Bundle Council of Governors - Public Session 23 February 2026

1 OPENING BUSINESS

1.1 16:00 - Welcome, apologies and Declarations of Interest
Apologies received from:
Cara Charles Barks
Duncan Murray

1.2 16:05 - Minutes from public meeting held on : 24th November 2025
For approval
1.2 Draft Public Council of Governors minutes - 24 November 2025

1.3 Matters arising / Action Log
1.3 CoG action log - Public meeting

2 ASSURANCE

2.1 16:10 - Chief Executive / Managing Director Report
Presented by Nick Johnson
For assurance
2.1 Group Chief Executive and Managing Director Update

2.2 16:20 - Environmental Sustainability Presentation
Presented by Mark Ellis
For assurance

2.3 16:30 - NED Escalation Reports

2.3.a Finance and Performance Committee
2.3a 2025-11-25 Finance and Performance Committee Escalation Report
2.3a 2025-12-23 Finance and Performance Committee Escalation Report

2.3.b Clinical Governance Committee
2.3b November 2025 CGC Escalation report to Board

2.3.c People and Culture Committee

2.3.d Audit Committee
2.3d December Audit Committee Escalation Report

3 PERFORMANCE AND FINANCE

3.1 16:35 - Integrated Performance Report
Presented by: Nick Johnson
For assurance
3.1a IPR Cover Sheet - Trust Board 2026-01
3.1b Integrated Performance Report - January 2026

3.2 16:40 - Financial Performance
Presented by Simon Wade
For assurance
3.2 Finance report M10 2025-26 F&P
3.2 Finance report

3.3 16:50 - Corporate Services Redesign
Presented by Jude Gray
For information
3.3 Corporate Services Redesign Briefing cover sheet
3.3 Briefing Corporate services redesign COG Briefing

4 QUALITY AND RISK

4.1 17:00 - Patient Experience Report Q2
Presented by Judy Dyos
For assurance
4.1 Patient Experience - Patient Feedback Report Q2 Annual Engagement Report 25-26 v2.1 Trust Board version

4.2 17:05 - Learning from Deaths Report

Presented by Nick Johnson
For assurance

4.2 Learning From Deaths Report Q2 v1.2

4.3 17:10 - National Inpatient Survey Results 2024
Presented by Judy Dyos
For assurance

4.3a National patient survey 2024 cover sheet - Trust Board January 2026

4.3b National Inpatient Survey 2025 - results report slide deck updated version

5 GOVERNOR BUSINESS

5.1 17:20 - Non-Executive Director Recruitment Update
Verbal Update by Eiri Jones

5.2 17:25 - Lead Governor / Deputy Lead Governor Election
Verbal update by Eiri Jones

5.3 17:30 - Committee Terms of Reference
Presented by Eiri Jones
For approval
- Membership and Assessment Committee
- Remuneration and Performance Committee

5.3a Terms of Reference cover sheet

5.3b Membership, Communications and Self-Assessment Committee - Terms of Reference 2025

5.3c Terms of Reference Nomination and Performance Committee

5.4 17:40 - Constitution Review
Presented by Eiri Jones
For approval

5.4 Draft Constitution 2025 cover sheet

5.4 Draft Constitution 2025 V.2.6 -

5.5 17:45 - Committee / Working group reports from governors

6 CLOSING BUSINESS

6.1 17:55 - Any other business

6.2 Date of next public meeting 18th May 2026

7 RESOLUTION

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

NHS Salisbury NHS Foundation Trust

DRAFT

Minutes of the Council of Governors meeting held on 24th November 2025 16:00 – 18:00 Trust Boardroom and via Microsoft Teams

Governors Present:

Joanna Bennett (JB)	Public Governor
Barry Bull (BB)	Public Governor (Teams)
Paul Russell (PaR)	Staff Governor (Teams)
Jayne Sheppard (JS)	Deputy Lead Governor
William Holmes (WH)	Public Governor
Jane Podkolinski (JP)	Volunteer Governor
Peter Russell (PeR)	Lead Governor
Paul Hedge (PH)	Public Governor
Susan Snoxall (SS)	Public Governor (Teams)
Salil Ray Chowdhury (SRC)	Public Governor (Teams)
Jason Goodchild (JG)	Public Governor (Teams)

In Attendance:

Eiri Jones (EJ)	Chair
Tapiwa Songore (TS)	Head of Corporate Governance
Cara Charles Barks (CCB)	Chief Executive Officer
Paul Cain (PC)	Non-Executive Director
Anne Stebbing (AS)	Senior Independent Director
Nick Johnson (NJ)	SFT Managing Director
Sasha Godfrey (SG)	Board Support Officer (minutes)

CoG 21/11/1 **OPENING BUSINESS** **Action**

CoG 24/11/1.1 **Welcome and Apologies**

EJ welcomed everyone to the Public Council of Governors meeting.

EJ noted apologies had been received from:
Frances Owen, Andy Rhind-Tutt, Sara Willan, Judy Dyos and Mark Ellis.

CoG 24/11/1.2 **Minutes from Public Meeting Held on 21st July 2025**

EJ presented the minutes from the meeting held on 21st July 2025. EJ noted a minor typo on page three, subject to this amendment the Council of Governors agreed the minutes were a correct record of the meeting held on 21st July 2025.

CoG 24/11/1.3 **Matters Arising / Action Log**

CoG 21/07/6.1 Any Other Business – NJ noted engagement with HCRG was going well with positive discussions taking place with the charity regarding service provision. It is hoped the service will continue as it currently operates. Action closed.

CoG 21/07/6.1 Any Other Business – Update to governors on the hospital's work on sustainability at next meeting – This item to be deferred to the next Council of Governors meeting.

CoG 21/07/6.1 Any Other Business – Competed

CoG 21/07/6.1 Any Other Business – Completed, Lecture Theatre booked for AGM

CoG 24/11/2 **Assurance**

Cog 24/11/2.1 **Chief Executive Report inc Group Update**

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

- The report had been refocused to highlight system-wide risks. The main challenge is financial sustainability, with £100m of deficit support funding currently supporting the hospital group. This creates a significant financial challenge this year and next, and the system is under scrutiny and formal financial recovery.
- Positively, all organisations had met their revised financial trajectories for the past three months, reflecting progress in cost control and recovery planning. NHS England has released withheld deficit support funding for Q1–Q3, demonstrating growing confidence in the recovery plans.
- Performance pressures, particularly in urgent and emergency care as winter approaches, with concerns about flu, overcrowding, and infection risk. Elective performance is stronger, but non-criteria-to-reside remains a concern at Salisbury, with insufficient assurance yet on reductions ahead of Christmas.
- Overall, financial sustainability and winter operational pressures remain key areas of focus.

NJ presented the Manging Director update and highlighted the following points:

- Operational and financial recovery remained on track in months 6 and 7, though further work needed to meet standards and get as close as possible to financial break-even, particularly as winter demand intensifies. Emergency demand is expected to be very challenging, but recent performance has been encouraging.
- Non-criteria-to-reside remained a significant issue, with 80–90 beds occupied at peak by patients awaiting onward care. Recent pilots, including early supported discharge, were beginning to have an impact and are planned for wider rollout.
- Regulatory activity had been largely positive. An unannounced CQC inspection of surgery highlighted innovation and strong patient-centred care, with known estate and day-surgery challenges already being addressed. Further reviews in plastics training and medicine are ongoing, with reports awaited.
- The recent industrial action had been managed well, with over 97% of planned activity delivered and strong mutual respect shown across staff groups. Colleagues continue to deliver high-quality care despite difficult circumstances.
- The trust had secured £366k through a solar scheme, enabling new solar installations that will generate clean energy and save around £35k per site per year.

PeR asked for clarity on how much improvement in NCTR was realistically achievable. CCB noted the focus had been on addressing what is within the hospital's direct control, ensuring internal processes are as efficient as possible, most delays related to community capacity and social care. The financial recovery plan is built on achieving agreed targets, which enable fewer escalation beds, reduced out-of-area beds, and more efficient staffing. Progress depended on delivery from system partners, which is why the issue is being escalated regionally. With winter approaching and long-standing challenges still unresolved, there is a strong emphasis on securing partner commitment, particularly with the new community service provider, to deliver the agreed reductions.

NJ noted length of stay had reduced significantly over the past two years, freeing up around 40 beds, demonstrating that current improvement work is having a real impact in

reducing demand. Non-criteria-to-reside patients are segmented by pathway, with a high proportion in more complex categories requiring rehabilitation or care packages, alongside some groups that are more within the hospital's control. Benchmarking shows there is still scope to improve hospital-led processes, including faster discharge for certain patient groups and increasing discharges before midday. The approach is therefore dual: continuing to improve internal processes while working with partners to strengthen community and social care responses.

JP asked what evidence had to be provided to NHSE to release the deficit funding. CCB noted monthly financial reporting had shown a shortfall in April, immediate financial recovery actions were taken, including vacancy controls and tightening delivery of existing savings plans. Since then, the monthly financial position had steadily improved and agreed recovery trajectories have been met for August, September and October. This progress has increased regional confidence that financial deterioration has been halted and deficit support funding has been released.

AS noted non executive directors were seeking clearer assurance on the financial recovery. The new Group Chief Finance Officer has committed to providing improved graphical reporting, to help assess progress more easily and support confidence in the region's assessment that financial performance is improving.

EJ suggested the new Group Chief Finance Officer attend a future Council of Governor meeting. **ACTION EJ/TS** **EJ/TS**

CoG 24/11/2.2 **Sustainability Presentation**

EJ noted the Trust remained a strong, positive performer on sustainability with many good initiatives underway. The Sustainability Presentation will be deferred to the next meeting taking place on 23rd February 2026.

CoG 24/11/2.3 **NED Escalation Reports of Trust Board Committees**

EJ asked the Council to take the NED Escalation reports as read.

Finance and Performance Committee
EJ noted RH was not able to attend, the Finance Committee Escalation report was noted.

PeR referred to a discussion in the pre meet regarding inconsistent patient communications, particularly appointment misdirection, late reminders, and duplication which caused frustration, especially for vulnerable patients. PeR proposed using a future development day to work collaboratively to review the patient communication process, understand patient experiences, and clarify actions being taken. To identify improvements, set a clear timeframe for rectifying issues, and enable effective communication back to constituents on progress.

PaR noted the issue had been raised by Facilities at the Operational Working Group as switchboard were taking a high volume of calls. GPs had reported they could not get through to hospital teams to make referrals, leading them to send patients directly to ED instead. GPs are also receiving calls meant for the hospital.

NJ recognised the impact on patients, their families and carers, and added the issues could be linked to longstanding administrative process challenges. A transformation programme looking at administration was hoped to deliver improvements. EJ suggested a development session with Governors to include the Director of Improvement. CCB referred to outpatient transformation and plans to introduce automatically generated appointment letters and using text reminders to reduce the administrative workload and free up staff to handle phone queries. EJ referred to a recent go and see to switchboard where concerns had been raised regarding loan working.

EJ agreed to organise a governor development day for governors and operational staff to include the Director of Improvement and Patient Liaison Team to try to resolve communication issues. **ACTION EJ/TS** **EJ/TS**

Clinical Governance Committee
There were no questions from Governors.

People and Culture Committee

EJ noted the organisation was mindful of the impact of current changes on staff and the executive team are actively focused on staff wellbeing.

PeR referred to the workforce plan and suggested an update is presented at the next Council meeting. EJ suggested that the new Group Chief People Officer attend a future meeting to update. AS noted the impact on patient safety **ACTION: EJ/TS** **EJ/TS**

NJ noted Sickness absence was now being addressed through a revised improvement objective focused on overall staff unavailability, with all divisions prioritising this and using more detailed data to inform actions. The organisation is also seeking to understand whether workforce pressures reflect local or national issues, with staff survey results expected to provide insight. Despite perceptions of reduced staffing and recruitment freezes, headcount is higher than at the start of the year, creating a need to better understand why this is not translating into reduced costs or improved capacity, and why staff feel there are fewer people. Further work is underway to get to the root of this.

BB expressed concern regarding the impact on staff working under sustained pressure. The Trust has been seen as a secure place to work, and any perceived threat to that security is creating fear and anxiety among staff.

Jayne Sheppard joined the meeting.

EJ referred to a recent visit to the Emergency Department which had revealed a more positive picture than expected. Despite being busy, staff were engaged and enthusiastic, with junior doctors and students expressing that they enjoy their work. EJ noted the importance of capturing and promoting the many positive experiences and achievements across the organisation. Senior leaders have a role in emphasising this, for example by sharing and celebrating good practice and awards more widely across the group.

Audit Committee
EJ noted the Committee had reviewed the discharge processes.

The Council noted the reports.

CoG 24/11/2.4 **Managing Directors Escalation Report – Trust Management Committee September and October**
NJ took the report as read and invited questions.

PeR suggested a session on the Electronic Patient Record at a future development session. While EPR is vital to transformation, it will not deliver change on its own and must be accompanied by cultural transformation. A session would help clarify EPR objectives, expected benefits across timescales, implementation options, workforce impacts, and how it fits within the wider transformation agenda, to support better understanding and alignment. **ACTION TS/EJ** PC suggested inviting clinicians to reflect the clinical implementation perspective. **TS/EJ**

The Council noted the report.

CoG 24/11/3 **PERFORMANCE AND FINANCE**

CoG 24/11/3.1 **Integrated Performance Report**

EJ noted the Integrated Performance Report was presented for information and had already been discussed at Trust Board and at the sub-committees. NJ took the report as read and noted the report reflected some good progress.

JP expressed concern that cancer performance had deteriorated which had been attributed to the departure of the cancer service lead to another role. NJ noted the report covered the September to October period, during which cancer service performance had been a concern. Since then, measures have been implemented to improve the position, including changes in oversight, leadership, management, and resource allocation. JB noted skin cancer cases are expected to rise due to population growth, increased awareness, and climate change. PaR noted Dermatology image hubs have been established across BSW, which will help reduce unnecessary referrals and allow patients who need urgent attention to be identified more quickly.

The Council noted the report.

CoG 24/11/4 **QUALITY AND RISK**

CoG 24/11/4.1 **Patient Experience Report**

EJ took the report as read and noted there would be a new Head of Patient Experience starting in January. EJ referred to the compliments data and challenges in response times.

JP expressed concern regarding a long-standing issue with the hospital's main entrance. Volunteers working there are facing extremely cold conditions (around 11°C) and had raised concerns for elderly patients waiting in that area. The space lacks clear ownership and is critical for patient support, particularly as the enquiries function has shifted away from telephonists. NJ noted the opportunity to improve the hospital's main entrance and plans had been discussed to revive and build on previous work.

The Council noted the report.

CoG 24/11/4.2 **Learning from Deaths Report**

EJ took the report as read and noted the Trust had reported positively with expectations for further improvement supported by reduced length of stay. An external review by the Regional Medical Director had confirmed the Trust was on the right track and had made recommendations for improvement.

PC noted the report had significantly improved from an assurance perspective over the past year and now highlighted learning rather than just presenting figures.

The Council noted the report.

NJ left the meeting.

CoG 24/11/5 **GOVERNOR BUSINESS**

CoG 24/11/5.1 **Non Executive Director Recruitment Update**

EJ noted non-executive recruitment was progressing well, eight candidates had been shortlisted for two roles with interviews scheduled for10th December.

The Council noted the update.

CoG 24/11/5.2 **Lead Governor Report – Deputy Lead Governor Role**

PeR noted JS would be stepping down as Deputy after four years, prompting an election for one of the elected governors to become Deputy and in due course Lead Governor. The election is expected to take place at the February Council of Governor meeting with the new deputy taking over in May. Governors nearing the end of their term are naturally excluded. The role is demanding but highly rewarding, offering close collaboration with executives and non-executives and opportunities to influence the Group. A formal notice inviting nominations will be sent out in the new year.

CoG 24/11/5.3 **Review of CoG structure and membership**

PeR referred to work on restructuring governor committees to improve efficiency The Membership and Communications Committee will take on the self-assessment role, while the Nominations Committee will operate under the Performance Committee to handle recruitment.

The Council of Governors agreed with the proposal.

CoG 24/11/5.4 **Results from the CoG Self-Assessment**

TS took the report as read and noted next steps were to discuss comments and develop an action plan to be presented at the Council of Governors in February.

EJ encouraged governors to consider what additional support they needed from the Board, non-executive directors and the leadership to improve engagement and effectiveness.

PeR asked if once the Group governance structure became clear NHS Providers could be invited to help explain how the Trust fits in, including understanding responsibility beyond statutory obligations. EJ suggested Simon Hackwell from Teneo attend to reflect on the governor's role. **ACTION: TS /EJ** **TS/EJ**

CoG 24/11/5.5 **Committee / Working Group Reports**

Thrombosis Committee

JB referred to concerns following a recent CQC inspection. EJ confirmed the concerns were being reviewed by the Clinical Governance Committee and escalated to the Board. Both the Chief Medical Officer and Chief Nurse Officer had been working with the CQC, challenging some feedback while remaining collaborative. AS noted the issue went beyond specific meetings and reflected wider organisational choices to prioritise certain objectives over some national targets. While this approach has been transparent and the Clinical Governance Committee understands the concerns, the organisation needs to revisit and risk-assess whether it remains reasonable. Delays to the EPR may prolong data-collection risks. Further discussion to be expected once the CQC draft feedback is received.

End Of Life Care
JP presented the report and expressed concern regarding capacity in the End of Lide Team.

Medicine 4 Members
JP explained Medicine 4 Members was a long-standing governance initiative to hold meetings six times a year, designed to allow clinicians to showcase their work. Recent attendance has been a challenge, though meetings are now recorded and held on Teams. There is a proposal from the STARS Charity to organise future Medicine for Members, which could improve reach due to their larger database. Governors expressed a desire to retain some ownership as it had been established as a governance initiative. EJ suggested not to rush decisions until the Board, as

corporate trustee, sets the strategic direction for the charity. The strategy will ensure the charity is used most effectively for the benefit of staff and patients, including education and development. Any existing governors' initiatives should continue, with scope for joint working once the strategic direction is clear.

Patient ESG
The Council noted the report.

PLACE
EJ recognised the importance of continuing to monitor PLACE and highlighted its importance for measuring care outcomes and patient experience.

Real Time Feedback
JP referred to a recent visit to Spinal where poor feedback had been received. AS suggested triangulating this feedback with a recent visit she had made to Spinal. AS observed the lighting in the organisation seemed dull and suggested better light bulbs could be used to improve this.

PLACE
The Council noted the report.

Dementia Steering Group

The Council noted the report.

EJ noted Non-Executives valued working group reports for providing meaningful insight. The range of reports was seen as particularly helpful, and EJ reaffirmed non-executive directors' openness to discuss governor's concerns at any time.

CoG 24/11/5.6 **CoG Forward Plan**

The Council noted the forward plan.

CoG 24/11/6 **CLOSING BUSINESS**

CoG 24/11/6.1 **Any Other Business**

EJ asked the Govrnors if there were any issues they would like to raise.

JB referred to the leisure centre which was experiencing significant staffing shortages. As a result, classes had been cut, hydrotherapy limited, and the centre now closes early on Fridays. This has affected vital rehabilitation services for spinal, post-surgery, respiratory and wellbeing patients, led to increased complaints, and threatened school swimming lessons. The centre remains a valuable asset whose wider role and impact are not always fully appreciated. EJ noted representation from concerned patients at a recent Trust Board and confirmed the issue was being investigated.

JB expressed concern about proposals to move the spinal unit to South Newton. JB acknowledged the current unit needed major upgrading and suggested there were alternative on site redevelopment options. Spinal patients can deteriorate rapidly and require immediate specialist care, creating significant safety risks if moved off site. Strong concern was expressed that relocation could endanger patients, and that any review must properly involve stakeholders.

EJ acknowledged that the issue is complex due to specialised commissioning requirements and ongoing work in this area. South Newton is already being used for non-clinical functions, with a development session planned to familiarise stakeholders with the site. EJ noted the concerns and agreed an update will be brought back to the Council once more information is available. **ACTION: EJ** **EJ**

CoG 24/11/6.2	**Date of Next Public Meeting: 23rd February 2026**
CoG 24/11/7	**RESOLUTION**
CoG 24/11/7.1	Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted).

Public Council of Governor Action log

Action log

Deadline passed. Completed Status = N	1
Deadline in future. Current progress made is updated. Completed status = 'N'	2
Completed status = 'Y'	3
Deadline in future. Current progress made is not updated	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
CoG 21/07/6.1 Any Other Business	Update governors on the hospital's work on sustainability at the next meeting.	Mark Ellis	24/11/2025	On the agenda	Y	3
CoG 24/11/2.1 Chief Executive Report	Group Chief Finance Officer to attend a future Council of Governors Meeting	Eiri Jones/Tapiwa Songore	01/02/2026	On the agenda	Y	3
CoG 24/11/2.3 NED Escalation Report of Trust Board Committees	Organise a governor development day for governors and operational staff to include the Director of Improvement and Patient Liaison Team to try to resolve communication issues	Eiri Jones/Tapiwa Songore	01/04/2026	To be arranged with the Director of Improvement for the April Development Day	N	4
CoG 24/11/2.3 NED Escalation Report of Trust Board Committees	Group Chief People Officer attend a future meeting to update on the workforce plan at the next Council meeting.	Eiri Jones/Tapiwa Songore	01/02/2026	On the agenda	y	3
CoG 24/11/2.4 Managing Directors Escalation Report – Trust Management Committee September and October	Session on the Electronic Patient Record at a future development session to clarify objectives and benefits, invite clinicians to reflct clinical implementation perspective.	Eiri Jones/Tapiwa Songore	01/02/2026	Completed	y	3
CoG 24/11/5.4 Results from the CoG Self-Assessment	Once the Group governance structure is clear NHS Providers be invited to help explain how the Trust fits in, including understanding responsibility beyond statutory obligations. Simon Hackwell from Teneo attend to reflect on the governor's role.	Eiri Jones/Tapiwa Songore	01//02/2026	Simon Hackwell from Teneo attend to attend the Private session	y	3
CoG 24/11/6.1 Any Other Business	Update on moving Spinal to South Newton to be brought back to the Council once more information is available.	Eiri Jones		Not due yet	N	4

Report to:	Council of Governors	Agenda item:	2.1
Date of meeting:	23rd February 2026		

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

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

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

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

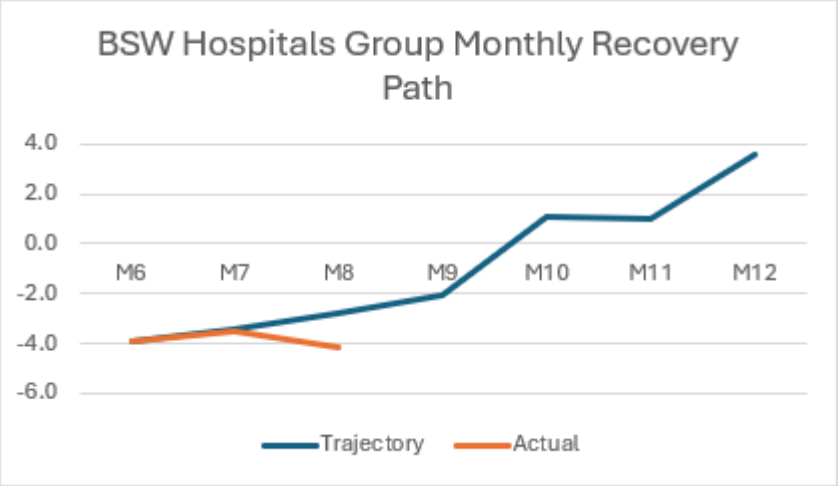
Chief Executive Update

Risks

Financial Position & Recovery

The Hospitals Group has made tangible progress in stabilising its financial position following a period of significant challenge in the early part of 2025/26. While the first quarter saw the components of the Group with significant adverse variances to plan, interventions implemented post Month 4 have begun to deliver tangible improvements. However, at Month 8 this progressed has slowed and the recovery plan trajectory has not been met, leading to a number of corrective actions being implemented. This ensured the confidence of Regulators was maintained and secured the release of Deficit Support Funding, totalling £15.6m, for the year to date.

At an organisational level the largest in month variance from the recovery plan was at Great Western Hospitals (£0.7m), with the Royal United Hospitals (£0.6m) and Salisbury Hospital (£0.3m) also off plan. In total for the year to date the Group is off plan by £43.3m, which is £1.6m adverse to the recovery plan position, the key drivers remain Urgent Care pressures, Non-Criteria to Reside numbers, Drug costs and inflationary impacts. As can be seen from the graph below, in future months there is a step up in the recovery trajectories at all Care Organisations so it is essential progress gets back on target, despite the pressures faced.



Urgent & Emergency Care (UEC) Update

UEC remains challenged across all three acutes in terms of demand and system flow. Internal actions are underway and will continue over the next few months.

There continues to be significant improvements in the average time for ambulance handovers at all three acute Trusts following the implementation of W45, and each of our hospitals are focusing on increasing P0 discharges and ensuring decisions regarding care are taken in a timely way to improve flow through our EDs.

The number of patients waiting to leave acute Trust beds remains a challenge – with continuing high numbers of No Criteria to Reside (NCTR) across all three. In December 2025, a system wide Mega MADE event was undertaken to support increased community daily discharges and P0 discharges, with on-site support from all partners to ensure timely discharge on the more complex pathways. This has

contributed to an increase in the number of future planned discharges and there is a dashboard being created to monitor the effects of the MADE impact.

As expected, winter flu has brought operational challenges. However, due to planning of cohort wards and testing, the impact has been less than in previous years despite the earlier presentation of flu across the system than predicted.

Demand into EDs continues to be a challenge and there is ongoing work with community providers to develop understanding of this change and what we can collectively action to mitigate the risks that are associated with this increase.

Elective

Whilst a number of risks exist in elective performance, it is worth celebrating the enormous hard work and perseverance by teams across BSW to reduce the number of patients waiting over 65 weeks. A year ago over 3.5% of our patients were waiting over a year for treatment – this now stands at 1.2%. At the end of December 2025, we had 18 patients waiting over 65 weeks (14 GWH, 4 SFT, 0 RUH).

Some of the key risks currently being managed in elective care are:

- Rising demand in referrals leading to challenges sustaining our access standards. This is being mitigated by the development of a clear demand management programme with the ICB.
- Loss of capacity due to winter pressures and industrial action. Clear winter plans have been developed across the group aiming to maximise elective activity during this period however this remains a significant risk.
- Planning for 2026/27 not providing sufficient capacity to meet our access goals. Given the challenged financial environment and high growth, the group needs to ensure adequate capacity and productivity is delivered in the year ahead to continue our positive progress in meeting our national targets around elective access. Each Trust is actively developing these plans to ensure we maximise the care we deliver within limited funds.

National Update

Resident Doctors Industrial Action

Resident Doctors took industrial action from 7.00 am on Wednesday 17th to 6.59 am on Monday, 22nd December 2025. Thanks to the staff across our hospitals who worked hard to keep services running and minimise the impact of Industrial Action on our patients as much as possible.

NHS Oversight Framework – NHS Trust Performance League Tables

In November 2024, the Secretary of State announced that NHS England would assess NHS Trusts against a range of performance criteria and publish the results. NHS England published the 2025/26 quarter two segmentation results and performance dashboard, an outline of performance within BSW Hospitals Group is outlined below:

Great Western Hospitals NHS Foundation Trust was ranked 82 out of 134 Trust's in the country, the previous quarter's ranking was 76.

Royal United Hospitals Bath NHS Foundation Trust was ranked 105 out of 134 Trust's in the country, the previous quarter's ranking was 112

Salisbury NHS Foundation Trust was ranked 70 out of 134 Trust's in the country, the previous quarter's ranking was 57.

The segmentation rating for each Trust remained the same since the last quarter, with both GWH and SFT rating 3 and the RUH 4.

Further information on the league tables can be found via https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/

Group Development

Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 17th December 2025 with focus being on discussion of Group Priorities and Prioritisation Approach, Financial Sustainability & Recovery, Care Organisation Risks, the EPR Programme, as well as our Clinical Transformation and Corporate Services Programmes. A report from the December Group Joint Committee has been included with January Trust Board papers.

Leadership Team

December saw changes to both the composition of the Group Executive and to the responsibilities associated with respective Executive Director portfolios considered at the Remunerations Committees in Common. The creation of a Chief Risk Officer role was approved, as were changes to the portfolio of responsibilities relating to the existing Chief Strategy Officer; Chief Transformation and Innovation Officer; and Strategic Clinical Transformation Director roles. The proposed changes are intended to ensure that respective Executive Director portfolios will effectively support the delivery of the Group's strategic aims, operational objectives, and regulatory requirements, and that the 'balance' of responsibilities across all Executive Director roles is appropriate.

The recruitment of the Group Chair continues with interviews scheduled during January.

Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, the Governance Working Group has continued developing the Group's detailed operating blueprint and governance and assurance framework. The Governance Working Group will work closely with the newly established Non-Executive Director Reference Group which met on 5th January 2026.

Group Priorities and Prioritisation Approach.

In November five areas of prioritised focus for the Group were agreed as follows:

1. Recovery (Performance & Finance)

2. EPR re-planning and implementation
3. Clinical transformation and clinical services framework design
4. Completion of the Corporate Services Review for services identified as mission critical
5. 2026/27 planning including Group Mobilisation

Interaction between these component parts (particularly recovery and EPR implementation) remains significant. To enable alignment and understanding of constraints a Group 'Engine Room' is to be established to sit alongside the CEO led Performance, Risk and Recovery Committee, the purpose of this forum is to facilitate agile and dynamic management of resources available in the delivery of the Group's programmes of work.

EPR Deployment Options Appraisal
A team of Executives from across the Group is nearing completion of an EPR Deployment programme options appraisal. Joint Committee review and decision is scheduled in January 2026.

Clinical Transformation Programme.
In November and December our BSW Hospitals Transforming Models of Care Programme mobilised, led by the Chief Transformation & Innovation Officer and a Clinical Transformation Steering Group. Three workstreams are planned:

- Designing single managed services
- Designing a model care organisation
- Supporting the medium-term financial planning

Through the Clinical Transformation Programme, clinical services will be supported to work together and explore potential service models. Clinical Transformation Groups (CTGs) will support clinical service transformation, with an ambition to mobilise six CTGs in 2026 – happy to put in public domain

Corporate Services Programme
Our Corporate Services Programme is making progress and the design stage for each of the services is underway with governance arrangements well established.

Group Board-to-Board Development Days.
The 2026/27 Group Board and a series of Board development days are being scheduled with the next Board-to-Board development day planned to take place in February 2026.

Councils of Governors Workshop
In early December 2025, the three Councils of Governors met to discuss the emerging Group Operating Model, our developing Group Narrative and Vision, and our Clinical Transformation Programme; the next session will be held in early February 2026.

Salisbury Managing Director Update:

We continue to experience pressure on our services arising from demand higher than planned and NCTR higher than planned as a result of limited out of hospital capacity. Nevertheless our dedicated colleagues continue to deliver for our patients. We had the third highest average improvement from data released in December 25. The biggest improvement came from UED 4 Hour All Type Performance.

As we go in to 2026 the key priorities for Salisbury in quarter 4 are:

- A Safe Winter: Maintaining patient safety and flow during our most pressured season
- Financial Discipline: Working hard to land a £5 million budget deficit and get as close to break-even as possible
- Operational Excellence: Moving as close as possible to our core operational standards
- 2026/27 Planning: Developing an ambitiously realistic plan for the next year so we can hit the ground running on 1st April
- Group Working: Increasing our clarity on, and transition toward, our Group working model

As we plan for 2026/27, we know it will be another year of challenge and change, which we will need to face in to, but the dedication from colleagues gives me great confidence and optimism that we will meet those challenges and positively influence the change.

There are also some exciting projects coming up such as the building of a new Urgent Treatment Centre, the re-fit of Radnor Intensive Care Unit, as well as holding our staff learning festival ‘Tent Talks’ on 19th-20th May.

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	2.3a
Date of meeting:	23rd February 2026		

Report from (Committee Name):	Finance and Performance Committee		Committee Meeting Date:	25 November 2025
Status:	Information	Discussion	Assurance	Approval
Prepared by:	Richard Holmes (Acting Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

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

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

- Finance Forecast – pressures still exist on meeting the £5m deficit plan if recovery actions are not successfully delivered. Activity has increased cw prior year despite eg half term, but unavailability of staff remains the biggest challenge. This causes additional costs to be incurred employing replacement staff eg through the Bank. Local initiatives are being implemented to manage authorisation of Bank expenditure.
- Qtr 1-3 deficit support funding of £10.4m has been approved, easing cash pressures. Qtr 4 not yet approved.
- The Committee received the Estates Quarterly update, and noted that the Estates Backlog was identified as one of the four critical SFT Risks identified to the Joint Committee by the Managing Director. The Committee challenged the report in that it felt that it did not reflect the criticality of estates issues sufficiently. The MD agreed that the report could better convey the operational importance and the sense of risk for the Committee to assess, and would adapt the report accordingly in the future.

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

- Despite a significant focus on Cancer performance over the last year seeing the Trust move out of tiering, Region is recommending that the Trust moves into Tier 2 for Cancer for next quarter following a slippage of performance, particularly in the 62-day target, primarily due to underperformance in the management of skin cancers.
- 1st cut business plan prepared, in advance of prior year timetables. Initial deficit of £36.7m remains unidentified, but further modelling anticipated to reduce deficit significantly. Current plan shows £20m CIPS and additional £4m cost reductions. The plan will be developed further and brought back to the Board development Day, F&P, and thence to Board on 8 January.
- An additional £2m has been awarded by the national team to fund estates backlog, bringing the total funds awarded to £7.7m.

NHS Salisbury NHS Foundation Trust

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

- Despite the significant challenges, early positive signs from Group working were acknowledged.
- The Committee received a Deep Dive into the Trusts management of Cancer Services. Sarah Needle, the Trust's newly appointed Deputy COO, reported that Operational management of Cancer Services has recently been moved from a clinical division to the corporate division to increase profile, accountability and focus on performance, and this has identified new improvement initiatives. Further, the Cancer Management Team has been strengthened with new appointments. An external review was conducted to assess processes and policies; these were generally robust and aligned with national guidance. The Committee was assured that the executive and senior medical team have oversight in place, and that sufficient capacity exists to address current challenges (note Tiering Alert above – with an expectation to move out of this in the following quarter).
- The Procurement Annual Report was presented to the Committee. Strong operational performance delivering significant on-target procurement savings and improved Supplier management has been delivered. The Committee requested that a review of potential income-generating activities be brought back to the Committee, in particular referencing full recovery of incomes due from the private sector health providers that SFT supports.
- The Committee received the Annual Cyber Security Framework, and were assured that the Trust's governance and awareness processes were effective in identifying and addressing issues. The Committee noted the plans to develop a single, Group level cybersecurity team to implement consistent cybersecurity measures. The Committee reflected the Trust's reliance on Supplier cybersecurity protocols and requested a review be carried out and reported back to the Committee.
- The Committee received an update on the Digital Plan, noting that significant progress has been made on delivery of multi-year programmes. The Committee asked for assurance that post-implementation reviews were conducted for all IT – and also all other – business investments to ensure that operational and financial benefits have been delivered. This will form part of future F&P business. It was acknowledged that future digital investment programmes will be significantly affected by the group-wide investment in the EPR programme.
- The Committee sought assurance from the newly appointed CFO about future financial governance arrangements, and was advised that this is currently under consideration at Exec and Board levels, with a potential move from Board-led assurance to Exec-led assurance from 1 April 2026, with a suitable period of transition.

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

- The Committee received a complex proposal to enter into a ground lease arrangement with Salutem to enable the development of the land currently occupied by the carparks and the land identified for future development adjacent to it. The Committee **DID NOT APPROVE** the proposal, but **APPROVED** expenditure of associated legal costs associated with advice to date. Further development of the case will be brought back to F&P for consideration.
- The Committee approved the case to award a contract for the supply of contract media to support imaging.
- The Committee approved a request to pursue direct award contracts for an MRI scanner and CT scanner via NHS Supply Chain, noting that the final location of the scanner installations was still under debate, consequent upon final CDC strategy.

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

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	2.3
Date of meeting:	23rd February 2026		

Report from (Committee Name):	Finance and Performance Committee		Committee Meeting Date:	23 December 2025
Status:	Information	Discussion	Assurance	Approval
Prepared by:	Richard Holmes (Acting Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

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

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

- The Committee welcomed the new Group CFO as a member in place of the previous Trust CFO who has stepped away from this committee, and who presented the Finance papers to the Committee. The Committee was advised that the Trust's recovery plan was off trajectory and hence a number of recovery actions from Qtr 4 had been brought forward to seek to bring this back into line. Additional Qtr 4 recovery actions will need to be identified in place of those brought forward. The Committee requested that clear differentiation between be made in future reports between Trust, Group and ICB numerics as the current presentation does not help the Committee to evaluate financial performance and forecasts at Care Organisation level. It was noted that Finance Governance will be moving to an Executive led governance model from April, with a clear transition period.
- Following the submission of the request to enter into a ground lease arrangement with Salutem that was not approved at the last F&P, and subsequent discussions with the Chair of F&P and F&P NEDs, a revised paper was presented. Whilst the paper made the general principles of the case much more clear, and whilst the Committee considered the approach appropriate and consistent with the Trust's strategic estate masterplan in principle, the Committee still did not feel sufficiently assured as to the finance case presented, and hence the Committee **DID NOT APPROVE** the request to enter into a ground lease. Further clarifications will be brought to the Board for consideration of approval in January.
- The strategic estate masterplan relies on the transfer of the ownership of the carpark land from the Stars Charity to the Trust. Whilst the Charity has agreed the transfer the land to the Trust, the Trust Board will need to approve the transfer of the land to it, and the Charity Commission will ultimately need to give final approval for the transaction.

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

- 2nd cut business plan is nearing completion for submission to January Board, and thence to the System in February. The updated plan has been triangulated with the other two Group Care Organisation plans, with an overarching Group value added input.

- In response to an action from the previous F&P, The Committee received a Business Case Tracker showing the 20 business cases that have been approved and delivered by the Trust in the last 18 months. The Committee welcomed sight of the tracker, but was not assured that this sufficiently demonstrated that operational and financial benefits of the investments had or had not been delivered in practice, and therefore could not give assurance of the effectiveness of the Business Case process, or that such investments give value for money. The Committee required that the paper be re-energised to provide this assurance.

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

- Whilst financial performance is still challenging, Operational Performance continued to demonstrate improvements month on month, despite continuing increase in UEC demand. In particular, Cancer performance showed improvement sufficient for the Executive to predict that the Trust has the potential to come out of short term Tiering next quarter. Further, improvements to planned new ED processes and initiatives have increased the Trust's capability to absorb demand increases, and collaborative improvements to the discharge process has reduced NCTR Pathway 1 average discharge times by 50% from c8 days to c4 days.

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

- The Committee received the final proposal for the creation of a joint southern counties pathology network in partnership with seven partner trusts – the 'Wessex Pathology Network'. The Committee noted that the proposal was in line with previously approved Outline Business Cases, and defines a pivotal change in the way pathology services are delivered across the entire region. The proposal provides for a 'Hosted Delivery Model', with two centralised Hubs supported by a lean Essential Service laboratory remaining at each Partner. All Pathology employees (c1,400) will be TUPEd into the new Network and will become employees of the Trust selected to be the Host. The Committee **APPROVED** the core proposal to support the development of the Wessex Pathology Network. The Committee noted and acknowledged that SFT had expressed an interest to the seven Partners in bidding to host the network, but noted that a detailed business case would need to be developed and approved at all levels of SFT prior to a formal bid being made. The Committee therefore **DID NOT APROVE** the submission of a Bid to act as Host for the Network.
- Following the approval at the last F&P for the investment in a CT and an MRI Scanner, the Committee noted that Chair's approval had been given to place the order to secure external funding in this financial year which would otherwise have been lost. It was also noted that arrangements had been agreed with the Auditors to accept a properly constituted Vesting Certificate as evidence to support the inclusion of the expenditure in this financial year, again securing external funding that otherwise would have been lost.
- The Committee **APPROVED** a proposal to award a contract for the supply and maintenance of Endoscopy Medical Equipment to support the Community Diagnostics Centres Project
- The Committee received a proposal from SSL to change its loan repayment agreement. SSL was established with £4m shareholder loan funding from Steris and SFT on a 50/50 basis, repayable in full at the end of the loan term. SFT and Steris are being requested to change the terms of the loan agreement to allow early repayment of the loan amount. After consideration the Committee **APPROVED** this proposal and agreed to the revision of the loan agreement accordingly. Steris will also need to approve this proposal as 50/50 shareholder for it to take effect.

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

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	2.3b
Date of meeting:	23rd February 2026		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	25/11/25
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Anne Stebbing			
Non-Executive Presenting:	Anne Stebbing, Chair, Clinical Governance Committee			
Appendices (if necessary)				

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

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

- Further to CGC report last month, CMB escalation report informs CGC that Aseptic Unit remains high risk following QA inspection in June. Immedate actions have been taken to maintain service continuity while modelling / business case are being developed for possible future investment.
- CGC remains very concerned that safeguarding training data is still unavailable, (see below), and is having to be collated manually. This has been escalated again to People and Culture Committee.

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

- Draft CQC report following visit to medicine has been received for checking, but SFT is awaiting response from CQC regarding the representations made by SFT after receipt of concerns raised about NEWS2 recording and VTW risk assessments.
- CGC further discussed results of the 2024 inpatient survey and discussed these alongside the results from the staff survey. CGC welcomed the approach to triangulating the results and noted that overall, the results were similar to previous years, but for 5 questions the trust had performed significantly worse than in previous years. For 3 questions SFT scored worse than other trusts, including being able to get a member of staff when you needed attention, which may link to staff reporting increased pressure.
- CGC noted the assurance provided by both the Perinatal Surveillance report (October data), and the Maternity Quality and Safety report for Q2.
- In addition CGC received a rapid review of 5 cases reported to MNSI in August and September which has identified the following themes: non- English speaking service users; military families; and foetal monitoring and clinical escalation. The full report from MNSI will be received in due course. CGC also noted (in CMB upward report), that the Badgernet Phase 2 CTG central monitoring had gone live in November 2025.
- CGC were informed that the Safeguarding Children's team are concerned that not all concerns are being identified, particularly in the emergency department. In the absence of reliable data on training compliance this is very concerning. The team are working with colleagues in ED to increase awareness, and to "think family". CGC asked that the executive consider a further deep dive into safeguarding if there is no improvement by next reports to CGC.

• The Surgery division report highlighted challenges in specific services due to vacant posts and slightly longer recruitment timetables due to the tight scrutiny of all posts. Assurance was provided regarding laser services. • CGC discussed an update on GIRFT noting that this advice is actively considered by divisions, alongside other initiatives. SFT and Group use "Improving Together" for improvement and CGC agreed that it would be more appropriate for updates from GIRFT, and any potential actions required to be considered at divisional performance review alongside updates on Improvement. CGC also requested that the Group Clinical Transformation Director incorporates GIRFT in the Group Clinical Strategy.
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• CGC noted good assurance provided by the 6 monthly IPC report and IPC BAF, noting also that clostridium difficile infection rates have increased both in and outside of the hospital setting. • CGC noted continued assurance from the Learning from Deaths report, but that also that there had been a rise in deaths in patients with a serious mental illness, which is receiving further review. • CGC noted the Internal Audit report into discharge processes which had previously been reviewed at FPC and Audit Committees.

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

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

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	2.3
Date of meeting:	23rd February 2026		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	11 December 2025
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

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

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

- The Committee received an Internal Audit Report reviewing Management of IT Applications, a joint report covering both SFT and GWH, which was rated 'Partial Assurance with improvements required', the third in four tier rating system, and in line with management expectations. The principal findings rated as High relate to the oversight of and communication with system suppliers, and the implementation of multi-factor authentication of a number of legacy IT systems. Management Actions have been agreed to address these issues by the end of the financial year.

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

- The Committee received no Internal Audits reports; the report on Research Governance due at the meeting was submitted to Management but the departure of the Head of Research in October has impacted on the timeliness of Management's response. It will be brought to a subsequent meeting.
- The Internal Audit Progress Report has for the first time indicated that a very small number of management actions from prior Internal Audit Reports have passed their deadline delivery dates, without prior approval for an extension. The Committee expressed its concern that this behaviour should be nipped in the bud and not represent the start of a slippery slope towards a future loss of focus on delivery of actions to mitigate risk.
- Deloitte LLP presented their proposed fee for the 2025/2026 year end audit as a straight 10% fee uplift on their 2024/2025 fee. The Committee did not approve the fee as presented and sought additional assurance from the CFO that this increase is reasonable in all the circumstances.
- The Committee noted that the CEO was requested by NHS England to confirm any post balance sheet events for the period ending 31 March 2025. The Trust submitted three events, covering the liquidation of Wiltshire Health and Care on 31 December 2025, a possible review of the valuation of the car park asset owned by the Charity, and the potential impact of the supreme court ruling re Northumbria Healthcare NHS Trust v HMRC which will have a £0.6m adverse impact on recoverable VAT.

NHS Salisbury NHS Foundation Trust

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

- The Committee received a deep dive into the continuing project to improve the effectiveness and controls of the Starters and Leavers process. The project commenced in November 2024 following an Internal Audit Report. The project has completed the delivery phase and is now in the project review phase. Processes have been streamlined and enhanced, management training has been delivered and a single point online access has been delivered, all of which reduce the risk of incomplete or inaccurate information, improving data quality and accuracy.
- The Committee welcomed Michelle Hopton from Deloitte LLP, the Trust's statutory Auditor who is replacing Chris Randall as Audit Partner who has moved overseas with the firm. Michelle presented the External Audit Plan for the year end 2025/26 in conjunction with the CFO. The Committee commended the plan.
- The Committee received its regular Counter Fraud Progress Report which highlighted no items for concern.
- The Committee received an enlightening summary report from the Internal Auditors demonstrating the potential for use of AI within the Trust. This is taken from their benchmark of the approaches to deploying AI across their NHS internal audit client base, with responses from 22 Trusts, and gave illustrated examples of both Clinical and Administrative examples of AI Implementations. The Committee recommended that this report be circulated to all members of the Trust Board, and that representatives from the Internal Auditors might be invited to support the future Board Development Session covering AI.

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

- None.

