TRUST BOARD PUBLIC – FEBRUARY 2013

Agenda Item Number: 35/13
Enclosure Number: (5)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Lorna Wilkinson – Deputy Director of Nursing/Head of Patient Safety Peter Mellor – Company Secretary Peter Mellor – Company Secretary
Purpose of paper *Why is this paper going to the Trust Board?*	Requires Trust Board guidance Discussion requested by Trust Board Regular Reporting Statutory Requirement
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Trust Board are asked to note • Top risks • New Risk 5.5 - Failure to obtain a contract for 2013/14 which enables achievement of financial targets. • Following Trust Board workshop 14/02/13 key actions were agreed regarding the format of the BAF which will be reflected in the next Board report
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented to Trust Board in March 2013.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: February 2013

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 20 February 2013

Top Risks

2.1 ◄► (Red 15): Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets

2.2 ◄► (Red 20): The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards

3.2 ◄► (Red 16): Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from:

Failures to target growth in appropriate specialties; and/or

Failures to achieve the profile of targeted elective activity growth

5.2 ◄► (Red 15): Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets **(Red 16):** Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure

5.4 ◄► (Red 16): 2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust Financial position

New Risks

5.5 (Red 20) : Failure to obtain a contract for 2013/14 which enables achievement of financial targets.

Risks with an Increased Score

5.2 ▲ (Red 20) Failure of Budgetary Control - The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure.

Risks with a Decreased Score

5.3 ▼ (Amber 8) The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners.

