TRUST BOARD PUBLIC – SEPTEMBER 2013

Agenda Item Number: 178/13
Enclosure Number: (6)

Subject:	Board Assurance Framework (BAF)
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Risk Coordinator Julie Dawes – Director of Nursing Julie Dawes – Director of Nursing
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 • New Risk 3.2
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 at Trust Board in October 2013.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	All
BAF/Corporate Risk Register Reference (if applicable)	N/A
Risk Description	N/A
CQC Reference	Outcome 16

Committees/Meetings at which paper has been approved:	**Date**
N/A	N/A

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: September 2013

Purpose:
To provide the Trust Board with an update on the Assurance Framework as of ……. September 2013

Top Risks

1.5 ◄► **(Red 20):** Failure to achieve Emergency Department quality standards

1.7 ◄► **(Red 20):** Failure to achieve cancer wait targets

1.6 ◄► **(Red 16):** The Trust fails to achieve referral to treatment (RTT) access targets

3.1 ◄► **(Red 16):** Threat to specialist services due to centralisation agenda (vascular)

5.3 ◄► **(Red 16):** 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

5.4 ◄► **(Red 16):** 2013/14 savings plans are not identified and delivered

New Risks

3.2 **(Amber 8):** Failure to Implement the Trust's IT Strategy

Revised Risks

Nil

Risks with an Increased Score

Nil

Risks with a Decreased Score

Nil

Removed Risks

Nil

Of Note

Senior Management Capacity discussed at RAC and added to the Trust Risk Register, IT Strategy risk has been developed and reflected on the BAF. Infection Control issues are to be reviewed at RAC in October

Prepared by: Annie Green – Risk Coordinator

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 PATIENT CENTERED CARE

- Year on year improvement in national, local and quality account metrics
- Achieve top 20% position across acute Trusts as measured by the East Midlands Quality Observatory dashboard
- Year on year reduction in avoidable harm
- Maintain compliance against Care Quality Commission outcomes
- Deliver good patient experience as measured by Friends and Family Test
- Consistently achieve all access standards in line with commissioning and regulatory requirements
- Partner with other organisations to deliver joined up emergency care
- Safeguard vulnerable groups through robust safeguarding procedures

STRATEGIC AIM 2: DEVELOP A REPUTATION FOR EXCELLENCE IN INNOVATION, RESEARCH & DEVELOPMENT AND EDUCATION IN THE TOP 20% OF OUR PEERS.

- Year on year increase in patient recruitment to clinical trials
- Establishment of academic/innovation centre within PHT
- Work in collaboration with AHSN to develop innovation and research projects
- Become a hospital of choice within Wessex for trainees to wish to work in.

STRATEGIC AIM 3: BECOME THE HOSPITAL OF CHOICE FOR GENERAL, SPECIALIST AND SELECTED TERTIARY SERVICES.

- Maintain and grow referral practice from General Practitioner surgeries in the local catchment area and beyond
- Maintain and grow specialist services with local national and international reputation
- Maintain and grow Renal and Transplantation service to become centre of excellence in the UK

STRATEGIC AIM 4: BE A HOSPITAL WHOSE STAFF RECOMMEND THE TRUST AS A PLACE TO WORK AND A PLACE TO RECEIVE TREATMENT.

- Overall staff engagement, as measured through the National Staff Survey, will improve and score above average in the 2014 survey for the following :
- Staff ability to contribute towards improvements at work
- Staff recommendation of the Trust as a place to work or receive treatment
- Staff motivation at work

STRATEGIC AIM 5: DEVELOP SUFFICIENT FINANCIAL STRENGTHS TO ADAPT TO CHANGE AND INVEST IN THE FUTURE.

- Reduce the underlying deficit to less than £5m in 2013/14 and move the underlying position to a surplus of at least £4m in 2014/15.
- Develop a full Integrated Business Plan underpinned by robust supporting strategies.
- Be in a position to make a credible application to Monitor to become a Foundation Trust in Q2 2014/15.
- Develop Clinical Service Centres as fully functioning developed business units with full profit and loss responsibility.
- Re-align corporate services to support all of the above

Trust Risk Profile - September 2013

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)					
Unlikely (2)			1.1 CQC compliance ◄ ► 2.2 Growth in R&D ◄ ►	3.2 IT Strategy *NEW* 4.2 Leadership Capability ◄ ►	
Possible (3)			1.4 Patient Experience ◄ ►	1.2 Quality and Safety Standards ◄ ► 1.3 Mortality rates ◄ ► 1.8 Data Quality ◄ ► 1.9 Equivalent workforce across seven days ◄ ► 2.1 Junior Doctor feedback ◄ ► 4.1 Staff engagement ◄ ► 4.3 Workforce planning ◄ ► 5.1 Foundation Trust status ◄ ► 5.2 Failure of budgetary control ◄ ►	
Likely (4)				1.6 RTT and Access targets ◄ ► 3.1 Threat to specialist services ◄ ► 5.3 Financial Penalties ◄ ► 5.4 Delivery of savings ◄ ►	1.7 Cancer Wait Targets ◄ ►
Highly Likely (5)				1.5 Failure to achieve Emergency Department Quality Standards ◄ ►	

