TRUST BOARD PART I – AUGUST 2012

Agenda Item Number: 132/12
Enclosure Number: (3)

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 • Changes to risk numbering following inclusion of additional risks • Top risks • New risks 1.3, 2.3, 3.1, 3.2, 3.3, 3.4, 5.1, 5.2, 5.5 (following review of the Assurance Framework against revised strategic aims) • Re-description of Risk 2.1 • Increase of risk 1.1
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 September 2012.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: August 2012

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 21 August 2012

Top Risks

2.1 ◄► (Red 20): Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets

3.2 (Red 16): Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from:
Failures to target growth in appropriate specialties; and/or
Failures to achieve the profile of targeted elective activity growth

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

5.2 (Red 16): Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure

New Risks

3.2 (Red 16): Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from:
Failures to target growth in appropriate specialties; and/or
Failures to achieve the profile of targeted elective activity growth

5.2 (Red 16): Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure.

1.3 (Amber 12): The financial controls/cost reductions in the local economy 2012/13 potentially impacts on quality of services provided to patients and patient safety and the ability of teams to fully engage in service improvement.

3.1 (Amber 12): The Trust is unable to provide required capacity for scheduled care services on a sustainable basis

3.3 (Amber 12): Insufficient evidence to enable effective analysis and identification of best practice elective pathways
Insufficient medical and / or operational engagement to implement changes to pathways

3.4 (Amber 12): Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share

5.1 (Amber 12): Inability to achieve Foundation Trust status within the agreed timetable

2.3 (Amber 10): The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network

5.5 (Yellow 6): Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance

Risks with an Increased Score

1.1 ▲ (Yellow 6 to Amber 12): Inability to maintain ongoing compliance with all CQC standards