Risks to be Removed

Nil

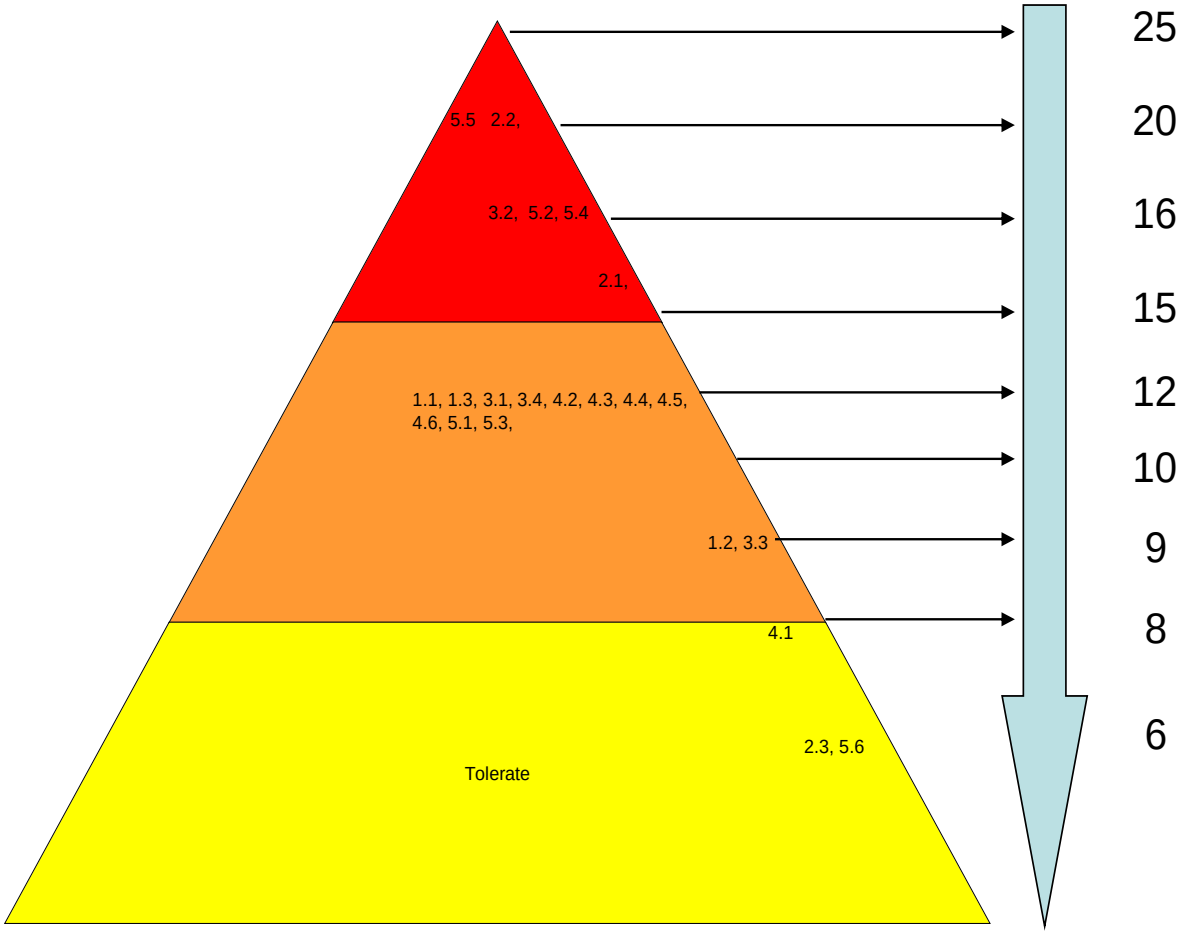
Target Date Changes

Nil

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

Presented by: Peter Mellor – Company Secretary

Trust Risk Snapshot – February 2013



Trust Risk Profile - February 2013

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Rare (1)					
Unlikely (2)			2.3 Growth in R&D ◄ ► 5.6 Information Technology strategy◄ ►	4.1 Learning and education outcomes ◄ ►	
Possible (3)			1.2 Inpatient survey ◄ ► 3.3 elective pathways ◄ ►	1.3 Quality of services and patient safety ◄ ► 3.1 Scheduled care capacity ◄ ► 3.4 Relationships with commissioners ◄ ► 4.2 Performance management ◄ ► 4.4 Capability of leadership ◄ ► 4.5 High level of temporary staff ▼ 4.6 Unfilled critical posts ◄ ► 5.1 Foundation Trust status ◄ ► 5.3 Contract penalties ◄ ►	2.1 Insufficient reduction in ED admissions ◄ ►
Likely (4)			1.1 CQC Standards ◄ ► 4.3 Engagement of workforce ◄ ►	3.2 Growth of targeted specialties ◄ ► 5.4 Delivery of savings targets ◄ ►	**5.5** Failure to obtain a contract for 2013/14 which enables achievement of financial targets.
Highly Likely (5)				2.2 Patient flow ◄ ► 5.2 Failure of budgetary control ▲	

ASSURANCE FRAMEWORK 2012/13 PROGRESS SUMMARY - February 2013

STRATEGIC AIM Executive Lead	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 AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS	1.1 FMcN	Inability to maintain ongoing compliance with all CQC standards	G&Q	All	9	9	6	6	12	12	8	8	8	12	12		Feb 13	8 Apr 13
	1.2 SB	Failure to improve patient satisfaction (measured through results of the national Inpatient survey) potentially affecting organisational reputation and achievement of CQUIN (financial penalty up to £436,500)	PEWG	16	9	9	9	9	9	9	9	9	9	9	9		Apr 13	3 Apr 13
JD/SH	1.3 LW	Failure to comply with internally and externally set standards impacting on quality of services provided to patients and patient safety	G&Q	4					12	12	12	12	12	12	12		Apr 13	8 Apr 13
2: PARTNER WITH OTHERS TO DELIVER THE RIGHT CARE IN THE RIGHT PLACE	2.1 RF	Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets	SMT	16			20	20	20	20	20	20	20	15	15		Mar 13	5 Apr 13
	2.2 RF	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards	SMT	16			9	9	9	9	20	20	20	20	20		Mar 13	4 Apr 13
JD/DH/SH/CW	2.3 SH	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	SMT	6					10	6	6	6	6	6	6		Mar 13	3 Mar 14
3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES	3.1 AG	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	SMT	4					12	12	16	16	16	12	12		Mar 13	4 Mar 14
DH/SH/CW	3.2 AG	Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from: Failures to target growth in appropriate specialties; and/or Failures to achieve the profile of targeted elective activity growth	SMT	26					16	16	16	16	16	16	16		Mar 13	4 Mar 14
	3.3 AG	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness	SMT	4					12	12	15	15	15	9	9		Mar 13	3 Mar 14
	3.4 RF	Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	SMT	6					12	12	12	12	12	12	12		Mar 13	4 Mar 14
4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND RETAINING THE BEST PEOPLE	4.1 RK	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust	SEC	All	12	12	12	12	12	12	8	8	8	8	8		Mar 13	4 Apr 13
	4.2	Performance management tools fail to deliver the step change required in performance to	SEC	All	12	12	12	12	12	12	12	12	12	12	12		Mar 13	8 Apr 13