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

Report to:	Council of Governors	Agenda item:	3.1
Date of meeting:	23rd February 2026		

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

Recommendation:

The Trust Board is asked to note the Trust's operational performance for Month 8 (November 2025).

Executive Summary:

Breakthrough Objectives

- *Reducing Pressure Injury* increased from 2.9 to 3.4 total in *Pressure Ulcer categories 1-4 (excluding specialist areas)* against the target of 1.5 and baseline of 3.08.
- *Time to First Outpatient Appointment* reduced from 121 to 120 days against the target of 90 and furthers the lowest point since measuring and baseline of 139 days in April 2023. This remains the key determinate of the Trusts Referral to Treatment (RTT) position.
- *Reducing Staff Unavailability* dropped from 22.8% to 18.4% total and lowest point since April 2025 against the target of 16% and baseline of 22.7%.
- *Productivity* increased slightly from -12.6% to -13% against the target of -5.33% and the baseline of -14.97% in April 2024.

Alert

- *Income* reported an in-month position as a deficit of £0.9m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan YTD, the Trust cannot access the national element of the deficit support funding.

Advise

- *Attendances* into the Emergency Department (ED) increased from 6,786 to 6,822 and remain circa 4% higher than 2024 although performance in month was exemplary:
  - *4-hour Performance* increased again from 68.2% to 75.1% against plan of 71%. Fastest in month recovery within NHS, and best performance for the Trust since March 2024.

- *Ambulance Handover* time reduced again from 23 to 19 minutes average against plan of 20.
- *Ambulance Handovers >60 minutes* reduced further from 33 to 15.
- *ED 12-hour Breaches (arrival to departure)* reduced from 557 to 384.

- Cancer performance began to recover although remains challenged (reporting October data as cancer reporting timeframes one month behind this report):
  - *28-day Faster Diagnosis Standard (FDS)* increased again from 73.9% to 76% against the plan of 80% with Colorectal and Urology lowest, Breast and Skin leading.
  - *62-day Standard* also increased from 57.9% to 65.8% against the plan of 80% with Skin and Head and Neck lowest, Breast and Upper GI leading.
  - *62-day Backlog* increased from 269 to 282 patients at month-end with Skin the top contributor (173) although has additional capacity in place to support and recover, so expect to see improvement in November.
- *Falls resulting in High Harm* and *Total Patient Falls* both reduced to 1 and 7.9 respectively.
- *Staff Absence* reduced from 4.4% to 4% in a welcome drop after previous growth and ahead of winter.
- *Bed Occupancy* reduced from 97% to 96.3% and is also a welcome drop after successive increases.
- *Staff Vacancies* increased from -5.2% to -5% continuing the net Trust position of over-establishment.
- *Stroke Care* measure of *Motor Minutes* increased again from 33 to 38 minutes although continues below the local target of 120 with Latest SSNAP score for the Trust remaining at E.

Assure

- *Referral to Treatment (RTT)* waiting list metrics were positive overall:
  - *RTT Performance* improved again from 67.8% to 68.2% and remains ahead of the March 2026 target of 65%. Highest performance since May 2022
  - *RTT Waiting List* increased from 29,135 to 29,203.
  - Patients waiting *>52 weeks* increased slightly from 161 to 170 although accounts for only 0.58% of the total waiting list ahead of the March 2026 target of 1%.
  - Patients waiting *>65 weeks* remained static at 2 against the rolling target of 0 and resulting from ongoing consultant sickness.
- Diagnostics *DM01 Standard* increased from 87.3% to 88.5% and continues above the plan of 87% with Urodynamics and Audiology lowest, Cystoscopy and Ultrasound leading. Continued sustained improvement in Endoscopy, going from circa 47.4% in February to 84.9% in November 2025.
- *Infection Control* measures of *E.Coli* and *C.Dificile* both reduced to 0 instances of each in month.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

January 2026

(November 2025 data)

Our Strategy 2022-26
IMPROVING together

Summary

NHS Salisbury NHS Foundation Trust

November was a challenging month for the Trust, set against periods of Industrial Action and maximum escalation resulting in critical incidents, although despite and considering this, performance was overwhelmingly positive.

Performance in Emergency Department (ED) had a significant recovery in month, as the *4-hour Standard* increased to 75.1% - which is the most improved in the country and the highest the Trust has performed since March 2024. The ED saw an increase in *Attendances* to 6,822 patients in month and remain circa 4% higher than in 2024. *Ambulance Handover* time reduced further to 19 minutes average, with both metrics in their best positions in almost 2 years. Wider metrics reinforced the strong performance, as *ED 12-hour Breaches* reduced to 384 and *Ambulance Handovers longer than 60 minutes* continued reduction to 15 total.

The Trust continues to drive at improvements with the number of patients with *No Criteria to Reside (NCTR)* and consequently *Bed Occupancy* levels, in the month both decreased to an average of 76 and 96.3% respectively. Aligned with this, the use of *ED Attendances in Temporary Escalation* also reduced significantly to 186 and *Inpatients in Temporary Escalation* was static at 10 total across the month, which is positive although masks pinch-points that contributed to critical incident declaration.

Cancer performance - reporting October data - continued its recovery although challenges in the Skin pathway persist, affecting the overall position and particularly the backlog. The *28-day Faster Diagnosis Standard (FDS)* increased to 76% and the *62-day Standard* also increased to 65.8%. However, the *62-day Backlog* increased to 282 patients at month end, with Skin the top contributor accounting for 173 patients and additional capacity is underway to support and recover. It is likely that the Trust will continue to experience performance challenges in some tumor sites for the next couple of months, as the focus is on clearing the over *62-day backlog*. The Trust continues to work towards reducing the backlog in November.

Diagnostics *DM01 Standard* - the percentage of patients waiting less than 6 weeks - performance improved to 88.5% and highest point in 2 years, remaining above the plan of 87%. Stroke care measure of *Motor Minutes per Patient per Day* increased again to 38 minutes on average although it remains below the local target of 120 as ongoing vacancies in the Therapy team are preventing improvement.

The quality breakthrough objective has changed to measure *Pressure Ulcers (PUs)* and is measured through *Hospital Acquired PUs Categories 1-4 (excluding specialist areas)* which increased to 3.4 total for the month against a target of 1.5. Wider quality metrics were positive, as *Infection Control* reduced to 0 instances of both *E.Coli* and *C.Dificile* in month, *Falls resulting in High Harm* and *Total Patient Falls per 1,000 Bed Days* both reduced to 1 and 7.9 respectively, and the number of *Mixed Sex Accommodation Breaches* halved to 6.

The access related breakthrough objective of *Wait Time to 1st Appointment* continued reduction to 120 days and new lowest point since measuring. Wait time performance improved overall despite the total *Referral to Treatment (RTT) Waiting List* increasing to 29,203 resulting in the *RTT level* - percentage of patients waiting less than 18 weeks from RTT - increasing further to 68.2% and ahead of the March 2026 target of 65%. The number of patients waiting *Longer than 52 weeks* increased to 170, although only accounts for 0.58% of total waiting list - against a March 2026 target of 1% - and the number of patients waiting *Longer than 65 weeks* remained static at 2 - against rolling target of 0 - due to ongoing consultant sickness.

The workforce breakthrough objective has changed to measure *Staff Unavailability* - combined Sickness with all leave types - began with a reduction to 18.4% against a target of 16%. *Staff Sickness Absence* specifically dropped to 4% overall and *Staff Vacancies* increased marginally to -5% and continues to indicate that the Trust remains above establishment overall.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* increased fractionally to -13% against the target of -5.33%. The Trust reported an in-month deficit of £0.9m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan year-to-date (YTD), the Trust cannot access the national element of the deficit support funding.

Strategic Planning Framework: 2025-26

NHS Salisbury NHS Foundation Trust

Vision

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

People working for us

Population our patients and their families

Partnerships working with us

Vision metrics 7 – 10 years

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

Strategic initiatives 3-5 years

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

Corporate Projects

Breakthrough Objectives 12-24 months

- Reducing pressure injury
- Reducing patients' wait time to first outpatient appointment
- Reducing staff unavailability
- Creating value for our patients

What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

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

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

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

People

Population

Partnerships

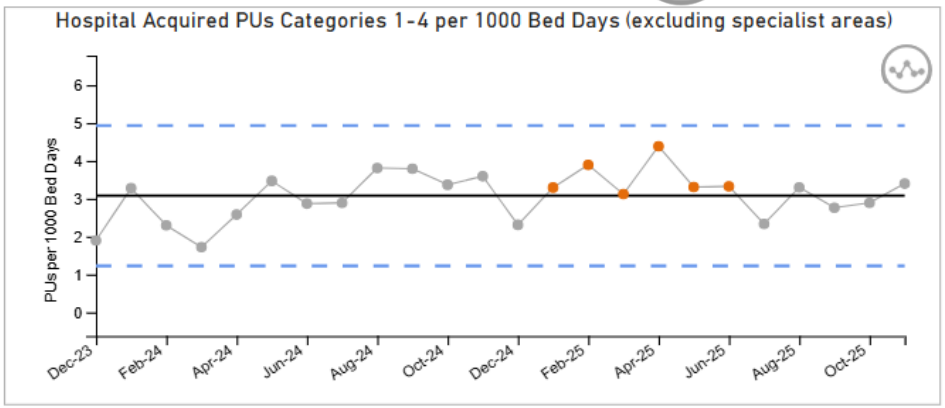
Reducing Pressure Injury

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 3.08 (November 2025)**	The prevention of pressure ulcers remains a clinical priority across healthcare settings due to their impact on patient wellbeing and healthcare resources. Pressure ulcers are listed among NHS England's top 10 harms and among the top harms reported at SFT. Pressure ulcers have significant implications for patients and healthcare providers in terms of mobility, pain management, infections, wellbeing and financial pressures. It is recognised that each pressure ulcer extends a patient length of stay by approximately 5 to 10 days. The Trust is committed to implementing the National pressure ulcer prevention and management strategy, allowing for review of local systems, processes, and pathways to reduce pressure ulcer incidence.

Target: 1.5 Performance: 3.4 Position: Common Cause



Understanding the Performance

In November, the total number of Pressure Ulcers (PUs) increased from 25 to 31 which equates to an increase from 2.9 to 3.4 per 1,000 occupied bed days (OBDs), against a baseline of 3.08 and a target of 1.5 per 1,000 OBDs.

The increase is largely attributable to a rise in category 3 PUs with a recognised contributory factor of patients being moved between wards more than once.

This performance relates to inpatient areas, excluding specialist areas of Spinal and Hospice which are recorded separately as a watch metric.

Moisture Associated Skin Damage (MASD) is also monitored as a watch metric.

Countermeasure Actions

	Due Date
• The Tissue Viability (TV) team identified key areas to focus on and set up a working group to look at data collection as a starting point. The aim is to have PU data in one place which is easily accessible for all appropriate staff to measure against their own performance.	Jan 2026
• The Trust participated in worldwide 'Stop the Pressure Ulcer' week and took the 'Red Bed' around the Hospital using visual pressure mapping equipment to demonstrate how quickly injury occurs. A training video will be produced for wider viewing.	Mar 2026
• Improving Together A3 is in development, with the counter measures and root cause analysis available next month.	Jan 2026

Risks and Mitigations

- Nursing and Midwifery forum - Staff have been advised to reduce the usage of procedure pads for managing patient incontinence (a risk factor for skin/pressure injury) as they have minimal wicking abilities and continue to use the available continence products.
- Increase of staff sickness absence.
- Increased waits in ED and bed occupancy raises the risks of pressure ulcers occurring.

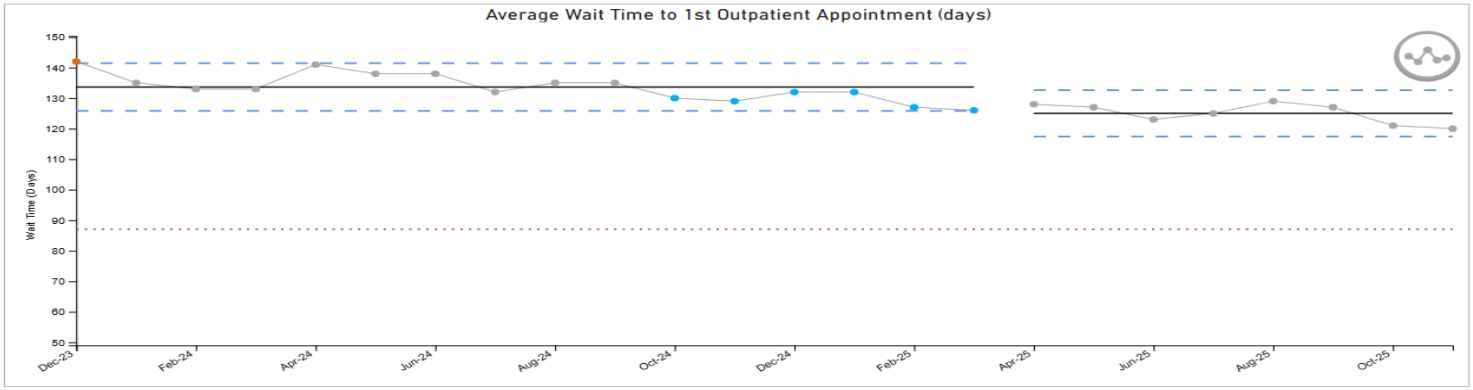
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≤90 days Performance: 120 days Position: Common Cause



Understanding the Performance

Time to First Outpatient Appointment (TT1OPA) shows a decrease from last month of 1 day, down to 120 and lowest point since measuring.

High waiting list specialties (>500 patients) with longest average wait times (in days) are:

- Rheumatology - 160 (decrease 5 days)
- Gynaecology - 154 (increase 4)
- Respiratory - 151 (increase 2)
- Trauma and Orthopaedics - 143 (decrease 4)

All have seen a relatively static Referral to Treatment (RTT) waiting list size compared to last month. However, the number of patients waiting over 52 weeks fluctuated, with increases seen in Gynaecology, Respiratory and T&O, whereas Rheumatology saw a decrease.

Countermeasure Actions	Due Date
• Rheumatology, Respiratory and T&O continue to be part of the focused specialties within Outpatient Operational Group (OOG). Gynaecology will be part of Phase 3 (Jan to Mar 2026) alongside Cardiology and ENT.	Mar 2026
• Central Booking have continued with their RTT focus weeks and this has now become BAU from Jan 2026 onwards.	Jan 2026

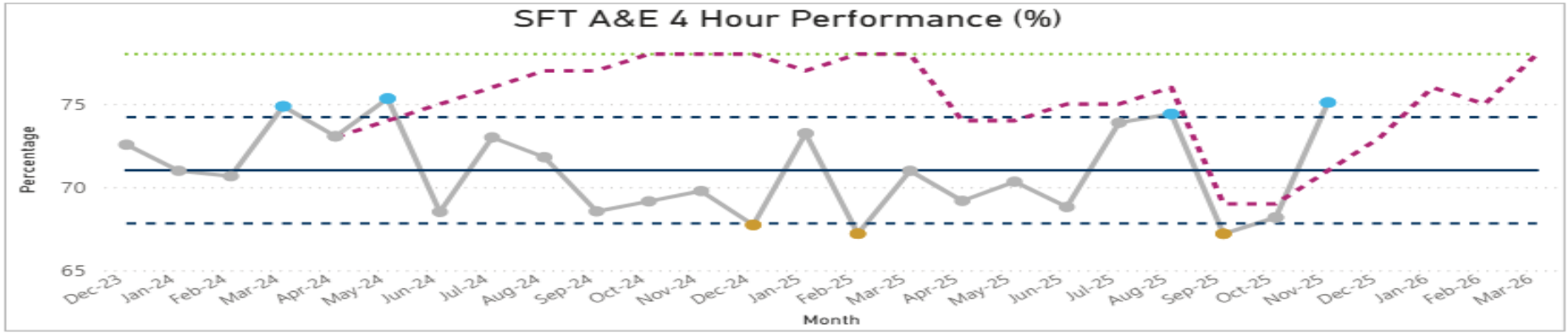
Risks and Mitigations

- Continued risk that overall TT1OPA improvements may not be realised due to declining performance in other specialties. Mitigation: The programme strategy includes monitoring and specific focus on top contributing areas.
- Staffing levels within Central Booking remain challenged due to vacancies and sickness. Continuing to explore overtime options and cross-team working as opposed to just cross-portfolio working as mitigating support.

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 75.1% Position: Special Cause Improvement



Month	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Proportion of patients spending more than 12 hours in an emergency department	7.1	7.8	10.5	8.7	8.9	9.1	6.6	4.8	5.3	10.9	11.4	8.1

Understanding the Performance

The Emergency Department (ED) performance continues to demonstrate positive momentum, with overall 4-hour performance of 75.1% in month against the national target of 78% and trajectory target of 71%. Type 1 attendances specifically achieved 62.4%. This represents special cause improvement above the trajectory target, underpinned by 45% of patients being seen by a clinician within 60 minutes, a key driver of enhanced flow and reduced breaches.

The Trust is seeing sustained improvement despite stable attendance volumes, highlighting the effectiveness of operational changes as a result of the introduction of the Clinical Decision Unit, additional AMU consultant cover, 7 day a week SDEC, introduction of send away clinic for minor patients and new ED medical rota to match demand. All of which are supporting delivery of the 4-hour standard. Further improvements are anticipated as the Trust aims to deliver further flow improvements.

Countermeasure Actions	Due Date
• UTC programme of works continues through board, clinical and operational working groups.	April 2026
• Twice daily huddles continue to have a positive impact on patient flow and create problem-solving opportunities with good engagement from assessment areas.	Dec 2025
• Expanded Early Supported Discharge service goes live in December, anticipated this will support reducing NC2R and support flow improvements.	Dec 2025
• MADE Event being launched in December to support trying to improve flow new ways of working including through front-door integration, triage, and streaming in line with SWAST pathways	Dec 2025

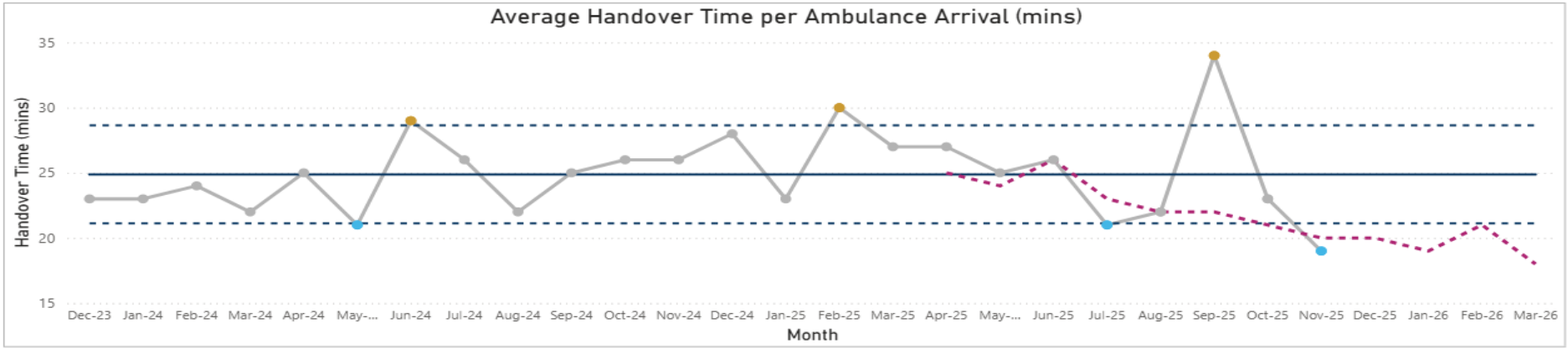
Risks and Mitigations

- During December 25 there is an anticipated spike in flu cases nationally. This is anticipated to have an impact on flow.
- Further industrial action has been declared by the BMA for resident doctors. This is will impact on the normal running of the hospital. This also impacts on the Trusts leadership time to undertake improvement.
- The Trusts flow is heavily impacted on urgent care demand and community supported discharges. Whilst improvement work is in place, there is a risk that this might not deliver as planned.

Ambulance Handover Delays

Salisbury NHS Foundation Trust

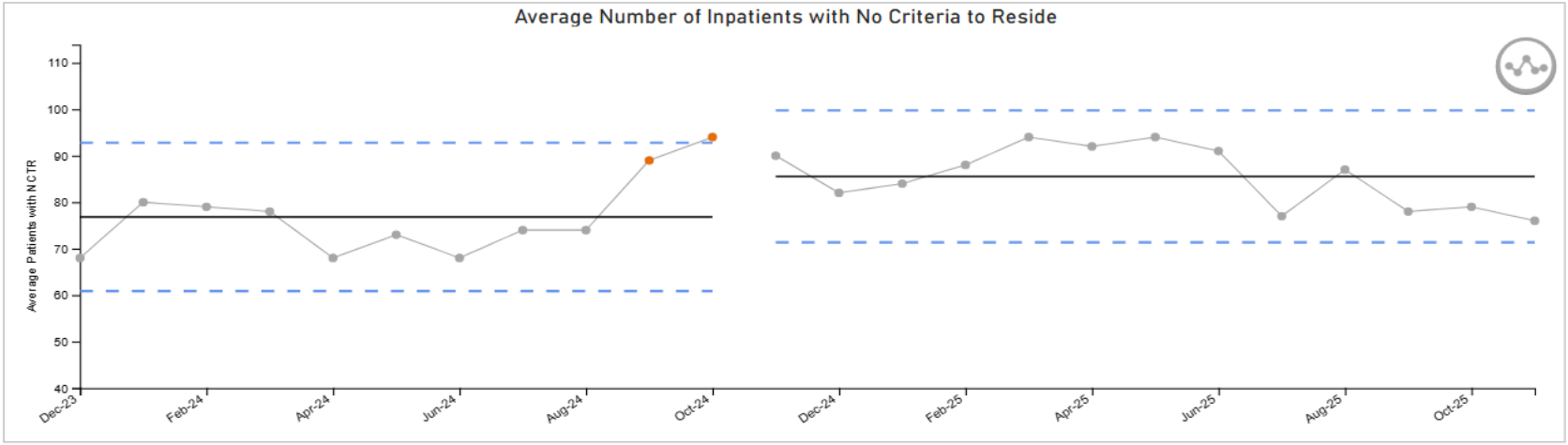
Target: <24 mins Performance: 19 mins Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Ambulance handover performance in M8 achieved 19 minutes which represents special cause improvement as well as delivery of the target trajectory. Except for a variance in September, the performance in ambulance handover continues a consistent downward trajectory in line with the target, underscoring the effectiveness of operational interventions. The enforcement of W45 - policy whereby handover does not exceed 45 minutes - has proven to be a critical lever in driving compliance and accelerating progress, though this has necessitated trade-offs in patient experience, with escalation and corridor care remaining a persistent feature of service delivery. Notably, the Clinical Decision Unit (CDU) has emerged as a key enabler of strategic capacity management in M8, releasing acute assessment space and strengthening offload capability. Industrial action during the month aided flow across the organisation, releasing pressure on the Emergency Department. The team have continued to utilise the ECIST RATT model to deliver rapid handover and have worked to maintain flow through this area despite escalation elsewhere in the department.	• CDU inclusion and exclusion criteria are under review, with proposed expansion to speciality-referred patients meeting pathway requirements. This will optimise CDU utilisation, release acute assessment space, and strengthen offload capacity. • A review is underway into the measurement of 'time to first assessment' in the Emergency Department. This covers both time to streaming for self-presenting patients and the documented 'time to first clinician' contact for those arriving by ambulance. Inconsistencies in documentation practices may risk inaccurately capturing performance times. Addressing this will be key to ensuring accurate monitoring and meaningful service improvement.	Dec 2025 Jan 2026	• The recent escalations to OPEL 4 status and the proximity to critical incident thresholds has necessitated a recalibration of departmental priorities, with strategic reconfiguration initiatives temporarily deferred to maintain operational stability. Current focus remains firmly on demand and capacity management, ensuring resilience in frontline delivery while safeguarding patient safety. This measured approach reflects a commitment to executing any future internal moves at a time that optimises service continuity and mitigates undue pressure on staff, thereby balancing immediate operational imperatives with longer-term transformation objectives.

Optimising Beds

Target: ≤25 (5%) Performance: 76 Position: Common Cause



Understanding the Performance

The November position continues to show that the Trust is holding the improvements delivered since the summer where there are circa 20 less No Criteria to Reside (NCTR) patients. This is supporting improvements in:

- Patients in pathway 1 have reduced in delayed Length of Stay (LoS) from 9.7 days in October to 7.8 days in November. This supports the work ongoing in Discharge Assessment and Action (DANA) - now BAU - and expanded Early Supported Discharge (ESD) services.
- Pathway 2 performance has dropped and seen an increase in bed days from 11.7 Days in October to 20 days in November. This has been recognised system-wide as a point of pressure. Commissioning conversations are continuing to review the P2 bed availability.
- Pathway 3 performance has increased from October. The delayed LoS has dropped by nearly 3 days (26.5 days in October to 24.6 days in November).

The countermeasures and actions are supported by the system recovery plan to bring NCTR back to 9% of bed base.

Countermeasure Actions	Due Date
• Focus on progress against NCTR trajectories within the system. Data still being worked through with ICB.	Dec 2025
• Redesign of Wiltshire Flow Hub (where duplication has been seen).	Dec 2025
• Expansion of ESD team to support delivery of 48-hour target for Pathway 1 discharges - funded by the ICB until end of Q4.	Mar 2026
• ICB led 'Home is Best' programme focused on redesign in Wiltshire to reduce NCTR Pathway 1 delays and length of stay.	Dec 2025
• Review of the Wiltshire P2 bed care home beds.	Dec 2025
• Reduction of length of stay within SFT and early discharge - Ward processes working group in place.	Mar 2026

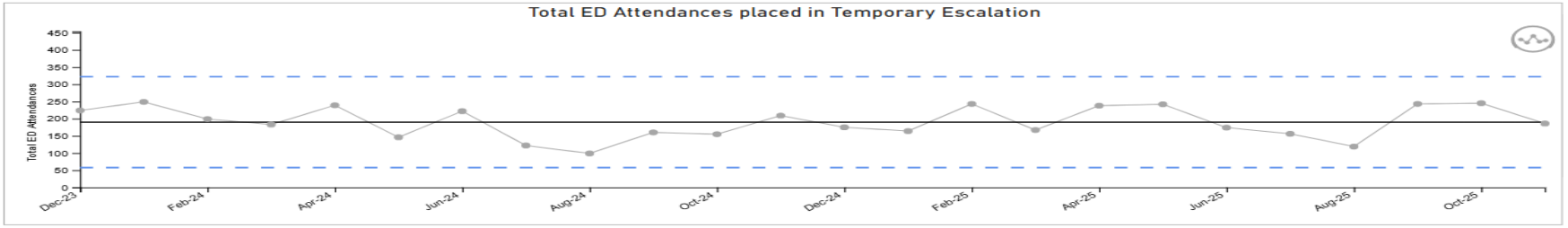
Risks and Mitigations

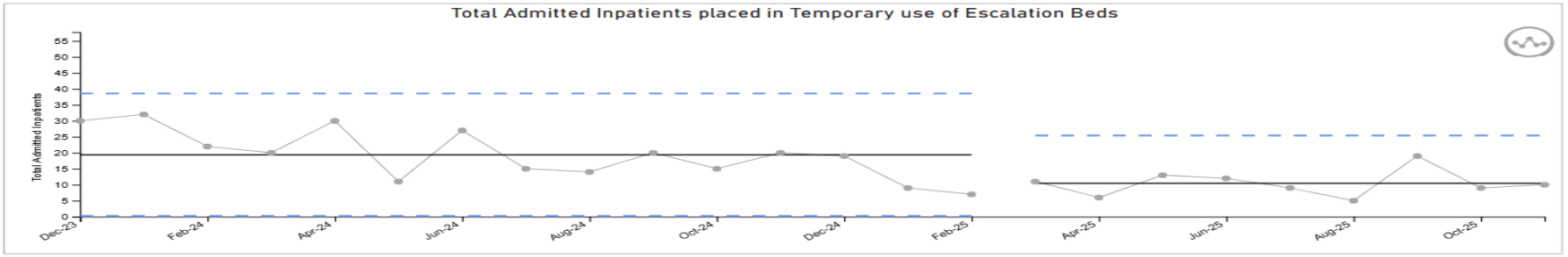
- Inability of the system to meet the NCTR trajectories for discharge. HCRG (Community Services Provider) changes to Hospital at Home (H@H) proposals which caused a pause to the project.
- External conflicts such as reduction in capacity in local authority social care teams and financial constraints.
- Changes to community models could be a risk.
- Clinical capacity and demand conflicts.
- Continued increased in ED and Non-elective admissions increasing NCTR demand.
- Seasonal respiratory virus peaks in demand.
- BMA Industrial action and inability to control when this will happen.

Use of Temporary Escalation Beds & ED Escalation

Salisbury NHS Foundation Trust

Target: 0 Performance: 186 Position: Common Cause





Understanding the Performance

ED escalation saw 186 patients in M8 from a total of 243 in M7, which demonstrates a reduction in month, however, remains consistent with the mean of 189 and therefore common cause variation.

The ED corridor (or Escalation 2) has been utilised for the third consecutive month following the enforcement of W45. Despite the increased flexibility to flow in and out of these additional escalation spaces, the performance this month demonstrates a sustained picture.

Temporary escalation beds have remained in use throughout M8 and the period of industrial action, which provided additional flexibility during this period, but the overall average has not reduced.

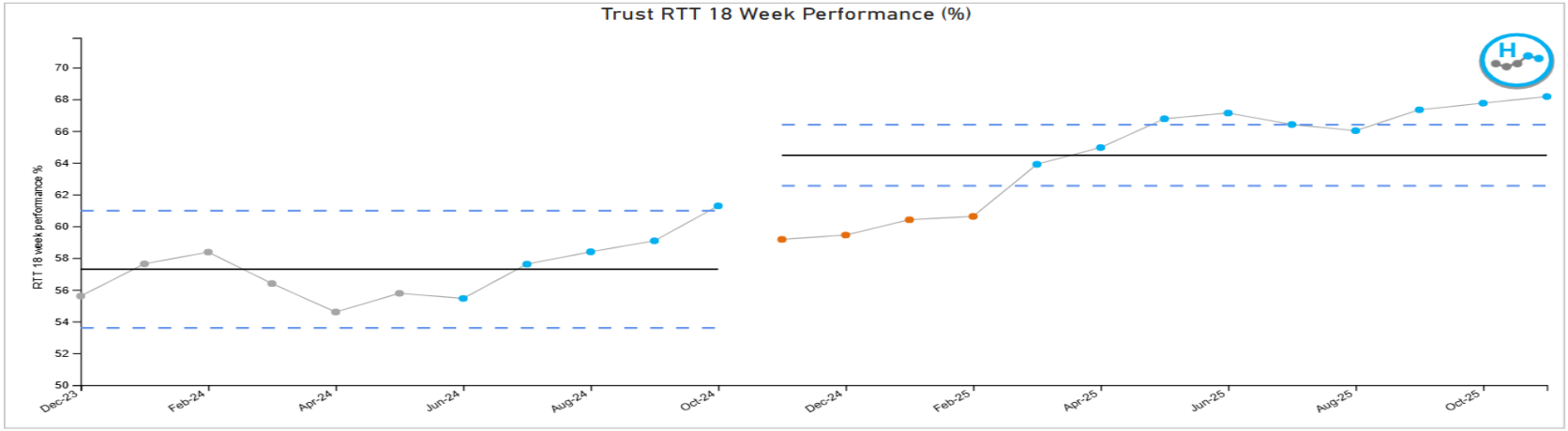
Countermeasure Actions	Due Date
• Review of the efficiency of Clinical Decision unit (CDU) remains ongoing, it attempts to release acute assessment space within the department.	Dec 2025
• Explore sustainable alternatives to ED escalation care and reliance on temporary escalation beds, with quarterly review.	Dec 2025

Risks and Mitigations

- The use of ED corridor care in addition to Trust-wide escalation spaces continues to pose risk to patients, due to the persistent overcrowding, limited visibility, and lack of appropriate clinical facilities in these areas. Patients cared for in corridors often experience delayed assessments, reduced monitoring, and compromised privacy, which can lead to missed signs of deterioration and increased anxiety. The environment is not designed for safe care delivery, meaning vital equipment and infection control measures are harder to maintain, further heightening the risk. This practice, while a response to system pressures, undermines both patient safety and dignity, and highlights the urgent need for more sustainable solutions to address capacity challenges across the Trust.

Elective Referral to Treatment

Target: ≥61% Performance: 68.2% Position: Special Cause Improvement



Balancing Metric	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Longest waiting patient	74	78	71	74	78	64	64	68	71	76	80	84	89	93

Understanding the Performance

Referral to Treatment (RTT) performance continued improvement, rising to 68.2% and its highest point since May 2022. Performance exceeds the plan of 63.5% and improvement aligns with the reduction in time to first outpatient appointment.

Highlight specialties with performance above the plan:
- Urology - 83.3%
- Ophthalmology - 75%
- General Surgery - 68.6%

The number of patients waiting more than 52 weeks increased to 170 although this accounts for only 0.58% of the total RTT waiting list - against March 2026 target of 1% - which also increased to 29,203 patients.

The number of patients waiting more than 65 weeks remained static at 2 due to ongoing consultant sickness.

Countermeasure Actions	Due Date
• Waiting list validation using direct contact with patients via Patient Led Validation (PLV) software planning to go-live in January to ensure accuracy of RTT waiting list and to ensure patients are waiting well.	Jan 2026
• Continued improvement and focus on the time to first outpatient work is driving further improvements in RTT.	April 2026
• Targeted RTT training being planned for 2026 Clinical Governance sessions.	Jan 2026
• Existing digital software for waiting list management (CCS) is being enhanced and expanded to improve the process overall.	Jan 2026

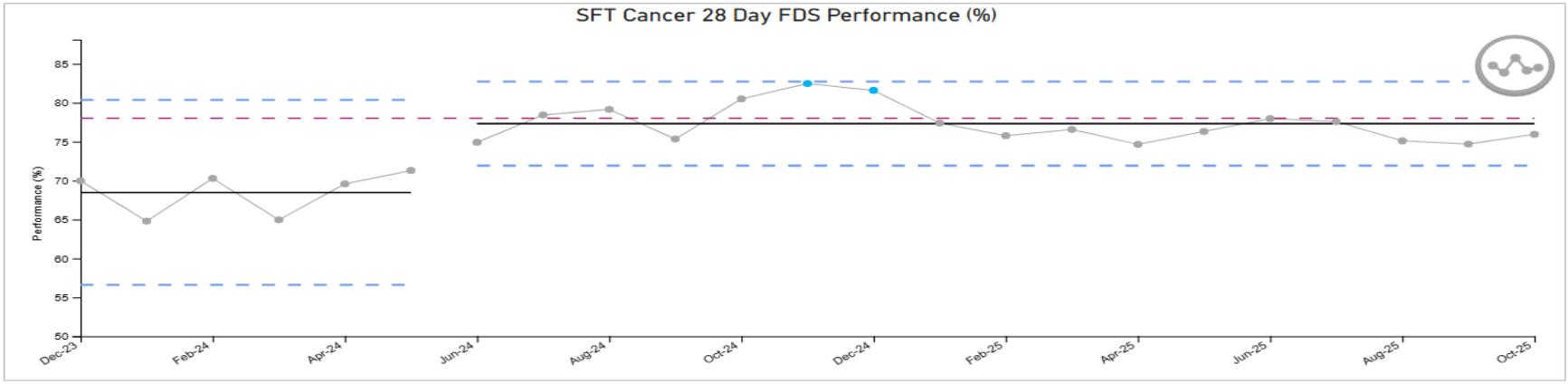
Risks and Mitigations

- Industrial Action will present a risk to all elements of the RTT waiting list.
- Patients incorrectly categorised as Non-RTT status in the Electronic Patient Record (EPR) system can be a risk if not correctly labelled, with mitigating processes to correct in place.
- Capacity of clinical services to treat patients within 18 weeks is a risk and being mitigated through additional capacity where necessary.
- Weekly Access Meeting ongoing with the aim of reducing risk around long wait times whilst also driving performance to meet national targets.

Cancer 28 Day Faster Diagnosis Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 76.0% Position: Common Cause



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

Understanding the Performance

28-day performance standard not achieved for M7, with month-end reported position of 76.0% (improvement from 73.9%).

Specialties not delivering the standard in month include:

- Lower GI - 56.9% (from 48.6%)
- Haematology - 38.5% (from 38.5%)
- Lung - 62.5% (from 75.9%)
- Non-Site Specific (NSS) - 40% (from 26.2%)
- Upper GI - 67.7% (from 68.5%)
- Urology - 61.5% (from 56.7%)

Breaches are driven by patient choice, insufficient diagnostic capacity and pathway complexity. Bowel Cancer Screening Colonoscopy capacity across BSW and associated patient choice remain a factor.
Operating capacity and differential diagnosis post-histology are drivers for Skin position whilst the backlog is cleared. There remains an ongoing risk to performance through M8 as a result.

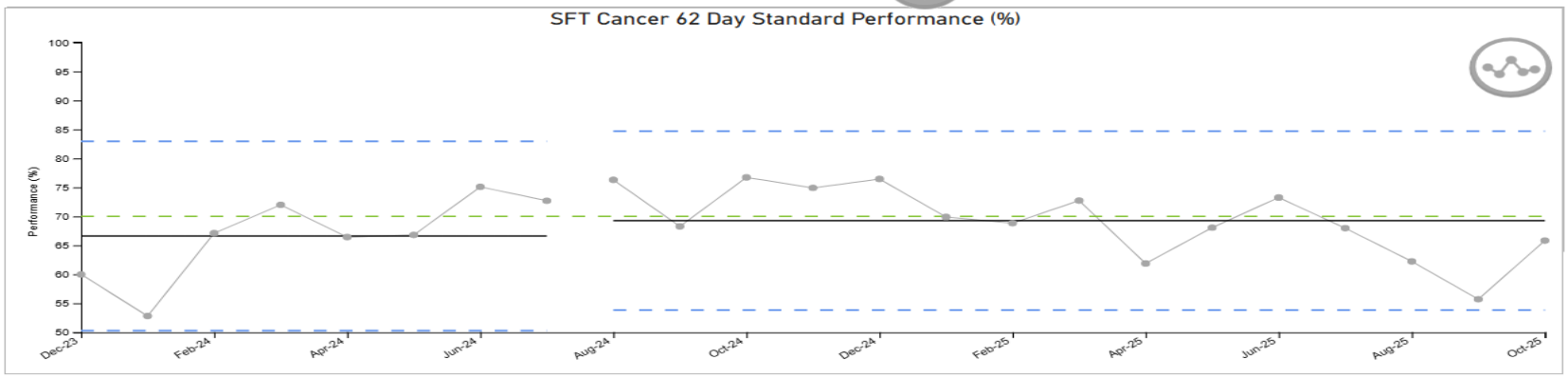
Countermeasure Actions	Due Date
• Implementation of insourcing agreement to support Skin first appointment and theatre capacity over M7 to support clearance of backlog. Additional theatre lists and clinics established across remainder of the financial year to maintain capacity.	Nov 2025
• Faster diagnosis touchpoint meetings in place, which includes specific focus on increasing template biopsy capacity to support waiting times within Urology.	Jan 2026
• Automation of processes via Blueprism software has now commenced in pilot sites, which alongside procurement of SCR modules will support efficiency within MDT function. FDP Cancer 360 PTL management tool to be in place from M10 onwards. Revisions made to existing PTL process to support easier identification of next steps within divisional teams. Escalation protocol under review with action plan collation based on recommendations of external review.	Jan 2026

Risks and Mitigations

- High referral volume across all pathways has significantly impacted capacity, particularly within skin. Insourcing in place, with daily huddles with booking teams to ensure patients are identified and actioned in a timely manner.
- Resource within MDT cancer services remains high risk, resulting in increased cross-cover and therefore detrimental impact on tracking and escalation of delays. Further gap anticipated within Breast services; service has not been at full establishment for >12 months.
- Impact of Industrial Action anticipated on waiting times for Urology biopsy. Demand and capacity modelling to be undertaken to reduce waiting time in template biopsy to 9 days as per best practice.

Cancer 62 Day Standard

Target: ≥70% Performance: 65.8% Position: Common Cause



Patients waiting over 62 days for treatment	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
	78	68	55	84	84	69	66	70	85	82	98	131	214	230

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

Understanding the Performance

Improvement in 62-day performance in M7, with submitted position of 65.8%. A total of 180 patients were treated against the standard with 61.5 patients breaching.

Specialties not delivering the standard in month include:

- Lower GI - 57.5% (8.5 of 20)
- Gynaecology - 57.9% (4 of 9.5)
- Haematology - 46.2% (7 of 13)
- Skin - 50% (13.5 of 27)
- Urology - 71.4% (17 of 59.5)

Breach reasons include complex diagnostic pathways, clinical delays, insufficient diagnostic, oncology and theatre capacity (including impact of Aseptics), as well as patient choice and engagement. Deterioration in performance anticipated over M8 whilst clearing waiting list backlog.

Countermeasure Actions	Due Date
• External review conducted in to existing PTL processes; positive feedback received, though recommendations are being collated into an action plan to support improve ownership of cancer within Divisions.	Nov 2025
• Revisions to existing process standard working to be supported by SWAG cancer alliance alongside clarification of roles and responsibilities.	Dec 2025
• Facilitation of FDP Cancer 360 PTL management tool in conjunction with BSW.	Jan 2026
• Confirmation that the Trust will enter NHS England 'tiering' because of deterioration in performance.	Dec 2025

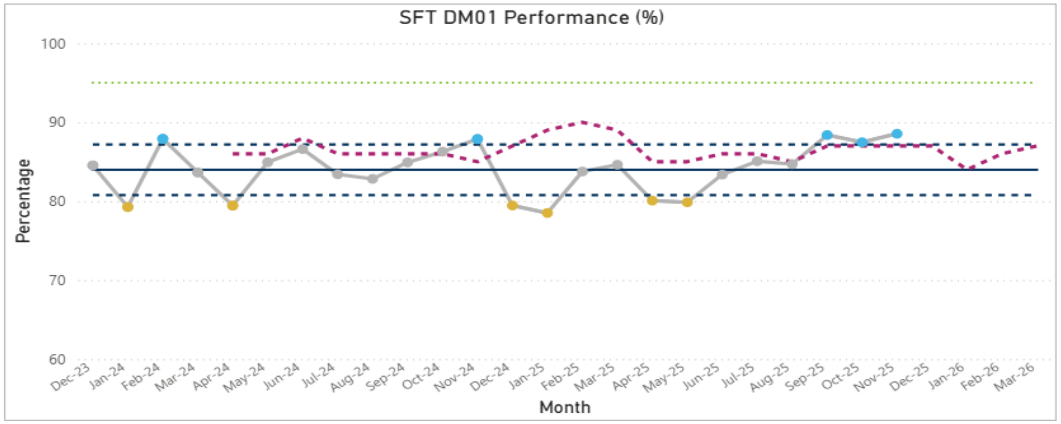
Risks and Mitigations

- Resource within MDT cancer services remains high risk, resulting in increased cross-cover and therefore detrimental impact on tracking and escalation of delays. Further gap anticipated within Breast services; service has not been at full establishment for >12 months.
- Variable ownership of cancer pathways within Divisional teams; action plan to be collated from external review to agree next steps. Session held with divisional teams in relation to roles and responsibilities.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 88.5% Position: Special Cause Improvement



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	82.1%	168	Dexa	100%	0	Colonoscopy	83.8%	41	Urodynamics	58.7%	31
CT	81.1%	115	Neurophysiology	100%	0	Gastroscopy	83.6%	51	Cystoscopy	96.2%	2
Ultrasound	98.5%	22	Echo	90.2%	25	Flexi Sigmoid	86.9%	8	Audiology	79.9%	113

Understanding the Performance

Performance against the 6-week standard increased in month to 88.5% from 87.5% last month and 1.25% above the plan position.

Modalities **below plan** are:

- MRI - 82.1% (plan of 84.7%)
- Audiology - 79.9% (plan of 85%)
- CT - 81.1% (plan of 93.1%)
- Cystoscopy - 96.2% (plan of 98.3%)
- Urodynamics - 58.7% (plan 75%)

Ultrasound has maintained a strong position for November and is driving the overall DM01 improvement. Urodynamics continue to be challenged, the variance is more extreme this month due to a planned increase in the M9 performance trajectory. Cystoscopy, although behind plan, have seen an improved performance from 83.75% to 96.2% due to additional weekend capacity. Extensive work is underway to improve Echo performance with CDC and CIU capacity expanded. New reporting is in place for individual Echo modalities and Respiratory will soon be added to reporting to ensure all tests are captured in the data.

Countermeasure Actions	Due Date
• Discussion with Nuffield re outsourcing for Cardiac CT, long term business case being written to include an additional (3rd) CTCA list at SFT.	Dec 2025
• Insourcing continues in all imaging modalities with quarterly review.	Mar 2026
• Urodynamics - Referral pathway to be reviewed and redesign of referral pro-forma. CNS lists to be stood up in December. Functional Reconstructive and Neuro-urology Consultant Business case approved and awaiting recruitment.	Dec 2025
• Continued focus on Audiology administration processes and digital optimisation.	Dec 2025

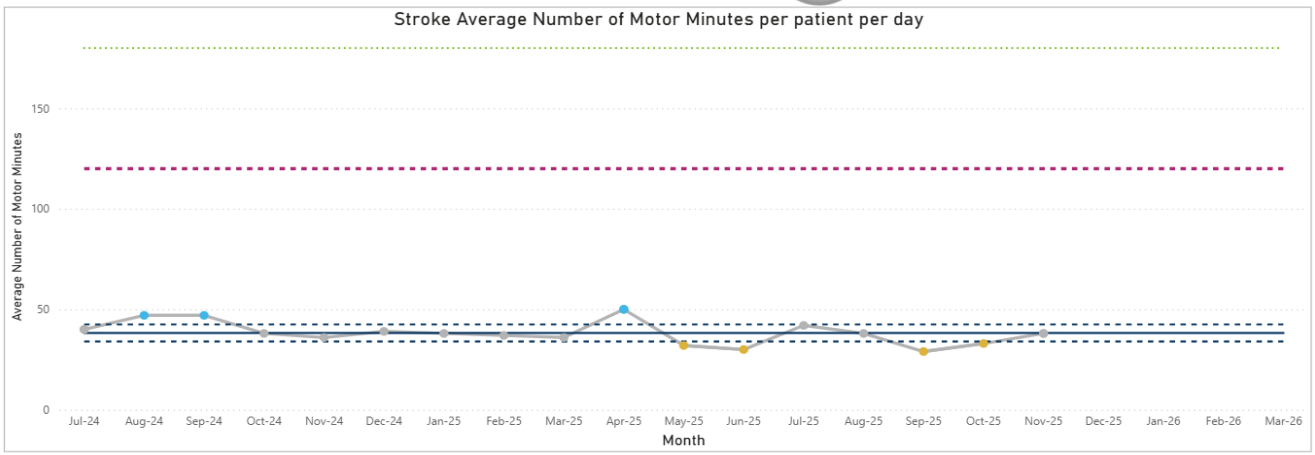
Risks and Mitigations

- Weekly delivery group tracking performance across all modalities.
- Capacity remains reliant on in house overtime / bank to meet demand for Radiology.
- Specialist Audiology capacity to include some weekend working and locum extension.
- Urodynamics - Intensive support to urodynamics booking team and CNS led lists to commence December.
- Tracking Ultrasound performance as DM01 total performance is reliant on maintaining a strong position.

