NHS
Salisbury
NHS Foundation Trust

Part 1
Trust Board Meeting in Public
Thursday 4 April 2019
10.00 am – 1.00 pm
Boardroom

Timings		Agenda	Initials of presenter	Purpose	Page
		Opening Business			
10:00	**1.**	Patient Story	LW		
10:20	**2.**	Apologies – Cara Charles-Barks, Jane Reid, Fiona McNeight Declarations of Interest, Fit & Proper/Good Character	NM		
10:25	**3.**	Minutes of the Trust Board Meeting held on 7 March 2019	NM	Approval	1
10:30	**4.**	Matters Arising and action log	NM	Information	14
10:35	**5.**	Chairman's Business	NM	Information	verbal
10.40	**6.**	Chief Executive's Report	CCB	Information	17
10.50	**7.**	Board Annual Work Plan	FMcN	Approval	20
		Assurance and Reports of Committees			
10.50	**8.**	Operating Plan 2019/20	LT	Assurance	To follow
11.00	**9.**	Finance & Performance Committee Report – 26 March 2019	PM	Assurance	23
11.05	**10.**	Charitable Funds Committee – 21 March 2019	NM	Assurance	25
11.10	**11.**	Clinical Governance Committee – 26 March 2019	PM	Assurance	26
11.15	**12.**	Subsidiary Governance Committee - 15 March 2019	PM	Assurance	27
11.25	**13.**	Workforce Committee – 28 March 2019	MvB	Assurance	28
11.30	**14.**	Integrated Performance Report	CB	Assurance	29
		a) Operational Performance			40
		b) Quality Indicators			60
		c) Safer Staffing			68
		d) Workforce Report			81
		e) Finance Report			103

12.00	**15.**	Review of Board Committee Terms of Reference	FMcN	Approval	114
12.05	**16.**	Integrated Governance Framework	FMcN	Approval	152
12.10	**17.**	Accountability Framework	AH	Approval	184
12.15	**18.**	Register of Seals	FMcN	Approval	204
		Quality and Risk			
12.15	**19.**	Board Assurance Framework & Corporate Risk Register	FMcN	Approval	205
12.20	**20.**	Patient Experience Report Q3	LW	Assurance	257
12.25	**21.**	National Staff Survey Results	PH	Assurance	275
12.30	**22.**	Freedom to Speak up Guardian Annual Report	ES	Assurance	285
	23.	CQC report	CCB	Information	292
		Strategy and Development			
12.40	**24.**	Strategy for Improvement	EP	Approval	293
12.45	**25.**	QI Operational Plan 2019/20	EP	Approval	300
		Closing Business			
12.50	**26.**	Agreement of principal actions			-
	27.	Any Other Business			-
	28.	Public Questions			
1.00	**29.**	Date of Next Public Meeting: 23rd May 2019, 9:00 am, The Board Room, Salisbury District Hospital			
	Resolution				
	30.	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)	NM		

Salisbury NHS Foundation Trust

DRAFT

Minutes of the Public Trust Board meeting held at 10:30 am on Thursday 7 March 2019 in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr N Marsden	Chairman
Ms T Baker	Non-Executive Director
Dr M von Bertele	Non-Executive Director
Mr P Kemp	Non-Executive Director
Mr P Miller	Non-Executive Director
Ms R Credidio	Non-Executive Director
Mrs C Charles-Barks	Chief Executive
Mr P Hargreaves	Director of Organisational Development and People
Mr A Hyett	Chief Operating Officer
Mrs L Thomas	Director of Finance

In Attendance:

Fiona Hyett	Deputy Director of Nursing (on behalf of Director of Nursing)
Fiona McNeight	Director of Corporate Governance
Andrea Prime	Deputy Head of Corporate Governance (minute taker)
Justine McGuiness	Head of Communications
Gavin MacDonald	System Winter Director (minute ref: TB1-0703/14)
Laurence Arnold	Programme Lead – Campus Project (minute ref: TB1-0703/15)
Rob Webb	Associate Director of Procurement and Commercial Services (minute ref: TB1-07/03/16)
Sir R Jack	Lead Governor (observer)
Dr J Lisle	Governor (observer)
Mr W Holmes	Governor (observer)
Mr N Evans	Consultant (observer)
Dr A Nash	Registrar (observer)
Mr E Leonardo	Liaison (observer)

ACTION

OPENING BUSINESS

TB1 - 0703/01 **Apologies**

Apologies were received from:

- Dr C Blanshard, Deputy Chief Executive and Medical Director
- Ms L Wilkinson, Director of Nursing
- Prof Jane Reid, Non-Executive Director

Declarations of Interest

Members of the Board were reminded that they have a duty to declare any impairment to being Fit and Proper and of good character as well as to avoid any conflict of interest and to declare any interests arising from the discussion. No member present declared any such interest or impairment.

TB1 - 0703/02 **Minutes of the Public Trust Board meeting held on 7 February 2019**

The minutes of the Trust Board meeting held in public 7 February 2019 were approved as a correct record.

TB1 - 0703/03 **Register of Attendance**

The register of attendance formed part of the Board papers.

TB1 - 0703/04 **Matters Arising and Action Log**

Progress on Trust Strategy:
The board agreed for the action to be closed. The Length of Stay (LOS) targets are being considered for 2019/20.

TB1 – 06/12/12 – Integrated Performance Report:
L Thomas has discussed with Wiltshire Health and Care (WH&C).
ACTION: As soon as the quality committee minutes have been released information will be provided as part of the IPR. **LT**

1701/07 - MRI scanner update:
A Hyett informed the board that the business case was currently under review. If there are any significant changes the business case it will come back to Board. **ACTION: C Charles-Barks asked that aspects relating to cardiology and MRI be incorporated when purchasing the scanner to ensure future proofing for advanced technology**. **AH**

TB1 - 0703/05 **Chairman's Business**

N Marsden reported that on Friday 1st March the formal publication of CQC report was released. N Marsden congratulated the whole organisation for achieving a good rating and noted that it was very positive for patients to see an improved rating in a number of hospital services. N Marsden has written to all staff and they are delighted with the outcome and can see their efforts have led to organisation improvements recognised by external bodies. The areas that were not inspected and unable to demonstrate their improvements were also delighted for the organisation. N Marsden recognised L Wilkinson and the team for their work on focusing on areas requiring improvement and the success in moving them from a 'requires improvement' rating to a 'good' rating and in some cases 'outstanding'.

It was announced on Friday 1st March that there were to be changes to the leadership of the combined entity of NHS Improvement (NHSI) and NHS England (NHSE), with a single chief executive, Simon Stevens. N Marsden noted that the Head of NHSI will be Chief Operating Officer of the combined organisation, which has yet to be recruited to. This now indicates a clear direction of travel for all NHS organisations, which are now subject to single board and single chief executive.

Discussion

- A Hyett queried the timescale for recruitment of a Chief Operating Officer. N Marsden explained that the process was expected to be quick. C Charles-Barks noted that an NHS Providers meeting due to be held in March may give an indication of a timescale of the appointment.

TB1 - **Chief Executive's Report**

0703/06

C Charles-Barks presented.

- C Charles-Barks explained that she would be presenting the Integrated Performance Report (IPR) later on the agenda.
- Last Friday 1st March indicated the 12 month anniversary of the Novichok incident which occurred in Salisbury. It is important to recognise this anniversary as a Board and to consider the ongoing repercussions for local business and the community in particular. The Trust will continue to play a critical role in regeneration of Salisbury and it is positive to see ongoing recognition of work done as an organisation
- The Trust is delighted to see maternity and neonatal services recognised as part of the CQC national survey. Our maternity team scored better than average in four areas. It has also been positive to see improved response rate as staff work hard to deliver and improve services.
- P Hargreaves attended the retirement fellowship group which recently celebrated their 40 year anniversary. C Charles Barks noted the good relationship between this group and the Trust and their engagement in the work of the hospital.

Discussion:

- T Baker queried when the Board would be receiving a Sustainability and Transformation Partnership (STP) update as part of the IPR. C Charles-Barks is working with the STP who recently appointed a joint chief executive and accountable officer across the three Clinical Commissioning Groups. The appointment of Tracey Cox as chief executive has formalised the role and a key objective will be to consolidate a single executive team across the STP. N Marsden and C Charles-Barks are due to meet T Cox in March. An update from the STP has been requested on numerous occasions and will be discussed with T Cox to ensure a monthly update is received by the Boards. As part of this meeting N Marsden and C Charles-Barks wish to discuss the difference between integrated and PLACE based systems. From a community perspective there is the formulation of primary care networks with three pilots currently underway across the STP. The Sarum pilot particularly affects the Trust and a recent meeting took place discuss collaborative working going forward. One of their priority areas is older people services, which aligns with one of the Trust's priorities. As the Trust moves towards integration there will be further discussion on working closely with the primary care network.
- P Miller queried when a board discussion would take place on how we work with the STP regarding integration. N Marsden stated that these discussions would take place through the Strategy Committee. C Charles-Barks explained that these wider discussions would take place as part of a private board meeting or seminar session.
- L Thomas noted that an individual appointment had been made to support strategic work and the successful candidate was due to start in March. C Charles-Barks explained that a series of papers would come to the board on the long term plan and the potential implications of legislation. **ACTION: In April/May 2019 a timeline with indicative milestones and a map of key papers will be coming to Board.** **LT**
- N Marsden explained that the acute alliance meeting with colleagues from Bath and Swindon took place on a monthly basis to ensure

projects are in place to maximise collaboration. The key focus has been on the GIRFT initiative. The three Trusts are looking to arrange a GIRFT system visit to help identify potential collaborations between the organisations.
- The Trust has been proactive in setting up a rural hospitals network to bring single voice from a policy development perspective. This provides an opportunity to initiate important strategic conversations. .

ASSURANCE AND REPORTS OF COMMITTEES

TB1 - 0703/07 **Clinical Governance Committee Report – 26 February 2019**

P Miller presented as he chaired the Committee meeting:

- As part of 7 day services the Trust is meeting all key standards. Further work required in regards to the stroke service, particularly around weekend. The Medical Director is leading this piece of work.
- Gastroenterology services were discussed at Clinical Governance Committee (CGC) and Finance and Performance Committee (F&PC). The key issues have been identified and prompt action taken to manage immediate risks. A paper will go to the private board to look at outsourced service for gastroenterology in short term.
- The positive CQC national survey results for the maternity department were noted.

Discussion:
- Regarding 7 day services weekend mortality rate has risen over recent months. P Miller confirmed that this has been raised by the committee and whilst answers have been provided the committee wish to look into this further to ensure this is not an issue. T Baker informed the board that the severity of patients will be taken account of in mortality data.
  ACTION: C Charles Barks asked for more comprehensive report on this at next CGC. **CB**

TB1 - 0703/08 **Finance & Performance Committee Report – 26 February 2019**

P Miller presented:

- The key issue under operational performance was the report from the Emergency Care Intensive Support Team (ECIST). ED performance deteriorated in January. The Trust has committed to achieving 95% by March 2019. The Trust is doing everything within its control to deliver the best service possible.
- Finance performance – on track for modified overspend.
- The operational planning process is going well with a submission date of 4th April 2019. P Miller recommended that the board delegate authority to F&PC on 26 March to ensure sign off of the 2019/20 operational plan before the submission date. L Thomas informed the board that feedback is not expected until 20th March.

Decision – The board agreed to delegate the decision to sign off the operational plan to the F&PC. All Board members are welcome to attend.

- The issue regarding community beds in South Wiltshire was raised

during the committee. This is a strategic discussion for board on community beds and services for south Wiltshire.
- The committee approved the Procurement and Commercial Services Strategy and thanks the team for their commitment and hard work to date.

TB1 - 0703/09 **Strategy Committee Report – 21 February 2019**

TB confirmed there were no further items to add given the meeting's agenda items.

TB1 - 0703/10 **Subsidiary Governance Committee – 14 February 2019**

P Miller presented:

The first meeting of Subsidiary Governance Committee took place and was largely focused on establishing the committee's purpose and key areas of focus. Key issues raised relating to Board or other committees will be signposted to those relevant committees.

N Marsden thanked P Miller for stepping forward to chair the committee. It was explained that N Marsden is a member of committee but would not be an appropriate chair due to being chairman of the Board. P Kemp is also member of committee but as chair of the Audit Committee it was not appropriate for him to chair this particular committee.

The committee's membership also includes M Hawker as an independent director. He is not a member of the Trust Board.

TB1 - 0703/11 **Constitution Review**

F McNeight presented the report for information.

There are no formal changes to the constitution which requires board approval. Following guidance from NHSI there was one matter relating to the Council Standing Orders, whereby the chief executive should not be involved in the appointment of a Chairman. In their meeting on 18th February the governors approved the amendment. All other changes were purely cosmetic and formatting.

The amendment was noted.

TB1 - 07/03/12 **Integrated Performance Report**

C Charles-Barks presented and highlighted the following:
- Operational performance – the trust has achieved strong performance against RTT standards. Plastics have achieved the 92% standard for the first time since 2016 and their hard work was recognised by the Board. Despite ongoing challenges in Endoscopy the trust have maintained two out of the three cancer pathway targets. The adjustments on reprioritising gastroenterology time is having a positive impact and a new service manager has been recently appointed.
- There was a lengthy discussion at F&PC with regards to ED

performance which continues to perform below trajectory. January was a busy month with a 65% increase in attendances during the month. January saw the highest number of patients ever seen in acute medical services as a result of direct referrals.

- Nurse recruitment remains ongoing challenge for ED. C Charles Barks was pleased to announce two new ED consultants, one of whom commenced this week, and another due to start in April. This will ensure the department has a full complement of senior medical staff.
- ECIST review completed with internal and external recommendations. Length of Stay (LOS) performance – finalising trajectory and will be reported on in new financial year.
- The trust achieved 98.9% against the 99% target for diagnostics with Endoscopy the key challenge.
- There are three cases of MRSA under investigation. All three cases occurred on different wards so there was not an issue of cross contamination. Feedback will be provided to the CQC.
- Operational pressures have continued leading to the use of escalation areas. Therefore, there have been mix sex breaches. The Trust is taking action to mitigate and is not compromising the privacy and dignity of patients. In February the decision was made to open Laverstock ward which has enabled the trust to reduce escalation into other areas of the hospital including day surgery.
- Workforce continues to be a significant risk in terms of staffing gaps and employee well-being. The Trust is continuing to exceed the agency control total. However, a lot of work is underway with recruitment improvements have been seen and there has been a drop in nursing vacancies which is positive. A key focus is to reduce LOS, reducing the demand for beds which will improve the working environment for staff.
- Work continues on the Well-Being Strategy which will be coming to the board in the coming months. The key focus is supporting staff and helping reduce turnover. A priority for the Workforce Committee will be staff retention, well-being and how we engage and communicate with staff. The Safer Staffing Report shows an overall improvement in nursing staffing
- Financial performance remains challenging. The trust didn't meet the quarter 3 (Q3) requirement. However, the trust is on track to meet the revised Q4 target. C Charles-Barks stated that the Trust has delivered approximately £10m in savings improvements in year and that the step change in financial management achieved over last 12 months has really continued to drive productivity.
- As part of CQC report the Trust had a use of resources inspection which was rated 'good'. Therefore, whilst experiencing deficit and financial challenges, the Trust is using its resources and finances productively.

Discussion

- P Kemp raised a query regarding the HMRC challenge in relation to the direct engagement model used by Brookson. P Hargreaves noted that this should not have impact and that Brookson is challenging this.
- P Kemp queried the workforce report and asked if long term sickness increased or decreased? P Hargreaves stated that long term sickness has decreased from 50% of case mix to 48%.
- R Credidio asked about the time to triage and treatment figures as it

appeared that the average time was less than times reported for majors and minors. A Hyett explained that resus is included in this as well and there is generally no queue or delay for resus. C Charles-Barks noted that following on from the discussions at the last F&PC there will be considerable work to pick up on issues in the operational report to include the data requested.

- T Baker asked for an update on the spinal step down pilot which is running until the end of March. A Hyett advised that the feedback from patients is largely is positive. There were concerns that these patients were not under the care of the hospital but regular visits from the clinical director provides reassurance and patients can be brought back into the hospital if required**. ACTION: It was noted that the directorate needed to produce a factual report on pilot outcomes**. **AH**
- P Miller noted that the report provided a wide scope of information and asked C Charles-Barks what the two key performance priorities were for the Trust over the next two months. C Charles-Barks explained that the trusts key focus over the coming months is LOS. Increased LOS has residual impact on patients, staff and provides a challenge from a finance perspective too. Additionally, resolving the number of Delayed Transfers of Care (DTOC) is a key focus. DTOC has risen dramatically over last month and results in patients waiting unnecessarily and the requirement for escalation beds. A second priority is further opportunity for day surgery services from productivity perspective. A step change is planned over next 3 months in day surgery to get more patients treated whilst using using existing resources.
- T Baker queried what the average target times are to triage and treatment. A Hyett explained that 60 minutes is the target for time to triage but at challenging times there can be quite a variance on this and checks are carried out to ensure safety is maintained during these periods. C Charles-Barks noted the importance of reviewing average times on a regular basis to ensure there isn't too much of a variance. A Hyett advised that the waiting times are now monitored on a live dashboard for both majors and minors.
- N Marsden had attended the NHS Providers Board where the ED 4 hour target had been discussed. If the method of measuring ED performance is reviewed and updated it is important that an agreed method of managing the ED 4 hour target is trialled and tested.

QUALITY AND RISK

TB1 - 0703/13 **CQC Report**

C Charles-Barks presented.

- There were nine core services that could have been reviewed. During this visit they reviewed four core services; urgent and emergency services, surgery, critical care and spinal services.
- The spinal services team have been doing an extraordinary amount of improvement work and whilst still rated as 'requires improvement' the changes that have been made to date are extremely positive and work will continue on improving the service for patients.
- In relation to the safety domain, this often links to staffing levels. A recommendation on spinal staffing has been received. However, there are no national recommendations and therefore further work is to be undertaken from a national perspective to indicate required staffing

improvements.

- C Charles-Barks explained the grading process of the CQC report. Of the five domains assessed over the 9 core services, if three 'requires improvement' then an overall grading of 'requires improvement' is received for that domain. Therefore for safety the Trust has received a grading of 'requires improvement'.
- Whilst four core services were inspected, all services have made considerable improvements. The Trust would expect the services not inspected to improve from a 'requires improvement' to 'good' rating but there was not the opportunity to demonstrate this.
- The Trust will continue to celebrate this great achievement. As organisations receive must do and should do recommendations. As part of the most recent inspection there were no must do recommendations, which is testament to the services provided. The CQC are not expected to return this year, it is expected another inspection will be in 2020. Children's services were disappointed not to be inspected following the great improvements made since the last inspection but there are opportunities to learn from the critical care department which achieved an 'outstanding' grade.
- Other components of inspection were use of resources and well led. C Charles-Barks was very pleased to report the trust's overall 'good' rating and the fantastic feedback for us as an organisation and good feedback for our journey to achieve an 'outstanding' grade in the future.

Discussion:

- T Baker asked what key components were to achieving an 'outstanding' grade. C Charles-Barks explained that in critical care there had been a lot of work in regards to team leadership. The major incident in 2018 provided the opportunity to demonstrate how these improvements had made a real difference. Whilst our critical care patients were under national scrutiny, the trust managed to maintain no impact or compromise to the other patients in the department. Additionally, there were great examples of care and compassion and how our team worked with families. The critical care team is keen to work with others in the organisation to share their learning and what they do well.
- C Charles-Barks stated that there are two elements to target from outstanding perspective. They are core services and collectively it is the responsibility of the Board to achieve outstanding from well-led perspective and will be reflected in the operational plan.
- The Communications Strategy, Quality Improvement Strategy, Equality and Diversity Strategy and the Freedom to Speak Up report will all be coming to the board in the coming months. P Hargreaves is chairing a small task force of communications, diversity and inclusion and Organisational Development change expertise to take this work forward. The Trust is continuing to evolve the way we work into outstanding by learning from other hospitals which have been rated as outstanding by CQC, for example West Suffolk Hospital.

TB1 - 0703/14 **Emergency Care Intensive Support Team (ECIST) System Review**

A Hyett presented.
G MacDonald attended for item.

- The Accident and Emergency local delivery board had an ECIST visit around pathways for flow and patient discharge.
- There are five high level actions with number of other sub-actions. Older people services, frailty work and end of life care work are already large pieces of work underway in hospital. The project lines have March 2020 as a deadline but there are key deliverables within these that will be delivered sooner. Therefore those lines will have staged milestones to demonstrate improvements
- Actions have already been embraced from the ECIST report and an ongoing review of our processes is underway in response to this. This ongoing piece of work will continue to report up through to the system and patient flow Project Management Board (PMB) and to the trust's Outstanding Every Time Board (OETB) group.

C Charles-Barks queried the hard metrics the Trust should use to track progress and provide assurance to the board that work is improving experience for patients. **ACTION: A Hyett informed the Board that a meeting had taken place to establish key metrics for all aspects of the ECIST report. These metrics will be reported on at F&PC.** **AH**

- G MacDonald informed that there were three key actions to impact on LOS and ED performance. Included in these three actions is the implementation of a trusted assessor. G MacDonald informed the board that good progress had been made on trusted assessment on wards and further work was required for trusted assessors across the community. Demand and capacity work is a key action to ensure capacity is in the right place at the right time across the system and an agreed model has been identified. There is also medium to longer term work on the frailty pathway for older people in terms of discharge from hospital and preventing admission to hospital.
- The short term system plan has picked up more immediate work. These actions have been compiled into an improvement programme for system for all partners in health and social care. The terms of reference and governance arrangements were outlined.
- The final plan will go to the A&E delivery board on 19th March 2019 for sign off.
- Now the project plans are in place there is the requirement for a clear view on what will be delivered in terms of Key Performance Indicators (KPIs) and the impact on ED and DTOC.
- There are four work streams reporting into a fortnightly project board chaired by G MacDonald and monthly reporting into the A&E Local Delivery Board.

Discussion:

- P Miller queried if the local authority is fully engaged. G MacDonald is meeting with the council today and the trust is working closely with Wiltshire Health and Care (WH&C). There is further work to do regarding the governance structure.
- P Miller queried the deadline for the action relating to trusted assessor as the report has not stated a date. G MacDonald informed the board that planned delivery is Q3 or Q4 this year.
- P Miller raised a query with regards to the SAFER bundle and asked about the trust's confidence in embedding the five aspects. A Hyett

informed that the trust has implemented SAFER before but there have been challenges, particularly related to workforce. Processes and Standing Operating Procedures (SOP) on ward rounds and SAFER have been implemented and there have been reviews to ensure standards are maintained. There are a number of workshops with clinical teams and national medical direction so teams can see how maintaining SAFER has a positive impact

- P Miller queried if standards regarding SAFER had slipped before, what the learning points are to ensure this doesn't happen in the future. F Hyett explained that workforce factors, for example, nursing vacancies and a high percentage of temporary staff had been challenging. However, more work is underway with ward staff and engagement with ward sisters has improved. The trust also embeds SAFER into training with overseas workforce to ensure standards are maintained.
- A Hyett informed the board that content had been added as part of the welcome to all new starters relating to everyone's contribution to improving patient flow. This reaffirms everyone's role in improving patient flow and prompt discharge.
- N Marsden asked what actions the trust would need to take to reduce DTOC down to the target of 14 or less cases. A Hyett informed that there were currently 40 DTOC cases and the last time 14 cases had been recorded was 27 March 2018. There is a requirement to improve capacity to move patients out of the hospital. G MacDonald explained that having clinical input and leadership from community into the hospital would be a positive step forward. Additionally, the Trust need to look into maximising community beds around social care use
- C Charles-Barks explained that the STP has had a programme of work on reducing LOS but this has not yet seen a great shift in working practices. There have been positive conversations with the local council and willingness to engage. Four small pilot projects have been agreed on which will be valuable in moving work forward. However, there is limited capacity available and there have been challenges in recruiting to domiciliary care vacancies. It is strongly felt that different recruitment solutions are required for the community in and around Salisbury. This could involve a collective recruitment offer to attract people into all three services on a rotation basis. The Trust would like to ideally close a ward to reinvest in staff in community but unfortunately the capacity is not currently there.
- P Hargreaves explained that this is an ongoing collaborative piece of work with the STP in relation to maximising care across the whole pathway and is still in its early planning stages. C Charles-Barks informed that the Trust is looking to learn from other organisations and that a meeting with the transformation lead from West Suffolk was in the pipeline to help learn from their transformation journey.
- R Credidio suggested that housing partners need to be included in these solutions and that going to the direct providers may lead to different solutions.

STRATEGY

TB1 - 0703/15 **Estates Strategy**

L Arnold attended to present.

- The Estates Strategy focuses on a 5 year plan from 2020 – 25 and

concentrates on the older areas of the estate. Some parts of the estate are 25 years old and these improvements needs to be delivered within the context of limited capital funds.

- The strategy describes current positions, challenges, opportunities, future requirements including efficiency and use of estate, working with other partners, particularly around the One Public estate.
- Main areas of risk are around day surgery which is based in the modular build, which is coming to end of its life.
- In maternity the delivery rooms of are approximately 50% of the ideal size.
- L Arnold described some early plans around campus development and informed the board of public engagement activities in March which will give the community the opportunity to put their views forward on how the site can be developed.
- The Sustainability Policy requires more work and the organisation needs to decide what is agreed in relation to sustainability and its ambitions for the future e.g. going carbon neutral.
- The strategy will be reviewed on a regular basis to ensure it remains relevant and up to date.

Discussion:

- P Miller stated that the strategy was informative and demonstrated a good understanding of weaknesses, risks and the limited resources. However, from a third party perspective there is not much information on how we intend to resolve these issues. The solution is based on a campus project but the strategy doesn't go into great detail about this. P Miller suggested an indicative break down of schemes will need to be addressed as part of the campus development, including timeframes and intended spend.
- **ACTION: C Charles-Barks asked L Arnold to meet with J McGuiness to ensure the strategy describes the ambition for the organisation.** **LA/JM**
- C Charles-Barks made reference to the CQC questions regarding the alignment of estates risk and compliance around health and safety and asked what steps had been taken to get further assurance on this. A Hyett advised that the Trust is undertaking an NHSI self-assessment by April 2019. Two of the six asset evaluations have already been carried out and estates and facilities have reviewed the risk register.
- **ACTION: P Kemp asked for the language in the strategy to be reviewed as the term "backlog maintenance and high risk" required context. L Arnold will provide context and bring back to the Board once changes have been made**. **LA**

TB1 - 0703/16 **Procurement and Commercial Services Strategy**

R Webb attended to present the report:

- R Webb advised that this was a refresh of original strategy. It was noted that the previous strategy had been delivered and had included upgrading infrastructure management capability. The department has won number of industry awards and the Trust was chosen to be one of six scan for safety sites nationally.
- The driver for updating the strategy is the changing landscape of NHS procurement with a new operating model across the NHS, which as an

organisation we need to feed into. Additionally the STP work involves working more collaboratively with great western hospitals and RUH bath. This new strategy takes into account the need to move from level 1 NHS procurement standard rating to level 2 to ensure the correct processes are followed in relation to procurement delivery and the understanding of responsibilities around this.
- The strategy will be peer reviewed on 11 March, including NHSI.
- The strategy does not ask for further investment into the procurement function but using resources more effectively and partnering with colleagues to use resources most effectively.

Discussion:
- There was a discussion around systems and upgrades. It was advised that, depending on outcome of new EPR system, there should not be a significant impact on delivering the strategy.
- N Marsden informed that the report had been to F&PC which had supported the strategy.

Decision:
Board approved the strategy.

TB1 - 0703/17 **Operating Plan 2019/20**

LT presented.

The board delegated approval to F&PC.

CLOSING BUSINESS

TB1 - 0703/18 **Any Other Business**

N Marsden thanked A Prime for her hard work and support she has given to the Board. K Nye has taken on the role as Corporate Governance Manager and will be supporting the Board of Directors.

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TB1 - 0703/19 **Public Questions**

R Jack congratulated the Trust on behalf of the Council of Governors on achieving a CQC rating of 'good'.

R Jack asked what the 4 hour ED performance for February was. A Hyett informed the board that the trust achieved 89% against the trajectory of 91%.

Dr J Lisle commented on the discussion regarding transferring patients from hospital to the community and the gaps in domiciliary care. Dr J Lisle stated that that it is difficult to understand how there could be a way of working together when there are significant gaps on both sides. This will affect the issue of transferring patients more rapidly into the community where they should ideally be.
- P Hargreaves explained that a piece of work to identify long term gaps in workforce is underway. Initial work has been done to ensure there is a faster recruitment system, TRAC. Some of the issues relating to long term gaps are linked to geography, accommodation, benefits and

health and well-being. It is hoped that additional support from workforce committee will give opportunity to court potential applicants for posts that have historically been difficult to fill.

- F Hyett informed that there are some real challenges in relation to how vacancies are recruited to outside of acute care and that the trust needs to promote the importance of community roles. The trust is going to do a piece of work with Southampton University, looking to bring over international students in partnership and recruiting people who want to work in the community.
- P Miller explained that there may be opportunities to create a more generic therapy role which would involve a range of cross-over skills enabling gaps to be filled. It could involve redesigning a role in order to meet the needs of the patients.

Dr J Lisle stated that it would take time to deliver these new roles.

- C Charles-Barker explained that there is no simple solution to resolve these recruitment problems. In the short term the Trust can review if there are roles that can be supported differently, utilising members of staff with varied skills. At the same time the solution has to be the longer term working partnerships with Wiltshire council and Wiltshire College, looking into apprenticeships and career pathways. The discussions with partners are lining up to deliver this new direction.
- P Hargreaves had attended the national future workforce meeting which is part of NHS long term plan. They want to review some of the drivers of the workforce situation and there is a national desire to resolve these longer term issues.

TB1 - 0703/20 **Date of Next Meeting**

The next public meeting of the Board will be held on Thursday 4 April 2019 at 10:30 am

TB1 - 0703/21 **ITEMS FOR INFORMATION**

The Board received the minutes of the Council of Governors meeting held in public on 19 November 2018.

TB1 - 0703/22 **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).

Trust Board Part 1 (Public) Action log

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

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
04 October 2018						
2374/07 - NHSI Quality Governance Framework Self-Assessment	increase publicity of the ways concerns can be raised and escalated if individuals feel they are not being heard	CCB	~~28/02/2019~~ 4/4/2019	New Head of Communications is building this into the internal/external communication strategy Communications Strategy to Private Board in April	N	2
06 December 2018						
TB1-06/12/23 - Clinical Strategy	Patient facing version of the document to be produced which also details the patient engagement and participation approach	CB	31/03/19	Met with JM on 28/12/18 to discuss comms and engagement approach. No comments received. Comms team to undertake stakeholder mapping and developing an engagement strategy No update re patient engagement - meetings happening with GPs and CCGs	N	2
17 January 2019						
1701/05 - Chief Executive's Report	Update on flu vaccine campaign uptake and learning for next year to go to Workforce Committee	PH	31/07/19	A meeting to discuss is being arranged.	N	2

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
1701/07 - MRI Scanner Update TB1 - 0703/04	Orginal figures and business case to be revisited	AH	31/01/19	First project board meeting 31/01/2019. The business case is under review. Any significant changes will come back to the Board. Aspects relating to cardiology and MRI to be incorporated when purchasing the scanner to ensure future proofing for advanced technology.	Y	3
07 February 2019						
0702/12 - Nurse Skill Mix Review	L Wilkinson to review how often the third nurse on Odstock is moved	LW	28/03/19	Underway. LW will report back to Workforce Committee 28/03/19	N	2
0702/12 - Nurse Skill Mix Review	C Blanshard, the clinical director for medicine and head of medical workforce will consider the new doctor safe staffing toolkit and will look to bring a future report to Board via the Workforce Committee	CB	06/06/19	Workforce agenda - 23rd May Trust Board - June	N	2
0702/14 - BAF & CRR	When committees next receive the BAF and CRR for review, the committees with oversight of the three strategic risks rated red to give consideration of the trajectory to green and the reflection of this within the BAF	FMcN with - F&PC - WFC	31/03/19	For discussion at March's committees. BAF/CRR on April Board agenda.	N	2
0702/15 - Learning From Deaths Q3, 2018/19	C Blanshard to include update on all learning from all quarters when bringing the Q4 report to Board to enable follow through of all learning actions to conclusion	CB	06/06/19		N	4
7th March 2019						
TB1 - 0703/06 - NHS Long Term Plan/ Legislation update	A series of papers would come to the Board on the long term plan and the potential implications on legislation. In April / May a timeline with with indicative milestones and a map of expected key papers will be coming to Board.	LT	04/04/19	First session planned for May Board.	N	4
TB1 - 0703/07 - 7 day services	A comprehensive report reviewing mortality rates at the weekend to go to the Clinical Governance Committee.	CB	14/05/19	Went to CGC on 22.1.19.	Y	3
TB1 - 0703/14 - ECIST	A Hyett informed the Board that a meeting had taken place to establish key metrics for all aspects of the ECIST report. This work will be reviewed at F&PC.	AH	26/03/19	Included in F&PC report.	Y	3

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 - 0703/15 - Estates Strategy	1. L Arnold to meet with J McGuiness to ensure the strategy describes the ambition for the organisation. 2. The language in the strategy to be reviewed as the term “backlog maintenance and high risk” required context. L Arnold will provide context and bring back to the Board once changes have been made	LA/JM	23/05/19		N	4

Report to:	Trust Board (Public)	**Agenda item:**	**6.**
Date of Meeting:	04 April 2019		

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

Recommendation:
None

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • **Performance –** update on current performance • **Finance –** update on our financial recovery plan • **Workforce –** update on workforce situation • **CQC Results** • **NHSmail migration** • **Regenerating our hospital site** • **Pride in practice awards**

Performance

We continue to experience problems in our emergency pathways and failed to deliver the 4 hour performance target again in February, achieving 89.4% which is below the standard of 95%. Our staff continue to work extremely hard to manage the situation.

We continued to deliver a strong 18 week referral to treatment target performance and we have met our diagnostic performance standard, which has seen significant improvement. We met the cancer two week wait standard, but did not meet the 62 day wait cancer standard and work is taking place to bring this back in line.

It is essential that we continue to provide good quality safe care. We had no reported cases of MRSA bacteraemia or C Difficile during February.

Finance

At the beginning of January the Trust submitted a revised control total forecast to NHS Improvement of a £10.6m deficit, an increase on the £8.9m deficit planned for. Following agreements with commissioners against 2018/19 contracts we have been able to revise this projection to meet the £8.9m planned deficit. As a consequence we are now expecting to be paid the final financial element of the Provider Sustainability Funding (£1.7m).

Workforce

We continue to organise recruitment events and campaigns, both domestically and overseas, and are looking forward to the RN event on 30th March. Internationally, we have developed a healthy pipeline of appointments; 9 overseas nurses passed OSCE during February. We continue to undertake Skype interviews with international nurses who have already passed the International English Language Testing System (IELTS). We have introduced ‘stay conversations’ for staff who are thinking about leaving the Trust and are already receiving enquiries about these.

The Trust’s overall sickness absence rate has decreased in the last month to 3.73%, above the 3% target, with long term absence reducing and short term absence slightly increased. We continue to focus on specific areas to proactively manage sickness absence with the aim of reducing it back below target to a sustainable level.

Mandatory training and medical appraisals are above target, whilst non-medical appraisals have slipped into amber at 84.9%.

CQC results

We were delighted to announce that the Care Quality Commission rated our hospital ‘outstanding’ for Critical Care and ‘good’ overall in their report published on 1 March 2019. The report is a ringing endorsement of the hard work of all our staff to deliver outstanding care for our patients. All of the four services reviewed during this latest inspection had made significant improvements since our last report.

During March we celebrated the results with our staff, through Executive Team walkabouts and a special Cascade Brief. We are planning more detailed briefings to all staff and will be reviewing where of course we can improve further. Our vision is to provide an ‘outstanding experience every time’ and this report shows how we are solidly and sustainably working towards this.

NHSmail migration

We have now successfully migrated to NHSmail, the national email system for the NHS. Our NHSmail project team, champions and floorwalkers did a fantastic job providing support during the migration and this support continues to be available to help people as they familiarise themselves with the new system.

One of the great features of NHSmail is that it will provide us with the opportunity to improve our shared distribution lists. We are encouraging all staff to ensure their profile on NHSmail is up to date so that we can start to build accurate distribution lists. This will reduce the number of all staff emails that are sent and help to ensure people are receiving messages that are relevant to them and their role.

Regenerating our hospital site

A series of public exhibitions were held during March to launch the Health, Education and Technology (HEAT) Project Salisbury, and to gather initial feedback from the public. Information was also provided to staff and exhibition material will be displayed within the hospital during April for staff and visitors.

The project is set to regenerate the Hospital site, creating a modern, sustainable, environmentally-friendly centre to serve the local community's changing needs.

The events were an important first step, allowing us to talk to people face-to-face and understand the priorities for the community. 132 attended the events and people were enthusiastic, with the vast majority of attendees expressing support for the project.

A thorough analysis of the comments will now be undertaken and we will consider the many topics and ideas that people discussed at the events.

We hope to run a further event in June with more detailed plans giving people the opportunity to comment further.

Pride in practice awards

On 21 March we held our annual Pride in Practice conference, where our nurses, midwives and therapists shared best practice, celebrated our achievements and highlighted improvements to patient care. Hearing the inspiring examples and stories of high-quality care from our nurses, midwives and allied health professionals was wonderful. We heard a passionate speech on the values that define our Trust from our first keynote speaker, writer and cardiac nurse Molly Case, while our second keynote speaker, the regional deputy director of NHSi in the South of England, Jonathan Webster, said that he was truly impressed by the Trust's performance. There were also over fifty posters (an all-time record) that represented all aspects of the Trust's care.

Cara Charles-Barks
Chief Executive
Performance

Report to:	Trust Board (Public)	**Agenda item:**	7
Date of Meeting:	04 April 2018		

Report Title:	Trust Board Annual Work Plan			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):				

Recommendation:
To approve the annual work plan of the public and private Trust Board.

Executive Summary:
As part of a Board assurance mapping exercise, all Board Committee terms of reference and annual work plans have been revised to make the function and responsibilities of the Committee explicit and to address any gaps in provision of assurance to the Trust Board. As part of this exercise the Board work plan has also been revised and updated.

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	☒

Public Trust Board Workplan 2019

	January 17th	February 7th	March 7th	April 4th	May 23rd	June 6th	July 4th	August 1st	September 5th	October 3rd	November 7th	December 5th	
Agenda Item													
Minutes of previous meeting	x	x	x	x	x	x	x	x	x	x	x	x	
Action log	x	x	x	x	x	x	x	x	x	x	x	x	
Annual Review of Committee Effectiveness Report				x									
Register of Attendance			x			x			x			x	
Chief Executive Report inc STP update	x	x	x	x	x	x	x	x	x	x	x	x	
Chairmans report (verbal)	x	x	x	x	x	x	x	x	x	x	x	x	
Patient/Staff Story		x		x		x		x		x		x	
BAF & CRR		x		x		x		x		x		x	
IPR	x	x	x	x	x	x	x	x	x	x	x	x	
Committee Escalation Reports		x		x		x		x		x		x	
CQC Report			x										
Register of Seals				x				x				x	
Learning from Deaths Report				x		x				x		x	
Customer Care Report		x		x				x		x			
Capital Development Report		x				x				x			
DIPC Report						x						x	
Skill Mix Review								x				x	
Guardian of Safe Working Report						x							
Medical Revalidation and Appraisal Annual Report								x					
Annual Reports													
Annual Report and Accounts 2018/19					x								
Annual Declaration for Provider Licence FT4				x									
PLACE		x											Think we can remove this. I Richardson said hasn't been to Board. Taken to TMC in Nov 18.
Annual statement on major incident preparedness				x									
Integrated Governance Framework				x									
Accountability Framework				x									
National Staff Survey Results				x									
National Staff Survey Progress Update												x	
Operating Plan 2019/20			x										
Voluntary Services Annual Report						x							
Equality and Diversity Annual Report						x							
Risk Management Strategy										x			
Risk Management Annual Report										x			
Clinical Governance Annual Report										x			
Annual Quality Governance Report										x			
NHSI Quality Governance Framework Self-Assessment										x			
Auditor Management Letter for 2018/19										x			
Health & Safety Annual Report								x					
Board Food Tasting										x			
Capital Development Report		x				x							
Capital Programme												x	
SFIs		x											
National In-Patient Survey													
Children and Young People Survey		x											
Maternity National Survey													
Trust Strategy progress update													
EPRR Annual Report 2019												x	
EPRR Compliance Statement												x	
CQUIN													
GDPR													
Freedom to Speak Up Gaurdian				x									
As required													
Internal Audit Reports													
Business Cases													
Minutes for noting													
Council of Governors Public Meeting			x			x		x				x	

Private Trust Board Workplan 2019

	January 17th	February 7th	March 7th	April 4th	May 23rd	June 6th	July 4th	August 1st	September 5th	October 3rd	November 7th	December 5th
Agenda Item												
Minutes of previous meeting	x	x	x	x	x	x	x	x	x	x	x	x
Action log	x	x	x	x	x	x	x	x	x	x	x	x
Register of Attendance			x			x			x			x
Chairmans report (verbal)	x	x	x	x	x	x	x	x	x	x	x	x
Clinical Reviews/SII Report		x		x		x		x		x		x
Legal and Litigation Report			x						x			
Draft Annual Accounts					x							
Draft Annual Report					x							
Quality Account					x							
Clinical Excellence Awards											x	
Financial Forecast	x											
Financial Planning 2019/20												
Recovery & Sustainability Plan												
Skill Mix Review												
Campus Project Update												
Pathology Service												
Corporate Governance Statement - Provider Licence Self Certification 2019 (G6, CoS7)					x							
Data Security and Protection Toolkit Self assessment					x							
Case for Change												
As required												
Business Cases												
Trust Strategies												
Minutes for noting												
Council of Governors Private Meeting			x			x		x				x
Audit Committee				x		x		x		x		
CGC		x	x	x		x	x	x		x	x	x
F&P Committee	x	x	x	x	x	x	x	x	x	x	x	
Strategy Committee			x		x	x	x	x		x	x	x
Subsidiary Governance												
Workforce Committee		x		x		x		x		x		x

Report to:	Trust Board (Public)	**Agenda item:**	9.
Date of Meeting:	4 April 2019		

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

Items for Escalation to Board
Operational Performance and ECIST report – Emergency Department (ED) performance as measured by the 4 hour target (95%) remained a concern with February 2019 performance at 89.4% only marginally better than January 2019 performance of 88.75%. That said the Committee were assured that considerable effort was being focused on key areas with the Emergency Department, as well as patient flow within the hospital and the wider community. These efforts are now summarised in an overarching action plan and the monthly integrated performance report is evolving in its content to report key progress and outstanding actions. **Financial Outturn Forecast 2018/19** – It has been a challenging year financially and for most of it the Trust has been behind its financial plan (control total) which was to achieve a deficit of £8.960m. However considerable work has been going on, both within the hospital and the wider NHS community and at the March F&P committee we were informed that it was now likely that we would successfully achieve our control total deficit. **Operating Plan 2019/20** – At the Trust Board meeting on the 7th March 2019 it was agreed, given National deadlines, to delegate the final approval of next years Operating Plan to the March F&P Committee. We can confirm than this plan was received, discussed and approved at this meeting. **Cardio Rhythm Management (CRM) tender evaluation report** – This tender outcome

report was received, discussed and supported. Normally given the value of the contract the Committee would then make a recommendation to the next Trust Board to approve. However given the urgency it was agreed that the Chairman would take Chairman's action and this would instead be reported retrospectively to the Trust Board.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	10
Date of Meeting:	4th April 2019		

Report from: (Committee Name)	Charitable Funds Committee		**Committee Meeting Date:**	21st March 2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Nick Marsden			
Board Sponsor (presenting):	Nick Marsden			

Recommendation
Summary Report below information only. The committee continues to debate the strategy in terms of were in how and where we make charitable fund investment decisions on behalf of the trust board. We are hoping to finalise our approach in the next quarters meeting and will report back to Board. We received a fundraising report with the outstanding success being the completion of the MRI Scanner Appeal. Future fundraising activity will now be focused on raising the requisite funds for ongoing activities such as Chaplaincy, Elevate, Art Care and Health and Wellbeing support for staff. The financial position is healthy but the committee is concerned with regard to the fund management performance in an uncertain economic environment.

Key Items for Escalation
None

Report to:	Trust Board (Public)	**Agenda item:**	11.
Date of Meeting:	4 April 2019		

Committee Name:	Clinical Governance Committee		**Committee Meeting Date:**	26th March 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 March 2019.

Items for Escalation to Board
Vascular services – the Trust is reliant upon other NHS Foundation Trusts for key medical staff to enable us to undertake certain vascular procedures safely on the Salisbury Hospital site. Unfortunately we now understand that these historic arrangements are no longer able to be supported going forward. Therefore we are looking urgently at alternative arrangements to support new service models. We were assured that future safe services can be provided, but in the worst case it would require an unplanned patient transfer to another hospital. Whilst this would be safe it would clearly not be optimal, therefore discussions are urgently ongoing to agree a new planned service model supported by an agreed service level agreement (SLA). **Gastroenterology services** – the Board have been previously made aware of short, medium and longer term sustainability issues around this key hospital service. In this regard the Committee received a detailed paper and action plan update on progress. The key outcomes of which were (a) we were assured that an effective service (supported by a new 3rd party contract) will be provided from the 1st April 2019 onwards and (b) the Committee was assured that strategic plans were in hand to discuss the medium and longer term future at the Trust Board in either May or June 2019. **End of Life Report 2018/19** – The Committee received this report and Dr Pippa Baker presented it. We were very impressed with the hard work and commitment of Dr Pippa Baker and her whole team, in particular their performance in the National audit for care at the end of life (NACEL) report.

Report to:	Trust Board (Public)	**Agenda item:**	12.
Date of Meeting:	4 April 2019		

Committee Name:	Subsidiary Companies Governance Committee		**Committee Meeting Date:**	15th March 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 Subsidiary Companies Governance Committee meeting of the15th March 2019.

Items for Escalation to Board
Salisbury Trading Limited (STL) – The Committee received a paper and presentation on the current performance of the laundry service, as well as the key issues for the future. The Committee noted the good current performance as well as the future risks and opportunities and were confident that these could be successfully managed over the forthcoming year. **Odstock Medical Limited (OML)** – Similarly the Committee received a paper and presentation on OML and in particular the current main product ,which is aimed at rehabilitation and enabling people to walk after illness, in particular strokes. During 2018/19 the company successfully managed a challenging in year position around overseas sales and is now back on plan. With regard to the future the company needs to further develop its medium and long term business plans and they are sighted on this. **Terms of reference and governance** – Terms of reference have been agreed and the future role of Mike Hawker as non-executive chair of each subsidiary company was discussed.

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NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	13
Date of Meeting:	04 April 2019		

Report from: (Committee Name)	Workforce Committee		**Committee Meeting Date:**	28/03/2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael Von Bertele (NED)			
Board Sponsor (presenting):	Paul Hargreaves, Director of People and OD			

Recommendation
The Trust Board are asked to note the items escalated from the Workforce Committee meeting held on 28/03/2019.

Key Items for Escalation
Staff Survey – The results from The Staff Survey highlighted that there is that there is work to be done in relation to Health and Well-Being. This will be taken forward as part of the Workforce Plan but further investment will be required. Freedom to Speak Up Guardian (FTSUG) – The newly appointed FTSUG updated the Board on progress. The committee discussed that the FTSUG is part of a wider network of champions and guardians across the Trust. It was agreed that a policy was required to detail how these staff members are given protected time to enable them to operate. Guardian of Safe Working - The Guardian of Safe Working report highlighted concerns regarding junior doctors and night work. A paper will be coming back to the next committee meeting in May to outline the risks, mitigating actions recommendations going forward.

Report to:	Trust Board (Public)	**Agenda item:**	14
Date of Meeting:	4 April 2019		

Report Title:	Integrated Performance Report, February 2019 (Month 11)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Executive Directors			
Executive Sponsor (presenting):	Executive Directors			
Appendices (list if applicable):				

Recommendation:
To note the information contained within the Integrated Performance Report for February 2019 (month 11).
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.

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

Performance Summary Narrative – February Performance, plus recent context

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Local Services (COO)	**RTT** • Trust achieved month end target of more than 92% of patients waiting for planned treatment having waited less than 18 weeks, highest performance since Nov 2015 • Plastics achieved 92% at specialty level not achieved since May 2016. • Managing waiting list size in line with trajectory.	• Particular areas of pressure in: general surgery, orthopedics, oral surgery and urology. • Impact of increase of non-elective activity on elective workload	• Weekly review of capacity fill is being undertaken for areas with biggest activity shortfall • Plans in place to reduce waiting list however they are dependent on impact of non-elective demand • Activity query notice has now been closed however activity has increased in Q4

Local Services (COO)	**Diagnostics** • The Trust was able to predict in advance the challenges to deliver the diagnostic standard and measures were put in place to mitigate the risk. • JAG accreditation continues to be a concern owing to the existing surveillance backlog. • Insourcing was secured to undertake procedures in Endoscopy. • Clinical teams work has been clinically prioritised	• There are continued workforce challenges in Radiology resulting in the clinical prioritisation of resources. These have been compounded by the unexpected failure of both CT scanners during the end of January / beginning of February. • Issues with the Gastroenterology team are having a significant impact on the Endoscopy waiting times. This has been mitigated by the successful introduction of a locum doing solely endoscopy work • A tender has now been awarded for a Gastroenterology service wef. 01.04.19. • Financial challenges face the Trust as a result of an ongoing reliance on additional capacity for Endoscopy and BSCP.	• Radiology workforce review is in draft, the costed and phased recommendations will be presented to the Executive Performance meeting in April 2019. • Demand and capacity modelling has been refreshed in Endoscopy to identify the shortfall. A recovery plan was submitted to the Trust Board who supported the need for insourcing during February to meet the Cancer targets • Both are being addressed with a task & finish group supported by the COO • Additional Endoscopy capacity has been approved.

	Positives	Challenges	Plans / Forecasts
Local Services (COO)	**ED** • ED 4 hour performance below trajectory for M11 (89.37% vs 91%) • ED Navigators in post 7 days per week to ensure safety of waiting room and navigation of patients to correct service • Successful recruitment of paramedics on 1 year fixed term to replace agency paramedics. • Change in clinical leadership has had a positive impact on morale within the department • Clarendon ward remains closed • Urgent Care Senior Leads Team (SLT) meeting set up by Medicine Directorate • 2 wte Consultants to join (one in M11 and one in M12). Fully staffed • 2 wte consultants both started in post. • Recruitment of experienced substantive middle grade doctor commenced in post M11 • Reduction in substantive nursing vacancies in M11	• Continued increases in ED attendance numbers as compared to 17/18 • Regular above average ED attendances – M10 – 17% M11 – 12% • Consultant morale challenging due to ongoing issue with medical director re. job plans/rota etc • Continued gaps in nursing and medical rotas resulting in poor skill mix and junior medical workforce. •1.6 wte consultants will be leaving over next 6 months. •Consultant annual leave in M11 has reduced amount of clinical leadership available.	• • Winter resilience plans in place to support increased demand, patient flow and bolster workforce (until end of March 2019) • Review ambulatory pathways to increase access to outpatient ambulatory services (away from the inpatient areas) (Feb 2019) • Project plan for SAFER re-launch agreed and to be embedded from M10 (from Jan 2019) • Continue with recruitment of nurses to reduce vacancies • Supervision and training of junior workforce • Urgent Care SLT to continue bi-monthly (second meeting planned Jan 2019). Improve cross working between ED and Acute Medical Unit • Consultant job planning and workforce review at final stages.

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Local Services (COO)	**Cancer** • Although not finalised Month 11 is showing achievement of all standards except 62 day and Breast symptomatic • Number of 104 day long waiters reducing	• Endoscopy capacity to support Lower GI pathways in particular • Clinical Oncology provision for Breast Services • Inequalities in MDT and time constraints for volume of patients to discuss. • Maintaining compliant 62 day performance following recent improvements to return to +85%. • Increasing waits to treatment at tertiary centers	• Locum Consultant recruited in Gastroenterology to support Endoscopy (Jan 2019) • Appointment of ID Medical for Gastro service provision from Q4 • Continue conversation with UHS re clinical oncology provision (March 2019) • Cancer Lead to review all MDT meetings to ensure efficiency. (to be completed by April 2019) • Maintain efficient tracking of patients on open pathways to ensure breach numbers remain low. (ongoing) • React to diagnostic delays quickly through patient tracking list meetings to expedite and reduce wait time. (ongoing) • Readiness for 28 FDS standard and implementing process to support this for SFT patients. • Twice weekly PTL meeting to mitigate issues.

	Positives	Challenges	Plans / Forecasts
Specialist Services (COO)	**MSK** • Spinal Injuries 'step down pilot underway' NHS E approved funding to extend to 31.03.19 • Zero spinal patients overdue an outpatient follow up appointment. • Wessex Rehabilitation pathway pilot for upper limb commenced in Q2 , to improve access and outcome for Major Trauma & plastics surgery patients • Review of Cleft service management in conjunction with Oxford to improve efficiency and reduce cost (complete) • Plastics network chaired by SFT COO well established.	• Increased waiting times for spinal rehabilitation • Some progress in Spinal urology surgery waits however still a challenge • Concern over VUD pathway. Short term and long term solution in place. Backlog of 51 patients will be reviewed by end of November 2018. • Continue to monitor the impact of the ward reconfiguration on plastics	• Business case for step down service for Spinal pathway redesign to Trust Management Committee (Feb 2019) – delay to March as Tender delayed – DMT 25.03.19 and then to TIG in April. • VUD - Short term mitigation in place and being addressed in wider Urology capacity and demand intensive support work. VUD practitioner interview 22.03.19. • Tender regarding step-down beds for Spinal Centre. Tender launched 1st Feb 2019 and awarded early April 2019 – see above. • Business case for commissioner investment in Wessex Rehabilitation being written . Draft Delayed to end of February 19. • Plans in place for regular meeting at COO/MD level between SFT and UHS to discuss pathways spanning both organisations • Focused validation on the waiting list for plastic surgery to clean the waiting list, identify patients to be seen and fast track review. Good progress, review April.

Salisbury NHS Foundation Trust

Performance Summary Narrative – February Performance, plus recent context

Vision – to deliver an outstanding experience for every patient

	Positives	Challenges	Plans/forecast
Innovation (MD)	• Continuing excellent R & D performance • 80% of open trials recruited to time and target • Haem-oncology research test now mainstreamed into clinical practice • Consultant paediatrician awarded for outstanding contribution to commercial research	• Smaller trials with few suitable participants	• Research fellows funded for a further year
Care (MD/DoN)	• Mortality rate remains as expected • SHMI has decreased to 100 and is as expected • Continued good performance on infection prevention and control. Ribotyping from C-dif cases in January show no link • Injurious falls decreased in month	• Rise in weekend HSMR has been investigated • Staffing remains challenging in a number of areas, with key hotspots MSK and ED. Although turnover is showing a decrease across the RN group and overseas pipeline is reducing vacancies across the Trust as a whole	• CQC mortality outlier alert for COPD/bronchiectasis has been investigated • NHSI Retention workstream for registered nurses continues

Care (MD/DoN)	Positives	Challenges	Plans/forecast
	• TIA performance 100% • SSNAP score B achieved • Final CQC inspection report published on 1 March with overall Good for the Trust and Outstanding for Critical Care Services	• Only 54% stroke patients reach the unit in 4 hours	• Direct to CT for stroke will start in April
		• Remain challenged on mixed sex accommodation – exclusively when ambulatory area of AMU is used overnight	• Links to patient flow PMB work. Winter ward opened Feb 2019, up to 16 beds. Patient flow workstreams continue with renewed focus on SAFER and action focussed daily whiteboard rounds. Weekly multi agency expert panel reviewing all stranded/superstranded patients continues. Revised national guidance on MSA expected and the Trust is refocusing and identifying how this will affect us.
	• Winter ward (Laverstock) continued – due to close end of March with good patient and staff feedback and reduction in medical outliers		

Salisbury NHS Foundation Trust

Performance Summary Narrative – February Performance, plus recent context

Vision – to deliver an outstanding experience for every patient

	Positives	Challenges	Plans/forecast
People (DoOD & P)	**Recruitment:** • 9 overseas nurses passed OSCE during February 2019. • Vacancy rate for registered nurses (improving) currently at 86.19 (due to reduction of leavers, OSCE conversion along with 3.46 wte domestic recruits commencing). • Improving conversion rate for overseas nurses. • Revised SLA's added to Trac.	**Recruitment:** • Lack of available domestic registered nurses • Managing fluctuating numbers of overseas nurses due to arrive. • Overall capacity in the Recruitment Team due to 1 member of staff leaving in September. • Lack of availability of Ward Managers to interview via skype for RN's.	**Recruitment:** • Revised NA Assessment Centre recruiting process to be implemented for April. First events 10 and 24 April. • RN recruitment event to be held on 30 March 2019.
	Agency Spend: • Locums Nest fill rate for February 78%. • Yeovil and Poole have joined the Locums Nest Collaborative. • Usage on Thornbury reduced	**Agency Spend:** • Centralisation of all staff banks within the Trust. • HMRC challenging DE model	**Agency Spend:** • Agency spend tracked in month and year to date control total • We are meeting with Locums Nest staff in the near future to look to register our senior doctors/consultants with the system

during the month of February (5 out of 12 shifts filled).

- Transitioning Nurse Bank into OD & People.

Sickness:

- Long term sickness has decreased this month.
- Overall sickness rate reduced to 3.73%

Sickness:

- Short term sickness increased in month slightly
- Stress a major element of absence case mix

Sickness:

- Support continuing on key long term cases to ensure resolution
- Investment cases to Trust for HAWB April 2019

Engagement:

- Senior Leadership Forum second meeting due in early April
- Staff engagement group uptake improved

Engagement:

- Maintaining improvement in Staff Engagement Group numbers and commitment to time for meetings and consequent work

Engagement:

- We have been offered and accepted consultancy support from HEE to undertake an Organisational Development diagnostic, leading to a plan for culture change at Salisbury Hospital.
- Staff Survey results in development plan

Other:

- MaST (Mandatory and Statutory Training) compliance continues to improve at 92.03%
- Medical appraisal improved and now complaint at slightly down at 91.46%

Other:

- Non-medical appraisal non complaint at remains compliant at 84.90%

Other:

- Non-medical appraisal improvement plan managed through executive performance review – expected compliance in April
- Developing capacity and capability for workforce planning

Vision – To Deliver an outstanding experience for every patient			
	Positives	**Challenges**	**Plans / Forecasts**
Resources (DoF)	• The February position was better than forecast and now shows an improved trajectory for year end. • The Trust has now agreed forecast outturn positions will all commissioners which has reduced the risk to the year-end position. • The Trust is now forecasting to achieve the control total for the year, through securing year end contract agreements with commissioners and therefore is eligible for the PSF funding related to quarter 3 and 4 (not the element related to ED performance due to being below trajectory).	• The outturn for 2018/19 relies on non-recurrent actions; therefore the underlying financial position is more challenging. • The financial position of the health economy remains a challenge, any reductions in funding within Wiltshire Council to adult social care could have a material risk to the delivery of the 2019/20 operating plan. • The control total for next year relies on the Trust achievement of £10m CIP programme, in the event of non delivery the Trust would need to seek additional borrowing from NHSI/Department of Health.	• Trust submitted draft operating plan and financial plan to NHSI at the beginning of February. Trust is working on the basis of agreeing to the control total offered for 2019/20. Further work is required in time for the final submission in April once feedback from NHSI is received.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	15a
Date of Meeting:	04 April 2019		

Report Title:	M11 Operational Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Andy Hyett, Chief Operating Officer			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):	Appendix 1: Patient Flow Appendix 2: Trust Board Report			

Recommendation:
The Trust Board are asked to note the Trust Performance for Month 11

Executive Summary:
The Trust did not deliver the ED standard reporting 89.4%. The RTT and Diagnostic standards were delivered. Cancer performance for month 11 is provisional.

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	☒

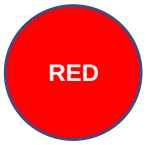
Executive Summary of Key Operational Performance – January 2019

( ) = national targets

ED Performance (95%)	**In month (11)**: **89.4%** **Year to date: 91%**	RED
RTT Performance (92%)	**In month (11): 93.41%** **Year to date: 92.55%**	GREEN
Diagnostics (99%)	**In month (11): 99.44%** **Year to date: 98.98%**	GREEN
Cancer **2ww 93%** **31 day 96%** **62 day 85%**	**In month (11):** . **2 ww = 94.4%** **31 day = 95.1%** **62 day = 79.1%** **Cancer performance is currently provisional**	RED

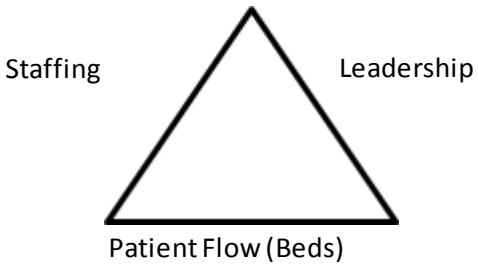
Key to the delivery of operational standards, financial performance and a quality service is patient flow. A more detailed analysis is provided in Appendix 1

Emergency Pathway Performance



Since June 2018 we have experienced challenge in managing our emergency pathways and performance has been below 95%. ED went in intensive support in October, stepping back from this in January after performance improved. However following deterioration in performance this is currently being reviewed. Following a review of our flow and discharge pathways the patient flow program and wider system improvement plans have been updated. We are sighted on national discussions about changes to emergency pathways standards – timely assessment, treatment and onward flow will remain essential to the delivery of any new standards. The committee will be kept updated with any changes.

The Trust failed to deliver the ED standard in Month 11 reporting 89.4%. A more detailed analysis is provided in Appendix 1.



Staffing
ED Dr staffing has been challenging through January and February however from March there are no consultant vacancies.

At February 2019 nurse vacancies had reduced to circa 8WTE. Clinical Navigators (3 WTE) have been appointed, start dates to be confirmed. This will reduce the vacancies to circa 5WTE (assuming no other leavers) and cease the agency contract that is in place for the navigator roles.

Leadership
The new leadership team in ED are now established and are focused on improving the service provided. The team are very proud of the CQC report and the improvement that they have demonstrated since the last inspection. Disagreements between consultants and the medical director re job planning have caused issues and the potential impact on performance is logged on the directorate risk register.

Patient Flow
Emergency flow dashboards are now live in ED, AMU and site management. The patient flow workstream is now chaired by the CD for medicine and the COO runs a weekly patient flow delivery group to review weekly action progress.

Table 1: Performance and Activity

Month		1	2	3	4	5	6	7	8	9	10	11
Performance	Type 1 (%)	92.5	90.7	91.3	90.2	95	82.7	81.7	83	90.4	84	84.8
	Type 1 + 2 (%)	93.1	91.3	91.8	90.8	86	83.9	93	84	90.9	95	85.6
	Type 1,2 + 3 (%)	95	93.5	93.9	93.1	89.7	87.9	86.7	87.5	93.3	88.8	89.4
Trajectory	Type 1,2 + 3 (%)	95	93.5	93.9	93.1	89.7	87.9	85.9	88.6	89.1	89	91
Attendances	Plan	3993	4258	4174	4358	4112	4077	4110	3848	3859	3718	3572
	Actual	4197	4640	4559	4832	4244	4338	4427	4205	4218	4331	3987
	Variance (%)	5	9	9	11	3	6	8	9	9	17	12
Average Daily Attendance	Plan	133	137	139	141	133	136	133	128	124	120	128
	Actual	140	150	152	156	137	145	143	140	136	140	142

Table 2: Time to Triage

Avg Median Time to Triage for week by team	All	Major & Resus	Majors	Minors	Resus
03/02/2019	13.7	10.5	12.7	20.1	*
10/02/2019	18.0	12.1	17.1	29.7	*
17/02/2019	13.4	9.9	12.7	20.4	*
24/02/2019	10.0	7.9	11.9	14.4	*
03/03/2019	14.0	8.1	12.3	24.9	*

Table 3: Time to Treatment

Avg Median Time to Treat for week by team	All	Major & Resus	Majors	Minors	Resus
03/02/2019	75.8	72.3	89.0	82.7	*
10/02/2019	89.3	72.6	103.4	122.6	*
17/02/2019	79.8	67.1	96.7	105.1	*
24/02/2019	66.8	63.3	87.7	74.3	*
03/03/2019	64.4	47.6	70.3	95.6	*

***** Some data discrepancies have been identified with Resus data and we are working with Informatics and Clinical teams to identify the issues to allow this data to be included going forward.