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					APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR		
TP	RK	deliver key DoH targets and the Trust's strategic priorities																
	4.3 RK	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities	SEC	14	12	12	12	12	12	12	12	12	12	12	12		Mar 13	6 Apr 13
	4.4 PS	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change	SEC	14	12	12	12	12	12	12	12	12	12	12	12		Mar 13	8 Apr 13
	4.5 RK	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels	SEC	13	16	16	16	16	16	16	16	16	16	12	12		Feb 13	8 Apr 13
	4.6 PS	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes	SEC	13	12	12	12	12	12	12	12	12	12	12	12		Mar 13	6 Apr 13
5: ENSURE SUSTAINABILITY	5.1 BC	Inability to achieve Foundation Trust status within the agreed timetable	TB	26					12	12	12	12	12	12	12		Feb 13	4 Mar 14
	5.2 SG	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure.	FC	26					16	16	20	20	20	16	20		Feb 13	12 Mar 13
RE	5.3 SG	The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners.	FC	26	12	12	12	12	12	12	12	12	12	12	8		Feb 13	8 Mar 13
	5.4 SG	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	FC/TC	26	12	12	12	12	12	16	20	20	20	16	16		Feb 13	8 Mar 13
	5.5 RE	Failure to obtain a contract for 2013/14 which enables achievement of financial targets.	FC	26											20		Mar 13	Unknown
	5.6 CT	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	ITSG	4					6	6	6	6	6	6	6		Apr 13	3 Oct 13

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

Responsible Executive: Medical Director/Nursing Director

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

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Review Date	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	RISK DESCRIPTION (Obstacle to achievement of Strategic Aim)	KEY CONTROLS Any **specific measures** currently in place to control the risk.	POSITIVE (ACTUAL) SOURCES OF ASSURANCE Evidence that shows risks are being reasonably managed	INITIAL RISK RATING (C x L)	CURRENT RISK RATING (C X L)	PREDICTED (RESIDUAL) RISK	GAPS IN CONTROLS The identification of any failure to establish effective Controls.	GAPS IN ASSURANCE The identification of any failure to gain evidence relating to the effectiveness of the Controls.	ACTION PLAN Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	On target Minor obstacle to achieving target Inability to achieve predicted target Review Date	Target Date
1.1 (All)	Inability to maintain ongoing compliance with all CQC standards	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • NHSLA Level 1 accreditation (Mar 12) • CSC risk registers • Mock CSC assessments and associated action plans • Monitor Quality Risk Profile monthly • Quarterly evidence and action plan review panels established • CQC awareness sessions • Action plan to address minor concerns for ongoing compliance with outcomes 4 , 5 and 21	• Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues) • Clinical dashboards / quality metrics • CSC governance reports • Mock CSC assessments • Internal CQC audit (Deloitte) Mar 12, demonstrating substantial assurance. • Compliance audits • CQC inspection Mar 12 for consent to termination of pregnancy compliant • CQC report September 2012 declaring Trust compliant with Outcome 21	12 (4x3) FMcN G&Q	12 (4x3)	8 (4x2)	• None	• New documentation education and training ongoing following pilot with continued roll out across Trust • Documentation audits show required 95% compliance is not being consistently achieved • Recent internal mock CQC visits highlighted inconsistencies across CSCs, in particular relating to Outcomes 4, 8 and 21 (predominantly infection control and documentation)	GA: Action plan complete although documentation audits ongoing GA: Ongoing mock CQC vists. GA: Continued documentation audits until compliance sustained GA: infection control issues addressed immediately. Report detailing findings and actions to January Board meeting. Mock CQC visits ongoing to monitor compliance	Feb 13	Apr 13

