy compared to the manual wipe systems. There will still be some devices which are incompatible with either system so we are not able to eradicate the wipe system completely, but are keen to utilise best practice options where able.

The bid for six dry storage cabinets (DSCs) was successful. This will offer an increase in storage capacity, longer validated storage times and ensure safe storage of our full range of endoscopes within the Endoscopy Unit. Although delayed due to the current situation, two are now installed, validated and about to 'go live' in a temporary location to facilitate environmental building work to improve the permanent location.

The Trust's Authorised Engineer for Decontamination (AE (D)) had early visits cancelled due to the pandemic, but has recently been back to site. During this visit the AE (D) spent some time in the Laboratories supporting the teams with their autoclaves to follow up on actions identified in response to a previous Health & Safety Executive (HSE) visit.

11.2 Key Success stories in quarters 1 and 2 of 2020/21
A bid to introduce single use 'buttons' on the fleet of Endoscopy scopes was recently agreed despite a significant cost pressure. The business case highlighted the challenges with cleaning and traceability of these small items and recognised the need to improve practice. Single use buttons will provide more robust assurance and improve patient safety.

In response to queries and requests for reassurance, updated posters were designed to support staff with decontamination of re-usable devices during the pandemic. In addition, an increase in options for single use items were made available to order within the Trust, such as blood pressure (BP) cuffs and saturation probes. This gave an alternative approach which was preferred by some clinical areas, especially those dealing with a high number of positive cases.

11.3 Key challenges for quarters 3 and 4 of 2020/21
Following completion of the environmental work, oversee the installation and validation of the remaining DSCs in the Endoscopy Unit. Ensure new SOPs are in place for the use of the cabinets and processes are refreshed in Sterile Services limited (SSL) to promote best practice in storing the scopes as soon as possible following reprocessing.

The Business Continuity Plan (BCP) has not yet been practically tested for reprocessing of surgical instrumentation. This was work suggested by the previous chair of SSL Operational Management Board (OMB) but has stalled. In addition, there is still no confirmed start date for the refurbishment work in SSL. Contingency plans for both instrumentation and scope reprocessing are required ahead of the refurbishment due to the increased risk of service interruptions.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities directorate.

12.1 Patient led assessment of the care environment (PLACE) internal audits
The Trust developed (with ward leaders) and implemented a programme of PLACE audits for 2019/20 and planned to undertake 60 internal PLACE assessments between June 2019 and March 2020, using the new NHSi PLACE criteria.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE Lite tool and discussed with ward leaders at the monthly Matrons Monitoring Group (replaced by the PLACE Steering Group, as from October 2020).

Due to the pandemic, in March (2020) the Director of Nursing approved the internal PLACE assessments and Housekeeping audits be temporarily suspended. Approval to recommence these has been given and a plan is in place to commence in October 2020.

To support social distancing and to minimise footfall within clinical areas the number of participants in PLACE inspections will be limited, with no Governors or Volunteers present.

12.2 National PLACE
We have been informed by NHSi that this year's National PLACE inspection has been cancelled due to the COVID pandemic; we await further information regarding the National PLACE for 2021.

12.3 Deep clean programme/rapid response team
The deep clean and decorating programme commenced in April 2020 (a copy of the Deep Clean programme is available from the Housekeeping Department). A monthly review of this plan is undertaken at the PLACE Steering Group Meeting and discussed with the ICNs and HoN/Matrons at weekly meetings.

12.4 Improvement Work Over the past 6 months
To support the Trust's COVID-19 response the Housekeeping Team are providing a 24 hour service with a small cleaning team on site out of hours. A recent recruitment drive was undertaken in August to fill all vacancies and ensure staff are trained prior to the winter period.

Housekeeping has undertaken 8557 cleans in the past six months, 4000 more than the previous six months. Housekeeping routinely monitors those bedspaces requiring a terminal clean (post infection clean) where furniture (including bed) is not present in the bedspace or room at the time of the clean. This information is fedback to ward leaders, HoN/Matrons and ICNs for further investigation and to ensure risks are reduced.

In response to poor service, the Housekeeping Department terminated the sanitary bin contract with Cannon Hygiene in June 2020, giving three months' notice, this service has been taken inhouse and will commence in October 2020.

12.5 Challenges for the coming 6 months
Housekeeping continues to see the demand for terminal cleans increase. We continue to resource the later shift with extra staff in order to meet demand for terminal cleans later in the day. Resourcing for three extra members of staff for six months (Winter Pressures) was approved and the recruitment has been successful to support the increased in activity during this time.

13. WATER SAFETY MANAGEMENT
This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2020/21. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and Deputy Responsible Person (dRP) water) from ETS and FES Ltd (Private Finance Initiative (PFI) maintenance contractor) are held on a monthly basis, to review progress with planned preventive maintenances' (PPMs) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

13.1 Legionella

Emergency review meetings (See Tables 1 and 2 for Legionella, listing counts reported >1000 cfu/l) and high counts for Pseudomonas (Table 3) have taken place in the Trust as a result of the sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mail communications as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 9th October 2020	
					Pre	Post
1	AMU	62	2.2.56 (WHB)	3rd clear, outlet returned to use	>20	>20
2	AMU	134	2.2.56 (Shower)	3rd clear, outlet returned to use	>20	>20
3	Sarum Ward	7	4.05.02 (WHB)	Disinfect outlet, flush and re-sample	1800	>20
4	Ear, Nose & Throat (ENT) Outpatients Department (OPD)	13	3.4.14 (WHB)	Remedial works ongoing on system by ETS	580	1500

(Table 1)

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 2nd October 2020	
					Pre	Post
5	ENT OPD	15	3.4.24	Disinfect outlet, flush and resample	4700	4000
6	Disabled WC (Level 3)	69	Level 3 street	Outlet replaced and works completed on the hot and cold supply, flush and resample	4000	1000
7	Laboratories (Level 3)	91	3.15.01	Remedial works ongoing on system by ETS	840	160
8	Laboratories (Level 3)	92	3.15.03	Remedial works ongoing on system by ETS	>20	340
9	Laboratories (Level 4)	96	4.16.22	Remedial works ongoing on system by ETS	>20	460
10	Respiratory Department	94	3.16.19	Continue to flush and resample	>20	>20
11	Respiratory Department	95	3.16.10	Continue to flush and resample	>20	>20
12	Amesbury Suite	PFI	4.10.245	Continue to flush and resample	>20	>20

(Table 2)

13.2 Pseudomonas Sampling

Live counts are being managed on Sarum and Odstock Wards, with the latest actions and results from resampling listed on Table 3 below.

Pseudomonas						
	Ward/ Department	PS Ref	Location	Action plan	Test result as of 6th October 2020	
					Pre	Post
1	Sarum Ward	193	4.06.09	3rd clear, outlet back in use	Not detected (ND)	ND
2	Sarum Ward	208	4.06.22	3rd clear, outlet back in use	ND	ND
3	Sarum Ward	217	4.06.32	3rd clear, outlet back in use	ND	ND
4	Sarum Ward	218	4.06.32	1st clear, resample	ND	ND
5	Sarum Ward	222	4.05.03	3rd clear, outlet back in use	ND	ND
6	Sarum Ward	233	4.05.11	3rd clear, outlet back in use	ND	ND
7	Odstock Ward	263	4.11.28	2nd clear, resample	ND	ND
8	Odstock Ward	112	4.11.29	2nd clear, resample	ND	ND
9	Odstock Ward	116	4.11.32	Outlet out of use, clean/disinfect and resample	>100	>100
10	Odstock Ward	123	4.11.33	Outlet out of use, clean/disinfect and resample	>100	>100
11	Odstock Ward	259	4.11.06	1ST clear, outlet to be resampled and returned to use	ND	ND
12	Odstock Ward	179	4.11.48	Outlet removed from use	>100	>100
13	Odstock Ward	175	4.11.53	2nd clear, resample	ND	ND

(Table 3)

13.3 Achievements for quarters 1 and 2 of 2020/21

- The Estates team have completed remedial works on the water systems (hot & cold), that have been identified as issues from the investigation of positive sample results.
- Remedial works on outlets that have returned positive from testing for Legionella and Pseudomonas have been successful in areas such as AMU (Legionella) and Sarum Ward (Pseudomonas).
- The level of flushing compliance for clinical areas has been maintained and the figures for quarters 1 and 2 are 73.36% for Priority 1 areas and 99% for Priority 2.
- Maintaining the temperature of the main hot and cold water systems.
- National funding awarded for Backlog Maintenance, a proportion of funding will be used for the replacement of the main heating and hot water systems for SDH North. This system feeds the majority of the wards and departments across the Trust.

13.4 Key Focus for quarters 3 and 4 of 2020/21

- Maintaining the temperature of the hot and cold water systems across the Trust.
- Completion of routine sampling for Pseudomonas on augmented wards – Radnor Ward (Intensive Care Unit), Neonatal Unit (NNU), Pembroke and Longford Wards.
- Ensuring sufficient resource (labour & financial) to complete all PPM's directly associated with water safety.
- Engagement of key members (DIPC, Consultant Microbiologist, ICNs) of the Water Safety Group (WSG) in supporting action plans and quarterly meetings of the WSG.
- Developing the Operational Procedures for Water Safety with the assistance of the Trust AE.

- Refresher training for the Trusts dRP Water (Operations Manager).
- Completion of the tender for the works associated with a new site Water Risk Assessment.

14. CONCLUSION

This six monthly update DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2020/21 in reducing HCAI rates for the Trust.

For quarters 3 and 4 of 2020/21, the key ambitions for the Trust will include:

- Continued response to the impact of the COVID-19 pandemic
- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

15. ACKNOWLEDGEMENTS

The author would like to acknowledge the assistance of the following people in the compilation of this report:

- Fiona McCarthy, Senior Nurse, Infection Prevention & Control Team (Sections 1, 2, 3, 4, 5, 6, 7, 9, 10, 14 and 15)
- Sithembile Ncube, Lead Pharmacist for Antimicrobials and Risk Management and Medicines Safety Officer (Section 8)
- Clare Goodyear, Trust Decontamination Lead and Medical Devices Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities (Section 12)
- Terry Cropp, Responsible Person for Water & Senior Estates Officer (Section 13).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2020/21

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPCT	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/PR/LA/PF	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/PR/LA/PF	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/CG	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings (renamed PLACE Steering Group from quarter 2 of 2020/21)	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	HoNs/Matrons/ IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/PR/LA/PF	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	PK/LM	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)		In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/SN	In place
Mandatory reporting HCAIs to Public health England (PHE)	JH	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IPCT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	GD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	TC	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	CG	In place

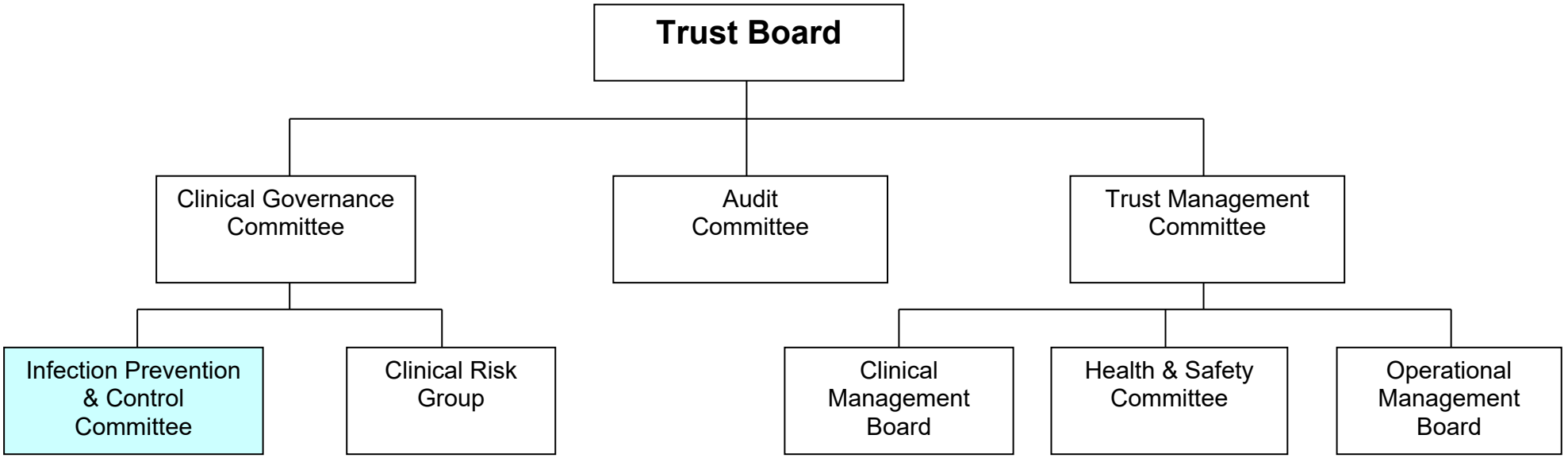
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & safety services (OHSS)	LL/LM	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	LM	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	HoN/Matrons/ICNs	Continuous

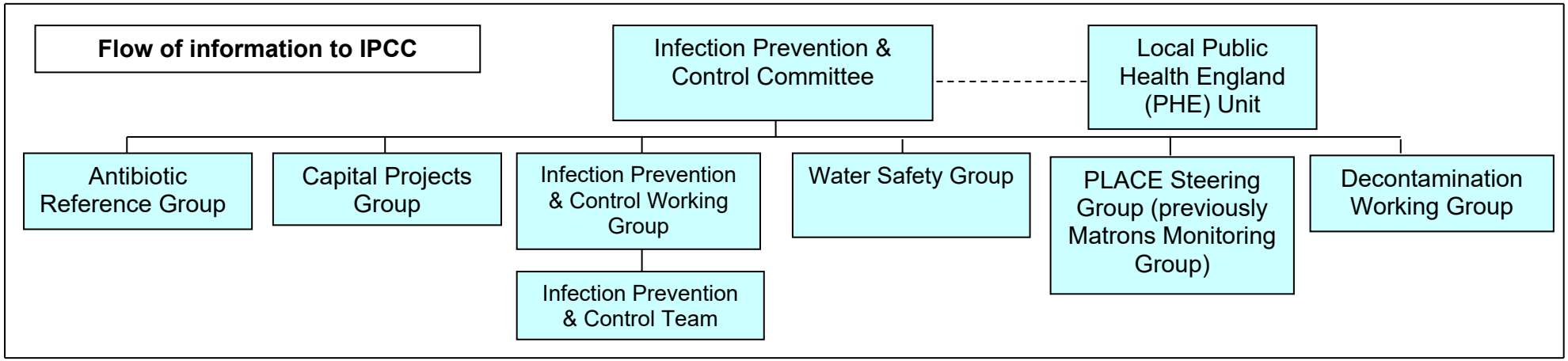
KEY INITIALS

DIPC Lorna Wilkinson, Director of Infection Prevention & Control (DIPC) *(until June 2020)*
DIPC Judy Dyos, Director of Infection Prevention & Control *(from June 2020)*
DDIPC Denise Major & Fiona Hyett, Deputy DIPCs
CG Clare Goodyear, Trust Decontamination Lead and Medical Devices Safety Officer
JH Julian Hemming, Consultant Microbiologist & Infection Control Doctor (ICD)
PR Paul Russell, Consultant Microbiologist
PF Paul Flanagan, Consultant Microbiologist & Antimicrobial Lead *(from July 2020)*
LA Layth Alsaffar, Consultant Microbiologist *(initially Locum then substantive post from September 2020)*
IR Ian Robinson, Operations Director, Estates & Facilities
TC Terry Cropp, Responsible Person for Water & Senior Estates Officer
HoN Heads of Nursing *(previously Directorate Senior Nurses)*
PK Paul Knight, Health & Safety Manager, Occupational Health (OH) Department
SN Sithembile Ncube, Lead Pharmacist for Antimicrobials and Risk Management and Medicines Safety Officer
GD Geoffrey Dunning, Neonatal Unit Charge Nurse
MF Maria Ford, Quality Improvement Matron *(previously Nurse Consultant in Critical Care)*
LL Lynn Lane, Interim Director of Organisational Development & People
MS Michelle Sadler, Facilities Manager
LM Lisa McLuckie, Head of Occupational Health and Well-being Lead *(new appointment April 2020)*

APPENDIX B

Formal Trust Reporting Structure





APPENDIX C (Quarters 1 & 2 of 2020/21)

		Clostridium difficile - all cases (reportable and not reportable)			Bacteraemias - all cases are reportable to Public Health England (PHE)													
		Sample taken			*MRSA*		*MSSA*		*E.coli*		*Pseudomonas aeruginosa*		*Klebsiella sp.*		Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC PWA % (mean score)
Clinical Directorates	**Inpatient areas/wards**	Hospital onset; healthcare associated	Community onset; healthcare associated	**No lapses in care**	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Number of days in outbreak			
Clinical Support & Family Services	Labour Ward																81.67%	N/A
	Neonatal Unit																98.33%	N/A
	Post-natal Ward																100%	N/A
	Sarum Ward (inc. Children DAU)		1					1	1								82.78%	99.4%
	CS&FS Totals:		1					1	1									
Medicine	AMU		2					1		1				1			63.08%	95.36%
	Durrington Ward	1															83.33%	93.57%
	ED (inc. SSEU)							6		24		2		7			80.4%	N/A
	Respiratory Care Unit (RCU) Level 2 template)	1								1		1					81.8%	94.84%
	Hospice Unit																100%	No audits
	Laverstock Ward (Stroke Unit Level 4 template)								1								64.99%	96.98%
	Pembroke Ward	3			1												100%	93.1%
	Pembroke Suite																97.14%	N/A
	Pitton Ward																96.56%	93.2%
	Redlynch Ward	1							2		1						82.07%	95.3%
	Spire Ward	1	1														99.41%	94.88%
	Tisbury CCU	1					1										94.64%	95.17%
	Whiteparish Ward								1								90.06%	92.7%
	Medicine Totals:	6 + 2	2 + 1		1		1	7	4	26	1	3		8				
Surgery	Amesbury Suite							1									81.16%	88.03%
	Breamore Ward																Closed	Closed
	Britford Ward/SAU		1								1						74.19%	97.48%
	Chilmark Suite																94.58%	97.26%
	Day Surgery Unit																73.69%	97.35%
	Downton Ward	2 + 1						1	2	2	1						96.57%	96.08%
	Longford Ward																98.02%	95.05%
	Odstock Ward						1										96.63%	90.4%
	Radnor Ward								2				1				92.89%	96.72%
	Surgery Totals:	2 + 1	1				1	2	4	2	2		1					
Additional info: Other samples e.g. GP, Emergency Assessment, OPD, Mortuary, Private Hospital			4					1		1				1				

All SFT samples including inpatient and outpatient areas, GP and other e.g. Emergency Assessment

C.difficile reportable cases = red

C.difficile not reportable cases = blue

Perfect Ward scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

APPENDIX D

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2020/21

Ward/ Dept	Division	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Sarum	Clinical Support & Family Services			26.06.20 (100%)	31.07.20 (97.6%)	26.08.20 (100%)	29.09.20 (100%)
Acute Medical Unit	Medicine	06.04.20 (86.3%)	13.05.20 (96.2%)		07.07.20 (100%)	05.08.20 (100%)	08.09.20 (94.3%)
Durrington Ward	Medicine	09.04.20 (92.3%)	12.05.20 (93.8%)	16.06.20 (96.1%)	07.07.20 (94.2%)	23.08.20 (96.2%)	06.09.20 (96.2%) 25.09.20 (86.2%)
Farley RCU Ward	Medicine	28.04.20 (92.2%)	20.05.20 (89.6%)	17.06.20 (96.1%)	01.07.20 (96.2%)	01.08.20 (96.2%) 04.08.20 (98.1%) 13.08.20 (92.2%) 31.08.20 (98.1%)	
Hospice Unit	Medicine						
Laverstock Ward (Stroke Unit)	Medicine	25.04.20 (96.2%)	20.05.20 (98.1%)	06.06.20 (97.9%)	12.07.20 (96%)	20.08.20 (95.6%)	20.09.20 (98.1%)
Pembroke Ward	Medicine			28.06.20 (93.9%)	11.07.20 (92.3%)		
Pitton Ward	Medicine	05.04.20 (96.1%)	08.05.20 (88.2%)	09.06.20 (96.2%)	09.07.20 (92.3%)	04.08.20 (90.2%)	20.09.20 (96.2%)
Redlynch Ward	Medicine	20.04.20 (94.1%)	20.05.20 (92.3%)		01.07.20 (96.1%)	05.08.20 (96%)	27.09.20 (98%)
Tisbury CCU	Medicine	15.04.20 (94.2%)	08.05.20 (92.3%)	04.06.20 (94.3%)	05.07.20 (96.1%)	30.08.20 (96.2%)	27.09.20 (97.9%)
Whiteparish Ward	Medicine		10.05.20 (88.5%)	21.06.20 (96.2%)	24.07.20 (96.1%)	13.08.20 (90.4%)	06.09.20 (92.3%)
Spire Ward	Medicine	29.04.20 (98%)	25.05.20 (94.3%)	03.06.20 (86.5%)	20.07.20 (94.3%)	28.08.20 (100%)	06.09.20 (96.2%)
Amesbury Suite	Surgery	01.04.20 (86.5%) 17.04.20 (94.2%)	06.05.20 (80%)	17.06.20 (94.2%)	16.07.20 (82.7%)	27.08.20 (88.2%)	20.09.20 (90.4%)
Chilmark Suite	Surgery	01.04.20 (100%)		22.06.20 (100%)	18.07.20 (97.8%)	26.08.20 (92.5%)	20.09.20 (96%)
Odstock Ward	Surgery	18.04.20 (88.2%)	27.05.20 (95.7%)	30.06.20 (98.1%)	28.07.20 (98%)	27.08.20 (98%)	12.09.20 (92.3%)
Longford Ward	Surgery	21.04.20 (86%)	28.05.20 (96.2%)	21.06.20 (91.8%)	23.07.20 (84%)	20.08.20 (88.2%)	13.09.20 (96.2%)
Britford Ward	Surgery		27.05.20 (97.7%)	23.06.20 (98%)	27.07.20 (95.7%)	27.8.20 (98%)	14.09.20 (98%)
Downton Ward	Surgery	15.04.20 (100%)	06.05.20 (94.3%)	09.06.20 (87.8%)	07.07.20 (98.1%)	31.08.20 (94.2%)	10.09.20 (98.1%) 15.09.20 (98.1%) 28.09.20 (98%)
Radnor Ward	Surgery	27.04.20 (94%)	15.05.20 (96.2%)	28.06.20 (94.1%)	18.07.20 (100%)	21.08.20 (98%)	25.09.20 (98%)
Day Surgery Unit	Surgery	08.04.20 (97.6%)	05.05.20 (97.7%)	22.06.20 (97.7%)	24.07.20 (93.2%)	13.08.20 (97.9%)	11.09.20 (100%)

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

APPENDIX E

Perfect Ward Application (PWA) QuickCOVID-19 Assessment Compliance scores for Quarters 1 & 2 of 2020/21

Ward/ Dept	Division	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Sarum	Clinical Support & Family Services				16.07.20 (100%)	26.08.20 (100%)	
Acute Medical Unit	Medicine	27.04.20 (100%)			10.07.20 (96%)		10.09.20 (96%)
Durrington Ward	Medicine	22.04.20 (97.7%)		16.06.20 (97.7%)	28.07.20 (96%)		10.09.20 (100%)
Farley RCU Ward	Medicine		29.05.20(100%)		24.07.20 (100%)		
Hospice Unit	Medicine						
Laverstock Ward (Stroke Unit)	Medicine		27.05.20 (100%)	17.06.20 (100%)	28.07.20 (100%)		
Pembroke Ward	Medicine	27.04.20 (96.6%)		09.06.20 (98.9%)	17.07.20 (100%)		
Pitton Ward	Medicine	22.04.20 (100%)	30.05.20 (100%)		28.07.20 (100%)		
Redlynch Ward	Medicine	27.04.20 (100%)	30.05.20 (96.3%)		28.07.20 (100%)		10.09.20 (100%)
Tisbury CCU	Medicine	27.04.20 (100%)	30.05.20 (100%)	16.06.20 (98.6%)	27.07.20 (96%)		
Whiteparish Ward	Medicine	27.04.20 (100%)	30.05.20 (100%)		24.07.20 (96%)		
Spire Ward	Medicine	24.04.20 (96.8%)	29.05.20 (100%)	17.06.20 (100%)	24.07.20 (92%)		
Amesbury Suite	Surgery	01.04.20 (85.7%) 02.04.20 (100%) 16.04.20 (100%)		09.06.20 (100%)	17.07.20 (100%)		
Chilmark Suite	Surgery	01.04.20 (85.7%)		24.06.20 (100%)	17.07.20 (100%)		
Odstock Ward	Surgery	02.04.20 (86.4%) 17.04.20 (100%)		23.06.20 (96%)			
Longford Ward	Surgery	01.04.20 (100%) 16.04.20 (100%)			08.07.20 (98.9%)		
Britford Ward	Surgery			24.06.20 (91.7%)			
Downton Ward	Surgery	23.04.20 (88.9%) 29.04.20 (84.9%)		24.06.20 (92.9%)			
Radnor Ward	Surgery	22.04.20 (100%) 29.04.20 (100%)			09.07.20 (100%)	24.08.20 (100%)	21.09.20 (100%)
Day Surgery Unit	Surgery	22.04.20 (95%)		25.06.20 (93.1%)			

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.5
Date of Meeting:	14 January 2021		

Report Title:	Overview of the Ockenden Report.			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		√		
Prepared by:	Judy Dyos			
Executive Sponsor (presenting):	Judy Dyos			
Appendices (list if applicable):	Copy of letter to the regional chief midwife Response form the regional chief midwife			

Recommendation:
To provide the Trust Board oversight of the Ockenden report into maternal and neonatal deaths at Shrewsbury and Telford NHS trust as per actions requested by NHSI . To provide the Trist board with Assurance assessment tool for Salisbury Foundation Trust

Executive Summary:
This slide pack is to ensure the Trust Board is given oversight of the Ockenden report into maternal and neonatal deaths at Shrewsbury and Telford NHS trust. All NHS Trusts that have maternity services have been directed to complete an Assurance Assessment in relation to Maternal and Neonatal Safety This presentation details the background to the Ockenden report and the Assurance assessment undertaken by Salisbury NHS Foundation Trust. To note • Our metrics show we are not a negative outlier for safety • We have undertaken proactive commissioning of external reviews due to soft intelligence and freedom to speak up and guardians • Oversight of our Serious Incidents has been brought to Clinical Governance Committee and Private Board

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

Ockenden Report Emerging findings

Judy Dyos

09/01/2022

Background

Concerns raised by bereaved families about the care at Shrewsbury and Telford Trust in 2017 about maternal and neonatal deaths

Jeremy Hunt commissioned an investigation by Donna Ockenden

250 case reviews completed by a group of independent experts

Through publicity of the review a further 1862 families made contact with the team related to case since 2000 . As full report is expected in 2021

Cases included maternal and Neonatal deaths

Failure to implement previous recommendations recognised as a factor and missed opportunities

Similar findings in a number of Maternity Services

Findings

- Turnover of Executive leadership impacting organisational knowledge and memory
- CTG interpretation and fetal monitoring was a concern
- There was a drive to keep to keep C section rates low as this was perceived as good maternal care but this was found to lead to traumatic births and increased risk
- Poor bereavement care was recognised
- Serous incident reviews not manage in a timely manner
- Concerns about the governance structure
- A lack of Consultant oversight of complex pregnancies

Immediate Actions

1) Enhanced safety
2) Listening to women and families
3) Staff training and working together
4) Managing complex pregnancy
5) Risk assessment throughout pregnancy
6) Monitoring fetal well being
7) Inform consent
8) Workforce
9) Reflection and assurance

Salisbury Foundation Trust

To Note

Our metrics show we are not a negative outlier for safety

We have undertaken proactive commissioning of external reviews due to soft intelligence and freedom to speak up and guardians

Oversight of our Serious Incidents has been brought to Clinical Governance Committee and Private Board

CTG training moved from 40% to 90 % over the autumn of 2020

Salisbury Foundation Trust

Report section	Recommendation	Recommendation met	Risk rating
ENHANCED SAFETY	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	No as not released yet	
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Yes	
LISTENING TO WOMEN AND FAMILIES	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Yes	
	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	Yes	

Salisbury Foundation Trust

Report section	Recommendation	Recommendation met	Risk rating
STAFF TRAINING AND WORKING TOGETHER	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Yes	
	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place	Yes	
	Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Yes	
MANAGING COMPLEX PREGNANCY	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Yes but further work required to ensure consistency	
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centre	On going engagement with UHS	

Salisbury Foundation Trust

Report section	Recommendation	Recommendation met	Risk rating
RISK ASSESSMENT THROUGHOUT PREGNANCY	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Further review of information to ensure all specialties and staff groups are undertaking a risk assessment as required	
MONITORING FETAL WELLBEING	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead.	Yes	
INFORMED CONSENT	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website	Information is available on the trust website and has been reviewed within last 3 months.	
REFLECTION AND ASSURNACE	Trust Board to review the Ockenden report at next Public Board meeting. Trust to complete the Assurance Assessment tool and use to support the discussions at Trust Board to reflect on whether the assurance mechanisms with your trust are effective and with your local Maternity system you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your organisation		

Next steps

Further data submission by 31st January 2021

Creation of an independent senior advocate

Increased PA's for medical staff to ensure twice daily ward rounds

Prompt training and overcoming covid challenge training plans

Maternity team restructure consultation

Managing the recommendations from the clinical and cultural review

NHS
Salisbury
NHS Foundation Trust

Ref: SH/ HW

Helen Williams
Regional Chief Midwife
South West House
Blackbrook Park Avenue
Taunton
TA1 2PE

Stacey Hunter
Chief Executive
Salisbury NHS Foundation Trust
Salisbury
Wiltshire
SP2 8BJ

Telephone (01722) 336262 Ext. 4249
Direct Line (01722) 429249
e-mail Stacey.hunter7@nhs.net

21 September 2020

Dear Helen,

Please find attached a response from Salisbury NHS Foundations Trust on our current position against the seven recommendations made in the Ockenden report as requested by the Chief Operating Officer, the Chief Nursing officer and the National Medical Director of NHSE in their letter of the 14th December.

We have reported our compliance against each recommendation as of 21/12/2020. For those areas we are not compliant with we are committed to delivering the necessary improvements given the significance of this review.

As requested the maternity team have worked with the Local Maternity and Neonatal System to provide a system wide response but this is details specifically the position of the Maternity Services at Salisbury NHS Foundations Trust. This response has been agreed with the local maternity and neonatal system and is consistent with what they will submit.

If you have any further queries, please do not hesitate to contact me.