The trust performance for ambulance handover remains good within the sector and region however below the trusts aspiration to never hold an ambulance

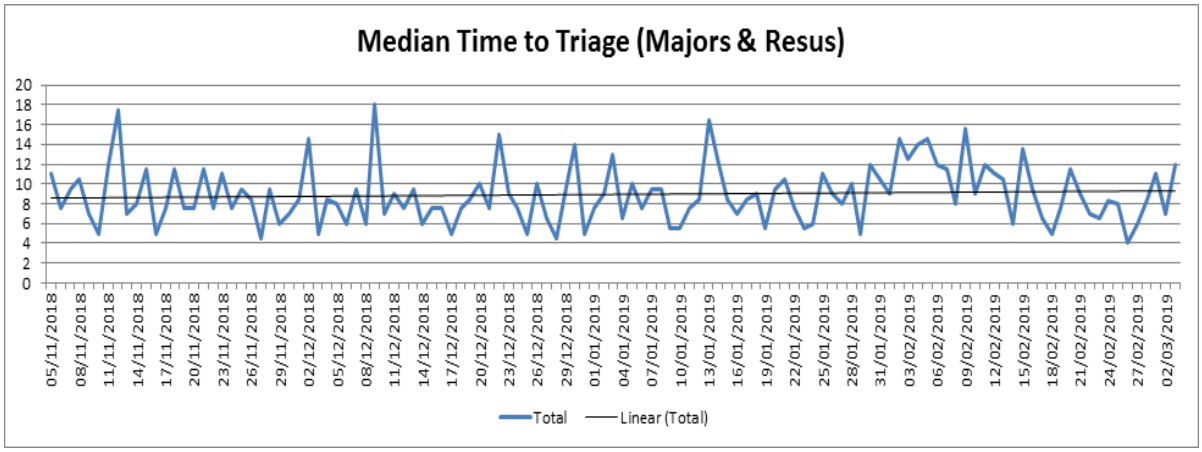
Table 4:

Daily Ambulance Waits February 2019

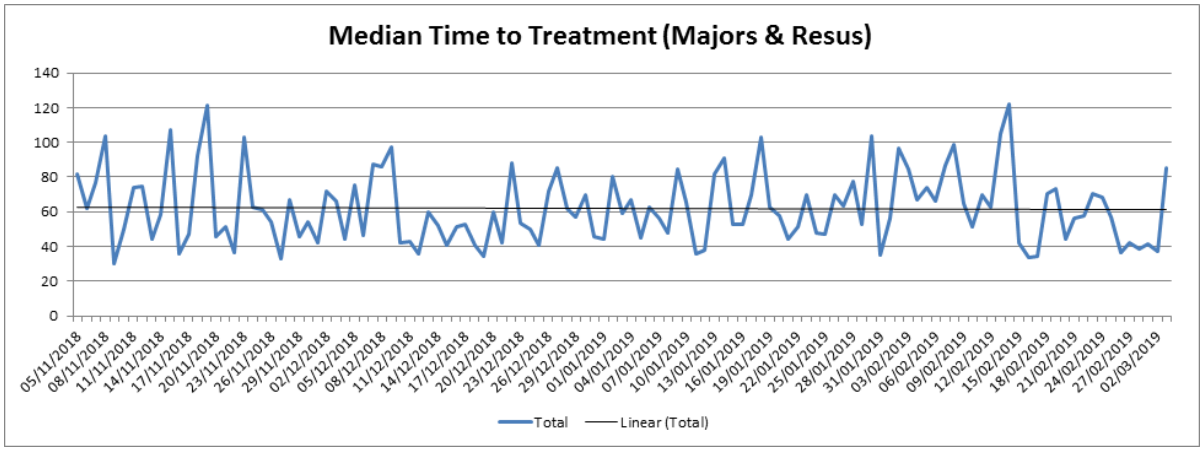
Total Reported: 44	
Total Breaches: 30	
Breaches > 1hr: 4	
Breaches < 1hr: 26	
Breaches >15 mins < 30 mins (for info) 133	
Total number of patients arriving by Ambulance: 1134	
% of patients met the target:	**97.35%**

The trust has seen less volatility in time to triage and time to assessment in February – accurate reporting and monitoring of these metrics will be a key piece of work in the forthcoming months.

Graph 1

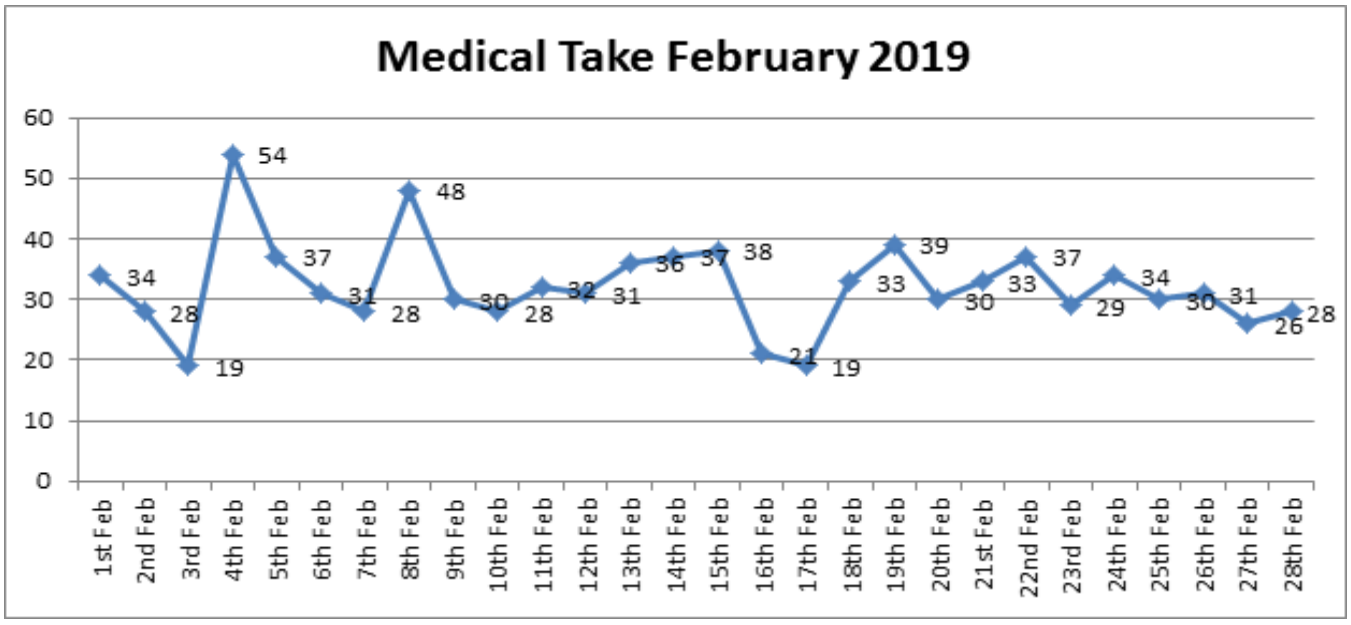


Graph 2



Medical admissions dropped in the second part of February and appear to be stabilising to a new norm around 30 – 35.

Graph 3



CANCER

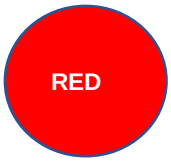


Table 5: Cancer Performance

A report to show the monthly and quarterly Cancer Target Performance figures for the current quarter. CUP patients are excluded from this report.

Description	Standard	January			February		
	%	In target	Total	%	In target	Total	%
All cancer Two Week wait	93	807.0	861.0	93.73	812.0	860.0	94.42
Symptomatic Breast Two Week wait	93	40.0	43.0	93.02	39.0	44.0	88.64
31 Day Standard	96	130.0	132.0	98.48	82.0	86.0	95.35
31 Day Subsequent: Drug	98	13.0	13.0	100.00	10.0	10.0	100.00
31 Day Subsequent: Surgery	94	22.0	22.0	100.00	13.0	13.0	100.00
62 Day Standard	85	76.5	91.0	84.07	38.0	47.5	80.00
62 Day Screening Patients	90	6.0	6.0	100.00	15.0	16.0	93.75

Although not finalised, M11 is showing achievement for all standards except 62 day (80.0%) and Breast symptomatic (88.64%). Histology for potential non breached treatments is awaited which will serve to increase the denominator and improve the position. It is also possible that 2 additional breaches may be incurred once histology is received. The 62 day standard is due to 9.5 breaches across all sites but particularly 3.5 in head and neck, 2.5 in urology and 2 in colorectal. The 2WW standard continues to be achieved despite endoscopy challenges. It is "usual" for the Breast Symptomatic target to reduce in terms of performance achieved, in a month where there is a half-term. This is because patients have reduced availability so more patients choice breaches occur. Achievement of 62 day performance for Q4 is vulnerable.

- Head and neck: capacity issues due to staff shortages (new consultant now started). Late referrals due to complex diagnostics. Pathway review underway in anticipation of 28 day standard.
- Urology: delays at the tertiary centre and late referrals by us. Appointment of CNS as cancer lead (in process) will improve the pathway .
- Colorectal – increased demand due to reduced gastro service. Gastro provider starting on 1st April – should have a positive impact in Q1/Q2.
- New processes to manage tracking of 28 day taster diagnosis is needed to ensure priority of tracking those on a cancer pathway is given. Non cancer patients not yet informed of diagnosis but remaining on tracking is causing the tracking lists to be large.

Referral to Treatment

***General Surgery – (Q4 target 85%)* Month 11 83.5%%**

Review of backlog following hernia work to identify other opportunities for additional capacity.

- Continued long term consultant sickness with no date for return
- Some outsourcing of cases to New Hall as part of CCG arrangement
- Further review of 18 week backlog to understand where pressures in pathway are.

Urology – (Q4 target = 91%) Month 11 90.4%

- Appointment made for permanent 7pa post from May 19, and further full time consultant appointment made with expected start date in Q3 2019/20. Start dates to be agreed and recovery plan with possible locum support is being developed.
- Work continuing to validate waiting list and clear long waiting patients

Trauma &Orthopaedics (T&O) (Q4 target = 90%) Month 11 89.1%

- High levels of Trauma in February
- Flexible Job Planning continues to maximise theatre useage
- 12th Consultant (Trust locum) appointed and some additional Trust locum cover secured for March
- Wiltshire activity passed to Newhall as per CCG request
- Wiltshire activity undertaken and planned for rest of Q4 to improve RTT for Wiltshire
- Improved visibility of waiting lists – realignment of waiting lists to sessions being implemented in Q4 with increased DSU activity
- Additional Limited Liability Partnership lists and additional Sunday list per month to continue for Q4

Oral and Maxillo Facial surgery (OMFS) : (Q4 target = 90%) Month 11 72.1%

- Clinic template work ongoing to improve booking
- Additional lists where possible
- Service review completed – Priority recommendations agreed with service

Dermatology – (Q4 target = 92%) Month 11 86.1%

- Performance challenges due to medical and surgical dermatologist shortages
- Maternity leave from June 2019 - Scoping – high volume locum opportunity for maternity cover – paper submitted to performance review in February
- Additional plastic lists as above

- Continued innovative and creative solution to national shortage of Dermatologists – to maintain – medical and surgical dermatology service
- Designing phase of piloting a new way of seeing rapid referrals to improve capacity management

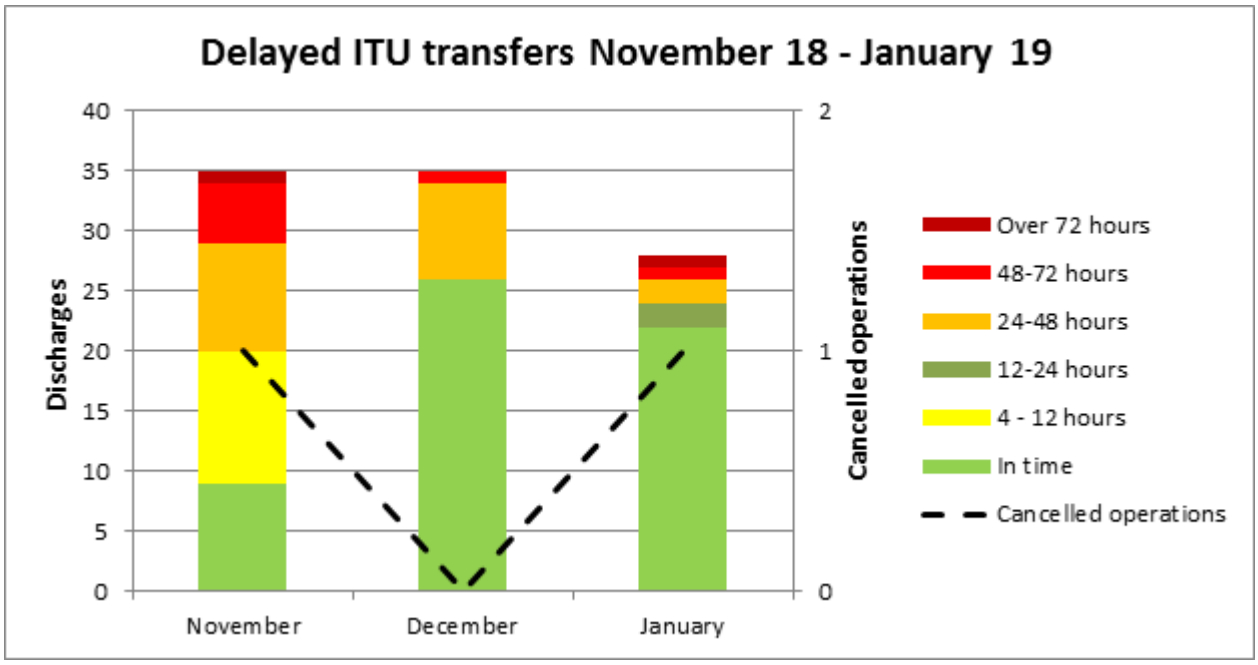
Table 6: Waiting list split by CCG

Total WL	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Dorset CCG (11J)	2,537	2,495	2,564	2,505	2,480	2,460	2,424	2,459	2,537	2,588	2,650	2,762
West Hampshire CCG (11A)	1,582	1,572	1,621	1,626	1,583	1,574	1,565	1,620	1,639	1,666	1,628	1,696
Wiltshire CCG (99N)	10,080	10,361	10,752	10,577	10,481	10,616	10,335	10,343	10,441	10,192	10,384	10,499
Other CCGs	2,839	2,886	3,024	3,138	3,135	3,016	2,989	2,834	2,526	2,411	2,180	2,106
Trust Total	**17,038**	**17,314**	**17,961**	**17,846**	**17,679**	**17,666**	**17,313**	**17,256**	**17,143**	**16,857**	**16,842**	**17,063**

Overall PTL (Patient Waiting List) has increased slightly with the biggest growth being in Opthalmology in the cohort under 18 weeks which has increased by 245 patients. We are currently analysing referral rates by sub specialty and CCG to understand this growth in more detail.

ICU

Graph 4



------ At the time of this cancellation in January there were no wardable patients in ICU.

Diagnostic (DM01)

Following significant investment, the Trust met the diagnostic standard in February reporting 99.44%

There were 20 breaches in Endoscopy – 4 colonoscopy, 13 gastroscopy, 3 flexible sigmoidoscopy.

Endoscopy

The recovery plan implemented for February, with a heavy reliance on insourcing, has delivered significant improvement. This has been helped by the continuation of the locum endoscopist.

Current wait times are now under 6 weeks.

The previously reported lack of cover from regular Endoscopists combined with the ongoing absence of CNS cover in Colorectal continues. A tender has been awarded to an external supplier for the provision of a more robust Gastroenterology service from April 2019.

Capacity is being outsourced at weekends to mitigate the backlog in BCSP. Further activity will be undertaken to address the surveillance backlog, a requirement for JAG accreditation. This is proving challenging as it has not been possible to secure a 2nd Locum.

Radiology

The MRI waiting list is currently at 411 with the majority of patients waiting less than 5 weeks. The demand remains constant so we are therefore continuing with the use of the mobile scanner for 3/4 days per week on a regular basis.

Whilst this is a significant cost, the demand and complexity of patient cohorts require additional capacity to the standard scanner which could not be met as efficiently with ad hoc arrangements.

Local health care providers have been notified of the available capacity on the MRI van but they have not taken advantage of this opportunity. The COO has highlighted our position to both the CCG and NHSi.

The CT breaches anticipated for February as a consequence of scanner failure have been avoided owing to the additional lists implemented.

CT wait times have remained static during February as additional capacity is continuing in the evenings and at weekends, however staffing is proving to be a challenge and measures continue to be investigated to improve recruitment and retention of staff.

Links to Assurance Framework/ Strategic Plan:

Choice – Ensuring deliver key of performance targets to encourage patients in choosing to be treated locally at SFT as a provider of high quality care and ensuring that intervention by regulators is not required

Appendix 1 Patient Flow

The four key objectives of the patient flow programme are:

1) To increase the number of discharges across all wards by midday from a baseline of 15% to 30%.
2) To ensure all patients have an accurate estimated date of discharge (EDD) recorded
3) Directorates to ensure a weekly review all patients with a LoS > 7 days who are not medically fit to ensure actions are taken to support prompt discharge.
4) Realignment of ED and ambulatory pathways.

The information below outlines the performance against key KPIs aligned to the above priorities and next steps

The trust did not deliver its trajectory of 91% reporting 89.4% however this was against an increase in attendances against pan of 12% (Table 7). There was a slight increase in conversion rates (graph 5) and a 5% increase in admissions against the average in Q1 – Q3 (Table 8)

Table 7 Performance and Activity

Month		1	2	3	4	5	6	7	8	9	10	11
Performance	Type 1 (%)	92.5	90.7	91.3	90.2	95.0	82.7	81.7	83.0	90.4	84.0	84.8
	Type 1 + 2 (%)	93.1	91.3	91.8	90.8	86.0	83.9	93.0	84.0	90.9	95.0	85.6
	Type 1,2 + 3 (%)	95.0	93.5	93.9	93.1	89.7	87.9	86.7	87.5	93.3	88.8	89.4
Trajectory	Type 1,2 + 3 (%)	95.0	93.5	93.9	93.1	89.7	87.9	85.9	88.6	89.1	89.0	91.0
Attendances	Plan	3993	4258	4174	4358	4112	4077	4110	3848	3859	3718	3572
	Actual	4197	4640	4559	4832	4244	4338	4427	4205	4218	4331	3987
	Variance (%)	5	9	9	11	3	6	8	9	9	17	12

Graph 5: ED type 1 attendances and conversion rates

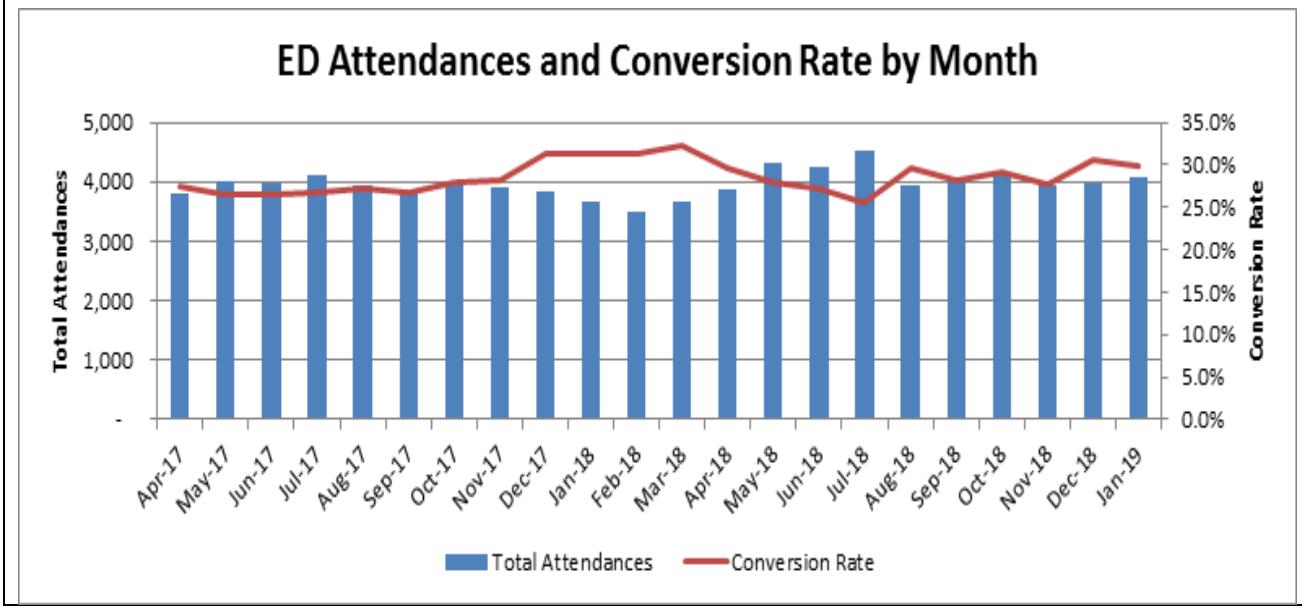
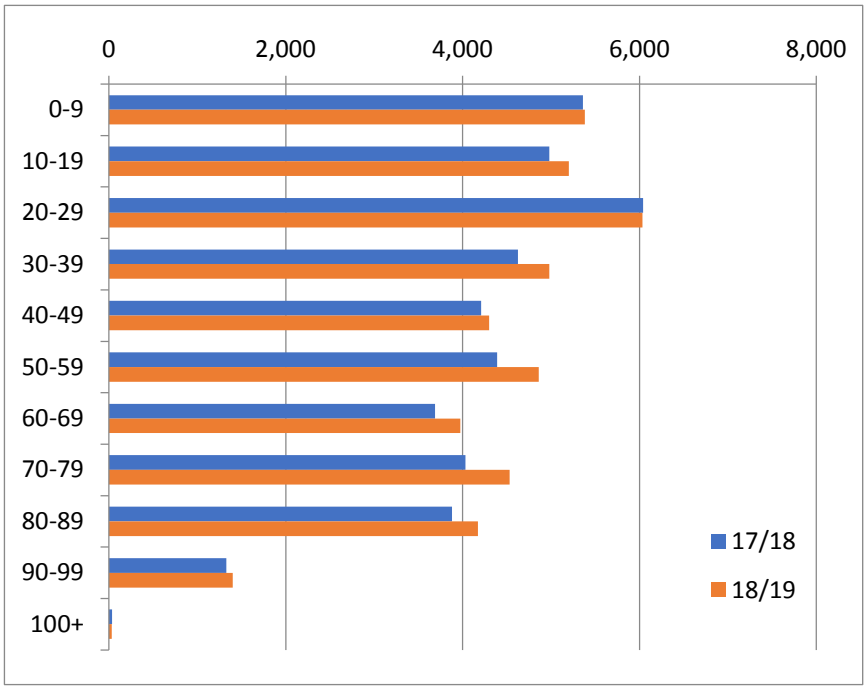


Table 8 - Admissions

Month	Total Emergency Admissions	Total Emergency Admissions / day
Mar-18	1954	63
Apr-18	1878	63
May-18	1889	61
Jun-18	1924	64
Jul-18	1943	63
Aug-18	1952	63
Sep-18	1842	61
Oct-18	2013	65
Nov-18	1876	63
Dec-18	1923	62
Jan-19	2106	68
Feb-19	1822	65

Graph 6 – age profile of admissions



Further analysis is under way to further understand the growth by condition.

Length of Stay

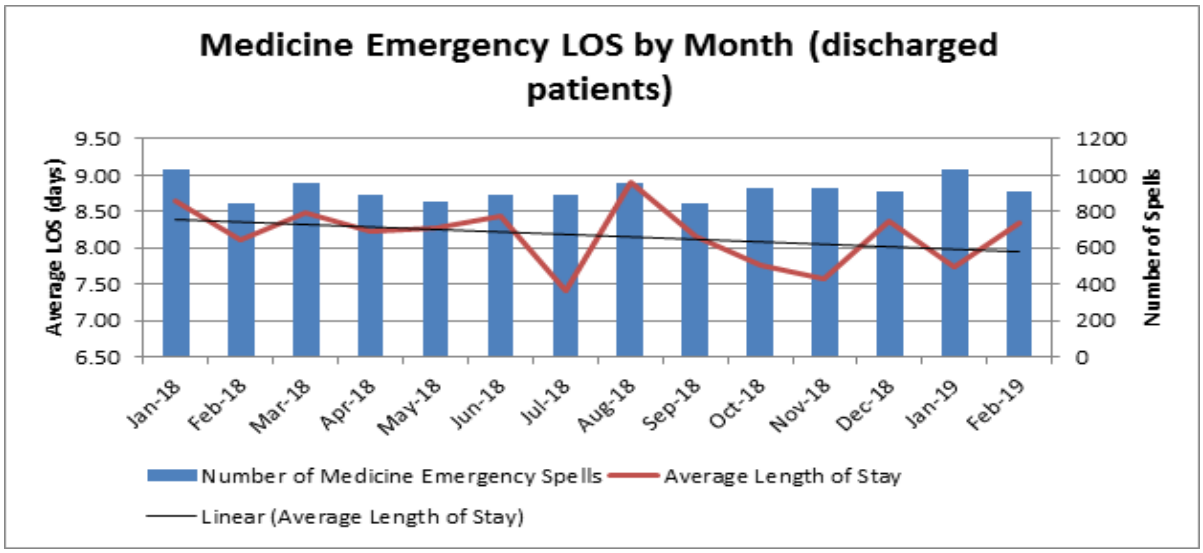
As described in last month's report the trust is moving length of stay reporting to align with model hospital definitions therefore making comparisons with benchmark trusts easier. Patient Flow and length of stay dashboards are now live and being tested. Trust performance compared to benchmark trusts at specialty is proving problematic and the trusts IT team are now in discussion with the Model Hospital team.

Graph 7 shows medicines length of stay based on discharge and shows a 0.5 day improvement in performance, this also needs to be viewed alongside the number of patients with a length of stay < 1day which are not included in the length of stay calculations (Graph 8). This improvement is down to improvements in our ambulatory pathways, rapid assessment and diagnostics. It should also be recognised that all of these patients will be returning to their normal place of home – 0 pathway patients.

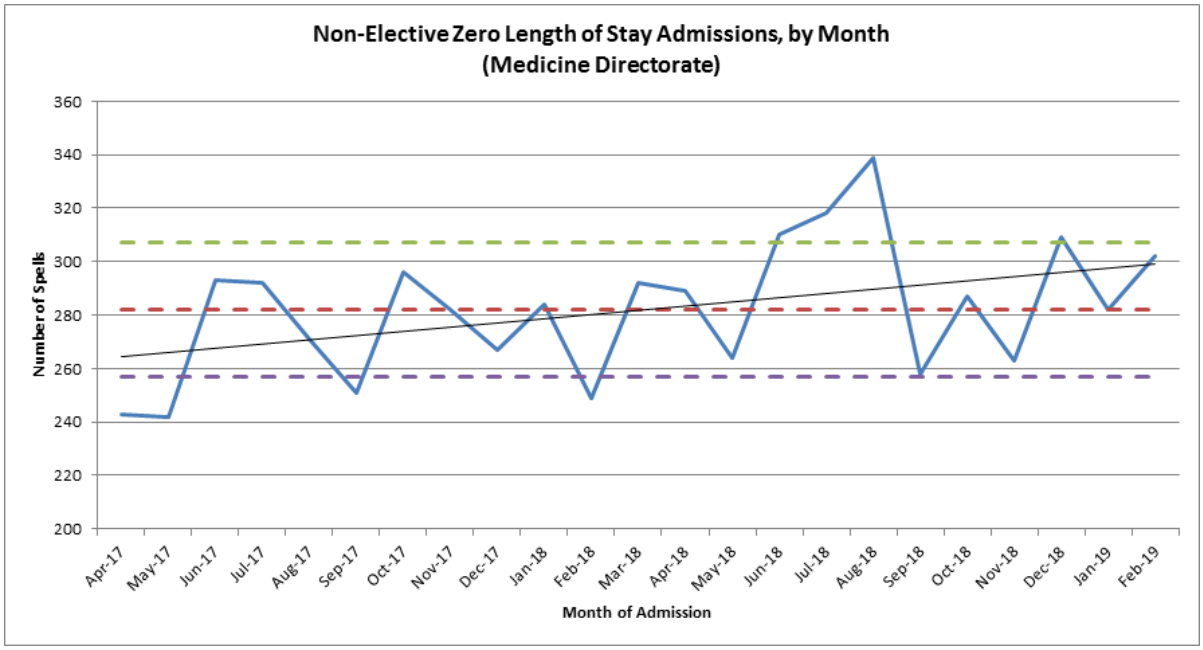
Length of stay will continue to be a key metric to monitor improvement in patient flow.

Reporting of LOS against Model hospital data is still in development and delayed due to challenges in replicating trust performance shown on the Model hospital portal. The trusts informatics team is in discussion with the Model Hospital data team.

Graph 7

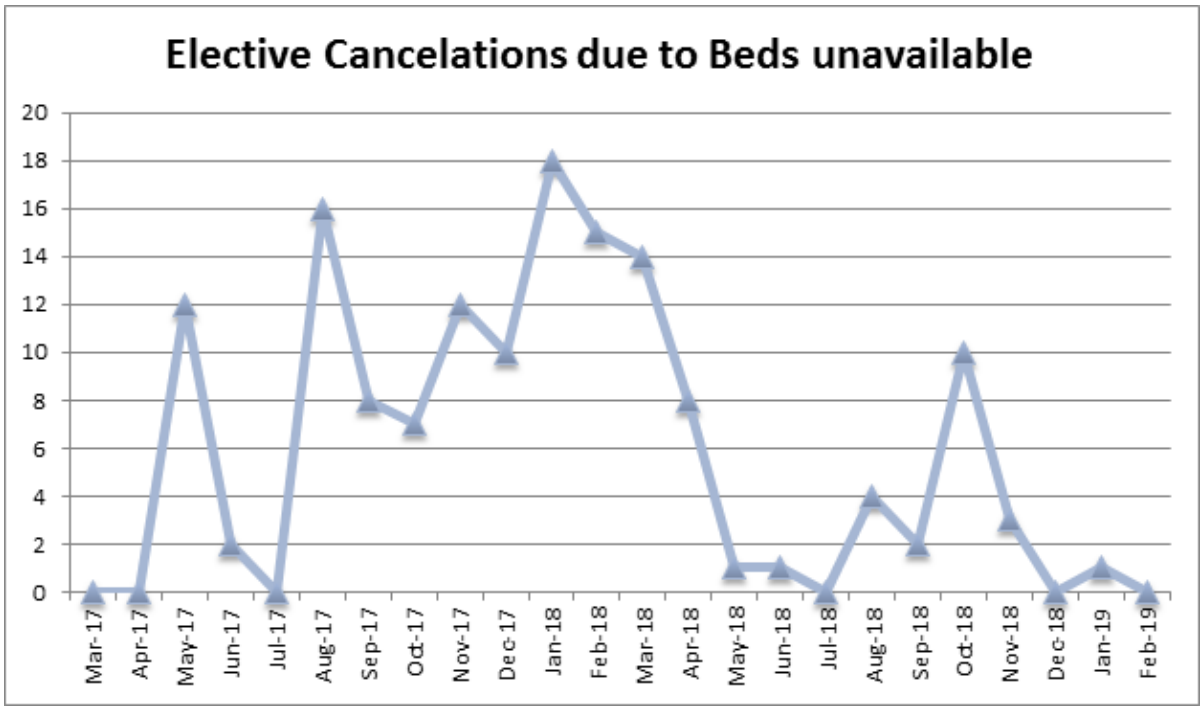


Graph 8



Elective cancellations due to beds continued to be at an all-time low (Graph 9). Three ward moves took place in January between 12:00 – 06:00; this will be audited in March.

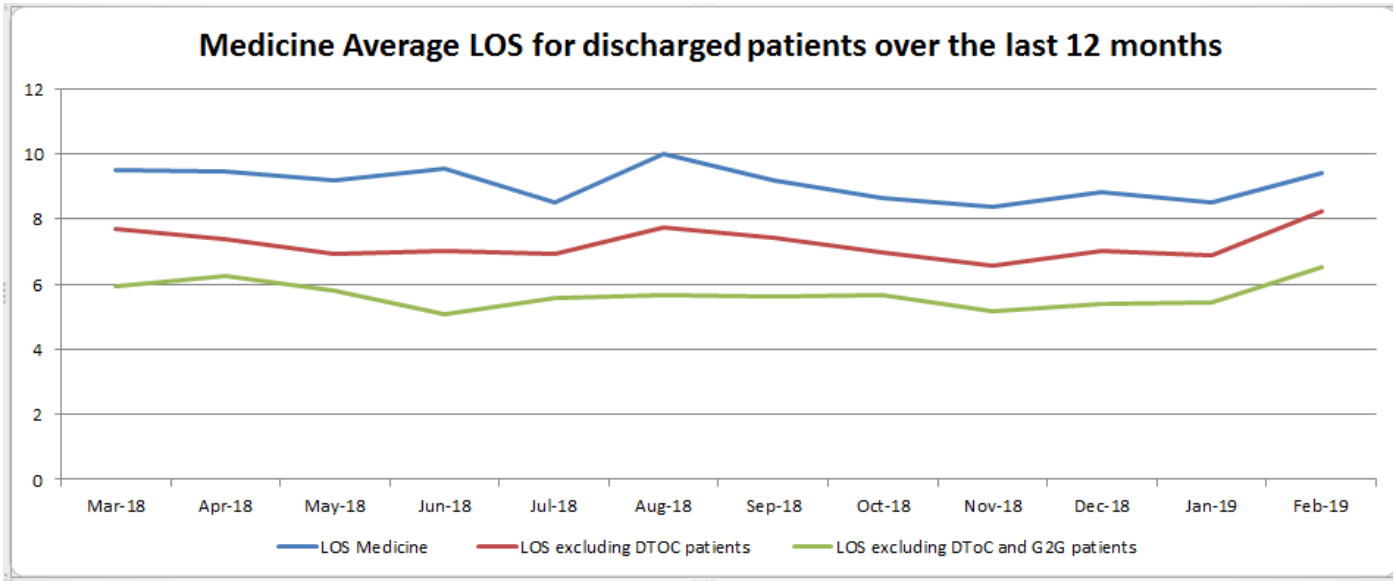
Graph 9



The number of patients whose discharge from hospital continues to be high with the number of patients coded as DTOCs reaching the highest level this year in February (Graph 10). The effect of delayed discharges being above target on length of stay is displayed in Graph 11.

Graph 10

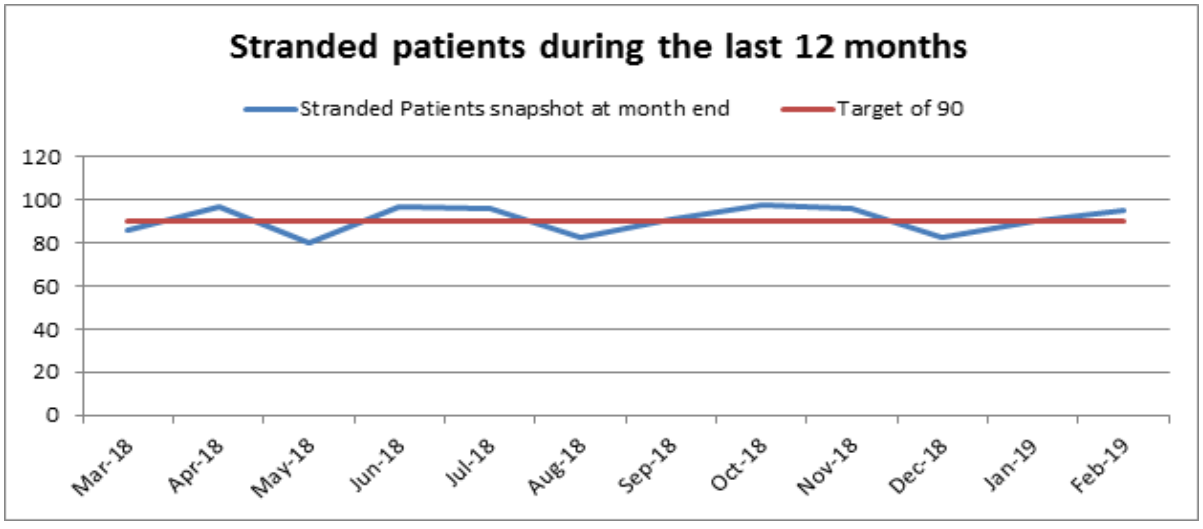
Graph 11



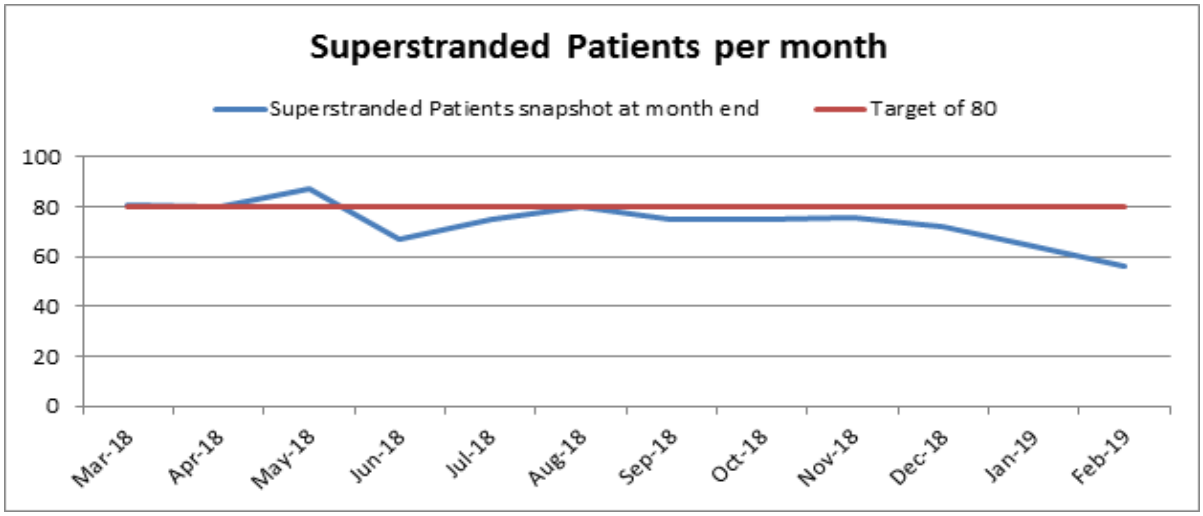
The number of stranded and super stranded patients are shown in Graph 12 and 13. From March all patients with a length of stay > 21 days who are not fit for discharge are reviewed by the Clinical Director for the Directorate and overseen by the COO.

In line with national requirements the target for stranded patients in 2019 will be 53.

Graph 12

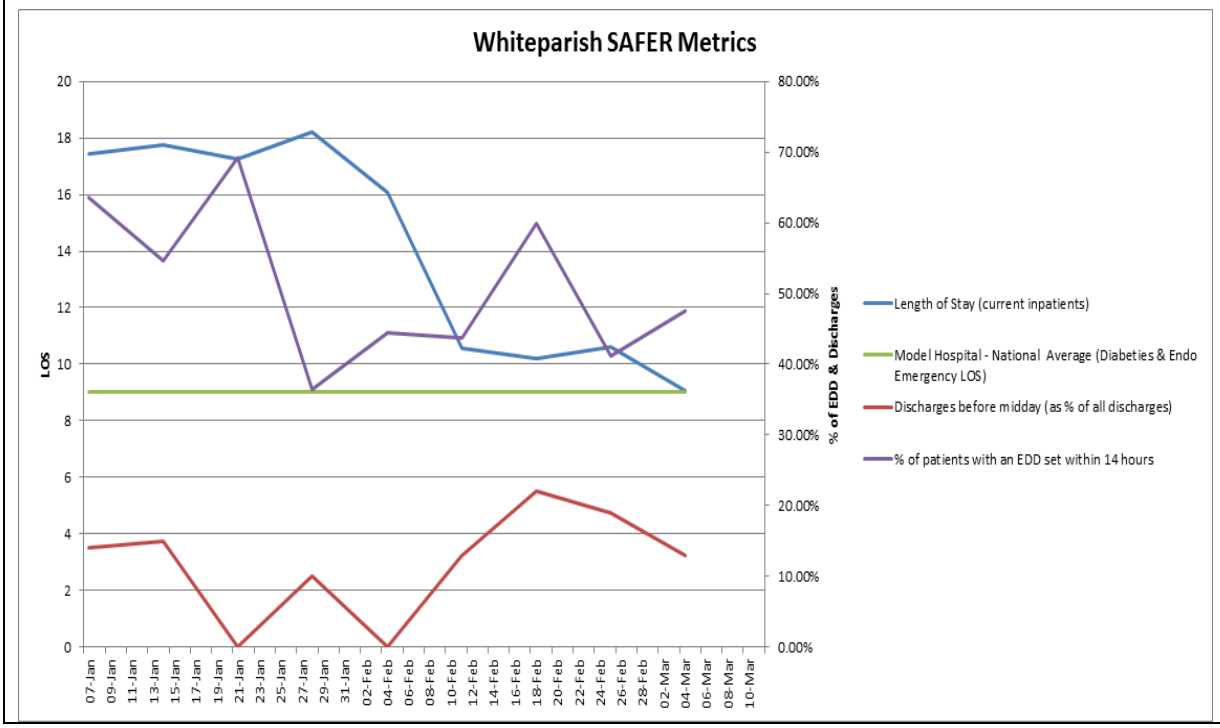


Graph 13



The continued embedding of SAFER in all wards continues to be raised and championed by the Directorate Management Team and Director of Nursing. The programme of work continues to respond to the different needs of the wards and teams, however, in all cases, an increased visibility, focus, challenge and coaching of staff who attend the daily e-whiteboard meetings to improve the patient journey and therefore improve 'flow' in being undertaken. MSK and Surgical wards are now being visited and supported. Improvements to key metrics on Whiteparish ward where SAFER has been implemented are show in Graph 14. The impact on length of stay for current in patients has shown a significant reduction, since January 2019, this will be as a result of the SAFER work, the increased availability of Doctors on a daily basis and management of speciality (endocrine) admissions/transfers into that ward.

Graph 14



Next Steps – Patient Flow

This programme of work will now be further supported by external colleagues from ECIST providing a series of 2 hour workshop sessions on the 2 and 3 May 2019 to increase awareness and education for Trust clinicians nursing, HCA, therapy teams.

The Operational delivery group monitors and reviews progress and developments on a weekly basis, with the PMB continuing to review strategic schemes and items raised from the operational group and OETB/other mtgs.

The patient flow project plan contains the Trust ECIST, system wide, MADE event actions/recommendations actions

The bed modelling tool, developed by the CSU with input from SFT and system partners is now available and will be used by the PMB and Directorate Teams to scope/test out new schemes and its impact.

A separate group is now developing patient 'bed-side' literature to educate/raise awareness and empower patients across a number of areas, including 'discharge plans/arrangements'.

The development of a specific discharge planning intranet/internet page is being pursued to provide ward staff with increased visibility and availability of necessary literature/forms/information regarding the discharge process, which is expected to further streamline the discharge processes.

The Older People and frailty group have an established strategic group, a series of smaller task and finish groups have been established to progress key areas of development (training/education, falls and implementation of the (Comprehensive geriatric assessment). The Trust submitted data as part of NHS Benchmarking, mandated by GIRFT and undertook an audit as part of the Wessex AHSN, these findings and the learning from this is being reviewed. Further meetings with local GP's will be arranged throughout March and April to develop/scope out locality based models of care.

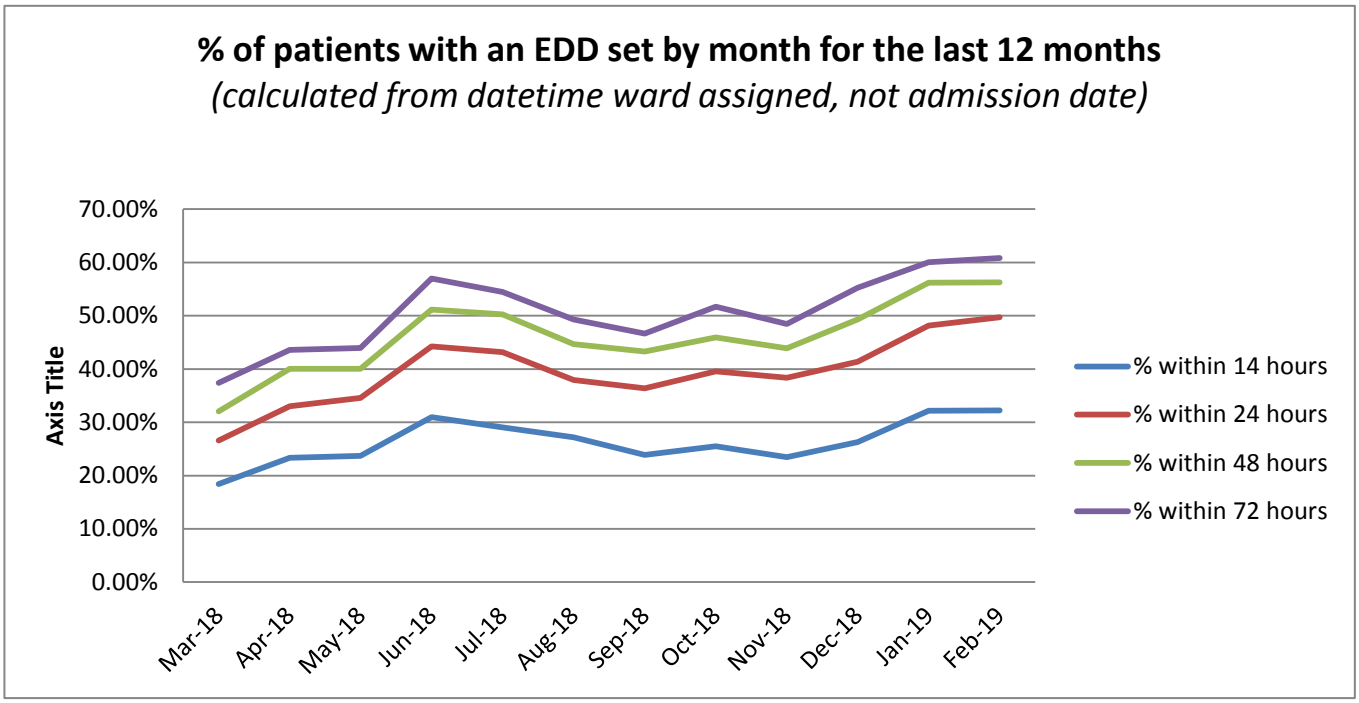
The Length of Stay for medicine continues to be monitored via the Patient Flow PMB. The target for medicine LoS (emergency and non-elective admissions) was set at 6.68 at the beginning of the financial year and the position currently stands at 8.10 with a total number of 10,052 patient spells. Compared to the same position in 17-18, length of stay was reported as 8.83 against 9,636 patient spells (graph 3). The Trust has notably reduced length of stay despite an increased number of patients being admitted.

Data analysis has shown that emergency surgery admissions LoS has reduced from 4.11 in 17/18 to 3.94 in 18/19 and within MSK LoS has slightly increased from 8.13 to 8.70.

As described in last month's report the trust is moving length of stay reporting to align with model hospital definitions therefore making comparisons with benchmark trusts easier. Patient Flow and length of stay dashboards are now live and as a result of the testing and comparison to Model Hospital metrics, further amends are required to align the dashboard to model hospital.

A key area of focus needs to be the setting of EDDs. The table below shows current performance – this data will be monitored daily for the rest of the month and a report is now available by directorate and ward to allow a targeted focus.

Graph 15



Next Steps - ED

Meeting with COO, CD and Clinical Lead to discuss next steps and action to address number of 1st Dr Breaches.

Review of process to record time to assesment and time to treatment to ensure accurate and timely recording.

Review of rotas and reasons for gaps

Re-launch of operational standards with Junior Drs

Next steps – System wide

DTOC trajectory required

Actions to deliver attendance reduction / control growth

Roll out of trusted assessor

Roll out of discharge to assess

Clear capacity visibility

Salisbury Hospital NHS Foundation Trust Board Report - February 2019

NHS Salisbury NHS Foundation Trust

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Feb-19**	**Patients Affected in Feb-19**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	93.41%	1,125	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		11 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Feb-19**	**Patients Affected in Feb-19**	**Trend Against National Standard**
A&E - 4 Hour wait from Arrival	95%	STF = 93.8%	**89.4%**	573	
A&E - 12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%		99.44%	20	
Diagnostic Test Compliance***	10 out of 10		7 out of 10		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Delivering same sex accommodation****	0		**62**		
Infection control – Clostridium difficile (YTD)	YTD: 17		YTD: 4	0	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Feb-19**	**Patients Affected in Feb-19**	**Trend Against National Standard**
All Cancer two week waits	93%		94.4%	48	
Symptomatic Breast Cancer - two week waits	93%		88.6%	5	
31 day wait standard	96%		95.6%	4	
31 day subsequent treatment : Drug	98%		100.0%	0	
31 day subsequent treatment : Surgery	94%		100.0%	0	
62 day wait standard from GP referral	85%		80.00%	9.5	
62 day screening patients	90%		93.8%	1.0	

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

**This excludes patients transferred to another Provider and now exceed 104 days

***Only Diagnostic examinations carried out in the reporting month shown are counted

****Please note MSA (Mixed sex accommodation) is now referred to as DSSA (Delivering same sex accommodation) since 01/08/2018

CLASSIFICATION
Unrestricted

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**14b**
Date of Meeting:	04 April 2019		

Report Title:	Quality indicator report – February 2019			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Quality indicator report – February 2019			

Recommendation:
To note the Trust quality indicators and actions being taken to improve.

Executive Summary:
Positive indicators – further reduction in SHMI from 105 to 100 within the expected range. 100% high risk TIA performance and an increase in the SNNAP score to B. Successful appeal of a C difficile case for no lapses in care. A reduction in injurious falls in February with a forecast of an overall reduction in falls resulting in harm compared with last year. Of concern – rise in weekend HSMR to higher than expected. We investigated this with the help of the Dr Foster team and reported to the Clinical Governance Committee in January 2019. Time to the stroke unit within 4 hours improved slightly, but remains below target, mainly due to delays in and from ED. The number of non-clinical mixed sex accommodation breaches within ambulatory areas decreased but privacy and dignity maintained and breaches resolved very quickly.

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	☐

1.0 Purpose

1.1 To provide the Board, Committees and Forums with the Trust's quality indicators.

2.0 Quality indicator report

2.1 No cases of Trust apportioned C Difficile in February. As there were no lapses in care, of one Trust apportioned C difficile case in December, we made a successful appeal to Somerset CCG who agreed the case could be removed from the Trust's figures. The Trust's C difficile upper limit for 2019/20 is 9 cases.

2.2 One MSSA bacteraemia possibly line related. Investigation ongoing.

2.3 No MRSA bacteraemias.

2.4 One E Coli bacteraemia - source of infection not identified.

2.5 Increase in in-hospital cardiac arrests in January despite the introduction of NEWS2. This will be monitored and investigated if it persists.

2.6 Three new serious incident inquiries commissioned in February. YTD 32 cases.

2.7 A decrease in crude mortality in February. HSMR is 105.5 to November 18 and is within the expected range. SHMI is 100 to September 18 and when adjusted for palliative care is 94 and both are within the expected range. Weekend HSMR increased to 120 to November 2018 and is higher than expected range. A review of weekend HSMR was presented to the Clinical Governance Committee in January 2019. A CQC mortality outlier alert for deaths from COPD is being investigated and will be reported in the Q4 Learning from Deaths report.

2.8 Hip fractures operated on within 36 hours of admission reduced to 80% in February due to awaiting medical review/investigation or stabilisation (3) and theatre space (1).

2.9 Grade 2 pressure ulcers sustained at a low level. Share and learn meetings continue.

2.10 In February, 1 fall resulting in moderate harm (fractured facial bone).

2.11 All stroke patients received a CT scan within 12 hours. Continued to be challenged in getting patients to the stroke unit (54%) within 4 hours, mainly due to delays in first doctor assessment in ED. Continued to exceed the 80% national target of patients spending 90% of their stay on the stroke unit. In Q3, SSNAP score increased to B. In April, a new process to transfer the patient straight from the ambulance to CT will start.

2.12 100% of high risk TIA patients seen within 24 hours of referral.

2.13 Escalation beds remained open in February. Laverstock ward was opened as an escalation ward until the 31 March 2019. Ambulatory areas continued to be used overnight. Multiple ward moves increased in February. Ongoing work with multi-agency partners continues on all aspects of patient flow.

2.14 In February, 9 non-clinically justified mixed sex accommodation breaches affecting 62 patients in ambulatory areas occurred, of which 7 were in AMU and 2 in SAU. All were resolved within 12 – 24 hours.

2.15 Patients rating the quality of their care sustained at previous year average. The Q2 staff friends and family test improved compared to Q1 of those recommending the Trust as a place to work and receive care or treatment.

3.0 Summary

Positive indicators – further reduction in SHMI from 105 to 100 within the expected range. 100% high risk TIA performance and an increase in the SNNAP score to B. Successful appeal of a C difficile case for no lapses in care. A reduction in injurious falls in February with a forecast of an overall reduction in falls resulting in harm compared with last year.

Of concern – rise in weekend HSMR to higher than expected investigated with the help of the Dr Foster's team and reported to the Clinical Governance Committee in January 2019. Time to the stroke unit within 4 hours improved slightly, but remains below target, mainly due to delays in and from ED. The number of non-clinical mixed sex accommodation breaches within ambulatory areas decreased but privacy and dignity maintained and breaches resolved very quickly.

Claire Gorzanski, Head of Clinical Effectiveness, 15 March 2019.

NHS Salisbury NHS Foundation Trust

Trust Quality Indicators - February 2019

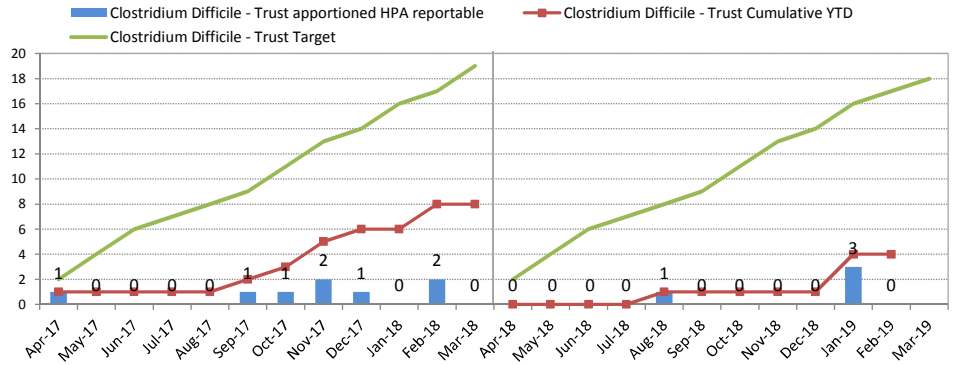
Quality Measures

Infection Control	2017-18 YTD	2018-19 YTD
MRSA (Trust Apportioned)	0	3

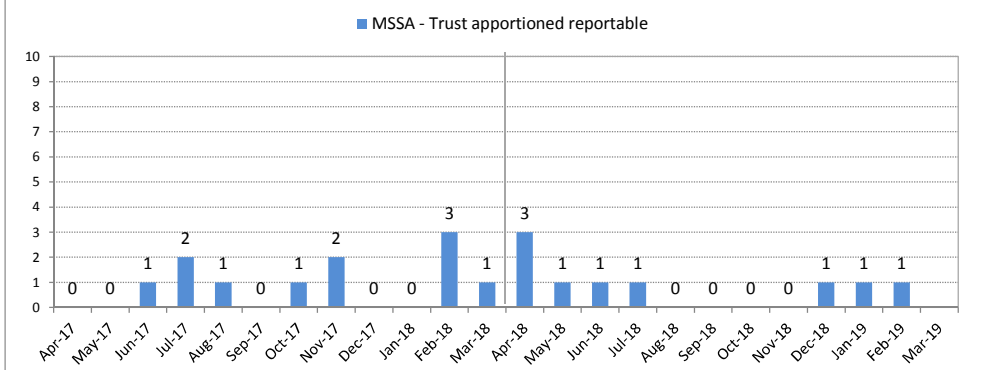
Trust Incidents	2017-18 YTD	2018-19 YTD
Never Events	3	2
Serious Incidents Requiring Investigation	25*	32

* Of these commissioned, 2 have been downgraded as they did not meet the SI definition. This was in agreement with the CCG.

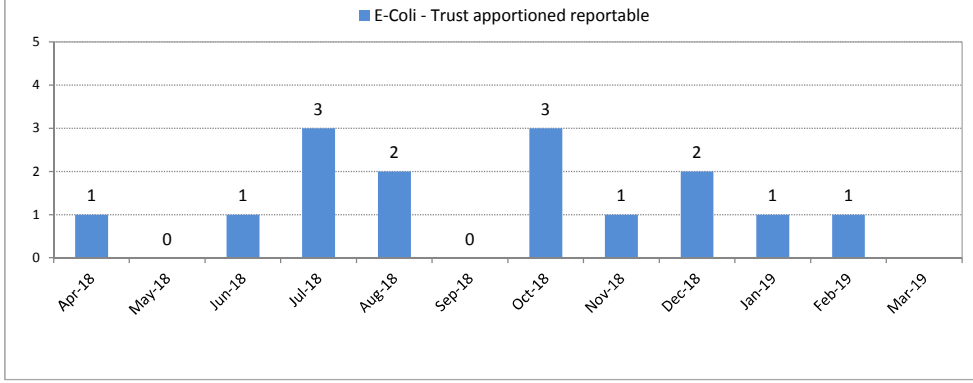
Clostridium Difficile - Trust Apportioned



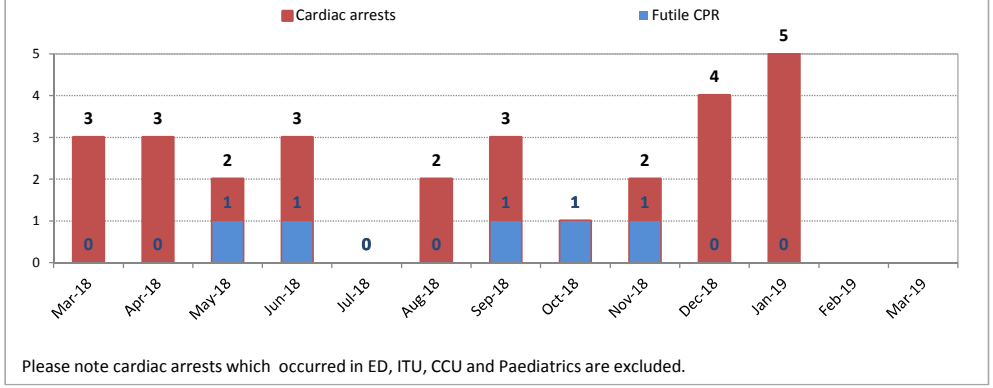
MSSA - Trust Apportioned



E-Coli - Trust apportioned reportable



In hospital cardiac arrests and futile CPR



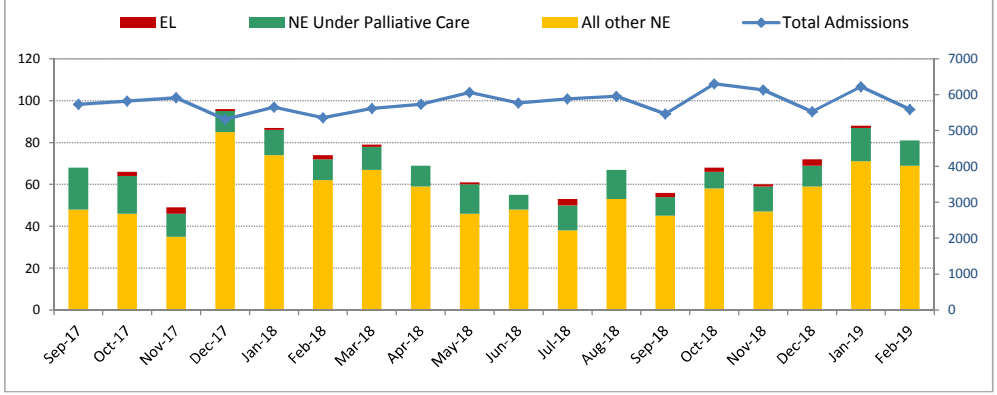
Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.

