

<p>Subject:</p>	<p>Assurance Framework</p>
<p>Prepared by:</p> <p>Sponsored by:</p> <p>Presented by:</p>	<p>Lorna Wilkinson – Deputy Director of Nursing/Head of Patient Safety</p> <p>Julie Dawes – Director of Nursing</p> <p>Julie Dawes – Director of Nursing</p>
<p>Purpose of paper</p> <p><i>Why is this paper going to the Trust Board?</i></p>	<p>Requires Trust Board guidance</p> <p>Discussion requested by Trust Board</p> <p>Regular Reporting</p> <p>Statutory Requirement</p>
<p>Key points for Trust Board members</p> <p><i>Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals</i></p>	<p>Trust Board are asked to note</p> <ul style="list-style-type: none"> • Top risks • Increase in risks 2.1 (ED) and 5.4 (CIPs) • Note that the Assurance Framework is currently under full review alongside the revised strategic objectives and will be reported to the July Trust Board
<p>Options and decisions required</p> <p><i>Clearly identify options that are to be considered and any decisions required</i></p>	<ul style="list-style-type: none"> • 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
<p>Next steps / future actions:</p> <p><i>Clearly identify what will follow the Trust Board's discussion</i></p>	<p>Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board in July 2013.</p>
<p>Consideration of legal issues (including Equality Impact Assessment)?</p>	<p>None</p>
<p>Consideration of Public and Patient Involvement and Communications Implications?</p>	<p>None</p>

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: June 2013

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 19 June 2013

Top Risks

- 2.1 ▲ (Red 25): Partnership working arrangements do not deliver sufficient reductions in emergency attendances to meet agreed and national targets
- 2.2 ◀▶ (Red 20): The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards
- 5.4 ▲ (Red 16) Delivery of savings targets 2013/14
- 3.2 ◀▶ (Red 16): Planned growth in elective activity does not materialise as forecast. resulting from:
Failures to target growth in appropriate specialties; and/or
Failures to achieve the profile of targeted elective activity growth
Planned elective activity not consistent with commissioners intentions/contract

New Risks

Nil

Risks with an Increased Score

- 2.1 ▲ (Red 25): Partnership working arrangements do not deliver sufficient reductions in emergency attendances to meet agreed and national targets. This was revised following discussion at RAC and alignment with risk register
- 5.4 ▲ (Red 16) Delivery of savings targets 2013/14. This was revised upwards following review by Deputy Director of Finance at the request of RAC

Risks with a Decreased Score

Nil

Risks to be Removed

- 5.5 ◀▶ (Red 20): Failure to obtain a contract for 2013/14 which enables achievement of financial targets. Request that this is removed following sign off of 13/14 contract.

Target Date Changes

Nil

Prepared by: Lorna Wilkinson – Deputy Director of Nursing/Head of Patient Safety

Presented by: Julie Dawes – Director of Nursing

Portsmouth Hospitals NHS Trust Strategic Aims

These aims inform the Trust's business objectives and vision for the future. The Board Assurance Framework identifies where there are risks to delivery of any of the objectives and provides assurance on risk mitigation and therefore delivery of objectives.

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS

- Minimise avoidable harm
- Engage clinical teams to lead key improvement projects
- Use evidence based best practice to improve pathways
- Encourage a safety first culture
- Achieve year on year improvements in patient satisfaction

STRATEGIC AIM 2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE

- Create an Integrated Care Organisation for high risk groups
- Partner with other providers to reduce unnecessary A & E attendances
- Work with partners to reduce delayed discharges
- Create a vibrant R & D culture as part of an Academic Health Sciences Network
- Partner with leading education providers to ensure that we continue to deliver a well trained and educated workforce

STRATEGIC AIM 3: PATIENTS AND GPs IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES

- Protect scheduled services from fluctuations in the demand for unscheduled care
- Implement simple, effective, standardised elective pathways
- Reduce waiting times until we are the best in the region
- Communicate effectively with key stakeholders across the region
- Grow target specialties year on year
- Increase share of referrals from key target GP practices year on year
- Grow private patient business year on year

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

- Plan our workforce effectively
- Grow our talent effectively
- Manage performance and accountability effectively
- Engage effectively with staff at all levels
- Develop a more visible leadership brand
- Achieve year on year improvements in the NHS National Staff Survey

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

- Become a Foundation Trust in 2013/14
- Make a financial surplus each year and reinvest this for the benefit of patients
- Ensure that we meet or exceed all national targets and standards
- Ensure the sustainability of clinical services
- Develop and implement an effective information technology strategy
- Develop and implement an effective innovation strategy
- Develop and implement an effective Corporate Social Responsibility strategy

