Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – SEPTEMBER 2011

Agenda Item Number: 147/11
Enclosure Number: (5)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Sheena King – Head of Risk Management Peter Mellor – Company Secretary Peter Mellor – Company Secretary
Purpose of paper *Why is this paper going to the Trust Board?*	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Trust Board are asked to note • New risks 1.4, 2.1 • Decrease of risks 1.2, 5.3, 5.4, 5.6 • Increase of risks 6.2 and 6.3
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented to Trust Board in October 11.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: September 2011

Purpose:

To provide the Trust Board with an update on the Assurance Framework

Top Risks

6.2 ▲ **(20):** The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration

1.3 ◄► **(16):** Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, identified at or more than 72 hours of admission.

6.3 ▲ **(16):** 2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position

6.5 ◄► **(16):** Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan

2.1 **(15):** Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant inability to support other specialties, detriment to patient experience and increase in required CIP

New Risks

1.4 **(9):** Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN

2.1 **(15):** Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant inability to support other specialties, detriment to patient experience and increase in required CIP.

Risks with an Increased Score

6.2 ▲ **(Red 16 to Red 20):** The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration– potential breach in Q2

6.3 ▲ **(Amber 12 to Red 16):** 2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position – increased shortfall

Risks with a Decreased Score

1.2 ▼ **(Amber 8 to Yellow 6):** Inability to maintain ongoing compliance with all CQC standards – robust control measures in place

5.3 ▼ **(Amber 9 to Yellow 6):** The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required level – controls are reducing number of breaches

5.4 ▼ **(Amber 9 to Yellow 6):** The Trust breaches required cancer referral/screening to treatment standards – all performance indicators achieved other than 62 day screening to treatment

5.6 ▼ **(Amber 9 to Green 3):** The Trust fails to undertake urgent CT scan for 50% of suspected stroke patients within 1 hour of arrival – target achieved in June

Prepared by: Sheena King – Head of Risk Management & Legal Services

Presented by: Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2011/12 – PROGRESS SUMMARY – AUGUST 2011

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE		PRINCIPAL RISK (Obstacle to achievement of strategic aim)	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
1. To provide best care as measured by clinical effectiveness, safety and patient experience (JD/SH)	FMcN (G&C)	1.2	Inability to maintain ongoing compliance with all CQC standards	ALL	9	12	9	8	8	8	8	6					6 Aug 11
	CM (ICMC)	1.3	Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, identified at or more than 72 hours of admission	8							16	16					4 Mar 12
	SB (SPSSG)	1.4	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	16								9					3 Mar 12
2. To be the hospital of choice for patients (JD/SH)	SW (EMT)	2.1	Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant inability to support other specialties, detriment to patient experience and increase in required CIP.	13								15					10 Oct 11
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (TS)	PG (SMT)	3.2	Inability to achieve and maintain Trust target of 75% compliance with statutory and mandatory training requirements at Q4 2010/11 and improve to 80% compliance by Q4 2011/12	14	6	6	6	6	6	6	6	6					3 Oct 11
	SC (SPSSG)	3.3	Failure to engage all staff in the PHT *'Bringing Values to Life'* campaign	16	6	6	6	6	6	6	6	6					3 Jul 12
	SC (SSCSG)	3.4	Trust fails to achieve improvement in staff satisfaction in line with the quality contract requirement to be placed above the bottom 20% of acute Trusts nationally for each key finding.	14							9	9					6 Jan 12
4. To be the employer of choice in South East Hampshire (TS)	TS (SMT)	4.1	Inability to attract the best staff to PHT, and continue to engage and motivate our current staff will compromise our ability to offer the best care	13	4	4	4	4	4	4	4	4					1 Jan 12
	RK (TAC)	4.2	Trust requirement to reduce workforce costs to meet needs of sustainability programme fails to deliver financial targets and has a detrimental effect on staff morale and Trust reputation	13							9	9					3 Dec 11
5. Be in the top quartile of NHS hospitals for 95% of all services we provide (CW)	CW	5.1	The Trust breaches emergency department quality standard key targets – A & E Patient Impact, A & E Timeliness	4							6	6					3 Dec11
	CW	5.2	The Trust fails to achieve the required referral to treatment targets for admitted patients and reduce the 18 week admitted backlog.	4							9	9					3 Jan 12
	CW	5.3	The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required level	4							9	6					3 Dec 11

