Bundle Trust Board Public 8 April 2021

1	Opening Business
1.1	10:00 - Presentation of SOX certificates
1.2	10:05 - Patient Story
1.3	Welcome and Apologies
1.4	Declaration of Interests/Fit and Proper/Good Character
1.5	10:20 - Minutes of the previous meeting
	Minutes attached from meeting held on 4th March 2021 *For approval* 1.5 Draft Public Board mins 4 March 2021.docx
1.6	Matters Arising and Action Log 1.5 Public Trust Board action log.pdf
1.7	10:25 - Chairman's Business
	Verbal update by NIck Marsden *For information*
1.8	10:30 - Chief Executive Report
	Presented by Stacey Hunter *For information* 1.8 CEO Board Report March for April.docx
2	ASSURANCE AND REPORTS OF COMMITTEES
2.1	10:40 - Clinical Governance Committee - 30 March
	Presented by Eiri Jones *For assurance* 2.1 Escalation report - from March CGC to April Board 2021.docx
2.2	10:45 - Finance and Performance Committee - 30 March
	Presented by Paul Miller *For assurance* 2.2 Board - Finance and Performance Committee escalation paper 30th March 2021.docx
2.3	10:50 - Trust Management Committee - 31 March
	Presented by Stacey Hunter *For assurance* 2.3 TMC Escalation report.docx
2.4	10:55 - People and Culture Committee - 25 March
	Presented by Nick Marsden *For assurance* 2.4 Escalation report - from P & C Committee 2532021.docx 2.4a BSW Academy proposal briefing March 2021.docx
2.5	11:00 - Audit Committee - 18 March
	Presented by Paul Kemp *For assurance* 2.5 Escalation report from Committee to Board - Audit Committee 18th March 2021.docx
2.6	11:05 - Charitable Funds Committee - 18 March
	Presented by Nick Marsden *For assurance* 2.6 Charity committee esclation report 18-03-21.docx
2.7	11:10 - Integrated Performance Report (M11) including Covid recovery
	Presented by Andy Hyett *For assurance* 2.7a 080421 IPR cover Board.docx 2.7b IPR April 2021 DRAFT.pdf 2.7c 080421 Covid update Board cover.docx 2.7d 240321 SFT Covid-19 briefing IPR.pdf

2.8 11:25 - BREAK

3 QUALITY AND RISK

3.1 11:35 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona McNeight
For assurance

- 3.1a Trust Board BAF Cover sheet April 2021.docx
- 3.1b BAF v2 March 2021_Trust Board Committees.docx
- 3.1c Draft Corporate Risk Register March 21 v2.1.pdf
- 3.1d CRR tracker v20_March Board Committees 2021v2.xlsx

3.2 11:45 - Patient Experience Report Q3

Presented by Judy Dyos
For assurance

- 3.2 - Patient Experience Report Q3 January 2021.docx

3.3 11:55 - Learning from Deaths ReportQ3

Presented by Peter Collins
For assurance

- 3.3 Learning from deaths report Q3 20 21 Jan 21.docx

4 FINANCIAL AND OPERATIONAL PERFORMANCE

4.1 12:05 - Standing Financial Instructions

Presented by Lisa Thomas
For assurance

- 4.1a SFI review Mar21.docx
- 4.1b DRAFT - Standing Finacial Instructions Mar21.docx
- 4.1c Appendix 2 - Schemeofdelegation Mar21.docx

5 PEOPLE AND CULTURE

5.1 12:15 - National Staff Survey Results

Presented by Susan Young
For information

- 5.1 Cover sheet Staff Survey Results 2020_Private Trust Board April 2021.docx

6 GOVERNANCE

6.1 12:25 - Annual Review of Directors Interests/Annual Review of Fit and Proper Persons Test

Presented by Fiona McNeight
For approval

- 6.1a Cover Trust Board Annual Review of Directors Interests and FPPR 2021.docx
- 6.1b Trust Board Register of Members Interest 2021.doc

6.2 12:35 - Integrated Governance Framework

Presented by Stacey Hunter
For approval

- 6.2a Draft Board cover sheet 2021 Integrated Governance Framework.docx
- 6.2b Draft Integrated Governance Framework 2021 v6.3 for Trust Board April.docx

6.3 12:45 - Accountability Framework

Presented by Andy Hyett
For approval

- 6.3a AF Board cover sheet April 2021.docx
- 6.3b 01 DRAFT 2021 -22 Accountability Framework.docx
- 6.3c (updated) Appendix 1 SFT AF 21 22 - Division to board flowchart.pptx
- 6.3d Appendix 2 2021 v1.2 TMC Terms of Reference.docx
- 6.3e (updated) Appendix 3 SFT AF 21-22 - ToR Divisional Management Committee.docx
- 6.3f Appendix 4 SFT AF 21-22 Agenda Executive Directorate Performance Meetings.docx

6.4 EPPR Compliance Statement (deferred to May meeting)

6.5 12:55 - Register of Seals

Presented by Fiona McNeight
For information

- 6.5 Register of Seals.docx

6.6 13:00 - External Well Led Review

Presented by Fiona McNeight
For approval

6.6 External Well Led Review.docx

7 CLOSING BUSINESS

7.1 13:10 - Agreement of Principle Actions and Items for Escalation

7.2 13:15 - Any Other Business

7.3 13:20 - Public Questions

7.4 Date next meeting

Date of next public meeting 6th May 2021

8 Resolution

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

Salisbury NHS Foundation Trust

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 4 March 2021 via MS Teams Salisbury NHS Foundation Trust

Present:

Nick Marsden (NM)	Chairman
Tania Baker (TB)	Non-Executive Director
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Lisa Thomas (LT)	Director of Finance
Lynn Lane (LL)	Director of OD and People
Judy Dyos (JDy)	Interim Director of Nursing
Peter Collins (PC)	Interim Medical Director
Andy Hyett (AH)	Chief Operating Officer

In Attendance:

Kylie Nye (KN)	Corporate Governance Manager (minutes)
Fiona McNeight (FMc)	Director of Corporate Governance
Esther Provins (EP)	Director of Transformation
Kat Glaister (KG)	Head of Patient Experience (for item TB1 4/3/1.2)
John Mangan (JM)	Lead Governor (lead observer)
Jenny Lisle (JL)	Governor (observer)
Kevin Arnold (KA)	Governor (observer)
Louise Couzens (LC)	Care Quality Commission (CQC) observer
Andrew Marshall (AM)	Public Observer

ACTION

TB1 4/3/1 OPENING BUSINESS

TB1 4/3/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

NM noted the following members of staff who had been awarded a SOX Certificate and details of the nominations were given.

- Gemma Ward, Responsive SOX
- Catering Department, March SOX of the Month

NM congratulated the members of staff who had received a SOX award and the Board noted the great effort from staff during what has been a challenging time.

TB1 4/3/1.2 Patient Story

KG joined the meeting to present the joint patient and staff story. The story was centered on a Community Palliative Care Clinical Nurse Specialist (CNS) who had taken the time and effort to collect a deceased patient's belongings and ensure they were personally delivered to the wife who was unfortunately unwell at home. The CNS had visited the bereavement suite and also collected a

compassion rose to take with her, knowing how difficult it must have been for the wife who had been unable to visit the hospital to see her husband before he passed away.

Discussion:

- NM noted that whilst the last 12 months had been difficult in the NHS it was positive to hear that staff were displaying the level of compassion detailed in the staff story and as part of the SOX nominations.
- EJ noted that the story indicated that staff are going over and above what is expected and really care about improving what has been an awful time for relatives whose family members are in hospital. EJ further noted that it is important to note that additional grief and bereavement support will be required for some time into the future.
- PM explained that the story resonates in terms of conversations about improvement at both public and private board, as it is a reminder that improvement is not always related to the larger pieces of work but the values, behavior and compassion shown by all staff.
- JDy explained that when speaking to ward staff one of the hardest situations of the last year has been the visitor restrictions and not having relatives there for patients, particularly those on an end of life care pathway.

TB1 4/3/1.3 Welcome and Apologies

NM welcomed everyone to the meeting and noted apologies from:

- Michael von Bertele, Non Exec Director
- Stacey Hunter, Chief Executive

TB1 4/3/1.4 Declarations of Conflicts of Interest

There were no declarations of conflicts of interest pertaining to the agenda.

TB1 4/3/1.5 Minutes of the part 1 (public) Trust Board meeting held on 14th January 2021

NM presented the minutes and the following points were noted:

- On Pg. 4 of 16 EJ noted that in the CEO report it stated that despite staffing challenges safe care was maintained. EJ asked for future reports to reflect that harm occurs in all sorts of situations and noted that there had been an increase in falls.
- On Pg. 12 of 16 EJ pointed out a minor typo which was subsequently corrected.

The minutes were agreed as an accurate record of the meeting held on 14th January 2021.

TB1 4/3/1.6 Matters Arising and Action Log

NM presented the action log and noted that all the actions were due in April at the next Public Board.

- **TB1 14/01/4.5 Maternity Ockenden Review -** PK asked for an update in relation to the reporting schedule for the Maternity Ockenden review. EJ noted that the team is now awaiting feedback from the regional/ national consideration of all Trust submissions. The action would be updated to reflect this.

There were no further matters arising.

TB1 4/3/1.7 Chairman's Business

NM highlighted the following key points:

- The Trust has been through difficult period and what has been positive is the way staff have pulled together to manage the stress and strain that the organisation has been going through.
- The scale and magnitude of change of the second wave of Covid-19 in comparison to the first wave was significant. This has affected patients, population and staff and it is recognised that as the Trust starts to move forward, staff need rest to and recover from what they have experienced. There is also a need to look at how the Trust treats and cares for Covid and non-Covid patients going forward.
- Additionally, the Trust is focused on the future and managing the long patient waiting lists effectively and safely and addressing those patient needs as promptly as possible.

TB1 4/3/1.8 Chief Executive's Report

LT presented the report in SH's absence and highlighted the following key points:

- Newsnight returned to the Trust and spent 12 hours shadowing a team in ICU, the report really showcased the Trust's compassionate staff and hardworking staff.
- The Salisbury City Hall Vaccination centre is managed by the Trust and has successfully vaccinated 10,000 people. LT thanked the vaccination leadership team and the number of volunteers who have given their time to help and support.
- The Board will be spending time to consider the Integrated Care System proposals, as well as aligning this to the Trust's clinical strategy and priorities to place based population health priorities.

The report was noted.

TB1 4/3/1.9 Trust Board Cycle of Business

FMc presented the report which provided a summary of reports to the public and private Trust Board from 1st April 2021 – 31st March 2022. FMc noted that the Annual Report and Accounts were currently scheduled for May. However, due to recently published

guidance it is likely that an Audit Committee and private Trust Board will be held in late June instead and dates are to be confirmed.

Discussion:

- AH noted that the Director of OD and People was the lead for the Health and Safety Annual Report.

Decision:
The cycle of business was approved subject to the amendment above. .

TB1 4/3/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 4/3/2.1 Clinical Governance Committee – 23 February

EJ presented the report, providing a summary of escalation points from the meeting held on 23rd February:

- The Committee received assurance that despite the impact of Covid-19 the Trust is focused on recovery and resuming services affected during the peak of the pandemic. There is more to review in terms of the longer term impact of Covid-19 through CGC and F&P and the Committees will continue to question and discuss those issues.
- A follow up report was provided in relation to maternity services in the Trust in response to the Ockenden report. It was agreed that the team and the Maternity Board now need time to focus on this and further updates will come back to CGC in due course.
- The increase in pressure ulcers and falls were discussed and it was agreed that a refocus on the fundamentals of care was required as part of the resetting and restarting services.
- An annual report was received on the Trust's position in relation to the Human Tissue Authority (HTA) licence requirements. The Trust evidenced compliance in relation to two licences – Stem Cell harvesting and Post Mortem examination.
- Detailed quarterly reports were received from the Research, Patient Experience, Children and Young People and Adult Safeguarding teams.

Discussion:
NM assured the Board that findings in relation to the Trust's response to the Ockenden report had an escalation route and would be highlighted promptly if something required urgent attention. JDy noted that maternity governance would be confirmed and explained that there would be a Maternity Safety Champion role introduced.

TB1 4/3/2.2 Finance and Performance Committee – 23 February

P Miller provided a summary of escalation points from the Finance

and Performance Committee held on 23 February:

- PM reiterated that January was an exceptional month with an increase of 280 patients waiting over 52 weeks. It is clear that the Trust was under significant pressure and the focus should now be on recovery. However, it is acknowledged that recovery will be constrained by a number of factors
- The Committee received an update on the IT and Digital agenda and the key concern is how the Trust supports a number of IT projects concurrently. A prioritisation plan will come to March's meeting which will provide assurance that approved projects can be successfully implemented.
- Following a lengthy discussion on the issues, it was agreed that a paper would be prepared for the Trust Board meeting on the 8th April 2021 and both the Chairs of the F&P and Clinical Governance Committees would assist in the preparation of this report.

Discussion:
NM queried if there had been any further guidance received on capital. LT confirmed that further guidance was still required. PM noted that due to resources being so constrained it is essential to prioritise and deliver them properly.

TB1 4/3/2.3 Trust Management Committee – 24 February

LT provided a summary of escalation points from the Trust Management Committee held on 24th February:

The meeting received, discussed and approved a number of business cases including:

- Clinical Coding
- Genetics - Staffing/Workforce
- Genetics – Automatic progression on registration
- Pathology LIMS

Discussion
EJ noted that the TMC escalation reports generally focus on business cases but explained she would expect more assurance from the other items discusses and asked that the escalation report reflects the true content of the meeting. **ACTION: SH/GT** **SH/GT**

TB1 4/3/2.4 People and Culture Committee – 25 February

NM provided a summary of escalation points from the People and Culture Committee held on 25th February.

- NM noted that as well as the key issues highlighted in the paper, the immediate priority is staff health and wellbeing and ensuring there is continued support for staff.

Discussion:

PM asked for an update in relation to progress on consultant job planning. PC referred to the job planning policy which is scheduled to be finalised by the end of March. It is acknowledged that this has been deferred and slippage has been partly due to Covid and also the negotiation process. There is a better relationship with the consultant body which means the job planning policy is agreed on a basis of trust which will help the process going forward.

TB1 4/3/2.5 Integrated Performance Report

P Collins presented the Integrated Performance Report to the Board and noted that this report provided a summary of January's performance. The following key points were noted:

- The impact of Covid-19 in January on the performance of the Trust was significant and operationally generated huge pressure and required escalation into acute medical and surgical wards. The median average of Covid positive patients in the Trust during January was 127 which was much higher than expected.
- There were high levels of Covid-19 related staff absence with the additional requirement to redeploy and use bedded capacity for escalation. This has inevitably had an impact on quality of care with a deterioration in relation to falls and pressure ulcers
- As described in the F&P escalation report, patients waiting over 52 weeks have increased, which is largely impacting plastics, oral surgery and ophthalmology. The situation in January also saw increased pressure on the diagnostic pathways.
- In relation to two week wait breast referrals a weekly one stop clinic began in January which will ensure reduced waiting times for clinic appointments.
- Outpatient activity levels for M10, exceeded the forecast Phase 3 trajectory with several specialties achieving 90% or above.
- In relation to mortality the Trust is looking at individual cases of Covid transmission within the hospital and a duty of candour letter will be sent to the bereaved families of the probable and definite healthcare associated deaths. The increase in hospital acquired Covid is attributed to the new variant which is 70% more transmissible.

Discussion:

- The Board discussed the patient waiting list and trajectories for patients waiting over 52 weeks. AH noted that some of the delays in care were specialty dependent as there were specific infection, Prevention and Control (IPC) requirements that needed to be adhered to. AH further explained that those patients who have declined to come in for an appointment were included on the waiting list which was not normal practice pre-Covid.
- JDy reported that whilst pressure ulcer cases had risen during the height of Covid, Level 3 and 4 pressure ulcers

have halved since last year and a quarter of pressures were device related.

- EJ asked if there were any new areas of concern that the Board should be aware of or areas of good practice. PC noted that the one of his key concerns is the impact on two week wait diagnostics, particularly breast services. There is work ongoing to fully understand this and extra measures have been put in place to recover by end of March. In relation to good practice, PC explained that responsiveness and the staff's ability to respond in times of crisis have helped to highlight areas of good practice.
- PM referred to ED (Emergency Department) and further to the issues in January asked for assurance that ED from a capacity perspective is fit for purpose. AH acknowledged that that ED is small and that Covid-19 meant that ED now requires two major areas. In relation to ambulance handovers, the 4 hour standard and onward flow there is an escalation process and performance has improved since January. AH, JDy and PC will need to discuss the hospital's configuration going forward with the likelihood of having Covid and non-Covid patients in the hospital.
- PC explained that in relation to patient flow one of the key factors will be reliable testing which could soon be completed within 90 mins.
- TB referred to the Trust's stroke performance and that access to quick diagnostics has an impact on outcomes and asked if the Trust will call upon the system to provide resilience. PC noted that Covid had an impact on the stroke service in January but there had been good collaboration with partners. In relation to delays in diagnostics for Stroke patients those pathways do need further work and there will be work to improve this going forward. A report is expected to go to F&P to provide further assurance.

TB1 4/3/2.6 Covid-19 Response

A Hyett presented the report and noted the current status in the Trust:

- There are 26 Covid positive patients in the Trust.
- There has been a reduction in the number of incident meetings as the Trust returns to normal governance structures. There is still the national requirement of 7 day a week reporting.
- There has been a drop in the number of presentations in the community and in the Trust.

Discussion:

- TB asked about low levels of vaccination uptake in certain communities and professional groups and asked how the Trust was going to focus its efforts. AH explained that the mass vaccination effort was now being overseen by PC. AH explained that the Trust is reviewing uptake in those groups and is looking at how different areas are targeted, i.e. social media. At a BSW (Bath and North East Somerset, Swindon

and Wiltshire) system level there is demand and capacity modelling which is taking into account uptake and each organisation is focusing on groups of staff where uptake is low.

PC explained that there is work in relation to national population health data looking at socio-economic groups and ethnicity at a regional and a BSW level.

TB1 4/3/3 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 4/3/3.1 Operational Plan Update 2021/22 – deferred to April

This item was deferred to April as LT reported the guidance has not been released on the operating plan. In the meantime there have been active conversations with clinical directors and divisional management emphasising good controls and governance.

PM noted the complexities and due to the Trust's finite resources and priorities asked if the Board were clear on constraints, e.g. workforce, capital, issues relating to the estate. LT explained that the key unknown is Covid-19 and therefore there will be assumptions in the plan. There is now a better understanding on how these constraints can be mitigated and the Trust has learnt a great deal from recent outbreaks. There will be challenges in balancing the national requirement whilst also protecting Infection, Protection and Control changes.

TB1 4/3/4 PEOPLE AND CULTURE

TB1 4/3/4.1 Best Place to Work Update

LL presented the report which asked the Board to note the Best Place to Work update report and endorse the recommendations detailed within the paper.

- The team is now focused on the recommendations in terms of how the Trust moves forward and ensuring there are clear and wide reaching communications on diagnostic elements of the work and a clear plan with agreed priorities.
- The is a continued focus on listening to staff and triangulate information from key areas like Occupational Health, Freedom to Speak Up and OD & People.
- As there is a small team leading this work it is acknowledged that additional resource is required to support and ensure everything the Trust does is designed to align with the NHS People Plan, Best Place to Work and the results of the staff survey. This will mean working with partners on the Quality Improvement and Transformation phase.

Decision:
The Trust Board were content to endorse the recommendations

detailed in the report.

TB1 4/3/4.2 Nursing Skill Mix Review

JDy presented the report asking the Trust Board to note the findings of the full establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels. JDy noted that the nursing skill mix usually draws data from previous years but due to the current situation the Trust have gathered staff information more recently due to the impact of the Covid-19 pandemic.

Discussion:

- RA noted that the challenges are clear and in a previous discussion there had been suggestion of reviewing skill mix in a different way going forward to include a multi-professional skill mix so safer staffing is not always dependent on the nursing workforce. JDy explained that the nursing skill mix review is a mandated process and that whilst nursing group are the focus there have been discussions about other groups of staff and how to review skill mix in a wider context. Additionally, hospitals have to work differently due to Covid-19 and therefore there is a requirement to consider how teams work together.
- RA reflected that pressure ulcers are not just the responsibility of nursing teams and suggested that the Trust needs to consider how everyone contributes to the success of reducing pressure ulcers and what needs to be put in place to release staff to attend training. JDy explained that the Tissue Viability Team is working on developing new ways of training and it is acknowledged that responsibility for the reduction of pressure ulcers and other quality indicators reaches wider than the nursing workforce.
- PM queried if Covid-19 has resulted in staff having to learn new skills due to re-deployment into other areas. JDy explained that there has been an increase in training to ensure safe redeployment. The focus has been infection risk, rather than speciality and management have been asking teams to be more flexible. The Trust have also been fortunate in receiving additional funding for critical care training for staff working outside of intensive care.
- PM noted that the report describes quantifiable measures but does not measure or mention attitude of staff or a ‘softer approach’. JDy explained that this is tied to leadership at ward level and there have been initial conversations with matrons about different ways of working, i.e. enabling ward areas and implementing work stations.
- PC agreed that the Trust should be working on reconfiguration and thinking about Allied Health Professional (AHP) and nursing teams to look beyond the ward base and become more flexible depending on Covid-19.

TB1 4/3/5 CLOSING BUSINESS

TB1 4/3/5.1 Agreement of Principle Actions and Items for Escalation

N Marsden noted the following highlights from the meeting:

- In the last year Covid-19 has changed the routine of reporting performance and whilst discussions should be focused on 2021/22 and beyond the Trust is awaiting national guidance. There is a clear agreement that the organisation has a number of work streams it would like to achieve but it is acknowledged that this work requires prioritisation and a focused delivery plan as part of service and organisational plans.
- The health and wellbeing of all staff is critical and NM encouraged all staff to take their annual leave and rest when possible.
- NM thanked the executive team for all the work they had done over the last 12 months. Whilst a challenging time NM noted that there has been a greater emphasis on team work which has a positive impact on the way in which the organisation care and treats patients.

TB1 4/3/5.2 Any Other Business

NM noted that this was LL's last Board meeting and thanked LL for her contribution and the significant progress made in relation to the ongoing People and Culture work. NM gave thanks on behalf of the Board and wished LL well in her new role.

TB1 4/3/5.3 Public Questions

JM echoed NM's sentiments in relation to the executive and wider workforce's hard work and commitment over the last year.

JM referred to previous efforts to reconfigure the Trust's bed space and asked if there would be a restructuring scheme taking into account Covid-19 and the possible need for more side rooms. LT explained that part of the plan going forward is to ensure the organisation has the capacity whilst considering Covid and IPC guidelines. AH explained that once clinical pathways have been reviewed and possibly changed this will infer the design of wards.

JM further asked if there was risk of retreating to familiar ways of working prior to Covid as it is recognised that the pandemic did influence some services in a positive way. EP explained that the Trust had started a campaign called 'No Going Back' which has been actively engaging with colleagues to look at how services have responded to Covid-19, the improvements and new methods that have been introduced so as not to revert back to old ways of working. There is a continual improvement approach.

JM further asked if the Trust collated data on the number of pressure ulcers in patients who are medically fit for discharge. JDy explained that this is not included in metrics but this can be

included going forward.

Thanks to all for attending.

TB1 4/3/5.4 Date of Next Public Meeting

Thursday 8th April March 2021, Board Room, Salisbury NHS Foundation Trust

TB1 4/3/6 RESOLUTION

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

Public Trust Board Action log

Deadline passed.	1
Update required /paper due at next meeting	2
Completed	3
Deadline in future.	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 05/11/3.1	**Patient Experience Report Q1 -** SH asked if the complaints and compliments could be triangulated with activity in the report.	**JD/KG**	~~04/02/2021~~ 08/04/2021	**Next report due April 2021**	N	2
TB1 05/11/3.2	**Learning from Deaths Report Q1 -** RA referred to how learning is evaluated and noted that the report details the learning that is required but there is no evidence of it. RA also referred to the deaths where "no learning points" have been identified. It was agreed that this would be picked up and reviewed in future reports.	**PC**	~~04/02/2021~~ 08/04/2021	**Next report due April 2021** **The report has been modified subject to previous comments, therefore a request to close this item.**	N	3
TB 05/11/5.1	**People Plan -** SH thanked LL for the report and asked for clear and specific trajectories that can measure what the Trust/System is trying to achieve.	**LL**	08/04/2021	~~Due March 2021~~ People Plan Update now due April 2020 **March Update - LL noted this is inlcuded as part of the IPR. Most actions have been completed with 2 outstanding that require funding for spaces for staff to rest and relax.**	N	2
TB1 14/1/4.5/ TB1 4/3/1.6 TB1 4/3/2.1	**Maternity Ockenden Review -** TB and SH asked for future maternity reports to include more specific actions in relation to the Trust's response to the Ockenden Review.	**Jdy**	No date confirmed	**The team is awaiting feedback from the regional/ national consideration of all Trust submissions. Further updates will come back to CGC and Trust Board in due course.**	N	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 14/1/5.1	**Equality and Diversity -** The Board to have a seminar to discuss what is required in relation to health inequalities and additionally, from an employee experience perspective how the Trust is going to focus on the opportunities that have arisen as a result of Covid-19 as this is a fundamental part of the Trust's response to Best Place to Work.	**LL/RW**	05/08/2021	**EDI session scheduled with Rex Web for August Trust Board development Day.**	Y	**3**
TB1 4/3/2.3	**Trust Management Committee** - EJ noted that the TMC escalation reports generally focus on business cases but explained she would expect more assurance from the other items discusses and asked that the escalation report reflects the true content of the meeting	**SH/GT**	08/04/2021	**GT to look review report and include more detail**	N	**2**

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of Meeting:	April 8th 2021		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	X	**X**		
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is asked to receive and note this paper as progress against the local, regional and national agenda and as an update against the leadership responsibilities within the CEO portfolio

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the board meeting on the 14th January 2021

1. One Year of COVID

The 8th March marked a full year since we saw the first patient with COVID-19 admitted to our hospital. It has been a year which none of us would have hoped for or expected. There have been some significant difficulties and challenges over the last 12 months, but I am proud to look back on our achievements and how our colleagues have stepped forward and gone the extra mile.

It is important that we are all able to reflect on and process the emotional impact of what has been an extraordinary period to be working at this hospital or anywhere in the NHS. To help this process of reflection and to collect and share some of the feelings, the Trust has commissioned poet Martin Figura to gather recollections from staff that will form the basis of a series of poems, creatively capturing those feelings and emotions and providing a permanent record of the voices and experiences of our colleagues. This commission has been made possible by the generous support of the Stars Appeal.

We have also provided a special memento badge for all of our colleagues as a small token of our appreciation.

I am pleased to report that the Trust Management Committee (TMC) approved a business case from the clinical psychology team on the 31st March to provide additional capacity to ensure we can

provide support to our teams or individuals impacted by their experiences over the last year, without this detracting from our patient psychology services

The vaccination programme and the efforts of everyone to reduce social contacts mean that we have seen a sustained decline in COVID-19 cases in the community and hospitalisations. At the time of writing, there are 3 inpatients in the Trust, 1 of whom is in critical care. This remains a challenge but is amongst the lowest number of COVID-19 patients the Trust has had for 6 months. It is positive therefore that we have been able to convert parts of the hospital and our wards back to provide other treatments and increase the amount of elective surgery we provide.

Whilst we will experience future increases in community transmission, we hope we will not see a return to the number of people requiring a hospital admission and our next 12 months are very different from the last. Our intention is to be able to dedicate more focus and resource on the reset of our services and to support our staff and patients.

2. Staff vaccination rates

I know the Board will want to understand what progress we are making in respect of our staff taking opportunity to have their COVID-19 vaccinations. The table below provides this by professional groups and is a snap shot as of the 24th March 2021. This information is also broken down to give the Board visibility of the rates for our BAME colleagues. The data is captured from the national database and referenced with our staff electronic records. The *No column* includes colleagues who are not eligible for vaccinations and colleagues who may have accessed their vaccination from their GP in addition to those who have declined the offer of a vaccination.

Our rates are consistent with other providers across the South West region and we are continuing to promote further uptake on an on-going basis. This includes some targeted 1-1 support for colleagues who have declined the vaccination so we can be assured that they have had access to all of the relevant information to help make an informed choice. We will continue to monitor the rates of staff vaccination to capture the impact of the continued focus and 1-1 discussions.

I know the Board will want to join me in thanking our colleagues who are leading and delivering the vaccination programme for staff and the general public. The pace and effectiveness of their efforts is simply brilliant.

Count of Staff Group	**Vaccinated?**		
Staff Group	**No**	**Yes**	**Grand Total**
Add Prof Scientific and Technic	9.96%	90.04%	100.00%
Additional Clinical Services	16.17%	83.83%	100.00%
Administrative and Clerical	8.13%	91.87%	100.00%
Allied Health Professionals	9.96%	90.04%	100.00%
Estates and Ancillary	11.16%	88.84%	100.00%
Healthcare Scientists	7.46%	92.54%	100.00%
Medical and Dental	27.81%	72.19%	100.00%
Nursing and Midwifery Registered	20.18%	79.82%	100.00%
Grand Total	**15.77%**	**84.23%**	**100.00%**

Count of Staff Group (BAME specific)	Vaccinated?		
Staff Group	**No**	**Yes**	**Grand Total**
Add Prof Scientific and Technic	14.29%	85.71%	100.00%
Additional Clinical Services	16.92%	83.08%	100.00%
Administrative and Clerical	21.05%	78.95%	100.00%
Allied Health Professionals	33.33%	66.67%	100.00%
Estates and Ancillary	14.29%	85.71%	100.00%
Healthcare Scientists	18.75%	81.25%	100.00%
Medical and Dental	25.37%	74.63%	100.00%
Nursing and Midwifery Registered	33.85%	66.15%	100.00%
Grand Total	**27.63%**	**72.37%**	**100.00%**

3. National updates

Colleagues will know that Sir Simon Stevens has announced that the national incident level for the NHS COVID-19 response has been reduced from level 4 to level 3. Andy Hyett our Chief Operating Officer continues to manage our internal incident response which although still required has been able to step down some of the frequency of meetings and reporting in line with these changes. It is important to note that this incident continues to have an international and national profile so the information we provide will continue to be a priority as it is needed to enable the NHS to provide the public with accurate and consistent details.

NHS England published the 20/21 NHS priorities and operational planning guidance on the 25th March and the guidance on the finance and contracting arrangements on the 26th March. Executive Directors and our Divisional leadership teams are currently working through the details aligned to our internal plans. The key priorities include:

a) Supporting the health and well-being of staff and taking action on recruitment and retention
b) Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
c) Building on what we have learnt during the pandemic to transform the delivery of services
d) Accelerate the restoration of elective and cancer care with a return to a zero tolerance of people waiting over 52 weeks for treatment
e) Transforming community and urgent/emergency care to prevent inappropriate attendances at EDs , admissions to hospitals and reduce the length of stay for patient in our hospitals
f) Working collaboratively across systems to deliver on these priorities

The Board will receive an update on our planning progress in our private Board meeting today.

4. Local and regional partnerships

During February the government published proposals to restructure parts of the NHS. Proposed legislation will see Clinical Commissioning Groups being disbanded and the creation of our Integrated Care Systems (ICS) as statutory NHS bodies. There will also be changes to the way procurement rules work in the NHS and the power the Secretary of State has to intervene in changes in the NHS. As a Trust we are an active partner in the existing ICS partnership in Bath, Swindon and Wiltshire (BSW) and work daily with our NHS, Social Care and Voluntary Sector partners in Wiltshire. Whilst we do not anticipate there will be a significant impact in our day to day work in the short term, our role in partnership working in Wiltshire and BSW is crucial if we are to achieve our goals of sustaining high quality hospital care and improving integrated care. This will be as important as ever as we continue to respond to the pandemic and recover from its impact.

A significant part of this partnership work will be connected to developing the integrated care partnership in Wiltshire (often referred to as place rather than system). This joint commitment with our place based partners needs increased focus and support from our leaders and clinical teams over this next year. We need to deliver on our contribution in moving from an episodic, reactive model of provision to a more proactive population health approach. Our refresh of the clinical strategy and corporate priorities will need to take account of this.

Our Acute Hospital Alliance (AHA) work with colleagues in Bath and Swindon continues to make good progress and I would highlight the work our colleague, Duncan Murray has led with the Medical Director from Swindon for children who are waiting for complex oral /dentistry work that needs to take place in a hospital setting. Duncan and colleagues from the 3 hospitals respective clinical teams have agreed a collaborative approach to doing some additional theatre sessions to respond to the children from BSW who have experienced the longest waits. This new way of working will improve the equity of access for individuals as well as reducing the overall waiting times for all children who need this type of surgery. The first of the additional planned lists is due to take place over the Easter holidays. Duncan's leadership and commitment has been instrumental in delivering this progressive change in approach. The AHA Board are fully supportive and expect that the learning of how we operationalise a service collectively will have broader application for other specialities.

5. Our focus in 2021/22

Whilst we work through the details of the national planning guidance, it is self-evident that as we progress forward a different set of challenges awaits us. For the Board and our leadership teams it is vital that we recognise the need to return our focus on:

a) **Reset on quality and experience:** we need to continue our work on achieving our ambition of providing an outstanding experience for all of the patients that use our services. This also requires us to play a greater role in the reducing the health inequalities that have been exposed in COVID -19.

b) **Recover our finances:** we start the year with a significant underlying deficit and although after a year where finances have not been a priority for us for obvious reasons, it is important for us to refocus our efforts to bring costs down.

c) **Regroup as team/teams:** our colleagues have worked incredibly hard in an intense incident response mode for a very long time. It has been helpful that we have had less pressure for the last month allowing some time for rest and leave and we will need to ensure we are providing the support needed going forward.

d) **Retain new ways of working and innovate:** the challenges we face in the reset of services to focus on seeing patients as quickly and safely as we can needs us to be ambitious. This is reliant on us building on the transformation and integration colleagues have delivered in response to the pandemic and not just than relying on how we have always done things. The work we are due to start with KMPG's operational excellence programme will help underpin this by embedding the principles of continuous quality improvement and innovation in the way we work.

6. Workforce

In month staff sickness reduced to 3.62%, a decline in staff COVID related absences was the key factor in this. The Trust has put in place a number of support strategies in place for staff. Anxiety, Stress and Depression was the top reason for sickness absence and was 24% of all absence in month. Support strategies all staff can access, from the national employee assistance programme to more local level support of clinical psychology are in place. The number of staff off with long term sickness reduced in all Clinical Divisions in month.

Both Mandatory training and Appraisals have increased and recovery plans are in place in all Divisions to increase compliance as business as usual returns.

Recruitment activity continues to focus on 'hard to recruit' posts and Medicine is undertaking a Workforce review for medical workforce.

In month 6, 8 posts were advertised and 41 people commenced employment with the Trust, with 24 leavers. Work remains ongoing with HCA recruitment with a further 13 job offers made and another event planned in month.

In month substantive appointments were made to the Chief Medical Officer and Chief Nurse positions and I know the Board will want to join me in congratulating Peter and Judy and welcoming them to our team on a permanent basis.

The Chief People Officer recruitment has commenced with the final parts of that process planned for mid-May .Susan Young has joined us in this role on an Interim basis for 6 months

In March we received the results from the annual NHS Staff Survey. Each year this gives us a picture of what it's like to work in our trust: areas where we are doing well and those where we need to do better. Our People and Culture Board sub-committee received the findings at their March meeting which indicated that the Trust scores were above average in 5 of the 10 key survey themes, at the average for 1 and below average for four themes. We were pleased that our overall response remained high at 54.2% as it gives greater rigour to the results.

The areas where we are above average reflect how hard everyone has worked over the last year to respond to the pandemic in line with our values. For those areas were we have received less favourable feedback we are committed to working with our teams as part of our Best Place to Work response to ensure we improve them. This work will be led by our Chief People Officer who will ensure the Board is updated as it progresses.

The Board will note in the TMC escalation report that a business case from Maternity to invest in strengthening the leadership capacity and capabilities in Midwifery has been approved. This is an important milestone for this service and aligns with the national Maternity Improvement Plan and the Ockenden review.

7. Finance

February saw the Trust benefit greatly from the combination of the national lockdown and the vaccination programme, with a c70% reduction in the number of beds occupied by confirmed cases of Covid-19 over the course of the month. This combined with the return to work of sick and isolating staff alleviated the financial impact of the backfill of staff seen in January.

It has now been agreed that NHS providers will receive national funding to cover all local income streams that have been affected by the pandemic in the second half of the financial year, this means the Trust now expects to break even, rather than incur a £3.2m deficit as had been originally forecast.

Work on financial planning and the ongoing recovery of 'Business as Usual' work streams for the NHS in 2021/22 continue at pace, we are anticipated a comparable level of funding for the first half of 2021/22 as the second half of this year. This means that although pressures and challenges remain, particularly in relation to increasing Elective workload while retaining an element of Covid-19 capacity, the Trust has the opportunity to start gaining some traction in working with system partners to improve the financial sustainability of South Wiltshire healthcare services.

8. News

As a 'thank you' for all of the hard work and commitment displayed by Trust employees on an everyday basis and in keeping with the organisations desire to prioritise staff wellbeing, the Trust has decided to offer substantive and fixed term employees an additional day's annual leave, per year, to use on their birthday.

The Trust is encouraging all eligible employees to use this additional day to step away from the work environment and to do something for themselves.

Stacey Hunter
Chief Executive
March 31st 2021

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	8th April 2021		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	30th March 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 30th March 2021. The report both provides assurance and identifies areas where further assurance was sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - Both the CNO and CMO were congratulated on their substantive appointments.
  - The focus for this month's Covid-19 update was the potential quality impact of the work to recover and restart services. The Trust still has small numbers of patients with Covid-19 and it was confirmed that it is expected that Covid-19 is going to be present for the foreseeable future. Further assurance was sought in relation to cancer, diagnostics and recovery of elective work. This is under constant focus by the Executives and updates will be provided each month to CGC. Positively, all outbreaks have now been closed. The learning from Wave 2 will be provided to CGC in due course. It was also reported that there had been media coverage of a hospital acquired infection.
  - Assurance was provided that the vaccination programme continues at pace with over 30,000 vaccinations to date. The data in relation to staff vaccinations is still being validated and this will be considered next month.
  - CGC received a presentation from the Clinical Lead for Paediatrics. It was a detailed presentation in relation to the last CQC inspection where the service was rated 'Requires Improvement'. The presentation covered both the progress made and the ongoing challenges. The challenges mainly relate to the care of children and young people requiring specialist mental health care and meeting the needs of children requiring day case surgery. Evidence of learning was provided. The discussion led into the clinical strategy session and it was proposed that the Clinical Lead works with the CMO to ensure the emerging strategy addresses the needs of children and young people. The recent engagement meeting with the CQC did not raise any specific concerns apart from the CAMHS issues flagged above (which is a national issue). Formal

feedback from the CQC has not yet been received.

- The CMO presented the emerging clinical strategy which is a unified strategy for the Trust with a clinical focus. The work undertaken to date was noted and this will come to the Board following further work and stakeholder engagement. It will be aligned with the Trust's role in the ICS.
- The draft Quality Account (QA) was presented outlining the progress made in priorities despite the challenge of Covid-19. Priorities for 2021-2 are under development with key stakeholders. The committee were informed that the QA will not be required as a separate document from next year, however the committee felt it was good practice and considered continuing to produce a quality report.
- Whilst the IPR is discussed at Board, the quality section was discussed alongside the BAF and CRR in relation to current issues and risks. Whilst there were no new issues to raise, the discussion focussed on the ambition for improvement and learning triangulating with the report and discussion at F&P.
- Discussion in relation to risks and Divisional risk registers demonstrated an increasing focus on Ward to Board assurance. Whilst this work is in its infancy it is positive to note the engagement from the Divisions working in partnership with the corporate quality and risk team and the weekly safety reviews being undertaken by the CNO and CMO.
- An update was provided in relation to transformation in three areas, namely electronic prescribing, BSW wide electronic patient records and the organisational development and quality improvement support being commissioned. This was for information rather than specific assurance at this point. Detailed assurance will be provided to future CGC meetings.
- The quarter 3 learning from deaths report was presented. A focus on Covid-19 deaths continues and positive feedback from relatives in relation to Duty of Candour from the Medical Examiners was praised. Assurance in relation to an emphasis on learning was provided. There has been a reduction in deaths post hip fractures due to improvement in the pathway of care in this area.
- An update on the emerging BSW Academy was provided. This is in the early phase of development and the quality benefits will be brought to future CGCs.

In summary, there was a strong focus on assurance in relation to learning in this month's CGC.

The Board is asked to note and discuss the content of this report.

Salisbury NHS Foundation Trust

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

Committee Name:	Finance and Performance		**Committee Meeting Date:**	30th March 2021
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 (F&P) Committee meeting of the 30th March 2021

Items for Escalation to Board
Approval of contracts – three contracts were presented to the Committee for support, prior to going to the Trust Board meeting on the 8th April 2021; (a) Outsourced outpatient pharmacy service provision (b) Supply and installation of air handling units (c) Hip and knee orthopaedic consumables All three recommended contract awards proposals were supported by the Committee. **Integrated Performance Report (including Covid-19 update) –** The key highlighted operational performance issues in January 2021 have continued to exist in February 2021 i.e.52 week elective waiting, two week cancer waiting times, particularly breast and colorectal and certain diagnostic investigations, particularly MRI and cardiology. As previously agreed the Committee received detailed reports on these key areas of under-performance and discussed the challenges surrounding recovering our performance, particularly back to pre-covid target levels. It was clear from the papers and discussion issues are understood and recovery plans are prepared, however it was also clear from the meeting that the full range of solutions are not straight forward, or totally under the control of the Trust. Finally what was also clear is the vital importance of swiftly recovering our operational performance back to pre-covid levels, as well as achieving national

constitutional targets in the future and the importance of this will be highlighted in the 2021/22 Operational Plan (see below).

Finance report as at 28th February 2021 and 2020/21 financial outturn – 2020/21 has been an extremely challenging and complicated year financially, despite this the Trust is reported to be on track to achieve its revised Covid-19 Phase 3 forecast deficit of £3.2m, which is a significant improvement on the Trusts original 2020/21 operational plan deficit of £15.2m

Draft 2021/22 Operational/Financial Plan – Full details of these papers will be presented to the Trust Board on the 8th April 2021 so there is no added value in summarising these in this highlight report. However what is important to highlight is the exceptional nature of the times we are living in, particularly with regard to NHS planning (a) the lateness of NHS planning guidance (b) the evolving nature of this guidance (c) the guidance that is available mainly covers the first 6 months of 2021/22 and (d) the new NHS planning roles of Integrated Care Systems (ICS) requires key issues to be discussed and agreed at a system level, before the consequences for Salisbury NHS FT are quantified, which delays and impacts on our organisational operational planning timetable.

Finally given all of the above uncertainty one thing is totally clear, that is the **vital importance of the entire NHS and Salisbury NHS FT recovering its operational performance during 2021/22 back to its pre-covid levels as a minimum** and it is against this task that we will be mainly judged.

Digital Prioritisation report – Given previously reported risks and constraints surrounding the Trusts digital/IT services the Committee had requested a list of digital/IT developments that would be prioritised going forward into 2021/22. This report was reviewed by the Committee and the four key priorities are;

(a) New electronic prescribing and medicines administration (ePMA)
(b) Replacement of the Pathology Laboratory Management System (LIMS) and the introduction of a new pathology management equipment service (MES)
(c) Replacement of the Trusts finance systems
(d) Development of a Full Business Case (FBC) and potential start of implementation for a new shared Electronic Patient Record (EPR)

The clarity of this report was welcomed, as was the identification of those digital/IT projects that had not been chosen for prioritisation.

Board Assurance Framework (BAF) and Corporate Risk Register – The Committee reviewed the BAF and risk register in light of recent updates and the current meeting and made recommendations to update it.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	31 March 2021		

Report Title:	Trust Management Committee (TMC)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		X	
Prepared by:	Stacey Hunter & Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 31st March 2021.

Executive Summary:
The meeting of the Trust Management Committee was held on the 31ST March and this was the first full meeting of the committee as previous meetings being reduced in length owing to operational pressures following COVID. The Divisional teams continue to report being able to increase operational activity due to a reduction in COVID patients and attendances at ED increasing as the public lockdown starts to ease. As part of the reset and recovery plan the Medicine Division have identified a significant challenge in the length of waits patients needing Cardiac Echocardiograms have. They are currently forecasting not being able to return the waiting times to the required standard (6 week diagnostic standard) until March 2022 which they recognise is not an acceptable position. They have taken opportunity at year end to purchase a 3rd Echocardiography machine which will provide some if the infrastructure needed to reduce the current backlog clearance trajectory. The team need to do further work to detail an appropriate room and the staffing required completing this work. TMC have asked to see this in the April meeting. The surgical Division are continuing to progress work for the reset of the Priority 3 and Priority 4 patients that are currently not be offered dates for their surgery. As the Board will be aware the backlogs included those waiting over 52 weeks for treatment have grown significantly over the last year, The IRP provides the detail of this. One of the significant constraints other than the activity lost due to the IPC measures in place for COVID is the continued vacancies in theatre staffing. This equates to 1.9 theatres which could offer an additional 19 half day theatres sessions a week if it was staffed. The Divisional Management

have been asked to review the actions associated with recruitment of theatre staff with the support of HR/OD and bring a comprehensive plan back to TMC in April.

From a corporate perspective, the committee received the first cut of the staff survey results which has shown a continued positive response rate, with the feedback being used as the drivers for change as the Trust embarks on its Best Place to Work programme.

From an escalation point of view from sub committees, the committee received feedback on national audits which were presented at Clinical Management Board and it was noted that Salisbury NHS Foundation Trust had performed well in these audits with no formal concerns noted or raised.

The integrated performance report showed a positive decrease in areas such as pressure ulcers and patient falls compared to those seen in January at the peak of the COVID pressures. The report also shows an improving picture in the Trust HSMR position, along with confirmation of no reports of hospital acquired Clostridium difficile or MRSA infections. The Chief Nurse and Medical Director have been asked to detail improvement trajectories for some of our quality standards e.g. falls, pressure ulcer to help us understand whether we are able to drive sustained improvements for patients. TMC have also asked whether we can start to use more SPC methodology as it is a more effective way of scrutinising trends

In respect of the operational reporting the committee were informed that we have not delivered against the national standards, but the committee were content that this was in large part due to the response to the COVID pandemic and were assured that as we unlock and bring services and systems back online, the Trust would see an improving picture moving forward. Improvements are being delivered in diagnostic waiting times, ECS performance and some of the key cancer standards which are encouraging.

The committee received a number of business cases this month and in particular I am pleased to report that the committee approved a case from the clinical psychology team to provide additional capacity to ensure we can provide support to our teams or individuals impacted by their experiences over the last year, without this detracting from our patient psychology service.

The Interim Head of Midwifery presented a midwifery workforce review which takes account of the recommendations in the external reviews of culture and clinical practice we received in 2020 and the support needed to deliver the immediate and urgent actions from the Dec 2020 Ockenden review . The review sought approval for investment of circa 475k in midwifery leadership roles. There was strong support from colleagues at TMC for the majority of the preferred option (Option 3) which resulted in everything in the preferred options except the request for a new role of Consultant Midwife being agreed by TMC.

TMC would like further work to be done in relation to the benefits of the Consultant Midwife role and the Chief Nurse suggested that this may be a role that should be considered across the BSW ICS and the Local Maternity System. TMC will review this at a later date once the Chief Nurse and the Interim HOM have had opportunity to do the additional work.

From a funding perspective it has been announced nationally that there will be some additional money available to support the implementation of the Ockenden recommendations. The mechanisms to claim against this fund are not yet detailed – it is likely that they will be routed through the ICS Local Maternity System . TMC have asked the Deputy Director of Finance with support as needed from the Chief Nurse to ensure that the LMS is aware of this investment at SFT to enable us to be able to access the Ockenden funding.

The Interim HOM was thanked for all of her work on this review and business case which is an important step in ensuring that we can secure the midwifery leadership capabilities and capacity needed to deliver on the Maternity Improvement Plan.

Additionally the committee approved a business case to fund a 5th One Stop Breast Clinic to ensure best practice in the management of symptomatic breast patients. This investment will support the service to accommodate all new symptomatic breast patient referrals in a one-stop clinic within 2 weeks, in accordance with nationally agreed best practice guidelines.

Furthermore the committee approved a proposal to recruit substantively to the Cancer Pathway Navigator post and increase the current establishment. These additional posts will support cancer services by alleviating pressure on Clinical Nurse Specialist (CNS) and Consultant time, enabling them to focus on delivery of clinical care; whilst facilitating a reduction in waiting times, earlier diagnosis and improve patient experience. These roles have been tested through the use of fixed term posts and delivered against the objectives set hence the agreement to adopt these roles permanently .

Additionally the committee were informed of a proposal for a 'BSW Academy' to support the whole workforce to deliver outstanding care to communities across BSW integrated care system.

The Academy will be centred around 5 pillars

- Leadership
- Learning
- Innovation
- Improvement
- Inclusion

With priorities being aligned to the needs of BSW's Population Health and Care and System Architecture work programmes.

The committee noted that the proposal was received at the BSW Executive Group on 12th February and supported in principle, although it was recognised that more engagement/socialisation within organisations and further detail and agreement on the financial model, including consideration of the re-purposing of resources and formalising the priorities for year one is needed before the business case is taken back to the Exec Group in April 2021 for final sign-off.

End of Report

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

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	8th April 2021		

Report from: (Committee Name)	People & Culture Committee		**Committee Meeting Date:**	25th March 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Nick Marsden			
Board Sponsor (presenting):				

Recommendation
The Trust Board are asked to note the items escalated from the People and Culture Committee on 25th March. The Committee noted good progress in several areas. We agreed the suggested terms of reference for the committee going forward. Best place to work – Phase 2 delivery commences in month as a rolling programme of events for 2021/22 NHS People Plan – significant progress has been made in month with the majority of actions completed. Actions relating to Health and Wellbeing remain ongoing, due to funding and further discussions around this are underway. Work continues across all Divisions on hard to recruit posts, focus is currently on Radiographers, Consultant Histopathologist and Consultant Dermatologist.

Key Items for Escalation
None

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4a
Date of Meeting:	08 April 2021		

Report Title:	BSW Academy			
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:
That the Committee note this briefing paper.

Executive Summary:
This paper provides an overview of the proposal for a 'BSW Academy' to support the whole workforce to deliver outstanding care to communities across BSW integrated care system. The Academy will be centred around 5 pillars: Leadership, Learning, Innovation, Improvement, and Inclusion, and priorities will be aligned to the needs of BSW's Population Health and Care and System Architecture work programmes. The proposal was received at the BSW Executive Group on 12th February and supported in principle, although it was recognised that more engagement/socialisation within organisations and further detail and agreement on the financial model, including consideration of the re-purposing of resources and formalising the priorities for year one is needed before the business case is taken back to the Exec Group in April 2021 for final sign-off. A more detailed paper will be presented after more detailed work regarding function and quantifiable benefits has been undertaken.

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	☒

1.0 Introduction and purpose

1.1 This paper provides an overview of the proposal for a 'BSW Academy' to support the whole workforce to deliver outstanding care to communities across our integrated care system.

1.2 The proposal was received at the BSW Executive Group on 12th February and supported in principle, although it was recognised that more engagement and work on detail is needed before a business case can be formally approved.

1.3 This is an initial briefing paper for information only. A more detailed paper will be presented after more detailed work regarding function and quantifiable benefits has been undertaken.

2.0 Background and context

2.1 The BSW ICS vision is to 'empower people to live their best life' and help the system to support broader social and economic development.

2.2 This will be achieved through the delivery of five key ambitions:

- To improve the health and wellbeing of our population
- Reduce health and care inequalities
- Improve the quality and experience of care for those receiving and those delivering it
- Ensure workforce development and wellbeing
- Make the best use of resources

2.3 Three ICS work programmes; System Architecture, Population Health and Care Models and System Capability work in collaboration to achieve these aims.

2.4 The System Capability Group focusses on developing culture to create capacity and capability needed to make change happen; it is this group that have developed the proposal for a BSW Academy.

2.5 The vision of the BSW Academy started in Dec 2019 when system partners agreed, in principle, to the value of a system academy to develop culture and to create the capacity and capability needed to make change happen.

2.6 In July 2021, with the progression of ICS designation and the agreement of the 3 work streams (System Architecture, System Capability and Population Health and Care), the System Capability group started to develop the BSW Academy proposal.

2.7 Learning from other ICS systems that have established a similar Academy (West Birmingham & the Black Country, Surrey Heartlands and West Yorkshire and Harrogate) was shared and actioned.

2.8 The System Capability group is chaired by Kevin McNamara, Chief Executive of GWH and made up of colleagues representing ICS health and care partners and external stakeholders such as the Academic Health Science Network (AHSN). Esther Provins, Director of Transformation represents SFT on this group.

3.0 Aims and objectives

3.1 The proposal is to establish a 'BSW Academy', centred around 5 pillars namely: Leadership, Learning, Innovation, Improvement, and Inclusion.

3.2 The aim of the Academy is to lead the way in workforce development to allow our workforce to deliver outstanding care to local communities.

3.3 The Academy has a five-year ambition to secure a thriving centre of excellence and deliver benefits under the following principles:

- Consistent and continuous improvement practice
- Learning and developing together
- Maximising learning opportunities
- Cultivating ideas and research
- Collaborative practice
- Consistent benefits evaluation
- Everyone has a voice
- Celebrating success.

3.4 Priorities for each pillar are as follows:

3.4.1 Leadership

- Development of a system intelligent leadership offer, supporting leaders across the system at all levels with the tools they need to operate effectively at a team, organisation, place and system level
- Accessible and comprehensive leadership development
- Establish key messaging and leadership principles to keep our approach consistent
- Establish talent management, from providing an accessible path for aspiring leaders to succession planning, ensuring that our leaders are representative of our workforce and the communities they work for
- Ensure networking and collaboration opportunities are utilised to their full potential in support of system working

3.4.2 Learning

- Maximising the apprenticeship levy spend as a system
- Increasing learners across the system (T-Levels, TNA's, RTP, higher apprenticeships) and improved accessibility from under-represented groups.
- Statutory and mandatory passporting
- Care certificate passporting this will significantly impact care homes and domiciliary care providers
- System wide Training Needs Analysis (TNA) to drive commissioning and programme development – commissioning CPD together, assisting smaller providers
- Placements as part of continuum of learning – recruit for potential, this will provide opportunities for learners to try alternative roles and organisations
- Building system-wide placement allocation capacity for all learners, creating opportunity from
- the system to support more learners
- Equalising student capacity and providing a better student experience
- Procuring a digital platform to shared learning opportunities
- One e-learning platform across the system
- Using the learning estate more effectively considering more virtual delivery
- Joint learning and development of policies
- System-wide careers advice – improving the links with Careers and Enterprise Company
- (CEC). Creating cornerstone employers (at ICA level)

3.4.3 Innovation

- Foster ideas and identify innovations from both within and outside BSW, learning from forerunners
- Share our innovations and learning across our partnerships, neighbourhoods, communities and between organisations, encouraging adoption and spread
- Identify and respond to funding opportunities in-line with BSW priorities
- Develop the BSW academy as multi-agency centre of excellence for innovation along with BSW partners and the AHSN, universities and research councils
- Evaluate the impact of our innovations to evidence benefit to population health

3.4.4 Improvement

- Improve our capability to continually improve by providing education, training and support for our workforce and wider community in continuous improvement approaches
- Provide hands-on coaching and support, particularly at a place level, to reduce unwarranted variation and unmet need
- Develop the BSW Academy as a multi-agency centre of excellence for continuous improvement along with BSW partners and the AHSN, universities and research councils

- Horizon scan for best practice both within and beyond BSW, ensuring learning and best practice is spread between both internal partners and external organisations

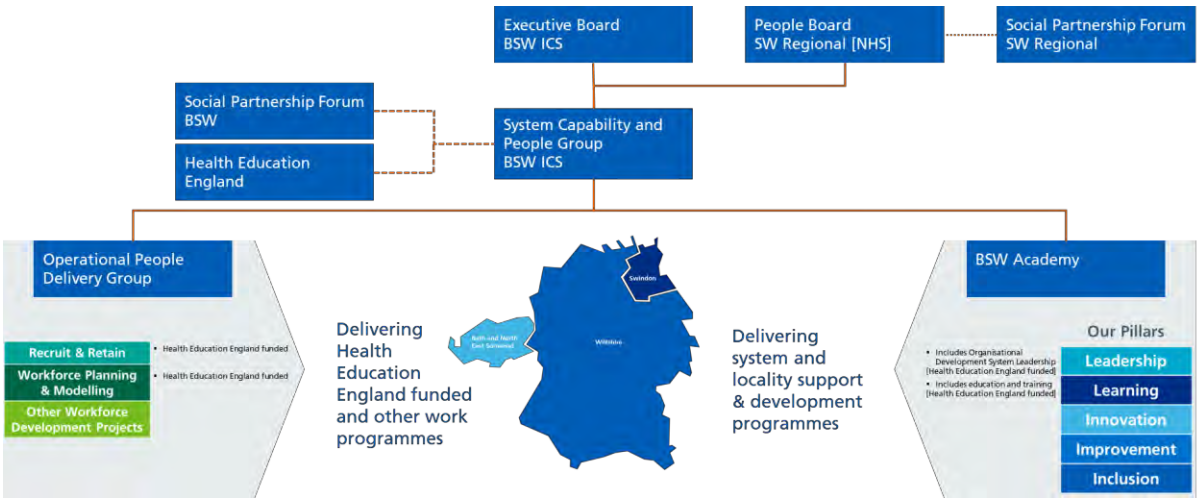
3.4.5 Inclusion

- Ensuring that the principles of equality, diversity and inclusion are embedded within our approach to change, improvement and skills
- Undertake an equality, diversity and inclusion diagnostic exercise across the system
- Build networks and connect people – we will support the development and implementation of thriving staff networks
- Develop and implement system-wide talent management and succession planning by the delivery of a stepping up programme
- Support the implementation of a consistent approach to the delivery of policies, procedures
- and mandatory training
- Ensure the right people are actively engaged in all transformation programmes
- Build and deliver a broad development programme to include the development of NEDS and governors.

3.5 The Academy priorities will be aligned to the needs of BSW's Population Health and Care and System Architecture work programmes.

4.0 Governance

4.1 The structure outlined in the diagram below identifies the governance arrangements for BSW System Capability. The System Capability and People Group (SCPG) will provide strategic direction and oversight of the ICS System Capability programme. This will involve commissioning BSW Academy to deliver specific programmes relating to the purpose of the Academy and the function of the 5 pillars and will provide the necessary oversight to ensure successful delivery. The SCPG will report directly to the ICS Executive Board and to the Regional People Board.



5.0 The BSW Academy will need to be 'hosted' by one of the system organisations until the ICS is formally established in organisational form. The hosting organisation has not yet been agreed.**Delivery structure and resources**

5.1 The establishment of an Academy will result in some activities currently done multiple times at an individual provider level, shifting to be undertaken once on behalf of the system.

5.2 It is proposed the Academy is resourced by using a mixture of resources already in existence within the system along with some new substantive roles.

5.3 The Academy will be led by a substantive Academy Director and supported by an implementation project manager (12-month fixed term contract proposed).

5.4 Sponsorship, advisory and associate (i.e. consultancy) roles will be supported and funded within existing organisational workforce capacity and offer real opportunities to people who are seeking system wide learning and development opportunities.

5.5 A 'Transformation and Change Centre' will be a core part of the Academy; this will support initiatives at organisational, locality (Place) and ICS (system). Operating through a hub and spoke model with local teams, it will coordinate access to resources for programme and project support and provide a co-ordination function for system wide transformational programmes and working with the BSW Academy to develop the improvement methodologies and skilled resources needed across the system.

6.0 Funding model

6.1 The current estimated running cost of the Academy is in the region of £700k per annum; however, this may well change / reduce as provider versus system roles, responsibilities and functions are agreed.

6.2 The proposed model suggests a base level agreed financial contribution per head (driven by organisation headcount), this could potentially be weighted so that larger system partners burden a slightly larger contribution over smaller ones. It is anticipated that some roles will be fulfilled by existing roles within the system, with some being funded by their home organisation.

6.3 It was agreed at the March BSW Executive Group that Directors of Finance from partner organisations will work together to develop a system financial model to support the Academy.

6.4 Further contributions would be expected from external sources, such as Health Education England (HEE), and from horizon scanning / bid

opportunities – although it is noted that exact levels cannot be guaranteed and that overall costs would need to be underwritten by the ICS partners.

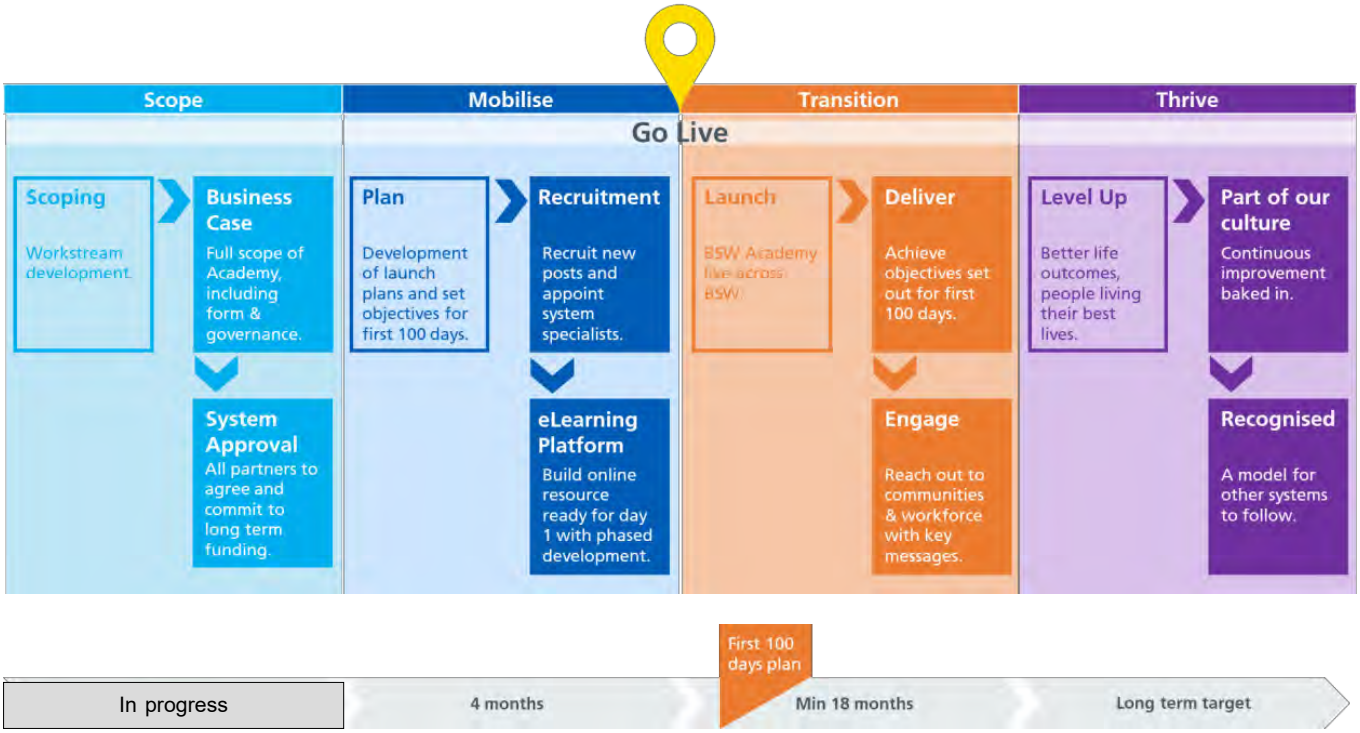
6.5 There will be off-setting of costs from elsewhere within the system and economies of scale.

7.0 Timeline and next steps

7.1 BSW Academy phasing has been proposed in the diagram below; currently the programme is still in the scoping phase.

7.2 Further work is being carried out to detail what would be undertaken at a system level, what would remain the responsibility of providers and associated benefits quantification and realisation.

7.3 A further update will be prepared when the above work has been completed.



Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	8th April 2021		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	18th March 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation

The Trust Board is asked to note the matters below.

