

<b>Subject:</b>	Board Assurance Framework (BAF)
<b>Prepared by:</b> <b>Sponsored by:</b> <b>Presented by:</b>	Annie Green – Acting Head of Risk Management Cathy Stone – Director of Nursing Cathy Stone – Director of Nursing
<b>Purpose of paper</b>  <i>Why is this paper going to the Trust Board?</i>	To provide the Trust Board with a monthly update of the Board Assurance Framework.
<b>Key points for Trust Board members</b>  <i>Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals</i>	Trust Board are asked to note <ul style="list-style-type: none"> <li>• Risks greater than 15 on the BAF</li> <li>• Increase of risk 19-1516</li> </ul>
<b>Options and decisions required</b>  <i>Clearly identify options that are to be considered and any decisions required</i>	<ul style="list-style-type: none"> <li>• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks.</li> <li>• Determine any further assurance required on any aspect of the Framework</li> </ul>
<b>Next steps / future actions:</b>  <i>Clearly identify what will follow the Trust Board's discussion</i>	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board in October 2015.
<b>Consideration of legal issues (including Equality Impact Assessment)?</b>	None
<b>Consideration of Public and Patient Involvement and Communications Implications?</b>	None

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

<b>CQC Reference</b>	S4,S5,E1,E2,E3,R1,R3,W1,W2,W5
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<b>Committees/Meetings at which paper has been approved:</b>	<b>Date</b>
N/A	N/A

# ASSURANCE FRAMEWORK REPORT

TRUST BOARD: September 2015

## Purpose:

To provide the Trust Board with a monthly update on the BAF as at 11 September 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

**19-1415 ▲ (Red 16 to Red 20):** 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) - currently not on target

### Risks with Decreased Score

Nil

### Risks to be Removed

Nil.

### Target Date Changes

**08-1516** Lack of equivalent workforce across seven days of the week – awaiting agreed changes to medical terms and conditions of employment

### Of Note

**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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## Trust Risk Profile - September 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 REFERENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
							JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1, 3, 5	1-1415	TS	G&Q	Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement Plan		All	6	6	9	9	12	12	12	12				Oct 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				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				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					Sep 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				Oct 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				Oct 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				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				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				Oct 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				Oct 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			Oct 15	6 Review Progress Oct 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				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				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					Sep 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				Oct 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				Oct 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				Oct 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				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	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 Apr 15	Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement plan	<ul style="list-style-type: none"> <li>CSC and Trust risk registers</li> <li>CQC Intelligent Monitoring Report indicators – process of review in place of data accuracy prior to publication</li> <li>CSC Executive Performance Reviews monitoring quality and safety of services.</li> <li>Quality Improvement Plan at Board, CSC, Corporate and Operational level to address compliance, 'must do' and 'should do' actions in place</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly compliance to TB and key committees + monthly exception reporting of key quality indicators (action plans in place for any identified compliance issues)</li> <li>Clinical dashboards / quality metrics</li> <li>CSC governance reports</li> <li>Mock CSC assessments</li> <li>Internal audit assurance</li> <li>CQC Intelligent Monitoring Report (Dec 2014) has placed the Trust in Band 5 (1 being poor, 6 being good)</li> <li>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'.</li> <li>Quality Care Reviews commenced in August 2015.</li> </ul>	12 (4X3)	12 (3X4)	6 (3X2)	<ul style="list-style-type: none"> <li>i. To introduce CSC peer review visits in September 2015 to incorporate CQC standards.</li> <li>ii. Identified gaps from CQC report include wide variation in quality and safety of services</li> <li>iii. CSC quality improvement plans (to include CQC actions) under development.</li> </ul>	<ul style="list-style-type: none"> <li>iv. Self assessment of compliance against the CQC Domains.</li> <li>v. Key areas of risk relate to unscheduled care (BAF reference: 4-1415</li> <li>vi. 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,</li> <li>vii. CQC inspection February 2015, Trust overall rated as 'requires improvement'.</li> </ul>	1. Director of Nursing 2. Acting Head of Governance 3. Governance & Quality Committee (G&Q)	Oct 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
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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.		



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	Pending publication of CQC report.
i)/ii) Review CQC Intelligent Monitoring Report upon publication	TS/FMc	November 2014	Complete and ongoing. July 2014 – Band 6 December 2014 – Band 5
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	<p><b>Failure to comply with internally and externally set standards on quality and safety</b></p> <p><b>Implications:</b></p> <ul style="list-style-type: none"> <li>• Avoidable harm to patients</li> <li>• Reputational damage</li> <li>• Failure to satisfy quality contract</li> <li>• Fines associated with some quality metrics</li> <li>• Loss of CQUIN income</li> </ul>	<ul style="list-style-type: none"> <li>• Governance Framework and monitoring – Quality Improvement Framework</li> <li>• Quality Performance measures</li> <li>• Monitor Compliance Framework</li> <li>• CSC performance reviews</li> <li>• Kitbag performance metrics</li> <li>• Clinical Audit programme</li> <li>• Gov &amp; Quality Committee</li> <li>• Patient safety Steering Group and associated Safety work streams</li> <li>• Monthly and Quarterly Board reporting</li> <li>• Quality Impact Assessments of CIP plans and transformation schemes</li> <li>• Clinical Effectiveness Steering Group</li> <li>• CSC Governance meetings</li> <li>• Specialty M&amp;M meetings</li> <li>• Electronic Mortality Review tool</li> <li>• Front door triage of patients</li> </ul>	<ul style="list-style-type: none"> <li>• Quality heatmap and exception reports to Trust Board monthly</li> <li>• Quality report quarterly to Trust Board</li> </ul>	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	RR

