Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC- JANUARY 2015

Agenda Item Number: 11/15
Enclosure Number: (5)

Subject:	Board Assurance Framework (BAF)
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Senior Risk Advisor Cathy Stone – Director of Nursing Cathy Stone – Director of Nursing
Purpose of paper *Why is this paper going to the Trust Board?*	To provide the Trust Board with a monthly update of the Board Assurance Framework.
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 • Risks greater than 15 on the BAF • Increase of risk 05-1415 • Decrease of risks 06-1415 and 14-1415
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board in February 2015.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

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

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

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: January 2015

Purpose:
To provide the Trust Board with a monthly update on the BAF as at 19 January 2015.

Top Risks

04-1415◄ ►(Red 20): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing

05-1415 ▲ (Red 16): The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED

17-1415◄ ►(Red 16): Current and future workforce demand is outstripping supply

18-1415◄ ►(Red 16): Inability to achieve Foundation Trust status within the agreed timetable – Unscheduled care not achieving national standard ad financial position off track

19-1415◄ ►(Red 16): Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2014/15 of a planned surplus on income and expenditure.

21-1415◄ ►(Red 16): 2014/15 Savings plans are not identified & delivered, with subsequent impact on Trust financial position

New Risks

Nil

Risks with Increased Score

05-1415 ▲ (Amber 8 to Red 16): The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED – increased demand on unscheduled care has resulted in increased cancellations.

Risks with Decreased Score

06-1415 ▼ (Red 16 to Amber 12): Failure to achieve cancer wait targets - December and Q3 performance better than risk forecast and appropriate assurance processes are in place to track and escalate all patients waiting past breach date.

14-1415 ▼ (Amber 8 to Yellow 6): Threat to specialist services due to centralisation agenda – agreement to provide outpatients service at Chichester

Risks to be Removed

Nil

Target Date Changes

10-1415 Lack of technical fire risk assessments throughout the whole of both new and retained estates and associated remedial works – sickness of key contractor has led to unavoidable delay in completion

Of Note

Prepared by: Annie Green – Senior Risk Advisor

Presented by: Cathy Stone – Director of Nursing

Portsmouth Hospitals NHS Trust Strategic Aims

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

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

- Year on year improvement in national, local and quality account metrics
- Year on year reduction in avoidable harm
- Maintain compliance against Care Quality Commission outcomes
- Deliver good patient experience as measured by Friends and Family Test
- Consistently achieve all access standards in line with commissioning and regulatory requirements
- Partner with other organisations to deliver joined up emergency care

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

- Year on year increase in patient recruitment to clinical trials
- Implementation of the academic/innovation centre within PHT
- Become a hospital of choice within Wessex for trainees to wish to work in

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

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

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

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

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

- Achieve a surplus in 2014/15 of at least £2m in 2014/15 and £4m in 2015/16.
- Develop and update annually a fully Integrated Business Plan underpinned by robust supporting strategies.
- Be in a position to make a credible application to Monitor to become a Foundation Trust in Q3 2014/15.
- Develop Clinical Service Centres as fully functioning developed business units with full profit and loss responsibility.
- Re-align corporate services to support all of the above
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- Re-align corporate services to support all of the above

Trust Risk Profile - January 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)			1 CQC compliance ◄ ► 13 Growth in R&D ◄ ► 14 Threat to specialist services ▼	12 Junior Doctor feedback ◄ ►	
Possible (3)			3 Patient Experience ◄ ► 16 Leader development ◄ ►	2 Quality and Safety Standards ◄ ► 6 Cancer Wait Targets ▼ 7 Data Quality ◄ ► 8 Equivalent workforce across seven days ◄ ► 9 IT Strategy ◄ ► 10 Lack of technical fire risk assessments ◄ ► 11 Prolonged LoS for MFDR patients ▼ 15 Staff engagement ◄ ► 20 Financial Income & Penalties ◄ ►	
Likely (4)				5 RTT and Access targets ▲ 17 Workforce demand & key skill shortages ◄ ► 18 Foundation Trust status ◄ ► 19 Failure of budgetary control ◄ ► 21 Delivery of savings ◄ ►	
Highly Likely (5)				4 Failure to achieve Emergency Department Quality Standards ◄ ►	

ASSURANCE FRAMEWORK 2014/15 PROGRESS SUMMARY – January 2015

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	TRUST RISK REGISTER REFERENCE	CQC OUTCOME REFENCE	PROGRESS MONTH ON MONTH APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
1, 3, 5	1-1415	TS	G&Q	Inability to maintain ongoing compliance with all CQC standards	3.3	All	9	6	6	6	6	6	6	6	6	6			Jan 15	6 Review Jan 15
1, 3, 5	2-1415	FMcN/CM	G&Q	Failure to comply with internally and externally set standards on quality and safety	3.3	4,7 8,9	12	12	12	12	12	12	12	12	12	12			Feb 15	8 Apr 15
1,3, 5	3-1415	CD	G&Q	Failure to achieve internal and external standards around patient experience	3.3	16 17	9	9	9	9	9	9	9	9	9	9			Feb 15	6 Apr 15
1,3,4,5	4-1415	MP	SMT	Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing	2.1 3.3	16	15	20	20	20	20	20	20	20	20	20			Feb 15	12 Mar 15
1,3, 5	5-1415	MD	SMT	The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED	3.3 3.5	4	8	8	8	8	8	8	8	8	8	16			Feb 15	8 Apr 15
1,3, 5	6-1415	NM	SMT	Failure to achieve cancer wait targets	3.3	4	8	8	8	8	8	16	16	16	16	12			Mar 15	8 Apr 15
1, 5	7-1415	PM	SMT	Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate	1.48	16	12	12	12	12	12	12	12	12	12	12			Mar 15	8 Mar 15
1,3	8-1415	SH	SMT	Lack of equivalent workforce across seven days of the week	3.3	4	12	12	12	12	12	12	12	12	12	12			Feb 15	8 Dec 15
1,3, 5	9-1415	CT	SMT	Failure to successfully implement the Trust's IT Strategy eHospital Programme to deliver an enterprise clinical system that better supports delivery of high quality, more efficient and cost-efficient patient centred care.		4, 11	8	8	8	8	8	16	16	12	12	12			Mar 15	4 Apr 15
1	10-1415	JA	SMT	Lack of technical fire risk assessments throughout the whole of both new and retained estates and associated remedial works	1.28	10, 13	12	16	16	16	16	16	12	12	12	12			Mar 15	**8** Mar 15
1,3,5	11-1415	SE	UCT	Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed				16	16	16	16	16	20	20	12	12			Feb 15	12 Mar 15
1,2,3	12-1415	PS	SMT	Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns	4.3 4.4	14	12	12	12	8	8	8	8	8	8	8			Apr 15	8 Now ongoing monitoring
2,3,5	13-1415	AC/KG	SMT	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network		6	6	6	6	6	6	6	6	6	6	6			Mar 15	3 Mar 15
1,3,5	14-1415	SH	SMT	Threat to specialist services due to centralisation agenda		6	12	12	12	8	8	8	8	8	8	6			Apr 15	6 Review Progress Apr 15
1,3,4	15-1415	RK	SMT	Insufficient engagement of workforce	4.1,4.3	13	12	12	12	12	12	12	12	12	12	12			Feb 15	6

