Bundle Trust Board Public 4 June 2020

1 OPENING BUSINESS

1.1 10:00 - Welcome and Apologies

Presented by Nick Marsden

1.2 Declaration of Interests

1.3 Minutes of the previous meeting

Minutes attached from Public Trust Board meeting held on 21st May
Presented by Nick Marsden
For approval

1.3 Draft Public Board mins 21 May 2020.docx

1.4 10:05 - Matters Arising and Action Log

1.4 Action log Public Board June 2020.docx

1.5 Register of Attendance

Register of Attendance - Public Board 2020-21.docx

1.6 10:10 - Chairman's Business

Presented by Nick Marsden
For information

1.7 10:15 - Chief Executive Report

Presented by Cara Charles-Barks
For information

1.7 CEO Board Report June 2020.docx

2 ASSURANCE AND REPORTS of COMMITTEES

2.1 10:25 - Trust Management Committee - 20 May

Presented by Cara Charles-Barks
For assurance

2.1 TMC Escalation report June.docx

2.2 10:30 - Finance and Performance Committee - 19 May

Presented by Paul Miller
For assurance

2.2 Finance and Performance Committee escalation paper 19th May 2020.docx

2.3 10:35 - Workforce Committee - 28 May

Presented by Michael von Bertele
For assurance
Verbal update

2.4 10:40 - Audit Committee - 3 June

Verbal report presented by Paul Kemp
For assurance

2.5 10:45 - Integrated Performance Report - M1

Presented by Christine Blanshard
For assurance

2.5a 200604 IPR.docx

2.5b IPR June 2020 FINAL.pdf

4 GOVERNANCE

4.1 11:05 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona McNeight
For assurance

3.1a BAF cover sheet June Board 2020.docx

3.1b BAF v16 for Board June 2020.docx

3.1c Corporate Risk Register May 2020 v4.pdf

3.1d CRR tracker v16_June Board 2020.pdf

4.2 11:15 - Board Governance Structure Review

Presented by Fiona McNeight
For assurance

3.2a Board Governance Structure Review Report March 2020.docx

3.2b Appendix 1_Task Mapping.pdf

3.2c Appendix 2_Statutory and Other Duties of the Board and its Committees.pdf

3.2d Appendix 3_Committee Assurance Map_Revised March 2020.pdf

3.2e Appendix 4_CURRENT Governance Structure Final.pdf

3.2f Appendix 5_PROPOSED Governance Structure V4.pdf

3.2g Appendix 6_DRAFT TMC Terms of Reference 2020.docx

3.2h Appendix 7_April 2020 Board and Committee Handbook.docx

5 WORKFORCE

5.1 11:25 - Freedom to Speak up Guardian Annual Report

Presented by Lynn Lane
For assurance

5.1 FTSU Annual Report to Board 2019-20 (v1) (3) (2).docx

6 QUALITY AND RISK

6.1 11:35 - Learning from Deaths Report Q4/Annual Report

Presented by Christine Blanshard
For assurance

6.1 Learning from deaths report Q4 19 20 April 20.docx

7 CLOSING BUSINESS

7.1 11:45 - Agreement of Principle Actions and Items for Escalation

7.2 Any Other Business

7.3 11:50 - Public Questions

7.4 Date next meeting

Next Public Trust Board meeting 2nd July 2020

8 RESOLUTION

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

Salisbury NHS Foundation Trust

DRAFT

Minutes of the Public Trust Board meeting held at 11:00am on Thursday 21 May 2020 via Skype in The Board Room, Salisbury NHS Foundation Trust

Present:

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

In Attendance:

Miss Kylie Nye	Corporate Governance Manager (minutes)
Mr John Mangan	Lead Governor (observer)
Mrs Fiona McNeight	Director of Corporate Governance
Ms Esther Provins	Director of Transformation

ACTION

TB1 21/5/1 OPENING BUSINESS

TB1 21/5/1.1 Welcome and Apologies

Apologies were received from:

- Lorna Wilkinson, Director of Nursing

TB1 21/5/1.2 Declarations of Conflicts of Interest

There were no declarations of conflicts pertaining to the agenda.

TB1 21/5/1.3 Minutes of the part 1 (public) Trust Board meeting held on 2 April 2020

E Jones noted that she had asked for the Clinical Cell information to come to CGC and this should be part of the minutes under the F&P escalation report.

Subject to these changes the minutes were agreed as an accurate record of the meeting held on 2 April 2020.

TB1 21/5/1.4 Matters Arising and Action Log

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

- **Action 182. Annual review of Directors Interests and Fit and Proper Person Test** – It was confirmed the changes had been made. Item closed.

There were no further matters arising.

TB1 21/5/1.5 **Chairman's Business**

N Marsden provided the following update:

At the most recent Chairs Advisory Panel the meeting had discussed three key topics:

Funding and Finance – The existing national block contract arrangements will continue until 31st August. The financial arrangements for the rest of the year until 31st March 2021 will be similar with a national block contract but with tighter guidelines and with organisations required to provide more evidence to support expenditure. N Marsden noted that it is hoped these tighter guidelines to not hinder initiatives that will drive the Long Term Plan.

It was discussed that there will need to be a balance; ensuring organisations are focused on patients and delivery of service, rather than focussing on finance. In relation to capital there is currently no view beyond 2021/22 and this approach is under development.

Discussion:

- L Thomas noted that the aspiration is to be block contract and that further work was required on the capital process to make it more simplistic.
- C Charles-Barks noted that in recent meetings she had been in the discussions have been focussed on how financial governance is reintroduced without impairing innovation.

Foundation Trust Status – The panel had discussed the issues arising in relation to accountability and responsibility and the ambiguous environment all Foundation Trusts are currently in.

Discussion:

- P Kemp noted that if the current structure continues the Foundation Trust status will become increasingly difficult and this needs to be factored in. N Marsden noted that this had been discussed at length alongside the issues around Trusts working towards an Integrated Care System (ICS). N Marsden explained that ICS's are driving organisations in a direction to ensure the best environment for patients but it is recognised that for Foundation Trust's there is individual accountability. P Kemp noted that this is a risk. N Marsden explained that NHSI/E is working on this and the Trust will

await guidance.

Reinstating Elective Services – The panel had discussed how a return to elective work will be implemented and this is currently a work in progress.

Discussion:

- C Charles-Barks noted that as part of the discussion relating to reintroducing elective work, there is also system based solutions to consider. By re-establishing services, the Trust needs to be prepared to work differently with its acute counterparts and the system.
- C Charles- Barks further noted that there have been conversations around health inequality and that the COVID-19 pandemic has exposed this. Work is now underway to review how systems and organisations are going to manage this.

N Marsden noted that he would keep the Board updated on any developments.

TB1 21/5/1.6 **Chief Executive's Report**

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

- C Charles-Barks thanked every member of staff at the Trust for their efforts in managing the coronavirus crisis. There have been numerous examples of incredible team work and a willingness to adapt to new ways of working and accept responsibilities.
- The Trust is now in phase 2 of the response to COVID-19 and is planning to step up non-COVID urgent services over the next 6 weeks. The Trust is working hard with its partners to ensure this can happen as effectively and as quickly as possible.
- The Trust has launched a joint social media campaign "We're here to Help You" with GPs' which urges people to contact their GP's if they feel unwell.
- It is important to highlight that the Trust only continues to provide safe and effective care for patients with the support of all key worker and our local community. Therefore, the Trust is proud to support a joint "We're All in it Together" campaign with Wiltshire Council and have encouraged the public to show the same level of respect for essential council staff as they do for the NHS.
- The health and well-being of staff continues to be a priority and the Trust has recently launched rainbow letters for staff with children. Children receive personalised letters from the Trust to let them know how much their parent or guardian's work is appreciated.

Discussion:

- P Miller referred to the Non-Executive role in

communicating with the public and the Trust's membership and this was discussed in detail. P Miller suggested that Non-Executive Directors are part of the framework and in an uncertain environment NEDs have a wider population accountability. N Marsden agreed that NEDs have a wider responsibility and an ambassadorial role.

- T Baker referred to the concerns regarding the vulnerability of BAME (Black, Asian & Minority Ethnic) staff and asked how the Trust is supporting them during this time, particularly the new overseas nurses. L Lane noted that in relation to overseas nurses, prior to the COVID-19 pandemic a comprehensive support programme had been developed. However, since further issues have developed in relation to COVID-19 a specific piece of work has taken place by the Equality, Diversity and Inclusion (EDI) team to support the Trust's BAME staff, which has included running webinars and workshops. Additionally, the EDI team have been closely working with the Trust's Freedom to Speak Up Guardian and a personal letter has been sent to all BME staff on behalf of Executive Team to note concerns about their health and well-being and that national guidance is being followed. Since then, the Trust has written again offering to provide a meeting with their line manager to ensure they supported and safe at work. There is also counselling and mentoring available for all staff and a detailed risk analysis process is underway. There has been very positive feedback from members of staff thanking the Trust for the support provided during this time.
- R Aggarwal referred to a national study in relation to BAME staff and asked how the Trust is contributing. L Lane noted that she is attending a weekly HR Directors Network meeting and the Trust has contributed its feedback via this forum. R Aggarwal noted the letters she had received from the Trust were really supportive.
- E Jones noted that this week is Mental Health Awareness week and it is important to recognise that front line staff who live alone and the Trust needs to be aware of the potential impact on staff mental health and well-being.
- C Charles-Barks explained that the Trust have been communicating a Mental Health message this week, "kindness matters" and is working closely with the psychology team. There is also a focus on additional support that is going to be required long term. L Lane noted that this is a discussion point on the HR Directors Network call and as a Trust a lot of work has been underway to support staff and new ideas and initiatives are under review.
- E Jones asked if employees have a separate point of contact they ask for help and support who is not their line manager. L Lane noted that are a number of initiatives internally and externally which staff have access to.

The Board noted the report.

TB1 21/5/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 21/5/2.1 **Trust Management Committee – 15 April**

C Charles-Barks presented the report, providing a summary of escalation points from Trust Management Committee held on 15 April.

- The key point of escalation is that the Trust is working through the COVID-19 response and there are three components. The key message is that the Trust is standing up all normal meetings throughout May and June.

Discussion:

- P Kemp asked if the business cases aligned to the new business case template and process. C Charles-Barks noted that Trust Investment Group is reviewing the business cases via the new framework and this is currently a work in progress.
- P Kemp referred to the Electronic Prescribing and noted that if the Trust is applying for national funding there are still concerns about the clarity in relation to using Lorenzo. L Thomas explained that the Lorenzo system has moved forward and it is now recognised to be the best way to proceed and there is a risk to not having an electronic prescribing system. E Provins noted that the business case presented to TMC does not tie the Trust to using a system but was acknowledging the immediate risk. E Provins explained that there is an opportunity to digitalise methods of working prior to choosing a system. E Provins suggested that a wider discussion take place as part of a digital update seminar in July. **ACTION: EP** **EP**
- P Kemp referred to a benefits realisation action on a business case that had been discussed at TMC and noted that this should be standard practice. C Charles-Barks explained that every business case comes back for a review and TMC is used to set the review dates and track them.

The Board noted the report.

TB1 21/5/2.2 **Finance and Performance Committee – 28 April**

P Miller provided a summary of escalation points from Finance and Performance Committee held on 28 April. P Miller noted that a meeting had taken place on 19th May and a written report would go to June's Board with the key escalation points.

- The Committee received an update on COVID-19 from an operational and financial perspective. The key operational concern is currently the availability of space within the hospital to support the recovery process, which will require social distancing and high levels of infection control.
- The Committee discussed COVID-19 recovery which currently has 4 work streams all reporting to gold command.

There are several constraints to managing the recovery process and it is recognised this will be complex. The impact of social distancing and infection control will have a huge impact of clinical service and productivity. Additionally, there are significant implications for future service planning within the Trust and STP.

- The Trust successfully achieved its January 2020 reforecast position with an overspend of £14.7m. This was £300k better than re-forecast, but £5.9m worse than the original plan for the year. Going forward into 2020/21, because of the COVID-19 financial measures relating to the first four months of 2020/21, the Trust should not require any cash borrowing at this time, though this will be reviewed as the incident progresses.
- The Committee received a detailed report on the additional digital work required within the Trust to respond to the COVID -19 incident, as well as the work-plan re-prioritisation required to allow this. The Committee gained assurance that the digital response had positively supported staff in responding to the incident and congratulated the digital team in their effective and flexible response.
- The Committee reviewed this self-certifications and will recommend its approval to the Trust Board at the meeting on the 21st May 2020

The Board noted the report.

TB1 21/5/2.3 **Integrated Performance Report**

L Thomas presented the Integrated Performance Report to the Board.

The report was noted.

TB1 21/5/2.4 **Clinical Governance Committee 31 March and 12 May**

E Jones noted that she had provided two reports, one from March's CGC meeting and one from 12 May. E Jones provided the key highlights from the most recent meeting as follows:

- A detailed discussion was undertaken in relation to the Gastroenterology Review letter. A further update is planned for the June Clinical Governance Committee.
- A presentation was provided in relation to governance for the Covid-19 work and the governance being implemented**.**
- The Safety and Experience elements of the Integrated Performance Report were presented and considered**.** Pressure ulcers remain under scrutiny and a presentation was requested for the next Clinical Governance Committee in June.
- It was noted that the planned cancer summit will take place remotely. An update will be provided at a future meeting.
- The six monthly Quality Impact Assessment report was

presented. The committee noted the assurance in relation to cost improvement impact assessment and requested that consideration should be given for using this type of approach in other non-financial areas. It was confirmed that the process is being reviewed as part of the work to further strengthen quality governance.

- It was agreed that the Quality Account would come to Trust Board for final approval alongside the Annual Report.
- An update on the current five year Clinical Strategy was presented. It was agreed that the clinical priorities would be reviewed and reset in line with the new ways of delivering care emerging as a result of the pandemic.
- The End of Life report was presented. There are two areas to escalate, workforce changes and challenges during the current year and funding of the Hospice at Home service
- A six monthly 'Getting it Right First Time' (GIRFT) report was presented. It provided detail on the last two deep dives in rheumatology and radiology with good practice identified in both. Further assurance has been requested and will come back to CGC.
- The Learning from Deaths review again provided good assurance. Two areas for further work were flagged, namely fractured femur and acute renal failure mortality.
- A positive Medicines Safety report was presented.
- A positive report was received from the Trust's Freedom to Speak Up Guardian (FTSU). The work with NHSI over the past year was noted as good practice and recognised the cultural improvement achieved.
- Upward reports from CMB and CRG were received with further assurance sought and gained in relation to a small number of audits.

Discussion:

- E Jones provided further clarity on what CGC are expecting as part of a response to the Gastroenterology Review letter. E Jones noted that the Committee has asked for a detailed update in June CGC with the assurance that all the key issues raised are being addressed. C Charles-Barks noted that this report is being pulled together and work is on-going.

TB1 21/5/3 **GOVERNANCE**

TB1 21/5/3.1 **COVID Governance arrangements**

F McNeight presented the report which provided a summary of the principles of Board assurance and governance that Salisbury NHS Foundation Trust is following during the period of COVID-19 Emergency Planning and Response.

Discussion:

- F McNeight asked the Board if they were content to keep these new arrangements until the end of June. A Hyett suggested that due to the category 4 incident status could the governance arrangements remain in place until the Trust is stood down from this position. E Jones highlighted her concerns with this approach, particularly in such a volatile environment in the current situation and suggested the Board should review at the end of June.
- FMc noted that many Trusts had been live-streaming their public Board with some experiencing thirty or more people virtually attending. This provides a level of accessibility and transparency for members of the public who want to join the meeting.

Decision:

- The Board approved the COVID governance arrangements and it was decided these would be reviewed at the end of June.
- There were no objections from the Board to streaming the public Board meeting.

TB1 21/5/3.2 **NHSI Self Certification - FT4, G6 CoS7**

F McNeight presented the report which had been to F&P and recommended for approval on 19th May 2020.

F McNeight noted that NHS Foundation Trusts are required to self-certify on an annual basis as if they have:

- Effective systems to ensure compliance with the conditions of the NHS Provider Licence, NHS legislation and the duty to have regard to the NHS Constitution (Condition G6).
- Complied with governance arrangements (condition FT4).
- The required resources available if providing commissioner requested services (CRS) (condition CoS7).
- Have provided Governors with the necessary training.

Decision:

- The Board approved the NHSI self-certifications for submission.

TB1 21/5/4 **CLOSING BUSINESS**

TB1 21/5/4.1 **Agreement of Principle Actions and Items for Escalation**

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

- The Non-Executive Team gave thanks to the Executive

team for closing 2019/20 in a slightly better position than had been forecast. N Marsden noted that it had been a challenging year.

- The Board acknowledges the current challenges the Trust and the wider NHS faces. There is a focus on workforce and staff health and well-being which will be a long term effort.
- The Board approved the COVID-19 Governance arrangements.
- The Board approved the NHSI Self certifications for submission.

TB1 21/5/4.2 **Any Other Business**

There was no other business.

TB1 21/5/4.3 **Public Questions**

- Dr J Lisle noted the difficulties in keeping in touch and connected with each other and constituencies. N Marsden agreed to work with Dave Roberts, Head of Communications, and the communications team to see how the Trust could support communication to members.

TB1 21/5/4.4 **Date of Next Meeting**

Thursday 4 June 2020, Board Room, Salisbury NHS Foundation Trust

TB1 21/5/5 **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 4 June 2020

Agenda item		Assigned to	Deadline	Status
2.1 Trust Management Committee - 15 April				
188.	Electronic Prescribing Business Case	Provins, Esther	02/07/2020	Pending
	Explanation action item Further to queries regarding the system preferences for a new electronic prescribing system, E Provins suggested that a wider discussion take place as part of a digital update seminar in July.			

Register of Attendance – Public Board 2020/21

	2 April	21 May	4 June	2 July	6 August	3 September	1 October	5 November	3 December	January 2021	February 2021	March 2021	attendance rate
Nick Marsden	✓	✓											2/2
Tania Baker	✓	✓											2/2
Michael von Bertele	✓	✓											2/2
Paul Kemp	✓	✓											2/2
Paul Miller	✓	✓											2/2
Cara Charles-Barks	✓	✓											2/2
Christine Blanshard	✓	✓											2/2
Lisa Thomas	✓	✓											2/2
Andy Hyett	✓	✓											2/2
Lorna Wilkinson	X	X											0/2
Lynn Lane	✓	✓											2/2
Eiri Jones	✓	✓											2/2
Rakhee Aggarwal	✓	✓											2/2
David Buckle	✓	✓											2/2

Governor Observer													
Raymond Jack													
John Mangan	✓	✓											2/2

Attended - ✓

Apologies – X

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	**1.7**
Date of Meeting:	4th June 2020		

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

Recommendation:
None

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • **Performance –** update on current performance • **Finance –** update on our financial recovery plan • **Workforce –** update on workforce situation • **COVID-19 response** • **International nurses and Midwives day** • **Mental health awareness week** • **'Games in the Garden' for patients with spinal injuries**

Performance

Finance

We are currently operating under 'Covid-19 response' financial arrangements, with block contracts in place with our key commissioners and a retrospective top-up from NHSE&I available should that be required.

These block arrangements were enough to cover the Trust's cost base in April 2020 and we reported a breakeven position in line with response guidance.

We are currently working to understand what social distancing and deep cleaning regimes, as well as other key constraints, mean for our underlying capacity as we look to increase the amount of clinical activity being undertaken both on and off site.

Workforce

We have continued to recruit during the month, conducting interviews by Skype or Microsoft Teams although the number of roles we are recruiting to is reducing.

We still continue to focus on our hard to recruit resourcing plan which concentrates on Medical and AHP staff. Induction is still continuing also with reduced numbers and in compliance with social distancing guidelines. In April, the Trust's overall sickness absence rate further increased sharply to 6.29%, well above the 3% target, although 2.88% of this is attributable to COVID.

Mandatory training has increased slightly at 89.3%, still above the 85% target, and non-medical appraisals have reduced slightly to 82.46%. Medical appraisals have been suspended by national agreement for the time being until such time as we are beyond the pandemic.

COVID-19 response

The health and wellbeing of all staff and patients remains our highest priority as we work to increase critical non COVID-19 services, and new processes are being put in place to ensure that our focus on safety remains.

A national framework on reducing the transmission of COVID-19 in hospitals has been published by NHS England and NHS Improvement and we are working to finalise a plan for what that means for how we run services.

We continue to ask patients to attend hospital only when it is really necessary. And where possible, appointments will continue to be offered using remote services such as a video or phone consultation. If patients do need to attend hospital, they will be asked to take steps to reduce the risk of transmitting coronavirus for their safety, the safety of our staff and other patients. This includes isolating at home for 14 days before admission for planned care (including day surgery), and only attending outpatient appointments if they have no symptoms of coronavirus.

The measures that we have already implemented across the Trust to reduce transmission of coronavirus (including remote working, hand hygiene and social distancing) have been fundamental to our response to date and it is important these continue with the same level of care.

International nurses and midwives day

On Tuesday 12th May, we celebrated International Nurses Day and the 200th anniversary of the birth of Florence Nightingale. On Tuesday 5th May we celebrated International Midwives day.

In the year of the nurse and midwife it was particularly important to celebrate this day to say thank you to our amazing nursing and midwifery staff. A full day of activities took place across the Trust to mark this special day. Nursing and midwifery staff were awarded commemorative 'Year of Nurses & Midwives' badges, thanks to generous funding from the League of Friends. The bespoke badges were designed by Artcare.

BBC South broadcast a nursing special and our nurses took over the local radio station, Spire FM – with 31 nurses either interviewed or introducing songs throughout the day.

Mental health awareness week

The Trust marked Mental Health Awareness week between 18th and 22nd May, to highlight the importance of looking after minds as well as bodies. This year's theme was 'kindness'. Every week staff across the Trust show kindness to each other, to patients and to visitors and staff were encouraged to share their own experiences of acts of kindness, so these could be spread more widely across the Trust.

The weekly ‘Clap For Carers’ has demonstrated how much the community appreciate what we do and the staff have been really touched by the kind donations of foods and gifts which have been distributed through the Star's Appeal donation hub to staff. To reverse this act of kindness, on the usual Thursday ‘Clap For Carers’, the Trust instead ‘Clapped For The Community’ – to say a heartfelt thank you for all their support.

‘Games in the Gardens’ for patients with spinal injuries

Patients with spinal injuries in our Spinal Treatment Centre are currently being shielded, are not able to have visitors and the usual external trips enjoyed by so many of the patients have had to be cancelled - to protect them from COVID-19 infection.

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

Cara Charles-Barks
Chief Executive

CLASSIFICATION: UNRESTRICTED

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	4 June 2020		

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

Recommendation
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 20 May 2020

Key Items for Escalation

The Trust Management committee took place on 20th May 2020. There were no business cases to review or approve this month, instead the Divisions were asked to report if there were any hot spots which needed to be escalated to the committee.

Each of the divisions reported that there were no areas of concern which required escalating to the committee at this moment in time.

The committee did receive a report on benefit realisation of business cases formerly approved, namely for Patient Records and Data capture within Children's DAU. The paper detailed the qualitative benefits of the Paediatric DAU. Not all benefits of the original business case have been realised and it was not possible to quantify the financial impact that the introduction of this role has had due to a slight reduction in activity over the last 6 months. The division will continue to monitor activity however; the committee was pleased to learn that all other benefits originally outlined in the business case are being recognised by the Unit. The financial benefit will be picked up via the Executive performance review process going forward

Other items for Escalation:

The committee reviewed the Corporate Governance Structure following an Internal Audit of Board Compliance and Reporting in November 2019, which identified areas for further improvement.

During the review, one of the findings was that "The overall structure of the Trust's Committees, subcommittees and working groups is unclear with no clear framework confirming the escalation route and pathway for information and reports.
A revised Board Committee structure is proposed which clearly identifies a clear divide between delivery and assurance.

The revised Corporate Governance Structure was approved.

End of report

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	4th June 2020		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	19th May 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance Committee meeting of the 19th May 2020

Items for Escalation to Board
Covid-19 from an operational performance and financial perspective – There was a further update on both the current operational and financial position within the Trust and the Committees reflections, based on this further update, is that the hospital continues to be in a good place to effectively manage the day-to-day covid-19 incident going forward. This is due to both the establishment and maintenance of effective incident management systems and processes, which have ensured timely decisions were made e.g. PPE procurement and the fantastic efforts of all staff. **Covid-19 Recovery –** The Trust continues to plan the detail and commence the recovery of non-covid services within the hospital and the expectation is over time the hospital will see most services reinstated, however there is likely to be a reduction in inpatient capacity, possibly 5% to 10%, due to social distancing rules. **Financial Performance 2020/21** – Following the achievement of the reforecast financial outturn in 2019/20, the Trust was able to achieve a “break even” financial performance in the first month of 2020/21. This was due to the NHS financial arrangements covering the national covid-19 incident. It is likely that these financial arrangements will have a significant impact on the Trusts finances throughout 2020/21 and further details will be confirmed when formally known. Finally the key issue is the Trusts finances i.e. cash, is in a reasonable position going forward.

Transformation Programme – In light of the covid-19 incident the Trust has taken the opportunity to reflect on the significant number of operational and clinical changes that were implemented during March and April 2020. Following this review the Trusts has comprehensively revised and reset the 2020/21 transformation programme, to ensure that the most valuable changes are kept, consolidated and built upon.

IT annual network penetration test – The outcome of this annual IT test was reported to the Committee and whilst it demonstrated an improvement on last years "challenged performance", there were still significant concerns outstanding. As a consequence the Executive team agreed to prioritise the closing off of risks that it was able to close and would produce a more "holistic" report, that put the remaining outstanding risks into wider context.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	04 June 2020		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Felicity Anscombe, Information Services Manager Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	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:
Throughout April the Covid-19 pandemic has continued to dominate all areas of the organisation. As expected the reduction in elective activity has reduced performance against the Referral to Treatment (RTT), Diagnostic and Cancer standards. RTT reduced from pre pandemic levels in February 2020 of 90.85% to 83% in April. The Trust also incurred ten 52 week breaches as a result. Diagnostic performance has fallen to 46.4% (99.9% in February). Cancer activity has been prioritised where possible throughout the pandemic, but performance has also suffered with the 62 day standard falling to 76.8%. This is largely linked to the ceasing of all non-emergency endoscopic procedures. With limited procedures resuming in May, it is expected to see this level of performance continue next month. Worryingly for the Trust, non-elective activity continues to remain below usual levels. ED attendances were 3139 (compared to 5887 in April 2019), as a result performance against the 4 hour standard improved to 92.5%. Bed occupancy fell to around 60% and both stranded and super stranded patients reduced. The Trust is assisting Primary Care with messaging to patients around ensuring they attend with urgent conditions, both planned and unplanned. Stroke & TIA performance continues to be a highlight, the percentage of patients arriving on the Stroke Unit within 4 hours was 96.2%, and the highest this has reached in the last 18

months. The national concern that patients with a stroke/TIA are not presenting to hospital due to fears about Covid-19 is borne out by our data. The average number of stroke admissions has reduced from 26.2 (Dec 19 – April 20) to 19.7 (Feb – April 20). There has also been a significant reduction of TIA patients attending a clinic within 24 hours – 25 in April compared to 40 – 60 patients a month normally.

We continued to report a high rate of category 2 pressure ulcers in April. Of these, 8 were in 3 critically ill patients associated with COVID-19 nursed prone who developed mucosal lesions in the mouth and nose and the other 16 were across a variety of wards. The cluster review is reporting to the Clinical Governance Committee in June and has highlighted a concern regarding baseline education in our nursing staff on prevention of pressure damage. The Tissue Viability team have trained over a 100 staff in the last month in skin care and will publish an item in the 'React to Red' bulletin.

Sickness absence rose in April, which was to be expected, driven by an increase in long term absences. Mandatory training has increased slightly, but appraisals have declined, in particular medical appraisals following the GMC halting of the process in response to Covid-19.

For the purposes of financial reporting in April 2020 the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £1.5m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. The block contracts and 'top-up' payment received as part of the Covid-19 response we enough to cover the cost base of the Trust, and in line with guidance received from NHSE&I the level of 'top-up' received was reduced by circa £0.1m to bring the Trust to a break even position.

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

June 2020

(data for April 2020)

An outstanding experience for every patient

Summary

Throughout April the response to the Covid-19 pandemic has continued to dominate all areas of the organisation. As expected the reduction in elective activity has reduced performance against the Referral to Treatment (RTT), Diagnostic and Cancer standards. RTT reduced from pre pandemic levels in February 2020 of 90.85% to 83% in April. The Trust also incurred ten 52 week breaches as a result. Diagnostic performance has fallen to 46.4% (99.9% in February).

Cancer activity has been prioritised where possible throughout the pandemic, but performance has also suffered with the 62 day standard falling to 76.8%. This is largely linked to the ceasing of all non-emergency endoscopic procedures. With limited procedures resuming in May, it is expected to see this level of performance continue next month.

It is a concern that non-elective activity continues to remain below usual levels. ED attendances were 3139 (compared to 5887 in April 2019), as a result performance against the 4 hour standard improved to 92.5%. Bed occupancy fell to around 60% and both stranded and super stranded patients reduced. The Trust is working with Primary Care to communicate to patients around ensuring they use the Trust's services for urgent conditions, both planned and unplanned.

Stroke & TIA performance continues to be a highlight, the percentage of patients arriving on the Stroke Unit within 4 hours was 96.2%, and the highest this has reached in the last 18 months. The national concern that patients with a stroke/TIA are not presenting to hospital due to fears about Covid-19 is borne out by our data. The average number of stroke admissions has reduced from 26.2 (Dec 19 – April 20) to 19.7 (Feb – April 20). There has also been a significant reduction of TIA patients attending a clinic within 24 hours – 25 in April compared to 40 – 60 patients a month normally.

We continued to report a high rate of category 2 pressure ulcers in April. Of these, 8 were in 3 critically ill patients associated with COVID-19 nursed prone who developed mucosal lesions in the mouth and nose and the other 16 were across a variety of wards. The cluster review is reporting to the Clinical Governance Committee in June and has highlighted a concern regarding baseline education in our nursing staff on prevention of pressure damage. The Tissue Viability team have trained over a 100 staff in the last month in skin care and will publish an item in the 'React to Red' bulletin.

Sickness absence rose in April, which was to be expected, driven by an increase in long term absences. Mandatory training has increased slightly, but appraisals have declined, in particular medical appraisals following the GMC halting of the process in response to Covid-19.

For the purposes of financial reporting in April 2020 the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £1.5m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed.The block contracts and 'top-up' payment received as part of the Covid-19 response we enough to cover the cost base of the Trust, and in line with guidance received from NHSE&I the level of 'top-up' received was reduced by circa £0.1m to bring the Trust to a break even position.

Structure of Report

Performance against our Strategic and Enabling Objectives

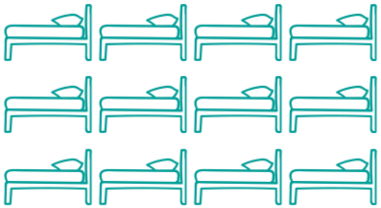
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
April 2020

NHS Salisbury NHS Foundation Trust

There were **1,950** Non-Elective Admissions to the Trust

We carried out **107** elective procedures & **366** day cases



46.6% ↓ of patients received a diagnostic test within **6 weeks**

Emergency (4hr) Performance
94.5% ↑
(Target trajectory: 95%)

We delivered **9,877** outpatient attendances cases (-11,072 vs plan)

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

Our income was **£21,998k** (£1,441k over plan)

890 patients arrived by Ambulance

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

RTT 18 Week Performance:
83.0% ↓
Total Waiting List: **15,958** ↓

21.3% ↑ of discharges were completed before 12:00

Our overall vacancy rate was
2.85% ↑

Reading a Statistical Process Control (SPC) Chart

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

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

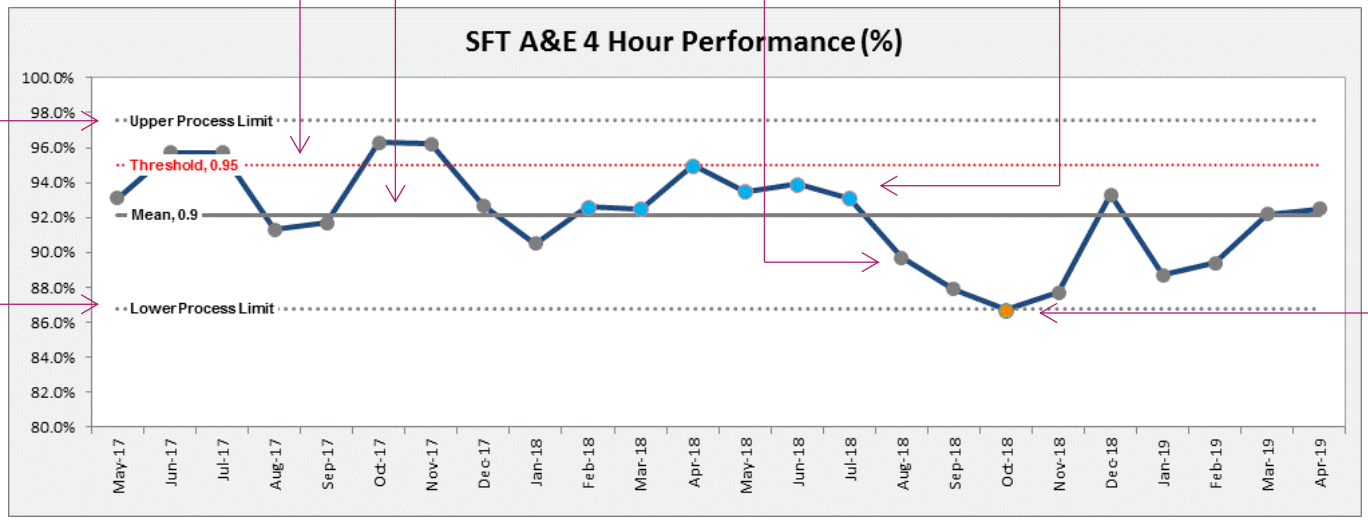
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

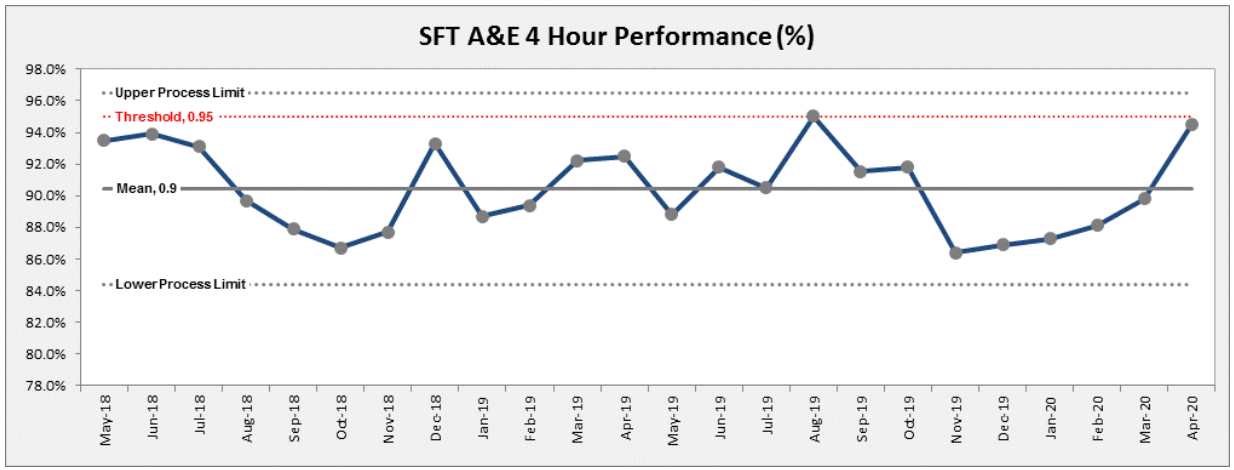
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	94.5%
Attendances:	3139
12 Hour Breaches:	0
ED Conversion Rate:	34.9%

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

M1 shows significant increase in 4hr performance from M12 (increase to 94.5% from 89.%).

Increase attributable to reduced footfall through ED due to C-19 incident.

Reduced footfall through Minors in particularly although this will increase through M2 and onwards.

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

Footfall is anticipated to increase as public behaviour changes post lockdown. A review of the minors footprint within Fracture Clinic is needed and this is being discussed by Space Allocation Group.

Joint working with Ortho and Plastics (with ED) has begun to improve the pathway for GP expected patients through the ED.

Engagement and implementation of single assessment form across all pathways required to reduce duplication and time inefficiencies.

Review role for ED Assistants either during incident or beyond to assist with 'runner' jobs to reduce time inefficiencies in patient pathways.

Risks to delivery and mitigations

Increasing footfall as public behaviour changes post lockdown.

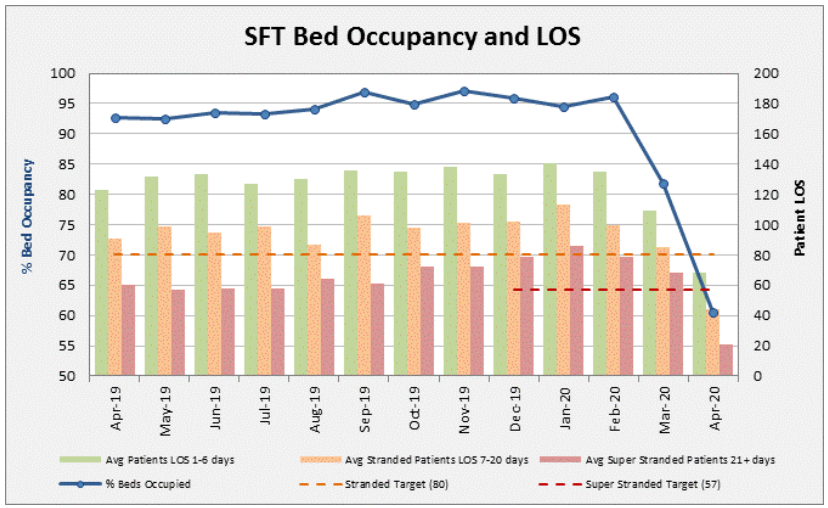
Space and social distancing constraints (particularly within Minors). Division, Space Allocation and Recovery group to review longer term plan for this service.

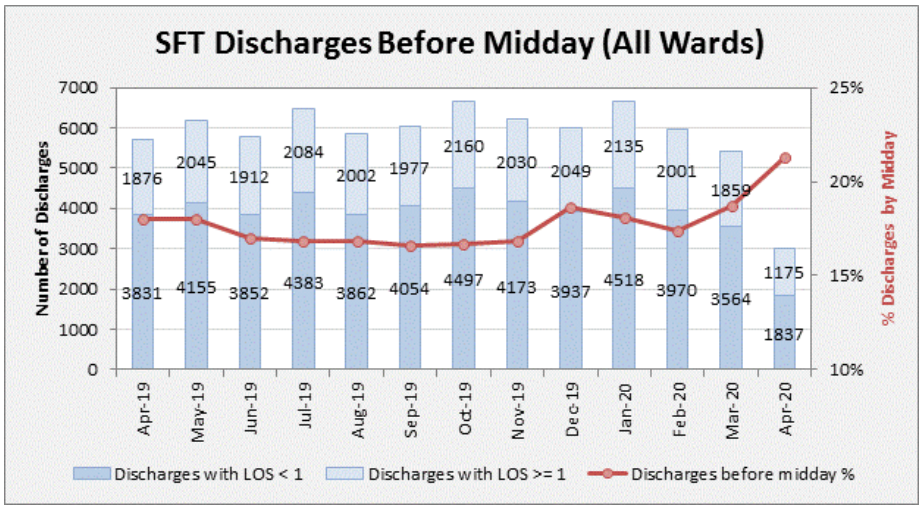
Statistical Process Control Chart Key:

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

Patient Flow and Discharge

Are We Effective?





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

M1 shows significant decrease again in all categories due to consistent drop in General Medical patients coming in to the hospital due to a combination of lack of primary care access and public concern.

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

On 11th May the Respiratory Care Unit will work in a different way. The 30 Farley beds will remain as a respiratory unit for new Category A cohort admissions however the 30 beds on Spire will be designated as a General Internal Medicine (GIM) ward to facilitate the cohorting of category B patients. This is reflective of a decreasing number of Covid -19 positive patients, and the need to screen all admissions.

Gastro will move back to Redlynch to allow surgical capacity to reopen for elective flow.

Pitton continues as the respiratory ward and ICU step down.

Risks to delivery and mitigations

Increase in General Medicine patients as COVID plateaus.

