Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – JUNE 2012

Agenda Item Number: 89/12
Enclosure Number: (2)

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 • Re-description of risk 4.1 • New risk 2.2 • Transfer of risk 1.3 from the Trust Risk Register • Reduction of risk 1.2 to a risk score of 6 and 5.3 to a risk score of 3
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented to Trust Board in July 12.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

Portsmouth Hospitals NHS
NHS Trust

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: June 2012

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 19 June 2012

Top Risks

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

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

New Risks

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

2.2 (Amber 9): The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards

Risks with an Increased Score

Nil

Risks with a Decreased Score

1.2 ▼ (Amber 9 to Yellow 6): Inability to maintain ongoing compliance with all CQC standards – increased compliance

5.3 ▼ (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 – target being achieved

Target Date Changes

Nil

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

Presented by: Peter Mellor – Company Secretary

ASSURANCE FRAMEWORK 2012/13 – PROGRESS SUMMARY – JUNE 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
					JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
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	8	12	12	9	9	9	6							6 Aug 12
	IG (SMT)	1.3	Lack of available capacity for patients ready to leave ED causing patients to be cared for in an inappropriate area without the correct levels of staff							20							4 Jul 12
2. To be the hospital of choice for patients (JD/SH)	SB (SPSSG)	2.1	Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in financial penalty up to £436,500	ALL					9	9							3 Feb 13
	CW	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							9							3 Aug 12
3. To achieve our strategic aims, through living our values and through the skills and personal development of our staff (TP)	TP	3.1	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust	14					12	12							8 Mar 13
	TP	3.2	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities	14					12	12							8 Oct 12
	TP	3.3	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	14					12	12							6 Oct 12
	TP	3.4	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.	14					12	12							8 Dec 12
4. To be the employer of choice in South East Hampshire (TP)	TP (SMT)	4.1	Future workforce demand requirements not be met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels	13					16	16							8 Oct 12
	TP (SMT)	4.2	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	13					12	12							6 Jan 13
5. Be in the top quartile of NHS hospitals for 95% of all services we provide	CW (SMT)	5.1	The Trust breaches emergency department quality standards key targets – ED Patient Impact, ED Timeliness	4					9	9							3 Jun 12
	CW (SMT)	5.2	The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog	4					6	6							3 Jun 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
					JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
(CW)																	
	CW (SMT	5.3	The Trust fails to meet standard for stroke care by failing to directly admit 90% of patients to the Stroke Unit	4					6	3							3 Jun 12
6. Work with our partners to create a sustainable economic enterprise, which eliminates waste and provides real value for money (RT)	SG (FC)	6.1	The Trust looses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners	26					12	12							8 Mar 13
	SG (FC)	6.2	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	26					12	12							8 Mar 13
	SG (FC)	6.3	The Trust's need to deliver £27m of savings in 2012/13 has a detrimental impact on the quality of services provided to patients.	26					12	12							8 Mar 13