Risks with a Decreased Score

Nil

Risks to be Removed

Nil

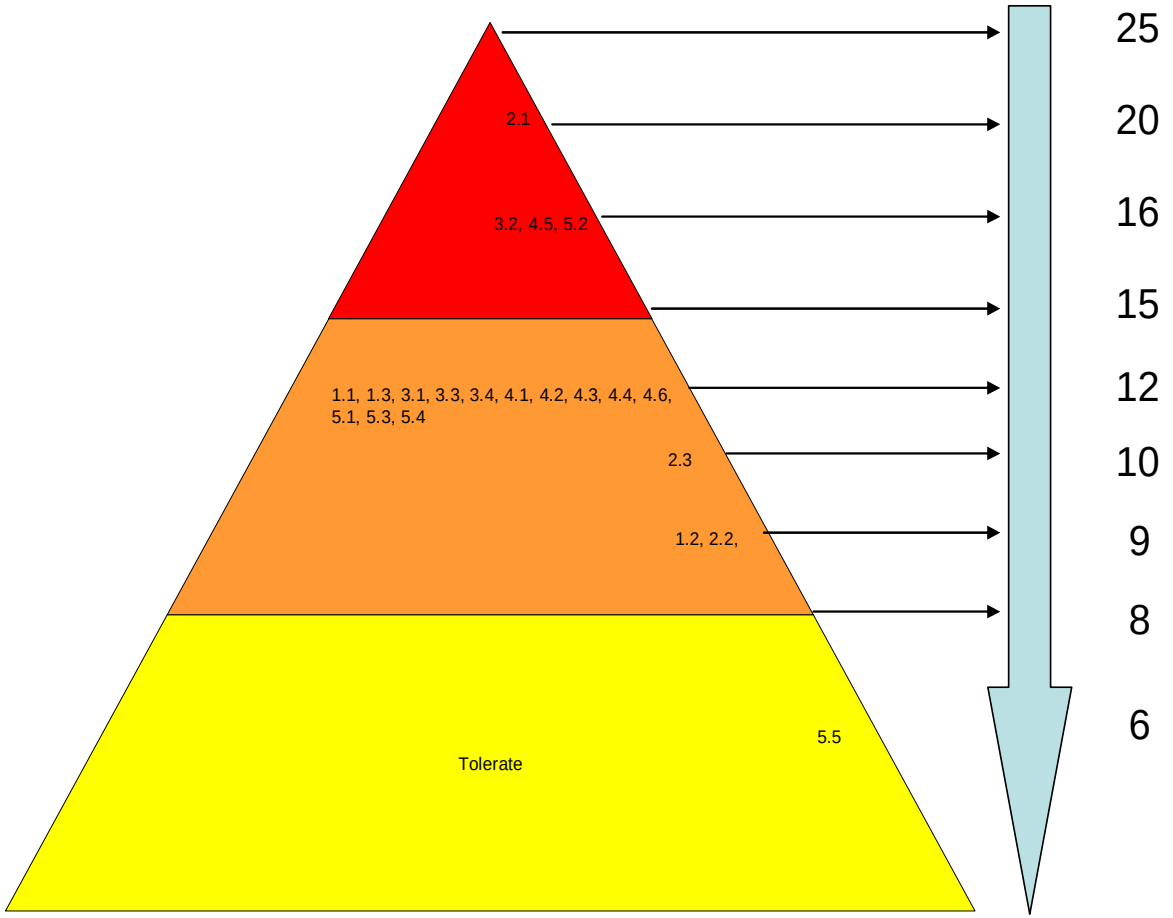
Target Date Changes

Nil

Prepared by: Annie Green – Risk Coordinator

Presented by: Peter Mellor – Company Secretary

Trust Risk Snapshot – August 2012



Trust Risk Profile - August 2012

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)					
Unlikely (2)			Information Technology strategy		Growth in R&D
Possible (3)			Inpatient survey ◄ ► Patient flow ◄ ►	CQC Standards ▲ Quality of services and patient safety Scheduled care capacity Relationships with commissioners Learning and education outcomes ◄ ► Performance management ◄ ► Capability of leadership ◄ ► Unfilled critical posts ◄ ► Foundation Trust status Contract penalties Delivery of savings targets	
Likely (4)			Best practice elective pathways Engagement of workforce ◄ ►	Growth of targeted specialties High level of temporary staff ◄ ► Failure of budgetary control	Insufficient reduction in ED admissions ◄ ►
Highly Likely (5)					

ASSURANCE FRAMEWORK 2012/13 PROGRESS SUMMARY - August 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	12								Oct 12	8 Apr 13
	1.2 SB	Failure to improve patient satisfaction (measured through results of the national Inpatient survey) potentially affecting organisational reputation and achievement of CQUIN (financial penalty up to £436,500)	PEWG	16	9	9	9	9	9								Oct 12	3 Feb 13
JD/SH	1.3 FMcN	The financial controls/cost reductions in the local economy 2012/13 potentially impacts on quality of services provided to patients and patient safety and the ability of teams to fully engage in service improvement.	G&Q	4					12								Sep 12	8 Apr 13
2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE	2.1 AG	Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets	SMT	16			20	20	20								Sep12	5 Apr 13
	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	SMT	16			9	9	9								Oct 12	3 Dec 12
JD/DH/SH/CW	2.3 SH	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	SMT	6					10								Nov 12	5 Mar 14
3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES	3.1 AG	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	SMT	4					12								Sep 12	4 Mar 14
DH/SH/CW	3.2 AG	Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from: Failures to target growth in appropriate specialties; and/or Failures to achieve the profile of targeted elective activity growth	SMT	26					16								Oct 12	4 Mar 13
	3.3 AG	Insufficient evidence to enable effective analysis and identification of best practice elective pathways. Insufficient medical and / or operational engagement to implement changes to pathways	SMT	4					12								Oct 12	3 Mar 14
	3.4 AG	Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	SMT	6					12								Oct 12	4 Mar 14
4: STAFF ARE PROUD TO WORK	4.1	Learning and education outcomes do not	WSC	All	12	12	12	12	12								Oct 12	8