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1.2 (16)	Failure to improve patient satisfaction (measured through results of the national Inpatient survey) potentially affecting organisational reputation and achievement of CQUIN (financial loss up to £436,500)	• Trust wide action plan • New 5 key questions survey • CSC targets for patient participation in survey • CQC assessment process – monitor essential standards of care • Complaints monitoring process	• Optimum real time patient survey	9 (3x3) SB PEW G	9 (3x3)	3 (3x1)	• No gaps currently	• Consistent reporting by CSCs to PESG	GA: monitor CSC reporting to PESG and escalate non-submission	Apr 13	Apr 13

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1.3 (26)	Failure to comply with internally and externally set standards impacts on quality of services provided to patients and patient safety and the ability of teams to fully engage in service improvement.	• Governance Framework and monitoring: • Quality Impact Assessments of CIP plans • Quality Performance measures • Monitor Compliance Framework • CSC executive performance reviews • Clinical Audit programme • Safety workstreams • Patient and user feedback process	• Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Trust Board • Dr Foster data • CQC feedback – QRP/review feedback	12 (4x3) FMcN G&Q	12 (4x3)	8 (4x2)	• All risk assessments to be completed and savings plans signed off • Real time data not fully available to allow proactive response • CSC performance framework not fully embedded • Identification of individual CSC quality performance 'hotspots'	• Real time data not fully available to allow proactive response	GC/GA: complete roll out of DatixWeb GC: Fully embed Quality Impact Assessment review process GC: Fully embed CSC performance review process GC: Further develop integrated performance report to include data at CSC level	Apr 13	Apr 13

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

Responsible Executive: Medical Director/Nursing Director/Chief Operating Officer/Strategy and Business Development Director/ Workforce and Organisational Development Director

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

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2.1 (16)	Partnership working arrangements do not deliver sufficient reductions in emergency admissions to meet agreed and national targets	• Emergency care model across MAU and ED • Unscheduled care Programme Board (reps from across health economy) chaired by PHT Medical Director • Integrated weekly PMO cross provider meetings to review and progress joint action plans • Trust Emergency Flow Action Plan incorporating ECIST recommendations • 18 point Health System in place for 2012/13 • Ambulatory Care programmes implemented in MAU, Respiratory and SAU • Weekly discharge improvement group • Pilot community discharge assessment lounge in ED	• Daily monitoring at Operational Flow meetings (5 meetings a day) • Performance reporting – Emergency Flow Dashboard in development as well as regular performance reports	20 (5x4) RF SMT	15 (5x3)	5 (5x1)	• PHT Emergency Flow governance structure yet to be implemented • Ongoing contracting discussions which may agree organisational penalties for failing to deliver on agreed actions to support reduction in emergency admissions. • Projects under discussion to implement 4 specific cross provider disease pathways	• Unable to easily measure effectiveness of controls at present as Programme Board is in its infancy • Work ongoing to develop PHT Performance dashboard to measure progress against individual projects and extend process system wide.	GC/GA: Ensure that all projects set up with an objective of reducing emergency admissions have explicit performance metrics agreed and that there are agreed consequences/penalties for non delivery of individual partners on actions agreed GC/GA: ensure the requirement to agree specific performance metrics is included in any development workshops and meetings during project set up. GA: Performance reporting on the delivery of agreed actions by partner organisations GC: top 20 frequent presenters to ED reported to community partners – awaiting response GC: CSCs to achieve weekly discharge improvement targets in increase discharges earlier in the day. GC: Trust wide roll out in other key areas to mirror Respiratory ambulatory programme.	Mar 13	Apr 13

