Bundle Trust Board Public 5 December 2019

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX Certficates

Presented by Nick Marsden

1.2 10:05 - Patient Story

1.3 Welcome and Apologies

Apologies received Rachel Credidio

1.4 Declaration of Interests

1.5 Register of Attendance

For noting

Register of Attendance - Public Board 2019-20.docx

1.6 10:25 - Minutes of the previous meeting

Minutes from Public Trust Board meeting on 7 November
For approval

Draft Public Board mins 7 November.docx

1.7 Matters Arising and Action Log

Trust Board action log Dec.docx

1.8 10:30 - Chairman's Business

Presented by Nick Marsden

1.9 10:35 - Chief Executive Report

Presented by Cara Charles-Barks
For approval

1.9 CEO Board Report December.pdf

2 ASSURANCE AND COMMITTEE REPORTS

2.1 10:40 - Trust Management Committe Report - 20th November

Presented by Cara Charles-Barks
For information

TB 2.1 TMC Escalation report November 2019.pdf

2.2 10:45 - Clinical Governance Committee Report - 26th November

Presented by Paul Miller
For assurance

TB 2.2 Clinical Governance Committee escalation paper 26th November 2019.docx

2.3 10:50 - Finance and Performance Committee Report - 26th November

Presented by Paul Miller
For assurance

TB 2.3 Finance and Performance Committee escalation paper 26th November 2019.docx

2.4 10:55 - Workforce Committee Report - 28th November

Presented by Michael Von-Bertele
For assurance

TB 2.4 Escalation report Workforce Committee.docx

2.5 11:00 - Register of Seals

Presented by Fiona Mcneight
For approval

2.5 Register of Seals.docx

2.6 11:05 - Integrated Performance Report

Presented by Andy Hyett
For assurance

TB 2.6 a 191205 IPR.docx

TB 2.6 b IPR December 2019.pdf

3 QUALITY AND RISK

3.1 11:25 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona Mcneight
For assurance

BAF cover sheet December 2019.docx

BAF v13.2 for Board _Dec 19.docx

Corporate Risk Register November 2019 v6.5_Final@271119.xlsx

CRR tracker v13_Nov 19_with committee amends.xlsx

3.2 11:30 - Learning from Death Report Q2

Presented by Christine Blanshard
For assurance

3.2 Learning from death report Q2 19 20 Nov 19.docx

3.3 11:35 - Director of Infection Prevention Control

Presented by Lorna Wilkinson
For assurance

3.3 a Trust Board Summary sheet DIPC Report Q1 & Q2 (2019-20).docx

3.3 b DIPC Report 6 monthly update 2019-20 (Final v.2).doc

3.4 11:40 - Safety and effectiveness of services at the weekend - update on action plan

Verbal update from Christine Blanshard
For assurance

4 CLOSING BUSINESS

4.1 11:45 - Agreement of Principle Actions and Items for Escalation

4.2 Any Other Business

4.3 11:50 - Public Questions

4.4 Date next meeting

Next Public Trust Board 9 January 2020

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)

Register of Attendance – Public Board 2019/20

	4 April	23 May	6 June	4 July	1 August	5 September	3 October	7 November	5 December	9 January	6 February	5 March	% attendance rate
Nick Marsden	✓	✓	✓	✓	✓	✓	✓	✓					
Tania Baker	✓	✓	✓	✓	✓	✓	✓	✓					
Michael von Bertele	✓	X	✓	✓	✓	✓	✓	✓					
Paul Kemp	✓	✓	✓	✓	✓	✓	✓	✓					
Jane Reid	X[1]	X[1]	X[1]	X[1]	✓	✓	✓	✓					
Rachel Credidio	✓	✓	✓	X	X	✓	✓	✓					
Paul Miller	✓	✓	✓	✓	✓	✓	X	✓					
Cara Charles-Barks	✓	✓	✓	X	✓	✓	✓	X					
Christine Blanshard	✓	✓	X	✓	✓	✓	✓	✓					
Lisa Thomas	✓	✓	✓	✓	X	✓	✓	✓					
Andy Hyett	✓	X	✓	X	✓	✓	✓	X					
Lorna Wilkinson	✓	✓	✓	✓	✓	✓	✓	X					
Paul Hargreaves	✓	X	✓	X[1]	X	✓							
Lynne Lane								✓					

Governor Observer													
Raymond Jack	✓	✓			✓								
John Managan			✓	✓		✓	✓	✓					

Attended - ✓

Apologies – X

X[1] – authorised absence

Salisbury NHS Foundation Trust

DRAFT
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 7 November 2019 in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr N Marsden	Chairman
Ms T Baker	Non-Executive Director
Mr P Kemp	Non-Executive Director
Ms R Credidio	Non-Executive Director
Mr M Von Bertele	Non-Executive Director
Mrs J Reid	Non-Executive Director
Mr P Miller	Non-Executive Director
Dr C Blanshard	Medical Director
Mrs L Thomas	Director of Finance
Ms L Lane	Director of OD and People

In Attendance:

Esther Provins	Director of Transformation
Fiona McNeight	Director of Corporate Governance
Justine McGuinness	Head of Communications
Gail Ng	Paediatric Emergency Medical Consultant (TB1 07/11/1.2)
Hilary Smith	Sister, Emergency Department (TB1 07/11/1.2)
Paul Bevis	Porter (TB1 07/11/1.1)
Greg Pearson	Consultant Gynecologist (TB1 07/11/1.1)
Kylie Nye	Corporate Governance Manager (minutes)
Eiri Jones	Non-Executive Director designate (observer)
John Mangan	Lead Governor (observer)
Ed Leonardo	Business Development Manager – Liaison Group (public)

ACTION

TB1 07/11/1 OPENING BUSINESS

TB1 07/11/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

N Marsden noted that each month the Patient Experience team will review SOX nominations and will choose one nomination which reflects the Trust's values and another general SOX nomination to receive a certificate at Trust Board.

N Marsden noted that this month the SOX certificates were being awarded to Greg Pearson and Paul Bevis. N Marsden thanked both members of staff for their hard work and contribution.

TB1 07/11/1.2 Staff Story

L Lane presented the Staff Story and introduced Hilary Smith and Gail Ng to the meeting to tell the Board about their experiences volunteering for the HALO Trust.

G Ng presented a brief summary of what the HALO Trust do and what she had undertaken in her 13 years as a volunteer for them. H Smith noted that this was her first year as a volunteer and provided a presentation summarising their recent trip to Columbia.

Discussion:
P Miller noted that as part of the presentation, he had recognised how complimentary G Ng and H Smith were of the team's skills and their capability after only a few short weeks of training. P Miller asked if there were any transferable learning points that had been picked up in relation to this. H Smith noted that as the Education Facilitator in ED, she had noted the repetitive nature of the training and how calm people were considering the circumstances and environment. H Smith noted that these lessons are transferable to practices within the Trust. G Ng noted that one of the biggest challenges is the language barrier and communicating with translators in simple terms, so the correct message is passed on. H Smith highlighted how rewarding the experience had been and noted how she had passed this message onto more junior members of the nursing team to highlight the great experiences they could also have during their career.

N Marsden thanked G Ng and H Smith for their work and for taking the time to present.

TB1 07/11/1.3 **Welcome and Apologies**

Apologies were received from.

- Cara Charles-Barks – Chief Executive
- Lorna Wilkinson – Director of Nursing
- Andy Hyett – Chief Operating Officer.

N Marsden welcomed Eiri Jones; newly appointed Non-Executive Director who he advised will formally start on Monday 11th November. N Marsden further noted that the Trust had also appointed two other Non-Executive Directors, Rakhee Aggarwal who will start on 1st January 2020 and David Buckle who will start on 27th January 2020.

N Marsden also welcomed Lynn Lane, the newly appointed Interim Director of OD and People.

TB1 07/11/1.4 **Declarations of Conflicts of Interest**

There were no declarations of interest pertaining to the agenda.

TB1 07/11/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 3 October 2019**

The minutes were agreed as a correct record of the meeting held on Thursday 3 October 2019.

TB1 07/11/1.6 **Matters Arising and Action Log**

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

- **Action 58/111: Medical Workforce Incl. weekend HSMR, Hospital at Night Team and Guardian of Safe Working:** N Marsden noted that a paper was on the public Trust Board agenda summarising the safety and effectiveness of services at the weekend and included an overview of actions to mitigate risk.

- **Action 113: DTOC (Delayed Transfers of Care) Data Quality.** EP noted that the DTOC data quality in the Integrated Performance report is RAG rated amber due to the timeliness of reporting. The process of collating accurate DTOC data includes organisation agreeing who the DTOC is attributed to, which can sometimes cause delay in reporting the figures. T Baker suggested that if the data quality is as good as it can be, taking into account the delayed process, perhaps the data quality should be RAG rated as green to avoid confusion. Item Closed.

N Marsden noted that all other actions were either closed or were related to a future agenda.

TB1 07/11/1.7 **Chairman's Business**

N Marsden reported that a key focus over the last 6 months from a national perspective has been the consolidation of NHS England and NHS Improvement into a single organisation. Whilst at a high level a team has been appointed and the organisation is functioning as one entity, N Marsden highlighted that there is further work to at a regional level.

N Marsden noted that further to his report at last month's Board, BaNES, Swindon and Wiltshire (BSW) CCG's will merge into a single entity from 1st April 2020. It is hoped this will initiate a focus on strategic commissioning, providing a series of outcomes better suited to the patient base.

The BSW STP is recruiting a Chair, with interviews on Wednesday 13th November. In parallel, BSW have also consolidated the Long Term Plans (LTP) and submitted a draft. It will be resubmitted in the next few weeks following feedback and the effects of this will be discussed by the Board in the near future.

N Marsden noted that there is a meeting of Non-Executive Directors for the 3 acute Trusts on Tuesday 12th November in Devices.

Discussion:

- P Kemp highlighted concerns in relation to a combined strategic commissioning approach to having one system control total. P Kemp asked if there was to be any transaction control implemented as part of this change. N Marsden noted that he was not aware of a detailed plan but noted the desire

for there to be a single controlled source of funding. L Thomas agreed to pick this point up in the private Trust Board meeting.

- P Kemp suggested that the Trust is in a transition state between statutory responsibility and being asked to act as a transition in the system. P Kemp noted that when there are potential risks the Trust should be challenging these. N Marsden noted that as part of the new configuration of the CCG, risk related discussions should be shared discussions across the system.

TB1 07/11/1.8 **Chief Executive's Report**

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

- The hospital was very busy and experienced unseasonably high demand; the Trust was at Opel level 4 for 23 days during September. This did affect the Trust's 4 hour performance, although 91% was achieved compared to a trajectory of 89%.
- The Trust's Flu campaign is progressing well, with over 40% of frontline staff vaccinated by the end of October. It is anticipated that the Tryst will surpass last year's total and reach the target of 80%.
- There has been a good response to the annual NHS Staff Survey which launched in October. The Trust is hoping to improve on last year's response rate with a targeted campaign of posters and messages on both paper and electronic payslips.
- On 25th September C Charles-Barks, A Hyett and L Thomas attended an STP wide risk summit to test confidence in all provider plans across the winter period. Concerns relating to gaps in clear timeframes and the impact were raised. Concerns were also raised regarding the deteriorating ED performance position and the need to identify different strategies to improve patient's experience and also improve the impact on staff working under extreme pressure.
- Two members of staff from Sarum Ward Staff Nurse, Andrea Rowe and Healthcare Assistant, Jan Keah, have been honoured with awards recognising their service to children's health at the Wessex Paediatric Awards for Training Achievements (PAFTA) 2019. The Children's Unit was nominated for the Training Unit of the Year Award.
- The Trust recently hosted the Bring a Pound to work day to raise funds for the Stars Appeal. The event was sponsored by Spire FM and raised £12,484 for the Stars Appeal Charity.
- The Trust, with support from its BAME Network, supported Black History Month in various ways this year, with special menus being offered in both the Springs and Hedgerows restaurant.
- The Friends Memory Lane Café opened this month which is a reminiscence room for elderly patients with dementia. The room includes award winning technology Tovertafel, known as magic tables. This has been made possible thanks due to

a generous donation from the League of Friends.
- In the Spinal Unit, two wards have been merged to create Longford Ward. It is hoped this will improve the deployment of staff and help improve patient pathways. The ward includes new facilities for patients, including the Silver Room and mini gym which were implemented as a response to patient feedback.

TB1 07/11/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 07/11/2.1 **Trust Management Committee Report – 16 October**

L Thomas presented the report, providing a summary of escalation points from the TMC held on 16th October:

The Committee received the following business cases:
- Lead Clinician and Consultant Endoscopist – funding to be managed within the Directorate's budget.
- Early Supported Discharge/ OPAL – The Committee recognised that further evaluation was required in relation to winter planning prior to allocating winter funding.
- Paediatric HDU in Sarum Ward - The Committee approved the business case to bring the High Dependency area is Sarum Ward up to an appropriate specification.
- RIS Business Case – The Committee recommended the business case for approval to the Finance and Performance Committee.

L Thomas asked the Board to note that TMC had received the Annual Sustainability report at its August meeting and progress had been noted.

Discussion:
P Miller queried which Board Committee the Annual Sustainability Report had gone to. F McNeight noted that further to a discussion outside of the meeting, it had been agreed for the paper to go to TMC and for this to be noted as part of the escalation report to Board. P Miller queried if the report should go to a Board Committee and N Marsden noted that he would pick this up outside of the meeting.

TB1 07/11/2.2 **Clinical Governance Committee Report – 24 September**

P Miller presented the report providing a summary of escalation points from CGC held on 24 September.

- There was only one non-executive director (NED) present which meant the meeting was not quorate. However, as reported earlier in the meeting three new NEDs have been appointed, which will strengthen membership of the Committee going forward.
- The Committee received the Risk Management Annual Report 2018/19 and the Maternity and Neonatal Risk Management Annual Report 2018/19 and it was recognised

that systems and processes to gain assurance were in place. However, it is essential that all parts of the Trust complied with these systems and processes for full assurance.

- The Committee received the Cancer Risk Summit Report, which identified a series of recommendations covering five areas. It was agreed that a process report on how these detailed actions were being progressed would come back to the November 2019 Committee Meeting and a full report would come back to May 2020.
- The Committee received the weekend HSMR paper and P Miller noted this would be picked up later in the meeting.
- The Committee received the GIRFT Annual Report covering the actions undertaken by this initiative, which aims to improve outcomes and reduced unwarranted clinical variation.

Discussion:

- R Credidio referred to the GIRFT report and noted that it would be useful for the Board to know how the Committee was assured by the report. P Miller noted this point and explained that the Committee was assured due to the Trust participating in the GIRFT process, the outcome and the triangulation with other programmes of work under way. P Miller noted that going forward he will highlight if the Committee is assured and why.

TB1 07/11/2.3 **Finance and Performance Committee Report – 22 October**

P Miller presented the report, providing a summary of escalation points from F&P Committee held on 22 October.

The Committee received the following business cases:

- Contract for the supply of a Picture Archiving System (PACS) system – The business case was recommended for approval to the Trust Board.
- Contract for the supply of a Radiology Information System (RIS) - The business case was recommended for approval to the Trust Board.

- The Committee will prioritise a discussion on in year productivity and income in 2019/20 at November's meeting.
- The Committee also received a presentation detailing the Campus project Strategic Outline Case (SOC). Further discussions are scheduled to take place at December's Board meeting.

Discussion:

- R Credidio queried the lengthy discussion that took place regarding the PACS/RIS contract business case. P Miller noted that it was a complicated process, encompassing several procurement processes. P Miller took note that his escalation reports should expand on the assurance going forward.

TB1 07/11/2.4 **Subsidiary Company Governance Committee – 7th October**

N Marsden noted that this item would be picked up in the private Board meeting due to the confidential nature of the business to be discussed.

TB1 07/11/2.5 **Integrated Performance Report**

L Lane presented the Integrated Performance Report and highlighted the following key points:

- Month 6 saw a reduction in the Trust's 4 hour ED performance as compared to Month 5. However, the Trust continues to achieve above the trajectory of 89%.
- The Trust was unable to maintain the Diagnostic DM01 standard achieved in August but is still benchmarking favourably compared to other Trust's in the region.
- Bed Occupancy levels have increased during September which reflects the ongoing challenges with timely discharges and high levels of DTOC patients. Continued operational pressures have also contributed to a significant increase in non-clinically justified mixed sex breaches.
- Whilst the Trust continues to deliver the RTT standard, there is a downward trend with performance falling and the waiting list size increasing. Specific actions are in place to mitigate this but the current position is challenging, particularly going into the winter.
- C. Difficile cases are closely monitored and the Trust continues to take mitigating actions to ensure that any lapses in case are identified and managed.
- Weekend HSMR remains a key focus and this is being closely monitored and more information reviewed by CGC. L Lane noted that the outcomes of these discussions and actions taken are reflected in the paper later in the meeting.
- The Trust has reported a £300k surplus for the period, taking the year to date control total deficit to £5220k. This means that the PSF and FRF for quarter 2 would be recognised. This was made possible following agreement with Wiltshire CCG on a minimum income guarantee on the acute contract. There are a number of factors affecting the financial position, including a continued decline in clinical productivity, high agency spend fuelled in part by hard to recruit posts. There are strategies in place to try and fill some of these vacancies.
- In relation to workforce, there was a slight increase in turnover compared to last month from 9.06% to 9.12%. However this remains below the Trust's target of 10%. There has been little improvement in in the proportion of exit interviews completed. However, a piece of work is underway to review the leaver process to ensure we gain more information about why people choose to leave.
- In September, the absence rate has reduced to 3.29%, resulting from a significant decrease in long term sickness. There has been an increase in short term sickness which is

being robustly managed in accordance with the Attendance Management Policy.

- Non-medical appraisal rates are just above the 85% target but medical appraisals have fallen below target for the first time since January 2019. There is work underway to help understand the drop in compliance and to assist the Medical Director and Clinical Director's to ensure appraisal rates increase.

Discussion:

- P Kemp noted that September's financial position is due to a change of contract and is not an internal performance change. Whilst this change to the contract is entirely appropriate, P Kemp noted that the next 6 months are going to be very challenging.
- P Miller noted that the report tells us the past and current situation and challenges but doesn't provide the Board with a forward view. P Miller noted that whilst the Trust's performance benchmarks well against other Trust's, there are £3.5m worth of risks and therefore suggested it would be useful for the Trust to have a sense of which targets might slip in the next 6 months. P Kemp suggested that this should be picked up as part of the Q3 forecast discussions at the next F&P meeting.
- L Thomas explained that the financial situation is complex and there will be continued challenges in the next 6 months and beyond. L Thomas noted that these risks and performance challenges should be shared as a system and this was why the STP risk summit had been scheduled. L Thomas suggested that there needs to be decision as a system, including primary care and GPs. L Thomas noted that the requirement for an acute hospital in Salisbury is essential and therefore the system should be appropriately allocating the funding. It was therefore suggested that a Board to Board meeting with the CCG would be useful to provide an understanding of the ongoing financial concerns in the context of the Trust's rurality, links to the council and funding and the strategic issues which face SFT. J Reid agreed and noted that considering the urgency of some of the issues this meeting should be expedited.
- T Baker noted that in terms of financial challenges there have been a number of discussions regarding funding over the last year and therefore queried if there was one document bringing all of this work together. L Thomas noted that the document has been written and outlines risks and what is within the Trust's gift to mitigate but does requires further work, including external input. L Thomas noted that the report is due to come to December's Board meeting. N Marsden asked L Thomas to share an initial draft with him. **ACTION: LT** **LT**
- P Miller noted that there had been evidence for some time that other parts of the STP have received more investment for community beds compared to Salisbury, and asked why this is now having a greater impact. LT explained that the

financial issues are not volume driven but the key problem is the cost structure and infrastructure required to meet the requirements for the patient base. C Blanshard explained that other systems have invested in frail and elderly services, including care home screening and initiatives for longer GP appointments. There have been investments in community care, not just additional beds.

TB1 07/11/3 **QUALITY AND RISK**

TB1 07/11/3.1 **Flu Vaccination of Healthcare Workers**

L Lane presented the report, providing the Board with assurance that there is a robust flu campaign in place and is proactive and responsive to the needs of the Trust. L Lane noted the following key points:

- The 2019/20 flu campaign was launched on 30 September 2019 and as of 28th October the total number of staff vaccinated was 37%.
- The Trust is on target to achieve over 80% of front line staff vaccinated by the end of the campaign.
- The Trust is working hard to promote a culture of increased flu vaccine update, focusing responsibility on every member of staff and is supported by a designated flu campaign team and Peer vaccinators.
- There have been challenges in relation to the supply of the vaccination but this issue has been resolved.

Discussion:

- R Credidio noted that there have been concerns regarding the level of uptake in previous years and asked how the Board could be assured that this year will experience an improvement. L Lane noted that compared to previous years the level of uptake is already better. Additionally, L Lane advised that the new Head of Occupational Health, Alison Evans had taken a different approach the campaign this year and publicity from a communications perspective started a lot earlier this year.

TB1 07/11/3.2 **Safety and Effectiveness of Services at the Weekend**

C Blanshard presented her report which had been requested in light of the higher than expected Weekend HSMR (Hospital Standardised Mortality Ratio). The paper highlights the probable causes of this and also summarises the concerns relating to safety and workload at weekends and the measures being taken to address these issues. C Blanshard highlighted the following key points:

- There are two separate issues which overlap and that is the weekend HSMR concerns and the issues raised by junior doctors regarding the intensity of the workload in the evenings and weekends.

- A large amount of work has been done to investigate the issues relating to HSMR and a number of potential contributing factors have surfaced. Notably, there are a number of patients nearing the end of their life being admitted to the acute site in extremis, particularly on a Sunday afternoon, including those with secondary malignancy as an admitting diagnosis.
- Whilst is has been difficult to identify a casual relationship between these factors and the high weekend HSMR, a number of actions are being taken to address the issues. These include working with partners to reduce inappropriate admissions, reviewing clinical pathways, uplifts in staffing in key areas, improving deployment and utilisation of exiting staff and improved documentation and coding.
- It is important to reiterate that the effects of these improvements may have a lag time of at least 6 months before any change is apparent but they will have a measurable impact on junior doctor wellbeing and Keogh standard 4.

Discussion:

- M Von-Bertele noted that the reasons for higher than normal weekend HSMR were multifactorial but what the Board need to be assured of is that the Trust is not missing anything in relation to managing risk. M Von-Bertele suggested that a key mitigating action would be to increase senior clinician review over the weekend.
- C Blanshard noted that some of the issues raised are caused by external factors which the Trust can only try to change via influence. C Blanshard noted that a number of patients who are admitted from care homes have treatment escalation plans, which involve them not being admitted to hospital. However, the Trust cannot turn these patients away at the front door and will always treat patients to the best standard. For these patients, C Blanshard noted that there needs to be an alternative to care homes calling for an ambulance as the only safe option.
- T Baker noted that there were a few core issues that were interrelated but the key question to address should be, is the hospital safe from a clinical staffing perspective at the weekends. C Blanshard noted that if the Trust had a better infrastructure and IT systems, the Trust would likely have enough staff. However, clinical staff are currently spending too much time doing non-clinical work due to poor systems and IT technology. C Blanshard noted that this is demonstrated in the new safer staffing tool which is described in a paper that will go to the Workforce Committee in November.
- T Baker suggested that SHMI data, if broken down might provide some reassurance on the variance in weekend and weekday HSMR.
- PM noted that the main issue with weekend HSMR relates to Sundays as this is when the most acutely sick patients are admitted and it is also when we have the least senior clinical

staff. PM suggested that there was the need for a robust action to improve this situation as soon as possible. C Blanshard noted that there wasn't a quick solution and that more staff would mean additional funding of approximately £500,000. LT noted that the Trust is planning for winter and staffing will increase in the next weeks. CB explained that those staff were to cover over the peak winter period and didn't account for planning for the difference in numbers at the weekend. LT suggested from a practical perspective, if additional funding was agreed, there are very little available clinical staff to recruit. LT noted that using agency staff is not a sustainable solution and will come at a significant cost.

- P Kemp asked what the Trust is learning from other Trust's in relation to HSMR. C Blanshard explained that active network learning is ongoing and the key themes that arise relate to coding and staffing. The HSMR review of 78 patients indicated that there is an issue in the initial clerking when a patient is first admitted. C Blanshard noted that there needs to be a process of adding patient's comorbidities electronically when they are first admitted.
- M Von-Bertele noted that from all the information received at Board and Board Committee level over the last few months it is reasonable to suggest that the Trust is clinically safe at the weekends but that the pressure placed upon staff to keep the hospital safe is much greater at the weekend. N Marsden noted that there is an obvious degree of concern from all Board members regarding this issue and asked for an update to come to the Board for the next few meetings. **ACTION: CB** Additionally, N Marsden asked the Executive team to take the question of safety outside of the meeting and, whilst the term is never easy to define, ensure that every action that can be taken is being carried out.

TB1 07/11/4 **CLOSING BUSINESS**

TB1 07/11/4.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden highlighted three key issues discussed at the Public Board Meeting:

- Weekend HSMR and the ongoing actions relating to the safety of services at the weekend.
- The ongoing financial challenges and mitigating actions. There will be a focus on productivity at November's F&P Committee.
- The Trust's Flu Campaign has had a really positive start and it is hoped with the continued momentum, over 80% of Trust line staff will be vaccinated this winter.

TB1 07/11/4.2 **Any Other Business**

N Marsden advised the Board that this was J Reid's last meeting. N Marsden extended his thanks to J Reid on behalf of the Board and organisation and wished her the best for the future. J Reid asked J Mangan to pass her thanks back to the Governors for their support

during her tenure.

TB1 07/11/4.3 **Public Questions**

J Mangan referred to the HSMR papers and noted his concerns. He suggested that the Trust establish a Palliative Care Coding Policy. C Blanshard explained that the Trust has this policy in place and is updated and adhered to. What has become apparent is that the palliative care code needs to be given at the appropriate time. C Blanshard noted as the End of Life Care Lead, she is assured that the team have worked extremely hard to get this balance right and patients are treated appropriately.

J Mangan referred to the staff flu vaccine campaign and noted that the standard has changed to not include the figures of those who choose to opt out. J Mangan asked if the Trust know who has opted out and asked if the figures could include these members of staff to reflect the Trust's position compared to previous years. L Lane noted that this could be added. F Hyett noted that there was a requirement to improve the uptake in certain staff groups, particularly nurses. L Lane explained that a lot of work is going on including, myth busting, use of internal communications, roving vaccinators and maximum accessibility of the drop in service on Laverstock Ward.

TB1 07/11/4.4 **Date of Next Meeting**

Thursday 5 December 2019, Board Room, Salisbury NHS Foundation Trust

TB1 07/11/5 **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 5 December 2019

Agenda item		Assigned to	Deadline	Status
2.5 Integrated Performance Report				
139.	TB1 07/11/2.5 (IPR) Finance	Thomas, Lisa	09/01/2020	Pending
	Explanation action item LT noted that a document bringing together risks and mitigating actions in relation to financial sustainability is due to come to a future Board meeting N Marsden asked L Thomas to share an initial draft with him.			
3.2 Safety and effectiveness of services at the weekend				
140.	TB1 07/11/3.2 - Safety and Effectiveness of Services at the Weekend	Blanshard, Christine	19/11/2019	Overdue
	Explanation action item N Marsden noted that there is an obvious degree of concern from all Board members regarding this issue and asked for an update to come to the Board for the next few meetings.			

Report to:	Trust Board (Public)	**Agenda item:**	**1.9**
Date of Meeting:	5 December 2019		

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

Recommendation:
Note the Report for Information only.

Executive Summary:
This report provides the Board with an overview of some of the current activities of the Executive Team and key issues locally. This report also provides an update for the Trust Board on some of the key issues and developments since the last Board meeting. This report will show progress on the following areas: • Performance • Finance • Workforce • Quality Improvement • Flu Campaign update • NHS Staff Survey 2019 • STP News • Events A number of areas raised in this report may also feature in more detail in Executive Directors reports as part of the Board's Business.

Background

This is the 12th Chief Executive Report being presented for 2019 and, where appropriate, has been informed by updates provided by members of the Executive Team.

Performance

The Trust saw 91.8% of patients within four hours - as a result we were one of the top 10 performing Trusts in the UK during October for the four hour performance standard. We also maintained good performance against all other standards. This is a fantastic achievement, which reflects the commitment of staff right across the hospital. I want to personally thank all our staff for going the extra mile for our patients.

The Trust continued to provide good quality, safe care and had no cases of MRSA. C Difficile cases have now significantly exceeded the upper limit of 9 cases, as a result of the changes in reporting which now include community onset healthcare associated cases. We have appealed seven of these cases and Wiltshire CCG has confirmed the successful appeal of five of these for no lapses in care.

Finance

The Trusts financial position as at the end of October shows a NHSI control deficit of £1.8m, which is £2.4m worse than our plan. There was a significant increase in non-pay expenditure during October, with spend exceeding the Trust plan by £1.1 million.

Delivery of the 2019/20 financial plan therefore remains extremely challenging and is contingent on the delivery of a £10m cost improvement programme, as well as managing the arising pressures over the winter months. For example, variability in demand and pressures from non-elective activity and delayed transfers of care will place additional pressure on the Trust to staff beds above planned costs.

Work is ongoing with our partners to help manage the flow of patients, as we move into this critical winter period. The challenges are complex, but our ambition is to meet our financial commitments in 2019/2020.

Workforce

We continue to organise recruitment events and campaigns, and plans are already in place for both newly qualified RN and HCA assessment dates for 2020 and this month we have attended the Southampton University Healthcare Science Career event.

During November we attended career event at Bournemouth University and the Acute & General Medical Conference. Internationally we continue to welcome registered nurses from overseas, with a further 20 expected to join before Christmas.

There were a total of 56 starters across all disciplines in the Trust during this month, with leaver numbers holding steady at 24. The Trust's overall sickness absence rate has increased this month to 3.6%, above the 3% target, with long term absence decreasing and short term absence increasing.

We are managing cases proactively in conjunction with the Head of Occupational Health, with the aim of reducing these levels back below target to a sustainable level. Mandatory training is above target at just over 90%, whilst medical and non-medical appraisals remain just below their respective targets, with work ongoing to remedy this.

Quality Improvement

As part of the Trust's Strategy for improvement, we want to foster and entrench a culture of continuous improvement. We know there are some excellent improvement initiatives already in places and our aim is to spread these good practices and enthusiasm for change. We have been encouraging staff to become QI Coaches and to support staff in this role, in November we carried out specially designed Quality Improvement training, funded by Health Education England for our first cohort of 36 QI Coaches.

The Trust recognises that staff on the ground are best placed to know what and how things could be improved in their specific areas of work. That's why, as part our transformation programme; we're also introducing the Salisbury Hospital Dragons' Den, which will take place twice a year, to encourage innovation and improvement. The first of these events will be held in April 2020.

Flu Campaign

The Trust continues its staff flu campaign with drop-in sessions being made available to all staff throughout the month of November. Arrangements continue to be made for occupational health to visit staff in their own areas for larger group sessions. Figures for flu vaccinations in November, by staff group, are shown below.

Staff Group Uptake (Clinical areas)	% Vaccinated
Add Prof Scientific and Technical	**55%**
Allied Health Professionals	**59%**
Medical and Dental	**63%**
Nursing and Midwifery Registered	**48%**
Support to Clinical Staff	**49%**

It is anticipated that the Trust will surpass last year's total and reach our target of 80%.

NHS Staff Survey 2019

The Staff survey continues to run and with only two weeks of the survey left to go we have now achieved 47.9% response rate, which is excellent. The Trust has historically achieved on average around 35%. Although this is better than the average response rate for Acute Trusts (37.5%), it's still a long way from where we aspire to be, amongst the best, which is currently 61.2%.

The results of the survey will be published in the spring and any recommendations listed in the Trust's action plan will be monitored at Board level.

STP News

The STP have been interviewing for a number of key leadership posts this past month. The process is just reaching conclusion but the following 3 positions have had formal offers made.

- Chief Operating Officer Wiltshire
- Chief Operating Officer Swindon
- Chair BSW

BSW Long Term Plan

BSW have submitted the next iteration of our collective response to the Long Term Plan in November. We anticipate further feedback from NHSI/E in due course.

Events

- **Compassionate Leadership Event**

To support our Leadership Academy, the Trust held a compassionate leadership event, with external guest speaker Professor Michael West - an expert in leadership within the NHS. The event was really well attended and I'm very grateful to Professor Michael West for delivering such an engaging and thought-provoking session. Everyone I spoke to after the event felt empowered to make a difference at a personal, team and organisational level, to help our organisation become outstanding every time.

- **Human Factors Event**

On 22 November we hosted a Human factors expert who came to talk to staff on the Clinical Governance half day. The title of this session was Introduction to the Practical Application of Human Factors in Healthcare. We had an incredible turnout whereby 200 staff attended. It was an insightful and fascinating morning and the feedback was overwhelmingly positive.

This was an introductory session and we will now consider how we build on this along with our SIM training programme to develop staff awareness and proficiency in human factors science and non-technical skills application.

- **National Remembrance Day Services**

Salisbury NHS Foundation Trust fell silent at the 11th hour on the 11th day in November to pay its respects to the fallen in the national remembrance services. The Trust held services in our chapel on Remembrance Sunday and again on the Monday with wreaths being laid.

- **Transgender Remembrance Day**

Salisbury NHS Foundation Trust recently took part in the Transgender Remembrance Day with a ceremony on the Green in front of Trust Offices. A short celebrant service was held and was finished with the raising of the Transgender flag which remained flying high for the remainder of the week.

- **Antibiotics Awareness Week**

Salisbury NHS Foundation Trust and the Pharmacy Department within the hospital, once again held an information stand, reminding people about the importance of keeping antibiotics working. The week was well promoted and we understand that the team were visited by many patients with questions.

- **Communications Team National Win**

Our Communications team recently won the PRCA National award for Public Sector internal communications. This was a huge honour for them and for the Trust and highlights the real progress we are making in ensuring our communications team works at the highest standards for the benefit of our patients and our staff.

Recommendation

The Board is asked to note this report.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	5th December 2019		

Report from: (Committee Name)	**Trust Management Committee (TMC)**		**Committee Meeting Date:**	20h November 2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Board Sponsor (presenting):	Cara Charles-Barks, Chief Executive			

Recommendation
The Trust Board are asked to note the items escalated from the Trust Management Committee meeting held on 20th November.

Key Items for Escalation

The Trust Management Committee considered the following business cases:

- **Consultant Maternity Leave and Succession Planning**– The business case was supported as funding would come from cost avoidance of high cost agency locums and also budget available during maternity leave from the substantive post.
- **Third CNS Post** - This business case was not supported owing to more detail required in the income expectation and also benefit analysis
- **Radiology Workforce Review** – This business case was not supported and it was requested that further work is completed on the benefits realisation and return on investment.
- **Pharmacy Workforce Review** – This business case was not supported and it was requested that further work is completed on the benefits realisation and return on investment.
- **Hospice at Home** – This business case was supported with the committee recommending that the charity provide another quarter of funding for the hospice while discussions are had with the CCG and the charity

The Committee also noted that for Month 7 the Trust failed to deliver the ED standard reporting 91.8% which was below the constitutional standards, it was above Trust trajectory of 89.5%

To note: The committee was informed that the BAF had undergone a refresh following the setting of new corporate objectives for 2019/20.

To note: The corporate risk register has been updated and revealed a significant increase in risk profile across the trust and the committee agreed that there needs to be an understanding of this and whether this accurately reflects the risk profile across the organisation.

To note: The committee also noted that the Trust is currently £2.2m away from plan with M5 forecast showing a £3.6m risk. It was further noted that the recent escalation to OPEL 4 and use of escalation beds had not helped this situation.

End of Report.

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	5 December 2019		

Committee Name:	Clinical Governance Committee		**Committee Meeting Date:**	26th November 2019
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 Clinical Governance Committee meeting of the 26th November 2019.

Items for Escalation to Board
Board Assurance Framework/Corporate Risk Register - The Committee undertook a detailed review of all risks relating to the strategic priorities of Innovation and Care. The key risk which the Committee wishes to highlight to the Board is risk 5970. This relates to "*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*". The Committee received assurance that in key areas our day to day care was appropriate, but relied on time consuming manual "work arounds". However we heard failure to successfully progress our digital strategy would significantly undermine our ability to innovate, be sustainable and meet future clinical service needs. **Cancer Serious Incidents, Report from Risk Summit** – The Committee previously received this report which identified a series of recommendations covering five areas; Appointment systems* Clinic outcome forms* Investigation reports* Follow up or access plans Multi-disciplinary team (MDT) working* Subsequent to this report four task and finish working groups have been created (as marked with an asterix* above) to progress further work. Each group has a lead,

appropriate clinical and managerial membership and an agreed timetable (though certain actions relating to IT maybe brought forward following executive discussions). These task and finish groups report up to the Cancer Board and Trust Management Committee if required. The Clinical Governance Committee will receive a full report on progress, at its 26th May 2020 meeting, after the next Cancer Summit to be held in April 2020.

NHS seven day board assurance framework, September 2019 – The Committee received this regular report which reported our progress against 10 standards (issued by NHSE&I in November 2018), 4 of which are deemed to be of a priority;

Standard (2) – time to first consultant review – within 14 hours of admission to hospital. The Trust met the overall standard of 90, but there was a different experience on a weekday (94%) to the weekend (81%).

Standard (5) – access to diagnostics, critical and urgent need – 7 days a week.

For patients admitted as an emergency, access to 6 diagnostic services is provided either on site or by a formal network arrangement, therefore the Trust is compliant with this standard. However in certain services there was a difference between what "access" meant on a week day and weekend. For example in gastroenterology where the Trust has only had 1 wte consultant since October 2019, on a week day for upper GI endoscopy the service is provided by the duty endoscopist and out of hours, including weekends, it is provided locally on a 1 in 5 basis with the University of Southampton (UHS). The remaining 4 in 5 slots are covered by UHS.

Standard (6) – *access to consultant-led interventions – 7 days a week*

For patients admitted as an emergency, access to 9 consultant directed interventions is provided either on site or by a formal network arrangement, therefore the Trust is compliant. However a key area of concern has been access to interventional radiology and the current service is provided by the Royal Bournemouth Hospitals NHS FT, who have started providing this service 2 days a week from the 12th November 2019 and other times they cover emergency patients under a formal arrangement.

Standard (8) – ongoing consultant-directed care, patients receiving once or twice daily reviews

Twice daily review performance was 100%. The overall once daily review performance was 92%, but compliance at the weekend dropped to 77% and all the patients who did not receive a review at weekends were medical patients. However in mitigation the Trust does have a formal process in place (NEWS2) to identify, escalate and act on deteriorating patients.

In conclusion despite being compliant with the 4 priority seven day standards, there is a marked difference between how the hospital operates on weekdays and weekends and this difference needs to be seen in the context of our weekend HMSR, which was reported in this paper at 133.8. Note our recent discussions at the Board meeting on the 7th November 2019. Finally this report will be shared externally with the relevant regularity bodies.

