Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – NOVEMBER 2011

Agenda Item Number: 182/11
Enclosure Number: (6)

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 • Top risks • Increase of risk 1.2 to a score of 12 • Decrease of risk 5.4 to a score of 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 December 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: November 2011

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 21 October 2011

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

Nil

Risks with an Increased Score

1.2 ▲ (Yellow 6 to Amber 12): Inability to maintain ongoing compliance with all CQC standards - CQC report contains moderate concerns

Risks with a Decreased Score

5.4 ▼ (Yellow 6 to Green 3): The Trust breaches required cancer referral/screening to treatment standards – all targets achieved

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

Presented by: Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2011/12 – PROGRESS SUMMARY – OCTOBER 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	12			6 Dec 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	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	9	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	15	15			10 Dec 11
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (RK)	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	6	6			3 Dec 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	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	9	9			6 Jan 12
4. To be the employer of choice in South East Hampshire (RK)	RK (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	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	9	6			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							9	6	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	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	6	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	6	3			3 Dec 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	9	9			3 Dec11
	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	3			3 Dec 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	20	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	16	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	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	16	16			8 Feb 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
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 • Action plan to address minor concerns for ongoing compliance with outcome 1 and 5	• 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) Apr 11, demonstrating substantial assurance. • CQC Jul 11 report for Outcome 1 (privacy & Dignity) and Outcome 5 (Nutrition) demonstrates overall compliance • Compliance audits	12 (4x3) FMcN G&Q	12 (4x3)	6 (3x2)	• Effectiveness of review panels	• CQC report following responsive review received. Moderate concern against outcomes 4 and 9. Complaint with remaining 5 outcomes assesses although minor improvement actions required for outcomes6, 7 and 13. Action plan in place to address concerns raised. • Following weekly meetings with DoN, Director of Pharmacy, HoG and CSC management team, non compliance with outcome 9 has been downgraded to a minor concern as the action plan has progressed significantly in the last 4 months.	GC: Review the current arrangements for the evidence review panels, assess effectiveness and establish way forward GA: Review progress against CQC action plan GA: continue weekly review to monitor completion of action plan. GA: action plan to be monitored monthly by Governance and Quality Committee	Oct 11 Nov 11 Complete Dec 11 Dec 11	Review Dec 11

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

Responsible Executive: Director of Nursing/Medical Director

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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 • Diagnostic testing to identify C.Diff carriers	• 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 • Need to revaluate efficacy of sproacidal agents used in the Trust with a view to improve cleaning • Nurse led cleaning of near patient environment requires improvement • Need to ensure appropriate testing for C. Diff • Need to ensure timely isolation (≤ 4 hours from start of symptoms) • Lack of resource to allow diagnostic C.Diff testing of GP samples • Lack of funding from commissioners to allow full testing of all GP samples for C Diff.	• Monitoring shows trajectory missed for first six months of 2011/12, • GDH testing will initially increase number of known C.Diff carriers • Results show an average of 50% of patients not being isolated as required • Growing body of evidence in literature to suggest that hypochlorite may not be the most effective agent available – high ATP scores still being detected from rooms with C.Diff patients • More than 80% of GP samples do not get a C.Diff diagnostic test • Approximately 8% of samples are inappropriate	GC/GA: implement all elements of the reduction action plan GC/GA: refine diagnostic testing to identify C Diff carriers – GDH testing introduced GC/GA: review meetings plan with Carillion soft FM to trial new cleaning products GC/GA: introduce the isolation of suspected C.Diff patients as a performance indicator and monitor at HoN and CSC level, include in daily operational updates. GC/GA: escalate plans for bed cleaning bureau and equipment library to TPC GC/GA: gain funding from commissioners to accommodate required C.Diff diagnostic testing	Oct 11 Mar 12 Complete Dec 11 Dec 11 Feb 12 Apr 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	• **None**	• Lack of real time patient feedback	GC: complete information prescription pilot for urology, diabetes, respiratory and cancer and evaluate.	Mar 12	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 SW SMT	15 5x3	10 5x2	• SHA have agreed that PHT develop formal option to deliver a vascular service with Chichester - to be finalised • No final decision for future service	• SHA have agreed that PHT develop formal option to deliver a vascular service with Chichester - to be finalised • No final decision for future service	GC/GA: gain support for review of proposal from other affected Trusts in the region GC/GA: ensure appropriate timescale for decision making	Ongoing Ongoing	Review Dec11