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE		PRINCIPAL RISK (Obstacle to achievement of strategic aim)	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
	CW	5.4	The Trust breaches required cancer referral/screening to treatment standards.	4							9	6					3 Sep 11
	CW	5.5	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	4							9	9					3 Oct11
	CW	5.6	The Trust fails to undertake urgent CT scan for 50% of suspected stroke patients within 1 hour of arrival	4							9	3					3 Oct 11
6. Work with our partners to create a sustainable economic enterprise, which eliminates waste and provides real value for money (RT)	SG (TAC)	6.2	The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration	26					12	12	16	20					8 Mar 12
	SG (TAC)	6.3	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	26					12	16	12	16					8 Mar 12
	SG (TAC)	6.4	The Trust's need to deliver £30.5m of savings in 2011/12 has a detrimental impact on the quality of services provided to patients	26					12	12	12	12					8 Mar 12
	DH (TAC)	6.5	Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan and to achieve Foundation Trust Status	26						16	16	16					8 Sep 11

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**	
1.2 (All)	Inability to maintain ongoing compliance with all CQC standards	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • NHSLA Level 1 accreditation (Feb 10) • Accepted for CQC registration without conditions 2010/11 • CSC risk registers • Mock CSC assessments and associated action plans • Monitor Quality Risk Profile monthly • Quarterly evidence and action plan review panels established including NED • CQC awareness sessions • Trust wide action plans for medicines management and privacy and dignity	• Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues) • Clinical dashboards / quality metrics • CSC governance reports • Mock CSC assessments • Outcome of second quarterly evidence review panels show continued improvement in outcome focused evidence • Internal CQC audit (Deloitte) undertaken in Apr 11, demonstrating substantial assurance. • CQC Jul 11 report for Outcome 1 (privacy & Dignity) and Outcome 5 (Nutrition) demonstrates overall compliance	12 (4x3) FMcN G&Q	6 (3x2)	6 (3x2)	•	• Evidence is more outcome focussed however, is still variable across CSCs. • Following quarterly assessment a moderate concern has been identified in relation to medicines management (outcome 9) • Awaiting CQC report relating as part of the Trust planned review • Minor concerns for ongoing compliance for Outcomes 1 and 5	GA: establish list of 'key' evidence for each outcome GA: audit compliance with action plan GA: develop action plan to address minor concerns for ongoing compliance with outcome 1 and 5 forwarded to CQC: to be submitted to Trust Board Aug 11 Predicted residual risk has been reviewed in light of current controls and amended to 6 from 4. This will be continually reviewed	Jul 11 - completed Jul 11 – completed. Monthly audit programme implemented and ongoing Aug 11 - completed	Aug 11 – to be reviewed after each quarterly internal assessment. Next review October 2011

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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1.3 (8)	Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, at or more than 72 hours of admission, thus prejudicing Trust's compliance to the Health & Social Care Act, Outcome 8 of CQC registration and overall Trust CQC registration. This may result in poor patient outcomes – including safety, experience and consequently damage to Trust reputation	• C.Diff reduction action plan • All emergency corridor patients with diarrhoea tested for C. Diff • Weekly C. Diff MDT ward rounds • Daily review by Infection Prevention & Control team to ensure optimal management of patients with C. Diff • Enhanced cleaning and decontamination of patient environment • Trust wide antimicrobial ward rounds between microbiology and pharmacy • Amber incident investigation for failures to isolate symptomatic patients within 4 hours	• Monitoring at ward, CSC and Trust level through clinical dashboards • July - 4 cases against a trajectory of 8	**16 (4x4)** **CM ICMC**	**16 (4x4)**	**4 (4x1)**	• Not all elements of the reduction action plan in place • Lack of diagnostic testing to identify C Diff carriers	• Monitoring shows trajectory missed for first three months of 2011/12	GC/GA: implement all elements of the reduction action plan GC/GA: introduce 'Amber' incident reporting and investigation for failure to isolate symptomatic patients within 4 hours GC/GA: refine diagnostic testing to identify C Diff carriers – resultant on completion of nation studies	Oct 11 Sep 11 Complete Mar 12	Mar 12