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2.2 (4,6)	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards This risk increases during times of peak demand and winter pressures.	• Trust-wide KPIs and monthly Integrated Performance Report • Bed rebalancing and ward staffing reviews • Patient flow projects – including additional input from key medical consultants • Weekly discharge improvement meetings to improve quality and speed of discharges • Outlier team in place, funded with partners, to ensure prompt medical and senior nursing review to fast track care and treatment interventions to improve patient pathway and flow. (Lead: MOPRS) •	• Trust-wide KPIs and monthly Integrated Performance Report • Daily early discharges targets agreed and monitored (10.00hrs and 12.00hrs targets) through weekly Discharge improvement group and daily in the Operations Centre.	9 (3x3) RF SMT	20 (4x5)	4 (4x1)	• Continued high numbers of medically stable patients awaiting discharge • Inconsistent implementation of patient flow policies across the Trust • Insufficient medical cover overnight and at weekends • Insufficient overnight duty managers • High numbers to triaged patients in MAU awaiting a bed • Insufficient Senior review of outliers creating an increase delay for patients in their journey	• The monthly Integrated Performance Report does not include any patient flow KPIs. However there is now an Emergency Flow Dashboard being developed in support of the Trust Emergency Flow Action Plan	GC: Implement PHT care pathway recovery and improvement action plans to support capacity, processes and workforce alignment. GC: undertake 2 month pilot of full capacity protocol in Cardiology and Respiratory to increase morning capacity. (unsuccessful as limited to just 2 beds) GC: decision pending to agree purchase of Medicare service on a pilot basis (not progressed) GC: review medical rostering and commence workforce plans to develop new nursing roles to cover medical rota gaps. GC: Ward rounds and identification of planned dates of discharge to be supported by Medical Leader, to identify gaps and actions to improve. GC: Consultant leader support at front door to fast track specialty decision making earlier in the patient pathway. GA: Productivity and efficiency KPIs are under development and will be included in future monthly Integrated Performance Reports	Mar 13	Apr 13

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

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2.3 (6)	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	• Medical Director participating in AHSN discussions with UHS • Trust R&D Strategy and framework • R&D income monitored by R&D Director	• Medical Director reporting back to Board on discussions • R&D income year on year increase	10 (5x2) SH SMT	6 (3x2)	3 (3x1)	• R&D Strategy requires review	• Quarterly R&D Board reporting to be established	GA – New quarterly R&D report to be submitted to the Board GC – R&D Strategy to be updated in 2012/13	Mar 13	Mar 14

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

Responsible Executive: Medical Director/Chief Operating Officer/ Strategy and Business Development Director

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

RISKS		CONTROLS AND ASSURANCE TO MITIGATE RISK		RISK RATING Risk Owner Responsible Committee			IDENTIFIED GAPS IN CONTROLS AND ASSURANCE		ACTIONS TO CLOSE IDENTIFIED GAPS/ACHIEVE PREDICTED RISK RATING	Review Date	Final target date for mitigation of risk RAG rated for progress
REF. NO (CQC Ref)	**RISK DESCRIPTION** (Obstacle to achievement of Strategic Aim)	**KEY CONTROLS** Any **specific measures** currently in place to control the risk.	**POSITIVE (ACTUAL) SOURCES OF ASSURANCE** Evidence that shows risks are being reasonably managed	**INITIAL RISK RATING (C x L)**	**CURRENT RISK RATING (C X L)**	**PREDICTED (RESIDUAL) RISK**	**GAPS IN CONTROLS** The identification of any failure to establish effective Controls.	**GAPS IN ASSURANCE** The identification of any failure to gain evidence relating to the effectiveness of the Controls.	**ACTION PLAN** Details of actions to address identified gaps in either Controls or Assurance **Plan** GC – Gap in Controls GA – Gap in Assurance	**On target** **Minor obstacle to achieving target** **Inability to achieve predicted target** **Review Date**	**Target Date**
3.1 (4)	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	• Detailed specialty-level activity plans • Weekly waiting list and theatre utilisation assurance meetings • Demand/capacity modelling at a specialty level refreshed periodically • Contractual trigger points relating to increased demand and patient backlogs at a specialty level	• No non-clinical cancellations of elective activity • Achievement of Operating Framework targets • Reduction in patient backlogs to the level required for sustainable target delivery • Reduced average waiting times for the majority of specialties (year-on-year basis)	12 (4x3) AG SMT	12 (4x3)	4 (4x1)	• Not all specialties have sufficient capacity to meet demand on a sustainable basis • Some patients wait more than 18 weeks for treatment - planned failure of RTT targets in 1 Specialty under consideration to ensure sustainability • Contracted activity levels transfer some of financial risks of reducing waiting times to 'best in region' to the Trust	• N/A	GC/GA: All at risk specialties have plan to deliver sustainable target delivery GC/GA: Specialty-level management of patient lists to reduce waiting times on a sustainable basis GC: 2013/14 contractual process GC: related financial support from commissioners required GC: implement management of flow initiatives as detailed in 2.2	Mar 13	Mar 14
3.2 (26)	Planned growth in elective activity does not materialise as forecast in the IBP and LTFM, resulting from: • Failures to target growth in appropriate specialties; and/or • Failures to achieve the profile of targeted elective activity growth	• Trust Planning & Capital Investment Committee • Annual planning process • Quarterly Board review	• Annual Plan • Quarterly Business Development report	16 (4x4) AG SMT	16 (4x4)	4 (4x1)	• Targeting of specialty growth is not undertaken on a systematic basis	• CSC business plans do not yet have robust plans to identify and deliver additional activity • Commissioner plans do not allow for activity growth at 'baseline' levels	GA/GC: Phased targeting of specialties to be based on market and pathway analysis (to include specific assurance measures) GA/GC: Refresh of annual planning process	Mar 13	Mar 14

