Report to:	Trust Board	**Agenda item:**	SFT 4050
Date of Meeting:	7 June 2018		

Report Title:	Board Assurance Framework and Corporate Risk Register			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	David Seabrooke, Head of Corporate Governance Andrea Prime, Deputy Head of Corporate Governance			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	- Revised BAF (June 2018) - Corporate Risk Register Summary (June 2018) - Corporate Risk Register (June 2018)			

Recommendation:
The Board are asked to consider and approve the revised Board Assurance Framework.

Executive Summary:
Background The Board Assurance Framework provides the Trust Board with a means for satisfying itself that its responsibilities are being discharged effectively and objectives delivered. This informs the Annual Governance Statement and annual cycle of business. **Process:** The Trust Board carries out an annual review of the Board Assurance Framework (BAF) process. The BAF format was adopted by the Board in December 2017 and is presented to the Board at each of its public meetings to ensure that the risks described are the most valid and the document remains fit for purpose following review of assigned sections through each of the Board's Committees: • Local Services : Finance & Performance Committee • Specialist Services : Finance & Performance Committee • Innovation: Clinical Governance Committee • Care : Clinical Governance Committee • People : Workforce Committee

- Resources : Finance and Performance Committee

In addition the Trust Management Committee will review the complete BAF and CRR as part of this bi-monthly process. The Strategy Committee also reviews some aspects relevant to its role.

The aims of the revised BAF are to:

- Ensure there is clear alignment between the Trust's Strategy, BAF and Corporate Risk Register
- Enable the Board to be able to clearly see progress / deterioration of risks on the Corporate Risk Register and where required request further assurance / deep dive
- Support the updating of actions against gaps in one place

The BAF:

The BAF has been revised and updated. In order to assist in the easy identification of changes to the document:

- New content is highlighted in yellow
- ~~Out-dated content to be removed is shaded grey~~

Supporting Documentation:

- *The Corporate Risk Register* (CRR) is presented alongside the BAF for review
- *The Corporate Risk Register Summary* supporting the CRR, tracking the risk previous months, detailing the date of addition to the risk register, Lead Executive and whether the risk is an internal or external risk. Updates can also be requested and tracked through this summary sheet

Review of Risks:

It is clear from the summary sheet that our highest risk areas are:

- People: continuing challenges in recruitment, particularly Registered Nurses
- Resources: higher than planned deficit position. Currently working with NHSI on financial recovery plan

Next Stages:

- The BAF will be reviewed during July for presentation to Board at its meeting in August
- The approach to cross-referring issues on the BAF will be reviewed
- Risks on the Corporate Risk Register will continue to be reviewed by the Executive Leads to ensure they are representative of the actual current risk and that actions are up to date
- Further work is needed to ensure that all gaps identified on the BAF are trackable, either through relevant risks on the risk register or further development of this template

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	x
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	x

Salisbury
NHS Foundation Trust

Board Assurance Framework
2018/19

Date: 1 June 2018

Trust Vision: An Outstanding Experience for Every Patient

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

Strategic Priorities

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

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

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

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

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

Board Assurance Framework – Glossary

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

Risk Matrix Score Key

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

Strategic Priorities – Risk Overview

	Overall risk score
Local Services We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.	
Specialist Services We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.	
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People We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	
Resources We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	

Strategic Priority:

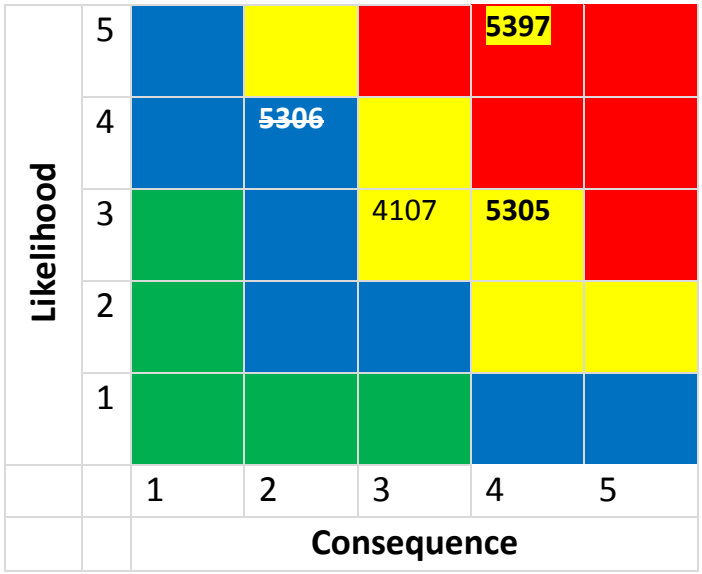
> **Local Services –** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Frail Elderly** - Development of an integrated frail elderly service	COO	April 2018	
2. **Emergency Care** - Implement new systems to manage the flow of emergency patients	COO	April 2018	
3. **Delayed Discharge** - Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	COO	April 2018	
4. **Access** - Improving access to core services to support prompt, responsive care	COO	April 2018	

Corporate Risk Register Principal Linked Risks



5305 – Consitutional performance standards may not be met as result of increased demand or decreased capacity

~~**5306** - Reduction in beds during site reconfiguration work~~

4107 - Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients.

5397 - inability to recruit enough nurse a decision has been taken not to open the additional medical beds

Key Controls	Assurance on Controls
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Ward reconfiguration governance structure • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wilts Health and Care	• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group

Key Headlines - Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
1. Development of an integrated frail elderly service	• Performance against quality metrics including increased number of discharges within 48 hours • Workshop to develop pathways for older people across the health economy has been agreed; actions being taken forward • Patient ward moves reduced (Getting the patient to the right place, first time) • Locality model for elderly pathways now fully implemented	• Unsuccessful recruitment of acute physicians		Completed
		• Agreeing pathways from ED/AMU to frailty	Perfect Week work being run through Medicine; learning and actions being embedded	June 18
		• Inability to create capacity between AMU and Durrington to support the frail elderly pathway	Address through Patient Flow workstream	July 2018
		• Records of patient moves not consistently kept up to date	Address through Patient Flow workstream	July 2018
		• Lack of single ~~acute~~ community bed base to ensure seamless pathway	Address through EDLBD	July 2018

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
2. Implement new systems to manage the flow of emergency patients	• Performance against national standards and internal quality metrics (improving length of stay and flow of patients) • Positive ED quality metrics • Good progress with new build, project on track - Ophthalmology, AMU and short stay surgery units open; Pembroke move completed May 2018 • Active use of escalation process over winter period • ~~Patient handovers (from ambulance) affected by staff shortages~~ • Escalation of ambulance handover delays has improved this issue	• ~~Unsuccessful recruitment of acute physicians – gaps in senior clinical posts effecting regular senior ward rounds~~	~~Medicine CD reviewing opportunities to recruit doctors – AH~~	~~April~~
		• Reliance on agency staff effecting ability to embed new ways of working	Workforce recruitment plan –	May 18
		• Accurate data entry at ward levels	Decision on viability of two-way link between Lorenzo and white board system – LA	May 18
		• Additional medical beds not opening in Q1	Actions to mitigate risk being quantified – AH	~~April~~ October 18
		• ~~Lack of daily metrics to monitor patient flow~~	~~Informatics implementing daily report – AH~~ completed	~~March 18~~
		• Medicine length of stay greater than benchmark	Refreshing length of stay action plan for medicine and addressing via patient flow workstream (metrics and trajectories agreed) AH	April 18

