Bundle Trust Board Public 6 February 2020

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates

Presented by NIck Marsden

1.2 10:10 - Patient Story

1.3 Welcome and Apologies

Apologies received from Michael von Bertele

1.4 Declaration of Interests

1.5 10:20 - Minutes of the previous meeting

Minutes attached from Public Trust Board meting held on 9th January 2020
For approval

1.5 Draft Public Board mins 9 January 2020.docx

1.6 Matters Arising and Action Log

1.6 List_of_action_items_Trust_Board_Public_9_January_2020.docx

1.7 10:25 - Chairman's Business

Presented by Nick Marsden

1.8 10:30 - Chief Executive Report

Presented by Cara Charles-Barks
For information

1.8 CEO Board Report Feb 2020.docx

2 ASSURANCE AND COMMITTEE REPORTS

2.1 10:40 - Trust Management Committee - 27 January 2020

Presented by Cara Charles-Barks
For assurance

2.1 TMC Escalation report Feb 2020.docx

2.2 10:45 - Finance and Performance Committee - 4 February 2020

Presented by Paul Miller, verbal update
For assurance

2.3 10:50 - Clinical Governance Committee - 4 February 2020

Presented by Paul Miller, verbal update
For assurance

2.4 10:55 - Workforce Committee - 23 January 2020

Presented by Nick Marsden
For assurance

2.4 Escalation report - Workforce Committee.docx

2.5 11:00 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona McNeight
For assurance

2.5a BAF cover sheet February Board.docx

2.5b BAF v14.1 for Board _January 2020.docx

2.5c Draft Corporate Risk Register January 2020 v1.2.pdf

2.5d CRR tracker v14_January Committees.pdf

2.6 11:10 - Integrated Performance Report - December Month 9

Presented by Christine Blanshard
For assurance

2.6a IPR.pdf

2.6b IPR February 2020 Final.pdf

3 QUALITY AND RISK

3.1 11:25 - Learning from Deaths Report

Presented by Christine Blanshard
For assurance

3.1 TB Learning from deaths report Q3 19 20 Jan 20.docx

4 GOVERNANCE

4.1 11:35 - Constitution

Presented by Fiona McNeight
For approval

4.1a Public Board cover sheet - Constitution Amendments.docx

4.1b Constitution January 2020 Draft.docx

4.2 11:40 - Board Evaluation

Presented by Fiona McNeight
For discussion

4.2 Board Effectiveness Review Report January 2020.docx

4.3 11:50 - EPRR Report

Presented by Andy Hyett
For assurance

4.3a Board Report - EPRR Annual Report 2019 Version 1.0.docx

4.3b EPRR Annual Report 2019 Version 1.0.docx

4.4 12:00 - Remuneration Committee terms of Reference

Presented by Fiona McNeight
For approval

4.4a Board cover sheet RemCom ToR February 2020.docx

4.4b Final Nomination and Remuneration Committee Terms of Reference_December 2019.docx

4.5 12:05 - 2020 Cycle of business

Presented by Fiona McNeight
For approval

DRAFT Trust Board Annual Business Cycle 2020-21 - public & private.xlsx

5 CLOSING BUSINESS

5.1 12:10 - Agreement of Principle Actions and Items for Escalation

Presented by Nick Marsden

5.2 12:15 - Any Other Business

Presented by Nick Marsden

5.3 12:20 - Public Questions

5.4 Date next meeting

Date of next Public Trust Board meeting is 5 March 2020

6 RESOLUTION

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

Salisbury NHS Foundation Trust

DRAFT
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 9 January 2020 in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr N Marsden	Chairman
Cara Charles Barks	Chief Executive Officer
Mr Andy Hyett	Chief Operating Officer
Ms T Baker	Non-Executive Director
Mr P Kemp	Non-Executive Director
Ms R Credidio	Non-Executive Director
Mr M Von Bertele	Non-Executive Director
Mr P Miller	Non-Executive Director
Ms E Jones	Non-Executive Director
Dr C Blanshard	Medical Director
Mrs L Thomas	Director of Finance
Mrs L Lane	Director of OD and People
Ms L Wilkinson	Director of Nursing

In Attendance:

Kylie Nye	Corporate Governance Manager (minutes)
John Mangan	Lead Governor (observer)
Raymond Jack	Public Governor (observer)
Dr J Lisle	Public Governor (observer)
Lucinda Herklots	Public Governor (observer)
Rex Webb	Head of Equality, Diversity & Inclusion (item TB109/1/3.1)
Jean Scrase	Head of Organisational Development and Engagement
Sharon Holt	Head of Resourcing
Thara Thomas	Nurse – AMU (item TB1 09/1/1.2)
Holly Gillespie	Pathology Technician (for item TB1 09/01/1.1)
Mel Hawkes	HR Recruitment Administrator (for item TB1 09/01/1.1)
Ed Leonardo	Business Development Manager – Liaison Group (public)
Damian Mayo	Public

ACTION

TB1 09/01/1 OPENING BUSINESS

TB1 09/01/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

N Marsden presented January's SOX awards to Holly Gillespie, Mel Hawkes and Dr Ian Jenkins and thanked them for their commitment and hard work.

TB1 09/1/1.2 Staff Story

L Lane introduced T Thomas, who was attending Trust Board to provide her experience of joining the Trust as an overseas nurse.

Discussion:

- N Marsden noted that her story had been a very positive one but asked T Thomas if there were any improvements that could have been made to make the experience an easier one. T Thomas noted that finding offsite accommodation had proved very difficult and trying to find a place to live whilst working had also been challenging. T Thomas suggested that it would be useful for new overseas nurses to have a chaperone or lead who has also been through the same experience. C Charles-Barks noted that the difficulties in overseas staff arranging accommodation outside of the Trust had been highlighted before and would be picked up outside of the meeting.
- The Board thanked T Thomas for attending and sharing her experience.

TB1 09/1/1.3 **Welcome and Apologies**

Apologies were received from.

- Fiona McNeight, Director of Corporate Governance
- Esther Provins, Director of Transformation

TB1 09/1/1.4 **Declarations of Conflicts of Interest**

There were no declarations of conflicts pertaining to the agenda.

TB1 09/1/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 5 December 2019**

The Board highlighted a few amendments to the attendance list.

Subject to these minor amendments the minutes were agreed as a correct record of the meeting held on Thursday 5th December 2019.

TB1 09/1/1.6 **Matters Arising and Action Log**

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

- **Action 3.4 Safety and Effectiveness of Services at the weekend –** N Marsden noted that this item was on the agenda. Item closed.

There were no further matters arising.

TB1 09/1/1.8 **Chairman's Business**

N Marsden reported that he had attended a leadership conference in December led by S Stevens and D Harding. N Marsden noted that a key discussion point was the focus on workforce and the national plans for recruiting nurses and clinicians. It is understood that the workforce issues across the NHS will take some time to understand and mitigate but it is important that individual Trusts focus on localised mitigations as far as possible in the interim.

N Marsden reported that during the meeting there was recognition

that winter is a real challenge and that the ongoing lack of investment and resource is having an impact on running effective services. The key messages taken from the meeting were supportive, recognising the number of complex challenges facing Trust's nationally.

N Marsden reported that the BSW (Bath and North East Somerset, Swindon and Wiltshire) STP had recently appointed a new Independent Chair, Stephanie Elsy. This appointment will provide independent leadership and help to oversee the improvement and integration of health and care services across the region.

Discussion:

- C Charles- Barks asked if there had been any indication at the conference of when the People Plan would be released. L Lane noted that the People Plan is expected to be published at the end of January and that its focus is on leadership and behaviours.
- T Baker queried S Elsy's alignment to Integrated Care Systems (ICS) and Place Based Systems. N Marsden noted that as part of S Elsy's role she'll be part of the process in relation to producing definite plans for the services in our region and is therefore recognises the need for an ICS and the differing requirements of each Trust.

TB1 09/1/1.9 **Chief Executive's Report**

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

- November was a challenging month, with high attendances in the Emergency Department and pressure across the hospital. The Trust was at Opel level status 4 for 27 days of the month, with an inevitable impact on the 4 hour standard, achieving 86.4% during November. C Charles-Barks thanked staff for their continued hard work during these challenging times.
- The financial position has deteriorated with the Trust reporting an NHSI control total deficit of £8.9m, which is £3.9m worse than plan. This has been driven by a number of factors and C Charles-Barks noted that the Board would be discussing the Trust's financial recovery as part of the seminar session later in the day.
- The international campaign to recruit nurses has been very successful with nursing vacancies having significantly reduced during 2019.
- The Trust's overall sickness rate has increased in month, with long term absence decreasing and short term absence increasing as a result of colds and flu. These cases are being actively managed with Occupational Health, with the aim of reducing the sickness rate from 4.1% to the Trust target of 3%.
- In relation to the Trust's Flu Campaign, 67% of frontline staff and over 200 employees have been vaccinated, which is closer to the 80% target needed to receive additional CQUIN

money from commissioners at the end of the financial year. Staff members are being urged to have the vaccine if they haven't already done so and flu nurses are visiting areas directly.

- The 2019 NHS Staff Survey has now closed and we have achieved a response rate of 54%, which is the highest achieve response rate by the Trust. C Charles –Barks noted that the Trust is committed to listening to the feedback staffs have provided, creating an action plan for improvements. The recommendations arising from the report are monitored at Board level.
- From November 2018 – February 2019 there was a consultation on the proposal to transform maternity services in Bath and North East Somerset, Swindon and Wiltshire.

TB1 09/1/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 09/1/2.1 **Trust Management Committee Report – 18 December**

L Wilkinson presented the report, providing a summary of escalation points from TMC held on 18th December.

- The following business cases were considered:
  - Pharmacy Workforce Review – The business case was partially supported to strengthen 7 day services, particularly on AMU, which also addresses some of the actions included as part of the weekend HSMR paper.
  - PACS Hosting – This business case was supported following a second review. The business case is going to the private Trust Board for final approval today.
  - Living with and Beyond Cancer – The business case was supported by the Committee, for an initial 6 month extension, pending a discussion with the CCG about ongoing funding.
- The Committee also approved the Car Travel Policy.

Discussion:

- P Miller queried the extension of 6 months for the Living with and Beyond Cancer business case. A Hyett noted that funding streams are being investigated. PM noted that if the CCG does not fund this service, any further decision regarding the business case would come back via TMC. L Thomas suggested that services, including cancer should be reviewed as a whole as part of operational planning. L Wilkinson agreed and noted that the Trust needs to be considering the entirety of what it needs to deliver plan.

TB1 09/1/2.2 **Finance and Performance Committee Report – 17 December**

P Miller presented the report providing a summary of escalation points from CGC held on 17 December.

- There is a theme of increasing challenge associated with the onset of winter which is reflected in the worsening financial position, with an in month overspend in November of £1.5m, compared to an original planned surplus of £0.3m.
- As a result the F&P Committee received a month 8 reforecast paper, which now predicts and overspend of £15m, which is £6.1m worse than the control deficit of £8.9m.
- There has been a system-wide reforecast process, that includes STP engagement and the paper is coming to the private Trust Board meeting for final approval, prior to formal submission to NHS Improvement/ NHS England during the second half of January 2020.
- Due to the significant hospital pressures, i.e. 97% bed occupancy in November 2019 and the challenges of urgent and emergency admissions, associated with workforce challenges the Committee had a discussion about the "art of the possible", with patient safety being the key priority. It was acknowledged that the Trust Executive team need to take action, where possible to operationally reduce pressures over the winter months and arguably the only area we are in control of is elective activity.
- The F&P Committee received the PACS hosting business case and due to the complexity and a number of significant risks, the Committee was not in a position to provide an opinion on the procurement recommendation. Given the tight timescales, the recommendation is to be reviewed and discussed at the private Trust Board meeting later today, with further assurance on the outstanding risks and mitigations.

TB1 09/1/2.3 **Charitable Funds Committee Report – 12 December**

N Marsden presented the report, providing a summary of escalation points from Charitable Funds Committee held on 12th December

- The Committee has been reviewing the charity and identifying the strategic pieces of work required to take it forward and improve the overall governance and longer term planning.
- The Committee approved the appointment of responsible officer for the Charity to strengthen the day to day governance and accountability, which is the Associate Director of Strategy. The Committee approved a non-recurrent cost of supporting additional resource to undertake this work.
- The Committee considered a number of bids and approved:
  - Funding for the ongoing elevate programme and Artcare for a further 12 months.
  - Funding to equip the new low birth maternity unit scheme.
  - Funding to replace the bedside cabinets for Odstock Ward.

Discussion:

- N Marsden noted that the number of bids for funding being

received by the Committee was a good indication that there is recognition of this resource across the Trust.
- C Charles-Barks noted the importance of aligning charity programmes with the Trust's strategic plans going forward.

TB1 09/1/2.4 **Audit Committee – 12th December**

P Kemp presented the report, providing a summary of escalation points from Audit Committee held on 12th December. P Kemp noted that the Committee had received the report from PwC regarding Board Governance and Compliance. The following key points were highlighted:

- The report was ranked overall as medium risk with the report identifying 5 key findings.
  - The Committee and working group structure is unclear with no clear framework confirming the escalation route and pathway for information and reports.
  - An improved focus is required during Committee meetings. The quality and timeliness of papers for Committee meetings also requires improvement.
  - Challenge and input from Non-Executive Directors at Committee meetings is varied.
  - The Workforce Committee requires improvement to ensure it is operating as effectively as other Committee meetings.
  - An improvement is required in the quality, level of rigour and engagement from executives at the Executive Performance Review meetings.
- P Kemp noted that the Board has taken the report seriously and there is an action plan with completion dates for April 2020 and July 2020.

Discussion:

- P Miller queried if the report had picked up the need to address the wider engagement of staff across the Trust. P Kemp noted that when PwC was appointed as the Trust's Internal Auditors, it was recognised that the Trust required a team with the capability to recognise these cultural issues and he was assured the team had taken this into account.

TB1 09/1/2.5 **Integrated Performance Report**

N Marsden thanked L Wilkinson for her leadership and support over the Christmas period, whilst C Charles-Barks has been on annual leave .

L Wilkinson presented the Integrated Performance Report to the Board and the following key points were noted.

- The Trust's performance report for November 2019 reflects the challenging picture that has already been described.
- Similarly to other NHS Trusts, the operational escalation,

demand and patient acuity has contributed to a significant fall in the Emergency 4 hour standard in November. ED attendances were up 9% compared to the same period last year, with bed occupancy also increasing due to the high number of patients staying in the hospital for >7 days.

- A Norovirus outbreak and an increase in flu episodes did impact flow across the hospital but this was resolved fairly promptly considering the other pressures on services and staff. The operational pressures did contribute to an increase in the use of mixed sex accommodation and patient moves.
- There has been an increase in the number of hospital acquired category 3 & 4 pressure ulcers across a range of wards. A service review is currently underway to ensure effective education can be delivered across the Trust. An aggregated review of all cases has commenced to initiate a Trust recovery plan.
- It is clear that there are ongoing pressures on workforce; the focus in quarter 4 will be on hard to recruit areas.
- As mentioned earlier in the meeting the Trust's control total deficit remains significantly worse than planned. Unplanned increased expenditure has been primarily driven by non-pay clinical supplies and services and the increased staff costs associated with an effective overseas recruitment campaign. Financial recovery actions must be focused on improved planned care and theatre productivity.

Discussion:

- P Kemp reiterated a concern that arose at the F&P Committee, which was that any system running over 95% capacity will suffer both in terms of quality and safety. P Kemp noted that there needs to be some assurance in terms of capacity management routines and how these are going to be sustained. AH explained that occupancy is worked out based on commissioned beds and Laverstock Ward is a planned winter ward which is not counted as part of this bed base. PK noted this but did reiterate that additional staff are still required in escalation areas.
- L Thomas noted that the Trust needs to invest some time looking at how bed stock and Length of Stay are reduced. L Thomas noted that in November the Trust was full of patients but still under plan in relation to activity levels and therefore the use of capacity needs to be looked at.
- E Jones noted the increase in ward moves and the negative impact this has on patient experience and pressure on staff. E Jones noted that it is important for the Trust at the end of the winter period to recognise where improvements can be made, to minimise the challenges next year. C Blanshard explained that the Trust always participates in a "winter wash-up". A Hyett further assured the Board that any patient move made after midnight is always reported directly to him to investigate.
- The Board discussed the shift from elective work to an increasing trend of having to manage non-elective work at SFT. C Blanshard explained that in terms of medical staffing,

the number of junior doctors for surgery and medicine isn't fairly balanced in relation to activity. If the Trust's activity is shifting, there also needs to be a shift in the balance of the medical workforce.

- P Miller referred to the Referral to Treatment performance and the Trust's growing waiting list and asked at what point the hospital would consider closing its waiting lists. AH explained that the trajectory of waiting lists in relation to certain services did need to be closely monitored in F&P. However at this point, with a number of neighbouring Trusts having already closed their waiting lists, there are limited options for patients already. C Charles-Barks suggested that a wider conversation with system partners would be required to mitigate this issue. C Charles-Barks noted her concerns with the Trust's RTT performance and asked for a recovery plan, including what sort of improvement the hospital is likely to see and an associated timescale. **ACTION:AH**
- T Baker referred to the increase in pressure ulcers and noted that if there have been more patients with increased co-morbidities, this would have an impact on the number of reported pressure ulcers. T Baker queried if there was any way of undertaking a crude risk adjustment to take these patients into account. L Wilkinson explained that a number of cases are complex and there are different cohorts of patients, particularly under Musculo-Skeletal who are at higher risk of developing pressure ulcers. L Wilkinson noted that when themes are identified, for example, patients with orthotic boots and braces, the Tissue Viability team work with these departments to consider lapses in care and develop improvement plans going forward.
- P Kemp noted that some of the SPC charts were not reflecting the standardised formatting and asked the team to check the charts within the report prior to publication. **ACTION: AH**
- C Charles-Barks noted that there was a requirement for the executive team to pick up some the discussions regarding performance as part of strategic and operational planning going forward. N Marsden noted that there needs to be a focus on operational targets for April 2020 and onwards as this will also infer a budget. Alongside this, the Trust also need to learn lessons from this winter and look at how flow can be improved.

TB1 09/1/3 **WORKFORCE**

TB1 09/1/3.1 **Equality and Diversity Annual Report**

R Webb and J Scrase attending the Board meeting to present the Annual Equality Report, which included as appendices the Gender Pay Gap Report, Workforce Disability Equality Standard Report, the Workforce Race Equality Standard Report and the Model Employer: Increasing Black and Minority Ethnics Representation at senior levels across SFT.

R Webb provided an update on the key items of work the EDI team have been working on over the past year and summarised some of the subsequent actions as a result of this ongoing work

Discussion:

- C Charles-Barks noted that the elements of WRES have an effect on the whole workforce and it's important for the Trust to pull together a plan for 2020/21, ensuring it's a fundamental platform and framework.
- T Baker noted the good work that has been done and is ongoing but highlighted that the key challenge is funding. High performing organisations perform well against these measures and they are really important for a happy and well-functioning workforce. T Baker asked if there were enough resources to ensure the suggested actions were completed. LT noted that resource for these projects is a challenge, particularly in the current operational and financial situation.
- AH asked if the Trust is fully benefitting from having such a diverse workforce. R Webb that there are examples of good work across the Trust but there is more work to do.
- M Von-Bertele noted that this piece of work is not a tick box exercise, and the Trust needs to understand it has a diverse workforce and the different ways of working with different staff members.
- R Credidio noted that it is the Board's responsibility to set the agenda and suggested that this wasn't about compliance. N Marsden reflected on the conversation and noted that this work is fundamental from a people perspective and EDI work does need to be included as part of the Trust's strategic thinking going forward.

TB1 09/1/4 **QUALITY AND RISK**

TB1 09/1/4.1 **Patient Experience Report Q2**

Lorna Wilkinson presented the report to the Board and the following key points were noted:

- PALS has been relocated to Admin Block 29 which has largely had positive feedback. Whilst there have been issues with signage, which K Glaister is managing, the short stay parking space has been popular. This is a temporary move and the plan is for the PALS team to move back into the main hospital in the future.
- There has been a 38.5% increase in compliance to responses being sent out within the agreed timescale.
- Real-time feedback continues to have a positive impact with 218 suggestions of how services can be improved. The graph shows that the most negative comments in the quarter relate to noise, call bells and food and nutrition.

Discussion:

- The real-time feedback graph was discussed. L Wilkinson

noted that the communication comments are linked to some of the challenges currently experienced with medical staff. This has been particularly noted in the Spinal Unit. There is an improvement plan for the unit underway to strengthen the nursing team. C Blanshard further noted that there had been a lack of senior clinicians due to long term sickness and a lack of junior doctors.

- R Credidio noted that the number of complaints has decreased, which could signal an improvement in services but she noted that comments had dropped too. L Wilkinson explained that K Glaister has taken on a piece of work in relation to coding, which could be the reason for this.

TB1 09/1/4.2 **Safety and Effectiveness of services at the weekend – update on action plan**

C Blanshard presented her report, providing progress against the weekend HSMR action plan. The following key points were highlighted:

- Good progress has been made with implementing the actions outlined at the meeting in November 2019, which are within the Trust's control in terms of resources. None of the actions will have had any effect on the Dr Foster figures to date, however C Blanshard noted that the most recent figures show that weekend HSMR has slightly decreased.
- It is evident that actions aimed at reducing inappropriate admissions from the community or improving pre-hospital care will take further work to implement as this requires communication with community partners to develop new and more efficient ways of working.

Discussion:

- C Blanshard provided a detailed explanation of the progress on actions to date. N Marsden thanks C Blanshard for the update and asked the Board if monthly updates on this action plan were still required. The Board agreed that they were confident that a lot of work was being done to mitigate the risks and that a quarterly update to the Board would be sufficient. **ACTION: CB** **CB**

TB1 09/1/5 **CLOSING BUSINESS**

TB1 09/1/5.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted that the key action from this Board meeting is for the Executive Team to meet and discuss what will be the key operational priorities going into 2020/21. N Marsden noted that he and C Charles- Barks would meet first to discuss this.

TB1 09/1/5.2 **Any Other Business**

The Board were informed that Dr Claire Page was standing down from her position as Director of Medical Education and that Dr Emma

Halliwell had been successfully appointed into the post.

TB1 09/1/5.3 **Public Questions**

J Lisle referred to the real-time feedback which had been discussed as part of the Patient Experience Report. J Lisle noted that she had spoken to patients who had raised concerns about disturbances at night and asked what was being done to improve patient experience.

L Wilkinson explained that the reasons for disturbances at night were due to a multitude of factors including patient care, admissions and the noise staff make. C Charles-Barks noted that there is on-going work to redevelop wards, which should hopefully help reconfigure ward design and help minimise noise on the wards.

TB1 09/1/5.4 **Date of Next Meeting**

Thursday 6 February 2020, Board Room, Salisbury NHS Foundation Trust

TB1 09/1/6 **RESOLUTION**

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

List of action items Trust Board Public 9 January 2020

Agenda item		Assigned to	Deadline	Status
2.5 Integrated Performace Report Month 8				
151.	RTT Performance	Hyett, Andy	05/03/2020	Pending
	Explanation action item C Charles-Barks noted her concerns with the Trust's RTT performance and asked for a recovery plan, including what sort of improvement the hospital is likely to see and an associated timescale. Four Eyes completing opportunity review of orthopaedics which will help inform this.			
152.	SPC Charts	Hyett, Andy	06/02/2020	Completed
	Explanation action item P Kemp noted that some of the SPC charts were not reflecting the standardised formatting and asked the team to check the charts within the report prior to publication.			
4.2 Safety and effectiveness of services at the weekend - update on ation plan				
153.	Safety and Effectiveness of services at the weekend	Blanshard, Christine	22/01/2020	Completed
	Explanation action item The Board agreed that they were confident that a lot of work was being done to mitigate the risks and that a quarterly update to the Board would be sufficient. Added to Board 2020 Work Plan - ITEM CLOSED			

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	**1.8**
Date of Meeting:	6 February 2020		

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

Recommendation:
The Board is asked to Note the report

Executive Summary:
This is the 2nd Board report for 2020 and provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • Performance • Finance • Workforce • Flu campaign • Events • Year of the Nurse and Midwife • The Crown stars Olivia Colman and Josh O'Connor visit the hospital • STP News

Performance

The Trust was under considerable pressure over the Christmas period and continued to experience challenges with the emergency pathway as a result. We saw only 86.9% of patients within 4 hours during December. However, we were in the top 15% of best performing trusts in the country on this target, reflecting the efforts of staff throughout the hospital who have worked hard to maintain the flow of patients.

The Trust continued to provide good quality, safe care and had no cases of MRSA and two case of hospital onset C.difficile. We need to maintain our focus on all quality indicators

and more detailed information on our performance across all indicators will be picked up further in the integrated performance report.

Finance

Our year to date financial position at the end of December is an NHSE&I control total deficit of £10.6m, this is in line with our revised financial forecast that has now been submitted to the regulators and culminates in a £6.1m shortfall versus plan by the end of the financial year. This revised forecast does mean that the Trust will not be in receipt of any further sustainability funding in 2019/20, but it remains essential that we retain our focus on financial control in order to ensure we being 2020/21 on a stronger footing.

During December we took the decision to open up additional bed capacity in order to meet increased demand in emergency admissions. Although this meant we incurred the additional costs of staffing, it did mean we were able to protect our planned care capacity utilisation, where work to streamline booking processes in order to make the most of available theatre time is on-going.

Workforce

We are currently focussing on “hard to recruit” consultant and AHP posts so that we can reduce the requirement to spend on costly Agency and locum workers, including planning to attend a Doctors Job Fair in London in February.

At the same time, we are forecasting our registered nursing pipeline to determine whether a further overseas campaign will be required (or not) this year. The Trust’s overall sickness absence rate has decreased very marginally this month to 4.09%, above the 3% target, with long term absence increasing and short term absence decreasing this month.

We continue to manage cases proactively in conjunction with Occupational Health, with the aim of reducing these levels back below target. Mandatory training is static at around 88%, and above the 85% target whilst medical and non-medical appraisals remain below their respective targets, although with some improvement since last month for medical appraisals.

Flu campaign

76% of frontline staff have now received their flu jab vaccination and we are now on track to achieve the 80% target we need to meet if we are to receive additional Commissioning for Quality and Innovation (CQUIN) money from our main commissioners at the end of the financial year. Our ambition has always been for 100% of our staff to be vaccinated and so we are continuing to encourage our staff to get their vaccination. Flu nurses are visiting areas directly and peer vaccinators are available to vaccinate staff inside and outside normal working hours.

Events

Year of the Nurse and Midwife

2020 is the International Year of the Nurse and the Midwife which provides us with a fantastic opportunity to celebrate and say thank you for the amazing work our nurses and midwives do each and every day. We will be encouraging all staff to join us in recognising the commitment, care and compassion it takes to be a nurse or midwife and celebrate the 200th anniversary of Florence Nightingale’s birth, who had close links with our hospital. There will be a number of activities and events planned throughout 2020 to commemorate this special year.

Salisbury NHS Foundation Trust

The Crown stars Olivia Colman and Josh O'Connor visit the hospital

We were delighted that Olivia Colman, who plays The Queen in the hit series the Crown, and co-star Josh O'Connor took a break from filming at nearby Wilton House to recently visit our hospital with the Earl of Pembroke to show their support for our charity, the Stars Appeal.

The Oscar-winning actress, along with co-star Josh, met with staff and patients as they visited the Breast Cancer Unit, Pembroke Unit and Neonatal Unit, all of which have benefitted from generous funding by the Stars Appeal.

Speaking about the visit, Olivia said: 'I have never really been on a visit to a hospital before, but there was such a beautiful positive atmosphere. There is a lot to be said about the Stars Appeal and the local community raising money for it. I've had a really lovely morning. We will come back!'

STP News

BSW CCG Clinical Chair Appointment

Dr Andrew Girdher has been successfully voted in as the new Clinical Chair for the merged B&NES, Swindon and Wiltshire (BSW) CCG. Dr Girdher is a GP Partner at Box Surgery, where he has worked since 2010.

Dr Girdher is currently Chair of the North and East Wiltshire locality as well as the CCG lead for diabetes in Wiltshire, the GP Federation in North Wiltshire and the sustainability and transformation lead for primary care.

As well as extensive experience in this country, Dr Girdher has worked in different healthcare systems around the world, including Vancouver in Canada and a four month stint in India last year. He volunteered in India for a Charity for girls from under-privileged backgrounds who wouldn't normally have access to education or healthcare.

Dr Girdher will start his new role officially on 1st April 2020, when the three existing CCGs formally merge, but he is already working with his new Governing Body colleagues, and the members who voted him in, to shape his role and develop the priorities for him to focus on.

Transforming Maternity Services Together Update

On 16th January 2020 the joint governing bodies of the BSW CCGs approved a proposal to improve and modernise maternity services across the region.
The decision follows a three-year period of engagement and consultation with more than 4,000 mums, families, staff and partners in the community.

The BSW CCG Governing Bodies approved the proposal to:

1. Create an Alongside Midwifery Unit at Salisbury Hospital Foundation Trust.
2. Create an Alongside Midwifery Unit at the Royal United Hospital in Bath.

3. Continue to support births in two, not four Freestanding Midwifery Units. This would mean births ceasing in Trowbridge and Paulton with antenatal and postnatal care continuing.
4. Enhance current provision of antenatal and postnatal care.
5. Improve and better promote home birth services.
6. Replace the five community postnatal beds in Paulton and the four community postnatal beds in Chippenham with support closer to, or in women's homes. This will be phased with four beds remaining in Chippenham for up to 12 months to support co-creation of new pathways.

These proposals will help us provide more choices for birth to more women and will build a strong foundation on which to enhance continuity of care so that more women can see the same midwife or small team of midwives before, during and after labour.
Further information can be found via http://www.transformingmaternity.org.uk/

CLASSIFICATION: UNRESTRICTED

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	06 February 2020		

Report from: (Committee Name)	**Trust Management Committee (TMC)**		**Committee Meeting Date:**	27 January 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Board Sponsor (presenting):	Cara Charles-Barks, Chief Executive			

Recommendation
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 27 January 2020

Key Items for Escalation

The Trust Management Committee this month was handed over to the Clinical Directorates of Medicine, Surgery, Musculoskeletal and Child Support and Family Services, to present their operational plans for 2020/2021. This was a key milestone in this year's planning process.

Each of the Directorates plans were well received with clear structured deliverables on what they wanted to achieve. Feedback from the committee was positive in all areas. The committee encouraged each clinical area to work on reviewing how the digital strategy could help inform their plans going forward into 2020/21.

In terms of next steps, following feedback at TMC, each directorate are now completing operational planning templates in draft, with a deadline of 31 January so that updates can be provided to Finance and Performance and Trust Board at February meetings. The directorate plans will then be included in the Trusts corporate plan / system planning.

The Corporate directorates (IT, HR, Finance, and Transformation) will then engage with the directorates on how they will support the implementation of priorities and alignment of workforce and financial planning.

Directorate Plans will be formally signed off for implementation at March Executive Performance Review meetings with the milestones monitored at monthly meetings throughout 2020/21.

The Board will be updated and informed of progress at regular intervals.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	6th February 2020		

Report from: (Committee Name)	Workforce Committee		**Committee Meeting Date:**	23rd January 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael Von-Bertele; Non-Executive Director			
Board Sponsor (presenting):	Nick Marsden, Chairman			

Recommendation
The Trust Board are asked to note the items escalated from the Workforce Committee meeting held on Thursday 23 January 2020.

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

Salisbury NHS Foundation Trust

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

Report Title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Board Assurance Framework v14.1 (draft) Draft Corporate Risk Register January 2020 v1.2 Draft Summary CRR tracker v14 January 2020			

Recommendation:
The Board to consider and approve the revised Board Assurance Framework Specifically, the Board is required to: • Review the overall risk profile for each strategic priority and agree this reflects all current risks • Consider the content of the corporate risk register and corporate risk tracker to ensure that it accurately reflects the corporate risks and related actions. • Agree the criteria for initiation of a corporate risk deep dive.

Executive Summary:
The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This informs the Annual Governance Statement and annual cycle of Business. The BAF has undergone a refresh following the setting of new corporate objectives for 2019/20. The BAF will continue to be reported to the relevant Board Committees bi-monthly to maintain appropriate scrutiny and updates. The Trust Board will receive a comprehensive update every 4 months which will include any specific discussion points from the board committees. <u>Corporate risk profile summary</u> Following the increase of the risk profile noted in the last report presented to Board in

December 2019, there has been a full review and rationalization of all corporate risks. This was undertaken by the Executive Directors and subsequently informed the Strategic Planning Board Seminar Session in January; which is now reflected in the corporate risk register and tracker with changes noted below.

Following NED discussion, this lead to development of criteria to initiate a deep dive or review into corporate risks. The Director of Nursing and Director of Corporate Governance have developed a set of criteria as outlined below.

A deep dive/further review of a corporate risk will be initiated in the following circumstances

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

If the above criteria was applied to the current corporate risk profile, a deep dive would be initiated for the following risk:

- 5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Score 16 for 6 months)

Risk 4107 (Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes and risk) and risk 5605 (Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment) will trigger a deep dive if the risk score remains unchanged in February.

A deep dive template will be developed to support risk owners.

<u>Extreme Risks</u>

There are 11 risks rated 15 or above.

- 4107 - Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes (Score 16)
- 5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Score 16)
- 6134 - Financial and workforce risk as a result of NHS England Specialist Commissioners driving centralisation of genetics and genomics clinical testing into fewer laboratories resulting in laboratory testing unlikely to be provided at the Trust in the longer term (Score 16)
- 6142 - Risk to recruitment, retention and staff morale within the genetics service as a result of the uncertainty of the future of the service (New risk; Score 16)
- 5605 - Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment (Score 15)
- 5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Score 16)
- 5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff. (Score 16)
- 5972 - Insufficient organisational development resources to delivery cultural change and lack of formal Trust wide approaches to seek best practices from elsewhere.(Score 16)
- 5860 - Risk of failure to achieve financial plan and NHSI control total for 2019/20

(Score 15)
- 5955 - Insufficient robust management control procedures (Score 15)
- 6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care (New Risk: Score 16)

Relevant new risks since December 2019
- 6134 (Specialist) - Financial and workforce risk as a result of NHS England Specialist Commissioners driving centralisation of genetics and genomics clinical testing into fewer laboratories resulting in laboratory testing unlikely to be provided at the Trust in the longer term (New risk; score 16)
- 6142 (Specialist) - Risk to recruitment, retention and staff morale within the genetics service as a result of the uncertainty of the future of the service (New risk; score16)
- 6129 (Innovation) - Risk of the non-delivery of the IT Improvement Plan (Score 9)
- 5729 (Care) - Risk of delay in potentially detecting life threatening melanomas due to limited resource capacity (Score 12)
- 6143 (Care) - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care (Score 16)

Risks removed
- 3322 (Specialist) - National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services (score 25). This risk has been replaced by Specialist risks 6134 and 6142.
- 5360 (Resources) - Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss (score 15). This risk has been replaced by Innovation risk 6129; Risk of the non-delivery of the IT Improvement Plan
- 5326 (Resources) – Risk of access to patient information through variety of clinical information systems and overhead of access. This risk has been replaced by Innovation risk 6129; Risk of the non-delivery of the IT Improvement Plan.
- 5345 (Resources) – Breaching key data regulations including General Data Protection Regulations (GDPR), Privacy and Electronic Communications Regulations (PECR) and NHS Code of Practice: Records Management 2016 could result in financial loss and reputational impact.
- 5480 (Resources) – Risk of poor controls to ensure the consistency and accuracy of information reporting. This risk has been replaced by Innovation risk 6129; Risk of the non-delivery of the IT Improvement Plan.
- 5808 (Local) – Lack of service provision for elective vascular angiography. This risk is now covered by Care risk 5966; Risk of compromised services due to hub and spoke model
- 5969 (Innovation) - Risk of failure to deliver GIRFT action plans
- 5870 (Care) - Failure to achieve quality projections set nationally due to changes in reporting definitions (CDiff, Pressure ulcers)
- 5850 (Innovation) - Potential non-delivery of CQUIN schemes resulting in a financial loss
- 4857 (Care) - A lack of resilience in infrastructure including a single access route to the national health and social care network (HSCN) and unsupported hardware/software, resulting in loss of access to IT systems and internet access. Now incorporated under Innovation risk 6129.

- 5804 (Care) - Risk of patients within hospital experiencing a fall
- 5851 (Care) - Weekend HSMR significantly higher than expected. Now incorporated under Care risk 6143.
- 5607 (Care) - Risk of error due to Hospital at Night Team capacity to address increasing workload. Now incorporated under Care risk 6143.

Risks with an increased score

- 5869 (People) **–** Failure to achieve required ward nursing establishment and skill mix with the following implications:

  - Quality and safety concerns at ward level
  - Poor patient experience
  - Agency spend not reducing as predicted
  - Pressure on substantive skilled workforce supervising and training new employees (score 9 to 12)

Risks with a decreased score

- 5799 (Local) - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients (score 15 to 9)
- 5487 (Resources) - The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation (score 9 to 6).
- 5966 - Risk of compromised services due to hub and spoke model (score 15 to 12).

Board Committee review

The Workforce Committee reviewed the BAF at the January 2020 meeting. Clinical Governance and Finance and Performance Committees have not met at the time of writing this report (due 4th February 2020) and therefore the risk profile may be subject to further change.

People risk profile

There has been a review of all risks associated with the People Strategic Priorities. These require further work to accurately describe the risks, control and assurance in place and any identified gaps.

The risks have been agreed in recent weeks with the Interim Director of OD & People and relate to:

- Workforce and hard to recruit posts
- ESR Functionality
- Delivery of the NHSI Organisational Development Programme
- New Junior Doctor contract
- Retention of overseas nurses
- Succession planning and talent management.

The senior HR team will be meeting on the 4th February to identify the most appropriate risks to be added to the Corporate Risk Register and ensure these are fully detailed.

Workforce Committee noted the underlying theme on review of the BAF and CRR relating to cultural change and noted the lack of assurance in controls in relation to this. This will be addressed and will inform the next Board Committee update in March 2020 and subsequently the Board update in June 2020.

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

Salisbury
NHS Foundation Trust

Board Assurance Framework
2019/20

V14.1 For January Board Committees

Trust Vision: An Outstanding Experience for Every Patient

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

Strategic Priorities

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

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

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

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

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

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

Board Assurance Framework – Glossary

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

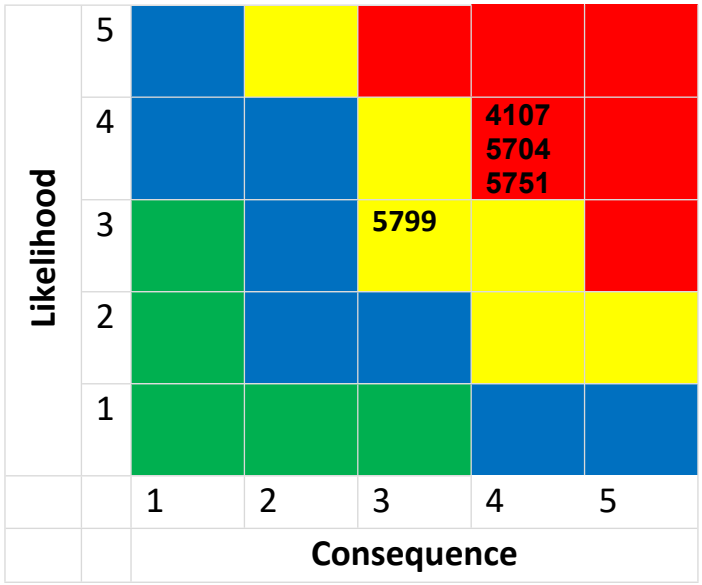
	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

Strategic Priority:

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

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

Distribution of Corporate Risks for Local Services



5704 – Inability to provide a full gastroenterology service due to a lack of medical staff capacity
4107 - Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes
5751 – Patient safety risk due to high numbers of delayed transfers of care due to lack of community capacity
5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients

Linked risks

5972 - Insufficient organisational development resources to delivery transformational and cultural change (Innovation)

6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care (Care)

Principle Internal Risk: Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population					
Key Controls			**Assurance on Controls**		
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO) • Workforce plans			• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group		
Gaps in Control			**Gaps in Assurance**		
• Variability in performance data to measure KPIs • Lack of a business intelligence tool • Informatics unable to access/link to all systems			• Use of multiple IT systems to manage performance • Data quality • Endoscopy data base does not record all activity		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Scoreboards and dashboards being developed	Director of Transformation	Programme commenced. High priority dashboards have been completed and are being used by Operational teams and transformation programmes	Procure and embed BI tool	Director of Transformation	2019/20 financial year
Develop and implementation of Integrated Performance Report for Board	Director of Finance	Implemented June 2019 and work on-going	Delivery of actions outlined in risk 5480	Director of Transformation	
			Endoscopy database developed and live	Chief Operating Officer	01.04.2020

Principle External Risk: Managing the complexity of relationships with our partners to lead and share our joint strategy plans for a place based integrated care system	
Monitoring information	**Areas of influence**
• Integrated Performance Report – impact on metrics • Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard) • STP Operational Plan	• Requested improvement trajectories for decreased attendances and delayed transfers of care • STP Executive Board (CEO) • STP Sponsorship Board (CEO and Chair) • Wiltshire Integration Board (CEO) • Stakeholder meetings / engagement • Acute Hospital Alliance

2019/20 Corporate Objectives – Local Services

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
Delivery of sustainable and improving local services through service and pathway review and develop new partnerships to deliver sustainable local services.	1. Patient Flow and Urgent Care Programme 2. Frailty Model Implementation 3. Gastroenterology Review 4. Implement Clinical Strategy	Lack of strategies to manage challenged services	Program for strategic review of services. Service reviews being linked to operational planning for 2020/21	31.12.2019 for high priority areas Completed workforce reviews for high risk areas. Workforce Summit planned for February 2020	A Hyett

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
Work collaboratively with system partners to maximise patient and partnership benefits.	1. Delivery of Provider Alliance Programmes 2. Active role in BSW clinical and operational strategy 3. Leadership role in Wiltshire Health & Care 4. Work proactively with Primary Care Networks 5. Establish clinical leadership roles focussed on partnership and network development 6. Consider potential to return activity from the private sector to acute hospitals	Maturity and development of wider health and care system/partners to develop new models of care.	Work with new PCN's to develop relationships and new models of care.	31.03.2020	LT
Improve access to services to support prompt responsive care.	1. Maintain waiting list size and delivery of RTT (incompletes) standard. 2. Reduce DNAs across service provision. 3. Benchmark First/Follow Up ratios as part of outpatients 4. transformation programme 5. Theatres capacity review and transformation programme 6. Delivery of new 28 day faster diagnosis cancer standard	Additional cases not scheduled on lists where gaps are evident (C) Lack of business intelligence tool	Outpatient and theatre project management Boards monitoring actions and improvement in utilisation Procure and embed tool (links to action associated with risk 5480)	31.03.2020 31.03.2020	E Provins E Provins

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need.	1. System wide MADE events 2. Roll out of increased ambulatory pathways 3. Consistent application and roll out of the SAFER care bundle and principles 4. Implementation of frailty new models of care 5. Increase the number of patients who are able to return to their preferred place of care at the end of their life 6. Plan to achieve/maintain top quartile performance in service delivery 7. Continue to increase the number of frail older people who are able to go home the same day or within 24 hours of admission	Lack of capacity / demand plan across Wiltshire	Urgent Care Delivery Group requiring capacity plan	31.08.2019 Completed – CSU developed capacity and demand plan for Wiltshire	A Hyett

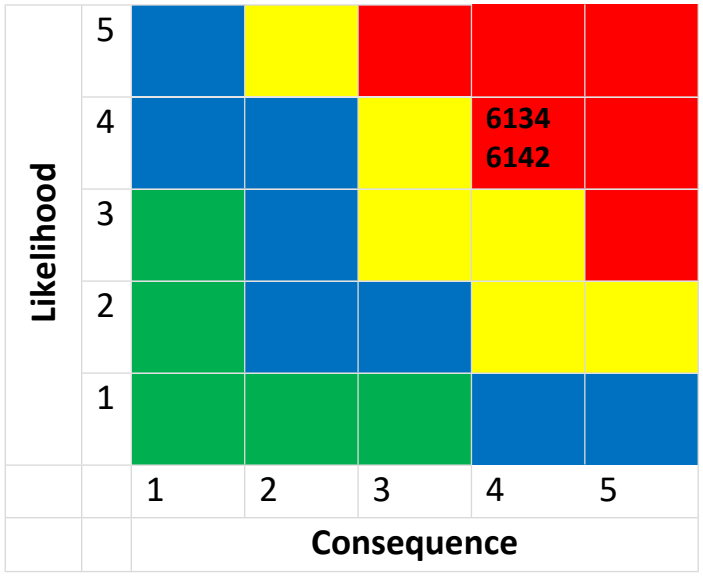
Strategic Priority:

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

Executive Lead: Chief Operating Officer

Reporting Committee: Finance & Performance Committee

Distribution of Corporate Risks for Specialist Services



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

6142 - Risk to recruitment, retention and staff morale within the genetics service as a result of the uncertainty of the future of the service