Normal levels of non-elective admissions would be challenging for the trust to manage given staff shortages and cohorting requirements for confirmed or suspected Covid-19. Capacity is currently under-utilised and a modest increase in admissions could be accommodated within the existing template.

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

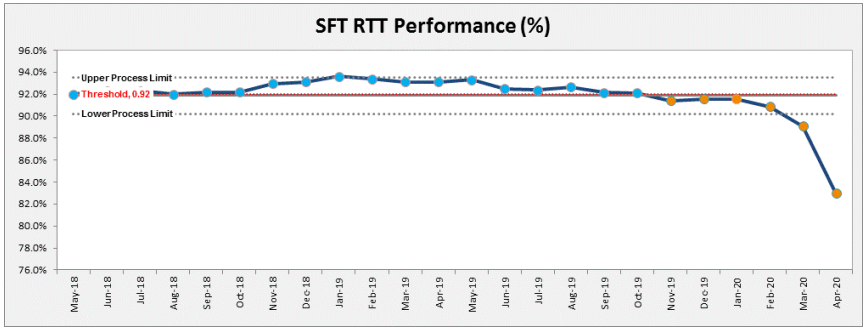
Total WL	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Dorset CCG (11J)	2,832	2,845	2,871	2,889	2,882	2,834	2,856	2,825	2,605	2,593	2,448	2,268
West Hampshire CCG (11A)	1,667	1,690	1,743	1,695	1,682	1,655	1,614	1,606	1,544	1,550	1,512	1,424
BSW (92G)	10,478	10,718	10,630	10,809	10,900	11,050	11,130	11,018	10,840	10,577	10,297	9,672
Other CCGs	2,323	2,498	2,732	2,800	2,822	2,729	2,718	2,747	2,643	2,722	2,667	2,594
Trust Total	**17,300**	**17,751**	**17,976**	**18,193**	**18,286**	**18,268**	**18,318**	**18,196**	**17,632**	**17,442**	**16,924**	**15,958**

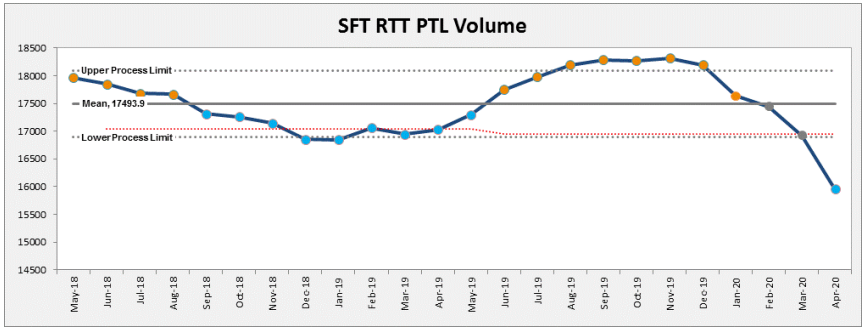
Data Quality Rating:

Performance Latest Month: 83.0%

PTL Volume: 15,958

52 Week Breaches: 10





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

Overall RTT performance fell further this month due to the continued impact of elective cancellations due to the COVID-19 pandemic. This has been further impacted by the sharp decline in routine referrals as the majority of these have been being held in primary care.

The focus this month has continued to be validating the PTL to ensure accuracy and also to support the continuation of the PTL size being below target.

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

The approach remains to continue with as much elective outpatient activity as possible using virtual solutions, both video and telephone, and enhanced advice and guidance referral triage and treatment pathways. Outpatient Recovery plans are currently being drawn up which will see a controlled increase in face-to-face activity from late May onwards where clinically necessary.

Urgent and cancer surgical activity continues to be undertaken and cases also continue to be transferred to Newhall, if clinically suitable to be undertaken there, and where there is available capacity.

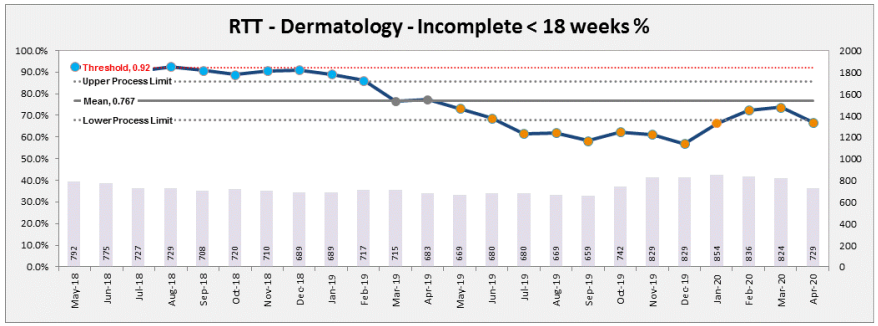
A clinical triage of the full surgery PTL has now been undertaken by the clinical teams in order to grade all patients listed based on the national priority levels and the specialty best practice guidance. This triage forms the basis of the Theatre Recovery Plan to restart further elective activity from the 21st May.

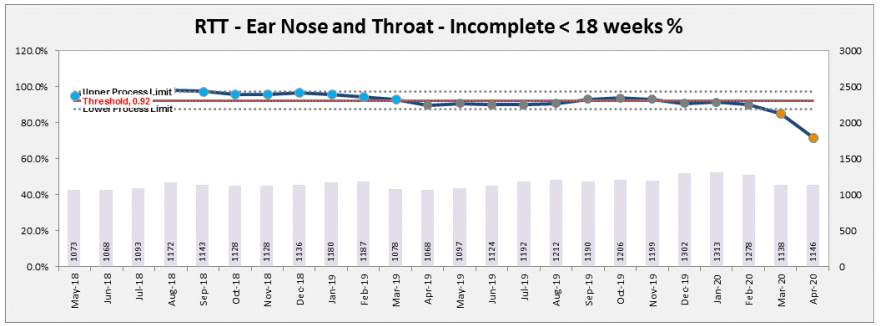
Risks to delivery and mitigations

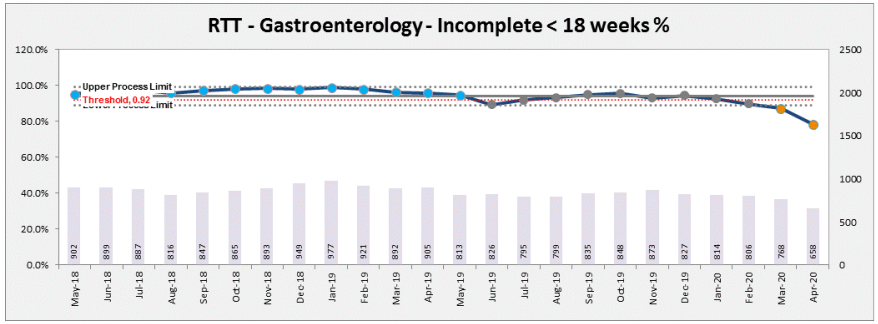
Continued risk of not achieving the performance standard in coming months due to the continued impact of the pandemic which has exacerbated the impact of previous capacity pressures.

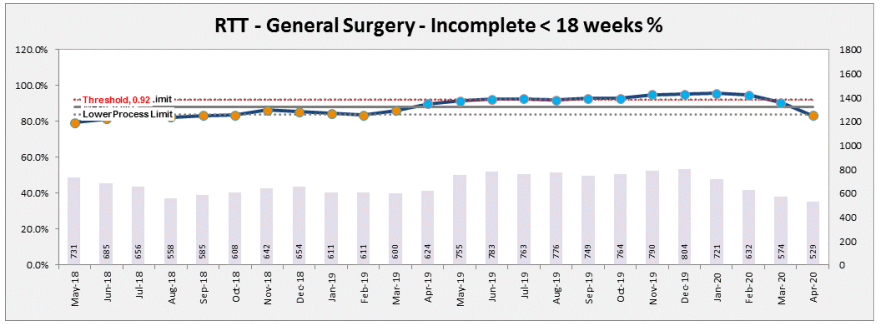
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

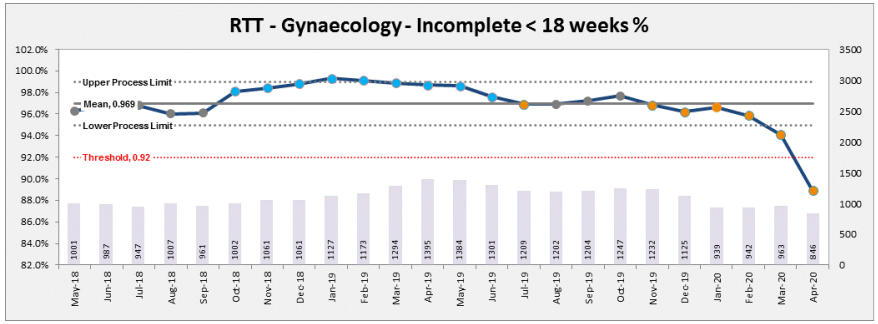
National Key Performance Indicators

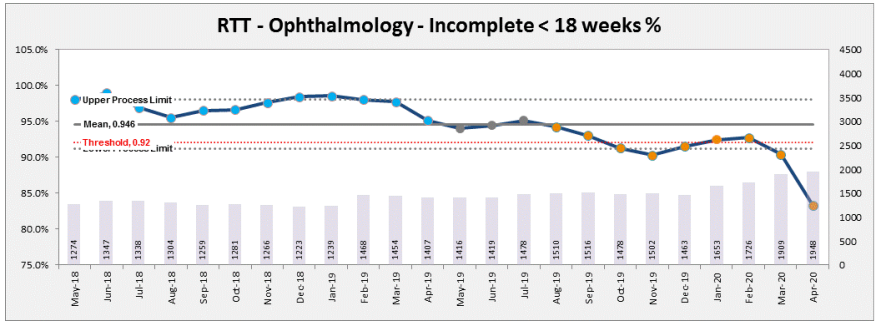






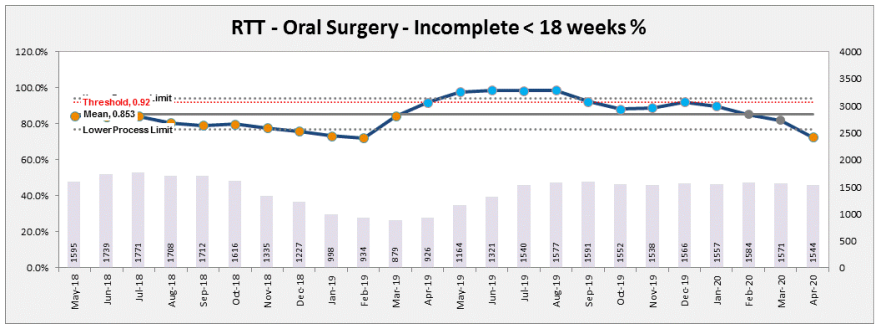


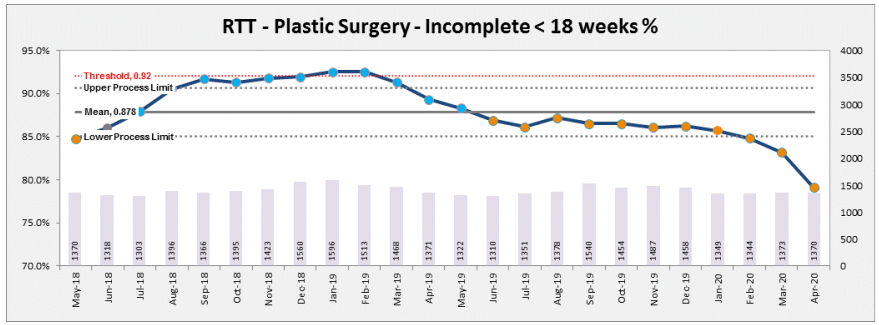


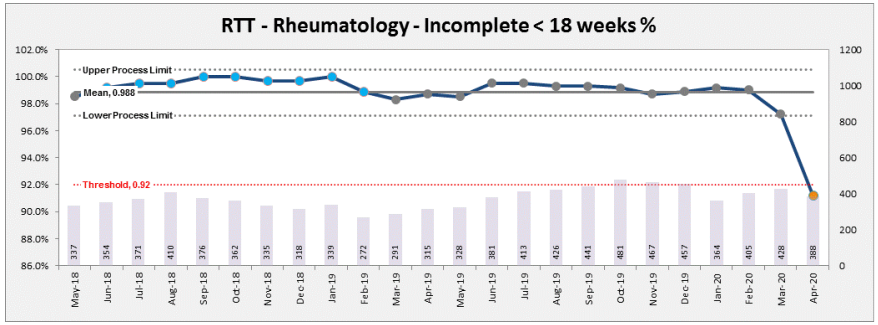


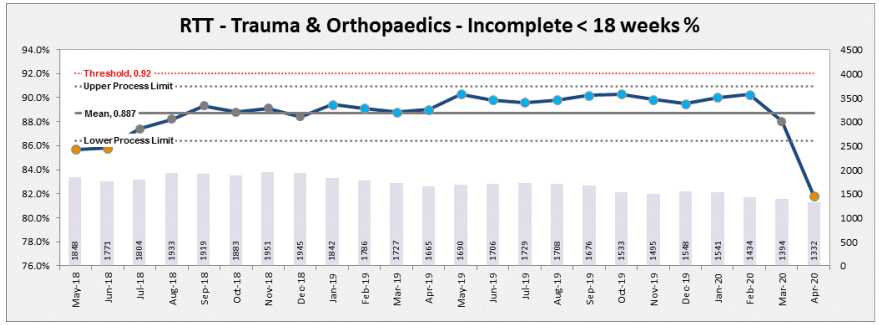
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

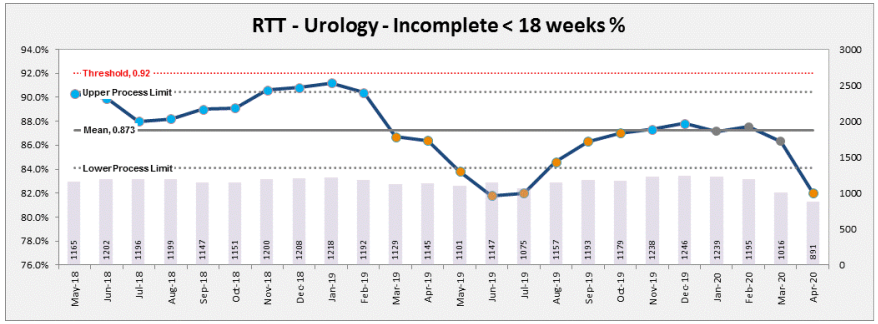
National Key Performance Indicators

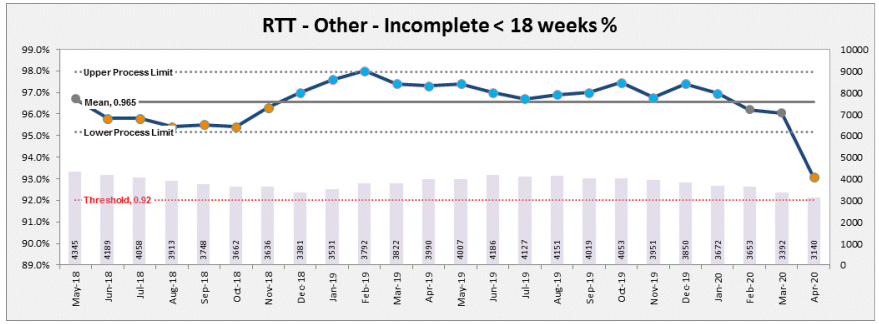






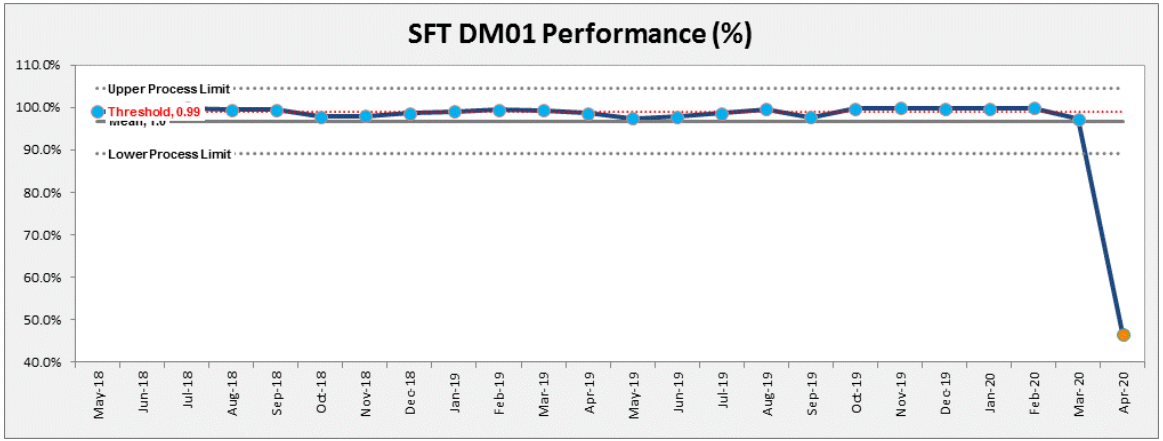






Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	46.6%
Waiting List Volume:	2,936
6 Week Breaches:	1,568
Diagnostics Performed:	2,420

Background, actions being taken and risks and mitigations

Performance standard in month has not been achieved as a direct impact of Covid-19. May projections confirm that the target is not achievable for M2 owing to limited activity taking place across all specialties and modalities.

Action is being taken at speciality level to produce SOPs, which will enable a proportion of routine work to commence. This will be entirely influenced by the capacity in waiting areas at specialty level, to ensure staff and patients are adequately protected.

Endoscopy

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

Radiology

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

Radiology Reporting

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

Audiology

0 confirmed in month breaches.

Cardiology

162 in month breaches – all attributable to Covid-19

Neurophysiology

148 in month breaches – all attributable to Covid-19

Cancer 2 Week Wait Performance Target 93%

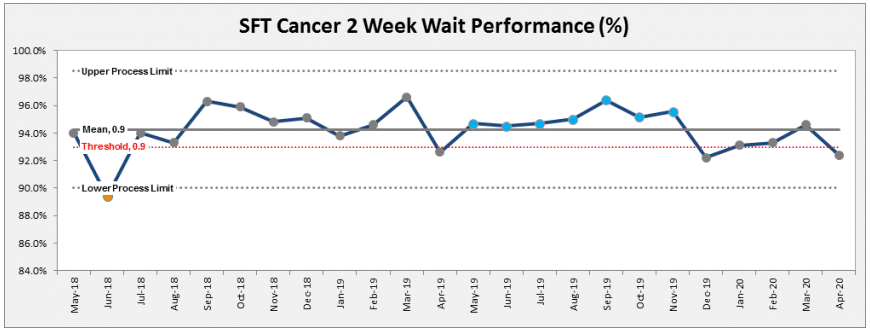
National Key Performance Indicators

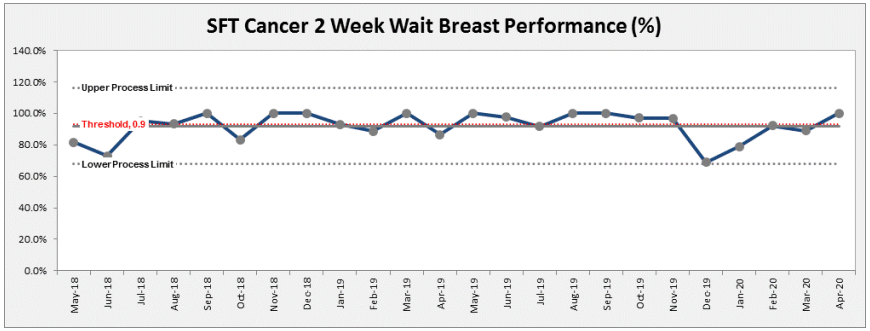
Performance Latest Month:

Two Week Wait Standard: 92.4%

Two Week Wait Breast Standard: 100%

Data Quality Rating:





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

M1 not achieved for 2WW though breast screening at 100%. Endoscopy provision during COVID-19 major factor in the lack of achievement of the 2WW standard. The Q1 figure for 2WW is 92.98%

We are experiencing a reduction of approximately 70% for 2WW referrals. Slight increase in M2. June numbers should rise substantially now endoscopy is up and running.

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

PTL format under review. Roll out has been delayed with organisational focus on Covid-19, it is planned to be implemented in June.

Options are being developed to develop a demand and capacity model/predictor to look at a potential forecast for 2WW referrals and associated capacity.

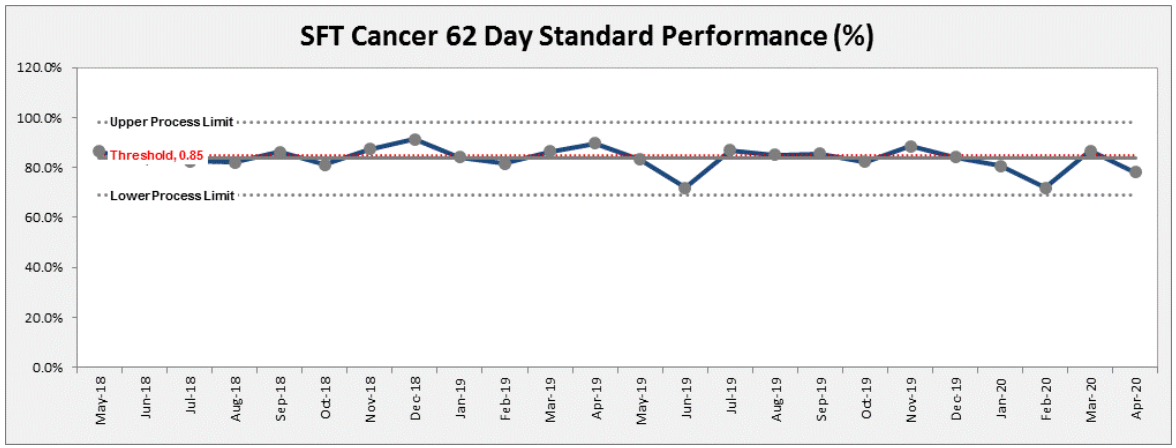
Risks to delivery and mitigations

Clinic capacity due to endoscopy guidance of 24th March has had a significant impact on large numbers of colorectal and upper GI patients are being 'held' on the PTL awaiting diagnostics.

As of 13th May, endoscopy services reintroduced and backlog (92 patients) are nearly all booked.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard: 76.8%

62 Day Screening: 100%

Risks to delivery and mitigations

M1 validated position of 76.79% with a total of 13 breaches. Deterioration in performance due to impact of Covid-19 in M1 and a Q1 62 day position of 79.87%.

Concerns over future performance as a result of Covid-19. All Endoscopy has been on hold, but will resume in Mid-May, albeit at a lower capacity due to screening and cleaning requirements between cases.. Robust processes in place to triage all patients and patient lists available to start prioritisation of cases once services can resume. Due to the lack of diagnostics available in this regard, patient's diagnosis and therefore treatment is likely to be significantly delayed and may affect cancer performance.

The majority of tumour sites which are not reliant on endoscopic diagnostics are able to continue with business as usual, though there are instances whereby patient's treatment options have changed in light of challenges at tertiary providers as a result of Covid-19.

Screening performing well with both 2WW and 62 day achieving 100% for M1.

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

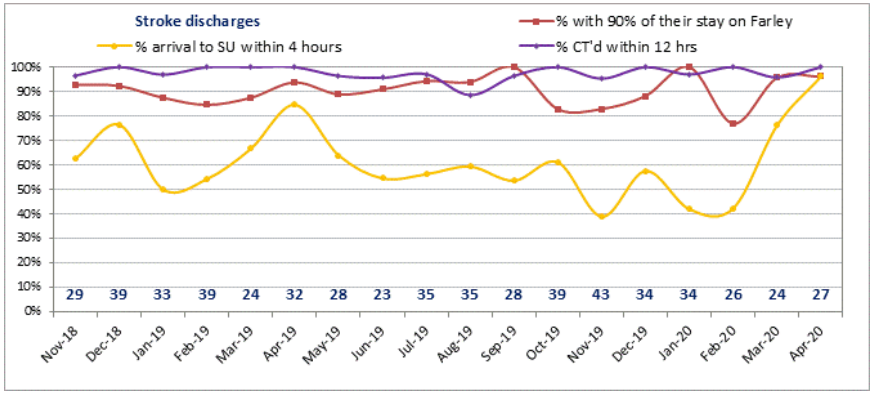
Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20	B	B	B	

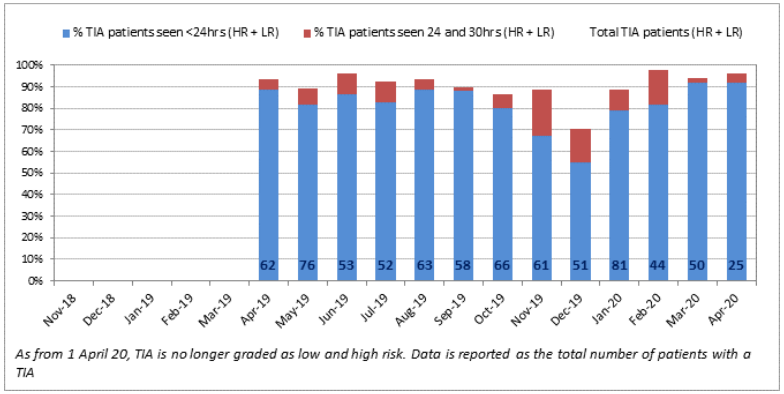
Data Quality Rating:

% Arrival on SU <4 hours: 96.2%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 92.0%





As from 1 April 20, TIA is no longer graded as low and high risk. Data is reported as the total number of patients with a TIA

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

The stroke unit remains relocated on Laverstock ward as part of the COVID-19 plans. It was anticipated this would have an adverse impact on the unit's performance but this has not proved to be the case in April. In fact, performance significantly improved. TIA performance is excellent. Note: As from 1/4/20 ,TIA is no longer graded as low and high risk. Data is reported on the total number of patients with a TIA.

Q3 SSNAP audit score was B helped by the increase in the number of SALT therapists. Q4 SSNAP audit score is expected in June. An A score depends on benchmark data, but some hospitals have been unable to report Q4 data during the COVID-19 emergency. An A score is therefore in doubt.

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

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

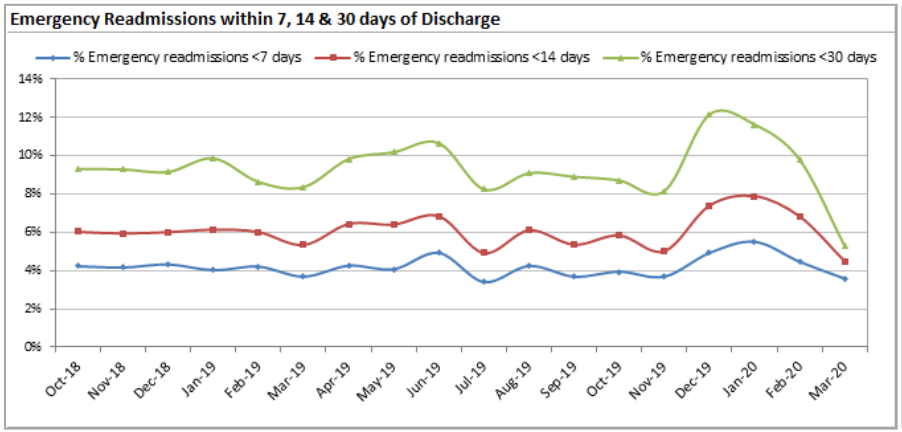
As part of the COVID-19 arrangements, the stroke unit has acted as a hyper-acute unit with patients who require rehabilitation discharged to community hospitals or 'discharge to assess' at home with therapy provision in the community. This model has replaced the early supported discharge (ESD) stroke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

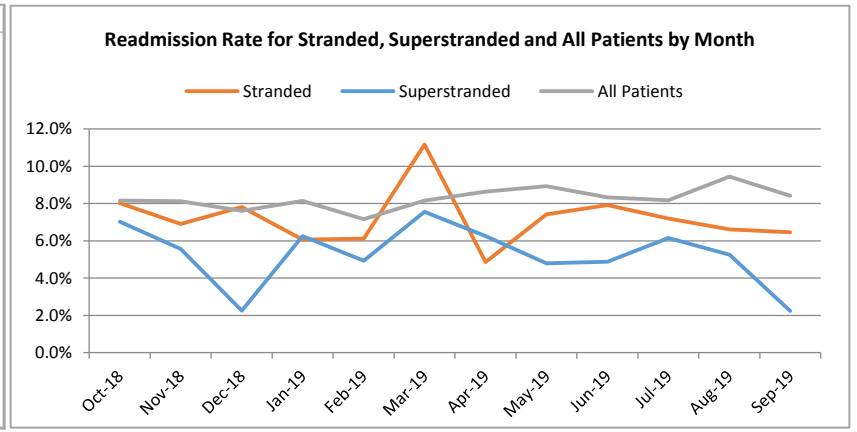
Risks to delivery and mitigations

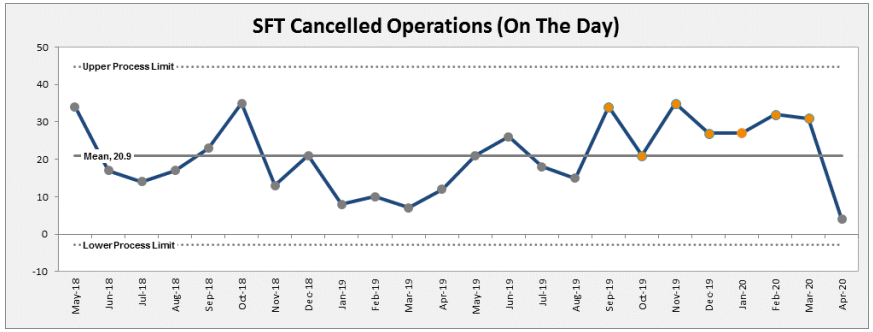
The national concern that patients with a stroke/TIA are not presenting to hospital due to fears about COVID-19 is born out by our data. The average number of stroke admissions has reduced from 26.2 (Dec 19 – April 20) to 19.7 (Feb – April 20). There has also been a significant reduction of TIA patients attending a clinic within 24 hours – 25 in April compared to an average of 40 – 60 patients a month. National news in the last few weeks has emphasised the importance of people seeking help for these conditions, as emergency services are open as business as usual.

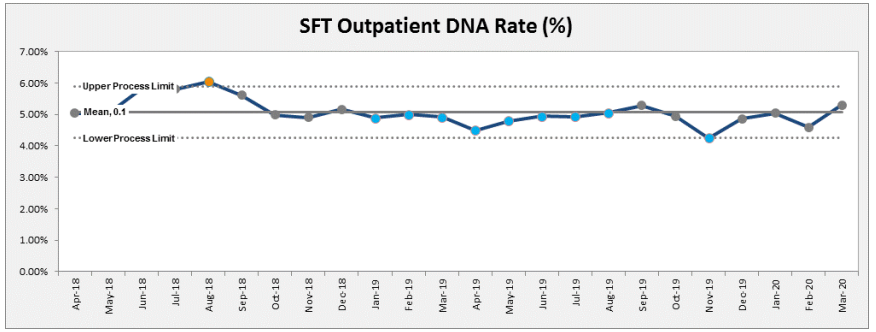
Other Measures

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		

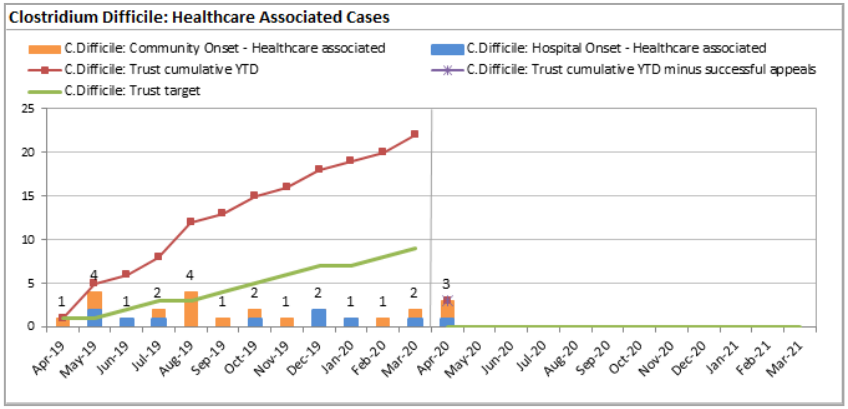
Infection Control

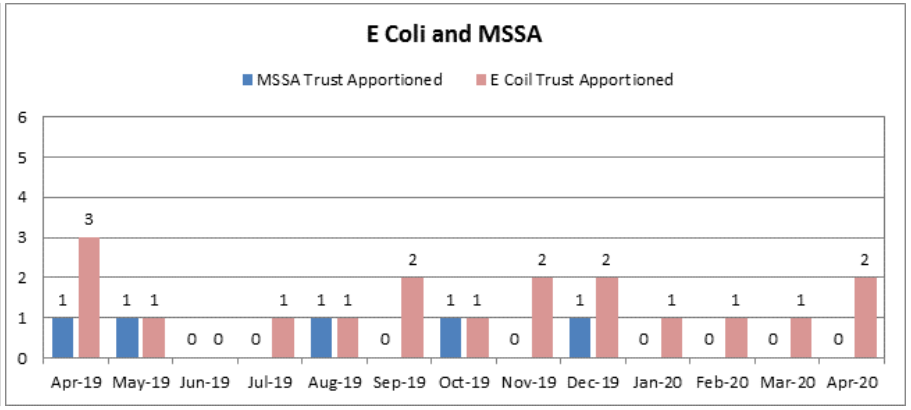
Data Quality Rating:

Are We Safe?

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

MRSA	2019-20	2020-21
Trust Apportioned	0	1





Summary and Action

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

In April, 1 hospital onset health care associated case of a patient on a surgical ward currently under investigation. Two community onset healthcare associated cases which means patients developed C.difficile within 30 days of discharge from hospital. Of these 2 cases, 1 patient was on the Acute Medical Unit and 1 was an inpatient at Westminster Memorial Hospital had had recent care between the two hospitals and was first identified as C.difficile positive in March 20 (classed as a new case).

One MRSA bacteraemia of a patient on the oncology ward. A review has been completed and will be presented at the Infection Prevention and Control Working Group. The patient has been successfully treated for MRSA and is now clear.

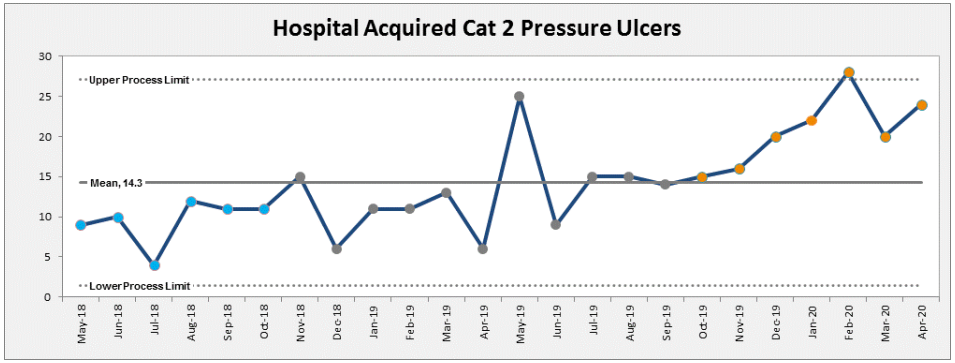
Two Trust apportioned E Coli bacteraemias - 1 case of a patient initially admitted with suspected ingestion of descaler (thought to be unlikely) and discharged home. Re-presented with vomiting and temperature. The patient was transferred to UHS due to blood results. Source of infection assessed as 'unknown'. The other case was an ICU patient where the source of infection was classified as gastrointestinal/intra-abdominal collection. The patient was admitted unwell, and identified as COVID-19 positive, later recovered and transferred to a medical ward.

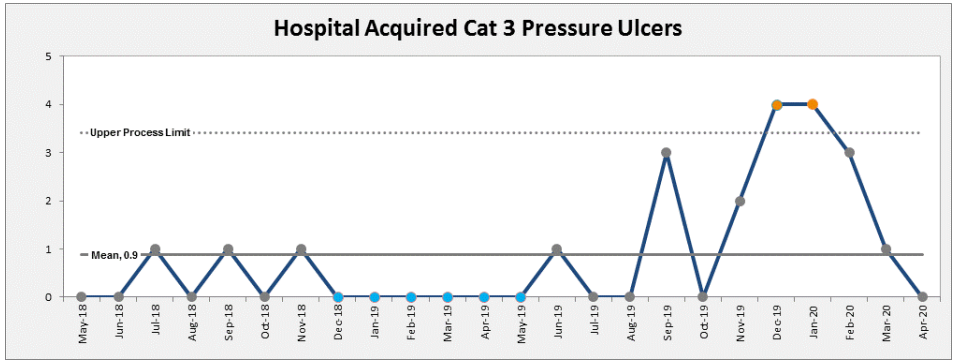
In respect of the COVID-19 emergency, the Trust continues to deal effectively with suspected and actual cases. Daily meetings take place to ensure national guidance is implemented. A COVID-19 clinical reference group meets twice a week to consider risks associated with service changes and mitigation and makes recommendations to the recovery cell.

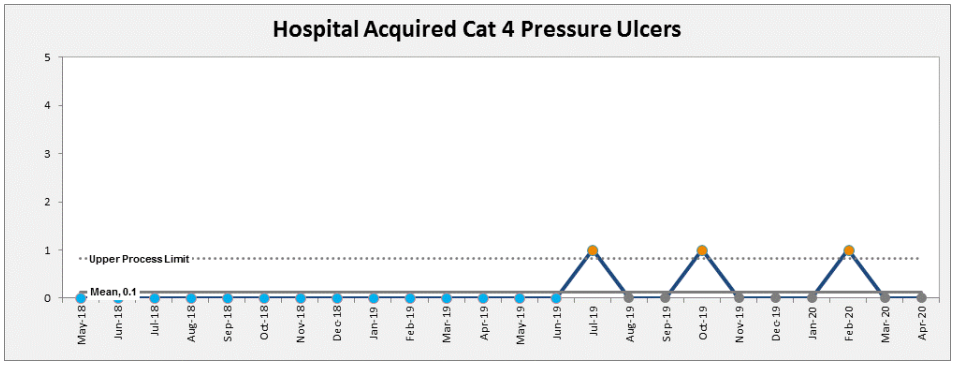
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1
Pressure Ulcers	1.05	1.10	1.22	1.73	3.35

Summary and Action

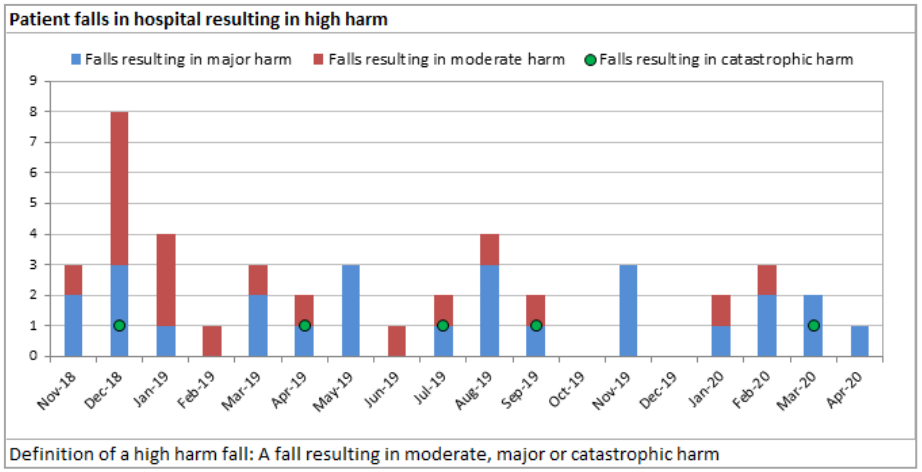
Of concern is, 24 category pressure 2 ulcers in April in a period of reduced activity. Of these, 8 have been in 3 critically ill patients associated with COVID-19 proning and mucosal lesions in the mouth and nose of patients with an ET tube and ventilation. The other 16 relate to a lack of knowledge about prevention, skin assessment and wound care. The Tissue Viability team have trained over a 100 staff in the last month in skin care and will publish an item in the 'React to Red' bulletin.

A pressure ulcer cluster review of Trust apportioned category 3 and 4 pressure ulcers and a Trust wide improvement plan is in place and will be overseen by the Nursing, Midwifery and AHP Forum and progress reported to the Clinical Risk Group. The report and action plan is due to be presented to the Clinical Governance Committee in June 20 by the Divisional Head of Nursing, Surgery and Head of Nursing, Medicine Division. The CCG will receive the cluster review and improvement plan report.

