Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC - MAY 2015

Agenda Item Number: 96/15
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 • Re-scope for 2015/16 of risks 01-1415, 05-1415, 02-1415, 15-1415, 16-1415, 19-1415, 20-1415, 21-1415 • New risk 22-1516 Mental Health Service Provision – transferred from the Trust Risk Register • Increase of risk 1-1415 Compliance with all CQC standards • Decrease of risk score 18-1415 Achievement of FT Status • Alignment of risks to CQC KLOEs
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 June 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: May 2015

Purpose:
To provide the Trust Board with a monthly update on the BAF as at 16 May 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

05-1516 (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.

19-1516 (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.

21-1516 (Red 16): 2015/16 Savings plans are not identified & delivered, with subsequent impact on Trust financial position

22-1516*NEW* (Red 16): Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital

New Risks

22-1516 (Red 16): Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital

Risks with Increased Score

01-1516 ▲ (Amber 9 to Amber 12): Inability to maintain ongoing compliance with all CQC standards

Risks with Decreased Score

18-1415 ▼ (Red 16 to): Inability to achieve Foundation Trust status within the agreed timetable – although Trust aspiration there is no national deadline to achieve FT status

Risks to be Removed

Nil

Target Date Changes

Nil

Of Note

22-1516 (Red 16): Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital – risk transferred from the Trust Risk Register

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

01-1415, 05-1415, 02-1415, 15-1415, 16-1415, 19-1415, 20-1415, 21-1415

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 - May 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)			13 Growth in R&D ◄ ► 14 Threat to specialist services ◄ ►	2 Quality and Safety Standards 6 Cancer Wait Targets ◄ ►	
Possible (3)			3 Patient Experience ◄ ► 15 Staff engagement 16 Leader development 18 Foundation Trust status ▼	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 ◄ ► 20 Financial Income & Penalties	
Likely (4)			1 CQC compliance ▲	5 RTT and Access targets 17 Workforce demand & key skill shortages ◄ ► 19 Failure of budgetary control 21 Delivery of savings 22 Mental Health Service Provision	
Highly Likely (5)				4 Failure to achieve Emergency Department Quality Standards ◄ ►	

ASSURANCE FRAMEWORK 2014/15 PROGRESS SUMMARY – May 2015

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	TRUST RISK REGISTER REF.	CQC KLOE REFENCE	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		All	6	6	9	9	12								Jul 15	6 Review Jul 15
1, 3, 5	2-1516	FMcN/CM	G&Q	Failure to comply with internally and externally set standards on quality and safety		S4, S5 W1	12	16	16	16	8								Jul 15	8 Mar 16
1,3, 5	3-1516	CD	G&Q	Failure to achieve internal and external standards around patient experience		S4, S5	9	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		S4, S5 R3	20	20	20	20	20								Jun 15	12 Jun 15
1,3, 5	5-1516	MD	SMT	The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED		S4, S5 R1 R3	16	12	16	16	16								Jun 15	8 Jun 16
1,3, 5	6-1516	NM	SMT	Failure to achieve cancer wait targets		S4, S5 R1	12	12	8	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		S4, S5	12	12	12	12	12								Jun 15	8 Jun 15
1,3	8-1415	SH	SMT	Lack of equivalent workforce across seven days of the week		S4, S5	12	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.		S4, S5	12	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		S4, S5	12	12	12	12	12								May 15	**8** Review risk Jun 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		S4, S5	12	12	12	12	12								Jun 15	8 Oct 15
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		S4, S5	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		S4, S5	6	6	6	6	6								Jul 15	6 Review Progress Jul 15
1,3,4	15-1516	RK	SMT	Insufficient engagement of workforce		S4, S5 E4 W4	12	12	12	12	9								Aug 15	6 Apr 16
1,3,4	16-1516	RK	SMT	Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to delivering change		S4, S5 W3	9	9	9	9	9								Aug 15	6 Apr 16
1,3,4,5	17-1415	RK	SMT	Current and future workforce demand is outstripping supply		S4, S5 E3	16	16	16	16	16								Jul 15	12 Apr 16
3,5	18-1415	BL	TB	Inability to achieve Foundation Trust status within the agreed timetable		S4, S5	16	16	16	16	9								Sep 15	8 Mar 16
5	19-1516	LWi	FC	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned deficit of £16m on income and expenditure		S4, S5	16	16	16	16	16								Jun 15	12 Mar 16
5	20-1516	LWi	FC	The Trust does not achieve sufficient PbR income from commissioners to meet the income plan, or sufficient cash is not available within commissioners to pay activity based invoices.		S4, S5	12	16	16	16	12								Jun 15	12 Mar 16
5	21-1516	LWi	FC	2015/16 Savings plans are not identified & delivered, with subsequent impact on Trust financial position		S4, S5	16	16	16	4	16								Jun 15	12 Mar 16
1	22-1516	FMcN	MHLD	Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital – risk transferred from the Trust Risk Register		S4,E1 E3,E4 R1,R2 R3					16								Jul 15	12 Mar 16

