TRUST BOARD- PUBLIC OCTOBER 2015

Agenda Item Number: 190/15
Enclosure Number: (6)

Subject:	Board Assurance Framework (BAF)
Prepared by: **Sponsored by:** **Presented by:**	Annie Green – Acting Head of Risk Management 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
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 November 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	S4,S5,E1,E2,E3,R1,R3,W1,W2,W5

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

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: October 2015

Purpose:

To provide the Trust Board with a monthly update on the BAF as at 16 October 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.

19-1516◄►(Red 20): Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned surplus on income and expenditure

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..

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

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.

New Risks

Nil

Risks with Increased Score

Nil

Risks with Decreased Score

Nil

Risks to be Removed

Nil.

Target Date Changes

Nil

Of Note

No update received for:

13-1516

Prepared by: Annie Green – Acting Head of Risk Management

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 - October 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)				2 Quality and Safety Standards ◄ ► 6 Cancer Wait Targets ◄ ► 13 Growth in R&D ◄ ►	
Possible (3)			3 Patient Experience ◄ ► 14 Threat to specialist services ◄ ► 15 Staff engagement ◄ ► 16 Leader development ◄ ► 18 Foundation Trust status ◄ ►	7 Data Quality ◄ ► 8 Equivalent workforce across seven days ◄ ► 9 IT Strategy ◄ ► 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 ◄ ► 21 Delivery of savings ◄ ► 22 Mental Health Service Provision ◄ ►	
Highly Likely (5)				4 Failure to achieve Emergency Department Quality Standards ◄ ► 19 Failure of budgetary control ◄ ►	

ASSURANCE FRAMEWORK 2015/16 PROGRESS SUMMARY

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 on-going compliance with all CQC standards and implement the Quality Improvement Plan		All	6	6	9	9	12	12	12	12	12	12			Nov 15	6 Mar 16
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	8	8	8	8	8			Nov 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	9	9	9	9	9			Nov 15	6 Apr 16
1,3,4,5	4-1415	MP	OB	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	20	20	20	20	20			Nov 15	12 Sep 15
1,3, 5	5-1516	MD	OB	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	16	16	16	16	16			Dec 15	8 Jun 16
1,3, 5	6-1516	NM	OB	Failure to achieve cancer wait targets		S4, S5 R1	12	12	8	8	8	8	8	8	8	8			Dec 15	8 Apr 16
1, 5	7-1516	PM	DQSG	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	12	12	12	12	12			Dec 15	8 Jun 16
1,3	8-1415	RK/CY	OB	Lack of equivalent workforce across seven days of the week		S4, S5	12	12	12	12	12	12	12	12	12	12			Dec 15	8 Apr 16
1,3, 5	9-1516	CT	ITSC	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	12	12	12	12	12			Dec 15	4 Apr 16
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	12	12	12	12	12			Dec 15	8 Oct 15
2,3,5	13-1415	AC/KG	OB	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network		S4, S5	6	6	6	6	6	6	6	8	8				Oct 15	3 Review Apr 16
1,3,5	14-1415	SH	OB	Threat to specialist services due to centralisation agenda		S4, S5	6	6	6	6	6	6	9	9	9	9			Dec 15	6 Review Progress Dec 15

1,3,4	15-1516	RK	OB	Insufficient engagement of workforce		S4, S5 E4 W4	12	12	12	12	9	9	9	9	9	9			Nov 15	6 Apr 16
1,3,4	16-1516	RK	OB	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	9	9	9	9	9			Nov 15	6 Apr 16
1,3,4,5	17-1415	RK	OB	Current and future workforce demand is outstripping supply		S4, S5 E3	16	16	16	16	16	16	16	16	16	16			Dec 15	12 Apr 16
3,5	18-1415	TB	TB	Inability to achieve Foundation Trust status within the agreed timetable		S4, S5	16	16	16	16	9	9	9	**TOLERATE**					Dec 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 £9.7m (or better) on income and expenditure.- as required by the TDA		S4, S5	16	16	16	16	16	16	16	16	20	20			Nov 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	12	12	12	12	12			Nov 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	16	16	16	16	16			Nov 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		S4,E1 E3,E4 R1,R2 R3					16	16	16	16	16	16			Nov 15	12 Mar 16