It is too early to conclude any impact of the improvement plan thus far.

Patient Falls

Are We Safe?



Definition of a high harm fall: A fall resulting in moderate, major or catastrophic harm

Data Quality Rating:

Per 1000 Bed Days	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1
Patient Falls	0.16	0.20	0.07	0.17	0.14

Summary and Action

For clarity, reporting amended to falls in hospital resulting in high harm. High harm falls are defined as a fall that results in moderate, major or catastrophic harm in line with national guidance.

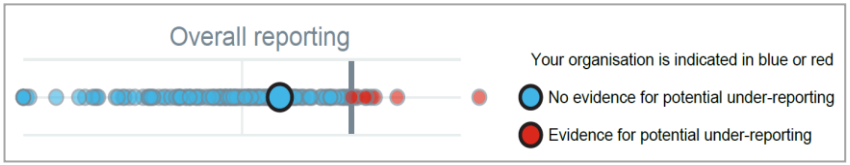
In April, 1 fall resulting in major harm of a fractured distal femur requiring surgical treatment. This case is not subject to a serious incident inquiry as the SWARM showed no lapses in care and no new learning.

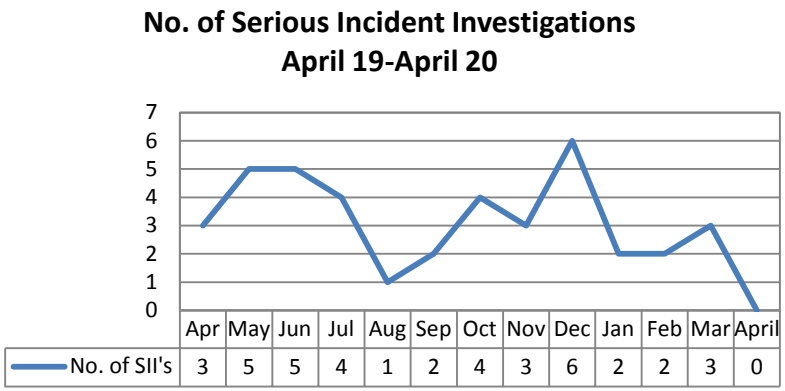
Incidents

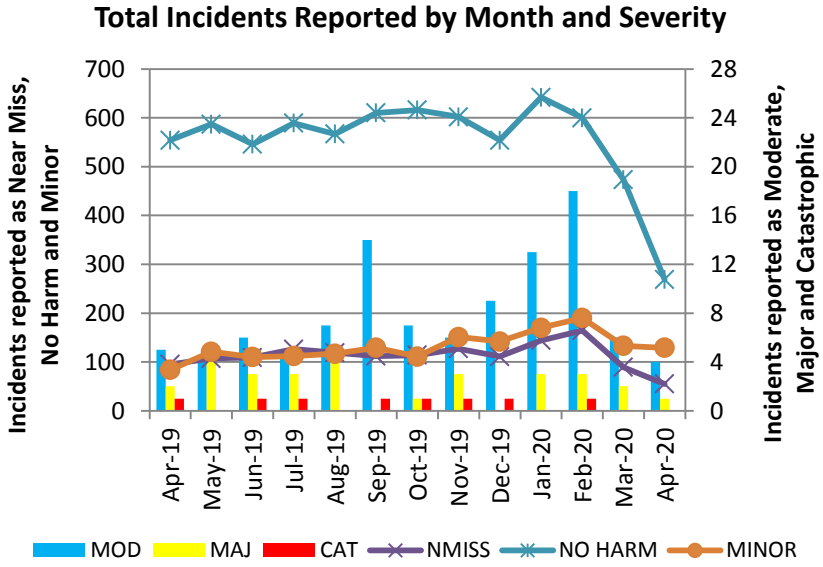
Are We Safe?

Year	2019-20	2020-21
Never Events	2	0

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







Summary and Action

There were no commissioned serious incidents in April.

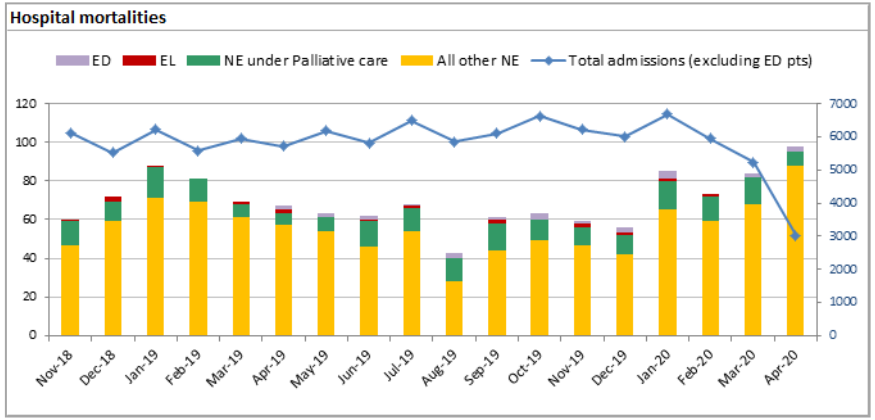
Of concern, is the number of category 3 and 4 pressure ulcers which increased from 3 in 18/19 to 21 in 19/20. A cluster review and aggregation of the key contributory factors was completed with an overarching action plan approved by the Clinical Risk Group. A quality improvement project is planned to support the ongoing quality improvement action plan. The Heads of Nursing will present on the cluster review and improvement plan at the Clinical Governance Committee in June 20.

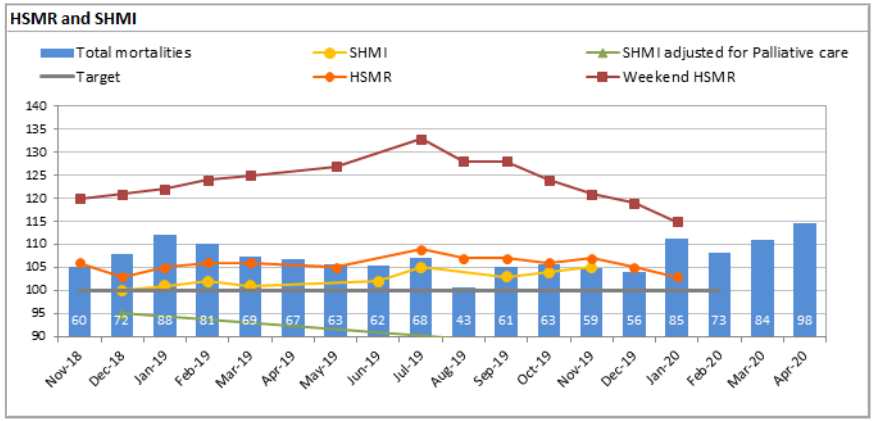
The cancer risk summit follow up meeting went ahead as a virtual meeting in May in a slightly different format than planned due to Covid-19. Three Task and Finish group leads presented the progress of their individual work streams and the outcome will be reported at the Clinical Governance Committee in June 20.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected. It is possible HSMR may start to rise again with an increase in the crude mortality rate in March and April due to COVID-19 deaths. The weekend HSMR trend has decreased and is now as expected.

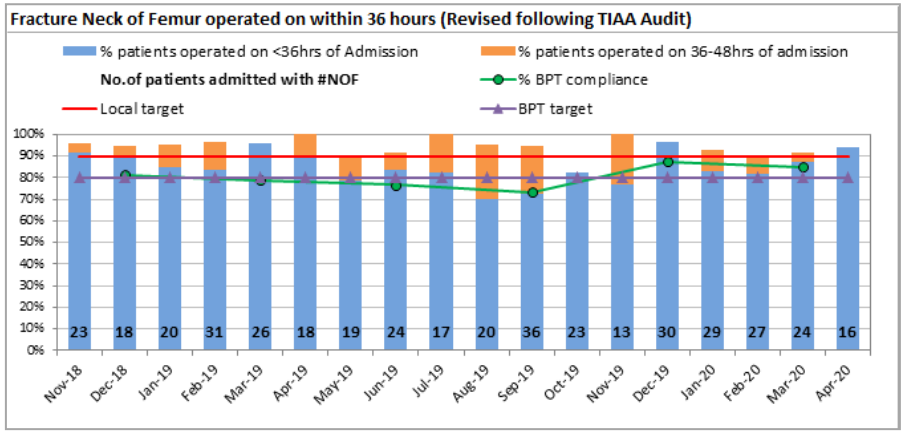
Total deaths associated with COVID-19 are 51 (18 May). 72% were men, the majority over 80 with underlying health conditions and the cause of death recorded as COVID-19 pneumonia. On 23 April, NHSE changed the definition to include patients who had a negative swab test result for COVID-19, but had coronavirus recorded on their medical cause of death certificate and these were reported nationally.

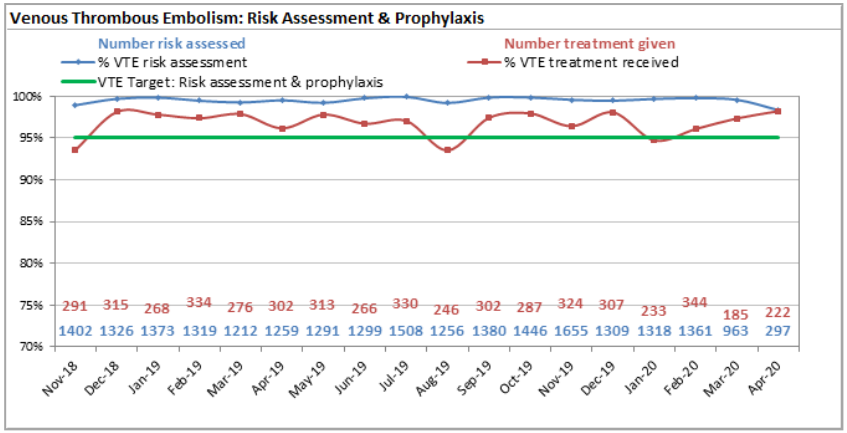
The Trust has started to review the deaths of patients who died from COVID-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate, and if patients required ventilation, received it. This will be reported to the Mortality Surveillance Group in September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

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

In April, 3 patients did not receive hip surgery for a fractured neck of femur within 36 hours whilst waiting for medical review or stabilisation - waiting for CT (1), pancreatic cancer waiting for transfusion prior to theatre (1), waiting for an investigation (1). These patients received surgery between 48 – 63 hours following admission.

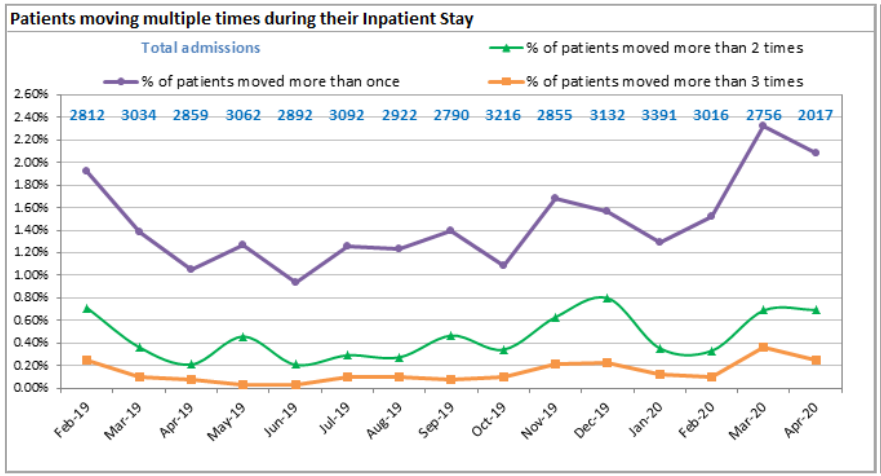
NHSE and NHSI suspended reporting of VTE assessment and prophylaxis in Q1 20/21 but the Trust continued to report a high level of performance to provide assurance on the quality of care.

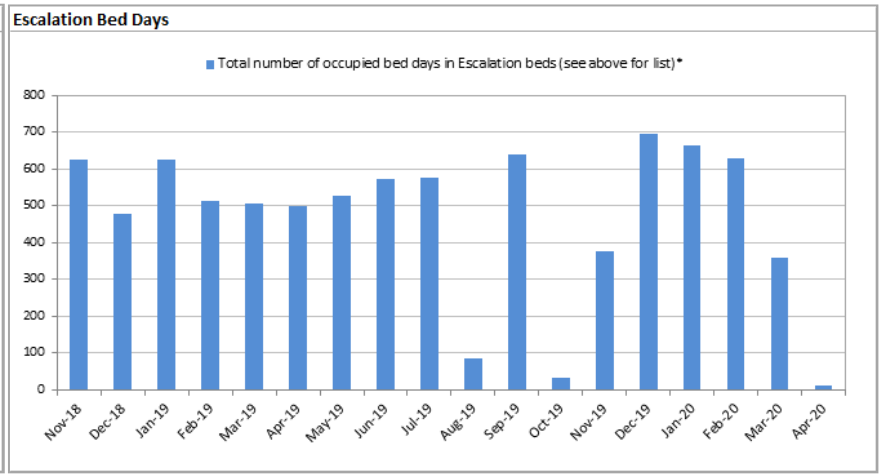
Patient Experience

Are We Safe?

Last 12 months	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
Bed Occupancy %	92.5	93.5	93.3	94.1	96.9	94.9	97.1	95.9	94.4	96.1	81.8	60.5

Data Quality Rating:





Summary and Action

Escalation bed capacity was minimal in April associated with a significant reduction in admissions. The number of multiple ward moves also decreased as the preparations for the COVID -19 emergency were completed in establishing a respiratory unit and designation of other wards.

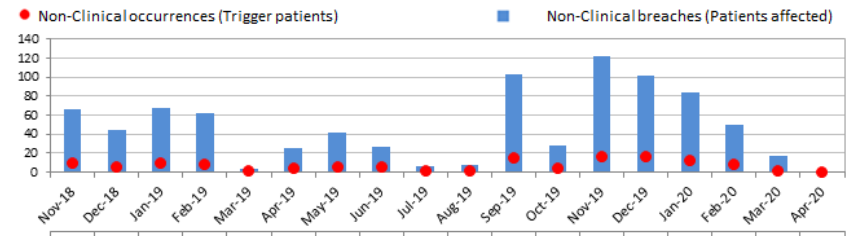
The national policy changed on 10 May to 'Stay alert, control the virus, save lives', as social distancing and hand hygiene have reduced the R rate and have been effective in maintaining sufficient critical care capacity in the hospital.

Patient Experience

Are We Safe?

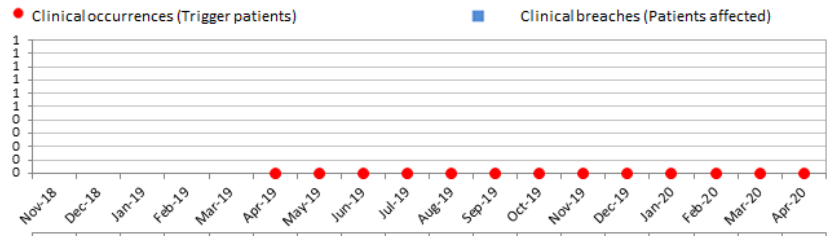
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	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	Jan-20	Feb-20	Mar-20	Apr-20
■	66	45	67	62	3	26	42	27	7	8	103	28	122	102	84	50	17	0
●	10	5	10	9	1	4	6	5	1	1	15	4	17	16	13	8	2	0

Delivering Same Sex Accommodation - Clinical



	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	Jan-20	Feb-20	Mar-20	Apr-20
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

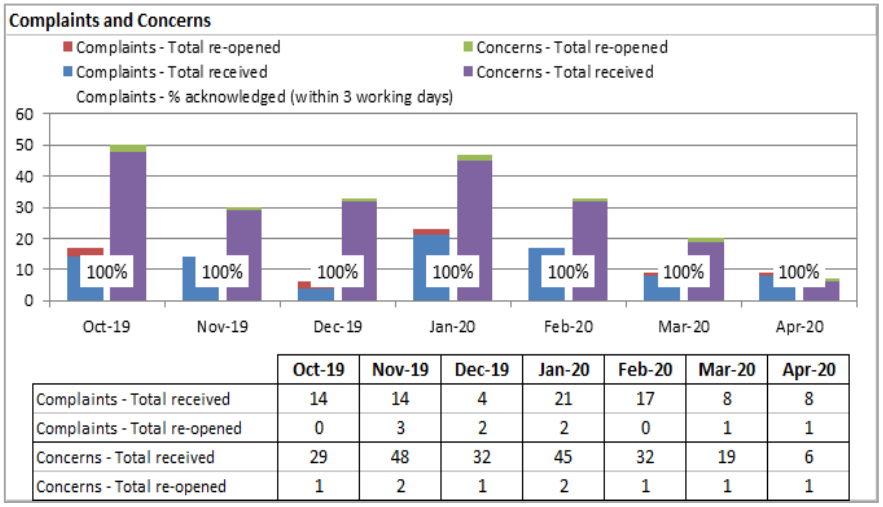
Summary and Action

No reported mixed sex accommodation breaches in April associated with a significant reduction in the number of admissions.

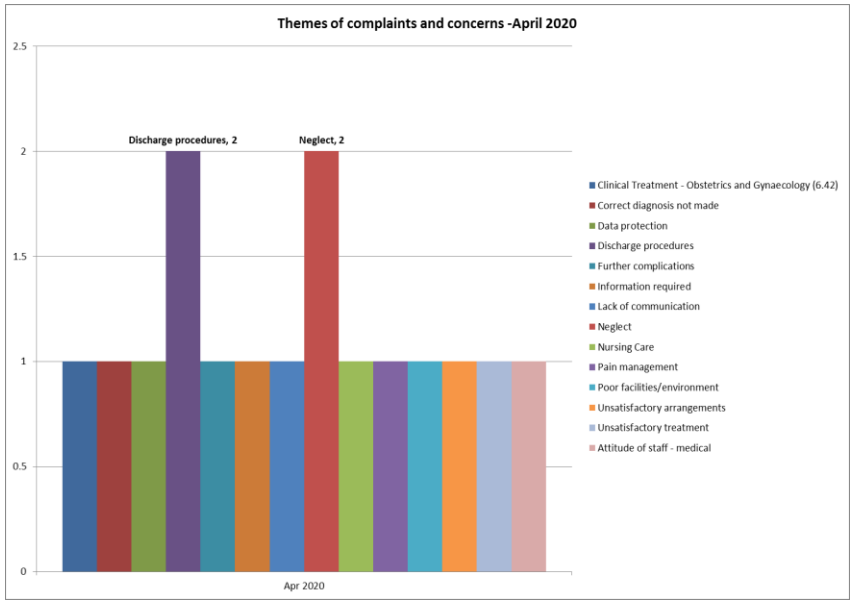
Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

Data Quality Rating:



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Complaints - Total received	14	14	4	21	17	8	8
Complaints - Total re-opened	0	3	2	2	0	1	1
Concerns - Total received	29	48	32	45	32	19	6
Concerns - Total re-opened	1	2	1	2	1	1	1

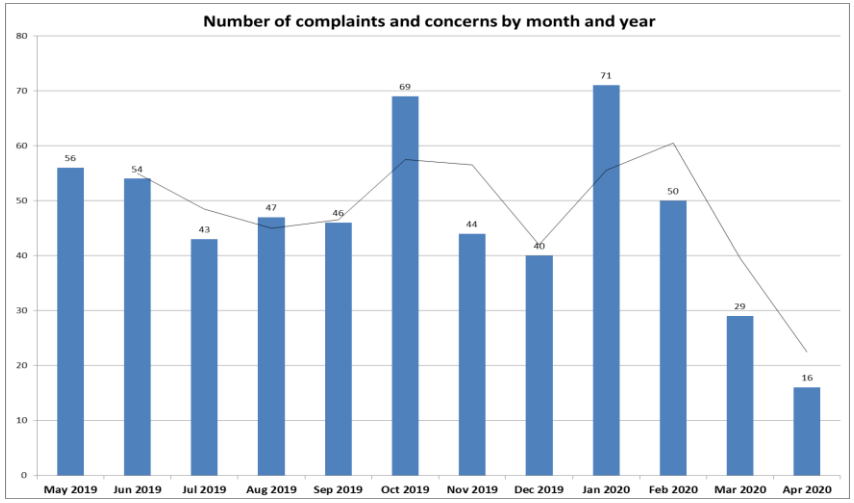


Summary and Actions

The PALS team have seen a significant reduction in complaints and concerns in March and April 2020. This could be due to the initial phase of the pandemic as patients and their families may have felt reluctant to raise concerns; not wishing to add additional pressure on the NHS, or simply that there has been a reduction in patient contact due to many departments running a limited service.

NHSE/I retain a 'pause' on complaint investigations. However, where Divisions have capacity, complaint investigations are ongoing.

Although small numbers, the top 2 themes of complaints and concerns in April was 'neglect' and 'discharge procedure'. The 2 complaints under the sub-subject of 'neglect' were raised by the adult safeguarding team. The focus being on delayed diagnosis of fractures. These are currently under investigation. The top theme for comments where related to COVID-19.



Part 3: Our People

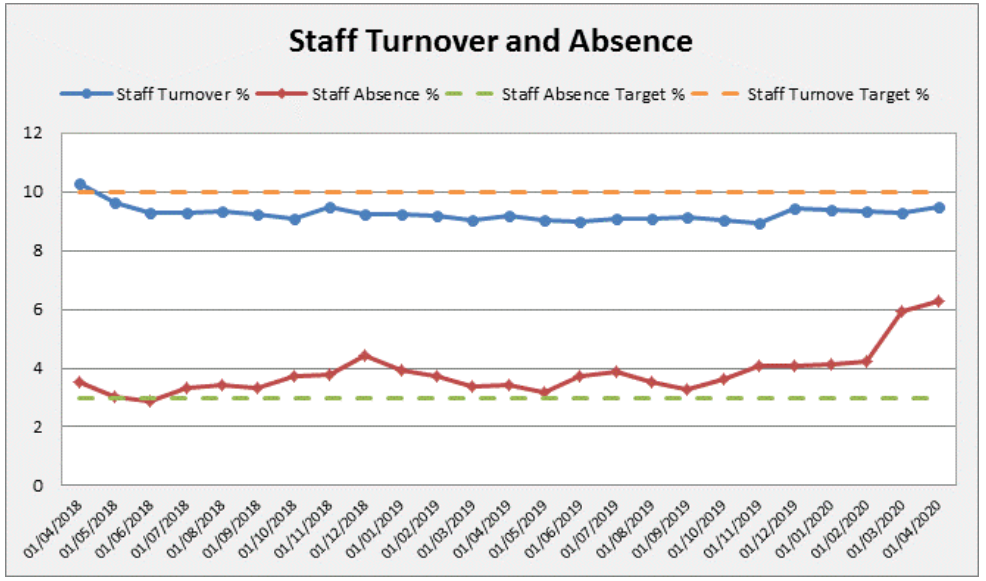
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Apr '20		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	424.9	418.1	6.8
Nursing	943.4	1,024.8	(81.4)
HCAs	411.9	518.1	(106.3)
Other Clinical Staff	614.1	616.3	(2.2)
Infrastructure Staff	1,177.0	1,043.2	133.9
TOTAL	**3,571.4**	**3,620.5**	**(49.1)**



Summary and Action

Staff turnover for April was 9.5%, an increase on last month, but remainning below the 10% target. There has been a significant increase in the number of leavers up to 37 (an increase of c.10) . However, 15 of these leavers (taking up 38%) were reported as age retirements with the remainder being a variety of reasons including relocation, work-life balance and adult dependents. It is unknown at this point whether there is any connection with Covid—19 although it is noted that the highest number of leavers occurred in Surgery which, in its new configuration from April, contains several services that were previously in MSK.

Sickness absence has again increased by 0.37% to 6.29% with the overall figure driven by a 10% increase in long term sickness and corresponding decrease in short term absence. It is also important to note that 2.88% of this total is COVID-19 related whereas 3.41% is not. Hot spot groups are Midwifery Care Assistants, RDAs, HCAs, Housekeeping and Theatres.

Across the Trust there are two cases at Stage 4, 25 at Stage 3 and 76 at Stage 2. Priority actions involve telephone, email or video call input from People Business Partners/Advisors to managers for advice and support, regular review of individual cases with Occupational Health Advisors where appropriate, and reinstatement of the sickness Forum for example in Estates & Facilities. There is anecdotal evidence that anxiety/stress is also on the increase as a result of the pandemic as individuals are concerned about their work potentially impacting on their domestic arrangements and those they live with.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

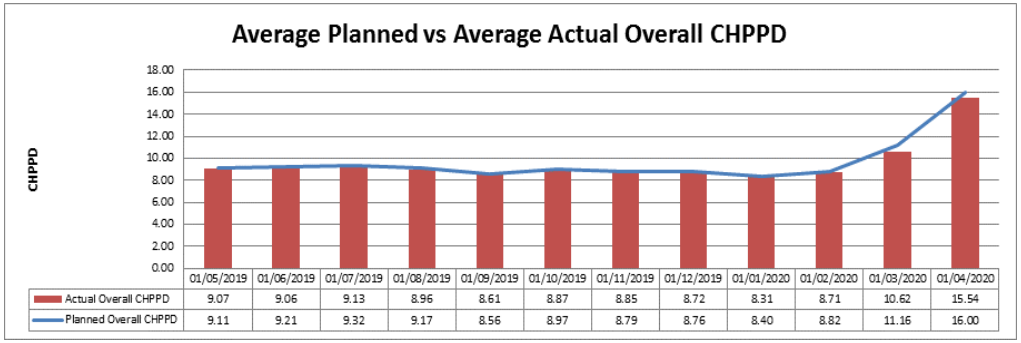
Table 1

Day	RN	HCA
Total Planned Hours	38332	19712
Total Actual Hours	38074	19345
Fill Rate (%)	99%	98%

Night	RN	HCA
Total Planned Hours	27313	12049
Total Actual Hours	26489	12193
Fill Rate (%)	97%	101%

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

Table 2



	01/05/2019	01/06/2019	01/07/2019	01/08/2019	01/09/2019	01/10/2019	01/11/2019	01/12/2019	01/01/2020	01/02/2020	01/03/2020	01/04/2020
Actual Overall CHPPD	9.07	9.06	9.13	8.96	8.61	8.87	8.85	8.72	8.31	8.71	10.62	15.54
Planned Overall CHPPD	9.11	9.21	9.32	9.17	8.56	8.97	8.79	8.76	8.40	8.82	11.16	16.00

Summary and Action

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

Aggregated Trust data appears to show a sharp increase in both planned and actual staffing levels, however on further analysis this is skewed by the number of ward and bed closures, staff who have been redeployed and staffing templates set to manage high numbers of COVID patients that was not realised. Due to issues in how this data is managed at ward level, which impacts on the reported data this will be cleansed and re-run. It is anticipated this will result in actual staffing levels being above planned. Due to the issues with the data the divisional level graphs have been removed.

Several wards flagged red (internal rating) for this reporting month, again due to roster housekeeping – this will again be reviewed next month. All wards had sufficient staff for the numbers of patients admitted, as bed occupancy was circa 60% and staffing templates set for normal bed occupancy.

The skill mix of RN:HCA has improved with RN 67% /HCA 33%. The broad recommendation is 65%:35%. For April and May the RN and HCA levels both sit at around 100% - due to both significant reduction in RN vacancy levels, and reduction in demand for enhanced care requiring additional staff.

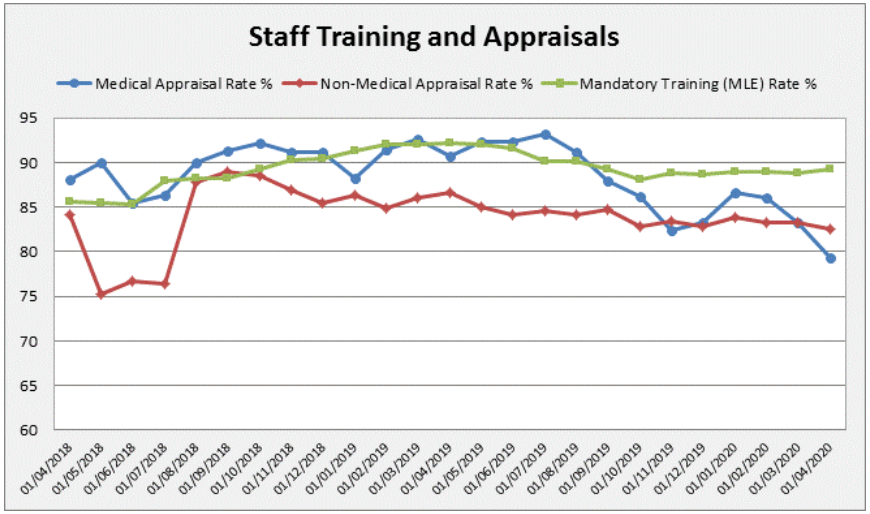
At the time of completing this report bank and agency spend for nursing is not available. The expectation is for the expenditure on agency to have significantly reduced across April/May. A small use of Thornbury (off framework agency) was used on Odstock for the enhanced care of a mental health patient.

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

Workforce – Staff Training and Appraisals

Use of Resources

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%
Jan-20	89.03%	86.62%	83.90%
Feb-20	88.95%	86.03%	83.33%
Mar-20	88.81%	83.27%	83.24%
Apr-20	89.33%	79.42%	82.46%
Totals	89.03%	83.84%	83.23%



Summary and Action

Training

Mandatory training has increased slightly in April to 89.3% and is expected to continue to rise as staff are working from home or working in quieter areas where they can have access to a PC during working hours.

All of the Divisions are above target, but issues are being reported with both GDPR and Hand Hygiene training. Safeguarding training also appears to be an issue as it appears that some staff (pharmacy, labs) have this in their learning tree but should not, and reports that Level 2 Safeguarding is being missed although individuals have done Level 3.

There is a data cleanse of the system under way to eradicate the Levels issue and review of the learning trees where necessary. Individuals are being encouraged to take every opportunity to reach their own 100% compliance.

Non Medical Appraisals

At 82.46% compliance against the target of 85%, this is area which has become affected by the capacity, opportunity and means to conduct them in the face of Covid-19 related issues. Managers are being encouraged to undertake these remotely although the availability of some managers working operationally has hampered the effort to manage these within time.

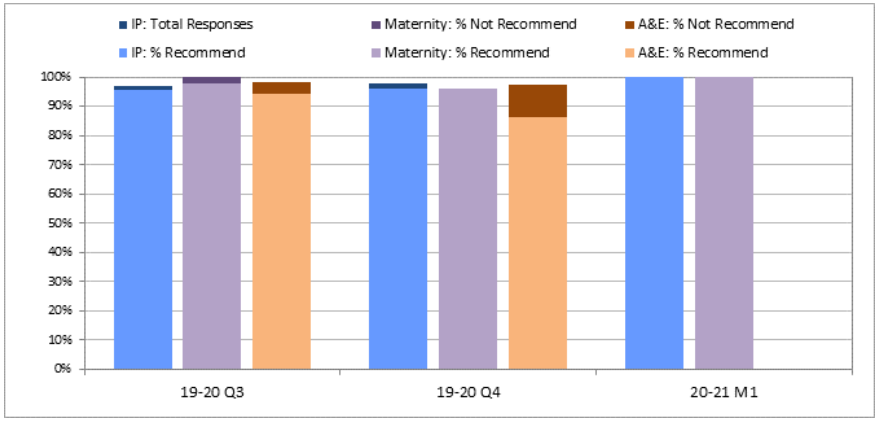
Medical Appraisals

Already rapidly reducing to 79.4% which was inevitable as the process was suspended by the GMC last month.

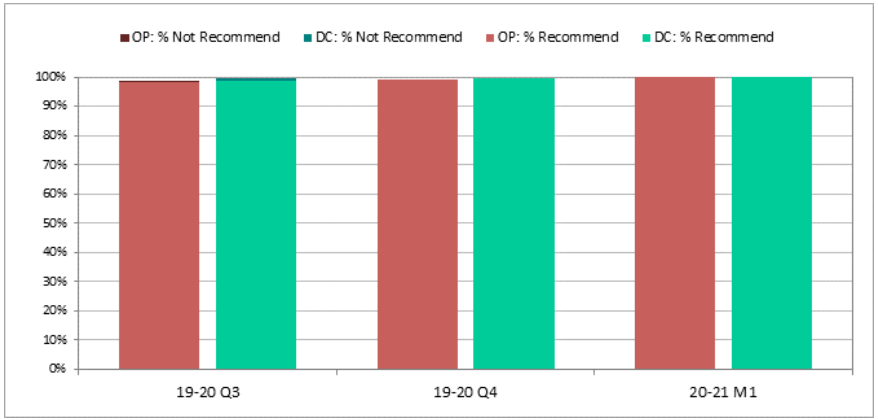
Friends and Family Test – Patients and Staff

Use of Resources

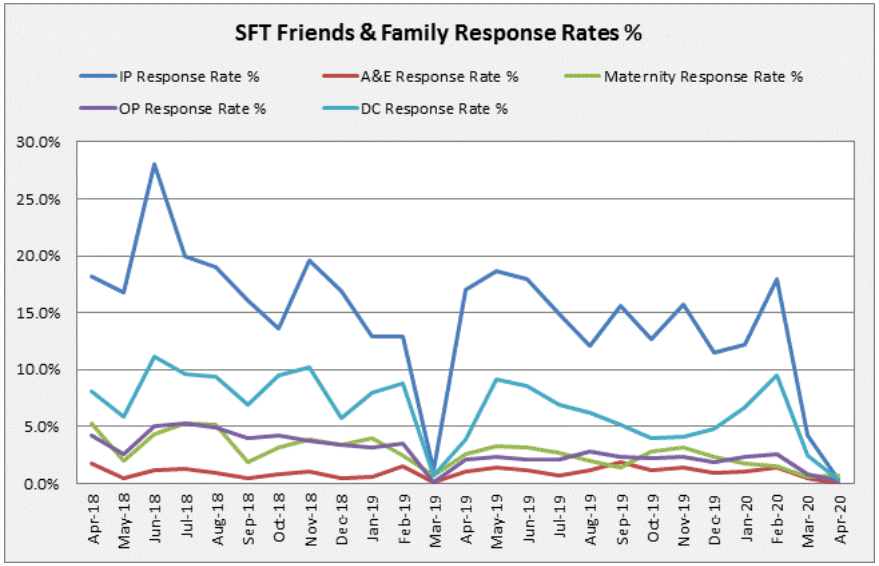
Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase

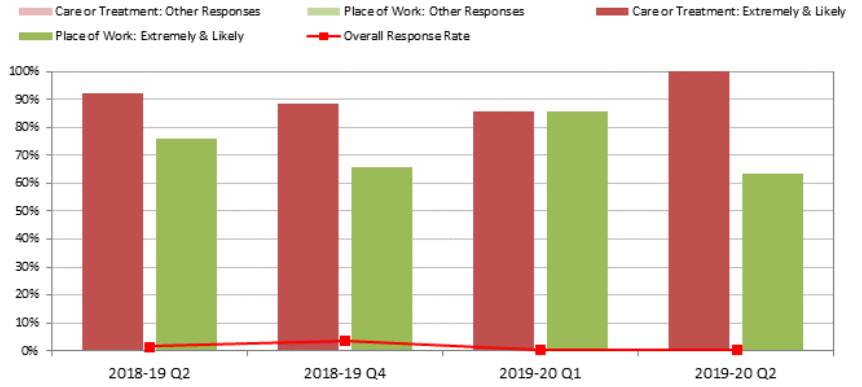


SFT Friends & Family Response Rates %



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

Staff Responses: Place of Work and Place of Care



In April 20:

- No ED patients responded.
- 4 responses from maternity patients, 2 day cases and 1 outpatient – all extremely likely & likely to recommend the service to their family and friends..

Part 4: Use of Resources

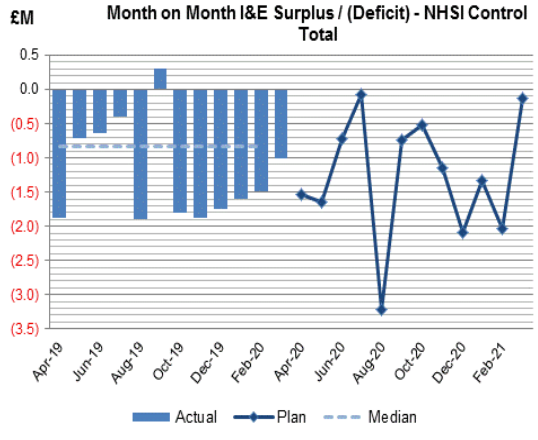
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Apr '20 In Mth			Apr '20 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	17,278	17,386	108	17,278	17,386	108	208,163
Other Clinical Income	863	2,352	1,489	863	2,352	1,489	12,789
Other Income (excl Donations)	2,416	2,260	(156)	2,416	2,260	(156)	28,992
Total income	**20,557**	**21,998**	**1,441**	**20,557**	**21,998**	**1,441**	**249,944**
Operating Expenditure							
Pay	(13,637)	(14,352)	(715)	(13,637)	(14,352)	(715)	(163,634)
Non Pay	(7,012)	(6,309)	703	(7,012)	(6,309)	703	(84,050)
Total Expenditure	**(20,649)**	**(20,660)**	**(11)**	**(20,649)**	**(20,660)**	**(11)**	**(247,684)**
EBITDA	**(92)**	**1,337**	**1,429**	**(92)**	**1,337**	**1,429**	**2,260**
Financing Costs (incl Depreciation)	(1,449)	(1,337)	112	(1,449)	(1,337)	112	(17,474)
NHSI Control Total	**(1,541)**	**(0)**	**1,541**	**(1,541)**	**(0)**	**1,541**	**(15,214)**
Add: impact of donated assets	*(48)*	*(66)*	*(18)*	*(48)*	*(66)*	*(18)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: PSF & FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(1,589)***	***(66)***	***1,523***	***(1,589)***	***(66)***	***1,523***	***(13,588)***



Variation and Action

For the purposes of financial reporting in April 2020 the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £1.5m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed.

The block contracts and 'top-up' payment received as part of the Covid-19 response we enough to cover the cost base of the Trust, and in line with guidance received from NHSE&I the level of 'top-up' received was reduced by circa £0.1m to bring the Trust to a break even position.

Due to social distancing and deep clean regimes, it is unlikely the original 2020/21 plan will ever for a realistic baseline for 2020/21, Instead a run rate methodology for financial performance management with M01 forming a baseline against which productivity improvements will be measured,

During this period the national efficiency target has been suspended (equivalent to £0.24m per month), however the disruption to normal business processes is being view as an opportunity in increase pace around transformation of care pathways.

Income & Activity Delivered by Point of Delivery

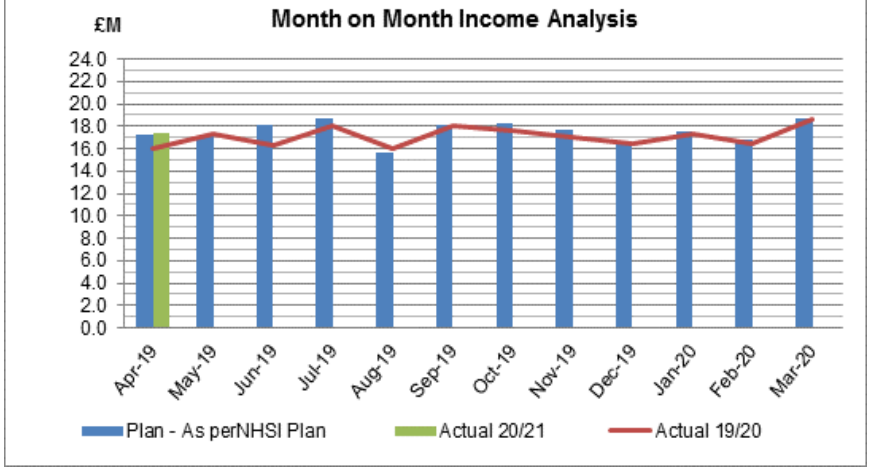
Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Apr '20 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	749	489	(260)
Elective inpatients	1,500	268	(1,232)
Day Case	1,416	262	(1,154)
Non Elective inpatients	5,131	3,203	(1,928)
Outpatients	2,696	1,151	(1,545)
Excluded Drugs & Devices (inc Lucentis)	1,598	1,288	(310)
Other	4,188	10,725	6,537
TOTAL	**17,278**	**17,386**	**108**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	9,603	9,692	90
Dorset CCG	1,963	2,070	107
West Hampshire CCG	1,410	1,435	25
Specialist Services	2,702	2,703	0
Other	1,600	1,485	(114)
TOTAL	**17,278**	**17,386**	**108**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance		Last Year Actuals	Variance against last year
Elective	397	105	(292)		399	(294)
Day case	1,873	366	(1,507)		1,668	(1,302)
Non Elective	2,618	1,624	(994)		2,231	(607)
Outpatients	20,949	9,877	(11,072)		20,883	(11,006)
A&E	5,882	3,035	(2,847)		4,054	(1,019)



Variation and Action

As anticipated due to the focus on the Covid-19 response, activity dropped substantially from historic baselines in April 2020.