		queuing in ED to allow differentiation and prioritisation according to severity of illness <ul style="list-style-type: none"> <li>VitalPac Dementia screening reporting anomalies being managed through manual process</li> <li><a href="#">Quality Heatmap</a></li> </ul>									
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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	<p><b>Failure to achieve internal and external standards around patient experience as measured through Friends and Family test and National Patient Surveys</b></p> <p><b>Implications:</b></p> <ul style="list-style-type: none"> <li>Poor patient experience</li> <li>Reputational damage</li> <li>Loss of income if fail to achieve CQUIN associated with friends and Family Test</li> </ul>	<ul style="list-style-type: none"> <li>CSC targets set to achieve friends and family test returns with weekly reporting loop</li> <li>Complaints and PALS process to capture patient feedback</li> <li>Patient Experience Steering Group</li> <li>Quality Improvement Framework</li> <li>Governance and Quality reporting</li> <li>Monthly and quarterly reporting to Trust Board</li> <li>Patient stories at the Board</li> <li>Monthly performance review with Heads of Nursing</li> <li>Review of complaints process completed</li> <li>Net promoter score replaced by % patient satisfaction score</li> </ul>	<ul style="list-style-type: none"> <li>Positive feedback from the ombudsman regarding individual complaints and level of investigation</li> <li>Positive patient survey results for cancer services and satisfactory for ED.</li> <li>Maintained reduction in number of complaints</li> <li>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%</li> <li>New Complaints and Experience Committee chaired by non executive to support greater organisational learning (July 15)</li> <li>Patient experience priorities developed with each CSC using feedback</li> <li>Draft Patient Engagement Strategy which aims to improve feedback methods and opportunities.</li> </ul>	9 (3x3)	9 (3x3)	6 (3x2)		<ul style="list-style-type: none"> <li>Evidence of improvement actions from negative Friends and Family response. Resolved but will need to be monitored to ensure sustained.</li> <li>National in-patient survey reported satisfactory experience overall but improvements required in some elements.</li> <li>CSC Quality improvement plans do not all include reference to FFT and/or surveys.</li> <li>Lack of on going intelligence for in-patient survey</li> <li>Variable FFT response rate from ED.</li> </ul>	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			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
4-1415 Apr 14	<p><b>Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing</b></p> <p><b>Implications:</b></p> <ol style="list-style-type: none"> <li>Poor patient experience</li> <li>Poor staff morale and wellbeing</li> <li>Trust reputation</li> <li>Financial penalties related to Emergency care quality targets</li> </ol>	<ul style="list-style-type: none"> <li>CSC Strategy</li> <li>PHT Unscheduled Care Quality Improvement Plan ratified by UCB and PHT Trust Board Phase II with implementation timetable</li> <li>12 Hour escalation process in place (standard: no patient to remain in ED for &gt;12 hours)</li> </ul>	<ul style="list-style-type: none"> <li>Reviewed at Operations Board Group and monthly by TDA</li> <li>Trust Board</li> <li>Plan monitored weekly by Urgent Care Quality Improvement Group and chaired by CEO.</li> <li>All patient arrival and departure times monitored by ED Coordinator and DHM</li> <li>Operational Board</li> <li>Transformation Board</li> </ul>	20 (4x5)	20 (4x5)	12 (4x3)	<ol style="list-style-type: none"> <li>Ability to control front door demand</li> <li>CSCs not Sustaining agreed discharge targets on a daily basis</li> <li>Inability of external partners to support increase in community capacity</li> <li>Sustained high number of medically fit patients remaining in acute beds</li> </ol>	<ol style="list-style-type: none"> <li>Performance against 4hour wait target of 95% currently at 82.37% YTD</li> </ol>	<ol style="list-style-type: none"> <li>Chief Operating Officer</li> <li>Director of Operations</li> <li>Operational Board</li> </ol>	Sep 15	Sep 15	CQC S4, S5 R3	RR 15-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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									FW	May 14	Plan agreed by Accountable Officers 19th June 2014		
I)/ii) Further WHE turnaround action plan being created, to be agreed – draft received and comments returned to F Wise													
i)ii)iii) ECIST assurance visit recommendations received, incorporated into Urgent Care Taskforce Recovery Plan									CW/GP	Jun 14	Implemented and on track		
i)ii)iii) Key actions agreed Post TDA/NHS England Urgent Care Summit 3 <sup>rd</sup> 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 11 <sup>th</sup> 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 4 <sup>th</sup> May 2015
i)ii)iii Review and enhance MDT Discharge Processes to increase daily discharge	SE	March 15	Commenced and on-going
i)/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	Planned
i)/iv)Ambulatory Emergency Care moved to dedicated ring fenced area	ED	June	Planned
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	Planned
ii)iv)Medical wards to review criteria for admission increasing availability of bed stock to ED/AMU	ED	June	Planned
i)ii)iii)iv)v) Mapping of frailty pathway commenced to agree WHE frailty strategy	DH	July	Planned
i)v) Enhanced role of ED Nurse in Charge to reduce 4o breaches	GMcD	July	commenced
i)ii)iii)iv)v) Auditing of internal professional standards	GMcD	July	Planned
i)ii)iii)iv)v) WHE KPIs to monitor performance against Phase II WHE plan	GMcD	July	<a href="#">Agreed – phase ii plan well underway</a>