Stroke Care

Salisbury NHS Foundation Trust

Target: ≥180 mins Performance: 38 mins Position: Common Cause



	2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2024/25 Q2	2025/26 Q3
SSNAP score	C	C	C	C	D	E	E	E

Understanding the Performance

In M8, provision of motor minutes for patients on the Stroke pathway was 38 minutes which represents common cause variation, although is an improvement of 4 minutes from M7. This is against a target of 180 minutes which is set nationally.

Slight improvement has been challenged by a gap of 4.74 WTE in the therapy team against the required level to meet the target. The reduction in motor minute performance has subsequently resulted in the Trust's SSNAP score declining from D to E in the last quarter. The performance reduction matches a national reduction as refreshed metrics have been published.

4-hour stroke performance declined to 46% in M8 compared to 60% in M7. Largely due to the ward being in escalation. The Specialty along with the Medicine Division are currently refreshing the A3 and mitigations.

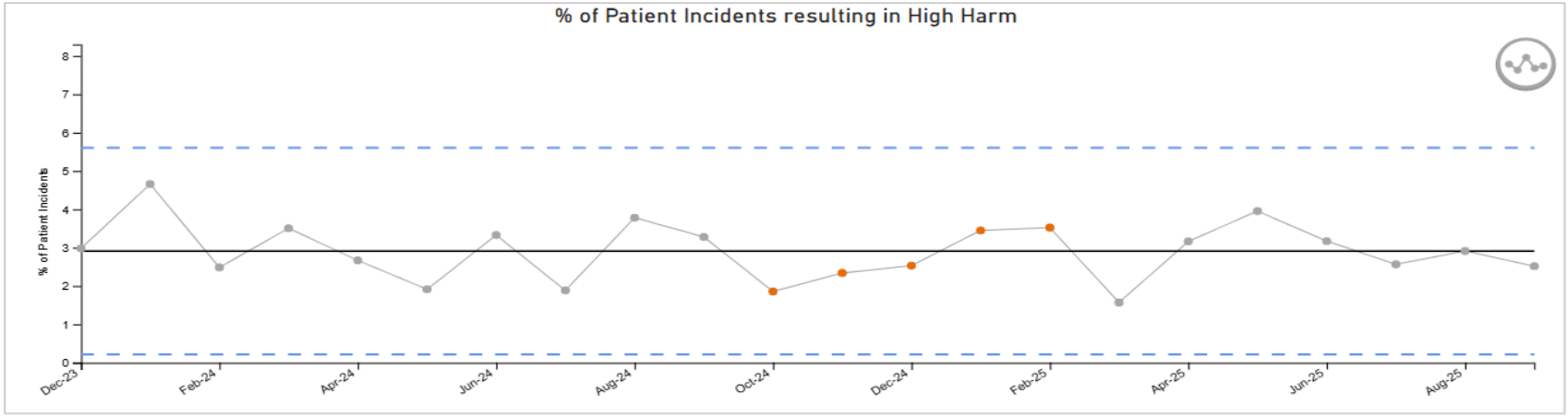
Countermeasure Actions	Due Date
• An A3 review is being be undertaken to encompass workforce and technology requirements within the Stroke Unit and understand the drivers of current performance.	Mar 2026
• To arrange 'Go and See' to other comparable Stroke Units to increase shared learning and practices.	Feb 2026
• MDT Stroke Study day to be arranged to include all new SNAPP targets and thrombolysis.	Feb 2026
• Development of Stroke dashboard ongoing, to capture performance in real time and therefore give opportunity to recognise where performance is being impacted, to enable earlier interception.	Dec 2025

Countermeasure Actions

- Key development areas include addressing workforce gaps in Therapy and Psychology to boost Motor Minutes and SSNAP scores. Workforce focus will remain a priority in the Business Service review.
- Winter pressures, especially out-of-hours and consistently being in escalation may affect timely stroke referrals and CT scanning, impacting Stroke target achievement. Ongoing review of stroke bleep holder redeployment.
- CT Perfusion Radiologists recruitment is ongoing with FASS and once established will enhance diagnostic imaging.

Incidents

Target: ≤2.5% Performance: 2.5% Position: Common Cause

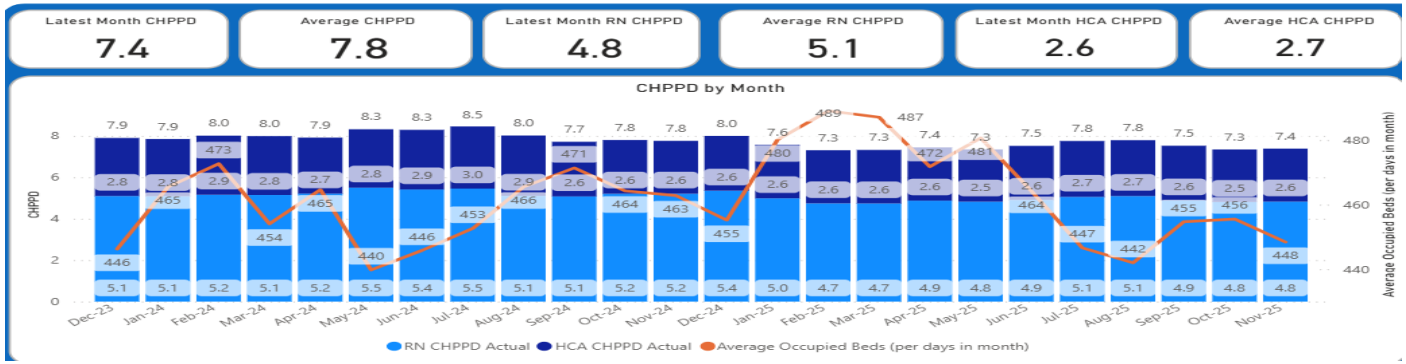


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
In September, a total of 996 incidents were reported, representing an increase of 39 incidents compared to the previous month, with 2.3% resulting in moderate or above harm. Of the 996 incidents reported in September, 816 were related to patient safety. Within this subset, 17 were reported as causing moderate harm, 1 major incident and 2 catastrophic incidents. There were 0 patient safety incidents that resulted in a patient safety incident investigation (PSII). Total number of patient safety incidents across the clinical divisions: • Medicine - 397 (318 no harm, 77 minor, 1 major, 1 catastrophic). • Surgery - 223 (174 no harm, 47 minor, 2 moderates). • FASS - 173 (129 no harm, 37 minor, 6 mod, 1 catastrophic).	The primary themes associated with reported harm in September were in relation to infection control and Maternity related incidents, therefore: • A Post Infection Review (PIR) to be carried out and reviewed at the infection, prevention and control working group. • Maternity team to undertake Patient Safety Reviews (PSR) and present at the weekly Patient Safety Summit following an MDT review and identification of appropriate learning and relevant actions.	Nov 2025 Oct 2025	During the month of September, the patient Safety Summit (PSS) addressed the following: • A total of 26 Patient Safety Reviews (PSR) were conducted with 17 cases closed with assurance and 2 cases requiring further review (mitigation). • All clinical incidents are reviewed at the morning huddle (mitigation).

Care Hours per Patient per Day (CHPPD)

NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 7.4 hours Position: N/A



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

Understanding the Performance

CHPPD for November is 7.4 and a slight increase compared to last month as shown in the chart above. This is a direct result of less patients in admitted beds at midnight and more shifts filled.

RMN usage this month has increased significantly with 1477.3 registered hours provided over the month (161 at bank and the remaining 1316.3 hours from agency). There were also 103.5 RMN hours which were not filled.

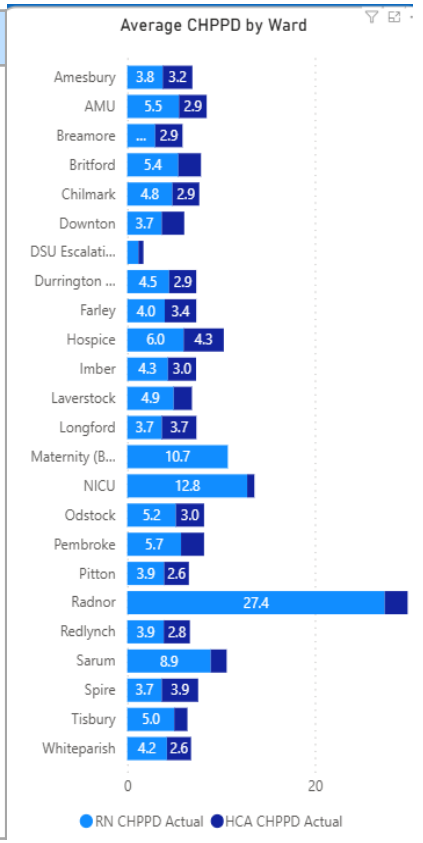
HCAs providing enhanced therapeutic observations and care (ETOC) have increased significantly also - a jump from 242 hours last month up to 1,067 hours in November. There were also 201 unfilled hours of requests for HCA 1:1 care. The increase has been due to a rise in the number of patients with specific needs which require enhanced support. There were also a substantial amount of security hours used to further support patients and staff.

There were no shifts above agency cap in November.

Countermeasure Actions	Due Date
• Additional 1:1 shifts requiring RMN or HCA can only be created by Matrons and above to ensure appropriate levels of restrictive practice, with quarterly process review.	Dec 2025
• All inpatient wards, including ICU and ED, now require Deputy Divisional Director of Nursing second-level approval for bank shifts to ensure all factors are considered before requesting temporary staff, with quarterly process review.	Dec 2025

Risks and Mitigations

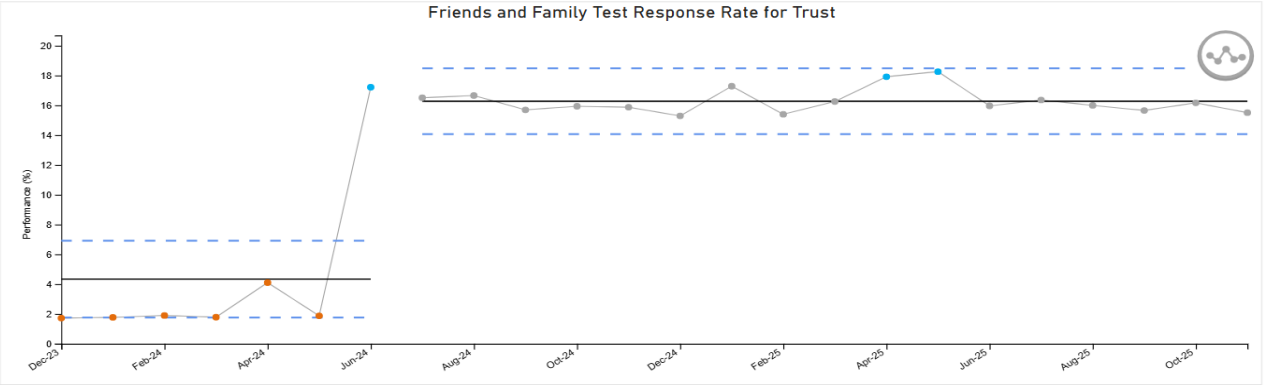
- Continued use of agency RMNs remains a financial pressure. SFT is part of NHSE's ETOC Collaborative, with an internal working group launching its first meeting later this month. The collaborative will include an NHSE site visit and a review of all policies and processes.
- HCA vacancy remain but are mitigated by the over templated numbers of RNs.
- Sickness rates remain high across most wards, with multiple daily absence calls. Increased scrutiny of backfilling shifts is ongoing, mitigated by using supernumerary and supervisory staff. This will impact completion of some managerial tasks and reduce practice educator availability.



Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: ≥18% Performance: 15.5% Position: Common Cause



Response Rate by Area	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
FFT Response Rate - A&E	21.7%	21.8%	20.0%	19.5%	21.1%	21.1%	20.2%	21.2%	20.3%	18.8%	22.2%	20.4%
FFT Response Rate - Day Case	10.1%	12.3%	9.6%	23.0%	17.0%	20.5%	14.3%	15.9%	13.9%	16.9%	18.3%	15.8%
FFT Response Rate - Inpatient	27.2%	30.2%	19.9%	34.6%	46.2%	39.3%	23.7%	30.2%	27.9%	24.5%	28.5%	21.9%
FFT Response Rate - Maternity	10.4%	10.3%	8.9%	3.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FFT Response Rate - Outpatient	14.5%	16.8%	15.4%	14.5%	15.5%	16.4%	15.3%	15.2%	15.0%	14.8%	14.9%	14.7%

Understanding the Performance

Our response rate in November was slightly decreased to 15.5% although with a slightly higher satisfaction rate of 95%. We fell ever so slightly short of our response rate target of 18% but met satisfaction rate target of 95%.

The top three themes for dissatisfaction are staff attitude, environment and waiting times. This data is reported to individual wards with an expectation that areas take these themes forward for improvements potentially as part of their Improving Together work. Reports are presented quarterly at divisional meetings ensuring senior management oversight.

It is to be noted that due to the BadgertNet upgrade we are still not surveying all Maternity patients until we have the data transferred correctly. Text messages can't be sent but manual feedback can still be captured although will be low numbers.

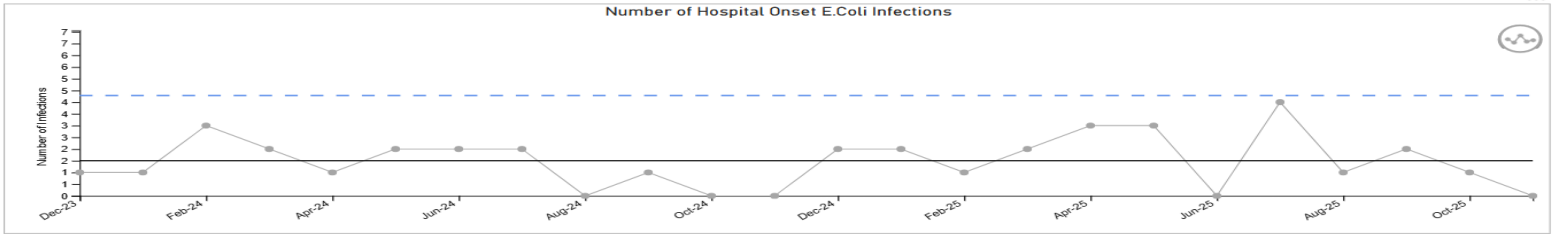
Countermeasure Actions	Due Date
• We understand that work has now commenced with Estates and that the FFT boards will be put up when they have capacity.	Mar 2026
• A new system will now need to be procured or provided internally as the currently company are ceasing their FFT product	Aug 2026
• Working with IT to resolve the issue with BadgerNet data to ensure we can capture feedback from all maternity patients.	Dec 2025

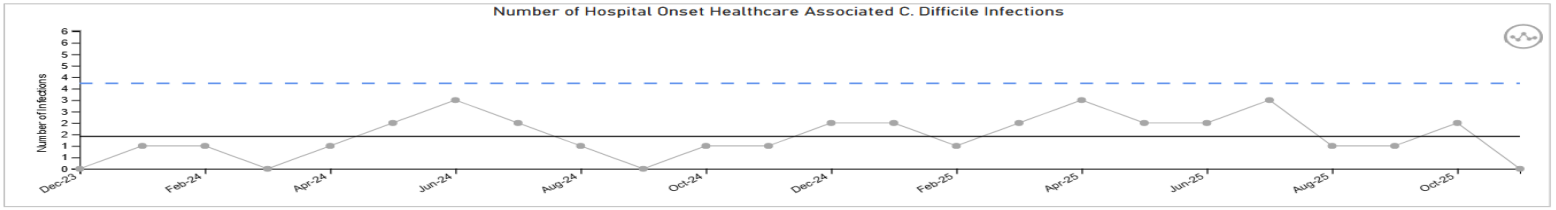
Risks and Mitigations

- Unfortunately, the future of our online system and gathering of feedback via SMS is currently being reviewed as we consider moving to a group wide process. We are still awaiting confirmation of our position moving forward given the company we are currently with (Envoy) will not be hosting an FFT platform past August 2026. Work is ongoing to ensure this risk is mitigated and replacement system sourced.

Infection Control

Target: 0 and 0 Performance: 0 and 0 Position: Common Cause





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

Understanding the Performance

There has been no Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* bacteraemia infections, compared with one last month. For HOHA reportable *C.difficile* cases, there has been no cases, compared with two last month. For Community Onset Healthcare Associated (COHA) reportable *C.difficile* cases, there has been one case, compared with two last month.

For *Pseudomonas aeruginosa* bloodstream infections (BSIs) the Trust has exceeded the threshold level for HA cases. The threshold is set at 7 cases, with 13 reported to date. For *Klebsiella sp.* bloodstream infections (BSIs) the Trust has also exceeded the threshold level for HA cases. The threshold is set at 9 cases, with 10 reported to date.

The period of increased incidence (PII) of *C.difficile* declared for Spire Ward in October was retrospectively declared as an outbreak on 10.11.25 following review of ribotyping results.

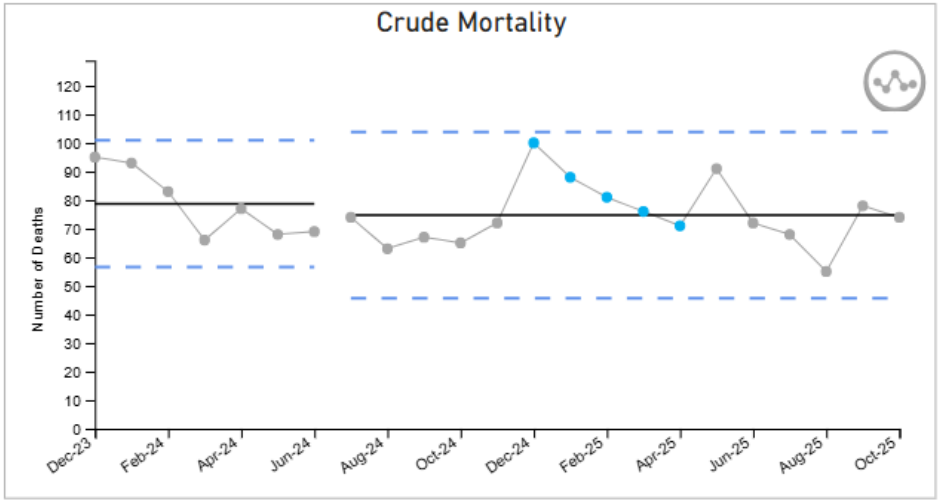
Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas / teams to identify good practice and any new learning continues with identified timeframes and quarterly review.	Dec 2025
• From reviews completed for *C.difficile,* lapses in care continue to be identified with ongoing themes. The divisions monitor those areas that have produced action plans and are required to provide updates to the IP&CWG, with quarterly process review.	Dec 2025
• Completion of Tendable inspections and specific IPC related audit work by the divisions, including commencement of peer auditing.	Dec 2025
• Review of IPC practice policies to further support staff.	

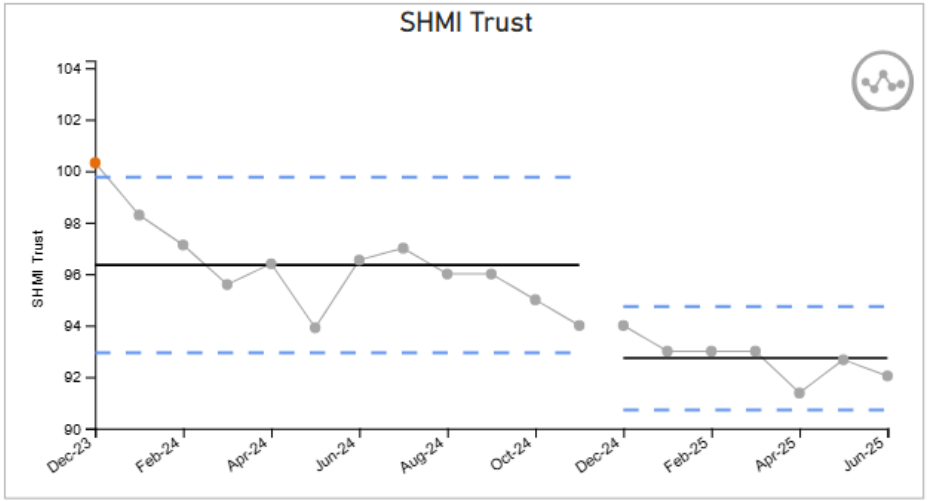
Risks and Mitigations

- Recruitment plan for Band 6 vacancy position has progressed, with the advert now authorised. Leave commitments and unexpected absence in November continues to impact IPC service provision.
- Underlying risk continues of potential increase in reportable HCAI with poor patient outcomes.
- Delays in completion of investigations and action plans by divisions to identify learning has impacted improvements in patient care outcomes.
- New WinPath system for results reporting (replacing T-Path system) continues to increase workload when processing alerts in a timely manner.
- Exceeding the NHS Standard Contract 2025/26 threshold levels set for SFT - currently for reportable *C.difficile*, the threshold is set at 21 HA cases, with 26 reported to date (14 HOHA and 12 COHA).

Mortality

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





Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in June 2025 is 0.9204 and remains statistically within the expected range. The Trust withdrew from their contract with Telstra Health U.K at the end of September 2025, and the Hospital Standardised Mortality Ratio (HSMR) is no longer being used by the Trust for monitoring mortality insights. Several improvements have been made to Trust mortality processes and reporting to mitigate any risks from the contract withdrawal, and a Power-Bi dashboard is being modified and updated to improve how mortality data is being reported across the Trust (see countermeasure actions).	• The online mortality system to support learning from deaths was launched in March last year, and activity has continued to be focused on improving reporting input / outputs from mortality reviews. • The Trust are working closely with mortality leads at RUH and GWH to improve how mortality data is being viewed and reported. Development work recently commenced to align our Power-Bi reporting across the 3 acutes. By using the same methodology, this will enable us to further improve our learning and understanding of the data.	Nov 2025 Dec 2025	• The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend to help us to interpret and analyse our mortality data and identify variations in specific disease groups. • Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken. • Benchmarked mortality data are shared via the regional System Mortality Group which included Bath, Salisbury and Swindon Acute Trusts.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	161	33	15		0		Special Cause Improving - Below Lower Control Limit	X	60
Beds Occupied %	96.3%	97.0%	96.3%	96.0%	92%		Common Cause Variation	X	3
Cancer 31 Day Performance Overall	87.6%	82.4%	90.1%		96%		Common Cause Variation	X	5
Complaints Closed within agreed timescale %	50.0%	46.0%	39.0%	85.0%			Common Cause Variation	X	60
ED 12 Hour Breaches (Arrival to Departure)	541	557	384		0		Common Cause Variation	X	60
Inpatients Undergoing VTE Risk Assessment within 14hrs %	16.5%	17.9%	18.6%		95%		Special Cause Improving - Above Upper Control Limit	X	60
Mixed Sex Accommodation Breaches	13	12	6	0	0		Special Cause Improving - Below Lower Control Limit	X	60
NEWS2 Compliance with Escalations	50.2%	48.5%	51.7%	60.0%			Special Cause Improving - Above Upper Control Limit	X	60
Number of High Harm Falls in Hospital	3	5	1	0	0		Common Cause Variation	X	18
RTT Incomplete Pathways: Total 65 week waits	3	2	2	0	0		Special Cause Improving - Below Lower Control Limit	X	7
Stroke patients receiving a CT scan within one hour of arrival	53.0%	55.0%	46.0%		50%		Special Cause Concerning - Below Lower Control Limit	X	1
Total Incidents (All Grading) per 1000 Bed Days	69	67	68				Special Cause Concerning - Above Upper Control Limit		
Total Number of Complaints Received	19	22	32				Special Cause Concerning - Above Upper Control Limit		
Total Number of Compliments Received	38	11	28				Special Cause Concerning - Run Below Mean		
Total Patient Falls per 1000 Bed Days	6.84	8.72	7.93	7			Special Cause Concerning - Above Upper Control Limit	X	2

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Performance in the Emergency Department (ED) was incredibly strong in November as noted, with watch metrics of Ambulance Handovers more than 60 minutes continuing its reduction to 15 in month and alerting positively. The number of patients waiting more than 12 hours also improved again to 384 as service model changes implemented in month - a Clinical Decision Unit (CDU) to support flow - and one implemented in October - a Send-Away clinic for evening arrival minor injuries - contributed to significant performance positions.

Patient Falls reduced to 7.93 although remains alerting negatively as above the upper control limit. Whereas the number of High Harm falls reduced significantly to 1 in month.

Cancer 31-Day performance - reporting October data - despite remaining below national target aligned with overall service recovery, increasing to 90.1% as additional capacity in the high-volume Skin tumour site positively impacted.

Bed Occupancy remains higher than national and trajectory targets at 96.3% and some way higher than November 2024 when 92.3% was reported.

Countermeasure Actions

- Reducing Pressure Injury and Reducing Staff Unavailability have become Trust Breakthrough Objectives from November, replacing Managing Patient Deterioration and Staff Retention, respectively.
- Monitoring of ED service model changes to track if improvements seen in performance are directly influenced and if they can be sustained.
- Caffeine project commenced, falls care plan and postural hypotension education delivered throughout wards in October. Review contribution to November improvements and how to maintain.
- Early Supported Discharge (ESD) team expansion will support targeted patient discharges with the aim of ensuring beds are available for those who need it most in line with Right Patient, Right Place policy and potentially improving Bed Occupancy and No Criteria to Reside levels.

Risk and Mitigations

- Critical incident / staff shortages / Industrial Action result in some areas being unable to provide 1:1 supervision for patients who need it. Poor compliance with Baywatch and falls care plans.
- Continued high attendances into ED circa 4% more than last year present an ongoing challenge.
- Suspected Skin cancer referrals are 20% above levels seen last year - seasonal pattern suggests this will reduce over Q3, but reduction not yet being seen.
- ESD team expansion only funded by the ICB until the end of Q4 so potentially need financial succession plan if proposed benefits realised.

Watch Metrics: Non-Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Diagnostics Activity	10795	10552	8865	8658			Special Cause Improving - Above Upper Control Limit	✓	0
ED Attendances	7006	6786	6822				Common Cause Variation		
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	58.3%	82.8%	83.7%				Special Cause Improving - Above Upper Control Limit		
RTT % of patients waiting less than 18 weeks for 1st Appointment	63.5%	65.3%	66.1%				Special Cause Improving - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	159	161	170	200	0		Special Cause Improving - Below Lower Control Limit	✓	0
Trust 30 day Emergency Readmission Rate	13.1%	11.5%	8.9%				Special Cause Improving - Below Lower Control Limit		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

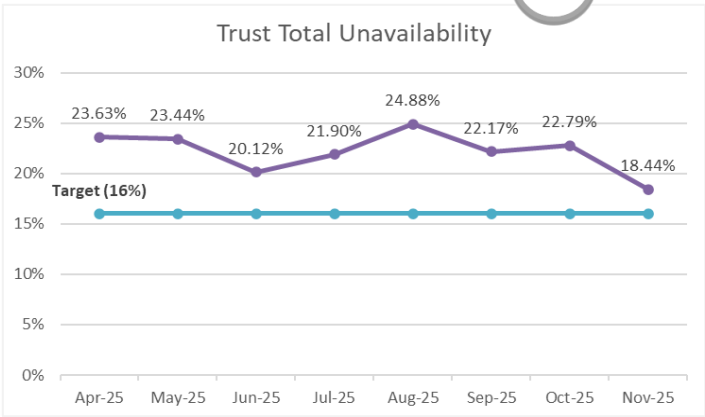
Reducing Staff Unavailability

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because…	Staff unavailability reduces the number of substantive staff able to safely deliver operational outputs, requiring unplanned use of Bank and Agency staff, as well as increased work for those staff who remain in work. This makes the workforce element of the budget unaffordable against plan, reduces performance attainment and increases the risk of poorer patient outcomes.
Baseline: 22.7% (November 2025)	Using an Improving Together A3 approach and measuring all types of leave, we are defining the areas of focus which will result in higher staffing availability and less reliance on temporary staff cover. This focus will deepen our understanding of our staffing picture across all professions.

Target: <16% Performance: 18.4% Position Common Cause



Understanding the Performance

Performance of 18.44% M8 (23.63% M1) continuing above the 16% target. Data is developing.

Temporary staffing YTD shows a variance of c£4.9M above plan, much of this variance is due to cover for staff unavailability. Highest contributor to Temporary staff spend is Medicine Division with £988,101 in month.

Staff turnover down to 12.17% from 12.38% in M7 against target of 12%. Corporate are the highest division at 13.54% and Medicine account for 136.1 WTE rolling 12 months by headcount.

Sickness rates reduced to 4% with highest division Surgery at 4.8% and highlight areas: GI Unit 7.23%, Plastics 6.96%, Surgery Management 6.9%, ICU 5%, General Surgery 5.1% and Theatres 4.92%.

Countermeasure Actions	Due Date
• Develop case study of well deployed team-based rostering.	Mar 2026
• Teams with high turnover identified work to triangulate with vacancy, temp staff usage and absence data.	Feb 2026
• Work to identify stratified data at divisional level to enable divisional support to the Breakthrough Objective (BTO).	Jan 2026

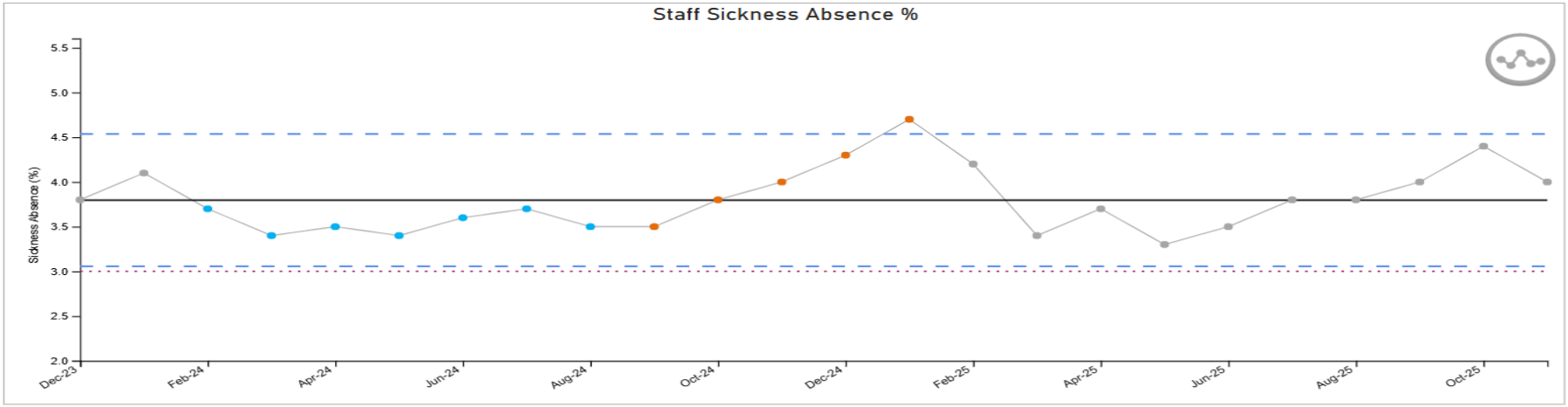
Risks and Mitigations

- An increase in national living wage from April 2026 will present further issues relating to the NHS salary awarded to Band 2 & 3 roles.
- Risks around high turnover in Corporate functions during period of redesign (and potentially lower job security).
- Operational issues of patient flow and acuity of patient condition both contribute to drive increased pressure on staff.
- This will now be the BTO tracked at the monthly Retention Steering Group.

Sickness Absence

NHS Salisbury NHS Foundation Trust

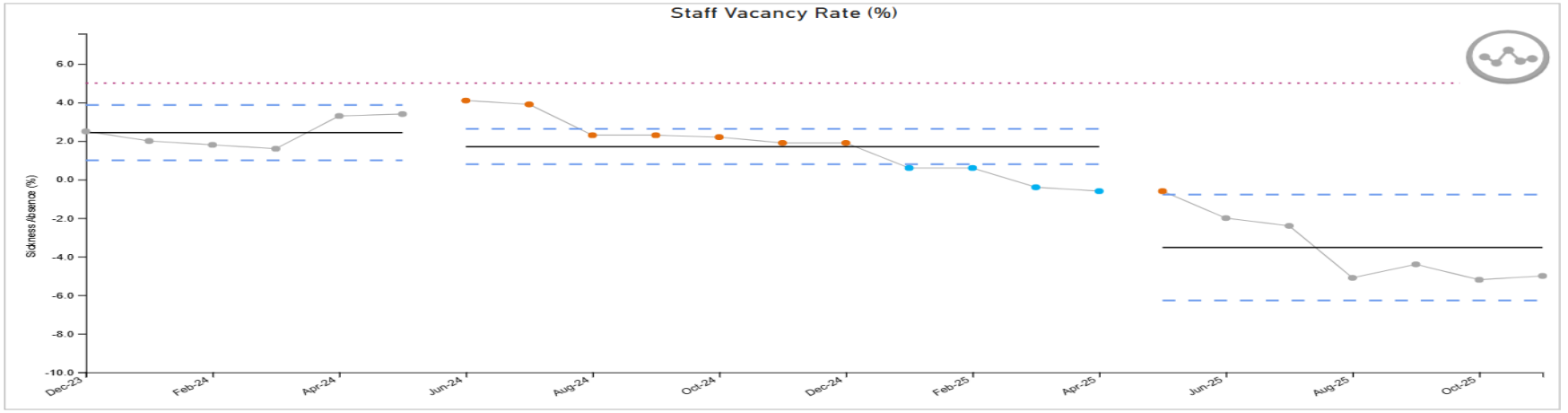
Target: ≤3% Performance: 4% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Absence has dropped to 4% (4.41% in October). This is the lowest since August. Surgery has the highest divisional absence of 4.82% (5.43% M7). Only Corporate division is below the 3% target. ACS are the highest by staff group at 6.34%. Only Medical and Dental and AHPs are below 3%. There were 930 occurrences (1170 M7). One employee has had 41 absences in 12 months, with 20 having 12 or more absences in 12 months. 5,000 WTE days taken in M8 (down 800+ from M7) with 1,307 WTE days due to anxiety / stress / depression & 863 WTE days due to cold / cough / flu. Regional absence average in Q1 is 4.5%.	• Delivery of bite size attendance management training by HR started w/c 08/12/2025. Sessions offered up until 24/12/2025. More sessions will be offered in January 2026.	Jan 2026	• Risk of inconsistency of policy application and attendance management processes due to range of management experience and training. • Risk of lack of availability of managers to attend training. • Limited number of HR advisors to support high demands of high-volume attendance cases. • Mitigation is via targeted approach to highest absence (individuals and teams) should provide most benefits to reducing overall absence levels. • Restorative approach to attendance management is hoped to enable higher attendance due to tailored support and reasonable adjustments.

Vacancies

Target: ≤5% Performance: -5% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Vacancy position continues to show a negative net figure and now -4.98% from -5.23% in M7. This is NET figure: SFT funded WTE is reducing each month to hit the year-end position as per workforce plan, however the contracted WTE remains higher than the funded hence the NET figure; this number is also including a figure set aside as 'In year management'. This potentially masks where actual vacancy numbers sit at department level. Based on the above however Nursing, Admin, Medical, ACS and AHP Staff Groups report Contracted WTE being above Funded WTE. M4 vacancy information as reported to ICS, which includes subsidiaries and hosted services show a total of 134 WTE M5 (240 WTE M4), a vacancy rate of 2.9%. Vacancy rate for South-West region is 5.5% in Q1.	• Proposed review of current vacancy control process after 3 months.	Jan 2026	• Recruitment pipeline is under external scrutiny from NHSE / Region / ICB. • New process being bedded in and resulting in longer approval timescales, this in turn may apply pressure to service provision particularly to support replacement of leavers from lower banded roles that have shorter notice periods. • Impact of Group People services review may reduce operational performance in resourcing and associated people roles during periods of consultancy and restructure likely to happen in Q4 current year and through 2026/27.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	80.5%	80.5%	80.4%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	60
Medical Appraisal Rate %	86.9%	86.8%	89.9%	90.0%			Common Cause Variation	X	4
Non-Medical Appraisal Rate %	73.8%	72.6%	71.4%		90%		Special Cause Concerning - Below Lower Control Limit	X	60

Watch Metrics: Alerting Narrative

People

Understanding the Performance

Mandatory training for M8 is almost 10% below target at 80.4% completion rate across the Trust (80.5% M7) .
The best performing area remains Facilities with 93% completion. The lowest contributors are Corporate at 74% and Surgery at 80%.
The 90% target has not been met since January 2023.

Work is continuing to update MLE records relating to Safeguarding Levels 1-3 which are currently ranging between 43-50%.

Medical appraisals rose to 89.9%. This is the highest since July, and just under 90% target. The number of out-of-date appraisals has decreased from 91 to 87, the number out of date by more than 3 months decreasing from 49 to 38.

Non-medical appraisals rates have dropped to 71.4% (72.6% M7). This is 1.6% higher than the previous September, but the lowest since February. This equates to 951/3322 appraisals being 'out of date'. The main contributors to poor appraisal rates across the Trust are Corporate at 61.7% (219 / 572 out of date) and Surgery at 66.9% (263 / 795 out of date).

Countermeasure Actions

- Education team is working to manually check/update compliance records on MLE with focus on safeguarding courses. This is planned to be completed by 24/12/2025.
- Reliance on management to undertake appraisals and complete ESR. Part of this process requires managers to sign off that employees are up to date with stat/man training.
- Non-medical appraisals are also now declining and so focus on these is required to correct the position and recover to the 90% completion rate.

Risk and Mitigations

- Inability to release staff to enable MLE completion is frequently cited as the main blocker to success.
- Completion of appraisals remains off target. OD&P delivered a new form, which improved the rate from April 2025, but this improvement has stalled despite further work to improve training and oversight of appraisals for line managers.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Staff Turnover (Trust overall)	12.4%	12.4%	12.2%	13.0%			Special Cause Improving - Below Lower Control Limit	✓	0
Staffing Availability	3.1%	3.2%	2.8%	3.7%			Common Cause Variation	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

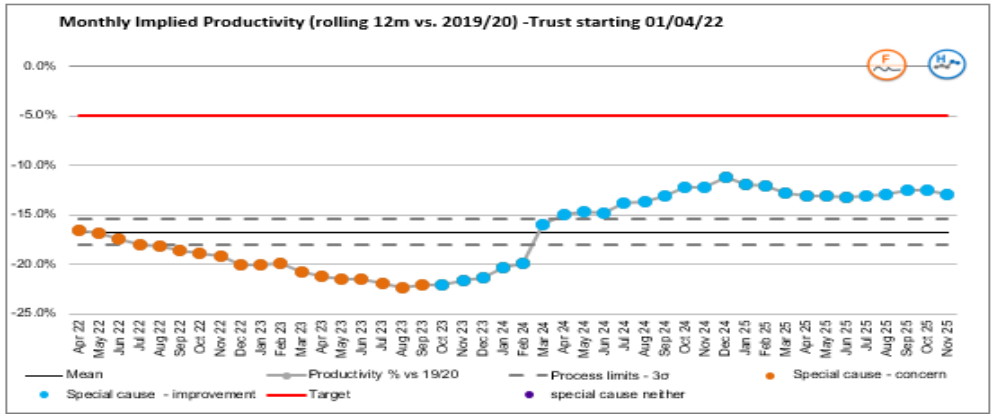
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -14.97% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services can affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: ≤-5.33% Performance: -12.98% Position H Special Cause Improvement



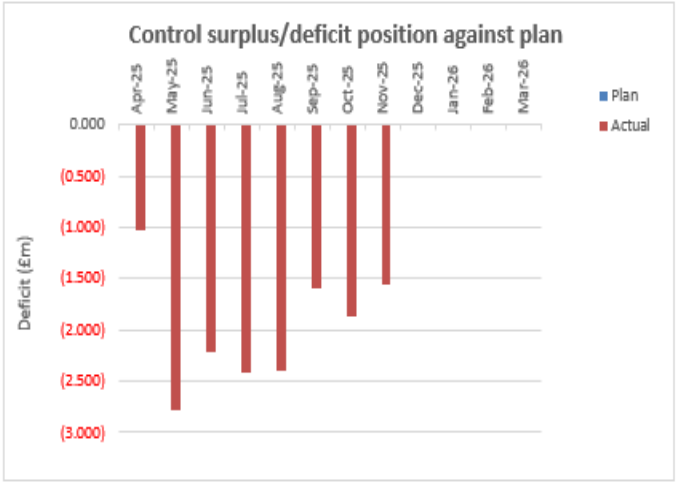
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Performance has slightly reduced in Month 8 to -12.98% from -12.56% in Month 7. High levels of inpatient activity in month but lower levels of day case and outpatient activity, alongside increased pay costs (both substantive and temporary staffing) have driven the deterioration in month. There is an improvement of 1.99% from April 2024 due to cost increases being mitigated by activity improvements across A&E, Elective inpatients and Non-Elective Inpatients 0 days. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• Detailed actions on the response to Division's productivity drivers are detailed within the A3 Productivity countermeasures and discussed at Divisional Performance Reviews.	Dec 2025	• The Finance Recovery Group and Delivery group supports the savings programme and Elective points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

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

	November '25 In Month			November '25 YTD			25-26 Plan
Operating Income							
NHS Clinical income	27,829	28,473	644	224,894	225,559	665	331,367
Other Clinical Income	1,487	1,928	441	11,327	12,033	706	21,586
Other Income (excl Donations)	3,152	3,078	(74)	26,573	25,107	(1,466)	39,984
Total income	**32,468**	**33,480**	**1,012**	**262,794**	**262,698**	**(96)**	**392,937**
Operating Expenditure							
Pay	(21,783)	(22,940)	(1,157)	(176,268)	(180,701)	(4,433)	(263,725)
Non Pay	(10,471)	(9,820)	651	(84,802)	(86,644)	(1,842)	(126,633)
Total Expenditure	**(32,254)**	**(32,759)**	**(505)**	**(261,070)**	**(267,345)**	**(6,275)**	**(390,358)**
EBITDA	**214**	**720**	**506**	**1,724**	**(4,647)**	**(6,371)**	**2,579**
Financing Costs (incl Depreciation)	(1,881)	(2,106)	(225)	(15,057)	(14,649)	408	(22,579)
NHSI Control Total	**(1,667)**	**(1,386)**	**281**	**(13,333)**	**(19,296)**	**(5,963)**	**(20,000)**
Deficit Support Funding - local	515	515		4,121	4,121		6,182
Deficit Support Funding - national	1,152		(1,152)	9,212		(9,212)	13,818
Reported Position		**(871)**	**(871)**		**(15,175)**	**(15,175)**	



Understanding the Performance

The financial plan submitted to NHS England on 7 May 2025 showed a breakeven position for the year and included an efficiency requirement of £20.9m. The plan assumes deficit support funding of £20m phased equally throughout the year. Identified efficiency schemes assumed significant length of stay reductions which will rely on effective system working.

The in-month position was a deficit of £0.9m against the breakeven plan. This position considers the fact that due to the underlying adverse variance against plan YTD, the Trust cannot access the national element of the deficit support funding.

The adverse month 8 position has been mainly driven by pay pressures due to Industrial action and staff unavailability with high levels of sickness and leave absences.

Countermeasure Actions

- Trust financial recovery plan resubmitted August 25 with actions for Trust wide departments and efficiency programmes.

Due Date

Mar 2026

Risks and Mitigations

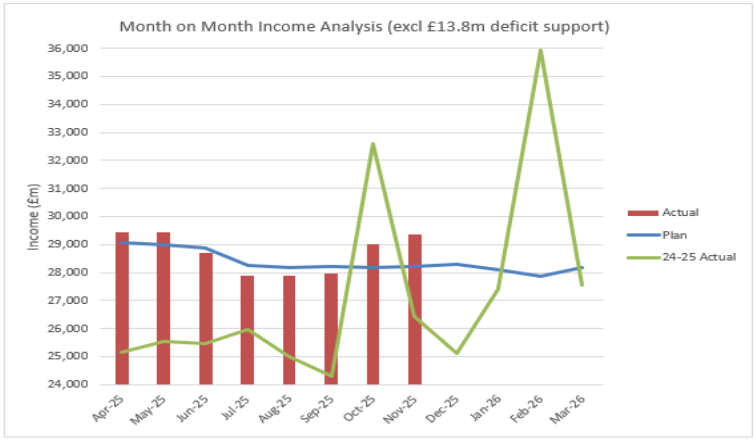
- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and system working.

Income and Activity Delivered by Point of Delivery

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

Income by Point of Delivery (PoD) for all commissioners	October Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	10,680	10,785	105
Day Case	19,393	19,165	(228)
Elective inpatients	13,122	12,192	(930)
Excluded Drugs & Devices (inc Lucentis)	20,325	22,096	1,771
Non Elective inpatients	62,291	63,559	1,268
Other	69,056	69,214	158
Outpatients	34,148	32,669	(1,479)
TOTAL	229,015	229,680	665

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	141,023	141,685	662
Dorset ICB	20,698	20,559	(139)
Hampshire, Southampton & IOW ICB	19,152	18,754	(398)
Specialist Services	32,083	31,663	(420)
Other	16,059	17,019	960
TOTAL	229,015	229,680	665



	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	53,413	54,073	660	52,787	1,286
Day case	19,170	18,726	(444)	18,462	264
Elective	2,657	2,507	(150)	2,446	61
Non Elective	20,611	21,290	679	20,654	636
Outpatients	218,076	209,640	(8,436)	200,267	9,373

Understanding the Performance

The Trust level performance is driven by lower Outpatient First attendances, Elective Inpatients and Day cases impacting on the ERF income offset by overperformance on High-cost drugs and Devices and Other points of delivery.