NHS Salisbury NHS Foundation Trust

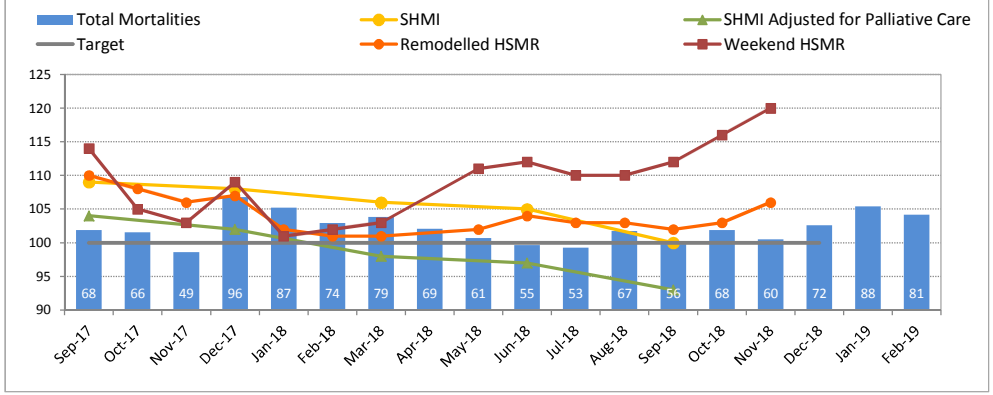
Trust Quality Indicators - February 2019

Quality Measures

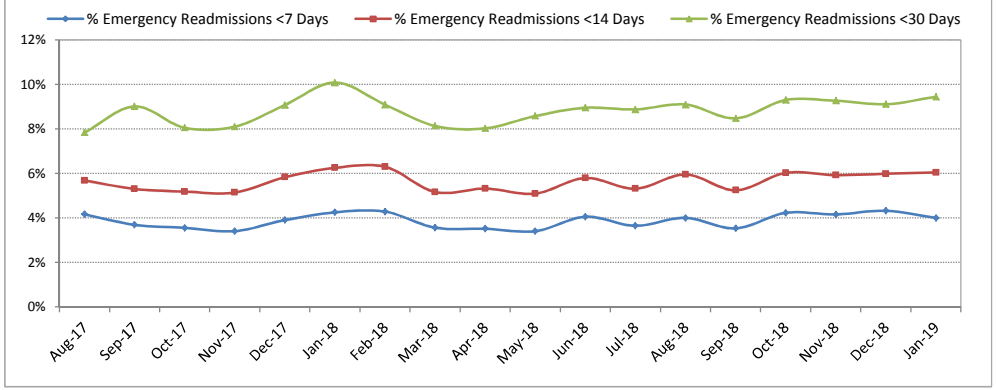
Hospital Mortalities



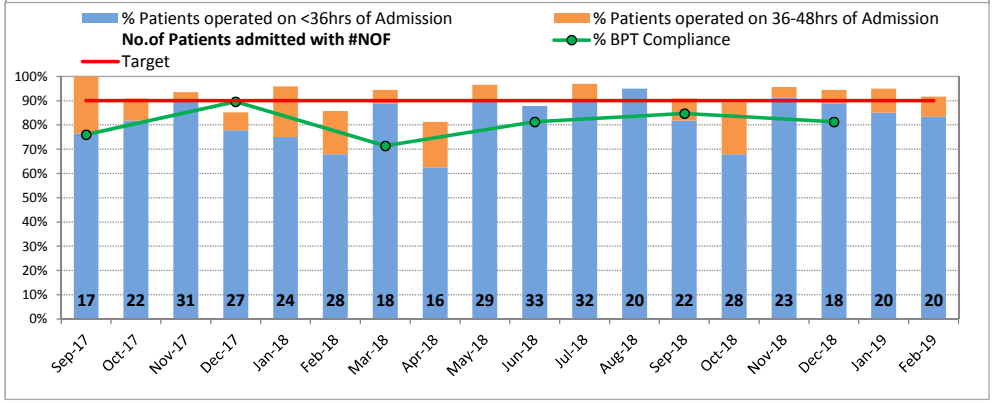
HSMR and SHMI



Emergency Readmissions within 7, 14 & 30 days of Discharge

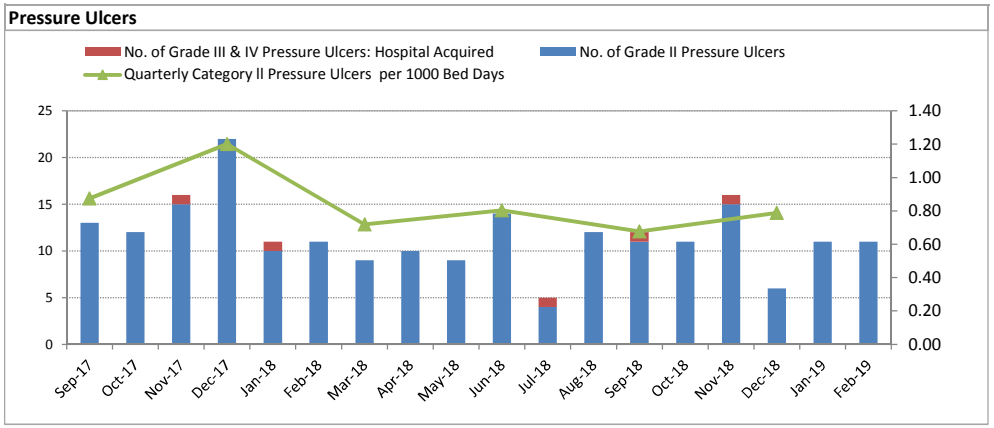


Fracture Neck of Femur operated on within 36 hours (Revised following TIAA Audit)

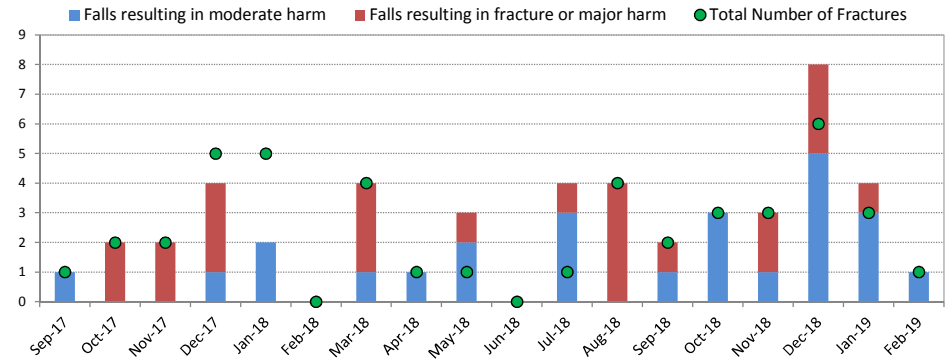


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

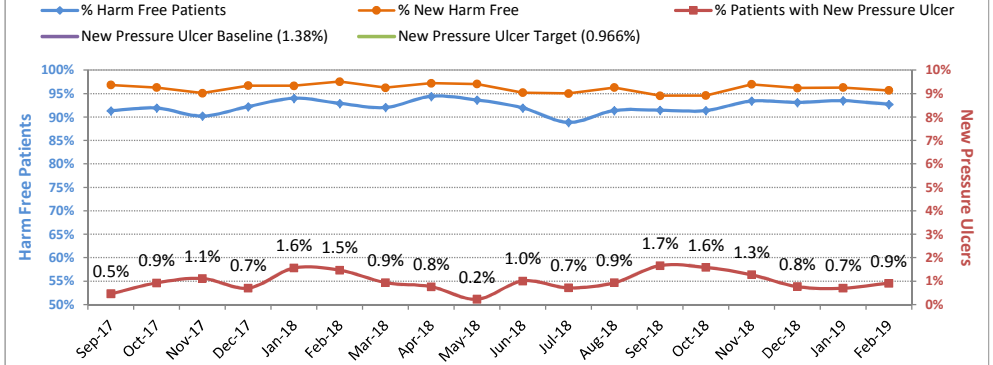
Pressure Ulcers



Patient Falls in Hospital



Safety Thermometer - One Day Snapshot per Month

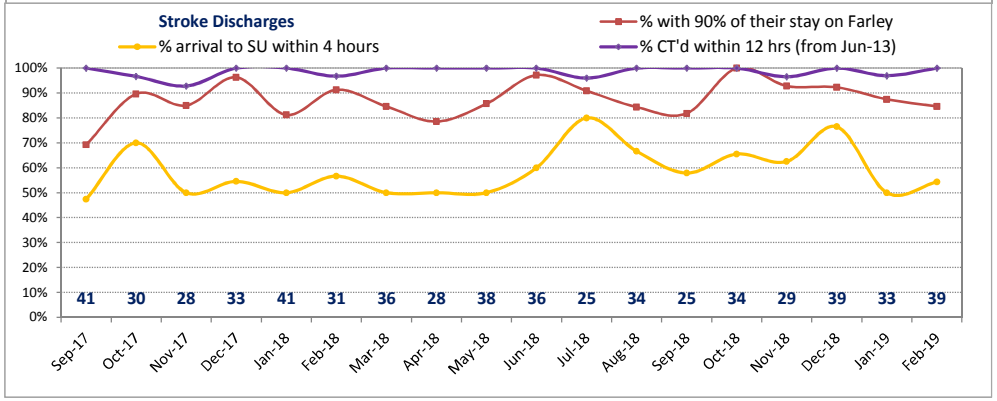


NHS Salisbury NHS Foundation Trust

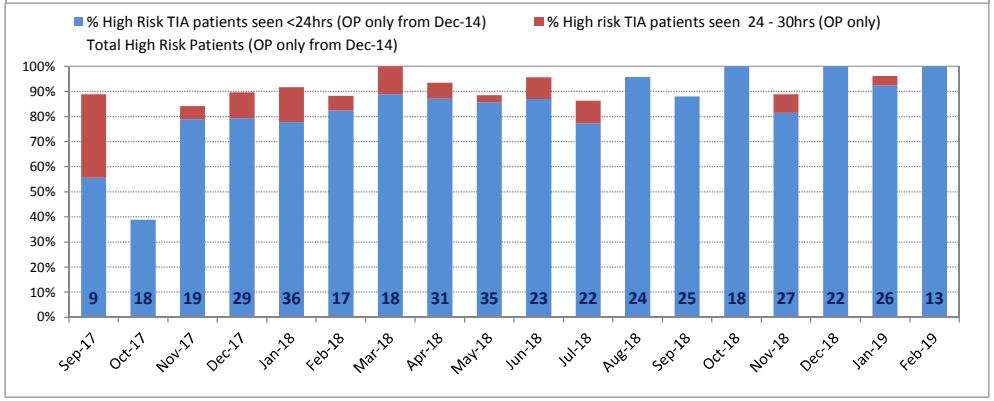
Trust Quality Indicators - February 2019

Quality Measures

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

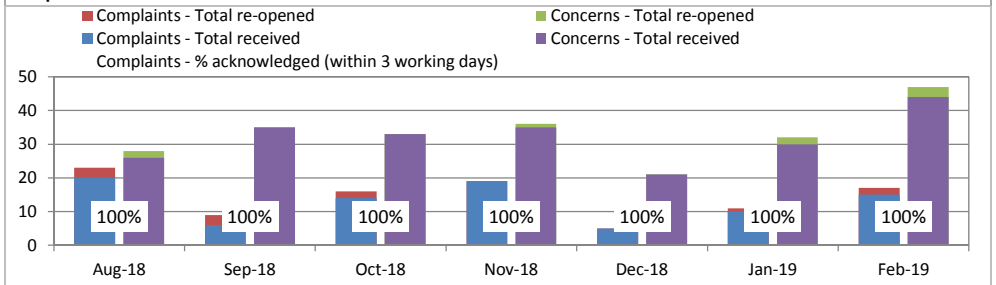
Highest level = Grade A

Lowest level = Grade E

Tri-annually	Apr - Jul	Aug - Nov	Dec - Mar
2016-17	B	B	D
2017-18	C	D	C

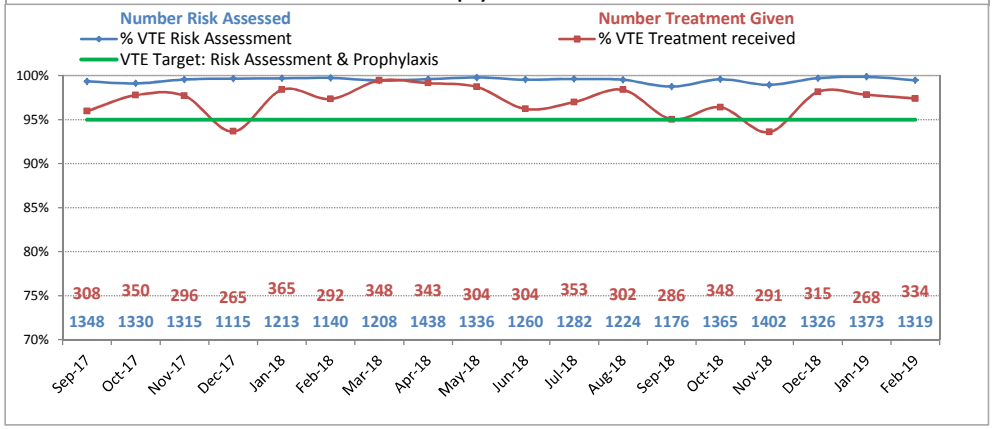
Quarterly	Q1	Q2	Q3	Q4
2018-19	B	C	B	

Complaints and Concerns



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Complaints - Total received	20	6	14	19	5	10	15
Complaints - Total re-opened	3	3	2	0	0	1	2
Concerns - Total received	35	26	33	35	21	30	44
Concerns - Total re-opened	0	2	0	1	0	2	3

Venous Thrombous Embolism: Risk Assessment & Prophylaxis



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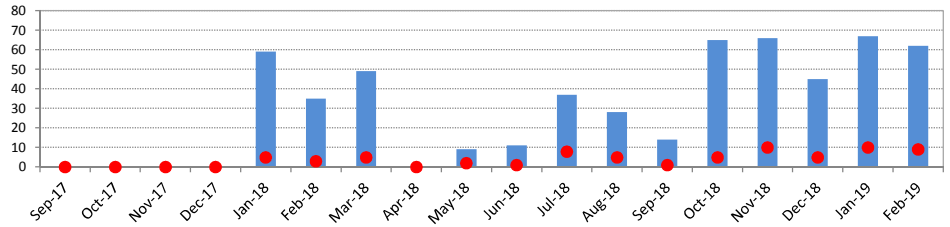
Trust Quality Indicators - February 2019

Quality Measures

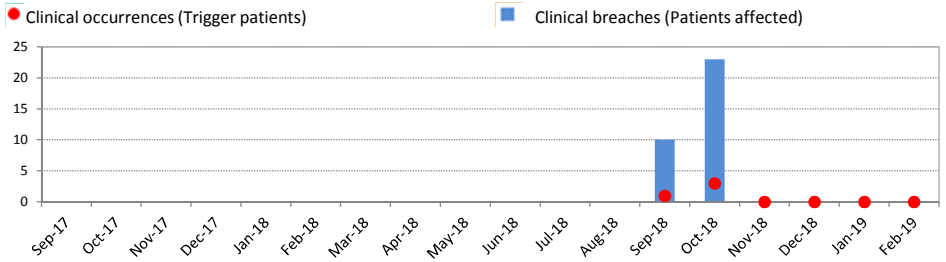
Delivering Same Sex Accommodation - Non-clinical



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
■	0	0	0	0	59	35	49	0	9	11	37	28	14	65	66	45	67	62
●	0	0	0	0	5	3	5	0	2	1	8	5	1	5	10	5	10	9

Please note MSA (Mixed sex accommodation) is now referred to as DSSA (Delivering same sex accommodation) since 01/08/2018

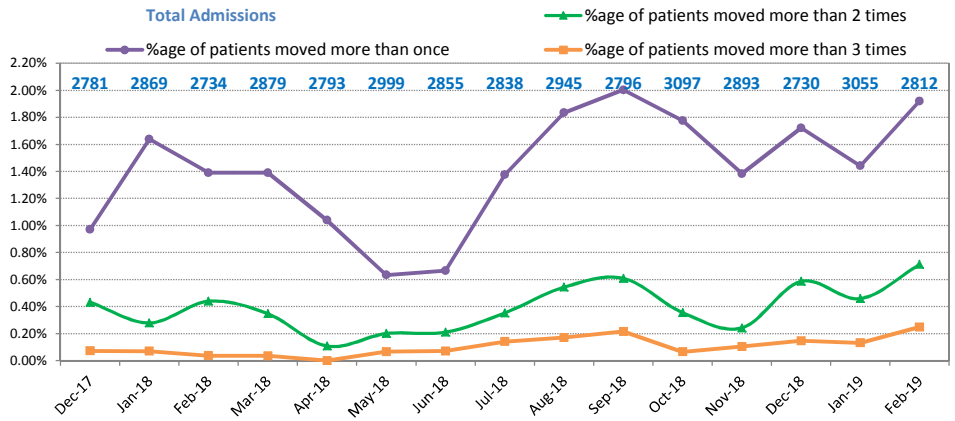
Delivering Same Sex Accommodation - Clinical



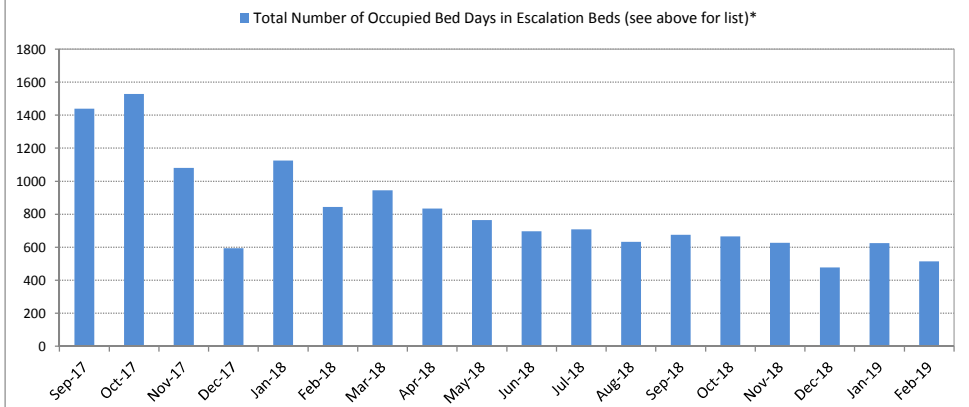
	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
■													10	23	0	0	0	0
●													1	3	0	0	0	0

Please note Clinical DSSA figures have been collected since June 2018

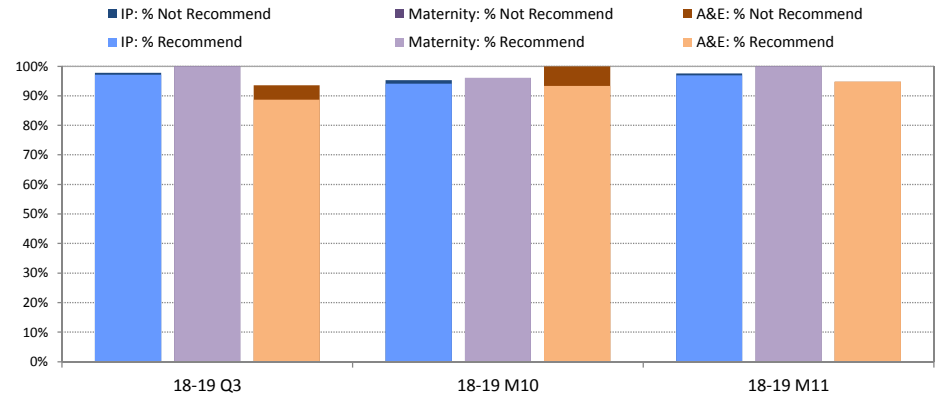
Patients moving multiple times during their Inpatient Stay

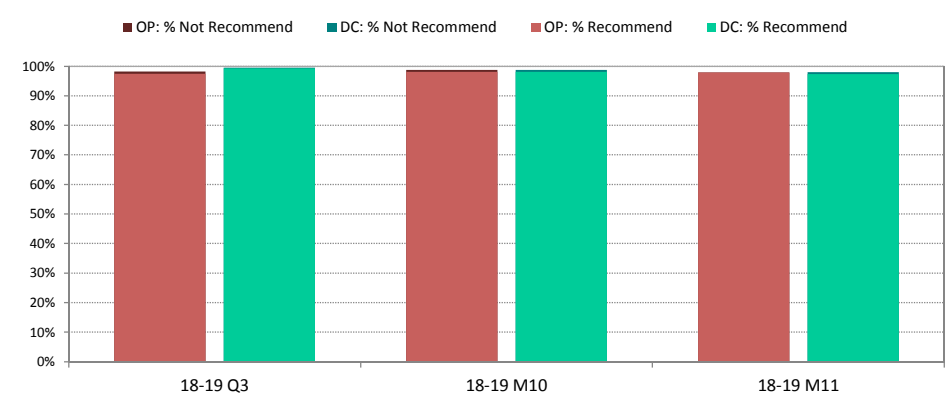


Escalation Bed Days

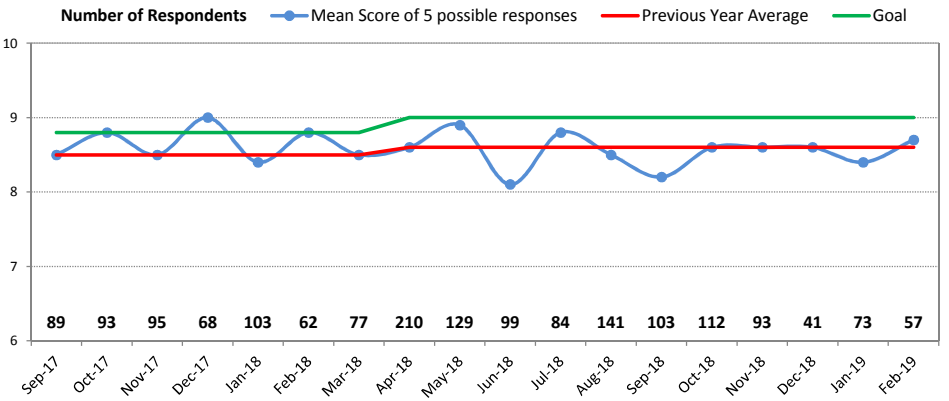


Friends & Family Test: Responses by Area

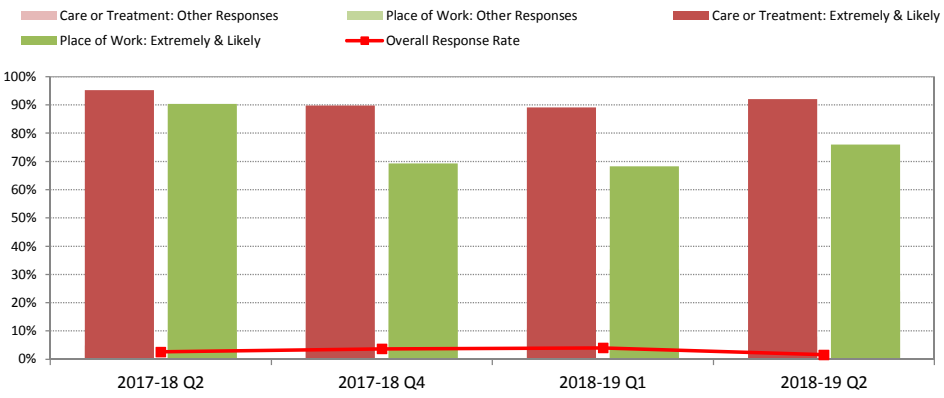




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



The new score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the percentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.

NHS
Salisbury
NHS Foundation Trust

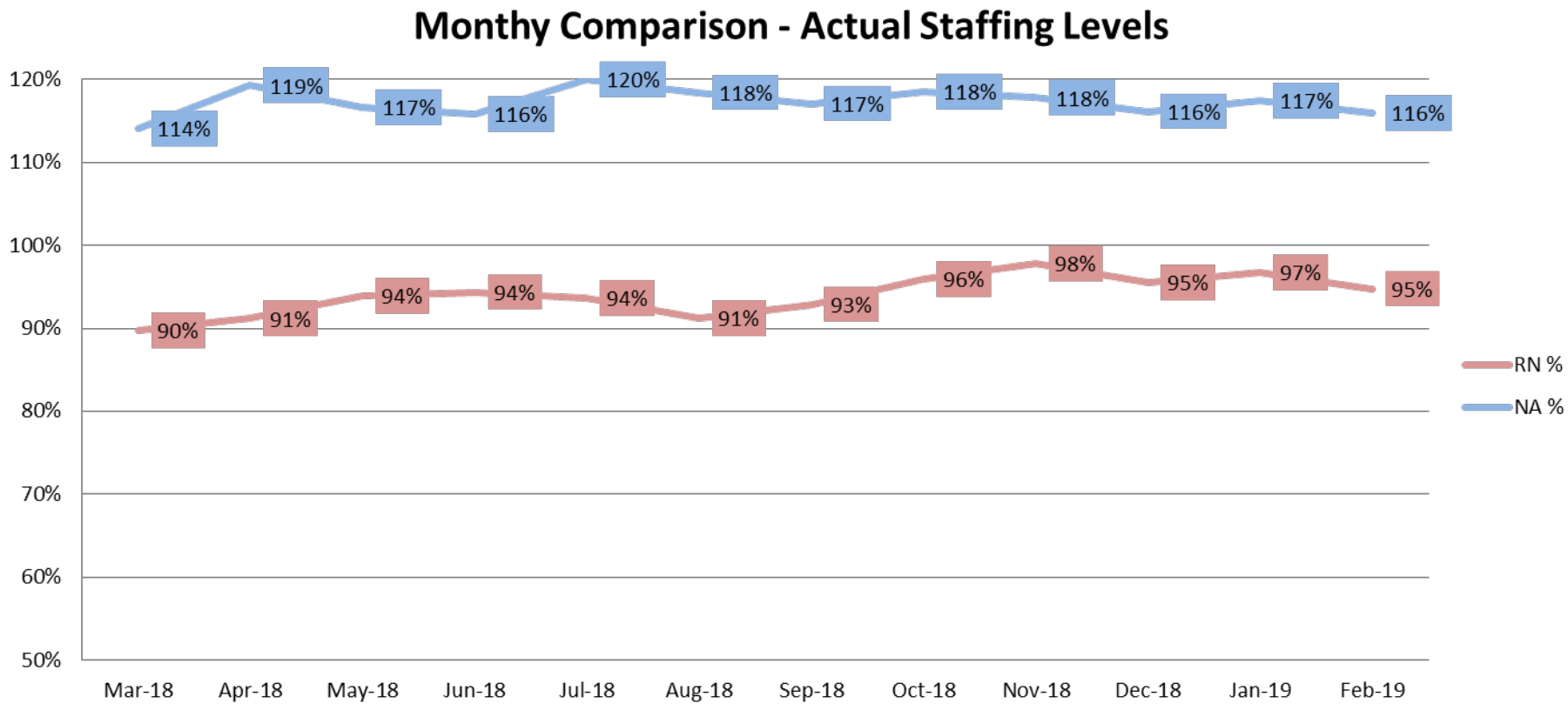
Safe Staffing NQB Report

February 2019

An outstanding experience for every patient

Monthly Comparisons – Actual Staffing Levels

	Registered Nurses			Nursing Assistants			Combined			Skill Mix	
Month	**Planned hours**	**Actual Hours**	**%**	**Planned Hours**	**Actual Hours**	**%**	**Planned Hours**	**Actual Hours**	**%**	**RN**	**NA**
Feb-19	56672	53702	95%	30099	34885	116%	86722	88587	102%	61%	39%



Overview of Nurse Staffing Hours – February 2019

Day	RN	NA
Total Planned Hours	34518	18894
Total Actual Hours	31718	22183
Fill Rate (%)	92%	117%

Night	RN	NA
Total Planned Hours	22154	11206
Total Actual Hours	21985	12702
Fill Rate (%)	99%	113%

The percentage hours are based on actual versus planned and are measured on a shift by shift basis.

Nursing Hours by Day Shifts

Row Labels	Day RN Planned	Day RN Actual	Day RN Fill Rate	Day NA Planned	Day NA Actual	Day NA Fill Rate
Medicine	**14356**	**13221**	**92%**	**9676**	**11734**	**118.3%**
AMU	1860	1975	106%	1301	1400	108%
Durrington	1124	975	87%	809	942	116%
Farley	2059	1770	86%	1367	1759	129%
Hospice	840	845	101%	832	836	100%
Pembroke	773	763	99%	326	328	101%
Pitton	1661	1577	95%	952	1358	143%
Redlynch	1460	1250	86%	1015	1248	123%
Tisbury	1947	1812	93%	632	582	92%
Whiteparish	1216	1011	83%	924	1304	141%
Spire	1417	1245	88%	1520	1978	130%
Surgery	**7000**	**6923**	**99%**	**2829**	**3062**	**105%**
Britford	1857	1883	101%	989	1280	129%
Downton	1221	1193	98%	855	814	95%
Radnor	2777	2745	99%	323	324	100%
Breamore Short Stay	1146	1102	96%	663	646	97%
MSK	**7515**	**6418**	**86%**	**6068**	**7069**	**122%**
Amesbury	1651	1419	86%	1290	1408	109%
Avon	1514	1192	79%	1746	1875	107%
Chilmark	1553	1278	82%	1029	1232	120%
Odstock	1459	1324	91%	643	1064	165%
Tamar	1338	1204	90%	1359	1492	110%
CSFS	**5648**	**5155**	**92%**	**322**	**318**	**100%**
Maternity	2751	2427	88%	0	0	100%
NICU	1041	974	94%	0	0	100%
Sarum	1856	1754	95%	322	318	99%
Grand Total	**34518**	**31718**	**92%**	**18894**	**22183**	**117.4%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Nursing Hours by Night Shifts

Row Labels	Night RN Planned	Night RN Actual	Night RN ill Rate	Night NA Planned	Night NA Actual	Night NA Fill Rate
Medicine	**9014**	**9264**	**102%**	**5411**	**6837**	**124%**
AMU	1406	1612	115%	644	633	98%
Durrington	644	644	100%	644	680	106%
Farley	966	950	98%	644	1023	159%
Hospice	532	535	100%	259	323	125%
Pembroke	644	646	100%	322	323	100%
Pitton	966	1093	113%	644	902	140%
Redlynch	966	920	95%	644	943	146%
Tisbury	1280	1268	99%	322	344	107%
Whiteparish	644	644	100%	644	690	107%
Spire	966	955	99%	644	978	152%
Surgery	**4654**	**4568**	**99%**	**2253**	**2366**	**103%**
Britford	962	998	104%	644	741	115%
Downton	644	632	98%	644	702	109%
Radnor	2404	2296	95%	322	289	90%
Breamore Short Stay	644	644	100%	643	636	99%
MSK	**3865**	**3828**	**100%**	**3542**	**3488**	**99%**
Amesbury	965	964	100%	966	943	98%
Avon	840	880	105%	840	779	93%
Chilmark	533	539	101%	532	551	104%
Odstock	967	875	90%	644	666	103%
Tamar	560	570	102%	560	550	98%
CSFS	**4622**	**4325**	**95%**	**0**	**12**	**100%**
Maternity	2565	2320	90%	0	0	100%
NICU	965	967	100%	0	0	100%
Sarum	1093	1038	95%	0	12	100%
Grand Total	**22154**	**21985**	**99.2%**	**11206**	**12702**	**113%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Overview of Areas Flagging Red

(Internal Rating Below 80%)

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	Avon	79%	√		Day	The ward has high level of vacancies and mitigated the RN gaps across the roster with support from the Respiratory shift nurse, Spinal Education Nurse and the Supervisory band 7 working on wards. NA staff were also used at times to support unfilled RN shifts.

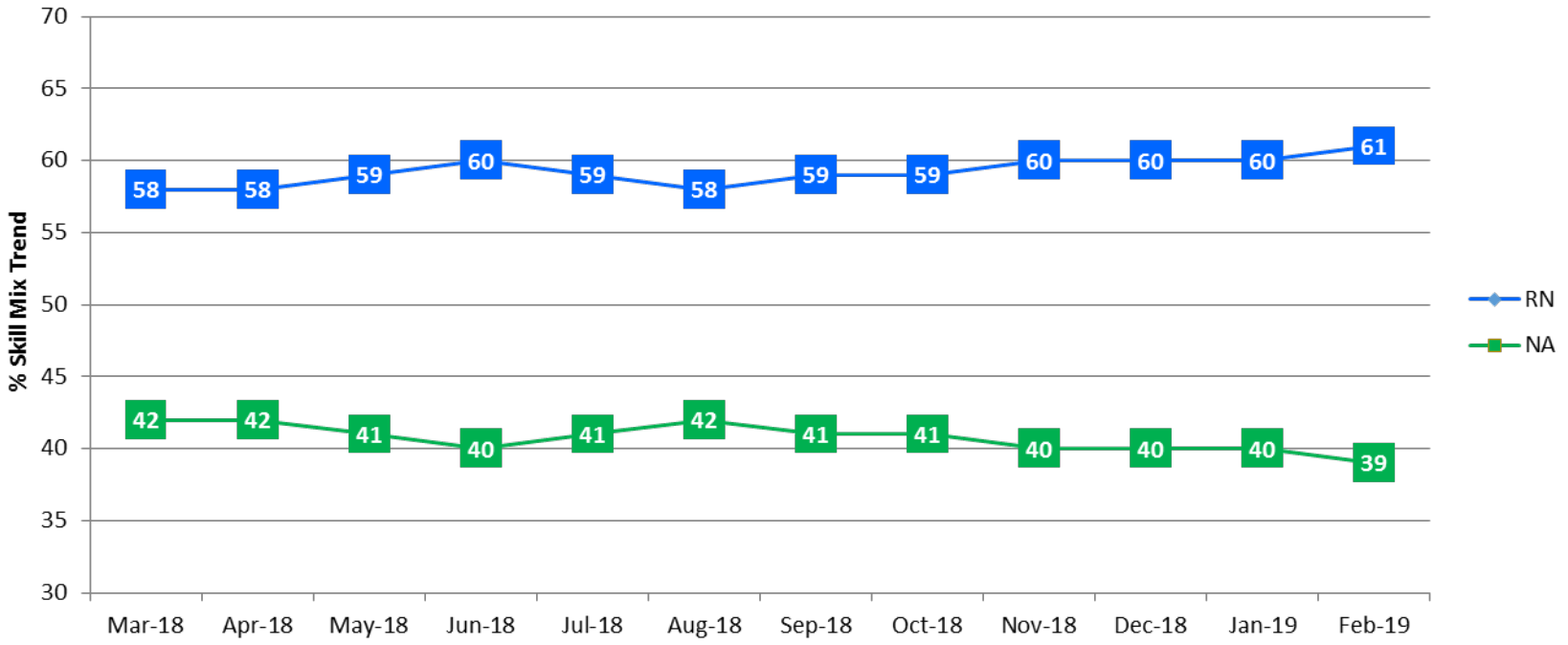
- For the second reporting month there is only one ward (Avon) flagging on the internal rating as Red .
- There are 7 wards flagging for Amber this reporting month plus Maternity
  - All are for RN /RM day shifts
  - All are for RN day shifts and (with the exception of maternity) demonstrate an uplift in NA day staffing numbers to help bolster the delivery of safe care.
  - All areas support the safe delivery of care by using other staff groups who are available during the day on an ad-hoc basis.

NB: Flags based on green 90% and above, amber 80-90%, red below 80% - no ratings yet agreed by NHS England

Trends and Themes

Overall % RN/NA Skill Mix

(March 2018 – February 2019)



The skill mix trend for both RN & NA, although consistent, evidences a rise in RN level for the first time in this reporting year at its highest level of 61%.

There is a corresponding reduction of 1% within the NA skill mix.

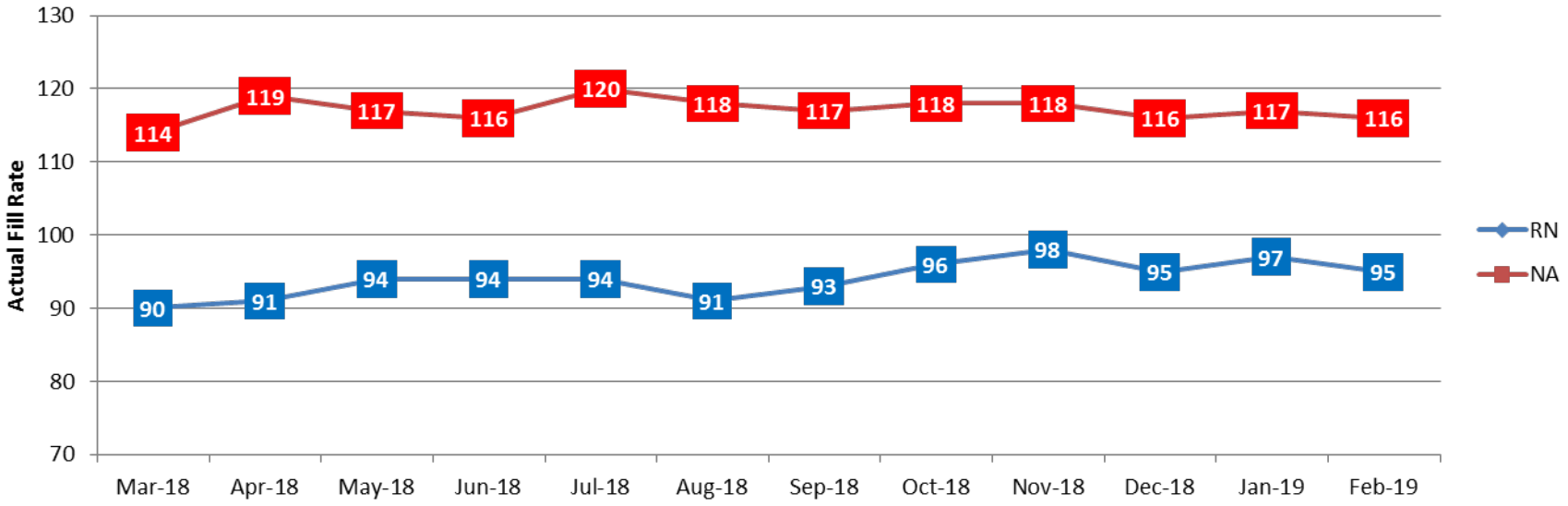
STAFFING NOTES

The reporting percentage *includes day time Ward Leader supervisory shifts* to reflect the continued demand for them to provide on-going clinical support from within this role & comply with CHPPD mandatory reporting . Whilst shifts may remain unfilled, staff of this calibre help guarantee the presence of high level skills sets to support the provision of safe care against existing challenges.

Themes and Trends

RN/NA Actual % Shift Fill Rate (Combined Day and Night)

(March 2018 – February 2019)



- The overall RN fill rate evidences at 95% and the NA fill rate trend remains consistent with minimal variation at 116%
- NA day shift fill rates are 117% demonstrating the higher shift fill rates where RN cover maybe reduced and/or permitted over recruitment has taken place.
- Band 4 staff continue to be used where patients need enhanced care.

RN night shifts evidence a 99% fill rate. Flexible rostering is used to ensure the focus is on the priority of RN cover at night where temporary staff may be less familiar with patient needs and cover is more challenging and expensive.

Unfilled shifts:- often there is utilisation of alternative grade cover. Some shifts may remain unfilled but are managed within the existing skills sets. All are based on assessing staffing skills & numbers against patient acuity and demand to ensure they are both
manageable and the provision of safe care.

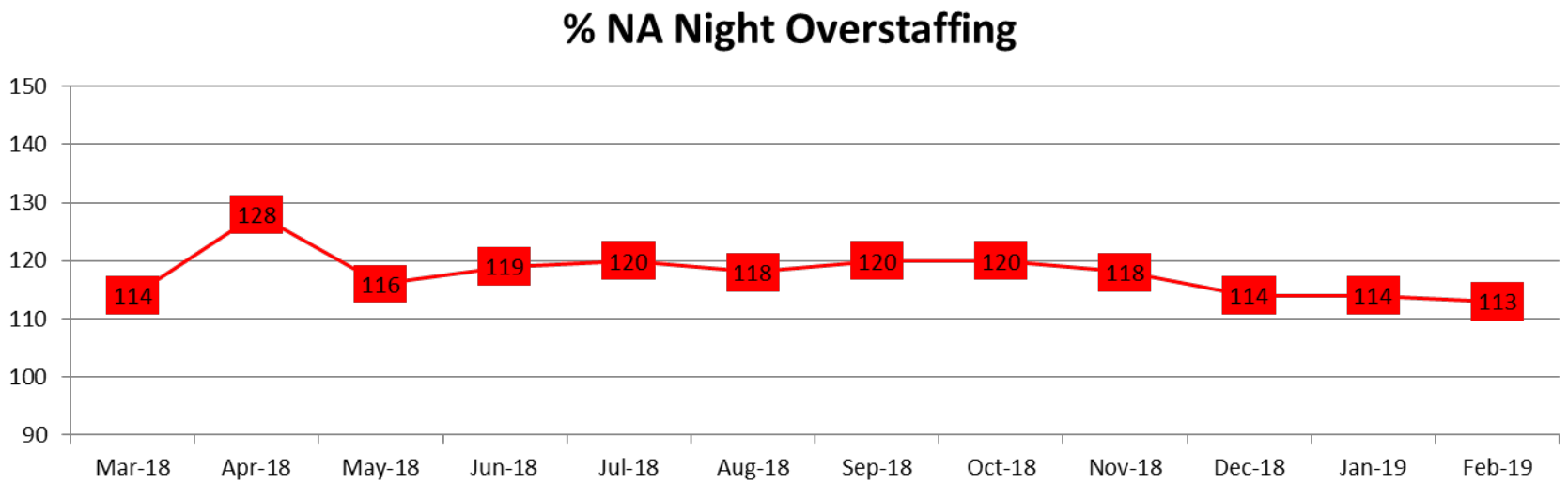
Over-staffing

Most additional shifts were for NA staff except for:-

- **Pitton** which had high patient acuity levels requiring increased staffing levels

- **AMU**:- as previously reported. The figures suggests there is overstaffing within both RN & NA groups. The extra numbers are agreed interim staffing increases but due to roster processes (that are outside of our control) extra staff for a short term duration can only be added as Additional Shifts. This will self –correct in April when the staffing demand decreases and reverts back to the standard template.

- The overall trend for NA overstaffing on nights shifts evidences and even lower percentage than last month and the lowest for this reporting year. There remains uplift showing for day shifts due to some permitted NA over-recruitment accounting for increased numbers.



The reasons for NA Overstaffing remains the same Enhanced 1:1 care for patients at risk of falls, mental health needs or confusion

1. Flexing bed stock and staffing levels to meet fluctuating patient demands
2. Supporting RN shifts (*Day shifts only*) .

Actions taken to mitigate risk

The nurse-in-charge of individual wards in discussion with the DSN/ADSN review the following on a shift by shift basis.

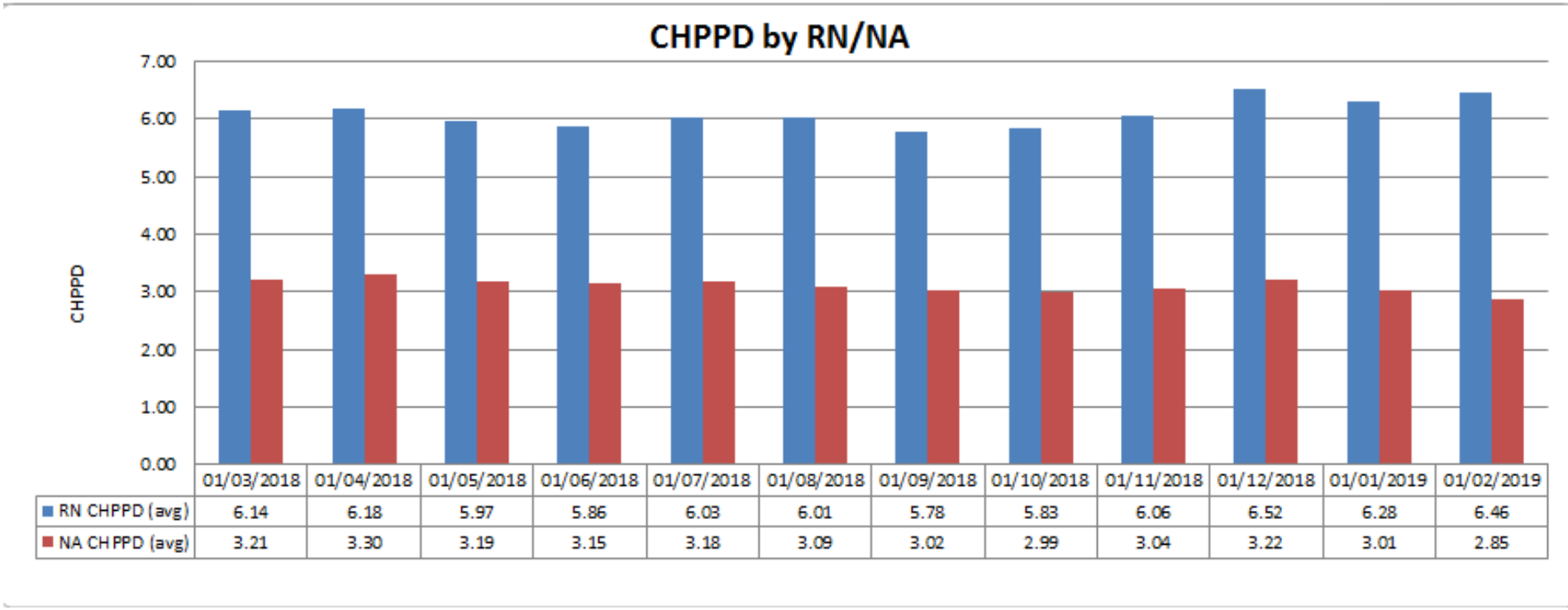
- The accounting of the staff skills set when deciding on the band of staff needed.
- Staffing is discussed via SafeCare using Shelford methodology at least twice daily with senior nurses in attendance.
- All shifts are gauged with staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required. This ensures safe levels of care are maintained whilst trying to reduce reliance on expensive temporary staff
- Staffing levels are reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- CCOT team support wards where acuity of patients high.

Internal CHPPD Reporting

Internal CHPPD

Monthly Trust aggregated figures showing Year Trend

Period :- **March 2018 – February 2019**



	01/03/2018	01/04/2018	01/05/2018	01/06/2018	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019
RN CHPPD (avg)	6.14	6.18	5.97	5.86	6.03	6.01	5.78	5.83	6.06	6.52	6.28	6.46
NA CHPPD (avg)	3.21	3.30	3.19	3.15	3.18	3.09	3.02	2.99	3.04	3.22	3.01	2.85

The CHPPD calculation is made over a whole month :- total actual hours vs the total number of patients at midnight.

CHPPD
February 2019
Inpatient Ward Breakdown

Row Labels	RN CHPPD	NA CHPPD	Overall CHPPD
Medicine	**4.06**	**3.16**	**7.22**
AMU	6.26	3.55	9.81
Durrington	2.78	2.79	5.57
Farley	3.55	3.63	7.18
Hospice	5.82	4.89	10.71
Pembroke	5.12	2.37	7.49
Pitton	3.69	3.12	6.81
Redlynch	2.96	2.99	5.95
Spire	2.64	3.55	6.19
Tisbury	5.13	1.54	6.68
Whiteparish	2.66	3.20	5.86
Surgery	**9.97**	**3.11**	**13.08**
Britford	5.66	3.97	9.63
Breamore Short Stay	3.48	2.56	6.04
Downton	3.05	2.53	5.58
Radnor	27.70	3.36	31.06
MSK	**3.39**	**3.45**	**6.83**
Amesbury	2.76	2.73	5.49
Avon	3.46	4.44	7.90
Chilmark	2.95	2.89	5.83
Odstock	4.79	3.77	8.56
Tamar	2.97	3.41	6.38
CSFS	**14.89**	**0.48**	**15.37**
Maternity	14.39	0.00	14.39
NICU	17.97	0.00	17.97
Sarum	12.30	1.45	13.75
Grand Total	**6.46**	**2.85**	**9.31**

N.B.

- Comparisons need to be viewed with caution i.e. Radnor where the nurse/patient ratio is widely different

Report to:	Trust Board (Public)	**Agenda item:**	14d
Date of Meeting:	04 April 2019		

Report Title:	Workforce Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Mark Geraghty, Head of Workforce Information & Planning Glennis Toms, Deputy Director of OD and People			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD and People			
Appendices (list if applicable):	Executive Summary of Key Workforce Performance Month 11 Workforce KPIs Month 11 2018/19 Areas for Concern Month 11 2018/19			

Recommendation:
It is recommended that the Trust Board note the report, areas of concern and actions underway.

Executive Summary:
The Executive Summary of Key Workforce Performance and the Month 11 Workforce Dashboard (see appendix) details the Trust's performance against the key workforce indicators. The pay bill is overspent by £522k in month. This overspend is mainly in Medicine (£360k) and is due to the opening of Laverstock, and the winter incentive payments to bank workers. However, agency spend across the Trust has decreased in month by £204k to £505k, with reductions in Registered Nursing (£43k), NHS Infrastructure Support (£23k) and Support to Nursing Staff (£15k). There was a £139k decrease in Medical agency spend, due to a provision of £170k in the previous month for a possible claim against the Trust by HMRC due to the PlusUs model for Direct Engagement now being deemed non-compliant against HMRC VAT rules. At the time of writing this is close to resolution with a similar scheme, in terms of savings, close to agreement. The Trust's sickness rate is Amber, over the 3% target in this month at 3.73%, and the year to date rolling absence figure is at 3.45%. Compared to last month's figure of 3.95%, short term sickness has increased, and long term sickness has decreased. There were 44 starters in February, and a decrease in leaver numbers at 19. Turnover decreased slightly to 9.20%.

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

1. Purpose

This report provides the position against workforce key performance indicators at Trust level, with trend analysis over time, and sets out actions underway or necessary to achieve targets.

2. Background

The pay bill is overspent by £522k in month. This overspend is mainly in Medicine (£360k) and is due to the opening of Laverstock, and the winter incentive payments to bank workers.

Agency spend has decreased by £204k to £505k, sickness absence has reduced to 3.73% and the vacancy rate has increased from 5.90% in month 10 to 6.68% in month 11, mainly as a result of a 35 FTE increase in budget establishment due to opening of additional beds on Laverstock Ward.

Mandatory training compliance remains green at 92.03%. Appraisal compliance for non-medical staff is amber at 84.90%, a deterioration on last month's compliance total of 86.30%.

Appraisal compliance for medical staff is above the 90% target at 91.46%, an improvement on last month's compliance rate of 88.16%.

3. Resourcing:

3.1. Recruitment & Retention Strategy

The Strategy is still under development and is expected to be ready for approval in April/May. It will include the use of a modelling tool able to forecast and initiatives using social media to raise our profile as an employer.

3.2. "90/10" fill across all staff groups

Nursing remains a challenging area to recruit; using the Month 11 baseline, the Trust needs to recruit 38 wte ward nurses to achieve a fill rate of 90% of establishment. Over the last year the Trust has recruited an average of 10.1 ward nurses per month, with 7.1 WTE leaving. This figure includes those who reduced to zero hours contracts.

If ward nurse recruitment remains at 10.1 wte per month (on average), it would take 13.0 months to reach our revised target of 90% establishment fill.

The recruitment pipeline for all groups of staff, from March to May 2019, shows decreasing vacancies, from the current 205 to 194, and taking into account predicted turnover. Of this total, Registered Nursing vacancies are forecast to reduce from 142 to 123, including nurses due to commence in March.

Nursing Summary

The gap between establishment and staff in post decreased in December 2018, due to a reduction in establishment of 5.56 FTE following the closure of Clarendon Ward.

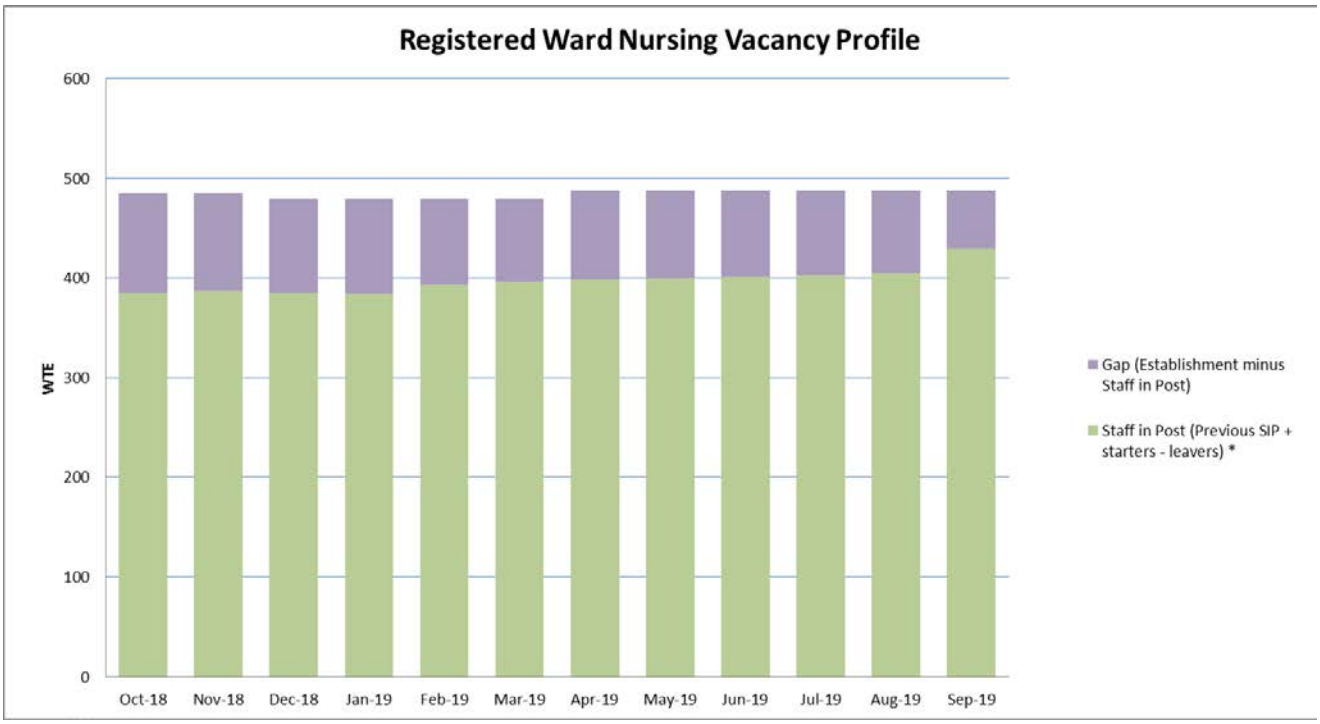
An increase in establishment by 8.59 FTE in April 2019 is planned due to the introduction of additional posts in ED, AMU, Pitton and Amesbury.

The table below excludes the temporary 12.39 FTE increase in RN budget establishment for Laverstock Ward, which is open for February and March 2019 only.

	Actual	Actual	Actual	Actual	Actual	Prediction	Prediction	Prediction	Prediction	Prediction	Prediction	Prediction
Ward Registered Nursing FTE	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**
Mat Leave (Actual and Predicted)	12.97	16.42	23.30	19.24	17.89	16.65	15.96	13.83	14.37	14.92	16.20	14.91
Total Ward Nursing Leavers, Transfers, Hours Reductions	7.61	6.12	9.49	7.75	2.45	6.68	6.68	6.68	6.68	6.68	6.68	6.68
International Recruits Due to Arrive	**0.00**	**0.00**	**0.00**	**0.00**	**7.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**
International Nurses Arrived and Pending OSCE	**22.20**	**28.49**	**19.41**	**13.00**	**6.00**	**6.00**	**7.00**	**6.00**	**6.00**	**6.00**	**6.00**	**6.00**
International Nurses Passed OSCE (in Month)	**0.00**	**0.00**	**0.00**	**0.00**	**8.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Newly Qualified	**12.80**	**0.00**	**0.00**	**0.00**	**0.00**	**6.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**20.00**
Other Recruitment (from induction lists from March)	**3.08**	**8.43**	**7.48**	**6.65**	**3.46**	**4.00**	**3.00**	**1.00**	**3.00**	**3.00**	**3.00**	**3.00**
Average Recruitment from Mar 2019 (balance)	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**5.38**	**7.38**	**5.38**	**5.38**	**5.38**	**8.38**
Budgeted Establishment *	484.83	484.83	479.27	479.27	479.27	479.27	487.86	487.86	487.86	487.86	487.86	487.86
Staff in Post (Previous SIP + starters - leavers) *	384.87	387.18	385.17	384.07	393.08	396.40	398.09	399.79	401.48	403.18	404.88	429.57
Gap (Establishment minus Staff in Post)	99.96	97.65	94.10	95.20	86.19	82.87	89.77	88.07	86.38	84.68	82.98	58.29

It is encouraging this month to see a reduction in leavers from the wards, the arrival of overseas nurses, and continuing OSCE passes. The above table indicates a predicted significant improvement in the vacancy gap between now and September 2019.

The vacancy profile is shown in the following table:



The following table describes the main areas of concern for Registered Nursing:

Registered Nursing	
Turnover (Rolling 12 Months)	
Nursing and Midwifery Registered	7.14%
Top 3 areas of turnover > 10.00 FTE	
Acute Medical Unit	18.91%
Plastics & Burns Unit	18.64%
Spinal - Tamar	17.76%
Vacancies	
Nursing and Midwifery Registered	15.20%
Top 3 areas of Vacancies >10.00 Budget FTE	
DSU Clinical Staff	15.69 FTE
Radnor Ward	9.98 FTE
Spinal - Avon	9.82 FTE
Sickness Absence Rolling 12 Months	
Nursing and Midwifery Registered	3.53%
Top 3 areas of sickness absence > 10.00 FTE	
Palliative Care/Hospice	7.81%
Theatres Recovery	6.90%
Spinal - Avon	6.65%

Voluntary Services

- The Helpforce project has been agreed, with funding secured for 18 months paid in 2 instalments of £35,500 (April and October 2019).
- Desiree Benson from Helpforce met with VSM and Sarah Homer, Engage Lead to understand the project in full and met with some Engage volunteers.
- Attended Bishop Wordsworth Grammar School Careers event. This is one of our biggest careers events, as South Wilts Grammar School for Girls, Burgate School, Trafalgar School, Godolphin School, Shaftesbury School, Avon Valley School also attend.
- Volunteering candidates secured as a result of the Helpforce and Daily Mail campaigns are due to be with us during March/April. This will increase our number of volunteers.

3.3. TRAC Implementation

We are extending the use of TRAC to the recruitment of volunteers and work experience applicants.

3.4. Retention Programmes

Staff turnover is below our 10% target, and decreased slightly at 9.20% compared to last month's 9.24%.

In addition to the work we are doing with NHSi in the 4th wave of the nursing retention programme, we are:

- Publishing staff benefits in a central booklet that has been agreed with the Staff Engagement Group.
- Monitoring the return of exit interview questionnaires and 100-day questionnaires to obtain useful individual information. Unfortunately, there are an insufficient number of returns at the present time to be able to reliably identify themes. Only 7 exit questionnaires were returned in February. The requirement of exit interviews will be re-communicated.

Workforce Committee have supported an investment bid for Recruitment and Retention and a Business Case is currently being written.

3.5. Centralisation of Bank

Month 11 agency spend has decreased to £505k which is a £242k overspend against our £263k NHSI agency control total for February. Of this overspend, £115k relates to Nursing agency spend and £74k to Medical agency spend. Compared to YTD for the same period last year (£7,611,808) the expenditure this year YTD is over £1m less, at £6,601,789.

Nursing Agency spend has reduced in the month, aided by the winter bank initiative which has enhanced payment rates for bank nurses that reduces reliance on Agency.

Opening Laverstock for winter resilience has cost £61k in Agency and medical agency has also increased as a result of additional work being done on discharges.

There was a £139k decrease in Medical agency spend, due to a provision of £170k in the previous month for a possible claim against the Trust by HMRC due to the PlusUs model for Direct Engagement now being deemed non-compliant against HMRC VAT rules.

The following table shows a breakdown of agency spend by staff group:

Excluding STL and OML	In-Month Expenditure			Year to Date Budget & Expenditure		
AGENCY STAFF SPEND BY STAFF GROUP	Month 10 2018/19	Month 11 2018/19	Change (+ / -)	Budget	Actual	Variance
Registered Nurses - Agency	£273,840	£231,083	-£42,757	£1,320,962	£3,363,721	£2,042,759
Allied Health Professionals - Agency	£76,046	£89,304	£13,258	£525,765	£1,029,487	£503,722
Health Care Scientists - Agency	£3,564	£5,309	£1,744	£23,405	£94,114	£70,709
Support to nursing staff - Agency	£16,629	£2,167	-£14,463	£9,163	£362,016	£352,853
Consultants - Agency	£217,900	£93,138	-£124,762	£741,377	£773,670	£32,293
Career/Staff Grades - Agency	£0	£0	£0	£122,430	£15,355	-£107,075
Trainee Grades - Agency	£76,305	£62,178	-£14,127	£176,436	£623,442	£447,006
NHS Infrastructure Support - Agency	£44,435	£21,638	-£22,797	£83,861	£339,984	£256,123
Total	**£708,719**	**£504,816**	**-£203,902**	**£3,003,399**	**£6,601,789**	**£3,598,390**

The Collaborative Locum's Nest has been extended by new members Yeovil and Poole, and their fill rate for February was 78%.

For Registered Nursing, the use of Thornbury reduced to only 5 shifts filled and this was largely due to the creative movement of staff around the Trust to avoid high costs. These movements were facilitated by the DSNs, supported by the Director of Nursing and her Deputies.

4. Education, Inclusion, Communications & Engagement:

We have been offered and accepted consultancy support from HEE to undertake an Organisational Development diagnostic, leading to a plan for culture change at Salisbury Hospital. This is also timely as it will coincide with an STP workstream I am co-leading with Clare Radley, HR Director at Bath Hospital.

Staff Engagement

Let's Get Engaged Meeting was held on 14th March with a focus on the Staff Survey results in relation to Health and Wellbeing matters. The meeting was attended by both Glennis Toms (Deputy Director of OD and People) and Alison Evans (Head of Occupational Health).

The discussion centred on the Trust's upcoming plans to refresh wellbeing services with the group providing a number of ideas as to where improvement could be made. The group were also requested to discuss this topic with their wider teams in order for further feedback to be gathered. Feedback will be fed into the Staff Survey Action Plan and the

Trust's Health and Wellbeing group in order that any introduced programmes truly align with the needs of the wider workforce.

The meeting also discussed a number of the areas raised at the last meeting with positive progress noted in relation to catering frustrations and staff facilities.

Further progress in relation to a 'spring Easter egg style' hunt and the completion of the staff benefits booklet were also discussed.

The next building block for the group is to improve communications linked to the activities that are already underway and this is a topic to be considered further over the next month.

4.1. Learning & Development Infrastructure and Strategy

Mandatory training

Compliance has improved slightly this month and remains in green at 92.03%. One Directorate is taking the approach of targeting courses with low compliance in order to improve their overall results.

Appraisals

Compliance for non-medical staff has reduced to 84.90%, which is rated amber, from last month's compliance of 86.30%. CSFS and Medicine are both below target and are holding audit days and following up with individuals in order to correct the position. The aim is to return to compliance by the end of April.

There appears to be a correlation between lower compliance and staffing/workload pressures where, for example, ward leaders are counted in the numbers and it is challenging to get time released. There are still some issues around data reliability but we do not believe that these are significant.

Medical staff appraisals are green at 91.46%, compared with last month's compliance rate of 88.16%, against the target of 90%.

Following the introduction of monthly appraisal training sessions which explore the principles of appraisal the Spida support team are receiving a stream of requests for 1:1 Spida support. This is not sustainable and the team are looking at how to integrate Spida training into the monthly programme.

Passport to Progression

This is intended to identify the knowledge, skills, and behaviours required to navigate a path from Band 2 to Band 9 within the NHS. This will then be mapped against our current internal and external training offer, with recommendations for how to plug the gaps, to develop a comprehensive offer for all staff. This process will also form the basis of a baseline assessment of current training provision.

Practice Education Team

Practice Education Team	**Feb 2019**

Students in Practice	-
Pre-Registration Nurses	53
Pre-Registration Nursing Associates	10
Trainee Assistant Practitioners	14
OSCE Nurses	21
OSCE Exam passes	9
Preceptorship Nurses	28
Training Programmes	**Attended**
Nursing Assistant Induction	14
NG Tube Insertion and Care- Drop In	6
IV Drug Admin	10
Urinary Catheterisation	8
Venepuncture and Cannulation	9
-	-
NMC Training	-
Mentor Updates	18

The Practice Education Team (PET) run mentor updates for student mentors to improve compliance with the introduction of the new NMC standards. Since January 2018, 149 staff have attended these sessions. The work of the PET has resulted in mentor compliance increasing from 39% in Sept 2018 to 48% Jan 2019.

The team offer drop in sessions for mentors and are starting Practice Supervisor Preparation days. These will run from September. These will be open to all registrants that have not gone on a mentor course with a programme to roll out the training across the Trust.

The PET have been addressing some concern about the lack of Clinical Skills training and this month have added NG Tube Insertion and Care to their portfolio.

Simulation Training

In a recent report submitted to HEE to justify their investment we reported that:

"Significant alterations and upgrades to our simulation centre and service have been possible thanks to the investment from HEE for the SuppoRTT programme.

Building works have been completed to enhance the use of the space and enable larger groups of candidates to attend simulation training. The AV kit has been upgraded and we now have the facility of viewing and hearing perfectly which was severely compromised prior to the works.

The investment for upgrading has benefitted not only our staff at Salisbury NHS Foundation Trust, but we are now able to support simulation training throughout the region and have hosted various events such as the ACCS simulation day, Urology Registrars event, NOTTS course and more.

With the support from the RTT Clinical Lead, we have secured dates and events for the RTT Doctors to be hosted at Salisbury NHS Foundation Trust, such as the Human Factors course (April), RTT Conference (May) and the Clinical skills and simulation event in July. We are also planning more, which we will continue to report.

The project spend on AV upgrade and building works was approximately £40,000.

We were also awarded monies to employ a SimTech for a one year temporary contract. Our appointed Tech has been crucial to supporting the increase in delivery of simulation based education. We are able to facilitate more scenarios with tech support and deliver clinical skills training.

We have been able to establish a robust 'point of care' simulation training programme, which is supporting all staff (including RTT Doctors, Nurses and AHPs) in clinical practice from Paediatric, Obstetric, Medical, Surgical and Emergency Care. Feedback from the sessions have been extremely positive -increasing confidence, testing the systems under pressure and enabling teams to not only work together but 'learn together'- valuable human factors training.

The project spend on appointing a Sim Tech was approximately £30,000. Total monies allocated were £70,000 which has all been accounted for by March 2019.

Strategy

Although complete, the training needs analysis (TNA) identified approximately £400K of training requests. This is 75% over the HEE funding allocation. We will therefore be working with the DMTs to help them to prioritise who should receive the funding. We are suggesting that where more people have requested to attend a course than we have been able to allocate places that department interview and select to ensure a transparent decision making process.

We are also aware that not everyone accessed the TNA process so the shortfall is greater than this.

This short fall in funding emphasises the need to develop our internal capability and capacity to offer training and the requirement to maximise our income generating potential

4.2. Leadership Development

Clinical Leadership Development Programme

The first three of four Clinical Leadership Development Workshops are now complete. Feedback has been very positive. The cycle of workshops will be reviewed and offered as a rolling programme. Delegates have agreed to join a WhatsApp group and have been invited to participate in regular Action Learning Sets to continue their conversations, share good practice and have the opportunity to deep dive into particular issues.

Senior Leadership Forum

The first senior leadership forum, facilitated by the OD&P directorate took place in February. 43 members of staff attended. The key results from the staff survey were presented, followed by a focussed activity exploring 'Quality of Care' within the Trust. Feedback was largely very positive but less time will be given for lunch in the future. The key now will be how the feedback informs our internal response and action.

The OD&P directorate will continue to facilitate the forum throughout the year with different members of the executive team leading the content later in year.

The Workforce Committee have supported an initial investment bid for funding to support these programmes, which is being written into a Business Case for TIG.

4.3. Apprenticeship set up & implementation

Apprenticeship Spend-	**Feb 2019**
Pending additional payments by April 2019	£23,062
Total spend in Feb 2019	£6,164
Total	£29,226
Average current spend into Levy	£50,000
Potential Percentage Spend by April 2019	58%
Plus potential Role on Role off	£761
Pending total spend by June 2019	£36,105
Potential Percentage Spend by June 2019	72%

There is likely to be a delay to the Senior Leaders Level 7 which is due to start in April and will affect figures.

The cost of the project management apprenticeship is about to drop from £9K to £6K which will affect our levy usage.

4.4. Communications

In addition to the regular, planned, internal and external communications activities the Communications Team progressed work on developing the Corporate Communications strategy and developing a corporate 'message house', as part of a suite of initiatives to modernise the Trust's approach to marketing and communications. Work was carried out to ensure alignment between the Transformation strategy and Digital strategy, in advance of Board-level discussion and agreement.

One member of the team had veteran aware champion training and another member of the team undertook diversity champion training. Meetings were held in February with 'Help for Heroes', with the aim of preparing for Armed Forces Weekend and arising further awareness of the Trust's 'Veteran Aware' status.

Awards
Applications for the Service Improvement Awards continued to be promoted ahead of entries closing at the end of the month. This year 20 entries were received, which is an improvement on number of entries received last year.

Maternity Services Consultation
The Public consultation closed on 24 February, following a public engagement event held in Salisbury market. During the consultation promotional materials were available across a range of locations including leaflets being provided to Salisbury library to promote the consultation; information was published through the local media.

HEAT – campus development
The Communications Team worked closely with Coast, an external communications agency, preparing for and supporting engagement initiatives for the hospital's regeneration. Internal communications delivered by the Trust's Communications team included a broadcast email to staff and information on the intranet.

Equality, Diversity and Inclusion
The team planned and executed a visit from Lord Victor Adebowale on 25 February. Over 50 members of staff attended a town hall event and questioned the Peer and a special closed event was held for our diversity champions. As a result of the Trust's media relations work, we secured positive coverage in the Salisbury Journal.

Media
Planned media relations included the start of a series of features about the hospital in the Salisbury Journal and work to improve the relationship with Spire FM.