Ref Date opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE On target Minor Obstacle to achieving target Inability to achieve predicted target	TARGET DATE (for mitigation of risk)	LINK TO CQC KLOEs AND TRUST RISK REGISTER	
1-1516 Apr 15	**Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement plan**	• CSC and Trust risk registers • CQC Intelligent Monitoring Report indicators – process of review in place of data accuracy prior to publication • CSC Executive Performance Reviews monitoring quality and safety of services. • Quality Improvement Plan at Board, CSC, Corporate and Operational level to address compliance, 'must do' and 'should do' actions in place	• Quarterly compliance to TB and key committees + monthly exception reporting of key quality indicators (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) • CQC inspection February 2015, rated as 'outstanding' for caring and 'good' for effective. Critical care core service rated as overall 'outstanding and maternity and outpatients core services rated as 'good'. • Quality Care Reviews commenced in August 2015.	**12 (4X3)**	**12 (3X4)**	**6 (3X2)**	i. Identified gaps from CQC report include wide variation in quality and safety of services ii. CSC quality improvement plans (to include CQC actions) developed – to be implemented	iii. Self assessment of compliance against the CQC Domains. iv. Key areas of risk relate to unscheduled care (BAF reference: 4-1415 v. CQC inspection report raised concerns regarding ability to comply with regulations as a result of issues within ED and the Unscheduled Care Pathway and surgical core service, vi. CQC inspection February 2015, Trust overall rated as 'requires improvement'.	1. Director of Nursing 2. Head of Governance and Quality 3. Governance & Quality Committee (G&Q)	Nov 15	Mar 16	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 CSC Quality Improvement plans to be developed and commence implementation	TS CSC Management Teams	Complete July 2015	Process reviewed. To be aligned to the CSC peer review process to embed CQC standards as 'business as usual' rather than a separate assurance process. To commence September 2015. Quality Care Reviews established.

			CSC Improvement Plans developed and monitored through the Executive Performance Reviews.
ii)/ iv)/vi)/vii Quality Improvement Plan monitored and implemented to deadlines - Monitoring through Trust Operational Board and Governance and Quality Committee, outcomes reported to the Trust Board.	TS/FMc	March 2016	Improvement plan developed. Good progress being made with closure of actions. On target for delivery.
i)/ii) Review CQC Intelligent Monitoring Report upon publication	TS/FMc	November 2014	Complete and ongoing. July 2014 – Band 6 December 2014 – Band 5 May 2015 – no banding as recently inspected.
vi)/vii) As per actions associated with BAF reference 4-1415 and actions within the Corporate Quality Improvement plan (ii and iv above)			

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
2-1516 Apr 15	**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 • Quality Impact Assessments of CIP plans and transformation schemes • Clinical Effectiveness Steering Group • CSC Governance meetings • Specialty M&M meetings • Electronic	• Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Trust Board	**8 (4x2)**	**8 (4x2)**	**8 (4x2)**		i. Deterioration in majority of FFT elements	1. Director of Nursing 2. Associate Director of Quality & Governance 3. G&Q	Nov 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

		Mortality Review tool • 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 • Quality Heatmap											

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	Completed
i. Link to FFT risk 03-1516	S Balchin	Oct 15	