Principle Internal Risk: Risk of balancing delivery of services that are 'outstanding' against the risk of economies of scale and cost effectiveness					
Key Controls			**Assurance on Controls**		
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board • COO Delivery Group • Genomics Consortium Board • Established performance monitoring and accountability framework • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO)			• Integrated Performance Report • Specialist Services dashboards • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group		
Gaps in Control			**Gaps in Assurance**		
• Clear SLAs for delivery of specialist services particularly plastics at UHS					
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Development of Plastics SLA with Southampton	COO	~~30.04.2019~~ ~~30.09.2019~~ SLA in place – being reviewed by DMT in line with further changes with provision to Southampton; awaiting response ~~31.12.2019~~ 29.02.2020			
Lack of specialist commissioning clinical and financial strategy for spinal services – Trust to write to specialist	Director of Finance	30.09.2019 Meeting held - complete			

commissioners to convene a summit					

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

2019/20 Corporate Objectives – Specialist Services

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
Work with partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience.	1. Implementation of Clinical Strategy 2. Expanding and networking specialist services	Board oversight of implementation of the Clinical Strategy (GA)	Requires confirmation of roll-out plan Nov 19 Action revised: Paper going to CGC in Nov 19	~~31.10.2019~~ 30.11.2019 Update paper presented	C Blanshard
Develop our specialist services to be centres of excellence, delivering outstanding, innovative and responsive patient care.	1. Benchmark specialist services including spinal and plastics/burns against national comparators 2. Plan to achieve/maintain top quartile performance in service delivery 3. Establish future for genetics service within regional consortium 4. Secure future of spinal pathway pilot.	Lack of strategy for specialist services (C)	Clear program of work to complete a service review, comparison against benchmark and improvement plan	31.12.2019	A Hyett

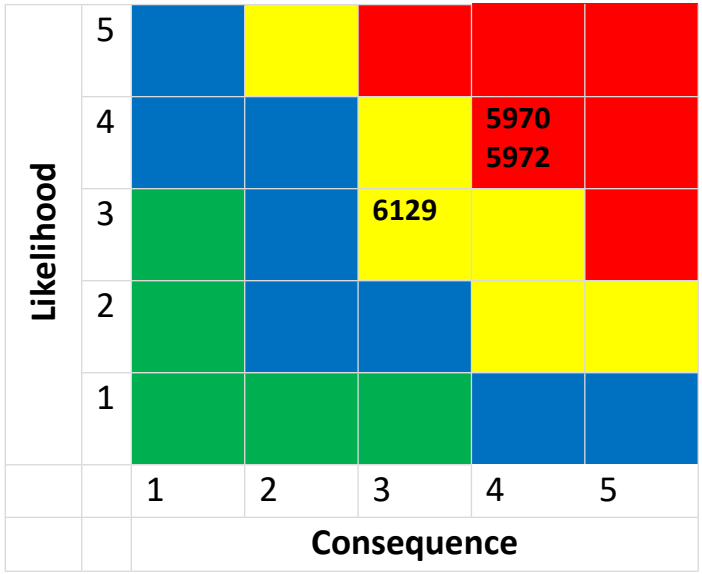
Strategic Priority:

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

Executive Lead: Director of Transformation

Reporting Committee: Clinical Governance Committee

Distribution of Corporate Risks for Innovation



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

5972 – Insufficient organisational development resources to delivery transformational and cultural change

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

Principle Internal Risk: Risk of a lack of capability and capacity to deliver innovation

Key Controls	Assurance on Controls
• Transformation Board • QI Operational plan and improvement strategy • QI Steering Group • Workforce and Clinical Governance Committees • Research Governance Framework • F&P Committee • Trist Board • Digital Steering Group • IT Improvement Plan • Digital Strategy Implementation Plan	• Model Hospital benchmarking • NIHR Wessex compliance reports • QI KPIs to evaluate success • Staff survey • Committee effectiveness review • Internal reports to F&P Committee, Trust Board and CGC
Gaps in Control	**Gaps in Assurance**
• Quality Improvement Strategy and plan yet to be fully implemented • Innovation Committee not fully functional • IT Improvement Plan yet to be fully implemented	• Progress reporting on Digital Strategy • Progress reporting IT improvement plan

Actions	Owner	Deadline	Actions	Owner	Deadline
QI Strategy and plan sign off	Director of Transformation	30.04.2019	Quarterly Digital Strategy update report to F&P Committee	Director of Transformation	Commence January 2020
Implement QI plan	Director of Transformation	Commenced April 2019	IT Improvement plan evaluation, (verbal report at March audit committee, formal report from PwC in May 2020)	Director of Transformation	30.05.2020
Review effectiveness of plan	Director of Transformation	31.10.2019 Completed			
Innovation Committee refresh	Director of Transformation	31.12.2019 Completed			
SOP for supporting & adopting innovative systems and practices	Director of Transformation	~~31.12.2019~~ 28.02.2020 Deadline changed – SOP drafted and awaiting committee approval			
IT Improvement Plan sign off	Director of Transformation	31.12.2019 Completed			

Implement IT Improvement plan	Director of Transformation	Commence December 2019			
Review effectiveness of IT improvement plan	Director of Transformation	Commence January 2020			

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

2019/20 Corporate Objectives – Innovation

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
Develop the culture, capacity and capability to support innovation, improvement and research throughout the Trust.	1. Delivery of the overarching transformation and cost improvement programme	Lack of defined process to support innovation (C)	Develop and implement clear processes	~~31.12.2019~~ 28.02.2020	Esther Provins
	2. Delivery of the QI operational plan for 19/20				
	3. Maximise participation and involvement in research within the Trust.				
	4. Hold a Dragon's Den forum to attract and support innovation				
	5. Strengthen links with AHSN				
	6. Improve organisational capability for change				
To maximise digital services to enable the	1. Implement year one of the digital strategy	Insufficient escalation reporting of deliverables	Strengthen escalation reporting to the Digital	30.09.2019 Reporting	Esther Provins

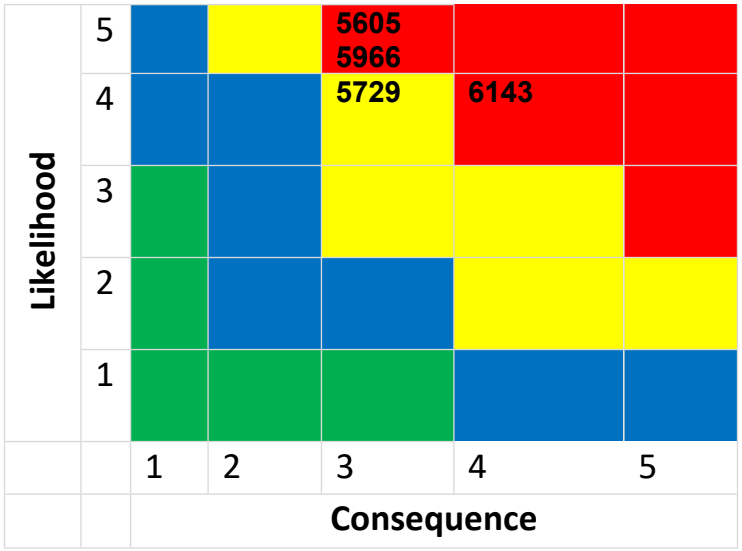
Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
provision of outstanding care.	2. Deliver internal audit action plans	(C)	Steering Group	structure revised Complete	
	3. Team development				
	4. Strengthen opportunities for engagement				
	5. Engage with partners to ensure plans are aligned and opportunities exploited				

Strategic Priority:

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

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

Distribution of Corporate Risks for Care



5605 – Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment
5966 – Risk of compromised services due to hub and spoke model
5729 - Risk of delay in potentially detecting life threatening melanomas due to limited resource capacity
6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care

Linked Risks
5869 – Failure to achieve required ward nursing establishment and skill mix with the following implications:

- Quality and safety concerns at ward level
- Poor patient experience
- Agency spend not reducing as predicted
- Pressure on substantive skilled workforce supervising and training new employees

Principle Internal Risk: Insufficient resources (skilled staff and infrastructure) to deliver safe effective care					
Key Controls			**Assurance on Controls**		
• Quality Governance Framework • Integrated Governance Framework • Accountability Framework • Clinical and HR policies and procedures • Workforce plan • Workforce Committee • Directorate Performance Meetings • Contract Quality Review Meeting / contractual monitoring • Annual audit programme (national and local) • GIRFT Programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Learning from Deaths Policy • Appraisal and revalidation of doctors			• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime – last inspection report March 2018 • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review completed March 18 • Internal Audit report on morbidity and mortality meetings • CQC peer review process • GIRFT reports and action plans • Annual appraisal quality assurance review		
Gaps in Control			**Gaps in Assurance**		
•			Availability of data to give ward to Board assurance Safe medical staffing not yet defined		
•					
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
			Ward Accreditation Programme	Director of Nursing	31.03.2020

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

2019/20 Corporate Objectives – Care

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead
Continue to reduce avoidable harm through agreed safety priorities and annual infection targets.	1. Demonstrate a responsive safety culture by training our staff in human factors, learning and sharing lessons when things go wrong and from when things go right				
	2. Achieve HCAI rates below trajectory	Redefinition of HCAI trajectories and what falls within 'hospital' apportioned at a national level (C)	Monthly reporting of hospital and community cases. Board transparency on any change being definition or internal issue	31.07.2019 Complete – raised through CGC and Board	C Gorzanski
	3. Improve the recognition of deteriorating patients through the embedding of NEWS2.	Compliance with escalation levels (C)	Educational plan developed and rolled out	31.03.2020	Maria Ford
	4. Reduce harm from sepsis by improving the number of inpatients screened for sepsis and treated with intravenous antibiotics within an hour of diagnosis of sepsis.	Development time available to POET (C)	POET Board working through development time requirements and associated case for prioritisation	31.08.2019 Complete	JBurwell /L Wilkinson
	5. Introduce Saving Babies Lives care bundle v2, and participate in wave 3 of the national maternity/neonatal safety collaborative	Increased number of SIs and concerns raised within maternity services (GA)	Aggregated review across all SIs Complete cultural survey and develop appropriate improvement measures	~~31.12.2019~~ Awaiting cultural survey results – amended deadline 28.02.2020	F Coker / A Kingston
	6. Demonstrate the implementation of high impact actions in the work to reduce falls	Development time available to POET to make necessary upgrades to capture all information (C)	POET Board working through development time requirements and associated case for prioritisation	31.08.2019 Complete	JBurwell /L Wilkinson

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead
		Number of falls resulting in injury not decreasing (A)	Commence an SII of serious falls and embedding learning	31.03.2019 Commenced and on-going	
Build our assurance on standards of ward-based care and compassion through development of ward accreditation process.	1. Design and develop ward accreditation programme 2. Develop range of metrics to support accreditation 3. Identify pilot areas to test and refine.	Availability of data to support the programme (C)	Deputy Director of Nursing working with subject matter experts	~~31.08.2019~~ ~~30.11.2019~~ 31.03.2020 Project lead met with Director of Transformation and CIO and agreed data dashboard requirements. Pilot wards identified	D Major
Work with our patients and partners to plan and develop services which meet the needs of our community.	1. Launch and implement the Treat Me Well campaign in April 2019. 2. Ensure that Patient voice is included in the planning and development of major Trust schemes.				
Work towards a CQC rating of Outstanding	1. Delivery of improvement plan arising from 2018 CQC inspection 2. Improve consistency of governance arrangements across Directorates and Clinical Units 3. Alignment of risks to corporate objectives through strengthening the Board Assurance Framework 4. Continued Board development				

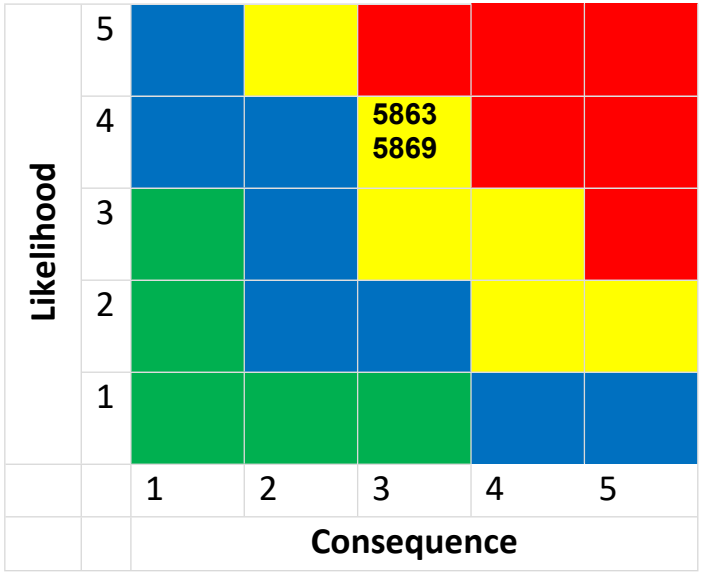
Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead
	programme to facilitate the Board developing into a high performing, unitary Board				

Strategic Priority:

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

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

Distribution of Corporate Risks for People



5863 – Risk of new HMRC rules for the NHS Pension Scheme impacting on consultant capacity across the Trust

5869 – Failure to achieve required ward nursing establishment and skill mix with the following implications:

- Quality and safety concerns at ward level
- Poor patient experience
- Agency spend not reducing as predicted
- Pressure on substantive skilled workforce supervising and training new employees

Principle Internal Risk: Risk that the Trust will be unable to recruit and sustain an engaged and effective workforce					
Key Controls			**Assurance on Controls**		
• Workforce Committee (EWC) • Health and Wellbeing strategy Board (from 19/7) • HR Policies • Directorate Performance meetings • People strategy Delivery Board • Safer Staffing Group • Equality, Diversity and Inclusion Committee (launch 29 July) • Health and Safety Committee • Freedom to Speak Up Guardians • JCC Staff Side Meeting • JLNC Committee (medical staff) • Vacancy control group			• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • Integrated Performance Report at Board • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report • Health and safety annual report • Guardian of safe working report • Volunteers annual report • Monthly Workforce Dashboard at EWC • Executive Safety Walks		
Gaps in Control			**Gaps in Assurance**		
• Ineffective data capture and reporting			• Lack of real time staff feedback		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Develop phase 2 and 3 business case and investment for ESR optimisation	Director of OD & People	21.08.2019 Submitted to TMC May 19 and JCC in August 19. Approved	Develop Health& Wellbeing Strategy business case to purchase real time feedback solution	Director of OD & People	21.08.2019 Submitted to TMC: requires further revision **January update:** business case on TMC agenda February 2020

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

2019/20 Corporate Objectives – People

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
To build, value and develop a skilled and motivated workforce.	1. Lead STP plans on workforce transformation. 2. Undertake Therapies/AHP workforce review to better align with operational functions 3. Build on leadership development of ward leaders through a formal leadership programme (with Director of Nursing and Quality) 4. Roll out e-rostering system across professional groups	Skills and capacity of Business Partners (C) Lack of roll-out plan (C)	Continuing to embed BP model in directorates Under discussion with Quality directorate	31.12.2019 Complete – includes introduction of CPD sessions 31.03.2020	S Crane G Toms
Develop a diverse and inclusive culture where staff feel engaged.	1. Support to Speak Up Programme 2. Roll out Phase 2 and 3 of ESR. 3. QI strategy 4. OD Programme	Lack of consistency of champions within defined networks	Meet with current dignity at work ambassadors – design and recruit to new role Nov 19 action updated: ambassador roles being reviewed to determine key roles and responsibilities to ensure appropriate support	~~30.09.2019~~ 31.03.2020	R Webb
Improve the health and well-being of staff.	1. Improved on site staff facilities 2. Targeted health/well-being campaigns and programmes 3. Consistent application of a flexible working policy	No investment for the proposed programme Policy requires significant update	Business case to TMC Nov 19 update: business case is currently under revision and redefined to cover the Employee	~~21.08.2019~~ 31.12.2019 Business case on TMC	A Evans

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
			Assistance Programme. To be submitted to TMC. Date TBC Paper to execs 5 August to propose what is included in the policy	agenda for February 2020 ~~05.08.2019~~ 28.02.2020 Discussed at Execs and agreed statement of flexible working supported by revision and re-launch of policies	G Dawson

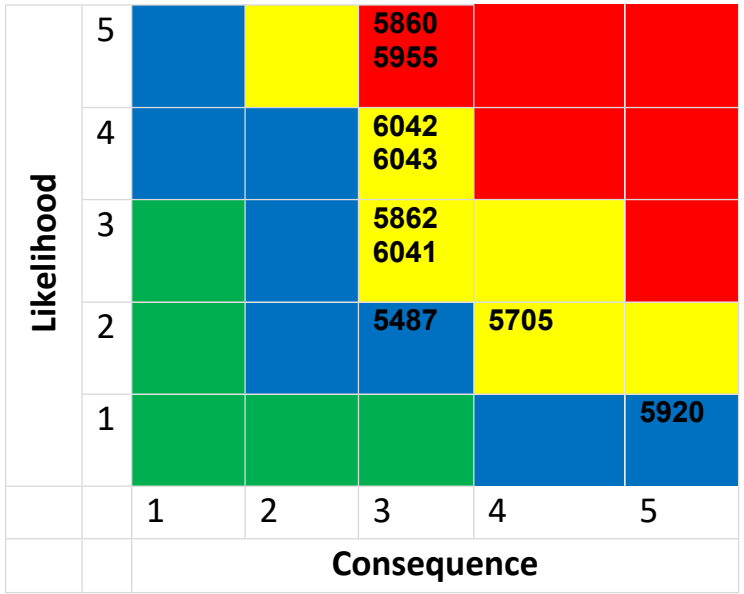
Strategic Priority:

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

Executive Lead: Director of Finance

Reporting Committee: Finance & Performance Committee

Distribution of Corporate Risks for Resources



5705 – Unknown impact on the running of the hospital as a result of the EU Exit
5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
5860 – Risk of failure to achieve financial plan and NHSI control total for 2019/20
5862 – Risk to buildings and equipment due to capital programme funding
5920 – Breaches of fire compartmentation in PFI building
5955 - Insufficient robust management control processes
6041 - Risk of delivery of the NHS Long Term Plan ambitions due to a lack of capacity to build strong partnerships with the number of newly forming organisations at the pace required
6042 - Risk of lack of CCG capacity and focus to deliver change required for SFT to deliver its core strategy due to local merger of 3 CCGs
6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities					
Key Controls			**Assurance on Controls**		
• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • OETB • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan			• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement		
Gaps in Control			**Gaps in Assurance**		
• Oversight of corporate processes and policies			•		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Set up task and finish group to develop a framework	Director of Finance	30.06.2019			
Finance and procurement training – rolling quarterly programme	Deputy Director of Finance	31/01/2020			
Improved communications with all staff, launch of budget holder leaflet	Deputy Director of Finance	31/01/2020			

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

2019/20 Corporate Objectives – Resources

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
Rationalise and re-profile the Trust estate in line with the Trust clinical and estates strategy, working in partnership to support sustainable delivery of patient services.	1. Complete SOC for estates redevelopment programme.	Lack of capital funding and STP process to progress case due to pressure on NHS funding.	Ensure SFT SOC completed and complies with STP deadlines.	31.03.2020	LT
Improve financial sustainability of SFT and the wider health economy.	1. Development and implementation of Transformation programme 2. Further develop our role within BSW to deliver financial sustainability. 3. Progression of outpatients transformation programmes in partnership 4. Implementation of Model Hospital based schemes where benchmarking shows opportunities for efficiency – for example pharmacy and medicines optimisation. 5. PMO maturity assessment of productivity 6. Clinical service reviews 7. Delivery of services in partnership with external organisations.	Maturity and development of wider health and care system/partners to develop new models of care.	Work with new PCN's to develop relationships and new models of care.	31.03.2020	LT/CCB

Corporate Risk Register
January 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5920	Facilities	Estates	16/07/2019	Other assurance not listed	6	Circa 900 breaches of fire compartmentation in PFI builing as highlighted in Oakleaf Survey in January 2017. This could result in lack of ability to contain a fire, formal notifications to the Trust from Fire Officer and Health and Safety Executive and reputational damage.	Cannot believe that this will ever happen again	Catastrophic	5	Operational Director for Estates and Facilities escalated to Building Owner. Work currently being completed. Operational Director for Estates working closely with Deputy COO to facilitate release of space for work completion.	28/02/2020		Robinson, Ian	Directorate Management Team Meeting	31/03/2020	2	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	17/07/2019
5487	Finance and Procurement	Finance Department	26/07/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation.	May recur occasionally	Minor	6	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	21/12/2018	19/12/2018	Thomas, Lisa	Finance and Performance Committee	31/01/2020	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	16/10/2018
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	31/01/2020		Thomas, Lisa							
										Subsidiary companies to recruit or establish suitable qualified financial support.	31/01/2020		Thomas, Lisa							
5705	Trustwide	Trustwide	31/01/2019	National guidance	12	Unknown impact on the daily running of the hospital as a result of Great Britain's exit from the European Union. The consequence is that the resources (stocks and staff) could be depleted affecting service provision.	Do not expect it to happen again but it is possible	Major	8	Completion of risks assessments.	31/03/2019	25/04/2019	Hyett, Andy	EU Exit Planning Group	31/01/2020	8	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	31/01/2019
										Delivery of any new national actions.	31/03/2019	25/04/2019	Hyett, Andy							
										Task and finish group to continue to meet on a monthly basis.	01/11/2019	22/10/2019	Hyett, Andy							
										Accountable Officer for EU Exit has been notified by National Audit Office that they will randomly audit Trusts preparedness. SFT may be randomly selected to be a Trust to be audited. If selected the Trust will comply with any necessary action.	31/10/2019	22/10/2019	Hyett, Andy							
										Submit daily SITREP to NHS Improvement.	30/11/2019	10/12/2019	Hyett, Andy							

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5799	Clinical Support and Family Services	Radiology	18/04/2019	Access targets, Cancer Plan, Directorate risk assessment	15	Due to increased activity there is a significant backlog of reporting. There is a high risk of reports being delayed. This is particularly significant to 2WW and GP patients. July 2019 - Medica have confirmed they are unable to receive any additional activity from the Trust, all reporting must therefore take place in house until an alternate arrangement has been identified.	May recur occasionally	Moderate	9	Action plan for mitigation of this risk is development.	31/07/2019	08/07/2019	Lloyd-Jones, Graham	Departmental Team meeting	28/02/2020	6	Care, Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer	30/04/2019
										Local tender undertaken, evaluated and awarded.	13/06/2019	13/06/2019	Vandyken, Mrs Ali							
										Implementation meeting with new supplier.	03/07/2019	03/07/2019	Clarke, Simon							
										Go live second 3rd party reporting provider	13/01/2020		Clarke, Simon							
										Continuation of additional sessions provided by Radiologists. Ongoing for at 3 month intervals.	31/12/2019		Lloyd-Jones, Graham							
										Active monitoring/management of outsourced backlog by Radiology Service Manager – ongoing for review monthly.	31/12/2019	11/12/2019	Clarke, Simon							
										Explore opportunity for Radiographers and Radiologists to have reporting station at home, as a method of increasing reporting capacity	27/12/2019		Clarke, Simon							
										Appointment of substantive Radiologist.	03/09/2019	09/09/2019	Lloyd-Jones, Graham							
										Workforce review of Consultant Radiologist's	31/01/2020		Clarke, Simon							
										Recruitment into vacant Radiologist posts	17/01/2020		Lloyd-Jones, Graham							

Corporate Risk Register
January 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5862	Finance and Procurement	Trust Offices	17/06/2019	Financial management	12	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	May recur occasionally	Moderate	9	Programme prioritised for national requirement for 20%	15/07/2019	19/08/2019	Thomas, Lisa	Finance and Performance Committee	31/03/2020	9	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	17/06/2019
										QIA assessment to be completed for all delayed schemes.	15/07/2019	19/08/2019	Thomas, Lisa							
										Process agreed with the STP providers on managing in year slippages	15/07/2019	19/08/2019	Thomas, Lisa							
										NHSI letter sent 18/08/19 confirming 20% reduction no longer required due to increase in national funding. Therefore review of capital programme now needs re- looking at in case of any logistical reasons for non delivery.	30/09/2019	21/10/2019	Thomas, Lisa							
										Trust reprioritising spend to ensure achievement of 2019/20 capital plan. This includes moving spend from 2020/21 to 2019/20 where schemes are delayed into the new financial year.	31/10/2019	16/12/2019	Ellis, Mark							
										Trust considering route for additional capital funding to support digital and estate investment. SOC due to Board of Directors in Q4 2019/20 and discussions with NHSI and STP on funding sources on going.	29/03/2020		Thomas, Lisa							
6129	Transformation & IM&T	Information Technology	19/12/2019	Trusts Objectives	20	There is a risk that the Trust does not deliver the IT Improvement Plan, which may result in compromised patient care, inaccurate reporting, loss of IT systems, financial and reputational loss, and breaches to data regulations (e.g. GDPR)	May recur occasionally	Moderate	9	Develop and produce monthly update and highlight report	16/01/2020		Burwell, Jonathan	Executive Director Meeting	18/01/2019	6	Innovation	Trust Board (Corporate Risk Register)	Director of Transformation	20/12/2019
										Complete internal service delivery model review (desktop exercise)	16/01/2020		Burwell, Jonathan							
										Procure support to deliver a service delivery model review of hot spots, including options appraisal and recommendations	13/01/2020		Provins, Esther							
										Executive team review and decision on recommendations arising from external service delivery review	21/02/2020		Provins, Esther							
										Board seminar to appraise Board of Directors as to agreed way forward regarding IT Service Delivery Models.	05/03/2020		Provins, Esther							
6041	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	6	The Trust lacks the Capacity to build strong partnerships with the number of newly forming organisations at the pace required e.g. Primary Care Networks. This could limit the ability of the organisation to deliver the NHS Long Term Plan ambitions.	May recur occasionally	Moderate	9	Agree and formalise programme of work with PCNs	31/12/2019		Humphrey, Kieran	Trust Board	30/11/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	25/10/2019

Corporate Risk Register
January 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
6042	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	12	The local merger of the three CCG's (BaNES, Wiltshire and Swindon) to form BSW will mean a short term lack of CCG capacity and focus to deliver the change required for SFT to deliver its core strategy.	Will probably recur, but is not a persistent issue	Moderate	12	Progressing plan of engagement and work programme with local Primary Care Networks	31/03/2020		Humphrey, Kieran	Trust Board	31/01/2020	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	25/10/2019
6043	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	12	The lack of a national clear model for small rural DGH services places future strategic planning uncertain at SFT. The funding regime and clinical models of care as advocated by royal college guidelines are built around average Trusts. SFT is more geographically challenged and smaller than an average DGH which in turn places its future as an independent Trust at risk which could limit and damage service provision to the local population.	Will probably recur, but is not a persistent issue	Moderate	12	Nuffield Trust are visiting SFT in January 2020 to assess and offer help on development of the South Wiltshire Urgent Care Model.	28/02/2020		Hyett, Andy	Trust Board	31/01/2020	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	25/10/2019
										Development of system plans for sustainability of NHS elective care	31/03/2020		Humphrey, Kieran							
5966	Trustwide	Trustwide	20/08/2019	Trustwide risk assessment	12	Services which are provided to the trust by another provider on a networked or hub-and-spoke arrangement can be compromised if the provider runs into operational or workforce difficulties. It is likely that services will be withdrawn from our site as they consolidate at the hub. Examples are vascular, interventional radiology, clinical oncology, medical oncology, renal medicine, neurology and various paediatric specialties.	May recur occasionally	Major	12	Interventional Radiology: Work with commissioners to secure service provision with another provider.	30/11/2019	31/12/2019	Vandyken, Mrs Ali	Trust Board	28/02/2020	6	Care	Trust Board (Corporate Risk Register)	Medical Director	21/08/2019
										Oncology: Develop additional joint working and new posts.	01/04/2020		Clarke, Lisa							
										Vascular: Set up a vascular network meeting.	30/09/2019	25/10/2019	Murray, Dr Duncan							
										Renal: Signed Service Level Agreement with Portsmouth for provision of renal services.	31/10/2019	25/10/2019	Clarke, Lisa							
5863	Finance and Procurement	Trust Offices	17/06/2019	Specialty Risk assessment	12	The risk that the HMRC rules on higher earners who in the NHS pension scheme are increasing the number of consultants who are reducing their job plan PA's and retiring earlier than planned. Leading to a loss of capacity across the Trust.	Will probably recur, but is not a persistent issue	Moderate	12	Collecting the data to confirm lost capacity identified to date.	12/07/2019	19/08/2019	Thomas, Lisa	Finance and Performance Committee	31/01/2020	6	People	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	17/06/2019
										Identify strategic partners to offer staff financial advice.	31/10/2019	16/12/2019	Thomas, Lisa							
										Trust considering alternative arrangements in lieu of national guidance e.g. LLP arrangements on a specialty by specialty basis.	31/01/2020		Thomas, Lisa							

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5869	Quality Directorate	Trustwide	20/06/2019	Trustwide risk assessment	12	Failure to achieve required ward nursing establishment and skill mix with the following implications: Quality and safety concerns at ward level Poor patient experience Agency spend not reducing as predicted Pressure on substantive skilled workforce supervising and training new employees	Will probably recur, but is not a persistent issue	Moderate	12	Contribute to Trust work on developing workforce safeguards.	01/10/2019	22/10/2019	Hyett, Fiona	Trust Board	31/03/2020	9	People (Care)	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing	20/06/2019
										Contribute to levels of attainment work on e-rostering /e-job planning.	01/04/2020		Hyett, Fiona							
										Overseas recruitment campaigns 19/20.	30/04/2020		Hyett, Fiona							
										Skill mix review x2 per year - 2019/2020	30/04/2020		Wilkinson, Lorna							
										Retention workstream to plan, including exit meetings, STAY conversations and career pathways, to be embedded.	01/01/2020		Hyett, Fiona							
										Develop apprenticeships and nursing associate opportunities to broaden access into nursing.	30/04/2020		Wilkinson, Lorna							
										Maintain full recruitment of Nursing Assistant Staff.	30/04/2020		Hyett, Fiona							
										Twice daily staffing review using safe care and roster data.	30/04/2020		Hyett, Fiona							
										Domestic recruitment campaign 2019/2020	01/03/2020		Holt, Sharon							
										Implementation of safer nursing care tool to evidence staffing levels.	01/04/2020		Hyett, Fiona							
										Establish working group to ensure 'on boarding' of overseas nurses is appropriate, from arrival to post OSCE, in order to maximise staff experience and therefore retention.	31/01/2020		Hyett, Fiona							
5729	Musculo-Skeletal	Dermatology Outpatients	20/02/2019	Waiting times	25	Limited capacity for Melanoma clinics. Currently led by locum consultant who has not made a regular commitment to the service. Capacity required a weekly session but sessions currently only booked every over week or occasionally every 3-4 weeks. MM follow up patients are not getting reviewed as per recommended NICE guidelines reducing the opportunity for early detection of potentially life threatening melanomas.	Will probably recur, but is not a persistent issue	Moderate	12	Prepare for additional ad hoc clinics as required to address demand	01/05/2019		Gordon, Kathryn	Directorate Management Team Meeting	30/11/2019	10	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer	16/12/2019
										Plan for rapid access clinic	28/06/2019		Hemming, Alison							
										Review of skin cancer types - MM, SCC, BCC and potential for primary care to follow up BCC.	30/11/2019		Khan, Mr Mansoor							

Corporate Risk Register
January 2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5605	Clinical Support and Family Services	Histopathology	18/10/2018	Departmental risk assessment	15	Problem: insufficient staff in cellular pathology laboratory, Consultant, Scientist and support staff groups. Also, equipment that is old and fails regularly. Risk: - slow report turnaround time - leading to failing UKAS accreditation - delaying patient treatment - delaying cancer treatment - increasing costs if work is outsourced to address the risks above - losing staff	Will undoubtedly recur, possibly frequently	Moderate	15	Locum Biomedical Scientist in laboratory for 3 months to cut backlog of tissue blocks awaiting microscopy.	11/01/2019	13/03/2019	White, Christine (Inactive User)	Departmental Team meeting	31/01/2020	9	Care, Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer	30/04/2019
										Cancer Lead - Dr J Cullis, to attend and watch MDT process to see if any recommendations can be made.	11/01/2019	13/03/2019	Cullis, Dr Jonathan							
										Dr M Flynn has discussed this with Cancer Lead and Nichola House, Deputy Directorate Manager. Ideally Histology would be notified at the time of biopsy/surgery, that a case is of a higher priority. If this notification took place, these cases would be prioritised and would very nearly remove the likelihood of delays in meeting Trust treatment time targets.	11/01/2019	13/03/2019	House, Nicki (Inactive User)							
										New Locum Consultant arrived in department on 12th June. Review affect this has on risk score in 6 weeks.	31/07/2019	06/08/2019	Baden-Fuller, Dr Joanna							
										Locum Consultant no longer in trust due to quality issues. His work being audited by Source Bioscience. Trust needs to revert back to using Source Bioscience for a proportion of analysis and reporting.	30/12/2019	31/12/2019	Phillips, Lee							
										Remedium-sourced Consultant to commence in Trust November 2019. To review risk score 6 weeks after staring in post	04/01/2020	06/01/2020	Flynn, Dr Matthew							
										Application made for locum Biomedical Scientist to reduce outsourcing microscopy	16/10/2019	22/10/2019	Phillips, Lee							
										200 cases, almost all of which are Cancer cases of cutaneous origin (incl systemic malignant neoplasia involving the skin) have been sent to Unilabs, a UKAS accredited outsourcing company.	04/10/2019	23/10/2019	Baillie, Jenny							
										Appoint B6 Agency staff, following WCP approval. Update Dec 19- Delay to completion of this action due to accommodation issues on site. Being worked on by COO.	01/11/2019		Phillips, Lee							
										Appoint Bank Admin staff to administrate and support outsourcing processes	31/10/2019	21/10/2019	Baillie, Jenny							
										Compile business case for 6th Histopathologist based on increasing demands on the service.	28/02/2020		Boyd, Hannah							

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5860	Finance and Procurement	Trust Offices	17/06/2019	Financial management, Trusts Objectives, Trustwide risk assessment	12	Trust fails to achieve the financial plan and NHSI Financial Control total for 2019/20. This impacts on the ability to achieve national funding including PSF and FRF, which in turn could lead to unplanned cash borrowing.	Will undoubtedly recur, possibly frequently	Moderate	15	Identify savings programme for residual £2m gap for 2019/20	30/09/2019	21/10/2019	Thomas, Lisa	Finance and Performance Committee	28/02/2020	9	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	17/06/2019
										Identify cost effective solution to increased costs associated with Gastro and endoscopy services.	31/07/2019	19/08/2019	Thomas, Lisa							
										Ensure contract with commissioners reflects appropriate risk for blended tariff in 2019/20 and is consummate with the ICS partners.	12/07/2019	19/08/2019	Thomas, Lisa							
										Trust to work with Commissioner to mitigate risk of contract underperformance at M4 and potential operational risks in winter which in turn create further financial risk	28/02/2020		Thomas, Lisa							
										Directorates to identify recovery plans to mitigate forecast risk	31/10/2019	16/12/2019	Thomas, Lisa							
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Will undoubtedly recur, possibly frequently	Moderate	15	reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020		Thomas, Lisa	Trust Board	31/01/2020	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	13/08/2019
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa							
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020		Willough by, Kelly							
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/01/2020		Thomas, Lisa							
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan							
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020		Scott, Andy							
										Approach to testing of backups agreed	17/01/2020		Cowling, Andrew							
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/03/2020		Burwell, Jonathan							
										Full review of policy and procedures including adherence	29/05/2020		Scott, Andy							
										Full implementation of IT general controls framework	31/12/2020		Scott, Andy							
										Complete a stocktake of all IT operational infrastructure	31/01/2020		Burwell, Jonathan							
										Implement a robust asset management system	30/10/2020		Burwell, Jonathan							
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020		Burwell, Jonathan							

Corporate Risk Register
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ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5970	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Will probably recur, but is not a persistent issue	Major	16	Development of an IT improvement plan which includes staffing, communications, infrastructure, governance and any outstanding pen test/audit actions.	22/11/2019	11/12/2019	Provins, Esther	Finance and Performance Committee	31/01/2020	9	Innovation	Finance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	23/08/2019
										Set up monthly executive performance reviews.	30/09/2019	11/10/2019	Provins, Esther							
										Completion of internal audit action plans and penetration test action plans.	31/12/2019		Burwell, Jonathan							
										To complete the review and proposal for improving our capacity to do business change.	31/03/2020		Provins, Esther							
										Agree long term direction of the EPR and short/medium term investment.	31/01/2020		Burwell, Jonathan							
										Develop, agree and implement a new range of informatics service standards	28/02/2020		Burwell, Jonathan							
										Conclude work to agree and commence implementation of a robust and fit for purpose service delivery model	29/03/2020		Burwell, Jonathan							
										Develop and implement a communications and engagement plan aligned to digital strategy	15/01/2020		Burwell, Jonathan							
										Evolve current change management approach, ensuring it is comprehensive, clinically led	31/01/2020		Burwell, Jonathan							
										Implement an Informatics team development programme	30/04/2020		Burwell, Jonathan							
										Strengthen clinical leadership in informatics by reaffirming priorities for CCIOs and appointing to CNIO roles	31/03/2020		Provins, Esther							
										Embed information analysts into directorate management teams	31/10/2020		Burwell, Jonathan							
										Informatics staff to undertake relevant customer service training	31/07/2020		Burwell, Jonathan							

Corporate Risk Register
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5972	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	Insufficient organisational development resources to deliver transformational and cultural change. This could potentially result in lack of transformation, improvement, poor quality services, reputational damage, financial impact, operational ineffectiveness and inability to attract and retain high quality staff, along with a risk to the Trust delivering its strategic priorities.	Will probably recur, but is not a persistent issue	Major	16	Review of role and purpose of Innovation Committee; develop a clear approach for innovation	13/12/2019		Provins, Esther	Trust Board	31/01/2020	12	Innovation (Resources)	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Director of Transformation	23/08/2019
										Introduce a Dragon's Den event to inspire, promote and reward innovation	30/04/2020		Provins, Esther							
										Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther							
										Review effectiveness of Quality Improvement plan.	29/03/2020		Provins, Esther							
										Implement Quality Improvement plan	31/03/2020		Provins, Esther							
										Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther							
										Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/01/2020		Provins, Esther							
										Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	31/12/2019		Hyett, Andy							
										Escalate discussions with system partners regarding levels of DToCs	31/12/2019		Hyett, Andy							
										Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	31/12/2019		Provins, Esther							
										Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020		Provins, Esther							
										Undertake a CIP assurance exercise for 19/20	11/01/2020		Provins, Esther							

Corporate Risk Register
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ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
6134	Clinical Support and Family Services	Genetics	20/12/2019	Trustwide risk assessment	16	NHS England Specialist Commissioners are driving centralisation of genetics and genomics clinical testing into fewer laboratories and this means it is unlikely that laboratory testing services can be provided at SFT in the longer term. This is a financial risk for the Trust and a Workforce Risk.	Will probably recur, but is not a persistent issue	Major	16	Work with UHS to centralise genomic testing in Wessex.	28/02/2020		Blanshard, Dr Christine	Trust Board	28/02/2020	8	Specialist Services	Trust Board (Corporate Risk Register)	Medical Director	02/10/2020
										Devise a business plan required to mitigate the financial risk.	28/02/2020		Blanshard, Dr Christine							
6142	Clinical Support and Family Services	Genetics	20/12/2019	Specialty Risk assessment, NHS England	16	There is uncertainty of the future of the Genetics service at SFT as a result of NHS England Specialist Commissioners driving centralisation of genetic and genomic clinical testing. This is expected to happen over the next 3-years, however there are currently no robust plans or timescales in place to achieve this (actions with UHS). This has resulted in uncertainty for SFT's Genetics staff as the Trust is unable to articulate what this means for them and as a result they have concerns around their future employment. The uncertainty is also adding complexity to recruitment processes, whereby individuals are either aware in advance of application and therefore not submitting, or made aware at interview, and therefore reconsidering. This will have significant impact on the delivery of the service via reduced staffing and therefore impacted turnaround times. Overall, there is a risk to recruitment, retention and staff morale within the Genetics service as a result of the uncertainty of the future of the service.	Will probably recur, but is not a persistent issue	Major	16	Keep staff updated as to developments (in relation to the future of the genetics service).	28/02/2020		Thomas, Lisa	Trust Board	28/02/2020	8	Specialist Services	Trust Board (Corporate Risk Register)	Medical Director	02/01/2020
6143	Quality Directorate	Trustwide	20/12/2019	Trustwide risk assessment	16	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Will probably recur, but is not a persistent issue	Major	16	Weekend safety and effectiveness action plan reported to Board on a monthly basis.	02/03/2020		Blanshard, Dr Christine	Trust Board	02/03/2020	6	Care	Trust Board (Corporate Risk Register)	Medical Director	02/01/2020

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5704	Medicine	Trustwide	31/01/2019	Directorate risk assessment	16	The inability to provide a full gastroenterology service due to a lack of medical and nursing staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed. See also linked Risk 5644 (CSFS Gastroenterology Risk).	Will probably recur, but is not a persistent issue	Major	16	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	Intensive Support Meeting	31/01/2020	12	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Operating Officer	31/01/2019
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa							
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali							
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali							
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew							
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy							
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy							
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy							
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart							
										Medical Director to link with other STP partners around system wide solution.	31/12/2019		Blanshard, Dr Christine							
										Case for change to develop a GI unit to be completed	31/12/2019		Hyett, Andy							

Corporate Risk Register
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5751	Trustwide	Trustwide	11/03/2019	Directorate risk assessment	16	Risk of impact on patients from high numbers with a delayed transfer of care. This risk is caused by lack of capacity within the community.	Will probably recur, but is not a persistent issue	Major	16	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	31/01/2020	12	Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer	11/03/2019
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy							
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy							
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy							
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy							
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy							
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy							
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy							
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy							
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy							
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019		Hyett, Andy							
										System wide actions to be monitored through the ED local delivery board.	01/04/2020		Hyett, Andy							
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019		Hyett, Andy							

Corporate Risk Register
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4107	Musculo-Skeletal	Musculo-Skeletal Directorate Management Offices	17/09/2015	Service Delivery Plan, Specialty Risk assessment	12	Patients are not being followed up in the time that has been stipulated by Consultants due to lack of clinic capacity, clinicians not recording correctly or failures in administrative processes. Which could result in patient harm. clinical deterioration in between follow-ups which could lead to untreatable disease progression. This risk relates to outpatients and to patients needing local anaesthetics (the risk to patients needing local anaesthetics was previously on risk 5421 which was merged with this risk on 07/01/19). Appointments requested for patients are not always being given in a timely manner, particularly a risk for oncology patients (follow up clinic) Failure to follow national guidelines for the management of patients with skin cancer - particularly melanoma patients not being seen at regular 3 month intervals. Significant risk of patient mis-management with long term effects - disease progression making treatment options limited. Risk of duty of candour. SEE ALSO CLOSED RISK ID 5421	Will probably recur, but is not a persistent issue	Major	16	Further recruitment of 2 plastics consultants	18/12/2015	11/10/2016	Wright, Jonathan	Directorate Management Team Meeting	31/12/2019	6	Local Services (Care)	Clinical Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Chief Operating Officer	24/07/2017
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	17/01/2017	25/01/2018	Insull, Victoria							
										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	17/01/2018	17/01/2018	Insull, Victoria							
										monitor and review capacity and time to follow up	31/12/2018	21/12/2018	Vandyken, Mrs Ali							
										Reviewing the cause of all patients lost to follow up. Cross refereeing Lorenzo, with Somerset Cancer registry. And reviewing admin process for follow-ups.	30/04/2018	08/05/2018	Hyett, Andy							
										Reviewing the cause of all patients who have been lost to follow up and reviewing admin processes.	31/08/2018	16/08/2018	Hyett, Andy							
										Full follow up PTL being validated at patient level for 2017 and 2018.	29/03/2019	25/04/2019	Hyett, Andy							
										Trajectory for clearing skin backlog to be agreed with COO by 31/04/2019.	30/04/2019	12/06/2019	Wright, Jonathan							
										Executives to review approach to patient pathway redesign.	31/03/2019	26/04/2019	Blanshard, Dr Christine							
										Trajectory for urology backlog clearance to be agreed by 31/05/19 by COO.	31/05/2019	12/06/2019	stephens, Mrs Davina							
										Internal auditors (pwc) to review process for booking new patient and follow up outpatient appointments including cancer.	01/11/2019		Blanshard, Dr Christine							
										Organise a Risk Summit to address Human Factors causing patients to be lost to follow-up.	30/09/2019	25/10/2019	Blanshard, Dr Christine							
										Task and Finish Groups set up improve bookings, results review, clinic outcomes and MDT effectiveness (to address issues identified at Risk Summit).	01/04/2020		Blanshard, Dr Christine							

Corporate Risk Register Summary - January 2020

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Nov-18	Jan-19	Mar-19	Jun-19	Jul-19	Sep-19	Nov-19	Jan-20	Target
Risk Detail				Score Trend									
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do													
5704	Inability to provide a full gastroenterology service due to a lack of medical staff capacity	Chief Operating Officer	31-Jan-19	16		16	16	12	12	16	16	16	12
4107	Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes	Medical Director	17-Sep-15	12	9	9	12	16	16	16	16	16	6
5751	Risk of impact on patients from high numbers with a delayed transfer of care	Chief Operating Officer	11-Mar-19	16			16	16	16	16	16	16	12
5799	Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients	Chief Operating Officer	18-Apr-19	15				20	16	20	15	9	6
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population													
6134	Financial and workforce risk as a result of NHS England Specialist Commissioners driving centralisation of genetics and genomics clinical testing into fewer laboratories resulting in laboratory testing unlikely to be provided at the Trust in the longer term	Medical Director	02-Jan-20	**16**								16	8
6142	Risk to recruitment, retention and staff morale within the genetics service as a result of the uncertainty of the future of the service	Medical Director	02-Jan-20	16								16	8
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered													
5970	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Director of Transformation	23-Aug-19	16						16	16	16	9
6129	Risk of the non-delivery of the IT Improvement Plan	Director of Transformation	19-Dec-19	20								9	6

5972	Insufficient organisational development resources to delivery transformational and cultural change	Director of Transformation	23-Aug-19	16						16	16	16	12

Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm														
5605	Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment	Chief Operating Officer	18-Oct-18	15				15	15	15	15	15	9
5729	Risk of delay in potentially detecting life threatening melanomas due to limited resource capacity	Chief Operating Officer	16-Dec-19	25								12	6
6143	Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care	Medical Director	02-Jan-20	16								16	6
5966	Risk of compromised services due to hub and spoke model	Medical Director	20-Aug-19	12						12	15	12	6
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams														
5863	Risk of new HMRC rules for the NHS Pension Scheme impacting on consultant capacity across the Trust	Director of Finance	17-Jun-19	12				12	12	12	12	12	6
5869	Failure to achieve required ward nursing establishment impacting on quality and safety and patient experience. High agency expenditure	Director of Nursing	20-Jun-19	12				12	12	12	9	12	9
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources														
5705	Unknown impact on the running of the hospital as a result of the EU Exit	Chief Operating Officer	31-Jan-19	12		12	8	8	8	8	8	8	8
5487	The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation	Director of Finance	26-Nov-18	12	12	12	12	9	9	9	9	6	6
5860	Risk of failure to achieve financial plan and NHSI control total for 2019/20	Director of Finance	17-Jun-19	12				12	12	12	15	15	9
5862	Risk to buildings and equipment due to capital programme funding	Director of Finance	17-Jun-19	12				12	12	12	9	9	9
5955	Insufficient organisation wide robust management control procedures	Director of Finance	13-Aug-19	15						15	15	15	9
5920	Breaches of fire compartmentation in PFI building	Chief Operating Officer	17-Jul-19	6						6	5	5	2
6041	Risk of delivery of the NHS Long Term Plan ambitions due to a lack of capacity to build strong partnerships with the number of newly forming organisations at the pace required	Director of Finance	25-Oct-19	6							9	9	6
6042	Risk of lack of CCG capacity and focus to deliver change required for SFT to deliver its core strategy due to local merger of 3 CCGs	Director of Finance	25-Oct-19	12							12	12	6

6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Director of Finance	25-Oct-19	12								12	12	6

Risk Score Key

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	06 February 2020		

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

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

Executive Summary:
While there was some improvement in performance against the Emergency Access (4hr) target, the Trust continued to feel the impact of winter pressure – though still maintaining performance well above the national average for December (89.6% vs 79.8% nationally). While the Trust was consistently on high escalation, the number of cancelled operations has remained within expected range. There was a marked improvement in month in discharges before 1200 but while overall bed occupancy fell in month, the longer term trend for this and beds occupied by DTOCs is one of sustained increase. Patients being moved during their inpatient spell, escalation bed days and Mixed Sex (Non-clinical) breaches have also remained high. The Trust's Referral to Treatment performance has remained as a special cause variation given the downward trend in performance (despite a marginal improvement in both performance and reduction in waiting list size in December). Falling performance trends in dermatology and plastic surgery have continued. There has, however, been some progress in the Theatres productivity programme seeing increased productivity (8%) in day theatres – this will contribute both a performance and financial impact of increased activity levels. The Trust has maintained its performance against the diagnostic waiting time standard, delivering 99.8% of diagnostic tests within 6 weeks in December.

