Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – FEBRUARY 2012

Agenda Item Number: 23/12
Enclosure Number: (5)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Sheena King – Head of Risk Management Peter Mellor – Company Secretary Peter Mellor – Company Secretary
Purpose of paper *Why is this paper going to the Trust Board?*	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Trust Board are asked to note • Top risks • Increase of risk 1.2 to a score of 12 • Decrease of risks 6.3 to a risk score of 12 and 6.5 to a risk score of 8
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 March 12.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: February 2012

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 17 January 2012

Top Risks

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

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

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

New Risks

Nil

Risks with an Increased Score

1.2 ▲ (Amber 9 to Amber 12): Inability to maintain ongoing compliance with all CQC standards – pending report from recent CQC responsive review

Risks with a Decreased Score

6.3 ▼ (Red 16 to Amber 12): 2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position – internal CIP on target

6.5 ▼ (Red 16 to Amber 8): Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan – estates rationalisation has closed deficit.

Risks to be Removed

Nil

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

Presented by: Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2011/12 – PROGRESS SUMMARY – JANUARY 2011

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	
1. To provide best care as measured by clinical effectiveness, safety and patient experience (JD/SH)	FMcN (G&C)	1.2	Inability to maintain ongoing compliance with all CQC standards	ALL	12	9	12										6 Feb 12
	CM (ICMC)	1.3	Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, identified at or more than 72 hours of admission	8	16	16	16										4 Mar 12
	SB (SPSSG)	1.4	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	16	9	9	9										3 Mar 12
2. To be the hospital of choice for patients (JD/SH)	SW (EMT)	2.1	Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant inability to support other specialties, detriment to patient experience and increase in required CIP.	13	15	15	15										10 Apr 12
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (RK)	PG (SMT)	3.2	Inability to achieve and maintain Trust target of 85% compliance with statutory and mandatory training requirements by Q4 2011/12	14	6	9	9										3 Mar 12
	SC (SPSSG)	3.3	Failure to engage all staff in the PHT *'Bringing Values to Life'* campaign	16	6	6	6										3 Jul 12
	SC (SSCSG)	3.4	Trust fails to achieve improvement in staff satisfaction in line with the quality contract requirement to be placed above the bottom 20% of acute Trusts nationally for each key finding.	14	9	9	9										6 Jan 12
4. To be the employer of choice in South East Hampshire (RK)	RK (SMT)	4.1	Inability to attract the best staff to PHT, and continue to engage and motivate our current staff will compromise our ability to offer the best care	13	4	4	4										1 Jan 12
5. Be in the top quartile of NHS hospitals for 95% of all services we provide (CW)	CW	5.1	The Trust breaches emergency department quality standard key targets – A & E Patient Impact, A & E Timeliness	4	6	6	6										3 Mar 12
	CW	5.2	The Trust fails to achieve the required referral to treatment targets for admitted patients and reduce the 18 week admitted backlog.	4	9	9	9										3 Mar 12
	CW	5.2A	The Trust fails to achieve the required referral to treatment targets for non-admitted patients and reduce the 18 week admitted backlog.	4		9	9										3 Mar 12

STRATEGIC AIM Executive Lead	OPERATIONAL LEAD RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)		CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												TARGET (RESIDUAL) RISK SCORE/DATE TO ACHIEVE
					NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	
	CW	5.3	The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required level	4	6	6	6										3 Mar 12
	CW	5.4	The Trust breaches required cancer referral/screening to treatment standards.	4	3	3	3										3 Mar 12
	CW	5.5	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	4	9	9	9										3 Mar 12
6. Work with our partners to create a sustainable economic enterprise, which eliminates waste and provides real value for money (RT)	SG (TAC)	6.2	The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration	26	20	16	16										8 Mar 12
	SG (TAC)	6.3	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	26	16	16	12										8 Mar 12
	SG (TAC)	6.4	The Trust's need to deliver £30.5m of savings in 2011/12 has a detrimental impact on the quality of services provided to patients	26	12	12	12										8 Mar 12
	DH (TAC)	6.5	Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan and to achieve Foundation Trust Status	26	16	16	8										8 Mar 12

