

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 <i>Why is this paper going to the Trust Board?</i>	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
Key points for Trust Board members <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>	Trust Board are asked to note <ul style="list-style-type: none"> • Top risks • New risk 4.4 • Increase of risks 1.1 and 1.5 • Decrease of risks 1.6 and 1.7 • Risk 1.5 re-described and increased
Options and decisions required <i>Clearly identify options that are to be considered and any decisions required</i>	<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
Next steps / future actions: <i>Clearly identify what will follow the Trust Board's discussion</i>	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board in November 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: October 2013

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 23 October 2013

Top Risks

- 1.5 ▲ (Red 25): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing
- 1.7 ▼ (Red 16): Failure to achieve cancer wait targets – associated funds highly unlikely to be withheld
- 3.1 ◀▶ (Red 16): Threat to specialist services due to centralisation agenda (vascular)
- 4.4 **NEW** (Red 16): The gaps in the current management team results in some specialties/CSCs not having sufficient capacity, capability and experience necessary to deliver the annual operating plan including delivery of key national targets
- 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

- 4.4 **NEW** (Red 16): The gaps in the current management team results in some specialties/CSCs not having sufficient capacity, capability and experience necessary to deliver the annual operating plan including delivery of key national targets

Revised Risks

- 1.5 ▲ (Red 25): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing

Risks with an Increased Score

- 1.1 ▲ (Yellow 6 to Amber 9): Inability to maintain on-going compliance with all CQC standards – Q2 assessments indicate concerns in Medicine with Outcomes 4, 10 and 13
- 1.5 ▲ (Red 20 to Red 25): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing – risk increased to mirror the score reflected on the Trust Risk Register

Risks with a Decreased Score

- 1.6 ▼ (Red 16 to Amber 12): The Trust fails to achieve referral to treatment (RTT) access targets – plans implemented and on track to deliver agreed position
- 1.7 ▼ (Red 20 to Red 16): Failure to achieve cancer wait targets – associated funds highly unlikely to be withheld

Removed Risks

Nil

Of Note

Infection Control issues were reviewed at RAC in October and are reflected in risk 1.2.
Risk 1.5 has been re-written to fully describe current issues

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 - October 2013

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)			2.2 Growth in R&D ◀▶	3.2 IT Strategy ◀▶ 4.2 Leadership Capability ◀▶	
Possible (3)			1.1 CQC compliance ▲ 1.4 Patient Experience ◀▶	1.2 Quality and Safety Standards ◀▶ 1.3 Mortality rates ◀▶ 1.6 RTT and Access targets ▼ 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)				1.7 Cancer Wait Targets ▼ 3.1 Threat to specialist services ◀▶ 4.4 Management capacity <i>NEW</i> 5.3 Financial Penalties ◀▶ 5.4 Delivery of savings ◀▶	
Highly Likely (5)					1.5 Failure to achieve Emergency Department Quality Standards ▲