Medicines safety bi-annual report – key issues to highlight from this regular report are (a) good progress is being made filling gaps in recruitment and in the last 6 months 9 new members of staff have joined the team, but they need to be inducted and receive ongoing

supported training (b) with regard to weekend working the Trust has been highlighted by NHSE&I as one of only 5 Trusts in England not to have a Sunday clinical pharmacy service, therefore no medicines reconciliation of non-elective patients is undertaken on a Sunday, which creates a backlog on a Monday and reduced pharmacy staffing on a Saturday can further compound this backlog, though there is access to emergency on-call Sunday pharmacy cover if required and (c) as a piece of good news a recent “perfect week” in AMU, where the pharmacy staffing was increased from 1.6wte to 4wte (including a pharmacy prescriber) led to reported savings in nursing time of 8 hours and 30 minutes and 5 hours of medical time over the week, with additional unquantified benefits to patient flow through AMU.

Clinical Strategy – an update on progress against this strategy was received and it was agreed to receive further updates on progress at the Committee on a six monthly basis (May and November)

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	5 December 2019		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	26th November 2019
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 26th November 2019.

Items for Escalation to Board
Deep dive productivity (including Trauma and Orthopedics) – The committee received a detailed presentation on progress to date for the reasons behind reduced levels of hospital productivity in 2019/20. The reflections to date were that the causes were multi-factorial and further detailed work was still required, but a more conclusive report would come back to the Committee on the 4th February 2020 and these lessons would be reflected into the 2020/21 operational planning process. **IT improvement plan** – This paper identified four objectives along with actions that will be taken to meet these objectives and the success criteria associated with each. The objectives are as follows; • To improve digital capability and capacity • To improve management controls • To improve cyber security and GDPR compliance • To improve the functionality and integration of current systems The plan was received and discussed and the following was acknowledged and agreed (a) there a significant number of IT related risks already identified in the Trusts risk register and Board Assurance Framework (BAF) (b) the overall informatics department has a budget of £7.6m which is 3.2% of our total budgeted expenditure in 2019/20 of £237.5m (c) the overall

informatics function, including medical records, clinical coding, service desk , information governance and other more technical IT functions) employs 117wte, with a total pay budget of £4.5m resulting in an average cost of £38,500 per wte. (d) benchmarked nationally, our informatics service is in the highest quartile for cost and we have a low digital maturity compared to peers and (e) the informatics service rarely makes use of agency staff and generally has a static core workforce.

The outcome of the discussion above was a detailed way forward for each part of the, wide ranging, Informatics service would be produced and agreed by the Executive team in February 2020 and discussed by the Trust Board in March 2020. With the aims of reducing informatics risks, improve the use of our existing informatics resources, accelerate the implementation of our digital strategy and thereby facilitate innovation and improve patient care.

Operational and Financial Performance 2019/20 (including Winter Plan) – operationally despite a very busy period the hospital is generally performing well against a range of operational performance targets, however delayed transfers of care are high and unbudgeted escalation capacity has been required in both October and November. Though anecdotally this “holding our own” performance wise has required a significant additional effort from staff.

Financially this “effort to deliver performance” and other factors has resulted in a worsening financial position. Last month the Trust Board were alerted to the fact there were potential additional year end financial risks of £3.5m, above our agreed control total deficit of £8.9m. Unfortunately these financial risks appear to have significantly increased and a more detailed paper will be included in the Board papers quantifying the amount and highlighting potential mitigations and other courses of action.

Update on the 2019/20 Capital Plan - £2.6m of capital slippage has identified against a total programme of £9.1m (29%). The reasons include campus development (£325k), midwifery unit (£650k), MRI2 (£560k), PACS (£400k) and unused contingency as the balance. It was agreed to bring forward capital expenditure prioritised for 2020/21 into 2019/20 and a detailed plan of schemes and high level benefits would come to the Trust Board at its meeting on the 5th December 2019 for approval. Finally this amended capital plan would still require individual business cases to be produced and approved in line with the delegated authorisation limits of the Trust.

Emergency Preparedness, Resilience and Response (EPRR) statement of compliance and Chemical, biological, radiological and nuclear (CBRN) preparedness audit – both of these important reports were received and approved by the committee on behalf of the Trust Board.

Board Assurance Framework (BAF) and corporate risk register – The strategic priorities and associated risks relating to the committee (local services, specialised services and resources) were reviewed and the increase in the total number and value of risks was noted.

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Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	5 December 2019		

Report from: (Committee Name)	Workforce Committee		**Committee Meeting Date:**	28/11/2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael Von Bertele			
Board Sponsor (presenting):	Michael Von Bertele			

Recommendation
The Trust Board are asked to note the items escalated from the Executive Workforce Committee meeting held on Thursday 28 November 2019.

Key Items for Escalation

- Following the extensive review of Hospital At Night, weekend working and the Guardian of Safe Working report the Committee identified an emerging problem with junior doctor rotas linked to the new contract provisions. The Medical Director will coordinate further work to explore this.
- The Committee took the Annual Equality and Diversity report which highlighted a gap in the Trust policy regarding disability and reasonable adjustment, the complexity of the gender pay gap, positive representation of BAME staff relative to the general population, and the importance of having a strong and active EDI committee.
- There is a long standing issue with job planning and sign off which impacts on the Trust's ability to carry out effective business planning. There is a planned focused piece of work to address compliance.
- Flu vaccination has started well but the momentum must be maintained.
- Staff survey is showing higher returns than previous years which will provide a richer source of data to inform and improvement programme linked to the wider organisational development work .
- Director of Medical Education report which included the GMC survey results showed that the Trust has made significant progress as a rewarding place to undertake foundation training.
- It was acknowledged that the risk profile for the People strategic priority required a complete review and will be reported at the next meeting in January. Many of the risks cross cover the other strategic priorities and this will be reflected.

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	05 December 2019		

Report Title:	Register of Seals			
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):				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in August 2019. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
352	13/8/2019	Lease to underlet Renal Dialysis (Block 08) SFT and Renal Services Operations Ltd and Renal Services Trading Ltd	Laurence Arnold	Cara Charles-Barks	Nick Marsden

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	05 December 2019		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Kieran Humphrey, Associate Director of Strategy Felicity Anscombe, Information Services Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

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

Executive Summary:
The Integrated Performance Report highlights key themes and issues across the organisation, attempting to make links between the various aspects of the Trust's business. As such it brings together themes from the: performance, quality, workforce and finance reports and seeks to set out the interlinking issues and plans to move forward the challenges faced. This report for December 2019 Board uses data and commentary available for performance to October 2019 across the Trust's services to produce a summary report. Elements of this report are also scrutinised by Board Committees using the same format. The Structure of the Report is being designed to align with the Trust's key strategic priorities and their related (CQC based) assessment frameworks. **Performance** Trust performance in October was marked by an increasing build up of operational pressure in non-elective pathways – although escalation beds were open for 14 days through the month, occupation was significantly lower than normal. The Trust was able to maintain its performance trajectory for the Emergency Access (4 hour) target and remains in the top 10 performing Trusts in England and achieved a decrease in mixed sex breaches from September's spike. Particular concerns are the increase in long length of stay (21 days+) which reached its highest level since December 2018 and discharges before midday, which continue to fall – now 16.6%. There are a number of

improvement actions from the 'Steady' workstream which are expected to address this. Related to this, the rise in DTOCs since June 2019 has been sustained.

The trend of reducing RTT performance has been maintained, although the increased in waiting list has stabilised in October – this should not mask the continued direction of travel. Despite the Trust being one of few in England to achieve the RTT standard in October, the continued maintenance of performance, and related clinical income, should be viewed as a risk. There are some specialties that have demonstrated sustained improvement (T&O, general surgery, oral surgery) and others experiencing a marked decline in performance (dermatology, ophthalmology). Specific actions to address these areas are set out in the report.

The Trust was able to recover and deliver the Diagnostic wait time standard following resolution of ultrasound performance in Month 6.

Infection control targets remain very challenging to maintain – a review of cases was held in October and will report by the end of Q3. Weekend HSMR remains a significant concern and the success of the agreed action plan for this area will be monitored closely. Risk of mortality related to gastrointestinal haemorrhage and hip fracture have also been reviewed.

The Trust's control total deficit of £1.8m is significantly worse than had been planned for. Expenditure is primarily being driven by spend on clinical supplies and higher than planned nursing costs (although the latter is allowing a 75% reduction in nursing agency costs). Shortfalls in clinical income and productivity (£-2.5m vs plan YTD) equally contributes to the adverse position and the non-elective pressures described above contribute to the Trust's inability to recover its financial position. The Board will consider a Q3 re-forecasting elsewhere on its agenda at this meeting.

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	☒

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Integrated Performance Report

December 2019

(data for October 2019)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

This report for December 2019 Board uses data and commentary available for performance to October 2019 across the Trust's services to produce a summary report. Elements of this report are also scrutinised by Board Committees using the same format. The Structure of the Report is being designed to align with the Trust's key strategic priorities and their related (CQC based) assessment frameworks.

Trust performance in October was marked by an increasing build up of operational pressure in non-elective pathways – although escalation beds were open for 14 days through the month, occupation was significantly lower than normal. The Trust was able to maintain its performance trajectory for the Emergency Access (4 hour) target and remains in the top 10 performing Trusts in England and achieved a decrease in mixed sex breaches from September's spike. Particular concerns are the increase in long length of stay (21 days+) which reached its highest level since December 2018 and discharges before midday, which continue to fall – now 16.6%. There are a number of improvement actions from the 'Steady' workstream which are expected to address this. Related to this, the rise in DTOCs since June 2019 has been sustained.

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Structure of Report

Performance against our Strategic and Enabling Objectives

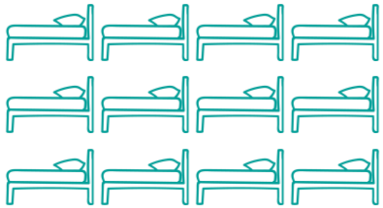
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
October 2019

NHS Salisbury NHS Foundation Trust

There were **2,901** Non-Elective Admissions to the Trust

We carried out **478** elective procedures & **2,301** day cases



99.1% ↑ of patients received a diagnostic test within **6 weeks**

Emergency (4hr) Performance **91.8%** ↑
(Target trajectory: 89.5%)

We delivered **23,426** outpatient attendances cases (-2,216 vs plan)

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

Our clinical income was **£20,961k** (£848k under plan)

1,312 patients arrived by Ambulance

We met **5 out of 7** Cancer treatment standards

RTT 18 Week Performance: **92.1%** ↓

Total Waiting List: **18,268** ↓

16.6% ↓ of discharges were completed before 12:00

Our overall vacancy rate was **3.75%** ↑

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

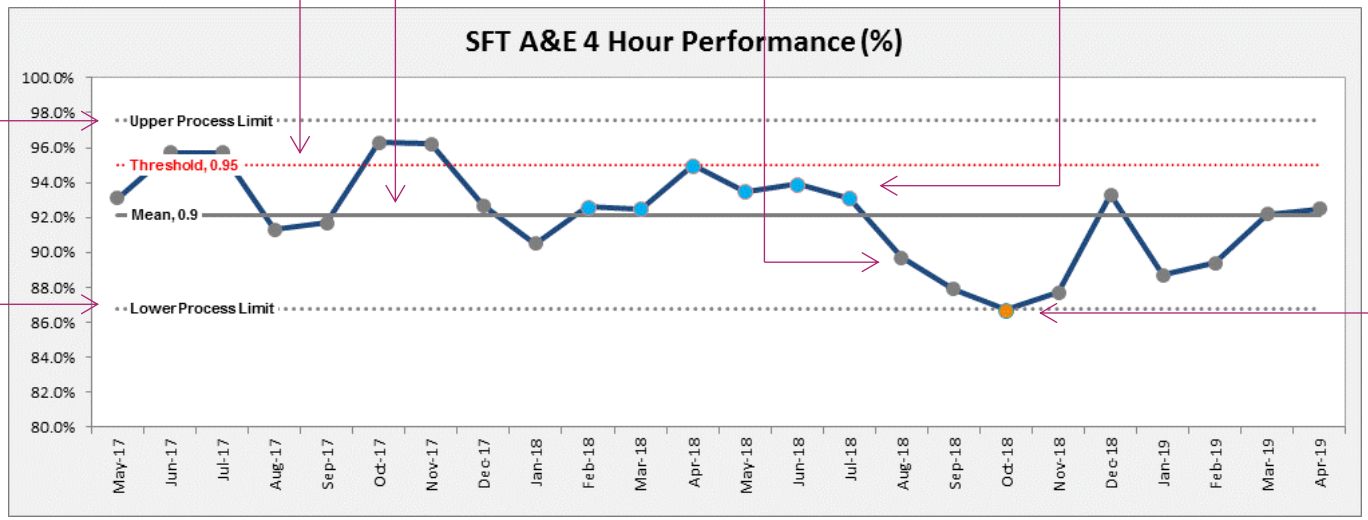
The red line shows the target for the KPI, if there is one

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

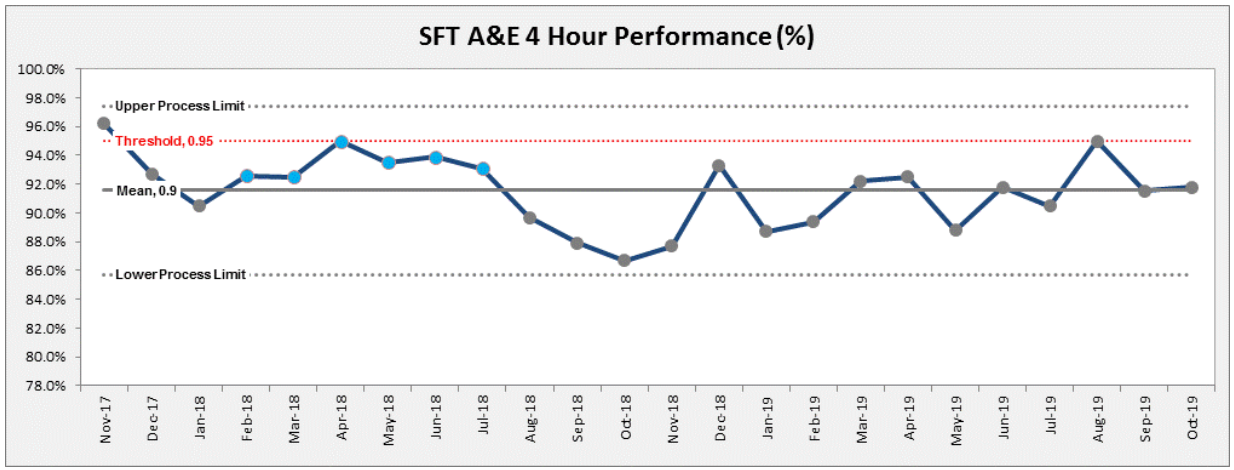
Salisbury NHS Foundation Trust

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 89.5%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	91.8%
Attendances:	6033
12 Hour Breaches:	0
ED Conversion Rate:	29.0%

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

M7 saw very minimal change to achievement of 4 hour performance at SFT, with trajectory positon being achieved (91.8% vs. 89.5%).

Continued challenges with workforce with two vacancies in ED and ongoing long term locum requirement in AMU. Locum cover necessary to ensure minimal level of cover is required.

Escalation beds open for 14 days of M7 with medical outlier numbers increasing, impacting overall efficiency of flow and ability for medical teams to manage. Resilience amongst the teams continues to be a concern which the Medicine Directorate are managing.

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

New Consultant in post in ED from 4/11/19 which will decrease reliance on locum shifts in ED. Gaps in rota for junior staffing being escalated to DMT.

Winter planning for additional weekend cover in Medicine Consultant rota for M9 and M10 to maintain optimum cover of senior decision makers.

Work within the 'Ready' work stream of Patient Flow Programme is working to improve OPAL presence at front door and increase use of ANPs and access to pathways in AMU/SDEC.

Encouraging use of single assessment form for clerking in ED to reduce duplication and time wasted using multiple forms to admit a patient.

Risks to delivery and mitigations

Workforce resilience.

Increase in demand (which could be an increase in patient acuity and higher conversion rate as much as an increase in footfall).

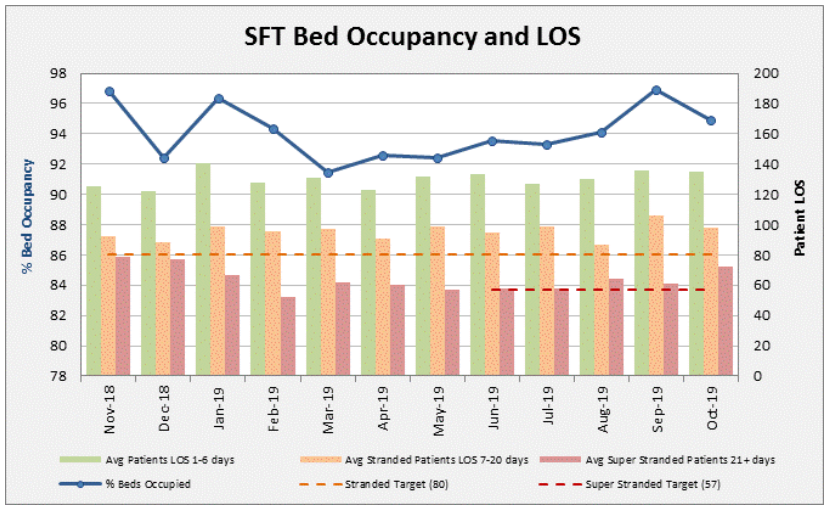
Lack of downstream ward capacity enable early flow from the ED.

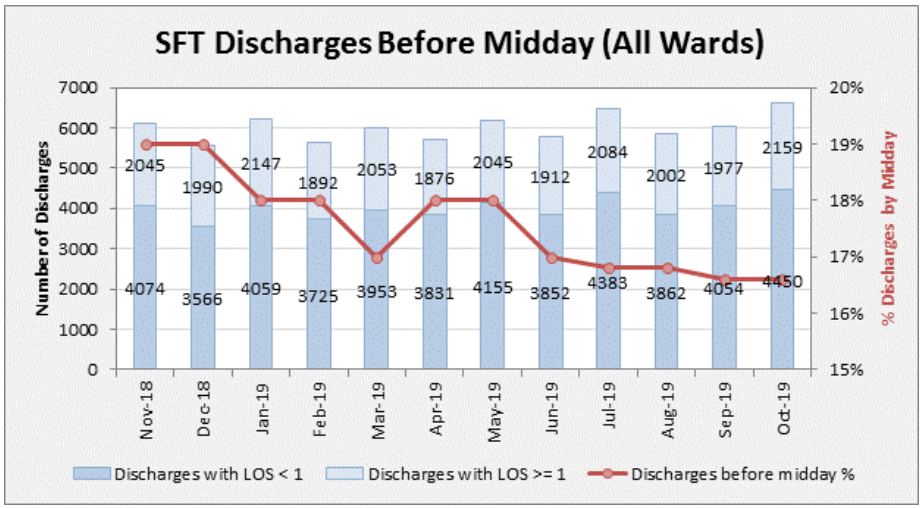
Inability of partners to deliver their plans.

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

October saw a reduction in bed occupancy overall from the previous month but still higher than the summer months. The 21 day+ LOS group of patients increased in October to levels not seen since December 2018. The 1-7 day group has maintained a high number and the 7-20 day group has dropped, potentially indicating that efforts to move on short stay patients have been successful, but discharging long stay patients has not and they have migrated from the 7 day+ group to 21 day + group.

Data not included in this slide from the DPTL submission (21 day+ data) to NHSi indicates that the most frequent code for inpatients in this cohort is not medically fit but scoring NEWS 4 or less. This might indicate a cohort of patients with complex chronic conditions who are difficult to maintain as fit whilst waiting for ongoing services, or the need to give more consideration to risk assessing discharge, or indeed both.

Discharges before midday continue to challenge the organisation. This issue has been examined in the 'Steady' patient flow group and efforts to improve performance in this area are planned.

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

Expert Panel has commenced looking at 14 day+ stay for all wards. Currently for most wards this review occurs every 2 weeks, the plan from December is for wards with particular challenges around LOS to attend weekly. This is felt by the panel and medical directorate senior nurse to support the prevention of the movement into the 21 day+ group as has been seen in October.

Actions from 'Steady' regarding discharges before midday include:

- Embed confirmation between nurse in charge and lead clinician on ward giving suggested 1530 deadline to report to bed meeting of identified patients
- Support golden patient as nurse led/criteria led discharge
- Embed principle of "early bird discharge" – i.e. pre 0900
- Ward round 'flow' – encourage early discharges being prioritised at early stages of ward round rather than last
- EDS/TTO process needs review to ensure organised well in advance of discharge
- Monthly data to be sent to ward teams to make them aware of their discharge rates and early discharge targets being met

Risks to delivery and mitigations

Sustained demand at the front door with no increased response internally at SFT for pathway 1 patients, and partners for pathway 2 and 3 patients.

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

Delayed Transfer of Care (DToC) Bed Days

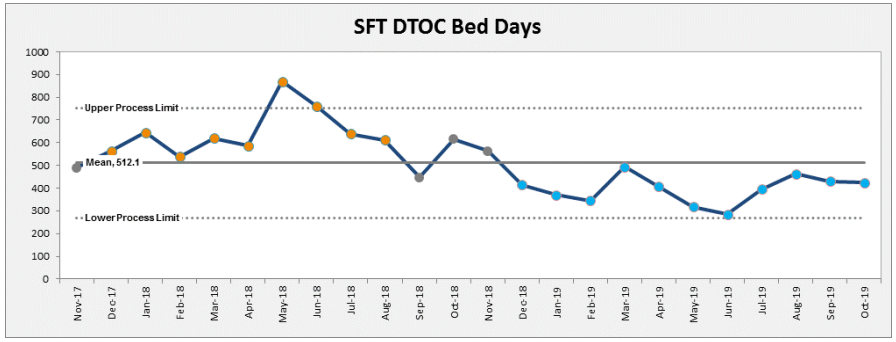
National Key Performance Indicators

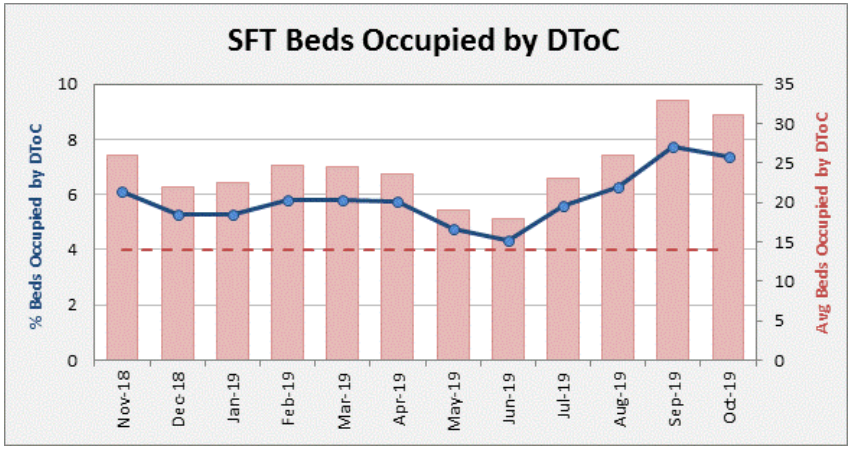
Performance Latest Month:

Data Quality Rating:

Days Lost to DToC: 147 NHS + 277 SS

DToC Patients (last Thursday of month snapshot): 24





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

The number of beds occupied by DTOC has come down from last month but remains much higher than the rest of the year. However the bed days occupied by DTOC are lower than Oct last year. This indicates a large number of people become DTOC but that the days they are delayed is improved from last year.

Days lost to NHS delays are outweighed by days lost to social care delays across Wiltshire, Dorset and Hampshire. This is a result of pressure across reablement services and accessing long term care and placements.

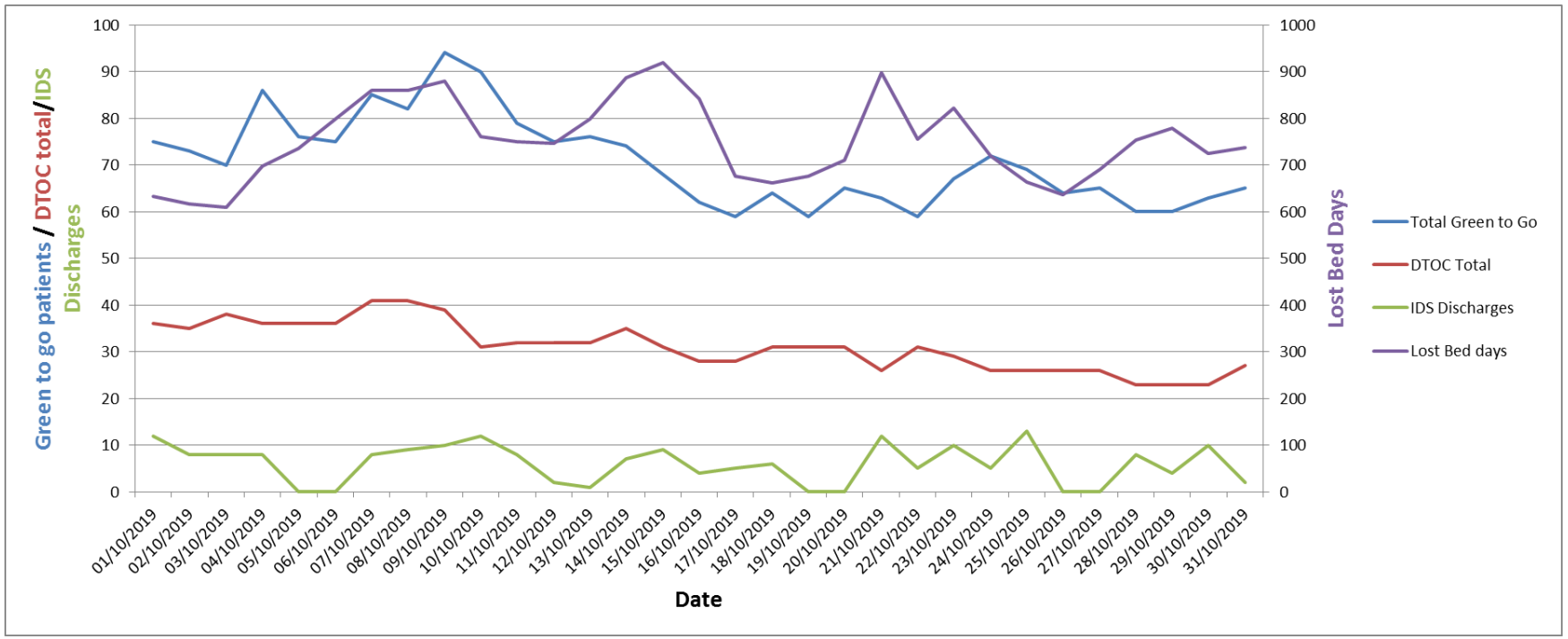
There is whole system focus on flow and DTOC and relationship building has been ongoing between operational teams in SFT and partner organisations. Key contacts for escalating DTOC issues are regularly updated and information flow between partners is improving. SFT and Wiltshire Health and Care are considering how to utilize therapy services across both organisations to best effect and a workshop is planned to work through operational detail on 17th December. The aim is to facilitate flow from acute to community services and deploying expertise where it is needed when it is needed from teams that have much to offer flow through the acute setting.

Dorset in reach is continuing to MAU providing a ‘pull’ model, and both Dorset and Hampshire have regular reliable social care presence in the Trust throughout the week.

Dorset have experienced DTOC increases and a meeting is planned for operational staff to discuss making best use of the winter plan for Dorset LA in November.

Delayed Transfer of Care (DToC) Bed Days

National Key Performance Indicators



This graph gives an overall picture of complex discharges in the Trust.

The number of 'green to go' or medically fit for discharge patients has decreased throughout the month slightly however the lost bed days has remained at a higher level, concurring with the picture of fewer patients staying longer. Lost bed days are significantly higher than the summer months when they were first reported. IDS or complex discharges between steady parameters throughout the month, being low at weekends. Medvivo continue to support the front door at weekends, Wiltshire Council have presence in the hospital, screening and supporting discharges and IDB are working to support weekend discharges where possible but it is acknowledged that this is an area requiring attention. IDB will be considering what complex discharges are required over a weekend in the context of Trust discharges as a whole and focus conversations with partners to ensure improvements in this area.

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

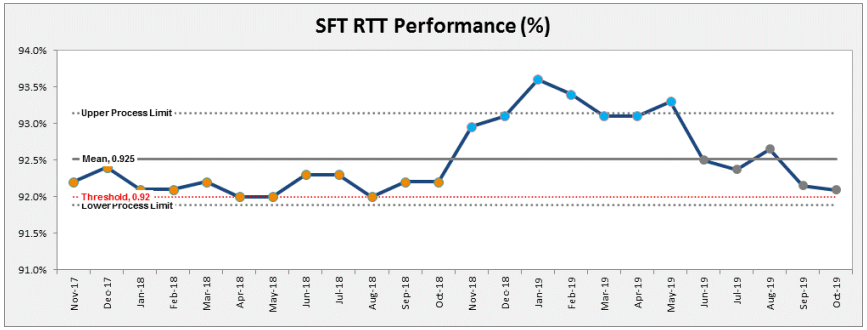
Total WL	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Dorset CCG (11J)	2,537	2,588	2,650	2,762	2,760	2,771	2,832	2,845	2,871	2,889	2,882	2,834
West Hampshire CCG (11A)	1,639	1,666	1,628	1,696	1,748	1,638	1,667	1,690	1,743	1,695	1,682	1,655
Wiltshire CCG (99N)	10,441	10,192	10,384	10,500	10,328	10,540	10,478	10,718	10,630	10,809	10,900	11,050
Other CCGs	2,526	2,411	2,180	2,105	2,113	2,083	2,323	2,498	2,732	2,800	2,822	2,729
Trust Total	**17,143**	**16,857**	**16,842**	**17,063**	**16,949**	**17,032**	**17,300**	**17,751**	**17,976**	**18,193**	**18,286**	**18,268**

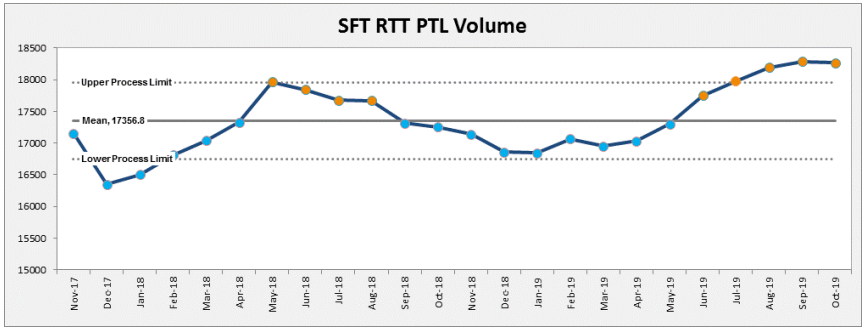
Data Quality Rating:

Performance Latest Month: 92.1%

PTL Volume: 18,268

52 Week Breaches: 0





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

Overall RTT Performance Standard achieved with General Surgery, ENT and Urology continuing to improve: General Surgery **92.8% (+0.14),** ENT **93.62% (+0.68)** and Urology **87.02% (+0.68)**

Dermatology **62.26%** and Plastic Surgery **86.4%** continue to be of concern as large numbers of long waiters are affecting overall compliance with Dermatology predicted waiting for first appointment in excess of 52weeks by April 2020.

Both Oral Surgery **88.08%** and T&O **89.64%** have fallen in performance despite a longer term positive trend. Ophthalmology also fell under target **91.27%.**

The total PTL has reduced by 18 in October but is still above target.

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

Dermatology: Skin Risk Summit held 20th November. Part time medical dermatologist started November.

Ophthalmology: Job plan changes due to commence in January to increase operating capacity to recover RTT position.

Urology: New FT Consultant due to start Feb 20.

Oral: Increased treatment capacity starting in November. Consultant who was off sick for a prolonged has now returned.

Orthopedics: Not effected by maintenance program in Q4, in depth review of capacity and constraints.

Risks to delivery and mitigations

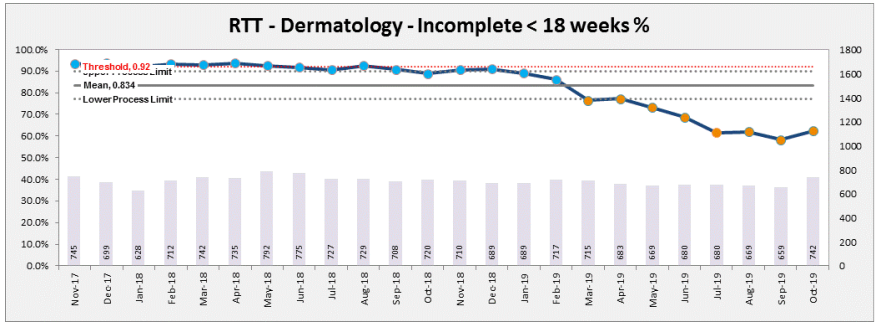
Lack of Capacity in Dermatology and Plastic Surgery.

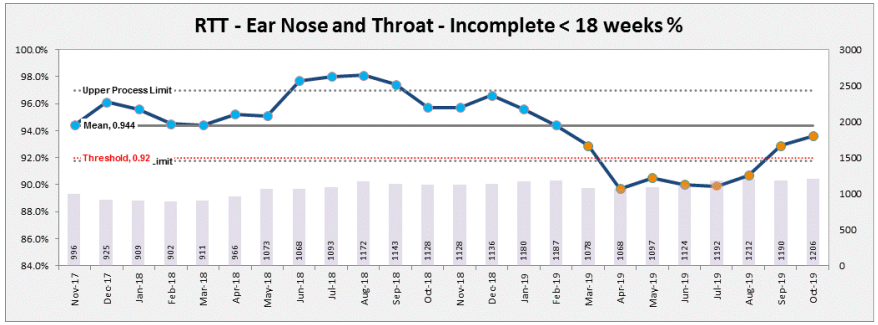
Risk of not achieving performance standard (92%) for November due to long waiters in dermatology as a result of increased referrals, increased IPTs and IPTs a latter stage of pathway. Raised as risk to commissioners and regulators.

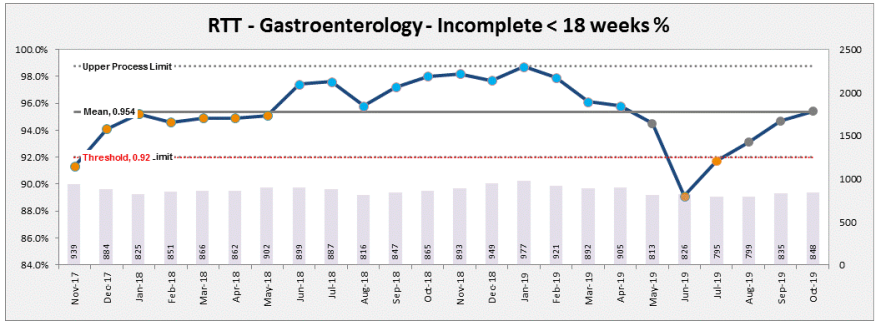
Impact of non elective demand and bed capacity over the winter is the biggest risk.