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE Responsible Executive: Director of Nursing/Medical Director												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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1.4 (16)	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	• Trust wide action plan • Discharge operational Group	• Not available until national survey results published	9 3x3 SB SPSS G	9 3x3	3 3x1	• August action plan not fully completed • No patient targeted information offered	• Lack of real time patient feedback	GC: Fully implement all points of the August action plan GA: invite and gather patient feedback for every day of August 11 GC/GA: Install Patient poll system GC/GA: Install red comment post boxes GC: complete information prescription pilot for urology, diabetes, respiratory and cancer and evaluate.	Aug 11 Aug 11 Aug 11 Aug 11 Mar 12	

STRATEGIC AIM 2: TO BE THE HOSPITAL OF CHOICE FOR PATIENTS Responsible Executive: Director of Nursing/Medical Director												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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2.1 (13)	Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant impact on level of support to other specialties, detriment to patient experience and increase in required CIP.	• Independent media campaign to retain service • Local council member support	• Referral to Portsmouth & Hampshire Health Overview & Scrutiny Committee	15 5x3	15 5x3	10 5x2	• No agreement for SHA to consider further options that include retaining service at PHT	• No agreement for SHA to consider further options that include retaining service at PHT	GC/GA: consultation with SHA to promote the consideration of alternative options GC/GA: gain support for review of proposal from other affected Trusts in the region GC/GA: ensure appropriate timescale for decision making	Achieved Ongoing Ongoing	Review Oct11

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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3.2 (14)	Inability to achieve and maintain Trust target of 75% compliance with statutory and mandatory training requirements at Q4 2010/11 and improve to 80% compliance by Q4 2011/12	• Diverse training delivery methods • Robust compliance recording • Increased essential update sessions • Regular performance review of CSC compliance with Trust target • Traffic light reports issued to each CSC identifying staff training requirements	• Monthly reports to TB and SMT (shows increase in compliance towards achieving target , currently end Q4 – improvement to75.1%)	6 (3x2) PG SMT	6 (3x2)	3 (3x1)	• ESR utilisation across whole Trust to be finalised • Incomplete Trust wide training needs analysis • EMOTs require updating • Departmental staff reductions may impact on ability to meet target dates	• Achieved Q4 2010/11 target, working towards achieving 2011/12 target	GC: complete roll out of ESR and ensure take up by all CSCs – Essential Skills eLearning to be transferred from Moodle to ESR Aug 11 GC: CSCs to review and evaluate job descriptions to identify essential skill needs for each relevant staff group. Learning and Development team to update identified requirements for ESR – in progress 60% of CSCs have returned data. Data inputted to ESR for 1 CSC and being audited for accuracy GC: evaluate South Central SHA proposed standardised learning package. If unacceptable review and revise Trust EMOTs – in progress. MOTs have been reviewed and refreshed for ESR	Jun 11 Complete Oct 11 Sep 11	Oct 11