Some changes to Standing Financial Instructions (SFI) regarding the approval process for capital projects were presented to the Committee, broadly strengthening the control over lower value projects. The Committee made a recommendation for a small change to one of the new controls, but was supportive of the changes proposed overall and recommend the approval of the revised SFI to the Board.

The Committee reviewed its Terms of Reference (ToR), including seeking feedback from the Executive. The Committee concluded that the current ToR remain appropriate and recommend them for approval to the Board.

The Committee reviewed the rationale put forward by the Executive as to why the Trust should report its annual accounts on a going concern basis. The paper demonstrated that the Trust was compliant with the government's interpretation of going concern as it relates to NHS Trusts, including the qualifications recommended to highlight the Trust's ongoing requirement for financial support. This matter is recommended to the Board for approval.

The Committee reviewed the processes used by the Trust to determine and maintain its Board Assurance Framework (BAF). Following a brief discussion, including follow up of previous questions raised about the processes and effectiveness of risk horizon scanning, the Committee concluded that the processes being used were appropriate for the Trust's needs.

Key Items for Escalation

Cancer Waiting List Management Deep Dive

The Committee received an excellent presentation from Jane Dickinson and Emmy Scutt regarding the processes involved with management of the waiting lists for cancer treatment.

There was a good discussion between members and the presenters on the topics raised and the Committee took assurance that the process was both effective and appropriate for patient care. The committee also supported the initiatives presented by the team for further improvements to the process.

Draft Year End Opinion from Head of Internal Audit

The Committee received a draft of the Head of Internal Audit Opinion for the 2020/21 annual report. The overall opinion was essentially the same as for last year, i.e. that the Trust's control environment is "**Generally satisfactory with some improvements required**".

Within the explanatory notes relating to this opinion, there were two particular items that the committee would draw to the Board's attention;

1. There was an extensive section listing examples of good practice that had been observed by audit teams in the course of their work.
2. It was disappointing to note that there were still six agreed management actions incomplete and overdue from an internal audit report completed in 2019/20 financial year and three management actions incomplete and overdue from a report signed off in 2020/21. Both of these items have been impacted by changes in the Executive team sponsorship and both are promised for completion within the first half of 2021/22.

Internal Audit Reports Received

The Committee received final reports for four internal audit investigations. By far the most significant was the report into **Key Financial Controls**, within which there were two findings rated as high risk relating to control processes in the Pharmacy. These control shortfalls are considered to have contributed to the outcome of the incident reported earlier regarding theft of drugs by a member of the nursing staff. It should be noted that none of the actions within the whole of this report related to required changes in Finance Department processes, despite their leadership in this area.

The other three areas reported were **Divisional Governance**, which had four medium risk and two low risk actions, Data Security and Protection Toolkit, which had one medium risk finding, and IT Improvement Plan Review, for which there were two medium risk findings.

The Committee were satisfied that the proposed management actions regarding all open items from the four reports were appropriate, but some concern was noted about the proposed timings promised for some of these. The Executive reassured the Committee that all timings were committed to by the relevant managers. The Committee also stated that it wished to follow up on progress against process improvements in the Pharmacy in October, given the seriousness of the findings in this area.

Draft Paper on Going Concern Basis for Annual Report

The Executive presented a paper to the Committee to provide assurance and rationale behind the assumption of a going concern basis for the upcoming annual report. It is required that the Board consider and approve this matter for each reporting cycle.

The paper demonstrated that the Trust was compliant with the government's interpretation of going concern as it relates to NHS Trusts, including the qualifications recommended to highlight the Trust's ongoing requirement for financial support. It should be noted that, although fully compliant with the government's specific requirements in this matter, were the Trust to be assessed on a commercial business basis, it would fail the Going Concern test by a considerable margin. This is probably the case for virtually all NHS Hospital Trust's.

Proposal for Update of Standing Financial Instructions

The SFI of the Trust require review annually at this date. The CFO presented a series of minor changes to the approval limits around capital projects, which essentially strengthen to process and allow delegation of minor matters to the second tier of Executive control. The Committee made one suggestion for a change – to find an appropriate way to ensure that changes to the overall capital budget could not be made without Executive approval – but were fully supportive of the changes overall.

Review of Terms of Reference

The Committee reviews its ToR on an annual basis to ensure that it remains appropriate for any changes of circumstances in the Trust. As part of this process, feedback is also sought from key Executives involved in the work of the Committee. Following a short discussion, the Committee agreed that the current ToR remained appropriate and so would not recommend any changes to the Board.

Update on Outstanding Counter Fraud Incidents

There were some updates regarding counter-fraud reactive work that are worth noting by the Board.

The theft from cashbox incident from 2019 was prosecuted in the magistrate's court in February, with the accused entering a not guilty plea. The case will now go to Salisbury Crown Court for trial, with an initial case management hearing in March.

The case of theft from the pharmacy was considered by local police, who decided that it would not be in the public interest to forward for prosecution. The case will now be managed through a referral to the Nursing and Midwifery Council as a disciplinary matter. The police decision not to pursue the case was influenced by the lack of evidence beyond the one non-controlled substance theft admitted, although other, more serious, matters were suspected. The new control procedures in pharmacy should ensure that any future incidents of this nature can be followed up in a more rigorous manner.

Board Assurance Framework Process Review

The Committee undertook its semi-annual review of the effectiveness of the processes adopted by the Trust to establish and maintain the BAF. Following a brief discussion, including follow up of previous questions raised about the processes and effectiveness of risk horizon scanning, the Committee concluded that the processes being used were appropriate for the Trust's needs.

Extension of PWC Contract to Provide Internal Audit Services

In a private session at the end of the meeting, the Committee received a paper from the CFO recommending extension of the PWC contract by one year, as originally provided for in the tender process. The Committee agreed that the services provided by PWC in this area were of a good quality and agreed with the recommendation of the CFO. (Note, this matter is within Executive delegated power and is not required to be approved at Board)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	8th April 2021		

Report from: (Committee Name)	Charitable Funds Committee		**Committee Meeting Date:**	18th March 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Lisa Thomas, Director of Finance			
Board Sponsor (presenting):	Nick Marsden, Chair			

Recommendation
The Trust Board are asked to note the items escalated from the charitable Funds Committee meeting held on 18th March 2021.

Key Items for Escalation
• The committee received an update on the new governance arrangements including the investment committee; this was proved to be working well. • The committee approved funding for the newly refurbished maternity unit. • The Committee agreed next steps would include a strategy workshop to ascertain the charities future direction and prioritisation of fundraising objectives.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.7
Date of Meeting:	08 April 2021		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

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

Executive Summary:
Pressure on the Trust from Covid-19 began to reduce in M11, with numbers of Covid-19 positive inpatients reducing from 101 on 1st February to 37 by the end of the month. As the number of Covid-19 areas reduced bed occupancy also fell, with overall occupancy for the month at 89.4% (92.4% in M10). The number of category 2 pressure ulcers decreased from 36 in M10 to 27 in M11 particularly in the Surgical Division from 20 category 2 pressure ulcers in M1 to 7 in M11. Overall, a 54% increase in category 2 pressure ulcers in 20/21 compared to 19/20 but a 52% reduction in category 3 and 4 pressure ulcers in the same time period. With lockdown restrictions in place for the whole month, attendances to ED were the lowest since April 20 when the first lockdown restrictions were in place. Emergency access 4 hour performance improved to 87.9%, and the number of ambulance handover delays also fell (222 in M11 compared to 474 in M10). Elective activity remains constrained, with escalation into Day Surgery early in the month, resulting in lower daycase levels (1173 compared to 1270 in M10, and 413 below the phase 3 trajectory). An ICU facility was maintained in theatre recovery for the whole month, elective activity was higher than in M11 than M10, but still a shortfall of 125 against the phase 3 plan.

As a result of the suppressed elective activity the RTT performance reduced to 67.06% (71.03% in M10), and the over 52 week backlog increased from 785 to 995.

Encouragingly performance against the diagnostic standard increased to 93.5%, with particular improvement in Audiology. Cardiology remains the diagnostic with the highest number of breaches.

There was an increase in performance against the Two Week Wait standard at 76.49% (65.5% in M10), although some way short of the 93% standard. Performance against the 62 day standard fell to 73.3%, in part due to three rare cancers being treated in month; such patients have a shortened referral to treatment timeframe (31 as opposed to 62 days).

Time to ward within 4 hours of a stroke remained at a low level (35.7%) along with a decrease in the number of patients (69%, target 80%) spending 90% of their care on the stroke unit. Reduced TIA performance in part due to the temporary closure of the service from consultant sickness in the last week of January and in part a locum stroke consultant who did not attend as planned. Time on the unit and TIA performance are expected to improve in March.

HSMR and weekend HSMR remain within the expected range. Of the 66 deaths in February, 27 were associated with COVID-19 disease - community onset (12), hospital onset indeterminate healthcare associated (2), hospital onset probable healthcare associated (7) and hospital onset definite healthcare associated (6). In February, there was 1 new outbreak of COVID-19 declared on 1 ward affecting 4 patients.

In February the Trust continued to report a financial position that is ahead of the phase 3 forecast, a surplus of £0.7m YTD compared to a Phase 3 forecast of a deficit of £2.4m.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

April 2021

(data for February 2021)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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In February the Trust continued to report a financial position that is ahead of the phase 3 forecast, a surplus of £0.7m YTD compared to a Phase 3 forecast of a deficit of £2.4m.

Structure of Report

Performance against our Strategic and Enabling Objectives

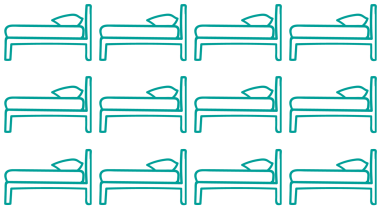
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
February 2021

NHS Salisbury NHS Foundation Trust

There were **2,247** Non-Elective Admissions to the Trust

We carried out **173** elective procedures & **1,223** day cases



93.5% ↑ of patients received a diagnostic test within **6 weeks**

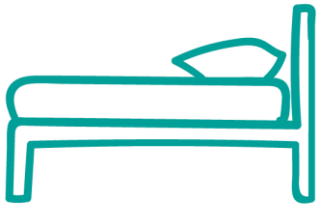
Emergency (4hr) Performance **87.9%** ↑
(Target trajectory: 95%)

We delivered **18,157** outpatient attendances, **32%** through video or telephone appointments

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

Our income was **£26,586k** (£6,528k over plan)

58 patients stayed in hospital for longer than 21 days



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

RTT 18 Week Performance: **67.6%** ↓

Total Waiting List: **19,207** ↑

19.1% ↑ of discharges were completed before 12:00

Our overall vacancy rate was **0.78%** ↓

Reading a Statistical Process Control (SPC) Chart

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

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

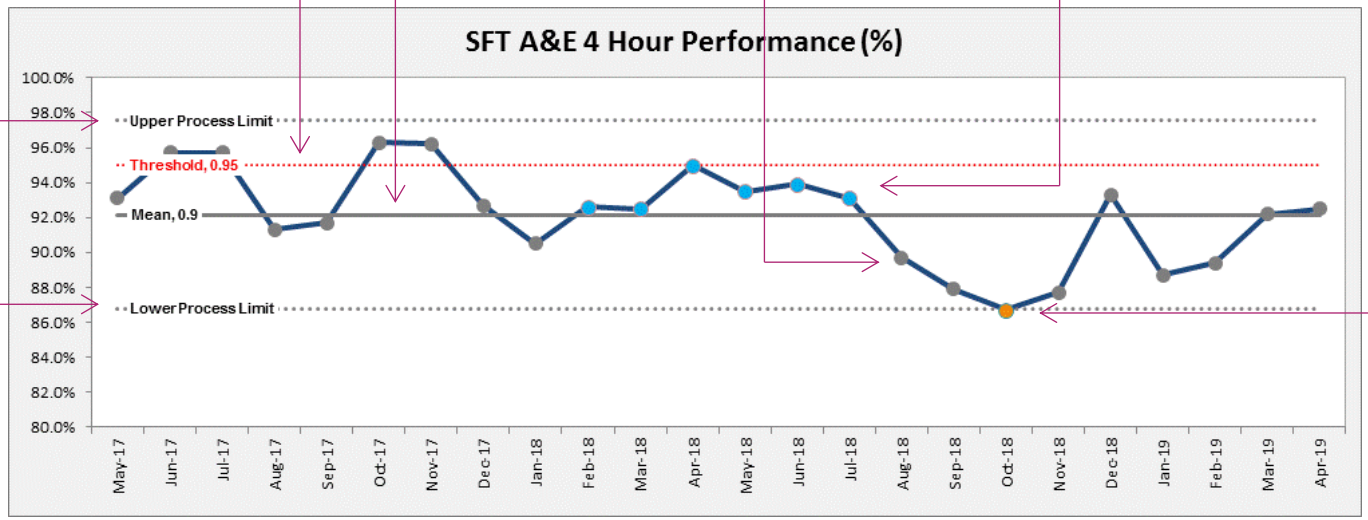
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points continuously improving or any point above the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points continuously deteriorating or any point below the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

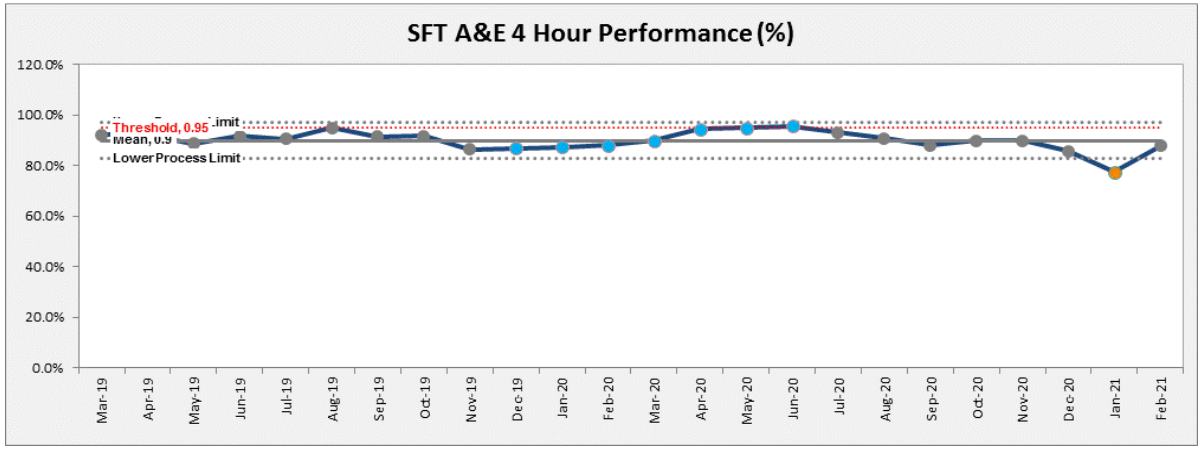
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	87.9%
Attendances:	3644
12 Hour Breaches:	0
ED Conversion Rate:	36.4%

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

M11 saw an increase in performance as compared to M10 (increasing from 77.6% to 87.9%). Attendances have also reduced in M11 (reduction of 114 as compared to M10), probably due to Covid-19 prevalence.

Time to assessment and time to triage remained within target ranges of 15 mins and 60 mins respectively for all patients attending via resus.

Flow out of the Department continues to remain challenging during the month due to constrained flow to RCU, although we are now starting to see a reduction in Covid-19 numbers. PCR testing also impacted this.

In terms of gaps in the rota, workforce improved sickness absence reduced from 5.18% in M10 to 2.05% M11

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

ED Trigger Tool (for escalation purposes) has been drafted by the ED Leadership team. This will clarify processes for escalation of ambulance delays, flow, performance etc.

Medical staffing rota coordinator has withdrawn, post is out to advert again, this will complete the recruitment of the operational coordinating administration team.

New Service Manager in post is establishing improved relationships between AMU and ED
Front door strategy meetings continuing, with a plan to commence an UEC Board

Planned consultant recruitment remains on track, advert out for 2 new Consultants.

Resolution of Mental Health room is now completed in SSEU to ensure appropriate environment for MH patients can be provided.

Risks to delivery and mitigations

Flow still remains a challenge through ED and can experience long waits for specialty Doctors and beds – which often means ED is blocked, awaiting transfer.

Ambulance handover and queuing has improved in M11 with reduction of arrivals waiting >1hour from 7% in M10 to less than 1% again in M11. It is noted that there is a junior paramedic workforce currently in Salisbury.

Middle Grade rota continues to have workforce gaps ,due to long term sickness and recruitment.

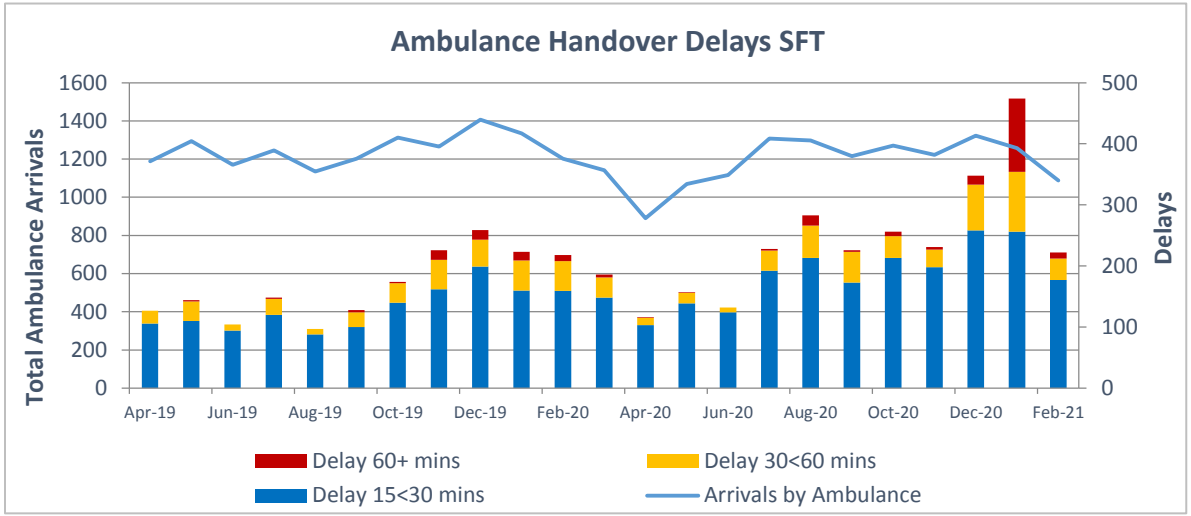
Nursing skill mix remains a pressure area within the department.

Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

Ambulance Handover Delays

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month (handover within 15 minutes):	79.6%
Arrivals by Ambulance	1088
60+ mins delay:	10

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

- Ambulance delays significantly improved in M11 in comparison to months 9 and 10.
- As a result of lowering numbers of Covid-19 positive inpatients in the hospital, flow throughout the Emergency Department into the hospital improved, and therefore supported improved ambulance handover times.

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

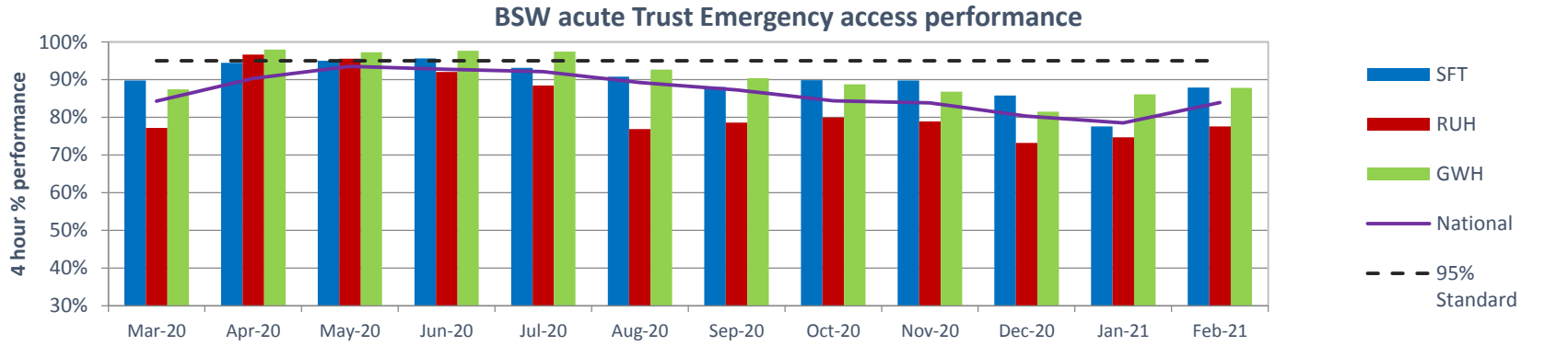
- Trigger tool in ED
- Clear escalation process in place to support anticipation of significant handover delays
- Regular monthly touch base with SWAST
- Quarterly meeting to work collaboratively on non-conveyance and feedback
- Exploring models of care that will reduce the numbers of patients coming in via ED and support direct admission to AMU and SAU
- Delays over 60 minutes now require an RCA to understand if and detrimental effects to patient care

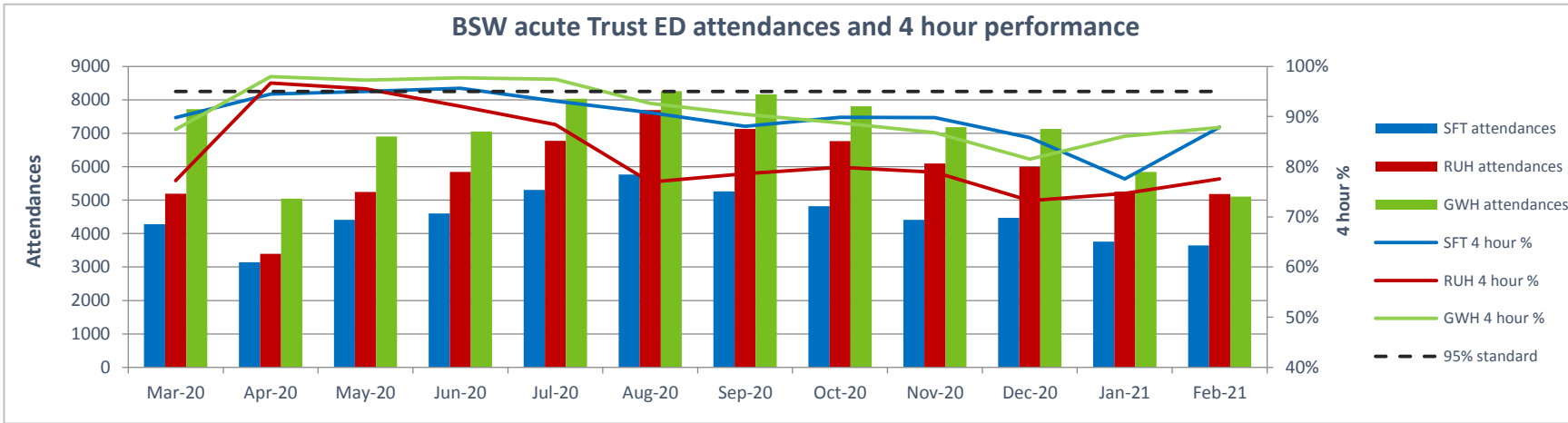
Risks to delivery and mitigations

- No visibility of SCAS arrivals which account for around 10% of arrivals.
- Need Surgical buy in for expanded SAU model
- Floor space and location to ED

Benchmarking – Emergency Access (4hr) standard

Are We Effective?

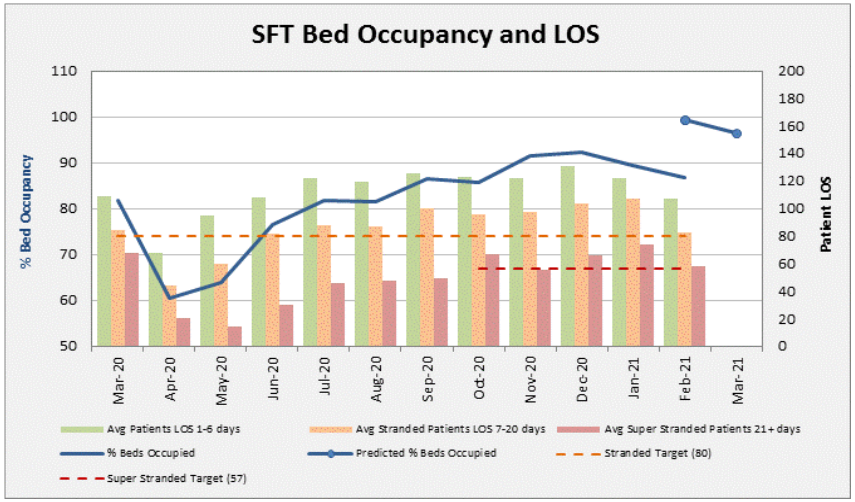


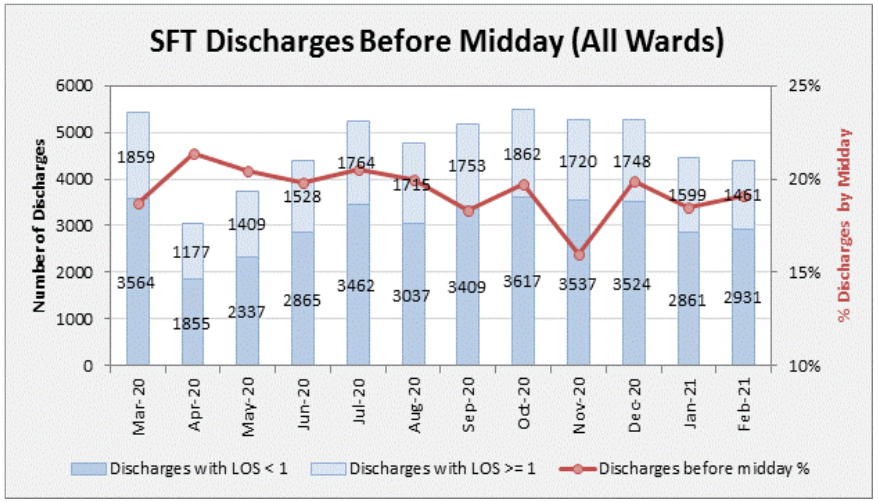


ED performance improved across the BSW system at all three Acute providers, with the biggest improvement from M10 at SFT (89.6% in M11 versus 77.6% in M10). As the National Lockdown period continued attendances remained low, similar to levels seen in the first Covid-19 wave and Lockdown.

Patient Flow and Discharge

Are We Effective?





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

February saw a decrease in occupancy – an indicator of the continued lockdown, a significant effort in the wider system to ensure flow from the acute setting, and infection prevention and control measures limiting capacity. This impacted on the groups of extended LOS groups, and both the 21day+ and 7day+ groups NHSE/I reached target levels.

Discharges before midday remain stable at just under 20% and in recovery will become an area of focus to support capacity maximisation in the morning. Rapid, short notice discharges into pathways 1-3 have been achieved, but are frequently later in the day which will contribute to the challenge of achieving 33% before 12.00. Staffing and Covid-19 challenges have influenced the new criteria led discharge which was designed to support 7 day and early morning discharge.

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

Additional beds in the community system are being sourced to accommodate pathway 2 and 3 discharges, and there is continued effort combining resource in health and social care to support pathway 1 discharges.

A rollout of Criteria To Reside guidance that informs both local and national reporting regarding the use of acute resource and the demand on community services is commencing in March. This has been in use since it was produced and distributed in March 2020 but there is a refreshed approach to its' use by the wider MDT in supporting the recovery process at SFT. It is expected to become recognised as a tool on wards that supports flow in the coming months.

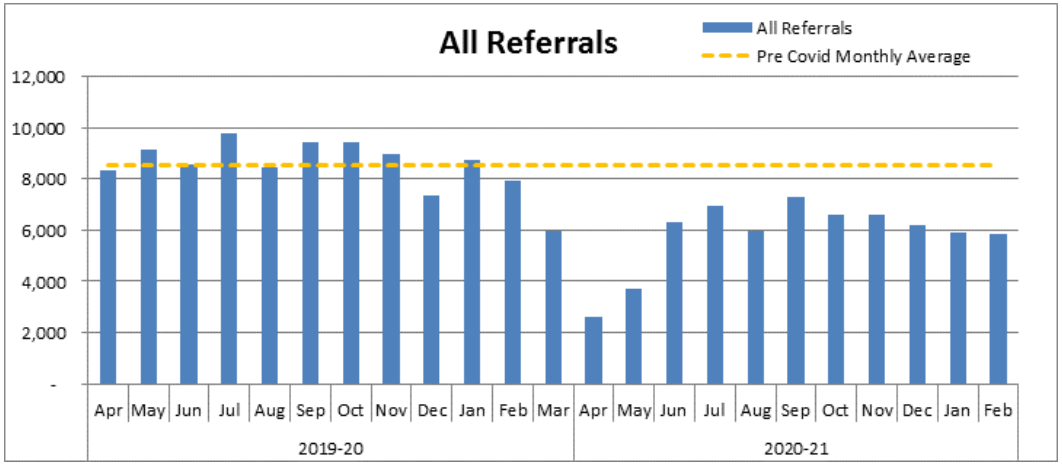
Risks to delivery and mitigations

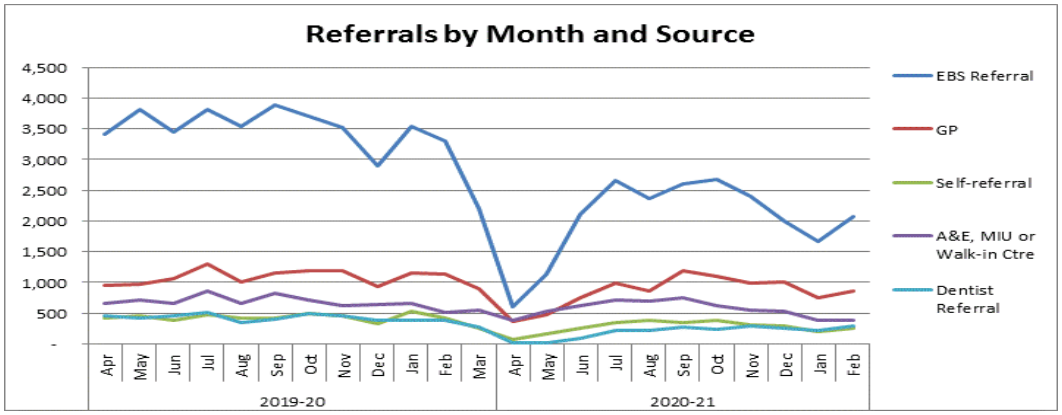
Risks include the resurgence of Covid-19 and the subsequent response of SFT to accommodate numbers safely. Staffing challenges will influence the stability of the patient journey and an increase in the community resource will need to continue to flow if the impact of February's measures are to continue, however this is dependent on staffing and care homes and wards remaining open.

Criteria to Reside is a large piece of cultural change work the will commence in March, but the impact is not likely to be proven for several months and so there is a risk to the roll out as the change process is undertaken.

Referrals

Additional Supporting Information





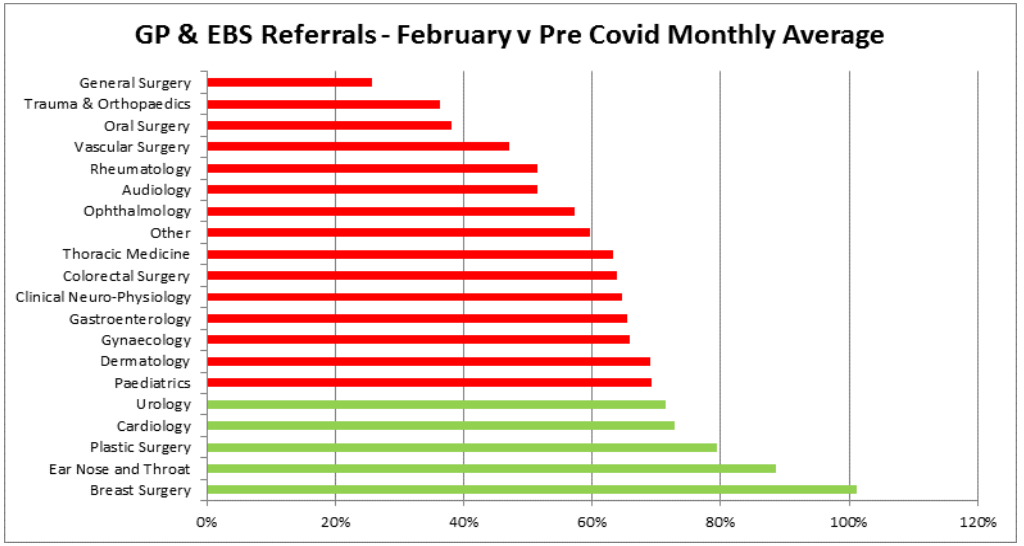
Comments

Referral levels fell again following the national lockdown period imposed from 5th January 21, and have continued to remain low throughout M11. Referral levels have not yet reached pre Covid-19 levels for the duration of the pandemic.

Referrals

Additional Supporting Information

Specialty	February '21	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Breast Surgery	227	225	101%
Ear Nose and Throat	268	303	89%
Plastic Surgery	233	294	79%
Cardiology	184	253	73%
Urology	172	241	71%
Paediatrics	118	170	69%
Dermatology	128	186	69%
Gynaecology	200	304	66%
Gastroenterology	107	164	65%
Clinical Neuro-Physiology	84	130	65%
Colorectal Surgery	183	287	64%
Thoracic Medicine	65	103	63%
Other	353	591	60%
Ophthalmology	236	412	57%
Audiology	159	309	52%
Rheumatology	87	169	51%
Vascular Surgery	27	57	47%
Oral Surgery	20	52	38%
Trauma & Orthopaedics	66	182	36%
General Surgery	22	86	26%

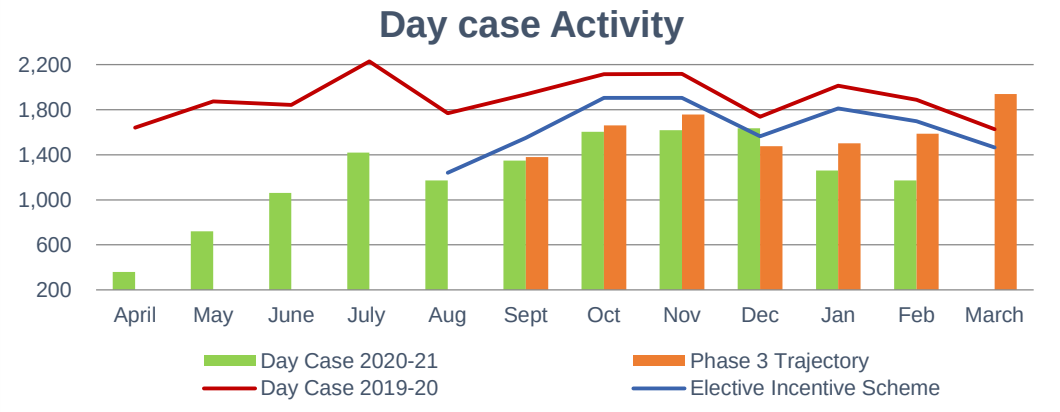


Comments

Referral levels remain high for Breast surgery, causing pressure on the 2 week wait pathway. For the majority of specialties though, referral levels are some way below the pre Covid-19 levels. There is regular communication to patients and GP's encouraging patients to seek healthcare services should they need to.

Activity recovery – Day case (target 80%)

Are We Effective?



Specialty	February	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Dermatology	11	8	143%
Respiratory Medicine	20	14	139%
General Surgery	195	202	96%
Plastic Surgery	208	218	95%
Urology	97	113	86%
Gastroenterology	316	379	83%
Breast Surgery	10	13	77%
Cardiology	66	108	61%
Vascular Surgery	6	11	55%
Neurology	11	21	51%
Rheumatology	48	109	44%
Interventional Radiology	6	14	44%
Oral Surgery	36	89	41%
General Medicine	36	89	40%
Colorectal Surgery	41	109	38%
Spinal Surgery Service	5	15	34%
Gynaecology	12	60	20%
ENT	9	45	20%
Ophthalmology	24	158	15%
Trauma & Orthopaedics	3	66	5%

Daycase activity in M11 was decreased from M10 (1173 in M11 compared to 1270 in M10) and this meant the activity was 413 below the Phase 3 trajectory submitted to NHSE/I.

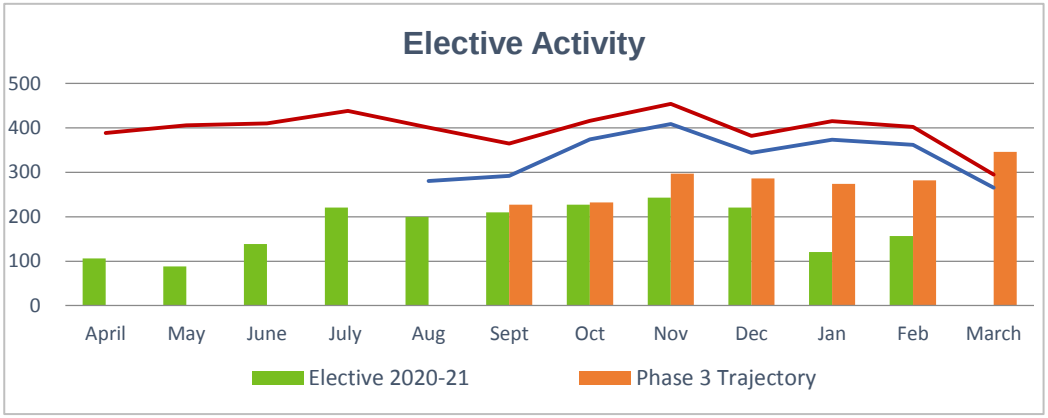
February continued to be particularly challenging in relation to Covid-19 in the Trust and the response to, and effects of, this impacted both theatre capacity and activity. The workforce impact of Covid-19 related sickness/isolation and the redeployment of theatre staff continued to result in the cancellation of some routine priority lists. Further impact was seen following escalation into the day surgery unit to increase bed capacity for inpatients leading to the temporary closure of the unit for elective activity at the start of M11.

Theatre space continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients such as ENT and Ophthalmology.

ENT and Oral Surgery remain challenging to increase with proportionally higher numbers of aerosol generating procedures.

Activity recovery – Electives (target 80%)

Are We Effective?



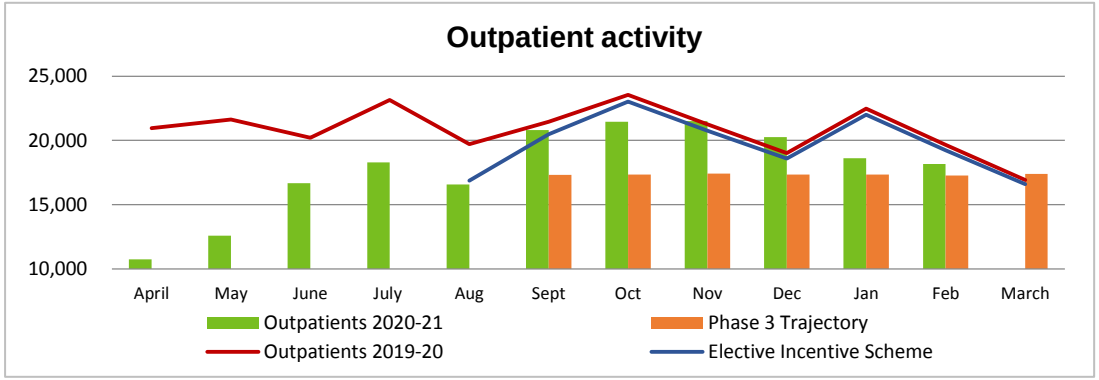
Specialty	February	Pre Covid Monthly Average	% of Pre Covid Monthly Average
General Medicine	9	6	143%
Clinical Haematology	6	4	135%
General Surgery	22	25	87%
Oral Surgery	10	12	84%
Gastroenterology	3	4	73%
Colorectal Surgery	14	21	65%
Urology	35	60	58%
Cardiology	6	10	58%
Plastic Surgery	28	84	34%
Breast Surgery	3	12	25%
Gynaecology	5	23	22%
ENT	5	28	18%
Trauma & Orthopaedics	2	89	2%
Spinal Surgery Service	0	16	0%

Elective activity continued to be significantly impacted by the Covid-19 challenges although it was increased from M10. 157 electives were performed against a trajectory of 282 resulting in a shortfall of 125 against the Phase 3 trajectory submitted to NHSE/I.

The specialties with the highest variance from plan were Trauma & Orthopaedics, ENT and Oral Surgery where, as with the daycases, having high proportions of clinically routine, low priority patients is impacting the access to theatre capacity as specialties with clinically urgent patients are being prioritised meaning that specialities with lower levels of urgent patients continue to recover activity levels more slowly.

Activity recovery – Outpatients (target 100%)

Are We Effective?



Specialty	February	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Respiratory Medicine	1635	578	283%
Endocrinology	390	260	150%
Medical Oncology	425	361	118%
Clinical Haematology	414	360	115%
Colorectal Surgery	524	458	114%
Rheumatology	879	868	101%
Gastroenterology	279	281	99%
Plastic Surgery	1794	1911	94%
ENT	674	735	92%
Genito-Urinary Medicine	501	550	91%
Gynaecology	575	657	87%
Cardiology	526	602	87%
Orthotics	475	555	86%
Diabetic Medicine	221	272	81%
Urology	649	803	81%
Breast Surgery	345	442	78%
Oral Surgery	563	742	76%
Orthodontics	218	296	74%
Paediatrics	626	861	73%
Audiology	640	908	71%
Dermatology	588	840	70%
Ophthalmology	1638	2441	67%
General Surgery	212	324	65%
Trauma & Orthopaedics	1144	1762	65%
Spinal Surgery Service	114	238	48%
Physiotherapy	0	393	0%

Outpatient activity levels for M11, although down slightly from M10, exceeded the forecast Phase 3 trajectory submitted to NHSE/I with outpatient activity in February 2021 being 895 ahead of plan with a range of specialties achieving 90% or above. Specialties with fewer Covid-19 related constraints can be seen to have fully recovered with activity for some being well over 100%.

With increased numbers of appointments being undertaken virtually, the level of outpatient procedures has reduced.

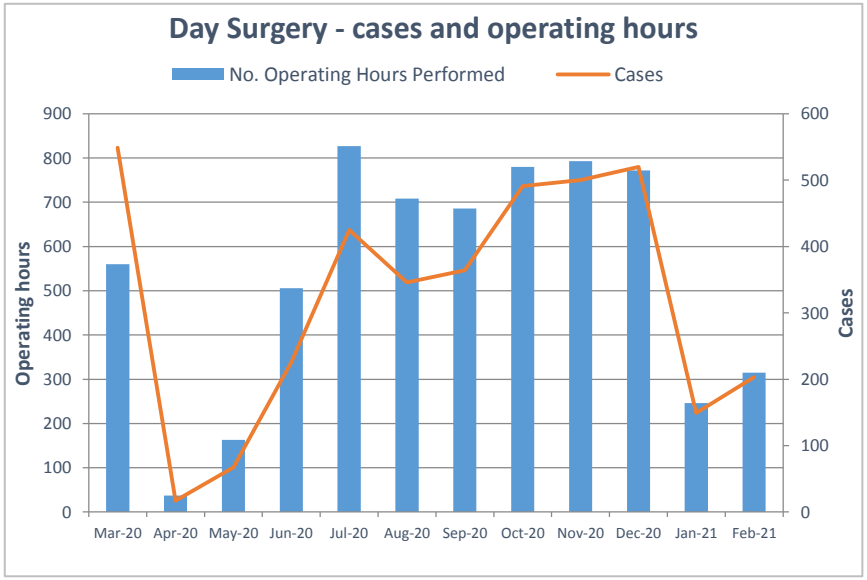
An air change solution for both the ENT & Oral Surgery outpatient departments has been identified, and work on this is commencing this month, with activity for these specialties expected to rise following this although there will be a reduction in activity while the work is undertaken.

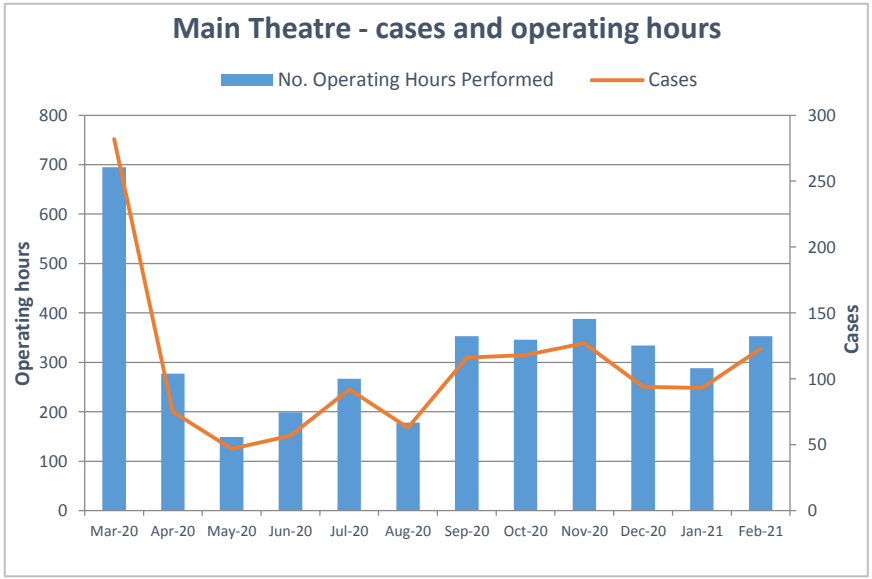
Space constraints across outpatient department continue to be a challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics. The modular build, which is due to open on 12th April, will increase the number of patients that can be safely seen.

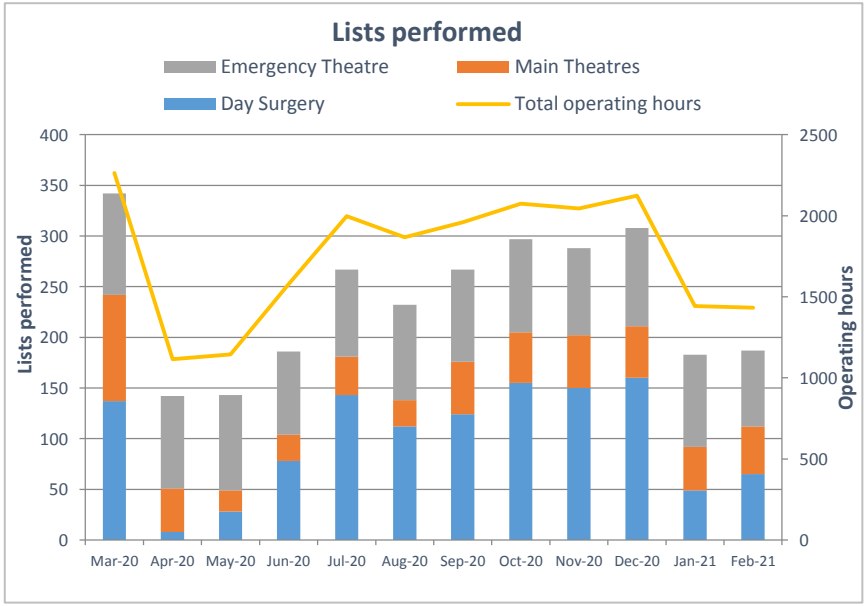
Virtual appointments are working well in some specialties with Gastroenterology seeing the majority of their outpatients virtually. Urology, Gynaecology and Cardiology are also seeing good use of virtual appointments.

Activity recovery - Theatres

Additional Supporting Information







Theatre activity continued to be limited in M11 and was behind plan in daycase and main theatres.

Theatre activity was expected to increase in Q4 with the further re-opening of Main Theatre capacity, but this has only been partially achieved, and has been further impacted by the increased escalation of ITU into the Main Theatre footprint due to the second wave of Covid-19, and much larger bed requirement. The temporary closure of the Day Surgery Unit to provide additional bed capacity resulted in cancellations of theatre lists at the start of the month with some theatres remaining closed.

Significant challenges remain around staffing, sickness levels, agency fill and recruitment and Covid-19 related absence remains a difficult issue to mitigate.

Theatre staff payment incentive continues.

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

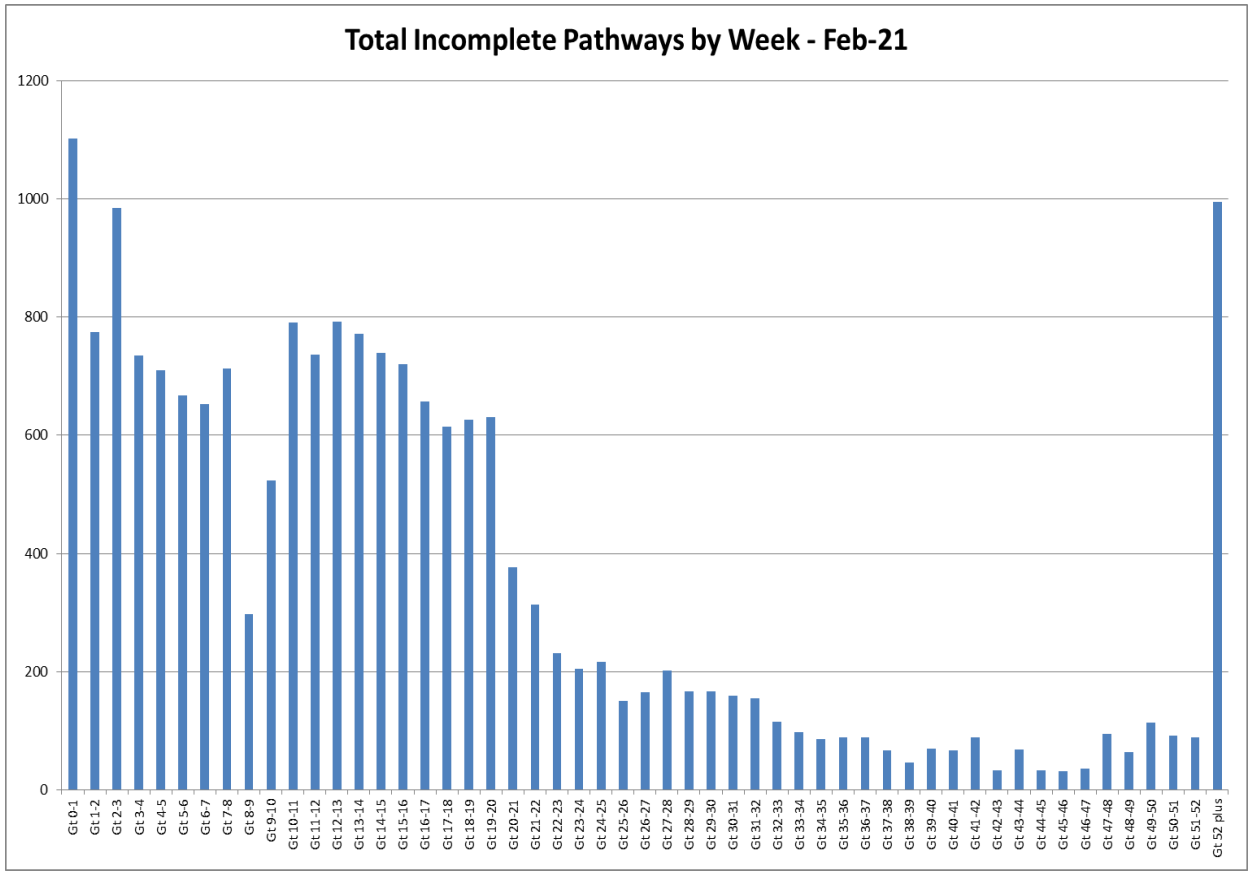
National Key Performance Indicators

Top 5 lowest 18 week performance

Specialty	WL Total	Total <18 weeks	% <18 weeks
Ophthalmology	2515	1226	48.7%
Plastic Surgery	1259	715	56.8%
Ear, Nose & Throat (ENT)	1651	946	57.3%
Oral Surgery	1456	857	58.9%
Trauma & Orthopaedics	1373	853	62.1%

Top 5 largest 18 week breach backlog

Specialty	WL Total	Total 18 wk breaches	% <18 weeks
Ophthalmology	2515	1289	48.7%
Ear, Nose & Throat (ENT)	1651	705	57.3%
Other	3093	648	79.0%
Oral Surgery	1456	599	58.9%
Plastic Surgery	1259	544	56.8%



RTT performance declined slightly in February at 67.06% (71.03% in M10). This is due to reduced theatre activity and continued challenges in outpatient capacity.

As part of the support work for areas with the poorest compliance, and largest volumes, the Surgical DMT continue to focus on Ophthalmology reviewing options to increase their outpatient capacity options and the transfer of patients to two outsourcing solutions commenced this month with 200 patients transferred so far. Additional Saturday outpatient clinics continue to run in the Eye Clinic providing additional capacity for the backlog of glaucoma patients.

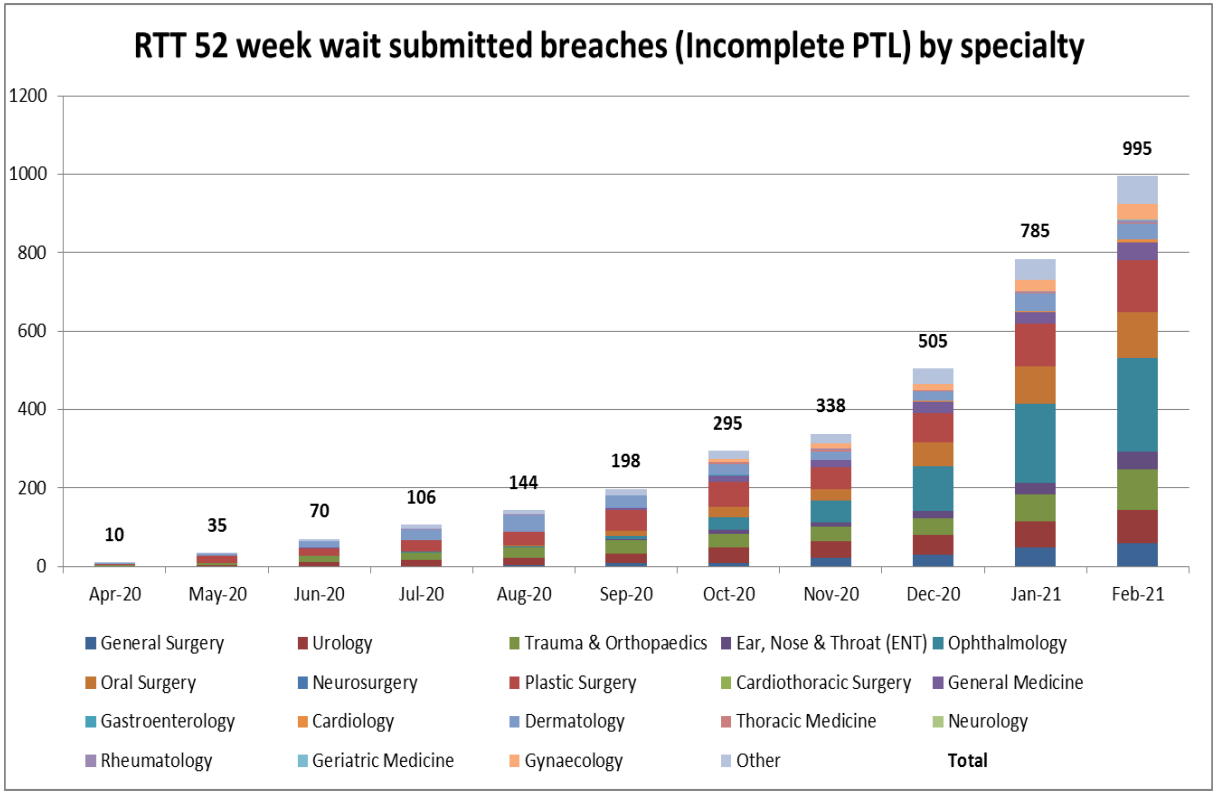
Additionally the air change solutions now identified for ENT and Oral Surgery, which are being installed this month, will improve their capacity but improvement will be limited until these are in place. The opening of the modular build in April will also provide additional capacity for ENT.

Work on Dermatology and Plastic Surgery productivity continues and additional minor operation capacity continues to be organised including Saturday outpatient and surgical lists.

Theatre allocation continues on the basis of clinical priority, and specialties with a lower proportion of higher priority patients have reduced operating space for routine procedures.

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

National Key Performance Indicators



Top 5 with highest 52 week wait submitted breaches (Incomplete PTL)

Treatment function	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	% change from previous month
Ophthalmology	0	0	0	2	3	7	32	55	115	202	238	18%
Plastic Surgery	3	18	21	28	33	54	64	54	74	107	132	23%
Oral Surgery	0	0	0	1	3	12	27	30	61	97	117	21%
Trauma & Orthopaedics	1	7	14	20	27	34	34	37	44	71	104	46%
Urology	2	3	11	15	18	25	38	44	49	65	84	29%

The number of patients waiting longer than 52 weeks has grown by 210 patients to a total of 995 of which almost 100 patients have requested to pause their pathway due to Covid-19 concerns.

As part of the phase 3 activity assumptions the Trust forecast that the number of over 52 week patients would grow every month until the end of 2020-21. The forecast position for M11 was 316 patients over 52 weeks. The forecast was completed when the Trust had zero Covid-19 inpatients and assumed that this level would continue.

Approximately 30% of patients waiting longer than 52 weeks are waiting at the non-admitted stage of their pathway and 70% are waiting on an admitted pathway.

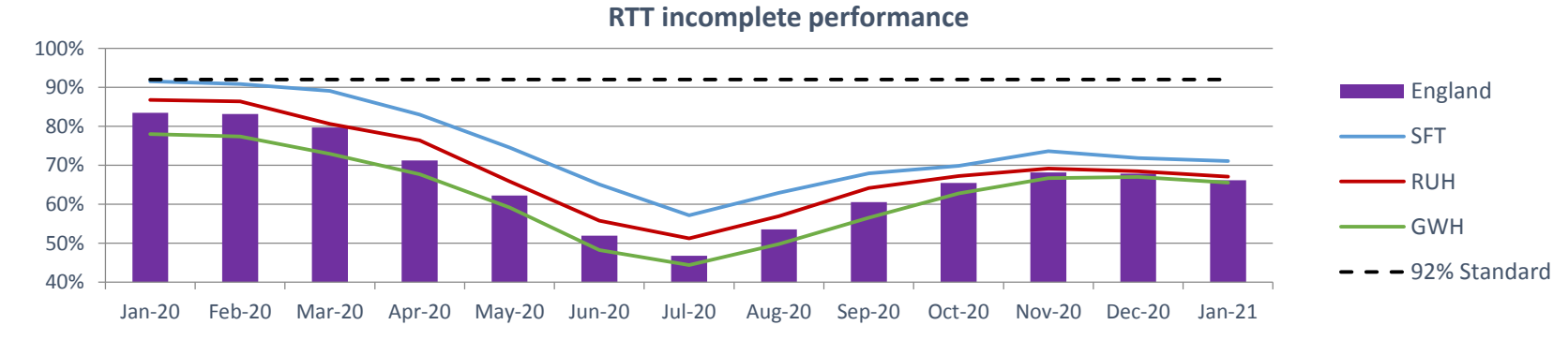
Of the 297 patients waiting on an outpatient pathway, over 200 are in Ophthalmology. There are specific challenges to increasing activity in Ophthalmology in relation to the ability to socially distance, outpatient capacity and the proportion of vulnerable patients in this group. Two additional outsourcing providers commenced as planned in M11.

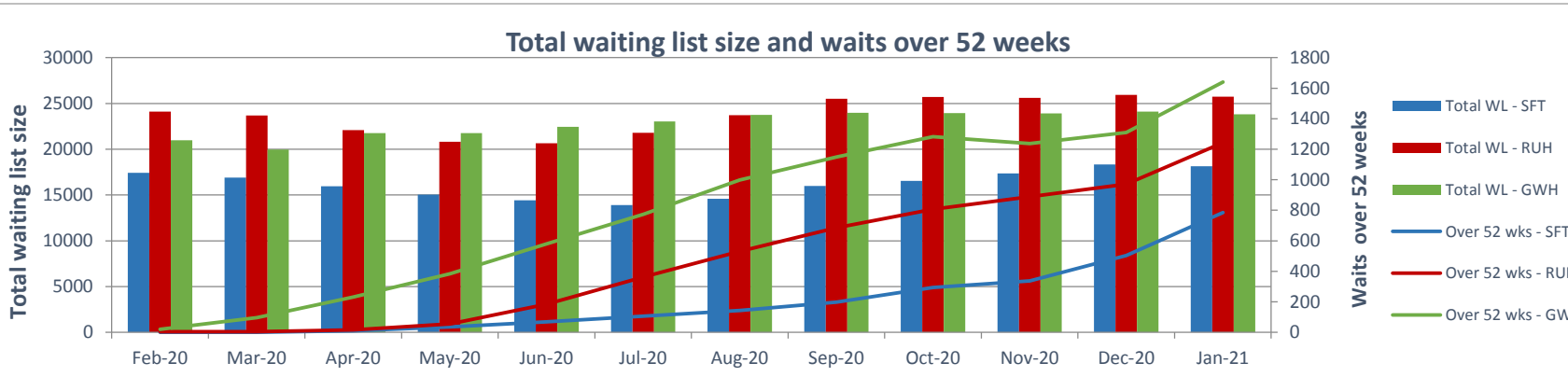
Of the patients waiting on an admitted pathway, there were 23 patients recently expedited to priority level 2 (should be treated within 4 weeks of prioritisation), 134 patients in priority level 3 (should be treated within 3 months), and the rest in levels 4, 5 and 6 (more than 3 months). The specialty split is more broad, with the highest being in plastics (123), Oral Surgery (114), Urology (82) and Orthopaedics (80).

Regular review of the prioritisation is undertaken to ensure that circumstances have not changed and the allocated priority is appropriate. Guidance issued from the Federation of Surgical Specialty Associations forms the basis for prioritisation.

Benchmarking – Referral To Treatment (RTT)

Are We Effective?



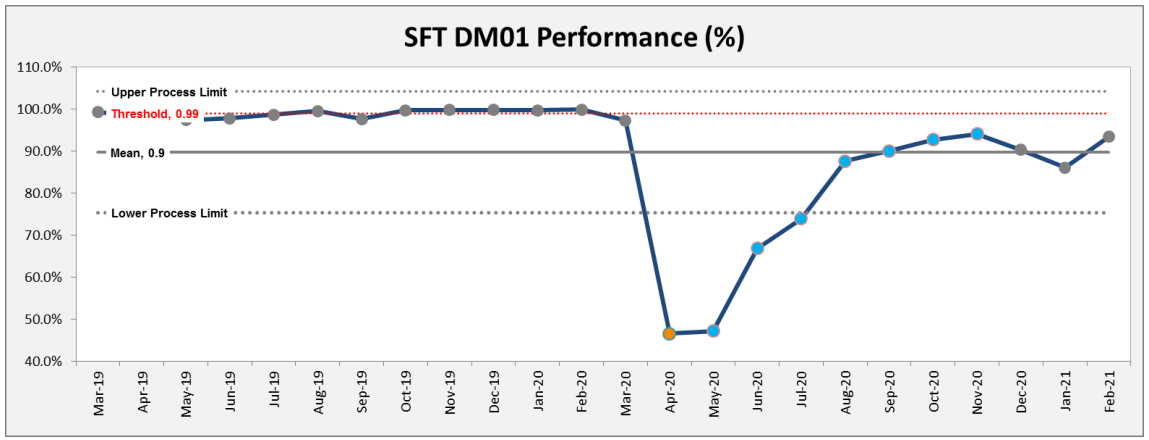


Total waiting list size remained broadly static at all three BSW acute Trusts in M10, however performance against the 18 week RTT standard reduced. This is likely due to a drop in incoming referrals as a result of the further lockdown period initiated in the month.

The biggest month on month increase to date was seen in the over 52 week backlogs, with a total of 1641 patients at GWH, 1243 at RUH and 785 at SFT. Proportionally, the over 52 week backlog represents 0.04% of the total waiting list at SFT and RUH, and 0.06% at GWH. The backlogs are expected to rise further throughout February with elective capacity restrained by high numbers of Covid-19 positive inpatients at all providers.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	93.5%
Waiting List Volume:	3054
6 Week Breaches:	2854
Diagnostics Performed:	6198

Background, actions being taken and risks and mitigations
Performance standard in month has not been achieved as a direct result of Covid-19. March projections confirm that the target is not achievable for M12 owing to a sustained increases in the Cardiology referral rate and reduced capacity for MRI owing to staffing issues. Activity for M11 has significantly improved across a number of Diagnostic tests, with a fantastic in month improvement in the number of reportable breaches in Audiology.