There has been marked deterioration in month in 2 week wait and 2 week wait (breast) cancer performance which has been attributed to patient choice and the impact of the holiday season – it is expected that performance will therefore recover in January.

While most quality indicators have continued to follow trends seen throughout the year, a notable increase in category 3 and 4 pressure ulcers is being investigated in January to identify root cause and improvement actions. There were encouragingly no falls resulting in moderate or major harm in December. Weekend HSMR has stabilised and further evaluation of the action plan in this area is being undertaken. A report and improvement plan relating to risk of mortality in gastrointestinal haemorrhage is being presented to Clinical Governance Committee in late February.

The Trust's control total deficit (£1.7m) is in line with forecast expectations shared with NHSE/I. This assumes escalation capacity opened in December will remain in place for the remainder of the financial year. Underlying financial challenges remain as per previous reporting months (agency spend – despite the 75% reduction in nursing agency spend), the impact of unfilled posts and underperformance in elective activity. A sharp rise in leavers in December will also contribute this staffing pressure. However, despite the management of a norovirus outbreak in December, staff sickness levels remained broadly static. Increased, unplanned use of escalation has also contributed financial pressure and an inability to achieve the Patient Flow CIP programme.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

February 2020

(data for December 2019)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

While there was some improvement in performance against the Emergency Access (4hr) target, the Trust continued to feel the impact of winter pressure – though still maintaining performance well above the national average for December (89.6% vs 79.8% nationally). While the Trust was consistently on high escalation, the number of cancelled operations has remained within expected range. There was a marked improvement in month in discharges before 1200 but while overall bed occupancy fell in month, the longer term trend for this and beds occupied by DTOCs is one of sustained increase. Patients being moved during their inpatient spell, escalation bed days and Mixed Sex (Non-clinical) breaches have also remained high.

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Structure of Report

Performance against our Strategic and Enabling Objectives

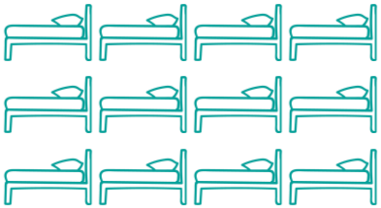
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
October 2019

Salisbury NHS Foundation Trust

There were **2,942** Non-Elective Admissions to the Trust

We carried out **415** elective procedures & **1,913** day cases



99.8% ↑ of patients received a diagnostic test within **6 weeks**

Emergency (4hr) Performance
86.9% ↓
(Target trajectory: 94.8%)

We delivered **18,881** outpatient attendances cases (+825) vs plan)

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

Our income was **£19,828k** (£642k over plan)

1,408 patients arrived by Ambulance

We met **3 out of 7** Cancer treatment standards

RTT 18 Week Performance:
91.6% ↑
Total Waiting List: **18,196** ↓

18.7% ↑ of discharges were completed before 12:00

Our overall vacancy rate was **2.83%** ↓

Reading a Statistical Process Control (SPC) Chart

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

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

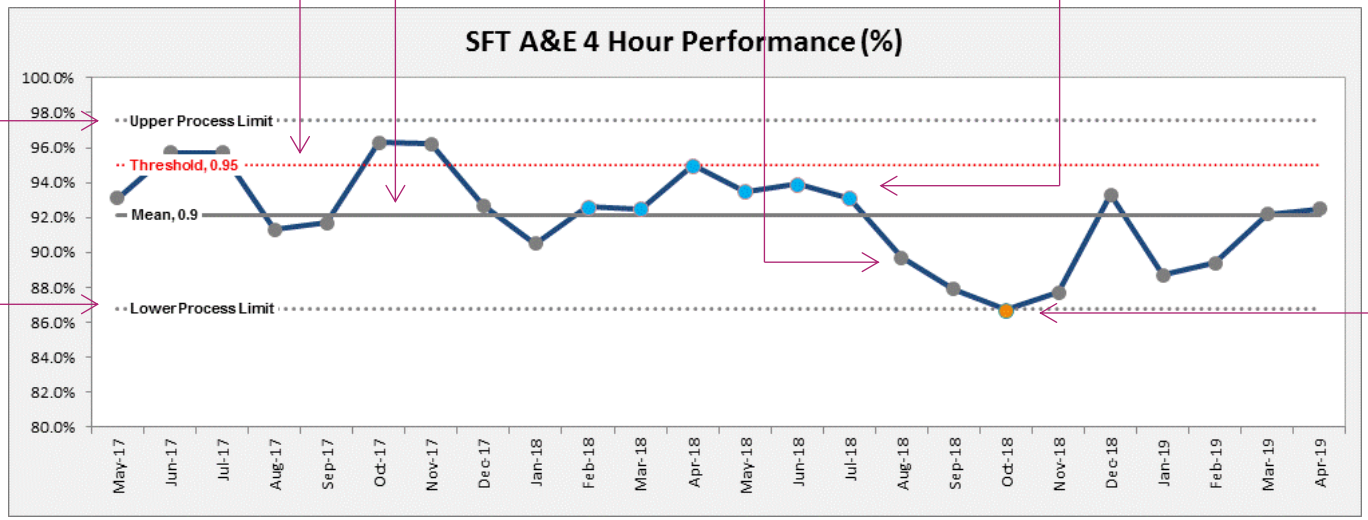
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

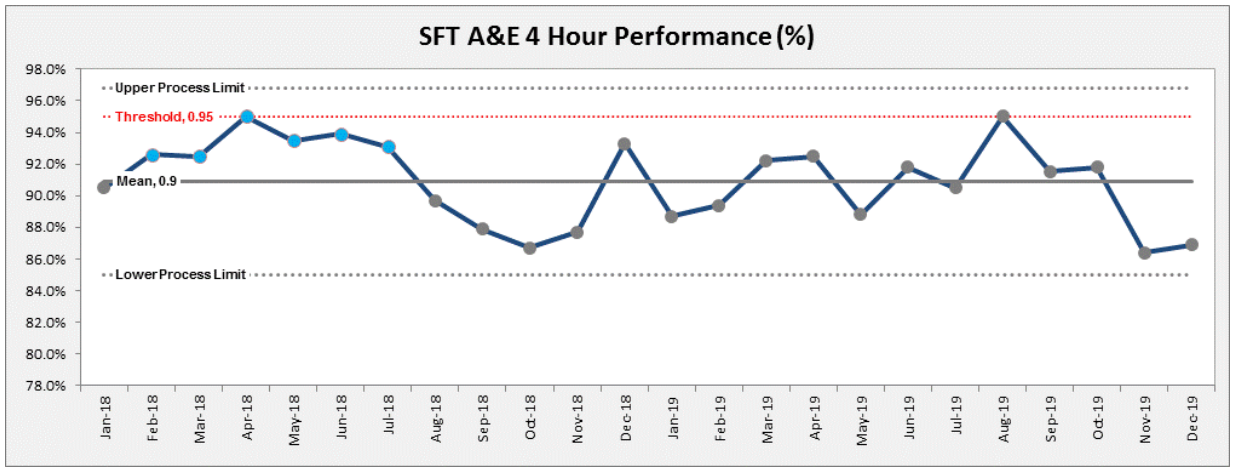
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

Emergency Access (4hr) Standard Target 95% / Trajectory 94.8%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	86.9%
Attendances:	6164
12 Hour Breaches:	0
ED Conversion Rate:	28.8%

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

M9 saw a slight improvement in 4hr performance as compared to M8. M8 saw a variety of challenges with hospital capacity which impacted on flow through ED and this continued to impact into M9. Multiple beds closures due to outbreaks of Norovirus and increased levels of Flu impacted on number of attendances through ED but also on staffing levels.

Number of Type 1 attendances in M9 rose by 369 (9%) from the same period in 2018. Gaps in middle grade and junior doctor rota continued to be covered by locum staff and at times the team had to run with staffing gaps which created some challenges with managing demand. In M9 there were 16 ambulances waiting over an hour to handover and a continued increase in ambulance conveyance rate.

Christmas and high levels of annual leave also made it challenging to recruit bank / agency staff to cover gaps.

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

Flow – continued work on single clerking processes for medicine.

Staffing – Continued support for supporting junior skill mix in nursing team.

Leadership – Work continuing on annualisation of middle grade and consultant rotas – to be launched in M10. ED strategy work commenced to be launched in M11.

Adverts out for SHO, Middle grades and consultants.

Risks to delivery and mitigations

Outbreaks of infection and ward closures

High levels of DTOC

High staff sickness and rota gaps

Christmas holiday period

Statistical Process Control Chart Key:

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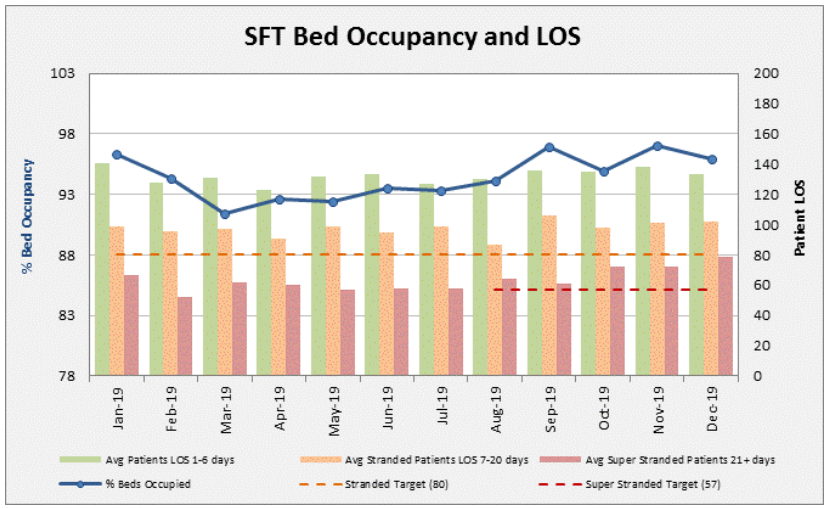
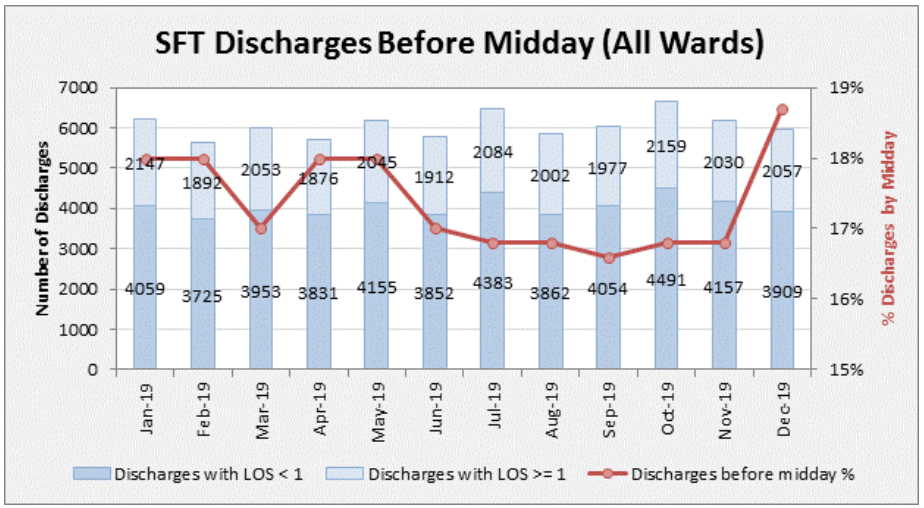
- Common Cause Variation

Patient Flow and Discharge

Are We Effective?





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

December saw a decrease in bed occupancy overall. The 1-7 day group has decreased slightly and the 7-20 day remained consistent with the previous month.

The 21 day + LOS group of patients increased compared with the previous month.

The discharging of long stay patients continues to be a challenge. The Norovirus outbreak and subsequent closure of medical wards has had an impact on these figures.

Discharges before midday is improving though it is still a challenge. Transport availability has been a factor this month.

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

Laverstock Ward was reopened on the weekend of 28th and 29th December after the two week fire break which started on the 9th December.

The ward is at 26 patients as an escalation ward with patients from four specialties (Respiratory, Elderly Medicine, Diabetes and AMU) with their respective teams looking after the patients. The nursing staff has been a challenge to maintain with gaps almost daily. Medicine Matrons providing ongoing support.

Expert Panel continues to review 14 day+ stay for all wards. The Medicine Head of Nursing continues to attend.

Risks to delivery and mitigations

Sustained demand at the front door continues.

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

Delayed Transfer of Care (DToC) Bed Days

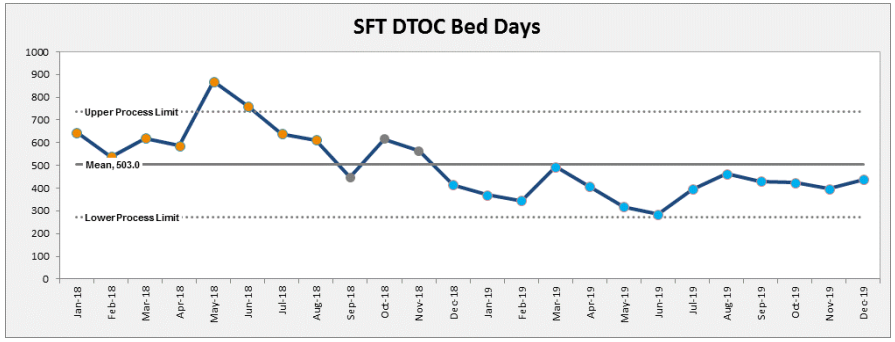
National Key Performance Indicators

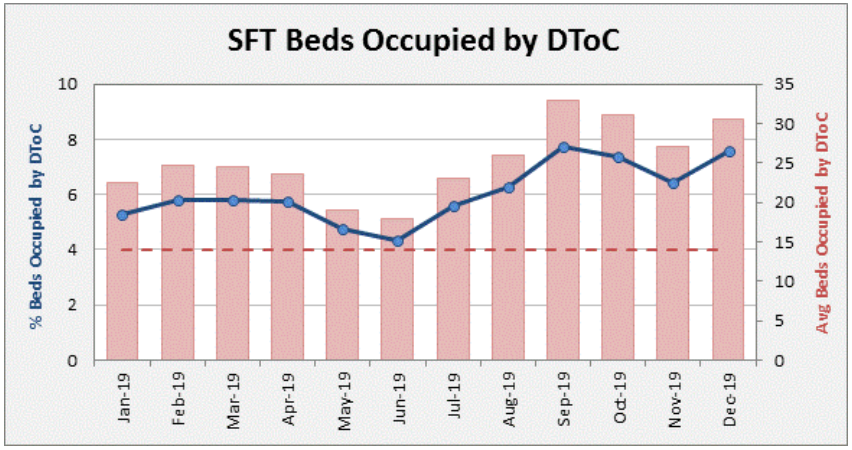
Performance Latest Month:

Data Quality Rating:

Days Lost to DToC: 151 NHS + 281 SS

DToC Patients (last Thursday of month snapshot): 16





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

The graph showing DToC bed days demonstrates these remained steady in December and not dissimilar to the same month in 2019. The percentage of beds occupied by DToC has remained at a steady high since September as has the average number of beds occupied by DToC but the information from Dec 2019 is not available for comparison. The date of the snapshot was Boxing Day, which was a quiet period for DToC following the concerted effort to discharge patients for Christmas.

December was affected by infection control measures at the acute Trust and also closures in the community affecting available resource for discharges from SFT.

Additionally winter measures that were planned to be available to Wiltshire Health and Care (WH&C) to increase capacity in Homefirst did not come on line as expected and additional delays resulted. Homefirst delays accounted for the majority of NHS delays in December. SS delays included reablement and care delays for Wiltshire and partners in Hampshire and Dorset.

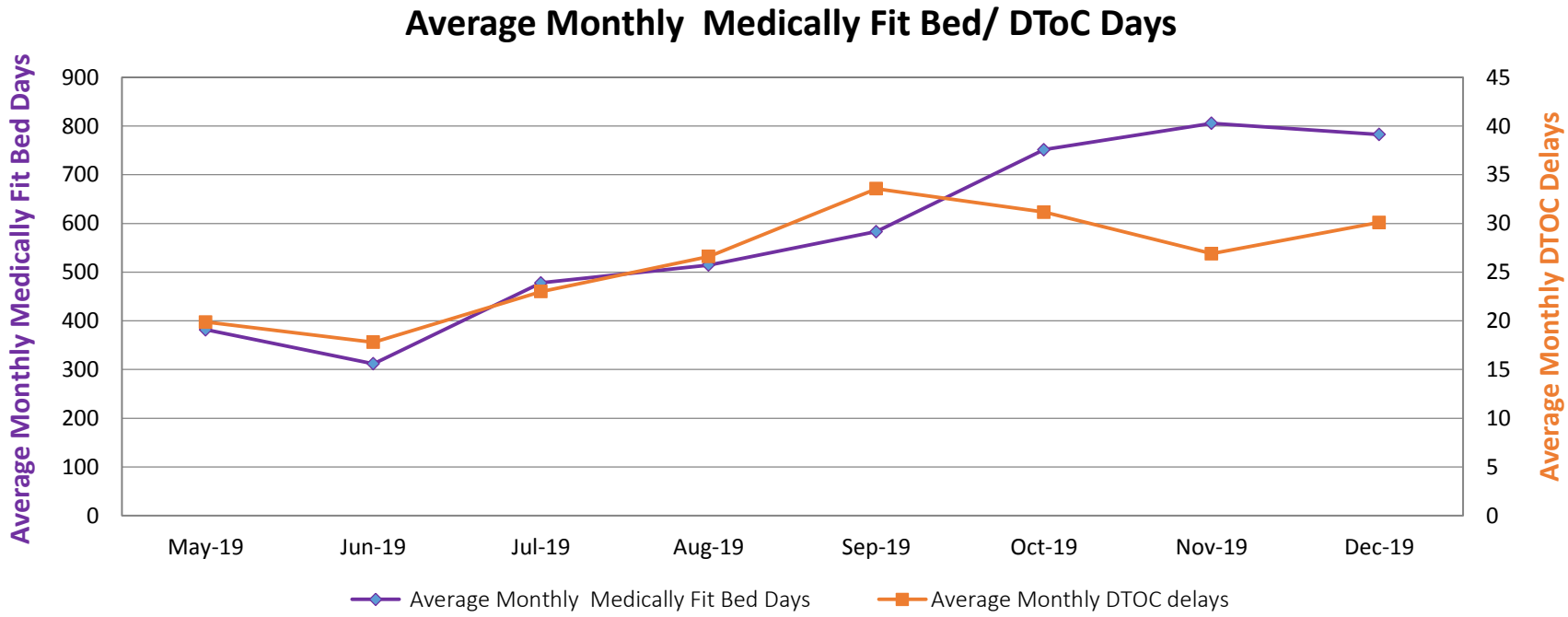
Plans for January include exceptional use of 10 Order of St Johns Care Trust beds and additional domiciliary care agency support for Wiltshire Health and Care which will be revisited at the end of the month to evaluate impact and inform next steps.

December saw the introduction of SHREWD at SFT which is a system overview dashboard. Data will be fed from the whole system to support the appropriate and timely allocation of resource and manage fluctuations in demand on services including the acute Trust, and has the potential to highlight the risk of DToC to the whole system so action may be undertaken to proactively manage the risk before it becomes reportable. This will require a process of embedding over the course of the next few months and it is anticipated the system will become business as usual.

Therapists and staff from both SFT and WH&C met in December at a workshop to explore ways of working that would ensure cross organisational working is as smooth and collaborative as it can be. It was a very productive workshop and it is anticipated that outcomes such as shared IT access, rotational posts, shared training and education will develop as a result in the new year.

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

National Key Performance Indicators



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

This graph is new to the IPR and uses data that has been collected by IDS since May 2019. There is now sufficient data to show a trend in average MFFD bed days compared with average monthly DToC. This will support the understanding of the impact of DTOC on the overall number of MFFD bed days.

The December position shows an increased number of MFFD bed days and a steady number of DToC delayed patients. This may indicate the infection control led bed closures will have delayed people who were waiting for onward services, but who will not appear as a DTOC for the same reason. The risk during a time of closure for people waiting for services is that they become unwell and require a further hospital stay before they are fit for discharge again. Additionally people who remain fit in closed areas do not register as DTOC and therefore do not highlight the genuine lack of resource, triggering sudden increases as wards reopen. IDB and partners work closely with infection control information to ensure discharges continue where possible and countdowns are considered vital to contribute to discharge plans when areas reopen.

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

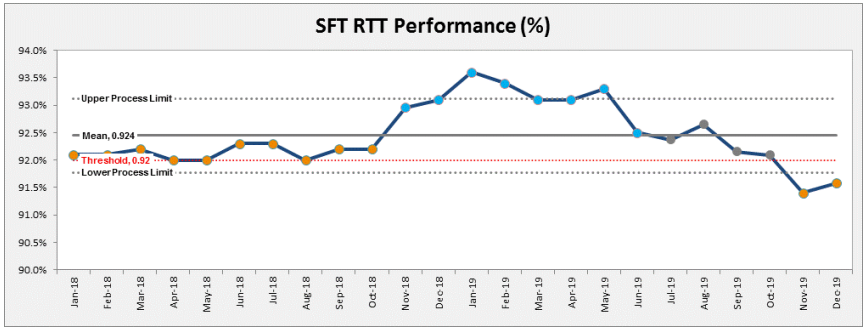
Total WL	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Dorset CCG (11J)	2,650	2,762	2,760	2,771	2,832	2,845	2,871	2,889	2,882	2,834	2,856	2,825
West Hampshire CCG (11A)	1,628	1,696	1,748	1,638	1,667	1,690	1,743	1,695	1,682	1,655	1,614	1,606
Wiltshire CCG (99N)	10,384	10,500	10,328	10,540	10,478	10,718	10,630	10,809	10,900	11,050	11,130	11,018
Other CCGs	2,180	2,105	2,113	2,083	2,323	2,498	2,732	2,800	2,822	2,729	2,718	2,747
Trust Total	**16,842**	**17,063**	**16,949**	**17,032**	**17,300**	**17,751**	**17,976**	**18,193**	**18,286**	**18,268**	**18,318**	**18,196**

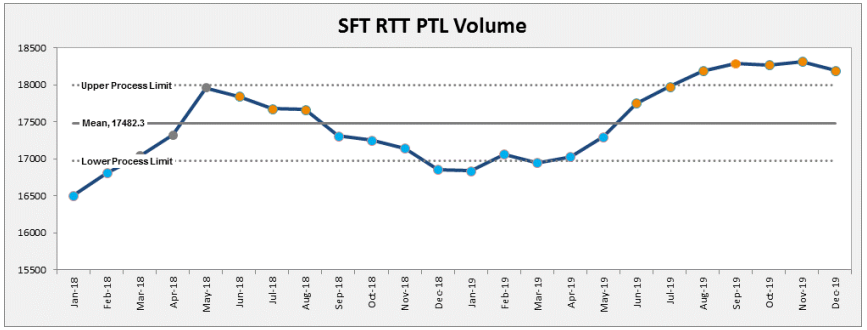
Data Quality Rating:

Performance Latest Month: 91.6%

PTL Volume: 18,196

52 Week Breaches: 0





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

Overall RTT Performance Standard remained just under 92% in December although increased by 0.2% from November's position.

The failure to achieve the performance standard is predominantly due to the high volume of long waiting patients in both Dermatology and Plastic Surgery. Both currently have a wait of around 30 weeks for first appointment.

Long first appointment wait times are also seen in Respiratory, 35 weeks, and Glaucoma first appointment wait times are also increasing, currently at 25 weeks, partly due to increasing referrals from surrounding CCG's. A high volume of long waiters is also seen in Oral Surgery due to capacity issues for surgery. Capacity pressures in ENT have also resulted in patients booked for first appointments between 30 – 40 weeks.

It is predicted that the above specialties will remain under target but continued improvement is expected in General Surgery and Urology and Ophthalmology is predicted to recover in January due to additional cataract activity.

The overall PTL is predicted to remain above target but continued reduction from December onwards is expected.

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

Ophthalmology: Job plan changes and additional activity plans have commenced in January as planned and the RTT position is predicted to recover this month. The activity plan has also now recovered due to this additional capacity.

Urology: New WTE consultant starts February. Job plan confirmed and clinics and theatres lists being populated. This will result in further RTT recovery from February onwards.

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

ENT – Work commenced with ENT to create a flexible rota to reduce first appointment wait times and to equalise surgical waiting lists.

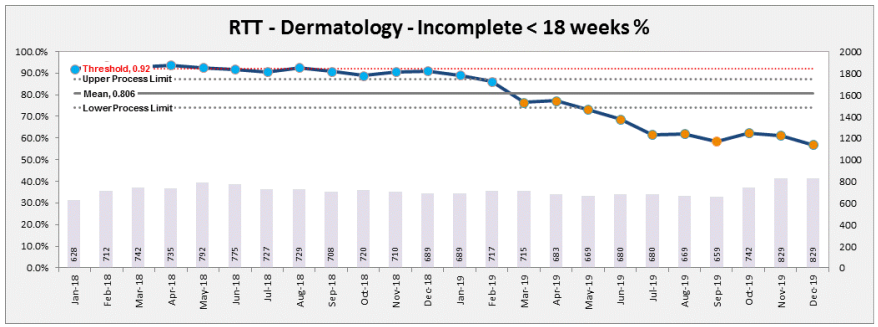
Risks to delivery and mitigations

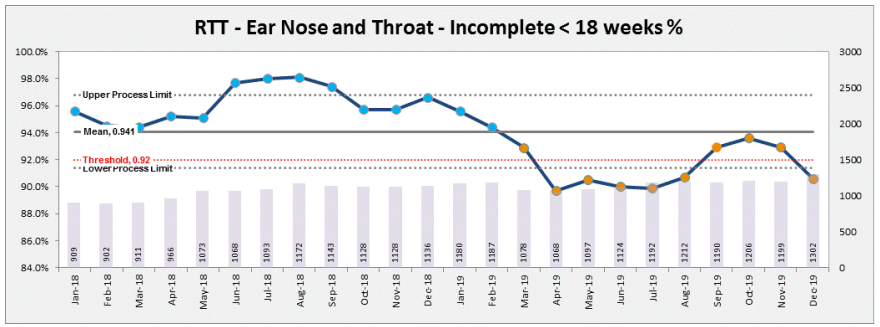
Continued risk of not achieving performance standard for January due to lack of capacity and high volumes of long waiters.

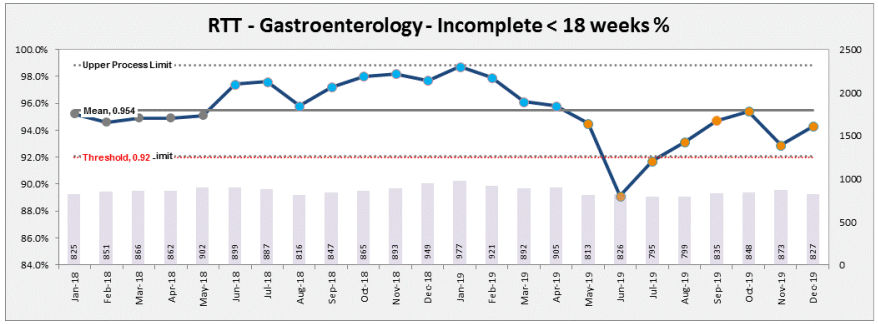
Impact of non elective demand and bed capacity over winter.

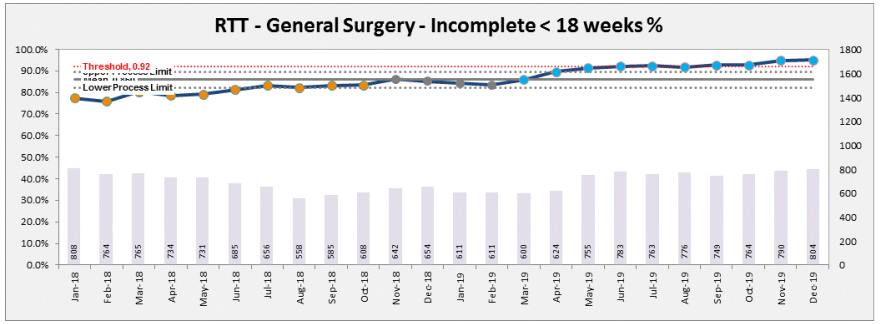
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

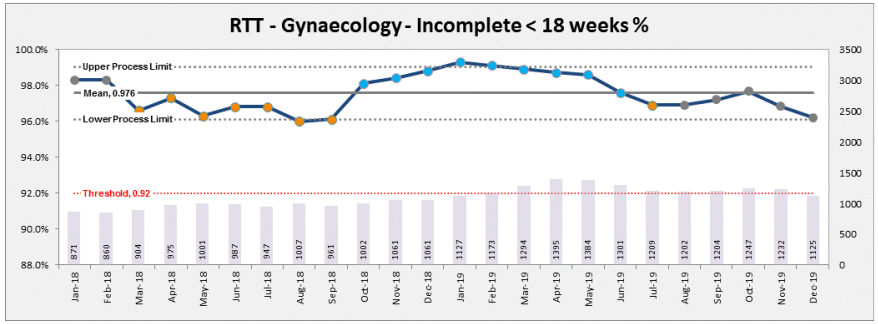
National Key Performance Indicators

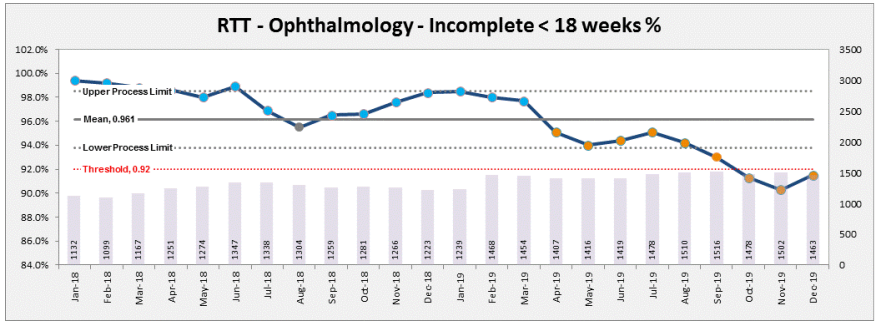






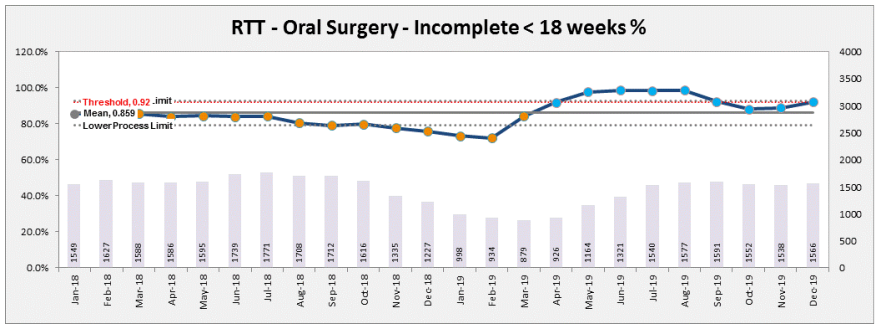


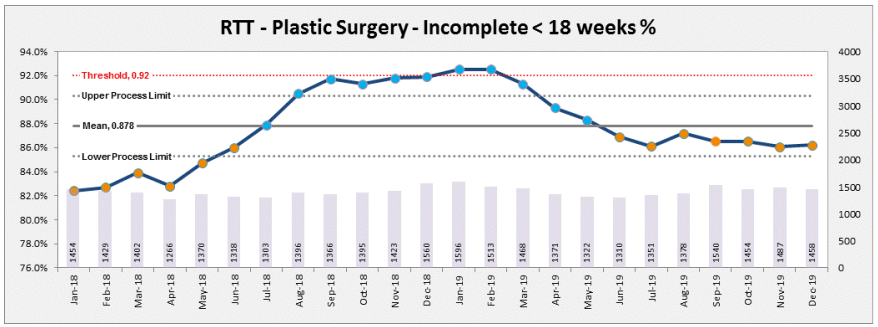


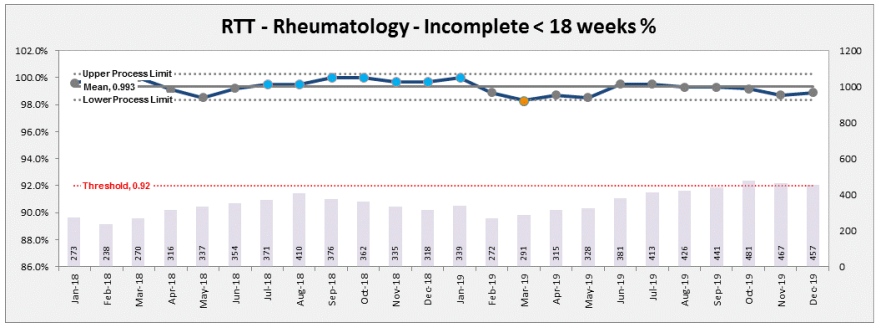


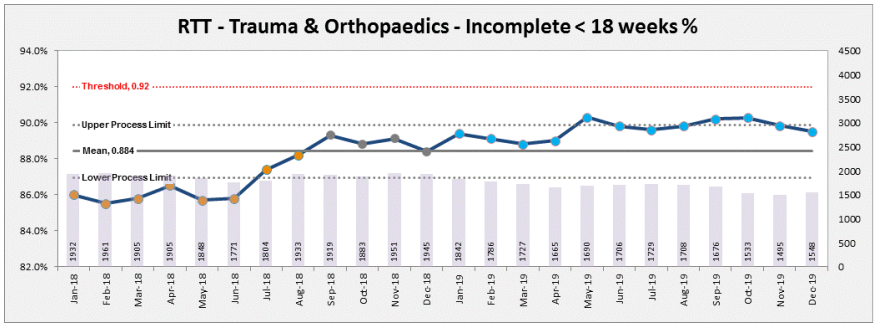
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

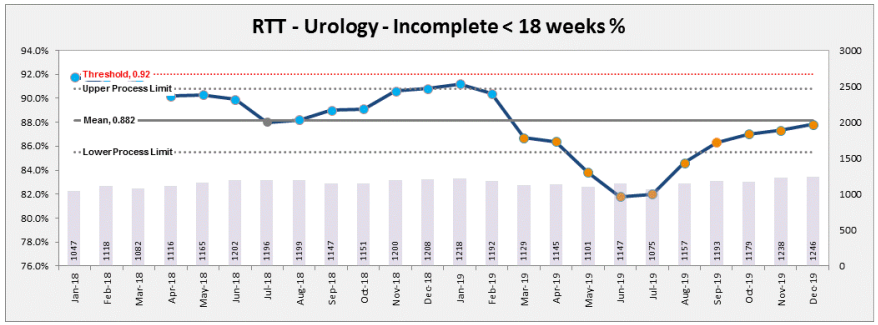
National Key Performance Indicators

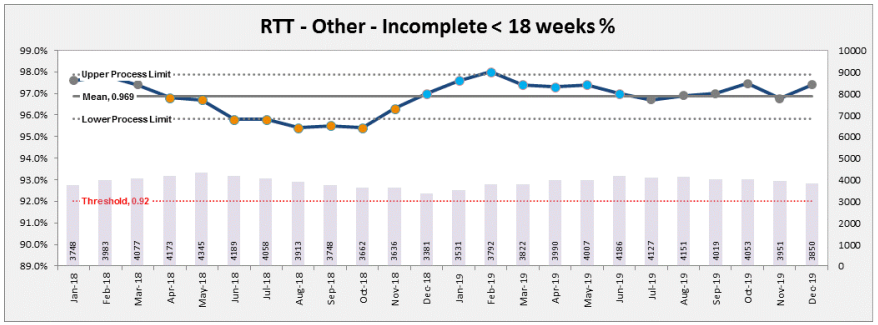






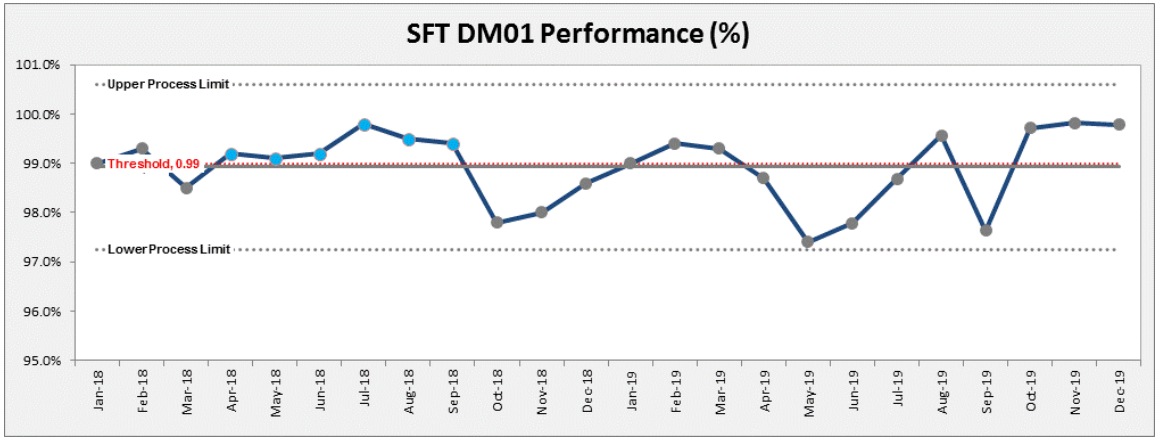






Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	99.8%
Waiting List Volume:	3,632
6 Week Breaches:	8
Diagnostics Performed:	6,989

Background, actions being taken and risks and mitigations

Performance standard in month achieved, with 8 in month breaches recorded for M9. January projections indicate no concerns in achievement of target for M10.

Endoscopy

4 confirmed in month breaches for M9.

Radiology

4 confirmed in month breaches for M9

Radiology Reporting

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

Audiology

0 in month breaches for M9

Cardiology

0 in month breaches for M9

Cancer 2 Week Wait Performance Target 93%

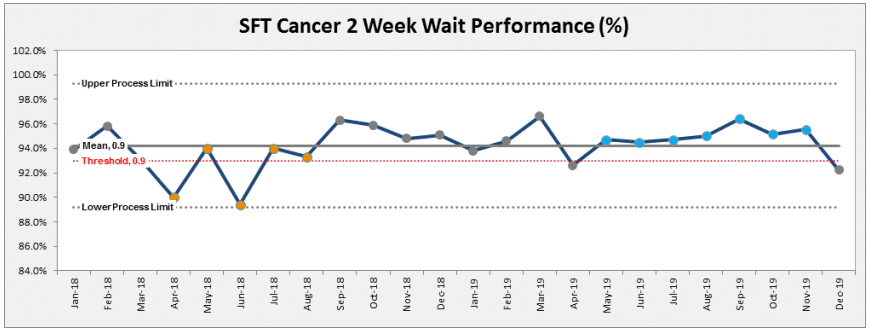
National Key Performance Indicators

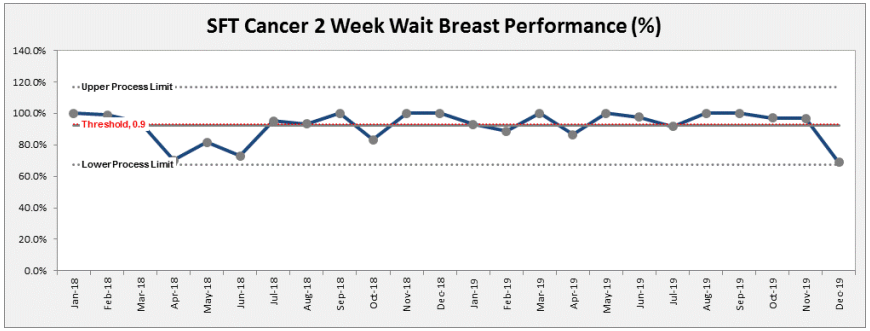
Performance Latest Month:

Two Week Wait Standard: 92.2%

Two Week Wait Breast Standard: 68.8%

Data Quality Rating:





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

Deterioration in 2WW and Breast Symptomatic performance as a result of patient choice and loss of clinics over the Christmas period.

Q3 performance achieved for 2WW standard.

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

Weekly cancer ops meetings with cross directorate representation to identify any potential issues continuing to work well.

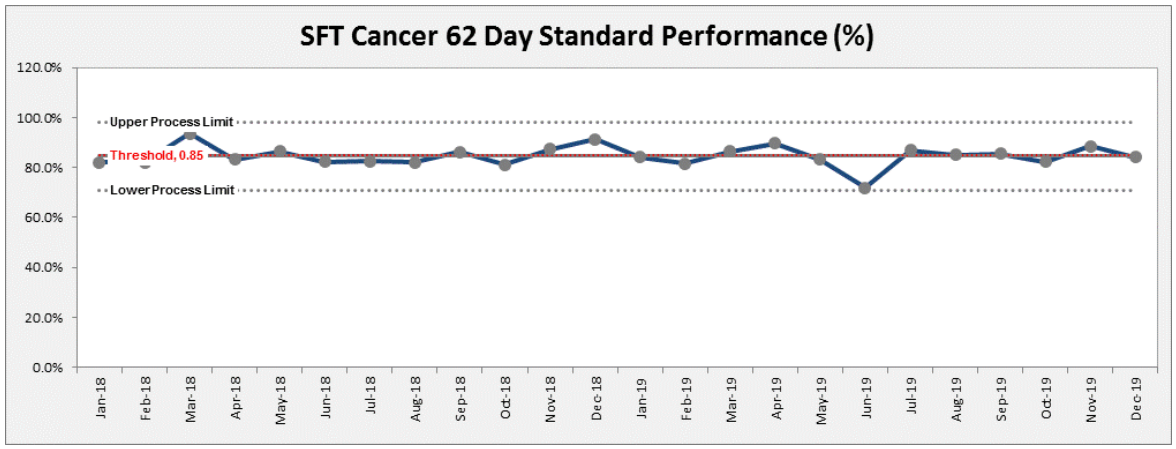
Risks to delivery and mitigations

Increasing demand across all specialties. Ad hoc clinics are being set up to accommodate, but this is not sustainable.