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

Responsible Executive: Medical Director/Chief Operating Officer/ Strategy and Business Development Director

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

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3.3 (4)	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness.	• On-going operational management processes	• Performance against standards and targets as shown in Integrated Business Report	12 (3x4) AG SMT	9 (3x3)	3 (3x1)	• None	• The Trust's benchmarked performance against MEQO (Midlands and East Quality Observatory) dashboard metrics is not consistently in upper quartile	GA: implement management of flow initiatives as detailed in 2.2 GA: MEQO is reported to the Trust's Clinical Effectiveness Steering Group	Mar 13	Mar 14
3.4 (6)	Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	• Clearly defined stakeholder management system • Medical Director meets GP Clinical Leads on weekly basis • Company Secretary meets OSCs on a regular basis • Outbound media relations	• Stakeholder feedback – largely informal	12 (4x3) RF SMT	12 (4x3)	4 (4x1)	• Lack of funding for communications team makes it difficult to achieve comms objectives • Senior clinicians have limited time to engage effectively with local GPs • Internal communication requires improving to establish a consistent approach to working with commissioners	•	GC – design more effective/efficient communications team function within budgetary constraints GC – Explore areas requiring job plan review GC: Increase contract team's understanding of operational and capability requirements	Mar 13	Mar 14

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

Responsible Executive: Workforce and Organisational Development Director

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

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4.1 (14)	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust.	• Training plans developed to reflect CSC strategic priorities. • Membership of the shadow Local Education and Training Board. • Evaluation of learning outcomes undertaken. • Director of Education appointed • Strategic Education Board	• Strategic Education Board in place. • Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback). • Learning and Education Strategy	12 (4x3) RK SEC	8 (4x2)	4 (4x1)	• Education Outcomes Framework not implemented Trust Wide	• There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes.	GC/GA – development and deployment of the education outcomes framework – workshop held on 23 January with Trust roll-out to follow	Mar 13	Apr 13
4.2 (14)	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities.	• Performance assurance framework trials for CSCs • SHA funded performance appraisal project for consultants introduced	• Significant improvement to staff survey results for effectiveness of appraisal • Performance assurance project board established.	12 (4x3) RK SEC	12 (4x3)	8 (4x2)	• Variation in performance at CSC and individual level. • Consequence management framework established - but requires evaluation.	• Appraisal performance measures currently only look at compliance with no individual rating scale evident. • Compliance with appraisal currently below target of 85% completion at 83.8%	GC / GA – review of performance appraisal process to introduce ratings and consequence management frameworks – ongoing GC/GA: CSC action plans in place to ensure compliance with appraisal target is achieved by end on month 7	Mar 13	Apr 13