Endoscopy
6 confirmed in month breaches, all attributable to Covid-19.

Radiology (Inc. DEXA)
19 confirmed in month breaches. 13 MRI attributable to M9 downtime @ SFT and Newhall and reduced Newhall capacity in M10. 3 CT owing to complexity and nature of scan request.

Radiology Reporting
2nd provider live from 08-12-2020. Sustained improvements in the number of scans week on week, marginally increased in month owing to half term consultant leave. Interventional Radiology remains the exception, owing to reduced functionality in the work station located at the Royal Bournemouth and Christchurch Hospital. SFT IT continue to provide support to identify resolution.

Audiology
19 confirmed in month breaches, all attributable to Covid-19. Activity within the service has once again increased in month, with an expectation that the service will be booking within the 6 week tolerance by the end of April 2021.

Cardiology
153 confirmed in month breaches, all attributable to Covid-19. Recovery trajectories are in place, but these are solely dependent on additional capacity in the form of a 3rd Echo Room. Estimated timescales currently between 6 and 12 months away.

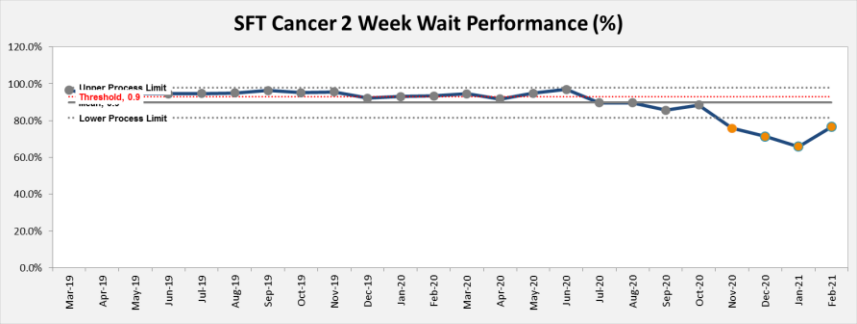
Neurophysiology
0 in month breaches.

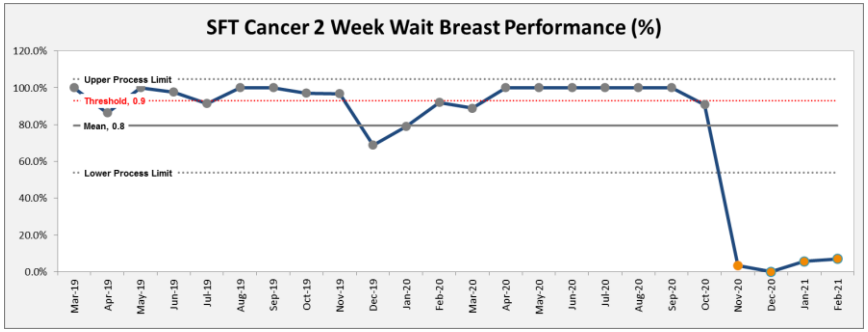
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	76.49%	563/736	173 (23 patient choice)
Two Week Wait Breast Symptomatic Standard:	6.98%	3/43	40 (2 patient choice)

Data Quality Rating:





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

Two week wait standard not achieve for M11 (736 patients seen in total; 563 seen within target; 173 breaches). This is due to a variety of reasons including:

- Face to face outpatient capacity (141 breaches, predominantly associated with breast one stop capacity);
- Patient choice (23 breaches);
- Late receipt of qFIT result (13 breaches);
- GP delay (3 breaches);
- Prison (2 breaches);
- Administrative delay (2 breaches)

Breast symptomatic two week wait performance standard not achieved for M11 (43 patients seen in total; 40 breaches). Majority of delays again associated with patient choice and breast one stop capacity.

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

Booking teams continue to prioritize cancer patients, though ongoing concerns related to patient choice and DNAs remain; this is likely to impact on service delivery for a significant period of time. GP comms is circulated on a weekly basis to remind GPs of the importance of ensuring patients are willing and able to attend.

Implementation of qFIT within primary care continues to become embedded. Revised colorectal 2ww referral form now in place and has resulted in an increase in the number of referrals received with the qFIT result.

Significant challenges within breast service due to increase in referrals, social distancing restrictions and outpatient capacity. Fifth one stop clinic now in place which is beginning to demonstrate reduced average waiting times from referral to first seen. Demand and capacity model completed.

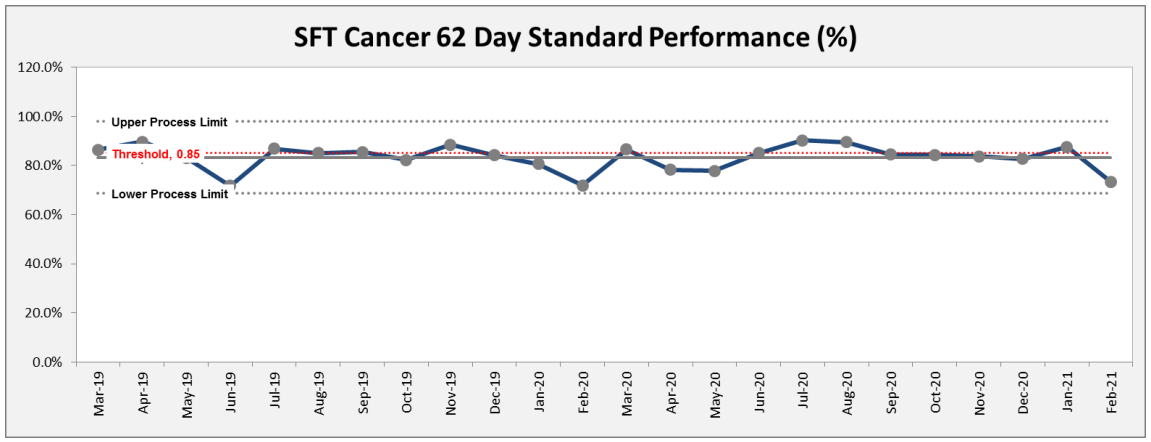
Weekly PTL, cancer ops and cancer action group in place to look to prevent avoidable breaches. This then enables cancer services to work with the relevant team to expedite where possible. Use of cancer escalation process is now business as usual to avoid unnecessary delays.

Risks to delivery and mitigations

The SWAG cancer alliance has confirmed that secondary care will be unable to book or perform diagnostic tests without the completion of qFIT; this should be completed by the patient prior to referral though there is a risk that as this is not mandated, that patient pathways will be delayed. This is affecting SDH's ability to book straight to test appointments in a timely manner within both radiology and endoscopy; a full audit is currently being undertaken within the rapid referral office to monitor the impact of this. Cancer services continue to work close with the colorectal team and CCG, who plan to target practices with low uptake.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

February 21	Performance	Num/Den
62 Day Standard:	73.3%	33/45
62 Day Screening:	0%	0/1

Risks to delivery and mitigations

Month 11 62 day performance standard not achieved, with month end performance of 73.33% (45 patients treated in total; 33 in target; 12 breaches). 3 rare cancers treated in month; such patients have a shortened referral to treatment timeframe (31 as opposed to 62 days)

Four 104 day breaches reported in February following treatment:

- Colorectal (1 breach): complex diagnostic pathway involving vascular and cardiology. Patient subsequently tested positive for Covid-19
- Head & Neck (1 breach): complex diagnostic pathway. Patient subsequently tested positive for Covid-19
- Skin (0.5 breach; shared allocation with RUH): Delay in receipt of patient from RUH. Subsequent delay due to consultant sickness absence due to Covid-19
- Upper GI (1 breach): complex diagnostic pathway. Treatment plan subsequently changed from surgery to chemotherapy

Month 11 62 day screening performance standard not achieved (1 patient treated in total; 1 breach). Breach associated with complex diagnostic pathway and patient requiring involvement/oversight from multiple tumour sites.

Future performance continues to remain fragile, though cancer treatments continue to be prioritised. Cancer services and DMT continue to focus on longest waiters and overall PTL backlog (patients waiting over 62 days); this continues to show improvement. Weekly cancer action group established to maintain DMT focus on cancer care delivery.

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

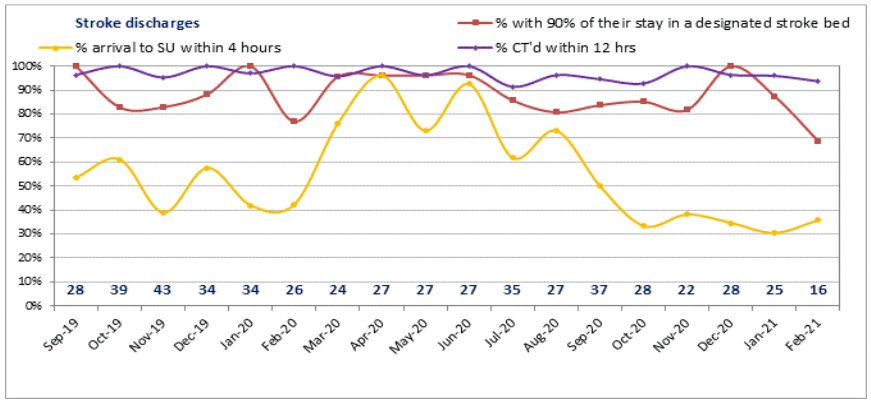
Year	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	

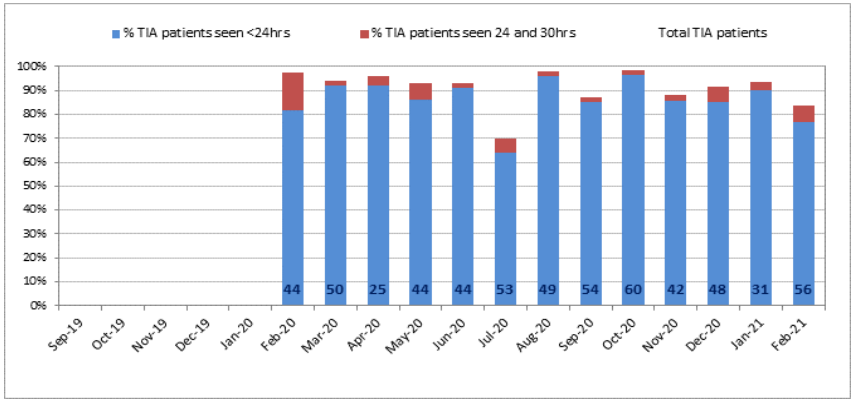
Data Quality Rating:

% Arrival on SU <4 hours: 35.7%

% CT'd < 12 hours: 93.8%

% TIA Seen < 24 hours: 76.8%





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

56% of stroke patients had a CT within 1 hour exceeding the 50% national target. Patients reaching the stroke unit within 4 hours remained at a low level (36%) affecting 9 patients. Delays were due to waiting for specialty doctor (2), transferred to AMU (2), workload (1), waiting for a bed (1), inpatient stroke (1), transferred to SSEU at end of life (1) and in ED at 4 hours (1). 1 (6%) stroke death within 7 days and 2 (12%) stroke deaths within 30 days both lower than expected. Only 69% of stroke patients spent 90% of their time on the stroke unit below the national target (80%), as 3 patients were admitted to AMU and 2 patients moved wards to make way for new stroke patients. The Stroke Unit was closed to new admissions between 22 January and 1 February due to consultant sickness. The Unit experienced above average levels of staff absence due to Covid-19.

Unusually, TIA performance reduced to 77% was affected by full clinics (6), MRI the next day (3), cancelled clinic (2), system error (1) and late GP referral (1) and consultant sickness (22 January - 1 Feb) with patients diverted to Bournemouth and Poole TIA clinics for 1 week. Normal service resumed on 1 February and performance is expected to recover in March.

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

Due to winter and Covid-19 pressures, Laverstock ward returned to its original configuration of 26 beds (up from 17) and Breamore ward was reconfigured from 17 to 23 beds giving a total of 49 beds. These additional beds are supporting medical patients.

Two new Sisters have been appointed from within the Stroke team. A replacement locum stroke consultant was due to start on 22 February but did not attend.

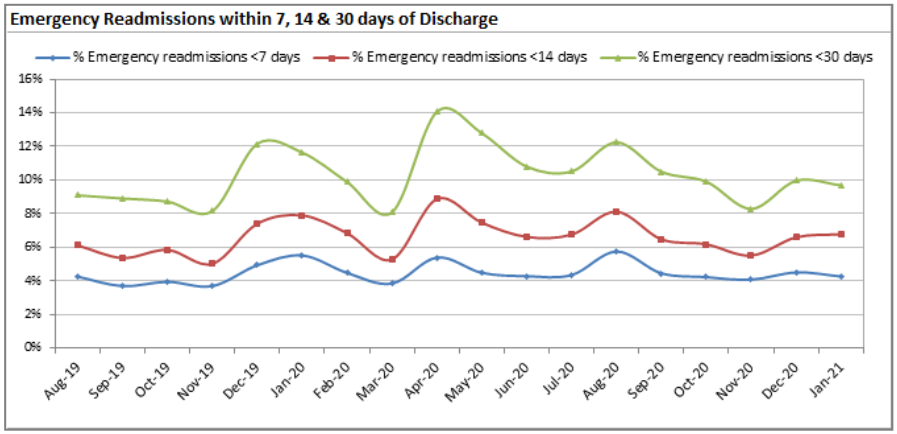
Risks to delivery and mitigations

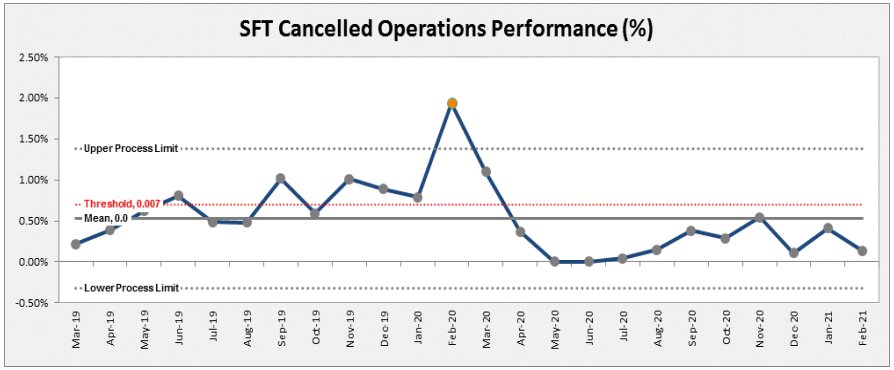
The assessment bed for GP direct admissions and transfers from ED within 4 hours was used for bed capacity due to the number of Covid-19 positive patients. Mitigated by virtual board rounds to decide on isolation and de-isolation of patients with Covid-19.

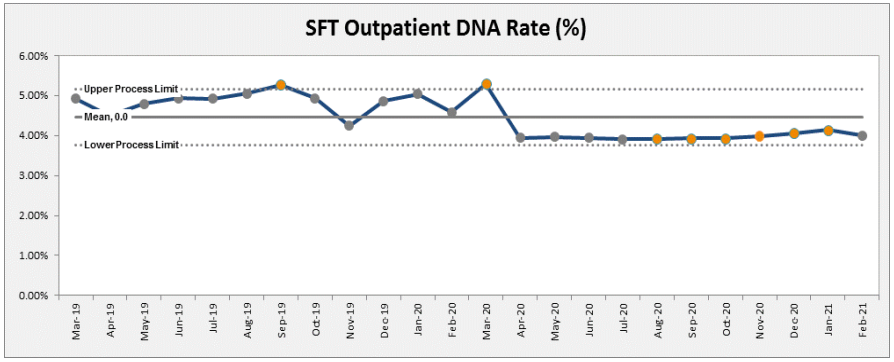
SSNAP data is not likely to be published for Q4 20/21.

Other Measures

Are We Effective?







To note, the outpatient DNA rate measurement was changed by the PMO OP Transformation Board in April 2020 to remove a filter that excluded a set of OP clinics. By removing the filter the number of attendances has gone up, and therefore the DNA rate has dropped.

Salisbury NHS Foundation Trust

Part 2: Our Care

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

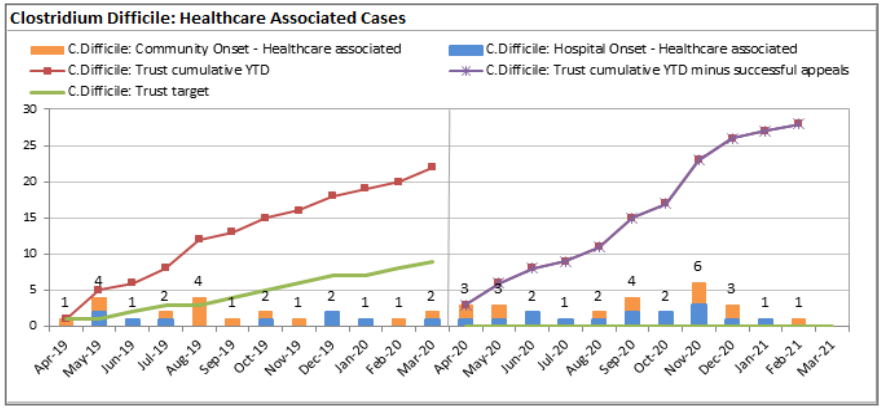
Infection Control

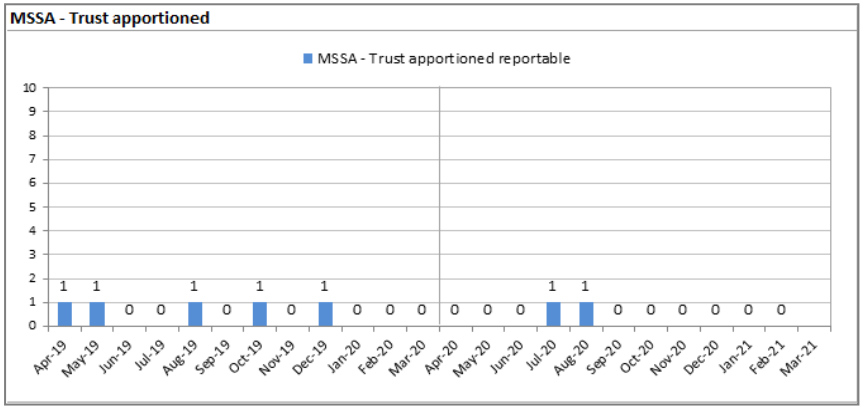
Data Quality Rating:

Are We Safe?

Clostridium Difficile	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Cases Appealed	0	0	0	0	0	0	0	0	0	0
Successful Appeals	0	0	0	0	0	0	0	0	0	0

MRSA	2019-20	2020-21
Trust Apportioned	0	2





Summary and Action

No hospital onset C.difficile healthcare associated cases in February.

1 community onset C.difficile healthcare associated case of a patient who had a sample taken at the GP surgery. The patient had numerous previous positive results and attended AMU on 2 occasions leading up to the sample date. The patient was managed appropriately on both occasions.

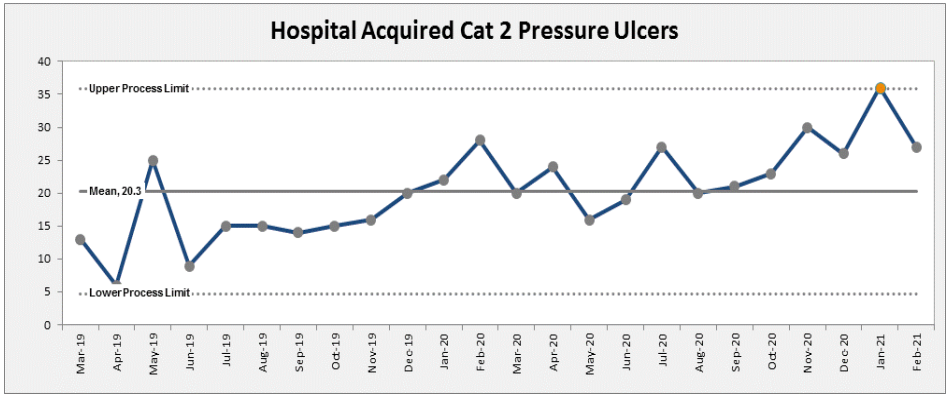
No hospital onset MRSA, MSSA, E Coli bacteraemia.

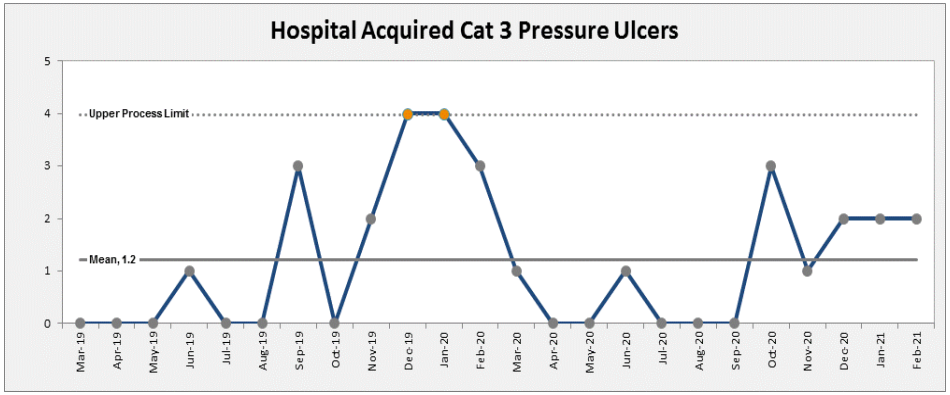
Outcome of investigations/learning from hospital onset healthcare associated cases not previously reported in January:

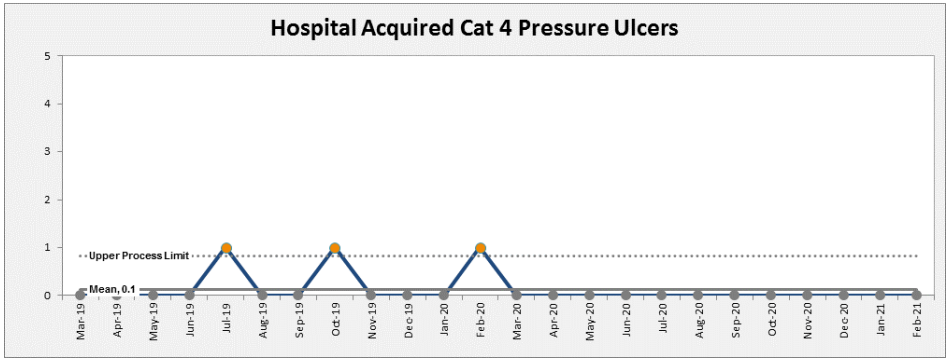
1 hospital onset healthcare associated C.difficile case of a patient on Chilmark ward. Learning: the patient was not isolated in a side room when the stool sample was sent, the reason for the omission was not clear. In addition, the bay was not closed on receipt of the positive result there was a delay in starting appropriate antibiotic treatment. This was followed up with the clinical team and the learning shared with the Chilmark team.

Pressure Ulcers

Are We Safe?







Data Quality Rating:

Per 1000 Bed Days	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2	2020-21 Q3
Pressure Ulcers	1.22	1.73	2.27	1.92	2.10

Summary and Action

The number of category 2 pressure ulcers decreased from 36 in January to 27 in February. The biggest decrease was seen in the Surgical Division from 20 category 2 pressure ulcers in January to 7 in February. One category 4 pressure ulcer in February. Overall, a 54% increase in category 2 pressure ulcers in 20/21 compared to 19/20 but a 52% reduction in category 3 and 4 pressure ulcers in the same time period.

Improvements implemented in February – Band 2 induction educational content changed to focus on skin inspection, accurate documentation and escalation with a plan for Tissue Viability link nurse upskilling in place.

Challenges - maintaining the focus on pressure ulcer prevention with current workforce challenges (sickness absence) and releasing staff for training.

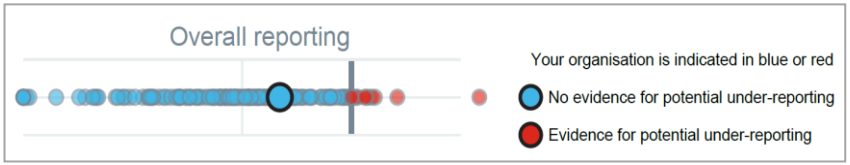
The plan remains to focus on pressure ulcer prevention and undertake a Plan, Do See, Act (PDSA) cycle with the new skin bundle. In addition, to re-establish the PDSA cycle for skin inspection in AMU. A second 'Stop the Pressure Event' is planned in April 21 and increased joint working with the Divisional Matrons.

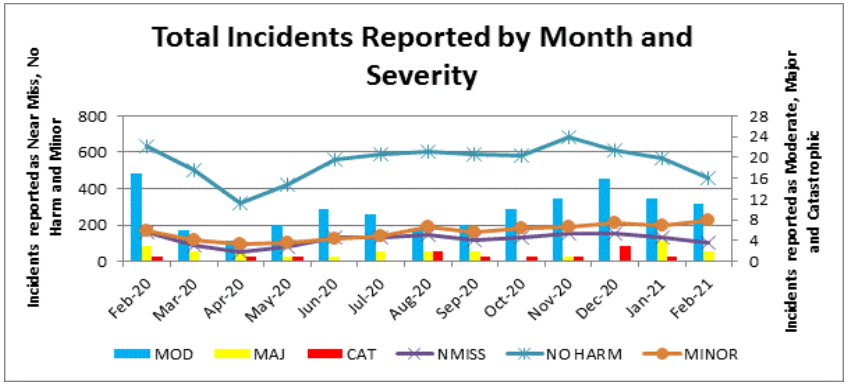
Incidents

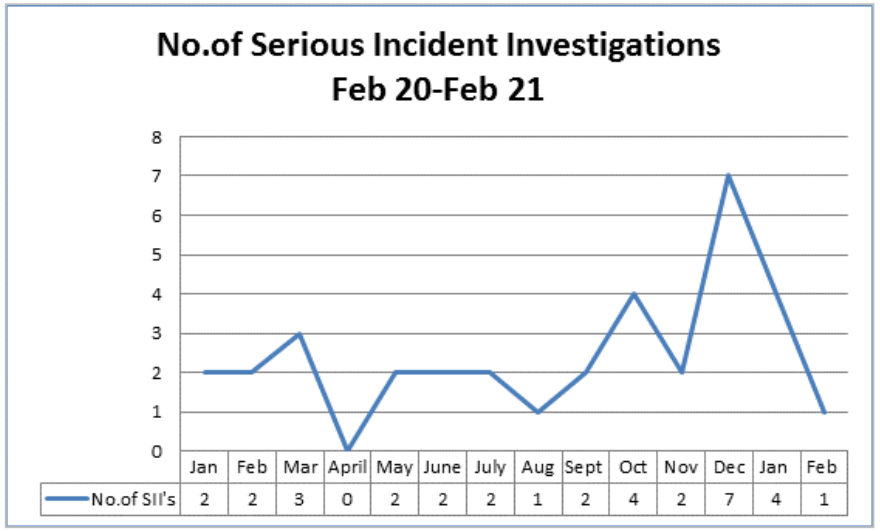
Are We Safe?

Year	2019-20	2020-21
Never Events	2	0

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







Summary and Action

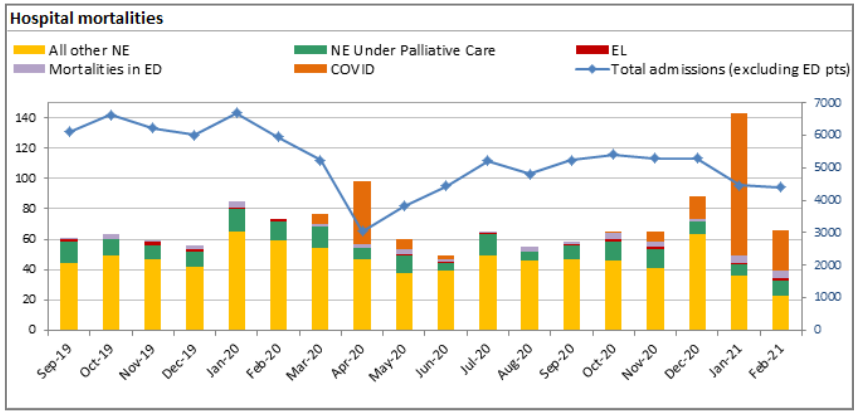
1 serious incident investigation commissioned in February:

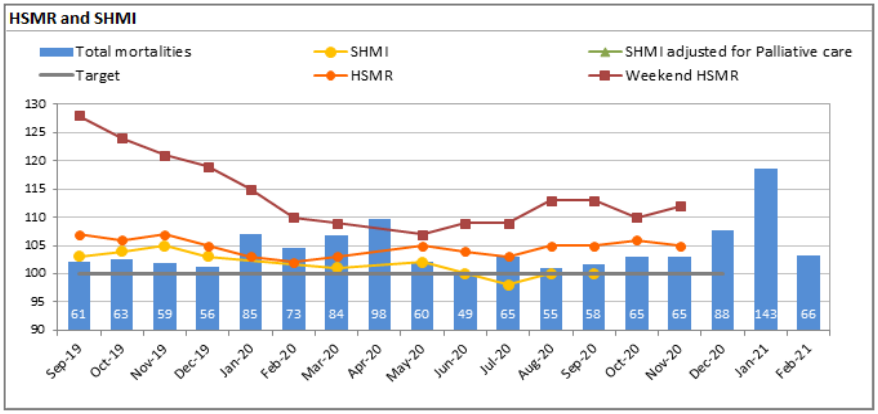
Surgical Division – Category 3 pressure ulcer of a patient on Downton ward resulting in moderate harm. Improvement actions are already part of the Trust wide improvement plan.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected to November 20. The weekend HSMR increased and remains within the expected range.

Of the 66 deaths in February, 27 were associated with Covid-19 disease and of these:

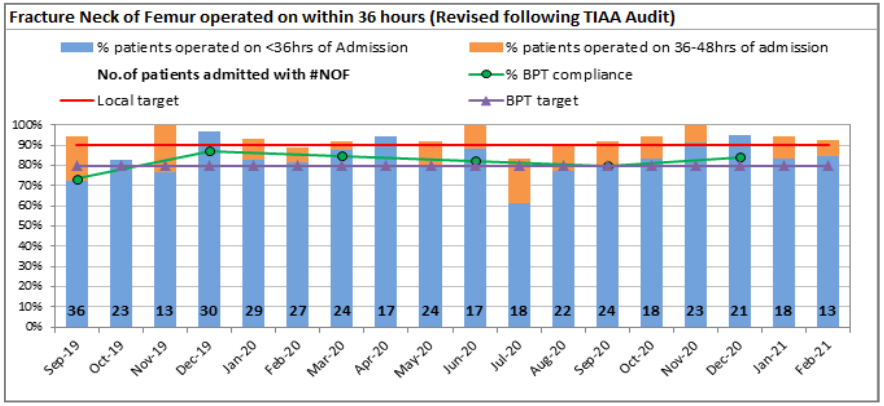
- 12 cases were community onset
- 2 were hospital onset indeterminate healthcare associated
- 7 were hospital onset **probable** healthcare associated
- 6 were hospital onset **definite** healthcare associated

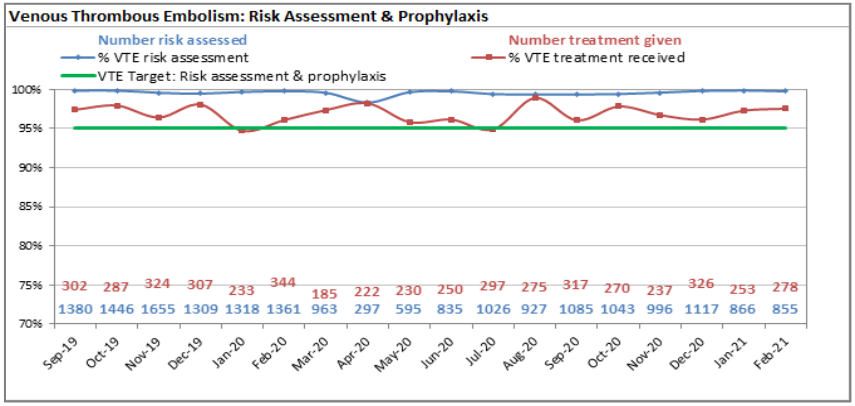
A duty of candour letter will be sent to the bereaved families of the probable and definite healthcare associated cases once contact tracing has been completed. In February, there was 1 new outbreak of Covid-19 declared on 1 ward affecting 4 patients.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

(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 the following month):

In February, 1 patient had a post-operative ortho-geriatric review at 87 hours compared to the 72 hour standard and therefore the best practice tariff was not achieved for this patient. The patient had a prolonged length of stay complicated by abdominal pain and treatment for diverticulitis.

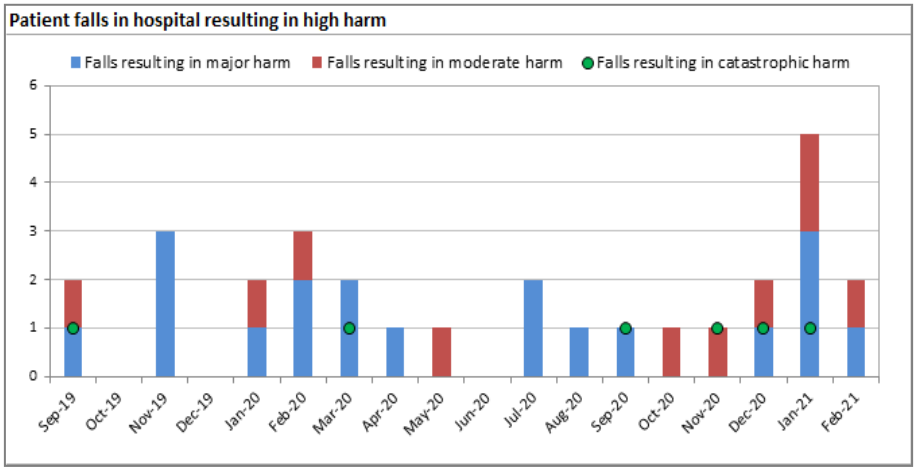
5 patients did not receive hip surgery for a hip fracture/peri-prosthetic fracture within 36 hours:

- A patient admitted following a fall and a fractured hip had surgery at 36.43 hours waiting for theatre space. The patient was Covid-19 positive and had post-operative delirium. The patient was transferred to a community hospital at day 16 for ongoing rehabilitation.
- A patient admitted following a fall and a fractured hip had surgery at 42 hours after stabilisation of his condition. The patient required a pre-operative blood transfusion for anaemia. The post-operative period was complicated by delirium, urinary tract infection and the requirement for an iron transfusion. The patient had a prolonged length of stay of 26 days (national average length of stay 15 days).
- A patient admitted from a nursing home following a fall and a fractured hip had surgery at 43 hours waiting for theatre space. The patient required a post-operative blood transfusion and was discharged on day 13.
- A patient admitted with a fractured femur had surgery at 46 hours waiting for theatre space. Uneventful post-operative period and discharged on day 4.
- A patient admitted with a pathological fracture from metastatic breast cancer required treatment for hypercalcaemia and waited for kit prior to surgery at 225 hours. The patient had a prolonged length of stay of 38 days.

The Trust continued to report good performance in VTE risk assessment and prophylaxis. A reduction in February in the number of inpatients with a new VTE (11 in December, 9 in January and 5 in February as measured by the Safety Thermometer). The majority occurred in Covid-19 positive patients who developed micro-thrombi in the lungs vessels due to the increase in the viral load and increased inflammation. Root cause analysis of all hospital acquired VTEs is undertaken and showed that patients having NIV/CPAP had an intermediate dose of prophylaxis compared to the standard dose in accordance with NICE guidance. A root cause analysis report is presented to the Thrombosis Committee quarterly.

Patient Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2	2020-21 Q3
Patient Falls	0.07	0.17	0.08	0.14	0.16

Summary and Action

In February, 2 falls resulting in harm:

- A patient suffered major harm from a fractured hip on Downton ward which required surgical treatment.
- A patient with confusion and delirium suffered moderate harm from a fractured pubic rami on Spire ward. No lapses in care were noted.

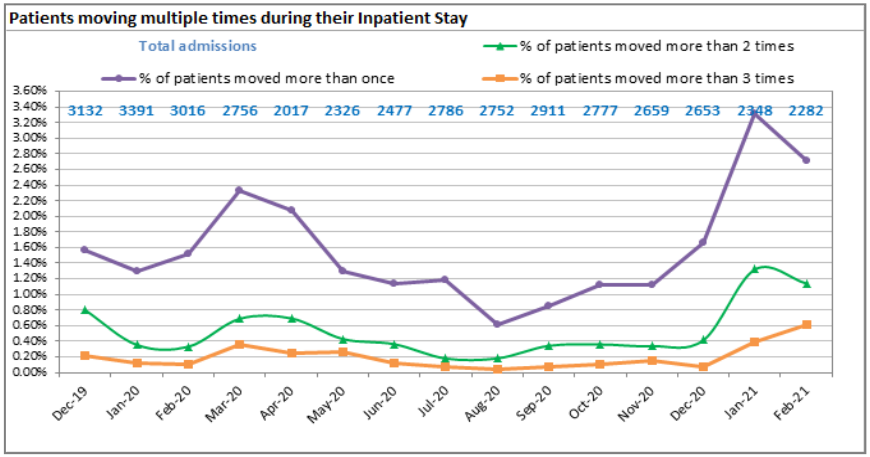
A Trust wide falls improvement plan with aggregated learning from SWARMs and serious incident inquiries is in place. There are plans to introduce a falls prevention facilitator to lead improvement work.

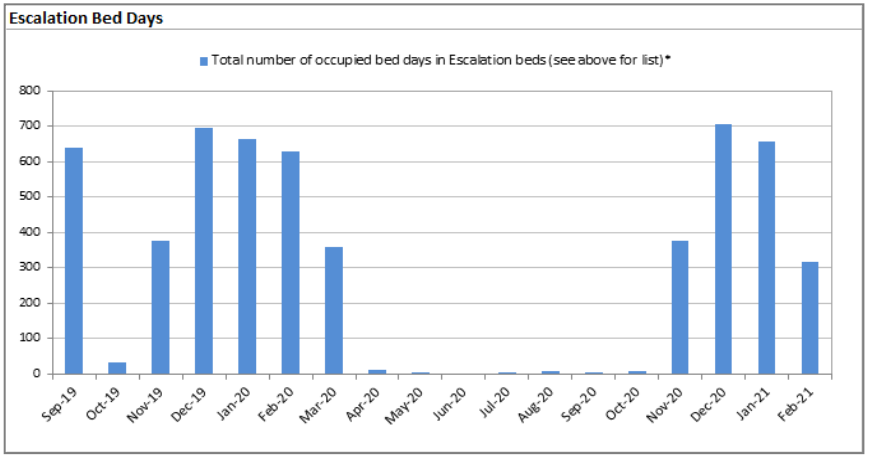
Patient Experience

Are We Safe?

Last 12 months	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
Bed Occupancy %	96.1	81.8	60.5	64.0	76.4	81.7	81.5	86.6	85.7	91.5	92.4	89.4

Data Quality Rating:





Summary and Action

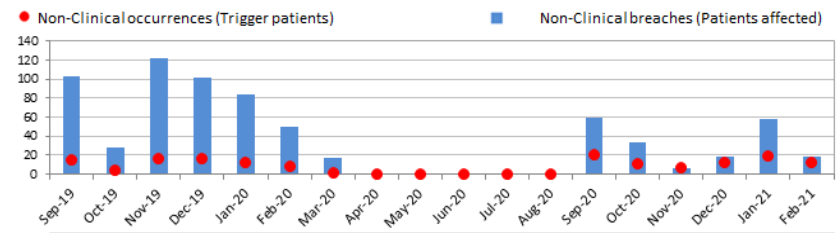
As the number of patients admitted with Covid-19 decreased in February, the number of multiple ward moves also decreased with the aim to continue separating Covid-19 positive from Covid-19 negative patients and maintain patient safety. The bed occupancy rate decreased to 89.4%.

Patient Experience

Are We Safe?

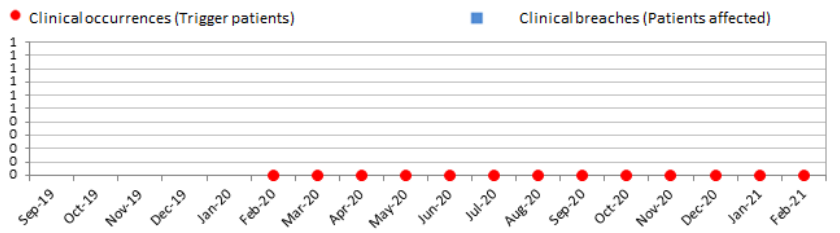
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
■	103	28	122	102	84	50	17	0	0	0	0	0	59	33	7	18	58	18
●	15	4	17	16	13	8	2	0	0	0	0	0	20	11	7	12	19	13

Delivering Same Sex Accommodation - Clinical



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

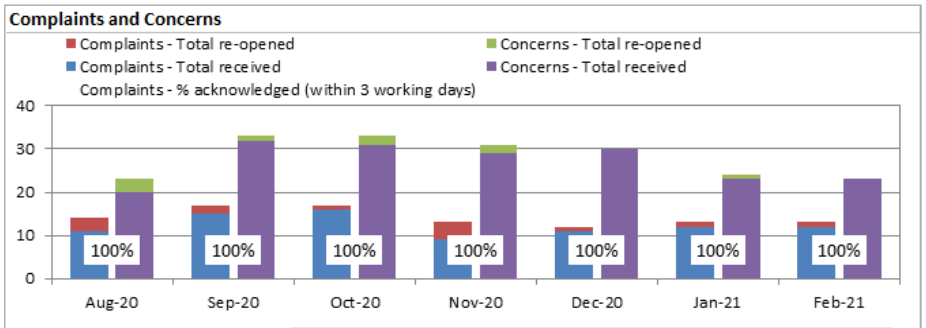
13 occurrences of non-clinical mixed sex accommodation breaches in February affecting 18 patients in the following areas:

- 11 breaches affecting 11 patients in Radnor ward. Privacy and dignity was maintained in the individual bed space. These were patients unable to be transferred to a general ward within 4 hours of the decision the patient was fit to move. The majority were resolved within 24 hours.
- 1 breach affecting 4 patients on AMU. Privacy and dignity was maintained with screens and separate bathrooms at each end of the assessment bay. The majority were resolved within 24 hours.
- 1 breach affecting 3 patients on Longford elective ward due to more female patients needing an overnight stay. The only space available was in a male bay and the patients were all unsuitable to be transferred to other wards as they were in a Covid-19 green pathway. The female patient was in the bay for 18 hours before discharge.

In September 20, NHSE&I notified the Trust that a pause on mixed sex accommodation data collection and publication will continue until March 2021. The Trust remains committed to a zero tolerance of mixed sex accommodation breaches unless there is an imminent threat to safe patient care.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Complaints - Total received	11	15	16	9	11	12	12
Complaints - Total re-opened	2	3	1	4	1	1	1
Concerns - Total received	32	20	31	29	30	23	23
Concerns - Total re-opened	1	3	2	2	0	1	0

Summary and Actions:

The top 2 themes for complaints include:

- Insensitive communication
- Further complications

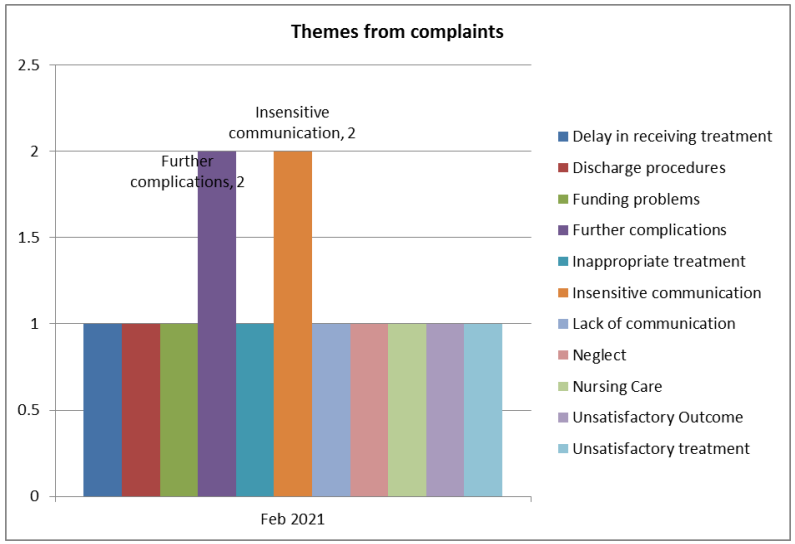
Top 3 themes form concerns include:

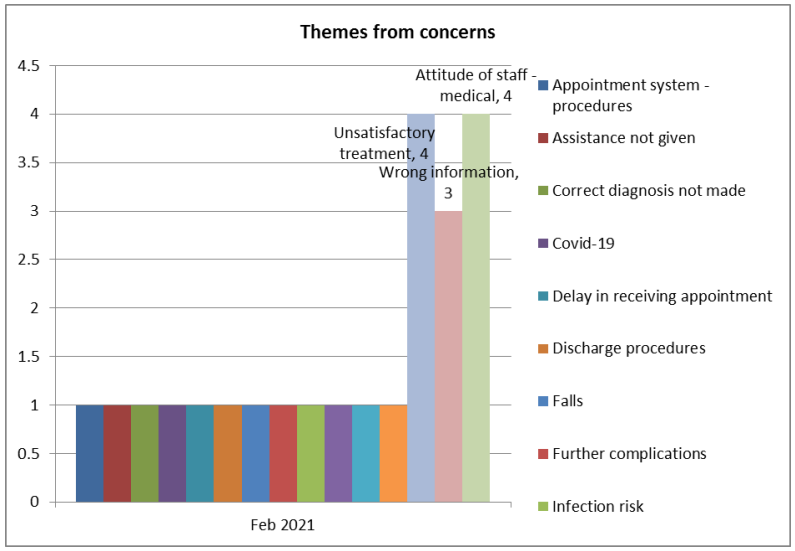
- Attitude of medical staff
- Unsatisfactory treatment
- Wrong information.

Example of actions which have arisen from complaints closed in February 21.

- Improved communications between the wards during transfers. The case to be discussed at the next clinical governance session.
- Amendments to be made to the community midwifery team's handover documentation, in order to clearly highlight those women with additional care needs. The Maternity Services are currently in the process of appointing a designated Bereavement Midwife. This appointment will provide the Maternity Department with the opportunity to expand the Service they offer to bereaved families, both in maternity and across the wider Trust.
- Learning from the case will be fed back to the workforce. Amendments have been made to the process of identifying ectopic pregnancies during ultrasound, thus ensuring that a second opinion is sought.

Data Quality Rating:





Part 3: Our People

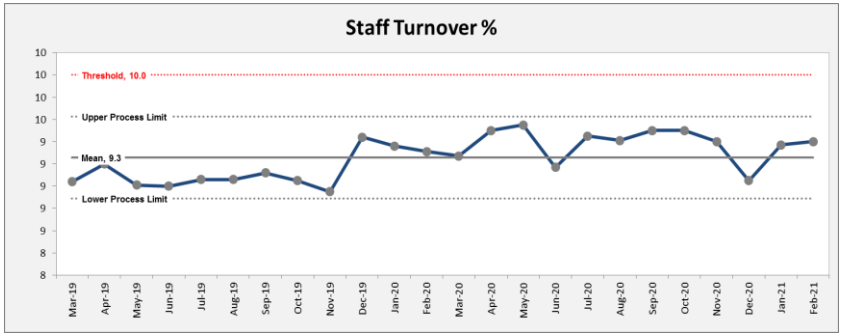
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

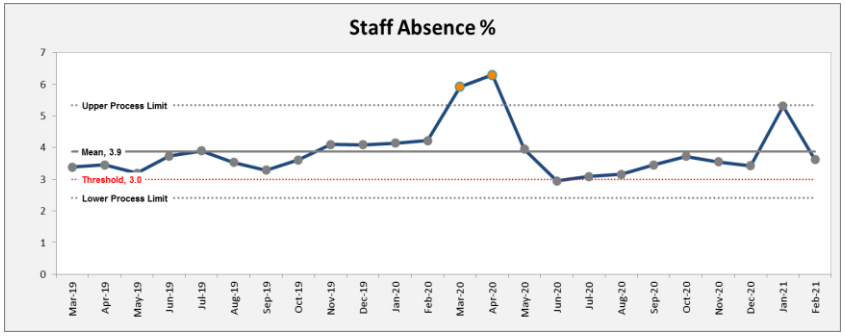
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Feb '21		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	450.4	(25.2)
Nursing	967.1	1,059.8	(92.7)
HCAs	425.2	486.0	(60.8)
Other Clinical Staff	623.8	652.5	(28.7)
Infrastructure staff	1,227.9	1,330.3	(102.4)
TOTAL	**3,669.1**	**3,978.9**	**(309.8)**





Summary and Action

Staff Turnover in month was 9.40%, slightly below target, in month 11 there were 24 leavers and 41 starters (by Headcount). This figure is comparative to month 10.

Work continues across all Divisions on hard to recruit posts, focus is currently on Radiographers and Consultants in Histopathology and Dermatology. Medicine have commenced the background work for the medical workforce review. All Divisions have plans in place to progress hard to recruit posts, such as advertising like to like posts through different platforms or remodelling the service to enable Associate Specialist level posts to be used.

In month 11 a total of 68 posts were advertised, with WTE of 82.97. This is an increase from month 10, but comparative to the number of vacancies advertised this time last year.

Work remains ongoing for HCA vacancies, with a further 13 in progress and more interviews scheduled for March.

Sickness – there was a significant decrease in sickness from 5.31% in month 10 to 3.62% for month 11.

16% of total absence was attributable to Covid-19. Sickness as a result of anxiety, stress and depression is now the top reason for sickness absence and is 24.2% of total absence.

All 3 Clinical Divisions were reporting Anxiety, Stress and Depression as the number one reason for sickness absence, with Covid-19 following second. As we are coming out of wave 2 of the pandemic the Trust is putting in place a number of support structures for staff wellbeing, such as clinical psychology, debrief sessions about the second wave and ways for staff to feed back to the Executives how they are feeling.

Currently there are 60 cases in stage 2-4 and 31 long term sickness cases currently being managed

Workforce – Nursing and Care

% Fill of Registered Nurse/HealthCare Assistant Shifts

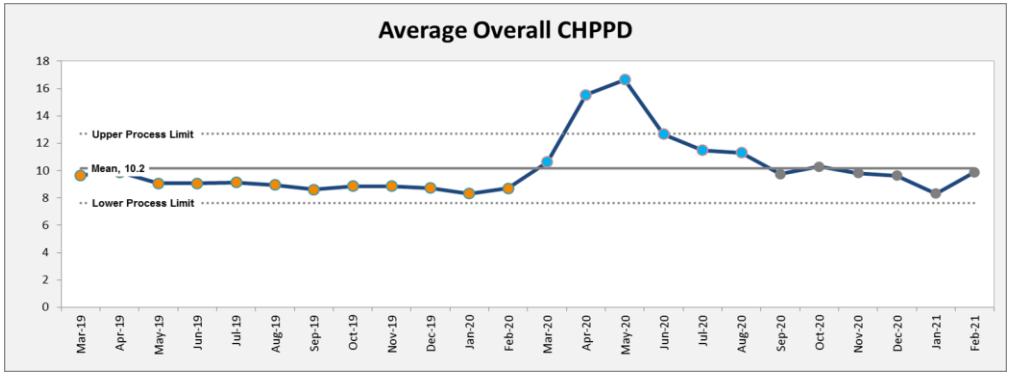
Table 1 – February Data

Day	RN	HCA
Total Planned Hours	37520	21760
Total Actual Hours	36470	17464
Fill Rate (%)	97%	80%

Night	RN	HCA
Total Planned Hours	25505	13588
Total Actual Hours	26814	11834
Fill Rate (%)	105%	87%

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

Table 2



Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for February. The graph on the right shows planned vs actual Care Hours per Patient Day at Trust level. (CHPPD is a simple calculation dividing the number of actual nursing/midwifery (both registered an unregistered) hours available on a ward per 24-hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.) The graph on the right shows the average overall CHPPD across all wards and the impact of bed closures for Covid-19 can be clearly seen in Wave 1 of the pandemic. The impact of wave 2 is far less defined and reminds on the caution related to CHPPD of viewing the data in an aggregated view when intended to be used at a local ward level, as there is wide variation on impact.

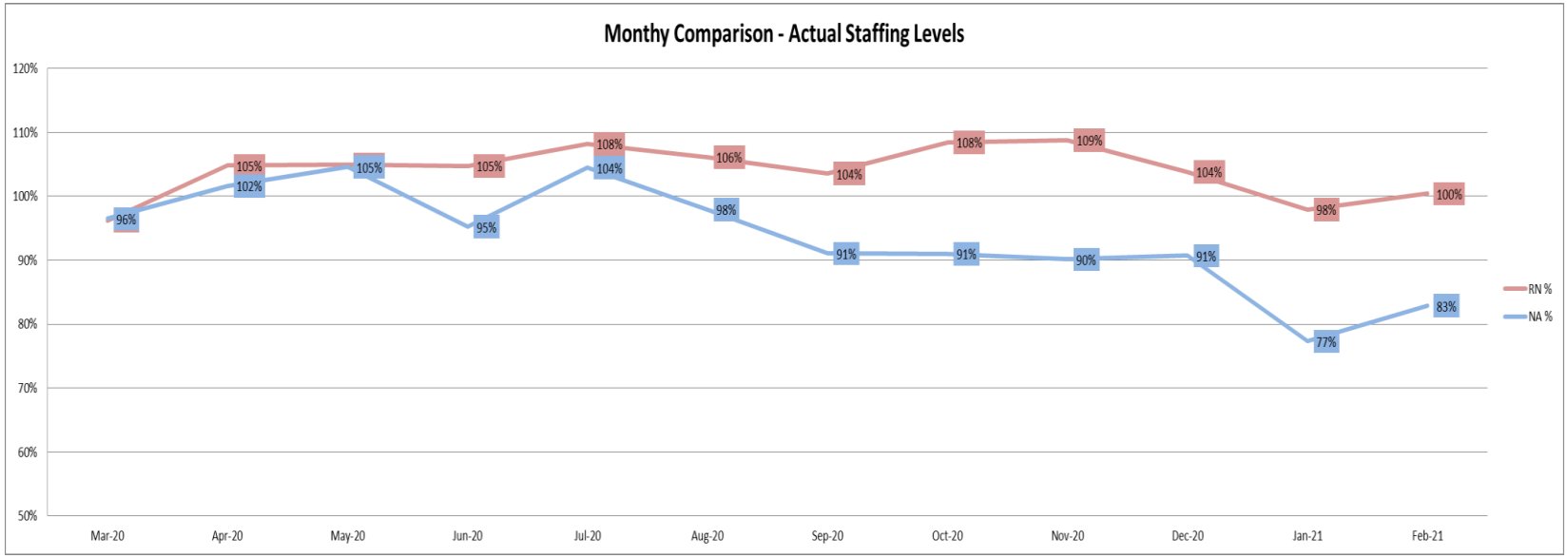
Table 1 shows the overall planned vs actual fill rate for February. Whilst these at first view indicate reasonable again the aggregated data masks significant shortfalls that were seen in some areas. Also areas such as ICU and RCU had uplifted staffing levels that would not be collated in planned but are captured in actual which distorts the data. Prior to wave 2 RN actual staffing levels had peaked as high as 109% so 100% average is a significant reduction and HCAs have dropped from 90% to 83% - graph of run rate over the months on next page (table 3). A minimum of twice daily staffing meetings continued to provide a review of actual staffing requirements during this period and a staffing SOP was introduced for rag rating of staffing levels and in some areas the red rating was breached. The skill mix of RN:HCA has remained fairly consistent with last month with RN 68% /HCA 32%, against broad recommendation is 65%:35% which is reflective of the successful RN recruitment campaigns.

2019/20 saw an overall nursing underspend. At the end of M11 (2020/21) there is a £1.7m overspend. Agency spend YTD is £266k in comparison to £1.7m for same period last year. Nurse staffing continues to be impacted by high risk / shielding staff needing to remain in non-clinical or extended leave ahead of maternity roles impacting on spend. In addition there is still additional pressure from areas requiring additional staffing due to Covid-19 e.g. ED RAZ, RCU and services such as Covid-19 testing.
Deep dives into nursing workforce spend been and skill mix review have been completed.

Provision of mental health support into paediatrics is also contributing to the agency spend

Workforce – Nursing and Care

Table 3



Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

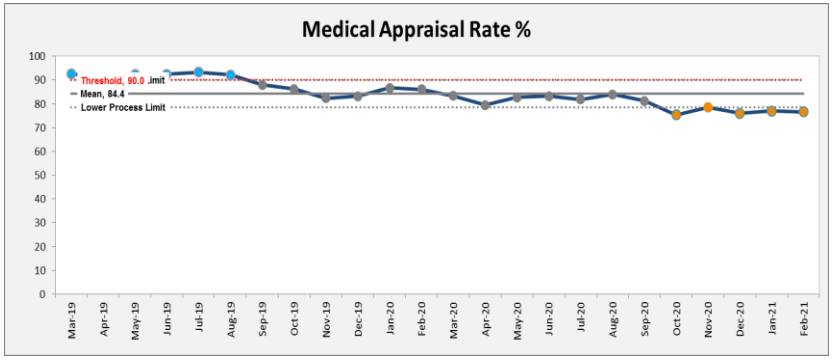
Mandatory and Statutory training overall is slightly above the 90% target at 90.38%, which is comparative to last month. For the same period last year compliance stood at 88.95%.

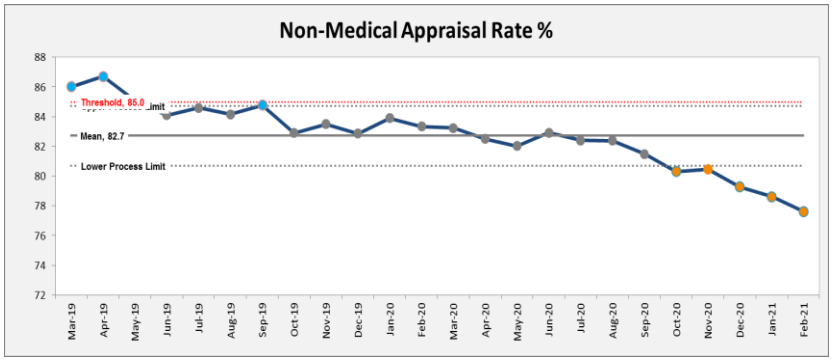
Two of the Clinical Divisions, Medicine and CSFS are slightly below target. CSFS have a detailed proactive plan in place to address this. Medicine are continuing to support those staff who have been heavily involved in the Covid-19 response coming back to BAU and as part of this process are putting plans in place to ensure training is up to date.

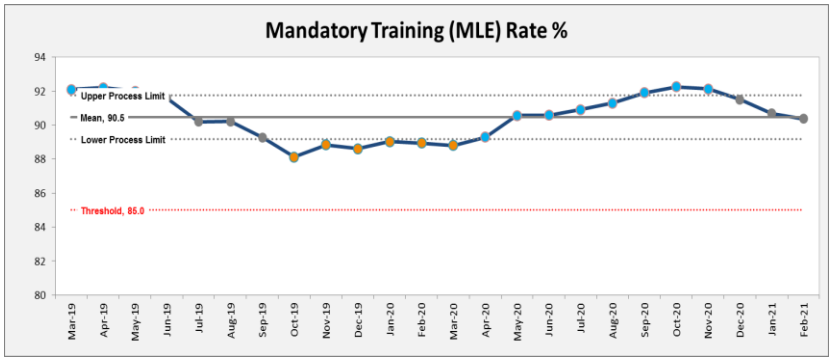
Reported subjects for lower compliance are Hand Hygiene and Safeguarding, the same as month 10. It is noted that issues regarding obtaining light boxes are being addressed to support compliance.

Non-medical appraisals remain comparative to last month at 77.62%. The year to date figure is 80.91%. As BAU returns the Clinical Divisions are all putting plans in place to schedule appraisals that have been delayed through the pandemic.

Medical appraisals remain under target, both Medicine and Surgery have seen improved figures in month 11 and the Clinical Directors and People Business Partner are continuing to put plans in place for further improvement.







Feedback from Friends and Family test

What was good about your experience?

February 2021

"Relaxed, friendly feeling during the whole of my infusion. The 2 nurses worked well together with giggles and laughter plus professional care. Each nurse passing jobs to one another knowing their own limitations. Great." ***Rheumatology***

"The pure care and dedication of your team has inspired me to listen, take on board their advise, put it into practice and aid my recovery for a degree. So thank you one and all." ***Odstock***

"Really well cared for from suffering Covid, kind, selfless and caring staff." ***Farley RCU***

"The staff are all friendly and helpful. Nothing was too much trouble, thank you" ***ED***

"The staff were friendly, and caring towards my little boy. They explained everything that was going to happen and at all times spoke to my son instead of me, which I feel helped. Having the TV to watch also made it very relaxing for both parent and child." ***Day Surgery Outpatients***

"Unfortunately I have been in wards and hospitals too often than I would wish. In general with a few exceptions, the experience has been very good but there should be an option to tick 'exceptional' in the case of Downton ward. Pleasant, friendly, most helpful staff who soldier on in the same view even when the odd customer is being difficult. All staff an absolute credit to the hospital and NHS" ***Downton***

"You the NHS are angels sent from heaven. Attentive to every need of every patient, even though at this time you are very stretched. Keep up your amazing work all of you and I applaud you all" ***Britford***

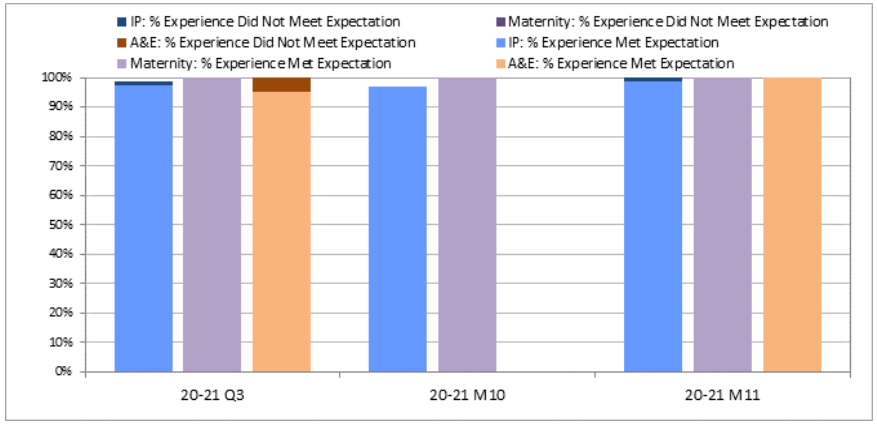
"Lovely ward with beautiful views and the most kind and caring staff. Such a friendly hospital. The nurses were so busy but still made time for me" ***Amesbury***

"Staff were professional and kind. I understood everything I was told and I knew what to expect. After procedure care was excellent." ***Endoscopy***

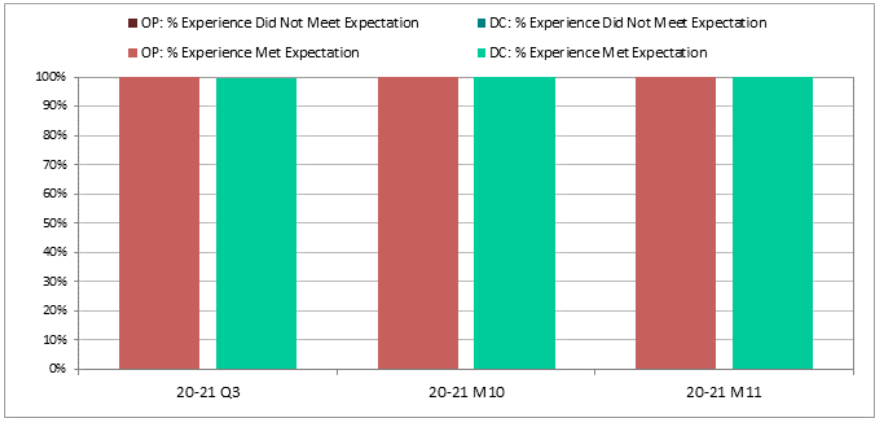
Friends and Family Test – Patients and Staff

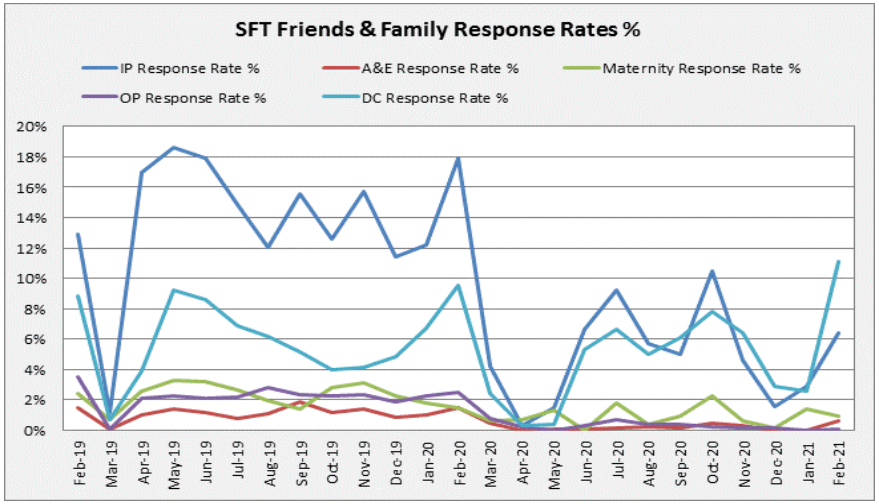
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





The overall response rate of the Friends and Family Test increased.