Straight to test pathways continue to support delivery of standard.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard:	84.2%
62 Day Standard (without shared care):	80.7%
62 Day Screening:	46.2%

Risks to delivery and mitigations

Q3 62 day performance achieved, though risk to January performance as a result of patient choice delays over the Christmas period.

Delay in diagnostics continue to delay patient's pathways. Ongoing escalation of outstanding histology to DMTs/CSFS as required.

High number of 104 day breaches on current PTL, majority relating to patient choice. Ongoing weekly escalation and action via radiology, central booking, cancer services and DMT as required.

Successful recruitment to Head & Neck and Upper GI Cancer Pathway Navigators. Rapid referral administrator post to go back out to advert as a substantive position.

SWAG cancer alliance undertook peer review of colorectal cancer service on 07/01; positive feedback received and full report awaited.

Audit of cancer pathways undertaken by PWC. Issues identified with paper processes (including completion/audit trail of outcome forms) and over-reliance on manual processes across services. Action plan to be developed in conjunction with the Cancer Risk Summit task and finish groups.

Statistical Process Control Chart Key:

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

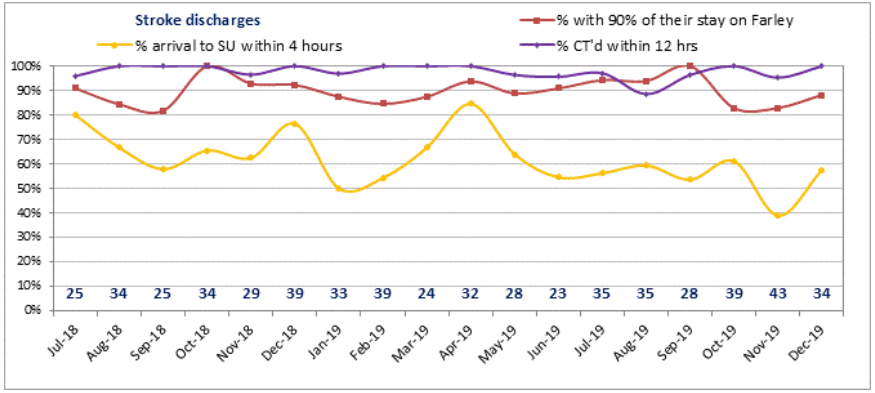
Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20	B	B		

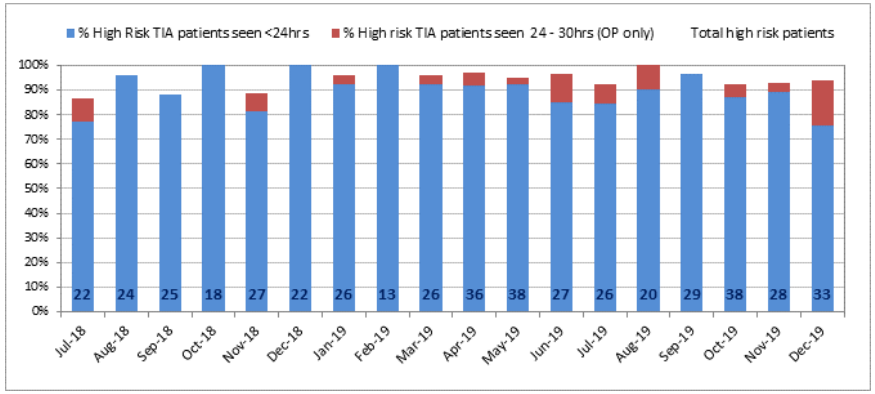
Data Quality Rating:

% Arrival on SU <4 hours: 57.6%

% CT'd < 12 hours: 100%

% High Risk TIA Seen < 24 hours: 75.8%





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

88% of patients spent 90% of their time on the stroke unit in December exceeding the national target of 80%. Those moved off the ward were to make room for new incoming stroke patients.

The reduction of patients reaching the stroke unit within 4 hrs reflected ED and bed pressures - delays were waiting for a stroke bed (7) and to see a doctor in ED (5).

High risk TIA performance fell to 75% due to a number of full clinics.

Q2 SSNAP sustained a B audit score.

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

The Stroke Unit trailed the nurse practitioner role for 12 days between 09:00 – 17:00 in December. The nurse met potential stroke patients on admission to ED and the Stroke Unit. He expedited the initial scan, assessments and transfer to the Stroke Unit. Whilst ED pressures were equal ,if not worse than November, the numbers meeting the 4 hours to stroke unit rose from 38.9% to 57.6% and receiving a CT within 1 hour rose from 39.5% to 73.5%.

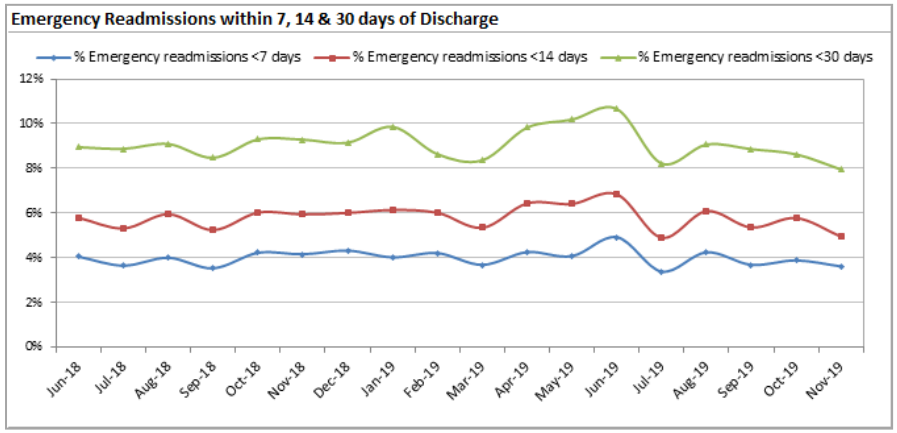
The outcome of the trial is to be presented to the Medicine DMC for consideration of a business case to fund the role substantively.

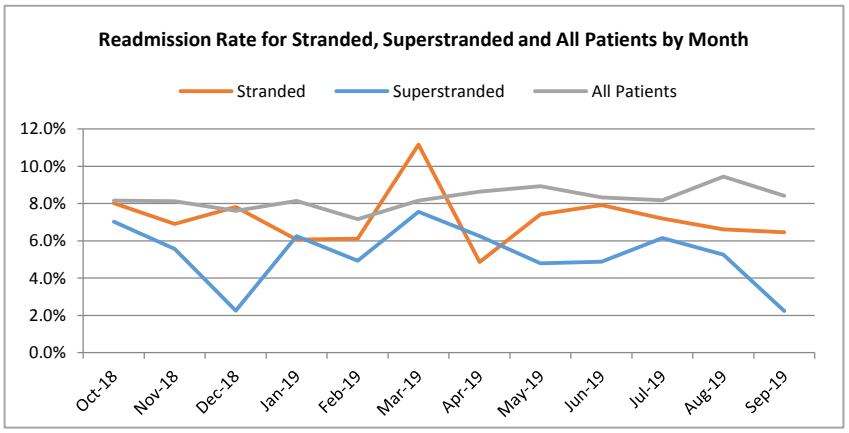
Risks to delivery and mitigations

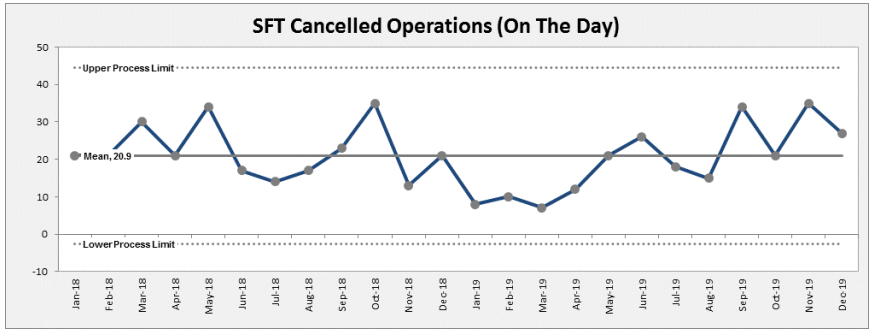
Ability to fund the nurse practitioner role and provide a consistent service 7/7.

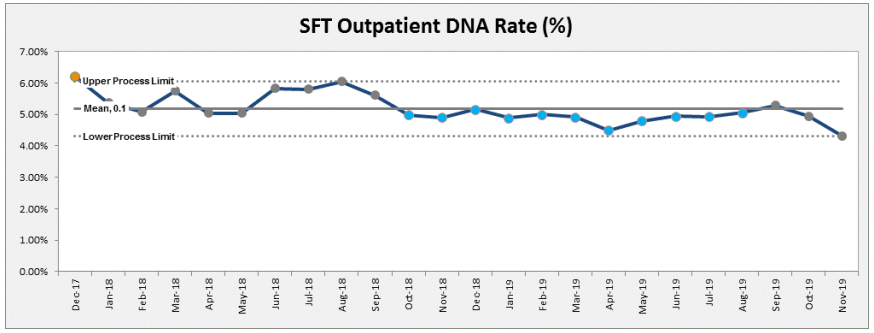
Other Measures

Are We Effective?









Salisbury NHS Foundation Trust

Part 2: Our Care

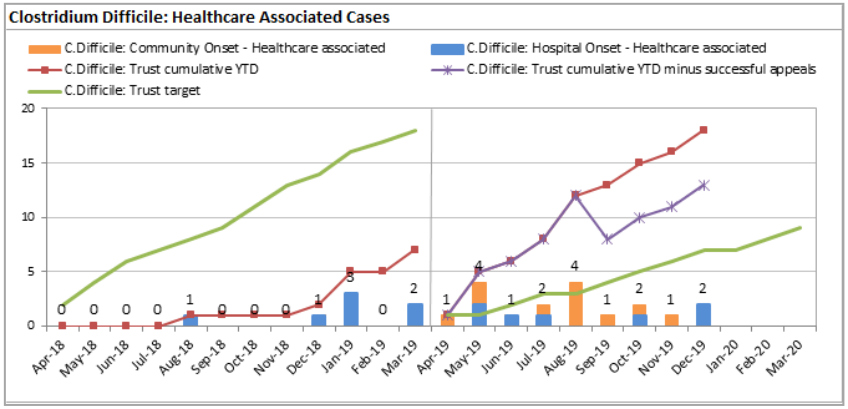
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

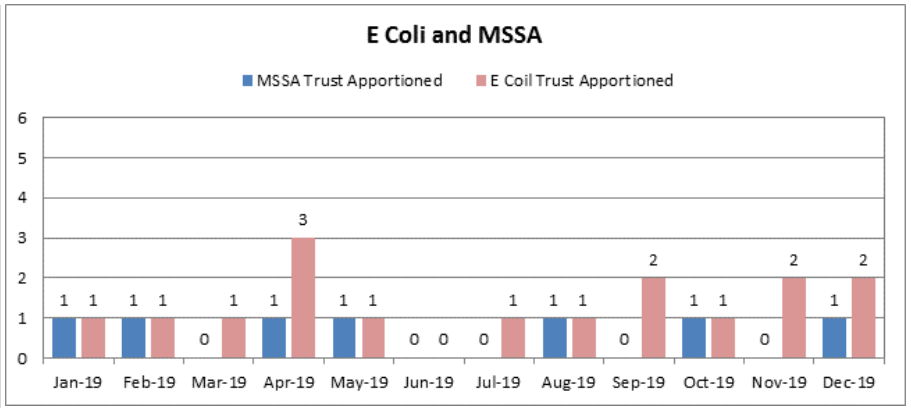
Infection Control

Are We Safe?

Year	2018-19	2019-20
MRSA (Trust Apportioned)	3	0

Data Quality Rating:





Summary and Action

C.Difficile cases have now significantly exceeded the upper limit of 9 cases with 2 hospital onset and healthcare associated cases reported in December. Investigations are ongoing into both cases and samples sent for ribotyping to establish if cases are linked.

The impact of the changes in the definitions show that 7 of the 18 cases were hospital onset with the remaining 11 cases classed as community onset healthcare associated (where patients were discharged within the previous 4 weeks). In October, 7 cases (Wiltshire CCG – 5 cases, West Hampshire CCG – 2 cases) were submitted for appeal for no lapses in care. In November, Wiltshire CCG confirmed SFT had successfully appealed 5 cases for no lapses in care. The outcome of the 2 cases sent to West Hampshire CCG is awaited following the submission of additional information.

An additional metric has been added to show the cumulative year to date C. Difficile figure minus the successful appeals. NHSI and the CCGs are regularly briefed on this issue with no further action currently.

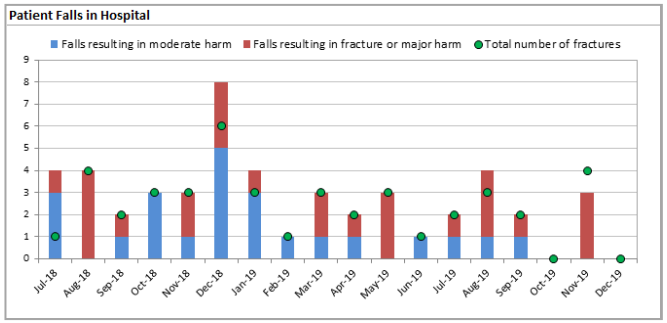
Two Trust apportioned E Coli bacteraemias: 1 with a likely lower urinary tract source from a catheter in situ. Both cases were considered unavoidable and were as a result of the patient's underlying conditions.

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

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

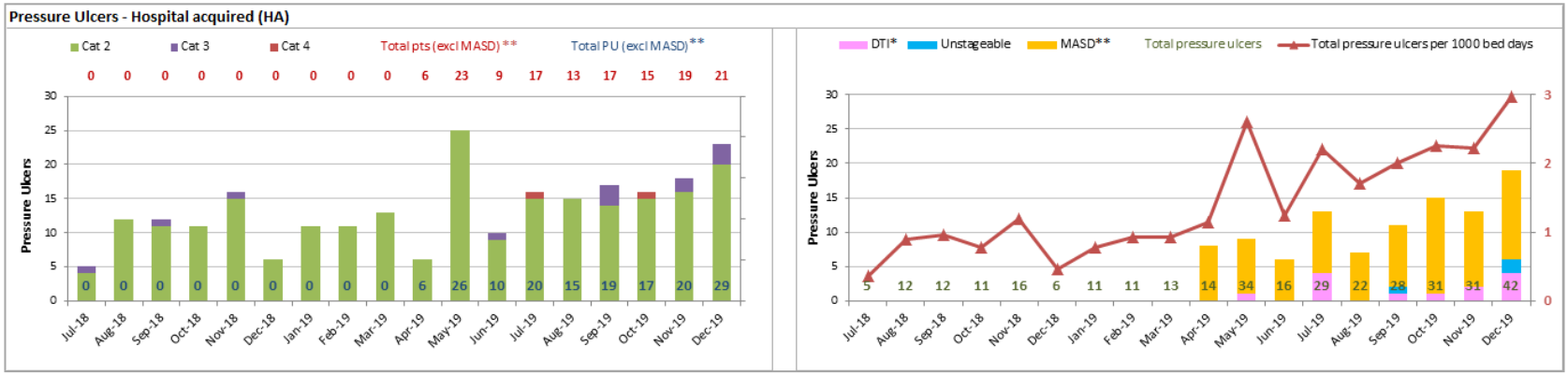
Pressure Ulcers / Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2018-19 Q3	2018-19 Q4	2019-20 Q1	2019-20 Q2	2019-20 Q3
Pressure Ulcers	0.79	0.88	1.05	1.10	1.12
Patient Falls	0.34	0.20	0.16	0.20	0.11



Summary and Action

An increase in the number of category 2 pressure ulcers is consistent with the national picture as there was a change in reporting in 19/20. However, of concern is the rise in reported category 3 and 4 ulcers across a range of wards. Following validation of the data, the year to date figures have been updated and show an increase on previous reports. Total year to date of category 3 pressure ulcers is 9 and the total of category 4 pressure ulcers is 2.

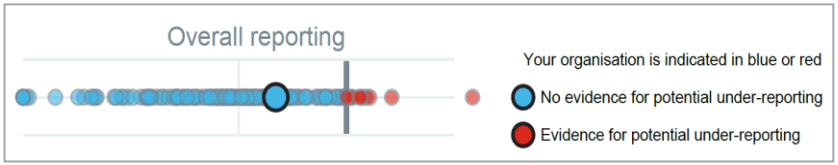
The first of several deep dive meetings was held with key staff, led by the Deputy Director of Nursing to evaluate themes and root causes in the first week of January. Further meetings are planned to aggregate the key contributory factors and plan improvement actions. Trustwide recovery plan will be signed off and overseen by the Nursing and Midwifery Forum.

No falls resulted in moderate or major harm in December.

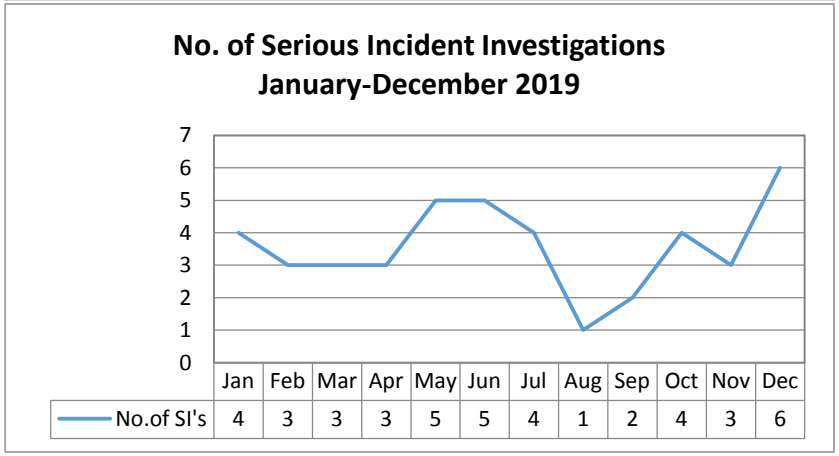
Incidents

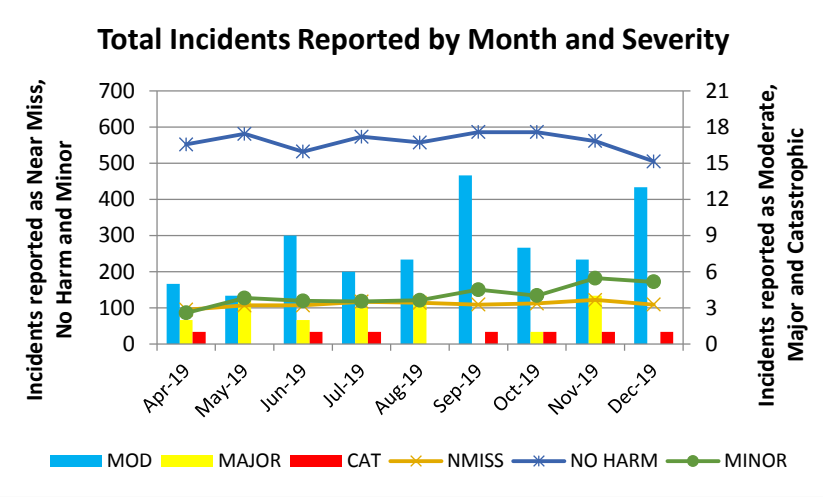
Are We Safe?

Year	2018-19	2019-20
Never Events	3	1



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





Summary and Action

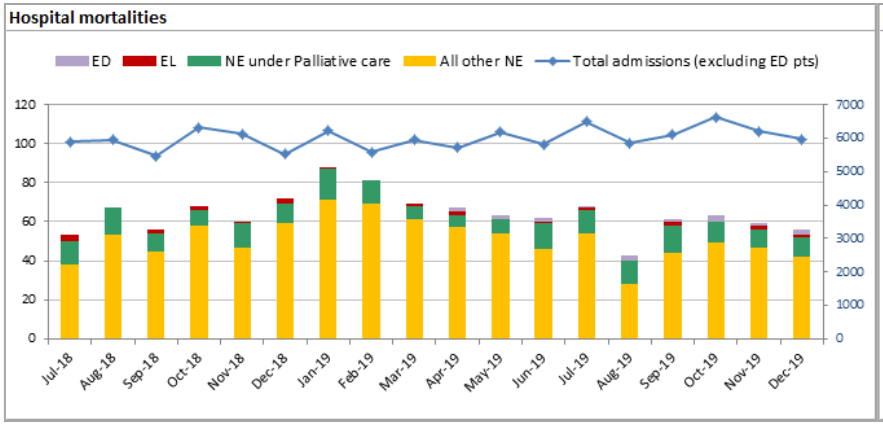
Throughout December 19, there was a continued theme of an increase in the number of reported category 3 pressure ulcers. The Director of Nursing declared a period of increased incidence of category 3 and 4 pressure ulcers to the CCG. SFT have reported 11 category 3 and 4 pressure ulcers to date, several of these occurring in the last couple of months. This is a sharp rise in our numbers on previous years, and is of concern.

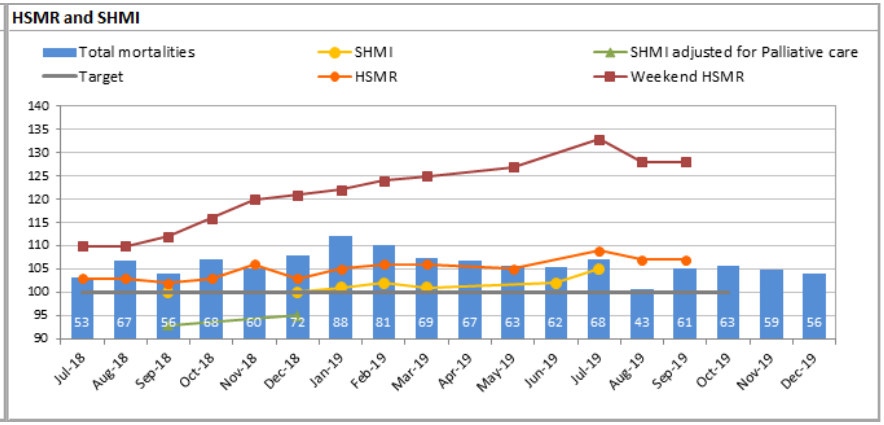
Arrangements are underway for the upcoming follow up to the Cancer Risk Summit that is scheduled to take place on 29th April 2020.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR overall has decreased and is as expected. The weekend HSMR trend has decreased due to a considerable fall in observed mortality in August 19 and a decrease in the crude rate for weekend mortality since May 2019.

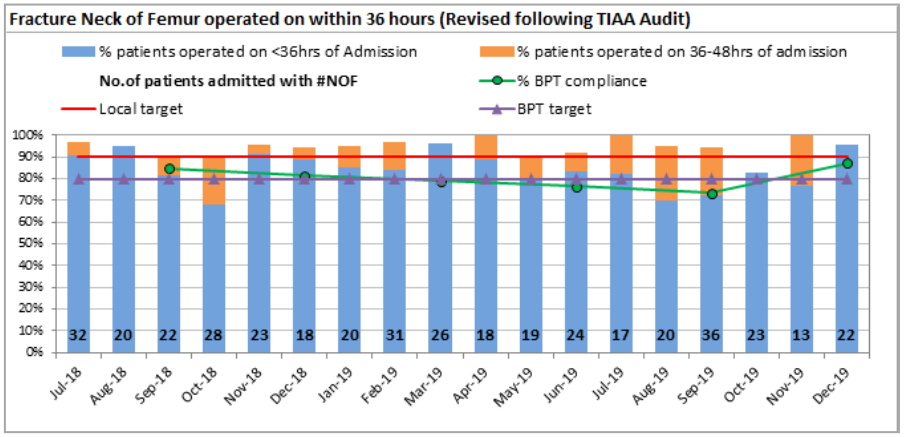
A review of 33 patients who died following a hip fracture between October 18 and September 19 was completed in October 19. Care was generally good but there was potential for improvement in the pathway and root cause analysis will be undertaken for all patients not meeting best practice standards. The report will be presented to the Clinical Governance Committee on 4 February 2020.

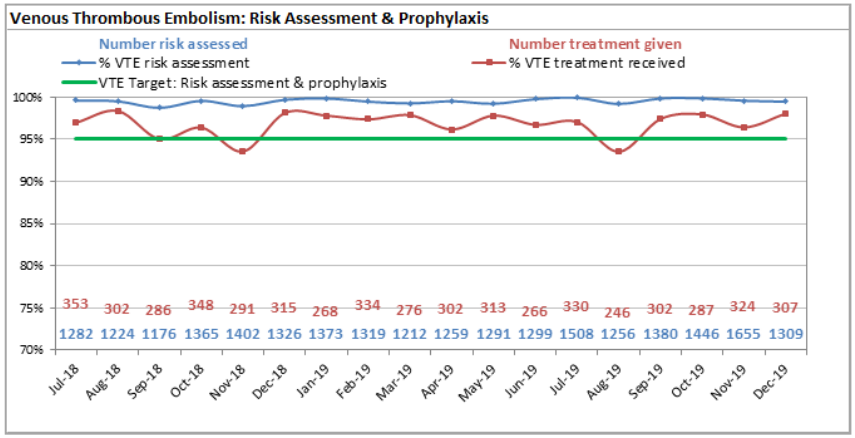
A case notes review of a new, higher than expected relative risk of mortality in gastrointestinal haemorrhage took place in October identifying some improvements needed in clinical pathways. The report will be presented to the Clinical Governance Committee on 25 February 2020.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

A significant improvement in compliance with hip fracture best practice tariff in Q3 to 87% and above the national target of 80%. During Q3, 7 patients had surgery between 36 – 63 hours due to theatre space (5) and kit (2). The nurse specialists introduced a root cause analysis to examine delays in Q3 which seems to be effective in reducing delays.

A multidisciplinary review of 33 patients who died with a fractured neck of femur was undertaken in October 2019. The review found some excellent care especially in the early recognition, management and communication of end of life care. 40 problems in care were identified, of which 5 contributed to catastrophic (2) and major harm (3) from inpatient falls resulting in a hip fracture. 26 deaths were definitely not avoidable, 4 had slight evidence of avoidability, 2 were possibly avoidable but not very likely and 1 death was probably avoidable.

An action plan is in place to:

Improve frailty scoring

Pre-operative analgesia

Time to theatre within 36 hours

Time to consultant review within 14 hours of admission

Falls prevention

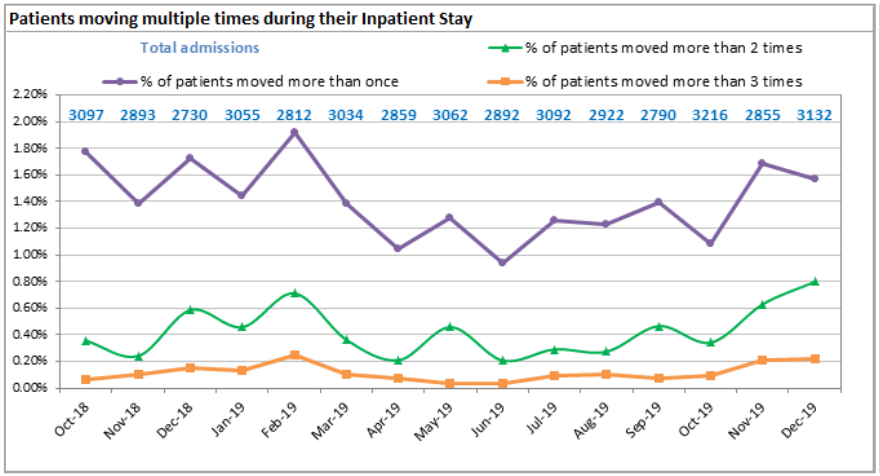
A continued focus on root cause analysis to identify the reason patients did not receive best practice standards

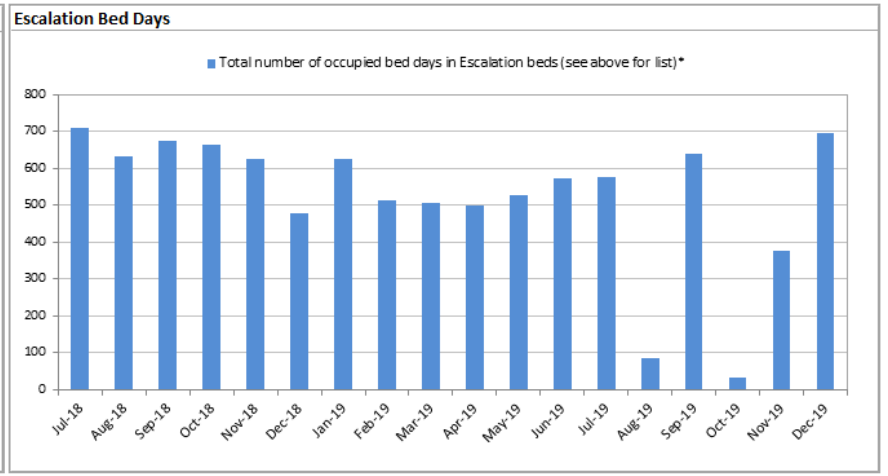
Patient Experience

Are We Safe?

Last 12 months	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
Bed Occupancy %	96.3	94.4	91.4	92.6	92.5	93.5	93.3	94.1	96.9	94.9	97.1	95.9

Data Quality Rating:





Summary and Action

Escalation bed capacity increased significantly in December as did the number of multiple ward moves. The Trust was in OPEL 4 status on 11 occasions and had a norovirus outbreak with beds closed during the month. The number of delayed transfer of care, stranded and super stranded patients are all above our internal targets and discharges before midday are below our internal target.

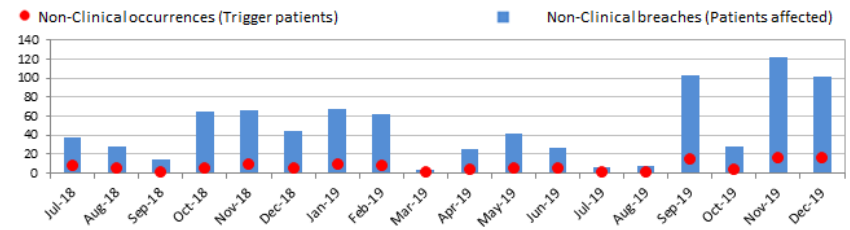
The 'Ready Steady Go' patient flow improvement work continues with a focus on increasing the number of patients discharged before midday and with multi-agency partners to decrease the number of delayed transfer of care, stranded and super stranded patients.

Patient Experience

Are We Safe?

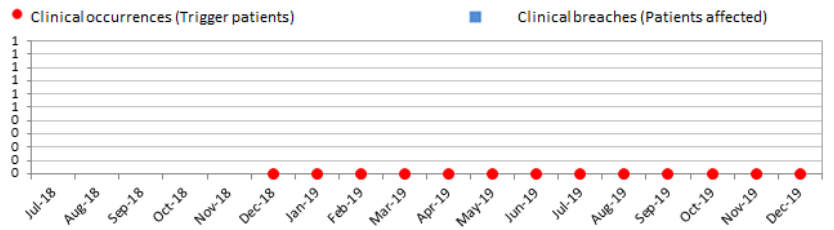
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
■	37	28	14	65	66	45	67	62	3	26	42	27	7	8	103	28	122	102
●	8	5	1	5	10	5	10	9	1	4	6	5	1	1	15	4	17	16

Delivering Same Sex Accommodation - Clinical



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

Summary and Action

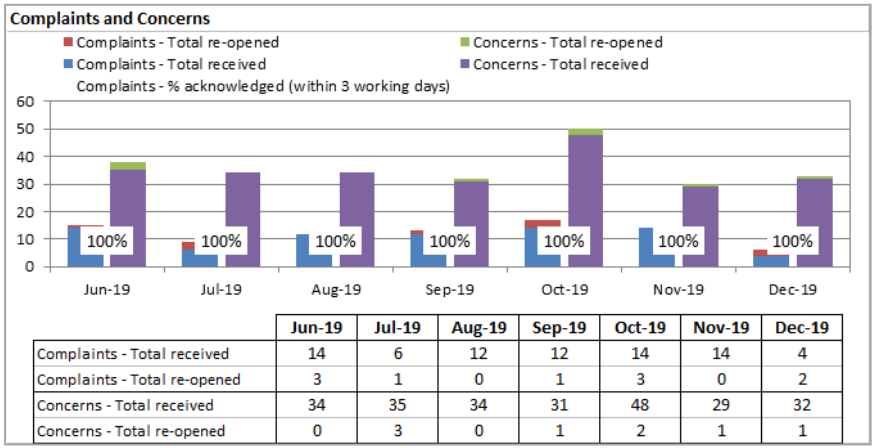
We continue to see a high number of non-clinical mixed sex accommodation breaches in December. These are occurring in our assessment areas only, when used as part of surge escalation, 92 patients were affected on 13 occasions on AMU and 10 patients were affected on SAU on 3 occasions. There is focus to ensure that these are resolved within 24 hours through the bed meetings. The Trust was in OPEL 4 status on 11 occasions and had a norovirus outbreak with beds closed during the month. There were no breaches on any of the wards.

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

The Chief Nursing Officer, England wrote to Trusts in September about the revised policy and reporting requirements on delivering same sex accommodation. Local meetings are taking place with staff and will need to take place with the CCG to confirm and agree how breaches will be reported in line with the revised national guidance. The main area that is likely to be affected with the new requirement to report is in Critical Care and the SSEU.

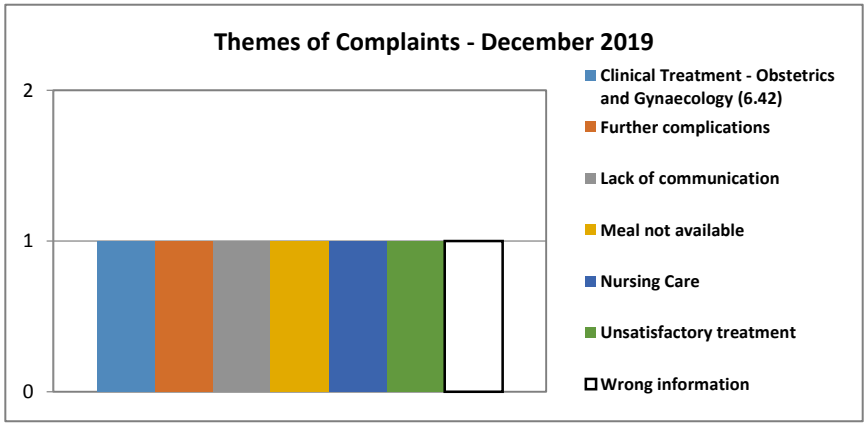
Patient & Visitor Feedback: Complaints and Concerns

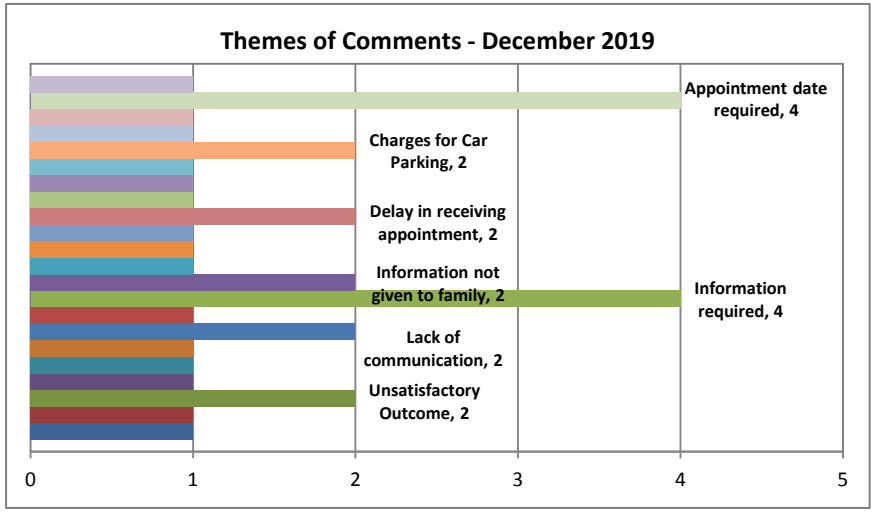
Are We Responsive?

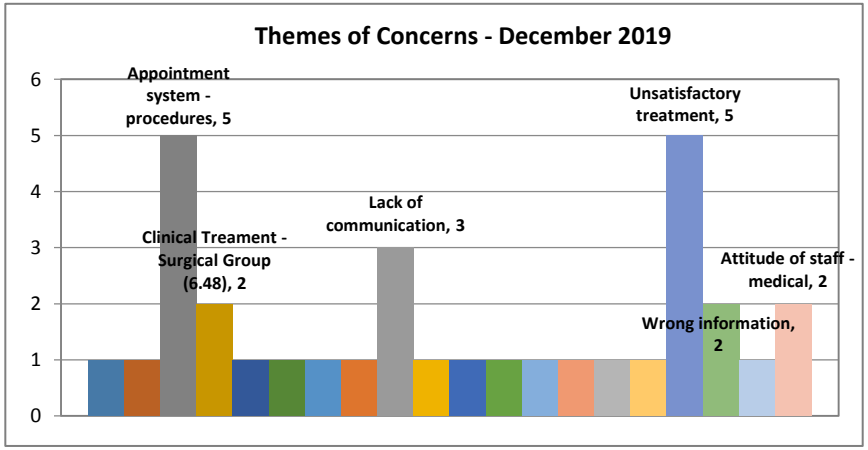


	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Complaints - Total received	14	6	12	12	14	14	4
Complaints - Total re-opened	3	1	0	1	3	0	2
Concerns - Total received	34	35	34	31	48	29	32
Concerns - Total re-opened	0	3	0	1	2	1	1

Data Quality Rating:







Summary and Actions

7 complaints were logged in December; no real themes were identified. 33 concerns were reported in the same period. The top 3 themes include: appointment system- procedures, unsatisfactory treatment and lack of communication. The top theme for comments, also includes appointments. Work is ongoing following the Cancer risk summit around appointment allocation.

Part 3: Our People

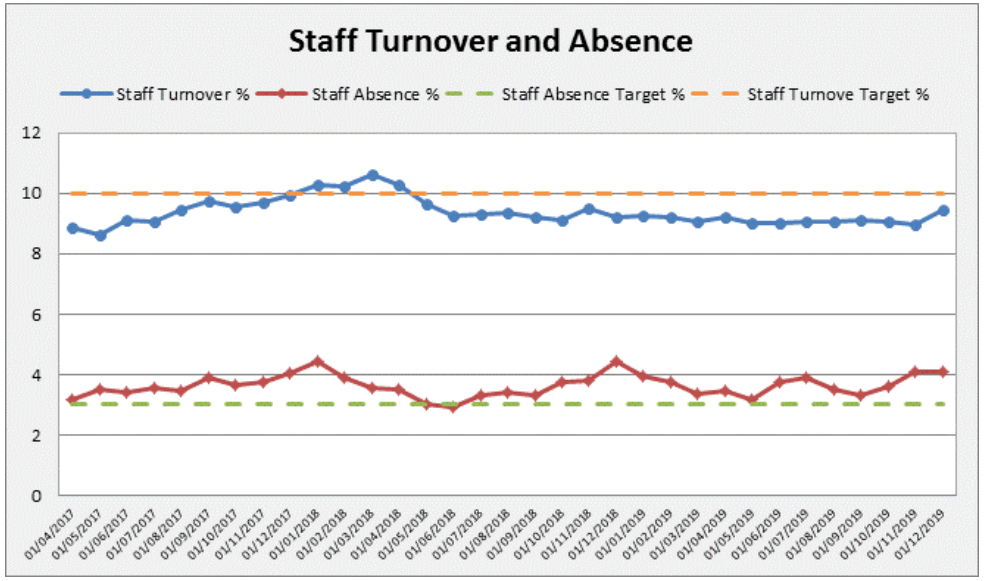
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Dec '19		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	402.6	409.9	(7.3)
Nursing	945.8	966.5	(21.0)
HCAs	411.0	550.3	(139.3)
Other Clinical Staff	609.8	603.8	6.1
Infrastructure Staff	1,202.1	1,067.8	134.3
TOTAL	**3,571.3**	**3,598.4**	**(27.3)**



Summary and Action

There was a sharp rise in the number of leavers in December, more than doubled over previous months up to 48, with a corresponding upturn in the turnover rate to 9.4%. The main areas of concern are Additional Clinical Services, Admin & Clerical, and Registered Nursing. Reasons for leaving recorded number 15 for retirement age and 13 for relocation. We are writing individually to all of these leavers, with an exit questionnaire for them to complete, so that we can fully understand the reason/s for such a massive increase in these numbers. Results will be shared through Workforce Committee to Board as soon as they are available. This was matched by the same number of starters, including in Additional Clinical Services (23) and Registered Nursing (11).

Having made significant inroads into ward based nursing vacancies, we are currently reviewing the overseas pipeline in order to determine whether a further overseas campaign will be required this year or not. We are also focusing on "Hard to Recruit" medical and AHP vacancies which will enable us to reduce costly Locum and Agency spend backfilling these vacancies.

Sickness has decreased over last month by a very marginal 0.01% to 4.09% with an increase in long term and decrease in short term absence. Reasons are not consistently anxiety/stress across the Directorates, with MSK being the biggest issue in Estates & Facilities and Gastro the biggest in MSK. As one of our highest sickness rates in in Estates and Facilities, this was benchmarked nationally and we found that our percentage of 4.16% compared favorably with the national rate for this group of staff at 5.84%. There is also a significant percentage of sickness in the Additional Clinical Services staff group where Business Partners are supporting managers to target short term absence to alleviate the winter pressures issues. Surgery have been hit during this period with norovirus in Britford and Downton wards.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

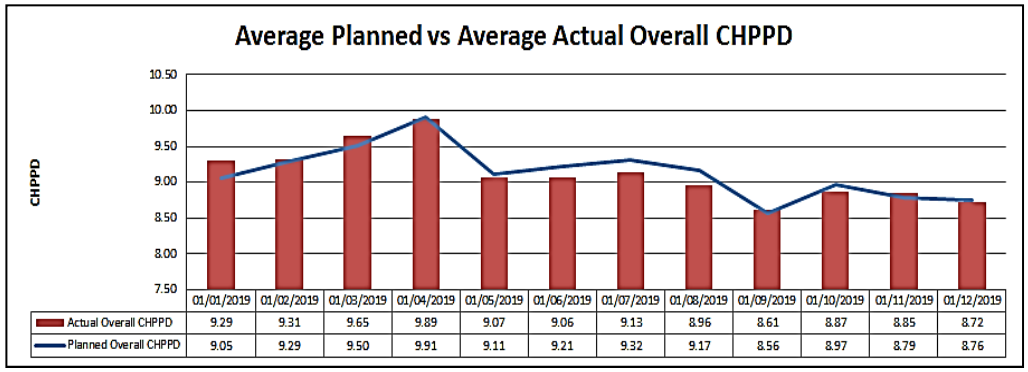
Table 1

Day	RN	HCA
Total Planned Hours	38674	20758
Total Actual Hours	36766	21009
Fill Rate (%)	95%	101%

Night	RN	HCA
Total Planned Hours	24999	12572
Total Actual Hours	25209	14792
Fill Rate (%)	101%	118%

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

Table 2



	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019	01/07/2019	01/08/2019	01/09/2019	01/10/2019	01/11/2019	01/12/2019
Actual Overall CHPPD	9.29	9.31	9.65	9.89	9.07	9.06	9.13	8.96	8.61	8.87	8.85	8.72
Planned Overall CHPPD	9.05	9.29	9.50	9.91	9.11	9.21	9.32	9.17	8.56	8.97	8.79	8.76

Table 1 above shows planned vs actual hours for RNs and HCAs across the wards for December. The graph on the right shows planned vs actual Care Hours Per Patient Day at Trust level, the graphs on the following slide shows this split by Directorate. (CHPPD is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24 hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.) MSK CHPPD is skewed by the amalgamation of Avon & Tamar wards to Longford during earlier reporting months

From aggregated Trust level data no real conclusions can be drawn other than to show that overall we are broadly meeting planned staffing levels, that there is a shortfall for RNs and slightly for HCAs – see Table 1.. The annual skill mix is a critical feature of determining that the baseline planned staffing levels are set correctly.

Only one flagged red this month for actual unfilled hours (based on internal rag ratings) –Radnor at 70% for HCA nights. This unit has such tiny numbers involved that this exaggerates the figures.