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
3. Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need	• Clarity on the number of non DTOC delays being reported • Early triggers in place to alert other providers when numbers of delays are increasing • Trust membership of Joint Commissioning Board • Trust membership of Health and Wellbeing Board • Trust representation on the Integration and Better Care Fund group	• Community/voluntary sector funding and capacity	3rd sector involvement in re-design	
		• Staff availability to identify and develop opportunities to improve pathways and discharge		
		• Inability of the health system to respond to increases in demand	Continuing to escalate concerns with more face to face meetings	
		• Community capacity not aligned to need	Wiltshire CCG/Council action plan	
		• Capacity within health system to step up discharge support as part of a major incident response	System-wide weekly meeting to agree actions to reduce the number of stranded patients – AH	April 18
4. Improving access to core services to support prompt, responsive care	• Delivering national access standard • Reports indicate current performance and waiting list now delivering • RTT waiting list has stabilised • Clarity obtained as to what capacity is required to clear backlogs	• Consultants' job plans currently do not allow accurate capacity and demand modelling		
		• Follow up waiting list still being validated		(Ongoing)
		• Additional short term capacity required to clear backlogs – concern about affordability and whether deliverable delivered	Capacity and demand modelling is addressing	
		• Inability to increase capacity to clear backlogs in a timely way (may be affected by financial position)	Capacity and demand modelling is addressing	
		• Review of Access policy (underway)	Updated policy going through approval process to OMB – AH	May 18

Strategic Priority:

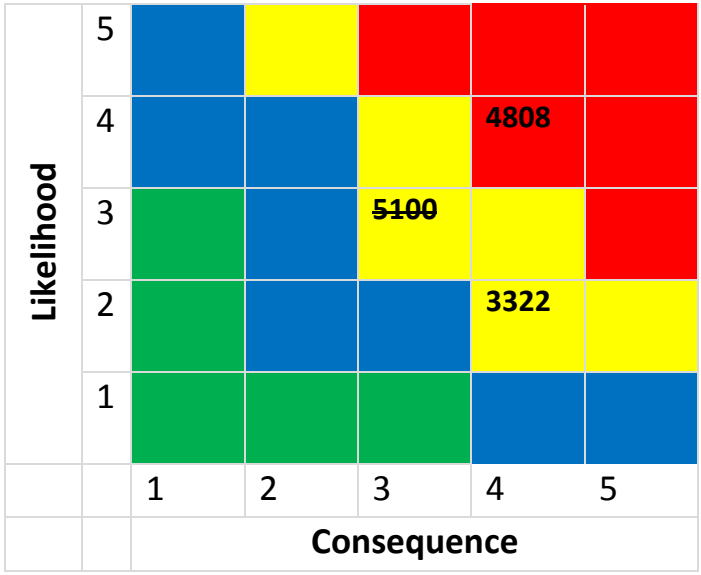
> **Specialist Services –** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Spinal Centre –** Service improvement initiatives within Spinal Cord Injury Centre	MD	April 2018 (Phase 1)	
2. **Plastics** - Delivery capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	COO	April 2018	
3. **Partnership Working** - Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genomics)	MD/COO/DoCD	June 2018 (Phase 1)	

Corporate Risk Register Principal Linked Risks



3322 - Genetics National reconfiguration

4808 - Vascular surgery cover

~~**5100** - Inability to provide robust activity & income performance reports~~

Key Controls	Assurance on Controls
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board	• Integrated Performance Report • Specialist Services dashboards

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
1. Service improvement initiatives within Spinal Cord Injury Centre	• Reducing the delay to admission and acceptance of admissions. • Reducing LoS by introducing intense rehab and standardisation of care, whilst also introducing a step down facility for rehab. • Ensuring a sustainable outpatient model, with every patient being recorded. • Improve inpatient decision making • Ensuring appropriate and reduce	• The historical and cultural national referral process restrictions.		
		• Workforce gaps in staffing levels and conflicting priorities.		
		• Levels of therapy engagement resulted in pilot work being stopped.	New approach from lead therapist to be worked through.	
		• Multi-disciplinary ward round, including support from urology not yet implemented and embedded	Recruitment of spinal urologist	

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
	unnecessary diagnostic tests • Improved therapy collaborative working across patient pathway, including inpatient and outpatient services • Recruitment of a clinical lead to support change within the teams • Implemented and embedded multi-disciplinary ward round, including support from respiratory • Improvement plan in place and maintained via Directorate Performance Reviews • Work ongoing on clinical pathways to embed best practice	• Common MDT vision and strategy not yet developed		
2. Plastic Surgery: Deliver capacity to separate elective and emergency care. Lead provision of plastic surgery network across Wessex	• Theatre timetables have been redesigned to ensure that elective and emergency capacity is separated • Support to PHT to become sustainable out of hours • Network approach to Plastic surgery service provision	• Required changes to operational and clinical practice/behaviour associated with reconfiguration of Burns and Plastics Inpatient Ward is not yet embedded	• Directorate revising bed model – AH – • COO monitoring numbers and location of outliers – AH	May 18 Ongoing
		• The proposed model of 1:8 on call at UHS is being scoped and costed, this on call would be in addition to SFT	Proposal with options being written – AH	May 18
		• Currently it's a short-term agreement between PHT and SFT, on how SFT can facilitate OOH services for PHT	SLA to be produced to cover all work with UHS and formalised – AH	June 18
		• Changes in operational practice from relocation of weekend Plastics Trauma Clinics to Burns and Plastics Inpatient dept		
		• Workforce and skills gaps in Nursing Team	Recruitment programme for nursing	Ongoing
		• Questions re tariff for complex plastics and burns work. A review of SLR coding/funding/tariff for Burns and Plastic is	Presentation to Board on 17 May from representatives of the MSK DMC	

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
3. Work with our partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience (eg burns, cleft lip, genetics/genomics)	• Cleft appointed new consultant cleft surgeon, who is also rotated on the plastic surgery O/C rota. • Work continues with Oxford and Southampton in ensuring the appropriate site is available for cleft surgery • Genetics - good progress in forming an alliance partnership with BWCH, UHB, OUH and UHS	being undertaken. Preliminary report published for comment December 2017; final version due January 2018		
		• Access Policy not reflective of changes in national requirements	Access policy reviewed and going through Trust approval processes – AH	May 18
		• As part of the national tender process for genetics/genomics the following gaps have emerged: - Financial model for the genetics service and implications for SFT - Clarity on what genetics services will continue to be offered at SFT - Clarity on genetics service implications for workforce, estates and infrastructure	Submit genomics bid	April 18 complete

Strategic Priority:

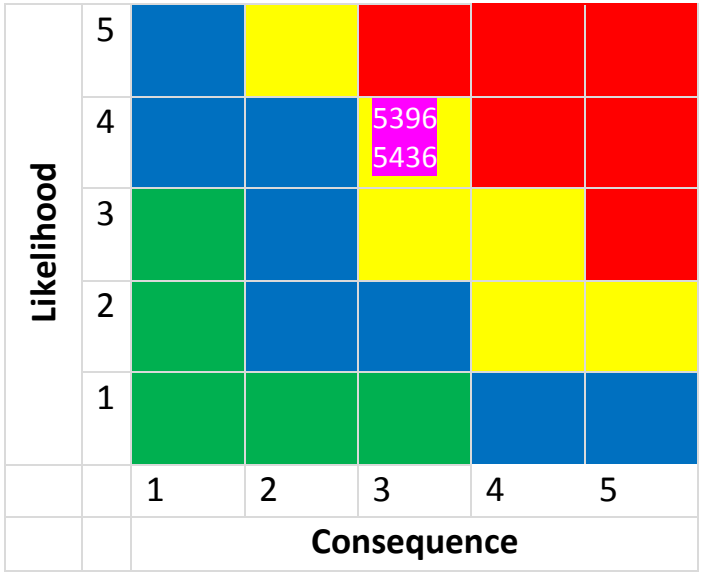
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Research -** Deliver an increased range of high quality research which directly benefits patient care and increases the Trust's reputation	MD	April 2019	
2. **Improvement -** Build a culture of innovation and continuous improvement adopting a consistent QI methodology	COO/MD	Jun 18	
3. **Innovation -** Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness of our services and to bring additional benefit for our patients	MD/COO	April 2019	

Corporate Risk Register Principal Risks



5396 – Delivery of CQUIN

5436 – Quality improvement methodology funding

Key Controls	Assurance on Controls
• Outstanding Every Time Board • QI training and coordination via PMO • Research Governance Framework	• Model Hospital benchmarking • NIHR Wessex