Yours sincerely,

Stacey Hunter
Chief Executive

Cc

Nick Marsden – Chairman, Salisbury NHS Foundation Trust
Peter Collins, Medical Director, Salisbury NHS Foundation Trust
Judy Dyos, Director of Nursing, Salisbury NHS Foundation Trust
Eiri Jones Non-Executive Director, Salisbury NHS Foundation Trust
Hannah Boyd Acting Head of Midwifery and Neonatal Services
Jo Baden-Fuller, Clinical Director, CSFS, Salisbury NHS Foundation Trust
Ali Vandyken – Divisional Manager, CSFS, Salisbury NHS Foundation Trust

Abigail Kingston, Gynaecology Consultant, Salisbury NHS Foundation Trust
Lucy Baker, Director of Planning and Transformational Programmes, BSW CCG

Salisbury NHS
NHS Foundation Trust

Salisbury NHS Foundation Trust response to the 12 Urgent Clinical Priorities from the IEA's (Ockenden report)

	Immediate Action	RAG rating	Comments
1	**Enhanced Safety**		
1a	A plan to implement the Perinatal Clinical Quality Surveillance Model	1	Awaiting for the model but plan to implement when available – SFT has clinical quality surveillance in place
1b	All maternity SI's shared with trust boards and LMS at least monthly in addition to reporting as required to HSIB	1	All SI's shared with Trust Board and all 72 hour reports and SI final reports shared across providers and the LMNS. BSW providers share learning in the dedicated monthly LMNS Safety Group and LMNS Clinical Safety Forum
2	**Listening to Women and their families**		
2a	Evidence that you have a robust mechanism for gathering service user feedback and that you work with service users through your Maternity Voices Partnership (MVP) to co-produce local maternity services	1	SFT gathers service user feedback through the • MVP • Friends and Family feedback • Maternity Survey completed Feb 2020 (awaiting feedback) SFT has a strong positive relationship with the MVP; MVP chair sits on LMNS Programme Board and works collaboratively with the maternity service.
2b	In addition to identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board Maternity Safety Champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	1	Identified Executive Director and Non-Executive Director responsible for maternity services. NED supports the DoN as Board Maternity Safety Champion and independently challenges maternity and neonatal services.
3	**Staff Training and working together**		
3a	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	2A	Currently consultant led ward rounds occur twice per day Monday to Friday and once on Saturday morning. Every evening, seven days a week, there is a consultant board

			round involving the middle grade on site and/or the labour ward lead midwife. Sunday morning ward round is either physical or board round with consultant depending on acuity on the ward. We are in the process of agreeing the resource to meet the requirements of twice daily 7 days per week and will have implemented this by the end of March 2021 at the latest.
3b	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	1	MDT Training schedule is place and resumption of MDT training following phase 1 of the C-19 pandemic commenced in small groups and virtually.
3c	Confirmation that funding allocated for maternity staff training is ring fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	1	Training money funded via the National Maternity Transformation route is ring fenced. Funding collaboratively allocated via LMNS Programme Board. Assurance from CEO and Director of Finance that future CNST money will be ring fenced for maternity services.
4	**Managing Complex Pregnancy**		
4a	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	1	Women with complex pregnancy have a named consultant lead. Regular audit of compliance will commence January 2021.
4b	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	1	SFT supports the ongoing development of the maternal medicine specialist centre (UHS).
5	**Risk Assessment throughout pregnancy**		
5a	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP) Regular audit mechanisms are in place to assess the PCSP compliance.	2A	All women risk assessed at all community midwife appointments. Intended place of birth discussed at 12 and 36 weeks of pregnancy. Further work around the formal documentation of risk

			assessment at every contact will be scoped by 15th January 2021.
6	**Monitoring Fetal Wellbeing**		
6a	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	1	SFT – fetal surveillance midwife and lead obstetrician in place. Weekly case reviews, regular MDT training sessions are scheduled on fetal surveillance are now scheduled until March 2022. Continue to regularly review compliance on all elements of the saving babies lives care bundle v2.
7	**Informed Consent**		
7a	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website	1	Information on website and BSW HANDIapp to be implemented in Q4 20/21.
Additional	**Workforce**		
8	Each trust to confirm that they have a plan in place to the Birthrate Plus standard by 31 January 2021 confirming timescales for implementation		LMNS paid for Birthrate plus assessments and acuity tools for each provider trust 19/20. SFT completed the assessment in December 2019. Identified the requirement to increase midwifery staffing by 5.2wte (2.87 wte clinical midwives and 2.33 wte non-clinical midwives). Recent discussion with DMT regarding increase in midwifery staffing levels for 21/22 Budget setting. Assurance that by 31st January 2021 implementation plan will be finalised with accompanying timescales.
	Reflection and Assurance		
9	Trust Board to review the Ockenden report at next Public Board meeting. Trust to complete the Assurance Assessment tool and use to support the discussions at Trust Board to reflect on whether the assurance mechanisms with your trust are effective and with your local Maternity system you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your organisation	1	The Ockenden report will be reviewed in January at the Public Board Meeting. Assurance tool now received and will be completed by 15th January 2021; this will support discussion at Trust Board in January 2021.
10	Report assurance assessment tool to BSW LMNS who will	1	Tool received and assured that

	share with regional teams by 15th Jan 2021		this will be completed and returned to the BSW LMNS for sharing with the regional team by 15th January 2021.

COMPLIANCE STATUS KEY (as declared by care group / division)	
1	Compliant
2B	Broadly compliant - no current actions/no significant risk to patients
2A	Action plan in place to achieve compliance
3	Non-compliant - no current actions
3 - not assessed	Assessment overdue - compliance not known (*6 months after date of issue*)
N/A	Not applicable
0	Awaiting status of compliance

To: South West NHS Trust and Foundation Trust Chief Executives

Helen Williams
South West Regional Chief Midwife
NHS England & NHS Improvement
Helen.Williams99@nhs.net

23rd December 2020

Dear Stacey

RE: Ockenden Review of Maternity Services Compliance submission for Immediate and Essential Actions

Thank you for your recent submission as requested. Your efforts are greatly appreciated given the tight deadline and the pressures under which you are currently working.

Following the review of your submission and subsequent clarification with the National Maternity team, we have identified some key evidence that would strengthen your next submission. Your Trust's completed Assurance Assessment Tool is due by 15th January 2021. Please could I ask that you send these back to Helen.Williams99@nhs.net and CC B.Morgan3@nhs.net.

As a supportive measure and in addition to the guidance given in the assurance template itself, to assist with the submission I would like to share with you the minimum evidence requirements that have been agreed with the National Maternity team. These are detailed in the table below.

	Minimum Evidence Required
1: Enhanced Safety	
a) Perinatal Clinical Quality Surveillance Model	**A statement of commitment and a plan to follow the new regional process that will be implemented in January 2021.**
b) SI's shared with Boards/LMS/HSIB	**SI's must be shared with Trust Boards on a monthly basis and any sub boards or committees will not be accepted as compliant; examples of evidence may include Trust Board minutes as well as LMS Board minutes and a monthly return of cases submitted to HSIB. Where Trust Boards do not meet monthly, a written maternity SI submission must be sent to Trust Board**

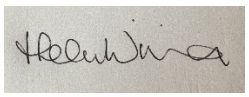
	members and then taken to the next Trust Board.
2: Listening to Women and their Families	
a) Robust service feedback mechanisms	**Minutes of meetings where co-production has taken place with the outputs available i.e. service user information / involvement in guideline development etc.**
b) Exec/Non-Exec directors in place	**Name of the Executive Board Level Safety Champion and the Name of the Non-Exec Director Board Maternity Champion.**
3: Staff training and working together	
a) Consultant led ward rounds twice daily	**Standard Operating Procedure for a minimum of twice daily consultant obstetrician labour ward rounds with supporting audit (spot check audit to be completed prior to 15th Jan submission if not already available as part of annual audit cycle).**
b) MDT training scheduled	**Up to date Maternity Services Department Multi-Disciplinary Training Needs Analysis.**
c) CNST funding ringfenced for maternity	**A statement of commitment that year 3 (21/22) CNST incentive scheme refunds will be ringfenced for use within maternity services.**
4: Managing complex pregnancy	
a) Named consultant lead/audit	**Name of the Consultant Obstetric Lead with supporting audit from the previous 12-month annual audit cycle or spot check audit complete prior to submission on 15th Jan '21.**
b) Development of Maternal Medicine Centres	**Commitment to developing Maternal Medicine Pathways when regional maternal medicine centres are established.**
5: Risk assessment throughout pregnancy	
a) Risk assessment recorded at every contact	**Ensure that antenatal documentation supports risk assessment or work**

	around if not in place. Spot check audit/notes review completed prior to the 15th Jan submission (if not already available as part of the annual audit cycle).
6: Monitoring Fetal Wellbeing	
a) Second lead identified	• **Name of the Midwife Lead for Fetal Monitoring and Well Being** • **Name of the Consultant Obstetrician Lead for Fetal Monitoring and Well Being**
7: Informed Consent	
a) Pathways of care clearly described, on website	**A working link must be provided to access the website directly for review**

As noted in the original letter from NHS England and NHS Improvement dated 14th December, local maternity leaders should align assessments, safety, and workforce plans to meet the needs of local communities. Trusts are therefore also asked to confirm that they have a plan in place to meet the Birthrate Plus (BR+) standard by 31 January 2021 confirming timescales for implementation.

I would like to thank you once again for your continuing commitment to improving maternity quality and safety across the South West region. If there is any further support I can provide to you or your teams at this stage, please do not hesitate to contact me directly.

Yours Sincerely



Helen Williams
South West Regional Chief Midwife
NHS England and Improvement

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.6
Date of Meeting:	14 January 2021		

Report Title:	Appraisal and Revalidation, Annual Report and Statement of Compliance			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Sallie Davies Deputy Medical Director			
Executive Sponsor (presenting):	Peter Collins Medical Director			
Appendices (list if applicable):				

Recommendation:
To note the report

Executive Summary:
SFT has appropriate processes in place for the appraisal and revalidation of doctors. Appraisal and revalidation was affected by the covid-19 pandemic with appraisal being cancelled in March for four months and revalidation being delayed by one year. The performance of doctors is monitored through governance systems and managed in accordance with national recommendations. There is an ambition to further improve the quality assurance of appraisal and to improve the experience for non-consultant doctors over the next year.

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	☐

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Introduction

The purpose of this paper is to assure the board of the processes in place for the appraisal and revalidation of doctors, that they comply with regulations and guidelines and to demonstrate continuous improvement.

As with all areas within the Trust medical appraisal in 2020 was impacted by Covid-19.

Normally doctors are required to have an annual appraisal and are revalidated every 5 years. During annual appraisals doctors are expected to submit supporting information that demonstrates that they meet the principles and values set out in the GMC's *Good Medical Practice.*

On the 19th March 2020 NHS England recommended that appraisals were cancelled to release doctors from the time taken to prepare and conduct appraisal. For those due to revalidate between March 2020 and March 2021, revalidation dates were postponed for one year. Those due to revalidate between March and July 2021 have had their dates pushed back 3 months.

In July 2020 the advice from NHS England was modified allowing a reinstatement of appraisals. At SFT appraisals were reinstated on July 20th with any request for delays needing authorisation by the Medical Director. Revalidation may also be recommended if the doctor wishes it. NHS England still recommends that no one should be forced to have an appraisal in the current climate and that appraisal should be geared towards support and wellbeing with a minimal requirement for paperwork.

This paper is in the format recommended by NHS England and describes a four-point checklist for the Trust in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC).

Designated Body Annual Board Report

Section 1 – General:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

No AOA submission was required in 2020

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

The Trusts substantive Medical Director (and RO) left the trust on secondment in August 2020. The Medical Director of a neighbouring organisation became temporary RO until the commencement of an interim Medical Director in October 2020.

Action for next year: For the deputy Medical Director to undergo RCO training

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

The Responsible Officer is supported by a Lead Appraiser (the Deputy Medical Director) and an appraisal administrator. The trust has also appointed an Educational and Development lead for locally appointed doctors who will be instrumental in the ongoing development of the appraisal process to make it valuable and relevant for all doctors.

Action for next year: For the lead appraiser to work with the lead for locally appointed doctors to improve the appraisal and revalidation system for that group.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The Responsible Officer and Appraisal Administrator have access to "GMC Connect" which lists all the doctors who list SFT as their designated body, this is checked regularly with ESR to ensure the data is up to date and correct.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Trust has a Medical Revalidation policy that is in line with GMC and NHS England guidance.

The Responsible Officer and Lead Appraiser also attend regular regional meetings held by the Regional Medical Director which provides national updates and advice

Action for next year: The Medical Revalidation Policy is due review.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

A Quality Assurance Board sits twice per year. It consists of the Medical Director, Lead Appraiser, Lead for Trust Appointed Doctors, Director of Education and Appraisal Administrator. It does not currently have a lay representative. The board assesses a random selection of 10% appraisals conducted in the trust grading the output forms against an assessment tool. Due to Covid restrictions the board met only once in 2020 in November.

The appraisal output forms reviewed at this meeting demonstrated a largely good quality of appraisal but with some themes emerging regarding the recording of the appraisal discussion and scope of work that will form the

basis of workshops in the coming year. The appraisers whose output forms were assessed will also receive feedback from the lead appraiser.

Action for next year: To reinstate twice yearly assurance board meetings.

To recruit a lay representative to the board.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Having an up to date appraisal is part of the employment checks for all doctors including locums.

Those who work at the trust for 6 months or more are offered an appraisal at SFT, those employed by a locum agency will have appraisals via the agency.

Part of conditions of employment is that doctors comply with the Trust's governance structures. The trust is committed to supporting doctors at all levels in their development.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Doctors' appraisal is supported by two appraisal systems. For those in substantive roles or employed for more than one year Premier IT is used which is a web based system. For those employed for 6-12 months a Medical Appraisal Guide (MAG) form is used as recommended by NHS England. Both systems are structured to include all the requirements for appraisal and revalidation. It is expected that appraisees include and reflect on complaints and involvement in serious incidents. Appraisees can ask the risk department and PALs for information pertaining to their involvement in incidents and complaints and provide that information in their supporting information. Appraisers are trained to look for the information and ask for it if it is not present.

The lead appraiser has met with the Risk Department with the intention to create a system that automatically populates an individual's input form with any serious incidents that they have been associated with which will allow the appraiser to discuss reflection with the individual. There is an ambition to have a similar system to capture complaints

Action for next year: Establish and embed a system for automatically populating supporting information on serious incidents and complaints.

2. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

SFT has 42 approved appraisers and 261 appraisees giving a ratio of one appraiser to 6 appraisees. National guidance suggests that appraisers ideally carry out between 4 and 10 appraisals per year.

3. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events.

To become an appraiser the doctor needs to provide proof of formal training, they are then added to the official list of approved trainers and subjected to the quality control described. The Premier IT system will only allow approved trainers to access input forms and create outputs for appraisal. The Lead Appraiser normally organises appraisal update workshops every quarter. The medical appraisal policy states that all appraisers should attend at least one half day session per year. A record of attendance is kept by the lead appraiser. Unfortunately only two sessions were held in 2020 due to restrictions brought about by Covid but the reinstatement of quarterly meetings is a priority for 2021. The lead appraiser has started discussions with leads from other trusts to share best practice and collaborate on the provision of workshops and training. Action for next year: To progress collaboration between Trusts in the region to deliver updates and training. There is also an ambition to start regular meetings for appraisees.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Since March 2020 revalidation has been delayed by one year. Doctors could request revalidation if they wished, few have taken this up but those that have have been revalidated successfully and in a timely manner.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

This is not applicable this year as deferral has occurred automatically for all doctors.

Section 4 – Medical governance

1. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Doctor's conduct and effectiveness are monitored via the Trust's governance systems including DATIX, patient safety monitoring, complaints and compliments.

Doctors can request information from risk and PALs regarding complaints and incidents they are named in. As stated above, there is a plan to populate an individual's supporting information with this in the future.

2. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Doctor's working for the Trust are subject to its "Dignity at Work (Bullying and Harassment" Policy which outlines the processes for investigation and disciplinary procedures for behavioural concerns. The "Handling Concerns about the Conduct and Performance of Doctors and Dentists" policy describes the investigation process for concerns regarding patient safety. It complies with the framework contained within "Maintaining High Professional Standards" and details the process of restriction and exclusion from work where that is appropriate.

3. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

All doctors subject to a concern are discussed at quarterly with the Trust's employment liaison adviser at the GMC.

Numbers, type and outcomes are kept by both the GMC and RO.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year: There is an ambition to improve quality assurance by setting up an assurance panel to monitor equality and consistence of outcomes of investigations and disciplinary hearings.

4. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Doctors are required to report any incidents as part of their appraisal.

When a doctor transfers from another organisation the responsible officer will complete a "Medical Practice Information (MPIT) form which would detail concerns.

If a concern arises in a doctor working for the trust their scope of practice is determined and if they work at another organisation the RO would be informed. This would also be the case for other organisations informing SFT of concerns regarding clinicians working here.

The RO has regular meetings with the ELA from the GMC who would share information regarding doctors that work at SFT that have been reported to the GMC.

5. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Currently cases of concern are discussed with NHS Resolution and the GMC when appropriate. These bodies provide advice regarding further actions and resolutions. SFT does not have formal in house scrutiny of these processes. There is an aspiration to set up a regular panel to scrutinise these processes and decisions.

Action for next year: To establish an assurance panel to scrutinise and advise on investigations into doctors to establish that they are consistent and free from bias.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

All appointments are subject to references which would include a question regarding skills appropriate to the post appointed to. There is a checklist of appropriate checks that is conducted for all doctors working in the Trust including locums and short term appointments.

Section 6 – Summary of comments, and overall conclusion

2020 was an atypical year for the revalidation of doctors at SFT. There were three Responsible Officers over the year with Dr Christine Blanshard leaving on secondment in August and a temporary arrangement with another trust for two months until Dr Peter Collins, the interim Medical Director, started in the Trust in October.

In addition Covid-19 led to NHS England cancelling all appraisals from 19th March 2020 and delaying those due to revalidate for one year. This has meant very few doctors revalidated this year.

Since July SFT have encouraged doctors to resume appraisals using the "light touch" method recommended by NHSe which focuses on wellbeing and development and requires less preparation and paperwork.

The number of updates available for appraisers has also been affected by the pandemic.

For the future there are aims to improve the quality processes around appraisal and managing concerns and investigations involving doctors. Updates will be reinstated and additional training planned particularly for appraisees who are new to the system. There will also be a focus on locally employed doctors to improve the appraisal experience for them.

Overall conclusion:

SFT has processes in place for the appraisal and revalidation of doctors. The management of concerns around doctors' behaviour and performance are managed via policies that are in line with the framework set out by "Maintaining High Professional Standards". Further improvements to these systems are planned over the next year.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.7
Date of Meeting:	14 January 2021		

Report Title:	Annual Medical Education Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Dr Emma Halliwell, Director of Medical Education			
Executive Sponsor (presenting):	Dr Peter Collins, although being presented by Dr Emma Halliwell			
Appendices (list if applicable):	Survey Monkey Results 2109 (other appendices embedded in report)			

Recommendation:
To make the committee aware of the developments in medical education over the past 12 months and the challenges that lie ahead.

Executive Summary:
• Challenging year for medical education due to the Covid pandemic. The pandemic has had long-term effects on education and training, which need to be mitigated when we look at service recovery going forward. • Trainees have exceeded themselves in response to the pandemic, but they are feeling vulnerable and morale is low. Wellbeing support, in all its forms, must continue to be prioritised and, indeed, enhanced. • There has been widespread change amongst the Educational Faculty in the last 12 months • Report has previously been discussed at the Medical Education and Training Committee and has been forwarded to Health Education Wessex

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

Director of Medical Education
Annual Medical Education Report
August 2019 to August 2020

Produced by **Dr. Emma Halliwell, Director of Medical Education**

August 2020

Acknowledgements

Dr. Georgina Morris, Foundation Programme Director

Dr. Annabel Harris, Associate Clinical Sub Dean

Dr. Ellen Neale, GP Vocational Training Scheme Programme Director

Mr. Paul Woodhouse, Salisbury DF1 Programme Director and Wessex Dental Postgraduate Tutor

Dr. Chalil Vinod, SAS Tutor

Members of the Medical Education Training Committee

Administrative Staff, Medical Education Department, Education Centre

Distribution List

Ms. Stacey Hunter, Chief Executive SFT

Dr. Paul Sadler, Dean Health Education Wessex

Dr. Peter Collins, Interim Medical Director SFT

Miss Sallie Davies, Deputy Medical Director SFT

All members of the Medical Education Training Committee (METC)

All members of People and Culture Committee (formally Executive Workforce Committee)

Posted on the Medical Education page of the Trust Intranet

Executive Summary

The last 12 months have been eventful for education in the Trust, as well as for the NHS in general, and a lot has happened since Dr. Page wrote her report last year. Our two main challenges have been wholesale changes within the Education Faculty and, of course, the Covid-19 pandemic.

After over seven years in post, Dr. Claire Page finally managed to step down as Director of Medical Education. She has been outstanding in this role and I want to thank her for her hard work on behalf of all the trainees that have been through Salisbury during her tenure. I was privileged to be appointed as her successor and took up post in February. I remain extremely grateful to Dr. Page for her mentoring and support, despite her 'retirement'; I know I have big shoes to fill.

My appointment created a domino effect within the Educational Faculty. Dr. Georgina Morris was appointed Foundation Programme Director, as my successor, and then Dr. Annabel Harris was appointed as Associate Clinical Sub-Dean, in succession to Dr. Morris. In addition Dr Chalil Vinod decided it was time to step down as SAS Tutor and we are grateful for all his contribution to that role over the years. Miss Rashi Arora was appointed to succeed him with a slightly different portfolio, covering both SAS and LED (Locally Employed Doctors). We have increasing numbers of Trust-appointed junior doctors and we are excited that, by this appointment, we can start supporting these individuals in a more structured manner. I am delighted to say that all these new appointments are settling in well, especially as they have taken on these responsibilities at a time of unprecedented clinical pressure in the NHS.

Nella Way (PA to the Director of Medical Education and the Foundation Programme Director) returned from maternity leave in October and so we had to say goodbye to Candice Berry whose enthusiasm, organisation and fresh approach had been appreciated by us all. However in April, Nella found alternative employment that was more compatible with her growing family commitments, so we welcomed Helen Clemow as her replacement. Helen, who is well known to many trainees from her work in the library, started with us in July and 'hit the ground running' as the summer inductions season was upon us. I am delighted to report she is settling in well and will be an asset to the education team.

Whilst all these personnel appointments were in full-swing, the NHS was hit by the global Covid-19 pandemic. Salisbury, along with everywhere else in the NHS, had to implement wholesale changes in clinical pathways, ward templates, respiratory/high/intensive care provision and, to manage this, redeployment of staff to departments in most need. Our junior doctors were in the thick of this, moving areas and upskilling to support the Trust-wide effort. I am grateful to the Trust for ensuring that the Educational Faculty were

intimately involved in decision-making around junior doctor redeployment, and to my consultant colleagues across the board for supporting them with appropriate clinical supervision at all times.

In parallel with these operational issues, our junior doctors were faced with the unravelling of everything that was familiar to them in terms of education and training – rotations were halted, interviews and exams put on hold, study leave and teaching days were cancelled etc. It was a genuinely unsettling time for them, which left many feeling vulnerable. It is a huge testament to them all that, despite this, they responded with flexibility, professionalism and maturity when such unprecedented demands were placed on them. I was extremely proud of all they achieved; an educational experience that surpasses any work-placed based assessment! It is paramount that the educational fraternity and employing organisations work together to prioritise education and training, alongside service recovery, as we move forward through the pandemic.

Well-being of staff has been moving up the NHS agenda for the past few years. This has been accelerated by the Covid-19 pandemic and with the recent publication of the NHS People Plan. We have been acutely aware of the need to support our trainees through the recent difficult times and I am grateful to Dr. Morris for all her help in establishing a dedicated E-mail address for well-being issues and pulling together a cohort of senior clinicians who are 'on call' to help our trainees if such issues arise.

Most of the elements of the Junior Doctor's Contract from 2016 and its 2019 amendments are embedded in Salisbury. We are still working hard to make the Palliative Care and Emergency Medicine rotas fully compliant with the 2019 Terms and Conditions. The next challenge will be assuring that all trainees have the 2 hours of 'self-development' time that the contract requires. We are aware that this is happening informally in many departments, so it will simply be a case of formalising arrangements. However, there will be a minority of departments where this will be a struggle to achieve without altering work schedules, which will either have a cost implications or result in reduced clinical activity from the trainees.

I believe that Salisbury remains a good place for training and that the experience of the majority of trainees that rotate here is a highly positive one. There is no doubt that "friendly, supportive and approachable" are all comments that continue to be used by trainees who have worked or are currently working here.

It's certainly been a challenging and interesting time to start my tenure as Director of Medical Education. As a result, I am immensely grateful to be supported by established members of an excellent Education Faculty and to have been joined by enthusiastic new colleagues. They all focus their energy on providing a high standard of education for our junior doctors and, as a result, Salisbury is well-placed to build on the legacy left by Dr. Page.

Dr. Emma Halliwell
Director of Medical Education

1.0 Introduction

This report gives an overview of medical and dental education in Salisbury NHS Foundation Trust (SFT) for the past 12 months from August 2019 until August 2020. These activities are assessed against our strategic objectives which are as follows:-

Objectives

1. **Maintain accreditation of training**
2. **Accreditation of medical and dental student placements via university medical schools**
3. **Maintain a strong educational and training environment for doctors**
4. **All Educational and Clinical Supervisors to be accredited in line with GMC requirements and trainees only allocated to those supervisors fully recognized**
5. **Keep the Trust management informed of national policy pertaining to doctors in training and the impact these polices will have on service delivery**
6. **Clinical Governance Framework and Patient Safety**
7. **Pastoral care, equality, diversity and personal development including career guidance**
8. **Medical Education incorporated into Directorate Annual Plans**
9. **Ensure good quality Trust and Departmental Induction with appropriate evaluation of these**
10. **Quality of training maintained in light of the European Working Time Regulations (EWTR) plus changes that result from trainee reductions, The Shape of Training, Broadening the Foundation Programme and the new Junior Doctors contract implemented from October 2016 and renegotiated 2019.**
11. **Ensuring trainees feel valued and an integral part of the Trust despite apparent poor morale recognised nationally.**

All these objectives have proven particularly challenging this year due to the Covid-19 pandemic and are likely to remain so for the foreseeable future.

2.0 The Medical Education Department

The Medical and Dental Tutors are:

Dr. Emma Halliwell	Director of Medical Education (DME)
Dr. Annabel Harris	Associate Clinical Sub Dean (ACSD)
Dr. Georgina Morris	Foundation Programme Director (FPD)
Dr. Ellen Neale	GP Vocational Training Scheme (GPVTS) Programme Director
Dr. Chalil Vinod	SAS Tutor
Mr. Paul Woodhouse	Salisbury DF1 Programme Director

The Education Centre based on Level 5 of the hospital is managed by Yvonne Donovan and there are 3 administrators for Medical Education:

Mrs. Nella Way	Medical Education Administrator and PA to the DME and FPD – until April 2020
Mrs. Helen Clemow	Medical Education Administrator and PA to the DME and FPD – from May 2020
Mrs. Sarah Shales	Medical Education Administrator and PA to the Associate Clinical Sub Dean
Mrs. Kelly Budgell	Medical Education Administrator

3.0 Quality Assurance Methods

The standards and outcomes for postgraduate medical education and training are set by the General Medical Council (GMC).

These standards form the basis for monitoring and implementing education and training of medical staff at Salisbury Foundation NHS Trust. Quality Assurance processes are in place in order to monitor and support the development of medical and dental education both at a local and regional level (Health Education England - Wessex). These processes are usually augmented by the annual GMC trainees and trainers' survey, and triggered visits from the various "schools" to programmes at the Trust when issues arise.

The Director of Medical Education is required to complete an "annual return" to HEE Wessex as part of the Quality Assurance process.

4.0 Accreditation of Medical Training Posts

4.1 Foundation Programme

I took over from Dr. Emma Halliwell as Foundation Programme Director in March 2020, just as the COVID 19 situation was escalating. Several changes to Foundation Programme placements were initiated nationally in response to managing the pandemic. As a result, I have had a busy, challenging but rewarding first 6 months in post.

FiY1s

One of the biggest changes was that Medical Student placements were cancelled from the end March 2020 and the date of graduation was brought forward for final year Medical Students in the majority of UK Medical Schools to allow them to join the work force early as Interim Foundation Doctors (FiY1). FiY1s could choose to work either close to their Medical School or start early in the Trust they were due to work in from August 2020 as an F1. Eight FiY1s commenced work in Salisbury from May 2020 (4 in Medical Specialties and 4 in General Surgery). Seven of these have stayed with us as F1s in August. Overall, of the 21 F1s starting with us in August as new Foundation trainees, 12 have been FiY1s, as 5 completed FiY1 placements in Trusts other than Salisbury NHS FT.

Feedback received from the FiY1s has been very positive. They felt well supported in their roles and were all able to shadow and work alongside existing Foundation trainees. Redeployments as a result of COVID 19 paradoxically meant they worked more closely with Consultants than they would have in a typical August placement, and they have all had a great introduction to the work expected of a new doctor which has made the transition to F1 relatively smooth for them.

In addition to the FiY1s, 2 F1s joined us 2 weeks early on extended Shadowing placements in July 2020, which were offered to those trainees who hadn't taken up the offer of being a FiY1.

Recruitment

Salisbury continues to be a popular hospital for trainees to undertake the Foundation Programme. We continue to be able to recruit a good standard of trainees from medical schools through the national competitive entry process and, as in previous years, have filled (and indeed slightly over-filled) all our F1 posts. In addition to our 21 F1 rotation posts, we have an existing F1 joining us from Jersey in August 2020 who has additional training requirements.

At F2, we were pleased to be granted funding for an addition 6 F2 'stand-alone' posts to be recruited to from August 2020. Two new F2 'stand-alone' rotations were created with 4 month placements: Rotation A in ED, Liaison Psychiatry and Obs. and Gynae., and Rotation B in ED, Sexual Health and Geriatrics. The proviso being that they had to be different from existing rotations, contain a non-GP 'community -facing' placement and be attractive to trainees considering a career in GP.

All of our F2 posts were successfully recruited to through the National UKFPO recruitment process (including a rotation that was vacant from 2019), but unfortunately, the COVID 19 situation has led to postponement of PLAB 2 exams and delays in awarding Tier 2 Visas, which has resulted in 2 F2s delaying their start in Salisbury until Dec 2020 and 1 withdrawing from their post entirely.

2020/21 will sadly be the last year that we will appoint an Academic Research Foundation Trainee to Salisbury. From 2021/22, all Research-focused Academic Placements will take place in Southampton, in keeping with a UKFPO decision to base them all in University-linked settings. However, I am pleased to report that we will retain our Academic Foundation rotation and appoint a new Academic Education Fellow post, the first in Wessex, which is an exciting development.

Redeployment, non-rotation and ARCP changes

I have been very impressed by the professionalism of our Foundation Doctors, and their willingness to be flexible. They coped admirably with the challenges they faced with redeployment to cover the Respiratory COVID 19 Unit and other acute areas, and the disappointment of not being able to rotate in April 2020 to their expected 3rd rotational post. The latter was a national decision made to reduce supervisory responsibilities for Consultants of trainees at the time of the COVID 19 peak. As a result, around 1 in 5 Foundation trainees will have either missed out on doing their community post or ended up with a rotation which is unbalanced in favour of either Medical or Surgical Specialties. Whilst accepting that many of the Foundation Competencies are generic and can be gained from any post, this has understandably led to some anxiety from trainees and supervisors. Efforts by the Foundation School to organise a voluntary swaps process for 2020/21 F2 posts (2nd and 3rd posts) has only benefitted a small number of trainees. Trainees have been encouraged to undertake taster placements in specialties they have missed. They have been reassured that this is a nationally recognised situation and will be taken into account at ARCP and when applying for ongoing specialist training to avoid them being disadvantaged.

Well-being

We continue to strive to ensure that our Foundation Doctors are supported pastorally as well as clinically to provide the best care for patients. Changes made to rotas as a result of COVID 19 have opened up possibilities for working differently and improving workload and supervision during weekend working in Medicine and H@NT surgical cover. A working group

has been established through the H@NT Board to develop ideas, act on trainee feedback and look to implement changes.
Renovations have been carried out to create a designated 24 hour Doctors Rest-Area in the Education Centre using money provided by the BMA in 2019. This is due to open in September 2020. In addition, money was provided by HEE to increase well-being support for doctors in the light of COVID 19. As part of this, a designated 'well-being' email address was established in the Trust, to facilitate linking trainees with experienced supervisors and/ or counsellors for support, to complement national and local support available through HEE, NHS staff well-being helplines, and Deanery PSU support. Pilot 'well-ness Inductions' have been initiated for FiY1s as well as F1s and new F2s, with 1 to 1 and/or group meetings focused on trainee well-being. HEE plan to evaluate feedback from this pilot to inform ongoing roll out.
I am greatly indebted to Dr. Emma Halliwell as DME and all the Foundation Training Clinical and Educational Supervisors and want to thank them for their ongoing support. I also wish to specifically thank Dr. Robert Scott Jupp, for his well-being expertise, and Dr. Tamsyn Street and Dr. Paul Taylor (Functional Electrical Stimulation) for mentoring and supervising our Academic Research Foundation Trainees.
I'd like to formally welcome and thank Helen Clemow who joined us recently as Foundation Programme Administrator, replacing Nella Way who left the Trust earlier this year. Helen joined us at a particularly busy time and has had to get up to speed incredibly quickly.