The skill mix of RN:HCA although remains generally stable, continues with RN down 1% on November at 63% and a corresponding increase for HCA to 37% (broad recommendation is 65%:35%, but this varies across specialties). The trend shows the closing gap between the overstaffing of HCA and understaffing of RN is retained bar a 1% shift with HCA actual staffing levels evidencing even further control now at 101% with RN levels at 95% for day shifts. Night shifts are covered at 101% demonstrating flexible rostering to ensure this period is well staffed when other staff groups are not readily available to support any unfilled gaps unlike day shifts

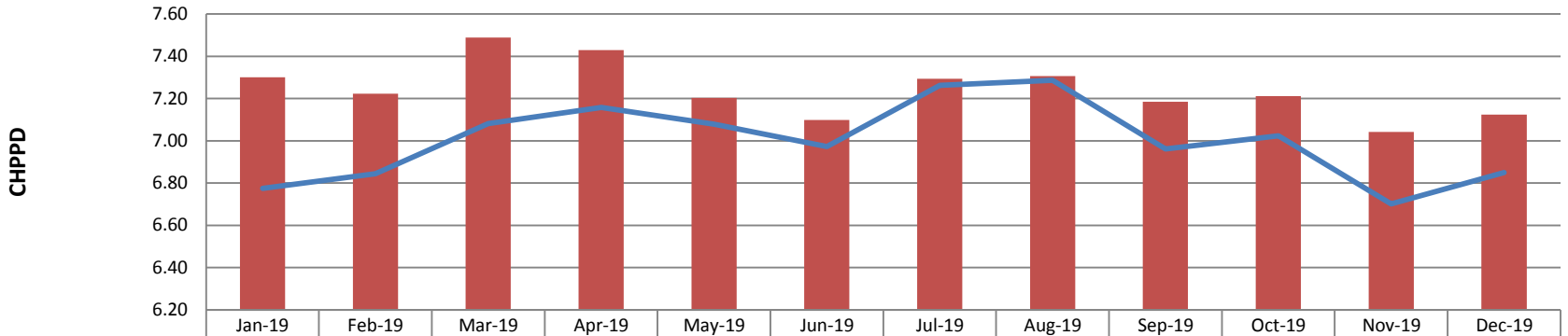
The trend continues this year of reduced agency costs associated with reducing vacancies as the pipeline of overseas nurse recruits come through. Nursing budgets are underspent overall. With regards to Nurse Sensitive Indicators there is concern regarding the increase seen in category 3 and 4 pressure ulcers. Trust wide review of practice and recovery programme underway. Increases in NSI's can be associated with suboptimal staffing levels, this is the only indicator currently flagging for us, and requires further investigation into underlying causes before a link can be made.

Workforce – Nursing and Care

Use of Resources

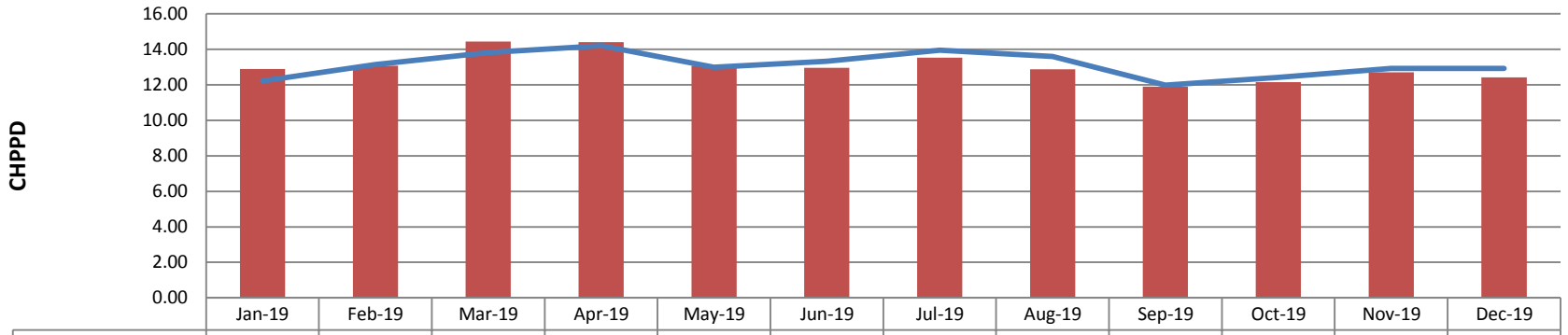
Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend by Directorate

Average Overall CHPPD for Medicine



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Actual CHPPD	7.30	7.22	7.49	7.43	7.20	7.10	7.29	7.31	7.18	7.21	7.04	7.12
Planned CHPPD	6.77	6.84	7.08	7.16	7.08	6.97	7.26	7.29	6.96	7.02	6.70	6.85

Average Overall CHPPD for Surgery

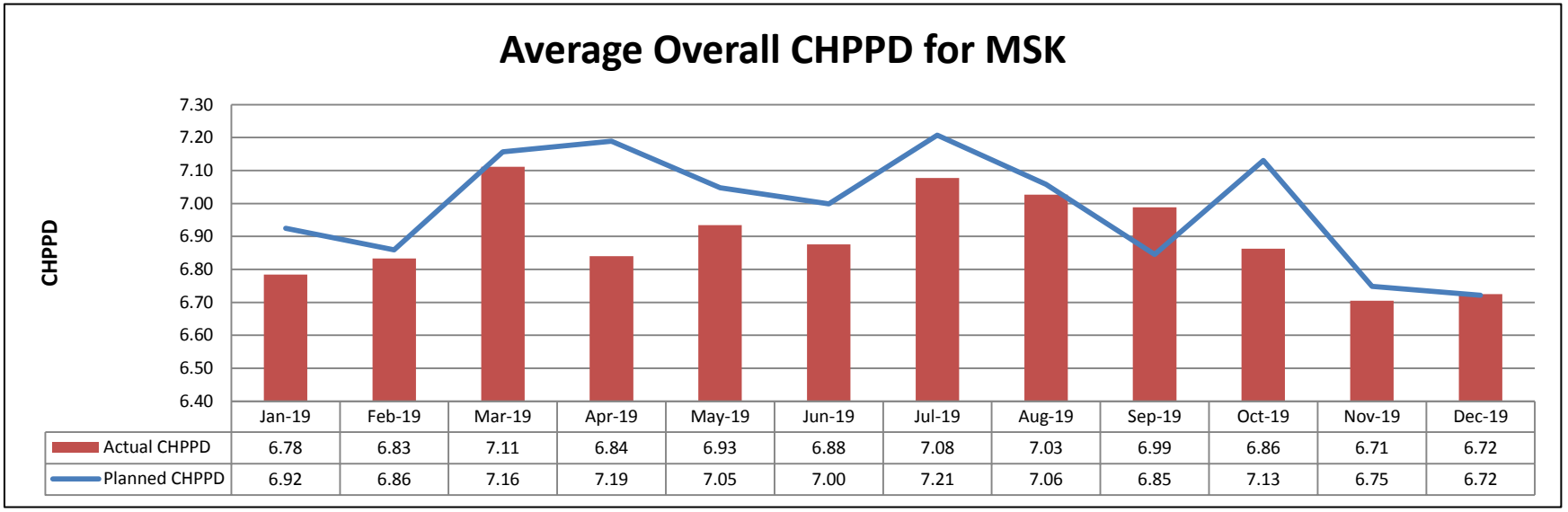


	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Actual CHPPD	12.89	13.08	14.44	14.40	13.07	12.96	13.54	12.88	11.90	12.15	12.72	12.42
Planned CHPPD	12.23	13.14	13.81	14.21	12.99	13.34	13.96	13.61	11.98	12.42	12.92	12.92

Workforce – Nursing and Care

Use of Resources

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

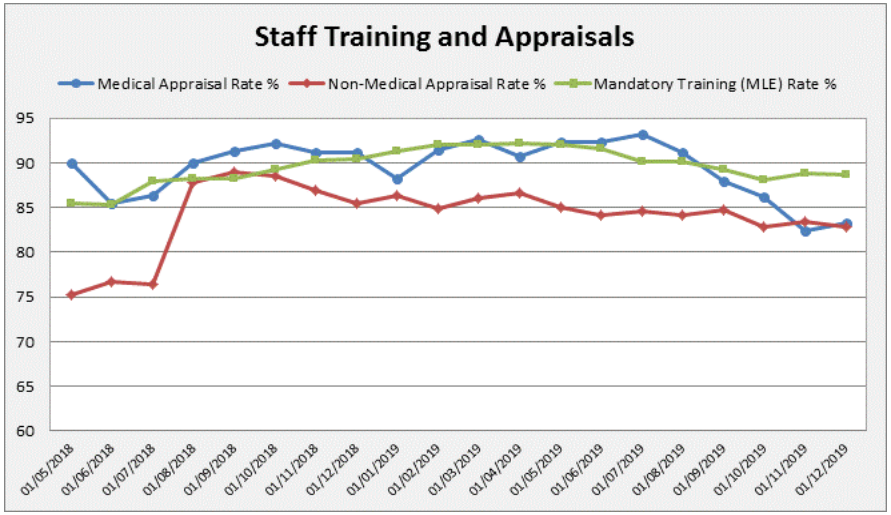


	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Actual CHPPD	6.78	6.83	7.11	6.84	6.93	6.88	7.08	7.03	6.99	6.86	6.71	6.72
Planned CHPPD	6.92	6.86	7.16	7.19	7.05	7.00	7.21	7.06	6.85	7.13	6.75	6.72

Workforce – Staff Training and Appraisals

Use of Resources

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



Summary and Action

Training

Compliance with training requirements has dropped marginally this month, although still overall above target. Both Estates & Facilities and Surgery are at 91% and all other Directorates in green. Compliance continues to be shared in all Directorates so that managers and ward leaders are aware of, and can improve, their overall compliance.

Non Medical Appraisals

Both Medicine and MSK Directorates have dropped below target in this month and this may be the result of having limited Business Partner support during this time due to sickness absence in OD & People. A temporary solution has been put in place (People Advisors are supporting) and interim support secured from 3rd February. Pembroke is a hot spot due to staff sickness and availability.

Estates and Facilities sign offs have been hampered by some management absence which should now improve with the return of key people. All Directorates are aware of their compliance rates and are working hard to return to target and above.

Medical Appraisals

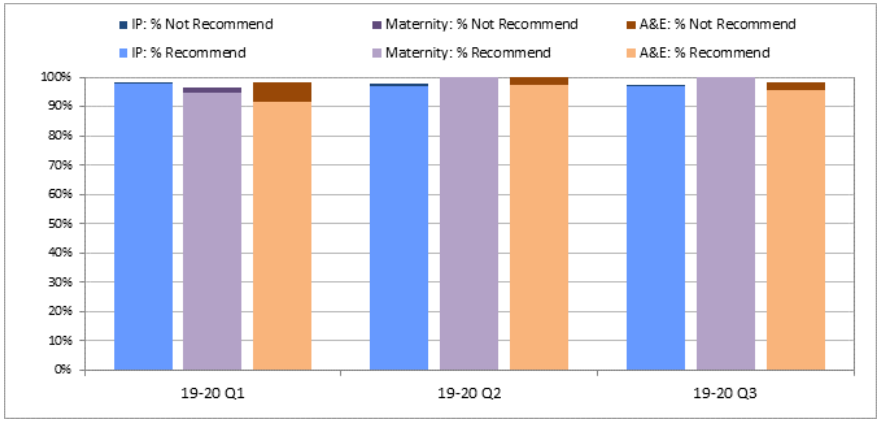
Rates are improving in CSFS at 89%, whilst they are dropping in Medicine and MSK, giving an overall below target compliance, potentially in two Directorates for the same reason as non-medical.

However, CDs are engaged with Education to ensure that recording and scheduling is being carried out effectively and aiming for a return to compliance by February 2020.

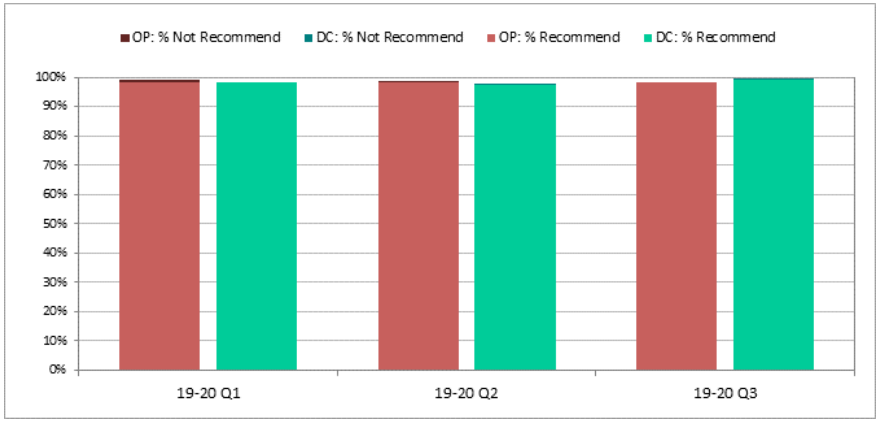
Friends and Family Test – Patients and Staff

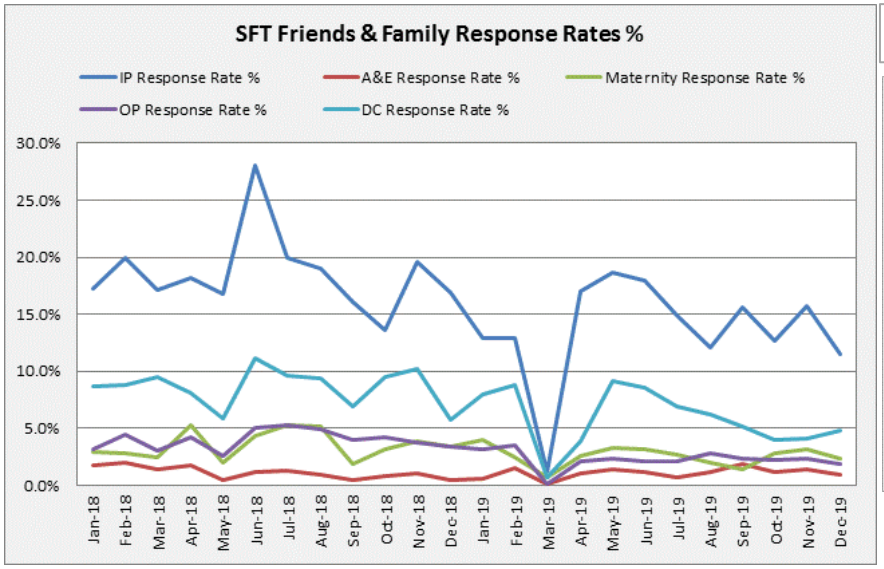
Use of Resources

Patient Responses: Inpatient, Maternity and A&E

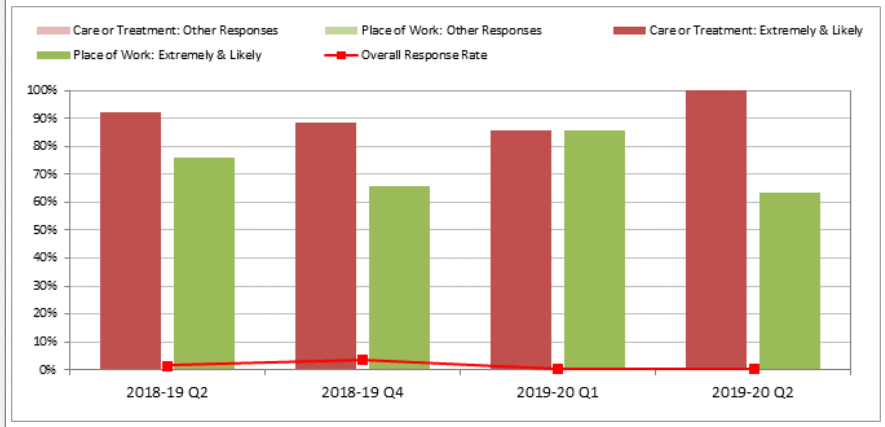


Patient Responses: Outpatient and Daycase





Staff Responses: Place of Work and Place of Care



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

Part 4: Use of Resources

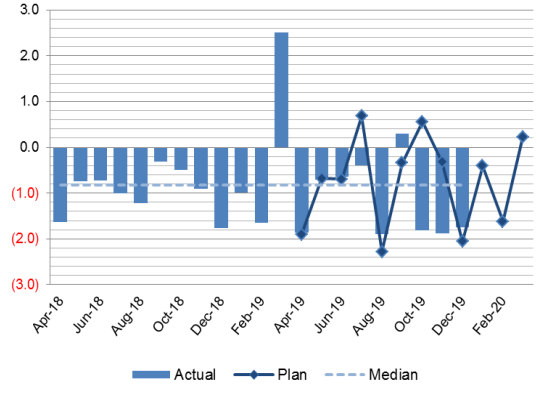
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Dec '19 In Mth			Dec '19 YTD			2019/20
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	16,406	16,413	367	155,603	152,724	(2,879)	208,163
Other Clinical Income	781	954	173	6,982	7,734	752	9,322
Other Income (excl Donations)	2,359	2,461	102	21,115	21,699	584	28,307
Total income	**19,186**	**19,828**	**642**	**183,700**	**182,156**	**(1,544)**	**245,792**
Operating Expenditure							
Pay	(13,055)	(13,365)	(310)	(117,921)	(119,287)	(1,366)	(157,326)
Non Pay	(6,756)	(6,712)	44	(59,959)	(61,034)	(1,075)	(80,163)
Total Expenditure	**(19,811)**	**(20,077)**	**(266)**	**(177,880)**	**(180,321)**	**(2,441)**	**(237,489)**
EBITDA	**(625)**	**(249)**	**376**	**5,820**	**1,835**	**(3,985)**	**8,303**
Financing Costs (incl Depreciation)	(1,429)	(1,496)	(67)	(12,867)	(12,473)	394	(17,157)
NHSI Control Total	**(2,054)**	**(1,745)**	**309**	**(7,047)**	**(10,638)**	**(3,591)**	**(8,854)**
Add: impact of donated assets	105	(53)	(158)	945	(223)	(1,168)	1,260
Add: Impairments	0	0	0	0	0	0	0
Add: Central MRET	173	174	1	1,563	1,563	0	2,082
Add: PSF & FRF	677	0	(677)	4,401	2,544	(1,857)	6,772
Surplus/(Deficit)	***(1.099)***	***(1,625)***	***(526)***	***(138)***	***(6,754)***	***(6,616)***	***1,260***



Variation and Action

The in month NHSI control total deficit of £1.7m is an improvement of £0.3m on that which had been planned for, although it is in line with forecast expectations as shared with NHSE&I.

The decision to open additional medical capacity was taken in early December, in order to allow for the more effective management of emergency patient flow (underlying non elective income was up 10% on November, and 7% on the YTD run rate), this capacity had initially been planned for two months and expected to be utilised in quarter 4. The revised forecast assumes these beds will be open for the remainder of the financial year.

The Trust is in the process of recruiting intakes of overseas nurses, an exercise with upfront costs but a payback period of approximately 9 months per nurse due to the upfront costs of c£10k per appointment and 12 weeks' supernumerary time. This strategy has led to a 75% reduction in monthly nursing agency costs year on year, although there remains an opportunity of £0.5m per month in temporary staffing.

Underlying challenges remain the same as in previous periods, with increasing agency spend on hard to fill posts driving adverse variances against plan. and shortfalls in delivery against elective activity plans. It should be noted the programme to improve the latter is starting to gain tracking, with initial reports demonstrating an 8% increase in productivity on utilised lists.

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

Income & Activity Delivered by Point of Delivery

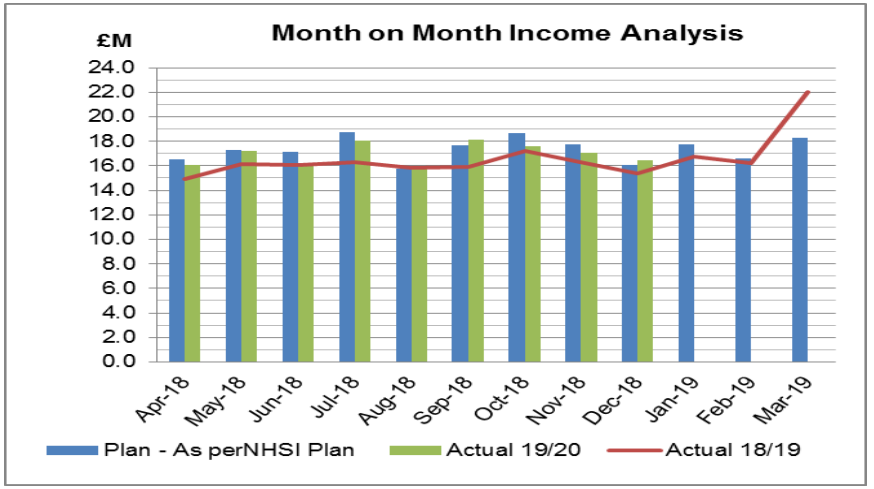
Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Dec '19 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	6,735	6,724	(11)
Elective inpatients	14,210	13,512	(698)
Day Case	13,250	12,739	(511)
Non Elective inpatients	42,928	41,358	(1,570)
Obstetrics	4,742	4,534	(208)
Outpatients	24,978	24,138	(840)
Excluded Drugs & Devices (inc Lucentis)	12,983	13,253	270
Other	35,777	36,466	689
TOTAL	**155,603**	**152,724**	**(2,879)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	83,712	84,000	288
Dorset CCG	17,831	17,814	(17)
West Hampshire CCG	12,410	12,480	70
Specialist Services	23,859	23,333	(526)
Other	17,791	15,097	(2,694)
TOTAL	**155,603**	**152,724**	**(2,694)**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance		Last Year Actuals	Variance against last year
Elective	4,011	3,690	(321)		3,911	(221)
Day case	16,796	17,269	473		16,176	1,093
Non Elective	21,260	20,241	(1,019)		19,351	890
Outpatients	198,481	190,811	(7,670)		189,119	1,692
A&E	52,707	52,745	38		50,754	1,991



Variation and Action

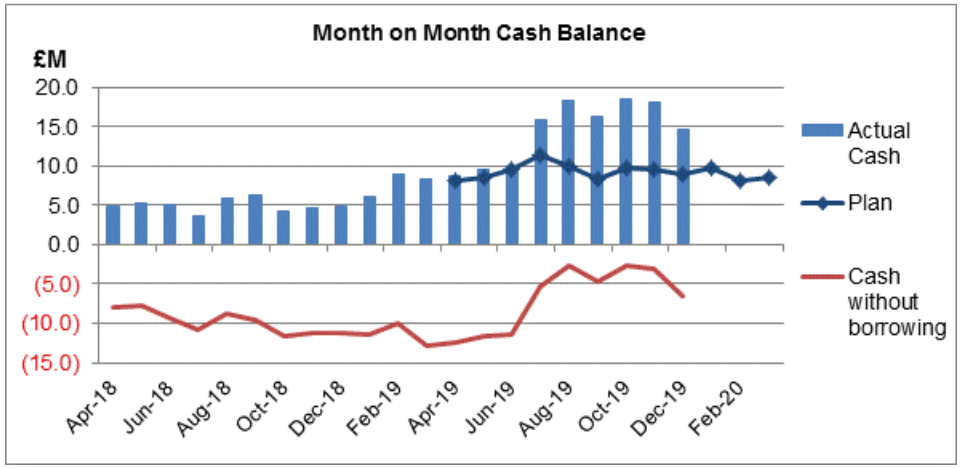
Income to date is £152,724k, £2,879 below plan and an under performance of £367k in December. Income has under performed on all points of delivery year to date with the exception of Excluded drugs and devices and Other. Cardiology Day cases are 195 cases and £298k below plan year to date with activity below plan in month and Orthopaedics Day cases are 122 cases and £319k below plan with a deterioration of 11 cases in month. Urology and Ophthalmology Day case activity is above plan due to recent Consultant appointments. Elective Orthopaedics are now 190 spells below the year to date plan of 956 which is a deterioration of 13 cases in month. The Non Elective position year to date position is driven by a combination of under performance on spells, mainly within Trauma and Orthopaedics, Plastic Surgery and Cardiology, and excess bed days activity. The Outpatients position is driven by underperformance across a range of specialties most notably in Dermatology and Plastic Surgery due to Consultant vacancies.

An adjustment of +£1,343k is included to reflect the blended approach, +£1,106k for Wiltshire CCG (£1,389k Month 8) and +£237k for West Hampshire CCG (£211k Month 8), due to under performance on the non elective element of the contract. An adjustment of +£187k is included to increase income to reflect the under performance on the Dorset managed contract at Month 9 (£276k Month 8). An adjustment of +£964k is included to increase income to reflect the minimum income guarantee with Wiltshire CCG at Month 9 (£446k at Month 8). The total impact is £2,494k within the income position (£2,322k Month 8).

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



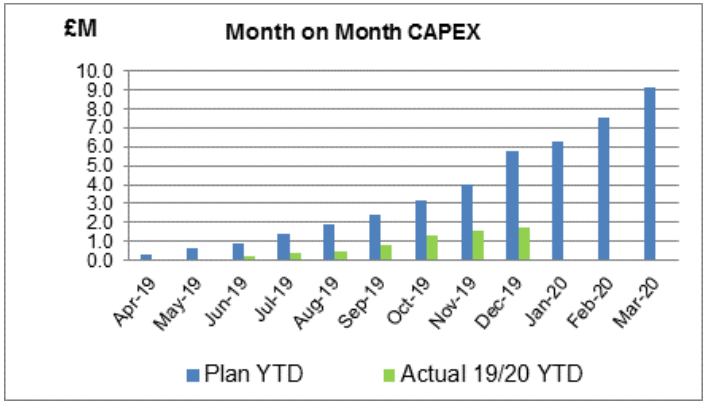
Cash remains higher than planned, primarily due to limited expenditure on the capital programme to date. Capital spend is due to increase considerably in the last two months of the year and will include Board approved schemes brought forward from 2020-21.

Borrowings include £9.4m of working capital loans due for repayment by 31 December 2020. The Trust will request these are reissued as it will not have the funds to repay them. The plan had assumed they will be reissued and hence they have remained in long term borrowings. The Trust is expecting updated guidance on the treatment of these loans moving forward to be included in the 2020/21 operating guidance.

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

Capital Expenditure Position

Schemes	Annual Plan £000s	Dec '19 Plan £000s	Dec '19 Actual £000s	Dec '19 Variance £000s
Building schemes	700	200	0	200
Building projects	1,814	1,265	437	828
IM&T	3,540	2,300	382	1,918
Medical Equipment	2,650	1,720	619	1,101
Other	420	315	316	(1)
TOTAL	**9,124**	**5,800**	**1,754**	**4,046**



Summary and Action

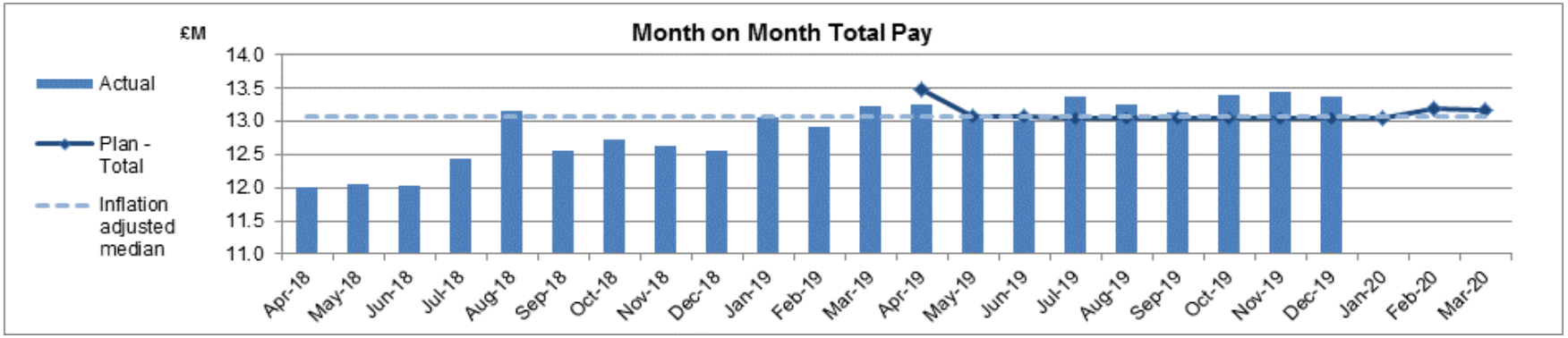
The Trust is primarily financing its capital spend in 2019-20 through depreciation. Additional national initiative public dividend capital funding of £188k has been drawn down towards the Single Sign on project and to purchase flu testing equipment. The Trust has also been awarded £1,019k for a second MRI Scanner under another national initiative but has yet to draw down this capital funding.

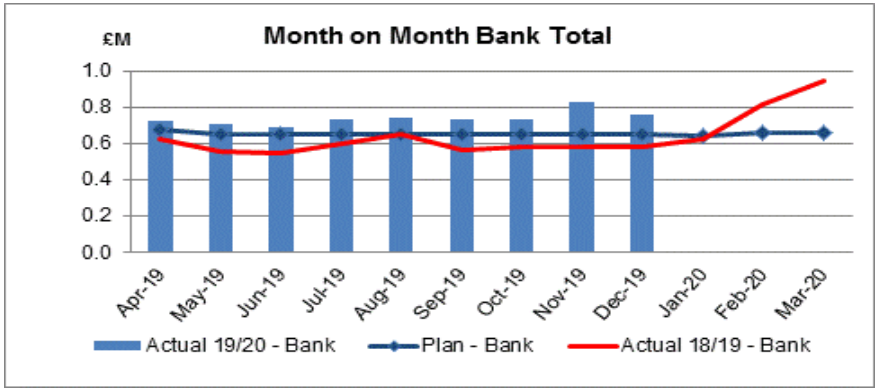
The Trust remains a considerable way behind the original plan for the year. In December the Trust Board approved a list of schemes originally scheduled for 2020-21 for bring forward into the current year to ensure the total expenditure included in the plan is met. Assurances were sought that these schemes can be completed by the end of the financial year and numerous purchase orders were issued in the month. It is anticipated expenditure will increase considerably in February although lead times mean that the bulk of spend will not go through until March 2020. The Capital Control Group continues to closely monitor the forecast outturn and take any additional steps required within its terms of reference to ensure the capital plan is achieved for the year.

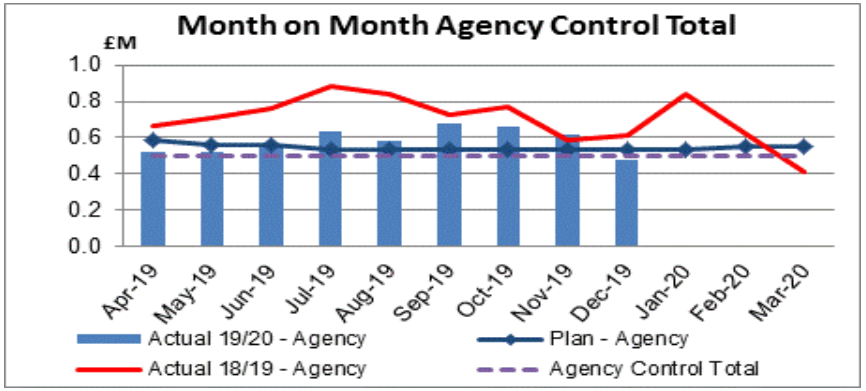
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure of £13,365k in December is £310k greater than planned.

A decision was taken to open escalation bed capacity in early December in order to allow for more effective management of emergency patient flow, this was then closed down over the holiday period and reopened at the end of the month. As previously reported, the Trust has c50-60 newly recruited overseas nurses who are currently acting in a largely supernumerary capacity while working towards their official registration. While this investment is having a material impact on the bottom line in the short term, the objective is to significantly reduce the reliance on agency staffing (£1.5m in reduction on 18-19 spend YTD to M09). The Trust spent circa £0.4m on temporary Nursing workforce in December.

Agency costs reduced by c£140k, half of this relates to the laundry subsidiary and although the reduction will be sustained (a positive from an agency cap perspective), it will be offset by a reduction in non-clinical income. The balance of the nursing agency reduction was seen in the nursing workforce reflecting the reduced number of vacancies, this reduction in agency comes despite the opening of escalation beds highlighted above.

Agency premium for the period is estimated at c£228k, roughly a quarter of which relates to medical staffing groups due to difficulties filling vacancies and rota gaps. Gastroenterology, Acute Medicine, Elderly Care, and Pathology account for the vast majority of the medical agency spend.

Efficiency – Better Care at Lower Cost

Efficiency:

Use of Resources

Position							
	Annual	Dec '19			YTD		
Directorate	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	2,192	185	166	(18)	1,618	952	(666)
Musculo Skeletal	1,385	120	84	(35)	991	717	(275)
Surgery	1,728	149	144	(5)	1,281	1,004	(277)
Clinical Support & Family Services	1,965	184	278	94	1,414	1,286	(128)
Corporate Services	1,730	137	167	30	1,216	1,474	258
Strategic	1,000	131	67	(63)	508	549	41
TOTAL	**10,000**	**905**	**907**	**2**	**7,029**	**5,982**	**(1,047)**

Position							
	Annual	Dec '19			YTD		
Scheme	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	1,068	89	44	(45)	801	137	(664)
Workforce	1,001	83	80	(3)	750	715	(36)
Diagnostics	600	42	42	0	375	375	0
Patient Flow	825	69	0	(69)	619	138	(481)
Outpatients	500	56	56	0	333	333	0
Non-Pay Procurement	1,494	138	156	18	1,082	1,121	38
Medicines Optimisation - Drugs	500	83	12	(72)	250	216	(34)
Clinical Directorate Plans	2,634	240	384	144	1,862	1,739	(123)
Corporate Directorate Plans	1,378	106	134	28	957	1,209	253
TOTAL	**10,000**	**905**	**907**	**2**	**7,029**	**5,982**	**(1,079)**

Summary and Action

The Trust has reported CIP delivery of £907k (100%) in December 2019, although it should be noted that £130k relates to achieving the maternity CNST incentive, that had been planned for delivery in March, meaning the underlying delivery was 86%.

Delivery against the theatres programme has started to gain some traction, following the implementation of a scheduling tool and additional support and challenge in the surgical booking processes. The period saw increased productivity (+8%) in day theatres, meaning that overall activity was comparable with November despite the reduced capacity utilisation associated with the holiday period. The Q4 opportunity versus the same period in 2018/19 is currently values in the range of £250k-380k.

The patient flow programme has once again not met its financial target. The Trust has spent an increased amount of time in OPEL 4, resulting in the opening of escalation beds, . Escalation had not been planned for until Q4, with the associated excess cost assumed in the baseline plan identified as opportunity for savings in the Patient Flow programme (as supported by the 2019/20 bed model).

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**3.1**
Date of Meeting:	6 February 2020		

Report Title:	Q3 Learning from Deaths 2019 - 2020			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Dr Belinda Cornforth, Consultant Anaesthetist Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard Q3 2019/20 Appendix 2 - Learning from death themes and improvement actions. Appendix 3 – Mortality dashboard explanation of terms			

Recommendation:
Recommendation – assurance that the Trust is learning from deaths and making improvements. The report was presented to the Clinical Governance Committee on 4 February 2020.

Executive Summary:
The report highlights the planned introduction of the Medical Examiner system in 2020 and outcomes and improvements in bereavement support. The Q3 mortality dashboard shows the number of deaths, outcome of reviews, learning themes and actions taken to improve. The majority of deaths were unavoidable and expected. 3 deaths were unexpected of which 2 are subject to a serious incident inquiry and the other a clinical review. The main theme arising in Q3 was the ability to recognise a dying patient and the importance of early discussions about ceilings of care to avoid unnecessary treatment. The emergency weekend HSMR started to decline from a peak of 133 in July to 127.5 by Sept 19 but remains significantly higher than expected. The decline has occurred due to a reduction in crude mortality rates for weekend and weekday admissions with a marked decrease in the crude rate for weekend mortality since May 2019. A case notes review of 33 patients with a hip fracture who died was completed. Care was generally good but there was potential for improvement in the pathway and root cause analysis will be undertaken for all patients not meeting best practice standards. A case notes review of a new relative risk of gastrointestinal haemorrhage took place in Q2 and will be reported to the Clinical Governance Committee on 25 February 2020.

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

Q3 2019/2020 Learning from Deaths report

1. Purpose

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

2. Background

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

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

3. Medical Examiners (ME)

A plan is now in place to start the new Medical Examiner system to ensure excellence in care for the bereaved by April 2020. This includes:

- A 5 day (ME) roster covering adult and paediatric deaths within the Trust, including cover for all leave.
- Adequate staffing is in place to ensure that the registration of a death is not delayed by the ME process.
- A facility for Qualified Attending Physicians (junior doctor) to discuss each death and death certification in a meaningful way with the ME.
- A facility for each ME or Medical Examiners' Officer (MEO) to have a meaningful discussion with the next of kin regarding care of a loved one and an explanation of the medical certificate of death.
- A framework for ensuring that deaths highlighted as requiring further review by the ME are forwarded to the Trust's Mortality Surveillance Group to ensure learning is shared across the organisation.
- The ability to fast track the ME process when required.
- The facility for accurate recording of ME datasets, and for our data to be submitted to the national ME.
- A local network of MEs to share learning and provide an independent review facility if needed.

Work undertaken so far has included:

- Dr Belinda Cornforth has agreed to take up the role of Lead Medical Examiner.
- Two of the 7 or 8 Medical Examiners are fully trained, a further 3 will complete it by the end of February. The remainder will have completed training by the end of May. Introduction of the system does require all to be trained but having larger numbers provides increased resilience.
- A Medical Examiners' Officer job description has been written and is to be submitted for a banding decision.
- A workshop with key stakeholders was held on 7 January to ensure the ME and MEO integrate with the existing system. A follow-up workshop is planned for February to report on progress of the actions.

4. Working with bereaved families

Our local bereavement survey 'Your views matter' continued to be offered to bereaved families when they collect the medical certificate. In Q3, 91 surveys were given to families with 7 (8%) returned. The response rate in Q3 was disappointing and the End of Life Care team have worked with the bereavement team to improve the distribution process. The survey is now in a bereavement folder that contains helpful contacts and charities to support the bereaved.

In Q3, four of the surveys were very positive and 3 had suggestions for improvement. The common theme stemmed from poor communication and on one occasion property belonging to another patient was given to a family. The End of Life Care team signposted three families to the PALS team for ongoing support. On each occasion, the Lead Nurse of the End of Life Care team has discussed the cases with ward leaders, medical staff and staff involved in the care of the patient. The information gained also helps to shape the ongoing teaching programme.

5. Mortality dashboard, learning, themes and actions

In Q3 2019/20, 178 deaths occurred in the Trust. The total includes patients who died in the Emergency Department and the Hospice. Of these, 169 (95%) deaths were screened to ascertain whether the death needed a full case review. 64 (36%) deaths had a full case review. No deaths were probably, strongly or definitely avoidable, 1 was possibly avoidable, and 3 had slight evidence of avoidability. The key theme arising from reviews was:

- Recognition of the dying patient and early discussions of ceilings of care to avoid unnecessary treatment.

6. Improvement actions in Q3 19/20 update:

- Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form) - BSW STP asked the Trust to put the introduction of ReSPECT on hold until the national version 3 is published in ?March 2020 and an STP launch can take place. SFT resuscitation officer attended the first BSW STP working group in December.
- Improve documentation of consent, risks and benefits of ward based procedures such as chest drains and ascitic taps - Clinical lead now identified. Chest drain insertion sticker - partially completed. Ascitic tap drainage - not started yet.
- Report compliance with senior review at a weekend via the 7DS Board Assurance Framework at the Clinical Governance Committee in November 19 and present a review of the safety and effectiveness of services at the weekend to the Clinical Governance Committee in October 19 – completed. Weekend HSMR declined to 127 to Sept 19 from a peak of 133.
- Improve the escalation of patients who deteriorate in accordance with the NEWS2 policy – ongoing education and quarterly escalation audits. Q1 & Q2 19/20 – 84%, M7 & M8 - 81% appropriate escalation (Target 95%).
- Improve the recognition of a dying patient and managed of good end of life care – ongoing end of life care education and quarterly monitoring of end of life care metrics in place.

7. CUSUM alerts

In Q3 19/20, 4 new CUSUM alerts:

- Malaise & fatigue (June 19) 3 vs 1 relative risk 303 - The Mortality Surveillance Group decided not to investigate this alert as it was previously investigated in March 18. No deaths were avoidable and there were no learning points.
- Inflammation of eye (Dec18) 1 vs 0.2 expected relative risk 570. Investigated and reported in Q2 19/20. This was investigated under another CUSUM alert - Operations on vitreous body 1 death vs 0 expected with a relative risk 539 – the procedure was for aspiration of vitreous humour to guide treatment of endophthalmitis. The patient had a serious eye infection and multiple co-morbidities. The patient had severe sepsis and died of heart failure (SII 296).
- Affective disorder 1 vs 0 relative risk 1907 (Sept 19) – to be discussed at the Mortality Surveillance Group in February 2020.
- Gastro-intestinal haemorrhage 19 vs 9.8 relative risk 194 (Aug 19) – review completed and will be reported to the Clinical Governance Committee on 25 February 2020.

Previously unreported alert in Q2 19/20:

- Gastritis and duodenitis – 3 deaths vs 0.1 expected, relative risk 2076. Cases investigated and will be reported to the Mortality Surveillance Group in February 2020.

8. Death following a planned admission to hospital

In Q3 19/20, 3 deaths of patients following a planned admission:

- Two patients, both with metastatic cancer were admitted to the Hospice for symptom control, and died of disease progression. Deaths were unavoidable. No learning points.
- An 89 year old patient admitted from clinic for drainage of pleural effusions and treatment of heart failure. Multiple comorbidities and frailty. The patient did not respond to treatment and the death was unavoidable. Learning points: 1) Improve documentation of pleural drainage (NatSIPPs) 2) Better medical certificate of death – Medical Examiner system will help improve this.

9. Unexpected deaths

In Q3, there were 3 unexpected deaths.

1. A patient had an uncomplicated laparoscopic cholecystectomy. The patient had a history of an abdominal aortic aneurysm and was waiting for surgery. 48 hours post-operatively was found unresponsive in cardiac arrest, resuscitated and transferred to ICU but did not recover and died (CR346).
2. An older patient with a massive bleed from a large duodenal ulcer but the bleeding could not be controlled and the patient died during the procedure (SII 347).
3. A 47 year old patient admitted via ED to AMU with atypical signs and symptoms of a stroke and a normal CT scan. CTPA 7 hours later showed a left hemispheric stroke due to blockage of the carotid artery in the neck. The patient was transferred to University Hospital Southampton but sadly died the next day (SII343).

10. Stillbirths, neonatal deaths and child death

- Two intra-uterine deaths in October, both term pregnancies. Neither baby was small for gestational age. No omissions in care.
- One intra-uterine death at 27 weeks in November (SII334) of a baby with abnormalities under the care of the Fetal Medicine Unit at Southampton.
- One intra-uterine death at 38 weeks in December.
- No neonatal or child deaths in Q3.

11. Patients with a learning disability

In Q3, two patients with a learning disability died:

- A 42 year old patient admitted with a bowel obstruction and perforation. P-POSSUM mortality score 52%. Managed conservatively and died receiving end of life care. Death was expected and unavoidable.
- A 38 year old patient admitted with aspiration pneumonia and despite active treatment, but short of invasive ventilation, continued to deteriorate and died. Death was expected and unavoidable.

The deaths will be reported to the LeDeR programme following a case notes review.

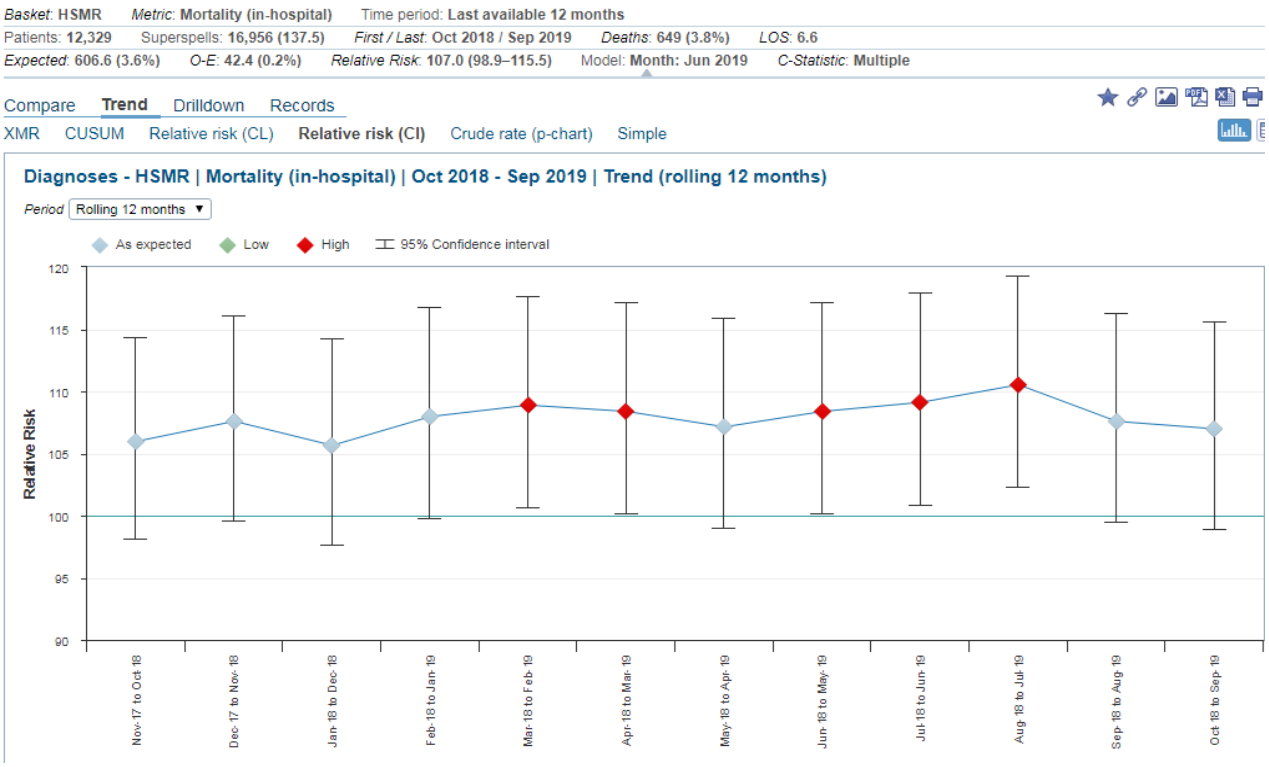
12. Patients with a serious mental illness

In Q3, 2 patients coded with a serious mental illness died:

- A 78 year old man admitted following a fall with schizophrenia, pneumonia and multiple pulmonary emboli and care that was generally good. Death was unavoidable.
- A 74 year old man with dementia admitted with a fall and lower respiratory tract infection and sleep apnoea. Death was unavoidable and care was generally good.