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
1. Deliver an increased range of high quality research which directly benefits patient care and increases the level of research income earned	• Attaining recruitment target • Increased number of departments are research active • Good progress in recruiting to time and target • Team won national Research Excellence Award • Approval to recruit two research fellows from NIHR support	• Availability of suitable high recruiting portfolio studies	Review NIHR bulletins to identify suitable studies - CB	Monthly
2. Build a culture of innovation and continuous improvement adopting a consistent QI methodology	• Business case approved setting out future QI approach	• Historically there has been no consistent approach to QI. Business case not funded; alternatives being explored. ~~Improvement on this will be dependent on business case being approved~~	Review opportunities within existing capacity - SW	Q1 18/19
		• Fragmented capture of QI work within the Trust and unclear accountability for delivery	Review opportunities within existing capacity - SW	Q1 18/19
3. Introduce innovative processes, pathways and to change how we deliver our services to improve effectiveness	• Trust weighted activity unit benchmark in top 10% of country as per the Model Hospital tool. • Consistently approving introduction of new procedures • New ambulatory gynaecology	• Surgical pathway requires improvement to reduce pre-surgery bed days	Length of Stay Project Board to identify pathways with excessive length of stay	Q2 18/19
		• Failure to embed standard operating procedure for Fractured neck of femur pathway	Review pathway for fractured neck of femur with a view to making improvements	Q2

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
of our services and to bring additional benefit for our patients	service • Introduction of virtual fracture clinic and patient initiated follow up • Roll out of email advice service	• Gaps in communications with GPs due to Consultant Connect not being commissioned for SFT		

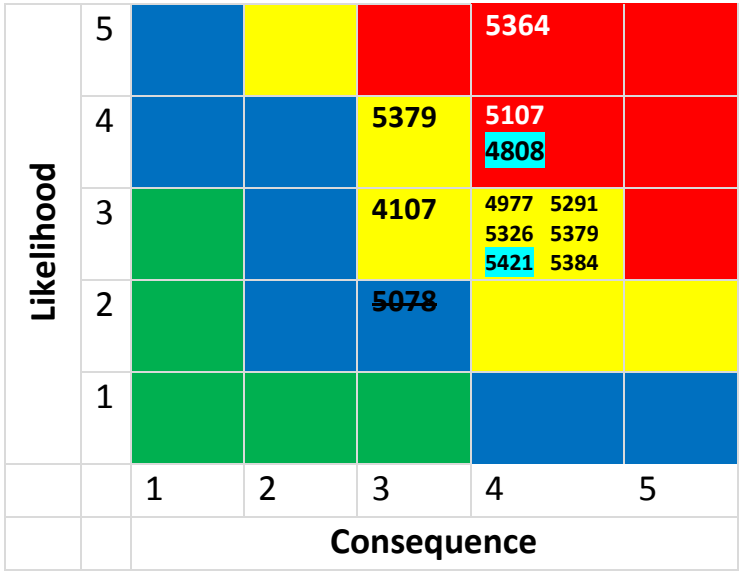
Strategic Priority:

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

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **CQC** - Achieve a CQC rating of Good	DoN	March 19	
2. **Safety -** Deliver on the local and national safety priorities	DoN	March 18	
3. **Infection -** Maintain our focus on reducing rates of infection	DoN	March 18	
4. **Learning from Deaths -** Review process to establish learning and improvement	MD	March 18	
5. **Patient Experience -** Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	DoN	March 19	



Corporate Risk Register Principal Risks

4107 – Risk of delay to patient follow-ups in Plastics
4808 Vascular surgery cover
4977 – Inpatient fall resulting in harm
~~**5078** – Mortality (HSMR) higher than expected range – risk to be reviewed – as now in normal range~~
5107 - Failure to recruit to vacant posts will result in an inability to provide outstanding patient care
5291 – Potential for bleep failure
5326 – Access to electronically held patient records
5364 - Failure to achieve required ward nursing establishment
5379 – Theratres patient safety
5421 – Incident reports – clinician requested timescales
Linked workforce risks (see People section):
~~**3925** - Failure of staff to maintain updated statutory /Mandatory Training~~
5384 - inpatient fall resulting in harm; increasing frail population

Key Controls	Assurance on Controls
• Quality Governance Framework • Integrated Governance Framework • Accountability Framework • Policies and procedures • Patient and user feedback mechanisms / patient stories at Board • Contract Quality Review Meeting / contractual monitoring • Annual audit programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Learning from Deaths Policy	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review commissioned for December 2017 • Internal Audit report on morbidity and mortality meetings

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
1. Achieve a CQC rating of Good	• Positive CQC Insights report on key benchmarks • Improvement delivery on Must do/ Should do's	• CQC will not normally grade a Trust Good if it is subject to NHS I enforcement action • Reliant on CQC scheduling next inspection	Continue to deliver the Enforcement Action Plan to close enforcement action and obtain NHS I certificate of compliance Maintain CQC preparation plan - LW	September 2018 Ongoing
2. Deliver on the local and national safety priorities ~~sign up to safety work streams~~	• Quarterly reports show most workstreams on track • ~~Positive NRLS report re reporting culture~~	• Never events continue to be reported • Falls continues to be biggest risk within the work streams	Intensive support commissioned for theatres – led by DMT with Executive oversight Implementation of Falls Reduction Strategy	Sept 18 March 19

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
		• Cluster of incidents relating to cancer pathway	Task and finish group set up and chaired by deputy COO to review patient pathways and processes – AH Draw together learning from all incidents for review by Clinical Risk Group, Cancer Board and CCG – LW/CB/AH	April 18 Complete July 18
3. Maintain our focus on reducing rates of infection	• Trust in best performing quartile ~~the upper quartile~~ for reportable infection rates in the South West in 2017/18 ~~Q1 and Q2~~ • Positive feedback received from NHS England re reduction ~~management~~ of E. coli bacteraemia			
4. Review process to establish learning and improvement on learning from deaths	• Mortality review reports show low levels of avoidability • HSMR is in normal range • Internal audit report on morbidity and mortality meetings • Learning from Deaths Policy published on Trust website • Mortality dashboard was published in February	• Improvement needed in some local Mortality and Morbidity meetings	Ongoing work with relevant directorates – CB	Ongoing
		Improvement needed in mortality review tool	Improvement work prioritised by IT – CB	Sept 18
5. Work with our patients to plan and improve the services we provide to ensure the care delivered meets patients' needs	• Positive survey results o ED o Cancer o Maternity o Paeds • High satisfaction shown in Friends and Family Test and Real Time Feedback			

Strategic Priority:

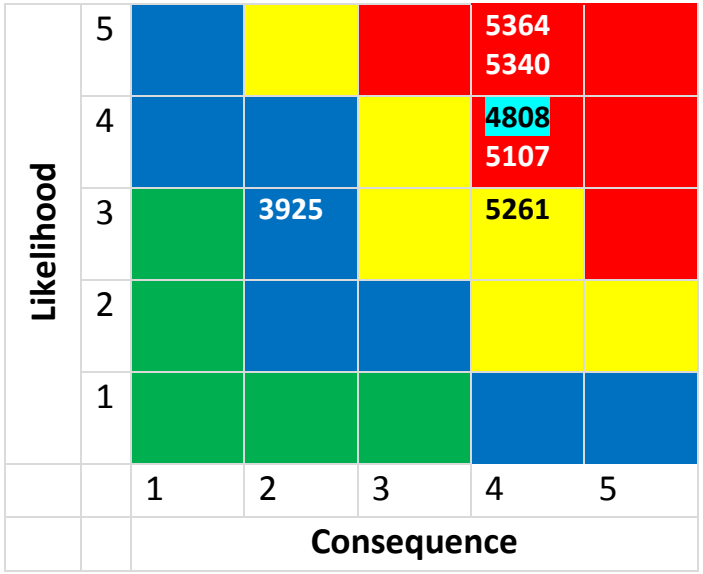
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: Director of Organisation and People **Reporting Committee:** Executive Workforce Committee