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 • CQC awareness sessions • Action plan to address minor concerns for ongoing compliance with outcomes 4 , 5 and 21	• Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues) • Clinical dashboards / quality metrics • CSC governance reports • Mock CSC assessments • Internal CQC audit (Deloitte) Mar 12, demonstrating substantial assurance. • Compliance audits • CQC inspection Mar 12for consent to termination of pregnancy compliant	12 (3x4) FMcN G&Q	6 (3x2)	6 (3x2)	• None	• Follow-up responsive review on 3rd and 4th January. • Final report received: compliant with outcomes 1 and 9, minor concerns with outcomes 4 and 5 and moderate concern with outcome 21. Action plans submitted to CQC. • No further correspondence from CQC. Action plan presented to Governance & Quality Committee monthly	GA: action plan to be monitored monthly by Governance and Quality Committee until remaining actions closed. GA: 3 clinical areas (Paediatric, Medicine and Surgery) under review by DoN.	~~Mar 12~~ Aug 12 Ongoing	Review ~~Feb 12~~ ~~Jun 12~~ Aug 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 (16)	Ongoing and persistent queue together with lack of available capacity for patients ready to leave ED causing patients to be cared for in an inappropriate area without the correct levels of staff	• ED attempt to routinely provide two and MAU 1 queue nurses at peak times • Arrangements to provide additional nursing staff from QAH site; for extra support • Medically expected patients to go directly to MAU as far as possible • Surge plan developed and implemented • New policy and procedure for escalation implemented • Queue reduction plan • M & L support • ED consultants present until midnight 5 days	• Monitored, via Emergency Pathway Workstream and intensive support • Daily monitoring at Trust wide morning matrons meeting	20 (5x4) IG SMT	20 (5x4)	4 (4x1)	• Consultant cover is not sufficient • Unavailability of required beds • Presentations to ED exceed capacity	• Monthly COO's Operational Performance Report	GC: two further consultant positions appointed, start date to be confirmed. GC/GA: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment. GC/GA: agree and implement unscheduled care transformation plan	Jul 12 Jun 12 Sep 12	Review Jul 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**	
2.1 (16)	Failure to improve results of the national Inpatient survey by 2 points as required by CQUIN results in 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 SPS SG	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 GA: real time reports to be analysed and presented to PESG and Income protection Group monthly	Jun 12	Feb 13
2.2 (4,6)	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards	• Trust-wide KPIs and monthly Integrated Performance Report • Bed rebalancing and ward staffing reviews • Patient flow project	• Trust-wide KPIs and monthly Integrated Performance Report	9 3x3	9 (3x3)	3 3x1	• Volume and hourly profile of attendances • Continued high numbers of medically stable patients awaiting discharge • Inconsistent implementation of patient flow policies across the Trust	• The monthly Integrated Performance Report does not include any patient flow KPIs.	GC: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment. GC: complete bed rebalancing exercise (June 2012). GA: Productivity and efficiency KPIs are under development and will be included in future monthly Integrated Performance Reports	June 12	Review Aug 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
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**	
3.1 (14)	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust.	• Training plans developed to reflect CSC strategic priorities. • Membership of the shadow Local Education and Training Board. • Evaluation of learning outcomes undertaken.	• Strategic Education Board in place. • Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback).	12 (4x3)	12 (4x3)	8 (4x2)	• Learning and education strategy is defined at a high level but requires greater detail. • Director of Medical Education is retiring in June 2012.	• There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes.	GC - Director of Medical Education post to be filled. GC - Strategic education board to define future learning strategy and monitor outcomes. GA – development and deployment of the education outcomes framework.	Jul 12 Oct 12 Mar 13	Review Mar 13
3.2 (14)	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities.	• Performance assurance framework trials for CSCs commenced • SHA funded performance appraisal project for consultants introduced	• 85% compliance with appraisal completions • Significant improvement to staff survey results for effectiveness of appraisal • Performance assurance project board established.	12 (4x3)	12 (4x3)	8 (4x2)	• Variation in performance at CSC and individual level. • Consequence management framework not established.	• Appraisal performance measures currently only look at compliance with no individual rating scale evident.	GC – Performance assurance framework deployed across all CSCs GC / GA – review of performance appraisal process to introduce ratings and consequence management frameworks.	Aug 12 Sep 12	Review Oct 12
3.3 (14)	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	• Staff survey action plans developed within CSCs • Health and well-being programme established. • Employee recognition programmes in place.	• Improved performance in 2011 national staff survey results. • Lower than average levels of sick absence and staff turnover.	12 (3x4)	12 (3x4)	6 (3x2)	• Staff survey results still show lower than acceptable scores against some key findings.	• Staff concerns or issues not captured sufficiently well enough with little Board visibility of underlying themes.	GC – bottom up action plans to be developed by CSCs. GA – review of internal communication process including team-brief. GA – regular reporting to Board on staff issues.	Jun 12 Sep 12 Jul 12	Review Oct 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)	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.	• Utlisisation of existing leadership development programmes. • SHA funded projects in development including team based working.	12 (4x3)	12 (4x3)	8 (4x2)	• Expectations of leaders not clearly defined.	• There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.	GC – development of a Trust wide leadership brand. GA – development of talent management process to capture potential future leaders GA – review the range of leadership development opportunities currently offered. GA – use of Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level	Aug 12 Oct 12 Oct 12 Oct 12	Review Dec 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)	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels.	• Corporate CIP plan developed to reduce temporary staffing levels. • Review of recruitment processes for Nursing cohort undertaken • Workforce Strategy Committee ensures critical posts are resourced.	• Business planning process has identified resource requirements for CSC service delivery. • WSC process reviewed to ensure critical posts are prioritised for recruitment	16 (4x4)	16 (4x4)	8 (4x2)	• Ineffective workforce planning at CSC level. • High levels of temporary resource currently in place. • Reduction in Junior Doctor resource will increase demand for consultants in some specialities. • Attraction strategy is poorly defined.	• Reporting of workforce metrics does not facilitate early decision making.	GC – Workforce planning tool to be developed to enable more effective resource plans to be developed in CSCs. GC – Temporary workforce control panel to be introduced GC – Speciality specific attraction strategies to be developed for CSCs in difficult to recruit areas. GA – full deployment of e-rostering system.	Aug 12 Jun 12 Aug 12 Sep 12	Review Oct 12
4.2 (13)	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	• Definition of critical posts established and used by WSC to prioritise recruitment.	• Remaining GM posts in process of being filled.	12 (3x4)	12 (3x4)	6 (3x2)	• Performance appraisal does not capture career progression potential. • Process for defining and identifying those with potential is not established. • Critical posts have not been reviewed to ensure the highest return on investment.	• Talent is not reviewed at senior management level or at CSC level. • Succession plans are not evident across the Trust	GC – review of appraisal process for Band 7 and above. GC – talent review process to be developed and linked to appraisal. GA – Talent review meetings to take place at Board and CSC levels GA – Succession plans at senior management level to be developed	Sep 12 Oct 12 Nov 12 Nov 12	Review Jan13