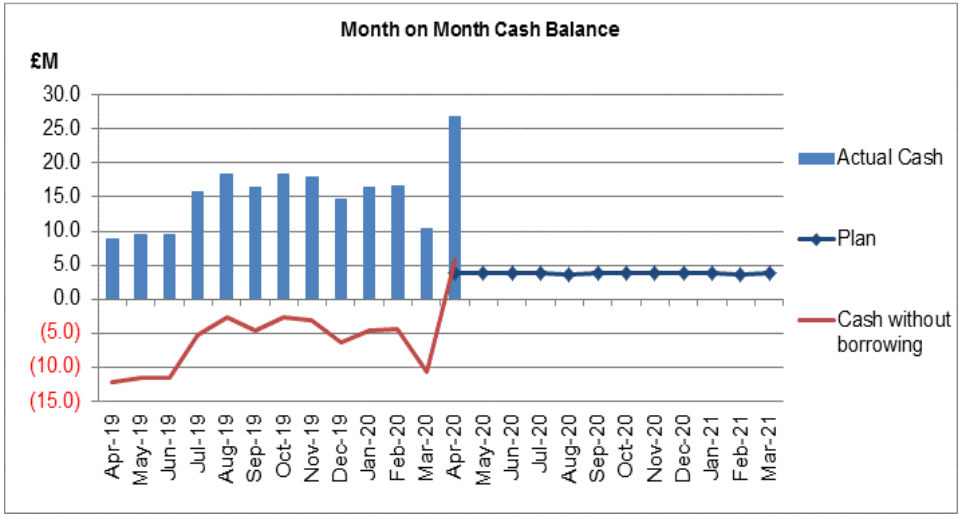
Contracts with main payment values with main commissioners have been based on month 9 agreement of Balances (from a provider perspective), adjusted by 2.8% for inflationary pressures.

Payment for lost non contract activity is considered to be captured by the 'top-up' payment received via NHSE&I.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



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

Payments on account in advance up until 31st July 2020 have been agreed. Plans for the next phase have yet to be communicated - this brings with it risk as at present there is no certainty around any payment in July.

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

The cash flow will continue to be closely monitored to ensure funds are available when required, although no additional borrowing is expected while under Covid-19 contractual arrangements.

Summary and Action

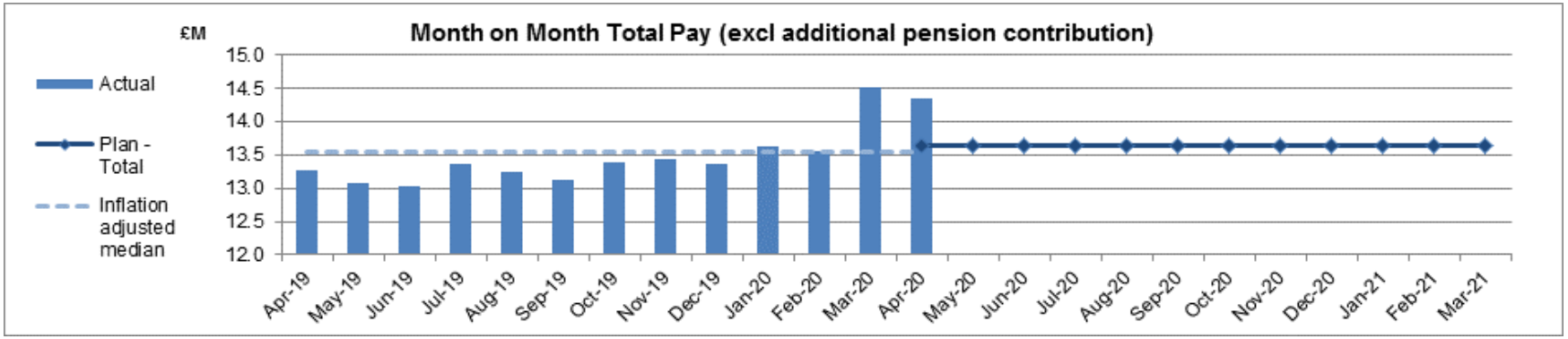
Although formal guidance from NHSE&I for the period post 31st July 2020 has not yet been received, the following statement has been made in May 2020:

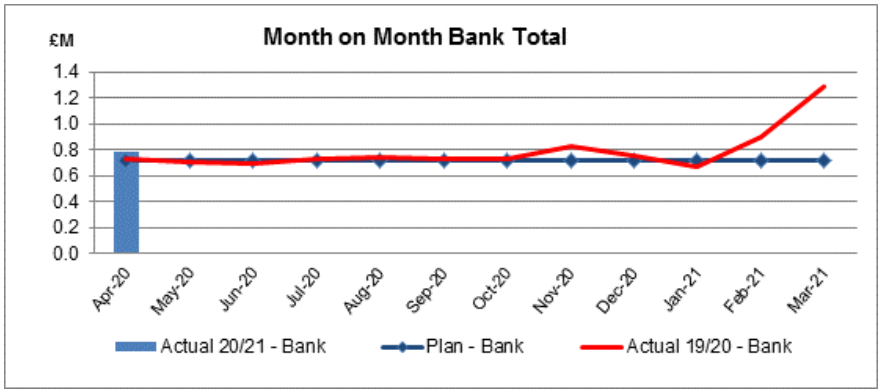
"…CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this."

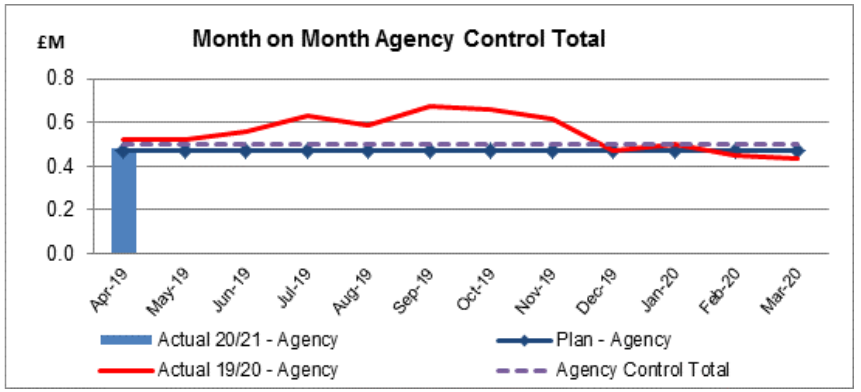
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

The Trust has incurred a significant pressure on Pay in April 2020, as staff have worked additional hours in response to the Covid-19 response. Staff in areas that have reduced clinical activity have been redeployed into other clinical areas, e.g. theatres staffing supporting the surge ICU capacity. Acting down policies have been enacted amongst senior medical staff in order to allow for increased resilience in the rostering of junior medical staff.

Sickness and self isolation peaked in April, most significantly in the nursing workforce.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	04 June 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 v16.0 (draft) Draft Corporate Risk Register May 2020 v4 Draft Summary CRR tracker v16 June Board 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.

Corporate risk profile summary

Since the Board meeting in April, there has been a significant change in the risk profile with a number of risks scores decreasing; with 8 extreme risks compared to 12.

The Director of Corporate Governance is working with the Associate Director of Strategy to align the corporate objective and strategy updates to Board with the Board Assurance Framework updates going forward, given these are intricately linked. This should provide

the Board with a complete view of strategy and corporate objective delivery and risks associated with this.

The BAF will be reviewed following completion of the corporate objective review.

The following risks have triggered a deep dive as they have been rated 16 or above for 6 months or longer:

- 5972 - Insufficient organisational development resources to delivery transformational and cultural change
- 5751 - Risk of impact on patients from high numbers with a delayed transfer of care

The outcome of the above deep dives will be reported through the relevant Board Committee.

Extreme Risks

There are 8 risks rated 15 or above.

- 6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm
- 6102 - Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service
- 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)
- 5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (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)
- 6235 – Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements (Score 16)
- 6471 - Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services **(New risk – Score 15)**

Relevant new risks since April 2020

- 6470 - Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged resulting in the Trust having to take emergency measures **(New risk – Score 12)**
- 6471 - Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services **(New risk – Score 15)**
- 6472 - Due to Covid-19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year **(New risk –**

Score 12)

Risks with an increased score

- 6235 - Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements (Score 9 to 16).
- 5487 - The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation (Score 6 to 10).
- 5966 - Risk of compromised services due to hub and spoke model (Score 9 to 12).

Risks with a decreased score

- 5955 - Insufficient robust management control procedures (Score 15 to 12)
- 6129 - Risk of the non-delivery of the IT Improvement Plan (Score 9 to 6)
- 6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked (Score 12 to 9)
- 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 (Score 9 to 6)
- 5605 - Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment (Score 12 to 9)
- 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 to 12)
- 6142 - Risk to recruitment, retention and staff morale within the genetics service as a result of the uncertainty of the future of the service (Score 16 to 12)
- 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 (Score 16 to 12)
- 5360 - Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss (Score 15 to 10)

Risks removed

- 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
- 5862 - Risk to buildings and equipment due to capital programme funding
- 5860 - Risk of failure to achieve financial plan and NHSI control total for 2019/20

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

V16 For June Board

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?

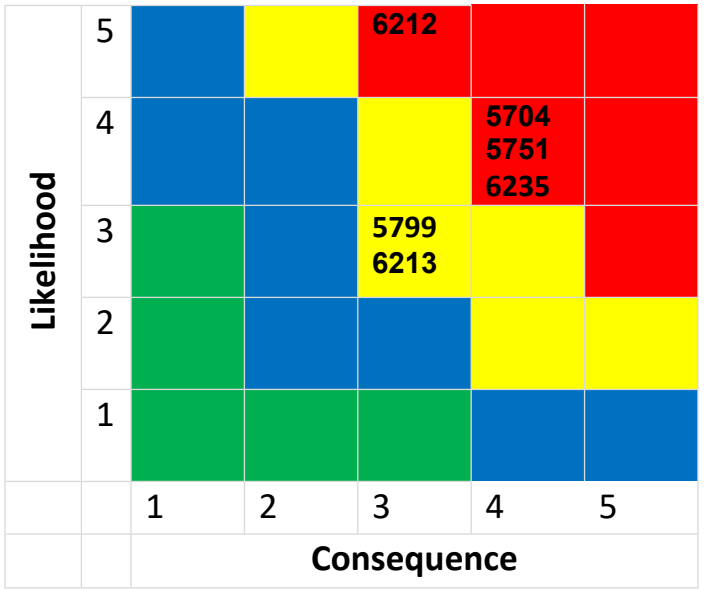
	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

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
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
6235 - Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements.
6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked.
6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm.

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)
5605 - Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment (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 Complete

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 (C)	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 April 2020	A Hyett

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
		Royal College of Physicians review of gastroenterology report (A)	Delivery of improvement action plan	Review 30.06.2020	C Blanshard
		Not seeing planned reduction in stranded patients or increase in discharges before midday (A)	External review and refresh of the action plan	30/04/2020 Action to be reviewed post Covid-19	A Hyett
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 March 20 update: Externally facilitated system workshop held with agreed priority areas for joint working	L Thomas

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
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 transformation programme 4. Theatres capacity review and transformation programme 5. Delivery of new 28 day faster diagnosis cancer standard	Additional cases not scheduled on lists where gaps are evident (C)	Outpatient and theatre project management Boards monitoring actions and improvement in utilisation	31.03.2020 Transformation programme update for 2019/20 to TMC in May 20. Theatre productivity improvement plan in place although behind target and impacted further by planned reduction in elective surgery (Covid-19 response)	E Provins
		Lack of business intelligence tool (C)	Procure and embed tool (links to action associated with risk 5480)	31.03.2020 Action closed as moving to a BSW system procurement solution	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 (C)	Urgent Care Delivery Group requiring capacity plan	31.08.2019 Completed – CSU developed capacity and demand plan for Wiltshire	A Hyett
		Not seeing planned reduction in stranded patients or increase in discharges before midday (A)	Delivery of Urgent Care delivery board agreed actions	On-going with Trust involvement	A Hyett/ CCB

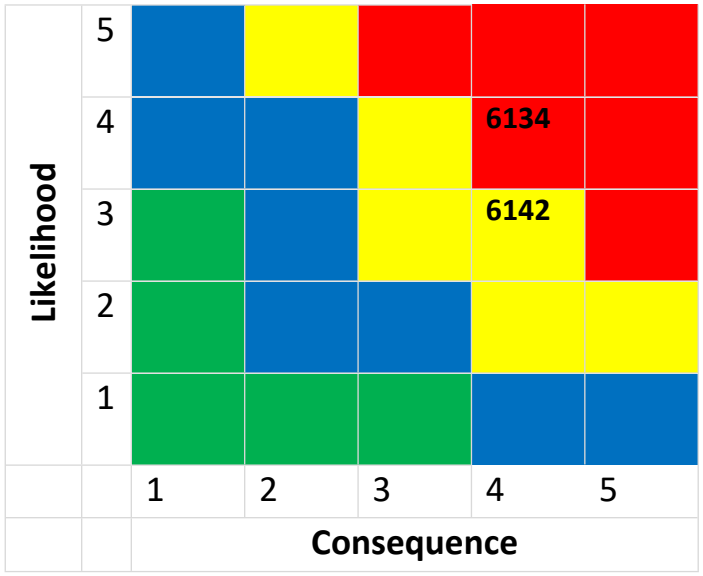
Strategic Priority:

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~~ Strategic plan being reviewed in light of DMT changes. Revised			

		deadline 01.05.2020			
Lack of specialist commissioning clinical and financial strategy for spinal services – Trust to write to specialist commissioners to convene a summit	Director of Finance	30.09.2019 Meeting held - complete			

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~~ Strategies under development linked to National work. Revised deadline 01.06.2020	A Hyett

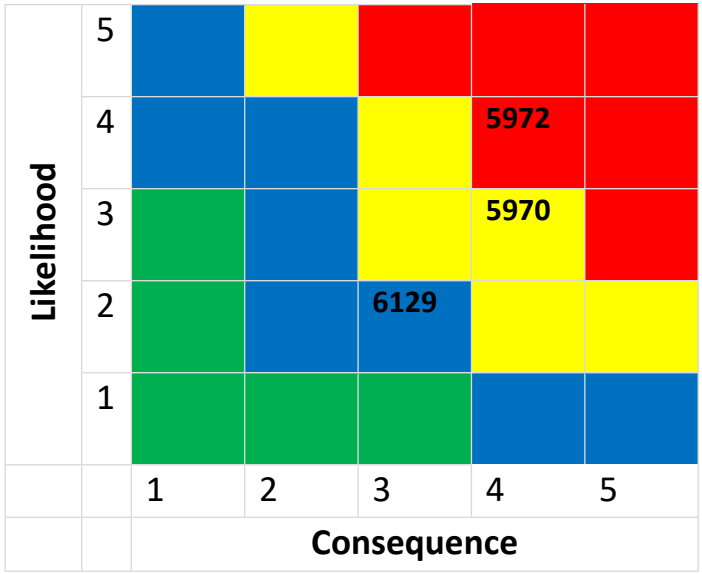
Strategic Priority:

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~~ 31.5.2020 **March 20 update:** Deadline changed due as low priority in current environment– 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 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	Lack of defined process to support innovation (C)	Develop and implement clear processes	~~31.12.2019~~ ~~28.02.2020~~ 30.05.2020 **March 20 update:** extended deadline due to department re-structure to address gaps in	Esther Provins

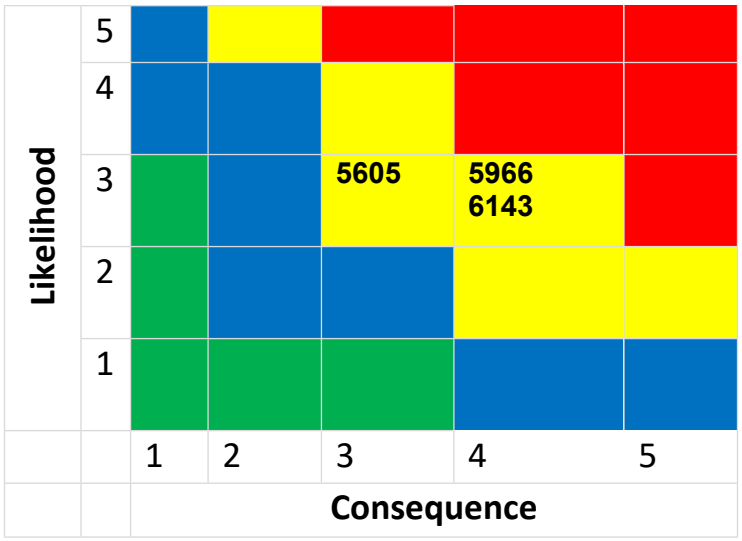
Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
	6. Improve organisational capability for change			control	
To maximise digital services to enable the provision of outstanding care.	1. Implement year one of the digital strategy	Insufficient escalation reporting of deliverables (C)	Strengthen escalation reporting to the Digital Steering Group	30.09.2019 Reporting structure revised Complete	Esther Provins
	2. Deliver internal audit action plans				
	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
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 (People):
5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients (Local)
6235 - Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements (Local)
6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked(Local)
6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm (Local)
5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Local)
5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Local)

Principle Internal Risk: Insufficient resources (skilled staff and infrastructure) to deliver safe effective care					
Key Controls			**Assurance on Controls**		
• 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 On hold (Covid-19)

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 Commenced and training enhanced due to Covid-19 upskilling of staff	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 Complete and reported to	F Coker / A Kingston

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead
				CGC in March 2020	
	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
		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 May 2020 update: On hold due to Covid-19 response	D Major
Work with our patients and partners to plan and develop services which meet the needs	1. Launch and implement the Treat Me Well campaign in April 2019. 2. Ensure that Patient voice is				

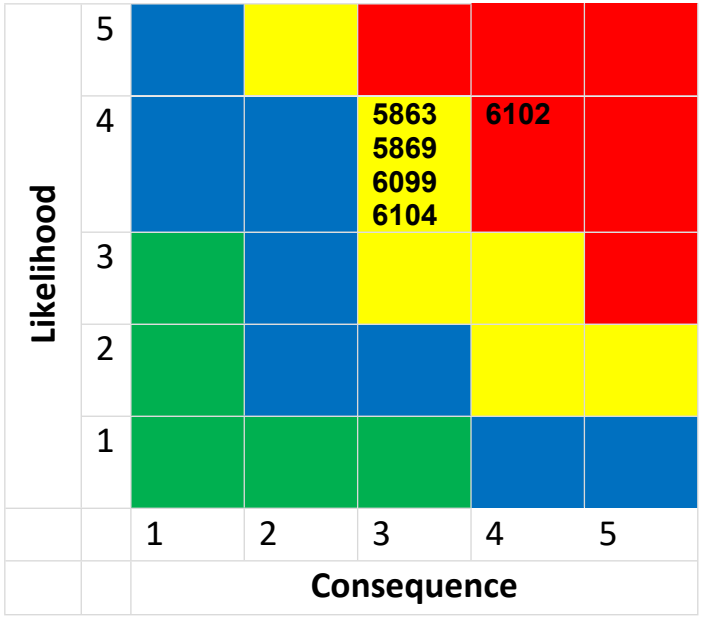
Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead
of our community.	included in the planning and development of major Trust schemes.				
Work towards a CQC rating of Outstanding	1. Delivery of improvement plan arising from 2018 CQC inspection 2. Improve 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 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

6099 - Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services.

6102 - Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service.

6104 - Failure to retain overseas nurses could result in increased reliance on temporary staff and need to run further recruitment campaigns.

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 • Critical high risk clinical vacancies action plan			• 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 **March 20 update:** Awaiting New Head of H&WB commencing April 2020 – to implement rolling programme of H&WB initiatives. Review 31 Aug 2020
Delivery of the Hard to Recruit to posts action plan	Director of OD & People	Review 31.05.2020 May 2020 update: Action plan for 2020/21 is currently being reviewed by the BP's with input from the Divisions. Additional support on the			

		delivery of the plan for 2020/21 will be provided by the PMO.			

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)	Skills and capacity of Business Partners (C)	Continuing to embed BP model in directorates	31.12.2019 Complete – includes introduction of CPD sessions	S Crane
	4. Roll out e-rostering system across professional groups	Lack of roll-out plan (C)	Under discussion with Quality directorate	31.03.2020 May 2020 update: Meeting delayed (Covid-19 response). Re-scheduled for 3rd June.	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	~~30.09.2019~~ 31.03.2020	R Webb

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead
			ensure appropriate support		
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 Assistance Programme. To be submitted to TMC. Date TBC Paper to execs 5 August to propose what is included in the policy	~~21.08.2019~~ ~~31.12.2019~~ March 20 update: Awaiting New Head of H&WB commencing April 2020 – to implement rolling programme of H&WB initiatives. Review 31 Aug 2020 ~~05.08.2019~~ 28.02.2020 **Complete.** Discussed at Execs and agreed statement of flexible working supported by revision and re-launch of policies	G Toms G Dawson

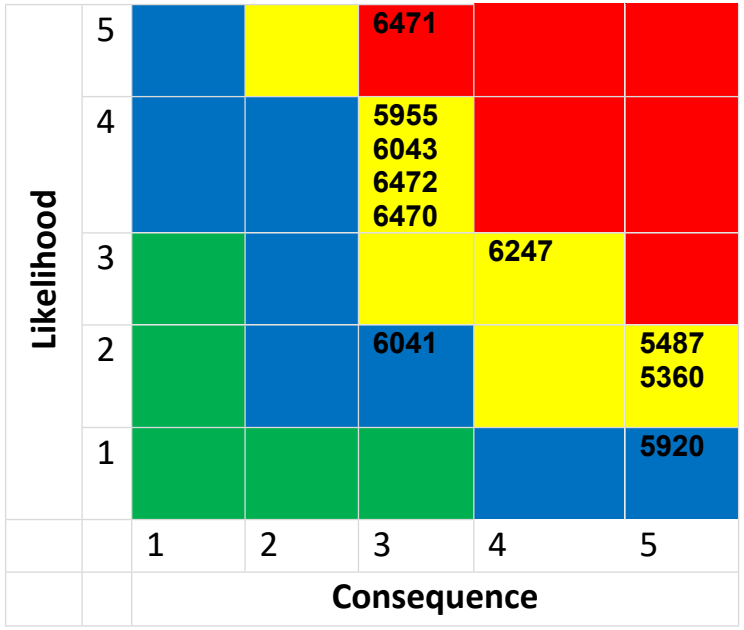
Strategic Priority:

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



5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
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
6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT
6247 - Risks associated with critical plant and building infrastructure that may result in utility or system failure.
5360 - Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss.
6472 – Risk of not delivering key objectives aligned to operational, activity and workforce plans in year due to Covid-19 and the final elements of the 2020/21 planning round not being completed in line with national guidance. **(New risk)**
6470 – Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged. **(New risk)**
6471 – Shortfall in funding available for capital programme with potential risk to safety and availability of buildings and equipment to deliver services. **(New risk)**

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

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities					
Key Controls			**Assurance on Controls**		
• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • Transformation Board • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan			• 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~~ 30.06.2020 Commenced. Further training required			
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 March 20 update: Externally facilitated system workshop held with agreed priority areas for joint working	LT/CCB

Corporate Risk Register
May 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.	01/06/2020		Robinson, Ian	Directorate Management Team Meeting	31/05/2020	2	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	17/07/2019
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 and newly merging CCG. This could limit the ability of the organisation to deliver the NHS Long Term Plan ambitions.	Do not expect it to happen again but it is possible	Moderate	6	Agree and formalise programme of work with PCNs	31/12/2019		Humphrey, Kieran	Trust Board	30/06/2020	4	Resources	Trust Board (Corporate Risk Register)	Director of Finance	25/10/2019
										Align resources internally to the CCG transformation programme to support COVID 19 and restart.	30/06/2020		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)	Do not expect it to happen again but it is possible	Moderate	6	Develop and produce monthly update and highlight report	16/01/2020	02/03/2020	Burwell, Jonathan	Executive Director Meeting	30/06/2020	6	Innovation	Trust Board (Corporate Risk Register)	Director of Transformation	20/12/2019
										Complete internal service delivery model review (desktop exercise)	16/01/2020	02/03/2020	Burwell, Jonathan							
										Procure support to deliver a service delivery model review of hot spots, including options appraisal and recommendations	13/01/2020	21/02/2020	Provins, Esther							
										Executive team review and decision on recommendations arising from external service delivery review	21/02/2020	21/02/2020	Provins, Esther							
										Board seminar to appraise Board of Directors as to agreed way forward regarding IT Service Delivery Models.	05/03/2020	02/03/2020	Provins, Esther							
										Add in to digital update in April 2020 next steps from the service model review informed by on the recommendations from PWC and linked to key elements of IT improvement plan.	10/05/2020	07/05/2020	Burwell, Jonathan							

Corporate Risk Register
May 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
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	01/06/2020	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	01/06/2020		Clarke, Simon							
										Continuation of additional sessions provided by Radiologists. Ongoing at 3 month intervals.	31/12/2019	05/03/2020	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	01/09/2020		Clarke, Simon							
										Appointment of substantive Radiologist.	03/09/2019	09/09/2019	Lloyd-Jones, Graham							
										Workforce review of Consultant Radiologist's	28/02/2020	09/04/2020	Clarke, Simon							
										Recruitment into vacant Radiologist posts	01/09/2020		Lloyd-Jones, Graham							

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	May recur occasionally	Moderate	9	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	30/04/2020	6	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							
										Department continues using Source Bioscience for a significant proportion of analysis and reporting while recruitment and training is underway.	31/03/2020	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	15/04/2020	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.	30/04/2020		Boyd, Hannah							
										Contract extension of locum beyond November 2020	30/09/2020		Phillips, Lee							
										Send backlog of skin cases to CPS once Procurement give the go ahead.	31/03/2020		Phillips, Lee							

Corporate Risk Register
May 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
6213	Medicine	Cancer Services	21/02/2020	Specialty Risk assessment	12	As a result of having three systems involved in the cancer pathway that are not contextually linked (Lorenzo, ERS and Somerset), there is a risk that patient could be missed or delayed, resulting in patient harm.	May recur occasionally	Moderate	9	Carry out an Investigation to confirm current position (take 10 patients randomly from breast and urology to compare the date stamps across eRS, Lorenzo, Somerset and the data warehouse)	31/12/2019	31/12/2019	Burwell, Jonathan	Trust Board	30/06/2020	6	Local Services (Care)	Trust Board (Corporate Risk Register)	Medical Director	06/03/2020
										Management actions agreed in response to pwc audit report.	06/03/2020	05/03/2020	Blanshard, Dr Christine							
										Management action from pwc audit: Cancer services will be reviewing random samples of patients on a monthly basis (alongside existing Lorenzo/SCR audit) to assess pathway across eRS, Lorenzo and SCR	30/04/2020	28/04/2020	Scutt, Emilia							
										Management action from pwc audit: Task and Finish Group in place to review opportunities around electronic outcome forms from a Trust-wide (not just cancer) perspective. Pilot in place within oral surgery and plans for roll out in breast services in due course. Task and Finish Group in place to review opportunities around electronic outcome forms from a Trust-wide (not just cancer) perspective. Pilot in place within oral surgery and plans for roll out in breast services in due course. Intention is to include tick box with reference to 'high risk' patients, as well as confirmation as to whether future appointments can be 'slipped'; this will support central booking in prioritisation of appointment bookings and ensure that this cohort of patients is prioritised. Next T&F group scheduled for 11/03 for update on progress.	01/06/2020		Burwell, Jonathan							
										Management action from pwc audit: Follow up Risk Summit scheduled for 29/04/2020 to review overall progress	01/06/2020		Blanshard, Dr Christine							
										Management action from pwc audit: Raise awareness to the Trust Board of the workarounds currently in place and the associated risks; this will enable the Board to make an informed cost/benefit assessment of improving the systems in place.	30/06/2020		Blanshard, Dr Christine							
										Management action from pwc audit: Cancer services are in the process of constructing a policy that which outlines clear data quality requirements for recording the referral to treatment data on the Trusts systems to ensure accuracy and completeness of the data and make it readily available to staff.	01/06/2020		Scutt, Emilia							
6104	Organisational Development and People	Trustwide	06/12/2019	Other assurance not listed	9	Failure to retain overseas nurses could result in increased reliance on temporary staffing and needing to run further recruitment campaigns	May recur occasionally	Moderate	9	Head of Resourcing to report progress to Deputy Director of OD and People	01/12/2020		Holt, Sharon	Executive Workforce Committee	30/06/2020	6	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	14/02/2020
										Leavers list to be reviewed monthly to identify any overseas nurses leaving the Trust prior to the end of their visa along with reasons as to leaving.	31/12/2020		Holt, Sharon							
										Regular review of visa renewal situation to be flagged to Deputy Director of OD & People	31/12/2020		Holt, Sharon							

Corporate Risk Register
May 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
5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob (Inactive User)	Information Governance Steering Group	30/06/2020	8	Resources	Trust Board (Corporate Risk Register)	Director of Transformation	11/02/2020
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob (Inactive User)							
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan							
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen							
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen							
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen							
										Windows 10 migration complete	31/10/2020		Arnold, Jon							
										Cyber essentials plus accreditation achieved	30/06/2021		Carman, Mr Stephen							
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan							
										Implementation of SIEM solution with regional leads	30/06/2020		Carman, Mr Stephen							
5487	Finance and Procurement	Finance Department	26/07/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation. Covid 19 places increased uncertainty with changes in demand impacting on subsidiary cash flows.	Will undoubtedly recur, possibly frequently	Minor	10	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	21/12/2018	19/12/2018	Thomas, Lisa	Finance and Performance Committee	30/06/2020	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	18/02/2020	Thomas, Lisa							
										Subsidiary companies to recruit or establish suitable qualified financial support.	31/03/2020	24/05/2020	Thomas, Lisa							
										- Issue of Subsidiary performance challenges in light of COVID 19 raised to NHSI/E for clarification of treatment	19/06/2020		Ellis, Mark							

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
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 probably recur, but is not a persistent issue	Moderate	12	reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020		Thomas, Lisa	Trust Board	30/06/2020	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		Willoughby, 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	02/03/2020	Scott, Andy							
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew (Inactive User)							
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	30/06/2020		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	02/03/2020	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	28/04/2020	Burwell, Jonathan							
5966	Medicine	Trustwide	20/08/2019	Trustwide risk assessment	12	Services which are provided to the trust by another provider on a networked or hub-and-spoke arrangement can be compromised if the provider runs into operational or workforce difficulties. It is likely that services will be withdrawn from our site as they consolidate at the hub. Examples are vascular, interventional radiology, clinical oncology, medical oncology, renal medicine, neurology and various paediatric specialties.	Will probably recur, but is not a persistent issue	Moderate	12	Interventional Radiology: Work with commissioners to secure service provision with another provider.	30/11/2019	31/12/2019	Vandyken, Mrs Ali	Trust Board	01/07/2020	6	Care	Trust Board (Corporate Risk Register)	Medical Director	21/08/2019
										Oncology: Develop additional joint working and new posts. update 06/05/20 - collaborative work with UHS continuing and they have been very supportive during COVID. We are currently not considering any joint posts but this may change as we ease out of COVID and head in to the recovery phase. We have an update meeting with UHS on 07/05/20.	01/09/2020		Clarke, Lisa							
										Vascular: Set up a vascular network meeting.	30/09/2019	25/10/2019	Murray, Dr Duncan							
										Renal: Signed Service Level Agreement with Portsmouth for provision of renal services.	31/10/2019	25/10/2019	Clarke, Lisa							

Corporate Risk Register
May 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
5970	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	May recur occasionally	Major	12	Development of an IT improvement plan which includes staffing, communications, infrastructure, governance and any outstanding pen test/audit actions.	22/11/2019	11/12/2019	Provins, Esther	Finance and Performance Committee	29/05/2020	9	Innovation	Finance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	23/08/2019
										Set up monthly executive performance reviews.	30/09/2019	31/10/2019	Provins, Esther							
										Completion of internal audit action plans and penetration test action plans.	31/12/2019	02/03/2020	Burwell, Jonathan							
										To complete the review and proposal for improving our capacity to do business change.	30/06/2020		Provins, Esther							
										Agree long term direction of the EPR and short/medium term investment.	30/05/2020		Burwell, Jonathan							
										Develop, agree and implement a new range of informatics service standards	19/05/2020		Burwell, Jonathan							
										Conclude work to agree and commence implementation of a robust and fit for purpose service delivery model	29/03/2020	28/04/2020	Burwell, Jonathan							
										Develop and implement a communications and engagement plan aligned to digital strategy	15/01/2020	02/03/2020	Burwell, Jonathan							
										Evolve current change management approach, ensuring it is comprehensive, clinically led	31/01/2020	02/03/2020	Burwell, Jonathan							
										Implement an Informatics team development programme	30/06/2020		Burwell, Jonathan							
										Strengthen clinical leadership in informatics by reaffirming priorities for CCIOs and appointing to CNIO roles	31/10/2020		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							
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	31/03/2020	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	18/02/2020	Thomas, Lisa							
										Once budget has been announced in March - consider impact for 2020/21 and offering to all staff	31/03/2020		Thomas, Lisa							

Corporate Risk Register
May 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
5869	Quality Directorate	Trustwide	20/06/2019	Trustwide risk assessment	12	Failure to achieve required ward nursing 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	30/06/2020	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	31/03/2020	Hyett, Fiona							
										Overseas recruitment campaigns 19/20.	30/04/2020	20/02/2020	Hyett, Fiona							
										Skill mix review x2 per year - 2019/2020	30/04/2020	20/02/2020	Wilkinson, Lorna							
										Retention workstream to plan, including exit meetings, STAY conversations and career pathways, to be embedded.	01/09/2020		Hyett, Fiona							
										Develop apprenticeships and nursing associate opportunities to broaden access into nursing.	30/04/2020	20/02/2020	Wilkinson, Lorna							
										Maintain full recruitment of Health Care Assistant Staff.	30/04/2020	31/03/2020	Hyett, Fiona							
										Twice daily staffing review using safe care and roster data.	30/04/2020	20/02/2020	Hyett, Fiona							
										Domestic recruitment campaign 2019/2020	01/03/2020	20/02/2020	Holt, Sharon							
										Implementation of safer nursing care tool to evidence staffing levels.	01/09/2020		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.	30/06/2020		Hyett, Fiona							
6043	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	12	The lack of a national clear model for small rural DGH services places future strategic planning uncertain at SFT. The funding regime and clinical models of care as advocated by royal college guidelines are built around average Trusts. SFT is more geographically challenged and smaller than an average DGH which in turn places its future as an independent Trust at risk which could limit and damage service provision to the local population.	Will probably recur, but is not a persistent issue	Moderate	12	Nuffield Trust are visiting SFT in January 2020 to assess and offer help on development of the South Wiltshire Urgent Care Model.	28/02/2020	18/02/2020	Hyett, Andy	Trust Board	30/06/2020	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	24/05/2020	Humphrey, Kieran							
										Trust part of BSW drivers of the deficit work to ascertain the financial issues in BSW, of which size and geography will be identified.	30/06/2020		Thomas, Lisa							
6099	Organisational Development and People	All clinical areas	06/12/2019	Other assurance not listed	12	Risk of not being able to recruit to posts identified as hard to recruit. Risk is that they will remain hard to fill with the result that we are forced to continue costly Agency/Locum support and/or outsourcing and/or discontinue services.	May recur occasionally	Major	12	Head of Resourcing to focus further time on Recruitment issues and to feedback to Deputy Director of OD and People	28/02/2020	03/02/2020	Holt, Sharon	Executive Workforce Committee	30/06/2020	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	14/02/2020
										Review and update of Directorate action plans to be undertaken monthly with Head of Resourcing, BP's, DM's and CD's. This includes planning for 2020/2021.	30/06/2020		Holt, Sharon							
										Follow up with Lead Clinicians possible leads for specific vacant posts and provide support as required.	30/06/2020		Holt, Sharon							

Corporate Risk Register
May 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
6472	Finance and Procurement	Trustwide	24/05/2020	COVID-19/Coronavirus, Financial management	12	Due to Covid 19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year.	May recur occasionally	Major	12	Ensure revised corporate Objectives are completed linked to restart	30/06/2020		Thomas, Lisa	Trust Board	30/06/2020	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	26/05/2020
6247	Facilities	Estates	10/03/2020	Directorate risk assessment	12	As a result of a comprehensive external review of the Estates function it has been identified that the Trust has significant risks associated with critical plant and building infrastructure, that may result in utility or system failure. Including: Water ingress leading to a loss of building use. Failure to maintain critical plant leading to failure of systems e.g. nurse call, ventilation, power, gas, water, lifts and pressure systems. Failure to ensure compliance with mandatory training, leading to an inability to maintain plant. Lack of appropriately trained staff to undertake preventative maintenance. In ability to complete mandatory returns or compliance checks/reporting. Failure to mitigate these risks may result in the loss of buildings and services/utilities, for clinical functions.	May recur occasionally	Major	12	The Estates Transformation Steering Group has been formed with an action plan detailed to mitigate these risks.	01/09/2020		Lane, Lynn	Executive Director Meeting	01/09/2020	4	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	16/03/2020
6470		Trustwide	24/05/2020	COVID-19/Coronavirus, Financial management	12	There is financial uncertainty for the year 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures. The guidance is currently issued to July 2020, beyond this it is unclear as to how the Trust will be funded. This	Will probably recur, but is not a persistent issue	Moderate	12	cash flow forecast to ensure cash flow risk monitored closely	30/06/2020		Ellis, Mark	Finance and Performance Committee	26/06/2020	9	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	26/05/2020

Corporate Risk Register
May 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
6142	Clinical Support and Family Services	Genetics	20/12/2019	NHS England, Specialty Risk assessment	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	Moderate	12	Keep staff updated as to developments (in relation to the future of the genetics service).	31/03/2020		Thomas, Lisa	Trust Board	31/07/2020	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.	May recur occasionally	Major	12	Weekend safety and effectiveness action plan reported to Board on a quarterly basis.	01/04/2020	28/04/2020	Blanshard, Dr Christine	Trust Board	30/06/2020	6	Care	Trust Board (Corporate Risk Register)	Medical Director	02/01/2020
										Report containing triangulation of all relevant information and associated action plan to be submitted to Clinical Governance Committee.	30/06/2020		Blanshard, Dr Christine							
6212	Medicine	Trustwide	21/02/2020	Service Delivery Plan, Specialty Risk assessment	15	As a result of not receiving a follow up appointment in the required time-frame, there is a risk that patients with cancer (e.g. melanoma patients) will experience clinical deterioration in between follow-up appointments which may result in patient mis-management, disease progression, limited treatment options and patient harm. Examples- Cancer, Opthalmology and Dermatology (particularly melanoma patients not being seen at 3 month intervals). See also closed risks 4107 and 5421.	Will undoubtedly recur, possibly frequently	Moderate	15	Development of new Lorenzo flag for patients whose follow-up appointments should not be slipped.	30/06/2020		Insull, Victoria	Directorate Management Team Meeting	31/07/2020	9	Local Services (Care)	Trust Board (Corporate Risk Register)	Medical Director	06/03/2020
										Develop telephone and virtual clinics to increase clinic capacity.	01/12/2020		Arnett, Louise							

Corporate Risk Register
May 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
6471		Trustwide	24/05/2020	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	Raise issue of capital funding for strategic replacement of key estate with regional director of FInance	30/06/2020		Thomas, Lisa	Trust Board	26/06/2020	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	26/05/2020
6235		Trustwide	05/03/2020	COVID-19/Coronavirus, National guidance	9	On 31/01/2020 NHSE announced a level 4 incident response. Level 4 is an incident that requires NHSE national command and control to support the NHS response and NHSE to coordinate the NHS response in collaboration with local commissioner at a tactical level. The risk is increased attendance at ED in relation to suspected Covid-19 cases; any potential admissions for suspected cases could impact patient flow due to the requirements of isolation and levels of appropriate PPE required. Should Covid-19 lead to epidemic/pandemic there will be implications in relation to numbers of patients, reduction in staffing, accessibility of stocks, reduction or stopping of planned electives therefor this could have a financial implication and increased media attention.	Will probably recur, but is not a persistent issue	Major	16	AEO assigned to lead the response IMT to meet daily Monday - Friday to manage at a Tactical level the response Briefing meetings to be undertaking initially twice per week SFT COVID-19 Response Plan to be reviewed daily based on changing daily national PHE guidance Situation reviewed and managed daily and linking to CCG calls and National calls as required	01/05/2020	31/03/2020	Hyett, Andy	Emergency Planning, Resilience and Response Steering Group	31/05/2020	6	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Operating Officer	05/03/2020
										Delivery of ongoing work through the Cells including incident management and recovery.	29/05/2020		Hyett, Andy						
6102	Organisational Development and People	Trustwide	06/12/2019	Other assurance not listed	16	Risk of being unable to fill Medical Workforce Gaps which may include posts identified as hard to fill. Risk is that they will remain hard to fill with the result that we are forced to continue costly Agency/Locum support and/or outsourcing and/or discontinue services	Will probably recur, but is not a persistent issue	Major	16	Head of Resourcing to focus time on Medical Recruitment issues and to feedback to Deputy Director of OD and People	31/01/2020	03/02/2020	Holt, Sharon	Executive Workforce Committee	30/06/2020	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	14/02/2020
										Lead Clinicians to follow up with potential recruitment leads for specific posts	30/06/2020		Holt, Sharon						
										Hard to recruit plans to be routinely updated with Head of Resourcing, BP's, CD's and DM's	31/12/2020		Holt, Sharon						
										Attendance at Doctors Job Fair (29 February 2020). To report back on success of event and any actions required.	31/03/2020	26/05/2020	Holt, Sharon						
										Review of current recruitment process to ensure efficient and conducted in timely manner to mitigate against the potential loss of candidates applying for positions.	29/02/2020	26/05/2020	Holt, Sharon						
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.	30/06/2020		Blanshard, Dr Christine	Trust Board	31/07/2020	8	Specialist Services	Trust Board (Corporate Risk Register)	Medical Director	02/10/2020
										Devise a business plan required to mitigate the financial risk.	30/06/2020		Blanshard, Dr Christine						

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
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	21/02/2020	Provins, Esther	Trust Board	30/06/2020	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	30/07/2020		Provins, Esther							
										Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther							
										Review effectiveness of Quality Improvement plan.	01/06/2020		Provins, Esther							
										Implement Quality Improvement plan (see also risk 6138).	31/03/2021		Provins, Esther							
										Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther							
										Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/07/2020		Provins, Esther							
										Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	28/08/2020		Hyett, Andy							
										Escalate discussions with system partners regarding levels of DToCs. *Action covered by Corporate Risk 5751. Please see risk 5751*	31/12/2019	04/03/2020	Hyett, Andy							
										Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	28/08/2020		Provins, Esther							
										Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020	21/02/2020	Provins, Esther							
										Undertake a CIP assurance exercise for 19/20	11/01/2020	21/02/2020	Provins, Esther							
										Delivery of Best Place to Work programme.	30/06/2020		Lane, Lynn							
										Delivery of phase 1 of NHS Improvement Cultural Leadership Programme.	31/07/2020		Lane, Lynn							

Corporate Risk Register
May 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	01/07/2020	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	21/02/2020	Blanshard, Dr Christine							
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy							
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy							
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	30/06/2020	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	04/03/2020	Hyett, Andy							
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy							
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy							
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy							
										Action plan to be developed for 2021.	30/06/2020		Hyett, Andy							

Corporate Risk Register Summary - May 2020

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Mar-19	Jun-19	Jul-19	Sep-19	Nov-19	Jan-20	Mar-20	May-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	12	12	16	16	16	16	16	12
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	16	16	12
6235	Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements.	Chief Operating Officer	05-Mar-20	9							9	16	6
6213	Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked	Medical Director	06-Mar-20	12							12	9	6
6212	Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm	Medical Director	06-Mar-20	15							15	15	9
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	9	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	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	16	12	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	16	12	9
6129	Risk of the non-delivery of the IT Improvement Plan	Director of Transformation	19-Dec-19	20						9	9	6	6
5972	Insufficient organisational development resources to delivery transformational and cultural change	Director of Transformation	23-Aug-19	16				16	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	12	9	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	16	12	6
5966	Risk of compromised services due to hub and spoke model	Medical Director	20-Aug-19	12				12	15	12	9	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	12	12	6
6099	Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services	Director of OD&People	14-Feb-20	12							12	12	9
6102	Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service	Director of OD&People	14-Feb-20	16							16	16	9
6104	Failure to retain overseas nurses could result in increased reliance on temporary staff and need to run further recruitment campaigns	Director of OD&People	14-Feb-20	9							9	9	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	12	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														
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	9	9	9	9	6	6	10	6
5955	Insufficient organisation wide robust management control procedures	Director of Finance	13-Aug-19	15				15	15	15	15	12	9
5920	Breaches of fire compartmentation in PFI building	Chief Operating Officer	17-Jul-19	6				6	5	5	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	9	6	4

6247	Risks associated with critical plant and building infrastructure that may result in utility or system failure	Chief Operating Officer	16-Mar-20	12							12	12	4
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Director of Transformation	11-Feb-20	15							15	10	8
6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Director of Finance	25-Oct-19	12					12	12	12	12	6
6472	Due to Covid-19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year **(New risk)**	Director of Finance	26-May-20	12								12	8
6470	Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged resulting in the Trust having to take emergency measures **(New risk)**	Director of Finance	26-May-20	12								12	9
6471	Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services **(New risk)**	Director of Finance	26-May-20	15								15	8

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:**	3.2
Date of Meeting:	04 June 2020		

Report Title:	Board Governance Structure Review			
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: Task Mapping Appendix 2: Key Duties and Responsibilities of the Board Appendix 3: Board Committee assurance map Appendix 4: Current governance structure Appendix 5: Proposed governance structure Appendix 6: Trust Management Committee revised Terms of Reference Appendix 7: Board and Committee Administration Handbook			

Recommendation:

It is recommended that the Board note the findings of the governance review and:

- Discuss the proposed future governance arrangements
- Approve the proposed governance arrangements
- Approve TMC terms of reference
- Approve all Board Committee Terms of Reference
- Approve the Board and Committee Administration Handbook
- Note that governance arrangements will be kept under review.