The figures in February (M11) are reported as the proportion of patients whose experience met their expectation or had not met their expectation. 1 (1.5%) inpatient reported a very poor or poor experience on 1 ward related to physiotherapy provision.

The previous slide provides some quotes from patients about what was good about their experience across a range of wards and departments.

The staff Friends and Family test was suspended this year due to Covid-19.

In September, the Best Place to Work discovery phase report was published which describes the experience of our workforce. The aim was to understand the culture and the 'way we do things around here' as these shape the behaviour of everyone in the organisation and directly affects the quality of care they provide.

The discovery work acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. A Board seminar was held on 11 February to discuss the top 3 themes and work towards a commitment to inform the Trust strategy.

Part 4: Use of Resources

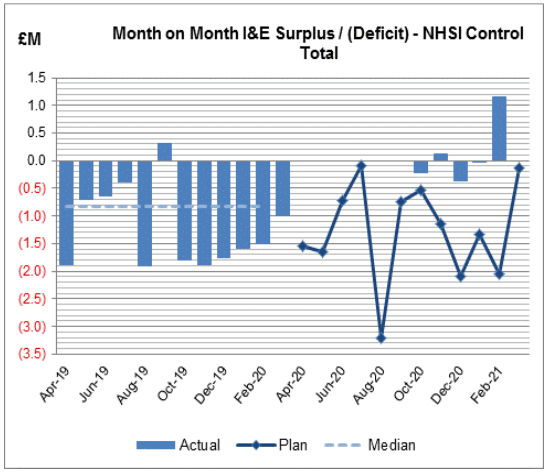
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Feb '21 In Mth			Feb '21 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	16,778	20,390	3,612	191,905	205,744	13,839	220,952
Other Clinical Income	864	710	(154)	9,519	5,771	(3,748)	0
Other Income (excl Donations)	2,416	5,486	3,070	26,576	41,370	14,794	28,992
Total income	**20,058**	**26,586**	**6,528**	**228,000**	**252,885**	**24,885**	**249,944**
Operating Expenditure							
Pay	(13,637)	(15,340)	(1,703)	(149,998)	(158,951)	(8,953)	(163,634)
Non Pay	(7,002)	(8,747)	(1,745)	(77,073)	(78,181)	(1,108)	(84,050)
Total Expenditure	**(20,639)**	**(24,087)**	**(3,448)**	**(227,071)**	**(237,132)**	**(10,061)**	**(247,684)**
EBITDA	**(581)**	**2,499**	**3,080**	**929**	**15,753**	**14,824**	**2,260**
Financing Costs (incl Depreciation)	(1,461)	(1,354)	107	(16,011)	(15,065)	946	(17,474)
NHSI Control Total	**(2,042)**	**1,145**	**3,187**	**(15,082)**	**687**	**15,769**	**(15,214)**
Add: impact of donated assets	*(48)*	*(62)*	*(14)*	*1,574*	*(554)*	*(2,128)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(2,090)***	***1,083***	***3,173***	***(13,508)***	***133***	***13,641***	***(13,588)***



Variation and Action

While the Trust continues to report against the original 2020/21 plan as a baseline for continuity reasons, a focus has shifted to the delivery of the Phase 3 forecast set out in page 7.

The plan had assumed a control total deficit of £2.0m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. Performance against the original plan is summarised in the table above. The Trust's improved performance against this target is due to the increase in funding made available to NHS providers in 2020/21. The Trust received further funding related to Covid-19 of £2.383m in month 11, relating to a national debate on the ability of Trusts to recover non-core contract income streams loss of income in the second half of the year, this has enabled the Trust to revise its forecast to that of a breakeven projection.

Notable is the increase in Pay costs versus those planned, with the temporary cessation of cost releasing efficiency schemes (although productivity schemes remain core to the phase 3 recovery). Pay costs directly related to Covid-19 now stand at £5.4m YTD.

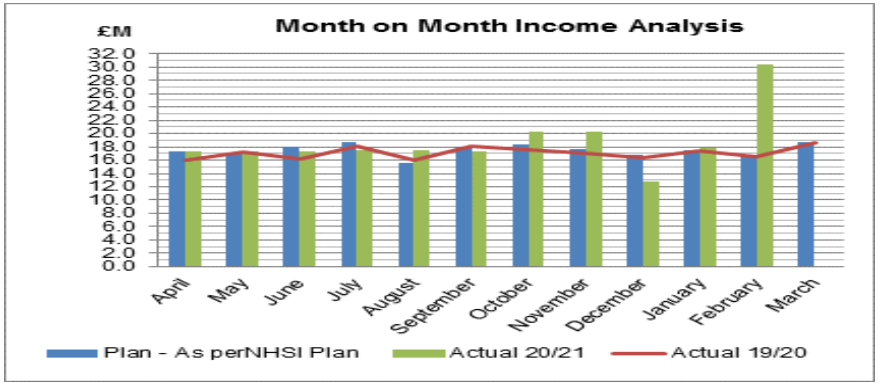
Loans due to DoH have been converted to PDC in 20-21 and as a consequence there is a favourable variance on loan interest payable. This is driving the under-spend on financing costs. The Elective Incentive Scheme (EIS) has been suspended.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Feb '21 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	8,465	7,088	(1,377)
Day Case	15,721	9,856	(5,865)
Elective inpatients	16,650	5,558	(11,092)
Excluded Drugs & Devices (Inc. Lucentis)	17,612	16,409	(1,203)
Non Elective inpatients	57,153	50,860	(6,293)
Other	46,383	94,701	48,318
Outpatients	29,921	21,272	(8,649)
TOTAL	**191,905**	**205,744**	**13,839**



SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s	Phase 3 Forecast (YTD) £000s	Phase 3 FC Var (YTD) £000s
BSW CCG	106,759	120,986	14,227	120,986	-
Dorset CCG	21,814	22,774	960	22,774	-
West Hampshire CCG	15,677	15,790	113	15,790	-
Specialist Services	29,910	29,942	32	29,726	216
Other	17,745	16,252	(1,493)	15,305	947
TOTAL	**191,905**	**205,744**	**13,839**	**204,581**	**1,163**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	66,153	47,130	(19,023)	63,670	(16,540)
Day case	20,794	13,366	(7,428)	21,176	(7,810)
Elective	4,411	1,933	(2,478)	4,488	(2,555)
Non Elective	25,508	23,079	(2,429)	25,155	(2,076)
Outpatients	232,534	195,659	(36,875)	232,811	(37,152)

Variation and Action

Activity in February has reduced below January across all of the main points of delivery with the exception of Elective. The most significant reductions by specialty are Gastroenterology Day cases, Trauma and Orthopaedics, General Medicine, Respiratory Medicine and Geriatric Medicine Non Elective spells and Urology, Ophthalmology and Respiratory Medicine Outpatients. General Surgery, Oral Surgery and Plastic Surgery were the main increases by specialty in Elective spells.

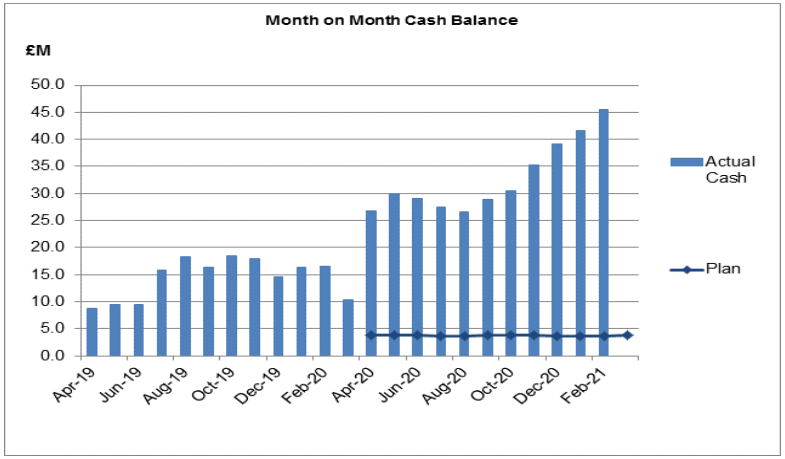
Covid-19 response contractual payment values with main commissioners were based on the Month 9 agreement of Balances (from a provider perspective), adjusted by 2.8% for inflationary pressures. From October onwards, Top up and Covid-19 funding is being received from BSW CCG c£2.5m per month and has been reclassified in month as Clinical income.

The underlying activity has been valued at less than the agreed block by £53,036k (26%) for the year to date due to the temporary cessation of non-urgent planned work and phased recovery response. The variance to the Phase 3 forecast is due to Specialist services High cost drugs and devices and Cancer drugs that sit outside of the block arrangements. The Elective Incentive scheme has now been suspended from November onward and no impact has been included within the position.

Cash Position & Capital Programme

Capital Spend: **Cash & Working:**

Use of Resources



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

Payments on account in advance up until 31st March 2021 have been received. The clawback of these funds will be in March 2021. Block contract payments for the first six months of 2021-22 will commence again in April 2021.

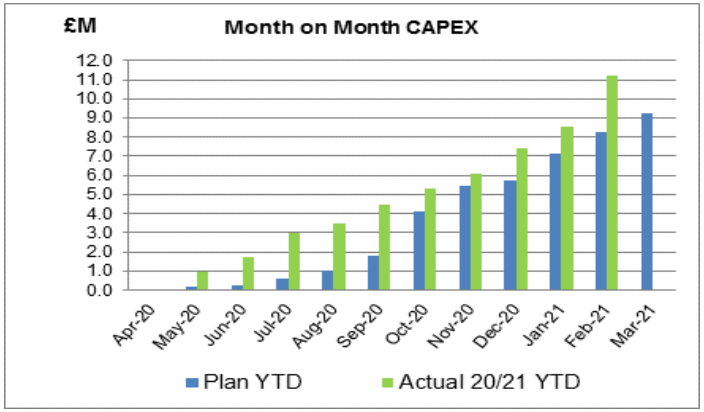
The Trust continues to hold considerable cash balances to cover the outstanding capital spend for the year. During February 2021 the Trust's cash position increased following the receipt of £0.649m additional PDC capital funding and £3.185m estimated compensation for deemed lost income due to Covid-19 in 2020-21. It is considered £0.325m of the latter funds will need to be returned.

The cash flow position will continue to be closely monitored to ensure any potential shortfalls are identified moving into 2020-21.

Borrowings have previously included £21m of working capital loans. These were repaid In September and funding was returned to the Trust simultaneously as Public Dividend Capital.

Capital Expenditure Position

	Annual	Feb '21 YTD		
	Plan	Plan	Actual	Variance
Schemes	**£000s**	**£000s**	**£000s**	£000s
Building schemes	850	850	96	754
Building projects	2,600	2,300	1,487	813
IM&T	2,600	2,300	3,226	(926)
Medical Equipment	2,778	2,400	1,366	1,034
Other	449	411	411	0
Addition: Critical Infrastructure Fund	3,455	2,505	989	1,516
Addition: Covid 19	6,773	778	3,622	(2,844)
TOTAL	**19,505**	**11,544**	**11,197**	**1,675**



Summary and Action

Delays in capital works at the end of 2019/20, including those due to the Covid-19 response, meant slippage into 2020/21. While agreed items were brought forward to offset a proportion of this slippage, the final 2019/20 outturn was c£900k short of that initially planned for. This has inevitably affected the phasing of the plan as the delays to committed spend has mostly been incurred in the first three months of 2020-21. The most material element falls in IT, where the Microsoft environment replacement project phases out Windows 7.

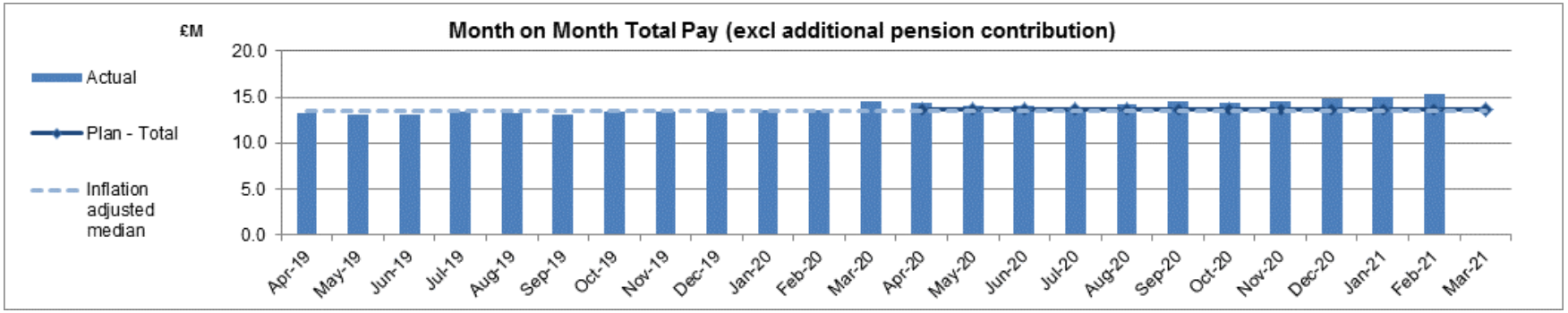
In addition to the Critical Infrastructure Fund of £3.455m, the Trust has received notification of various Covid-19 approved schemes totalling £7.895m in the year. These schemes are all funded through additional Public Dividend Capital. The Trust has still to receive cash of £1.107m relating to this additional capital. These funds are expected to be received during March 2021.

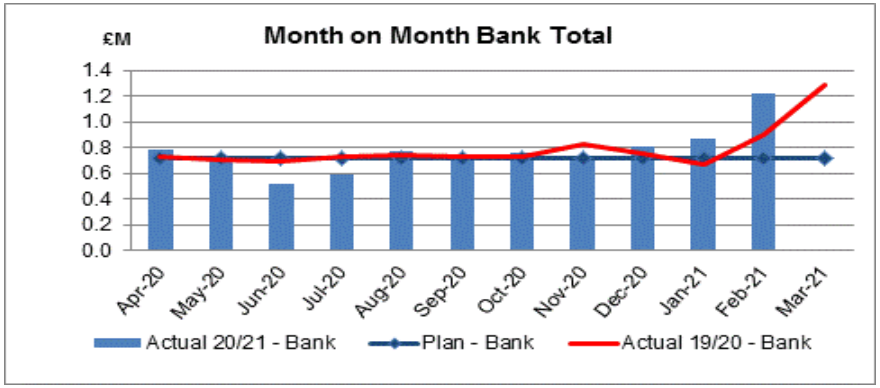
As a result of the considerable additional funding allocated to the Trust in the year, substantial funds still remain to be spent in order to achieve a balanced capital position for 2020-21. The short timescales given to the Trust to spend these funds by NHSE/I, together with the impact of the latest lockdown period means there is a significant risk the Trust will be unable to achieve a balanced position by 31 March 2021. The Trust has identified a potential shortfall of circa £2m against the total in year capital allocation. The matter is being discussed by the Regional Office with opportunities to redeploy funds being explored. A draft capital programme for 2021-22 has been compiled and is being reviewed in the context of this risk of slippage.

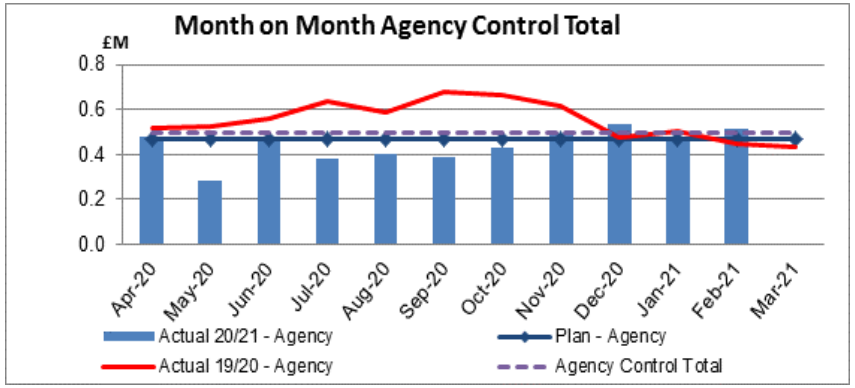
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure increased by £0.3m, or 2.0%. This was driven by an increase in Infrastructure staff costs (£337k), which in turn were due to Covid-19 and vaccination costs and also a technical adjustment reflecting the bank staff costs worked.

The costs directly driven by the Covid-19 response have now reached £5.4m, 62% of which relates to hours worked by the Trust's existing workforce, though a combination of redeployment from BAU duties and additional hours. The high costs seen in month 10 have continued into month 11 due to the level of Covid-19 activity; bank nursing, junior doctor additional shifts and ancillary staff are the areas mainly affected.

In addition to these directly reported costs, analysis has been undertaken on the reduced availability of rostered staff (caused by a variety of reasons including sickness, self-isolation, shielding etc.), this now stands at c30%, Trust 2020/21 budgeted assumptions had been 19%. The Trust's strong recruitment position means that despite this reduction in availability, there have been sufficient temporary staffing availability to limit the increase in unfilled shifts (thought this does however lead to increased costs).

The Trust's WTE increased by 94 wtes month on month, almost entirely in temporary staffing, and particularly in infrastructure staff, which accounted for 57 wtes of the increase. Of the increase in infrastructure staff 19 wte were due to covid related activity, particularly the centrally funded vaccination programme, while overall staffing in Salisbury trading increased by 13 wte due to an increase in activity. There was an increase of 17 wte in infrastructure staff in the clinical directorates, mainly in junior admin grades.

There was an increase of 17 wtes in medical staff, 10 of which were accounted for by an increase in junior grades as part of the training rotation. Agency medics increased by 4.17, mainly in Medicine.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.7
Date of Meeting:	08 April 2021		

Report Title:	Covid-19 Response			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The attached presentation is provided to update the committee on the Covid-19 response

Executive Summary:

The number of Covid-19 positive inpatients in the Trust continued to reduce (from 101 on 1st Feb to 37 on 28th Feb) in M11 as the rates of community transmission moved past the peak. The impact in ITU was slower to reduce, moving from 8 patients at the start of the month to 6 by the end of the month.

Throughout the month ward areas were slowly returned to their usual functions as the Covid-19 bed base reduced.

As sadly expected, deaths continued to rise beyond the peak in community cases, and a further 27 deaths from Covid-19 occurred in the hospital in M11. By far the majority of deaths have occurred in ward areas, the Trust is offering staff various wellbeing and support options, recognising the impact this may have had on some staff.

Staff absences related to Covid-19 continued to reduce throughout February, from 84 on 1st February down to 42 by 28th February.

The vaccination centre onsite will reopen in March to begin the rollout of the second dose of Covid-19 vaccine to staff, health & social care staff and some patient groups.

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

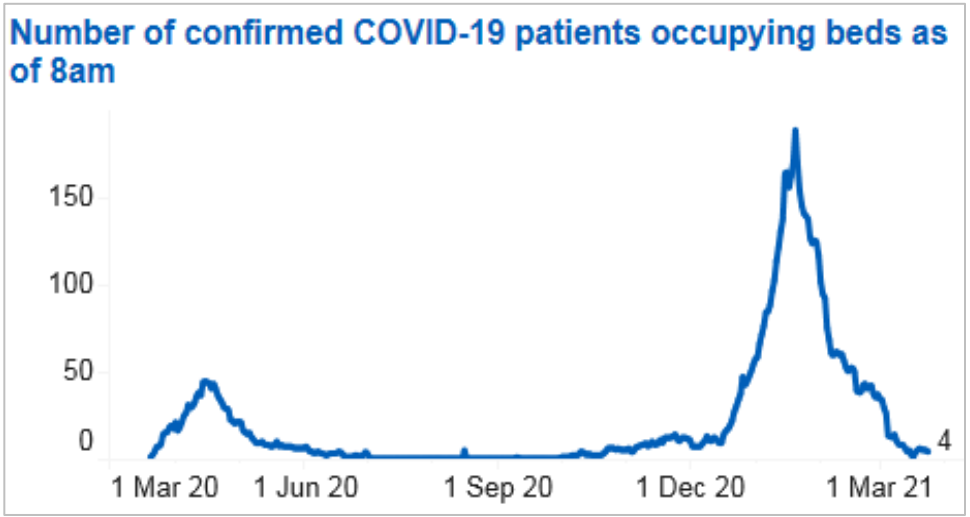
SFT COVID-19 Briefing

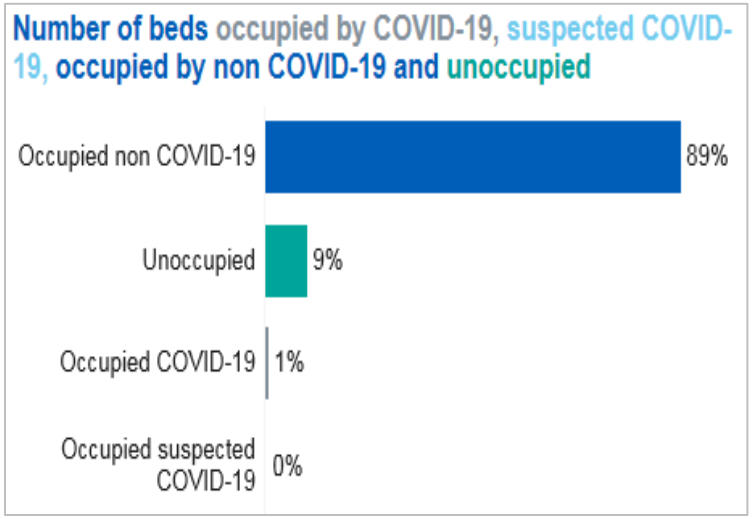
24/03/2021

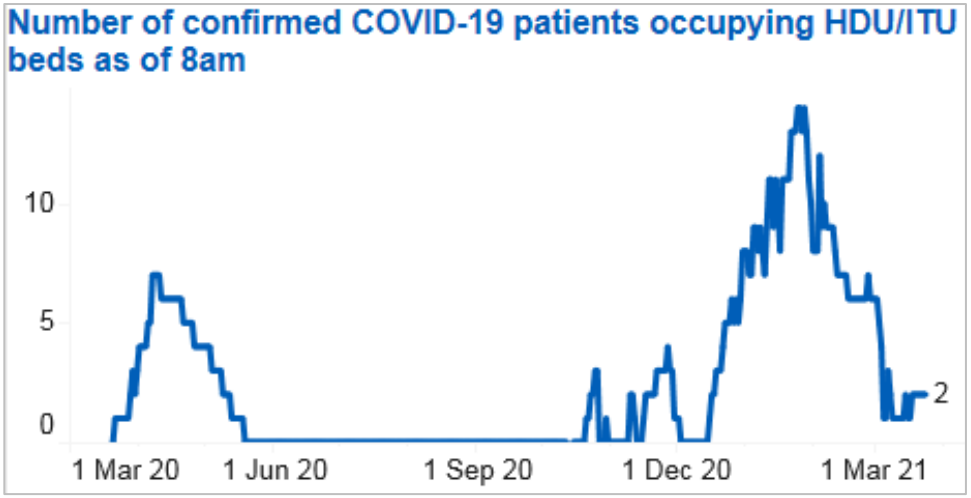
An outstanding experience for every patient

Covid-19: bed occupancy

Additional Supporting Information







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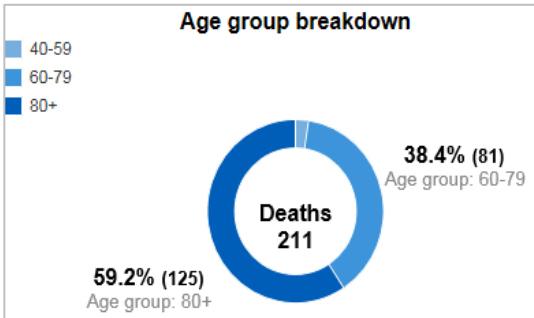
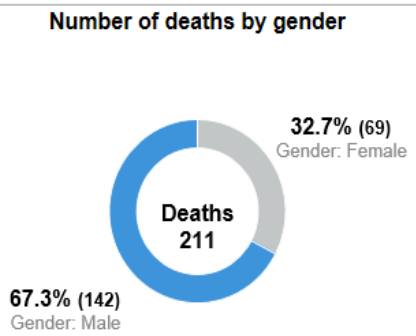
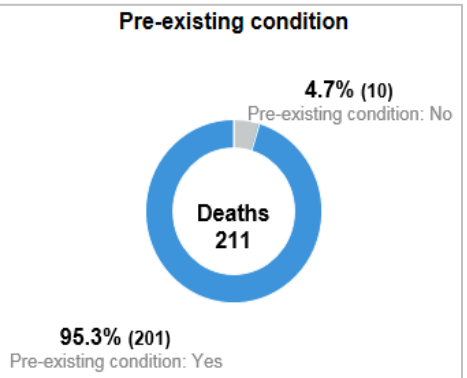
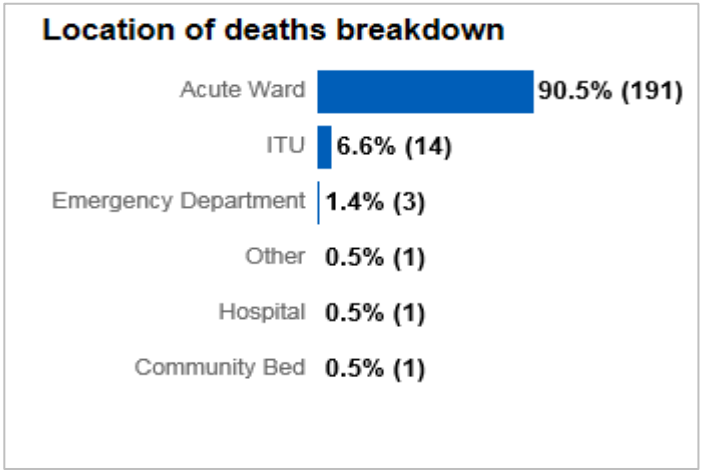
Covid-19: mortality

Additional Supporting Information









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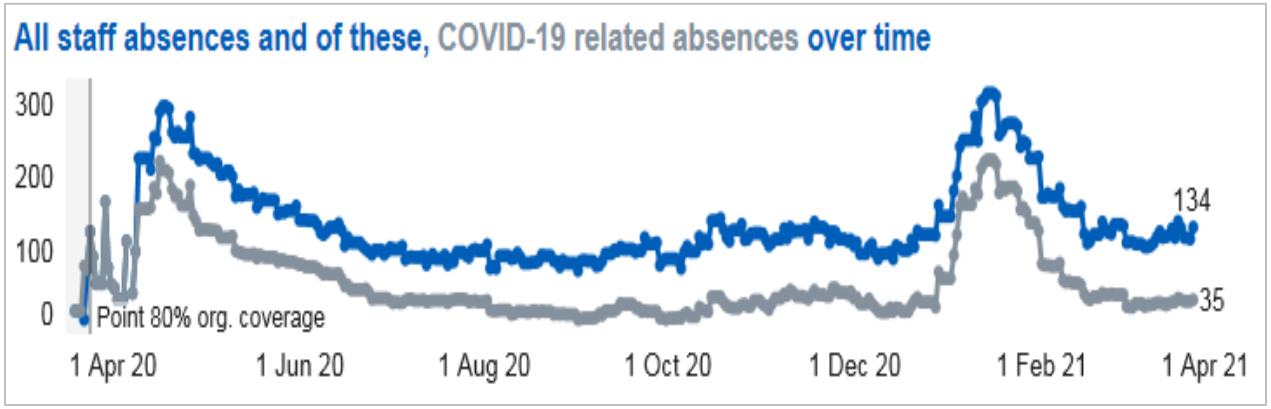
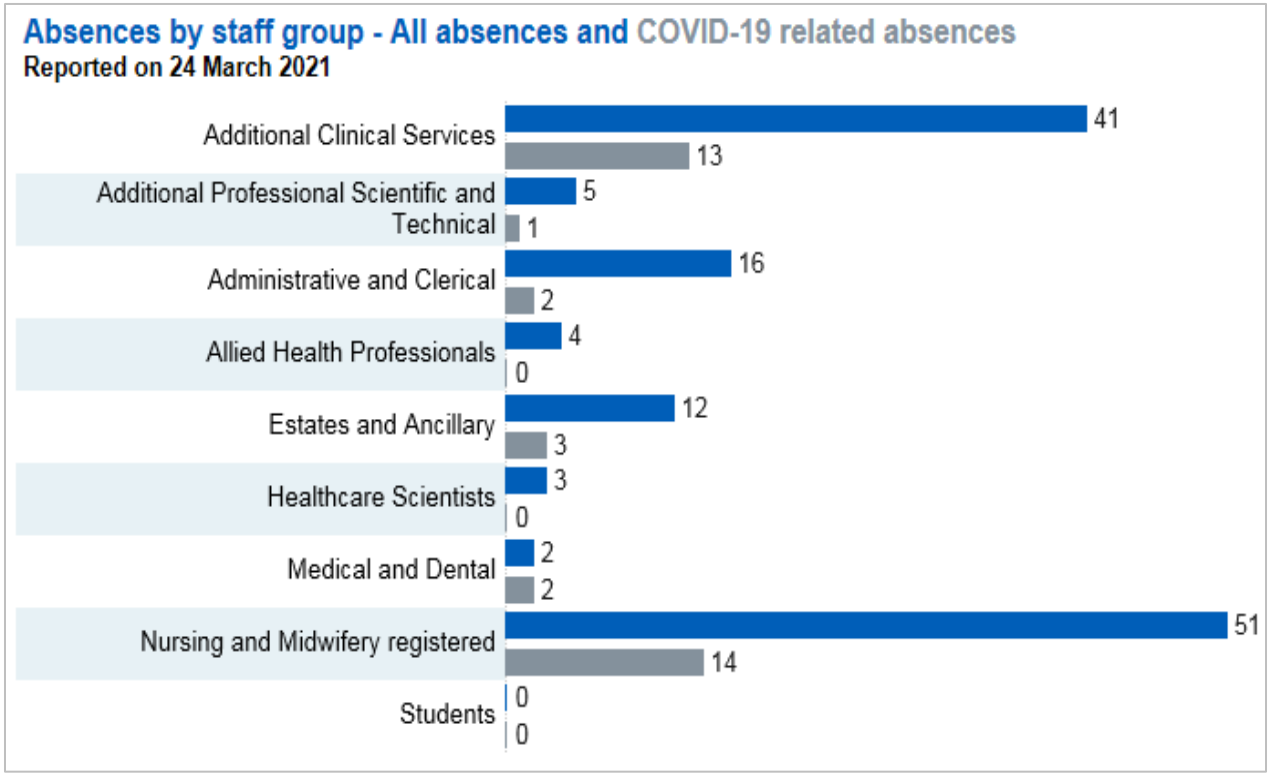
Covid-19: workforce

Additional Supporting Information





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NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	08 April 2021		

Report Title:	Board Assurance Framework and Corporate Risk Register Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x	x	
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	Appendix 1: PWC Risk Radar Healthcare Tool Board Assurance Framework v2 March 2021 (draft) Draft Corporate Risk Register March 2021 v2.1 Draft Summary CRR tracker v20 March 2021			

Recommendation:

The Trust Board are asked to review, discuss and make any updates to the following:

- Board Assurance Framework (BAF)
- The Corporate Risk Register (CRR)
- The Corporate Risk Tracker

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current risks
- Review the corporate risk register to ensure that it accurately reflects the corporate risks and related actions with particular attention to mitigating actions, risk score and residual risk score.
- Review the principle risks and any associated gaps in control or assurance identified against the delivery of the strategic priorities and review delivery of associated actions
- Review the gaps in control and assurance against delivery of the 2020/21 corporate objectives and review associated actions to address these gaps

Executive Summary:

Summary

The risk profile across all strategic priorities has seen a significant shift since the January 2021 report with 7 new risks, 4 risks removed and 6 risks with score changes.

The Trust adopted the use of a risk radar tool provided by the Internal Auditors to inform

review of strategic risks and any potential gaps as part of the Executive meeting discussion.

The risks on the current CRR were mapped against the tool and this identified a gap in risks associated with stakeholder engagement/reputation and political and regulatory change. Strategic risks within these domains have been considered and these additional risks have been reflected in this March update. Following a meeting with the Director of Finance and Associate Director of Strategy, it was acknowledged that the tool did not reflect population health and demographics and therefore this is being addressed as part of a Board workshop in April regarding the Trust strategy and strategic risk.

Following the March Board Committees, further risks for consideration include:

- Mental Health provision, particularly in relation to CAMHS (Clinical Governance Committee)
- Delays to recruitment of the surgery division Director of Operations (People and Culture Committee)
- Covid recovery and waiting list management (Finance and Performance Committee and Clinical Governance Committee).

Extreme risks

- 5970 (Innovation) - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff (Score 16).
- 6779 (Care) - Risk of inconsistent and uncoordinated tracking of patient progress along cancer diagnostic and treatment pathways provides opportunities for missed or delayed cancer diagnosis (Score 16).
- 6654 (Local) - The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance (Score 15).
- 6471 (Resources) - Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services (Score 15)
- 5751 (Local) - Risk of patient harm caused by a delayed discharge from hospital (Score 15).
- 6834 (People) - As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave (Score 16).
- 6247 (Resources) - Risks associated with critical plant and building infrastructure that may result in utility or system failure (Score 12 to 16).

New risks

- 6825 (Specialist) - The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service (Score 10). This replaces risk 5966 which has been removed.
- 6836 (Care) - There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety (Score 12).

- 6834 (People) - As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave (Score 16).
- 6857 (Resources) - There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses (Score 6).
- 6858 (Resources) - There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives (Score 9).
- 6855 (Resources) - The financial regime for 2021/22 is uncertain, Covid-19 has meant a delay to the planning guidance and suspension to the existing regime. This places significant uncertainty on the ability to develop a financial plan to support the Trust delivering its objectives for 2021/22. There is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures (Score 12). This risk replaces risk 6470.
- 6856 (Resources) - Due to Covid-19, the guidance for the 2021/22 planning round has not been released. There is a risk that the Trust will not deliver key objectives aligned to operational, activity and workforce plans (Score 12). This risk replaces risk 6472.

Risks removed

- 6787 (Local) - The Trust is commissioned to provide a 2 pod vaccination hub at the City Hall which is new service provision set up at pace.
- 5966 (Care) - Risk of compromised services due to hub and spoke model. This risk has been replaced with risk 6825.
- 6472 (Resources) - Due to Covid-19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year. This risk has been replaced by risk 6856.
- 6470 (Resources) - Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged resulting in the Trust having to take emergency measures. This risk has been replaced by risk 6855.

Risks with an increased score

- 6247 (Resources) - Risks associated with critical plant and building infrastructure that may result in utility or system failure (Score 12 to 16).

Risks with a decreased score

- 6782 (Local) - As a result of a significant increase in Covid-19 patients in the Trust, there is a risk the Trust will become overwhelmed which may result in compromised patient care, staffing levels, patient and staff experience and well-being and operational efficiency of the hospital (Score 20 to 12)
- 6570 (Care) - Risk of Covid-19 outbreaks within the Trust either for staff and/or patients (Score 16 to 9)
- 6487 (People) - Risk of not being able to safely staff ward areas, ED and Critical Care as a result of the potential second wave of Covid-19 (Score 16 to 4).
- 6781 (Resources) - Risk of audit, governance oversight and data management for a

number of services and reporting streams being delayed due to redeployment of staff to support front line services during the peaks of the wave 3 pandemic and the vaccination programme (Score 12 to 6)

Deep Dive

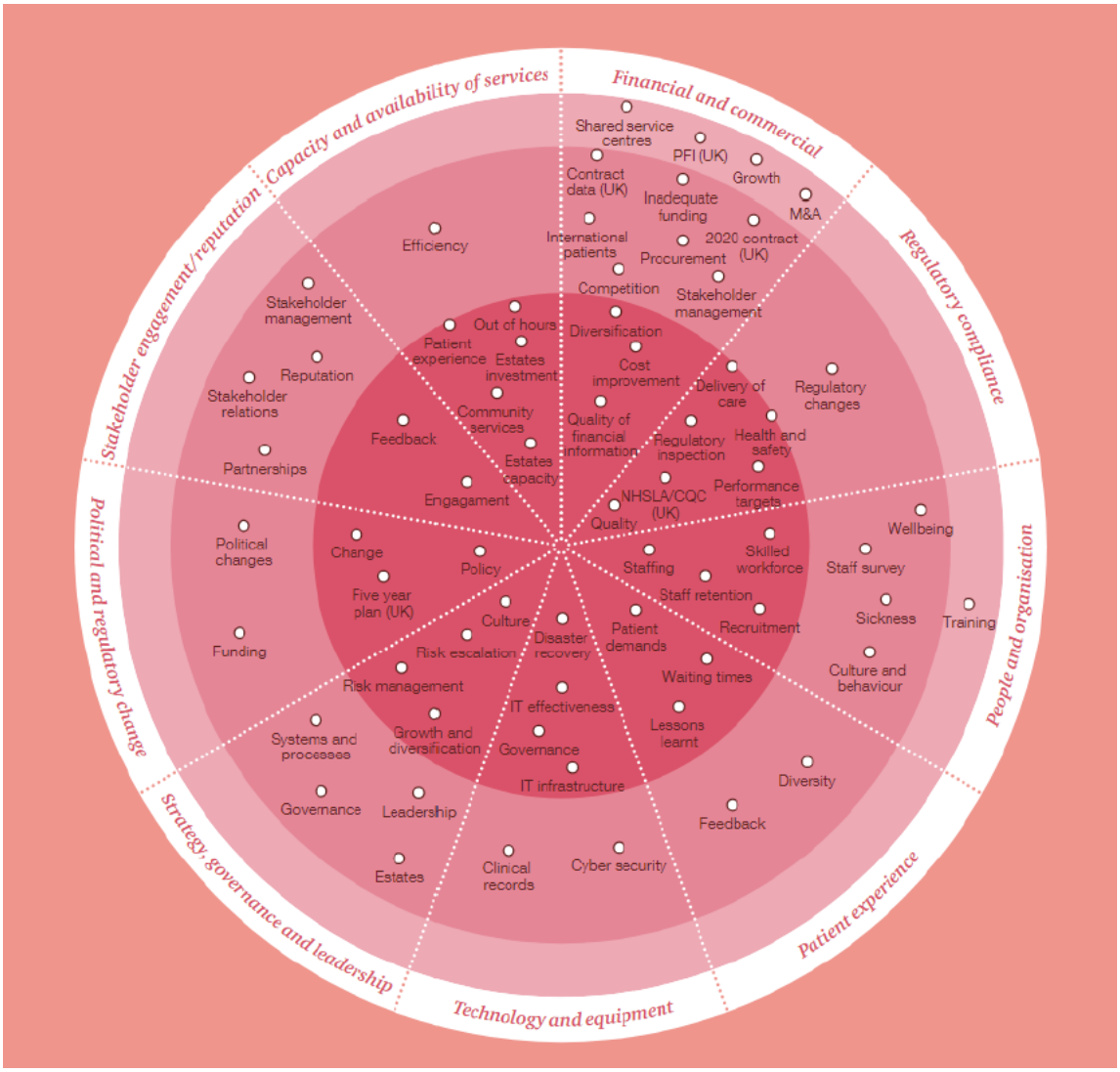
The Board approved the criteria for the initiation of a deep dive of a risk on the corporate risk register in February 2020. The criteria is set out below:

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

Risk 6471 has triggered a deep dive as this has been scored at 15 since March 2020. The Director of Finance is reviewing this risk and this will be reported back to Board Committees. There has been a delay in completing the deep dive due to other priorities in dealing with the response to Covid.

Risk 6043 has triggered a deep dive as a corporate risk score <16 unchanged for 12 months. This risk is under review by the Director of Finance.

Appendix 1: PWC Risk Radar Healthcare Tool



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	☒

Board Assurance Framework

Incorporating the revised Corporate Objectives for 2020/21

2020/21

Trust Vision: An Outstanding Experience for Every Patient

V2 March 2021

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

Strategic Priorities

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

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

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

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

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

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

Board Assurance Framework – Glossary

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

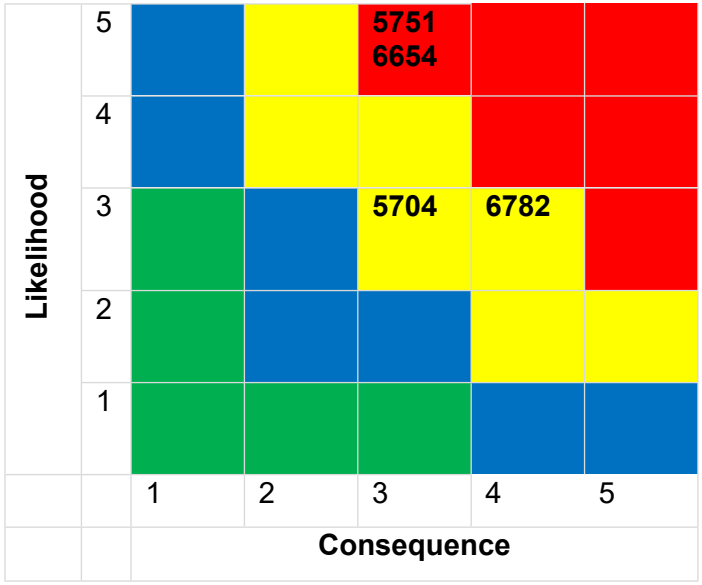
	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

Strategic Priority: Local Services

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

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

Distribution of Corporate Risks for Local Services



5704 – Inability to provide a full gastroenterology service due to a lack of medical staff capacity
5751 – Patient safety risk due to high numbers of delayed transfers of care due to lack of community capacity
6654 - The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance
6782 - As a result of a significant increase in Covid-19 patients in the Trust, there is a risk the Trust will become overwhelmed which may result in compromised patient care, staffing levels, patient and staff experience and well-being and operational efficiency of the hospital

Linked risks
5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.(Innovation)
6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care (Care)
6825 - The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service (Specialist)

Principle Internal Risk: Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population	
Key Controls	**Assurance on Controls**
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Engagement with commissioners and system (Elective and Urgent Care Boards) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Recruitment process for vacant posts • Executive engagement in all ICS workstreams	• Integrated performance report • Performance review meetings with CCG • Whole system reports (ICS) • Performance reports to weekly Delivery Group • Divisional performance reviews • Governance assurance map • BAF and CRR
Principle External Risk: Managing the complexity of relationships with our partners to lead and share our joint strategy plans for a place based integrated care system	
Monitoring information	**Areas of influence**
• Integrated Performance Report – impact on metrics • Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard) • STP Operational Plan	• Requested improvement trajectories for decreased attendances and delayed transfers of care • STP Executive Board (CEO) • STP Sponsorship Board (CEO and Chair) • Wiltshire Integration Board (CEO) • Stakeholder meetings / engagement • Acute Hospital Alliance

2020/21 Corporate Objectives – Local Services

Objective	Target Measures
Develop with partners initiatives to ensure patients do not stay in hospital any longer than they need.	• Achieve average of 30% discharges before 1200 • Reduce Super Stranded Patients to 14%

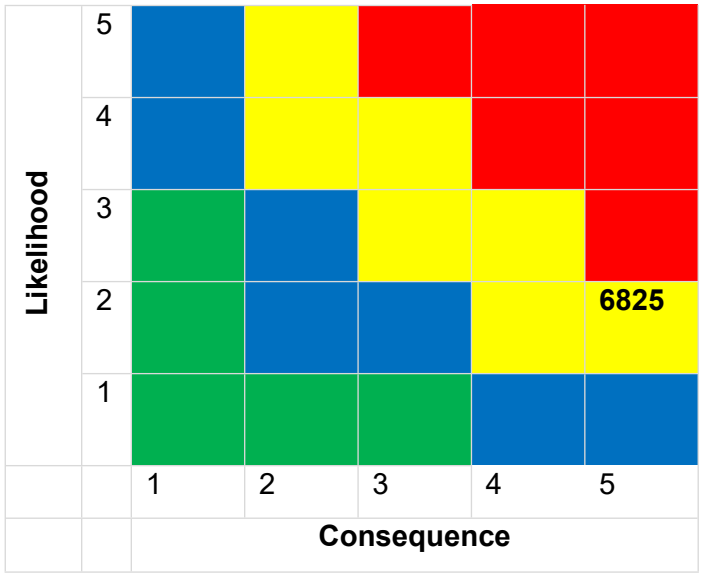
Gaps in Control/Assurance	Action	Deadline	Lead
Local Authority adopting a change to the approval process for packages of care (GC)	Chief Operating Officer to liaise with the CCG *October update: Process change adopted. Lack of assurance due to increasing numbers of medically fit stranded patients. Action closed. New action below*	Review 30/09/2020 *Reviewed – action closed*	Chief Operating Officer
	Discharge workstream with new project lead to meet weekly to drive improvements in discharge pathways	31/12/2020 In place – action complete	Chief Operating Officer
Community capacity being directed to areas with Covid-19 peaks (GC)	No internal action		
During the peak of the pandemic, system processes were not sufficient to support the required volume of patients to be discharged	Initiate a Trust programme for Right to Reside	30/04/2021	Chief Operating Officer
	Full implementation of the programme	30/09/2021	Chief Operating Officer
	Audit of compliance	31/12/2021	Chief Operating Officer

Strategic Priority: Specialist Services

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

Executive Lead: **Medical Director** **Reporting Committee:** **Clinical Governance Committee**

Distribution of Corporate Risks for Specialist Services



6825 - The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service

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

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

2020/21 Corporate Objectives – Specialist Services

Objective	Target Measures
Refresh the clinical strategy	• Strategy approved by CGC, and implementation plan agreed.

Gaps in Control/Assurance	Action	Deadline	Lead
Current strategy does not reflect changes in service delivery as a result of: • Covid pandemic and recovery phase • Shift in national priorities • Understanding how specialist services affect relationships at an ICS and Regional level	Refresh of the Clinical Strategy to reflect changes and Phase 3 proposals	~~30.10.2020~~ Revised date ~~31/3/2021~~ 30/06/2021 *Interim update to CGC in December 20 – Board agreement for final strategy by June 2021*	Medical Director

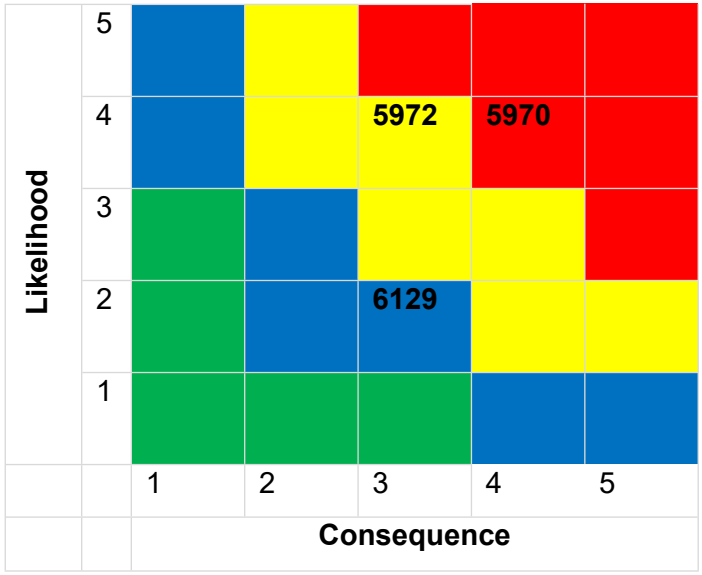
Strategic Priority: Innovation

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

Executive Lead: **Director of Transformation**

Reporting Committee: **Clinical Governance Committee**

Distribution of Corporate Risks for Innovation



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

5972 – Risk that improvement and transformation is not delivered in a timely manner

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

Principle Internal Risk: Risk of a lack of capability and capacity to deliver innovation	
Key Controls	**Assurance on Controls**
• Transformation, Innovation and Digital Board • QI Operational plan and improvement strategy • QI Steering Group • People and Culture Committee • Clinical Governance Committee • Research Governance Framework • F&P Committee • Trust Board • IT Improvement Plan • Digital Strategy Implementation Plan • Shared Acute Alliance EPR Progamme Board • BSW system capability workstream • Joint Acute Alliance improvement approach	• Model Hospital benchmarking • NIHR Wessex compliance reports • QI KPIs to evaluate success • Staff survey • Committee effectiveness review • Internal reports to F&P Committee, Trust Board and CGC • Executive performance reviews • EPR programme reports and plan • BSW system capability reports • Acute Alliance reports

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

2020/21 Corporate Objectives – Innovation

Objective	Target Measures
No Going Back programme - Embed the use of virtual outpatient appointments	• 60% of outpatient appointments carried out virtually

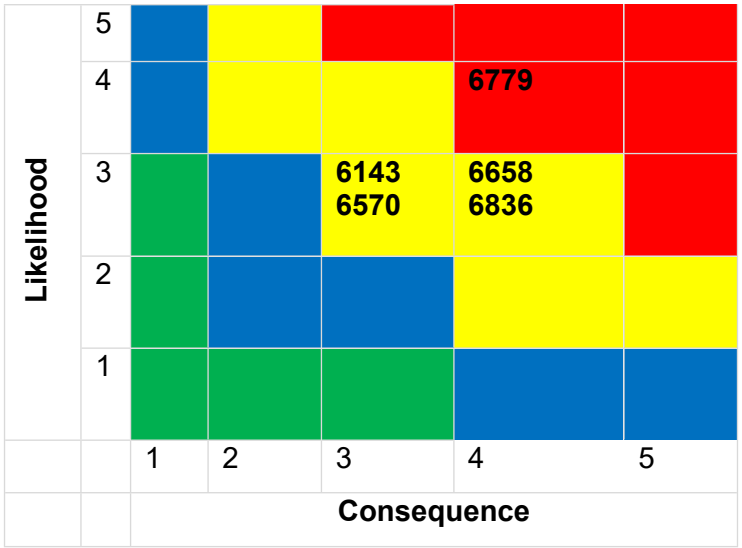
Gaps in Control/Assurance	Action	Deadline	Lead
Reduction in virtual appointments since April (36% in September, 29% in December 2020) (GA) Phase 3 recovery plan performance against target: • 25% of all appointments carried out virtually – SFT Dec 29% • 60% of all follow-ups carried out virtually – SFT Dec, 31%	Delivery of Phase 3 recovery actions to increase the use of virtual appointments *October update: Additional actions below to address compliance*	Review 31/10/2020 *Review complete* ~~Review 31/12/2020~~ Revised date 31/05/2021	Director of Transformation
	Increase oversight and accountability of the percentage of virtual appointments through Executive Performance Reviews	Commencing October 2020 Complete – included within EPR dashboard	Chief Operating Officer
	Increase clinical engagement targeting challenged areas by Deputy Medical Director	Commencing October 2020	Deputy Medical Director
	Adoption of National Service Redesign Best Practice. *Action replaced with the below (Dec 2020):* Ground up review to establish all clinics that are suitable for virtual and all clinics that can be virtual by default	~~31/12/2020~~ ~~31/03/2021~~ 31/05/2021	Deputy Medical Director/Clinical Leads/ Director of Transformation
	Delivery of training for clinical staff to conduct virtual appointments *March 21 update: Regional offer. Pilot in SFT ranging across specialties*	~~31/03/2021~~ Revised date 31/05/2021	Deputy Medical Director/ Director of Transformation
	Offer patient choice regarding type of appointment	31/03/2021 Revised date 31/05/2021	Deputy Medical Director/Clinical Leads/ Director of Transformation

Strategic Priority: Care

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

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

Distribution of Corporate Risks for Care



6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care
6658 - Maternity service inability to complete serious incident actions within expected timeframes leading to concerns regarding failure to embed learning. Further concerns have been raised via the FTSUG in relation to cultural behaviours
6570 - Risk of Covid-19 outbreaks within the Trust either for staff and/or patients
6779 – Risk of inconsistent and uncoordinated tracking of patient progress along cancer diagnostic and treatment pathways provides opportunities for missed or delayed cancer diagnosis
6836 - There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety

Linked Risks
6825 - The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service
5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Local)
5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Local)

Principle Internal Risk: Insufficient resources (skilled staff and infrastructure) to deliver safe effective care	
Key Controls	**Assurance on Controls**
• Integrated Governance Framework • Accountability Framework • Clinical and HR policies and procedures • Workforce plan • Clinical Governance Committee • Clinical Management Board • People and Culture Committee • Divisional Performance Meetings • Contract Quality Review Meeting / contractual monitoring • Annual audit programme (national and local) • GIRFT Programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Infection Control Board Assurance Framework • Learning from Deaths Policy • Appraisal and revalidation of doctors	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime – last inspection report March 2018 • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Internal Audit report on morbidity and mortality meetings • GIRFT reports and action plans • Annual appraisal quality assurance review • 15 steps reviews • Weekly patient safety summit • CQC engagement with specialist services • Ward performance reviews

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

2020/21 Corporate Objectives – Care

Objective	Target Measures
1. Implement the National Patient Safety Strategy 2. Agree a Quality Assurance Framework incorporating ward accreditation and ward performance review process 3. Ensure that service delivery during the COVID-19 recovery phase is supportive of changing staff and patient needs.	• Patient Safety Strategy implementation plan agreed with time lines for delivery signed off • 2 Pilot wards undertaken first full ward accreditation and 100% of wards have undertaken first Ward Performance Review • Review of IPC Covid-19 BAF with Trust Board signoff. Target 90 % compliance with KLoE

Gaps in Control/Assurance	Action	Deadline	Lead
Lack of ward accreditation system (GC)	Development of a ward accreditation system	31/03/2021	Director of Nursing
Lack of a clinical summary dashboard (GC)	Development of a clinical summary dashboard	~~31/12/2020~~ Review 31/03/2021 *Delay due to Covid. Work in progress. Ward performance review data pack in place as an interim solution. Pilot dependent on dashboard. 100% of wards have had a review*	Director of Nursing
External estates review identified inadequate ventilation standards (GA)	Executive lead task and finish group to oversee delivery of the estates action plan	Commenced – in place	Chief Operating Officer
	Quotes for critical areas requested by Chief Operating Officer *October update: Action closed. All critical risks mitigated and reviewed on a regular basis by Execs and F&P Committee*	Review 30/09/2020 Complete	
	Appoint additional 0.3wte microbiologist	30/09/2020 Complete – in post	

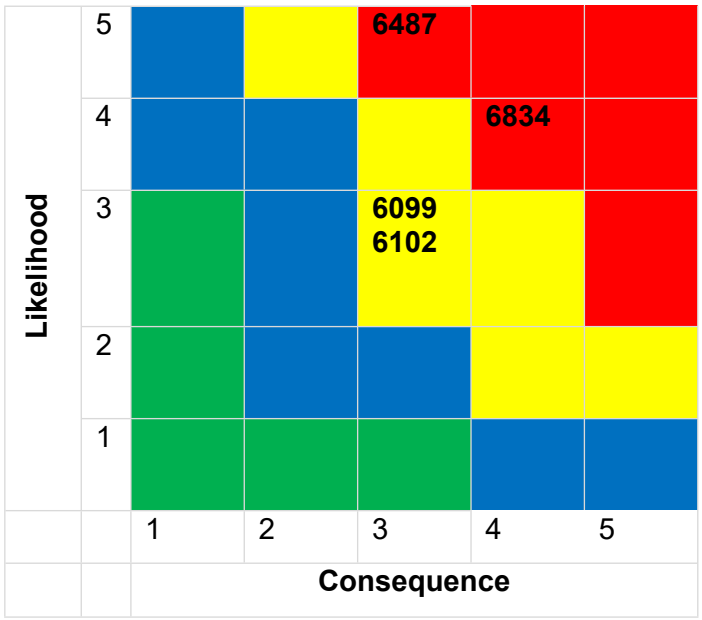
Gaps in Control/Assurance	Action	Deadline	Lead
Non-compliance with Constitutional standards (GA)	Weekly monitoring of recovery through the Delivery group	Elective recovery being managed through Phase 3 recovery plan which is reported to F&P and Board	Chief Operating Officer
Infection Prevention Board Assurance Framework non-compliance regarding anti-microbial stewardship (GA)	Re-commencement of anti-microbial ward rounds	30/09/2020 Complete – re-started	Director of Nursing
Awaiting formal patient safety strategy guidance			

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:** **People and Culture Committee**

Distribution of Corporate Risks for People



6099 - Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services.
6102 - Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service.
6487 - Risk of not being able to safely staff ward areas, ED and Critical Care as a result of the potential second wave of Covid-19
6834 - As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave

Principle Internal Risk: Risk that the Trust will be unable to recruit and sustain an engaged and effective workforce	
Key Controls	**Assurance on Controls**
• People and Culture Committee • OD & People Management Board • Health and Wellbeing strategy Board (from 19/7) • HR Policies • Directorate Performance meetings • People strategy Delivery Board • Safer Staffing Group • Equality, Diversity and Inclusion Committee (launch 29 July) • Health and Safety Committee • Freedom to Speak Up Guardians • JCC Staff Side Meeting • JLNC Committee (medical staff) • Vacancy control group • People Plan • Best Place To Work Programme	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • Integrated Performance Report at Board • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report • Health and safety annual report • Guardian of safe working report • Volunteers annual report • Monthly Workforce Dashboard at EWC • Executive Safety Walks

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

2020/21 Corporate Objectives – People

Objective	Target Measures
• Best Place To Work Programme	Staff survey: • 65% response rate • Equality, Diversity and Inclusion score 9.4 • Health and Well-being score 6.5 • Staff engagement score 7.5

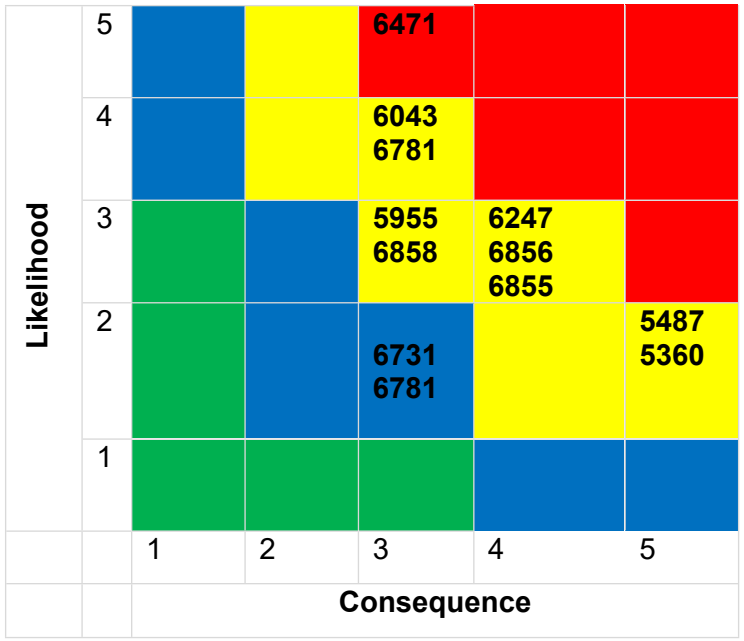
Gaps in Control/Assurance	Action	Deadline	Lead
No current identified gaps in control or assurance			

Strategic Priority: Resources

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

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

Distribution of Corporate Risks for Resources



5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
5955 - Insufficient robust management control processes
6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT
6247 - Risks associated with critical plant and building infrastructure that may result in utility or system failure.
5360 - Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss.
6857 - There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses
6858 - There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives
6855 - The financial regime for 2021/22 is uncertain, Covid-19 has meant a delay to the planning guidance and suspension to the existing regime. This places significant uncertainty on the ability to develop a financial plan to support the Trust delivering its objectives for 2021/22. There is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures
6471 – Shortfall in funding available for capital programme with potential risk to safety and availability of buildings and equipment to deliver services.
6731 - This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach.
6781 - Risk of audit, governance ovbersight and data management for a number of services and reporting streams being delayed due to redeployment of staff to support fron line services during the peaks of the wave 3 pandemic and the vaccination programme
6856 - Due to Covid-19, the guidance for the 2021/22 planning round has not been released. There is a risk that the Trust will not deliver key objectives aligned to operational, activity and workforce plans

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities	
Key Controls	**Assurance on Controls**
• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • Transformation Board • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan • Acute Alliance Programme Board • Local urgent and planned care boards	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement

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

2020/21 Corporate Objectives – Resources

Objective	**Target Measures**
With Partners, develop BSW Integrated Care System	• ICS rated as maturing by April 2021

Gaps in Control/Assurance	Action	Deadline	Lead
Lack of National guidance on finance regime for 2020/21 M6+ and future years	No internal action		
Unclear guidance beyond this financial year making planning for 2021/22 challenging	No internal action		
Increased spending in 2020/21 in response to Covid-19 and Phase 3 recovery	To ensure control totals agreed for 2020/21 for Divisions and monitoring in place	November 2020 Action complete	Director of finance

Corporate Risk Register
March 2021

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	Risk Owner	Date Escalated to Corporate Risk Register
6487	Quality Directorate	Trustwide	04/06/2020	COVID-19/Coronavirus	12	As a result of the potential second wave of the Covid-19 pandemic there is a risk that the Trust will not be able to safely staff ward areas, Emergency Department and Critical Care. Not being able to safely staff these areas may result in patient harm, staff undertaking duties for which they are not fully prepared, creating a risk to patient safety, poor patient experience and the quality of fundamental standards of care. Specifically, pressure injury, nosocomial infection, falls and other patient safety issues.	Do not expect it to happen again but it is possible	Minor	4	Agree rebased staffing levels for ICU and RCU.	30/11/2020	05/01/2021	Hyett, Fiona	Trust Board	30/04/2021	4	People (Care)	Trust Board (Corporate Risk Register)	Director of Nursing	Hyett, Fiona	10/07/2020
										Continue recruitment of nursing staff.	01/09/2020	30/10/2020	Holt, Sharon								
										Ongoing upskilling of the nursing workforce.	01/04/2021	09/03/2021	Hyett, Fiona								
										Continuation of the returning workforce and paid student placement programmes.	14/08/2020	10/07/2020	Hyett, Fiona								
										Twice daily staffing review using safe care and roster data.	30/09/2020	10/07/2020	Hyett, Fiona								
										Work with Exec Director of OD&P regarding management of shielding staff.	30/09/2020	03/11/2020	Dyos, Judy								
										Review of Covid Risk Assessment process in light of new guidance.	31/12/2020	07/01/2021	Lane, Lynn								
										Revision of the re-deployment list and development of role descriptors for non-clinical staff.	12/01/2021	09/03/2021	Dunn, Bernie								
6129	Transformation & IM&T	Information Technology	19/12/2019	Trusts Objectives	20	There is a risk that the Trust does not deliver the IT Improvement Plan, which may result in compromised patient care, inaccurate reporting, loss of IT systems, financial and reputational loss, and breaches to data regulations (e.g. GDPR)	Do not expect it to happen again but it is possible	Moderate	6	Develop and produce monthly update and highlight report	16/01/2020	02/03/2020	Burwell, Jonathan	Executive Director Meeting	31/03/2021	4	Innovation	Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	20/12/2019
										Complete internal service delivery model review (desktop exercise)	16/01/2020	02/03/2020	Burwell, Jonathan								
										Procure support to deliver a service delivery model review of hot spots, including options appraisal and recommendations	13/01/2020	21/02/2020	Provins, Esther								
										Executive team review and decision on recommendations arising from external service delivery review	21/02/2020	21/02/2020	Provins, Esther								
										Board seminar to appraise Board of Directors as to agreed way forward regarding IT Service Delivery Models.	05/03/2020	02/03/2020	Provins, Esther								
										Add in to digital update in April 2020 next steps from the service model review informed by on the recommendations from PWC and linked to key elements of IT improvement plan.	10/05/2020	07/05/2020	Burwell, Jonathan								
										pwc final assurance review to be completed.	28/02/2021	24/02/2021	Burwell, Jonathan								
										Create and finalise management action plan from pwc internal audit report.	10/03/2021		Provins, Esther								
6731	Operations Directorate	Trustwide	19/11/2020	Trustwide risk assessment	8	This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach. The worst case planning assumptions the flow rate through the straits could reduce to 60 -80%.	Do not expect it to happen again but it is possible	Moderate	6	D20 - will be a standing agenda item on the IMT daily meetings D20 - information from central and national teams is being cascaded through the SFT SPOC, which is monitored 7/7 08.00 - 20.00 UK GOV D20 alerts have been subscribed to by TM, and this if received are cascaded to the D20 group The D20 group can be stood up as a separate entity if required	29/01/2021	05/03/2021	Merrifield, Tracey	Covid 19 SCG (Strategic Coordination Group)	30/04/2020	1	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	19/11/2020