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 KLOEs AND TRUST 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**	• Quarterly CSC self-assessment + compliance statements • CSC and Trust risk registers • 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 • Internal audit assurance • CQC Intelligent Monitoring Report (Dec 2014) has placed the Trust in Band 5 (1 being poor, 6 being good) •	**12 (4X3)**	**12 (3X4)**	**6 (3X2)**	i. CQC internal inspection and monitoring process using CQC methodology and domains; requires review. ii. Any gaps in control identified in CQC report to be addressed.	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 Committee (G&Q)	July 15	Review July 15	CQC All	RR 2-1415 3-1415 8-1415 9-1415 12-1415 13-1415 15-1415 17-1415 18-1415 19-1415 20-1415 21-1415 23-1415 26-1415 27-1415 30-1415 32-1415 33-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
I & iii CQC Internal quality assurance, inspection and monitoring programme to be reviewed and aligned to domains and standards.	TS	June 15	
ii Action plan to address any gaps in control identified from CQC report once published to be developed.	TS	July 15	Pending publication of CQC report.
I & iii Ongoing mock CQC visits (CSCs) using new CQC domains	HoNs	Apr 13	Implemented and Ongoing
i)/ii)	TS / FMc	~~Nov 13~~ June '15	
i)/ii) Review CQC Intelligent Monitoring Report upon publication	TS/FMc	November 2014	Complete and ongoing. July 2014 – Band 6 December 2014 – Band 5
Iv & v) As per actions associated with BAF reference 4-1415			

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										On target / Minor Obstacle to achieving target / Inability to achieve predicted target			
2-1516	**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	**8 (4x2)**	**8 (4x2)**	**8 (4x2)**		i. Quality metrics in the process of being finalised within the contract ii. Monitoring of metrics for April is based on 2014/15 quality metrics	1. Director of Nursing 2. Head of Quality 3. G&Q	Jul 15	Mar 16	CQC S4, S5 W1	RR 3-1415 8-1415 9-1415 13-1415 18-1415 19-1415 20-1415 21-1415 23-1415 24-1415 26-1415 30-1415 32-1415 33-1415

		• 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. Once agreed in contract, quality heatmap to be updated with 2015/16 metrics	F.McNeight	June 15	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
3-1516	**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 • Review of complaints process completed • Net promoter score replaced by % patient satisfaction score	• 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)**		i. Evidence of improvement actions from negative Friends and Family response. Resolved but will need to be monitored to ensure sustained. ii. Gaps in compliance against Clywd/Hart recommendations for further action 2015/16. iii. Initial management report for 2014 inpatient survey shows need for improvement. CQC publication due 21 May 2015. iv. CSC Quality improvement plans do not all include reference to FFT and/or surveys. v. Lack of on going intelligence for in-patient survey questions other than 4 key questions. vi. Variable FFT response rate from ED.	1. Director of Nursing 2. Head of Patient Experience 3. G & Q	Jul 15	Apr 16	CQC S4, S5	RR 3-1415 7-1415 8-1415 9-1415 12-1415 13-1415 15-1415 17-1415 18-1415 19-1415 20-1415 21-1415 23-1415 30-1415 32-1415 33-1415

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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										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 • 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)	• 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)**	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 82% YTD	1 Chief Operating Officer 2. Head of Operations 3. ODG	Jun 15	Jun 15	CQC S4, S5 R3	RR 15-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Phase 2 (paperlite) and 3 (paperless) of ED IT system to be implemented	MP	Apr 15	Complete
iii) 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) 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 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 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 11-18th 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	Establishment commenced 11th May 2015
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	Commenced 4th May 2015
i)ii)iii Review and enhance MDT Discharge Processes to increase daily discharge	SE	March 15	Commenced and on-going

