TRUST BOARD PUBLIC – APRIL 2013

Agenda Item Number: 59/13
Enclosure Number: (7)

Subject:	Assurance Framework
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Risk Coordinator Lorna Wilkinson – 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 • Decrease of risks 4.5, 5.4 and 5.6 • Consideration of removal of risk 5.6
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board workshop in May 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: April 2013

Purpose:

To provide the Trust Board with an update on the Assurance Framework as of 17 April 2013

Top Risks

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

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

3.2 ◄► (Red 16): Planned growth in elective activity does not materialise as forecast. resulting from:
Failures to target growth in appropriate specialties; and/or
Failures to achieve the profile of targeted elective activity growth
Planned elective activity not consistent with commissioners intentions/contract

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

New Risks

Nil

Risks with an Increased Score

Nil

Risks with a Decreased Score

4.5 ▼ (Amber 12 to Amber 9): Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels – temporary staffing spend reduced and in control

5.4 ▼ (Amber 12 to Amber 8): 2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position – significant savings delivered against plan

5.6 ▼ (Yellow 6 to Green 3): 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 - strategy developed and agreed

Risks to be Removed

Nil

Target Date Changes

1.1 (CQC):

Achieved residual risk at year end but risk carried into 2013/14 as a major reputational risk associated with regulator assurance.

1.2 (Patient Experience):

Not achieved predicted residual risk due to only partial achievement of improvement required for full

CQUIN payment. Although improvement noted across inpatient survey results generally. Risk carried over into 2013/14 and will be reviewed to incorporate friends and Family test.

1.3 (Safety & Quality):

Not achieved predicted residual risk at target date due to year end position on MRSA and ED performance.

2.1/2.2/3.1 (Performance & Patient Flow):

Not achieved residual risk due to ongoing performance and capacity issues, risk updated and carried into 2013/14.

2.3 (Research & Development):

Not achieved residual risk although risk reducing. Further assurance being put into place and risk carried into 2013/14.

3.2 (Elective Activity Growth):

Not achieved residual risk and carried into 2013/14 due to ongoing concern that commissioner intentions and assumptions do not match those of the Trust.

3.3 (Elective Pathway Performance):

Residual risk not achieved and risk carried into 2013/14 due to issues identified in Newton work.

3.4 (CCG Relationships):

Residual risk not achieved and risk carried over into 2013/14 due to evolving external structure.

4.1/4.2/4.3 (Workforce):

Residual risk not achieved, risks carried over into 2013/14, ongoing as part of OD work.

4.6 (Critical Posts):

Residual risk not achieved and so carried into 2013/14.

5.1 (Foundation Trust):

Achieved residual risk but due to ongoing FT work risk carried into 2013/14.

5.2/5.3 (Budgetary Control/Income):

Achieved residual risk but will be carried into 2013/14 due to ongoing significant financial pressures.

5.6 (IT Strategy):

Not achieved residual risk, risk to be carried into 2013/14due to ongoing reconfiguration and impact of IT support to clinical and non-clinical services.

Prepared by:	Annie Green – Risk Coordinator
	Lorna Wilkinson – Head of Patient Safety
Presented by:	Peter Mellor – Company Secretary