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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3.3 (16)	Failure to engage all staff in the Trust *'Bringing Values to Life'* campaign	• Staff and Patient Satisfaction Steering Group (SPSSG) • Communications Strategy • Key communicators in each CSC • Briefing sessions for managers • 'Best People' awards • CEO Weekly Message, Team Brief and Open Forum • 'real time' staff pulse surveys • Team brief cascaded to all staff via line managers	• None available: campaign in its infancy	6 (3x2) SC SPSSG	6 (3x2)	3 (3x1)	• Four core values not incorporated into all HR policies • DVD to publicise our values to staff and stakeholders not yet complete • Further engagement of staff required • Values not incorporated into recruitment process	• Results of national staff satisfaction survey show improvement but concerns in key areas	GC: agree and introduce 'standard values' paragraph to be included in all HR policies and procedures GC: produce, advertise and distribute DVD – first draft completed GC: introduce values pledge key card GC: re write policies and associated documents and introduce values based recruitment	Jul 12 Aug 11 Nov 11 Jan 12	Jul 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF

Responsible Executive: Chief Operating Officer

RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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3.4 (14)	Trust fails to achieve improvement in staff satisfaction in line with the quality contract requirement to be placed above the bottom 20% of acute Trusts nationally for each key finding.	• Staff Satisfaction Campaign Steering Group (SSCSG) • Improvement plan to address 9 key findings • Individual CSC improvement plans • Agreed establishment with associated recruitment to nursing posts • Staff suggestion scheme – Pound Saving Ideas	• Not available until national staff survey results Mar 12	9 (3x3) SC SSC SG	9 (3x3)	6 (3x2)	• Survey results show • The quality of a percentage of appraisal is unsatisfactory • Organisational information is not communicated to all staff • Lack of staff recognition • Lack of engagement with senior leaders	• Pulse survey does not contain all relevant questions • Lack of appraisal quality data	GC: incorporate values into appraisal process GC: ensure use of ESR appraisal template GC: audit the cascade of team brief GC: publicise information to improve work-life balance Trust wide GC: begin to introduce employee of the month award into CSCs GC: launch CSC leaders 'back to the floor' sessions GC: CSC 'marketplace' at Governors open day GA: redesign pulse survey and launch GA: audit of appraisals in each CSC	Sep 11 Jan 12 Sep 11 Dec 11 Sep 11 complete Jan 12 Nov 11 Sep 11 Sep 11	Jan 12

STRATEGIC AIM 4: TO BE THE EMPLOYER OF CHOICE IN SOUTH EAST HAMPSHIRE
Responsible Executive: Director of Human Resources

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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4.1 (13)	Inability to attract the best staff to the Trust, and continue to engage and motivate our current staff will compromise our ability to offer the best care	• The Values Campaign • Oasis • Family friendly policies • Tax efficient purchase schemes • On site nursery • Childcare vouchers • Staff lottery	• Sickness absence and turnover continue to be below target. • Advertised posts receive high quality applicants	4 (2x2) TS SMT	4 (2x2)	1 (1x1)	• Values not embedded • Values not incorporated into recruitment process	•	GC: bring the Trust values to life to continually improve staff survey results GC: re-write policies and associated documents and introduce values based recruitment	Review Sep 11 Jan 12	Jan 12

STRATEGIC AIM 4: TO BE THE EMPLOYER OF CHOICE IN SOUTH EAST HAMPSHIRE
Responsible Executive: Director of Human Resources

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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4.2 (13)	Trust requirement to reduce workforce costs in line with the sustainability programme fails to deliver financial targets and has a detrimental effect on staff morale and Trust reputation.	• Turnaround workstream • Voluntary redundancy to mitigate compulsory • Previously identified workforce plans • Each post individually risk assessed to ensure patient care not compromised or staff workload increased and approved by EMT. • Clear staff communications re workforce proposals • Individual support package for affected staff • WSC approved posts held for redeployment opportunities	•	9 3x3 RK TAC	9 3x3	3 3xa	• Redundancy process not finalised • Lack of staff confidence in all Trust communications	• Results of Staff survey show areas of concern • Results of pulse survey show areas of areas of concern	GC/GA: complete redundancy process GC/GA: further strengthen and ensure timely robust communication with staff, community and media	Sep 11 Dec 11	Dec 11

STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE

Responsible Executive: Chief Operating Officer

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**	
5.1 (4)	The Trust breaches emergency department quality standards key targets – A & E Patient Impact A & E Timeliness	• Key performance indicators • Patient flow project	• Monthly COO's Operational Performance Report (shows 4 of 7 standards met)	9 3x3	6 3x2	3 3x1	• Common pathway developed for all patients to achieve rapid assessment and start of treatment – pilot to be planned and undertaken	• Monthly COO's Operational Performance Report (shows 3 of 7 standards unmet) • Unplanned re - attendance rates not audited	GC/GA: introduce unplanned re-attendance action plan initiatives GC: undertake common patient pathway pilot	Aug 11 Aug 11	Dec 11
5.2 (4)	The Trust fails to achieve the required referral to treatment targets for admitted patients and reduce the 18 week admitted backlog.	• Key performance indicators • Clinically urgent and MOD patients managed in order of clinical priority • Demand management workstream	• Monthly COO's Operational Performance Report (shows 8 of 12 standards met)	9 3x3	9 3x3	3 3x1	•	• Monthly COO's Operational Performance Report (shows 4 of 12 standards unmet)	GA: ensure routine patients booked in turn GA: agree additional capacity with PCT GA: PCT to introduce 'red flag' orthopaedic referrals	Jul 11 complete Jul 11 Ongoing Jul 11 complete	Jan 12
5.3 (4)	The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required level	• Key performance indicators	• Monthly COO's Operational Performance Report (shows 1 of 2 standards met)	9 3x3	6 3x2	3 3x1	• Insufficient capacity to reduce non-obstetric ultrasound patient waits • Insufficient capacity to reduce colonoscopy patient waits	• Monthly COO's Operational Performance Report (shows 1 of 2 standards unmet: number of >6 week waits exceed 100)	GC: extra manpower to be sourced to address ultrasound demand GC: business case approved to support increased colonoscopy capacity. Plan to be implemented	Jul 11 Compete Sep 11	Dec 11

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5.4 (4)	The Trust breaches required cancer referral/screening to treatment standards.	• Key performance indicators • Intensive support	• Monthly COO's Operational Performance Report (shows 8 of 9 standards met)	9 3x3	6 3x2	3 3x1	• Lack of information relating to patient un-acceptance of offered appointment • Lack of capacity	• Monthly COO's Operational Performance Report (shows number of 62 day screening to treatment < 90% target)	GC: audit of un-acceptance of offered appointment to be conducted GC/GA: escalation process to alert where capacity is required	Jul 11 complete Jul 11 complete	Sep 11
5.5 (4)	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	• Key performance indicators • Breach tracking • Agreement with ambulance trust to pre-alert PHT of patient on their way to ED • Escalation process in place for breaches by ambulance Trust	• Monthly COO's Operational Performance Report (shows 4 of 6 standards met)	9 3x3	9 3x3	3 3x1	• Not all patients are directly admitted to Stroke Unit	• Monthly COO's Operational Performance Report (shows 74.5% direct admission, target 90%)	GC/GA: fully implement agreement with ambulance Trust to direct admit all suspect stroke patients to ED GC/GA: complete education and training of staff in ED GC/GA: restructure specialist nurse function to provide extended presence of stroke co-ordination function	Jul 11 complete Jul 11 Complete Aug 11	Oct 11
5.6 (4)	The Trust fails to undertake urgent CT scan for 50% of suspected stroke patients within 1 hour of arrival.	• Key performance indicators • Breach tracking • Agreement with ambulance trust to pre-alert PHT and deliver patients direct to MAU	• Monthly COO's Operational Performance Report (shows 2 of 6 standards met)	9 3x3	3 3x1	3 3x1	• Pre alert system not always implemented	• Monthly COO's Operational Performance Report (shows 51% completion of urgent CT scan target 50%)	GC/GA: fully implement agreement with ambulance Trust to pre alert Trust of all suspected stroke patients to ensure capability to complete CT scan	Jul 11 complete	Oct 11