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
5-1516	**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 Deputy COO/Head of Performance • Performance team co-ordination of breach position at Trust aggregate level • RTT compliance plans and 35 week recovery plans for all "at risk" specialties – reviewed weekly • Increased use of ISTC to support gaps in capacity	• Activity plans to meet GURROO 3 model. Including growth plans • Performance dashboard and weekly assurance meeting • Reports to TDA, Commissioners and Trust Board	**12 (4x3)**	**16 (4x4)**	**12 (4x3)**	i. Unscheduled care demands leading to lack of capacity ii. Reduction in inpatient bed base and associated risk to capacity iii. Required rolling programme of theatre upgrade reducing capacity iv. Diagnostic target at risk on monthly basis within Gastro speciality due to capacity gap v. Colorectal service	vi. Capacity plans dependent on recruitment in MSK and Surgery vii. Theatre utilisation below level required to deliver GUROO 3 viii. OP utilisation/ productivity improvements required	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Operational Board	Jun 15	Jun 16	CQC S4, S5 R1 R3	RR 13-1415 19-1415 20-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i Daily risk balance decision decided within Ops Centre to include identification of patients suitable for cancellation	MD/CSC Managers	Jan 15	On-going
Ii Transformation work streams reviewing elective care pathways	DB/MD	Sep 15	
Iii Action plan and weekly reviews trough TTRG	DM/MD	Mar 15	On-going thru to Jun 16
Iv Business case in development to increase capacity	SB/MM	Jun 15	
V See Trust Risk Register for specific action			
Vi Recruit to vacancies	UB/NM	Oct 15	
Vii Reviewed on weekly basis with gaps escalated to CoS and GMs	DM/MD	May 15	
Viii Transformation project in development	MM/SJ	Sep 15	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
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)**	**8 (4x2)**	**8 (4x2)**	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 .	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.	1 Chief Operating Officer 2. General Manager - Cancer 3. SMT	Jun 15	Apr 16	CQC S4, S5 R1	RR 19-1415 20-1415

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	**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 • Data Quality Steering Group (DQSG) • Documentation now produced; Data Quality Steering Group TORs, Data Quality Strategy, Data Quality Policy	• Data Quality Steering Group monthly, since Feb '15, to increase momentum and ensure all CSCs and Information Asset Managers will review and feed back their compliance with local and national standards across the 12-month period since the group was formed (in progress). • As per TORs for Data Quality Steering Group, exceptional issues will be fed into SMT, including an annual DQ Report to Trust Board • Information Services have produced a new DQ reporting suite, which includes a local replica of the national SUS Data Quality Dashboard. All reporting will allow for local drilling down to specialty level performance • Attendance from a member of Contracts team as part of Data Quality Steering Group, to ensure insight into contractual and financial implications • Increased focus on sign off of national returns by both operational services and Head of Performance.	**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	Jun 15	Jun 15	CQC S4, S5	RR 16-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Devise and implement Data Quality Strategy and policy	DQSG	Jun 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 have been circulated ahead of the Apr 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	These are now on-going with a plan to complete a full round within 1 year of 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 in place amongst the new suite of DQ reporting on Information Services Intranet Page
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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										On target		

										Minor Obstacle to achieving target Inability to achieve predicted target			
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	Jun 15	Dec 15	CQC S4, S5	RR 18-1415

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
i/iv) Development of unscheduled care medical model	SH/SJ	Apr 15	

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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 • TDA / Treasury business case approval process	• 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**	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	Jun 15	Sep 15	CQC S4, S5	RR 6-1415 22-1415

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
• 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 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	**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	May 15	Review of risk Jun 15	CQC S4, S5	RR 5-1415

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	Assessments are complete now under review with a view to re-write risk June 2015
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	**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'** • **Increased risk of breaching 4 hour ED target** • **Poor patient experience of prolonged waiting** • **Impact on elective programme**	• 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	• 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**	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. Unscheduled transformation – OPAS/Admission avoidance vi. System wide transformation	vii. CSC's failure to complete 123 Escalation updates viii. Not performing against outlier trajectory ix. Discharge numbers fluctuate against target x. Operational controls	1. Chief Operating Officer 2. General Manager 3. Urgent Care Improvement Group	Jun 15	Oct 15	CQC S4, S5	RR 9-1415 13-1415 15-1415 17-1415

			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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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	May 15	Mar 15 Review of risk May 15	CQC S4, S5	RR 26-1415
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									**By Whom**	**By**	**Date Completed**		