Dr. Georgina Morris
Foundation Programme Director

4.2 Medical Posts within Salisbury NHS Foundation Trust

Trainee posts within SFT are currently as follows:

F1	21
F2	28
Specialty Trainees	99
Trust Grades	35 - 55 (variable)
Total	183 - 203 (dependent of Trust Grade posts recruited to and in post).

4.3 General Practice Training

I commenced my first year in post as Training Programme Director for mid-Wessex with responsibility for Salisbury ST1 and ST2 trainees in August 2020 following on from Dr. Martin Essigman who had been in post for 10 years. It has certainly been a memorable year.
2020-2021 has been a successful, if somewhat unusual year, for GPVTS training at Salisbury District Hospital.
As outlined in the previous report financial cutbacks continue to feature in medical education.

Recruitment

All GPVTS posts were successfully filled at recruitment for August 2020, with one post being deferred. Disappointingly we had two late withdrawals. One of these was the Integrated Training Post (ITP) trainee. An additional training post in Psychiatry had been created to accommodate this ITP trainee increasing the total trainee numbers.
There is an application for the Accreditation of Transferable Competencies Framework scheme for one new ST1 trainee. If successful, this trainee would then complete 18 months rather than 2 years within hospital posts.
The challenges of LTFT doctors and placing them in hospital posts remain. Job sharing has become a necessary means of accommodating these trainees.

Teaching

The half day monthly schedule was successfully delivered, receiving positive feedback from trainees, until all education provision was placed on hold due to the COVID-19 pandemic in March 2020. In its place, fortnightly pastoral care sessions were provided via the virtual meeting platform of Zoom in April and May 2020. Monthly half day teaching resumed on 20/5/20 via MS Teams. Many thanks to those departments who have contributed to this virtual teaching schedule so far and a pre-emptive thank you to those who have agreed to teach in future sessions. A virtual teaching schedule up until the end of 2020 has been established. It is unknown at present whether face-to-face teaching will be able to resume from the start of 2021 as the social distancing requirements remain uncertain. Should face-to-face teaching be unable to resume then teaching will continue to be delivered virtually.

I would like to take this opportunity to express my thanks to Sarah Shales for her support and hard work in assisting with sourcing speakers for the teaching schedule.

Dr. Ellen Neale
GPVTS ST1/ST2 Programme Director

5.0 Accreditation of Medical and Dental Student Placements

5.1 Medical student placements

This has been my first few months as ACSD having taken over from Dr. Georgina Morris in June 2020. It has certainly been an interesting time to take over this role with the ongoing Covid-19 challenges facing the Trust. The lion's share of the previous academic year and the preparation for Covid had been undertaken by my predecessor Dr, Morris and Sarah Shales, and both have been a huge support to me in taking over this role. Thank you.

This report is covering the academic year 2019-2020.

I'll address the Covid-19 impact on the medical students first. In March 2020 Southampton University made the decision to suspend all medical student clinical placements. In addition they also brought forward the final year graduation. Unfortunately this meant that final years missed out on their assistantship and elective placements, which was of course disappointing for them, but almost 2/3rds of trainees (nationally) took up the opportunity to be an FiY1 and from feedback we are to understand that they gained huge amounts from this - I believe that Dr Morris has covered this in her Foundation year report.

Prior to March 2020 it was business as usual. Starting during the summer 2019 we saw 12 fifth year students start their 6 month rotation at Salisbury, although 1 student did return to Southampton after a few weeks (for family reasons). They were then joined by around 21 fourth year students, in different blocks, between September 2019 and lockdown.

The final years were here for a total of 6 months, during which they rotated through medicine, surgery, primary care and their Student Selected Unit. The mock OSCE was also repeated in November 2019 and this involved over 20 doctors to get it off the ground. The feedback for this was excellent and thanks must be extended to Mr. Greg Pearson and Dr. Georgina Morris for their support in this project. The development of simulation within the education of final years was also seen. The 'mind the bleep project' led by Claire Levi was very well received.

The fourth years rotated through O&G, Child Health and Acute Care, until rotations were ceased in March. The feedback for these specialties has always been positive - and thanks to the leads in these areas for consistently high feedback.

Salisbury received an excellent University Quality Assurance inspection report in December 2019. This highlighted the ongoing work needed on ACCs and the training and delivery of these, but otherwise was hugely positive. A few direct quotes from this report:

- All of the students commended Sarah Shales for her excellent organisational skills whilst they were on placement. Students felt that they could approach her with any placement queries as well as for pastoral support.
- Year 4 students commented that they found all staff welcoming and encouraged them to be 'hands on'.
- Students commented that they felt that all staff at Salisbury District Hospital were keen to teach and were more engaged with the students than they had experienced elsewhere. All students felt part of the team.

Many thanks to Sarah Shales, Dr. Georgina Morris, Dr. Emma Halliwell, Claire Levi and the undergraduate faculty, the teaching block/rotation leads and everyone involved in providing high quality supervision and teaching to the medical students 2019-2020. Many thanks

Dr. Annabel Harris
Associate Clinical Sub Dean

5.2 Dental student placements

The Foundation Dentists attending the study days come from a wide area covering all of Dorset and part of Wiltshire and Somerset.

The Foundation Dentists work for 4 days in carefully selected practices with experienced and supportive Educational Supervisors and staff.

This year COVID-19 has severely disrupted their clinical training and the study day programme with all courses now being online. The Foundation Dentists were initially all transferred to their nearest Nightingale hospital but were thankfully released back to us when it was apparent that they were not going to be required. We cannot see this changing for the 200-2021 academic year. The study day programme normally aims to cover a diverse range of areas with practical hands-on skill sessions and conflict resolution sessions using trained actors. We are all learning a whole new skill set trying to deliver these online with the help of their educational supervisors.

All Foundation Dentists have an online portfolio to complete as well as projects in the community and case presentations. The highlight of the year is the intensive 4 day study programme at Centerparcs where all 7 schemes from the South West meet.

Educational Supervisors and Foundation Dentists have been selected for the 2020-2021 year and a wide range of lectures and courses booked. We have a new online portfolio to get to grips with this year - it looks to be a challenging time but we are all looking forward to the year ahead.

Mr. Paul Woodhouse
Dental Foundation Training Programme Director

6.0 Strengthen the Education Environment

6.1 SAS Tutor

It has been my privilege to be the SAS tutor for Salisbury since May 2015. In August 2020 I shall be stepping down from this role and handing over to Miss Rashi Arora as she takes up the position of joint SAS/LED (Locally Employed Doctor) tutor.

The role of the SAS Tutor is to provide support and guidance to the SAS doctors as well as improving their Personal and Professional Non-Clinical Development. I started with a challenge to engage the SAS doctors actively; there were some successes in this regard within the Trust.

I had responsibility for 29 SAS doctors during the year, of whom 6 are Associate Specialists & 23 Speciality Doctors. One SAS doctor is currently employed as Honorary Consultant by the Trust. A Speciality Doctor was recently re-graded as an Associate Specialist paving the way for more career development opportunities in line with the national trend. There has been an unmet need to engage & support Locally Employed Doctors in their career development. It is hoped that the appointment of a joint SAS/LED tutor will be a first step towards this.

The financial support from HEW for the year 2019-2020 was only for the SAS tutor. The support from the Deanery has been less than ideal for most of the year due the vacancy of the Programme Director, a position that they are currently trying to appoint to. A new Associate Dean, Dr Fatima El-Bakri, has taken responsibility for SAS doctors in the Wessex region. A sum of £5000 was allocated to the Trust last month to support SAS development.

As a part of the collaborative effort, SAS doctors' development days are held across Wessex and these include regional study days. Many SAS doctors from Salisbury have participated in these.

I organised a joint mandatory study for SAS doctors in Salisbury NHS Foundation Trust and a regional study day for the SAS doctors in Wessex in January 2020 on the topic of clinical law and medical ethics. The day was attended by 54 SAS doctors and 1 consultant. Also in attendance were the Associate Dean & our Deputy Medical Director. The study day was well received by the delegates.

Other development opportunities during the year have included:
eCliPS Programme – embedded Clinical Leadership in Practice Scheme for SAS doctors has been funded by the Deanery for the year 2020/21.
SAS QI Fellowship programme – This financial year, funds were allocated for the SAS Quality Improvement Fellowship programme.
Funding for courses – remaining funds were allocated to SAS doctors individually, to part-fund courses that they had enrolled and did not have sufficient funds in their study leave budgets.
COVID-19 – There was support available from the Deanery for the SAS doctors for their wellbeing.

Obtaining an up to date list of SAS doctors in the Trust remains challenging, as before.

I wish Miss Rashi Arora success as she takes over an expanded role.

Dr. C P Vinod
SAS Tutor

6.2 Medical Education Training Committee (METC)

This committee includes medical and dental tutors, specialty education leads (College Tutors) and staff from the Education Centre and Medical Personnel. During the past 12 months the Committee met on 5 occasions and, as in previous years, has been proactive in its approach to sharing information and implementing changes to medical education and training. These meetings also provide a forum for the educational faculty to be made aware of concerns and issues in the various departments with regarding to training.

These meetings have been particularly helpful during the COVID pandemic, as they have ensured that we have a Trust-wide approach to supporting our trainees during this challenging time.

The Medical Education and Training Committee reports to the Executive Workforce Committee (EWC) and the minutes of meetings held are therefore submitted to EWC for review and if necessary, action.

6.3 Quality Assurance Monitoring Data

Local processes to quality assure in addition to the annual GMC survey of trainees include:

Local (optional) survey of trainees who started in August 2019 to collate their views of the induction process, educational and clinical supervision and overall support provided by senior members of the Trust. The full results are included in this report – **Appendix B**
It was pleasing to note from this survey that all doctors who responded had met with their Educational Supervisor within 4 weeks of starting the post (the majority within 2 weeks) and all felt this meeting was useful and positive. In addition they all knew who their Clinical Supervisor was and by far the majority were clear about who their sessional supervisor was. Whilst the majority of respondents were happy with their Departmental Induction, we are aware that this is an area where more clarity is needed as to what should be included and it is being addressed

Annual feedback sessions with both the Foundation Year 1 and Foundation Year 2 doctors – summarised and distributed as appropriate by the Foundation Programme Director.

Formal evaluation of both the "F1 shadowing week" and the main August induction when a large number of doctors "change over". – **Appendix C**

Over the last 12 months there have been not any triggered visits from HE Wessex to the Trust.

6.4 The Hospital Round

The Hospital Round is a multi-professional educational opportunity which covers a broad range of topics from clinical specialties and lesser known areas of the hospital, to presentations on service improvements projects and other Trust wide issues. All members of the Trust are welcome to attend.

Sadly attendance at these events has been poor for the last few years and shows no sign of improving. Plans to review its long-term viability were being looked into when the COVID pandemic hit; at which point the programme was suspended. These will need to be revisited in light of the ongoing restrictions in capacity in the Education Centre. If anything such constraints will only serve to jeopardise the long-term future of the Hospital Round even further.

6.6 Educational Supervision

All Educational Supervisors in Wessex are required to have undertaken "The Essentials" course. Historically, this is the 2-day course run by HE Wessex that equips Educational Supervisors for their role. All new supervisors will continue to be required to 'attend' the HE Wessex induction course, although this is now running as a combination of E-learning and virtual tutorials.
However, HEE Wessex changed the process for maintaining recognition of trainers within the last couple of years. They have increased the duration of recognition from the induction course/last refresher course from three years, to five years. They have asked that the appraiser completes a form at their appraisal during the fifth year that confirms that the trainer has met the requirements for ongoing recognition. This form must be returned to the Quality team at HE Wessex. In addition, the trainer will be emailed by the Deanery team in the fifth year.

The requirements for renewal of recognition are all of the following:

1. Discussion of the role in appraisals as part of scope of practice and reflected on the role

2. Provide evidence of ten hours of relevant CPD in five years, at least eight hours are face to face with reflections. **Examples** could be:

    a. A refresher course as now (Trusts have been instructed to take many of these over)*
    b. Careers guidance for doctors
    c. Exam support, dyslexia etc.
    d. Managing doctors in difficulty style courses
    e. Managing doctors who lack insight, managing difficult conversations
    f. Writing an ARCP report, sitting on an ARCP panel
    g. Managing clinical decision making issues
    h. Giving feedback
    i. Reflective writing
    j. Motivational interviewing
    k. Resilience
    l. Supporting doctors during complaints and SIRIs

3. Discuss and reflect on feedback which will be provided on reports completed for ARCPs.

    * the latest Trust Refresher was run in November 2019 with 8 attendees. The feedback was very positive **(Appendix D**). A further Trust Refresher planned for April 2020 had to be cancelled due to the Covid pandemic, but the next one is scheduled for November 2020 and already has 18 Educational Supervisors booked onto it.

There are now several senior educationalists who have been trained to facilitate on these Trust-base courses.

Trainers recognised for these roles are now identified on the GMC register.

6.7 Medical Education Budgets

The department is supported by the following budgets:

Medical Education Director (Infrastructure)
Specialty Doctors' Training
Study Leave (since April 2018 held centrally by HE Wessex and reimbursed to SFT)
Southampton University - Service Increment for Teaching (SIFT)

These budgets have been the responsibility of the Director of Medical Education since July 2013.

The annual SIFT business plan, which outlines how the £500,000 of SIFT monies will be spent, is drawn up by the DME and then approved by the Medical Director. This year funds have been allocated for the purchase of the following items of equipment:

- Anaesthetics – ultrasound machine
- Simulation - SimBaby
- Histology – text books
- ENT – tonsil trainer
- Plastic surgery – ultrasound probe
- Obstetrics – birthing simulator
- Education – laptops, hardware and training for virtual learning
- Up-to-Date

6.8 Revalidation for Trainees

The GMC revalidation process for secondary care and doctors in training has been in place since 2012, which requires each doctor to revalidate on a 5 yearly cycle. Doctors that were due to revalidate in the midst of the Covid pandemic were given a 12 month extension to their revalidation date.

The Dean of HEE Wessex (Dr. Paul Sadler) is the Responsible Officer for all doctors in training.

The Trust reports on every trainee involved in an SII or Clinical Review or named in a Complaint. This information is collated by the DME and returned to the Deanery in the requested format known as an exception report (not to be confused with exception reports introduced as part of the new junior doctors contract). Previously HEE Wessex wanted this information sent every 6 months. There had been a drive for this process to become a 'live reporting' system, but it has been recognised that this is not practical as such reports are difficult to complete until any investigation has been fully investigated. As a result, we continue to collate this information every 6 months, with the DME meeting formally with the Head of Risk Management, Patient Safety Facilitator, Clinical Governance Lead for Maternity and the Head of Customer Care to review the information required to generate the required reports.

All trainees about whom an exception report is completed are informed of this and sent a copy of the information submitted.

These reports feed into the ARCP process where information should triangulate with self-reported incidents on trainee Form Rs.

7.0 Strengthen the Education Environment within the Health Community

The Salisbury Medical Education Department hosted the following courses between August 2019 and the onset of the Covid pandemic: SAS study day, Wessex Endocrine and Diabetes Regional Training days, Wessex post-FRCA study day, a well-attended regional training day for General Internal Medicine, BAUS regional urology meeting and the Educational Supervisors Refresher course in November

In addition the facilities were used by the BMA for a doctors' meeting and by the Ministry of Defence for a training event.

8.0 Inform Trust Management of National Policy

The Medical Education and Training Committee (METC) is a cohesive and useful group as it provides a forum for cascading information out to Departments and trainees within SFT via the Educational Leads. The Director of Medical Education sits on the Executive Workforce Committee and continues to highlight the impact of national directives regarding education and training and of recruitment issues on service delivery and safe patient care. Finally the Director of Medical Education meets monthly with the Medical Director to discuss issues that have arisen at Deanery, Trust and trainee level.

9.0 Clinical Governance Framework

The Director of Medical Education receives clinical review reports involving trainees and has regular communications with the Head of Risk Management. The Trust completes exception reports, which are forwarded to the Deanery, on all trainees involved in SIIs and Clinical reviews and named in Complaints (please see section on Revalidation for Trainees). This work has ensured close working with the Risk Departments for both maternity and the overall Trust.

Salisbury's inter-professional Healthcare Improvement Programme (HImP) is a well-established course to help Foundation doctors learn basic improvement skills by undertaking service improvement projects.

The broad aims for HImP are that by the end of the programme:

- Participants will have completed an improvement project and will be able to demonstrate knowledge, skills and attitudes in improving healthcare and patient safety that they can use in other settings
- Participants will have an appreciation of the broader organisational context for their improvement activities, the importance of inter-professional team working and the relationship between improving processes and improving patient care
- There will be a legacy for the Trust of improvements that will provide benefits for patients

HImP is currently led by Dr. Christina Cox and Louise Arnett, Head of Service Improvement.

Although this course was established over 10 years ago at Salisbury, being involved in a service improvement project became an objective of the Foundation curriculum a few years back and providing evidence of this involvement is a requirement for a successful outcome at ARCP. The greatest challenge for HImP remains ensuring sustainability of the projects undertaken. To achieve this trainees are informed of the Trust Transformation Programme and encouraged, but not forced, to choose projects to map to this work. They also have the opportunity to present at a special sitting of Clinical Management Board to engage with the Executive Team early in their projects.

The programme now runs from January of one year through until around November of the next, so that projects embarked upon by the Foundation trainees are started during their F1 year but completed whilst they are in F2.

10.0 Careers Advice and Pastoral Care

Career support and pastoral care from the Director of Medical Education, Foundation Programme Director, College, GP and Dental Tutors continues to ensure that trainees receive appropriate and timely assistance and guidance throughout the duration of their time in Salisbury.

As previously outlined, career guidance for Foundation Trainees takes place in both years of the Foundation Programme. There are 2 generic career guidance sessions, with additional specific sessions on interview preparation and applying for GPVTS in Foundation year 2.

The Director of Medical Education and Foundation Programme Director continue to provide pastoral care for trainees who require additional support for reasons both within and outside the working environment.

As a general rule the Foundation Programme Director mainly supports the Foundation trainees as issues with respect to their welfare are usually escalated in that direction.

The Director of Medical Education (DME) usually provides pastoral support to trainees above the level of Foundation but not exclusively. Referrals from the Trust to the Wessex PSU (Professional Support Unit) for the few trainees needing this higher level of support are usually made by the Director of Medical Education and always with her knowledge and support.

With the Covid pandemic, the need for pastoral care and well-being support has been in forefront of everyone's mind. As well as an increased awareness of this at 'shop floor' level, a generic well-being Email address was set up so any trainee could ask for additional help and support out with their day-to-day working environment. In addition a database of experienced senior doctors willing to provide such support was established so that trainees could be put in contact with such individuals.

The BMA money that the Trust was given to support trainee well-being has been spent. There is a new kitchen/relaxation facility in the Education Centre that the trainees can use out of hours. Building work on this was delayed due to the Covid pandemic, but it is now open. Unfortunately, the area ear-marked as a rest area is still in clinical use so, whilst the recliner chairs have been purchased, this facility is not yet functional. It is hoped that this will change in the imminent future or an alternative room will be found for this purpose.

11.0 Trust and Departmental Inductions

As stated in the Foundation Programme Director's report, we had 8 FiY1s start with us ahead of the usual shadow week in July. As each batch commenced work, a paired down induction was organised for them.

They were joined by the rest of the Foundation Year 1 doctors (making a total of 22) for their formal and "shadowing week" on Wednesday 29th July 2020. They commenced work a week later.

45 new doctors joined the Trust on Wednesday 5th August 2020, all receiving a mandatory induction followed by their departmental inductions. Due to the restraints of social distancing this proved to be a huge challenge to organise. The Education centre staff are to be commended for all their hard work in ensuring a blended approach of face-to-face and virtual induction worked so well in the circumstances.

Regular monthly inductions (of up to 20 doctors) follow a similar format but are often held in an alternative venue to the Education Centre.

Formal evaluation of both the F1 induction and main August induction was undertaken and as stated in paragraph 6.3 is attached to this document in **Appendix C.**

12.0 Challenges for 2020/2021:

- Responding proactively to the educational issues that have arisen, and will to continue to arise, as a result of the Covid-19 pandemic in order to ensure that our junior doctors continue to progress in their training in a safe and supervised manner.
- Continuing to ensure that all Named Clinical and Educational Supervisors who are GMC accredited trainers maintain this accreditation and comply with the updated requirements.
- Continuing to work with the Trust so that, even when vacancies in a rota are at the level that the viability of a rota is jeopardised, the impact on the quality of education provided and the time available by senior doctors to train is minimised.
- Ensuring full implementation of the self-development time for trainees at all levels, as required by the Junior Doctors' contract
- Working with trainees, supervisors, the GoSW and Trust management to ensure that issues raised by doctors in training through "exception reports" are appropriately addressed and sustainable solutions put in place to resolve recurrent concerns.
- Supporting departments where there have been concerns about training and supervision raised by trainees at their ARCPs or via the GMC survey.
- Building good relationships and support within the broadly new education team to ensure a cohesive approach across all areas of medical education in the Trust.
- Looking at our Locally Employed Doctor cohort and, specifically, how we can support and develop these individuals.
- Emphasis on trainee well-being is maintained and initiatives to improve the lives of junior doctors completed in a timely manner.

The following documentary evidence supporting this report is held in the Medical Education Department:

- Medical Education Strategic Plan: 2019-20
- Evaluation of locally organised teaching
- Nationally analysed formal assessment of feedback from medical students on placement
- Feedback and analysis from the medical students of the local teaching sessions
- Evaluation forms received from shadowing week and induction August 2019
- Study leave database – Intrepid
- METC agenda and minutes
- Junior Doctors Induction and H@NT course programmes
- Website documentation
- Archives retained according to local policy

Appendix A

GMC Trainee Survey 2020

Due to the Covid pandemic, this year's GMC survey (which usually takes place between March and May) was cancelled. The GMC did open a targeted survey for all trainees, which closed mid-August, specifically to look at issues around the pandemic. We are currently awaiting its results.

Appendix B

Survey Monkey Responses about Induction Process

Please see accompanying PDF file.

Appendix C1

EVALUATION OF F1 INDUCTION DAYS
Wednesday, 29th and Thursday, 30th July 2020

	EXCELLENT	GOOD	OK	POOR	COMMENTS
Introduction & Welcome					
Dr Christine Blanshard Medical Director	**5**	**2**	**1**		**"Very warm welcome from all speakers!"**
Dr Emma Halliwell Director of Medical Education	**7**		**1**		
Dr Georgina Morris Foundation Programme Director	**7**	**1**			
Dr Neha Gupta Mess President#	**6**	**1**	**1**		

	Dr Rudrik Thakkar BMA Representative	**5**	**2**	**1**		
	SESSIONS					
	Speak Up Guardian	**5**	**2**			
	Equality and Diversity Lead	**4**	**2**	**1**	**1**	**"A very engaging and interactive session." "Really engaging, thoroughly enjoyable."**
	Q&A Session	**4**	**3**	**1**		**"Difficult with technology and current Covid situation"**
	Medical HR	**3**	**4**			**A number of F1s had already sorted this aspect of the induction out.**
	Facilities – ID Badges & Parking	**1**	**4**			**A number of the F1s already had their cards etc. so this was n/a.**
	SMART Cards	**1**	**4**			**A number of the F1s already had their cards etc. so this was n/a.**
	H@N – Hospital at	**4**	**3**			**"Handout with essential info would have been**

Night					**appreciated."**
Resuscitation	**5**	**2**			**"This was very useful thank you." " Very long at the end of the day."**
Occupational Health (if applicable)	**1**			**1**	**"Mix up with documents, not read documents from previous OH, not easily contactable"**
IT	**2**	**4**			
Information Governance	**1**	**6**			
Bereavement / Coroner's Office	**4**	**2**		**2**	**"Assumed that we were taught what to do. No real explanation on what to do." "No slides, team unable to explain process clearly, didn't bring the relevant forms that need to be filled in."**
Top Tips for surviving F1 / HImP	**7**				

Appendix C2

EVALUATION OF INDUCTION DAY
Wednesday, 5th August 2020

	EXCELLENT	GOOD	OK	POOR	COMMENTS
Introduction & Welcome	**4**	**5**			**Difficult over webcam but understandable**
Dr. Emma Halliwell Director of Medical Education	**7**	**7**			**Beset with IT problems**
Dr. Christine Blanshard Medical Director	**4**	**6**	**1**		**Beset with IT problems**
Neha Gupta Mess Representative	**5**	**6**	**3**		**Very little information about the mess/events. Where the mess actually is, Beset with IT problems**
Freedom to Speak Up Guardian Elizabeth Swift	**6**	**6**	**2**		**Beset with IT problems**
Diversity and	**5**	**7**	**2**		**Beset with IT problems, difficult on video chat**

Inclusion Rex Webb						**but came across approachable and friendly**
Blood Transfusion	**2**	**6**	**5**			**IT issues. Difficult to hear and see presentation, Beset with IT problems, couldn't see major transfusion protocol, AV problems, slides not legible, difficult to hear over teams**
Anti-coagulation	**2**	**6**	**5**			**Beset with IT problems, AV problems**
Documentation						**Did not happen**
SESSIONS						
Resuscitation	**11**	**3**				**Jane was great – explained things that are different in the Trust well.**
IT & SMART cards	**7**	**5**	**1**			**Excellent run through wizards on common IT applications**
Medical HR, Facilities – ID Badges/Car Parking/IT Login	**5**	**4**	**2**	**1**		**No parking permit, had to go to office and queue, why did we need to go to this, appeared to have**

					already been covered at library, walked to and from facilities for no reason
Occupational Health	**1**	**2**			**N/A**

14 doctors submitted feedback

Appendix D

EVALUATION TRUST REFRESHER COURSE
27th November 2019

Facilitators: Claire Page and Adam Hughes
Shadowing: Emma Halliwell and Katharine Backhouse
Attendees = 8

Content: poor / satisfactory / good / very good = 2x good 6x very good
Delivery: poor / satisfactory / good / very good = 2x good 6x very good
Any topics covered particularly well? Comments received
Trainees in need of support x4
LTFT
Paperwork
All equally good
We discussed difficulties that we all experience with providing supervision especially for trainees that we do not see a lot ourselves

Any topics that could have been covered better? Comments received
No x3
Don't think so
In the time frame, no

Any topics that you feel should have been covered but weren't? Comments received
No x4

Was 5 hours for this Refresher: too short / about right / too long = 7x about right 1x too short

Any other suggestions or comments? Comments received
Glad it's an in-house course
Thank you – extremely useful session
No – well done, thanks

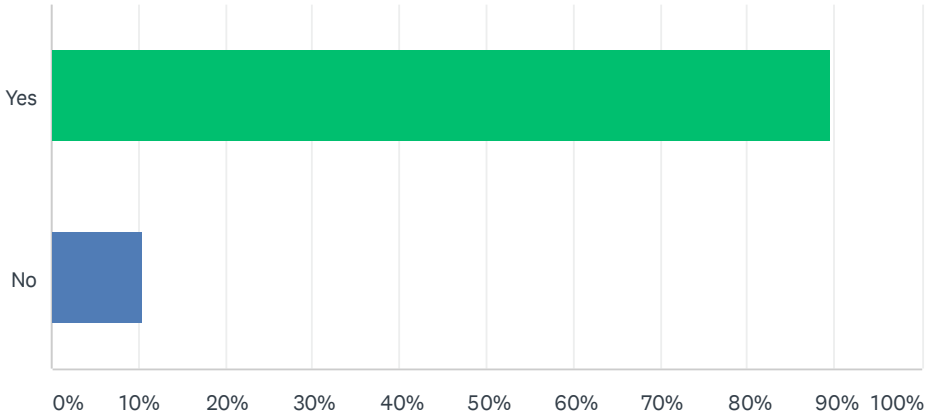
Excellent in-house course

It was a well facilitated useful discussion regarding clinical/educational supervision. I enjoyed the session and found it useful – although in practice it won't resolve the challenges of multiple e-portfolio forms, changing curriculum requirement and limited time in which to undertake them!

This sort of forum is a very effective method of pooling our experience, suggestions, and ideas and to discuss our frustrations. There were a number of ideas that I have taken away which should help me in the future with supervision.

Q1 Did you have a Departmental Induction on arrival in Salisbury?

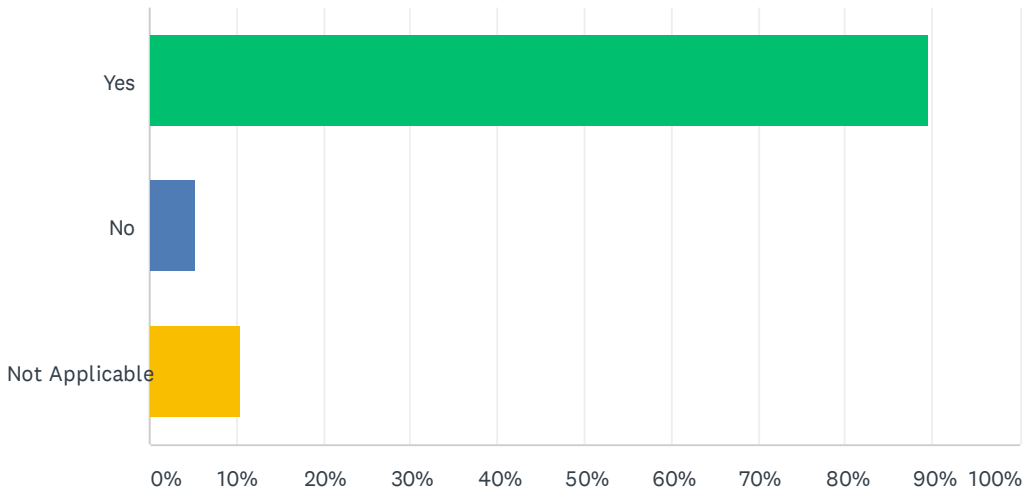
Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	89.47%	17
No	10.53%	2
Total Respondents: 19		

Q2 Did it cover the essential information you needed?

Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	89.47%	17
No	5.26%	1
Not Applicable	10.53%	2
Total Respondents: 19		

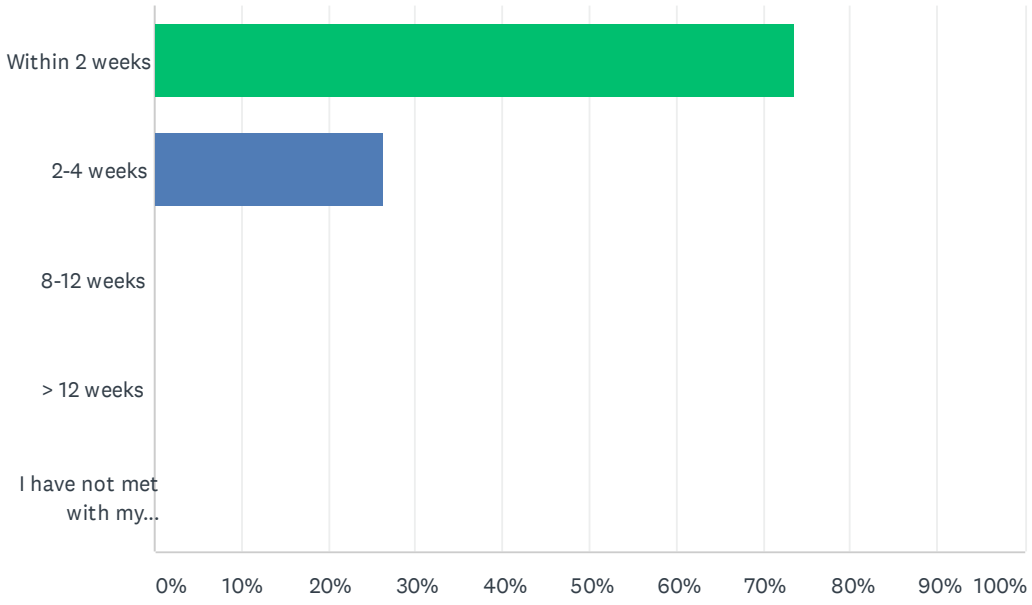
Q3 If no, please comment on what was not covered that you would have found useful.