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
3-1516 Apr 15	**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 • Positive patient survey results for cancer services and satisfactory for ED. • Maintained reduction in number of complaints • Response rates increased to 48%% of inpatients, 22% of Emergency Department attender but ED rates very variable.. % of patients who would recommend the Trust 96%, not recommend 1.5% • New Complaints and Experience Committee chaired by non executive to support greater organisational learning (July 15) • Patient experience priorities developed with each CSC using feedback • Draft Patient Engagement Strategy which aims to improve feedback methods and opportunities.	**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. National in-patient survey reported satisfactory experience overall but improvements required in some elements. iii. CSC Quality improvement plans do not all include reference to FFT and/or surveys. iv. Lack of on going intelligence for in-patient survey v. Variable FFT response rate from ED.	1. Director of Nursing 2. Head of Patient Experience 3. G & Q	Nov 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	SB	Jul 2015	June 2015
i)/ii)/iv) CQC report will be reviewed and action plan agreed and monitored by PESG	SB	Jun 2015	June2015
i)/iv)/vi) CSC s to review PE elements of QI plans and include actions required and monitoring processes.	CSCs	Jul 2015	June 2015
iv)/v)/vi) Develop and implement local survey with target response rates , agree, implement and monitor via PESG	CD	May 2015	NB Replaced with action below
iv) The new system enabling analysis of FFT comments in real time is used to assess current status against in patient survey questions.	CD/SB	July 2015	July 2015
iv) A detailed thematic analysis of all sources of patient experience feedback is to be undertaken	CD	October 2015	

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										On target			
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4-1415 Apr 14	**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 • PHT Unscheduled Care Quality Improvement Plan ratified by UCB and PHT Trust Board Phase II with implementation timetable • 12 Hour escalation process in place (standard: no patient to remain in ED for >12 hours)	• Reviewed at Operations Board Group and monthly by TDA • Trust Board • Plan monitored weekly by Urgent Care Quality Improvement Group and chaired by CEO. • All patient arrival and departure times monitored by ED Coordinator and DHM • Operational Board • Transformation Board	**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. Sustained high number of medically fit patients remaining in acute beds	v. Performance against 4hour wait target of 95% currently at 82.37% YTD	1 Chief Operating Officer 2. Director of Operations 3. Operational Board	Nov 15	Dec 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 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
i)/ii/iv)Internal Professional Standards to be ratified at Operational Board	AB	May 15	Completed
i)/iv)Frailty Intervention Team (FIT) commenced replacing OPAS	ED	June	Business care for approval end October 2015
i)/iv)Ambulatory Emergency Care moved to dedicated ring fenced area	ED	June	Completed
i)/ii)AUM Orange 22 beds re introduced to assessment bed stock allowing post taking to move from ED and off 4 hr clock	ED	June	Completed
ii)iv)Medical wards to review criteria for admission increasing availability of bed stock to ED/AMU	ED	June	Completed
i)ii)iii)iv)v) Mapping of frailty pathway commenced to agree WHE frailty strategy	DH	July	Underway
i)v) Enhanced role of ED Nurse in Charge to reduce 4o breaches	GMcD	July	Completed
i)ii)iii)iv)v) Auditing of internal professional standards	GMcD	July	On-going
i)ii)iii)iv)v) WHE KPIs to monitor performance against Phase II WHE plan	GMcD	July	Agreed – phase ii plan well underway

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5-1516 Apr 15	**The Trust fails to achieve referral to treatment (RTT) access targets in two specialties:** ▪ **General Surgery** ▪ **Orthopaedics** **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 ii. Required rolling programme of theatre upgrade reducing capacity v. Diagnostic target at risk on monthly basis within Gastro speciality due to capacity gap v. Colorectal service vi. Pressures of cancer demand ii. Increase in backlog of patients due to cancellations	ii. Capacity plans dependent on recruitment in MSK and Surgery x. Theatre utilisation below level required to deliver GUROO 3 x. OP utilisation/ productivity improvements required xi. Additional theatre capacity required supported by investment and recruitment	1. Chief Operating Officer 2. Deputy Chief Operating Officer 3. Operational Board	Dec 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	On-going
ii) realignment of up to 10 beds across gynaecology and PPU to support required capacity for surgery and cancer CSC delivery.	MD	Jul 15	Completed
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	Ongoing – investment decisions to be confirmed. Locum appointment Oct 2015
V See Trust Risk Register for specific action			
Vi Recruit to vacancies	UB/NM	Oct 15	Superceded by strategic changes in spinal service. Awaiting outcome of discussions with SUHT. Colorectal service recruitment under review
Vii Reviewed on weekly basis with gaps escalated to CoS and GMs	DM/MD	May 15	On-going
Viii/x Transformation project in development	MM/SJ	Sep 15	On-going
Viii/ix/xi Weekend operating sessions/programme in place. Consultation commenced to support 6 day working in theatres	MS/DM	Dec 15	
i Admitted and non admitted standards abolished but still monitored internally. Validation exercise required to support position.	CSCs/JL	Nov 15	Validation 1st phase completed in Gastro with positive impact. Further phase commenced.

