TRUST BOARD PART I – OCTOBER 2012

Agenda Item Number: 171/12
Enclosure Number: (7)

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 • Top risks • Increase of risks 2.2, 3.1, 3.3, 5.2, 5.4 • Decrease of risks 1.1 and 4.1 • Re-description of risk 3.3
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 November 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: October 2012

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 16 October 2012

Top Risks

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

2.2 ▲ (Red 20): The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards

5.2 ▲ (Red 20): 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

5.4 ▲ (Red 20): 2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position

3.1 ▲ (Red 16): The Trust is unable to provide required capacity for scheduled care services on a sustainable basis

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

3.3 ▲ (Red 15): Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness

New Risks

Nil

Risks with an Increased Score

2.2 ▲ (Amber 9 to Red 20): The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards – reports show failure of some targets

3.1 ▲ (Amber 12 to Red 16): The Trust is unable to provide required capacity for scheduled care services on a sustainable basis– reports show failure of some targets

3.3 ▲ (Amber 12 to Red 15): Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness – some specialties failing targets

5.2 ▲ (Red 16 to Red 20): 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 – reports show unlikely to reach plan

5.4 ▲ (Red 16 to Red 20): 2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position – reports show planned savings not being achieved

Risks with a Decreased Score

1.1 ▼ (Amber 12 to Amber 8): Inability to maintain ongoing compliance with all CQC standards - CQC report shows compliance

4.1 ▼ (**Amber 12 to Amber 8):**	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust – Education Outcomes Framework now established