Answered: 2 Skipped: 17

#	RESPONSES	DATE
1	Not relevant to departmental induction so to speak but would have been useful to explain what each of the sign off things were on e portfolio e.g. minicex, CBD etc	1/12/2020 8:03 PM
2	i have only been told 4 months into the job that I have a locker and inbox tray	12/10/2019 4:40 PM

Q4 When did you first meet with your Educational Supervisor to set your Learning Agreement / PDP?

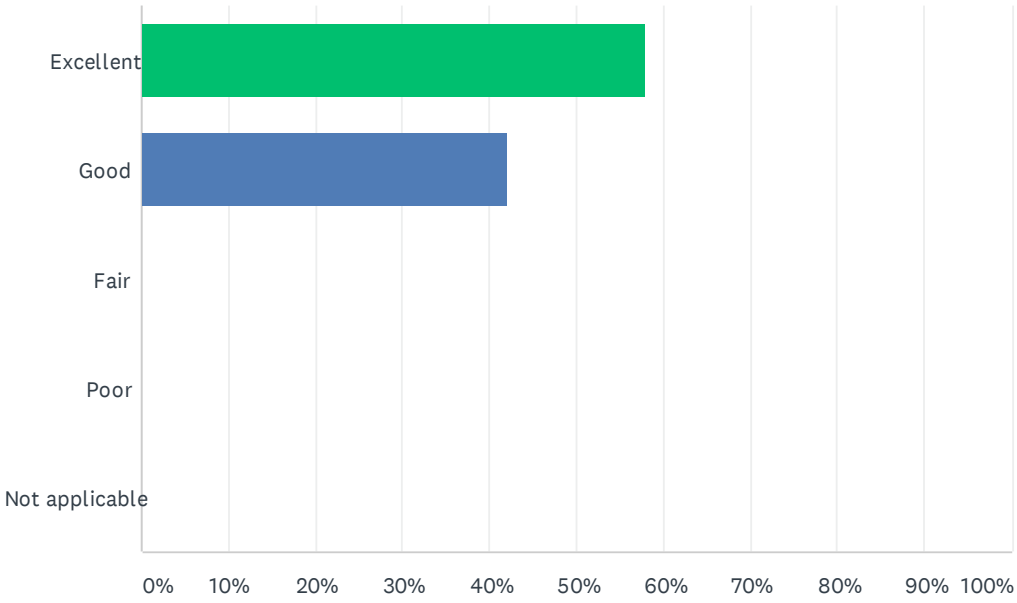
Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Within 2 weeks	73.68%	14
2-4 weeks	26.32%	5
8-12 weeks	0.00%	0
> 12 weeks	0.00%	0
I have not met with my Educational Supervisor	0.00%	0
Total Respondents: 19		

Q5 How would you rate the overall quality of your meeting with your Educational Supervisor?

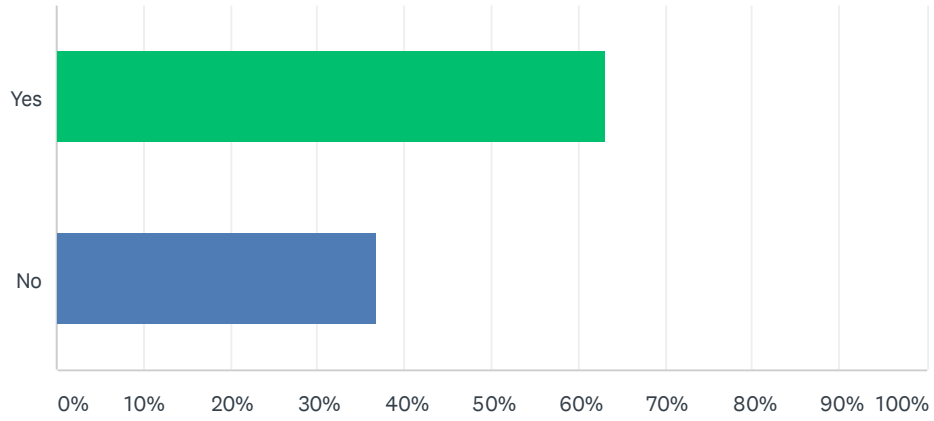
Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	57.89%	11
Good	42.11%	8
Fair	0.00%	0
Poor	0.00%	0
Not applicable	0.00%	0
Total Respondents: 19		

Q6 Have you had a subsequent appraisal with your Educational Supervisor? If no, please explain why.

Answered: 19 Skipped: 0

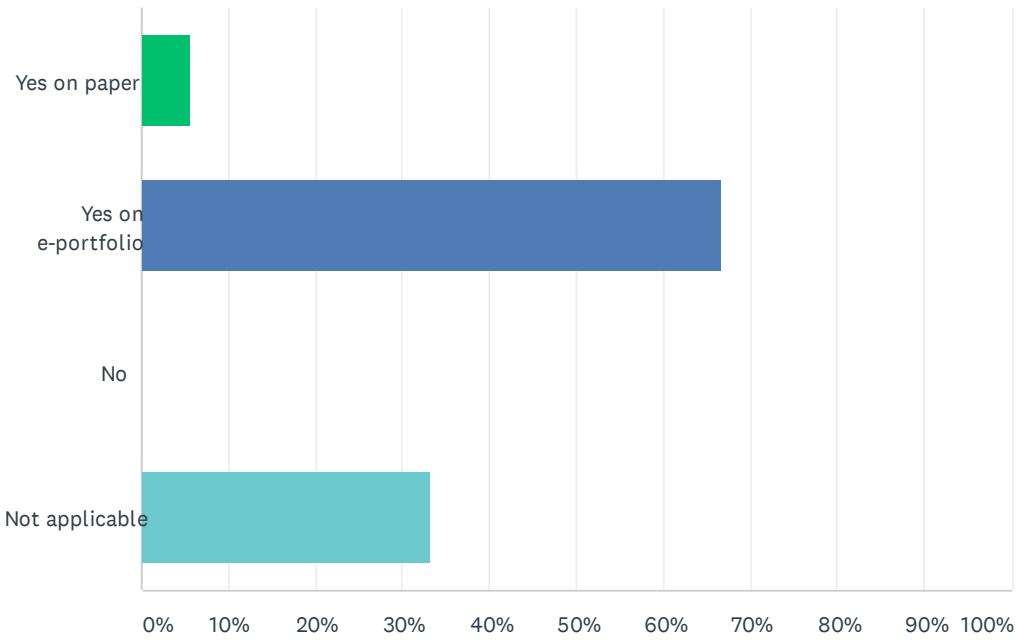


ANSWER CHOICES	RESPONSES	
Yes	63.16%	12
No	36.84%	7
TOTAL		19

#	IF NO, PLEASE SPECIFY:	DATE
1	Haven't yet organised. But have ongoing close communication within department.	1/8/2020 3:49 PM
2	Due to have one soon	12/17/2019 8:57 PM
3	Difficult to arrange time to meet as she isn't always based in Salisbury	12/11/2019 10:02 PM
4	Only been in the job for 2 months	12/11/2019 10:38 AM
5	Not due yet	12/11/2019 10:22 AM
6	Not yet at halfway point of rotation	12/10/2019 9:05 PM
7	LTFT- but awaiting next review	12/10/2019 4:40 PM

Q7 If yes, was this meeting documented?

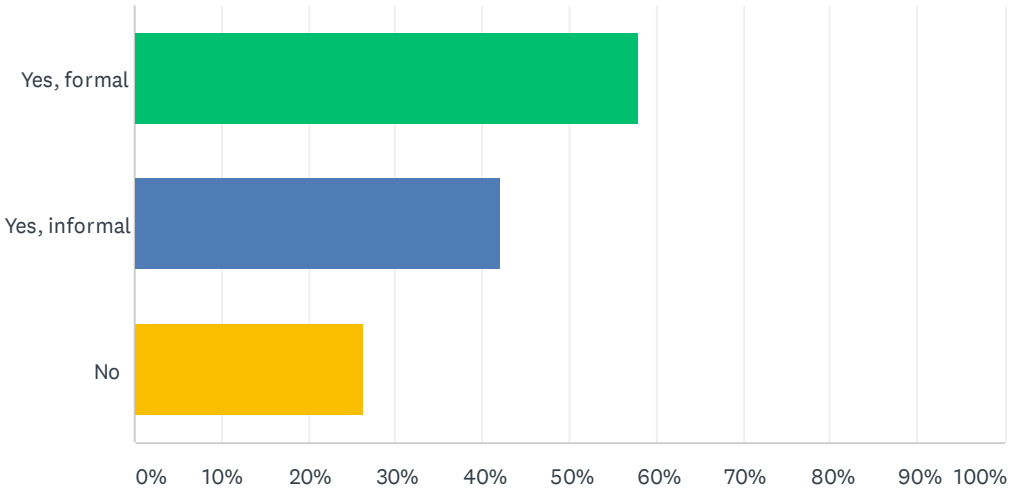
Answered: 18 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes on paper	5.56%	1
Yes on e-portfolio	66.67%	12
No	0.00%	0
Not applicable	33.33%	6
Total Respondents: 18		

Q8 Have you been given any feedback about your performance from your Clinical or Educational Supervisor?

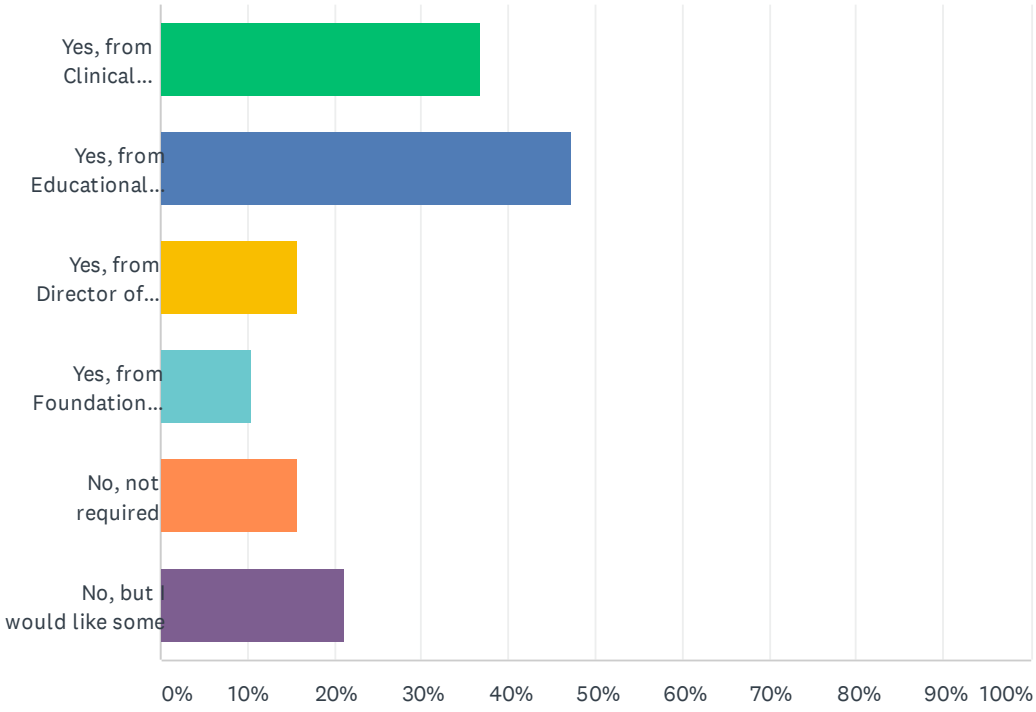
Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, formal	57.89%	11
Yes, informal	42.11%	8
No	26.32%	5
Total Respondents: 19		

Q9 Have you received any career guidance?

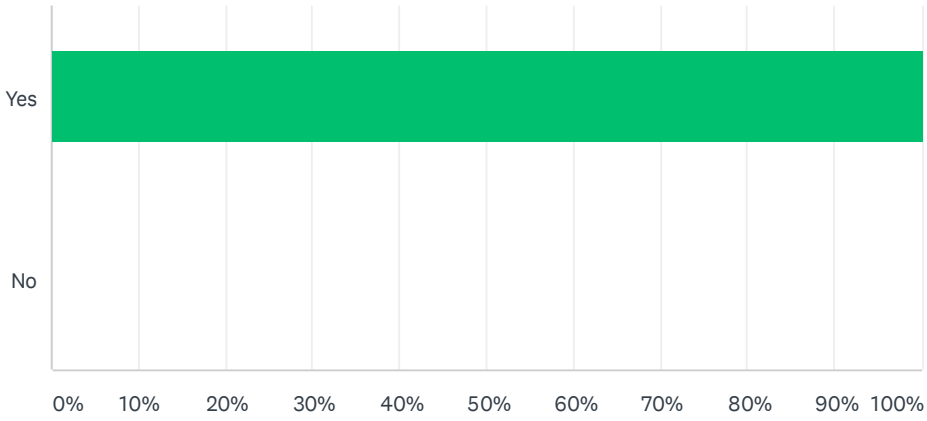
Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, from Clinical Supervisor	36.84%	7
Yes, from Educational Supervisor	47.37%	9
Yes, from Director of Medical Education	15.79%	3
Yes, from Foundation Programme Director	10.53%	2
No, not required	15.79%	3
No, but I would like some	21.05%	4
Total Respondents: 19		

Q10 Do you know who your named Clinical Supervisor is for your current placement?

Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	19
No	0.00%	0
Total Respondents: 19		

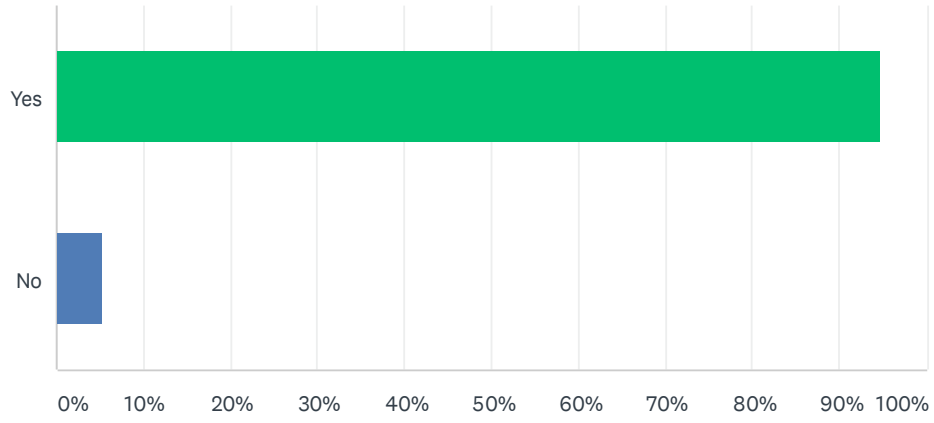
Q11 Who is your named Clinical Supervisor? (optional)

Answered: 6 Skipped: 13

#	RESPONSES	DATE
1	Mr Padwick	1/12/2020 8:03 PM
2	Same as my educational supervisor - Dr A Harris	12/27/2019 11:18 AM
3	Dr Henderson	12/16/2019 7:45 PM
4	Dr Pippa Baker	12/11/2019 3:25 PM
5	Dr Roger Palmer	12/11/2019 3:10 PM
6	Simon Hunter	12/10/2019 4:40 PM

Q12 Do you always know who is clinically supervising you at any time (may not always be your named Clinical Supervisor)?

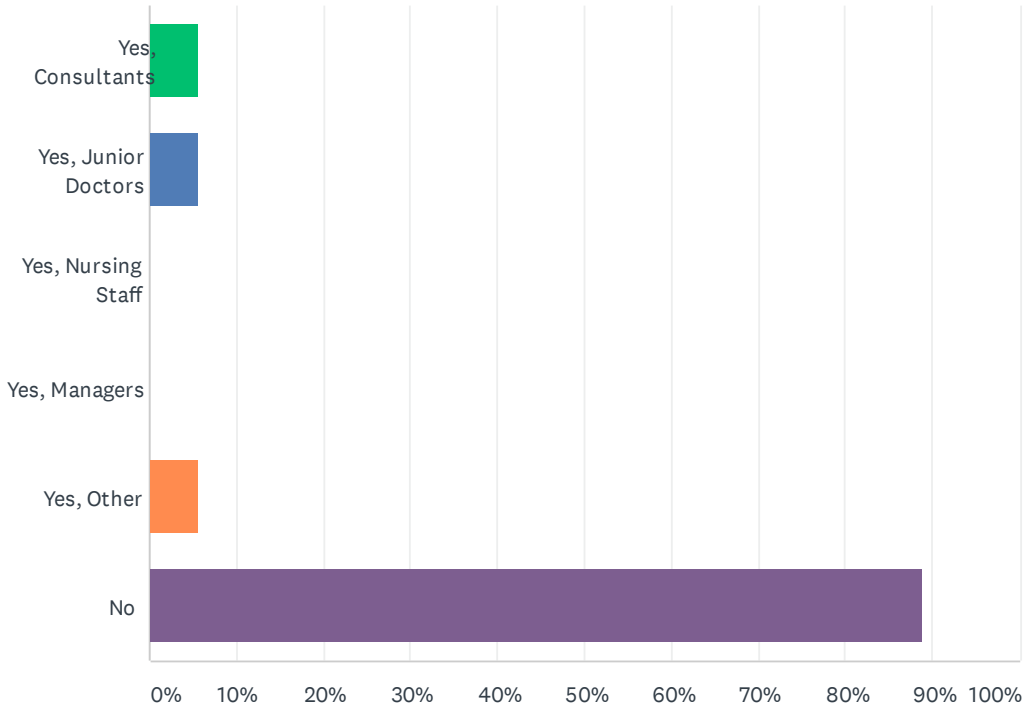
Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	94.74%	18
No	5.26%	1
Total Respondents: 19		

Q13 During your time in Salisbury have you felt persistently undermined by other Trust staff?

Answered: 18 Skipped: 1

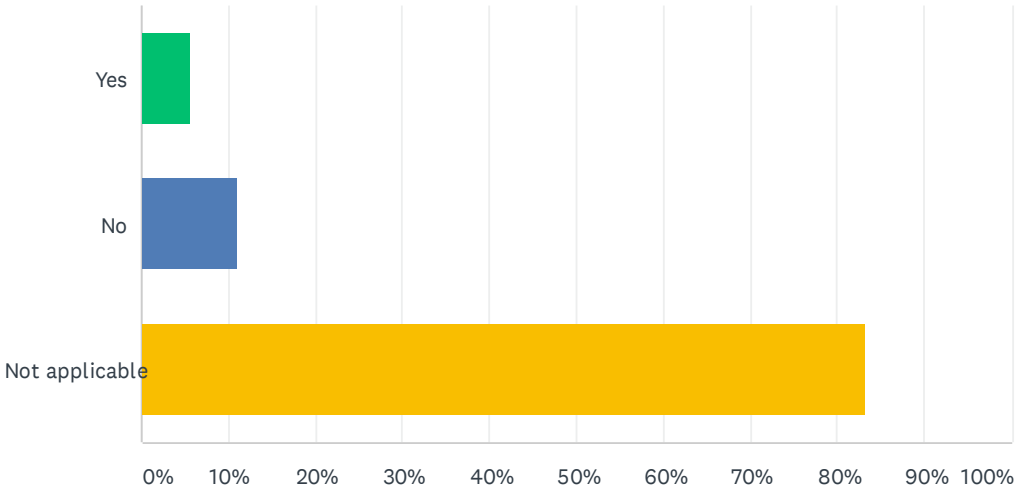


ANSWER CHOICES	RESPONSES	
Yes, Consultants	5.56%	1
Yes, Junior Doctors	5.56%	1
Yes, Nursing Staff	0.00%	0
Yes, Managers	0.00%	0
Yes, Other	5.56%	1
No	88.89%	16
Total Respondents: 18		

#	IF 'OTHER' (PLEASE SPECIFY)	DATE
1	Sometimes, nursing staff, particularly senior/very senior nurses.	12/18/2019 1:37 PM
2	Rota coordinator	12/11/2019 6:20 PM

Q14 If yes, have you discussed this with anyone (Clinical Supervisor, Educational Supervisor, Tutor, Director of Medical Education, Human Resources etc.)?

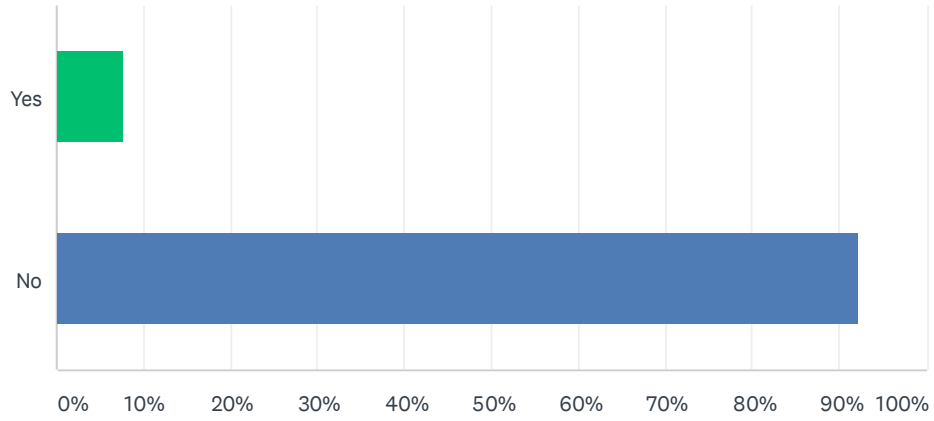
Answered: 18 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	5.56%	1
No	11.11%	2
Not applicable	83.33%	15
Total Respondents: 18		

Q15 Have you had any study leave requests refused since starting in Salisbury? (This question is not applicable to F1 doctors)

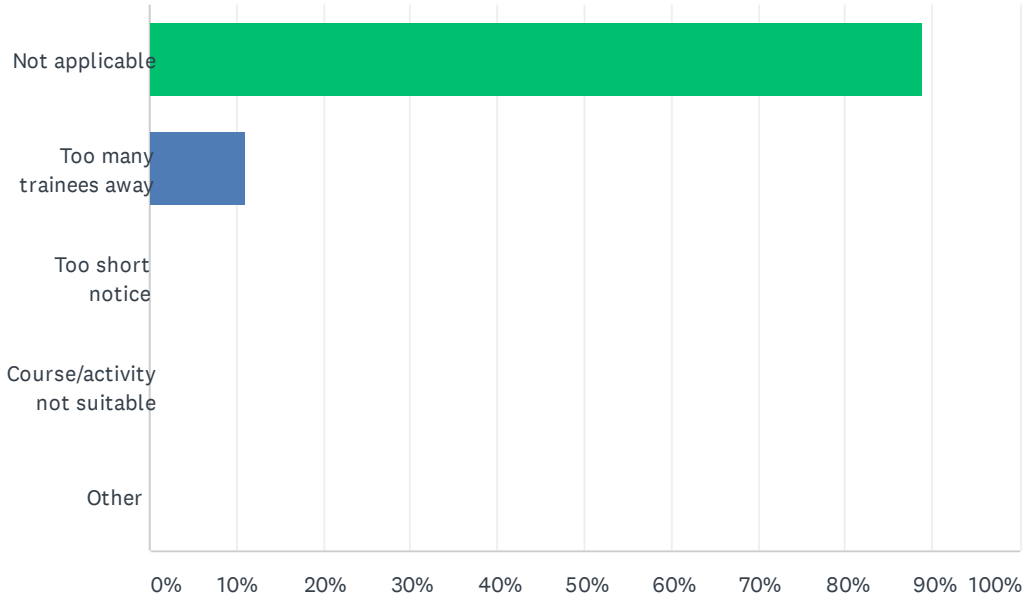
Answered: 13 Skipped: 6



ANSWER CHOICES	RESPONSES	
Yes	7.69%	1
No	92.31%	12
Total Respondents: 13		

Q16 If yes, what was the given reason

Answered: 9 Skipped: 10

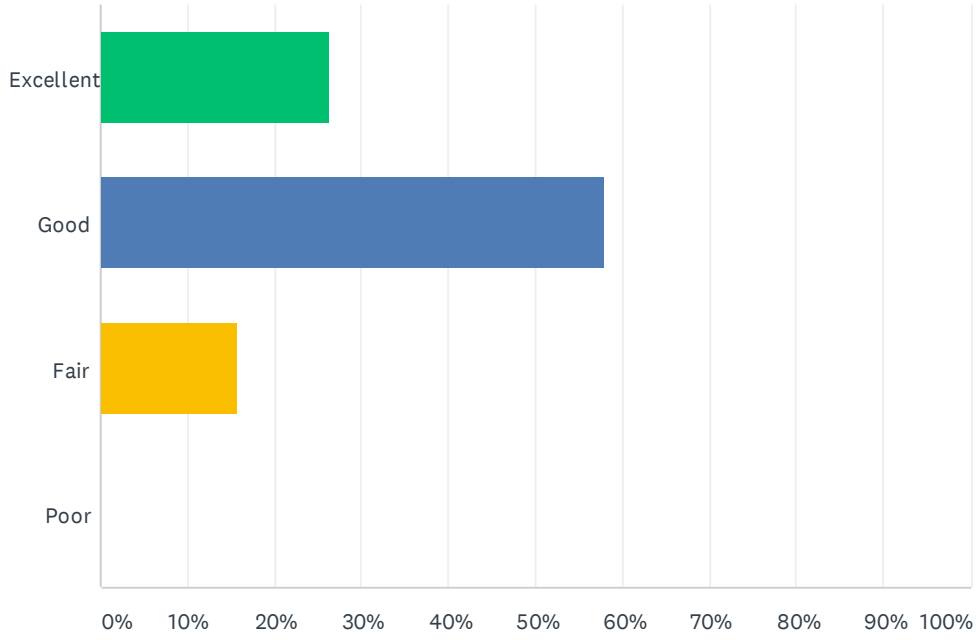


ANSWER CHOICES	RESPONSES	
Not applicable	88.89%	8
Too many trainees away	11.11%	1
Too short notice	0.00%	0
Course/activity not suitable	0.00%	0
Other	0.00%	0
TOTAL		9

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q17 How would you rate your overall experience so far in Salisbury?

Answered: 19 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	26.32%	5
Good	57.89%	11
Fair	15.79%	3
Poor	0.00%	0
Total Respondents: 19		

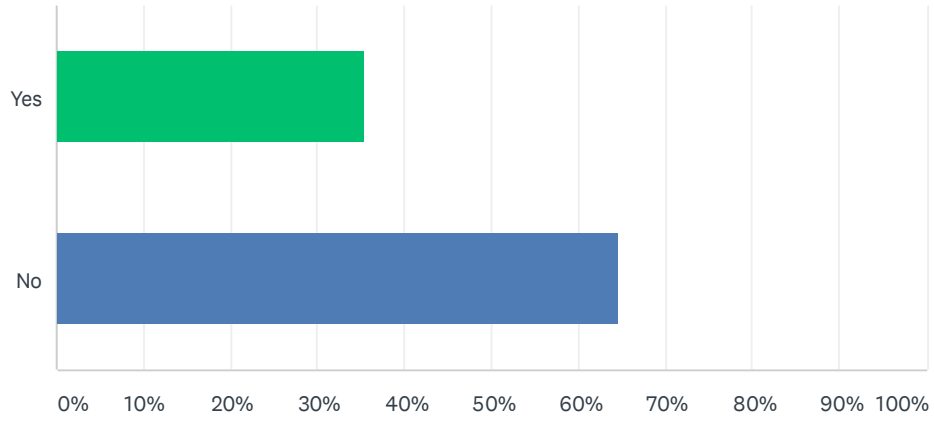
Q18 If fair or poor, please comment on what you feel the issues are.

Answered: 3 Skipped: 16

#	RESPONSES	DATE
1	I had a hard time on my first job because there were not enough junior doctors present on the ward consistently the first 3 months. Job was strongly admin based and extremely stressful and as a result experience and learning were limited.	12/11/2019 10:02 PM
2	Problems with understaffed recovery/overbooked surgical lists meaning less opportunity for trainees to operate, and the impact of this on my learning.	12/10/2019 9:05 PM
3	Poor management, poor rota outline in ED, variable consultant lead- unfortunately i seem to have worked with a weaker consultant - concerns have been raised.	12/10/2019 4:40 PM

Q19 With regards to your training, are there any other areas that you think the Director of Medical Education should know about and explore?

Answered: 17 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	35.29%	6
No	64.71%	11
TOTAL		17

#	IF YES, PLEASE COMMENT BELOW	DATE
1	Emma Halliwell foundation programme lead could be more approachable outside of set teaching times	1/6/2020 6:28 PM
2	The training opportunities in ED are excellent.	12/27/2019 11:18 AM
3	Persistent issue, but H@NT SHO shifts. Widely considered to be old-fashioned/not compatible with modern working standards.	12/18/2019 1:37 PM
4	More teaching and training. Some of the core teaching sessions are basic and inappropriate i.e. types of respiratory failure, catheterisation. These sessions are at a level of medical studnets and assessed at medical school thoroughly. More appropriate core teaching sessions which help junior doctors would be of benefit.	12/17/2019 8:57 PM
5	Consideration during ARCP for those working on an understaffed ward (not enough doctors) should be made, as teaching was very difficult to come by as was completing portfolio tasks.	12/11/2019 10:02 PM
6	Opportunity to promote Grand Round for all hospital staff - to encourage CPD, and cohesion amongst the medical teams (inc. Consultants!).	12/11/2019 10:38 AM
7	On the shop floor- great work load. Some consultants have been great at helping complete WBA's- so no complaints there. Would like to see better hand over, better leadership and control of the department and lead by example (rather than just sit and organise) from some of the ED consultants.	12/10/2019 4:40 PM

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	14 January 2021		

Report Title:	Annual Equality Report 2020			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	x
Prepared by:	Rex Webb, Head of Diversity & Inclusion.			
Executive Sponsor (presenting):	Lynn Lane, Director of OD & People			
Appendices (list if applicable):	Equality Report 2020			

Recommendation:

It is recommended that the Trust consider the following recommendations to continue our equality, diversity and inclusion journey.

- The EDI Committee to consider this report together with the Gender Pay Gap, WRES and WDES reports to create a SMART equality action plan in line with the NHS Long Term Plan, NHS People Plan and the Public Sector Equality Duty.
- The Head of Diversity and Inclusion to work with Information governance to develop an Equality Monitoring Policy to ensure that a standard set of equality data is recorded across all directorates in the Trust.
- The Head of Diversity & Inclusion to work with the Education department to ensure EDI is embedded into all training provided by the Trust.
- The EDI Committee to develop a mechanism for identifying and collecting EDI related work across all directorates.

Executive Summary:

The Annual Equality Report 2020 reflects the activity and progress made in the Trust between April 2019 and March 31st 2020 with our ED&I agenda.

The report makes reference to three further mandated reports: the Workforce, Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) which contain further detail.

This annual report aims to highlight some of the key successes and challenges faced during

the 2019/2020 period. We are mindful that as we move forward into 2021 we will need to focus our activity and approach to the ED&I agenda by working closely with and through our networks. We will report progress against the actions agreed by the ED&I committee in January 2021 in quarterly ED&I update reports to assure the board of our progress over time. It is on this basis that we ask the OD&P Management Board to approve the above recommendations.

The annual ED&I report identifies the demographics of the people within our organisation and the patients we care for. On the 31st March 2020 the Trust employed 3863 people, this amounts to an increase of 7% on the previous year.

The Trust employs people from 72 different countries and during the year there was an increase of 4% in the number of people employed from a BAME background.

When we look at the equality data of our workforce March 2019 to March 2020 we see that we still have a low number of people who are identifying as LGBT+. This amounts to 2% (85) of all staff which remains the same as the previous year.