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										Minor Obstacle to achieving target			
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5-1516 Apr 15	<p><b>The Trust fails to achieve referral to treatment (RTT) access targets in two specialties:</b></p> <ul style="list-style-type: none"> <li>General Surgery</li> <li>Orthopaedics</li> </ul> <p><b>Implications:</b></p> <ul style="list-style-type: none"> <li>Patient experience</li> <li>Reputation</li> <li>financial penalties</li> </ul>	<ul style="list-style-type: none"> <li>Weekly specialty PTL meetings led by CSC GM.</li> <li>Weekly assurance meeting chaired by Deputy COO/Head of Performance</li> <li>Performance team co-ordination of breach position at Trust aggregate level</li> <li>RTT compliance plans and 35 week recovery plans for all "at risk" specialties – reviewed weekly</li> <li>Increased use of ISTC to support gaps in capacity</li> </ul>	<ul style="list-style-type: none"> <li>Activity plans to meet GURROO 3 model. Including growth plans</li> <li>Performance dashboard and weekly assurance meeting</li> <li>Reports to TDA, Commissioners and Trust Board</li> </ul>	12 (4x3)	16 (4x4)	12 (4x3)	<ul style="list-style-type: none"> <li>i. Unscheduled care demands leading to lack of capacity</li> <li>ii. Reduction in inpatient bed base and associated risk to capacity</li> <li>iii. Required rolling programme of theatre upgrade reducing capacity</li> <li>iv. Diagnostic target at risk on monthly basis within Gastro speciality due to capacity gap</li> <li>v. Colorectal service</li> <li>vi. Pressures of cancer demand</li> <li>vii. Increase in backlog of patients due to cancellations</li> </ul>	<ul style="list-style-type: none"> <li>ii. Capacity plans dependent on recruitment in MSK and Surgery</li> <li>x. Theatre utilisation below level required to deliver GUROO 3</li> <li>x. OP utilisation/ productivity improvements required</li> <li>xi. Additional theatre capacity required supported by investment and recruitment</li> </ul>	<ul style="list-style-type: none"> <li>1. Chief Operating Officer</li> <li>2. Deputy Chief Operating Officer</li> <li>3. Operational Board</li> </ul>	Oct 15	Jun 16	CQC	RR
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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 realignment of up to 10 beds across gynaecology and PPU to support required capacity for surgery and cancer CSC delivery.									MD	Jul 15	Ongoing		
iv Action plan and weekly reviews through TTRG									DM/MD	Mar 15	On-going thru to Jun 16		
v Business case in development to increase capacity									SB/MM	Jun 15	Ongoing – investment decisions to be confirmed		
vi See Trust Risk Register for specific action													
vii Recruit to vacancies									UB/NM	Oct 15			
viii Reviewed on weekly basis with gaps escalated to CoS and GMS									DM/MD	May 15	Ongoing		
ix/x Transformation project in development									MM/SJ	Sep 15			
xi Weekend operating sessions/programme in place. Consultation commenced to support 6 day working in theatres									MS/DM	Dec 15			
xii Admitted and non admitted standards abolished but still monitored internally. Validation exercise required to support position.									CSCs/JL	Nov 15			



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6-1516 Apr 15	<p><b>Failure to achieve cancer wait targets</b></p> <p><b>Implications:</b></p> <ul style="list-style-type: none"> <li>Risk to patient safety if we cannot meet access targets for cancer</li> <li>Financial penalties may be applied by commissioner</li> </ul>	<ul style="list-style-type: none"> <li>Capacity and demand modelling undertaken and in place within CSCs</li> <li>Weekly assurance meeting with forecast planning and triggers for escalation</li> <li>Weekly PTL meetings with clinical leads of tumour sites and CSC rep to track progress of patients on cancer pathway</li> <li>Monthly Cancer steering group receives update on performance and key issues</li> </ul>	<ul style="list-style-type: none"> <li>Annual training on Cancer Access policy for all staff involved in managing cancer</li> <li>Improved visibility and tracking of long waiting</li> <li>Improved ability to predict performance accurately</li> <li>Cancer improvement plan reviewed monthly and now including trajectories for delivery of at risk site e.g. urology</li> <li>Increased national focus with weekly reporting of 62 day FDT performance</li> <li>Weekly review between D of Ops Scheduled Care and TDA performance director</li> </ul>	12 (4x3)	8 (4x2)	8 (4x2)	<ul style="list-style-type: none"> <li>i. Ability to control referral rates</li> <li>ii. Impact of national campaigns</li> <li>iii. Patient choice rules means clock doesn't stop if patient defers anywhere on pathway</li> <li>iv. Impact of late inter Trust referrals</li> <li>v. Reduced access to theatre capacity due to rewiring works</li> <li>vi. Conflicting demand in theatres from tumour sites for robotic theatre capacity</li> <li>vii. Attendance at Cancer Steering Group variable and moved to quarterly</li> <li>viii. Effective escalation not always adhered to.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>1 Chief Operating Officer</li> <li>2. General Manager - Cancer</li> <li>3. Operational Board</li> </ul>	Oct 15	Apr 16	CQC S4, S5 R1	RR 19-1415 20-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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			
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	
vii) Detailed improvement plan and trajectories to be developed for urology, to present to Trust Board and TDA	AT/NM	Sept 15	
viii) Assessment of 8 key cancer priorities to be submitted to TDA, with input from CCG	MD	Sept 15	
ix) Overall cancer improvement plan to also incorporate all tumour site risks and actions to resolve	MD/CSCs	Sept 15	
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	
Xiii) CCG to attend monthly reviews of cancer improvement plan to improve working relationships and support	MD/LH	Sept 15	
xiv) Reinstatement of weekly review of full PTL in Waiting List Assurance Meeting to improve traction and sight performance	MD/JL	Sept 15	