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6-1516 Apr 15	**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 and now including trajectories for delivery of at risk site e.g. urology • Increased national focus with weekly reporting of 62 day FDT performance • Weekly review between D of Ops Scheduled Care and TDA performance director	**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. Reduced access to theatre capacity due to rewiring works vi. Conflicting demand in theatres from tumour sites for robotic theatre capacity vii. Attendance at Cancer Steering Group variable and moved to quarterly viii. Effective escalation not always adhered to. ix. Resignation of urology cancer consultant and risks associated with successful recruitment	i. 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. Operational Board	Dec 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
iii) Management of patient choice breaches in Breast symptomatic 2WW – review and secure regular capacity required to reduce risk of breach	AT	Jul 15	Completed
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	Completed on-going live document
v) Development of cancer recovery plan and trajectories of delivery to be presented to Trust Board, Commissioners and TDA -	NM	Jul 15	Completed
vi) Short term solution for breast 2ww symptomatic capacity developed and implemented. Medium and long term plan to be formalised	AT/JH	Oct 15	Completed
vii) Detailed improvement plan and trajectories to be developed for urology, to present to Trust Board and TDA	AT/NM	Sept 15	Completed
viii) Assessment of 8 key cancer priorities to be submitted to TDA, with input from CCG	MD	Sept 15	Completed
ix) Overall cancer improvement plan to also incorporate all tumour site risks and actions to resolve	MD/CSCs	Sept 15	On-going live document
x) Cancer Access Policy to be revised to incorporate operational policy as per 8 key priorities	MD/JL	Oct 15	
xi) Cancer management structure including MDT team to be reviewed and proposal to be presented to Board	LH	Nov 15	
xii) Reinstatement of monthly cancer steering group to include Director of Operations	MD/SH	Oct 15	Completed
Xiii) CCG to attend monthly reviews of cancer improvement plan to improve working relationships and support	MD/LH	Sept 15	Ongoing
xiv) Reinstatement of weekly review of full PTL in Waiting List Assurance Meeting to improve traction and sight performance	MD/JL	Sept 15	Ongoing
ix) Urology Consultant post currently advertised. CSC to produce potential rationalisation proposal for Board should recruitment be unsuccessful	NM/CY	Nov 15	