					4.4,5.1														Apr 15
1,3,4	16-1415	RK	SMT	Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to delivering change	4.4, 5.1	14, 26	9	9	9	9	9	9	9	9	9	9			Feb 15	6 Apr 15
1,3,4,5	17-1415	RK	SMT	Current and future workforce demand is outstripping supply	4.4, 5.1	14, 26	16	16	16	16	16	16	16	16	16	16			Feb 15	12 Apr 15
3,5	18-1415	BL	TB	Inability to achieve Foundation Trust status within the agreed timetable	5.1	26	12	12	12	12	16	16	16	16	16	16			Feb 15	8 Mar 15
5	19-1415	LWi	FC	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2014/15 of a planned surplus on income and expenditure.	5.1	26	12	12	16	16	16	16	16	16	16	16			Feb 15	12 Mar 15
5	20-1415	LWi	FC	The Trust does not receive income due for 2014/15 as a result of the contract agreed or due to application of contract penalties and levers or failure to achieve CQUIN payments	5.1	26	12	12	12	12	12	12	12	12	12	12			Feb 15	12 Mar 15
5	21-1415	LWi	FC	2014/15 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	5.1	26	12	12	16	16	16	16	16	16	16	16			Feb 15	12 Mar 15

Ref	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target Minor Obstacle to achieving target Inability to achieve predicted target			
1-1415	**Inability to maintain ongoing compliance with all CQC standards**	• Quarterly CSC self-assessment + compliance statements • Outcome Leads • CSC risk registers • HealthAssure – web based compliance software covering all registered locations • Internal assurance programme revised to include CSC quarterly peer reviews plus quality data analysis to improve the focus of the inspections • CQC Intelligent Monitoring Report indicators – process of review in place of data accuracy prior to publication	• 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 • Compliance audits • CQC compliance and Monitor Returns Internal Audit (Deloitte) Aug 13 demonstrating substantial assurance • CQC dementia themed inspection 13th March 2014 – full compliance by CQC • PWC quality stocktake assessment of 'good' against the domains. • Informed of CQC announced inspection 9th February to 13th February 2015. Project and Steering Group established. • CQC Intelligent Monitoring Report (Dec 2014) has placed the Trust in Band 5 (1 being poor, 6 being good)	**12 (4X3)**	**6 (3X2)**	**6 (3X2)**	i. CQC inspection using new methodology and domains.	ii. Self assessment of compliance against the CQC Domains. iii. Provider Information Request Received; information submitted to the CQC – awaiting key lines of enquiry/feedback from CQC. iv. Changes to HealthAssure based on the CQC domains. v. Key areas of risk relate to unscheduled care (Risk Register reference: 4-1415)	1. Acting Director of Nursing 2. Acting Head of Governance 3. Governance & Quality (G&Q)	Jan 15	Review January 15	CQC All	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i, ii & iii CQC preparedness project group and Steering Group in place to oversee preparation for the CQC inspection	TS	November 2014	Ongoing meetings
i & ii CSCs to undertake gap analysis against CQC domains and CSC performance reviews to identify any issues/actions	CSCs	January 2015	Ongoing meetings CSC Performance reviews around the CQC Domains and extended performance reviews for specific CSCs.
i, ii & iii Leads for information identified and to be informed of requirements.	TS	Complete	Complete. Information provided in line with CQC Provider Informtion Request.
i)/ii) Ongoing mock CQC visits (CSCs) using new CQC domains	HoNs	Apr 13	Implemented and Ongoing
i)/iiv) Awaiting updated HealthAssure software to reflect CQC domains	TS	Dependent on update of software by Allocate	Ongoing
i)/ii) Revised internal quality assurance inspection programme commencing November 2013 aligning with Keogh inspection methodology - Continue with revisions to process as appropriate as national guidance emerges and changes to CQC inspections are finalised	FMc	Nov 13	Complete –Process will be under continual review as the need arises
i)/ii) Review CQC Intelligent Monitoring Report upon publication	TS/FMc	November 2014	Complete and ongoing. July 2014 – Band 6 December 2014 – Band 5
i) Quarter 2 self assessment of non-compliance with minor impact for outcome 13 (staffing) in Medicine and Trust-wide outcome 10 (premises) . Concerns being addressed through the CSC and through Carillion.	N M/JAC/CM	Jan 15 following Q3 assessment	Specific actions on-going for outcome 10 but not affecting overall compliance with standard. Complete
I & ii) Quality stock take in conjunction with PwC in July 2014 assessment of 'good' against the domains, particularly caring.	TS/FM	Sept 14	Report received on 8th Sept. Actions included in CSC Quality Improvement Plans,

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
2-1415	**Failure to comply with internally and externally set standards on quality and safety** **Implications:** • **Avoidable harm to patients** • **Reputational damage** • **Failure to satisfy quality contract** • **Fines associated with some quality metrics** • **Loss of CQUIN income**	• Governance Framework and monitoring – Quality Improvement Framework • Quality Performance measures • Monitor Compliance Framework • CSC performance reviews • Kitbag performance metrics • Clinical Audit programme • Gov & Quality Committee • Patient safety Steering Group and associated Safety work streams • Monthly and Quarterly Board reporting • Monthly CQUIN Meetings • Quality Impact Assessments of CIP plans and transformation schemes • Clinical Effectiveness Steering Group • CSC Governance meetings • Specialty M&M meetings • Electronic Mortality Review tool	• Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Trust Board • Dr Foster data • CQC feedback – QRP/review feedback • CQC intelligence monitoring Band 6 • HSMR/SHMI as expected • Results of external reviews on quality and safety example: TDA and CCG reviews • Achieved Dementia Screening requirements in Q2 and Q3 to date	**12 (4x3)**	**12 (4x3)**	**8 (4x2)**		i. Failed ED performance target at year end 2013/14 and Q1/Q2 and in Q3 to date 2014/15 ii. Pressure ulcers above target Q1 and Q2 and in Q3 to date (CQUIN linked) iii. Failure to meet dementia screening requirements in Q1 (90% for CQUIN) iv. VitalPac Dementia screening reporting anomalies v. C Diff rates above trajectory in Q1 and Q2 and Q3 to date vi. Increased falls during admission resulting in harm Q1. Over trajectory in Q3 to date (CQUIN linked) vii. Electronic mortality tool in roll out phase – reporting in development viii. Evidence of poor adherence to the sepsis 6 bundle	1. Director of Medicine 2. Head of Clinical Safety/Head of Quality 3. G&Q	Feb 15	Apr 15	CQC 4, 7, 8 9, 11	RR 3.3

		• Front door triage of patients queuing in ED to allow differentiation and prioritisation according to severity of illness • VitalPac Dementia screening reporting anomalies being managed through manual process											

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) See risk 1.5 for actions	MP		
ii) Full implementation of turnaround plan to include weekly compliance audits with Braden assessment and SKIN bundle	AF	Apr 14	Date collection commenced, performance managed through HoN
ii) Performance support framework in place for those CSCs with repeat high grade pressure damage	AF	May 14	May 14
iii) Switch to full VitalPac reporting	GG	Apr 14	Completed
iii) Daily and weekly monitoring and reporting of patients requiring screening. Performance management of CSCs and individual medical staff tracked through VP	GG	Apr 14	Ongoing and now at individual level
iv) Continue to work with TLC on a solution for the VP Dementia Screening programme	GG/SH	Jul 14	Ongoing and escalated to exec level
v) Recovery plan in place including cleaning standards, antibiotic prescribing – monitored by Infection Prevention Committee	CM	Jun 14	In Place
vi) falls task and finish Group commenced in MOPRs for all of the 11 falls resulting in fractured NoF	CM	May 14	Ongoing work with MOPRS CSC
vii) Reporting of mortality tool roll out and outcome measures to be established and monitored through CESG – upgrade to be completed Further work to proceed to audit use and validity of tool	SH	Mar 15	
viii) Work in sepsis committee to mirror national patient safety initiatives on sepsis. Participation in national sepsis audit and internal evaluation of in house sepsis bundle	CM/NS	Mar 15	On going work at regional and local level. Local audits in June and August 2014