13. HSMR rolling 12 month trend to September 2019

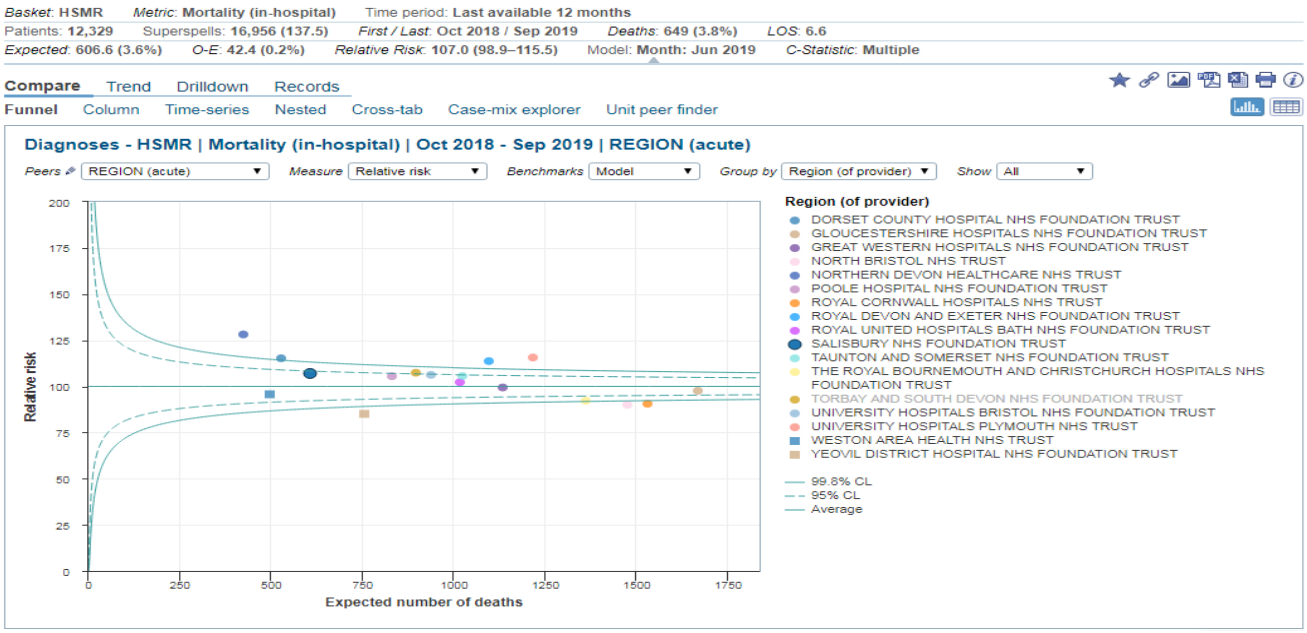
Figure 1: HSMR relative risk of all diagnoses Oct 18 – Sept 19



HSMR has decreased to 107 and is as expected over the last 12 month rolling period.

14. Mortality (in-hospital) regional peer comparison Oct 18 – Sept 19

Figure 2: Mortality (in-hospital) regional peer comparison Oct 18 – Sept 19

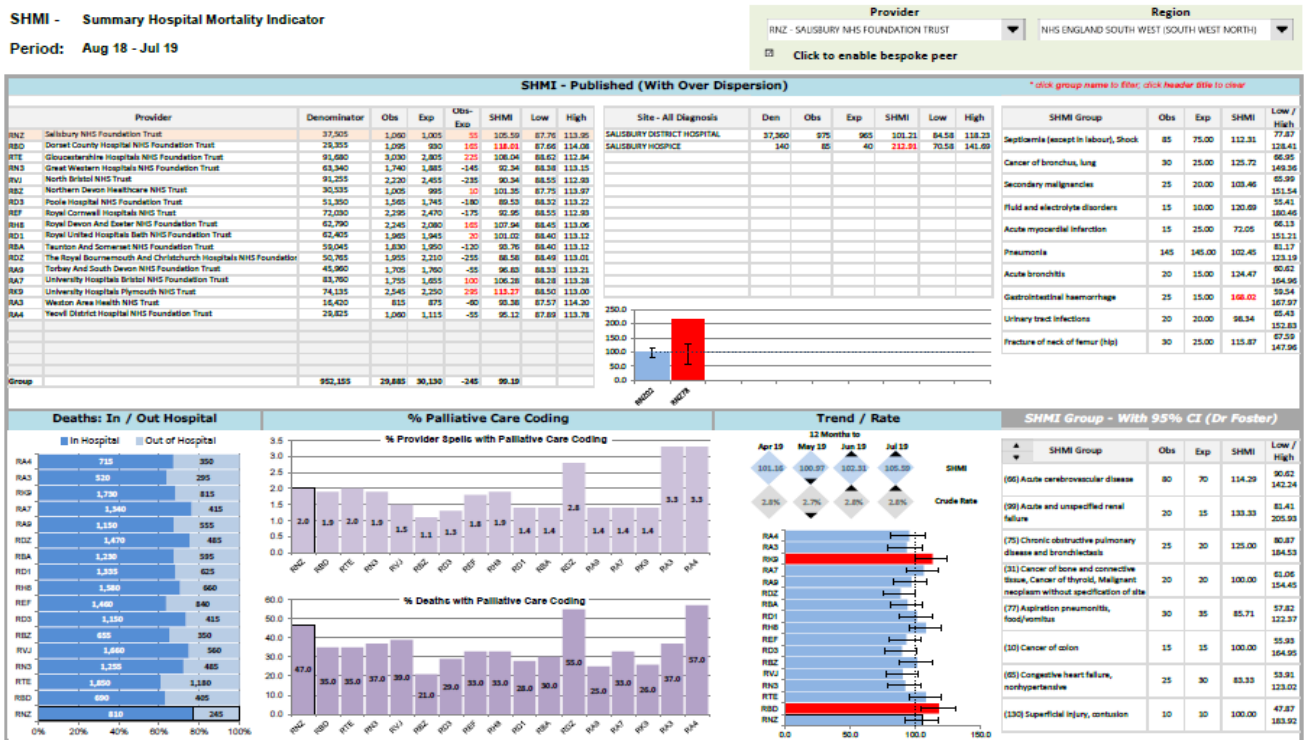


Regional peer comparison shows 5 other acute Trusts have a higher in-hospital mortality than this Trust.

15. SHMI August 2018 – July 2019

SHMI is 105.59 within the expected range. When comparing SHMI by site Salisbury District Hospital is 101.21 and Salisbury Hospice is 212. When compared with regional peers the Trust has a SHMI within the expected range.

Figure 3: SHMI regional peer comparison August 2018 – July 2019



16. Comorbidity and palliative care profile 19/20

Trends in comorbidity coding show that the Trust has a Charlson comorbidity upper quartile rate for the HSMR basket of 24.3% and is 98 as an index of national.

Figure 4: Trend in comorbidity profile

Comorbidity Profile

Organisation: **SALISBURY NHS FOUNDATION TRUST**

Report Date: **6 January 2020**

	2016/17	2017/18	2018/19	2019/20
Upper-quartile comorbidity	24.2%	24.5%	24.2%	24.3%
as index of national (100)	97	98	97	98

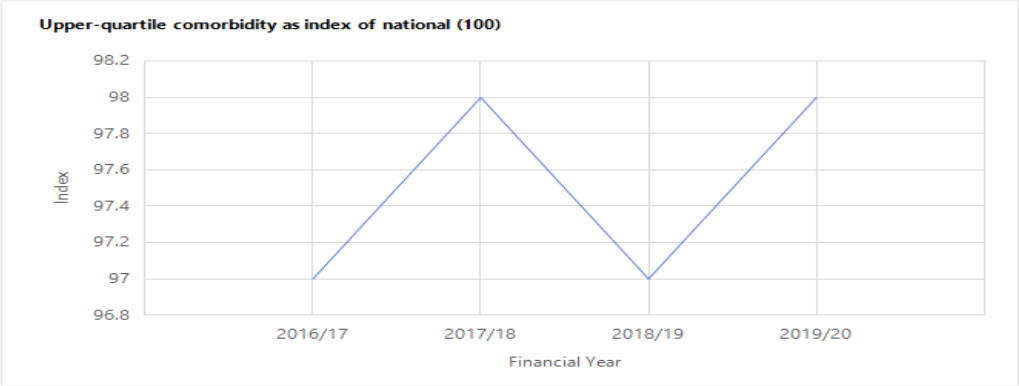


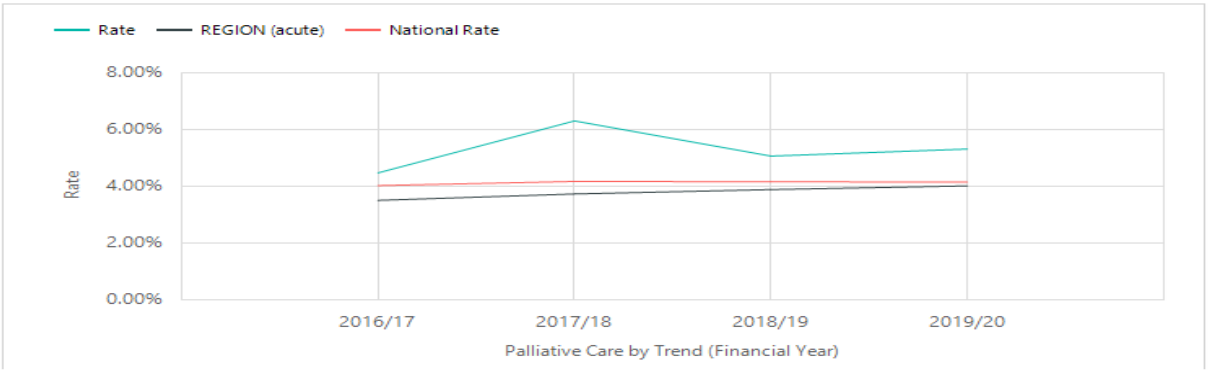
Figure 5: Trend in palliative care profile

Palliative Care Profile

Organisation: **Salisbury NHS Foundation Trust** *Report Date:* **6 January 2020**

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

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2016/17	9,523	426	4.47%	4.03%	3.51%
2017/18	9,773	616	6.30%	4.17%	3.73%
2018/19	9,971	505	5.06%	4.16%	3.88%
2019/20	5,082	270	5.31%	4.15%	4.01%



A slowly increasing trend in the Trust's palliative care coding rate for 19/20 and higher than the national rate of 4.15%.

17. Weekday/weekend HSMR

Emergency weekday HSMR is within the expected range at 101.1 but weekend HSMR is statistically significantly higher than expected at 127.5 having reduced from a peak of 133.8 in July 2019.

Figure 6: HSMR Emergency weekday/weekend admission Oct 2018 – Sept 2019

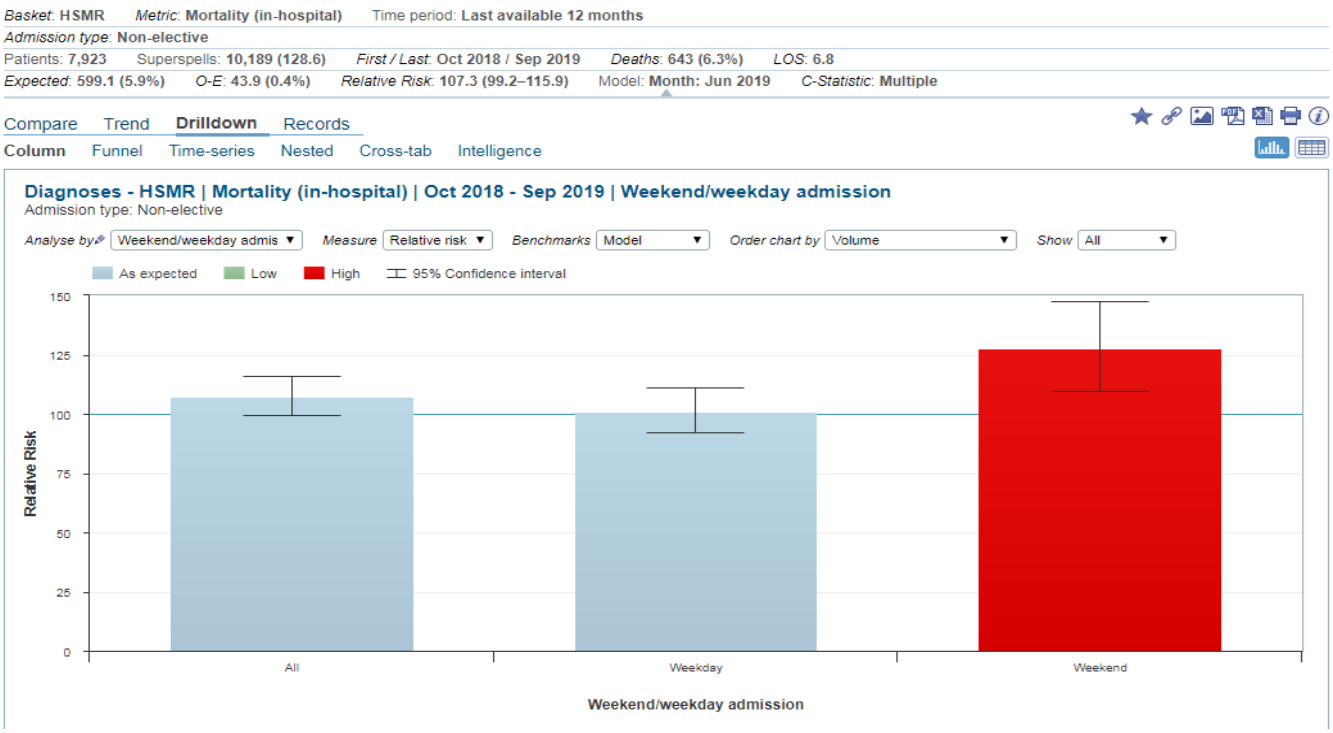
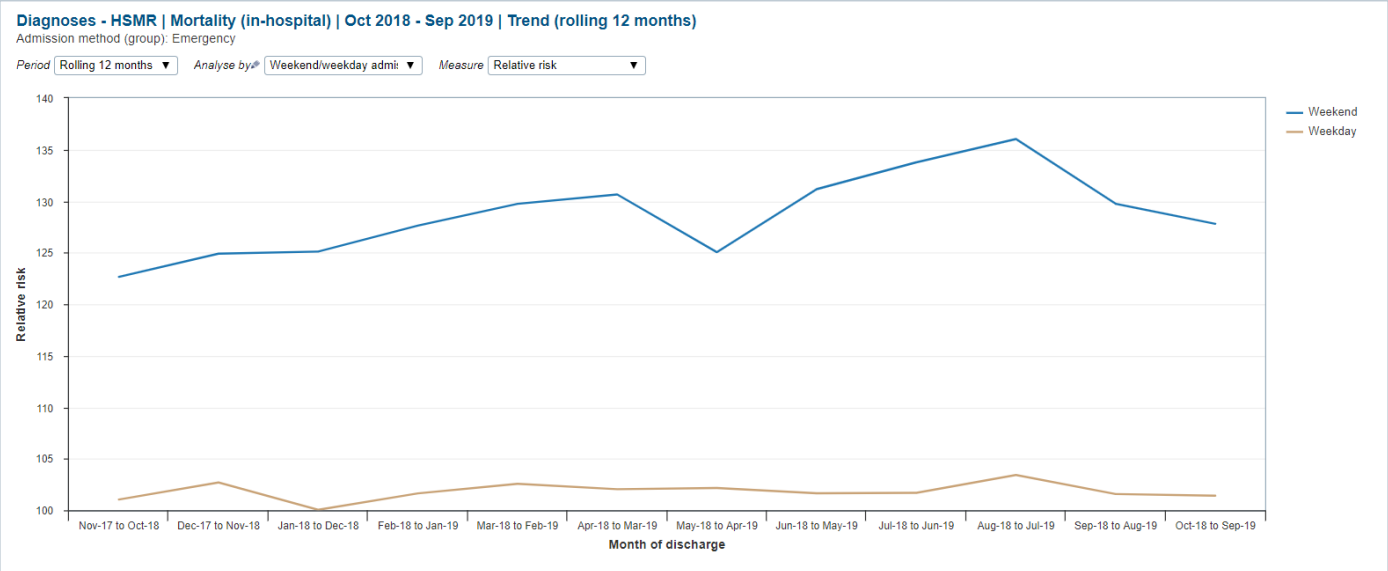


Figure 7: Rolling 12 month trend in emergency weekend and weekday HSMR Oct 18 – Sept 19



The emergency weekend HSMR started to decline from a peak of 133 in July to 127.5 by Sept 19 but remains significantly higher than expected. The decline has occurred due to a reduction in crude mortality rates for weekend and weekday admissions with a marked decrease in the crude rate for weekend mortality since May 2019.

A detailed case review of patients admitted as an emergency on a Sunday was undertaken and reported to the Clinical Governance Committee in September 2019. A supplementary report on weekend safety and effectiveness which brought together related issues potentially impacting on the services provided at the Trust at weekends concluded the issue is multi-factorial – particularly the workload of staff at the weekends both in primary and community care and in the Trust along with the reduced availability of some services. An action plan to mitigate the risk factors was presented to the Trust Board in November 2019.

18. Deaths in high risk diagnosis groups (Oct 18 – Sept 19)

The Mortality Surveillance Group monitors a 12 month rolling trend in the relative risk for 7 high risk diagnosis groups.

Figure 8: Trend in relative risk for septicaemia (except in labour)

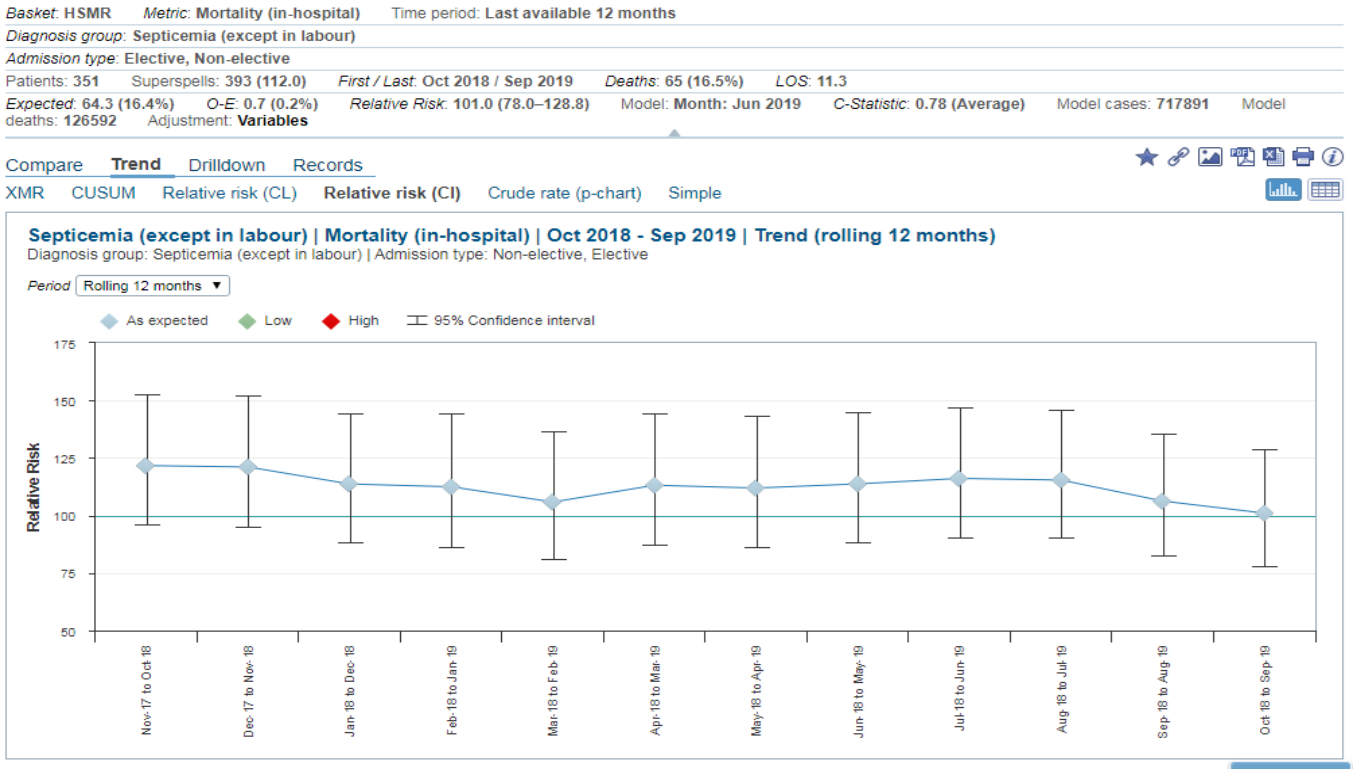


Figure 9: Trend in relative risk for pneumonia

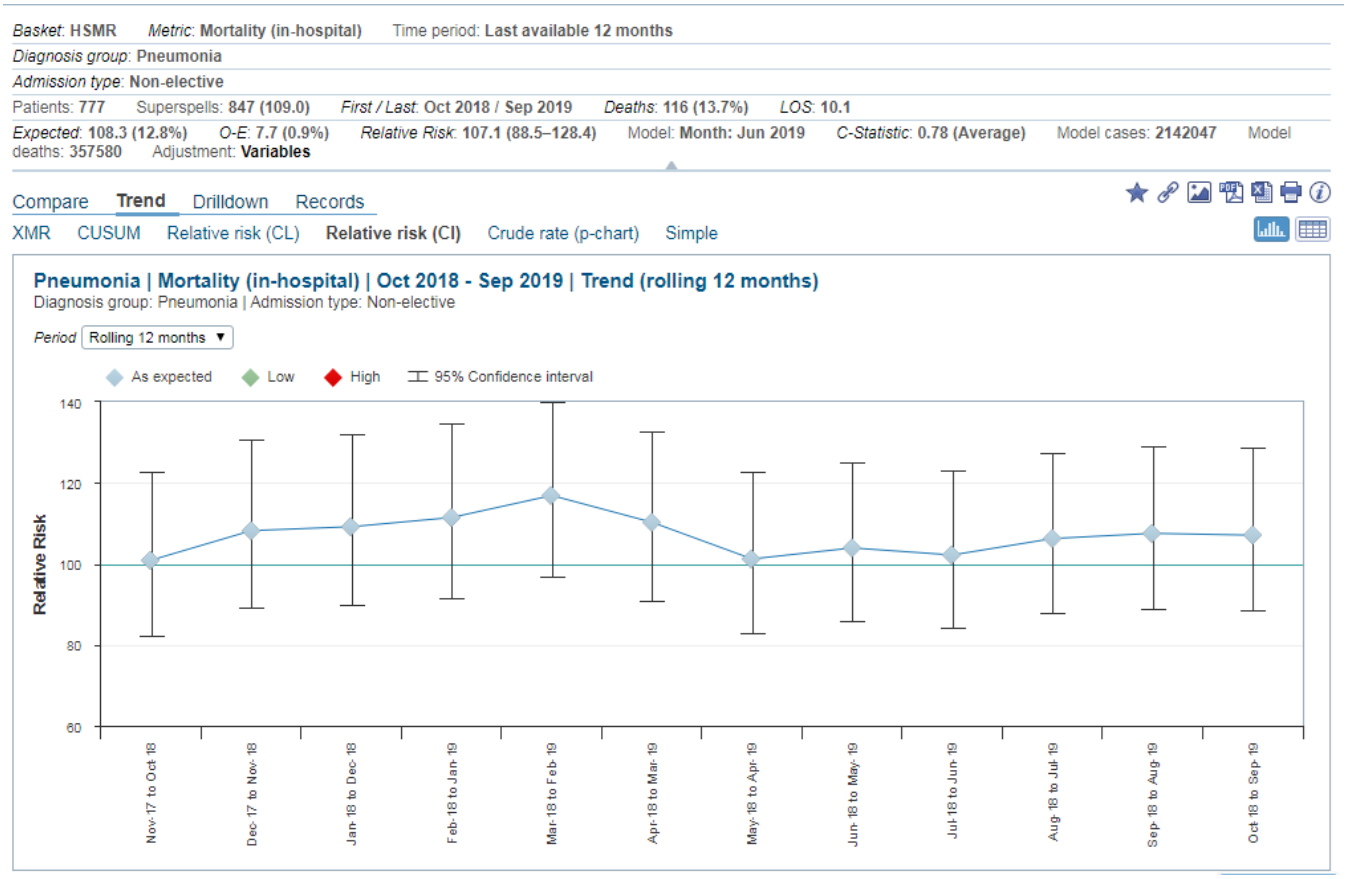


Figure 10: Trend in relative risk for acute cerebrovascular disease

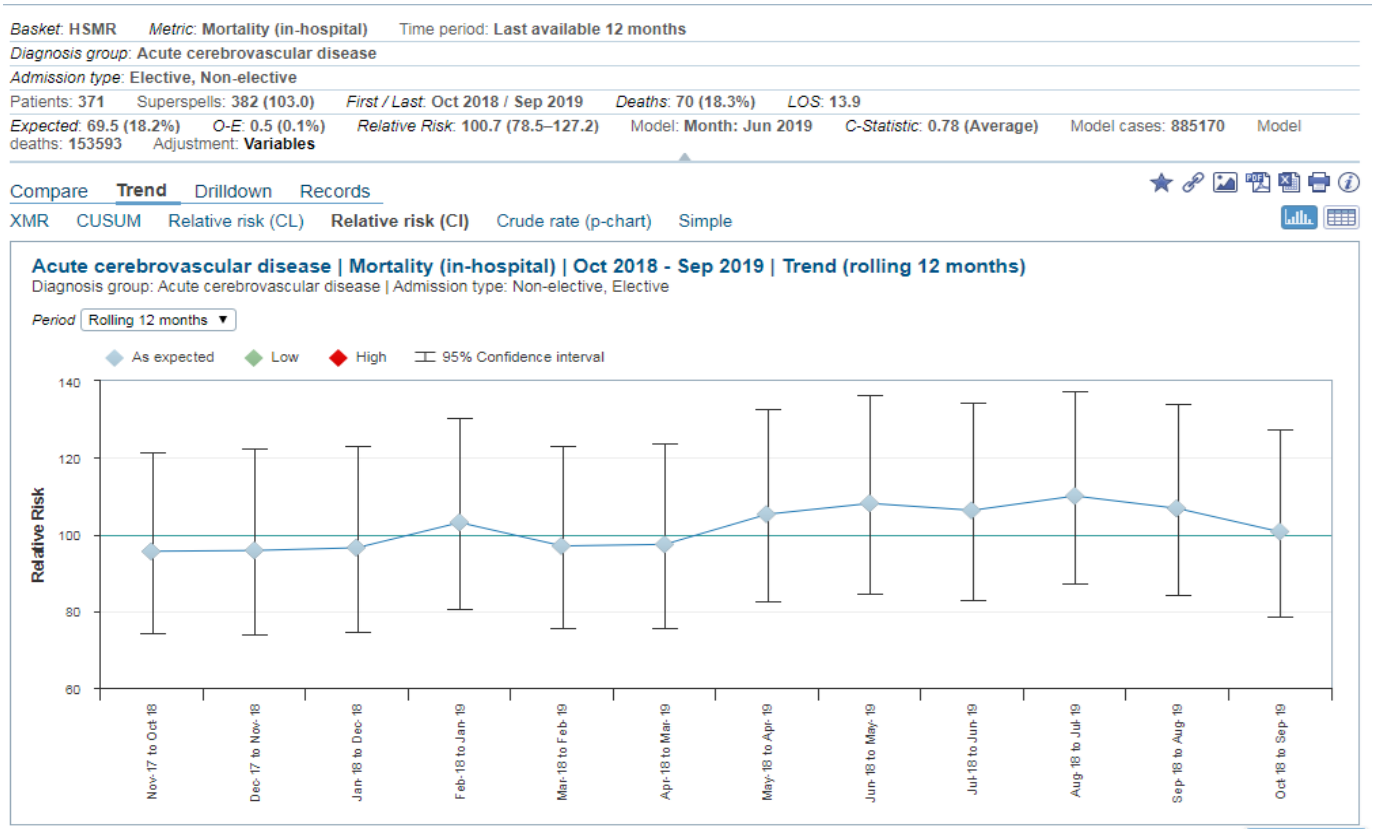


Figure 11: Trend in relative risk for acute myocardial infarction

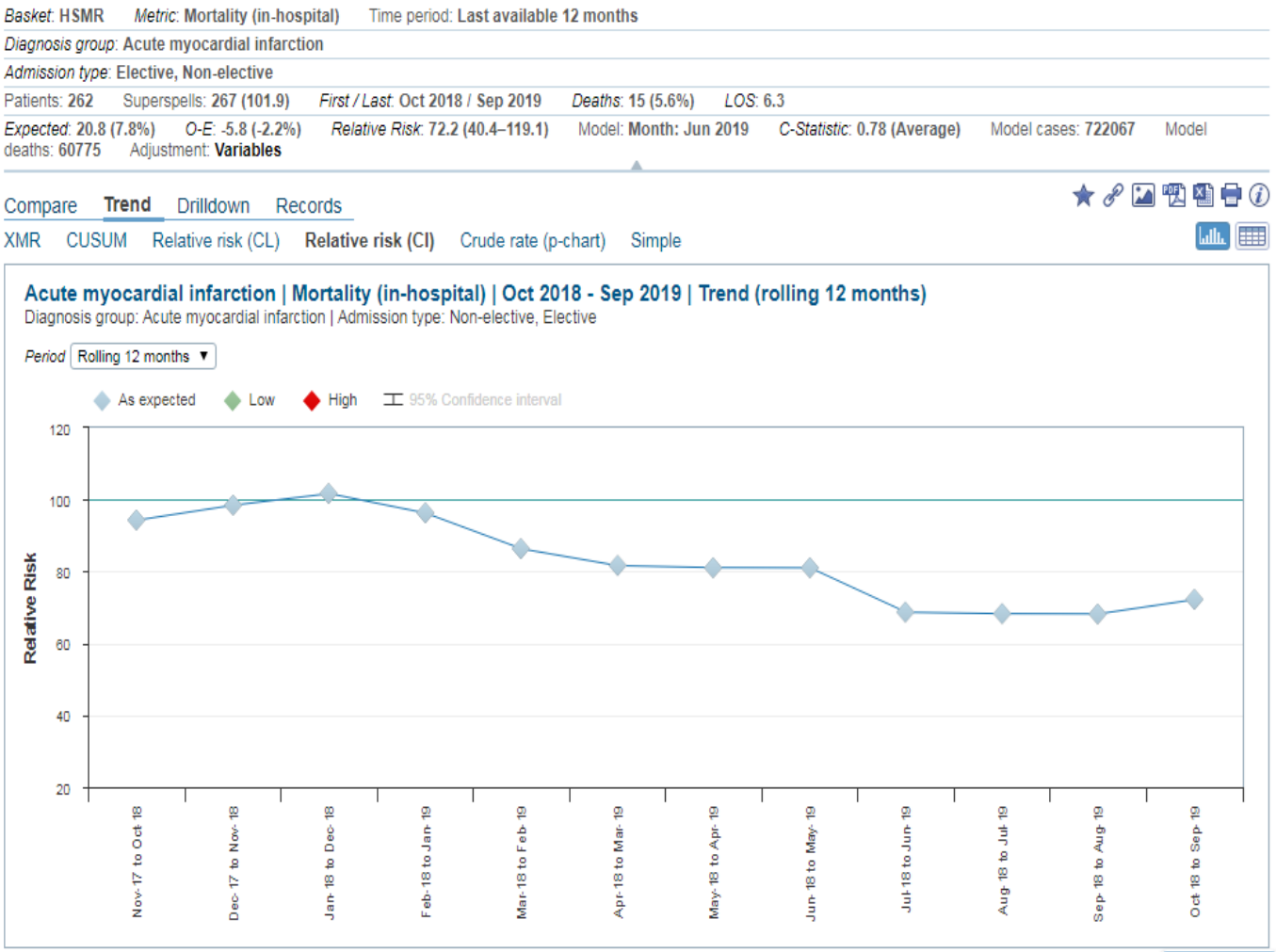


Figure 12: Trend in relative risk for congestive cardiac failure

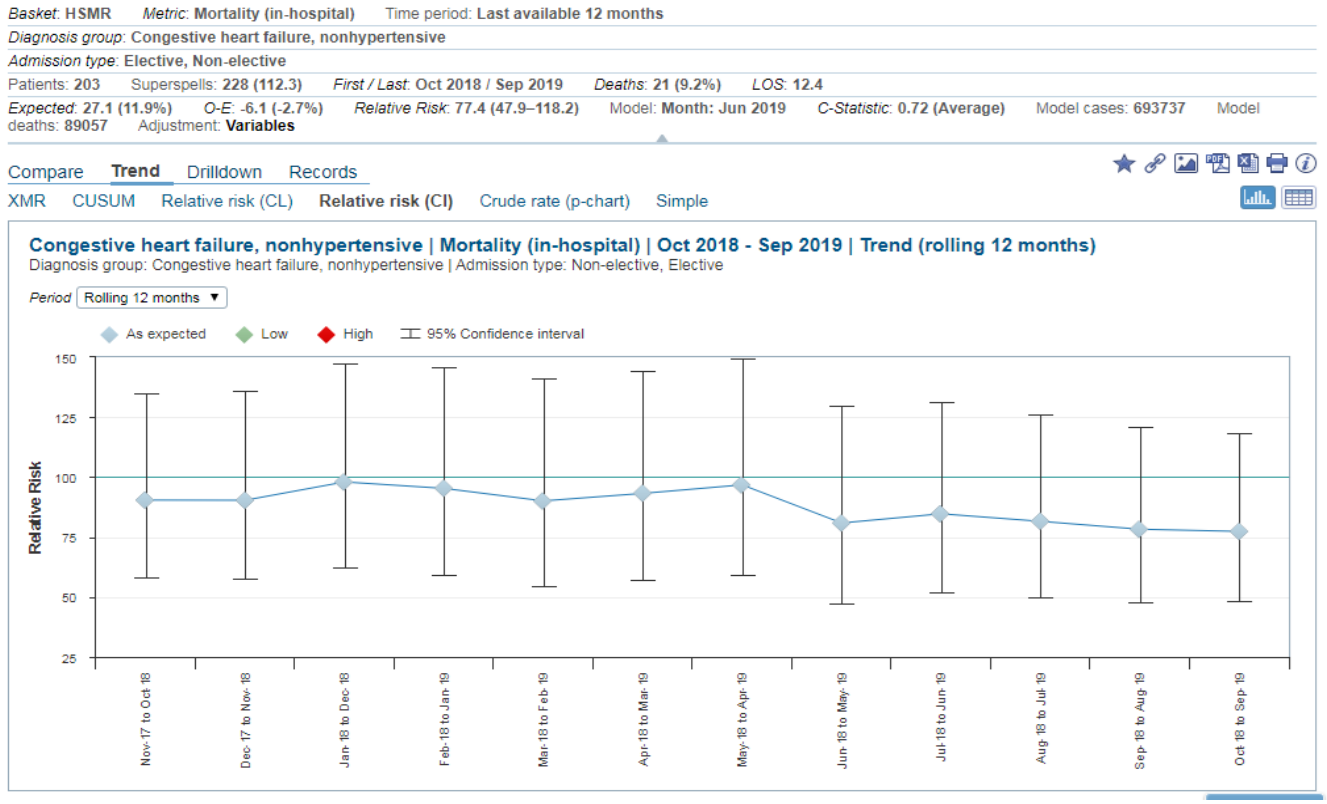


Figure 13: Trend in relative risk for acute and unspecified renal failure

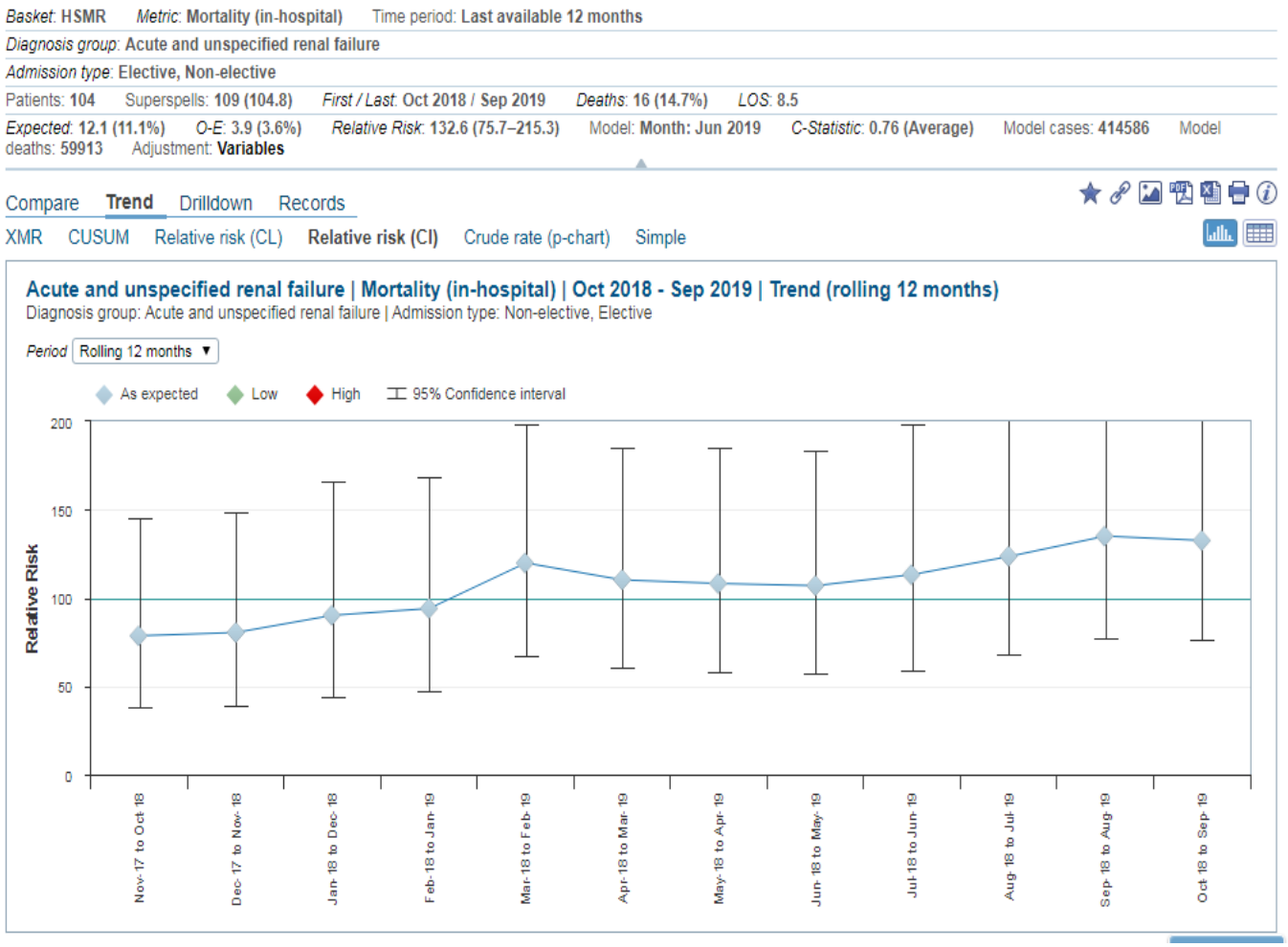
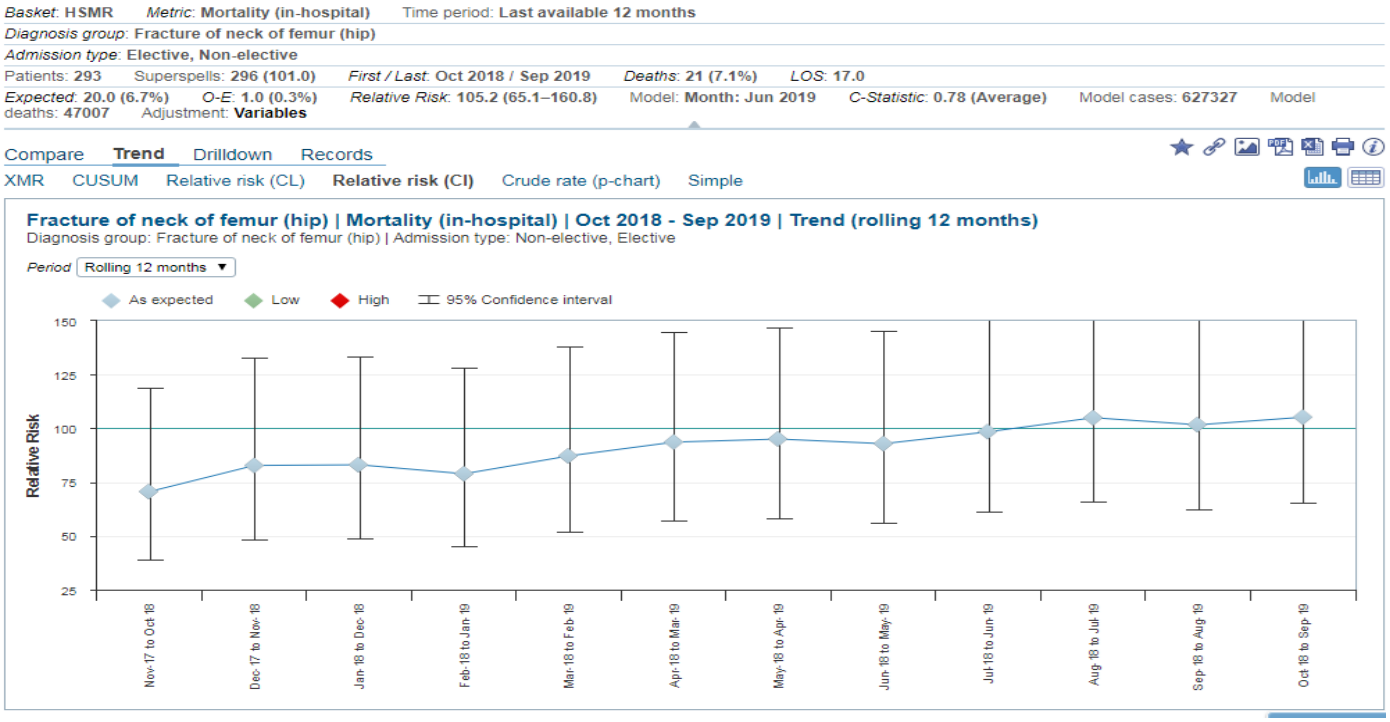


Figure 14: Trend in relative risk for fracture of neck of femur



A multidisciplinary review of 33 patients who died with a fractured neck of femur was undertaken in October 2019. The review found some excellent care especially in the early recognition, management and communication of end of life care. 40 problems in care were identified, of which 5 contributed to catastrophic (2) and major harm (3) from inpatient falls resulting in a hip fracture. 26 deaths were definitely not avoidable, 4 had slight evidence of avoidability, 2 were possibly avoidable but not very likely and 1 death was probably avoidable.

An action plan is in place to:

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

19. Summary

The report highlights the planned introduction of the Medical Examiner system in 2020 and outcomes and improvements in bereavement support. The Q3 mortality dashboard shows the number of deaths, outcome of reviews, learning themes and actions taken to improve. The majority of deaths were unavoidable and expected. 3 deaths were unexpected of which 2 are subject to a serious incident inquiry and the other a clinical review. The main theme arising in Q3 was the ability to recognise a dying patient and the importance of early discussions about ceilings of care to avoid unnecessary treatment.

The emergency weekend HSMR started to decline from a peak of 133 in July to 127.5 by Sept 19 but remains significantly higher than expected. The decline has occurred due to a reduction in crude mortality rates for weekend and weekday admissions with a marked decrease in the crude rate for weekend mortality since May 2019.

A case notes review of 33 patients with a hip fracture who died was completed. Care was generally good but there was potential for improvement in the pathway and root cause analysis will be undertaken for all patients not meeting the best practice standards

A case notes review of a relative risk of death associated with gastrointestinal haemorrhage took place in Q2 and will be reported to the Clinical Governance Committee on 25 February 2020.