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7-1516 Jun 15	**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 Reporting Dashboard • All national returns signed-off by operational services & Head of Performance • 2 Access Data Quality Managers now in post	• Data Quality Steering Group meets monthly and all CSCs and Information Asset Managers report on their compliance with local and national standards annually. • Exceptional issues will be fed into SMT, including an annual DQ Report to Trust Board • Data Quality Reporting Dashboard provides a local replica of the national SUS Data Quality Dashboard at CSC and Specialty level.	**12 (4X3)**	**12 (4x3)**	**8 (4X2)**	i. Significance of data quality is not recognised Trust wide ii. Lack of Standard Operating Procedures for internal report production	iii. Further development of data quality reporting required	1. Chief Operating Officer 2. Head of Information Services 3. Data Quality Steering Group	Dec 15	Jun 16	CQC S4, S5	RR 16-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust, ensuring engagement in Data Quality Steering Group from the appropriate level to effect organisational change.	MK / PM	Oct 15	
ii) All new job descriptions to have personal responsibility for ensuring the quality of data included	RK	Nov 13	Ongoing
iii) Further development of the Data Quality Reporting Dashboard (referencing Information Governance toolkit where appropriate)	MK	Jun 16	Data Quality Dashboard in place amongst the new suite of DQ reporting on Information Services Intranet Page
iv) Standard Operating Procedures in place for routine internal reports, covering data quality checks and sign-off	MK	Jun 16	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 Apr 14	**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 • Gradual increase in Consultant presence out of hours across the Trust • Mortality review toolkit • Scheduled care is also provided at weekends • All staff groups contractually have to work weekends if required and 7 day working has been implemented in most parts of the Trust – medical staff are the only group who cannot be compelled to work 7 days	• Review of hospital mortality with emphasis on weekend mortality with TDA • Weekend HSMR shows no significant difference from rates recorded during the week • Mortality review toolkit	**12 (4X3)**	**12 (4x3)**	**8 (4X2)**	i. Delays in progressing patient pathways ii. Delay in investigations	iii. IPR indicates lengths of stay could be reduced	1. Medical Director 2. Chief of Service 3. Operational Board	Dec 15	Apr 16	CQC S4, S5	RR 18-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Increase consultant presence at weekends	SH	Nov 13	Ongoing
• Business planning 2014/15	SH/ CSCs	Sep 14	Ongoing

i)/iii) Business plan to be produced for consultation	SH/CSCs	Sep 14	Complete and under consideration
i/iv) Development of unscheduled care medical model	SH/ED	Aug 15	Complete but expensive; further review required
vi) Introduction of new junior and consultant medical contract	SH/CY/RK	Apr 16	Significant change in medical terms and conditions of employment expected which will result in new hours of working.

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9-1415 Sep 14	**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 approved by Trust Board • Trust Board approved production of Outline Business Case Sept 2015	**8 4x2**	**12 4x3**	**4 4x1**	i. Lack of funding for eHospital Programme. 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 Strategy 2. Head of IT 3. IT Strategy Committee	Jan 16	Apr 16	CQC S4, S5	RR 6-1415 22-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
1) Gain Trust Board approval to progress with production of OBC & OBS	Head of IT / Dir.of Strategy	Sep 15	24.10.2015
2) Establish eHospital Programme Team sufficient to successfully complete production of Outline Business Case (OBC) & Output-Based Specification (OBS) from within existing Trust resources			
a) Agree eHospital Programme Governance arrangements	Head of IT / Dir.of Strategy	Oct 15	
b) Produce eHospital Programme Resources Plan for OBC/OBS Stage & identify external resources required	Head of IT	Oct 15	

c) Produce eHospital Programme Resources role descriptions	Head of IT	Oct 15	
d) Agree release of internal resources, including clinical, to support OBC/OBS production with executive directors & chiefs of service	Dir.of Strategy	Nov 15	
e) Identify all eHospital Programme Team members & work stream leads and agree roles & time available to Programme with them and their line managers	Head of IT / Dir.of Strategy	Nov 15	
3) Revise Strategic Outline Case (SOC) to reflect revised Trust approach			
a) Gain formal approval from Trust Board for final SOC document	Head of IT / Dir.of Strategy		
b) Gain formal approval from Trust Development Agency for final SOC	Head of IT / Dir.of Strategy		
4) Involve eHospital Programme Team in Producing Project Plan for OBC/OBS Stage			
a) Produce work stream plans	Work Stream Leads	Dec 15	
b) Produce Programme Plan for OBC/OBS Stage	Head of IT	Dec 15	