		When	
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	**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** • **Further services such as Stroke may be centralised in the future**	• 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 • Recent confirmation from commissioners that arterial vascular surgery will continue in Portsmouth	**16 (4x4)**	**6 (3x2)**	**6 (3x2)**	i. Decision ultimately out with PHT control as specialist commissioner led ii. Currently no absolute and written 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	Jul 15	Review progress Jul 15	CQC S4, S5	RR 30-1415

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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15-1516	**Insufficient engagement of workforce** **Implications:** • **Lack of understanding/ buy in, and therefore delivery of strategic priorities** • **Suboptimal delivery of patient care** • **Declined staff survey results**	• Listening into Action programme adopted. • Staff survey action plans developed across the organisations and within CSCs • Health and well-being programme established. • Employee recognition programmes in place. • Leadership development • Quarterly staff pulse survey • Development of appraisal quality framework linked to values • Full work plan introduced to address key issues of bullying & harassment	• Significantly Improved performance in 2014 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 • When compared to all acute trusts, movement from 7 key findings in the bottom 20% and only 2 in the top 20% in 2013 to 10 in the top 20% and none in the bottom in 2014 • Staff recommendation as a place to work or receive treatment has increased from 3.54 to 3.71 as measured in the 2014 NSS	**12 (4X3)**	**9 (3X3)**	**6 (3x2)**	i. Lack of engagement from clinical staff in delivering the change agenda	ii. Trust is positioned as average for overall staff engagement when compared to other Trusts within the full 2014 staff opinion survey. iii. A 1% reduction reported in staff reporting incidents, errors or near misses in the last month iv. Staff agreeing that their role makes a difference to patients is below the national average	1. Director of Workforce and Organisational Development 2. Head of Organisational Development 3. Operational Board	Aug 15	Apr 16	CQC S4, S5 E4 W4	RR 24-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) CSCs continuing to adopt the LiA approach to address key findings and encourage new ideas for improvements	Chiefs/GMs/HoN	Jul 15	
ii) Clinician pioneering LiA and forming part of the sponsor group to influence colleagues	UW/LR	Jul 15	
iiii) Quarterly staff pulse survey with key questions linked to the priority areas from 2014 national staff survey	LR	May 15	
iv) Specific medical engagement events set up to build relationships and partner in change programmes	UW/LR	Jul 15	

<table>
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AND RISK REGISTER</th></tr>
<tr><td>16-1516</td><td>Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to delivering change</td><td>• Leadership development programmes in place to support leaders at various levels.
• 360 and self-assessment completed at Executive level
• Trust wide leadership qualities and behaviours identified
• Clinical Directors leadership programme in place
• Performance appraisal process to assess behaviours and leadership performance in place.</td><td>• Utilisation of existing leadership development programmes
• 360 completed for executive team and included for medical revalidation. Roll our to all senior managers as part of appraisal process
• PHT representation on Thames Valley and Wessex Leadership Academy Board
• Leadership Academy funded programmes launched and locally developed bite sized training on specific skills gaps
• Performance management framework in place supporting talent development and succession planning
• Bespoke leadership development roll out to CSC and corporate senior teams using MindGym</td><td>12 (4x3)</td><td>9 (3X3)</td><td>6 (3x2)</td><td>i. Programmes and framework for leadership development in place but needs to be embedded to ensure compliance.
ii. Evidence of behavioural change and a culture shift in collective responsibility and holding to account</td><td>iii. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.
iv. Leaders setting clear direction and engaging the workforce in the vision of the organisational and how each role contributes to it</td><td>1. Director of Workforce and Organisational Development
2. Head of Organisational Development
3. Operational Board</td><td>Feb 16</td><td>Apr 16</td><td>CQC

S4, S5
W3</td><td>RR</td></tr>
<tr><th colspan="9">ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</th><th>By Whom</th><th>By When</th><th colspan="3">Date Completed</th></tr>
<tr><td colspan="9">i) Audit the quality of appraisals defining expected behaviours with personal development plans outlining development needs – all aligned to organisational priorities</td><td>LR</td><td>Aug 15</td><td colspan="3"></td></tr>
<tr><td colspan="9">ii)Increased utilisation of the national leadership academy resources from 2014 numbers</td><td>LR</td><td>Nov 15</td><td colspan="3"></td></tr>
<tr><td colspan="9">iii)Successfully secure graduate management trainee placements</td><td>LR</td><td>Sep 15</td><td colspan="3"></td></tr>
</table>

iv)Ensure robust talent development plans and succession planning is undertaken for critical posts	LR	Jul 15	
v)Create a performance management culture as measured by the NSS and workforce metrics	LR	Mar 16	
vi)All senior managers (band 8b+) to complete a 360 every 2 years as part of appraisal process	LR	Feb 16	