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7-1516 Jun 15	<p><b>Quality of data produced and provided for use in internal performance reporting and for external reporting may include inaccuracies (data entry and/or reporting)</b></p> <p><b>Implications</b></p> <ul style="list-style-type: none"> <li>• Reputation damage</li> <li>• Financial penalties</li> <li>• Incorrect business decisions made using incorrect data assumptions impacting on patient experience</li> </ul>	<ul style="list-style-type: none"> <li>• Data validation processes in place in some areas but patchy</li> <li>• Data Quality Steering Group (DQSG)</li> <li>• Documentation now produced; Data Quality Steering Group TORs, Data Quality Strategy, Data Quality Policy</li> <li>• Data Quality Reporting Dashboard</li> <li>• All national returns signed-off by operational services &amp; Head of Performance</li> <li>• 2 Access Data Quality Managers now in post</li> </ul>	<ul style="list-style-type: none"> <li>• Data Quality Steering Group meets monthly and all CSCs and Information Asset Managers report on their compliance with local and national standards annually.</li> <li>• Exceptional issues will be fed into SMT, including an annual DQ Report to Trust Board</li> <li>• Data Quality Reporting Dashboard provides a local replica of the national SUS Data Quality Dashboard at CSC and Specialty level.</li> </ul>	12 (4X3)	12 (4x3)	8 (4X2)	<ul style="list-style-type: none"> <li>i. Significance of data quality is not recognised Trust wide</li> <li>ii. Lack of Standard Operating Procedures for internal report production</li> <li>iii. Further development of data quality reporting required</li> </ul>	<ul style="list-style-type: none"> <li>1. Chief Operating Officer</li> <li>2. Head of Information Services</li> <li>3. Data Quality Steering Group</li> </ul>	Dec 15	Jun 16	CQC S4, S5	RR 16-1415	
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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	<p><b>Lack of equivalent workforce across seven days of the week</b></p> <p><b>Implications</b></p> <ul style="list-style-type: none"> <li>Damage to Trust reputation</li> <li>Poor patient experience</li> <li>Reduced quality of care</li> </ul>	<ul style="list-style-type: none"> <li>Governance systems in place to ensure patient safety and quality of care is maintained</li> <li>Increased consultant presence introduced at weekends</li> <li>Gradual increase in Consultant presence out of hours across the Trust</li> <li>Mortality review toolkit</li> <li>Scheduled care is also provided at weekends</li> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>Review of hospital mortality with emphasis on weekend mortality with TDA</li> <li>Weekend HSMR shows no significant difference from rates recorded during the week</li> <li>Mortality review toolkit</li> </ul>	12 (4X3)	12 (4x3)	8 (4X2)	<ul style="list-style-type: none"> <li>i. Delays in progressing patient pathways</li> <li>ii. Delay in investigations</li> </ul>	<ul style="list-style-type: none"> <li>iii. IPR indicates lengths of stay could be reduced</li> </ul>	1. Medical Director 2. Chief of Service 3. Operational Board	Dec 15	Apr 16	CQC S4, S5	RR 18-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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	<p><b>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.</b></p> <p><b>Implications:</b></p> <ul style="list-style-type: none"> <li>Increased fragmentation of clinical data flows leading to faulty processes and poor information</li> <li>Worsening patient experience</li> <li>Waste of staff time on manual processes</li> <li>Failure to achieve clinical process improvements</li> <li>Failure to meet more exacting national &amp; local standards</li> </ul>	<ul style="list-style-type: none"> <li>Board approval for IT Strategy</li> <li>IT Strategy Committee</li> <li>Clinical Information Systems Programme Board</li> <li>Robust IT project and programme management processes</li> <li>Robust IT procurement processes</li> <li>Treasury Green Book 5 Case Model</li> <li>TDA / Treasury business case approval process</li> </ul>	<ul style="list-style-type: none"> <li>Bi-monthly reporting to IT Strategy Committee</li> <li>Bi-monthly reporting to Clinical Information Systems Programme Board</li> <li>eHospital Programme Highlight Reports to ODG</li> <li>Supplier engagement completed, providing an understanding of solution market</li> <li>Strategic Outline Case approved by Trust Board</li> </ul>	8 4x2	12 4x3	4 4x1	<ul style="list-style-type: none"> <li>i. Lack of identified revenue budget for eHospital procurement (Programme put On Hold May 15 pending review by external consultant</li> <li>ii. Lack of specialist procurement &amp; contractual expertise</li> <li>iii. No eHospital Programme team</li> <li>iv. Lack of engagement of clinicians, CSCs and other stakeholders to specify requirements and own changes</li> <li>v. Lack of Programme plan</li> <li>vi. No defined specification of requirements to support procurement</li> </ul>	<ul style="list-style-type: none"> <li>vii. Current Trust focus on tactical developments rather than strategic</li> <li>viii. Focus on Trust requirements rather than those of whole care community involved in caring for patients</li> </ul>	<ul style="list-style-type: none"> <li>1. Director of Strategy</li> <li>2. Head of IT</li> <li>3. IT Strategy Committee</li> </ul>	Oct 15	Apr 16	CQC S4, S5	RR 6-1415 22-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
i) Establish protected eHospital Programme budget sufficient to successfully complete procurement phase													
a) Gain Trust Board & CSCs commitment to fund eHospital Programme as number one development priority for 2015/16									Head of IT / Dir.of Strategy	May 15	02.10.2014 - Board approval to produce Strategic Outline Case		
<ul style="list-style-type: none"> <li>Run Trust Board &amp; CSCs Workshop to decide key objectives for eHospital</li> </ul>									Head of IT	Nov 14	06.11.2014		
<ul style="list-style-type: none"> <li>Complete Specification of Requirements and go to market for specialist consultancy to help write Strategic outline Case (SOC)</li> </ul>									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	22.04.2015
• Present SOC to Trust Board and gain approval to produce Outline Business Case with associated funding	Head of IT / Dir.of Strategy	Apr 15	30.04.2015
• Consider output from external consultancy review of eHospital Programme and decide shape of Programme and how to fund it	Dir. Of Strategy	Sep 15	
• Present 'way forward' for eHospital to Trust Board and gain approval of this and any associated funding	Dir. Of Strategy	Sep 15	
b) Produce eHospital Programme Revised Resources Plan for 2015/16	Head of IT	Sep 15	
c) Confirm funding for eHospital Programme	Dir. Of Strategy	Oct 15	
Further actions to be identified following agreement of way forward.			

