Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – JULY 2012

Agenda Item Number: 112/12
Enclosure Number: (6)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Risk Coordinator 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 • Updated format • Changes to risk numbering following realignment to new strategic aims • Top risks • Decrease of risks 1.2 to a risk score of 6 and 3.1 to a risk 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 August 12.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: July 2012

Purpose:
To provide the Trust Board with an update on the Assurance Framework as of 17 July 2012

Top Risks

2.1 ◄► (Red 20): Lack of available capacity for patients ready to leave ED causing patients to be cared for in an inappropriate area without the correct levels of staff

4.5 ◄► (Red 16): Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels

New Risks

Nil

Risks with an Increased Score

Nil

Risks with a Decreased Score

1.2 ▼ (Amber 9 to Yellow 6): The Trust breaches emergency department quality standards key targets – ED Patient Impact, ED Timeliness

3.1 ▼ (Yellow 6 to Green 3): The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog

Risks to be Removed

Nil

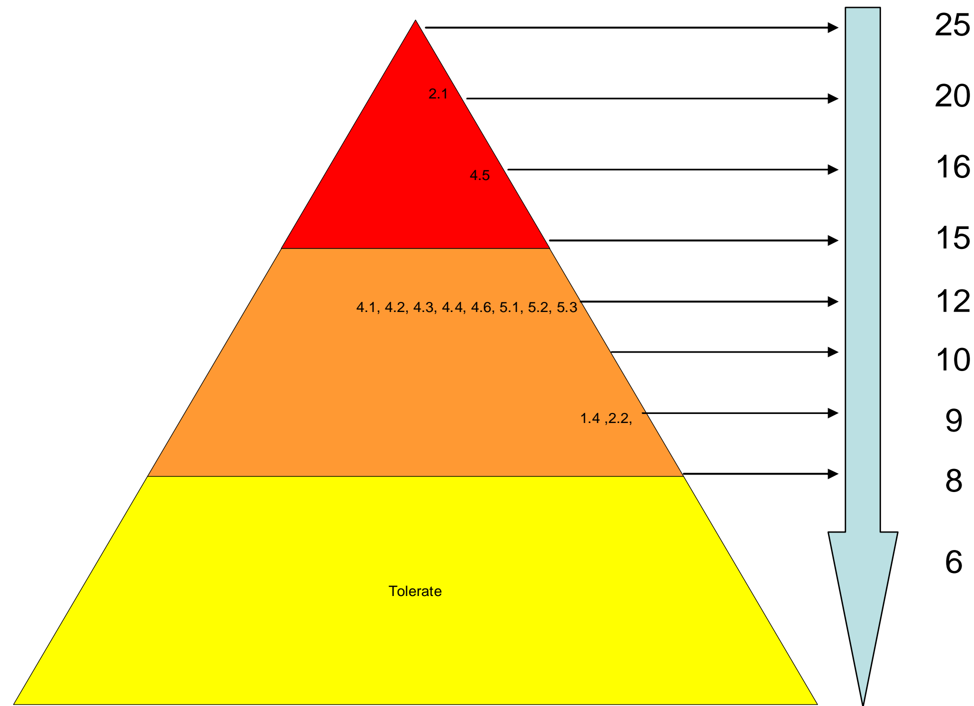
Target Date Changes

Nil

Prepared by: Annie Green – Risk Coordinator

Presented by: Peter Mellor – Company Secretary

Trust Risk Snapshot – July 2012



Trust Risk Profile - July 2012

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)			Stroke Care Standards ◄ ► RTT Targets ▼		
Unlikely (2)			CQC Standards ◄ ► ED Quality Standards ▼		
Possible (3)			Inpatient Survey ◄ ► Patient Flow ◄ ►	Learning and Education Outcomes ◄ ► Performance Management ◄ ► Engagement of Workforce ◄ ► Capability of Leadership ◄ ► Unfilled Critical Posts ◄ ► Lost Income ◄ ► Undelivered Savings Targets ◄ ► Savings Impact on Quality ◄ ►	
Likely (4)				High Level of Temporary Staff ◄ ►	ED Capacity ◄ ►
Highly Likely (5)					