Portsmouth Hospitals NHS Trust Strategic Aims

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

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

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

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

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

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

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

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

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

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

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

Trust Risk Profile - April 2013

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

ASSURANCE FRAMEWORK 2012/13 PROGRESS SUMMARY - April 2013

STRATEGIC AIM	Risk Reference Operational Leads	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	RESPONSIBLE COMMITTEE	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
					JAM	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1 : DELIVER SAFE, HIGH QUALITY AND EFFECTIVE CARE IN THE TOP 20% OF OUR PEERS	1.1 FMcN	Inability to maintain ongoing compliance with all CQC standards	G&Q	All	12	12	8	8									May 13	8 Apr 13
	1.2 SB	Failure to achieve required response rate for the Friends and Family test potentially affecting organisational reputation and achievement of CQUIN	PEWG	16	9	9	9	9									Jun13	3 Mar 14
	1.3 LW	Failure to comply with internally and externally set standards impacting on quality of services provided to patients and patient safety	G&Q	4	12	12	12	12									Jun13	8 Apr 14
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 attendances to meet agreed and national targets	SMT	16	15	15	15	15									Jun 13	10 Apr 14
	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	20	20	20	20									Jun 13	12 Apr 14
	2.3 SH	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network	SMT	6	6	6	6	6									Jun 13	3 Mar 14
3: PATIENTS AND GPS IN THE REGION WILL CONSISTENTLY CHOOSE TO USE OUR SERVICES	3.1	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	SMT	4	12	12	12	12									Jun 13	4 Mar 14
	3.2	Planned growth in elective activity does not materialise as forecast, resulting from: Failures to target growth in appropriate specialties; and/or Failures to achieve the profile of targeted elective activity growth Planned elective activity not consistent with commissioners intentions/contract	SMT	26	16	16	16	16									Jun13	4 Mar 14
	3.3	Inefficient elective pathways result in failure of performance standards and financial targets and impacts on clinical effectiveness	SMT	4	9	9	9	9									Jun13	3 Mar 14
	3.4	Relationships and communication with evolving commissioners (CCGs) and key stakeholders across the region does not develop as planned impacting on income and market share	SMT	6	12	12	12	12									Jun 13	4 Mar 14
4: STAFF ARE PROUD TO WORK HERE, AND WE WILL HAVE NO DIFFICULTY RECRUITING AND	4.1 PS	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance	SEC	All	8	8	8	8									Jun 13	4 Apr 14

RETAINING THE BEST PEOPLE		and strategic priorities for the Trust																
	4.2 RK	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities	SEC	All	12	12	12	12									Jun13	8 Apr 14
	4.3 RK	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities	SEC	14	12	12	12	12									Jun 13	6 Apr 14
	4.4 PS	Leadership capability is insufficient to deliver change management programmes and build staff commitment in delivering change	SEC	14	12	12	12	12									Oct 13	8 Apr 14
	4.5 RK	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels	SEC	13	12	12	12	9									Jul 13	9 Sep13
	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									Oct 13	6 Apr 14
5: ENSURE SUSTAINABILITY	5.1 BC	Inability to achieve Foundation Trust status within the agreed timetable	TB	26	12	12	12	12									May 13	12 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	20	12	12									May13	12 Apr 14
	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	8	8	8									May13	8 Apr 14
	5.4 SG	2012/13 Savings targets are not identified & delivered, with subsequent impact on Trust financial position	FC/TC	26	16	16	12	8									May13	8 Apr 14
	5.5 RE	Failure to obtain a contract for 2013/14 which enables achievement of financial targets.	FC	26		20	20	20									Jun 13	May 13
	5.6 CT	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	ITSG	4	6	6	6	3	Consider removal of risk								Apr 13	3 Oct 13

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE On target Minor Obstacle to achieving target Inability to achieve predicted target	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
1.1	Inability to maintain ongoing compliance with all CQC standards	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • NHSLA Level 1 accreditation (Mar 12) • Accepted for CQC registration without conditions 2010/11 • CSC risk registers • Mock CSC assessments and associated action plans • Monitor Quality Risk Profile monthly • Quarterly evidence and action plan review panels established CQC awareness	• 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 • Report received, declaring compliance with outcome 21. No outstanding improvement actions and compliant with all outcomes.	**12 (4X3)**	**8 (4X2)**	**8 (4X2)**	**None**	i. New documentation education and training ongoing following pilot with continued roll out across Trust ii. Documentation audits show required 95% compliance is not being consistently achieved	1. Director of Nursing 2. Head of Governance 3. Governance & Quality (G&Q)	May 13	Apr 13	CQC All	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i). Action plan to be monitored monthly by Governance and Quality Committee until remaining actions closed.	FMcN	Mar 13	Mar 13
i). Ongoing mock CQC visits.	JD	Apr 13	
i) Completed action plan submitted to CQC for a desk top review;	NL	Nov 12	Nov 12
ii). Continued documentation audits until compliance sustained	HoN	Apr 13	

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

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.2	Failure to achieve required response rate for the Friends and Family test potentially affecting organisational reputation and achievement of CQUIN	• 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 • Increase across 5 key questions (potential achievement of CQUIN 80%)	9 (3x3)	9 (3x3)	3 (3x1)	No gaps currently	i. Inconsistent reporting by CSCs to PESG ii. Trust was required to achieve a 2 point increase in 5 key questions to achieve full CQUIN payment iii. Friends and Family test in its infancy, response rate of 75 patients per day not being achieved	1. Director of Nursing 2. Head of Patient Experience 3. Patient Experience Steering Group (PESG)	Jun 13	Mar 14	CQC 16	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) CSC reporting to be monitored at PESG and escalate to DoN any non submission	SB	Mar 13	Mar 13
ii.) Analysis and subsequent action plan to be completed	SB	Jun 13	
iii) Implementation plan in place and monitored by ward/CSC	SB/NL	Jan 13	Jan 13