20. Recommendation

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

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

Claire Gorzanski, Head of Clinical Effectiveness,
21 January 2020

Appendix 1

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD 2019/2020

	Apr 19	May 19	Jun 19	Q1	Jul 19	Aug 19	Sep 19	Q2	Oct 19	Nov 19	Dec 19	Q3	Jan 20	Feb 20	Mar 20	Q4	Total
Deaths	67	63	62	**192**	68	43	61	**172**	63	59	56	**178**					**542**
1st screen	65	58	62	**185**	65	40	59	**164**	59	59	51	**169**					**518**
% 1st screen	97%	92%	100%	**96%**	96%	93%	97%	**95%**	94%	100%	93%	**95%**					**96%**
Case reviews	23	19	20	**62**	27	11	19	**57**	17	30	17	**64**					**183**
% case reviews	34%	30%	32%	**32%**	40%	26%	31%	**33%**	27%	51%	30%	**36%**					**34%**
Deaths with Hogan score 1	63	60	60	**183**	65	40	58	**163**	60	58	56	**174**					**520**
Deaths with Hogan score 2 - 3	4	3	1	**8**	3	3	3	**9**	3	1	0	**4**					**21**
Deaths with Hogan score 4 - 6	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**					**1**
Learning points	7	7	6	**20**	5	3	7	**15**	4	2	4	**10**					**45**
Family/carer concerns	1	1	2	**4**	1	1	2	**4**	2	1	2	**5**					**13**
CUSUM alerts	3	1	0	**4**	0	4	0	**4**	2	0	2	**4**					**12**
CUSUM investigated	3	0	0	**3**	0	1	0	**1**	1	0	1	**2**					**6**
Deaths investigated as an SII	0	2	2	**4**	1	0	2	**3**	1	1	0	**2**					**9**
Death following an elective admission	2	0	1	**3**	1	0	2	**3**	0	2	1	**3**					**9**
Unexpected	0	3	1	**4**	0	0	2	**2**	2	1	0	**3**					**9**
Stillbirths/ neonatal/child death	0	1	0	**1**	1	0	0	**1**	2	1	1	**4**					**6**
Learning disability deaths	0	1	0	**1**	0	0	0	**0**	2	0	0	**2**					**3**
Reported to LeDeR programme LeDeR	0	1	0	**1**	0	0	0	**0**	*0	0	0	**0**					**1**
Serious mental illness	0	0	2	**2**	0	0	0	**0**	0	0	2	**2**					**4**
Maternal death	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**					**0**

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

MORTALITY DASHBOARD THEMES AND ACTIONS 2019/2020 **Appendix 2**

No	Learning points	Action point	By whom	By when	Update 16/1/2020	Status
1	Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form)	Work programme developed with planned implementation on 4/11/2019	Resuscitation Committee	31/03/20	BSW STP asked the Trust to put the introduction of ReSPECT on hold until the national version 3 is published in ?March 2020 and an STP launch can take place. SFT resuscitation officer attended the first BSW STP working group in December.	
2	Improve documentation of consent, risk and benefits of ward based procedures such as chest drains and ascitic taps	Ongoing education programme on consent Implementation of LocSSip	B Cornforth Risk Team	31/03/20	Clinical lead now identified. Chest drain insertion sticker - partially completed. Ascitic tap drainage - not started yet.	
3	Acutely unwell patients did not have a medical review at a weekend.	• Report compliance with senior review via the 7DS Board Assurance Framework & • Present a review of the safety and effectiveness of services at the weekend to the Clinical Governance Committee	S Davies C Blanshard	26/11/19 22/10/19	Report to the Clinical Governance Committee in Nov 19. Reported to the Clinical Governance Committee in Oct 19 - completed. Weekend HSMR declined to 127 to Sept 19 from a peak of 133.	
4	Recognising deteriorating patients and escalate to the appropriate level.	Improve the escalation of patients in accordance with the NEWS2 policy.	N Finneran M Ford	31/03/20	Ongoing education and quarterly escalation audits. Q1 & Q2 19/20 – 84% appropriate escalation. M7 & M8 81% appropriate escalation (Target 95%).	
5	Recognition of a dying patient and management of good end of life care	Teaching on end of life care	Palliative Care and End of Life Care Teams	31/03/20	Ongoing end of life care education and quarterly monitoring of end of life care metrics	

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

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

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

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

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

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

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

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

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

9. Deaths investigated as a SII (serious incident inquiry).

10. Elective deaths – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had metastatic cancer and were admitted to hospital for symptom control or a procedure to relieve their symptoms and died from disease progression.

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

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

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

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

15. Learning disability deaths – all patients with learning disabilities aged 4 to 74 years. The Trust reports all these deaths to the LeDeR programme.

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

17. Serious mental illness – all patients who die with a serious mental illness.

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

References

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

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	06 February 2020		

Report Title:	Constitution			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Isabel Cardoso – Membership Manager Lucinda Herklots – Public Governor			
Executive Sponsor (presenting):	Fiona McNeight – Director of Corporate Governance			
Appendices (list if applicable):	None			

Recommendation:
The Board is asked to approve the changes to the Constitution.

Executive Summary:
The Council of Governors undertook a review of the existing constituencies after being unable to recruit a Governor to post after two elections. • West Wiltshire – has been up for elections twice, once in 2018 and in 2019. On both occasions no-one has come forward to stand for Governor. It was then considered that it would be best to merge this constituency with South Wiltshire Rural. The Governors Constituency Committee looked at and considered the best options for West Wiltshire. It was decided that the best solution would be for the constitution to be amended by: a) The insertion of the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency b) The deletion of West Wiltshire as a constituency c) The number of governors for the South Wiltshire Rural constituency be increased from five to six governors. • The above consideration was taken to the Council of Governors meeting in November 2019, and was approved by the full Council.

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

SALISBURY NHS FOUNDATION TRUST

CONSTITUTION

CONTENTS

- Standing Financial Instructions
- Scheme of Delegation

Amendment history – 2013 to 201~~6~~9

- The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
- Amendment of paragraph 37 of the Constitution was approved by the Board of Directors on 29 February 2016 and by the Council of Governors on 11 April 2016.
- The new Model Election Rules were issued by the former Foundation Trust Network (NHS Providers) in August 2014 and formally adopted by the trust on 29 February/11 April 2016
- Amendment of paragraph 16 of the Council's standing orders was approved by the Council on 16 May 2016.
- April 2018 minor amendments to Board Standing Orders
- Addition of Standing Financial Instructions – approved February 2018
- Amendment of Annex 1 to a) insert the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency; (b) delete West Wiltshire as a constituency; (c) increase the number of governors for the South Wiltshire Rural Constituency from 5 to 6. – approved November 2019.

1. INTERPRETATION AND DEFINITIONS

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

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

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

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

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

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

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

2. NAME

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

3. PRINCIPAL PURPOSE

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

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

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

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

3.3.2. the promotion and protection of public health.

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

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

4. POWERS

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

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

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

5. Membership and Constituencies

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

5.1.1. A public constituency

5.1.2. A staff constituency

6. Application for Membership

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

7. Public Constituencies

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

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

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

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

8. Staff Constituency

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

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

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

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

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

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

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

9. AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF

9.1. An individual who is:

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

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

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

10. PATIENTS' CONSTITUENCY

There is no Patients' Constituency.

11. PARAGRAPH 11 IS NOT USED

12. RESTRICTIONS ON MEMBERSHIP

12.1. An individual who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.

12.2. An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any other constituency.

12.3. An individual must be at least 16 years old to become a member of the Trust.

12.4. An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.

12.5. A member of the Trust shall inform the Secretary of the Trust of any circumstances which may affect their entitlement to be a member.

12.6. Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.

12.7. A member may resign by written notice to the Secretary of the Trust.

13. ANNUAL MEMBERS' MEETING

13.1. The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public.

14. COUNCIL OF GOVERNORS – COMPOSITION

14.1. The Trust is to have a Council of Governors comprising both elected and appointed governors.

14.2. The composition of the Council of Governors is specified in Annex 4.

14.3. The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.

14.4. No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

15. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

15.1. Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.

15.2. The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.

15.3. A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).

15.4. An election, if contested, shall be by secret ballot.

15.5. In the event of an elected governor ceasing to hold office, if there are then more than 15 months of his term of office left after his resignation, ceasing to hold office or death, then an election shall be held for his replacement. The person elected shall hold office for the remainder of the period for which the governor he is replacing was last elected.

16. COUNCIL OF GOVERNORS – TENURE

16.1. Subject to 15.5 and 16.2, an elected governor may hold office for a period of up to 3 years.

16.2. An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than 9 years in all.

16.3. An appointed governor may hold office for a period of up to 3 years and may then be re-appointed but shall not hold office for more than 9 years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

16.4. A governor may resign by giving notice in writing to the Chairman of the Trust.

16.5. In the event of an appointed governor ceasing to hold office, the body appointing him may make a further appointment.

16.6. The limits of 9 years in sub-paragraphs 16.2 and 16.3 shall in the case of an elected governor include any time served as an appointed governor, and in the case of an appointed governor include any time served as an elected governor.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND TERMINATION OF OFFICE

17.1. The following may not stand for election or continue as a member of the Council of Governors:

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

17.1.2. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

17.1.3. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

17.1.4. The further persons set out in Annex 6.

17.2. An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

17.3. If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

17.3.1. the failure was in their opinion due to a reasonable cause or causes, and

17.3.2. he will be able to, and will, start attending meetings of the Council within such period as they consider reasonable.

17.4. A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

17.4.1. acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or

17.4.2. failed to declare a material interest pursuant to paragraph 22 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

17.5. Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 17.3 and 17.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

17.6. In the event of a notice being given under sub-paragraph 17.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's ability to remain a governor (other than those set out in paragraphs 17.3 and 17.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

17.7. A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

17.8. If a governor who is an employee of the Trust is suspended as an employee as a part of a disciplinary process, the Chairman of the Trust may suspend the governor from acting as a governor while the governor remains suspended as an employee.

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS, EQUIPPING GOVERNORS, LEAD GOVERNOR & DEPUTY LEAD GOVERNOR

18.1. The general duties of the Council of Governors are–

18.1.1. to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

18.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public.

18.2. The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

18.3. The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

19.1. The Chairman of the Trust, that is the Chairman of the Board of Directors, or in his absence, the Deputy Chairman or, in his absence, the Lead Governor (or Deputy Lead Governor), shall preside at meetings of the Council of Governors.

19.2. Where it is inappropriate by reason of the subject matter of a meeting that it should be chaired by the Chairman, the Deputy Chairman may preside unless it is also inappropriate that the Deputy Chairman preside, in which case the Lead Governor or in his absence the Deputy Lead Governor may preside.

19.3. Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

19.4. The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

19.5. The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

19.6. For the purpose of obtaining information about the Trust's performance of its functions or the directors performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

19.7. The Council of Governors will establish statutory committees to carry out such functions as are required by law and to carry out such functions as the Council specifies.

19.8. The Council of Governors will establish working groups to carry out such functions as the Council specifies.

20. COUNCIL OF GOVERNORS – STANDING ORDERS

20.1. The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

21. COUNCIL OF GOVERNORS – REFERRAL TO THE PANEL

21.1. In this paragraph the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

21.1.1. to act in accordance with its constitution, or

21.1.2. to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

21.2. A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

22. COUNCIL OF GOVERNORS – CONFLICTS OF INTEREST OF GOVERNORS

22.1. If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

22.2. For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

23. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

23.1. The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

24. PARAGRAPH 24 IS NOT USED

25. BOARD OF DIRECTORS – COMPOSITION

25.1. The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

25.2. The Board of Directors is to comprise:

25.2.1. a non-executive Chairman

25.2.2. a maximum of 7 other non-executive directors

25.2.3. a maximum of 6 executive directors (subject to 25.4 below), to include:

25.2.3.1. a Chief Executive who shall be the Accounting officer,

25.2.3.2. a Finance Director.

25.3. One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

25.4. The number of non-executive directors including the Chairman must always exceed the number of executive directors. At any meeting where there is parity of non-executive and executive directors the Chairman, or in his absence the Deputy Chairman, shall have a casting vote.

25.5. Only a member of a public constituency or the patients' constituency is eligible for appointment as a non-executive Director.

26. BOARD OF DIRECTORS – GENERAL DUTY

26.1. The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

27. PARAGRAPH 27 IS NOT USED

28. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIRMAN AND NON-EXECUTIVE DIRECTORS

28.1. The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other non-executive directors.

28.2. Removal of the Chairman or any other non-executive director shall require the approval of 75% of the members of the Council of Governors.

28.3. The Standing Orders of the Council shall provide for nomination committees to identify appropriate candidates for appointment as Chairman and as non-executive directors.

29. PARAGRAPH 29 IS NOT USED

30. BOARD OF DIRECTORS – DEPUTY CHAIRMAN

30.1. After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chairman. The Deputy Chairman shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

31. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS

31.1. The non-executive directors shall appoint or remove the Chief Executive.

31.2. The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3. A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

32. PARAGRAPH 32 IS NOT USED

33. BOARD OF DIRECTORS – DISQUALIFICATION

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

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

33.1.2. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

33.1.3. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

33.1.4. The persons referred in Annex 9.

34. BOARD OF DIRECTORS – MEETINGS

34.1. Before holding a meeting the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

34.2. As soon as practical after holding a meeting the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

34.3. Meetings of the Board of Directors shall be open to members of the public.

34.4. Members of the public may be excluded from all or any part of a meeting by a resolution of the Board for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

35. BOARD OF DIRECTORS – STANDING ORDERS

35.1. The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8. They may be amended as provided in them.

36. BOARD OF DIRECTORS – CONFLICTS OF INTEREST OF DIRECTORS

36.1. The duties that a director of the Trust has by virtue of being a director include in particular–

36.1.1. a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust;

36.1.2. a duty not to accept a benefit from a third party by reason of being a director or by reason of doing or not doing anything in that capacity.

36.2. The duty referred to in sub-paragraph 36.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.3. The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.4. In sub-paragraph 36.1.2 'third party' means a person other than the Trust or a person acting on its behalf.

36.5. If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors before the Trust enters into the transaction or arrangement.

36.6. If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

36.7. Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

36.8. This paragraph does not require a declaration of an interest of which the director is not aware, or where the director is not aware of the transaction or arrangement in question.

36.9. A director need not declare an interest –

36.9.1. if it cannot be reasonably regarded as likely to give rise to a conflict of interest;

36.9.2. if, or to the extent that, the directors are already aware of it;

36.9.3. if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors, or by a committee of the directors appointed for the purpose under the constitution.

37. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

37.1. The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

37.2. The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms of office, of the Chief Executive and the other executive directors.

37.3. The Chairman and other non-executive directors may be appointed for initial terms of up to 4 years, which may be renewed by the Council for a further term of up to 4 years, and may be renewed thereafter for such term, if any, as will bring the total length of service to 8 years. Where a director has served 8 years, his appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal.

38. REGISTERS

38.1. a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.

38.2. a register of members of the Council of Governors;

38.3. a register of interests of Governors;

38.3.1. a register of directors; and

38.3.2. a register of interests of directors.

39. PARAGRAPH 39 IS NOT USED

40. REGISTERS – INSPECTION AND COPIES

40.1. The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.

40.2. The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

40.2.1. any member of the Patients' Constituency; or

40.2.2. any other member of the Trust, if the member so requests.

40.3. So far as the registers are required to be made available:

40.3.1. They are to be available for inspection free of charge at all reasonable times; and

40.3.2. A person who requests a copy or extract from the registers is to be provided with a copy or extract.

40.4. If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

41. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

41.1. The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1. A copy of the current constitution;

41.1.2. A copy of the latest annual accounts and of any report of the auditor on them; and

41.1.3. A copy of the latest annual report.

41.2. The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.2.1. A copy of any order made under section 65D (appointment of special trust administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

41.2.2. A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

41.2.3. A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act;

41.2.4. A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

41.2.5. A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

41.2.6. A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

41.2.7. A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

41.2.8. A copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

41.2.9. A copy of any statement published under section 65J (power to extend time), or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

41.2.10. A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

41.3. Any person who requests a copy or extract from any of the above documents is to be provided with a copy.

41.4. If the person requesting an extract or copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. AUDITOR

42.1. The Trust shall have an auditor.

42.2. The Council of Governors shall appoint or remove the auditor at a general meeting of the Council.

42.3. The auditor must be qualified to act as auditor in accordance with paragraph 23 of schedule 7 to the 2006 Act.

42.4. The auditor shall comply with schedule 10 of the 2006 Act and shall have the rights and powers there set out.

42.5. The Trust shall provide the auditor with every facility and all information which he may reasonably require for the purpose of his functions.

43. AUDIT COMMITTEE

43.1. The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

44. ACCOUNTS

44.1. The Trust must keep proper accounts in such form as Monitor may with the approval of the Treasury direct and proper records in relation to those accounts.

44.2. Monitor may, with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

44.3. The accounts are to be audited by the Trust's auditor.

44.4. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

44.4.1. the accounts;

44.4.2. the records relating to them; and

44.4.3. any report of the Auditor on them.

44.5. The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as Monitor may with the approval of the Secretary of State for Health direct.

44.6. Monitor may with the approval of the Secretary of State for Health direct the Trust:

44.6.1. to prepare accounts in respect of such period or periods as may be specified in the direction; and/or

44.6.2. that any accounts prepared by it by virtue of sub-paragraph 44.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

44.7. In preparing its annual accounts or in preparing any accounts by virtue of sub-paragraph 44.6.1 above, the Trust is to comply with any directions given by Monitor with the approval of the Secretary of State for Health as to:

44.7.1. the methods and principles according to which the annual accounts are to be prepared; and/or

44.7.2. the content and form of the annual accounts

44.8. The Trust must –

44.8.1. lay a copy of the annual accounts, and any report of the Auditor on them, before Parliament; and

44.8.2. send copies of the annual accounts, and any report of the Auditor on them to Monitor within such a period as Monitor may direct

44.9. The Trust must send a copy of any accounts prepared by virtue of paragraph 44.6 above and a copy of any report of the Auditor to Monitor within such a period as Monitor may direct.

44.10. The functions of the Trust referred to in this paragraph 44 shall be delegated to the accounting officer.

45. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

45.1. The Trust shall prepare an annual report and send it to Monitor.

45.2. The annual report must give:

45.2.1. information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and of the patients' constituency is representative of those eligible for membership.

45.2.2. information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 19.5 hereof.

45.2.3. information on the corporation's policy on pay and on the work of the committee established under paragraph 37(2) hereof and such other procedures as the corporation has on pay.

45.2.4. information on the remuneration of the directors and on the expenses of the governors and the directors

45.2.5. any other information that Monitor requires

45.3. he Trust shall give information as to its forward planning in respect of each financial year to Monitor

45.4. The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

45.5. In preparing the document, the directors shall have regard to the views of the governors, and the directors shall provide the governors with information appropriate for them to be able to form their views.

45.6. Each forward plan must include information about:

45.6.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

45.6.2. the income it expects to receive from doing so.

45.7. Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 45.6.1, the Council of Governors must:

45.7.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

45.7.2. notify the directors of the Trust of its determination.

45.8. If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England, the Trust may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

46. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

46.1. The following documents are to be presented to the Council of Governors at a general meeting of the Council:

46.1.1. the annual accounts

46.1.2. any report of the auditor on them

46.1.3. the annual report.

46.2. The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

46.3. The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. INSTRUMENTS

47.1. The Trust shall have a seal.

47.2. The seal shall not be affixed except under the authority of the Board of Directors.

48. AMENDMENT OF THE CONSTITUTION

48.1. The Trust may make amendments of its constitution only if –

48.1.1. more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

48.1.2. more than half of the members of the Board of Directors of the Trust voting approve the amendments.

48.2. Amendments made under paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

48.3. Where amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

48.3.1. at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

48.3.2. the Trust must give the members an opportunity to vote on whether they approve the amendment.

48.4. If more than half of the members voting approve the amendment, the amendment continues to have effect. Otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

48.5. Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

49. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

49.1. The Trust may only apply for a merger, acquisition, separation or dissolution, as referred to in sections 56,56A, 56B, and 57A of the 2006 Act with the approval of more than half of the members of the Council of Governors.

49.2. The Trust may only enter a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

49.3. A ‘significant transaction’ is a transaction which, if entered into by the Trust:

49.3.1. would increase or reduce the turn-over of the Trust (in a financial year relative to the previous financial year) by £20 million or by 10%, whichever is the greatest;

49.3.2. would involve a receipt of or capital expenditure of £10 million or more; in the case of expenditure, this is after the deduction of any grant or gift which specifically relates to the expenditure in question;

49.3.3. would involve a service contract, asset rental or lease running for period of 3 years or more with a planned income or cost over its duration of £10 million or more.

49.3.4. would be likely to put at risk the Trust’s ability to provide its services as a whole, or a significant part of its services, to the appropriate regulatory standard;

49.3.5. would be likely to put at risk the Trust’s ability to maintain the minimum required financial risk rating/ continuity of service risk rating

49.4. Not used

49.4.1. Where it might reasonably be considered that a transaction falls within paragraph 49.3 the Board shall inform the Council of the transaction at the earliest opportunity.

49.4.2. The Board shall in any event inform the Council of a transaction which it is considering and which may involve a sum which is greater than 2% of the Trust’s income in the previous year, but the Board need not so inform the Council of any such transaction if the transaction has been clearly identified in the Annual Estimate, the Capital Programme or the Annual Plan.

49.5. In deciding whether to approve a proposed significant transaction the Council will:

49.5.1. act in accordance with its judgment of the best interests of the Trust; and

49.5.2. have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail.

49.6. If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council’s discussion of the transaction for and against approval shall be recorded in the minutes.

49.7. The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust’s income or capital in the previous year.

50. INDEMNITY

50.1. Members of the Council of Governors and of the Board of Directors who act honestly and in good faith will be indemnified by the Trust against any civil liability which is incurred in the execution or purported execution of their functions relating to the Trust, save where they have acted recklessly. The Trust shall take out insurance against liability under this indemnity.

51. DISPUTE RESOLUTION

51.1. In the event of a dispute arising between the Board of Directors and the Council, the Chairman shall take the advice of the Secretary and such other advice as he sees fit, and he shall confer with the Vice-Chairman and the Lead Governor and shall seek to resolve the dispute.

51.2. If the Chairman is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

51.3. If the dispute is not resolved, the Chairman may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 - THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
~~West Wiltshire~~	~~1~~	~~50~~
Salisbury City	3	50
South Wiltshire Rural	6~~5~~	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area covered by North Dorset District Council, comprising the following electoral wards: ▪ Blandford Damory Down ▪ Blandford Hilltop ▪ Blandford Old Town ▪ Blandford St Leonards ▪ Blandford Station ▪ Bourton & District ▪ Cranborne Chase ▪ Gillingham Lodbourne ▪ Gillingham Town ▪ Hillforts ▪ Milton ▪ Motcombe ▪ Marnhull ▪ Portman ▪ Riversdale ▪ The Beacon ▪ Shaftesbury Underhill ▪ Shaftesbury Central ▪ Shaftesbury Grosvenor ▪ Shaftesbury Christy's ▪ Stour Valley ▪ The Stours ▪ The Lower Tarrants ▪ Wyke
Kennet	The area formerly covered by Kennet District Council comprising the following electoral divisions: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South

	• Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings
New Forest	The following wards within New Forest District Council: ▪ Downlands & Forest ▪ Fordingbridge ▪ Forest North West ▪ Ringwood North ▪ Ringwood South ▪ Ringwood East & Sopley
~~West Wiltshire~~	~~The area covered by the former West Wiltshire District Council comprising the following electoral divisions:~~ ~~• Ethandune~~ ~~• Warminster Copheap & Wylye~~ ~~• Warminster East~~ ~~• Warminster West~~ ~~• Warminster Broadway~~ ~~• Warminster Without~~ ~~• Westbury West~~ ~~• Westbury North~~ ~~• Westbury East~~
Salisbury City	The following electoral divisions formerly covered by Salisbury District Council: • Bemerton • Fisherton & Bemerton Village • Harnham • St. Paul's • St. Francis & Stratford • St. Marks & Bishopdown • St. Edmund's & Milford • St. Martin's & Cathedral
South Wiltshire Rural	The following electoral divisions • Alderbury & Whiteparish • Amesbury West • Amesbury East • Bourne & Woodford Valley • Bulford, Allington & Figheldean • Durrington & Larkhill • Downton & Ebble Valley • Ethandune

	• Fovant & Chalke Valley • Laverstock, Ford & Old Sarum • Mere • Nadder & East Knoyle • Redlynch & Landford • Till & Wylye Valley • Tisbury • Warminster Copheap & Wylye • Warminster East • Warminster West • Warminster Broadway • Warminster Without • Westbury West • Westbury North • Westbury East • Wilton & Lower Wylye Valley • Winterslow
East Dorset	The following electoral wards within the area covered by East Dorset District Council: • Alderholt • Crane • Handley Vale • Holt • Newton • St. Leonards & St. Ives East • St. Leonards & St. Ives West • Three Legged [Cross] & Potterne • Verwood Dewlands • Verwood Stephen's Castle • West Moors
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 8).

The Staff Constituency is divided into 6 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUB GROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries
	Health Care Support Workers (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers
	Orthoptists
	Physiotherapists and Helpers
	Art/Music/Drama Therapists
	Speech and Language Therapists and Helpers
	Psychologists and Psychology Technicians
	Psychotherapists
	Medical Physicists and Technicians
	Pharmacists and Pharmacy Technicians
	Dental Technicians
	Operating Department Practitioners
	Social Workers
	Chaplains
	Clinical Scientists
	Biomedical Scientists and Technical Staff
	Geneticists and Technicians
	Audiology Staff
	Cardiographers and Support Staff
Hotel and Property Staff	Ancillary Staff
	Works and Maintenance Staff
	Ambulance Staff
Clerical, Administrative and Managerial Staff	
Voluntary Staff	

1. The minimum number of members of each class shall be 10.
2. The Secretary to the Trust shall assign persons to the classes set out above in accordance with the groups set out by each. In case of any difficulty the Secretary shall have discretion to allocate the person to the class which is in his opinion the most appropriate.
3. The Secretary shall maintain a register of volunteer schemes designated for the purposes of membership of the Trust.
4. A volunteer is a person who carries out functions on behalf of the Trust on a voluntary basis under a scheme on the register referred to in paragraph 4 above.
5. Where a person is eligible to be included both in the volunteers class and another class, the Secretary shall assign the person to that other class.

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

See paragraph 14.

1. There shall be 15 public governors as set out in Annex 1.
2. There shall be 6 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.
3. Wiltshire Council may appoint one governor by notice in writing signed by the senior executive of the Council.
4. There shall be one governor appointed by Wessex Community Action.
5. The following Clinical Commissioning Groups may each appoint one governor.
    a. Wiltshire
    b. Dorset
    c. West Hampshire
6. There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 15]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

PART 12: MISCELLANEOUS

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination forms may be obtained;
(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,
(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,
(b) their declaration of interests as required under rule 11, is true and correct, and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination form is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be

elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
    (i) configured in accordance with these rules; and
    (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;
(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
    (i) configured in accordance with these rules; and
    (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;
(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
    1. (i) configured in accordance with these rules; and
    2. (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from

that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

3.

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or

after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the

purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:
  (i) enter his or her voter ID number; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;
  in order to be able to cast his or her vote;
(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
  (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
  (v) instructions on how to vote and how to make a declaration of identity,
  (vi) the date and time of the close of the poll, and
  (vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;
(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
  (i) the voter’s voter ID number;
  (ii) the voter’s declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and
(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to
  (i) enter his or her voter ID number in order to be able to cast his or her vote; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;
(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected

from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;
(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;
(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;
(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote
(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,
(b) has no reason to doubt that the voter did not receive the original voting information,
(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:
(a) a covering envelope, or
(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,
before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

Notes

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes,
(d) the list of lost ballot documents,

(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

41-[NOT USED]

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

PP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if

an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he or she has declared elected:
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
    (ii) in any other case, to the chairman of the corporation; and
(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –
  (i) any rejected ballot papers, including ballot papers rejected in part,
  (ii) any rejected text voting records, including text voting records rejected in part,
  (iii) any disqualified documents, or the list of disqualified documents,
  (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
  (v) the list of eligible voters, or

4. (b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the

board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and
(ii) that Monitor has declared that the vote was invalid.

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates

standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 17)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation;

2. A person who is disqualified from being a company director under the laws of England and/or Wales;

3. A person who is a director of the Trust, or a governor, director, Chairman or chief executive of another NHS Foundation Trust or NHS Trust;

4. A person who is incapable by reason of mental disorder or illness or injury of managing his property and affairs;

5. A person who occupies the same household as an existing governor or a director of the Trust;

6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election, or becomes employed by the Trust

7. A person who has been removed from any list prepared under Part II of the National Health Service Act 1977, or has been removed from a list maintained pursuant to regulations made under section 28X of that Act, and has not been reinstated.

ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(See paragraph 20)

CONTENTS

1. INTRODUCTION

1.1. Paragraph 14 of Schedule 7 to the National Health Service Act 2006 provides that the constitution of an NHS foundation trust must make provision for the practice and procedure of the Council of Governors. The Council made such provision in its standing orders adopted in 2006. Paragraph 3.13 of those orders provided that they might be amended as there set out. At a meeting of the Council on 25 February 2013 in accordance with paragraph 3.13, these standing orders as set out herein were adopted in substitution of those orders.

2. INTERPRETATION

2.1. The expressions and terms used herein shall have the same meaning as in the Trust's Constitution.

2.2. 'The Constitution' means the constitution of the Trust.

2.3. 'The Council' means the Council of Governors.

2.4. A 'motion' means a formal proposition to be considered and voted on at a meeting of the Council.

2.5. An 'item for the agenda' means a matter to be considered at a meeting of the Council.

2.6. 'The Secretary' means the person appointed as the Secretary to the Trust.

3. MEETINGS OF THE COUNCIL

3.1. Paragraph 19.3 of the Constitution provides that meetings of the Council shall be open to members of the public but that the public may be excluded as there set out.

3.2. The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given.

3.3. If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4. Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5. Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. AGENDA ITEMS AND MOTIONS

4.1. Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chairman and the Lead Governor.

4.2. A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second

the motion, and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chairman of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3. A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the chairman of the meeting.

4.4. No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chairman of the Trust.

4.5. The proposer of a motion shall propose it and shall have a right to speak before a vote is taken.

4.6. During the consideration of a motion a governor may move:
- 4.6.1. an amendment to the motion;
- 4.6.2. that the consideration of motion be adjourned to a subsequent meeting;
- 4.6.3. that the motion be summarily dismissed and the meeting to proceed to the next business;
- 4.6.4. that the motion be voted on immediately.

4.7. No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the chairman of the meeting.

4.8 Save where the chairman of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. QUORUM

5.1. No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. RELEVANCE AND CONCISION

6.1. Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2. The chairman of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3. In any matter relating to the interpretation of the Constitution and Standing Orders the chairman of the meeting shall consider the advice of the Secretary.

7. VOTING

7.1. Save where it is otherwise provided by the constitution or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2. In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3. At the discretion of the chairman of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4. Save in the case of a secret paper ballot, if at least one third of the governors present request, the voting for and against of each governor shall be minuted.

7.5. If a governor requests, his vote shall be minuted.

7.6. No one may vote unless physically present: there shall be no votes by proxy.

8. MINUTES

8.1. Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting and signed by the chairman of that meeting.

8.2. The minutes shall record the names of those attending.

9. SUSPENSION OF STANDING ORDERS

9.1. Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the chairman of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2. A decision to suspend standing orders shall be recorded in the minutes.

9.3. A separate record of matters while the orders were suspended shall be made, and shall be provided to the governors with the minutes.

10. COMMITTEES

10.1. The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2. The powers of the Council may be delegated to a committee for a specific purpose if the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3. The powers of the Council shall be exercised in general meeting.

10.4. The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5. Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. NOMINATION COMMITTEES

11.1. Paragraph 28 of the Constitution provides for the appointment and removal of the Chairman of the Trust and the other non-executive directors by the Council. Paragraph 28.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2. For the appointment of the Chairman, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director

11.3. For the appointment of non-executive directors, the Nominations Committee shall consist of:

- the Chairman (or, at the Chairman's request the Deputy Chairman)
- 2 public governors
- 1 staff governor
- 1 appointed governor
- the Chief Executive.

11.4. When the formation of a Nomination committee is required the Secretary shall:

11.4.1. ask governors to put themselves forward as members within 10 days of his request, and if more governors put themselves forward than are places for particular categories of governor shall conduct an election or elections for each category with each governor having one vote in respect of each governor place on the committee;

11.4.2. In the case of a nomination for Chairman invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5. If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. DECLARATIONS AND REGISTER OF INTERESTS

12.1. Paragraph 22 of the Constitution provides for declarations of interest. It states:

22.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

22.2. For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

12.2. Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3. If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4. Subject to the exceptions below, material interests include:

12.4.1. any directorship of a company;

12.4.2. any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3. any interest in an organisation providing health and social care services to the National Health Service;

12.4.4. a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5. any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter

before the Council fairly.

12.5. The exceptions are:

12.5.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2. an employment contract with the Trust held by a staff governor;

12.5.3. an employment contract held with the appointing body by an appointed governor;

12.6. If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7. The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

12.8. The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9. If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the chairman of the meeting shall rule on the question having taken the advice of the Secretary.

12.10. A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11. A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 17.4 of the Constitution.

13. CODE OF CONDUCT

13.1. Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders, and shall at all times comply with the Code.

14. CONFIDENTIALITY

14.1. It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2. Governors must keep secure all confidential matter recorded on paper or electronically, and must ensure that their NHS mail and forum details are not disclosed.

14.3. Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4. The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5. A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the

information has entered the public domain.

14.6. Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. EXPENSES

15.1. Paragraph 23 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2. Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3. The total of the expenses paid to governors will be published in the Annual Report.

16. LEAD AND DEPUTY LEAD GOVERNOR'S APPOINTMENT

16.1. The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR - ROLES

17.1. The role of the Lead Governor is:

17.1.1. to chair meetings of the Council which cannot for any reason be chaired by the Chairman or the Deputy Chairman;

17.1.2. to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chairman;

17.1.3. to communicate regularly with the Chairman, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4. to be a point of contact for Monitor when appropriate;

17.1.5. to provide input into the appraisal of the Chairman;

17.1.6. to take an active role in the activities of the Council;

17.1.7. to be a point of contact for governors when they have concerns;

17.2. The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. LEAD AND DEPUTY LEAD GOVERNORS - VOTE OF NO CONFIDENCE

18.1. If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor and present it to the Chairman, the Chairman shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2. The Chairman will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting.

18.3. The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4. At the meeting the Chairman will present the reasons for the motion and it will

be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5. A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governors present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6. A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. DIRECTORS' ATTENDANCE

19.1. Paragraph 19.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2. The attendance of a director pursuant to paragraph 19.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chairman. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. FORWARD PLAN

20.1. Paragraph 45.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2. The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3. The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting.

21. AMENDMENT OF STANDING ORDERS

21.1. Paragraph 20.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2. The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3. No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;

2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;

3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;

4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;

5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;

6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;

7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;

8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;

9. Recognise that the Trust is a non-political organisation;

10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;

11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;

12. Comply with the Council's Standing Orders;

13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;

14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    (a) before making any statement for publication in the media a governor should take the advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    (b) any request by the media for comment should be forwarded to the Trust's press officer;
    (c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer

rather than responding himself;

(d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;

15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Governor's undertaking

I, , of ,
undertake as a governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed Date

ANNEX 9 – ADDITIONAL PROVISIONS - DIRECTORS – DISQUALIFICATION

(See Paragraph 33)

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

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	06 February 2020		

Report Title:	Board Evaluation			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	Appendix 1: Board member questionnaire results Appendix 2: Good Governance Maturity Matrix			

Recommendation:

The Board members are asked to:

- Consider the information presented;
- Consider how effective the Board is in delivering its priorities and setting the culture of the organisation; and
- Agree specific actions to support further Board development.

Executive Summary:

The NHS FT Code of Governance sets out the requirements that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

In order to do this, the Board should use a range of information to determine whether they are working effectively. The Board agreed at the August 2019 Trust Board meeting that the following evidence should inform the board evaluation:

- Facilitated 360 review
- Board member questionnaire
- Board member self-assessment against the Good Governance Maturity Matrix
- Annual report 2018/19 overview of performance
- Review of board papers – the purpose of papers to better understand the balance of items being considered

This paper seeks to set out the evidence to support a discussion about the Board's

effectiveness.

The evidence presented helps to demonstrate that the Board is operating to a satisfactory standard with a higher level of maturity in relation to Board governance, probity and reputation and quality performance.

The evidence suggests that the following are areas which could inform further Board development and the Board may wish to discuss and prioritise:

- Ensuring that the Board is representative of the population it serves.
- Ensuring appropriate succession planning for key Board members and that Board members are appraised and inducted effectively.
- Board members have timely, high quality information which supports decision making.
- Ensuring that the Board operates strategically and that it focuses time on issues that only it can consider, and that the balance of assurance activities and driving improvement is correct.
- Board members are actively involved in establishing the organisation's risk appetite.
- Ensuring consistency of delivery against all standards; quality, operations, finance and workforce and that there are adequate resources to achieve this.
- Ensuring that there is a robust framework for the Board to evaluate its own performance and to set clear objectives for itself.
- Ensuring strong partnership arrangements which include communicating more proactively with key stakeholders and taking account of these views.

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

1 Purpose

1.1 To provide a suite of evidence to support a discussion about the effectiveness of the Board and any actions to inform the Board Development Programme.

2 Background

2.1 The NHS FT Code of Governance sets out the requirements that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

In order to do this, the Board should use a range of information to determine whether they are working effectively. The Board agreed at the August 2019 Trust Board meeting that the following evidence should inform the board evaluation:

- Facilitated 360 review
- Board member questionnaire (Appendix 1)
- Board member self-assessment against the Good Governance Maturity Matrix (Appendix 2)
- Annual report 2018/19 overview of performance
- Review of board papers – the purpose of papers to better understand the balance of items being considered

2.2 This paper seeks to set out the evidence to support a discussion about the Board's effectiveness.

3 Evidence Summary

3.1 Facilitated 360 Review

A 360 review will form part of this process and is currently being established. A group report will be produced at the end of the review process which will be reviewed in light of the conclusions drawn in this report.

3.2 Board Member Questionnaire

All Board members were requested to complete a questionnaire which sought to help the Trust better understand how, from an individual perspective, the Board was operating. A summary of the average scores for each question can be found at Appendix 1. Those questions with an average score of less than 4 are highlighted below (in ascending order). All 13 Board members completed the questionnaire. Of the 44 questions, 34 had an average score of less than 4. If the action is being addressed through an existing programme of work, this is indicated in green in the table below. Actions not already within existing work programmes will need to take priority.

	Question	**Score**
7.	There is appropriate succession planning for key Board members and senior executives.	2.46
10.	Board members receive proper induction on appointment and ongoing training is available to meet development needs.	2.83
5b.	The Board is made up of individuals from a diversity of	2.84

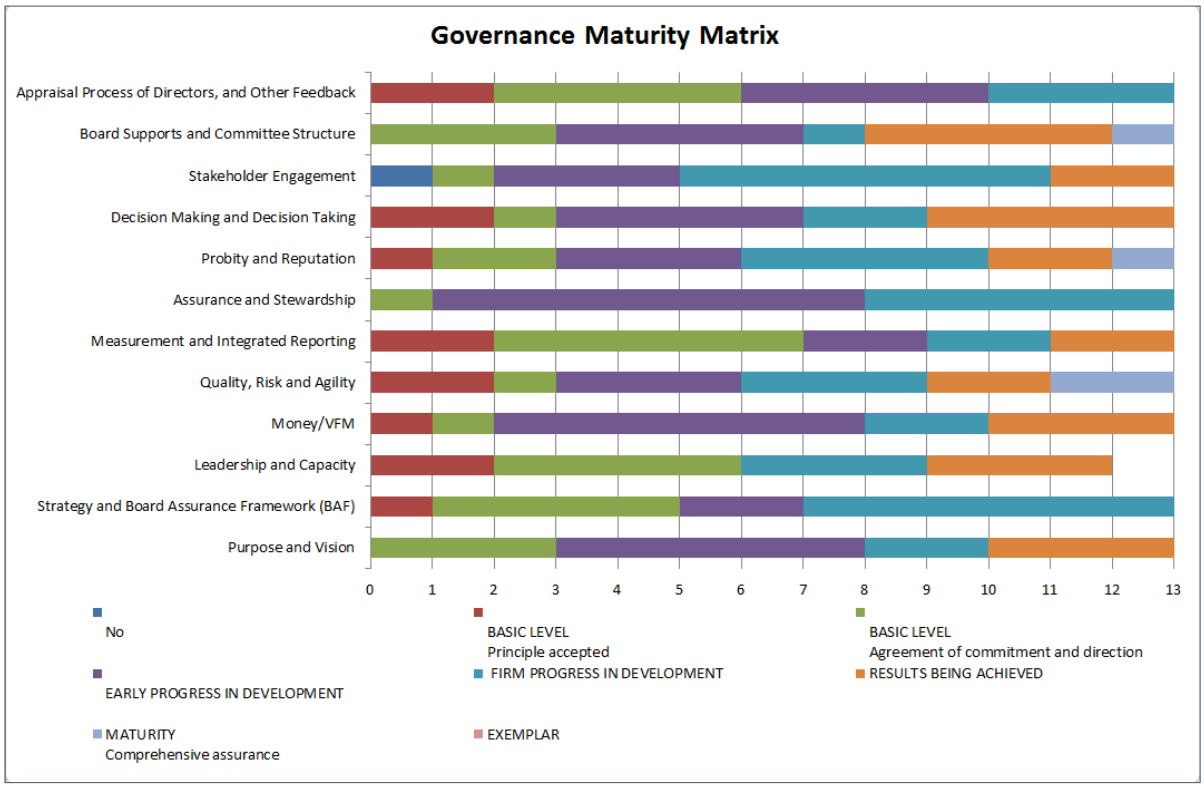
	gender, background and psychological type.	
27b.	The Board carries out a rigorous annual evaluation of its own performance; and	2.84
17a.	The Board has appropriate data to monitor the organisation's performance, including around quality, operational, financial and workforce which includes appropriate benchmarking with peers; and	2.92
	This is being addressed through the well-led action plan	
17b.	Uses the available data effectively.	2.92
	This is being addressed through the well-led action plan	
21a.	The Board communicates effectively with all of the organisation's stakeholders and takes into account their interests;	3.07
11b.	Board information is of a quality that enables the Board to determine whether the organisation is on track to meet its strategic objectives and is acting within its risk appetite	3.15
	This is being addressed through the well-led action plan	
15b.	The Board ensures the necessary financial and human resources are in place to implement them (strategic aims).	3.15
16a.	The Board is sufficiently involved in establishing the organisation's appetite for risk in respect of its strategic aims	3.15
21c.	Reports on Board effectiveness including the role of the chairman, diversity, succession planning and Board evaluation.	3.15
16b.	The Board satisfies itself that the integrity of the financial controls and systems of risk management are robust and resilient.	3.30
27a.	The Board sets itself objectives	3.30
27c.	There is effective external facilitation at least every third year	3.30
25a.	The Executive Directors carry out their duties as directors as members of the Board rather than as senior management	3.31
12b.	The board sets an appropriate tone from the top that permeates through the organisation	3.46
25b.	Executive Directors represent an effective link through to senior management.	3.46
	This is being addressed through the well-led action plan	
5a.	The Board has an appropriate mix of skills, experience, and knowledge	3.53
9.	Non-executive Directors are able to commit sufficient time to the organisation to discharge their responsibilities effectively	3.53
11a.	The information that is supplied to the Board is provided on a timely basis	3.53
13.	Board meetings are characterised by a high quality of debate with robust and probing discussions and no 'no-go areas'	3.53
20a.	The Board makes well-informed high quality decisions based on clear line of sight into the business; and	3.53
20b.	Appropriate processes are used to facilitate complex	3.53

	judgements – for example obtaining input from experts, establishing separate sub-committees or allowing additional time for debate and decision-making.	
4b.	The Board's committees are subject to appropriate revision	3.69
19.	The Board is involved in major developments in the business in the right level of detail and at the right time.	3.69
4a.	The Board's committees are properly constituted and perform their delegated roles under clear terms of reference;	3.76
14.	All Board members have a clear understanding of the organisation's core business and strategic direction.	3.76
15a.	The Board sets the organisation's strategic aims robustly and effectively, with appropriate challenge from the Non-executive Directors	3.76
2b.	Board members attend and actively contribute at meetings	3.84
4c.	The Board's committees report back effectively and promptly to the Board, with sufficient time for the Board to consider matters arising.	3.84
24.	The SID is effective and fulfils the role in a way commensurate with the circumstances of the Board.	3.91
3.	The Board's role, responsibilities, and matters that it has reserved, are clearly defined	3.92

The main themes arising from the comments provided by members as part of the questionnaire related to data quality and availability and effective use of data, Board stewardship, diversity of the Board, risk appetite, succession planning and Board evaluation.

3.3 Board Maturity

The Board members have considered where they believe the Board sits against the maturity matrix for NHS Trust Boards as published by the Good Governance Institute. The results of this assessment are shown below:



The results of the maturity assessment indicate that the Board view a higher level of maturity in relation to:

- Board supports and committee structures
- Probity and reputation
- Quality, risk and agility

The results indicate that the following areas could require additional focus:

- Appraisal process of directors and other feedback
- Assurance and stewardship
- Measurement and integrated reporting
- Strategy and Board Assurance Framework
- Money/VFM
- Purpose and vision

3.4 <u>Annual Report 2018/19 overview of performance</u>

The latest annual report includes the following statements within the Chief Executive summary:

Once again, it has been a busy and eventful twelve months. Patient safety remained our first priority in care; in 2018/19 there was significant work undertaken to improve levels of safety and respond to the feedback we had received over previous years.

Similarly, over the last year steps have been taken to support the achievement of the core cancer standards (two week wait, 31 day and 62 day), with a particular focus on pathway redesign and making transformational change rather than managing issues on a small scale.

Our approach has reaped results. The Care Quality Commission (CQC) gave us an overall rating of 'Good' following their inspections in 2018/19. The Trust had an unannounced inspection of four core services in November 2018; urgent and emergency services, surgery, critical care and spinal services. This was followed by an inspection of 'use of resources' and a 'well-led' review in December 2018.