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4.3 (14)	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	• Staff survey action plans developed within CSCs • Health and well-being programme established. • Employee recognition programmes in place.	• Improved performance in 2011 national staff survey results. • Lower than average levels of sick absence and staff turnover. • Integrated performance report to Board included staff feedback	12 (3x4) RK SEC	12 (3x4)	6 (3x2)	• Staff survey results still show lower than acceptable scores against some key findings – PULSE surveys show some improvement	• Results of 2012 national staff survey not available until Feb 12	GC/GA – review of internal communication process including team-brief. GC/GA – workforce engagement task and finish group established to review core messages and communication tools for staff to recommend actions by end of Dec 12 GC/GA: Trust has been accepted on the Listening into Action programme due to commence in April 2013	Mar 13	Apr 13
4.4 (14)	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change.	• Leadership development programmes in place to support leaders at various levels. • 360 and self-assessment completed at Executive level • Trust wide leadership competencies identified • Delivery of Working Together for Patients on plan	• Utilisation of existing leadership development programmes. • SHA funded projects in development including team based working. • Local Leadership Academy for Wessex LETB has been authorised.	12 (4x3) PS SEC	12 (4x3)	8 (4x2)	• Expectations of leaders not clearly defined. • Managing development framework to be defined • All relevant staff have not undertaken Working Together for Patients	• There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.	GC/GA – development of talent management process to capture potential future leaders GC/GA – use of Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level GC/GA – roll out Working together for Patients milestones to agreed timescale as set by the Transformation Projects Governance Group.	Mar 13	Apr 13

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4.5 (13)	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels.	• Corporate CIP plan developed to reduce temporary staffing levels. • 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	• Business planning process has identified resource requirements for CSC service delivery. • WSC process reviewed to ensure critical posts are prioritised for recruitment • Temporary staffing costs have reduced by c£1m a month at month 8	16 (4x4) RK SEC	12 (4x3)	8 (4x2)	• Temporary resource currently above planned level of 3%. • Reduction in Junior Doctor resource will increase demand for consultants in some specialities. • Attraction strategy needs further development to enable recruitment of high level candidates. • Only one University intake per annum for newly qualified nurses results in excessive vacancy fluctuation	• Reporting of workforce metrics does not facilitate early decision making.	GA – full deployment of e-rostering system - ongoing. GC: Mobilisation of existing workforce – ongoing where applicable GC: Review of corporate functions – ongoing GC – Attraction Strategy to be defined for 2013/14 intake. GC – concern raised with LETB for discussion with higher education institutions	Feb 13	Apr 13

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4.6 (13)	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	• Definition of critical posts established and used by WSC to prioritise recruitment.	• Succession plan meeting for Board level posts held.	12 (3x4) PS SEC	12 (3x4)	6 (3x2)	• Performance appraisal does not capture career progression potential. • Process for defining and identifying those with potential is not established.	• Talent is not reviewed at senior management level or at CSC level. • Succession plans are not evident across the Trust • Some critical posts not filled – GM in ED	GC – review of appraisal process for Band 7 and above. GC – talent review process to be developed and linked to appraisal. GA – Talent review meetings to take place at Board and CSC levels – Board level completed CSC Management Teams to be completed by April 2013 GA – Succession plans at senior management level to be developed	Mar 13	Apr 13

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Responsible Executive: Finance and Investment Director

- Become a Foundation Trust in 2013/14
- Make a financial surplus each year and reinvest this for the benefit of patients
- Ensure that we meet or exceed all national targets and standards
- Ensure the sustainability of clinical services
- Develop and implement an effective information technology strategy
- Develop and implement and effective innovation strategy
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5.1 (26)	Inability to achieve Foundation Trust status within the agreed timetable	• Dedicated FT project support • FT project plan • FT project Committee • Trust Board and Transformation Committee scrutiny • Performance management systems • Public published tripartite formal agreement • Project managed against TFA milestones • Integrated Action Plan – HDD, BGAF and Quality Governance	• Monthly FT pipeline paper presented to Trust Board shows milestones being achieved • KPMG Board governance Framework Assessment • Operational key targets being achieved • Monitor quality framework targets on trajectory • PWC – HDD Phase 1 Report • RSM Tenon – External Review of Quality Governance •	12 (4x3) BC TB	12 (4x3)	4 (4x1)	• Financial performance off trajectory at month 7	• Financial report shows Trust plan currently in deficit	GC/GA: Recovery plan to be implemented to restore financial performance	Feb 13	Mar 14