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11-1516 Apr 15	**Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed. This results in:** • **Poor patient experience of prolonged waiting and increased risk of patient de-compensation** • **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** • **Impact on elective programme** • **Increased cost of care due to prolonged LOS and ward moves**	• Daily IDB meetings chaired by Director of Operations - 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 • Weekly LOS meetings for all CSCs with Chief Operating Officer • Development of	• 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 4 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 • Sitrep reporting • Length of stay reports • Next steps agreed and shared with partners • Working with the	**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. Unscheduled transformation v. System wide transformation vi. Recruitment issues in Adult Social Care vii. Challenges sourcing packages of care in Hmapshire viii. Increased Nursing Home refusals	ix. CSC's failure to complete 123 Escalation updates x. Not performing against outlier trajectory xi. Discharge numbers fluctuate against target xii. Operational controls xiii. Newton Database (PTL) failing and frequently fails.	1. Chief Operating Officer 2. Director of Operations for Unscheduled Care 3. Urgent Care Improvement Group	Dec 15	Dec 15	CQC S4, S5	RR 9-1415 13-1415 15-1415 17-1415

		QA@H social care business • Discharge targets	system to develop a whole system frailty service										

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Increase focus on medically fit patients	CSCs	Nov 14	Complete and on-going
i) 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
ii) 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	Aug 15	
Ix i. Await new system to be agreed - IT working with DC Matron to agree new IT system to replace Newton		TBC	
Reviewed IDM meeting with partners and CSC clinical teams	SE	Jul 15	Complete and on-going
PHT Participation in the Systems transfer group hosted by the CCG	GMac	Aug 15	Ongoing

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13-1415 Apr 14	**The Trust fails to secure growth in Research and Innovation**	• Research & Innovation strategy launched May 2015 by Director of Research & Innovation • Medical Director participating in AHSN discussions with UHS • R&D income monitored by R&I and CEO • CEO now Executive sponsor • Director and Deputy Director to have oversight of the CTIMP studies and lead RQC following MHRA inspection • No further PHT sponsored CTIMPS until we have assurance to continue • Research & Quality Manager now been cleared to advertise • Contracts management outsourced. • Data management outsourced.	• R&D income year on year increase • National NIHR and Guardian League tables shows good competitive performance by PHT • 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 • Quarterly performance and finance reports submitted to Board • Research activity monthly reports to CSC Boards • R&I strategy monitored quarterly by R&I strategy group	**10 (5x2)**	**8 (4x2)**	**3 (3x1)**	i. Low levels of portfolio recruitment recorded in 2014 ii. Lack of adequate monitoring identified by March 2015 MHRA inspection ii. Lack of research facilitator capacity to support CTIMPs in set-up (MHRA risk)	Iv Lack of adequate monitoring identified by March 2015 MHRA inspection	1. CEO 2. Director & Deputy Director of Research & Innovation 3. Trust Board	Oct 15	Apr 16	CQC S4, S5	RR 26-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) LIA event for recruitment to be held with focus on research recruitment	GW	Oct 14	Completed
i) Embed actions and ideas from LiA event to increase recruitment	GW/CSCs	Mar 16	

ii) CAPA plan implementation	HM	Mar 16	
iii) Identifying funding for RSO (R&I position) to release capacity of senior facilitators to support CTIMPs.	HM	Oct15	
ii)/iii)iv) Recruit to vacant Research & Quality Manager post	GW	Oct 15	