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3-1415	**Failure to achieve internal and external standards around patient experience as measured through Friends and Family test and National Patient Surveys** **Implications:** • **Poor patient experience** • **Reputational damage** • **Loss of income if fail to achieve CQUIN associated with friends and Family Test**	• CSC targets set to achieve friends and family test returns with weekly reporting loop • Complaints and PALS process to capture patient feedback • Patient Experience Steering Group • Quality Improvement Framework • Governance and Quality reporting • Monthly and quarterly reporting to Trust Board • Patient stories at the Board • Monthly performance review with Heads of Nursing • Recovery plan in place for each ward area	• Overall improvement in inpatient survey from previous years across 5 key questions • Positive feedback from the ombudsman regarding individual complaints and level of investigation • Friends and Family test inpatients and ED now achieving over required response rate – on track for CQUIN • PHT in top quarter of all NHS trusts • Sustained improvement in patient response rates Sep 2014. • Positive patient survey results for cancer services	**9 (3x3)**	**9 (3x3)**	**6 (3x2)**		i. Post Francis the Board have requested a review of the complaints process to ensure robust as possible. First completed second required ii. 2013 inpatient survey although improved shows need for improvement iii. Evidence of improvement actions from negative Friends and Family response. iv. Gaps in compliance against Clywd/Hart recommendations for further action 2014/15. v. No decision on Net promoter score changes nationally	1. Director of Nursing 2. Head of Patient Experience 3. G & Q	Feb 14	Apr 15	CQC 16, 17	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ iii) Weekly monitoring of F&F returns at dept level	NL	Jul 13	Jul 13 and ongoing
i) Further review of Complaints Process – MD/MA workshop with patients, members of the public & carers to initiate re-write of local complaints policy in light of all national publications and local feedback	SB	Apr 14	Workshop completed – policy review to be undertaken as a result of feedback
i) Re-write and ratification of complaints management pathway and associated policy	SB	Oct 14	Policy review ongoing
ii) Inpatient Survey Action plan down to CSC level to be agreed and published	NL/FMc	Jul 13	Completed refresh Dec 13
iii) Further action plans to be implemented including wider MDT approach, and identifying themes for improvement per tumour site and service	LH/Leads	Jun 14	Completed
iii)Provide quarterly Status reports to Trust Board	LH	May 14	Reported through Cancer Steering Group

iii) All inpatient areas to introduce 'you said we did' dashboards on ward notice boards to highlight initiatives undertaken based on patient feedback	All CSCs	Jan 15	
iii) Monthly review of all responses to Friends and Family with clear actions from CSC requested to act upon feedback. evidence of CSC actions needs to be provided.	NL	Monthly	Reviewed process September 2013. - ongoing
iv) Outline business case 2014/15 includes service improvement fund for CSCs to apply for funds to support changes required to be approved and implemented	SB	Apr 14	Completed
v) National NHS Choices net Promoter score for Friends and Family is being revised to address the methodology national concerns on inappropriately raising a reputation concern- to be introduced April 2015.		Apr 15	National ruling pending

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
4-1415	**Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing Implications:** **1. Poor patient experience** **2. Poor staff morale and wellbeing** **3. Trust reputation** **4. Financial penalties related to Emergency care quality targets**	• CSC Strategy • ED IT System Go Live next 26 Feb 2015 • CEO chairing Urgent Care Task Force to oversee PHT recovery plan • Gold Command operational management • Substantive HCSW now employed to support. • Implementation of visual hospital in Ops Centre - Bedview – electronic bed management system roll out Trust wide. Commenced 3rd November • Streaming for all non-blue light Ambulance patients July 14 • Queue SOP in place to improve safety, privacy & dignity for patients in the Queue-Oct 14	• Reviewed at Trust Recovery Group and monthly by TDA • Trust Board • Plan monitored weekly by PHT Urgent Care Task Force chaired by CEO and TDA • Operational Delivery Group • WHE Turnaround Director for Urgent Care • COO PHT Commenced	**20 (4x5)**	**20 (4x5)**	**12 (4x3)**	i. Ability to control front door demand ii. CSCs not Sustaining agreed discharge targets on a daily basis iii. Inability of external partners to support increase in community capacity	iv. Performance against 4hour wait target of 95% currently at 83% YTD	1 Chief Operating Officer 2. Head of Operations 3. ODG	Feb 15	Mar 15	CQC 4, 6, 16	RR 2.1 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i/ii) Consultation process commenced to bring patient flow/bed management under central Ops team working to Trust wide bed declaration plan – policy to be ratified at SMT	MP	Mar 14	Completed
i)/ii) Phase 2 (paperlite) and 3 (paperless) of ED IT system to be implemented	MP	Feb 15	On track to complete
iv) 7 point action plan to be agreed with Commissioners and Community Providers to increase discharge I)/ii) Further WHE turnaround action plan being created, to be agreed – draft received and comments returned to F Wise	FW	May 14	Plan agreed by Accountable Officers 19th June 2014

i)/ii)/iii) PHT Urgent Care Task Force Recovery Plan	MP	Mar 14	Agreed and implemented
i)/ii)/iii) Centralise bed management	MP	Mar 14	Completed
i)/ii)/iii) Clinical Mondays with no non-urgent meetings to be undertaken	MP/NL	Mar 14	Completed
i)/ii)/iii) Increase presence of acute physicians in ED	MP	Mar 14	Completed
i)/ii)/iii) Cardiology Ambulatory Service restarted	MP	Mar 14	Completed
i)ii)iii) Urgent Care Improvement Director to oversee whole health economy recovery plan to be appointed	CW	May 14	Completed
i)ii)iii) ECIST assurance visit recommendations received, incorporated into Urgent Care Taskforce Recovery Plan	CW/GP	Jun 14	Implemented and on track
i)ii)iii) WHE Organisational Development Director appointed	FW	Sept 14	Completed
i)ii)iii) Winter bed plan agreed for implementation opening 21st September	MP	Sept 14	Completed
i)ii)iii) Key actions agreed Post TDA/NHS England Urgent Care Summit 3rd September, linked to whole system working to decrease medically fit/discharge ready patients to agreed target of 30.	WHE	Oct 14	Ongoing
i)ii)iii)Replacement Urgent Care Improvement Director appointment (Stephen Haynes)	UW	Aug 14	Completed
i)ii)iii ED Recovery Plan refined post TDA/NHS England Meeting 30/11/14	WHE	Nov 14	On track
i)ii)iii Perfect Week planned for January 2015	COO	Jan 15	Completed
i)ii)iii Focused Safer Discharge Bundle week 11-18th November	ECIST	Nov 14	Completed
i)ii)iii Consultant Early Senior Review in ED 1000-1800Hrs	SH	Dec 14	On track
i)ii)iii Operational Standards linked to Medical Model agreed	SJ	Dec 14	On Track
i)ii)iii Head of Ops (substantive commenced)	SJ/PH	Dec 14	Completed
i)ii)iii Perfect Week lessons learnt to be embedded	PH	Feb 15	

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										On target / Minor Obstacle to achieving target / Inability to achieve predicted target			
5-1415	**The Trust fails to achieve referral to treatment (RTT) access targets in three specialties:** ▪ **General Surgery** ▪ **Orthopaedics** ▪ **Urology** **Implications:** • **Patient experience** • **Reputation** • **financial penalties**	• Weekly specialty PTL meetings led by CSC GM. • Weekly assurance meeting chaired by COO • BI co-ordination of breach position at Trust aggregate level. • Weekly monitoring of activity plans at ODG	• RTT compliance plans and 35 week recovery plans for all "at risk" specialties • Activity plans to meet GURROO 3 model. Including growth plans • RTT resilience funding to reduce backlog • Diagnostic waits recovery plan •	**12 (4x3)**	**16 (4x4)**	**8 (4x2)**	i. Unscheduled care demands leading to lack of capacity	ii. Capacity plans dependent on recruitment in MSK, Surgery and Urology. iii. Theatre utilisation below level required to deliver GUROO 3 iv. OP utilisation/ productivity improvements required	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. SMT	Feb 15	Apr 15	CQC 4	RR 3.3 3.5