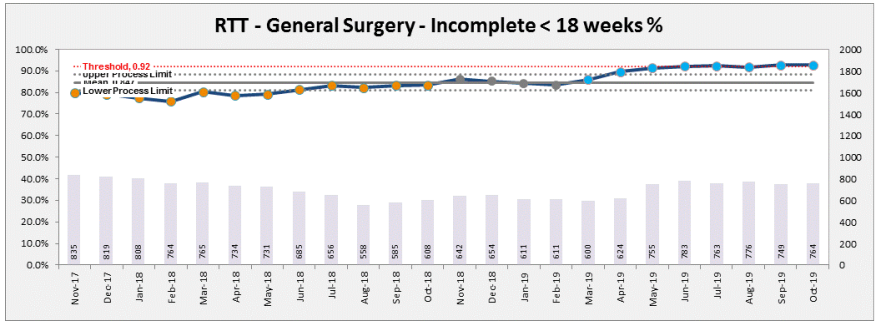
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

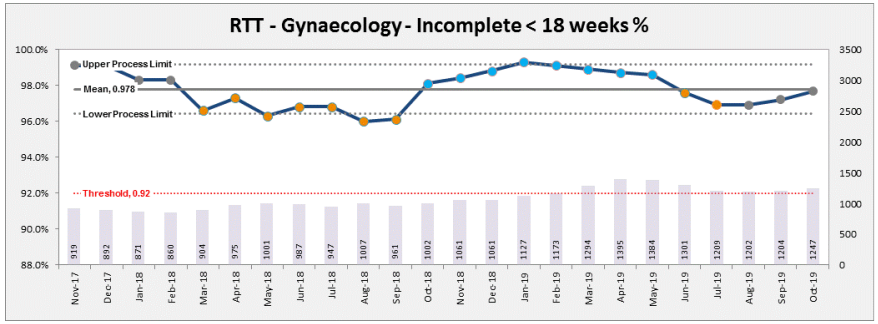
National Key Performance Indicators

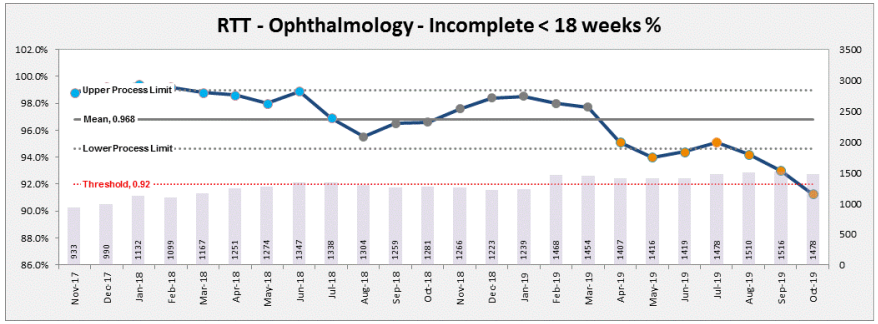






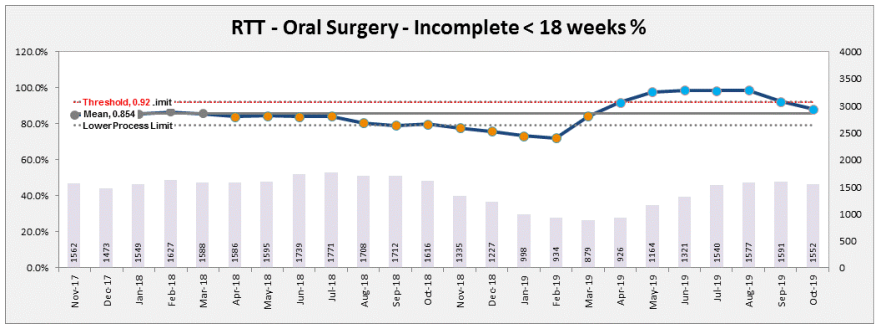


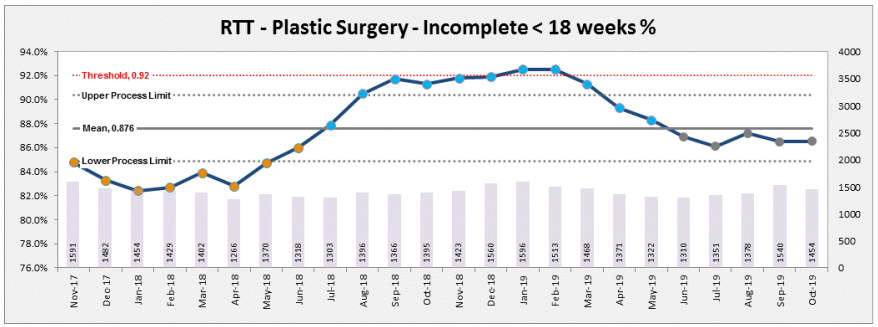


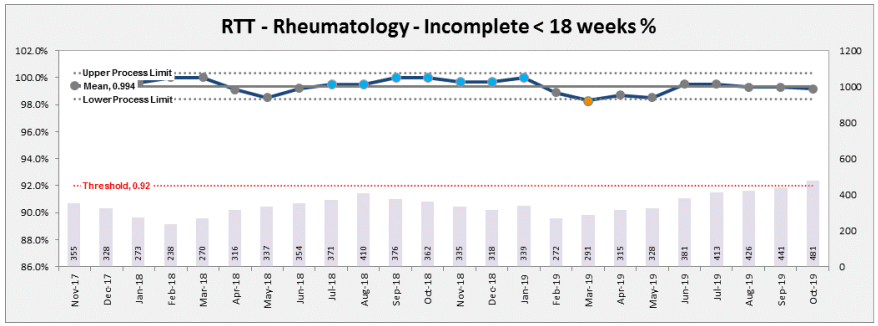


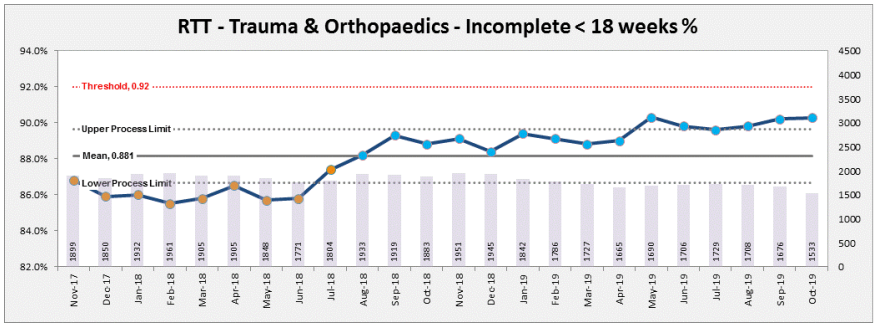
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

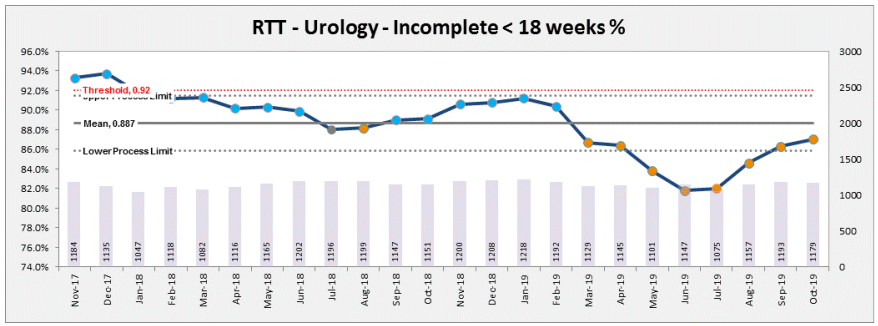
National Key Performance Indicators

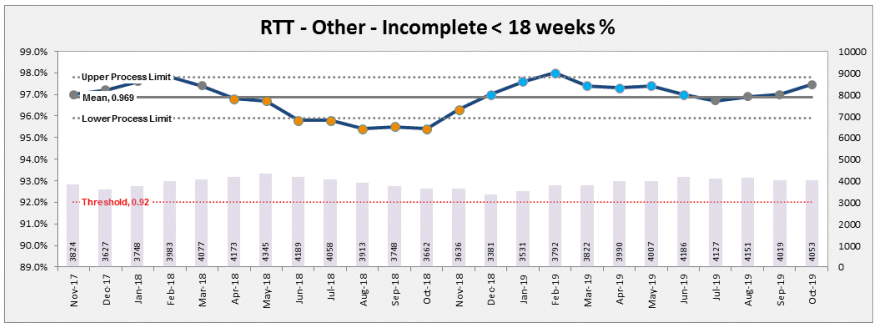






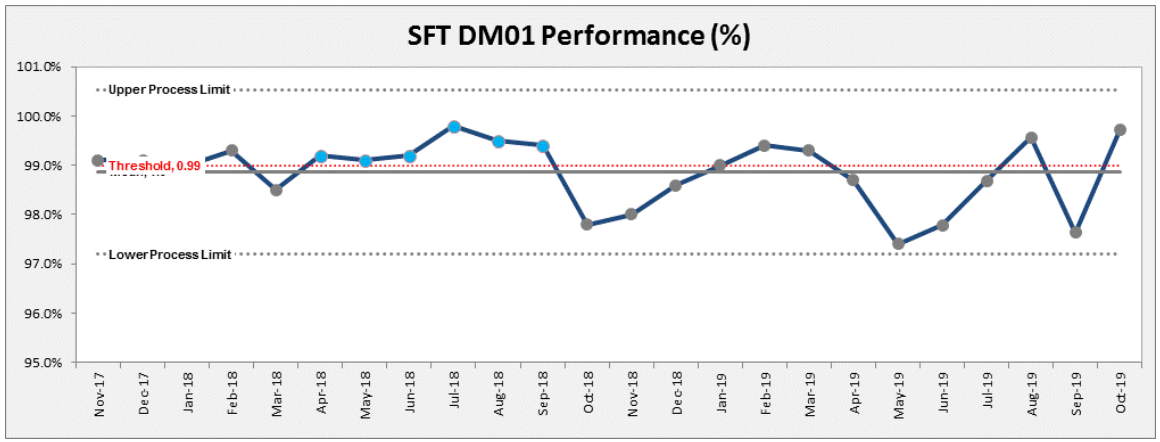






Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	99.7%
Waiting List Volume:	4,144
6 Week Breaches:	12
Diagnostics Performed:	8,111

Background, actions being taken and risks and mitigations

Performance standard achieved in month following resolution of Ultrasound position in M6. November projections indicate no concerns in achievement of target in M8.

Endoscopy

12 in month breaches.

Radiology

0 in month breaches.

Radiology Reporting

Contractual and technical discussions associated with the provision of a second provider for outsourced reporting have concluded. With an expected go live date of 9th December.

Outstanding reports are being monitored on a weekly basis, and clinically prioritised where appropriate.

Audiology

0 in month breaches.

Cancer 2 Week Wait Performance Target 93%

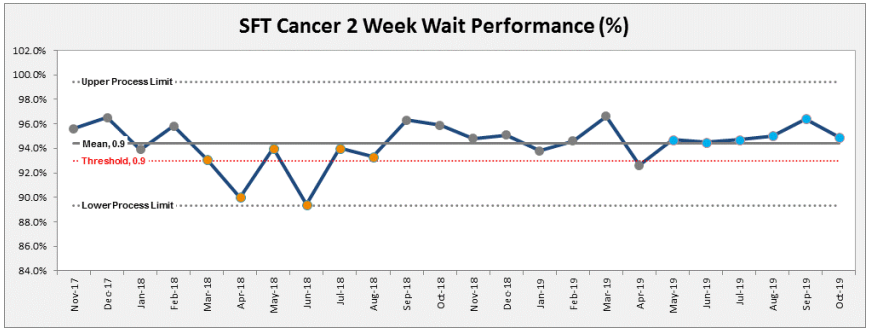
National Key Performance Indicators

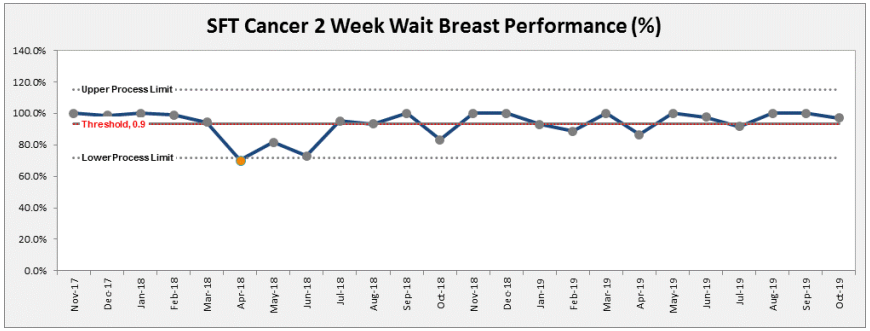
Performance Latest Month:

Data Quality Rating:

Two Week Wait Standard: 94.9%

Two Week Wait Breast Standard: 97.1%





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

Consistent performance for both standards.

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

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

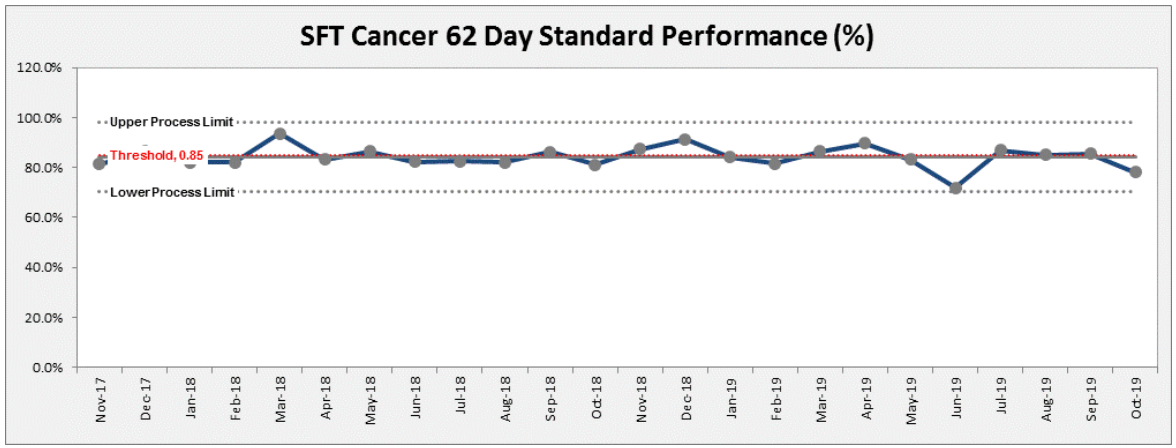
Capacity issues in colorectal, skin and head and neck; all three sites looking at additional clinics pre Christmas.

Risks to delivery and mitigations

Currently on track for November, also already achieved. Q3 also achieved.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard:	78.2%
62 Day Standard (without shared care):	77.3%
62 Day Screening:	81.3%

Risks to delivery and mitigations

Review of all October breaches (15.5) on 22/11/2019 – could improve 62 day position post validation (only 2 possible) though unlikely to meet 62 day (need 10.5 breaches). There are still 34 outstanding histopathology for October, 14 of those now escalated to CSFS as would influence position. Q3 looking more achievable.

Urology: Urology pathway meeting scheduled 06/12/2019. Tertiary delays continue to negatively impact on SFT performance. Pathway meeting will focus on ensuring referrals are made before 31 days.

Dermatology: Skin Risk Summit on 20/11/2019 went well – recovery plan actions and possible start of LWBC for skin patients on SSMP which will free up clinician time to focus on 62 day patients.

Recruitment to Cancer Pathway Navigators underway, interview date 26/11/2019. Successful recruitment to UGI co-ordinator post and interviews scheduled for rapid referral administrator;

SWAG cancer alliance looking to undertake peer review of colorectal cancer services, 07/01/2019.

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:

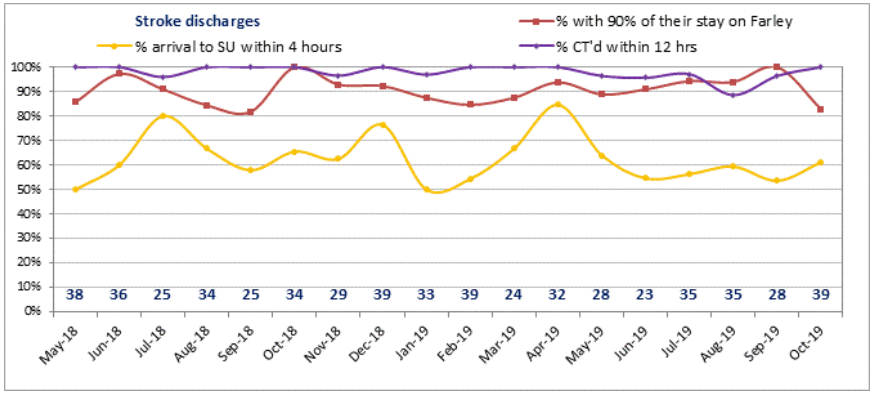
Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20	B			

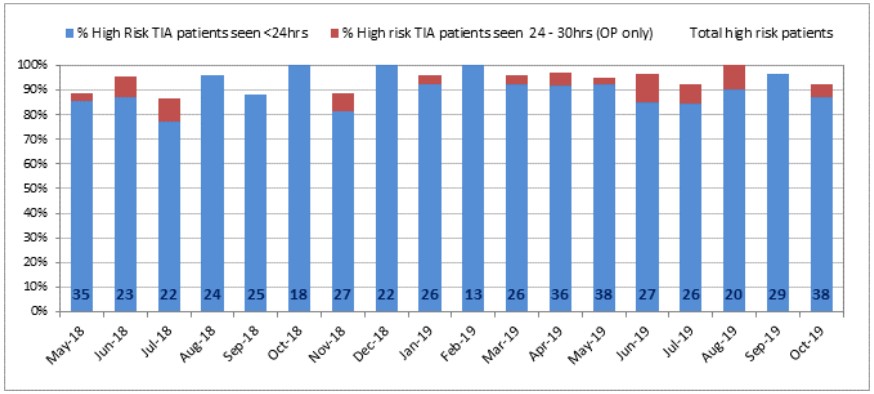
Data Quality Rating:

% Arrival on SU <4 hours: 61.1%

% CT'd < 12 hours: 100%

% High Risk TIA Seen < 24 hours: 86.8%





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

The reduction of patients spending 90% of their time on the stroke unit reflects the need to move patients off the ward to make room for the 35 new incoming stroke patients. and a low number of discharges in October. The national target is 80%.

We continue struggle to get more than 60% of patients to the stoke unit in 4 hrs due to delays waiting to see a doctor in ED (8), direct admission to AMU (4), waiting for a stroke bed (4) and remaining in ED over 4 hours (4). Multiple delays can affect a single patient.

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

SSNAP case ascertainment expected to improve and be sustained at 'A' . Speech and Language Therapists have now been appointed. 3.0wte therapists will be in post on the stroke unit from 6/1/20. This will ensure patients receive the recommended input. Improvements should be seen from Q4 onwards.

Short term trial of a ANP role on the Stroke Unit to assist with patients arriving from ED to the stroke unit within 4 hours is planned.

STP stroke strategic clinical network has been set up to drive improvements for all patients in BSW.

Risks to delivery and mitigations

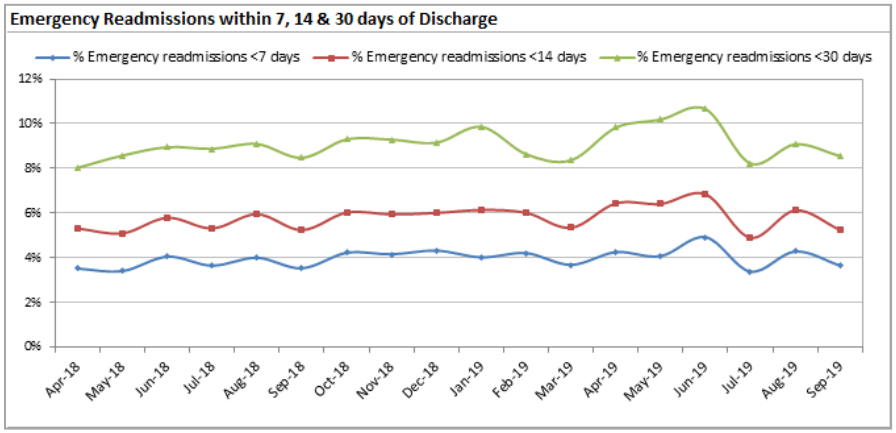
CT capacity to fast-track all patients.

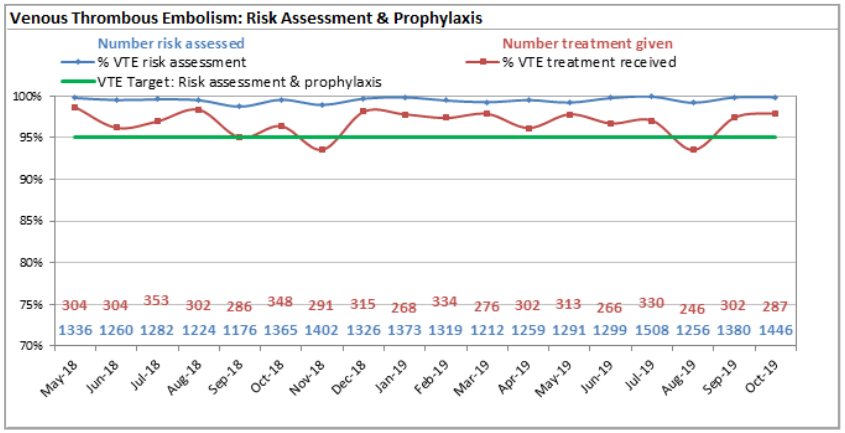
Atypical presentations resulting in delayed diagnosis.

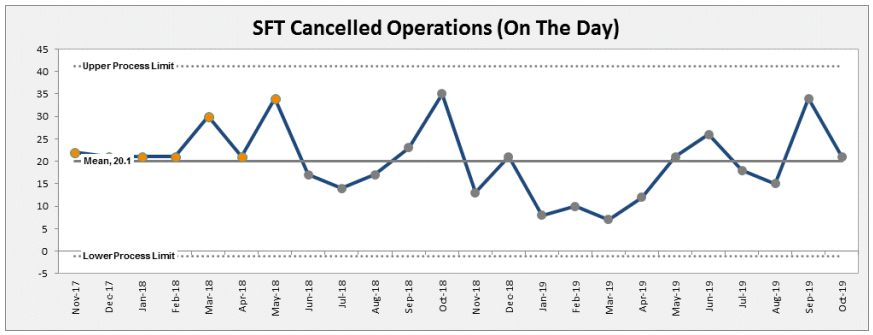
Improvements in streaming to the stroke unit has not started yet as the ANP is currently in training. This is not expected to start until Q4 and will not be a 7/7 service.

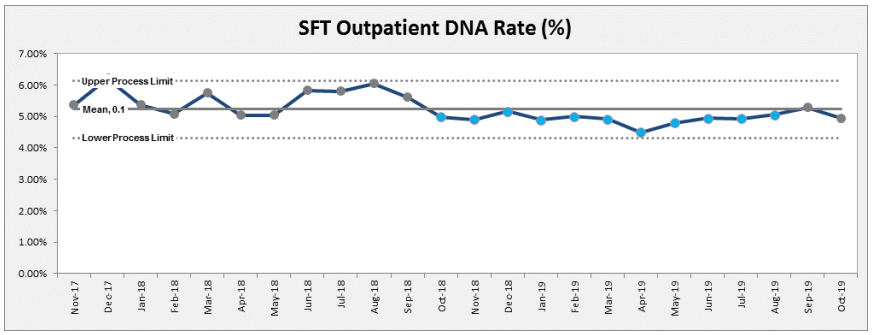
Other Measures

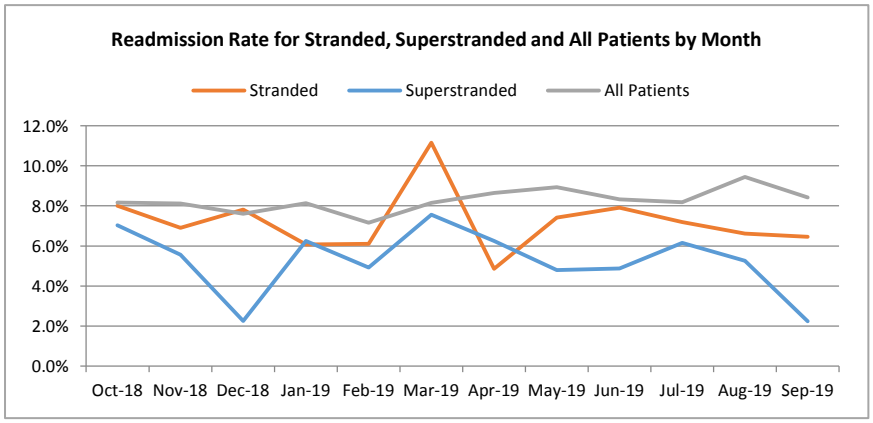
Are We Effective?











Salisbury NHS Foundation Trust

Part 2: Our Care

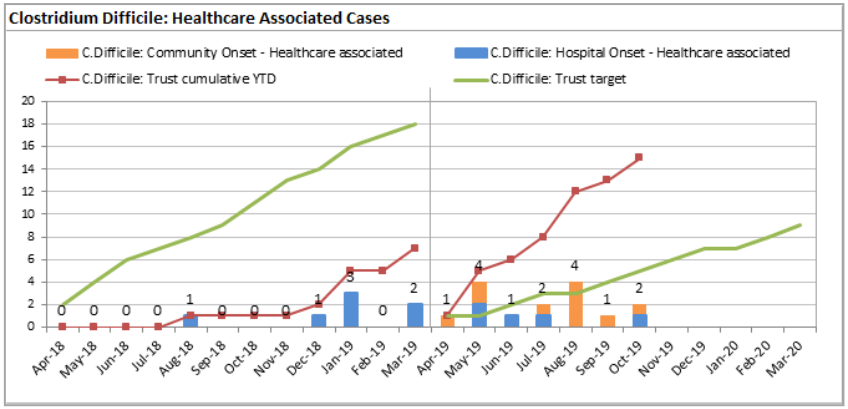
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

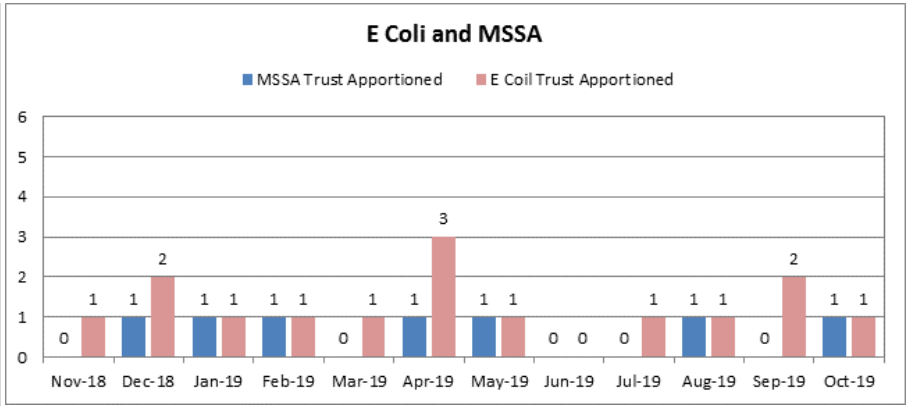
Infection Control

Are We Safe?

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

Data Quality Rating:





Summary and Action

C.Difficile cases have now significantly exceeded the upper limit of 9 cases.

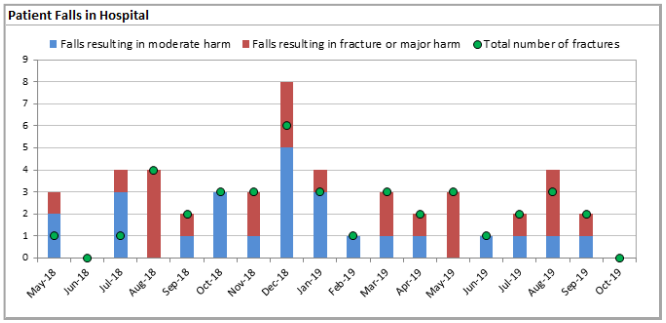
The impact of the changes of the definitions is clear to see in that 5 of the 15 cases were hospital onset with the remaining 10 cases classed as community onset healthcare associated (where patients were discharged within the previous 4 weeks). In October, 7 cases (Wiltshire CCG – 5 cases, West Hants CCG – 2 cases) were submitted for appeal for no lapses in care. Wiltshire CCG confirmed SFT has successfully appealed 5 cases for no lapses in care. NHSI and the CCGs are regularly briefed on this issue with no further action currently.

A deep dive into the year to date cases was completed in October at a joint meeting with the Infection Prevention and Control Team, antimicrobial clinical lead and Pharmacist with the Heads of Nursing to review themes and learning. The main theme was patients being appropriately assessed and documentation. An action plan from a previous CCG critical friend review of C difficile cases in 2015 was revisited. The meeting were assured that the actions implemented in 2015 have been sustained in practice with the exception of the introduction of antibiotic champions.

One E coli septicaemia and Public Health England figures indicate SFT has one of the lowest rates of gram negative infections in the region.

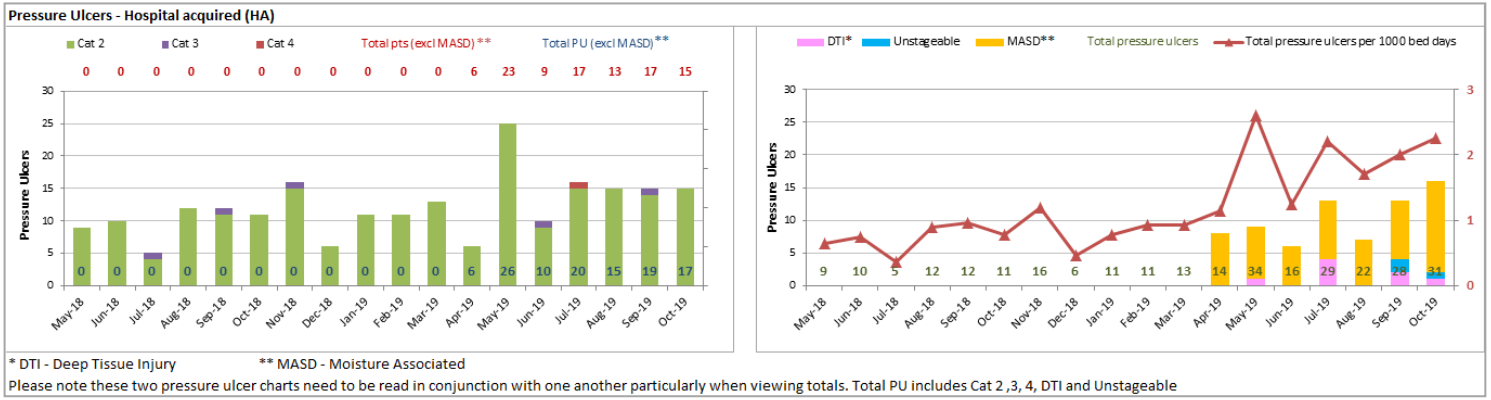
Pressure Ulcers / Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2018-19 Q2	2018-19 Q3	2018-19 Q4	2019-20 Q1	2019-20 Q2
Pressure Ulcers	0.68	0.79	0.88	1.05	1.10
Patient Falls	0.25	0.34	0.20	0.16	0.20



* DTI - Deep Tissue Injury ** MASD - Moisture Associated

Please note these two pressure ulcer charts need to be read in conjunction with one another particularly when viewing totals. Total PU includes Cat 2 ,3, 4, DTI and Unstageable

Summary and Action

Pressure Ulcers - Category 2 pressure damage remains elevated since the change in reporting requirements but figures remain constant since April. There is one suspected deep tissue injury of a patient that would have previously been classified as a Kennedy ulcer (skin failure at end of life) but the change in reporting requirements categorises it as pressure damage. There is one patient with unstageable pressure damage. This is a minimum of a Category 3 ulcer which is currently under investigation.

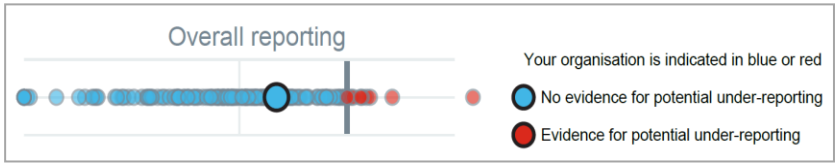
The Tissue Viability Lead Nurse continues to work on improvement actions with the Heads of Nursing & Matrons and the Deputy Director of Nursing. The key to reducing pressure ulcer damage is to introduce a robust education package. Work is being undertaken within the Tissue Viability team to release time to provide this education but may require further resource. The Trust is taking part in a Global event called 'Stop the Pressure' in the week beginning 18 November 19.

Falls - A CQUIN of 3 high impact interventions to prevent hospital falls is in place. Q2 performance showed some improvement to 22% (Q1 - 19%). In October performance improved to 50%. Prevention work is led by the Falls Working Group and reported to the Patient Safety Steering Group.

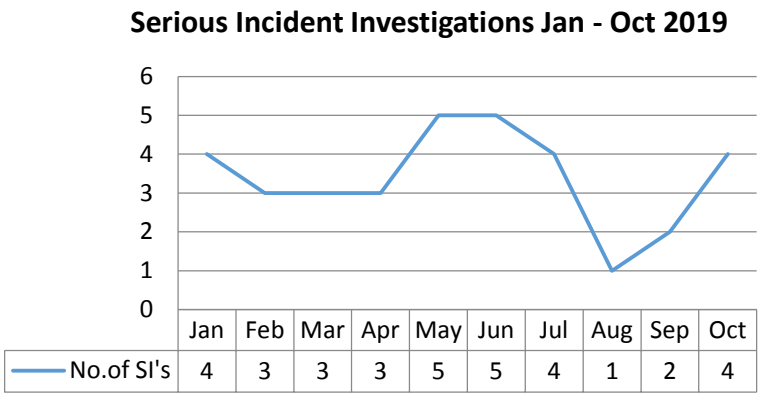
Incidents

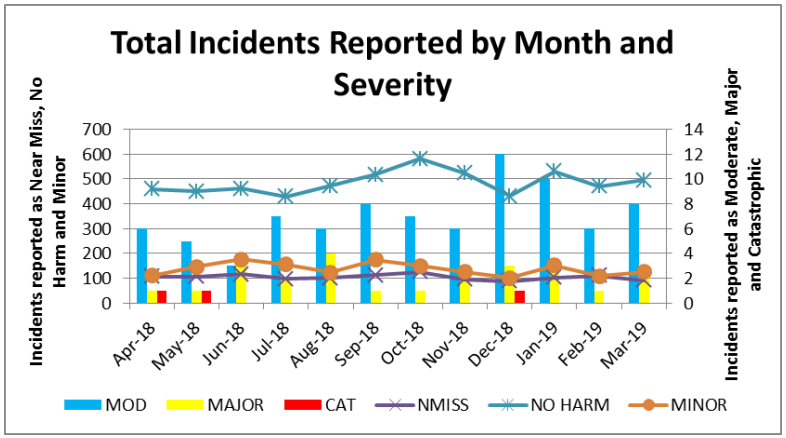
Are We Safe?

Year	2018-19	2019-20
Never Events	3	1



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





Summary and Actions

Four serious incidents in October with no particular themes.

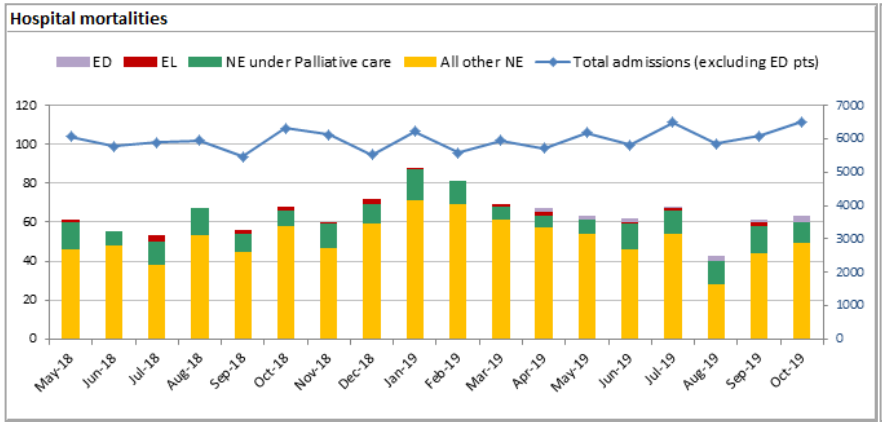
As an outcome of the Trust cancer risk summit, Task and Finish Groups have been formed with leads identified and meetings scheduled. An update on progress will be presented to the Clinical Governance Committee in November 19. A follow-up cancer risk summit is booked for April 2020.

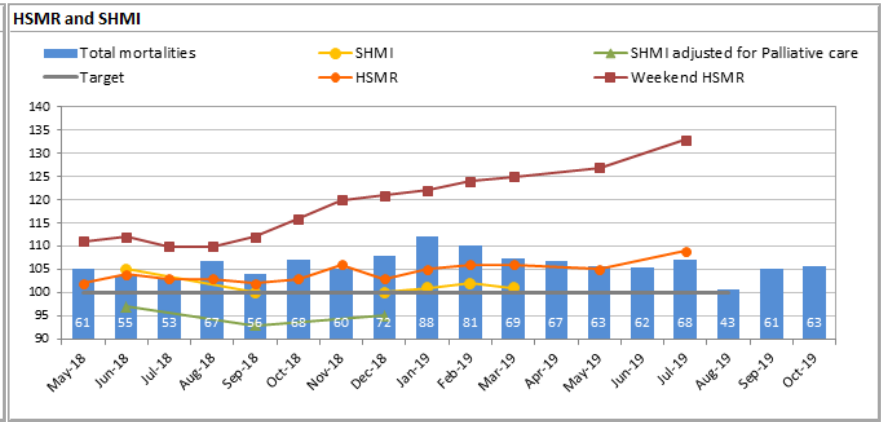
A maternity services thematic review is underway with senior medical and midwifery staff and will be reported to the Clinical Risk Group.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

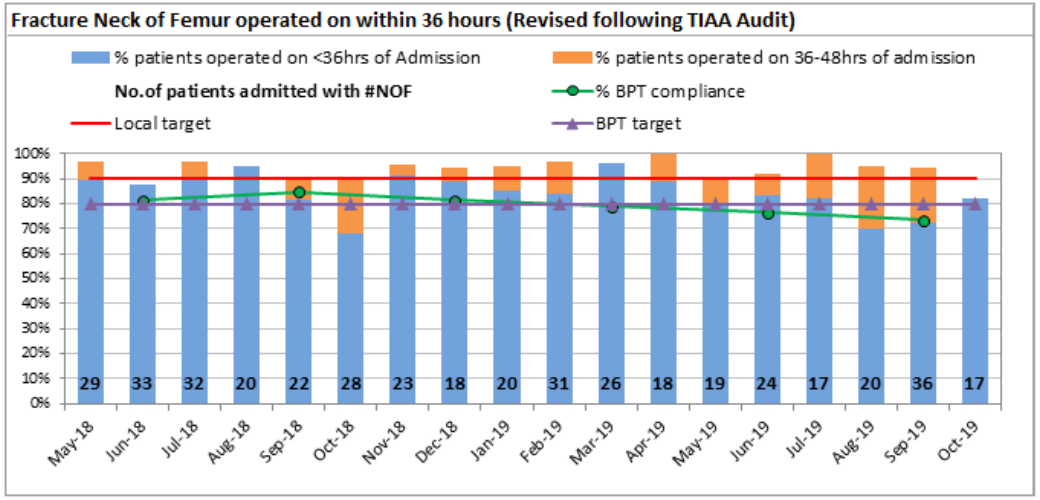
HSMR overall has increased slightly but remains as expected. The rising trend of weekend HSMR to 133.8 is of concern. A review of 78 deaths of patients admitted as an emergency on a Sunday found no direct causal link with patients being admitted as an emergency at a weekend. A report on weekend safety and effectiveness was presented to CGC in September. An action plan to mitigate the risk factors was presented to the Trust Board in November 2019. The action plan describes actions the executive team are leading on to address these issues, including working with partners to reduce inappropriate admissions, review of clinical pathways, uplifts in staffing in key areas, improving deployment and utilization of existing staff and improved documentation and coding.

A case notes review of a new, higher than expected relative risk of mortality in gastrointestinal haemorrhage took place in October as did a review of 33 patients with a hip fracture and these will be reported in Q3.

Fracture Neck of Femur

Are We Safe?

Data Quality Rating:



Summary and Action

An improvement in October of patients being operated on within 36 hours of admission. Four patients had surgery between 49 – 63 hours after admission due to waiting for theatre space and kit.

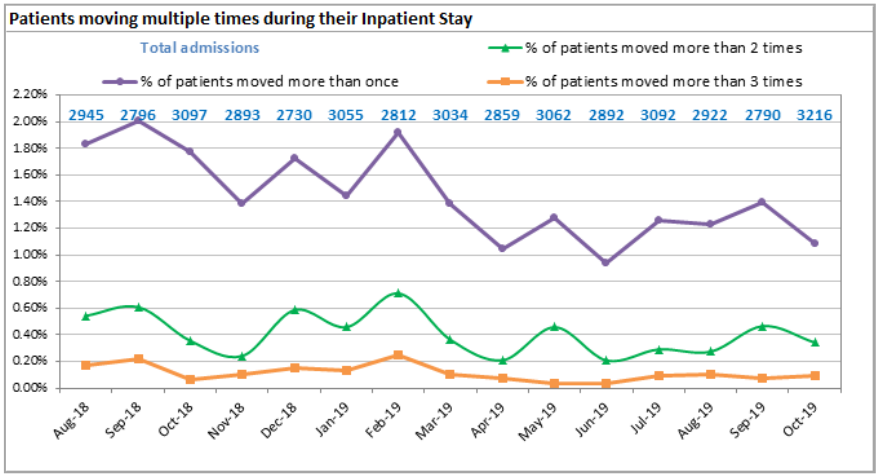
Dr Foster's data showed an upward trend in the relative risk of death of patients with a fractured neck of femur but still remains within the expected range. A multidisciplinary review of 33 hip fracture deaths was completed in October and will be reported to the Mortality Surveillance Group in February.

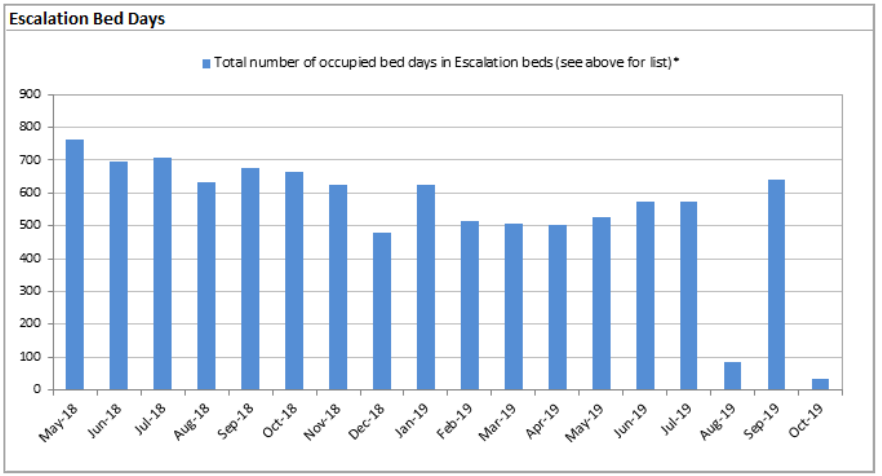
Patient Experience

Are We Safe?