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

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
1.3	Failure to comply with internally and externally set standards impacts on quality of services provided to patients and patient safety	• Governance Framework and monitoring: • Quality Impact Assessments of CIP plans – policy ratified March 13 following extensive pilot • Quality Performance measures • Monitor Compliance Framework • CSC executive performance reviews • Clinical Audit programme • Safety workstreams • Patient and user feedback process	• 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)	12 (4x3)	8 (4x2)	i. All risk assessments to be completed and savings plans signed off for CIP programme ii. Real time incident data not fully available to allow proactive response ii. CSC performance framework under review v. Identification of individual CSC quality performance 'hotspots'	v. Finished year above trajectory for MRSA (6 against a trajectory of 4) vi. Failed ED performance target at year end 2012/13	1. Director of Nursing 2. Head of Patient Safety 3. G&Q	Jun13	Apr 14	CQC 26	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Fully embed Quality Impact Assessment review process for 2013/14	DB/LW	Apr 13	Apr 13
ii,) Complete roll out of DatixWeb	LW	Jun 13	
iii.) Fully imbed CSC performance review process	AG	Mar 13	Mar 13 and review ongoing
iv.) Further develop integrated performance report to include data at CSC level	AG	Mar 13	Mar 13
v) Implementation of MRSA Recovery Plan	CM	Jun 13	
vi) See risk 2.1 and 2.2 for actions			

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

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	Partnership working arrangements do not deliver sufficient reductions in emergency attendances 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 • 3 key workstreams identified with project leads and overall clinical lead. • 2 weekly reports into Emergency Flow Improvement Programme Steering Group chaired by COO • 18 point Health System in place for 2013/14 • Ambulatory Care programmes implemented in MAU, Respiratory and SAU • Weekly discharge improvement group • Pilot community discharge	• 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)	15 (5x3)	10 (5x2)	i. PHT Emergency Flow governance structure yet to be implemented. ECIST programme delivery in its infancy ii. Ongoing contracting discussions – CQUIN penalties on delivery of ECIST action plan iii. Projects under discussion to implement 4 specific cross provider disease pathways – cross boundary work reliant on partners iv. Lack of medical cover overnight and at weekends in ED. Need for senior clinical decision makers at the front door during peak demand	v. Work ongoing to develop PHT Performance dashboard to measure progress against individual projects and extend process system wide.	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Apr 14	CQC 16	RR 2.1 3.3

		assessment lounge in ED											

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

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

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2.2	The Trust fails to maintain an effective patient flow through the hospital, adversely impacting patient experience, care quality and performance against targets and standards This risk increases during times of peak demand and winter pressures.	• 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)	20 (4x5)	12 (4x3)	i. Continued high numbers of medically stable patients awaiting discharge ii. Inconsistent implementation of patient flow policies across the Trust iii. Lack of real time information on PAS regarding discharges and capacity. Bed Declaration Policy not being followed	iv). The monthly Integrated Performance Report does not include any patient flow KPIs. However there is now an Emergency Flow Dashboard being developed in support of the Trust Emergency Flow Action Plan	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Apr 14	CQC 4,6	RR 2.1 4.1 4.3 4.4

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) / ii.) / iv.) Implement EDD project as part of ECIST action plan	NL/PS	Jun 13	
i)/ ii) /iv) Monitor against CSC discharge targets	RF	Jan 13	Jan 13 and ongoing
iii) Bed Declaration Policy to be reviewed	MP	Jun13	
iii)IT solution to be explored	CW	Jun 13	
vii.) Implement Consultant leader support at front door to fast track speciality decision making early in patient pathway	SH	Jun 13	