Trust Risk Profile - June 2013

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)			5.6 Information Technology strategy ◀▶		
Unlikely (2)			1.1 CQC Standards ▼ 2.3 Growth in R&D ◀▶	4.1 Learning and education outcomes ◀▶	
Possible (3)			1.2 Inpatient survey ◀▶ 3.3 elective pathways ◀▶ 4.5 High level of temporary staff ◀▶	1.3 Quality of services and patient safety ◀▶ 3.1 Scheduled care capacity ◀▶ 3.4 Relationships with commissioners ◀▶ 4.2 Performance management ◀▶ 4.4 Capability of leadership ◀▶ 4.6 Unfilled critical posts ◀▶ 5.1 Foundation Trust status ◀▶ 5.2 Failure of budgetary control 5.3 Contract penalties	
Likely (4)			4.3 Engagement of workforce ◀▶	3.2 Growth of targeted specialities ◀▶ 5.4 Delivery of savings targets ▲	
Highly Likely (5)				2.2 Patient flow ◀▶	2.1 Insufficient reduction in ED attendances to meet national targets ▲

ASSURANCE FRAMEWORK 2013/14 PROGRESS SUMMARY - June 2013

STRATEGIC AIM	Risk Reference Operational Leads	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	RESPONSIBLE COMMITTEE	CQC OUTCOME REFERENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
					JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1 : DELIVER SAFE, HIGH QUALITY AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS	1.1 FMcN	Inability to maintain ongoing compliance with all CQC standards	G&Q	All	12	12	8	8	6	6						Jul 13	6 Apr 14	
	1.2 SB	Failure to achieve required response rate for the Friends and Family test potentially affecting organisational reputation and achievement of CQUIN	PEWG	16	9	9	9	9	9	9						Aug 13	3 Mar 14	
	1.3 LW	Failure to comply with internally and externally set standards impacting on quality of services provided to patients and patient safety	G&Q	4	12	12	12	12	12	12						Aug13	8 Apr 14	
2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE	2.1 HD	Partnership working arrangements do not deliver sufficient reductions in emergency attendances to meet agreed and national targets	SMT	16	15	15	15	15	15	25						Jun 13	10 Apr 14	
	2.2 HD	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards	SMT	16	20	20	20	20	20	20						Jun 13	12 Apr 14	
	2.3 SH	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	SMT	6	6	6	6	6	6	6						Jun 13	3 Mar 14	
3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES	3.1 CW	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	SMT	4	12	12	12	12	12	12						Jun 13	4 Mar 14	
	3.2 CW	Planned growth in elective activity does not materialise as forecast, resulting from: Failures to target growth in appropriate specialties; and/or Failures to achieve the profile of targeted elective activity growth Planned elective activity not consistent with commissioners intentions/contract	SMT	26	16	16	16	16	16	16						Jun 13	4 Mar 14	
	3.3 CW	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness	SMT	4	9	9	9	9	9	9						Jun 13	3 Mar 14	
	3.4	Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	SMT	6	12	12	12	12	12	12						Jun 13	4 Mar 14	
4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND	4.1 PS	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance	SEC	All	8	8	8	8	8	8						Jun 13	4 Apr 14	

RETAINING THE BEST PEOPLE		and strategic priorities for the Trust																
	4.2 RK	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities	SEC	All	12	12	12	12	12	12							Jun 13	8 Apr 14
	4.3 RK	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities	SEC	14	12	12	12	12	12	12							Jun 13	6 Apr 14
	4.4 PS	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change	SEC	14	12	12	12	12	12	12							Oct 13	8 Apr 14
	4.5 RK	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels	SEC	13	12	12	12	9	9	9							Jul 13	9 Sep 13
4.6 PS	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes	SEC	13	12	12	12	12	12	12							Oct 13	6 Apr 14	
5: ENSURE SUSTAINABILITY	5.1 BC	Inability to achieve Foundation Trust status within the agreed timetable	TB	26	12	12	12	12	12	12							Jun 13	12 Mar 14
	5.2 RH	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a surplus or agreed deficit on income and expenditure.	FC	26	16	20	12	12	12	12							Jul 13	8 Apr 14
	5.3 RH	The Trust does not receive income due for 13/14 as a result of the contract agreed or due to application of contract penalties and levers or failure to achieve CQUIN payments	FC	26	12	8	8	8	12	12							Jul 13	8 Apr 14
	5.4 RH	2013/14 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	FC/TC	26	16	16	12	12	12	16							Jul 13	8 Apr 14
	5.5 RE	Failure to obtain a contract for 2013/14 which enables achievement of financial targets.	FC	26		20	20	20	20		Request removal					Jun 13	May 13	
	5.6 CT	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	ITSG	4	6	6	6	3		Risk being redefined as part of BAF review					Jul 13	3 Oct 13		