Executive Summary:

An Internal Audit of Board Compliance and Reporting, November 2019, identified areas for further improvement. One of the findings was that “The overall structure of the Trust’s Committees, subcommittees and working groups is unclear with no clear framework confirming the escalation route and pathway for information and reports. We identified terms of references which have not been reviewed annually as required. In addition the purpose and role of the Trust Management Committee is not clearly defined”.

An extensive review has been undertaken in response to this finding and to propose strengthened governance arrangements. A revised Board Committee structure is proposed which clearly identifies a clear divide between delivery and assurance.

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 outline the work undertaken following the Internal Audit of Board Compliance and Reporting in November 2019 and propose strengthened governance arrangements, which clearly identify the delivery and assurance pathways in the organisation.

2 Background

2.1 An Internal Audit of Board Compliance and Reporting, November 2019, identified areas for further improvement. One of the findings was that “The overall structure of the Trust’s Committees, subcommittees and working groups is unclear with no clear framework confirming the escalation route and pathway for information and reports. We identified terms of references which have not been reviewed annually as required. In addition the purpose and role of the Trust Management Committee is not clearly defined”.

To address the finding, an action plan was developed setting out a programme of activities. This review has included:

- Non-Executive Director lead governance workshop with Executives and Directorate Management Team representatives on 3 February 2020. This workshop initiated a review of key tasks required by the organisation to fulfil its regulatory, statutory and governance responsibilities. These tasks were then grouped with the purpose of informing the appropriate Trust Committee structure required to deliver the assurance and management functions of the organisation. Meetings between the Director of Corporate Governance and each Executive Director completed this work. The outcome of this is detailed in appendix 1.

- Analysis of key duties and responsibilities of the Board to determine the current oversight arrangements and where these are supported by or delegated to board committees. This analysis was done with reference to the NHSI provider licence under which the Trust operates, as well as other key documents such as the Well-Led Framework, the current strategic objectives and the Scheme of Delegation. The outcome of this is detailed in appendix 2.
- Revision of the assurance mapping of Board Committees completed in January 2019. The outcome of this is detailed in Appendix 3.
- Assurance mapping of all committees and groups below board committee level to determine routes for escalation, gaps in assurance and duplication.
- Working with the Trust Internal Auditors to establish best practice; together with a review of other Foundation Trusts governance arrangements as a way of benchmarking any Trust proposal.

Key elements in developing the proposals contained in this paper are:

- That the committee structures and governance arrangements in place take account of the NHS Foundation Trust Code of Governance and other best practice guidance.
- That all board committees are chaired by a Non-Executive Director.
- Board committees and sub committees are streamlined with inter-connectivity between them.
- There are clear lines of escalation and accountability with audit trail of decision making.
- There is clarity between delivery and assurance.

3 Findings

3.1 *Current Governance Structure*

The current governance structure is outlined in Appendix 4. When considering the outputs of all aspects of the review, the following has been identified:

- **Delivery vs Assurance:** there is a lack of a defined ‘delivery arm’ to the organisation which has manifested itself in blurring of the purpose of some Committees. The purpose and objectives of the Trust Management Committee is unclear as a result of the lack of clarity over the delivery function governance arrangements; with committees and groups reporting into the ‘assurance arm’ of the organisation (Board Committees).
- **Executive and Non-Executive Roles and Responsibilities:** the roles of the Executives and Non-Executive Directors are not clearly defined in documentation and there is blurring of these given the current governance arrangements.
- **Board Committee assurance map:** the review identified no gaps in assurance reporting. The Strategy Committee was disbanded since the previous review in January 2019. The assurance function is now overseen by the Board with the introduction of a strategy session at each Private Board meeting.
- **Statutory and key responsibilities of the Board:** all requirements are currently covered by the existing Board Committee structure.

- **Organisation Committee assurance map:** the review identified all groups and committees in operation within the Trust and therefore there is transparency now over the structure. The Clinical Governance arrangements require streamlining as currently all groups/committees within that structure report to Clinical Management Board (CMB) directly and not through a sub-structure. The current structure does not support clear lines of escalation and reporting. In addition, the purpose and function of some groups/committees is unclear and terms of reference require review.
- **Task mapping:** This work identified a range of organisational development and workforce tasks. There is a lack of an oversight delivery group for the organisational development (OD) and people function, with groups reporting directly to Workforce Committee. The remaining grouped tasks are covered by existing Committees.

3.2 ***Proposed Governance Structure***

The proposed governance structure is outlined in Appendix 5. To note, the clinical governance structure requires further review and this is being undertaken in conjunction with the Quality Directorate. The following sets out the proposals in more detail and required actions:

- **Delivery vs Assurance:** the revised structure provides a clear divide between delivery and assurance as follows:
    - Delivery – overall management of the organisation
    - Assurance – seek assurance on behalf of the Board that the systems and processes being put in place by management are robust and effective.

  The proposed governance structure sets out clear lines of reporting and escalation up to the Executive Directors and Senior Management through TMC with the assurance function carried out by the Board Committees. The purpose of the Board Committees is to focus on seeking assurance in relation to their portfolio; predominantly through:
    - Review of relevant performance metrics
    - Review of risks – operational and strategic
    - Deep dives into areas of concern
    - Review of external review data
    - Internal audit and peer reviews.

  The terms of reference for TMC have been revised in line with the proposed governance structure and can be found in Appendix 6.
- **Executive and Non-Executive Roles and Responsibilities:** roles and responsibilities have been clearly defined in the Board and Committee Handbook (Appendix 7).
- **Board Committee assurance map:** there is no recommended change to the Board Committee structure or any significant changes to the terms of reference of the Board Committees. Public Trust Board will move back to bi-monthly meetings. The Subsidiary Governance Committee will remain until the Subsidiary Holding Company is established. All Board Committee terms

of reference can be found in Appendix 8; any changes are tracked for ease of reference.

- **Statutory and key responsibilities of the Board:** there is no recommended action required.
- **Organisation Committee assurance map:** key stakeholders have contributed to this work and proposed arrangements. The Clinical Governance arrangements require further review. This work has commenced in conjunction with the Corporate Governance Team and the Quality Team; the main focus on agreement of a sub-committee structure to CMB with potential to introduce Clinical Effectiveness, Patient Safety and Patient Experience Steering Groups to streamline the reporting to CMB of key items and risks. Assurance on completion of this work will be provided to Clinical Governance Committee.
- **Task mapping:** the Director of OD and People is in agreement to establish an OD and People Management Board to provide oversight of this management function. Terms of reference are to be agreed.

3.3 ***Committee Principles***

The principles of effective meetings were agreed at the workshop on 3 February 2020 as follows:

- All attendees commit to the meeting
  - Any pre-reading distributed in good time and read
  - Ban personal technology
- Clear objective for the meeting
- The right people are attending
- Stick to the agenda
- Start on time and finish on time
- Follow up and ensure everyone has the same view of decisions made

4 Implementation

If the proposed governance structure is approved, it is intended that the new structure will be in place by 30 June 2020 (acknowledging the current priorities in relation to Covid-19).

The Director of Corporate Governance and Corporate Governance Manager will ensure that all Board and Board Committee terms of reference are reviewed in conjunction with the Chairs and Lead Executive Director which will inform the Integrated Governance Framework update. This will be presented to the Board at the meeting in July, together with the Accountability Framework 2020.

Committee meeting dates are set for 2021.

5 Summary

5.1 An Internal Audit of Board Compliance and Reporting, November 2019, identified areas for further improvement. One of the findings was that “The overall structure of the Trust’s Committees, subcommittees and working groups is unclear with no clear framework confirming the escalation route and pathway for information and reports. We identified terms of references which have not been reviewed annually as required. In addition the purpose and role of the Trust Management Committee is not clearly defined”. An extensive review has been undertaken in response to this finding and to propose strengthened governance arrangements. A revised Board

Committee structure is proposed which clearly identifies a clear divide between delivery and assurance.

6 Recommendations

5.1 The Board is asked to:

- Discuss the proposed future governance arrangements
- Approve the proposed governance arrangements
- Approve TMC terms of reference
- Approve all Board Committee Terms of Reference
- Approve the Board and Committee Administration Handbook
- Note that governance arrangements will be kept under review.

Fiona McNeight
Director of Corporate Governance

Appendix 1: Task Mapping	
Individual Task	**Group Tasks**
Review Annual Report and Accounts	Finance
SFIs	
Standing Orders	
Finance Report	
Contracting Report	
Financial Forecasting	
CQUIN Report	
Review Procurement & Commercial Services Annual Report	
Budget approval	
Patient Level Costing	
Private Patients Performance data	
Workforce performance data	
CIP Performance data	
Business case approval up to £500,000	
Reference Cost Submission	
Productivity, benchmarking & Model Hospital Report	Performance
Operational performance data	
Winter Plan	
Emergency Planning Assurance Report	
Estates/infrastructure risk management	
Operating Plan	
Health & Safety Annual Report	People and OD
Equality, Diversity & Inclusion Annual report	
Nursing skill mix review	
Medical revalidation inc.appraisal/MHPS report/GMC	
Guardian of Safe Working Annual Report	
National staff survey report	
Job planning compliance report	
Education and Training Annual Report	
Gender pay gap	
WRES performance data	
WDES performance data	
Workforce performance data	
Organisational Development Plan	
Clinical Excellence Awards Report	
Voluntary services performance data	
Corporate Governance statements	Corporate Governance
Approve contracts exceeding £1.5m	
Corporate Objective Delivery	
Approve annual capital plan	
Approve Annual Business Plan	
Approve Financial Plan/strategy	
CQC compliance report	
Approve Trust Annual Report	
Approve Annual Governance Statement	
Set Trust Values	
Well-led review	
Board evaluation	
Use of Resources	
Approve all long-term borrowing	
Approve capital business cases above £750,000	

Approve estate strategy and acquisition of property over £200,000	
Approve disposal of property over £100,000	
Approve the granting of property leases where the annual value is in excess of £200,000	
Approve loan/overdraft application	
Approve level of non-pay expenditure	
Accountability Framework	
Approve changes to Constitution	
Integrated Governance Framework	
Trust Seal Report	
Safer Staffing	
Set organisation risk appetite	
Board Assurance Framework	
Real-time patient feedback monitoring	Quality (Patient Experience, Patient Safety, Clinical Effectiveness
Annual Complaints Survey Report	
Complaints performance data	
Quarterly patient experience report	
Family & Friends Performance data	
Plaudit Data	
Corporate Risk Register	
SII / Clinical Review Performance Report	
Incident data review	
Risk Annual Report	
Quality Account	
Quality Impact Report	
GIRFT Report	
Annual Clinical Governance Report	
Annual Clinical Audit Plan	
Annual NICE Report	
Learning from Deaths Report	
7 Day Services Board Assurance Framework	
Infection Prevention & Control/DIPC report	
Research and Development Annual Report	
Annual Clinical Governance Report	
Annual Human Tissue Authority Report	
Dementia Strategy Annual Report	
End of Life Care Annual Report	
Annual Safeguarding Adults Report	
Annual Safeguarding Childrens Report	
Mortality and Morbidity Performance Data	
National Maternity Survey Benchmark Report	
National Children & Young People Survey Benchmark Report	
National In-Patient Survey Benchmark Report	
National Cancer Patient Survey Report	
New Health Technologies Report	
Medical device/equipment safety	
Clinical visit recommendation oversight	
Medication safety Performance data	
National Patient Safety Programme Annual Report	
Approve Transformation Strategy	Strategy
Approve Digital Strategy	
Approve Risk Management Strategy	
Approve Dementia Strategy	
Approve Patient Experience strategy	
Approve Research Strategy	
Transformation Programme Assurance Reporting	

Transformation priorities setting	Transformation and Trust Management
Business case approval	
Quality Improvement Programme Delivery	
New procedures approval	
Corporate risk management	
Approve Sustainability Strategy	
Transformation Programme Delivery	
Review IT Improvement Plan delivery	IT
SIRO Report (inc. Data Protection & Security Toolkit Performance)	
Review Digital Strategy Implementation Plan delivery	
Ratify Clinical Policies	Policy review and approval
Ratify Non-Clinical Policies	
Review of Subsidiary Performance Data	Subsidiary Governance and Performance
Approve Subsidiary Strategy	
Review of subsidiary risk profile	
Approve Subsidiary Governance Framework	

Statutory and Other Duties of the Board and its Committees

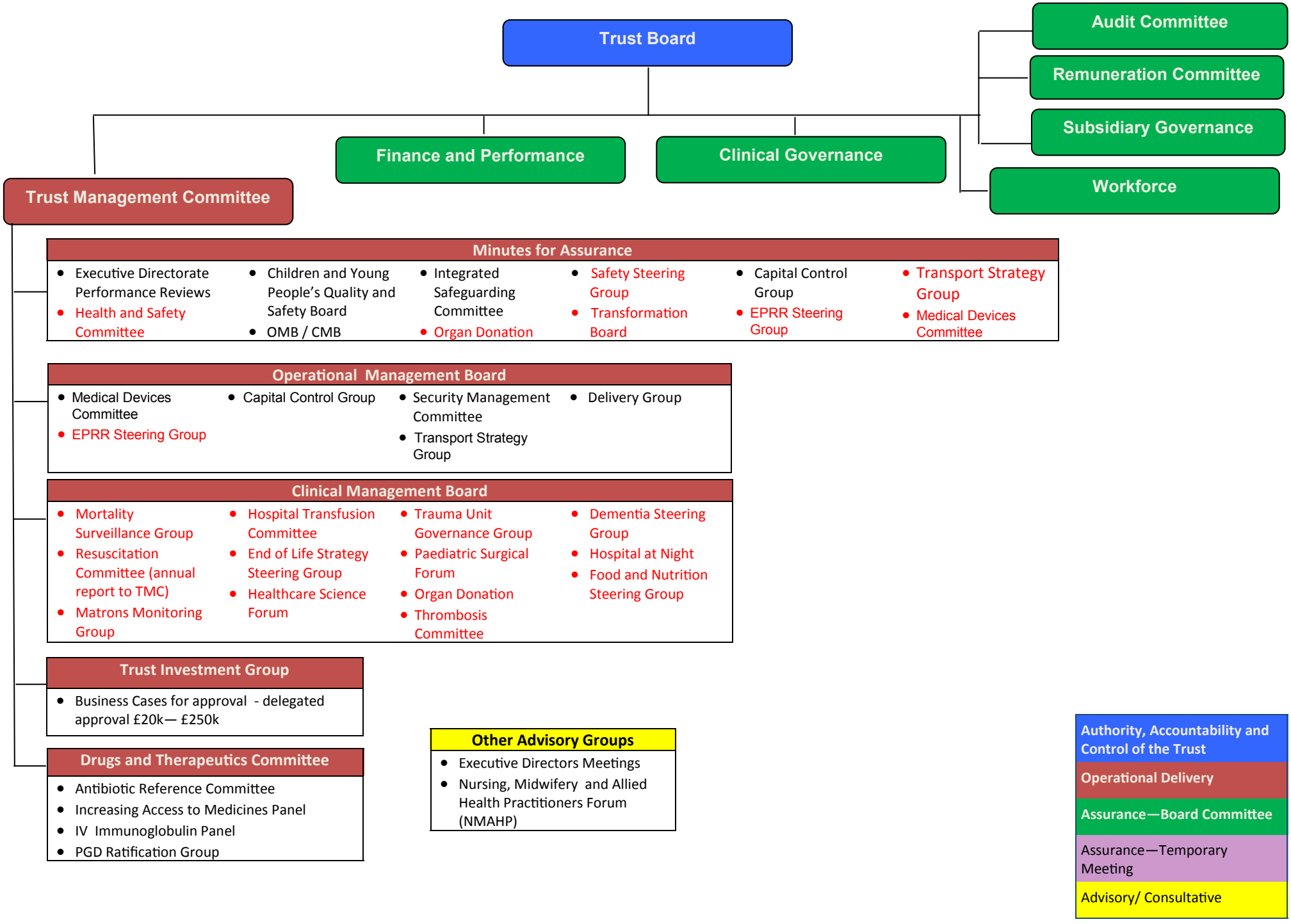
Source	Ref (if applicable)	Requirement	Board	Audit Committee	Remcom	Finance and Performance Committee	Clinical Governance Committee	Workforce Committee	Charitable Funds Committee	Subsidiary Governance Committee	Comments
Monitor Provider Licence (FT4)	3a	The Licensee shall have **regard to such guidance on good corporate governance** as may be issued by Monitor from time to time		✓							
Monitor Provider Licence (FT4)	4a	The licensee shall establish and implement **effective board and committee structures**	✓								
Monitor Provider Licence (FT4)	4b	The licensee shall establish and implement **clear responsibilities for its Board**, **for committees** reporting to the Board and for **staff reporting to the Board and those committees**	✓								
Monitor Provider Licence (FT4)	4c	The licensee shall establish and implement **clear reporting lines and accountabilities** throughout its organisation	✓								
Monitor Provider Licence (FT4)	5a	The Licensee shall establish and effectively implement **systems and/or processes** to ensure compliance with the Licensee's **duty to operate efficiently, economically and effectively**		✓							
Monitor Provider Licence (FT4)	5b	The Licensee shall establish and effectively implement **systems and/or processes** for **timely and effective scrutiny and oversigh**t by the Board of the Licensee's **operations**	✓								
Monitor Provider Licence (FT4)	5c	The Licensee shall establish and effectively implement **systems and/or processes** to ensure **compliance with health care standards** binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions					✓				
Monitor Provider Licence (FT4)	5d	The Licensee shall establish and effectively implement **systems and/or processes** for **effective financial decision-making, management and control** (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)				✓					
Monitor Provider Licence (FT4)	5e	The Licensee shall establish and effectively implement **systems and/or processes** to **obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making**		✓							
Monitor Provider Licence (FT4)	5f	The Licensee shall establish and effectively implement **systems and/or processes** to **identify and manage** (including but not restricted to manage through **forward plans**) **material risks** to compliance with the Conditions of its Licence;	✓	✓		✓	✓	✓			Audit Committee reviews overall system and process. Other Committees will review risks on the corporate risk register
Monitor Provider Licence (FT4)	5g	The Licensee shall establish and effectively implement **systems and/or processes** to **generate and monitor delivery of business plans** (including any changes to such plans) and to **receive internal and where appropriate external assurance on such plans and their delivery**		✓		✓					
Monitor Provider Licence (FT4)	5h	The Licensee shall establish and effectively implement **systems and/or processes** to ensure **compliance with all applicable legal requirements**	✓								
Monitor Provider Licence (FT4)	6a	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure that there is **sufficient capability at Board level to provide effective organisational leadership on the quality of care provided**			✓						
Monitor Provider Licence (FT4)	6b	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure that the Board's **planning and decision-making processes take timely and appropriate account of quality of care considerations**					✓				
Monitor Provider Licence (FT4)	6c	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure the **collection of accurate, comprehensive, timely and up to date information on quality of care**					✓				
Monitor Provider Licence (FT4)	6d	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure that the **Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care**					✓				
Monitor Provider Licence (FT4)	6e	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure that the Licensee including its Board **actively engages on quality of care with patients, staff and other relevant stakeholders** and takes into account as appropriate views and information from these sources					✓				
Monitor Provider Licence (FT4)	6f	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure that there is **clear accountability for quality of care** throughout the Licensee's organisation including but not restricted to **systems and/or processes for escalating and resolving quality issues including escalating them to the Board** where appropriate.					✓				
Monitor Provider Licence (FT4)	7	The Licensee shall ensure the **existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence**	✓		✓			✓			
Monitor Provider Licence (FT4)	8a	The Licensee shall submit to Monitor within three months of the end of each financial year a **corporate governance statement** by and on behalf of its Board **confirming compliance with this Condition** as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks		✓							
Monitor Provider Licence (FT4)	8b	The Licensee shall submit to Monitor within three months of the end of each financial year if required in writing by Monitor, a statement from its auditors either: (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.		✓							
Strategic Objectives		**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.				✓					

Strategic Objectives		**Specialist Services –** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.				✔					
Strategic Objectives		**Innovation –** We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered				✔	✔				
Strategic Objectives		**Care –** We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm					✔				
Strategic Objectives		**People -** We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams						✔			
Strategic Objectives		**Resources –** We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources				✔					
Well-Led Framework	1	Is there the **leadership capacity and capability** to deliver high quality.sustainable care						✔			
Well-Led Framework	2	Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver	✔								
Well-Led Framework	3	Is there a **culture** of high quality, sustainable care					✔				
Well-Led Framework	4	Are there clear responsibilities, **roles** and systems of accountability to support good governance and management		✔							
Well-Led Framework	5	Are there clear and effective processes for managing **risks**, issues and **performance**		✔							
Well-Led Framework	6	Is appropriate and accurate **information** being effectively processed, challenged and acted on		✔							
Well-Led Framework	7	Are the **people**, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services	✔								
Well-Led Framework	8	Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**					✔				
Scheme of Delegation	SFI 1.1.8	Referring action or ratification of any non-compliance with SFIs.		✓							
Scheme of Delegation	SFI 1.2.1	Formulate the financial strategy	✓								
Scheme of Delegation	SFI 1.2.1	Approve budgets	✓								
Scheme of Delegation	SFI 1.2.1	Define and approve essential features of important procedures and financial systems	✓								
Scheme of Delegation	SFI 1.2.1	Define delegated responsibilities.	✓								
Scheme of Delegation	SFI 2.3	Appointment of the external auditor in compliance with the constitution and that they comply with the Audit Code.		✓							
Scheme of Delegation	SFI 3.1.2	Approve the Annual Business Plan	✓								
Scheme of Delegation	SFI 3.1.8	Approve business cases up to £500,000				✓					
Scheme of Delegation	SFI 4.5	Approve Annual Report and Accounts including the auditor's report.	✓								
Scheme of Delegation	SFI 5.1.3	Approve the opening of new bank accounts.	✓								
Scheme of Delegation	SFI 7.3	Authorise contracts with Suppliers which exceed £1.5m.	✓								
Scheme of Delegation	SFI 8.1.1	Regularly review and maintain capacity and capability to provide mandatory goods and services per the terms of the licence.	✓								
Scheme of Delegation	SFI 10.1.1	Approve the level of non-pay expenditure.	✓								
Scheme of Delegation	SFI 11.1.3	Approve application for a loan/overdraft.	✓								
Scheme of Delegation	SFI 11.1.5	Approve all long-term borrowing.	✓								
Scheme of Delegation	SFI 11.3.2	Set Investment Policy. Oversee all investment transactions. Approve Treasury Policy		✓							
Scheme of Delegation	SFI 11.3.3	Approve investments made in forming/acquiring an interest in bodies corporate.	✓								
Scheme of Delegation	SFI 11.3.4	Approve short term investment vehicle.		✓							
Scheme of Delegation	SFI 12.1.3	Approve the Annual Capital Plan.	✓								
Scheme of Delegation	SFI 12.2.2	Approve all capital business cases above £750,000	✓								
Scheme of Delegation	SFI 12.6.2	Approve Estate Strategy and acquisition of property (freehold & lease) over £200,000.	✓								
Scheme of Delegation	SFI 12.6.8	Approve disposal of property over £100,000.	✓								
Scheme of Delegation	SFI 12.6.10 & 12.6.11	Seek approval from NHS Improvement for the disposal of protected assets and major disinvestments.	✓								
Scheme of Delegation	SFI 12.6.12	Approve the granting of property leases where the annual value is in excess of £200,000	✓								

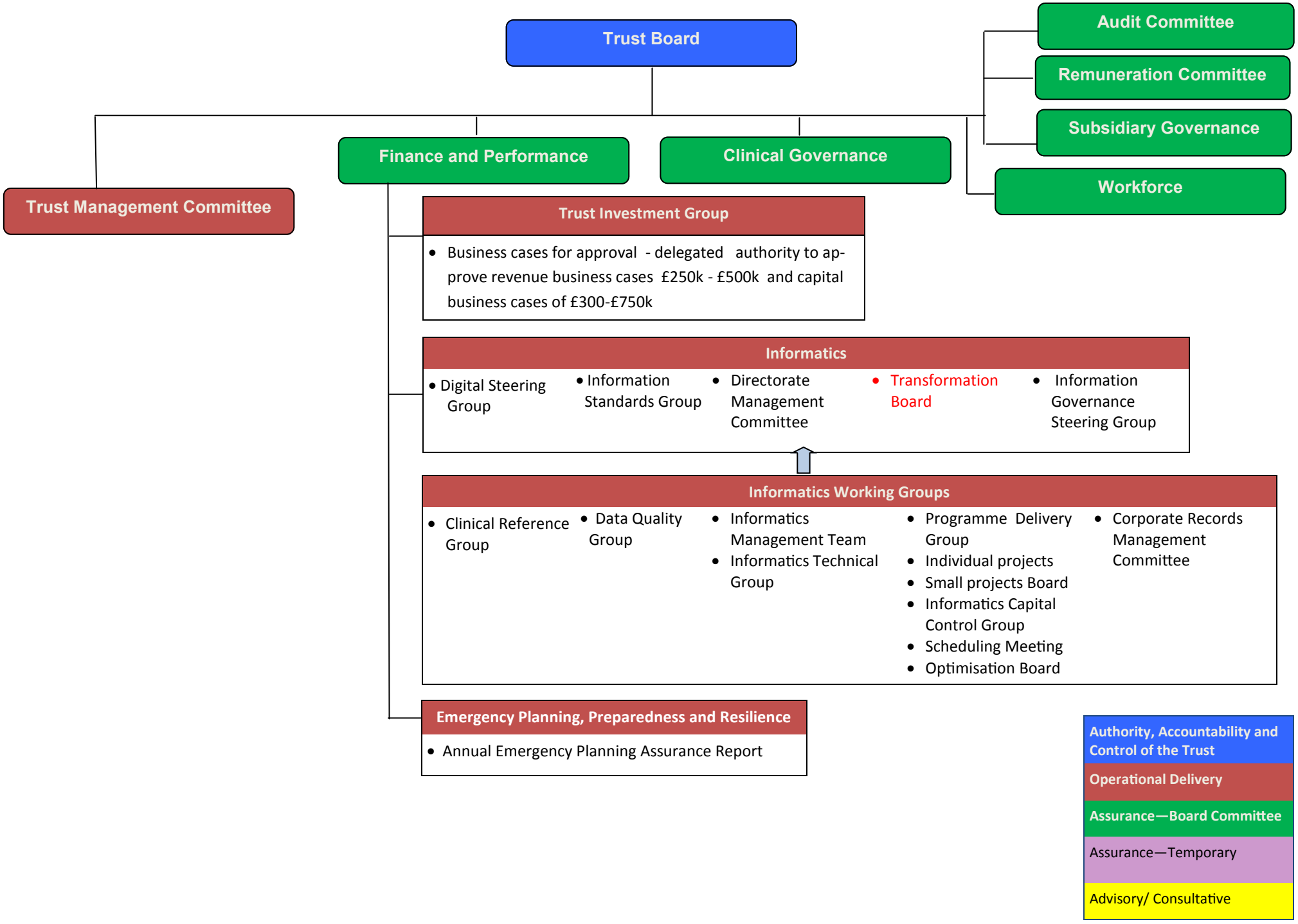
Assurance map: Board Committees

Committee	Clinicial Governance Committee	Finance & Performance Committee	Audit Committee	Workforce Committee	Subsidiary Governance Committee	Remuneration Committee	Charitable Funds Committee
Frequency	9 per year	Monthly	Quarterly	Bi-monthly	Quarterly	Bi-Annual	Quarterly
Areas of Assurance	Regulator and Professional Body compliance Clinical risk Patient Safety and annual safety plan Clinical Effectiveness including NICE Patient Experience including National and local surveys Adult and Child Safeguarding Quality Strategy Quality Performance including QIA oversight Internal Audit - oversight of delivery of relevant audit recommendations Assurance Framework (Innovation & Care) Quality objectives Quality Priorities Quality Performance Risk Management Strategy and Policy Serious Incidents Never Events Complaints Safe Staffing Research and Development Infection Prevention & Control Clinical Litigation Clinical Service Transformation Quality Improvement	Financial Strategy, Policy, management & reporting Financial risk Financial performance Cost Improvement Programme Assurance Framework (Local, Specialist & Resources) Financial Recovery Plan Internal Audit - oversight of delivery of relevant audit recommendations IT/Digital Data Quality Information Governance Estates and facilities Operational risk Operational Performance	Governance and internal control Assurance on financial & operational systems Risk Management Internal Audit Plan Oversight of internal audit recommendations External Audit Plan Counter Fraud Financial Reporting (SFIs & Sos) Assurance Framework Accounting Policies Annual Report and Financial Statements	People Strategy Assurance Framework (People) Workforce performance Workforce Planning Organisational development HR Policies and Procedures Internal Audit - oversight of delivery of relevant audit recommendations Guardian of Safe Working OD & People Operating Plan Compliance with employment legislation Educational and professional development Recruitment & Retention Staff engagement Occupational Therapy and Counselling Services Health & Safety Equality & Diversity Leadership and Talent Management Staff Wellbeing FTSUG Workforce Transformation Quality Improvement	Subsidiary risk Subsidiary governance Performance monitoring of all subsidiaries	Executive Remuneration Policy Chief Executive and Executive Director Performance	Charitable Funds Performance Policy

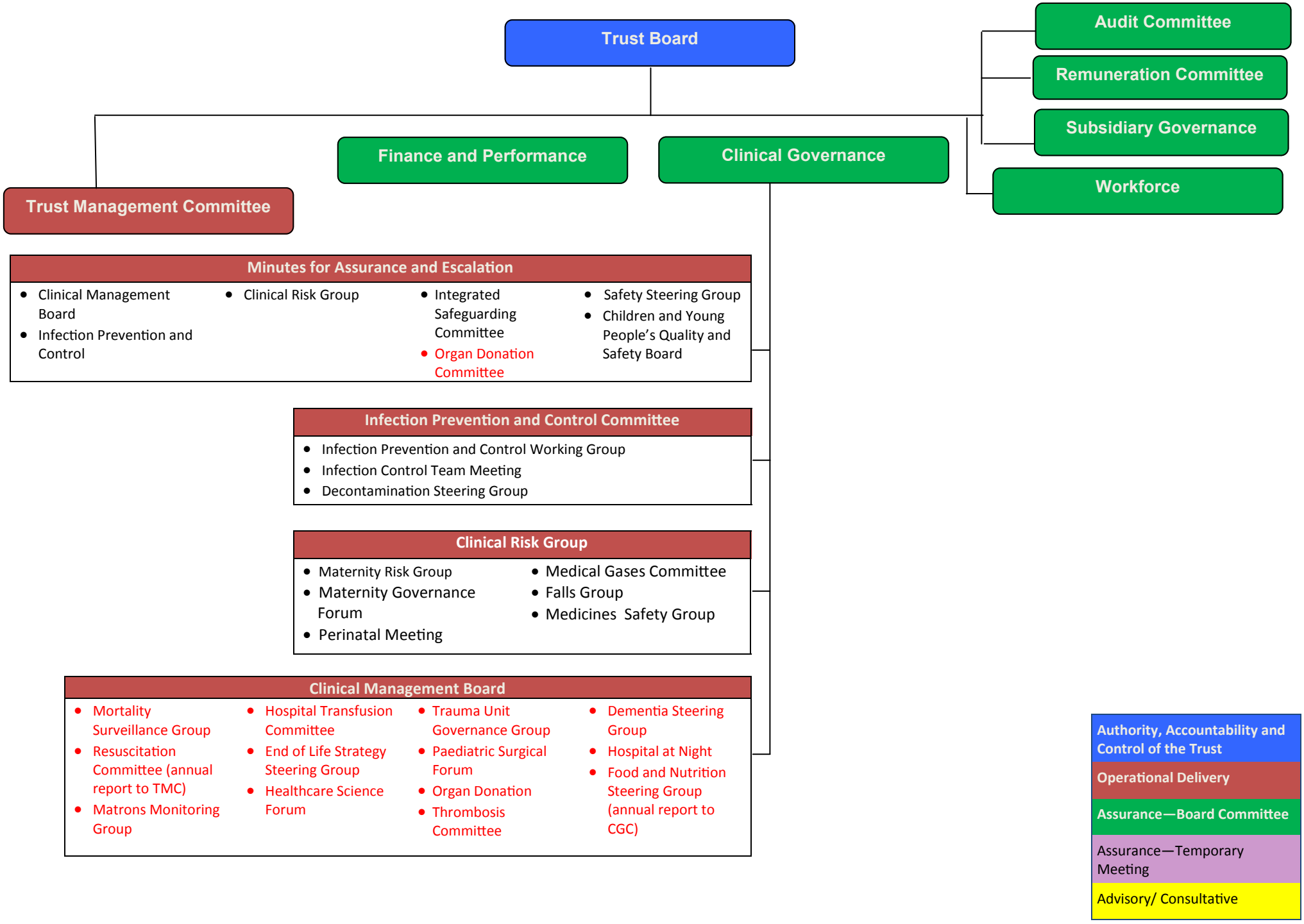
Salisbury NHS Foundation Trust— Organisational Structure