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					APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE TP	RK	deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust																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	WSC	All	12	12	12	12	12								Oct 12	8 Apr 13
	4.3 RK	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities	WSC	14	12	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	WSC	14	12	12	12	12	12								Dec 12	8 Apr 13
	4.5 RK	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels	WSC	13	16	16	16	16	16								Oct 12	8 Apr 13
	4.6 RK	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes	WSC	13	12	12	12	12	12								Nov 12	6 Apr 13
5: ENSURE SUSTAINABILITY	5.1 BC	Inability to achieve Foundation Trust status within the agreed timetable	TB	26					12								Oct 12	4 Mar 14
	5.2 SG	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure.	FC	26					16								Sep 12	12 Mar 13
RT	5.3 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	12								Sep 12	8 Mar 13
	5.4 SG	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	FC/TC	26	12	12	12	12	12								Sep 12	8 Mar 13
	5.5 DH	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	ITSG	4					6								Oct 12	3 Oct 13

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY AND EFFECTIVE 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 (4x3) FMcN G&Q	12 (4x3)	8 (4x2)	• None	• New documentation education and training ongoing following pilot with continued roll out across Trust • Documentation audits show required 95% compliance is not being consistently achieved	GA: action plan to be monitored monthly by Governance and Quality Committee until remaining actions closed. GA: Ongoing mock CQC vists. GA: Continued documentation audits until compliance sustained	Oct 12	Apr 13

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS
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1.2 (16)	Failure to improve patient satisfaction (measured through results of the national Inpatient survey) potentially affecting organisational reputation and achievement of CQUIN (financial penalty up to £436,500)	• 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	• Optimum real time patient survey	9 (3x3) SB PEW G	9 (3x3)	3 (3x1)	• CSCs need to achieve increasing patient participation targets	• No reports available at present	GC: leads for 5 key questions to be identified in each CSC and undertake patient surveys to achieve target –first analysis end of Q2 GA: real time reports to be analysed and presented to PESG and Income Protection Group monthly - now implemented and ongoing GC: Medication side effect information cards to be supplied to patients from Aug 12 GC: Patient information leaflets relating to 5 key questions to be provided to patients from Aug 12	Oct 12	Feb 13
1.3 (26)	The financial controls/cost reductions in the local economy 2012/13 potentially impacts on quality of services provided to patients and patient safety and the ability of teams to fully engage in service improvement.	• Governance Framework and monitoring: • Quality Impact Assessments of CIP plans • Quality Performance measures • Monitor Compliance Framework • CSC executive performance reviews	• Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Trust Board	12 (4x3) FMcN G&Q	12 (4x3)	8 (4x2)	• All risk assessments to be completed and savings plans signed off • Real time data not fully available to allow proactive response • CSC performance framework not fully imbedded • Identification of individual CSC quality performance 'hotspots'	• Real time data not fully available to allow proactive response	GC/GA: complete roll out of DatixWeb GC: Fully imbed Quality Impact Assessment review process GC: Fully imbed CSC performance review process GC: Further develop integrated performance report to include data at CSC level	Sep 12	Apr 13

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)	Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets	• Emergency care model across MAU and ED • Unscheduled care Programme Board (reps from across health economy) chaired by PHT Medical Director	• Daily monitoring at Trust wide morning matrons meeting • Performance reporting	20 (5x4) RF SMT	20 (5x4)	5 (5x1)	• No explicit schemes to avoid emergency admissions are yet in place for 2012/13 • Lack of any formal agreement in respect of organisational penalties for failing to deliver on agreed actions to support reduction in emergency admissions • Integrated care organisation in development	• Unable to measure effectiveness of controls at present as Programme Board is in its infancy	GC: Ensure that all projects set up with an objective of reducing emergency admissions have explicit performance metrics agreed and that there are agreed consequences/penalties for non delivery of individual partners on actions agreed GC: ensure the requirement to agree specific performance metrics is included in any development workshops and meetings during project set up. GA: Performance reporting on the delivery of agreed actions by partner organisations	Sep 12	Apr 13
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 • Bed rebalancing	• Trust-wide KPIs and monthly Integrated Performance Report	9 (3x3) AG SMT	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. GA: Productivity and efficiency KPIs are under development and will be included in future monthly Integrated Performance Reports	Oct 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