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 85% 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 • Essential skills training transferred to ESR • Updated MOTs for ESR	• Monthly reports to TB and SMT (shows increase in compliance towards achieving target , currently end Q4 – improvement to73.6%)	6 (3x2) PG SMT	6 (3x2)	3 (3x1)	• Incomplete Trust wide training needs analysis • Departmental staff reductions may impact on ability to meet target dates	• Achieved Q4 2010/11 target, working towards achieving 2011/12 target	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 –2 CSCs yet to return data. Data inputted to ESR for CSCs and being audited for accuracy GC: South Central SHA proposed standardised learning package now received and being evaluated.	~~Oct 11~~ Nov 11 ~~Sep 11~~ Nov 11	~~Oct 11~~ Review Dec 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												
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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 • Trust Values DVD	• 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: introduce values pledge key card - postponed GC: re write policies and associated documents and introduce values based recruitment – awaiting commencement of Recruitment Manager	Jul 12 ~~Nov 11~~ Mar 12 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 • CSC employee of the month award	• 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 – delayed awaiting commencement of new Director of HR and OD GC: publicise information to improve work-life balance Trust wide GC: launch CSC leaders 'back to the floor' sessions GA: redesign pulse survey and launch – completed and approved by steering group, launch delayed until commencement of new Director of HR and OD GA: audit of appraisals in each CSC- ongoing	~~Sep 11~~ Dec11 Jan 12 Jan 12 Jan 12 Nov 11 ~~Sep 11~~ Dec 11 Review Jan 12	Review 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) 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 Dec 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 Complete 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
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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 • Assessment to arrival pilot undertaken in July, showed improvement	9 3x3 CW	6 3x2	3 3x1	• Common pathway developed for all patients to achieve rapid assessment and start of treatment – to be assessed	• Monthly COO's Operational Performance Report	GC/GA: introduce unplanned re-attendance action plan initiatives GC: undertake common patient pathway pilot GC/GA: review September pilot findings GA: undertake further audit and monitoring of unscheduled returns in both majors and minors	Aug 11 Complete Aug 11 Complete Nov 11 Nov 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 • Routine patients booked in turn • Additional capacity agreed with PCTs • PCT 'red flag' orthopaedic referrals • PCT contacting patients offering choice of treatment with the ISTC	• Monthly COO's Operational Performance	9 3x3 CW	9 3x3	3 3x1	• 18 week backlog impacting on 95th percentile	• Monthly COO's Operational Performance Report	GC/GA: activity plan and trajectory in place to clear the admitted backlog, and monitored GC/GA: demand management schemes in place and monitored		Jan 12

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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 • Extra manpower sourced for ultrasound demand • Additional screener accredited	• Monthly COO's Operational Performance Report – reported a decrease in breaches and diagnostic trajectory improvement for Sep 11	9 3x3 CW	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	GC/GA: business case approved to support increased colonoscopy capacity. Plan implemented Sep 11	Sep 11 complete	Dec 11
5.4 (4)	The Trust breaches required cancer referral/screening to treatment standards.	• Key performance indicators • Intensive support • Escalation process • Additional screener accredited	• Monthly COO's Operational Performance Report	9 3x3 CW	6 3x2	3 3x1	• Lack of capacity	• Monthly COO's Operational Performance Report	GC/GA: business case approved to support increased colonoscopy capacity. Plan implemented Sep 11	Sep 11 complete	Dec 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 improvement on CT access within 1 hour, CT scan within 24 hours of arrival and high risk TIA patients being seen and treated within 24 hours of first contact.	9 3x3 CW	6 3x2	3 3x1	• Not all patients are directly admitted to Stroke Unit	• Monthly COO's Operational Performance Report (shows 87% direct admission, target 90%)	GC/GA: restructure specialist nurse function to provide extended presence of stroke co-ordination function	Sep 11 complete	Dec 11