ASSURANCE FRAMEWORK 2013/14 PROGRESS SUMMARY - October 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	
					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	9						Nov 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	12						Nov 13	8 Apr 14
	1.3 LW	Failure to achieve mortality rates within national range	G&Q	4				10	12	12	12						Dec 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	9						Nov 13	6 Apr 14
	1.5 MP	Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing	SMT	16	15	15	20	20	20	20	25						Nov 13	15 Nov 13
	1.6 MM	The Trust fails to achieve referral to treatment (RTT) access targets	SMT	4	12	12	12	12	16	16	12						Nov 13	8 Apr 14
	1.7 MM	Failure to achieve cancer wait targets	SMT	4				12	20	20	16						Nov 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	12						Dec 13	8 Apr 14
	1.9 LW	Lack of equivalent workforce across seven days of the week	SMT	4					12	12	12						Nov 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	12						Dec 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	6						Dec 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	16						Dec 13	16 Mar 14
	3.2	Failure to Implement the Trust's IT Strategy	RAC	4 11						8	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	12						Nov 13	6 Apr 14
	4.2 LR	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change	SMT	14	12	12	12	8	8	8	8						Dec 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	12						Nov 13	9 Mar 14
	4.4 RK	The gaps in the current management team results in some specialties/CSCs not having sufficient capacity, capability and experience necessary to deliver the annual operating plan including delivery of key national targets	SMT	14							16						Dec 13	8 Review Apr 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	12						Jan 14	8 Mar 15
	5.2 BL	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	12						Dec 13	8 Apr 14
	5.3 BL	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	16						Dec 13	12 Apr 14
	5.4 BL	2013/14 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	FC	26	12	12	16	16	16	16	16						Dec 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	<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 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)	9 (3X3)	6 (3X2)	<ul style="list-style-type: none"> i. HealthAssure software solution not yet fully populated ii. Robustness of internal quality assurance inspection process iii. Changes in CQC surveillance mechanism and potential impact on the Trust 	<ul style="list-style-type: none"> iv. HealthAssure system training on-going. System needs to be fully populated with robust evidence to support compliance status across all CSCs and locations v. Awaiting publication of CQC surveillance indicators to undertake a gap analysis to identify any gaps in assurance vi. Increased current rating to '9' from '6' due to the result of Q2 assessment highlighting concerns within Medicine CSC with outcomes 4 and 13 and outcome 10 concerns raised by the Outcome Lead. In addition, C.Diff numbers are just under trajectory. 	1. Director of Nursing 2. Head of Governance 3. Governance & Quality (G&Q)	Nov 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.)/ iv) HealthAssure training									TS	Jun 13	Complete and ongoing		
ii) Revised internal quality assurance inspection programme commencing November 2013 aligning with Keogh inspection methodology									FMc	Nov 13			
iii) Review CQC surveillance indicators once published (expected to commence publication 24 October 13)													

iv) Consistency checking through Governance department, ad hoc training for users until familiar with the system	TS/FMc	Nov 13	(pending publication)
v) Undertake a gap analysis once CQC publish surveillance final indicators and Trust position	N Martin J A'Court C Mitchell	Jan 13	(following Q3 assessment)
vi) CQC self-assessment concerns in Medicine being addressed through the CSC.Full review of Outcome 10 being undertaken by Outcome Lead. Enhanced C.Difficile procedures have been actioned which focus on enhanced clinical cleans and timely isolation of suspected or confirmed cases of C.Difficile.	TS	Oct 13 Nov 13	Complete but further checking required following gaps identified during Q2 assessment

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										On target	Minor Obstacle to achieving target		
1.2	<p>Failure to comply with internally and externally set standards on quality and safety</p> <p>Implications:</p> <ul style="list-style-type: none"> Reputational damage Poor patient safety Failure to satisfy quality contract Fines associated with some quality metrics Loss of CQUIN income 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Quality heatmap and exception reports to Trust Board monthly Quality report quarterly to Trust Board Dr Foster data CQC feedback – QRP/review feedback Q1 and Q2 achievement of VTE CQUIN requirement Sep 13 achievement of 90% dementia screening targets 	12 (4x3)	12 (4x3)	8 (4x2)	<p>i. All risk assessments to be completed and savings plans signed off for CIP programme</p>	<p>ii. Finished year above trajectory for MRSA (6 against a trajectory of 4) 12/13</p> <p>iii. Failed ED performance target at year end 2012/13 and Q1 and Q2 13/14</p> <p>iv. Q1 and Q2 13/14 grade 3 and 4 pressure ulcers above trajectory (Quality Contract) – although Q2 numbers showing a slow down</p> <p>v. Safety Thermometer CQUIN to reduce prevalence of pressure ulcers at risk (Q1 showing no improvement)</p> <p>vi. EDS solution not fully rolled out and functioning across all areas</p> <p>vii. Increasing C Diff figures</p>	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		

i) Review and refine policy process	DB/LW	Sept 13	In draft
i) Following up recovery plan QIAs	DB	Nov 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
v 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
vi) Weekly dashboard review of performance and identification at patient level where compliance not 100%	SF	Jul 13	Jul 13
Fully embed CSC performance review process	CW	Jul 13	Jul 13 and work around an accountability framework ongoing
vi) I Desktop to be fully rolled out	CT	Apr 14	
vi) EDS light to be agreed and implemented as mandatory requirement to complete	CT/CJ	Apr 14	
vi) CCG GP representatives to communicate Trust position and plans	PM	Dec 14	
vii) Infection Control action plan to tackle C.Diff in place	CM	Nov 14	