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

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5.2 (26)	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £4.3m surplus on income and expenditure.	• Finance reporting and monitoring mechanisms at CSC to Board level • Updates on Financial position provide to Board, SMT Finance Committee and Transformation Committee • Delegated budgetary control framework including monthly accounts meetings • Trust wide savings and transformation programme • Income and contract monitoring arrangements • Trust financial recovery plan with actions.	• Significant improvement in the Trusts financial position over the last two months with the Trust's deficit going from £8.1m to £1.6m • This is due in part to one off items but the Trust's underlying position has also improved with December seeing a reduction in its monthly run rate deficit.	16 (4x4) SG FC	20 (4x5)	12 (4x3)	• Financial forecast still over reliant on top down forecast produced by finance team rather than bottom up intelligence from the CSCs	• Trust financial position at the end of January 13 remains a concern with the Trust reporting a £1.6m deficit • Discussions have been ongoing with the SHA and commissioners regarding £4m of additional funding to recognise the failure of the system wide non-elective plan. It now appears highly likely that the Trust will not receive this £4m, hence the Trust is now forecasting a year end position of break-even as a best case. There still remains considerable risk to achieving break-even.	GC –Bottom up financial forecasts have been introduced as part of the monthly accounts process with transition being made towards this model of forecasting. GA – Ending the year at break-even, whilst not what was planned at the start of the year, still represents a creditable recovery from the £8.1m deficit reported at the end of September. The finance team is working closely with CSC's to ensure the specific actions required to achieve break-even are implemented.	Mar 13	Mar 13

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

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5.3 (26)	The Trust loses income for treating patients due to application of contract penalties and levers or failure to respond to contract challenges for Commissioners.	• Monthly contract monitoring reports • Monthly contract review meetings • Income Protection Group • Monthly CSC performance meetings • Monthly CQUIN meeting.	• The Trust has now agreed a year end position with its major commissioners thus mitigating this risk and giving certainty around the majority year end income.	12 (4x3) SG FC	8 (4x2)	8 (4x2)	• Resource constraints within contracts team due to staff departures. Risk this could lead to potential issues of concern not being clearly communicated to CSCs.	• None	GC: Interim Head of Contracts in place and recruitment underway to support team.	Mar13	Mar 13
5.4 (26)	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	• Review of savings performance at Transformation and Finance Committees and Finance Recovery Group • Monthly CSC performance meetings • PMO tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements	• Monthly reporting to Finance Committees currently providing assurance that £16.4m of savings have been delivered, with a further £8.9m being targeted over remaining months of the year including technical items.	12 (4x3) SG FC/ TC	16 (4x4)	8 (4x2)	• Current actions do not enable the Trust to deliver the level of savings that was identified at the start of the year (£27m)	• The latest review of the Trust's savings plans indicates that the Trust is only likely to deliver £25m of savings by year end. This is £2m adrift of original target.	GC/GA: Existing schemes continue to be closely monitored to ensure delivery over the coming months. Additional contingency actions have been developed to help address the shortfall in the Trust's financial position.	Mar 13	Mar 13

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

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5.5 (26)	Failure to obtain a contract for 2013/14 which enables achievement of financial targets. This covers the general contract but also specialist commissioning which is at risk of being under resourced during external changes to health economy	• Interim Contracts Manager in post • Contracts team • Contract negotiation meetings including line by line review of each item, CQUIN, and QIPP • Structure developed for reporting and monitoring • Alignment across CSCs, contract requirements, CCGs • Working with CCG/LAT to ensure that sums transferred for specialist commissioning are correct	• Contract meetings being held and discussions with commissioners	20 (5x4)	20 (5x4)	Unable to quantify as evolving picture	•	• This is an emerging picture due to external changes	Close working between contracts team and clinicians and CSC management in achieving an appropriate contract(GA/GC) Close working between contracts team and commissioners in achieving a mutually agreeable contract (GA)	Mar 13	Apr 13

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5.6 (4)	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	• Current working partnership with IPHIS • Draft updated strategy being discussed at Board/SMT	• 2011-12 IT strategy • 2012-13 IT strategy presentation • IPHIS SLA • IPHIS risk register • IPHIS projects log	6 (3x2) CT ITSG	6 (3x2)	3 (3x1)	• New IT Strategy currently under development which will set out the future direction and key milestones	• New IT strategy not agreed or implemented	GC/GA – IT Strategy to be published September 2012	Apr 13	Oct 13

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