4.5. Diversity & Inclusion

February was LGBT history month, and to celebrate the Rainbow Flag was raised on the green by the Cara Charles-Barks on 4th February. We also used this occasion to raise awareness of the Rainbow Shed, which is the support network for our LGBT staff. The Rainbow flag represents diversity in a much broader sense and our rainbow lanyards represent inclusion of all our staff from minority or protected backgrounds which were also referenced at the cascade brief on 6th February.

EDI and Freedom to Speak Up sessions now regularly appear in Monday Trust inductions every week. We are working hard to integrate both programmes as they target the same audience.

On 26th February the first Equality, Diversity & Inclusion and Freedom to Speak Up training sessions "What's it got to do with me?" were delivered in the Lecture Theatre. 40 staff attended the two sessions and very positive feedback was received. Work is being done to streamline the training as the learning indicated that more time was required to deliver the entire contents of the workshop.

On 27th February FTSUG attended the Hospice Admin Team meeting to raise awareness of the FTSU and EDI agenda for the Trust. On the back of this, we have been invited to attend the clinical governance session for the Hospice in May.

The FTSUG is continuing to be involved in a pilot facilitated supervision programme with the Central London FTSU network, with the aim of how Guardians can be supported nationally and also locally due to the nature of the role.

The second BAME meeting took place and work is continuing to revive other established but not properly engaged staff networks and develop new networks, such as the Women's Network.

5. Health & Wellbeing:

5.1. Staff Engagement

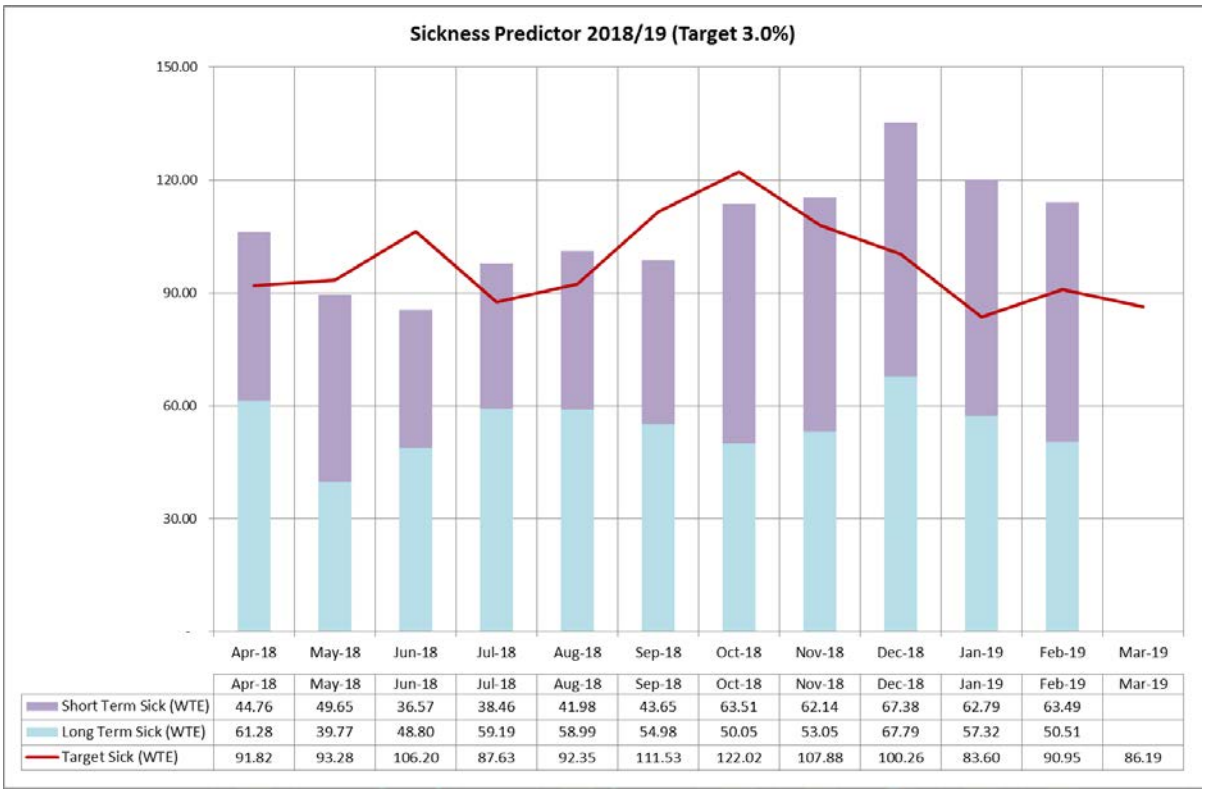
As reported in the previous section under 4.1.

5.2. Attendance Management

Our current sickness absence rate of 3.73% in month 11 is over our 3% target and a 0.22% improvement on last month. There has been a significant reduction in long term sickness and a slight increase in short term sickness.

Please note, sickness figures contain all returns input as at sickness cut-off date, and may be subject to change due to late receipt of information/corrections.

The chart below shows current and anticipated sickness absence for the year:



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Short Term Sick (WTE)	44.76	49.65	36.57	38.46	41.98	43.65	63.51	62.14	67.38	62.79	63.49	
Long Term Sick (WTE)	61.28	39.77	48.80	59.19	58.99	54.98	50.05	53.05	67.79	57.32	50.51	
Target Sick (WTE)	91.82	93.28	106.20	87.63	92.35	111.53	122.02	107.88	100.26	83.60	90.95	86.19

Only one Directorate is below target, at 2.90%, the others recording between 3.51% and 5.81%. Actions which are being taken to manage, particularly long term absences, are expected to produce results commencing in March with further reductions in long term sicknesses recorded.

Since the Head of Occupational Health has implemented some process changes, we have already seen an improvement in recruitment clearance activity and the "turn around" of this work. There are strategies and pathways being developed to further improve the OH service provision and address the Wellbeing agenda. These will be detailed once finalised and rolled out but align to mental health, MSK and general wellbeing.

There is work to be done with the current data base in order to capture data to better inform and evidence activity and outcomes. For example we are not currently able to capture and identify the difference between cancellations and DNA activity. The figures below are largely manually captured and for the last 3 months are:

Occupational Health Advisors activity

Management Referrals (New)	Dec 18 24 Cancelled/DNA (6)	Jan 19 55 Cancelled/DNA (10)	Feb 19 20 Cancelled/DNA (3)	Total 99 (19)
Self Referrals	Dec 18 8 (0)	Jan 19 7 (0)	Feb 19 7 (1)	Total 22 (1)

Occupational Health Physician activity

Management Referrals (1 day)	Dec 18 8 (1)	Jan 19 2 (2 days A/L)	Feb 19 3 (1 day A/L)	Total 13 (1)
Self Referrals	Dec 18 0	Jan 19 0	Feb 19 0	Total 0

The manual data capture is necessary as the Department does not currently have a fully functioning electronic system for recording activity. This has been raised as a risk and is being rectified as part of the ESR Optimisation Project.

Flu Campaign: The final figures were reported at the close of the flu campaign in February 2019 as:

65.7 actual frontline staff received vaccine
82% of frontline staff including those who "opted out"
The number of "opt outs" were reported as 627 of frontline staff.

There have been a number of challenges in rolling out the campaign however these will be addressed and a "wash-up" meeting is scheduled for 1st April. The agenda will focus on lessons learned and the tactics for conducting the 2019/20 flu campaign can be planned now, agreed and implemented at the appropriate time.

5.3. Stress & Mental Health issues

We currently have in post a Staff Counsellor, who mostly sees self-referrals, and a Mental Health Nurse, who responds mainly to management referrals. According to our manual records, the referrals for the last 3 months are:

Staff Counsellor (F/T) New Referrals (each referral has potential to offer 5 further sessions)	Dec 18 23	Jan 18 11 (1 wk A/L)	Feb 19 13 (A/L)	Total 47
Mental Health Nurse Management Referrals (2 day contract) Self-Referrals	Dec 18 (Canc/DNA) 1 (1) 4 (2)	Jan 19 (Canc/DNA) 8 (2) 11 (4)	Feb19 (Canc/DNA) 6 (1) 3 (2)	Total 15 (4) 18 (8)

5.4. Ergonomic/MSK issues (Physiotherapists)

The Head of Occupational Health is considering models and practices in order to promote a proactive Occupational Health & Wellbeing service with respect to ongoing and more complex MSK needs.

In the meantime, the physiotherapy referral activity for the three months to February 2019 is:

Management Referrals (New) (F/T 1.00)	Dec 18 5	Jan 19 7	Feb 19 18	Total 30
Self Referrals	Dec 18 4	Jan 19 0	Feb 19 15	Total 19

The wide fluctuations in activity over the three months appear to be as a result combinations of:

- Annual leave
- Short periods of snow
- TB tracing activity
- Better use of clinical time due to changing processes.

The Workforce Committee have supported an initial investment bid for funding to support Attendance Management, which is being written into a Business Case for TIG.

6. Business Partnering:

Much of the work of the Business Partners centres on supporting their designated Directorates in achieving the KPI targets for the workforce. Therefore, much of what is reported here is influenced by their work, for example, resourcing (including retention and turnover), Agency spend, attendance, statutory and mandatory training, and appraisals.

6.1. ESR Optimisation

The Project Initiation Document (PID) and Business Case for this project are nearing completion and will go to TIG on 4th April 2019. This will encompass all Phases of the project from start to 2021. The Workforce Committee have supported an initial investment bid for funding to support this.

6.2. Workforce Planning

An urgent staffing review has been undertaken in Pharmacy due to high turnover of skilled pharmacists and technicians. Reasons are varied and include:

- competition from GPs and nursing homes offering better pay and bespoke hours,
- geographical isolation,
- SFT is behind other acute trusts in the implementation of modern practice such as e-prescribing,
- lean team in the bottom 10% national for WTE per 100 beds,
- fewer progression opportunities for technicians.

Authorisation has been given to recruit two extra newly-qualified band 6 pharmacists and a locum band 7 to cover immediate gap in the dispensary until the dispensary/stores restructure is complete. Permission to extend the current RRP for

band 7 pharmacists is to be requested in June. We are also looking at extending the length of student technician and pre-registration pharmacists' contracts.

The Radiology workforce paper is due for presentation on revised date of 25th March. Pathology has begun a whole service review, discipline by discipline, in order to produce a workforce plan by May 2019 aimed at mitigating/reducing the risk to service delivery and quality on the Trust risk register and highlighted by UKAS and a recent Executive safety walk-around.

Operational plans, including the workforce elements, have been submitted for all Directorates with the involvement of the Business Partners.

6.3. Policies

Our Policies, now on a rolling programme of renewal, are subject to consultation with JCC or JNG for medical policies. There are currently five medical policies with extended dates because of awaiting JNG agreement, and two general which still need JCC agreement before being approved by OMB.

6.4. Business Partner role

The Business Partners are heavily involved in all employee relations cases involving performance, discipline, grievance and bullying and harassment. We are now reporting the number of cases opened and closed so that, over time, we will be able to track completion times and create Key Performance Indicators for casework.

The following table shows new and closed activity for the past 11 months:

Employee Relations Cases - Formal										
	Performance/ Capability		Disciplinary		Grievance		Bullying and Harassment		Total Cases Opened	Total Cases Closed
	Opened/closed cases within the month - Source of Data - ESR									
Month	Cases Opened in Month	Cases Closed in Month	Cases Opened in Month	Cases Closed in Month	Cases Opened in Month	Cases Closed in Month	Cases Opened in Month	Cases Closed in Month	Total Cases Opened in Month	Total Cases Closed in Month
Apr-18	7	1	5	1	1	1			13	3
May-18	7			1					7	1
Jun-18	7	3	1	1					8	4
Jul-18	2	8			2	1			4	9
Aug-18	1	6		1					1	7
Sep-18	5	3							5	3
Oct-18	2	1					1		3	1
Nov-18	9				1				10	0
Dec-18	1	2			1				2	2
Jan-19	14	3	2			2			16	5
Feb-19	10	6		2					10	8
	65	33	8	6	5	4	1		79	43

In CSFS there are currently two restructures/consultations underway; reasonable adjustments made to accommodate a disability (following a stay conversation); a mediation agreed; team coaching set up; and an issue being dealt with under the Handling Concerns Policy.

In MSK an appeal was rejected, an informal disciplinary process is underway, a junior doctor banding appeal was upheld, and a registered nurse has been dismissed.

In the Medicine Directorate, a member of staff on long term sick has had an application for ill health retirement accepted and another member of staff has resigned rather than go through a disciplinary process.

A grievance has been raised concerning the outcome of the theatres consultation, which we are hoping to be able to resolve without the need for formal grievance process.

In Estates & Facilities an employee who had been on long-term suspension was dismissed for "some other substantial reason" (SOSR). Another employee was dismissed for ill-health capability on 14th March.

7. Workforce Risks

Work continues to align our risks to the revised Board Assurance Framework and our key priorities in the developing People Strategy, namely:

- Resourcing - Failure to recruit and retain staff will result in SFT being unable to deliver safe, sustainable services for patients.
- Business Partnering – Inaccurate workforce information will result in misalignment between the organisational and workforce strategies.
- Health and Wellbeing - Failure to achieve an outstanding experience for every patient because staff do not feel valued and able to contribute fully to work as a consequence of low morale.
- Organisational Development and Engagement - Failure to deliver excellence for all patients if the workforce is not appropriately skilled and staffed to the right level
- Leadership - inability to develop strong leadership capability across all levels of the organisation to support an innovation culture.

The Corporate Risk Register, and the Directorate Register have both been updated this month and actions are ongoing to mitigate the risks recorded.

8. Summary

The situation remains challenging, although improving in most areas except Agency spend and sickness. The actions described in sections 3, 4, 5 and 6 will ensure that the workforce is appropriately engaged and managed to maximise patient care and

experience. However, it is acknowledged that the key areas of pressure remain recruitment, temporary staffing overspend and sickness absence.

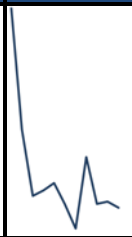
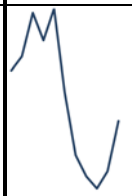
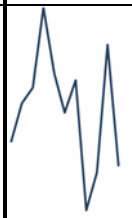
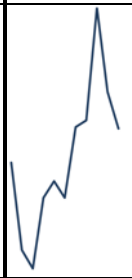
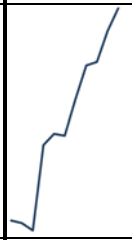
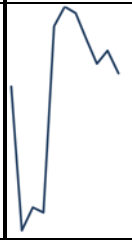
Our focus at a local level continues to be supporting both managers and staff in resolving these difficult areas while we begin to build sustainable solutions through the OD & People restructure at Salisbury. In doing this we continue to be at the centre of the workforce collaboration in the STP and the emerging STP Workforce strategy.

9. Recommendations

The Trust Board note the report, areas of concern and actions underway.

Paul Hargreaves
Director of Organisational Development and People

Executive Summary of Key Workforce Performance

Area of Review	Key Highlights	Status	Trend	Target
Turnover/ Retention	**In Month:** In month there were 19 leavers (headcount), and 44 starters (headcount), compared to 29 leavers and 56 starters in the month before. **Year to Date:** For the rolling year to date, the turnover rate was below target at 9.20%, this compares to last months position which was 9.24%. For the rolling year to M11 2017/18, the Trust's turnover rate was 10.24%. **Top 3 Hotspots:** The Directorate with the highest turnover rate for the rolling year was Facilities at 12.17%, followed by Musculo-Skeletal (11.27%) and Clinical Support & Family Services (9.30%).	GREEN		10.00%
Vacancies	**In Month:** Vacancies have increased from 5.90% in month 10 to 6.68% in month 11. **Year to Date:** The average vacancy rate is 7.02%, this compares to last months average position which was 7.06%. The Trust's vacancy rate for the same period last year was 6.40%. **Top 3 Hotspots:** The Directorate with the highest vacancy rate for the month was Facilities at 12.11%, followed by Medicine (9.43%) and Musculo-Skeletal (8.61%).	AMBER		5.00%
Temporary Spend	**In Month:** There has been a decrease in agency spend this month to £504,816, compared to last month's position which was £708,719. **Year to Date:** The financial year to date total agency spend is £6,601,789, compared to the spend for the same period in the previous year which was £7,611,808. **Top 3 Hotspots:** The Directorate with the highest agency spend for the month was Medicine with £312,375, followed by Musculo-Skeletal (£70,751) and Surgery (£61,420).	RED		£262,605
Sickness	**In Month:** There has been a decrease in the sickness rate this month at 3.73%, this compares to last months position of 3.95%. **Year to Date:** The year to date rolling sickness rate is at 3.45%, which compares to last months position which was 3.49%. The sickness rate for same period last year was 3.68%. **Top 3 Hotspots:** The Directorate with the highest sickness rate for the month was Facilities with 5.81%, followed by Surgery (4.11%) and Medicine (4.04%). ***Please note: Sickness figures contain all returns input as at sickness cut-off date, and may be subject to change due to late receipt of information/corrections.***	AMBER		3.00%
Training	**In Month:** Mandatory training compliance levels have increased this month to 92.03%, this compares to last months position of 91.32%. Compliance for the same period last year stood at 85.49%. **Year to Date:** The year to date average compliance level is 88.54%, this compares to last months position of 88.19%. **Top 3 Hotspots:** The Directorate with the lowest compliance rate was Corporate with 88.55%, followed by Medicine (89.00%) and Musculo-Skeletal (92.10%).	GREEN		85.00%
Non-Medical Appraisals	**In Month:** Non-Medical Appraisal compliance has decreased this month to 84.90%, this compares to last months position of 86.30%. Non-medical appraisal compliance for the same period last year stood at 84.40%. **Year to Date:** The year to date average compliance is 83.78%, this compares to last months position of 83.67%. **Top 3 Hotspots:** The Directorate with the lowest compliance rate was Medicine with 80.90%, followed by Corporate (81.60%) and Clinical Support & Family Services (84.20%).	AMBER		85.00%

Salisbury NHS Foundation Trust Workforce Dashboard

	Strs/Lvrs				Turnover (FTE)			Vacancies				Temporary Spend					Sickness						Training	Appraisal	
	Starters *(head count in month)*	Starters *(FTE in month)*	Leavers *(head count in month)*	Leavers *(FTE in month)*	Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Budget Wte (Ledger)	Staff In Post Wte *(Ledger - month end)*	Vacant Wte	Vacancy Rate	spend on Agency	% Temp Spend on Agency *(in month)*	spend on Bank	Total Temp Spend	Agency Budget	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend	*Data excludes: Docs in Training, Tupe Transfers, Bank Staff*																								
Month Trend																									
Target			29			245	10.00%			163.34	5.00%	£ 262,605	40.00%								89.55	3.00%	85.00%	90.00%	85.00%
Apr-18	49	40.13	22	18.25	2,880	296	10.28%	3,225.96	2,985.01	240.95	7.47%	£ 544,973	46.73%	£ 621,206	£ 1,166,179	Over	61.28	58%	44.76	42%	106.04	3.53%	85.59%	88.11%	84.10%
May-18	32	24.16	29	24.58	2,904	280	9.63%	3,233.45	2,984.76	248.69	7.69%	£ 609,792	52.48%	£ 552,149	£ 1,161,941	Over	39.77	44%	49.65	56%	89.42	3.01%	85.51%	89.96%	75.30%
Jun-18	31	26.29	27	23.26	2,925	271	9.27%	3,230.80	2,960.48	270.32	8.37%	£ 636,006	53.82%	£ 545,666	£ 1,181,672	Over	48.80	57%	36.57	43%	85.37	2.90%	85.29%	85.54%	76.70%
Jul-18	40	34.77	29	25.47	2,948	274	9.30%	3,247.56	2,989.67	257.89	7.94%	£ 771,812	54.55%	£ 643,158	£ 1,414,970	Over	59.19	61%	38.46	39%	97.64	3.32%	87.87%	86.31%	76.40%
Aug-18	38	36.94	35	30.85	2,970	277	9.34%	3,251.42	2,977.13	274.29	8.44%	£ 661,512	49.26%	£ 681,274	£ 1,342,786	Over	58.99	58%	41.98	42%	100.97	3.42%	88.21%	90.04%	87.80%
Sep-18	72	65.90	17	14.81	2,994	276	9.22%	3,252.88	3,021.03	231.85	7.13%	£ 594,056	49.79%	£ 599,139	£ 1,193,195	Over	54.98	56%	43.65	44%	98.64	3.32%	88.15%	91.32%	89.00%
Oct-18	79	72.72	19	16.93	3,020	275	9.09%	3,277.16	3,075.45	201.71	6.16%	£ 648,581	51.12%	£ 620,192	£ 1,268,773	Over	50.05	44%	63.51	56%	113.56	3.74%	89.27%	92.16%	88.60%
Nov-18	33	27.40	29	26.90	3,034	287	9.48%	3,266.10	3,075.89	190.21	5.82%	£ 428,578	41.11%	£ 613,830	£ 1,042,408	Over	53.05	46%	62.14	54%	115.20	3.78%	90.27%	91.20%	87.00%
Dec-18	15	12.69	26	20.35	3,043	281	9.22%	3,245.35	3,062.45	182.90	5.64%	£ 492,943	44.80%	£ 607,466	£ 1,100,409	Over	67.79	50%	67.38	50%	135.17	4.45%	90.38%	91.24%	85.50%
Jan-19	56	48.23	29	25.77	3,053	282	9.24%	3,266.78	3,073.92	192.86	5.90%	£ 708,719	51.17%	£ 676,229	£ 1,384,948	Over	57.32	48%	62.79	52%	120.11	3.95%	91.32%	88.16%	86.30%
Feb-19	44	38.59	19	16.57	3,064	282	9.20%	3,305.58	3,084.69	220.89	6.68%	£ 504,816	36.90%	£ 863,124	£ 1,367,940	Over	50.51	44%	63.49	56%	114.01	3.73%	92.03%	91.46%	84.90%
totals	489	427.82	281	243.74		Average	9.39%			Average	7.02%	£ 600,163									Rolling Year	3.45%	88.54%		

Note: Month 11 position shows an overspend on workforce of £1.03m.

Key Areas of Concern

KPI	Overall Commentary
Turnover *(measured in a rolling year)* ***Target 10.00%***	Turnover decreased this month and remains green rated. ***For Service Lines this month*** : the highest number of leavers for the year to date was from Therapy Services (23), Finance & Procurement (17) and Clinical Radiology (17). ***For Staff Groups this month:*** highest number of leavers was Administrative and Clerical (94) in the year to date. The average Headcount turnover for local Trusts is 9.46%, which we are below at 9.20% FTE.

highest Turnover rates

		Jan-19	Feb-19	T
1	Cancer	28.49%	27.90%	↓
2	E.N.T.	25.38%	25.57%	↑
3	Chief Executive	15.29%	22.68%	↑
1	Musculo-Skeletal Directorate	12.43%	12.08%	↓
1	Allied Health Professionals	14.26%	14.85%	↑

highest number of leavers

1	Therapy Services	22	23	↑
2	Finance & Procurement	17	17	→
3	Clinical Radiology	17	17	→
1	Clinical Support & Family Services	79	77	↓
1	Administrative and Clerical	99	94	↓

Vacancies ***Target 5%***	Vacancies have increased from 5.90% in month 10 to 6.68% in month 11 following an increase in establishment of 39 FTE, 35.27 of which was due to the temporary opening of additional beds on Laverstock Ward, for two months only. Recruitment Activity is detailed in Section 3 of the accompanying report.

highest Vacancy rate

		Jan-19	Feb-19	T
1	Adult Medical Wards	10.65%	24.96%	↑
2	Spinal Unit	19.85%	20.49%	↑
3	Dermatology	26.97%	20.37%	↓
1	Facilities Directorate	10.16%	12.11%	↑
1	Nursing and Midwifery Registered	14.95%	16.12%	↑

highest WTE Vacant

1	Adult Medical Wards	14.68	43.72	↑
2	Spinal Unit	21.00	21.97	↑
3	Clinical Radiology	19.16	18.78	↓
1	Medicine Directorate	42.83	65.63	↑
1	Nursing and Midwifery Registered	137.84	150.79	↑

Key Areas of Concern

KPI	Overall Commentary
Temporary Spend ***Agency Control Total £269,105***	The Trust is endeavouring to reduce the proportion of temporary spend on agency staff to 40% or below. For some areas the nature of work makes this difficult. ***For Service Lines this month*** : Stroke and Gastroenterology record all of their temporary spend as agency as this was in Medical & Dental (locum cover) covering difficult to recruit to vacancies. The agency usage is also required to avoid breaches of access/waiting times. ***For Staff Groups this month*** : The highest spend is on Nursing and Midwifery Registered.

Highest proportion of temporary spend spent on Agency

		Jan-19	Feb-19	T
1	Stroke - Medical Staff	100.00%	100.00%	→
2	Gastroenterology - Medical Staff	100.00%	100.00%	→
3	Clin Radiology Ex Spin/CT	100.00%	100.00%	→
1	Medicine Directorate	48.99%	46.38%	↓
1	Professions Allied to Medicine	100.00%	100.00%	→

highest £ spent on Agency

1	Laverstock Ward	£ -	£ 60,976	↑
2	Stroke - Medical Staff	£ 36,252	£ 47,072	↑
3	Gastroenterology - Medical Staff	£ 21,911	£ 39,534	↑
1	Medicine Directorate	£ 250,111	£ 312,375	↑
1	Nursing and Midwifery Registered	£ 273,840	£ 231,083	↓

Sickness Year to date ***Target 3%***	Sickness for February (M11) is at 3.73%. Sickness for the rolling year to date is 3.45% which is average for the surrounding Local Acute hospital Trusts. Our sickness project team are working with departments to identify those individuals whose sickness absence remains problematic (both short and long term). Ensuring the above individuals are managed in an appropriate manner which will either support their return to work or see them being escalated through the Management of Attendance Policy. For Service Lines this month: the highest sickness rate was Main Outpatients at 7.55% in the rolling year to date. For Staff Groups this month: the highest sickness rate was Additional Clinical Services at 5.42% in the rolling year to date. ***Please note: Sickness figures contain all returns input as at sickness cut-off date, and may be subject to change due to late receipt of information/corrections.***

highest Sickness rate

		Jan-19	Feb-19	T
1	Main Outpatients	7.23%	7.55%	↑
2	Surgery Management	6.79%	6.81%	↑
3	Trading & Support Services	6.16%	6.22%	↑
1	Facilities Directorate	4.89%	4.87%	↓
1	Additional Clinical Services	5.39%	5.42%	↑

highest WTE sick in month

1	Theatres	10.36	10.86	↑
2	Hotel Services	5.33	5.78	↑
3	Adult Medicine Wards	5.13	5.77	↑
1	Medicine Directorate	23.42	25.51	↑
1	Nursing and Midwifery Registered	26.98	29.37	↑

Key Areas of Concern

KPI	Overall Commentary
Mandatory Training ***Target 85%***	Compliance has increased this month and is green rated at 92.03%. A focus on hand hygiene Training is required for Clinical staff as this is the subject with the least compliance. Focus needs to be on employees completing training before they come out of compliance.

lowest Mandatory training rates

		Feb-19	Mar-19	T
1	Medical Staff - Orthopaedics	70.53%	70.00%	↓
2	Medical Staff - Child Health	71.43%	72.85%	↑
3	Occupational Health	94.06%	73.88%	↓
1	Corporate Directorate	87.36%	88.55%	↑
1	Medical and Dental	82.16%	83.16%	↑

Non-Medical Appraisals *Target 85%*	Appraisal compliance has decreased to 84.90% and is Amber rated. 49 departments are red rated and these will be the focus over the next month to reach target.	**lowest appraisal rates**				
				Feb-19	**Mar-19**	**T**
		1	Pitton Ward	50.00%	53.85%	⇧
		2	Acute Medical Unit	65.63%	61.76%	⇩
		3	Patient at Risk Team	100.00%	63.64%	⇩
		1	Medicine Directorate	83.70%	80.90%	⇩
		1	Add Prof Scientific and Technical	82.18%	82.22%	⇧

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	15e
Date of Meeting:	04 April 2019		

Report Title:	Finance Report Month 11			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Mark Ellis, Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the financial position for February 2019, the key risks and the actions being taken to mitigate them.

Executive Summary:
The purpose of this report is to set out the Trust's financial performance for the period to 28th February 2019. The position (against the NHSI Control total) for February was a year to date deficit of £11,457k, bringing the YTD shortfall against plan to £2,738k. As a result the Trust remains unable to recognise any further PSF in the reported figures. Although the Trust remains behind its control total it has now been signaled to NHS Improvement that this shortfall will be recovered in Q4 meaning the financial element of PSF (1.7m) will also become payable. 2018/19 has seen significant risks and issues against the delivery of the financial plan, these include: • The on-going productivity challenge to achieve the Elective and Day Case plan, particularly in Orthopaedics and Plastic surgery specialties, this is related to ensuring theatre scheduling and resourcing supports optimum delivery. • The financial pressure arising from the delivery of required performance standards in Endoscopy through outsourcing. • Workforce constraints impacting on the ability for the Trust to achieve the optimum productivity in areas such as Endoscopy, not only in terms of direct gaps like Consultant vacancies, but also in terms of supporting clinical staff e.g. theatre workforce capacity. • Increasing demand and pressures from Non Elective activity placing additional

pressure on areas impacted by significant workforce gaps, driving an increase in temporary staffing.
- The pause on the implementation of wholly owned subsidiaries, the Trust had assumed the commencement of savings in Q3.
- Technical impairments relating to the construction of a new sterile services unit and a review of intangible assets.

In response the Trust is:

- Detailed planning is currently underway about the potential resource impact of winter and the Trust has developed a plan to mitigate the risk of increased length of stay, underpinned by additional MRET funding from the commissioners..
- Focusing on the schemes for Theatre productivity and Patient flow, as the key schemes that underpin the financial plan this year.
- Working with the MSK directorate on weekly basis to ensure delivery of actions to improve activity and subsequent income with particular focus on Orthopaedics and Plastics.

Cash flow continues to be monitored closely in light of the financial risks to the plan, NHSI have now agreed access to working capital loans for the remainder of the financial year.

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

Executive Summary of Key Financial Performance - February 2019

Page	Area of Review	Key Highlights	Status against Plan
1	Income & Expenditure	The position (against the NHSI Control total) for February was a year to date deficit of £11,457k, bringing the YTD shortfall against plan to £2,738k . As a result the Trust remains unable to recognise any further PSF in the reported figures. Although the Trust remains behind its control total it has now been signalled to NHS Improvement that this shortfall will be recovered in Q4 meaning the financial element of PSF (1.7m) will also become payable.	Red
2	NHS Clinical Income	Overall income YTD was £177,043k which was £1,734k behind plan. In month actual income was £16,237k this was £622k ahead of the Trust plan. The Trust reached agreement with West Hampshire & Southampton CCGs and NHSE Military on the year end contract value which improved the position by £492k.	Red
3	Workforce	Expenditure on Pay stood at £12,927k in the period, this includes the cost of opening Laverstock ward to cope with pressures in emergency pathways. Underlying spend is equivalent to that seen in January once the provision for the challenge by HMRC on medical agency staffing models made in January is taken into account. The 2018/19 CIP plan had assumed £4,015k in Pay savings in 2018/19, forecast as at February 2018/19 is that £2,160k will be delivered.	Amber
4	Non Pay	Pressures arising from growth in activity within Pathology and Genetics, as well as a shortfall in savings that had been planned through the delivery of a wholly owned subsidiary are being offset by reductions in drugs costs due to a switch to biosimilars.	Green
5	Efficiency - Better Care at Lower Cost	Overall CIP delivery in February is £885k (52%) short of target. YTD delivery of £9,260k represents 76% of the planned full year delivery. The level of savings delivered on a monthly basis have reached steady state and material movements in March 2019 are unlikely.	Amber
6	Use of Resources	The Trust's overall risk rating score remains at the lowest value of 4, following the deterioration distance from plan to 2.4%. This rating is forecast to return to an overall 3 by the end of the financial year as the distance from financial plan is expected to return to a 2. Distance from financial plan includes the impact of PSF not achieved (1.1%).	Red
7	Capital Expenditure	Close management of the capital plan over the final quarter of the year has led to the identification of schemes which can be brought forward into the current year to replace those slipped into next year, expectation is that the recover the cumulative shortfall seen in February.	Green
8	Cash Management	The Trust did not achieve its control total for quarter 3 and did not receive any Provider Sustainability Funding (PSF) for that quarter. The Trust now expects to recover this shortfall against plan in the final quarter and therefore receive the £1.7m remaining financial component in early 2019/20.	Amber
	Risk & Mitigation	The key issues in the delivery of the 2018/19 financial plan are: - The reliance on outsourcing to delivery the required performance in Endoscopy - Vacancies and the associated Agency cost of cover - Consistent delivery of the productivity gains - Controlling LOS as Non Elective demand rises - The impact on the savings plan of the NHSI 'pause' on the development of wholly owned subsidiaries. These factors represent risks that have crystallised over the course of the financial year.	Amber

Page 1 - Income & Expenditure

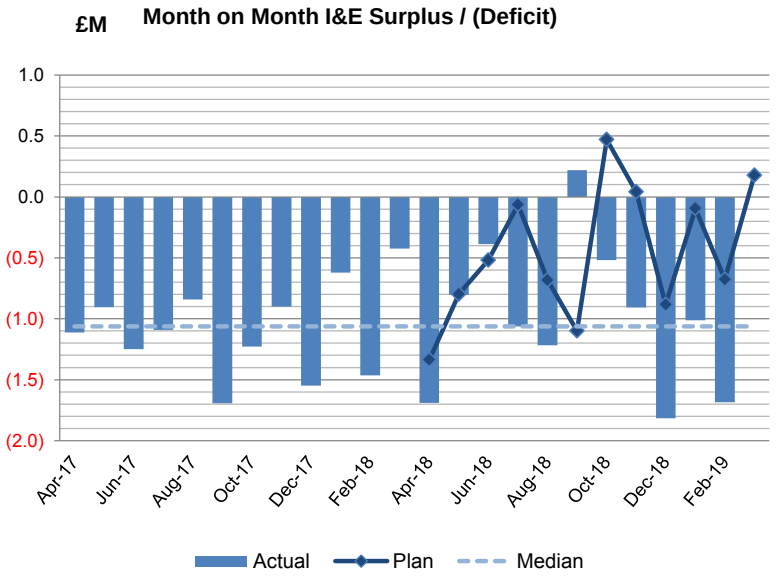
Status

Income & Expenditure

Position

	Feb '19 In Mth			Feb '19 YTD			2018/19
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	15,068	15,741	673	178,777	177,043	(1,734)	196,036
Other Clinical Income	1,443	1,354	(89)	9,843	10,352	509	9,843
Other Income (excl Donations)	2,349	2,420	71	24,463	25,065	602	26,922
Total income	**18,860**	**19,514**	**654**	**213,083**	**212,460**	**(623)**	**232,801**
Operating Expenditure							
Pay	(12,375)	(12,927)	(552)	(136,506)	(138,184)	(1,678)	(148,862)
Non Pay	(6,358)	(6,292)	66	(72,081)	(71,928)	153	(78,460)
Total Expenditure	**(18,733)**	**(19,220)**	**(487)**	**(208,587)**	**(210,112)**	**(1,525)**	**(227,322)**
EBITDA	**127**	**295**	**168**	**4,496**	**2,348**	**(2,148)**	**5,479**
Financing Costs (incl Depreciation)	(1,221)	(1,945)	(724)	(13,215)	(13,804)	(589)	(14,439)
NHSI Control Total	**(1,094)**	**(1,650)**	**(556)**	**(8,719)**	**(11,457)**	**(2,738)**	**(8,960)**
Add: impact of donated assets	*(25)*	*(34)*	*(9)*	*(275)*	*(421)*	*(146)*	*(300)*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: PSF	*443*	*0*	*(443)*	*3,353*	*930*	*(2,423)*	*3,795*
Surplus/(Deficit)	***(676)***	***(1,684)***	***(1,008)***	***(5,641)***	***(10,948)***	***(5,307)***	***(5,465)***

Trend



Variation & Action

The position (against the NHSI Control total) for February was a year to date deficit of £11,457k, bringing the YTD shortfall against plan to £2,738k . As a result the Trust remains unable to recognise any further PSF in the reported figures. The reported deficit had been planned to increase in February due to the largely fixed cost base combined with the reduction in both working and colander days impacting activity driven clinical income.

An in-month NHSI Control Total deficit of £1,650k was reported vs a forecast of a deficit of £2,157k. The key driver of the favourable movement was agreement over the financial outturn of the military contract held with NHSE, with £418k over and above forecast reported. This variance is expected to translate directly through to an improved outturn at year end.

The Trust has mitigated the risk arising capacity gaps in the Endoscopy service present to cancer and diagnostic waiting time performance by outsourcing to a private provider, the cost of this increase in capacity was £42k for the period of February and £297k year to date. The Trust has reviewed alternative arrangements for providing this capacity that will be in place for 2019/20.

Financing costs include impairments relating to assets under construction, and the development of intangible assets, this technical adjustments were included within the forecast submitted to NHSI in January.

Although the Trust remains behind its control total it has now been signalled to NHS Improvement that this shortfall will be recovered in Q4 meaning the financial element of PSF (1.7m) will also become payable.

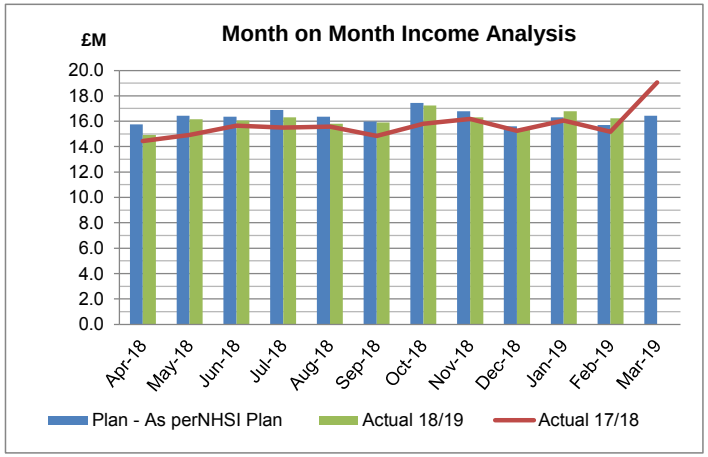
Page 2 - NHS Commissioner Income

Status	Position	Trend

NHS Clinical Income

Income by Point of Delivery (PoD) for all commissioners	Feb '19 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Elective inpatients	18,082	16,052	(2,030)
Day Case	16,198	15,810	(388)
Non Elective inpatients	45,616	45,703	87
Obstetrics	6,481	6,059	(422)
Outpatients	28,951	28,470	(481)
Excluded Drugs & Devices (inc Lucentis)	16,879	16,072	(807)
Other	46,570	48,877	2,307
TOTAL	**178,777**	**177,043**	**(1,734)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	90,659	93,397	2,738
Dorset CCG	20,264	20,267	3
Hants CCG	14,054	14,488	434
Specialist Services	27,800	28,807	1,007
Other	26,000	20,084	(5,916)
TOTAL	**178,777**	**177,043**	**(1,734)**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
Elective	5,285	4,694	(591)	4,565	129
Day case	20,142	19,881	(261)	19,722	159
Non Elective	24,243	23,908	(335)	23,103	805
Outpatients	232,730	231,104	(1,626)	237,771	(6,667)
A&E	44,079	44,872	793	42,502	2,370

Variation & Action

Overall income YTD was £177,043k which was £1,734k behind plan. In month actual income was £16,237k this was £622k ahead of t he Trust plan. The Trust reached agreement with West Hampshire & Southampton CCGs and NHSE Military on the year end contract value which improved the position by £492k.

Looking at the productivity metrics the Trust has continued see strong productivity performance for day case, non elective, a nd ED activity, but the elective and outpatients performance has dropped. Elective activity was down by 58 (12.7%) mainly due to general surgery, T&O and cardiology being beh ind plan. Outpatients attendances were down against plan by 934 (4.7%) and this was broadly across most specialities.

Elective performance was £189k (12%) behind plan in month activity was down in general surgery, T&O and cardiology. however, T&O and cardiology over-performed on non-elective activity which partly offset this underperformance. Day Cases were above plan by £52k and this was attributable to continued outsourcing of work for endoscopy. Non Elective excluding obstetrics was down against plan by £306k but activity was on plan. The adverse financial variance was a result of the case mix and patient acuity being lower than expected. Obstetrics (births) improved with 165 birth spells which was 18 less than plan. Out patient attendances was £162k down against plan and activity was generally down across most specialities. Other activity PODs were within reasonable tolerance limits of the plan.

Page 3 - Workforce

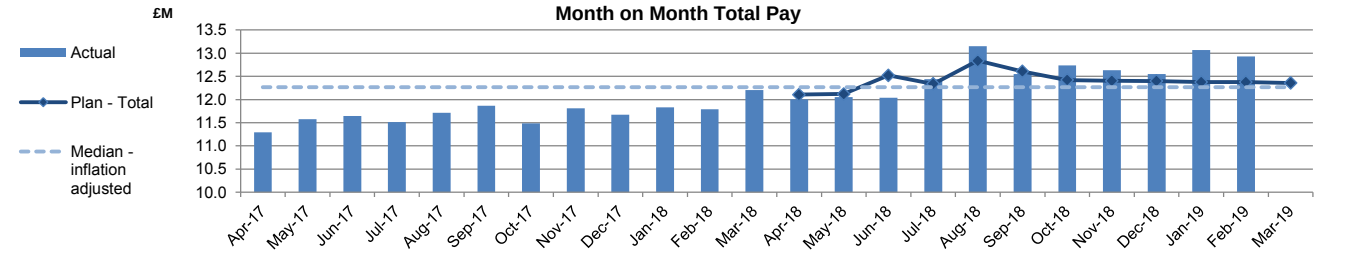
Status	Position	Position

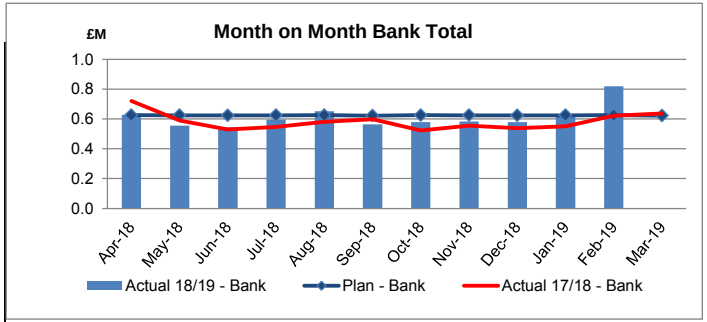
PAY

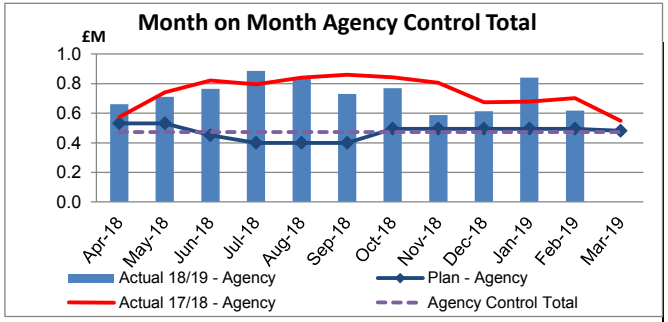
	Feb '19 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	121,325	123,044	(1,719)
Pay - Bank	6,800	6,607	193
Pay - Agency	5,189	8,018	(2,829)
Other (eg. Apprenticeship Levy)	3,192	515	2,677
TOTAL	**136,506**	**138,184**	**(1,678)**
Medical Staff	36,407	37,802	(1,395)
Nursing	35,994	34,986	1,008
HCAs	9,753	12,371	(2,618)
Other Clinical Staff	21,025	21,628	(603)
Infrastructure staff	30,135	30,883	(748)
Other (eg. Apprenticeship Levy)	3,192	515	2,677
TOTAL	**136,506**	**138,184**	**(1,678)**

	Feb '19 Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	396.5	410.3	(13.8)
Nursing	937.7	910.4	27.4
HCAs	430.2	512.1	(81.9)
Other Clinical Staff	584.3	595.5	(11.3)
Infrastructure staff	1,108.4	1,113.5	(5.1)
TOTAL	**3,457.1**	**3,541.8**	**(84.7)**

Trend







Variation & Action

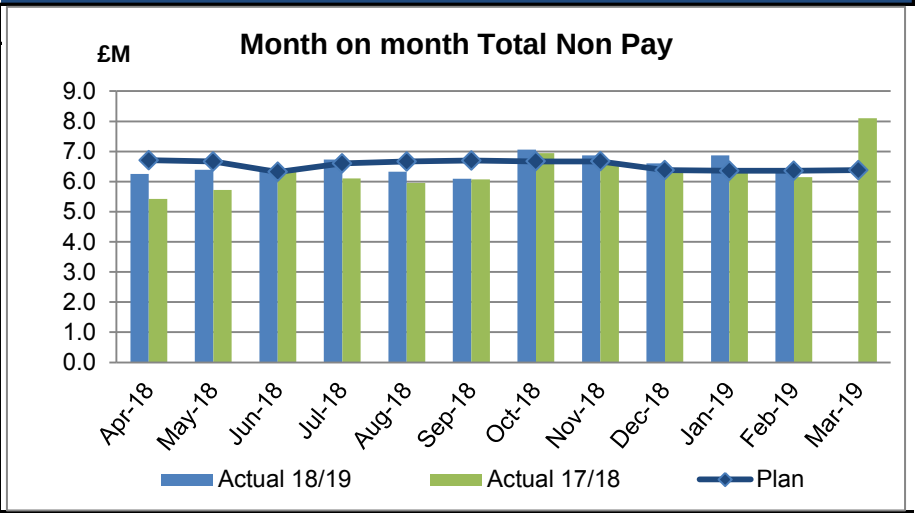
Expenditure on Pay stood at £12,927k in the period, this includes the cost of opening Laverstock ward to cope with pressures in emergency pathways. Underlying spend is equivalent to that seen in January once the provision for the challenge by HMRC on medical agency staffing models made in January is taken into account.

The charts above make clear an increase in pay Run rate over the course of the year, with the run rate increasing by circa £900k since the same period in 2017/18, key drivers of this increase are as follows:
- 2018/19 pay award: £295k (33%)
- Increases in nursing and ward staff: £207k (23%)
- Directly funded posts: £233 (26%)
- Staff previously engaged in capital projects £74k (8%)

The 2018/19 CIP plan had assumed £4,015k in Pay savings in 2018/19, forecast as at February 2018/19 is that £2,160k will be delivered.

Page 4 - Non Pay Expenses (excluding Finance Charges & Depreciation)

Status	Position				Trend
		Feb '19 YTD			
		Plan £000s	Actual £000s	Variance £000s	
NON-PAY	Drugs	20,486	18,930	1,556	
	Clinical Supplies	18,710	21,076	(2,366)	
	General Supplies	4,432	3,182	1,250	
	Outsourced healthcare	4,408	4,792	(384)	
	Other Non Pay expenses	24,045	23,948	97	
	TOTAL	**72,081**	**71,928**	**153**	



Variation & Action

The 2018/19 financial plan had assumed four months of benefit of operating a wholly owned subsidiary, the pause and review of this project accounts for circa £200k in February and £900k of the year to date clinical supplies overspend. Pathology and Genetics budgets are also under pressure due to volumes of activity, driving a £100k overspend between them.

The pressures set out about are offset in the period by two key factors:
- Expenditure on excluded drugs is £180k less than plan due to a switching programme to biosimilar formulas, the associated reduction of income was already accounted for in the 2018/19 contract settlement with Wiltshire CCG.
- A provision for the costs of the final phase of the WOS implementation has been released.

Page 5 - Efficiency - Better Care at Lower Cost

Status	Position							
	Directorate	Annual Plan £000s	Feb '19			YTD		
			Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
	Medicine	1,845	178	100	(78)	1,666	1,248	(419)
	Musculo Skeletal	2,665	270	189	(81)	2,395	1,959	(436)
	Surgery	1,820	202	126	(76)	1,616	1,184	(432)
	Clinical Support & Family Services	2,048	229	118	(111)	1,800	1,406	(394)
	Corporate Services	1,732	178	135	(44)	1,533	1,395	(138)
Efficiency	Trustwide	2,106	639	144	(496)	2,899	2,098	(800)
	TOTAL	**12,217**	**1,696**	**811**	**(885)**	**11,909**	**9,290**	**(2,619)**

Position							
Scheme	Annual Plan £000s	Feb '19			YTD		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	2,335	237	96	(141)	2,098	1,223	(875)
Workforce	640	56	7	(49)	584	87	(497)
Outpatients	646	80	(0)	(80)	560	524	(36)
Diagnostics	822	94	(10)	(103)	711	107	(605)
Patient Flow	336	28	28	0	308	310	2
Non-Pay	1,741	186	198	12	1,553	1,540	(12)
Directorate Plans	5,397	761	388	(373)	4,517	4,649	132
Drugs	298	25	27	2	273	125	(148)
Sub-total	**12,215**	**1,466**	**734**	**(732)**	**10,604**	**8,565**	**(2,039)**
Risk Mitigation	1,535	230	77	(153)	1,305	725	(580)
TOTAL		**1,696**	**811**	**(885)**	**11,909**	**9,290**	**(2,619)**

Variation & Action

Overall CIP delivery in February is £885k (52%) short of target. YTD delivery of £9,260k represents 76% of the planned full year delivery. The level of savings delivered on a monthly basis have reached steady state and material movements in March 2019 are unlikely.

Workforce continues to under deliver year to date, planned schemes had been focused on reductions in premium head count costs, but even after recent recruitment demand is still driving a need for temporary staffing. Utilisation, particularly prompt starts, remains challenging to resolve in the theatres PMB. An unrealised plan to sell MRI capacity to 3rd parties has also impacted on delivery throughout the year.

Of the planned reductions in spend phased for the latter part of the year, the most material was that associated with the implementation of a wholly owned subsidiary, which was paused in line with NHSI guidance.

Page 6 - Use of Resources

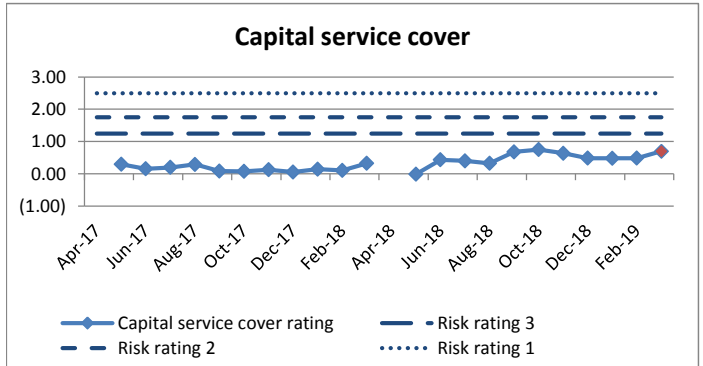
Status	Description	Position			
		Metric	Definition	YTD Plan Number	YTD Actual Number
Use of Resources	NHSI measures an organisation's use of resources on a scale of 1-4 with 4 being the highest risk and 1 the lowest risk	Capital service cover rating	Degree to which income covers financial obligations	4	4
		Liquidity rating	Days of operating costs held in cash	2	2
		I&E margin rating	I&E surplus/deficit / total revenue	4	4
		I&E margin: distance from financial plan	YTD actual I&E surplus/deficit compared to YTD plan		4
		Agency rating	Distance from cap		4
		Risk rating after overrides			4

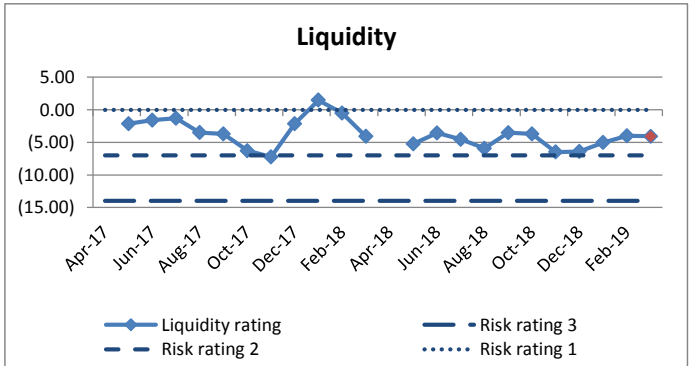
Variation & Action

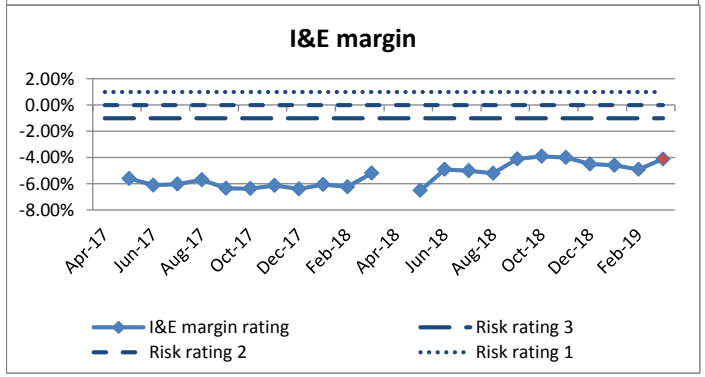
The Trust's overall risk rating score remains at the lowest value of 4, following the deterioration distance from plan to 2.4%. This rating is forecast to return to an overall 3 by the end of the financial year as the distance from financial plan is expected to return to a 2.

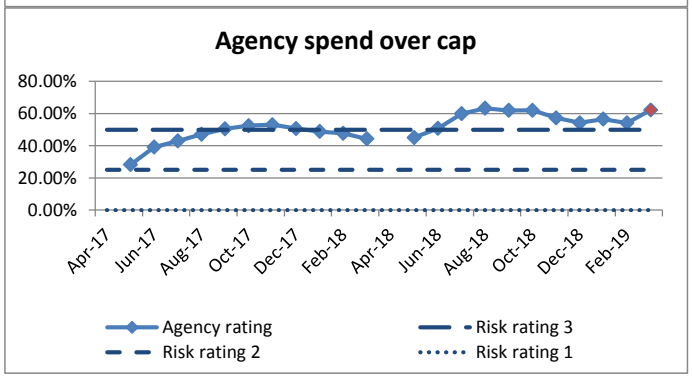
Distance from financial plan includes the impact of PSF not achieved (1.1%).

The Trust continues to monitor progress against the NHS enforcement notice action plan.



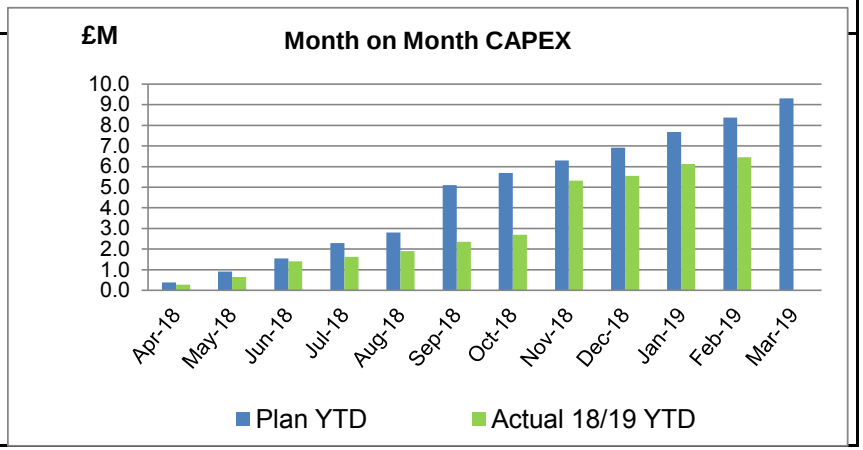






Page 7 - Capital Expenditure

Status	Position				
		Annual	Feb '19		
	Schemes	Plan £000s	Plan £000s	Actual £000s	Variance £000s
Capital Spend	Building schemes	617	450	345	105
	Building projects	1,730	1,562	850	712
	IM&T	4,404	3,918	3,716	202
	Medical Equipment	2,755	2,105	1,210	895
	Other	366	335	335	0
	TOTAL	**9,872**	**8,370**	**6,456**	**1,914**



Variation & Action

Close management of the capital plan over the final quarter of the year has led to the identification of schemes which can be brought forward into the current year to replace those slipped into next year, expectation is that the recover the cumulative shortfall seen in February.

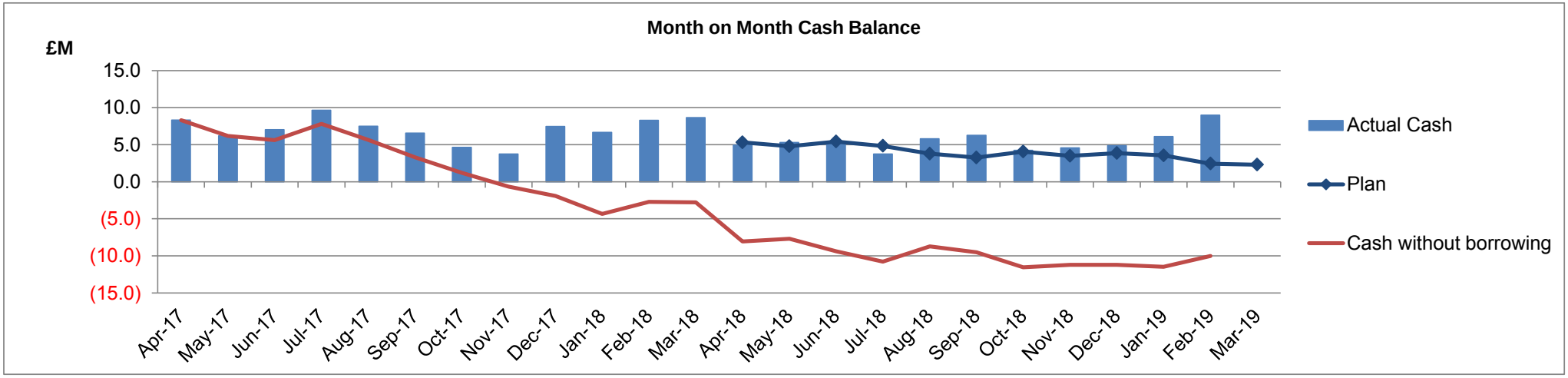
Of the £1,060k PDC received in December 2018, £500k has been identified as undeliverable within the required time frame and the Trust has signalled to NHSI that this will not be spent.

In addition, the Trust has drawn down a further £250k PDC (out of a possible £543k) from the Provider Digitalisation Fund in 2018-19 with the funds being deployed in March 2019.

Page 8 - Cash & Working Capital

Status	Position						Variation & Action
Cash and working		Opening Balance April 2018 £000s	Plan £000s	Current Month Balance £000s	Variance £000s	Actual In Year Movement £000s	The Trust did not achieve its control total for quarter 3 and did not receive any Provider Sustainability Funding (PSF) for that quarter. The Trust now expects to recover this shortfall against plan in the final quarter and therefore receive the £1.7m remaining financial component in early 2019/20. The cash flow continues to be closely monitored to ensure funds are available when required. The Trust is not planning for additional borrowing in 2019/20.
	Inventories (Stock)	6,214	6,214	6,808	594	594	
	Debtors	15,396	15,900	15,653	(247)	257	
	Cash	8,641	3,548	8,986	5,438	345	
	TOTAL CURRENT ASSETS	**30,251**	**25,662**	**31,447**	**5,785**	**1,196**	
	Creditors	(24,438)	(20,349)	(25,325)	(4,976)	(887)	
	Borrowings	(1,164)	(1,488)	(1,532)	(44)	(368)	
	Provisions	(292)	(292)	(292)	0	0	
	TOTAL CURRENT LIABILITIES	**(25,894)**	**(22,129)**	**(27,149)**	**(5,020)**	**(1,255)**	
	TOTAL WORKING CAPITAL	**4,357**	**3,533**	**4,298**	**765**	**(59)**	

Trend



Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	15
Date of Meeting:	04 April 2019		

Report Title:	Board Assurance – Committee Terms of Reference Strategic Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Appendix 1: Assurance Map Appendix 2: Board Committee revised Terms of Reference			

Recommendation:
Members are asked to consider the analysis and approve the changes to the Terms of Reference as described in section 4. Once approved, the revised terms of reference will be included in the revised Integrated Performance Framework.

Executive Summary:
Purpose To present an analysis of how the Board currently receives assurance against the key items of business through the Committee structure and seek to close any identified gaps and remove potential duplication. Key issues to note The review has identified that the Board has not explicitly aligned the following areas of required assurance to one of its Committees though their Terms of Reference: • Information Technology • Data Quality • Information Governance • Estates and Facilities The review has also highlighted that the Board Committee terms of reference were not consistent in setting out key functions and responsibilities. Should the Board agree to the proposed allocations, the Terms of reference and work plans for the Committees will be finalized accordingly.

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

1 Purpose

1.1 To present an analysis of how the Board currently receives assurance against the key items of business through the Committee structure and seek to close any identified gaps and remove potential duplication.

2 Background

2.1 Following the establishment of the Strategy Committee and the Subsidiary Governance Committee, the Director of Corporate Governance reviewed the current allocation of assurance activities amongst the Committees to identify any areas of overlap or gaps in the assurance arrangements.

2.2 The analysis is provided in the form of an assurance map which describes, based on the Terms of Reference and work plan for each Committee, the areas they are focussed on to provide assurance to the Board, and any areas of potential duplication.

2.3 The totality of the assurance arrangements were then considered to identify if there were any gaps in the assurance arrangements.

2.4 The Executive Directors have contributed to the analysis for their respective areas.

3 Assurance Map Analysis

3.1 The full assurance map is presented in Appendix 1, which has helped to identify the following:

- Service improvement and change management are duplicated across the Clinical Governance Committee and the Workforce Committee. The Executive Directors agreed that this was appropriate and should remain given the potential impact on quality of care and resources (people).
- The Terms of Reference for Audit Committee required strengthening to outline the role of the Committee in developing integrated governance arrangements.
- The following areas of required assurance are not currently described in the Committee Terms of Reference:
    - Information Technology
    - Data Quality
    - Information Governance
    - Estates and Facilities

3.2 The analysis highlighted the lack of a consistent approach to describing the functions and responsibilities to ensure this was explicit for each committee.

4. Proposed changes to the Terms of Reference

Based on the review the following changes are proposed:

4.1 Audit Committee

- A substantial revision to the terms of reference to ensure each assurance function is explicit.
- Providing clarity of the role of the committee in developing integrated governance arrangements

4.2 Clinical Governance Committee

- A substantial revision to the terms of reference to ensure each assurance function is explicit.
- Addition of clinical audit to the assurance function.
- Membership reviewed and amended to two Non-Executive Directors from three.
- Amended the responsibility for the administration function of the Committee.

4.3 Finance and Performance Committee

- A substantial revision to the terms of reference to ensure each assurance function is explicit.
- Addition of the review of Information Technology, Information Governance, Data Quality and Estates and Facilities to seek assurance on behalf of the Board.
- Addition of the review of operational risk.
- Removal of reference to commercial holdings operation as this assurance is now obtained via the Subsidiary Governance Committee

4.4 Workforce Committee

- A substantial revision to the terms of reference to ensure each assurance function is explicit.
- Amended the responsibility for the administration function of the Committee.

4.5 Strategy Committee

- Addition of the review of the Estates Strategy to seek assurance on behalf of the Board.
- No further changes.

4.6 Subsidiary Governance Committee

- Recently approved at the committee meeting on 15th March.

4.7. Each committee terms of reference revisions have been agreed with the relevant Executive Director and Committee Chair. The terms of reference can be found in Appendix 2.

5 Summary

5.1 All Board Committee terms of reference have undergone revision and all revisions have been agreed by the relevant Executive Director and Committee Chair. Once agreed by the Trust Board, the revised terms of reference will be included in the revised Integrated Governance Framework.

6 Recommendations

6.1 Members are asked to consider the analysis and approve the changes to the Terms of Reference as described in section 4. Once approved, the revised terms of reference will be included in the revised Integrated Performance Framework.

Fiona McNeight
Director of Corporate Governance

Appendix 1: Assurance map

Assurance map: Board Committees

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

New assurance items

Duplication

Salisbury NHS Foundation Trust

Audit Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	

Date Adopted	April 2018
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Audit Committee –
Adoption and ratification of changes	Board of Directors –

1) Purpose and function

The purpose and function of the Committee is to:

a) Monitor the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them
b) Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes
c) Review the effectiveness of the Trust's internal audit and external audit function; and
d) In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.
e) Report to the Board as to how it is discharging its responsibilities as a Committee

2) Authority

a) The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee.

b) The Committee is a standing committee of the Board of Directors (the Board).

c) The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and any such employee will be directed to co-operate with any request made by the Committee.

d) The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise. Should the projected cost of any such external advice exceed £50k, consent of the CEO and Director of Finance should be sought in advance of engagement.

e) A Non-Executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference

3) Membership and Attendance

Membership

a) The Committee shall be appointed by the Board of Directors and shall consist of four Non-Executive Directors, with at least one of whom shall have recent and relevant financial experience.

b) A Non-Executive Director shall be appointed as Chair of the Committee.

c) The Chairman of the Board of Directors shall not be a member of the Committee.

d) The Chair of the Committee shall not be the Senior Independent Director of the Board of Directors.