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.3	<p>Failure to achieve mortality rates within national range (HSMR/SHMI)</p> <p>Implications:</p> <ul style="list-style-type: none"> Reputational damage Not hospital of choice for GPs or patients 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> HSMR/SHMI as expected No reduction in referral patterns Weekend death review completed and showed no flags/issues Elective maternity review in first phase of development 	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> Incomplete individual mortality review Inadequate depth of coding 	<ul style="list-style-type: none"> 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	Dec 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	First prototype developed – will not be refined to roll out until Dec 13		
i)ii)iii) Hospital Mortality Working Group review of procedures									LW	Oct 13	Completed		
ii) Complete coding project to improve depth of coding									SH	Dec 13			

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1.4	<p>Failure to achieve internal and external standards around patient experience as measured through Friends and Family test and National Patient Surveys</p> <p>Implications:</p> <ul style="list-style-type: none"> Poor patient experience Reputational damage Loss of income if fail to achieve CQUIN associated with friends and Family Test 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 Friends and Family test commenced in Maternity 1st October 2013, confirmed will not count in CQUIN Q4 response rate. Friends and Family test inpatients and ED now achieving over 20% response rate – on track for CQUIN. National NHS Choices net Promoter score for Friends and Family is being revised to address the methodology national concerns on inappropriately raising a reputation concern. 	9 (3x3)	9 (3x3)	6 (3x2)		<ul style="list-style-type: none"> Post Francis the Board have requested a review of the complaints process to ensure robust as possible 2012 inpatient survey although improved shows need for improvement Lack of improvement in cancer survey results Net promoter score for Friends and Family rank PHT as in the NHS Choices "worst" category, impacting on reputation. 	<ul style="list-style-type: none"> Director of Nursing Head of Patient Experience G & Q 	Nov 13	Apr 14	CQC 16, 17	RR 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By	Date Completed		

		When	
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	Aug 13
ii) Inpatient Survey Action plan down to CSC level to be agreed and published	NL/FMc	Jul 13	Aug 13
iii) Responsive action plan being worked up through cancer leads	HM	Oct 13	
iv) No decision on Net promoter score changes nationally			National ruling pending

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										On target			
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										Inability to achieve predicted target			
1.5	<p>Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing</p> <p>Implications:</p> <ul style="list-style-type: none"> Poor patient experience Poor staff morale and wellbeing Trust reputation Financial penalties related to Emergency care quality targets 	<ul style="list-style-type: none"> Weekly discharge improvement meetings in place to improve quality and speed of discharges Daily review of breaches and 2 hourly escalation to COO OOHS Direct referral from ED and Gosport minor injuries unit. Deputy DHMs now in post supporting OOHS GPs in ED at weekends. ED consultants present until midnight 7 days Extra consultant shift on Saturday and Sunday Newly qualified nurses start Oct will bring staff to establishment Trust wide recovery plan approved and in place Mitigation plan 	<ul style="list-style-type: none"> Performance metrics showing 3 weeks of significant reduction in overcrowding and breaches Successful transition of direct admission to MAU Interim Deputy COO for Emergency flow Weekly Trust Recovery Group SMT Plan monitored weekly by Deputy COO and monthly by TDA Trust Board 	20 (4x5)	25 (5x5)	15 (5x3)	<ul style="list-style-type: none"> Ability to control front door demand CSCs not achieving agreed discharge targets Inability of external partners to support flow 		1 Chief Operating Officer 2. Deputy COO 3. SMT	Nov 13	End Nov 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	Due for launch Nov 13 as per Trust Recovery plan		
i) Mitigation plan									RS	Oct 13	Oct 13		
ii) iii) IDB meeting refocused 24/24 focus on escalation process, and to increase frequency of meetings									MQ	Sep 13	Sep 13		