ASSURANCE FRAMEWORK 2013/14 PROGRESS SUMMARY - September 2013

STRATEGIC AIM	Risk Reference Operational Leads	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	RESPONSIBLE COMMITTEE	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
					APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
1: DELIVER SAFE, HIGH QUALITY, PATIENT CENTERED CARE	1.1 FMcN	Inability to maintain ongoing compliance with all CQC standards	G&Q	All	8	6	6	6	6	6							Oct 13	6 Apr 14
	1.2 LW	Failure to comply with internally and externally set standards on quality and safety	G&Q	4 7 8 9	12	12	12	12	12	12							Nov 13	8 Apr 14
	1.3 LW	Failure to achieve mortality rates within national range	G&Q	4				10	12	12							Oct 13	8 Apr 14
	1.4 SB	Failure to achieve internal and external standards around patient experience	PEWG	16 17	9	9	9	9	9	9							Nov 13	6 Apr 14
	1.5 MP	Failure to achieve Emergency Department Quality Standards	SMT	16	15	15	20	20	20	20							Oct 13	Apr 14
	1.6 MM	The Trust fails to achieve referral to treatment (RTT) access targets	SMT	4	12	12	12	12	16	16							Oct 13	8 Apr 14
	1.7 MM	Failure to achieve cancer wait targets	SMT	4				12	20	20							Oct 13	8 Apr 14
	1.8 PM	Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate	SMT	16					12	12							Oct 13	8 Apr 14
	1.9 LW	Lack of equivalent workforce across seven days of the week	SMT	4					12	12							Oct 13	8 Review Nov 13
2: DEVELOP A REPUTATION FOR EXCELLENCE IN INNOVATION, RESEARCH & DEVELOPMENT AND EDUCATION IN THE TOP 20% OF OUR PEERS.	2.1 PS	Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns	SMT	14				12	12	12							Nov 13	8 Apr 14
	2.2 AC/KG	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							Nov 13	3 Mar 14
3: BECOME THE HOSPITAL OF CHOICE FOR GENERAL, SPECIALIST AND SELECTED TERTIARY SERVICES	3.1 SH	Threat to specialist services due to centralisation agenda	SMT	6				16	16	16							Nov 13	16 Mar 14
	3.2	Failure to Implement the Trust's IT Strategy	RAC	4 11						8							Nov 13	4 Feb 14

4: STAFF WOULD RECOMMEND THE TRUST AS A PLACE TO WORK AND RECEIVE TREATMENT	4.1 RK	Insufficient engagement of workforce	SMT	14	12	12	12	12	12	12							Nov 13	6 Apr 14
	4.2 PS	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change	SMT	14	12	12	12	8	8	8							Oct 13	6 Apr 14
	4.3 RK	Future workforce demand requirements are not met by substantive staff impacting on care delivery	SMT	13	9	9	9	9	12	12							Nov 13	9 Mar 14
5: DEVELOP SUFFICIENT FINANCIAL STRENGTHS TO ADAPT TO CHANGE AND INVEST IN THE FUTURE	5.1 BL	Inability to achieve Foundation Trust status within the agreed timetable	TB	26	12	12	12	12	12	12							Nov 13	8 Mar 15
	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	12	12	12	12	12	12							Oct 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	12	12	12	16	16							Oct 13	12 Apr 14
	5.4 RH	2013/14 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	FC	26	12	12	16	16	16	16							Oct 13	12 Apr 14

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY, PATIENT CENTERED CARE

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**	• 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 • QuarterkyMock 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	• 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 • Positive report following CQc responsive visit in May 2013 • Gap analysis against proposed CQC surveillance model (metrics) identifies no significant areas of concern • HealthAssure training completed	**12 (4X3)**	**6 (3X2)**	**6 (3X2)**	i. HealthAssure software solution not yet fully embedded None ii. Gap analysis against proposed CQC surveillance model (metrics) identifies no significant areas of concern	iii. New HealthAssure system training on-going. System needs to be fully populated with evidence across all CSCs and locations iv. Consistency of use of Health assure software – lack of regular updates across all sites in some areas	1. Director of Nursing 2. Head of Governance 3. Governance & Quality (G&Q)	Oct 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.)/ iii) HealthAssure training	TS	Jun 13	Complete and ongoing
ii) Undertake Gap analysis	FMcN / TS	Aug 13	Jul 13
iv) Consistency checking through Governance department, ad hoc training for users until familiar with the system	TS	Oct 13	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
1.2	**Failure to comply with internally and externally set standards on quality and safety** **Implications:** • **Reputational damage** • **Poor patient safety** • **Failure to satisfy quality contract** • **Fines associated with some quality metrics** • **Loss of CQUIN income**	• Governance Framework and monitoring – Quality Improvement Framework • Quality Impact Assessments of CIP plans – policy ratified March 13 following extensive pilot • Quality Performance measures • Monitor Compliance Framework • CSC performance reviews • Kitbag performance metrics • Clinical Audit programme • Gov & Quality Committee • Patient safety Steering Group and associated Safety workstreams • Monthly and Quarterly Board reporting • Monthly CQUIN meetings	• Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Trust Board • Dr Foster data • CQC feedback – QRP/review feedback • Q1 achievement of VTE CQUIN requirement	12 (4x3)	12 (4x3)	8 (4x2)	i. All risk assessments to be completed and savings plans signed off for CIP programme	ii. Finished year above trajectory for MRSA (6 against a trajectory of 4) 12/13 iii. Failed ED performance target at year end 2012/13 and Q1 13/14 iv. Q1 13/14 grade 3 and 4 pressure ulcers above trajectory (Quality Contract) v. Safety Thermometer CQUIN to reduce prevalence of pressure ulcers at risk (Q1 showing no improvement) vi. Dementia CQUIN for screening not achieved in Q1 vii. CSC performance framework under review viii. EDS solution not fully rolled out and functioning across all areas	1. Director of Nursing 2. Head of Patient Safety 3. G&Q	Nov 13	Apr 14	CQC 4, 7, 8 9, 11	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 – extended due to budget resetting exercise	DB/LW	Aug 13	Aug 13