There is underperformance across all main commissioners, except for BSW, and overperformance on Provider-to-Provider contracts, Cross border, Channel Islands and Local authorities. Activity across the main points of delivery was lower in November than October for A&E, Day cases and Outpatients with A&E attendances on average 4 below plan per day and SWIC attendances on average 8 per day higher than October.

Countermeasure Actions

- Agreements with Dorset and HIOW ICBs are being finalised following formal dispute resolution.

Due Date

Jan 2026

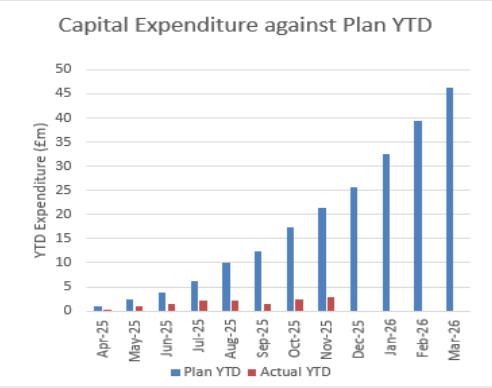
Risks and Mitigations

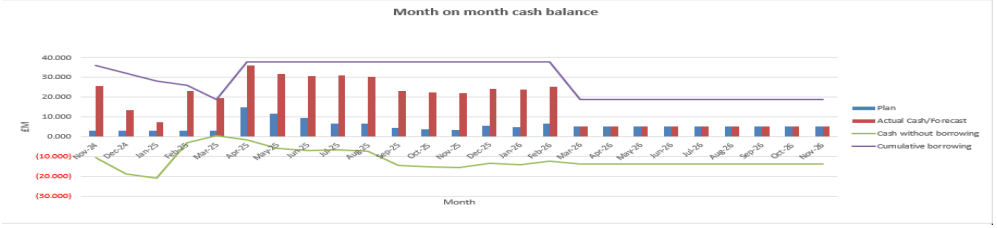
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements as outlined within the Trust recovery plan.

Cash Position and Capital Programme

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

	Closing Balance March 2025 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,520	8,326	806
Debtors	19,291	31,880	12,589
Cash	22,530	29,749	7,219
TOTAL CURRENT ASSETS	**49,341**	**69,955**	**20,614**
Creditors	(49,082)	(65,160)	(16,078)
Borrowings	(1,391)	(19,845)	(18,454)
Provisions	(590)	(553)	37
TOTAL CURRENT LIABILITIES	**(51,063)**	**(85,558)**	**(34,495)**
TOTAL WORKING CAPITAL	**(1,722)**	**(15,603)**	**(13,881)**





Schemes	Annual Plan £000s	November '25 YTD Plan £000s	November '25 YTD Actual £000s	November '25 YTD Variance £000s
Position				
CDEL Schemes				
Building schemes CIR	2,915	1,166	621	(545)
Building projects	1,392	554	426	(128)
Fire schemes	608	242	34	(208)
IM&T	5,370	1,852	1,016	(836)
Medical Equipment	3,000	1,200	225	(975)
Leases	750	750	593	(157)
Total CDEL schemes	**14,035**	**5,764**	**2,915**	**(2,849)**
National Funding				
Shared EPR - Nationally funded element	3,199	3,199	2,114	(1,085)
Estates Safety Funding Phase I	5,254	2,476	552	(1,924)
Estates Safety Funding Phase II	2,105	165	165	
25/26 Community Diagnostic Centre	12,160	3,025	137	(2,888)
25/26 Seed Funding for Elective Care Centre	5,400	4,100	396	(3,704)
25/26 Procedure room	300	200	35	(165)
25/26 Urgent Treatment Centre	7,000	2,666	2,242	(424)
Diagnostics Physiological Equipment - Audiology	200			
Diagnostics Physiological Equipment - Cardiology	40			
25-26 Reach Programme for LIMS	332			
GB Energy Solar	366		1	1
Fibroscan	150		150	150
LIMS set up costs	210			
Total National Funding	**36,716**	**15,831**	**5,792**	**(10,039)**
GRAND TOTAL	**50,751**	**21,595**	**8,707**	**(12,888)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £8.7m in Month 8. This is mainly driven by UTC, EPR and building projects. Nationally funded schemes are dependent on the successful submission of business cases, except for Shared EPR which has already been approved, and the Estates Safety Funding which has already received NHSE approval.

The cash balance at the end of Month 8 was £29.7m. The position excludes non recurrent deficit support funding but includes an additional month's contractual payment from BSW of £18.7m. BSW ICB paid 2 month's contract payments in April to mitigate the requirements for PDC support in 25/26.

Countermeasure Actions

- Due to the challenged BSW revenue position, and the subsequent loss of deficit support funding, CDEL capital schemes which are not yet in progress, or have a high-risk rating and are required to proceed, are being paused to preserve cash to support the revenue position. The same constraint does not apply to nationally funded schemes, which are cash backed. This position will be reviewed quarterly.

Due Date

Dec 2025

Risks and Mitigations

- The ageing estate, medical equipment and digital modernisation means that the Trust's capital requirements are in excess of resources. The Trust seeks to mitigate the constraint of available system capital by proactively bidding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.
- Deficit support funding in 25/26 is contingent on the system financial plan delivery which was not achieved at Month 7. The funding will be achieved if the system can recover the position by the end of the financial year. Financial recovery is of paramount importance.

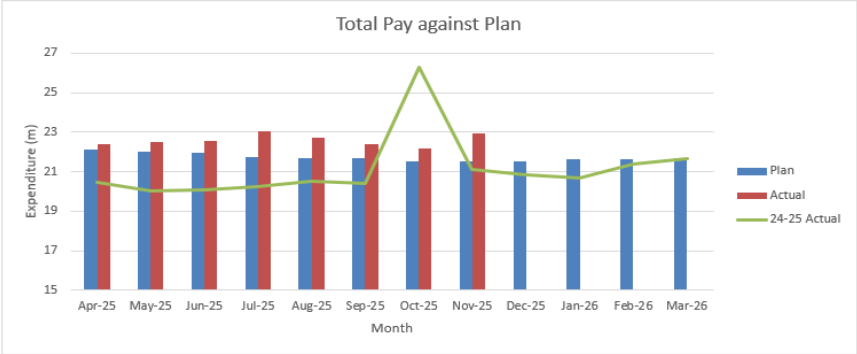
Workforce and Agency Spend

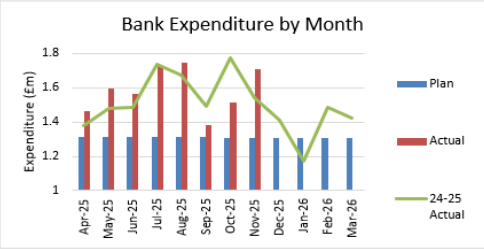
NHS Salisbury NHS Foundation Trust

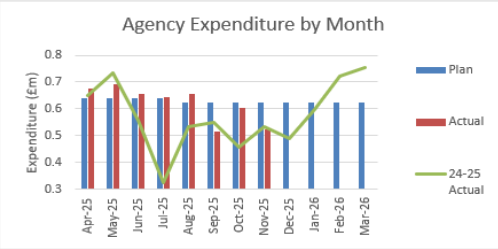
Target: N/A Performance: N/A Position: N/A

	November '25 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	162,887	162,324	563
Pay - Bank	10,428	12,711	(2,283)
Pay - Agency	2,381	4,967	(2,586)
Other (eg apprenticeship levy)	572	699	(127)
TOTAL	**176,268**	**180,701**	**(4,433)**
Medical Staff	45,738	51,954	(6,216)
Nursing	48,223	47,920	303
Support to Nursing	13,457	14,101	(644)
Other Clinical Staff	25,813	24,310	1,503
Infrastructure staff	42,465	41,716	749
Other (eg apprenticeship levy)	572	699	(127)
TOTAL	**176,268**	**180,701**	**(4,433)**

	November '25 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	571.5	608.14	36.7
Nursing	1,239.0	1,322.44	83.4
Support to Nursing	528.2	560.82	32.6
Other Clinical Staff	650.0	696.86	46.9
Infrastructure staff	1,359.8	1,368.17	8.4
TOTAL	**4,348.4**	**4,556.4**	**208.0**







Understanding the Performance

In November pay costs were £22.9m against a plan of £21.8m, an in-month variance of £1.1m leading to an adverse YTD variance of £4.4m.

The pay expenditure run rate increased by £0.8m mainly due to Industrial action costs and operational pressures related to urgent and emergency care pathways. Unavailability of staff remained high across all leave and sickness categories excluding any absences related to Industrial Action.

The WTE trajectory is a reduction from the funded establishment of 4,509 WTE in month 1 to 4,349 WTE in month 12: a reduction of 160 WTE. At month 8 there is an over establishment of 208 WTE.

Countermeasure Actions

- Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients), and oversight groups for workforce focused transformation programmes are producing countermeasures by workstream. These range from non-clinical vacancy controls, weekly temporary staffing expenditure scrutiny and bed escalation policy review to enable the planned reduction in bed numbers.

Due Date

Dec 2025

Risks and Mitigations

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

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Change Control Log 2025/26

Salisbury NHS Foundation Trust

Change	Date	Metric	Description of Change
1	01/04/2025	Elective Referral to Treatment	Revised from measuring Total Elective Waiting List in 2024/25 to Referral to Treatment (RTT) Performance % in line with national target for 2025/26
2	01/04/2025	Productivity	Revised target from -8% to -5.33%
3	01/04/2025	Elective Referral to Treatment	Watch metric of '78+ week waits' removed and '% of patients waiting less than 18 weeks for first appointment' added as a Watch metric
4	01/04/2025	Urgent and Emergency Care	Metric added for '% of ED attendances over 12 hours'
5	01/04/2025	Cancer	Cancer 31-day performance slide removed and now reported as a Watch metric
6	01/04/2025	Friends and Family Response Test Rate	Target increased from 15% to 18%
7	01/10/2025	Mortality	HSMR no longer used for reporting as contract with Telstra ended, amending metrics to only those not reported within that system: Crude Mortality and SHMI
8	01/12/2025	SPC Charts Re-based	Metrics had their SPC charts re-based due to months of continuous special cause improvement: Reducing Time to First Outpatient Appointment, Optimising Beds, Use of Temporary Escalation Beds and ED Escalation, Elective Referral to Treatment, Cancer 28-Day Standard, Cancer 62-Day Standard, Mortality, Vacancies

Appendix

Change Control Log 2025/26

Salisbury NHS Foundation Trust

Change	Date	Metric	Description of Change
9	01/12/2025	Breakthrough Objectives Revised	Revised in quality from *Managing Patient Deterioration* to *Reducing Presure Injury* and in people from *Increasing Staff Retention* to *Reducing Staff Unavailability* as both previous objectives have seen common cause variation in performance close to targets since launch in April 2024 and April 2025 respectively, redirecting focus to other key drivers.

Appendix

Business Rules – Driver Metrics

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

NHS Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

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

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

Appendix

Reading a Statistical Process Control (SPC) Chart

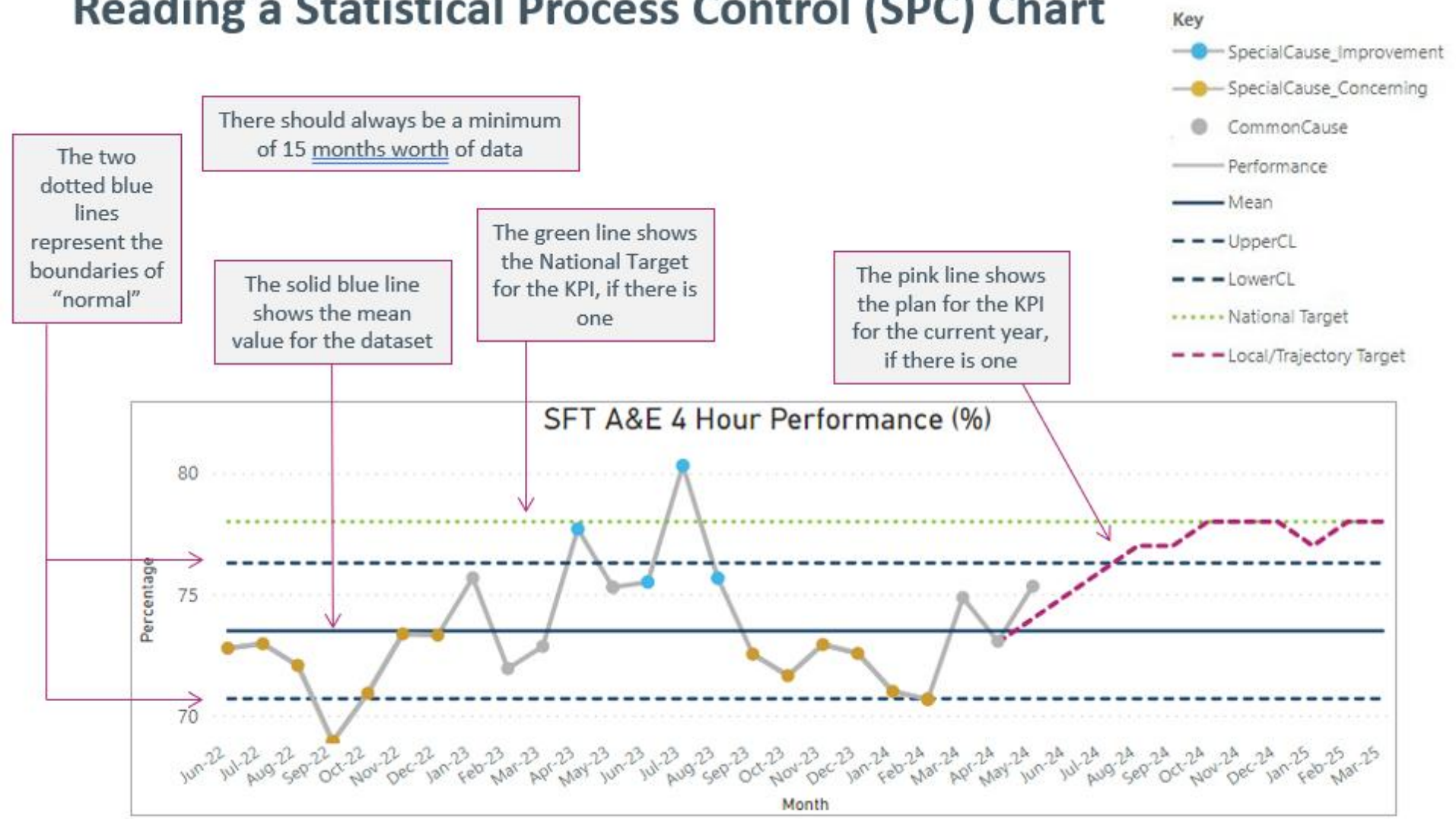
There should always be a minimum of 15 months worth of data

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

The solid blue line shows the mean value for the dataset

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

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



Report to:	Council of Governors	Agenda item:	3.2
Date of meeting:	23 February 2026		

Report tile:	Finance Report Month 10 Appendix 1 Aged Creditors and Debtors M10 Appendix 2 University Hospitals Southampton NHS Foundation Trust Aged Creditors and Debtors M10			
	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Lynne Abbott, Associate Director of Finance Holly Racey, Associate Director of Finance			
Executive Sponsor: (presenting)	Mark Ellis, Group Risk Officer			

Recommendation:

The Committee is asked to note the financial position for January 2026. The Trust has recorded a shortfall year to date against its operating plan of £8.4m.

Full year national deficit support funding offsets the planned c£13.8m deficit but is conditional on the delivery of the planned breakeven position. NHSE has confirmed that Quarter 4 deficit support funding of c£3.5m will not be received.

Key issues to escalate to the Committee are as follows:

ADVISE – detailed financial performance is highlighted within the report on the following areas:

- Pay costs are £225.1m against a plan of £219.9m - an adverse variance of £5.1m. In Month 10 the position increased due to the maintenance of activity levels throughout the critical incidents and high unavailability but was partially mitigated by the capitalisation of a group of posts and better pay expenditure controls, particularly bank approvals.

  The pay savings target at month 10 is £9.1m of which £4.1m was delivered, with 54% through non-recurrent vacancies. The non-delivery was driven by delays to the planned ward closure (which closed in first week of July), unavailability of staff with sickness and parental leave above plan plus Critical incident and Industrial action costs.

  The substantive workforce, including Subsidiaries, has reduced by 51 WTE on contracted levels from March 25 although worked substantive reduced by 90 WTE.

- The year to date Non Pay position has resulted from overspends within Drugs, partially offset by pass through payments, and Clinical supplies and Outsourced healthcare driven by additional non elective activity. The position includes a non-pay efficiency target of £3.6m and £1.5m has been delivered, driven mainly by procurement savings and biosimilar usage across the Trust.

- The 25-26 efficiency target totals £20.9m. The Month 10 savings achieved 54% of the target year to date with 39% of these savings non-recurrent with the majority being delivered from vacant substantive posts. Enhanced recruitment controls are reducing substantive levels within the administrative staff group whilst workflows are

being reviewed with an objective of increasing efficiency and effectiveness and temporary staffing levels across all staff groups.

- The Clinical income position is driven by lower Outpatient First attendances, Elective Inpatients and Day cases impacting on the ERF performance and income offset by overperformance on High cost drugs and Devices and Other points of delivery. There has been overperformance across all of the main commissioners, with the exception of Dorset and Specialised commissioning, due to Elective points of delivery, High cost drugs and devices and non activity backed income streams, with overperformance on Provider to Provider contracts, Channel Islands and Local authorities.

ALERT – areas for highlighting where further actions are being taken:

- The HIOW and Dorset ICBs contract variations are progressing to signature with all issues resolved. HIOW ICB issued an Activity Query Notice on the Month 7 overperformance on Elective activity which is above their Contract envelope and an Activity Management Plan has been agreed.

ASSURE – the following areas of assurance are provided:

- Revenue cash requirements from April 25 have been supported by the timing of cash payments from BSW ICB in advance of the Cash support guidance for revenue and capital.
- The Capital programme has been revised for 2025/26 following sub group review and approval at Capital Control Group and Strategic Capital Committee with an amended approval process in place. This is to preserve cash to support the revenue position.
- Divisional recovery huddles and Delivery Group are ongoing to ensure that productivity improvements and remedial or mitigating actions are taken where appropriate with a specific focus on Day case and Elective activity and outpatient procedures recording and coding.
- Content Oversight forums have been stood up to monitor the pace and delivery of the programmatic efficiency schemes within the operational plan.
- Monitoring of staffing availability and rotas to ensure staffing in excess of funded levels are understood and acknowledged with specific focus on RMNs and patient acuity in conjunction with a review of the agency and bank rates and processes at Divisional level through the recovery huddles
- Temporary medical staff regional rates were introduced from September 2024 with monitoring of the numbers of staff in excess of the rate via Medical workforce contracts and financial appraisals undertaken. Oversight for this expenditure, and all agency expenditure within the medical workforce sits with the Medical Workforce Control group, escalating into Financial Recovery Group.
- Proactive debt recovery and recovery of outstanding contract payments active management of cash payments to suppliers to maximise available cash balances.

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

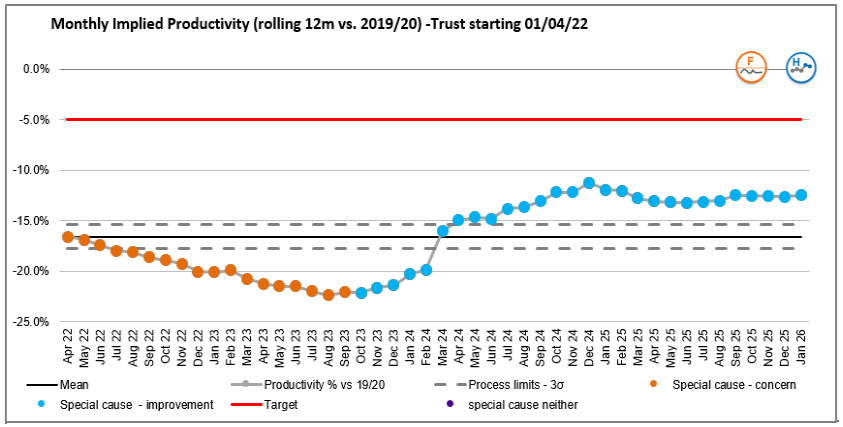
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -14.97% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services can affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: ≤-5.33% Performance: -12.47% Position Special Cause Improvement



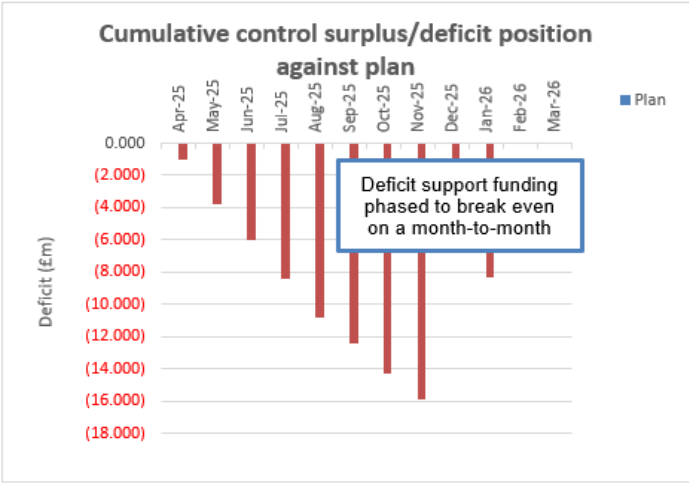
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Performance has slightly improved in Month 10 to -12.47% from -12.62% in Month 9. High levels of non-elective and elective inpatient activity in month but lower levels of daycases due to estates and operational challenges, alongside increased pay (both substantive and bank staffing) and non-pay (subcontracting costs) have driven the movement in month. There is an improvement of 2.5% from April 2024 due to cost increases being mitigated by activity improvements across A&E, Elective inpatients and Non-Elective Inpatients 0 days. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• Detailed actions on the response to Division's productivity drivers are detailed within the A3 Productivity countermeasures and discussed at Divisional Performance Reviews and Financial Recovery Group (FRG).	Feb 2026	• The Finance Recovery Group, Delivery group and Planned Care Board support the savings programme and Elective points of delivery.

Income and Expenditure

NHS Salisbury NHS Foundation Trust

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

	January '26 In Month			January '26 YTD			25-26 Plan
Operating Income							
NHS Clinical income	27,697	28,264	567	285,632	282,501	2,024	331,367
Other Clinical Income	1,459	1,773	314	14,278	15,515	1,237	21,586
Other Income (excl Donations)	3,402	2,136	(1,266)	33,127	30,444	(2,683)	39,984
Total income	**32,558**	**32,173**	**(385)**	**327,882**	**328,460**	**578**	**392,937**
Operating Expenditure							
Pay	(21,863)	(22,543)	(680)	(219,928)	(225,070)	(5,142)	(263,725)
Non Pay	(10,481)	(11,737)	(1,256)	(105,802)	(109,880)	(4,078)	(126,633)
Total Expenditure	**(32,344)**	**(34,280)**	**(1,936)**	**(325,730)**	**(334,949)**	**(9,219)**	**(390,358)**
EBITDA	**214**	**(2,107)**	**(2,321)**	**2,152**	**(6,489)**	**(8,641)**	**2,579**
Financing Costs (incl Depreciation)	(1,880)	(2,042)	(162)	(18,818)	(18,541)	277	(22,579)
NHSI Control Total	**(1,666)**	**(4,149)**	**(2,483)**	**(16,666)**	**(25,030)**	**(8,364)**	**(20,000)**
Deficit Support Funding - local	515	515		5,151	5,151		6,182
Deficit Support Funding - national	1,151	1,151		11,515	11,515		13,818
Reported Position		**(2,483)**	**(2,483)**		**(8,364)**	**(8,364)**	



Understanding the Performance

The financial plan submitted to NHS England on 7 May 2025 showed a breakeven position for the year and included an efficiency requirement of £20.9m. The plan assumes deficit support funding of £20m phased equally throughout the year. Identified efficiency schemes assumed significant length of stay reductions which will rely on effective system working.

The in month position was a deficit of £2.5m against the breakeven plan. This position considers the fact that the Trust has accessed the national element of the deficit support funding of £11.5m in Month 10, but NHSE has confirmed that this will not be available for Quarter 4.

The YTD adverse variance against plan is £8.4m and has been mainly driven by pay pressures due to the critical incident and high levels of sickness absences, non pay sub contracting costs and income reductions due to the impact of car parking VAT. The trends of temporary staffing levels and developing productivity gains will need to be addressed further in order to meet the revised forecast of £10m deficit.

Countermeasure Actions

- Trust financial recovery plan resubmitted August 25 with actions for Trust wide departments and efficiency programmes.

Due Date

March 26

Risks and Mitigations

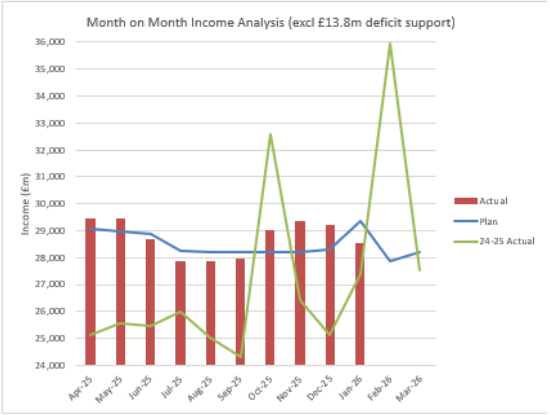
- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and system working.

Income and Activity Delivered by Point of Delivery

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

Income by Point of Delivery (PoD) for all commissioners	January Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance £000s
A&E	13,442	13,468	26
Day Case	24,094	23,709	(385)
Elective inpatients	16,490	15,433	(1,057)
Excluded Drugs & Devices (inc Lucentis)	25,460	27,294	1,834
Non Elective inpatients	78,118	79,540	1,422
Other	85,679	87,391	1,712
Outpatients	42,345	40,817	(1,528)
TOTAL	285,628	287,652	2,024

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD)
BSW ICB	187,984	188,347	363
Dorset ICB	25,828	25,761	(67)
Hampshire, Southampton & IOW ICB	23,212	23,357	145
Specialist Services	40,574	40,389	(185)
Other	8,030	9,798	1,768
TOTAL	285,628	287,652	2,024



	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	66,766	67,344	578	65,984	1,360
Day case	23,816	23,010	(806)	23,018	(8)
Elective	3,332	3,132	(200)	3,067	65
Non Elective	25,848	26,630	782	25,830	800
Outpatients	269,840	261,715	(8,125)	252,567	9,148

Understanding the Performance

The Trust level performance is driven by lower Outpatient First attendances, Elective Inpatients and Day cases impacting on the ERF income offset by overperformance on High cost drugs and devices and Other points of delivery. There is overperformance across all of the main commissioners, with the exception of Dorset and Specialised commissioning, and overperformance on Provider to Provider contracts, Channel Islands and Local authorities.

Activity was higher in January than December for Elective Inpatients and Day cases. A&E attendances were on average 7 below plan per day and SWIC attendances were marginally above plan. Day cases increased by 217 spells above December but 49 below plan due to operational and estates challenges. Non Elective Inpatients were 3 spells per day lower than in December.

Countermeasure Actions

- The contract variations for HIOW and Dorset ICBs are being progressed to signature.

Due Date

Feb 26

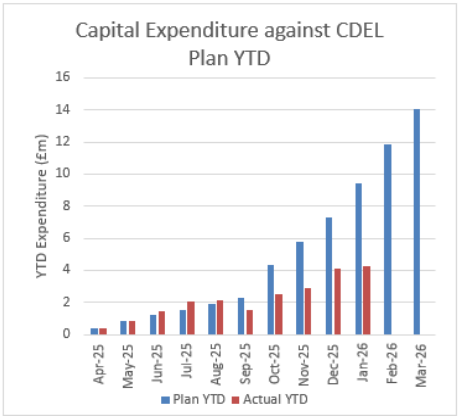
Risks and Mitigations

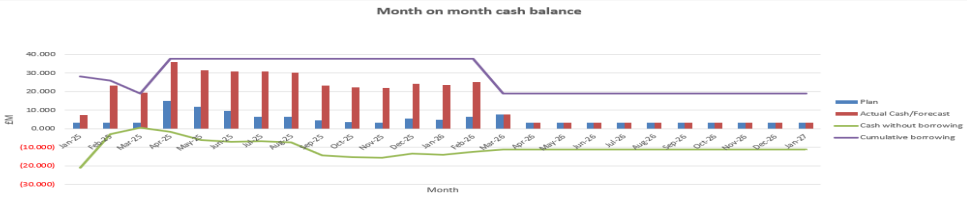
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements as outlined within the Trust recovery plan.
- HIOW ICB has issued an Activity Management Plan based on Month 7 projected overperformance. The Trust is deferring HIOW ICB Orthopaedic activity in March.

Cash Position and Capital Programme

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

	Closing Balance March 2025 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,520	8,264	744
Debtors	19,291	34,440	15,149
Cash	22,530	24,992	2,462
TOTAL CURRENT ASSETS	**49,341**	**67,696**	**18,355**
Creditors	(49,082)	(54,366)	(5,284)
Borrowings	(1,391)	(19,845)	(18,454)
Provisions	(590)	(536)	54
TOTAL CURRENT LIABILITIES	**(51,063)**	**(74,747)**	**(23,684)**
TOTAL WORKING CAPITAL	**(1,722)**	**(7,051)**	**(5,329)**





Position				
	Annual	January '26 YTD		
Schemes	Plan £000s	Plan £000s	Actual £000s	Variance £000s
CDEL Schemes				
Building schemes CIR	2,915	1,940	392	(1,548)
Building projects	1,392	926	429	(497)
Fire schemes	608	404	44	(360)
IM&T	5,370	3,433	2,401	(1,032)
Medical Equipment	3,000	2,000	406	(1,594)
Leases	750	750	593	(157)
Total CDEL schemes	**14,035**	**9,453**	**4,265**	**(5,188)**
National Funding				
Shared EPR - Nationally funded element	3,199	3,199	3,170	(29)
Estates Safety Funding Phase I	5,253	3,306	2,437	(869)
Estates Safety Funding Phase II	2,105	165	165	
25/26 Community Diagnostic Centre	12,160	6,610	132	(6,478)
25/26 Seed Funding for Elective Care Centre	5,400	4,750	440	(4,310)
25/26 Procedure room	300	300	35	(265)
25/26 Urgent Treatment Centre	7,000	4,832	3,156	(1,676)
Diagnostics Physiological Equipment - Audiology	200	104	104	
Diagnostics Physiological Equipment - Cardiolog	40			
25-26 Reach Programme for LIMS	332	187	187	
GB Energy Solar	366	1	1	
Fibroscan	150	150	150	
LIMS set up costs	210			
GB Energy (Solar) LED Lighting	228			
GB Energy Solar Energy Partnership	595			
Blood Pressure Monitors	60			
Total National Funding	**37,598**	**23,604**	**9,977**	**(13,627)**
GRAND TOTAL	**51,633**	**33,057**	**14,242**	**(18,815)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £14.2m in Month 10. This is mainly driven by UTC, EPR and building projects. Nationally funded schemes are dependent on the successful submission of business cases, with the exception of Shared EPR which has already been approved, and the Estates Safety Funding which has already received NHSE approval.

The cash balance at the end of Month 10 was £25.0m which includes Deficit support funding but this will not be paid for Quarter 4 due to the revenue position.

BSW ICB paid 2 month's contract payments in April to mitigate the requirements for PDC support in 25/26.

Countermeasure Actions

- Due to the challenged BSW revenue position, and the subsequent loss of Q4 deficit support funding, CDEL capital schemes which are not yet in progress, or have a high risk rating and are required to proceed, are being paused in order to preserve cash to support the revenue position. The same constraint does not apply to nationally funded schemes, which are cash backed.

Due Date

Feb 26

Risks and Mitigations

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

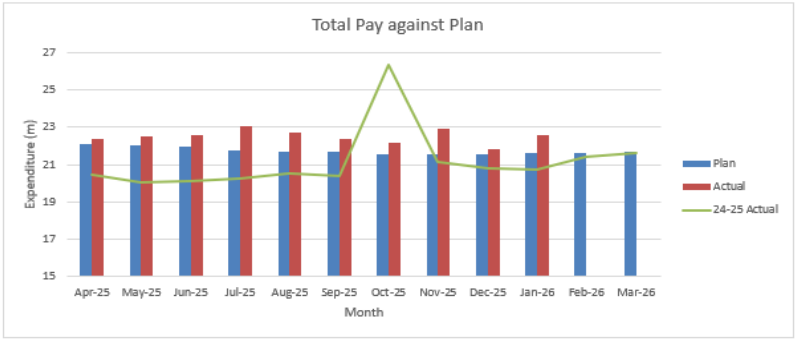
Workforce and Agency Spend

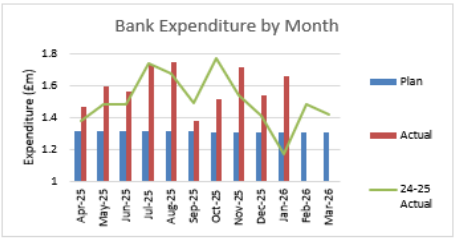
Salisbury NHS Foundation Trust

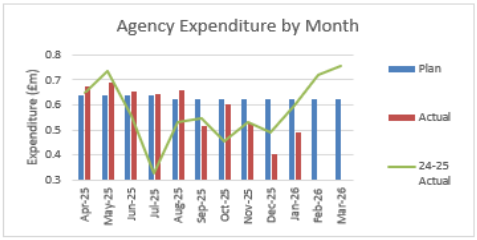
Target: N/A Performance: N/A Position: N/A

	January '26 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	203,246	202,428	818
Pay - Bank	13,002	15,906	(2,904)
Pay - Agency	2,964	5,862	(2,898)
Other (eg apprenticeship levy	716	874	(158)
TOTAL	**219,928**	**225,070**	**(5,142)**
Medical Staff	57,105	65,155	(8,050)
Nursing	60,131	59,854	277
Support to Nursing	16,769	17,576	(807)
Other Clinical Staff	32,239	30,590	1,649
Infrastructure staff	52,968	51,021	1,947
Other (eg apprenticeship levy	716	874	(158)
TOTAL	**219,928**	**225,070**	**(5,142)**

	January '26 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	570.5	591.39	20.9
Nursing	1,233.0	1,287.12	54.1
Support to Nursing	533.2	541.19	8.0
Other Clinical Staff	648.7	693.32	44.6
Infrastructure staff	1,364.8	1,325.85	(38.9)
TOTAL	**4,350.2**	**4,438.9**	**88.7**







Understanding the Performance

In month 10 pay costs were £22.5m against a plan of £21.9m. The underlying pay expenditure run rate increased by £0.7m in month mainly due to the operational pressures associated with the critical incidents.

Unavailability of staff in month improved due to lower annual leave but sickness levels remained high.

The WTE trajectory is a reduction from the funded establishment of 4,509 wte in month 1 to 4,349 wte in month 12: a reduction of 160 WTE. At month 10 there is an over establishment of 89 WTE.

Countermeasure Actions

- Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients), and oversight groups for workforce focussed transformation programmes are producing countermeasures by workstream. These range from non-clinical vacancy controls, weekly temporary staffing expenditure scrutiny and bed escalation policy review to enable the planned reduction in bed numbers.

Due Date

Feb 26

Risks and Mitigations

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

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	3.3
Date of meeting:	23 February 2026		

Report title:	Corporate Services Redesign Briefing			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process: (where has this paper been reviewed and approved):	Provide details on where the paper has been previously discussed/ approved.			
Prepared by:	Jude Gray, CPO, BSW Hospitals Group			
Executive Sponsor: (presenting)	Jude Gray, CPO, BSW Hospitals Group			
Appendices	N/A			
BAF Risk link				

Recommendation:
N/A

Executive Summary:
The purpose of this paper is to brief the Council of Governors on the Corporate Services Redesign Programme.

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

BSW HOSPITALS GROUP

NHS

Briefing – Corporate Services Redesign

One Group, One Team, One Service on behalf of many

Council of Governors

23 February 2026

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

Key messages

- As a group of local care organisations, we now have the opportunity to reduce duplication and design effective corporate services around the needs of the people who use them.
- In doing so we plan to reduce our costs by around 11 per cent, and design structures, roles and career pathways that support us to retain talent within the Group.
- Service leads, who know their areas the best, have been asked to propose what their service will look like in the future.
- A governance process is in place to ensure feedback from peers is provided to services before they are put forward for approval by the CEO, Managing Directors, and other Executives from across our Group.
- A common Managing Organisational Change Policy has been agreed with each Care Organisation's Staff side.
- Through consultation and by offering internal opportunities, we are committed to avoiding redundancy wherever possible. In areas where roles may close, it is likely that new opportunities will be created within the group, providing alternative options for affected staff. We are developing a digitally enabled redeployment process to support staff who are impacted by proposed changes.

CSR Programme: Structure & Governance

ASSURANCE

DECISION

DESIGN

FORUM	MEMBERSHIP	RESPONSIBILITIES	WHEN
BSW Hospitals Joint Committee	**Chair:** Liam Colman, Group Chair	• Receives briefings from Corporate Services Steering Group (SRO)regarding group corporate service model development and transition plans. • Seeks assurance that risks associated with corporate services, developments are appropriately defined and managed.	**Monthly**
CSR Steering Group	**Chair:** Group CEO **Members:** Managing Directors, Design SROs, CSR Programme Team	• Responsible for final sign-off for all deliverables and decision-making • Provide exec-level direction on overall ambition and design principles • Track and update on progress and key risks using standardised reporting templates	**Monthly**
Design Authority	**Chair:** Group Chief People Officer **Members:** Managing Directors, SRO's, Design Leads, CSR Programme Team	• Providing a cross-functional forum to feed into the design work, test progress, and resolve design conflicts • Provide support and oversight to the development of emerging models, ensuring appropriate application of the design principles • Review and provide recommendations of new operating model proposals for approval at Steering Group	**Monthly**
CSR Programme Team	**Chair:** Group Chief People Officer **Members:** Programme Team	• Programme Deliverables, Group CSR Coordination, Financial Baselining, Reporting	**Weekly**
Task & Finish Groups	1) Resourcing 2) Change Management 3) AlignOrg Change Partners	• **Resourcing:** Creation of digitally enabled redeployment process • **Contractual Changes:** Preparation of consultation and engagement documentation • **Design Change Partners:** Leading service re-design process in preparation for decision making routes	**Weekly**

Services in Scope

Service area	Status
People	Approved and in consultation
Finance	Approved – consultation to commence once change paper completed
Corporate Governance	Design in development
Procurement	Approved and in consultation
Digital	Approved – consultation to commence once change paper completed
Communications	Design in development
Estates &	Approved – consultation to commence once change paper completed
Strategy/Planning and Improvement	Approved – consultation to commence once change paper completed

3 further workstreams – Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer – have been paused over the winter period with collaboration to continue to take place across the three Trusts to drive improvement.

High level Timeline

Core Design Principles

Design one service on behalf of three care organisations where;

- Services are delivered once.
- Have a single set of policies, systems & processes
- Adopt digital solutions

Services must be redesigned to deliver;

- A reduction in headcount
- 11% reduction in costs
- consider the benefits across three financial years

Service design should be user-centric and requires leads to be bold, brave and take calculated risks rather than retaining the status quo

Structures, roles and career pathways will be designed to support us to retain talent and high potential employees in the Group

DESIGN
By November 2025

Actions

- Engage with allocated change partners to complete your design work
- Agree final designs with steering group

Design Principles to be met

- All services will be underpinned by single set of leaders, aligned policies, systems and processes across the Group. Each function will have a clear set of service level agreements.
- One leadership team (Levels 1 to 3 at minimum) should be in place from April 2026 for each of the 11 functions.

CONSULT
By 31st March 2026*

Actions

- Engage with your HR Business Partner and prepare for your consultation pre-engagement and launch.
- Get job descriptions prepared and send for job evaluation (factoring in lead time).
- Ensure that your consultation timeline meets statutory timescales and allows for post consultation activities (such as recruitment processes).

IMPLEMENT
By 1st April 2026

Actions

- Level 1, 2, 3 structures to be implemented.
- Services will be digitally enabled using AI where appropriate and following a self-service, efficient model of delivery.

REPEAT
On-going

Actions

Repeat each design, consult and implement stage for levels 4 and beyond

BSW HOSPITALS GROUP

NHS

Briefing – Corporate Services Redesign

One Group, One Team, One Service on behalf of many

Council of Governors

23 February 2026

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	4.1
Date of meeting:	23 February 2026		

Report tile:	Patient Experience Report – Q2 2025/26			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 25th November 2025 Patient Experience Steering Group 26th November 2025			
Prepared by:	Sophie Rolfe – PALS Lead Helen Rynne – Patient Engagement Lead Jayne Sheppard – Deputy Chief Nursing Officer			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	None			

Recommendation:

This report is for assurance and noting by the Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported during Q2 of 2025/26.

Patient Experience Feedback – Q2:

To summarise the contents of this section of the report:

Complaints/concerns/compliments and enquiries:

- Overall patient activity across the Trust has increased this quarter to 124,463 from 102,131 in Q1.
- A total of 510 comments/enquiries were logged by the PALS team in Q2, this is slightly more than the previous quarter. The top three locations these related to were Cardiology (12%), Orthopaedics (6%) and Gynaecology (5%). These top locations are the same as Q1.
- The total number of complaints and concerns also increased to 159 logged in Q2, compared to 137 in Q1. The top three most prevalent high-level themes for complaints across the Trust were largely the same as those in previous quarterly reports. Patient Care (37.7%), Communication (23.8%), Appointments (10.7%).
- Timely closure target: 85% – Achieved 52% in Q2 which is an improvement from the 40% in Q1.
- Reopened complaints: Significant increase this quarter, but year-on-year trend improving.

The PALS team and the Divisions continue to focus on early resolution and de-escalation of complaints. 57 complaints/concerns were considered to achieve an earlier resolution than anticipated. The Medicine division accounted for the highest proportion, responding to 51% of these 57 early resolution cases.

- A total of 114 compliments were recorded on Datix for Q2 which is 100 less than Q1 however there is a backlog of compliments which are still to be logged. Formal reporting still being promoted for correlation with complaints and FFT.

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Friends and Family Test (FFT) :

16,811 responses in Q2, which is 324 less more than in Q1 and equates to an average response rate of 18% (of eligible population) and meets the Trust 18% target . FFT experience ratings have stabilised at 94%, with those surveyed rating their experience of our hospital as Good or Very Good . Waiting times now top concern (previously communication).

Triangulation of data with ICB Acute Trusts:

ICB comparison: Salisbury KPI for response time not at Trust target, currently 52% vs GWH 70%, RUH 76.8%.

Themes for complaints are largely similar, communication and patient care being the top themes across all three Trusts.

FFT response rate Salisbury 16% vs GWH 32%, RUH 24%.

Positive themes for FFT are similar, with staff attitude being top. However, it is also the top negative theme. Amongst the top negative themes, waiting times are common across all three Trusts.

Local Surveys:
Real-time feedback (RTF)
continues to be a standing item for discussion at the PESG. 100 surveys completed in Q2slight reduction from 108 in Q1, average satisfaction 84.48%.

- Highest scores: Cleanliness (95%), Trust in care team (94%).
- Lowest scores: Discharge planning (14%), Staff explanations (52%).

Your Views Matter (YVM) Bereavement survey – Q2

Bereavement Survey: 143 sent, 13 responses (9% return rate). Positive feedback on communication, compassion, dignity.

National Surveys:

Adult Inpatient Survey: Response rate 51.49%; negative themes include drinks not offered, communication, staffing, discharge, noise.

Children & Young People's Survey: SFT highest in region for overall experience.

Cancer Patient Experience Survey: Overall score 9.1 vs national average 8.9; 20 positive outliers, 0 negative.

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

Patient Experience
Patient Feedback Q2 Report

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints and demonstrate that learning and actions are being taken to improve services in response to feedback.

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight into how patients experience our hospital.

Background

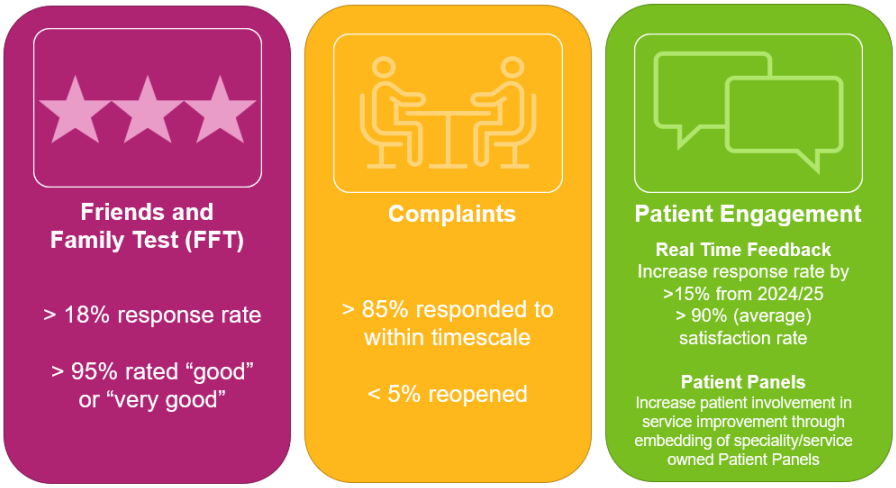
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback and in transparency and honesty on when healthcare goes wrong.

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 concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

In line with the Trust’s Improving Together Methodology and under the Patient Experience Quality Priorities approved through the Patient Experience Steering Group, the following areas remain the focus for 2025/26. Friends and Family Testing, Complaints and Patient Engagement.

