TRUST BOARD PART I – APRIL 2012

Agenda Item Number: 57/12
Enclosure Number: (6)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Sheena King – Head of Risk Management Peter Mellor – Company Secretary Peter Mellor – Company Secretary
Purpose of paper *Why is this paper going to the Trust Board?*	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Trust Board are asked to note • Top risks • Reduction of risks 5.2, 6.2, 6.3, 6.4
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 May 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: April 2012

Purpose:
To provide the Trust Board with an update on the Assurance Framework as of 19 April 2012

Top Risks

Nil

New Risks

Nil

Risks with an Increased Score

Nil

Risks with a Decreased Score

5.2 ▼ (Yellow 6 to Green 3): The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit – standard achieved

6.2 ▼ (Red 16 to Amber 8): 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 – year end income position agreed with commissioners

6.3 ▼ (Amber 12 to Amber 8): 2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position – risk unlikely to affect year end break even position

6.4 ▼ (Amber 12 to Amber 8): 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 – to be constantly monitored by CSCs

Risks to be Removed

1.3 (4): 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 – under trajectory at year end. Risk for 2012/13 to be monitored by Infection Control

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

Presented by: Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2011/12 – PROGRESS SUMMARY – APRIL 2012

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	12	9	9							6 Jun 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	16	12	4	To be removed						4 Apr 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	9	9	9							3 May 12
2. To be the hospital of choice for patients (JD/SH)																	
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (TP)																	
4. To be the employer of choice in South East Hampshire (TP)																	
5. Be in the top quartile of NHS hospitals for 95% of all services we provide (CW)	CW (SMT)	5.1	The Trust breaches emergency department quality standard key targets – A & E Timeliness	4	6	6	6	6	9	9							3 Mar 12
	CW (SMT)	5.5	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	4	9	9	9	9	6	3							3 Mar 12
6. Work with our partners to create a sustainable economic enterprise, which eliminates waste and provides real value for money	SG (FC)	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	16	16	8							8 Mar 12
	SG (FC)	6.3	2011/12 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	26	16	16	12	12	12	8							8 Mar 12
	SG (FC)	6.4	The Trust's need to deliver £30.5m of savings in 2011/12	26	12	12	12	12	12	8							8 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	
(RT)			has a detrimental impact on the quality of services provided to patients														
	DH (FC)	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	8	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 (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 including NED • 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 • Outcome of second quarterly evidence review panels show continued improvement in outcome focused evidence • Internal CQC audit (Deloitte) Apr 11, demonstrating substantial assurance. • Compliance audits	12 (3x4) FMcN G&Q	9 (3x3)	6 (3x2)	• None	• Follow-up responsive review on 3rd and 4th January. Update • Final report received: compliant with outcomes 1 and 9, minor concerns with outcomes 4 and 5 and moderate concern with outcome 21. Action plans submitted to CQC. • No further correspondence from CQC. Action plan presented to Governance & Quality Committee 03 April	For ongoing monitoring until all actions complete – Action plan complete. GA: action plan to be monitored monthly by Governance and Quality Committee	~~Mar 12~~ Jun 12 Ongoing	Review ~~Feb 12~~ Jun 12

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

Responsible Executive: Director of Nursing/Medical Director

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Target Date for specific actions Each action RAG rated for progress	Final target date for mitigation of risk RAG rated for progress
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1.3 (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 • Trial bed cleaning	• Monitoring at ward, CSC and Trust level through clinical dashboards • Monitoring shows currently under trajectory • Isolation of suspected C.Diff patients included in performance indicators at CSC level	**16 (4x4)** **CM ICMC**	**4 (4x1)**	**4 (4x1)**	• Need to revaluate efficacy of sproacidal agents used in the Trust with a view to improve cleaning • Need to ensure appropriate testing for C. Diff • Need to ensure timely isolation (≤ 4 hours from start of symptoms)	• GDH testing will initially increase number of known C.Diff carriers • Results show an average of 65% 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 completed, results being reviewed GC/GA: gain funding from commissioners to accommodate required C.Diff diagnostic testing Risk to be removed, under trajectory at year end. Position to be monitored by Infection Control	~~Jan 12~~ Ongoing Apr 12 Complete	Review Apr 12

STRATEGIC AIM 1: TO PROVIDE BEST CARE AS MEASURED BY CLINICAL EFFECTIVENESS, SAFETY AND PATIENT EXPERIENCE Responsible Executive: Director of Nursing/Medical Director												
RISKS		**CONTROLS AND ASSURANCE TO MITIGATE RISK**		**RISK RATING** **Risk Owner** **Responsible Committee**			**IDENTIFIED GAPS IN CONTROLS AND ASSURANCE**		**ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING**	**Target Date for specific actions** Each action RAG rated for progress	**Final target date for mitigation of risk** RAG rated for progress
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1.4 (16)	Failure to improve results of the national Inpatient survey by 3 points as required by CQUIN	• Trust wide action plan • Discharge operational Group	• Not available until national survey results published	9 (3x3) SB SPSS G	9 (3x3)	3 (3x1)	• **None**	• Lack of real time patient feedback • Awaiting final report due Apr 12	GC: complete information prescription pilot for urology, diabetes, respiratory and cancer and evaluate. GA: preliminary report findings show improvement in some areas but not all.	Mar 12 Complete	Review May 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
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**	

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
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**	

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
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	

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**	
5.1 (4)	The Trust breaches emergency department quality standards key targets – A & E Timeliness	• Key performance indicators • Patient flow project • Common pathway developed for all patients to achieve rapid assessment and start of treatment	• Monthly COO's Operational Performance Report	9 (3x3) CW SMT	9 (3x3)	3 (3x1)	• Demand has increased by 9% above predicted	• Monthly COO's Operational Performance Report	GA: undertake further audit and monitoring of unscheduled returns in both majors and minors Update GC/GA: Implement PHT care pathway improvement action plan to support capacity, processes and workforce alignment.		Mar 12
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 SMT	3 (3x1)	3 (3x1)	• Some patients are not directly admitted to Stroke Unit	Update • Monthly COO's Operational Performance Report (shows 91.3% direct admission, target 90%)	Significant and sustained improvement - 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

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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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	Update • Revised year end income position agreed with Commissioners that reflects projected end of year contract performance	12 (4x3) SG FC	8 (4x2)	8 (4x2)	• Timelag in reporting activity means that monitoring is produced 4 weeks after the event.	Update • The 30% Marginal reat for emergency admissions still effectively means the Trust is not receiving payment that covers cost	None	Apr 12 – Final review following year end SLA monitoring reports..	Mar 12
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 • Sustainability Board	• Monthly reporting to SHA, TB and CSCs • 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 FC	8 (4x3)	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	Update • Trust is adrift (£300k) of its overall internal savings target at month 11, which is unlikely to jeopardise achievement of year end break-even 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)	Apr 12 – Review once month 12 savings reported.	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

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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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 FC	8 (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 12 - Review at end of quarter 4	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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6.5 (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 FC	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 • Turnaround Committee now dissolved, transferring responsibility to other major committees e.g SMT, Finance and Transformation Committees	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) GC: further scheme may assist to ensure Trust is at break even or surplus at year end.	Ongoing Mar 12	Mar 12

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