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target	Minor Obstacle to achieving target	Inability to achieve predicted target	
1.1	Inability to maintain ongoing compliance with all CQC standards	<ul style="list-style-type: none"> 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 Quarterly Mock CSC assessments and associated action plans Monitor Quality Risk Profile monthly Quarterly evidence and action plan review panels established HealthAssure – web based compliance software covering all registered locations 	<ul style="list-style-type: none"> 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 4th and 5th March 2013 – full compliance by CQC – Outcome 1, 4, 7, 8, 14 and 17 	12 (4X3)	6 (3X2)	6 (3X2)	<ul style="list-style-type: none"> i. HealthAssure software solution not yet fully embedded None 	<ul style="list-style-type: none"> ii. New HealthAssure system training ongoing. System needs to be fully populated with evidence across all CSCs and locations iii. Consistency of use of Health assure software – lack of regular updates across all sites in some areas iv. Awaiting report following responsive visit May 2013 	1. Director of Nursing 2. Head of Governance 3. Governance & Quality (G&Q)	Jul 13	Apr 14	CQC All	RR 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
Ongoing mock CQC visits.									JD	Apr 13	Implemented and ongoing		

i./ii.) Continued documentation audits until compliance sustained	HoN	Apr 13	Mar 13
i./ ii.) Complete HealthAssure training	TS	Jun 13	Jun 13
iii) Consistency checking through Governance department, ad hoc training for users until familiar with the system,	TS	Oct 13	
iv) Await CQC report following responsive visit and work up actions as required	FMc	Jun 13	

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.2	Failure to achieve required response rate for the Friends and Family test potentially affecting organisational reputation and achievement of CQUIN	<ul style="list-style-type: none"> Trust wide implementation plan CSC targets for patient participation in survey CQC assessment process – monitor essential standards of care Complaints monitoring process Weekly performance data at ward/dept level 	<ul style="list-style-type: none"> Optimum real time patient surveys 	9 (3x3)	9 (3x3)	3 (3x1)		<ul style="list-style-type: none"> i. Inconsistent reporting by CSCs to PESG ii. Trust was required to achieve a 2 point increase in 5 key questions to achieve full CQUIN payment iii. Friends and Family test in its infancy, response rate of 75 patients per day not being achieved 	1. Director of Nursing 2. Head of Patient Experience 3. Patient Experience Steering Group (PESG)	Aug 13	Mar 14	CQC 16	RR 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) CSC reporting to be monitored at PESG and escalate to DoN any non submission									SB	Mar 13	Mar 13		
ii.) Analysis and subsequent action plan to be completed									FMc/NL	Jun 13			
iii) Refocus on CSC level responsibility regarding return rate through weekly performance results									NL	Jun 13	Jun 13		
iii) Switch on of Hospedia bedside solution									NL	Jun 13	Jun 13		

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.3	Failure to comply with internally and externally set standards impacts on quality of services provided to patients and patient safety	<ul style="list-style-type: none"> Governance Framework and monitoring: Quality Impact Assessments of CIP plans – policy ratified March 13 following extensive pilot Quality Performance measures Monitor Compliance Framework CSC executive performance reviews Clinical Audit programme Safety workstreams Patient and user feedback process 	<ul style="list-style-type: none"> Quality heatmap and exception reports to Trust Board monthly Kit bag under development Quality report quarterly to Trust Board Dr Foster data CQC feedback – QRP/review feedback 	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> All risk assessments to be completed and savings plans signed off for CIP programme Real time incident data not fully available to allow proactive response CSC performance framework under review Identification of individual CSC quality performance 'hotspots' 	<ul style="list-style-type: none"> Finished year above trajectory for MRSA (6 against a trajectory of 4) Failed ED performance target at year end 2012/13 Q1 increase in hospital acquired pressure ulcers being seen Rule 43 received regarding inpatient falls 	1. Director of Nursing 2. Head of Patient Safety 3. G&Q	Aug13	Apr 14	CQC 26	RR 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) Fully embed Quality Impact Assessment review process for 2013/14									DB/LW	Apr 13	Apr 13		
ii.) Complete roll out of DatixWeb									LW	Jun 13			
iii.) Fully imbed CSC performance review process									AG	Mar 13	Mar 13 and review ongoing		
iv.) Further develop integrated performance report to include data at CSC level									AG	Mar 13	Mar 13		
v) Implementation of MRSA Recovery Plan									CM	Jun 13			
vi) See risk 2.1 and 2.2 for actions													
vii) RCAs currently being completed – will then extract themes/learning to ensure improvement									LW	Jul 13			
viii) Response to rule 43 letter being drafted									JW	Jul 03			