There is also a similar situation when we look at people who identify with a disability. On our ESR system 3% (98) of our staff disclosed a disability, whereas in the NHS staff survey 330 people identified as having a disability.

For the first time this year we have included the equality data for our volunteers. We have a total of 600 volunteers and you will see we do not have accurate equality data for all of them. The report details the action we are taking to rectify this.

During the past twelve months we ran a number of events and programs to celebrate and promote equality, diversity and inclusion. Full details of these are recorded in this report. Activity was disrupted by the Covid-19 Pandemic and this made us all think creatively about how we maintain the focus on equality, diversity and inclusion issues.

The pandemic has focused us on supporting the most vulnerable groups within our workforce and patients. We have engaged closely with all our staff and in particular those who were disproportionally affected (e.g. BAME people and people with health conditions.)

We have continued to develop and support a number of staff networks. At the present time the following networks are operating at various stages of development:

- BAME Forum
- Rainbow Shed Network – LGBT+ network
- Women's network
- Mental Health First Aiders Network
- #LoveOUREUStaff network

Work has also started on creating a Disability network.

The Trust EDI Committee has been meeting throughout the year and is a link between the Staff Networks and OD & P Management Board. The Committee is continuing to align our work programmes to The NHS People Plan and the results of the Best Place To Work program.

The close link between EDI and the Freedom To Speak Up Program has continued over the past twelve months. The Head of Diversity & Inclusion and The Freedom To Speak Up Guardian regularly running training sessions together and attend Trust Induction every Monday. During the year 2019/20 they engaged with 1058 members of staff in this way.

The Trust has continued to meet its legal and contractual duties by engaging with the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap reporting program. Summaries of the relevant reports for 2020 are included in the report. The original reports are available on the Trust website.

During the past twelve months the Trust has reviewed its EDI Policy, introduced a new Equality Impact Assessment process and updated its equality pages on the Trust website.

The full EDI Report 2020 provides greater detail and includes a number of recommendations in section 16.

The Annual Equality Report has been circulated to the EDI Committee members. In January 2021 it will be presented to the Trust Board for final ratification.

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

Equality Report 2020

An outstanding experience for every patient

1. Commitment

Statement from Stacey Hunter, Chief Executive Officer:

"I am privileged to be the CEO of Salisbury NHS Foundation Trust. I am really pleased to have been given the opportunity to input into this year's Equality report.

I am passionate about equality and fair treatment for all and want to promote a culture that does not tolerate discrimination and injustice.

I know that colleagues here at SFT recognise how fundamental it is to remain committed to the delivery of fair, equitable and inclusive services both as a health care provider and as an employer.

Structural inequalities and racism are not simply intelligent concepts – COVID 19 has once again shown us that inequality is real. It impacts upon our physical health as well as our mental health and it shortens lives. I recognise that for many these are tough and uncomfortable views however it is critical we are able to be open to hearing what more we need to do together to effect change.

We need to re-double our efforts to ensure we seek out the voices that are seldom heard and often ignored so that we can change outcomes for patients, our people and the communities we serve.

I recognise that this takes commitment and hard work but I know you will want to support me as we continue to progress our ambitions to deliver truly inclusive services and ensure that all of our people at SFT feel that this is a place where they can bring their whole selves to work and truly belong.

Diversity in our teams brings benefits for everyone both employees and patients – the evidence clearly shows that it improves experiences for our people, leads to better patient outcomes and is associated with being more innovative and efficient . I look forward to working with you all as we seek further continuous improvements on this critical agenda over the coming year."

N.B. The majority of photographs in this report were taken pre Covid-19.

2. Executive Summary

Rex Webb
Head of Diversity & Inclusion

At Salisbury NHS Foundation Trust we respect and value the diversity of our patients, their relatives and carers, and our people and we are committed to meeting the needs and expectations of the diverse communities we serve, providing high quality care.

The Annual Equality Report is a legal requirement and a real opportunity to update the Board and the public on progress being made towards the development of a culture of inclusion as a service provider and an employer, where all people are valued and respected for their individual differences in accordance with the Trust values.

The report also provides the Board and the public with assurance about the steps taken to meet the Trust's commitment to comply with the Public Sector Equality Duty under the Equality Act 2010, our compliance with equality and diversity requirements of the NHS standard contract, NHS Constitution and CQC criteria. (See Appendix 1 for details of Public Sector Equality Duty requirements).

The following pages identify the demographics of the people within our organisation and the patients we care for. On the 31st March 2020 the Trust employed 3863 people, this amounts to an increase of 7% on the previous year.

The Trust employs people from 72 different countries and during the year there was an increase of 4% (175) in the number of people employed from a BAME background.

When we look at the equality data of our workforce we see that we still have a low number of people who are identifying as LGBT+. This amounts to 2% (85) of all our people which remains the same as the previous year.

There is also a similar situation when we look at people who identify with a disability. On our ESR system 3% (98) of our people disclosed a disability, whereas in the NHS staff survey 330 people identified as having a disability.

For the first time this year we have included the equality data for our volunteers. We have a total of 600 volunteers and you will see we do not have accurate equality data for all of them. The report details the action we are taking to rectify this.

N.B. The majority of photographs in this report were taken pre Covid-19.

During the past twelve months we ran a number of events and programs to celebrate and promote equality, diversity and inclusion. Full details of these are recorded in this report. Activity was disrupted by the Covid-19 Pandemic and this made us all think creatively about how we maintain the focus on equality, diversity and inclusion issues.

The pandemic has focussed us on supporting the most vulnerable groups within our workforce and patients. We have engaged closely with all our people and in particular those who were disproportionally affected (e.g. BAME people and people with a health conditions.)

We have continued to develop and support a number of staff networks. At the present time the following networks are operating at various stages of development:

- BAME Forum
- Rainbow Shed Network – LGBT+ network
- Women's network
- Mental Health First Aiders Network
- #LoveOUREUStaff network

Work has also started on creating a Disability network.

The Trust EDI Committee has been meeting throughout the year and is a link between the Staff Networks and the OD& P Management board. The Committee is continuing to align our work programmes to The NHS People Plan and the results of the Best Place To Work program. They are also mindful of other external factors detailed later in this report (see section 15).

The close link between EDI and the Freedom To Speak Up Program has continued over the past twelve months. The head of Diversity & Inclusion and The Freedom To Speak Up Guardian regularly running training sessions together and attending Trust Induction every Monday. During the year April 2019 to March 2020 they engaged with 1058 of our people in this way.

The Trust has continued to meet its legal and contractual duties by engaging with the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap reporting program. Summaries of the relevant reports for 2020 are included in this report. The original reports are available on the Trust website.

During the past twelve months the Trust has reviewed its EDI Policy, introduced a new Equality Impact Assessment process and updated its equality pages on the Trust website.

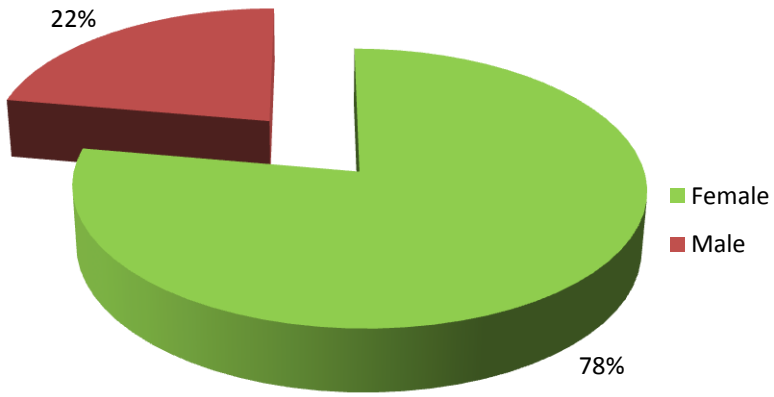
The full EDI Report 2020 provides greater detail and includes a number of recommendations in section 16.

N.B. The majority of photographs in this report were taken pre Covid-19.

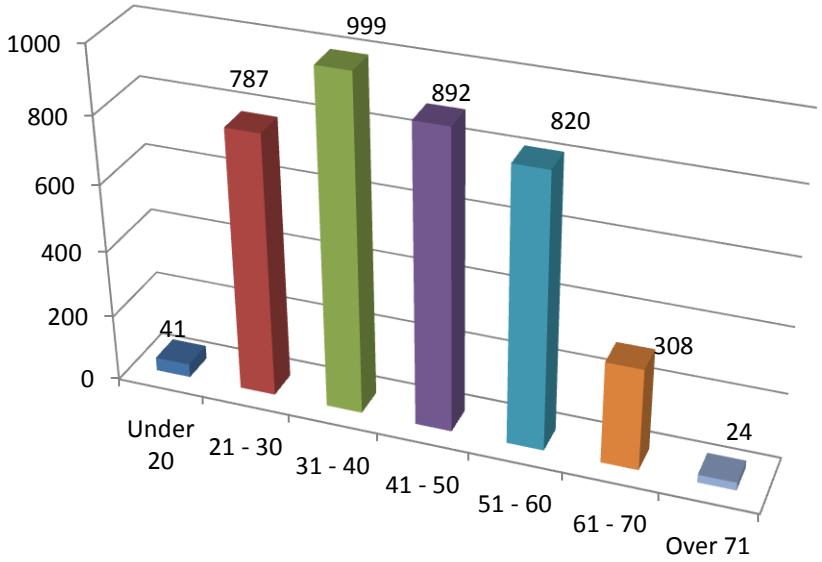
3. Our Workforce Demographic

On the 31st March 2020 our paid workforce consisted of a total of 3863 people. The following graphs show the percentage of our people with differing protected characteristics.

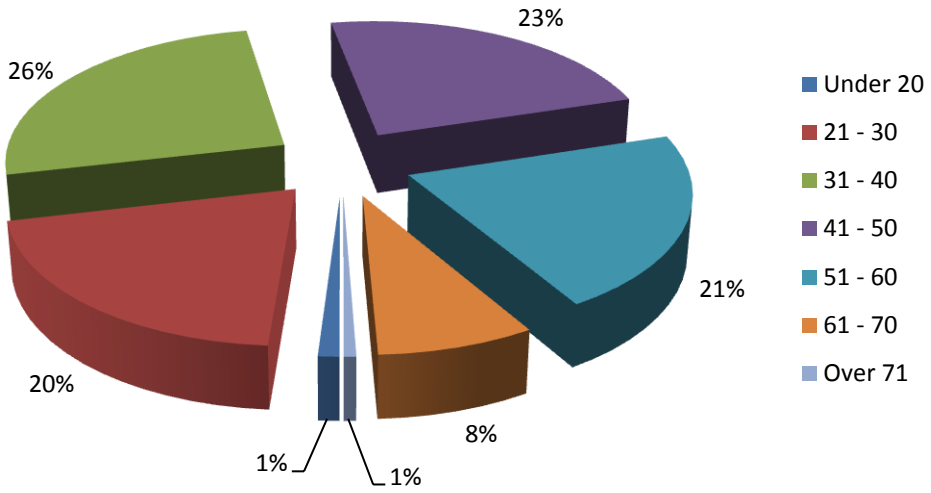
Sex:



Age:

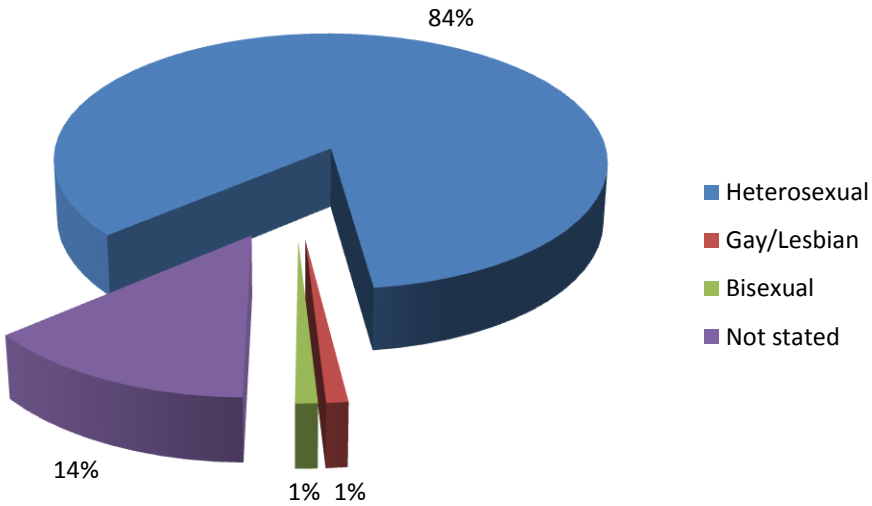


N.B. The majority of photographs in this report were taken pre Covid-19.



As can be seen in the above graphs there is an even spread of our people between the ages of 21 and 60.

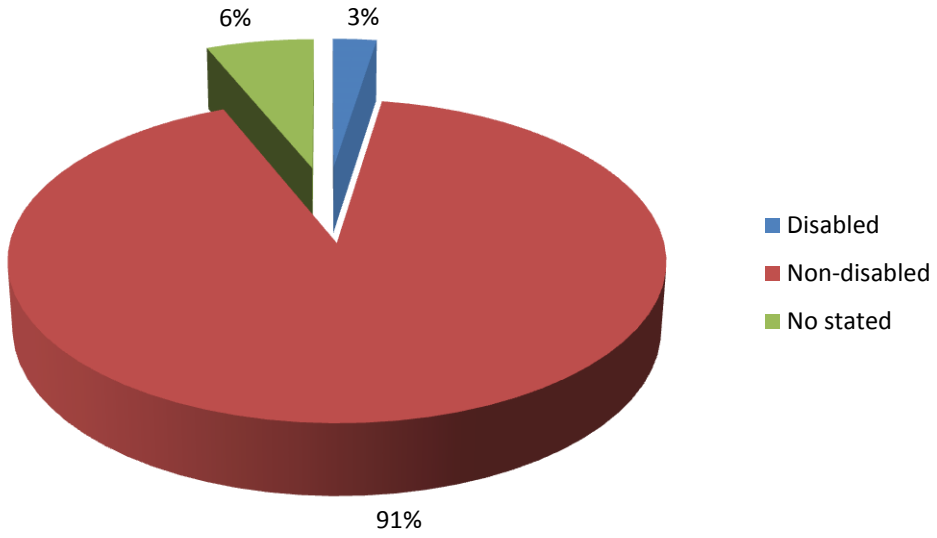
Sexual orientation:



Individuals who have identified as Lesbian, Gay, or Bisexual has not changed since the last annual report.

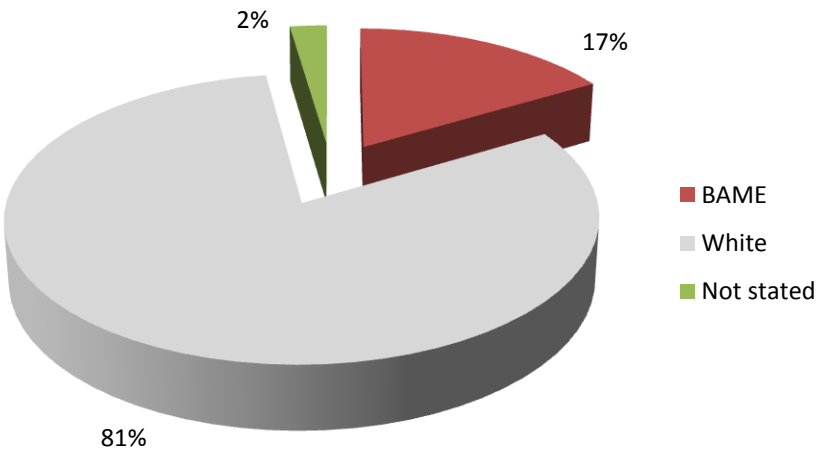
N.B. The majority of photographs in this report were taken pre Covid-19.

Disability:



3% of our people have indicated that they have a disability, this equates to 98 people. The Workforce Disability Standard (WDES) Report, referred to in section 13 of this report, has identified that the number of our people identifying with a disability in the NHS Staff Survey is much higher and does not reflect this number. We are working with the disability network to encourage our people to feel confident to disclose their relevant disabilities.

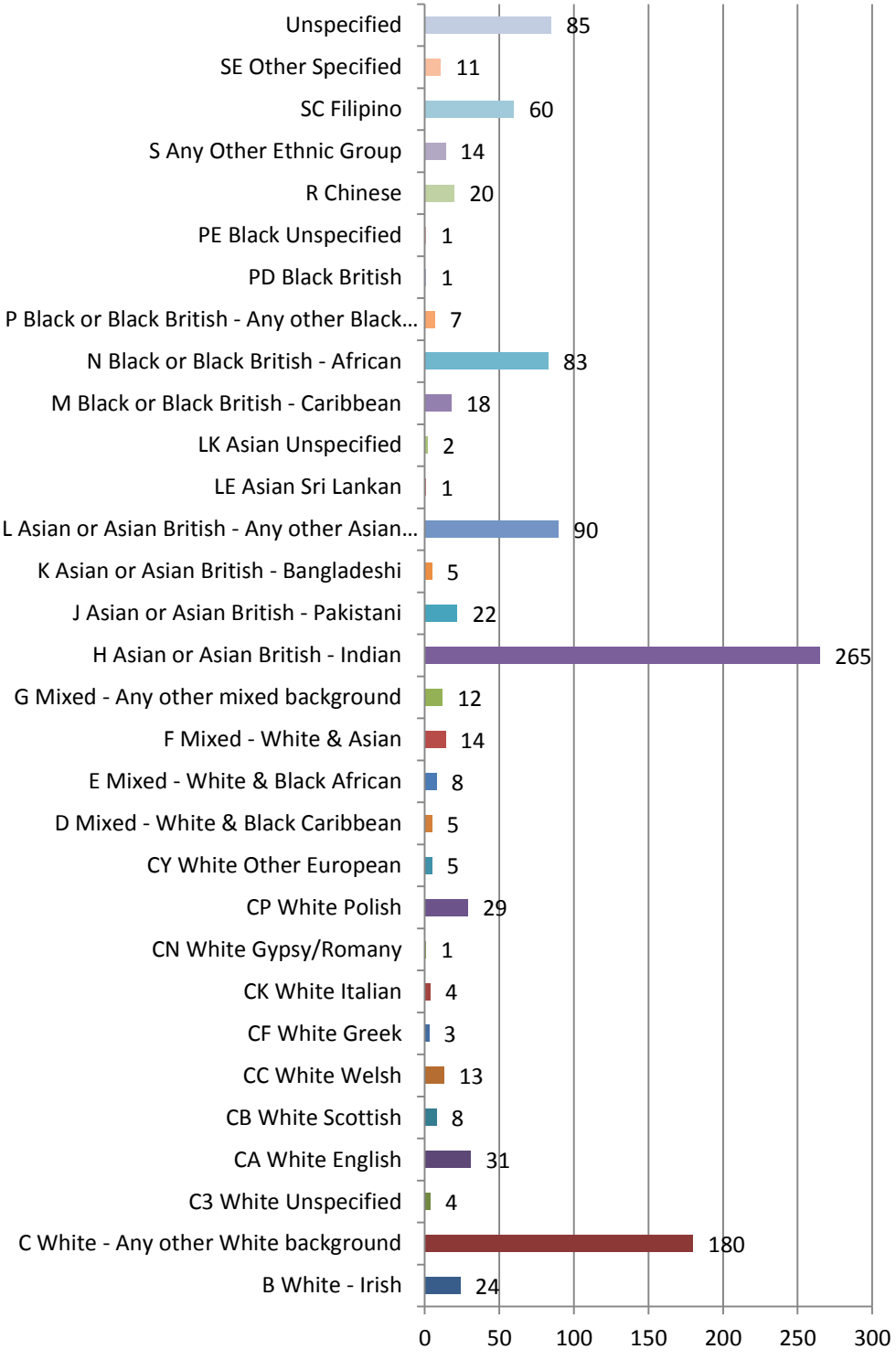
Ethnicity:



In 2019/20 our BAME workforce increased by 4% (175) on last year and now makes up 17% of our total workforce. This equates to 638 people.

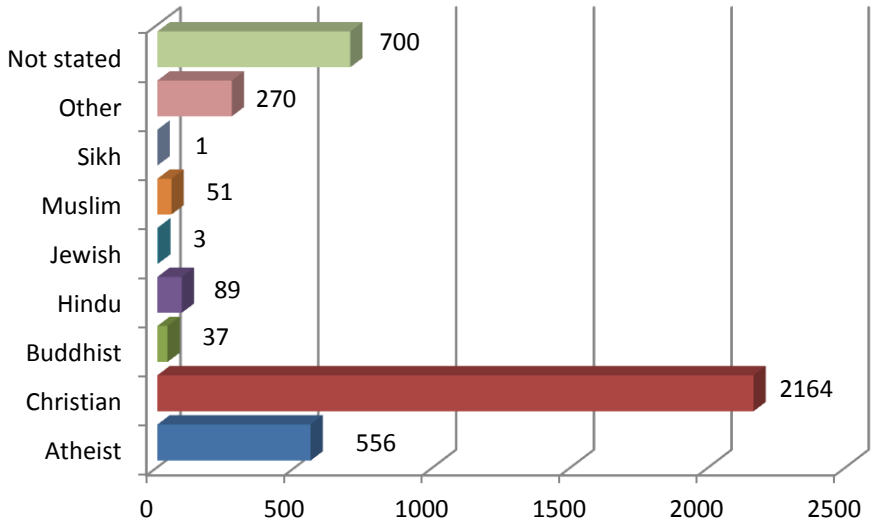
N.B. The majority of photographs in this report were taken pre Covid-19.

On closer examination we have identified that we have people from 72 different countries working for the Trust.



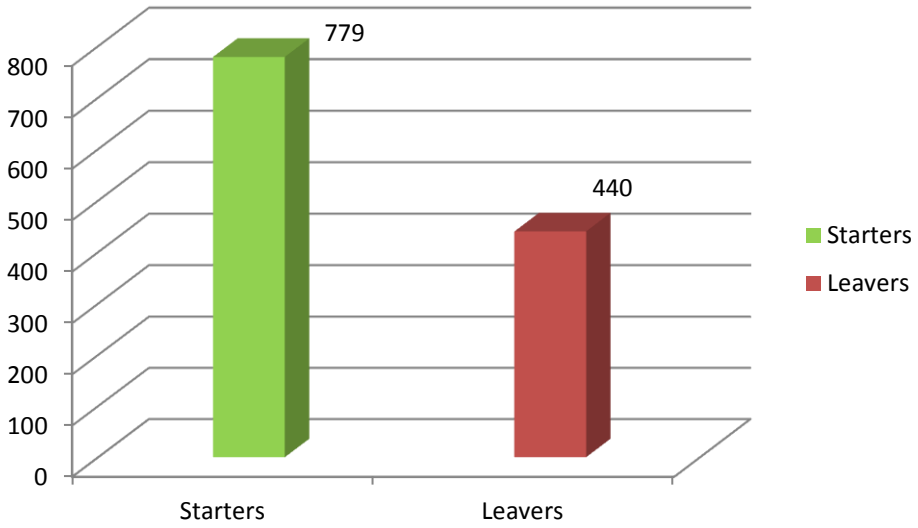
N.B. The majority of photographs in this report were taken pre Covid-19.

Religion and Belief:



4. Starters and Leavers

In the year 2019/20 a total of 440 of our people left the Trust and 779 people joined. This gives a net increase of 339.

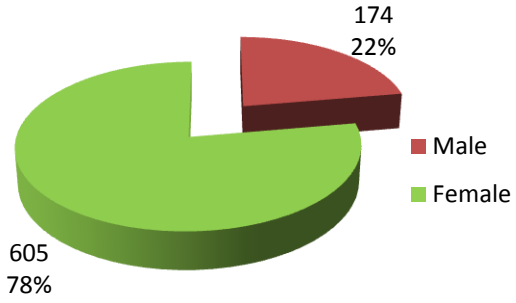


N.B. The majority of photographs in this report were taken pre Covid-19.

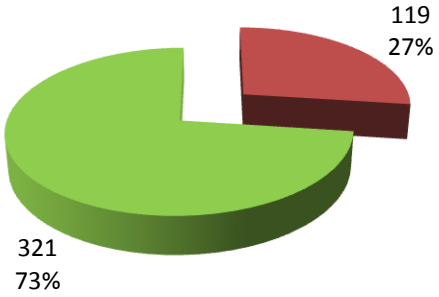
The following graphs show the numbers of people who joined and left by their known protected characteristics.

Sex:

Starters

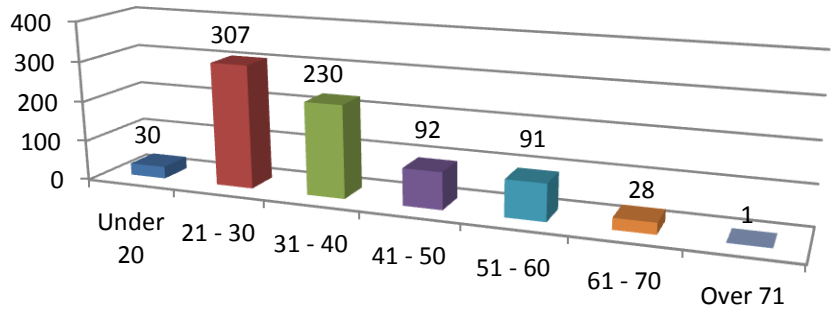


Leavers

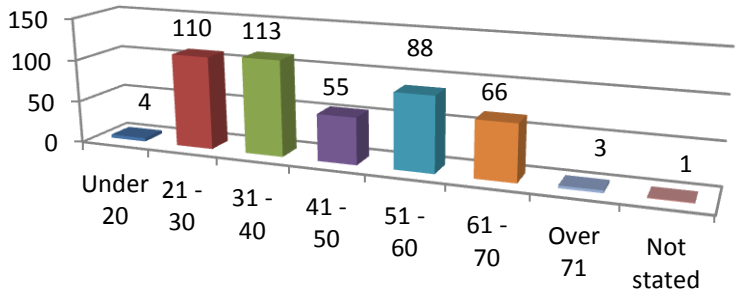


Age:

Starters



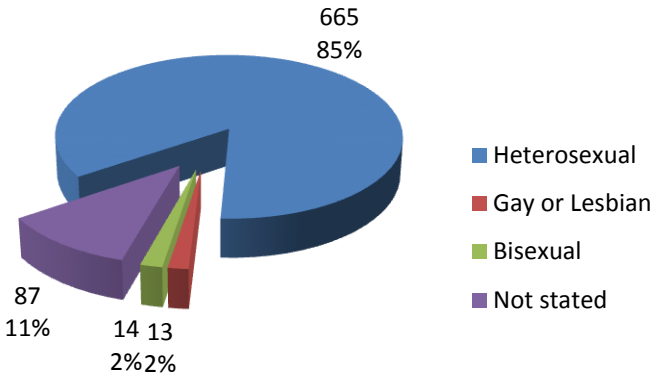
Leavers:



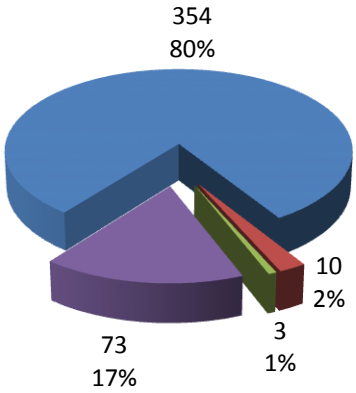
N.B. The majority of photographs in this report were taken pre Covid-19.

Sexual Orientation:

Starters

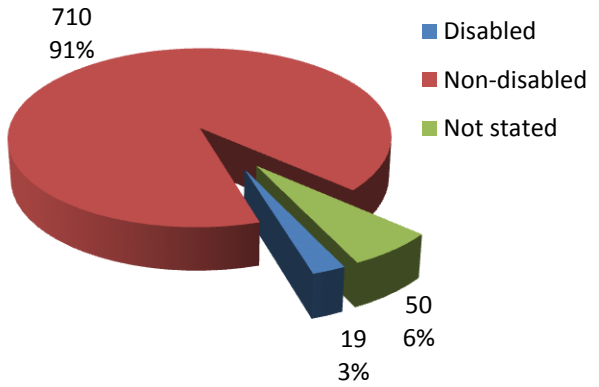


Leavers

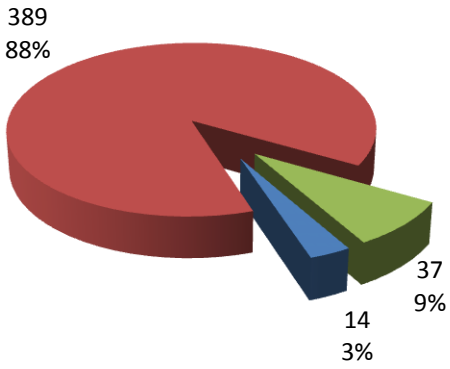


Disability:

Starters

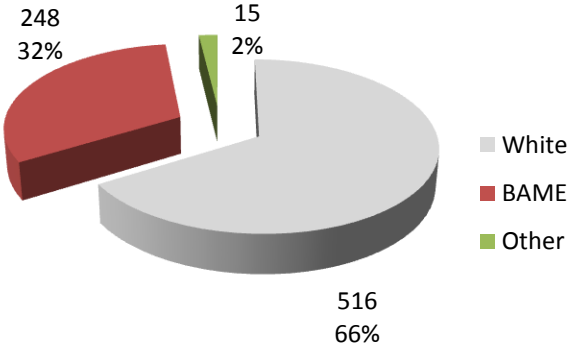


Leavers

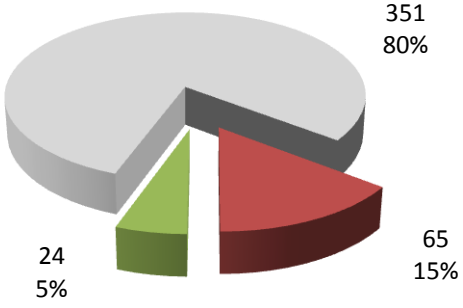


Ethnicity:

Starters



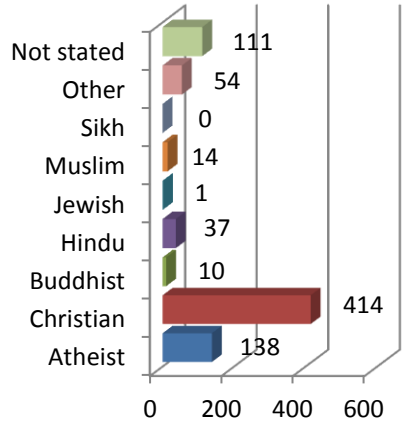
Leavers



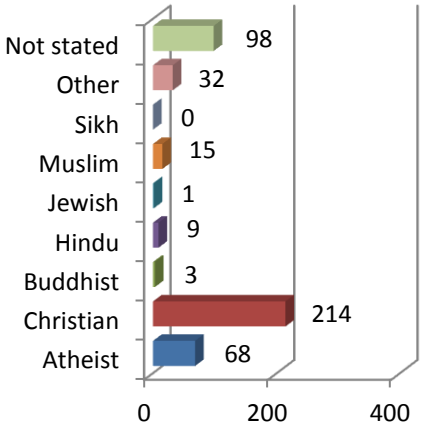
N.B. The majority of photographs in this report were taken pre Covid-19.

Religion and Belief:

Starters



Leavers



5. Volunteers

In the past the Trust has only kept one full years' worth of equality data, so although this does not provide data for the full 600 volunteers, it will give a snapshot of the demographics of our volunteers.

This is the first year that equality data on volunteers has been included in the Annual Equality Report. In future the Trust will ensure that we capture this data electronically so that we can provide the relevant information.