Corporate Risk Register
March 2021

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	Risk Owner	Date Escalated to Corporate Risk Register
6781	Quality Directorate	Trustwide	12/01/2021	COVID-19/Coronavirus	12	Risk of audit, governance oversight and data management for a number of services and reporting streams being delayed due to redeployment of staff to support front line service during the peaks of the wave 3 pandemic and the vaccination project.	Do not expect it to happen again but it is possible	Moderate	6	Executives to review reporting streams and prioritise functions	28/02/2021	09/03/2021	Dyos, Judy	Trust Board	14/05/2021	6	Resources	Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	12/01/2021
										Vaccination of front line staff to reduce sickness aiming for 90 % by 28/2/2021	14/05/2021		Hyett, Fiona								
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	May recur occasionally	Minor	6					Departmental Team meeting	30/04/2021	4	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	12/03/2021
6858		Trustwide	12/03/2021	Trusts Objectives	9	There is a risk as new guidance and models of working emerge the immaturity of partnerships between SFT and wider BSW organisations will impact on progress to achieve key objectives.	May recur occasionally	Moderate	9					Trust Board	30/04/2021	6		Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	12/03/2021
6143	Quality Directorate	Trustwide	20/12/2019	Trustwide risk assessment	16	Risk that inadequate medical staffing in the organisation (due to insufficient budgeted workforce and/or failure to recruit and retain staff) will impact on the ability of the Trust to maintain safe and effective services across 7 days.	May recur occasionally	Moderate	9	Weekend safety and effectiveness action plan reported to Board on a quarterly basis.	01/04/2020	28/04/2020	Blanshard, Dr Christine (Inactive User)	Trust Board	31/03/2021	6	Care	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	02/01/2020
										Report containing triangulation of all relevant information and associated action plan to be submitted to Clinical Governance Committee.	30/06/2020	07/07/2020	Blanshard, Dr Christine (Inactive User)								
										Reinstate the weekend working Task and Finish Group.	31/03/2021	24/02/2021	Collins, Peter								
										The work reviewing the weekend working arrangements to be carried out as part of the Medical Division workforce review and overseen by new Medical workforce group.	31/05/2021		Henderson, Dr Stuart								
										Physicians Associates training programme to be commenced.	01/09/2021		Davies, Miss Sallie								
										Medical e-roster business case to be refreshed by Medical Director and reconsidered by TIG and TMC.	31/05/2021		Collins, Peter								
										Medical Workforce recruitment and retention strategy to be developed through Medical Workforce Group.	31/05/2021		Collins, Peter								
6099	Organisational Development and People	All clinical areas	06/12/2019	Other assurance not listed	12	Risk of not being able to recruit to posts identified as hard to recruit. Risk is that they will remain hard to fill with the result that we are forced to continue costly Agency/Locum support and/or outsourcing and/or discontinue services.	May recur occasionally	Moderate	9	Head of Resourcing to focus further time on Recruitment issues and to feedback to Deputy Director of OD and People	28/02/2020	03/02/2020	Holt, Sharon	Executive Workforce Committee	31/05/2021	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Holt, Sharon	14/02/2020
										Review and update of Directorate action plans to be undertaken monthly with Head of Resourcing, BP's, DM's and CD's. This includes planning for 2020/2021.	30/06/2020	06/07/2020	Holt, Sharon								
										Follow up with Lead Clinicians possible leads for specific vacant posts and provide support as required.	30/06/2020	06/07/2020	Holt, Sharon								
										Business case for funding for marketing and branding expertise to be resubmitted to TIG.	30/10/2020	11/11/2020	Holt, Sharon								

Corporate Risk Register
March 2021

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	Risk Owner	Date Escalated to Corporate Risk Register
6102	Organisational Development and People	Trustwide	06/12/2019	Other assurance not listed	16	Risk of being unable to fill Medical Workforce Gaps which may include posts identified as hard to fill. Risk is that they will remain hard to fill with the result that we are forced to continue costly Agency/Locum support and/or outsourcing and/or discontinue services	May recur occasionally	Moderate	9	Head of Resourcing to focus time on Medical Recruitment issues and to feedback to Deputy Director of OD and People	31/01/2020	03/02/2020	Holt, Sharon	Executive Workforce Committee	31/03/2021	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Holt, Sharon	14/02/2020
										Lead Clinicians to follow up with potential recruitment leads for specific posts	30/06/2020	06/07/2020	Holt, Sharon								
										Hard to recruit plans to be routinely updated with Head of Resourcing, BP's, CD's and DM's	31/12/2020	06/07/2020	Holt, Sharon								
										Attendance at Doctors Job Fair (29 February 2020). To report back on success of event and any actions required.	31/03/2020	26/05/2020	Holt, Sharon								
										Review of current recruitment process to ensure efficient and conducted in timely manner to mitigate against the potential loss of candidates applying for positions.	29/02/2020	26/05/2020	Holt, Sharon								
										Successful recruitment to Medical Workforce Manager post.	31/10/2020	08/01/2021	Craine, Sarah								
										Paper to be submitted to Executive Team on possible Trust incentives to be offered/applied to Medical vacant posts.	01/02/2021	07/01/2021	Holt, Sharon								
										Approval of Job Planning Policy at the Local Negotiating Committee and TMC.	30/04/2021		Collins, Peter								
6570	Quality Directorate	Trustwide	15/07/2020	COVID-19/Coronavirus	12	There is a risk that an outbreak of COVID-19 could occur within the Trust either for staff and/or patients.	May recur occasionally	Moderate	9	COVID positive cohort wards to have daily COVID-19 inspections on PWA, all other wards weekly to be implemented by HoN and Matrons.	29/01/2021	22/01/2021	Major, Denise	Infection Prevention and Control Committee	30/04/2021	6	Care	Trust Board (Corporate Risk Register)	Director of Nursing	Major, Denise	15/01/2021
										The IT support for data to support swabbing dates being more easily accessed.	16/03/2021		Burwell, Jonathan								
										Outbreak review to be undertaken and SII to be completed.	14/04/2021		Major, Denise								
										SJR of all patient that died of Covid to be undertaken and report completed.	16/04/2021		Gorzanski, Claire								

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	Risk Owner	Date Escalated to Corporate Risk Register
5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver comprehensive safe and effective care to patients.	May recur occasionally	Moderate	9	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	Intensive Support Meeting	31/03/2021	6	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	31/01/2019
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa								
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali								
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali								
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew								
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy								
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy								
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy								
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart								
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine (Inactive User)								
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy								
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy								
										To recruit medical and nursing staff for the GI Unit.	31/03/2021		Lane, Lynn								

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	Risk Owner	Date Escalated to Corporate Risk Register
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	May recur occasionally	Moderate	9	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	30/04/2021	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	13/08/2019
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa								
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly								
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa								
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan								
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy								
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew (Inactive User)								
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020		Burwell, Jonathan								
										Full review of standard operating procedures including adherence	31/12/2020		Scott, Andy								
										Full implementation of IT general controls framework	31/12/2020		Scott, Andy								
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan								
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	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	Risk Owner	Date Escalated to Corporate Risk Register
5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob (Inactive User)	Information Governance Steering Group	31/03/2021	6	Resources	Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	11/02/2020
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob (Inactive User)								
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan								
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen								
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen								
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen								
										Windows 10 migration complete	30/06/2021		Arnold, Jon								
										Cyber essentials plus accreditation achieved	30/06/2021		Carman, Mr Stephen								
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan								
										Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen								
										ATP to be installed on Servers	31/12/2020	08/01/2021	Gibson, Richard								
										External CORS review to be undertake to support progress review	31/01/2021	24/02/2021	Burwell, Jonathan								
										Test implementation of IT Health Assurance Dashboard	31/05/2021		Burwell, Jonathan								
										Review of proposed actions outlined by NHSD cyber team and CORS assessment to develop an 2021/22 updated cyber plan.	15/04/2021		Gibson, Richard								

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ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5487	Finance and Procurement	Finance Department	26/07/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation. Covid 19 places increased uncertainty with changes in demand impacting on subsidiary cash flows.	Will undoubtedly recur, possibly frequently	Minor	10	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	21/12/2018	19/12/2018	Thomas, Lisa	Finance and Performance Committee	30/04/2021	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	16/10/2018
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	31/01/2020	18/02/2020	Thomas, Lisa								
										Subsidiary companies to recruit or establish suitable qualified financial support.	31/03/2020	24/05/2020	Thomas, Lisa								
										- Issue of Subsidiary performance challenges in light of COVID 19 raised to NHSI/E for clarification of treatment	15/07/2020	26/08/2020	Ellis, Mark								
6825	Trustwide	Trustwide	11/02/2021	Service Delivery Plan, Specialty Risk assessment, Trusts Objectives	15	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.	Do not expect it to happen again but it is possible	Catastrophic	10	GI action plan includes recruitment to substantive posts with a view to reintroducing onsite GI bleed service.	11/02/2022		Branagan, Mr Graham	Trust Board	31/05/2021	8	Specialist Services	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	11/02/2021
										Oncology: Develop additional joint working and new posts.	01/09/2020		Clarke, Lisa								
										Refresh of current clinical strategy to reflect response to the NHS long term plan, formation of the BSW ICS and strengthening of specialist service operational delivery networks(ODNs).	31/03/2021		Collins, Peter								
6836	Clinical Support and Family Services	Neonatal Unit	24/02/2021	Directorate risk assessment	12	There is a risk that the re-designation of the neonatal intensive care unit will result in restricted access to neonatal intensive care for women in Wiltshire with the resulting impact on quality and safety.	May recur occasionally	Major	12	Service review to ensure patient safety following re-designation.	31/03/2021		Davies, Miss Sallie	Trust Board	31/03/2021	10	Care	Trust Board (Corporate Risk Register)	Medical Director	Baden-Fuller, Dr Joanna	24/02/2021
6782	Operations Directorate	Trust Offices	12/01/2021	COVID-19/Coronavirus	20	As a result of a significant increase in Covid-19 patients in the Trust, there is a risk the Trust will become overwhelmed which may result in compromised patient care, staffing levels, patient and staff experience and well being and Operational efficiency of the hospital.	May recur occasionally	Major	12	Roll-out of vaccination programme to all staff.	28/02/2021	05/03/2021	Dyos, Judy	Trust Board	30/04/2021	12	Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	12/01/2021
										Review of Hospital Configuration to manage Clinical Pathways and Covid-19.	31/03/2021		Hyett, Andy								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5972	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	As a result of deeply rooted historic ways of working, resistance to change and the absence of a mature continuous improvement culture, there is a risk that improvement and transformation is not delivered in a timely manner. This may result in poor quality services, reputational damage, financial impact, ineffectiveness, an inability to attract and retain high quality staff and non-delivery of strategic and or corporate priorities.	Will probably recur, but is not a persistent issue	Moderate	12	Review of role and purpose of Innovation Committee; develop a clear approach for innovation	13/12/2019	21/02/2020	Provins, Esther	Trust Board	31/03/2021	6		Innovation (Resources) Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Director of Transformation	Provins, Esther	23/08/2019
										Introduce a Dragon's Den event to inspire, promote and reward innovation	30/07/2020	19/08/2020	Provins, Esther								
										Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther								
										Review effectiveness of Quality Improvement plan.	01/06/2020	19/08/2020	Provins, Esther								
										Implement Quality Improvement plan (see also risk 6138).	31/03/2021		Provins, Esther								
										Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther								
										Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/03/2021		Provins, Esther								
										Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	28/08/2020	03/09/2020	Hyett, Andy								
										Escalate discussions with system partners regarding levels of DToCs. *Action covered by Corporate Risk 5751. Please see risk 5751*	31/12/2019	04/03/2020	Hyett, Andy								
										Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	28/08/2020	19/08/2020	Provins, Esther								
										Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020	21/02/2020	Provins, Esther								
										Undertake a CIP assurance exercise for 19/20	11/01/2020	21/02/2020	Provins, Esther								
										Delivery of Best Place to Work programme.	31/03/2021		Lane, Lynn								
										Delivery of phase 1 of NHS Improvement Cultural Leadership Programme.	31/07/2020	18/08/2020	Lane, Lynn								
										Delivery of 20/21 Transformation Priorities.	31/03/2021		Provins, Esther								

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ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6043	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	12	The lack of a national clear model for small rural DGH services places future strategic planning uncertain at SFT. The funding regime and clinical models of care as advocated by royal college guidelines are built around average Trusts. SFT is more geographically challenged and smaller than an average DGH which in turn places its future as an independent Trust at risk which could limit and damage service provision to the local population.	Will probably recur, but is not a persistent issue	Moderate	12	Nuffield Trust are visiting SFT in January 2020 to assess and offer help on development of the South Wiltshire Urgent Care Model.	28/02/2020	18/02/2020	Hyett, Andy	Trust Board	31/03/2021	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	25/10/2019
										Development of system plans for sustainability of NHS elective care	31/03/2020	24/05/2020	Humphrey, Kieran								
										Trust part of BSW drivers of the deficit work to ascertain the financial issues in BSW, of which size and geography will be identified.	31/07/2020	26/08/2020	Thomas, Lisa								
										work with BSW to develop Financial sustainability plan for BSW to be agreed by March 2021	30/06/2021		Thomas, Lisa								
										once the guidance is published with regards to the new Consultation on integrated care and provider collaboration, develop action plan accordingly	31/05/2021		Thomas, Lisa								
6658	Clinical Support and Family Services	Maternity Administration	08/09/2020	Specialty Risk assessment	16	Nationally maternity services have been an area for concern and review . Within this Trust a higher number of Serious incidents have been noted and the maternity team have struggled to complete actions plans within expected timeframes leading to concerns that there has been a failure to embedded lessons learned. Further concerns have arisen via the Freedom to speak up guardian in relation to cultural behaviours.	May recur occasionally	Major	12	Externally led Cultural review to be undertaken reviewing key Terms of reference related to culture and behaviours	30/11/2020	05/01/2021	Lane, Lynn	Trust Board	07/06/2021	4	Care	Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	08/09/2020
										Externally led Clinical review to be undertaken reviewing key Terms of reference related to key clinical processes, SII management and maternity governance .	31/10/2020	03/11/2020	Dyos, Judy								
										Intensive executive support and SII exit meetings to be expedited	30/11/2020	05/01/2021	Provins, Esther								
										Executive Director of Nursing to attend monthly CNST meeting	30/09/2020	24/09/2020	Dyos, Judy								
										Improvement programme to be developed based on external clinical review findings.	07/06/2021		Dyos, Judy								
										Development of action plan from external review and Ockenden report.	07/06/2021		Boyd, Hannah								
6855	Finance and Procurement	Trustwide	12/03/2021	Trusts Objectives	12	The Financial regime for 2021/22 is uncertain, Covid 19 has meant a delay to the planning guidance and suspension to the existing regime. This places significant uncertainty on the ability to develop a financial plan to support the Trust delivering its objectives for 2021/22. there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures.	May recur occasionally	Major	12	Trust to issue interim budget in April 2021 in absence of financial guidance	30/04/2021		Thomas, Lisa	Finance and Performance Committee	30/04/2021	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	12/03/2021
6856	Finance and Procurement	Trustwide	12/03/2021	Trusts Objectives	12	Due to Covid 19 the guidance for the 2021/22 planning round has not been released . This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year.	May recur occasionally	Major	12					Finance and Performance Committee	30/04/2021	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	12/03/2021
6471	Finance and Procurement	Trustwide	24/05/2020	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	Raise issue of capital funding for strategic replacement of key estate with regional director of FInance	31/07/2020	26/08/2020	Thomas, Lisa	Trust Board	30/04/2021	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	26/05/2020
										In response to critical infrastructure review need to prioritise capital spending plan for next 5 years to address concerns.	30/10/2020		Robinson, Ian								
										Escalate risks to estate through NHSI capital funding route, with a view to source funding for replacement day surgery as a minimum	31/12/2020		Thomas, Lisa								
										confirm capital programme estate priority for next year compared to funding availability	01/02/2021		Thomas, Lisa								
6654	Operations	twide	9/2020	COVID-19/Coronavirus,	15	The impact on service delivery as a result of Covid 19 and the subsequent infection control requirements impacting on the ability of the Trust to recover	btedly recur, frequently	derate	15	Delivery of Phase 3 action plan.	31/01/2021	05/03/2021	Hyett, Andy	Board	4/2021	9	s (Care, People)	Corporate Risk ister)	ating Officer	, Andy	9/2020
										Short term pay incentives for Theatre staff.	01/11/2020	05/01/2021	Dyos, Judy								

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	Directorate	Trus	02/0	National guidance		activity to pre-Covid Levels. The consequence of not achieving this would be delay to treatments, impact to quality of care and impact on performance.	Will undou possibly	Mod		Managing Estates priorities and risk mitigation.	01/04/2021		Hyett, Andy	Trust	30/0		Local Services	Trust Board (Reg	Chief Oper	Hyett	02/0
										Preparation of Recovery Plan for cancer breast tumour sites, diagnostics and patients waiting over a year.	30/04/2021		Hyett, Andy								

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ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	16	Risk of patient harm caused by a delayed discharge from hospital. This risk is caused by lack of capacity within the community and delay in internal processes within the hospital.	Will undoubtedly recur, possibly frequently	Moderate	15	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	30/04/2021	12	Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	11/03/2019
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy								
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy								
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy								
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy								
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy								
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy								
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy								
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy								
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy								
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy								
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy								
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy								
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy								
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021		Hyett, Andy								
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy								
										Development of Transformation Programme for improved Discharge processes.	30/04/2021		Provins, Esther								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
5970	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Will probably recur, but is not a persistent issue	Major	16	Development of an IT improvement plan which includes staffing, communications, infrastructure, governance and any outstanding pen test/audit actions.	22/11/2019	11/12/2019	Provins, Esther	Finance and Performance Committee	31/03/2021	9	Innovation	Finance Committee, Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	23/08/2019
										Set up monthly executive performance reviews.	30/09/2019	31/10/2019	Provins, Esther								
										Completion of internal audit action plans and penetration test action plans.	31/12/2019	02/03/2020	Burwell, Jonathan								
										To complete the review and proposal for improving our capacity to do business change.	30/06/2020	18/06/2020	Provins, Esther								
										Agree long term direction of the EPR and short/medium term investment.	15/07/2020	19/08/2020	Burwell, Jonathan								
										Develop, agree and implement a new range of informatics service standards	19/05/2020	19/06/2020	Burwell, Jonathan								
										Conclude work to agree and commence implementation of a robust and fit for purpose service delivery model	29/03/2020	28/04/2020	Burwell, Jonathan								
										Develop and implement a communications and engagement plan aligned to digital strategy	15/01/2020	02/03/2020	Burwell, Jonathan								
										Evolve current change management approach, ensuring it is comprehensive, clinically led	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement an Informatics team development programme	30/06/2020	01/08/2020	Burwell, Jonathan								
										Strengthen clinical leadership in informatics by reaffirming priorities for CCIOs and appointing to CNIO roles	31/03/2021		Provins, Esther								
										Embed information analysts into directorate management teams	31/03/2021		Burwell, Jonathan								
										Informatics staff to undertake relevant customer service training	30/09/2020	23/10/2020	Burwell, Jonathan								
										Work with BSW to agree a shared EPR approach.	31/05/2021		Provins, Esther								
										Recruitment of Lead Information Business Partner	30/11/2020	08/01/2021	Burwell, Jonathan								
										Consider further resource requirements to strengthen strategic Informatics leadership.	31/03/2021		Provins, Esther								
										Recruitment of Joint Chief Digital Officer.	30/04/2021		Provins, Esther								

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ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk Register
6247	Estates	Estates	10/03/2020	Directorate risk assessment	12	As a result of a comprehensive external review of the Estates function it has been identified that the Trust has significant risks associated with critical plant and building infrastructure, that may result in utility or system failure. Including: Water ingress leading to a loss of building use. Failure to maintain critical plant leading to failure of systems e.g. nurse call, ventilation, power, gas, water, lifts and pressure systems. Failure to ensure compliance with mandatory training, leading to an inability to maintain plant. Lack of appropriately trained staff to undertake preventative maintenance. In ability to complete mandatory returns or compliance checks/reporting. Failure to mitigate these risks may result in the loss of buildings and services/utilities, for clinical functions.	Will probably recur, but is not a persistent issue	Major	16	The Estates Transformation Steering Group has been formed with an action plan detailed to mitigate these risks.	01/09/2020	18/08/2020	Lane, Lynn	Executive Director Meeting	30/04/2021	8	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	16/03/2020
										Work through action plan to address health and safety breaches identified in the Critical Plant Survey.	31/12/2020	30/10/2020	Frith, Gerry								
										Completion of actions arising from the independent Estates review (Cammies Report). The delivery of these objectives are managed via the Estates Transformation Board.	31/12/2020	31/12/2020	Frith, Gerry								
										A plan for investment needs to be identified to address remaining concerns highlighted in the critical plant survey in July 2020.	31/08/2021		Frith, Gerry								
										As a result of the May 2020 review, a plan for investment to reduce the Trusts back log of maintenance is required.	31/08/2021		Frith, Gerry								
										Capital Prioritisation Group to prioritise funds for Estates.	01/04/2021		Thomas, Lisa								
										BSW solution for Estates Management to be identified.	30/04/2021		Thomas, Lisa								
										Plan to recruit to all vacant posts.	01/09/2021		Frith, Gerry								
6779	Medicine	Cancer Services	07/01/2021	Incident reports	25	The risk of inconsistent and uncoordinated (often paper based) tracking of patient progress along cancer diagnostic and treatment pathways provides opportunities for missed or delayed cancer diagnosis.	Will probably recur, but is not a persistent issue	Major	16					Cancer Board	30/04/2021	8	Care	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	07/01/2021
6834	Organisational Development and People	Trustwide	23/02/2021	COVID-19/Coronavirus	16	As a result of the Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave.	Will probably recur, but is not a persistent issue	Major	16					Trust Board	31/03/2021	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and	Lane, Lynn	23/02/2021

ID v2.1	Rating (initial)	Rating (current)	Rating (Target)
5360	15	10	6
5487	12	10	6
5704	16	9	6
5751	16	15	12
5955	15	9	9
5970	16	16	9
5972	16	12	6
6043	12	12	6
6099	12	9	9
6102	16	9	9
6129	20	6	4
6143	16	9	6
6247	12	16	8
6471	15	15	8
6472			
6487	12	4	4
6570	12	9	6
6654	15	15	9
6658	16	12	4
6731	8	6	1
6779	25	16	8
6781	12	6	6
6782	20	12	12
6825	15	10	8
6834	16	16	9
6836	12	12	10
6858	9	9	6
6857			
6856			
6855			

ID v1.2	Rating (initial)	Rating (current)	Rating (Target)
5360	15	10	6
5487	12	10	6
5704	16	9	12
5751	16	15	12
5955	15	9	9
5966	12	12	9
5970	16	16	9
5972	16	12	6
6043	12	12	6
6099	12	9	9
6102	16	9	9
6129	20	6	6
6143	16	9	6
6247	12	12	8
6470	12	6	6
6471	15	15	8
6472	12	8	8
6487	12	15	6
6570	12	16	6
6654	15	15	9
6658	16	12	4
6731	8	6	1
6779	25	16	8
6781	12	12	8
6782	20	20	12
6787	9	9	4

Initial Diff	Current Di	Target Diff
0	0	0
0	0	0
0	0	**6**
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	**2**
0	0	0
0	**-4**	0
0	0	0
0	**11**	**2**
0	**7**	0
0	0	0
0	0	0
0	0	0
0	0	0
0	**6**	**2**
0	**8**	0

ID v1.2	Rating (initial)	Rating (current)	Rating (Target)
5360	15	10	6
5487	12	10	6
5704	16	9	12
5751	16	15	12
5955	15	9	9
5966	12	12	9
5970	16	16	9
5972	16	12	6
6043	12	12	6
6099	12	9	9
6102	16	9	9
6129	20	6	6
6143	16	9	6
6247	12	12	8
6470	12	6	6
6471	15	15	8
6472	12	8	8
6487	12	15	6
6570	12	16	6
6654	15	15	9
6658	16	12	4
6731	8	6	1
6779	25	16	8
6781	12	12	8
6782	20	20	12
6787	9	9	4

Corporate Risk Register Summary - March 2021 v20

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Jan-20	Mar-20	May-20	Jul-20	Sep-20	Nov-20	Jan-21	Mar-21	Target
Risk Detail				Score Trend									
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do													
5704	Inability to provide a full gastroenterology service due to a lack of medical staff capacity	Medical Director	31-Jan-19	16	16	16	16	12	12	12	9	9	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	16	16	16	12	12	15	15	15	12
6654	The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance	Chief Operating Officer	02-Sep-20	15					15	15	15	15	9
6787	The Trust is commissioned to provide a 2 pod vaccination hub at the City Hall which is new service provision set up at pace. **New Risk**	Chief Operating Officer	15-Jan-21	9							9		4
6782	As a result of a significant increase in Covid-19 patients in the Trust, there is a risk the Trust will become overwhelmed which may result in compromised patient care, staffing levels, patient and staff experience and well-being and operational efficiency of the hospital	Chief Operating Officer	12-Jan-21	20							20	12	12
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population													
6825	The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service **New risk**	Medical Director	11-Feb-21	**15**								10	8
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered													
5970	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Director of Transformation	23-Aug-19	16	16	16	12	12	12	12	16	16	9

6129	Risk of the non-delivery of the IT Improvement Plan (incorporating clinical risk)	Director of Transformation	19-Dec-19	20	9	9	6	6	6	6	6	6	4
5972	Risk that improvement and transformation is not delivered in a timely manner	Director of Transformation	23-Aug-19	16	16	16	16	9	9	9	12	12	6

Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm														
6143	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Medical Director	02-Jan-20	16	16	16	12	8	8	8	9	9	6
6658	Maternity service inability to complete serious incident actions within expected timeframes leading to concerns regarding failure to embed learning. Further concerns have been raised via the FTSUG in relation to cultural behaviours	Director of Nursing	08-Sep-20	16					12	12	12	12	4
6779	Risk of inconsistent and uncoordinated tracking of patient progress along cancer diagnostic and treatment pathways provides opportunities for missed or delayed cancer diagnosis	Medical Director	07-Jan-21	25							16	16	8
6570	Risk of Covid-19 outbreaks within the Trust either for staff and/or patients	Director of Nursing	15-Jan-21	12							16	9	6
6836	Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety **New risk**	Medical Director	24-Feb-21	12								12	10
5966	Risk of compromised services due to hub and spoke model	Medical Director	20-Aug-19	12	12	9	12	12	12	12	12		9
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams														
6099	Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services	Director of OD&People	14-Feb-20	12		12	12	9	9	9	9	9	9
6102	Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service	Director of OD&People	14-Feb-20	16		16	16	12	12	12	9	9	9

6834	As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave **New risk**	Director of OD&People	23-Feb-21	16								16	9
6487	Risk of not being able to safely staff ward areas, ED and Critical Care as a result of the potential second wave of Covid-19	Director of Nursing	04-Jun-20	12				12	12	12	16	4	4
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources													
5487	The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation	Director of Finance	26-Nov-18	12	6	6	10	10	10	10	10	10	6
6781	Risk of audit, governance ovbersight and data management for a number of services and reporting streams being delayed due to redeployment of staff to support front line services during the peaks of the wave 3 pandemic and the vaccination programme	Director of Nursing	12-Jan-21	12							12	6	6
6731	This risk relates to our preparedness in relation to the end of the EU transition period at 31st December 2020 with the possibility of not having a free trade agreement (FTA) in place with the EU. From 31/12/2020 new border and customs procedures will apply for all goods entering the UK from the EU, the UK will implement border controls in a staged approach. The worst case planning assumptions the flow rate through the straits could reduce to 60 -80%.	Chief Operating Officer	19-Nov-20	8							6	6	1
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **New risk**	Director of Finance	12-Mar-21	6								6	4
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives **New risk**	Director of Finance	12-Mar-21	9								9	6

6855	The financial regime for 2021/22 is uncertain, Covid-19 has meant a delay to the planning guidance and suspension to the existing regime. This places significant uncertainty on the ability to develop a financial plan to support the Trust delivering its objectives for 2021/22. There is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures **New risk**	Director of Finance	12-Mar-21	12								12	8
6856	Due to Covid-19, the guidance for the 2021/22 planning round has not been released. There is a risk that the Trust will not deliver key objectives aligned to operational, activity and workforce plans **New risk**	Director of Finance	12-Mar-21	12								12	8
5955	Insufficient organisation wide robust management control procedures	Director of Finance	13-Aug-19	15	15	15	12	12	9	9	9	9	9
6247	Risks associated with critical plant and building infrastructure that may result in utility or system failure	Chief Operating Officer	16-Mar-20	12		12	12	12	20	12	12	16	8
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Director of Transformation	11-Feb-20	15		15	10	10	10	10	10	10	6
6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Director of Finance	25-Oct-19	12	12	12	12	12	12	12	12	12	6
6472	Due to Covid-19 the final elements of the 2020/21 planning round were not completed in line with national guidance. This risks the Trust not delivering key objectives aligned to operational, activity and workforce plans in year	Director of Finance	26-May-20	12			12	12	8	8	8		8
6470	Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged resulting in the Trust having to take emergency measures	Director of Finance	26-May-20	12			12	12	12	9	6		6
6471	Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services	Director of Finance	26-May-20	15			15	15	15	15	15	15	8

Risk Score Key

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

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	08 April 2021		

Report Title:	Q3 Patient Experience Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Katrina Glaister, Head of Patient Experience			
Executive Sponsor (presenting):	Judy Dyos, 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 2020/21 in relation to complaints and the opportunities for learning and service change. Some key changes are highlighted below:

- The PALS team have been found a new home in offices close to The Green Entrance and hopes to move in Q3. This will make PALS more visible and accessible for visitors.
- There is no national pause on complaints (as was seen in the first wave of the pandemic) but under the Complaint Regulations we can extend the response time frame (for six months or more) as long as we explain this to complainants. Currently we are advising complainants that the COVID-19 pandemic is causing a strain on services and that their response is likely to be delayed.
- Compliance with agreed response times are not as good as previous quarters; it is thought that the pressure on clinical services due to the COVID-19 pandemic is to blame
- Opportunities for patient/general public engagement have been much reduced due to social distancing and the national lockdown. The sampling timeframe for the Children and Young People survey has been extended to the end of January 2021

This report provides assurance that the Trust is responding and acting appropriately to patient feedback and assurance of patient and public involvement in service co-design and improvement.

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	☐

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

Patient experience is defined as "the sum of all interactions, shaped by an organisation's culture that influence patient perceptions across the continuum of care."[1] Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative, 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.

Making a complaint takes courage. Patients fear that speaking up could affect their care, but we are clear that this is not the case and welcome complaints as a means to improve our services.

The Trust takes concerns and complaints seriously. They are an important opportunity for us to learn and improve. Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where complaints are welcomed and learnt from.

Actions going forward

- The PALS team have been found a new home in offices close to The Green Entrance and moved in Q3. This will make PALS more visible and accessible for visitors. A free short-stay car parking space is available for visitors to PALS.

1. Complaints responses during the third wave of the pandemic

From March - July 2021 there was a national pause on complaints to allow clinical teams to manage their workload during the first wave of the pandemic. This has not been repeated as NHSE/I can only do this once. To allow them to do it a second time the Department of Health would have to take over and rewrite the Regulations and get these approved through the House Library again. Any changes would take time and would necessitate going out to consultation.

The existing Complaint Regulations allow individual organisations to explain to complainants that the COVID-19 pandemic is causing a strain on services and that responses will be delayed.

Under the regulations we have at least up to 6 months to answer a complaint and then we can extend that as long as we explain to complainants the reasons and write to them with this information. All this is covered by Regulation 13(7) and 14(3) https://www.legislation.gov.uk/uksi/2009/309/contents/made

When we acknowledge their complaint we are currently advising all complainants that a response to their complaint may well be delayed.

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.

The PALS team (and patient representatives going forward) review all the SOX nominations and chose a selection to go forward to the Trust Board where recipients receive a certificate.

Increasingly we are seeing patients use the email address to give unsolicited feedback. For example:

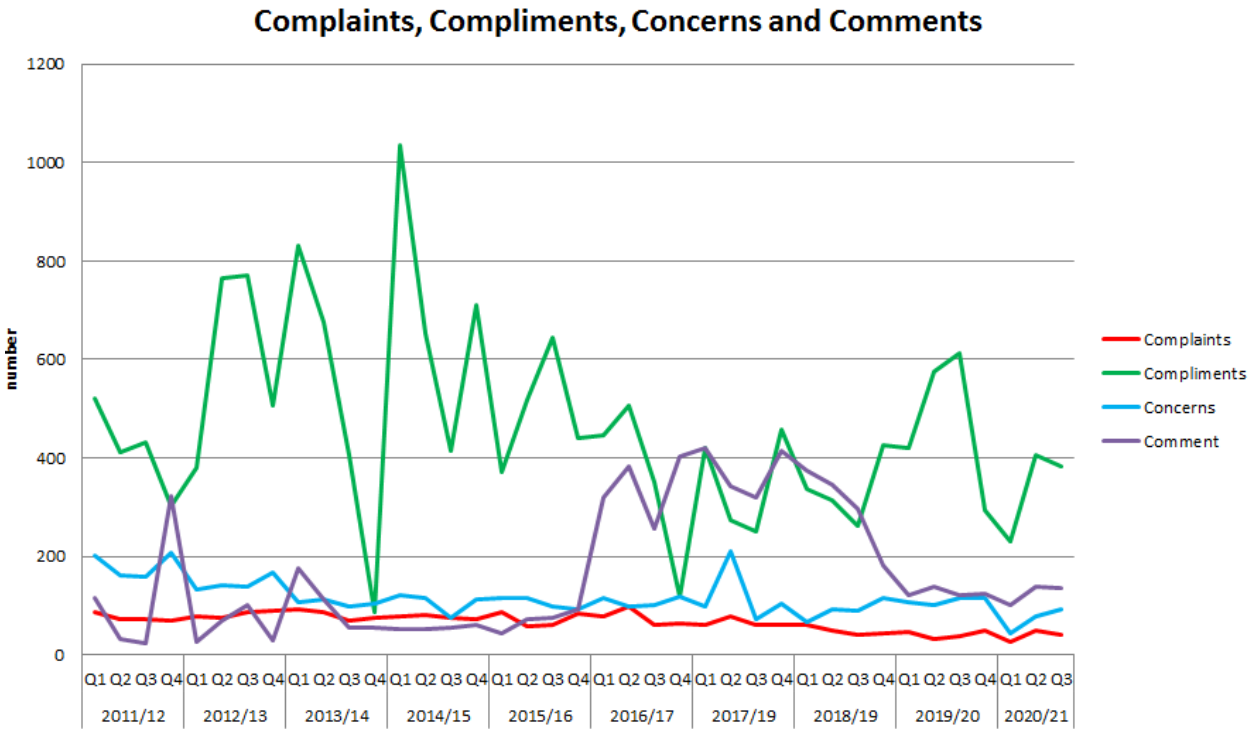
- I would just like to thank all involved with my care between the 22nd and 23rd of December. Truly amazing support and going above and beyond to get me home for Christmas. I will never forget it! I was admitted to hospital with a suspected appendicitis and within 24 hours I had surgery, wonderful care and am on my way home. I cannot express my true level of gratitude with everyone concerned. Everyone I met was helpful, kind, understanding and lovely. I haven't had treatment in

an English hospital for over 20 years and I was blown away by the service. Thank you thank you thank you.

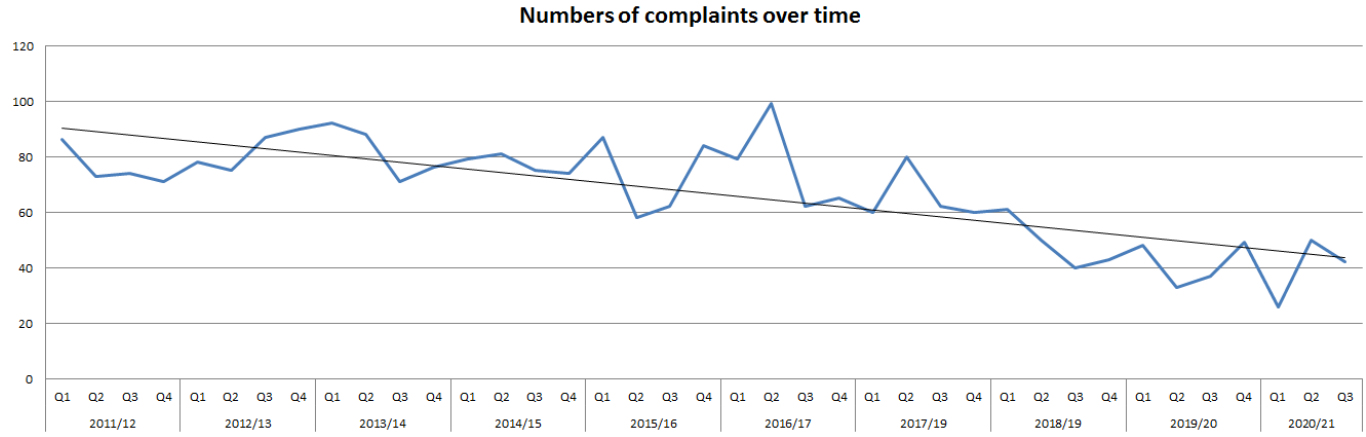
- I attended SDH yesterday for oral surgery where I had a significant amount of teeth out. I'm autistic and when I woke up I was inconsolable, and very upset, one of your nurses (she may of been a HCA) who was working on the DSU went above and beyond. She stood in my room stroking my hair, putting cold compresses on my face and calming me down out of a meltdown. This act of kindness was absolutely amazing and I cannot thank her, or the hospital enough. Please could you pass on this message to her and her superiors, thank you

3. Complaints

The graphs below shows the numbers of complaints, compliments, concerns and comments over time.



Below you can see that complaints continue to show a slight downward trend.



Complaint themes Q3

Themes	CSFS	Medicine	Surgery	total
Appointment date required	0	0	1	1
Appointment system - procedures	0	0	1	1
Clinical Treatment - General Medicine	0	1	0	1
Correct diagnosis not made	1	1	0	2
Delay in making diagnosis	0	0	2	2
Delay in receiving treatment	0	1	0	1
Discharge procedures	0	1	1	2
Early discharge	0	1	0	1
Falls	0	2	0	2
Further complications	0	3	3	6
Harm	0	1	1	2
Information not given to family	0	1	0	1
Neglect	1	1	0	2
Operation delayed	0	0	1	1
Treatment unavailable	1	0	1	2
Unsatisfactory arrangements	0	0	1	1
Unsatisfactory treatment	3	4	1	8
Attitude of nursing staff	1	0	1	2
Attitude of staff - medical	0	1	2	3
Discrimination on racial grounds	0	1	0	1
total	7	19	16	42

In Q3 the Trust treated 15,976 people as inpatients, day cases and regular day attendees. Another 28,487 people were seen in the Emergency Department (includes the walk-in clinic) and 69,295 as outpatients (this excluded telephone calls). 42 complaints were received which is 0.027% of the number of patients treated.

383 compliments were received across the Trust in Q3. Those sent directly to the Chief Executive, PALS or via the SOX inbox are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment/national patient survey/RTF/FFT the PALS team complete a SOX which is sent to the individual and their line manager.

Concerns, comments and enquiries closed within 10 working days of receipt.

A total of 348 comments, concerns and enquiries were logged by PALS this quarter. Of this number 80.75% were closed within 0 -10 days.

Concerns, enquiries and comments - closed within 10 working days	No.	%
Not yet closed	20	5.75
0-10 working days	281	80.75
11-24 working days	22	6.32
25+working days	25	7.18
Total	**348**	

Concern themes Q3

1. Clinical divisions

	CSFS	Medicine	Surgery	Total
Appointment system - procedures	0	0	1	1
Assistance not given	0	1	0	1
Correct diagnosis not made	0	1	0	1
Delay in making diagnosis	0	0	1	1
Delay in receiving appointment	0	0	2	2
Delay in receiving treatment	0	1	3	4
Dementia	0	0	1	1
Discharge procedures	0	2	0	2
Drug error	0	1	0	1
Early discharge	0	1	0	1
Further complications	2	0	2	4
Information not given to family	0	1	0	1
Information required	0	0	1	1
Insensitive communication	4	3	1	8
Lack of communication	4	4	2	10
Lack of equipment/aids/appliances	0	1	0	1
Missing patient	0	1	0	1
Nursing Care	0	1	1	2
Operation cancelled	0	0	1	1
Operation delayed	0	0	3	3
Operation delayed following admission	0	0	1	1
Pain management	0	0	1	1
Unsatisfactory arrangements	0	3	1	4
Unsatisfactory outcome	0	1	0	1
Unsatisfactory treatment	4	7	3	14
Attitude of nursing staff	0	5	0	5
Attitude of staff - admin	1	0	1	2
Attitude of staff - medical	2	2	8	12
Total	17	36	34	87

2. Non-clinical divisions

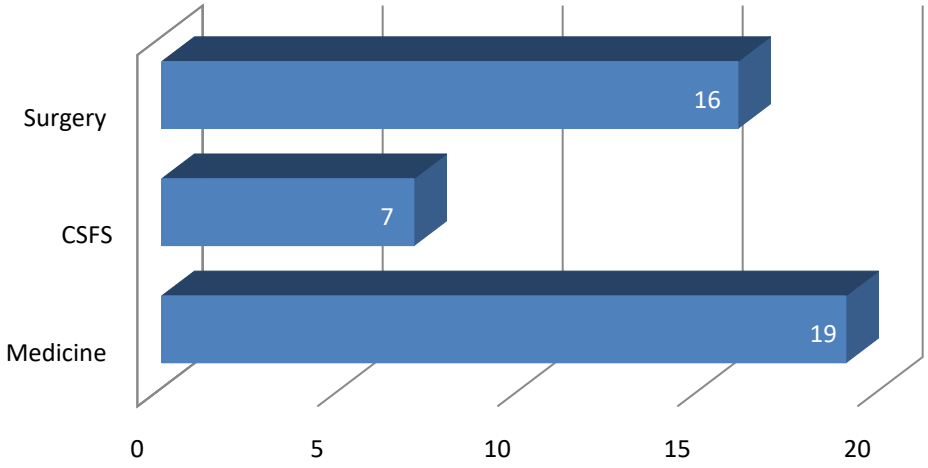
	IT	Facilities	Finance and Procurement	OD & P	Quality	Estates	Total
Discharge procedures	0	1	0	0	0	0	1
Funding problems	0	0	1	0	0	0	1
Insensitive communication	0	0	0	1	0	0	1
Lack of communication	0	0	0	0	1	0	1
Patient confidentiality	2	0	0	0	0	0	2
Poor facilities/environment	0	0	0	0	0	1	1
Total	2	1	1	1	1	1	7

Outcome and actions:

- In regards to concerns raised pertaining to the theme 'patient confidentiality', reassurance was offered that the patient's records were not accessed inappropriately.
- An apology was offered regarding the lack of information surrounding the transport arrangements.

- A charge incurred by a non-UK citizen for accessing treatment was reduced.
- Clarity was offered regarding the restrictions in placed surrounding face-to-face interpreting.
- A faulty concrete block was fixed and an apology offered.
- One case remains under investigation.

Q3's - Complaint numbers per Division.



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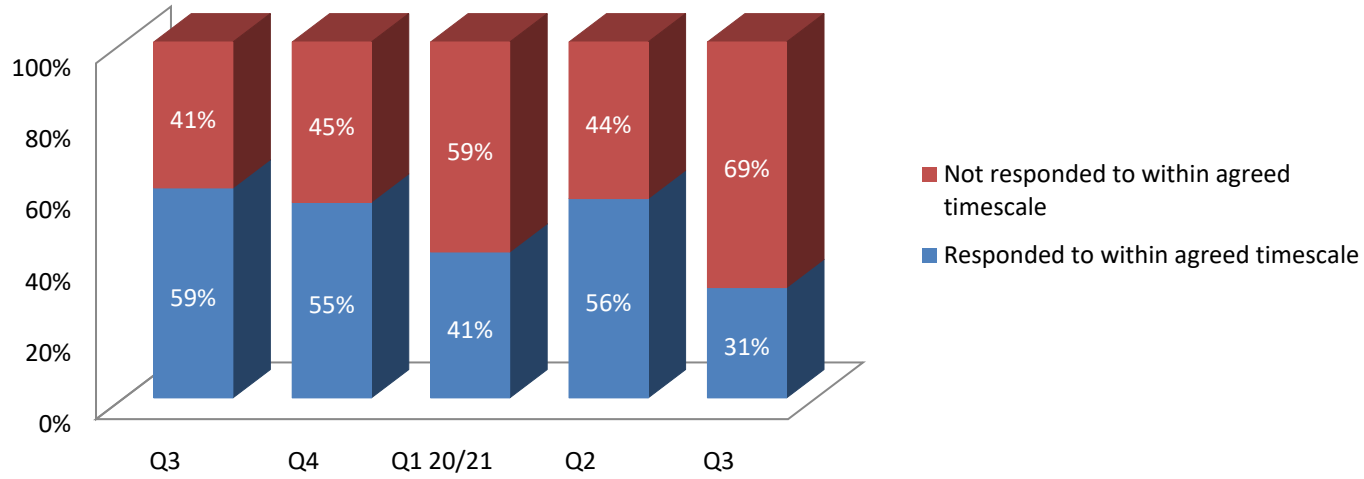
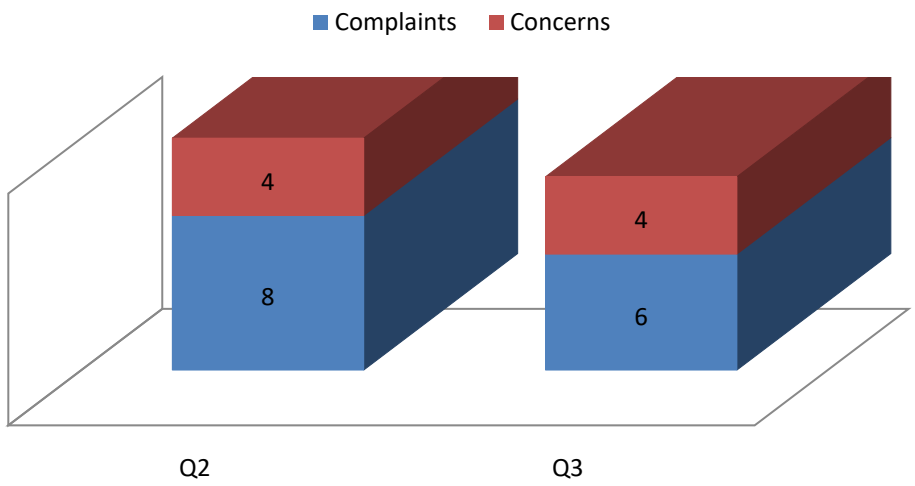
Graph to show the percentage of complaints responded to within target times



The chart demonstrates that we have seen a significant decrease in complaints being responded to within the agreed target times. It is unclear as to why this is the case, however, this is likely to be due to investigation managers' workloads during the pandemic.

Graph to show the number of reopened complaints



There has been a small reduction in reopened complaints in Q3. Reasons why the complaints were reopened include:

- The response did not fully address the concerns raised.
- Additional clarity sought as to why the surgery was cancelled.
- A request to amend the patient's care plan.

4. Complaints by directorate

Clinical Support and Family Services

	Q3 2019-20	Q2 2020-21	Q3 2020-21
Complaints	6	12	7
Concerns	21	7	17
Compliments	70	32	37
Re-opened complaints	2	4	0
% closed complaints responded to within agreed timescale	50%	12%	44%
Complaints closed in this quarter	1	8	9
% closed concerns responded to within 25 working days	52%	75%	38%

- There were 7 complaints raised in Q3 with no evident themes.
- No complaints were re-opened in Q3.
- 9 complaints were closed in Q3; with 44% being responded to within the agreed timescale. The reason for delay on the others was due to awaiting statements from staff/clinicians.
- 17 concerns were raised in Q3 which is a significant increase from the previous quarter. The Maternity Department received the most (n=8). The main themes were unsatisfactory treatment and insensitive/lack of communication.
- The PALS department received 15 comments and enquiries for CSFS in Quarter 3 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 8089 and of this number 0.08% raised a complaint.
- There are no action plans outstanding from the division.

Themes and actions from concerns and complaints closed in this quarter

Q3 themes		
Department	**Themes**	**Actions**
The Maternity Department	Unsatisfactory treatment and Insensitive/lack of communication	A learning opportunity has been identified for a newly appointed midwife to the community team. It was felt that in order to enhance her experience with low risk, uncomplicated pregnancies she will be supported by midwives who are experienced in this model of care. Several concerns have been raised in relation to the restrictions surrounding accompanying partners, family and friends to the antenatal clinic. As from the 14th December 2020, partners are welcome to attend all clinic appointments. In regards to concerns raised surrounding staff behaviour and insensitive communications, in all cases supervised personal refection has been undertaken. Themes from complaints will be shared with the workforce via the monthly Maternity and Neonatal newsletter.
Q2 themes		
Department	**Actions**	**Update**
Gynaecology Unsatisfactory clinical treatment	The lead clinician will review the previous 12 months of concerns and complaints relating to Gynaecology. Themes and learnings to be presented to CSFS DMT.	Due to current pressures on services/resources, this action has not yet been completed. The department are planning on suspending this action for 6 months and will then revisit.
Q1 themes - There were no themes identified in Q1		

Compliments

CSFS received 37 compliments in Q3; the breakdown is as follows;

Bowel Screening =11, Maternity =7, Pathology =1, Radiology =2, SALT =2 and Sarum =14.

Medicine Division

	Q3 2019-20	Q2 2020-21	Q3 20-21
Complaints	16	19	19
Concerns	32	31	36
Compliments	292	126	250
Re-opened complaints	0	4	2
% closed complaints responded to within agreed timescale	55%	79%	40%
Complaints closed in this quarter	9	19	15
% concerns responded to within 25 working days	75%	88%	68%

19 complaints were received in Quarter 3. The Stroke Unit and Emergency Department received the most with 3 each. No clear theme is seen for those received by the Emergency Department however ‘further complications’ in a theme in the Stroke Unit complaints.

15 complaints were closed in Q3 and of these 40% were responded to within the agreed timescale. This is a significant decrease from Quarter 2 and is due to awaiting statements from relevant staff/clinicians.

2 complaints were re-opened in Q3 and the reason for these being re-opened were due to complainants needing further clarification and feeling that their concerns had not been resolved satisfactorily.

There were 36 concerns raised in Quarter 3. The Emergency Department received the most with 7 with no particular theme identified.

The PALS department received 76 comments and enquiries for Medicine in Quarter 3 which were investigated, managed and responded to by the team.

Total activity within the directorate was 28979 and of this number 0.06% raised a complaint.

The Complaints Co-ordinator is waiting for 16 outstanding action plans for upheld/partially upheld closed complaints since 1st April 2020 for the Medicine directorate.

Themes and actions from concerns and complaints closed in this quarter

Q3 20-21 themes		
Area	**Topic**	**Action**
Stroke Unit	Further complications	During Q3 the Stroke ward had an enlarged template to manage (i.e. Laverstock and Breamore) so 26 beds to 49. The team was therefore unable to give the level of care that they would have liked. Another factor is that the Locum Consultant (who had been with them for some time) became increasingly burnt out which would have had a negative impact on the patients and other staff.

Feedback on actions from the previous quarter's themes		
Q2 (2020/21)	**Actions**	**Updates**
Emergency Department Unsatisfactory discharge procedures. Incorrect diagnosis made. Insensitive communication Attitude of nursing and admin staff	Continued work to ensure the all patients have an ED discharge summary and that all junior doctors ask for a senior review prior to discharging patients. Each complaint is reviewed by a clinician to ascertain if a diagnosis has been missed or simply perceived to have been missed. If there are learning points the consultants have been reviewing the pathways and ensuring that all staff are aware of the learning from the complaint. During this difficult time we have several issues with communication – complex, new processes for patients, regular changes to staff workloads etc. It has undoubtedly raised the number of dissatisfied customers in ED and for a lot of staff has been the most challenging time of their career. We have dealt with these complaints on an individual basis with each member of staff taking time to reflect on attitudes and behaviours and how this could be improved upon whilst recognising the processes which have created patient unrest – Planned changes to waiting areas, navigation around department should help reduce confusion and support	Junior Doctor induction explicit in covering discharges and escalation processes. Junior Doctors require an agreed Consultant peer group sign off to be allowed to formulate their own management and discharge plans. Complaints are reviewed by clinicians and any immediate learning disseminated via safety briefs, email, comms diary and complaints and learning also incorporated into quarterly M&Ms open to all from the Dept via Teams and face to face. Improved signage now in place understand crowding in waiting rooms at time can be an issue which hopefully will be resolved once new Outpatients build completed and specialities in shared areas move out. Feedback and constant reminders to staff around compassionate conversations, privacy in Dept as some cubicles are still curtains and close to areas where conversations occur. This has been a real challenge since COVID. We have tried to have prompt contact but in reality complaints have fallen quite out of date. We have displayed posters with House Rules and reminders to be kind etc. There are still ongoing challenges with regards to the lack of visitors due to the COVID restrictions. The Medical wards are trialling new handover

	staff with irate patients	sheets to better communication between staff and relatives.
Q1 themes	**Actions**	**update**
Emergency Department Unsatisfactory treatment	Prompt telephone contact with complainants. Work within the department with setting professional behaviours and encouraging civility, compassion etc. Focus on education and training of staff - increased SIM activity which includes communication of difficult news to patients and relatives. Development of a new junior doctor rota pattern to include dedicated time for learning and development.	This is ongoing with commitment to ongoing SIM training and the new rota has been launched and we are seeing protected SPA time for junior docs as well as our senior doctors happen regularly.
Farley RCU Unsatisfactory treatment and communication	Many of these concerns are around the problems highlighted because of Covid-19 and the lack of visiting by relatives. A white board has been set up in the office on RCU to record all conversations with families and should be completed at least once during the day. There has been a general theme around communication throughout medicine as a whole. Also Farley/RCU, Spire and Laverstock are setting up communication sessions for staff especially around end of life issues. 1 has taken place more to be announced	There are still ongoing challenges with regards to the lack of visitors due to the COVID restrictions. The Medical wards are trialling new handover sheets to improve communication between staff and relatives.

Compliments for Q3

AMU=18, Durrington=29, Emergency Department=12, Farley=1, Hospice=72, Pembroke=11, Tisbury=18, Spire=55, Stroke unit=19 and Whiteparish =9.

Surgical Division

	Q3 2019-2020		Q2 2020-21	Q3 2020-21
	Surgery	MSK	Surgery	Surgery
Complaints	2	12	18	16
Concerns	27	30	37	32
Compliments	190	58	165	88
Re-opened Complaints & Concerns	6	1	5	6
% closed complaints responded to within agreed timescale	0%	50%	36%	37%
Complaints closed in this quarter	2	6	11	19
% closed concerns responded to within 25 working days	71%	52%	41%	44%

- There were 16 complaints received this quarter with Cleft Lip and Palate Service, Gastroenterology, Orthopaedics and Plastics Department each receiving 2. The main themes for the departments were further complications (n=3) and delay in making diagnosis (n=2).
- There were 4 complaint meetings held in this quarter.
- There were 32 concerns raised in Quarter 3. Gastroenterology, Ophthalmology and Plastics received the most with four concerns each. Two cases in Gastroenterology and Plastics were due to attitude of staff – medical as their themes.
- The main themes for concerns was; Attitude of staff - medical, with 8 cases across 6 specialities; and Operation delayed or cancelled, with 5 cases across 4 specialities.
- There were 4 complaints and 2 concerns re-opened in Quarter 3. Four are still open and meetings have been offered for two of the cases.
- The main themes for the 21 complaints closed in Q3 were; Appointment system (n=3), Attitude of medical staff (n=3) and further complications (n=3).
- The main themes for the 37 concerns closed in Q3 were; Delay in receiving treatment (n=6) across 4 specialities; lack of communication (n=5) across 4 specialities; and attitude of staff - medical (n=5) across 5 different specialities.
- The PALS department received 60 comments and enquiries for Surgery in Quarter 3 which were investigated, managed and responded to by the team.
- Total activity within the Division was 21,448 and of this number 0.07% raised a complaint.
- There are no action plans outstanding from closed complaints since 1st April 2020 for the Surgery Division.

Themes and actions from concerns and complaints closed in this quarter:

Q3 2020-2021 themes		
Department/Ward	**Topic**	**Action**
Central Booking	Appointment System	Human error when moving provisional operation date and not informing the patient of the change. Member of team informed of error and discussed with line manager.
Cleft	Appointment System	Glidescope missing resulting in operation order change and then cancellation when Theatres ran out of operating time.
General Surgery	Appointment System	Telephone appointment was cancelled without telling patient due to human error and volume of cancellations being processed because of Covid-19. Raised with team involved.
8347 Endoscopy	Attitude of Medical Staff	Case discussed at team's Clinical Governance session to highlight issues raised, particularly around communication with patient.
Endoscopy		Complaint fed back to outsourcing company who employed Consultant involved. Consultant no longer works for Trust.

Endoscopy Endoscopy	Further Complications General Service Provision and Creation of New GI Unit	Nursing staff and Consultants will ensure that patients fully understand about what to expect post-colonoscopy, especially post procedure complications. This has been discussed at the team's Clinical Governance session. A new GI Unit and a new GI Unit Manager and Clinical Lead was finalised in 2020 to pull the GI/Endoscopy/Colonoscopy services together. This will help reduce the complaints received, as the Clinical Lead and GI Manager have already started to work with the team to change the attitude and improve the service for patients.
Ophthalmology Outpatients	Attitude of Medical Staff	Raised with Consultant who has had follow up appointment with patient and apologised in person, as well as in written complaint response.
Plastics Department	Attitude of Medical Staff	We have appointed 2 new Deputy (part time) Surgery Clinical Divisional Directors to support the Clinical Director, one of them is the Plastic Surgery Lead. He is supporting the Plastic Surgeons and other staff who may need some guidance in their attitude and behaviour.
ENT	Further Complications	Patient booked with wrong doctor for follow up due to template issues in Central Booking – this has been rectified.
Division-wide	Delay in receiving treatment	Delays due to ongoing Covid-19 pandemic and impact on surgery and outpatient appointments. We are prioritising our patients using the NHS England national framework and criteria. Every patient has been triaged by the clinicians according to the national triage criteria. This means that some patents who may think they were urgent were not allocated as a high priory because of the pandemic and the need to only operate on clinically urgent patients such as cancer patients and those who are categorised as risk to life and limb. However, the Central Booking team have been given information and advice on how to explain this to patients when providing updates and cancelling appointments/surgery.
Division-wide	Attitude of Medical Staff	We have appointed 2 new Deputy (part time) Surgery Clinical Divisional Directors to support the Clinical Director. One of them has been very supportive in talking to staff who may need some guidance in their attitude and behaviour.

Feedback on actions that remain open from previous quarters:

Q2 2020-2021 themes

Department/Ward	**Topic**	**Action and update:**
Endoscopy	Communication & Care	Case will be discussed at the next Clinical Governance Session by the Band 6 Nursing Team on 19/11/2020.
Endoscopy	Attitude of Consultant	The doctor was providing services under the outsourced 18 Week Support contract. Case was highlighted to their Head of Governance & Risk, who liaised with doctor involved and provided written response assuring they will remind staff of importance of communication; summarise experience on learning log to aid reflection; and monitor complaints and feedback for this clinician over the next 3 months.

Endoscopy	Unhappy with Treatment	No action identified as procedures were followed correctly and complaint was unjustified.
Spinal Treatment Centre	Unhappy with Inpatient Care	No action identified on one case as we followed correct procedures. The other case is still being investigated due to staff sickness and is subject to an SII which is going to CRG on 29th October for review.
Central Booking	Appointment Delays/Restrictions due to Covid	All outpatient and elective procedure waiting lists have been triaged by the specialty consultants and activity is taking place based on clinical priority. The Division is utilising telephone and video facilities for outpatient appointments where possible and clinically appropriate, and this supports activity taking place that would otherwise not be possible due to restrictions such as social distancing.
Orthopaedics	Appointment/Operation Delays due to Covid	All outpatient and elective procedure waiting lists have been triaged by the specialty consultants and activity is taking place based on clinical priority. The Division is utilising telephone and video facilities for outpatient appointments where possible and clinically appropriate, and this supports activity taking place that would otherwise not be possible due to restrictions such as social distancing.
Q4 2019/20 – all closed		
Q3 2019/20 themes and updates		
Central Booking	Appointment Dates: Central Booking unable to book appointments in time due to capacity pressures in clinical areas meaning there aren't appointments available.	This is ongoing. Capacity issues are escalated to the department heads of the areas involved and discussed regularly to clinically triage those waiting and add extra clinics and appointments wherever possible. Due to the COVID-19 pandemic all outpatient and elective procedure waiting lists have been triaged by the specialty consultants and activity is taking place based on clinical priority. The Division is utilising telephone and video facilities for outpatient appointments where possible and clinically appropriate, and this supports activity taking place that would otherwise not be possible due to restrictions such as social distancing.

Compliments

88 compliments were received in Quarter 3, the breakdown is as follows:

Radnor Ward = 46, Downton Ward = 21, Odstock Ward = 5, DSU = 4, Plastics = 4, Urology = 2, Discharge Team = 1, Eye Clinic = 1, Gastroenterology = 1, Med/Surg O/P = 1, Oral and Max Fax = 1, Wessex Rehab = 1.

5. Parliamentary and Health Service Ombudsman (PHSO)

There were no new Ombudsman's cases reported this quarter.

The PHSO notified the Trust that it was their decision not to uphold a complaint that was referred to them back in 2020. Therefore, no further actions were required by the Trust.

For the first time the PHSO has published data about their recommendations for upheld and partially upheld cases. They have also published a data table of complaints received, assessed and investigated about NHS Organisations. This data will be published every quarter alongside their existing health complaints statistics report.

6. Trust wide feedback

Patients surveyed

A total of 636 patients provided feedback during the quarter through the Friends and Family Test (FFT). This is up from 512 in the last quarter.

Friends and Family Test

Please note new question:

"**Thinking about…**" (**Britford Ward** for example) **"Overall, how was your experience of our service?"**

The possible responses are:

- ❑Very good
- ❑Good
- ❑Neither good nor poor
- ❑Poor
- ❑Very poor
- ❑Don't know

In addition to the new question there are two new free text boxes for patients to give specific feedback:

- What was good about your experience?
- Please tell us about anything we could have done better?