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17-1415	Current and future workforce demand is outstripping supply leading to: 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 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. 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 Lack of supply of	• 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	• 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 11 % 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)**	i) Temporary resource spend £20m for 2013/14 In December Temporary workforce spend reached £1.97m. Trust vacancies at March 201 were 211 FTE. ii) Reduction in Junior Doctors and difficulty in recruiting ongoing in many specialities. 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. iv) 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, Urology, Colorectal,	i) High levels of substantive vacancies in some CSCs – Medicine, Surgery & Cancer and MOPRs ii) Qualified N&M – 179 FTE Vacancies iii) Supply of newly qualified nursing workforce is insufficient for PHT required demand.	1. Director of Workforce and Organisational Development 2. Deputy Director of Human Resources 3. SMT	Jul 15	Apr 16	CQC S4, S5 E3	RR

	staff leads to lack of substantive recruitment which leads to potentially low staff morale and increased turnover of existing staff exacerbating the issue						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 WLIs
i)Temporary staffing remains at critical levels and there has been no reduction- 375 more offer contracts issued in 2014/15 compared to 2013/14. Substantive staff increased by ***	RK	Sept 14	Completed
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 Completed
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. Completed
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	
Iii/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	Jul 15	
v/vi/vii) Workforce aligned to elective/non elective pathway action plan in place – to be monitored through Transformation Board.	RK	Aug 15	
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
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 16	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**	• 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	**12 (4x3)**	**9 (3x3)**	**8 (4x2)**	i. 15/16 Financial Plan shows circa £16m deficit ii. Performance against key targets	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. Interim Director of Finance 2. Interim Deputy Director of Finance 3. Trust Board	Sep 15	Mar 16	CQC S4, S5	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Ii), iii), iv), v) Revised performance review process in place from May 2015 to monitor performance and drive change	Interim DoF	May 15	Ongoing
iii) System wide working party on emergency care pathway	Chief Executive	?	
v) Contract performance meetings with commissioners	Interim DoF	Jun 15	Ongoing
vi) Working Capital Group established May 2015	Interim DoF	May 15	Ongoing

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19-1516	**Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned deficit of £16m 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 • Pre-performance review meetings	• Financial plan income reflects detailed activity modelling (GooRoo3) and cost of delivery incorporated into cost base. • Budgets reflect rolling forecast with 14/15 full year effect run-rates • Monthly performance reviews with all CSCs • Weekly Financial overview at Operational Development Group • Formal Sign off of budgets and supporting Quality Impact Assessments • Visibility of financial information through Qlikview	12 (4x3)	16 (4x4)	9 (3x3)	i) Savings opportunities can be challenged by operational pressures e.g. additional workforce costs (often at premium rates).		1. Interim Director of Finance 2. Finance Committee 3. Transformation Committee	Jun 15	Mar 16	CQC S4, S5	RR 26-1415 27-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Formal sign off of budgets and monitoring performance via performance review meetings	Interim DoF	May15	
i) See risk 21 for action plan related to savings	Interim DoF/CSC Managers		

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20-1516	**The Trust does not achieve sufficient PbR income from commissioners to meet the income plan, or sufficient cash is not available within commissioners to pay activity based invoices.**	• Monthly contract monitoring reports • Monthly contract review meetings (CRM) • Forecast and capacity reviews corporately on working day 1 and during performance reviews (monthly) • CQUIN monitored through the TSO function • Contract issues unable to resolve escalated to Execs via ECRM	• 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 Dashboard	**12 (4x3)**	**12 (4x3)**	**12 (4x3)**		i. ED target consistently not being achieved. ii. Cancer & RTT targets require increased activity to achieve sustainability. iii. Discussions on-going with CCG's about re-investment of existing fines and penalties. Actions need to be completed for the Unscheduled Care Board for ED 4 Hr reinvestment. iv. CQUIN schemes not received from local CCGs requiring agreement by 31st May.	1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Development Group	Jun 15	Mar 16	CQC S4, S5	RR 8-1516 9-1415 13-1516 19-1516 20-1415 26-1415 27-1415