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
Diagnostics "User Group" established to understand demand / capacity gap and agree on actions to improve waiting times	AF	Jun 14	Jun 14 – Oct 14 Now mitigated
ii Referrals and CQUIN plans monitored weekly at ODG to facilitate "early warning" of capacity / demand problems	KP	In place	Ongoing
ii Recruitment plans monitored weekly and escalated as appropriate	MD	In place	Ongoing – posts vacant reducing in January 15
iii Diagnostic recovery plan in place to deliver Q3 compliance	KP	Sep 14	In place
iv OP transformation project launched led by Mandy Mugridge	KP	Sep 14	In place
i Perfect week exercise to be completed and lessons learnt embedded	PH	Feb 15	Ongoing
i/ii/iii detailed RTT compliance recovery strategy being developed for TB approval Jan 15	MD	Mar 15	
ii/iii Theatre scheduling policy and cancellation day of surgery policy produced in draft and shared with CSCs to improve management of cancellations of surgery. For ratification.	MD	Mar 15	

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6-1415	**Failure to achieve cancer wait targets** **Implications:** • **Risk to patient safety if we cannot meet access targets for cancer** • **Financial penalties may be applied by commissioner**	• Capacity and demand modelling undertaken and in place within CSCs • Weekly assurance meeting with forecast planning and triggers for escalation • Weekly PTL meetings with clinical leads of tumour sites and CSC rep to track progress of patients on cancer pathway • Monthly Cancer steering group receives update on performance and key issues	• Annual training on Cancer Access policy for all staff involved in managing cancer • Improved visibility and tracking of long waiting • Improved ability to predict performance accurately • Cancer improvement plan reviewed monthly	**12 (4x3)**	**12 (4x3)**	**8 (4x2)**	i. Lack of resilience in cancer waiting times within Urology ii. Increasing referrals iii. Patient choice rules means clock doesn't stop if patient defers anywhere on pathway – pts increasingly choosing robot which has limited capacity iv. Impact of late inter Trust referrals .	v. Metrics indicate a fail for Q3 against 2 standards (validation still taking pace) and Q4 early risks are for 3 standards vi. Training overdue due to intention to roll out as E learning.	1 Chief Operating Officer 2. General Manager - Cancer 3. SMT	Mar 15	Apr 15	CQC 16	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Recruit Consultant Uro-oncologist	NM	Oct 14	Completed
ii) Monitoring of referral patterns so that additional capacity can be added in response	NM	In place	Ongoing
ii) Issue new 2WW referral forms, with enhanced guidance on criteria for referral	NM / SC	Jul 14 Sep 14	Completed
iii) Monitoring of individual patient pathways via PTL meetings	NM / CSC GM's	In place	Ongoing
iii) Review of Cancer Access Policy	NM / JL	Sep 14	Complete
iv) Development of dashboards by tumour site part of Information Services schedule of work	MK	Jul 14	Complete
v Escalation of late inter-trust referrals through Deputy COO	NM	Oct 14	Complete
vi) E Learning on Cancer Access policy roll out	JL	Jan 15	On track for completion

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7-1415	**Quality of data produced and provided for use in internal performance reporting and for external reporting may include inaccuracies (data entry and/or reporting)** **Implications** • **Reputation damage** • **Financial penalties** • **Incorrect business decisions made using incorrect data assumptions impacting on patient experience**	• Data validation processes in place in some areas but patchy	•	**12 (4X3)**	**12 (4x3)**	**8 (4X2)**	i. Lack of Trust wide data quality Strategy ii. Significance of data quality is not recognised Trust wide iii. Lack of formalised checking procedures and sign off	iv. Deloitte internal audit highlighted issues in several areas v. Incorrect data supplied externally resulting in internal investigation	1. Director of Corporate Affairs & Business Development 2. Head of Information Services 3. Data Quality Steering Group	Mar 15	Mar 15	CQC 16	RR 1.48

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Data Quality Steering Group (DQSG) to be formed	PM/MK	Oct 14	First meeting held 07 Oct 14. Meetings to be held bi-monthly Second meeting held Dec 14. ToRs and Strategy signed off by SMT
i) Devise and implement Data Quality Strategy and policy	DQSG	Mar 15	Draft strategy submitted to COO for approval June 2014. Final draft to SMT Aug 14 to sign off Nov 14 Strategy formally signed off by SMT
ii) Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust	COO	Dec 14	Dec 13 (COO accountable at Exec level & DQ Policy sets out responsibility at other levels – available Dec 14))
iii)/iv) Introduce templates for system level data quality assessments and action plans and train relevant staff to use	DQSG	Mar 15	System level data quality assessments will form part of information asset owners & CSCs reporting to DQSG. Roll out and training will of the assessment

			templates will be undertaken by Information Services. Responsibility for system data quality training is the responsibility of CSCs
ii) All new job descriptions to have personal responsibility for ensuring the quality of data included	RK	Nov 13	Dec 13
iii) Data Quality Dashboard to be rolled out, providing a mechanism for monitoring data quality and ensuring accountability across the organisation (referencing Information Governance toolkit where appropriate)	MK	Mar 15	Pilot demoed at Dec DQSG. Single point of access to data quality designed. Accesses via intranet portal.
iv) Lessons learnt from internal investigations to be reviewed by Information Services and taken to DQSG for action planning	MK	Aug 13	Aug 13 – now ongoing
v) Solutions documents to be in place all key national returns, signed off by key stakeholders, including Head of Performance	MK	Mar 15	Key national targets to be written up by Dec 14, with further Trust-wide review in Q4- In progress
v) Review effectiveness of data quality processes and structure put in place in improving Trust data quality and reducing inaccuracies in external and internal reporting.	MK	Oct 15	Part of annual review of effectiveness of DQSG

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8-1415	**Lack of equivalent workforce across seven days of the week** **Implications** • **Damage to Trust reputation** • **Poor patient experience** • **Reduced quality of care**	• Governance systems in place to ensure patient safety and quality of care is maintained • Increased consultant presence introduced at weekends	• Review of hospital mortality with emphasis on weekend mortality with TDA • Weekend HSMR shows no significant difference to comparable Trusts • Weekend HSMR shows no significant difference from rates recorded during the week	**12 (4X3)**	**12 (4x3)**	**8 (4X2)**	i. Delays in progressing patient pathways ii. National consultant contract negotiations are underway and outcomes awaited iii. Gap analysis completed, business plan to be produced following findings	iv. IPR indicates lengths of stay could be reduced	1. Medical Director 2. Chief of Service 3. SMT	Feb 15	Dec 15	CQC 4	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Introduce Mortality review Toolkit to allow monitoring of week end mortality	SH/PY	Apr 14	Currently being tested
i)/ii) Increase consultant presence at weekends	SH	Nov 13	Nov 13
• Business planning 2014/15	SH/ CSCs	Sep 14	Ongoing
iii) Complete Gap analysis	SH/CSCs	Mar 14	Completed
i)/iii)/iv) Business plan to be produced for consultation	SH/CSCs	Sep 14	Paper being presented to Trust Board Sep 14 for discussion