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11-1516 Apr 15	<p>Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed. This results in:</p> <ul style="list-style-type: none"> <li>Poor patient experience of prolonged waiting and increased risk of patient de-compensation</li> <li>Reduced daily capacity to meet acute demand.</li> <li>Increased risk for patients being kept in an acute environment</li> <li>Increased likelihood of patient moves and the need to outlie 'out of speciality'</li> <li>Increased risk of breaching 4 hour ED target</li> <li>Impact on elective programme</li> <li>Increased cost of care due to prolonged LOS and ward moves</li> <li>New</li> </ul>	<ul style="list-style-type: none"> <li>Daily IDB meetings chaired by <a href="#">Director of Operations</a> - Full review of IDB across WHE moving to an integrated Health &amp; Social IDB Team</li> <li>Discharge Planning Teams covering whole hospital</li> <li>Daily IDB report (all delayed in hospital patients)</li> <li>Next steps</li> <li>Community Beds capacity available notified daily</li> <li>CQUIN Community In-reach Team</li> <li>QA@H (Hospital at Home)</li> <li>Weekly SITREP report</li> <li>7 day availability of Discharge Planner (Trust-wide)</li> <li>Medicine CSC focused discharge resource deployed 21 Aug 2014.</li> <li>Safer discharge bundle roll out completed.</li> <li>CHC assessor in house</li> <li>Increased Hampshire discharge pathways</li> <li>Weekly LOS meetings for all CSCs with Chief Operating Officer</li> <li>Development of</li> </ul>	<ul style="list-style-type: none"> <li>Backdoor Tracker reported via ODG</li> <li>Medicine weekend discharge report</li> <li>Daily IDB opening and closing balance</li> <li>Daily update from CSC's following the 123 Escalation</li> <li>Discharges reported via Operations Centre meetings x 4 daily</li> <li>QA@H virtual ward trajectory (May 14 – April 16)</li> <li>IDB Action Plan* agreed by WHE and shared with ECIST</li> <li>Implementation of the SAFER discharge bundle</li> <li>Additional community capacity being sourced by PHT (plan for 22 beds by end August 2014)</li> <li>Ward D2 now operating as acute medical ward</li> <li>Implement MDT Board Rounds as per IDB action plan</li> <li>Weekly length of stay report &gt; 7/14 day</li> <li>Metric reports</li> <li>Outlier – trajectory and performance reporting</li> <li>Discharge numbers</li> <li>Sitrep reporting</li> <li>Length of stay reports</li> <li>Next steps agreed and shared with partners</li> <li>Working with the</li> </ul>	16 4x4	12 4x3	8 4x2	<ul style="list-style-type: none"> <li>i. Demand from complex patients due to high volume</li> <li>ii. IDB still based across multiple venues, needs central base for MDT office'</li> <li>iii. Different IT systems across organisations</li> <li>iv. Unscheduled transformation</li> <li>v. System wide transformation</li> <li>vi. Recruitment issues in Adult Social Care</li> <li>vii. Challenges sourcing packages of care in Hmapshire</li> <li>viii. Increased Nursing Home refusals</li> </ul>	<ul style="list-style-type: none"> <li>ix. CSC's failure to complete 123 Escalation updates</li> <li>x. Not performing against outlier trajectory</li> <li>xi. Discharge numbers fluctuate against target</li> <li>xii. Operational controls</li> <li>xiii. <a href="#">Newton Database (PTL) failing and frequently fails.</a></li> </ul>	1. Chief Operating Officer 2. <a href="#">Director of Operations for Unscheduled Care</a> 3. Urgent Care Improvement Group	Oct 15	Oct 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							
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>								<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>
i) <a href="#">Increase focus on medically fit patients</a>								CSCs	Nov 14	Complete and on-going
i) <a href="#">Executive focus to identify central base</a>								Exec team	Mar 15	Complete and on-going
iii) <a href="#">Escalated discussions to be led by PHT IT to ensure systems are compatible</a>								SE	Feb 15	Complete and on-going
ii) <a href="#">Implement IT access for all partners</a>								SE	Jun 15	
iii) <a href="#">Complete evaluation of IT system to ensure fit for purpose to support discharges</a>								SE	Oct 15	
iv) <a href="#">Recruitment by PHT and all partner organisations</a>								SE	Apr 15	
i-v) <a href="#">Additional Community bed capacity being commissioned (22 beds)</a>								SE	Oct 14	Completed
i-v) <a href="#">IDB Action Plan implementation of MDT Board Rounds</a>								MQ	Nov 14	Completed
i-x) <a href="#">Implement system transformation of internal discharge processes</a>								SE	Aug 15	
<a href="#">Ix i. Await new system to be agreed - IT working with DC Matron to agree new IT system to replace Newton</a>									TBC	
<a href="#">Reviewed IDM meeting with partners and CSC clinical teams</a>								SE	Jul 15	<a href="#">Complete and on-going</a>