Action	By Whom	By When	Date Completed
i) Review and refine policy process	DB/LW	Sept 13	
ii) Implementation of MRSA Recovery Plan	CM	Jul 13	Implemented and monitoring ongoing
iii) See risk 1.5 for actions	MP		
Iv & v) Q1 review of hot spots and themes and identify learning for action	BT	Jul 13	Aug13
Iv & v) Commit to being active participant in the whole health economy pressure ulcer improvement programme hosted by the CCG	LW/BT	Jul 13	Jul 13
Iv & v) Rapid implementation of SKIN bundle across the Trust with weekly audits at ward level	AF/BT	Aug 13	Aug13
vi) Daily meetings reinstated to review performance	GG	Jun 13	Jun 13
vi) Vitalpac solution to be implemented across the Trust	GG	Aug 13	Deferred to September
vii) Weekly dashboard review of performance and identification at patient level where compliance not 100%	SF	Jul 13	Jul 13
viii.) Fully embed CSC performance review process	CW	Jul 13	Jul 13 and work around an accountability framework ongoing
viii) I Desktop to be fully rolled out	CT	Apr 14	
viii) EDS light to be agreed and implemented as mandatory requirement to complete	CT/CJ	Apr 14	
viii) CCG GP representatives to communicate Trust position and plans	PM	Dec 14	

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										On target / Minor Obstacle to achieving target / Inability to achieve predicted target			
1.3	**Failure to achieve mortality rates within national range** **(HSMR/SHMI)** **Implications:** • **Reputational damage** • **Not hospital of choice for GPs or patients**	• Governance Framework and monitoring – Quality Improvement Framework • Clinical Effectiveness Steering Group • Clinical Audit Programme • M&M meetings • Participation in national audits • Governance and Quality Committee reporting	• HSMR/SHMI as expected • No reduction in referral patterns	12 (4x3)	12 (4x3)	8 (4x2)	i. Incomplete individual mortality review ii. Inadequate depth of coding	iii. Patient deaths not reviewed in a systematic way to draw out learning from across the Trust	1. Medical Director 2. Head of Patient Safety 3. G & Q	Oct 13	Jan 14	CQC 4	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Electronic intranet based tool being developed to capture mortality data from across the Trust	LW/SE	Oct 13	
i)ii)iii) Hospital Mortality Working Group review of procedures	LW	Oct 13	
ii) Complete coding project to improve depth of coding	SH	Dec 13	

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										On target / Minor Obstacle to achieving target / Inability to achieve predicted target			
1.4	**Failure to achieve internal and external standards around patient experience as measured through Friends and Family test and National Patient Surveys** **Implications:** • **Poor patient experience** • **Reputational damage** • **Loss of income if fail to achieve CQUIN associated with friends and Family Test**	• CSC targets set to achieve friends and family test returns with weekly reporting loop • Variety of methods allowing patients/carers to feedback through surveys • Complaints and PALS process to capture patient feedback • User groups established within the Trust • Patient Experience Steering Group • Quality Improvement Framework • Governance and Quality reporting • Monthly and quarterly reporting to Trust Board • Patient stories at the Board	• Overall improvement in 2012 inpatient survey from previous years across 5 key questions • Positive feedback from the ombudsman regarding individual complaints and level of investigation • Annual Complaints report identifies reduction in number of complaints and PALS contacts on previous year and significant reduction in complaints relating to nursing care	9 (3x3)	9 (3x3)	6 (3x2)		i. Post Francis the Board have requested a review of the complaints process to ensure robust as possible ii. 2012 inpatient survey although improved shows need for improvement iii. Did not achieve response rate on FFT for Q1 CQUIN iv. Lack of improvement in cancer survey results	1. Director of Nursing 2. Head of Patient Experience 3. G & Q	Nov 13	Apr 14	CQC 16, 17	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ iii) Weekly monitoring of F&F returns at dept level	NL	Jul 13	Jul 13 and ongoing
ii) Review of Complaints Process with recommendations for improvement	LW	Aug 13	
iii) Inpatient Survey Action plan down to CSC level to be agreed and published	NL/FMc	Jul 13	Aug 13
iv) Responsive action plan being worked up through cancer leads	HM	Oct 13	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
1.5	**Failure to achieve Emergency Department Quality Standards** **Implications:** • **Poor patient experience** • **Financial penalties** • **Poor staff morale**	• System wide action plan • Daily operational forum • Revised Performance Assurance Framework • Published performance operating standards • Urgent Care model which has got full health economy sign up • Revised accountability structure (clinical and managerial) • IDB meeting – timing brought forward in the day Update • 2 hourly escalations to expedite issues	• Performance metrics showing improving picture although very early days • Revised accountability structure having an impact on the above improvements and synergies across the Trust in how teams work to promote dynamic patient flow • Proposed implementation of integrated Urgent care centre at the front door. • Expansion of the Ambulatory service	20 (4x5)	20 (4x5)	12 (4x3)	i. Ability to control front door demand ii. Complex patients achieving discharge destination in a timely manner with minimal delays		1 Chief Operating Officer 2. Managing Director ED & Renal 3. SMT	Oct 13	Apr 14	CQC 4, 6, 16	RR 2.1 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) PHT to ensure full commitment to weekly health economy meetings – these involve COOs from 3 providers and commissioners to ensure that system is pulling together	CW	Jun 13	Completed and ongoing engagement
i) Develop and launch urgent care model	CW	Sep 13	
ii) IDB meeting refocused 24/24 focus on escalation process, and to increase frequency of meetings	MQ	Sep 13	