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Resourcing and Talent Management -** Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	DoODP	March 2019 (phase 1)	
2. **Business Partnering** - Establish effective partnerships to align business and HR strategies	DoODP	March 2019 (phase 1)	
3. **Health and Wellbeing** - Improve the health and wellbeing of staff	DoODP	March 2019 (phase 1)	
4. **OD and Engagement** - Develop a diverse and inclusive culture where staff feel engaged	DoODP	March 2019 (phase 1)	
5. **Leadership -** Develop strong leadership capability across all levels of the organisation to support an innovation culture	DoODP	March 2019 (phase 1)	

Corporate Risk Register Principal Risks



3925 - Failure of staff to maintain updated statutory /Mandatory Training

4808 – Vascular surgery cover

5107 – High level of vacant clinical posts incurs costs due to increasing use of agency staff

5261 – Rechecking system inadequate to maintain current DBS recheck requirement

5364 - Failure to achieve required ward nursing establishment with the following implications: Quality and safety concerns at ward level

5340 – ESR Portal Access

Key Controls	Assurance on Controls
• ~~Executive~~ Workforce Committee (EWC) • Health and Wellbeing Board • ~~People Strategy Programme Group (not yet established)~~ • HR Policies • Directorate Performance meetings • Trust values and behaviours • Workforce Pay Control group • Safer Staffing Group • Equality, Diversity and Inclusion Steering Group (under review) • Health and Safety Committee • Integrated Performance Report at Board • Monthly Workforce Dashboard • Executive Safety Walks • Freedom to Speak Up Guardians • JCC Staff Side Meeting	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
1. Deliver a cohesive plan to attract, deploy, retain and reward a flexible workforce	• Staff turnover remains steady (reported through EWC) • Growing medical locum bank (Locums Nest engaged ~~trial~~) • Engaged with regional streamlining work stream • Engaged with STP Agency cap and control work stream • Chair of the STP Social Partnership Forum • Proactive engagement with the	• Impact of Brexit not yet clear	Continue to review as new information becomes available	Ongoing
		• Impact and delay of IELTS / OSCE for international recruits	Explore alternative IETLTs rules with NMC	July 2018
		• Recruitment data not easily reportable	TRAC system due to go live July 18 - PH	July 18
		• No retention strategy and associated resource	Implement Engagement Plan	July 18
		• Potential for shortage areas to be removed from Shortage Occupation list (e.g. Nursing)	Continue external conversations and ensure awareness of proposed changes	Ongoing

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
	Local Workforce Action Board • Staff side balloting on government proposals on Agenda for Change	Process not in place to gather recruitment experience	• Implement recruitment strategy – PH • Procurement of TRAC recruitment system — PH	Q3 18/19 Q3 18/19
		Implementation of new approaches to retention	Pilot innovative approaches to retention e.g. transfer windows	July 18
		Feedback gaps (candidate/ starter/ leaver)	Exit interviews –- PH	Commenced March 18
		Inability to triangulate hard and soft metrics on wellbeing of staff /depts	Triangulating hard and soft workforce metrics - PH	Q2 18/19
		E-Roster not rolled out to wider workforce	Integration and roll out of eRoster –PH	Q4 18/19
		Resourcing strategy does not align temporary and substantive staffing needs	Transfer of Bank function into OD & People Directorate – PH	Q3 18/19
		~~Have not got a fully developed Retention strategy~~	~~Retention Strategy –PH~~	~~Q1 18/19~~
		Programme of staff benefits not fully developed	Programme of staff benefits – PH	Q2 18/19
2. Establish effective partnerships to align business and HR strategies	• New Workforce KPI Dashboard • New structure for HR implemented 3 April with vacancies going out and some interim cover	• Lack of management training and toolkits on key people management topics	Rolling programme commencing Q1 - PH	Q1 18/19
		• Inaccurate data captured within ESR	Data cleanse and review of ESR feeder systems –PH	March 19
		• Maximising ESR system capabilities	Optimise use of ESR to enable accurate reporting and feeder systems to function	March 19
		• Current inability to triangulate hard and soft data across depts	Triangulating hard and soft workforce metrics - PH	Q2 18/19

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
		• Immature Business partner model for service delivery	• ~~OD & People restructure – PH~~ • Appoint to vacant senior posts –- PH	~~Q2 18/19~~ Completed Q3 18/19
3. Improve the health and wellbeing of staff	• Staff sickness benchmarks well against local Trusts at approx. ~~3.8%~~ 3.6% as an average. • Shape up at Salisbury offering for staff well supported. • Onsite Occupational Health and staff counselling services • Over ~~60%~~ 70% of front line staff vaccinated against influenza	• Staff sickness remains above 3% target • Sickness absence management inconsistent • Sickness absence reporting processes and data not robust • Current inability to triangulate hard and soft data across depts.	• Redesign electronic sickness reporting process – PH • New sickness absence policy –- PH • Managers' tool kit - PH • Health & Well Being Strategy –- PH • Trust wide E-Roster roll out to provide real time sickness data	Q4 18/19 Q1 18/19 Q2 18/19 Q1 18/19 Q4 18/19
4. Develop a diverse and inclusive culture where staff feel engaged	• Staff survey results in upper quartile nationally • Staff Friends and Family Test results are positive • WRES Trust action plan in place • Publication of Trust's Gender Pay Report	• Mandatory Training compliance ~~remains below~~ above target of 85% • Appraisal rates for non-medical staff remain below target of 85% • Funding gap for education and training	L&D full service review –PH	Q2 18/19
5. Develop strong leadership capability across all levels of the organisation to support an innovation culture	• Leadership programmes in place • Strong relationships with local providers • Values embedded • Equality and Diversity System 2 (EDS2) in place	• Lack of robust talent management and leadership development programme across the Trust. • Leadership programme not aligned to culture (in development) •	OD and engagement plan ~~in development~~ implementation	~~Q2 18/19~~ July 18
		• Lack of comprehensive engagement and communication strategy in place.	Service redesign and delivery following L&D full service review –– PH	Q3 18/19

Strategic Priority:

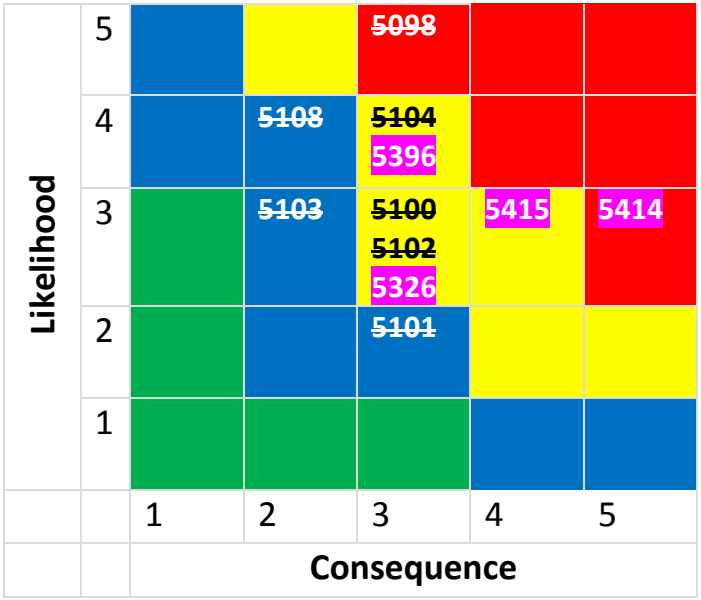
> **Resources –** We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

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

Plan to do:

Objective	Exec Lead	Due Date	Progress
1. **Financial Recovery Plan -** Deliver on financial recovery plan to secure financial sustainability	DoF	March 2019	
2. **Campus Scheme** - Develop a financially viable scheme to rejuvenate and improve the utilisation of the estate	DoCD	April 2021	
3. **Digital Strategy -** Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	DoCD	April 2021	
4. **Service Reviews -** Undertake reviews of core services to ensure ongoing plans for sustainability and delivery of key objectives	MD	March 2018	