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13-1415 Apr 14	The Trust fails to secure growth in Research and Innovation	<ul style="list-style-type: none"> <li>Research &amp; Innovation strategy launched May 2015 by Director of Research &amp; Innovation</li> <li>Medical Director participating in AHSN discussions with UHS</li> <li>R&amp;D income monitored by R&amp;I and CEO</li> <li>CEO now Executive sponsor</li> <li>Director and Deputy Director to have oversight of the CTIMP studies and lead RQC following MHRA inspection</li> <li>No further PHT sponsored CTIMPS until we have assurance to continue</li> <li>Research &amp; Quality Manager now been cleared to advertise</li> <li>Contracts management outsourced.</li> <li>Data management outsourced.</li> </ul>	<ul style="list-style-type: none"> <li>R&amp;D income year on year increase</li> <li>National NIHR and Guardian League tables shows good competitive performance by PHT</li> <li>Local network performance reports received and reviewed by Director of research monthly</li> <li>Improved reputation through winning HSJ research impact award</li> <li>Increase in successful grant awards seen</li> <li>Increase in successful innovation awards via AHSN</li> <li>Increase in successful collaborative projects via Wessex CLARCH</li> <li>Increase in clinical academics to build growth</li> <li>Quarterly performance and finance reports submitted to Board</li> <li>Research activity monthly reports to CSC Boards</li> <li>R&amp;I strategy monitored quarterly by R&amp;I strategy group</li> </ul>	10 (5x2)	8 (4x2)	3 (3x1)	<ul style="list-style-type: none"> <li>i. Low levels of portfolio recruitment recorded in 2014</li> <li>ii. Lack of adequate monitoring identified by March 2015 MHRA inspection</li> <li>iii. Local network performance reports received and reviewed by Director of research monthly</li> <li>iv. Lack of adequate monitoring identified by March 2015 MHRA inspection</li> <li>v. Lack of research facilitator capacity to support CTIMPS in set-up (MHRA risk)</li> </ul>	<ul style="list-style-type: none"> <li>1. CEO</li> <li>2. Director &amp; Deputy Director of Research &amp; Innovation</li> <li>3. Trust Board</li> </ul>	Oct 15	Apr 16	CQC S4, S5	RR 26-1415	
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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	<p><b>Threat to specialist services due to centralisation agenda</b></p> <p><b>Implications:</b></p> <ul style="list-style-type: none"> <li>Potential loss of major vascular surgery at PHT due to centralisation to a tertiary unit</li> <li>This carries longer term implications for the viability of other services such as interventional radiology and renal</li> <li>Further services such as Stroke may be centralised in the future</li> </ul>	<ul style="list-style-type: none"> <li>Outcome data</li> <li>Vascular Society requirements for a service</li> <li>Fully covered clinical rota with committed team</li> <li>National audit results</li> </ul>	<ul style="list-style-type: none"> <li>Positive outcome data for this group of patients</li> <li>Fulfilment of vascular society recommendations for service delivery</li> <li>Good clinical outcome data</li> <li>Network vascular MDT with UHS has commenced</li> <li>Providing some vascular service to Chichester</li> <li>Recent confirmation from commissioners that arterial vascular surgery will continue in Portsmouth</li> </ul>	16 (4x4)	9 (3x3)	6 (3x2)	<ul style="list-style-type: none"> <li>Decision ultimately out with PHT control as specialist commissioner led</li> <li>Currently no absolute and written assurances from specialist commissioning teams as to the medium and long term direction</li> <li>NHS England have rejected two hub model and recommended another Vascular Service review</li> </ul>	<ul style="list-style-type: none"> <li>Lack of approved vascular service</li> </ul>	<ul style="list-style-type: none"> <li>1 Medical Director</li> <li>2. Medical Director</li> <li>3. Operational Board</li> </ul>	Oct 15	Review progress Oct 15	CQC S4, S5	RR 30-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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 SH	Sep 14 Nov 14	Completed and ongoing		
i)/ii)/iii) Agreement to provide vascular outpatients in Chichester											Completed and 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	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
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										Inability to achieve predicted target			
15-1516 Apr 15	<p>Insufficient engagement of workforce</p> <p>Implications:</p> <ul style="list-style-type: none"> <li>Lack of understanding/ buy in, and therefore delivery of strategic priorities</li> <li>Suboptimal delivery of patient care</li> <li>Declined staff survey results</li> </ul>	<ul style="list-style-type: none"> <li>Listening into Action programme adopted.</li> <li>Staff survey action plans developed across the organisations and within CSCs</li> <li>Health and well-being programme established.</li> <li>Employee recognition programmes in place.</li> <li>Leadership development</li> <li>Quarterly staff pulse survey</li> <li>Development of appraisal quality framework linked to values</li> <li>Full work plan introduced to address key issues of bullying &amp; harassment</li> </ul>	<ul style="list-style-type: none"> <li>Significantly Improved performance in 2014 national staff survey results.</li> <li>Lower than average levels of sick absence and staff turnover when compared to other acute organisations.</li> <li>Integrated performance report to Board including staff feedback</li> <li>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</li> <li>Staff recommendation as a place to work or receive treatment has increased from 3.54 to 3.71 as measured in the 2014 NSS</li> <li>Staff Friends and family quarterly pulse survey in 2014/15 Q4 demonstrates PHT as top in Wessex for recommendation as a place to work</li> </ul>	12 (4X3)	9 (3X3)	6 (3x2)	<ul style="list-style-type: none"> <li>Lack of engagement from clinical staff in delivering the change agenda</li> <li>Unbalanced focus on operational delivery verse strategic planning</li> </ul>	<ul style="list-style-type: none"> <li>Trust is positioned as average for overall staff engagement when compared to other Trusts within the full 2014 staff opinion survey.</li> <li>A 1% reduction reported in staff reporting incidents, errors or near misses in the last month</li> <li>Staff agreeing that their role makes a difference to patients is below the national average</li> </ul>	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
iii) 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	<ul style="list-style-type: none"> <li>Leadership development programmes in place to support leaders at various levels.</li> <li>360 and self-assessment completed at Executive level</li> <li>Trust wide leadership qualities and behaviours identified</li> <li>Clinical Directors leadership programme in place</li> <li>Performance appraisal process to assess behaviours and leadership performance in place.</li> </ul>	<ul style="list-style-type: none"> <li>Utilisation of existing leadership development programmes</li> <li>360 completed for executive team and included for medical revalidation. Roll out to all senior managers as part of appraisal process</li> <li>PHT representation on Thames Valley and Wessex Leadership Academy Board</li> <li>Leadership Academy funded programmes launched and locally developed bite sized training on specific skills gaps</li> <li>Performance management framework in place supporting talent development and succession planning</li> <li>Bespoke leadership development roll out to CSC and corporate senior teams using MindGym</li> </ul>	12 (4x3)	9 (3X3)	6 (3x2)	<ul style="list-style-type: none"> <li>i. Programmes and framework for leadership development in place but needs to be embedded to ensure compliance.</li> <li>ii. Evidence of behavioural change and a culture shift in collective responsibility and holding to account</li> <li>iii. Optional' approach to leadership development influenced by operational demands</li> </ul>	<ul style="list-style-type: none"> <li>iv. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered.</li> <li>v. Leaders setting clear direction and engaging the workforce in the vision of the organisational and how each role contributes to it</li> </ul>	1. Director of Workforce and Organisational Development 2. Head of Organisational Development 3. Operational Board	Nov 15	Apr 16	CQC	RR
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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	
<a href="#">Clear leadership development plan in place at a trust level aligned to critical skills gaps identified and cascaded to teams</a>	LW	Feb 16	