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1.6	**The Trust fails to achieve referral to treatment (RTT) access targets in four specialties:** ▪ **Trauma & Orthopaedic (T&O)** ▪ **Ear, Nose & Throat (ENT)** ▪ **Urology** ▪ **Colorectal** **Implications:** • **Patient experience** • **Deterioration of patient health** • **Reputation** • **financial penalties(2% 18/52 activity) on any planned fails dependant on commissioning discussions**	• All services have mapped forecast demand and capacity so have forward plans in place • Weekly assurance meeting – this is a forward look to identify trigger points for escalation and action • Ophthalmology action plan	• Specialities with specific issues have had agreements in place for planned fail • Action plan rectifies Trust performance in 3 out of 4 from Nov 13 • Plan for 4th speciality (Urology) due for completion 13/9/13 • Contingency plan for additional IS capacity under development if required	12 (4x3)	16 (4x4)	8 (4x2)	i. Orthopaedics and urology are growing risks with increased numbers of patients > 18 weeks ii. T&O – Waiting list growing, particularly substantial increase in hips and knees iii. ENT – waiting list backlog has increased as demand had increased by 7% iv. Colorectal – backlog increased due to surgeons on-call commitments and leave v. Urology – Cancer Urology consultant vacancy has decreased capacity	vi. Whole Trust fail in September and October	1. Chief Operating Officer 2. Managing Director 3. SMT	Oct 13	Apr 14	CQC 4	RR 3.3 3.5

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Urology – work ongoing for planned fail in July	LP	Jul 13	Jul 13
i) Orthopaedics – work ongoing to map back log and capacity with potential for planned fail in July	MM	Jul 13	Jul 13
All) Keep commissioners involved in all of the above plans	MM	Jul 13	Jul 13
ii)/vi) Change waiting list to look longest waiting patients first in Sep and Oct	CSC leads	Nov 13	Aug 13
ii)/vi)Increase hip and knee operations in Sep and Oct	T & O CD	Nov 13	Aug 13
iii)/vi) Employ 2 additional middle grade doctors	MM	Aug 13	Aug 13
iii)/vi) Increase pooling of referrals, particularly to hip and knee surgeons prior to first out-patient appointment	T & O CD	Aug 13	Aug 13
iii)/iv) Improve joint productivity within theatre operating lists	T & O CD	Nov 13	
iii)/vi) Convert one MaxFax day list to ENT for Sep and Oct	Chief H & N	Sep 13	Aug 13
iii)vi) Improve utilisation of current plain time lists	Chief H & N	Aug 13	Aug 13
iii)/vi) Implement enhanced booking process to improve productivity	Chief H & N	Aug 13	Aug 13
iv)vi) Employ two additional locum surgeons	MM	Aug 13	Aug 13