Responses for the quarter are set out in the table below.

		Rating											
	Total Responses Received	Very good		Good		Neither Good nor poor		Poor		Very poor		Don't know	
Day Case	312	282	90%	28	9%	2	1%	0		0		0	
ED	20	15	75%	4	20%	0		0		1	5%	0	
Inpatients	228	186	81%	36	16%	2	1%	2	1%	1	0.5%	1	0.5%
Maternity	20	20	100%	0		0		0		0		0	
Outpatients	56	53	95%	3	5%	0		0		0		0	

Some feedback received this quarter

What was good about your experience?

Wonderfully high level of care and compassion. All so lovely. You made me feel safe and nothing was too much trouble.

Everyone doing their utmost under very difficult C19 situation. Wards spotless and kept very clean

Jan explained the general anaesthetic well and put us at ease. All the nurses on the ward have been super and the mobile TV/DVD machine really cheered up the patient. Hoping the procedure has been successful. Thanks to everyone involved.

Excellent care from start to finish. COVID safety throughout. Attended with my mother who has dementia and we were treated with dignity and respect by all staff. Student nurse Teresa was diligent and attentive. Please pass accolade to all staff on DSU from initial reception to discharge. In Mr Tiernan's theatre we were treated very well. The consultant was, as always, a gentleman and put my mother at ease. Other theatre staff were professional and efficient yet friendly.

Very welcoming and kind staff throughout appointment from front desk to discharge. Everything was made clear to me and I was given plenty of opportunity to ask questions.

I was extremely distressed and every member of staff have been outstanding. They treated us with kindness, compassion and respect. Bev & Andrea were wonderful and nothing too much trouble. They went out of their way to make me comfortable. Jim and Seb were friendly, kind and reassuring. Every contact in the hospital has been great. Thank you all.

What could we have done better?

Very noisy at night! Do you really need all the bleeps! Staff could whisper first before being so loud!

Handover station just outside my door, thought I heard a comment about myself, which made me upset.

The procedure was carried out by someone who was obviously under instruction. I was not told beforehand that this would be the case.

To add more toys to the play room for older boys and girls. For a cup dispenser for the cups because of COVID. People could have touched the cups and left them there.

Calls come from a withheld number; why not have Salisbury district hospital?

Directions for booking in at reception could be clearer. Very confusing.

Patient and Public Involvement – National surveys

No national survey results were published within the reporting period.

Urgent and Emergency Care Survey 2020

This has been delayed due to the pandemic. Work commenced September 2020.

Adult inpatient survey 2020

Work commenced November 2020

Children and Young Persons Survey 2020

Work commenced November 2020. Data collection has been extended to include children/young people in hospital in January 2021.

Maternity Survey 2020

This has been delayed and will commence in February 2021

Action taken on areas of concern

Wards, the Emergency Department and Maternity, have action plans in place to address the main areas of concern in their location. Progress is monitored via the Trust's Matrons Monitoring Group and is overseen by the Clinical Management Board.

7. Health Watch Wiltshire feedback

Regular virtual meetings are held between PALS and Health Watch Wiltshire and any feedback they receive about this hospital is shared with us.

8. Translation and Interpretation

The Procurement team have been working with PALS on a new tender for the interpretation and translation (Inc. BSL) managed service. The idea is that a 'one stop' service will be provided (BSL, video, telephone, face-to-face and translation of written material) .This piece of work has been done in conjunction with the other organisations in our STP. The invitation to respond to the tender closed mid Q3. Work continues with the STP complete this.

9. Patient Stories

Patient stories are taken to every public Board meeting. The Head of Patient Experience has now completed a Masters level course on digital patient stories.

10. NHS Digital

NHS Digital had suspended both the KO41a secondary care and KO41b primary care collections for Q4 2019-20 and Q1 2020-21 but have begun retrospectively collecting data from secondary care.

They aim to publish the 2019-20 Q4 data in November 2020 and the 2020-21 Q1 and Q2 data in January 2021.Q3 data (2019-20) is available here https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2019-20-quarter-3-ns

11. Patient and public involvement (PPI)

New website

The feedback facility that sits on the new website continues to receive helpful comments. Patients are additionally using this facility to feedback (positive) experiences with visits to the hospital. These are all shared with the relevant team.

Patient information app

The beta version of the hospital's patient information app has been tested and feedback has been very positive. It is hoped that the app will go live in Q4. The app developers are currently working to improve the print function from the web-viewer. It is hoped that the font size can be chosen to make sure that the printed copy meets the patient's accessibility needs.

Low Risk Birthing Unit

An online meeting platform was used to meet with Mums to discuss design and décor of the birthing unit. Sessions were advertised on social media platforms and shared by the local breastfeeding support group and the Maternity Voices Partnership. A variety of engagement methods were offered by Artcare including a pack with a Dulux paint catalogue enclosed that was posted out to interested women

PALS and Stars Appeal

A new piece of work has started to explore improvement ideas that arise from the Friends and Family Test Feedback. PALS are working with the Stars Appeal team to identify possible areas for Stars Appeal funding/patient engagement.

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

The PPI toolkit is available here: https://viewer.microguide.global/guide/1000000334#content,1df17a5a-25ee-4524-ab5e-96031930d247

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12. Social media

NHS Website feedback

There were 12 items of feedback posted on the NHS Website in Q3. All were positive and rated the service they received as 5 stars (Emergency Department (n = 3), Radiology, Haematology, COVID-19 testing team, Urology, Respiratory Medicine, ITU, Gastroenterology, Coronary Care Unit and

For example:

I was admitted via A&E to Tisbury ward at Salisbury District Hospital. I was having a heart attack, and went on to have another and 3 "arrest episodes". The treatment, world-class, the staff from around the world outstanding. But what stands out - the meals, the food. The taste, the variation, was something that made my stay a pleasure in a national treasure. I kept photos and menus, and "taste bud" memories. The Chef/cooks at this hospital deserve to be applauded for some of the nicest meals that I have tasted and devoured. Top marks.

I visited the A&E at Salisbury hospital in rather unpleasant circumstances but the staff has been great at dealing with my situation. I was also surprised to see night time cleaners as the place was very clean and tidy. I noticed the nurses were very happy to have them as it was a very busy night over there. I was moved to Farley ward very soon and was told it use to take very long but it has changed since they have night cleaning staff. Big thank you to the whole team, very friendly and pleasant nurses, and to the cleaning team who was working very hard!

All feedback is responded to via the NHS Website and those that leave negative feedback are given the contact details for PALS. All feedback (positive and negative) is shared with the relevant divisions.

All feedback is available here: https://www.nhs.uk/services/hospital/salisbury-district-hospital/P1700/ratings-and-reviews

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**3.3**
Date of Meeting:	30 March 2021		

Report Title:	Q3 Learning from Deaths 2020 - 2021			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Dr Belinda Cornforth, Consultant Anaesthetist, Chair of the Mortality Surveillance Group Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Peter Collins, Medical Director			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard Q3 2020/21 Appendix 2 - Learning from deaths action plan. Appendix 3 – Mortality dashboard explanation of terms			

Recommendation:
Recommendation – assurance that the Trust is learning from deaths and making improvements.

Executive Summary:
Learning from deaths in the Q3 report has been dominated by deaths of patients who died from COVID from the new more transmissible variant of COVID-19. This has resulted in an increase in the number of hospital acquired COVID cases mitigated by additional measures already put in place to reduce the risk of nosocomial transmission. More relatives have been able to be with their loved ones at end of life with PPE or enabled to have virtual discussions where relatives felt the risk of visiting was too high. A theme emerged from relative feedback about the length of time it takes to get through to the ward by telephone to find out the progress of their loved one or not receiving any communication at all, even though the intention was often recorded in the notes. Mitigated to some extent by the PALS team who are able to ascertain information and relay it back to relatives. Positive assurance on the outcome of completed actions from the hip fracture review shows a steady decline in the mortality rate.

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

Q3 2020/2021 Learning from Deaths report

1. Purpose

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

2. Background

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

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

3. Q3 learning in 20/21

Trust and departments:

- Q3 has been dominated by deaths of patients who died from COVID from the new more transmissible variant of COVID-19. This has resulted in an increase in the number of hospital acquired COVID cases mitigated by additional measures put in place to reduce the risk of nosocomial transmission (see section 7).
- End of life care – more relatives have been able to be with their loved one with PPE or enabled to have virtual discussions where relatives felt the risk of visiting was too high.
- A theme emerged from relative feedback about the length of time it took to get through to the ward by telephone to find out the progress of their loved one or not receiving any communication at all, even though the intention was often recorded in the notes. Mitigated to some extent by the PALS team who are able to ascertain information and relay it back to the relatives.
- Improvement actions completed since the review of 33 deaths of patients with a hip fracture in October 2019 has shown a steady decline in the mortality rate (see figure 16) attributed to prioritising hip fracture patients for surgery within 36 hours (83% in Nov 20 compared to 68% nationally), an increase in spinal anaesthetics (from 14% in Oct 19 to 34% in Nov 20) and more nerve blocks given pre-theatre (from 31% to 75%) leading to fewer opioids.

Individual level:

- Individual case discussion with doctors and nurses to enable assisted reflection has continued in Q3.

4. Medical Examiners (ME)

The new ME system was introduced in April 20 to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The system was established in the Trust by August 2020 and the following progress made in Q3:

- In Q3, 79% of acute hospital deaths were scrutinized by a Medical Examiner and relatives were contacted to ensure they understood and agreed with the cause of death and to give them the opportunity to raise any concerns.
- The process for scrutinising Hospice and Emergency Department deaths is the next stage and will be progressed in early 2021/22 once the COVID pandemic has subsided.
- A summary of our data is submitted to the regional ME. It is anticipated that we will be required to submit data to the national ME IT system if and when it is available.
- A local network of MEs exists to share learning and provide an independent review facility if needed.

5.0 Working with bereaved families

5.1 Telephone follow up

As well as the ME/MEOs contacting families in the days after death, the Specialist Palliative Care Team (HPCT) and the End of Life Care (EOLC) team provide a one off bereavement call to families of patients who were supported by them. This occurs between 1-4 weeks after the death and is an opportunity to offer condolences, listen and support the bereaved. and allow families to ask questions or raise concerns which can either be resolved at the time or a second call is arranged once action has been taken. If the patient was supported by the HPCT, referral to the family support team can be made if formal bereavement support is indicated. Currently this support is not available to families known to the EOLC team. Instead, the team signpost to GPs or local bereavement organisations such as Cruse. In exceptional circumstances families can be referred to the family support team after consultation with a member of the senior management team of Salisbury Hospice.

5.2 'Your Views Matter' bereavement survey

In October 2020, the bereavement survey was adapted to acknowledge the pandemic including the impact of visiting restrictions. The survey was relaunched and is sent a month after a death to a nominated person for every deceased patient who has died in the acute Trust. Seven bereavement surveys were returned to 31/12/20. A further 33 were returned in the month of January 2021. The majority contained positive comments about the kindness, care and compassion relatives saw and experienced themselves. Relatives who were able to be with their loved ones at end of life, expressed their appreciation at being able to do so. The main concern was about communication – specifically not being able to get through on the telephone to the wards. The table below sets out the main themes for improvement and actions taken in response.

Relative feedback	Trust action
Families not able to get through to wards for meaningful updates	PALS offer a go-between service encouraging families to contact them direct if they are unable to get through. PALS then contact the wards, obtain the relevant information and relay it back to relatives.
Families not aware of hospital chaplaincy service. When patients have received chaplaincy support, families have rated this as very good.	Role of chaplaincy service highlighted in daily staff bulletin stressing the importance of offering to ALL end of life care patients, irrespective of faith/religion. Also importance of communication with relatives so that they are aware patients are receiving this support. Request that Star's Appeal use their social media platform to publicise role that the hospital chaplaincy team has been supporting patients at end of life
Families not aware of message to a loved one / virtual visiting	EOLC and HPCT teams to encourage use of other forms of communication when talking with relatives who cannot visit. Hospital to use social media platforms to promote.
A small minority of families had been given inaccurate information / or did not hear the correct information on what to do next after their loved one had died. This led to them waiting for bereavement suite staff to contact them instead of them making contact with the bereavement team.	"What to do when someone dies" leaflet is usually handed to a relative at the time of death but as relatives are not present as frequently now due to restricted visiting, they don't always receive it. Updated leaflet with current procedures to be uploaded to hospital internet site so that relatives can view correct procedures online. Meeting planned 4/2/21.

6. Mortality dashboard, learning, themes and actions

In Q3 20/21, 218 deaths occurred in the Trust. The total includes patients who died in the Emergency Department and the Hospice. Of these, 207 (95%) deaths were reviewed by a Qualified Attending Practitioner. The Medical Examiners scrutinised all acute hospital deaths (excluding deaths in the Emergency Department) and by the end of Q3, 169 (77%) of deaths had been scrutinised. 7 deaths were unexpected. The second wave of the COVID-19 pandemic started in October with 23 deaths of patients who tested positive for COVID by 31 December 20. In Q3, 3 deaths were possibly avoidable and 3 had slight evidence of avoidability.

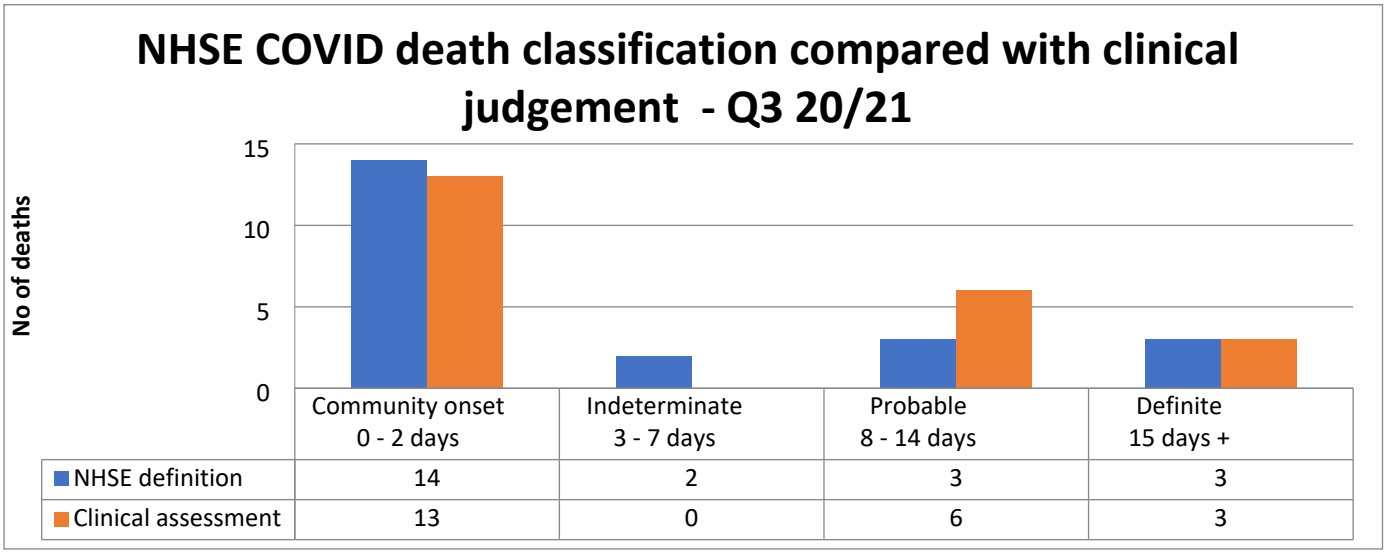
7. Review of deaths of patient with COVID-19 and learning

The review of the 1st wave (11 March – 13 June 2020) of deaths of patients who tested positive for COVID was reported to the Clinical Governance Committee in November 2020. The Committee were assured that the review did not find any lapses in care or failure to follow national guidance published at the time and noted that the Trust had made changes to the environment and pathways of care to reduce the risk of nosocomial transmission in line with national guidance and as new learning emerged. Of the 14 cases classified as hospital onset definite (9) or probable (5) healthcare associated, 13 bereaved relatives received a Duty of Candour letter and the opportunity for a further discussion with the Chair of the Morality Surveillance Group. In one case, the relative had had a face to face meeting with the Medical Director and Director of Nursing in July 2020.

In the 2nd wave (11 October – 31 Dec 20), 22 COVID positive patients died and 2 patients died who tested negative for COVID but had a strong clinical suspicion of COVID and was recorded on the medical certificate of cause of death. In total 24 deaths from COVID in Q3.

The emergence of a new more transmissible variant of COVID-19 increased the number of patients affected by nosocomial transmission. By clinical assessment, 6 patients probably acquired COVID in hospital and 3 definitely acquired it. The majority of hospital acquired cases occurred in December on the 3 wards where outbreaks were declared.

Figure 1: COVID death classification by NHSE definition compared with clinical judgement



Additional measures put in place to mitigate the risk of nosocomial transmission were:

- As the number of cases increased additional bed capacity was opened.
- To enable beds to be socially distanced some beds were removed from wards.

- Enhanced existing Level 1 PPE for staff working in close contact with patients within the ward environment and wards that had COVID-19 positive patients cohorted in bays. The enhancement was a change from wearing the recommended Level 1 surgical face mask to a Level 3 FFP3 face mask for which each individual was successfully fit tested.
- Provided mutual aid to the Mental Health Trust (AWP) where an outbreak of COVID affecting 63 patients was declared at Fountain's Way Hospital. This Trust provided oxygen and oxygen saturation monitors and a respiratory consultant to review patients at the hospital, thus reducing admissions to this hospital.
- Invited NHS Improvement to review practice which took place in January. The main advice was to increase the level of audits so rapid changes could be made where needed.

8. CUSUM alerts

6 new CUSUM alerts raised in Q3 20/21:

- Cancer of bronchus - 23 cases compared to 15.9 expected, relative risk 144. CUSUM alert previously investigated in September 2017. 14 deaths were reviewed and no deaths were considered avoidable. No iatrogenic events were noted. No learning points. The Mortality Surveillance Group decided the alert did not need to be investigated again.
- Procedure group – rest of upper GI 23 cases compared to 14.5 expected, relative risk 159. All the patients who died had undergone an insertion of a nasogastric tube (NGT) which was the dominant procedure the patient had during their admission but did not mean that the procedure caused the death. Nevertheless, the issue related to NGTs was triangulated with incidents reported on Datix. This showed 20 incidents reported between November 2018 – November 2020 of which 19, were unrelated to tube misplacement (missed medicines, tubes pulled or fallen out, wrong feed) and no harm. One incident occurred where a patient was fed despite a high pH which was the focus of a local review and suffered minor harm. Training is available via the Practice Education Team but the majority of staff undertake experiential learning in the clinical area.
- GI haemorrhage - 16 cases compared to 4.6 expected, relative risk 144 – these cases are currently under investigation.
- Procedure group - blood transfusion 1 case compared to 0.2 expected, relative risk 629. A woman with widespread metastatic breast cancer and a community DNAR, attended for a blood transfusion for the treatment of anaemia but was admitted due to shortness of breath and reduced oxygen saturations. One unit of blood was given the next day without complication. No reversible causes identified. The patient died peacefully several days later likely due to disease progression. Expected death, no problems in care identified and no learning points.
- Rest of bones, joints of cranium, face and jaw 1 case compared to 0 expected, relative risk 2263. A man admitted following a fall with facial trauma requiring surgery. Two unit platelet transfusion given without complication for low platelets pre-operatively. Maximal treatment and care on ICU post-operatively. Surgery uncomplicated and patient transferred to the ward on day 8. Despite active treatment of pneumonia the patient did not improve and later died peacefully. Expected death no learning points.
- Cancer of brain and nervous system 6 cases compared to 2.5 expected, relative risk 42.9. All 6 patients died in the Hospice. Agenda item at the February Mortality Surveillance Group to decide if this alert should be investigated.

CUSUM alerts raised in Q2 20/21:

- Secondary malignancies – 19 cases compared to 12.2 expected, relative risk 155. CUSUM alert previously investigated in 2012 and again in 2018 when 32 cases were reviewed. None of the deaths were considered avoidable. The Mortality Surveillance Group felt examination of this current alert was unlikely to lead to any additional learning as it is common for Trusts with an on-site Hospice to alert for this diagnosis group.

- Cancer of pancreas – 13 cases compared to 8 expected, relative risk 162. CUSUM alert previously investigated in November 2018. 17 deaths were reviewed of which 10 patients died in the Hospice. There were no iatrogenic events that contributed to their deaths. One learning point was noted about initiating and documenting ceilings of care early and continuing to review the ceiling of care regularly as the patient's condition changes. Ceiling of care assessment and review has been well documented during the second wave of the COVID-19 pandemic. The Mortality Surveillance Group decided this alert did not need to be investigated again.

9. Death following a planned admission to hospital

In Q3 20/21, 3 deaths of patients following a planned admission:

- An 80 year old man admitted with back pain and relapse of myeloma and spinal involvement confirmed on MRI for chemotherapy and radiotherapy. Regular blood products given but developed pneumonia with a poor response to antibiotics and was unable to continue with treatment and sadly died. Expected death, no learning.
- A 69 year old man admitted for salvage chemotherapy for progressive multiple myeloma not responding to initial treatment. He developed neutropenic sepsis, acute kidney injury and likely ischaemic hepatitis, coagulopathy secondary to liver failure. Unexpected death – referred to the coroner.
- A 76 year old woman with metastatic breast cancer rapidly deteriorated at home over the preceding week and was admitted to the Hospice for symptom control and end of life care and died peacefully. Expected death, no learning points.

10. Unexpected deaths

In Q3, there were 7 unexpected deaths:

1. A 55 year old woman admitted with sudden onset atypical chest pain and was managed as unstable angina/acute coronary syndrome. Cardiology review felt it was not an ischaemic event. In the early hours of the following morning she was found collapsed and unresponsive and in cardiac arrest. 90 minutes of resuscitation was unsuccessful during which time she was thrombolysed for possible pulmonary embolism. Post mortem showed a dissecting abdominal aortic aneurysm. Learning: 1) A CT chest should be considered in a patient with atypical chest pain 2) Consideration should be given to whether AMU should have its own massive pulmonary embolism kit.
2. A 69 year old man admitted for salvage chemotherapy for progressive multiple myeloma not responding to initial treatment. He developed neutropenic sepsis, acute kidney injury and likely ischaemic hepatitis, coagulopathy secondary to liver failure. Unexpected death – referred to the coroner.
3. A 79 year old man admitted for excision of a soft tissue mass – uncomplicated surgery, went home with drains is situ later removed. Re-admitted with cellulitis of wound treated with antibiotics and became fit for discharge. Sudden cardiac arrest but unsuccessful resuscitation. Cause of death agreed by coroner as 1a) hypertensive heart disease 2) atrial fibrillation (on apixiban), type 2 diabetes mellitus. Case discussed at mortality and morbidity meeting. No learning identified.
4. An 83 year old woman admitted following a fall, long lie and hypoglycaemia. No glucose recording and monitoring overnight (SII385).
5. An 81 year old man with metastatic renal cell carcinoma developed acute liver failure secondary to chemotherapy. Anticoagulants held due to low platelets. Deteriorated and sudden cardiac arrest and died. Coroner agreed cause of death 1) pulmonary embolism 1b) metastatic renal cell carcinoma 2) acute liver failure secondary to pazopanib. Case to be presented and discussed at an Oncology mortality and morbidity meeting.

6. A 79 year old man with multiple comorbidities admitted with acute confusion and included an abdominal aortic aneurysm which had increased in size. Investigations were ongoing when the patient had a cardiac arrest where there was a possible delay in starting CPR (SII393).
7. A 72 year old man deteriorated following complications of surgery and sepsis from multiple sources and a decision was made to withdraw treatment. Case to be presented at Surgical mortality and morbidity meeting.

11. Stillbirths, neonatal deaths and child deaths

In Q3 20/21:

- In November a neonatal death at 37 weeks. An ante natal woman attended clinic with a normal scan, but reduced fetal movements. Transferred to the labour ward, fetal heart below 50bpm, emergency C-section, full resuscitation and transfer to Southampton for cooling therapy. Care withdrawn the next day and baby repatriated to Salisbury for end of life care, died from hypoxic, ischaemic encephalopathy.
- An intra-uterine death at 39 weeks of a women with a high risk pregnancy with an undiagnosed small for gestational age baby.
- An intra-uterine death at 26 weeks of a baby with known fetal anomalies.
- An intra-uterine death at 38 weeks of an undiagnosed small for gestational age baby. Case currently under investigation by the HSIB as an intrapartum stillbirth.
- An intra-uterine death at 39 weeks of a high risk pregnancy of an undiagnosed small for gestational age baby (SII 391).
- No child deaths.

12. Patients with a learning disability

In Q3, 2 patients with learning disabilities died in November and December 20:

- An 83 year old woman with a mild learning disability, dementia and bi-polar disorder. Admitted following a fall at her care home – no injuries, treated for possible underlying infection. Long admission became drowsy and agitated when quetiapine dose reduced, treated for infection but little improvement. Gradual decrease in oral intake and in agreement with the family care was provided on the personalised care framework. Death expected. No potential learning identified.
- A 59 year old man with a severe learning disability admitted from his care home where 16 staff and other residents were COVID positive. He had a fever, cough and cyanosis and tested positive for COVID. He was treated for chest sepsis and low dose dexamethasone. ICU review – ward based ceiling of care. Rapid deterioration and desaturation – medical review concluded the patient was dying on maximal medical treatment. Following discussion with the next of kin it was agreed to keep him comfortable. Sudden but not unexpected death. No potential learning identified.

In Q2, 1 patient with a learning disability died in September.

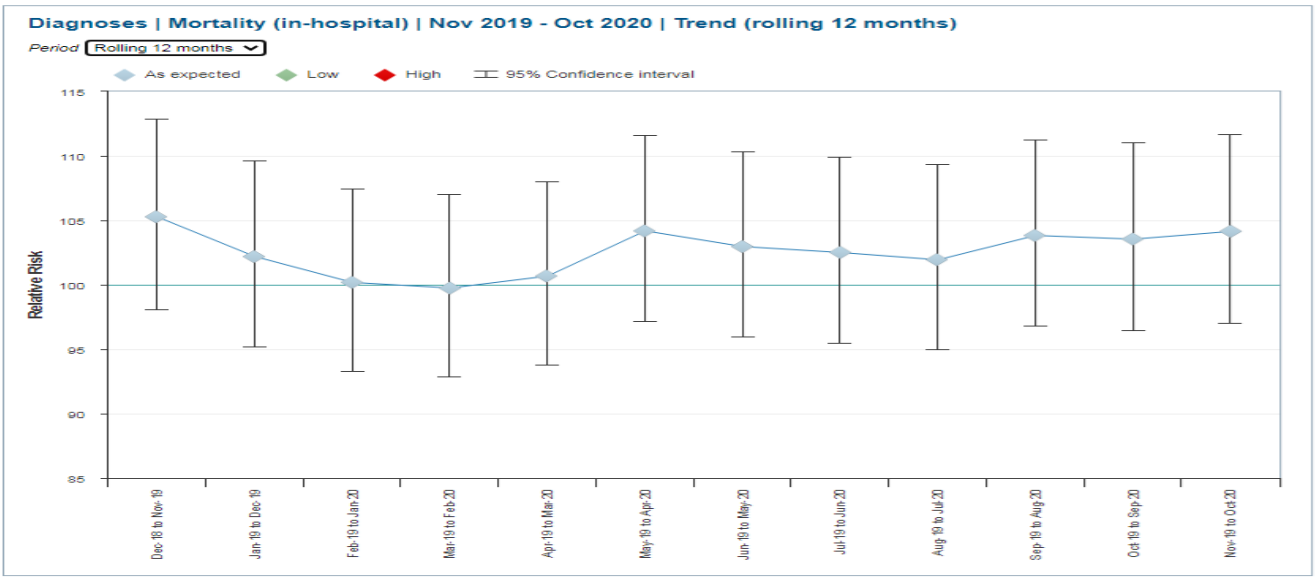
- A 65 year old woman with multiple comorbidities and mild learning disability. Admitted with a cerebellar haemorrhage and INR corrected. 13 days later became increasingly breathless which improved with diuretics but her oxygen requirement remained very high. Some improvement but then deteriorated again and reached the ceiling of care. Expected death. No learning points.

13. Patients with a serious mental illness

No deaths of patients with serious mental illness in Q3.

14. HSMR rolling 12 month trend to October 2020

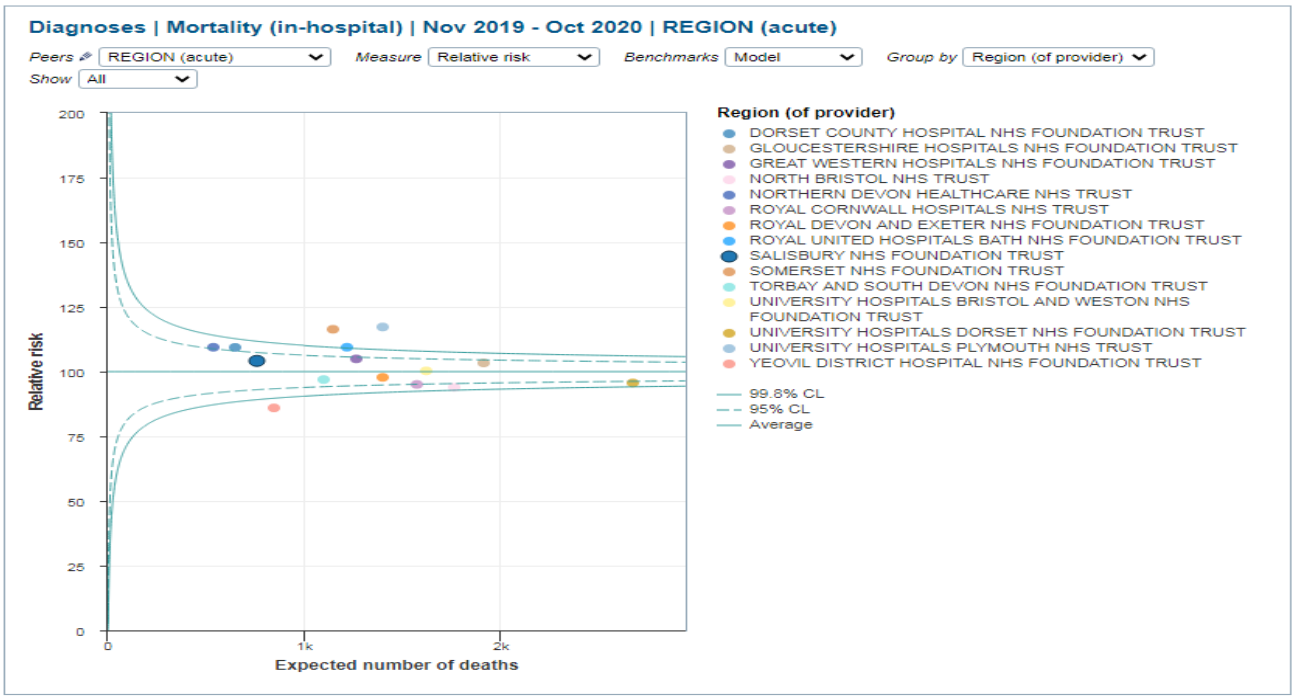
Figure 2: HSMR relative risk of all diagnoses Nov 19 – Oct 20



HSMR is 105.7 and is as expected over the last 12 month rolling period to October 20.

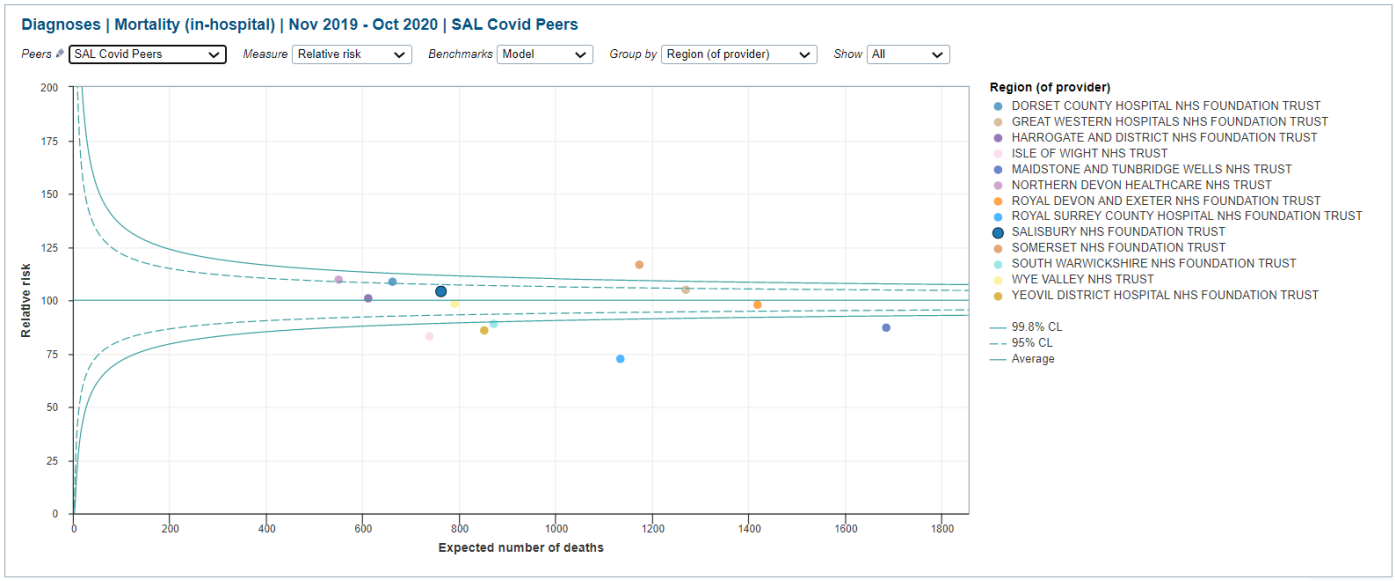
15. Mortality (in-hospital) regional peer comparison Nov 19 – Oct 20

Figure 3: Mortality (in-hospital) regional peer comparison Nov 19 – Oct 20



HSMR regional peer comparison shows the Trust is one of 9 acute Trusts with an HSMR within the expected range. Four Trusts have an HSMR that is statistically significantly higher than expected.

Figure 4: Mortality (all diagnoses) comparison to COVID similar peers (Nov 19 – Oct 20)

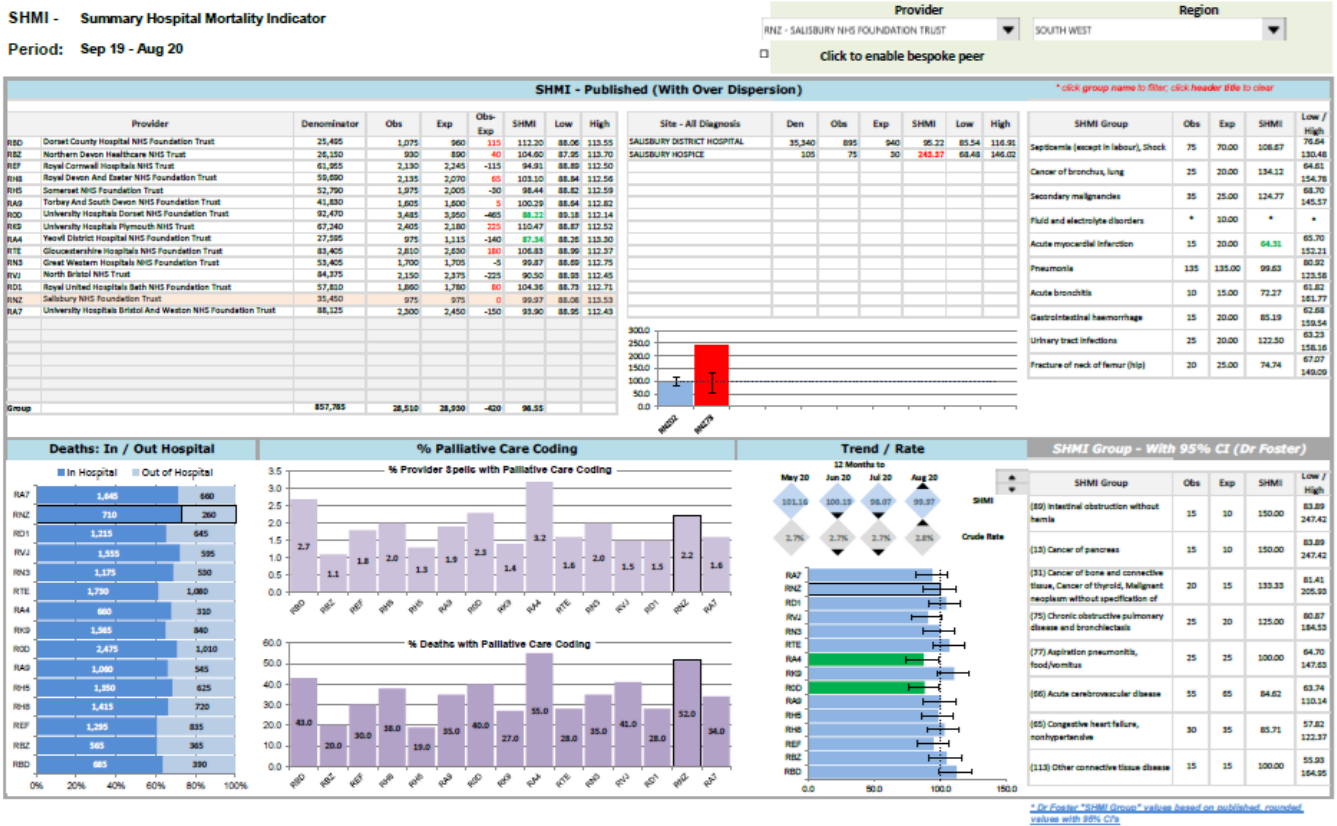


Over the coronavirus pandemic period, when the Trust is compared with a peer group of Trusts that had a similar cohort and number of COVID-19 spells and similar baseline capacity, the Trust is within the funnel plot.

16. SHMI Sept 2019 – Aug 2020

SHMI is 99.97 within the expected range to August 2020 and when adjusted for palliative care is 88.43. When comparing SHMI by site Salisbury District Hospital is 95.22 and Salisbury Hospice is 243.37. When compared with regional peers the Trust has a SHMI within the expected range.

Figure 5: SHMI regional peer comparison Sept 2019 – Aug 2020



17. Comorbidity and palliative care profile 20/21

Trends in comorbidity coding have shown an improvement since the Q2 20/21 report in the Trust's Charlson comorbidity upper quartile rate for the HSMR basket from 21.5% in Q2 to 22.3% in Q3 and an improvement as an index of national from 86 in Q2 to 89 in Q3. This means the proportion of a Trust's HSMR spells are where the Charlson comorbidity score for the primary diagnosis episode is in the national upper quartile for that diagnosis and admission type (the observed value). The expected value is the equivalent proportion nationally (100).

It was noted in the Q1 report that SFT had a lower than average number of secondary diagnosis codes overall. In response, the Clinical Coding Department undertook an audit and made a number of improvements. A further audit took place in Q2 based on Dr Foster's diagnosis group, highest numbers under the P25 centile with no Charlson comorbidities and those recorded outside of the first 14 codes. So far, abdominal hernia, acute stroke, anal and rectal conditions, biliary tract disease and pneumonia have been examined. COPD and bronchiectasis and other upper respiratory disease will also be reviewed. The audit will be reported to the Information Standards Group on 17 February 2021.

Figure 6: Trend in comorbidity profile

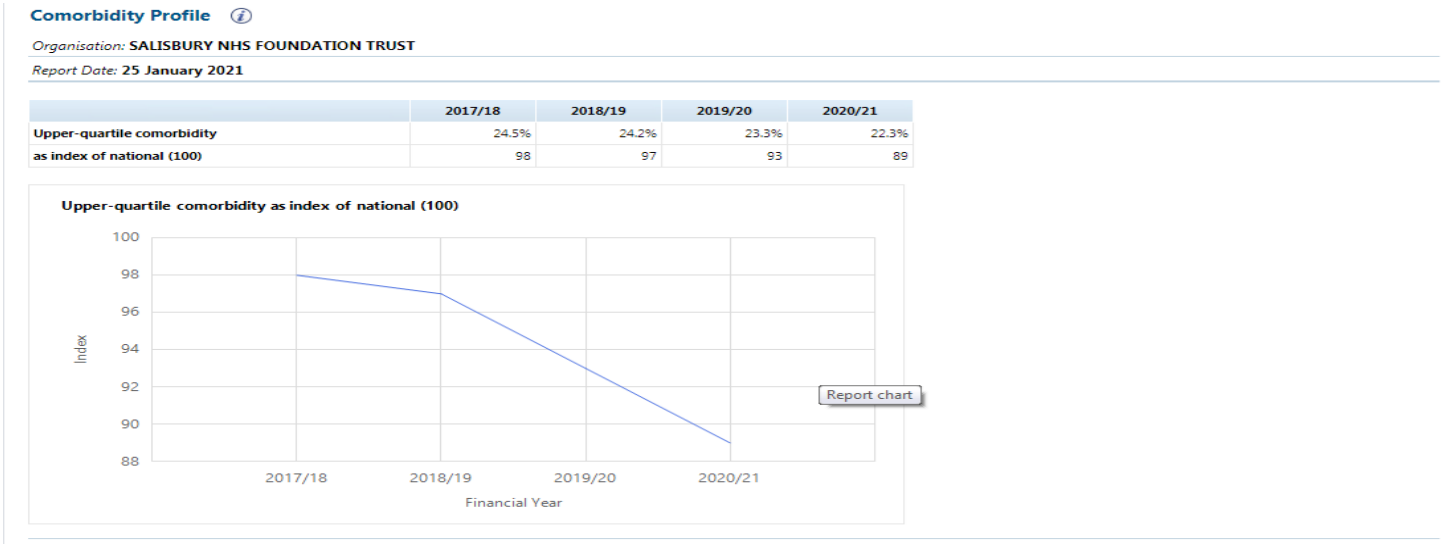
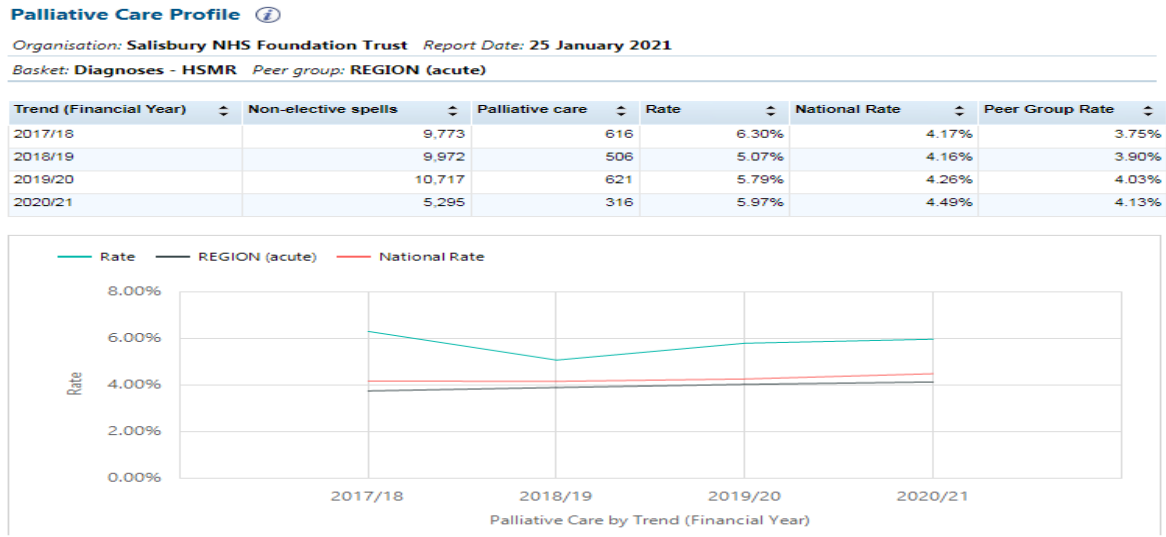


Figure 7: Trend in palliative care profile



The trend in the Trust's palliative care coding rate for non-elective spells in 20/21 is 5.97% and remains higher than the national rate of 4.49% and peer group rate of 4.13%.

18. Weekday/weekend HSMR

Figure 7 shows the non-elective weekday HSMR is 102.6 and weekend HSMR is 109.3 to October 20 having reduced from a peak of 133.8 in July 2019. Both are within the expected range. It should be noted that Saturday HSMR is 103 and Sunday HSMR is 116.7. Both are within the expected range.

Figure 8: HSMR weekday/weekend admission Nov 2019 – Oct 20

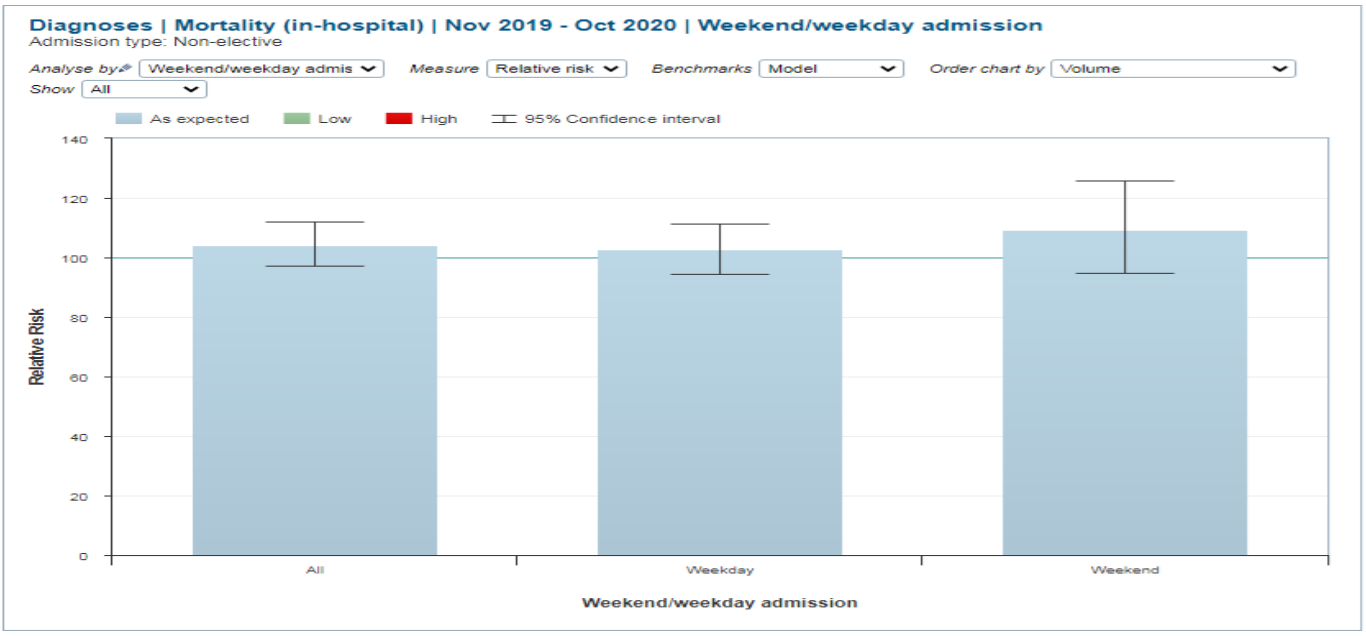
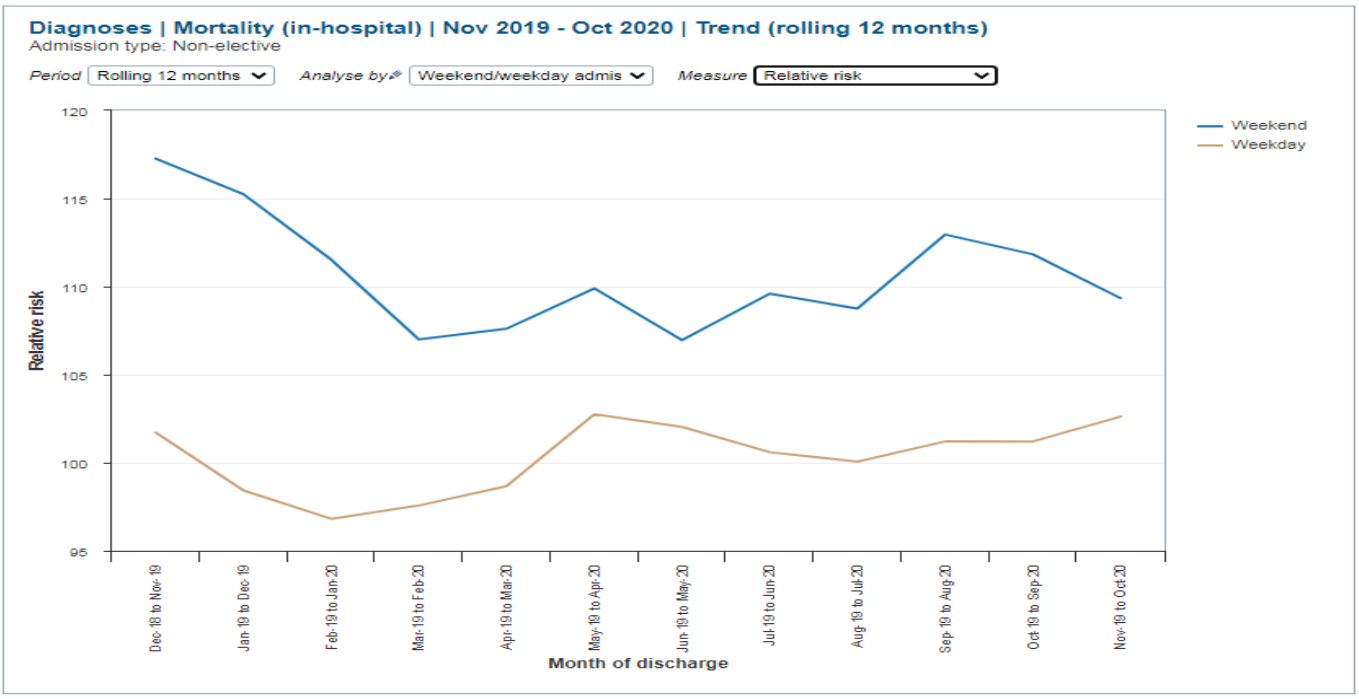


Figure 9: Rolling 12 month trend in emergency weekend and weekday Nov 19 – Oct 20



The emergency weekend HSMR trend started to decline from a peak of 117.3 in November 19 to 110 in October 20 and remains within the expected range. The reduction in weekend HSMR is due to a combination of a decrease in the crude mortality rate and an increase in the expected mortality rate.

A weekend quality improvement group was set up in January 20 which included the Chief Registrar and 3 doctors in training with the aim of improvng the management of the workload at weekends, particularly on a Sunday. It was planned to re-establish the group but has been put on hold due to the second wave of the COVID-19 emergency and will re-form in 2021/22.Improvements progressed so far have been the weekend handover and a pilot of a Critical Care Outreach Team co-ordinator on a Sunday from 2 – 10 pm to triage and allocate the workload. Feedback from doctors in training was positive.

An NHS 7 Day Services survey in September 20 showed that 95% of patients at a weekend received an assessment by a consultant within 14 hours of admission compared to 81% in September 2019. A

significant improvement in the proportion of patients who needed a daily review at the weekend who received it at 97% compared to 77% in September 19. The improvement was considered to be a change in the weekend physician rota which removed the ward cover consultant and replaced it with a hybrid model where patients were seen by the person with the right level of seniority.

19. Deaths in high risk diagnosis groups (Nov 19 – Oct 20)

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

Figure 10: Trend in relative risk for septicaemia (except in labour)

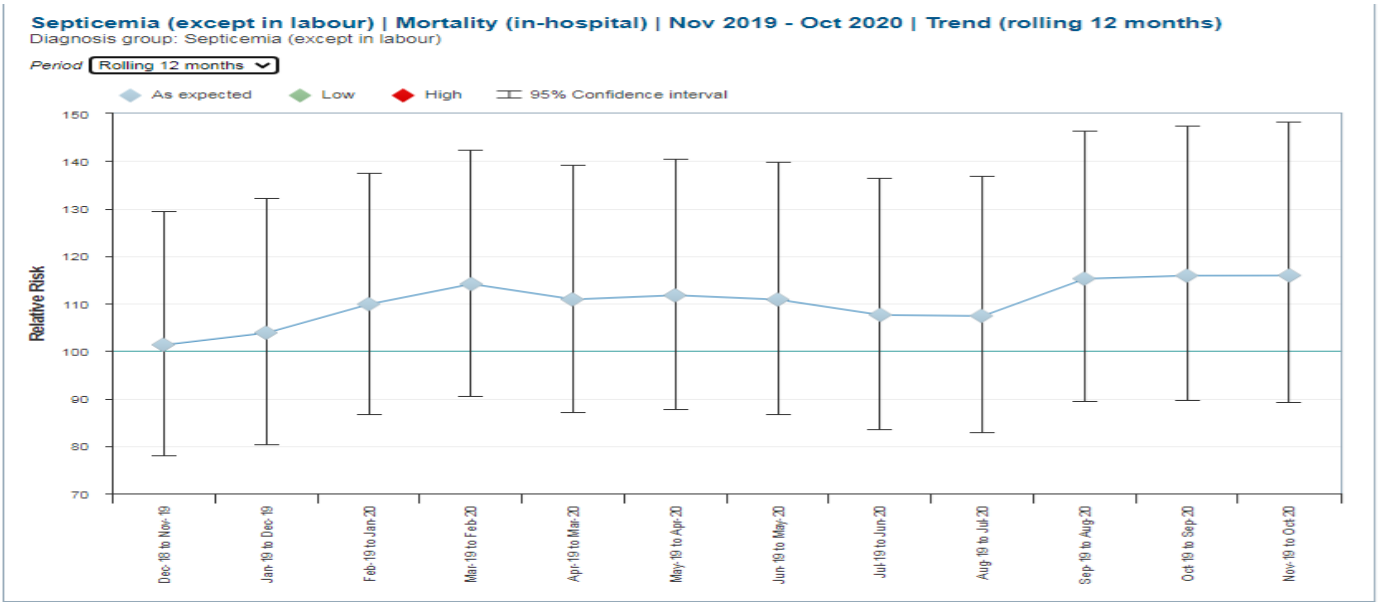


Figure 11: Trend in relative risk for pneumonia

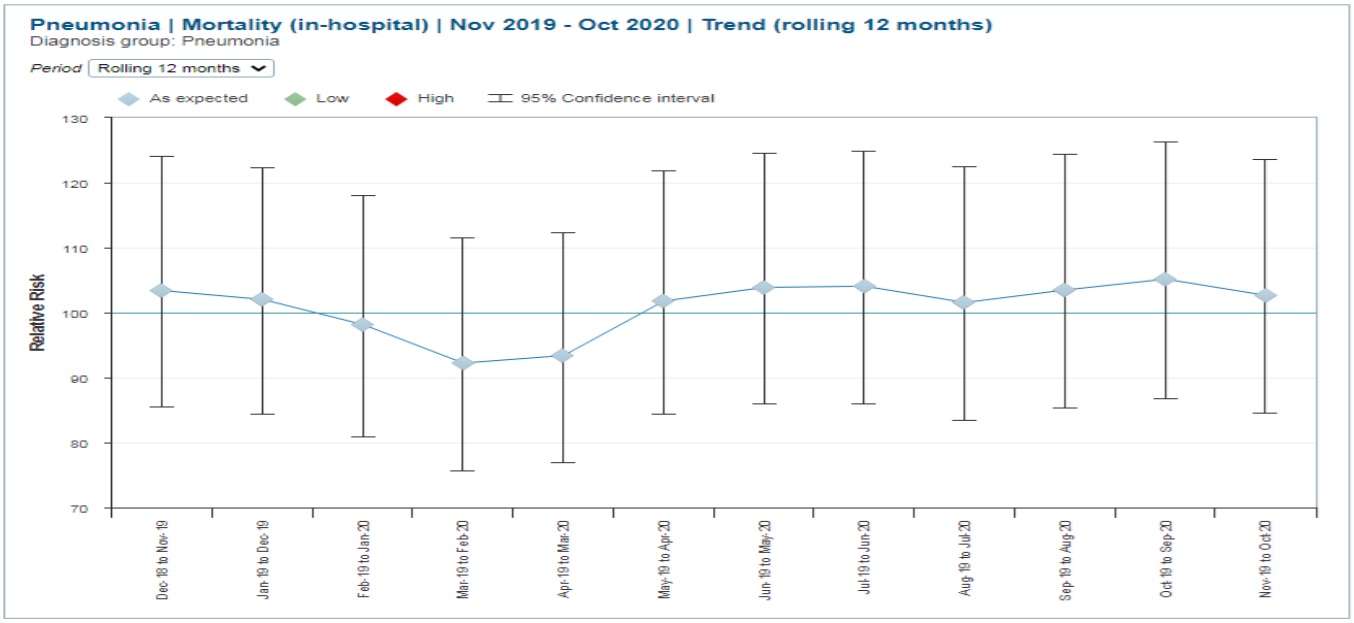


Figure 12: Trend in relative risk for acute cerebrovascular disease

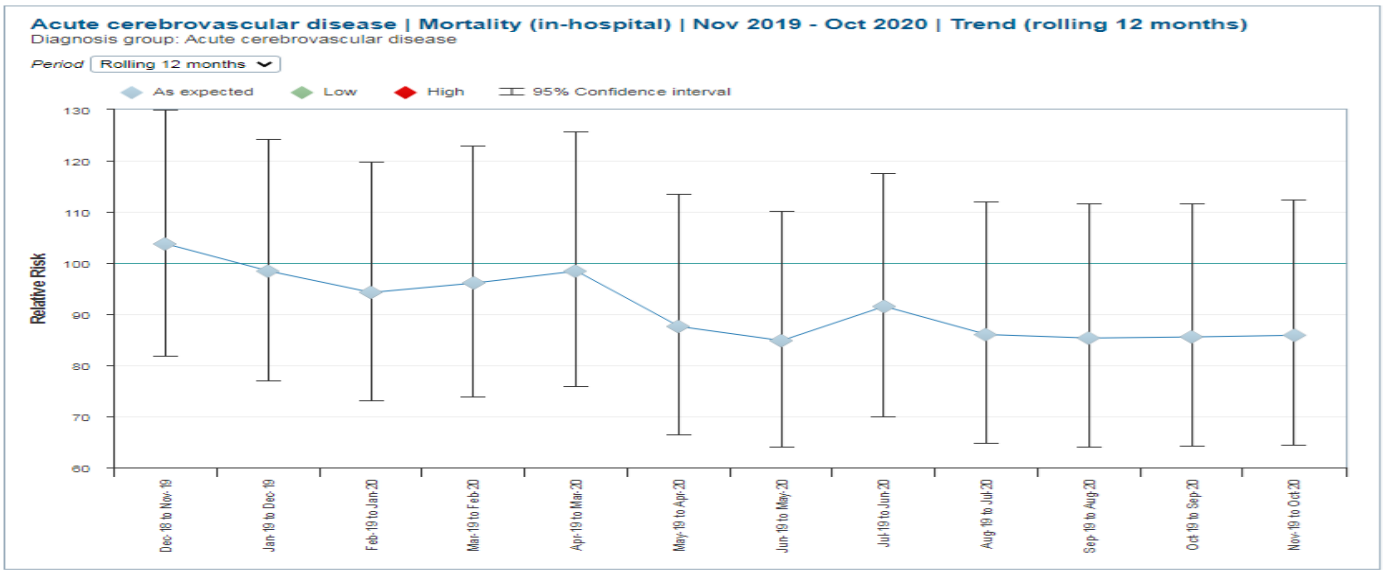


Figure 13: Trend in relative risk for acute myocardial infarction

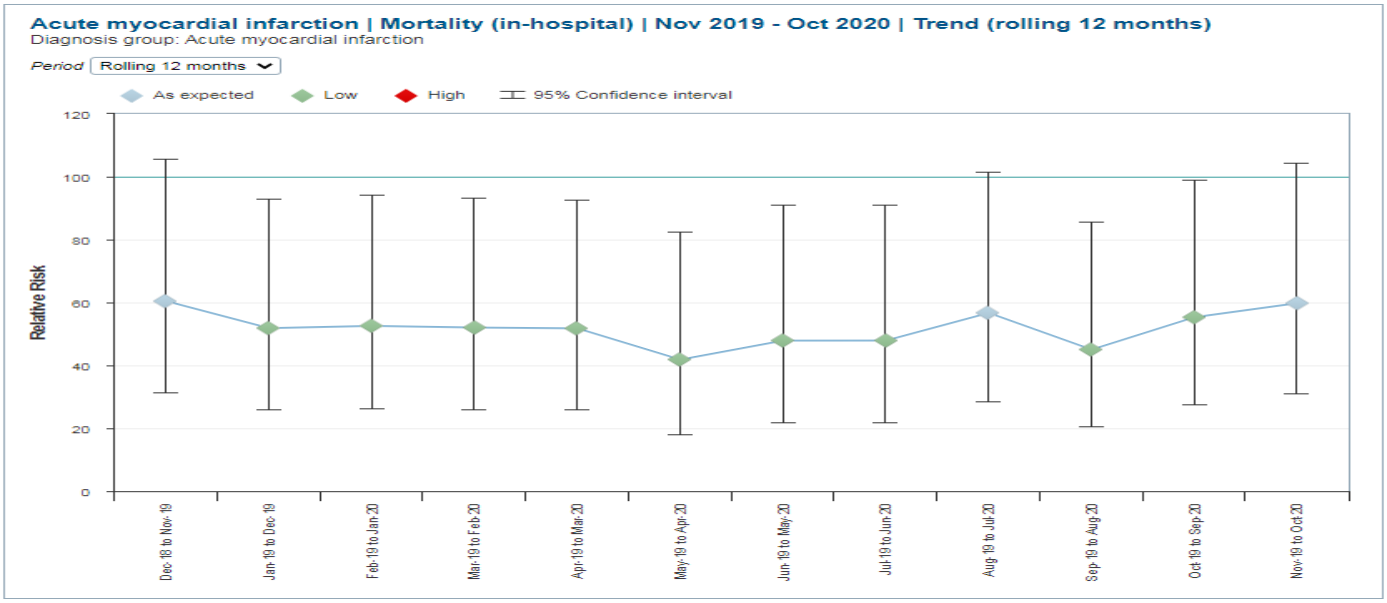


Figure 14: Trend in relative risk for congestive heart failure

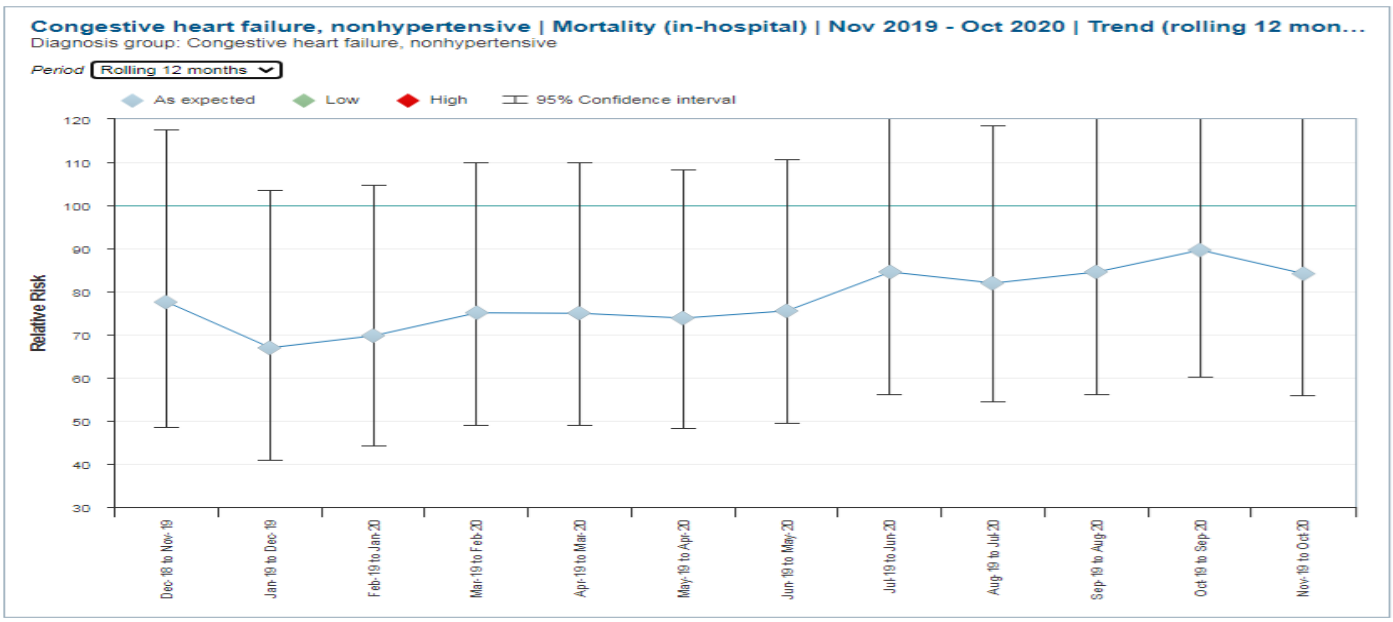
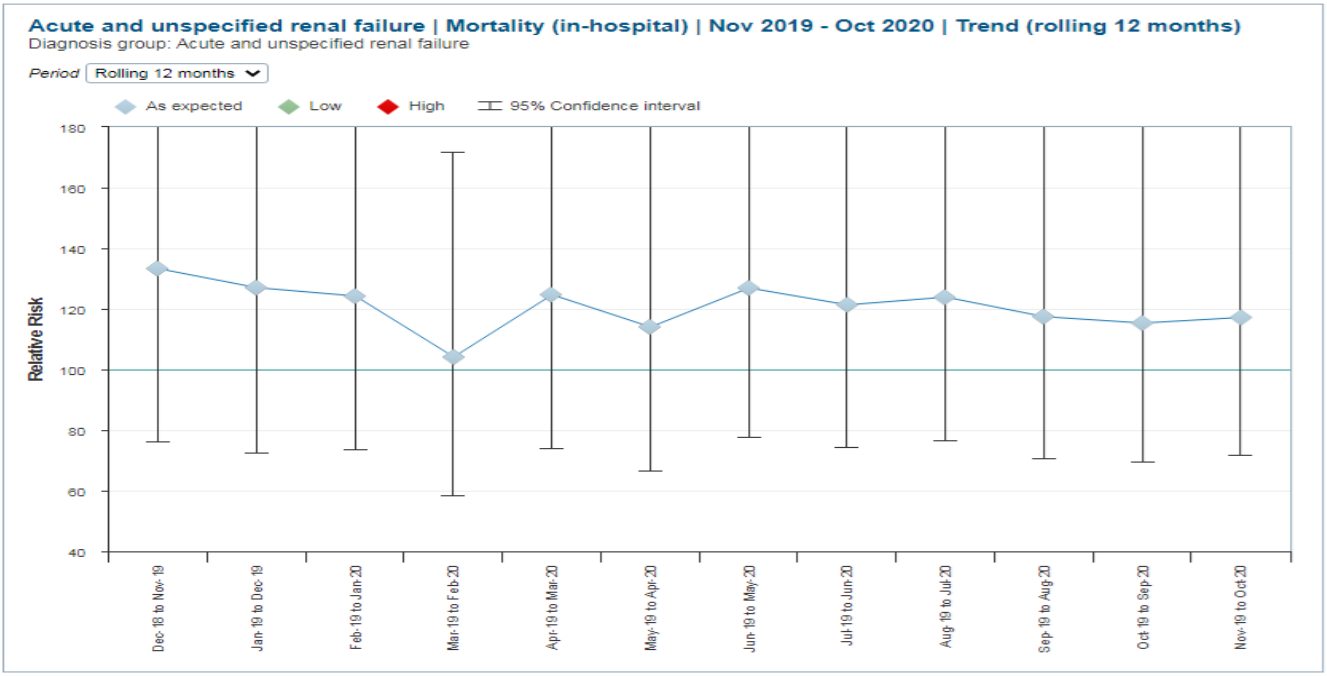


Figure 15: Trend in relative risk for acute and unspecified renal failure



The relative risk of death from acute renal failure has stabilised and remains within the expected range. A review of patients who died with acute kidney injury concluded that 86% (12/14) of patients had acute kidney injury on admission to hospital and despite initial treatment only 1 patient's renal function improved. Although, the cause of the acute kidney injury was felt to be pre-renal in nature, no urinalysis was carried out to confirm this hypothesis or determine the urgency of the medical treatment plan. There were significant gaps in the monitoring and accuracy of fluid balance therefore treatment evaluation and early detection was delayed. Sepsis screening was missed in 2 cases and specimen results were not reviewed which may represent a missed opportunity to review antibiotic therapy. It is recognised however that changing antibiotic therapy may not have changed the overall outcome. Despite these omissions, all patients had significant co-morbidities which would account for the increased mortality rate in this group.