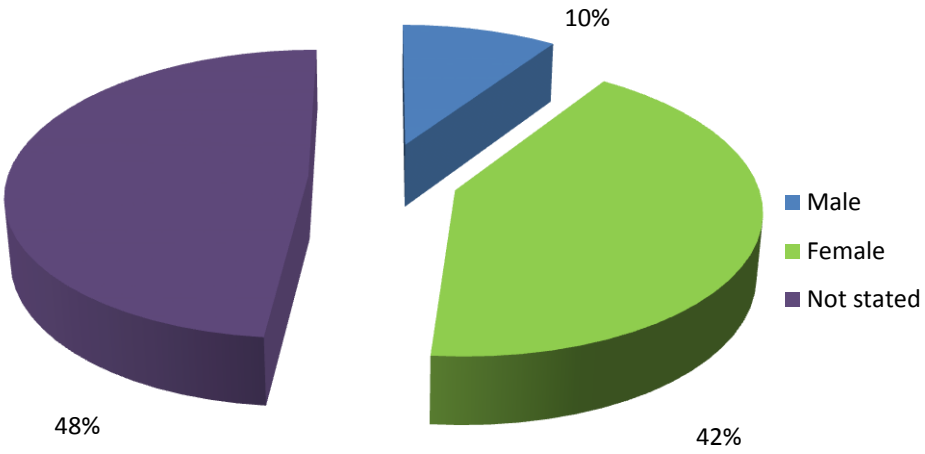
During the Covid-19 pandemic the majority of volunteers have not been attending the hospital site. As we slowly return our volunteers back to their roles we will ask volunteers to complete new equality information and next year we will have a whole picture of the volunteers on site.

The following graphs show the equality data relating to 126 volunteers who joined the Trust in 2019.

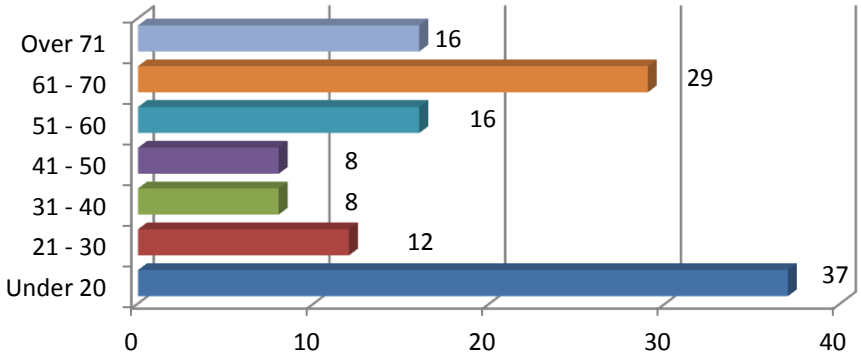
Jo Jarvis
Voluntary Services Manager

N.B. The majority of photographs in this report were taken pre Covid-19.

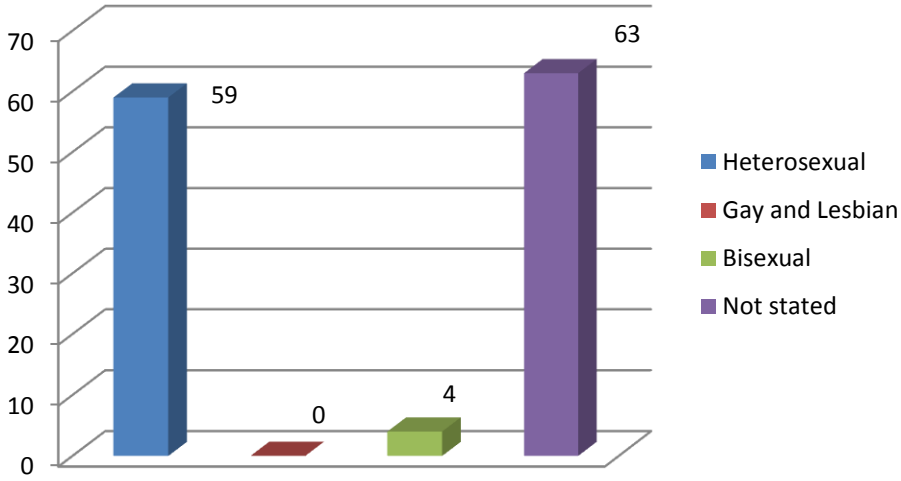
Sex:



Age:

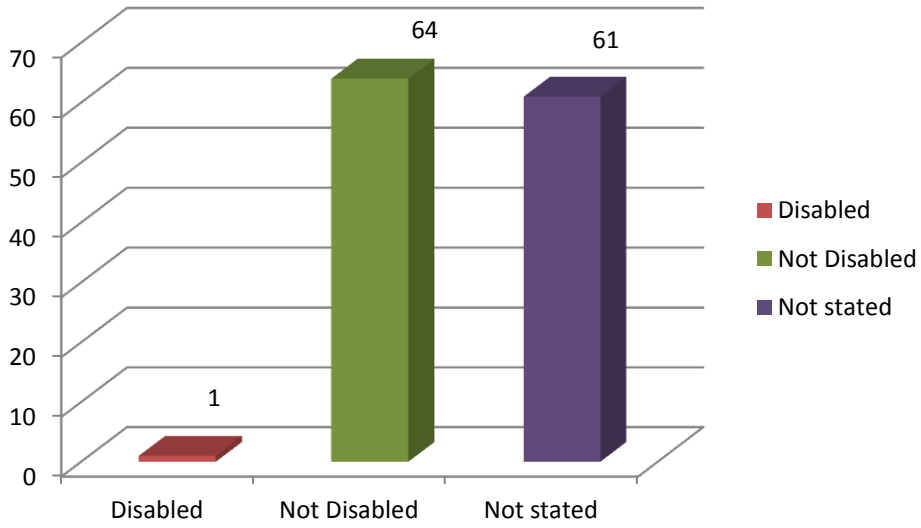


Sexual Orientation:

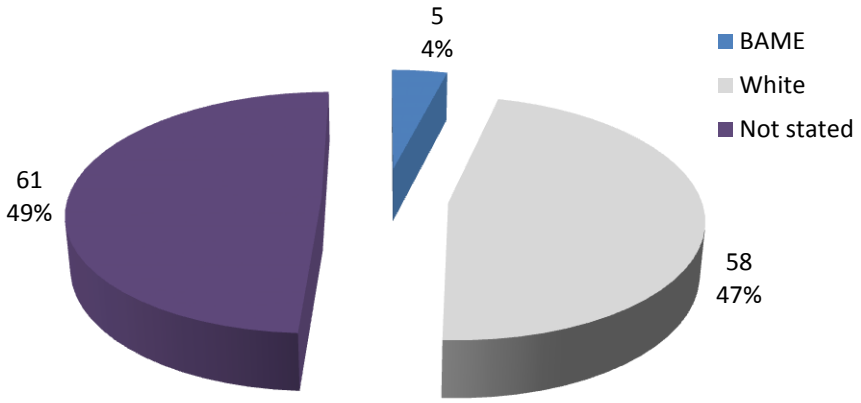


N.B. The majority of photographs in this report were taken pre Covid-19.

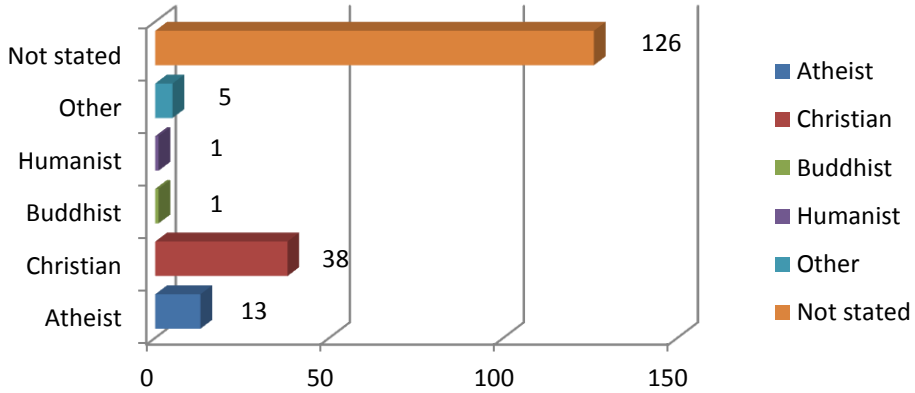
Disability:



Ethnicity:



Religion and Belief:

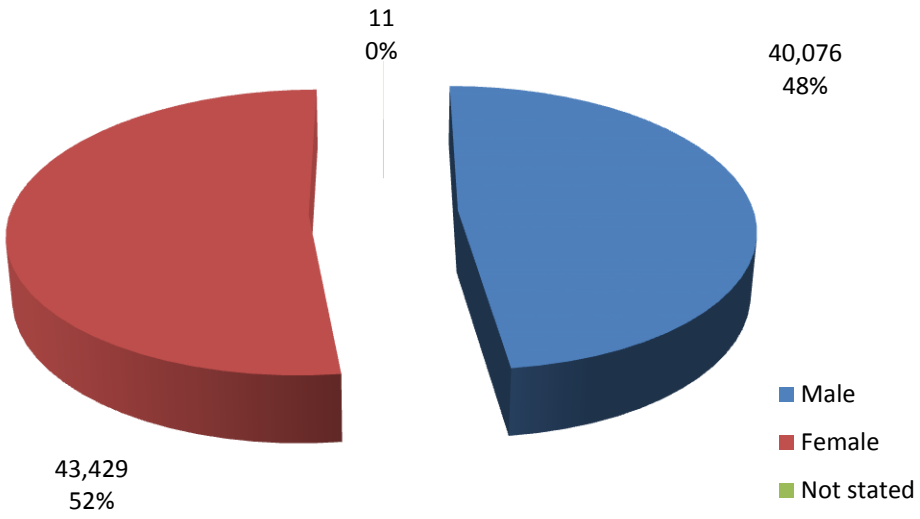


N.B. The majority of photographs in this report were taken pre Covid-19.

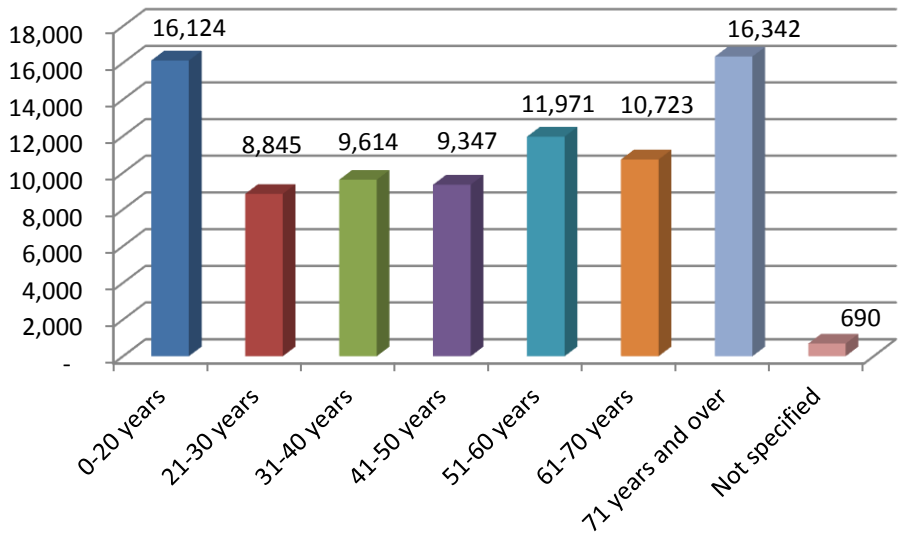
6. Our patients.

During the financial year 2019/20 Salisbury NHS Foundation Trust cared for 83,516 patients.

Sex:



Age:

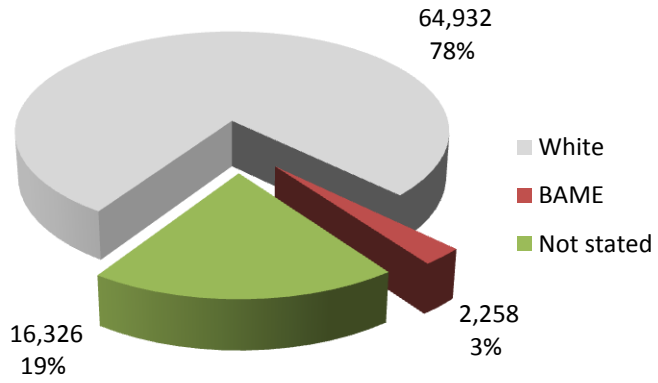


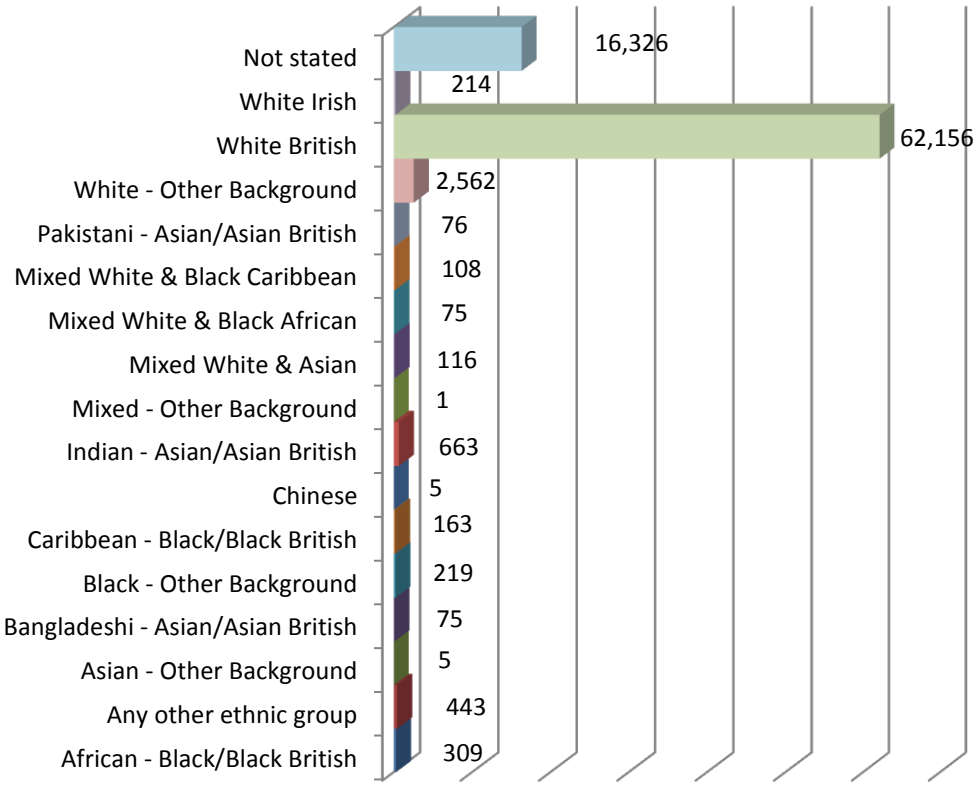
N.B. The majority of photographs in this report were taken pre Covid-19.

Sexual Orientation:

At the present time the Trust does not record the sexual orientation of its patients.

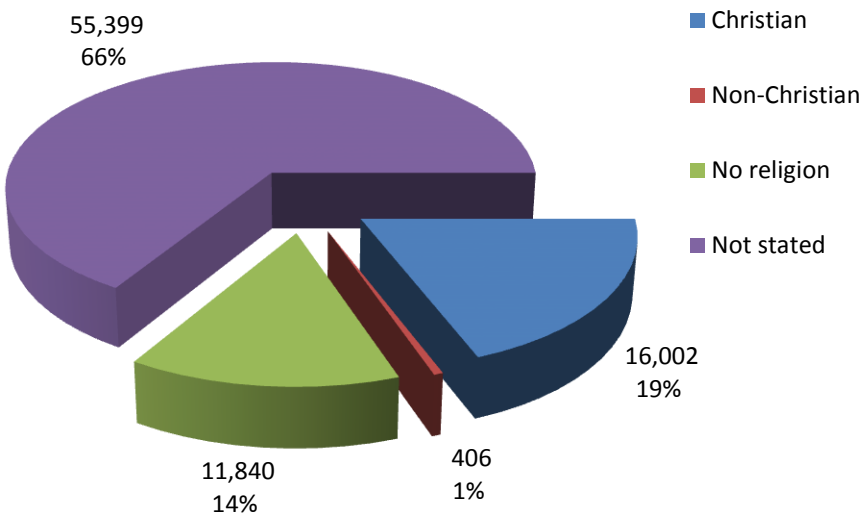
Ethnicity:





N.B. The majority of photographs in this report were taken pre Covid-19.

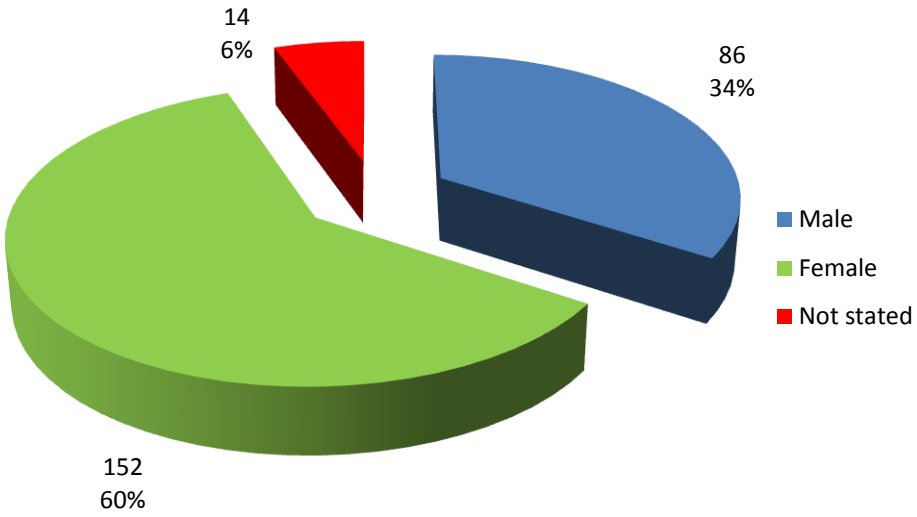
Religion and Belief:



Complaints:

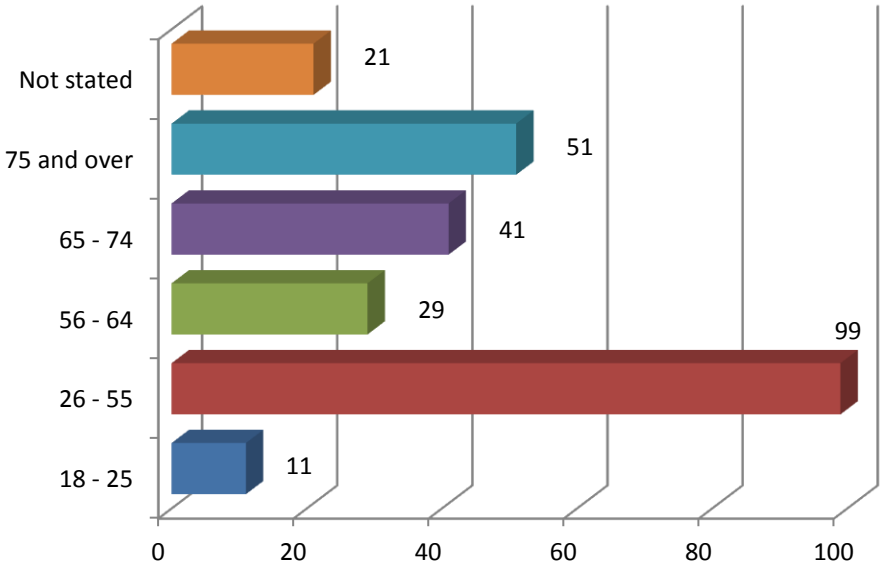
During 2019 there were 252 complaints received from patients. The following graphs show the equality data relating to the complainants.

Sex:

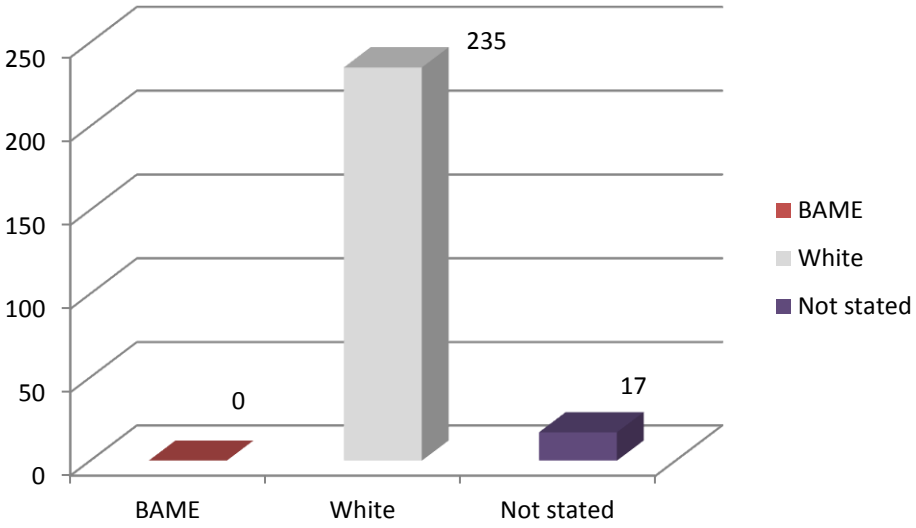


N.B. The majority of photographs in this report were taken pre Covid-19.

Age:



Ethnicity:



N.B. The majority of photographs in this report were taken pre Covid-19.

7. EDI Activity since October 2019

October is a significant month in the equality calendar, being both Black History Month and Freedom To Speak Up month. In 2019 a number of events were organised by the BAME Forum within the Trust to celebrate Black History Month.

These included organising an awareness stand in Springs Restaurant in association with the Royal College of Nursing, arranging a week of special meals in the Springs Restaurant on the theme of food from around the world and a special screening of the BBC series "Small Island".

The BAME Forum also took an active part in raising awareness of Freedom to Speak Up Month. Together with the Freedom to Speak Up Guardian and people from across the Trust they took part in the national #SpeakUpToMe campaign.

In November the Trust organised an event to raise a flag as an act of remembrance on the International Transgender Day of Remembrance. People from the Trust were joined by representatives from the Police, Local Council and the Salisbury Pride Committee to take part in a short act of remembrance before the flag was raised outside the Trust Offices.

N.B. The majority of photographs in this report were taken pre Covid-19.

In February 2020 the Trust celebrated LGBT+ (Lesbian, Gay, Bisexual, Transgender plus) History month by organising a multi-agency event and a flag-raising. Representatives from the local councils, Police, Army, Churches and Salisbury Pride Committee joined a number of our people in the Board room for a small ceremony prior to raising the flag. The flag was flown on site for the majority of the month.

On Valentine's day 2020 the BAME Forum organised an awareness event to raise awareness of the network. They held a trolley dash around the hospital giving away cards and sweets engaging with a diverse range of our people and patients.

N.B. The majority of photographs in this report were taken pre Covid-19.

February also saw the launch of a reverse mentoring programme entitled “Walk in My Shoes!” The programme involves members of the Trust Board together with representatives from the BAME Forum working together over a six month period. This is covered in more detail in the WRES report.

In March 2020 the Trust began to feel the effects of the Covid-19 pandemic. This had a dramatic effect on activity around EDI. A number of equality champions were either diverted from their roles, were shielding or working from home.

Originally the NHSE/I suspended the Workforce Race Equality Standard and the Workforce Disability Equality standard programmes. However when it became clear that the effects of the pandemic had a direct effect on equality, diversity and inclusion issues the programmes were reinstated. This years WRES and WDES reports are referred to later in this report (see sections 12 and 13).

Covid-19 was responsible for the cancellation of a number of EDI events and meetings. The pandemic also highlighted disproportionate effects on people from BAME communities and those with disabilities. This is evidenced in the WRES and WDES reports referred to later in this report. During this period the Trust has engaged closely with the BAME Forum in particular to identify the issues and help to resolve them.

During this time there was an opportunity to review the Trust Equality, Diversity and Inclusion Policy and to develop a new Equality Impact Assessment (EIA) Policy and process. Both of these have now been completed and authorised by the Trust

N.B. The majority of photographs in this report were taken pre Covid-19.

governance process. The impact and assurance resulting from these developments will be reviewed and included in the 2021 annual report.

An implementation plan is now being developed for the new EIA process.

The following section of this report documents the progress of our staff support networks during 2019/20.

8. Staff Support Networks

BAME Forum:

Over the past year our BAME Forum members have worked together to develop the network. This involved creating a What's App Group and having regular meetings throughout the year.

Covid-19 has posed some problems for the Forum although they are now regularly meeting virtually to continue to develop the network and engage with our BAME colleagues.

This year has brought to the forefront longstanding challenges and health inequalities faced by the BAME community. Within the NHS there has been a call to action to raise the profile of the BAME networks within NHS organisations. Salisbury NHS Foundation Trust have started that journey, the network has active Executive Engagement, collaboration with our communications and recruitment and contribute towards the COVID-19 response.

Our members have had the opportunity to participate in advertising campaigns and share their stories with leaders within the organisation. This is just the beginning, we aim to continue to grow the network and work with the organisation on the Workforce Race Equality Standard and People plan.

Candice Berry
Chair of the BAME Forum

N.B. The majority of photographs in this report were taken pre Covid-19.

The Rainbow Shed Network has been in existence for some time as the Trust LGBT+ network. Efforts have been made during the year to engage with LGBT+ people within the Trust to ensure that they can come to work and be who they really are.

The current pandemic has postponed and cancelled many LGBTQ+ community events for 2020. Therefore we have not been able to promote the connection we have made between Salisbury Pride UK and The Rainbow Shed Network at Salisbury District Hospital. The Rainbow Shed Network is a proud partner of Salisbury Pride UK.

The network goals are to encourage, welcome and celebrate the LGBT+ community and diversity in Salisbury NHS Foundation Trust.

During 2019-2020, The Rainbow Shed Network hosted local events and invited local Salisbury City Council Wiltshire Police, Dorset and Wiltshire Fire Service, NHS Employers, Wiltshire Council, Salisbury Pride UK and many more which included LGBT history month, Transgender day at Salisbury District Hospital.

Craig Douglas, Elizabeth Swift, Joe Cousins
Rainbow Shed Members

N.B. The majority of photographs in this report were taken pre Covid-19.

Women's Network:

The Women's Network was launched in June 2019 with an event on the subject of the menopause. This event was well attended and we received very positive feedback on the talk given by Dr Annie Hawkins and the information that was shared.

We now have 8 core committee members and are meeting on Teams to discuss how we would like to this network to move forward.

We have particularly been reflecting on the challenges and pressures faced by all during the pandemic, and will be discussing the impact this may have had on our staff here at the Trust; including but not limited to workplace pressures, working from home, home schooling, and being isolated from friends and family. Each of these could have an impact on the mental and physical wellbeing of women who work at SFT and we would like to explore how we can best respond to this.

One avenue being explored is working closely with Odstock Health and Fitness, who are keen to support the network. We are in the early stages of identifying what advice and support we could provide together. The on-going, overarching aim of the network is to provide information and support on the areas that women who work here need the most; the menopause was suggested by staff as a topic last year and this year the pandemic is something that has affected everyone.

We hope to continue to engage with staff to understand what support they would like, and to empower the members to play an active role to enable this to be a success.

Kelly Kerrigan
Chair of the Women's Network

N.B. The majority of photographs in this report were taken pre Covid-19.

Mental Health First Aiders Network

A number of Mental Health First Aiders have now completed training within the Trust. The aim of this network of first aiders is to provide peer support and signposting for our people with issues relating to their mental health. They will also assist in breaking the myths of talking about mental health in the workplace.

In aiming to prevent the development of mental health problems among employees, as an organisation we should develop a comprehensive mental health and wellbeing strategy. This Strategy should be integrated with the broader health and Wellbeing policy, and should address work-related risks to employee mental health, using a systematic approach to planning, implementation and monitoring.

In order to ensure sustainability, the mental health and wellbeing strategy should be integrated within the organisation's broader strategic management processes and should not be seen as an 'added project'.

An ideal mental health and wellbeing strategy should be systematically implemented and evaluated and should cover the following:

- The development of a positive work environment that supports and encourages mental health
- Effective management of performance issues
- development of a mental health and wellbeing policy
- Provision of mental health education.
-

We currently have 18 mental health first aiders in the organisation. This is quite an achievement. Our aim is for us to have a workforce that sees mental and physical wellbeing as one entity.

Sandy Woodbridge
Mental Health First Aider Lead

N.B. The majority of photographs in this report were taken pre Covid-19.

Disability Network:

A specific action was included in the 2019 WDES action plan to work with the Disability Diversity Champions to facilitate the development of a Disability Network. During the year we have run a number of workshops, attended by the champions, a number of our people with disabilities and mangers to begin the development of the network. This work has been disrupted by the onset of the Covid19 pandemic.

I joined Salisbury Hospital in February 2016 and work within Informatics as a Project Manager. I have always worked in the public sector, previously with Wiltshire Police and Wiltshire Council and am proud to feel that I make a difference (if only a small one!)

One of my anxieties over the past few years is how I could cope with work, being a single mum and how my disability may hold me back. Needless to say, my outlook has changed; I have found a work environment that is inclusive, one where I feel a valued member of a team. Not for what I can't do, but for how I add value.

As one of the Disability Champions I am here to support those with disabilities and Mental Health problems.

Wendy Ashton
Disability Diversity Champion

N.B. The majority of photographs in this report were taken pre Covid-19.

EU Staff Support Network: #LoveOurEUStaff

The Trust has two EU Diversity Champions, who have been working since 2017 to raise awareness for our EU people and support them during the lead up to Brexit and prepare them for the new EU settlement regulations. During 2019/20, following the NHS settled status trial, these Champions, together with the support of the Trust and the Head of EDI, assisted Trust EU staff in taking part in the government settled status programme which opened to all as part of #LoveOurEUStaff (NHS Employers campaign) .

Since we started we have organised a number of activities including various advisory drop-in sessions in the Education Department (attended by people from 8 different nationalities) and promotional display stands, to help people register for settled status.

A device was provided in the Education Department to support our people through the application process, we supported more than a 100 of our people to process their settled/pre-settled status applications, while others took the opportunity to get in touch for advice. Following this success, we both carried on supporting the EU staff network, with the purpose of identifying issues that our people may have as the UK leaves the European Union.

We set up a Webinar get together inviting OD Personnel / EDI / Union lead. This webinar was organised by NHS Employers (recording) aiming to ensure the Trust had an understanding of the background of the scheme and the importance of applying and supporting our people.

While COVID has meant no physical meeting since March, in the last 12 months six eBulletins (example: July 2020, October 2020)were published and distributed by EMAIL, Daily Staff Updates (08/01…) via the Trust Communications Department, and distributed using our cascading networks.

Stéphane Guégan and Isabel Cardoso
EU Diversity Champions

N.B. The majority of photographs in this report were taken pre Covid-19.

9. Freedom To Speak Up Program

National Guardian
Freedom to Speak Up

I have been the full time Guardian at Salisbury NHS Foundation Trust for the past two years. This role is independent, autonomous and has direct access to the CEO and is supported by a Non-Executive Director.

Elizabeth Swift
Freedom To Speak Up Guardian

Promoting FTSU – the FTSUG is working with the Communications Team to continue to promote the role. As a result the intranet page has been refreshed; a FTSU Screen Saver has been introduced; Unique FTSU logo for SFT has been developed to be used for posters and merchandise and regular Trust wide bulletins giving details of how our people can access FTSU.

Key relationships – the FTSUG continues to collaborate with many teams in order to support speaking up. Regular meetings are held with People Business Partners, Risk, PALS, Litigation, Clinical Psychology, Staff Side, Counter Fraud, Chaplaincy, Guardian of Safe Working, Chief Registrar, Executives and Non-Executives and protected groups such as the BAME forum. FTSU is also a member of the Leadership Forum and has been involved with the NHSI Culture and Leadership Programme.

The FTSUG has access to the CEO, Chairman and Director of OD & People as well as having monthly 1:1's. All these relationships help to develop an open culture where speaking up is fostered and welcomed.