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9-1415	**Failure to successfully implement the Trust's IT Strategy eHospital Programme to deliver an enterprise clinical system that better supports delivery of high quality, more efficient and cost-efficient patient centred care.** **Implications:** • **Increased fragmentation of clinical data flows leading to faulty processes and poor information** • **Worsening patient experience** • **Waste of staff time on manual processes** • **Failure to achieve clinical process improvements** • **Failure to meet more exacting national & local standards**	• Board approval for IT Strategy • IT Strategy Committee • Clinical Information Systems Programme Board • Robust IT project and programme management processes • Robust IT procurement processes • Treasury Green Book 5 Case Model	• Bi-monthly reporting to IT Strategy Committee • Bi-monthly reporting to Clinical Information Systems Programme Board • eHospital Programme Highlight Reports to ODG • Supplier engagement completed, providing an understanding of solution market • Communications resource recruited to eHospital Programme Team	**8 4x2**	**12 4x3**	**4 4x1**	i. Lack of identified revenue budget for eHospital procurement (Programme put On Hold June 14) ii. Lack of specialist procurement & contractual expertise iii. No eHospital Programme team iv. Lack of engagement of clinicians, CSCs and other stakeholders to specify requirements and own changes v. Lack of Programme plan vi. No defined specification of requirements to support procurement	vii. Current Trust focus on tactical developments rather than strategic viii. Focus on Trust requirements rather than those of whole care community involved in caring for patients	1. Director of Finance 2. Head of IT 3. SMT	Mar 15	Apr 15	CQC 4, 11	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Establish protected eHospital Programme budget sufficient to successfully complete procurement phase			
a) Gain Trust Board & CSCs commitment to fund eHospital Programme as number one development priority for 2015/16	Head of IT	~~Nov 14~~ Feb 15	02.10.2014 - Board approval to produce Strategic Outline Case
• Run Trust Board & CSCs Workshop to decide key objectives for eHospital	Head of IT	Nov 14	06.11.2014
• Complete Specification of Requirements and go to market for specialist consultancy to help write Strategic outline Case (SOC)	Head of IT	Nov 15	03.11.2014

• Contract for specialist consultancy to help write SOC	Head of IT	Nov 15	14.11.2014
• Complete stakeholder consultations over SOC content	Head of IT	Dec 15	28.01.2015
• Complete Final Draft SOC and submit to Trust Board	Head of IT	Jan 15	
• Present SOC to Trust Board and gain approval to produce Outline Business Case with associated funding	Head of IT	Feb 15	
b) Produce eHospital Programme Resources Plan for 2015/16 & include in financial planning framework as number one development priority	Head of IT / Dir. of Finance	Feb 15	
c) Confirm date of eHospital Programme recommencement	Director of Finance	~~Nov 14~~ Feb 15	02.10.2014 - Board approval to produce Strategic Outline Case
d) Update eHospital 2014/15 resource plan & provide to Director of Finance	Head of IT	Nov 14	10.10.2014 (CCGs agreed to fund SOC consultancy)
ii) Acquire appropriate procurement and contracting advice and expertise to enable the eHospital Programme to successfully complete procurement phase			
a) Research supplier market for specialist NHS procurement and contracting advice and expertise services	Head of IT / Head of Proc.	Oct 14	02.10.2014 - Board approval to produce Strategic Outline Case
b) Complete Specification of Requirements and go to tender for required specialist NHS procurement and contracting advice and expertise services	Head of IT / Head of Proc.	~~Dec 14~~ Mar 15	
c) Contract for specialist NHS procurement and contracting advice and expertise services	Head of IT / Head of Proc.	Apr 15	
iii) Establish eHospital Programme Team with adequate resources to work with CSCs, clinicians and other stakeholders to complete procurement phase, including specification of requirements			
a) Recruit eHospital Programme Manager	Head of IT	TBC	
b) Recruit required clinical and other eHospital Programme team members for procurement phase	Head of IT	TBC	
c) Provide suitable accommodation for eHospital Programme Team	Dir.of Redevelopment	TBC	
iv) Gain commitment of CSCs & individual clinicians to engage on eHospital Programme implementation			
a) Recruit half-time clinical leads for eHospital Programme	Head of IT / Associate Medical Director - IT	TBC	
b) Request & receive nominations for CSC eHospital Programme leads from CSCs	Head of IT	~~Dec 14~~ Mar 15	Leads for 4 of 10 CSCs identified
c) Agree CSC eHospital Programme leads job plans for 2015/16 incorporating eHospital responsibilities	Chiefs of Service	Apr 15	
v) Develop Programme Plan as programme develops and gain approval from Clinical Information Systems Programme Board & IT Strategy Committee	IT Program. Manager	TBC	
vi) Develop eHospital specification of requirements			
a) Gain advice from specialist NHS procurement and contracting consultants on best way to approach creation of specification of requirements	Head of IT	TBC	
b) Produce programme plan for engagement with stakeholders to gather requirements and gain approval	IT Program. Manager	TBC	
c) Schedule CSC and other workshops to engages clinical staff and other stakeholders in creating specification of requirements	IT Program. Manager	TBC	
d) Commence engagement with stakeholders to gather requirements	IT Program. Manager	TBC	
e) Complete requirements gathering	IT Program. Manager	TBC	
viii) Regain commitment of SMT to deploy required clinical & corporate resources on eHospital Programme once it recommences	Head of IT	TBC	
ix) Engage with CCGs, community trusts, GPs & social care organisations to determine best way of involving them in requirements gathering	Head of IT	TBC	

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10-1415	**Fire risk assessments across the whole of the estate are not considered suitable and sufficient.** • **Patient and staff safety** • **Trust reputation** • **Service disruption** • **Contravening the Regulatory Reform (Fire Safety) Order 2005** • **Remedial works will be required to address any deficiencies**	• The current PHT/Carillion risk assessment process is not sufficiently robust to capture all potential risks • The parties (PHT / THC / Carillion) appointed specialist to undertake the comprehensive fire risk assessments needed and identify any undiscovered risks. - Completion expected end February 2015 • Risk assessor has been appointed and commenced work.. Programme expected to complete Dec/Jan. • HFRS secondment extended for a further 3 months	• Completion of PHT operational risk assessments/CSL Technical Audits and control measures. • Some rectification work already completed, underway or planned to coincide with life cycle works. • Fortnightly joint fire issues meetings (PHT/CSL/THC) • Agenda item at PFI Liaison Committee, Security and Fire Committee and Risk Assurance Committee. •	**16** **4x4**	**12** **4x3**	**8** **4x2**	i. Technical audits are not comprehensive so there may be undiscovered risks. ii. Technical audits identify potential deficiencies that require further investigation that has yet to be undertaken. iii. No prioritised, agreed plan to address all risks identified to date. iv. Lack of effective control measures (Maintenance, staff training and housekeeping) for all known risks. v. Rectification and upgrading works will require significant investment and cause disruption to clinical services – to be assessed.	vi. Significant numbers of issues arising in risk assessments and audits will require prioritisation to ensure highest risks are dealt with early. vii. Risk assessment and rectification/control measures will need to be kept under constant review as issues are resolved and new issues emerge.	1. Director of Corporate Affairs & Business Development 2. Head of Estates and Facilities 3. SMT	Mar 15	Mar 15	CQC 10, 13 RR 1.28

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Fire compliance review being arranged for early January 2014 – Joint responsibility accepted and proposed joint risk assessment process agreed.	THC/CSL/PHT	~~Jan 14~~ Jun 14	Complete
ii)/iii)/iv) Action plan to be agreed. Action plan is to undertake joint comprehensive risk assessments and identify all deficiencies.	THC/CSL/PHT	~~Feb 14~~ Jun 14	Complete
ii)/iii)/iv) Action plan to be completed - (works will be prioritised and programmed) upon completion of risk assessment. Oct 14 – Risk assessor appointed and commenced work. Programme under preparation. Nov 14 -Pilot Risk Assessment completed and reviewed. Programme underway for entire site. Jan 15 – Pilot Risk Assessment programme delayed (mid Dec) due to sickness of key individual. Recommenced mid Jan, one month delay to overall programme	THC/CSL/PHT	~~Jan 15~~ Mar 15	
i)/ii) iii) iv) WSP to undertake all risk assessments throughout the Trust and report on findings	WSP	Jan 15	E1-E4 completed approved by HFRS rest of Estate to be completed
All) HFRS have offered to second an officer to QAH for six months to support the improvement programme	PHT/HFRS	Jul 14	Complete