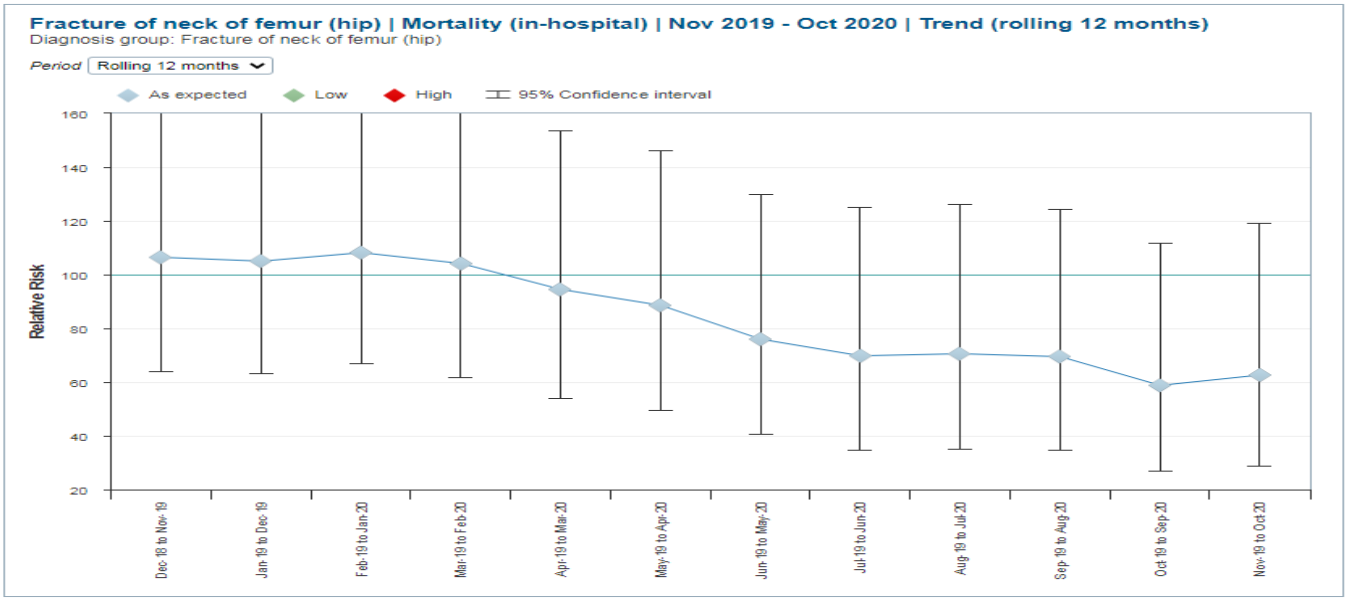
Two patients, developed iatrogenic acute kidney injury following contrast administration which may have contributed to a destabilisation of their pre-existing comorbidities and thus to their death. One patient had a missed diagnosis of acute kidney injury and was discharged but readmitted the same day.

Action plan:

1. Review the Trust guidelines for the management of metabolic acidosis
2. Obtain an update on the implementation of NHSI (2019) alert 'resources to support safe and timely management of hyperkalaemia' – completed.
3. Improve the compliance with accurate fluid balance monitoring
4. Ensure all patients admitted to hospital with acute kidney injury or those that develop the disease have a urinalysis undertaken as part of the screening process.
5. Evaluation of the use of the acute kidney injury care bundle.
6. Evaluate the follow up monitoring of patients who have received IV contrast as an inpatient

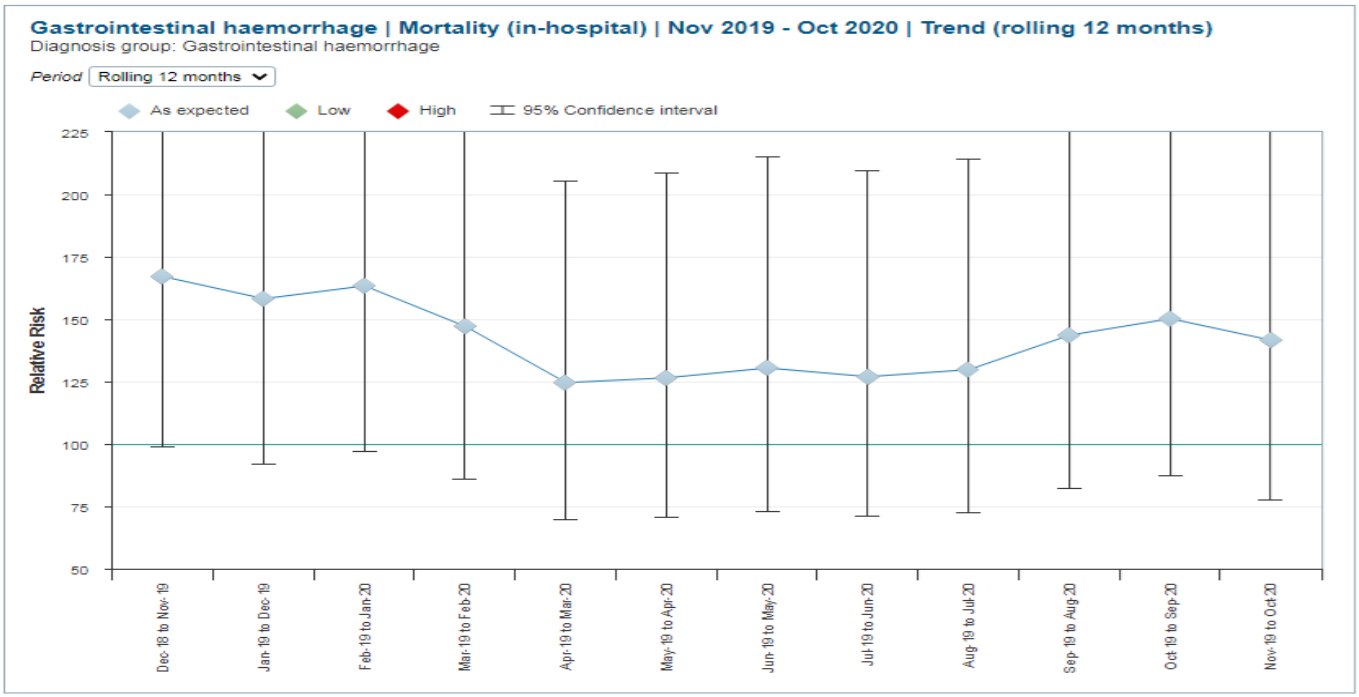
An update on progress of the acute kidney injury action plan will be presented to the Mortality Surveillance Group in April 21.

Figure 16: Trend in relative risk for fracture of neck of femur



Improvement actions completed since the review of 33 deaths of patients with a hip fracture in October 2019 have shown a steady decline in the mortality rate since February 2020. This can be attributed to prioritising hip fracture patients to ensure they are operated on within 36 hours (83% in Nov 20 compared to 68% nationally), an increase in spinal anaesthetics (from 14% in Oct 19 to 34% in Nov 20) and more nerve blocks given pre theatre (from 31% to 75%) leading to fewer opioids.

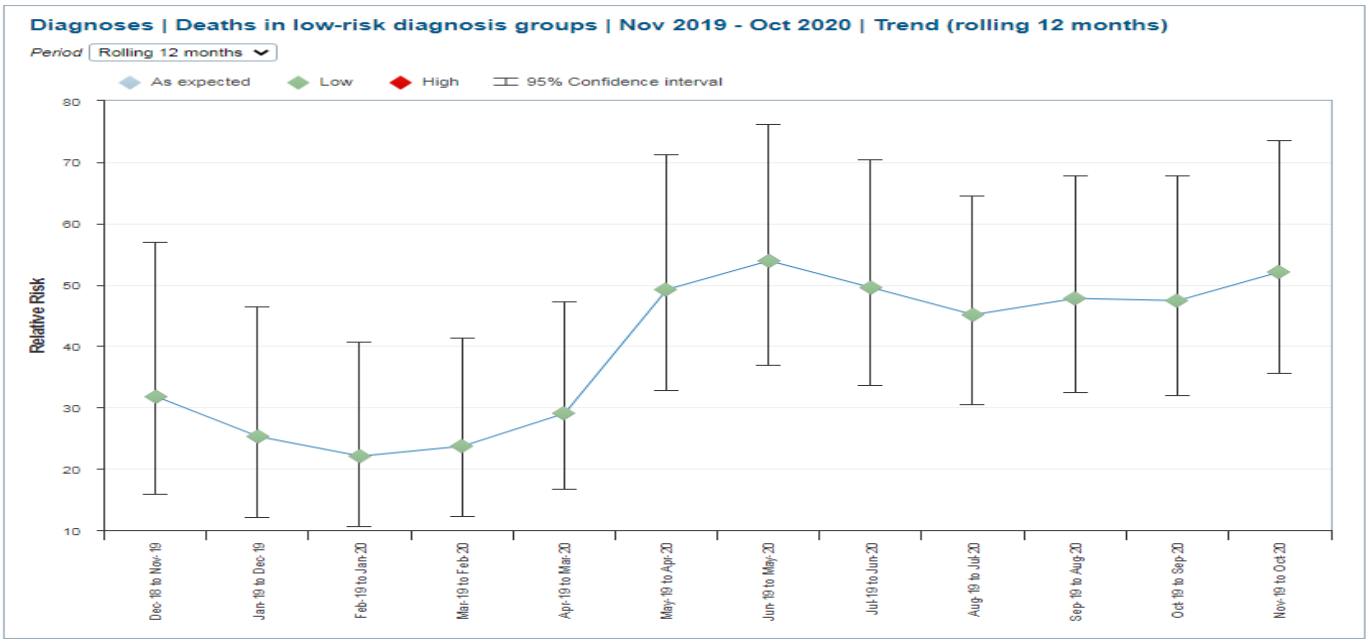
Figure 17: Trend in relative risk for gastrointestinal haemorrhage



A gastrointestinal haemorrhage CUSUM alert arose in August 2020 of 16 patients who died compared to 4.6 expected with a relative risk of 144. The 16 deaths occurred between October 2019 and October 2020 and are currently under review. The outcome will be reported to the Mortality Surveillance Group in April 2021.

20. Deaths in low risk diagnosis groups (Nov 19 – Oct 20)

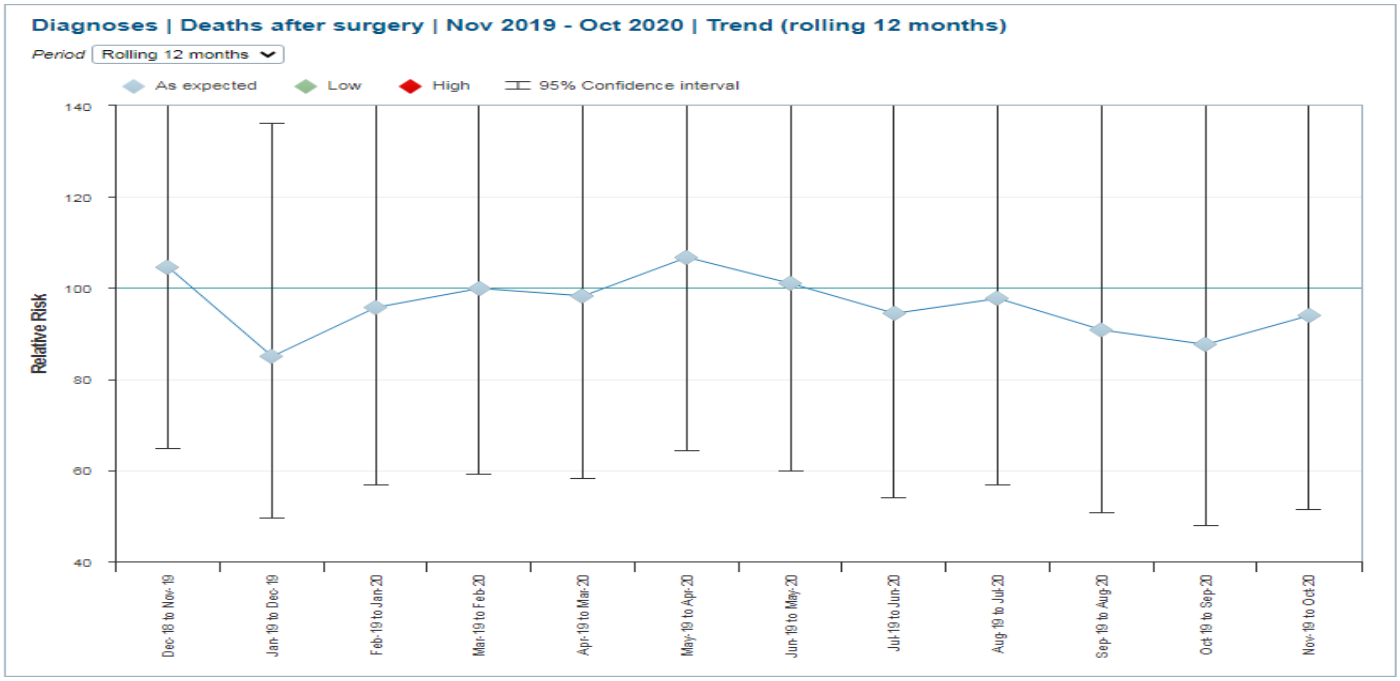
Figure 18: Trend in relative risk for deaths in low risk diagnosis groups



The relative risk of death in a low risk group is 52.1 and is lower than expected. The rise in April 2020 is attributed to deaths in the viral infection group (COVID-19) which is considered low risk.

21. Deaths after surgery (Nov 19 – Oct 20)

Figure 19: Trend in relative risk for deaths after surgery



The relative risk of death after surgery is 94 and is as expected.

22. Summary

Learning from deaths in the Q3 report has been dominated by deaths of patients who died from COVID-19 from the new more transmissible variant. This has resulted in an increase in the number of hospital acquired COVID cases mitigated by additional measures already put in place to reduce the risk of nosocomial transmission. More relatives have been able to be with their loved ones at end of life with PPE or enabled to have virtual discussions where relatives felt the risk of visiting was too high. A theme emerged from relative feedback about the length of time it takes to get through to the ward by telephone to find out the progress of their loved one or not receiving any communication at all, even though the intention was often recorded in the notes. Mitigated to some extent by the PALS team who are able to ascertain information and relay it back to relatives.

Positive assurance on the outcome of completed actions from the hip fracture review shows a steady decline in the mortality rate.

23. Recommendation

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

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

Claire Gorzanski,
Head of Clinical Effectiveness

27 January 2021

Appendix 1 **SALISBURY NHS FOUNDATION TRUST - MORTALITY DASHBOARD 2020/2021**

	Apr 20	May 20	Jun 20	Q1	Jul 20	Aug20	Sep 20	Q2	Oct 20	Nov 20	Dec 20	Q3	Jan 21	Feb 21	Mar 21	Q4	Total
Deaths	98	60	49	**207**	65	55	58	**178**	65	65	88	**218**					**603**
1st screen	94	56	48	**198**	63	47	54	**164**	60	61	86	**207**					**569**
% 1st screen (QAP)	96%	93%	98%	**96%**	97%	85%	93%	**92%**	92%	94%	98%	**95%**					**94%**
Medical Examiner (ME) scrutiny						22	43	**65**	47	48	74	**169**					**234**
% ME scrutiny						40%	74%	**57%**	72%	74%	84%	**77%**					**71%**
Case reviews (SJR)	54	16	10	**80**	11	0	0	**11**	3	11	21	**35**					**126**
% case reviews	55%	27%	20%	**39%**	17%	0%	0%	**6%**	4%	17%	24%	**16%**					**21%**
COVID deaths	41	7	3	**51**	0	0	0	**0**	1	7	15	**23**					**74**
Deaths with Hogan score 1	89	58	47	**194**	65	54	55	**174**	64	64	86	**214**					**582**
Deaths with Hogan score 2 - 3	7	2	2	**11**	0	1	3	**4**	1	1	2	**4**					**19**
Deaths with Hogan score 4 - 6	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**					**2**
Learning points	13	4	2	**19**	0	2	4	**6**	6	6	9	**21**					**46**
Family/carer concerns	1	6	5	**12**	0	2	3	**5**	3	2	5	**10**					**27**
CUSUM alerts	1	0	0	**1**	1	13	1	**15**	2	3	1	**6**					**22**
CUSUM investigated	0	0	0	**0**	1	12	0	**13**	0	2	0	**2**					**15**
Deaths investigated as a SII	1	1	0	**2**	0	0	1	**1**	1	1	4	**6**					**9**
SIIs graded as catastrophic	0	0	0	**0**	0	0	1	**1**	1	1	2	**4**					**5**
Death following an elective admission	0	1	1	**2**	1	0	1	**2**	1	2	0	**3**					**7**
Unexpected death	1	1	0	**2**	2	0	0	**2**	1	3	3	**7**					**11**

Stillbirth	1	1	0	**2**	0	0	1	1	0	0	4	**4**					**7**
Neonatal death	1	0	0	**1**	0	2	0	2	0	1	0	**1**					**4**
Child death	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**					**0**
Learning disability deaths	1	0	0	**1**	0	0	1	**1***	0	1	1	**2***					**4**
Reported to LeDeR programme	1	0	0	**0**	0	0	0	**0**	0	0	0	**0**					**0**
Serious mental illness	0	0	0	**0**	0	3	0	**3**	0	0	0	**0**					**3**
Maternal deaths	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**					**0**

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

MORTALITY DASHBOARD THEMES AND ACTIONS 2020/2021 **Appendix 2**

No	Learning points	Action point	By whom	By when	Update 25/1/2021	Status
1	Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form)	Work programme to be developed with planned implementation by 31/3/2021	BSW CCG and Resuscitation Committee	31/03/21	The national version 3 was published in August 20. BSW CCG are leading the introduction of ReSPECT with support from SFT's Resuscitation Officer and Resuscitation Committee. However, there has been little progress to report since the onset of the 2nd wave of COVID-19 pandemic.	
2.	Learning arising from the COVID death (1st wave) review in Q1 & Q2 20/21	Evaluate the effectiveness of the actions already taken from the review of patients who die from COVID in the 2nd wave.	Divisonal Management Teams	31/03/21	The review of deaths of patients with COVID-19 was presented to the Clinical Governance Committee in November 20.	
3	Learning arising from the COVID death (2nd wave) review	Raise learning themes as they arise so that changes can be made in real time.	Medical Examiners SPCT/EOLC teams	31/3/2021	Additional measures put in place to mitigate the risk of nosocomial transmission – see section 3 of Q3 20/21 report	

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

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

2. 1st screen - the Qualified Attending Practitioner (QAP) develops and records their own preliminary view of the cause of death before discussing the case with the Medical Examiner or Medical Examiner Officer and only completes the medical certificate of the cause of death (MCCD) after this discussion.

3. Medical Examiner scrutiny – the number and proportion of deaths scrutinised by a Medical Examiner. Medical Examiners are senior medical doctors who review deaths and are trained in the legal and clinical elements of the death certification processes. The purpose of the Medical Examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased and to improve the quality of death certification.

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

5. COVID deaths – the number of patients who died in hospital who tested positive for COVID.

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

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

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

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

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

11. Deaths investigated as a SII (serious incident inquiry) - the number of deaths investigated as a serious incident inquiry and graded as catastrophic.

12. Deaths following a planned admission – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had progressive disease and were admitted to hospital for symptom control or a procedure to relieve their symptoms.

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

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

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

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

17. Learning disability deaths – all patients with a learning disability aged 4 to 74 years who die in hospital. The Trust reports all these deaths to the LeDeR programme.

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

19. Serious mental illness – all patients who die in hospital with a serious mental illness.

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

References

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

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	08 April 2021		

Report Title:	Review of Standing Financial Instructions			
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):	Draft Standing Financial Instructions Draft Scheme of Delegation			

Recommendation:
To accept the proposed amendments to the Salisbury NHS Foundation Trust's Standing Financial Instructions, including changes to the delegated limits set out in the document and to update the text to accurately reflect the current decision structure of the organisation.

Executive Summary:
Following a review of the Trust's Standing Financial Instructions five key amendments are being proposed. The objective of these amendments are: to update the document in line with the current structure of the organisation, to improve responsiveness in decision making through targeted changes to delegated authorisation limits, and to improve the control environment and culture of the Trust by setting a clear standard in the signing of contracts.

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 The purpose of this report is to brief the Board on the review of the Trust's Standing Financial Instructions, and to recommend amendments as appropriate.

2 Background

2.1 The Trust's Standing Financial Instructions (SFIs) have been in place since 1st December 2017. The SFIs are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs should be reviewed for effectiveness and appropriateness on a regular basis, the last such review of the Trust's SFIs was August 2019.

2.3 Where the Board does elect to set delegated limits, the Chief Executive Officer remains ultimately accountable to the Board as Accountable Officer, retaining overall responsibility for the Trust's activities. All delegated powers can be re-assumed by the CEO should the need arise.

3 Drawing a distinction between Capital planning and approval

3.1 At present the SFIs dictate that Board approval of the annual capital plan may be taken by default as full and final approval for each constituent programme. This fails to draw a clear distinction between assurance provided through the planning process, and the governance of decision making.

3.2 It is recommended that this default full and final approval is removed and individual capital programme are subject to the same delegated limits as in year amendments to the capital plan.

3.3 As such, the wording in section 12.2.1 of the SFIs will be amended to:
Where a capital scheme is approved within the annual capital plan, full and final approval to proceed is still required as set out in the delegated limits in table 4.

3.4 In order to avoid an overly cumbersome governance process, approval of the annual plan will still allow for a recommendation on the full and final approval to proceed on specific projects, but such projects will be clearly set out in a dedicated schedule in the planning papers. This will apply to projects that fall outside out for the Trust's business case process such as critical infrastructure works and core medical equipment replacement.

3.5 This recommended change does not affect the Trust's procurement governance processes, including recommendation report delegated limits.

4 Delegated limits

4.1 <u>Approval of Capital projects</u>

At present the capital delegated limits in the SFIs state (section 12.2.1) are as follows:

Capital Plan	**Capital for new schemes (not in Capital Plan), or changes to the Capital Plan**	**Forum**
N/A	<£100k	CapCG (TMC informed via minutes) Director of Finance
N/A	£200k to <£300k	TMC Chief Executive
N/A	£300k to <£750k	Finance and Performance Committee
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	£750k+ Any proposed major scheme within FT compliance arrangements	Trust Board
Any proposed major scheme within FT compliance arrangements	Any proposed major scheme within FT compliance arrangements	NHS Improvement

4.2 Subsequent to the previous review of SFIs, and a deep dive into the Trust's approach to large scale projects a Strategic Capital Committee, chaired by the Director of Finance, has been established. This therefore needs to replace the more operational Capital Control Group (CapCG), chaired by the Deputy Director of Finance, in the SFIs and adopt CapCG's delegated limit. This replacement occurs in sections 12.1.1 and 12.1.2 of the SFI document.

4.3 It is recommended the CapCG retains a delegated limit of up to £100k for additions and amendments to the capital plan in order to maintain responsiveness to minor alterations in plans and forecasts.

4.4 In order to maintain responsiveness in decision making, an increase to the capital expenditure limits of SCC and the DoF to up to £350k, and the CEO and TMC to £500k is recommended. This change will also align capital delegated limits with procurement delegated limits for the placing of contracts (whereby £500k is the threshold for recommendation reports to go to Finance and Performance Committee.

4.5 For information, the projects with a forecast 2020/21 spend greater than £300k in 2020/21 are:

Project	Sub-group	20020/21 Forecast £'000
ED Configuration	CPG	1,830
Laverstock Critical Care Surge Capacity (Radnor/Laverstock)	CPG	420
MRI 2 + Infrastructure	CPG	1,302
Building & Works Total		**3,552**
Client Devices	IT	508
Pathology - Laboratory Information Management System	IT	874
M/soft Environment Replacement	IT	1,080
Network Kit	IT	819
PACS	IT	408
Information Technology Totals		**3,689**
Anaesthetics Machines	MDC	614
Cardiac Cath Lab 1	MDC	941
Medical equipment Totals		**1,555**
Total		**8,796**

4.6 In order to maintain oversight, capital projects of over £350k will be itemised and reported to Trust Board on a quarterly basis.

4.7 The revised delegated limits in section 12.2.1 will be as follows:

Capital Plan	***Approval to proceed, or changes to previously approved Capital.***	**Forum**
N/A	**<£100k**	CapCG (TMC informed via minutes)
N/A	**£100k to <£350k**	Strategic Capital Committee Director of Finance
N/A	**£350k to <£500k**	TMC Chief Executive
N/A	**£500k to <£750k**	Finance and Performance Committee
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	£750k+ Any proposed major scheme within FT compliance arrangements	Trust Board
Any proposed major scheme within FT compliance arrangements	Any proposed major scheme within FT compliance arrangements	NHS England & Improvement

5 Recommendation

It is recommended that Audit Committee support the proposed changes for approval at Trust Board. Below is a summary of these changes:

1	Remove approval by default of capital projects on plan approval	Section 12.2.1 p.35
2	Amendment to delegated limits for capital expenditure: Insert Strategic Capital Committee in place of Capital Control Group, but retain a delegated limit of up to £100k for the latter.	Section 12.2.1 Sections 12.1.1 & 12.1.2 p.34
3	Amendment to delegated limits for capital expenditure: Increase delegated limits for the DoF and SCC to up to £350k, and the delegated limit for the CEO and TMC to up to £500k.	Section 12.2.1 p.34

Mark Ellis
Deputy Director of Finance

Salisbury
NHS Foundation Trust

Standing Financial Instructions

Version:	**Audit Committee draft ~~July 2019~~March**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	
Signature of authorising Committee:	
Ratification Committee (Category 1 documents):	
Date of Ratification (Category 1 documents):	
Signature of ratifying Committee Group/Chair(Category 1 documents):	
Lead Job Title of originator/author:	**Director of Finance**
Name of responsible committee/individual:	**Lisa Thomas**
Date issued:	
Review date:	
Target audience:	**All Directorates**
Key words:	**Trust powers; Trust Board; Chairman; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Directorates**
Consultation:	**Audit Committee** **Executive Directors**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**55**
Type of document:	

Standing Financial Instructions

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Salisbury NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st June 2006, following authorisation by "NHS Improvement", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).

1.1.3 The Single Oversight Framework details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in The Audit Code for NHS Foundation Trusts, and the Department of Health Group Accounting Manual (DH GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors.

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the Director of Finance, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Trust Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Director of Finance (DOF)

1.2.4 The Chief Executive and DOF will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Trust Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Director of Finance

1.2.7 The DOF is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the DOF include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

Board of Directors and Employees

1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.9 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the DOF.

2. AUDIT

2.1 Director of Finance

2.1.1 The DOF is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS Improvement's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Annual Governance Statement" and also provides assurances to the Audit Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

2.1.2 The DOF and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access during normal working hours to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the DOF;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the DOF must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.2.4 The Head of Internal Audit or equivalent title, will normally attend Audit Committee meetings and has a right of access to Audit Committee members, the Chairman and Chief Executive.

2.2.5 The reporting system for internal audit shall be agreed between the DOF, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DH Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee.

2.3.2 The Audit Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.3.6 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the DOF is required to authorise expenditure.

2.3.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and DOF shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to NHS Protect's standards.

2.4.2 The DOF is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Protect anti-crime Standards.

2.4.4 The LCFS shall report to the DOF and shall work with staff in NHS Protect, in accordance with the NHS Protect anti-crime Standards, the anti-fraud manual and NHS Protect's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the DOF to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Protect.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the DOF and outcomes fed back to the Audit Committee.

2.4.8 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Protect.

2.4.9 The Trust will report annually on how it has met the standards set by NHS Protect in relation to anti-fraud, bribery and corruption work and the DOF shall sign-off the annual self-review and authorise its submission to NHS Protect. The DOF shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHS Protect's standards.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHS Protect anti-crime standards.

2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management

2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD). who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Trust Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in patient care activity, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS Improvement (NHSI).

3.1.2 The annual plan must be approved by the Trust Board and submitted to NHSI in accordance with their requirements.

3.1.3 All executive directors, directorate management teams and corporate service managers shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

3.1.4 The DOF will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Trust Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with patient care activity and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks and mitigating actions;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

3.1.5 The Trust Business Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.6 The DOF shall monitor financial performance against budget, and report to the Finance and Performance Committee and Trust Board of Directors.

3.1.7 All budget holders must provide information as required by the DOF to enable budgets to be compiled.

3.1.8 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to forecast will be made in year for those that are subsequently approved. Table 1 sets outs the delegated limits for the approval of business cases:

'In year' revenue value	Authorisation to approve
<£25k	Division Management Team
£25k to <£250k	Trust Management Committee Chief Executive
£250k to <£750k	Finance and Performance Committee
>£750k	Trust Board

Table 1

3.1.9 The DOF has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the DOF, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

e) Achievement of planned levels of service;

f) Authority to exercise virements.

g) The provision of regular reports.

3.2.2 Except where otherwise approved by the Chief Executive, taking account of advice from the DOF, budgets shall only be used for the purpose for which they were provided.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the DOF, subject to guidance on budgetary control in the Trust.

3.2.4 Non-recurring budgets shall be agreed by the Chief Executive or the DOF and should not be used to finance recurring expenditure without their authority in writing.

3.2.5 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.6 Clinical Directors or Service Leads, who are responsible for 'trading activities' must ensure the integrity and supply of information to other users. Price increases in such departments should be monitored by the DOF to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

3.3.1 The DOF will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Finance & Performance Committee and Trust Board of Directors in a form approved by the Trust Board of Directors containing sufficient information to allow the Finance & Performance and the Trust Board of Directors to ascertain the financial performance of the Trust. This may include the following:

   i) Income and expenditure to date, showing trends and the forecast year-end position;
   ii) Workforce spend and WTEs;
   iii) NHS commissioner's contractual performance to date;
   iv) Movements in working capital (including cash);
   v) Capital project spend and projected outturn against plan;
   vi) Explanations of any material variances from budget;
   vii) Details of any corrective action where necessary and the Chief Executive's and/or DOF's view of whether such actions are sufficient to correct the situation;

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, workload and manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget-holder must account to their Directorate Management Team or line manager for the overspending and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

3.3.3 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Trust's Vacancy Control Panel, other than medical and nursing staff provided for within the budgeted workforce establishment.

3.3.4 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS Improvement's Single Oversight Framework, finance and use of resources metrics.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The DOF on behalf of the Chief Executive, will ensure that the appropriate monitoring forms and returns are submitted to NHSI in accordance with the national annual timetable. The performance figures to the Trust Board of Directors should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The DOF, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS Improvement and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS Improvement as to their technical accounting content and information/data shown therein, before submission to NHS Improvement.

4.2 The Chief Executive will prepare the Annual Report in accordance with the guidance in the DH Group Accounting Manual.

4.3 The Director of Nursing will prepare the Annual Quality Report in the format prescribed by NHS Improvement/Care Quality Commission and in accordance with the DH Group Accounting Manual. The Quality Report presents a balanced picture of the Foundation Trust's performance over the financial year and up to the agreed submission date.

4.4 The Trust's Annual Report, Annual Accounts and financial returns to NHS Improvement and Annual Quality Report must be audited by the external auditor in accordance with appropriate international auditing standard, where relevant.

4.5 The Annual Report, Accounts and Quality Report (including the auditor's report), shall be approved by the Board of Directors after review by the Audit Committee. The Clinical Governance Committee will also review the Quality Report prior to its submission to the Audit Committee.

4.6 The Annual Report, Accounts and Quality Report (including the auditor's report) is submitted to NHS Improvement (in accordance with its timetable) by the DOF and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.7 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.8 The Chief Executive, Chairman and DOF, as appropriate, will sign the various documentation relating to the Annual Report, Annual Accounts and financial returns to NHS Improvements and Annual Quality Report on behalf of the Trust Board.

4.9 Where a subsidiary is owned or partially owned by the Trust in a manner to require consolidation under the requirements of IFRS then the annual accounts of the subsidiary will be completed as a part of undertaking the consolidated accounts for the Trust. Should the Trust be involved with an Associate Company the results will be reported in line with recognised accounting requirements.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The DOF is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The DOF will review the banking needs of the Trust at regular intervals to ensure they reflect current business patterns and represent value for money.

5.1.3 The Trust Board will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The DOF is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made, or there is a right of set-off with another account held with that bank;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

f) Monitoring compliance with NHS Improvement or DH guidance on the level of cleared funds;

g) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The DOF will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit, if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The DOF must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The DOF will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The DOF is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The DOF is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the "Payment by Results" ("PbR") financial regime determined by the DH where applicable.

6.2.2. The DOF is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Responsibility for arranging the level of property rentals, and for reviewing rental and other charges regularly shall rest upon the Director of Finance who shall take into account independent professional advice on matters of valuation. The Director of Finance shall be consulted about the pricing of goods and services offered for sale.

6.2.3 All Employees must inform the DOF promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The DOF is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Financial Controller
£10,001 to £100,000	DOF
£100,000 plus	Audit Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit Committee should be presented to the Trust board for information.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The DOF is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The Director of Finance shall be responsible for the arrangements for security and issue of bulk stocks of cheques.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the DOF.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed “declarations of indemnity” must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 14 Disposals and Condemnations, Losses and Special Payments).

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

Table 2

Contract Value (Excl VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 - Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage

of the procurement process.

Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method and authorisation).

The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

7.3 Placing Contracts

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 3 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 3.

Table 3

Contract Value	Recommendation Report Requirement	Authorisation To Place or sign Contract
<£10,000 (Inclusive of zero nominal value)	No	As per purchase order system approval hierarchy approval
£10,000 – £24,999	Recommendation report required only if contract has not be awarded to the most economically advantageous offer	As per purchase order system approval hierarchy approval
£25,000 - £99,999	Yes	Head of Procurement
£100,000 – £249,999	Yes	Director of Procurement
£250,000 - £499,999	Yes	Director of Finance
£500,000 - £999,999	Yes	Finance Committee
>£1,000,000	Yes	Trust Board/Chairman

The Director of Finance, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

7.4 Electronic Tendering

All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal.

All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.12 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

7.5 Manual Tendering – General Exception Rules

No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.6 Receipt, Safe Custody and Record of Formal Tenders submitted manually

All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

The appropriate officer shall designate an officer or officers, not from the

originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.7.

7.7 Opening Formal Tenders

As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

Every tender received shall be stamped with the date of opening and if manually opened they shall be initialed by two of those present at the opening.

A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record, where a manual process has been conducted.

Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialed by two of those present at the opening.

A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

7.8 Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Director of Finance, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

Tenders received after the due time and date may be considered only if the Director of Finance or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Director of Finance, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Director of Finance or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.8.

Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Director of Finance.

Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.10 below).

All tenders should be treated as confidential and should be retained for inspection.

7.9 Extensions to Contract

In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

7.10 Quotation & Tendering Procedures

Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2 and will involve procurement department in line with Table 2.

Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

No tender shall be considered which bears any mark or name indicating the sender.

Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2

Tender lists for building and engineering works will be compiled in conjunction with the Director of Corporate Development from “Construction line” the Trust’s approved list of Contractors.

Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Director of Finance for further instructions.

The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

Quotation/tenders will be completed accordance with these SFIs.

Adjudication must be made in accordance with SFI 7.8 recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2).

All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 2.

7.11 Quotation & Tendering Procedures Summary - Contracts

Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

No Pre Qualifications stages should be conducted in accordance with Public Contract Regulations
Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 2 in specified in SFI 7.2.

Quotations/ tenders will be issued in accordance with these SFI’s and shall

incorporate standard NHS Terms and Conditions of Contract.

After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.8.

A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Table 2 in SFI 7.3 according to delegated limits.

All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee on a six monthly basis highlighting all waivers over £10,000 in line with STA's approved by the Director of Finance.

All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations.

All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source To Contract System. Any exceptions to this are at the discretion of the Director of Procurement.

7.12 Waiving or Variation of Competitive Tendering/Quotation Procedure

Signed Contracts will be required for all Single Tender Action waivers over £25,000.

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value out in in SFI 7.2 Table 2

b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with

c. The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (eg/ change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor

d. The expenditure relates to agency pay however internal governance and authorisation will apply

e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health

f. A direct award to a supplier on a national or regional framework is

permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with SFI 7.3 Table 2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. The requirement is to attend a seminar, conference or similar unique event

h. A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement but the nominated Officer must still ensure value for money

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Trust Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the NHS England (NHSE) or NHS Improvement are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

(a) Costing and pricing (in accordance with Payment by Results) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff. Any local price should be at least equal to the appropriate cost of the service being provided.

8.1.7 Any local changes in the counting and coding of patient activity will need to be notified to the DOF prior to implementation

8.1.8 The DOF shall produce regular reports detailing actual and forecast income.

8.1.9 The DOF shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

Annex
8.1.10 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs

and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where SFT is a competing body)

8.3.1 Where SFT participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Directorate Management Team	**Trust Management Committe**	**Finance & Performance Committee**	**Trust Board**
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£5m	<£15m	>£15m
Annual value	£20k pa	<£1m pa	>£1m<£5m pa	>£5m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to Executive Directors for noting.

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration Committee

9.1.1 The Trust Board shall establish a Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and most Senior Manager Posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director Posts above the salary of the Prime Minister (currently circa £150k) must be referred to NHS Improvement and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Workforce Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees

after consultation with their Human Resources Manager and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off payroll engagements must be approved by the DOF prior to contract signature.

9.2.3 Each employee shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be submitted to the Director of Finance at the earliest opportunity.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the intranet.

9.2.6 A "Notification of Termination" form and such other documents as the Director of Finance may require, shall be completed and forwarded to the payroll department immediately upon the date of; an employee's resignation, retirement, or termination, being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Payroll Manager shall be informed immediately.

9.2.7 Changes forms covering an Employee's Personal Details i.e. Name, Address or Job Details shall be completed and forwarded to the payroll department immediately upon the Manager becoming aware of the change.

9.2.8 The Trust Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its Managing Implications of Organisational Change Policy.

9.2.11 The Trust must seek approval from NHS Improvement before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

9.3.1 The Director of Finance shall be responsible for the final determination of monetary pay, (including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts), the proper compilation of the payroll and for payments made. No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the Director of Finance.

9.3.2 All pay sheets, and other pay records including travel expense claim forms supported by vouchers/receipts where appropriate, shall be in a form approved by the Director of Finance (manual or electronic) and shall be certified and submitted in accordance with his/her instructions.

9.3.3 The Director of Finance shall determine the dates on which salaries and wages shall be paid.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed otherwise by the Director of Finance.

9.3.5 Payment shall not be made in advance of the pay dates determined as in 9.3.3 above except where prior approval has been obtained from the Chief Executive, Director of Finance (or duly appointed representative) or the Director of Organisational Development and People. In such cases the payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 Where the Trust HR Policies so allow, loans may be made to staff and recovered in accordance with arrangements that the Director of Finance and Director of Organisational Development and People shall determine jointly.

9.3.7 The Director of Finance shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours. Any claims over 3 months old will need to be approved by the DOF.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Director of Finance will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the DOF shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition. Only for agreed goods and services (i.e. agency staff and utilities) should a good or service be obtained without a purchase order.

10.3.3 The DOF or if delegated, the Financial Controller, shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.4 The DOF will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are

evidenced;

- In the case of contract for building and engineering works which require payment to be made on account during process of the works the DOF shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the DOF and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the DOF of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.5 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The DOF must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.6 Managers must ensure that they comply fully with the guidance and limits specified by the DOF and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the DOF in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the DOF on behalf of the Chief Executive;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the DOF;

e) Petty cash records are maintained in a form as determined by the DOF;

f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and

g) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the DOF who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Where managers are unsure of the VAT status of any particular transaction advice will be provided from the Finance Department.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS Improvement's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Trust Board and will only be made by the DOF or a person with specific delegated powers from the DOF. Use of such loans or overdraft facilities must be approved by the DOF.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the DOF.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 Any application for an increase in public dividend capital on behalf of the Trust shall only be made by the Director of Finance or their nominated representative and will be notified to the Trust Board or the Finance and Performance Committee on the Board's behalf.

11.2.2 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 Investment of cash on a short or long term basis shall be in accordance with the Trust's Treasury Management Policy as approved from time to time by the Finance and Performance Committee. The Director of Finance shall compile and regularly review the Trust's Treasury Management Policy and advise the Finance and Performance Committee of any necessary changes.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Trust Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

11.3.5 The DOF is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Finance and Performance Committee.

11.3.6 The DOF will prepare detailed procedural instructions on the operation of

investment accounts and on the records to be maintained.

11.3.7 The DOF (or a senior finance manager with specific delegated powers from the DOF) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Finance and Performance Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Strategic Capital ~~Control Group~~Committee (~~Cap CG~~SCC) chaired by the Director of Finance to oversee its allocation of capital investment. The DOF will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The ~~Cap CG~~SCC will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The DOF shall establish systems to ensure that approved capital schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The financial performance of the Capital Programme shall be reported to the Trust Board on a monthly basis with fuller details of the larger schemes on a quarterly basis.

12.2 Approval of Capital Business Cases

12.2.1 Approval of Capital Business Cases will be as follows:

Table 4

Capital Plan	~~*Capital for new schemes (not in Capital Plan)*~~*Approval to proceed, or changes to ~~the~~ previously approved Capital.* ~~*Plan*~~	Forum
N/A	<£1200k	CapCG (TMC informed via minutes) ~~Direcotr of Finance~~
N/A	£100k to <£350k	Strategic Capital Committee Director of Finance
N/A	£~~200k~~ 350k to <£~~300k~~500k	TMC Chief Executive
N/A	£5300k to <£750k	Finance and Performance Committee
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	£750k+ Any proposed major scheme within FT compliance arrangements	Trust Board
Any proposed major scheme within FT compliance	Any proposed major scheme within FT compliance	NHS England & Improvement

arrangements	arrangements	

Where a capital scheme is approved within the annual capital plan, full and final approval to proceed is still required as set out in the ~~monitoring will take place through CapCG with only changes subjected to the~~ delegated limits in table 4.

Approvals for capital projects over £350k, will be itemised in a schedule to Trust Board on a quarterly basis.

Programme allocations within Capital Plan	**Group/ individual responsible for approval**
Building and Works	The Building and Works Group
Medical Equipment	Medical Devices Committee
Information Systems	Information Systems Steering Group

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Investment Group for approval or review prior to request for approval by the Finance and Performance Committee or Trust Board if required.

12.4 Asset Registers

12.4.1 The DOF is responsible for the maintenance of registers to record capital fixed assets. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The DOF shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the DOF. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the DOF who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for Equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £200,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £200,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £200,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £100,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets requires the approval of NHS Improvement.

12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework requires the approval of NHS Improvement.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £200,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net reliable value. Inventory shall be controlled on a First in First out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the DOF for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the DOF. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; and the control of fuel oil the Head of Estates.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Logistics Manager wherever practicable; stocks should be marked as Health Service property.

13.1.4 The DOF, in conjunction with the Associate Director of Procurement, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the DOF and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the DOF.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the DOF.

13.1.7 The Director of Procurement shall be responsible for a system approved by the DOF for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the DOF (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net reliable value. The write down shall be approved by the DOF and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Director of Procurement shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The DOF shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice or the assistance of the Procurement department where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the DOF;

b) Recorded by the condemning officer in a form approved by the DOF which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the DOF.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the DOF, who will take the appropriate action.

14.1.5 Disposals of assets valued between £100,001 - £200,000k (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The DOF must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DH Group Accounting Manual and prepare a register.

14.2.2 The DOF must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See the Trust's Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Fraud, Bribery and Corruption Policy.

14.2.4 The DOF is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHS Protect.

14.2.5 The Directorate or Service Manager shall inform the DOF of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the DOF shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The DOF shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the DOF should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the DOF and investigated in such a manner as the DOF may require. Write-off action shall be recorded against each entry in the register.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Senior Information Risk Owner (SIRO), supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The DOF shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The DOF shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the DOF shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the DOF shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Informatics Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

It will be at the discretion of the Director of Corporate Development or the Director of Informatics whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The DOF will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the DOF.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), and is responsible for the management of funds it holds on trust. For the purposes of these SFI's the Trust Board members shall be termed Trustees. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust with the exception that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and be made only with the approval of the Fund Manager appointed by the Trustees or the Trustees themselves. This section covers those instructions which are specific to the management and governance of funds held on trust.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The DOF has primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.2 Administration of Charitable Funds

17.2.1 The DOF shall:

a) Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust Board as Trustees of charitable funds. These shall be maintained in accordance with legislative requirements and any directions from the Charity Commission.

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within designated or restricted accounts in accordance with charity law;

e) Periodically review the funds, rationalise funds within statutory guidelines, and report changes to the Salisbury District Hospital Charitable Fund Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals to the Salisbury District Hospital Charitable Fund Committee at their quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Salisbury Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising and Incoming Funds

17.3.1 All gifts, donations and proceeds of fund raising activities are the responsibility of the Trustees and shall be handed immediately to the DOF to be banked in the Charitable Funds bank account.

17.3.2 All gifts accepted shall be receipted and held in the name of the Trustees and administered in accordance with the Trustees' policies, subject to the terms of specific trusts. As the Trustees can accept gifts only for all or any purposes relating to the Health Service, managers shall, in cases of doubt, or where there are material revenue expenditure implications, consult the DOF before accepting gifts.

17.3.3 The DOF shall advise the Trustees on the financial implications of any proposal for fund raising activities which may be initiated, sponsored or approved.

17.3.4 The DOF shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. All correspondence concerning legacies shall be dealt with on behalf of the Trustees by the DOF who alone shall be empowered to provide an executor a good discharge.

17.4 Investments and Investment Income

17.4.1 The Trustees shall be responsible for:

a) Appointing investments advisors to manage investments and provide relevant investment advice on these. Charitable funds shall be invested in a manner to maximize medium term value,

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

17.4.2 The DOF will allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Expenditure from any Charitable Fund shall be conditional upon the item being within the terms of the appropriate trust, the procedures approved by the Trustees and sufficient funds being available.

17.5.2 Day to day management of individual expenditure is delegated to Fund Managers who shall not enter into any transaction which will result in any fund under their control becoming overdrawn without first obtaining authorisation in writing from the DOF.

17.5.3 The DOF shall act on behalf of the Trustees in ensuring that all expenditure incurred is in accordance with the purposes identified by the donor.

17.5.4 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.5 A connected multiple orders could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.6 **Levels of Authority**

No expenditure can take place without the approval of the following:

£	**Orders can only be processed once the following people give their authority**
Up to £10,000	The Fund Manager
Over £10,000	The Fund Manager + The Salisbury District Hospital Charitable Funds Committee (reported to the Trust Board)

17.5.7 Where charitable fund expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.6 Asset Management

17.6.1 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure.

17.6.3 The Charity shall not be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The DOF will be responsible for updating an annual risk register for

agreement by the Salisbury District Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. Public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. Breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's Conflicts of Interest Policy. This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Head of Corporate Governance for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Conflicts of Interest and Freedom to Speak Up: Raising Concerns policies, available via the intranet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS Improvement / DH guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	Director of Corporate Development
Building & Engineering Contracts	Director of Corporate Development & Director of Procurement
Estate Maintenance Contracts	Director of Corporate Development & Director of Procurement
Maintenance Contracts	Director of Procurement
Commissioner Contracts	Director of Finance
Contracts for goods and services other than the above	Director Procurement

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Director of Procurement for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS Improvement / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or DOF. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control

cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /NHS Improvement guidance.

20.2 Insurance

20.2.1 On an annual basis, the DOF shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Financial Controller shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.2.3 The Financial Controller shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Financial Controller shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3 Clinical Risk Management/CNST

20.3.1 The Director of Nursing shall:

a) Provide a central point of contact within the Trust for NHSLA/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution (formerly NHS Litigation Authority)/Claims Handler considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the trust within the excess of £3k will be notified to the Head of Litigation and Insurance Services for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the Salisbury NHS Foundation Trust as the defendant.

Up to £100k	NHSLA/Claims handler	Head of Litigation
£100k-£250k	NHSLA/Claims handler	Director of Nursing
£250k-£500k	NHSLA/Claims handler	Chief Executive
>£500k	NHSLA/Claims handler	Trust Board

The DH must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made contrary to legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Salisbury NHS Foundation Trust the act provides that SFT is exempt from repaying their "own" costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Director of HR.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Director of HR and the DOF. In certain cases, additional approval should be sought from NHS Improvement and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Director of Human Resources advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £30,000	Director of Human Resources
£30,001 to £100,000	Chief Executive
£100,000 plus	Trust Board

22.4 NHS Improvement must be consulted before making any special payments that are novel, contentious or repercussive. The Director of HR, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against/contrary to legal advice must be approved by the Trust Board.

23. WHOLLY OWNED SUBSIDIARIES

23.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

24. RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, 'Attributing the costs of health and social care research and development' (AcoRD DH2012) using the national costing guidance/templates. Excess treatment costs should be submitted to CRN:Wessex for funding.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 The Standing Orders and other sections of the SFIs apply equally to the undertaking of research and this includes declaration of interests, security of assets, budgetary control, purchasing and contracting, charitable funds, and the section on casual gifts, hospitality and commercial sponsorship.

24.5 The submission of grant applications to support research shall be signed by the Director of Finance or designated representative.

24.6 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

24.7 The principles governing probity and public accountability shall apply equally to work undertaken through research.

Annex 1

Authorisation Levels For Electronic Requisitioning System

1.1 All staff authorised to approve the purchase of goods or services, and signing of invoices where appropriate, will be allocated an authorisation level. Each Directorate can set its own authorisation levels under Level 3 below (Levels 1 and 2 are shown as suggested levels only)

Level 1 - Up to and including £500 per total requisition (e.g. nurses, ward assistants, staff with requisitioning responsibility in smaller departments)

Level 2 - £501 - £5,000 per total requisition. The actual level of authority will depend on the work area and the following are examples**:**
- £1,000: requisitioning staff in larger departments
- £2,000: ward sisters
- £3,000: supervisory levels in departments, requisitioners in theatres, staff club manager
- £5,000: catering manager, medical physics manager, deputy head in genetics

Level 3 - £5001 - £10,000 per total requisition
- £10,000: DSNs, DMs, heads of larger departments
- £10,000: Head of Facilities

Level 4 - Up to £50,000 per total requisition: Deputy Director of Finance, Financial Controller

Level 5 - Up to £100,000 per total requisition: Chief Operating Officer, Director of HR, Director of Nursing, and Medical Director

Level 6 - Over £100,000 per total requisition (but subject to any other limits approved by the Trust Board): Chief Executive, Director of Finance

1.2 Each Directorate is responsible for compiling their own authorised signatories list, including determining which staff should be given authorisation below level 3.

Amendments to the above levels of authorisation may be approved in specific cases but will need to be approved by the Director of Finance.

1.3 The Finance Department will maintain a database of staff on each authorisation level per Directorate. Directorates will be responsible for notifying the Finance Department of any additions, deletions or other changes to their authorised signatories' lists. The Finance Department will ensure the database is amended to reflect the changes and ensure the computer security is amended accordingly**.**

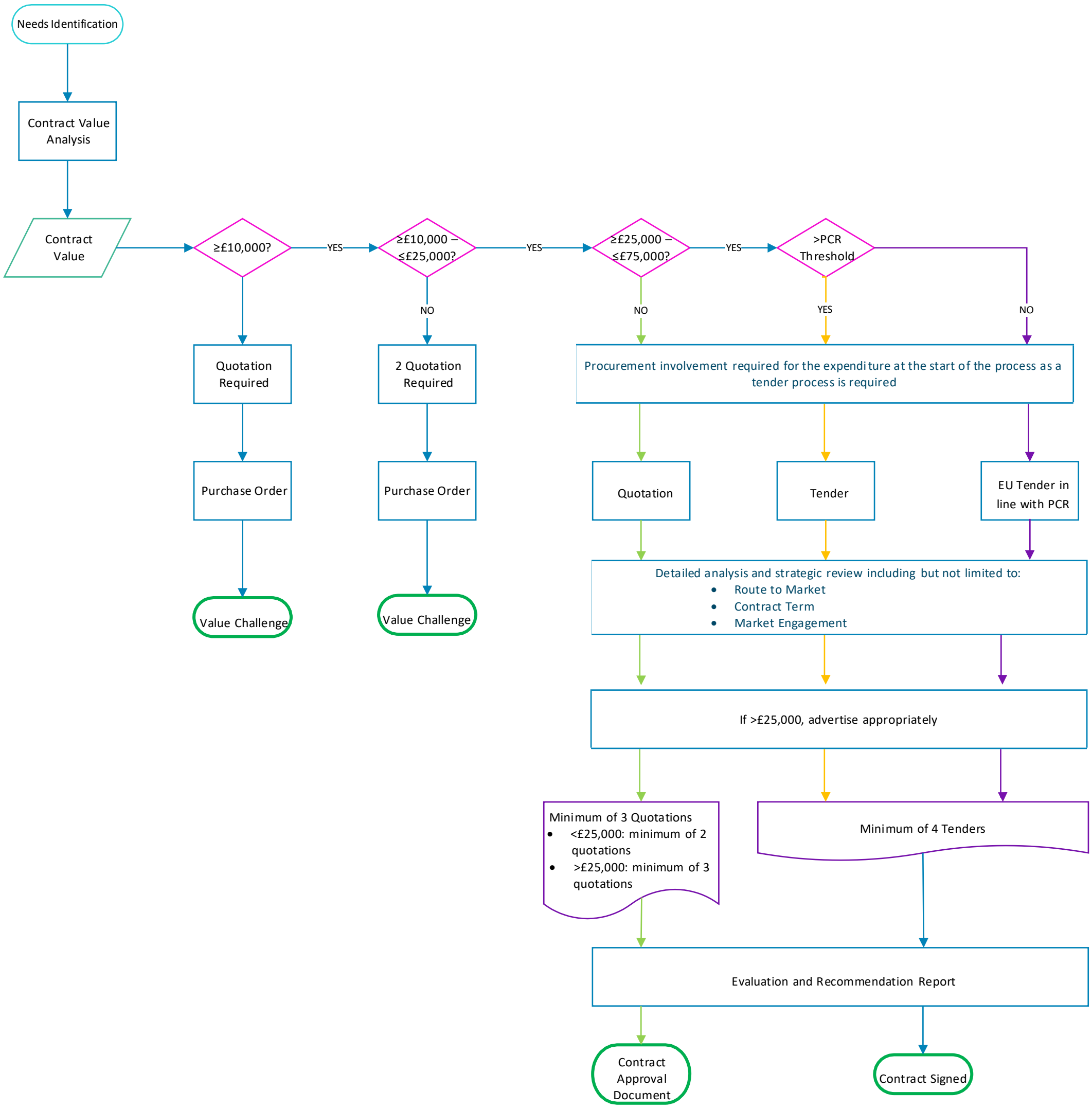
Authorisation Levels for Electronic Ordering System

2.1 All requisitions will be converted to Orders and processed within the Procurement Department where individual staff will have specific levels of authorisation below that of the Head of Procurement's £50,000 level. The electronic requisition will have already been authorised at the appropriate level within the organisation prior to receipt by Procurement.

2.2 The Director of Procurement will have authority to process orders up to - £350,000. Any orders beyond this amount will need to be authorised by the Chief Executive or Director of Finance.

Annex 2 Tendering & Contracting Procedures (where SFT is the procuring body)

Competitive Tendering Process Requirements



Annex 3

Contracting for Income - Financial Limits

NON NHS
All limits **exclude** Value Added Tax where applicable.

Lifetime Contract value	**Approval**
Up to £20,000 (Inclusive of zero nominal value)	**Deputy Director of Finance/Director of Procurement**
£20,000 to < £300,000	**DOF**
£300,000 to <£1.5million	**CEO**
£1.5m +	**Trust Board**

Lifetime Contract value (NHS)
Service Level Agreements
Up to £100,000,000 Director of Finance
Over £100,000,000 Chief Executive

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Schedule of Decisions Reserved to the Board and the Scheme of Delegation

March 2021

Introduction

1. The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. This document sets out the powers reserved to the Board and those that the Board has delegated.
2. The Board remains accountable for all of its functions; even those delegated to the Chair, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
3. All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee of the Board shall be exercised on behalf of the Board by the Chief Executive or another executive director.
4. The Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligations. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that targets are met.
5. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. Whilst the detailed responsibility can be further delegated the Chief Executive remains accountable for that responsibility to Board. All powers delegated can be re-assumed by him/her should the need arise.
6. The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.
7. In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Deputy Chief Executive Officer or in his/her absence by the Executive Director who is formally acting-up as Chief Executive. Formal acting-up status shall be confirmed in writing by either the Chief Executive or the Chair.
8. The Scheme of Delegation is reviewed annually.
9. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

Schedule of Decisions Reserved to the Board

SFI Ref	Decision reserved to the Board
1.2.1	• Formulate the financial strategy • Approve budgets • Define and approve essential features of important procedures and financial systems • Define delegated responsibilities.
3.1.2	Approve the Annual Business Plan

4.5	Approve Annual Report and Accounts including the auditor's report.
5.1.3	Approve the opening of new bank accounts.
7.3	Authorise contracts with Suppliers which exceed £1.5m.
8.1.1	Regularly review and maintain capacity and capability to provide mandatory goods and services per the terms of the licence.
9.1.1	Establish a Remuneration Committee.
10.1.1	Approve the level of non-pay expenditure.
11.1.3	Approve application for a loan/overdraft.
11.1.5	Approve all long-term borrowing.
11.3.3	Approve investments made in forming/acquiring an interest in bodies corporate.
12.1.1	Establish a Capital Control Group.
12.1.3	Approve the Annual Capital Plan.
12.2.2	Approve all capital business cases above £750,000
12.6.2	Approve Estate Strategy and acquisition of property (freehold & lease) over £200,000.
12.6.8	Approve disposal of property over £100,000.
12.6.10 & 12.6.11	Seek approval from NHS Improvement for the disposal of protected assets and major disinvestments.
12.6.12	Approve the granting of property leases where the annual value is in excess of £200,000.
16.1	Provide safe custody for money and other personal property of patients.

Decisions/Duties delegated by the Board to Committees

Committee	Duties delegated by the Board
Audit Committee	See Terms of Reference (available from Head of Corporate Governance). In addition: SFI 11.3.2 Set investment policy. Oversee all investment transactions. Approve treasury policy. SFI 11.3.4 Approve short term investment vehicle.
Remuneration Committee	See Terms of Reference (available from Director of Corporate Governance)
Salisbury District Hospital Charitable Fund Committee	See Terms of Reference (available from Director of Corporate Governance)

Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities / Duties Delegated
1.1.8	Audit Committee	Referring action or ratification of any non-compliance with SFIs. Also need to be disclosed to the DOF.
1.2.6 & 1.2.9	Chief Executive	Ensuring that all members of the Board and employees of the Trust understand their responsibilities within SFIs.

1.2.7	DOF	• Ensuring that SFIs are appropriate and up to date • Implementing the Trust's financial policies • Maintaining an effective system of internal financial control • Maintaining records of financial transactions • Providing financial advice to Board and employees.
1.2.8 & 1.2.9	All directors, staff and contractors	Security of Trust property, avoiding loss, exercising economy and efficiency in the use of resources, and conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation.
2.1.1	DOF	• Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. • Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards. • Ensuring that an annual internal audit report is prepared for the consideration of the Audit and Assurance Committee.
2.2.2	Head of Internal Audit	Reviewing, appraising and reporting upon compliance with established policies and procedures such as the Audit Code.
2.3	Chief Executive / Audit Committee	Ensure that an external auditor is appointed in compliance with the constitution and that they comply with the Audit Code. Ensure that the Council of Governors are aware as appropriate.
2.4	Chief Executive / DOF	Ensure compliance with the directions on NHS fraud and corruption. Appoint a Local Counter Fraud Specialist and consult with him/her as to the involvement of the police in cases of fraud and corruption.
2.5	Chief Executive	Control and coordinate security management. Appoint a Local Security Management Specialist.
3.1.1	Chief Executive	Submit to the Board the Annual Trust Business Plan which takes into account financial targets and forecast limits of available resources.
3.1.4	DOF	Prepare and submit an annual budget.
3.1.6	DOF	Monitor financial performance against budget and report to Board.
3.1.8	Chief Executive	Approve business cases up to £250,000.
3.1.8	Finance and Performance Committee	Approve business cases up to £500,000
3.1.9	DOF	Ensure that adequate training is delivered to budget holders to help them manage successfully.
3.2.1	Budget holders	The management of a budget to permit performance of a defined range of activities.