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										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.6	<p>The Trust fails to achieve referral to treatment (RTT) access targets in four specialties:</p> <ul style="list-style-type: none"> ▪ Trauma & Orthopaedic (T&O) ▪ Ear, Nose & Throat (ENT) ▪ Urology ▪ Colorectal <p>Implications:</p> <ul style="list-style-type: none"> • Patient experience • Deterioration of patient health • Reputation • financial penalties(2% 18/52 activity) on any planned fails dependant on commissioning discussions 	<ul style="list-style-type: none"> • Trust Board approved all plans for all specialties, being implemented and are on track to deliver agreed position • Contingency plan agreed for additional surgeon beginning Nov 13 for 8 weeks • All lists covered by additional consultant sessions 	<ul style="list-style-type: none"> • 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) completed 	12 (4x3)	12 (4x3)	8 (4x2)	<p>i. Urology – Cancer Urology consultant vacancy has decreased capacity</p> <p>ii. Whole Trust fail in September and October – Urology plan fail to end 2013</p>	<p>1. Chief Operating Officer</p> <p>2. Managing Director</p> <p>3. SMT</p>	Nov 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
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	Oct 13
v) vi) Work up recovery plan for Urology	MM	Sep 13	Oct 13
vi) Secure additional capacity in the independent sector as contingency to ensure plan is delivered by end October 2013	MM	Sep 13	Completed for T & O but different plan for Urology agreed

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	
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										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.7	<p>Failure to achieve cancer wait targets</p> <p>Implications:</p> <ul style="list-style-type: none"> ensuring that patients are seen in a timely manner Financial penalties may be applied by commissioner s 	<ul style="list-style-type: none"> 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 New cancer reporting tool 	<ul style="list-style-type: none"> Roll out for Cancer Access policy training completed 17 Oct Weekly cancer operational meeting established New exception reporting process operational Remedial Action plan updated 	12 (4x3)	16 (4x4)	8 (4x2)	<ul style="list-style-type: none"> Lack of resilience in cancer waiting times Increasing referrals Patient choice rules means clock doesn't stop if patient defers anywhere on pathway Decrease in Urology capacity 	<ul style="list-style-type: none"> Failure to remedy breach to satisfaction of CCGs Recent patient survey results are unsatisfactory 	1 Chief Operating Officer 2. Managing Director 3. SMT	Nov 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	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	Oct 13		
v) Monthly updates to RAP diarised with assigned manager									LP	Sep 13	Sep13		
v) Rectify remedial action plan breach									MM	Aug 13	Aug 13		
vi) Agreed to establish internal cancer improvement plan to include the areas of poor performance (bottom 20% of Trusts) from cancer survey									LP	Oct 13	First meeting planned 22 Oct plan to be signed off mid 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	
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										Inability to achieve predicted target			
1.8	<p>Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate</p> <p>Implications</p> <ul style="list-style-type: none"> • Reputation damage • Financial penalties • Incorrect business decisions made using incorrect data assumptions impacting on patient experience 	<ul style="list-style-type: none"> • Data validation processes in place in some areas but patchy 	•	12 (4X3)	12 (4x3)	8 (4X2)	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	Dec 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	Group has met and outline of Data Quality Strategy agreed to be implemented by 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	Communication agreed regarding personal responsibility for data quality		
iii)/iv) Introduce templates for system level data quality assessments and action plans and train relevant staff to use									CT	Dec 13	Exemplar date quality sites identified , to be approached for methodology and action plans to share Trust wide		
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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1.9	<p>Lack of equivalent workforce across seven days of the week</p> <p>Implications</p> <ul style="list-style-type: none"> • Damage to Trust reputation • Poor patient experience • Reduced quality of care 	<ul style="list-style-type: none"> • Governance systems in place to ensure patient safety and quality of care is maintained 	<ul style="list-style-type: none"> • Review of hospital mortality with emphasis on weekend mortality with TDA • Weekend HSMR shows no significant difference to comparable Trusts • Weekend HSMR shows no significant difference from rates recorded during the week 	12 (4X3)	12 (4x3)	8 (4X2)	<ul style="list-style-type: none"> i. Delays in progressing patient pathways ii. IPR indicates lengths of stay could be reduced 	1. Medical Director 2. Chief of Service 3. SMT	Nov 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	<p>Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns</p> <p>Implications:</p> <ul style="list-style-type: none"> Service delivery Reputation as an organisation delivering high standards of education and training to medical trainees 	<ul style="list-style-type: none"> Director of Medical education Educational Supervisors Deanery links Foundation Programme Directors Foundation Doctors educational programme 	<ul style="list-style-type: none"> AAA rating Positive feedback on level of experience gained Direct feedback of trainees to DME more positive of late. 4 monthly survey from DME to all trainees focussing on areas of concern and improvements 	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> Junior doctors although exposed to positive clinical experience report that they are not receiving the educational support expected of their training posts Two areas (cardiology & neonates) where allegations of undermining behaviour are outliers on GMC trainee survey Patient safety concerns raised by trainees to GMC relating to out of hours cover 	<ul style="list-style-type: none"> Pending deanery visits to neonates and surgery 	1 Medical Director 2. Director of Education 3. SMT	Dec 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	Sep 13		
I, ii, iii) Survey of outgoing trainees to assess impact of initial plans and inform further action									PS	Sep 13	Sep 13		
ii) Director of Education meeting departments where undermining concerns raised (consultants and trainees met separately)									PS	Oct 13	Oct 13		