ASSURANCE FRAMEWORK 2012/13 PROGRESS SUMMARY - July 2012

STRATEGIC AIM Executive Lead	Risk Reference Operational Leads	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	RESPONSIBLE COMMITTEE	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
					APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
1 : DELIVER SAFE, HIGH QUALITY AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS	1.1 FMcN	Inability to maintain ongoing compliance with all CQC standards	G&Q	All	9	9	6	6									Aug 12	6 Apr 13
	1.2 AG	The Trust breaches emergency department quality standards key targets – ED Patient Impact, ED Timeliness		4	9	9	9	6									Aug12	3 Apr 13
	1.3 AG	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit		4	6	6	3	3									Sep12	3 Apr 13
JD/SH	1.4 SB	Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in financial penalty up to £436,500	PEWG	16	9	9	9	9									Aug 12	3 Feb 13
2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE	2.1 AG	Lack of available capacity for patients ready to leave ED causing patients to be cared for in an inappropriate area without the correct levels of staff	SMT	16			20	20									Aug 12	5 Dec 12
JD/DH/SH/CW	2.2 AG	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards		16			9	9									Aug 12	3 Oct 12
3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES DH/SH/CW	3.1 AG	The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog		4	6	6	6	3									Sep 12	3 Apr 13
4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE	4.1 RK	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust		All	12	12	12	12									Oct 12	8 Apr 13
	4.2 RK	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities		All	12	12	12	12									Sep 12	8 Apr 13
	4.3 RK	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities		14	12	12	12	12									Oct 12	6 Apr 13
	4.4 RK	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change		14	12	12	12	12									Dec 12	8 Apr 13
TP	4.5 RK	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and		13	16	16	16	16									Oct 12	8 Apr 13

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					APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
		unaffordable staffing levels																
	4.6 RK	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes		13	12	12	12	12									Nov 12	6 Apr 13
5: ENSURE SUSTAINABILITY	5.1 SG	The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners	FC	26	12	12	12	12									Aug 12	8 Apr 13
	5.2 SG	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	FC	26	12	12	12	12									Aug 12	8 Apr 13
RT	5.3 SG	The Trust's need to deliver £27m of savings in 2012/13 has a detrimental impact on the quality of services provided to patients.	FC	26	12	12	12	12									Aug 12	8 Apr 13

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY AND EFFETIVE CARE IN THE TOP 20% OF OUR PEERS
Responsible Executive: Medical Director/Nursing Director

- Minimise avoidable harm
- Engage clinical teams to lead key improvement projects
- Use evidence based best practice to improve pathways
- Encourage a safety first culture
- Achieve year on year improvements in patient satisfaction

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	Review Date	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 **Review Date**	**Target Date**
1.1 (All)	Inability to maintain ongoing compliance with all CQC standards	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • NHSLA Level 1 accreditation (Mar 12) • 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 • CQC awareness sessions • Action plan to address minor concerns for ongoing compliance with outcomes 4 , 5 and 21	• 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 • Internal CQC audit (Deloitte) Mar 12, demonstrating substantial assurance. • Compliance audits • CQC inspection Mar 12for consent to termination of pregnancy compliant	12 (3x4) FMcN G&Q	6 (3x2)	6 (3x2)	• None	• Follow-up responsive review on 3rd and 4th January. • Final report received: compliant with outcomes 1 and 9, minor concerns with outcomes 4 and 5 and moderate concern with outcome 21. Action plans submitted to CQC. • No further correspondence from CQC. Action plan presented to Governance & Quality Committee monthly	GA: action plan to be monitored monthly by Governance and Quality Committee until remaining actions closed. GA: 3 clinical areas (Paediatric, Medicine and Surgery) under review by DoN.	Aug 12	Apr 13

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(4)</td><td>The Trust breaches emergency department quality standards key targets –
A & E Timeliness</td><td>• Key performance indicators
• Patient flow project
• Common pathway developed for all patients to achieve rapid assessment and start of treatment</td><td>• Monthly Integrated Performance Report
• 95% target achieved in June</td><td>9
(3x3)
AG</td><td>6
(3x2)</td><td>3
(3x1)</td><td>• Volume and hourly profile of attendances
• Continued high numbers of medically stable patients awaiting discharge
• Inconsistent implementation of patient flow policies across the Trust</td><td>• Monthly Integrated Performance Report</td><td>GC: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment.</td><td>Aug 12</td><td>Apr 13</td></tr>
<tr><td>1.3
(4)</td><td>The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit</td><td>• 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</td><td>• Monthly Integrated Performance Report</td><td>9
(3x3)
AG</td><td>3
(3x1)</td><td>3
(3x1)</td><td>• n/a</td><td>• n/a</td><td>GC/GA: Dedicated Stroke Co-ordination Nurse Team appointed in April 2012</td><td>Sep 12</td><td>Apr 13</td></tr>
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(16)</td><td>Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in financial penalty up to £436,500</td><td>• Trust wide action plan
• Quality Improvement Group
• New 5 key questions survey
• CSC targets for patient participation in survey – subject to performance review
• Monitored by Income Protection Group</td><td>• Optimum real time patient survey</td><td>9
(3x3)
SB
PEW
G</td><td>9
(3x3)</td><td>3
(3x1)</td><td>• CSCs need to achieve increasing patient participation targets</td><td>• No reports available at present</td><td>GC: leads for 5 key questions to be identified in each CSC and undertake patient surveys to achieve target
GA: real time reports to be analysed and presented to PESG and Income Protection Group monthly</td><td>Aug 12</td><td>Feb 13</td></tr>
</table>