Last 12 months	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Bed Occupancy %	96.8	92.5	96.3	94.4	91.4	92.6	92.5	93.5	93.3	94.1	96.9	94.9

Data Quality Rating:





Summary and Action

Escalation bed capacity reduced to its lowest level this year in a quiet October.

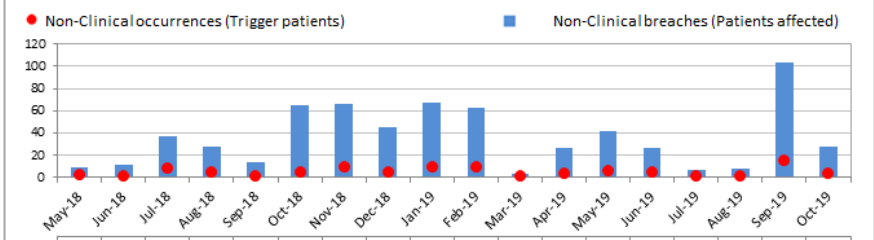
The 'Ready Steady Go' patient flow improvement work continues with a focus on increasing the number of patients discharged before midday and with multi-agency partners to decrease the number of delayed transfer of care, stranded and super stranded patients.

Patient Experience

Are We Safe?

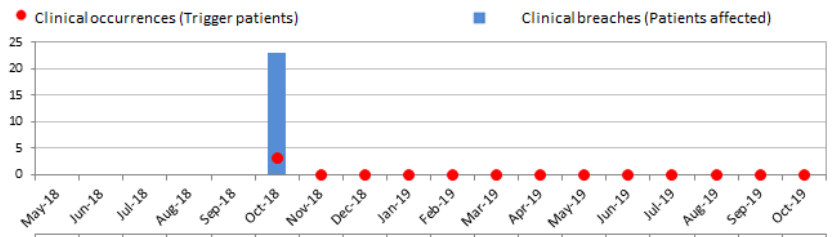
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
■	9	11	37	28	14	65	66	45	67	62	3	26	42	27	7	8	103	28
●	2	1	8	5	1	5	10	5	10	9	1	4	6	5	1	1	15	4

Delivering Same Sex Accommodation - Clinical



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
■						23	0	0	0	0	0	0	0	0	0	0	0	0
●						3	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

A significant decrease in non-clinical mixed sex accommodation breaches in October. Those patients affected were all in AMU and were all resolved within 24 hours.

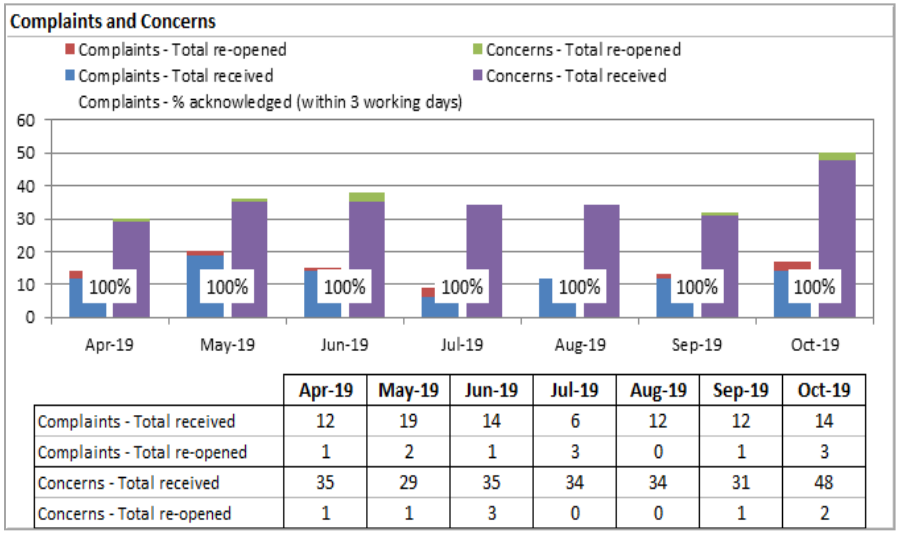
Privacy and dignity is maintained during these times with the use of quick screens and identification of separate bathroom facilities.

The Chief Nursing Officer, England wrote to Trusts in September about the revised policy and reporting requirements on delivering same sex accommodation. Local meetings are taking place with staff and will need to take place with the CCG to decide how breaches will be reported in line with the revised national guidance.

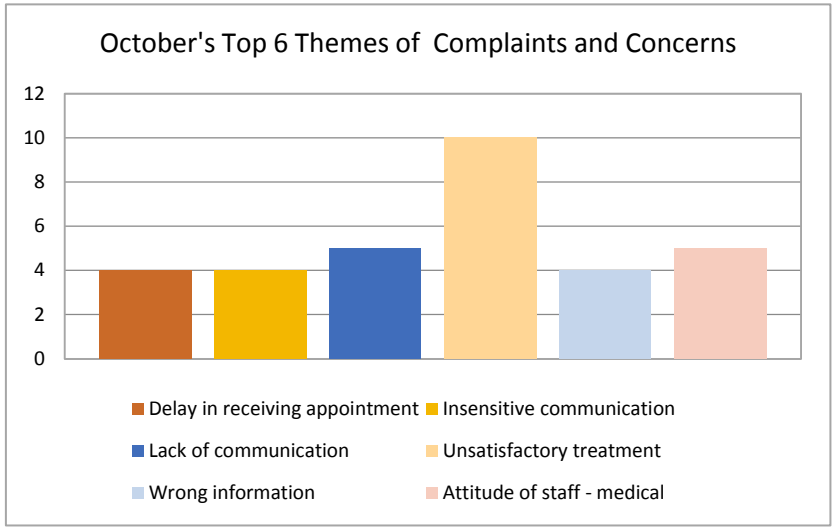
Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

Data Quality Rating:



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



Summary and Actions

The top 6 themes of complaints/concerns:

1. Unsatisfactory treatment
2. Attitude of staff
3. Lack of communication
4. Insensitive communication
5. Delay in receiving appointments
6. Wrong information

These themes are being acted upon by the clinical directorates.

Part 3: Our People

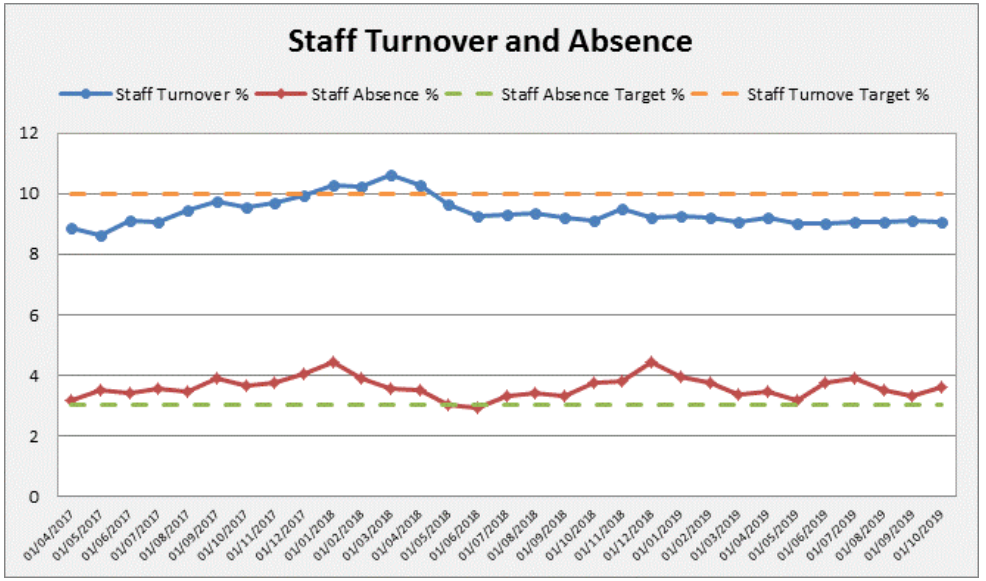
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Oct '19		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	403.6	420.1	(16.5)
Nursing	942.7	941.2	1.5
HCAs	407.0	548.2	(141.1)
Other Clinical Staff	609.2	603.5	5.7
Infrastructure Staff	1,201.9	1,082.8	119.2
TOTAL	**3,564.5**	**3,595.8**	**(31.3)**



Summary and Action

The number of leavers in October remained steady at 24 and staff in post was also static, with turnover consequently reducing slightly to 9.05%, below the target of 10%. In ward nursing areas vacancies are reducing steadily, or being eliminated, due to the significant number of overseas recruits arriving. However, this produces a challenge in terms of those individuals who are only able to operate at Band 4 level whilst they study for and take their Objective Structured Clinical Examination (OSCE) which they must do within 12 weeks of entering the country. The hard to recruit posts, mostly medical and AHP vacancies, are the focus of attention and in some areas (Radiology and Histopathology are examples) are being covered by outsourcing.

The sickness absence rate has increased to 3.6%, over the target of 3%. With a slight decrease in the percentage of long term sickness due to people either returning to work or leaving, there has been a sharp increase in the incidence of short term sickness which seems to be indicating a combination of stress and seasonal (coughs, colds, flu) reasons for absence although Estates and Facilities are facing particular challenges with MSK issues. Currently the People Business Partners are targeting the short term cases, ensuring that staff are supported in returning to work and appropriate action is taken at the trigger points at the same time as continuing to drive down long term absence.

The seasonal elements of the sickness absence rate provide us with an opportunity to continue to promote the flu vaccination which currently stands at 53% uptake for front line staff. In terms of the stress related absences we are paying particular attention to multiple absences from the same area which may require group intervention and making speedy referrals to Occupation Health for individual issues.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

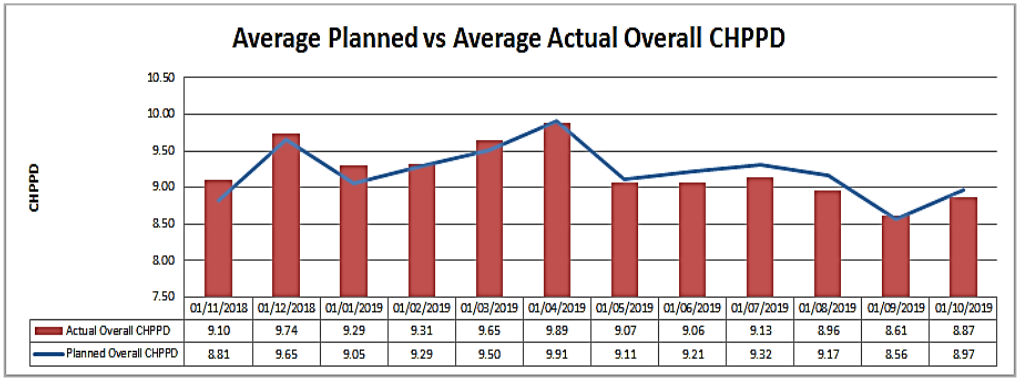
Table 1

Day	RN	HCA
Total Planned Hours	39270	21056
Total Actual Hours	36558	21947
Fill Rate (%)	93%	104%

Night	RN	HCA
Total Planned Hours	25188	12623
Total Actual Hours	25574	14591
Fill Rate (%)	102%	116%

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

Table 2



Summary and Action

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

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

2 wards flagged red this month for actual unfilled hours (based on internal rag ratings) – Pembroke and Whiteparish wards both at 78% for RN days.

The skill mix of RN:HCA remains broadly stable with a slight increase for RN to 63% and drop for HCA to 39% (broad recommendation is 65%:35%, but this varies across specialties).

RN vacancy at ward level currently 115wte vacancies across the Trust, however there are approximately 80 nurses at Band 4 level completing OSCE so the number of true vacancy is much lower.

Nurse agency expenditure in month was up approx £10k on last month, although at £231k was still £170k less than last year. Areas with a significant rise in month include ED (12k), Durrington (11k) ,Theatres (21k) and Tamar (8k). Agency expenditure YTD is £1,300,00 less than last year and overall nursing budgets are £760k underspent.

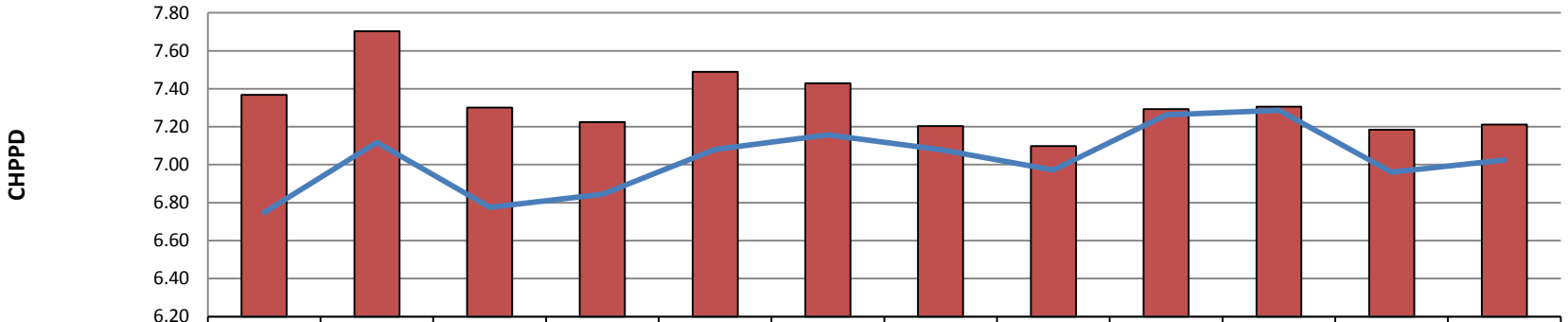
Nurse sensitive indicators remain broadly stable – anomalies with changes in national reporting requirements for clostridium difficile and pressure ulcers. NSI's should be reviewed in context of staffing levels – increases in NSI's can be associated with suboptimal staffing levels. Slight increase in pressure ulcers seen in month but a reduction in falls. All will be subject to close review to ensure lessons learnt.

Workforce – Nursing and Care

Use of Resources

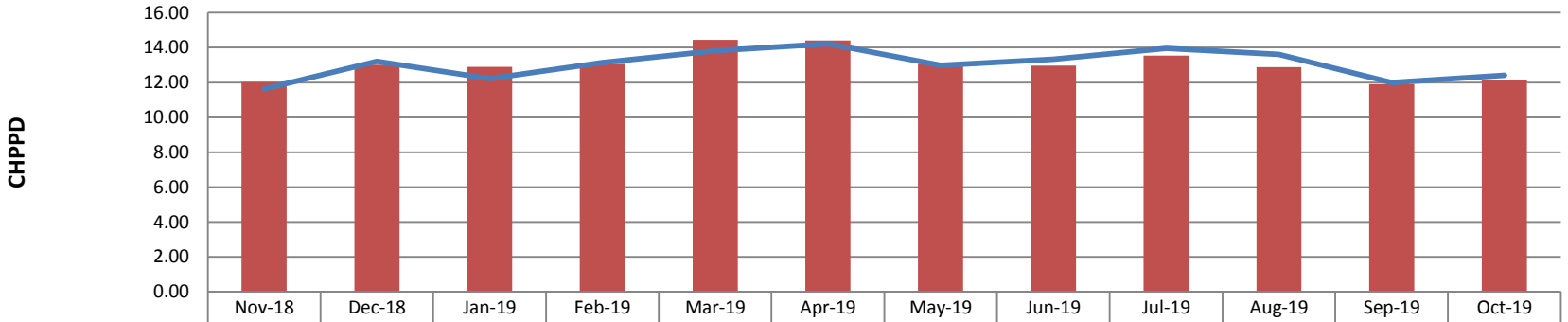
Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend by Directorate

Average Overall CHPPD for Medicine



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Actual CHPPD	7.37	7.70	7.30	7.22	7.49	7.43	7.20	7.10	7.29	7.31	7.18	7.21
Planned CHPPD	6.75	7.12	6.77	6.84	7.08	7.16	7.08	6.97	7.26	7.29	6.96	7.02

Average Overall CHPPD for Surgery

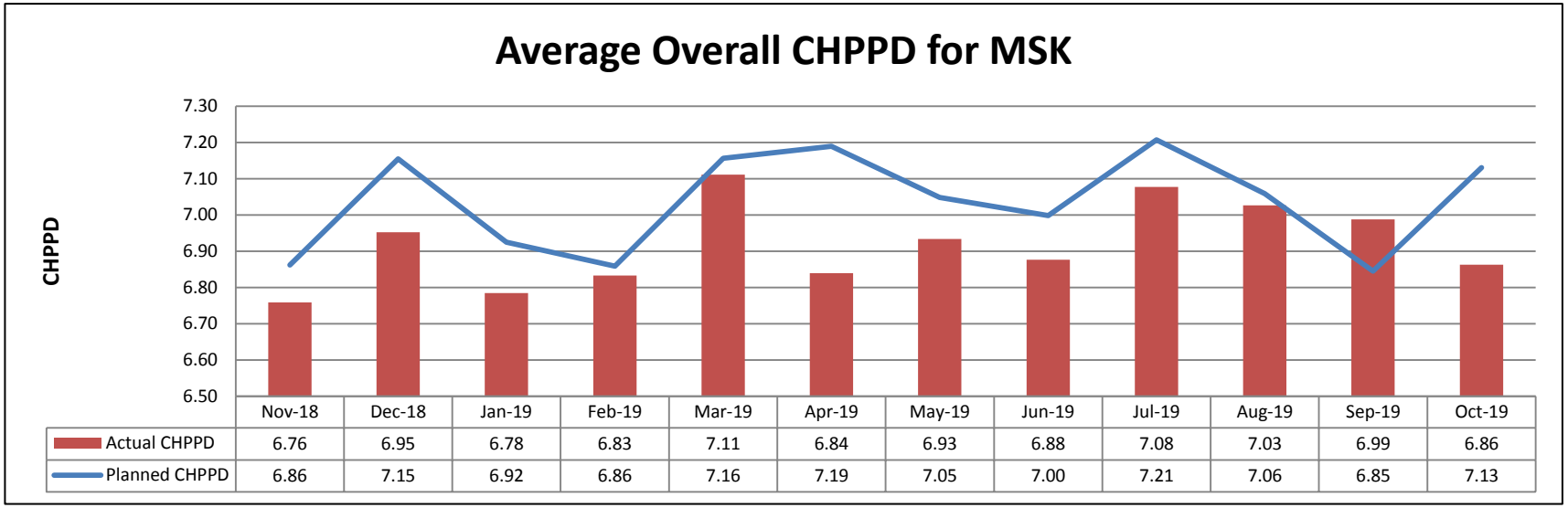


	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Actual CHPPD	12.03	13.02	12.89	13.08	14.44	14.40	13.07	12.96	13.54	12.88	11.90	12.15
Planned CHPPD	11.63	13.21	12.23	13.14	13.81	14.21	12.99	13.34	13.96	13.61	11.98	12.42

Workforce – Nursing and Care

Use of Resources

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

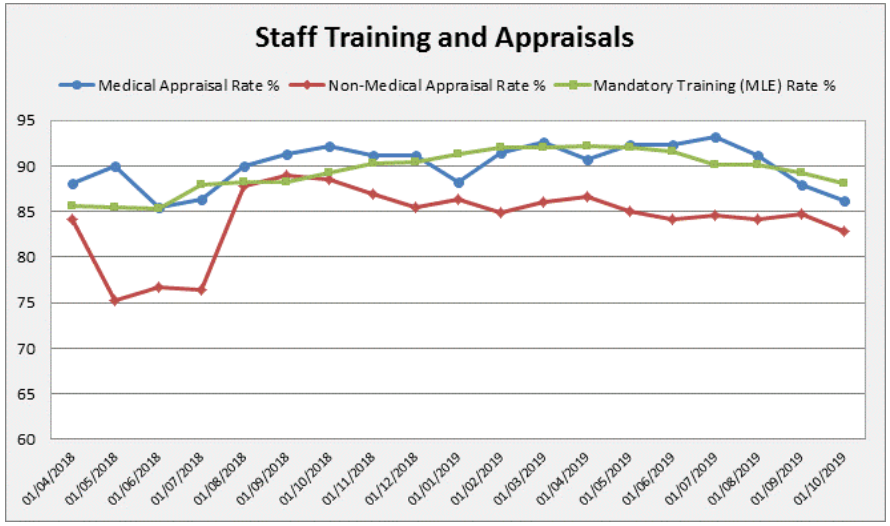


	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Actual CHPPD	6.76	6.95	6.78	6.83	7.11	6.84	6.93	6.88	7.08	7.03	6.99	6.86
Planned CHPPD	6.86	7.15	6.92	6.86	7.16	7.19	7.05	7.00	7.21	7.06	6.85	7.13

Workforce – Staff Training and Appraisals

Use of Resources

Salisbury NHS Foundation Trust Workforce Dashboard	Training	Appraisal	
	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend			
Month Trend	↓	↓	↓
Target	85.00%	90.00%	85.00%
Apr-19	92.19%	90.65%	86.70%
May-19	91.99%	92.31%	85.05%
Jun-19	91.60%	92.42%	84.08%
Jul-19	90.20%	93.25%	84.59%
Aug-19	90.22%	92.19%	84.15%
Sep-19	89.27%	87.95%	84.77%
Oct-19	88.12%	86.17%	82.91%
totals	90.51%	90.71%	84.61%



Summary and Action

Training

Although still above target at 88%, compliance for mandatory training has been dropping for the last 3 months seemingly as a result of operational challenges to releasing people. This month we have identified hotspot subjects and areas. Hand Hygiene appears regularly, Information Governance is of concern and Level 2 Safeguarding Adults has been mentioned by two Directorates. Business Partners are continuing to work with their DMTs to improve compliance.

Non Medical Appraisals

With similar operational challenges to releasing people for the appraisal meeting, compliance has dropped to 82.9%, below the 85% target and three of the Directorates are below target internally. DMTs have identified their hotspots and are committed to returning to full compliance. Some hotspot areas are reporting that staff sickness has affected their ability to conduct timely appraisals. Individual compliance is being tracked where Directorates are below target and at least one will return to full compliance in November, with the others following by the end of this quarter.

Medical Appraisals

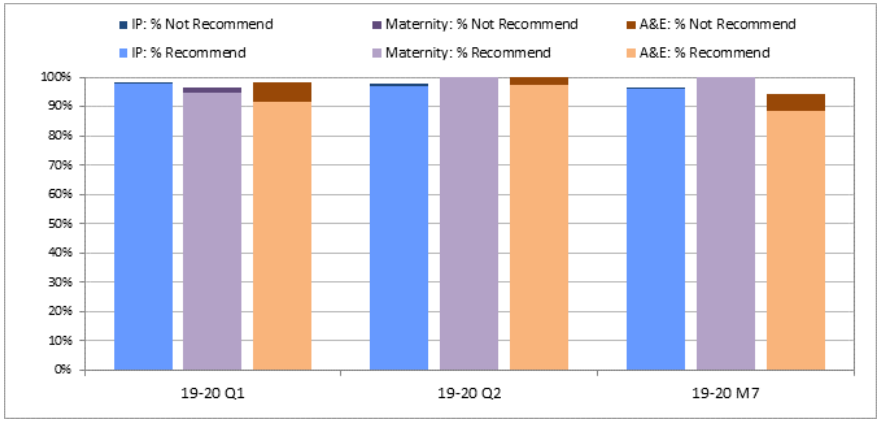
Having maintained above the target compliance of 90% for the first five months of this year there has now been a slight dip in compliance to 86.17% for October. There has been a change in the administration team who manage medical appraisals and this appears to be a contributory factor which we will ensure is reduced if it cannot be eliminated altogether.

The Business Partners are following up with Clinical Directors and there is one particular Directorate that has much lower compliance than the others, where some additional assistance will be focussed.

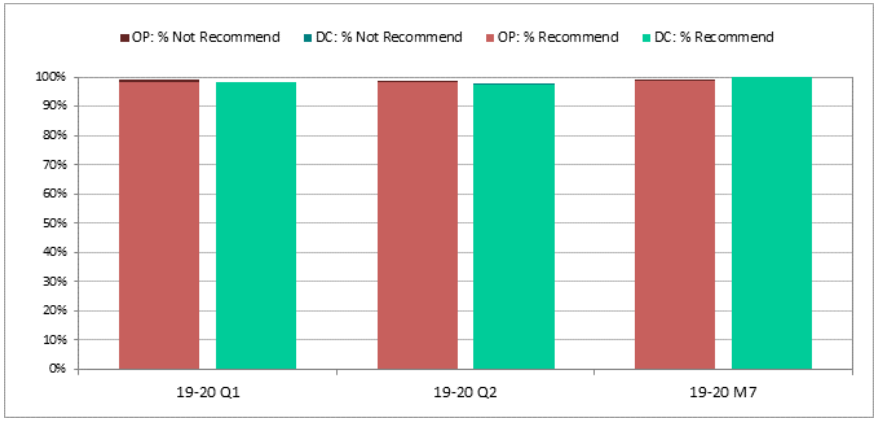
Friends and Family Test – Patients and Staff

Use of Resources

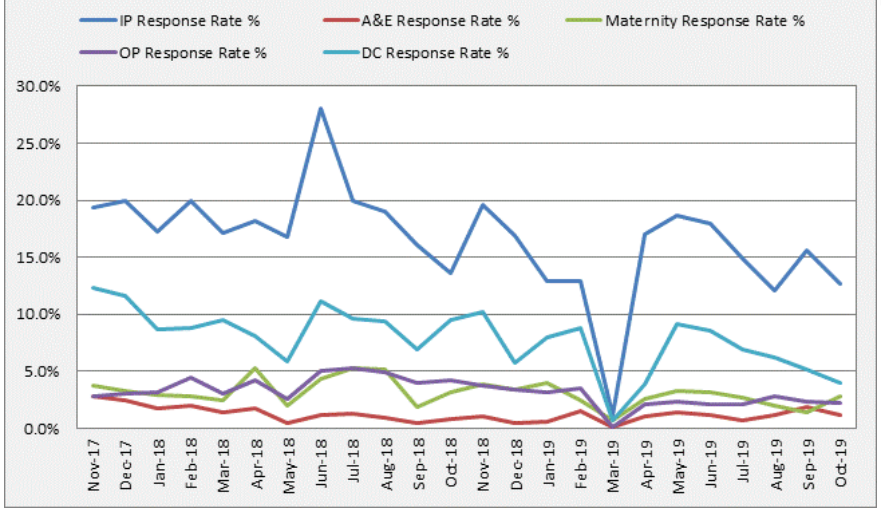
Patient Responses: Inpatient, Maternity and A&E



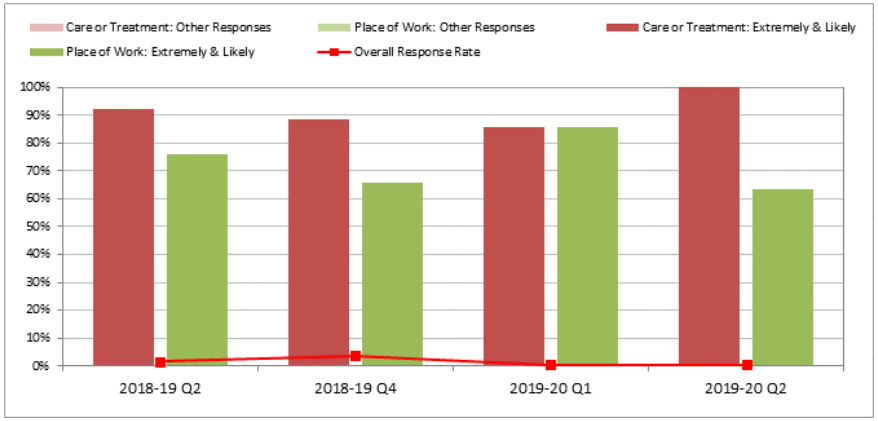
Patient Responses: Outpatient and Daycase



SFT Friends & Family Response Rates %



Staff Responses: Place of Work and Place of Care



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

Part 4: Use of Resources

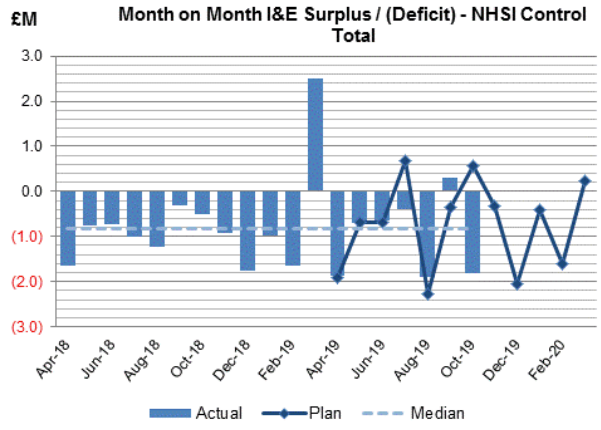
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Oct '19 In Mth			Oct '19 YTD			2019/20
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	18,671	17,561	(1,110)	121,783	119,239	(2,544)	208,163
Other Clinical Income	779	934	155	5,423	6,008	585	9,322
Other Income (excl Donations)	2,359	2,465	106	16,397	16,678	281	28,307
Total income	**21,809**	**20,961**	**(848)**	**143,603**	**141,925**	**(1,678)**	**245,792**
Operating Expenditure							
Pay	(13,055)	(13,388)	(333)	(91,811)	(92,485)	(674)	(157,326)
Non Pay	(6,770)	(7,884)	(1,114)	(46,450)	(46,909)	(459)	(80,163)
Total Expenditure	**(19,825)**	**(21,272)**	**(1,447)**	**(138,261)**	**(139,395)**	**(1,134)**	**(237,489)**
EBITDA	**1,984**	**(312)**	**(2,296)**	**5,342**	**2,531**	**(2,811)**	**8,303**
Financing Costs (incl Depreciation)	(1,430)	(1,496)	(66)	(10,008)	(9,549)	459	(17,157)
NHSI Control Total	**554**	**(1,807)**	**(2,361)**	**(4,666)**	**(7,019)**	**(2,353)**	**(8,854)**
Add: impact of donated assets	105	(21)	(126)	735	(237)	(972)	1,260
Add: Impairments	0	0	0	0	0	0	0
Add: Central MRET	174	174	(0)	1,216	1,216	(0)	2,082
Add: PSF & FRF	677	0	(677)	3,047	2,544	(503)	6,772
Surplus/(Deficit)	***1,510***	***(1,654)***	***(3,164)***	***332***	***(3,496)***	***(3,828)***	***1,260***



Variation and Action

The NHSI control total deficit of £1.8m is significantly wore that the £0.5m surplus that had been planned for. The forecast presented to F&P in early September had assumed a £0.1m deficit, and the review of revenue recognition undertaken in M06 had added another £1.1m to this figure, but this still leaves actual reported figures £0.6m worse than anticipated.

Shortfalls against forecast are driven by two key factors:

- Non Pay, specifically spend on clinical supplies and services where spend has increased over and above that which would have been expected based on changes in activity alone.

- Nursing costs, where increased escalation combined with the supernumerary cost of newly recruited overseas nurses are both over and above that which had been expected.

The Trust is in the process of recruiting intakes of overseas nurses, an exercise with upfront costs but a payback period of approximately 9 months per nurse. This strategy has led to a 75% reduction in monthly nursing agency costs, although there remains an opportunity of £0.5m per month in temporary staffing.

Underlying challenges remain the same as in previous periods, with shortfalls in clinical productivity and increasing agency spend on hard to fill posts driving adverse variances against plan. In addition, there is increasing pressure on the bed base due to emergency admissions.

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

Income & Activity Delivered by Point of Delivery

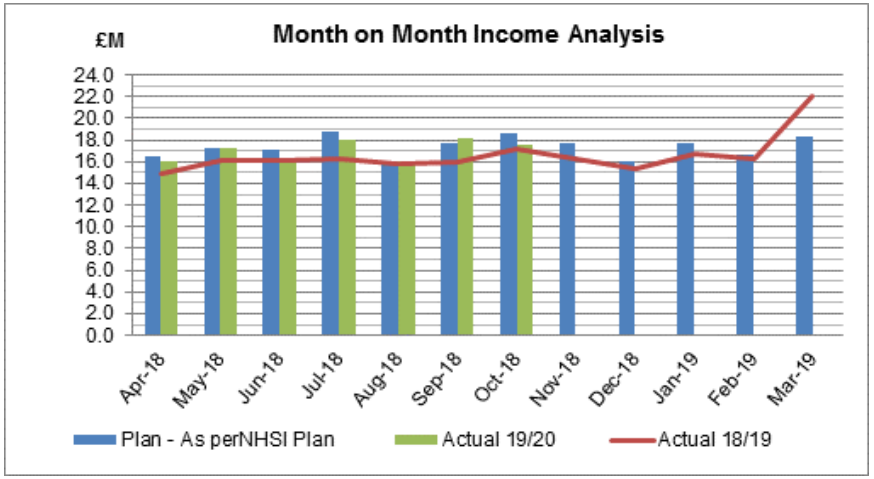
Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Oct '19 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	5,289	5,226	(63)
Elective inpatients	11,232	10,450	(782)
Day Case	10,471	9,984	(487)
Non Elective inpatients	33,291	32,433	(858)
Obstetrics	3,672	3,564	(108)
Outpatients	19,741	18,993	(748)
Excluded Drugs & Devices (inc Lucentis)	10,098	10,398	300
Other	27,989	28,191	202
TOTAL	**121,783**	**119,239**	**(2,544)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	65,503	65,439	(64)
Dorset CCG	13,969	13,792	(177)
West Hampshire CCG	9,737	9,867	130
Specialist Services	18,685	18,161	(524)
Other	13,889	11,980	(1,909)
TOTAL	**121,783**	**119,239**	**(2,544)**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance		Last Year Actuals	Variance against last year
Elective	3,169	2,845	(324)		3,032	(187)
Day case	13,275	13,407	132		12,480	927
Non Elective	16,478	15,601	(877)		15,117	484
Outpatients	156,852	150,552	(6,300)		148,310	2,424
A&E	41,088	41,183	95		39,567	1,616



Variation and Action

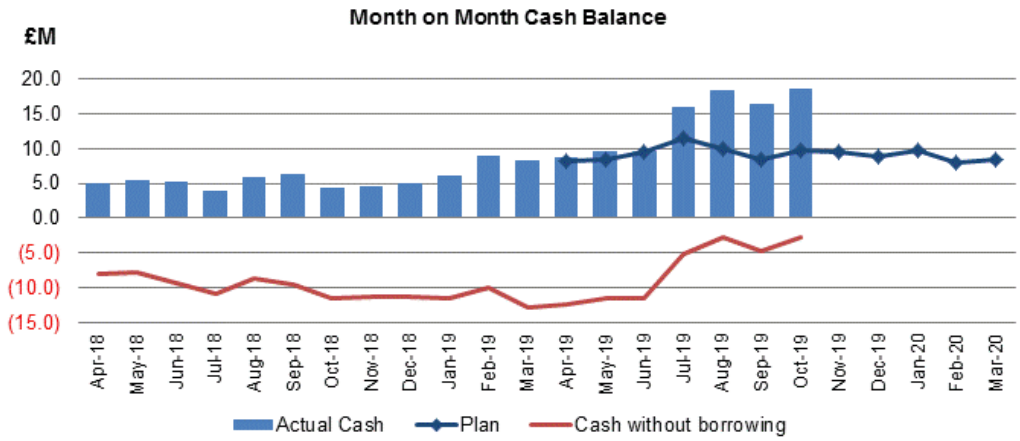
Income to date is £119,239k, £2,544k below plan and an under performance of £1,110k in October. Income has under performed on all points of delivery year to date with the exception of Excluded drugs and devices and Other. Cardiology Day cases are 165 cases and £251k below plan year to date due to the Pensions impact and Orthopaedics Day cases are 76 cases and £218k below plan with a deterioration of 31 cases in month. Elective Orthopaedics are now 168 spells below the year to date plan of 756 which is a deterioration of 28 cases in month. The Non Elective position year to date position is driven by a combination of under performance on spells, mainly within Trauma and Orthopaedics and Cardiology, and excess bed days activity. The in month Non elective spells position was above the activity plan for the first month this year. The Outpatients position is driven by underperformance across a range of specialties most notably in Dermatology due to Consultant vacancies with cover being provided by other specialties.

An adjustment of +£1,527k is included to reflect the blended approach, +£1,443k for Wiltshire CCG and +£84k for West Hampshire CCG, due to under performance on the non elective element of the contract. An adjustment of +£181k is included to increase income to reflect the under performance on the Dorset managed contract at Month 7. An adjustment of £593k is included to increase income to reflect the minimum income guarantee with Wiltshire CCG at Month 7. The total impact is £2,301k included within the income position.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources

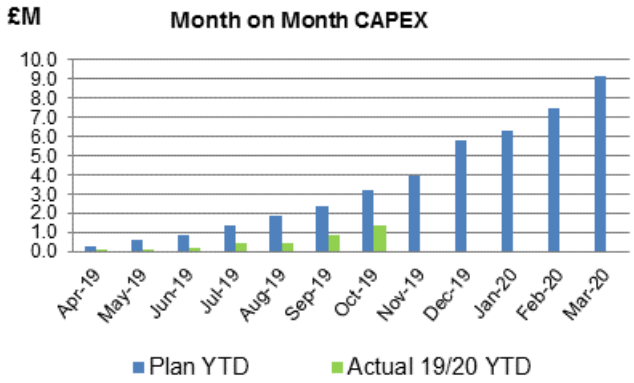


The Trust's cash position was assisted in the month by the quarterly payment in advance from Health Education England and MRET funding covering the period to 31 December 2019. The cash position is also higher than planned due to limited expenditure on the capital programme to date.

The cash flow will continue to be closely monitored during 2019-20 to ensure funds are available when required. Although the Trust is not planning for additional borrowing in 2019/20 this will be constantly reviewed in line with the financial performance to date, forecast for the remainder of the year and anticipated significant capital expenditure in the last quarter of the year.

Capital Expenditure Position

Schemes	Annual Plan £000s	Oct '19 Plan £000s	Oct '19 Actual £000s	Oct '19 Variance £000s
Building schemes	700	0	0	0
Building projects	1,814	890	370	520
IM&T	3,540	1,400	360	1,040
Medical Equipment	2,650	665	211	454
Other	420	245	248	0
TOTAL	**9,124**	**3,200**	**1,186**	**2,014**



Summary and Action

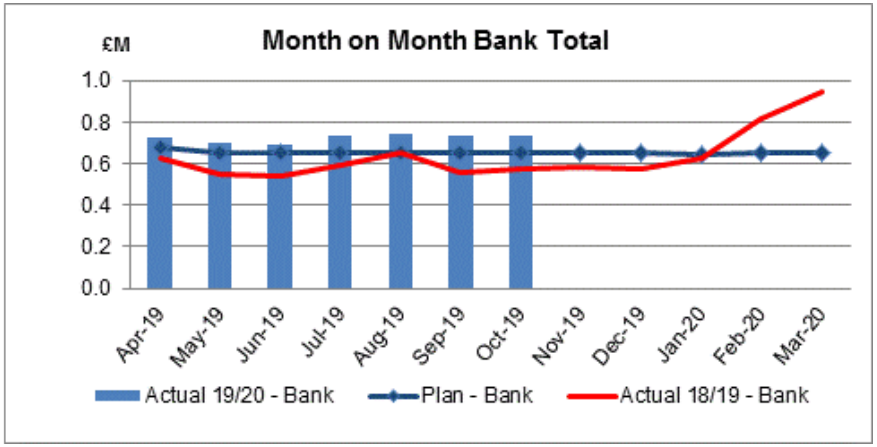
The Trust is financing its capital spend in 2019-20 through depreciation.