STRATEGIC AIM 2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE

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										On target			
										Minor Obstacle to achieving target			
Inability to achieve predicted target													
2.1	Partnership working arrangements do not deliver sufficient reductions in emergency attendances to meet agreed and national targets	<ul style="list-style-type: none"> Emergency care model across MAU and ED Unscheduled care Programme Board (reps from across health economy) chaired by PHT Medical Director Integrated weekly PMO cross provider meetings to review and progress joint action plans Trust Emergency Flow Action Plan incorporating ECIST recommendations 3 key workstreams identified with project leads and overall clinical lead. 2 weekly reports into Emergency Flow Improvement Programme Steering Group chaired by COO 18 point Health System in place for 2013/14 Ambulatory Care programmes implemented in MAU, Respiratory and SAU Weekly discharge improvement group Pilot community discharge 	<ul style="list-style-type: none"> Daily monitoring at Operational Flow meetings (5 meetings a day) Performance reporting – Emergency Flow Dashboard in development as well as regular performance reports 	20 (5x4)	25 (5x5)	10 (5x2)	<ul style="list-style-type: none"> i. PHT Emergency Flow governance structure yet to be implemented. ECIST programme delivery in its infancy ii. Contract penalties on delivery of ECIST action plan iii. Projects under discussion to implement 4 specific cross provider disease pathways – cross boundary work reliant on partners iv. Lack of medical cover overnight and at weekends in ED. Need for senior clinical decision makers at the front door during peak demand 	<ul style="list-style-type: none"> v. Work ongoing to develop PHT Performance dashboard to measure progress against individual projects and extend process system wide. 	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Apr 14	CQC 16	RR 2.1 3.3

		assessment lounge in ED										
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE								By Whom	By When	Date Completed		
i) Agree and implement Emergency Flow governance structure								CW	Apr 13	Apr13		
i) Delivery of ECIST action plan through 3 key workstreams								CW	Sep 13			
ii) Continue 2013/14 contract negotiations								LB	4/13	05/13		
iii)PHT input and active partnership in pathway design								CW	Mar 13	Completed and ongoing work		
iv) Review medical rostering and commence workforce plans to develop new nursing roles to cover medical rota gaps in ED								IG/MP	Jun 13			
v) Monitor achievement of CSC weekly discharge targets								RF	Mar 13	Completed and continues		
v.) Agree explicit performance metrics and penalties for all projects to reduce emergency admissions								RF	Apr 13	Apr 13		

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
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 This risk increases during times of peak demand and winter pressures.	<ul style="list-style-type: none"> Trust-wide KPIs and monthly Integrated Performance Report Bed rebalancing and ward staffing reviews Patient flow projects – including additional input from key medical consultants Weekly discharge improvement meetings to improve quality and speed of discharges Outlier team in place, funded with partners, to ensure prompt medical and senior nursing review to fast track care and treatment interventions to improve patient pathway and flow. (Lead: MOPRS) 	<ul style="list-style-type: none"> Trust-wide KPIs and monthly Integrated Performance Report Daily early discharges targets agreed and monitored (10.00hrs and 12.00hrs targets) through weekly Discharge improvement group and daily in the Operations Centre. 	9 (3x3)	20 (4x5)	12 (4x3)	<ul style="list-style-type: none"> i. Continued high numbers of medically stable patients awaiting discharge ii. Inconsistent implementation of patient flow policies across the Trust iii. Lack of real time information on PAS regarding discharges and capacity. Bed Declaration Policy not being followed 	<ul style="list-style-type: none"> iv). The monthly Integrated Performance Report does not include any patient flow KPIs. However there is now an Emergency Flow Dashboard being developed in support of the Trust Emergency Flow Action Plan 	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Apr 14	CQC 4.6	RR 2.1 4.1 4.3 4.4
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / ii.) / iv.) Implement EDD project as part of ECIST action plan									NL/PS	Jun 13	commenced		
i)/ ii) /iv) Monitor against CSC discharge targets									RF	Jan 13	Jan 13 and ongoing		
iii) Bed Declaration Policy to be reviewed									MP	Jun13			
iii)IT solution to be explored									CW	Jun 13	Tendering in process		
vii.) Implement Consultant leader support at front door to fast track speciality decision making early in patient pathway									SH	Jun 13			

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
2.3	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	<ul style="list-style-type: none"> Medical Director participating in AHSN discussions with UHS Trust R&D Strategy and framework R&D income monitored by R&D Director 	<ul style="list-style-type: none"> Medical Director reporting back to Board on discussions R&D income year on year increase 	10 (5x2)	6 (3x2)	3 (3x1)	i. R&D Strategy requires review	iv. Quarterly R&D Board reporting to be established	1. Medical Director 2. Head of Research & Development 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 6	RR
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / ii.) Quarterly Research & Development report to be submitted to Trust Board – KPIs to be developed, Board reporting structure to be agreed with MD									AC	Jun 13			
i.) / ii.) Research & Development strategy to be developed and agreed – annual framework review to be implemented									AC	Jul 13			