Friends and Family Testing and Complaints are covered in this Patient Experience report and reported on every quarter.

Summary of the performance metrics in relation to these areas for 2025/26 is summarised below:



Salisbury NHS Foundation Trust

Contents

Patient Feedback Q2 Report

1. Complaints, Concerns and Compliments - Trust Overview

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate feedback on a per 1,000 basis within this report (see Figure 1.1). The Trust has seen a slightly higher level of patient activity, when compared with the same quarter last year.

Table 1.1 – Patient Activity

Patient Activity by Division / Quarter	FASS	Medicine	Surgery	Total
Q2 2025-26	43,561	38,821	42,081	124,463
Q1 2025 - 26	41,844	39,748	42,318	102,131
Q4 2024 - 25	36,076	36,343	43,856	121,251
Q3 2024 - 25	36,087	37, 514	44,472	123,125
Q2 2024 - 25	36,567	36,800	43,222	121,862

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment, the PALS team complete a SOX which is sent to the SOX administrator for formal recognition. Whilst compliments continue to be retained locally within the department areas, the PALS team continue to work to promote the importance of sharing these to allow for more formal reporting enabling correlation with complaints and FFT.

Complaints and Concerns

Figure 1.1 shows an overall increase in the total number of both complaints and concerns received for Q2, in comparison with Q1.

FFT feedback continues to maintain high response rates, but we are yet to meet the Trust target again this quarter.

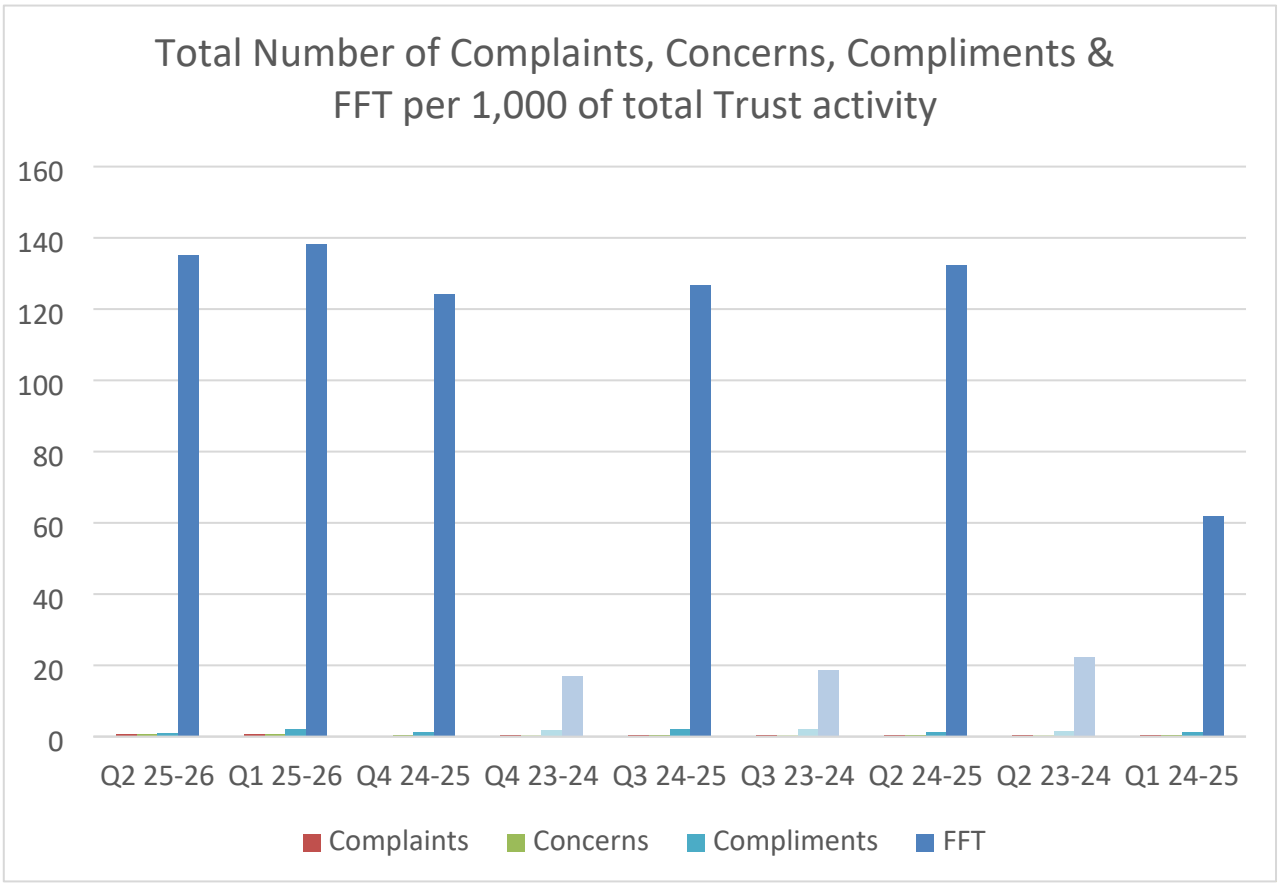
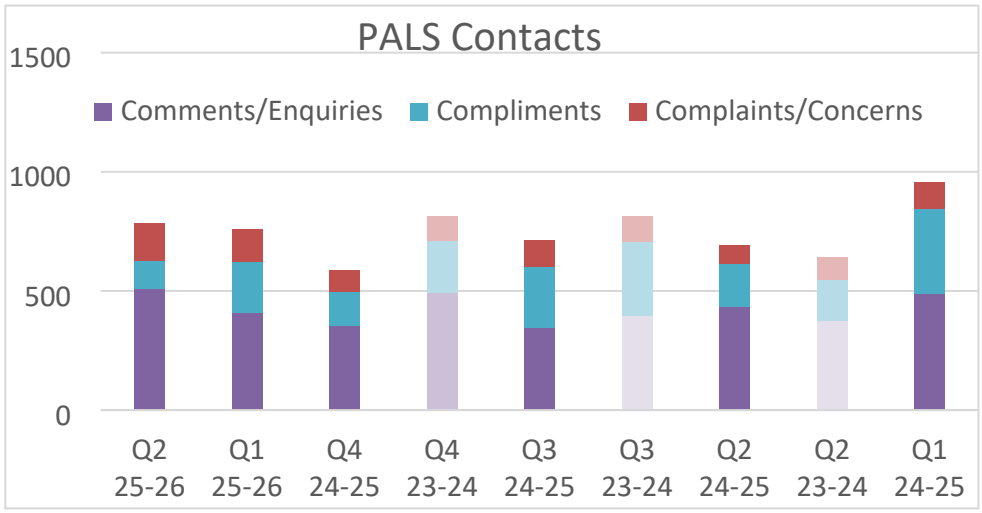


Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of Trust activity

Compliment numbers have continued to fluctuate, as we balance the continued promotion of formally recording these with PALS and the resources needed to undertake this. A total of **114** compliments were recorded on Datix for Q2 which is 100 less than Q1 however there is a backlog of compliments which are still to be logged. A volunteer is joining the PALs team soon to support with this process.

In Q2, the PALS department logged **510** comments/enquiries – 103 more than Q1 which is a sizeable increase. The top three locations these related to were Cardiology (12%), Orthopaedics (6%) and Gynaecology (5%). These top locations are the same as Q1.

This equates to an average of 4.0 contacts per 1,000 patient activity across the Trust. These contacts are in addition to the complaints, concerns and compliments.



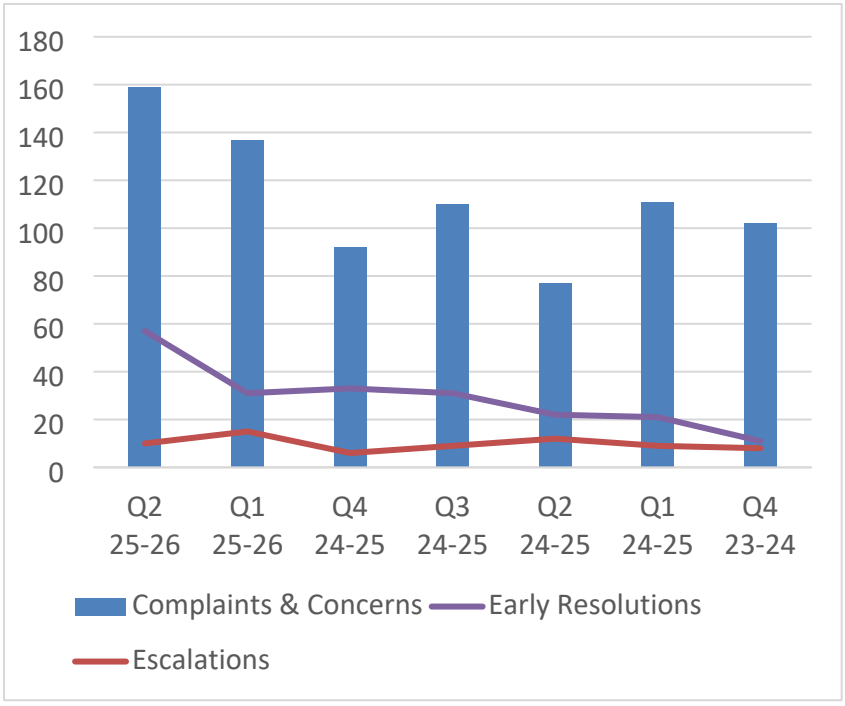
During Q2 there were a total of **159** complaints and concerns logged (137 in Q1).

The Trust has seen an overall increase in contacts this quarter.

Figure 1.1a Total Number of Complaints & Concerns, Comments/enquiries, and Compliments logged by PALS with quarter comparisons 2023/24 – 2024/25 – 2025/26

Work continues across the Divisions to promote the principles of **early resolution** of complaints.

Figure 1.1b Total Number of Complaints & Concerns, Early resolutions, and Escalations



57 complaints/concerns were considered to have achieved an earlier resolution than anticipated in Q2.

10 concerns/complaints were noted to have escalated from a comment or enquiry into a concern or complaint, which is 5 less than Q1.

Figure 1.1b shows how this correlates with previous quarters and demonstrates a steady positive trajectory of early achieving earlier resolution.

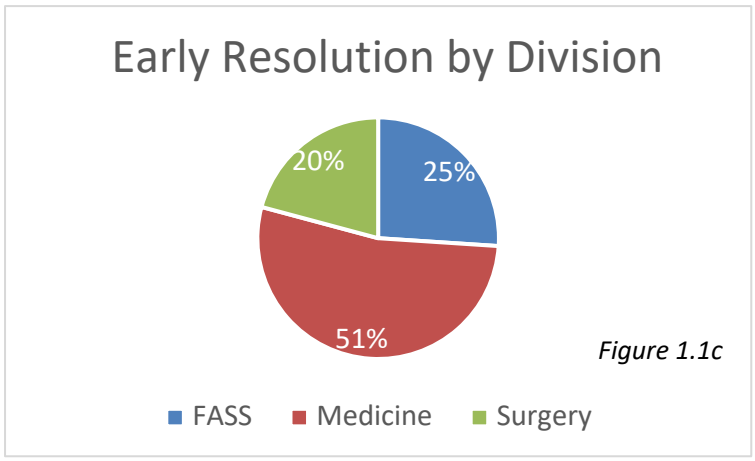


Figure 1.1c

Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.

In Q2, a total of 159 complaints and concerns were recorded, with 57 resolved through early resolution (within the first week of being sent the concern/complaint). The Medicine division accounted for the highest proportion, responding to 51% of these 57 early resolution cases.

Themes from Complaints/Concerns

Table 1.2 below shows the themes for complaints and concerns received in Q2 (Trust-wide).

Highlighted are the top three most prevalent themes: **Patient Care** and **Communication** are consistent themes with the previous quarter, along with **Appointments, including delays and cancellations.**

These top three themes are further broken down into sub-categories for deeper analysis in Table 1.2.

Table 1.2 Raw data - Themes from Q1 Complaints/Concerns

	FASS	Medicine	Surgery	Non-Clinical	Total by theme	% of total by theme
Access to treatment or drugs	1	4	10		15	9.4%
Admissions, discharge and transfers	2	4	2		8	5.0%
Appointments including delays and cancellations	2	4	11		17	**10.7%**
Clinical Treatment			1			0
Commissioning Services						0
Communications	11	15	10	2	38	**23.8%**
End of Life Care						0
Facilities Services		1			1	0.6%
Other		1	1	2	4	2.5%
Patient Care	15	25	20		60	**37.7%**
Prescribing errors		1			1	0.6%
Privacy, dignity & wellbeing	2	1			3	1.8%
Trust Administration						0
Values and behaviours (Staff)	2	4	6		12	7.5%
Waiting times						0
Total by Division	**35**	**60**	**60**	**4**		
Divisions Total	**159**					

Unsatisfactory treatment was again the highest sub-category this quarter under **Patient Care.** This was the same for the last four quarters.

Insensitive and lack of communication was again the highest causes for complaints under the **Communications** category. This was the same for the last four quarters.

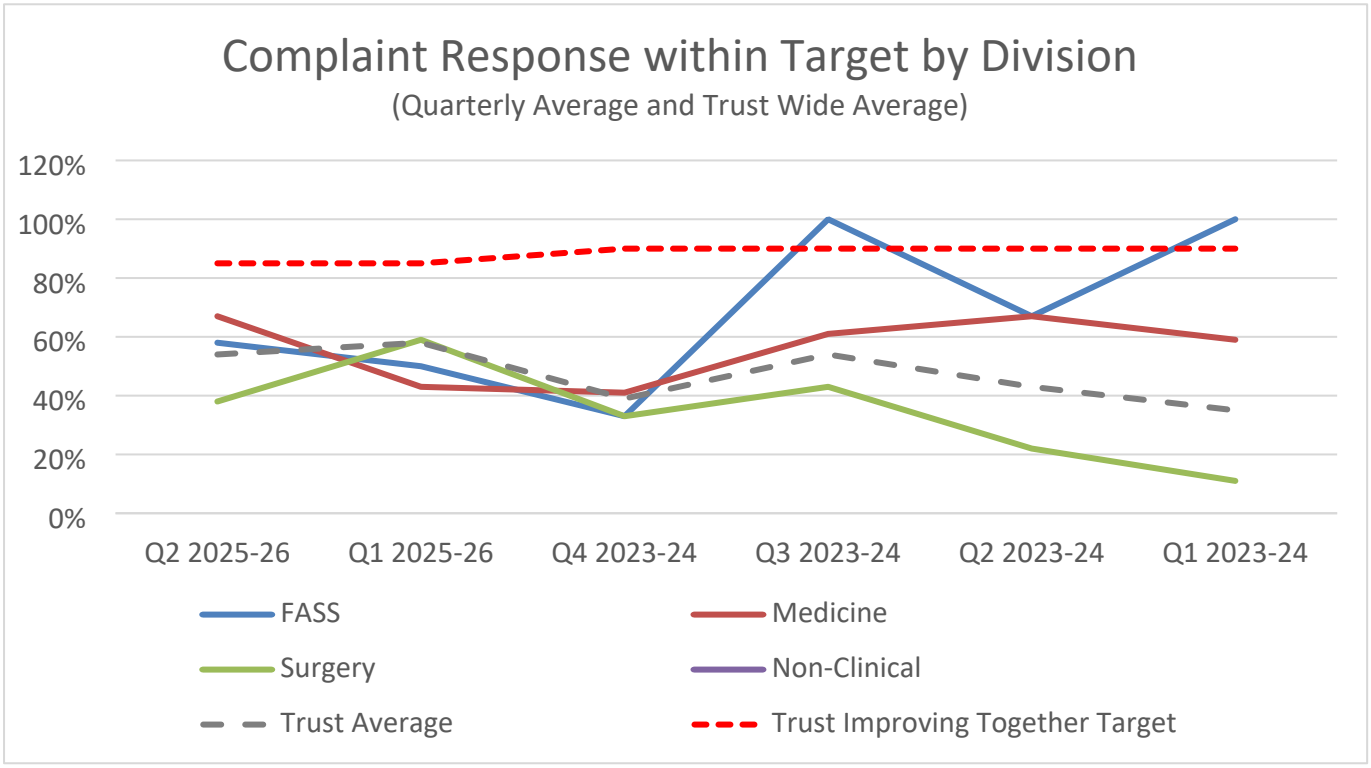
Appointments including delays and cancellations continues to be theme this quarter from Q1. **Appointment date required and appointment system procedures** feature as the highest causes under this category.

Overdue Complaints

The Trust's Improving Together Target for response to complaints within their agreed timescale for 2025/26 remains at 85%. Overdue complaints will therefore continue to be a focus for the Patient Experience Quality Priorities going into 2025/26.

Live performance data is monitored monthly via the Patient Experience Steering Group, and the tracking of this target through this forum is being demonstrated in Figure 1.3.

Figure 1.3 – Complaints closed within timescale (live, in month reporting at PESG)



There are various factors that can influence the inability to achieve the timescale for response.

PALS continue to work with individual areas to understand these challenges and to help improve processes to progress towards achieving the 85% target.

This target also continues to be monitored via the Integrated Performance Report (IPR) as a watch metric and also features in the "Our Population Helps Improve our Services" A3.

The Trust averaged a **52%** closure on target rate for complaints and concerns in Q2 compared to 40% in Q1, which is an improvement.

Reopened Complaints

Figure 1.4 – Number of re-opened complaints or concerns

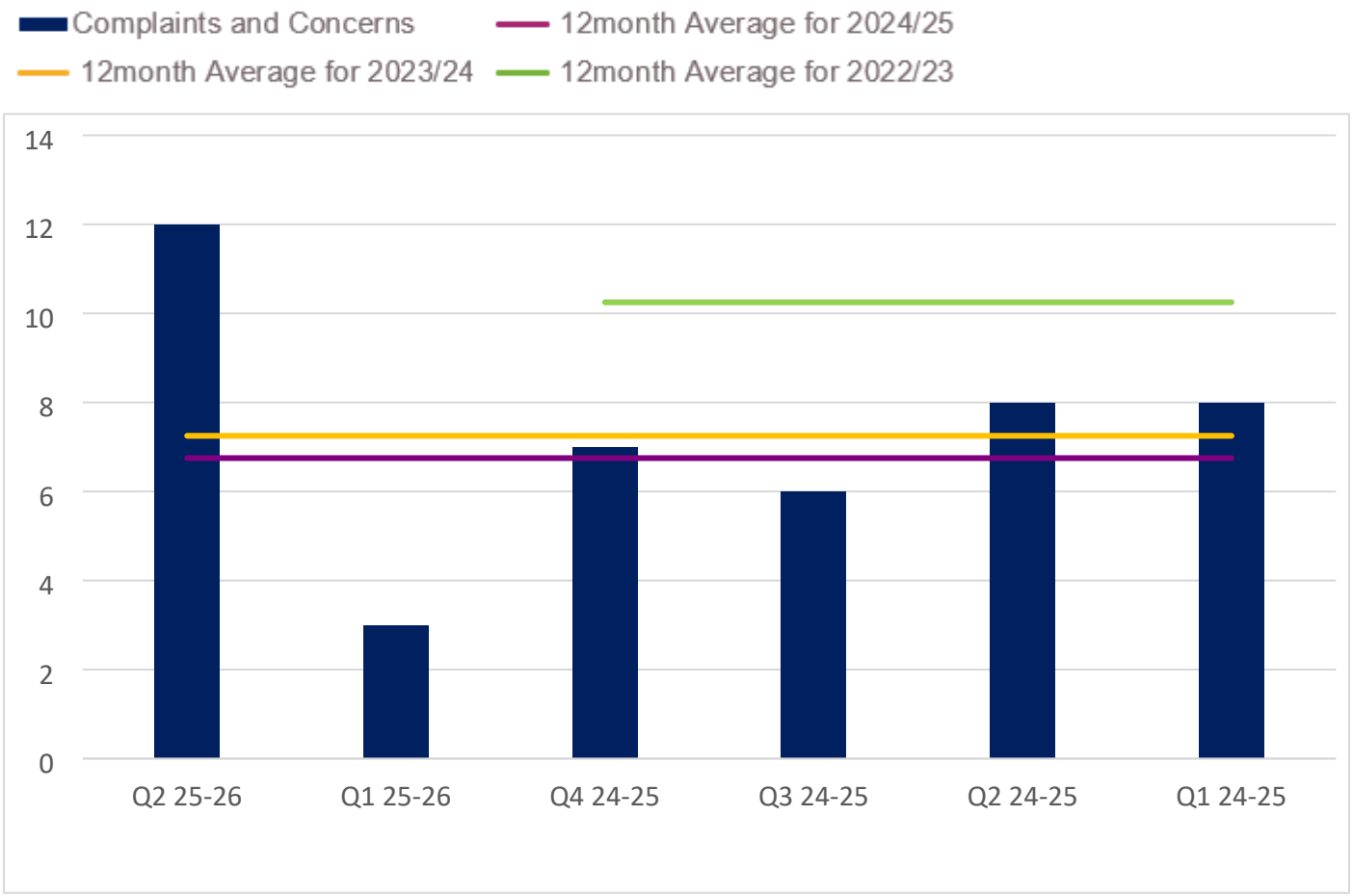


Figure 1.4 shows the number of reopened complaints and concerns (in total), compared with previous quarters. There is a significant increase noted in Q2.

The lines indicate the average number of reopened complaints for that year. This demonstrates a year-on-year reduction to the number of reopened complaints. This is indicative of an increasing success rate of first-time resolution.

2. Learning from Patient Experience

Patient Stories

July PESG: Patient Story – Chrissie's story

Chrissie attended ED with severe abdominal pain. She was diagnosed with an ectopic pregnancy. She was observed overnight but knew something was wrong. The ectopic pregnancy had ruptured badly but this was not immediately identified. She was not scanned or diagnosed until late the next morning when she then went into emergency surgery.

August PESG and subsequent Trust Board - Patient Story – Poppy's story

Poppy, a young adult had transitioned from paediatrics to adult care and the difference in how she was treated with her complex medical problems and communication issues between the different specialties was vast. She became ill with bladder problems which then escalated to no feeling in her lower body. This affected her ability to walk. Care while under paediatrics until she was 18 was very good. She then transferred to adult care and going onto an adult ward was very hard. The ward was cramped and with patients who were a lot more elderly, some with dementia. Poppy heard a patient being given a diagnosis of cancer which she found very distressing and concerning regarding lack of confidentiality. Staff assumed things about Poppy, were not interested in her and seemed too busy to care. There was no comprehensive plan of care produced. The individual care from doctors was good. Poppy was under 8 different specialties at one point but she still felt that staff were not sympathetic. They insinuated it was in her head. A lack of compassion was noticeable even from senior members of staff. There has been a lack of effective communication between departments.

September PESG: Patient story – Dave's story

Following a diagnosis of bowel cancer Dave commenced chemotherapy following an op. Unfortunately, due to side effects the chemotherapy had to stop after 4 months. A subsequent PET scan showed prostate cancer as well as a non-cancerous tumour on his bladder. Dave was invited to join the Wellbeing group run in the Trust, following his treatment for the prostate cancer and it has helped his recovery pathway enormously. The Cancer Wellbeing group has been running for nearly 10 years now. A group of 10-15 patients will be invited to attend a 6 week course covering exercise, anxiety, tiredness and sleep amongst other things. After the 6 weeks, patients are invited to carry on their wellbeing journey by attending further classes, protected swimming time and free leisure centre passes.

Patient Experience Division Presentations

The development of the Patient Experience Steering Group agenda ensures that there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q2, complaints and FFT data from Q1 were shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on what mitigations could be considered to change poor experiences and replicate those things which were being done well.

Work continues to embed the process for Divisions attending the Patient Experience Steering Group to reflect on their data and provide updates on any areas of focus which they are pursuing.

Table 2.1 – Q1 Patient Experience data presented to Divisions during Q2:

Division	Data presented to Division	Division update to PESG
Surgery	16th July 2025	29th Oct 2025 (deferred from Sept)
Medicine	8th July 2025	27th August 2025
Family and Support Services	30th June 2025	24th September 2025
Facilities (Food & Nutrition /PLACE)	3rd July 2025	27th August 2025

Table 2.2 – Q2 Patient focus groups that have taken place

Focus group	Date met	Recurring/one off
Stoma patient panel	03/07/25	Recurring 3 monthly
Spinal inpatient engagement part 1	21/07/25	One off
Learning disabilities and autism focus group	23/07/25	Recurring 6 weekly
Cancer patient panel	29/07/25	Recurring 6 weekly
Spinal inpatient engagement part 2	31/07/25	One off
Gynaecology patient panel	07/08/25	One off
Cancer patient panel	09/09/25	Recurring 6 weekly
Learning disabilities and autism focus group	17/09/25	Recurring 6 weekly
Discharge focus group	17/09/25	One off
Spinal injury research patient advisory group	25/09/25	Recurring

Table 2.3 – Q2 Patient information leaflets reviewed by our patient readership panel

Patient information leaflets reviewed	Reviewed by panel
Plasma Metanephrine Test	03/07/2025
Short Synacthen Test for CAH	03/07/2025
SST patient information leaflet	03/07/2025
Water Deprivation test	03/07/2025
Free Car Parking	11/07/2025
Early Supported Discharge Service Leaflet	18/07/2025

Novasure PIL Updated	25/07/2025
Lap BSO Patient leaflet	11/08/2025
Draf PAL Medical Cannabis	02/09/2024
Breamore ward information	12/09/2025
Self-administration of medicines in hospital	19/09/2025
Orthoptics Website link	26/09/2025
Safe Swallowing' document review.	26/09/2025
First contact with lung CNS	26/09/2025

Facilities Update to PESG (27th August 2025):

Summary of the following:

- 5 SOX received for the last 12 months
- 3 complaints received in the last 12 months
- Artcare have launched programme of events for staff.
- We have negotiated a free day for bus travel for staff.
- Catering barbecues in the summer for all customers.
- We provided free servicing for bikes; this service is available 4 times a year.
- Facilities had 32 nominations for staff awards. There are 9 finalists.
- Car park updates – we want to make parking on site for patients and visitors as easy as possible. New barriers have been fitted to prevent staff access to patient/visitor car parks.
- 13 additional blue badge parking spaces have been made available. Increasing these around the Green. Also, executive parking spaces are going to be changed to disabled bays.
- Green plan – The Trust has just published our new plan; it is now available on the intranet and Trust website. It explains how we have reduced our carbon footprint.
- Catering – all Trusts need to have digital menu. We are a bit behind and will complete the roll out by early November.
- A Theatre show has been taken around the country. This was developed in Salisbury under Artcare and has been launched nationally.
- Sustainability team – Gemma Heath picked up award.

3. Training & Development for Staff

The PALS Lead continues to work with Division leads and individual staffing groups to ensure staff understand the complaints process and the role of PALS within this.

The following training packages were delivered this quarter:

- Band 6 training – 9th July 2025
- Spinal Staff Induction – 16th September 2025

4. CQC & PHSO Complaints Summary

CQC

Concerns raised through the CQC can emit three main types of action/response:

- These can be for information only and no further action.
- These can be general action requests for assurances either related to a specific area of the hospital or particular staff group.
- These can be actions, responses or assurances related to a specific complainant's case details.

Table 4.1 Concerns received via the Care Quality Commission (CQC) – quarterly comparison

	Q3 24-25	Q2 24-25	Q1 25-26	Q2 25-26
Across all Directorates	▼2	▲6	0	0

Parliamentary Health Service Ombudsman (PHSO)

The Ombudsman investigates complaints about government departments and the NHS in England. They make the final decisions on complaints that have not been resolved by the Trust. Every complainant is advised of their option to take their complaint to the PHSO once they have received their final response from the Trust. The service is free for everyone.

In Q2 the Trust received 0 requests for further information from the PHSO.

Table 4.2a Concerns received via the Ombudsman (PHSO) – quarterly comparison

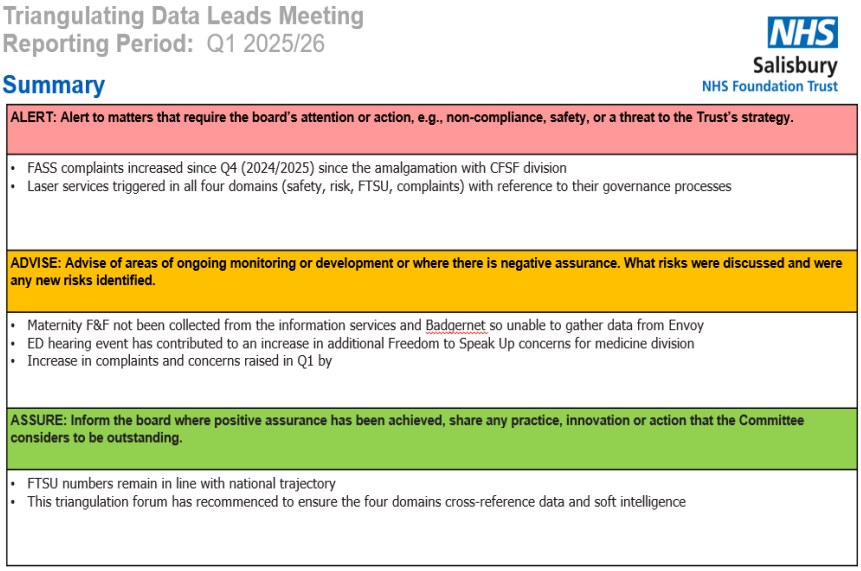
	Q3 24-25	Q2 24-25	Q1 25-26	Q2 25-26
Across all Directorates	▲2	0	2	0

5. Triangulation of data (Risk, Safety, Experience, Freedom to Speak Up)

This quarter leads from Risk, Patient Safety, Experience and Freedom to Speak Up met. This meeting reviewed data from Q1 and Table 5.1 below is a summary of the key conclusions from these discussions:

Table 5.1 Triangulating Data – Leads Meeting Summary – Q1 25/26

This is scheduled to be presented to the Clinical Management Board in November as the appropriate escalation committee for this report.
This escalation report will also be presented to the "We Are Safe and Well Committee".



Triangulating Data Leads Meeting
Reporting Period: Q1 2025/26

Summary

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.
• FASS complaints increased since Q4 (2024/2025) since the amalgamation with CFSF division • Laser services triggered in all four domains (safety, risk, FTSU, complaints) with reference to their governance processes
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.
• Maternity F&F not been collected from the information services and Badgernet so unable to gather data from Envoy • ED hearing event has contributed to an increase in additional Freedom to Speak Up concerns for medicine division • Increase in complaints and concerns raised in Q1 by
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• FTSU numbers remain in line with national trajectory • This triangulation forum has recommenced to ensure the four domains cross-reference data and soft intelligence

6. Triangulation of data – ICB Acute Trusts

The Heads of Patient Experience across the three acute Trusts (Salisbury, Bath and Swindon) are working together to create a format to compare activity and themes across complaints, concerns, compliments and FFT. A template was agreed and trialled with Q3 data. This demonstrates the following contrasts across the three acute trusts:

- PALS and Patient Experience department structure and resourcing.
- Trust KPIs for response to complaints/concerns within timescale.

Table 6.1 Trust KPIs for complaints/concerns

Trust	Complaint	Concern
GWH	25 working days	7 working days
SFT	40 or 60 working days	25 working days (5 working days for informal concerns)
RUH	35 working days or Agreed with complainant	2 working days for acknowledgement

- The Trust's compliance with these timescales.

Table 6.2a KPI complaint response target table (Q2)

	Salisbury Hospital	Great Western Hospital	RUH
Target	85%	80%	90% (for within 35 w/days)
Performance	52%	70%	76.8%

Table 6.2b Total contacts via PALS (per 1,000 patient activity) – Q2

	Salisbury Hospital	Great Western Hospital	Royal United Hospital
Total patient Activity	124,473	176,495	196,086
Number of complaints and concerns (per 1,000 patient activity)	1.27%	8.56%	3.81%
Number of total PALS contacts (per 1,000 patient activity)	4.09%	9.0%	4.41%

Themes for complaints are largely similar, with communication and patient care being the top themes across all three Trusts.

Table 6.3 FFT performance comparisons – Q2

	Salisbury Hospital		Great Western Hospital		Royal United Hospital	
	Response rate *(of eligible population)*	Satisfaction rate	Response rate *(of eligible population)*	Satisfaction rate	Response rate *(of eligible population)*	Satisfaction rate
Q2 2025-26	16.03%	93.63%	32.13%	90.2%	24.34%	93.4%
Q1 2025-26	17.00%	93.76%	37.61%	90.64%	25.22%	94%
Q4 2024-25	16.96%	93.74%	33.39%	90.27%	24.90%	94.50%
Q3 2024-25	16.13%	93.82%	28.25%	89.28%	21.50%	94.00%

Positive themes for FFT are similar with staff attitude being top. It is also the top negative theme. Amongst the top negative themes, waiting times are common across all three Trusts.

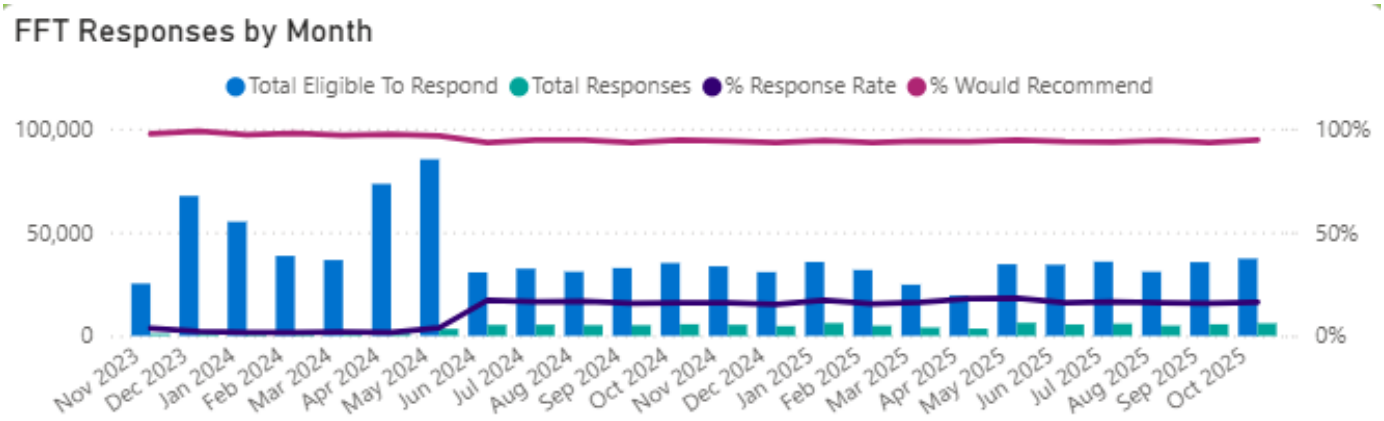
7. Process reviews, audits and policies

Nil to update this quarter.

8. Friends and Family (FFT)

Response Rates

Fig 8.1 Number of FFT responses, broken down by quarter with Trust response rate target.



A total of **16811** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q1. This is **324 less** than the previous quarter.

The future of our online system and gathering of feedback via SMS is currently being reviewed as we consider moving to a group wide process.

The overall target response rate for the quarter was not achieved now the Trust target has increased to 18%. In addition, the overall satisfaction rate has decreased below the Trust's target of 95%.

94% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q2 2025-26)

16%* Response rate (*of eligible population and averaged for Q2 2025-26)

Of the 16,811 comments received during this period the following positive/negative themes (and their proportion of these comments) are demonstrated below:

Positive

- 65% Staff attitude
- 33% Implementation of care
- 24% Environment

Negative

- 4% Staff attitude
- 3% Environment
- 2.5% Waiting time

Most of these themes are consistent with the last quarter although waiting times are one of the top negatives over communication last quarter.

Tables 8.1a and 8.1b show the quarterly comparatives for both response rates and satisfaction rates. The satisfaction rate is noted to have dropped below the Trust's target of 95, however this was anticipated due to the significant increase in sampling.

Table 8.1a Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q2 25-26	Q1 25-26	Q4 24-25	Q3 24-25	Q2 24-25
Across all Directorates	▼ 135.07 (124,463)	▲ 138.2 (123, 910)	▼ 124.25 (121, 251)	▼ 126.86 (123, 125)	▲ 132.31 (121, 862)

Table 8.1b Satisfaction rate across the (averaged from responses received)

	Q2 25-26	Q1 25-26	Q4 24-25	Q3 24-25	Q2 24-25
Across all Directorates	94% (124,463)	94% (123, 910)	94% (15, 964)	94% (16, 039)	▼ 94% (16, 123)

Progress to update all FFT boards in the Inpatient areas is still ongoing and the phase 2 rollout of the Outpatient boards has also been logged with Estates – this is on hold due to capacity issues therefore this work has not been carried out yet.

9. Patient and Public Feedback – Local Surveys

Real-Time Feedback (RTF)

The aim of RTF is to give a "real-time" view of a patient's perspective of their care.

Surveys are taken at the patient's bedside and results are sent to ward leads within one week of these being completed for reflection. Real-time feedback is not currently undertaken within the Maternity Inpatient areas or on Sarum ward.

The survey mirrors the focuses of the National Inpatient Survey and includes questions to assess the following areas: admission to hospital, the ward environment, doctors & nurses, care and treatment, operations and procedures, leaving hospital, respect & dignity and overall experience.

In Q2 a total of 100 surveys were completed – achieving an average satisfaction rating of 84.48%. This quarter has seen slightly less surveys completed to that in Q1 (n~108), and the overall satisfaction score has remained pretty much the same. See Table 10.1 for in month breakdown.

RTF is a standing agenda item presented to the Patient Experience Steering Group.

Table 9.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
July	34	11	Durrington, Imber, Laverstock, Longford, Postnatal, Odstock, Pembroke, Pitton, Redlynch, Spire, Tisbury	81.43%
Aug	34	12	AMU, Breamore, Britford, Chilmark, Downton, Durrington, Imber, Longford, Maternity, Pembroke, Whiteparish,	85.73%
Sept	32	11	Farley, Imber, Laverstock, Longford, Maternity, Odstock, Pembroke, Pitton, Redlynch, Spire, Tisbury	86.40%
Total	**100**	**34**	84.48%	

Table 9.1a Average ratings breakdown by ward (April 2025):

Area	Number of inspections	Average score
Durrington	1	78.62%
Imber	2	62.75%
Laverstock	3	96.28%
Longford Ward	3	66.03%
Maternity	4	91.55%
Odstock	3	91.51%
Pembroke	1	100%
Pitton	9	76.91%
Redlynch	3	74.83%
Spire	2	90.38%
Tisbury	3	79.78%

Table 9.1b Average ratings breakdown by ward (May 2025):

Area	Number of inspections	Average score
Amesbury	5	86.18%
AMU	2	86.23%
Breamore	2	85.03%
Britford	3	85.82%
Chilmark	3	82.22%
Downton	2	78.52%
Durrington	2	89.22%
Imber	7	86.61%

Longford Ward	1	63.81%
Maternity	3	91.02%
Pembroke	1	100%
Whiteparish	3	86.26%

Table 9.1c Average ratings breakdown by ward (June 2025):

Area	Number of inspections	Average score
Farley	2	68.32%
Imber	2	77.20%
Laverstock	3	78.24%
Longford Ward	3	81.14%
Maternity	3	86.33%
Odstock	4	87.79%
Pembroke	2	90%
Pitton	5	90.53%
Redlynch	2	92.73%
Spire	3	92.84%
Tisbury	3	96.30%

Tables 9.2 and 9.3 shows the breakdown of average response to specific questions (highest and lowest).

Table 9.2 highest scoring questions:

Question Text	Answer score (% good)	Responded Answers
How would you rate the cleanliness of the ward you are in?	95%	100
How would you describe the trust and confidence you have in those involved in your care?	94%	98
How would you rate the cleanliness of the toilets and wash facilities	88%	92
How would you rate the level of privacy when being examined or treated?	87%	97
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	82%	61

Table 9.3 lowest scoring questions:

Question Text	Answer score (% poor)	Responded Answers
How well have the medical staff explained things to you?	52%	21
How well did the staff explain how you might feel following your operation or procedure? (for example any scans or bloods being taken)	25%	8
How would you describe your understanding or involvement with your discharge plan?	14%	83
How would you describe the quality and selection of dietary options available to you?	5%	99

Again, there are notable consistencies with last quarter in relation to negative themes around involvement with discharge plans and staff explaining things in a way that can be understood. A patient focus group around discharge has taken place to address areas for further improvement and we hope to have an update on this for the next quarter.

Your Views Matter (YVM) Bereavement survey – Q2

The Your Views Matter (YVM) Bereavement survey was established in 2020 and was relaunched in April 2025 after being replaced by a National NACEL Quality Bereavement Survey from 2024-2025 to allow for national benchmarking. The YVM survey was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives can name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

The surveys are sent out by the Bereavement suite via an email link alongside the release form (the day after the pts death). There are 3 survey links which include ED, Hospice and the acute trust. The ED and Hospice are new areas for SFT to receive feedback from.

Currently, due to staffing pressures within the bereavement team, if there is no email address or the patient has been referred to the coroner then a survey is not sent (this only occurs in a small percentage of families).

The end-of-life lead nurse is looking to improve the process by enabling families/loved ones to receive a bereavement survey and by providing support in completing and returning them to increase response rates.

During Q2 there was 158 deaths in the Acute Trust and 43 in the Hospice. **143** surveys have been sent via email from the bereavement team to families/loved ones. 13 surveys have been returned, 10 from the Acute trust, 3 from the Hospice and none from ED. (9% of the total sent returned).

Key themes identified:

Communication good or very good – 10/13 (77%)

Compassion good or very good – 11/13 (85%)

Privacy and dignity good or very good – 12/13 (92%)

Timely access to pain relief good or very good – 9/13 (69%)

Overall, how would you rate the care and support provided for your loved one good or very good 11/13 (85%)

Other Improvements:

There was some feedback from a family regarding sympathy cards not being completed and then given to relatives blank.

- An audit was completed on the nursing record of death (NRD) documentation, and it identified that all wards were working differently regarding phoning GPs and sending copies of the NRD to bereavement
- From this we sent out our quarterly newsletter with updates on new processes and ensuring staff are aware to complete the sympathy cards.
- We EOL time continue to adapt their education and training study days to reflect concerns/complaints that have come through PALS.

EOL Care – Correlation with Complaints

There was a total of 159 complaints/concerns logged during this period, of which 0 were related to end-of-life care.

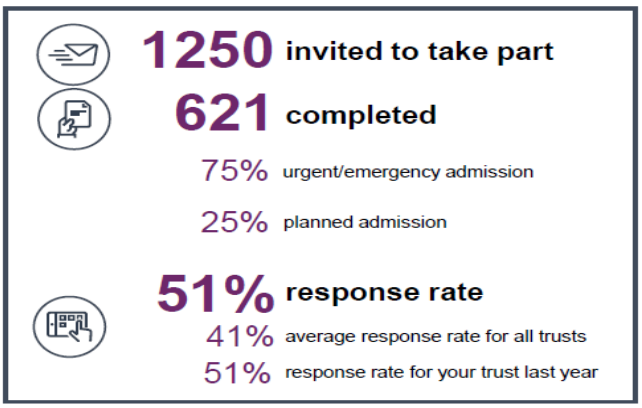
10. Patient and Public Feedback – National Surveys

Adult Inpatient Survey 2024

We have now received and reviewed the 2024 survey

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51.49%.

Matrons are focused on the main areas of concern and action plans are in place.



Positive themes

- Care and general treatment
- Staff
- Hospital/ ward stay

Where patient experience is best

- ✓ **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving
- ✓ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- ✓ **Leaving hospital:** Staff telling patients who to contact if worried about condition/treatment after leaving hospital
- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival

Negative themes include:

- Communication / information giving by staff
- Insufficient staff
- Discharge process/information
- Noise and disruption

Where patient experience could improve

- **Information while on virtual wards:** Patients feeling they were given enough information about care and treatment on virtual ward
- **Waiting list:** Length of time on waiting list before hospital admission
- **Information while on waiting list:** Quality of information given while on waiting list
- **Drink:** Patients getting enough to drink
- **Help when needing attention:** Patients being able to get help from staff when they need attention

These themes were noted to have some correlations with the Trust's Real-Time Feedback themes captured over the past year. Particularly in relation to noise at night, discharge process and communication.

The Trust scored worse than expected for 3 questions compared with all other Trusts:

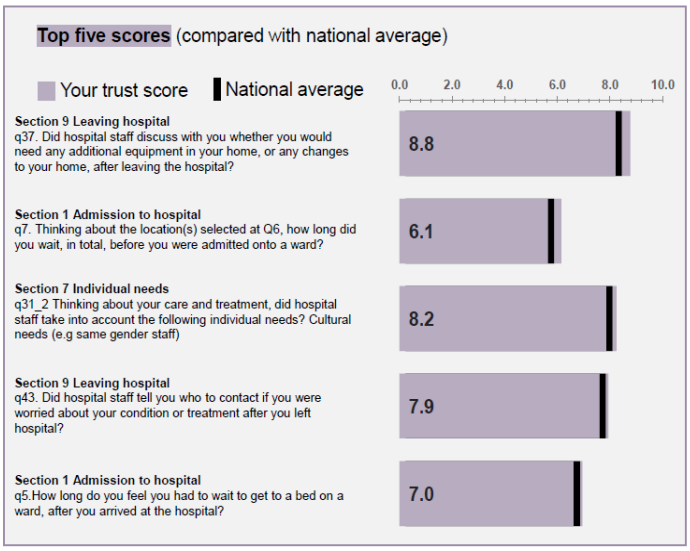
- During your time in hospital, did you get enough to drink?
- When you asked nurses questions, did you get answers you could understand?
- Were you able to get a member of staff to help you when you needed attention?