Action	By Whom	By When	Date Completed
iv)vi) Create additional all day Saturday theatre list	MM	Sep 13	Aug 13
iv)/vi) Recruit new permanent consultant	CEO	Dec 13	
iv)/vi) Review of on-call rotas	MM	Nov 13	
v) vi) Work up recovery plan for Urology	MM	Sep 13	
vi) Secure additional capacity in the independent sector as contingency to ensure plan is delivered by end October 2013	MM	Sep 13	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
1.7	**Failure to achieve cancer wait targets** **Implications:** • **ensuring that patients are seen in a timely manner** • **Financial penalties may be applied by commissioners**	• Capacity and demand modelling undertaken and in place within CSCs • Weekly assurance meeting with forecast planning and triggers for escalation • Daily PTL meetings within CSCs to track progress of patients on cancer pathway • Cancer action plan	• Roll out for Cancer Access policy training on track • Weekly cancer operational meeting established • New exception reporting process agree with Business Intelligence	12 (4x3)	20 (5x4)	8 (4x2)	i. Failed 62 day screening target in May and June ii. Increasing referrals iii. Patient choice rules means clock doesn't stop if patient defers anywhere on pathway iv. Decrease in Urology capacity	v. Failure to update Remedial Action Plan vi. Failure to remedy breach to satisfaction of CCGs vii. Recent patient survey results are unsatisfactory	1 Chief Operating Officer 2. Managing Director 3. SMT	Oct 13	Apr 14	CQC 16	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Histopathology backlog recovery plan in place to resolve waits	DC	Aug 13	Aug 13
ii) Monitoring of referral patterns so that additional capacity can be added in response – currently occurring in urology	MM	Sep 13	
iii) Monitoring of individual patient pathways via PTL meetings	MDs	Jul 13	Jul 13
iv) v) Develop capacity plan for Urology	MM	Sep 13	
v) Monthly updates to RAP diarised with assigned manager	LP	Sep 13	Sep13
vi) Rectify remedial action plan breach	MM	Aug 13	Aug 13
vii) Agreed to establish internal cancer improvement plan to include the areas of poor performance (bottom 20% of Trusts) from cancer survey	LP	Oct 13	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
1.8	**Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate** **Implications** • **Reputation damage** • **Financial penalties** • **Incorrect business decisions made using incorrect data assumptions impacting on patient experience**	• Data validation processes in place in some areas but patchy	•	**12 (4X3)**	**12 (4x3)**	**8 (4X2)**	i. Lack of Trust wide data quality Strategy ii. Significance of data quality is not recognised Trust wide iii. Lack of formalised checking procedures and sign off	iv. Deloitte internal audit highlighted issues in several areas v. Incorrect data supplied externally resulting in internal investigation	1. Director of Corporate Affairs & Business Development 2. Head of IT 3. SMT	Oct 13	Apr 14	CQC 16	RR 1.48

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Data Quality Working Group (DQWG) to be formed	PM/CT	Aug 13	Aug 13
i) Devise and implement Data Quality Strategy and action plan	DQWG	Dec 13	
ii) Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust	CW	Dec 13	
iii)/iv) Introduce templates for system level data quality assessments and action plans and train relevant staff to use	CT	Dec 13	
ii) All new job descriptions to have personal responsibility for ensuring the quality of data included	RK	Nov 13	
iii) Devise formal checking procedure	JL	Dec 13	
iv) Lessons learnt from internal investigation to be actioned by Business Intelligence	JL	Aug 13	Aug 13

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
1.9	**Lack of equivalent workforce across seven days of the week** **Implications** • **Damage to Trust reputation** • **Poor patient experience** • **Reduced quality of care**	• Governance systems in place to ensure patient safety and quality of care is maintained	• Review of hospital mortality with emphasis on weekend mortality with TDA • Weekend HSMR shows no significant difference to comparable Trusts	12 (4X3)	12 (4x3)	8 (4X2)	i. Delays in progressing patient pathways	ii. IPR indicates lengths of stay could be reduced	1. Medical Director 2. Chief of Service 3. SMT	Oct 13	Review agreed action Nov 13	CQC 4	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) 7 Day Working Group to report to Trust Board by end Sep 13 where action will be agreed	SH/PY	Sep 13	

STRATEGIC AIM 2: DEVELOP A REPUTATION FOR EXCELLENCE IN INNOVATION, RESEARCH & DEVELOPMENT AND EDUCATION 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			
2.1	**Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns** **Implications:** • **Service delivery** • **Reputation as an organisation delivering high standards of education and training to medical trainees**	• Director of Medical education • Educational Supervisors • Deanery links • Foundation Programme Directors • Foundation Doctors educational programme	• AAA rating • Positive feedback on level of experience gained	12 (4x3)	12 (4x3)	8 (4x2)	i. Junior doctors although exposed to positive clinical experience report that they are not receiving the educational support expected of their training posts		1 Medical Director 2. Director of Education 3. SMT	Nov 13	Apr 14	CQC 14	RR 4.3 4.4

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Meetings with groups of junior doctors to explore issues	PS	Jul 13	Jul 13
i) Forums set up for Director of Medical Education and Juniors to meet and discuss issues proactively	PS	Jul 13	Jul 13
i) Director of Medical Education visit to all relevant departments regarding outcome of report	PS	Jul 13	Jul 13
i) Directive issued and now to be implemented which states that educational supervision must be included in all Consultant job plans as part of the job planning review	Chiefs	Sep13	
i) Survey of outgoing trainees to assess impact of initial plans and inform further action	PS	Sep 13	

<table>
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2. Manager
3. Responsible Committee</th><th>REVIEW DATE</th><th>TARGET DATE (for mitigation of risk)</th><th colspan="2">LINK TO CQC STANDARDS