Corporate Risk Register Principal Risks



~~**5098** – As result of not delivering the Trust's savings programme for 2017/18 the Trust is in financial deficit and therefore experiences cash flow shortfalls~~
~~**5108** – Commissioners able to successfully implement material referral management QIPP schemes which will leave the Trust with significant stranded costs~~
~~**5101** – Unable to borrow funds to keep supporting the operating expenditure of the Trust meaning the Trust may run out of cash~~
~~**5102** – risk Trust cannot fund full capital programme requirement~~
~~**5103** – Escalation of contract penalties~~
~~**5104** – Potential monies at risk through non delivery of some of the CQUIN targets in 17/18~~
~~**5100** – Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system.~~
5393 - Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system
5326 - Review, PACS, POET, Lorenzo, WinDip & Paper Records
5396 – Delivery of CQUIN
5414 – Achievement for 2018/19 financial plan
5415 – Funding of all capital expenditure
Risk to be added – risk of further enforcement action if not making sufficient progress on financial recovery plan (red risk)

Key Controls	Assurance on Controls
• Finance and Performance Committee • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • OETB • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • Strategy Committee	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement

Key Headlines – Objectives

Objective	Positive Assurance	Gaps in Control / Assurance	Action	Due
1. Deliver on financial recovery plan to secure financial sustainability	• Outstanding Every time Board established with CEO chairing monthly • Plan developed with savings opportunities identified as part of the financial plan 2018/19 • Transformation Director appointed (commenced April 18)	• Engagement with STP and Commissioners on SFT recovery plan	Continue to actively participate in STP recovery plan actions – LT/CB/LA/CCB	Ongoing
		• Capability and capacity across the organisation to deliver change at pace	• Transformation Director to identify gaps - SW • ~~Trust considering QI training – LT~~	Q1 ~~April 18~~ CLOSED
		• Recruitment challenges across the organisation limit delivery of the plan	Implement recruitment strategy – PH	Q3 18/19
		• Two-year financial recovery and sustainability plan yet to be finalised	Submit 2 year financial recovery and sustainability plan – LT	June 18
		• Action plan to be completed in response to NHSI Enforcement Letter	~~Finalise~~ Deliver enforcement action plan – LT	~~March 18~~ June 18
2. Develop a financially viable	• Additional management capacity with experience in delivering similar projects	• Link into wider Trust strategic estate plans needs strengthening	Produce strategic estates plan – LA	Sept 18

scheme to rejuvenate and improve the utilisation of the estate	secured • National schemes are coming on line which offer potential frameworks for development • Support from Wiltshire Council and commissioners for proposed scheme • Advanced discussions with potential private sector partner for Joint Venture agreement • Positive early clinical engagement • Communication/PR expertise appointed • Strategy Committee commenced in March 2018 • Signed agreement for private sector partner	• Reliance on private sector investment, agendas/timescales may not align	A milestone level project plan with external partners to be agreed and monitored – LA	May 2018 Complete
		• Requirement for communications and engagement plan	Work plan for external consultants ~~new post holder~~ to be agreed – LA	May 18
		• Absence of detail to progress financial modelling	~~Agreement to be signed – LA~~ Development of overarching business case - LA	~~mid April 18~~ Sept 18
3. Develop and implement a digital strategy which will enable the delivery of more effective care through the use of technology	• Early draft of document developed to begin consultation • Foundation of an integrated patient record system exists which can be linked to other systems • Strong engagement from some clinical quarters, eg nursing • External support commissioned to support development of digital strategy	• Delay in subsequent phases of EPR, delivery against business case • System supplier engagement	Escalation of issues at director level with supplier – LA	ongoing
		• Because of usability issues, risk around engagement • Lack of capital funds to invest (potential national funds will be allocated by the STP)	Develop business case for Electronic Prescribing – CB/LA	June 18
		• Need to redefine the role of ISSG in taking forward the digital strategy	Redefine role following agreement of digital strategy– LA	~~April~~ July 18
		• Difficulties from information held in both paper and digital form	• Develop Digital Strategy – LA • ~~Future~~ further development of EPR in line with digital strategy, on a module-by-module basis commencing with electronic prescribing – LA	~~Sept~~ July 18 ~~June 18~~ Post July 18
4. Undertake reviews of core services to	• Outstanding Every time Board established with CEO chairing monthly to	• Timeliness of publication of relevant benchmarking information to support		

ensure ongoing plans for sustainability and delivery of key objectives	oversee programme. • Additional capacity procured to support the development and delivery of the recovery programme (core services one element) • Use of Model hospital and GIRFT to support pathway change in place.	decision making. • Capacity to undertake reviews then implement change at pace. • Structured framework to evaluate core clinical services for sustainability		

Corporate Risk Register Summary – June 2018

Risk Score Key

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

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	Nov 17	Jan 18	April 18	Jun 18 current	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									
5305	Consitutional performance standards may not be met as result of increased demand or decreased capacity	Chief Operating Officer	Nov 2017	15		9	9	12	6
5306	~~Reduction in beds during site reconfiguration work~~ - CLOSED	Chief Operating Officer	May 2017	15	15	8	8		8
5397	inability to recruit enough nurse a decision has been taken not to open the additional medical beds – NEW	Chief Operating Officer	Apr 2018	20				20	9
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population									
3322	Genetics National Reconfiguration	Medical Director	Aug 2013	12	12	8	8	6	6
5100	~~Inability to provide robust activity & income performance reports~~ - CLOSED	Director of Finance	Apr 2017	15	15	9	9		6
4808	Vascular surgery provision – NEW	Chief Operating Officer	Sept 16	16				16	3
Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered									
5104	~~Potential monies at risk through non delivery of some of the CQUIN targets in 17/18~~ - CLOSED	Director of Finance	Apr 2017	16	16	12	6		8
Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm									
5384	Inpatient fall resulting in harm; increasing frail population	Director	Apr	12			12	12	8

Risk (Datix) Ref	Risk Title	Exec Lead	Date Risk added	Initial score	Nov 17	Jan 18	April 18	Jun 18 current	Target
		of Nursing	2018						
5078	~~Mortality (HSMR) ratio~~ - CLOSED	Medical Director	Aug 2017	9	9	6	4		3
4107	Failure to adhere to clinician requested timeframes for follow-up appointments for skin cancer patients	Chief Operating Officer	Sept 2015	12		9	9	9	6
~~5421~~	~~There is a risk that the Trust cannot fund all capital expenditure requirements to support the delivery of high quality care due to the deficit position and the limitations of cash availability~~ ~~- NEW~~	~~Chief Operating Officer~~	~~May 2018~~	~~12~~				~~12~~	~~6~~
5291	Potential for bleep failure	Chief Operating Officer	Nov 2017	20		12	12	12	4
5379	Risk to perioperative safety due to increased number of never events reported in 17/18	Medical Director	Mar 2018	12			12	12	6
4808	Vascular surgery cover - NEW	Chief Operating Officer	Sept 16	16				16	3
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams									
3925	Failure of staff to maintain updated statutory /Mandatory Training	Director of OD & People	May 2015	12	12	6	6	6	6
5107	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care.	Director of OD & People	Apr 2017	12		16	16	16	12