Quorum

e) The quorum necessary for the transaction of business shall be two members of the Committee

f) In the absence of the Chair of the Committee, the Secretary will invite one of the other Committee members to chair the meeting.

Attendance

g) Meetings of the Committee shall normally be attended by:

- The Chief Executive
- The Director of Finance, or a nominated Deputy
- Representatives from the External (Appointed) Auditors, Internal Auditors and Counter Fraud advisors
- The Director of Corporate Governance, or nominated deputy, will act as Secretary to the Committee and will therefore attend all meetings
- Financial Controller
- Others by invitation – this may include executive sponsors in the case of audit reports

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

4.1 Financial reporting

The Committee shall:

a) Ensure the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain

b) Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement, focusing in particular on:
    - Any changes in accounting policies and practices
    - Major judgmental areas
    - Value for Money considerations
    - Significant adjustments arising from the audit
    - The going concern basis
    - Compliance with accounting standards
    - Major risks to the Trust

c) Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust.

d) Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements)

e) Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of both the Trust Executive and the External Auditor

f) Review the clarity of disclosure in the Trust's financial reports and the context within which statements are made
g) The Committee Chair shall report formally to the Board on its proceedings after each meeting on all escalation matters
h) The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

4.2 Governance, Risk Management and Internal Control

The Committee shall:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives
b) Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board
c) Review the Trust's processes to establish and maintain an effective Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements
d) Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security as required by the NHS Counter Fraud Authority
e) Receive assurance from Internal Audit, External Audit, Directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.3 Internal Audit and Counter Fraud

The Committee shall:

a) Ensure that there is an effective Internal Audit function that meets the aspirations of the Trust's Executive, *Government Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors
b) Consider and approve the Internal Audit Strategy and annual plan recommended by the Director of Finance and ensure there are adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions
c) Review promptly all reports on the Trust from the Internal and External Auditors, review and monitor the Executive Management's responsiveness to the findings and recommendations of reports, and ensure coordination between Internal and External Auditors to assist the Executive to optimise use of audit resource
d) Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried

out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee

e) Conduct a review of the Executive's use of internal audit and counter fraud consultancy resources, including an assessment of the effectiveness of these services.

4.4 External Audit

The Committee shall:

a) In conjunction with the Director of Finance, consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor
b) Work with the Director of Finance and the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors
c) Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts
d) Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted
e) Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work
f) Meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit
g) Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, and the impact on the audit fee
h) Review all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

4.5 Other Board Assurance Functions

a) The Committee will initiate investigations or reviews of any matters within its scope of authority in response to any indicators or matters of concern arising at the Committee or raised elsewhere and referred to the Committee.
b) The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators and professional bodies with responsibility for the performance of staff or functions
c) The Committee shall review the work of other Committees within the organization, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework,

including the Clinical Governance Committee and the Finance and Performance Committee. In reviewing the work of the Clinical Governance Committee, and issues around clinical risk management, the Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function.

5). Reporting and Accountability

a) The Committee Chair shall report formally to the Trust Board of Directors through the template escalation report, and make recommendations the Committee deems appropriate on any area within its remit where action or improvement is needed
b) The Committee shall report to the Trust Board annually on its work in support of the Annual Governance Statement and Accounts
c) The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate
d) The Chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances
e) Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation
f) The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year
g) The Committee shall review its own terms of reference annually.

6) Conduct of Business

Administration

a) The Director of Corporate Governance shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

b) The Committee shall be supported administratively by the Director of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- minute the proceedings of all Committee meetings, and draft minutes of Committee meetings shall be made available promptly to all members of the Committee
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

Enabling the development and training of Committee members

c) The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

d) Meetings will be held at least quarterly, an additional meeting to review the draft annual report and accounts, with additional meetings where necessary.

Notice of meetings

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

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

Salisbury NHS Foundation Trust

Clinical Governance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose

The Committee has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board and the Chief Executive that high quality care is provided to patients throughout the Trust.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee (the Committee).

2.2. The Committee is a standing committee of the Board of Directors (the Board).

2.3. A non-executive Committee of the Trust Board of Directors has no executive powers, other than those specifically delegated in these Terms of Reference

2.4. The Committee is authorized to monitor, scrutinize and where appropriate, investigate any quality activity considered to be within its terms of reference

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Two Non-Executive Directors
- Medical Director, Director of Nursing (joint Lead executive)
- Chief Operating Officer

3.2. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.3. A Non-Executive Director shall be appointed as Chair of the Committee.

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director member or nominated deputy.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Any nominated deputy attending in place of a designated Committee member.
- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.
- The PA to the Director of Nursing and Medical Director will act as Secretary to the Committee.
- Governor observer

- The Director of Corporate Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

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

4.1. The function of the Committee is to ensure:

4.1.1. That the Board establishes and maintains compliance with health care standards including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission and statutory regulators of health care professionals (including NHS Improvement)

4.1.2. Provision of assurance that high quality care is provided to patients throughout the Trust, actively engaging with patients, staff and other key stakeholders as appropriate.

4.1.3. There is clear accountability for quality of care throughout the Trust including but not restricted to, systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate

4.1.4. Support for the Trust's objective to strive for continuous quality improvement and outcomes, through the Care and Innovation objectives.

4.1.5. Consideration of the clinical risks to the Trust's ability to achieve high quality care and continuous quality improvement through review of the Care and Innovation sections of the Board Assurance Framework

4.2. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

4.2.1. Development and Review

- Agree the annual quality plan (quality account priorities) and monitor progress**.**
- Extend the Boards monitoring and scrutiny of the standards of quality, compliance and performance of Trust services
- Make recommendations to the Board on opportunities for improvement in the quality of services
- Support and encourage quality improvement where opportunities are identified
- Working in conjunction with the Audit Committee, Workforce Committee and Finance and Performance Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each committee
- Review the Trust's Annual Quality Report prior to submission to the Trust's Board of Directors for approval
- Monitor the status of the Trust's quality objectives as set out in the Annual Plan
- Review the quality indicator report (forming part of the Integrated Performance Report) prior to inclusion in the Trust Integrated Performance Report.
- Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust

- Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, and patient safety
- Provide oversight of relevant Internal Audit recommendations as directed by the Audit Committee

4.2.2. Review of Trust activity in assigned area

Patient Safety:

- Agree the annual safety plan and monitor progress.
- Ensure risks to patients are minimised through application of a comprehensive risk management system in accordance with the risk management strategy. Identify areas of significant risk, set priorities and agree actions using the Assurance Framework and Corporate Risk Register process.
- Monitor and review the clinical risks in the Assurance Framework and corporate risk register as per the risk management strategy and policy.
- Assure that there are processes in place that safeguard adults and children within the trust and review the annual safeguarding adult and children's reports prior to submission to Trust Board
- Receive and review bi-annual reports from the Director of Infection Prevention and Control.

Clinical Effectiveness / Clinical Outcomes:

- Ensure that care is based on evidence of best practice and national guidance.
- Assure the implementation of all new procedures and technologies according to Trust policies
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.
- Review the Annual Clinical Audit plan and receive a bi-annual report on progress with the plan.

Patient Experience:

Assure that the Trust has reliable, real time, up to date information about what it is like to be a patient experiencing care in this hospital, to identify areas for improvement and ensure that these improvements are made. This will be provided through a comprehensive patient engagement programme. This will be achieved through:

- Review of the patient experience quarterly report
- Agree the annual patient experience/engagement plan and monitor progress.
- Receipt of reports regarding patient experience and engagement and review the results and outcomes of local and national patient surveys

Learning:

- Ensure the Trust is outward looking and incorporates learning and recommendations from external bodies into practice with mechanisms to monitor their delivery
- Request reports to monitor against action plans arising from Serious Incidents, complaints and Never Events to ensure Trust-wide learning.

4.2.3. Policy monitoring and review

Ensure the research programme and governance framework is implemented and monitored.

5. Conduct of Business

Administration

5.1. The PA to the Director of Nursing and Medical Director shall be Secretary to the Committee

5.2. The Committee shall be supported administratively by the PA to the Director of Nursing and Medical Director whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

The Head of Clinical Effectiveness will provide an escalation report to the Board of Directors following each meeting, in the public session where possible; agreed with the Committee Chair.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4. Meetings will be held at least nine times per year, with additional meetings where necessary.

Notice of meetings

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

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

Reporting

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

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner through the Board escalation report template.

5.9. Reporting arrangements into the Committee from Sub-Committees

The following groups and committees report to the Clinical Governance Committee:

- Clinical Management Board (Minutes and raising concerns)
- Infection Prevention and Control Committee (Minutes and raising concerns)
- Clinical Risk Group (Minutes and raising concerns)
- Children and Young People's Quality & Safety Board (Minutes and raising concerns)
- Integrated Safeguarding Committee (Minutes and raising concerns) NB: quarterly reports presented to the CGC.
- Organ Donation Committee (minutes and annual report)
- Safety Steering Group

6. Review

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

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

6.3. These terms of reference were approved by the Clinical Governance Committee with amendments and ratified by the Board of Directors on xxxxxx.

Salisbury NHS Foundation Trust

Finance & Performance Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Finance & Performance Committee
Adoption and ratification	Trust Board

1. Purpose

1.1. The Committee is established to provide the Board of Directors with assurance on the trust's financial and operational performance. The Committee also supports the Board's strategic direction and stewardship of the Trust's finances, investments and sustainability.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Finance & Performance Committee (the Committee).

2.2. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3. The Committee may take any legal or other professional advice with regard to the financial performance of the Trust as necessary.

2.4. The Committee is authorized by the Board to review, monitor, and where appropriate, investigate any financial matter within its terms of reference, and seek such information as it requires facilitating this activity.

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Four non-Executive Directors
- Director of Finance (Lead Executive)
- Chief Executive
- Chief Operating Officer
- Director of O.D. & People

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.

3.3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.4. Each member may nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least two Non-Executive Director member.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Core members defined in para 3.1 above
- Deputy Director of Finance
- Other directors and other staff by invitation
- Governor observer

The Director of Corporate Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

4. Roles and responsibilities

The aim of the Finance and Performance committee is to provide an objective view of the financial and operational performance, and financial strategy of the Trust, together with an understanding of the risks and assumptions within the Trust plans and projections.

The Committee will routinely consider four key reports in detail:

- The monthly performance report
- The monthly finance report,(including forecast outturn report quarterly)
- The monthly contracting monitoring report
- The monthly savings/transformation report

The duties of the committee can be categorised as follows:

Reporting

- To oversee the ongoing development of the Integrated Performance Report.

- To seek assurance that the measures incorporated in the Board report meet the requirements of external stakeholders.

- To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support operational management of the organisation.

- Monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.

- To review in detail via a deep dive any major performance variations, in order to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.

- To consider changes to the Trust reporting requirements under any new regulatory arrangements.

Financial and Operational performance management

- To undertake high-level, exception based monitoring of the delivery of operational and financial performance to ensure that the Trust is operating in line with its annual

business plan objectives and, where not, satisfy itself that appropriate action is being taken by Executive Directors;

- To take an overview of the Trust's performance against financial and performance objectives (including delivery of recovery and transformation plans) ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

- Review forecast performance against operational targets and improvement trajectories, escalating issues of non-delivery to the Board, and monitoring against achievement of any national funding (e.g. Provider sustainability funding).

- Monitor identification of schemes within the Cost Improvement Programme and overall forecast delivery, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Board of Directors.

- Review operational performance in relation to information technology, information governance, data quality and estates and facilities.

Income and Contracts management

- Review the Trust contracting approach with key commissioners

- Monitor in-year income against contract and levels of risk, including commissioner challenges, accrued income, fines and penalties, and income disputes.

- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

- Consider material opportunities to grow new commercial income streams and market share of existing services.

Annual Trust planning cycle

- To consider the Trust's medium & long term financial strategy, in relation to both revenue and capital.

- To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business plans, including workforce plans, linked to the Trust's Corporate Objectives.

- To ensure that the Trust has an appropriate Recovery and Transformation Programme in place and provide Board level oversight of its delivery

- Consider proposals for Commercial and Business Development activities in accordance with Standing Financial instructions.

- Review the process for developing the transformation plan and for the oversight and delivery of the programme within the Trust. Consider and recommend any major transformation programmes that the Trust should undertake.

- Review the annual CIP and transformation plan to provide assurance that delivery risk is minimised and productivity and efficiency maximised, in particular that contingency, phasing and risk mitigation plans are appropriate and that savings programmes are realistic and deliverable.

- Receive benchmarking and other information (for example from Carter metrics) to assess Trust productivity and ensure targeting or efficiency programmes.

- Review the Trust procurement strategy, systems and arrangements for obtaining best value. Monitor progress against the NHS standards of Procurement within the Trust.

Capital management

- Review the strategic five year capital programme and the annual capital budgets and recommend as appropriate to the Board of Directors;

- To consider the financial proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Approve capital business cases in accordance with the Trust's Detailed Scheme of Delegation (DSoD).

Treasury management

- To review the cash position of the Trust and the related treasury management policies of the Trust;
- Review Trust finance applications including loan applications.

Risk Management

- The Committee shall ensure the Trust has robust financial and operational risk management systems and processes in place.

Other

- To review any matter referred to this committee by the Board of Directors;

- To make arrangements as necessary to ensure that all Board members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.

- To notify the Audit Committee of any statutory reporting concerns or system weaknesses identified.

5. Conduct of Business

Administration

5.1. The Corporate Governance Manager shall be Secretary to the Committee

5.2. The Committee shall be supported administratively by the Corporate Governance Manager, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible in conjunction with the Committee Chair.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4. Meetings will be held at least twelve times per year, with additional meetings where necessary.

Notice of meetings

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

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

Reporting

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

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

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

6. Review

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

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

Salisbury NHS Foundation Trust

Workforce Committee Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
April 2018	1	Approved version	Approved by the Trust Board of Directors	
February 2019	2	Major	All sections revised	

Date Adopted	~~April 2018~~
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose and function

1.1 The purpose of the Committee is to ensure that the Trust has a workforce strategy in place that recognises the importance of all of the people who work within the Trust, and that will enable it to recruit and retain sufficient numbers of people with the necessary skills, training and motivation to deliver its clinical objectives. Specifically:

- That the Trust has a clear understanding of its strategic workforce needs and that plans are in place to deliver these;
- That the Board receive assurance that all legislative and regulatory requirements relating to the workforce are met;
- That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented.

1.2 To achieve this, the Committee shall:

- Support the development and monitoring of a workforce strategy
- Champion workforce issues ensuring adequate oversight of all workforce areas by the Board.

1.3 The Committee shall discharge this function on behalf of the Board of Directors by:

- Monitoring key workforce metrics to ensure that the expected standards are being delivered
- Receiving reports to provide assurance around compliance with legislation and regulations
- Considering workforce plans and improvement plans on behalf of the Board

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Workforce Committee (the Committee).

2.2. The Committee is a standing committee of the Board of Directors (the Board).

2.3. The Committee is a Non-Executive Committee and has no Executive powers.

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Three Non-Executive Directors
- Director of Organisational Development (OD) & People (Lead Executive)
- Medical Director
- Director of Nursing

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.

3.3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least one Non-Executive Director member or nominated deputy.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

Deputy Director of OD & People	Deputy Director of Nursing
Associate Director of Education, Inclusion, Communication and Engagement	
Director of Medical Education	
And others by invitation	

The Director of Corporate Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

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

4.1. Developing and advising the Board on a workforce strategy taking into account relevant best practice and alignment with strategic objectives for the Trust

4.2. Oversight and monitoring of the People section of the Board Assurance Framework to ensure appropriate risk management

4.3. Oversight of the delivery of the HR operating plan and associated policy management which includes but is not restricted to:

- Equality and Diversity
- Staff engagement
- Staff well-being
- Health and Safety
- Performance management
- Workforce planning
- Management and Leadership Development
- Organisational development
- Medical and clinical education
- Apprenticeships
- Essential training
- Recruitment and retention
- Talent management
- ESR optimization
- E-rostering
- Bullying and harassment

4.4. Oversight of the development and delivery of the People Strategy and people aspect of the Clinical Strategy

4.5. Oversight and development of actions in response to local and National staff surveys

4.6. Monitoring an agreed set of HR related Key Performance Indicators

4.7. Receipt and review of the Workforce Report prior to submission to Trust Board as part of the Integrated Performance Report

4.8. Oversee the implementation of Internal Audit recommendations as directed by the Audit Committee

4.9. To receive and review reports of the Guardian of Safe Working on the Board's behalf

4.10. To receive and review reports of the Freedom to Speak up Guardian

4.11. To receive and review Safe Staffing reports

5. Conduct of Business

Administration

5.1. The PA to the Director of OD and People shall be Secretary to the Committee

5.2. The Committee shall be supported administratively by the PA to the Director of OD and People whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4. Meetings will be held at least six times per year, with additional meetings where necessary.

Notice of meetings

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

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

Reporting

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

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board through use of the Board Escalation Report template. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

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

5.10. The Committee will receive, for oversight and information, the minutes of the following committees:

- Medical Education and Training Committee
- Diversity and Inclusion Committee
- Health and Safety Committee
- JCC
- JNC
- Safe Staffing Steering Group

6. Review

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

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

6.3. These terms of reference were approved by the Workforce Committee with amendments on ~~26 March 2018~~ and ratified by the Board of Directors on ~~12 April 2018.~~

Salisbury NHS Foundation Trust

Strategy Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
March 2018	1	Approved version	Approved by the Trust Board of Directors	Director of Corporate Development
March 2019	2	Minor	Inclusion of oversight of the Estates Strategy	Director of Corporate Governance

Date Adopted	~~March 2018~~
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Development
Review and Approval	Strategy Committee
Adoption and ratification	Board of Directors

1. Purpose

The Committee is established to provide the Board of Directors with assurance on development of the Trust strategy and particularly progress with developing new models of care, many of which will be related to the whole site redevelopment project.

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Strategy Committee ("the Committee").

2.2. The Committee is a standing committee of the Board of Directors (the Board).

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- 2 Non-Executive Directors
- Chief Executive Officer
- Director of Corporate Development
- Director of Finance
- Director of Nursing / Medical Director

3.2. A Non-Executive Director shall be appointed Chair of the Committee.

3.3. Two clinical members of staff shall be invited to be in attendance

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These deputies will have voting rights.

Quorum

3.5. Quorum shall be at least half the members being present, including at least one Non-Executive Director.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

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

4.1. The duties of the Committee can be described as follows:

4.1.1. Strategy Development:

- To oversee the development of the Trust strategy, embracing all matters of long-term, medium-term and short-term planning. To ensure the alignment of all aspects of the Trust's strategy and planning, in relation to operational, financial, technical and human resource planning
- To consider the impact of major external changes and the possible impact on the organisation's strategy, including the impact of STP-wide developments
- To monitor strategic risks and assess the degree to which the strategy needs to be adapted to address those risks

4.1.2. Monitoring of Delivery of the Strategy

- To consider performance against agreed plans KPIs and on a three times a year provide feedback to the Board of Directors on the effectiveness of strategy implementation in meeting the Trust's objectives, linked to presentation of the Board Assurance Framework.

4.1.3. Review of Major Projects

- To oversee the development of major schemes, linking in with the Finance & Performance Committee and the Outstanding Every Time Board on the transformational aspects of such projects, and advise the Board on progress with those schemes. The projects to include:
  - The Salisbury campus programme and how the site can be adapted to facilitate a major clinical transformation programme and to bring on site a range of services and industries from different sectors (Estates Strategy).
  - The development of new models of care taking forward opportunities to transform how services are provided and delivering services which are

more integrated with other health and care providers in line with the Trust strategy.

- Development of the Trust's Digital Strategy and subsequent monitoring of delivery against the strategy

5. Conduct of Business

Administration

5.1. The Head of Corporate Governance shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

5.2. The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Meetings will be held at least six times per year, with additional meetings where necessary.

Notice of meetings

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

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

Reporting

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

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

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

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

6. Review

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

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

Salisbury NHS Foundation Trust

Subsidiary governance Committee: Terms of Reference

1. Purpose

The Committee is established to provide the Board of Directors with assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company (known as related company/entity).

Date Adopted	15/03/2019
Review Frequency	Annual
Terms of Reference Drafting	Director of Finance
Review and Approval	Trust Board
Adoption and ratification	Trust Board

2. The committee is established to:

- Ensure that where the Trust has an interest, or shareholding, the Trust has appropriate oversight and governance

3. Authority

3.1. The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Subsidiary Governance Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3.2. The Committee is a standing committee of the Board of Directors (the Board).

3.3. The Committee is authorised to:

- Perform any of the activities within its terms of reference;
- Obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- Consider and make recommendations to the Board of Directors any and all items of which they should be aware to fulfil their responsibility

4. Membership and Attendance

Membership

4.1. The Committee shall be appointed by the Board of Directors and shall consist of:

2 Non-Executive Directors

Independent Chairman of OML and STL

Director of Finance

Director of Organisational Development and People.

A Non-Executive Director shall be appointed as Chair of the Committee. In the absence of the Chair, a Non-Executive Committee member will perform this role.

4.2. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

4.3. Three voting members of the Board of Directors (at least one Executive Director and one Non-Executive Director). A nominated Deputy for the Director of Finance must be in attendance if the Director of Finance is absent.

Attendance (non-voting members)

4.4. Meetings of the Committee shall be attended by:

- Director of Procurement and commercial services
- Director of Corporate Governance
- Specialist expertise as required

Attendance by Other Trustees

4.5. Any member of the Board of Directors can attend.

4.6. Note: All Board of Directors will be sent copies of the agenda for each meeting and may attend the meeting should they wish to do so.

5. Roles and Responsibilities

The duties of the Committee can be categorised as follows:

5.1. Ensuring the Trust has a clear strategy for the use and development of subsidiary and related companies/entities.

5.2. Maintaining a clear view of the subsidiary level risk profile and exposure (operational, reputational and financial) across the group profile.

5.3. Ensuring the Trust has a clear governance framework and structure for oversight of any related company/entity. This framework will ensure:

- That any related company/entity identifies and evaluates all potential commercial opportunities in line with its agreed strategy.
- That any related company/entity complies with its relevant industry regulatory framework.
- That the related company/entity achieves the planned financial and operational performance levels.
- That the related company/entity has due regard for the issue of public accountability in the context of ethical responsibilities, corporate and social responsibility, statutes and other regulations e.g. tax.
- That the related company/entity has appropriate governance mechanisms in place (including SFI's, business planning process).
- The process for appointing the senior leadership team (Managing Director, Non-Executive Directors).

6. Conduct of Business

Administration

The Director of Corporate Governance is a member of the committee and has corporate responsibility for:

6.1. Liaising with the chair on all aspects of the work of the committee, including providing advice.

6.2. Ensuring the committee acts in accordance with standing orders and scheme of reservation and delegation.

6.3. Identifying an officer to undertake the role of secretary.

Frequency

6.4. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

6.5. Meetings will be held no less than four times per year, with additional meetings where necessary.

Notice of meetings

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

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

Reporting

6.8. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

6.9. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

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

6.11. Any items of specific concern or which require the Board of Directors approval will be subject to a separate report.

7. Review

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

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	16
Date of Meeting:	04 April 2019		

Report Title:	Integrated Governance Framework			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):				
Appendices (list if applicable):	Integrated Governance Framework – March 2019			

Recommendation:
The Trust Board is asked to approve the revised Integrated Governance Framework, March 2019

Executive Summary:
Following a review of the Trust's Integrated Governance Framework a number of minor changes have been made to bring the document up to date. The attached contains tracked changes to enable Board members to easily identify the revisions that have been made. Amendments include: • Recognition of changes to Board level Committees including the establishment of the Subsidiary Governance Committee and the Charitable Funds Committee • Incorporation of the role of the new Directorate Governance Committees • Re-presentation of some aspects of the document's content to remove duplication between the main body of the document and its appendices • Combining information from two appendices into one to form a new appendix 1 providing an overview of the Committees which report to Board with a summary of their roles • Minor adjustments to reflect current working terminology

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

INTEGRATED GOVERNANCE FRAMEWORK

~~April 2018~~
March 2019

	Contents	Page

1. INTRODUCTION

Integrated Governance is the means by which the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of the delivery of "an outstanding experience for every patient", by an organisation that is well managed, cost effective and has a skilled and motivated workforce.

Salisbury NHS Foundation Trust is committed to operating by the principles of good governance. This framework sets out to describe the system of integrated governance used within the Trust with particular reference to the provision of quality services.

This document is underpinned by the Accountability Framework which specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focussing across the breadth of quality, operations, finance and workforce.

2. STRATEGIC OBJECTIVES

The Trust's strategic objectives are set out in its 2018-20 strategy. Underpinning delivery of these objectives, there is a business planning process. The corporate goals are:

Local Services - Our aim is to meet the needs of the local population by developing new and improved ways of working which always put the patient 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 – more than 11 million across Southern England for the Spinal Centre and over three million for patients across Wessex for burns and plastics, cleft lip and palate, genomics and specialist rehabilitation services.

Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of the Trust.

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 an outstanding place to work where everyone feels valued, supported and engaged 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.

3. SCOPE OF THE FRAMEWORK FOR INTEGRATED GOVERNANCE

Integrated Governance is based on the understanding that all elements of governance are important and they should not be managed in silos. To achieve focused decision-making and deliver strategic objectives, the Board considers all aspects of accountability in the round. This framework sets out the principal strands of governance and describes how Salisbury FT arrangements bring these together.

4 ELEMENTS OF GOVERNANCE

4.1 Corporate Governance

The term is used in the NHS to mean the system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness. Corporate governance, led by the Trust Board, is about achieving objectives, providing quality services and delivering value for money.

4.2 Financial Governance

Financial governance will be the responsibility of the Board supported by the Audit Committee, (governance, risk management and internal control, internal audit; external audit, other assurance functions, counter fraud, financial reporting and raising concerns) and the Finance & Performance Committee (financial strategy and policies, effective and efficient use of resources, appraise annual budgets, cost improvement plans, financial issue management, performance reporting and management~~, performance management and strategy overview~~).

Standing Orders and Standing Financial Instructions

The Trust Constitution, Standing Orders and Standing Financial Instructions provide the regulatory framework for the financial conduct of the Trust. This includes guidance on delegation limits and procurement rules. The Constitution sets out the workings of the Foundation Trust – the membership, Council and Board. Appendices to the Constitution include formal procedures for the conduct of meetings and membership elections.

4.3 Clinical Governance

This is a responsibility of the Trust Board, supported by the Clinical Governance

Committee for continuously improving the quality of the services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical governance is the mechanism for understanding and learning, to promote the components that facilitate the delivery of quality care: candour, learning, questioning, a just culture, and excellent leadership.

Demonstrating Quality

The Integrated Governance Framework will provide evidence to the Trust Board through demonstrating its compliance with the quality and safety standards relevant to an NHS provider organisation. This will include: Quality Accounts national framework, Data Security and Protection Toolkit,~~Information Governance Toolkit~~, CQC standards and the Trust's performance monitoring framework.

4.4 Risk Management Strategy & Board Assurance Framework

The Risk Management Strategy and Board Assurance Framework enable the Trust to manage risk at all levels in the organisation.

The key objectives of the risk framework are to:

- Ensure that the Board Assurance Framework is a dynamic Board assurance tool, underpinned by the Corporate and Directorate Risk Registers
- Clearly evidence the control and management of risk to achieve the Trust's strategic aims and objectives.
- Provide assurance that the Trust has an appropriate Assurance Framework in place and adheres to guidance on the Annual Governance Statement.
- Ensure that principal risks to meeting corporate objectives are identified and mitigated to an acceptable level.

The Board will be responsible for the Board Assurance framework, but the Audit Committee will undertake scrutiny and review of the evidence, to provide assurance to the Board, supported by the fivefour assuring committees;, Strategy Committee, Clinical Governance Committee, and Finance & Performance Committee, Workforce Committee and Subsidiary Governance Committee and also the Trust Management Committee.

The Board Assurance Framework is reported to the Trust Board at every quarterly public meetings, with a detailed review undertaken in advance by the assurance committees.

4.5 The Role of the Trust Board

Comprising executive and non-executive directors, the Trust Board will work actively to promote and demonstrate the values and behaviours which underpin integrated governance.

It will ensure a balanced focus on all aspects of its business.

Further to this:

- The Integrated Governance Framework ensures the Board and its committees are structured effectively and properly constituted.
- The Board will ensure it promotes a culture where patients are at the centre; staff learn from experience; and the Trust engages with patients, ~~and~~ the public and partners to develop services in the future.
- Board business cycles will be clearly set out with actions implemented.
- The Board will ensure codes of conduct are upheld and the public service values of accountability, probity and openness in the conduct of business are maintained.
- Board members will receive appropriate induction and ongoing training and development to ensure they can undertake their responsibilities effectively and appropriately.

Charitable Trustees

The Trust Board is the corporate trustee of the Salisbury District Hospital Charitable Fund, known as the STARS appeal. Members of the Board meet ~~periodically~~ quarterly as the Charitable ~~Trustees~~ Funds Committee to oversee the work of the charity, decide how charitable money should be used to support the hospital, manage its investments and the reporting requirements to the Charity Commission.

4.6 Annual Governance Statement

The Annual Governance Statement (AGS) is produced and signed off by the Accounting Officer having regard to the model template and following discussion at the Audit Committee and comment from the auditors on the effectiveness of the Trust's internal controls. This is supported by the Board Assurance Framework and the underpinning Trust risk management arrangements.

Any significant weaknesses identified in the Trust's internal control mechanisms are highlighted in the AGS, together with the actions necessary to address the issues reported on.

5 INTEGRATED GOVERNANCE FRAMEWORK

The following describes the Trust's Integrated Performance Management Framework.

Committee	Membership	Principal Reporting Documents
Level 1: SFT Trust Board		
Trust Board	All directors	Corporate Strategy Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management Performance Reports – quality, workforce, operations, finance Board Committee supporting information Customer Care and Legal Reports
Board Committees	Non-Executive Directors, CEO and lead Executives	Presentation on key performance information, including detailed information and actions on any key business targets currently being failed Scrutiny of the Trust's commercial holdings Scrutiny and assurance regarding risks and adequacy of actions Escalation actions from Directorate Performance Reviews (by exception)
↕		
Level 2: Review of Directorate Management		
Executive Performance Review Meetings	Lead Executives Directorate Management Team HR and Finance Business Partners	Detailed performance dashboard for Directorate Directorate commentary Risk Registers Other issues by exception

		
Level 3: Directorate management		
Directorate Management Committees	Directorate Management Committee, HR and Finance Business Partners	Directorate performance dashboard Individual dashboards, locally held performance information, and directorate risk register
Directorate Governance Committees		Team/specialty goals and measures Improvement as set out in the Trust's Annual Quality Account Annual CQUIN indicators Patient Safety Clinical Effectiveness Patient Experience
		
Level 4: Specialty / Service Line		
Specialty and department review process	Directorate Management Committee, HR and Finance Business Partners Specialty Director, Service Lead and Senior Sister	Specialty-level performance dashboard Individual dashboards, locally held performance information, Risk assessment and mitigation
		
Level 5: Team / Individual		
Ward and clinical area reviews	Specialty Director, and Service Lead, with Ward Sister or equivalent	Ward trigger tools and dashboards, budget review and other specific governance indicators
Individual performance management arrangements (non-medical)	Individual line manager	Agree objectives Appraisal and appraisal documentation

6. COMMITTEES

The Board's purpose is to govern effectively and in doing so build patient, public and stakeholder confidence that sustained, quality services are delivered. A number of meetings and processes support the Board in its role.

Level 1: Assurance Committees of the Board

6.1 Audit Committee

The Audit Committee's terms of reference detail its role in providing assurance by independently and objectively monitoring and reviewing the Trust's processes of integrated governance, risk management, assurance and internal control and, where appropriate, to require the Executive to instigate actions necessary to mitigate gaps.

The Committee fulfils its governance and accounting responsibilities by consideration of the integrity, completeness and clarity of annual accounts and the risks and controls around its management.

The Committee adopts a risk-based approach, but this does not, however, preclude the Committee from investigating, any specific matter relevant to their purpose.

Principal functions:

To oversee the governance and management of risk and internal control including the provision of the following:

- Governance
- Risk Management
- Internal Audit
- External Audit
- Other Assurance Functions
- Counter Fraud
- Financial Reporting
- Raising Concerns

6.2 Clinical Governance Committee

The Clinical Governance Committee's terms of reference detail its responsibility in delivering clinical governance and the quality agenda i.e. patient safety, clinical effectiveness and patient experience.

The Committee reviews the Quality Account and agrees priorities for the forthcoming year and monitoring of the current year.

The Committee provides assurance to the Board, through ensuring the supporting processes are embedded and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

Principal functions:

To provide assurance to the Board on:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Service Improvement and Change Management

6.3 Finance & Performance Committee

The Finance & Performance Committee provides assurance to the Board that the finance and performance of the Trust is meeting its targets and proposes mitigating strategies as required. It will do this through continual review of financial, risk and performance issues. The Committee has delegated powers to scrutinise, on behalf of the Board, all high level operational matters and finance related matters, providing assurance regarding reported results and compliance with NHS Improvement requirements.

Principal functions:

To provide assurance on and scrutinise high level operational and finance related matters, providing assurance to the Board regarding reported results and compliance with NHSI requirements and in particular:

- Financial strategy, policy, management and reporting
- Management and reporting Performance
- Monitoring Cost Improvement Programme
- Operational performance

6.4 Workforce Committee

The Workforce Committee has responsibility for the delivery and assurance of the People Strategy. In addition it has responsibility for:

- ensuring the mechanisms are in place to support the development of leadership capacity and capability within the Trust
- the development and design of the workforce, to ensure that the Trust has productive staff, with the skills, competencies and information to meet the required contractual obligations

- the mechanisms of improving how the Trust engages with its workforce so that they are motivated to do the best they can for the organisation and for the communities the Trust serves;
- Organisational Development and Change Management.

Principal functions:

To provide assurance on:

- Workforce Effectiveness Programme
- HR Strategy
- Scrutiny of Workforce Performance
- Organisational Development
- Policies and Procedures
- Key workforce KPIs
- Compliance with employment legislation
- Educational and professional development
- Recruitment and retention
- Staff engagement
- Change Management
- Occupational therapy and counselling services
- Service Improvement and Change Management

6.5 Strategy Committee

The Strategy Committee provides the Board of Directors with assurance on development and delivery of the Trust's strategy and particularly progress with developing new models of care, many of which will be related to the whole site redevelopment project. It also leads on the development of a digital strategy.

Principal functions:

- Development of the Trust Strategy
- Monitoring of delivery of the trust strategy
- Oversight of the One Estate project
- Development of new models of care
- Development of Digital Strategy

6.6 Subsidiary Governance Committee

The Subsidiary Governance Committee was established late 2018 to provide assurance to the Board of Directors on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company. Meetings commenced in early 2019.

Principal Functions:

- Oversight of the subsidiary level risk profile and exposure
- Ensuring a governance framework and structure for oversight of any related company/entity

6.7 Remuneration Committee

The purpose of the Remuneration Committee is to ensure there is a fair and transparent procedure for developing and maintaining policy on executive remuneration and for setting the remuneration packages of individual Directors.

Specifically, the Committee will make decisions, on behalf of the Board, on the appropriate remuneration and terms of service for the Chief Executive, Executive Directors within the remit of the Remuneration Committee, including:

- all aspects of salary, including any performance related/bonus elements;
- arrangements for termination of employment and other contractual terms;
- monitor and evaluate the performance of the Chief Executive and Executive Directors;
- succession planning

6.~~8~~6 Level 2 – Review of Directorate Management

Executive Performance Review Meetings are held monthly with the clinical Directorates, consisting of three executive directors and each Directorate Management ~~Committee~~ Team to review performance across quality, finance, operations, and workforce. The reviews have been extended in early 2019 to include Corporate Functions.

Further detail is given in the Accountability Framework.

Level 3: Directorate Arrangements

6.~~7~~9 Directorate Clinical Governance Arrangements

The Trust manages the delivery of its services through a directorate structure with each accountable for its contribution to the Trust's strategic objectives and integrated business plan. Authority to act is set out in the Trust's Scheme of Delegation and Accountability Framework as appropriate to each individual post or generic staff group.

There are also specific corporate functions in place to support the Directorates to achieve their objectives and to provide assurance to the Trust Board in its performance management role. These include: finance; human resources; quality; operations, and informatics.

6.~~8~~10 Directorate Management Committees

Each directorate is led and managed by a Directorate Management Team, made up of the Clinical Director, Directorate Manager and Directorate Senior Nurse.

This Directorate Management Committee is supported by Lead Clinicians, operational managers, and the corporate functions such as HR and Finance. For the Facilities Directorate, this is the Head of Service and General Managers.

The Directorate Management Committee is responsible for providing leadership within the clinical directorates. They ensure the Trust delivers an outstanding experience for every patient, which represents best value and includes working with partner organisations to deliver innovative models of care.

Directorate Management Committees, together with Specialty Leads, have specific roles and responsibilities to ensure that the care and treatment provided to patients meets with the Care Quality Commission's standards.

Each Directorate will have governance arrangements appropriate to their services as set out in the Accountability Framework.

6.11~~9~~ Level 4: Quality Assurance within Directorates

The Directorates will have in place arrangements for quality governance that is accountable, through the DMC and Directorate Governance Committee and escalation via the Executive Performance Meetings to the executive team.

Directorate Governance Committees will be held monthly. Standard Terms of Reference can be found in Appendix 6.

The scope of matters covered by Directorate Governance Committee agendas will include:

- Development of team/specialty quality goals and measures
- Areas designated for improvement as set out in the Trust's Annual Quality Account
- Achievement of indicators defined in the annual CQUIN payment framework.

Patient Safety:

- Morbidity and mortality reports
- Incident reports and trends including Serious Incident learning
- Learning from claims
- Directorate risk register items
- CAS alerts

- Infection, prevention and control issues

Clinical Effectiveness:

- Compliance with and implementation of national guidelines and standards, including the Care Quality Commission standards, NICE guidance, quality standards and pathways, together with any other statutory framework or set of standards relevant to the services provided by the directorate
- Clinical audits
- Research
- Information Governance

Patient Experience:

- Complaints and concerns themes/trends and identified action,
- Patient and Public involvement activity
- Ward-based audits

All of the above to include:

- the monitoring of progress against associated action plans.
- Monitor progress with current quality initiatives.
- Provide a forum for continuous improvement and development.
- The DMC will ensure that clinical specialties have relevant supporting/ parallel working arrangements.

Executive and Committees

6.120 Accounting Officer – Chief Executive

Under the Accounting Officer Memorandum, the Chief Executive is responsible for the stewardship of all the resources entrusted to the Trust. This role also carries extensive delegated authority from the Trust Board for the delivery of the Trust's services.

6.131 Trust Management Committee

The Trust Management Committee (TMC) comprises the Executive Directors, Clinical Directors, Directorate Managers and is the senior Executive committee. The purpose of TMC is to support the Chief Executive in ensuring the delivery of Trust services, meeting required financial, organisational and governance requirements.

The TMC brings together reports from, medicines management, information governance, operations, and health & safety (see appendix 3). Further information and Terms of Reference are ~~is~~ set out in the Accountability Framework.

Public accountability

6.142 Council of Governors

The Council of Governors comprises Public, Staff and Appointed governors and has a number of responsibilities to hold the Trust Board to account through the Non-executive directors, to appoint and remunerate the Non-executives, to appoint the Trust's auditor (in conjunction with the Audit Committee). It has an essential role in representing the views of the membership to the Trust Board.

Board Appointments

6.153 Nominations Committees

The non-executive directors are appointed by the Council of Governors and a Nominations Committee that is run jointly with the Board, oversees the appointments process. Executive Directors are appointed by a committee of the non-executive directors and the Chief Executive. The Chief Executive is appointed by the non-executive directors, and the appointment is subject to approval by the Council of Governors.

7. GOVERNANCE SUPPORT ARRANGEMENTS

Quality Directorate

The Quality Directorate provides trust-wide guidance, facilitation & support for the following elements of the integrated governance agenda, linked to Directorates:

- Collecting and storing evidence to support external assessments and preparing submissions to the CQC and NHS Resolve.
- Monitoring compliance with NICE guidelines and standards, alerts and other national frameworks.
- Producing the Trust's annual Quality Account
- Practice development associated with Patient Safety.
- CQUINs and clinical audit element of the annual contract.
- Risk management, including operational and corporate risk registers.
- Serious, critical and other Incident investigation and reporting.
- Aggregating learning from Incidents, Complaints, PALs, Claims, Mortality Review, Inquests and ~~Rule 43~~Regulation 28 letters.
- Monitoring and reporting with National Institute of Health Research and clinical Research Network high level objectives'
- Customer Care: Complaints and PALs
- Clinical audit programme
- Mortality review processes
- Administering the CAS process

The Trust's CQC registration is overseen by the Head of Corporate Governance.

8. SUSTAINABILITY & TRANSFORMATION PARTNERSHIP

The Trust is part of the Bath & North East Somerset, Swindon and Wiltshire Sustainability Partnership. Under its emergent plan the agencies that comprise the partnership are working to address five priorities:

1. ~~-~~Create locality-based integrated teams supporting primary care
2. Shift the focus of care from treatment to prevention and proactive care
3. We will develop an efficient infrastructure to support new care models
4. Establish a flexible and collaborative approach to workforce
5 Enable better collaboration between acute providers

The Trust Board will receive periodic updates on progress being made through the partnership.

9. MONITORING AND REPORTING PROCESS

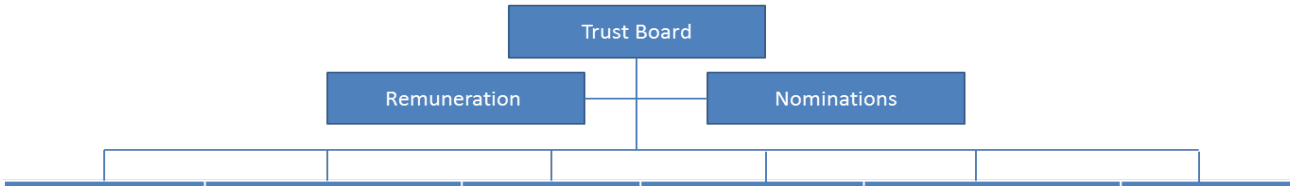
The Trust Board monitors the delivery of this framework primarily through report~~sing~~ to the Board from the following committees:

- Audit
- Finance & Performance
- Clinical Governance
- Strategy
- Workforce
- Subsidiary Governance

In addition, reports will be received from internal and external audit, and other regulatory bodies to provide independent assurance to the Board. ~~and their inspections evidenced by integrated reports to provide further assurance directly to Trust Board, such as equalities, infection control or safe working for trainees.~~

All committees receive reports and regular monitoring information as set out in ~~the workstream structures~~ each Committee's workplan. This covers all principal strands of governance as part of the Trust-wide assurance framework.

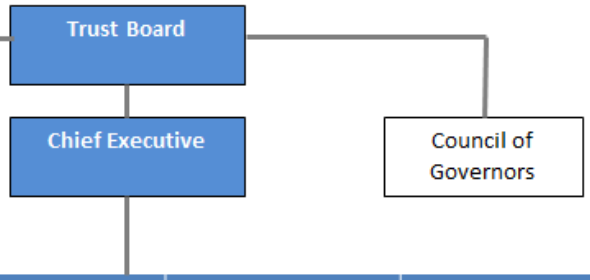
Appendix 1: Overview of Committees that report to Trust Board



Audit	Finance & Performance	Clinical Governance	Strategy	Workforce	Subsidiary Governance
To oversee the governance and management of risk and internal control including the provision of the following: -Governance -Risk Management -Internal Audit -External Audit -Other Assurance functions -Counter Fraud -Financial reporting -Raising concerns	To provide assurance and scrutinise high level operational and finance related matters, providing assurance to Board regarding reported results and compliance with NHSI requirements, in particular: -financial strategy, policy, management and reporting -Performance management and reporting -service improvement and change management -monitoring cost improvement programme -Operational performance	To provide assurance on: -Patient safety -Clinical effectiveness -Patient experience -Service improvement and change management	To provide assurance on development of the Trust strategy and particularly progress with developing new models of care, many of which will be related to the whole site redevelopment project: -Development of the Trust Strategy -Monitoring of delivery of the Trust strategy -Oversight of the One Estate project -Development of new models of care -Development of Digital Strategy	To provide assurance on: -workforce effectiveness programme -HR strategy -Scrutiny of workforce performance -Organisational Development -Policies and procedures -Key workforce KPIs -Compliance with employment legislation -Educational & professional development -Recruitment & retention -Staff engagement -Change management -Occupational therapy & counselling services -Service improvement and change	To provide assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholdin or interest in a company: -Oversight of the subsidiary level ri profile and exposure -Ensuring a governance framework and structure for oversight of any related company/entity

Committee reporting comprises an Escalation Report prepared by the Chairman of the committee and Lead Executive, and is supported by the minutes presented to the Trust Board.

Appendix 2 – Committee structure and accountability of direct reports to Chief Executive



Medical Director (Executive)	Director of Nursing (Executive)	Chief Operating Officer (Executive)	Director of Finance (Executive)	Director of People & OD (Executive)	Director of Transformation	Director of Corporate Governance
Themes Professional leadership Responsible Officer (Medical Appraisal) Clinical Effectiveness Caldicott Guardian Mortality Reviews Research Medical Education	**Themes** Nursing, Midwifery, Therapy workforce Patient Safety Patient experience Risk management Litigation Customer Care Adult and children's safeguarding DIPC	**Themes** Operation Performance Facilities Medical Equipment Emergency planning	**Themes** Financial Recovery Plan Contracting Procurement Financial Control Trust-owned companies Capital control Site development	**Themes** Organisational development Education Equalities Occupational Health Volunteers	**Themes** Cost improvement planning Informatics Information governance Policy planning SIRO	**Themes** Corporate Governance Well-Led Board Assurance Framework Board and Committee business and standards Integrated Governance Framework Foundation Trust Governors and members function

Directorate Management Committees			
Medicine	Surgery	Clinical Support & Family Services	Musculo-skeletal

Note: Executive Directors are Board level positions

Appendix ~~5~~2 continued: Accountability of Direct Reports to the Chief Executive

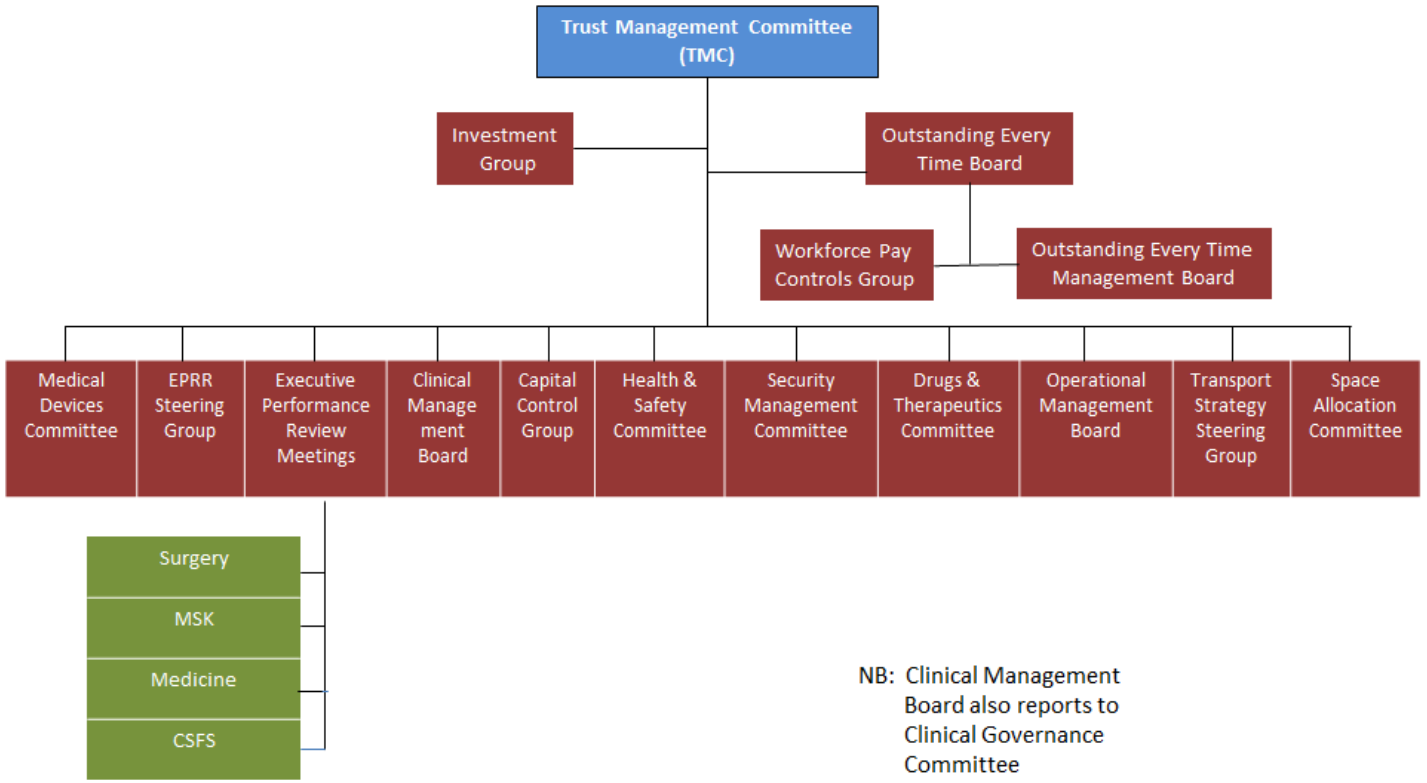
Note: Executive Directors are Board level positions

	Lead for Board Objective
Chief Executive Officer	Delivery of strategic and corporate objectives Working across the wider health and social care system Financial Recovery Plan Accounting Officer for Annual Governance Statement Executive governance arrangements Corporate governance – policies and compliance Board Assurance Framework
Chief Operating Officer (Executive Director)	Clinical Directorates and Facilities Service delivery; transformation and improvement Change management/CIP programme Performance delivery of directorates Accountable Officer for emergency planning and business continuity Medical Equipment Security Management Estates Hard Facilities Management
Medical Director (Executive Director)	Professional leadership – medical Responsible Officer (Medical Appraisal) Clinical Effectiveness Quality Account (joint with Director of Nursing) Caldicott Guardian Mortality reviews Clinical audit and effectiveness Medical-legal matters Research and Development Medical Education QIA approval (joint with Director of Nursing) Medicines Management Joint management of the Quality Directorate (with Director of Nursing) Chief Knowledge Officer

Director of Nursing (Executive Director)	Professional lead – nursing, midwifery, therapists Patient Safety Patient Experience Quality Account (joint with MD) Joint management of the Quality Directorate with Medical Director Risk management Infection, prevention and control (DIPC) Safeguarding adults and children Legal Services CQC lead (liaison and reporting) QIA approval (joint with Medical Director) CQUIN and Quality Schedule negotiation
Director of Finance (Executive Director)	Financial Recovery Plan Financial planning and performance Financial management and accounting Audit and counter fraud Performance management Oversight Capital planning and management Commissioning and Contracting Payroll Procurement Charitable Trustees Trust-owned companies and Wholly Owned Subsidiary project Wiltshire Health & Care Estate strategy and management Trust Strategy and business planning GP relationships Commercial – tenders co-ordination
Director of People & Organisational Development (Executive Director)	Human resources Health & Safety Learning, Training and development Equality and diversity (staff, patient and public) Corporate Communications Volunteers Chaplaincy Fire Safety Occupational Health Employment law Staff involvement Radiological Protection lead

Director of ~~Corporate Development~~ Transformation	~~Estates Strategy and Management~~ Chief Information Officer Chief Clinical Information Officer ~~Hard Facilities Management~~ ~~Trust Strategy and business planning~~ Information Governance and records management ~~GP relationships~~ ~~Commercial – tenders co-ordination~~ Informatics ~~Sustainability & Transformation Partnership~~ Senior information risk owner (SIRO)
Director of Corporate Governance	Corporate Governance Well-Led Board Assurance Framework Board and Committee business and standards Integrated Governance Framework Foundation Trust Governors and members function

Appendix 3: Executive Groups reporting to Trust Management Committee (TMC)



NB: Clinical Management Board also reports to Clinical Governance Committee

Appendix ~~6A~~ 4 – Annual review of Committees

In devising their annual reviews, committees are requested to follow the template set out here

1. Conduct of business throughout the year

- Committee membership and any changes
- Frequency of meetings and register of attendances
- Administration arrangements
- Reports to Board

2. Terms of Reference

- Delivery against terms of reference and work programme
- Key decisions or recommendations
- Key risks identified and mitigations
- Key issues managed or escalated to board
- Any changes made~~,~~ or requested to the Terms of Reference

3. Future plans

- Areas of focus ~~in~~ for the coming year

4. Timings of reviews

- ~~Audit and Remuneration committees: April to fit into Annual Report~~
- ~~Finance & Performance and Strategy – September~~
- ~~Clinical Governance – October~~
- ~~Workforce – November~~

Committees to review their effectiveness in Quarter 1 each year.

A report providing an overview of the outcomes of this process will be presented to the Board at their meeting in public in August each year.

.

Appendix 5 ~~6B~~ – Terms of Reference of Board Committees [to be added]

Appendix 6 – Standard Terms of Reference of Directorate Governance Committees

??? DIRECTORATE GOVERNANCE COMMITTEE
Terms of Reference

1. Constitution

Directorate Governance Committees are established to form part of the Directorate assurance function in conjunction with the Directorate Management Committees. The Governance Committees have no executive powers, other than those specifically delegated in these terms of reference.

The **???** Directorate comprises of the following Specialties insert specialties below relevant to Directorate:

- Urgent Care.
- Medicine.
- Older Persons Medicine.etc

2. Purpose

The purpose of the Directorate Governance Committee is to ensure effective governance and quality assurance to support the organisational structure and corporate objectives; hence promoting a positive and responsible culture, and one which supports continuous quality improvement.

The Committee is responsible for the local delivery of the Trust's Corporate Objectives, ensuring that local standards are met and concerns and risks that have been identified locally are effectively managed.

The Committee will take into account Care Quality Commission (CQC) Fundamental Standards, national best practice guidelines, including National Strategies and associated improvement strategies, NICE guidance and NPSA guidance.

The Committee will also consider the implications arising out of national reports and enquiries relevant to the Directorate, including the National Confidential Enquiries and will consider the outcomes of the national audit programme co-ordinated by the Healthcare Quality Improvement Partnership (HQIP).

The above will provide assurance that the risks associated with the Directorate activities are appropriately managed and that there is continuous quality improvement.

3. Objectives

To ensure effective governance arrangements by:

- Developing, implementing and monitoring a Directorate Quality Improvement Plan (QIP) to address actions arising from incidents, complaints, patient feedback, audit and other quality intelligence. The aim of the plan is to drive quality improvement across the Directorate.
- Monitoring and ensuring compliance with the complaints process, including oversight of compliance with response deadlines and quality of the complaint response.
- Monitoring and ensuring compliance with the incident process, including oversight of compliance with timely review and closure of incidents including the mandated timeframes for investigation and report completion. In addition, ensuring reports are of high quality and address any concerns raised by patients, carers and families.
- Ensuring compliance with the Duty of Candour requirements with meaningful engagement with patients, carers and families when dealing with complaints and incidents.

- Providing oversight of risk management across the Directorate. This will include ensuring the Directorate risk register is current, regularly reviewed, that risks are appropriately graded and actions are appropriate to mitigate the risk in line with the Risk Management Strategy and Policy.
- Ensuring development of monitoring systems to provide the committee that activity is being carried out appropriately.
- Ensuring compliance with the Information Governance Compliance requirements.
- Development of a risk based, annual clinical audit plan and providing an annual audit report.
- Triangulation of all quality intelligence (related to safety, experience and outcomes) to understand the functioning of the Directorate in respect of the quality of care and outcome for patients.
- Receiving regular reports from Specialties to obtain assurance of effective governance, audit and risk management.
- Sharing learning from quality intelligence across the Directorate, and organisation as appropriate, through a variety of methods to ensure all staff are communicated with effectively to support sustainable change.
- Any points for escalation will be through the Executive Performance Reviews.
- Promoting a just and open culture where continuous quality improvement is encouraged and internal scrutiny is seen as an integral and seamless component in the delivery of healthcare.
- Monitoring Directorate compliance with all local and national quality standards, including the CQC fundamental standards, ensuring that all deficits are addressed.
- Encouraging user involvement in service improvement and planning at all levels.
- Supporting the Directorate as required in the review and development of the action plan for the National Staff Survey.
- Monitoring learning and development reports in order to provide assurances that Directorate staff have the right knowledge, experience, qualifications and skills to support care delivery e.g. APDR, Essential Skills Training compliance.
- Acting as a discussion forum to challenge the existing practice in the light of evidence-based medicine or clinical effectiveness data as it is presented to the committee.
- Undertaking the role in approval of new policies and guidelines within the Directorate as appropriate/required.
- Receiving and act on reports as required from the CQC, Confidential Enquiries and any other National reports and also any relevant local reports.
- Assessing benchmark or audit data and recommending action with regard to changing clinical practice and improving value for money.
- Provide assurance reports to other Committees as required.

4. Authority

The committee will investigate or approve any activity within the Terms of Reference. Items for escalation will be through the Directorate Management Committee and subsequently via the Executive Performance Reviews.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

5. Membership

The Committee shall consist of the following members:

Need to discuss and identify Chair and Vice Chair and add any Directorate specific attendees

- Clinical Director
- Directorate Senior Nurse
- Directorate Manager
- Senior representation for each specialty

Other members may be co-opted on to the committee as required, either for additional work or for the purpose of communication or presentation.

6. Attendance

Attendance is required by members at 75% of meetings. Members are requested to nominate a deputy to attend who is appropriately briefed to participate in the meeting.

A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members.

7. Administration

The committee will be appropriately supported with an administration function to ensure effective management of the committee.

Accurate minutes will be recorded and maintained in accordance with Information Governance requirements.

8. Meetings

Meetings will be held on a monthly basis. The length of the meeting will be determined by Directorate requirements; however, should be a minimum of 2 hours to address the objectives effectively.

9. Reporting

The Committee will provide escalation points through the Executive performance Reviews.

10. Quorum

A quorum is determined as being one third of the members (or nominated deputies) in attendance but must include the Chair or Vice-Chair.

11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Clinical Quality Committee.

ToRs agreed by:		**Date of agreement:**	
ToRs ratified by:		**Date of ratification:**	
Review date:			

Appendix 7: Version control

Document Title	Integrated Governance Framework			
Date Issued/Approved:	~~12 April 2018~~ 4 April 2019			
Date Valid From:	~~1 April 2018~~ 5 April 2019			
Date Valid To:	~~28 February 2021~~ 31 March 2021			
Directorate / Department responsible (author/owner):	~~Head~~ Director of Corporate Governance			
Brief summary of contents	Description of the integrated governance operated within the Trust. It is designed to ensure the delivery of high quality patient focussed care from an organisation that is well managed, cost effective and has a well-trained and motivated work force.			
Executive Director responsible for Policy:	Chief Executive			
Date revised:	~~20 February 2018~~ March 2019			
Approval route (names of committees)/consultation:	~~Chief Executive in consultation with trust board~~ Trust Board April 2019			
Name and Post Title of additional signatories	Not Required			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet		Intranet Only	x
Document Library Folder/ Folder	Constitution			

Links to key external standards	~~None~~ Well-Led Framework
Related Documents:	~~None~~ Accountability Framework Constitution Standing Orders Standing Financial Instructions Scheme of Delegation
Training Need Identified?	No

Version Control Table

Date	**Version No**	**Summary of Changes**	**Changes Made by** *(Name and Job Title)*
1 March 2017	V1.0	Initial Issue	David Seabrooke Head of Corporate Governance
1 April 2017	V2.0	Completed version	David Seabrooke Head of Corporate Governance
8 August 2017	V 3.0-	Amended Exec responsibilities from away awayday – appendix 4	David Seabrooke Head of Corporate Governance
16 November 2017	V v4.0	Minor amendments to exec responsibilities and introduction of OETB	David Seabrooke Head of Corporate Governance
22 January 2018	V 5.0	Introduction of Trust Management Committee and Strategy Committee	David Seabrooke Head of Corporate Governance
20 February	V 5.1	Minor updates and clarifications; addition of Charitable Trustees	David Seabrooke Head of Corporate Governance
19 March 2018	V5.2	Comments by CEO and DoN Attendance at Strategy C'ttee Removed Exec Oversight of Directorates (previously extracted from Accountability Framework) and individual extract of Terms of	David Seabrooke Head of Corporate Governance

		Reference of Trust Management Team Proposed removal of committee memberships Added review of committees Added Nominations Committees	
26 March 2019	V6.0	Document updated to reflect changes to Board Committees including introduction of a Subsidiary Governance Committee, update to accountabilities of direct reports to the chief executive and condensing of content to remove duplication	Fiona McNeight Director of Corporate Governance

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	17
Date of Meeting:	04 April 2018		

Report Title:	Accountability Framework 2019/2020			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Andy Hyett, Chief Operating Officer			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
To approve the updated Accountability Framework.

Executive Summary:
First adopted in 2017, this document provides a framework for how the Trust will maintain and manage its performance and focuses on the accountability relationship between the Executive and the management of the five directorates that are subject to performance review meetings. It sets out the required agenda/reporting content, the assessment, rating and support criteria which are outlined in the Single Oversight Framework, issued by NHS Improvement in November 2017, looking at operations, quality, finance, leadership and cooperation with inter-agency initiatives.

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

Accountability Framework

2019/2020

March 2019

CONTENTS

PURPOSE

The purpose of the Accountability Framework is to ensure that Salisbury NHS Foundation Trust has sufficient mechanisms in place to monitor and drive delivery of the Trust's strategic and operational plans during 2018/19 and beyond.

The Accountability Framework pulls together, in one place, the Trust's business as usual performance, including delivery against its contracts and transformational programmes including Cost Improvement Plans (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) plans and Commissions for Quality and Innovation (CQUIN) schemes.

The Accountability Framework sets out the expectations of the Trust as a whole and as individual directorates. It provides a framework for how the Trust will monitor and manage its own performance. In order to achieve its ambitions, the Trust must ensure consistency in its approach to managing and delivering its plans, and that sufficient escalation triggers are in place and the Board is routinely sighted on and involved in the mitigation of key risks.

The Accountability Framework has been designed to align as closely as possible with the NHS Improvement Single Oversight Framework November 2017. This framework reflects the requirements of the Care Quality Commission (CQC), Financial sustainability/stability, performance management and improvement capability. It will ensure that as an organisation we are pro-active in providing assurance to our regulators.

There are five themes to the Accountability Framework (these match the themes defined in the Single Oversight Framework November 2017), each set out below:

Theme	Aim
Quality of care (safe, effective, caring, responsive)	To continuously improve care quality, helping to create the safest, highest quality health and care service
Finance and use of resources	For the Trust to balance its finances and improve its productivity
Operational performance	To maintain and improve performance against core standards
Strategic change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build leadership and improvement capability to deliver sustainable services

PERFORMANCE FRAMEWORK

The performance function will oversee the delivery of all elements of Trust performance throughout the year, including service performance and quality of care, linked to the delivery of the Trust's Transformational and Financial plans. No one element of the Trust's business plan can be assessed in isolation.

The Performance Framework sets out the metrics that each directorate will be held accountable against, these metrics will be taken from the Trust's Operational Plan, individual directorate plans and will include all national and contractual requirements.

The dashboard is based on the five themes that will be used as part of the overall assessment of performance at a directorate and organisational level.

To mirror the Single Oversight Framework the Trust is using the segmentation methodology and for each theme there will be an assessment:

Segment	Description of support needs
1 Maximum autonomy	No actual support needs identified across the 5 themes
2 Targetted support	Support needed in one or more of the 5 themes
3 Mandated support	Significant support needs
4 Special measures	Very serious/complex issues

Below is the summary of the five themes with the information used and the triggers that will highlight issues or concerns.