Risks to be Removed

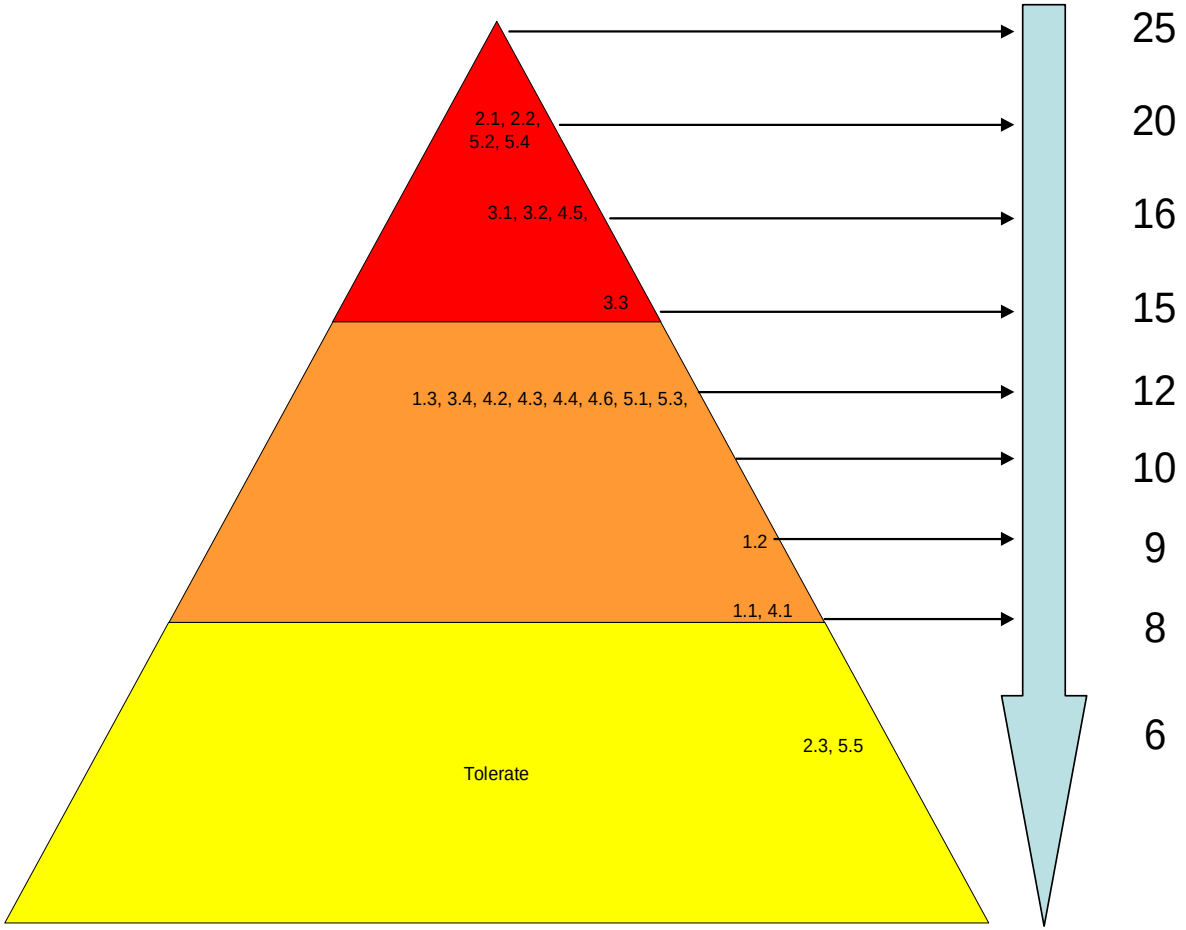
Nil

Target Date Changes

2.2	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards – realigned to year end

Prepared by:	Annie Green – Risk Coordinator
Presented by:	Peter Mellor – Company Secretary

Trust Risk Snapshot – October 2012



Trust Risk Profile - October 2012

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)					
Unlikely (2)			2.3 Growth in R&D ◄ ► 5.5 Information Technology strategy◄ ►	4.1 Learning and education outcomes ▼	
Possible (3)			1.2 Inpatient survey ◄ ►	1.3 Quality of services and patient safety ◄ ► 3.4 Relationships with commissioners ◄ ► 4.2 Performance management ◄ ► 4.4 Capability of leadership ◄ ► 4.6 Unfilled critical posts ◄ ► 5.1 Foundation Trust status ◄ ► 5.3 Contract penalties ◄ ►	
Likely (4)		1.1 CQC Standards ▼	4.3 Engagement of workforce ◄ ►	3.1 Scheduled care capacity ▲ 3.2 Growth of targeted specialties ◄ ► 4.5 High level of temporary staff ◄ ►	2.1 Insufficient reduction in ED admissions ◄ ►
Highly Likely (5)			3.3 elective pathways ▲	2.2 Patient flow ▲ 5.2 Failure of budgetary control ▲ 5.4 Delivery of savings targets ▲	

ASSURANCE FRAMEWORK 2012/13 PROGRESS SUMMARY - October 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	12	8						Jan 13	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	9	9						Dec 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	12	12						Nov 12	8 Apr 13
2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE	2.1 RF	Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets	SMT	16			20	20	20	20	20						Dec 12	5 Apr 13
	2.2 RF	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	9	20						Dec 12	4 Apr 13
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	6	6						Jan 13	3 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	12	16						Jan 13	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	16	16						Jan 13	4 Mar 14
	3.3 AG	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness	SMT	4					12	12	15						Jan 13	3 Mar 14
	3.4 RF	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	12	12						Jan 13	4 Mar 14
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	SEC	All	12	12	12	12	12	12	8						Feb 13	4 Apr 13