STRATEGIC AIM 2: PARTNER WITH OTHERS TO DELIVERTHE RIGHT CARE IN THE RIGHT PLACE

Responsible Executive: Medical Director/Nursing Director/Chief Operating Officer/Strategy and Business Development Director/ Workforce and Organisational Development Director

- Create an Integrated Care Organisation for high risk groups
- Partner with other providers to reduce unnecessary A & E attendances
- Work with partners to reduce delayed discharges
- Create a vibrant R & D culture as part of an Academic Health Sciences Network
- Partner with leading education providers to ensure that we continue to deliver a well trained and educated workforce

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	Review Date	Final target date for mitigation of risk RAG rated for progress
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2.1 (16)	Ongoing and persistent queue together with lack of available capacity for patients ready to leave ED causing patients to be cared for in an inappropriate area without the correct levels of staff	• ED attempt to routinely provide two queue nurses at peak times • Arrangements to provide additional nursing staff from QAH site; for extra support • Medically expected patients to go directly to MAU as far as possible • Surge plan developed and implemented • New policy and procedure for escalation implemented • Queue reduction plan • M & L support • ED consultants appointed and present until midnight 5 days	• Monitored, via Emergency Pathway Workstream and intensive support • Daily monitoring at Trust wide morning matrons meeting	20 (5x4) IG SMT	20 (5x4)	5 (5x1)	• Unavailability of required beds • Presentations to ED exceed capacity	• Monthly COO's Operational Performance Report	GC: Interviews are ongoing to substantively appoint ED nurse to manage the queue. Planned start Oct 12 GC/GA: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment. GC/GA: Agree and implement unscheduled care transformation plan	Aug 12	Dec 12

STRATEGIC AIM 2: PARTNER WITH OTHERS TO DELIVERTHE RIGHT CARE IN THE RIGHT PLACE

Responsible Executive: Medical Director/Nursing Director/Chief Operating Officer/Strategy and Business Development Director/ Workforce and Organisational Development Director

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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**	**Review Date**	**Final target date for mitigation of risk** RAG rated for progress
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2.2 (4,6)	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards	• Trust-wide KPIs and monthly Integrated Performance Report • Bed rebalancing and ward staffing reviews • Patient flow project	• Trust-wide KPIs and monthly Integrated Performance Report	9 (3x3) AG	9 (3x3)	3 (3x1)	• Volume and hourly profile of attendances • Continued high numbers of medically stable patients awaiting discharge • Inconsistent implementation of patient flow policies across the Trust	• The monthly Integrated Performance Report does not include any patient flow KPIs.	GC: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment. GC: complete bed rebalancing exercise (June 2012). GA: Productivity and efficiency KPIs are under development and will be included in future monthly Integrated Performance Reports	Aug 12	Oct 12

STRATEGIC AIM 3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES

Responsible Executive: Medical Director/Chief Operating Officer/ Strategy and Business Development Director

- Protect scheduled services from fluctuations in the demand for unscheduled care
- Implement simple, effective, standardised elective pathways
- Reduce waiting times until we are the best in the region
- Communicate effectively with key stakeholders across the region
- Grow target specialties year on year
- Increase share of referrals form key target GP practices year on year
- Grow private patient business year on year

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	Review Date	Final target date for mitigation of risk RAG rated for progress
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3.1 (4)	The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog.	• Key performance indicators • Clinically urgent patients managed in order of clinical priority • Breach of target in four specialties to reduce backlog agreed with commissioners	• Monthly COO's Operational Performance • RTT targets achieved in June	9 (3x3) AG	3 (3x1)	3 (3x1)	• 18 week backlog in key specialties impacting on aggregate 95th percentile	• Monthly COO's Operational Performance Report	GC/GA: activity plan and trajectory in place to clear the admitted backlog in key specialties, and monitored	Sep 12	Apr 13