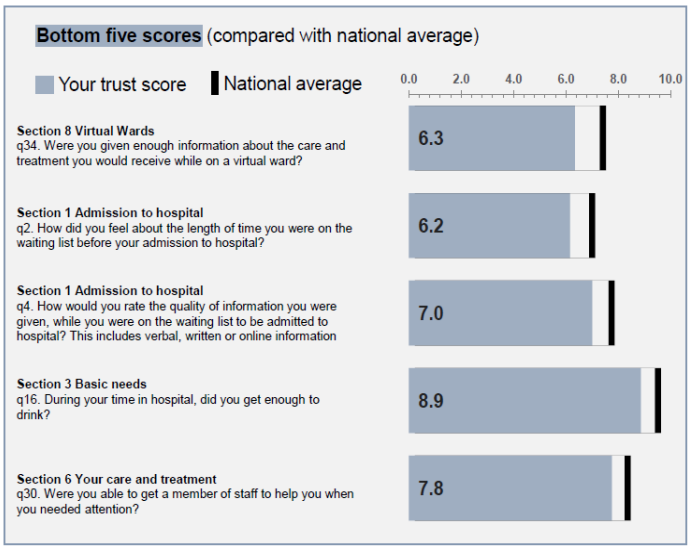
All other 43 questions were scored comparatively the same with all other Trusts.

Our results this year were significantly worse than our 2023 survey results, for 5 questions:

- Getting enough to drink
- Able to get the answers you could understand, from nurses
- Ability to get medical staff to help when attention was needed
- Overall feeling of being treated with kindness and compassion

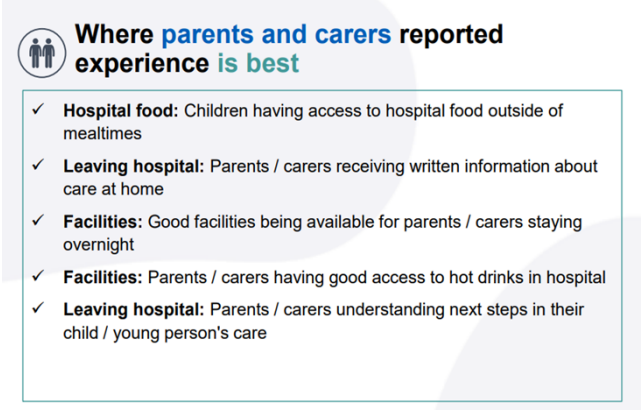
- Overall experience whilst in hospital

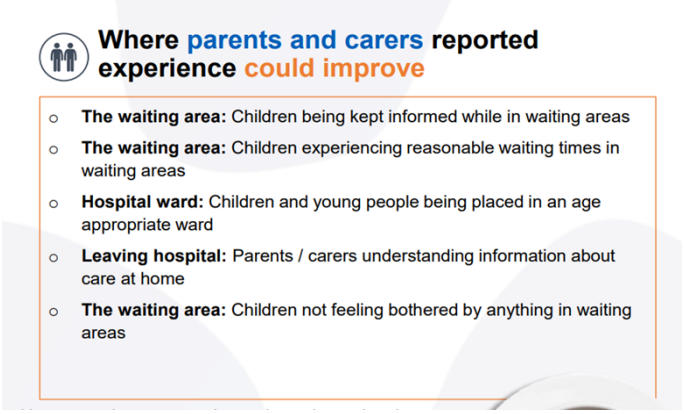




National Children and Young People's Survey 2024

Children and Young People's Survey 2024 reported that SFT are scoring as the highest Trust in our region for overall experience.

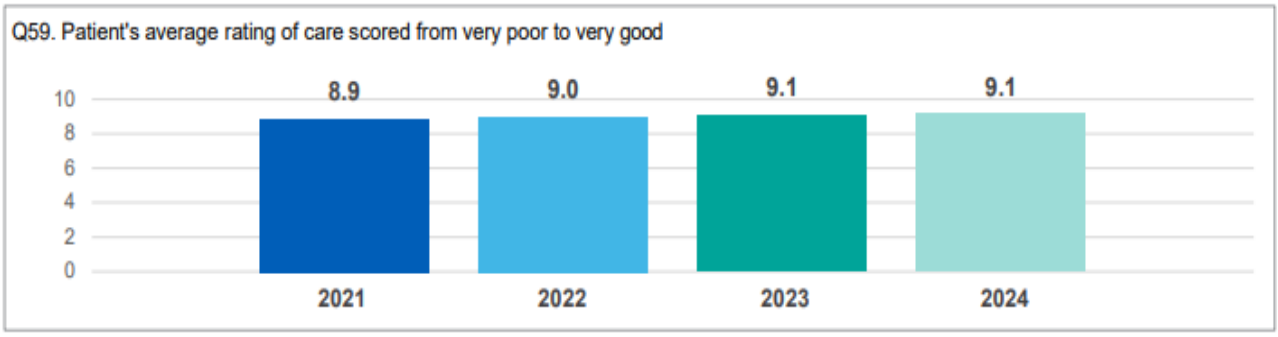




National Cancer Patient Experience Survey 2025

- The report scores 61 questions at Trust level, which are compared to the national average, expected lower and upper ranges.
- 41 questions were within the expected range.
- 20 questions were positive outliers compared to 23 in 2023 and 8 in 2022
- 0 questions were negative outliers compared to 0 in 2023 and 0 in 2022.

Patients are asked to rate their care from very poor (0) to very good (10). The Trust score was **9.1** compared to a national average of **8.9**, consistent with 2023.



Report to:	Council of Governors	Agenda item:	4.2
Date of meeting:	23rd February 2026		

Report Title	Learning From Deaths Report Q2		Approval Process	Clinical Governance Committee 25 November 2025
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Mr Charles Ronaboldo, Trust Mortality Lead/ Dr Ben Browne, Associate Medical Director, Duncan Murray, Chief Medical Officer			
Executive Presenting:	Nick Johnson, Managing Director			
Appendices (if necessary)	Embedded – Appendices A-C			

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

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

- Nil

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

- There has been an increase in observed cases of death in patients with serious mental illness by the medical examiners – actions being taken as outlined in report (page 8)
- The Trust has formally withdrawn from their contract with Tesltra Health U.K – mitigated by improvements in internal reporting

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

- At the time of publication, the latest Summary Hospital-level Mortality Indicator (SHMI) figure for the Trust is 0.9267 (12-month period ending in May 2025). This continues to be the lowest figure that the Trust has observed in recent times and remains statistically within the expected range.
- Using statistical modelling from NHS England, during this 12-month period there were 1,015 observed deaths reported in the Trust against an expected figure of 1,095.
- The mortality SHMI figures will now be published monthly in a new 'group' integrated performance reported (IPR), which will help to ensure improved oversight of the data, actions, and shared learning across each of the three acute hospitals that we are grouped with. This includes Royal United Hospital (RUH) Bath and Great Western Hospital (GWH) Swindon. In addition to local processes, the three hospitals continue to convene monthly at a BSW (Bath, Swindon, Wiltshire) systems mortality meeting, where data is reviewed, and learning is shared and discussed.
- A new alert tab has been developed within the Trust's Bi mortality dashboard to provide early warning for statistical outliers (both positively and negatively alerting using SPC methodology). This can be used to track variations in diagnosis group, ward, and clinical specialty. The new dashboard will be presented at the MSG meeting in November for feedback.
- Across the trust during this period there were a total of 159 complaints/concerns logged, of which none were related to end-of-life care.

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

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

LEARNING FROM DEATHS REPORT

Quarter 2: 2025-2026

GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

MaMR
The Mortality and Morbidity Review Module that the Trust uses for electronic recording of learning from deaths.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of 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, ensure the appropriate direction of deaths to the coroner, 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, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

PSIRF
Patient Safety Incident Response Framework

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR
A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX
Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

SPC
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

Learning from Deaths 2025-26
Quarter 2 Report

Purpose

1.1 This is a summary document outlining learning from deaths at Salisbury NHS Foundation Trust during the second financial quarter of 2025/26. 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. The Learning from Deaths initiative aims to promote a reflective and inquisitive clinician culture, driving learning and to improve how Trusts support and engage bereaved families and carers of those who die in our care.

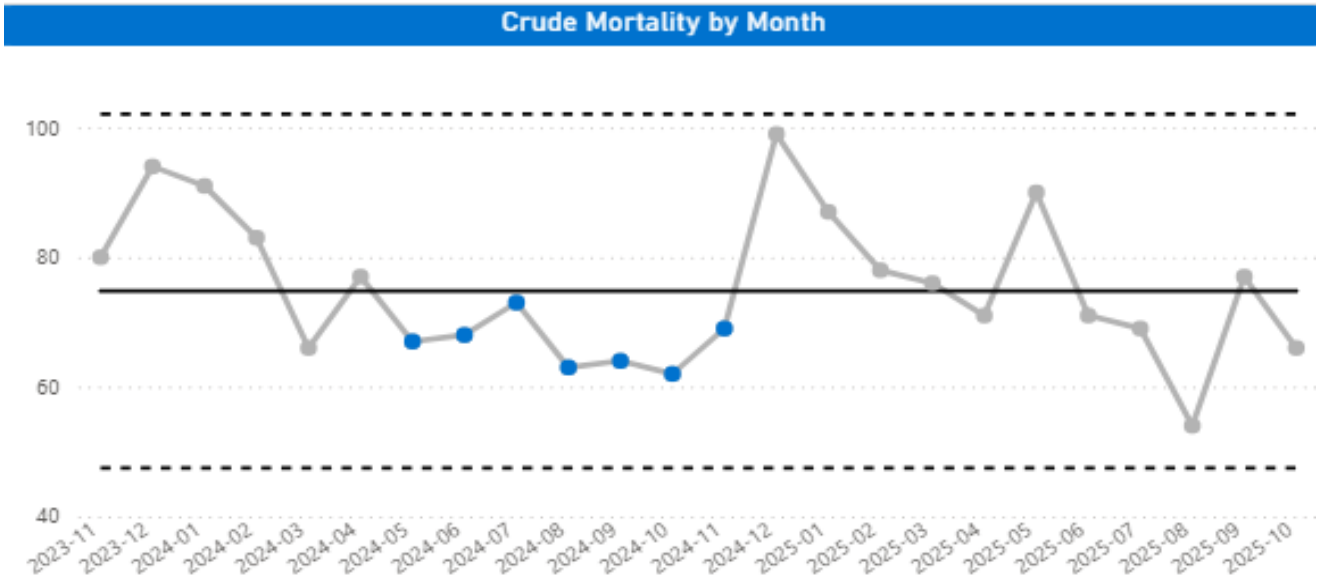
Executive Summary

- At the time of publication, the latest Summary Hospital-level Mortality Indicator (SHMI) figure for the Trust is 0.9267 (12-month period ending in May 2025). This continues to be the lowest figure that the Trust has observed in recent times and remains statistically within the expected range.
- Using statistical modelling from NHS England, during this 12-month period there were 1,015 observed deaths reported in the Trust against an expected figure of 1,095.
- The mortality SHMI figures will now be published monthly in a new 'group' integrated performance reported (IPR), which will help to ensure improved oversight of the data, actions, and shared learning across each of the three acute hospitals that we are grouped with. This includes Royal United Hospital (RUH) Bath and Great Western Hospital (GWH) Swindon. In addition to local processes, the three hospitals continue to convene monthly at a BSW (Bath, Swindon, Wiltshire) systems mortality meeting, where data is reviewed, and learning is shared and discussed.
- All three acute Trusts have now formally ended their contracts with Telstra Health UK (formerly Dr Foster), as of 30.09.2025, and have been meeting to improve share practice and deliver 'real time' reporting of mortality through improvements in internal Power Bi reporting.
- A new alert tab has been developed within the Trust's Bi mortality dashboard to provide early warning for statistical outliers (both positively and negatively alerting using SPC methodology). This can be used to track variations in diagnosis group, ward, and clinical specialty. The new dashboard will be presented at the MSG meeting in November for feedback.
- There has been a recent increase in observed cases of death in patients with serious mental illness by the medical examiners – actions being taken as outlined in report (page 8).
- Across the trust during this period there were a total of 159 complaints/concerns logged, of which none were related to end-of-life care.

2 Learning highlights from Quarter 2

2.1 The hospital mortality group (MSG) met on September 9th during Q2, where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights, and the information reviewed and discussed at the MSG.

2.2 Local Data – Crude Mortality



The above graph has been obtained from the Trust's Power-Bi dashboard and shows the crude mortality figures by month. There has been a general downward trend in the figures from Jan 2025. During quarter 2 (Q2), the crude mortality figure was lower than the mean average during the months of July and August and was closer to the mean average in September 2025.

2.3 Local Data – Breakdown including Medical Examiner Information

Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2025-09	78	78	8	5	19	0	1	0	0	1	0	0	1	2
2025-08	55	55	3	5	12	0	1	0	1	0	0	0	0	2
2025-07	68	68	2	2	12	0	0	0	0	0	0	0	0	2
2025-06	72	71	5	6	11	0	0	0	0	0	0	0	1	4
2025-05	91	91	2	5	16	0	1	0	0	1	0	0	0	0
2025-04	71	71	2	1	11	0	2	0	1	1	0	0	0	0
2025-03	76	74	0	2	10	0	0	0	0	0	0	0	0	0
2025-02	81	81	5	2	15	0	1	0	1	0	0	0	0	0
2025-01	88	88	4	2	19	0	0	0	0	0	0	0	0	3
2024-12	100	97	7	7	12	1	2	0	1	1	0	0	0	0
2024-11	72	70	2	6	14	2	0	0	0	0	1	0	0	0
2024-10	65	65	2	2	11	2	1	0	1	0	0	0	0	0
2024-09	67	66	3	2	18	2	0	0	0	0	0	0	0	0

All inpatient deaths were reviewed by the medical examiners during Q2. This represents a total of 201 deaths and was achieved despite the ME service being under significant staffing pressure.

Thirteen additional reviews (primary reviews or SJRs) were requested by the medical examiners during Q2 which were linked to the following categories [**note**: cases can be classified under multiple categories]:

- *Serious mental illness* (SMI) [6]
- *Learning disability and autism* [1]*
- *Bereaved or staff raised concern about care* [5]
- *Will inform quality improvement work* [3]

In addition, there were no maternal deaths, and two stillbirths reported during Q2

For the patients who were considered to have a serious mental illness, upon initial examination from the ME there were no specific themes associated with these cases. There is a regular operational mental health group and quarterly combined mental health governance meeting (including representatives from adult and CYP teams and external partners in particular AWP and Oxford Health), chaired by one of the Trust's Deputy CMO's, where mortality and incidents involving patient with SMI are discussed. These deaths are flagged to the chair to ensure that a review is undertaken, and the cases are subsequently presented to the governance meeting for discussion. As there has been an increase in the number of cases raised during Q2, these cases will also be discussed at the upcoming Trust mortality meeting in November to determine whether any further actions are required.

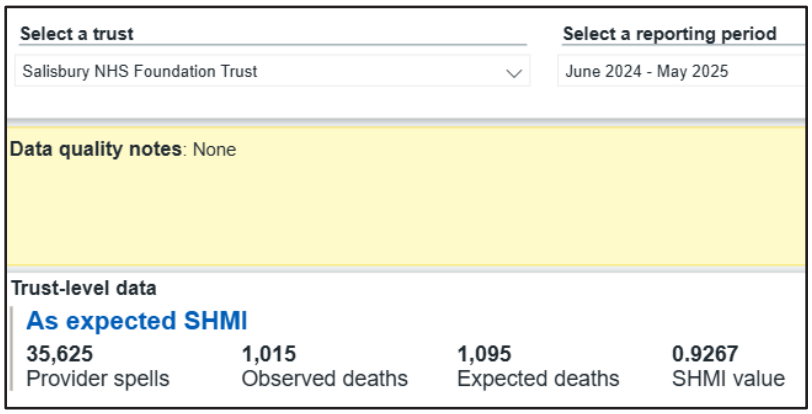
** As per standard practice these patients would be subjected to a mortality review (using the validated SJR method) and a review by our learning disability/autism nurse for a specialist input of potential learning. The specialist nurse is also invited to attend the MSG at least annually to share learning from these cases and to present the findings of any local/national reports related to deaths in patients with learning disability/autism.*

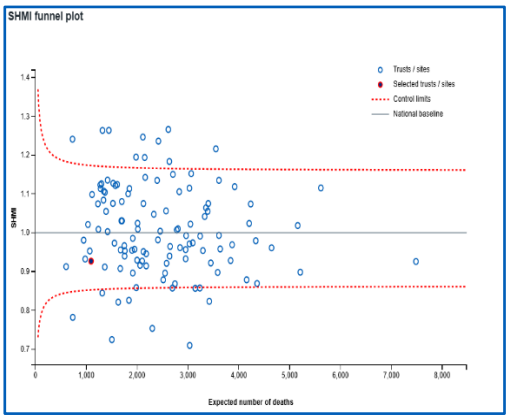
2.4 National Benchmarking

The SHMI methodology determines an 'expected' deaths number by comparison with an equivalent group of patients from a national pool of data from patient who have similar characteristics (including age, sex and comorbidities). It is the ratio between the actual number of patients who die following hospitalisation at the Trust and number that would be expected to die based on average England figures, given the characteristics of the patients treated there.

It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding stillbirths. The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital. The data in this section of the report is therefore taken from those published by NHS Digital on their website.

Data as published by NHS England at digital.nhs.uk

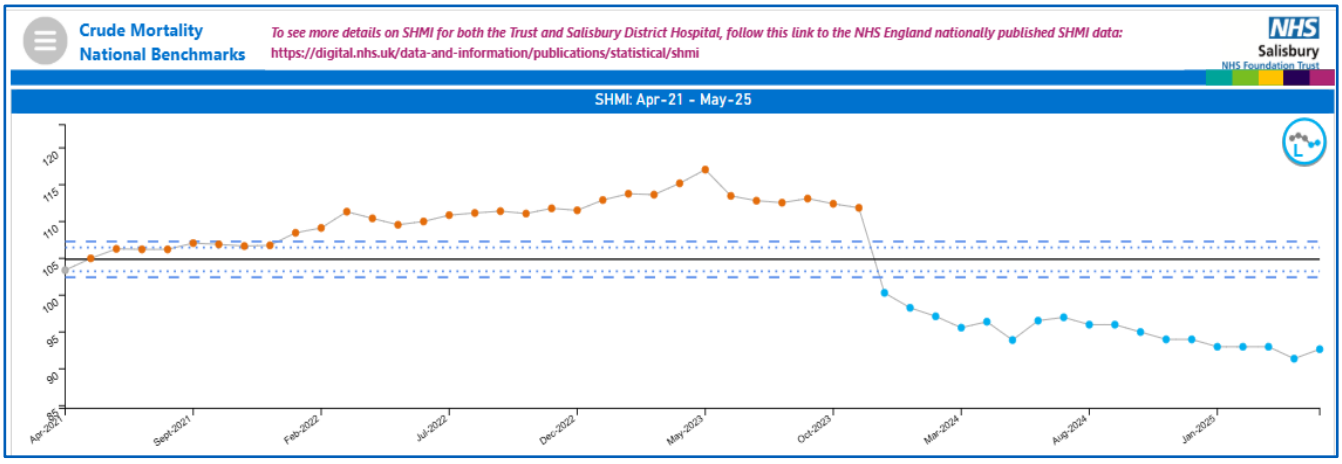




2.5 The SHMI for Salisbury NHS Foundation Trust for the latest reported date range (June 2024 to May 2025) is 0.9267 and represents 1,015 observed deaths verses 1,095 expected deaths.

2.6 The Trust currently lies below national baseline (represented by the red dot on the funnel chart above).

2.7 The graph below highlights the Trust's SHMI position as reported using the SPC methodology. The Trust's SHMI is statistically 'as expected,' and there has been a downward improved trajectory overall.



2.8 Summary of Learning Highlights

Processes	Outcomes
Updates to the Trust's Power BI mortality dashboard now allow individuals specialties to look at their own trends and any early warning patterns Configuration of these dashboards are being shared between the 3 Acute Trusts in BSW to optimise care across the system Improvements to the MaMR online mortality review platform now allow analysis by admission diagnosis and of cases where death occurred shortly after discharge from hospital The BSW System Mortality group continues to meet and enable shared learning and approaches to alerts arising from SHMI data Attendance at the Salisbury Patient Safety Summit by members of the Mortality team has been established, giving a further opportunity to share learning and to ensure that Datix alerts and any PSIIs are fed back and recorded in MaMR	An alert relating to cases with a diagnosis of *Pneumonia*** triggered by the September 2025 Telstra Health UK (THUK) report has led to a review of a cohort of cases which has concluded that the overall quality of care has been to a good standard The latest SHMI figure for Pneumonia is 0.94, now statistically within the expected range A separate review** of surgical mortality cases has confirmed good or excellent care in 92% of cases, and adequate in the remaining 8% The proper use of the *learning point* and *actions* section of the online proforma has been highlighted by this surgical review and there is an opportunity for further improvement and sharing here In both reviews, numerous specific learnings were recorded, and these are shared within the specialties as well as being escalated to the Trust's Mortality Surveillance Group for further dissemination via divisional leads as appropriate *Septicaemia (non-labour), shock* where there has been a previous alert now has a SHMI of 0.78 which is statistically lower than expected Improvements are being made regarding overall access to mortality metrics within the Trust and to learnings for individual teams so that they can respond to real time data and continue to work to enhance patient safety and quality of care

***Further information and learning related to the reviews mentioned above can be found in the appendices section of this report (section 5)*

3 End of Life (EOL) Care

3.1 The Your Views Matter (YVM) Bereavement survey was established in 2020 and was relaunched in April 2025 after being replaced by a National NACEL Quality Bereavement Survey from 2024-2025 to allow for national benchmarking. The YVM survey was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives can name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

The surveys are sent out by the Bereavement suite via an email link alongside the release form (the day after the patient's death). There are 3 survey links which include the emergency department (ED), hospice and the acute Trust. The ED and **h**ospice are new areas for SFT to receive feedback from.

3.2 During Q2 there were 158 deaths in the acute Trust and 43 in the hospice. 143 surveys were sent via email from the bereavement team to families/loved ones. 13 surveys have been returned, 10 from the Acute trust, 3 from the Hospice and none from ED. (9% of the total sent returned).

Key themes identified:

- Communication good or very good – 10/13 (77%)
- Compassion good or very good – 11/13 (85%)
- Privacy and dignity good or very good – 12/13 (92%)
- Timely access to pain relief good or very good – 9/13 (69%)
- Overall, how would you rate the care and support provided for your loved one good or very good 11/13 (85%)

If could be implied from the low rate of response that there is a low rate of dissatisfaction with the care delivered

Currently, due to staffing pressures within the bereavement team, if there is no email address or the patient has been referred to the coroner then a survey is not sent (this only occurs in a small percentage of families).

The end-of-life lead nurse is looking to improve the process by enabling families/loved ones to receive a bereavement survey and by providing support in completing and returning them to increase response rates.

OTHER IMPROVEMENTS
There was some feedback from a family regarding sympathy cards not being completed and then given to relatives blank. • An audit was completed on the nursing record of death (NRD) documentation, and it identified that all wards were working differently regarding phoning GPs and sending copies of the NRD to bereavement • From this we sent out our quarterly newsletter with updates on new processes and ensuring staff are aware to complete the sympathy cards. • The end-of-life team continue to adapt their education and training study days to reflect concerns/complaints that have come through PALS.

3.3 **EOL Care – Correlation with Complaints**

There was a total of 159 complaints/concerns logged during this period, of which 0 were related to end-of-life care.

3.4 **Education and Training**

The End-of-Life team currently run a robust education programme including a staff nurse SD, chronic conditions course and a communication course which runs 10 times a year and covers all aspects of communication and over 139 staff attended training for this course alone in 2024-25. New HCAs attend an EOL session within their induction program and a new online training package has been developed to support staff who care for EOL patients and their families. There are strong links between the PALS and end-of-life team to support with any complaints which come in so wards/staff can be supported with any further training/education that is required.

3.5 **The National Audit of Care at the End of Life (NACEL)**

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales, and Jersey. NHS Benchmarking Network is commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government.

The results of NACEL 2024-25 notes audit have now been published – see key findings in appendix B. The action plan related to this is aligned to staff results and was shared in the previous Q1 report.

4 Litigation

4.1 New Enquiries from the Coroner in Q2

During this reporting period, there were five new enquiries from the coroner concerning the deaths of patients known to SFT. Statements have been requested in all five of those cases. Of the five cases 2 are subject to internal review.

4.2 Inquests concluded in Q2 from previous reporting periods

Two inquests were concluded in this quarter. Statements were provided by SFT in both cases. SFT was an interested party in both cases. In one case the patient was considered to have died because of a combination of the injuries sustained in a road traffic collision and a recognised complication of an elective surgical procedure. In another case the patient was considered to have died because of the injury sustained and complications arising from a fall which occurred in 2024.

4.3 There were no jury cases and no Prevention of Future Deaths reports.

[Authors (multiple)
***Primary Contributors**: Members of the SFT Mortality Team*
November 2025]

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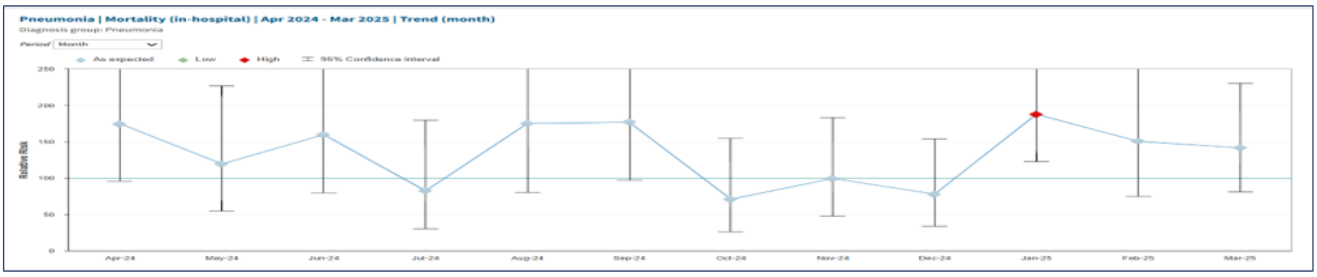
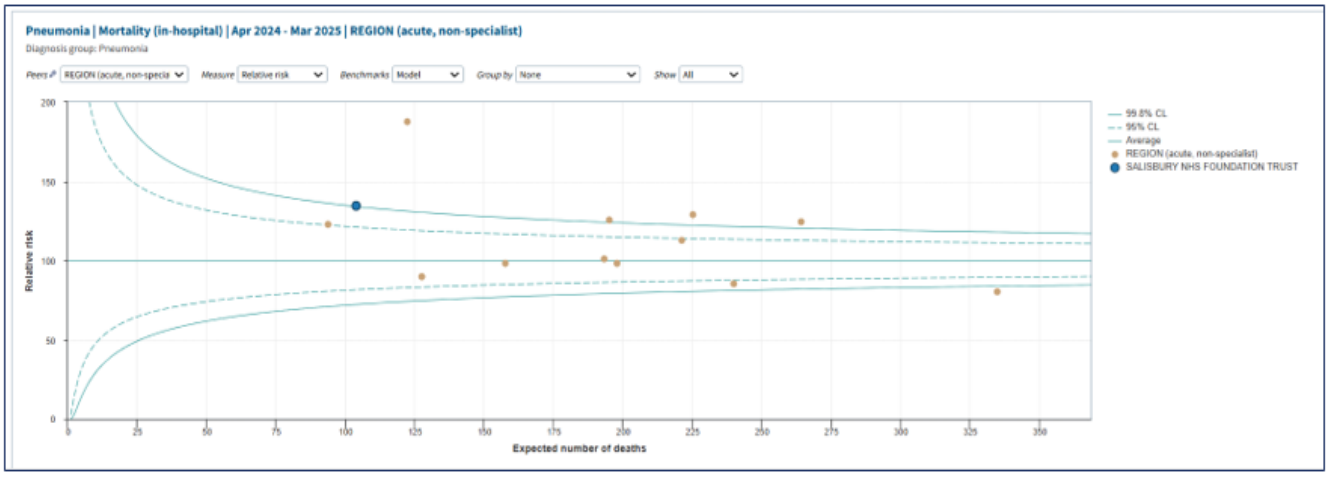
5 Appendices

5.1 Appendix A – *Pneumonia* Alert

In August 2025, a mortality alert was reported by Telstra Health UK (previously mortality insight provider) for patients with an admission diagnosis of pneumonia. This was triggered particularly by a statistically higher than expected number of deaths in January 2025, but the period April 2024 to March 2025 showed that the Trust was just lying outside the 99.8% confidence limits meaning that it was highly unlikely that the results had occurred by chance.





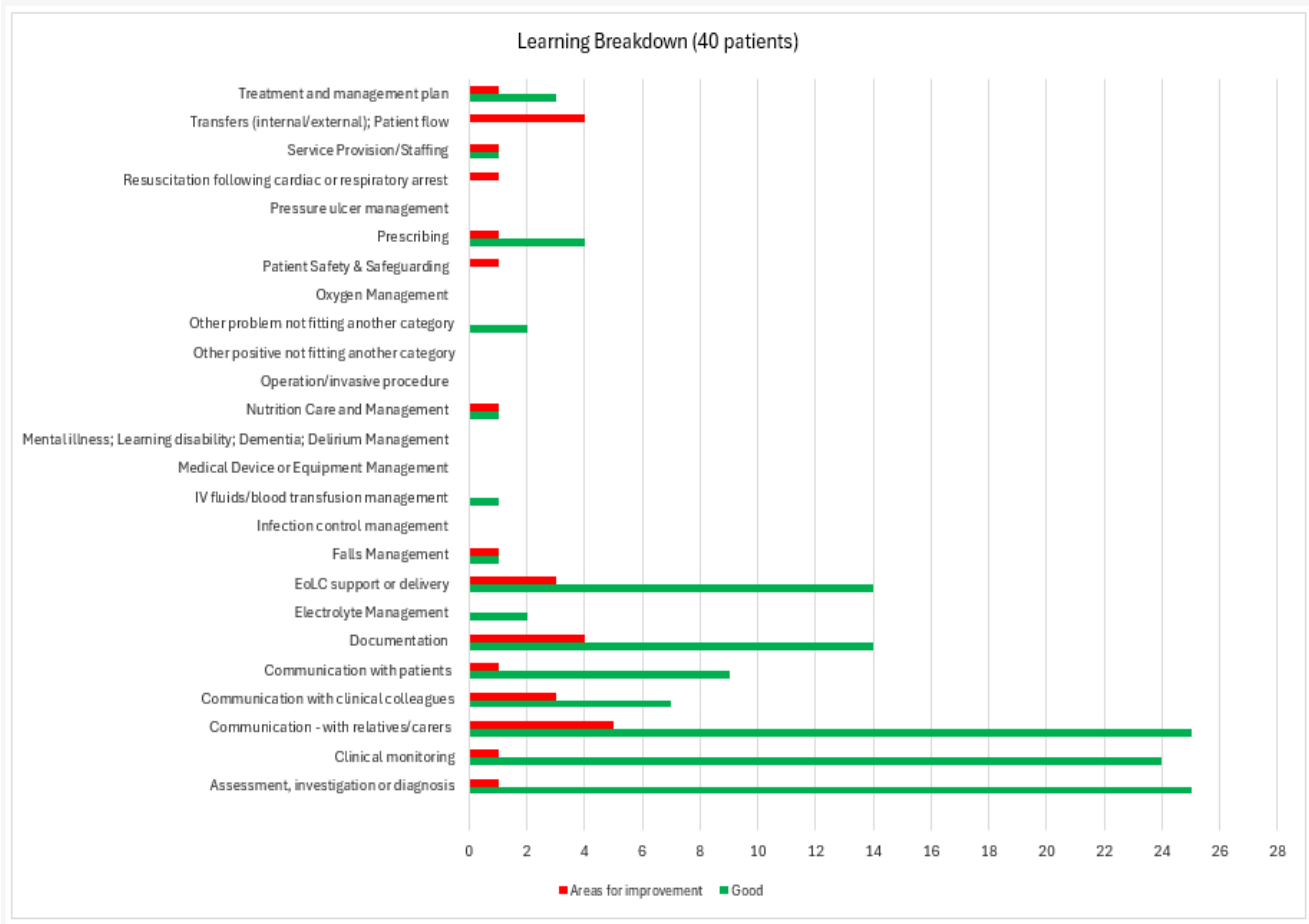
A previous alert for this diagnosis group in 2022 was addressed by a detailed case note review of 45 cases based on the paper records and a paper mortality review proforma following the Royal College of Physicians Structured Judgement Review format. This was a cumbersome process but confirmed that although there was some evidence of poor documentation and falls prevention, overall quality of care had been good and that there were no specific areas of concern where practice needed to be changed.

This new alert was dealt with using the mortality reviews already included in the Trust's online platform (the AMaT MaMR module). There was a total of 138 deaths in the cohort considered to have led to the alert, of which 93 had already received a detailed review. This large (67% of the total number of cases) sample was used in the main overview analysis.

The average age was 83 years (range 56 - 102), with a male: female ratio of 77: 61. The average length of stay was 11 days (range 0 - 76). The comorbidity score which is an indication of how fragile this group was ranged from 0 - 64 with an average of 27.

Reviews of a representative sample of 16 cases were studied in more detail looking at the incidence of sepsis, the quality of end-of-life care (EoLC) delivered, and also the overall quality of care (OAoC) scores. The average age of this subgroup was 89, with sepsis being present in 10/16, of which it was considered to have contributed to death in 8 cases. Three EoLC parameters were analysed: regular consultant review, ReSPECT form completed and PCP (Personalised Care Plan) in place. Every patient had both been regularly reviewed by their consultants and had a ReSPECT form completed. Twelve had a PCP completed, in three the person completing the review was unable to tell if a PCP had been completed, and in only one case had it been omitted. 19/45 cases had had a PCP completed in the review of the 2022 alert so this has improved from 42% to 75% in 2024/2025. Overall completion of these 3 key EoLC parameters was 92%. The Overall Assessment of Care (OAoC) scores averaged 4.25 (range 3 - 5): with a score of 5 being "Excellent", 4 "Good" and 3 "Adequate".

There were 40 learning points documented in the main sample of 138 reviews. The majority were positive, shown in green in the following chart. Communication with relatives and carers was particularly good, also clinical monitoring and assessment, investigation and diagnosis, all of which are cornerstones of good medical and nursing practice. EoLC support and delivery also scored highly, confirmed by the more detailed analysis reported above in the smaller sample, although there were some areas for improvement identified and documented. Transfers and patient flow issues were picked up as noted in previous alert responses and some areas where documentation could be improved.



Specific examples of learnings include good documentation and monitoring of deteriorating patient and good communication with patient. Also, clear concise and timely case note entries. Areas for improvement included documentation issues such as a ReSPECT form not signed by consultant and inappropriate transfers; these are discussed at the relevant clinical governance or MDT sessions which also included specific feedback to a doctor regarding some medication dosing. Further analysis of any specific actions arising from these learnings is in motion. Another consideration is whether there are errors in coding which may have contributed to the initial alert being triggers, as a similar trend has been observed across other BSW Trusts.

5.2 Appendix B – Surgery Mortality Review

A review of all surgical mortality cases was carried out up to the end of Q2 (30 September) for the calendar year 2025.

This included mortality across all surgical specialties. The focus was on what learning had been collected, and key metrics related to quality of care including the incidence of Sepsis, Acute Kidney Injury (AKI), Pressure ulcer and Falls. The Overall Assessment of Care (OAoC) scores were also analysed.

Between 1 January and 30 September there were 50 cases added to the MaMR online review platform with a M: F ratio of 16: 34. One death occurred in the Hospice, the others on the main wards.

Sepsis was reported as having occurred in 18 cases, and in all but one of these was considered to have contributed to the death. It was recorded as not having occurred in 17 cases, was allocated to "unable to tell" in two, and "not stated" in 13. AKI occurred in 13 cases and was considered to have contributed to death in 4 of these. Pressure ulcer was reported in 3 cases, in none of which was it thought to have contributed to death. Finally, Falls occurred in 3 cases and, as with Pressure ulcer, was not thought to have been contributory.

The subsection "Signs of deterioration not acted upon" was recorded as "no" in 35 cases, left blank in 13 and recorded as a "yes" in one, but in that case the failure to act was not considered to have contributed to the death. The latter case had an OAoC score of 5 ("excellent") attributed to it with a learning point and action associated in the narrative. It was considered that symptom control at the very end of life might not have been adequate (which is not exactly what that subsection was intended to identify) and the action resulting was to formally debrief with palliative care and establish further palliative care teaching to nursing staff and clinicians.

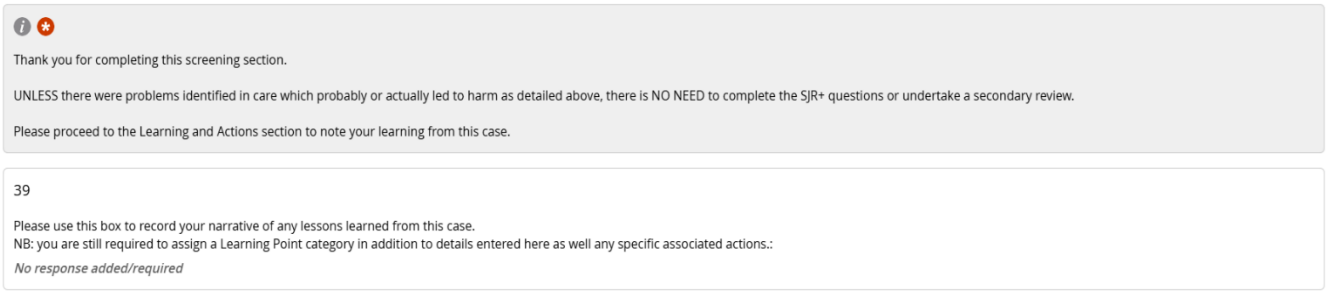
A further 17 cases had comments relating to learning included in their reviews. In five of these the comment was that no specific learning had been identified during case discussions, leaving an overall total of 12 with specific learning comments, which represents 12/50 = 24% of reviews.

Positive comments recorded related to timely progression to PCP completion, good communication and MDT discussions between ITU and the ward team, as well as family involvement.

Areas for improvement included delays to scans in two cases, also delay to dietician involvement on return from ITU, perhaps because the patient was taking oral nutrition at the time. There was a further case where there had been a delay in actioning an intervention but had not impacted significantly, and the OAoC was 4 ("good" care).

Actions related to specific issues to do with communication, for example, improving the pathway with University Hospital Southampton (UHS) for follow up and sharing reports of scans between the two Trusts. M&M discussion of one case shared the need to check past medical history carefully in the context of a patient who had received thromboembolism chemoprophylaxis when in ED, but who had already been taking an oral anticoagulant; this was the only prescription-related learning recorded.

A further generic action for the surgical teams relates to the extensive and exclusive use by them of the narrative box #39 in the proforma whereby no learning point category has been allocated (see below).



Thank you for completing this screening section.

UNLESS there were problems identified in care which probably or actually led to harm as detailed above, there is NO NEED to complete the SJR+ questions or undertake a secondary review.

Please proceed to the Learning and Actions section to note your learning from this case.

39

Please use this box to record your narrative of any lessons learned from this case.
NB: you are still required to assign a Learning Point category in addition to details entered here as well any specific associated actions.:

No response added/required

The instructions do ask for the user to proceed to assign a learning point category (as well as any associated actions) but that was not done in this cohort of 50 cases. This meant that although 24% had learnings recorded, these could not readily be analysed by type (positive or negative) nor by category.

OAoC scores were recorded in 37 cases with an average of 4.4 (range 3 - 5); a score of 5 is "excellent", 4 is "good" and 3 is "adequate". There were three cases scored as a 3, fifteen cases as a 4, and nineteen scored as a 5. In other words, in this large sample of mortality reviews, 51% scored as having received "excellent" overall care.

In conclusion, this analysis of 50 surgical mortality cases confirmed good or excellent practice overall but with many learning points and some specific actions arising from those in addition to the team discussions.

5.3 Appendix C - The National Audit of Care at the End of Life (NACEL)

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	4.3
Date of meeting:	23rd February 2026		

Report title:	National Inpatient Survey Results 2024			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee - 25th November 2025 Patient Experience Steering Group - 29th October 2025			
Prepared by:	Jayne Sheppard – Deputy Chief Nursing Officer			
Executive Sponsor : (presenting)	Judy Dyos – Chief Nursing Officer			
Appendices (if necessary)	National Inpatient Survey Results (2024) – Results Report Slide Deck updated version			

Recommendation:

This report is for assurance and noting by the Trust Board.

Executive Summary:

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51.49%.

The Trust scored worse than expected for 3 questions compared with all other Trusts:

- During your time in hospital, did you get enough to drink?
- When you asked nurses questions, did you get answers you could understand?
- Were you able to get a member of staff to help you when you needed attention?

All other 43 questions were scored comparatively the same with all other Trusts.

Our results this year were significantly worse than our 2023 survey results, for 5 questions:

- Getting enough to drink
- Able to get the answers you could understand, from nurses
- Ability to get medical staff to help when attention was needed
- Overall feeling of being treated with kindness and compassion
- Overall experience whilst in hospital

“Significantly worse” means a hospital’s score is statistically lower than what would normally be expected when compared with other trusts and the difference is unlikely to be due to random sampling variability given the number of responses.

Positive themes from comments in relation to:

- Care and general treatment
- Staff

- Hospital / ward stay

Negative themes from comments in relation to:
- Communication / information giving by staff
- Insufficient staff
- Discharge process / information
- Noise and disruption

These themes were noted to have some correlations with the Trust's **Real-Time Feedback** themes captured over the past year. Particularly in relation to noise at night, discharge process and communication.

Correlation of staff and inpatient survey data reveals strong links between workforce experience and patient outcomes. Communication shows improvement but gaps remains, with miscommunication impacting patient experience. Environment and facilities are a concern, with low staff morale mirrored by 72% negative patient feedback on ward conditions. Clinical teamwork stands out positively, correlating with patient praise for kindness, compassion and coordinated care. Recognition remains a cultural challenge—internal staff recognition has improved compared to previous years but remains outside top tier despite high external patient appreciation. Staffing pressures reported as unrealistic time by staff that is reflected in patient survey which reports delays and reduced presence, strongly aligned with patient dissatisfaction.

National Cancer Patient Experience Survey 2024 report painted a more positive picture with 9.1 rating for overall care compared to a national average of 8.9.

Children and Young People's Survey 2024 reported that SFT are scoring as the highest trust in our region for overall experience.

Focused work has already commenced by Matrons and operational teams to address the inpatient survey results with action plans shared at Nursing and midwifery forum.

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

Salisbury
NHS Foundation Trust

National Inpatient Survey Results (2024)

Results Report - Oct 2025

Salisbury NHS Foundation Trust National Inpatient Survey 2024

Sample: Patients aged 16years+ who had spent at least one night in hospital and discharged during November 2024

Scoring: Each question in the survey that can be scored are converted into scores on a scale of 0 to 10. Scores of 10 are assigned to the most positive and scores of 0 are assigned to the least positive.