Risk (Datix) Ref	Risk Title	Exec Lead	Date risk added	Initial score	Nov 17	Jan 18	April 18	Jun 18 Current	Target
5261	Rechecking system inadequate to maintain current DBS recheck requirement	Director of OD & People	Sept 2017	15		12	12	12	9
5340	ESR portal access	Director of OD & People	Jan 2018	20		20	20	20	1
5364	Failure to achieve ward nursing establishment	Director of Nursing	Mar 2018	16			20	20	12
5379	Risk to perioperative safety due to increased number of never events reported in 17/18	Medical Director	Mar 2018	12			12	12	6
4808	Vascular surgery cover - NEW	Chief Operating Officer	Sept 16	16				16	3
Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources									
5100	~~Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system~~ - CLOSED	Director of Corporate Development	Apr 2017	15	15	9	9		6
5102	~~Risk to capital programme funding~~ - CLOSED	Director of Finance	Apr 2017	9		9	9		6
5104	~~Potential monies at risk through non delivery of some of the CQUIN targets in 17/18~~ - CLOSED	Director of Finance	Apr 2017	16	16	12	6		8
5098	~~As result of not delivering the Trust's savings programme for 2017/18 the Trust is in financial deficit and therefore experiences cash flow shortfalls -~~ CLOSED	Director of Finance	Apr 2017	12	12	15	10		9
5108	~~Commissioners able to successfully implement material referral management QIPP schemes which will leave the Trust with significant stranded costs -~~ CLOSED	Director of Finance	Apr 2017	8	8	8	8		8
5101	~~Unable to borrow funds to keep supporting the operating expenditure of the Trust meaning the Trust may run out of~~	Director of	Apr 2017	10	10	6	6		4

Risk (Datix) Ref	Risk Title	Exec Lead	Date risk added	Initial score	Nov 17	Jan 18	April 18	Jun 18 Current	Target
	~~cash~~ - CLOSED	Finance							
~~5393~~	~~Inability to provide robust activity & income performance reports due to problems with data warehouse and EPR system~~	~~Director of Finance~~	~~Mar 2017~~	~~15~~				~~9~~	~~6~~
5326	Review, PACS, POET, Lorenzo, WinDip & Paper Records - NEW	Director of Corporate Dev	Dec 17	6				9	4
5396	Potential non delivery of CQUIN schemes – NEW	Director of Finance	Apr 18	16				12	6
5415	Risk the Trust cannot fund all capital expenditure requirements to support the delivery of high quality care due to the deficit position and the limitations of cash availability – NEW	Director of Finance	May 18	12				12	6
5414	Trust does not achieve its financial plan in 2018/19 - NEW	Director of Finance	May 18	15				15	10
5421	There is a risk that the Trust cannot fund all capital expenditure requirements to support the delivery of high quality care due to the deficit position and the limitations of cash availability - NEW	Chief Operating Officer	May 2018	12				12	6
5436	Funding for quality improvement (QI) methodology - NEW	Medical Director	May 2018	12				12	9

Corporate Risk Register
May 2018

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
3925	Human Resources	Trustwide	26/05/2015	Trustwide risk assessment	12	Failure of staff to maintain updated Statutory/Mandatory Training There is a high rate of completion of statutory and mandatory training by staff on entry to the Trust. However there is a failure amongst some staff to update with regards to these modules. There is a risk that staff may be practising without having completed updates - this is identified as a low risk from a patient safety perspective as staff will have knowledge from initial completion, however it has implications for regulation activity and organisational reputation.	May recur occasionally	Minor	6	Raise staff awareness of their individual and professional responsibilities in relation to training.	31/03/2017	05/04/2017	KINGSC	Executive Workforce Committee	30/03/2018	6	People	Joint Board of Directors, Trust Board (Corporate Risk Register), Workforce Committee	Director of Organisational Development and People
										Monitor staff training records with individuals through appraisal.	31/03/2017	05/04/2017	KINGSC						
										Appropriate sanctions to be managed with staff where evidence of non completion i.e. failure of pay progression	31/03/2017	05/04/2017	KINGSC						
										Monitoring of training records through Directorate Performance Meetings	31/03/2017	05/04/2017	KINGSC						
										Provide an exception report of all staff who are over 6 and 12 months non compliant with any statutory mandatory training and ensure line manager schedules completion within following 3 months.	28/02/2018	25/01/2018	Salisbury, Hilary						
3322	Clinical Support and Family Services	Genetics	29/08/2013	Organisational risk assessment	12	National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury.	Do not expect it to happen again but it is possible	Major	8	A genomics strategy group, co-chaired by Christine Blanshard (MD), has been established that involves University Hospitals Southampton and the University of Southampton. A pilot project is planned for 2015 and will formulate a regional strategy once details of the proposed reorganisation are known. This was not released until Nov 2016 These meetings have restarted with additional parties due to the updated project named ''re-procurement'' Genomic tender meetings occurring regularly between UHS and SFT including Trust representative. Partnership negotiations begun for a wider partnership bid.	01/04/2018	25/01/2018	Blanshard, Dr Christine	Trust Board	04/06/2018	6	Specialist Services	Clinical Governance Committee, Finance Committee, Trust Board (Corporate Risk Register)	Medical Director
										Tender document issued. Alliance formed with UHB, BWCH, OUH and UHS to respond to the tender. BWCH proposed to become the central laboratory hub and WRGL will become a local genomics laboratory.	31/05/2018		Blanshard, Dr Christine						

Corporate Risk Register
May 2018

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
4107	Musculo-Skeletal	Plastic Outpatients	17/09/2015	Service Delivery Plan, Specialty Risk assessment	12	Failure to adhere to clinician requested timeframes for follow-up appointments for cancer patients. Risk of clinical deterioration in between follow-ups which could lead to untreatable disease progression. Appointments requested for patients are not always being given in a timely manner, particularly a risk for oncology patients (follow up clinic) Failure to follow national guidelines for the management of patients with skin cancer - particularly melanoma patients not being seen at regular 3 month intervals. Significant risk of patient mis-management with long term effects - disease progression making treatment options limited. Risk of duty of candour	May recur occasionally	Moderate	9	Further recruitment of 2 plastics consultants	18/12/2015	11/10/2016	Wright, Jonathan	Directorate Management Team Meeting	31/05/2018	6	Care	Clinical Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Chief Operating Officer
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	17/01/2017	25/01/2018	Insull, Victoria						
										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	17/01/2018	17/01/2018	Insull, Victoria						
										monitor and review capacity and time to follow up	31/05/2018		Vandyken, Ali						
										Reviewing the cause of all patients lost to follow up. Cross refereeing Lorenzo, with Somerset Cancer registry. And reviewing admin process for follow-ups.	30/04/2018	08/05/2018	Hyett, Andy						
										Reviewing the cause of all patients who have been lost to follow up and reviewing admin processes.	31/05/2018		Hyett, Andy						
5326	Corporate Development	Electronic Patient Record Team	20/12/2017	Electronic Patient Record	6	Review, PACS, POET, Lorenzo, WinDip & Paper Records - information in these systems are required to fully assess patients - access is required to all the above systems and there is a risk that information may be missed due to overhead of access and or clarity on what information is where - leading to inefficiency delays and potential patient harm	May recur occasionally	Moderate	9	Training review being commissioned to provide holistic training for clinical staff	01/11/2018		Lees, Susan	Electronic Patient Record	31/07/2018	4	Resources	Trust Board (Corporate Risk Register)	Director of Corporate Development
										Describe within digital strategy how information from a range of sources will be used	13/07/2018		Cowling, Andrew						
										Set up governance structure for development of digital strategy	31/05/2018		Arnold, Laurence						
										Secure support from clinicians to be CCIO and Clinical safety officer	31/05/2018		Blanshard, Dr Christine						
										Upgrade to WinDip	31/01/2019		Ford, Nicola						
5261	Human Resources	Trustwide	15/09/2017	Human Resources	15	Identified that a number of DBS checks have not been recorded in ESR consistently. In addition existing staff are not in a 3 year check programme, as required. The existing policy is not compliant and requires updating with additional clear guidance on posts that require a standard or enhanced DBS check	May recur occasionally	Major	12	Policy review	30/04/2018	09/05/2018	Holt, Sharon	Executive Workforce Committee	04/05/2018	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development
										Consistent recording of electronic ESR.	31/07/2018	09/05/2018	Holt, Sharon						
										Identify posts that require checking.	30/04/2018	30/04/2018	Holt, Sharon						
5291	Facilities	Trustwide	24/10/2017	Incident reports	20	There have been incidents whereby emergency bleeps have failed and bleeps have not been received. Currently a bleep can be recorded as being sent, but there is not way of tracing whether it was received, therefore the bleep could fail due to a number of issues - signal black spot, low battery or failure of unit, for example. In an emergency situation such as an emergency caesarean this could have severe consequences. Bleep system expected to be replaced Dec 17/Jan 18. 20th November - anaesthetic registrar now carrying a baton internet mobile phone. This allows for greater coverage of signal in areas affected by poor bleep signal coverage.	May recur occasionally	Major	12	Install and commission PageOne bleep system by end of January 2018. 8/5/18 - Working with company to deliver by end of May 2018.	31/05/2018		Robinson, Ian	Operational Management Board	01/05/2018	4	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
5305	Operations Directorate	Trustwide	08/11/2017	Trustwide risk assessment	12	As a result of Increased demand or decreased capacity there is a risk that constitutional performance standards may not be met, which may result in a decrease in quality of patient care, longer waiting times, fines, damage to Trusts reputation and action from regulators.	May recur occasionally	Major	12	Assurance to Finance and Performance Committee and Trust Board	31/07/2018		Hyett, Andy	Weekly Delivery Group	29/06/2018	6	Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Capacity and demand modelling for all areas.	29/06/2018		Hyett, Andy						
										Weekly Delivery Group monitoring performance and agreeing actions	31/10/2018		Hyett, Andy						
										Whole system actions to reduce delays transfers of care. Being review.	29/06/2018		Hyett, Andy						