Although there is much to celebrate, it has not all been plain sailing; we have had our challenges. Later in this report there are references to the Trust's response to a well-publicised major incident that started in the previous financial year and continued in 2018/19. For our staff it was business as usual, whatever area of the Trust they worked in – doing their best to provide an outstanding experience for every patient. I (*CEO)* am proud to be able to report that despite being at the centre of the longest running major incident in the 70 year history of the NHS, our doors stayed open through-out.

In addition, the performance analysis states:

The Trust's performance is monitored against key national standards. In addition, our Board of Directors review progress against a range of internal and external metrics through our Integrated Performance Report.

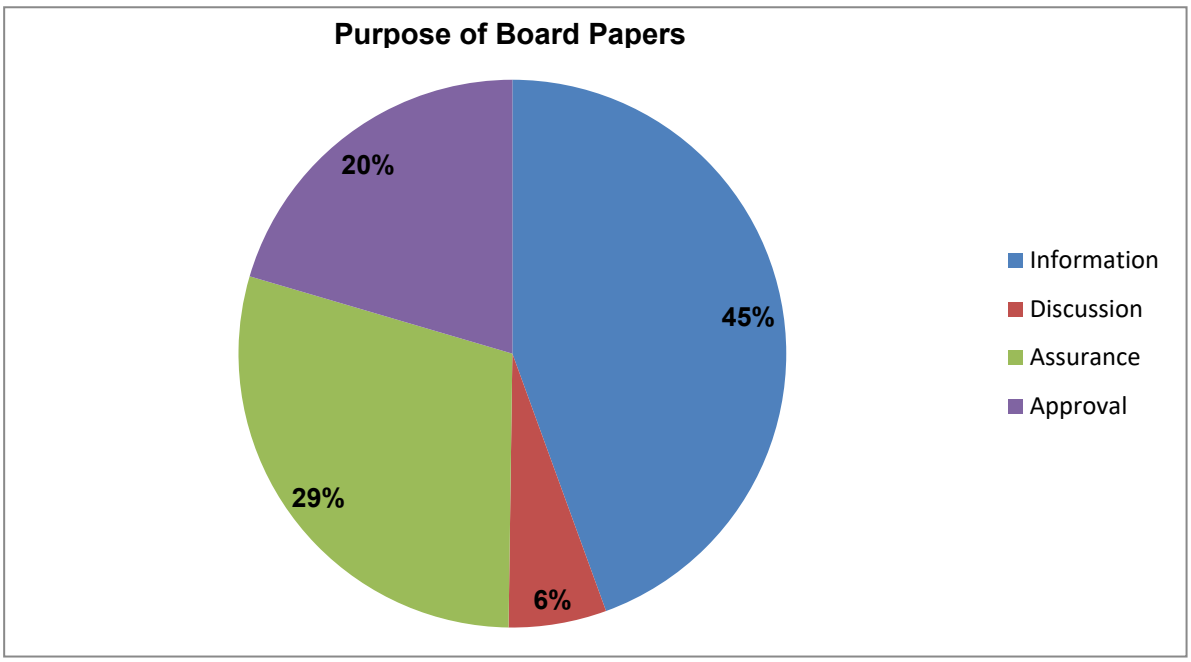
The key indicators relate to waiting times and access to treatment, which are monitored monthly by the Trust Board. During 2018/19 the Trust still performed well against its main targets. For every month of the 2018/19 year the Trust has met the target for patients waiting less than 18 weeks from the point of referral from GP. Despite some challenges in capacity for endoscopy the Trust delivered the diagnostic standard of 6 weeks in 8 out of 12 months and finished the year delivering the standard.

The Trust ended the year delivering the 2 week wait and 31 day cancer standards. Due to some challenges around capacity in Head and Neck and Urology cancer pathways the Trust has not delivered the 62 day standard, with 82% of patients being treated within 62 days of GP referral against a standard of 85%.

Throughout the year emergency attendances to the hospital have been high and the south Wiltshire system continues to struggle with capacity to discharge patient in a timely way. Despite this the Trust has continued to perform well when compared nationally, with 91% of patients being admitted or discharged within 4 hours against a standard of 95%.

3.5 Review of Board Papers

The Corporate Governance Team has undertaken a review of the purpose of Board papers from June 2018 to June 2019 to better understand the balance of items being considered. This analysis demonstrated the following:



- The majority of papers (45%) were for information.
- 20% of papers were for approval/decision.

Whilst it is recognised that the content of the papers is not reflected in this analysis, it provides a high level indication of the balance of the Board's time.

4 Summary

4.1 The evidence presented helps to demonstrate that the Board is operating to a satisfactory standard with a higher level of maturity in relation to Board governance, probity and reputation and quality performance.

4.2 The evidence suggests that the following are areas which could inform further Board development and the Board may wish to discuss and prioritise:

- Ensuring that the Board is representative of the population it serves.
- Ensuring appropriate succession planning for key Board members and that Board members are appraised and inducted effectively.
- Board members have timely, high quality information which supports decision making.
- Ensuring that the Board operates strategically and that it focuses time on issues that only it can consider, and that the balance of assurance activities and driving improvement is correct.
- Board members are actively involved in establishing the organisation's risk appetite.
- Ensuring consistency of delivery against all standards; quality, operations, finance and workforce and that there are adequate resources to achieve this.
- Ensuring that there is a robust framework for the Board to evaluate its own performance and to set clear objectives for itself.
- Ensuring strong partnership arrangements which include communicating more proactively with key stakeholders and taking account of these views.

5 Recommendations

5.1 The Board is asked to:

- Consider the information presented
- Consider how effective it has been in delivering its priorities and setting the culture of the organisation
- Agree specific actions to support further Board development

Fiona McNeight
Director of Corporate Governance

Appendix 1

A	COMPOSITION AND PROCESSES	Average score
1.	**Size of Board**	
	The Board is of sufficient size that the requirements of the business can be met, without being so large as to be unwieldy	4.07
2.	**Meetings**	
a)	The number of meetings of the Board is appropriate, including ad hoc meetings where necessary.	4.23
b)	Board members attend and actively contribute at meetings	3.84
3.	**Terms of reference**	
	The Board's role, responsibilities, and matters that it has reserved, are clearly defined	3.92
4.	**Committees of the Board**	
a)	The Board's committees are properly constituted and perform their delegated roles under clear terms of reference;	3.76
b)	Are subject to appropriate revision; and	3.69
c)	Report back effectively and promptly to the Board, with sufficient time for the Board to consider matters arising.	3.84
5.	**Mix of skills, experience and knowledge & diversity**	
a)	The Board has an appropriate mix of skills, experience, and knowledge;	3.53
b)	Is made up of individuals from a diversity of gender, background and psychological type.	2.84
6.	**Independence**	
	The Board has the right balance of independent Non-executive Directors and Executive Directors.	3.84
7.	**Succession planning**	
	There is appropriate succession planning for key Board members and senior executives.	2.46
8.	**Appointment process**	
	There is a formal, rigorous and transparent process for the appointment of new directors to the Board.	4.15
9.	**Time commitment**	
	Non-executive Directors are able to commit sufficient time to the organisation to discharge their responsibilities effectively	3.53
10.	**Induction and training**	
	Board members receive proper induction on appointment and ongoing training is available to meet development needs.	2.83
11.	**Timeliness and quality of information**	
	The information that is supplied to the Board is:	
a)	Provided on a timely basis; and	3.53
b)	Of a quality that enables the Board to determine whether the organisation is on track to meet its strategic objectives and is acting within its risk appetite	3.15
B	**BEHAVIOURS AND ACTIVITIES**	
12.		
a)	The Board operates in line with the values of the organisation; and	4.15
b)	Sets an appropriate tone from the top that permeates through the organisation	3.46
13.	**Board discussions**	
	Board meetings are characterised by a high quality of debate with robust and probing discussions and no 'no-go areas'	3.53

14.	**Understanding of the business**	
	All Board members have a clear understanding of the organisation's core business and strategic direction.	3.76
15.	**Setting strategy**	
a)	The Board sets the organisation's strategic aims robustly and effectively, with appropriate challenge from the Non-executive Directors; and	3.76
b)	Ensures the necessary financial and human resources are in place to implement them.	3.15
16.	**Risk appetite and risk management**	
a)	The Board is sufficiently involved in establishing the organisation's appetite for risk in respect of its strategic aims; and	3.15
b)	Satisfies itself that the integrity of the financial controls and systems of risk management are robust and resilient.	3.30
17.	**Monitoring performance**	
a)	The Board has appropriate data to monitor the organisation's performance, including around quality, operational, financial and workforce which includes appropriate benchmarking with peers; and	2.92
b)	Uses the available data effectively.	2.92
18.	**Crisis management**	
	The Board responds positively and constructively in the event of a crisis, and has well-established business continuity and disaster recovery plans	4.30
19.	**Major developments and transactions**	
	The Board is involved in major developments in the business in the right level of detail and at the right time.	3.69
20.	**Quality of decision-making**	
a)	The Board makes well-informed high quality decisions based on clear line of sight into the business; and	3.53
b)	Appropriate processes are used to facilitate complex judgements – for example obtaining input from experts, establishing separate sub-committees or allowing additional time for debate and decision-making.	3.53
21.	**Demonstrating the Board's stewardship**	
a)	The Board communicates effectively with all of the organisation's stakeholders and takes into account their interests;	3.07
b)	Exhibits a leadership style and tone that promotes effective decision making, constructive debate and ensures that the Board works as a team; and	3.77
c)	Reports on Board effectiveness including the role of the chairman, diversity, succession planning and Board evaluation.	3.15
22.	**Role of the Chairman**	
a)	The Chairman has sufficient time to commit to the role;	4.16
b)	Exhibits a leadership style and tone that promotes effective decision making, constructive debate and ensures that the Board works as a team; and	4.16
c)	Sets an effective agenda for the Board and ensures it is debated fully.	4.08
23.	**Chairman and CEO relationship**	
	The Chairman and the Chief Executive work well together and their different skills and experience complement each other.	4.38
24.	**Role of the Senior Independent Director ('SID')**	
	The SID is effective and fulfils the role in a way commensurate with the circumstances of the Board.	3.91
25.	**Executive directors**	

a)	The Executive Directors carry out their duties as directors as members of the Board rather than as senior management; but also	3.31
b)	Represent an effective link through to senior management.	3.46
26.	**Trust Secretary**	
	The Trust Secretary is effective and works well with the Chairman, Non-Executive Directors and Executive Directors.	4.15
27.	**Performance evaluation**	
a)	The Board sets itself objectives;	3.30
b)	Carries out a rigorous annual evaluation of its own performance; and	2.84
c)	There is effective external facilitation at least every third year	3.30

Appendix 2: Good Governance Maturity Matrix

Good Governance Institute

NHS TRUST BOARD
GOOD GOVERNANCE MATURITY MATRIX

AUGUST 2017

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
PURPOSE AND VISION	No	Purpose, values, and drivers are debated and priorities are being formulated. The board is involved in shaping these discussions demonstrating quality as a fundamental driver.	Our purpose and vision are agreed, and affirmed in public and internal / partnership documents. The board has an agreed set of values / principles.	National targets and local priorities agreed with stakeholders. Variance from HWB and commissioners plans / priorities recognised and explained.	The board has a robust and inclusive mechanism for adding and removing services and / or changing care settings that matches agreed purpose, values and priorities.	We can evidence that sustained progress towards the vision is being made. Our purpose and vision are systematically revisited as board membership changes or at least annually.	Partner organisations and internal stakeholders understand and support the purpose and vision of the organisation. Strategic decisions do not change our fundamentals.	Success has allowed trust / board to redefine / extend its role. We are able to consistently influence other organisations to meet our own and our wider stakeholders purpose.
STRATEGY AND BOARD ASSURANCE FRAMEWORK (BAF)	No	Our strategic objectives are agreed by the board and have been tested with our partners. Formal strategic planning is in place and is able to address HWB and CCG priorities.	The strategy is owned and agreed by the board, after canvassing views and input from commissioners, partners and other stakeholders.	The BAF is used as the key instrument to grasp strategic focus. Operational plans reflect trajectory milestones against agreed strategy.	Progress against our objectives is made during year. The board has protected long-term priorities from short-term pressures.	The board is continually testing how changing environment effects the delivery of its strategy. First goals being met.	We can evidence that strategic aims are being adhered to, meeting agreed milestones on trajectory.	The trust / board is able to demonstrate consistent achievement of strategic goals over the last 3 years.
LEADERSHIP AND CAPACITY	No	Role profiles for all board members agreed and understood, with specific job descriptions agreed.	We have undertaken a skills assessment of our board linked to the succession plan. A planned board development programme is in place.	Our board development programme is based on prior systematic review. Clinical leadership accepts accountability for delivery against strategic objectives. Assessment and PDPs are in place for board members.	Succession plan in place. Individual PDPs for directors being delivered.	The board is confident it is visible. The organisation is leading rather than following local development agenda.	The organisation is identified as well led throughout and as health and wellbeing system leader in local economy.	The board is considered a national leader, providing buddying support and examples to provider chains and other organisations.
MONEY/VFM	No	Budget, cost pressures and efficiency targets are clearly identified and understood by the board.	All in-year plans are costed and trajectory of spend / savings have been established to achieve breakeven / target. Quality implications are robustly tested.	The organisation has a record of meeting planned cost reductions / CIPs and agreed investments, whilst rejecting proposals with an unacceptable impact on quality.	The board is demonstrably reinvesting whole budget, rather than being limited by 'affordability' at margins.	Unexpected in year pressures are identified and the board show timely reprioritisation of deliverables.	Our services consistently run under benchmark cost. Headroom is created for developments / improvements.	We successfully leverage wider community resources to improve service delivery and outcomes.
QUALITY, RISK AND AGILITY	No	Known risks are identified and continuity plans in place. The board understands risk as a comprehensive strategic instrument.	A forward-looking risk system is in place for the board identifying both threats and opportunities. Quality impact is embedded in systems.	Risk appetite for key issues such as safe staffing levels is known and built into plans/BAF.	Continuity plans and 'what if?' scenarios are regularly tested to respond to material issues and opportunities.	The board is confident it can both anticipate and respond to a crisis/opportunity in timely fashion. The organisation can provide case studies of successful escalation and intervention.	The board is able to measure and demonstrate risk appreciation by avoiding or rapidly responding to predictable incidents.	The board has a successful and demonstrable risk mitigation track record. Organisational systems respond well to unknowns as they occur.

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PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
MEASUREMENT AND INTEGRATED REPORTING	No	The board understands and recognises the value of quality assured processed data. Board reports are accurate and timely.	Resources are aligned to sustainable targets, standards and local priorities. All board papers integrate activity, cost, quality and transformation agendas. the BAF and board reporting relate.	The board has agreed public reporting for social, economic and environmental impact / opportunities (integrated reporting).	Health improvement / harm reduction targets are agreed. Systematic outcome-related reporting to board and stakeholders is in place. The board is confident it understands how it deploys its capitals.	Annual review of the board demonstrates candid self awareness and progress against agreed action plans / deliverables.	The board systematically receives reports from stakeholders providing feedback of impact of plan implementation.	The organisation benchmarks as a national leader in terms of positive impact on local health economy.
ASSURANCE AND STEWARDSHIP	No	An integrated audit committee is in place, with an annual cycle of business agreed. The board assures itself that its Assurance Framework is balanced and can reflect changing priorities.	Control mechanisms are in place for the entire BAF. The board has identified, agreed and owns assurances. Annual review of the audit committee, and of committee cycles of business agreed by the board.	Independent assurance is systematically sought through internal and clinical audit. All regulatory compliances, tests and actions met or explained.	The board annually delegates / confirms tolerance levels for assurance to sub-committees. The board can demonstrate robust scrutiny.	The organisation is able to invest significant resources derived from its own savings / service change to community wellbeing, research, innovation and staff development.	The board is confident it has evidence based, intelligent analysis and assurance of all systems and drivers across the health economy.	The organisation benchmarks as a national leader in terms of sustainable outcomes and impact against resources.
PROBITY AND REPUTATION	No	Standards of Conduct for the board are explicit and accepted. Plans are in place to manage conflicts of interest.	Our conflicts of interest system includes board and senior staff, is up-to-date and records actions.	The board has third party evidence of its reputation and standing. Risk appetite thinking includes reputation.	Probity is expected of all partners, suppliers and providers and this is written into contracts.	Reputational risk is considered in scenario and 'what if?' exercises. Reputational risk appetite is agreed.	The organisation seeks and acquires good governance recognition by independent authority.	The organisation is able to demonstrate how its high-standing benefits achievement of the strategy including recruitment and partnership working.
DECISION-MAKING AND DECISION-TAKING	No	Decision-making includes appropriate consultation and option/impact appraisal.	Information processing and analysis is focussed on evidence. The board and committee agendas reflect materiality.	Integrated information, audit, assurance and risk-assessments are used by board.	The board consistently takes decisions based on materiality and evidence.	We can evidence that the board and staff are confident that decisions are taken in a robust, transparent manner. Assurances are made available to stakeholders.	The audit committee has reviewed the key decisions of the board and delegated committees for robustness and alignment.	The board is able to successfully to influence national decision taking on policy and priorities.
STAKEHOLDER ENGAGEMENT	No	An engagement policy and strategy is in place based on stakeholder mapping.	Service user, staff, public and partner engagement is recognised as a resource to focus, design and deliver service improvement.	Membership targets met and a board of governors / users panel in place with own development plans.	Stakeholders confirm the organisation effectively engages with them and this is reflected in strategies and plans. Governors' contribution is valued.	Governance between organisations issues regularly tested with partners.	Partners, service users and the local public trust organisation. The organisation is seen as employer of choice.	The organisation recognised as a national leader in effective engagement with stakeholders.
BOARD SUPPORTS AND COMMITTEE STRUCTURES	No	The audit committee's role is developed to take on the independent scrutiny function. Committee structure confirmed by last annual board review.	The board secretary or other holds compliance and tracking role for all assurance issues of the board. A SID has been appointed from the NEDs.	Workload and agendas for committees have been planned and task groups have time-limited existence.	The audit committee is meeting at least 'firm progress' against the audit committee matrix. Internal and external auditors and advisors aligned to agenda and role.	The annual cycle of board business is reviewed at year-end, planned activities are completed and developed roles are refreshed.	The overall time investment in board and committees is reduced through organisation effectiveness.	The board's systems adopted by others as examples of good governance practice.
APPRAISAL PROCESS OF DIRECTORS, AND OTHER FEEDBACK	No	Board member roles are understood and explicit.	A board induction and development process is in place and working. An annual board review has been conducted and actioned.	Third party views are included in the annual board review process. The chair reviews board contribution of all the executives.	Annual review and director appraisal has informed current board development programme which is clearly actioned.	Systematic feedback is sought on the added value of board. Exit interviews are always offered.	The board is recognised as adding value by CEO and stakeholders.	The board is recognised 'as public appointment of choice' nationally.

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Report to:	Trust Board (Public)	**Agenda item:**	**4.3**
Date of Meeting:	6 February 2020		

Report Title:	Emergency Preparedness Resilience & Response (EPRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Tracey Merrifield – EPRR Manager			
Executive Sponsor (presenting):	Andy Hyett – EPRR Accountable Officer			
Appendices (list if applicable):	None			

Recommendation:

Recommendations:
The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to sign off this annual EPRR assurance report as part of the NHSE/I assurance process.

Purpose of Report:
To provide assurance to the Trust Board as part of the National EPRR Assurance process. The Trusts self-assessment against the National EPRR Core Standards has been confirmed by Wiltshire CCG and approved by NHSE/I, as delivering FULL assurance.

This report, through a summary of EPRR activity, including the assurance process and training and exercising demonstrates our compliance.

Background:
The Trust is defined as a category 1 responder under the Civil Contingencies Act and is subject to civil protection duties discharged through the EPRR assurance process.

Executive Summary:

Based on the National RAG status for EPRR compliance SFT has been rated by Wiltshire CCG and NHSE/I as 'Fully' compliant for the third consecutive year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Fully compliant means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve to the minimum level.

1. Purpose

This paper provides an annual report on the Trust's emergency preparedness in order to meet our statutory requirements of the Civil Contingencies Act (CCA) (2004) and the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework 2015 and NHS England Business Continuity Framework.

2. Background & Statutory Framework

The Civil Contingencies Act outlines a single framework and establishes clear roles and responsibilities. SFT are defined as a category 1 responder in the CCA and is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place Emergency Plans;
- Put in place Business Continuity Arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with local responders to enhance co-ordination;
- Co-operate with other local responders to enhance coordination

3. National EPRR Framework & Core Standards

The NHS England EPRR Frameworks contain principles for health emergency planning for the NHS in England and the NHS Core Standards for EPRR provides the minimum standards that an NHS organisation must meet.
It is expected that that the level of preparedness will be proportionate to the role of the organisation and the services provided:

- SFT must meet the minimum core standards and provide evidence these standards are being met
- SFT must identify an Accountable Office (Chief Operating Officer) who is responsible for ensuring these standards are met

4. Wiltshire and Swindon EPRR Assurance process 2019-20

The responsibility for undertaking the local assurance process for SFT was undertaken by the Wiltshire Clinical Commissioning Group (CCG) in conjunction with NHSE/I. SFT provided the CCG with a core standard spreadsheet with each standard RAG rated with supporting evidence to support this rating.
Our self-assessment stated (August 2019): As part of the national EPRR assurance process for 2019/20, Salisbury NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 64 of the core standards which are applicable to the organisation, Salisbury NHS Foundation Trust:

- Is compliant with all 64 of the core standards: - the overall rating is 'Full'

The CCG conducted the 'confirm and challenge' meeting on 23rd August 2019, with Julie-Anne Wales, Head of Corporate Governance and Planning, Wiltshire CCG, Louise Cadle, Interim Head of EPRR, NHSE/I and Andy Ewens, EPRR Manager NHSE/I SW.

The outcome letter detailed areas of good practice within the EPRR agenda at SFT:

- Strong governance and robust planning arrangements in place.
- Lessons identified are built upon and processes improved with good examples The right healthcare, for you, with you, near you listed e.g. snow debrief and liaison post the event with Wiltshire Council, Salisbury REDS (local bus company) and the voluntary sector. Also, information sharing protocols because of the Novichok incidents of 2018 and the demands from agencies including police for information.
- Horizon scanning plays an important part of planning and risk assessment e.g. during planning for National Armed Forces Day (not what you would think to be the immediate concern for an Acute – not only was A&E prepared but work was undertaken 2019 to ensure mortuary capacity was available).
- Peer review of procedures takes place e.g. Lockdown procedures tested with Portsmouth Hospitals Trust.
- Use of all staff to support major incident (not just the frontline staff) e.g. Informatics Trainers used to assist with the management of Lorenzo (patient system).
- CBRN training is innovative with staff wearing Personal Respiratory Protective Suits Personal Protective Equipment and playing games to gain confidence in wearing the kit and enabling them to experience a period in the kit in a fun environment.
- It should be noted that Trustees of the Trust have also funded the purchase of an Emergo kit which will undoubtedly offer SFT the opportunity to unreservedly test the internal procedures in small and large exercises.

The final outcome letter was received on 30th October with the final compliance rating for SFT for EPRR Core Standards 2019/20 based on the National RAG status for EPRR compliance stating that SFT are rated in the 'Fully' category. See figure 1 below for compliance levels:

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.

Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis

Figure 1:

5. Training & Exercising

Statutory requirement set out that the Trust will undertake:

- Live Exercise – Every 3 years
- Table Top Exercise – Yearly
- Communication Test – Every 6 months

A variety of training and exercising and live events have taken place in the last year, including the continued recovery from the major incident responses which concluded 31st May 2019.

See tables below in relation to training and awareness and exercises and live incidents:

Table 1: Training Completed October 2018 – to date

Type of Training/Awareness	Audience/Description	Date
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EPRR Duty Manager Training	2 Duty Managers	12th November 2018
EPRR Duty Manager Training	2 Duty Managers	15th November 2018
LRF Multi Agency Operational Training (MAOT)	2 Duty Managers	20th November 2018
Exercise Evolving CBRN Consequence Training	ED CBRN Lead & EPRR Manager	8th November
HHFT Emergo multi agency teleconference	EPRR Manager	21st November 2018
EPRR Duty Manager Refresher Training	1 Duty Manager	4th December 2018
SWAST CBRN & PRPS Train the Trainer	2 staff	30th January 2019
Exercise Kite Emergo Mass Casualty	7 attended – Representation from: ED, ITU, Anaesthetics, paediatrics, clinical site	27th February 2019
Exercise Crossley Green	EPRR Manager & Duty	28th February 2019

MTFA TCG	Manager	
Exercise Manoeuvre CSE BCP TBX	33 attended	2nd April 2019
SWAST Mass Casualty Distribution Exercise	3 attended – ED & EPRR	17th April 2019
Executive / Duty Manager EPRR Training	6 attended	8th April, 3rd May, 16th May, 22nd May,
Emergo Facilitator Training	EPRR Manager	30th April – 2nd May 2019
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Fire Evacuation Exercises	72 staff attended	9th July 2019
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Loggist Training	4 attended	23rd September 2019
NHHFT Emergo Exercise Ignis II	8 attended	10th October 2019
Loggist Training	4 attended	22nd October 2019

Table 2: Live Incidents, including internal incident responses December 2018 – to date

Type of Exercise/Live	Audience/Description	Date
Water Supply failure DSU	DSU	6th December 2018
Telepath Failure	Pathology and impact to service users	7th December (wash up completed 3rd January 2019)
Page One (Bleep) Failure	Trust wide for bleep users	7th April 2019
Social Media Incident	Theatres	29th April 2019
PHE Listeria Alert	Catering/ Infection Control/ Microbiology	May 2019
National Armed Forces Day	IMT	28th, 29th and 30th June 2019
Telecoms Failure	Trust wide	10th September 2019

All exercises and live events are debriefed so lessons learnt and action plans can be captured, and plans updated/modified as required.

6. 2019/20 Exercising Schedule – dates planned

Live Exercises	Table Tops	Communications Test	Training
CBRN Exercise Alchemic 24/6	Informatics BCP TBX including service users – TBC Jan 2020	Everbridge MI Cascades adhoc – no notice	PREVENT WRAP February/ May/ November
Fire Evacuations (Laverstock) 10/6	MSK Burns Emergo TBX 7/2		NPAG February / May / September
Fire Evacuations (Laverstock) 14/7	Regional EPRR Exercise 4/3		Loggist Training March / September / December
	Clinical Governance Day – Radiology BCP TBX 23/4		

In May 2019 the EPRR Manager approached the Salisbury District Hospital League of Friends (LOF) for funding for an Emergo Train System (ETS), and on 5th June was invited to present to the LOF Trustees on how funding the training system would benefit the Trust. The Trustees of the LOF kindly supported this bid and the Trust have now procured and received the Emergo Train System in September 2019. The Emergo Train system is a simulation training tool, and is based on magnetic symbols plotted onto magnetic whiteboards. The system was developed in Sweden, and is used in more than 30 countries worldwide to provide disaster and incident management training. Having the LOF sponsor this training system means that the EPRR team at Salisbury District Hospital can provide all staff with in house major incident simulation exercises to test and evaluate command and control arrangements, medical management and resilience in the event of a major incident scenario using the Emergo Train System.

Training still to be scheduled includes: MAOT, MATT via LRF dates yet to be confirmed, Emergo in house training to include exercising of iRespond actions cards in relation to ED Relocation and a Paediatric incident and further Emergo departmental exercises.

7. Partnership Working

Externally the Trust is embedded in multi-agency planning through the Wiltshire & Swindon Local Health Resilience Partnership LHRP. This ensures a proactive and coordinated approach to planning and sharing of best practice. The Trust participates on a regular basis on the Everbridge SWAST communications cascade as well as regular Health Community Response Plan activities, and actively works on the LHRP task and finish groups where appropriate and works with partners with the coordinated planning of the modular response tool iRespond which has been implemented across the Health economy in Wiltshire.

Partnership working continued in 2019 with EPRR involved in the planning and implementation of the Salisbury National Armed Forces Day's (NAFD), throughout the early part of 2019 there were a number of planning meetings with a variety of partners and we

provided additional cover for the weekend in relation to command and control should an incident be escalated.

The EPRR team have also been involved since December 2018 in the EU Exit Planning for the Trust, and there is an established EU Exit Planning Steering Group and this links with our partnership working through the LHRP/LRF for EU Exit Planning. In addition we have attended a number of EU Exit planning workshops at a regional and local level.

This partnership working has been strengthened further with the multi-agency partnership working during the live major incident recovery phases, where partners have worked together and evolved further in 2019 as partners and other NHS organisations requested SFT to share lessons learnt from the major incident responses which provoked national and international attention, see table below for EPRR presentations:

Presentation	Venue/Audience	Date
Salisbury Learning Consolidation	NHSE	27th November 2018
Salisbury & Amesbury MI Responses EPRR	Avon & Somerset LHRP (Weston Super Mare)	29th November 2018
Salisbury & Amesbury MI Responses EPRR & LSMS	Cheshire & Merseyside LHRP	19th December 2018
Salisbury & Amesbury MI Responses EPRR & LSMS	Birmingham Hospitals EPRR Seminar	20th December 2018
Salisbury & Amesbury MI Responses EPRR	Birmingham Children's Hospital	26th April 2019
Salisbury & Amesbury MI Responses EPRR, Tactical, Clinical	CBRN Clinical Day, St Georges London	28th June 2019
Salisbury & Amesbury MI Responses EPRR	SFT hosted Maidstone & Tunbridge Wells Trust	16th July 2019
Salisbury & Amesbury MI Responses EPRR	Kent LRF Annual Seminar	14th November 2019

Following these events the EPRR Manager has forged EPRR relationships with North Hampshire NHS Foundation Trust and Maidstone and Tunbridge Wells Trust and we continue to share best practices.

8. Identified Gaps in EPRR portfolio & Next Steps

Gaps	Action	Date
Instigate a switchboard automated procedure for our internal cascade procedures	Investigate options e.g. Confirmer, PageOne and Everbridge	2019/2020
In a mass casualty type MI response, ED currently revert to paper, need to enact an electronic module to enable the flow throughout the organisation which rely on patient ID e.g. the laboratories, theatres etc.	Investigate with Informatics the use of the MI module in Lorenzo	Raised and on the proposed work schedule for Informatics
Maintain compliance against	To ensure we maintain full	August 2020

the core standards and improve on these minimum standards	compliance at the next Core Standards CCG Confirm and Challenge meeting	
Continue to build on the links with the Wessex network of the LHRP, to ensure a consistent approach for response to an incident linking the Trauma Centre and Units and to build on the relationships and sharing with MTW	Continued participation in regional exercising, building on links with partners at other organisations	2019/20
Include an element of recovery, in table top exercises		2020

In summer 2019, the Trust agreed to fund an EPRR Officer for 20 hours for an initial six month contract. This post was advertised on nhs.job in September and was successfully recruited to, and the EPRR Officer started in post 28th October 2019, the successful recruitment to this post has enabled us to plan and commit to a number of exercises in 2020 and enhances our EPRR resilience internally.

9. Summary

Based on the National RAG status for EPRR compliance SFT have been rated by Wiltshire CCG and NHS England as 'Fully' compliant for the third consecutive year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Full compliance means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve.

10. Recommendation

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to approve this full compliance statement by signing off this annual EPRR assurance report as part of the NHS England assurance process.

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Report to:	Trust Board	**Agenda item:**	**5.3**
Date of Meeting:	December 2019		

Report Title:	Emergency Preparedness Resilience & Response (EPRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Tracey Merrifield – EPRR Manager			
Executive Sponsor (presenting):	Andy Hyett – EPRR Accountable Officer			
Appendices (list if applicable):	None			

Recommendation:

Recommendations:
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Purpose of Report:
To provide assurance to the Trust Board as part of the National EPRR Assurance process. The Trusts self-assessment against the National EPRR Core Standards has been confirmed by Wiltshire CCG and approved by NHSE/I, as delivering FULL assurance.

This report, through a summary of EPRR activity, including the assurance process and training and exercising demonstrates our compliance.

Background:
The Trust is defined as a category 1 responder under the Civil Contingencies Act and is subject to civil protection duties discharged through the EPRR assurance process.

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5. Training & Exercising

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CBRN Exercise Alchemic 24/6	Informatics BCP TBX including service users – TBC Jan 2020	Everbridge MI Cascades adhoc – no notice	PREVENT WRAP February/ May/ November
Fire Evacuations (Laverstock) 10/6	MSK Burns Emergo TBX 7/2		NPAG February / May / September
Fire Evacuations (Laverstock) 14/7	Regional EPRR Exercise 4/3		Loggist Training March / September / December
	Clinical Governance Day – Radiology BCP TBX 23/4		

In May 2019 the EPRR Manager approached the Salisbury District Hospital League of Friends (LOF) for funding for an Emergo Train System (ETS), and on 5th June was invited to present to the LOF Trustees on how funding the training system would benefit the Trust. The Trustees of the LOF kindly supported this bid and the Trust have now procured and received the Emergo Train System in September 2019. The Emergo Train system is a simulation training tool, and is based on magnetic symbols plotted onto magnetic whiteboards. The system was developed in Sweden, and is used in more than 30 countries worldwide to provide disaster and incident management training. Having the LOF sponsor this training system means that the EPRR team at Salisbury District Hospital can provide all staff with in house major incident simulation exercises to test and evaluate command and control arrangements, medical management and resilience in the event of a major incident scenario using the Emergo Train System.

Training still to be scheduled includes: MAOT, MATT via LRF dates yet to be confirmed, Emergo in house training to include exercising of iRespond actions cards in relation to ED Relocation and a Paediatric incident and further Emergo departmental exercises.

7. Partnership Working

Externally the Trust is embedded in multi-agency planning through the Wiltshire & Swindon Local Health Resilience Partnership LHRP. This ensures a proactive and coordinated approach to planning and sharing of best practice. The Trust participates on a regular basis on the Everbridge SWAST communications cascade as well as regular Health Community Response Plan activities, and actively works on the LHRP task and finish groups where appropriate and works with partners with the coordinated planning of the modular response tool iRespond which has been implemented across the Health economy in Wiltshire.

Partnership working continued in 2019 with EPRR involved in the planning and implementation of the Salisbury National Armed Forces Day's (NAFD), throughout the early part of 2019 there were a number of planning meetings with a variety of partners and we

provided additional cover for the weekend in relation to command and control should an incident be escalated.

The EPRR team have also been involved since December 2018 in the EU Exit Planning for the Trust, and there is an established EU Exit Planning Steering Group and this links with our partnership working through the LHRP/LRF for EU Exit Planning. In addition we have attended a number of EU Exit planning workshops at a regional and local level.

This partnership working has been strengthened further with the multi-agency partnership working during the live major incident recovery phases, where partners have worked together and evolved further in 2019 as partners and other NHS organisations requested SFT to share lessons learnt from the major incident responses which provoked national and international attention, see table below for EPRR presentations:

Presentation	Venue/Audience	Date
Salisbury Learning Consolidation	NHSE	27th November 2018
Salisbury & Amesbury MI Responses EPRR	Avon & Somerset LHRP (Weston Super Mare)	29th November 2018
Salisbury & Amesbury MI Responses EPRR & LSMS	Cheshire & Merseyside LHRP	19th December 2018
Salisbury & Amesbury MI Responses EPRR & LSMS	Birmingham Hospitals EPRR Seminar	20th December 2018
Salisbury & Amesbury MI Responses EPRR	Birmingham Children's Hospital	26th April 2019
Salisbury & Amesbury MI Responses EPRR, Tactical, Clinical	CBRN Clinical Day, St Georges London	28th June 2019
Salisbury & Amesbury MI Responses EPRR	SFT hosted Maidstone & Tunbridge Wells Trust	16th July 2019
Salisbury & Amesbury MI Responses EPRR	Kent LRF Annual Seminar	14th November 2019

Following these events the EPRR Manager has forged EPRR relationships with North Hampshire NHS Foundation Trust and Maidstone and Tunbridge Wells Trust and we continue to share best practices.

8. Identified Gaps in EPRR portfolio & Next Steps

Gaps	Action	Date
Instigate a switchboard automated procedure for our internal cascade procedures	Investigate options e.g. Confirmer, PageOne and Everbridge	2019/2020
In a mass casualty type MI response, ED currently revert to paper, need to enact an electronic module to enable the flow throughout the organisation which rely on patient ID e.g. the laboratories, theatres etc.	Investigate with Informatics the use of the MI module in Lorenzo	Raised and on the proposed work schedule for Informatics
Maintain compliance against	To ensure we maintain full	August 2020

the core standards and improve on these minimum standards	compliance at the next Core Standards CCG Confirm and Challenge meeting	
Continue to build on the links with the Wessex network of the LHRP, to ensure a consistent approach for response to an incident linking the Trauma Centre and Units and to build on the relationships and sharing with MTW	Continued participation in regional exercising, building on links with partners at other organisations	2019/20
Include an element of recovery, in table top exercises		2020

In summer 2019, the Trust agreed to fund an EPRR Officer for 20 hours for an initial six month contract. This post was advertised on nhs.job in September and was successfully recruited to, and the EPRR Officer started in post 28th October 2019, the successful recruitment to this post has enabled us to plan and commit to a number of exercises in 2020 and enhances our EPRR resilience internally.

9. Summary

Based on the National RAG status for EPRR compliance SFT have been rated by Wiltshire CCG and NHS England as 'Fully' compliant for the third consecutive year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).
Full compliance means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve.

10. Recommendation

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to approve this full compliance statement by signing off this annual EPRR assurance report as part of the NHS England assurance process.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.4
Date of Meeting:	06 February 2020		

Report Title:	Remuneration, Nominations and Appointments Committee Terms of Reference			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):				

Recommendation:
It is recommended that the Trust Board approve the terms of reference.

Executive Summary:
The Remuneration, Nominations and Appointments Committee Terms of Reference are new and were approved by the Remuneration Committee on 5 December 2019. These require approval by the Trust Board and will be included in the Integrated Governance Framework together with all other Board Committee terms of reference.

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

Salisbury NHS Foundation Trust

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance

Date Adopted	05 December 2019
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Remcom 05 December 2019
Adoption and ratification	Trust Board

1. Purpose

1.1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service

1.2. When appointing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

2. Authority

2.1. The Remuneration, Nominations and Appointments Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

2.2. The committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.

2.3. The committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Membership and Attendance

Membership

3.1. The membership of the Committee shall consist of:

- The Trust Chair
- The other Non-Executive Directors
- And in addition, when appointing Executive Directors (other than the Chief Executive), the Chief Executive.

3.2. The Trust Chair shall chair the Committee

3.3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair.

3.4. Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Quorum

3.5. The quorum necessary for the transaction of business shall be the Chair of the Committee and three other Non-Executive Directors

Attendance

3.6 Only members of the Committee have the right to attend the meetings

3.7 At the invitation of the Committee, meetings may be attended by the Director of OD & People

Secretary

The Director of Corporate Governance shall be secretary to the Committee

4. Duties

4.1 Appointments

The Committee will:

4.11 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes.

4.12 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

4.13 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.14 Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

4.15 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.16 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

4.17 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.18 Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

4.2 Remuneration

The Committee will:

4.21 Establish and keep under review a remuneration policy in respect of Executive Board Directors.

4.22 Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

4.23 In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments.

4.24 In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

4.25 Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them;

4.26 Be sensitive to pay and employment conditions elsewhere in the Trust.

4.27 Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels.

4.28 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

5. Conduct of Business

Administration

5.1 The Director of Corporate Governance shall be Secretary to the Committee

Frequency

5.2 The Committee will be held bi-annually and at such other times as the Chair of the Committee shall require.

Notice of meetings

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting,

Reporting

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

6 Review

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

Board of Directors
Annual Business Cycle 2020/21

	Private Meeting
	Public Meeting
	Both

	Sponsor	Author	April	May	June	July	August	September	October	November	December	January	February	March
Board Administration														
Preliminary Business														
Apologies for absence	Chair	Verbal												
Declarations of interest	Chair	Verbal												
Patient story	Director of Nursing	Various												
Staff story	Director of OD & People	Various												
Minutes from the last meeting	Chair	Director of Corporate Governance												
Matters arising and action log	Chair	Director of Corporate Governance												
Register of attendance	Chair	Director of Corporate Governance												
Chairman's business	Chair	Verbal												
Chief Executive report inc STP update	Chief Executive	Head of Communications												
Approve Board and Committee dates for next year														
Assurance and reports of Committees														
Committee escalation reports	Executive Director	NED Chair of Committee												
Subsidiary Governance Escalation Report to Private Board		NED Chair of Committee												
Integrated Performance Report (inc, operational perf, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors												
Quality and Risk														
Board Assurance Framework and Corporate Risk Register	Director of Nursing	Director of Corporate Governance												
Patient Experience Report	Director of Nursing	Head of Complaints	Q3			Q4/Annual Report			Q1			Q2		
Learning from Deaths Report	Medical Director	Head of Clinical Effectiveness			Q4/Annual Report				Q1		Q2		Q3	
Clinical Review/SII Report	Director of Nursing	Head of Clinical Effectiveness												
Legal and Litigation Report	Director of Nursing	Head of Legal Services												
DIPC Report	Director of Nursing	Lead Nurse Infection Control			Annual Rep									
Safeguarding Annual Report (Adult)	Director of Nursing	Lead Nurse Adult Safeguarding			Remove from work plan - goes to CGC									
Safeguarding Annual Report (Children)	Director of Nursing	Lead Nurse Child Safeguarding			Remove from work plan - goes to CGC									
Annual Quality Report and External Auditors Assurance (Quality Accounts)	Director of Nursing	Head of Clinical Effectiveness												
Clinical Governance Annual Report	Director of Nursing	Head of Clinical Effectiveness					Annual Rep							
Risk Management Strategy (3 yrly, due 2020)	Director of Nursing	Head of Risk												
Quality Improvement Progress update	Director of Transformation	Director of Transformation												
Research Annual Report	Medical Director	Head of R&D					Annual Rep							
Risk Management Annual Report	Director of Nursing	Head of Risk												
Strategy and Development														
Capital Development Report	Director of Finance	Campus Project Programme Lead			moved to F&P 2019 add to F&P work plan for 2020									
Trust Strategy (progress reports) - timings TBC	Director of Finance	Assistant Director of Strategy												
Annual Sustainability Strategy Report	Director of OD & People	Campus Project Programme Lead			Annual Report									
Campus Development	Director of Finance	Campus Project Programme Lead												
Communications Strategy	Director of OD & People	Head of Communications												
Gastroenterology strategy paper	Chief Operating Officer	Directorate Manager												
Strategy Session (90 mins)		Associate Director of Strategy												
Digital Strategy	Director of Finance	Interim Chief Information Officer												
Financial and Operational Performance														
Annual Report and Accounts	Director of Finance	Deputy Director of Finance												
Operating Plan 2019/20 and quarterly review	Director of Finance	Associate Director of Strategy												
Approval of the 2019/20 budget	Director of Finance	Deputy Director of Finance												
Data Security & Protection Toolkit Self-Assessment														
Data Protection Officer Annual Report and Compliance with GDPR														
CIP & QIA	Director of Transformation	Director of Transformation/Head of Transformation			moved to F&P 2019 add to F&P work plan for 2020									
Workforce														
Nursing Skill Mix Review	Director of Nursing	Deputy Director of Nursing												
Guardian of Safe Working Annual Report	Director of OD & People	Guardian of Safe Working					Annual Rep							
Equality & Diversity Annual Report	Director of OD & People	Head of Diversity and Inclusion							Annual Rep					
National Staff Survey Results	Director of OD & People	Deputy Directof of OD & People												
Medical Revalidation and Appraisal Annual Report	Medical Director	Medical Director					Annual Rep							
Freedom to Speak Up Guardian Annual Report (quarterly to Workforce Cttee)	Director of OD & People	FTSUG Lead												
Voluntary Services Annual Report	Director of OD & People	Head of Voluntary Services			moved to WFC 2019 add to WFC work plan for 2020									
Health & Safety Annual Report	Chief Operating Officer	Health and Safety Manager						Annual Rep						
Clinical Excellence Awards	Medical Director	Medical Workforce Transformation Lead			moved to WFC 2019 add to WFC work plan for 2020									
Education & Development Annual Report	Director of OD & People	Associate Director Education, Inclusion, Comms & Engagement									Annual Rep			
Medical Education Performance Report	Medical Director	Director of Medical Education									Annual Rep			
Board Administration														
Governance														
Annual review of Board effectiveness	Director of Corporate Governance	Director of Corporate Governance					Annual Rep							
Annual review of Committee effectiveness	Director of Corporate Governance	Director of Corporate Governance					Annual Rep							
Annual review of Directors Interests/ Annual Review Fit and Proper Persons Test	Director of Corporate Governance	Director of Corporate Governance												
Review of Board Committee Terms of Reference	Director of Corporate Governance	Director of Corporate Governance												
Integrated Governance Framework	Chief Executive	Director of Corporate Governance												
Accountability Framework	Chief Operating Officer	Chief Operating Officer												
Emergency Preparedness Annual Report	Chief Operating Officer	EPRR Manager									Annual Rep			
EPRR Compliance Statement	Chief Operating Officer	EPRR Manager												
Register of Seals	Director of Corporate Governance	Director of Corporate Governance	Q4				Q1		Q2			Q3		
Corporate Governance Statement Self-Assessment (Well-Led Review)	Chief Executive	Director of Corporate Governance												
Annual Governance Statement	Chief Executive	Director of Corporate Governance												
Annual Review of the Constitution	Chief Executive	Director of Corporate Governance												
NHSI Self-Certification (FT4, G6, CoS7)	Director of Finance	Director of Corporate Governance												
Concluding Business														
Any Other Business	Chair	Verbal												
Date of Next Meeting														
Hosptial Menu														

	Private Meeting
	Public Meeting
	Both