3.3	DOF	Devise and maintain systems of budgetary control including monthly reports to Board containing sufficient information to ascertain financial performance.
3.3.4	Chief Executive	Identify and implement cost improvement programmes.
3.5.1	Chief Executive/ DOF	Appropriate monitoring forms and returns are submitted to Monitor.
4.1	DOF	Prepare annual financial accounts and returns ensuring that they comply with current guidelines.
4.2	Chief Executive	Prepare an Annual Report.
4.3	Director of Nursing	Prepare the Annual Quality Account.
4.6	DOF	Submit the annual report and accounts to NHS Improvements.
4.8	Chief Executive & Chair	Sign the Statement of Directors' Responsibilities in Respect of the Quality Report.
5.1.1 & 5.4.1	DOF	Advise on and manage the Trust's banking arrangements ensuring that these are reviewed regularly.
5.1.2	DOF	Review banking arrangements.
5.2.2	DOF	Managing the Trust's Government Banking Service (GBS) bank account, establishing non-exchequer bank accounts, ensuring funds stay in credit unless arrangements have been made,
5.3	DOF	Prepare detailed instructions of the operation of GBS accounts and advise the Trust's bankers of the conditions under which accounts will be operated.
6.1	DOF	Design and maintain income systems.
6.2.2	DOF	Approve and review the level of all fees and charges.
6.2.3	All Staff	Inform the DOF of income arising from transactions which they have initiated.
6.3.1	DOF	Take appropriate recovery action on all debts.
6.4	DOF	Provide the required documents for recording cash, cheques and negotiable instruments, and ensure adequate system and procedures for handling cash etc.

7	Chief Executive	Arrangements for tenders where SFT is the procuring body.
7.8	Director of Finance	Report the acceptance of any late tenders to the Board.
7.11	DOF	Report all waiving of variation of competitive tendering/quotation procedures to Audit Committee.
8	Chief Executive	Arrangements for contracts re provision of services.
9.2.1	Budget holder	Recruit to vacancies provided that this is within the establishment.
9.4.1	DOF	Final determination of pay.
10.1.1	DOF	Determine level of delegation of non-pay expenditure to budget managers.
10.2	DOF	Set out the list of managers and their limits for requisitioning goods and services.
10.3.3	DOF	Prompt payment of accounts and claims.
10.3.4	DOF	Recommend the thresholds for quotations or tenders and prepare procedural instructions, ensure prompt payment and maintain a system for managing all amounts payable.
11.3.5 – 11.3.7	DOF	Determine the investments required and ensure that policies and procedures are drawn up for their operation and maintenance.
12.4.1	DOF	Maintain registers of assets.
12.4.2	DOF	Prepare procedural instructions in disposal of assets.
12.4.5	DOF	Approve procedures for reconciling fixed asset accounts to fixed asset register.
12.5.1	Chief Executive	Establish procedures for the control of fixed assets.
12.5.2 & 12.5.3	DOF	Approve asset control procedures and manage process.
12.6.2	Chief Executive	Approve acquisition of property up to £500,000.

13.1.2	DOF	Systems of control for stores and stocks.
13.1.4 - 13.1.5	DOF	Establish procedures for the management of stores and stocks.
14.1	DOF	Establish processes for disposals and condemnations.
14.2	DOF	Maintain a register of condemnations, losses and special payments, prepare a fraud response plan, and take appropriate actions for any losses, condemnations and special payments.
15.1.1	Senior Information Risk Owner	Devise and implement procedures to safeguard the Trust's data, programs and computer hardware, have regard to the Data Protection Act 1984, ensure adequate controls over data entry, processing, storage etc.
15.1.2 – 15.1.5	DOF	Ensure that financial systems are appropriately procured and tested; ensure that there are adequate controls in operation in place.
16.1.3	DOF	Arrangements for the administration of patient property.
17	DOF	Ensure that the charitable funds are appropriately administered and managed.
17.2.1	DOF	Prepare the Charity's annual accounts for audit and authorise transactions of funds between investment vehicles.
18.1	Chief Executive	Ensure all staff are aware of the behaviour expected of all staff as set out in the Conflict of Interests Policy.
19	Chief Executive	Maintain archives for all records, information and data.
20.1	Chief Executive	Ensure that the Trust has a risk management policy and procedures and that these are monitored.
20.2.1	DOF	Review membership of the Non-Clinical Risk Pooling Scheme and other insurance arrangements.
20.2.2 – 20.2.5	DOF	Liaise with insurance brokers; ensure timely reporting of incidents, losses and submission of claims against the third party liability scheme and insurance provision.
20.3	Director of Nursing	Manage claims on NHSLA and report activity to Board.
21	Chief Executive	Managing claims from staff, patients and the public.
22	Chief Executive	Managing Employment Tribunals.

23	Wholly owned subsidiary	Manage governance process.

Other issues to be delegated

10. Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Director of IM&T
Health and Safety Arrangements	Director of Organisational Development and People
Terms and conditions for non-AfC staff	Chief Executive provided this is in line with the AfC terms and conditions

11. This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within his/her Directorate. He/she should produce a scheme of delegation for matters within his/her Directorate. In particular the scheme of delegation should include how the directorate budget and procedures for approval of expenditure are delegated.

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Report to:	Trust Board Public	**Agenda item:**	5.1
Date of Meeting:	08 March 2021		

Report Title:	Staff Survey Results 2020			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	☞	☞		
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Lynn Lane, Director of OD & People			
Appendices (list if applicable):	N/A			

Recommendation:

The Board to note the results of the staff survey 2020.

The Board are also asked to note that further details regarding trust wide and division specific actions will be developed in the next couple of weeks and will be aligned to the "Best Place to Work" and NHS People Plan respectively.

Executive Summary:

- The Trust response rate for the 2020 staff survey was 54.2% (2,062 responses). This compares to a response rate of 54% in 2019 (1,954 responses).
- The Trust is benchmarked against 129 acute and acute community trusts.
- For 2020 the survey results are grouped into ten key themes; 11 themes in 2019.
- The Trust score is above average for five of the ten key survey themes; compared to above average for eight of eleven themes in 2019):
  - Health and wellbeing
  - Immediate managers
  - Morale
  - Safe environment (bullying and harassment)
  - Staff engagement
- The Trust score is below average for four of the ten key themes; compared to below average for one of eleven themes (quality of care) in 2019:
  - Quality of Care
  - Safe environment (violence)
  - Safety culture

- Team working

- The Trust score is average for one of the ten key themes; compared to average for two of eleven themes in 2019:
  - Equality, diversity and inclusion

Themes with improvement in score
- Health and wellbeing
- Safe environment (bullying and harassment)

Themes with the score remaining unchanged
- Morale
- Quality of care
- Staff engagement

Themes with a deterioration in score
- Equality, diversity and inclusion
- Immediate managers
- Safe environment (violence)
- Safety culture
- Team working

The Trust scored 9th out of 15 Acute Trusts (South West Region)

The top 5 Acute Trusts in the South West Region:

- Yeovil District Hospital NHS Foundation Trust
- Northern Devon Healthcare NHS Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Somerset NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust

The Trust scored 52nd out of 129 Acute Trusts (Nationally)

The top 5 Acute Trusts Nationally:

- Northumbria Healthcare NHS Foundation Trust
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Alder Hey Children's NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust

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:**	6.1
Date of Meeting:	08 April 2021		

Report Title:	Annual Review of Directors Interests and Fit and Proper Person Test			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:	Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Register of Directors' Interests			

Recommendation:
To note the updated Trust Board Director's Register of Interests and the outcome of the annual Fit and Proper Person Review as at March 2021.

Executive Summary:
There is a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. The Board previously agreed that this is also to include deputies. The Senior Independent Director (SID) and the Corporate Governance Department review any positive declaration from Trust Board members and deputies and the agreed outcome is documented. No concerns have been raised as part of this process although the SID has yet to confirm their agreement. The Corporate Governance Department further collate and monitor a definitive list of all band 8d and above or equivalent staff required to complete an annual Conflict of Interest Declaration. These are monitored and recorded by the Corporate Governance team. The process of collating these declarations is currently under review due to the low return rate in 2020 and a new process will be in place by 2022 as agreed by the executive team. There is also a requirement for all Executive and Non-Executive Directors to complete an annual form of declaration confirming that they continue to be a fit and proper person. This has been completed and no concerns have been raised.

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
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SALISBURY NHS FOUNDATION TRUST
REGISTER OF MEMBERS' INTERESTS 2021
Trust Board Members and Deputies

Name	Company	Position
Rakhee Aggarwal **Non-Executive Director**	Nil return	
Tania Baker **Non-Executive Director**	Nil Return	
Dr Michael von Bertele **Non-Executive Director**	Grenadenburg Consulting Rutherford Health Rutherford Innovations Rutherford Estates Rutherford Diagnostics Rutherford Infrastructure Trayned Insight Aspen Medical Ultra-Genetics Ltd Ministry of Defence: Army HQ	Owner / Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Director Non-Executive Director Director Chairman of Appeal Body for employment related complaints.
David Buckle **Non-Executive Director**	Society for Assistance of Medical Families East and North Hertfordshire NHS Hospital Trust Stroke Association Berkshire Healthcare NHS Foundation Trust	President Non-Executive Director Vice President Non-Executive Director
Sallie Davies **Deputy Medical Director**	Nil return	
Jane Dickinson **Divisional Director of Operations for Medicine & Deputy Chief Operating Officer**	Nil Return	
Judy Dyos **Director of Nursing**	Nil return	
Mark Ellis **Deputy Director of Finance**	Nil return	
Kieran Humphrey **Associate Director of Strategy**	Nil return	
Stacey Hunter **Chief Executive**	Nil return	

Andy Hyett **Chief Operating Officer**		Married to Fiona Hyett, Deputy Director of Nursing
Fiona Hyett **Deputy Director of Nursing**	Nil return	
Eiri Jones **Non-Executive Director**	EJP ltd. Borough Welsh Chapel London London Welsh School Homerton University Hospital NHS Foundation Trust	Director Trustee Governor Clinical Non-Executive Director
Paul Kemp **Non-Executive Director**	Magistrates Association	Honorary Treasurer
Lynn Lane **Director of Organisational Development and People**	Nil return	
Denise Major **Deputy Director of Nursing**	Nil return	
Nick Marsden **Chairman**	Nil Return	
Fiona McNeight **Director of Corporate Governance**	Nil Return	
Paul Miller **Non-Executive Director**	Sparrow Healthcare Consulting Limited Healthcare Financial Management Association (HFMA) Hampshire CCGs	Director / Undertakes work on behalf of the Jersey Comptroller and Auditor General who scrutinises the performance of the Jersey Government. 50% owner of Sparrow Healthcare Consulting Sparrow Healthcare provide services to the Healthcare Financial Management Association (HFMA) Wife is a bank employee.
Esther Provins **Director of Transformation**	Salisbury Plain Academies Multi-Academy Trust Dorset HealthCare NHS Foundation Trust	Member of the Board Partner is an Executive Director
Lisa Thomas **Director of Finance**	Sterile Services Ltd (SSL) Salisbury Linen Services (STL) Bed Storage Solutions Dauntsey Academy Primary School	Director Director Director Vice Chair

Susan Young **Interim Chief People Officer**	PSCA Consulting LTD Birmingham and Solihill Mental Health NHS Foundation Trust	Owner/ Director Executive Director of Strategy People and Partnerships (employment ends 31/03/2021)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.2
Date of Meeting:	08 April 2021		

Report Title:	Integrated Governance Framework			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Fiona McNeight, Director of Corporate Governance Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Integrated Governance Framework – March 2021			

Recommendation:
The Trust Board is asked to approve the revised Integrated Governance Framework and the Board Committee's Terms of Reference.

Executive Summary:
Following a review of the Trust's Integrated Governance Framework the following amendments have been made. • Executive director job titles have been updated in the document as this change comes into effect from 1st April 2021. • The revised corporate priorities have been included for 2021/22. • Section 8, has been updated to reflect the Trust's work as part of the Bath & North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS) and Acute Hospital Alliance (AHA). • The most recent version of Appendix 3 Trust Organisation Committee Assurance Map has been added. • All Board Committee Terms of Reference have been to their respective Committee's and have been reviewed, updated and recommended for approval.

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

March 2021

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 AIMS AND 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 strategic aims 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.

In reviewing our current corporate and clinical strategies, we have settled on a refined set of strategic priorities for 2021/22 which centre around:

- improving the health and well-being of the population we serve
- the partnerships that will help us achieve this
- investing in the people who work for us to ensure they can deliver the best possible care.

Delivery of these emerging priorities will be underpinned by establishing, prioritising and monitoring a small set of corporate objectives as set out here.

Division	Priorities
Medicine	• Frailty – integrated pathway • Embed discharge improvements including therapies/rehab model • Integration of urgent care services
Surgery	• Elective programme recovery (incl. system planning)
CSFS	• Maternity review • Review of mental health services to the Trust
Quality	• Sustain recovery from COVID • Staff health and well being • Improve safety vs known risks • Ward to Board assurance on safety • Strengthen partnerships to improve population health • Developing a coherent strategy for specialist commissioned services focused around rehab and reablement
Corporate services	• IT – ePMA, Pathology LIMS, shared EPR, SBS (ledger) • Strategy review and implementation • OD and Improvement programme • Best Place to Work

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).

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, CQC standards and the Trust's performance monitoring framework.

4.4 Continuous Quality Improvement

Trust Board are responsible for ensuring that a continuous quality improvement approach is adopted and embedded throughout the organisation. This should be evidenced at all levels across the organisation. This approach should be evident at Trust Board and all Board Committees and at Executive Committees.

4.5 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 Divisional 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 three assuring committees; Clinical Governance Committee, Finance & Performance Committee, People and Culture Committee and also the Trust Management Committee.

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

4.6 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, 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 quarterly as the Charitable 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. The Terms of Reference can be found in Appendix 6.

4.7 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 Divisional Performance Reviews (by exception)
↕		
Level 2: Review of Divisional Management		
Executive Performance Review Meetings	Lead Executives Divisional Management Team HR and Finance Business Partners	Detailed performance dashboard for Division Division commentary Risk Registers Other issues by exception

		
Level 3: Divisional management		
Divisional Management Committees	Divisional Management Committee, HR and Finance Business Partners	Divisional performance dashboard Individual dashboards, locally held performance information, and divisional risk register
Divisional 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	Divisional 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
- Continuous Quality Improvement

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 People and Culture Committee

The People and Culture 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.
- Continuous Quality Improvement

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 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

6.6 Remuneration and Nominations 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

6.7 Level 2 – Review of Divisional Management

Executive Performance Review Meetings are held monthly with the clinical Divisions, consisting of three executive directors and each Divisional Management Team to review performance across quality, finance, operations, and workforce. Further detail is given in the Accountability Framework.

Level 3: Divisional Arrangements

6.8 Divisional Clinical Governance Arrangements

The Trust manages the delivery of its services through a divisional 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 Divisions 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.

6.9 Divisional Management Committees

Each division is led and managed by a Divisional Management Team, made up of the Clinical Director, Divisional Director and Divisional Head of Nursing.

This Divisional Management Committee (DMC) is supported by Lead Clinicians, operational managers, and the corporate functions such as Organisational

Development and People and Finance. For the Facilities Directorate, this is the Head of Service and General Managers.

The Divisional Management Committee is responsible for providing leadership within the clinical divisions. 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.

Divisional 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 Division will have governance arrangements appropriate to their services as set out in the Accountability Framework.

6.10 Level 4: Quality Assurance within Divisions

The Divisions have in place arrangements for quality governance that is accountable, through the DMC and Divisional Governance Committee and escalation via the Executive Performance Meetings to the executive team.

Divisional Governance Committees will be held monthly. Standard Terms of Reference can be found in the Accountability Framework.

The scope of matters covered by Divisional 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.

Core Standard Items

- Divisional Governance Agenda / Specialty Risk Register
- New Serious Incidents Commissioned
- Triangulation of quality intelligence relating to safety, experience and outcomes
- New Trust policies / guidelines for noting
- Quality Impact assessments for Cost Improvement Plans

Patient Safety:

- SI management
- Incident analysis and learning
- Claims analysis and learning
- Safety Alert notifications and progress against compliance

- Progress against patient safety initiatives/work programmes
- Safety walkabouts – progress against any identified actions

Clinical Effectiveness:

- Compliance with clinical audit plan (National and local audits)
- Compliance with NICE and NICE Quality Standards
- New Divisional Policies / guidelines for sign off
- External visits / NCEPOD / inspections
- Outcome data (e.g. Dr Foster, PROMs, Mortality & Morbidity lessons learned)
- GIRFT outcomes and action plan compliance
- Information Governance compliance

Patient Experience:

- Progress against patient and public involvement projects/initiatives
- Complaint, PALS, SOX, patient feedback and plaudit analysis and learning
- Progress against improvement action plan
- Progress against CQC action plan/preparedness
- Quality improvement initiatives/programmes of work

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

6.12 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.

6.13 Trust Management Committee

The Trust Management Committee (TMC) comprises the Executive Directors, Clinical Directors, and Divisional 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 Terms of reference which were completely revised at the beginning of 2020 set out clear lines of reporting and escalation up to Executive Directors and Senior

Management. The Terms of Reference can be found in Appendix 5.

Further work continues on the meeting structure to streamline the lines of escalation and reporting. This can be found in Appendix 3.

Public accountability

6.14 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

6.15 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 Divisions:

- 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 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 Director of Corporate Governance.

8. COLLABORATIVE WORKING AND PARTNERSHIPS

The Trust is part of the Bath & North East Somerset, Swindon and Wiltshire Sustainability and Transformation Partnership (BSW STP). 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

As part of the move towards more collaborative working the Trust is also part of the Acute Hospital Alliance (AHA) with Great Western Hospital and RUH Bath NHS Foundation Trusts. The AHA is focused on improving clinical services and closing the gaps in relation to health and care inequalities and finance to benefit the population of BSW.

In late 2020 health and care partners in BSW were awarded Integrated Care System (ICS) status. This will allow partners to take collective responsibility for the health and wellbeing of the population across the region. There has been an NHS consultation of ICS's and the next steps have been outlined to help build strong and effective systems across England. This will be aligned to the emerging BSW ICS and the Trust's strategic priorities. The local place based Wiltshire Integrated Care Alliance will be a priority for the executive team and clinical leaders over the coming year.

The Trust Board receives updates on system working and discusses progress on a regular basis.

9. MONITORING AND REPORTING PROCESS

The Trust Board monitors the delivery of this framework primarily through reports to the Board from the following committees:

- Audit
- Finance & Performance
- Clinical Governance
- People and Culture
- Subsidiary Governance

In addition, reports will be received from internal and external audit, and other regulatory bodies to provide independent assurance to the Board.

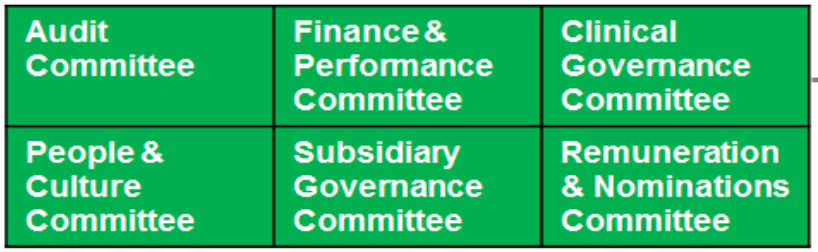
All committees receive reports and regular monitoring information as set out in each committee's work plan. This covers all principal strands of governance as part of the Trust-wide assurance framework.

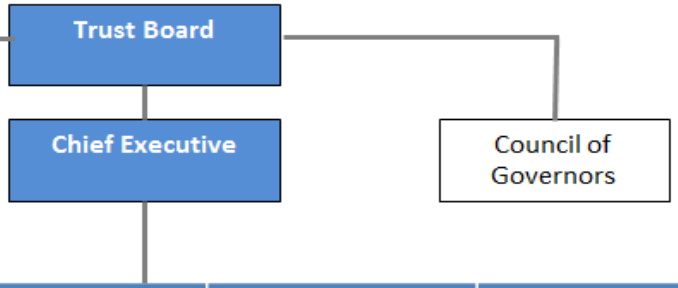
Appendix 1: Overview of Assurance Committees that report to Trust Board

Audit	Finance & Performance	Clinical Governance	People and Culture	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 concems	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: • 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 shareholding or interest in a company: • Oversight of the subsidiary level risk profile and exposure • Ensuring a governance framework and structure for oversight of any related company/entity

NB: 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





Chief People Officer (Executive)	Chief Nursing Officer (Executive)	Chief Operating Officer (Executive)	Chief Finance Officer (Executive)	Chief People Officer (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

Note: Executive Directors are Board level positions

APPENDIX 2 CONTINUED: ACCOUNTABILITY OF DIRECT REPORTS TO THE CHIEF EXECUTIVE

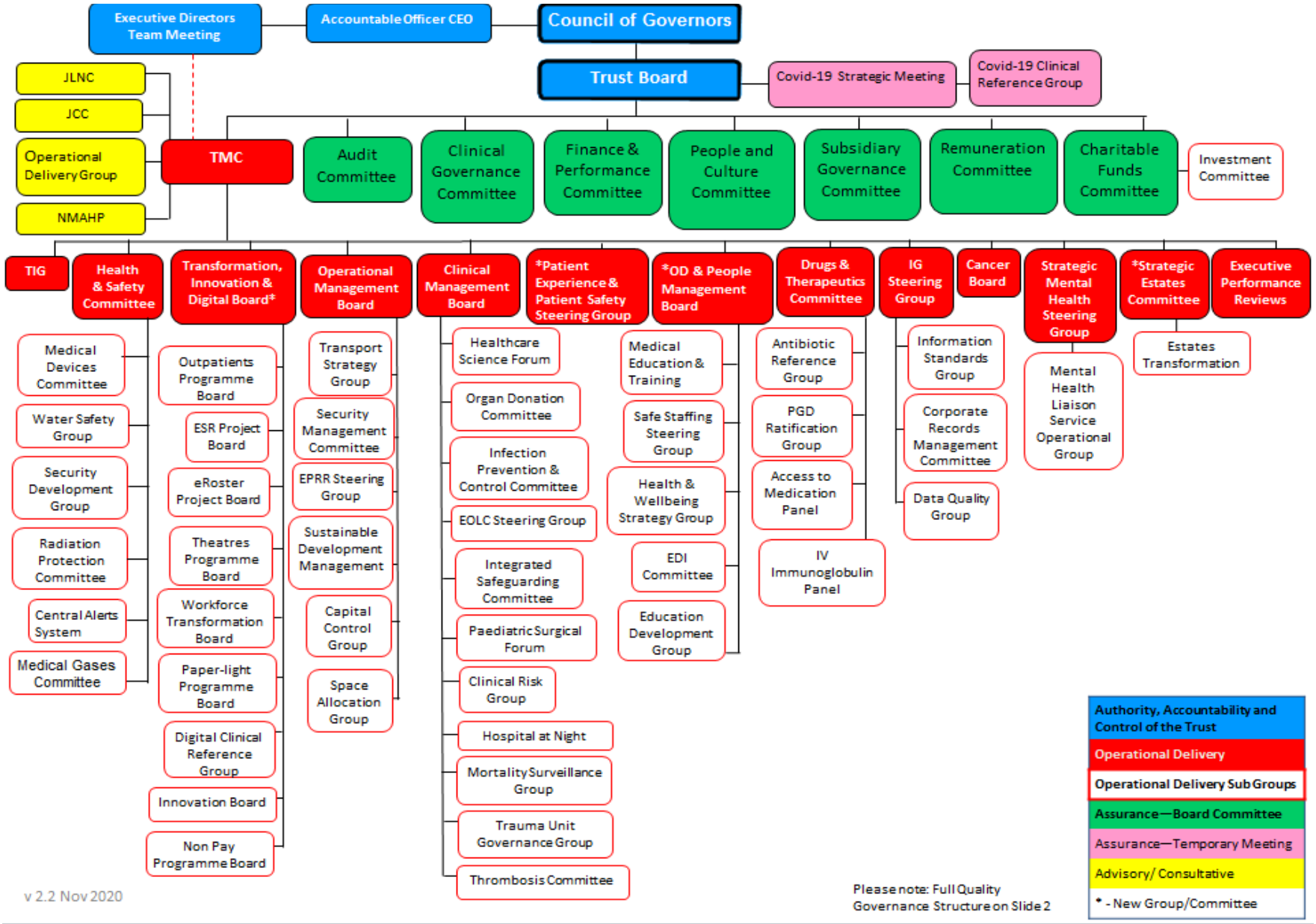
Note: Executive Directors are Board level positions

	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 Divisions and Facilities Service delivery Performance delivery of divisions Accountable Officer for emergency planning and business continuity Medical Equipment Security Management Estates Hard Facilities Management
Chief Medical Officer (Executive Director)	Professional leadership – medical Responsible Officer (Medical Appraisal) Clinical Effectiveness Quality Account (joint with Chief Nursing Officer) Caldicott Guardian Mortality reviews Clinical audit and effectiveness Medical-legal matters Research and Development Medical Education QIA approval (joint with Chief Nursing Officer) Medicines Management Joint management of the Quality Directorate (with Chief Nursing Officer) Chief Knowledge Officer

Chief Nursing Officer (Executive Director)	Professional lead – nursing, midwifery, therapists Patient Safety Patient Experience Quality Account (joint with MD) Joint management of the Quality Directorate with Chief Medical Officer Risk management Infection, prevention and control (DIPC) Safeguarding adults and children Legal Services CQC lead (liaison and reporting) QIA approval (joint with Chief Medical Officer) CQUIN and Quality Schedule negotiation
Chief Finance Officer (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
Chief People Officer (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 Transformation	Chief Information Officer Chief Clinical Information Officer Information Governance and records management Informatics / Digital Senior information risk owner (SIRO) Change management/CIP programme Transformation and improvement Innovation Quality Improvement/ continuous improvement
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 – Salisbury Hospital NHS Foundation Trust Organisation Committee Assurance Map



APPENDIX 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 for the coming year

4. Timings of reviews

- 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 – TRUST MANAGEMENT COMMITTEE TERMS OF REFERENCE

Trust Management Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
March 2020	1.1	Major Revision	All sections revised	Corporate Governance Manager
March 2021	1.2	Minor - Annual Review	All sections reviewed	Corporate Governance Manager

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

1) Purpose

1. The Committee is established by the Chief Executive as the senior executive committee of Salisbury NHS Foundation Trust.
2. The Trust Management Committee is responsible for the coordination and operational management of the system of internal control and for the management of the achievement of the Trust's objectives as agreed by the Board of Directors.
3. It is the formal route to support the Chief Executive in effectively discharging their responsibilities as Accounting Officer.

2) Authority

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

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

3) Membership and Attendance

Membership

1. The Committee shall be appointed by the Chief Executive and shall consist of:
   - Chief Executive
   - Chief Medical Officer
   - Chief Operating Officer
   - Chief Finance Officer
   - Chief People Officer
   - Chief Nursing Officer
   - Director of Transformation
   - Director of Corporate Governance
   - Divisional Directors of Operations
   - Clinical Directors
   - Chief Information Officer

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

Quorum

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

4) Roles and Responsibilities

Strategy and Business Planning

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

2. Clear recommendations to the Trust Board on key strategic and operational decisions which are retained by the Board;
3. To ensure effective arrangements are in place to manage key partnerships and stakeholder engagement;
4. Maintain the Board Assurance Framework, reviewing and mitigating gaps in evidence and assurance to align with and support the Trust's objectives.
5. To determine business cases for approval which require investment of £20k - £250k and ensure that approved business cases are reviewed within the agreed time-frame.

Operational, Quality and Performance

6. Ensuring collective and individual responsibility and accountability for delivering operations, required performance and addressing current and emerging risk to maintaining successful delivery;
7. Develop and monitor the implementation of plans to improve the efficiency, effectiveness, quality and safety of services;
8. Clear decision making in accordance with the decision making framework on a timely basis and subsequent communication as appropriate;
9. The monthly Integrated Performance Report will be circulated for information.
10. Receive assurance and have oversight of Care Quality Commission (CQC) preparedness and to ensure subsequent actions are effectively embedded.

Governance and Risk

11. Monitor the management of organisational risk;
12. Receive and review the Corporate Risk Register and manage actions to effectively mitigate risks;
13. Receive assurance that both the clinical and non-clinical Register of External Visits and Accreditations is maintained and that the outcome of these visits has been appropriately actioned;
14. Monitor the Register of Gifts, Interests and Hospitality.

Procedural Documents in line with the Policy for Policies

15. Review and approve procedural documents, including strategies, policies, protocols and procedures;
16. Monitor and provide updates for the schedule of Matters Arising and ensure agreed actions are appropriately and promptly completed.

Receive Reports from the following sub-groups*

17. Clinical Management Board (CMB)
    Operational Management Board (OMB)
    Trust Investment Group (TIG)
    Transformation, Innovation and Digital Board

Strategic Estates Committee
Health and Safety Committee
Executive Performance Reviews
Information Governance Steering Group (IGSG)
Organisational Development and People Management Board
Patient Experience and Patient Safety Steering Group
Drugs and Therapeutics Committee
Strategic Mental Health Steering Group

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

5) Conduct of Business

Administration

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

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

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

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

Notice of meetings

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

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

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

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

8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.
9. The Committee will report to the Board of Directors annually on the performance of its duties as reflected within its Terms of Reference.
10. The Committee will report to the Board of Directors after six months on its effectiveness in meeting responsibilities as reflected within this Terms of Reference.
11. The Committee will receive minutes for information from the sub-groups listed under point 4.13 and from the following advisory groups:
    Joint Local Negotiating Committee (JLNC)
    Joint Consultative Committee (JCC) Nursing, Midwifery and Allied Health Professionals Forum (NMAHP)

6) Review

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.

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

APPENDIX 7 – BOARD COMMITTEE TERMS OF REFERENCE

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	Director of Corporate Governance
Nov 2019	3	Minor	Added delegated authority limits	Corporate Governance Manager
May 2020	4	Minor	Annual Review	Corporate Governance Manager
March 2021	4.1	Minor	Annual Review	Corporate Governance Manager

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. 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

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

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

    - Three non-Executive Directors
    - Chief Finance Officer Lead executive)
    - Director of Transformation
    - Chief Executive
    - Chief Operating Officer
    - Chief People Officer

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

5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members.
6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

7. Meetings of the Committee shall normally be attended by:
    - Core members defined in para 1 above
    - Deputy Director of Finance
    - Other directors and other staff by invitation
    - Governor observer(s)

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.
Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

4) Roles and responsibilities

1. 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.

2. 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

3. The duties of the committee can be categorised as follows:

i) 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.

ii) 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.

iii) 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.

4.3.4. 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. The Finance and Performance Committee has delegated authority to approve revenue business cases from £250k - £750k. The Committee has delegated authority to approve capital business cases from £300k - £750k.

- 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.

4.3.5. 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

1. 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

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

Notice of meetings

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. 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. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
7. 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.
8. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6) Review

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.
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.
3. These terms of reference were reviewed and approved by Trust Board on {INSERT DATE}

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	
March 2019	2	Major	All sections revised	Director of Corporate Governance
May 2020	3	Minor	Annual review	Corporate Governance Manager
March 2021	3.1	Minor	Annual Review	Corporate Governance Manager

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

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

1. The Committee shall be appointed by the Board of Directors and shall consist of:
    - Three Non-Executive Directors
    - Chief Medical Officer, Chief Nursing Officer (joint Lead executive)
    - Chief Operating Officer
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. A Non-Executive Director shall be appointed as Chair of the Committee.
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

5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members or nominated deputy.
6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

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 Chief Nursing Officer and Chief Medical Officer will act as Secretary to the Committee.
- Governor observer(s)
- 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.
- Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

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

1. The function of the Committee is to ensure:

i) 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).

ii) 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.

iii) 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

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

v) 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

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

i) 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, People and 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 Integrated Performance Report Quality and Care section prior to inclusion in the Board 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
- Quarterly Strategic focus to include population health.

ii) 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:

- Commitment to strengthen learning across the organisation aligned with continuous improvement and improve patient safety, experience and outcomes.
- 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.

iii) Policy monitoring and review

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

5) Conduct of Business

Administration

1. The Committee shall be supported administratively by the PA to the Chief Nursing Officer and Chief Medical Officer 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 Committee chair 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

2. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
3. Meetings will be held 12 times per year, with additional meetings where necessary.

Notice of meetings

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. 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. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.
7. 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.
8. Reporting arrangements into the Committee from Sub-Committees

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

- Clinical Management Board Escalation Report (Minutes)

6) Review

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.

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.

3. These terms of reference were approved by the Clinical Governance Committee with amendments and these terms of reference were reviewed and approved by Trust Board on {INSERT DATE}

People and Culture 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	Director of Corporate Governance
May 2020	3		Annual Revision	Corporate Governance Manager
March 2021	3.1	Minor	Annual Revision	Corporate Governance Manager

Date Adopted	2/07/2020
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	People and Culture Committee
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

1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the People and Culture Committee (the Committee).
2. The Committee is a standing committee of the Board of Directors (the Board).
3. The Committee is a Non-Executive Committee and has no Executive powers.

3) Membership and Attendance

Membership

1. The Committee shall be appointed by the Board of Directors and shall consist of:
    - Two Non-Executive Directors
    - Chief People Officer (Lead Executive)
    - Chief Medical Officer

- Chief Nursing Officer
- Director of Transformation

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

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.

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

5. Quorum shall be at least half the members being present, including at least two Non-Executive Director members or nominated deputy.
6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

7. Meetings of the Committee shall normally be attended by:
   Deputy Director of OD and People
   Associate Director of Education, Inclusion, Communication and Engagement
   Chief People Officer
   Chief Nursing Officer
   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.
Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

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

1. Oversee progress on the development and delivery of workforce, OD and cultural change strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives.
2. Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance. The detail of this review will be upwardly reported to the Board to provide oversight.

3. Oversight of the delivery of the HR operating plan and associated policy management.
4. Maintaining oversight of the business of the newly developed Organisational Development and People Management Board and associated sub-structure. Escalation reports will come to the People and Culture Committee summarising the themes and providing assurance on operational decisions affecting workforce performance, organisational change and the implementation of initiatives.
5. Oversight of the development and delivery of the People Strategy and the people aspect of the Clinical Strategy
6. Monitor effectiveness of compliance with local and National staff surveys and the implementation of action plans to deliver against identified areas of concern.
7. Receipt and review of the Workforce Report prior to submission to Trust Board as part of the Integrated Performance Report. This includes a review of the Trust's workforce performance indicators to provide assurance that mitigating actions are in place where appropriate.
8. Oversee the implementation of Internal Audit recommendations as directed by the Audit Committee
9. To receive and review quarterly and annual reports of the Guardian of Safe Working on the Board's behalf.
10. To receive and review quarterly reports of the Freedom to Speak up Guardian, including an annual report.
11. To receive and review Safe Staffing reports to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the needs of patients and service users.
12. Maintaining oversight of the Trust's employment related equality, diversity and inclusion agenda. To receive and review the minutes of the Equality and Diversity Committee.

5) Conduct of Business

Administration

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

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

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

Notice of meetings

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

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

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

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.

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

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

- Organisational Development and People Management Board

6) Review

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.

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.

3. These terms of reference were approved by the People and Culture Committee with amendments on and ratified by the Board of Directors on INSERT DATE

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	Director of Corporate Governance
March 2020	2.1	Minor	Annual Revision	Director of Corporate Governance
March 2021	2.2	Nil changes	Annual Revision	Director of Corporate Governance

Date Adopted	
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:

1. 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
2. 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
3. Review the effectiveness of the Trust's internal audit and external audit function; and
4. 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.
5. Report to the Board as to how it is discharging its responsibilities as a Committee

2) Authority

1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee.
2. The Committee is a standing committee of the Board of Directors (the Board).
3. 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.
4. 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.
5. 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

1. 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.

2. A Non-Executive Director shall be appointed as Chair of the Committee.
3. The Chairman of the Board of Directors shall not be a member of the Committee.
4. The Chair of the Committee shall not be the Senior Independent Director of the Board of Directors.

Quorum

5. The quorum necessary for the transaction of business shall be two members of the Committee
6. In the absence of the Chair of the Committee, the Secretary will invite one of the other Committee members to chair the meeting.

Attendance

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

- The Chief Executive
- The Chief Finance Officer, 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

Executive and Non-Executive Directors can attend any Board Committee in order to exercise their functions.

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 Chief Finance Officer 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 Chief Finance Officer, 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 Chief Finance Officer 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.

Subsidiary Governance Committee
Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1.0	Major	Drafted	Director of Corporate Governance
Jan 2019	1.0	Minor	Minor amendments agreed at the first meeting	Director of Corporate Governance
May 2020	1.1	Minor	Annual Revision	Director of Corporate Governance
March 2020	1.2	Minor	Annual Revision	Corporate Governance Manager
March 2021	1.3	Minor	Annual Revision	Corporate Governance Manager

Date Adopted	
Review Frequency	Annual
Terms of Reference Drafting	Chief Finance Officer
Review and Approval	Subsidiary Governance Committee
Adoption and ratification	Trust Board

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).

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:

- Two Non-Executive Directors
- Independent Chairman of OML and STL
- Chief Financial Officer
- Chief People Officer

- 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 Chief Finance Officer must be in attendance if the Chief Finance Officer 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.

Charitable Funds Committee Terms of Reference

The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), operating under the working name of Stars Appeal, and is responsible for the management of funds it holds on trust.

In line with the registration to the charity commission the Board of Directors of Salisbury NHS Foundation Trust collective is the Corporate Trustee. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately.

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
August 2018	1	Approved version	Approved by the Trust Board of Directors	
March 2019	2	Minor	Added role of secretary to the Committee	Director of Corporate Governance
December 2020	2.1	Minor	Membership and Administration	Investment Planning and Policy Manager

Date Adopted	1st January 2021
Review Frequency	Annual
Terms of Reference Drafting	Investment Planning and Policy Manager
Review and Approval	Trust Board
Adoption and ratification	Trust Board

1. Purpose

The Committee is established to provide the Board of Directors with assurance on the appropriate management and use of charitable funds it holds on trust.

2. The committee is established to:

2.1. Ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to Salisbury District Hospital Charitable Fund for charitable fund purposes.

2.2. Determining an investment strategy and arrangements for the investment of funds which are no immediately required for use.

2.3. Coordinating the provision of assurance to the Board of Directors, acting as trustee of the funds, that the funds are accounted for, deployed and invested in line with legal and statutory requirements.

2.4. Considering and approving the annual accounts for charitable funds for submission to the Board of Directors, acting as trustee of the funds.

3. Authority

3.1. The Board of Directors, acting as the Trustee for the Salisbury Hospital Charitable Fund Charity, hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds 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;
- To approve or ratify as appropriate those policies and procedures for which it has responsibility (including SFI and SO's).
- 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 as corporate trustee.
- Approve use of charitable funds in line with the SFI's.

4. Membership and Attendance

Membership

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

- Non-Executive Directors

- Executive Directors, of which one is the Chief Finance Officer (lead Executive)

4.2. 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

4.3. 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

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

Attendance (non-voting members)

4.5. Meetings of the Committee shall be attended by:

- Senior Responsible Officer for the Charity
- Financial Controller or Financial Accountant
- Director of Corporate Governance
- Representative from the Fundraising Team
- Staff representation – in the form of representatives from the Charity Ambassador board
- Patient representation – in the form of representatives from the PALS team
- Community representation – in the form of the Chairman for the Fundraising Committee which is external to the Trust

Attendance by Other Trustees

4.6. Any member of the Board of Directors (Trustee) can attend.

4.7. 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

5.1. The duties of the Committee can be categorised as follows:

Assurance

5.2. Manage the affairs of the Salisbury District Hospital Charitable Fund within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations.

5.3. Scrutinise requests for the use of charitable funds to ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.

5.4. Review the Charitable Funds annual accounts and comment/ recommend approval to the Trustee as appropriate.

5.5. Ensure that the NHS Foundation Trust's Constitution, Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.

5.6. Receive and discuss all audit reports on charitable funds and recommend action to the Trustee.

Investments

5.7. Recommend an investment advisor to the Trustees following appropriate tendering procedures and regularly monitor and review their performance.

5.8. Ensure that the investment policy for Charitable Funds set by the Trustees is implemented and that sufficient funds are kept readily available to meet planned requirements.

5.9. Review the performance of investments on a regular basis with the external investment advisors to ensure the optimum return from surplus funds.

Fundraising

5.10. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commissioner guidance and legislation.

5.11. Ensure the sources of income and the terms on which donations are received are acceptable to the Trustee.

5.12. Ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law.

5.13. Ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments

5.14. Ensure effective communication regarding whistle blowing relating to fundraising, donations or subsequent use of funds.

6. Conduct of Business

Administration

6.1. The Chief Finance Officer is a member of the committee and has corporate responsibility for:

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

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

6.4. The Executive Services Manager will act as the role of secretary to the Committee.

Frequency

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

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

Notice of meetings

6.7. 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

6.8. 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

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

6.10. 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.

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

6.12. 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.

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance
November 2020	1.1	Minor	Updates to membership and attendance sections and minor formatting	Director of Corporate Governance

Date Adopted	03 December 2020
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Governance
Review and Approval	Remcom 03 December 2020
Adoption and ratification	Trust Board

1) Purpose

1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service

2) Authority

1. The Remuneration, Nominations and Appointments Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.
2. The committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.
3. The committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.
4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3) Membership and Attendance

Membership

1. The membership of the Committee shall consist of:
    - The Trust Chair
    - The other Non-Executive Directors
    - When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act). When appointing or removing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act (that is, the Chairman, Chief Executive and the Non-Executive Directors).
2. The Trust Chair shall chair the Committee.

Attendance

3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair. At the invitation of the Committee, meetings shall normally be attended by the Director of OD and People.

4. Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Quorum

5. The quorum necessary for the transaction of business shall be the Chair of the Committee and three other Non-Executive Directors

Secretary

6. The Director of Corporate Governance shall be secretary to the Committee.

4) Duties

4.1 Appointments

The Committee will:

4.11 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes. The Constitution sets out the requirements of the Board composition.

4.12 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

4.13 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.14 Be responsible for identifying and appointing Executive Director candidates to fill posts within its remit as and when they arise.

4.15 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.16 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

4.17 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.18 Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

4.2 Remuneration

The Committee will:

4.21 Establish and keep under review a remuneration policy in respect of Executive Board Directors.

4.22 Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

4.23 In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments.

4.24 In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

4.25 Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them;

4.26 Be sensitive to pay and employment conditions elsewhere in the Trust.

4.27 Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels.

4.28 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

5) Conduct of Business

Administration

5.1 The Director of Corporate Governance shall be Secretary to the Committee.

Frequency

5.2 The Committee will be held bi-annually and at such other times as the Chair of the Committee shall require.

Notice of meetings

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting,

Reporting

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

6 Review

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

Appendix 7: Version control

Document Title	Integrated Governance Framework			
Date Issued/Approved:	TBC 8th April 2021			
Date Valid From:	8th April 2021			
Date Valid To:	7th April 2022			
Division / Department responsible (author/owner):	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:	March 2021			
Approval route (names of committees)/consultation:	Trust Board			
Name and Post Title of additional signatories	Not Required			
Publication Location (refer to Policy on Policies – Approvals	Internet & Intranet		Intranet Only	x

and Ratification):	
Document Library Folder/ Folder	Constitution
Links to key external standards	Well-Led Framework
Related Documents:	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 Reference of Trust Management Team Proposed removal of committee memberships Added review of committees Added Nominations Committees	David Seabrooke Head of Corporate Governance
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
2 July 2020	V6.1	Document updated to reflect the changes as a result of the Internal Audit of Board Compliance and Reporting in November 2019. The Strategy Committee has been removed. The Workforce Committee's name has been changed to People and Culture Committee. Charitable Funds Committee and Remuneration Committee Terms of Reference added. Directorates are now called Divisions. The Divisional Governance Committee remit has been strengthened.	Fiona McNeight Director of Corporate Governance
15 March 2021	V6.2	The executive directors titles have been updated to reflect changes from 1st April 2021 Board Committee Assurance Map updated to reflect changes that have occurred in reporting and committee structure. Section 8 – updated title 'Collaborative	Fiona McNeight Director of Corporate Governance

		Working and Partnerships' to reflect the developing ICS work.	

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.3
Date of Meeting:	08 April 2021		

Report Title:	Accountability Framework			
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 – Divisions to Board Flowchart Appendix 2 – Trust Management Committee Terms of Reference Appendix 3 – Divisional Management Committee Terms of Reference Appendix 4 – Executive Performance Review Meeting Agenda.			

Recommendation:
The Board is asked to approve the changes following the annual review of the Trust's Accountability Framework.

Executive Summary:
The Accountability Framework has been reviewed in conjunction with the Integrated Governance Framework. There have been no major amendments. An additional section has been added on the Trust's recently agreed Programme Management Approach, which sets out how the Trust manages its change programmes. The Accountability Framework will go to TMC for information following Trust Board approval.

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	☐

Accountability Framework

2021/22

Version	V 3.0
Author	Andy Hyett, Chief Operating Officer

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 2020 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 divisions. 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 Oversight Framework. 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 Oversight Framework) 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 division will be held accountable against, these metrics will be taken from the Trust's Operational Plan, individual divisional 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 divisional and organisational level.

To mirror the 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. Targeted 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 divisional 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 Division 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 Division'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 (e.g. 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 Division's operational performance
Strategic change	Extent to which Division's and departments are working with partners to address local challenges and to improve services for patients • Division's contribution to developing, agreeing and delivering the objectives of sustainability and transformation partnerships (STPs) • Nature of Division's relationships with local partners, their role in	Material concerns about support for the local transformation agenda, including (where relevant) new care models and devolution

	any agreed service transformation plans and how far these plans have been implemented.	
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 divisions • Information from third parties e.g. Healthwatch, MPs, complaints, whistle-blowers, coroners' reports • Staff/patient surveys • Level of Divisional 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 Divisional health indicators • Other material concerns about a Division'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

**Well Led Performance Indicators*

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.

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

Measure	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: a) Urgent GP referral for suspected cancer b) NHS cancer screening service referral	Monthly	 85% 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	Quarterly	

an emergency for more than 72 hours: a) Who have a diagnosis of dementia or delirium or to whom case finding is applied b) Who, if identified as potentially having dementia or delirium, are appropriately assessed and c) Where the outcome was positive or inconclusive, are referred on to specialist services		90% 90% 90%

Monthly performance packs will be produced which outline current performance against plan or set targets. Divisions 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 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

Divisional 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
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 Frequent	By Exception[1]
Quality of Care	In year quality information to identify any areas for improvement	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters.
Finance and	Monthly returns	Annual Operational	One-off financial

Use of Resources		Plans Information relating to Use of Resources assessments.	events (e.g. sudden drops in income/ increase in costs) Transactions/ mergers
Operational Performance	Quarterly/monthly/weekly operational performance information		Any sudden 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 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]	Finds 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 of routine monitoring.

[2] E.g. reports from quality surveillance groups (QSGs) General Medical Council, ombudsmen, CCGs, Healthwatch England, NHS Digital, auditors, Health and Safety Executive, patient groups, complaints, whistle-blowers, 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

Division's 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 Divisional operational plan.

Overall Performance Ratings and Oversight Model

Individual domain ratings will then be aggregated to provide an overall rating for the Division. 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.

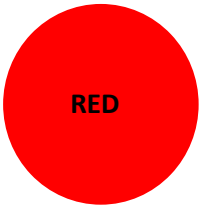
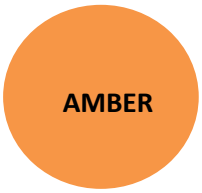
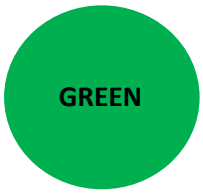
RAG ratings will be routinely reported to the Trust Management Committee to ensure that appropriate scrutiny is given to the most significant areas of risk.

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 Division's 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 Divisional rating will determine the regularity of performance review meetings and other escalation meetings. These Divisional Performance Review meetings will take place routinely, however for those divisions 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 divisions assessing data, re-focusing 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 • Division 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 ➢ Presentation of recovery plan at Trust Management Committee and monthly update on recovery ➢ Further assurance to the Finance & Performance Committee may be
	• 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 • Division is forecasting moderate variance to plan at year end, however there is confidence in recovery trajectories	➢ Agreed trajectories for improvement ➢ DMT Monitoring weekly ➢ Monthly Executive Performance Review Meetings
	• 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 division will act as the trigger for any additional support or escalation. For Division's 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 Division 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 normally take the form of intensive support. Depending upon the issues causing concern this may be department specific, ward specific, or, across the division. Executive Directors will be allocated based on the areas of concern. At the initial meeting the scope and focus will be agreed along with the KPI's for success. More serious measures, such as removal of delegated division 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. Through the use of agreed KPI's, the point at which intensive support will cease shall be set and agreed early on.

GOVERNANCE

Throughout this document the term Division is used to describe the following clinical and corporate departments;

- Surgery
- Medicine
- Clinical Support and Family Services

Monthly Executive Performance Review meetings will take place with each of the above Divisions. Once in Quarters 1 and 3, Executive Performance Review meetings will be chaired by the CEO. All Division's will receive a RAG rating and escalation will be the same for Division's as outlined on page 14.

CORPORATE DEPARTMENTS

Additional information to support the Governance process is provided in the attached
Appendices;

- Appendix 1 - Division to Board flow chart
- Appendix 2 - Trust Management Committee Terms of Reference
- Appendix 3 - Divisional Management Committee Terms of Reference
- Appendix 4 - Executive Performance Meeting Agenda

Performance of Corporate Services will be monitored by the relevant Director and assurance provided to the Chief Executive Officer. Where the Chief Executive Officer is not satisfied with performance, they will ask the Chief Operating Officer to commence intensive support with the area. This will be led by two Executive Directors and progress will be reported via the standard escalation reports.

TRUST PROGRAMME MANAGEMENT APPROACH

In 2020 a Programme Management Approach was agreed which proposed the Trust adopt a set of key principles and actions to manage Change Programmes. These agreed changes will improve the organisation's change capability by:

- Improved capability to deliver programmes and change.
- Greater assurance over successful delivery.
- Common understanding of terminology which will lead to improved engagement and understanding of initiatives.
- Improved control and visibility of programmes and change initiatives with the understanding and ability to mitigate changes, risk, issues and dependencies.

This approach will also allow a clear framework for delivery of programme and projects and an ability to demonstrate and assure standards are in place for major change initiatives.

This work is led by the Transformation Team with regular progress reporting through the Transformation, Innovation and Digital Board with bi-annual assurance reports to the Trust Audit Committee planned for 2021.

Version control

Document Title	Accountability Framework 2020/21			
Date Issued/Approved:				
Date Valid From:	08/04/2021			
Date Valid To:	07/04/2022			
Division / 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 three Divisions' that are subject to performance review meetings.			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2019 December 2019 June 2020 March 2021			
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
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 and approved .	Andy Hyett, Chief Operating Officer
03/12/19	V2.8	Draft document	Andy Hyett, Chief Operating Officer
25/06/20	V2.9	Draft document – presented to Board and approved	Andy Hyett, Chief Operating Officer

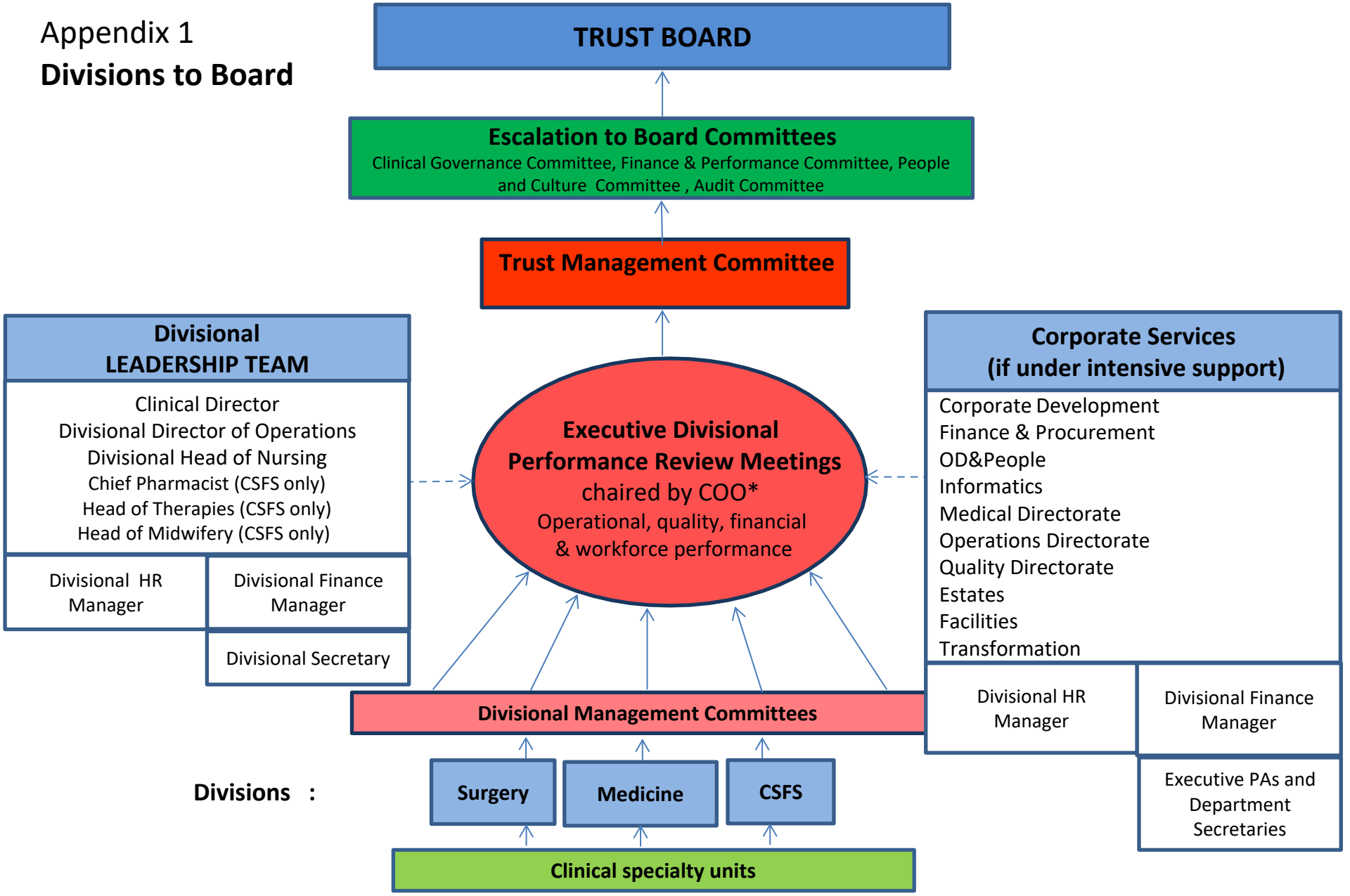
12/01/21	V3	Draft document	Andy Hyett, Chief Operating Officer

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

Appendix 1

Divisions to Board



* Executive Divisional Performance Review meetings attended by Chief Operating Officer, Director of Finance, Director of Nursing, Medical Director, Director of Organisational Development and People to provide support, oversight and challenge to the Divisional leadership team regarding delivery against all requirements in preparation for providing assurance to the Trust Management Committee

Salisbury NHS Foundation Trust

Trust Management Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
March 2020	1.1	Major Revision	All sections revised	Corporate Governance Manager
March 2021	1.2	Minor - Annual Review	All sections reviewed	Corporate Governance Manager

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

1. Purpose

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

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

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

2. Authority

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

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

3. Membership and Attendance

Membership

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

- Chief Executive
- Chief Medical Officer
- Chief Operating Officer
- Chief Finance Officer
- Chief People Officer
- Chief Nursing Officer
- Director of Transformation
- Director of Corporate Governance
- Divisional Directors of Operations
- Clinical Directors
- Chief Information Officer

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

Quorum

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

4. Roles and Responsibilities

Strategy and Business Planning

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

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

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

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

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

Operational, Quality and Performance

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

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

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

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

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

Governance and Risk

4.11. Monitor the management of organisational risk;

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

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

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

Procedural Documents in line with the Policy for Policies

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

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

Receive Reports from the following sub-groups*

4.17. Clinical Management Board (CMB)

Operational Management Board (OMB)

Trust Investment Group (TIG)

Transformation, Innovation and Digital Board

Strategic Estates Committee

Health and Safety Committee

Executive Performance Reviews

Information Governance Steering Group (IGSG)

Organisational Development and People Management Board

Patient Experience and Patient Safety Steering Group

Drugs and Therapeutics Committee

Strategic Mental Health Steering Group

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

5. Conduct of Business

Administration

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

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

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

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

Notice of meetings

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

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

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

Reporting

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

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

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

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

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

Joint Local Negotiating Committee (JLNC)

Joint Consultative Committee (JCC) Nursing, Midwifery and Allied Health Professionals Forum (NMAHP)

6. Review

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

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

Appendix A

Salisbury NHS Foundation Trust

Agenda Template
Trust Management Committee
Date, Time
Room

Timings	1	Opening Business	To present	Purpose	Verbal/ Enc.
	1.1	Welcome and apologies:	CCB	Noting	
	1.2	Minutes of the previous TMC meeting held on **DATE**	CCB	Approval	Enc
	1.3	Matters Arising and action log	All	Discussion	Enc
	2	**Urgent Business**			
	2.1	Hot spots/ Feedback from frontline visits			
	4	**Sub-Group Exception Reports**			
	4.1				
	5	**Operational, Quality and Performance**			
	5.1	Integrated Performance Report		Information	
	6	**Strategy and Partnerships**			
	6.1				
	7	**Business and Commercial**			
	7.1				
	8	**Governance and Risk**			
	8.1				
	9	**Minutes for Information**			
	9.1				
	10	**Closing Business**			
	10.1	Agreement of principal actions / Items for Escalation			
	10.2	Any Other Business			
	10.3	**Date of next meeting:**			

Agenda and papers circulated to:

Committee members:
Chief Executive
Medical Director
Chief Operating Officer
Director of Finance
Director of OD and People
Director of Transformation
Director of Nursing
Clinical Director, Surgery
Clinical Director, Medicine
Clinical Director, CSFS
Divisional Director of Operations, Surgery/ Deputy COO
Divisional Director of Operations, Medicine/ Deputy COO
Divisional Director of Operations, CSFS
Chief Information Officer
Director of Corporate Governance

Regular Attendees

Deputy Director of Finance
Associate Director of Strategy
Executive Services Manager (minutes)

Appendix 3

Salisbury NHS Foundation Trust

DIVISIONAL MANAGEMENT COMMITTEE

TERMS OF REFERENCE

1. Formation of this Committee

The Divisional Management Committees role is to consider key strategic and managerial issues within the Division and to ensure that performance is in line with agreed objectives.

2. Role

The Division will function as a decision making body in line with its delegated authority. It will provide effective and proactive leadership to the Division and ensure that robust governance arrangements are in place and high quality care is consistently delivered. It will provide information and assurances to the Board via meetings with the Chief Operating Officer (COO).

3. Membership of the Divisional Management Committee

The committee shall be comprised of Division members as follows:

- Clinical Director (CD)
- Divisional Director of Operations
- Divisional Manager (DM)
- Divisional Head of Nursing
- Chief Pharmacist (CSFS only)
- Head of Therapies (Medicine only)
- Head of Midwifery (CSFS only)
- Divisional Finance Manager
- Divisional Human Resources Manager
- Speciality Lead Clinicians
- Ward Sisters
- Heads of departments

It is expected that all members will attend at least 75% of meetings of the committee. An annual attendance report will be submitted to the COO for information and action as required.

4. Chair of the Divisional Management Committee

The chair of the Divisional Management Committee shall be the Clinical Director, with the Divisional Director of Operations adopting the role of Vice Chair.

5. Quorum

The quorum shall be the chair or vice chair, and at least 50% of the other representation.

6. Meetings

The Divisional Management Committee shall meet monthly. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7. Attendance at meetings

Other employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that employee.

8. Notice of meetings

Meetings of the committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the committee not less than five working days before the date of the meeting.

9. Agenda and action points

The agenda and action points of all meetings of the board shall be produced in the standard agreed format of the Trust and kept by the Divisional Administration Team.

10. Reporting arrangements

The Divisional Management Committee has a direct reporting line to the Trust Management Committee. Assurance responsibility is delegated to the Chief Operating officer who along with the Medical Director, Director of Nursing, Director of Finance and Director of Organisational Development & People will meet with the Divisional Management team in line with the Accountability Framework.

11. Responsibilities of the Divisional Management Committee

The Divisional Management Committee is responsible for providing information and assurances to the COO that the Division is safely managing all issues relating to the strategic objectives of the Division and the Trust. In addition it has responsibility to:

11.1 based on the Trust strategy and emerging risks develop an annual divisional operational plan to form part of the Trust's operational plan

11.2 identify any risks which may prevent the achievement of the work plan and ensure that they are assessed, placed on the Divisional Risk Register and the action plan is monitored

11.3 evaluate its own membership and performance on at least an annual basis

11.4 provide assurance to the Trust Board via meetings with COO and other executive Directors as outlined in the Accountability Framework

11.5 review and monitor the Division against its Operating Plan

11.6 review and monitor the Quality Metrics on at least a quarterly basis.

11.7 escalate any significant issues that impact on the corporate objectives

12. Administration

The Committee shall be supported administratively by the Divisional Administration Team who will agree the agenda with the chair, produce all necessary papers, produce and distribute minutes and action points, and generally provide support to the chair and members of the Committee.

Appendix 4

Executive Performance Review Meeting

Agenda Template

1. **Welcome and apologies**
2. **Minutes of the last meeting**
3. **Action log review**
4. **Performance Overview**
5. **Key Issues**
6. **Data dashboards**
7. **Quality performance (to include Directorate Governance meeting minutes)**
8. **Operational performance**
9. **Financial performance**
10. **Workforce performance**
11. **Performance against Divisional Operational Plan**
12. **Risk Register Review**
13. **Key issues for escalation**
14. **External Visits**
15. **RAG rating**

Report to:	Trust Board (Public)	**Agenda item:**	6.5
Date of Meeting:	08 April 2021		

Report Title:	Register of Seals			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Prepared by:	Sasha Grandfield, PA and Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
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 November 2020. 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:
361	26/11/2020	Lloyds Pharmacy Unit – licence to carry out works at former hydro pool, Level 3, SFT	Laurence Arnold	Stacey Hunter	Michael von Bertele
362	17/3/2021	Lease between SFT (landlord) and Inspire (tenant) for part of Block 90 for a term of one year	Laurence Arnold	Stacey Hunter	Nick Marsden

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.6
Date of Meeting:	08 April 2021		

Report Title:	External Well-Led Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		x
Prepared by:	Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	N/A			

Recommendation:
To approve the deferral of the Trust Board external Well-Led assessment to 2022.

Executive Summary:
NHSI/E Guidance "Developmental reviews of leadership and governance using the well-led framework" indicates the requirement for foundation trusts to undertake an external review of the CQC Well Led Framework every 3-5 years. The Trust was last reviewed in May 2018 and is therefore due another review from May 2021. Given the ongoing executive recruitment and the continued work to manage Covid-19 and focus on the recovery effort, the Executive Team feel that an external review this year would not be useful or add value and should be deferred until 2022. In the meantime, it is proposed that the Trust Board undertake a self-assessment against the Well-Led Framework later this year which will highlight specific areas of focus for improvement, prior to the external review. It is worth noting that NHSI/E Guidance differs slightly from the NHS FT Code of Governance which states in provision B.6.2 that "Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years." Therefore, if this proposal is approved the Trust's 2021 Annual Report will make reference to this non-compliance and rationale for deferral.

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	☐