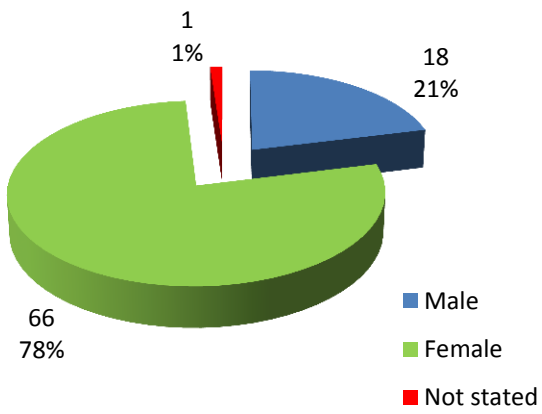
Ambassadors - 5 FTSU Ambassadors have been recruited from across the organisation to ensure our people have appropriate support and opportunities to speak up, signpost where necessary and support the Guardian in raising awareness of the FTSU programme.

N 

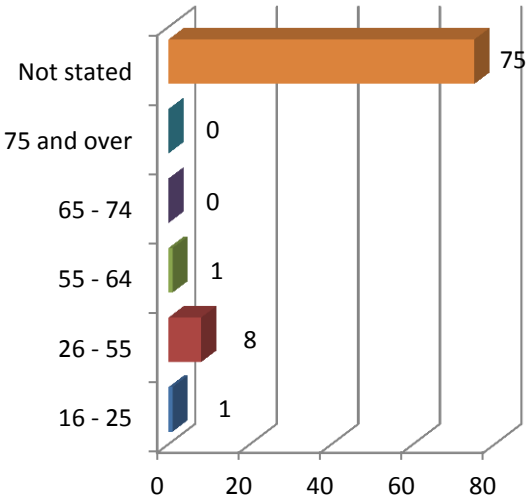
During the year 2019/20 a total of 85 people approached the Freedom To Speak Up Guardian. Full details of their equality data were not recorded, however 10 of them provided feedback with some of their equality data. The following graphs illustrate the equality data received. Further information is provided in the FTSU annual report.

The Freedom To Speak Up Guardian is reviewing the way equality data is recorded.

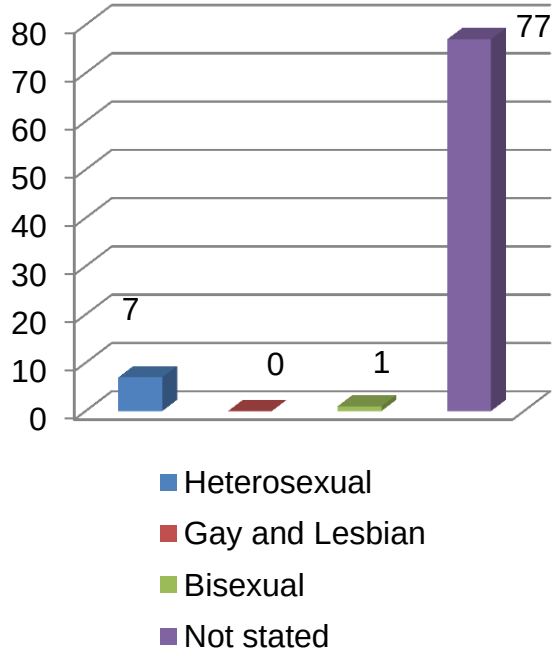
Sex:



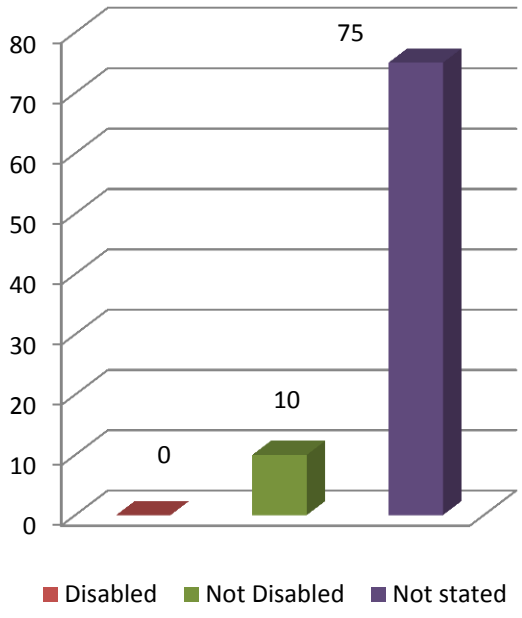
Age:



Sexual Orientation:

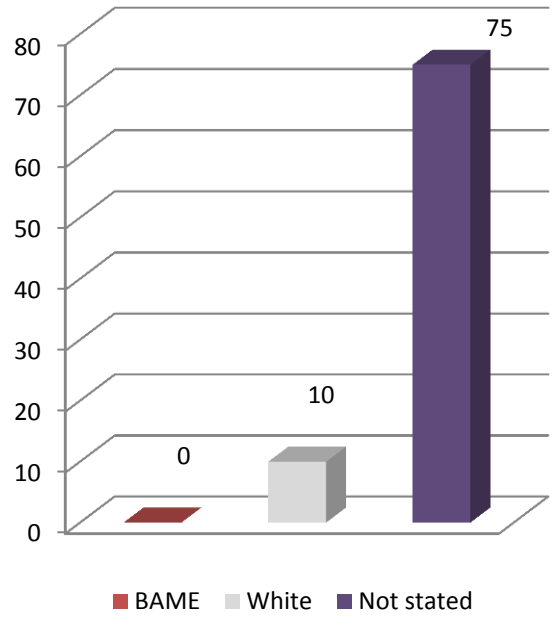


Disability:

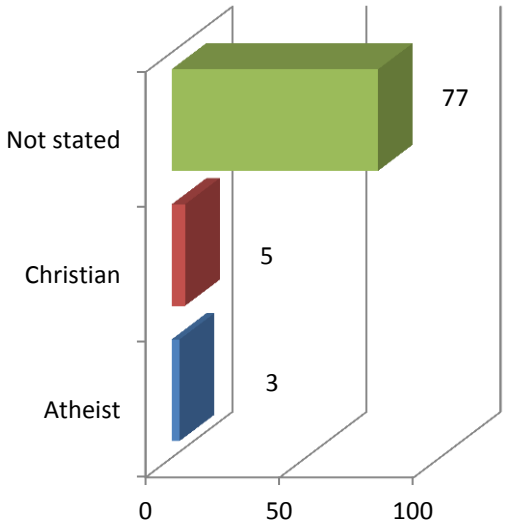


N.B. The majority of photographs in this report were taken pre Covid-19.

Ethnicity:



Religion and Belief:



N.B. The majority of photographs in this report were taken pre Covid-19.

10. Equality, Diversity and Inclusion training

During the past 12 months the Freedom To Speak Guardian and the Head of Diversity and Inclusion have delivered face to face interactions through Trust Induction, volunteer induction, workshops and delivering training at departmental meetings. In doing this they have engaged with 1058 of our people.

Despite the Covid-19 pandemic restrictions the Head of Diversity and Inclusion, the Freedom To Speak Up Guardian and one of the Chaplains have maintained a face to face input to all new starters. This 30 minute contact with our new starters has been well received and regularly gets favourable feedback.

"Had humour but also good content, felt able to go to them without fear."
"Interesting, informative, friendly and welcoming presentation."

"Lovely! What nice people, already feel I could speak up if necessary, Lizzie explained her role well."

"Very well presented, uplifting, great message, very friendly, looking forward to meeting again."

N.B. The majority of photographs in this report were taken pre Covid-19.

We have continued to run quarterly face to face EDI and FTSU training sessions, although these were slightly interrupted by the pandemic. We were forced to review the way we ran the session to ensure that we could still run our interactive session whilst maintaining social distancing.

It has been a challenge to run these sessions in this way especially whilst wearing a mask. However, we have managed to do this and maintain the effectiveness of the session.

Photo taken pre-Covid-19.

In order to reach more people we have worked with specific departments within the Trust to arrange extra trainings sessions for our people. These have followed the same format as the quarterly sessions. We have been able to introduce case studies within each session which are relevant to issues faced in specific departments.

This training has also been well received and feedback suggests that all our people, no matter what their role should at least have access to this training. Attendees commented that the training stimulated them to think about EDI and FTSU issues in a different way.

At the present time the Head of Diversity and Inclusion is design a training package to introduce the new Equality Impact Assessment process to the Trust.

During 2020/21 we will be working with those running training within the Trust to embed equality, diversity and inclusion within each training program. Our aim is to ensure that EDI runs through everything we do.

N.B. The majority of photographs in this report were taken pre Covid-19.

11. Gender Pay Gap

The Trust has reported similar pay gap data for the past four years. Over that period of time there has been a slight reduction in the overall pay gap. This amounts to 3.4%.

As can be seen from the above data there has been some movement across each of the staff groups. However these are modest percentages and a few have increased and not decreased.

The three staff groups with double figure pay gaps remain the same as last year:

- Administrative and Clerical
- Additional Professional, Scientific and Technical
- Medical and Dental

When we look at other local, similar NHS Trusts we see that Salisbury NHS Foundation Trust is recording the lowest mean pay gap and the second lowest median gap.

There have been no specific, targeted initiatives within the Trust to reduce the gender pay gap in the past year. Although a number of actions were highlighted and considered by the EDI Committee within the EDI Action Plan. This being reviewed, agreed and will be acted upon during 2020/2021.

It would appear that the movement on the pay gap has been the result of movement in and out of the staff groups identified.

The gender pay audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. As an organisation that employs more than 250 people and listed in Schedule 2 to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 we must publish and report specific information about our gender pay gap

.

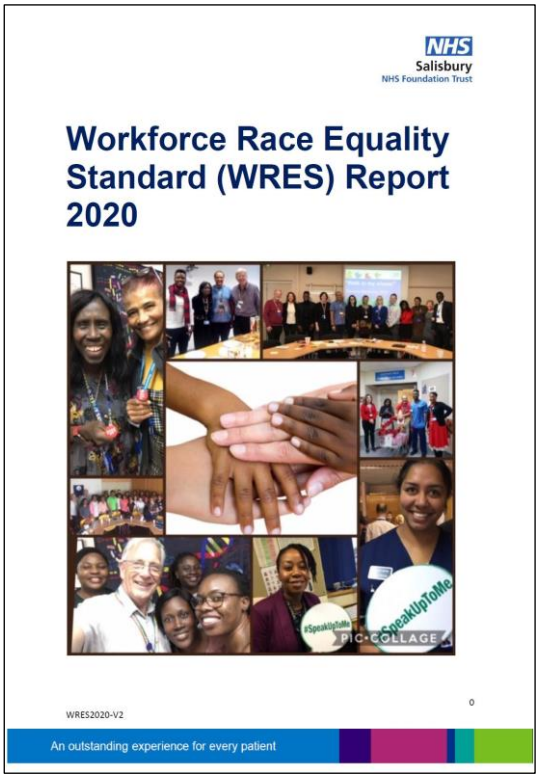
N.B. The majority of photographs in this report were taken pre Covid-19.

12. WRES (Workforce Race Equality Standard)

2019 saw the Trust recruit a significant number of people from a BAME background into a variety of clinical and non-clinical roles across the range of pay bandings. Since 2018 the likelihood of BAME people being appointed has also increased.

This year we have looked in more detail at who are included within the overall definition of BAME people. Section 2 of this report details the actual breakdown of the ethnic origin of our people. It can be seen that the blanket term BAME covers a wide range of ethnic groups and the Trust employs people from 72 different countries.

The number of our people engaging with the staff survey has also increased this year. The full details are listed in Section 10 of this report. This has shown a significant change in the willingness of BAME people to engage with the staff survey, some 115% increase.



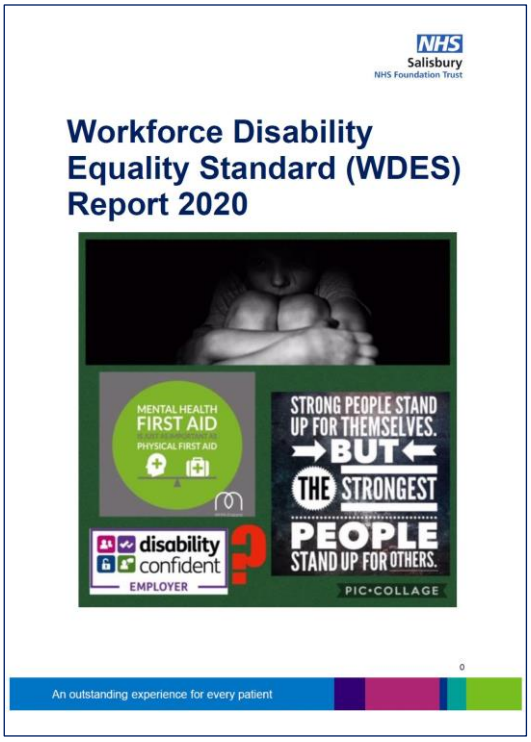
Covid-19 has had a significant effect on the Trust and our Diversity and Inclusion agenda. It has provided an opportunity to engage more closely with our BAME colleagues both within the workforce and importantly through the BAME community who are starting to take on a much more proactive role within the organisation.

Our challenge for 2020/21 will be to harness this improved engagement and work through our ED&I steering group and networks to continue to improve the working lives of our BAME people.

The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis.

N.B. The majority of photographs in this report were taken pre Covid-19.

13. WDES (Workforce Disability Equality Standard)



This is the second year that the Workforce Disability Equality Standard has operated which now gives us the opportunity to make a comparison to the previous year. This report includes a number of such comparisons which indicate that we made slight progress in identifying people with disabilities.

In collecting the data within the Trust we have identified that we do not have a true picture of people with a disability within our Electronic Staff Record (ESR) system. Within those systems 98 people have identified as having a disability and 242 of our people did not state whether they had a disability or not. These two figures give us a total of 340 people. When we looked at the response to the NHS Staff Survey we see that 330 of our people identified as having some form of disability. In comparing these two figures it is clear they are very similar and a number of our people do not feel confident in disclosing their disability to the organisation.

This indicates that we need to encourage our people to provide accurate and up-to-date equality data.

One main influencing factor this year has been the effect of the Covid19 pandemic. Many of our people who have disabilities or underlying health condition, have been shielding, are self-isolating or are working remotely. This has disrupted the development of a Disability Network and the progress of our Disability Confident self-assessment. These issues with engagement were not reflected in our more mature BAME network as the people involved already knew each other.

Covid19 has also highlighted the disproportionate effect the virus has had on high risk groups. These include those with underlying health problems, those with disabilities, those from low socio-economic backgrounds and members of BAME communities.

A system of risk assessments for all people falling within the high risk categories has been developed. All our people with disabilities have been included within the risk assessment process.

N.B. The majority of photographs in this report were taken pre Covid-19.

Work has continued over the past year to review and develop an appropriate reasonable adjustment process, to establish a Disability Network and to encourage our people to update and complete their equality data on ESR.

It is clear that a number of people are still reluctant to provide equality data as can be seen in this report, including members of the Board as indicated in Metric10.

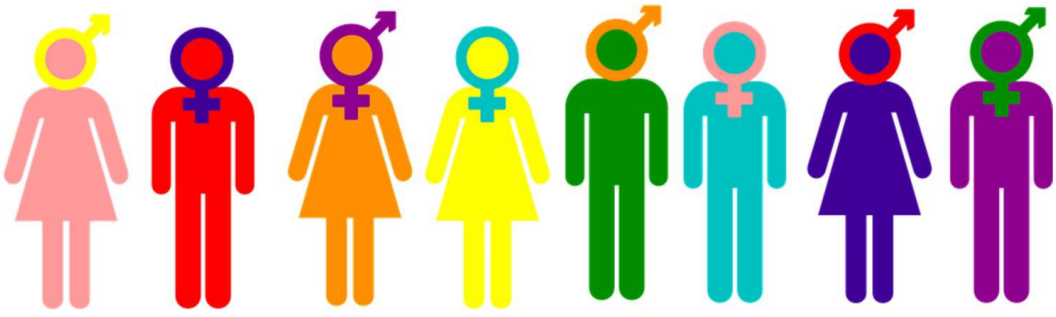
The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts from April 2019. The WDES is a data-based standard that uses a series of measures (Metrics) to improve the experiences of Disabled people in the NHS.

14. Equality Analysis/Monitoring

A new Equality Impact Assessment Policy has now been written and authorised by the Trust. A new form has been developed to bring the process up to date. At the present time the Head of Diversity & Inclusion is preparing a training program for those responsible for carrying out Equality Impact Assessments.

Equality Monitoring

At the present time the Trust does not have a central Equality Monitoring policy to ensure standardised equality data is collected across the organisation. The Head of Diversity and Inclusion is working with the information governance team to develop an appropriate Equality Monitoring policy which will be ready for April 2021.



N.B. The majority of photographs in this report were taken pre Covid-19.

15. Future influencing factors

The following initiatives will have an effect and influence our approach to ED&I over the coming months:

- NHS People Plan
- Best Place To Work Program
- The NHS Long Term Plan
- Annual contribution to the WRES and WDES programmes
- Annual reporting against the Gender Pay Gap programme.
- The NHS Workforce Race Equality Standard (WRES) leadership strategy.
- The Learning Disability programme
- The Sexual Orientation Monitoring programme
- Equality Delivery system three.
- The Ethnicity Pay Gap Reporting
- Annual NHS staff Survey
- EU Exit
- Covid-19 pandemic response

During 2021 the EDI Committee will be considering the 2019/20 action plan in the light of the WRES, WDES and gender pay gap reports mentioned in this report. The aim will be to identify a number of SMART actions which can further embed equality, diversity and inclusion across all areas of the Trust. Consideration will also be given of the influencing factors above. Progress on these actions will be monitored on a quarterly basis by the OD and People Management Board.

Work has commenced across the emerging Bath and North East Somerset, Swindon and Wiltshire Integrated Care System to identify EDI resources and opportunities to promote the inclusion agenda across the system. The Head of Diversity & Inclusion has been seconded, one day a week to the role of BSW Workforce EDI Lead. A focus of this role is to develop an EDI Leads Network across the system and identify areas of joint working to create an inclusive and fair culture.

A Key part of the EDI agenda going forward both within Salisbury NHS Foundation Trust and across the ICS is the development of Staff Networks. The above secondment has created the opportunity to recruit a part time networks coordinator to facilitate development of the networks.

N.B. The majority of photographs in this report were taken pre Covid-19.

16. Recommendations

It is recommended that The Trust should consider the following action to continue our equality, diversity and inclusion journey.

- The EDI Committee should consider this report together with the Gender Pay Gap, WRES and WDES reports to create a SMART equality action plan in line with the NHS Long Term Plan, NHS People Plan and the Public Sector Equality Duty.
- The Head of Diversity and Inclusion to work with Information governance to develop an Equality Monitoring Policy to ensure that a standard set of equality data is recorded across all directorates in the Trust.
- The Head of Diversity & Inclusion to work with the Education department to ensure EDI is embedded in all training provided by the Trust.
- The EDI Committee to develop a mechanism for identifying and collecting EDI related work across all directorates.
- The Trust continues to provide appropriate resources to ensure the development of efficient and effective staff support networks.

Our overall ambition for ED&I within the Trust is to empower our diversity networks to be able to implement the actions prioritised by the ED&I committee and for the networks to drive the agenda going forward.

As part of BSW, and our commitment to delivering the People Plan we will work with our regional partners to develop a joined up approach to ED&I for the future.

17. Author and Sponsor

Author: Rex Webb, Head of Diversity and Inclusion
Rex.webb@nhs.net

Sponsor: Lynn Lane, Director of OD and People
Lynn.lane@nhs.net

N.B. The majority of photographs in this report were taken pre Covid-19.

Appendix 1: Public Sector Equality Duty

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the general duty and all public authorities are adherent to the following obligations to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general duty is underpinned by a set of actions and assurances termed the specific duties. These serve as guidance on how the general duty can be met, through a range of actions and the provision of evidence in varied formats. The specific duties are to:

- Publish Information outlining how they will comply with the general duty by 31/1/2012 (Annually thereafter).

- Formulate at least one Equality objective

- All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public.

The Equality Act 2010

Report to:	Trust Board (Public)	**Agenda item:**	6.1
Date of Meeting:	14 January 2021		

Report Title:	Register of Seals Q3			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Sasha Grandfield, PA and Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in November 2020. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
361	26/11/2020	Lloyds Pharmacy Unit – Licence to carry out works at former hydro pool, Level 3, SFT	Laurence Arnold	Stacey Hunter	Michael von Bertele

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.2
Date of Meeting:	14 January 2021		

Report Title:	Remuneration, Nominations and Appointments Committee Terms of Reference			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Appendix 1: Remuneration, Nominations and Appointments Committee Terms of Reference Appendix 2: Annex A Established pay ranges in acute NHS Trusts and Foundation Trusts Appendix 3: NHSI Guidance on pay for very senior managers in the NHS March 2018			

Recommendation:
It is recommended that the Trust Board approve the terms of reference and delegate authority to the Remuneration, Nominations and Appointments Committee to operate within the NHS guidance outlined in appendix 2 and 3.

Executive Summary:
The Remuneration, Nominations and Appointments Committee Terms of Reference (Appendix 1) were approved by the Remuneration Committee on 3 December 2020 and require Trust Board approval. Once approved, these will inform the Integrated Governance Framework together with all Board and Board Committee terms of reference. The Remuneration Committee recommended that the Board delegate authority to the Chairman and Chief Executive Officer to operate within the current NHS guidance regarding Very Senior Manager (VSM) pay outlined in appendix 2 and 3. If remuneration is out with the guidance then explicit approval for remuneration must be sought from the Remuneration Committee. The Trust is classified as a medium acute Trust (£200-£400m turnover) for the purpose of benchmarking pay scales as set out in Appendix 2.

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

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance
November 2020	1.1	Minor	Updates to membership and attendance sections and minor formatting	Director of Corporate Governance

Date Adopted	03 December 2020
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Remcom 03 December 2020
Adoption and ratification	Trust Board

1. Purpose

1.1. 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. Authority

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

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

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

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

3. Membership and Attendance

Membership

3.1. The membership of the Committee shall consist of:

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

3.2. The Trust Chair shall chair the Committee.

Attendance

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

3.4. 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

3.5. The quorum necessary for the transaction of business shall be the Chair of the Committee and three other Non-Executive Directors

Secretary

The Director of Corporate Governance shall be secretary to the Committee.

4. Duties

4.1 Appointments

The Committee will:

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

4.12 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.

4.13 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.

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

4.15 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.

4.16 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.

4.17 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.

4.18 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:

4.21 Establish and keep under review a remuneration policy in respect of Executive Board Directors.

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

4.23 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.

4.24 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;

4.25 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;

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

4.27 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.

4.28 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.

Annex A: 'Established' pay ranges in acute NHS trusts and foundation trusts

Small acute NHS trusts and foundation trusts (£0-£200m turnover) *	Lower quartile	Median	Upper quartile
Chief executives	£ 141,000	£ 167,500	£ 182,500
Deputy CEO	£ 107,500	£ 117,500	£ 132,500
Director of finance	£ 109,000	£ 125,000	£ 137,500
HR/Workforce directors	£ 88,000	£ 98,000	£ 102,500
Medical directors	£ 134,000	£ 170,000	£ 198,500
Nursing directors	£ 95,000	£ 102,500	£ 107,500
Chief operating officer	£ 100,000	£ 112,500	£ 142,500
Corporate affairs/Governance directors	£ 75,000	£ 87,500	£ 92,500
Strategy and planning directors	£ 92,000	£ 110,000	£ 120,000
Director of facilities/Estates	£ 86,000	£ 89,000	£ 105,000

Medium acute NHS trusts and foundation trusts (£200-400m) *	Lower quartile	Median	Upper quartile
Chief executives	£ 160,000	£ 182,500	£ 202,500
Deputy CEO	£ 123,000	£ 142,500	£ 160,000
Director of finance	£ 123,000	£ 135,000	£ 147,500
HR/Workforce directors	£ 100,000	£ 107,500	£ 125,000
Medical directors	£ 169,000	£ 178,000	£ 199,000
Nursing directors	£ 103,000	£ 117,500	£ 127,500
Chief operating officer	£ 110,000	£ 122,500	£ 146,500
Corporate affairs/Governance directors	£ 77,500	£ 97,500	£ 107,500
Strategy and planning directors	£ 100,000	£ 115,000	£ 124,000
Director of facilities/Estates	£ 93,500	£ 95,000	£ 120,000

Large acute NHS trusts and foundation trusts (£400-£500m)	Lower quartile	Median	Upper quartile
Chief executives	£ 190,000	£ 197,500	£ 230,000
Deputy CEO	£ 130,000	£ 155,000	£ 180,000
Director of finance	£ 126,000	£ 140,000	£ 155,000
HR/Workforce directors	£ 117,000	£ 128,000	£ 143,000
Medical directors	£ 170,000	£ 182,000	£ 202,000
Nursing directors	£ 115,000	£ 131,000	£ 137,500
Chief operating officer	£ 117,000	£ 136,000	£ 152,000
Corporate affairs/Governance directors	£ 83,000	£ 100,000	£ 112,500
Strategy and planning directors	£ 110,000	£ 122,500	£ 132,500
Director of facilities/Estates	£ 103,000	£ 126,000	£ 135,000

Very large acute NHS trusts and foundatin trusts (£500m+)	Lower quartile	Median	Upper quartile
Chief executives	£ 195,000	£ 225,000	£ 267,500
Deputy CEO	£ 143,500	£ 165,000	£ 200,000
Director of finance	£ 148,500	£ 157,500	£ 190,000
HR/Workforce directors	£ 120,000	£ 130,000	£ 145,000
Medical directors	£ 189,000	£ 215,000	£ 230,000
Nursing directors	£ 130,000	£ 142,500	£ 157,500
Chief operating officer	£ 141,000	£ 190,000	£ 198,000
Corporate affairs/Governance directors	£ 88,000	£ 105,000	£ 117,500
Strategy and planning directors	£ 112,000	£ 137,500	£ 162,000
Director of facilities/Estates	£ 120,000	£ 135,000	£ 145,000

*** Specialist trusts can apply for a 15% premium**

Note all the figures in these tables are under discussion and are liable to change.
However, any change up or down will not be applied retrospectivly.

“Established” pay ranges in Mental Health NHS FTs and NHS Trusts

Small Mental Health FTs and Trusts (£0-£200M turnover)	Lower quartile	Median	Upper quartile
Chief Executives	£ 147,500	£ 150,000	£ 161,000
Deputy CEO	£ 110,000	£ 112,000	£ 117,000
Director of Finance	£ 102,500	£ 112,500	£ 122,500
HR/Workforce Directors	£ 90,000	£ 95,000	£ 112,000
Medical Directors	£ 102,500	£ 140,000	£ 156,000
Nursing Directors	£ 100,000	£ 111,000	£ 116,000
Chief Operating Officer	£ 97,500	£ 102,500	£ 107,500
Strategy, Planning and Corporate Directors	£ 100,000	£ 102,500	£ 115,000

Note all the figures in these tables are still under discussion and are liable to change.
However, any change up or down will not be applied retrospectivly.

Medium Mental Health FTs and Trusts (over £200m turnover) *	Lower quartile	Median	Upper quartile
Chief Executives	£ 172,500	£ 177,500	£ 182,500
Deputy CEO	£ 119,000	£ 127,500	£ 140,000
Director of Finance	£ 125,000	£ 141,000	£ 149,000
HR/Workforce Directors	£ 97,500	£ 107,500	£ 117,500
Medical Directors	£ 138,500	£ 162,700	£ 187,000
Nursing Directors	£ 107,500	£ 122,500	£ 127,500
Chief Operating Officer	£ 127,500	£ 132,500	£ 138,500
Strategy, Planning and Corporate Directors	£ 97,500	£ 105,000	£ 126,000

*** Trusts with High Secure Psychiatric Hospitals can apply for a 10% premium.**

“Established” pay ranges in Ambulance FTs and NHS Trusts

Ambulance NHS Trusts and FTs	Lower quartile	Median	Upper quartile
Chief Executives	£ 141,000	£ 150,000	£ 157,500
Director of Finance	£ 103,500	£ 110,000	£ 120,000
HR/Workforce Directors	£ 92,500	£ 107,500	£ 110,000
Medical Directors	£ 125,000	£ 132,000	£ 141,000
Nursing Directors	£ 105,000	£ 115,000	£ 123,000
Chief Operating Officer	£ 99,500	£ 103,000	£ 114,500
Strategy, Planning and Corporate Directors	£ 108,500	£ 110,000	£ 120,000

Note all the figures in these tables are still under discussion and are liable to change.
However, any change up or down will not be applied retrospectivly.

“Established” pay ranges in Community NHS FTs and NHS Trusts

Community NHS FTs and Trusts	Lower quartile	Median	Upper quartile
Chief Executives	£ 137,000	£ 142,500	£ 154,000
Director of Finance	£ 102,500	£ 110,000	£ 122,500
HR/Workforce Directors	£ 89,500	£ 97,500	£ 110,000
Medical Directors	£ 110,000	£ 135,000	£ 157,500
Nursing Directors	£ 92,500	£ 97,500	£ 112,500
Chief Operating Officer	£ 97,000	£ 107,000	£ 114,000
Strategy, Planning and Corporate Directors	£ 78,500	£ 92,500	£ 103,500

Note all the figures in these tables are still under discussion and are liable to change.
However, any change up or down will not be applied retrospectivly.

NHS Improvement

Guidance on pay for very senior managers in NHS trusts and foundation trusts

March 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Published separately

Annex A: ‘Established’ pay ranges in acute NHS trusts and foundation trusts

Annex B: Application for approval (for NHS trusts) or opinions (for NHS foundation trusts) of new or uplifted salaries/remuneration at or above £150,000 pa

Annex C: Off-payroll engagement template

Purpose of this guidance

1. Ahead of publication of the very senior manager (VSM) national pay framework by the Department of Health and Social Care (DHSC), this brief guide provides advice to NHS trusts seeking executive VSM salary approval and NHS foundation trusts seeking VSM salary opinion. It does not cover chair and non-executive director pay.

Guidance on managing very senior pay in all providers

2. All providers[1] should refer to the national VSM pay framework once it is published by DHSC.

3. In the interim the VSM pay review process requires:

   - NHS trusts to seek approval via nhsi.vsmcases@nhs.net from NHS Improvement, DHSC, the Minister of State for Health and Her Majesty's Treasury (HMT) before confirming VSM salaries at appointment or any individual/group VSM pay increase (outside any nationally recommended cost of living increase).
   - NHS foundation trusts to seek the opinion via nhsi.vsmcases@nhs.net of NHS Improvement, DHSC and the Minister of State for Health before confirming VSM salaries at appointment or any individual/group VSM pay increase (outside of any nationally recommended cost of living increase).

4. This process covers:

   - all on-payroll appointments (substantive and fixed term) for VSM roles in NHS ambulance and community trusts (note reference should still be made to the *Pay framework for very senior managers in strategic and special health authorities, primary care trusts and ambulance trusts* for these cases)[2] until this is replaced by the new pay framework
   - on-payroll VSM appointments (substantive and fixed term) in all other NHS trusts and in all NHS foundation trusts where the annual salary is £150,000 or above (irrespective of whether the new salary is an increase or not)

[1] In this guidance 'providers' refers to both NHS trusts and NHS foundation trusts.
[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/211964/Pay_Framework.pdf

- acting-up arrangements, promotions/pay rises for individuals already in post and earning £150,000 or above, and NHS secondments and conversion of off-payroll interims into on-payroll arrangements
- directors who by virtue of their qualifications and the requirements of the post are eligible to be on the standard NHS consultant contract. In such cases NHS trusts should seek approval and NHS foundation trusts should seek opinion on any discretionary payments proposed as part of a chief executive/director's salary, where the total salary is or exceeds £150,000 pa. NHS Improvement should be advised of the total salary and its make-up
- chief executives or executive directors who plan to resign and take their pension benefits when they reach pensionable age, and then return to work. In these cases NHS trusts are required to contact NHS Improvement before any resignation, and to seek approval from NHS Improvement before re-appointment is authorised by the trust. For such cases at both NHS trusts and foundation trusts, we expect the total post-retirement salary plus pension not to exceed the pre-retirement salary total, and that the necessary salary approvals (for NHS trusts) and opinions (for NHS foundation trusts) are sought.