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Responsible Executive: Workforce and Organisational Development Director

- Plan our workforce effectively
- Grow our talent effectively
- Manage performance and accountability effectively
- Engage effectively with staff at all levels
- Develop a more visible leadership brand
- Achieve year on year improvements in the NHS National Staff Survey

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	Review Date	Final target date for mitigation of risk RAG rated for progress
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4.1 (14)	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust.	• Training plans developed to reflect CSC strategic priorities. • Membership of the shadow Local Education and Training Board. • Evaluation of learning outcomes undertaken.	• Strategic Education Board in place. • Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback).	12 (4x3) RK	12 (4x3)	8 (4x2)	• Learning and education strategy is defined at a high level but requires greater detail. • Director of Medical Education is retiring in June 2012.	• There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes.	GC - Director of Medical Education post to be filled. GC - Strategic education board to define future learning strategy and monitor outcomes. GA – development and deployment of the education outcomes framework.	Oct 12	Apr 13
4.2 (14)	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities.	• Performance assurance framework trials for CSCs commenced • SHA funded performance appraisal project for consultants introduced	• 85% compliance with appraisal completions • Significant improvement to staff survey results for effectiveness of appraisal • Performance assurance project board established.	12 (4x3) RK	12 (4x3)	8 (4x2)	• Variation in performance at CSC and individual level. • Consequence management framework not established.	• Appraisal performance measures currently only look at compliance with no individual rating scale evident.	GC – Performance assurance framework deployed across all CSCs GC / GA – review of performance appraisal process to introduce ratings and consequence management frameworks.	Sep 12	Apr 12

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4.3 (14)	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	• Staff survey action plans developed within CSCs • Health and well-being programme established. • Employee recognition programmes in place.	• Improved performance in 2011 national staff survey results. • Lower than average levels of sick absence and staff turnover.	12 (3x4) RK	12 (3x4)	6 (3x2)	• Staff survey results still show lower than acceptable scores against some key findings.	• Staff concerns or issues not captured sufficiently well enough with little Board visibility of underlying themes.	GC – bottom up action plans to be developed by CSCs. GA – review of internal communication process including team-brief. GA – regular reporting to Board on staff issues.	Oct 12	Apr 12
4.4 (14)	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.	• Leadership development programmes in place to support leaders at various levels.	• Utilisation of existing leadership development programmes. • SHA funded projects in development including team based working.	12 (4x3) RK	12 (4x3)	8 (4x2)	• Expectations of leaders not clearly defined.	• There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.	GC – development of a Trust wide leadership brand. GA – development of talent management process to capture potential future leaders GA – review the range of leadership development opportunities currently offered. GA – use of Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level	Dec 12	Apr 13

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Responsible Executive: Workforce and Organisational Development Director

- Plan our workforce effectively
- Grow our talent effectively
- Manage performance and accountability effectively
- Engage effectively with staff at all levels
- Develop a more visible leadership brand
- Achieve year on year improvements in the NHS National Staff Survey

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	Review Date	Final target date for mitigation of risk (RAG rated for progress: On target; Minor obstacle to achieving target; Inability to achieve predicted target)
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	**Review Date**	**Target Date**
4.5 (13)	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels.	• Corporate CIP plan developed to reduce temporary staffing levels. • Review of recruitment processes for Nursing cohort undertaken • Workforce Strategy Committee ensures critical posts are resourced.	• Business planning process has identified resource requirements for CSC service delivery. • WSC process reviewed to ensure critical posts are prioritised for recruitment	16 (4x4) RK	16 (4x4)	8 (4x2)	• Ineffective workforce planning at CSC level. • High levels of temporary resource currently in place. • Reduction in Junior Doctor resource will increase demand for consultants in some specialities. • Attraction strategy is poorly defined.	• Reporting of workforce metrics does not facilitate early decision making.	GC – Workforce planning tool to be developed to enable more effective resource plans to be developed in CSCs. GC – Temporary workforce control panel to be introduced GC – Speciality specific attraction strategies to be developed for CSCs in difficult to recruit areas. GA – full deployment of e-rostering system.	Oct 12	Apr 13
4.6 (13)	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	• Definition of critical posts established and used by WSC to prioritise recruitment.	• Remaining GM posts in process of being filled.	12 (3x4) RK	12 (3x4)	6 (3x2)	• Performance appraisal does not capture career progression potential. • Process for defining and identifying those with potential is not established. • Critical posts have not been reviewed to ensure the highest return on investment.	• Talent is not reviewed at senior management level or at CSC level. • Succession plans are not evident across the Trust	GC – review of appraisal process for Band 7 and above. GC – talent review process to be developed and linked to appraisal. GA – Talent review meetings to take place at Board and CSC levels GA – Succession plans at senior management level to be developed	Nov 12	Apr13