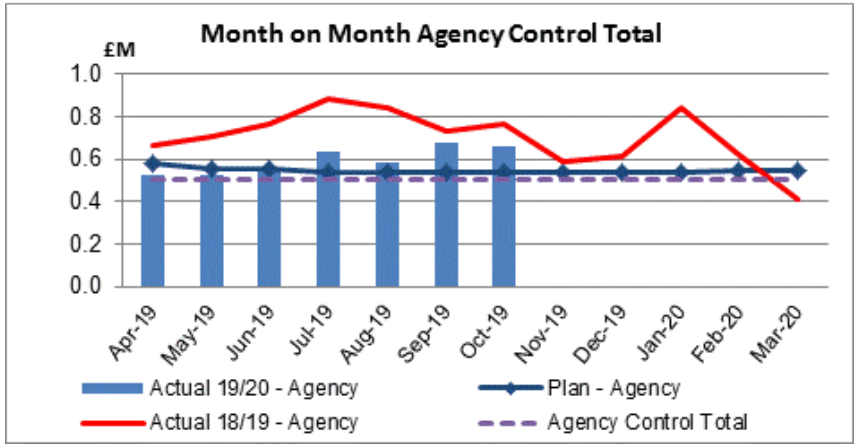
Although the Trust was anticipating to be behind plan for the first half of the year following a revision to the phasing of schemes within the capital programme, slippage into 2020-21 has been identified on a few larger schemes e.g. low risk birthing rooms, PACS and MRI infrastructure costs. A list of schemes originally scheduled for next year has been compiled for prioritisation to bring forward into the current year to ensure the total expenditure included in the plan is met. The schemes to bring forward will be submitted to the December Trust Board for approval. Assurances have also been sought that these schemes can be completed by the end of the financial year.

Workforce and Agency Spend

Pay:

Use of Resources





Summary and Action

Pay expenditure of £13,388k in October is £333k greater than planned for. Expenditure on Nursing and Support to Nursing showing a step change owing to two key factors: increased costs associated with escalation beds required to cope with emergency admissions; and c50-60 newly recruited overseas nurses who are currently acting in a largely supernumerary capacity while working towards their official registration. While this investment is having a material impact on the bottom line in the short term, the objective is to significantly reduce the reliance on temporary staffing (£0.5m in M07).

Agency costs continue exceeded plan at £662k, a figure comparable with September. A modest reduction in medical staffing agency costs has been offset by the increase in escalation costs highlighted above (+£12k), and ODPs in theatres (+£23k).

Agency premium for the period is estimated at c£245k, roughly a third of which relates to medical staffing groups due to difficulties filling vacancies and rota gaps. Gastroenterology, Acute Medicine, Elderly Care, and Pathology account for the vast majority of the medical agency spend.

Efficiency – Better Care at Lower Cost

Efficiency:

Use of Resources

Position							
	Annual	Oct '19			YTD		
Directorate	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	2,192	185	83	(101)	1,248	673	(575)
Musculo Skeletal	1,385	120	73	(47)	752	554	(198)
Surgery	1,728	151	135	(16)	984	728	(255)
Clinical Support & Family Services	1,965	184	166	(18)	1,046	873	(174)
Corporate Services	1,730	135	166	31	941	1,138	196
Strategic	1,000	131	93	(37)	247	385	137
TOTAL	**10,000**	**905**	**716**	**(189)**	**5,219**	**4,351**	**(868)**

Position							
	Annual	Oct '19			YTD		
Scheme	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	1,068	89	29	(60)	623	64	(560)
Workforce	1,001	83	54	(30)	584	572	(11)
Diagnostics	600	42	42	0	292	292	0
Patient Flow	825	69	14	(55)	481	138	(344)
Outpatients	500	56	56	0	222	222	0
Non-Pay Procurement	1,494	139	145	6	806	816	10
Medicines Optimisation - Drugs	500	83	38	(46)	83	163	79
Clinical Directorate Plans	2,634	239	207	(32)	1,383	1,142	(241)
Corporate Directorate Plans	1,378	105	133	28	745	942	198
TOTAL	**10,000**	**905**	**716**	**(189)**	**5,219**	**4,351**	**(868)**

Summary and Action

The Trust has reported CIP delivery of £716k (79%) in October 2019, comparable to that delivered in August.

Delivery against the Theatres programme remains limited due to slippage in implementation timeframes. External support for the implementation of a theatre scheduling tool is now in place with a £200k Q4 opportunity in DSU being investigated. The is a risk that other constraints to capacity utilisation (e.g. beds, kitting) could limit delivery, however a shift in current booking practice will deliver in the longer term.

The patient flow programme has once again not met its financial target. The Trust has spent an increased amount of time in OPEL 4, resulting in increased outliers and overnight use of ambulatory areas, thereby reducing efficiency and slowing patient flow through the pathway. Escalation had not been planned for until Q4.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	05 December 2019		

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 v13.2 (draft) Draft Corporate Risk Register August 2019 v6.5 Draft Summary CRR tracker v13 November 2019 (with board committee amendments)			

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.

Executive Summary:

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This informs the Annual Governance Statement and annual cycle of Business.

The BAF has undergone a refresh following the setting of new corporate objectives for 2019/20. The BAF will continue to be reported to the relevant Board Committees bi-monthly to maintain appropriate scrutiny and updates. The Trust Board will receive a comprehensive update every 4 months which will include any specific discussion points from the board committees.

Corporate risk profile summary

There has been a significant increase in the risk profile relating to service delivery and potential impact on patient care, weekend HSMR and deteriorating financial position. Rationale for increasing risk scores is provided below. 14 risks are rated 15 or above compared to 6 reported to Board in August 2019.

Extreme Risks

There are 14 risks rated 15 or above.

- 4107 - Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes (Score 16)
- 5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Score 16)
- 5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients (Score 15)
- 5605 - Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment (Score 15)
- 5607 - Risk of error due to Hospital at Night Team capacity to address increasing workload (Score 16)
- 5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Score 16)
- 3322 - National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services (Score 25)
- 5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff. (Score 16)
- 5972 - Insufficient organisational development resources to delivery cultural change and lack of formal Trust wide approaches to seek best practices from elsewhere.(Score 16)
- 5851 - Weekend HSMR significantly higher than expected (Score 15)
- 5966 - Risk of compromised services due to hub and spoke model (Score 15)
- 5860 - Risk of failure to achieve financial plan and NHSI control total for 2019/20 (Score 15)
- 5360 - Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss. (Score 15)
- 5955 - Insufficient robust management control procedures (Score 15)

New risks added since last presented to the Board in August 2019

- 5969 - Risk of failure to deliver GIRFT action plans (Innovation): current score 6
- 5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff (Innovation): current score 16
- 5972 - Insufficient organisational development resources to delivery cultural change and lack of formal Trust wide approaches to seek best practices from elsewhere (Innovation): current score 16
- 5966 - Risk of compromised services due to hub and spoke model (Care): current score 15
- 5955 - Insufficient robust management control procedures (Resources): current score 15

- 5920 - Breaches of fire compartmentation in PFI building (Resources): current score 5
- 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 (Resources): current score 9
- 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 (Resources): current score 12
- 6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT (Resources): current score 12
- 5345 - Breaching key data regulations including General Data Protection Regulations (GDPR), Privacy and Electronic Communications Regulations (PECR) and NHS Code of Practice: Records Management 2016 could result in financial loss and reputational impact (Resources): current score 9

Risks with an increased score

- 5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Score 16 from 12). This risk score was increased as there was little confidence the service provision start date would be met. This was not the case and therefore this risk score will reduce.
- 3322 - National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services (Score 25 from 9). The increase in risk score reflects that there has been confirmation that the service will not be provided by the Trust in the future.
- 5851 - Weekend HSMR significantly higher than expected (Score 15 from 9). The increase in risk score reflects the rising weekend HSMR.
- 5966 - Risk of compromised services due to hub and spoke model (Score 15 from 12). The increase in risk score reflects the evidence that service provision not being provided relating to vascular and interventional radiology services.
- 5860 - Risk of failure to achieve financial plan and NHSI control total for 2019/20 (Score 12 to 15). This reflects the deteriorating financial position.
- 5360 - Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss (Score 15 from 10). The risk 5360 description has been updated to reflect the wider corporate risk of not having sufficient cyber controls in place linked to cyber essentials compliance. The risk was previously reduced to 10 reflecting the likely impact of not having cyber insurance given the controls in place however given widening of the risk scope the score has been increased to 15 in recognition that we have yet to achieve cyber essentials plus.

Risks with a decreased score

- 5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients (Score 20 to 15).
- 5969 - Risk of failure to deliver GIRFT action plans (Score 12 to 6)
- 5869 - Failure to achieve required ward nursing establishment impacting on quality and safety and patient experience. High agency expenditure (Score 12 to 9)
- 5862 - Risk to buildings and equipment due to capital programme funding (Score 12

to 9)

Risks removed since last presented to the Board in August 2019

- 5971 - Insufficient organisational development resource to deliver cultural change (merged with risk 5972)

Board Committee review

The strategic priorities have been considered by the Clinical Governance Committee (Innovation and Care), Finance & Performance Committee (Local, Specialist and Resources) and the Workforce Committee (People) and the key points noted below:

Local risk profile

The risk profile was agreed as an accurate reflection. Particular consideration was given to risks 5751 (Risk of impact on patients from high numbers with a delayed transfer of care) and 5799 (Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients) given the static scoring over a number of months. Further review of effectiveness of mitigating actions to be undertaken.

Specialist risk profile

The risk regarding the genetics service is to be redefined as 2 separate risks; a short term risk relating to impact on staff currently within the department and a longer term risk regarding the strategic nature of the service. The current scoring of 25 will subsequently change.

Innovation risk profile:

The risk profile was agreed, acknowledging the significance of the lack of digital capability across the organisation with the identified gaps in control and assurance. There was discussion regarding the organisational development risk and the wording of this. This risk will be reviewed in light of this discussion.

Care risk profile

The risk profile was agreed as an accurate reflection. A gap in the risk profile was identified regarding the impact of the new junior doctor contract. This risk will be added to the corporate risk register.

People risk profile

It has been acknowledged that the people risk profile requires a significant review. A meeting with the Interim Director of OD&People, Director of Corporate Governance and Deputy Director of OD&People is scheduled in December to undertake this review. The outcome will be presented in the next BAF submission to the Committee in January 2020.

Resources risk profile

The risk profile was agreed acknowledging the deterioration in the financial position. New risks identified relate to longer term strategy delivery capability.

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

V13.2 For December 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?

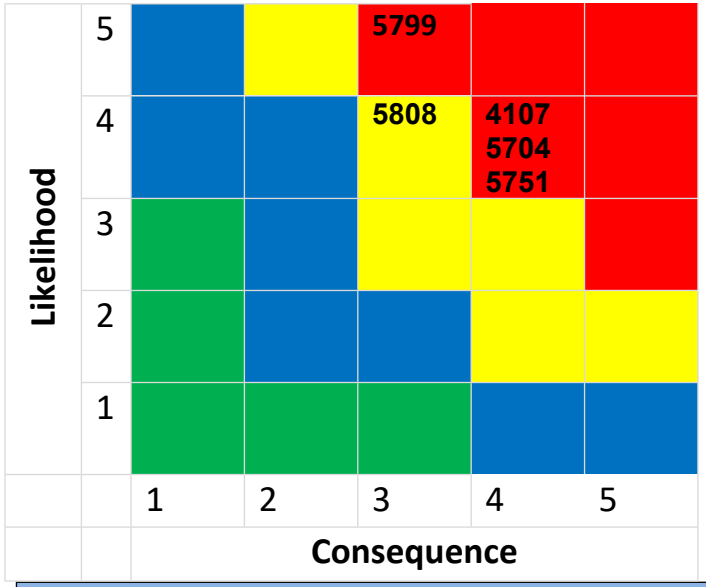
	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

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



5808 – Lack of service provision for elective vascular angiography
5704 – Inability to provide a full gastroenterology service due to a lack of medical staff capacity
4107 - Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes
5751 – Patient safety risk due to high numbers of delayed transfers of care due to lack of community capacity
5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients

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	• Integrated performance report

• 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)	• 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			

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	• Requested improvement trajectories for decreased

• Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard) • STP Operational Plan	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	Linked corporate risks
Delivery of sustainable and improving local services through service and pathway review and develop new partnerships to deliver sustainable local services.	1. Patient Flow and Urgent Care Programme 2. Frailty Model Implementation 3. Gastroenterology Review 4. Implement Clinical Strategy	Lack of strategies to manage challenged services	Program for strategic review of services. Service reviews being linked to operational planning for 2020/21	31.12.2019 for high priority areas	A Hyett	5808 5704 5751 5966

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Work collaboratively with system partners to maximise patient and partnership benefits.	1. Delivery of Provider Alliance Programmes 2. Active role in BSW clinical and operational strategy 3. Leadership role in Wiltshire Health & Care 4. Work proactively with Primary Care Networks 5. Establish clinical leadership roles focussed on partnership and network development 6. Consider potential to return activity from the private sector to acute hospitals	Maturity and development of wider health and care system/partners to develop new models of care.	Work with new PCN's to develop relationships and new models of care.	31.03.2020	LT	5751
Improve access to services to support prompt responsive care.	1. Maintain waiting list size and delivery of RTT (incompletes) standard. 2. Reduce DNAs across service provision. 3. Benchmark First/Follow Up ratios as part of outpatients 4. transformation programme 5. Theatres capacity review and transformation programme 6. Delivery of new 28 day faster diagnosis cancer standard	Additional cases not scheduled on lists where gaps are evident (C) Lack of business intelligence tool	Outpatient and theatre project management Boards monitoring actions and improvement in utilisation Procure and embed tool	31.03.2020 31.03.2020	E Provins E Provins	4107 5799

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need.	1. System wide MADE events 2. Roll out of increased ambulatory pathways 3. Consistent application and roll out of the SAFER care bundle and principles 4. Implementation of frailty new models of care 5. Increase the number of patients who are able to return to their preferred place of care at the end of their life 6. Plan to achieve/maintain top quartile performance in service delivery 7. Continue to increase the number of frail older people who are able to go home the same day or within 24 hours of admission	Lack of capacity / demand plan across Wiltshire	Urgent Care Delivery Group requiring capacity plan	31.08.2019 Completed – CSU developed capacity and demand plan for Wiltshire	A Hyett	5751

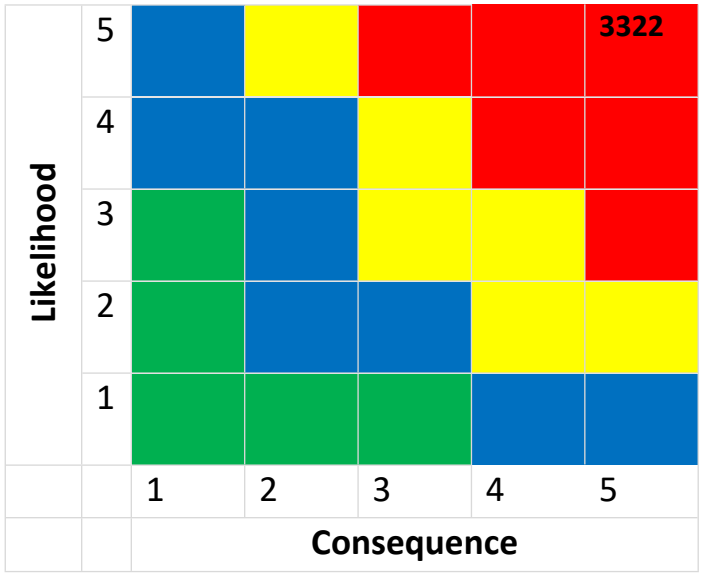
Strategic Priority:

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



3322 – National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services

Principle Internal Risk: Risk of balancing delivery of services that are 'outstanding' against the risk of economies of scale and cost effectiveness					
Key Controls			**Assurance on Controls**		
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board • COO Delivery Group • Genomics Consortium Board • Established performance monitoring and accountability framework • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO)			• Integrated Performance Report • Specialist Services dashboards • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group		
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. Review December 31.12.2019			
Lack of specialist commissioning clinical and financial strategy for spinal services – Trust to write to specialist	Director of Finance	30-09.2019 Meeting held - complete			

commissioners to convene a summit					

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

2019/20 Corporate Objectives – Specialist Services

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
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	C Blanshard	
Develop our specialist services to be centres of excellence, delivering outstanding, innovative and responsive patient care.	1. Benchmark specialist services including spinal and plastics/burns against national comparators 2. Plan to achieve/maintain top quartile performance in service delivery 3. Establish future for genetics service within regional consortium 4. Secure future of spinal pathway pilot.	Lack of strategy for specialist services (C)	Clear program of work to complete a service review, comparison against benchmark and improvement plan	31.12.2019	A Hyett	3322

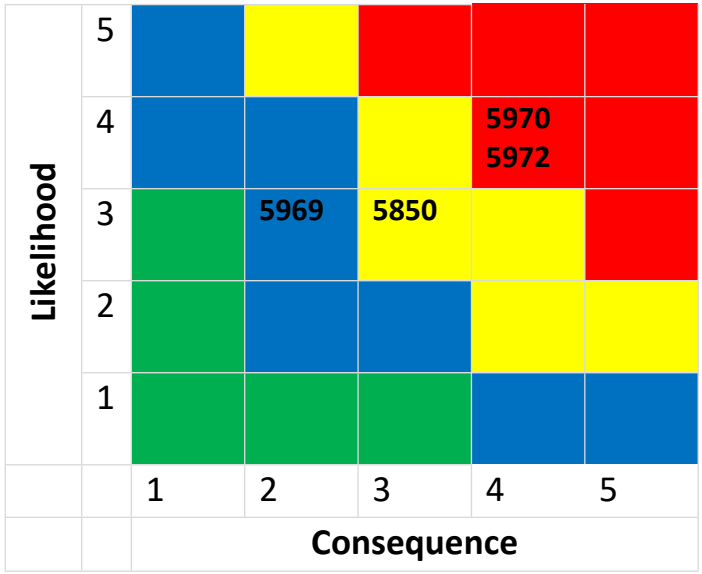
Strategic Priority:

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



5850 – Potential non-delivery of CQUIN schemes resulting in a financial loss
5969 – Risk of failure to deliver GIRFT action plans
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 – No formal organisational approach, process or resource to seek best practice from elsewhere

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			
SOP for supporting & adopting innovative systems and practices	Director of Transformation	31.12.2019			
IT Improvement Plan sign off	Director of Transformation	31.12.2019			
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	Linked corporate risks
Develop the culture, capacity and capability to support innovation, improvement and research throughout the Trust.	1. Delivery of the overarching transformation and cost improvement programme	Lack of defined process to support innovation (C)	Develop and implement clear processes	31.12.2019	Esther Provins	5970
	2. Delivery of the QI operational plan for 19/20					
	3. Maximise participation and involvement in research within the Trust.					
	4. Hold a Dragon's Den forum to attract and support innovation					
	5. Strengthen links with AHSN					
	6. Improve organisational capability for change					
To maximise digital services to enable the provision of	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	Esther Provins	5970 4857 5326

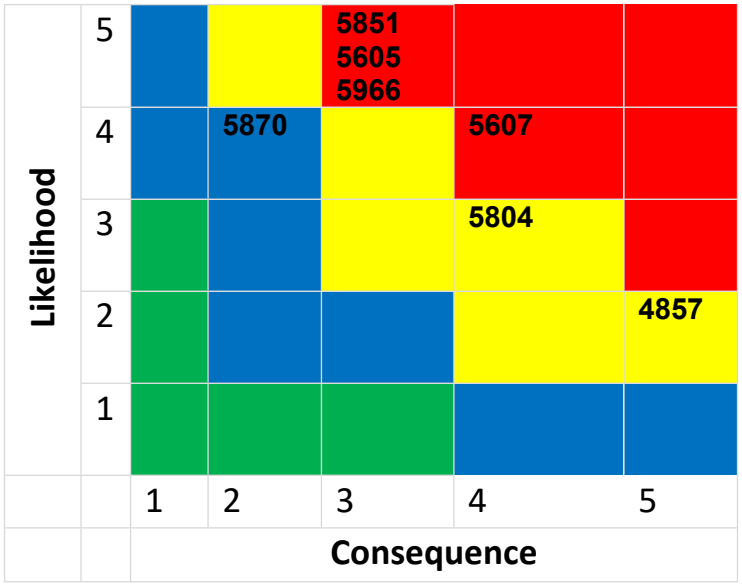
Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
outstanding care.	2. Deliver internal audit action plans			revised Complete		5360
	3. Team development					
	4. Strengthen opportunities for engagement					
	5. Engage with partners to ensure 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



4857 – Risk of loss of all external communications to N3 due to current dual N3 connections (would affect clinical systems access)
5851 – Weekend HSMR significantly higher than expected
5804 – Risk of patients within hospital experiencing a fall
5870 – Failure to achieve quality projections set nationally due to changes in reporting definitions (CDiff, Pressure ulcers)
5605 – Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment
5607 – Risk of error due to Hospital at Night Team capacity to address increasing workload
5966 – Risk of compromised services due to hub and spoke model

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

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

2019/20 Corporate Objectives – Care

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead	Linked corporate risks
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					4107 5851 5804 5605 5607
	2. Achieve HCAI rates below trajectory	Redefinition of HCAI trajectories and what falls within 'hospital' apportioned at a national level (C)	Monthly reporting of hospital and community cases. Board transparency on any change being definition or internal issue	31.07.2019 Complete – raised through CGC and Board	C Gorzanski	
	3. Improve the recognition of deteriorating patients through the embedding of NEWS2.	Compliance with escalation levels (C)	Educational plan developed and rolled out	31.03.2020	Maria Ford	
	4. Reduce harm from sepsis by improving the number of inpatients screened for sepsis and treated with intravenous antibiotics within an hour of diagnosis of sepsis.	Development time available to POET (C)	POET Board working through development time requirements and associated case for prioritisation	31.08.2019 Complete	JBurwell /L Wilkinson	
	5. Introduce Saving Babies Lives care bundle v2, and participate in wave 3 of the national maternity/neonatal safety collaborative	Increased number of SIs and concerns raised within maternity services (GA)	Aggregated review across all SIs Complete cultural survey and develop appropriate improvement measures	31.12.2019	F Coker / A Kingston	
	6. Demonstrate the implementation of high impact actions in the work to reduce falls	Development time available to POET to make necessary upgrades to capture all information (C)	POET Board working through development time requirements and associated case for prioritisation	31.08.2019 Complete	JBurwell /L Wilkinson	

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead	Linked corporate risks
		Number of falls resulting in injury not decreasing (A)	Commence an SII of serious falls and embedding learning	31.03.2019 Commenced and on-going		
Build our assurance on standards of ward-based care and compassion through development of ward accreditation process.	1. Design and develop ward accreditation programme 2. Develop range of metrics to support accreditation 3. Identify pilot areas to test and refine.	Availability of data to support the programme (C)	Deputy Director of Nursing working with subject matter experts	~~31.08.2019~~ ~~30.11.2019~~ 31.03.2020 Project lead met with Director of Transformation and CIO and agreed data dashboard requirements. Pilot wards identified	D Major	
Work with our patients and partners to plan and develop services which meet the needs of our community.	1. Launch and implement the Treat Me Well campaign in April 2019. 2. Ensure that Patient voice is included in the planning and development of major Trust schemes.					5966 5808 5704 3322
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					

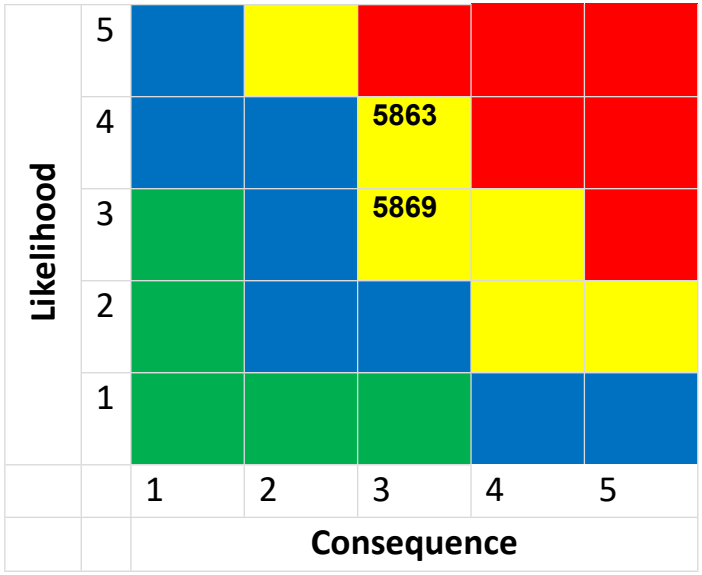
Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead	Linked corporate risks
	4. Continued Board development programme to facilitate the Board developing into a high performing, unitary Board					

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 impacting on quality and safety and patient experience. High agency expenditure

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)	• Staff Survey

• 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 Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • Integrated Performance Report at Board • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report • Health and safety annual report • Guardian of safe working report • Volunteers annual report • Monthly Workforce Dashboard at EWC • Executive Safety Walks

Gaps in Control			**Gaps in Assurance**		
• Ineffective data capture and reporting			• Lack of real time staff feedback		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Develop phase 2 and 3 business case and investment for ESR optimisation	Director of OD & People	21.08.2019 Submitted to TMC May 19 and JCC in August 19. Approved	Develop Health& Wellbeing Strategy business case to purchase real time feedback solution	Director of OD & People	21.08.2019 Submitted to TMC: requires further revision **Nov 19 update:** business case is currently under revision and redefined to cover the Employee Assistance Programme. To be submitted to TMC. Date TBC

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	Linked corporate risks
To build, value and develop a skilled and motivated workforce.	1. Lead STP plans on workforce transformation. 2. Undertake Therapies/AHP workforce review to better align with operational functions 3. Build on leadership development of ward leaders through a formal leadership programme (with Director of Nursing and Quality) 4. Roll out e-rostering system across professional groups	Skills and capacity of Business Partners (C) Lack of roll-out plan (C)	Continuing to embed BP model in directorates Under discussion with Quality directorate	31.12.2019 31.03.2020	S Crane G Toms	5863 5869
Develop a diverse and inclusive culture where staff feel engaged.	1. Support to Speak Up Programme 2. Roll out Phase 2 and 3 of ESR. 3. QI strategy 4. OD Programme	Lack of consistency of champions within defined networks	Meet with current dignity at work ambassadors – design and recruit to new role Nov 19 action updated: ambassador roles being reviewed to determine key roles and responsibilities to ensure appropriate support	~~30.09.2019~~ 31.03.2020	R Webb	
Improve the health and	1. Improved on site staff facilities					

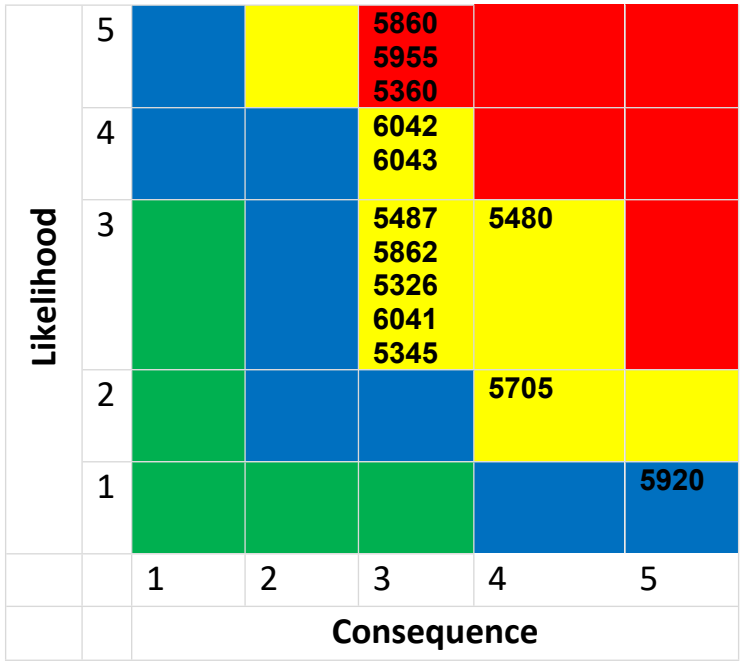
Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
well-being of staff.	2. Targeted health/well-being campaigns and programmes 3. Consistent application of a flexible working policy	No investment for the proposed programme Policy requires 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 Business case submitted to TMC: requires further revision ~~05.08.2019~~ 28.02.2020 Discussed at Execs and agreed statement of flexible working supported by revision and re-launch of policies	A Evans G Dawson	

Strategic Priority:

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

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

Distribution of Corporate Risks for Resources



5705 – Unknown impact on the running of the hospital as a result of the EU Exit
5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
5326 – Risk of access to patient information through variety of clinical information systems and overhead of access
5860 – Risk of failure to achieve financial plan and NHSI control total for 2019/20
5480 – Risk of poor controls to ensure the consistency and accuracy of information reporting
5862 – Risk to buildings and equipment due to capital programme funding
5360 - Risk of cyber attack or ransomeware attack
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 **New risk**
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 **New risk**
6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT **New risk**
5345 - Breaching key data regulations including General Data Protection Regulations (GDPR), Privacy and Electronic Communications Regulations (PECR) and NHS Code of Practice: Records Management 2016 could result in financial loss and reputational impact **New risk**

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities

Key Controls	Assurance on Controls
• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • OETB • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement
Gaps in Control	**Gaps in Assurance**
• Oversight of corporate processes and policies	•

Actions	Owner	Deadline	Actions	Owner	Deadline
Set up task and finish group to develop a framework	Director of Finance	30.06.2019			

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	Linked corporate risks
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	5862
Improve financial sustainability of SFT and the wider health economy.	1. Development and implementation of Transformation programme 2. Further develop our role within BSW to deliver financial sustainability. 3. Progression of outpatients transformation programmes in partnership 4. Implementation of Model Hospital based schemes where benchmarking shows opportunities for efficiency – for example pharmacy and medicines optimisation. 5. PMO maturity assessment of productivity 6. Clinical service reviews 7. Delivery of services in partnership with external organisations.	Maturity and development of wider health and care system/partners to develop new models of care.	Work with new PCN's to develop relationships and new models of care.	31.03.2020	LT/CCB	5487 5860 6041 6042 6043

Corporate Risk Register
November 2019

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	7/16/2019	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.	2/28/2020		Robinson, Ian	Directorate Management Team Meeting	12/1/2019	2	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	7/17/2019
5969	Trustwide	Trustwide	8/23/2019	Trusts Objectives	12	Capacity issues, lack of ownership and operational pressures taking precedence may result in failure to deliver the GIRFT action plans. This would result in failure to deliver service improvement, innovation and failure to improve efficiency and productivity.	May recur occasionally	Minor	6	Director of Transformation to discuss current assurance process with the Exec sponsor.	9/30/2019	10/15/2019	Provins, Esther	Finance and Performance Committee	12/31/2019	6	Innovation	Finance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	8/23/2019
5870	Quality Directorate	Trustwide	6/20/2019	National guidance	12	Failure to achieve quality projections set nationally or to appear as though quality declining due to changes in reporting definitions from April 2019. **Clostridium difficile reporting requirements changed so that patients who develop C. difficile in the community but who have had a hospital admission in previous 4 weeks will count in Trust figures and be deemed as 'Community onset, healthcare associated'. This will increase the numbers attributable to the Trust at a time when the ceiling was reduced by 50% (18 to 09). Potential risk to attract fines, contract notices and reputational damage. **Pressure Ulcers- definition of hospital acquired changed from developed post 48 hours of admission to anything not identified within 6 hours of admission. **see linked risk 5848**	Will probably recur, but is not a persistent issue	Minor	8	Transparent discussions with commissioners and NHSI re: the implications of the changes in reporting definitions.	6/20/2019	6/20/2019	Wilkinson, Lorna	Trust Board	1/1/2020	8	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing	6/20/2019
										Board and public awareness.	8/1/2019	7/31/2019	Wilkinson, Lorna							
										Continued improvement work on these safety work streams.	4/1/2020		Wilkinson, Lorna							
										Transparent and clear reporting to Board.	8/1/2019	7/31/2019	Wilkinson, Lorna							
										Use of appeals process.	4/1/2020		Wilkinson, Lorna							
										Update Datix NRLS coding in order to become compliant with the new NHS Improvement Pressure Ulcer Framework, to ensure submission of accurate pressure ulcer data to NRLS.	7/31/2019	8/19/2019	Densham, Annie							
5705	Trustwide	Trustwide	1/31/2019	National guidance	12	Unknown impact on the daily running of the hospital as a result of Great Britain's exit from the European Union. The consequence is that the resources (stocks and staff) could be depleted affecting service provision.	Do not expect it to happen again but it is possible	Major	8	Completion of risks assessments.	3/31/2019	4/25/2019	Hyett, Andy	EU Exit Planning Group	11/30/2019	8	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	1/31/2019
										Delivery of any new national actions.	3/31/2019	4/25/2019	Hyett, Andy							
										Task and finish group to continue to meet on a monthly basis.	11/1/2019	10/22/2019	Hyett, Andy							
										Accountable Officer for EU Exit has been notified by National Audit Office that they will randomly audit Trusts preparedness. SFT may be randomly selected to be a Trust to be audited. If selected the Trust will comply with any necessary action.	10/31/2019	10/22/2019	Hyett, Andy							
										Submit daily SITREP to NHS Improvement.	11/30/2019		Hyett, Andy							

Corporate Risk Register
November 2019

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
5850	Quality Directorate	Trustwide	6/13/2019	Commissioning for Quality & Innovation (CQUIN)	12	Potential non delivery of CQUIN schemes that are high risk which would result in a financial loss for the Trust. CCG 1a) Antimicrobial resistance/lower urinary tract infections in older people. £181K at risk. CCG1b) Antimicrobial resistance/antibiotic prophylaxis in colorectal surgery. Medium risk. CCG2) Staff flu vaccinations. Improve the uptake of flu vaccine for frontline staff to 80% (no opt-out for West Hampshire. £362K at risk. CCG7) 3 high impact actions to prevent hospital falls to achieve 80% of older inpatients receiving 3 key falls prevention actions. £362K at risk. Moderate risk. NHSE Specialised commissioning - Medicines Optimisation 4 workstreams. 1 of the 4 parts antifungal stewardship. £17k at risk. Please note the payment calculation has changed in 19/20 and in essence the better the performance between the minimum and maximum payment levels, the greater the income. Total potential loss at year end is £415K.	May recur occasionally	Moderate	9	CCG1a)Antimicrobial resistance/lower UTI in older people. Band 6 full time pharmacy technician is being appointed to lead on this work.	7/31/2019	7/31/2019	Whittles, Lou	Finance and Performance Committee	1/31/2020	6	Innovation (Resources)	Trust Board (Corporate Risk Register)	Director of Finance	6/21/2019
										CCG1a). Trustwide education programme to change practice and ongoing data collection and regular feedback to ED and the wards and the Junior medical staff.	4/30/2020		Whittles, Lou							
										CCG1b) Antimicrobial resistance/antibiotic prophylaxis in colorectal surgery. Clinical Lead for colorectal service to engage with Surgeons and Anaesthetists with the results of the April and May 19 audit and implement improvement actions.	7/31/2019	7/31/2019	Branagan, Mr Graham							
										CCG2) Staff flu vaccinations. Improve the uptake of flu vaccine for frontline staff to 80%. A flu working group to plan the annual flu campaign and vaccination approach.	9/30/2019	6/13/2019	Evans, Alison							
										CCG7) 3 high impact actions to prevent hospital falls to achieve 80% of older inpatients receiving 3 key falls prevention actions. Patient Safety Facilitator supporting improvements via the Falls Working Group. Key improvement required is the recording of lying and standing blood pressures.	4/30/2020		Lowe, Tarah							
										CCG7) 3 high impact actions to prevent hospital falls to achieve 80% of older inpatients receiving 3 key falls prevention actions. POET is to have mandatory fields added to ensure the recording of lying and standing blood pressures as routine for patients over 65.	7/31/2019	9/5/2019	Ford, Maria							
										CCG11c) Same day emergency care/community acquired pneumonia. Collect quarter 1 data to determine baseline performance and report to the SDEC working group.	7/31/2019	7/31/2019	Finneran, Dr Nicola							
5326	Transformation & IM&T	Trustwide	12/20/2017	Electronic Patient Record	9	Risk of limited access to patient information due to the variety of clinical information systems in use, the lack of integration between systems and associated working practices, resulting in inefficiency delays and potential patient harm.	May recur occasionally	Moderate	9	Training review being commissioned to provide holistic training for clinical staff	1/31/2019	2/8/2019	Lees, Susan	Directorate Management Team Meeting	12/20/2019	6	Care	Trust Board (Corporate Risk Register)	Director of Transformation	2/8/2018
										Describe within digital strategy how information from a range of sources will be used	3/7/2019	4/15/2019	Burwell, Jonathan							
										Set up governance structure for development of digital strategy	9/28/2018	10/24/2018	Arnold, Laurence							
										Secure support from clinicians to be CCIO and Clinical safety officer	10/30/2018	10/24/2018	Blanshard, Dr Christine							
										Upgrade to WinDip	12/27/2019		Ford, Nicola							
										STP EPR Model options appraisal to be undertaken by July 2019. Post this future consideration of Lorenzo modules will be undertaken.	12/20/2019		Burwell, Jonathan							
										Collation of the list of shared mailboxes and where it is currently used for managing patient care	12/6/2019		Polley, Ms Cathy							