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

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 On target Minor Obstacle to achieving target Inability to achieve predicted target	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
2.3	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)	6 (3x2)	3 (3x1)	i. R&D Strategy requires review	iv. Quarterly R&D Board reporting to be established	1. Medical Director 2. Head of Research & Development 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 6	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) / ii.) Quarterly Research & Development report to be submitted to Trust Board – KPIs to be developed, Board reporting structure to be agreed with MD	AC	Jun 13	
i.) / ii.) Research & Development strategy to be developed and agreed – annual framework review to be implemented	AC	Jul 13	

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

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.1	The Trust is unable to provide required capacity for scheduled care services on a sustainable basis	• 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)	12 (4x3)	4 (4x1)	i. Not all specialties have sufficient capacity to meet demand on a sustainable basis ii. Some patients wait more than 18 weeks for treatment - planned failure of RTT targets in 1 Specialty under consideration to ensure sustainability. Increased use of urgent referrals can alter case mix and risk substantially iii. Contracted activity levels transfer some of financial risks of reducing waiting times to 'best in region' to the Trust iv.	None	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 4	RR 2.1 3.4

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) At risk specialties to achieve agreed plan to deliver sustainable target delivery	GMs	Apr 13	Apr 13 but will be ongoing through year
i.) Implement management of flow initiatives as detailed in 2.2	RF		
ii.) Speciality level management of patient lists to reduce waiting times on a sustainable basis	GMs	Apr 14	Ongoing throughout year
ii) Weekly monitoring of referrals with GMs	CW	Apr 14	Ongoing throughout year
iii.) Agree 2013/14 contract to ensure delivery of national and local targets and sustain scheduled care services	LB	Apr 13	Negotiations ongoing

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

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.2	Planned growth in elective activity does not materialise resulting from: • Failures to target growth in appropriate specialties; and/or • Failures to achieve the profile of targeted elective activity growth Planned elective activity not consistent with commissioners intentions/contract	• Annual planning process • Quarterly Board review • Performance Assurance meetings and agreed action plans • Monthly Exec contract review meeting • Reconfigured capacity with new activity plan for 2013/14	• Quarterly Business Intelligence report	16 (4x4)	16 (4x4)	4 (4x1)		i. Commissioner plans do not allow for activity growth at 'baseline' levels	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 26	RR 2.1 2.2 3.4 4.3 4.4 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
iii) Continue 2013/14 contract negotiations	CW/BL	May 13	Negotiations ongoing

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

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3.3	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)	9 (3x3)	3 (3x1)	None	i. The Trust's benchmarked performance against MEQO (Midlands and East Quality Observatory) dashboard metrics is not consistently in upper quartile	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Senior Management Team (SMT)	Jun 13	Mar 14	CQC 4	RR 2.1 3.3 3.4 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Implementation of Newton work to drive productivity and efficiency agenda within the organisation	CW	Sep 14	
i.) Report MEQO to Clinical Effectiveness Steering Group for focussed work to be commissioned as appropriate	GS	Apr 13	Apr 13

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

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

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Appointed Business Development Manager April 2013	TP	Apr 13	Apr 13

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.1	Learning and education outcomes do not deliver the required outcomes in terms of patient experience, operational performance and strategic priorities for the Trust.	i. Training plans developed to reflect CSC strategic priorities. ii. Membership of the shadow Local Education and Training Board. iii. Evaluation of learning outcomes undertaken. iv. Director of Education appointed v. Strategic Education Board	• Strategic Education Board in place. • Trainee feedback in relation to programmes positive (national Staff Survey, post graduate training feedback). • Learning and Education Strategy	12 (4x3)	8 (4x2)	4 (4x1)	i. Education Outcomes Framework not implemented Trust Wide	ii. There is no evaluation process in place to identify the link between learning and education programmes and patient outcomes.	1. Director of Workforce and Organisational Development 2. Director of Education 3. Strategic Education Committee (SEC)	Jun 13	Apr 14	CQC 14	RR 3.3 4.2

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) / ii.) Develop and deploy education outcomes framework	PS	Mar 14	

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.2	Performance management tools fail to deliver the step change required in performance to deliver key DoH targets and the Trust's strategic priorities.	• 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. • Compliance target achieved in Feb 13	12 (4x3)	12 (4x3)	8 (4x2)	i. Variation in performance at CSC and individual level. ii. Consequence management framework established - but requires evaluation.	iii. Appraisal performance measures currently only look at compliance with no individual rating scale evident.	1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Jun 13	Apr 14	CQC 14	RR 3.3 4.2