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

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**	
1.2 (All)	Inability to maintain ongoing compliance with all CQC standards	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • NHSLA Level 1 accreditation (Feb 10) • Accepted for CQC registration without conditions 2010/11 • CSC risk registers • Mock CSC assessments and associated action plans • Monitor Quality Risk Profile monthly • Quarterly evidence and action plan review panels established including NED • CQC awareness sessions • Trust wide action plans for medicines management and privacy and dignity • Action plan to address minor concerns for ongoing compliance with outcome 1 and 5	• Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues) • Clinical dashboards / quality metrics • CSC governance reports • Mock CSC assessments • Outcome of second quarterly evidence review panels show continued improvement in outcome focused evidence • Internal CQC audit (Deloitte) Apr 11, demonstrating substantial assurance. • CQC Jul 11 report for Outcome 1 (privacy & Dignity) and Outcome 5 (Nutrition) demonstrates overall compliance • Compliance audits	12 (3x4) FMcN G&Q	12 (4x3)	6 (3x2)	• None	• CQC report following responsive review received. Moderate concern against outcomes 4 and 9. Compliant with remaining 5 outcomes assessed although minor improvement actions required for outcomes 6, 7 and 13. Action plan in place to address concerns raised. • Following weekly meetings with DoN, Director of Pharmacy, HoG and CSC management team, non compliance with outcome 9 has been downgraded to a minor concern as the action plan has progressed significantly in the last 4 months. • Follow-up responsive review on 3rd and 4th January. Awaiting report from CQC	New process to commence at next panel in February 12 3 remaining actions related to management of medicines – on target to be closed end of March 12 For ongoing monitoring until all actions complete GA: continue weekly review to monitor completion of action plan. GA: action plan to be monitored monthly by Governance and Quality Committee	Feb 12 Mar 12 Ongoing Mar 12	Review Feb 12

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

Responsible Executive: Director of Nursing/Medical Director

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1.3 (8)	Trust fails to achieve monthly and annual trajectories for hospital acquired cases of C. Difficile infection, at or more than 72 hours of admission, thus prejudicing Trust's compliance to the Health & Social Care Act, Outcome 8 of CQC registration and overall Trust CQC registration. This may result in poor patient outcomes – including safety, experience and consequently damage to Trust reputation	• C.Diff reduction action plan • All emergency corridor patients with diarrhoea tested for C. Diff • Weekly C. Diff MDT ward rounds • Daily review by Infection Prevention & Control team to ensure optimal management of patients with C. Diff • Enhanced cleaning and decontamination of patient environment • Trust wide antimicrobial ward rounds between microbiology and pharmacy • Amber incident investigation for failures to isolate symptomatic patients within 4 hours • Diagnostic testing to identify C.Diff carriers	• Monitoring at ward, CSC and Trust level through clinical dashboards • Dec 1 case below trajectory for year • Isolation of suspected C.Diff patients included in performance indicators at CSC level	**16 (4x4)** **CM ICMC**	**16 (4x4)**	**4 (4x1)**	• Not all elements of the reduction action plan in place • Need to revaluate efficacy of sproacidal agents used in the Trust with a view to improve cleaning • Nurse led cleaning of near patient environment requires improvement • Need to ensure appropriate testing for C. Diff • Need to ensure timely isolation (≤ 4 hours from start of symptoms) • Lack of resource to allow diagnostic C.Diff testing of GP samples • Lack of funding from commissioners to allow full testing of all GP samples for C Diff.	• Monitoring shows trajectory missed for first six months of 2011/12, • GDH testing will initially increase number of known C.Diff carriers • Results show an average of 50% of patients not being isolated as required • Growing body of evidence in literature to suggest that hypochlorite may not be the most effective agent available – high ATP scores still being detected from rooms with C.Diff patients • More than 80% of GP samples do not get a C.Diff diagnostic test • Approximately 8% of samples are inappropriate	GC/GA: review meetings plan with Carillion soft FM to trial new cleaning products – trial scheduled Jan 12 GC/GA: escalate plans for bed cleaning bureau and equipment library. GC/GA: gain funding from commissioners to accommodate required C.Diff diagnostic testing	Jan 12 ongoing Feb 12 Apr 12	Mar 12

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE Responsible Executive: Director of Nursing/Medical Director												
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1.4 (16)	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	• Trust wide action plan • Discharge operational Group	• Not available until national survey results published	9 3x3 SB SPSS G	9 3x3	3 3x1	• **None**	• Lack of real time patient feedback	GC: complete information prescription pilot for urology, diabetes, respiratory and cancer and evaluate.	Mar 12	Mar 12