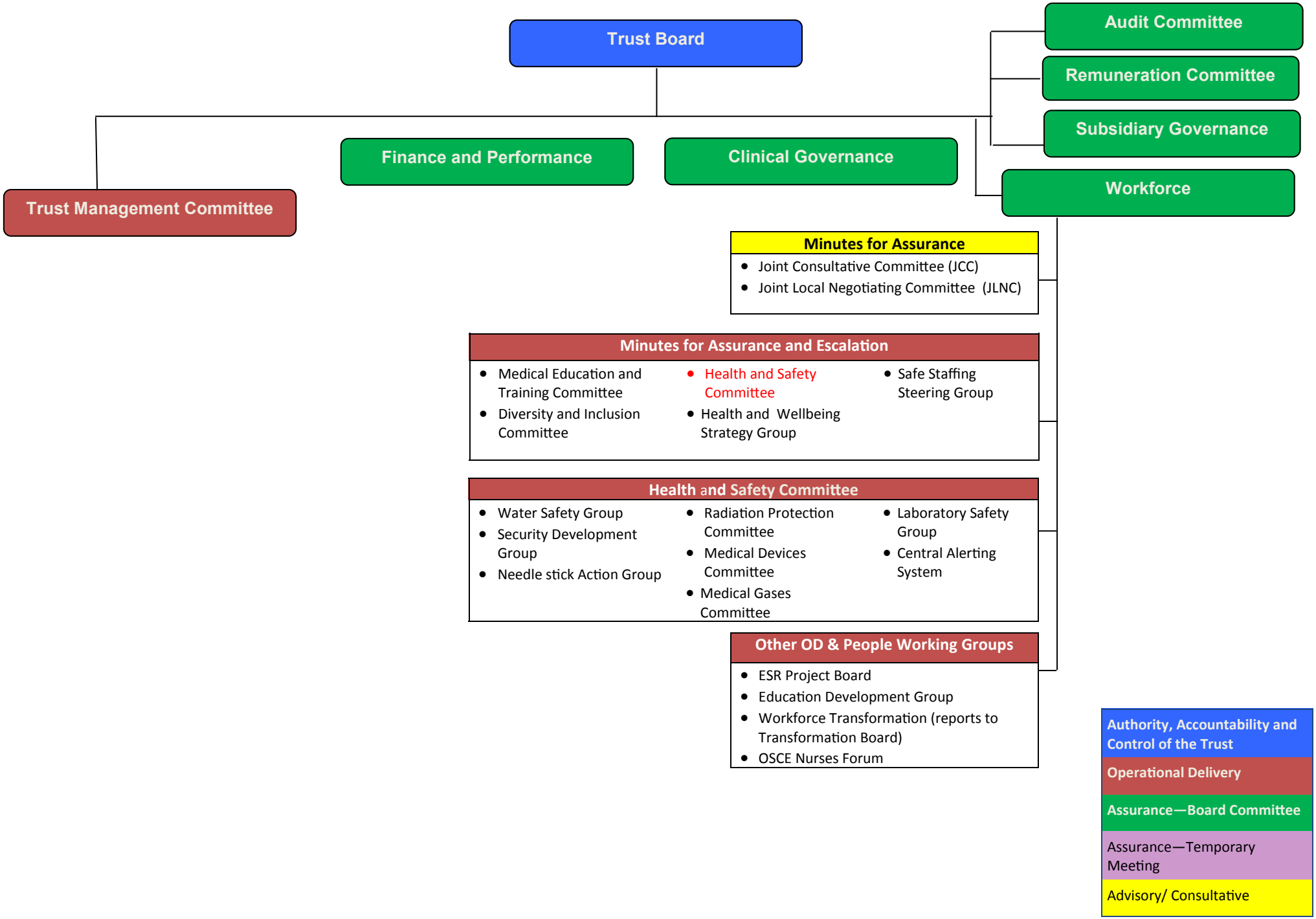
Salisbury NHS Foundation Trust — Organisational Structure

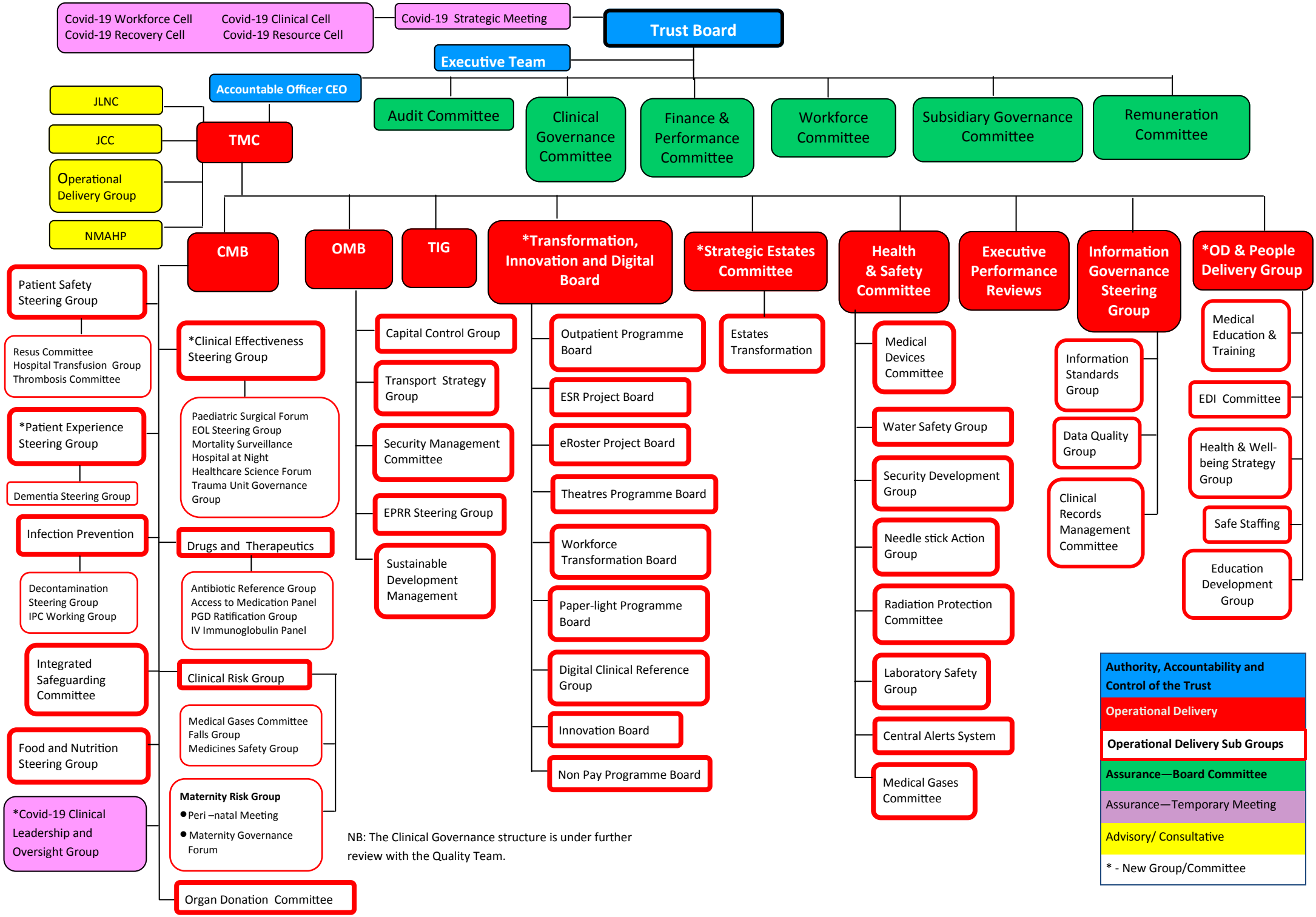


Salisbury NHS Foundation Trust - Organisational Structure



Salisbury NHS Foundation Trust - Organisational Structure




Covid-19 Workforce Cell
Covid-19 Recovery Cell
Covid-19 Clinical Cell
Covid-19 Resource Cell
Covid-19 Strategic Meeting
Trust Board
Executive Team
Accountable Officer CEO
JLNC
JCC
Operational Delivery Group
NMAHP
TMC
Audit Committee
Clinical Governance Committee
Finance & Performance Committee
Workforce Committee
Subsidiary Governance Committee
Remuneration Committee
CMB
OMB
TIG
*Transformation, Innovation and Digital Board
*Strategic Estates Committee
Health & Safety Committee
Executive Performance Reviews
Information Governance Steering Group
*OD & People Delivery Group
Patient Safety Steering Group
Resus Committee
Hospital Transfusion Group
Thrombosis Committee
*Patient Experience Steering Group
Dementia Steering Group
Infection Prevention
Decontamination Steering Group
IPC Working Group
Integrated Safeguarding Committee
Food and Nutrition Steering Group
*Covid-19 Clinical Leadership and Oversight Group
*Clinical Effectiveness Steering Group
Paediatric Surgical Forum
EOL Steering Group
Mortality Surveillance
Hospital at Night
Healthcare Science Forum
Trauma Unit Governance Group
Drugs and Therapeutics
Antibiotic Reference Group
Access to Medication Panel
PGD Ratification Group
IV Immunoglobulin Panel
Clinical Risk Group
Medical Gases Committee
Falls Group
Medicines Safety Group
Maternity Risk Group
Peri –natal Meeting
Maternity Governance Forum
Organ Donation Committee
Capital Control Group
Transport Strategy Group
Security Management Committee
EPRR Steering Group
Sustainable Development Management
Outpatient Programme Board
ESR Project Board
eRoster Project Board
Theatres Programme Board
Workforce Transformation Board
Paper-light Programme Board
Digital Clinical Reference Group
Innovation Board
Non Pay Programme Board
Estates Transformation
Medical Devices Committee
Water Safety Group
Security Development Group
Needle stick Action Group
Radiation Protection Committee
Laboratory Safety Group
Central Alerts System
Medical Gases Committee
Information Standards Group
Data Quality Group
Clinical Records Management Committee
Medical Education & Training
EDI Committee
Health & Well-being Strategy Group
Safe Staffing
Education Development Group
NB: The Clinical Governance structure is under further review with the Quality Team.
Authority, Accountability and Control of the Trust
Operational Delivery
Operational Delivery Sub Groups
Assurance—Board Committee
Assurance—Temporary Meeting
Advisory/ Consultative
* - New Group/Committee

Salisbury NHS Foundation Trust

DRAFT
Trust Management Committee

Terms of Reference

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

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

1. Purpose

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

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

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

2. Authority

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

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

3. Membership and Attendance

Membership

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

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

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

Quorum

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

4. Roles and Responsibilities

Strategy and Business Planning

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

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

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

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

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

Operational, Quality and Performance

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

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

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

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

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

Governance and Risk

4.11. Monitor the management of organisational risk;

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

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

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

Procedural Documents in line with the Policy for Policies

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

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

Receive Reports from the following sub-groups*

4.17. Clinical Management Board (CMB)

Operational Management Board (OMB)

Trust Investment Group (TIG)

Transformation, Innovation and Digital Board

Strategic Estates Committee

Health and Safety Committee

Executive Performance Reviews

Information Governance Steering Group (IGSG)

Digital Steering Group (DSG)

Organisational Development and People Management Board

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

5. Conduct of Business

Administration

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

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

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

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

Notice of meetings

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

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

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

Reporting

5.7. Formal minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any

significant concerns in relation to the business undertaken directly with the Board in a timely manner.

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

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

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

Joint Local Negotiating Committee (JLNC)

Joint Consultative Committee (JCC)

Operational Delivery Group

Nursing, Midwifery and Allied Health Professionals Forum (NMAHP)

6. Review

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

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

Appendix A

NHS Salisbury NHS Foundation Trust

Agenda Template
Trust Management Committee
Date, Time
Room

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

	10	**Minutes for Information**			
	10.1				
	11	**Closing Business**			
	11.1	Agreement of principal actions / Items for Escalation			
	11.2	Any Other Business			
	11.3	**Date of next meeting:**			

Agenda and papers circulated to:

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

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

Salisbury NHS Foundation Trust

BOARD AND COMMITTEE ADMINISTRATION HANDBOOK

Author: Kylie Nye, Corporate Governance Manager
Version: 1.0
Date: February 2020

Contents

1. Introduction

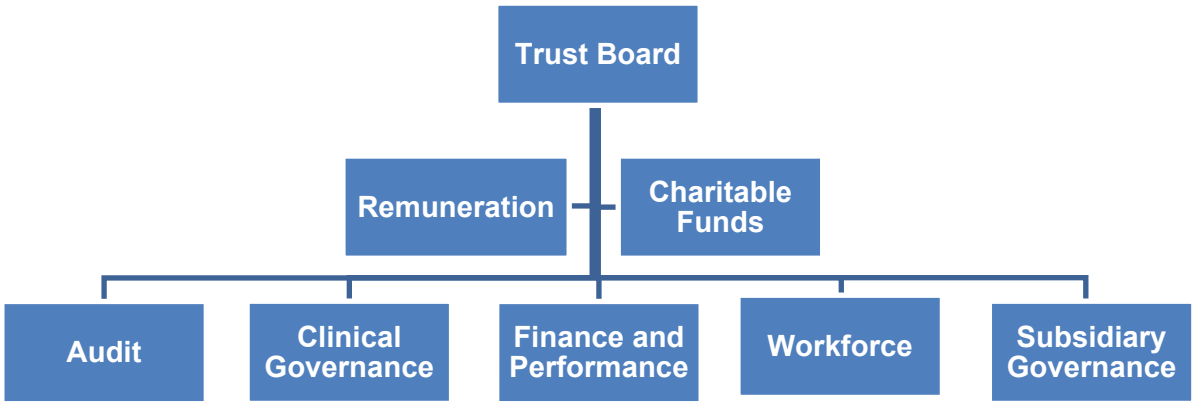
1.1. In common with all NHS Foundation Trusts, the Board of Directors of Salisbury NHS Foundation Trust (SFT) functions as the organisation's main corporate decision making body. Its role is to formulate and drive the Trust's strategic objectives and to ensure that these are being delivered. The Board is required to take account of the key risks that may prevent the Trust from meeting its objectives and assure itself that the controls and other measures that have been put in place are suitably robust to manage or avoid those risks.

1.2. There are five main committees of the Board, in addition to the Management Team:

- Audit
- Workforce
- Finance and Performance
- Charitable Funds
- Clinical Governance Committee

The board is additionally supported by a Remuneration Committee which determines matters of executive pay and determines executive appointments and Subsidiary Governance Committee, which ensures the Trust has appropriate oversight on its interests and shareholdings.

1.3. Their collective role is to assist the Board in managing the entirety of the Board's business and to seek assurance that key strategic risks are being effectively managed, that the Trust is meeting its objectives and that legal, regulatory and ethical requirements are being met.



1.4. The purpose of the Committee Handbook is to clearly set out the duties of, and expectations on, all staff involved supporting the committees, including agenda setting, business planning, and preparations of papers and associated documentation, and, importantly, carrying out the actions that emanate from Board and committee deliberations.

1.5. The Trust Management Committee is the key executive decision making body within the organisation, and enables the Executive Team and directorate management to effectively oversee the operational management of the Trust's services. The committee supports the development of the Trust's Annual Plan and plays a key role in

implementing the overall strategy of the Trust. In order to ensure consistency to all major corporate governance functions and promote best practice across the organisation, it is intended that this Committee Handbook will also apply to the Directorate Management Teams and their sub structures.

2. Scope

2.1. The Committee Handbook applies to all staff involved in the preparation, presentation of papers and management of the Board of Directors, its committees, and sub groups.

3. Duties and Responsibilities

The Chief Executive

3.1. The Chief Executive has overall responsibility for ensuring, through the establishment and maintenance of sound procedure, that the organisation complies with all legal, regulatory and good practice requirements.

Director of Corporate Governance

3.2. The Director of Corporate Governance is responsible for ensuring, on behalf of the Chief Executive, that the organisation has robust procedures in place to facilitate the efficient running of the Board and committee business.

Executive Directors

3.3. Executive Directors are responsible for delivering operational objectives and define how they will be delivered. Executive Directors support the requirements set out in these procedures, and ensure designated leads within their directorates responsible for production of Board and committee papers are aware of and comply with these procedures.

Lead Executive

3.4. Each Committee will have a nominated Lead Executive who will work with the Committee Chair and Director of Corporate Governance to ensure that the Committee operates effectively. These individuals will be involved in setting the agendas, agreement of the escalation report to the Board and other actions as required.

3.5. Non-Executive Directors

Non-Executive Directors are responsible for seeking assurance about the delivery of systems and processes and hold the Executives to account for delivery. The Non-Executive Directors (NEDs) have a key role as Board Committee chairs. Working alongside the committee administrator and lead executive, it is the NED's role as chairman to ensure an appropriate and timely agenda has been set. The chairman should be reviewing the draft minutes and action log to ensure the correct business has been recorded and actions have been completed. As a NED committee member it is their responsibility to provide a sufficient level of challenge.

Personal Assistants

3.6. Personal Assistants will provide high level administrative support to their respective Executive Directors in the production and submission of Board and committee papers in accordance with the requirements set out in these procedures. They will also support Executive Directors and committee chairs in ensuring that action points from previous meetings are followed up and reported back within the agreed timescales.

4. Chairman's Packs

4.1. A new Committee Chairman will be provided with an information pack including;

- The Board and committee organisational chart
- Annual cycle of business
- Meeting Dates and timeline for the production of agenda and papers
- Terms of Reference
- Details of Board and Committee Assessment and Evaluation Processes (in the case of Audit, this will be based on the Self-Assessment Checklist in the NHS Audit Committee annual review).

4.2. Other items may be included at the discretion of the Chairman or following a recommendation from the Committee's annual review.

5. Board and Committee Process

Annual Cycles of Business

5.1. The Corporate Governance Team will develop and maintain the Board of Director's annual Cycle of Business in conjunction with the Chief Executive and Trust Chairman. The Corporate Governance Team will also develop and maintain the committee's annual Cycles of Business in conjunction with the Lead Executive and Chairman of each Committee.

5.2. The Board and committees Cycles of Business will include the matters set out in the Trust's Standing Orders, and in the case of committees, items included in their Terms of Reference, which are updated annually. These cycles will be reviewed and finalised by the Corporate Governance Team by the end of December each year.

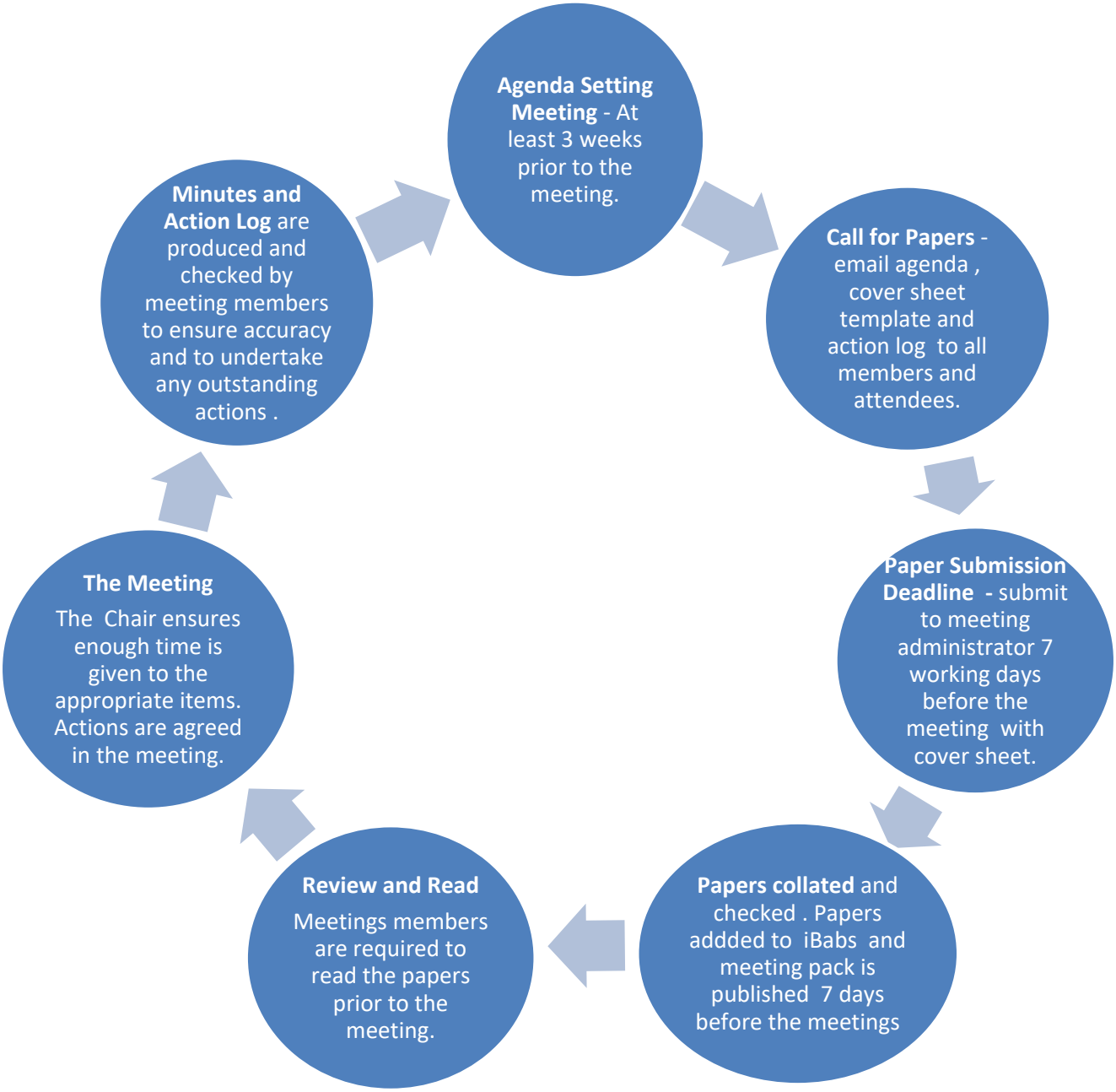
5.3. The Cycles of Business will be developed based on inputs from the following sources:

- Annual Business Plan
- Risk Register
- Board Assurance Framework
- Well-Led Framework
- Terms of Reference
- Board or other sub-committee requests
- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Internal and External Audit Reports
- NHS Improvement's Code of Governance

5.4. In relation to the Audit Committee, the specific requirements set out in the NHS Audit Committee Handbook, the Financial Reporting Council guidelines and NHS Improvement's Code of Governance will determine the timing and sequencing of agenda items.

The Meeting Cycle

5.5. The cycle of a meeting can be summarised as follows:



Agenda Setting for Board and Committee Meetings

5.6. A draft agenda for the next meeting should available for the agenda setting meeting (usually held after the Committee meeting) or sent to the lead executive and chair to amend if required. The draft agenda should be confirmed with the meeting administrator at least 3 weeks before the meeting.

5.7. The agenda setting meeting includes the meeting administrator, Lead Executive and the Chair. The draft agenda will inform this meeting and will include items from the annual cycle of business, action log and other items of business as agreed with the Lead Executive and Chair.

The Chairman and Lead Executive Directors for the Board and Committee are:

	CHAIRMAN	LEAD EXECUTIVE DIRECTOR
Trust Board	Nick Marsden, Trust Chairman	Chief Executive
Audit Committee	Paul Kemp, Non-Executive Director	Director of Finance
Clinical Governance Committee	Eiri Jones, Non-Executive Director	Director of Nursing Medical Director
Finance and Performance Committee	Paul Miller, Non- Executive Director	Director of Finance
Workforce Committee	Michael Von-Bertele, Non-Executive Director	Director of OD and People
Subsidiary Governance Committee	Paul Miller, Non-Executive Director	Director of Finance

5.8. It is expected that a majority of items for discussion at Board meetings will be included in the public part of the agenda. Items to be discussed in the confidential part 2 meeting include:

- Commercially confidential or sensitive discussions about the award of contracts, tenders, business plans and aspects of the Trust's financial position where it has not yet been finalised;
- Discussions and/or reports concerning identifiable patients or members of staff;
- Initial discussions relating to internal or external review of the Board or individual Board members;
- Detailed information about external assessments when still in draft;
- Initial discussions and proposals relating to service change, development, reconfiguration or business cases;
- Information supplied to the Trust by an external agency requiring confidentiality.

5.9. Although this list is not exhaustive, Executive Directors need to indicate why an item not within the above categories ought to be on the confidential agenda. The rationale for inclusion of a paper on the confidential agenda should be stated in the paper. Items to be discussed in the confidential part of the meeting must be classified as NHS Confidential. The final decision on whether an item should be on the public or private agenda is retained by the Chairman. Further advice can be sought from the Director of Corporate Governance.

Formatting of Agenda Papers

5.10. It is the responsibility of the author to produce the paper and any supporting documents in the correct format. Papers not in the correct format will be sent back to the author for amendment. The author is also responsible for ensuring that the cover sheet is fully completed. Papers without a cover sheet will be returned will be sent back to the author. A cover sheet and report template is attached – Appendix A.

5.11. A summary of good reporting principles are as follows:

- Alignment with aims and objective
- Allow for informed and timely decision making
- Exception based
- Executive summary must be capable of standing alone
- Forward looking/ trend based wherever appropriate
- Succinct, with a use of visual aids
- Action orientated using SMART actions
- Reports should be bespoke for the intended audience
- Transparent and agreed criteria over KPI performance rating
- Performance data should be validated prior to reporting
- The use of benchmarking and comparators

Production, Submission and Distribution of Papers

5.12. Executive approved papers must be submitted to the administrator, **no later than 7 days** before the meeting. The exceptions to this are as follows:

- There are times when performance information is not available due to the tight meeting schedules in the month, for this reason Finance and Performance Committee is always published **5 days** prior to the meeting.
- Late papers are unacceptable and will only be added to the meeting papers after the deadline if permission has been given by the Chair of that meeting.
- Trust Board papers are reviewed by the Director of Corporate Governance prior to publication to ensure the correct standards have been met. Therefore, the Trust Board administrator should receive the papers **10 days** before the meeting to allow time to review.

5.13. The administrator of the meeting will ensure the papers are sent out to members and regular attendees at least **7 days** before the meeting. A copy of the papers for the public Trust Board meeting will be published on the Trust website. The private Trust Board agenda will be circulated to the Council of Governors.

IBabs

5.14. All Trust Board and Committee papers are now uploaded to iBabs by the meeting administrators. This is an online system which supports the upload and distribution of meeting papers. All Board members and deputies should have access so they are able to review the papers prior to the meeting. An iBabs administration user guide can be found in Appendix B.

6. Procedure at Meetings

Attendance at meetings

6.1. All members of the Board and its committees should attend each meeting. Where this is not possible, members will notify the administrator of the meeting of any absences and confirm if a deputy will be attending. A record of individual attendances is included in the Trust's annual report. The Chair will discuss any individual concerns about attendance rates.

Presentations

6.2. Ideally, presentations should be distributed with the meeting papers when they are published. However, where this is not possible a copy of the slides should be sent to the administrator at least the day before the meeting. The administrator is responsible for ensuring that suitable arrangements have been made for the presentation to be delivered in its intended format. Similar arrangements must be made where a DVD or other form of audio-video presentation is to be made.

6.3. Copies of any presentation should be circulated to members of the Committee via iBabs if they were not included in the meeting papers.

6.4. Minute Taking

Executive approved papers must be submitted to the administrator, no later than 7 days before the meeting. The exceptions to this are as follows:

- There are times when performance information is not available due to the tight meeting schedules in the month, for this reason Finance and Performance Committee is always published 5 days prior to the meeting.
- Late papers are unacceptable and will only be added to the meeting papers after the deadline if permission has been given by the Chair of that meeting.
- Trust Board papers are reviewed by the Director of Corporate Governance prior to publication to ensure the correct standards have been met. Therefore, the Trust Board administrator should receive the papers 10 days before the meeting to allow time to review.

The Corporate Governance Manager will take the minutes at Trust Board and Finance and Performance Committee. The Director of Corporate Governance will take the minutes at Audit Committee and Charitable Funds Committee. The other Board Committees are minuted by the Executive Secretariat. Draft Board and Committee minutes will be reviewed and amended as appropriate by the Executive team and Committee Chair. Draft minutes and updated action logs to be sent to the lead Executive Director and Chairman no later than 10 working days following the meeting.

6.5. The final draft of the minutes will be circulated with the meeting papers for approval at the next meeting.

6.6. Approved private Trust Board minutes will be circulated to Governors for information.

Committee Escalation Reports to the Board

6.7. At the end of each Board Committee agenda there is a standard item “Agreement of principal actions / Items for Escalation”. This should be a discussion regarding the items for inclusion in the report to the Trust Board. The Committee should consider:

- Significant issues requiring escalation;
- Key risks discussed;
- Key decisions taken;
- Agreed actions;
- Matters deferred for future consideration;
- Assurance required from/ actions required by other Board Committees.

6.8. The Chair will draft the Committee Escalation Report with the support of the Lead Executive Director. The report will be presented to the next meeting of the Trust Board.

7. Record Keeping and Archiving

7.1. Electronic Records

Electronic copies of all Board and Committee agendas, papers, minutes and actions logs will be kept and managed by the Corporate Governance Team within the shared drive. No documents relating to Trust Board, Committees or sub groups should be saved in staff members' personal drives. Access to the electronic files will be closely managed to ensure only those with an appropriate need to access these files are able to do so.

7.2. The Trust is required to retain master copies of Board and Committee agendas and associated papers for at least 30 years.

7.3. iBabs is not to be used to store Board and Committee papers. They should always be saved in the appropriate folder in the shared drive.

8. Review Process

8.1. The process for creating agendas and meeting papers; resulting in minutes and action logs will be reviewed annually to ensure that;

- Quality is maintained**,**
- papers are of appropriate content and length,
- agendas accurately reflect the annual cycles of business, the requirements of the Trust's strategic and corporate objectives and that they can evidence compliance with legal and regulatory requirements,
- the views and suggestions of those working with these procedures are taken into account.

8.2. The review will be undertaken as part of the annual review of Board and Committee effectiveness. The Chair and Lead Executive Director are responsible for producing and completing this report. A summary report of Board and Committee effectiveness will be produced by the Corporate Governance Team, which will go to Trust Board.

9. Monitoring Compliance

9.1. Compliance with the document will be monitored through an annual audit of papers to ensure:

- All papers conform to the agreed template
- Papers are distributed according to the agreed timescales
- Minutes are produced according to the agreed timescales

9.2. The Board and its Committees will undertake an annual review of effectiveness to ensure the content and format of papers supports decision making and the provision of assurance to the Board.

10. References

10.1. This handbook was developed with the support of:

- NHS Providers/ DAC Beachcroft: The Foundations of Good Governance, A compendium of Best Practice -https://nhsproviders.org/media/1738/foundations-of-good-governance-web-file.pdf

- NHS Audit Committee Handbook - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf

- NHS Records Management: Codes of Practice Parts 1 and 2 - https://www.gov.uk/government/publications/records-management-nhs-code-of-practice

- Trust Standing Orders, including Standing Financial Instructions, Schedule of Reservations of Powers and Scheme of Delegated Authorities. These can be found on Microguide, under Non-Clinical Trust Wide Policies, Finance.

- NHS Code of Governance - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf

11. Document History

Date of Revision	Version Number	Reason for review or update
13 August 2017	**0.1**	**First Draft**
Feb 2020	**1.0**	**Completely revised draft**

Appendix A – Cover sheet and report template

CLASSIFICATION: please select

Salisbury NHS Foundation Trust

Report to:	Insert name of Committee	**Agenda item:**	
Date of Meeting:	31 January 2020		

Report Title:	Insert Title of Report			
Status: (tick appropriate box)	**Information**	**Discussion**	**Assurance**	**Approval**
Prepared by:	Name (Job Title)			
Executive Sponsor (presenting):	Name (Job Title)			
Appendices (list if applicable):	Add titles of appendices. If there are none put N/A			

Recommendation:
Provide a clear rationale and purpose of the paper i.e. what you want the committee to do with the paper

Executive Summary:
• Identify the key issues. What are the 3 main points from the paper that you want the Committee to know? • Provide details on where the paper has been previously discussed

- Provide details on where the paper is going next (e.g. is it going to Trust Board for final ratification?)

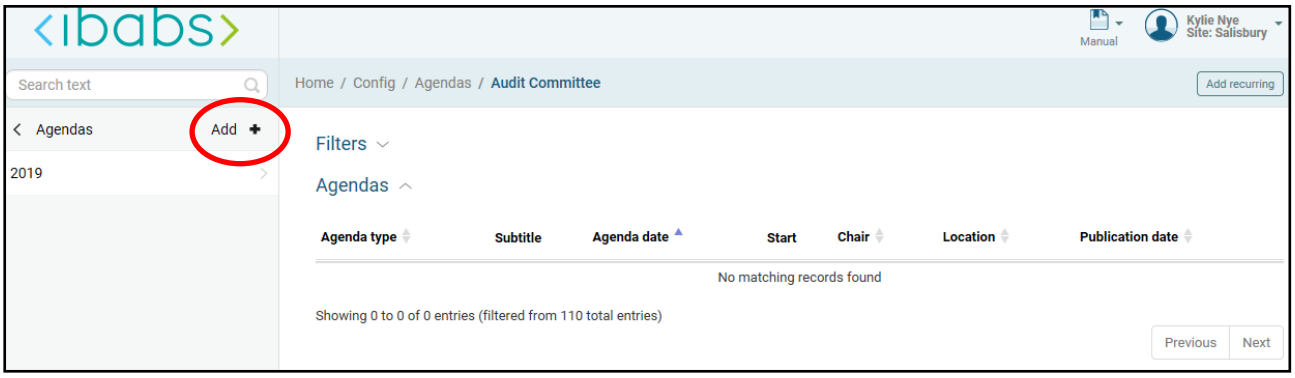
(click the relevant boxes below)

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	☐

Appendix B - iBabs Administrator User Guide

1.1. How to add a meeting

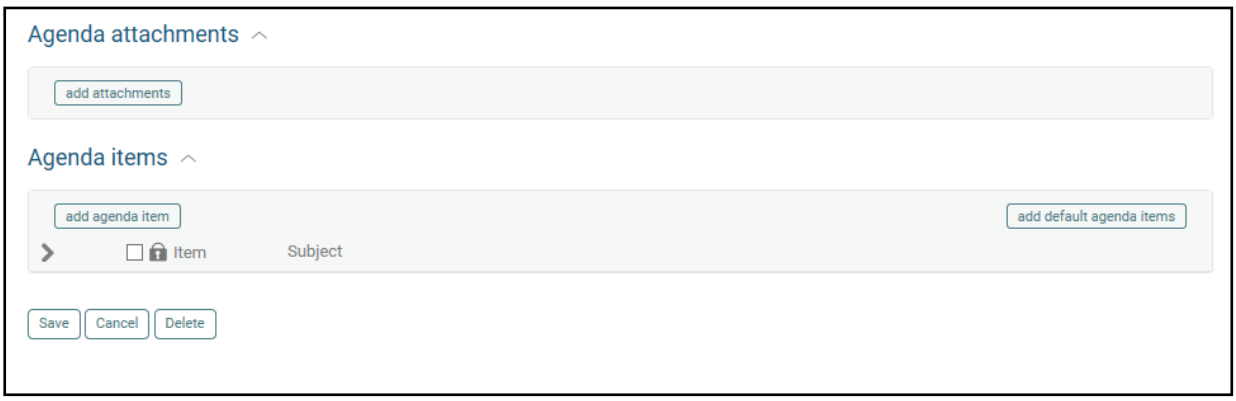
- Locate the iBabs home screen by clicking on the icon on the top left hand side of the screen.
- Click **Config → Agendas**
- Once you are in the **Agendas** screen there should be a list of Board and Committee meetings down the left hand side of the screen.
- Click on the meeting you wish to organise, and you will get this page:



- Click the **Add+** button circled in red above and this will open an **Agenda Maintenance** page.
- Most of the meeting details including Title and Chair will have been automatically filled but you will have to add the time of the meeting. You will also need to add the agenda items to this page.

1.2. Adding agenda items

- When the meeting agenda was first added to iBabs default agenda items should have been added. Please click the button circled in red and these default agenda items will appear.



- There will other items to add from the agenda each month so click **add agenda item** and this will provide a new box on the agenda**.**

- Add the agenda number and title and ensure you save the page as you go along so your work is not lost.

- Once all items have been added, you can add the time required for each item. Just add the number of minutes required in the box next to the **Subject** box as indicated by the red arrow in the below diagram.

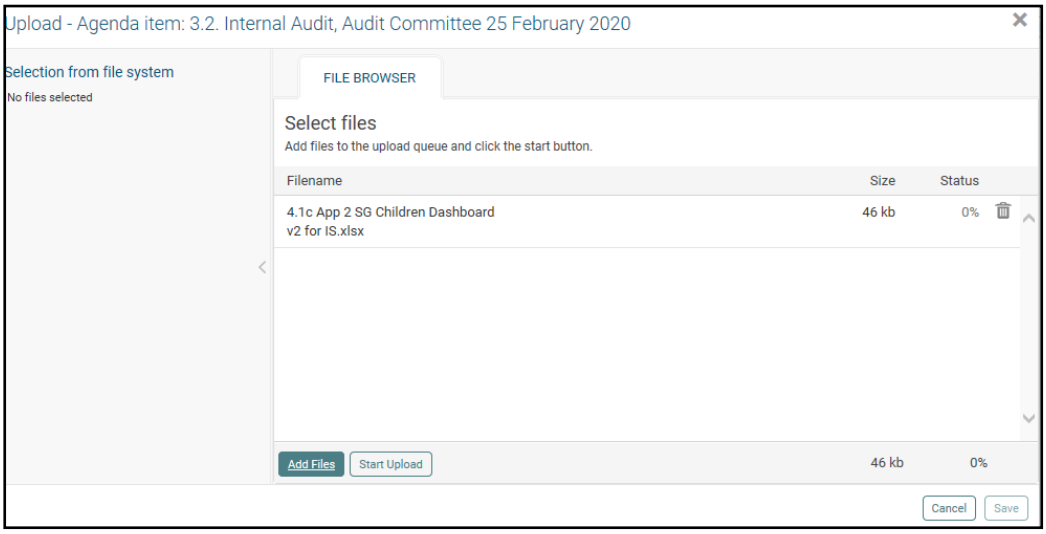
- You can also add notes below each item, for example, the presenter of the paper and the purpose i.e. for approval, for information etc. If you click on the > symbol indicated by the blue arrow above the item will provide a drop down **Explanation** box where you can add this additional information.

1.3. Adding papers

- Before adding the papers please ensure they have received Executive approval, have been numbered correctly and they have been saved in a sensible order to make this process easier.

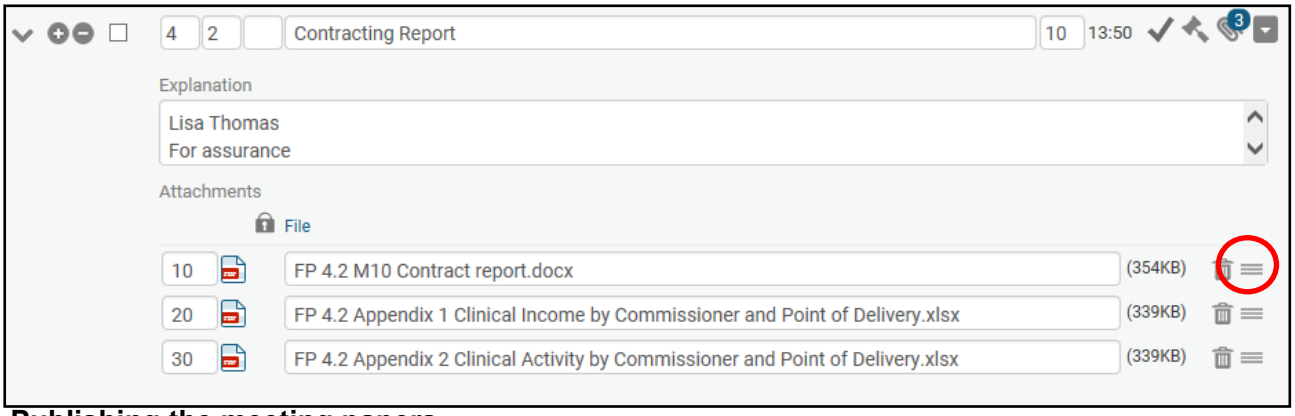
- In order to add papers to each agenda item you will need to click the symbol circled in red below.

- A window will appear as below asking you to select files. Click the **Add files** button and you will be able to search through your folders to find the paper. Click on the file and press **Open**. The file will appear in the window and you will need to click **Start Upload.**



- Once uploaded click **Save** and that file will be saved with the agenda item on iBabs. A number will appear on the attachment icon to identify how many papers are attached to that item.

- If there is more than one paper per item you need to ensure they are in the correct order so the meeting pack is correct once published. Click the icon circled below and drag the item up or down depending on where it needs to be.

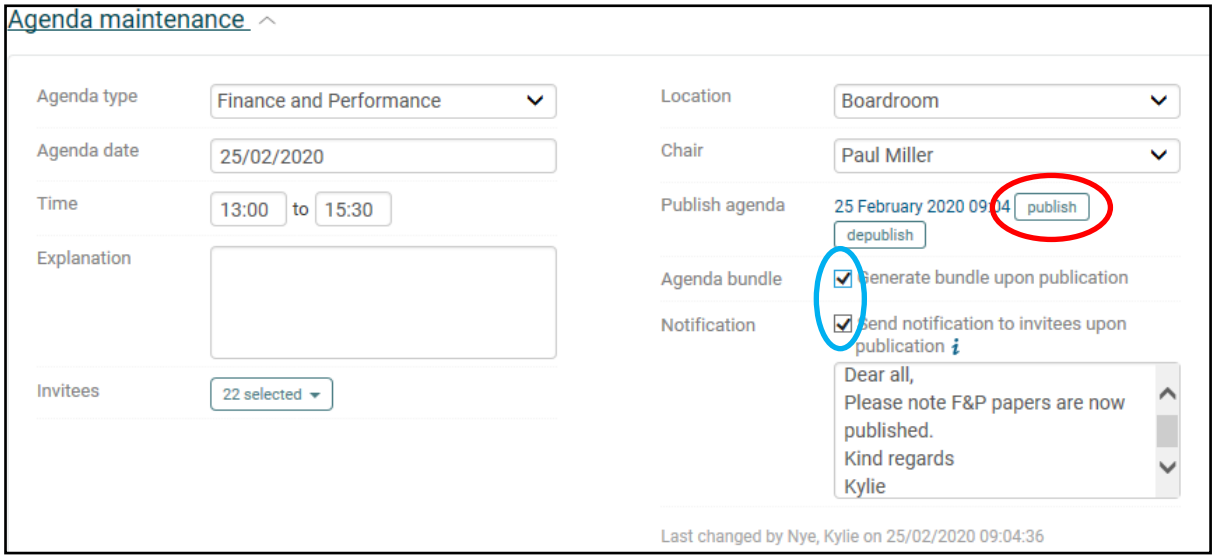


1.4. Publishing the meeting papers

- Once all of the papers have been uploaded and you are happy they are in order and formatted correctly, you can publish the meeting pack.