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
iii.) / ii.) Review of performance appraisal process to introduce ratings and consequence management frameworks	RK	Jun 13	
i) / iii.) Establish CSC actions plans to ensure compliance with appraisal target	RK	Ongoing	

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.3	Workforce is insufficiently engaged to understand and deliver the Trust's strategic priorities.	• 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)	12 (3x4)	6 (3x2)	i. Staff survey results still show lower than acceptable scores against some key findings – PULSE surveys show some improvement, although numbers not representative		1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Jun 13	Apr 14	CQC 14	RR 3.3 4.2

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Review of internal communication processes including team brief	TP/RK	Jun 13	
i.) Implement actions regarding core messages and communication tools for staff from workforce task and finish group	RK	Jun 13	
i.) Commence Listening in Action programme and roll out Trust wide	RK	Mar 13	Ongoing
i) New workforce structure in consultation to move to transformation structure to allow for significant change to occur in staff engagement	TP	May 13	

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.4	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. • >1000 staff trained as part of WT4P • 360 completed for executive team	12 (4x3)	8 (4x2)	8 (4x2)	i. Expectations of leaders not clearly defined. ii. Managing development framework to be defined iii. All relevant staff have not undertaken Working Together for Patients	iv. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.	1. Director of Workforce and Organisational Development 2. Director of Education 3. Strategic Education Committee (SEC)	Apr 13	Apr 14	CQC 14	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) / ii.) Develop talent management process to capture future leaders	TP		This is pending due to work currently being undertaken by the National Leadership Academy
ii.) / iv.) Implement Leadership Framework 360 and self assessment tool to identify development needs at Trust and individual level – CSC management teams, CDs and identified critical posts now timetabled for 2013/14	TP	Dec 13	26/07/12 for Executive Team
iii.) Trust wide roll out of Working Together for Patients initiative	SS		31/03/13 – 1000 staff trained, ongoing
i-iv) Organisational Development strategic review to be undertaken - developed	TP	Sep 12	Sep 12

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.5	Future workforce demand requirements are not met by substantive staff resulting in higher than acceptable levels of temporary staff and unaffordable staffing levels.	• 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)	9 (3x3)	9 (3x3)	vi. Temporary resource currently above planned level of 3%. vii. Reduction in Junior Doctor resource will increase demand for consultants in some specialities. viii. Attraction strategy needs further development to enable recruitment of high level candidates. ix. Only one University intake per annum for newly qualified nurses results in excessive vacancy fluctuation	x. Reporting of workforce metrics does not facilitate early decision making.	1. Director of Workforce and Organisational Development 2. Head of Human Resources 3. Strategic Education Committee (SEC)	Jul 13	Sep 13	CQC 13	RR 4.1 4.3 4.4 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) / v.) Fully deploy E-rostering system	RB	Jul 13	
i.) / ii.) / v.) Mobilise existing workforce where applicable	RK	Ongoing	
i) Continue to monitor temporary spend on bi-weekly basis	AW/RK	Ongoing	
i) Execs continue to sign off temporary staffing requests	EDs	Ongoing	
ii.) Ongoing discussions with Deanery linking into workforce strategy for the future	PS	Ongoing	
iii.). Define Attraction Strategy for 2013/14 intake	NSa	Jun 13	
iv.) Discuss future intake structure with Higher Education institutions	DE	Ongoing	

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

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4.6	Critical posts are not filled within the Trust due to a lack of succession planning and associated development programmes.	• Definition of critical posts established and used by WSC to prioritise recruitment.	• Succession plan meeting for Board level posts held. • GM post filled in ED	12 (3x4)	12 (3x4)	6 (3x2)	i. Performance appraisal does not capture career progression potential. ii. Process for defining and identifying those with potential is not established.	iii. Talent is not reviewed at senior management level or at CSC level. iv. Succession plans are not evident across the Trust v. Some critical posts not filled	1. Director of Workforce and Organisational Development 2. Director of Education 3. Strategic Education Committee (SEC)	Oct 13	Apr 14	CQC 13	RR 4.1 4.3 4.4

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.)/ iii.) Review appraisal process for Band 7 and above	TP	Sep 13	
i.) Develop talent review process and link to appraisal	TP	Sep 13	
ii.) / iii.) Undertake talent review meetings at Trust Board and CSC level	PS	Dec 12	Dec 12 and ongoing
iv.) / v.) Develop senior management level succession plans	GMs/RK	Dec 12	Dec 12 and ongoing