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November 2019

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5345	Transformation & IM&T	Trustwide	2/1/2018	Information Governance	12	Breaching key data regulations including General Data Protection Regulations (GDPR), Privacy and Electronic Communications Regulations (PECR) and NHS Code of Practice: Records Management 2016 could result in financial loss and reputational impact.	May recur occasionally	Moderate	9	Corporate Records Committee to agree an approach to start reviewing the Trust corporate records.	12/20/2019	11/12/2019	McNeight , Fiona	Digital Steering Group	12/27/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Transformation	11/13/2019
										Trust to consider risk appetite of records retention on electronic systems (e.g. Lorenzo). Paper to be produced with proposal to go through IGSG and F&P Committee	12/27/2019		Doubtfire-Lynn, Heidi							
										Business case for website project to support ensuring Trust owned or commissioned websites are GDPR and PECR compliant.	12/18/2019		Burwell, Jonathan							
5487	Finance and Procurement	Finance Department	7/26/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation.	May recur occasionally	Moderate	9	- 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	12/21/2018	12/19/2018	Thomas, Lisa	Finance and Performance Committee	11/29/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	10/16/2018
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	12/31/2019		Thomas, Lisa							
										Subsidiary companies to recruit or establish suitable qualified financial support.	1/31/2020		Thomas, Lisa							
5862	Finance and Procurement	Trust Offices	6/17/2019	Financial management	12	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	May recur occasionally	Moderate	9	Programme prioritised for national requirement for 20%	7/15/2019	8/19/2019	Thomas, Lisa	Finance and Performance Committee	11/29/2019	9	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	6/17/2019
										QIA assessment to be completed for all delayed schemes.	7/15/2019	8/19/2019	Thomas, Lisa							
										Process agreed with the STP providers on managing in year slippages	7/15/2019	8/19/2019	Thomas, Lisa							
										NHSI letter sent 18/08/19 confirming 20% reduction no longer required due to increase in national funding. Therefore review of capital programme now needs re- looking at in case of any logistical reasons for non delivery.	9/30/2019	10/21/2019	Thomas, Lisa							
										Trust reprioritising spend to ensure achievement of 2019/20 capital plan. This includes moving spend from 2020/21 to 2019/20 where schemes are delayed into the new financial year.	10/31/2019		Ellis, Mark							
6041	Finance and Procurement	Trustwide	10/25/2019	Trusts Objectives	6	The Trust lacks the Capacity to build strong partnerships with the number of newly forming organisations at the pace required e.g. Primary Care Networks. This could limit the ability of the organisation to deliver the NHS Long Term Plan ambitions.	May recur occasionally	Moderate	9	Agree and formalise programme of work with PCNs	12/31/2019		Humphrey, Kieran	Trust Board	11/30/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	10/25/2019
4857	Transformation & IM&T	Information Technology	10/14/2016	Trustwide risk assessment	10	A lack of resilience in infrastructure including a single access route to the national health and social care network (HSCN) and unsupported hardware/software, resulting in loss of access to IT systems and internet access.	Do not expect it to happen again but it is possible	Catastrophic	10	14/09/18 A/w pricing and plans from MLL (HSCN supplier)	11/30/2018	4/8/2019	Noble, Bob (Inactive	Departmental Team meeting	12/27/2019	5	Care	Trust Board (Corporate Risk Register)	Director of Transformation	4/11/2019
										Business case to be written for phase 2 of N3 to HSCN migration which will include creating a diverse entry into the Trust and mitigate this risk.	6/14/2019	5/31/2019	Cowling, Andrew							
										Order second HSCN line and implementation	3/27/2020		Arnold, Jon							
										Undertake comprehensive baseline of infrastructure	1/31/2020		Burwell, Jonathan							

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5480	Transformation & IM&T	Trustwide	7/23/2018	Incident reports	16	Risk of poor controls to ensure the consistency and accuracy of information reporting resulting in reputational harm or misinform for internal/external stakeholders.	May recur occasionally	Major	12	Agree content and approach to undertaking analysis work and reporting approach to IGSG	8/31/2018	11/1/2018	Doubtfire-Lynn, Heidi	Audit Committee	11/29/2019	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	7/26/2018
										Complete Serious Incident Inquiry in order to review what additional controls require adding.	11/30/2018	11/2/2018	Arnold, Laurence							
										Creation of Information Standards Committee to oversee external information accuracy and timeliness	1/31/2019	2/18/2019	Burwell, Jonathan							
										Review of progress to improve medium and high risks for external information reports	4/23/2019	6/11/2019	Burwell, Jonathan							
										IS undertaking review of DQ against core DQ standards for key metrics as part of development of new Integrated Performance Report.	6/28/2019	8/28/2019	Anscombe, Felicity							
										Extend review of metrics against data quality standards across all information services reports and metrics	11/29/2019		Anscombe, Felicity							
5804	Trustwide	Trustwide	4/26/2019	Incident reports	12	Risk of patients within hospital experiencing a fall, with the potential to result in significant harm. This is an issue recognised nationally due to the increasing frail population.	May recur occasionally	Major	12	Create version 2 of nursing post falls assessment sticker for cascade out across the Trust	8/1/2019	9/10/2019	Lowe, Tarah	Falls Group	1/1/2020	8	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing	4/26/2019
										Falls improvement plan to be written for 2019/20. The actions from the strategy will then be added to this risk.	7/31/2019	9/10/2019	Lowe, Tarah							
										CQUIN for falls prevention to be planned out.	3/2/2020		Lowe, Tarah							
										Version 4 of nursing post falls assessment sticker was finalised however there were suggestions for changes from staff. Head of Nursing for Medicine to re-develop the sticker.	3/31/2020		Peebles, Allison							
										Designation of action leads required for 4 actions on Falls improvement action plan for 19/20. To be discussed at CMB.	11/29/2019		Lowe, Tarah							
5808	Surgery	Surgical Directorate Management offices	5/1/2019	Other assurance not listed	10	Lack of service provision for elective vascular angiography as a result of the attendance of vascular surgeons and attendance of IR consultants not being aligned. This results in a risk of a backlog of patients awaiting elective treatment until a pathway is agreed.	May recur occasionally	Major	12	Medical Director has escalated to Regional Medical Director and awaiting a meeting.	7/1/2019	8/21/2019	Blanshard, Dr Christine	Finance and Performance Committee	11/30/2019	6	Local Services	Finance Committee, Trust Board (Corporate Risk Register)	Chief Operating Officer	5/1/2019
										Approach UHS to ask if they can take the referrals and agree a pathway.	5/31/2019	6/12/2019	Hyett, Andy							
										COO liaising with Bournemouth regarding operationalizing the clinical pathway.	11/1/2019	10/22/2019	Hyett, Andy							
										DM for CSFS liaising closely with Bournemouth re: the starting of service at the beginning of November. Following discussion with Bournemouth, intended service go live date is 11/11/2019. RBCH will cover the service for 47 weeks per year, and attend SFT on a Tuesday and a Thursday. SLA to be agreed by both Trust's and Honorary contracts to be set up for RBCH Consultants providing the service @ SFT.	11/11/2019		Vandyken, Ali							

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6042	Finance and Procurement	Trustwide	10/25/2019	Trusts Objectives	12	The local merger of the three CCG's (BaNES, Wiltshire and Swindon) to form BSW will mean a short term lack of CCG capacity and focus to deliver the change required for SFT to deliver its core strategy.	Will probably recur, but is not a persistent issue	Moderate	12	Progressing plan of engagement and work programme with local Primary Care Networks	3/31/2020		Humphrey, Kieran	Trust Board	11/29/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	10/25/2019
6043	Finance and Procurement	Trustwide	10/25/2019	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.	2/28/2020		Hyett, Andy	Trust Board	11/29/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	10/25/2019
										Development of system plans for sustainability of NHS elective care	3/31/2020		Humphrey, Kieran							
5863	Finance and Procurement	Trust Offices	6/17/2019	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.	7/12/2019	8/19/2019	Thomas, Lisa	Finance and Performance Committee	11/29/2019	6	People	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	6/17/2019
										Identify strategic partners to offer staff financial advice.	10/31/2019		Thomas, Lisa							
										Trust considering alternative arrangements in lieu of national guidance e.g. LLP arrangements on a specialty by specialty basis.	11/29/2019		Thomas, Lisa							
5869	Quality Directorate	Trustwide	6/20/2019	Trustwide risk assessment	12	Failure to achieve required ward nursing establishment with the following implications: Quality and safety concerns at ward level Poor patient experience High agency expenditure (financial risk to the Trust)	Will probably recur, but is not a persistent issue	Moderate	12	Contribute to Trust work on developing workforce safeguards.	10/1/2019	10/22/2019	Hyett, Fiona	Trust Board	1/1/2020	9	People (Care)	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing	6/20/2019
										Contribute to levels of attainment work on e-rostering /e-job planning.	4/1/2020		Hyett, Fiona							
										Overseas recruitment campaigns 19/20.	4/30/2020		Hyett, Fiona							
										Skill mix review x2 per year - 2019/2020	4/30/2020		Wilkinson, Lorna							
										Retention workstream to plan, including exit meetings, STAY conversations and career pathways, to be embedded.	1/1/2020		Hyett, Fiona							
										Develop apprenticeships and nursing associate opportunities to broaden access into nursing.	4/30/2020		Wilkinson, Lorna							
										Maintain full recruitment of Nursing Assistant Staff.	4/30/2020		Hyett, Fiona							
										Twice daily staffing review using safe care and roster data.	4/30/2020		Hyett, Fiona							
										Domestic recruitment campaign 2019/2020	3/1/2020		Holt, Sharon							
										Implementation of safer nursing care tool to evidence staffing levels.	4/1/2020		Hyett, Fiona							

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5799	Clinical Support and Family Services	Radiology	4/18/2019	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.	Will undoubtedly recur, possibly frequently	Moderate	15	Action plan for mitigation of this risk is development.	7/31/2019	7/8/2019	Lloyd-Jones, Graham	Departmental Team meeting	12/31/2019	9	Care, Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer	4/30/2019
										Local tender undertaken, evaluated and awarded.	6/13/2019	6/13/2019	Vandyken, Ali							
										Implementation meeting with new supplier.	7/3/2019	7/3/2019	Clarke, Simon							
										Go live second 3rd party reporting provider	11/29/2019		Clarke, Simon							
										Continuation of additional sessions provided by Radiologists. Ongoing for at 3 month intervals.	12/31/2019		Lloyd-Jones, Graham							
										Active monitoring/management of outsourced backlog by Radiology Service Manager – ongoing for review monthly.	12/31/2019		Clarke, Simon							
										Explore opportunity for Radiographers and Radiologists to have reporting station at home, as a method of increasing reporting capacity	12/27/2019		Clarke, Simon							
										Appointment of substantive Radiologist.	9/3/2019	9/9/2019	Lloyd-Jones, Graham							
5955	Finance and Procurement	Trustwide	8/13/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Will undoubtedly recur, possibly frequently	Moderate	15	reviewing Trust wide risk training, aiming to roll out programme to all middle managers	3/31/2020		Thomas, Lisa	Trust Board	12/31/2019	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	8/13/2019
										Process mapping underway for business critical controls	12/31/2019		Thomas, Lisa							
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	11/29/2019		Willoughby, Kelly							
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	12/31/2019		Thomas, Lisa							
5966	Trustwide	Trustwide	8/20/2019	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 undoubtedly recur, possibly frequently	Moderate	15	Interventional Radiology: Work with commissioners to secure service provision with another provider.	11/30/2019		Vandyken, Ali	Trust Board	12/31/2019	6	Care	Trust Board (Corporate Risk Register)	Medical Director	8/21/2019
										Oncology: Develop additional joint working and new posts.	4/1/2020		Clarke, Lisa							
										Vascular: Set up a vascular network meeting.	9/30/2019	10/25/2019	Murray, Dr Duncan							
										Renal: Signed Service Level Agreement with Portsmouth for provision of renal services.	10/31/2019	10/25/2019	Clarke, Lisa							

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5851	Quality Directorate	Trustwide	6/13/2019	Clinical audit	12	Weekend HSMR Significantly Higher than Expected (at 123.5 for the last 5 12 month rolling data periods to February 2019)- A potential risk to patient safety in the diagnosis groups of pneumonia and sepsis, and patients with a length of stay of 7-13 days with no co-morbidities aged 65 to 74. A risk of reputational damage to the Trust.	Will undoubtedly recur, possibly frequently	Moderate	15	Undertake a case notes review of all the patients in the categories defined in the above section to determine the cause and any improvement actions required.	9/30/2019	8/21/2019	Cornforth, Dr Belinda	Clinical Governance Committee	11/30/2019	9	Care	Trust Board (Corporate Risk Register)	Medical Director	6/17/2019
										Case notes review to be reported to the mortality surveillance group and Clinical Governance Committee in September 2019.	9/30/2019	10/25/2019	Cornforth, Dr Belinda							
										Review safety and effectiveness of weekend service and report to CGC in September.	9/30/2019	9/30/2019	Blanshard, Dr Christine							
										Summarise actions to improve safety at weekends and report to CGC in October.	10/31/2019	10/25/2019	Blanshard, Dr Christine							
										Propose uplift in staffing at weekends and operational measures to improve safety and experience of medical staff at weekends. Report to Workforce Committee in October. Update 25/10/19: October Workforce Committee cancelled. Defer to November.	11/29/2019		Blanshard, Dr Christine							
										Extend OPAL and ESD services to 7 days a week. Business case submitted to TMC in October.	10/31/2019	10/25/2019	Blanshard, Dr Christine							
										Increase clinical Pharmacy staffing at weekends. Business case to TMC in November.	11/30/2019		Blanshard, Dr Christine							
5860	Finance and Procurement	Trust Offices	6/17/2019	Financial management, Trusts Objectives, Trustwide risk assessment	12	Trust fails to achieve the financial plan and NHSI Financial Control total for 2019/20. This impacts on the ability to achieve national funding including PSF and FRF, which in turn could lead to unplanned cash borrowing.	Will undoubtedly recur, possibly frequently	Moderate	15	Identify savings programme for residual £2m gap for 2019/20	9/30/2019	10/21/2019	Thomas, Lisa	Finance and Performance Committee	11/29/2019	9	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	6/17/2019
										Identify cost effective solution to increased costs associated with Gastro and endoscopy services.	7/31/2019	8/19/2019	Thomas, Lisa							
										Ensure contract with commissioners reflects appropriate risk for blended tariff in 2019/20 and is consummate with the ICS partners.	7/12/2019	8/19/2019	Thomas, Lisa							
										Trust to work with Commissioner to mitigate risk of contract underperformance at M4 and potential operational risks in winter which in turn create further financial risk	11/29/2019		Thomas, Lisa							
										Directorates to identify recovery plans to mitigate forecast risk	10/31/2019		Thomas, Lisa							

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5605	Clinical Support and Family Services	Histopathology	10/18/2018	Departmental risk assessment	15	Problem: insufficient staff in cellular pathology laboratory, Consultant, Scientist and support staff groups. Also, equipment that is old and fails regularly. Risk: - slow report turnaround time - leading to failing UKAS accreditation - delaying patient treatment - delaying cancer treatment - increasing costs if work is outsourced to address the risks above - losing staff	Will undoubtedly recur, possibly frequently	Moderate	15	Locum Biomedical Scientist in laboratory for 3 months to cut backlog of tissue blocks awaiting microscopy.	1/11/2019	3/13/2019	White, Christine (Inactive User)	Departmental Team meeting	12/30/2019	9	Care, Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer	4/30/2019
										Cancer Lead - Dr J Cullis, to attend and watch MDT process to see if any recommendations can be made.	1/11/2019	3/13/2019	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.	1/11/2019	3/13/2019	House, Nicki (Inactive User)							
										New Locum Consultant arrived in department on 12th June. Review affect this has on risk score in 6 weeks.	7/31/2019	8/6/2019	Baden-Fuller, Dr Joanna							
										Locum Consultant no longer in trust due to quality issues. His work being audited by Source Bioscience. Trust needs to revert back to using Source Bioscience for a proportion of analysis and reporting.	12/30/2019		Phillips, Lee							
										Remedium-sourced Consultant to commence in Trust November 2019. To review risk score 6 weeks after staring in post	1/4/2020		Flynn, Dr Matthew							
										Application made for locum Biomedical Scientist to reduce outsourcing microscopy	10/16/2019	10/22/2019	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.	10/4/2019	10/23/2019	Baillie, Jenny							
										Appoint B6 Agency staff, following WCP approval	11/1/2019		Phillips, Lee							
										Appoint Bank Admin staff to administrate and support outsourcing processes	10/31/2019	10/21/2019	Baillie, Jenny							
										Compile business case for 6th Histopathologist based on increasing demands on the service.	11/30/2019		Boyd, Hannah							
5360	Transformation & IM&T	Information Technology	2/28/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	May recur occasionally	Catastrophic	15	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	12/14/2018	Noble, Bob (Inactive User)	Information Governance Steering Group	3/27/2020	10	Resources	Trust Board (Corporate Risk Register)	Director of Transformation	10/30/2018
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	2/28/2019	2/20/2019	Noble, Bob (Inactive User)							
										Review of practicalities of getting ransomware with financial controller.	7/24/2019	9/9/2019	Burwell, Jonathan							
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	12/20/2019		Carman, Mr Stephen							
										Review of options for SIEM automated logging and impact of this on resource	1/31/2020		Carman, Mr Stephen							

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4107	Musculo-Skeletal	Musculo-Skeletal Directorate Management Offices	9/17/2015	Service Delivery Plan, Specialty Risk assessment	12	Patients are not being followed up in the time that has been stipulated by Consultants due to lack of clinic capacity, clinicians not recording correctly or failures in administrative processes. Which could result in patient harm. clinical deterioration in between follow-ups which could lead to untreatable disease progression. This risk relates to outpatients and to patients needing local anaesthetics (the risk to patients needing local anaesthetics was previously on risk 5421 which was merged with this risk on 07/01/19). Appointments requested for patients are not always being given in a timely manner, particularly a risk for oncology patients (follow up clinic) Failure to follow national guidelines for the management of patients with skin cancer - particularly melanoma patients not being seen at regular 3 month intervals. Significant risk of patient mis-management with long term effects - disease progression making treatment options limited. Risk of duty of candour. SEE ALSO CLOSED RISK ID 5421	Will probably recur, but is not a persistent issue	Major	16	Further recruitment of 2 plastics consultants	12/18/2015	10/11/2016	Wright, Jonathan	Directorate Management Team Meeting	12/31/2019	6	Local Services (Care)	Clinical Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Medical Director	7/24/2017
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	1/17/2017	1/25/2018	Insull, Victoria							
										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	1/17/2018	1/17/2018	Insull, Victoria							
										monitor and review capacity and time to follow up	12/31/2018	12/21/2018	Vandyken, Ali							
										Reviewing the cause of all patients lost to follow up. Cross refereeing Lorenzo, with Somerset Cancer registry. And reviewing admin process for follow-ups.	4/30/2018	5/8/2018	Hyett, Andy							
										Reviewing the cause of all patients who have been lost to follow up and reviewing admin processes.	8/31/2018	8/16/2018	Hyett, Andy							
										Full follow up PTL being validated at patient level for 2017 and 2018.	3/29/2019	4/25/2019	Hyett, Andy							
										Trajectory for clearing skin backlog to be agreed with COO by 31/04/2019.	4/30/2019	6/12/2019	Wright, Jonathan							
										Executives to review approach to patient pathway redesign.	3/31/2019	4/26/2019	Blanshard, Dr Christine							
										Trajectory for urology backlog clearance to be agreed by 31/05/19 by COO.	5/31/2019	6/12/2019	stephens, Mrs Davina							
										Internal auditors (pwc) to review process for booking new patient and follow up outpatient appointments including cancer.	11/1/2019		Blanshard, Dr Christine							
										Organise a Risk Summit to address Human Factors causing patients to be lost to follow-up.	9/30/2019	10/25/2019	Blanshard, Dr Christine							
										Task and Finish Groups set up improve bookings, results review, clinic outcomes and MDT effectiveness (to address issues identified at Risk Summit).	4/1/2020		Blanshard, Dr Christine							

Corporate Risk Register
November 2019

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
5607	Surgery	All clinical areas	10/19/2018	Data quality, Incident reports	12	Hospital at night (H@N) data has shown a year on year increase in workload, but no increase in night team staffing. The workforce (originally set up in 2010) is regularly under pressure to manage the volume of new admissions and respond to unwell inpatients. The H@N management board feel there is a high risk of minor errors regularly occurring (i.e. delayed patient review & medicine prescriptions) and a risk of an occasional serious event, as a result of delayed review and intervention, particularly during busy periods, when the Trust is in escalation.	Will probably recur, but is not a persistent issue	Major	16	Throughout the month of December the H@N board will monitor workload to examine the impact of extra workload due to winter pressures. The Clinical Lead for H@N will then escalate to DMT if appropriate.	6/7/2019	5/7/2019	Payne, Gill	H@NT Management Board	12/1/2019	6	Care	Trust Board (Corporate Risk Register)	Medical Director	12/3/2018
										Workforce review of H@NT team	7/31/2019	8/21/2019	Henderson, Dr							
										Review of weekend mortality rates.	7/31/2019	8/21/2019	Blanshard, Dr Christine							
										Nursing lead for H@N to attend April DMT to formally present H@N activity report.	5/31/2019	6/19/2019	Payne, Gill							
										Review of out of hours safety within the hospital to be taken to Clinical Governance Committee in September.	9/30/2019	10/25/2019	Blanshard, Dr Christine							
										Ongoing review of the situation. Financial commitments and recruitment challenges will impact on the ability to increase staffing.	12/1/2019		Blanshard, Dr Christine							
5704	Medicine	Trustwide	1/31/2019	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.	9/30/2019	4/25/2019	Clarke, Lisa	Intensive Support Meeting	12/31/2019	12	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Operating Officer	1/31/2019
										Continual clinical prioritisation to ensure that high risk areas are covered.	4/1/2019	4/17/2019	Clarke, Lisa							
										Continuing insourcing of private provider to endoscopy.	6/30/2019	4/25/2019	Vandyken, Ali							
										Quantification and mitigation of the risk to bowel scope.	4/1/2019	4/17/2019	Vandyken, Ali							
										Tender for elements of the Gastroenterology service.	4/1/2019	4/17/2019	Stagg, Andrew							
										Monthly update to F&P Committee and CGC.	5/10/2019	4/25/2019	Hyett, Andy							
										Presentation of gastro strategy to Finance and Performance Committee.	5/31/2019	6/12/2019	Hyett, Andy							
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	10/1/2019	10/22/2019	Hyett, Andy							
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	9/30/2019	8/29/2019	Henderson, Dr Stuart							
										Medical Director to link with other STP partners around system wide solution.	12/31/2019		Blanshard, Dr Christine							
										Case for change to develop a GI unit to be completed	12/31/2019		Hyett, Andy							

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
5751	Trustwide	Trustwide	3/11/2019	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.	5/1/2019	6/12/2019	Hyett, Andy	Trust Board	11/30/2019	12	Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer	3/11/2019
										Winter Director coordinating trajectory for delivery of DTOC target.	5/1/2019	6/12/2019	Hyett, Andy							
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	5/1/2019	6/12/2019	Hyett, Andy							
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	5/1/2019	6/12/2019	Hyett, Andy							
										Trust implementing discharge PTL	7/1/2019	9/4/2019	Hyett, Andy							
										Escalation to EDLDB non delivery of trajectory	7/1/2019	9/4/2019	Hyett, Andy							
										Mitigation actions being prepared to mitigate lack of capacity in the community.	8/1/2019	9/4/2019	Hyett, Andy							
										All providers required to present their winter plans to EDLDB in September.	9/30/2019	10/22/2019	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	11/30/2019		Hyett, Andy							
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	10/31/2019		Hyett, Andy							
5970	Transformation & IM&T	Trustwide	8/23/2019	Trusts Objectives	16	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Will probably recur, but is not a persistent issue	Major	16	Development of an IT improvement plan which includes staffing, communications, infrastructure, governance and any outstanding pen test/audit actions.	11/22/2019		Provins, Esther	Finance and Performance Committee	11/29/2019	9	Innovation	Finance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	8/23/2019
										Set up monthly executive performance reviews.	9/30/2019	10/11/2019	Provins, Esther							
										Completion of internal audit action plans and penetration test action plans.	11/29/2019		Provins, Esther							
										To complete the review and proposal for improving our capacity to do business change.	11/29/2019		Provins, Esther							
5972	Transformation & IM&T	Trustwide	8/23/2019	Trusts Objectives	16	Insufficient organisational development resources to delivery cultural change and lack of formal Trust wide approaches to seek best practices from elsewhere. This could potentially result in lack of improvement, poor quality services, reputational damage, financial impact, operational ineffectiveness and inability to attract and retain high quality staff.	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	12/13/2019		Provins, Esther	Trust Board	11/29/2019	12	Innovation (Resources)	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Director of Transformation	8/23/2019
										Introduce a Dragon's Den event to inspire, promote and reward innovation	4/30/2020		Provins, Esther							
										Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	12/31/2019		Provins, Esther							
										Review effectiveness of Quality Improvement plan.	12/31/2019		Provins, Esther							
										Implement Quality Improvement plan	12/31/2019		Provins, Esther							
										Finalising procurement of external support to develop a QI coach network.	10/31/2019	11/6/2019	Provins, Esther							
										Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	1/31/2020		Provins, Esther							

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Date Escalated to Corporate Risk Register
3322	Clinical Support and Family Services	Genetics	8/29/2013	Organisational risk assessment	12	National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury. Consequence of this risk includes a risk to clinical quality during any transition phase.	Will undoubtedly recur, possibly frequently	Catastrophic	25	A genomics strategy group, co-chaired by Christine Blanshard (MD), has been established that involves University Hospitals Southampton and the University of Southampton. A pilot project is planned for 2015 and will formulate a regional strategy once details of the proposed reorganisation are known. This was not released until Nov 2016 These meetings have restarted with additional parties due to the updated project named "re-procurement" Genomic tender meetings occurring regularly between UHS and SFT including Trust representative. Partnership negotiations begun for a wider partnership bid. Update Oct 18: Wessex Oxford and West Midland Genomics Consortium (WOWMC)has been established and chosen as the preferred provider of genetic/genomic diagnostic testing for Wessex, The West Midlands, Oxfordshire and Thames Valley. The Central Laboratory Hub will be in Birmingham.	4/1/2018	1/25/2018	Blanshard, Dr Christine	Trust Board	12/1/2019	6		Specialist Services Clinical Governance Committee, Finance Committee, Trust Board (Corporate Risk Register)	Medical Director	11/16/2017
										Tender document issued. Alliance formed with UHB, BWCH, OUH and UHS to respond to the tender. BWCH proposed to become the central laboratory hub and WRGL will become a local genomics laboratory.	10/31/2018	11/30/2018	Blanshard, Dr Christine							
										Need to consolidate DNA extraction into a single lab in Wessex. Will require negotiations with UHS.	8/30/2019	8/21/2019	Cross, Prof. Nick							
										Communication plan with referring hospitals to inform they will be required to fund cancer testing from tariff.	4/1/2019	8/19/2019	Thomas, Lisa							
										Options approval strategy to be prepared by the Associate Director of Strategy (initial strategy not approved in March 2019).	8/30/2019	8/21/2019	Blanshard, Dr Christine							
										UHS to produce a paper for their September Board Meeting, presenting their views on the pros and cons of consolidating genetic testing for Wessex at UHS. Will be shared with the Consortium on 10/09/19. Update October 19- Aiming for the draft paper to be presented at their December Board Meeting.	12/31/2019		Blanshard, Dr Christine							

Corporate Risk Register Summary - November 2019

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Sep-18	Nov-18	Jan-19	Mar-19	Jun-19	Jul-19	Sep-19	Nov-19	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													
5808	Lack of service provision for elective vascular angiography	Chief Operating Officer	1-May-19	10					10	10	10	12	6
5704	Inability to provide a full gastroenterology service due to a lack of medical staff capacity	Chief Operating Officer	31-Jan-19	16			16	16	12	12	16	16	12
4107	Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes	Medical Director	17-Sep-15	12	9	9	9	12	16	16	16	16	6
5751	Risk of impact on patients from high numbers with a delayed transfer of care	Chief Operating Officer	11-Mar-19	16				16	16	16	16	16	12
5799	Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients	Chief Operating Officer	18-Apr-19	15					20	16	20	15	9
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population													
3322	National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services	Medical Director	29-Aug-13	12	12	12	9	9	9	9	9	25	6
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered													
5850	Potential non-delivery of CQUIN schemes resulting in a financial loss	Director of Finance	13-Jun-19	12					12	12	9	9	6
5969	Risk of failure to deliver GIRFT action plans	Director of Transformation	23-Aug-19	12							12	6	6
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	9
5972	Insufficient organisational development resources to delivery cultural change and lack of formal Trust wide approaches to seek best practices from elsewhere.	Director of Transformation	23-Aug-19	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													
4857	A lack of resilience in infrastructure including a single access route to the national health and social care network (HSCN) and unsupported hardware/software, resulting in loss of access to IT systems and internet access.	Director of Transformation	1-Jan-19	10			10	10	10	10	10	10	5
5851	Weekend HSMR significantly higher than expected	Medical Director	13-Jun-19	12					12	12	9	15	9
5804	Risk of patients within hospital experiencing a fall	Director of Nursing	26-Apr-19	12					12	12	12	12	8
5870	Failure to achieve quality projections set nationally due to changes in reporting definitions (CDiff, Pressure ulcers)	Director of Nursing	20-Jun-19	12					12	12	8	8	8
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	9
5607	Risk of error due to Hospital at Night Team capacity to address increasing workload	Medical Director	19-Oct-18	12			12	16	16	16	16	16	6
5966	Risk of compromised services due to hub and spoke model	Medical Director	20-Aug-19	12							12	15	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	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	9
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources													
5705	Unknown impact on the running of the hospital as a result of the EU Exit	Chief Operating Officer	31-Jan-19	12			12	8	8	8	8	8	8
5487	The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation	Director of Finance	26-Nov-18	12		12	12	12	9	9	9	9	6
5326	Risk of access to patient information through variety of clinical information systems and overhead of access	Director of Transformation	20-Dec-17	9	9	9	9	9	9	9	9	9	6
5860	Risk of failure to achieve financial plan and NHSI control total for 2019/20	Director of Finance	17-Jun-19	12					12	12	12	15	9
5480	Risk of poor controls to ensure the consistency and accuracy of information reporting	Director of Transformation	23-Jun-18	16	12	12	12	12	12	12	12	12	8
5862	Risk to buildings and equipment due to capital programme funding	Director of Finance	17-Jun-19	12					12	12	12	9	8
5360	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Director of Transformation	28-Feb-18	15		15	15	15	15	15	10	15	10
5955	Insufficient robust management control procedures	Director of Finance	13-Aug-19	15							15	15	9
5920	Breaches of fire compartmentation in PFI building	Chief Operating Officer	17-Jul-19	6							6	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	6
6042	Risk of lack of CCG capacity and focus to deliver change required for SFT to deliver its core strategy due to local merger of 3 CCGs	Chief Operating Officer	25-Oct-19	12								12	6
6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Director of Finance	25-Oct-19	12								12	6
5345	Breaching key data regulations including General Data Protection Regulations (GDPR), Privacy and Electronic Communications Regulations (PECR) and NHS Code of Practice: Records Management 2016 could result in financial loss and reputational impact.	Director of Transformation	12-Nov-19	12								9	6

Risk Score Key

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**3.2**
Date of Meeting:	5 December 2019		

Report Title:	Learning from deaths Q2 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 Q2 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 planned introduction of the Medical Examiner system in 2020 and the improvements in bereavement support. The Q2 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. 2 deaths were unexpected and are subject to serious incident inquiries. A new theme emerged in Q2 on recognition and management of end of life care, particularly by new trainees, emphasising the importance of ongoing end of life care education. A case notes review of a new, higher than expected relative risk of mortality in gastrointestinal haemorrhage in Q2 took place as well as a review of 33 patients with a hip fracture and these will be reported in Q3. HSMR overall has increased slightly but the rising trend of weekend HSMR to 133.8 is of concern. A review of 78 deaths of patients admitted as an emergency on a Sunday found no direct causal link with patients being admitted as an emergency at a weekend. A supplementary report on weekend safety and effectiveness brought together related issues potentially impacting on the services provided by the Trust at weekends and concluded the issue is multi-factorial. An action plan to mitigate the risk factors was presented to the Trust Board in November 2019.

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

Q2 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 agenda item and present a paper to a public board meeting.

2. Background

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

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

3. Medical Examiners (ME)

A plan is now in place to provide the new Medical Examiner service to ensure excellence in care for the bereaved to start as soon as sufficient MEs have been trained. The national guidance is that this should be implemented by no later than 1 April 2020. This includes:

- A 5 day (ME) roster covering adult and paediatric deaths within the Trust, including cover for all leave.
- Adequate staffing is in place to ensure that the registration of a death is not delayed by the ME process.
- A facility for Qualified Attending Physicians (junior doctor) to discuss each death and death certification in a meaningful way with the ME.
- A facility for each ME or Medical Examiners' Officer (MEO) to have a meaningful discussion with the next of kin regarding the end of life care of a loved one and an explanation of the medical certificate.
- 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.

Meetings planned to ensure smooth implementation from January 2020.

4. Working with bereaved families

Our local bereavement survey 'Your views matter' continues to be offered to bereaved families when they collect the medical certificate. To date (1/7/19 – 31/10/19), 103 surveys have been given to relatives with 17 (16%) returned. The response rate is comparable with the national position. Most feedback received is positive with some being outstanding. All feedback is shared with the individual wards and any named staff.

All bereaved families that complete a survey are given the option of a follow up phone call with a member of the end of life care team. To date, 6 families have received a follow up call, and of these 2 have been referred to Cruse Bereavement Care (a charity that offers support, advice and information to people when someone dies), 3 have been signposted to their GP for physical and psychological support and 1 family were referred to the Palliative Care bereavement follow up team.

The main theme identified for improvement is around poor communication, in particular when medical staff handover to each other. The Lead Nurse of the End of Life Care team attended the relevant departmental mortality and morbidity meeting and facilitated a discussion with the consultant body about communication on handover day. This generated ideas for improvement and will be followed up with a further meeting in 6 months time.

5. Mortality dashboard, learning, themes and actions

In Q2 2019/20, 172 deaths occurred in the Trust. The total includes patients who died in the Emergency Department. Of these, 164 (95%) were screened to ascertain whether the death needed a full case review. 57 (33%) deaths had a full case review. No deaths were probably avoidable, 3 were possibly avoidable but not very likely, less than 50/50 chance, and 6 had slight evidence of avoidability. Key themes arising from the 15 learning points were:

1. End of life care – recognition of the dying patient, communication with patients and families, ceilings of care.
2. Treatment escalation plans (TEPs) – patients admitted with TEPs who did not want admission to hospital and others receiving full investigations and treatment.

6. Improvement actions in Q2 19/20

- Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form) - the CCG have asked the Trust to put the introduction of ReSPECT on hold until the national version 3 is published in ?March 2020 so that it can be launched as an BSW STP wide piece of work. A BSW STP steering group is due to re-start in December 19.
- Improve documentation of consent, risks and benefits of ward based procedures such as chest drains and ascitic taps - Chest drain insertion sticker - partially completed. Ascitic drainage requires a lead to prepare a LoCSSIP.
- Report compliance with senior review at a weekend via the 7DS Board Assurance Framework at the Clinical Governance Committee in November 19 and present a review of the safety and effectiveness of services at the weekend to the Clinical Governance Committee in October 19 – completed.
- Improve the escalation of patients who deteriorate in accordance with the NEWS2 policy – ongoing education and quarterly escalation audits. Q1 & Q2 19/20 – 84% appropriate escalation (Target 95%).
- Improve the recognition of a dying patient and managed of good end of life care – ongoing end of life care education and quarterly monitoring of end of life care metrics in place.

7. CUSUM alerts

In Q2 19/20, 5 new CUSUM alerts:

- Cancer of bronchus, lung 26 deaths vs 17 expected, relative risk 152. 10 patients died in the Hospice. The Mortality Surveillance Group decided this group did not need to be investigated as a similar alert had been investigated in September 2017. No death was avoidable and there were no learning points.
- Gastritis and duodenitis – 3 deaths vs 0.1 expected, relative risk 2076. Cases to be investigated and reported to the Mortality Surveillance Group in February 2020.
- Secondary malignancies (2nd alert) 25 vs 13.3 expected, relative risk 187. 16 patients died in the Hospice. The Mortality Surveillance Group decided this group did not need to be investigated as two previous alerts were investigated in November 2018 and in 2012. No death was avoidable. 3 cases were investigated as part of the weekend HSMR review in September 19 – no death was avoidable, all 3 received excellent care and there were no problems in care.
- Systemic lupus and connective tissue disorder – 1 death vs 0 expected, relative risk 1281. The Mortality Surveillance Group decided not to investigate this alert.
- Therapeutic endoscopic procedure on ureter – 2 deaths vs 1 expected, relative risk 191. The Mortality Surveillance Group decided not to investigate this alert as 1 death previously investigated where the procedure was unrelated to the cause of death from neutropenic sepsis related to stage 4 lymphoma.

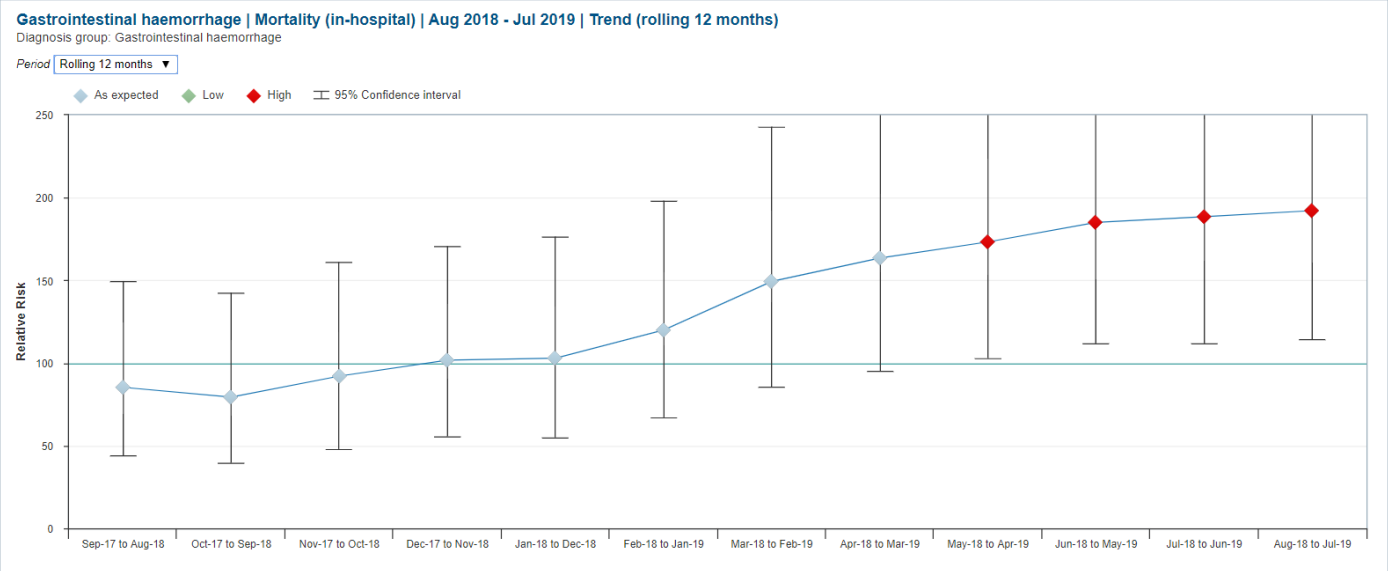
Previously unreported alert in Q1 19/20:

- Operations on vitreous body 1 death vs 0 expected with a relative risk 539 – the procedure was for aspiration of vitreous humour to guide treatment of endophthalmitis. The patient had a serious eye infection and multiple serious co-morbidities. The patient was subject to a drug error during his stay, but died of severe heart failure (SII 296).