STRATEGIC AIM 2: TO BE THE HOSPITAL OF CHOICE FOR PATIENTS Responsible Executive: Director of Nursing/Medical Director											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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2.1 (13)	Implementation of the South Central Strategic Health Authority proposal to centralise provision of vascular surgery results in the loss of service from PHT with concomitant impact on level of support to other specialties, detriment to patient experience and increase in required CIP.	• Independent media campaign to retain service • Local council member support	• Referral to Portsmouth & Hampshire Health Overview & Scrutiny Committee	15 5x3 SW SMT	15 5x3	10 5x2	• none	• None	GC/GA: three month consultation process commencing January 2012		Review Apr 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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3.2 (14)	Inability to achieve and maintain Trust target of 85% compliance with statutory and mandatory training by Q4 2011/12	• Diverse training delivery methods • Robust compliance recording • Increased essential update sessions • Regular performance review of CSC compliance with Trust target • Traffic light reports issued to each CSC identifying staff training requirements • Essential skills training transferred to ESR • Updated MOTs for ESR	• None	6 (3x2) PG SMT	9 (3x3)	3 (3x1)	• Incomplete Trust wide training needs analysis • Departmental staff reductions may impact on ability to meet target dates	• Currently not achieving 2011/12 target	GC: CSCs to review and evaluate job descriptions to identify essential skill needs for each relevant staff group. Learning and Development team to update identified requirements for ESR – 1 CSCs yet to return data. Data inputted to ESR for CSCs and being audited for accuracy GC: South Central SHA standardised learning package to be recommended to Trust Board for acceptance to replace elements of Essential Training and release trainers to focus on priority areas for training. PHT to work with SHA on introducing a Skills Passport which will enable training undertaken in other organisations to be recognised in PHT.	~~Oct 11~~ Feb 12 Feb 12 Apr 12 Apr 12	~~Oct 11~~ Review Mar 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer											
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3.3 (16)	Failure to engage all staff in the Trust *'Bringing Values to Life'* campaign	• Staff and Patient Satisfaction Steering Group (SPSSG) • Communications Strategy • Key communicators in each CSC • Briefing sessions for managers • 'Best People' awards • CEO Weekly Message, Team Brief and Open Forum • 'real time' staff pulse surveys • Team brief cascaded to all staff via line managers • Trust Values DVD	• Increase in staff satisfaction through Pulse surveys	6 (3x2) SC SPSSG	6 (3x2)	3 (3x1)	• Four core values not incorporated into all HR policies • Further engagement of staff required • Values not incorporated into recruitment process	• Results of national staff satisfaction survey show improvement but concerns in key areas	GC: agree and introduce 'standard values' paragraph to be included in all HR policies and procedures GC: re write policies and associated documents and introduce values based recruitment GC: introduce values pledge key card - postponed	Jul 12 ~~Nov 11~~ Mar 12	Jul 12

STRATEGIC AIM 3: TO ACHIEVE OUR STRATEGIC AIMS, THROUGH LIVING OUR VALUES AND THROUGH THE SKILLS AND PERSONAL DEVELOPMENT OF OUR STAFF Responsible Executive: Chief Operating Officer											
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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3.4 (14)	Trust fails to achieve improvement in staff satisfaction in line with the quality contract requirement to be placed above the bottom 20% of acute Trusts nationally for each key finding.	• Staff Satisfaction Campaign Steering Group (SSCSG) • Improvement plan to address 9 key findings • Individual CSC improvement plans • Agreed establishment with associated recruitment to nursing posts • Staff suggestion scheme – Pound Saving Ideas • CSC employee of the month award • Pulse Survey • CSC leaders recognition and engagement programmes	• Not available until national staff survey results Mar 12	9 (3x3) SC SSC SG	9 (3x3)	6 (3x2)	• Survey results show • The quality of a percentage of appraisal is unsatisfactory • Organisational information is not communicated to all staff • Lack of staff recognition • Lack of engagement with senior leaders	• Pulse survey does not contain all relevant questions • Lack of appraisal quality data	GC: incorporate values into appraisal process GC: ensure use of ESR appraisal template GC: audit the cascade of team brief – included in new pulse survey Nov 11 GC: publicise information to improve work-life balance Trust wide GA: audit of appraisals in each CSC- ongoing	~~Sep 11~~ Dec11 Jan 12 Jan 12 Completed and ongoing Review Jan 12	Review Jan 12