Theme	Information used	Triggers
Quality of care (safe, effective, caring, responsive)	• CQC information • Quality information • 7 day services	• CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the key questions for - 'Safe' - 'Caring' - 'Effective' - 'Responsive' • CQC warning notices relating to the directorates' core areas • Any other material concerns identified through, or relevant to, CQC's monitoring process, such as civil or criminal cases raised or raising concerns information • Concerns arising from trends in Quality Indicators • Failure to deliver against agreed commitments regarding the four priority standards for seven- day hospital services • Any other material concerns about a providers quality of care arising from intelligence gathered
Finance and use of resources	• A monthly finance score (Trust level) • A use of resources assessment (where available) • Other relevant information on financial performance, operational productivity and whether a directorate is making optimal use of its resources	• Poor levels of overall financial performance, such as monthly finance score of 4 or 3 (at Trust level) • A use of resources rating of 'inadequate' or 'requires improvement' (at Trust level) • Any other material concerns about a directorate's finances or use of resources
Operational performance	- NHS Constitution standards • A&E waiting times • Referral to treatment times • Cancer treatment times	• Failure to meet any operational performance standard for at least two consecutive months • Other factors (eg a significant deterioration in a single month or multiple potential support needs across standards and/or other themes) indicate the need to get involved before two months have elapsed • Any other material concerns about a directorates's operational performance

Strategic change	• Extent to which directorates and departments are working with partners to address local challenges and to improve services for patients • Directorate's contribution to developing, agreeing and delivering the objectives of sustainability and transformation partnerships (STPs) • Nature of directorate's relationships with local partners, their role in any agreed service transformation plans and how far these plans have been implemented	• Material concerns about support for the local transformation agenda, including (where relevant) new care models and devolution
Leadership and improvement capability (well-led)	**Effective Boards and Governance:** • CQC well led inspections and outcomes of developmental well-led reviews where these generate material concerns relating to directorates • Information from third parties eg Healthwatch, MPs, complaints, whistleblowers, coroners' reports • Staff/patient surveys • Level of directorate management team turnover • Organisational health indicators • Delivering Workforce Race Equality Standards (WRES) **Continuous improvement capability:** • Assessments of learning, improvement and innovation within well-led reviews undertaken by CQC or in developmental reviews using the well-led framework **Use of data:** • Adoption of measurement-for-improvement approach	• CQC 'inadequate' or 'requires improvement' assessment against 'well-led' in relevant core areas • Concerns arising from trends in directorate health indicators • Other material concerns about a directorate's governance, leadership and improvement capability

Quality of Care

The following metrics will constitute the metrics that the Trust will use to establish the quality of care provided by the Trust.

	Measure	Type	Frequency	Source
	Written Complaints - rate	Caring	Quarterly	HSCIC (publicly available)
	Staff Friends and Family Test Percentage Recommended - Care	Caring	Quarterly	NHSE (publicly available)
	Never events	Safe	Monthly	NHSE (publicly available)
	Serious Incidents count	Safe	Monthly	StEIS
	Potential under-reporting of patient safety incidents	Safe	Monthly	NRLS (publicly available)
	Central Alerting System (CAS) alerts outstanding	Safe	Monthly	NRLS (publicly available)
	Mixed Sex Accommodation Breaches	Caring	Monthly	NHSE (publicly available)
	Inpatient Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	A&E Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	Emergency c-section rate	Safe	Monthly	HES
	CQC Inpatient Survey	Organisational Health	Annual	CQC (publicly available)
	Maternity Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
	Percentage of new harms	Safe	Monthly	NHSE (publicly available)
	VTE Risk Assessment	Safe	Quarterly	NHSE (publicly available)
*	*Clostridium Difficile* - variance from plan	Safe	Monthly	PHE (publicly available)
	Clostridium Difficile - infection rate	Safe	Monthly	PHE (publicly available)
*	MRSA bacteraemias	Safe	Monthly	PHE (publicly available)
	Hospital Standardised Mortality Ratio (DFI)	Effective	Quarterly	DFI
	Summary Hospital Mortality Indicator	Effective	Quarterly	HSCIC (publicly available)
	Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	Effective	Monthly	HES

	MSSA bacteraemias	Safe	Monthly 12 month rolling	PHE
	E Coli bacteraemias	Safe	Monthly 12 month rolling	PHE
	Total number of deaths & total number of admissions	Safe	Monthly 12 month rolling	Local

The Quality of Care is underpinned by the production of performance packs to provide the Executive Directors (via Executive Performance Review Meetings) and ultimately the Board with a clear line of sight on current performance. The information available is reviewed and amended annually to ensure it captures all required metrics.

*Well Led performance indicators

Workforce Metrics (organisational health indicators)

	Measure	Type	Frequency	Source
*	Staff sickness	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
*	Staff turnover	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
	Proportion of Temporary Staff	Organisational Health	Quarterly	FT return

*Well Led performance indicators

Operational Performance

Standard	Frequency	Standard
Acute and specialist providers		
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	92%

All cancers – maximum 62-day wait for first treatment from:	Monthly	
a) Urgent GP referral for suspected cancer		85%
b) NHS cancer screening service referral		90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%
Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:	Quarterly	
a) Who have a diagnosis of dementia or delirium or to whom case finding is applied		90%
b) Who, if identified as potentially having dementia or delirium, are appropriately assessed and		90%
c) Where the outcome was positive or inconclusive, are referred on to specialist services		90%

Monthly performance packs will be produced which outline current performance against plan or set targets. Directorates will be expected to respond to any concerns or risks highlighted within the performance reports to the Executive Performance Review meetings. Any additional assurance sought by way of recovery plans or increased monitoring of specific measures will be overseen by the performance function and monitored through the weekly performance meeting.

Financial Performance

The financial metrics show the Trust's financial sustainability, efficiency and controls relating to high profile policy imperatives such as agency staffing, capital expenditure and the overall financial performance of the Trust.

The scoring mechanism for the metrics mirror the Single Oversight framework and scoring from 4 (poorest) to 1 (best). A score of 3 or 4 will trigger a concern with NHS Improvement and trigger potential or mandated support.

Trust Level Finance Metrics

Area	Metric	Definition
Financial sustainability	Capital service capacity	Degree to which the provider's generated income covers its financial obligations
	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
Financial efficiency	Income and expenditure (I&E) margin	I&E surplus or deficit / total revenue
Financial controls	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to Year-to-date plan I&E margin (surplus/deficit) on a control total basis
	Agency spend	Distance from provider's cap

Directorate level finance metrics

Metric	Considerations
Revenue	Spend versus budget for pay and non pay
Income	Income in line with contracts and production plan
Cost Improvement Plans	Delivery against cost improvement trajectories and plans

Use of Resources Assessments

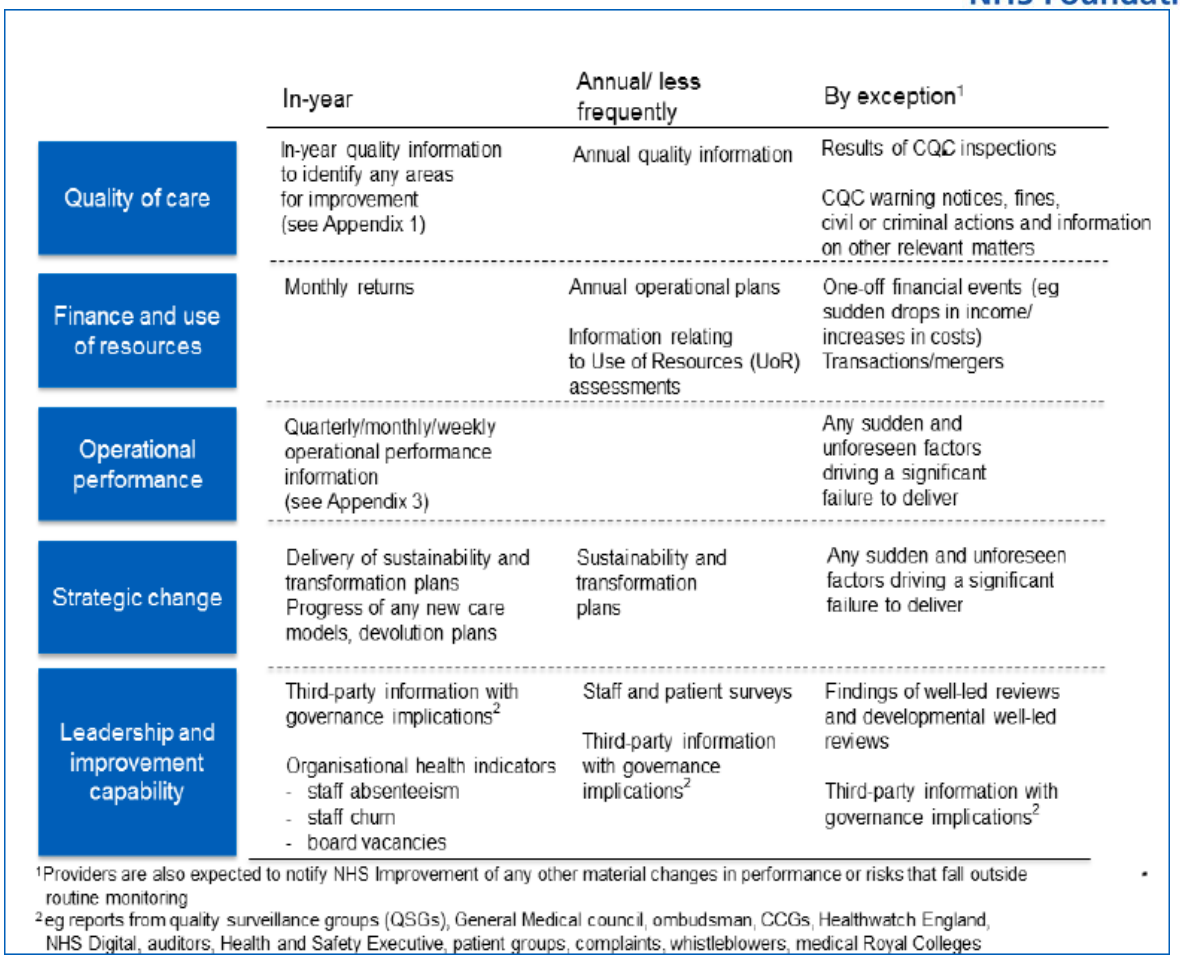
NHS Improvement's Use of Resources assessments aim to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. NHS Improvement will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are and how efficiently they use their workforce, clinical and operational services to deliver high quality care for patients. NHS Improvement will introduce Use of Resources assessments alongside the CQC's new inspection approach from autumn 2017.

Use of resources area	Key lines of enquiry (KLOEs)	Initial metrics
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?	- Pre-procedure non-elective bed days - Pre-procedure elective bed days - Emergency readmissions (30days) - Did not attend (DNA) rate
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?	• Staff retention rate • Sickness absence rate • Pay cost per weighted activity unit (WAU) • Doctors cost per WAU • Nurses cost per WAU • Allied health professionals cost per WAU (community adjusted)
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?	• Top 10 medicines – percentage delivery of savings target • Overall cost per test
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?	• Non-pay cost per WAU • Finance cost per £100 million turnover • Human resources cost per £100 million turnover • Procurement Process Efficiency and Price Performance Score • Estates cost per square metre
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?	• Capital service capacity • Liquidity (days) • Income and expenditure margin • Distance from financial plan • Agency spend

NHS IMPROVEMENT MONITORING

NHS Improvement use information to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in segment 1 and may benefit from support) and judgement, based on consistent principles, to determine whether or not they are in breach of licence and, if so, whether the issues are serious or very serious/complex.

Summary of information requirements for monitoring



	In-year	Annual/ less frequently	By exception[1]
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 1)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance and use of resources	Monthly returns	Annual operational plans Information relating to Use of Resources (UoR) assessments	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Quarterly/monthly/weekly operational performance information (see Appendix 3)		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of sustainability and transformation plans Progress of any new care models, devolution plans	Sustainability and transformation plans	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[2] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and patient surveys Third-party information with governance implications[2]	Findings of well-led reviews and developmental well-led reviews Third-party information with governance implications[2]

[1]Providers are also expected to notify NHS Improvement of any other material changes in performance or risks that fall outside routine monitoring

[2]eg reports from quality surveillance groups (QSGs), General Medical council, ombudsman, CCGs, Healthwatch England, NHS Digital, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges

Support needs and segment descriptions

The support offered by NHS Improvement will be Trust specific but is defined below:

Description of support needs	Level of support offered	Segment
No actual support needs identified across our five themes. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider will support providers in other segments.	**Universal**	**1 (Maximum autonomy)**
Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed.	**Universal** **+ Targeted** support as agreed with the provider to address issues identified and help move the provider to Segment 1	**2 (Targeted support)**
The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts), but is not in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to address specific issues and help move the provider to segment 2 or 1	**3 Mandated support)**
The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to minimise the time the provider is in special measures	**4 (Special measures)**

LOCAL ASSESSMENT CRITERIA

Directorates will be assigned an overall RAG rating based on performance against the domains of quality, operational , financial and workforce performance as well as delivery of the directorate's operational plan.

Overall Performance Ratings and Oversight Model

Individual domain ratings will then be aggregated to provide an overall rating for the directorates. The proposed criteria for the overall ratings are shown in the overall performance ratings and oversight model on page 14. The criteria for assigning the overall RAG rating is not limited to the reasons shown, discretionary decisions regarding ratings may be made in agreement at the Executive Performance Review Meetings should they feel that either increased or lesser scrutiny would be more appropriate.

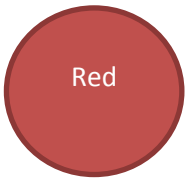
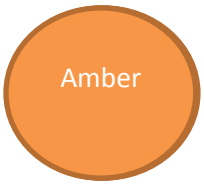
RAG ratings will be routinely reported to the Trust Management Committee to ensure that appropriate scrutiny is given to the most significant areas of risk.

The 'Overall Performance Ratings and Oversight model' below sets out how the Trust Board, Finance and Performance Committee, Trust Management Committee, and the Executive Performance Review Meetings will hold directorates to account for delivery in a consistent and transparent way. The oversight arrangements are directly linked to the Performance Framework, as outlined above.

The overall directorate rating will determine the regularity of performance review meetings and other escalation meetings. These Directorate Performance Review meetings will take place routinely, however for those directorates rated red or amber that require additional intervention of support, increased oversight will be established.

Preparatory work for each of these meetings will be required and the Information Team will work to standardise the documentation as much as possible. This will ensure consistency in the way in which performance is reviewed across the organisation and will align reporting requirements across multiple meetings. This will minimise the amount of time taken by directorates assessing data, re-focussing efforts on ensuring sufficient plans are in place to address areas of under-performance.

Overall Performance Ratings and Oversight Model:

RAG rating	Definitions	Oversight requirement
	• 3 or more domains are rated red • 2 or more domains are rated red and considerable risks to other areas of performance have been identified • Directorate is forecasting significant variances to plan at year end and there is not sufficient confidence in recovery trajectories	➢ Weekly performance challenge meetings ➢ Weekly submission of recovery trajectories and progress ➢ Bi-weekly transformational plan review meetings ➢ Presentation of recovery plan at Trust Management Committee and monthly update on recovery ➢ Further assurance to the Finance & Performance Committee may be required ➢ Dedicated project support as relevant
	• 1 or more domain is rated red • 3 or more domains are rated amber • 2 or more domains are rated amber and risks to other areas of performance have been identified • Directorate is forecasting moderate variance to plan at year end, however there is confidence in recovery trajectories	➢ Weekly submission of recovery trajectories and progress ➢ Bi-weekly performance challenge meetings ➢ Monthly Executive Performance Review meetings ➢ Dedicated project support as relevant
	• No more than 2 domains are rated amber, which indicates small variance to plan • There are no significant risks to delivery identified • Robust recovery trajectories are in place for any variance to plan	➢ Monthly Executive Performance Review meetings ➢ Agreement regarding resource and support required to enable delivery

ESCALATION

The overall RAG rating for each directorate will act as the trigger for any additional support or escalation. For directorates who are rated 'Amber' or 'Red' and/or have failed to deliver any improvements for a sustained period of time, additional interventions may be enacted to support the return of performance to acceptable levels.

The decision to escalate a directorate may be made on the basis of significant underperformance against multiple metrics; however, it may also be as a result of just one core area of underperformance which presents a significant risk to the overall delivery of the Trust's plan. The decision to escalate will be taken by the Trust's Executive Directors at the Executive Performance Review meetings.

Additional interventions will range from putting in place a support package for a particular area of performance, such as peer review, Intensive Support Team (e.g. ECIST support for Emergency Care) supported by the Project Management Office (PMO) where applicable. More serious measures, such as removal of delegated directorate budgets, should there be significant deterioration in performance which does not appear recoverable will also exist, though it is expected that such measures would only be implemented in extreme circumstances.

GOVERNANCE

Throughout this document the term Directorates is used to describe the following clinical and corporate directorates;

- Surgery
- Musculo Skeletal Services
- Medicine
- Clinical Support and Family Services
- Facilities Directorate

Monthly Executive Performance Review meetings will take place with each of the above Directorates. Once in Quarters 1 and 3, Executive Performance Review meetings will be Chaired by the CEO. All Directorates will receive a RAG rating and escalation will be the same for Directorates as outlined on page 14.

CORPORATE DEPARTMENTS

The Trust has a well-established process for monitoring the performance of clinical areas against financial metrics, operational delivery and quality KPIs through the well established Executive Performance Reviews. Historically, there has been no formal structure to oversee the performance of the corporate services which presents a risk to delivery of the CIP programme and the Trust's strategic objectives.

In order to address this, a new programme of Executive Performance Reviews for corporate areas was initiated in 2018. These provide a bi-annual review of the corporate functions and an opportunity to hold the Head of Service or nominated deputy to account for performance within the relevant corporate area. These reviews are Executive led by those not responsible for delivery of that corporate service.

Additional information to support the Governance process is provided in the attached Appendices;

- Appendix 1 – Directorates to Board flow chart
- Appendix 2 - Trust Management Committee Terms of Reference
- Appendix 3 - Directorate Management Committee Terms of Reference
- Appendix 4 – Executive Performance Meeting Agenda
- Appendix 5 – Directorate Management Committee Agenda

Salisbury NHS Foundation Trust

Version control

Document Title	Accountability Framework 2019/20			
Date Issued/Approved:				
Date Valid From:	4 April 2018			
Date Valid To:	31 March 2020			
Directorate / Department responsible (author/owner):	Chief Operating Officer			
Brief summary of contents	This document provides a framework for how the Trust will maintain and manage its performance and focuses on the accountability relationship between the Executive and the management of the five directorates that are subject to performance review meetings.			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2019			
Approval route (names of committees)/consultation:	Chief Operating Officer in consultation with Trust Board			
Name and Post Title of additional signatories	Not Required			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet		Intranet Only	x
Document Library Folder/ Folder	Standing Financial Instructions & Orders			
Links to key external standards	• NHS Improvement Single Oversight Framework November 2017 • NHS Improvement and Care Quality Commission Use of Resources: Assessment Framework August 2017			

Related Documents	Integrated Governance Framework April 2018
Training Need Identified?	No

version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
03/02/18	V1.0	Draft document	Andy Hyett, Chief Operating Officer
28/02/18	V1.1	Draft document	Andy Hyett, Chief Operating Officer
15/03/18	V1.2	Final version	Andy Hyett, Chief Operating Officer
15/03/18	V2.1	Draft annual review of document updated to reflect NHS Improvement Single Oversight Framework November 2017	Andy Hyett, Chief Operating Officer
29/03/18	V2.2	Ongoing annual review of document, including updates to document appendices	Andy Hyett, Chief Operating Officer
04/04/18	V2.3	Ongoing annual review of document, including incorporation of key lines of enquiry from CQC & NHSI Use of Resources Assessment Framework August 2017	Andy Hyett, Chief Operating Officer
05/04/18	V2.4	Ongoing annual review of document and supporting appendices	Andy Hyett, Chief Operating Officer
09/04/18	V2.5	Draft document – presented to Board. Approved with need to further update key metrics	Andy Hyett, Chief Operating Officer
22/05/18	V2.6	Final document – updated key quality of care and operational performance metrics for presentation to Finance & Performance Committee	Andy Hyett, Chief Operating Officer
04/04/19	V2.7	Draft document – presented to Board.	Andy Hyett, Chief Operating Officer

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

Report to:	Trust Board (Public)	**Agenda item:**	18
Date of Meeting:	04 April 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 December 2018. 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:
346	12/2/2019	Lease between SFT (landlord) and Inspire Foundation (tenant) for part of Block 40 for a term of 1 year	Laurence Arnold	Cara Charles-Barks	Nick Marsden

Report to:	Trust Board (Public)	**Agenda item:**	19
Date of Meeting:	4 April 2019		

Report Title:	Board Assurance Framework and Corporate Risk Register			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		**x**
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	- Revised Board Assurance Framework (v9.1 2019) - Corporate Risk Register Summary tracker (9v1 March 2019) - Corporate Risk Register (v2.2 March 2019)			

Recommendation:
The Board are asked to consider and approve the revised Board Assurance Framework.

Executive Summary:

Background
The Board Assurance Framework (BAF) provides the Trust Board with a means for satisfying itself that its responsibilities are being discharged effectively and objectives delivered. This informs the Annual Governance Statement and annual cycle of business.

The BAF:
The BAF has been revised and updated to include items raised through the Board Committees.

Supporting Documentation:
- The Corporate Risk Register (CRR) is presented alongside the BAF for review
- The Corporate Risk Register Summary supporting the CRR, tracks the risk over previous months, detailing the date of addition to the risk register and Lead Executive. Updates can also be requested and tracked through this summary sheet

Review of Risks:
It is clear from the 'Strategic Priorities – Risk Overview' summary that our highest risk areas are:

- People: continuing challenges in recruitment and retention, particularly Registered

Nurses and excessive agency use.
- Resources: ability to achieve the financial plan and deliver financially sustainable services.

Following discussion at Finance and Performance Committee on 26 March 2019, local services was downgraded from red to amber risk rating.

New Risks
The following new risks have been added to the CRR:

- 5558 – Risk of inability to provide tumour site specific services to patients due to medical workforce establishment in oncology (Care).
- 5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Local)

Risks removed
- 5540 - Potential impact on Trust's internal governance standards from new external HSIB investigation processes (Care)
- 5530 - Consultation on wholly owned subsidiary proposal (People)
- 5397 - Inability to recruit enough nurse a decision has been taken not to open the additional medical beds (Local)

Risks with decreased scores
- No risks with decreased score

Risks with an increased score
- 4107 - Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients (Care): 9 to 12
- 5007 - Endoscopy Unit JAG accreditation deferred for 6 months to address 18 key actions (Specialist): 12 to 15
- 5577 - Risk to patient safety due to overcrowding in ED (Care): 12 to 16

5607 - Risk of minor errors regularly occurring and potential risk of serious incident within the Hospital at Night team due to increase in workload but no increase in staffing (Care): 12 to 16

Review of gaps in control:
Through the review process, the following new gaps in control have been identified:

3322: Genetics National reconfiguration
- Gap is in knowledge of the service specification, what is in / out of scope, what testing will be directed to the National whole genome sequencing centre, financial arrangements following tender.

5480: Risk of inaccurate information being used in reporting
- List of data leaving the organisation still needs to expand to break down some of the aggregated data provided further so that risks in validation/accuracy can be clearly understood including the level of risk, the impact if data is not correct, the sign off processes and owner.
- KPIs and reporting internally need to have a routine review plan and ensure there

are only single consistent and accurate definitions and ways of reporting.

5558: Medical workforce in Oncology

- Substandard or unavailable locum support
- Difficulties in recruitment to substantive posts
- No pool of suitable Advanced Nurse Practitioners (ANPs) so have to train new ANP's each time someone leaves

Changes to the BAF

- A Board workshop was held on 17 January 2019 with the purpose of identifying any internal or external principle risks to achievement of the strategic objectives. The identified internal principle risks have now been included within this version of the BAF with associated gaps in control/assurance and associated actions to address any gaps.
- The identified external principle risks have also been included. The presentation of these risks differ to the internal risks in that the Trust has no or limited control over mitigation. Therefore, monitoring information is presented along with any influencing factors the Trust may have. This is work in progress and the Executive team are currently reviewing this information which will be completed prior to the next presentation of the BAF to the Board.

Next steps

- The newly appointed Associate Director of Strategy is undertaking a review of the Trust corporate objectives, and this work will inform the revised objectives within the next version of the BAF, and associated actions, to be presented to the Board in June.
- The BAF will be presented to Board thereafter on a quarterly basis with a detailed report outlining the current position of the risk profile.

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
2018/19

V9.1 as of 11/03/2019

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?

Risk Matrix Score Key

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

Strategic Priorities – Risk Overview

	Overall risk score
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	

Strategic Priority:

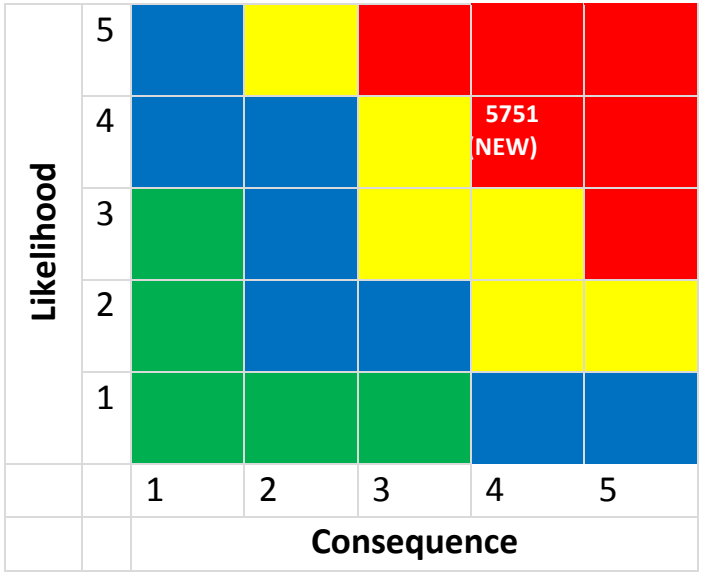
> **Local Services –** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Frail Elderly** - Development of an integrated frail elderly service	COO	April 2019	
2. **Emergency Care** - Implement new systems to manage the flow of emergency patients	COO	Dec 2018	
3. **Delayed Discharge** - Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	COO	April 2019	
4. **Access** – Improving access to core services to support prompt, responsive care	COO	Oct 2018	

Corporate Risk Register Principal Linked Risks



5751 - Risk of impact on patients from high numbers with a delayed transfer of care (NEW RISK).

Principle Internal Risk: Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population

Key Controls	Assurance on Controls
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • War reconfiguration governance structure • 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 • 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	• Data quality

Actions	Owner	Deadline	Actions	Owner	Deadline
Scoreboards and dashboards being developed	Chief Information Officer	Programme commenced			

Principle External Risk: Managing the complexity of relationships with our partners to lead and share our joint strategy plans for a place based integrated care system

Monitoring information	Areas of influence
• Integrated Performance Report – impact on metrics • Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard)	• Requested improvement trajectories for decreased attendances and delayed transfers of care • STP Executive Board (CEO) • STP Sponsorship Board (CEO and Chair) • Wiltshire Integration Board (CEO)

Key Headlines - Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Development of an integrated frail elderly service	• Performance against quality metrics including increased number of discharges within 48 hours • Workshop to develop pathways for older people across the health economy has been agreed; actions being taken forward • Patient ward moves reduced (Getting the patient to the right place, first time) • Locality model for elderly pathways now fully implemented	• Unsuccessful recruitment of acute physicians	Interview with aim to appoint 19 November 18 Ensure locum in post on-going Re-advertise early 2019	~~Nov 18~~ 30 June 18	On-going advert out for vacancies. Jan 19 update: Recent recruitment unsuccessful. Plan to re-advertise early 19. March 19 update: out to advert. Mitigation through locums
		• Agreeing pathways from ED/AMU to frailty	Fortnightly huddles with each medical ward to embed learning and monitor patient flow measures	June 18	Implemented and on-going
			Recovery Action Plan to be presented to COO - AH	Sept 18	Complete
		• Inability to create capacity between AMU and Durrington to support the frail elderly pathway	Address improvements through Patient Flow workstream Improvement actions to be embedded through the daily operational meetings - AH	July 2018 Nov 2018	Complete Work on-going. Next step is creating early community capacity to discharge patients
		• Records of patient moves not consistently kept up to date	Systems and processes to be addressed through Patient Flow workstream (delivery linked to recruitment plan)	Q3 18/19	Linked to action below
			Audit July moves between 9 pm and 6 am - AH	~~Oct 18~~ ~~Dec 18~~ 30/04/19	Audit completed and demonstrated that bed moves not accurate on Lorenzo. Being addressed with wards as part of SAFER. Revised deadline

					30/04/19
		• Lack of single community bed base to ensure seamless pathway	Address through EDLBD: Weekly senior leaders meeting reviewing community capacity	Oct 18	Complete
		• Lack of community pathways to facilitate discharge	Monthly Strategic Frailty meetings established (Acute, Community)	Sept 18	Complete
			STP launch (Older Persons)	Sept 18	Complete
			SFT Operational working group meetings established (bi-monthly)	Oct 18	Complete
			Process map patient pathway (internal, external partners including outreach clinics)	Oct 18	Complete
			Research National Older persons work and present findings to Strategic Group	Oct 18	Complete
			Comprehensive Geriatrician Assessment (CGA) forms reviewed and revised (Internal/External)	Dec 18	A working group has been set up to review the existing version used in the Trust, and those available outside of the Trust, including local partners. The group are working to align community and acute forms to reduce duplication.

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
2. Implement new systems to manage the flow of emergency patients	• Performance against national standards and internal quality metrics (improving length of stay and flow of patients) • Positive ED quality metrics • Good progress with new build, project on track - Ophthalmology, AMU and short stay surgery units open; Pembroke move completed May 2018 • Active use of escalation process over winter period • Escalation of ambulance handover delays has improved this issue	• Reliance on agency staff effecting ability to embed new ways of working	Trust wide recruitment plan –PH	~~Q3 18/19~~ 31/03/2019	Revised deadline as action aligned to operating plan. This relates to the Recruitment Strategy which is on track
		• Accurate data entry at ward levels	SFT IT team working with supplier to develop the two way link – AH/LA	July 18	Complete
		• Medicine length of stay greater than benchmark	Improvements in patient flow, including length of stay reductions, being managed through a revised action plan with agreed KPIs and via a weekly PMB - AH	~~Nov 18~~ 1 April 19	DTOC trajectory from system requested by the Winter Director
		• Inability to fill ED navigator role	Escalate workforce requirement with ambulance service – AH	Oct 18	Complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
3. Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	• Clarity on the number of non DTOC delays being reported • Early triggers in place to alert other providers when numbers of delays are increasing • Trust membership of Joint Commissioning Board • Trust membership of Health and Wellbeing Board • Trust representation on the Integration and Better Care Fund group	• Community/voluntary sector funding and capacity	Being addressed through Council CQC action plan and ED Local Delivery Board - AH	~~Dec 18~~ Review 1 April 19	Awaiting modelling from CSU – CCG chasing
		• Staff availability to identify and develop opportunities to improve pathways and discharge	Local Workforce Action Board (LWAB) system wide workforce recruitment plan - PH	Q4 18/19	Close. This is being driven by the STP. Workstreams are in the process of being allocated and progress will be reported through the Workforce Committee
		• Inability of the health system to respond to increases in demand	Regular senior decision maker meetings taking place across the health economy to address actions - AH	Sept 18	Complete
			In-depth review of all delayed discharges across south Wiltshire – AH	June 18	Complete
			NHSE escalation framework being followed due to lack of community capacity including daily gold calls now including CEO level – AH	Oct 18	Complete and on-going
			Development of Trust plan should community capacity not be delivered - AH	~~Oct 18~~ Nov 18	Complete
		• Community capacity not aligned to need	STP capacity and demand modelling across the system - AH	~~Oct 18~~ Review 1 April 19	Awaiting modelling from CSU – CCG chasing
		• Capacity within health system to step up discharge support as part of a major incident response	System-wide weekly meeting to agree actions to reduce the number of stranded patients – AH	Ongoing	In place and on-going

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
4. Improving access to core services to support prompt, responsive care	• Delivering national access standard • Reports indicate current performance and waiting list now delivering • RTT waiting list has stabilised • Clarity obtained as to what capacity is required to clear backlogs	• Accurate capacity and demand modelling to inform consultant job planning	Operational demand and capacity mapping – AH	~~Oct 18~~ March 19	Being completed by Directorates and picked up through the budget setting meetings with the COO and DoF
			Job planning process and job planning review framework set up and managed through PMB – PH	Q3 18/19	Complete Process established
		• Follow up waiting list still being validated	Plastics and Urology follow up waiting list being administratively validated up to 2017 –AH	July 18	Complete
			All follow-up waiting lists being administratively validated up to 2018 - AH	Dec 18	Complete
		• Additional short term capacity required to clear backlogs – concern about affordability and whether deliverable delivered	Capacity and demand modelling is addressing backlog- AH	Sept 18	Complete
		• Inability to increase capacity to clear backlogs in a timely way (may be affected by financial position)	Capacity and demand modelling to identify gap to be addressed - AH	Sept 18	Targets currently being delivered
		• Review of Access policy (underway)	Access policy shared with other providers and CCGs – AH	Sept 18	Complete and shared with partners
		• Assurance that all capacity is being fully utilised	Forward look tool and weekly assurance meetings being developed - SW	Sept 18	Complete – regular meetings in place

Strategic Priority:

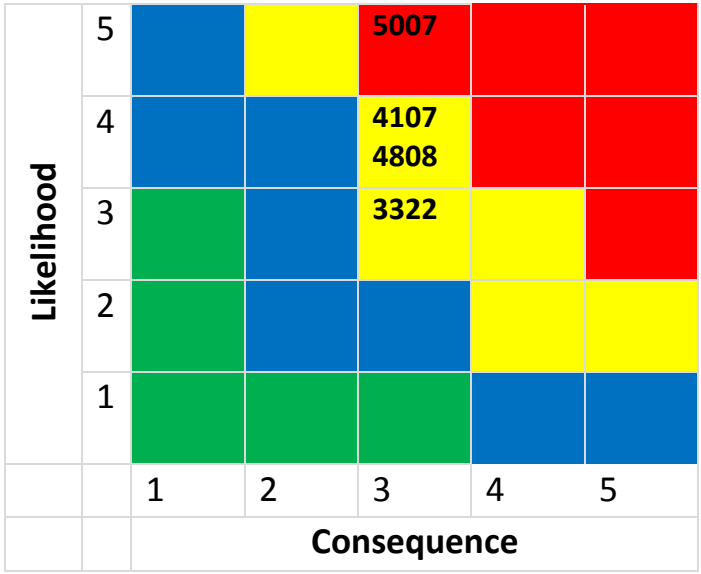
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Spinal Centre –** Service improvement initiatives within Spinal Cord Injury Centre	MD	April 2018 (Phase 1) Phase 2 tbc	
2. **Plastics** - Delivery capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	COO	Dec 2018	
3. **Partnership Working** - Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genomics)	MD/COO/DoCD	June 2018 (Phase 1)	

Corporate Risk Register Principal Linked Risks



3322 - Genetics National reconfiguration
4808 - Vascular surgery cover
5007 – Endoscopy unit JAG accreditation

Linked risks:

4107 - Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients. (Care section)

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			• Integrated Performance Report • Specialist Services dashboards		
Gaps in Control			**Gaps in Assurance**		
• Clear SLAs for delivery of specialist services					
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Development of Plastics SLA with Southampton	COO	30.04.2019			

Principle External Risk: National drive and policy regarding further centralisation	
Monitoring information	**Areas of influence**
•	•

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Service improvement initiatives within Spinal Cord Injury Centre	• Reducing the delay to admission and acceptance of admissions. • Reducing LoS by introducing intense rehab and standardisation of care, whilst also introducing a step down facility for rehab. • Ensuring a sustainable outpatient model, with every patient being recorded. • Improved therapy collaborative working across patient pathway, including inpatient and outpatient services • Recruitment of a clinical lead to support change within the teams • Implemented and embedded multi-disciplinary ward round, including support from respiratory • Improvement plan in place and maintained via Directorate Performance Reviews	• The historical and cultural national referral process restrictions.	Delivery of the spinal action plan	TBC	Complete
		• Workforce gaps in staffing levels and conflicting priorities.			
		• Levels of therapy engagement resulted in pilot work being stopped.			
		• Multi-disciplinary ward round, including support from urology not yet implemented and embedded	Recruitment of spinal urologist	Complete	Post appointed
		• Common MDT vision and strategy not yet developed	Delivery of the spinal action plan	TBC	Complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
2. Plastic Surgery: Deliver capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	• Theatre timetables have been redesigned to ensure that elective and emergency capacity is separated • Support to PHT to become sustainable out of hours • Network approach to Plastic surgery service provision • Recruited band 7 lead for Plastics and Burns	• Required changes to operational and clinical practice/behaviour associated with reconfiguration of Burns and Plastics Inpatient Ward is not yet embedded	COO monitoring numbers and location of outliers – AH	Ongoing	Implemented and on-going
		• SLAs for providing services to other Trusts are not in place across the network	Trust wide piece of work to establish SLAs with other Trusts - AH	~~Aug 18~~ Jan 19	SLAs in place. Need for a further Trust-wide SLA piece of work
		• Changes in operational practice from relocation of weekend Plastics Trauma Clinics to Burns and Plastics Inpatient dept	Monitoring via Executive Performance Reviews with MSK - AH	Ongoing	Implemented and on-going
		• Workforce and skills gaps in Nursing Team	Trust wide recruitment programme for nursing – PH	~~Q3 18/19~~ 31/03/2019	Deadline revised to align to the operating plan. This relates to the Recruitment Strategy and is on track
			Working with Deputy Director of nursing to mitigate training risk - AH	July 18	Complete
		• Gap between income and expenditure in plastics and burns	Implement action plan - AH	Mar 19	Complete
		Effect of changes in capacity and pathways in other Trusts affecting flow	Plastics network launched – AH	July 18	Complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
		of patients to SFT	Meeting with Southampton Trauma Director - AH	Sept 18	Complete
			Meeting with COO of Portsmouth - AH	~~Sept 18~~ Dec 18	Meetings cancelled by Portsmouth so action closed
3. Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genetics/genomics)	• Cleft appointed new consultant cleft surgeon, who is also rotated on the plastic surgery O/C rota. • Work continues with Oxford and Southampton in ensuring the appropriate site is available for cleft surgery • Genetics - good progress in forming an alliance partnership with BWCH, UHB, OUH and UHS	• As part of the national tender process for genetics/genomics the following gaps have emerged: - Clarity on what genetics services will continue to be offered at SFT - Clarity on genetics service implications for workforce, estates and infrastructure • Forum for discussing pathways with Southampton as the tertiary provider • NHSE Commissioning approach for genetics from 1 October 2018	Responding to NHSE requests for further information in advance of procurement decision - LA	Ongoing	Implemented and on-going
			Meeting with Southampton regarding laboratory services - LA	10 Aug & 5 Sept	Meetings held. Non agreement
			Quarterly meetings between MDs and COOs - AH	Dec 18	All actions now superseded with the creation of the consortium which is now in place and progressing the agenda
			Continue to engage with commissioners and consider implications of new commissioning arrangements - LA	Dec 18	

Strategic Priority:

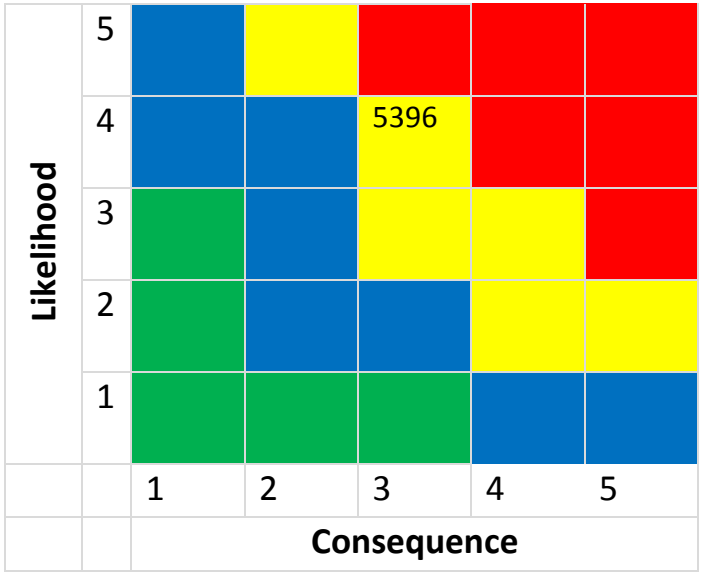
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: Medical Director **Reporting Committee:** Clinical Governance Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Research -** Deliver an increased range of high quality research which directly benefits patient care and increases the Trust's reputation	MD	April 2019	
2. **Improvement -** Build a culture of innovation and continuous improvement	COO/MD	Oct 18	
3. **Innovation -** Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	MD/COO	April 2019	

Corporate Risk Register Principal Risks



Linked risks:

5396 – Delivery of CQUIN (resources section)

Principle Internal Risk: Risk of a lack of capability and capacity to deliver innovation					
Key Controls			**Assurance on Controls**		
• Outstanding Every Time Board • QI Operational plan and improvement strategy • QI Steering Group • Workforce and Clinical Governance Committees • Research Governance Framework			• Model Hospital benchmarking • NIHR Wessex • QI KPIs to evaluate success • Staff survey • Committee effectiveness review		
Gaps in Control			**Gaps in Assurance**		
• Quality Improvement Strategy and plan yet to be implemented					
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
QI Strategy and plan sign off	Director of Transformation	30.04.2019			
Implement QI plan	Director of Transformation	Commence April 2019			
Review effectiveness of plan	Director of Transformation	31.10.2019			

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

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	• Attaining recruitment target • Increased number of departments are research active • Good progress in recruiting to time and target • Team won national Research Excellence Award • Approval to recruit two research fellows from NIHR support • Reviewing NIHR bulletins monthly to identify suitable studies • Exceeding recruitment target for Q3	Nil at present		Monthly	Complete
2. Build a culture of innovation and continuous improvement adopting a consistent QI methodology	• Business case approved setting out future QI approach	Historically there has been no consistent approach to QI. Business case not funded; alternatives being explored Fragmented capture of QI work within the Trust and unclear accountability for delivery	Scope current QI activity, capacity and capability in the organisation – LW/LAr	End Oct 18	Complete
3. Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	• Trust weighted activity unit benchmark in top 10% of country as per the Model Hospital tool. • Consistently approving introduction of new procedures • New ambulatory gynaecology service • Introduction of virtual fracture clinic and patient initiated follow up • Roll out of email advice service	Surgical pathway requires improvement to reduce pre-surgery bed days	Length of Stay Project Board to identify pathways with excessive length of stay	Q2 18/19	Complete In upper quartile on model hospital
		Failure to embed standard operating procedure for Fractured neck of femur pathway	Review pathway for fractured neck of femur with a view to making improvements	Q2	Complete Pathway reviewed and controls in place
		Gaps in communications with GPs due to Consultant Connect not being commissioned for SFT	Joint GP and consultant session to review	July 18	Complete

Strategic Priority:

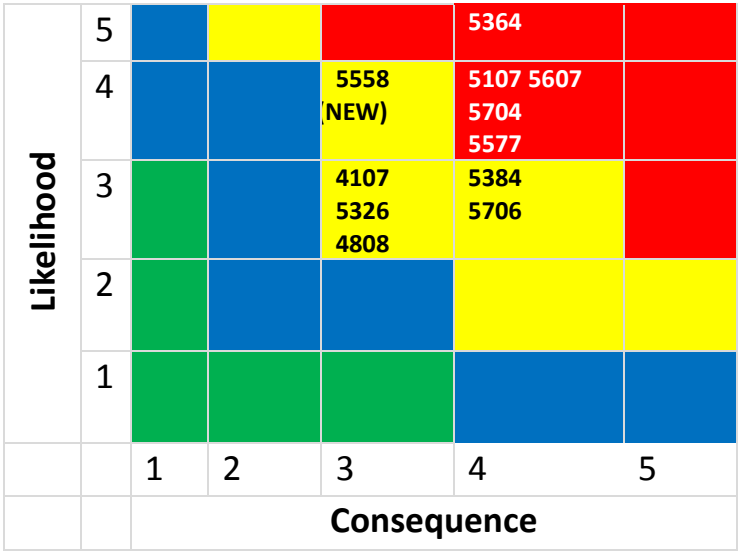
> **Care –** We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **CQC** - Achieve a CQC rating of Good	DoN	March 19	
2. **Safety -** Deliver on the local and national safety priorities	DoN	March 19	
3. **Infection -** Maintain our focus on reducing rates of infection	DoN	March 19	
4. **Learning from Deaths -** Review process to establish learning and improvement	MD	March 19	
5. **Patient Experience -** Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	DoN	March 19	

Corporate Risk Register Principal Risks



5384 – inpatient fall resulting in harm; increasing frail population
4107 – Risk of delay to patient follow-ups in Plastics
5577 – Risk to patient safety from overcrowded ED
5607 - Risk of minor errors regularly occurring and potential risk of serious incident within the Hospital at Night team due to increase in workload but no increase in staffing (Care)
5704 - Inability to provide a full gastroenterology service due to a lack of medical 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 (Care)
5706 - Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment (Care)
5558 – Risk of inability to provide tumour site specific services to patients due to medical workforce establishment in oncology **(NEW)**
Linked risks:
4808 - Vascular surgery cover (specialist services section)
5107 - Failure to recruit to vacant posts will result in an inability to provide outstanding patient care (people section)
5364 - Failure to achieve required ward nursing establishment (people)
5326 – Access to electronically held patient records (resources)

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 • Policies and procedures • Patient and user feedback mechanisms / patient stories at Board • Contract Quality Review Meeting / contractual monitoring • Annual audit programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Learning from Deaths Policy			• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime • 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		
Gaps in Control			**Gaps in Assurance**		
• Out of hours availability of Section 12 approved doctors (mental health) and approved mental health professionals (AMHP)					
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
CCG Mental Health Commissioner is undertaking an audit of out of hours mental health service provision	CCG				

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	

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Achieve a CQC rating of Good	• Positive CQC Insights report on key benchmarks • Improvement delivery on Must do/ Should do's	• CQC will not normally grade a Trust Good if it is subject to NHS I enforcement action	Continue to deliver the Enforcement Action Plan to close enforcement action and obtain NHS I certificate of compliance	~~September 2018~~ Review 30 April 19	Paper going to Audit Committee March 19 for subsequent submission to NHSI
		• Findings of Well Led review have identified areas for improvement	Complete CQC inspection preparation - LW	Nov 18	Complete
			Implement Well Led action plan – CCB/FMc	Dec 18	Action plan progressing and additional actions included. Monthly monitoring through Execs
2. Deliver on the local and national safety priorities	• Quarterly reports show most workstreams on track	• Never events continue to be reported	Intensive support commissioned for theatres – led by DMT with Executive oversight	Sept 18	Complete
		• Falls continues to be biggest risk within the work streams • Poor compliance with falls risk assessments	Implementation of Falls Reduction Strategy	March 19	
		• Cluster of incidents relating to cancer pathway	Task and finish group set up and chaired by deputy COO to review patient pathways and processes – AH	April 18	Complete
			Draw together learning from all incidents for review by Clinical Risk Group, Cancer Board and CCG – LW/CB/AH	Sept 18	Complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
			Cancer Board review of patient pathways and MDT efficiencies – CB	~~Sept 18~~ March 19	Significant piece of work. Deadline revised **March update:** Action plan under review and to be presented to CCG in April
3. Maintain our focus on reducing rates of infection	• Trust in best performing quartile for reportable infection rates in the South West in 2017/18 • Positive feedback received from NHS England re reduction of E. coli bacteraemia	• Did not achieve the required reduction in defined daily doses across all anti-microbials for CQUIN 17/18 • Currently do not have resource required to have adequate oversight of anti-microbial stewardship in practice	CSFS business case addressing gaps and potential resource requirements	~~Sept 18~~ 31/03/19	Deadline revised as not progressed
4. Review process to establish learning and improvement on learning from deaths	• Mortality review reports show low levels of avoidability • HSMR is in normal range • Internal audit report on morbidity and mortality meetings • Learning from Deaths Policy published on Trust website • Mortality dashboard was published in February	• Improvement needed in some local Mortality and Morbidity meetings	Ongoing work with relevant directorates – CB	Ongoing	
		Improvement needed in mortality review tool	Improvement work prioritised by IT – CB	Sept 18	The mortality tool has been redesigned but it has not been released into the live environment yet. The reason is that a Medical Examiner section needs to be included which must be live by March and the IT developer is away until 17 December. In the meantime, we are continuing with the existing system which is

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
					adequate for our needs at present.
5. Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	• Positive survey results o ED o Cancer o Maternity o Paeds • High satisfaction shown in Friends and Family Test and Real Time Feedback	Not yet achieving improvement on NHS Inpatient Survey results (all areas average)	Action plan in development, with key focus for corporate support being established - LW	Sept 18	Complete

Strategic Priority:

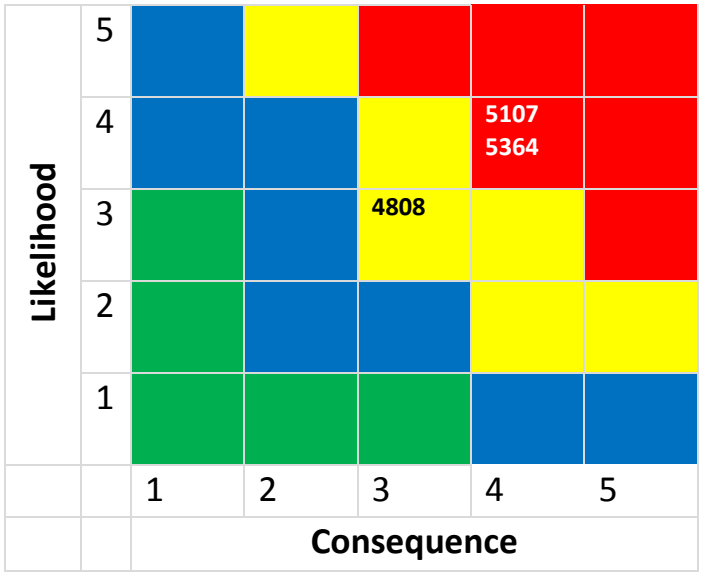
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Resourcing and Talent Management -** Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	DoODP	March 2019 (phase 1)	
2. **Business Partnering** - Establish effective partnerships to align business and HR strategies	DoODP	March 2019 (phase 1)	
3. **Health and Wellbeing** - Improve the health and wellbeing of staff	DoODP	March 2019 (phase 1)	
4. **OD and Engagement** - Develop a diverse and inclusive culture where staff feel engaged	DoODP	March 2019 (phase 1)	
5. **Leadership -** Develop strong leadership capability across all levels of the organisation to support an innovation culture	DoODP	March 2019 (phase 1)	

Corporate Risk Register Principal Risks



5107 – High level of vacant clinical posts incurs costs due to increasing use of agency staff

5364 - Failure to achieve ward nursing establishment

Linked risks:
4808 – Vascular surgery cover (specialist services section)

Principle Internal Risk: Risk that the Trust will be unable to recruit and sustain an engaged and effective workforce	
Key Controls	**Assurance on Controls**
• Workforce Committee (EWC) • Health and Wellbeing Board • HR Policies • Directorate Performance meetings • Trust values and behaviours • Workforce Programme Management Board • Safer Staffing Group • Equality, Diversity and Inclusion Steering Group (under review) • Health and Safety Committee • Integrated Performance Report at Board • Monthly Workforce Dashboard • Executive Safety Walks • Freedom to Speak Up Guardians • JCC Staff Side Meeting	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report
Gaps in Control	**Gaps in Assurance**
• Ineffective data capture and reporting	• Lack of real time staff feedback

Actions	Owner	Deadline	Actions	Owner	Deadline
Develop business case for roll-out of ESR	Director of OD&People	31.05.2019	Develop Health& Wellbeing Strategy business case to purchase real time feedback solution	Director of OD&People	31.05.2019

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	

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	• Staff turnover remains steady (reported through EWC) • Growing medical locum bank (Locums Nest engaged) • Engaged with regional streamlining work stream • Engaged with STP Agency cap and control work stream • Chair of the STP Social Partnership Forum • Proactive engagement with the Local Workforce Action Board • Staff side balloting on government proposals on Agenda for Change	• Impact of Brexit not yet clear	Continue to review as new information becomes available	Ongoing	Staff led Brexit group established Nov 18
		• Impact and delay of IELTS / OSCE for international recruits	Explore alternative IETLTs rules with NMC	July 2018	Complete
		• Recruitment data not easily reportable	TRAC system due to go live July 18 - PH	July 18	Complete
		• No retention strategy and associated resource	Implement Engagement Plan	~~July 18~~ ~~Jan 19~~ Review 31 July 2019	This action has changed. Will form part of OD plan once diagnostic completed. Engagement work continues in the meantime.
		• Potential for shortage areas to be removed from Shortage Occupation list (e.g. Nursing)	Continue external conversations and ensure awareness of proposed changes	Ongoing	Complete Change in Government process has enabled the Trust to obtain Tier 2 visas. No longer a gap in control
		Process not in place to gather recruitment experience	• Implement recruitment strategy – PH	~~Q3 18/19~~ 31/03/2019	Deadline revised to align to the operating plan
			• Procurement of TRAC recruitment system –– PH	Q3 18/19	Complete
		Implementation of new approaches to retention	Pilot innovative approaches to retention e.g. transfer windows	July 18 – Jan 19	'Stay' conversation commenced November 18. Action complete

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
		Feedback gaps (candidate/ starter/ leaver)	Exit interviews –- PH 100 day new starter survey - PH	March 18 June 18	In place
		Inability to triangulate hard and soft metrics on wellbeing of staff /depts	Triangulating hard and soft workforce metrics - PH	Q2 18/19	Action closed as duplicated below
		E-Roster not rolled out to wider workforce	Integration and roll out of eRoster ~~–PH~~ LW	Q4 18/19	
		Resourcing strategy does not align temporary and substantive staffing needs	Transfer of Bank function into OD & People Directorate – PH	~~Q3 18/19 Date TBC~~ 1 April 2019	Work commenced. Alignment period with HR and nursing working together for transition. March update: Transfer scheduled for 1 April 19
		Programme of staff benefits not fully developed	Programme of staff benefits –PH	~~Q2 18/19~~ March 19	Options appraisal underway. Action aligned to operating plan deadline
2. Establish effective partnerships to align business and HR strategies	• New Workforce KPI Dashboard • New structure for HR implemented 3 April with vacancies going out and some interim cover	• Lack of management training and toolkits on key people management topics	Rolling programme commencing Q1 – PH - First tool kit – sickness absence	Q1 18/19	Commenced
		• Maximising ESR system capabilities – inaccurate establishment hierarchy in ESR	Optimise use of ESR to enable accurate reporting and feeder systems to function - PH	March 19	ESR group established. Business case for December
		• Current inability to triangulate hard and soft data across the organisation	Triangulating hard and soft workforce metrics - PH	~~Q2 18/19 Dec 18~~ 30/06/2019	Paper being presented at Workforce Committee January 19. Investment required. Deadline revised

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
		• Immature Business partner model for service delivery	• Appoint to vacant senior posts –- PH	~~Q3 18/19~~ ~~In progress~~ 31/03/2019	Failed to appoint following Nov 18. Re-advertising Jan 19interviews. Deadline revised
3. Improve the health and wellbeing of staff	• Staff sickness benchmarks well against local Trusts at approx 3.6% as an average. • Shape up at Salisbury offering for staff well supported. • Onsite Occupational Health and staff counselling services • Over 70% of front line staff vaccinated against influenza	• Staff sickness remains above 3% target • Sickness absence management inconsistent • Sickness absence reporting processes and data not robust • Current inability to triangulate hard and soft data across depts.	• Redesign electronic sickness reporting process – PH	Q4 18/19	
			• New sickness absence policy –- PH	Q1 18/19	Completed
			• Managers' tool kit – PH	Q3 18/19	In place for sickness. Further development planned
			• Health & Well Being Strategy –- PH	~~Q2 18/19~~ ~~Dec 18~~ 31/03/2019	New lead commenced Jan 19. Strategy aligned to operating plan. Deadline revised
			• Trust wide E-Roster roll out to provide real time sickness data - PH	Q4 18/19	
4. Develop a diverse and inclusive culture where staff feel engaged	• Staff survey results in upper quartile nationally • Staff Friends and Family Test results are positive • WRES Trust action plan in place • Publication of Trust's Gender Pay Report	• Mandatory Training compliance above target of 85% • Appraisal rates for non-medical staff remain below target of 85% • Funding gap for education and training	L&D full service review –PH	Q2 18/19	Complete Department re-structured
			Delivery of the operating plan	March 19	

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
5. Develop strong leadership capability across all levels of the organisation to support an innovation culture	• Leadership programmes in place • Strong relationships with local providers • Values embedded • Equality and Diversity System 2 (EDS2) in place	• Lack of robust talent management and leadership development programme across the Trust. • Leadership programme not aligned to culture (in development	OD and engagement plan implementation - PH	~~Q3 18/19~~ 31/03/2019	Paper to Workforce Committee January 19. Alignment to operating plan. Deadline revised
		• Lack of comprehensive engagement and communication strategy in place.	Service redesign and delivery following L&D full service review — PH	~~Q3 18/19~~ 31/03/2019	To be completed by J Scrase on return end January 19.