Full CQC Benchmark Report:

FINAL_RNZ_Salisbury NHS Foundation Trust (1).pdf

Summary of comparisons with other Trusts

Salisbury NHS Foundation Trust

131 NHS Acute Trusts involved
(131 last year)

62, 444 Total responses received average return rate of 41%
(63,573 responses and a return rate of 41.7% last year)

621 Total responses received for SFT (624 last year)

51.49%* Response rate *same as last year

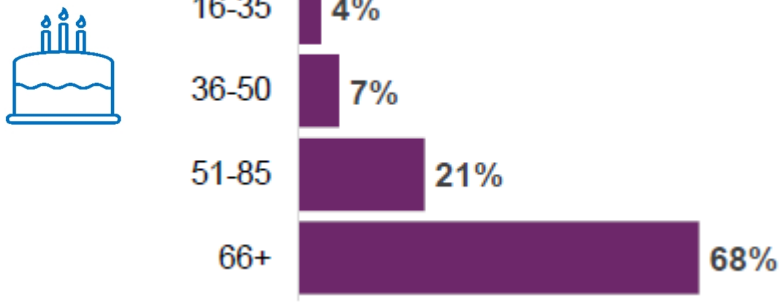
No. of questions where SFT scored better than other Trusts = 0

No. of questions where SFT scored about the same as other Trusts = 43

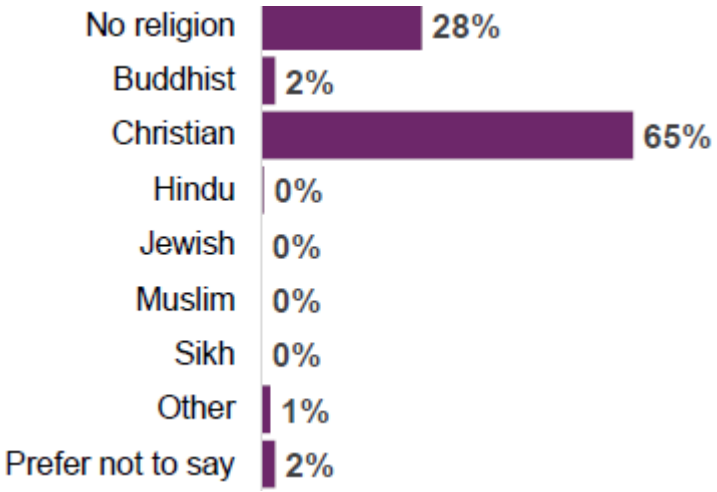
No. of questions where SFT scored worse or somewhat worse than other Trusts = 3

Demographic breakdown

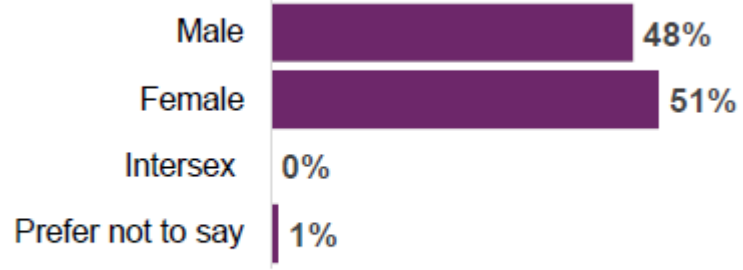
Age



Religion

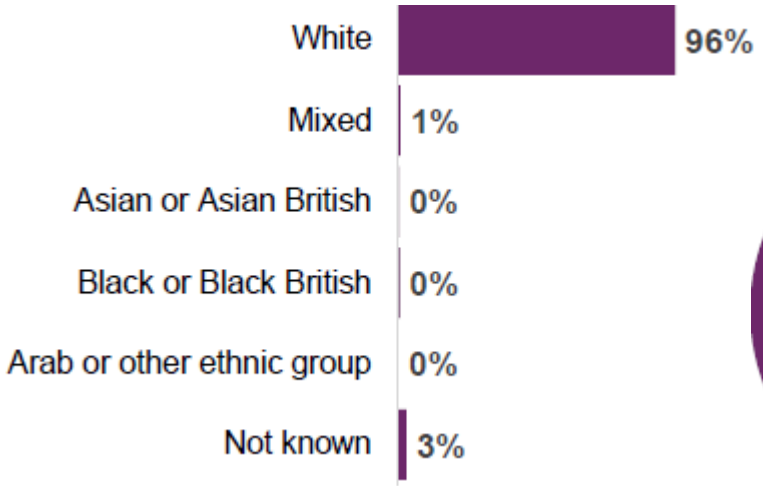


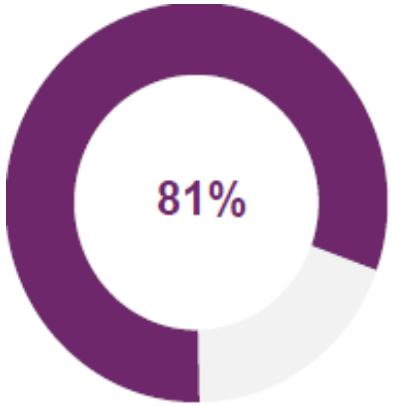
Sex



0% of patients said their **gender is different from the sex they were assigned with at birth.**

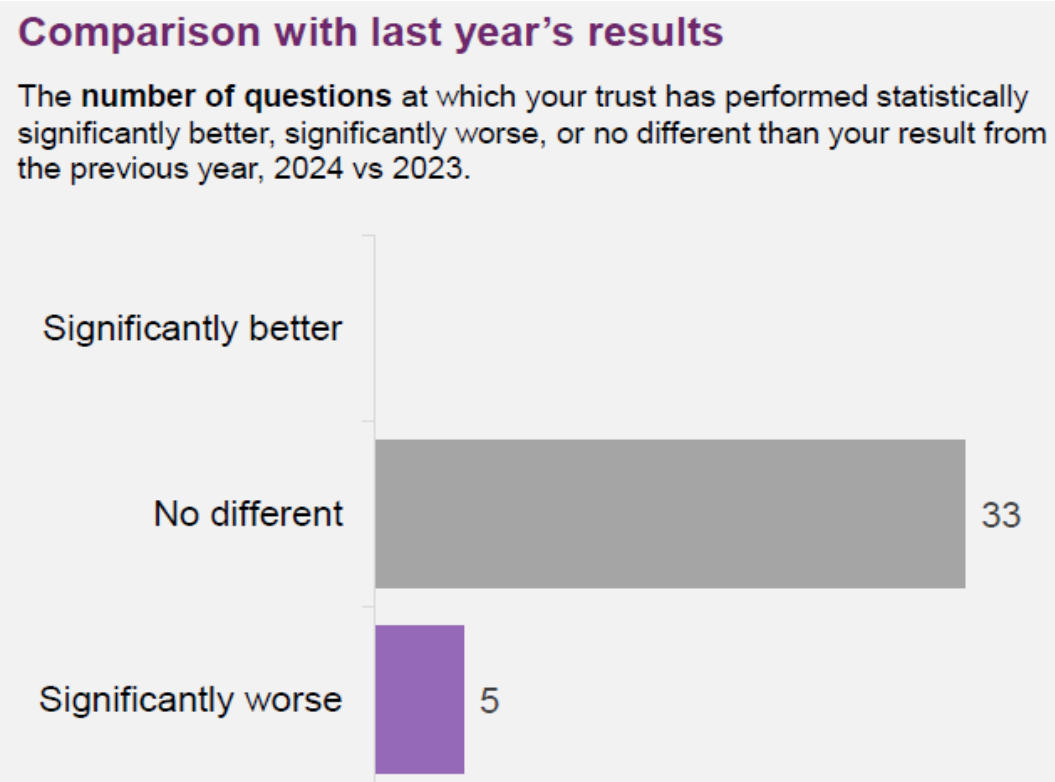
Ethnicity





of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

Comparison with SFT's 2023's survey results



5 results were significantly worse than last year

- Q 16. During your time in hospital, did you get enough to drink?
- Q20. When you asked nurses questions, did you get answers you could understand?
- Q30. Were you able to get a member of staff to help you when you needed attention?
- Q46. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?
- Q48. Overall, how was your experience while you were in the hospital

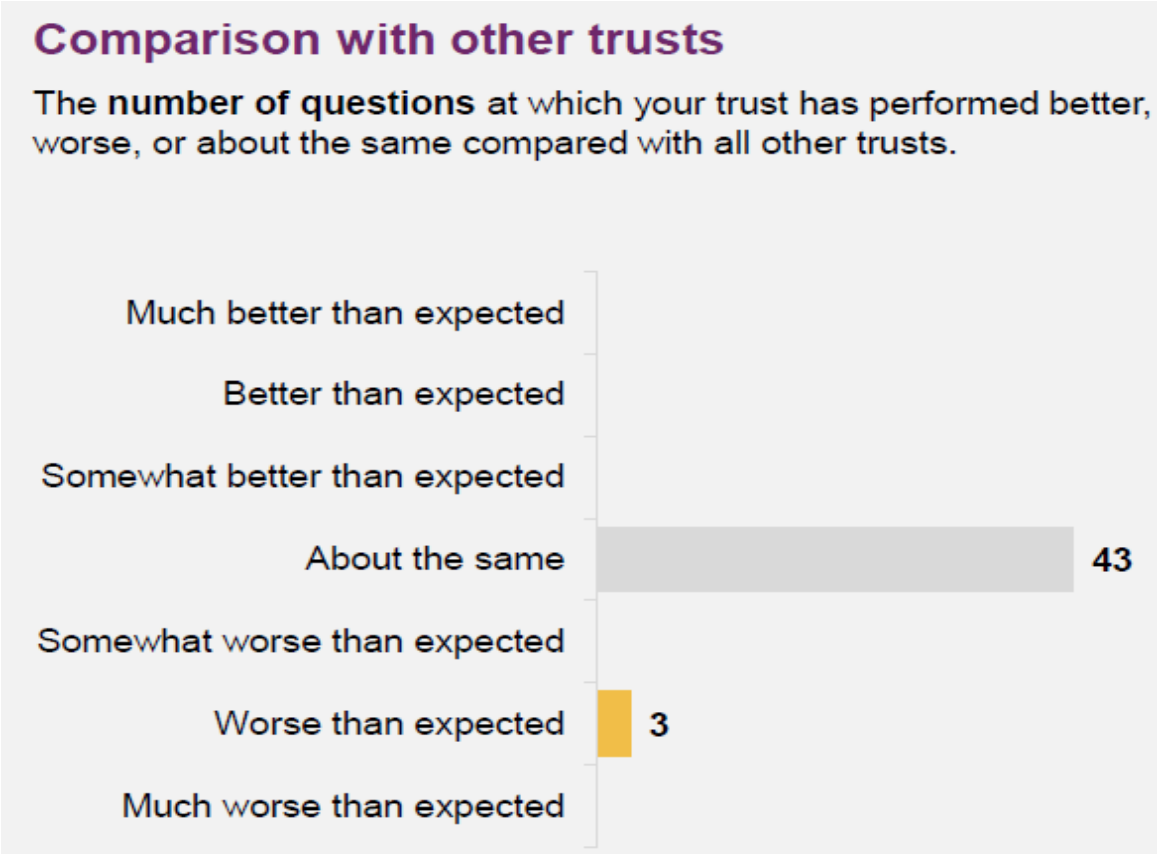
In the NHS National Adult Inpatient Survey, "significantly worse" means a hospital's score is statistically lower than what would normally be expected when compared with other trusts. It isn't just a small difference — it means the score falls outside the expected statistical range, so the lower performance is unlikely to be due to chance. It shows a trust is genuinely underperforming in that area compared with others

Comparison with other Trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

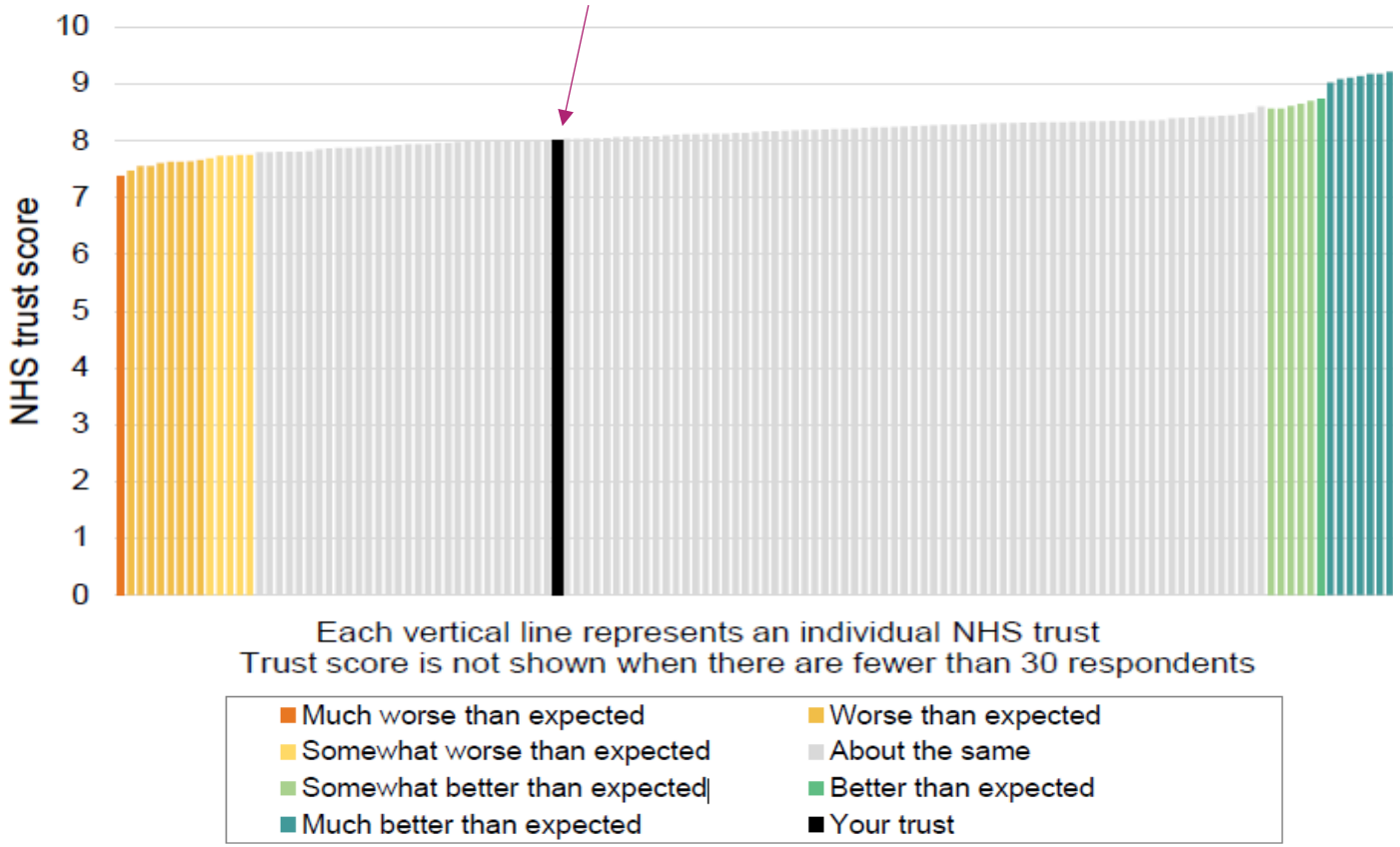
- Q16. During your time in hospital, did you get enough to drink?
- Q20. When you asked nurses questions, did you get answers you could understand?
- Q30. Were you able to get a member of staff to help you when you needed attention?



	2024	2023	2022
Overall Experience	Patient Response 8.0	Patient Response 8.3	Patient Response 8.0

NHS Salisbury NHS Foundation Trust

*SFT's position is indicated by the black line below



Comparison with other trusts within your region

Trusts with the highest scores

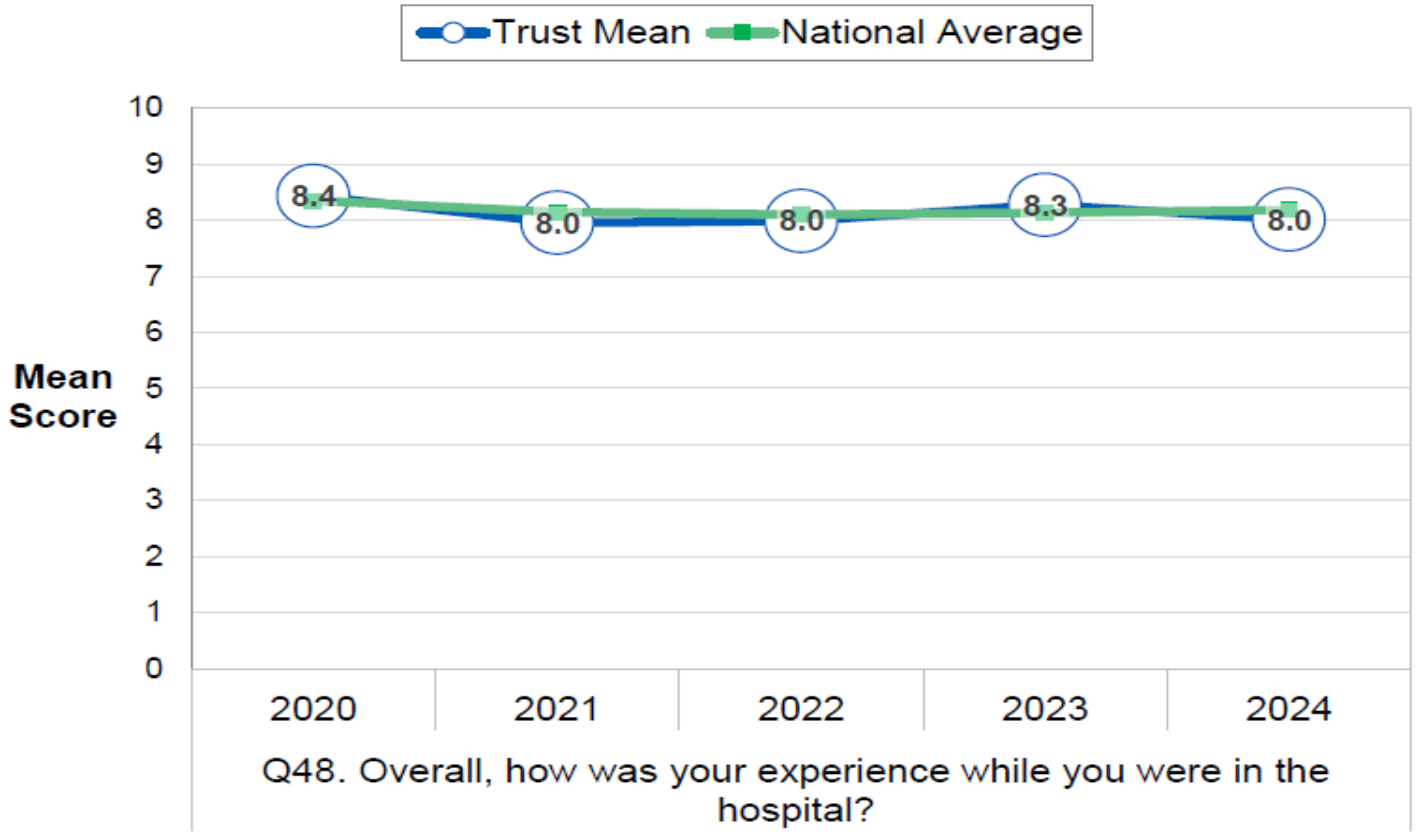
Royal Devon University Healthcare NHS Foundation Trust	8.6
University Hospitals Dorset NHS Foundation Trust	8.3
Gloucestershire Hospitals NHS Foundation Trust	8.3
University Hospitals Plymouth NHS Trust	8.3
Royal Cornwall Hospitals NHS Trust	8.3

Trusts with the lowest scores

Great Western Hospitals NHS Foundation Trust	7.9
Salisbury NHS Foundation Trust	8.0
Somerset NHS Foundation Trust	8.2
North Bristol NHS Trust	8.2
Torbay and South Devon NHS Foundation Trust	8.2

Overall Experience

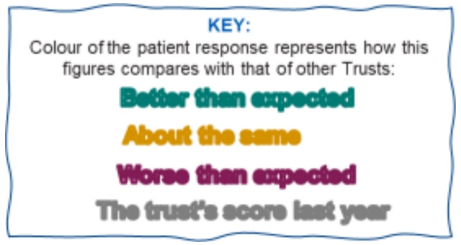
Salisbury NHS Foundation Trust



Significant change 2024 vs 2023	Decrease
Significant change 2024 vs 2022	No change

Answered by all.
Number of respondents: 2020: 680; 2021: 577; 2022: 610; 2023: 615; 2024: 615

Comparison with 2023



Salisbury NHS Foundation Trust

	2024	2023
Admission to hospital	Patient Response 6.6	Patient Response 7.5
Hospital and Ward	Patient Response 7.2	Patient Response 7.7
Doctors	Patient Response 8.9	Patient Response 9.0
Nurses	Patient Response 8.2	Patient Response 8.4
Care and treatment	Patient Response 8.1	Patient Response 8.3
Virtual Wards	Patient Response 6.6	Patient Response 7.1
Leaving hospital	Patient Response 7.1	Patient Response 7.1
Basic needs	Patient Response 7.8	Patient Response *No data available*
Kindness and Compassion	Patient Response 8.9	Patient Response 9.2
Respect and dignity	Patient Response 9.2	Patient Response 9.3

Results for Salisbury NHS Foundation Trust
NHS Adult Inpatient Survey 2024

Salisbury NHS Foundation Trust

Where patient experience is best

- ✓ **Leaving hospital:** Staff discussing with patient whether they would need any additional equipment in their home after leaving
- ✓ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- ✓ **Leaving hospital:** Staff telling patients who to contact if worried about condition/treatment after leaving hospital
- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival

Where patient experience could improve

- **Information while on virtual wards:** Patients feeling they were given enough information about care and treatment on virtual ward
- **Waiting list:** Length of time on waiting list before hospital admission
- **Information while on waiting list:** Quality of information given while on waiting list
- **Drink:** Patients getting enough to drink
- **Help when needing attention:** Patients being able to get help from staff when they need attention

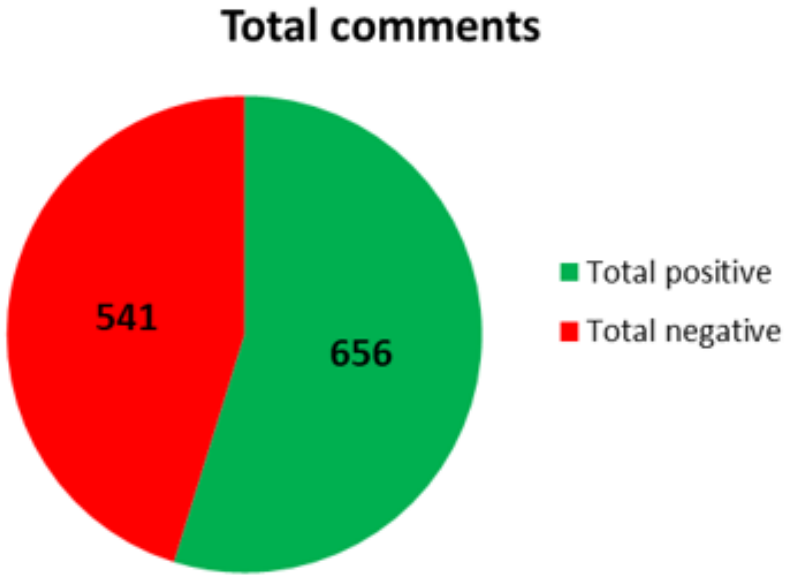
These questions are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.

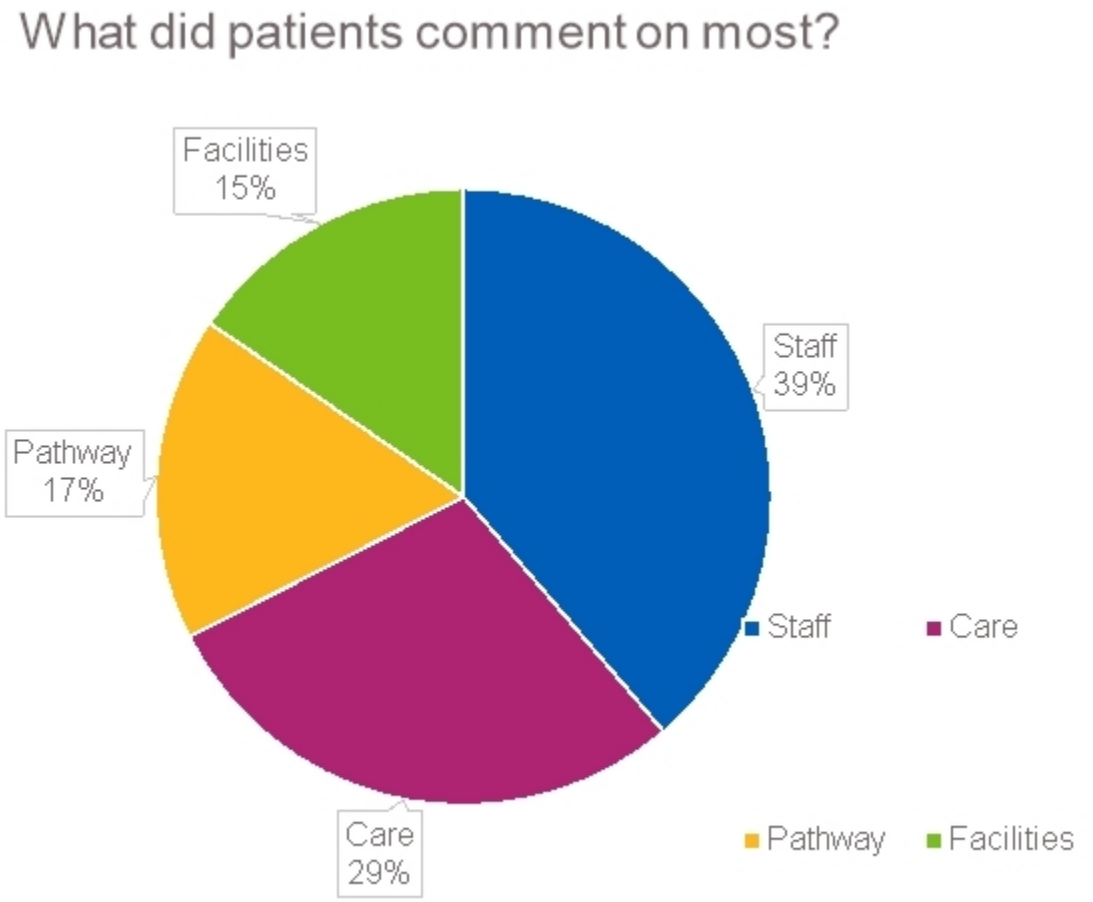
Themes from comments

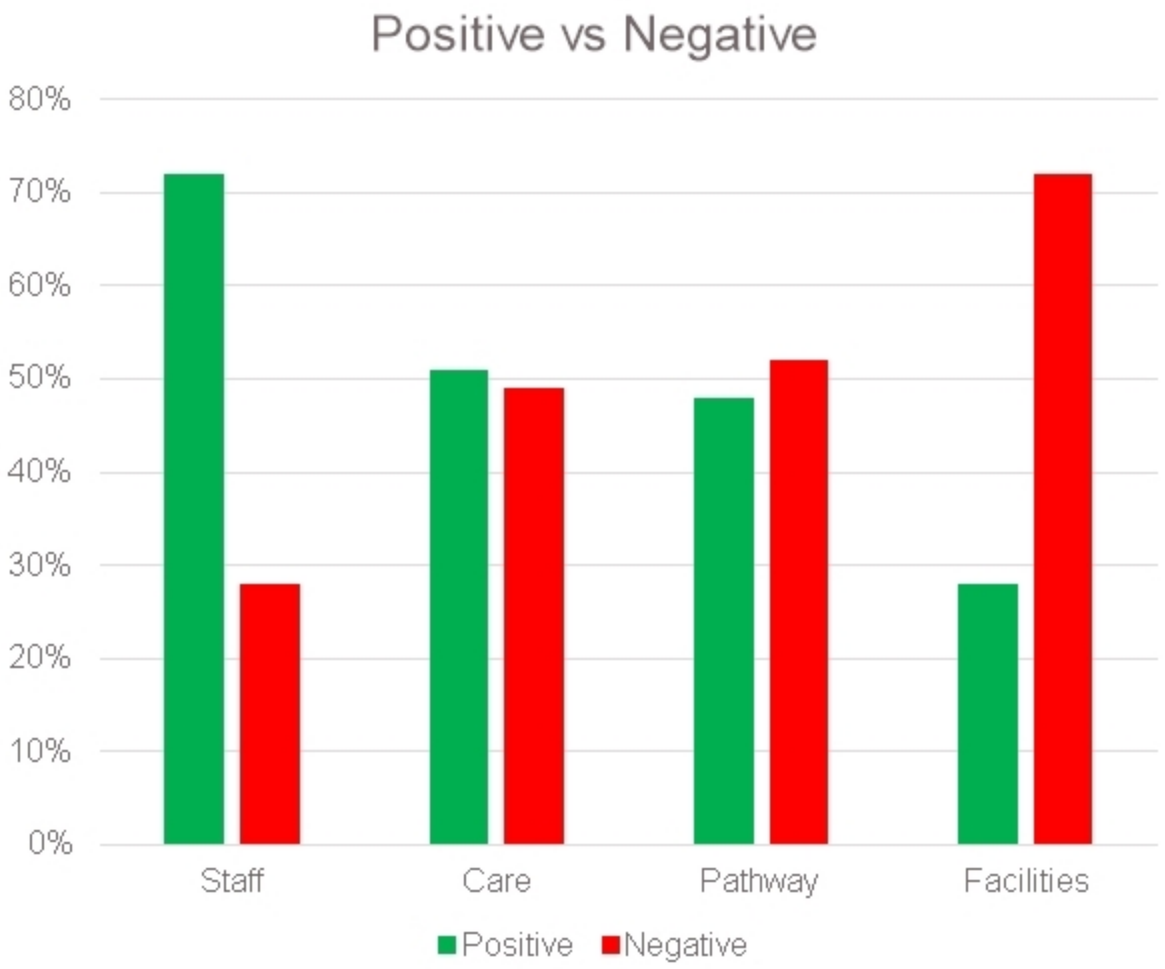
Salisbury NHS Foundation Trust

Total comments received: 1,197
(1,277 last year)

Overall positive: 55%
(56% last year)







While 72% of comments about staff and 51% of comments about care and treatment were positive, 52% of comments about the pathway of care and 72% of comments on hospital environment & facilities were negative.

Themes from comments

NHS
Salisbury
NHS Foundation Trust

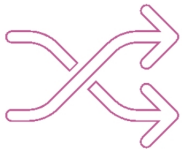
Positives

Care and general treatment

Staff (nurses and doctors and generally)

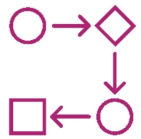
Hospital / ward stay

Negatives



Communication / information giving by staff

Insufficient staff / staff shortages



Discharge process and/ or information

Noise and disruption

Correlations with Real-Time Feedback (RTF)

Salisbury NHS Foundation Trust

Real-Time Feedback is a face-to-face opportunistic survey undertaken by the patient's bedside whilst they are in hospital. This is usually undertaken by volunteers or governors.

The aim of the feedback to give a "real-time" view of a patient's perspective of their care.

Real-time feedback is currently undertaken in all inpatient areas with the exception of maternity inpatient areas or on Sarum ward.

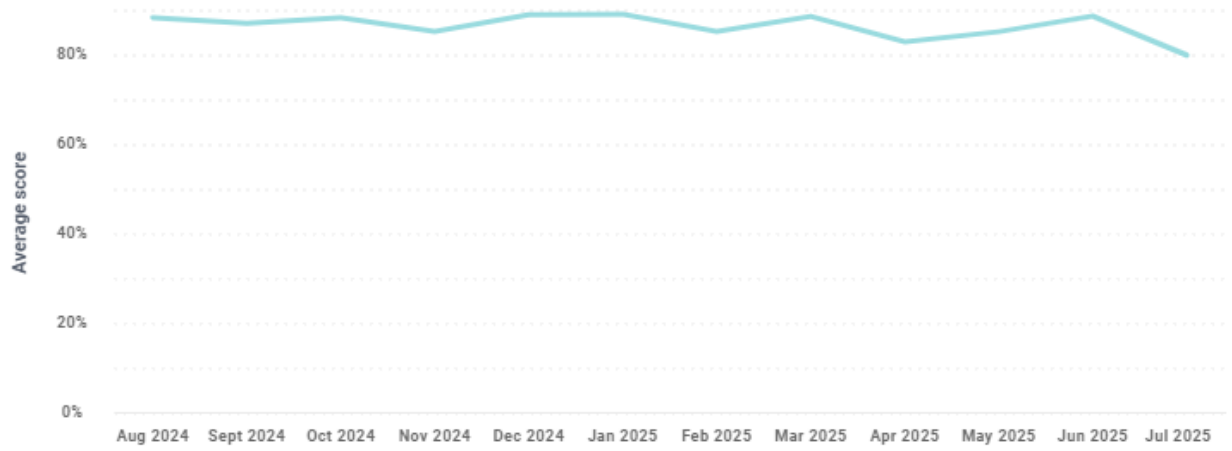
The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas:

- Admission to hospital
- The ward environment
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Respect and Dignity
- Overall experience

Aug 2024 – Jul 2025

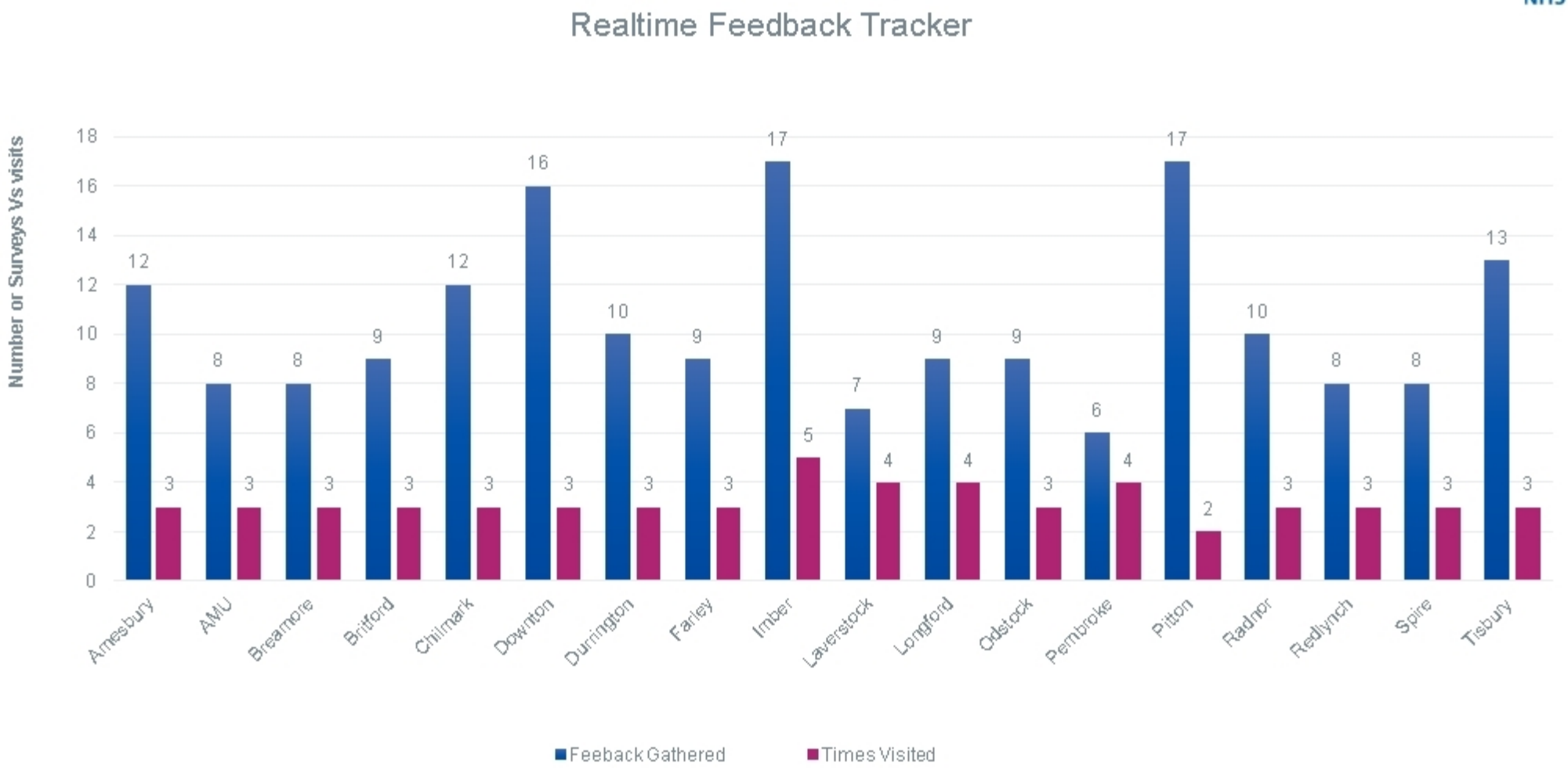
Total surveys undertaken: 415

Average satisfaction rating: 87%



Activity Tracker

NHS Salisbury NHS Foundation Trust



Themes from Real-time Feedback

NHS
Salisbury
NHS Foundation Trust

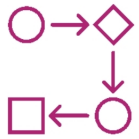
Positives

Cleanliness of the wards, toilets and wash facilities

Levels of assistance for basic care such as eating drinking and washing

Trust and confidence in those involved in their care

Negatives

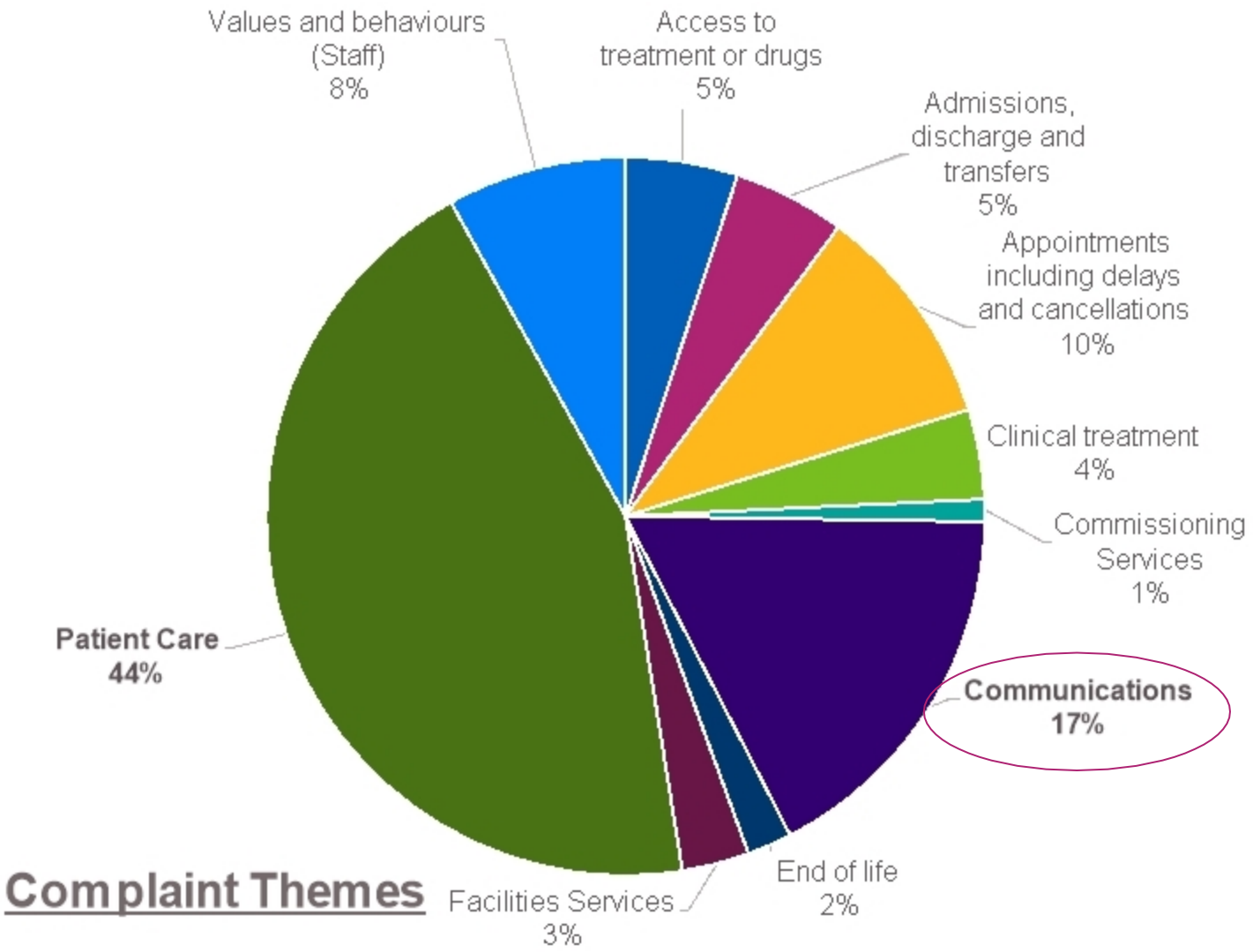


Understanding and involvement with discharge planning

How well medical staff are explaining things

How well staff explain how you might feel after an operation or procedure

Themes from Complaints



Data from RTF during the survey period demonstrated low scoring questions in relation to communication

It was noted to have correlated with themes from complaints seen in Q3 (of which 17% of complaints were noted to be in relation to insensitive and lack of communication which was the highest causes for complaints under the Communications category)

Complaints and concerns during the survey reporting period were small when compared with the number of Friends and Family Test (FFT) feedback received across the Trust and satisfaction rates associated with these. This represents the proportion of good or very good experiences (as rated by the service users) and how vast this is in comparison to the number who have raised a complaint or concern.

Correlation of Inpatient survey with Staff survey 2024

Salisbury NHS Foundation Trust

Theme	Staff Survey	Inpatient Survey	Correlation
Communication	'Voice that counts' trending upwards but still a gap compared to other trusts, especially on raising concerns	Complaints about miscommunication	High alignment
Environment & Facilities	Low morale in Estates & Facilities. However no dedicated facilities condition metric in staff survey. Reasonable satisfaction with health, safety and resource provision	72% negative comments on ward conditions	Some alignment
Clinical Teamwork	High 'We are a Team' scores; staff feel part of a cohesive team and have good management relationships.	Positive patient narratives, Praise for kindness	Positive correlation
Recognition	Internal recognition improved compared to previous years but remains outside top tier of excellent recognition	High external praise from both in patient and Realtime feedback	Inverse pattern
Staffing levels	Unrealistic time pressures	Reports of delays and lack of staff presence	Strong alignment

Staff experience can be a leading indicator of patient experience, Patients often describe consequences whilst staff describe cause.

Key Department Correlations

NHS
Salisbury
NHS Foundation Trust

Emergency Department

Emergency department staff survey reports low scores for staff morale, recognition and ‘we are safe and healthy. Patient complaints about long waits and pain management. The system pressures within ED are experienced by both patient and staff

Surgery

Surgical areas have mixed staff survey feedback, strong teamwork but low flexibility. There is fragmentation across surgical flow pathways contributing to frequent patient complaints about cancellations and communication. Praise for surgical technical skills and clinical quality but focus required to enhance pathway coordination.

Facilities and Estates

Facilities departments report low morale and recognition, linked to patient dissatisfaction with ward conditions and amenities. Operational staffing constraints within estate services are felt by patients.

There were several high performing teams across the trust with high scores from both staff and patient feedback “unfailingly kind, compassion, professionalism and excellent teamwork” was praised.

Next Steps

Salisbury NHS Foundation Trust

Enough to Drink

Patient Hydration Challenges
Patients reported insufficient access to drinks, affecting comfort and recovery during hospital stays.

Improvement Actions
Leads introduced hydration rounds and ensured water accessibility to improve patient hydration.

Monitoring and Feedback
Patient feedback and spot checks will monitor progress, with updates from Matrons planned for upcoming Nursing and midwifery meeting.

Nurses Answering Questions Clearly

Patient Satisfaction Challenges
Patients reported dissatisfaction with how nurses answered questions clearly, impacting their confidence and safety.

Communication Improvement Initiatives
Nursing Team is focusing on improving bedside communication through training and patient engagement strategies.

Strategies for Clear Communication
Using plain language and verifying patient understanding are key strategies to enhance communication effectiveness.

Ongoing Monitoring and Review
Progress on communication improvements will be monitored improvement with anticipated positive outcomes from recent initiatives. Review planned in December

Staffing levels

Retention focused to the People Plan, including support networks for staff, flexible working, leadership training and line management support. Daily staffing reviews continue to ensure safe staffing levels, triangulation with quality, safety and workforce metrics, skill mix and staffing red flags.

Next Steps

Salisbury NHS Foundation Trust

Getting Staff Attention When Needed

Patient Safety and Satisfaction
Delayed staff response can negatively impact patient safety and satisfaction, especially in critical care areas.

Ward Process Review
Matrons will lead a review focusing on call bell audits, staff allocations, and workflow improvements to enhance response times.

Monitoring and Progress
Progress will be tracked and reported at the Nursing and Midwifery forum and Patient experience steering group.

Discharge process and/ or information

Committed focus remains to enhance discharge and follow-up process led by Chief Operating Officer working with community partners to eliminate inefficiencies and streamline process

Noise at Night

Sources of Nighttime Noise
Common noise sources include bin lids, staff conversations, moving equipment, aprons, and bed transfers disrupting patient rest.

Improvement Strategies
Implementing 'Quiet Hours', fitting soft-close bin lids, relocating noisy equipment, and staff awareness aim to reduce disturbances.
Patient safety partners working with ward-based staff to identify other opportunities to reduce noise
Head of Facilities reviewing curfew for deliveries out of hours.
Linking with colleagues from across Royal United Hospital, Bath and Great Western Hospital, Swindon to implement 'Putting the hospital to bed at night' initiative.

Importance of Quiet Environment
A restful environment is critical for patient recovery and overall experience, requiring immediate and robust interventions.

Monitoring and Feedback
Progress will be reviewed at the Nursing and Midwifery Forum and Patient experience steering group, with feedback from Matrons to ensure continuous improvement.

National Cancer Patient Experience Survey (NCPES) 2024

NHS Salisbury NHS Foundation Trust

- Annual survey, commissioned & managed by NHS England (since 2010)
  - ➢ New design from 2021, now have 4 years of comparable data.

- Picker - responsible for designing, running & analysing the survey

Designed to

- Monitor progress in cancer care
- Provide information to drive local quality improvements
- Assist commissioners and providers of cancer care
- Inform the work various charities and stakeholder groups, supporting cancer patients

NCPES Methodology

NHS Salisbury NHS Foundation Trust

•Provider survey samples

- Adults (16 and over), with a confirmed diagnosis of cancer
- Discharged from SFT (after an inpatient or day-case attendance for cancer related treatment) in April, May and June 2024

•Trusts submitted sample of patients September 2024

•Survey fieldwork Nov. 2024 – Feb. 2025.

•Mixed mode methodology. Questionnaires were sent by post, with two reminders where necessary, but also included an option to complete the questionnaire online.

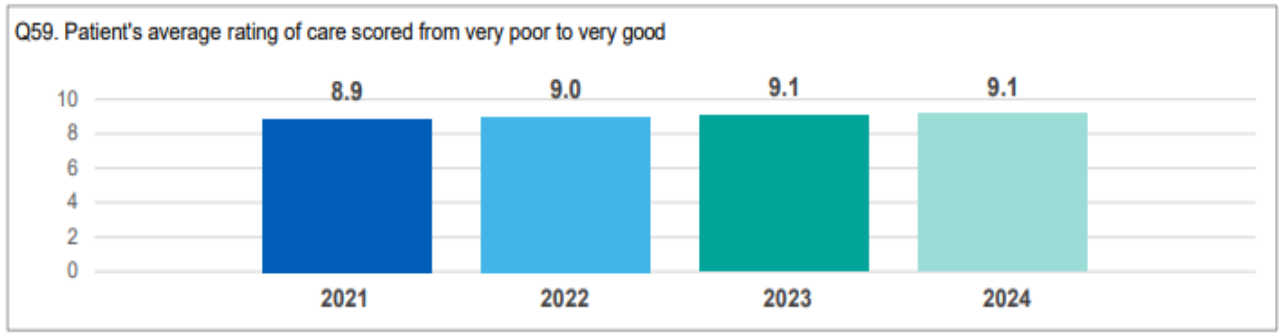
•Reports published July 2025 (National, Alliance, ICS, Trust)

Key Messages

Salisbury NHS Foundation Trust

- The report scores 61 questions at Trust level, which are compared to the national average, expected lower and upper ranges.
- **41** questions were within the **expected range**.
- **20** questions were **positive** outliers compared to **23 in 2023 and 8 in 2022**
- **0** questions were **negative** outliers compared to **0 in 2023** and **0 in 2022**.