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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	• Monthly COO's Operational Performance Report	9 3x3 CW	3 3x1	3 3x1	• ED assessment within 15 minutes	• Monthly COO's Operational Performance Report (shows 53.3% completion of urgent CT scan target 50%)	GC: tracking breached attendances for stroke patients to support patients being navigated through their pathway	Dec 11	Dec 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

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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	• Both NHS Hampshire and NHS Portsmouth Have breached their annual activity caps based on August activity information (extrapolated for September)	GC: work with business intelligence team to try and establish weekly early warning system if activity is moving in the wrong direction GC/GA: Trust had escalated to SHA through monthly monitoring returns and flagged the potential risk that is posed to the Trust's year end I&E position. CEO has written to CEO of SHIP PCTs GC/GA: the Trust is close to finalising a financial recovery plan with Commissioners that will aim to deliver a break-even year end position. This is likely to include additional income from PCTs GA: Trust has produced a range of financial scenarios for the SHA indicating potential impact.	Nov 11 Review risks once health economy recovery plan is finalised and agreed	Mar 12

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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 • Trust is ahead of plan on it's own internal schemes at end of month 6	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	• Trust is slightly adrift (£822k) of it's overall savings target at month 6. This relates to non-delivery of demand management schemes for the year to date. • Trust is still developing additional CIP schemes to ensure that any remaining slippage against current schemes can be covered.	GC: PMO is encouraging the use of lead indicators and milestones; to enable early warning of plans 'off-track' GC/GA: A system wide recovery plan is being developed to reduce activity levels part of which is ensuring that existing demand management schemes are delivering (see 6.2 above) GC/GA: Weekly CIP meetings are being held with GMs led by COO to develop additional schemes to bridge the gap	Nov 11 – Review risks once health economy recovery plan is finalised and agreed	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												
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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	Dec 11 - Review at end of quarter 3	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 TAC • Quarterly risk report to TAC • Minutes of TAC, Whole System Programme Board, SPB reporting Boards • Scrutiny by Non-Executive Director as member of TAC	16 (4x4) DB TAC	16 (4x4)	8 (4x2)	• Currently £2m gap in savings • Further opportunity being investigated through estates rationalisation • End of year delivery pipeline projects diagnostic output and delivery to be sorted • 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 internal QUIPP meetings and feasibility work (CSCs) 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)	Nov 11 Nov 11 Dec 11 Nov 11	Feb 12 (review)

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
SB	Sarah Balchin		BI	Business Intelligence		CEO	Chief Executive Officer
DB	Deborah Burrows		CQRM	Clinical Quality Review Meeting		CHOC	Combined Haematology Oncology Centre
SC	Samm Coley		CSC	Clinical Service Centre		COO	Chief Operating Officer
JD	Julie Dawes		EMT	Executive Management Team		CoS	Chief of Service
SG	Steve Gooch		G&Q	Governance & Quality Committee		CQC	Care Quality Commission
PG	Penny Gordon		ICMC	Infection Control Management Committee		CQUIN	Commissioning for Quality and Innovation
SH	Simon Holmes		CQRM	Clinical Quality Review Meeting		EMSA	Eliminating Mixed Sex Accommodation
RK	Rebecca Kopacek		PEWG	Patient Experience Working Group		ESR	Electronic Staff Record
FM	Fiona McNeight		PSWG	Patient Safety Working Group		HSDU	Hospital Sterilisation and Decontamination Unit
CM	Caroline Mitchell		SMT	Senior Managers Team		HNU	Head and Neck Unit
RT	Robert Toole		SPSSG	Staff & Patient Satisfaction Steering Group		IQP	Improving Quality Programme
CW	Cherry West		SSCSG	Staff Satisfaction Campaign Steering Group		LoS	Length of Stay
SW	Steve Williamson		SB	Sustainability Board		MHI	McKensie Hospital Institute
			TAC	Turnaround Committee		MSK	Musculoskeletal
			WSC	Workforce Strategy Committee		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.