Corporate Risk Register
May 2018

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
5415	Finance and Procurement	Trustwide	01/05/2018	Trustwide risk assessment	12	There is a risk that the Trust cannot fund all capital expenditure requirements to support the delivery of high quality care due to the deficit position and the limitations of cash availability. This could lead to a negative impact on the delivery/quality of care, the ability to achieve performance and access targets and the ability to transform and innovate to become more efficient.	May recur occasionally	Major	12	Trust identifying opportunities for additional capital funding as per STP (8th June).	29/06/2018		Thomas, Lisa	Finance Committee	04/06/2018	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Business being developed for Cath lab funding as a material risk in year- 8th June.	29/06/2018		Thomas, Lisa						
5421	Musculo-Skeletal	Musculo-Skeletal Directorate Management Offices	08/05/2018	Incident reports	12	Failure to adhere to clinician requested time frames for surgical appointments for skin cancer patients. Risk of clinical deterioration while on waiting list which could lead to untreatable disease progression. Due to capacity, appointments requested are not given in a timely manner.	May recur occasionally	Major	12	Monitor & review surgical capacity and time from booking to surgical procedure.	02/08/2018		Wright, Jonathan	Directorate Performance meeting	02/08/2018	6	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Review of the pathway for surgical plastic patients requiring excision of ?cancer lesions.	02/08/2018		Wright, Jonathan						
										Undertake a Review of known patients who have experienced delay.	02/08/2018		Wright, Jonathan						
5436	Quality Directorate	Trustwide	25/05/2018	Other assurance not listed	12	Agreed a paper to embed Quality Improvement methodology across the Trust but not identified funding for this. There is a risk will not have embedded methodology & QI work won't undertaken.	Will probably recur, but is not	Moderate	12	Quality Directorate and PMO is supporting some limited Quality Improvement work.	31/08/2018		Gorzanski, Claire	Clinical Governance Committee	31/08/2018	9	Innovation	Trust Board (Corporate Risk Register)	Medical Director
										Review ongoing as to what support for QI the PMO can provide in the medium term.	02/07/2018		Thomas, Lisa						
5379	Surgery	Main Theatres	26/03/2018	Incident reports	12	Risk to perioperative safety due to increased number of never events reported in 17/18, process and control issues identified by Internal Audit, staff vacancies and sickness impacting on morale	May recur occasionally	Major	12	Human factors training running through 2017/18.	05/04/2018	05/04/2018	Wilkinson, Lorna	Directorate Management Team Meeting	31/05/2018	6	Care, People	Trust Board (Corporate Risk Register)	Medical Director
										Intensive support led by Directorate Management Team with Executive Directors oversight initiated April 2018.	31/10/2018		Drayton, Louise						
5384	Quality Directorate	Trustwide	29/03/2018	Incident reports	12	Risk of patients within hospital experiencing a fall resulting in injury. This is an issue recognised nationally due to the increasing frail population.	May recur occasionally	Major	12	Create version 2 of nursing post falls assessment sticker for cascade out across the Trust.	31/07/2018		Collier, Karen	Falls Group	31/07/2018	8	Care	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Implementation of nursing assessment documentation which incorporates a multifunctional assessment and intervention form.	30/04/2018	02/05/2018	Collier, Karen						
										Compliance audits of falls care plans and interventions.	30/04/2018		Collier, Karen						
										DSN's and Associates to be in attendance at the SWARMs	30/04/2018		Harvey, Ian						
										DSN's and Associates to be in attendance at the SWARMs	29/03/2018	29/03/2018	Wilding, Henry						
										DSN's and Associates to be in attendance at the SWARMs	29/03/2018		Dunn, Bernie						
										DSN's and Associates to be in attendance at the SWARMs	30/04/2018		Montgomery, Alison						
										Refreshed Share and Learn sessions	30/04/2018	02/05/2018	Major, Denise						
										Reduce the level of work related stress and MSK work related problems in groups of staff who have the highest rates. Target high risk groups for action through work led by DD of HR and staff & health wellbeing group. Actively promote the staff health and wellbeing programme.	31/10/2018		Hargreaves, Paul						

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5396	Quality Directorate	Trustwide	04/04/2018	Commissioning for Quality & Innovation (CQUIN)	16	Potential non delivery of CQUIN schemes that are high risk: 1a - improvement of health and wellbeing of NHS staff - 5% improvement in 2 out of 3 questions in the staff survey required. Responses to all 3 questions decreased between 2016 & 2017 survey. ?£166K at risk. 1C - Improving uptake of flu vaccine for front line staff - no opt out for West Hampshire CQUIN. £23k at risk. 2A & 2B - Sepsis - achievement of 90% of inpatients with severe sepsis screened and IV antibiotics given within 1 hour of diagnosis may not be achieved. £70K at risk 2D - Antibiotic consumption reduction in 2 of the 3 antibiotic groups on 2017 baseline may not be achieved. £125K at risk. 4 - Reducing mental health frequent flyers in A&E - sustaining the reduction in attendances of the selected cohort and 10% reduction in A&E attendances of people with a primary mental health diagnosis. £450K at risk. 7 - Reducing risky behaviours - achieving 90% screening of all inpatients for smoking and alcohol. £150K at risk. Possible monies at risk £984K	Will probably recur, but is not a persistent issue	Moderate	12	Increase the uptake of the flu vaccine of front line staff by running a comprehensive flu campaign based on learning in 17/18.	31/12/2018		Major, Denise	Finance Committee	31/07/2018	6	Innovation, Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Improve the screening and treatment of inpatients for severe sepsis by continuation of the current ward based CCOT education programme, regular feedback on timeliness of screening and IV antibiotics audit. Monitor progress through the Sepsis working group.	31/07/2018		Finneran, Dr Nicola						
										Reduce the consumption of all antibiotics, carbapenem and piperacillin/tazobactum through AMR stewardship ward rounds, education and feedback to individual clinicians and teams on practice. Take part in antibiotic awareness week. Agree protocol changes at the Infection Prevention and Control Group.	31/10/2018		Williams, Lou						
										Identify the top 10% of patients who attend ED with primary mental health needs and ensure each has a personalised care plan to reduce attendances. Continue to ensure all patients in the identified cohort of ED frequent attenders have a personalised care plan agreed with them. For relevant patients agree a multi-agency plan with police, ambulance service, AWP, primary care. Monitor attendance of the cohort and target ongoing frequent attenders.	31/10/2018		Davies, Dr Stephen						
										Screen 90% of inpatients for alcohol and smoking by the ward pharmacy teams. Review screening data weekly until 90% is sustained.	31/07/2018		Smale, Maria						
5414	Finance and Procurement	Trustwide	01/05/2018	Trustwide risk assessment	15	There is a risk that the Trust does not achieve its financial plan in 2018/19. Due to the inability to deliver the CIP programme and planned activity levels alongside cost pressures. Could result in further regulatory action, the Trust entering special measures. The Trust needing to borrow additional cash and the impact on the reputation of the Trust.	May recur occasionally	Catastrophic	15	Trust currently developing plan to achieve revised control total, with additional savings/cost reduction schemes scheduled for Board approval 7th June.	29/06/2018		Thomas, Lisa	Finance Committee	04/06/2018	10	Resources	Trust Board (Corporate Risk Register)	Director of Finance
										Trust following arbitration with Dorset, agreeing terms of data quality audit by 6th June.	29/06/2018		Thomas, Lisa						
						Vascular surgeon cover is provided from RBH at SDH onsite 3 days per week. Currently due to staffing issues RBH are unable to provide 3 days cover and clinics are being	not a			Meeting with RBH and SDH representatives to resolve issues regarding cross site IT access and on site IR provision	18/02/2018		Drayton, Louise	m Meeting			e, Care	Register)	er