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		
TP	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	SEC	All	12	12	12	12	12	12	12						Dec 13	8 Apr 13
	4.3 RK	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities	SEC	14	12	12	12	12	12	12	12						Feb 13	6 Apr 13
	4.4 PS	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change	SEC	14	12	12	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	SEC	13	16	16	16	16	16	16	16						Dec 12	8 Apr 13
	4.6 PS	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes	SEC	13	12	12	12	12	12	12	12						Jan 12	6 Apr 13
5: ENSURE SUSTAINABILITY	5.1 BC	Inability to achieve Foundation Trust status within the agreed timetable	TB	26					12	12	12						Dec 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	16	20						Nov 12	12 Mar 13
RE	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	12	12						Nov 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	16	20						Nov 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	6	6						Dec 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 12 for consent to termination of pregnancy compliant • CQC report September 2012 declaring Trust compliant with Outcome 21	12 (4x3) FMcN G&Q	8 (4x2)	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 GC: Completed action plan submitted to CQC for a desk top review; Report received, declaring compliance with outcome 21. No outstanding improvement actions and compliant with all outcomes.	Jan 13	Apr 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
1.2 (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 Responsible lead has no update to provide	Dec 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	Nov 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
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**
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 • Underuse of discharge lounge in critical early morning period • New Trust project to introduce Ambulatory Care Programme not implemented	• 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/GA: 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 GC: Discharge improvement group established – effective use of discharge lounge to be enforced with nursing staff GC: Agree and implement Ambulatory pilot in Respiratory and follow with Trust wide roll out in other key areas. GC: develop and implement discharge to access ward for older patients GC: top 20 frequent presenters to ED reported to community partners – awaiting response	Dec 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
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
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 • Weekly discharge improvement meetings to improve quality and speed of discharges	• Trust-wide KPIs and monthly Integrated Performance Report	9 (3x3) RF SMT	20 (4x5)	4 (4x1)	• Volume and hourly profile of attendances • Continued high numbers of medically stable patients awaiting discharge • Inconsistent implementation of patient flow policies across the Trust • Insufficient medical cover overnight and at weekends • Insufficient overnight duty managers	• 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 GC: undertake 2 month pilot of full capacity protocol in Cardiology and Respiratory to increase morning capacity. GC: decision pending to agree purchase of Medicare service on a pilot basis GC: review medical rostering	Dec 12	Apr 13
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	6 (3x2)	3 (3x1)	• 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	Jan 13	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
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**
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 refreshed periodically • 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	16 (4x4)	4 (4x1)	• Not all specialties have sufficient capacity to meet demand on a sustainable basis • Some patients wait more than 18 weeks for treatment - requiring planned failures of RTT targets in 2 Specialties to ensure sustainability • Contracted activity levels transfer some of financial risks of reducing waiting times to 'best in region' to the Trust	• Integrated Performance report shows not all Specialties achieving RTT targets	GC/GA: All specialties are updating plans to ensure sufficient capacity for sustainable target delivery GC/GA: 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 GC: implement management of flow initiatives as detailed in 2.2	Jan 13	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	Jan 13	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
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**
3.3 (4)	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness.	• On-going operational management processes	• Performance against standards and targets as shown in Integrated Business Report	12 (3x4) AG SMT	15 (3x5)	3 (3x1)	• Planned failure of RTT targets as reported in Integrated Performance Report partly due to inefficient pathways • Unsustainable Ophthalmology activity	• The Trust's benchmarked performance against MEQO (Midlands and East Quality Observatory) dashboard metrics is not consistently in upper quartile	GC/GA: Speciality specific performance recovery plans developed to be implemented end Oct 12 GC/GA: Ophthalmology outsourcing to commence Oct 12 GC/GA: implement management of flow initiatives as detailed in 2.2	Jan 13	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 • Internal communication requires improving to establish a consistent approach to working with commissioners	•	GC – design more effective/efficient communications team function within budgetary constraints GC – Explore areas requiring job plan review GC: Increase contract team's understanding of operational and capability requirements	Jan 13	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
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**
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). • Learning and Education Strategy	12 (4x3) RK SEC	8 (4x2)	4 (4x1)	• Education Outcomes Framework not implemented Trust Wide	• There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes.	GC/GA – development and deployment of the education outcomes framework – completed ready to pilot in January until March with Trust roll-out to follow	Feb 13	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 • SHA funded performance appraisal project for consultants introduced	• Significant improvement to staff survey results for effectiveness of appraisal • Performance assurance project board established.	12 (4x3) RK SEC	12 (4x3)	8 (4x2)	• Variation in performance at CSC and individual level. • Consequence management framework established - but requires evaluation.	• Appraisal performance measures currently only look at compliance with no individual rating scale evident. • Compliance with appraisal currently below target of 85% completion at 81%	GC / GA – review of performance appraisal process to introduce ratings and consequence management frameworks – ongoing GC/GA: CSC action plans in place to ensure compliance with appraisal target is achieved by end on month 7	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
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**
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 SEC	12 (3x4)	6 (3x2)	• Staff survey results still show lower than acceptable scores against some key findings – PULSE surveys show some improvement	• Results of 2012 national staff survey not available until Feb 12	GC/GA – review of internal communication process including team-brief. GC/GA – workforce engagement task and finish group established to review core messages and communication tools for staff to recommend actions by end of Dec 12	Feb 13	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. • 360 and self-assessment completed at Executive level • Trust wide leadership competencies identified • Delivery of Working Together for Patients on plan	• Utilisation of existing leadership development programmes. • SHA funded projects in development including team based working.	12 (4x3) PS SEC	12 (4x3)	8 (4x2)	• Expectations of leaders not clearly defined. • Managing development framework to be defined • All relevant staff have not undertaken Working Together for Patients	• There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.	GC/GA – development of talent management process to capture potential future leaders GC/GA – use of Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level GC/GA – roll out Working together for Patients to agreed timescale	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
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**
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. • 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 • Ongoing recruitment of nursing staff	• 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 SEC	16 (4x4)	8 (4x2)	• Temporary resource currently above planned level of 3%. • Reduction in Junior Doctor resource will increase demand for consultants in some specialities. • Attraction strategy needs further development to enable recruitment of high level candidates. • Only one University intake per annum for newly qualified nurses results in excessive vacancy fluctuation	• Reporting of workforce metrics does not facilitate early decision making.	GA – full deployment of e-rostering system - ongoing. GC: Mobilisation of existing workforce – ongoing where applicable GC: Review of corporate functions – ongoing GC – Attraction Strategy to be defined for 2013/14 intake. GC – concern raised with LETB for discussion with higher education institutions	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
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**
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 filled.	12 (3x4) PS SEC	12 (3x4)	6 (3x2)	• Performance appraisal does not capture career progression potential. • Process for defining and identifying those with potential is not established. •	• 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 – Board to be completed by end Nov 12 followed by Management Teams by year end. GA – Succession plans at senior management level to be developed	Jan 13	Apr 13