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

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

STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE Responsible Executive: Chief Operating Officer												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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5.1 (4)	The Trust breaches emergency department quality standards key targets – A & E Patient Impact A & E Timeliness	• Key performance indicators • Patient flow project	• Monthly COO's Operational Performance Report • Assessment to arrival pilot undertaken in July, showed improvement	9 3x3 CW	6 3x2	3 3x1	• Common pathway developed for all patients to achieve rapid assessment and start of treatment	• Monthly COO's Operational Performance Report	GC/GA: review September pilot findings GC/GA: Revised model being piloted GA: undertake further audit and monitoring of unscheduled returns in both majors and minors		Mar 12
5.2 (4)	The Trust fails to achieve the required referral to treatment targets for admitted patients and reduce the 18 week admitted backlog.	• Key performance indicators • Clinically urgent and MOD patients managed in order of clinical priority • Demand management workstream • Routine patients booked in turn • Additional capacity agreed with PCTs • PCT 'red flag' orthopaedic referrals • PCT contacting patients offering choice of treatment with the ISTC	• Monthly COO's Operational Performance	9 3x3 CW	9 3x3	3 3x1	• 18 week backlog impacting on 95th percentile • 18 week backlog impacting on 90% admitted performance	• Monthly COO's Operational Performance Report	GC/GA: activity plan and trajectory in place to clear the admitted backlog, and monitored GC/GA: demand management schemes in place and monitored GC/GA: additional capacity to clear backlog		Mar 12

STRATEGIC AIM 5: TO BE IN THE TOP QUARTILE OF NHS HOSPITALS FOR 95% OF ALL THE SERVICES WE PROVIDE Responsible Executive: Chief Operating Officer												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target**	
5.2A (4)	The Trust fails to achieve the required referral to treatment targets for non-admitted patients and reduce the 18 week admitted backlog.	• Hand and foot referrals redirected to other providers by PCT • Additional validation of non-admitted waiting lists • Additional capacity to reduce out-patient waits	• Monthly COO operational performance report to review 95% standard • Weekly waiting list assurance meetings	9 3x3 CW	9 3x3 CW	3 3x1	• > 18 week out-patient waits impacting on 95th non-admitted performance	• Monthly operational performance report	GC/GA:		Mar 12
5.3 (4)	The Trust fails to manage demand and capacity to reduce the number of > 6 week diagnostic breaches to required level	• Key performance indicators • Extra manpower sourced for ultrasound demand • Additional screener accredited • Increased colonoscopy capacity	• Monthly COO's Operational Performance Report – reported a decrease in breaches and diagnostic trajectory improvement for Sep 11	9 3x3 CW	6 3x2	3 3x1	• Insufficient capacity to reduce non-obstetric ultrasound patient waits	• Monthly COO's Operational Performance Report			Mar 12
5.4 (4)	The Trust breaches required cancer referral/screening to treatment standards.	• Key performance indicators • Intensive support • Escalation process • Additional screener accredited	• Monthly COO's Operational Performance Report	9 3x3 CW	3 3x1	3 3x1	• Lack of capacity	• Monthly COO's Operational Performance Report	GC/GA: Review of lower GI to be undertaken GGC/GA: new screening requirements may impact on achievement of targets		Mar 12

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5.5 (4)	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	• Key performance indicators • Breach tracking • Agreement with ambulance trust to pre-alert PHT of patient on their way to ED • Escalation process in place for breaches by ambulance Trust	• Monthly COO's Operational Performance Report shows improvement on CT access within 1 hour, CT scan within 24 hours of arrival and high risk TIA patients being seen and treated within 24 hours of first contact.	9 3x3 CW	9 3x3	3 3x1	• Not all patients are directly admitted to Stroke Unit	• Monthly COO's Operational Performance Report (shows 87% direct admission, target 90%)	Breaches now mainly due to asymptomatic presentations		Mar 12