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
4808	Surgery	Vascular Assessment Unit and Diabetes Unit	26/09/2016	Departmental risk assessment	16	cancelled. Cover has been reduced to 1 day on most weeks, with some weeks there being none. As a result patients are being delayed in attending outpatients. Urgent patients may need to travel to RBH for treatment rather than SDH. Angio procedures are unable to be undertaken at SDH without onsite vascular cover which has resulted in cancellations. There is a lack of MDT meetings which has slowed progressing patients on their pathways and delays results and treatments to patients. The vascular department do not have access to advice and support when managing nurse led clinics or patient queries.	Will probably recur, but is not a persistent issue	Major	16	Escalate IR provision issues through Exec performance review process.	31/01/2018		Drayton, Louise	Directorate Management Tea	07/05/2018	3	Specialist Services, People	Trust Board (Corporate Risk	Chief Operating Offic
5107	Human Resources	Trustwide	27/03/2017	Trustwide risk assessment	12	Failure to recruit to vacant posts will result in an inability to provide outstanding patient care. The impact of this effects staff morale and is unsustainable for the existing workforce if not addressed. Patient safety is at risk with gaps in substantive clinical workforce and cost of workforce increases over budgets. NHSI control total will be at risk. of the organisation to deliver excellence to all patients and places additional responsibility on existing staff to manage services. Identified specialities are not recruited to establishment and therefore there is a reliance on a temporary workforce such as bank and agency. This has an impact on reputation, quality and financial aspects of the organisation. Posts identified include specialist Medical Posts (i.e. Dermatology, Community Geriatricians, Gastroenterology, Opthalmology) where this is a national recruitment problem and nursing post (particualrly medicine) where this is a supply problem	Will probably recur, but is not a persistent issue	Major	16	Procurement agency staff at tier 1 rates only.	30/03/2018	23/01/2018	Wilkinson, Lorna	Finance Committee	29/06/2018	12	People	Finance Committee, Trust Board (Corporate Risk Register)	Director of Organisational Development and People
										Review and consider threshold of care whilst maintaining safe patient services.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Tight control of agency and specialing.	30/03/2018	23/01/2018	Wilkinson, Lorna						
										Recruitment and retention initiatives eg introduction of automated exit questionnaires, career clinics for nurses and transfer process.	30/03/2018	29/05/2018	Hargreaves, Paul						
										Seek to pay capped rates only. Review rosters to reduce reliance on agency staff	31/05/2018		Blanshard, Dr Christine						
										Look to partnerships with other Trusts to cover hard to fill posts.	29/06/2018		Hargreaves, Paul						
										Review of loss making clinical activities predominately supported by locums as part of business planning.	30/03/2018	23/04/2018	Blanshard, Dr Christine						
										Launch overseas recruitment and more focussed recruitment in the UK.	30/03/2018	02/05/2018	Wilkinson, Lorna						
										Review & update (if appropriate) financial section of business case template for the appointment of medical staff.	30/03/2018	23/04/2018	Blanshard, Dr Christine						
										Transitioning work with Army - making links with the groups moving back onto the plain - promoting careers at Salisbury with Army spouses	31/12/2017	25/01/2018	Holt, Sharon						
										Focus on retention of current staff - Developing of 'fresh eyes' approach for new staff - Reviewing Exit Interview to increase update and learning	29/09/2017	25/01/2018	Salisbury, Hilary						
										Use of head hunting agencies to secure medical locums	31/03/2017	05/04/2017	Hargreaves, Paul						
										Monitoring agency usage via 'Reducing Agency Spend' group.	31/03/2017	05/04/2017	Wilkinson, Lorna						
										Monitoring of vacancies	31/03/2017	05/04/2017	Hargreaves, Paul						
										'Branding' of Salisbury to promote reputation.	31/03/2017	05/04/2017	Hargreaves, Paul						
										Use of other medias including social media (Facebook and Twitter) to promote Trust	31/03/2017	05/04/2017	Hargreaves, Paul						
										Liaison with University to assess and promote student experience to ensure students consider SFT a positive place to work.	31/03/2017	05/04/2017	Hargreaves, Paul						

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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
5340	Human Resources	Trustwide	25/01/2018	Trustwide risk assessment	20	ESR access is moving to a web portal which requires updating of browsers. Patient and finance systems will not work with the updated version of the browsers.	Will undoubtedly recur, possibly frequently	Major	20	Browser to be compatible with ESR upgrade. 8/5/18 - The ESR Portal is currently live across the Trust, using an older version of Java that works for both ESR and Finance. In June/July this year ESR is due to be migrated to a new version of Java that is not currently supported by the finance application. The vendor for the finance application has an upgrade ready which should address this issue but it has not yet been scheduled and we are waiting for finance to provide the proposed date.	31/07/2018		Dunham, Linda	Executive Workforce Committee	29/06/2018	1	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People
5364	Quality Directorate	Trustwide	01/03/2018	Trustwide risk assessment	16	Failure to achieve required ward nursing establishment with the following implications: Quality and safety concerns at ward level Poor patient experience High agency expenditure (financial risk to the Trust)	Will undoubtedly recur, possibly frequently	Major	20	Domestic recruitment campaigns	30/04/2019		Wilkinson, Lorna	Trust Board	29/06/2018	12	People	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Overseas recruitment campaigns.	30/04/2019		Wilkinson, Lorna						
										Skill mix review x 2 per year	30/04/2019		Wilkinson, Lorna						
										Retention workstream to be completed	30/04/2019		Wilkinson, Lorna						
										Participate in NHSI collaborative for enhanced care.	31/12/2018		Wilkinson, Lorna						
										Development of microsite	31/10/2018		Wilkinson, Lorna						
										Develop apprenticeships and Nursing associate opportunities to broaden access into nursing	30/04/2019		Wilkinson, Lorna						
										Continue full recruitment of Nursing Assistant staff	30/04/2019		Wilkinson, Lorna						
										Continue to ensure governance processes as listed within controls are embedded and influencing clinical practice, cleaning and antibiotic stewardship.	01/04/2019	02/05/2018	Wilkinson, Lorna						

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5397	Operations Directorate	Trustwide	05/04/2018	Other assurance not listed	20	Due to an inability to recruit enough nurse a decision has been taken not to open the additional medical beds in line with bed modelling signed off by board. This presents a risk to performance, quality and finances.	Will undoubtedly recur, possibly frequently	Major	20	Daily KPI metrics being developed.	08/04/2018	10/05/2018	Hyett, Andy	Trust Board	01/05/2018	9	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Patient flow and medicine length of stay actions being brought together into one action plan	15/04/2018	10/05/2018	Hyett, Andy						
										Board to be briefed next week on possible mitigations and impact on income and contract delivery being built into financial modelling.	30/04/2018	01/05/2018	Thomas, Lisa						
										Ward level dashboards being developed	31/08/2018		Arnold, Laurence						