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11-1415	**Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed. This results in:** • **Reduced daily capacity to meet acute demand.** • **Increased risk for patients being kept in an acute environment** • **Increased likelihood of patient moves and the need to outlie 'out of speciality'**	• Daily IDB meetings chaired by Trust General Manager - Full review of IDB across WHE moving to an integrated Health & Social IDB Team • Daily whole system conference call • Discharge Planning Teams covering whole hospital • Daily IDB report (all delayed in hospital patients) • 123 Escalation List • Community Beds capacity available notified daily • CQUIN Community In-reach Team • QA@H (Hospital at Home) • Weekly SITREP report • 7 day availability of Discharge Planner (Trust-wide) • Medicine CSC focused discharge resource deployed 21 Aug 2014. • Safer discharge bundle roll out completed. • CHC assessor in house • Increased Hampshire discharge pathways	• Backdoor Tracker reported via ODG • Medicine weekend discharge report • Daily IDB opening and closing balance • Daily update from CSC's following the 123 Escalation • Discharges reported via Operations Centre meetings x 5 daily • QA@H virtual ward trajectory (May 14 – April 16) • IDB Action Plan* agreed by WHE and shared with ECIST • Implementation of the SAFER discharge bundle • Additional community capacity being sourced by PHT (plan for 22 beds by end August 2014) • Ward D2 now operating as acute medical ward since 4th August • Implement MDT Board Rounds as per IDB action plan	**16 4x4**	**12 4x3**	**12 4x3**	i. Demand from complex patients due to high volume ii. IDB still based across multiple venues, needs central base for MDT office' iii. Different IT systems across organisations iv. 7 day working limited but plans in place to recruit	v. CSC's failure to complete 123 Escalation updates	1. Chief Operating Officer 2. General Manager 3. Urgent Care Taskforce	Feb 15	Mar 15	CQC 4, 6, 16	RR 1.46, 1.49, 1.52

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Increase focus on complex discharges	CSCs	Nov 14	Complete and on-going
ii) Executive focus to identify central base	Exec team	Feb 15	
iii) Escalated discussions to be led by PHT IT to ensure systems are compatible	SE	Feb 15	
iv) Recruitment by PHT and all partner organisations	SE	Apr 15	
i-v)Additional Community bed capacity being commissioned (22 beds)	SE	Oct 14	Completed
i-v)IDB Action Plan implementation of MDT Board Rounds	MQ	Nov 14	Completed

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12-1415	**Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns** **Implications:** • **Service delivery** • **Reputation as an organisation delivering high standards of education and training to medical trainees**	• Director of Medical education • Educational Supervisors • Deanery links • Foundation Programme Directors • Foundation Doctors educational programme	• AAA rating • Positive feedback on level of experience gained • Direct feedback of trainees to DME more positive of late. • 4 monthly survey from DME to all trainees focussing on areas of concern and improvements • Positive outcome from Deanery visit to neonatal department with grading moved from C to A • Visits by DME to department where undermining reported revealed little evidence of on-going concerns. Action plans already implemented where appropriate.	**12 (4x3)**	**8 (4x2)**	**8 (4x2)**	i. Junior doctors although exposed to positive clinical experience report that they are not receiving the educational support expected of their training posts ii. Two areas (cardiology & neonates) where allegations of undermining behaviour are outliers on GMC trainee survey. Next survey revealed 5 areas were outlier (Cardiology a repeat) iii. Patient safety concerns raised by trainees to GMC relating to out of hours cover		1 Medical Director 2. Director of Education 3. SMT	Review Apr 15	Now On going monitoring	CQC 14	RR 4.3 4.4

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Meetings with groups of junior doctors to explore issues	PS	Jul 13	Jul 13
i) Forums set up for Director of Medical Education and Juniors to meet and discuss issues proactively	PS	Jul 13	Jul 13
i) Director of Medical Education visit to all relevant departments regarding outcome of report	PS	Jul 13	Jul 13
i,) Directive issued and now to be implemented which states that educational supervision must be included in all Consultant job plans as part of the job planning review	Chiefs	Sep13	Sep 13
I, ii, iii) Survey of outgoing trainees to assess impact of initial plans and inform further action	PS	Sep 13	Sep 13
ii) Director of Education meeting departments where undermining concerns raised (consultants and trainees met separately)	PS	Oct 13	Oct 13 Repeated July 14
i/ii/iii) Director of education to update SMT on a monthly basis on issues and progress	PS	Dec 13	Dec 13 ongoing and will continue to monitor concerns raised
i) Foundation School vist to Trust 25 April to review progress against previous issues and review C grading on a number of posts	PS	Aug 14	Jun 14
• STOPIT course aimed at bullying and undermining being run in departments where issues flagged along with HR organised training packages	PS / RK	Mar 15	

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13-1415	**The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network**	• Wessex AHSN confirmed by DH • Innovation strategy to be taken forward by Director of Research • Medical Director participating in AHSN discussions with UHS • Trust R&D Strategy and framework • R&D income monitored by R&D Director • Interim strategy for 2014-2015 agreed by Board • Consulting firm BDM engaged to produce an integrated Research & Innovation strategy embedded within the Trust's clinical strategy. This will have a focus on business development and contribute directly Trust's business development capabilities	• Medical Director reporting back to Board on discussions • R&D income year on year increase • National NIHR and Guardian League tables 2013 shows good competitive performance by PHT • 6 monthly progress and performance reports submitted to the board via the clinical effectiveness group. • Research strategy monitored quarterly by strategy group • Local network performance reports received and reviewed by Director of research monthly • Improved reputation through winning HSJ research impact award • Increase in successful grant awards seen • Increase in successful innovation awards via AHSN • Increase in successful collaborative projects via Wessex CLARCH • Increase in clinical academics to build growth	**10 (5x2)**	**6 (3x2)**	**3 (3x1)**	i. Lack of long term 3-5 year strategy for research and innovation ii Low levels of portfolio recruitment recorded in 2014		1. Medical Director 2. Director of Research & Development/ Research Manager 3. SMT	Mar 15	Mar 15	CQC 6	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Research & Development strategy to be developed and agreed July Update: Quarterly Strategy review meetings have been in place since 2012 and are ongoing. Revised strategy to include innovation is due 2014	AC	Jul 13	PHT Research Business Plan and Interim Strategy for 2014-2015 transition has been written and approved by the Board (December 2013)
i) Agree and establish long term business plan for long term research and innovation strategy	AC	Mar 15	
i) Overview of Strategy to be presented to TDA	AC/DB	Jul 14	Completed
ii) LIA event for recruitment to be held with focus on research recruitment	GW	Oct 14	Completed
iii)Board report template drafted and to be issued in the new year	AC		Completed
iv) CSC reports drafted and to be issued in the new year	AC		Completed
v)Business and enterprise lead clinician appointed	AC		Completed
vi) Deputy Director of Research Appointed	AC		Completed

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14-1415	**Threat to specialist services due to centralisation agenda** **Implications:** • **Potential loss of major vascular surgery at PHT due to centralisation to a tertiary unit** • **This carries longer term implications for the viability of other services such as interventional radiology and renal**	• Outcome data • Vascular Society requirements for a service • Fully covered clinical rota with committed team • National audit results	• Positive outcome data for this group of patients • Fulfilment of vascular society recommendations for service delivery • Good clinical outcome data • Network vascular MDT with UHS has commenced • Providing some vascular service to Chichester	**16 (4x4)**	**6 (3x2)**	**6 (3x2)**	i. Decision ultimately out with PHT control as specialist commissioner led ii. Currently no assurances from specialist commissioning teams as to the medium and long term direction	iii Lack of approved vascular service	1 Medical Director 2. Medical Director 3. SMT	Apr 15	Review progress Apr 15	CQC 6	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Continue to work closely with specialist commissioners and TDA on this issue	SH	Oct 13	Ongoing
i)/ii) Consultation scheduled for October 13 - View of Clinical Senate is awaited	SH	Oct 13	Completed/ongoing
i)/ii)/iii) New meetings of the Vascular Implementation Board to commence 07 May 2014 to agree a vascular service that meets the needs of Southampton, Portsmouth and specialist Commissioners	CEO	May	Ongoing
i)/ii)/iii) Establish joint MDT with UHS by end September 2014	SH	Sep 14	Completed and ongoing
i)/ii)/iii) Agreement to provide vascular outpatients in Chichester	SH	Nov 14	Completed and ongoing