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY

Responsible Executive: Director of Finance

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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6.2 (26)	The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration.	• Monthly contract monitoring reports • Information on Referral levels • Monthly contract review meetings • Escalation procedures as outlined in contract • Planned Care and Unscheduled Care Boards schemes to manage risk	• None	12 (4x3) SG TAC	20 (4x5)	8 (4x2)	• Timelag in reporting activity means that monitoring is produced 4 weeks after the event. • Concern that PCT demand management schemes have not seen required reduction in activity levels	• NHS Hampshire has now breached their annual cap at month 3 of the financial year. NHS Portsmouth will be close to breaching their cap in month 4 if activity levels continue as per current levels.	GC: work with business intelligence team to try and establish weekly early warning system if activity is moving in the wrong direction GC: system wide meeting held in Jul to progress plans to reduce demand/activity – actions agreed with an aim to achieve this GC/GA : Trust to escalate issue to SHA as part of month 4 reporting process and monthly assurance meetings.	Sep 11 – Review at end of Quarter 2	Mar 12

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Responsible Executive: Director of Finance

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6.3 (26)	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	• Monthly CSC performance meetings • PMO tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements • Turnaround Committee • Sustainability Board	• Monthly reporting to SHA, TB and CSCs • Weekly reporting to TRC • The above shows the Trust has identified plans that amount to its total internal CIP target of £25m and is on track with delivery as at month 3	12 (4x3) SG TAC	16 (4x4)	8 (4x2)	• Retrospective analysis of savings assessment could lead to 6-week lag in detection of target failure • Concern remains around the delivery of the £5.5m of savings associated with reduced activity in relation to PCT demand management schemes	• Under achievement on Trust savings target at month 3 relates to non-achievement of PCT demand management schemes. • There is a shortfall in the Trust overall savings plans at month 3 of £922k	GC: PMO is encouraging the use of lead indicators and milestones; to enable early warning of plans 'off-track' GC: work is ongoing with PCT colleagues to understand fully the impact of demand management schemes and correlate to the contract over-performance seen in April and May GA : system wide meeting held in Jul to progress plans to reduce demand/activity and ensure DM schemes are successfully implemented – actions agreed to achieve this GA: additional schemes are being identified to close the £922k gap	Sep 11 – Review at end of Quarter 2	Mar 12

STRATEGIC AIM 6: WORK WITH OUR PARTNERS TO CREATE A SUSTAINABLE, ECONOMIC ENTERPRISE, WHICH ELIMINATES WASTE AND PROVIDES REAL VALUE FOR MONEY Responsible Executive: Director of Finance												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** Risk Owner Responsible Committee			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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6.4 (26)	The Trust's need to deliver £30.5m of savings in 2011/12 has a detrimental impact on the quality of services provided to patients.	• Quality assurance of plans by CSC management teams. • All Turnaround plans have supporting risk analysis completed highlighting how risks to services will be managed • Review of savings plans at both monthly performance reviews and Turnaround Committee	• Risk assessment performed by CSCs and Corporate workstreams as part of savings plan submission	12 (4x3) SG TAC	12 (4x3)	8 (4x2)	• There is a need to ensure that the risk analysis focuses on the risk to service quality as well as the risk of non-delivery.		GC: clear guidance given to CSCs and Corporate workstreams that they need to report both risks through this mechanism	Sep 11 - Review at end of second quarter	Mar 12