8. Relative risk alerts

One new relative risk alert arose in Q1 19/20: Gastrointestinal (GI) haemorrhage – 18 deaths vs 10.2 expected with a relative risk 176.5 is statistically significantly higher than expected. There has been an upward trend in relative risk for GI haemorrhage over the last 7 data points. The weekend cohort has a statistically significantly higher than expected relative risk. These are mostly frail patients of 75 years and over. The Mortality Surveillance Group undertook a multidisciplinary review of the 18 deaths and will report findings at the February 2020 meeting.

Figure 1: Trend in relative risk for gastro-intestinal haemorrhage



9. Death following a planned admission to hospital

In Q2 19/20, there were 3 deaths of patients following a planned admission:

- A patient admitted electively for drainage of ascites with a diagnosis of metastatic ovarian cancer died from disease progression. Death was expected and not avoidable. No learning points.

- A patient with a diagnosis of acute myeloid leukaemia admitted for salvage chemotherapy as first line treatment had failed. Refractory disease noted with poor prognosis. Developed a pericardial effusion which was drained. Maximal ITU therapy and given full supportive care but continued to deteriorate and died. Death was expected and not avoidable. No learning points.

- A patient with a diagnosis of metastatic mesothelioma with an indwelling pleural catheter was admitted electively to the Hospice for symptom control of shortness of breath and treated for a lower respiratory tract infection. Deteriorated and died from disease progression. Death was expected and not avoidable. No learning points.

10. Unexpected deaths

In Q2, there were 2 unexpected deaths.

1. An intra-uterine death at 27 weeks of a known high risk pregnancy receiving care at the Fetal Medicine Unit at Princess Anne Hospital, Southampton. Pathological cardiotocograph. Admitted to Salisbury and then transferred to Southampton but the baby died within 15 minutes of arrival (SII334).
2. An older patient with multiple co-morbidities and exacerbation of chronic obstructive pulmonary disease. Plan for discharge made but had an unwitnessed fall and fractured a hip. Surgery undertaken although very high risk of death (SII335).

11. Stillbirths, neonatal deaths and child death

One stillbirth in July of a pregnancy that was terminated at 25 weeks for a fetal anomaly. No neonatal or child deaths in Q2.

12. Patients with a learning disability

In Q1 & Q2 one patient with a learning disability died:

- A patient with an out of hospital cardiac arrest was resuscitated for 45 minutes before the return of spontaneous circulation. Rapid transfer to ITU and maximal treatment. Decision to withdraw treatment on day 5 due to an unsurvivable hypoxic brain injury. The death was expected and not avoidable. Family well supported and provided with on site accommodation and welfare.

The death was reported to the LeDeR programme following a case notes review.

13. Patients with a serious mental illness

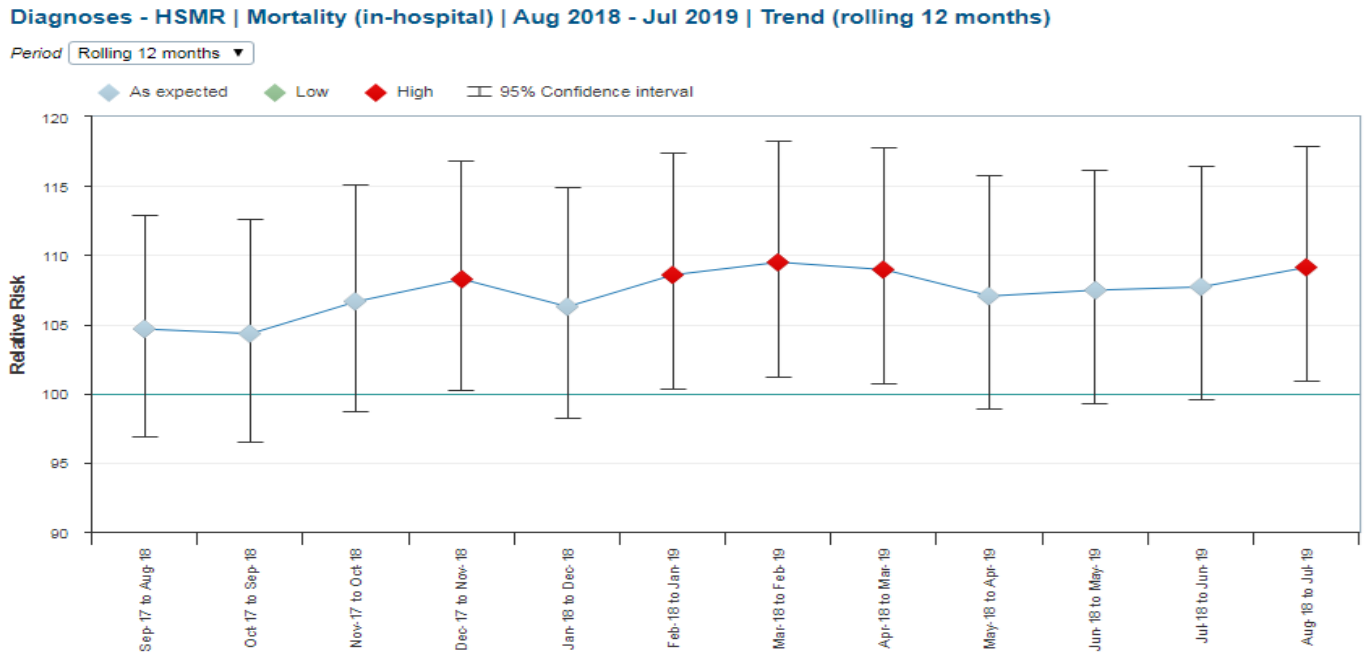
In Q1 & Q2 19/20, two patients with a serious mental illness died:

- A 67 year old woman with a schizoaffective disorder admitted from a long term residential placement under a Deprivation of Liberty Safeguards with a pyrexia, diarrhoea and vomiting. Diagnosis of E Coli sepsis with acute kidney injury. Treated with fluids and intravenous antibiotics. Community DNAR in place. Despite active treatment the patient continued to deteriorate and care was switched to a palliative approach. Good practice identified: collateral history from carers and family and good liaison with the care home and the family to judge best interests. The death was expected and not avoidable.

- A 70 year old man with schizophrenia receiving Depot treatment. Long term tracheostomy in place for obstructive sleep apnoea. Recurrent admissions for aspiration pneumonia. Admitted from Fountains Way Hospital with increased agitation and pneumonia and uncontrolled blood sugars. Actively treated but eventually succumbed to pneumonia. The death was expected and not avoidable.
  Learning: PEG feeding considered but no evidence of a best interests meeting to confirm the plan not to insert a PEG tube.

14. HSMR rolling 12 month trend to July 2019

Figure 2: HSMR relative risk of all diagnoses August 2018 – July 2019



HSMR has increased to 109 and is higher than expected over the last 12 month rolling period.

15. Mortality (in-hospital) regional peer comparison August 2018 – July 2019

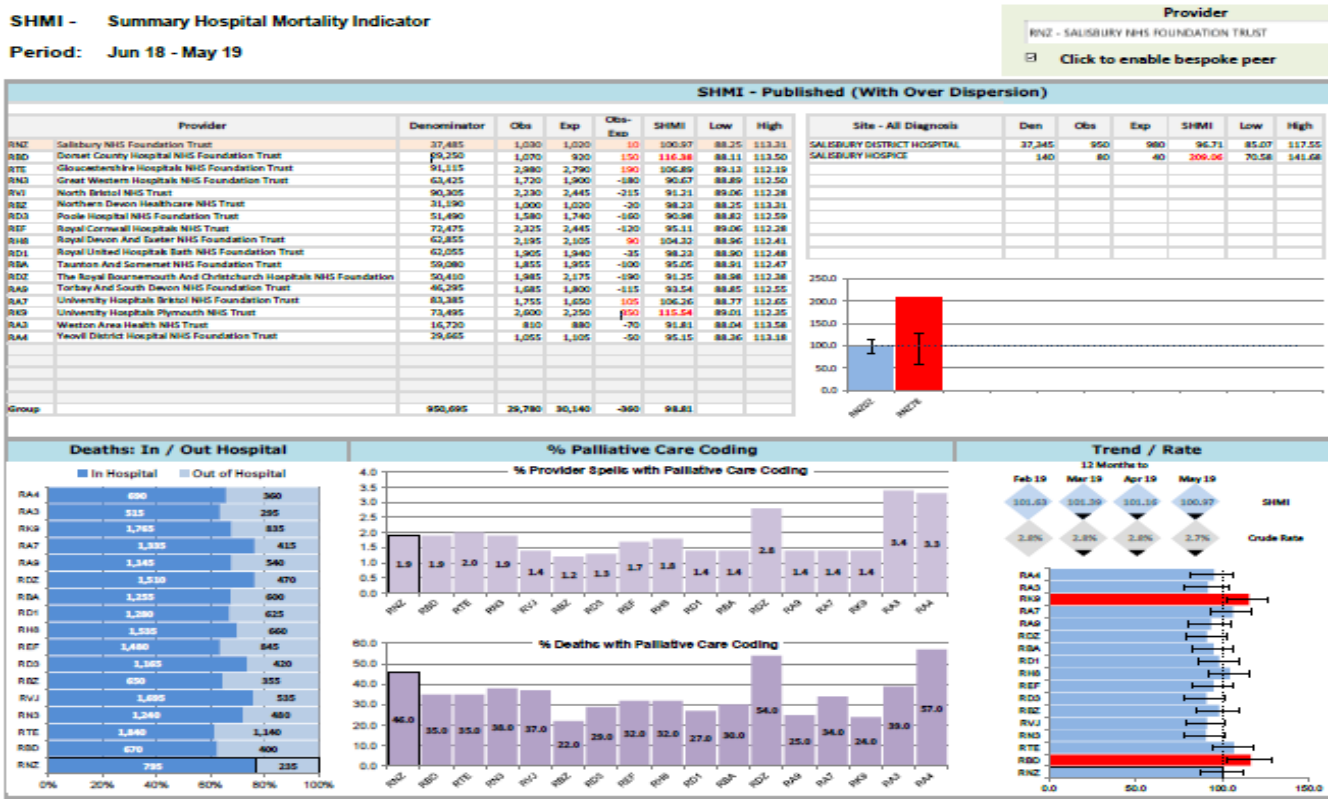
Figure 3: Mortality (in-hospital) regional peer comparison August 2018 – July 2019

Regional peer comparison shows 4 other acute Trusts have a higher in-hospital mortality than this Trust.

16. SHMI June 2018 – May 2019

SHMI is 100.97 within the expected range. When comparing SHMI by site Salisbury District Hospital is 96.71 and Salisbury Hospice is 209. When compared with regional peers the Trust has a SHMI within the expected range.

Table 4: SHMI regional peer comparison June 2018 – May 2019



17. Comorbidity and palliative care coding 19/20

Trends in comorbidity coding show that the Trust has a Charlson comorbidity upper quartile rate for the HSMR basket of 24.5% which is 98 as an index of national.

Figure 5: Trend in Charlson Comorbidity upper quartile rate

Comorbidity Profile

Organisation: **SALISBURY NHS FOUNDATION TRUST**

Report Date: **5 November 2019**

	2016/17	2017/18	2018/19	2019/20
Upper-quartile comorbidity	24.2%	24.4%	24.7%	24.5%
as index of national (100)	97	98	99	98

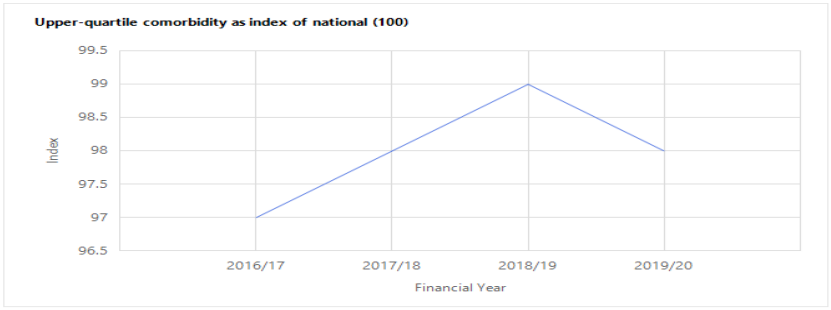


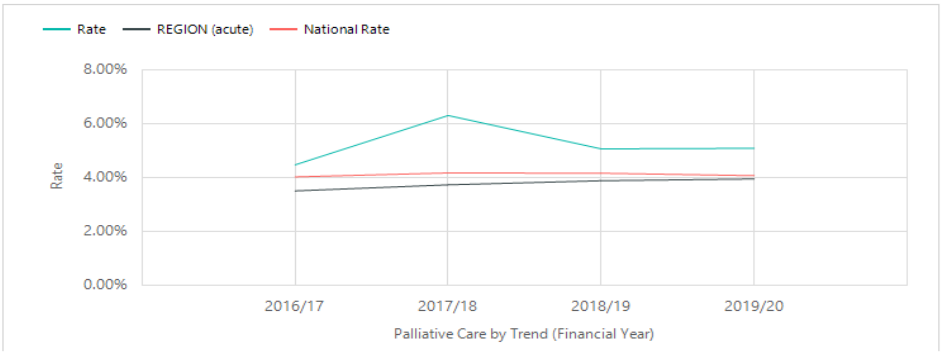
Figure 6: Trend in Palliative Care coding rate

Palliative Care Profile

Organisation: **Salisbury NHS Foundation Trust** *Report Date:* **5 November 2019**

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

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2016/17	9,523	426	4.47%	4.03%	3.51%
2017/18	9,773	616	6.30%	4.17%	3.73%
2018/19	9,971	505	5.06%	4.16%	3.88%
2019/20	3,381	172	5.09%	4.07%	3.95%



Trends in palliative care coding show that for 19/20 the Trust has a palliative care coding rate for non-elective spells of 5.09% which is higher than the national rate of 4.07%. The Trust's rate has decreased compared to the 18/19 financial year.

18. Weekday/weekend HSMR

Emergency weekday HSMR is within the expected range at 102.2 but weekend HSMR is statistically significantly higher than expected at 133.8. Sunday has a statistically significant higher than expected relative risk.

Figure 7: HSMR Emergency weekday/weekend admission August 2018 – July 2019

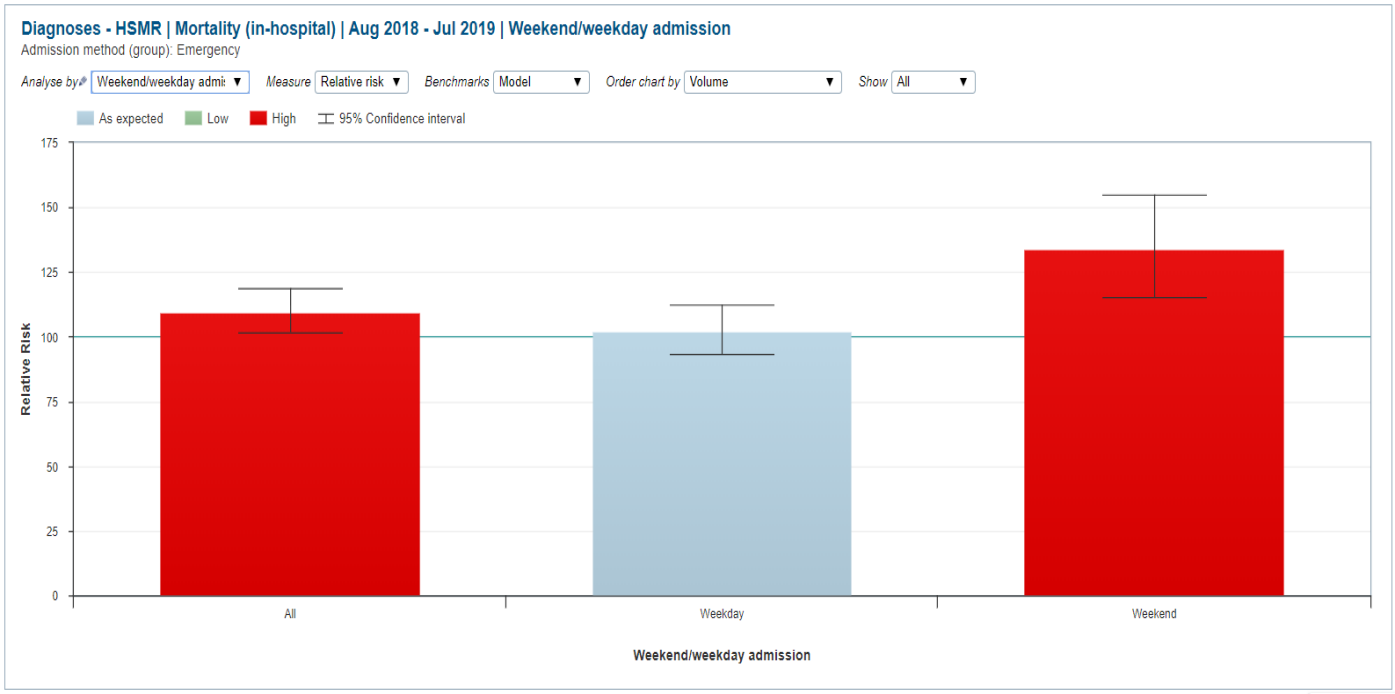
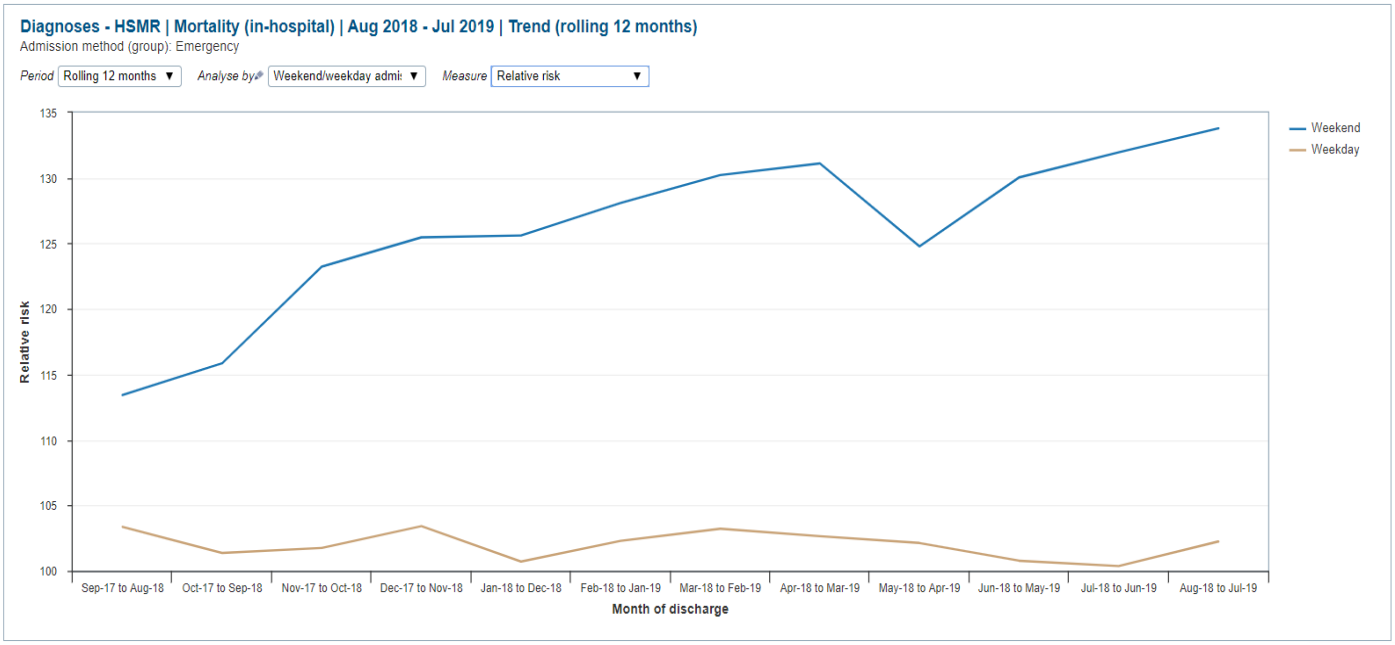


Figure 8: Rolling 12 month trend in emergency weekend and weekday HSMR August 18 – July 19



The emergency weekend HSMR has been statistically significantly higher than expected since October 2018. A detailed review of 78 deaths of patients admitted as an emergency on a Sunday to determine whether there were any adverse events that may have contributed to these deaths was presented to the Clinical Governance Committee in September 2019. The review found no direct causal link with patients being admitted as an emergency at a weekend. A supplementary report on weekend safety and effectiveness was also presented at the same meeting. This brought together related issues potentially impacting on the services provided at the Trust at weekends and concluded the issue is multi-factorial – particularly the workload of staff at the weekends both in primary and community care and in the Trust along with the reduced availability of some services. An action plan to mitigate the risk factors was presented to the Trust Board in November 2019.

19. Deaths in high risk diagnosis groups (August 2018 – July 2019)

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

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

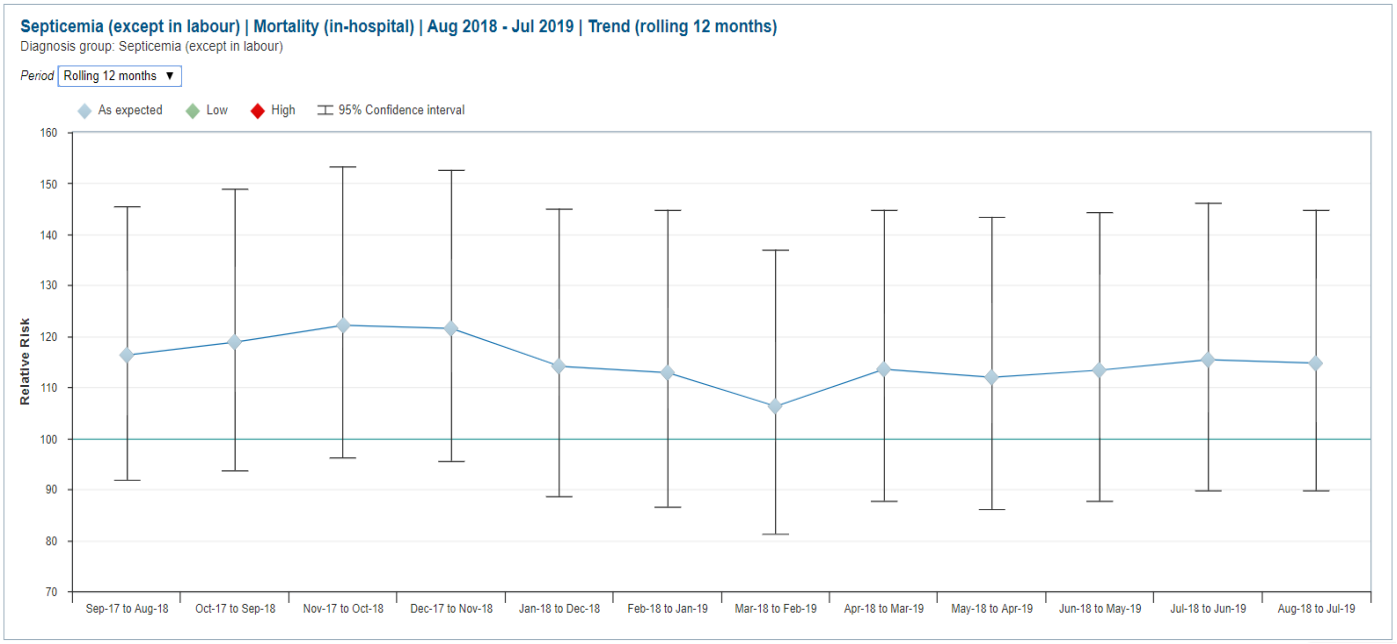


Figure 10: Trend in relative risk for pneumonia

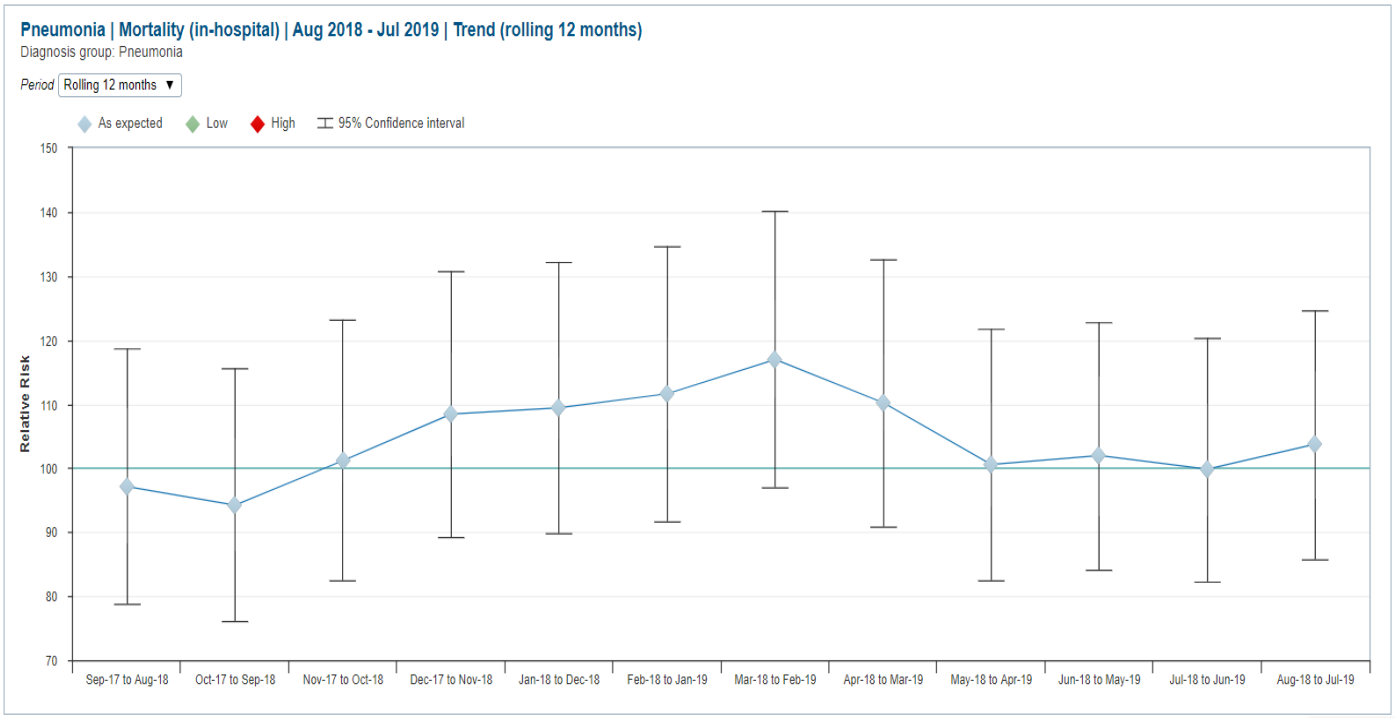


Figure 11: Trend in relative risk for acute cerebrovascular disease

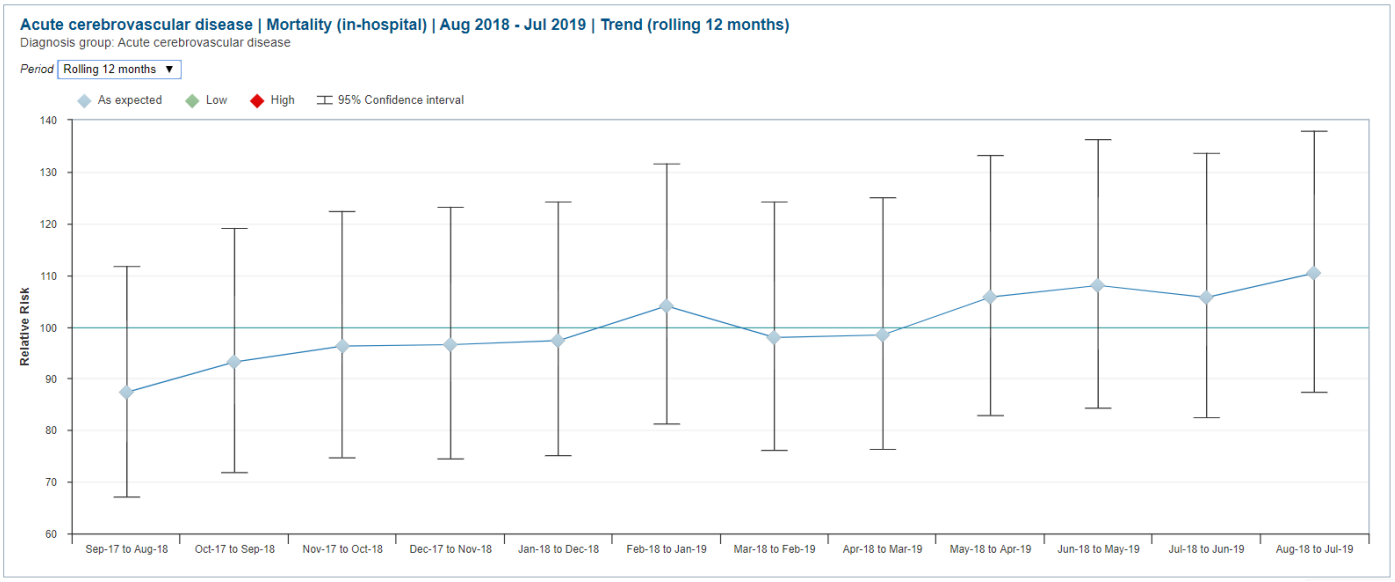


Figure 12: Trend in relative risk for acute myocardial infarction

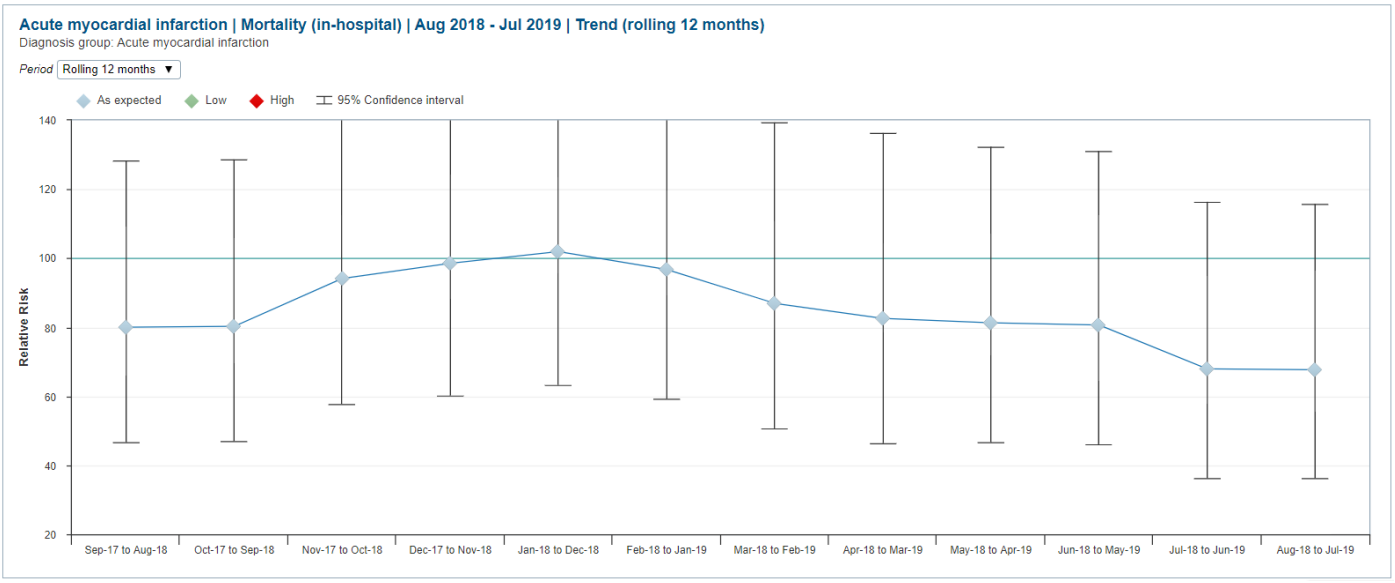


Figure 13: Trend in relative risk for congestive cardiac failure

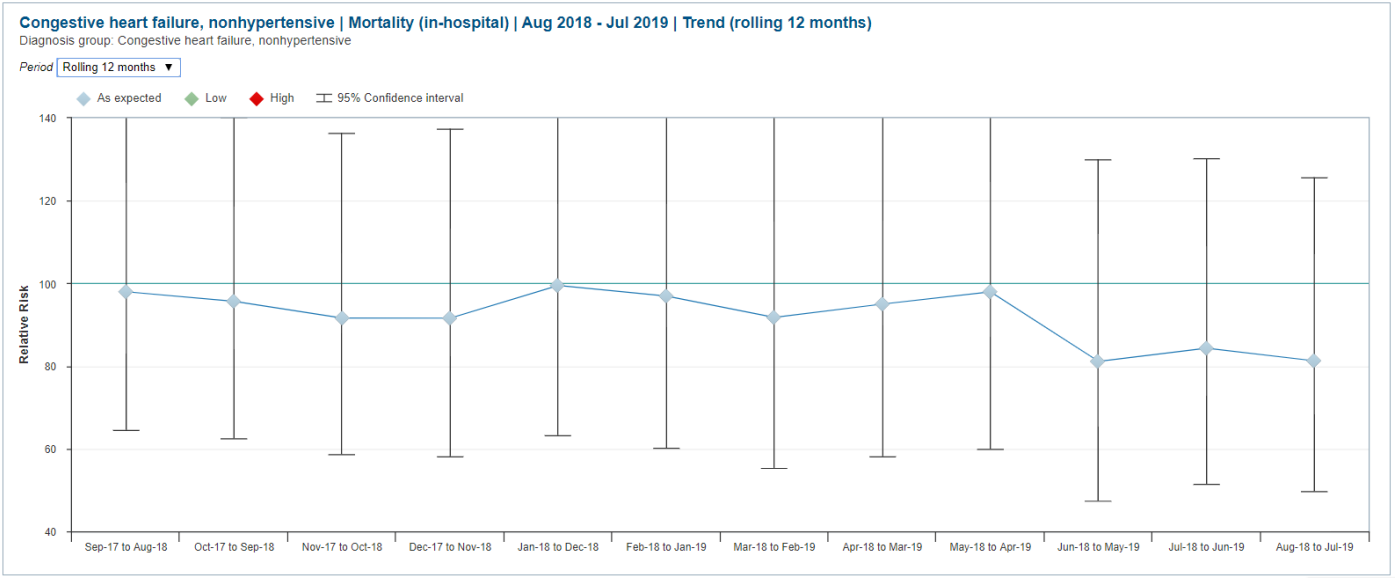


Figure 14: Trend in relative risk for acute and unspecified renal failure

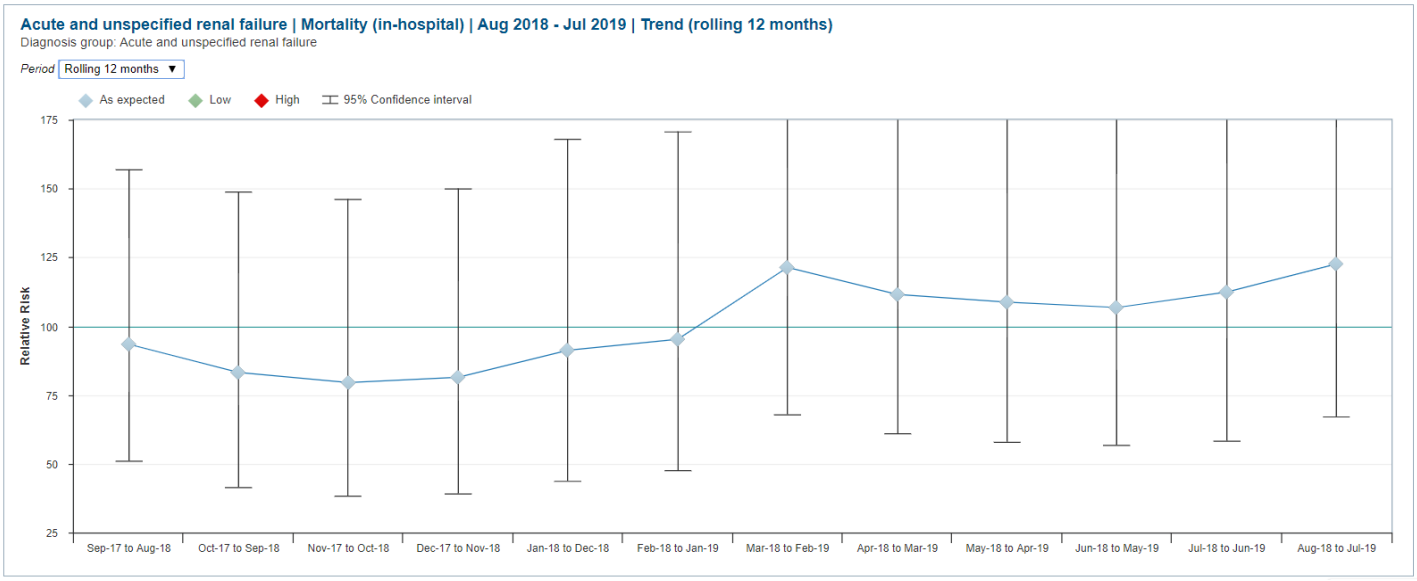
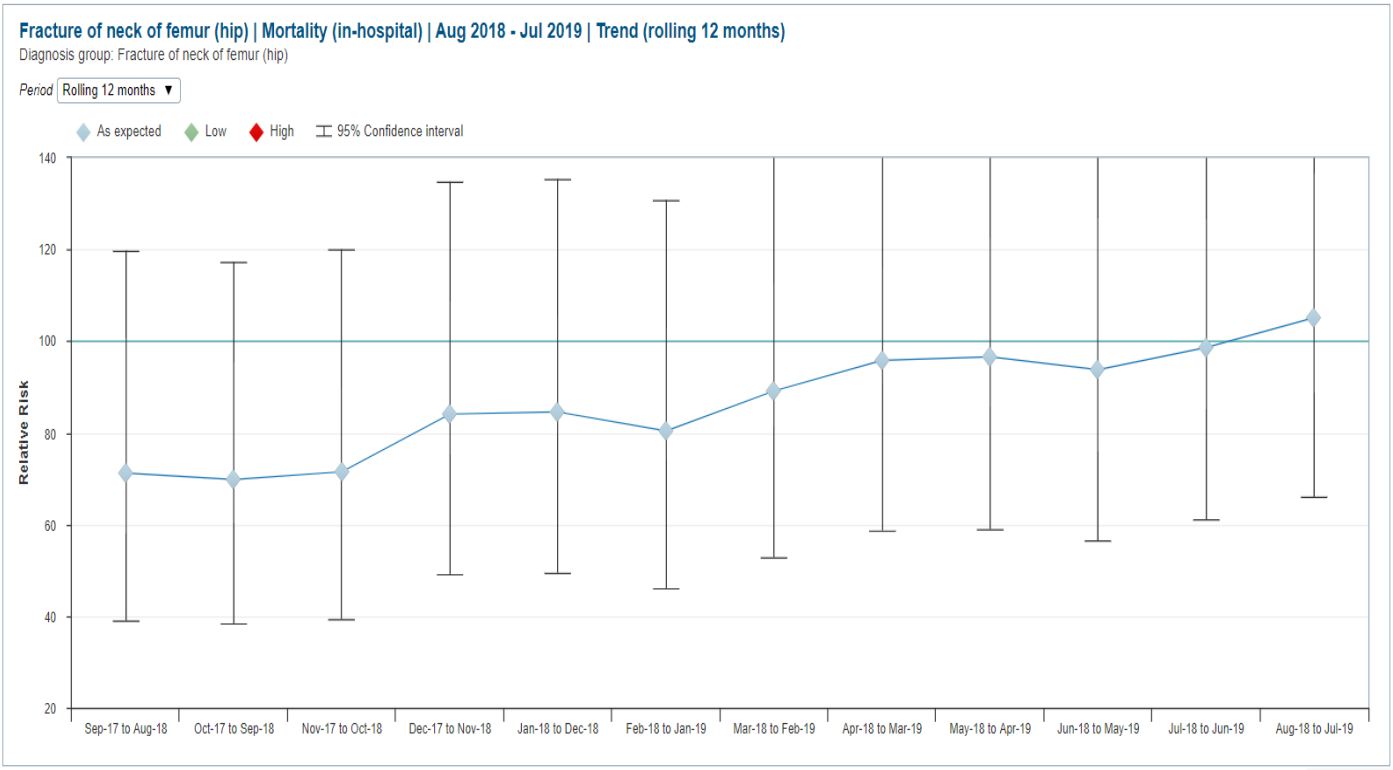


Figure 15: Trend in relative risk for fracture of neck of femur



The Mortality Surveillance Group have undertaken a multidisciplinary review of 33 patients who died with a fractured neck of femur arising from the alert (June 18 – May 19) and this will be reported to the meeting in February 2020 and the Q3 Learning from Deaths report.