STRATEGIC AIM 3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.1	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	<ul style="list-style-type: none"> Detailed specialty-level activity plans Weekly waiting list and theatre utilisation assurance meetings Demand/capacity modelling at a specialty level refreshed periodically Contractual trigger points relating to increased demand and patient backlogs at a specialty level 	<ul style="list-style-type: none"> No non-clinical cancellations of elective activity Achievement of Operating Framework targets Reduction in patient backlogs to the level required for sustainable target delivery Reduced average waiting times for the majority of specialties (year-on-year basis) 	12 (4x3)	12 (4x3)	4 (4x1)	<ul style="list-style-type: none"> i. Not all specialties have sufficient capacity to meet demand on a sustainable basis ii. Some patients wait more than 18 weeks for treatment - planned failure of RTT targets in 1 Specialty under consideration to ensure sustainability. Increased use of urgent referrals can alter case mix and risk substantially iii. Contracted activity levels transfer some of financial risks of reducing waiting times to 'best in region' to the Trust iv. 	None	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 4	RR 2.1 3.4
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) At risk specialties to achieve agreed plan to deliver sustainable target delivery									GMs	Apr 13	Apr 13 but will be ongoing through year		
i.) Implement management of flow initiatives as detailed in 2.2									HD/CW	Jun 13	Commenced		
ii.) Speciality level management of patient lists to reduce waiting times on a sustainable basis									GMs	Apr 14	Ongoing throughout year		
ii) Weekly monitoring of referrals with GMs									CW	Apr 14	Ongoing throughout year		
iii.) Agree 2013/14 contract to ensure delivery of national and local targets and sustain scheduled care services									LB	Apr 13	may 13		

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										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.2	<p>Planned growth in elective activity does not materialise resulting from:</p> <ul style="list-style-type: none"> Failures to target growth in appropriate specialties; and/or Failures to achieve the profile of targeted elective activity growth <p>Planned elective activity not consistent with commissioners intentions/contract</p>	<ul style="list-style-type: none"> Annual planning process Quarterly Board review Performance Assurance meetings and agreed action plans Monthly Exec contract review meeting Reconfigured capacity with new activity plan for 2013/14 	<ul style="list-style-type: none"> Quarterly Business Intelligence report 	16 (4x4)	16 (4x4)	4 (4x1)		i. Commissioner plans do not allow for activity growth at 'baseline' levels	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 26	RR 2.1 2.2 3.4 4.3 4.4 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
iii) Continue 2013/14 contract negotiations									CW/BL	May 13	May 13		

STRATEGIC AIM 3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.3	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness.	<ul style="list-style-type: none"> On-going operational management processes 	<ul style="list-style-type: none"> Performance against standards and targets as shown in Integrated Business Report 	12 (3x4)	9 (3x3)	3 (3x1)	None	i. The Trust's benchmarked performance against MEQO (Midlands and East Quality Observatory) dashboard metrics is not consistently in upper quartile	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 4	RR 2.1 3.3 3.4 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) Implementation of Newton work to drive productivity and efficiency agenda within the organisation									CW	Sep 14			
i.) Report MEQO to Clinical Effectiveness Steering Group for focussed work to be commissioned as appropriate									GS	Apr 13	Apr 13		

STRATEGIC AIM 3: PATIENTS AND GPs IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.4	Relationships and communication with commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	<ul style="list-style-type: none"> Clearly defined stakeholder management system Medical Director meets GP Clinical Leads on weekly basis Company Secretary meets OSCs on a regular basis Outbound media relations Monthly key issues meeting. Exec to exec (CCG) 	<ul style="list-style-type: none"> Stakeholder feedback – largely informal 	12 (4x3)	12 (4x3)	4 (4x1)	i. Senior clinicians have limited time to engage effectively with local GPs ii. Internal communication requires improving to establish a consistent approach to working with commissioners	None	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 6	RR 2.2 3.1 3.3 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i)/ii) Appointed Business Development Manager April 2013									TP	Apr 13	Apr 13		

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.1	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust.	<ul style="list-style-type: none"> i. Training plans developed to reflect CSC strategic priorities. ii. Membership of the shadow Local Education and Training Board. iii. Evaluation of learning outcomes undertaken. iv. Director of Education appointed v. Strategic Education Board 	<ul style="list-style-type: none"> • Strategic Education Board in place. • Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback). • Learning and Education Strategy 	12 (4x3)	8 (4x2)	4 (4x1)	<ul style="list-style-type: none"> i. Education Outcomes Framework not implemented Trust Wide ii. There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes. 	<ul style="list-style-type: none"> 1. Director of Workforce and Organisational Development 2. Director of Education 3. Strategic Education Committee (SEC) 	Jun 13	Apr 14	CQC 14	RR 3.3 4.2	
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / ii.) Develop and deploy education outcomes framework									PS	Mar 14			

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.2	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities.	<ul style="list-style-type: none"> Performance assurance framework trials for CSCs SHA funded performance appraisal project for consultants introduced 	<ul style="list-style-type: none"> Significant improvement to staff survey results for effectiveness of appraisal Performance assurance project board established. Compliance target achieved in Feb 13 	12 (4x3)	12 (4x3)	8 (4x2)	i. Variation in performance at CSC and individual level. ii. Consequence management framework established - but requires evaluation.	iii. Appraisal performance measures currently only look at compliance with no individual rating scale evident.	1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Jun 13	Apr 14	CQC 14	RR 3.3 4.2
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
iii.) / ii.) Review of performance appraisal process to introduce ratings and consequence management frameworks									RK	Jun 13			
j) / iii.) Establish CSC actions plans to ensure compliance with appraisal target									RK	Ongoing			