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Responsible Executive: Finance and Investment Director

- Become a Foundation Trust in 2013/14
- Make a financial surplus each year and reinvest this for the benefit of patients
- Ensure that we meet or exceed all national targets and standards
- Ensure the sustainability of clinical services
- Develop and implement an effective information technology strategy
- Develop and implement and effective innovation strategy
- Develop and implement an effective Corporate Social Responsibility strategy

<table>
<tr><th colspan="2">RISKS</th><th colspan="2">CONTROLS AND ASSURANCE TO MITIGATE RISK</th><th colspan="3">RISK RATING
Risk Owner
Responsible Committee</th><th colspan="2">IDENTIFIED GAPS IN CONTROLS AND ASSURANCE</th><th>ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING</th><th>Review Date</th><th>Final target date for mitigation of risk
RAG rated for progress</th></tr>
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GA – Gap in Assurance</th><th colspan="2">On target
Minor obstacle to achieving target
Inability to achieve predicted target
Review Date / Target Date</th></tr>
<tr><td>5.1
(26)</td><td>The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners.</td><td>• Monthly contract monitoring reports
• Monthly contract review meetings
• Income Protection Group
• Monthly CSC performance meetings</td><td>• Monthly contract monitoring reports</td><td>12
(4x3)
SG
FC</td><td>12
(4x3)</td><td>8
(4x2)</td><td>• Current monthly reports do not adequately expose the financial risk (especially at CSC level).</td><td>• Current monthly reports do not adequately expose the financial risk (especially at CSC level).</td><td>GC/GA: Monthly reports to be revised to ensure they meet requirements</td><td>Aug 12</td><td>Apr 13</td></tr>
<tr><td>5.2
(26)</td><td>2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position</td><td>• Review of savings performance at Transformation and Finance Committees
• Monthly CSC performance meetings
• PMO tracker providing clear information on which initiatives are ‘off-track’
• Defined CSC reporting arrangements</td><td>• Monthly reporting to Transformation and Finance Committees</td><td>12
(4x3)
SG
FC</td><td>12
(4x3)</td><td>8
(4x2)</td><td>• Need to develop clear detailed project plans for each of the savings schemes
• Need to identify project leads for each of the savings schemes</td><td>• Project plans incomplete – under continuous development</td><td>GC/GA: Project plans and leads currently being finalised</td><td>Aug 12</td><td>Apr 13</td></tr>
</table>

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Responsible Executive: Finance and Investment Director

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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**	**Review Date**	**Final target date for mitigation of risk** RAG rated for progress
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5.3 (26)	The Trust's need to deliver £27m of savings in 2012/13 has a detrimental impact on the quality of services provided to patients.	• Quality Assurance of plans by CSC management teams • Review of savings plans at Transformation and finance committees • All savings plans to be signed off by Directors of Medicine and Nursing.	• None available yet	12 (4x3) SG FC	12 (4x3)	8 (4x2)	• All risk assessments to be completed and savings plans signed off	• All risk assessments to be completed and savings plans signed off	GC/GA: complete risk assessments and savings plans	Aug 12	Apr 13

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
SB	Sarah Balchin		EMT	Executive Management Team		CQC	Care Quality Commission
JD	Julie Dawes		G&Q	Governance & Quality Committee		CSC	Clinical Service Centre
AG	Alistair Glen		H&S	Health & Safety Steering Group		DoH	Department of Health
IG	Isabel Gaylard		FC	Finance Committee		KPI	Key Performance Indicator
SG	Steve Gooch		PEWG	Patient Experience Working Group		WSC	Workforce Scrutiny Committee
DH	Dominic Hardisty		SB	Sustainability Board			
SH	Simon Holmes		SMT	Senior Managers Team			
RK	Rebecca Kopecek		WSC	Workforce Strategy Committee			
FMcN	Fiona McNeight						
TP	Tim Powell						
RT	Robert Toole						
CW	Cherry West						