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15-1415	**Insufficient engagement of workforce** **Implications:** • **Lack of understanding/ buy in, and therefore delivery of strategic priorities** • **Suboptimal delivery of patient care** • **Poor staff survey results**	• Listening into Action programme adopted. • Staff survey action plans developed within CSCs • Health and well-being programme established. • Employee recognition programmes in place. • Leadership • Quarterly staff pulse survey • Development of appraisal quality framework linked to values • Full work plan introduced to address key issues of bullying & harassment	• Improved performance in 2013 national staff survey results. • Lower than average levels of sick absence and staff turnover when compared to other acute organisations. • Integrated performance report to Board including staff feedback • 13% increase in staff recommendation as a place to work to 65% as measured by the FFT for staff Q2 (2014)	**12 (4X3)**	**12 (4X3)**	**6 (3x2)**	i. Lack of engagement from clinical staff in delivering the change agenda	ii. Trust remains in the bottom 20% for overall staff engagement when compared to other Trusts within the full 2013 staff opinion survey.	1. Director of Workforce and Organisational Development 2. Head of Organisational Development 3. SMT	Feb 15	Apr 15	CQC 14	RR 3.3 4.2

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) CSCs adopting the LiA approach to address key findings and encourage new ideas for improvements	MDs	Jul 13	Jul 13
i)/ii) Clinically led pioneer teams set up to engage and empower staff to make positive changes for the benefit of patients and staff	UW/LR	Nov 13	Complete and ongoing
i)/ii) Quarterly staff pulse survey launched with key questions linked to the national staff survey	TP	Jun 13	Launched and ongoing
i)/ii) Development of an appraisal quality assurance framework linked to values	LR	Nov 13	Complete and ongoing
i)/ii) Widen medical engagement opportunities via a regular staff forum	LR	Sept 14	Complete and ongoing

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16-1415	**Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to 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 • Clinical Directors leadership programme in place • Performance appraisal process to assess behaviours and leadership performance in place.	• Utilisation of existing leadership development programmes. • >1000 staff trained as part of WT4P • 360 completed for executive team and included for medical revalidation • PHT representation on Thames Valley and Wessex Leadership Academy Board • Leadership Academy funded programmes launched	**12 (4x3)**	**9 (3X3)**	**6 (3x2)**	i. Programmes and framework for leadership development in place but needs to be embedded to ensure compliance.	ii. 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. Head of Organisational Development 3. SMT	Feb 15	Apr 15	CQC 14	RR 3.3

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i.)ii) Full deployment of the new appraisal system with leadership defined in terms of behaviours expected of those in people management roles	LR	Jun14	Jul 14
i)ii)Leadership development programmes enhanced to include induction for new leaders, networking lunches and inspirational speakers	LR	Ongoing	
i.)ii)Utilisation of the national leadership academy resources	LR	Ongoing	
i)ii)Develop a strategy for the creation of a graduate management trainee scheme	LR	Sep 14	Completed Sep 14
i).ii)Create, establish and maintain a talent plan for leaders	LR	Jan 15	
i)ii)Create a performance management culture	LR	Sep 14	On-going as part of performance management framework

<table>
<tr><th>Ref</th><th>RISK DESCRIPTION</th><th>KEY CONTROLS</th><th>POSITIVE ASSURANCE</th><th>INITIAL RATING (CXL)</th><th>CURRENT RATING (CXL)</th><th>PREDICTED (RESIDUAL RISK)</th><th>GAPS IN CONTROL</th><th>GAPS IN ASSURANCE</th><th>1. Exec Owner
2. Manager
3. Responsible Committee</th><th>REVIEW DATE</th><th>TARGET DATE (for mitigation of risk)
On target
Minor Obstacle to achieving target
Inability to achieve predicted target</th><th colspan="2">LINK TO CQC STANDARDS
AND RISK REGISTER</th></tr>
<tr><td>17-1415</td><td>Current and future workforce demand is outstripping supply leading to:
National skill shortages being reflected locally which is leading to an increasing expensive temporary workforce supply which may impact on patient care
Lack of commissioned places for newly qualified staff leading to shortages now and in the future
Workforce design is not keeping pace with changing service delivery
Lack of substantive recruitment leads to potentially low staff morale and increased turnover of existing staff exasperating the issue</td><td>• Corporate CIP plan developed to reduce temporary staffing levels.
• Speciality specific attraction strategies developed for CSCs in difficult to recruit areas
• Executive sign off required for temporary spend
• Ongoing recruitment of nursing staff from overseas.
• E-Rostering deployed for all staff groups</td><td>• Business planning process has identified resource requirements for CSC service delivery.
• WSC process removed to ensure no barriers to substantive recruitment</td><td>16 (4x4)</td><td>16 (4x4)</td><td>12 (4x3)</td><td>i. Temporary resource spend £20m for 2013/14 In October Temporary workforce spend reached £2.4m in one month – the highest ever in the Trust.
ii. Reduction in Junior Doctors and difficulty in recruiting ongoing in many specialities
iii. Trust maintaining targets leading to an increased need for staff
iv. High level of premium payments including WLIs and overtime.
v. Temporary workforce is used to fill local and national shortages in some key skill areas which may result in some critical skill gaps in clinical rotas, specifically nursing, junior doctors and some other specialist areas eg ED, histopathology, orthotics.</td><td>i. High levels of substantive vacancies in some CSCs – Medicine, Surgery & Cancer and MOPRs
ii. Supply of newly qualified nursing workforce is insufficient for PHT required demand.</td><td>1. Director of Workforce and Organisational Development
2. Deputy Director of Human Resources
3. SMT</td><td>Feb 15</td><td>Apr 15</td><td>CQC
13</td><td>RR
4.1
4.3
4.4
5.1</td></tr>
<tr><td colspan="9">ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</td><td>By Whom</td><td>By When</td><td colspan="3">Date Completed</td></tr>
<tr><td colspan="9">i) Eliminate premium work and repatriate outsourced work to improve productivity to ensure maximum optimisation of the workforce to realise increased income opportunities and minimise the need for further investment.</td><td>CSC</td><td>Ongoing</td><td colspan="3">Agreements made to continue to pay WLIs</td></tr>
<tr><td colspan="9">i)Temporary staffing remains at critical levels and there has been no reduction – reduction is expected in the coming months with the introduction of such high levels</td><td>RK</td><td>Sept 14</td><td colspan="3">In discussion with Director of HR and Finance Director</td></tr>
</table>

of substantive staffing. Other methods are being considered to reduce spend.			
i) Reduce the cost of the temporary workforce by investing where necessary to create capacity for patient care; this includes recruitment from overseas to fill critical vacancies, abolition of WSC and a deft recruitment process	RK	Oct 14	Significant recruitment from overseas and WSC abolished
iv) Develop "gain share" approaches to reducing the medical workforce bill specifically	RK	Oct 14	Not supported by LNC
Reduce the junior medical workforce bill by the creation of increased trust doctor posts to fill gaps and remove bandings as appropriate.	RK	Aug 14	Agreed and implemented – fill rate for this year is significantly higher than last year.
v) Establish new ways of working and new roles to maximise skills to ensure the workforce is equipped with the required skills to deliver patient care in the most efficient and effective manner.	BH	Ongoing	
v) Succession plan for all critical posts identified	LR	Sep 14	Completed
V) Working with CSCs to develop thorough recruitment plans	RK	May 14	Medical recruitment plans drawn up with CSC support for implementation in Aug 14 and on-going
v) Project plan in development to manage on-going CSC action plans to be monitored through Operational Delivery Group	RK	Apr 14	Ongoing
vi) Develop a reward strategy using existing mechanisms under the contract to more creatively develop performance	RK	Oct 14	Not supported by JCNC, but some on-going work
i) Maximise skills to ensure the workforce is equipped with the required skills to deliver patient care in the most efficient and effective manner	DK	Oct 14	Complete and ongoing
ii) Bi-weekly temporary spend meeting underway with each CSC to understand and make suggestions to decrease spend to be reported to ODG bi-weekly.	RK	Apr 15	Complete and on-going
vi) Develop plans to introduce 7/7 working where appropriate to be reported to ODG.	RK	Apr 15	Consultation implemented particularly within Clinical Support
iii) Continue to develop potential pipeline of recruitment from overseas by utilising agencies and NHSP as appropriate.	RK	Apr 15	New Agencies are in place and on-going work with NHSP to look at potential other solutions.

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18-1415	**Inability to achieve Foundation Trust status within the agreed timetable**	• Trust Board development • Well led organisation development • CSC development • TDA monthly assurance programme • Clear trajectories for improvement in key national standards and financial sustainability • LTFM and 5 year strategy refreshed as at 30 Sep 14 • Continuity of service risk ratings	• TDA monthly assurance programme • Significant improvement in many key performance targets/metrics. However unscheduled care performance continues not to achieve the national standard and therefore remains a key area of focus • Plan for 2014/15 is a surplus of £1.2m	**12 (4x3)**	**16 (4x4)**	**8 (4x2)**	i. Pressures from unscheduled care still dominating the agenda with consequential unfunded capacity and associated costs ii. Financial performance at month 8 is £4.8m variance from plan	iii. Unscheduled care pressures across the Trust iv. Pace of delivery of savings programme v. Impact of fines, penalties and contractual payments vi. Not achieving required Continuity of Services Risk Ratings (3 or above)	1. Director of Finance 2. Deputy Director of Finance 3. Trust Board	Feb 15	Mar 15	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Work programme to improve unscheduled care performance	UW	Nov 14	Ongoing
ii)/ iv)See action plan risk 21 relating to savings			
v)See action plan on risk 19 relating to run rate			
iii) Long Term Financing is being applied for which will improve the Continuity of Service Risk Ratings	BL	Jan 15	

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19-1415	**Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2014/15 of a planned surplus on income and expenditure.**	• Finance reporting and monitoring mechanisms at CSC to Board level • Updates on Financial position provided to Board, SMT Finance Committee • Delegated budgetary control framework • Trust wide savings and transformation programme • Income and contract monitoring • Bottom up forecasting in place • Additional finance board meetings in advance of monthly performance reviews	• Financial plan income reflects detailed activity modelling (GooRoo3) and cost of delivery incorporated into cost base. • Budgets rebased to reflect 13/14 run rate including detailed review of new year cost pressures • Monthly performance reviews with all CSCs • Weekly Financial overview at Operational Development Group • Formal Sign off of budgets and supporting Quality Impact Assessments • Additional control through introduction of new finance reporting tool (Qlikview)	12 (4x3)	16 (4x4)	16 (4x4)	i) Savings opportunities have been inhibited by operational pressures which have led to additional workforce costs (often at premium rates) and the cancellation of a significant number of planned operations to assist with the availability of beds. ii) Month 9 SLA income forecast shows over performance activity not yet agreed with commissioners		1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group	Feb 15	Mar 15	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Formal sign off of budgets	BL and CSC Managers	May14	Completed
i) See risk 21 for action plan related to savings	BM/CSC Managers/ ODG		

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20-1415	**The Trust does not receive income due for 2014/15 as a result of the contract agreed or due to application of contract penalties and levers or failure to achieve CQUIN payments**	• Monthly contract monitoring reports • Monthly contract review meetings • Income & Contracts Group • Monthly CSC performance meetings • Monthly CQUIN meeting. • Contract issues unable to resolve escalated to Execs via ECRM • CCG offers have been accepted • Monthly penalty assessment to ODG • CQUIN Meeting in place to monitor performance and reported monthly in IPR • 2014/15 negotiating round has now completed (contracts signed Sep 14) and CQUIN agreed.	• Agreed capacity required with CSCs and activity volumes secured through the commissioning contract • Agreed PbR compliant contract • Daily metrics via KitBag • Monthly CSC performance reviews strengthened • Increased reporting through Income & Contracts Group • CQUIN Meeting in place to monitor performance and reported monthly in IPR	12 (4x3)	12 (4x3)	12 (4x3)	i. Control now lies with the CSCs to implement the plans to achieve CQUIN	ii. ED target consistently not being achieved. iii. Cancer & RTT targets require increased activity to achieve sustainability, posing an affordability issue for Commissioners possibly leading to non payment for work done iv. Discussions on-going with CCG's about full re-investment of existing fines and penalties – agreement has yet to be reached	1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group	Feb15	Mar 15	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/iv) Finalise and agreed contracts with commissioners	ET/IH	Sep 14	Sep 14
ii)/iii) Maintain intensive CSC performance meetings which cover contract performance review – performance assurance framework agreed and implemented	EMT	Ongoing	Ongoing
iii) Continue negotiations with commissioners over the full re-investment of fines and penalties	ET/IH	Jan 15	

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21-1415	**2014/15 Savings plans are not identified & delivered, with subsequent impact on Trust financial position**	• Review of savings performance at Finance Committee and Operational Development Group • Monthly CSC performance meetings • Tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements • CSCs submitted initial savings plans • Operational Development Group to accelerate pace of savings delivery • Risks and opportunities tracked monthly	• Monthly reporting to Finance Committee • External support commissioned to support savings delivery • Robust Programme Management Office in place • Monthly refresh of year end forecast • Clear lead against all recovery programme workstreams • Closer Financial Monitoring	**12 (4x3)**	**16 (4x4)**	**12 (4x3)**	i. CSC savings plans require continued challenge to ensure assumptions remain valid and to maintain buy-in to ensure delivery of savings targets ii. CSCs to be held to account to develop more schemes through the monthly performance review process iii. Insufficient contingency to guarantee delivery of year end forecast	iv. CSCs not identified sufficient savings to meet year end comfort totals v. Risks on delivery of corporate work streams and ability to release the saving (Length of Stay, Theatres, Outpatients and Medical Staffing)	1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group	Feb 15	Mar 15	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) ii) iii) iv v) vi)): Operational Development Group to complete testing of CSC savings schemes and identify any subsequent savings plan required	ODG	Sep 14	On-going fortnightly
ii) v): CSC performance meetings to be held monthly	BM and CSC Managers	Apr 14	On-going Monthly
i) The Trust Board considered proposals to deliver the £1.2m surplus at its meeting on 30th October. Mitigating actions to be developed into robust plans.	EMT, SMT and ODG	Dec 14	On-going fortnightly

Care Quality Commission - Outcomes

Involvement and Information

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

Personalised care, treatment, support

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

Safeguarding and safety

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

Suitability of Staffing

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

Quality and Management

15. Statement of purpose
16. Assessing and monitoring the quality of service provision
17. Complaints
18. Notification of death of a person who uses services
19. Notification of death or absence of person detained under Mental Health Act 1983
20. Notification of other incidents
21. Records

Suitability of Management

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

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
SC	Saliya Caldera		EMT	Executive Management Team		CQC	Care Quality Commission
AC	Anoop Chauhan		G&Q	Governance & Quality Committee		CSC	Clinical Service Centre
MD	Michelle Dixon		FC	Finance Committee		DoH	Department of Health
SH	Simon Holmes		SEC	Strategic Education Committee		KPI	Key Performance Indicator
MK	Michael Kellagher		SMT	Senior Managers Team			
RK	Rebecca Kopecek		TB	Trust Board			
BL	Ben Lloyd						
JL	Jane Lowe						
NM	Natasha Martin						
FMcN	Fiona McNeight						
TP	Tim Powell						
MQ	Mike Quinn						
LR	Lucy Rutter						
PS	Paul Sadler						
TS	Tracey Stenning						
LW	Lee Williams						