- Create an Integrated Care Organisation for high risk groups
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2.3 (6)	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	• Medical Director participating in AHSN discussions with UHS • Trust R&D Strategy and framework • R&D income monitored by R&D Director	• Medical Director reporting back to Board on discussions • R&D income year on year increase	10 (5x2) SH SMT	10 (5x2)	5 (5x1)	• R&D Strategy requires review	• Quarterly R&D Board reporting to be established	GA – New quarterly R&D report to be submitted to the Board GC – R&D Strategy to be updated in 2012/13	Nov 12	Mar 14

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 is unable to provide required capacity for scheduled care services on a sustainable basis	• Detailed specialty-level activity plans • Weekly waiting list and theatre utilisation assurance meetings • Demand/capacity modelling at a specialty level • Contractual trigger points relating to increased demand and patient backlogs at a specialty level	• No non-clinical cancellations of elective activity • Achievement of Operating Framework targets • Reduction in patient backlogs to the level required for sustainable target delivery • Reduced average waiting times for the majority of specialties (year-on-year basis)	12 (4x3) AG SMT	12 (4x3)	4 (4x1)	• Not all specialties have sufficient capacity to meet demand on a sustainable basis • Some patients wait more than 18 weeks for treatment • Contracted activity levels transfer some of financial risks of reducing waiting times to 'best in region' to the Trust	• The impact of variations in unscheduled care demand on scheduled care lengths of stay has not been quantified • Benchmarked waiting times are not monitored on a consistent basis at a specialty level •	GC: All specialties have developed plans to ensure sufficient capacity for sustainable target delivery from Q2 2012/13 GC: Specialty-level management of patient lists to reduce waiting times on a sustainable basis GC: 2013/14 contractual process GC: related financial support from commissioners required GA: Information services review	Oct 12	Mar 14
3.2 (26)	Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from: • Failures to target growth in appropriate specialties; and/or • Failures to achieve the profile of targeted elective activity growth	• Trust Planning & Capital Investment Committee • Annual planning process • Quarterly Board review	• Annual Plan • Quarterly Business Development report	16 (4x4) AG SMT	16 (4x4)	4 (4x1)	• Targeting of specialty growth is not undertaken on a systematic basis	• N/A	GA/GC: Phased targeting of specialties to be based on market and pathway analysis (to include specific assurance measures) GA/GC: Refresh of annual planning process	Oct 12	Mar 13

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
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- Grow private patient business year on year

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3.3 (4)	Insufficient evidence to enable effective analysis and identification of best practice elective pathways Insufficient medical and / or operational engagement to implement changes to pathways	• Definition and documentation of key elective pathways • On-going professional management processes	• Benchmarked service-level lengths of stay	12 (3x4) RF SMT	12 (3x4)	3 (3x1)	• Information systems and processes do not allow for the continuous analysis of elective pathways	• Information systems and processes do not enable lengths of stay to be continuously and systematic benchmarking of length of stay	GA/GC: Information services review	Oct 12	Mar 14
3.4 (6)	Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	• Clearly defined stakeholder management system • Medical Director meets GP Clinical Leads on weekly basis • Company Secretary meets OSCs on a regular basis • Outbound media relations	• Stakeholder feedback – largely informal	12 (4x3) RF SMT	12 (4x3)	4 (4x1)	• Lack of funding for communications team makes it difficult to achieve comms objectives • Senior clinicians have limited time to engage effectively with local GPs	•	GC – design more effective/efficient communications team function within budgetary constraints GC – Explore areas requiring job plan review	Oct 12	Mar 14

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. • Director of Education appointed • Strategic Education Board	• Strategic Education Board in place. • Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback).	12 (4x3) RK WSC	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.	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 – implemented for W & C and Medicine • 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 WSC	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.	Oct 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

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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. • Integrated performance report to Board included staff feedback	12 (3x4) RK WSC	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.	GA – review of internal communication process including team-brief.	Oct 12	Apr 13
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 WSC	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 – completed at Executive level	Dec 12	Apr 13