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.1 (26)	Inability to achieve Foundation Trust status within the agreed timetable	• 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)	12 (4x3)	12 (4x3)	i. Financial performance off trajectory ii. Performance against key target A&E not being achieved	iii. Financial report shows Trust plan currently in deficit	1. Chief Executive 2. Associate Director Foundation Trust 3. Trust Board	May 13	Mar 14	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
I.) / iii.) Implement financial recovery plan	RE	Mar 13	
ii) See 2.1 and 2.2 for actions linked to achieving ED targets	RF	Apr 13	

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.2	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year of a £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. • Monthly accounts meetings	• 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. • SHA has given Trust £4m as non recurring non contractual income to cover acknowledgement of significant financial pressures the Trust has incurred as a result of unscheduled demand • Draft accounts show £4.3m surplus achieved	16 (4x4)	12 (4x3)	12 (4x3)	i. Financial forecast still over reliant on top down forecast produced by finance team rather than bottom up intelligence from the CSCs		1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	May13	Apr 14	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Fully implement bottom up financial forecasts as part of monthly accounts process	SS	Dec 12	Dec 12
ii.) / iii.) Finance team working with CSCs to ensure specific actions to achieve 'break even' position are implemented	Finance team and CSC management teams	Mar 13	Mar 13

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.3	The Trust 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. • Interim contract lead in place	12 (4x3)	8 (4x2)	8 (4x2)	i. 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	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	May 13	Apr 14	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Recruit to vacancies in Contract team	SS/RE	Apr 13	Apr 13 Contracts Manager appointed but team remains under resourced

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.4	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 • SHA has given Trust £4m as non recurring non contractual income to cover acknowledgement of significant financial pressures the Trust has incurred as a result of unscheduled demand • £22.1 million of identified 26 million achieved. • Overall year end position of surplus position	12 (4x3)	8 (4x2)	8 (4x2)	i. Identification of savings for 13/14 below target	ii. 2013/14 rounds identifying gaps going forward	1. Director of Finance 2. Deputy Director of Finance 3. Finance Committee	May13	Apr 14	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) Closely monitor existing schemes and additional contingency actions to address shortfall in Trust financial position	SS	May13	
i.) / ii.) Impact of contracting process to be considered	SS	May 13	

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE On target Minor Obstacle to achieving target Inability to achieve predicted target	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
5.5	Failure to obtain a contract for 2013/14 which enables achievement of financial targets. This covers the general contract but also specialist commissioning which is at risk of being under resourced during external changes to health economy	• 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 Meeting to discuss and seek to agree the Activity schedule to take place 15th April. • Intention by both parties to achieve Heads of Agreement, week ending Friday 19th April. • Formal Position statement to be submitted to TDA Thursday 18th April: will be agreed by both parties.	20 (5x4)	20 (5x4)	Unable to quantify as evolving picture	•	i) This is an emerging picture due to external changes ii) As at 15th April, there is still a gap between PHT view of activity required for 2013/14 and the Commissioner perspective.	1. Director of Finance 2. Head of Contracts 3. Finance Committee	Jun 13	May 13	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i). Close working between contracts team, clinicians and CSC Management teams to ensure appropriate contract	Contracts team, CSC Management and Clinicians	May 13	
i). Close working between Contracts team and Commissioners to achieve a mutually agreeable contract	Contracts Team	May 13	

STRATEGIC AIM 5: ENSURE SUSTAINABILITY

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
5.6	Failure to develop and implement a cohesive Information Technology strategy putting the current systems at risk and halting future development required to underpin organisational and clinical performance	• 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)	3 (3x1)	3 (3x1)	i. New IT Strategy currently under development which will set out the future direction and key milestones	ii. New IT strategy not agreed or implemented	1.Director of Finance 2. Head of ICT 3. Information Technology Steering Group (ITSG)	Apr 13	Oct 13	CQC 4	RR 1.20 1.24 1.31 3.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.) / ii.) IT Strategy to be developed, agreed and implemented	CT	Apr 13	Feb 13 – removal of risk to be considered

Care Quality Commission - Outcomes

Involvement and Information

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

Personalised care, treatment, support

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

Safeguarding and safety

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

Suitability of Staffing

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

Quality and Management

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

Suitability of Management

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

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