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.3	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	<ul style="list-style-type: none"> Staff survey action plans developed within CSCs Health and well-being programme established. Employee recognition programmes in place. 	<ul style="list-style-type: none"> Improved performance in 2011 national staff survey results. Lower than average levels of sick absence and staff turnover. Integrated performance report to Board included staff feedback 	12 (3x4)	12 (3x4)	6 (3x2)	i. Staff survey results still show lower than acceptable scores against some key findings – PULSE surveys show some improvement, although numbers not representative		1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Jun 13	Apr 14	CQC 14	RR 3.3 4.2
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) Review of internal communication processes including team brief									TP/RK	Jun 13			
i.) Implement actions regarding core messages and communication tools for staff from workforce task and finish group									RK	Jun 13			
i.) Commence Listening in Action programme and roll out Trust wide									RK	Mar 13	Ongoing		
i) New workforce structure in consultation to move to transformation structure to allow for significant change to occur in staff engagement									TP	Jul 13			

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target	Minor Obstacle to achieving target		
4.4	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.	<ul style="list-style-type: none"> Leadership development programmes in place to support leaders at various levels. 360 and self-assessment completed at Executive level Trust wide leadership competencies identified Delivery of Working Together for Patients on plan 	<ul style="list-style-type: none"> Utilisation of existing leadership development programmes. SHA funded projects in development including team based working. Local Leadership Academy for Wessex LETB has been authorised. >1000 staff trained as part of WT4P 360 completed for executive team 	12 (4x3)	8 (4x2)	8 (4x2)	<ul style="list-style-type: none"> i. Expectations of leaders not clearly defined. ii. Managing development framework to be defined iii. All relevant staff have not undertaken Working Together for Patients 	<ul style="list-style-type: none"> iv. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered. 	1. Director of Workforce and Organisational Development 2. Director of Education 3. Strategic Education Committee (SEC)	Oct 13	Apr 14	CQC 14	RR 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / ii.) Develop talent management process to capture future leaders									TP		This is pending due to work currently being undertaken by the National Leadership Academy		
ii.) / iv.) Implement Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level – CSC management teams, CDs and identified critical posts now timetabled for 2013/14									TP	Dec 13	26/07/12 for Executive Team		
iii.) Trust wide roll out of Working Together for Patients initiative									SS		31/03/13 – 1000 staff trained, ongoing		
i-iv) Organisational Development strategic review to be undertaken - developed									TP	Sep 12	Sep 12		

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.5	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels.	<ul style="list-style-type: none"> Corporate CIP plan developed to reduce temporary staffing levels. Workforce Strategy Committee ensures critical posts are resourced. Speciality specific attraction strategies developed for CSCs in difficult to recruit areas Executive sign off required for temporary spend Ongoing recruitment of nursing staff 	<ul style="list-style-type: none"> Business planning process has identified resource requirements for CSC service delivery. WSC process reviewed to ensure critical posts are prioritised for recruitment Temporary staffing costs have reduced by c£1m a month at month 8 	16 (4x4)	9 (3x3)	9 (3x3)	<ul style="list-style-type: none"> vi. Temporary resource currently above planned level of 3%. vii. Reduction in Junior Doctor resource will increase demand for consultants in some specialities. viii. Attraction strategy needs further development to enable recruitment of high level candidates. ix. Only one University intake per annum for newly qualified nurses results in excessive vacancy fluctuation 	<ul style="list-style-type: none"> x. Reporting of workforce metrics does not facilitate early decision making. 	1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Jul 13	Sep 13	CQC 13	RR 4.1 4.3 4.4 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / v.) Fully deploy E-rostering system									RB	Jul 13			
i.) / ii.) / v.) Mobilise existing workforce where applicable									RK	Ongoing			
j) Continue to monitor temporary spend on bi-weekly basis									AW/RK	Ongoing			
j) Execs continue to sign off temporary staffing requests									EDs	Ongoing			
ii.) Ongoing discussions with Deanery linking into workforce strategy for the future									PS	Ongoing			
iii.) Define Attraction Strategy for 2013/14 intake									NSa	Jun 13			
iv.) Discuss future intake structure with Higher Education institutions									DE	Ongoing			

STRATEGIC AIM 4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
		Inability to achieve predicted target											
4.6	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	<ul style="list-style-type: none"> Definition of critical posts established and used by WSC to prioritise recruitment. 	<ul style="list-style-type: none"> Succession plan meeting for Board level posts held. GM post filled in ED 	12 (3x4)	12 (3x4)	6 (3x2)	<ul style="list-style-type: none"> i. Performance appraisal does not capture career progression potential. ii. Process for defining and identifying those with potential is not established. 	<ul style="list-style-type: none"> iii. Talent is not reviewed at senior management level or at CSC level. iv. Succession plans are not evident across the Trust v. Some critical posts not filled 	1. Director of Workforce and Organisational Development 2. Director of Education 3. Strategic Education Committee (SEC)	Oct 13	Apr 14	CQC 13	RR 4.1 4.3 4.4
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i./ iii.) Review appraisal process for Band 7 and above									TP	Sep 13			
i.) Develop talent review process and link to appraisal									TP	Sep 13			
ii.) / iii.) Undertake talent review meetings at Trust Board and CSC level									PS	Dec 12	Dec 12 and ongoing		
iv.) / v.) Develop senior management level succession plans									GMs/RK	Dec 12	Dec 12 and ongoing		