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14-1415 **Apr 14**	**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)**	**9 (3x3)**	**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. NHS England have rejected two hub model and recommended another Vascular Service review	iii Lack of approved vascular service iv Service review recommends centralisation to UHS.	1 Medical Director 2. Medical Director 3. Operational Board	Oct 15	Review progress Oct 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 Apr 15	**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 • Staff Friends and family quarterly pulse survey in 2014/15 Q4 demonstrates PHT as top in Wessex for recommendation as a place to work	**12 (4X3)**	**9 (3X3)**	**6 (3x2)**	i. Lack of engagement from clinical staff in delivering the change agenda ii. Unbalanced focus on operational delivery verse strategic planning	iii. Trust is positioned as average for overall staff engagement when compared to other Trusts within the full 2014 staff opinion survey. iv. A 1% reduction reported in staff reporting incidents, errors or near misses in the last month v. 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	Nov 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	Completed but on-going to embed.
ii) Clinician pioneering LiA and forming part of the sponsor group to influence colleagues	UW/LR	Jul 15	Completed
iiii) Quarterly staff pulse survey with key questions linked to the priority areas from 2014 national staff survey	LR	May 15	Completed
iv) Specific medical engagement events set up to build relationships and partner in change programmes	UW/LR	Jul 15	Completed
OD interventions to be identified which enable delivery of CSCs 'well-led' quality improvement plan following CQC report	CSCs/LW	Dec 15	

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16-1516 Apr 15	**Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to delivering change**	• Leadership development programmes in place to support leaders at various levels. • 360 and self-assessment completed at Executive level • Trust wide leadership qualities and behaviours identified • Clinical Directors leadership programme in place • Performance appraisal process to assess behaviours and leadership performance in place.	• 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	**12 (4x3)**	**9 (3X3)**	**6 (3x2)**	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 iii. Optional' approach to leadership development influenced by operational demands	iv. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered. v. Leaders setting clear direction and engaging the workforce in the vision of the organisational and how each role contributes to it	1. Director of Workforce and Organisational Development 2. Head of Organisational Development 3. Operational Board	Nov 15	Apr 16	CQC S4, S5 W3	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Audit the quality of appraisals defining expected behaviours with personal development plans outlining development needs – all aligned to organisational priorities	LR	Aug 15	
ii)Increased utilisation of the national leadership academy resources from 2014 numbers	LR	Nov 15	
iii)Successfully secure graduate management trainee placements	LR	Sep 15	Completed
iv)Ensure robust talent development plans and succession planning is undertaken for critical posts	CSCs	Nov 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	
Clear leadership development plan in place at a trust level aligned to critical skills gaps identified and cascaded to teams	LW	Feb 16	

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17-1415 Apr 14	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	• 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 • On-going 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 workforce spend remains high and is not sustainable. This is recognised as a national problem and the DH/Monitor are increasingly mandating actions to which the Trust is compliant. 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. v) Temporary workforce is used to fill local and national shortages in some key skill areas which may result in some critical skill gaps in clinical rotas, specifically nursing, junior doctors and some other specialist areas	v) High levels of substantive vacancies in some CSCs – Medicine, Surgery & Cancer and MOPRs vi) Qualified N&M – 179 FTE Vacancies vii) 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. Operational Board	Dec 15	Apr 16	CQC S4, S5 E3	RR
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									**By Whom**	**By**	**Date Completed**		

		When	
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)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 ongoing.
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	
v/vi/vii)Working with CSCs to develop thorough workforce plans which will create recruitment plans	LW	Jul 16	
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	
vi) All DH/TDA mandates have or are being implemented by the Trust which should reduce the cost of temporary staffing.	RK	Nov 15	

Ref Date Opened	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			
18-1415 Apr 14	**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 **TOLERATE**	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	Dec 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

Ref Date Opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE On target Minor Obstacle to achieving target Inability to achieve predicted target	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
19-1516 Apr 15	**Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned deficit of £9.7m (or better) on income and expenditure.- as required by the TDA**	• 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. • Monthly performance reviews with all CSCs • Visibility of financial information through Qlikview • Budgets set for 2015/16 • Financial overview at E.M.T, Finance Committee and Operational Board • Formal Sign off of CIPs and supporting Quality Impact Assessments • Greater CSC scrutiny at Finance Committee – re action plans and assurance of recovery of position • ECF Process now in place (Non Pay Controls	**16 (4x4)**	**20 (4x5)**	**12 (4x3)**	i) Savings opportunities can be challenged by operational pressures e.g. additional workforce costs (often at premium rates). ii) Remaining CSC cost pressure iii) Insufficient bed capacity in key specialties iv) ED unfunded queue management	i) Income position started one month in arrears ii) CIP programme under achieving iii) Adverse staff cost variances	1. Interim Director of Finance 2. Finance Committee 3. Transformation Board	Nov 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	May 15
ii-vi) See risk 21 for action plan related to savings	Interim DoF/CSC Managers		