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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. • Speciality specific attraction strategies developed for CSCs in difficult to recruit areas • Executive sign off required for temporary spend	• 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 WSC	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 GA – full deployment of e-rostering system. GC: Mobilisation of existing workforce GC: Review of corporate functions	Oct 12	Apr 13

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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 WSC	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	Apr 13

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Responsible Executive: Finance and Investment Director

- Become a Foundation Trust in 2013/14
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5.1 (26)	Inability to achieve Foundation Trust status within the agreed timetable	• Dedicated FT project support • FT project plan • FT project Committee • Trust Board and Transformation Committee scrutiny • Performance management systems • Public published tripartite formal agreement • Project managed against TFA milestones	• Monthly FT pipeline paper presented to Trust Board shows milestones being achieved • KPMG Board governance Framework Assessment • Operational key targets being achieved • Monitor quality framework targets on trajectory	12 (4x3) BC TB	12 (4x3)	4 (4x1)	• Financial performance off trajectory at month 4	• Financial report shows Trust plan currently in deficit	GC/GA: Recovery plan to be implemented to restore financial performance GA: PWC to conduct historical due diligence (Phase1) GA: RSM Tenom to undertake external quality governance assessment	Oct 12	Mar 14

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5.2 (26)	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure.	• Finance reporting and monitoring mechanisms at CSC to Board level • Updates on Financial position provide to Board, SMT Finance Committee and Transformation Committee • Delegated budgetary control framework • Trust wide savings and transformation programme • Income and contract monitoring arrangements • Trust financial recovery plan with actions.	• Income position performing better than planned due to activity being above planned levels • Majority (>90%) of savings schemes are being delivered and robust plans in place for remainder of the year.	16 (4x4) SG FC	16 (4x4)	12 (4x3)	• Controls in respect of workforce expenditure not having required impact. This is especially true in respect of temporary staffing where costs have exceeded historic peaks at c£2m per month.	• Gaining evidence in respect of temporary staffing controls on a weekly basis remains a challenge. System remains reliant on accuracy of information provided by CSC's and Departments.	GC – Controls around temporary workforce have been escalated such that all temp spend requires Exec Director sign off. GC – A range of additional savings schemes have been implemented as part of the Trust's recovery plan. This includes several 'corporate' aimed at reducing temporary staffing spend such as closing capacity and switching off specific projects.	Sep 12	Mar 13

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5.3 (26)	The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners.	• Monthly contract monitoring reports • Monthly contract review meetings • Income Protection Group • Monthly CSC performance meetings	• Monthly contract monitoring reports and meetings currently providing assurance that the Trust is managing this risk.	12 (4x3) SG FC	12 (4x3)	8 (4x2)	• Current monthly reports do not adequately expose the financial risk (especially at CSC level).	• Delays in agreeing final details of local CQUIN scheme does present risk in terms of transparency of Trust's performance against this scheme.	GC: Monthly reports continue to be revised to ensure they meet requirements of both the Trust as a whole and the need for responsibility and ownership at CSC level. GA: As final details are confirmed this will be reflected in the existing monitoring process.	Sep 12	Mar 13
5.4 (26)	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	• 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	• Monthly reporting to Transformation and Finance Committees currently providing assurance that >90% of savings are being delivered.	12 (4x3) SG FC/ TC	12 (4x3)	8 (4x2)	• Month 4 position shows some workstreams as being considerably off plan with corrective action required. Most notably the workforce project.	•	GC: Corrective actions have been implemented as part of the recovery plan process. Including escalation of controls and specific remedial actions.	Sep 12	Mar 13

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5.5 (4)	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	• Current working partnership with IPHIS	• None	6 (3x2) DH ITSG	6 (3x2)	3 (3x1)	• New IT Strategy currently under development which will set out the future direction and key milestones	• New IT strategy not agreed or implemented	GC/GA – IT Strategy to be published September 2012	Oct 12	Oct 13

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