Strategic Priority:

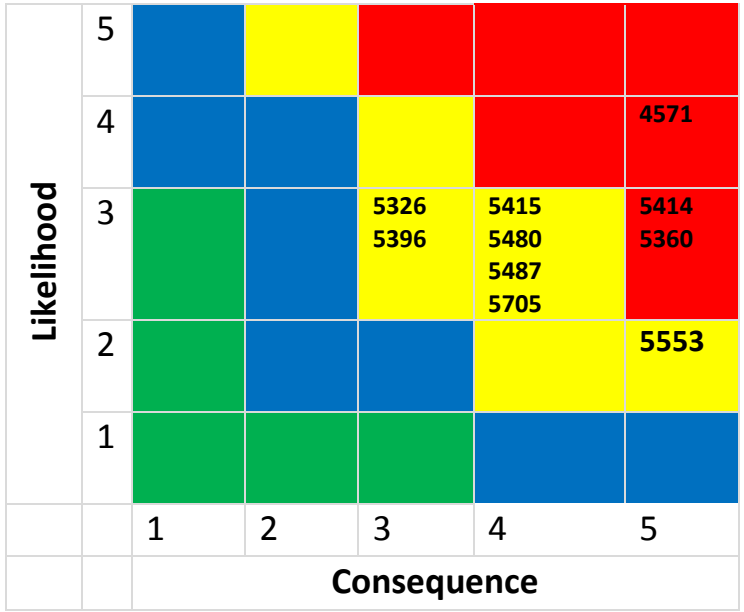
Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Financial Recovery Plan -** Deliver on financial recovery plan to secure financial sustainability	DoF	March 2019	
2. **Campus Scheme** - Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	DoCD	April 2021	
3. **Digital Strategy -** Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	DoCD	April 2021	
4. **Service Reviews -** Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	MD	March 2018	

Corporate Risk Register Principal Risks



5326 - Review, PACS, POET, Lorenzo, WinDip & Paper Records
5396 – Delivery of CQUIN
5415 – Funding of all capital expenditure
5414 – Achievement for 2018/19 financial plan
5480 – Control of quality of information submitted externally
4571 - Potentail failure of sterilisers, washers and associated plant
5553 – SUS/SLAM reconciliation
5487 - Subsidiary impact on financial position
5360 - Risk of cyber attack
5705 - Impact on the daily running of the hospital as a result of Great Britain's exit from the European Union

Linked risks:

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 • 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) • Strategy Committee			• 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**
• Health Education England Board reporting • NHS England board reports • NHSI board reports • Professional body sector reporting (BMA, RCN, RSP)	• Key members of the local Workforce Delivery Board • BSW STP transformation plan and development of STP response to NHS Long Term Plan NHSI collaborative participation in workforce programmes

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due	Progress
1. Deliver on financial recovery plan to secure financial sustainability	• Outstanding Every time Board established with CEO chairing monthly • Plan developed with savings opportunities identified as part of the financial plan 2018/19 • Transformation Director appointed (commenced April 18)	• Engagement with STP and Commissioners on SFT recovery plan	Continue to actively participate in STP recovery plan actions – LT/CB/LA/CCB	Ongoing	Implemented and on-going
		• Capability and capacity across the organisation to deliver change at pace	Transformation Director to identify gaps - SW	Ongoing	Completed
		• Recruitment challenges across the organisation limit delivery of the plan	Implement recruitment strategy – PH	~~Q3 18/19~~ 31/03/2019	Deadline revised to align to the operating plan
		• Two-year financial recovery and sustainability plan yet to be finalised	Submit 2 year financial recovery and sustainability plan – LT	9 July 18	Complete
			Further work on 2 year financial recovery and sustainability plan following NHSI feedback - LT	~~Oct 18~~ 31/01/19	Re-submission due Jan 19
		• Action plan to be completed in response to NHSI Enforcement Letter	Delivery against action plan - LT	Ongoing	Nov 18 update to F&P Committee
2. Develop a financially viable scheme to rejuvenate and improve the utilisation of the	• Additional management capacity with experience in delivering similar projects secured • National schemes are coming on line which offer potential frameworks for development	• Link into wider Trust strategic estate plans needs strengthening	Produce strategic estates plan – LA	~~Sept 18~~ ~~28/02/2019~~ 31/03/2019	Estates Strategy on March Board agenda. Deadline revised

estate	• Support from Wiltshire Council and commissioners for proposed scheme • Advanced discussions with potential private sector partner for Joint Venture agreement • Positive early clinical engagement • Communication/PR expertise appointed • Strategy Committee commenced in March 2018 • Signed agreement for private sector partner • Master planning commenced and working effectively • Submitted capital bid for low risk maternity unit	• Absence of detail to progress financial modelling	Development of overarching business case - LA	~~Dec 18~~ 30/06/19	Extensive piece of work. Deadline revised to 30/06/19
3. Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	• Early draft of document developed to begin consultation • Foundation of an integrated patient record system exists which can be linked to other systems • Strong engagement from some clinical quarters, eg nursing • External support commissioned to support development of digital strategy	• Delay in subsequent phases of EPR, delivery against business case • System supplier engagement	Escalation of issues at director level with supplier – LA	Dec18	Complete
		• Because of usability issues, risk around engagement • Lack of capital funds to invest (potential national funds will be allocated by the STP) • Gap in control due to pharmacy resources to progress the business case	Develop business case for Electronic Prescribing – CB/LA	Oct 18	Business case developed
		• Need to redefine the role of ISSG in taking forward the digital strategy	Redefine role following agreement of digital strategy– LA	Oct 18	Complete

		• Difficulties from information held in both paper and digital form	Develop Digital Strategy – LA	~~Sept 18~~ March 19	Going to Nov Strategy Committee with plan for Board in Dec 18. Now to Board in March 19
			Further development of EPR in line with digital strategy, on a module-by-module basis commencing with electronic prescribing – LA	~~Q3, 2018~~ Jan 19	
4. Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	• Outstanding Every time Board established with CEO chairing monthly to oversee programme. • Additional capacity procured to support the development and delivery of the recovery programme (core services one element) • Use of Model hospital and GIRFT to support pathway change in place.	• Timeliness of publication of relevant benchmarking information to support decision making. • Capacity to undertake reviews then implement change at pace. • Structured framework to evaluate core clinical services for sustainability	Improvement plan process to be agreed	Nov 18	Complete
			Project plan and governance in place for GIRFT review	Nov 18	Complete
			Review of the Model Hospital to support improvement programme2019/20	Jan 19	

Corporate Risk Register Summary – March 2019

Risk Score Key

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

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	April 18	Jun 18	Jul 18	Sep 18	Nov 18	Jan 19	Mar 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												
5751	Risk of impact on patients from high numbers with a delayed transfer of care (NEW).	Chief Operating Officer	March 2019	16							16	4
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population												
3322	Genetics National Reconfiguration	Medical Director	Aug 2013	12	8	6	12	12	12	9	9	6
4808	Vascular surgery provision	Chief Operating Officer	Sept 16	16		16	15	9	9	12	12	3
5007	Endoscopy Unit JAG accreditation deferred for 6 months to address 18 key actions	Chief Operating Officer	Nov 18	9					12	12	15	2
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered												
	No identified risks											
Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm												
5384	Inpatient fall resulting in harm; increasing frail population	Director of Nursing	Apr 2018	12	12	12	12	12	12	12	12	8
4107	Failure to adhere to clinician requested timeframes	Chief	Sept	12	9	9	9	9	9	9	12	6

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	April 18	Jun 18	Jul 18	Sep 18	Nov 18	Jan 19	Mar 19	Target
	for follow-up appointments for skin cancer patients	Operating Officer	2015									
5577	Risk to patient safety due to overcrowding in ED	Chief Operating Officer	Nov 18	20					15	12	16	8
5607	Risk of minor errors regularly occurring and potential risk of serious incident within the Hospital at Night team due to increase in workload but no increase in staffing	Director of Nursing	Oct 18	12						12	16	6
5704	The inability to provide a full gastroenterology service due to a lack of medical 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	Chief Operating Officer	Jan 19	16						16	16	8
5706	Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment	Chief Operating Officer	Jan 19	12						12	12	8
5558	Risk of inability to provide tumour site specific services to patients due to medical workforce establishment in oncology (NEW)	Chief Operating Officer	March 19	15							12	8
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams												
5107	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care	Director of OD & People	Apr 2017	12	16	16	16	16	16	16	16	12
5364	Failure to achieve ward nursing establishment	Director of Nursing	Mar 2018	16	20	20	20	20	20	16	16	12

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	April 18	Jun 18	Jul 18	Sep 18	Nov 18	Jan 19	Mar 19	Target
Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources												
5326	Review, PACS, POET, Lorenzo, WinDip & Paper Records	Director Corporate Dev	Dec 17	6		9	9	9	9	9	9	4
5396	Potential non delivery of CQUIN schemes	Director of Finance	Apr 18	16		12	12	12	12	9	9	6
5415	Unable to fund all capital expenditure requirements	Director of Finance	May 18	12		12	12	12	12	12	12	12
5414	Trust does not achieve its financial plan in 2018/19	Director of Finance	May 18	15		15	15	15	15	15	15	10
5480	Control of the quality of information submitted externally	Director Corporate Dev	July18	12			12	12	12	12	12	6
4571	Potential failure of sterilisers, washers and associated plant	Chief Operating Officer	Sept 2018	12				15	20	20	20	6
5553	Failure of the SUS/SLAM reconciliation process	Director Corporate Dev	Sept 2018	15				15	10	10	10	5

5487	Subsidiary financial performance and risk to SFT financial position	Director of Finance	Nov 2018	12					12	12	12	9
5360	Risk of cyber attack	Director of Finance	Nov 2018	15					15	15	15	9
5705	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	Chief Operating Officer	Jan 2019	12						12	12	8

Corporate Risk Register
March 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
3322	Clinical Support and Family Services	Genetics	29/08/2013	Organisational risk assessment	12	National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury. 05/07/2018 CAW: Funding flows for Genetic testing will change following re-procurement. NHSE planned start date is 1st Oct 2018. SNHSFT will no longer be commissioned for Genetic tests via the SW specialist services commissioning group so the Block contract will end. Instead funding for rare and inherited genetic tests will be received via the Genomics Hub (Birmingham). All acquired cancer genetic tests will be moved to provider to provider funding. This includes many haemato-oncology tests currently funded by the Block contract (estimated £900k p.a.)Referring departments will be expected to fund genetic tests from within tariff. There is therefore a risk that income will be reduced if Clinicians/Trusts have to mitigate against the increased costs by applying greater clinical thresholds to testing. 20-12-18: Funding arrangement for 2019/20 likely to be rolled over by NHSE.	May recur occasionally	Moderate	9	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.	01/04/2018	25/01/2018	Blanshard, Dr Christine	Trust Board	29/03/2019	6	Specialist Services	Clinical Governance Committee, Finance Committee, Trust Board (Corporate Risk Register)	Medical Director
										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.	31/10/2018	30/11/2018	Blanshard, Dr Christine						
										Need to consolidate DNA extraction into a single lab in Wessex. Will require negotiations with UHS.	29/03/2019		Cross, Prof. Nick						
										Communication plan with referring hospitals to inform they will be required to fund cancer testing from tariff.	01/04/2019		Thomas, Lisa						
5326	Corporate Development	Electronic Patient Record Team	20/12/2017	Electronic Patient Record	6	Review, PACS, POET, Lorenzo, WinDip & Paper Records - information in these systems are required to fully assess patients - access is required to all the above systems and there is a risk that information may be missed due to overhead of access and or clarity on what information is where - leading to inefficiency delays and potential patient harm	May recur occasionally	Moderate	9	Training review being commissioned to provide holistic training for clinical staff	31/01/2019	08/02/2019	Lees, Susan	Electronic Patient Record	12/04/2019	4	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Describe within digital strategy how information from a range of sources will be used	07/03/2019		Burwell, Jonathan						
										Set up governance structure for development of digital strategy	28/09/2018	24/10/2018	Arnold, Laurence						
										Secure support from clinicians to be CCIO and Clinical safety officer	30/10/2018	24/10/2018	Blanshard, Dr Christine						
										Upgrade to WinDip	12/04/2019		Ford, Nicola						

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
5396	Quality Directorate	Trustwide	04/04/2018	Commissioning for Quality & Innovation (CQUIN)	16	Potential non delivery of CQUIN schemes that are high risk: 1a - improvement of health and wellbeing of NHS staff - 5% improvement in 2 out of 3 questions in the staff survey required. Responses to all 3 questions decreased between 2016 & 2017 survey. £138K at risk. 1C - Improving uptake of flu vaccine for front line staff - no opt out for West Hampshire. Target increased from 70% - 75% and includes all temporary staff. £34k at risk. 2A & 2B - Sepsis - achievement of 90% of inpatients with severe sepsis screened and given IV antibiotics within 1 hour of diagnosis may not only achieve a partial payment due to small numbers. £62K at risk 2D - Antibiotic consumption reduction - 2% reduction on 17/18 baseline in total antibiotic consumption and an increase to > 55% in the proportion of antibiotics usage within the Access group of the AWaRe category. £69K at risk. 9A - Reducing risky behaviours - achieving 90% screening of all inpatients for smoking due to sheer volume of patients. £2.5K at risk. 19/7/18 Monies at risk £305.5K at year end. 31/12/18 Wiltshire CCG and associates have agreed the payment of CQUIN in full as we have achieved over 50% compliance in Q1 and Q2 18/19. 30/1/2019 Monies at risk increased to £363K at year end as in Q3 failed to meet 90% target of NHSE CA2 SACT scheme - mitigated by working with UHS on priority drugs to be dose banded. Year end deal in place of £65K loss on CQUINs compared to an actual loss of £237K)	May recur occasionally	Moderate	9	Reduce the level of work related stress and MSK work related problems in groups of staff who have the highest rates. Target high risk groups for action through work led by DD of HR and staff & health wellbeing group. Actively promote the staff health and wellbeing programme.	01/04/2019		Hargreaves, Paul	Finance and Performance Committee	30/04/2019	6	Innovation, Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Increase the uptake of the flu vaccine of front line staff by running a comprehensive flu campaign based on learning in 17/18.	31/01/2019	30/01/2019	Major, Denise						
										Improve the screening and treatment of inpatients for severe sepsis by continuation of the current ward based CCOT education programme, regular feedback on timeliness of screening and IV antibiotics audit. Monitor progress through the Sepsis working group.	31/07/2018	31/07/2018	Finneran, Dr Nicola						
										Reduce the consumption of carbapenem by 2% on the 17/18 baseline.	31/10/2018	02/11/2018	Williams, Lou						
										This action is no longer relevant as NHSE withdrew the requirement of a 10% reduction in all people who attend ED with mental health needs who had a personalised care plan. Instead a 2nd cohort was identified with specific work tailored to their needs to help them reduce ED attendances.	19/07/2018	19/07/2018	Davies, Dr Stephen						
										Screen 90% of inpatients for alcohol and smoking by the ward pharmacy teams. Review screening data weekly until 90% is sustained.	31/07/2018	31/07/2018	Smale, Maria						
										Reduce the consumption of all antibiotics by 2% on the 17/18 baseline.	31/03/2019		Williams, Lou						
										Increase to >55% in the proportion of antibiotic usage within the Access group of the AWaRe category.	31/03/2019		Williams, Lou						
										Consider the introduction of antibiotic stewardship rounds, education and feedback to individual clinicians and teams on practice.	31/03/2019		Williams, Lou						
										Take part in antibiotic awareness week. Agree protocol changes at the Infection Prevention and Control Group.	30/11/2018	16/11/2018	Williams, Lou						

Corporate Risk Register
March 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
5553	Corporate Development	Trustwide	21/08/2018	Data quality	15	SFT send a regular data feed to the secondary usage service (SUS) which should be broadly consistent with the contractual data provided - the contract requires within 2%. An incident occurred whereby the year end SUS refresh greatly exceeded that level putting into question the lack of a robust reconciliation process.	happen again but it is possible	Catastrophic	10	Documented process for Monthly SUS Slam Reconciliation.	01/04/2019		Mortimore, Martin	Audit Committee	01/04/2019	5	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Reconciliation Dashboard for PbR to be finalised and published for key internal stakeholders access.	12/12/2018	19/12/2018	Mortimore, Martin						
										Trust to support CSU to update commissioner reporting with accurate 2017/18 dataset for outpatients.	02/11/2018	08/11/2018	Anscombe, Felicity						
5558	Medicine	Oncology Outpatients	21/09/2018	Specialty Risk assessment	15	The medical workforce establishment in oncology comprises 3 medical and 2 clinical oncology consultants (all employed by UHS but working at SFT 2-3 days per week), a specialty doctor working 2 days a week, plus 1.0wte middle grade doctor employed by SFT to provide medical support to the Acute Oncology team (AOT). Each consultant works only within a specific tumour type, so there is no cross cover for scheduled or unscheduled leave, with reliance on locum support for prolonged periods of leave such as vacancies or maternity/sickness leave. NHS locum support has been extremely hard to obtain, and agency locum cover is expensive, and can be unreliable or of substandard quality. This has potential to result in inability to provide tumour site specific services to patients if posts are unfilled either substantively or by locums. The middle grade AOT post has historically been hard to recruit to, with long gaps between appointments, or expensive agency locums. This means that there may be no medical input to the AOT which may result in inadequate medical assessment of patients or unnecessarily prolonged inpatient stays.	Will probably recur, but is not a persistent issue	Moderate	12	Discuss with UHS re plan for cover - ? locum to be put in place whilst substantive appointment is made Deputy DM for Medicine to meet with team at UHS to discuss plan.	28/02/2019		Barrett, Mrs Jessica	Directorate Management Team Meeting	31/03/2019	8	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Telephone call with UHS planned between DDM, Clinical Lead and DM at UHS re future provision	06/03/2019		Barrett, Mrs Jessica						
5415	Finance and Procurement	Trustwide	01/05/2018	Trustwide risk assessment	12	There is a risk that the Trust cannot fund all capital expenditure requirements to support the delivery of high quality care due to the deficit position and the limitations of cash availability. This could lead to a negative impact on the delivery/quality of care, the ability to achieve performance and access targets and the ability to transform and innovate to become more efficient.	May recur occasionally	Major	12	Trust identifying opportunities for additional capital funding as per STP (8th June). 22/6/18 - Trust submitted bids for Cath Lab and Maternity to STP, awaiting outcome.	29/06/2018	22/06/2018	Thomas, Lisa	Finance and Performance Committee	30/04/2019	12	Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Business being developed for Cath lab funding as a material risk in year-end of June	30/04/2019		Thomas, Lisa						
										Trust currently has slippage against capital programme, evaluation of capital forecast and potential spend for Q4 presented to F&P in January	26/02/2019		Thomas, Lisa						
5480	Corporate Development	Trustwide	23/07/2018	Incident reports	16	Risk of poor controls to ensure the consistency and accuracy of information reporting including validation practices leading to inaccurate information being used either within the organisation or leaving the organisation which could lead to 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	31/08/2018	01/11/2018	Doubtfire-Lynn, Heidi	Audit Committee	23/04/2019	6	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Complete Serious Incident Inquiry in order to review what additional controls require adding.	30/11/2018	02/11/2018	Arnold, Laurence						
										Creation of Information Standards Committee to oversee external information accuracy and timeliness	31/01/2019	18/02/2019	Burwell, Jonathan						
										Review of progress to improve medium and high risks for external information reports	23/04/2019		Burwell, Jonathan						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5487	Finance and Procurement	Finance Department	26/07/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation.	May recur occasionally	Major	12	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	21/12/2018	19/12/2018	Thomas, Lisa	Finance and Performance Committee	29/03/2019	9		Trust Board (Corporate Risk Register)	Director of Finance
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	29/03/2019		Thomas, Lisa						
5705		Trustwide	31/01/2019	National guidance	12	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.	May recur occasionally	Major	12	Completion of risks assessments.	31/03/2019		Hyett, Andy	EU Exit Planning Group	31/03/2019	8	Resources	(Corporate Risk Register)	Chief Operating Officer
										Delivery of any new national actions.	31/03/2019		Hyett, Andy						
5706		Trustwide	31/01/2019	Directorate risk assessment	12	Risk of inability to provide interventional radiology service due to a lack of interventional radiologists with potential delay in care, treatment and diagnosis. Patients may have to travel to other centres to receive treatment.	May recur occasionally	Major	12	Continued dialogue with UHS.	01/04/2019		Hyett, Andy	Directorate Performance meeting	31/03/2019	8	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										In discussion with other providers to provide an interventional radiology service.	01/04/2019		Hyett, Andy						
										COO, MD and CDs to meet to review clinical impact.	15/03/2019		Hyett, Andy						
4107	Musculo-Skeletal	Musculo-Skeletal Directorate Management Offices	17/09/2015	Service Delivery Plan, Specialty Risk assessment	12	Failure to adhere to clinician requested timeframes for follow-up appointments for cancer patients . Risk of 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	Moderate	12	Further recruitment of 2 plastics consultants	18/12/2015	11/10/2016	Wright, Jonathan	Directorate Management Team Meeting	31/03/2019	6	Care	Clinical Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Chief Operating Officer
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	17/01/2017	25/01/2018	Insull, Victoria						
										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	17/01/2018	17/01/2018	Insull, Victoria						
										monitor and review capacity and time to follow up	31/12/2018	21/12/2018	Vandyken, Ali						
										Reviewing the cause of all patients lost to follow up. Cross refereeing Lorenzo, with Somerset Cancer registry. And reviewing admin process for follow-ups.	30/04/2018	08/05/2018	Hyett, Andy						
										Reviewing the cause of all patients who have been lost to follow up and reviewing admin processes.	31/08/2018	16/08/2018	Hyett, Andy						
										Full follow up PTL being validated at patient level for 2017 and 2018.	29/03/2019		Hyett, Andy						
										Trajectory to be agreed with COO by 31/04/2019.	30/04/2019		Burwell, Jonathan						
										Executives to review approach to patient pathway redesign.	31/03/2019		Blanshard, Dr Christine						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
4808	Surgery	Vascular Assessment Unit and Diabetes Unit	26/09/2016	Departmental risk assessment	16	Vascular surgeon cover is provided from RBH at SDH onsite 3 days per week. Currently due to staffing issues RBH are unable to provide 3 days cover and clinics are being cancelled. Cover has been reduced to 1 day on most weeks, with some weeks there being none. As a result patients are being delayed in attending outpatients. Urgent patients may need to travel to RBH for treatment rather than SDH. Angio procedures are unable to be undertaken at SDH without onsite vascular cover which has resulted in cancellations. There is a lack of MDT meetings which has slowed progressing patients on their pathways and delays results and treatments to patients. The vascular department do not have access to advice and support when managing nurse led clinics or patient queries. Update 16/08/18: Service reinstated from RCBH into SFT. External review ongoing which we are participating in.	Will probably recur, but is not a persistent issue	Moderate	12	Meeting with RBH and SDH representatives to resolve issues regarding cross site IT access and on site IR provision	18/02/2018	11/06/2018	Drayton, Louise	Directorate Management Team Meeting	31/03/2019	3	Care, People, Specialist Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Escalate IR provision issues through Exec performance review process.	31/01/2018	30/04/2018	Drayton, Louise						
										Escalated to the Chief Exec, Medical Director & Chief operating officer equivalents at RBH	31/08/2018	16/08/2018	Hyett, Andy						
										Meeting scheduled for 12/09/18 between SFT and RBH on 12/09/18. Risk, actions, and target to be updated following meeting.	12/09/2018	02/11/2018	Hyett, Andy						
										Meet Bournemouth in Q4 to ensure service has been sustained and quality issues have not returned (with a view to closing this risk if there is a positive outcome from this meeting).	31/03/2019		Blanshard, Dr Christine						
5384	Quality Directorate	Trustwide	29/03/2018	Incident reports	12	Risk of patients within hospital experiencing a fall resulting in injury. 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.	01/08/2019		Lowe, Tarah	Falls Group	15/04/2019	8	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Implementation of nursing assessment documentation which incorporates a multifunctional assessment and intervention form.	30/04/2018	02/05/2018	COLLK						
										Compliance audits of falls care plans and interventions.	28/09/2018	16/10/2018	COLLK						
										DSN's and Associates to be in attendance at the SWARMs	30/04/2018	15/08/2018	Benson, Rebekah						
										DSN's and Associates to be in attendance at the SWARMs	29/03/2018	29/03/2018	Wilding, Henry						
										DSN's and Associates to be in attendance at the SWARMs	29/03/2018	15/08/2018	Dunn, Bernie						
										DSN's and Associates to be in attendance at the SWARMs	30/04/2018	15/08/2018	Montgomery, Alison						
										Refreshed Share and Learn sessions	30/04/2018	02/05/2018	Major, Denise						
										Participate in NHSI Falls Collaborative.	03/12/2018	20/12/2018	Major, Denise						

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
5007	Clinical Support and Family Services	Endoscopy	15/12/2017	Departmental risk assessment	9	As a result of the JAG visit on the 29th August 2018, the visiting assessment team's made the decision to defer awarding the Endoscopy Unit with accreditation for 6 months. As a result of this decision, the Trust/Endoscopy Unit has six months from receipt of the official Report to meet any key actions required before the cut off date in order for accreditation to be awarded. There were 18 Key actions that were identified form the report There is a risk that all the actions may not be met which may result in accreditation not be awarded to the Endoscopy Unit. These action relate to various IT issues inaccurate date collection, insufficient IT systems to support the Service, HAL data base not NEDS and JETS compliant, aspects of the Decontamination process not clearly auditable. Booking processes need consideration and action plans.	Will undoubtedly recur, possibly frequently	Moderate	15	[27/06/2017 15:32:49 Henry Wilding] Miss Chave laising with Mark Newton (IT) to confirm what JAG requirements are and how in house system can be adjusted to meet these needs	28/09/2018	28/08/2018	Phillips, Lisa	Directorate Management Team Meeting	31/03/2019	2	Specialist Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Will discuss with Miss Chave to see where we are with this process for update.	31/01/2018	28/08/2018	Phillips, Lisa						
										Delays were escalated to Exec Team by DMC. Head of IT involved. Currently trialling system with fabricated data. HSC/LP to keep DMC informed of progress at Endo DMC meeting.	28/09/2018	28/08/2018	Phillips, Lisa						
										Post JAG visit 29 Aug, full responsibility for resolution to sit with IT. Discuss at Exec Performance review Sep ? escalation to Corporate Risk Register.	31/10/2018	23/10/2018	Montgomery, Alison						
										Working group established to work towards achieving all 18 actions identified on the JAG report. Please note that updates and are to be submitted to JAG in November 2018, January and March 2019	30/11/2018	30/11/2018	Stagg, Andrew						
										Update to be submitted to JAG Nov 18	30/11/2018	30/11/2018	Phillips, Lisa						
										Update to be submitted to JAG Jan 19	31/01/2019	28/02/2019	Phillips, Lisa						
										Completed action plan and evidence to be submitted to JAG Mar 19	29/03/2019		Phillips, Lisa						
										Update on progress/issues to escalate to Execs via monthly CSFS Performance meeting	29/03/2019		House, Nicki						
5414	Finance and Procurement	Trustwide	01/05/2018	Trustwide risk assessment	15	There is a risk that the Trust does not achieve its financial plan in 2018/19. Due to the inability to deliver the CIP programme and planned activity levels alongside cost pressures. Could result in further regulatory action, the Trust entering special measures. The Trust needing to borrow additional cash and the impact on the reputation of the Trust.	Will undoubtedly recur, possibly frequently	Moderate	15	Trust currently developing plan to achieve revised control total, with additional savings/cost reduction schemes scheduled for Board approval 7th June. Trust Board approved plan - submitted to NHSI 20/6/2018. Update on additional savings going to 6th July Board of Directors.	31/07/2018	26/07/2018	Thomas, Lisa	Finance and Performance Committee	29/03/2019	10	Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Trust following arbitration with Dorset, agreeing terms of data quality audit by 6th June. Trust Board agreed indicative contract - going to Finance & Performance Meeting 26/6/18	29/06/2018	26/07/2018	Thomas, Lisa						
										Year end forecast to be completed by the end of Q1 identifying key risks to financial position	24/07/2018	24/07/2018	Thomas, Lisa						
										Close scrutiny of savings programme and directorate financial performance monitored monthly, with recovery plans for areas projecting overspends. Trust reforecast to NHSI in January 2019, gap against control total expected of £1.6m. Cash borrowing in place to support revised position.	31/03/2019		Thomas, Lisa						
										LT to have a discussion with commissioners on support to the Trust achievement of the revised control total. LT to discuss with Wiltshire CFO on what support can be provided.	31/08/2018	15/08/2018	Thomas, Lisa						

Corporate Risk Register
March 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
5360	Corporate Development	Information Technology	28/02/2018	Data Protection	15	On Friday 12 May 2017, a global ransomware attack, known as WannaCry, affected a wide range of countries and sectors. Although WannaCry impacted the provision of services to patients, the NHS was not a specific target. There is a significant risk that Salisbury NHS Foundation Trust could potentially be hit by a rogue cyber attack or ransomeware attack in the not too distant future. This could result in IT systems being shut down, compromising patient care which will result in lost revenue. Even the most robust information security and disaster recovery plan is never failsafe. At this present moment in time SFT will be unable to obtain cyber security and ransomeware insurance as it is unable to demonstrate that all appropriate organisational and technical measures are in place to prevent the Trust IT infrastructure being breached. Data breach insurance generally covers incidents including and not limited to: *Forensic investigations *Legal advice/assistance *Public relations *Specialist contractors *Revenue protection Response to a data breach as a result of actions by an employee, contractor or external party such as a hacker - includes physical theft of data on paper or digital media. Time used in remedial actions directly related to the breach. Costs incurred through dealing with third parties i.e. hosting companies. 25/05/18 Risk ownership transferred from LA to BN. About to go out to tender for new anti virus software. This will include Ransomware software. Once installed this risk can be closed. Funded from capital - 7955C0 30/08/18 Tender complete. Order placed. Installation planned to complete by end November 2018 3/12/18 Order stopped. Now being re-raised, Complete by end February	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	14/12/2018	Noble, Bob	Information Governance Steering Group	23/04/2019	9	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob						
5364	Quality Directorate	Trustwide	01/03/2018	Trustwide risk assessment	16	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	Major	16	Domestic recruitment campaigns	30/04/2019		Wilkinson, Lorna	Trust Board	01/04/2019	12	People	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Overseas recruitment campaigns.	30/04/2019		Wilkinson, Lorna						
										Skill mix review x 2 per year	30/04/2019		Wilkinson, Lorna						
										Retention workstream to be completed	30/04/2019		Wilkinson, Lorna						
										Participate in NHSI collaborative for enhanced care.	31/12/2018	20/12/2018	Wilkinson, Lorna						
										Development of microsite	31/10/2018	29/06/2018	Wilkinson, Lorna						
										Develop apprenticeships and Nursing associate opportunities to broaden access into nursing	30/04/2019		Wilkinson, Lorna						
										Continue full recruitment of Nursing Assistant staff	30/04/2019		Wilkinson, Lorna						
										Closed as not applicable to this risk (Continue to ensure governance processes as listed within controls are embedded and influencing clinical practice, cleaning and antibiotic stewardship.)	01/04/2019	02/05/2018	Wilkinson, Lorna						
										Twice daily staffing review using safe care and roster data.	30/04/2018	30/04/2018	Hyett, Fiona						

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
5107	Organisational Development and People	Trustwide	27/03/2017	Trustwide risk assessment	12	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care. The impact of this effects staff morale and is unsustainable for the existing workforce if not addressed. Patient safety is at risk with gaps in substantive clinical workforce and cost of workforce increases over budgets. NHSI control total will be at risk. of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services. Identified specialities are not recruited to establishment and therefore there is a reliance on a temporary workforce such as bank and agency. This has an impact on reputation, quality and financial aspects of the organisation. Posts identified include specialist Medical Posts (i.e. Dermatology, Community Geriatricians, Gastroenterology, Opthalmology) where this is a national recruitment problem and nursing post (particualrly medicine) where this is a supply problem	Will probably recur, but is not a persistent issue	Major	16	Procurement agency staff at tier 1 rates only.	30/03/2018	23/01/2018	Wilkinson, Lorna	Finance and Performance Committee	01/04/2019	12	People	Finance Committee, Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Review and consider threshold of care whilst maintaining safe patient services.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Tight control of agency and specialing.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Recruitment and retention initiatives eg introduction of automated exit questionnaires, career clinics for nurses and transfer process.	30/03/2018	29/05/2018	Hargreaves, Paul						
										Review rosters and job plans.	01/04/2019		Blanshard, Dr						
										Look to partnerships with other Trusts to cover hard to fill posts. Have joined 'Clinicians Connected' and Locums Nest collaborative bank. STP Workforce strategy in development - recruitment stream.	01/04/2019		Hargreaves, Paul						
										Review of loss making clinical activities predominately supported by locums as part of business planning.	30/03/2018	23/04/2018	Blanshard, Dr Christine						
										Launch overseas recruitment and more focussed recruitment in the UK.	30/03/2018	02/05/2018	Wilkinson, Lorna						
										Review & update (if appropriate) financial section of business case template for the appointment of medical staff.	30/03/2018	23/04/2018	Blanshard, Dr Christine						
										Transitioning work with Army - making links with the groups moving back onto the plain - promoting careers at Salisbury with Army spouses	31/12/2017	25/01/2018	Holt, Sharon						
										Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning	29/09/2017	25/01/2018	SALISH						
										Use of head hunting agencies to secure medical locums	31/03/2017	05/04/2017	Hargreaves, Paul						
										Monitoring agency usage via 'Reducing Agency Spend' group.	31/03/2017	05/04/2017	Wilkinson, Lorna						
										Monitoring of vacancies	31/03/2017	05/04/2017	Hargreaves, Paul						
										'Branding' of Salisbury to promote reputation.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Use of other medias including social media (Facebook and Twitter) to promote Trust	31/03/2017	05/04/2017	Hargreaves, Paul						
										Liaison with University to assess and promote student experience to ensure students consider SFT a positive place to work.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Working with training institutions to raise the profile of Salisbury and attendance at careers fairs such as university or national.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Recruitment initiatives such as 'refer a friend', European Recruitment, job fairs	31/03/2017	05/04/2017	Hargreaves, Paul						
										Implementation of a collaborative medical bank through Locums Nest.	01/05/2018	29/05/2018	Holt, Sharon						
										To develop additional international recruitment pipeline by attending events in Australia and the UAE during 2018. Recruitment would be direct hire therefore saving the Trust an agency recruitment fee.	31/03/2019		Holt, Sharon						
										Develop "grow our own" approach for hard to fill vacancies.	31/03/2019		Holt, Sharon						
										Develop the use of apprenticeship roles within the Trust.	31/03/2019		Holt, Sharon						
										Maximising the use of 'Locums Nest' as a shared Medical Staff bank.	31/10/2018	16/10/2018	Blanshard, Dr Christine						
										Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning, introducing stay conversation, 100 day survey and staff transfer scheme (repeat of previous action - re-opened).	01/03/2019	08/03/2019	Holt, Sharon						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5577	Medicine	Emergency Department	02/10/2018	Departmental risk assessment	20	There is a risk to patient safety due to overcrowding in the ED and increasing time to first assessment and time to treatment. This is influenced by key staff shortages and increasing demand. Nursing vacancies have reached a level whereby a 24/7 rota with experienced and substantive staff is not possible and agency staffing is being used. There is a risk of failing the ED 4 hour constitutional standard due to increased demand, increased acuity and inability to transfer patients into wards. At peak times in ED there is a risk of ambulances waiting to handover for prolonged periods of time. The ambulance service implement a SOP to prevent ambulances being delayed. Ambulances queuing or SOP being implemented has implications for patient safety as staff work under increased pressure to move patients out of ED to create space. When the SOP is implemented, patients are managed by and ED member of staff in a trolley queue which is unsafe for patients.	Will probably recur, but is not a persistent issue	Major	16	Discussions with SWAST and other Paramedic providers re provision of Navigator role	31/01/2019	01/02/2019	East, Rachael	Directorate Management Team Meeting	29/03/2019	8	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Nurse recruitment at Band 5 and Band 6 level. Recruitment initiatives with HR - exploring social media, updating of adverts, updating of JDs, develop a B5 role solely for SSEU	28/02/2019	27/02/2019	Heydon, Nicola						
										Skill mix review. Need for dedicated education lead/practise educator role (Band 7). 8pm - 2am shift to be piloted.	02/11/2018	09/11/2018	Heydon, Nicola						
										Promote early escalation to DM and/or site team to support patient flow and pulling of patients from ED to ease congestion.	31/03/2019		Clarke, Lisa						
										To work towards an ED model for rapid assessment ands treatment across Majors and Minors in conjunction with senior decision makers in the Department	30/04/2019		Oaten, Rachel						
										Intensive support meetings implemented following submission of ED Improvement/Recovery Plan	16/11/2018	13/12/2018	Clarke, Lisa						
										Triage escalation plan to be developed to support early escalation at times of surge / inability to meet 15 min time to treatment.	19/10/2018	17/10/2018	Heydon, Nicola						
										Capacity issues are discussed twice daily at bed meetings. Clear agreed escalation plan only to be used with prior agreement from Exec on call. Medicine do have an additional ward (Laverstock) currently agreed not to open for 18/19 *Action transferred from risk 5516*	16/11/2018	24/12/2018	Clarke, Lisa						
										Ongoing monitoring of current controls as listed below. 1. Patient flow action plan 2. Emergency Department action plan 3. System action plan *Action transferred from risk 5516*	01/04/2019		Hyett, Andy						
										recruit paramedic navigators on a 1 year fixed term contract provide stability for ED front door processes.	31/03/2019		East, Rachael						
5607	Surgery	All clinical areas	19/10/2018	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.	31/03/2019		Payne, Gill	H@NT Management Board	01/04/2019	6	Care	Trust Board (Corporate Risk Register)	Director of Nursing

Corporate Risk Register
March 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
5704	Medicine	Trustwide	31/01/2019	Directorate risk assessment	16	The inability to provide a full gastroenterology service due to a lack of medical 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.	01/04/2019		Clarke, Lisa	Intensive Support Meeting	15/04/2019	8	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019		Clarke, Lisa						
										Continuing insourcing of private provider to endoscopy.	01/04/2019		House, Nicki						
										Quantification and mitigation of the risk to bowel scope.	01/04/2019		House, Nicki						
										Tender for elements of the Gastroenterology service.	01/04/2019		Stagg, Andrew						
										Monthly update to F&P Committee and CGC.	01/04/2019		Hyett, Andy						
5751		Trustwide	11/03/2019	Directorate risk assessment	16	Risk of impact on patients from high numbers with a delayed transfer of care.	Will probably recur, but is not a persistent issue	Major	16	Winter director managing Trustwide ECIST actions.	01/05/2019		Hyett, Andy	Trust Board	01/04/2019	4	Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019		Hyett, Andy						
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019		Hyett, Andy						
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019		Hyett, Andy						
4571	Facilities	Estates	17/06/2016	Other assurance not listed	12	[17/06/2016 18:27:00 Terry Cropp] Potential risk of failure of sterlisers, washers and associated plant and equipment used to sterlise equipment for the Trust and external customers. 03-04-2018 SDU are still operating on site within the existing facility (Level 2 Sector 3) and utilising the existing equipment (Autoclaves, Washers & AER's), this equipment is end of life, and a new facility was due to be operational July 2018. The risk of the failure of this equipment and or it being deemed not safe to use (failure of insurance inspections) is significant. One of the 5 x Autocalves is currently 'out of service' and requires major welding to enable a subsequent insurance inspection, there is a risk that this machine will not pass inspection due age (16+ yrs old) Note Autoclaves 1,2,4 + 5 are 18 years old, two of which are due insurance inspections in September 2018. At SSL July 2018 Board meeting decision taken to repair (cahmbers only) x 3 Autoclaves (Numbers 1, 2 & 3). This will enabel pressure tests and re-certification of vessells for insurance inspection. Options being explored for new AER's, a report to be produced by Steris for the August SSL Board meeting. Update 30th August 2018. Ancillary equipment that should also be covered by thsi risk should include the Dry Storage Cabinets. These units are used to store / hold the flexible endescopes after they have been processed by the AER's. These are loacted in Endescopy, Main Theaters and DSU. This equipment is circa 10 years old and is critical to the delivery of the Endoscopy service at SFT. Update January 19- Autocloave number 1 has a new jacket but unable to put into service due to faults. Relying on 3 autoclaves in use. Awaiting confirmation of status of repairs required.	Will undoubtedly recur, possibly frequently	Major	20	Refurbishment of 3 x Autoclaves	29/03/2019		Cropp, Terry	Not known	29/03/2019	6		Trust Board (Corporate Risk Register)	Chief Operating Officer
										SSL looking at options for the replacement of the AER's as instructed by the SSL Board, a report with the options and costs will be presented at the October 18 SSL board meeting.	29/03/2019		Cropp, Terry						
										Replacement of 1 x Autoclave, as an interim measure prior to the refurbishement of the new facility.	28/02/2019	28/02/2019	Cropp, Terry						

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	20
Date of Meeting:	04 April 2018		

Report Title:	Patient Experience Report Q3 2018-19			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Katrina Glaister, Head of Patient Experience			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note this report.

Executive Summary:
This report provides a report of activity for Q3 2018/19 in relation to patient experience, complaints, public engagement, and the opportunities for learning and service change. Some key changes are highlighted below: • The Customer Care team has been rebranded as PALS (Patient Advice and Liaison Service) • The line manager of members of staff named in negative feedback (via FFT cards) are now given the patient's comments so that they can follow up with the named member of staff • Compliance with agreed timescales remains challenging but has improved since last quarter. A new compliance report is being compiled and will be shared with the directorates every quarter. A quarterly PALS meeting with all the directorates is being considered. Other Trusts have found this a useful way to share learning from PALS issues. • PALS attendance at all directorate management monthly committee meetings is being actively pursued This report provides assurance that the Trust is responding and acting appropriately to patient feedback.

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	☐

Patient Experience Report - Quarter 3

1/10/2018 to 29/12/2018

Purpose of paper

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

To provide assurance of patient and public involvement in service co-design and improvement.

Background

Nationally, the scrutiny in relation to compassionate healthcare as well as engaging with the public to understand their voice and feedback is an imperative, including learning from feedback, transparency and honesty when healthcare goes wrong. This report provides some evidence of the patient experience feedback and activities in relation to self-improvement based on that feedback.

1. Patient Advice and Liaison Service

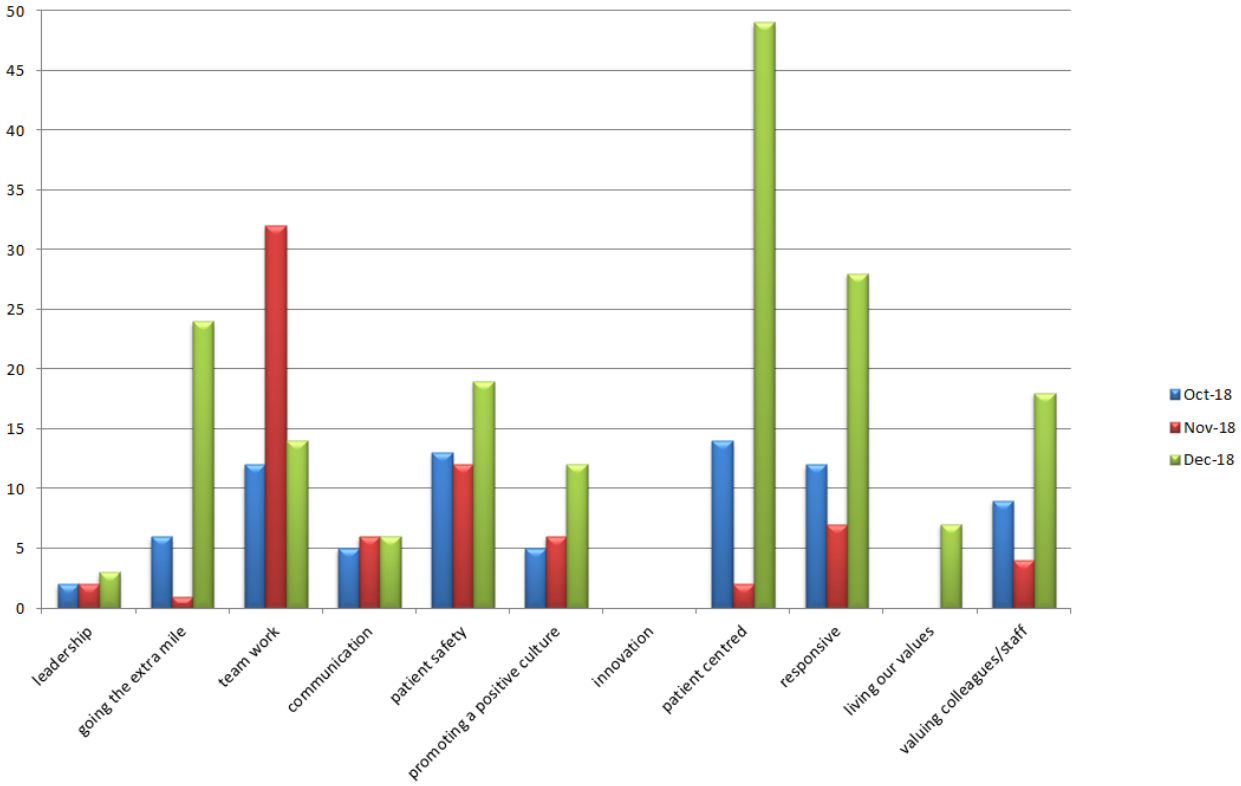
'PALS' is a nationally recognised NHS service providing advice, information and guidance to those wishing to raise a concern or as a way of signposting the enquirer to the relevant service. Because of recognition of the term nationwide, the name of the Customer Care Team has changed to Patient Advice and Liaison Service (PALS). To reduce costs, signposting to the department will change as and when other signage is changed.

To improve access for patients and their visitors a new venue for PALS continues to be sought.

2. Sharing Outstanding Excellence (SOX)

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

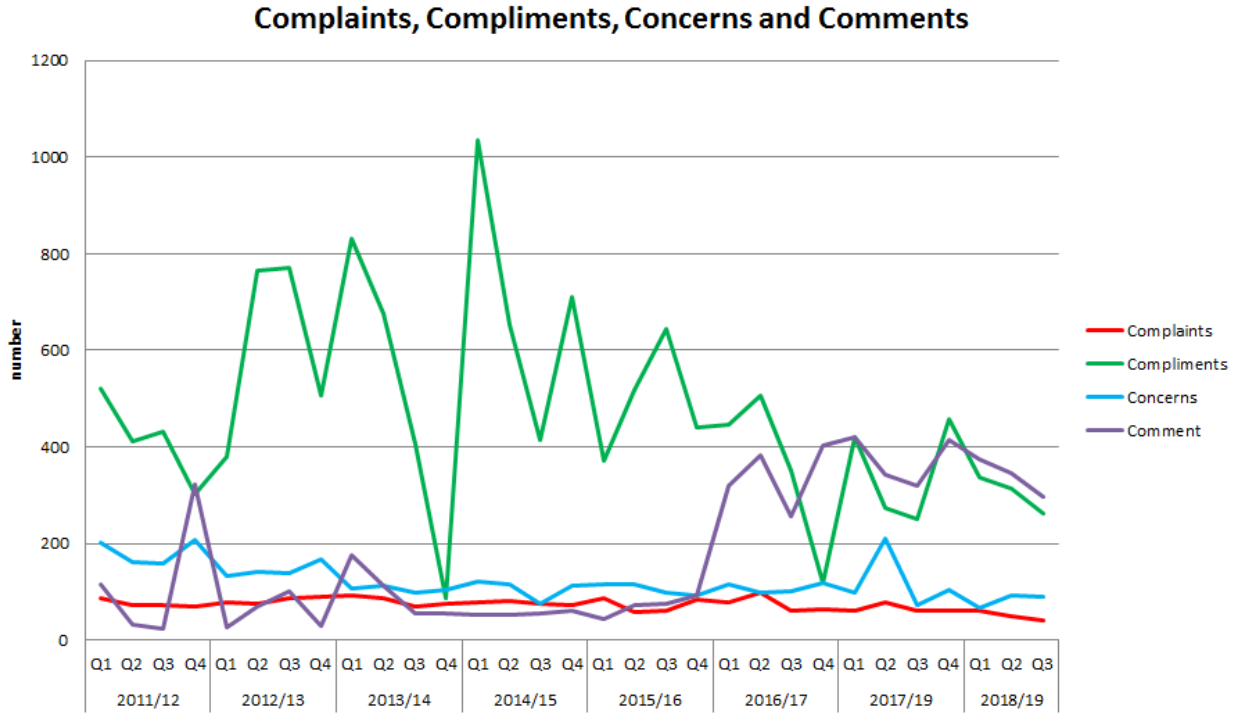
Themes from the SOX excellence reports for Q3 are shown here:



3. Complaints

The graph overleaf shows the numbers of complaints, compliments, concerns and comments over time. Complaints show a slight reduction over time. There is more variation in concerns and comments and the PALS team are working to clarify what constitutes a comment vs what constitutes a concern, as whilst

concerns can be themed, comments cannot be and it is important that key themes are not missed.



Actions taken since last report

- PALS attendance at all directorate management monthly committee meetings is being actively pursued
- A new complaints compliance report is being pulled together and will be sent to the directorates each quarter.
- A quarterly PALS meeting with all the directorates is being considered. Other Trusts have found this a useful way to share learning from PALS issues.
- The line manager for members of staff named in negative feedback (via FFT cards) are now forwarded the patient's comments so that they can follow up the issue with the named member of staff
- Compliments for staff mentioned by name in patient feedback is sent out in a SOX (Sharing Outstanding Excellence form).

Complaint themes

The K041 categories are used to theme complaints. The main themes this quarter are:

- Patient care (including nutrition and hydration) (n = 16) and
- Clinical treatment (n = 8).

There were 90 concerns in Q3. The main issues from concerns are:

- Patient care (including nutrition and hydration) (n = 21), with half of these in the Medicine Directorate.
- Appointments including delays and cancellations (n =18).
- Communication (n = 15).

40 complaints were received in Q3. A breakdown of numbers and themes from complaints according to the K041 subject code is listed below by directorate:

	CSFS	Finance and Procurement	Medicine	MSK	Surgery	Total
Access to treatment or drugs	0	0	0	1	1	2
Admissions, discharge and transfers	0	0	1	0	2	3

Appointments	0	0	0	0	2	2
Clinical Treatment	3	0	2	2	1	8
Communications	0	0	1	0	0	1
Consent to treatment	0	0	0	0	1	1
End of Life Care	0	0	1	0	0	1
Patient Care including Nutrition / Hydration	1	0	8	6	1	16
Prescribing errors	0	0	0	1	0	1
Privacy, Dignity and Wellbeing	0	0	0	0	1	1
Trust Administration	0	1	0	0	0	1
Values and behaviours	1	0	0	0	2	3
Totals:	**5**	**1**	**13**	**10**	**11**	**40**

In Q3 the Trust treated 17,863 people as inpatients, day cases and regular day attendees. Another 16,751 were seen in the Emergency Department (includes the walk-in clinic) and 30,450 as outpatients. 40 complaints were received which is 0.06% of the number of patients treated.

263 compliments were received across the Trust in Q3. Those sent directly to the Chief Executive or Customer Care Department were acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team now complete a SOX which is sent to the individual and their line manager.

Timeliness of response

100% of complaints were acknowledged within 3 working days.

Two complaints (1 each in MSK and CSFS) were re-opened in Q3; both were unhappy with the response received.

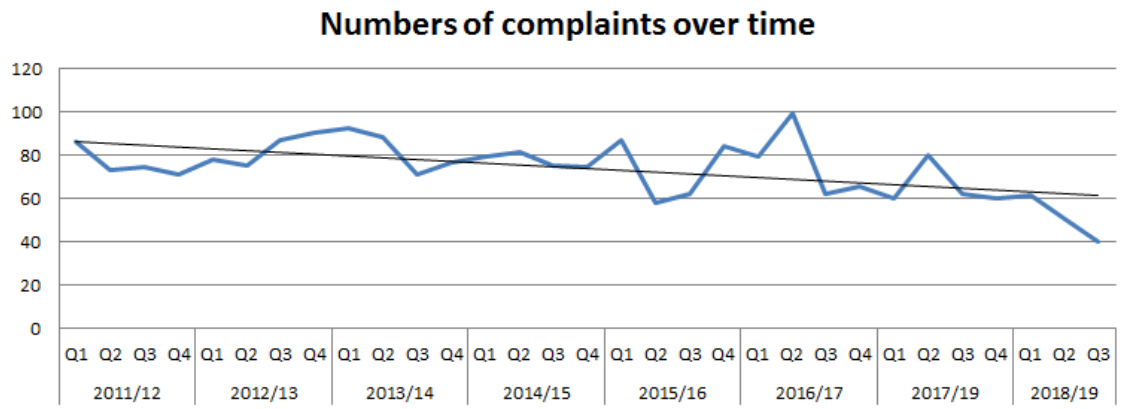
The total number of enquiries, comments, concerns and complaints received by the team in Q3 was 446. Of these 76.7% were dealt with within 10 days (47.5% were dealt with on the same day).

0-10 working days		11-24 working days		25+ working days	
351	78.7%	37	8.3%	45	10.0%

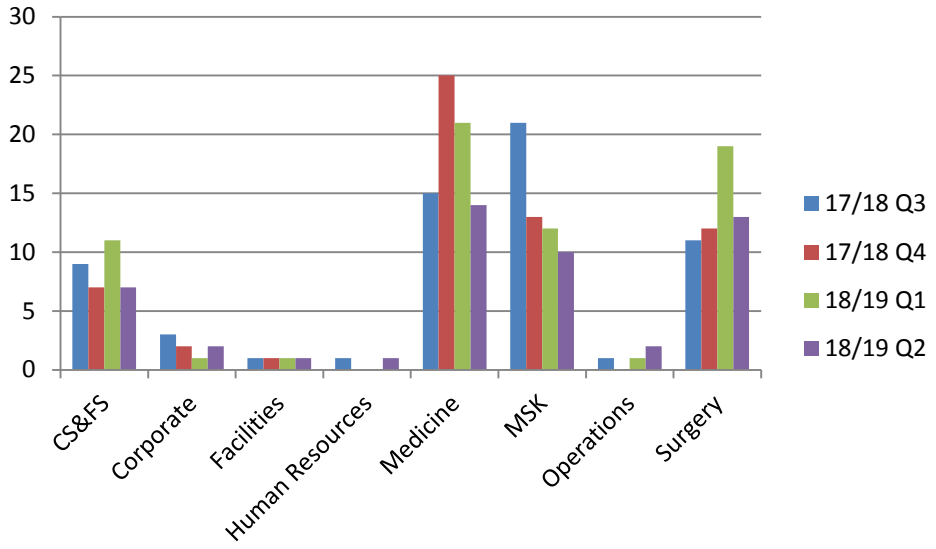
Response timescales for complaint responses going out beyond 25 working days has improved slightly this quarter. However, whilst complainants are kept informed of delays further work within the directorates needs to be done to improve agreed response timescales. See individual directorate reports for the maximum length of time a complainant waited for a response this quarter.

0-10 working days		11-24 working days		25+ working days	
2	5%	7	17.5%%	23	57.5%

4. Complaints by directorate



The following graph shows the number of complaints by directorate over the last four quarters.



Clinical Support and Family Services Directorate

	Quarter 3 2017-18	Quarter 2 2018-19	Quarter 3 2018-19
Complaints	9	7	5
Concerns	10	21	13
Compliments	36	93	121
Re-opened complaints	0	2	1
% complaints responded to within agreed timescale	33%	14%	40%

- There were 5 complaints in this quarter. There are no particular themes. One of the complaints was retracted; however the department still followed it up and responded.
- One complaint meeting was held this quarter. Resolution was reached and the complaint was closed.
- There were 2 complaints which were open for 42 days. One was delayed due to the directorate having to contact a third party provider for statements. The other was delayed due to waiting for staff to make statements and further review being needed before sign-off from the CEO.
- 13 concerns were raised in quarter 3. Endoscopy and Radiology received 3 each. The theme for the Endoscopy Department was delays in being seen. There was no particular theme for the Radiology department; concerns included poor attitude of staff and complications during the procedure.
- Response compliance has increased during this quarter. Any delays have been due to waiting for statements from relevant staff.
- The PALS team received 44 comments and enquiries in Quarter 3 which were resolved at the time by the team.
- Total activity within the directorate was 8822 and of this number 0.05% raised a complaint.
- The Complaints Co-ordinator is waiting for responses from CSFS regarding 5 outstanding action plans from closed complaints.

Of the complaints responded to in quarter 3, these are the following outcomes:

Upheld	Partially Upheld	Not Upheld
3		2

Themes and actions

Department/Ward	Topic	Actions
Endoscopy Department	Waiting times or no bed available.	Issues were raised with 18 Week Support who are the insourcing provider. Waiting times were unavoidable due to bed availability.
Radiology Department	Poor attitude of staff and complications during the procedure.	Going forward, Radiology will be providing after care leaflets for all patients who undergo IV injection of contrast. Staff members were spoken to as part of the investigation.

Compliments

121 compliments were received in quarter 3, the breakdown is as follows:

Community Midwives - 11, Endoscopy - 9, Labour ward - 17, NICU - 26, Pathology - 2, Postnatal - 37, Radiology - 3, SALT - 2, Sarum - 14.

Medicine Directorate

	Quarter 3 2017-18	Quarter 2 2018-19	Quarter 3 2018-19
Complaints	15	14	13
Concerns	19	25	28
Compliments	102	116	258
Re-opened complaints	4	2	0
% complaints responded to within agreed timescale	40%	35%	53%

- Total activity within the Directorate was 30756 and of this number 0.04% raised a complaint
- Farley ward received the most complaints (n= 5). There were no particular themes for these complaints. The issues raised were regarding EOL care, neglect in care and treatment given and lack of communication.
- 1 complaint meeting and 1 concern meeting was held this quarter and both reached resolution and they were closed.
    - There is still one complaint open which was raised on the 20th November 2018. Several chases have been sent to the investigating manager but no reason has been given for the delay.
- Response compliance has increased from quarter 2 and other quarters however the reason for some delays are due to complaint meeting being held in March 2019.
- There were 28 concerns raised in Quarter 3. The Emergency Department received the most with 6.
    - The themes for the Emergency Department were attitude of staff and unsatisfactory clinical treatment. Pitton ward received 5 concerns regarding unsatisfactory treatment and discharge procedures.
- The PALS Team received 65 comments and enquiries in Quarter 3 which were resolved at the time by the team.
- The Complaints Co-ordinator is waiting for 15 outstanding action plans from Medicine's closed complaints (since 1st April 2018).

Of the complaints responded to in Quarter 3, these are the following outcomes:

Upheld	Partially Upheld	Not upheld
1	8	1

Themes and actions

Department/Ward	Topic	Actions
Farley Ward	Unsatisfactory care and treatment including EOL care on the ward. Communication concerns.	Ongoing feedback for teams to improve communication when dealing with EOL issues. Encouraging the need to repeat explanations allowing time for families/NOK to take information on board. Highlighting to individuals the importance of timely communication.
Emergency Department	Unsatisfactory Clinical treatment and attitude of staff.	Continued feedback to individuals about the impact of negative communication to patients. Specific focus on recording of cannulation and improvement plan in place.
Pitton Ward	Unsatisfactory treatment and discharge procedures.	Individual feedback to staff to acknowledge the importance of clear and timely communication. Setting up of clear communication expectations for both family and staff.

Compliments

258 compliments were received in Quarter 3, the breakdown is as follows:

AMU - 52, Cardiology - 8, Durrington - 7, Emergency Department - 58, Endocrinology - 2, Farley ward - 51, Hospice - 10, Neurophysiology - 1, Pembroke ward - 1, Pitton ward - 7, Redlynch ward - 22, Spire ward - 8, SSEU - 1, Tisbury ward - 16, Whiteparish - 20.

Musculo-Skeletal Directorate

	Quarter 3 2017-2018	Q2 2018-2019	Quarter 3 2018-2019
Complaints	21	10	10
Concerns	13	27	28
Compliments	51	42	48
Re-opened complaints	4	4	1
% Complaints responded to within agreed timescale	29%	30%	20%

- The total activity in the Directorate was 14,791 and of this number 0.07% raised a complaint
- There has been one re-opened complaint, which is now being dealt with by the Chairman.
- The largest number of complaints received were for Odstock Ward, Orthopaedics and Tamar Ward with 2 complaints each.
    - The main theme for complaints was nursing care (3 complaints) and clinical treatment (2 complaints)
    - The longest time a complaint (8002) was open for this quarter was 86 working days. The updates given said that they were waiting for a response from a clinician. A meeting has been arranged with the complainant (to be held March 21st 2019).
- The highest number of concerns received were for Orthopaedics (7 concerns) and Amesbury Suite (4 concerns).
    - The main themes for concerns were the delay in receiving treatment (n = 4) and a delay in receiving appointments (n = 3).
- There were no complaint/concern meetings held in this quarter.

- The PALS department received 53 comments and enquiries in Quarter 3 which have been resolved by the team.
- The MSK directorate has one action plan outstanding (complaints 7987) from closed complaints since 1st January 2018

Upheld	Partially Upheld	Not upheld
1	**6**	**2**

Themes and actions

Department/Ward	Topic	Actions
Odstock Ward, Orthopaedics, Tamar	Nursing Care	• Actively recruiting staff to reduce vacancies • Study days with consultant support to upskill junior staff to expected level • Review incidents with ward leads in a timely manner • Poor performance by agency staff to be challenged and reported back to agencies.
Orthopaedics & Plastics	Clinical Treatment	No themes of treatment or individual clinician so individual actions relating to complaint taken to resolve issues.
Cross Directorate	Delays in receiving treatments and appointments	• Continue to review long waiters • Increase capacity in specialities through additional sessions • Informatics support to provide accurate waiting list information • Active waiting list validation by specialty to reduce waiting list times

Compliments

In total 48 compliments have been received across the Directorate with the breakdown as: Chilmark Suite = 26, Orthopaedics = 12, Avon and Tamar = 3, Plastic surgery = 3, Orthopaedic O/P = 2, Max Fax = 1, Oral surgery = 1

Surgical Directorate

	Quarter 3 2017-18	Quarter 2 2018-2019	Quarter 3 2018-19
Complaints	11	13	11
Concerns	27	18	18
Compliments	52	50	171
Re-opened complaints	3	1	1
% complaints responded to within agreed timescale	36%	0%	9%

- Total inpatient and outpatient activity within the Directorate was 10,695 and of this number 0.10% raised a complaint.
    - There are 4 complaints still open.
    - There have been 4 complaint meetings held for this quarter.
    - The Audiology Department, Downton Ward and General Surgery all had 2 complaints each.

- The oldest complaint open is 8021 which was due out on 17th December 2018. PALS were told on 27th December 2018 that the Directorate Manager was going to telephone the patient to discuss his issues as the consultant has already written to the patient and feels the complaint has been fully answered. Further reminders have been sent but we are awaiting confirmation that this telephone call has taken place. A further letter was received from the complainant on 12th February 2019 which has been forwarded to the Directorate team. The response has since been chased by the PALS team.

- The most common theme for complaints and concerns was for appointments being postponed (4 complaints/concerns), insensitive communication (3 complaints/concerns), clinical treatment (3 complaints/concerns) and appointment system – procedures (3 complaints/concerns).
- The highest number of concerns were for both the Central Booking Department and Urology with 5 concerns. Ophthalmology had 3 concerns.
- The PALS office have received 59 enquiries and comments which were resolved by the PALS team.
- Surgery have two action plans outstanding – 8036 and 8024.

Upheld	Partially Upheld	Not upheld
2	**1**	**1**

Themes and actions

Department/Ward	Topic	Actions
Central Booking	Netcall telephone system, failure to record automated cancellations.	Redesign IBR to remove automated voice notes – to be carried out in April 2019

Compliments

In total 171 compliments have been received across the Directorate with the breakdown as:

Britford Ward = 75, Downton Ward = 43, Ophthalmology O/P = 11, ENT = 10, Radnor Ward = 7, Urology = 6, Breamore Ward = 6, Ophthalmology = 3, Breast Service = 2, DSU = 2, Anaesthetics = 1, Audiology = 1, Breast reconstruction = 1, General Surgery = 1, Main theatres = 1, Vascular = 1

5. Trustwide feedback

The top areas for improvement from inpatient real time feedback, the Friends and Family Test and complaints are:

Feedback area	Theme	Actions
Complaints	Patient care Values and behaviours Clinical treatment	• Ward leaders are incorporating themes into their improvement plans. Individual staff are managed by the ward leaders on a case-by-case basis. Continue recruitment and retention work. • Staff attitudes have been raised with the Ward Leads and particular concerns have been raised with identified staff and managed through appropriate HR processes. Identified staff are being closely monitored in their areas and supported to ensure behaviours are not repeated. • No themes of treatment or individual clinician so individual actions relating to complaint taken to resolve issues.
Inpatient, Maternity, Paediatrics and Spinal RTF	Noise Food and nutrition on the ward (this is also one of the highest areas reported	• Wards review progress on their action plans and 'You Said – We Did' information should be displayed on the Customer Care boards. • Limited action can be taken as noise in certain ward

	positively) Toys and entertainment Call bells Weekends Communication	areas is due to location and deliveries to the Laundry. These areas are offering earplugs to aid sleep. • Trialling mobile call bell system to reduce noise in Spinal. • Food and in particular temperature, is checked regularly. Trialling food service on a course by course basis to see if this improves the patient experience.
FFT	Numbers too low to theme	• Wards reviewed progress on their action plans.

Patients surveyed

A total of 4,536 patients provided feedback during the quarter through national patient surveys, real-time feedback and the Friends and Family Test. This is in line with the previous two quarters.

The total number of patients providing feedback in the quarter does not include those responding through the Perfect Ward App as this information is not currently available. We are checking with the suppliers to see whether this can be provided in the future.

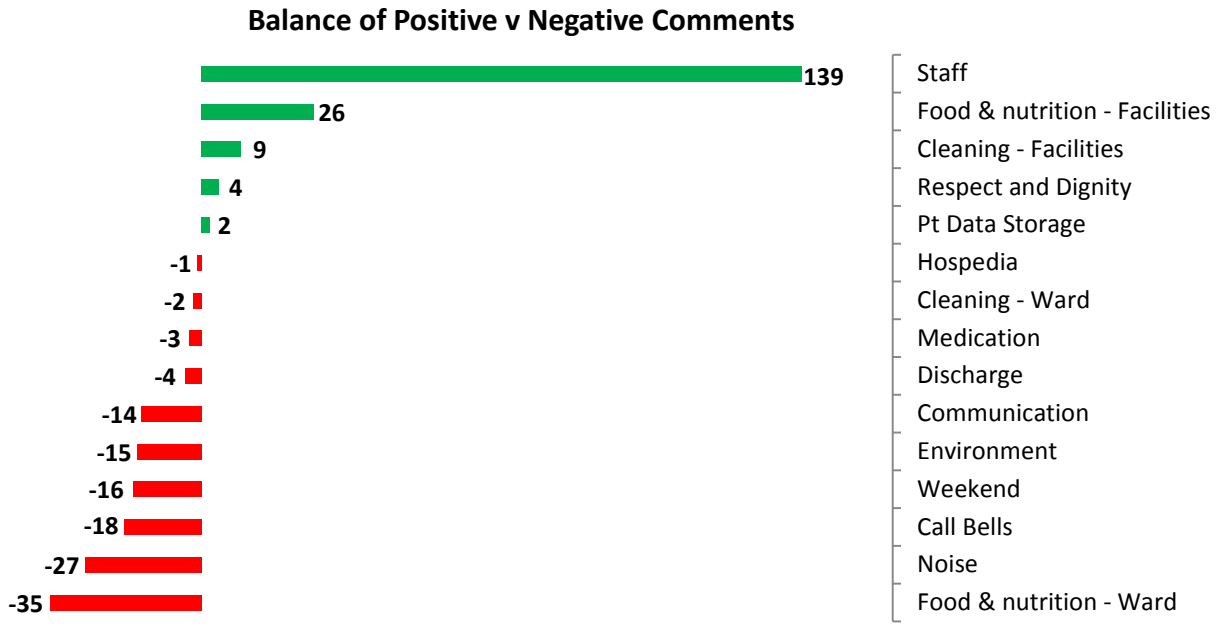
The line manager of members of staff named in negative feedback (via FFT cards) are now given the patient's comments so that they can follow up the feedback with the named member of staff

2 negative comments were received in January and February (when this initiative started). One was for endoscopy (staff attitude) and the other for dermatology (poor consent process).

6. Real time feedback

Inpatients

A total of 246 inpatients were surveyed in the quarter. They made 260 positive comments and shared 217 suggestions of areas where services could be improved. These have been categorised and the balance of positive to negative comments is shown in the graph below.



Food and nutrition on the ward

Three positive and 38 negative comments were received regarding food and nutrition on the ward. The negative comments are shown in the word cloud below. Please note that word clouds give greater prominence to words that appear more frequently in the source text.

Temperature was cited most on Amesbury Ward (n=10)

Noise

A total of 12 positive and 39 negative comments were received regarding noise. The negative comments are shown in the word cloud below.

Noise is an issue Trust-wide.

There is no one specific area that receives negative comments about noise.

Call bells

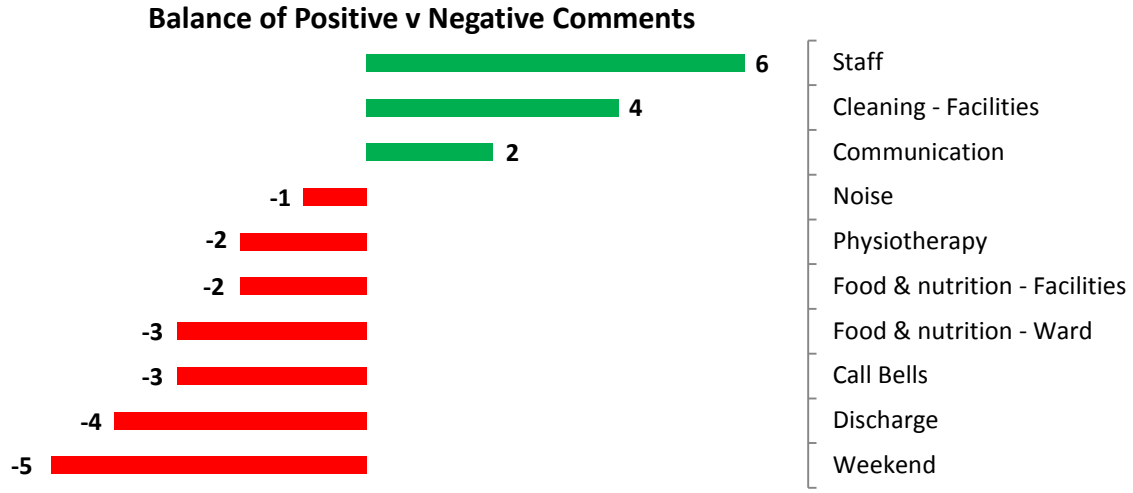
Five positive and 23 negative comments were received regarding patients getting attention at the time they needed it. The wards where the negative comments were made are:-

Whiteparish (6)	Amesbury (2)	Breamore (1)	Farley (1)
Chilmark (3)	Durrington (2)	Britford (1)	Pitton (1)
Redlynch (3)	Spire (2)	Downton (1)	

Spinal

A total of 16 patients were surveyed in the quarter. They made 21 positive comments and shared 30 suggestions of areas where services could be improved.

These have been categorised and the balance of positive to negative comments is shown in the graph below.



Lack of services at the weekend

- One patient was concerned that the gym was not available at the weekend. Another stated that when it was open, it could get busy resulting in a wait for equipment.
- Another patient said they would like physiotherapy at the weekend to stop them seizing up and another said that they needed to be turned on Sunday but kept being put off resulting in a skin problem developing.
- Another patient wanted to speak to someone at the weekend regarding their discharge

Discharge

- A patient was due to be discharged within a few weeks but did not know what the care package would be when they left.
- Another patient was concerned that they were not getting clear information about their discharge so could not ask questions.
- Another had not had any conversations with Trust staff about discharge, only a social worker. The patient had no idea what community support was available.
- A patient reported on community and social difficulties surrounding discharge. The patient was concerned that no physiotherapy was being provided and they classed themselves as a bed-blocker.

Maternity

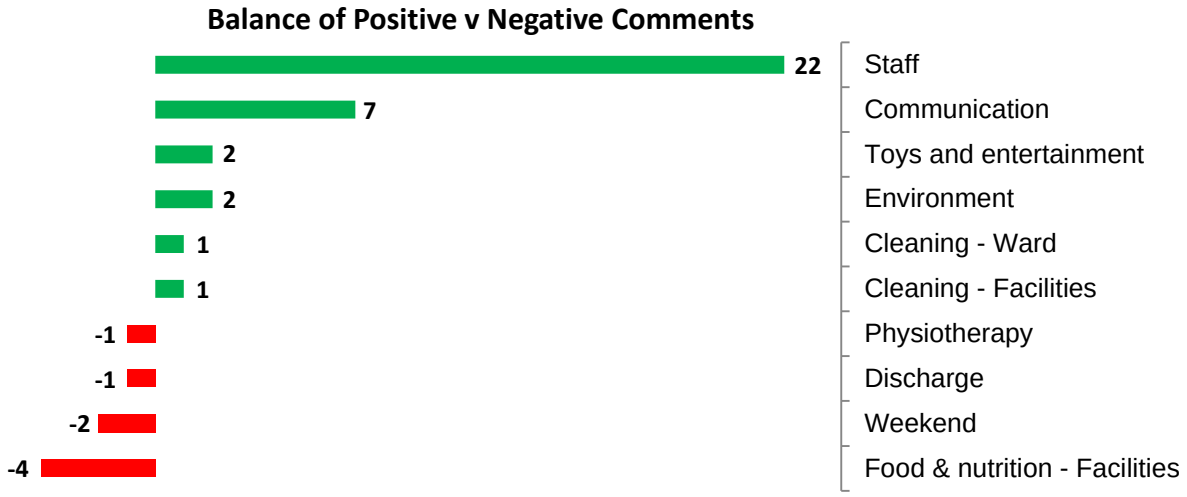
A total of 18 new mothers were surveyed in the quarter. They made 19 positive comments and shared 9 suggestions of areas where services could be improved.