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

Responsible Executive: Director of Finance

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6.2 (26)	The Trust performs a level of activity in 2011/12 that exceeds the cap agreed on the 2011/12 contract. This will effectively mean that the Trust is undertaking activity for no remuneration.	• Monthly contract monitoring reports • Information on Referral levels • Monthly contract review meetings • Escalation procedures as outlined in contract • Planned Care and Unscheduled Care Boards schemes to manage risk	• Revised financial recovery plan agreed with PCT's. This has seen an extra £3.7m invested into the contract baseline to recognise the level of activity being performed above plan. • Beyond this the PCTs have agreed to increase the cap by an additional £4m to recognise over performance on Pbr drug exclusions and activity to improve RTT performance	12 (4x3) SG TAC	16 (4x4)	8 (4x2)	• Timelag in reporting activity means that monitoring is produced 4 weeks after the event.	• The additional investment of £3.7m together with the increase to the cap of a further £4m has helped to reduce the financial risk to the Trust of activity above plan not being paid for. Despite this there remains a possibility that the Trust will perform a level of activity that still exceeds this new investment plus the revised cap.	GC: work with business intelligence team to try and establish weekly early warning system if activity is moving in the wrong direction GA: The Trust will continue to monitor performance against the revised contract baseline and new cap very closely and continue to flag where work is being done in excess of these levels.	Feb 11 - Review position following December's activity information.	Mar 12

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6.3 (26)	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	• Monthly CSC performance meetings • PMO tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements • Turnaround Committee • Sustainability Board	• Monthly reporting to SHA, TB and CSCs • Weekly reporting to TRC • The above shows the Trust has identified plans that amount to its total internal CIP target of £25m except a small shortfall of £91k • Trust is ahead of plan on it's own internal schemes at end of month 9	12 (4x3) SG TAC	12 (4x2)	8 (4x2)	• Retrospective analysis of savings assessment could lead to 6-week lag in detection of target failure • Concern remains around the delivery of the £5.5m of savings associated with reduced activity in relation to PCT demand management schemes	• Trust is slightly adrift (£2,906k) of its overall savings target at month 9. This relates to non-delivery of demand management schemes for the year to date which to a large extent will be compensated by additional income for activity above plan. Once this is taken into consideration the Trust is only £300k adrift of target.	GC: PMO is encouraging the use of lead indicators and milestones; to enable early warning of plans 'off-track' GC/GA: A system wide recovery plan has been agreed to reduce activity levels part of which is ensuring that existing demand management schemes are delivering (see 6.2 above)	Feb 11 – Review at end of quarter 4	Mar 12

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6.4 (26)	The Trust's need to deliver £30.5m of savings in 2011/12 has a detrimental impact on the quality of services provided to patients.	• Quality assurance of plans by CSC management teams. • All Turnaround plans have supporting risk analysis completed highlighting how risks to services will be managed • Review of savings plans at both monthly performance reviews and Turnaround Committee	• Risk assessment performed by CSCs and Corporate workstreams as part of savings plan submission	12 (4x3) SG TAC	12 (4x3)	8 (4x2)	• There is a need to ensure that the risk analysis focuses on the risk to service quality as well as the risk of non-delivery.		GC: clear guidance given to CSCs and Corporate workstreams that they need to report both risks through this mechanism	Mar 11 - Review at end of quarter 4	Mar 12

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6.5 (26)	Challenges associated with ability to ensure the effective delivery of the agreed PHT efficiency plan, as part of the overall whole system plan and to achieve Foundation Trust Status (links to 6.2 and 6.3)	• Turnaround workstreams/CSC initiatives with executive sponsorship • Whole System Sustainability • Planned Care Board • Unscheduled Care Board • Estates Rationalisation Board - Gap in savings plan closed by estates rationalisation	• Monthly CSC performance management & escalation, corporate workstream, finance, workforce and savings reports to TRC • Quarterly risk report to TRC • Minutes of TRC, Whole System Programme Board, SPB reporting Boards • Scrutiny by Non-Executive Director as member of TRC	16 (4x4) DB TAC	8 (4x2)	8 (4x2)	• Projected year end savings with additional income adjustment leaves £300k shortfall	• £5.5m demand management savings reduced due to additional activity delivery, • Ability to deliver activity reductions impacted by numerous parties / interface issues and limited enforceable accountability • Non-Executive Director has resigned	GA: monitor activity plan/actual month by month and track updates to CSC plans for removal of costs associated with removed activity. Production of automated report to enable weekly provision by activity type (BIU/ICT/FIN) GA: DoF to approach Chairman for a replacement non-Executive Director representative for the TRC GC: further scheme may assist to ensure Trust is at break even or surplus at year end.	Ongoing Jan 12 Mar 12	Mar 12

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

Guidance for the Assessment of Risk Rating

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

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

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