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6.5 (26)	Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan and to achieve Foundation Trust Status (links to 6.2 and 6.3)	• Turnaround workstreams/CSC initiatives with executive sponsorship • Whole System Sustainability • Planned Care Board • Unscheduled Care Board • Estates Rationalisation Board	• Monthly CSC performance management & escalation, corporate workstream, finance, workforce and savings reports to TRC • Quarterly risk report to TRC • Minutes of TRC, Whole System Programme Board, SPB reporting Boards • Scrutiny by Non-Executive Director as member of TRC	16 (4x4) DH TAC	16 (4x4)	8 (4x2)	• Currently £922k gap in savings • Further opportunity in LoS savings and clinical productivity • End of year delivery pipeline projects diagnostic output and structure to be finalised • Unidentified additional £2m/annum savings associated with whole system plan related to estates rationalisation	• £5.5m demand management savings associated with £11m reduction in income being finalised. • Ability to deliver activity reductions impacted by numerous parties / interface issues and limited enforceable accountability • Requires detail of what will be removed in response to demand management of IP and OP activity	GC: CSCs working up plans for a number of schemes to close the gap and provide for a small surplus in savings to mitigate any red rated savings plans (CSCs) GC: set up of project structure for clinical productivity, workforce related savings from redundancy programme to be shown across CSCs (PMO) GC: investigate best practice across PMOs via Monitor/MHI in relation to additional schemes for delivery in 2011/12 (PMO) GA: monitor activity plan/actual month by month and track updates to CSC plans for removal of costs associated with removed activity. Production of automated report to enable weekly provision by activity type (BIU/ICT/FIN)	Aug 11 Aug 11 Aug 11 Aug 11	Sep 11 (review)

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
CA	Chris Ash		BI	Business Intelligence		CEO	Chief Executive Officer
SB	Sarah Balchin		CQRM	Clinical Quality Review Meeting		CHOC	Combined Haematology Oncology Centre
MC	Michelle Coles		CSC	Clinical Service Centre		COO	Chief Operating Officer
SG	Steve Gooch		EMT	Executive Management Team		CoS	Chief of Service
SH	Samantha Hedley		G&Q	Governance & Quality Committee		CQC	Care Quality Commission
DH	Deborah Hutchison		ICMC	Infection Control Management Committee		CQUIN	Commissioning for Quality and Innovation
NL	Nicky Lucey		CQRM	Clinical Quality Review Meeting		EDS	Electronic Discharge Summary
PK	Paul Knight		PEWG	Patient Experience Working Group		EMSA	Eliminating Mixed Sex Accommodation
FM	Fiona McNeight		PSWG	Patient Safety Working Group		ESR	Electronic Staff Record
CM	Caroline Mitchell		SMT	Senior Managers Team		HSDU	Hospital Sterilisation and Decontamination Unit
MP	Maria Purse		SPSSG	Staff & Patient Satisfaction Steering Group		HNU	Head and Neck Unit
TS	Tony Short		SSCSG	Staff Satisfaction Campaign Steering Group		HRL	Healthcare Records Library
RT	Robert Toole		SB	Sustainability Board		IQP	Improving Quality Programme
CW	Cherry West		TRC	Turnaround Committee		LoS	Length of Stay
JW	Jeremy Whiteley		WSC	Workforce Strategy Committee		MHI	McKensie Hospital Institute
						MSK	Musculoskeletal
						PMO	Performance Management Office
						SHA	Strategic Health Authority
						SHIP	Southampton, Hampshire, IOW & Portsmouth
						SLAM	Service Level Agreement Manager
						SPB	Strategic Partnering Board

Guidance for the Assessment of Risk Rating

LIKELIHOOD (frequency)		CONSEQUENCE (impact/severity)				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare	(1)	1	2	3	4	5
Unlikely	(2)	2	4	6	8	10
Possible	(3)	3	6	9	12	15
Likely	(4)	4	8	12	16	20
Highly likely	(5)	5	10	15	20	25

Green	Low Risk (1 – 3)
Yellow	Moderate Risk (4 – 6)
Amber	High Risk (8 – 12)
Red	Extreme Risk (15 – 25)

Levels of Severity of Patient Safety Indicators	
None	A situation where no harm occurred: either a Prevented Patient Safety Incident or a No Harm Patient Safety Incident.
Low	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm to one or more persons.
Moderate	Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.
Severe	Any unexpected or unintended incident which caused permanent or long term harm to one or more persons.
Death	Any unexpected or unintended incident which caused the death of one or more persons.