- To publish you need to tick both boxes circled in blue below. The notification tick box will provide a drop down box where you can write a message also indicated below. Press the

publish button and this will send an automatic email to all members and attendees with a link to meeting and your message.



- You will need to save the **Agenda Bundle** in the shared drive. To get the bundle from iBabs click the **Show agenda** button in the top right hand corner and the bundle will appear under **Agenda attachments**. You can then save this PDF meeting pack in your shared drive and email to those attendees who do not have access to iBabs.

- If, after you have published, amendments to the meeting pack are required you can click on **Edit** in the top right hand corner and make the necessary changes. To ensure everyone can see these changes you do not need to send a new notification but just click **publish** again and **save.**

1.5. Helpful Tips

- Please note that Excel spreadsheets and PowerPoint presentations should ideally be put into PDF format prior to upload.
- If you want just one tab of an Excel document please hide the other tabs, otherwise they will also be included in the meeting papers.
- Before uploading an Excel document, ensure the formatting has been amended to fit to one page.

CLASSIFICATION: please select

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	04 June 2020		

Report Title:	Freedom to Speak Up Guardian Annual Report 2019-20			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		√	
Prepared by:	Elizabeth Swift, Freedom to Speak Up Guardian Jean Scrase , Associate Director EICE			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive Officer			
Appendices (list if applicable):	NHSI recommendations – Appendix A Gap Analysis Update – Appendix B			

Recommendation:
The Board is asked to **note** the contents of the report which is provided for information and assurance.

Executive Summary:
For information: • FTSU Annual Report 2019-20 • Update on NHSI recommendations for FTSU at SFT • Summary and gap analysis of Freedom to Speak Up National Survey

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 present an overview of the work of the Freedom to Speak Up (FTSU) Guardian over the year including high level details of the number of cases raised, a thematic analysis and any learning from the cases.

2 Background

2.1 The report by Sir Robert Francis, Freedom to Speak Up; An Independent review into creating an open and honest reporting culture in the NHS (2015) highlighted 20 Key Principles for NHS organisations to implement, which included an emphasis on creating a culture of safety, raising concerns, culture free from bullying, visible leadership and valuing staff.

2.2 In addition, the review introduced the role of the Freedom to Speak Guardian to act as an;

> Independent and impartial source of advice to staff, with access to anyone in the organisation including the CEO, or if necessary outside the organisation. They can ensure that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and case addressed; and that there are no repercussions for the person who raised it.

2.3 Salisbury NHS Foundation Trust is committed to implementing the recommendations of the Francis Report 2015 and embedding a strong culture throughout the Trust.

2.4 NHS England and NHS Improvement published Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trust1 in July 2019. A summary of the expectations on Boards is as follows:

- The Board demonstrates its commitment to creating an open and honest culture where workers feel safe to speak up
- The Board has a clear vision for the speaking up culture in their trust that links the importance of encouraging workers to speak up with patient safety, staff experience and continuous improvement
- The Board demonstrate their commitment to creating a positive speaking up culture by having a well-resourced FTSU Guardian
- The Board needs to be assured that workers will speak up about things that get in the way of providing safe and effective care and that will improve the experience of workers

2.5 Board members are encouraged to read the guidance and seek further assurance to ensure that it is performing its role effectively.

3 Freedom to Speak Up Guardian Progress against NHSI recommendations

In June 2019 the Trust's Guardian along with the Director of OD & People, was invited to meet with NHSI at the London Headquarters to discuss what support they could give us to improve Freedom to Speak Up at Salisbury. Working together, 12

[1] https://improvement.nhs.uk/documents/2468/FTSU_guidance.pdf

recommendations were agreed in order to help develop a stronger speaking up culture in the organisation. An update on progress can be found in **Appendix A.**

4 Freedom to Speak Up Annual Survey 2019

The annual survey was carried out resulting in a gap analysis which identifies key areas for future focus. **Appendix B** contains the detail.

.https://www.nationalguardian.org.uk/wp-content/uploads/2020/01/ftsu_guardian_survey_report_2019.pdf

5 Freedom to Speak Up Guardian Activity

5.1 **National work -** The Trust's Guardian has attended and completed a 12 month facilitated supervision pilot and action learning set with the Central London Freedom to Speak Up Guardians. This was funded by East London Foundation Trust. As a group of Guardians, we have worked together in supervision and research to identify what helps and hinders the effectiveness of Guardians, in particular the key relationships with the Executive Team. The findings have been published as a blog by NHS Providers. The pilot schemed proved to be very successful in terms of support, learning and self- development and as a result the CEO is supporting the Trust's Guardian to complete another year of supervision in London.

5.2 **Regional Work -** The FTSUG attends Regional Network meetings and actively participates in driving the FTSU agenda forward. The South West Regional Integration and Development Event held in March 2020 focussed on how Guardians can support and be vanguards for our Primary Care colleagues. Recent discussions with Primary Care colleagues have taken place and will result in a proposal for SFT to provide FTSU services by the end of 2020.

In the New Year the FTSUG met with the regional CQC inspector to give an update on how FTSU has progressed since our last CQC inspection and the delivery of the FTSU Action Plan. The Trust received excellent feedback and the CQC have raised no concerns.

5.3 **Local work –**

- **Regulations and legal considerations –** CQC Inspections, FTSU contributes to the Well Led Domain
- **Training** - During the past 12 months there have been over 1,200 face to face interactions through Trust Induction, volunteer induction, workshops and delivering training at departmental meetings. This has included a workshop with the Executive and Non-Executive Teams and the Governors.
- **The National Guardians Office** has published national guidelines on Freedom to Speak Up in the health sector for all staff. The guideline is set out in three parts covering core training for all workers, line and middle management training, and senior leader training. National training materials are currently being developed. Once available, SFT will incorporate them into our training offer.
- **Promoting FTSU** – the FTSUG is working with the Communications Team to continue to promote the role. As a result the intranet page has been refreshed; a FTSU Screen Saver has been introduced; Unique FTSU logo for SFT has been developed to be used for posters and merchandise and

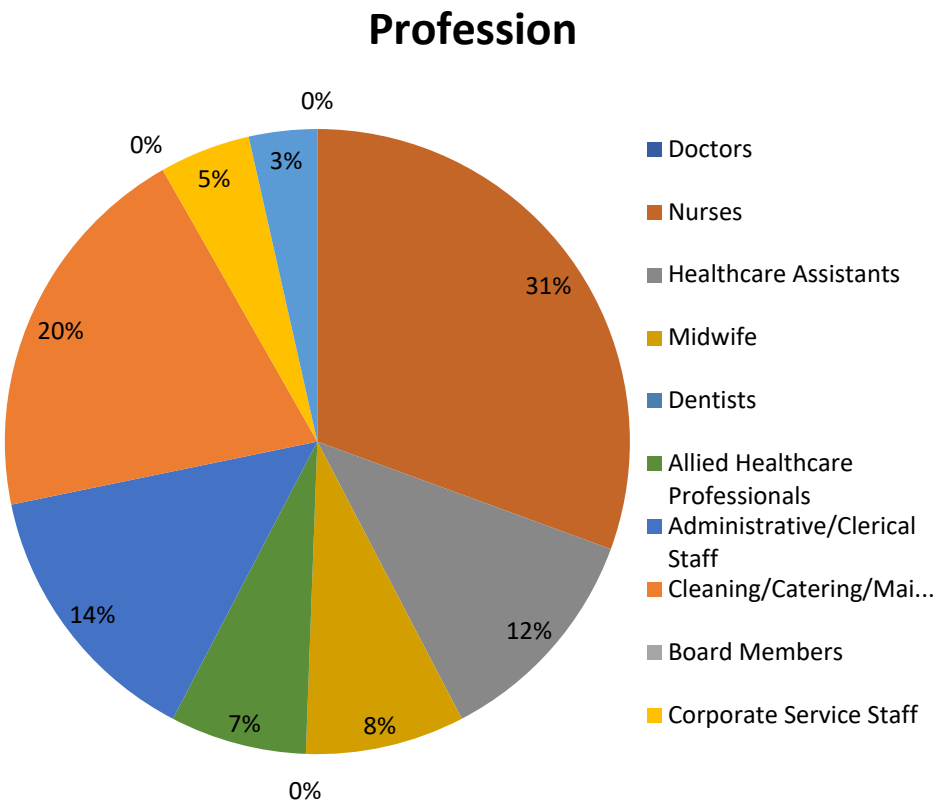
regular Trust wide bulletins raised giving details of how staff can access FTSU.

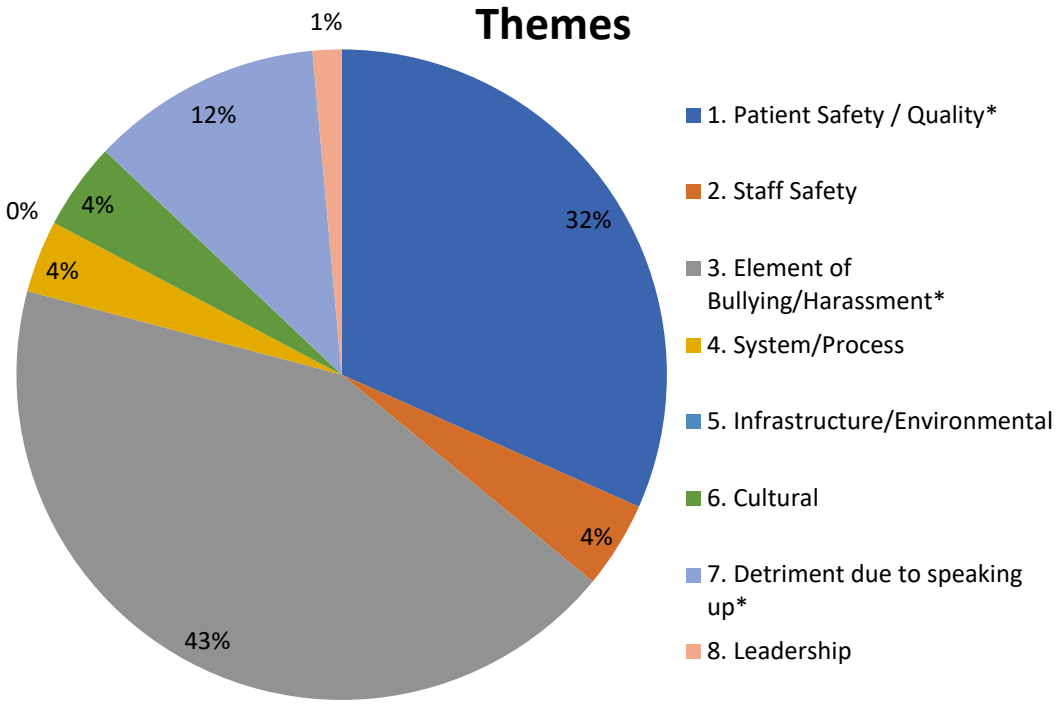
- **Key relationships** – the FTSUG continues to collaborate with many teams in order to support speaking up. Regular meetings are held with People Business Partners, Risk, PALS, Litigation, Clinical Psychology, Staff Side, Counter Fraud, Chaplaincy, Guardian of Safe Working, Chief Registrar, Executives and Non-Executives and protected groups such as the BAME forum. FTSU is also a member of the Leadership Forum and has been involved with the NHSI Culture and Leadership Programme. The FTSUG has access to the CEO, Chairman and Executive Lead as and when required, as well as having monthly 1:1's. All these relationships help to develop an open culture where speaking up is fostered and welcomed.
- **FTSU Ambassadors** - Although SFT have appointed to a substantive Freedom to Speak Up Guardian role, the Trust has not yet appointed Ambassadors. The recommendation for Ambassadors is waiting for agreement at the Trust Management Committee. Appointment to the Ambassador roles will help provide assurance that all workers have appropriate support and opportunities to speak up. Ambassadors will be recruited during July 2020.
- **Cases** – concerns raised to the FTSUG has increased significantly from 21 cases during 2018-19 to 85 cases, which is an increase of 75% during 2019-20. This increase is due to the success of promoting FTSU and also the training that has been delivered. Where these issues are complex external investigations commissioned by the Executive Team have taken place.

6 Summary of cases raised during 2019/20

6.1 Annual data - summary of issues raised 1st April 2019 – 31st March 2020

During this period 85 cases were raised with the FTSUG and the charts below show the breakdown by professional group and National Guardian Office identified themes:





*Themes required to be reported to the National Guardians Office. The other themes are for local use. Some cases will contain more than one theme.

Cases that have an element of patient safety or quality have been reported to the Clinical Governance Committee and assurance provided that appropriate steps have been taken.

Whilst cases across all themes are addressed, much work is being carried out by the People Business Partners and DMTs to try and understand and address the large proportion of bully and harassment cases reported.

7 Benchmarking

7.1 The national data is summarised below for 2018/19 and the first three quarters of 2019/20:

	2018/19	2019/20		
		Q1	Q2	Q3
Total cases	12,244	3,173	3,486	4,120
Element of Patient Safety	3,523	744	846	915
Element of Bullying & Harassment	4,969	1,230	1,246	1,496
Suffered Detriment	564	116	127	147
Anonymous	1,491	439	455	469

The following should be noted from a comparison of the Trust data with the national data:

- The trends described, particularly the increase in the number concerns, reflects the picture seen nationally
- The Guardian has only received one anonymous concern
- Bullying and harassment is similar as is patient safety
- SFT reports higher numbers of staff who suffer detriment

We plan to also benchmark against our BSW STP partners and the South West region for 2020/21.

7.2 **Feedback -** A feedback form is sent to all staff who raise a concern, which asks if they would speak up again, how they found the experience and if they have suffered detriment due to speaking up. Approximately 10% of staff returned the form and there has been positive feedback from staff who have raised concerns and are satisfied with the outcome:-

“Within the process I felt it was dealt with professionally and in confidence at all times.
The matters were dealt with promptly and appropriately whether you felt it was small or large you were listened to”.

“I found the experience very intimidating, as throughout the process, I was afraid that my managers would become involved and take it out on me. If I feel like that as an outspoken senior Sister, I cannot imagine how others in lower bands or with less confidence must feel when coming to you with concerns. I continue to be relieved that I did not get the response I feared!”

All concerns have been followed up and feedback provided to the individual staff

members. Of the concerns raised in 2019/20, 8 remain open with investigations in progress, and appropriate action has been taken whenever possible.

Other feedback would suggest that an area for improvement would be looking at the timeliness of responding to concerns and does the Trust have enough trained investigators.

Going forward we aim to increase the response rate and aim to achieve at least 50%.

8 Summary of Learning from Speaking Up

The majority of the concerns raised have resulted in learning for the Trust. A summary of this learning is described below:

- Revised policies and procedures have been put in place to support staff and managers.
- Adjusted rostering to ensure consistency for all staff
- Identified training needs for staff and managers
- Challenged poor behaviours to include openness and visibility of managers, disciplinary action taken where appropriate.
- Increased resource following an independent review
- Workforce review resulting in development opportunities for staff
- Managers should hold regular meetings with their teams to ensure that staff are aware of local changes and issues, as well as wider Trust changes that may affect them.
- Raised awareness of inclusion issues with protected groups

All these improvements will help our staff deliver an outstanding experience every time for our patients.

Speaking up is about anything that gets in the way of delivering high quality care.

9 Summary

9.1 All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report and recent guidance from NHSI/E and the CQC: This paper provides the Committee with assurance that best employment practice for FTSUG has been adopted at Salisbury NHS Foundation Trust.

10 Recommendations

10.1 The Board is asked to note the Freedom to Speak Up Annual Report 2019/20.

Elizabeth Swift
Freedom to Speak Up Guardian

Appendix A

FREEDOM TO SPEAK UP ACTION PLAN IN RESPONSE TO NHSI RECOMMENDATIONS JULY 2019

Recommendation 1: Increase NED understanding of FTSU, their role and the national picture	Completed	In progress	Not started
Plan: • Distribute updated Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts from the National Guardian's Office (09/09/2019) • Freedom to Speak Up Guardian to meet regularly with named NED • Freedom to Speak Up Guardian to meet regularly with Chairman of The Trust Board • Freedom to Speak Up Guardian to meet at least once annually with all Trust Board members	√ √ √	√	
Recommendation 2: Include FTSU and other related cultural topics in your board development session – NHSI happy to lead a session			
Plan: • FTSU has recently been included in the board development session • Invite NHSI to attend a session within the next 12 months if significant progress is not made • Board attending Freedom to Speak Up and Equality, Diversity and Inclusion training session "What's it got to do with me?" on 5th September 2019. Positive feedback from session – unanimously feel that all staff should attend training	√ √	*TBC	
Recommendation 3: Include FTSU in your staff story slot at Board and consider using story as a basis for a self-reflection case study			
Plan: • FTSUG has identified a staff story for Board meeting (FTSUG annual report scheduled for April 2020) – new guidance states this should now be withdrawn • FTSUG to write self-reflection case study for consideration, once current case is concluded (June 2020)	N/A		√
Recommendation 4: The trust completes the work it identifies as necessary to help ensure that workers, in particular those responsible for responding to speaking up matters, have the appropriate skills to handle difficult conversations			
Plan:			

• Business Partners have planned breakfast meetings with line managers to help them develop skills around difficult conversations and speaking up issues (first one to be held 13/10/2019) • Continue to advertise Coach to Lead training sessions – ongoing throughout the year • Continue to advertise Conflict Resolution sessions – ongoing throughout the year • Identify how to evaluate the effectiveness of training and how this fits in as part of the trust wide leadership development programme. FTSU is now incorporated. Clinical Leadership sessions scheduled for Autumn 2019 and middle management programme March 2020. Feedback received and evaluated from all training sessions • Integrate recently published training guidance from National Guardians Office. Head of Education will deliver Trust wide FTSU training plan by January 2020	√ √ √ √ √ √		
Recommendation 5: Consider greater use of social media to highlight speaking up channels, change that has occurred and to generate debate			
Plan: FTSUG to work with Comms Team to set up social media accounts (meeting scheduled for 2nd September), this also fits in with Speaking Up Month which is October	√		
Recommendation 6: Establish FTSU champion role, scope out role, recruit and train.			
Plan: • Workforce Committee supports principle of protected time for Champions, proposal to go to TMC for agreement in May 2020. • FTSUG to obtain a job description from an established Ambassador network (meeting on 3rd September) • Workforce Committee to sign off recruitment process for Ambassadors. (meeting scheduled for 28th May 2020) • FTSUG recruit and arrange regional training for Champions	√	√ √	√
Recommendation 7: Develop an effective and transparent way to triangulate staff and patient experience data to identify emerging patient safety issues.			
Plan: • Identify patient safety trends by collecting data from patient complaints, patient claims, serious incidents, near misses and never events. Attending quarterly meetings with Litigation, PALS, Risk and FTSU. • Use new Organisational Development &	√ √		

People 'Heatmaps' which identify employee experience trends by collecting data from grievance numbers and themes, tribunal claims, exit interview themes, sickness rates, retention figures, staff survey results, polls/pulse surveys, WRES and WDES data, levels of suspension and use of settlement agreements. • Use this data to identify the areas that have recurring issues • Identify the areas that have reduced the number of issues • Identify the areas that have no issues and why – use SOX data (sharing outstanding excellence) positive reporting. • Causes of unexpected spikes in issues • Identify any areas that may have an overlap of patient and staff issues – meeting with PALS 12/09/2019	√ √ √ √ √		
Recommendation 8: Consider how to manage confidentiality and information governance issues that arise having multiple people handling speaking up cases.			
Plan: • FTSUG to be clear with person raising the concern about how their information will be used. • FTSUG to be clear when discussing or forwarding on details of cases about confidentiality and the use of the information disclosed. • Clarity from all parties handling a case around timely feedback and to whom.	√ √ √commenced and ongoing		
Recommendation 9: Take all appropriate steps to ensure that its network of cultural ambassadors reflects the diversity of the workforce that it supports.			
Plan: • Work with EDI Lead to assess which groups face particular barriers and ensure support is available to those staff groups (ie. Jnr doctors induction, overseas nurses forum) • Tailor FTSU and EDI training to identified staff groups that may face additional barriers to speaking up, commenced programmed and continue to roll out during next 6-12 months • FTSUG to attend network meetings to raise awareness of the Speaking Up agenda	√ √ √		
Recommendation 10: Design, issue and evaluate 30 and 100 day surveys sent to people who have spoken up to understand if they have suffered any detriment.			
Plan: • Work with Business Partners to draft the		√	

surveys and have it agreed by December 2019 and published January 2020. • Agree how the data collected from these surveys should be used and stored • Agree a plan of how to support staff suffering detriment from speaking up • Agree a plan of how to manage staff causing the detriment to the person(s) speaking up • There is a rolling programme of policy renewal established to ensure all related policies are up to date.	 √	√ √ √	
Recommendation 11: Freedom to Speak Up Guardian to attend Patient Safety Committee			
Plan: • FTSUG to meet with Head of Risk to discuss attending meetings	√		
Recommendation 12: Freedom to Speak Up Guardian to understand the decline in how secure staff feel to speak up in order to assure the board of causes and solutions.			
Plan: • Triangulate data from exit interviews, Datix, speaking up data etc to identify areas within the Trust that have a decline in raising concerns. • Work with DMT's to formulate plans to address the findings i.e. Bespoke training, manager training – in line with the recently published training guide. • Ensure that the recent NGO training guidelines are rolled out for all staff – training plan to be delivered by the end of 2020. (NGO to be sending out training packages to Trusts)	√ √	 √	

Appendix B

Freedom to Speak Up Guardian Survey 2019
Findings and Recommendations Gap Analysis

	Area	Recommendation	How SFT Meet the Recommendation
1.	Appointment	We continue to recommend that appointment to any Freedom to Speak Up role is made in a fair and open way.	Full time FTSUG appointed through the formal process, in a fair and open way.
2.	Ring Fenced Time	We continue to recommend that all guardians have ring-fenced time for their guardian responsibilities. We recommend that CQC ask about ring-fenced time whenever they speak to Freedom to Speak Up Guardians as part of their inspections and consider allocating a maximum of a requires improvement rating for the 'Well-led' domain to any organisation that does not follow the principle that guardians should be allocated ring-fenced time for their role. We will work with CQC to ensure that indicators of how the guardian role is being implemented are incorporated into appropriate ratings descriptors.	This requirement is fully met as FTSUG is full time.
3.	Access to Senior Leadership and Board Reporting	We repeat our expectation that guardians should have appropriate access at the board level and report to their board (or equivalent) in person. Trust and Foundation Trust boards should comply with the guidance set out in 'Guidance for Boards on Freedom to Speak Up'. If guardians or board members feel that they are unable to comply with these expectations, for any reason, we ask that they contact the NGO.	FTSUG meets monthly with CEO and Exec Lead. Meets with other Executives as needed. Meets quarterly with Non-Exec Lead and Chair. FTSUG reports in person to Workforce Committee and Clinical Governance Committee quarterly and to Board annually.
4.	Training for middle managers	Providing training for middle-managers, in line with the guidance that the NGO has issued, should bolster the capabilities and understanding	Developing training plan with Associate Director of Education, Inclusion, Comms & Engagement. Further guidance to be released by

		of middle managers in relation to speaking up.	NGO later in the year.
5.	Support for Guardians	We ask that senior leaders actively support their guardians and remain sensitive to the pressure that they are under and the impact this can have, and support their guardians in their continued development. We would expect immediate action to be taken against any individual who actively displays hostility or otherwise puts further pressure on guardians for carrying out their role.	SDH Senior Leaders fully support FTSUG. FTSUG attends facilitated external supervision and action learning funded by CEO. FTSUG also has access to internal supervision and Clinical Psychology for additional support.
6.	Training	Over the coming year, we expect all organisations in the health and care sector to implement a training programme on speaking up in accordance with our guidelines.	Developing training plan with Associate Director of Education, Inclusion, Comms & Engagement. Further guidance to be released by NGO later in the year. FTSUG does face to face training with all new staff and quarterly workshop training. Approximately 100 staff per month.
7.	Detriment	We stress the need for action when detriment for speaking up happens, wherever this occurs in an organisation.	SDH reports fairly high levels of detriment to speaking up. This will be included in the training programmes for middle managers.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of Meeting:	4 June 2020		

Report Title:	Q4 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 Q4 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.

Executive Summary:
The report highlights the introduction of the Medical Examiner system from April 20 and outcomes and improvements in bereavement support. The Q4 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 and therefore subject to a serious incident inquiry. The weekend HSMR started to decline from a peak of 133 in July to 114.5 to Jan 20 and is now as expected. In Q4, a working group to improve the safety and effectiveness of services at the weekend was set up focusing on an improved structure and co-ordination at the weekend. This will be measured at the next NHS 7 day services survey in the autumn 20. A multidisciplinary review of 33 patients who died with a fractured neck of femur was discussed at a joint Trauma and Orthopaedic and Anaesthetic meeting in February 20 and the action plan agreed for improvements in the pathway. A case notes review of patients who died from a gastrointestinal haemorrhage was reported to the Clinical Governance Committee in February 20. An action plan is in place to improve the referral and booking process and the acute upper GI bleed pathway. An update will be reported in June 20. The relative risk of death from acute renal failure has been rising since July 2018 but remains within the expected range. The Mortality Surveillance Group commissioned a review of these deaths which will be reported to the Group in June 20.

On 11 March 20, the WHO declared a global pandemic caused by coronavirus (COVID-19). A policy of 'stay at home, protect the NHS and save lives' started on 23 March and continues to this day (28 April). The lockdown, social distancing and hand hygiene has worked in slowing down the rate of infection and protecting the NHS from being overwhelmed. Hospital bed and ICU capacity have remained available during this period. The Medical Director has commissioned a review of 45 patients who died of COVID-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate and if ventilation was required, whether it was provided. The review will be reported to the Clinical Governance Committee in September 20.

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	☐

Q4 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 was introduced in April 2020 to strengthen the support of bereaved families and drive improvements in the investigation and reporting of deaths.

3. Medical Examiners (ME)

The new Medical Examiner system was introduced in April 20 to ensure excellence in care for the bereaved but it has been a slow start due to the COVID-19 pandemic. Once fully established the system will include:

- A 5 day (ME) roster covering adult and paediatric deaths within the Trust, including cover for all leave.
- Adequate staffing 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 in Q4 has included:

- Dr Belinda Cornforth is the Lead Medical Examiner and has contacted a number of relatives in Q4 where concerns about care have been raised by loved ones identified in the screening process or incident reports.
- Four of the 7 Medical Examiners are fully trained. One will complete in September as the Royal College of Physicians face to face training was cancelled in May due to COVID. Introduction of the system requires all to be trained but it can function with 4 people. However, having larger numbers provides increased resilience.
- Two Medical Examiners' Officers have been appointed to work 22.5 hours each per week to support the MEs. Their expected start date is 22 June 2020.

4. Working with bereaved families

In 19/20, our local bereavement survey 'Your views matter' was offered to bereaved families when they collected the medical certificate. In total, 40 surveys were returned, the majority of which were very positive about the quality of end of life care. In total, 6 surveys had suggestions for improvement. The commonest theme was about poor communication (4 cases) from 3 different wards, property belonging to another patient was given to a family (1 case) and in the other case the relative raised concerns about dignity at the end of life. On each occasion, the Lead Nurse of the End of Life Care team discussed the cases with ward leaders, medical staff and staff involved in the care of the patient and in 3 cases relatives were signposted to the PALs team for support and advice. The information gained has helped to shape the ongoing teaching programme.

At the beginning of April 20, the bereavement survey was suspended until the situation with COVID-19 has resolved as far as possible.

5. Mortality dashboard, learning, themes and actions

In 19/20, 784 deaths occurred in the Trust. The total includes patients who died in the Emergency Department and the Hospice. Of these, 747 (95%) deaths were screened to ascertain whether the death needed a full case review. 252 (32%) deaths were subject to a full case review. In Q4 19/20, 4 deaths were probably avoidable, 2 were possibly avoidable, and 9 had slight evidence of avoidability.

6. Improvement actions in Q4 19/20 update:

- Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form) – due to the COVID-19 pandemic the national version 3 is still not published. BSW STP have put the introduction of ReSPECT on hold until the COVID situation has resolved. SFT's resuscitation officer attended the first BSW STP working group in December and is actively involved in preparation work. Extend to 30/9/20.
- Improve documentation of consent, risks and benefits of ward based procedures such as chest drains and ascitic taps - Clinical lead now identified. Chest drain LocSIPP completed. Ascitic tap drainage - not started yet. LocSIPP implementation plan in place. Partially completed. Extend to 30/9/20.
- Ensure the number of patients who need a medical review at the weekend receive it - weekend HSMR declined from a peak of 133 in July 19 to 118.7 to Dec 19. In Q4, a working group to improve the safety and effectiveness of services at the weekend was set up focusing on an improved structure and co-ordination at the weekend. This will be measured at the next NHS 7 day services survey in the autumn 20.
- Improve the escalation of patients who deteriorate in accordance with the NEWS2 policy – ongoing education and quarterly escalation audits. Escalation (recorded) improved from 73% in 18/19 to 83% in 19/20 and will continue as an area for improvement in 20/21 (Target 95%) – completed.
- 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. In 19/20, 42% of patients were known to have received care in accordance with the personalised care framework. There was also an increase in the number of patients who were able to go home as the preferred place of care at end of life from 36 (62%) 18/19 to 109 (69%) patients in 19/20 – completed.

7. CUSUM alerts

No new CUSUM alerts raised in Q4 19/20.

Previously unreported in Q3 19/20::

- Affective disorder 1 vs 0 relative risk 1907 (Sept 19) – the Mortality Surveillance Group discussed the alert in February 2020 but considered it did not need further investigation as it was unlikely to produce any meaningful insight.
- Gastro-intestinal haemorrhage 19 vs 9.8 relative risk 194 (Aug 19) – a review was reported to the Clinical Governance Committee in February 20. An action plan is in place to improve the referral and booking process – completed, implement the acute upper GI bleed care bundle, improve continuity of care, commence an ongoing audit to understand the delays of patients needing an emergency and urgent OGD and continue to review all deaths of patients having an endoscopic procedure. Progress will be reported to the Clinical Governance Committee in June 20.

Previously unreported alert in Q2 19/20:

- Gastritis and duodenitis – 3 deaths vs 0.1 expected, relative risk 2076. Case 1 – successfully treated for gastritis but was re-admitted two days after discharge with a STEMI and valve disease – transferred to UHS for CABG but had a cardiac arrest and died. Case 2 – treated for gastritis but later developed an acute abdomen and died from a perforated small bowel. Learning: poor documentation of care. Case 3 – no concerns about gastritis management. Died from progression of myelodysplasia.

8. Death following a planned admission to hospital

In Q4 19/20, 2 deaths of patients following a planned admission:

- A 68 year old patient admitted for a subtotal colectomy for severe ulcerative colitis. Maximal treatment post-operatively in ICU and improved. On ward developed pneumonia and ascites, re-admitted to ICU. Patient declined further treatment. Excellent care. No learning points.
- An 82 year old patient with skin necrosis on abdominal wall. Transferred to Portsmouth for surgery to remove skin necrosis. Recovered and returned to SFT but developed a perforated diverticulum and was not fit for surgery. Good care. No learning points.

9. Unexpected deaths

In Q4, there were 3 unexpected deaths:

1. A 96 year old patient overprescribed Naproxen which caused a gastrointestinal bleed and acute kidney injury which led to death (SII352).
2. An older patient with cancer at end of life had a fall and head injury managed conservatively (SII358).
3. An older patient admitted following a fall at home with a missed diagnosis of a spinal fracture leading to paralysis (SII359).

10. Stillbirths, neonatal deaths and child death

In Q4 19/20:

- In February, one neonatal death at 21 weeks and 4 days died from extreme prematurity.
- Two intra-uterine deaths in March, one at 38 weeks and one at 25 weeks of pregnancy. Neither baby was small for gestational age. No omissions in care.

11. Patients with a learning disability

In Q4, 1 patient with a learning disability died in March. The case has not been reviewed yet and will be reported in the Q1 20/21 report. The case will also be reported to the LeDeR programme.

12. Patients with a serious mental illness

In Q4, no patients with a serious mental illness died in the Trust.

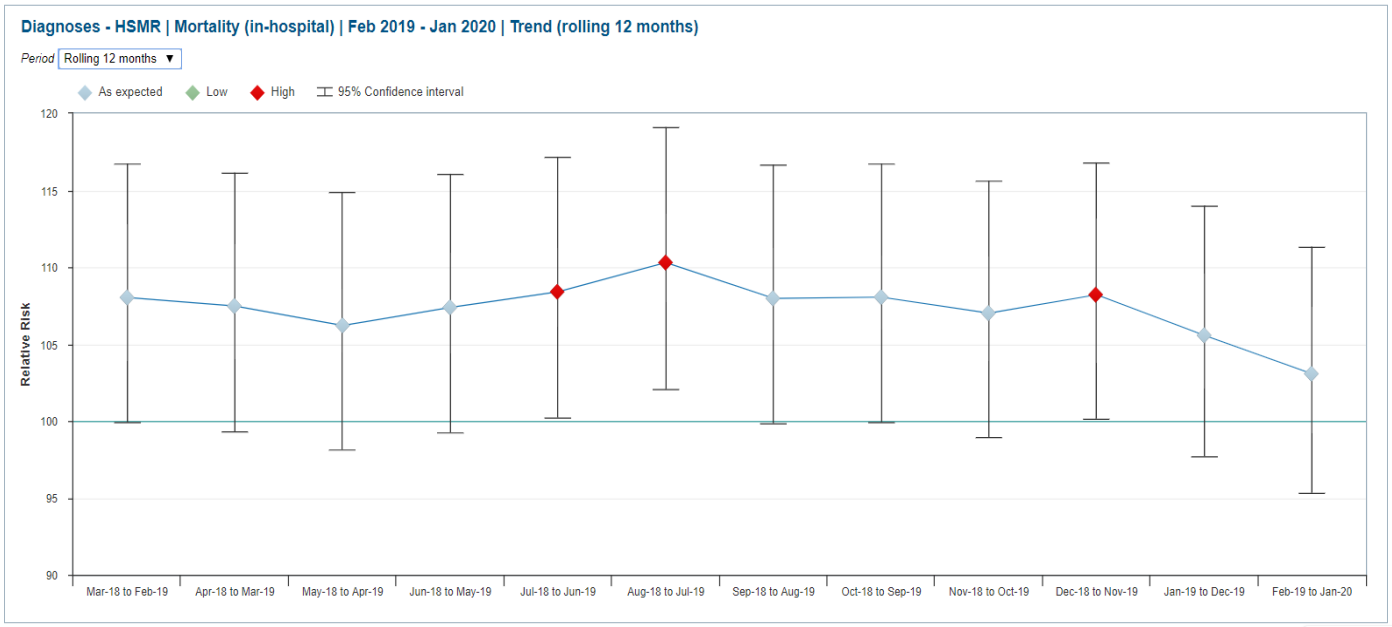
13. Deaths from coronavirus (COVID-19)

On 11 March 20, the WHO declared a global pandemic caused by coronavirus (COVID-19). A policy of 'stay at home, protect the NHS and save lives' started on 23 March and continues to this day (28 April). The lockdown, social distancing and hand hygiene has worked in slowing down the rate of infection and protecting the NHS from being overwhelmed. Hospital bed and ICU capacity have remained available during this period.

To date, the Trust has had 45 deaths (28 April) of patients tested positive for COVID-19. The Medical Director has commissioned a review of this group of patients to ascertain whether patients were involved in decisions about their care, escalation was appropriate and if ventilation was required whether it was provided. The review will be reported to the Clinical Governance Committee in September 20.

13. HSMR rolling 12 month trend to January 2020

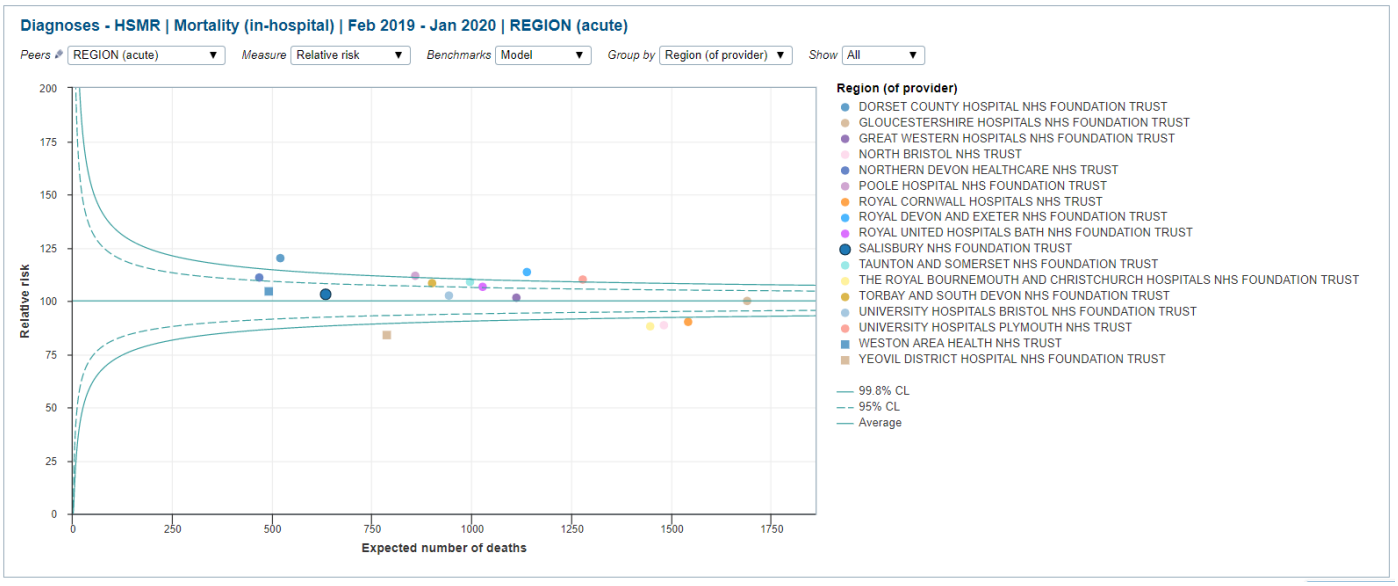
Figure 1: HSMR relative risk of all diagnoses Feb 19 – Jan 20



HSMR has decreased to 103.1 and is as expected over the last 12 month rolling period.