Five of the concerns related to the quality of information. Two were concerns about the bathrooms. One related to inconvenient visiting times for her partner and one new mother had a delivery which was different to her birth plan.

Paediatrics

A total of 13 adults or carers and 7 children were surveyed during the period. They made 44 positive comments and shared 21 suggestions of areas where services could be improved.

These have been categorised and the balance of positive to negative comments is shown in the graph below.



Food and nutrition - Facilities

Two positive and six negative comments were received.

Three of the negative comments related to poor food options. Two were concerning the opening hours of the restaurant, particularly at weekends and one related to the timing of meals.

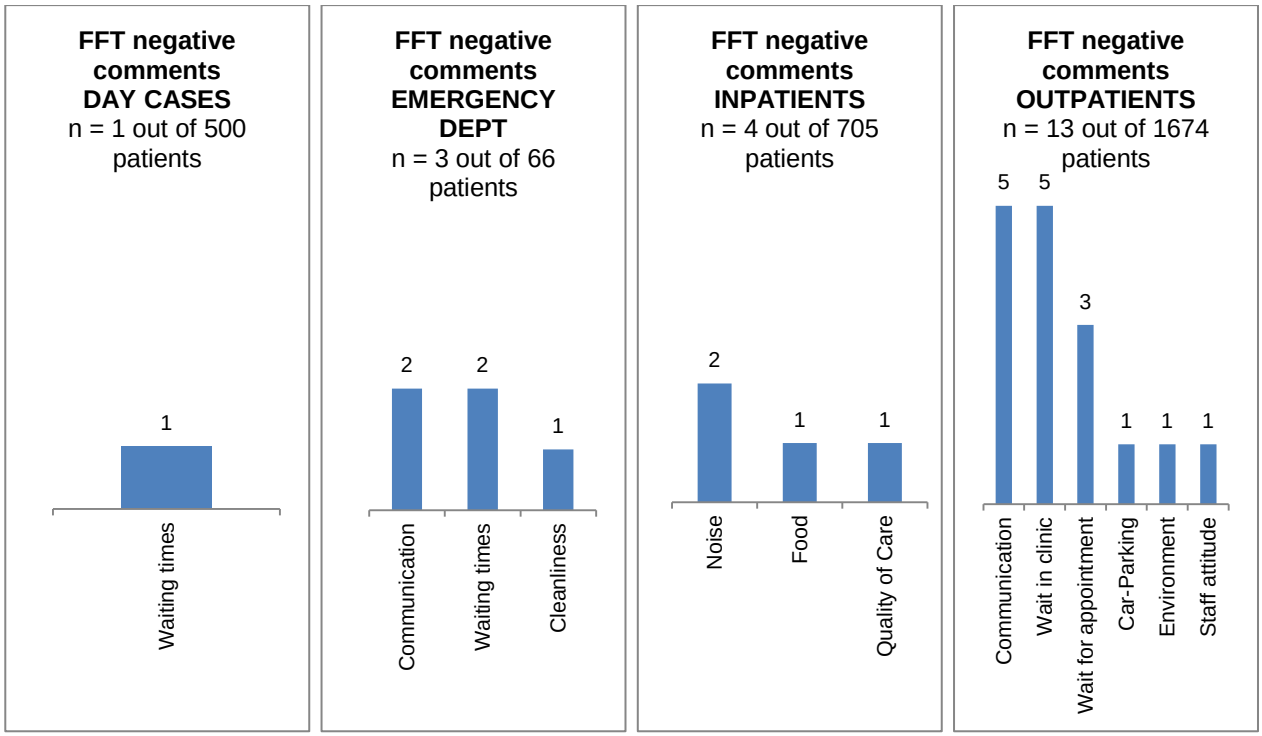
Friends and Family Test

Responses for the period were as follows:-

		Rating									
	Total Responses Received	Extremely Likely		Likely		Neither likely nor unlikely		Unlikely		Extremely Unlikely	
Day Case	500	476	95%	21	4%	2	0.4%	0		1	0.2%
Emergency Dept	66	57	86%	2	3%	3	4.5%	3	4.5%	0	
Inpatients	705	641	91%	44	6%	16	2%	3	0.5%	1	0.1%
Maternity	77	73	95%	4	5%	0		0		0	
Outpatients	1674	1527	91%	111	7%	21	1%	7	0.5%	6	0.5%

* Shortfall between combined totals in rating columns and overall totals above equates to those who responded “don’t know”.

Comments made by those patients who stated they would be unlikely or extremely unlikely to recommend the hospital have been categorised as set out in the graphs below.



Please note, the numbers of negative comments are very low and it is difficult therefore to generalise from the themes.

Action taken on areas of concern

Wards, the Emergency Department and Maternity Unit, have action plans in place to address their areas of concern.

7. National surveys

No national patient survey benchmark results have been published by the Care Quality Commission within the reporting period.

8. Patient Stories

Patient stories are presented at the public Trust Board 6 times a year. Explicit consent is obtained to share the taped stories and, as soon as the Trust's Intranet is developed, these will be uploaded along with a structured reflection guide for staff to use for revalidation and personal/team learning.

9. Patient and public involvement (PPI)

In this quarter there have been 4 new projects, 2 completed projects and 2 new national patient surveys commenced.

Clinical Support and Family Services

Completed projects

- Maternity carried out a survey to find out patients views on whether an alongside maternity centre would be welcomed in Salisbury. Over 300 responses were gathered, mainly by utilising the Breastfeeding support Facebook group.

Medicine

New projects

- Head and Neck Cancer services are developing a patient satisfaction questionnaire to use to develop services.
- Data is being collected on an ad hoc basis around patient views on mixed sex bay breaches in AMU. Further discussion is needed.

Musculo-Skeletal Directorate

New projects

- A workshop with patients following 3 clinical pathways in the Wessex Rehabilitation Centre (chronic pain, lower limb rehabilitation and upper limb rehabilitation) was held in January 2019. The team are now working on the feedback and an update will be provided in the Q4 report.

Surgery Directorate

New projects

- A patient satisfaction survey has been developed for the nurse-led prostate follow up clinic with the aim of establishing how effective the nurse-led service is.

Completed projects

- The patient story on the issues surrounding living with an HIV diagnosis went to the December Trust Board to coincide with World AID's Day and was well received.

10. National Patient Surveys

National Maternity Survey 2018

The benchmark results will be published by the CQC on the 29th January 2019. Reports presented to the Clinical Governance Committee and Clinical Management Board in February 2019.

National Inpatients Survey 2018

The current response rate remains at 57% compared with 60% this time last year. Analysis is now being carried out at ward level.

Urgent & Emergency Care 2018

The current response rate is 47% compared with 32% at this stage in 2016. The survey closes 26 March 2019.

Children and Young People 2018

The final version of the questionnaire sent to the Co-ordination Centre for approval. First mailing of questionnaires w/c 11 February 2019.

PPI Projects are shared on the following web page on the Intranet: http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/home.asp

To increase the number of staff taking part in PPI projects work is underway to improve the way that PPI projects are displayed in the Intranet. The PPI Toolkit is also being refreshed.

11. Interpreting and Translation

The annual spend on interpretation and translation has risen year on year. As a result of this, reminders and updates about the interpreting service will be sent out to all email users and updates in Cascade Brief are planned.

The PALS team have started to look at the use of face to face language interpreters, to ensure they are being used appropriately, and reduce the overall cost of interpreting to the Trust. It is hoped that by increasing staff awareness of the telephone language interpreting service and clarifying when the use of face-to-face language interpreters is appropriate, costs can be reduced but an excellent service can still be provided. This may involve vetting of requests for face-to-face language interpreters, as well as the option of video (via iPad) language/BSL interpreting.

This quarter's top five most frequently used language for face-to-face interpreting:

Polish 22.5%	Nepalese 19.4%
Arabic 16%	Hungarian 6.5%
Chinese 6.5%	

Total number of interpreters used: 31. Number of British Sign Language interpreters used: 16

Total costs for interpreting and translation in Q3 - £7,866.70 (of this 61% relates to bookings in the Endoscopy Unit).

12. Patient Information

Patient Information has moved from the Quality Directorate to PALS.

All new patient information is given a sense check by a group of volunteers prior to the information being approved for use in the Trust. The Trust is certified against NHS England's Information Standard. Work is underway to provide all patient information within an app. Currently there are over 800 information sheets available on a wide variety of clinical conditions.

All information leaflets will move to a web-based app over Q1 and Q2 2019/20.

13. Equality and Diversity

The PALS team are working with the recently appointed Equality and Diversity Lead and will undertake additional work under this heading going forwards.

14. Parliamentary and Health Service Ombudsman (PHSO)

The PHSO received no new requests for independent review in Q3.

The PHSO publishes complaints data on a quarterly basis that includes numerical information on the complaints received, assessed, and investigated and is available at: http://www.ombudsman.org.uk/reports-and-consultations/reports/health/quarterly-reports-on-complaints-about-acute-trusts

15. NHS Choices website

In Q3 there were 8 comments posted on the NHS Choices website relating to 7 different areas. Of the 5 positive comments, one person wrote about his time in the AMU and Tisbury Ward '*The whole experience, although alarming for me and for my wife, was reassuring and positive. And even the food was good - thank you! My treatment was absolutely first class, and I am hugely grateful.'*

Of the 3 negative comments, one person referred to the Trust's systems and process as being '*archaic'* as he/she could not be admitted to the Spinal Centre. Another reported that the ED staff '*couldn't wait to get rid of me*'. There is no department mentioned in the other one.

The NHS Choices feedback has been managed by the Communication Team in the past but is being handed to PALS from April 2019. This will allow faster response and earlier sharing with the named teams.

16. Facebook

Eight comments (3 negative, 5 positive) were posted on our Facebook page in Q3. Clinical care was mentioned in 5 positive and 2 negative comments. Two negative comments highlighted difficulty parking.

17. Summary

This report brings together the themes from patient experience feedback and where improvements can be made.

Actions for the PALS team for Q4:

- Review the PPI toolkit and explore a new website to share projects/improvements across the Trust
- Review the Complaint Handling Policy
- Work with directorate teams to improve compliance against the agreed complaint response timescales
- Compliance Reports to be pulled together and shared with the directorate teams
- Item in Cascade Brief regarding interpreting/translation.
- Ratify the Patient Engagement Strategy and Engaging 'Hard to Reach Groups' paper.

Actions for the PALS team for Q1:

- Attend the Always Event training event (end of April 2019) and use this QI methodology to explore noise at night in more detail
- Start to move all the patient information onto the new app-based portal

18. Recommendations

The Board is asked to note this report and agree the actions going forwards.

AUTHOR: Katrina Glaister

TITLE: Head of Patient Experience

Report to:	Trust Board (Public)	**Agenda item:**	21
Date of Meeting:	04 April 2019		

Report Title:	NHS Staff Survey 2018 Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Mark Geraghty, Head of Workforce Information & Planning Glennis Toms, Deputy Director of OD and People			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD and People			
Appendices (list if applicable):				

Recommendation:
It is recommended that the Trust Board note the report, and approve the areas for action.

Executive Summary:
A total of 1,344 of our staff (39% of those eligible) took part in the 2018 NHS Staff Survey. Salisbury scored higher than average in eight of the ten key survey themes. The Trust score was below average in the "Quality of Care" theme. The Trust's score deteriorated in the Health and Wellbeing theme, and the Safe Environment - Bullying and Harassment theme. These themes will form the basis of our areas for action.

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

1. Purpose

To show the key findings of the 2018 NHS Staff Survey, and highlight proposed areas for action.

2. Background

A total of 1,344 of our staff (39% of those eligible) took part in the 2018 NHS Staff Survey. By comparison, the response rate for the previous year's survey (2017) was 46%. The average response rate for Acute Trusts in 2018 was 44%. As in previous years, a combination of email and paper questionnaires were sent to staff. Paper questionnaires were sent to those staff groups who have traditionally experienced more difficulty accessing email. (Facilities staff and Nursing Assistants).

A full copy of our results may be obtained from http://nhsstaffsurveys2018.com/sections/44

3. Survey methodology

For 2018, the National Staff Survey Co-ordination centre has adopted a new results reporting methodology. Instead of the 39 key findings used in previous years, results have been grouped into 10 key survey "themes". Themes are scored on a 0-10pt scale where 10 is the best score attainable.

The 10 survey themes are

- Equality Diversity and Inclusion
- Immediate Managers
- Quality of appraisals
- Safe Environment – Violence
- Safety Culture
- Staff Engagement
- Health and Wellbeing
- Quality of Care
- Bullying and Harassment
- Morale

Our survey report benchmarks our performance against similar organisations, and against the Trust's own performance over time.

Detailed question level scores are included in the report, which allow Trusts to see how the underlying components of each theme compare to other Trusts, and how they have developed over time.

4. Results

Salisbury scored higher than average in eight of the ten key survey themes. (See chart below). The Trust score was average for the "Safe Environment – Violence" theme, and below average in the "Quality of Care" theme.

Compared to the 2017 survey, the Trust's score remained the same for the following key survey themes :

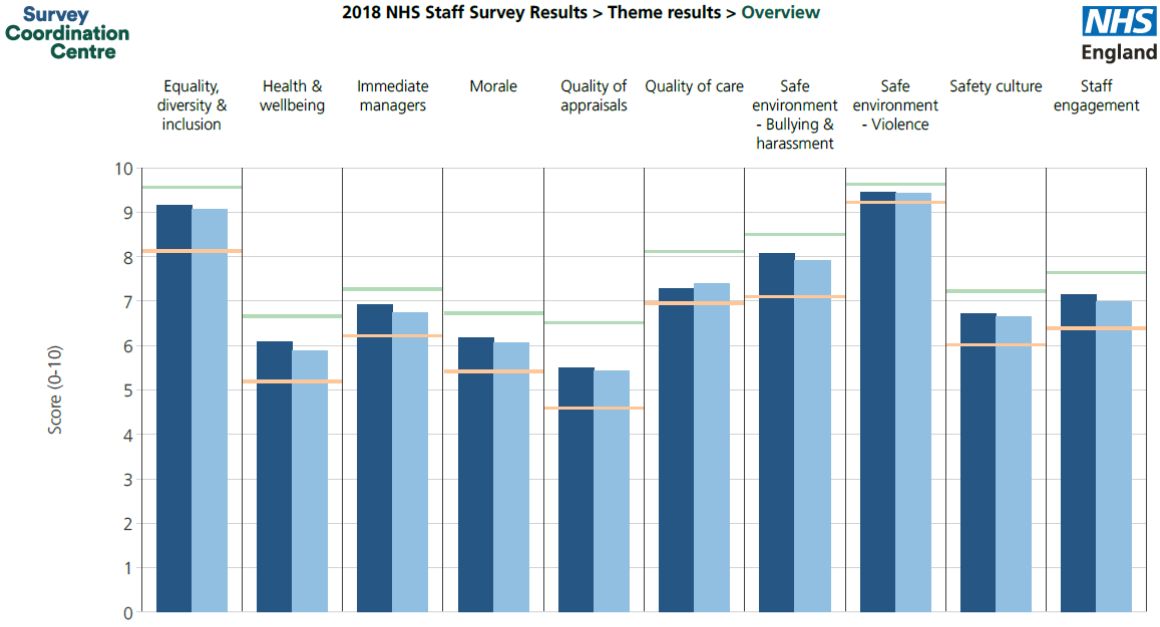
- Equality Diversity and Inclusion (0.1 point higher than average)
- Immediate Managers (0.2 points higher than average)
- Quality of appraisals (0.1 point higher than average)
- Safe Environment – Violence (same as average)
- Safety Culture (0.1 point higher than average)

- Staff Engagement (0.2 points higher than average)

The Trust's score deteriorated in the following areas :

- Health and Wellbeing (0.2 points higher than average, 0.3 points lower than last year)
- Quality of Care (0.1 point lower than average, 0.1 point lower than last year)
- Safe Environment - Bullying and Harassment (0.2 points higher than average, 0.1 point lower than last year)

There was no comparison with previous years included for the "Morale" theme. The Trust score was 0.1 point higher than average for this theme.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.2	6.1	6.9	6.2	5.5	7.3	8.1	9.4	6.7	7.2
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	1,299	1,306	1,312	1,289	1,127	1,149	1,295	1,293	1,296	1,334

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5. Recommendations

It is recommended that priority areas for action focus on the areas where the Trust scored lower than average for similar Trusts and where the Trust score deteriorated compared to last year. These are

- Quality of Care, (0.1 point below average and 0.1 point deterioration compared to last year)
- Health and Wellbeing, (0.3 point deterioration)
- Safe Environment - Bullying and Harassment, (0.1 point deterioration).

6. Development of an Action Plan

It is proposed that OD & P present the survey results and request initial feedback from:

- Senior leaders Forum - completed
- Staff Engagement Group - completed
- All Diversity Groups
- Joint Consultative Committees
- Directorate Management Teams

This process has already started and feedback is to be returned to OD & People by the middle of April.

We will create a plan, from the feedback, which is intended to be limited to two visible and tangible actions for each of the three areas of concern. This plan will then be sent out for consultation across all the above groups and Executive Directors with feedback by the 6th May 2019.

The aim is to publish and implement the plan directly after the 23 May 2019 Trust Board meeting.

Paul Hargreaves
Director of Organisational Development and People

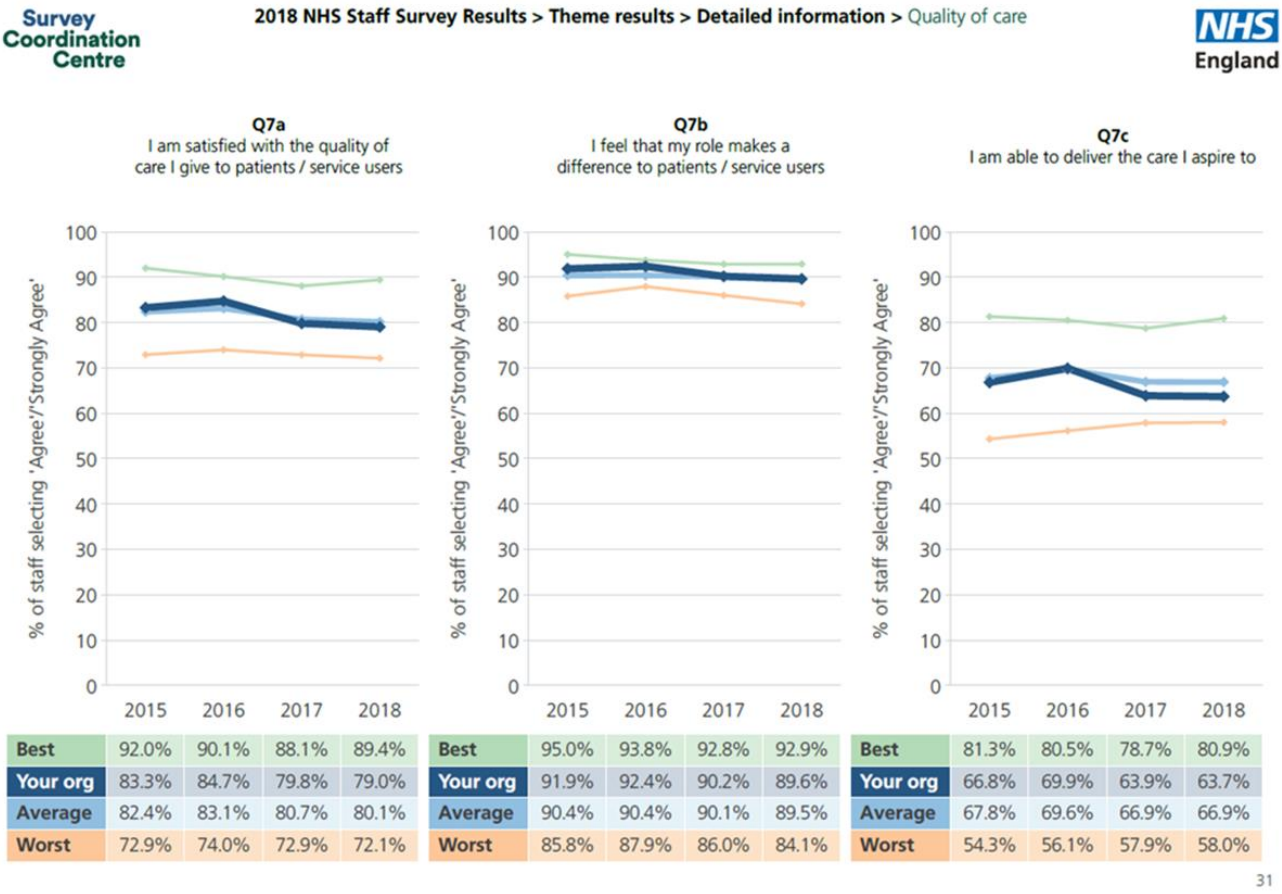
See following Appendices, showing

1. Detailed Charts for Areas for Action
2. Comparisons with other Trusts in our Local Sustainability and Transformation Programme footprint (STP).

Appendices

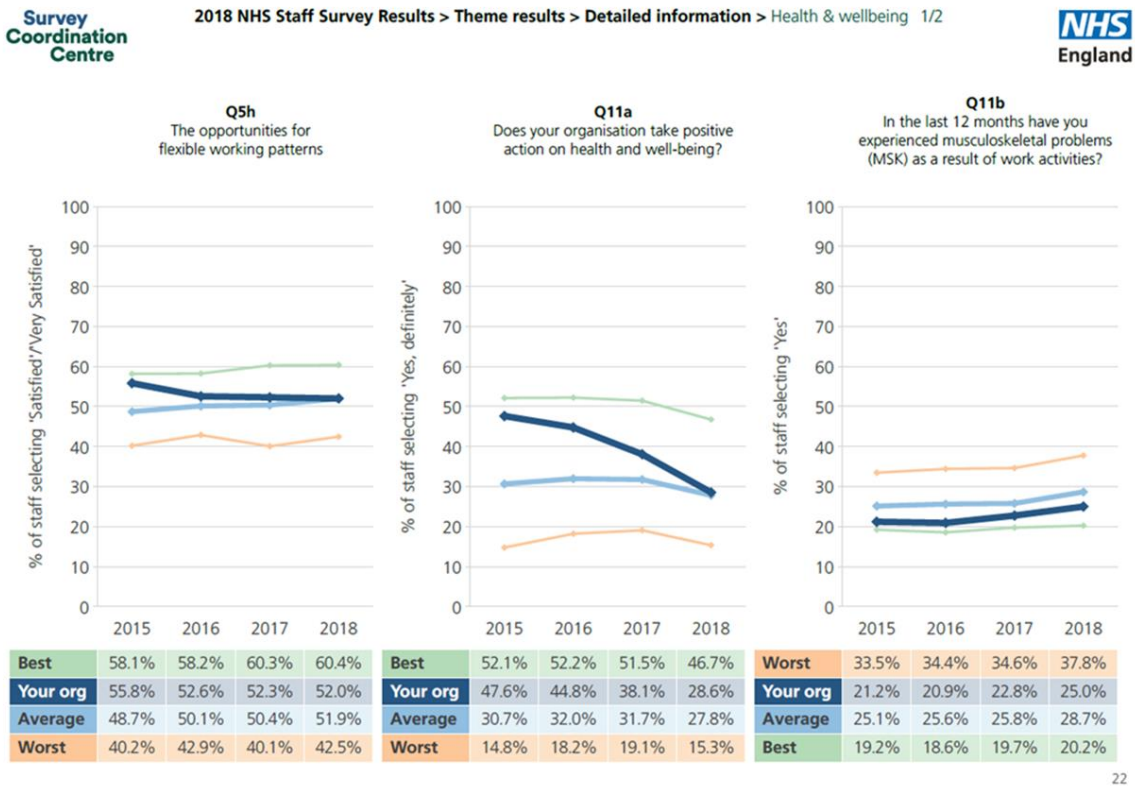
Areas for Action – Quality of Care

The following charts show Trust performance in the questions that constitute the "Quality of Care" theme.



Areas for Action – Health and Wellbeing

The following charts show the Trust's performance in the "Health and Wellbeing" questions.



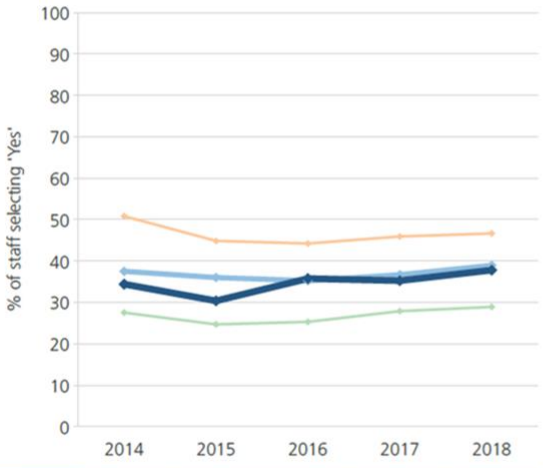
Salisbury NHS Foundation Trust

Survey Coordination Centre

2018 NHS Staff Survey Results > Theme results > Detailed information > Health & wellbeing 2/2

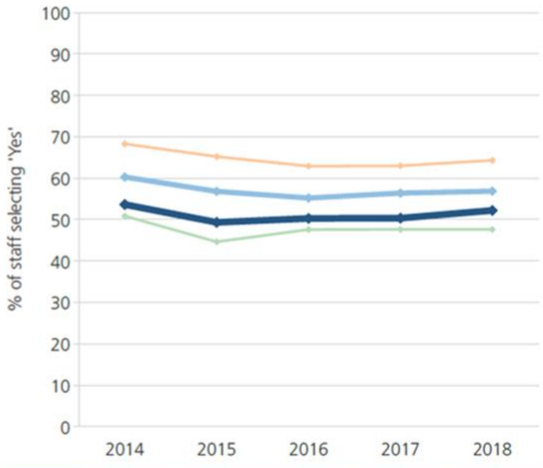
NHS England

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



	2014	2015	2016	2017	2018
Worst	50.8%	44.9%	44.2%	45.9%	46.7%
Your org	34.4%	30.4%	35.8%	35.3%	37.8%
Average	37.5%	36.0%	35.3%	36.7%	38.9%
Best	27.5%	24.7%	25.3%	27.9%	28.9%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2014	2015	2016	2017	2018
Worst	68.3%	65.2%	62.9%	63.0%	64.3%
Your org	53.6%	49.3%	50.3%	50.3%	52.2%
Average	60.3%	56.8%	55.2%	56.4%	56.9%
Best	50.9%	44.6%	47.6%	47.6%	47.6%

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Areas for Action – Safe Environment – Bullying and Harassment
The following charts show Trust performance in the Safe Environment – Bullying and Harassment questions.

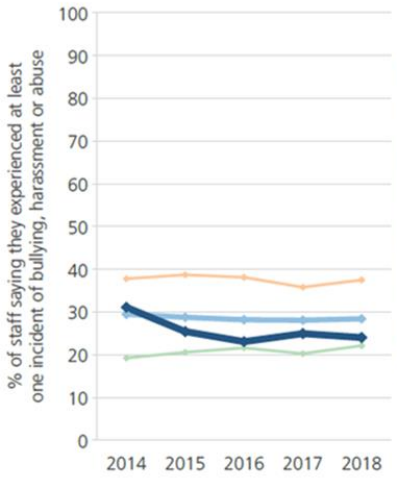
Salisbury NHS Foundation Trust

Survey Coordination Centre

2018 NHS Staff Survey Results > Theme results > Detailed information > Safe environment - Bullying & harassment

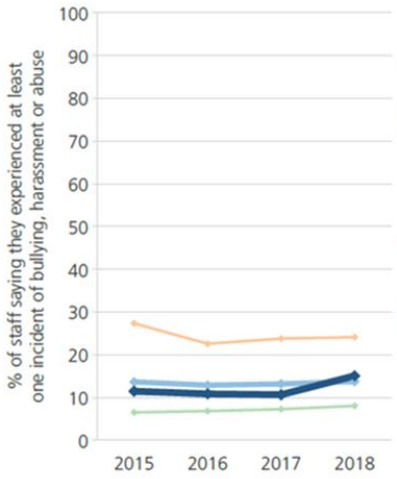
NHS England

Q13a
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



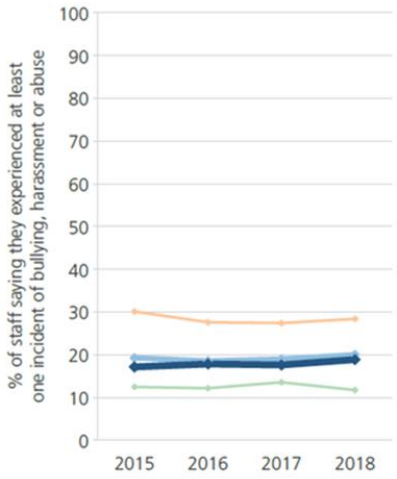
	2014	2015	2016	2017	2018
Worst	37.8%	38.7%	38.1%	35.8%	37.5%
Your org	31.1%	25.4%	23.1%	24.9%	24.0%
Average	29.5%	28.8%	28.2%	28.1%	28.4%
Best	19.2%	20.6%	21.6%	20.3%	22.1%

Q13b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018
Worst	27.3%	22.6%	23.8%	24.1%
Your org	11.5%	10.8%	10.6%	15.1%
Average	13.6%	12.9%	13.2%	13.7%
Best	6.5%	6.8%	7.3%	8.0%

Q13c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018
Worst	30.1%	27.6%	27.4%	28.4%
Your org	17.1%	17.8%	17.6%	18.9%
Average	19.3%	18.6%	19.0%	20.0%
Best	12.5%	12.2%	13.6%	11.7%

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Comparisons with other Trusts in our Local Sustainability and Transformation Programme (STP).

On average overall, Salisbury scores were higher than other similar Trusts in our Local Sustainability and Transformation Programme (STP) area. (See chart below).

Salisbury scored highest (or equal highest) in 8 of the 10 survey themes as follows :

Themes where Salisbury scored highest or equal highest of our local STP Trusts

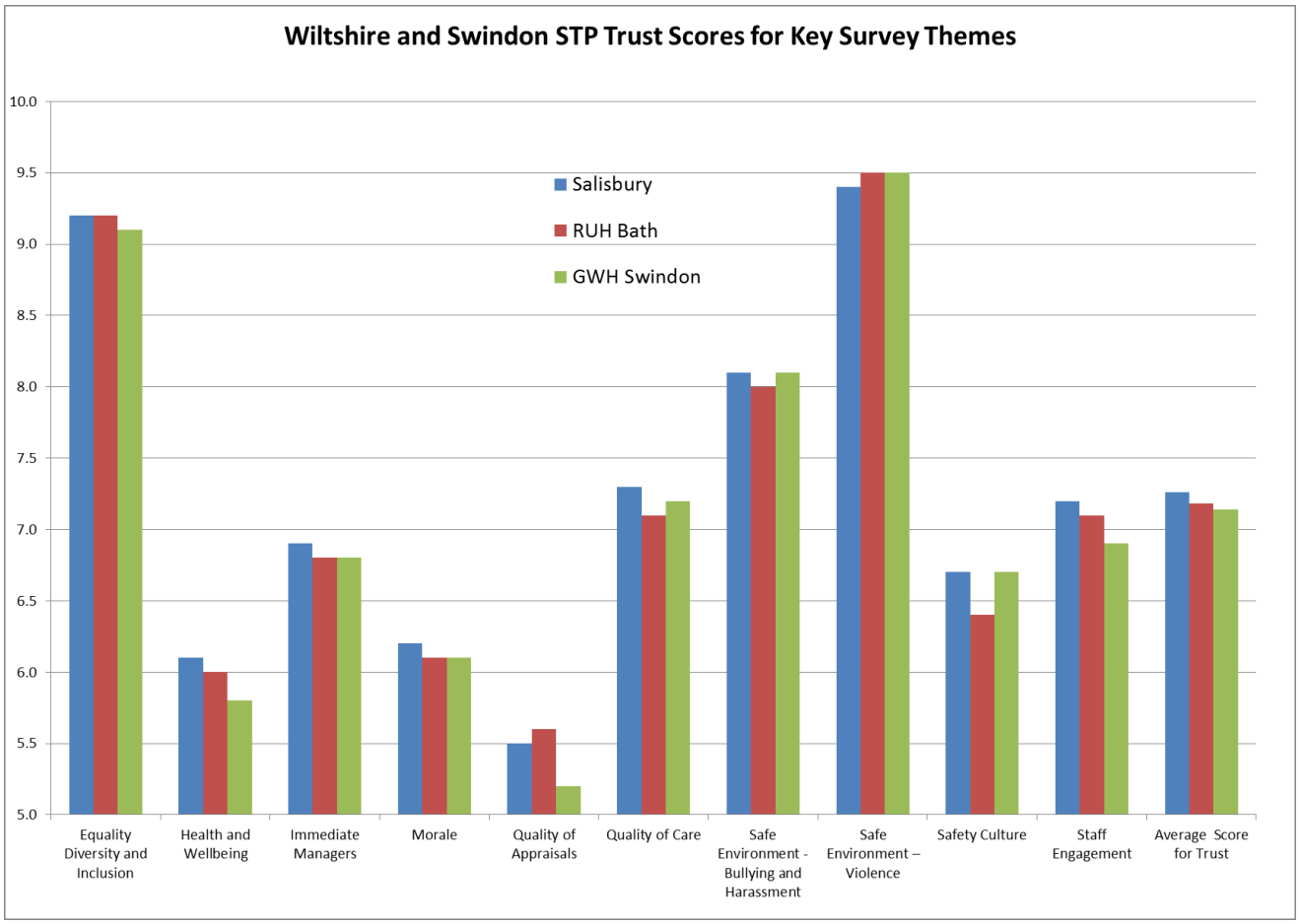
- Equality and diversity
- Health and wellbeing
- Immediate managers
- Morale
- Quality of care
- Safe environment – bullying and harassment (equal highest)
- Safety culture
- Staff engagement

Themes where SFT scored second highest of our local STP Trusts

- Quality of appraisals

Themes where SFT scored lowest of our local STP Trusts

- Safe environment – violence.



Paul Hargreaves
Director of Organisational Development and People

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	22
Date of Meeting:	04 April 2019		

Report Title:	Freedom to Speak Up Guardian Annual Report 2018-19			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:	Elizabeth Spicer, Freedom to Speak Up Guardian			
Executive Sponsor (presenting):	Paul Hargreaves, Director of Organisational Development and People			
Appendices (list if applicable):	Gap Analysis Update – Appendix A			

Recommendation:
The Board is asked to note the report.

Executive Summary:
All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report: This paper provides the Board with examples of best employment practice for FTSUG across the NHS, with the intention that Salisbury NHS Foundation Trust adopts a similar approach.

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

1 Purpose

1.1 This is the first annual report to the Trust Board by the newly appointed Freedom to Speak Up Guardian. The plan is to report annually to a Public Board Meeting and quarterly to the Workforce Committee. The purpose of this paper is to provide the Board with assurance that highlights progress nationally and within the Trust in relation to the Freedom to Speak Up Guardians (FTSUG) agenda.

2 Background

2.1 The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC, NHS England and NHS Improvement.

The Mid-Staffordshire Inquiry and subsequent Freedom to Speak Up review by Sir Robert Francis highlighted the tragic consequences for patients and their families when health staff feel unable to speak up, are victimised for doing so, or their concerns are ignored. Following the Francis review, all Trusts are now required to appoint a named Freedom to Speak Up Guardian who reports independently to the Board on whistleblowing matters and can support the organisation in developing an open culture. The Care Quality Commission in its inspections will look at how effectively Freedom to Speak schemes work and whether they are well supported by a Trust's Board.

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS - http://freedomtospeakup.org.uk

The CQC report for Salisbury NHS Foundation Trust published on 1st March 2019 stated 'the arrangements for the Freedom to Speak-up Guardian did not reflect the recommendations of the National Guardian's office. Work is needed on producing an integrated performance report that identifies where there may be variations and/or a need for change or improvement.'

3 Appointment of Freedom to Speak Up Guardian

3.1 Job description and business case has been agreed and funding approved by Workforce Committee. Elizabeth Spicer has been interviewed and appointed as the full time FTSUG from 2nd January 2019.

3.2 The FTSUG is a unique role and has direct access to the Chief Executive Officer, Director of Organisational Development and people and is supported by a Non-Executive Director in line with the national recommendations.

3.3 The FTSUG is linked to a regional Freedom to Speak Up network, attends regular training and is currently on a pilot supervision scheme with the London FTSU network.

4 Forward Plan

4.1 To complete the actions required in order that SFT achieves the recommendations of the National Guardian's Office.

- Immediate plans are to work with Equality Diversion and Inclusion to align strategies to include Communications Strategy, updating Policies and a recruitment strategy for FTSU Champions. Protected time for Champions to be discussed and agreed.
- Delivering education on how to raise concerns and on how to respond when concerns are raised.
- Working with the Executive Team and the Board in an independent capacity; providing challenge where appropriate.
- Ensure investigations are carried out appropriately and ensure staff that raise concerns are treated fairly.
- Target staff networks to ensure that all staff members know how to access the FTSUG
- Reporting on concerns that have been raised to the Chief Executive and to the Board, reporting quarterly to the Workforce Committee and also submitting quarterly and annual reports to the National Guardian's Office.

4.2 **Summary of issues raised April 2018- March 2019**

From April 2018 – March 2019 21 cases were raised with the FTSUG and the table below shows a breakdown by professional group:

Profession	**Cases**
Doctors	1
Nurses	5
Healthcare Assistants	2
Midwife	2
Dentists	0
Allied Healthcare Professionals	4
Administrative/Clerical Staff	5
Cleaning/Catering/Maintenance/Ancillary Staff	0
Board Members	0
Corporate Service Staff	2
Other	0

The cases are recorded against the following themes which have been set by the National Guardian's Office. Please note that some cases will contain more than one theme.

	Themes	**Cases**
1	Patient Safety/Quality	11
2	Staff Safety	11
3	Behavioural/Relationship	12
4	Bullying/Harassment	8
5	System/Process	4
6	Infrastructure/Environmental	0
7	Cultural	5
8	Leadership	13
9	Senior Management Issue	5
10	Middle Management Issue	2
11	Other	0

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

Since the beginning of the FTSU programme some serious concerns have been raised, but it is vital that the FTSUG is used effectively and appropriately, in line with national guidance and expectations of the role and is not here to police investigations. Further communication and education for staff and managers is required around this aspect of the role.

All concerns have been followed up and feedback provided to the individual staff members. Of the concerns raised in 2018/19, 7 remain open, with investigations in progress.

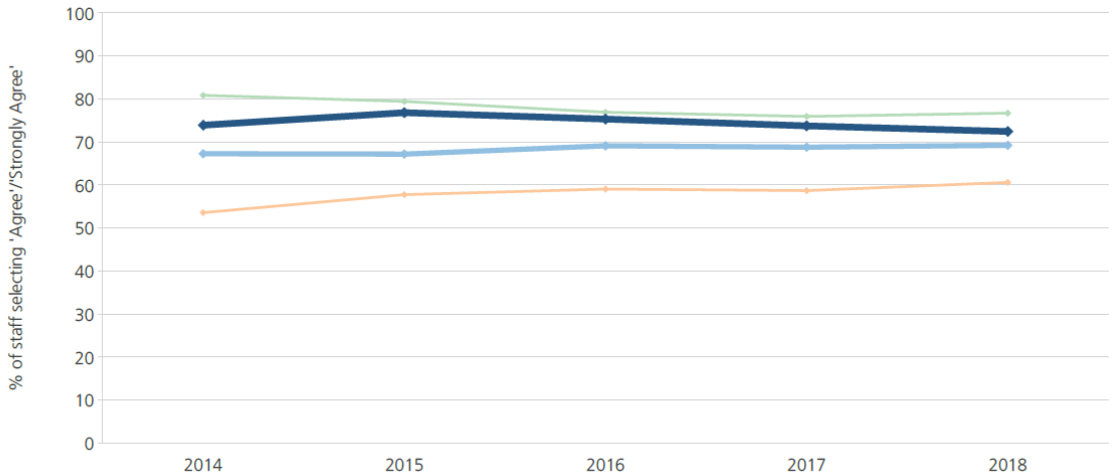
4.3 The National Guardian's Office has published the 2017/18 Annual Report which shows that 7087 cases were raised nationally, 45% of which include an element of bullying and harassment, 37% included an element of patient safety and 5% include perceived detriment. The report is available at: https://www.cqc.org.uk/sites/default/files/CCS119_CCS0718215408-001_NGO%20Annual%20Report%202018_WEB_Accessible-2.pdf

The 2018 Staff Survey for SFT shows that there has been a significant increase in bullying and harassment and over the past 12 months, and steady decline from 2015 with regards to staff feeling secure in raising concerns about unsafe clinical practice and a steady decline in confidence that the organisation would address concerns raised. This is an area of particular focus in the Forward Plan.

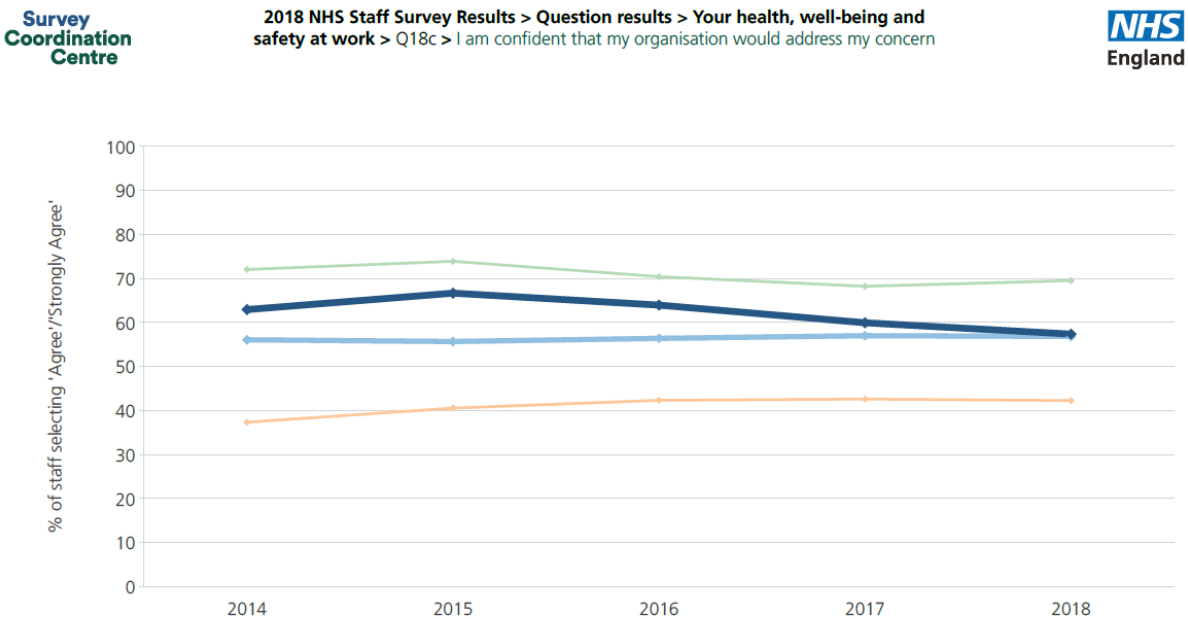
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q18b > I would feel secure raising concerns about unsafe clinical practice

NHS England



	2014	2015	2016	2017	2018
Best	80.8%	79.4%	76.9%	75.9%	76.7%
Your org	73.9%	76.8%	75.3%	73.7%	72.4%
Average	67.2%	67.1%	69.1%	68.8%	69.2%
Worst	53.5%	57.7%	59.0%	58.7%	60.6%
No. responses	471	951	1,133	1,457	1,292



	2014	2015	2016	2017	2018
Best	72.0%	73.9%	70.4%	68.2%	69.5%
Your org	62.9%	66.6%	63.9%	59.9%	57.3%
Average	56.0%	55.7%	56.4%	57.0%	56.8%
Worst	37.3%	40.5%	42.3%	42.6%	42.2%
No. responses	468	943	1,131	1,452	1,289

4.5 Board Self-Assessment Tool will be sent to Board Members for completion in May 2019. Completing the self-review tool and developing an improvement action plan will help Trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the Trust's speaking up culture is.

5 Summary

5.1 All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report: This paper provides the Committee with examples of best employment practice for FTSUG across the NHS, with the intention that Salisbury NHS Foundation Trust adopts a similar approach.

6 Recommendations

6.1 The Board is asked to note the report.

Elizabeth Spicer
Freedom to Speak Up Guardian

Appendix A

Freedom to Speak Up Guardian Survey 2018
Findings and Recommendations Gap Analysis

	Area	Recommendation	How SFT Meet the Recommendation
1.	Appointment	We recommend that appointment of guardians is made in a fair and open way, and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee(s).	Full time FTSUG appointed through the formal process, in a fair and open way.
2.	Training	We recommend that FTSUG undertake refresher training provided by the National Guardian's Office or guardians trained by the National Office to provide this training every 12 months. We recommend that all FTSUG regularly assess their training and developmental needs using the NGO Education and Training Guide and that their employers support them by providing the resources needed to enable them to continually develop their skills, knowledge and abilities.	FTSUG due for refresher training in Spring 2019. . FTSUG to complete NGO Training Guide with appropriate support. Training for FTSUG includes: CEO arranged for FTSUG to trial a pilot supervision scheme with the London FTSUG network for 12 months to share best practice. Annual FTSU conference FTSU Ambassadors are required to attend the same training when appointed.
3.	Local networks	We recommend that regional FTSUG networks seek local opportunities to enable all guardians to learn and improve, including sharing skills and knowledge amongst peers and seeking the support of local partners and ensure their organisation is represented at every regional meeting by a Guardian or Ambassador.	FTSUG attends regional network meetings regularly and seeks peer support. Ambassador posts have not been recruited to yet. SDH to host regional meeting in 2019
4.	Conflict	We recommend that those in a speaking up role make an assessment of the possible conflicts that any other role that they have may bring.	FTSUG is full time therefore no conflict of interest
5.	Diversity	We recommend that a local assessment is made by FTSUG of any groups that face particular barriers to	Established Trust Equality Champions network, needs strengthening with further promotion.

		speaking up and take action to ensure that those barriers are tackled. Where a local FTSU network is established, action should be taken to ensure that it reflects the diversity of the workforce that it supports.	Bi-monthly meetings as from 2018 led by Head of Equality, Diversity and Inclusion. FTSU Ambassadors to be recruited by 31/03/2019
6.	Ring fenced time	We recommend that all organisations with a FTSUG make a full and honest assessment of the time required by a guardian to carry out their role and meets the needs of workers. All guardians must have the ring-fenced time to satisfy this basic requirement.	This requirement is fully met as FTSUG is full time.
7.	Feedback	We recommend that all organisations review their mechanisms for seeking feedback on cases raised to FTSUG, take action to ensure that these are compliant with NGO guidance and ensure that sufficient time is allocated to ensure that this essential activity is undertaken.	Feedback is requested on all cases. Approximately 30% response.
8.	Access to senior leadership	We recommend that all guardians have direct and regular access to their CEO and non-executive director with the responsibility for speaking up.	Monthly meetings with CEO. Bi-annual meetings with Non-Executive Director .
9.	Board reporting	We recommend that FTSUG report to their Board in person, and are allocated sufficient time to ensure this is done.	Quarterly reporting to Workforce Committee.

Updated: April 2019

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	23
Date of Meeting:	04 April 2018		

Report Title:	CQC Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Prepared by:	Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Cara Charles-Barks Chief Executive			
Appendices (list if applicable):				

Recommendation:
To note the CQC report.

Executive Summary:
The CQC inspected the Trust from 13th November – 7th December 2018. On 1st March 2019 the report was published which gave the Trust an overall rating of good. The CQC report and accompanying documents can be found on the CQC website - https://www.cqc.org.uk/provider/RNZ

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	24
Date of Meeting:	4th April 2019		

Report Title:	An outstanding experience for every patient: *our strategy for improvement 2019-2021*			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Esther Provins, Director of Transformation			
Executive Sponsor (presenting):	Esther Provins – Director of Transformation			
Appendices (list if applicable):	n/a			

Recommendation:
The Board is asked to approve this strategy.

Executive Summary:
Adopting a continuous improvement approach has been shown to deliver better patient outcomes alongside improvement in operational, organisational and financial performance. To meet our full potential, we need to make 'making change' an intrinsic part of everyone's job, every day, in every part of the organisation. Our success relies on a step change in three distinct areas; our *culture*, our *capability* and our *capacity*. The purpose of this strategy is to set out what we mean by 'improvement', how we will make sustainable improvement, roles and responsibilities, actions we plan to take and how we will measure our success. Delivery of this strategy will be overseen jointly by the Clinical Governance and Workforce committees, and will be reported to the Board on a 6 monthly basis.

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	☐

An outstanding experience for every patient: *our strategy for improvement 2019-2021*

Introduction and background

Salisbury NHS Foundation Trust is operating under challenging circumstances. Workforce shortages across health and care in our local area are common, and this, along with financial challenges and a rising demand for our services means we are operating under significant pressure.

Notwithstanding the above the Trust has a clear vision: **to achieve an outstanding experience for every patient**. Our strategic priorities remain clear and focused with a clear foundation in improvement: "to meet the needs of the local population by developing new and improved ways of working…" "to provide innovative, high quality specialist care…" and "to promote new and better ways of working…"

There is a clear commitment to improvement and getting the best for our patients in all we do.

The purpose of this strategy is to set out:

- What we mean by improvement
- how we will make sustainable improvements
- roles and responsibilities, and
- actions we plan to take.

Improvement, change and transformation

Often these terms are used interchangeably however there are some subtle but important differences.

Improvement refers to making something better, something that already exists in the first place whereas change means to make something different. Transformation refers to a complete overhaul or the emergence of an entirely new state, involving both improvement and change. In healthcare is often incremental in nature rather than truly transformational *per se*[1] however it nonetheless it requires a fundamental rethink along with a new approach to enable new and better solutions to be found.

Where are we now?

It is clear that our staff are dedicated to delivering high quality care and are passionate about improving the quality of services we provide. However, there is more we can do to support continuous improvement throughout the Trust.

Our latest CQC report confirmed this when stating *"the trust is committed to quality improvement and innovations. However, it is important that improvement principles and practices are given pace and prioritisation within the organisation".* This recognition of commitment is positive and recognises our progress to date, whilst also recognising the need to prioritise improvement.

[1] (Durka Dougall, 2018)

Our scores for 'quality of care' in our latest staff survey results have deteriorated by a slight margin of 0.1 point. Of particular note are scores for how satisfied our staff are with the quality of care they provide (79% compared to the best result of 89.4%); whether our staff feel their role makes a difference (89.6% against the best of 92.9%) and whether are staff feel they are able to deliver the care they aspire to (63.7% compared to the best result of 80.9%).

These recent measures highlight we still have many opportunities to improve patient care, improve job satisfaction and morale. It is for this reason we need a different approach to improvement and transformation.

Aims and Objectives

Adopting a continuous quality improvement approach has been shown to deliver better patient outcomes alongside improvement in operational, organisational and financial performance. Organisations that have adopted this new approach 'feel different'– there is a palpable focus on quality and patient centred care[2]. Thus, the aim of this strategy is ultimately to improve patient care.

The following objectives will help us to achieve this.

1. Every member of staff is supported to do their job and improve their job
2. Everyone takes every opportunity to improve patient care on a daily basis
3. Every member of staff feels satisfied about what they have achieved each day and want to return the next, and
4. Every member of staff uses the lived experience of friends, family, patients, partners and community to improve.

Quite simply, we want to reach our full potential. As an organisation, as services, teams, wards, and as individuals.

How we will achieve our objectives

To meet our full potential, we need to make 'making change' an intrinsic part of everyone's job, every day, in every part of the organisation.

Our success relies on a step change in three distinct areas; our *culture*, our *capability* and our *capacity*.

Culture describes our way of life, our behaviour and what is normal to us. Our organisational culture in Salisbury NHS FT has grown over time and we are more than likely comfortable with the way things have always been. In order to improve and sustain improvement our culture needs to shift, to a culture where:

- Continuous improvement is built into everything we do. This means each and every member of staff is encouraged to initiate, support and lead improvement initiatives. Just because this is the 'way we have always done things around here' does not make it the most effective or appropriate way of doing things now.

[2] (Care Quality Commission, 2018)

- Each and every member of staff is encouraged to keep an open mind, and to adopt a questioning approach of 'appreciate enquiry'. This means listening to, and being open to consider opposing opinions, and being open to trying something new.

- We shift from an 'organisation as a machine to an organisation as an organism'[3].This means a shift away from a top-down hierarchy to an environment where leaders set direction and empower staff on the ground to take action. A culture of 'no more heroes'[4] where the role of a leader is about 'creating bridges, holding the space in the middle and facilitating change[5].'

- We co-produce change and improvement with our patients and carers and partners, harnessing the power of our community and using the collective wisdom of our lived experience.

- We continue to learn, where staff are encouraged to try new things in safe environments and not worry if something doesn't work out as expected. A culture where we evaluate the changes we make and we build on lessons learned to improve further.

- Teams celebrate success together and support and challenge each other.

- We involve all stakeholders and their representatives in transformation, rather than imposing top down change.

Capability describes our ability or power to do something. In the context of improvement, capability refers to our 'understanding, readiness and commitment to improvement and its skilled resources to achieve transformation'[6]. It not only describes the knowledge of how to do something, but the ability to do it well. Building our capability for improvement means:

- We have the right people, in the right number, with the right skills in the right place at the right time. This particularly relates to both clinical and non-clinical staff leading and supporting change programmes.

- All members of staff know where to go to access easy to use tools and resources to support them with improvement projects.

- Training in quality improvement, planning, project management and evaluation is available to all staff.

- We focus on building capacity in others by adopting a coaching approach.

- We build our competencies by doing, practicing and experiencing, whilst safely managing any associated risk.

- We provide supportive leadership that promotes taking time for improvement.

[3] (Wouter Aghina, 2018)
[4] (The Kings Fund, 2011)
[5] (Timmins, 2015)
[6] (Hamer, 2012)

- We encourage everyone to be empowered and take ownership for things within their control, reducing reliance on power from 'above'.

Capacity, in this context, refers to an individuals, team or organisations ability to absorb change effectively[7]. Both individuals and organisations can only assimilate a certain amount of change before negative symptoms occur, affecting both individuals and the success of change. Building our capacity for improvement means:

- The pace and scope of change is managed, to ensure we are able to absorb and sustain such change.

- Everyone understands the emotional impact of change, and people are given time and space to think through the purpose of change.

- Staff are given opportunities to undertake new challenges in line with opportunity and ability.

- Improvement and transformation programmes are led, support and facilitated by multi-disciplinary staff across different staff groups.

- Resources are freed up or introduced where needed.

- Different and new ways of working to increase our capacity to support and lead improvement are encouraged.

Actions we will take

1. We will **embed a culture of quality improvement** throughout the organisation, to include adoption of a standard quality improvement methodology across the Trust and provision of tools, techniques and training. This will commence in 2019/20.

2. We will work with our partners across our STP to **a consistent system-wide approach** to improvement, starting in 2019/20.

3. We will **develop a network of improvement agents**, by developing our current network of Save 7 agents and supporting them to champion improvement. This will commence in 2019/20.

4. We will **embed a new approach to clinical and non-clinical leadership** involving a shift away from problem solving to 'being enablers of change'. This will start in 2019/20, as part of our People Strategy.

5. We will **encourage innovation and reward good practice**, commencing with a Dragons Den Innovation Forum in 2019/20.

6. We will **introduce a programme of team development**, firstly targeting teams that are involved in leading change but rolling out to all teams over time. This will commence in 19/20, as part of our People Strategy.

[7] (Kealey, 2015)

7. We will build on our **talent management strategy**, increasing our improvement capability and capacity by matching available skills and ability to opportunities. This will commence in 19/20, as part of our People Strategy.

8. We will ensure that **all major transformation schemes are co-produced and have patient representation** included in project board membership. This will be reviewed and during 2019/20.

9. We will continue to **improve our programme management approach**, resulting improved governance and oversight of our transformation and improvement programmes. We will do this in 2019/20.

10. We will **review the business support** available to clinical services to support major transformation, along with our systems and processes. We will do this in 2019/20.

How we will measure our success

In addition to the deliverables listed above, we will monitor the success of our improvement strategy by the following measures.

Process measures: (short / medium term achievement 2019/20

- All major change programmes are co-produced with patients / carers and appropriate partners
- We will provide a transparent view of all improvement initiatives being undertaken
- All improvement programmes demonstrate the impact on patient care and experience
- Our staff feel able and empowered to make improvements themselves
- The majority of improvements are initiated 'bottom up'; rather than 'top down'.

Outcome measures (medium / long term achievement) 2021/22 and beyond

- A positive impact on patient care and experience (Family & Friends Test, outcomes)
- Staff job satisfaction has improved (staff survey)
- Staff retention has improved (workforce metrics)
- Improved efficiency and productivity (performance metrics)
- Financial performance (performance metrics)
- Our stakeholders view of Salisbury NHS FT (feedback)

Governance arrangements

Delivery of this strategy will be overseen jointly by the Clinical Governance and Workforce committees, and will be reported to the Board on a 6 monthly basis.

Esther Provins
Director of Transformation
18th March 2019

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	25
Date of Meeting:	4th April 2019		

Report Title:	Quality Improvement Operational Plan 2019/20			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Esther Provins, Director of Transformation			
Executive Sponsor (presenting):	Esther Provins – Director of Transformation			
Appendices (list if applicable):	n/a			

Recommendation:
The Board is asked to approve this plan.

Executive Summary:
This paper outlines our 2019/20 operational plan to embed a quality improvement approach, to deliver the quality improvement elements of our improvement strategy. This plan will deliver the following six key objectives during 2019/20: 1. To embed quality improvement into Trust leadership & governance 2. To adopt and socialise a common and easy to use quality improvement methodology 3. To provide tools and techniques to support staff in leading quality improvement initiatives 4. To provide support, expertise and training in quality improvement 5. To embed a quality improvement approach into day to day activities 6. To reward and share good practice and evaluate progress. The Workforce Committee and the Clinical Governance Committee will jointly oversee the Quality Improvement agenda and will receive regular progress updates.

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	☐

Quality Improvement – Operational Plan 2019/20

1.0 Introduction and Purpose

1.1 Quality improvement can be defined as the combined and unceasing efforts of everyone – clinicians and non-clinicians alike – to make changes that will lead to better patient outcomes, better care and better professional development[1].

1.2 This plan is set in the context of our overarching strategy for improvement entitled '*An outstanding experience for every patient: our strategy for improvement*'.

1.3 This paper outlines our 2019/20 operational plan to embed a quality improvement approach, to deliver the quality improvement elements of our improvement strategy.

2.0 Background and context

2.1 Innovation and improvement are at the very heart of our vision and our drive to be 'Outstanding Every Time'. In our strategic priorities we have committed to developing 'new ways of working', providing 'innovative, high quality specialist care' and promoting 'new and better ways of working'. This requires us to focus on continuous improvement. We are ambitious, and determined to continue on our improvement journey at pace.

2.2 Achieving a systematic approach to quality improvement is as much about nurturing a culture of quality improvement as it is about encouraging the adoption of a consistent implementation model.

2.3 Quality improvement is not a quick fix but a continuous process requiring a sustained focus over time. Building an organisation-wide commitment to our approach will involve a cultural shift in ways of thinking, leading and working.

2.4 Over the last few years the Trust has implemented a number of targeted quality improvement initiatives. For example, the annual Health Improvement Programme (HIMP) for F1 doctors run by the Trust requires junior doctors to identify and undertake a quality improvement initiative, with support and guidance from qualified members of staff. In 2018, 10 members of staff were successful in being accredited by Wessex AHSN as 'Q' practitioners. The Save7 campaign was started, with 82 champions (one from each service) trained. The Trust also introduced Sharing Outstanding Excellence (SOX) to look at interactions that 'go right' so that good practice and lessons learned are shared.

2.5 Whilst in themselves these initiatives have been successful, it is recognised that to date, there has not been a consistent Trust-wide approach to embed quality improvement.

2.6 In February 2018 a business case proposing a £591k investment into resources for QI over a period of 4 years was developed. Although the business case was approved in principle by the Joint Board of Directors (now the Trust Management Committee), due to operational pressures there has not been sufficient funding available during 2018/19 to release the

[1] Batalden PB, Davidoff F. What is "quality improvement" and how can it transform healthcare? Qual Saf Health Care. 2007;16(1):2–3. doi: 10.1136/qshc.2006.022046. [PMC free article] [PubMed] [CrossRef]

additional resource requested. This has prompted a review of our proposed approach to quality improvement considering the current financial constraints the Trust is operating within.

2.7 In December 2018 the Trust underwent a CQC Well-Led review and in their subsequent feedback the CQC clearly identified that additional work to embed a quality improvement approach in the Trust is needed. They also recommended that an executive lead be identified, to champion and drive quality improvement at senior level.

2.8 In January 2019 a new Director of Transformation officially started in post, and is now appointed to take the lead in embedding a quality improvement approach throughout the organisation.

2.9 Conversations are underway with Banes, Swindon & Wiltshire STP partners to ascertain opportunities for a long term strategic partnership to support continuous quality improvement; and this approach will form part of our wider strategy.

3.0 Aims and objectives

3.1 To meet our full potential we need to make 'making improvements' an intrinsic part of everyone's job, every day, in every part of the organisation. We want our staff to be open to try new things and for our leaders and managers to offer support with a collaborative and coaching approach. We want our staff to be empowered to act at the top of their game and take ownership for improving things within their control.

3.2 This requires a shift in our culture, our mind-set, in the way that we lead and the way we all go about our day to day business.

3.3 This plan aims to support us in achieving this aim by delivering the following six key objectives during 2019/20:

1. To embed quality improvement into Trust leadership & governance
2. To adopt and socialise a common and easy to use quality improvement methodology
3. To provide tools and techniques to support staff in leading quality improvement initiatives
4. To provide support, expertise and training in quality improvement
5. To embed a quality improvement approach into day to day activities
6. To reward and share good practice and evaluate progress.

4.0 Constraints

4.1 The Trust is in a period of financial recovery, and is not currently in a position to make significant new investment into dedicated resources for quality improvement. The plan outlined in this document is therefore constrained to the use of existing resources with little or no additional investment being required.

5.0 Governance

5.1 A quality improvement steering group will convene to oversee the development and implementation of this operational plan.

5.2 The Workforce Committee and the Clinical Governance Committee will jointly oversee the Quality Improvement agenda and will receive regular progress updates.

5.3 Progress will be reported to the Board on a six monthly basis.

Esther Provins
Director of Transformation
1st March 2019

Embedding a culture of quality improvement - operational plan 2019/20

Objective	Action	Delivery date	Lead
Embed QI into trust leadership & governance	• Set up QI task-finish steering group • Secure patient & stakeholder representation • Agree measures of success • Ensure QI programme has Board oversight, via appropriate Board sub-committee	February 2019 March 2019 March 2019 March 2019	Director of Transformation Director of Transformation Director of Transformation Director of Corporate Governance
Adopt a common QI methodology	• Review current methodology/best practice • Agree common methodology at steering group/committee level	February 2019 March 2019	Director of Transformation Director of Transformation (DoT)
Provide tools and techniques to support QI initiatives	• Set up QI Virtual Academy • Agree standard project management approach • Develop and provide tools to support use of statistical process control (SPC)	August 2019 March 2019 June 2019	Communications team PMO DoT / IT
Provide support, expertise and training in QI	• Develop a central team/network of 'improvement agents' (using virtual team of current 'Q' facilitators and Save7 champions to start) • Develop and agree role of network/virtual team • Train the virtual team (train the trainer) • Training included in clinical leadership programme • Training included in general leadership programme • Make training available to all staff • Set up rapid improvement support	May 2019 May 2019 October 2019 January 2019 Quarter 4 19/20 Quarter 4 19/20 Quarter 4 19/20	DoT Virtual team / DoT 'Buddy Trust' / external DoT / PMO DoT / PMO PMO / L&D Virtual team / DoT
Embed a QI approach into day to day activities	• Promote and encourage discussions about QI in 1:1's, team & directorate meetings • Review QI activities at a team/specialty/directorate level • Include QI in appraisal conversation materials	December 2019 December 2019 December 2019	All managers Heads of Service Learning & Development
Communication & engagement	• Prepare communications plan (to reach all staff groups, to include public facing material on website)	May 2019	Communications team
Reward and share good practice and evaluate progress	• Release regular updates on progress and successes	From May 2019	Comms / Virtual team

	• Set up annual ‘Dragons Den’ to encourage innovation • Reward good practice – Service Improvement Awards • Review progress on 6 monthly basis • Evaluate measures of success, including feedback from staff, patients and partners	Quarter 3/4 19/20 Quarter 1 19/20 From Sept 2019 From Sept 2019	DoT / Communications DoT / Communications Committees / Board Committees / Board