- Patients are asked to rate their care from very poor (0) to very good (10). The Trust score was **9.1** compared to a national average of **8.9**, lower expected of 8.7 and upper of 9.1. **Consistent with 2023.**



Link to full CPES presentation report : [My Documents\PESG\CPES 2024 General Presentation.pptx]

Children and Young People's Survey 2024

NHS Salisbury NHS Foundation Trust

SFT scoring as the highest trust in our region for overall experience

Where parents and carers reported experience is best

- ✓ **Hospital food:** Children having access to hospital food outside of mealtimes
- ✓ **Leaving hospital:** Parents / carers receiving written information about care at home
- ✓ **Facilities:** Good facilities being available for parents / carers staying overnight
- ✓ **Facilities:** Parents / carers having good access to hot drinks in hospital
- ✓ **Leaving hospital:** Parents / carers understanding next steps in their child / young person's care

Where parents and carers reported experience could improve

- **The waiting area:** Children being kept informed while in waiting areas
- **The waiting area:** Children experiencing reasonable waiting times in waiting areas
- **Hospital ward:** Children and young people being placed in an age appropriate ward
- **Leaving hospital:** Parents / carers understanding information about care at home
- **The waiting area:** Children not feeling bothered by anything in waiting areas

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	5.3
Date of meeting:	23 February 2026		

Report title:	Committee Terms of Reference			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Tapiwa Songore, Head of Corporate Governance			
Executive Sponsor: (presenting)	Eiri Jones, Chair			
Appendices	Two			
BAF Risk link	All			

Recommendation:
The Council is asked to approve the Terms of Reference for the Membership and Assessment Committee and the Remuneration and Performance Committee

Executive Summary:
At the Council meeting on meeting held on 24 November 2025, Governors approved the proposal to merge the Membership with the Assessment Committee, and to set up the Nominations as a standing Committee, merging it into the Performance Committee. Appendices A and B are the draft Terms of Reference for the Membership and Assessment Committee and the Remuneration and Performance Committee for Council approval.

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

Salisbury NHS Foundation Trust

Membership, Communications and Self-Assessment Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
13/01/2025	V1.0	Major	Merge of two committees' terms of reference	Head of Corporate Governance

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Chair of Committee and Membership Manager
Review and Approval	Membership, Communications and Self-Assessment Committee
Adoption and ratification	{insert date}

1. Purpose

The Membership & Communications Committee aims to:

1. Recruit and sustain an engaged membership of Salisbury NHS Foundation Trust, ensuring it is broadly representative of the population served, with attention to age, ethnicity, and diversity.
2. Facilitate communication with members, enabling participation in the Trust's service development and decision-making processes.
3. Support governors in understanding and representing members' and the public's views to fulfil their statutory duties effectively.
4. Lead and consult on the Governor Self-Assessment process in accordance with the Code of Governance. This includes periodic performance assessment and communication of responsibilities discharged to members and the public.
5. Ensure governors are effectively supported in fulfilling their roles, including providing necessary training and reviewing forward plans for improvement.

2. Authority

The Council of Governors resolves to establish this committee as a standing committee with specific delegated responsibilities outlined in these terms of reference. It has no executive powers unless explicitly stated.

3. Membership and Attendance

3.1. Membership

The Committee will consist of 6 governors, including:

- At least three public governors.
- One staff governor and one nominated governor.
- The governor responsible for "Medicine for Members."
- The Head of Corporate Governance, Membership Manager, and the Trust's Head of Communications will normally attend meetings.
- Additional attendees may be invited as required.

3.2. Chairman

The Chairmanship shall be determined as provided by paragraph 16 of the Council's Protocol on Committees. That provides:

- 16. The chairmanship of a committee shall be decided by the committee (by vote of the members if necessary) or as directed in its Terms of Reference. In the event of determination by a vote any two members of the committee may refer the issue to a meeting of the Council, which shall determine the chairmanship. The Council of Governors will resolve the issue.

3.3. Quorum

At least four governors must be present to meet the quorum.

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

4.1. Membership Engagement

- Advise the Council on membership targets and strategies, ensuring appropriate diversity by constituency and age.
- Review the Membership Strategy

4.2. Communication

- Develop and oversee methods for effective communication with members, including newsletters, public meetings, and outreach to schools and colleges.
- Collaborate with the Head of Communications on content and governor input for newsletters.

4.3. Self-Assessment:

- Facilitate periodic self-assessments of the Council's collective performance as per the Code of Governance
- Ensure governors fulfil their statutory duties and receive necessary training.
- Review the structure, composition, and procedures of the Council to incorporate best practices.

5. Conduct of Business

5.1. Administration

The Membership Manager will act as Secretary, advising on functions and setting meeting agendas in consultation with the Chair.

5.2. Frequency

The Committee will meet at least four times a year, but not less than twice annually.

5.3. Notice of meetings

Agendas will be prepared by the Membership Manager in consultation with the Chair and sent five working days before the meeting, along with supporting papers.

5.4. Reporting

Minutes of meetings will be provided to the Council of Governors at the next appropriate meeting.

6. Review

6.1. The Terms of Reference will be reviewed annually. The Committee will:

a) Conduct a self-assessment of its performance against the Terms of Reference
b) Evaluate whether it receives adequate support and whether the workload is manageable.

Salisbury NHS Foundation Trust

Council of Governors
Nomination and Performance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
Feb 2026			New ToRs developed on the merger of the Nomination and the Performance Committee	Head of Corporate Governance / Lead Governor

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Lead Governor
Review and Approval	Nomination and Performance Committee
Adoption and ratification	Council of Governors

1. Purpose

1.1 The Governors' Nomination and Performance Committee (the Committee) is responsible for advising and/or making recommendations to the Council of Governors (the CoG) on:

- the appointment of the Chair and Non-Executive Directors (NEDs) positions on the Board of directors (the Board)
- the remuneration, allowances and terms and conditions of the Chair and NEDs;
- the evaluation of the performance of the Chair and NEDs; and the effectiveness of the Trust Board as a whole,
- the approval of the appointment of the Chief Executive.
- To make a recommendation to the full Council of Governors on the suitability of either the Chair or any Non-Executive Director wishing to undertake a further term of office

2. Authority

- This Committee is a standing committee of the Council of Governors.
- This Committee has no executive powers, other than those specifically delegated in these terms of reference.

3. Membership and Attendance

3.1. **Membership**

The members of the Committee will be as follows:

- The Chair of the Board/Council of Governors
- Lead Governor or Deputy Lead Governor
- Six other Governors (with at least one from each of Public Governor, Nominated and Staff Governor)

The Lead Governor will chair the regular meetings of the Committee. In the absence of the Committee Chair and/or an appointed deputy, the governors present will elect one of themselves to chair the meeting.

The specific meetings around appointing the Trust Chair and NEDs will be undertaken in accordance with the Constitution.

The following will be invited to attend meetings of the Committee on a regular basis

- The Group Chief People Officer
- Head of Corporate Governance
- Membership Manager

3.2. **Quorum**

A quorum will consist of four members.

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

The duties of the Committee/Group can be described as follows:

Nomination Role

4.1. To periodically review the balance of skills, knowledge, experience and diversity of the NEDs and have regard to the views of the Board and relevant guidance on Board composition.

4.2. To make recommendations to the CoG with regard to the outcome of the review.

4.3. Give consideration to succession planning for NEDs, taking into account the challenges and opportunities facing the Trust and its plans to address them, and consulting with the Board as to the skills and expertise needed on the Board in the future.

4.4. To agree with the CoG a clear process for the appointment of the Chair or a NED, including, in the case of any new appointments to the Board:

- preparing a description of the role and capabilities required for the Chair or each NED appointment and the expected time commitment, taking into account the views of the Board on the qualifications, skills and experience required
- the use of open advertising and/or the services of appropriate advisers to facilitate the search.
- the composition of the interview panel, which shall include a majority of governors and may include invited external parties to aid the governors in their decision making

4.5. To identify and nominate suitable candidates for appointment by the CoG, considering candidates from a wide range of backgrounds on merit and against objective criteria.

4.6. Review of the time commitment of appointed NEDs

Performance Role

4.7. To evaluate the effectiveness of the Trust Board as a whole.

4.8. To review the performance objectives and appraisal process for the Chair and Non-Executive Directors prior to submission to the Council of Governors.

4.9. To evaluate the performance of the Trust Chair with the assistance of the Senior Independent Director (SID) and report to the Council on the outcome.

4.10. To evaluate the performance of the Non-Executive Directors collectively and individually, with the assistance of the Trust Chair and report to the Council on the outcome.

4.11. To agree procedures for the above evaluations with the Chair and SID.

4.12. To make recommendations to the Council as to whether the Trust Chair and Non-Executive Directors should be invited to undertake further terms of office having, if the Lead Governor is not a member of the Committee, sought their view.

4.13. To review the terms and conditions of the Foundation Trust's Chair and NEDs in accordance with all relevant Trust policy and national benchmarking, including remuneration and other relevant provisions and allowances and make recommendations to the Council of Governors, as appropriate.

4.14. To undertake, at least every three years, a full assessment of remuneration to test market levels for the Chair and Non-Executive Directors. This is to be guided by information from NHSE or other such national body that provided comparison information or guidance.

5. Conduct of Business

5.1. Administration

The Head of Corporate Governance will act as the Secretary to the Committee advising the Committee as to its functions and in consultation with the Committee's Chair setting the agenda for its meetings. The provision of minutes and other administrative services shall be provided by the Trust's Membership Manager.

5.2. Frequency

The Committee will typically meet four times per year in accordance with the forward plan of work. Additional meetings may be scheduled as needed.

5.3. Notice of meetings

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

5.4. Reporting

Meetings of the Committee shall be minuted and the minutes circulated to governors at the next appropriate meeting of the Council. Due to the confidential nature of these minutes they will normally be presented in the private session of the CoG.

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.

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

NHS Salisbury NHS Foundation Trust

Report to:	Council of Governors	Agenda item:	5.3
Date of meeting:	23 February 2026		

Report title:	Constitution			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Tapiwa Songore, Head of Corporate Governance			
Executive Sponsor: (presenting)	Eiri Jones, Chair			
Appendices	One			
BAF Risk link	All			

Recommendation:
The Council is asked to approve the changes to the Constitution

Executive Summary:
At the Council meeting on meeting held on 24 November 2025, Governors approved the proposal to set up the Nominations as a standing Committee, merging it into the Performance Committee, and the Constitution has been amended to reflect that.

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

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

Post Holder Responsible for Policy:	Director of Integrated Governance
Directorate Responsible for Policy:	Chief Executive's
Contact Details:	Ext: 2774
Date Written:	2005
Date Revised:	April 2024
Approved by:	Council of Governor's/ Trust Board
Date Approved:	
Next Due for Revision:	April 2025 (Annual Review)
Date Document Becomes Live:	

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

Introduction

Salisbury NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the three organisations and wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB)

In line with current legislation all three trusts remain as individual statutory organisations with individual constitutions. Therefore, for the purposes of this document references to the chief executive will remain singular and not ‘joint’ or ‘group’.

NHS
Salisbury
NHS Foundation Trust

Table of Contents:

Amendment History:

Year	Amendment
2014	• The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
2016	• Amendment of paragraph 37 of the Constitution was approved by the Board of Directors on 29 February 2016 and by the Council of Governors on 11 April 2016. • The new Model Election Rules were issued by the former Foundation Trust Network (NHS Providers) in August 2014 and formally adopted by the trust on 29 February/11 April 2016 • Amendment of paragraph 16 of the Council's standing orders was approved by the Council on 16 May 2016
2018	• April 2018 minor amendments to Board Standing Orders • Addition of Standing Financial Instructions – approved February 2018
2019	• Amendment of Annex 1 to a) insert the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency; (b) delete West Wiltshire as a constituency; (c) increase the number of governors for the South Wiltshire Rural Constituency from 5 to 6. – approved November 2019
2020	• Annex 8 Standing Orders of the Board of Directors has been completely revised and is included as an appendix to the Constitution. • The wards and constituencies have been updated. This includes merging West Wiltshire into South Wiltshire Rural. North Dorset and East Dorset constituencies have also been updated based on the electoral ward. • Within Annex 2 the Hotel and Property Class in the Staff Constituency is merged with the Clerical, Administrative and Managerial staff class. The name has been amended to "Administrative, Facilities and Managerial". • The unused paragraphs have been removed and the document renumbered and reformatted to reflect this.
2021	• Wiltshire Clinical Commissioning Group (CCG) is now called Bath and North-East Somerset, Swindon and Wiltshire (BSW)
2022	• Amendments to Annex 6 and Annex 9 to update Governor and Board disqualification criteria. • Document renumbered.
2023	• Minor formatting updates. • Item 32.3 updated to reflect NED terms of office (2 x 3-year terms plus 1 x 2-year term). • Annex 4 – Composition of the Appointed Governors updated to reflect the distinction between local authority and partnership organisations. • Annex 7 – Item 11.3 updated to include 'external stakeholder' in the composition of future Nominations Committees
2025	• Updating para 1 to reflect the Health and Social Care Act 2022. • Para 4 – Powers updated to recognise joint committees and the 2006 Act (revised 2022). • Para 4.5 added as specified in the Health and Care Act 2022. • Para 17 updated to recognise joint committees. • Annex 4 updated to reflect changes to 'partnership organisations' in relation to Appointed Governors. • Annex 8, para 5.9 added to reflect the establishment of Joint Committees and Committee-in Common. • Para 14.5 – the wording around Governor elections has been further clarified

	• Para 21 – Board Composition has been updated and aligns with Great Western Hospitals NHS Foundation Trust. • Para 23 – updated to include the associate NED reference. • Para 25 – Updated to reflect the Fit and Proper Persons (FPPR) regulations. • Para 26 – new section added reflecting the latest Code of Governance relating to the appointment and removal of the Company Secretary. • Para 31 – Updated wording for terms of office for Chair and Non-Executive Directors to reflect the latest Code of Governance. Ultimately, any decision to extend a NED term of office beyond 6 years should be subject to rigorous review. • Para 42 – The wording around significant transactions has been strengthened following feedback from the Council of Governors • Annex 9 – updated wording to reflect an exception to board membership

1. Interpretation and definitions

1.1 Unless otherwise stated, words or expressions used in this constitution have the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022.

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

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

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

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

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

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

2. Name

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

3. Principal purpose

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

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

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

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

3.3.2 the promotion and protection of public health.

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

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

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act, updated in the 2012 Health and Social Care Act and the 2022 Health and Care Act.

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

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

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

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

5. Membership and constituencies

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

5.1.1 A public constituency

5.1.2 A staff constituency

6. Application for membership

6.1 An individual who is eligible to become a member of the Trust shall become a member on his application to the Trust to become a member or by being invited by the Trust to become a member of the staff constituency in accordance with paragraph 9.

7. Public Constituency

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

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

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

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

8. Staff Constituency

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

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

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

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

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

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

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

9. Automatic Membership by default – Staff

9.1 An individual who is:

9.1.1 Eligible under paragraph 8.1 to become a member of the Staff Constituency, and
9.1.2 invited by the Trust to become a member of the Staff Constituency, shall become a member of the Staff Constituency and in the appropriate staff class without an application being made, unless they inform the Trust that they do not wish to do so.

10. Patients' Constituency

There is no Patients' Constituency

11. Restrictions on Membership

11.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.
11.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any other constituency.
11.3 An individual must be at least 16 years old to become a member of the Trust.
11.4 An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.
11.5 A member of the Trust shall inform the Secretary of the Trust of any circumstances which may affect their entitlement to be a member.
11.6 Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.
11.7 A member may resign by written notice to the Secretary of the Trust.

12. Annual Members' Meeting

12.1 The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public. This should be held no later than 30th September.

13. Council of Governors – Composition

13.1 The Trust is to have a Council of Governors comprising both elected and appointed governors.
13.2 The composition of the Council of Governors is specified in Annex 4.
13.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.
13.4 No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

14. Council of Governors – Election of Governors

14.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.
14.2 The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.
14.3 A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).
14.4 An election, if contested, shall be by secret ballot.

14.5 Where membership of the Council of Governors ceases within 12 months of election, public and staff governors shall be replaced by the candidate in the same constituency and class with the next highest number of votes at the last election. If the vacancy cannot be filled by this method the Trust will commence another election process at the earliest opportunity, in accordance with the Model Election Rules

15. Council of Governors – Tenure

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

15.2 An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than nine years in all.

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

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

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

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

16. Council of Governors – Disqualification and Termination of Office

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

- **16.1.1** a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- **16.1.2** a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.
- **16.1.3** a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.
- **16.1.4** The further persons set out in Annex 6.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

16.3 If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

- **16.3.1** the failure was in their opinion due to a reasonable cause or causes, and
- **16.3.2** he will be able to, and will, start attending meetings of the Council within such period as they consider reasonable.

16.4 A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

- **16.4.1** acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or
- **16.4.2** failed to declare a material interest pursuant to paragraph 21 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

16.5 Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 16.3 and 16.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

16.6 In the event of a notice being given under sub-paragraph 16.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's

ability to remain a governor (other than those set out in paragraphs 16.3 and 16.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

16.7 A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

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

17. Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

17.1 The general duties of the Council of Governors are–

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

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

17.2 The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

17.3 The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

18. Council of Governors – Meetings of Governors

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

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

18.3 Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

18.4 The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

18.5 The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

18.6 For the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18.7 The Council of Governors may appoint committees consisting wholly or partly of its members to assist it in carrying out its functions as are required by law and to carry out such functions as the Council specifies.

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

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

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

19. Council of Governors – Standing Orders

19.1 The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

20. Council of Governors – Referral to the Panel

20.1 In this paragraph the Panel means a panel of persons appointed by NHS England to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

20.1.1 to act in accordance with its constitution, or

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

20.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

21. Council of Governors – Conflicts of Interest of Governors

21.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.2 For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

22. Council of Governors – Travel Expenses

22.1 The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

23. Board of Directors – Composition

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

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chair

23.2.2 a minimum of 5 other non-executive directors

23.2.3 a minimum of 5 executive directors to include:

23.2.4 One of the Executive Directors shall be the Chief Executive.

23.2.5 The Chief Executive shall be the Accounting Officer.

23.2.6 One of the Executive Directors shall be the Chief Finance Officer

23.2.7 One of the Executive Directors shall be the Managing Director

23.3 One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

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

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

24. Board of Directors – General Duty

24.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors – Appointment and removal of Chair and Non-Executive Directors, including Associate Non-Executive Directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other non-executive directors, including Associate Non-Executive Directors.

25.2 Removal of the Chair or any other non-executive director, including Associate Non-Executive Directors shall require the approval of 75% of the members of the Council of Governors (in person or virtual attendance).

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

26. Board of Directors – Deputy Chair

26.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chair. The Deputy Chair shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

27. Board of Directors – Appointment and removal of the Chief Executive and Executive Directors

27.1 The non-executive directors shall appoint or remove the Chief Executive. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

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

27.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

28. Board of Directors – appointment and removal of the Company Secretary

28.1 The whole Board shall appoint or remove the Company Secretary (Director of Corporate Governance)

29. Board of Directors – Disqualification

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

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

29.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

29.1.4 The persons referred in Annex 9.

30. Board of Directors – Meetings

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

30.2 As soon as practical after holding a meeting the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

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

30.4 Members of the public may be excluded from all or any part of a meeting by a resolution of the Board for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

31. Board of Directors – Standing orders

31.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8. They may be amended as provided in them.

32. Board of Directors – Conflicts of Interest of Directors

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

32.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust.

32.1.2 a duty not to accept a benefit from a third party by reason of being a director or by reason of doing or not doing anything in that capacity.

32.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

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

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors before the Trust enters into the transaction or arrangement.

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

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

32.8 This paragraph does not require a declaration of an interest of which the director is not aware, or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 if it cannot be reasonably regarded as likely to give rise to a conflict of interest.

32.9.2 if, or to the extent that, the directors are already aware of it.

32.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors, or by a committee of the directors appointed for the purpose under the constitution.

33. Board of Directors – Remuneration and Terms of Office

33.1 The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms of office, of the Chief Executive and the other executive directors.

33.3 The Chair and other non-executive directors should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years for a valid reason and should be subject to rigorous review which may be renewed by the Council. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly

where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

34. Registers

34.1 The Trust shall have a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.
34.2 a register of members of the Council of Governors.
34.3 a register of interests of Governors.
34.4 a register of interests of directors.
34.5 and a register of directors.

35. Registers – Inspection and copies

35.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.
35.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:
- **35.2.1** any member of the Rest of England Constituency; or
- **35.2.2** any other member of the Trust if the member so requests.

35.3 So far as the registers are required to be made available:
- **35.3.1** They are to be available for inspection free of charge at all reasonable times; and
- **35.3.2** A person who requests a copy or extract from the registers is to be provided with a copy or extract.

35.4 If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

36. Documents available for public inspection

36.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
- **36.1.1** A copy of the current constitution.
- **36.1.2** A copy of the latest annual accounts and of any report of the auditor on them; and
- **36.1.3** A copy of the latest annual report

36.2 The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:
- **36.2.1** A copy of any order made under section 65D (appointment of special trust administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
- **36.2.2** A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
- **36.2.3** A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act.
- **36.2.4** A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
- **36.2.5** A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.
- **36.2.6** A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
- **36.2.7** A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

36.2.8 A copy of any final report published under section 65I (administrator's final report) of the 2006 Act.

36.2.9 A copy of any statement published under section 65J (power to extend time), or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

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

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

36.4 If the person requesting an extract or copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. Auditor

37.1 The Trust shall have an auditor.

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

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

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

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

38. Audit Committee

38.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

39. Accounts

39.1 The Trust must keep proper accounts in such form as NHS England may with the approval of the Treasury direct and proper records in relation to those accounts.

39.2 NHS England may, with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

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

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

39.4.1 the accounts.

39.4.2 the records relating to them; and

39.4.3 any report of the Auditor on them

39.5 The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State for Health direct.

39.6 NHS England may with the approval of the Secretary of State for Health direct the Trust:

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

39.6.2 that any accounts prepared by it by virtue of sub-paragraph 38.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

39.7 In preparing its annual accounts or in preparing any accounts by virtue of sub-paragraph 44.6.1 above, the Trust is to comply with any directions given by NHS England with the approval of the Secretary of State for Health as to:

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

39.7.2 the content and form of the annual accounts

39.8 The Trust must –

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

39.8.2 send copies of the annual accounts, and any report of the Auditor on them to NHS England within such a period as NHS England may direct

39.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 38.6 above and a copy of any report of the Auditor to NHS England within such a period as NHS England may direct.

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

40. Annual Report, Forward Plans and Non-NHS work

40.1 The Trust shall prepare an annual report and send it to NHS England.

40.2 The annual report must give:

40.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and of the patients' constituency is representative of those eligible for membership.

40.2.2 information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 18.5 here of

40.2.3 information on the corporation's policy on pay and on the work of the committee established under paragraph 32(2) hereof and such other procedures as the corporation has on pay.

40.2.4 information on the remuneration of the directors and on the expenses of the governors and the directors

40.2.5 any other information that NHS England or requires.

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

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

40.5 In preparing the document, the directors shall have regard to the views of the governors, and the directors shall provide the governors with information appropriate for them to be able to form their views.

40.6 Each forward plan must include information about:

40.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

40.6.2 the income it expects to receive from doing so.

40.7 Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 39.6.1, the Council of Governors must:

40.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

40.7.2 notify the directors of the Trust of its determination.

40.8 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England, the Trust may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

41. Presentation of the Annual Accounts and Reports to the Governors and Members

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

41.1.1 the annual accounts

41.1.2 any report of the auditor on them

41.1.3 the annual report.

41.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

41.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

42. Instruments

42.1 The Trust shall have a seal.

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

43. Amendment of the Constitution

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

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

43.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.

43.2 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

43.3 Where amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

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

43.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

43.4 If more than half of the members voting approve the amendment, the amendment continues to have effect. Otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

43.5 Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

44. Mergers etc. and Significant Transactions

44.1 The Trust may only apply for a merger, acquisition, separation or dissolution, as referred to in sections 56,56A, 56B, and 57A of the 2006 Act with the approval of more than half of the members of the Council of Governors.

44.2 The Trust may only enter a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction. The threshold for a significant transaction differs depending upon whether the transaction relates to UK or non-UK healthcare investment or disinvestment.

44.3 A Significant Transaction is a transaction deemed to be high risk and will include Statutory Transactions, (as set out in clause 44.1), and a transaction which the Trust's Finance Director, reporting to the Board, determines is covered by ANY of the following:

44.3.1 Assets, (i.e. the gross assets of the proposed transaction divided by the gross assets of the Trust), will exceed or be reduced by 10% or more

44.3.2 Income, (i.e. the income of the proposed transaction divided by the operating income of the Trust), will exceed or be reduced by 10%, or more

44.3.3 Any transaction that might lead to the Trust breaching its licence conditions

44.3.4 would be likely to put at risk the Trust's ability to provide its services as a whole, or a significant part of its services, to the appropriate regulatory standard**.**

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

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

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

44.4.2 have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail.

44.5 If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council's discussion of the transaction for and against approval shall be recorded in the minutes.

44.6 The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust's income or capital in the previous year.

45. Indemnity

45.1 Members of the Council of Governors and of the Board of Directors who act honestly and in good faith will be indemnified by the Trust against any civil liability which is incurred in the execution or purported execution of their functions relating to the Trust, save where they have acted recklessly. The Trust shall take out insurance against liability under this indemnity.

46. Dispute Resolution

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

46.2 If the Chair is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

46.3 If the dispute is not resolved, the Chair may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area formerly covered by North Dorset District Council, comprising the following electoral wards: ▪ Beacon ▪ Blandford ▪ Cranborne Chase ▪ Gillingham ▪ Hill Forts & Upper Tarrants ▪ Shaftesbury Town ▪ Stalbridge & Marnhull (Marnhull parish) ▪ Sturminster Newton
Kennet	The area formerly covered by Kennet District Council comprising the following electoral wards: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke

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

East Dorset	The following electoral wards within the area formerly covered by East Dorset District Council: • Cranborne & Alderholt • St. Leonards & St. Ives • Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes • Verwood • West Moors & Three Legged Cross
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 6)

The Staff Constituency is divided into 5 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUBGROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries Health Care Assistants (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers Orthoptists Physiotherapists and Helpers Art/Music/Drama Therapists Speech and Language Therapists and Helpers Psychologists and Psychology Technicians Psychotherapists Medical Physicists and Technicians Pharmacists and Pharmacy Technicians Dental Technicians Operating Department Practitioners Social Workers Chaplains Clinical Scientists Biomedical Scientists and Technical Staff Geneticists and Technicians Audiology Staff Cardiographers and Support Staff
Administrative, Facilities and Managerial Staff	Ancillary Staff Works and Maintenance Staff Ambulance Staff
Voluntary Staff	

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

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

Public Governors

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

Staff Governors

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

Appointed Governors

3. There shall be 4 appointed governors:

- **Local Authority**

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

- **Partnership Organisations**

3.2 There shall be a maximum of five partnership organisations (or successor organisations) who may appoint one governor by notice in writing, signed by the chief executive (or equivalent) of that organisation and delivered to the chair. These partnership organisations are decided by the Board of Directors and Council of Governors.

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

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

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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

PART 5: CONTESTED ELECTIONS

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

Action to be taken before the poll

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

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

41- [NOT USED]
42. Arrangements for counting of the votes
43. The count
FPP44. Rejected ballot papers and rejected text voting records
[45-50 NOT USED]
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

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

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19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
   i. configured in accordance with these rules; and
   ii. will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system.

b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
   i. configured in accordance with these rules; and
   ii. will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system.

c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
   i. configured in accordance with these rules; and
   ii. will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

a) the name of the corporation,

b) the constituency, or class within a constituency, for which the election is being held,

c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

d) the names and other particulars of the candidates standing for election, with the details and

order being the same as in the statement of nominated candidates,
e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:
a) that the voter is the person:
i. to whom the ballot paper was addressed, and/or
ii. to whom the voter ID number contained within the e-voting information was allocated,
b) that he or she has not marked or returned any other voting information in the election, and
c) he particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:
a) a postal address; and,
b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:
a) the name of the corporation,
b) the constituency, or class within a constituency, for which the election is being held,
c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
f) the methods of polling by which votes may be cast at the election by voters in a constituency

or class within a constituency, as determined by the corporation in accordance with rule 19.3,
g) the address for return of the ballot papers,
h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located.
i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
k) the date and time of the close of the poll,
l) the address and final dates for applications for replacement voting information, and
m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:
a) a ballot paper and ballot paper envelope,
b) the ID declaration form (if required),
c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
d) a covering envelope.
("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:
a) instructions on how to vote and how to make a declaration of identity (if required),
b) the voter's voter ID number,
c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
d) contact details of the returning officer,
("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:
a) only be sent postal voting information; or
b) only be sent e-voting information; or
c) be sent both postal voting information and e-voting information.
for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
a) the address for return of the ballot paper printed on it, and
b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
a) the completed ID declaration form if required, and

b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election, then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election, then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election, then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

a) require a voter to:
   i. enter his or her voter ID number; and
   ii. where the election is for a public or patient constituency, make a declaration of identity;
   in order to be able to cast his or her vote;

b) specify:
   i. the name of the corporation,
   ii. the constituency, or class within a constituency, for which the election is being held,
   iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
   iv. the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
   v. instructions on how to vote and how to make a declaration of identity,
   vi. the date and time of the close of the poll, and
   vii. the contact details of the returning officer.

c) prevent a voter from voting for more candidates than he or she is entitled to at the election.

d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
   i. the voter’s voter ID number.
   ii. the voter’s declaration of identity (where required).
   iii. the candidate or candidates for whom the voter has voted; and
   iv. the date and time of the voter’s vote,

e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

a) require a voter to
   i. enter his or her voter ID number in order to be able to cast his or her vote; and
   ii. where the election is for a public or patient constituency, make a declaration of identity.

b) specify:
   i. the name of the corporation,
   ii. the constituency, or class within a constituency, for which the election is being held,
   iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
   iv. instructions on how to vote and how to make a declaration of identity,
   v. the date and time of the close of the poll, and
   vi. the contact details of the returning officer.

c) prevent a voter from voting for more candidates than he or she is entitled to at the election.

d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
   i. the voter’s voter ID number.
   ii. the voter’s declaration of identity (where required).

iii. the candidate or candidates for whom the voter has voted; and
iv. the date and time of the voter's vote

e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this.
f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

a) require a voter to:
   i. provide his or her voter ID number; and
   ii. where the election is for a public or patient constituency, make a declaration of identity;
   in order to be able to cast his or her vote;
b) prevent a voter from voting for more candidates than he or she is entitled to at the election;
c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
   i. the voter's voter ID number;
   ii. the voter's declaration of identity (where required);
   iii. the candidate or candidates for whom the voter has voted; and
   iv. the date and time of the voter's vote
d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

a) is satisfied as to the voter's identity; and
b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

a) the name of the voter, and
b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on

the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity**.**

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes")**:**

a) the name of the voter, and
b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

a) is satisfied as to the voter's identity,
b) has no reason to doubt that the voter did not receive the original voting information,
c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

a) the name of the voter
b) the details of the unique identifier of the replacement ballot paper, if applicable, and
c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

a) the name of the voter,
b) the unique identifier of any replacement ballot paper issued under this rule;
c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote**.**

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote

at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.
34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.
34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.
34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.
34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.
35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.
35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:
a) a covering envelope, or
b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,
before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.
36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
a) the candidate for whom a voter has voted, or
b) the unique identifier on a ballot paper.
36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.
37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:
a) put the ID declaration form if required in a separate packet, and
b) put the ballot paper aside for counting after the close of the poll.
37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:
a) mark the ballot paper “disqualified”,
b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of

disqualified documents"); and
d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:
a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:
a) mark the ID declaration form "disqualified",
b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
b) mark as "disqualified" all other votes that were cast using the relevant voter ID number.

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
a) mark the ballot paper "disqualified",
b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents.
d) place the document or documents in a separate packet; and
e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

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

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

a) the disqualified documents, together with the list of disqualified documents inside it,
b) the ID declaration forms, if required,
c) the list of spoilt ballot papers and the list of spoilt text message votes,
d) the list of lost ballot documents,
e) the list of eligible voters, and
f) the list of tendered voting information

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

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**.**

FPP44.8 A text voting record on which a vote is marked:

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

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

FPP44.9 The returning officer is to:

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

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

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

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

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

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

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

b) give notice of the name of each candidate who he or she has declared elected:

i. where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

ii. in any other case, to the Chair of the corporation; and

c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

a) the total number of votes given for each candidate (whether elected or not), and

b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

a) declare the candidate or candidates remaining validly nominated to be elected,

b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and

c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

b) the ballot papers and text voting records endorsed with “rejected in part”,

c) the rejected ballot papers and text voting records, and

d) the statement of rejected ballot papers and the statement of rejected text voting records,

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

54.2 The returning officer must not open the sealed packets of:

a) the disqualified documents, with the list of disqualified documents inside it,
b) the list of spoilt ballot papers and the list of spoilt text message votes,
c) the list of lost ballot documents, and
d) the list of eligible voters,

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

54.3 The returning officer must endorse on each packet a description of:

a) its contents,
b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

a) any voting documents are received by the returning officer after the close of the poll, or
b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

a) the inspection of, or the opening of any sealed packet containing –
   i. any rejected ballot papers, including ballot papers rejected in part,
   ii. any rejected text voting records, including text voting records rejected in part,
   iii. any disqualified documents, or the list of disqualified documents,
   iv. any counted ballot papers, internet voting records, telephone voting records or text voting records, or
   v. the list of eligible voters, or

b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

a) persons,
b) time,
c) place and mode of inspection,
d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

a) in giving its consent, and
b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

i. that his or her vote was given, and
ii. that NHS England has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39 and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

a) account and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

a) its contents,
b) the date of the publication of notice of the election,
c) the name of the corporation to which the election relates, and
d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS England (previously Monitor) under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:
a) personal expenses,
b) travelling expenses, and expenses incurred while living away from home, and
c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:
a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:
a) compile and distribute such information about the candidates, and
b) organise and hold such meetings to enable the candidates to speak and respond to questions,
as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:
a) objective, balanced and fair,
b) equivalent in size and content for all candidates,
c) compiled and distributed in consultation with all of the candidates standing for election, and
d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the

corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

a) a statement submitted by the candidate of no more than 250 words,

b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS England (previously Monitor) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS England (previously Monitor) by:

a) a person who voted at the election or who claimed to have had the right to vote, or

b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

a) describe the alleged breach of the rules or electoral irregularity, and

b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS England (previously Monitor) will refer the application to the independent election arbitration panel appointed by NHS England (previously Monitor).

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS England (previously Monitor) shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

a) the returning officer,
b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

i. the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
ii. the unique identifier on any ballot paper,
iii. the voter ID number allocated to any voter,
iv. the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

a) a member of the corporation,
b) an employee of the corporation,
c) a director of the corporation, or
d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

a) the delivery of the documents in rule 24, or
b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 16)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the laws of England and/or Wales.
3. A person who is a director of the Trust, Chair or chief executive of another NHS Foundation Trust or NHS Trust; However, a governor (other than the lead governor) may be a governor or non-executive director (other than Chair) of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two governorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected.
5. A person who occupies the same household as an existing governor or a director of the Trust.
6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election or becomes employed by the Trust.
7. A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor.

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

(See paragraph 19)

CONTENTS

1. Introduction

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

2. Interpretation

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

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

2.3 'The Council' means the Council of Governors.

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

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

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

3. Meetings of the Council

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

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chair and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given

3.3 If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4 Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5 Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. Agenda Items and Motions

4.1 Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chair and the Lead Governor.

4.2 A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second the motion and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chair of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3 A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the Chair of the meeting.

4.4 No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chair of the Trust.

4.5 The proposer of a motion shall propose it and shall have a right to speak before a vote is taken.

4.6 During the consideration of a motion a governor may move:

4.6.1 an amendment to the motion;
4.6.2 that the consideration of motion be adjourned to a subsequent meeting;
4.6.3 that the motion be summarily dismissed and the meeting to proceed to the next business;
4.6.4 that the motion be voted on immediately.

4.7 No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the Chair of the meeting.

4.8 Save where the Chair of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. Quorum

5.1 No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. Relevance and Concision

6.1 Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2 The Chair of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3 In any matter relating to the interpretation of the Constitution and Standing Orders the Chair of the meeting shall consider the advice of the Secretary.

7. Voting

7.1 Save where it is otherwise provided by the constitution, or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2 In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3 At the discretion of the Chair of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4 Save in the case of a secret paper ballot, if at least one third of the governor's present request, the voting for and against of each governor shall be minuted.

7.5 If a governor requests, his vote shall be minuted.

7.6 No one may vote unless physically present: there shall be no votes by proxy.

8. Minutes

8.1 Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting.

8.2 The minutes shall record the names of those attending.

9. Suspension of Standing Orders

9.1 Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the Chair of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2 A decision to suspend standing orders shall be recorded in the minutes.

9.3 A separate record of matters while the orders were suspended shall be made and shall be provided to the governors with the minutes.

10. Committees

10.1 The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2 The powers of the Council may be delegated to a committee for a specific purpose if the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3 The powers of the Council shall be exercised in general meeting.

10.4 The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the

committee on such terms as the Council may determine.

10.5 Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. Nominations Committee

11.1 Paragraph 27 of the Constitution provides for the appointment and removal of the Chair of the Trust and the other non-executive directors by the Council. Paragraph 27.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2 For the appointment of the Chair, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director
- 1 external stakeholder

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

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

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

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

~~**11.4.2** In the case of a nomination for Chair invite the non-executive directors to appoint a non-executive director to serve on the committee.~~

~~**11.5**~~**11.4** If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. Declarations and Register of Interests

12.1 Paragraph 21 of the Constitution provides for declarations of interest. It states:

- **21.1** *If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.*
- **21.2.** *For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question***.**

12.2 Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3 If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4 Subject to the exceptions below, material interests include:

12.4.1 any directorship of a company;

12.4.2 any interest held in any firm, company or business, which, in connection with the

matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3 any interest in an organisation providing health and social care services to the National Health Service;

12.4.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5 any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter before the Council fairly.

12.5 The exceptions are:

12.5.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2 an employment contract with the Trust held by a staff governor;

12.5.3 an employment contract held with the appointing body by an appointed governor;

12.6 If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7 The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting

12.8 The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9 If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the Chair of the meeting shall rule on the question having taken the advice of the Secretary.

12.10 A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11 A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 16.4 of the Constitution.

13. Code of Conduct

13.1 Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders and shall at all times comply with the Code.

14. Confidentiality

14.1 It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2 Governors must keep secure all confidential matter recorded on paper or electronically and must ensure that their NHS mail and forum details are not disclosed.

14.3 Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4 The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5 A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the information has entered the public domain.

14.6 Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. Expenses

15.1 Paragraph 22 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2 Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3 The total of the expenses paid to governors will be published in the Annual Report.

16. Lead and Deputy Lead Governor's Appointment

16.1 The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.

b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.

c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. Lead Governor and Deputy Lead Governor – Roles

17.1 The role of the Lead Governor is:

17.1.1 to chair meetings of the Council which cannot for any reason be chaired by the Chair or the Deputy Chair;

17.1.2 to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chair;

17.1.3 to communicate regularly with the Chair, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4 to be a point of contact for NHS England when appropriate;

17.1.5 to provide input into the appraisal of the Chair;

17.1.6 to take an active role in the activities of the Council;
17.1.7 to be a point of contact for governors when they have concerns;

17.2 The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. Lead and Deputy Lead Governors – Vote of No Confidence

18.1 If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chair, the Chair shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2 The Chair will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting.

18.3 The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4 At the meeting the Chair will present the reasons for the motion, and it will be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5 A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governor's present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6 A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. Directors' Attendance

19.1 Paragraph 18.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2 The attendance of a director pursuant to paragraph 18.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chair. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. Forward Plan

20.1 Paragraph 39.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2 The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3 The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting.

21. Amendment of Standing Orders

21.1 Paragraph 19.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX 7.1

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;
2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;
3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;
4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;
5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;
6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;
7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;
8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;
9. Recognise that the Trust is a non-political organisation.
10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;
11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;
12. Comply with the Council's Standing Orders;
13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;
14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    a) advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    b) any request by the media for comment should be forwarded to the Trust's press officer;
    c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer rather than responding himself;
    d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;
15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness:

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity:

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity:

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability:

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness:

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty:

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership:

Holders of public office should promote and support these principles by leadership and example

Governor's undertaking

I,_____, of ,
undertake as a Governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed:_____ Date:_____

ANNEX 8 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(see paragraph 30)

1. Interpretations and Definitions

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3. Any expression to which a meaning is given in the Health and Social Care Act 2012, or any legislation or any regulations made under this Act, shall have the same meaning in these standing orders and in addition:

1.3.1 **"Accounting officer"** means the person responsible and accountable for funds trusted to the Trust. The Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, this shall be the Chief Executive;

1.3.2 **"Board"** means the Board of Directors, consisting of the Chair, the independent non-executive directors and the executive directors;

1.3.3 **"Audit Committee"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework;

1.3.4 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

1.3.5 **"Committee"** means a committee or sub-committee appointed by the Trust;

1.3.6 **"Committee Members"** shall be persons formally appointed by the Trust to sit on or to chair specific committees;

1.3.7 **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

1.3.8 **"Council"** means the Council of Governors, formally constituted in accordance with the constitution and presided over by the Chair;

1.3.9 **"Director of Finance"** means the chief financial officer of the Trust;

1.3.10 **"Executive Director"** means a member of the board who is an officer of the Trust;

1.3.11 **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting;

1.3.12 **"Nominated Officer"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

1.3.13 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

1.3.14 **"SFIs"** means standing financial instructions;

1.3.15 **"SOs"** means Standing Orders.

1.3.16 **"Trust"** means Salisbury NHS Foundation Trust

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP AND ROLE OF MEMBERS

2.1 Composition of the Board of Directors

The composition of the Board of Directors shall be in accordance with paragraph 23 of the Constitution.

2.2 Role of Members of the Board of Directors

The Board of Directors will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal members. Their role will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. The Director of Finance shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may; however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair

The Chair shall be responsible for the operation of the Board of Directors and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of employment and with these Standing Orders.

The Chair shall take responsibility either directly, or indirectly, for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

The Chair shall work in close conjunction with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the discussion and ultimate resolutions.

Senior Independent Director

The Board of Directors should in consultation with the Council of Governors, appoint a Non-Executive Director to be the Senior Independent Director. Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another Non-Executive Director as Senior Independent Director.

2.3 Corporate role of the Board of Directors.

2.3.1 All business shall be conducted in the name of the Trust.

2.3.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3.3 The powers of the Trust established under statute shall be exercised by the Board except as otherwise provided for under Section 4 of this annex.

2.3.4 The Board has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the

'Schedule of Matters reserved to the Board' and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 Admission of the Public and the Press

3.1.1 The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.1.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.2 Observers at Board Meetings

3.2.1 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.2.2 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

3.3 Calling of Meetings

3.3.1 Ordinary meetings of the Board shall be held at such times and places as the Board determines. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board of Directors so resolves for special reasons.

3.3.2 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

3.4.1 Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear days before the meeting.

3.4.2 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.10 below

3.4.3 Agendas will normally be sent to members of the Board seven calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than five clear days before the meeting, save in emergency.

3.4.4 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the

Trust's website at least five clear days before the meeting.

3.5 Agendas and supporting papers

3.5.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.7 Chair of Meeting

3.7.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he/she is present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, then the remaining non-executive directors present shall choose which non-executive director shall preside.

3.8 Notices of Motion

3.8.1 A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 12 clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chair shall include in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. This Standing Order 3.8.1 shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda.

3.8.2 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8.3 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Motions – procedure at and during meetings

3.9.1 Who may propose?

A motion may be proposed by the Chair or any Director present at the meeting. Such motion must also be seconded by another Director.

3.9.2 Contents of Motions

The Chair may (at his discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.8, other than a motion relating to:

(a) the reception of a report;
(b) consideration of any item of business before the Trust Board;
(c) the accuracy of minutes;
(d) that the Board proceed to next business;
(e) that the Board adjourn;
(f) that the question be now put.

3.9.3 Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.9.4 Rights of reply to motions

Amendments: The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9.5 Motions Once Under Debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put;
- that a Director be not further heard;
- a motion resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the ‘next business’ or ‘that the question be now put’ in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.10 Emergency Motions

Subject to the agreement of the Chair and SO 3.9 above, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.11 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matter shall be final.

3.12 Voting

3.12.1 Save as provided in SO 3.15 Suspension of Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.12.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.12.4 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.14 Quorum

3.14.1 The quorum of a meeting will be at least half of the whole number of members of the Board of Directors (including at least one Non-Executive Director and one Executive Director).

3.14.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.14.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of

interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.15 Suspension of Standing Orders

3.15.1 Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present votes in favour of suspension.

3.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.15.4 No formal business may be transacted while Standing Orders are suspended.

3.15.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.16 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.6 Scheme of Delegation

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Discharge of the Direct Accountability

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8

The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by NHS England), the Board of Directors may appoint committees of the Trust

5.2 Applicability of Standing Orders and Standing Financial Instructions to committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of Powers

The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.5 Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6 Approval of appointments to committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.8 Committees established by the Board of Directors

The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

5.9 Joint Committees

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

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Disclosure of Interests

The Constitution, the 2006 Act and the Foundation Trust Code of Governance requires Board Directors to declare interests which are relevant and material to the NHS board of which they

are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 Declaring interests

6.3.1 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.3.2 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.3.3 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.3.4 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.

6.3.5 Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3.6 This standing order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

6.4 Register of Interests

6.4.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.4.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.4.4 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their respective Directors for clarification.

6.5 Exclusion of Chair and Members in proceedings on account of pecuniary interests

6.5.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.5.2 The Board of Directors may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.5.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.5.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 6.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7 STANDARDS OF BUSINESS CONDUCT POLICY

7.1 All staff and members must comply with the Trust's Standards of Business Conduct, the Regulatory Framework and the National guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4 Canvassing of and Recommendations by, Directors in Relation to Appointments

7.4.1 Canvassing of Directors of the Trust or of any Committee or joint committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 7 shall be included in application forms or otherwise brought to the attention of candidates.

7.4.2 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 7 shall not preclude a Director from giving written testimonial of a candidate's

ability, experience or character for submission to the Trust.

7.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 Relatives of Directors or Officers

7.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

7.5.2 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.5.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

8.2 Sealing of Documents

8.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Trust Secretary; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly.

(The report shall contain details of the seal number, a description of the document and the date of sealing).

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

ANNEX 9 – Additional Provisions - Directors – DISQUALIFICATION

(See Paragraph 28)

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

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, Chair or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the Chair) may be a non-executive director or a governor of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two

directorships or directorship and governorship. With exception to when a Board member is appointed to a joint role within a group structure

4. A person whose physical or mental wellbeing is such that their ability to act as a director of the Trust is materially affected.
5. A person who occupies the same household as an existing director of the Trust or a governor.
6. A person who has had their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list and, due to the reasons(s) for such removal, they are considered by the Trust to be unsuitable to be a Director.