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 Timeliness	• Key performance indicators • Patient flow project • Common pathway developed for all patients to achieve rapid assessment and start of treatment	• Monthly Integrated Performance Report	9 3x3	9 (3x3)	3 3x1	• Volume and hourly profile of attendances • Continued high numbers of medically stable patients awaiting discharge • Inconsistent implementation of patient flow policies across the Trust	• Monthly Integrated Performance Report (performance is ahead of recovery trajectory at the end of May 2012)	GC: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment.	June 12	Review Jun 12
5.2 (4)	The Trust fails to achieve the required referral to treatment targets for admitted patients at a specialty level and reduce the 18 week admitted backlog.	• Key performance indicators • Clinically urgent patients managed in order of clinical priority • Breach of target in four specialties to reduce backlog agreed with commissioners	• Monthly COO's Operational Performance	9 3x3	6 3x2	3 3x1	• 18 week backlog in key specialties impacting on aggregate 95th percentile	• Monthly COO's Operational Performance Report	GC/GA: activity plan and trajectory in place to clear the admitted backlog in key specialties, and monitored	Jun 12	Review Jun 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 Integrated Performance Report	9 3x3	3 3x1	3 3x1	• n/a	• n/a	GC/GA: Dedicated Stroke Co-ordination Nurse Team appointed in April 2012	May 12 Completed	Review Jun 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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6.1 (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	12 (4x3) SG FC	12 (4x3)	8 (4x2)	• Current monthly reports do not adequately expose the financial risk (especially at CSC level).	• Current monthly reports do not adequately expose the financial risk (especially at CSC level).	GC/GA: Monthly reports to be revised to ensure they meet requirements	Jul 12	Mar 13
6.2 (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	12 (4x3) SG FC	12 (4x3)	8 (4x2)	• Need to develop clear detailed project plans for each of the savings schemes • Need to identify project leads for each of the savings schemes	• Project plans incomplete – under continuous development	GC/GA: Project plans and leads currently being finalised	Jun 12	Mar 13

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

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
SB	Sarah Balchin		BI	Business Intelligence		CEO	Chief Executive Officer
JD	Julie Dawes		CQRM	Clinical Quality Review Meeting		COO	Chief Operating Officer
SG	Steve Gooch		CSC	Clinical Service Centre		CoS	Chief of Service
SH	Simon Holmes		EMT	Executive Management Team		CQC	Care Quality Commission
FM	Fiona McNeight		FC	Finance Committee		CQUIN	Commissioning for Quality and Innovation
TP	Tim Powell		G&Q	Governance & Quality Committee		ESR	Electronic Staff Record
RT	Robert Toole		ICMC	Infection Control Management Committee		PMO	Performance Management Office
CW	Cherry West		CQRM	Clinical Quality Review Meeting		SHA	Strategic Health Authority
			PEWG	Patient Experience Working Group		SHIP	Southampton, Hampshire, IOW & Portsmouth
			PSWG	Patient Safety Working Group			
			SMT	Senior Managers Team			
			SPSSG	Staff & Patient Satisfaction Steering Group			
			SSCSG	Staff Satisfaction Campaign Steering Group			
			SB	Sustainability Board			
			TC	Transformation Committee			
			WSC	Workforce Strategy Committee			

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.