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

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21-1415	**2015/16 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 • Transformation Committee • 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)**	**9 (3x3)**	i. CSCs to be held to account in pursuing schemes through the monthly performance review process ii. Transformation program is still being fully identified		1. Interim Director of Finance 2. Finance Committee 4. Transformation Committee	Jun 15	Mar-16	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) ii): Performance reviews and Transformation Committee to complete testing of CSC savings schemes and identify any subsequent savings plan required	Interim DoF	Jun 15	
ii) ii): CSC performance meetings to be held monthly	Interim DoF	May 15	
i) All Savings Schemes to have been fully identified and plans in place for delivery	Interim DoF	Jun 15	

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22-1516	**Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital** • Current service can result in a complex and fragmented provision based on age and locality with gaps in inpatient psychiatry provision for adults of a working age • No SLA with Solent for Responsible Clinician (RC) provision results in gap in service and risk to compliance with the Mental Health Act requirements • OPMH service constrained by resources (Solent funding withdrawn) • Lack of consistent provision of mental health advice regarding young persons Impacts • Patient and staff safety • Organisational reputation	• Mental Health Team liaison presence in ED for patients who present having self-harmed or for whom ED medics consider a mental health assessment is required. • Mental health in acute setting on junior doctors rolling educational programme • Alcohol liaison service team MAU/ED • Mental Health operational Group up and running – led by Lead Liaison nurse • Mental Health Lead identified within DHMs reviewing completion of Section papers and follow up. • MH and LD committee reinstated • SLA with Southern Health to provide mental health administration function	• Complaints and incidents – monthly exception report and quarterly quality performance report. • Reports to MH & LD Committee • Reports to G&Q Committee	**12** **4x3**	**16** **4x4**	**12** **4x3**	i. Service specification for Trust to provide Mental Health support for inpatients to be agreed ii. No agreement between Southern and Solent to provide RC provision iii. Mental Health Policy in draft iv. Limited staff training programme	v. Lack of full compliance with Mental Health Act requirements	1. Medical Director 2. Head of Quality 3. MH & LD Committee	Jul 15	Mar 16	S4,E1, E3, E4, R1, R2, R3,

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE		By Whom	By When	Date Completed
i.	Meeting arranged with Commissioners 29th May 15 to review service specification. Further actions will come out of initial meeting	S.Holmes	May 15	
ii.	Will form part of overall service specification once agreed	S.Holmes /F.McNeight	Sept 15	
iii.	Policy to be finalised and ratified	F.McNeight	July 15	
iv.	Establish training programme	D.Knight / F.McNeight	July 15	
v.	Specific training required for Duty Hospital Managers arranged for May 15	F.McNeight	May 15	

Care Quality Commission – Key Lines of Enquiry

Safe

S1 What is the **track record** on safety?
S2 Are **lessons learned and improvements made** when things go wrong?
S3 Are there **reliable systems, processes and practices** in place to keep people safe and safeguarded from abuse?
S4 How are **risks to people who use services** assessed, and their safety monitored and maintained?
S5 How well are potential risks to the service **anticipated** and **planned** for in advance?

Effective

E1 Are people's needs assessed and care and treatment delivered in line with legislation, standards and **evidence-based guidance**?
E2 How are people's care and treatment **outcomes monitored** and how do they **compare** with other services?
E3 Do **staff** have the **skills, knowledge and experience** to deliver effective care and treatment?
E4 How well do **staff, teams and services work together** to deliver effective care and treatment?
E5 Do staff have all the **information they need** to deliver effective care and treatment to people who use services?
E6 Is people's **consent** to care and treatment always sought in line with legislation and guidance?

Caring

C1 Are people treated with kindness, **dignity**, **respect** and **compassion** while they receive care and treatment?
C2 Are people who use services and those close to them **involved as partners** in their care?
C3 Do people who use services and those close to them receive the support they need to **cope emotionally** with their care, treatment or condition?

Responsive

R1 Are **services planned** and delivered to meet the needs of people?
R2 Do services take account of the **needs of different people**, including those in vulnerable circumstances?
R3 Can people access care and treatment in a **timely** way?
R4 How are people's **concerns and complaints** listened and responded to and used to improve the quality of care?

Well Led

W1 Is there a clear **vision** and a credible **strategy** to deliver good quality?
W2 Does the **governance** framework ensure that **responsibilities** are clear and that **quality, performance and risks** are understood and managed?
W3 How does the **leadership** and **culture** reflect the vision and values, encourage openness and transparency and promote good quality care?
W4 How are **people** who use the service, the **public** and **staff engaged** and **involved?**
W5 How are services **continuously improved** and **sustainability** ensured?

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						