AND RISK REGISTER</th></tr>
<tr><th colspan="10"></th><th colspan="2">On target
Minor Obstacle to achieving target
Inability to achieve predicted target</th><th colspan="2"></th></tr>
<tr><td>2.2</td><td>The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network</td><td>• Wessex AHSN confirmed by DH
• Innovation strategy to be taken forward by Director of Research
• Medical Director participating in AHSN discussions with UHS
• Trust R&D Strategy and framework
• R&D income monitored by R&D Director</td><td>• Medical Director reporting back to Board on discussions
• R&D income year on year increase
• National NIHR and Guardian League tables 2013 shows good competitive performance by PHT</td><td>10 (5x2)</td><td>6 (3x2)</td><td>3 (3x1)</td><td></td><td>i. Quarterly R&D reporting to be established</td><td>1. Medical Director
2. Director of Research & Development/ Research Manager
3. SMT</td><td>Sep 13</td><td>Mar 14</td><td>CQC

6</td><td>RR</td></tr>
<tr><th colspan="9">ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</th><th>By Whom</th><th>By When</th><th colspan="3">Date Completed</th></tr>
<tr><td colspan="9">i) Quarterly Research & Development report to be submitted to Trust Board – KPIs to be developed, Reporting structure to be agreed with MD
July Update: Formal papers are submitted 6 monthly to the Clinical Effectiveness Group. Success of the R&D strategy is monitored quarterly via the PHT Research Strategy group. CLRN reports on PHT performance are sent regularly to the CEO. Research performance is also reviewed by the board in the quality account and annual report submission. KPI dashboard has been drafted</td><td>AC</td><td>Jul 13</td><td colspan="3">Jun 13</td></tr>
<tr><td colspan="9">i) Research & Development strategy to be developed and agreed
July Update: Quarterly Strategy review meetings have been in place since 2012 and are ongoing. Revised strategy to include innovation is due 2014</td><td>AC</td><td>Jul 13</td><td colspan="3">Ongoing</td></tr>
</table>

STRATEGIC AIM 3: BECOME THE HOSPITAL OF CHOICE FOR GENERAL, SPECIALIST AND SELECTED TERTIARY 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			
3.1	**Threat to specialist services due to centralisation agenda** **Implications:** • **Potential loss of major vascular surgery at PHT due to centralisation to a tertiary unit** • **This carries longer term implications for the viability of other services such as interventional radiology and renal**	• Outcome data • Vascular Society requirements for a service • Fully covered clinical rota with committed team • National audit results	• Positive outcome data for this group of patients • Fulfilment of vascular society recommendations for service delivery • Good clinical outcome data	16 (4x4)	16 (4x4)	16 (4x4)	i. Decision ultimately outwith PHT control as specialist commissioner led ii. Currently no assurances from specialist commissioning teams as to the medium and long term direction		1 Medical Director 2. 3. SMT	Nov 13	Mar 14	CQC 6	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Continue to work closely with specialist commissioners and TDA on this issue	SH	Oct 13	
i)/ii) Consultation scheduled for October 13	SH	Oct 13	

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			
3.2	**IT department is unable to implement Trust IT Strategy because clinical staff cannot be released to participate in the selection and implementation of required IT solutions, tactical It developments prevent the necessary resources being released, or there is inadequate funding to recruit staff or procure required IT solutions** **Implications:** • **Failure to improve efficiency, effectiveness and cost effectiveness of Trust clinical services through the utilisation of new IT** • **Waste of finance and staff resource on aborted or unsuccessful procurement of IT solution** • **Failure to meet national and local performance targets**	• Board approval for IT Strategy • IT Strategy Committee • Robust IT project and programme management processes	• IT Strategy Committee • Programme Highlight Reports • Business case	**8 4x2**	**8 4x2**	**4 4x1**	i. Lack of Clinical Information Systems Programme Board ii. No Clinical Information Systems Programme team iii. Lack of specialist procurement expertise iv. Lack of Programme plan v. Lack of engagement of clinicians, CSCs and other stakeholders to specify requirements	i. Lack of Clinical Information Systems Programme Board	1. Director of Finance 2. Head of IT 3. RAC	Nov 13	Feb 14	CQC 4, 11	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Set up Clinical information Systems Programme Board	Head of IT / Chief Operating Officer	Nov 13	
ii) Identify funding in IT Capital programme for Clinical information Systems Programme Resources and employ / back-fill for required staff as required	Head of IT	Ongoing	
iii) Liaise with Director of Procurement & Commercial Services to identify and obtain suitably skilled procurement support to Programme	Head of IT	Nov 13	
iv) Develop Programme Plan as programme develops and gain approval from Clinical information Systems Programme Board & IT Strategy Committee	Head of IT	Jan 14	
v) Establish Clinical Reference Group for Programme	Associate Medical Director - IT	Nov 13	

STRATEGIC AIM 4: BE A HOSPITAL WHOSE STAFF RECOMMEND THE TRUST AS A PLACE TO WORK AND A PLACE TO RECEIVE TREATMENT.