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2.2	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	10 (5x2)	6 (3x2)	3 (3x1)		i. Quarterly R&D reporting to be established	1. Medical Director 2. Director of Research & Development/ Research Manager 3. SMT	Dec 13	Mar 14	CQC 6	RR
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
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									AC	Jul 13	Jun 13		
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									AC	Jul 13	Ongoing		

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	<p>Threat to specialist services due to centralisation agenda</p> <p>Implications:</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Outcome data Vascular Society requirements for a service Fully covered clinical rota with committed team National audit results 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Decision ultimately outwith PHT control as specialist commissioner led Currently no assurances from specialist commissioning teams as to the medium and long term direction 		1. Medical Director 2. 3. SMT	Dec 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 - View of Clinical Senate is awaited									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	
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3.2	<p>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</p> <p>Implications:</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Board approval for IT Strategy IT Strategy Committee Robust IT project and programme management processes 	<ul style="list-style-type: none"> IT Strategy Committee Programme Highlight Reports Business case 	8 4x2	8 4x2	4 4x1	<ul style="list-style-type: none"> Lack of Clinical Information Systems Programme Board No Clinical Information Systems Programme team Lack of specialist procurement expertise Lack of Programme plan Lack of engagement of clinicians, CSCs and other stakeholders to specify requirements 	<ul style="list-style-type: none"> Lack of Clinical Information Systems Programme Board 	<ul style="list-style-type: none"> Director of Finance Head of IT 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			
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										Inability to achieve predicted target			
4.1	Insufficient engagement of workforce Implications: <ul style="list-style-type: none"> Lack of understanding/ buy in, and therefore delivery of strategic priorities Suboptimal delivery of patient care Poor staff survey results 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Maintaining appraisal compliance rate Lack of engagement from clinical staff in delivering the change agenda 	<ul style="list-style-type: none"> 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)/iii) 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)/iii) Quarterly staff pulse survey launched with key questions linked to the national staff survey									TP	Jun 13	Launched and ongoing		
i)/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	
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4.2	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 	<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)	6 (3x2)	<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. SEC	Dec 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	On the November Trust Board agenda		
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	Nov 13	Launch pushed back to November		
ii) Clinical Directors development programme commenced jointly with Southern									TP/LR	Oct 13	Commencing 17th Oct		
iii) Embed Working Together for Patients into ward accreditation programme									TP/LR	Oct 13	Application being submitted to Health Foundation in October to develop a bundled module for roll out to clinical teams		

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										On target			
										Minor Obstacle to achieving target			
Inability to achieve predicted target													
4.3	<p>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</p> <p>Implications:</p> <ul style="list-style-type: none"> • Workforce design does not keep pace with changing service delivery • Poor patient experience • Higher than acceptable levels of temporary staff and unaffordable staffing levels. • Poor recruitment and retention • Poor staff morale 	<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 • E-Rostering 	<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 • High levels of rota fill from recent junior doctor intake 	16 (4x4)	12 (3x4)	9 (3x3)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	Nov 13	Mar 14	CQC 13	RR 4.1 4.3 4.4 5.1

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
j) 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	