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.1 (26)	Inability to achieve Foundation Trust status within the agreed timetable	<ul style="list-style-type: none"> Dedicated FT project support FT project plan FT project Committee Trust Board and Transformation Committee scrutiny Performance management systems Public published tripartite formal agreement Project managed against TFA milestones Integrated Action Plan – HDD, BGAF and Quality Governance 	<ul style="list-style-type: none"> Monthly FT pipeline paper presented to Trust Board shows milestones being achieved KPMG Board governance Framework Assessment Operational key targets being achieved Monitor quality framework targets on trajectory PWC – HDD Phase 1 Report RSM Tenon – External Review of Quality Governance 	12 (4x3)	12 (4x3)	12 (4x3)	<ul style="list-style-type: none"> i. Financial performance off trajectory ii. Performance against key target A&E not being achieved 	<ul style="list-style-type: none"> iii. Financial report shows Trust plan currently in deficit 	1. Chief Executive 2. Associate Director Foundation Trust 3. Trust Board	Jun 13	Mar 14	CQC 26	RR 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / iii.) Implement financial recovery plan									BL	Mar 13	Work continues		
ii) See 2.1 and 2.2 for actions linked to achieving ED targets									HD/CW	Jun 13			

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.2	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a surplus or agreed deficit on income and expenditure.	<ul style="list-style-type: none"> Finance reporting and monitoring mechanisms at CSC to Board level Updates on Financial position provide to Board, SMT Finance Committee Delegated budgetary control framework Trust wide savings and transformation programme Income and contract monitoring 	<ul style="list-style-type: none"> Financial plan revised to reflect agreed commissioning contracts Budgets rebased to reflect current run rate 	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> i. Formal sign off of budgets and supporting Quality Impact Assessments ii. Bottom up run rate forecasting not fully in place currently iii. Monthly performance reviews require strengthening iv. Accountability of CSCs requires strengthening 	<ul style="list-style-type: none"> v. Daily monitoring of key metrics via KitBag to be fully implemented 	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	Jul 13	Apr 14	CQC 26	RR 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i) Formal sign off of budgets by each CSC with supporting QIAs									Finance team and CSC management teams	Jun 13			
ii) Fully implement bottom up run rate forecasts and reconcile to top down forecasts as part of monthly accounts process									SS	Jun 13			
iii) Introduce intensive CSC performance meetings which cover financial and non-financial performance									EMT	Jun 13			
iv) Introduce and clarify the role of the CSC managing Director and cluster CSCs where required									EMT	Jun 13	Jun 13		
v) Implementation of KitBag early warning system reporting key metrics									IH	Jun 13	First run Jun 13		

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.3	The Trust does not receive income due for 13/14 as a result of the contract agreed or due to application of contract penalties and levers or failure to achieve CQUIN payments	<ul style="list-style-type: none"> Monthly contract monitoring reports Monthly contract review meetings Income Assurance Group Monthly CSC performance meetings Monthly CQUIN meeting. 	<ul style="list-style-type: none"> Agreed capacity required with CSCs and activity volumes secured through the commissioning contract Agreed PbR compliant contract 	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> i. Resource constraints within contracts team due to staff departures. ii. Monthly CSC performance reviews require strengthening iii. Identification required of key owners of risk components re penalties, CQUIN etc 	<ul style="list-style-type: none"> iv. Daily monitoring of key metrics via KitBag to be fully implemented 	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	Jul 13	Apr 14	CQC 26	RR 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.): Recruit to vacancies in Contract team									IH/BL	Jul 13	Apr 13 Contracts Manager appointed but vacancies in team remain		
ii) Introduce intensive CSC performance meetings which cover contract performance review									EMT	Jun 13			
iii) Identify key owners for risk components re penalties, CQUIN etc									IH	Jun 13			
iv) Implementation of KitBag early warning system reporting key metrics									IH	Jun 13	First run Jun 13		

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.4	2013/14 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	<ul style="list-style-type: none"> Review of savings performance at Finance Committee and Finance Recovery Group Monthly CSC performance meetings PMO tracker providing clear information on which initiatives are 'off-track' Defined CSC reporting arrangements CSCs submitted savings plans 	<ul style="list-style-type: none"> Monthly reporting to Finance Committee Overall Trust savings target identified External support commissioned to support savings delivery Robust Programme Management Office in place 	12 (4x3)	16 (4x4)	12 (4x3)	<ul style="list-style-type: none"> i. CSC savings plans require challenge review to ensure delivery of savings target ii. CSCs to be held to account to develop more schemes through the monthly performance review process ii. Workforce plan requires development and alignment with savings plan 	<ul style="list-style-type: none"> iv. Not all CSC savings schemes have been tested for robustness 	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	Jul 13	Apr 14	CQC 26	RR 5.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.): Financial recovery group to complete testing of CSC savings schemes and identify any subsequent savings plan required									FRG	May13	Ongoing		
ii) Introduction of intensive CSC performance meetings which cover CIP identification and delivery									EMT	Jun 13			
iii) Production of workforce plan which aligns with savings requirements									TP	Jun 13			
iv): As i) above									FRG	Jun 13			