14. Mortality (in-hospital) regional peer comparison Feb 19 – Jan 20

Figure 2: Mortality (in-hospital) regional peer comparison Feb 19 – Jan 20

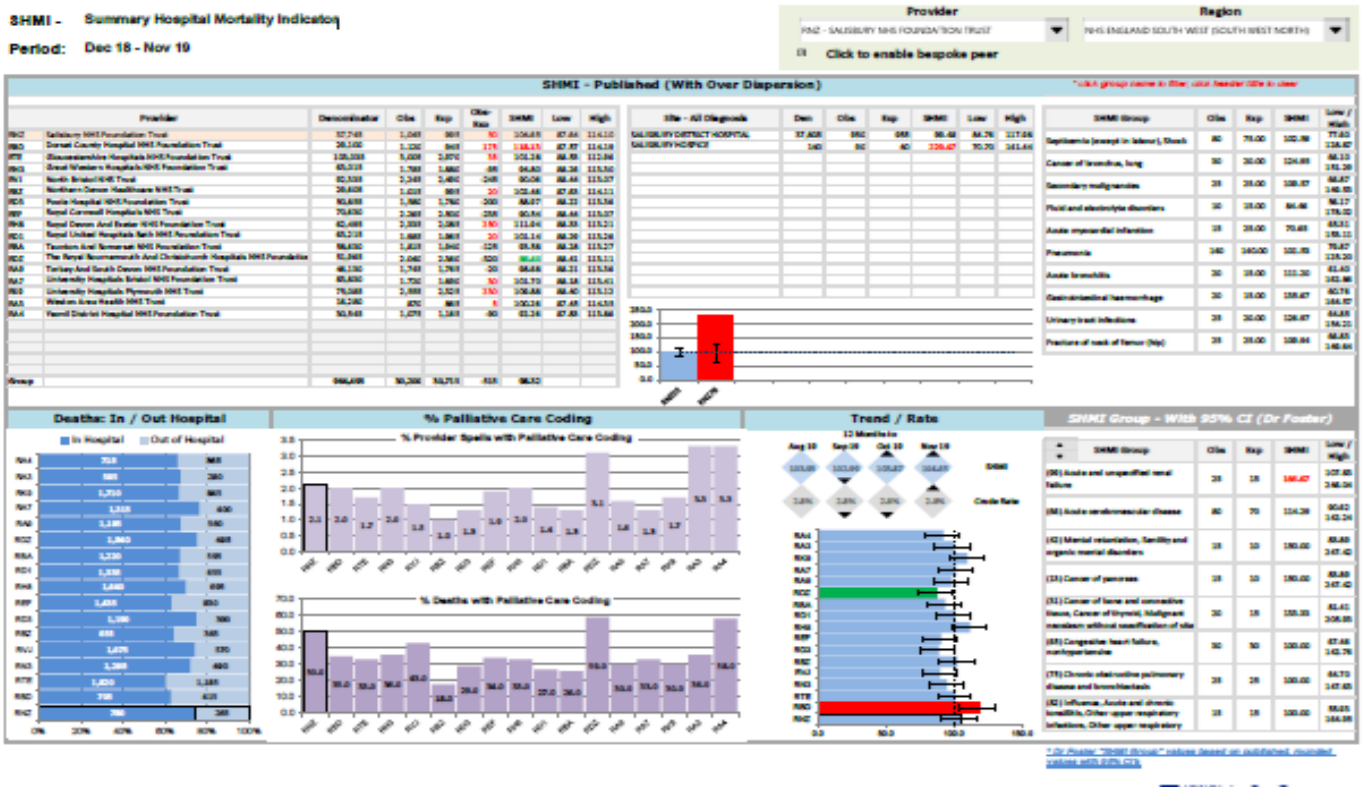


HSMR regional peer comparison shows 8 other acute Trusts have a higher HSMR than this Trust.

15. SHMI December 2018 – November 2019

SHMI is 104.6 within the expected range. When comparing SHMI by site Salisbury District Hospital is 99.48 and Salisbury Hospice is 229. When compared with regional peers the Trust has a SHMI within the expected range.

Figure 3: SHMI regional peer comparison Dec 2018 – Nov 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 23.9% and is 96 as an index of national. This means the proportion of a Trust's HSMR spells are where the Charlson comorbidity score for the primary diagnosis episode is in the national upper quartile for that diagnosis and admission type (the observed value). The expected value is the equivalent proportion nationally.

Figure 4: Trend in comorbidity profile

Comorbidity Profile

Organisation: **SALISBURY NHS FOUNDATION TRUST**

Report Date: **4 May 2020**

	2016/17	2017/18	2018/19	2019/20
Upper-quartile comorbidity	24.2%	24.5%	24.2%	23.9%
as index of national (100)	97	98	97	96

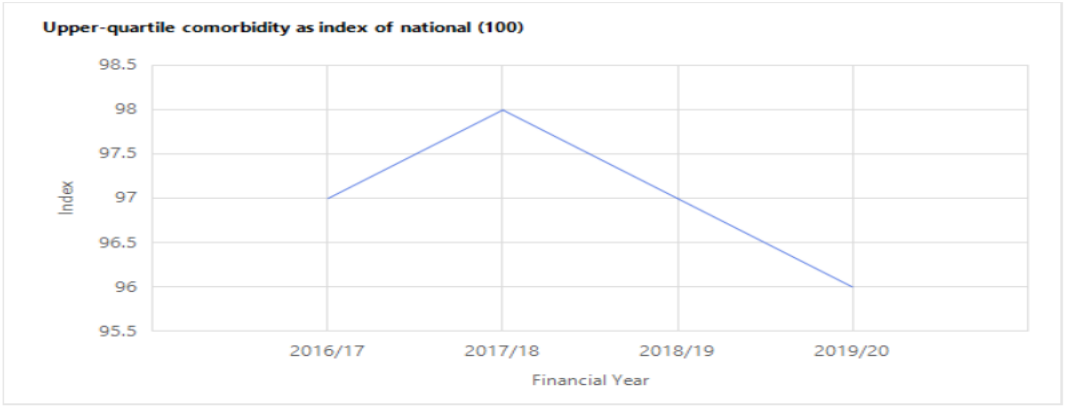


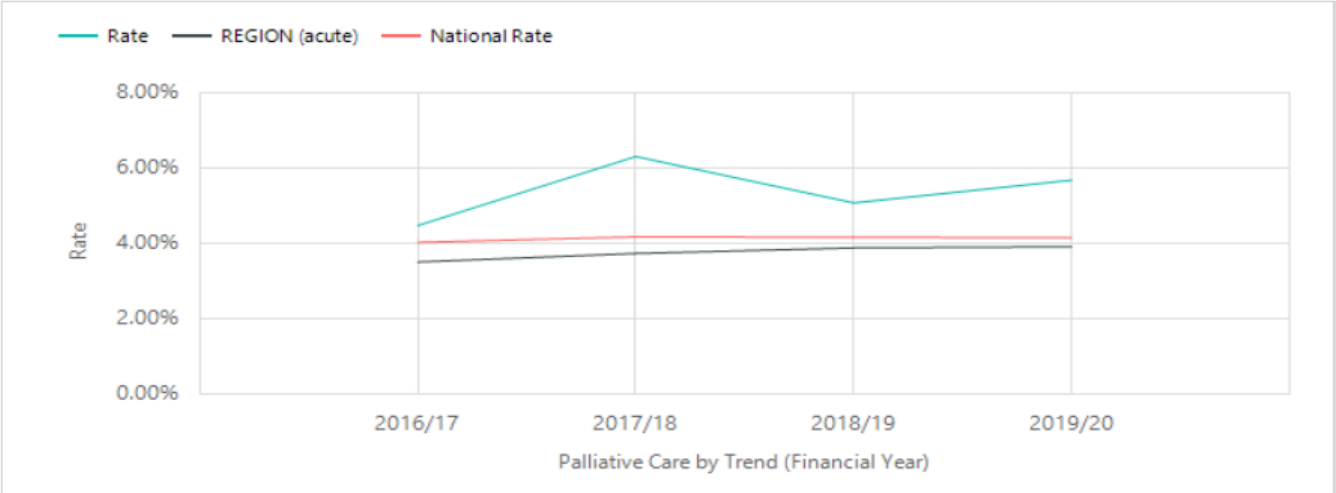
Figure 5: Trend in palliative care profile

Palliative Care Profile

Organisation: **Salisbury NHS Foundation Trust** *Report Date:* **4 May 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	9,972	506	5.07%	4.16%	3.88%
2019/20	8,931	507	5.68%	4.15%	3.91%



A slowly increasing trend in the Trust's palliative care coding rate for 19/20 and higher than the national rate of 4.15% and peer group rate of 3.91%.

17. Weekday/weekend HSMR

Figure 6 shows the emergency weekday HSMR is within the expected range at 99.4 and weekend HSMR is now as expected at 114.5 to January 20 having reduced from a peak of 133.8 in July 2019.

Figure 6: HSMR weekday/weekend admission Feb 2019 – Jan 20

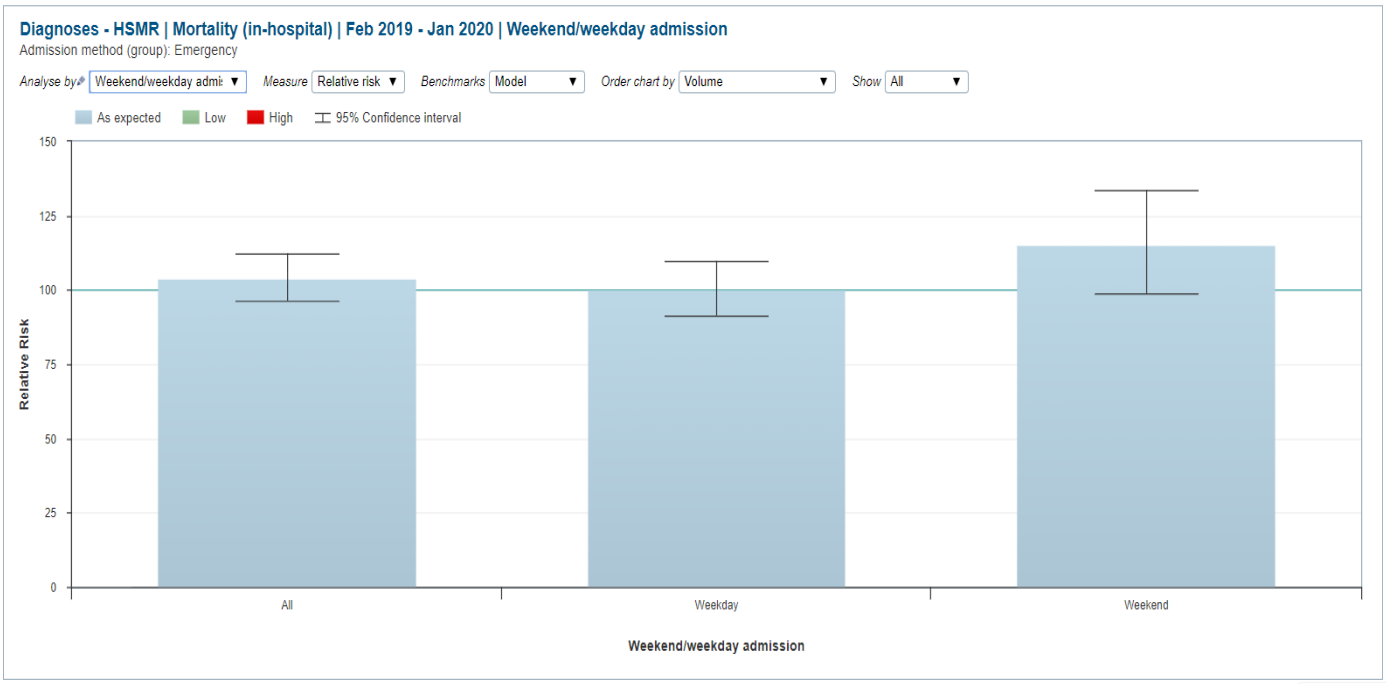
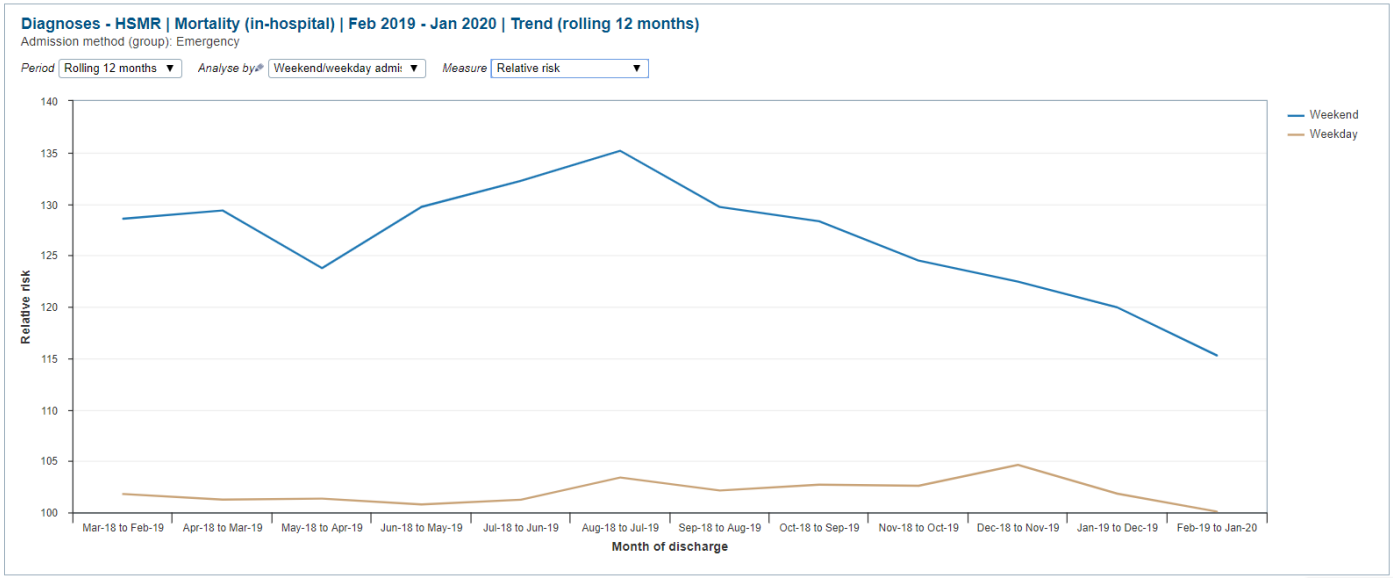


Figure 7: Rolling 12 month trend in emergency weekend and weekday HSMR Feb 19 – Jan 20



The emergency weekend HSMR started to decline from a peak of 133.8 in July 19 to 114.5 by January 20 and is now as expected. The continuing decrease in relative risk is due to a combination of a decreasing crude rate and a slight increase in the expected rate over the last three data periods.

A weekend quality improvement group was set up in January 20 which included the Chief Registrar and 3 doctors in training with the aim of improvng the management of the workload at weekends. Improvements progressed so far have been the weekend handover and a pilot of a Critical Care Outreach Team co-ordinator on a Sunday from 2 – 10 pm to triage and allocate the workload. Feedback from doctors in training has been positive.

18. Deaths in high risk diagnosis groups (Feb 19 – Jan 20)

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

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

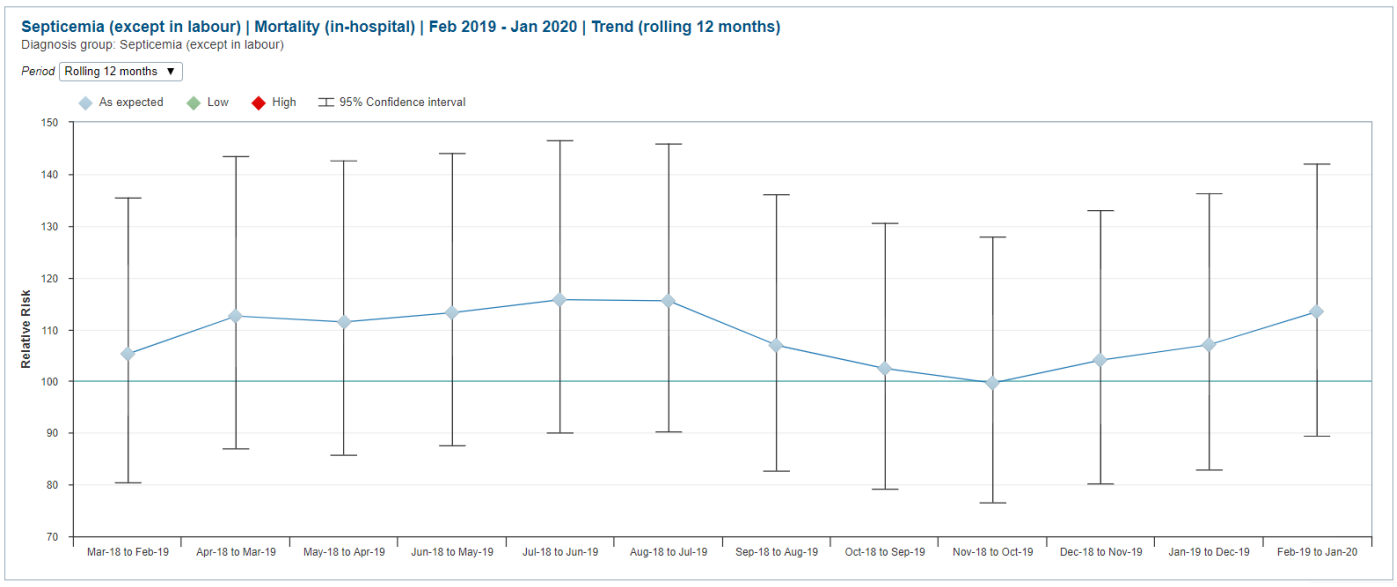


Figure 9: Trend in relative risk for pneumonia

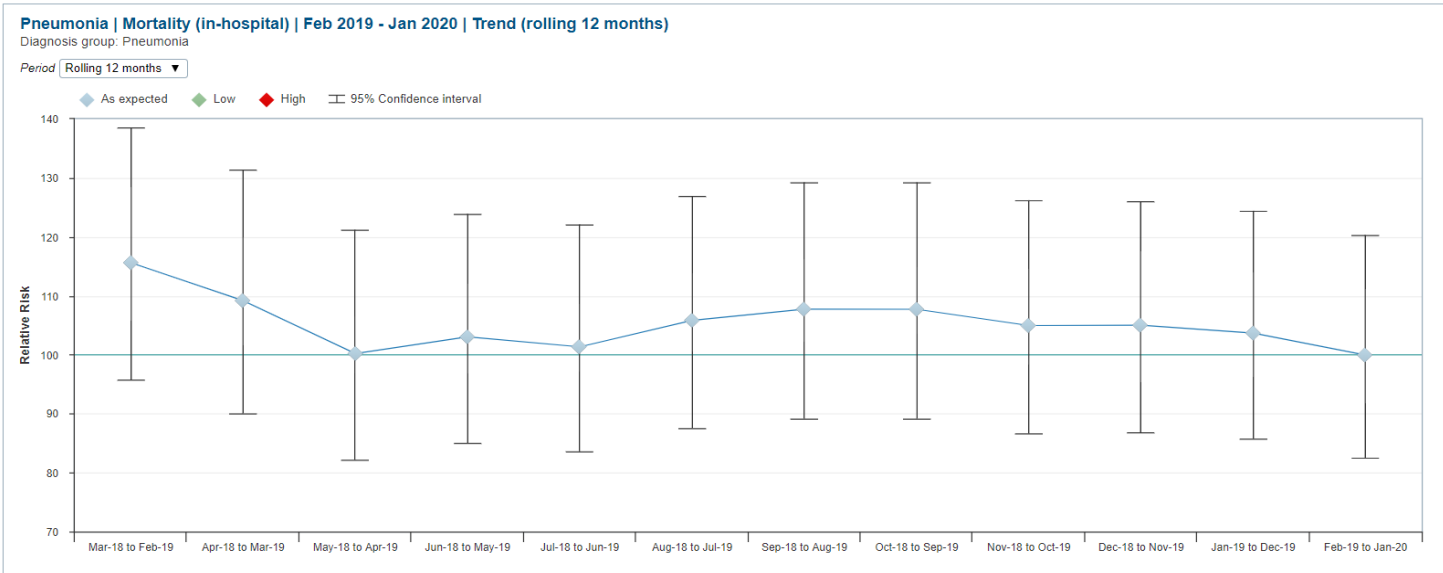


Figure 10: Trend in relative risk for acute cerebrovascular disease

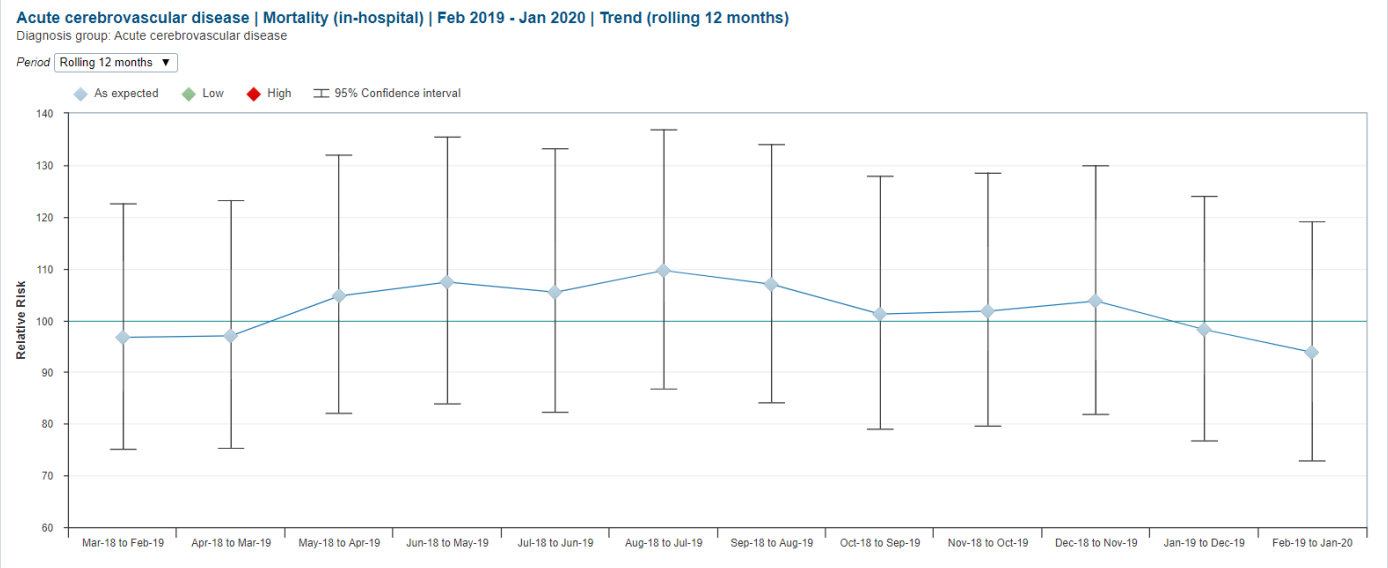


Figure 11: Trend in relative risk for acute myocardial infarction

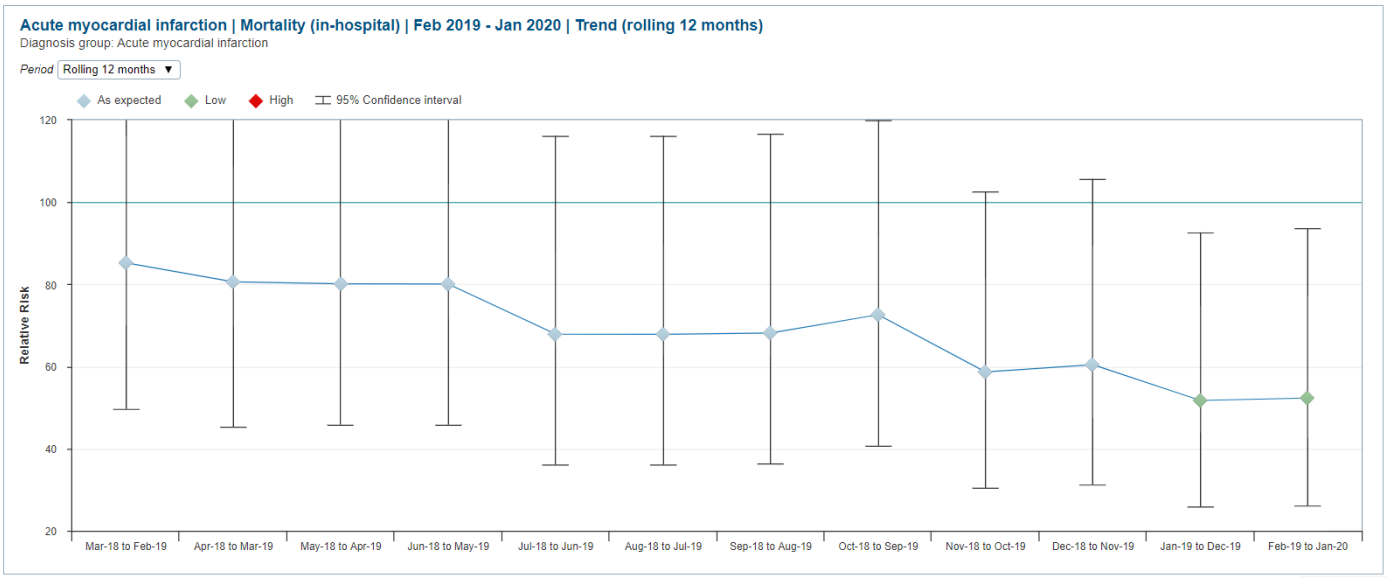


Figure 12: Trend in relative risk for congestive cardiac failure

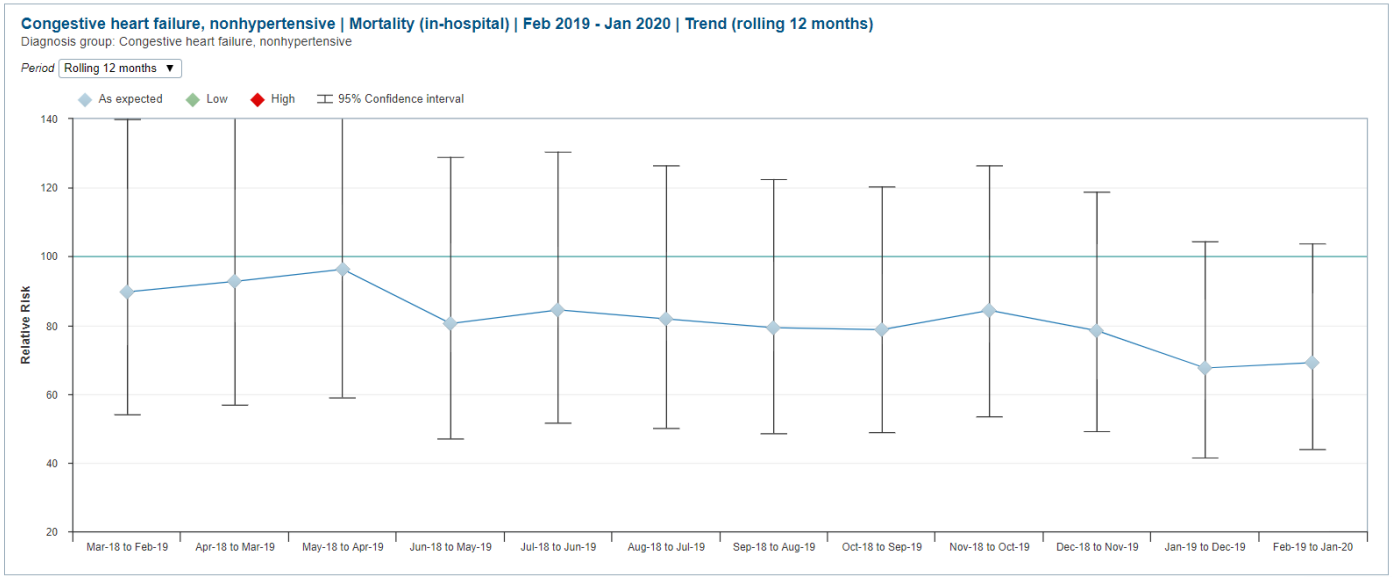
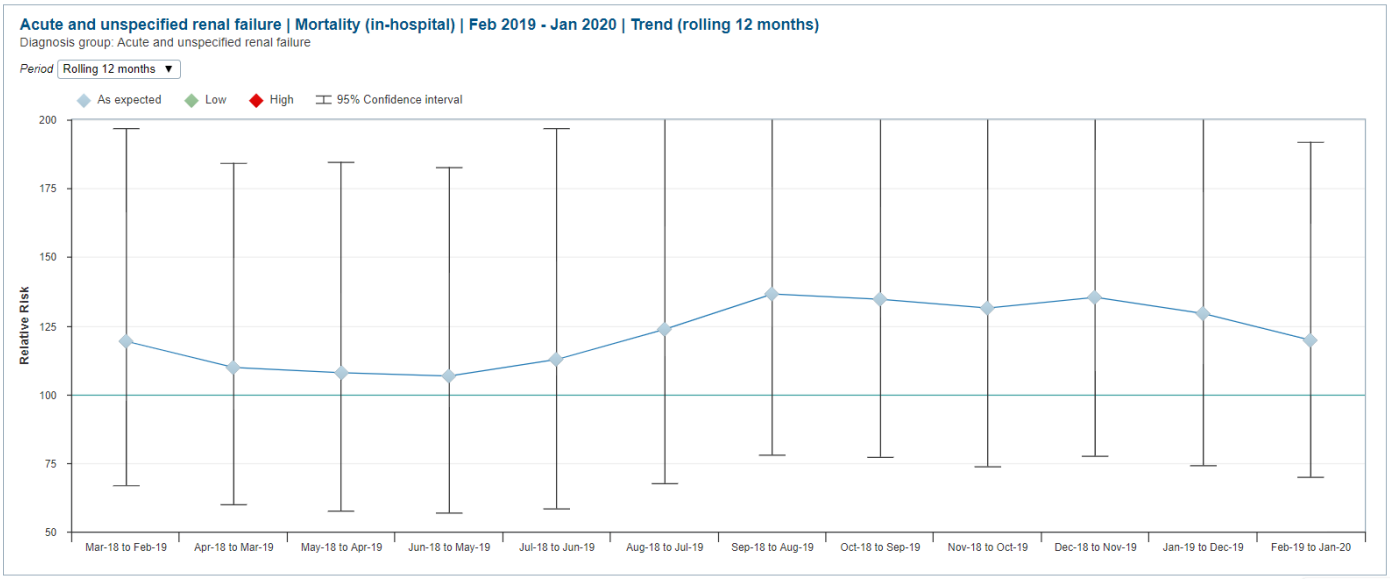
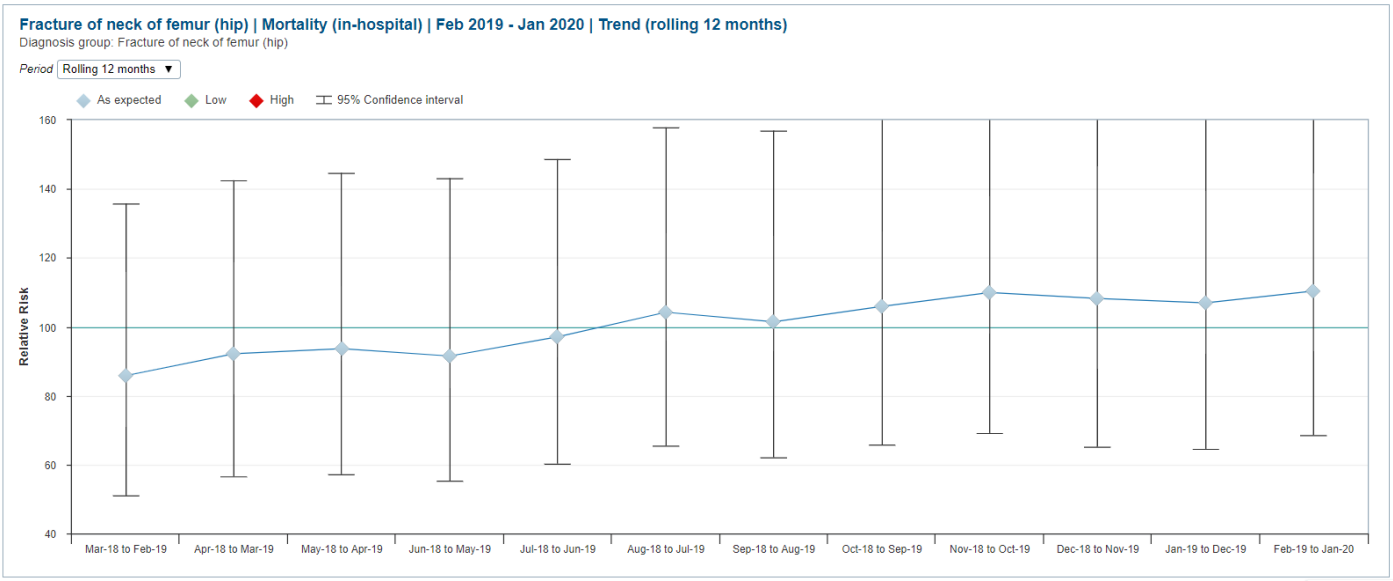


Figure 13: Trend in relative risk for acute and unspecified renal failure



The relative risk of death from acute renal failure has been rising since July 2018 but remains within the expected range. The Mortality Surveillance Group commissioned a review of these deaths and will be reported to the Group in June 20.

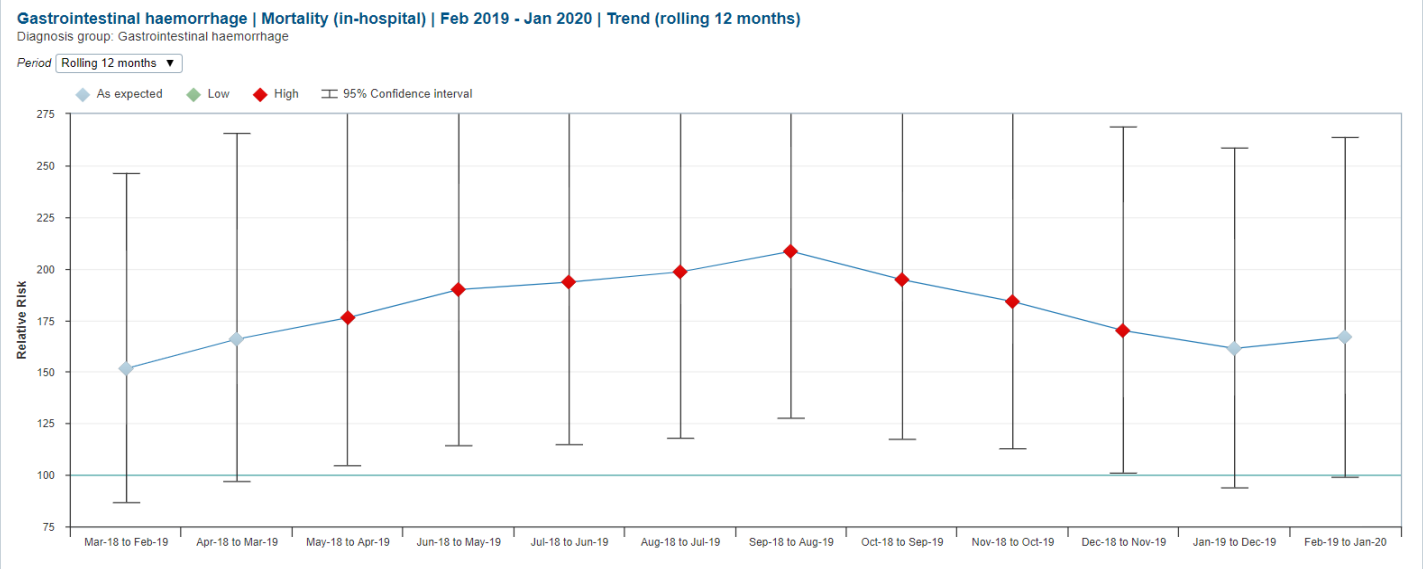
Figure 14: Trend in relative risk for fracture of neck of femur



A multidisciplinary review of 33 patients who died with a fractured neck of femur was undertaken in October 2019. The review was discussed at a joint Trauma and Orthopaedic and Anaesthetic meeting on 7 February 20 and the action plan agreed 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

Figure 15: Trend in relative risk for gastrointestinal haemorrhage



A multidisciplinary review of 18 patients who died following a gastrointestinal haemorrhage was completed by December 19. The review found some excellent care especially in time to consultant review, management of medication and procedural care. 16 problems in care were identified, of which 4 contributed to harm. An action plan is in place to improve:

- Referral and booking process – electronic process introduced 17/3/20 – completed.
- Implement the acute upper GI bleed care bundle.
- Continuity of care with patients cared for by the GI team
- Start an ongoing audit to understand delays of patients needing emergency and urgent OGDs.
- Continue to review all deaths of patients having an endoscopic procedures

The review was presented to the Clinical Governance Committee on 25 February 20 and a further update will be given in June 20 on progress of the action plan.

19. Summary

The report highlights the introduction of the Medical Examiner system from April 20 and outcomes and improvements in bereavement support. The Q4 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 all are subject to a serious incident inquiry.

The weekend HSMR started to decline from a peak of 133 in July 19 to 114.5 by January 20 and is now as expected. In Q4, a working group to improve the safety and effectiveness of services at the weekend was set up focusing on an improved structure and co-ordination at the weekend. This will be measured at the next NHS 7 day services survey in the autumn 20.

A multidisciplinary review of 33 patients who died with a fractured neck of femur was discussed at a joint Trauma and Orthopaedic and Anaesthetic meeting in February 20 and the action plan agreed to make improvements in the pathway. A case notes review of patients who died from a gastrointestinal haemorrhage was reported to the Clinical Governance Committee in February 20. An action plan is in place to improve the referral and booking process and the acute upper GI bleed pathway. An update will be reported in June 20.

As the trend in the relative risk of death of patients with acute renal failure has been elevated for the last 5 data points, the Mortality Surveillance Group commissioned a review which will be reported to the Group in June 20.

On 11 March 20, the WHO declared a global pandemic caused by coronavirus (COVID-19). A policy of ‘stay at home, protect the NHS and save lives’ started on 23 March and continues to this day (28 April). The lockdown, social distancing and hand hygiene has worked in slowing down the rate of infection and protecting the NHS from being overwhelmed. Hospital bed and ICU capacity have remained available during this period.

The Medical Director has commissioned a review of 45 patients who died of COVID-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate and if ventilation was required, whether it was provided. The review will be reported to the Clinical Governance Committee in September 20.

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,

4 May 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**	85	73	84	**242**	**784**
1st screen	65	58	62	**185**	65	40	59	**164**	59	59	51	**169**	77	71	81	**229**	**747**
% 1st screen	97%	92%	100%	**96%**	96%	93%	97%	**95%**	94%	100%	93%	**95%**	91%	97%	96%	**95%**	**95%**
Case reviews	23	19	20	**62**	27	11	19	**57**	17	30	17	**64**	29	26	14	**69**	**252**
% case reviews	34%	30%	32%	**32%**	40%	26%	31%	**33%**	27%	51%	30%	**36%**	34%	36%	14%	**28%**	**32%**
Deaths with Hogan score 1	63	60	60	**183**	65	40	58	**163**	60	58	56	**174**	79	66	82	**227**	**747**
Deaths with Hogan score 2 - 3	4	3	1	**8**	3	3	3	**9**	3	1	0	**4**	5	5	2	**12**	**33**
Deaths with Hogan score 4 - 6	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	1	2	0	**3**	**4**
Learning points	7	7	6	**20**	5	3	7	**15**	4	2	4	**10**	7	4	5	**16**	**61**
Family/carer concerns	1	1	2	**4**	1	1	2	**4**	2	1	2	**5**	1	2	0	**3**	**16**
CUSUM alerts	3	1	0	**4**	0	4	0	**4**	2	0	2	**4**	0	0	0	**0**	**12**
CUSUM investigated	3	0	0	**3**	0	1	0	**1**	1	0	1	**2**	0	0	0	**0**	**6**
Deaths investigated as an SII**	0	2	2	**4**	1	0	2	**3**	1	1	0	**2**	1	0	2	**3**	**11**
SIIs graded as catastrophic	1	0	1	**2**	1	0	2	**3**	1	1	1	**3**	1	0	2	**3**	**11**
Death following an elective admission	2	0	1	**3**	1	0	2	**3**	0	2	1	**3**	1	1	0	**2**	**11**
Unexpected	0	3	1	**4**	0	0	2	**2**	2	1	0	**3**	1	2	0	**3**	**12**
Stillbirths/ neonatal/child death	0	1	0	**1**	1	0	0	**1**	2	1	1	**4**	1	0	2	**3**	**9**
Learning disability deaths	0	1	0	**1**	0	0	0	**0**	2	0	0	**2**	0	0	1	**1**	**4**
Reported to LeDeR programme LeDeR	0	1	0	**1**	0	0	0	**0**	*0	0	0	**0**	0	0	*0	**0**	**3**
Serious mental illness	0	0	2	**2**	0	0	0	**0**	0	0	2	**2**	0	0	0	**0**	**4**
Maternal death	0	0	0	**0**	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 27/4/2020	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	Due to COVID-19 pandemic the national version 3 is still not published. BSW STP has put the introduction of ReSPECT on hold until the COVID situation has resolved. SFT resuscitation officer attended the first BSW STP working group in December and is actively involved in preparation work. Extend to 30/9/20.	
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 LocSIPP completed. Ascitic tap drainage - not started yet. LocSSip implementation plan in place.	
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 114.5 to Jan 20 from a peak of 133 and is now as expected. A working group to improve the safety and effectiveness of services at the weekend was set up in Q4 – the focus is on improved structure and co-ordination at the weekend.	
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. Escalation (recorded) improved from 73% in 18/19 to 83% in 19/20 and will continue as an area for improvement in 20/21. (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. Increase in home as the preferred place of care at end of life from 36 (62%) 18/19 to 109 (69%) patients in 19/20.	

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.