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	
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4.4	<p>Gaps in the current management team structure</p> <p>Impact:</p> <ul style="list-style-type: none"> Some specialties/ CSCs not having sufficient capacity, capability and experience necessary to deliver the annual operating plan including delivery of key national targets Suboptimal patient care Risk to 	<ul style="list-style-type: none"> Performance assurance framework and performance review process 	<ul style="list-style-type: none"> NTDA self-certification process 	16 (4x4)	16 (4x4)	8 (4x2)	<ul style="list-style-type: none"> i. Short and long term vacancies at MD, GM and BM level ii. Develop and instigate attraction and remuneration strategies iii. Trust lacks an operational management training scheme iv. Agree and implement process for succession planning to critical senior management posts 	v. Some posts vacant	<ul style="list-style-type: none"> 1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. SMT 	Dec 13	Review Apr 14	CQC 26	RR 5.1

	delivery of financial savings programme											
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE								By Whom	By When	Date Completed		
i)	Short term interim resource has been sourced to fill short and long term vacancies at MD, GM and BM level						TP/BL	Sep 13	Completed			
ii)	COO to confirm requirements						CW	Nov 13				
iii) /iv)/v)	Operational Management training and succession planning schemes in progress						LR	Apr 14				

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	
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										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.1	Inability to achieve Foundation Trust status within the agreed timetable	<ul style="list-style-type: none"> Trust Board scrutiny Performance management systems Trust now in formal recovery to improve clinical and financial performance 	<ul style="list-style-type: none"> Dedicated support from TDA Performance improvement being reviewed in line with improvement trajectory External resource mobilised to support key workstreams 	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 achieved for September 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	Jan 14	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 Authority									BL	Oct-13 Nov 13			
iii)/iv) Instigate the development programme against agreed plan with TDA									BL	Dec 13			

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										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 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 Agreed recovery plan in place, progress monitored weekly 	<ul style="list-style-type: none"> Financial plan revised to reflect agreed commissioning contracts Budgets rebased to reflect current run rate Daily metrics via KitBag 	12 (4x3)	12 (4x3)	8 (4x2)	<ul style="list-style-type: none"> i. Formal sign off of budgets and supporting Quality Impact Assessments ii. Monthly performance reviews require strengthening iii. Accountability of CSCs requires strengthening 		<ul style="list-style-type: none"> 1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee 4. Trust Recovery Group 	Dec 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	Jul 13	Completed		
ii) Fully implement bottom up run rate forecasts and reconcile to top down forecasts as part of monthly accounts process									RH	Aug 13	Jul 13		
ii)/iii) Performance Assurance Framework to be agreed and implemented with CSCs									EMT	Oct 13	Aug 13		
iii) Introduce and clarify the role of the CSC managing Director and cluster CSCs where required									EMT	Jun 13	Complete		
ii)/iii) Implementation of KitBag early warning system reporting key metrics									JL	Jln 13	Jul 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	
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										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. Contract issues unable to resolve escalated to Execs via ECRM 	<ul style="list-style-type: none"> Agreed capacity required with CSCs and activity volumes secured through the commissioning contract Agreed PbR compliant contract Daily metrics via KitBag Monthly CSC performance reviews strengthened 	12 (4x3)	16 (4x4)	12 (4x3)	<ul style="list-style-type: none"> i. Identification required of key owners of risk components re penalties, CQUIN etc ii. ED, Cancer and RTT targets not being achieved 	<ul style="list-style-type: none"> 1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee 4. Trust Recovery Group 	Dec 13	Apr 14	CQC 26	RR 5.1	
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
ii) Introduce intensive CSC performance meetings which cover contract performance review – performance assurance framework to be formally agreed and implemented									EMT	Sep13	Sep 13		
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		
i)/ ii) See 1.5, 1.6 and 1.7 for actions linked to achieving targets									MM/MP	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			
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 Tracker providing clear information on which initiatives are 'off-track' Defined CSC reporting arrangements CSCs submitted savings plans Creation of Trust Recovery Group to accelerate pace of savings delivery Risks and opportunities tracked weekly 	<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 Monthly refresh of year end forecast Clear lead against all recovery programme workstreams External support mobilised on all work streams 	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 iii. Workforce plan requires development and alignment with savings plan iv. Insufficient contingency to guarantee delivery of year end forecast 	v. CSCs not identified sufficient savings to meet year end comfort totals	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	Dec 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	On-going		
iv) Performance management of CSCs to agreed year end budgetary control totals									BL	Aug 13	Aug 13 and on-going		
iii)/v) Trust recovery group developed plan to hit target of deficit of £5m									BL / CSC management teams	Sep 13	Complete and on-going		
iii)/iv) Key workstreams developed to deliver additional savings (medical 1m, nursing 1m, capacity 1.5m, waste 0.5m)									BL / CSC management teams	Sep 13	Complete and on-going		

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
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				