Although all 7 diagnosis groups remain within the expected range, acute kidney injury; and acute cerebrovascular disease and fractured neck of femur have shown an upward trend over the last 4 and 6 data points respectively.

19. Summary

The report highlights the planned introduction of the Medical Examiner system in 2020 and the improvements in bereavement support. The Q2 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. 2 deaths were unexpected and are subject to serious incident inquiries. A new theme emerged in Q2 on recognition and management of end of life care, particularly by new trainees, emphasising the importance of ongoing end of life care education.

A case notes review of a new relative risk of gastrointestinal haemorrhage in Q2 took place as well as a review of 33 patients with a hip fracture and these will be reported in Q3.

HSMR overall has increased slightly but the rising trend of weekend HSMR to 133.8 is of concern. A review of 78 deaths of patients admitted as an emergency on a Sunday found no direct causal link with patients being admitted as an emergency at a weekend. A supplementary report on weekend safety and effectiveness brought together related issues potentially impacting on the services provided by the Trust at weekends and concluded the issue is multi-factorial. An action plan to mitigate the risk factors was presented to the Trust Board in November 2019

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,
13 November 2019

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**									**364**
1st screen	65	58	62	**185**	65	40	59	**164**									**349**
% 1st screen	97%	92%	100%	**96%**	96%	93%	97%	**95%**									**96%**
Case reviews	23	19	20	**62**	27	11	19	**57**									**119**
% case reviews	34%	30%	32%	**32%**	40%	26%	31%	**33%**									**32%**
Deaths with Hogan score 1	63	60	60	**183**	65	40	58	**163**									**346**
Deaths with Hogan score 2 - 3	4	3	1	**8**	3	3	3	**9**									**17**
Deaths with Hogan score 4 - 6	0	0	1	**1**	0	0	0	**0**									**1**
Learning points	7	7	6	**20**	5	3	7	**15**									**35**
Family/carer concerns	1	1	2	**4**	1	1	2	**4**									**8**
CUSUM alerts	3	1	0	**4**	0	5	0	**5**									**9**
CUSUM investigated	3	0	0	**3**	0	1	0	**1**									**4**
Deaths investigated as an SII	0	2	2	**4**	1	0	2	**3**									**7**
Death following an elective admission	2	0	1	**3**	1	0	2	**3**									**6**
Unexpected	0	3	1	**4**	0	0	2	**2**									**6**
Stillbirths/ neonatal/child death	0	1	0	**1**	1	0	0	**1**									**2**
Learning disability deaths	0	1	0	**1**	0	0	0	**0**									**1**
Reported to LeDeR programme LeDeR	0	1	0	**1**	0	0	0	**0**									**1**
Serious mental illness	0	0	2	**2**	0	0	0	**0**									**2**
Maternal death	0	0	0	**0**	0	0	0	**0**									**0**

Note explanatory notes in appendix 3

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

No	Learning points	Action point	By whom	By when	Update 31/10/2019	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	The CCG have asked the Trust to put the introduction of ReSPECT on hold until the national version 3 is published in March 2020 and it can be launched as an STP wide piece of work.	
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	Chest drain insertion sticker - partially completed. Ascitic tap drainage requires a lead to develop this work further	
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 November 19. Report to the Clinical Governance Committee in October 19 - completed	
4	Recognising deteriorating patients and escalate to the appropriate level.	Improve the escalation of patients in accordance with the NEWS2 policy.	N Finneran M Ford	31/03/20	Ongoing education and quarterly escalation audits. Q1 & Q2 19/20 – 84% appropriate escalation (Target 95%).	
5	Recognition of a dying patient and management of good end of life care	Teaching on end of life care	Palliative Care and End of Life Care Teams	31/03/20	Ongoing end of life care education and quarterly monitoring of end of life care metrics	

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

References

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

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.3
Date of Meeting:	05 December 2019		

Report Title:	Director of Infection Prevention & Control (DIPC) Six Monthly Report for Quarters 1 and 2 of 2019/20			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy, Senior Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing and DIPC			
Appendices (list if applicable):	Included within the report			

Recommendation:

The Board is asked to:

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

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

Executive Summary:

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

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

The purpose of this six monthly DIPC Report is to inform the Trust Board of the progress made against the 2019/20 Annual Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

For the reported period, the Trust has experienced a positive six months for infection prevention and control performance. The Trust has achieved good outcomes to date and maintained compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015).

This six monthly report takes the opportunity to celebrate the successes and highlights the increasing challenges moving forward:

1. There have been no declared outbreaks of healthcare associated infections (HCAIs) or alert organisms.

2. The Trust continues to report low HCAI rates overall, with no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified.

3. *Clostridium difficile (C.difficile)* definition changes (April 2019) have resulted in higher numbers reported as 'healthcare associated' which include a group of cases where the onset was in the community. This is a significant performance challenge for the organisation. The Trust has had 13 reported healthcare associated *C.difficile* cases against a trajectory of no more than 9 cases for 2019/20. For this reported period, a total of 7 healthcare associated *C.difficile* cases have been submitted for appeal with the relevant Clinical Commissioning Group (CCG), as no lapses in care were identified from the incident investigations undertaken by the Trust.

4. Mandatory surveillance of orthopaedic surgery has continued with no identified deep infections for knee replacement surgery.

5. Antimicrobial stewardship continues to be one of the key measures to reduce the risk of *Clostridium difficile* infection and the single most important measure to reduce the selection of multiple antibiotic resistant bacteria. There have been considerable achievements with antibiotic prescribing standards over the years and concerted effort continues with decreasing consumption for the use of all antibiotics. There will be particular focus on our antibiotic stewardship campaign and audit work for quarters 3 and 4 of 2019/20.

6. Continued use of the Perfect Ward App provides transparency of infection prevention and control practices through audit within each ward area.

7. Significant amounts of work have been completed and remain ongoing with our decontamination services, which has been escalated to executive level.

8. Environmental cleanliness standards, which are monitored regularly and validated quarterly, are maintained to a high standard. The Patient Led Assessment of the Care Environment (PLACE) scores showed an improvement to what was already a high standard of environmental cleanliness and is above the national average.

9. Water safety has been the subject of ongoing focus, with our ageing estate and environment posing challenges, to ensure we have effective controls and proactive management in place.

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

Salisbury
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

6 MONTHLY REPORT

April 2019 – September 2019

LORNA WILKINSON
Director of Infection Prevention and Control (DIPC)

November 2019 (Final v.2)

CONTENTS **PAGE**

APPENDICES

1. INTRODUCTION

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

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

The purpose of this six monthly DIPC Report is to inform the Trust Board of the progress made against the 2019/20 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

For the reported period, the Trust has experienced a positive six months for infection prevention and control performance. This has involved:

- No declared outbreaks of HCAIs or alert organisms.
- The Trust continues to report low HCAI rates overall, with no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified.
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination and cleaning services.
- Water safety has been the subject of ongoing focus, with our ageing estate and environment posing challenges, to ensure we have effective controls and proactive management in place.

However, it is important to note that the following risks to delivery have been identified:

- The retirement of a Consultant Microbiologist who supported the antimicrobial stewardship work. There is a locum Microbiologist in place and one of the substantive Consultant Microbiologists will focus on the antimicrobial work, so this gap lessens into the second half of the year.
- *Clostridium difficile* definition changes (April 2019) have resulted in higher numbers reported as 'healthcare associated' which include a group of cases where the onset was in the community. This has had a direct impact on workload for the Infection Control Nurses (ICNs) as all require full root cause analysis and substantial time commitment in not only the investigation but preparation for appeals panels.
- Fragility of the decontamination services which is escalated to executive level.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2019/20 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix B).

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

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

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead. *(Of note: one Consultant Microbiologist retired in June 2019, with a locum currently covering that position).*

4. ASSURANCE ACTIVITIES

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

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

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

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

During quarters 1 and 2 of 2019/20, the Trust has had **no** declared outbreaks of:

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

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

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

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

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends.

It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridium difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by Public Health England (PHE).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During quarters 1 and 2 of 2019/20, there have been no MRSA bacteraemia cases. The Trust's MRSA hospital onset case target for 2019/20 is zero.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During quarters 1 and 2 of 2019/20, there have been 3 hospital onset MSSA bacteraemia cases, with one of these cases identified to be probably line related. In depth post infection reviews were carried out and key learning included:

- Continuing monitoring of all invasive devices by staff and maintaining the required care documentation
- Adhering to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset.

6.3 Gram-negative organism bloodstream infections (GNBSIs)

The increase in gram negative organism bacteraemia infections is a national concern. Mandatory surveillance of *Escherichia coli* (E.coli), *Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias has been introduced by the Department of Health (DH). This reporting at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work is undertaken by the ICNs. National targets have been applied to reduce GNBSIs by 50% by 2020 and the latest statistics show, the Trust is heading in the right direction to achieve this.

6.3.1 *Escherichia coli (E.coli)*

Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 8 hospital onset cases identified during quarters 1 and 2 of 2019/20, four were unknown or unclear source of infection and the remaining four cases had a source of infection identified. Of these unrelated four cases, the sources of infection were:

- Hepatobiliary (one case)
- Lower urinary tract (three cases)

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of E.coli bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection. In addition, the ICNs are working collaboratively with the relevant CCGs who are leading on achieving this Quality Premium guidance.

6.3.2 *Klebsiella sp.* and *Pseudomonas aeruginosa*

During quarters 1 and 2 of 2019/20, there has been one hospital onset *Klebsiella spp.* bacteraemia case and one hospital onset *Pseudomonas aeruginosa* bacteraemia case.

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis

6.4 *Clostridium difficile (C.difficile)*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to PHE. For 2019/20, changes have been made to the *C.difficile* reporting algorithm. This has included the addition of a prior healthcare exposure element for community onset cases, and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20, the *C.difficile* case objective set for the Trust by NHSi and NHS England (NHSE) is no more than 9 healthcare associated reportable cases. This was a 50% reduction on the previous year's limit. These objectives have been set using the data from 1st April 2018 to 31st December 2018. Guidance for testing and reporting *C.difficile* cases remains unchanged and the safety and care of patients remains our concern and priority. It is important that the Trust Board are aware that this poses a risk when such small numbers are considered, as it is one of the lowest ceilings set across the South West region due to previous good performances.

Unfortunately, during quarters 1 and 2 of 2019/20, the Trust has reported 13 healthcare associated *C.difficile* cases to PHE, of which 9 cases were community onset and 4 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is led by the ICNs to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs undertake a case review for the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

In 4 of these 13 cases, lapses of care were identified. Key learning included improvements required for the use of the Diarrhoea Pathway and completion of stool charts; timeliness of patient reviews and sampling of symptomatic patients.

For the reported period, a total of 7 healthcare associated *C.difficile* cases have been submitted to the 'Appeals Process Panel' with the relevant CCG. The Trust is awaiting final formal confirmation as to whether these appeals have been successful. *(Of note: there are two cases from quarter 2 that are being prepared for appeal by the ICNs.)*

During quarter 3 of 2019/20, a 'deep dive' exercise to review all *C.difficile* cases (hospital and community onset) is taking place. This will be with the involvement of key personnel including the Heads of Nursing (HoN) to identify core learning.

During quarters 1 and 2 of 2019/20, the ICNs have completed additional investigations for *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

6.4.1 Periods of increased incidence of *C.difficile*
During quarter 1, a period of increased incidence (PII) of *C.difficile* was declared within the medical directorate (for Spire Ward). This was due to an increase in the number of cases (both reportable and not reportable to PHE) nursed within the clinical area. As previously reported for 2018/19, the PII for Pembroke Ward was extended to include the suite facility. The required incident investigations were completed with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant senior staff including HoN and Matrons.

Ribotyping of the specimens by the External Reference Laboratory confirmed that there was no cross transmission between patients. All the results were identified to be different types, and therefore could not be linked.

Please see Appendix C for the Infection Prevention & Control 'Dashboard' for Quarters 1 and 2 of 2019/20 for further detail.

6.5 Surgical Site Infection Surveillance (SSIS)
The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved.

The Trust complies with this annual requirement to undertake SSIS. There were no identified deep infections for hip replacement surgery during quarter 1 of 2019/20, when active surveillance was undertaken.

6.6 MRSA screening
The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Directorate Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For quarters 1 and 2 of 2019/20, the Trust compliance rate for MRSA emergency screening ranged from 86.45% - 93.85% and for MRSA elective screening, 68.66% - 80.60%. Outcomes of any follow up of actions undertaken by the clinical directorates are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health (DH) guidance published in 2015, and is under further review by the Trust for 2019/20.

6.7 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of BSIs in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, no further updates have been provided by PHE.

6.8 Private Healthcare Information Network (PHIN)
The Trust is now mandated to report externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data reviewed and provided by the ICNs, there have been no externally reportable infection alert organisms identified for this patient group.

7. HAND HYGIENE
52 areas (including wards and departments) across the four clinical directorates carry out a monthly audit of hand hygiene compliance in their area against the World health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the directorates to take the necessary action.

For quarters 1 and 2 of 2019/20, the overall compliance rate from 10 external audits completed across 9 clinical areas at different times was 71.24%, with one clinical area being audited twice during the six month period. This is a decrease on the previously reported overall compliance rate of 75.85% from 15 external audits completed across 13 clinical areas (with several areas audited more than once), during quarters 1 and 2 of 2018/19.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and also following removal of gloves. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed by the clinical areas the overall average compliance rate for quarters 1 and 2 of 2019/20 ranges from 81.5% - 87.7%. The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures being monitored by the IPCWG, DMTs and Matrons Monitoring Group (MMG).

8. ANTIBIOTIC STEWARDSHIP
Quarters 1 and 2 of 2019/20, have been very challenging for the Antibiotic Reference Group (ARG) due to the retirement of one of the Consultant Microbiologists and reduced staffing within Pharmacy. We have not had the resources to progress with our antimicrobial stewardship campaign and our fortnightly ward antibiotic audits have been on hold since May 2019.

However, we have successfully recruited our first antimicrobial/CQUIN Pharmacy Technician, who has been in post since August 2019. The Technician has been focusing on the lower urinary tract infections (UTI) in older people CQUIN and we have already seen an improvement since being in post.

8.1 CQUIN CCG1a: Improving the management of lower urinary tract infections in older people

This CQUIN aims to improve the diagnosis and treatment of lower UTI in patients aged over 65 years. Research shows that elderly patients in particular are often treated for a urinary tract infection based on a positive dipstick but lack of clinical symptoms.

Quarter 1 results have shown a 19% adherence to all standards. Since the Technician has been in post we have initiated a Trust wide 'To dip or not to dip' campaign and have seen an improvement in results. There are 4 individual standards that we need to meet and we have seen an improvement in each area. Overall compliance is proving difficult as diagnosis and management of UTI is not always consistent. However, preliminary data for quarter 2 shows overall compliance at 33%. Work is still ongoing in this area, including attending Consultants meetings to present evidence to reduce the use of urine dipsticks and encourage adherence to PHE and National Institute of Clinical Excellence (NICE) guidance.

8.2 CQUIN CCG1b: Improving surgical prophylaxis in elective colorectal surgery

This aims to improve surgical prophylaxis in patients undergoing colorectal surgery by ensuring patients receive a single dose of prophylaxis prescribed in accordance with local antibiotic guidelines. Our year end target is 90% compliance. Quarter 1 results were poor at 47% but a Consultant Surgeon has led on this piece of work and we have seen an improvement up to 82% for quarter 2 (preliminary data only).

8.3 Antifungal Medicines optimisation CQUIN

Our target for quarter 2 was to identify an antifungal stewardship team. This has been achieved with the team consisting of a Consultant Microbiologist, Antimicrobial Pharmacist, Haematology Consultant and Haematology Pharmacist.

8.4 Total antibiotic consumption

Reducing total antimicrobial usage has now become part of the NHS contract. Our target is to reduce by 1% every year. Quarters 1 and 2 data shows that our total antibiotic usage increased by 1.8% compared to quarters 1 and 2 of 2018/19 and this is a concern.

The main focuses are to concentrate on the antimicrobial CQUINs and to ensure that all antimicrobial guidelines are updated on Microguide as per NICE guidelines. With staff shortages in Microbiology and Pharmacy ongoing, we will continue to be unable to carry out antibiotic ward audits and thus will struggle to achieve a reduction in antibiotic usage.

9. AUDIT

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme. The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have not undertaken any formal policy audit during quarters 1 and 2 of 2019/20, but have been actively involved in supporting identified clinical areas to complete the *'Perfect Ward' Application'* infection prevention and control (IPC) inspections. Findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the app), with formal reports fedback via MMG meetings. (Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas). Please see Appendix D for further details, the results show an improving direction and continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Compliance scores for quarters 1 and 2 of 2019/20 were 82% for staff completion of hand hygiene assessments and 96% for staff completion for IPC computer based learning (CBL) package (as of 1st October 2019).

The ICNs have continued to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical directorates facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their directorate areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. These include core induction sessions in addition to specific topic requests. The facilitation of learning has also involved members of staff shadowing of the ICNs in addition to the monthly scheduled Infection Control Link Professional (ICLP) meetings. Details of education opportunities provided are available from the ICNs.

The ICNs continue to explore different methods for educational opportunities/activities e.g. use of social media (Twitter account) and physical IPC 'Trolley Dash' (completed during quarter 1 of 2019/20).

11. DECONTAMINATION

Progress on actions from quarters 1 and 2 of 2019/20

- Standard operating procedures (SOPs) are in place for the use of invasive ultrasound probes: there has been some progress on this for those areas still outside 'best practice'. One team are exploring the potential for the introduction of a Trophon automated cleaning cabinet. Another team have undertaken training of staff in order to introduce a manual High Level Disinfection (HLD) process into one area of practice, with another anticipated to follow shortly after.
- The responsibility of maintenance of decontamination equipment in Sterile Services Limited (SSL) has been transferred from Salisbury NHS Foundation Trust (SFT) Estates Technical Services (ETS) team to STERIS.
- The planned test of business continuity plans for theatre instrumentation was cancelled and a new date is yet to be confirmed.
- Decontamination audits continue in order to monitor compliance of areas. This year we are trialling a new option of allowing self-audit for some areas who have proven sustained compliance previously.

Key success stories in quarters 1 and 2 of 2019/20

- Electronic scanning has been installed in SSL to facilitate tracking of scopes through the decontamination process.
- One new automated endoscope reprocessor has been validated and is in use, with a second awaiting validation. This will result in two (out of five) new machines to improve reliability.

Key challenges for quarters 3 and 4 of 2019/20

- Increasingly fragile sterilisation department due to ageing decontamination equipment and (due to staff movement) a relatively junior staffing workforce. In addition there has been a delay in receiving confirmation of the planned refurbishment and associated delay in replacing equipment which is known to be beyond its recommended life.
- There is a need to test the efficacy of the newly installed electronic traceability for endoscopes in SSL and to progress the option for electronic tracking within the clinical areas. An electronic traceability system is considered 'best practice' and will be more robust and efficient should an event occur which requires patient recall.

- A bid and specification has been prepared in order to progress the purchase of new Dry Storage Cabinets (DSCs) with the initial priority area being to increase storage capacity (and safe storage time) in endoscopy. This will have the added advantage of improving contingency arrangements for the endoscopy department as well as removing the excess scopes stored in SSL to a more suitable location.
- Increasing checks on device/instrument compatibility with SSL processing parameters has improved robustness of the introduction of new instruments into the system and, ultimately, patient safety but identified some issues which need resolving; such as what happens when a new instrument does not conform but is clinically required.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities directorate.

12.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust developed (with ward leaders) and implemented a programme of PLACE audits for 2019/20 and planned to undertake 60 internal PLACE assessments between June 2019 and March 2020, using the new NHSi PLACE criteria.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE lite tool and discussed with ward leaders at the monthly MMG meeting.

12.2 National PLACE

The Trust has been informed that the 2019 National PLACE assessment must be undertaken between 16th September 2019 and 22nd November 2019, with results due for publication in early 2020. The Trust completed the 2019 PLACE assessment on Friday 18th October. In accordance with NHSi PLACE criteria, a total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 6 outpatient areas audited. External spaces (including car parking), signage and communal areas were also assessed.

12.3 Deep clean programme/rapid response team

The deep clean and decorating programme commenced in April 2019 (a copy of the Deep Clean programme is available from the Housekeeping Department). A monthly review of this plan is undertaken at MMG meeting and discussed with the ICNs and HoN/Matrons at weekly meetings.

12.4 Improvement Work Over the past 6 months

The two Bioquell hydrogen peroxide vapour (HPV) machine systems are now fully operational and we currently undertake approximately 46 HPV cleans per month.

Housekeeping has undertaken 3547 terminal cleans in the past 6 months of which 9 fell outside of our KPI, to commence the clean within 3 hours of request and 99.75% of terminal cleans were commenced within 3 hours.

Housekeeping routinely monitors those bedspaces requiring a terminal clean (post infection clean) where furniture (including bed) is not present in the bedspace or room at the time of the clean. This information is feedback to ward leaders, HoN/Matrons and ICNs for further investigation and to ensure risks are reduced.

12.5 Challenges for the coming 6 months

Housekeeping continues to see the demand for terminal cleans increase. During May 2019, the Housekeeping Team undertook 720 terminal cleans against 287 in May 2014. We continue to resource the later shift with extra staff in order to deliver the demand for terminal cleans later in the day.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2019/20.

The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) *Pseudomonas* (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and Deputy Responsible Person (dRP) water) from ETS and FES Ltd (Private Finance Initiative (PFI) maintenance contractor) are held on a monthly basis, to review progress with planned preventive maintenances' (PPMs) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (see table below) have taken place in the Trust as a result of the positive sample results, the actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella					
	Ward/ Department	Location	Action plan from review meeting	Test result as of 10th September 2019 (cfu)	
				Pre	Post
1	Durrington Ward	Rooms 2.2.18 + 20	Re-sampled on the 14th October, awaiting result for PHE.	<20	<20
2	L3 Paediatrics	Room 3.6.38	Re-sampled on the 14th October, awaiting result for PHE.	5700	60
3	L3 Paediatrics	Room 3.6.48	Re-sampled on the 14th October, awaiting result for PHE.	2400	320
4	Tisbury CCU	Bay 2	Outlet fitted PALL filter, ETS surveying area to remove dead legs/faulty TMVs.	6700	6500

ETS have completed a full survey of the hot and cold water system on Level 3 Paediatric Outpatients Department (OPD), which identified some issues with local thermostatic mixer valves (TMVs) and strainers, which were removed and replaced. An updated action plan was circulated to the WSG and the clinical teams in the affected areas. Re-sampling was completed on the outlets identified on the action plan during quarter 3 (on the 14th of October) and awaiting the results of these tests.

ETS are now reviewing the hot and cold water systems on Tisbury CCU and ED, and currently in the process of removing some 'dead legs' pipework and faulty TMVs.

13.1 Achievements for quarters 1 and 2 of 2019/20

- New heating and hot water system installed and commissioned for the accommodation Blocks Compton, Grovely and Langley and Odstock Health + Fitness. The new boilers plus new hot water generation (plate heat exchangers) will greatly improve the temperatures of the hot water systems which feed these areas.
- The level of flushing compliance for clinical areas has been maintained and the figures for quarters 1 and 2 are 93.6% for Priority 1 areas and 98.5% for Priority 2.
- Good results (2 x clear results as of the 10th of September) have been received on the re-sampling of Durrington Ward which has been a problematic area for some time with PALL filters fitted in siderooms 2.2.18 and 2.2.20 to provide a safe hot water system.
- Competent person (CP) training has been delivered to ETS staff that monitor and maintain the Trusts hot and cold water system. The training was completed on the 10th of June and staff from Band 2 to Band 5 received the training which was delivered by the Trusts Authorising Engineer for Water (AE Water) Mr Paul Limbrick.

13.2 Key focus for quarters 3 and 4 of 2019/20

- Maintaining the temperature of the hot and cold water systems across the Trust.
- Completion of routine sampling for Pseudomonas on the augmented wards – Radnor, Sarum, Odstock (Burns & Plastics) and Avon Wards, NNU and Pembroke Unit.
- Ensuring sufficient resource (Labour & Financial) to complete all PPMs directly associated with water safety.
- Securing Capital Funding for replacement of hot water systems where necessary e.g. the Hospice, a bid has been submitted for the 2020/21 programme.
- Engagement of key members (DIPC, Deputy DIPC, Consultant Microbiologist, ICNs) of the Water Safety Group (WSG) in supporting action plans and attending quarterly meetings of the WSG.
- Developing the Operational Procedures for Water Safety with the assistance of the Trust Authorised Engineer (AE).
- Refresher training for the Trusts dRP Water (Operations Manager).
- Completion of the tender for the works associated with a new site water risk assessment.

14. CONCLUSION

This six monthly update report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2019/20 in reducing HCAI rates for the Trust.

For quarters 3 and 4 of 2019/20, the key ambitions for the Trust will include:

- Continued focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Continued achievements for antimicrobial stewardship.
- Review and jointly identify clear improvement plans for decontamination services.
- Sustain progress with education, training and audit relating to infection control practices and policies.
- Monitor and manage water safety.
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

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- Terry Cropp, Head of Estates

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2019/20

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention and Control Committee	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	ICNs	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/SC/PR	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/SC/PR	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/CG	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings	DIPC/HoN	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	DSNs/IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/SC/PR	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	PK/AE	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	SK	In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/LW	In place
Mandatory reporting HCAIs to Public health England (PHE)	JH	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IP&CT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	TC	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	CG	In place

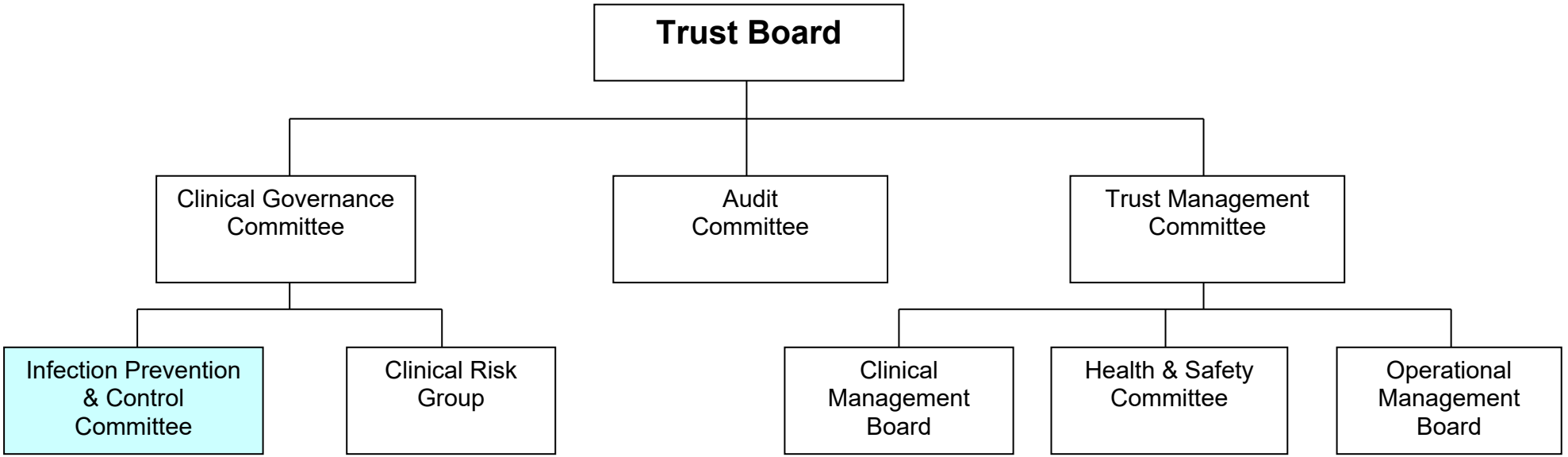
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health & safety services (OHSS)	PH/AE	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	PK/AE	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	HoN/Matrons/ICNs	Continuous

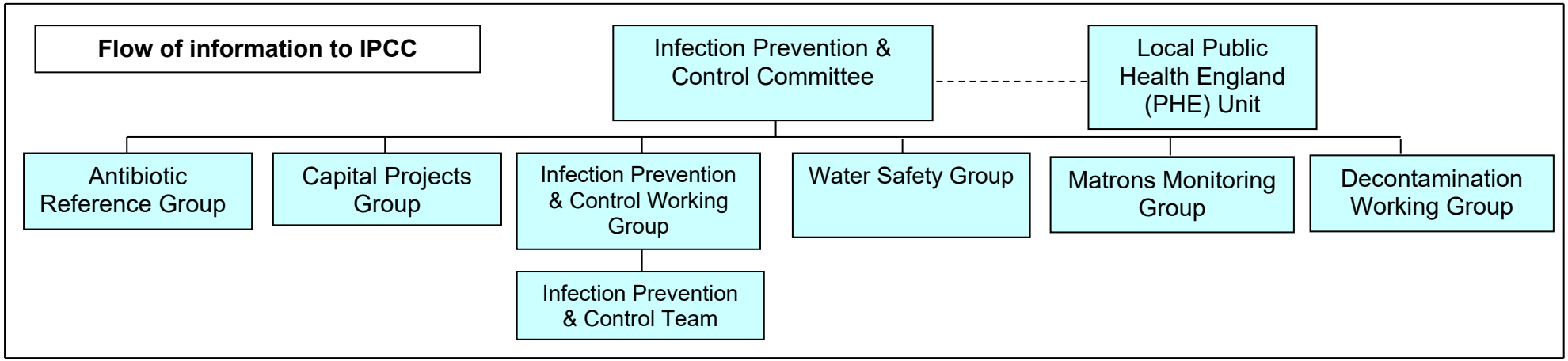
KEY INITIALS

DIPC Lorna Wilkinson, Director of Infection Prevention & Control (DIPC)
DDIPC Denise Major & Fiona Hyett, Deputy DIPCs
CG Trust Decontamination Lead
JH Julian Hemming, Consultant Microbiologist & Infection Control Doctor (ICD)
SC Stephen Cotterill, Consultant Microbiologist & Deputy ICD *(Retired June 2019)*
PR Paul Russell, Consultant Microbiologist & Antimicrobial Lead
IR Ian Robinson, Head of Facilities
TC Terry Cropp, Responsible Person for Water & Head of Estates
HoN Heads of Nursing *(previously Directorate Senior Nurses)*
SK Sarah Knight, Head of Patient Flow
PK Paul Knight, Health & Safety Manager, OH Department
GL Geoff Lucas, Safety Advisor, OH Department
LW Louise Whittles, Principal Pharmacist
JD Jacqui Dalley, Neonatal Unit Sister
MF Maria Ford, Quality Improvement Matron *(previously Nurse Consultant in Critical Care)*
PH Paul Hargreaves, Director of Human Resources *(until September 2019)*
MS Michelle Sadler, Facilities Manager
AE Alison Evans, Occupational Health Lead

APPENDIX B

Formal Trust Reporting Structure





APPENDIX C

		Clostridium difficile - all cases (reportable and not reportable)			Bacteraemias - all cases are reportable to Public Health England (PHE)													
		Sample taken			*MRSA*		*MSSA*		*E.coli*		*Pseudomonas aeruginosa*		*Klebsiella sp.*		Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC PWA % (mean score)
Clinical Directorates	**Inpatient areas/wards**	Hospital onset; healthcare associated	Community onset; healthcare associated	**No lapses in care**	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Number of days closed			
Clinical Support & Family Services	Labour Ward																95.1	N/A
	Neonatal Unit																98.3	N/A
	Post-natal Ward																95.46	N/A
	Sarum Ward																99.2	88.63
	CS&FS Totals:	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**N/A**	**N/A**		
Medicine	AMU		1*	1				3		9		1					56.78	89.82
	Durrington Ward						1			1							77.38	88.66
	Emergency Department		1					18		35		5		10			83.04	N/A
	Farley Stroke Unit																81.4	90.66
	Hospice Unit																98.3	91.57
	Pembroke Ward	1							1								78.2	88.2
	Pembroke Suite																83.3	82.9
	Pitton Ward	2	1*	1													66.25	86
	Redlynch Ward	1	1*	1			1		4	2							79.3	84.63
	Spire Ward	2 + 1							1							Jun-19	84.45	82.56
	Tisbury CCU		1* + 1	1			1		1								82.3	86.88
	Whiteparish Ward	1 + 1															93.01	78.2
	Medicine Totals:	**2 + 7**	**5 + 1**	**4**	**0**	**0**	**3**	**21**	**7**	**47**	**0**	**6**	**0**	**10**				
Musculoskeletal	Amesbury Suite							1									90	85.76
	Avon Ward																46.09	96.38
	Chilmark Suite	1*		1													83.3	86.48
	Odstock Ward						1				1		1				93.25	87.05
	Tamar Ward	1															95.66	94.4
	MSK Totals:	**1 + 1**	**0**	**1**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**0**	**1**	**0**				
Surgery	Breamore Ward (Relocated to Laverstock Ward template on 29.09.19)																73.07	91.43
	Britford Ward	1								1				1			93.8	91.46
	Day Surgery Unit																81.16	82.08
	Downton Ward								1	2							93.48	91.63
	Radnor Ward									1							95.38	97.94
	Surgery Totals:	**1**	**0**		**0**	**0**	**0**	**0**	**1**	**4**	**0**	**0**	**0**	**1**	**0**	**0**		
Additional info: Other samples e.g. GP, Emergency Assessment, OPD, Mortuary, Private Hospital			1 + 2 + 2*	2														

* denotes reportable C.difficile cases that have been submitted for appeal at the Clinical Commissioning Group (CCG).

All SFT samples including inpatient and outpatient areas, GP and other e.g. Emergency Assessment

C.difficile reportable cases = red
C.difficile not reportable cases = blue

Perfect Ward scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

APPENDIX D

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores

Ward/ Dept	Directorate	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Sarum	Clinical Support & Family Services	16.04.19 (95.6%)		28.06.19 (77.8%)		01.08.19 (92.5%)	
Acute Medical Unit	Medicine	02.04.19 (98.1%) & 26.04.19 (98.1%)	29.05.19 (63.5%) & 31.05.19 (96.2%)		12.07.19 (88.7%)	11.08.19 (94.3%)	
Durrington Ward	Medicine	08.04.19 (90.4%)	08.05.19 (92.3%)	03.06.19 (92.3%)	14.07.19 (94.3%)	16.08.19 (74%)	
Farley Ward	Medicine	05.04.19 (76.9%) & 26.04.19 (88.5%)	15.05.19 (90.4%) & 30.05.19 (92.3%)		26.07.19 (92.3%)	17.08.19 (94.2%) & 31.08.19 (100%)	
Hospice Unit	Medicine	08.04.19 (89.8%)		10.06.19 (95.6%)			20.09.19 (89.6%)
Pembroke Ward	Medicine		30.05.19 (88.2%)		**Pembroke Suite** 24.07.19 (82.9%)		
Pitton Ward	Medicine	26.04.19 (92.5%)	24.05.19 (80.8%)	12.06.19 (84.6%)	19.07.19 (98.1%)	12.08.19 (74%)	
Redlynch Ward	Medicine	22.04.19 (88.5%)		14.06.19 (74%)	29.07.19 (100%)	12.08.19 (76%)	
Tisbury CCU	Medicine		21.05.19 (90.4%)	19.06.19 (90.4%)	08.07.19 (94.2%)	13.08.19 (72.5%)	
Whiteparish Ward	Medicine		15.05.19 (88.2%)			02.08.19 (73.1%)	20.09.19 (73.3%)
Spire Ward	Medicine		15.05.19 (76.9%)	14.06.19 (74.5%)	29.07.19 (69.2%)	04.08.19 (90%); 13.08.19 (82.7%); 24.08.19 (88.5%)	22.09.19 (96.1%)
Amesbury Suite	Musculoskeletal	17.04.19 (86.5%)	02.05.19 (82.7%)	07.06.19 (78.8%)		02.08.19 (90.4%)	18.09.19 (90.4%)
Chilmark Suite	Musculoskeletal	26.04.19 (84.9%) & 29.04.19 (90.4%)	30.05.19 (87.8%)	20.06.19 (86.7%)		02.08.19 (88.7%)	17.09.19 (80.4%)
Odstock Ward	Musculoskeletal	04.04.19 (86.3%)	25.05.19 (90.4%)	18.06.19 (88.2%)		13.08.19 (83.3%)	
Avon Ward	Musculoskeletal	05.04.19 (95.5%) & 23.04.19 (98.1%)	28.05.19 (98%)		11.07.19 (94.2%)	13.08.19 (96.1%)	
Tamar Ward	Musculoskeletal	22.04.19 (96%)		06.06.19 (96%)	10.07.19 (100%)	15.08.19 (100%)	09.09.19 (80%)
Breamore Ward	Surgery	16.04.19 (84.3%)	21.05.19 (98%)		11.07.19 (97.7%)	16.08.19 (85.7%)	
Britford Ward	Surgery	17.04.19 (92.3%)	29.05.19 (86.3%)		29.07.19 (90%)	15.08.19 (96.2%)	23.09.19 (92.5%)
Downton Ward	Surgery	11.04.19 (80.4%)	14.05.19 (88.5%)	16.06.19 (96.2%)	22.07.19 (96.2%)	29.08.19 (92.3%)	24.09.19 (96.2%)
Radnor Ward	Surgery	25.04.19 (95.5%)		19.06.19 (98%)	07.07.19 (100%)	31.08.19 (98.1%)	30.09.19 (98.1%)
Day Surgery Unit	Surgery	25.04.19 (42.9%)	08.05.19 (76.2%)	17.06.19 (88.1%)	17.07.19 (97.6%)	20.08.19 (92.5%)	10.09.19 (95.2%)

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed