

TRUST BOARD PUBLIC - APRIL 2015

Agenda Item Number: 76/15
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 <i>Why is this paper going to the Trust Board?</i>	To provide the Trust Board with a monthly update of the Board Assurance Framework.
Key points for Trust Board members <i>Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals</i>	Trust Board are asked to note <ul style="list-style-type: none"> • Risks greater than 15 on the BAF • Decrease of risk 21-1415 • Risks re-scoped for 2015/16 • Recommendation for removal of risk 12-1415
Options and decisions required <i>Clearly identify options that are to be considered and any decisions required</i>	<ul style="list-style-type: none"> • Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: <i>Clearly identify what will follow the Trust Board's discussion</i>	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board in May 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: April 2015

Purpose:

To provide the Trust Board with a monthly update on the BAF as at 17 April 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
- 02-1415 ◀ ▶ (Red 16):** Failure to comply with internally and externally set standards on quality and safety
- 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 leading to; national skill shortages in nursing, scientific and other professions.
- 18-1415 ◀ ▶ (Red 16):** Inability to achieve Foundation Trust status within the agreed timetable – Unscheduled care not achieving national standard and 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.
- 20-1415 ◀ ▶ (Red 16):** 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

New Risks

Nil

Risks with Increased Score

Nil

Risks with Decreased Score

- 21-1415 ▼ (Red 16 to Yellow 4):** 2014/15 Savings plans are not identified & delivered, with subsequent impact on Trust financial position - draft year end position shows that £17.646m savings have been achieved against a CIP plan of £17.524m

Risks to be Removed

- 12-1415 (Amber 8):** Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns – Director of Education has closed risk on department and CSC Framework following recent positive Deanery visits

Target Date Changes

- 10-1415 (Amber 12):** Lack of technical fire risk assessments throughout the whole of both new and retained estates and associated remedial works – delay in completion of assessments impacts on review of report findings by PFI parties

Of Note

The following risks have been reviewed and re-scoped for 2015/16:

- 09-1516 (Amber 12):** 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.
- 11-1516 (Red 16):** Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed

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 - April 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)				21 Delivery of savings ▼	
Unlikely (2)			13 Growth in R&D ◀ ▶ 14 Threat to specialist services ◀ ▶	6 Cancer Wait Targets ◀ ▶	
Possible (3)			1 CQC compliance ◀ ▶ 3 Patient Experience ◀ ▶ 16 Leader development ◀ ▶	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 ◀ ▶	
Likely (4)				2 Quality and Safety Standards ◀ ▶ 5 RTT and Access targets ◀ ▶ 17 Workforce demand & key skill shortages ◀ ▶ 18 Foundation Trust status ◀ ▶ 19 Failure of budgetary control ◀ ▶ 20 Financial Income & Penalties ◀ ▶	
Highly Likely (5)				4 Failure to achieve Emergency Department Quality Standards ◀ ▶	

ASSURANCE FRAMEWORK 2014/15 PROGRESS SUMMARY – April 2015

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	TRUST RISK REGISTER REFERENCE	CQC OUTCOME REFERENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
							JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1, 3, 5	1-1415	TS	G&Q	Inability to maintain ongoing compliance with all CQC standards	3.3	All	6	6	9	9								Jun 15	6 Review Jul 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	16	16	16								May 15	8 Re-scope May 15	
1,3, 5	3-1516	CD	G&Q	Failure to achieve internal and external standards around patient experience	3.3	16 17	9	9	9	9								Jun 15	6 Apr 16	
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	20	20	20	20								May 15	12 Jun 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	16	12	16	16								Apr 15	8 Re-scope May 15	
1,3, 5	6-1516	NM	SMT	Failure to achieve cancer wait targets	3.3	4	12	12	8	8								Jun 15	8 Apr 16	
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								May 15	8 Jun 15	
1,3	8-1415	SH	SMT	Lack of equivalent workforce across seven days of the week	3.3	4	12	12	12	12								Jun 15	8 Dec 15	
1,3, 5	9-1516	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	12	12	12	12								Jun 15	4 Sep 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	12	12	12								May 15	8 May 15	
1,3,5	11-1516	SE	UCT	Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed			12	12	12	12								Jun 15	8 Oct 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	8	8	8	Risk recommended for removal							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								May 15	3 Review May 15	
1,3,5	14-1415	SH	SMT	Threat to specialist services due to centralisation agenda		6	6	6	6	6								Jul 15	6 Review Progress Jul 15	

1,3,4	15-1415	RK	SMT	Insufficient engagement of workforce	4.1,4.3 4.4,5.1	13	12	12	12	12									May 15	6 Risk review 15/16 May 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									May 15	6 Risk review 15/16 May 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									May 15	12 Apr 16
3,5	18-1415	BL	TB	Inability to achieve Foundation Trust status within the agreed timetable	5.1	26	16	16	16	16									Jul 15	8 Sep 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	16	16	16	16									May 15	12 Risk review 15/16 May 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	16	16	16									May 15	12 Risk review 15/16 May 15
5	21-1415	LWi	FC	2014/15 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	5.1	26	16	16	16	4									May 15	12 Risk Review 15/16 May 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			
1-1516	Inability to maintain ongoing compliance with all CQC standards	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Quarterly compliance to TB and key committees + monthly exception reporting (action plans in place for any identified compliance issues) Clinical dashboards / quality metrics CSC governance reports Mock CSC assessments Compliance audits PWC quality stocktake assessment of 'good' against the domains. CQC Intelligent Monitoring Report (Dec 2014) has placed the Trust in Band 5 (1 being poor, 6 being good) All evidence requested during recent CQC inspection was readily available and supplied as required 	12 (4X3)	9 (3X3)	6 (3X2)	<ul style="list-style-type: none"> i. CQC inspection using new methodology and domains. ii. Internal monitoring of compliance process to be determined 	<ul style="list-style-type: none"> iii. Self assessment of compliance against the CQC Domains. iv. Key areas of risk relate to unscheduled care (BAF reference: 4-1415) v. Verbal feedback following CQC inspection raising concerns regarding ability to comply with regulations as a result of issues within ED and the Unscheduled Care Pathway, 	1. Director of Nursing 2. Acting Head of Governance 3. Governance & Quality (G&Q)	Jun 15	Review Jul 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	Completed – inspection Feb 15		
i & ii CSCs to undertake gap analysis against CQC domains and CSC performance reviews to identify any issues/actions									CSCs	January 2015	Completed – inspection Feb 15		
i, ii & iii Leads for information identified and to be informed of requirements.									TS	Complete	Complete. Information provided in line with CQC Provider Information Request.		

i)/ii) Ongoing mock CQC visits (CSCs) using new CQC domains	HoNs	Apr 13	Implemented and Ongoing
i)/iv) Awaiting updated HealthAssure software to reflect CQC domains	TS	Dependent on update of software by Allocate	Current discussions regarding future use of Allocate
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 Apr 15	Complete --Process will be under continual review as the need arises Internal monitoring process to be revised
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 8 th Sept. Complete - ctions included in CSC Quality Improvement Plans,
v) As per actions associated with BAF reference 4-1415			

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2-1516	<p>Failure to comply with internally and externally set standards on quality and safety</p> <p>Implications:</p> <ul style="list-style-type: none"> Avoidable harm to patients Reputational damage Failure to satisfy quality contract Fines associated with some quality metrics Loss of CQUIN income 	<ul style="list-style-type: none"> Governance Framework and monitoring – Quality Improvement Framework Quality 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 	<ul style="list-style-type: none"> Quality heatmap and exception reports to Trust Board monthly Quality report quarterly to Trust Board Dr Foster data CQC feedback – QRP/review feedback CQC intelligence monitoring Band 5 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 Achieved end of year target for avoidable pressure ulcers Electronic mortality tool in place 	12 (4x3)	16 (4x4)	8 (4x2)		<ul style="list-style-type: none"> Failed ED performance target at year end 2014/15 VitalPac Dementia screening reporting anomalies C Diff year end objective failed Failed year end falls reduction target of 32 red and amber falls (CQUIN linked) - year end total 43 with 8 outstanding investigations Evidence of poor adherence to the sepsis 6 bundle Failed medication year end target – 16 against target of 11 1 avoidable MRSA bacteraemia under arbitration with 1 pending PIR 	1. Director of Medicine 2. Head of Clinical Safety/Head of Quality 3. G&Q	May 15	Risk to be re-assessed May 15	CQC 4, 7, 8, 9, 11	RR 3.3

		<ul style="list-style-type: none"> • 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 Complete – year end target achieved
ii) Performance support framework in place for those CSCs with repeat high grade pressure damage								AF	May 14	May 14 – on-going
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 CESHG – upgrade to be completed Further work to proceed to audit use and validity of tool								SH	Mar 15	Complete – on-going work regarding mortality and increased focus through CESHG
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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										On target			
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										Inability to achieve predicted target			
3-1516	<p>Failure to achieve internal and external standards around patient experience as measured through Friends and Family test and National Patient Surveys</p> <p>Implications:</p> <ul style="list-style-type: none"> Poor patient experience Reputational damage Loss of income if fail to achieve CQUIN associated with friends and Family Test 	<ul style="list-style-type: none"> CSC targets set to achieve friends and family test returns with weekly reporting loop 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 Review of complaints process completed Net promoter score replaced by % patient satisfaction score 	<ul style="list-style-type: none"> Positive feedback from the ombudsman regarding individual complaints and level of investigation Small reduction in number of complaints FFT response rates increased to 38% of inpatients, 18% of Emergency Department attenders. % of patients who would recommend the Trust 96%, not recommend 1.5%. Positive patient survey results for cancer services and satisfactory for ED. 	9 (3x3)	9 (3x3)	6 (3x2)		<ul style="list-style-type: none"> Evidence of improvement actions from negative Friends and Family response. Resolved but will need to be monitored to ensure sustained. Gaps in compliance against Clywd/Hart recommendations for further action 2015/16. Initial management report for 2014 inpatient survey shows need for improvement. CQC publication due 21 May 2015. CSC Quality improvement plans do not all include reference to FFT and/or surveys. Lack of on going intelligence for in-patient survey questions other than 4 key questions. Variable FFT response rate from ED. 	1. Director of Nursing 2. Head of Patient Experience 3. G & Q	Jul 15	Apr 16	CQC 16, 17	RR 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i)/ii)/vi) Formal FFT performance management process will be implemented to include response and satisfaction rate, and action on written feedback from patients										Jul 2015			
i)/ii)/iv) CQC report will be reviewed and action plan agreed and monitored by PESG										Jun 2015			

i)/(iv)/(vi) CSC s to review PE elements of QI plans and include actions required and monitoring processes.		Jul 2015	
iv)/(v)/(vi) Develop and implement local survey with target response rates , agree, implement and monitor via PESG		May 2015	

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4-1415	<p>Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing</p> <p>Implications:</p> <ol style="list-style-type: none"> Poor patient experience Poor staff morale and wellbeing Trust reputation Financial penalties related to Emergency care quality targets 	<ul style="list-style-type: none"> CSC Strategy CEO chairing Urgent Care Task Force to oversee PHT recovery plan PHT Unscheduled Care Improvement Plan ratified by UCB and PHT Trust Board with 3 Phase implementation timetable ED IT System Go Live April 2015 12 Hour escalation process in place (standard: no patient to remain in ED for >12 hours) 	<ul style="list-style-type: none"> 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 Transformation programme commenced All patient arrival and departure times monitored by ED Coordinator and DHM 	20 (4x5)	20 (4x5)	12 (4x3)	<ol style="list-style-type: none"> Ability to control front door demand CSCs not Sustaining agreed discharge targets on a daily basis Inability of external partners to support increase in community capacity 	<ol style="list-style-type: none"> Performance against 4hour wait target of 95% currently at 82% YTD 	<ol style="list-style-type: none"> Chief Operating Officer Head of Operations ODG 	May 15	Jun 15	CQC 4, 6, 16	RR 2.1 3.3
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
i) Phase 2 (paperlite) and 3 (paperless) of ED IT system to be implemented									MP	Apr 15	On track to complete		
iii) 7 point action plan to be agreed with Commissioners and Community Providers to increase discharge									FW	May 14	Plan agreed by Accountable Officers 19th June 2014		
I) Further WHE turnaround action plan being created, to be agreed – draft received and comments returned to F Wise													
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) Key actions agreed Post TDA/NHS England Urgent Care Summit 3 rd 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) ED Recovery Plan refined post TDA/NHS England Meeting 30/11/14									WHE	Nov 14	Ongoing		
i) ii) iii) Perfect Week planned for January 2015									COO	Jan 15	Completed		
i) ii) iii) Focused Safer Discharge Bundle week 11-18 th November									ECIST	Nov 14	Completed		
i) ii) iii) Consultant Early Senior Review in ED 1000-1800Hrs									SH	Dec 14	Ongoing		
i) ii) iii) Operational Standards linked to Medical Model agreed									SJ	Dec 14	Ongoing		
i) ii) iii) Perfect Week lessons learnt to be embedded									PH	Feb 15	Commenced and on-going		
i) ii) iii) PHT UC Improvement programme ratified									SJ	Feb 15	Commenced and on-going		

i)ii)iii Additional Medical Consultant in ED/AMU 7/7 1700-2200	MR	March 15	Completed
i)ii)iii Plan to increase ACE spaces to increase admissions avoided	SH	March 15	Completed
i)ii)iii Create AMU Short Stay ward to decrease LoS	SH	May 15	In discussion
i)ii)iii Commence planned transfer from ED to MOPRS and Medicine Wards to decrease LoS	ED	March 15	Completed
i)ii)iii Create third General Medicine Ward	MR	March 15	Completed
i)ii)iii Recommence OPAS Frail Elderly model at Front door	ZH	May 15	On Track
i)ii)iii Review and enhance MDT Discharge Processes to increase daily discharge	SE	March 15	On Track

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										Inability to achieve predicted target			
5-1516	<p>The Trust fails to achieve referral to treatment (RTT) access targets in three specialties:</p> <ul style="list-style-type: none"> General Surgery Orthopaedics Urology <p>Implications:</p> <ul style="list-style-type: none"> Patient experience Reputation financial penalties 	<ul style="list-style-type: none"> Weekly specialty PTL meetings led by CSC GM. Weekly assurance meeting chaired by Deputy COO/Head of Performance Performance team co-ordination of breach position at Trust aggregate level 	<ul style="list-style-type: none"> RTT compliance plans and 35 week recovery plans for all "at risk" specialties Activity plans to meet GURROO 3 model. Including growth plans Support from TDA for aggregate fail for remainder of Q4 to support backlog reduction Further focus on reduction of backlog throughout March Diagnostic recovery and resilience plan 	12 (4x3)	16 (4x4)	8 (4x2)	<ul style="list-style-type: none"> i. Unscheduled care demands leading to lack of capacity ii. Demand/capacity gaps in Gastro for diagnostic and 2ww referrals 	<ul style="list-style-type: none"> ii. Capacity plans dependent on recruitment in MSK, Surgery and Urology. v. Theatre utilisation below level required to deliver GURROO 3 v. OP utilisation/ productivity improvements required 	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. SMT	May 15	Apr 15 Risk to be re-scoped May 15	CQC 4	RR 3.3 3.5
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									By Whom	By When	Date Completed		
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	Approved and on-going		
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	Apr 15	Draft requires amendments for ratification April 2015		

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6-1415	<p>Failure to achieve cancer wait targets</p> <p>Implications:</p> <ul style="list-style-type: none"> Risk to patient safety if we cannot meet access targets for cancer Financial penalties may be applied by commissioner 	<ul style="list-style-type: none"> Capacity and demand modelling undertaken and in place within CSCs Weekly assurance meeting with forecast planning and triggers for escalation 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 	<ul style="list-style-type: none"> 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)	8 (4x2)	8 (4x2)	<ul style="list-style-type: none"> i. Ability to control referral rates ii. Impact of national campaigns iii. Patient choice rules means clock doesn't stop if patient defers anywhere on pathway iv. Impact of late inter Trust referrals 	<ul style="list-style-type: none"> v. Cancer Improvement plan 15/16 not yet finalised. Detailed work on clinical pathways due in 15/16 to improve ability to deliver wait times consistently. 	<ul style="list-style-type: none"> 1 Chief Operating Officer 2. General Manager - Cancer 3. SMT 	Jun 15	Apr 16	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) Appoint to vacant Cancer Improvement Manager post									NM	Jun 15	Completed		
v) Finalise Cancer Improvement plan and implement clinical pathway improvements									NM	Sep 15			

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7-1415	<p>Quality of data produced and provided for use in internal performance reporting and for external reporting may include inaccuracies (data entry and/or reporting)</p> <p>Implications</p> <ul style="list-style-type: none"> • Reputation damage • Financial penalties • Incorrect business decisions made using incorrect data assumptions impacting on patient experience 	<ul style="list-style-type: none"> • Data validation processes in place in some areas but patchy 		12 (4X3)	12 (4x3)	8 (4X2)	<ul style="list-style-type: none"> i. Lack of Trust wide data quality Strategy ii. Significance of data quality is not recognised Trust wide iii. Lack of formalised checking procedures and sign off 	<ul style="list-style-type: none"> iv. Deloitte internal audit highlighted issues in several areas v. Incorrect data supplied externally resulting in internal investigation 	<ul style="list-style-type: none"> 1. Director of Corporate Affairs & Business Development 2. Head of Information Services 3. Data Quality Steering Group 	May 15	Jun 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	Further meeting post CQC visit Feb-15 -Group will run monthly for 6-months across 2015 from Mar-15 to ensure the correct level of momentum is in place, with each service to feed back within this window		
i) Devise and implement Data Quality Strategy and policy									DQSG	Mar 15	Strategy formally signed off by SMT. DQ Policy has been written in draft form (version 5.4). A full briefing on the policy content was presented at Feb-15 DQSG. Final checks and changes to be applied ahead of circulation of the document at the Mar-15 DQSG.		
ii) Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust									COO	Mar 15	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 . The templates for CSC assessment and system administrator feedback were presented at Feb-15 DQSG. Information Services to liaise and support services that will feed back in first round of assessment presentations in Mar-15 DQSG
ii) All new job descriptions to have personal responsibility for ensuring the quality of data included	RK	Nov 13	Ongoing
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	Jun 15	Data Quality Dashboard scoped, specified and designed. Agreement that the Trust has a single point where data quality can be accessed (a single Intranet page), Intranet site development led by IT, in progress but delayed due to the prioritisation of the main Trust site and the CQC Preparedness website. IT to confirm release date to Information Services.
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	Jun 15	Key national targets to be written up by Dec 14, with further Trust-wide review in Q4- In progress Currently being developed, due to the level of returns this will need to extend into the beginning of 2015/16
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	<p>Lack of equivalent workforce across seven days of the week</p> <p>Implications</p> <ul style="list-style-type: none"> Damage to Trust reputation Poor patient experience Reduced quality of care 	<ul style="list-style-type: none"> Governance systems in place to ensure patient safety and quality of care is maintained Increased consultant presence introduced at weekends 	<ul style="list-style-type: none"> Review of hospital mortality with emphasis on weekend mortality with TDA Weekend HSMR shows no significant difference to comparable Trusts Weekend HSMR shows no significant difference from rates recorded during the week 	12 (4X3)	12 (4x3)	8 (4X2)	<ul style="list-style-type: none"> Delays in progressing patient pathways National consultant contract negotiations are underway and outcomes awaited Gap analysis completed, business plan to be produced following findings 	<ul style="list-style-type: none"> IPR indicates lengths of stay could be reduced 	<ul style="list-style-type: none"> 1. Medical Director 2. Chief of Service 3. SMT 	Jun 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		
<ul style="list-style-type: none"> 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		
i)/iv) Development of unscheduled care medical model									SH/SJ	Apr 15			

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9-1415	<p>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.</p> <p>Implications:</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 TDA / Treasury business case approval process 	<ul style="list-style-type: none"> 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 Strategic Outline Case drafted 	8 4x2	12 4x3	4 4x1	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 1. Director of Finance 2. Head of IT 3. SMT 	Jun 15	Sep 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 / Dir.of Strategy	May 15	02.10.2014 - Board approval to produce Strategic Outline Case		
<ul style="list-style-type: none"> Run Trust Board & CSCs Workshop to decide key objectives for eHospital 									Head of IT	Nov 14	06.11.2014		
<ul style="list-style-type: none"> 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 Consultation Draft SOC and submit to Trust Board	Head of IT	Apr 15	Due 22.04.2015
• Present SOC to Trust Board for discussion and agreement of required changes to gain approval	Head of IT / Dir.of Strategy	Apr 15	Due 30.04.2015
• Complete Final Draft SOC and submit to Trust Board	Head of IT	May 15	
• Present SOC to Trust Board and gain approval to produce Outline Business Case with associated funding	Head of IT / Dir.of Strategy	May 15	
b) Produce eHospital Programme Resources Plan for 2015/16	Head of IT	Apr 15	12.03.2015
c) Confirm funding for eHospital Programme	Director of Finance	May 15	
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.	TBC	
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.	TBC	
c) Contract for specialist NHS procurement and contracting advice and expertise services	Head of IT / Head of Proc.	TBC	
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	TBC	Leads for 4 of 10 CSCs identified
c) Agree CSC eHospital Programme leads job plans for 2015/16 incorporating eHospital responsibilities	Chiefs of Service	TBC	
d) Arrange integrated system demonstration days to raise awareness of clinicians and other stakeholders of potential benefits and pitfalls	Head of IT	TBC	
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	<p>Fire risk assessments across the whole of the estate are not considered suitable and sufficient.</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 1. Director of Corporate Affairs & Business Development 2. Head of Estates and Facilities 3. SMT 	May 15	May 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. Mar 15 - Further sickness has presented a challenge and alternative staff have been drafted in. Reports are being received by PHT and comments are being fed back to the assessors. Peripheral buildings still to be assessed. Still expected to have all reports reviewed by end of March Apr 15 – All areas have been surveyed and further reports submitted for review. The Trust reported some concerns over the quality of some of the reports and WSP agreed to revise. Updated reports are now being received and reviews of these have commenced. Early indications are that these reports are likely to be acceptable. WSP have committed to providing all reports by the end of April. The PFI parties have commenced review of the findings of the reports and this is likely to be concluded by the end of May 15.									THC/CSL/PHT	Jan 15 Mar 15 May 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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11-1516	<p>Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed. This results in:</p> <ul style="list-style-type: none"> 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' Increased risk of breaching 4 hour ED target Poor patient experience of prolonged waiting Impact on elective programme 	<ul style="list-style-type: none"> Daily IDB meetings chaired by Trust General Manager - Full review of IDB across WHE moving to an integrated Health & Social IDB Team Discharge Planning Teams covering whole hospital Daily IDB report (all delayed in hospital patients) Next steps 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 	<ul style="list-style-type: none"> 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 Implement MDT Board Rounds as per IDB action plan Weekly length of stay report > 7/14 day Metric reports Outlier – trajectory and performance reporting Discharge numbers 	16 4x4	12 4x3	8 4x2	<ul style="list-style-type: none"> Demand from complex patients due to high volume IDB still based across multiple venues, needs central base for MDT office' Different IT systems across organisations 7 day working limited but plans in place to recruit Unscheduled transformation – OPAS/Admission avoidance System wide transformation 	<ul style="list-style-type: none"> CSC's failure to complete 123 Escalation updates Not performing against outlier trajectory Discharge numbers fluctuate against target Operational controls 	1. Chief Operating Officer 2. General Manager 3. Urgent Care Improvement Group	Jun 15	Oct 15	CQC 4, 6, 16	RR 1.46, 1.49, 1.52

		<ul style="list-style-type: none"> • Sitrep reporting • Length of stay reports • Next steps agreed and shared with partners 									
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	Mar 15	Complete and on-going		
iii) Escalated discussions to be led by PHT IT to ensure systems are compatible							SE	Feb 15	Complete and on-going		
iii) Implement IT access for all partners							SE	Jun 15			
iii) Complete evaluation of IT system to ensure fit for purpose to support discharges							SE	Oct 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		
i-x) Implement system transformation of internal discharge processes							SE	Jun 15			

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12-1516	<p>Loss of junior doctor accreditation due to perceived lack of educational support in deanery returns</p> <p>Implications:</p> <ul style="list-style-type: none"> Service delivery Reputation as an organisation delivering high standards of education and training to medical trainees 	<ul style="list-style-type: none"> Director of Medical education Educational Supervisors Deanery links Foundation Programme Directors Foundation Doctors educational programme 	<ul style="list-style-type: none"> AAA rating Positive feedback on level of experience gained Direct feedback of trainees to DME more positive of late. 4 monthly survey from DME to all trainees focussing on areas of concern and improvements 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)	<p>i. Junior doctors although exposed to positive clinical experience report that they are not receiving the educational support expected of their training posts</p> <p>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)</p> <p>iii. Patient safety concerns raised by trainees to GMC relating to out of hours cover</p>	Risk recommended for removal	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		
ii) 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 visit 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	<ul style="list-style-type: none"> Wessex AHSN confirmed by DH Innovation strategy to be taken forward by Director of Research Medical Director participating in AHSN discussions with UHS Trust R&D Strategy and framework R&D income monitored by R&D Director 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 	<ul style="list-style-type: none"> Medical Director reporting back to Board on discussions R&D income year on year increase National NIHR and Guardian League tables 2013 shows good competitive performance by PHT 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)	<ul style="list-style-type: none"> Lack of long term 3-5 year strategy for research and innovation Low levels of portfolio recruitment recorded in 2014 		1. Medical Director 2. Director of Research & Development/ Research Manager 3. SMT	May 15	Mar 15 Review of risk May 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	Long term high level strategy for research and innovation to be presented to the Board March 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
ii) CSC and board reports to be issued	GW	Mar 15	Completed and ongoing

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14-1415	<p>Threat to specialist services due to centralisation agenda</p> <p>Implications:</p> <ul style="list-style-type: none"> Potential loss of major vascular surgery at PHT due to centralisation to a tertiary unit This carries longer term implications for the viability of other services such as interventional radiology and renal Further services such as Stroke may be centralised in the future 	<ul style="list-style-type: none"> Outcome data Vascular Society requirements for a service Fully covered clinical rota with committed team National audit results 	<ul style="list-style-type: none"> Positive outcome data for this group of patients Fulfilment of vascular society recommendations for service delivery Good clinical outcome data Network vascular MDT with UHS has commenced Providing some vascular service to Chichester Recent confirmation from commissioners that arterial vascular surgery will continue in Portsmouth 	16 (4x4)	6 (3x2)	6 (3x2)	<ul style="list-style-type: none"> Decision ultimately out with PHT control as specialist commissioner led Currently no absolute and written assurances from specialist commissioning teams as to the medium and long term direction 	<ul style="list-style-type: none"> Lack of approved vascular service 	1. Medical Director 2. Medical Director 3. SMT	Jul 15	Review progress Jul 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 15	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: <ul style="list-style-type: none"> Lack of understanding/ buy in, and therefore delivery of strategic priorities Suboptimal delivery of patient care Poor staff survey results 	<ul style="list-style-type: none"> Listening into Action programme 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 	<ul style="list-style-type: none"> 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	May 15	Review risk 15/16 May 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	<ul style="list-style-type: none"> Leadership development programmes in place to support leaders at various levels. 360 and self-assessment completed at Executive level Trust wide leadership competencies identified Clinical Directors leadership programme in place Performance appraisal process to assess behaviours and leadership performance in place. 	<ul style="list-style-type: none"> 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)	<p>i. Programmes and framework for leadership development in place but needs to be embedded to ensure compliance.</p> <p>ii. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.</p>	<p>1. Director of Workforce and Organisational Development</p> <p>2. Head of Organisational Development</p> <p>3. SMT</p>	May 15	Review risk 15/16 May 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		
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			
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	On-going		
ii)Create a performance management culture									LR	Sep 14	On-going as part of performance management framework		

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17-1415	<p>Current and future workforce demand is outstripping supply leading to:</p> <p>National skill shortages in nursing, scientific and other professions being reflected locally which is leading to an increasing expensive temporary workforce supply which may impact on patient care</p> <p>Adult nursing commissions have been increasing since 2013 but they have not kept pace with requirements due to the impact of increased demand post Francis.</p> <p>Workforce design has not kept pace with changing service delivery, for example, terms and conditions of service have not fundamentally changed for many years, but increasingly we need staff to work 24/7 on an ongoing basis</p> <p>Lack of supply of</p>	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Business planning process has identified resource requirements for CSC service delivery. WSC process removed to ensure no barriers to substantive recruitment Trust turnover is currently at 10.6% which is lower than many Trusts and the stability of staff that have been in post over 1 year is 87.7%. Budgeted Workforce establishment has increased by 320 FTE since 31st March 1014, – currently 6,280 FTE as a result of investment in services for growth/activity and to maintain safe staffing levels is accordance with Francis and Keogh report recommendations (£7.6m). 	16 (4x4)	16 (4x4)	12 (4x3)	<p>i) Temporary resource spend £20m for 2013/14 In December Temporary workforce spend reached £1.97m. Trust vacancies at 31st March 2014 were 300 FTE. Almost all of these have been filled, however the additional establishment of 320 FTE added since March 2014 has not yet been filled. Current total Trust Vacancies – 334.13 vacancies.</p> <p>ii) Reduction in Junior Doctors and difficulty in recruiting ongoing in many specialities.</p> <p>iii) The Trust has maintained many of its referral to treatment targets leading to an increased need for staff which resulted in a high level of premium payments including Waiting List Initiative payments for consultant medical staff and overtime in other staff groups.</p> <p>v) Temporary workforce is used to fill local and national shortages in some key skill areas which may</p>	<p>) High levels of substantive vacancies in some CSCs – Medicine, Surgery & Cancer and MOPRs</p> <p>i) Qualified N&M – 206.77 FTE Vacancies (of which 178.77 FTE are Band 5 and 154.58 are qualified ward based vacancies)</p> <p>ii) Supply of newly qualified nursing workforce is insufficient for PHT required demand.</p>	1. Director of Workforce and Organisational Development 2. Deputy Director of Human Resources 3. SMT	May 15	Apr 16	CQC 13	RR 4.1 4.3 4.4 5.1

staff leads to lack of substantive recruitment which leads to potentially low staff morale and increased turnover of existing staff exacerbating the issue						result in some critical skill gaps in clinical rotas, specifically nursing, junior doctors and some other specialist areas eg ED, histopathology, orthotics, Urology, Colorectal, Physiotherapy, Pharmacy and Pathology.					
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE								By Whom	By When	Date Completed	
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.								CSC	Ongoing	Agreements made to continue to pay WLLs	
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 of substantive staffing. Other methods are being considered to reduce spend.								RK	Sept 14	In discussion with Director of HR and Finance Director	
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 including: NHS jobs website, NHS Jobs 2, Linked-in, Careers Fairs, local Universities, Job Centre Plus and introduced a Sector Based Working Academ. We have actively recruited overseas nursing and medical staff to address vacancies and lack of supply of staff in the national labour market.								RK	Oct 14	Significant recruitment from overseas and WSC abolished	
i) Develop “gain share” approaches to reducing the medical workforce bill specifically.								RK	Oct 14	Not supported by LNC	
ii) Reduce the junior medical workforce bill by the creation of increased trust doctor posts to fill gaps and remove bandings as appropriate. We specifically set out to over-recruit this year to try and ease some of these problems which has resulted in an over-establishment of 28.4WTE, but with a reduction in cost of £739k as confirmed by Finance.								RK	Aug 14	Agreed and implemented – fill rate for this year is significantly higher than last year. We have already started considering what we should be looking at for August 2015.	
iii) 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. This is being implemented but tends to be slow due to the need to ensure appropriate new staff are in place with the appropriate skills and training e.g. Clinicians Associates, Associate Practitioners, Advanced Clinical Practitioners in Histopathology, Critical care Practitioners who are designed to replace junior doctors, First Assist etc.								BH	Ongoing		
lii/iv/v) Succession plan for all critical posts identified								LR	Sep 14	Completed	
v/vi/vii) Working with CSCs to develop thorough workforce plans which will create recruitment plans								RK	May 14	Complete 13/14 – now considering 14/15 plans	
v/vi/vii) Project plan in development to manage on-going CSC action plans to be monitored through Operational Delivery Group. For 14/15 looking at a Transformational Programme Approach.								RK	Apr 14	Complete	
v/vi/vii) 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/iv) In certain areas it has become clear that overtime has not been very effective and therefore a number of areas specifically clinical support are currently introducing 7 day working.								CSC	Apr 15	Consultation implemented	
iii) 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	
iv) 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	
v/vi/vii) Continue to develop potential pipeline of recruitment from overseas by utilising agencies and NHSP as appropriate. Internal poorly performing staff bank for admin & clerical, and management and medical staff has been replaced by NHS Professionals								RK	Apr 15	New Agencies are in place and on-going work with NHSP to look at potential other solutions.	
vii) Actively working with Health Education Wessex and to look at increasing nursing commissions by having a dual output for adult nurses.								DK	Sept 15		
v) An initial meeting has been held with Southern and Solent HRDs to look at areas where we can cooperate with staffing rather than constantly compete.								RK/TP	Dec 14	On-going discussions underway.	

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18-1415	Inability to achieve Foundation Trust status within the agreed timetable	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> i. Pressures from unscheduled care still dominating the agenda with consequential unfunded capacity and associated costs ii. Financial performance at month 10 is £6.7m variance from plan 	<ul style="list-style-type: none"> 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) vii. Draft year end position is £657k deficit, subject to audit and result of technical adjustments evaluation 	1. Director of Finance 2. Deputy Director of Finance 3. Trust Board	Jul 15	Sep 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/vi) See action plan risk 21 relating to savings													
v/vii) 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 – anticipated receipt of financing is March 2015									BL	Jan 15 Jun 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.	<ul style="list-style-type: none"> Finance reporting and monitoring mechanisms at CSC to Board level Updates on Financial position provided to Board, SMT Finance Committee Delegated budgetary control framework Trust wide savings and transformation programme Income and contract monitoring Bottom up forecasting in place Additional finance board meetings in advance of monthly performance reviews 	<ul style="list-style-type: none"> 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)	<p>i) Savings opportunities have been inhibited by operational pressures. These have led to additional workforce costs (often at premium rates) and the cancellation of circa 400 planned operations in December and January to assist with the availability of beds.</p> <p>ii) Month 12 draft annual accounts show a £657k deficit subject to audit and the results of technical accounting adjustments</p>	<p>1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group</p>	May 15	Risk to be reviewed for 15/16 financial year May 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Agreed capacity required with CSCs and activity volumes secured through the commissioning contract Agreed PbR compliant contract Daily metrics via KitBag Monthly CSC performance reviews strengthened Increased reporting through Income & Contracts Group CQUIN Meeting in place to monitor performance and reported monthly in IPR 	12 (4x3)	16 (4x4)	12 (4x3)	<ul style="list-style-type: none"> 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. Engagement with Commissioners has been challenging. Final settlements will not be reached until March activity data is available and validated, which will be early 2015/16 	<ul style="list-style-type: none"> 1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group 	May 15	Risk to be reviewed for 15/16 financial year May 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 Mar 15			

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21-1415	2014/15 Savings plans are not identified & delivered, with subsequent impact on Trust financial position	<ul style="list-style-type: none"> Review of savings performance at Finance Committee and 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 	<ul style="list-style-type: none"> 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 Draft year end position shows that £17.646m savings have been achieved against a CIP plan of £17.524m. The accounts are draft and subject to audit. While the Trust has achieved it's overall CIP target, the profile of delivery was different from originally planned 	12 (4x3)	4 (4x1)	12 (4x3)	i. CSCs to be held to account in pursuing schemes through the monthly performance review process ii.		1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group	May 15	Risk to be reviewed for 15/16 financial year May 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 30 th 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
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	
AC	Anoop Chauhan	EMT	Executive Management Team	CQC	Care Quality Commission
MD	Michelle Dixon	G&Q	Governance & Quality Committee	CSC	Clinical Service Centre
SH	Simon Holmes	FC	Finance Committee	DoH	Department of Health
MK	Michael Kellagher	SEC	Strategic Education Committee	KPI	Key Performance Indicator
RK	Rebecca Kopecek	SMT	Senior Managers Team		
NM	Natasha Martin	TB	Trust Board		
FMcN	Fiona McNeight				
TP	Tim Powell				
MQ	Mike Quinn				
LR	Lucy Rutter				
PS	Paul Sadler				
TS	Tracey Stenning				
LW	Lee Williams				