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target		CQC	RR
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.5	Failure to obtain a contract for 2013/14 which enables achievement of financial targets. This covers the general contract but also specialist commissioning which is at risk of being under resourced during external changes to health economy	<ul style="list-style-type: none"> Interim Contracts Manager in post Contracts team Contract negotiation meetings including line by line review of each item, CQUIN, and QIPP Structure developed for reporting and monitoring Alignment across CSCs, contract requirements, CCGs Working with CCG/LAT to ensure that sums transferred for specialist commissioning are correct 	<ul style="list-style-type: none"> Contract meetings being held and discussions with commissioners Meeting to discuss and seek to agree the Activity schedule to take place 15th April. Intention by both parties to achieve Heads of Agreement, week ending Friday 19th April. Formal Position statement to be submitted to TDA Thursday 18th April: will be agreed by both parties. 	20 (5x4)	20 (5x4)	<ul style="list-style-type: none"> Unable to quantify as evolving picture 	<ul style="list-style-type: none"> i) This is an emerging picture due to external changes ii) As at 15th April, there is still a gap between PHT view of activity required for 2013/14 and the Commissioner perspective. 	1. Director of Finance 2. Head of Contracts 3. Finance Committee	Jun 13	May 13	26	5.1	
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i). Close working between contracts team, clinicians and CSC Management teams to ensure appropriate contract									Contracts team, CSC Management and Clinicians	May 13	May 13		
i). Close working between Contracts team and Commissioners to achieve a mutually agreeable contract									Contracts Team	May 13	May 13		

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.6	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	<ul style="list-style-type: none"> Current working partnership with IPHIS Draft updated strategy being discussed at Board/SMT 	<ul style="list-style-type: none"> 2011-12 IT strategy 2012-13 IT strategy presentation IPHIS SLA IPHIS risk register IPHIS projects log 	6 (3x2)	3 (3x1)	3 (3x1)	i. New IT Strategy currently under development which will set out the future direction and key milestones	ii. New IT strategy not agreed or implemented	1. Director of Finance 2. Head of ICT 3. Information Technology Steering Group (ITSG)	Apr 13	Oct 13	CQC 4	RR 1.20 1.24 1.31 3.1
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i.) / ii.) IT Strategy to be developed, agreed and implemented									CT	Apr 13	Feb 13 – removal of risk to be considered with BAF review		

Care Quality Commission - Outcomes

Involvement and Information

1. Respecting and involving people who use services
2. Consent to care and treatment
3. Fees

Personalised care, treatment, support

4. Care and welfare of people who use services
Act 1983
5. Meeting nutritional needs
6. Cooperating with other providers

Safeguarding and safety

7. Safeguarding people who use services from abuse
8. Cleanliness and infection control
9. Management of medicines
10. Safety and suitability of premises
11. Safety, availability and suitability of equipment

Suitability of Staffing

12. Requirements relating to workers
13. Staffing
14. Supporting workers

Quality and Management

15. Statement of purpose
16. Assessing and monitoring the quality of service provision
17. Complaints
18. Notification of death of a person who uses services
19. Notification of death or absence of person detained under Mental Health
20. Notification of other incidents
21. Records

Suitability of Management

22. Requirements where the service provider is an individual/partnership
23. Requirements where the provider is a body other than a partnership
24. Requirements relating to registered managers
25. Registered person: training
26. Financial position
27. Notifications – notice of absence
28. Notifications – notice of changes

LEADS		COMMITTEE/GROUP ABBREVIATIONS		OTHER ABBREVIATIONS	
SB	Sarah Balchin	EMT	Executive Management Team	CQC	Care Quality Commission
BC	Brian Courtney	G&Q	Governance & Quality Committee	CSC	Clinical Service Centre
JD	Julie Dawes	H&S	Health & Safety Steering Group	DoH	Department of Health
RF	Roberta Fuller	FC	Finance Committee	KPI	Key Performance Indicator
RH	Richard Harvey	ITSG	Information Technology Steering Group	TDA	Trust Development Agency
SH	Simon Holmes	PEWG	Patient Experience Working Group		
RK	Rebecca Kopecek	SEC	Strategic Education Committee		
FMcN	Fiona McNeight	SMT	Senior Managers Team		
TP	Tim Powell	TC	Transformation Committee		
PS	Paul Sadler	WSC	Workforce Strategy Committee		
CT	Chris Tite				
CW	Cherry West				