5. For the purposes of deciding whether the pay level for a particular appointment meets the threshold, pay should include all elements of salary, fees and allowances, plus the cost to the employer of any fringe benefits and pensions in excess of normal levels. It does not include the normal reimbursement of expenses incurred in the course of official duties available to all staff. If the amount payable under a performance-related pay arrangement exceeds £17,500, the excess should be added to the other elements of pay to assess whether the pay level for the appointment is £150,000 or above.

6. Approval should be sought for part-time appointments at salaries of £150,000 or above pro rata. The only exception to this requirement for ministerial approval is where an individual in an NHS ambulance trust or NHS community trust is eligible for a spot rate of over £150,000, provided only the spot salary is paid and there are no enhancements, eg recruitment and retention premia (RRP) and additional responsibility payment (ARP).

7. Where providers intend to recruit VSMs on salaries of £150,000 or above, wish to increase the pay of current VSMs to £150,000 or above, or wish to increase the salary of current VSMs already paid £150,000 or above they should:

   - Refer to the pay ranges in Annex A. (If there is no comparator role, please seek advice from NHS Improvement at nhsi.vsmcases@nhs.net.) In proposing executive remuneration levels, providers should take account of the government policy of senior pay restraint as communicated in the letter of 2 June 2015 from the Secretary of State to provider chairs. Ministers expect:
     - pay will not exceed the median without a strong and exceptional case
     - any pay increases on appointment should be limited to a maximum of 10% unless this is insufficient to raise the pay level to the lower quartile point of the relevant range
     - an element of earn-back pay will be included, ie a requirement to meet agreed performance objectives to earn back an element of base pay (normally at least 10%) placed at risk
   - Complete the template at Annex B in discussion with NHS Improvement regional colleagues and/or the NHS Improvement trust resourcing team.
   - Email the case to the NHS Improvement trust resourcing team at nhsi.vsmcases@nhs.net. Once the team has reviewed the case and is content to recommend it, it will forward the case to the NHS Improvement provider leadership committee for approval (NHS trusts)/opinion (NHS foundation trusts) before submission to DH, and for NHS trusts also to the Chief Secretary to the Treasury. If the trust resourcing team is not content with the case, it will advise the provider of the reasons why and the next steps.

8. All providers are strongly advised to start the VSM pay process described in paragraph 2 at the start of the recruitment process – to manage expectations at the outset, agree acceptable pay ranges/conditions in advance of appointment and minimise any delays while views/approvals are sought after appointment. NHS trusts should note that the Chief Secretary to the Treasury's approval is normally required before appointments are confirmed; failure to obtain this approval may be regarded as a breach of process with an associated significant fine.

9. The level of pay on appointment and any pay changes for current VSM staff should not be confirmed to staff until the necessary approvals or opinions have been given.

Off-payroll engagements

10. Board office holders – HMRC has confirmed that all appointments to posts defined as 'office holders' should be on payroll regardless of the expected duration of the appointment. This includes virtually all VSMs and only a very limited exception is available. We have previously published *Guidance for the use of off-payroll interims*.[3]

11. Where exceptionally interim VSMs are engaged off payroll, including occasions where the office holder is still in post but temporarily unable to perform their duties, eg owing to illness, providers must comply with the HMT guidance referenced in *Guidance for the use of off-payroll interims*. NHS trusts and foundation trusts are expected to appoint on payroll. Where exceptionally they propose to appoint a VSM on off-payroll terms, NHS Improvement should be consulted:

    - For directly engaged interim office holder appointments, please complete Annex C and send to Mark Bailey (mark.bailey15@nhs.net).
    - For engagements via an agency refer to the interim agency very senior manager approval process and the HM Treasury guidelines referenced in *Guidance for the use of off-payroll interims* and *Interim agency very senior manager approval process*.[4]

12. Please note the government changes regarding IR35 compliance planned for April 2017 will change how the current intermediaries legislation (known as IR35) is applied to off-payroll working in the public sector. Where the rules apply, people who work in the public sector through an intermediary will pay employment taxes in a similar way to employees.[5]

[3] https://improvement.nhs.uk/uploads/documents/Off-payroll_guidance_-_ed_V2.0_final_3_1.pdf
[4] https://improvement.nhs.uk/uploads/documents/interim_agency_VSM_approval_process.pdf
[5] https://www.gov.uk/guidance/off-payroll-working-in-the-public-sector-reform-of-intermediaries-legislation

Interim consultant engagements

13. Providers should review if any engagements are more properly reviewed as consultancy under the consultancy spending approval criteria.

Contact details for further advice and submission of cases

14. Advice is available from the NHS Improvement trust resourcing team. Please email nhsi.vsmcases@nhs.net and a member of the team will contact you within one working day. Cases should be sent to the same email address.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

Follow us on Twitter @NHSImprovement

This publication can be made available in a number of other formats on request.

 Publication code: CG 47/18

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.3
Date of Meeting:	14 January 2020		

Report Title:	Constitution			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Prepared by:	Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	N/A			

Recommendation:
It is recommended that the Board approve the updated constitution.

Executive Summary:
The Trust's constitution has been completely revised with the following updates summarised below: • Annex 8 Standing Orders of the Board of Directors has been completely re-written and is included as an appendix to the Constitution. • The wards and constituencies have been updated. This includes merging West Wiltshire into South Wiltshire Rural. North Dorset and East Dorset constituencies have also been updated based on the electoral wards. • It is proposed that within Annex 2 the Hotel and Property class in the Staff Constituency is merged with the Clerical, Administrative and Managerial Staff class. It is proposed that due to merging the staff classes, the name should be amended to "Administrative, Facilities and Managerial". The vacancy of the Hotel and Property class has not been filled for several years and these staff would benefit from better representation. • The unused paragraphs have been removed and the document renumbered and reformatted to reflect this. The revised Constitution was presented the Council of Governors' in November 2020 and the changes were supported.

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

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

Post Holder Responsible for Policy:	Director of Corporate Governance
Directorate Responsible for Policy:	Chief Executive's
Contact Details:	Ext: 2774
Date Written:	2005
Date Revised:	October 2020
Approved by:	Council of Governor's/ Trust Board
Date Approved:	
Next Due for Revision:	March 2022
Date Policy Becomes Live:	Jan 2021

Version No.	Updated By	Updated On	Description of Changes
1.0	Director of Corporate Governance	See amendment history below	
1.1	Director of Corporate Governance	April 2020	Annex 9 Updated
2.0	Director of Corporate Governance	October 2020	Complete revision
2.1	Corporate Governance Manager/ Membership Manager	December 2020	Further amendments as per amendment history below agreed at CoG.

CONTENTS:

Amendment history – 2013 to 2019

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

1 Interpretation and definitions

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

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

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

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

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

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

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

2 Name

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

3 Principal Purpose

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

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

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

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

3.3.2 the promotion and protection of public health.

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

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

4 Powers

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

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

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

5 Membership and Constituencies

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

5.1.1 A public constituency

5.1.2 A staff constituency

6 Application for Membership

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

7 Public Constituencies

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

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

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

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

8 Staff Constituencies

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

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

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

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

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

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

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

9 Automatic Membership by default – Staff

9.1 An individual who is:

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

9.1.2 invited by the Trust to become a member of the Staff Constituency, shall become a member of the Staff Constituency and in the appropriate staff class without an application being made, unless they inform the Trust that they do not wish to do so.

10 Patients' Constituency

There is no Patients' Constituency

11 Restrictions on Membership

11.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.

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

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

11.4 An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.

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

11.6 Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.

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

12 Annual Members' Meeting

12.1 The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public. This should be held no later than 30th September.

13 Council of Governors - Composition

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

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

13.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.

13.4 No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

14 Council of Governors – Election of Governors

14.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.

14.2 The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).

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

14.5 In the event of an elected governor ceasing to hold office, if there are then more than 15 months of his term of office left after his resignation, ceasing to hold office or death, then an election shall be held for his replacement. The person elected shall hold office for the remainder of the period for which the governor he is replacing was last elected.

15 Council of Governors - Tenure

15.1 Subject to 14.5 and 15.2, an elected governor may hold office for a period of up to 3 years.

15.2 An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than 9 years in all.

15.3 An appointed governor may hold office for a period of up to 3 years and may then be re-appointed but shall not hold office for more than 9 years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

15.4 A governor may resign by giving notice in writing to the Chairman of the Trust.

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

15.6 The limits of 9 years in sub-paragraphs 15.2 and 15.3 shall in the case of an elected governor include any time served as an appointed governor, and in the case of an appointed governor include any time served as an elected governor.

16 Council of Governors – Disqualification and Termination of Office

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

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

16.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

16.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

16.1.4 The further persons set out in Annex 6.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

16.3 If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

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

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

16.4 A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

16.4.1 acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or

16.4.2 failed to declare a material interest pursuant to paragraph 21 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

16.5 Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 16.3 and 16.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

16.6 In the event of a notice being given under sub-paragraph 16.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's ability to remain a governor (other than those set out in paragraphs 16.3 and 16.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

16.7 A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

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

17 Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

17.1 The general duties of the Council of Governors are–

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

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

17.2 The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

17.3 The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

18 Council of Governors – Meetings of Governors

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

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

18.3 Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

18.4 The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

18.5 The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

18.6 For the purpose of obtaining information about the Trust's performance of its functions or the directors performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18.7 The Council of Governors will establish statutory committees to carry out such functions as are required by law and to carry out such functions as the Council specifies.

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

19 Council of Governors – Standing Orders

19.1 The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

20 Council of Governors – Referral to the Panel

20.1 In this paragraph the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

20.1.1 to act in accordance with its constitution, or

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

20.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

21 Council of Governors – Conflicts of Interest of Governors

21.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.2 For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

22 Council of Governors – Travel Expenses

22.1 The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

23 Board of Directors – Composition

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

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 a maximum of 7 other non-executive directors

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

23.2.4 a Chief Executive who shall be the Accounting officer,

23.2.5 a Finance Director.

23.3 One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

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

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

24 Board of Directors – General Duty

24.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25 Board of Directors – Appointment and Removal of Chairman and Non-executive Directors

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

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

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

26 Board of Directors – Deputy Chairman

26.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chairman. The Deputy Chairman shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

27 Board of Directors – Appointment and Removal of the Chief Executive and Executive Directors

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

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

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

28 Board of Directors – Disqualification

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

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

28.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

28.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

28.1.4 The persons referred in Annex 9.

29 Board of Directors – Meetings

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

29.2 As soon as practical after holding a meeting the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

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

29.4 Members of the public may be excluded from all or any part of a meeting by a resolution of the Board for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings

30 Board of Directors – Standing Orders

30.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8. They may be amended as provided in them.

31 Board of Directors – Conflicts of Interest of Directors

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

31.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust;

31.1.2 a duty not to accept a benefit from a third party by reason of being a director or by reason of doing or not doing anything in that capacity.

31.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

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

31.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors before the Trust enters into the transaction or arrangement.

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

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

31.8 This paragraph does not require a declaration of an interest of which the director is not aware, or where the director is not aware of the transaction or arrangement in question.

31.9 A director need not declare an interest –

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

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

31.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors, or by a committee of the directors appointed for the purpose under the constitution.

32 Board of Directors – Remuneration and Terms of Office

32.1 The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

32.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms of office, of the Chief Executive and the other executive directors.

32.3 The Chairman and other non-executive directors may be appointed for initial terms of up to 4 years, which may be renewed by the Council for a further term of up to 4 years, and may be renewed thereafter for such term, if any, as will bring the total length of service to 8 years. Where a director has served 8 years, his appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal.

33 Registers

33.1 The Trust shall have a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.

33.2 a register of members of the Council of Governors;

33.3 a register of interests of Governors;

33.4 a register of interests of directors;

33.5 and a register of directors.

34 Registers – Inspection and Copies

34.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.

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

34.2.1 any member of the Rest of England Constituency; or

34.2.2 any other member of the Trust, if the member so requests.

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

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

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

34.4 If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

35 Documents Available for Public Inspection

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

35.1.1 A copy of the current constitution;

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

35.1.3 A copy of the latest annual report

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

35.2.1 A copy of any order made under section 65D (appointment of special trust administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

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

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

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

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

35.2.6 A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

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

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

35.2.9 A copy of any statement published under section 65J (power to extend time), or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

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

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

35.4 If the person requesting an extract or copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36 Auditor

36.1 The Trust shall have an auditor.

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

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

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

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

37 Audit Committee

37.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

38 Accounts

38.1 The Trust must keep proper accounts in such form as NHS Improvement may with the approval of the Treasury direct and proper records in relation to those accounts.

38.2 NHS Improvement may, with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

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

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

38.4.1 the accounts;

38.4.2 the records relating to them; and

38.4.3 any report of the Auditor on them

38.5 The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as NHS Improvement may with the approval of the Secretary of State for Health direct.

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

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

38.6.2 that any accounts prepared by it by virtue of sub-paragraph 38.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

38.7 In preparing its annual accounts or in preparing any accounts by virtue of sub-paragraph 44.6.1 above, the Trust is to comply with any directions given by Monitor with the approval of the Secretary of State for Health as to:

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

38.7.2 the content and form of the annual accounts

38.8 The Trust must –

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

38.8.2 send copies of the annual accounts, and any report of the Auditor on them to NHS Improvement within such a period as NHS Improvement may direct

38.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 38.6 above and a copy of any report of the Auditor to NHS Improvement within such a period as NHS Improvement may direct.

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

39 Annual Report, Forward Plans and Non-NHS work

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

39.2 The annual report must give:

39.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and of the patients' constituency is representative of those eligible for membership

39.2.2 information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 18.5 hereof

39.2.3 information on the corporation's policy on pay and on the work of the committee established under paragraph 32(2) hereof and such other procedures as the corporation has on pay

39.2.4 information on the remuneration of the directors and on the expenses of the governors and the directors

39.2.5 any other information that NHS Improvement or requires

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

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

39.5 In preparing the document, the directors shall have regard to the views of the governors, and the directors shall provide the governors with information appropriate for them to be able to form their views.

39.6 Each forward plan must include information about:

39.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

39.6.2 the income it expects to receive from doing so

39.7 Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 39.6.1, the Council of Governors must:

39.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

39.7.2 notify the directors of the Trust of its determination

39.8 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England, the Trust may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

40 Presentation of the Annual Accounts and Reports to the Governors and Members

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

40.1.1 the annual accounts

40.1.2 any report of the auditor on them

40.1.3 the annual report.

40.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

40.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

41 Instruments

41.1 The Trust shall have a seal.

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

42 Amendment of the Constitution

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

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

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

42.2 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

42.3 Where amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

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

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

42.4 If more than half of the members voting approve the amendment, the amendment continues to have effect. Otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

42.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

43 Mergers etc. and Significant Transactions

43.1 The Trust may only apply for a merger, acquisition, separation or dissolution, as referred to in sections 56,56A, 56B, and 57A of the 2006 Act with the approval of more than half of the members of the Council of Governors.

43.2 The Trust may only enter a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

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

43.3.1 would increase or reduce the turn-over of the Trust (in a financial year relative to the previous financial year) by £20 million or by 10%, whichever is the greatest;

43.3.2 would involve a receipt of or capital expenditure of £10 million or more; in the case of expenditure, this is after the deduction of any grant or gift which specifically relates to the expenditure in question

43.3.3 would involve a service contract, asset rental or lease running for period of 3 years or more with a planned income or cost over its duration of £10 million or more

43.3.4 would be likely to put at risk the Trust's ability to provide its services as a whole, or a significant part of its services, to the appropriate regulatory standard;

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

43.3.6 Where it might reasonably be considered that a transaction falls within paragraph 43.3 the Board shall inform the Council of the transaction at the earliest opportunity

43.3.7 The Board shall in any event inform the Council of a transaction which it is considering and which may involve a sum which is greater than 2% of the Trust's income in the previous year, but the Board need not so inform the Council of any such transaction if the transaction has been clearly identified in the Annual Estimate, the Capital Programme or the Annual Plan

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

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

43.4.2 have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail

43.5 If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council's discussion of the transaction for and against approval shall be recorded in the minutes.

43.6 The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust's income or capital in the previous year.

44 Indemnity

44.1 Members of the Council of Governors and of the Board of Directors who act honestly and in good faith will be indemnified by the Trust against any civil liability which is incurred in the execution or purported execution of their functions relating to the Trust, save where they have acted recklessly. The Trust shall take out insurance against liability under this indemnity.

45 Dispute Resolution

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

45.2 If the Chairman is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

45.3 If the dispute is not resolved, the Chairman may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area formerly covered by North Dorset District Council, comprising the following electoral wards: ▪ Beacon ▪ Blandford ▪ Cranborne Chase ▪ Gillingham ▪ Hill Forts & Upper Tarrants ▪ Shaftesbury Town ▪ Stalbridge & Marnhull (Marnhull parish) ▪ Sturminster Newton
Kennet	The area formerly covered by Kennet District Council comprising the following electoral wards: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings

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

East Dorset	The following electoral wards within the area formerly covered by East Dorset District Council: • Cranborne & Alderholt • St. Leonards & St. Ives • Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes • Verwood • West Moors & Three Legged Cross
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 8)

The Staff Constituency is divided into 5 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUB GROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries
	Health Care Assistants (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers
	Orthoptists
	Physiotherapists and Helpers
	Art/Music/Drama Therapists
	Speech and Language Therapists and Helpers
	Psychologists and Psychology Technicians
	Psychotherapists
	Medical Physicists and Technicians
	Pharmacists and Pharmacy Technicians
	Dental Technicians
	Operating Department Practitioners
	Social Workers
	Chaplains
	Clinical Scientists
	Biomedical Scientists and Technical Staff
	Geneticists and Technicians
	Audiology Staff
	Cardiographers and Support Staff
Administrative, Facilities and Managerial Staff	Ancillary Staff
	Works and Maintenance Staff
	Ambulance Staff
Voluntary Staff	

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

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

1. There shall be 15 public governors as set out in Annex 1.
2. There shall be 5 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.
3. Wiltshire Council may appoint one governor by notice in writing signed by the senior executive of the Council.
4. There shall be one governor appointed by Wessex Community Action.
5. The following Clinical Commissioning Groups may each appoint one governor.
    a. Bath and North-East Somerset, Swindon and Wiltshire (BSW)
    b. Dorset
    c. West Hampshire

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

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

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

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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

PART 5: CONTESTED ELECTIONS

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

Action to be taken before the poll

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

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)

33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

41- [NOT USED]
42. Arrangements for counting of the votes
43. The count
FPP44. Rejected ballot papers and rejected text voting records
[45-50 NOT USED]
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"***corporation***" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:
- **a)** a Saturday or Sunday;
- **b)** Christmas day, Good Friday, or a bank holiday, or
- **c)** a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

---

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:
- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

---

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:
- (a) the constituency, or class within a constituency, for which the election is being held,
- (b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (c) the details of any nomination committee that has been established by the corporation,
- (d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:
(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,
but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:
(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:
(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,
and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:
(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after

publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge**.**

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:
(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,
(b) that he or she has not marked or returned any other voting information in the election, and
(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter his or her voter ID number; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;
  in order to be able to cast his or her vote;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote and how to make a declaration of identity,
  (vi) the date and time of the close of the poll, and
  (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
  (i) the voter’s voter ID number;
  (ii) the voter’s declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to
  (i) enter his or her voter ID number in order to be able to cast his or her vote; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may

apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election,

notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she

wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified

documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:
(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
(a) the disqualified documents, together with the list of disqualified documents

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

inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

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

PART 6: COUNTING THE VOTES

---

41. -[NOT USED]

42. Arrangements for counting of the votes

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

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

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

43. The count

43.1 The returning officer is to:

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

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

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

PP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

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

except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

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

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

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

(a) elsewhere than in the proper place,

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

(c) by more than one mark,

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

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

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

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

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

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

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

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

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

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

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

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

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

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

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

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

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

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he or she has declared elected:
  (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
  (ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are

forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

F**PP59.3** Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:
(a) account and record the number of ballot papers, internet voting records, t telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

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

FPP59.6 The returning officer is to endorse on each packet a description of:
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 16)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation;

2. A person who is disqualified from being a company director under the laws of England and/or Wales;

3. A person who is a director of the Trust, or a governor, director, Chairman or chief executive of another NHS Foundation Trust or NHS Trust;

4. A person who is incapable by reason of mental disorder or illness or injury of managing his property and affairs;

5. A person who occupies the same household as an existing governor or a director of the Trust;

6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election, or becomes employed by the Trust

7. A person who has been removed from any list prepared under Part II of the National Health Service Act 1977, or has been removed from a list maintained pursuant to regulations made under section 28X of that Act, and has not been reinstated.

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

(See paragraph 19)

CONTENTS

1. Introduction

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

2. Interpretation

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

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

2.3 'The Council' means the Council of Governors.

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

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

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

3. Meetings of the Council

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

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given

3.3 If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4 Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5 Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. Agenda Items and Motions

4.1 Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor.

4.2 A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second the motion, and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chairman of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3 A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the chairman of the meeting.

4.4 No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chairman of the Trust.

4.5 The proposer of a motion shall propose it and shall have a right to speak before a

vote is taken.

4.6 During the consideration of a motion a governor may move:

4.6.1 an amendment to the motion;

4.6.2 that the consideration of motion be adjourned to a subsequent meeting;

4.6.3 that the motion be summarily dismissed and the meeting to proceed to the next business;

4.6.4 that the motion be voted on immediately.

4.7 No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the chairman of the meeting.

4.8 Save where the chairman of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. Quorum

5.1 No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. Relevance and Concision

6.1 Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2 The chairman of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3 In any matter relating to the interpretation of the Constitution and Standing Orders the chairman of the meeting shall consider the advice of the Secretary.

7. Voting

7.1 Save where it is otherwise provided by the constitution or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2 In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3 At the discretion of the chairman of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4 Save in the case of a secret paper ballot, if at least one third of the governors present request, the voting for and against of each governor shall be minuted.

7.5 If a governor requests, his vote shall be minuted.

7.6 No one may vote unless physically present: there shall be no votes by proxy.

8. Minutes

8.1 Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting.

8.2 The minutes shall record the names of those attending.

9. Suspension of Standing Orders

9.1 Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the chairman of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2 A decision to suspend standing orders shall be recorded in the minutes.

9.3 A separate record of matters while the orders were suspended shall be made, and shall be provided to the governors with the minutes.

10. Committees

10.1 The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2 The powers of the Council may be delegated to a committee for a specific purpose if

the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3 The powers of the Council shall be exercised in general meeting.

10.4 The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5 Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. Nominations Committee

11.1 Paragraph 27 of the Constitution provides for the appointment and removal of the Chairman of the Trust and the other non-executive directors by the Council. Paragraph 27.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2 For the appointment of the Chairman, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director

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

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

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

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

11.4.2 In the case of a nomination for Chairman invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5 If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. Declarations and Register of Interests

12.1 Paragraph 21 of the Constitution provides for declarations of interest. It states:

21.1 *If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.*

21.2. *For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question*.

12.2 Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3 If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4 Subject to the exceptions below, material interests include:

12.4.1 any directorship of a company;

12.4.2 any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3 any interest in an organisation providing health and social care services to the National Health Service;

12.4.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5 any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter before the Council fairly.

12.5 The exceptions are:

12.5.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2 an employment contract with the Trust held by a staff governor;

12.5.3 an employment contract held with the appointing body by an appointed governor;

12.6 If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7 The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting

12.8 The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9 If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the chairman of the meeting shall rule on the question having taken the advice of the Secretary.

12.10 A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11 A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 16.4 of the Constitution.

13. Code of Conduct

13.1 Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders, and shall at all times comply with the Code.

14. Confidentiality

14.1 It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2 Governors must keep secure all confidential matter recorded on paper or electronically, and must ensure that their NHS mail and forum details are not disclosed.

14.3 Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4 The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5 A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the information has entered the public domain.

14.6 Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. Expenses

15.1 Paragraph 22 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2 Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3 The total of the expenses paid to governors will be published in the Annual Report.

16. Lead and Deputy Lead Governor's Appointment

16.1 The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead

Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. Lead Governor and Deputy Lead Governor – Roles

17.1 The role of the Lead Governor is:

17.1.1 to chair meetings of the Council which cannot for any reason be chaired by the Chairman or the Deputy Chairman;

17.1.2 to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chairman;

17.1.3 to communicate regularly with the Chairman, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4 to be a point of contact for NHS Improvement when appropriate;

17.1.5 to provide input into the appraisal of the Chairman;

17.1.6 to take an active role in the activities of the Council;

17.1.7 to be a point of contact for governors when they have concerns;

17.2 The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. Lead and Deputy Lead Governors – Vote of No Confidence

18.1 If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chairman, the Chairman shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2 The Chairman will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting

18.3 The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4 At the meeting the Chairman will present the reasons for the motion and it will be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5 A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governor's present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6 A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. Directors' Attendance

19.1 Paragraph 18.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2 The attendance of a director pursuant to paragraph 18.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chairman. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. Forward Plan

20.1 Paragraph 39.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2 The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3 The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting

21. Amendment of Standing Orders

21.1 Paragraph 19.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX 7.1

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;
2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;
3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;
4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;
5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;
6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;
7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;
8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;
9. Recognise that the Trust is a non-political organisation;
10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;
11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;
12. Comply with the Council's Standing Orders;
13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;
14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    a) advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    b) any request by the media for comment should be forwarded to the Trust's press officer;
    c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer rather than responding himself;
    d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;
15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness:

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity:

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity:
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability:
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness:
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty:
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership:
Holders of public office should promote and support these principles by leadership and example

Governor's undertaking

I,_____, of , undertake as a Governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed:_____ Date:_____

ANNEX 8 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(see paragraph 30)

1. INTERPRETATIONS AND DEFINITIONS

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3. Any expression to which a meaning is given in the Health and Social Care Act 2012, or any legislation or any regulations made under this Act, shall have the same meaning in these standing orders and in addition:

1.3.1 **"Accounting officer"** means the person responsible and accountable for funds trusted to the Trust. The Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, this shall be the Chief Executive;

1.3.2 **"Board"** means the Board of Directors, consisting of the Chairman, the independent non-executive directors and the executive directors;

1.3.3 **"Audit Committee"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework;

1.3.4 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

1.3.5 **"Committee"** means a committee or sub-committee appointed by the Trust;

1.3.6 **"Committee Members"** shall be persons formally appointed by the Trust to sit on or to chair specific committees;

1.3.7 **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

1.3.8 **"Council"** means the Council of Governors, formally constituted in accordance with the constitution and presided over by the Chairman;

1.3.9 **"Director of Finance"** means the chief financial officer of the Trust;

1.3.10 **"Executive Director"** means a member of the board who is an officer of the Trust;

1.3.11 **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting;

1.3.12 **"Nominated Officer"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

1.3.13 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

1.3.14 **"SFIs"** means standing financial instructions;

1.3.15 **"SOs"** means Standing Orders.

1.3.16 **"Trust"** means Salisbury NHS Foundation Trust

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP AND ROLE OF MEMBERS

2.1 Composition of the Board of Directors

The composition of the Board of Directors shall be in accordance with paragraph 23 of the Constitution.

2.2 Role of Members of the Board of Directors

The Board of Directors will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal members. Their role will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. The Director of Finance shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however; exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair

The Chair shall be responsible for the operation of the Board of Directors and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of employment and with these Standing Orders.

The Chair shall take responsibility either directly, or indirectly, for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

The Chair shall work in close conjunction with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the discussion and ultimate resolutions.

Senior Independent Director

The Board of Directors should in consultation with the Council of Governors, appoint a Non-Executive Director to be the Senior Independent Director. Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another Non-Executive Director as Senior Independent Director.

2.3 Corporate role of the Board of Directors.

2.3.1 All business shall be conducted in the name of the Trust.

2.3.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3.3 The powers of the Trust established under statute shall be exercised by the Board except as otherwise provided for under Section 4 of this annex.

2.3.4 The Board has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters reserved to the Board' and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 Admission of the Public and the Press

3.1.1 The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.1.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.2 Observers at Board Meetings

3.2.1 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.2.2 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

3.3 Calling of Meetings

3.3.1 Ordinary meetings of the Board shall be held at such times and places as the Board determines. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board of Directors so resolves for special reasons.

3.3.2 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

3.4.1 Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear days before the meeting.

3.4.2 In the case of a meeting called by Directors in default of the Chair, the notice shall

be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.10 below

3.4.3 Agendas will normally be sent to members of the Board seven calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than five clear days before the meeting, save in emergency.

3.4.4 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

3.5 Agendas and supporting papers

3.5.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.7 Chair of Meeting

3.7.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he/she is present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, then the remaining non-executive directors present shall choose which non-executive director shall preside.

3.8 Notices of Motion

3.8.1 A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 12 clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chairman shall include in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. This Standing Order 3.8.1 shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda.

3.8.2 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8.3 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Motions – procedure at and during meetings

3.9.1 Who may propose?

A motion may be proposed by the Chair or any Director present at the meeting. Such motion must also be seconded by another Director.

3.9.2 Contents of Motions

The Chair may (at his discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.8, other than a motion relating to:

(a) the reception of a report;
(b) consideration of any item of business before the Trust Board;
(c) the accuracy of minutes;
(d) that the Board proceed to next business;
(e) that the Board adjourn;
(f) that the question be now put.

3.9.3 Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.9.4 Rights of reply to motions

Amendments: The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9.5 Motions Once Under Debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put;
- that a Director be not further heard;
- a motion resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.10 Emergency Motions

Subject to the agreement of the Chair and SO 3.9 above, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.11 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matter shall be final.

3.12 Voting

3.12.1 Save as provided in SO 3.15 Suspension of Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.12.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.12.4 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.14 Quorum

3.14.1 The quorum of a meeting will be at least half of the whole number of members of the Board of Directors (including at least one Non-Executive Director and one Executive Director).

3.14.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.14.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.15 Suspension of Standing Orders

3.15.1 Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present votes in favour of suspension.

3.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the

meeting.

3.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.15.4 No formal business may be transacted while Standing Orders are suspended.

3.15.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.16 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.6 Scheme of Delegation

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Discharge of the Direct Accountability

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or NHS Improvement requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by NHS Improvement), the Board of Directors may appoint committees of the Trust

5.2 Applicability of Standing Orders and Standing Financial Instructions to committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of Powers

The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute, or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.5

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6 Approval of appointments to committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.8 Committees established by the Board of Directors

The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Disclosure of Interests

The Constitution, the 2006 Act and the Foundation Trust Code of Governance requires Board Directors to declare interests which are relevant and material to the NHS board of

which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 Declaring interests

6.3.1 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.3.2 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.3.3 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.3.4 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.

6.3.5 Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3.6 This standing order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

6.4 Register of Interests

6.4.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.4.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.4.4 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their

respective Directors for clarification.

6.5 Exclusion of Chair and Members in proceedings on account of pecuniary interests

6.5.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.5.2 The Board of Directors may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.5.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.5.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 6.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7 STANDARDS OF BUSINESS CONDUCT POLICY

7.1 All staff and members must comply with the Trust's Standards of Business Conduct, the Regulatory Framework and the National guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4 Canvassing of and Recommendations by, Directors in Relation to Appointments

7.4.1 Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 7 shall be included in application forms or otherwise brought to the attention of candidates.

7.4.2 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 7 shall not preclude a Director from giving written testimonial of a

candidate's ability, experience or character for submission to the Trust.

7.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 Relatives of Directors or Officers

7.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

7.5.2 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.5.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS ANDSIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

8.2 Sealing of Documents

8.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Trust Secretary; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly.

(The report shall contain details of the seal number, a description of the document and the date of sealing).

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

ANNEX 9 – Additional Provisions - Directors – DISQUALIFICATION

(See Paragraph 28)

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

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, chairman or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the chairman) may be a non-executive director or a governor of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two directorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a director of the Trust is materially affected.
5. A person who occupies the same household as an existing director of the Trust or a governor.