Ref Date Opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE On target Minor Obstacle to achieving target Inability to achieve predicted target	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
20-1516 Apr 15	**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 ECR • Approval to recruit to Costing Team posts given by Back Office Work Stream Group (August 2015)	• 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 • Recruitment to costing team has completed with start date expected of mid November	**12 (4x3)**	**12 (4x3)**	**12 (4x3)**	i. Capacity will be the biggest issue in achieving predicted levels of income	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 and remain unagreed v. Reference Costs Audit did not provide assurance over costing process (and thereby the income the Trust receives)	1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Board	Nov 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	Aug 15	
ii)/iii) Maintain intensive CSC performance meetings which cover contract performance review – performance assurance framework agreed and implemented	EMT	Ongoing	Ongoing
iv) Continue negotiations with commissioners over the full re-investment of fines and penalties	ET/IH	Ongoing	Ongoing
v) Assurance given to Audit Committee that the Costing Team is now fully staffed allowing complete focus on costing and income to occur. Recent resignation of one member of the team means a case will be going to the back office work stream group to recruit – approval gained but need in post	RE/IH	Nov 15	

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										Inability to achieve predicted target			
21-1516 Apr 15	**2015/16 Savings and recovery plans are not identified & delivered, with subsequent impact on Trust financial position**	• Review of savings performance at Finance Committee and Operational Board • Monthly CSC performance meetings • Tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements • CSCs submitted initial savings plans • Transformation Board • Risks and opportunities tracked monthly • TSO function in place	• 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 • Transformation Board bi weekly review	**16 (4x3)**	**16 (4x4)**	**12 (4x3)**	i. CIP programme not achieving profiled target ii. Some target areas still to be identified - (circa £3.0m CIP remains unidentified) iii. TDA letter 23rd July setting a "stretch" position of £9,724k. An initial action plan has been developed to achieve this but full detail has yet to be confirmed		1. Interim Director of Finance 2. Finance Committee 4. Transformation Board	Nov 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	May 15 – review meetings are scheduled for the year and ongoing
i) All Savings Schemes to have been fully identified and plans in place for delivery	Interim DoF	Jul 15	See iii)
ii) Finance and the TSO are developing a linked tracking system (to monitor financial and non-financial performance)	Head of Finance Business Partners/TSO	Aug-15	Completed
iii) Board to agree further details of recovery plan necessary to achieve the "stretch" target of £9.7m deficit set by the TDA	DoF/Board	Nov 15	

Ref Date Opened	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
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22-1516 Jun 15	**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 – to commence 01 August 15 • Mental Health Act policy	• 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. Limited staff training programme	iv. Lack of full compliance with Mental Health Act requirements	1. Medical Director 2. Head of Quality 3. MH & LD Committee	Nov 15	Mar 16	S4,E1, E3, E4, R1, R2, R3,
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									**By Whom**	**By**	**Date Completed**	

			When	
i.	Meeting arranged with Commissioners 29th May 15 to review service specification. Further actions will come out of initial meeting	S.Holmes	May 15	Meeting held and draft service specification circulated. The Trust has sent back comments. Further meeting to be arranged
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	Completed
iv.	Establish training programme	D.Knight / F.McNeight	July 15	Training established. Basic awareness training sessions commissioned through Southern Health. Further training funded through charitable funds to commence delivered by Solent MH Lead
v.	Specific training required for Duty Hospital Managers arranged for May 15	F.McNeight	May 15	Completed – additional training also received from Southern Health aligned to new SLA and section paper administration

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						