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	**Insufficient engagement of workforce** **Implications:** • **Lack of understanding/ buy in, and therefore delivery of strategic priorities** • **Suboptimal delivery of patient care** • **Poor staff survey results** • . Lack of engagement from clinical staff in delivering the change agenda	• Listening into Action programme • Staff survey action plans developed within CSCs • Health and well-being programme established. • Employee recognition programmes in place. • Leadership • Appraisal and performance management process	• Improved performance in 2012 national staff survey results. • Lower than average levels of sick absence and staff turnover when compared to other acute organisations. • Integrated performance report to Board including staff feedback • Improved staff engagement levels • Q1 Pulse survey demonstrates higher levels of engagement than 2012 results	12 (3x4)	12 (3x4)	6 (3x2)	i. Maintaining appraisal compliance rate	ii. Staff survey results still show lower than acceptable scores against some key findings	1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Nov 13	Apr 14	CQC 14	RR 3.3 4.2

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) CSCs adopting the LiA approach to address key findings and encourage new ideas for improvements	MDs	Jul 13	Jul 13
i) Clinically led pioneer teams set up to engage and empower staff to make positive changes for the benefit of patients and staff	UW/LR	Nov 13	
i) Quarterly staff pulse survey launched with key questions linked to the national staff survey	TP	Jun 13	Launched and ongoing
ii) Development of an appraisal quality assurance framework linked to values	LR	Nov 13	

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	**Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.**	• Leadership development programmes in place to support leaders at various levels. • 360 and self-assessment completed at Executive level • Trust wide leadership competencies identified	• 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)	**6 (3x2)**	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	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. 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
i/iv) Identify mandatory leadership development programmes for key leadership roles	TP/LR	Oct 13	
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
ii) Launch of internal clinical leadership programme	TP/LR	Oct 13	
ii) Clinical Directors development programme commenced jointly with Southern	TP/LR	Oct 13	
iii) Embed Working Together for Patients into ward accreditation programme	TP/LR	Oct 13	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
4.3	**Future workforce demand requirements to deliver a quality service are not met by substantive staff, impacting on care delivery. Due to constraints in training numbers for some professions on a national level, poor proactive workforce planning internally, lack of succession planning, external and internal economic factors** **Implications:** • **Workforce design does not keep pace with changing service delivery** • **Poor patient experience and suboptimal care delivery** • **higher than acceptable levels of temporary staff and unaffordable staffing levels.** • **Poor recruitment and retention** • **Poor staff**	• 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 • E-Rostering	• 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 • High levels of rota fill from recent junior doctor intake	16 (4x4)	12 (3x4)	9 (3x3)	i. Temporary resource currently above planned level of 3%. ii. Reduction in Junior Doctor resource will increase demand for consultants in some specialities. iii. Attraction strategy needs further development to enable recruitment of high level candidates.	iv. High levels of nursing vacancies in some CSCs – MSK, Cancer & Surgery and MOPRs v. Supply of newly qualified nursing workforce is insufficient for PHT required demand	1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. SEC	Nov13	Mar 14	CQC 13	RR 4.1 4.3 4.4 5.1

	morale												

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Fully deploy E-rostering system – opportunities from E-Rostering to be realised	RK	Jul 13/ Dec 13	Jul 13
i) Continue to monitor temporary spend on bi-weekly basis	AW/RK	Ongoing	
i) Execs continue to sign off temporary staffing requests	EDs	Ongoing	
i) Demand and capacity review to ensure productivity is improved	MDs	Oct 13	
ii.) Ongoing discussions with Deanery linking into workforce strategy for the future	PS	Ongoing	
ii) Skill mix review by CSC as necessary and to develop roles such as Assistant Practitioners	MDs	Oct 13	
ii) Medical workforce capacity improved through robust job planning	TP/SH	Dec 13	
iii.). Define Attraction Strategy for 2013/14 intake – to include values based recruitment	NSa	Nov 13	
iv.) / v.) Demand forecast under discussion with Health Education England to secure higher fill rate for newly qualified staff	DE	Nov 13	
iv.) / v.) Overseas recruitment planned to meet shortfall of newly qualified nurses required	DE	Nov 13	

STRATEGIC AIM 5: DEVELOP SUFFICIENT FINANCIAL STRENGTHS TO ADAPT TO CHANGE AND INVEST IN THE FUTURE

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	**Inability to achieve Foundation Trust status within the agreed timetable**	• Dedicated FT project support • FT project plan • Trust Board scrutiny • Performance management systems	• Some operational key targets being achieved • Dedicated support from TDA in Sir Ian Carruthers	12 (4x3)	12 (4x3)	8 (4x2)	i. Trust currently planning for a deficit in 13/14 (as agreed with TDA) ii. Performance against key targets in A&E, RTT and cancer not being achieved iii. Lack of development programme	iv. Financial report shows Trust plan currently in deficit v. Revised financial strategy and Long Term Financial Model required which demonstrates how the Trust becomes financially sustainable. Timeline, level and nature of support for the Trust to become an FT yet to be agreed with the TDA.	1. Director of Finance 2. Deputy Director of Finance 3. Trust Board	Nov 13	Mar 15	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
I.) / iii.) Build savings programme which eradicates underlying deficit	BL	Sep 13	
ii) See 1.5, 1.6 and 1.7 for actions linked to achieving targets	MM/MP	Nov 13	
iv) Agree timing with the TDA, articulate the financial strategy and refresh the Long Term Financial Model - exact timing to be confirmed by the Trust Development Agency	BL	Oct 13	
iii)/iv) Instigate the development programme against agreed plan with TDA	BL	Dec 13	