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

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**
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 • Integrated Action Plan – HDD, BGAF and Quality Governance	• 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 • PWC – HDD Phase 1 Report • RSM Tenon – External Review of Quality Governance •	12 (4x3) BC TB	12 (4x3)	4 (4x1)	• Financial performance off trajectory at month 5	• Financial report shows Trust plan currently in deficit	GC/GA: Recovery plan to be implemented to restore financial performance	Dec 12	Mar 14

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

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**
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. • Temporary staffing levels have reduced in Aug 12 by £0.5m and by a further £0.2m in Sept 12	16 (4x4) SG FC	20 (4x5)	12 (4x3)	• Controls in respect of workforce expenditure have been slow in having required impact. This is especially true in respect of temporary staffing where costs have exceeded historic peaks at c£2m per month, although some improvement has been observed in Aug and Sep12. • Insufficient control and scrutiny surrounding individual CSC financial management	• Trust financial position at the end of Sep 12 remains a significant concern with the Trust reporting a £7.4m deficit • 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. GC – monthly accounts review meetings have been established by the new interim Finance Director. The purpose of which is to review each CSCs financial position in detail and agree recovery actions. The meetings will commence early Oct 12.	Nov 12	Mar 13

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

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**
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.	Nov 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 70% of savings are being delivered.	12 (4x3) SG FC/ TC	20 (4x5)	8 (4x2)	• Current actions do not enable the Trust to deliver the required level of savings	• Month 6 savings position shows the Trust is now £3.2m adrift of it's planned savings target at this point in the year. This is due to underachievement on the Workforce and Non-Pay schemes. • The latest review of all Trust's savings plans indicates that the Trust is only likely to deliver £22.5m of savings by the end of the year. This is £4.5m adrift of target	GC/GA: A weekly Recovery Group established to review and agree additional proposals to address the shortfall in current plans	Nov 12	Mar 13

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

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**
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 • Draft updated strategy being discussed at Board/SMT	• 2011-12 IT strategy • 2012-13 IT strategy presentation • IPHIS SLA • IPHIS risk register • IPHIS projects log	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	Dec 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
RE	Richard Eley		FC	Finance Committee		KPI	Key Performance Indicator
RF	Roberta Fuller		ITSG	Information Technology Steering Group			
AG	Alistair Glen		PEWG	Patient Experience Working Group			
SG	Steve Gooch		SEC	Strategic Education Committee			
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						
PS	Paul Sadler						
CW	Cherry West						