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17-1415 Apr 14	<p>Current and future workforce demand is outstripping supply leading to:</p> <p>National skill shortages in nursing, scientific and other professions being reflected locally which is leading to an increasing expensive temporary workforce supply which may impact on patient care</p> <p>Adult nursing commissions have been increasing since 2013 but they have not kept pace with requirements due to the impact of increased demand post Francis.</p> <p>Workforce design has not kept pace with changing service delivery, for example, terms and conditions of service have not fundamentally changed for many years, but increasingly we need staff to work 24/7 on an ongoing basis</p>	<ul style="list-style-type: none"> <li>Corporate CIP plan developed to reduce temporary staffing levels.</li> <li>Speciality specific attraction strategies developed for CSCs in difficult to recruit areas</li> <li>Executive sign off required for temporary spend</li> <li>On-going recruitment of nursing staff from overseas.</li> <li>E-Rostering deployed for all staff groups</li> </ul>	<ul style="list-style-type: none"> <li>Business planning process has identified resource requirements for CSC service delivery.</li> <li>WSC process removed to ensure no barriers to substantive recruitment</li> <li>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%.</li> <li>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).</li> </ul>	16 (4x4)	16 (4x4)	12 (4x3)	<p>i) Temporary workforce spend is at its highest level ever with a £3.4m spend in June 2015. This has been exacerbated by the increase in establishment for safer staffing resulting in current vacancies of 316 wte which is not affordable for the Trust.</p> <p>ii) Reduction in Junior Doctors and difficulty in recruiting ongoing in many specialities.</p> <p>iii) The Trust has maintained many of its referral to treatment targets leading to an increased need for staff which resulted in a high level of premium payments including Waiting List Initiative payments for consultant medical staff and overtime in other staff groups.</p> <p>v) Temporary workforce is used to fill local and national shortages in some key skill areas which may result in some critical skill gaps in clinical rotas, specifically nursing, junior doctors and some</p>	<p>) High levels of substantive vacancies in some CSCs – Medicine, Surgery &amp; Cancer and MOPRs</p> <p>i) Qualified N&amp;M – 179 FTE Vacancies</p> <p>ii) Supply of newly qualified nursing workforce is insufficient for PHT required demand.</p>	1. Director of Workforce and Organisational Development 2. Deputy Director of Human Resources 3. Operational Board	Sep 15	Apr 16	CQC S4, S5 E3	RR

							other specialist areas eg ED, histopathology, orthotics, Urology, Colorectal, Physiotherapy, Pharmacy and Pathology.					
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>								<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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		
ii) 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 Apr 14	Inability to achieve Foundation Trust status within the agreed timetable	<ul style="list-style-type: none"> <li>Trust Board development</li> <li>Well led organisation development</li> <li>CSC development</li> <li>TDA monthly assurance programme</li> <li>Clear trajectories for improvement in key national standards and financial sustainability</li> <li>LTFM and 5 year strategy refreshed as at 30 Sep 14</li> <li>Continuity of service risk ratings</li> </ul>	<ul style="list-style-type: none"> <li>TDA monthly assurance programme</li> <li>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</li> </ul>	12 (4x3)	9 (3x3)	8 (4x2)	<ul style="list-style-type: none"> <li>i. 15/16 Financial Plan shows circa £16m deficit</li> <li>ii. Performance against key targets</li> </ul>	<ul style="list-style-type: none"> <li>iii. Unscheduled care pressures across the Trust</li> <li>iv. Pace of delivery of savings programme</li> <li>v. Impact of fines, penalties and contractual payments</li> <li>vi. Not achieving required Continuity of Services Risk Ratings (3 or above)</li> </ul>	1. Interim Director of Finance 2. Interim Deputy Director of Finance 3. Trust Board	Dec 15	Mar 16	CQC S4, S5	RR
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
j) 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 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	<ul style="list-style-type: none"> <li>Finance reporting and monitoring mechanisms at CSC to Board level</li> <li>Updates on Financial position provided to Board, SMT Finance Committee</li> <li>Delegated budgetary control framework</li> <li>Trust wide savings and transformation programme</li> <li>Income and contract monitoring</li> <li>Bottom up forecasting in place</li> <li>Pre-performance review meetings</li> </ul>	<ul style="list-style-type: none"> <li>Financial plan income reflects detailed activity modelling (GooRoo3) and cost of delivery incorporated into cost base.</li> <li>Monthly performance reviews with all CSCs</li> <li>Visibility of financial information through Qlikview</li> <li>Budgets set for 2015/16</li> <li>Financial overview at E.M.T, Finance Committee and Operational Board</li> <li>Formal Sign off of CIPs and supporting Quality Impact Assessments</li> <li>Greater CSC scrutiny at Finance Committee – re action plans and assurance of recovery of position</li> <li>ECF Process now in place (Non Pay Controls)</li> </ul>	16 (4x4)	20 (4x5)	9 (3x3)	<ul style="list-style-type: none"> <li>i) Savings opportunities can be challenged by operational pressures e.g. additional workforce costs (often at premium rates).</li> <li>ii) Remaining CSC cost pressure</li> <li>iii) Insufficient bed capacity in key specialties</li> <li>iv) ED unfunded queue management</li> </ul>	<ul style="list-style-type: none"> <li>i) Income position started one month in arrears</li> <li>ii) CIP programme under achieving</li> <li>iii) Adverse staff cost variances</li> </ul>	1. Interim Director of Finance 2. Finance Committee 3. Transformation Board	Sep 15	Mar 16	CQC S4, S5	RR 26-1415 27-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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				