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Minor Obstacle to achieving target
Inability to achieve predicted target</th><th></th><th></th></tr>
<tr><td>5.2</td><td>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.</td><td>• Finance reporting and monitoring mechanisms at CSC to Board level
• Updates on Financial position provided to Board, SMT Finance Committee
• Delegated budgetary control framework
• Trust wide savings and transformation programme
• Income and contract monitoring
• Bottom up forecasting in place</td><td>• Financial plan revised to reflect agreed commissioning contracts
• Budgets rebased to reflect current run rate
• Daily metrics via KitBag</td><td>12 (4x3)</td><td>12 (4x3)</td><td>8 (4x2)</td><td>i. Formal sign off of budgets and supporting Quality Impact Assessments
ii. Monthly performance reviews require strengthening
iii. Accountability of CSCs requires strengthening</td><td></td><td>1. Director of Finance
2. Deputy Director of Finance
3. Finance Committee</td><td>Oct 13</td><td>Apr 14</td><td>CQC
26</td><td>RR
5.1</td></tr>
<tr><th colspan="9">ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</th><th>By Whom</th><th>By When</th><th colspan="3">Date Completed</th></tr>
<tr><td colspan="9">i) Formal sign off of budgets by each CSC with supporting QIAs</td><td>Finance team and CSC management teams</td><td>Jul 13</td><td colspan="3">Completed</td></tr>
<tr><td colspan="9">ii) Fully implement bottom up run rate forecasts and reconcile to top down forecasts as part of monthly accounts process</td><td>RH</td><td>Aug 13</td><td colspan="3">Jul 13</td></tr>
<tr><td colspan="9">ii)/iii) Performance Assurance Framework to be agreed and implemented with CSCs</td><td>EMT</td><td>Oct 13</td><td colspan="3"></td></tr>
<tr><td colspan="9">iv) Introduce and clarify the role of the CSC managing Director and cluster CSCs where required</td><td>EMT</td><td>Jun 13</td><td colspan="3">Complete</td></tr>
<tr><td colspan="9">v) Implementation of KitBag early warning system reporting key metrics</td><td>JL</td><td>Jln 13</td><td colspan="3">Jul 13</td></tr>
<tr><td colspan="9"></td><td></td><td></td><td colspan="3"></td></tr>
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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**	• Monthly contract monitoring reports • Monthly contract review meetings • Income Assurance Group • Monthly CSC performance meetings • Monthly CQUIN meeting. • Contract issues unable to resolve escalated to Execs via ECRM	• Agreed capacity required with CSCs and activity volumes secured through the commissioning contract • Agreed PbR compliant contract • Daily metrics via KitBag	12 (4x3)	16 (4x4)	12 (4x3)	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	iv. ED, Cancer and RTT targets failed	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	Oct 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 July 13 -Update -Two key appointments made (1 in post to date) to support resilient Commissioner interface. Operational link post to be appointed to.	IH/BL	Jul 13	Jul 13 – recruitment complete to commence post Aug 13
ii) Introduce intensive CSC performance meetings which cover contract performance review – performance assurance framework to be formally agreed and implemented	EMT	Sep13	
iii) Identify key owners for risk components re penalties, CQUIN etc July 13 -Update - National CQUIN owners identified. Local CQUIN schemes under renegotiation with commissioner to reduce key risks. Owners identified. Some resources needed to operationalize schemes, but largely in place> Specialised CQUINs schemes TBA with CSCs. Penalty owners TBA. Key risks – ED delays and RTT.	ET	Aug 13	Jul 13
iv) Implementation of KitBag early warning system reporting key metrics	IH	Jun 13	Jul 13 Update - Testing completed June, performance reviews being implemented in July
iv) ii) See 1.5, 1.6 and 1.7 for actions linked to achieving targets	MM/MP	Nov 13	

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5.4	**2013/14 Savings plans are not identified & delivered, with subsequent impact on Trust financial position**	• 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	• 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)	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 iii. Workforce plan requires development and alignment with savings plan	iv. Not all CSC savings schemes have been tested for robustness - gaps have been identified	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	Oct 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	Jul 13
ii) Introduction of intensive CSC performance meetings which cover CIP identification and delivery	EMT	Jun 13	Jul 13 Update - Start w/c 15/07/13
iii) Production of workforce plan which aligns with savings requirements	TP	Jun 13	Jun 13
iv): As i) above	FRG	Jun 13	Ongoing
iv) CSCs tasked with identifying actions to achieve break even position	CSC management teams	Sep 13	
iv) Performance management of CSCs to agreed year end budgetary control totals	BL	Aug 13	Aug 13 and ongoing

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
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 Act 1983
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
SH	Simon Holmes	G&Q	Governance & Quality Committee	CSC	Clinical Service Centre
RH	Richard Harvey	FC	Finance Committee	DoH	Department of Health
RK	Rebecca Kopecek	SEC	Strategic Education Committee	KPI	Key Performance Indicator
BL	Ben Lloyd	SMT	Senior Managers Team		
FMcN	Fiona McNeight	TB	Trust Board		
MM	Mark Morgan				
TP	Tim Powell				
PS	Paul Sadler				
CW	Cherry West				
LW	Lorna Wilkinson				
PY	Phil Young				