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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.	<ul style="list-style-type: none"> <li>Monthly contract monitoring reports</li> <li>Monthly contract review meetings (CRM)</li> <li>Forecast and capacity reviews corporately on working day 1 and during performance reviews (monthly)</li> <li>CQUIN monitored through the TSO function</li> <li>Contract issues unable to resolve escalated to Execs via ECR</li> <li>Approval to recruit to Costing Team posts given by Back Office Work Stream Group (August 2015)</li> </ul>	<ul style="list-style-type: none"> <li>Agreed capacity required with CSCs and activity volumes secured through the commissioning contract</li> <li>Agreed Pbr compliant contract</li> <li>Daily metrics via KitBag</li> <li>Monthly CSC performance reviews strengthened</li> <li>Increased reporting through Income &amp; Contracts Dashboard</li> </ul>	12 (4x3)	12 (4x3)	12 (4x3)	<ul style="list-style-type: none"> <li>i. Capacity will be the biggest issue in achieving predicted levels of income</li> </ul>	<ul style="list-style-type: none"> <li>i. ED target consistently not being achieved.</li> <li>ii. Cancer &amp; RTT targets require increased activity to achieve sustainability.</li> <li>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.</li> <li>iv. CQUIN schemes not received from local CCGs requiring agreement by 31<sup>st</sup> May and remain unagreed</li> <li>v. Reference Costs Audit did not provide assurance over costing process (and thereby the income the Trust receives)</li> </ul>	1. Director of Finance 2. Head of Financial Accounting 3. Finance Committee 4. Operational Board	Oct 15	Mar 16	CQC S4, S5	RR 8-1516 9-1415 13-1516 19-1516 20-1415 26-1415 27-1415
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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 – <a href="#">approval gained but need in post</a>									RE/IH	Oct 15			

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21-1516 Apr 15	2015/16 Savings and recovery plans are not identified & delivered, with subsequent impact on Trust financial position	<ul style="list-style-type: none"> <li>Review of savings performance at Finance Committee and Operational Board</li> <li>Monthly CSC performance meetings</li> <li>Tracker providing clear information on which initiatives are 'off-track'</li> <li>Defined CSC reporting arrangements</li> <li>CSCs submitted initial savings plans</li> <li>Transformation Board</li> <li>Risks and opportunities tracked monthly</li> <li>TSO function in place</li> </ul>	<ul style="list-style-type: none"> <li>Monthly reporting to Finance Committee</li> <li>External support commissioned to support savings delivery</li> <li>Robust Programme Management Office in place</li> <li>Monthly refresh of year end forecast</li> <li>Clear lead against all recovery programme workstreams</li> <li>Closer Financial Monitoring</li> <li>Transformation Board bi weekly review</li> </ul>	16 (4x3)	16 (4x4)	9 (3x3)	<ul style="list-style-type: none"> <li>i. CIP programme not achieving profiled target</li> <li>ii. Some target areas still to be identified - (circa £3.0m CIP remains unidentified)</li> <li>iii. TDA letter 23<sup>rd</sup> 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</li> </ul>	<ul style="list-style-type: none"> <li>1. Interim Director of Finance</li> <li>2. Finance Committee</li> <li>4. Transformation Board</li> </ul>	Oct 15	Mar 16	CQC 26	RR 5.1	
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>									<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
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			
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 full details of recovery plan to convert opportunities identified in the initial action plan to achieve the "stretch" target of £9.7m deficit set by the TDA									Interim DoF/Board	Sep 15			

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										Minor Obstacle to achieving target		
										Inability to achieve predicted target		
22-1516 Jun 15	<p><b>Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital</b></p> <ul style="list-style-type: none"> <li>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</li> <li>No SLA with Solent for Responsible Clinician (RC) provision results in gap in service and risk to compliance with the Mental Health Act requirements</li> <li>OPMH service constrained by resources (Solent funding withdrawn)</li> <li>Lack of consistent provision of mental health advice regarding young persons</li> </ul> <p>Impacts</p>	<ul style="list-style-type: none"> <li>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.</li> <li>Mental health in acute setting on junior doctors rolling educational programme</li> <li>Alcohol liaison service team MAU/ED</li> <li>Mental Health operational Group up and running – led by Lead Liaison nurse</li> <li>Mental Health Lead identified within DHMs reviewing completion of Section papers and follow up.</li> <li>MH and LD committee reinstated</li> <li>SLA with Southern Health to provide mental health administration function – to commence 01 August 15</li> <li>Mental Health Act policy</li> </ul>	<ul style="list-style-type: none"> <li>Complaints and incidents – monthly exception report and quarterly quality performance report.</li> <li>Reports to MH &amp; LD Committee</li> <li>Reports to G&amp;Q Committee</li> </ul>	12 4x3	16 4x4	12 4x3	<ul style="list-style-type: none"> <li>i. Service specification for Trust to provide Mental Health support for inpatients to be agreed</li> <li>ii. No agreement between Southern and Solent to provide RC provision</li> <li>iii. Limited staff training programme</li> <li>iv. Lack of full compliance with Mental Health Act requirements</li> </ul>	1. Medical Director 2. Head of Quality 3. MH & LD Committee	Nov 15	Mar 16	S4,E1, E3, E4, R1, R2, R3,	

	<ul style="list-style-type: none"> <li>• Patient and staff safety</li> <li>• Organisational reputation</li> </ul>										
<b>ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE</b>							<b>By Whom</b>	<b>By When</b>	<b>Date Completed</b>		
i.	Meeting arranged with Commissioners 29 <sup>th</sup> 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				