Surrey and Sussex Healthcare NHS Trust Assurance Framework 2009/10

Detailed Risks

No	Principal Risks	Lead	No Initial Risk	Existing Controls	Assurances on Controls	Positive Assurances	Gaps in Controls	Gaps in Assurances	Residual Risk rating	Action Plan	Links to Regulators
	What could prevent the objective being achieved?			What controls/systems do we have in place to assist in securing delivery of this objective? (After controls have been considered)	Where can we gain evidence that our control systems on which we are placing reliance are effective?	We have evidence that shows we are reasonably managing our risks and objectives are being delivered.	Where are we failing to put controls/systems in place	Where we are failing to gain evidence of our systems, on which we place reliance, are effective			
Domain 1. Safe, High Quality Coordinated Care											
Objective 1.1. Cause No avoidable harm to patients											
1.1.1	Patients could experience avoidable harm due to lack of ownership of a coordinated approach to patient safety at specialty level	RH/ MS	S5, L5 = 25	1. Work ongoing to finalise patient safety strategy. Once finalised, will need an implementation strategy including the resources to deliver safety improvements for patients. 2. Process in place to assign lead and assess new NICE guidance. Audit built to specialty porogramme. 3. Patient safety lead included in consultation on new structure. Example JD received from foundation Trust. Generic Trust JD prepared.	1. More accurate assessment after strategy is launched. Increased involvement from clinical staff since launch of management board. New clinical services structure with defined roles for patient safety 2. Accurate record of position against NICE guidance. Impoving assurance position re historic NICE guidance. 3. Dr Foster mortality data regularly interogated and reported. Regular programme for use of GTT.	1. Improvements in risk reporting and investigation in quantity and quality. Encouraging early reults from GTT. 2. Speciality audit programmes increasingly focused on Trust and National priorities including NICE guidance. Compliance monitroing evidences >90% compliance with NICE. 3. Mortality rates below national average. HSMR 86 Nov 2010	1. Implementation strategy and resources not identified. Clinical Governance arrangements for leadership structure discussed but not yet in place. Few staff in able to use GTT. Implementation strategy and resources not identified. 2. No gaps 3. New leadership structure and appointment of patient safety lead not yet in place.Need ownership of mortality rates at directorate and departmental level.	1. Lack of ownership of patient safety programmes at directorate level. GTT not embedded. New roles in clinical services directorate focused on patient safety need embedding 2. Lack of audit re NICE compliance. 3. Lack of assurance resources to deliver patient safety strategy. Mortality rates above SHA average	C4, L4 = 16	Appoint the Patient Safety Nurse. Approve the Patient Safety Strategy. Complete the mortality reviews underway and identify actions and embed. Implement the actions arising from the Orthopaedic review.	DH performance Framework, CQC Registration, ALE, PCT Contract
Objective 1.2 Reduce Avoidable Healthcare Acquired Infections											

1.2.1	Lack of understanding of the breadth and depth of the hygiene code	RH/MS	C5,L4 = 20	1. Increased focus on hygiene code.IPCAS work programme, KPI's in place for ongoing compliance, schedule of environmental audits, cleaning schedules, 2.CD for CSS reports on surgical site infections. 3. performance objectives for key indibiduals. 4. Dr Foster data available on mortality.	Trust policies follow hygiene code. Medical Devices Group in place with workplan. Directorate action plans in place in relation to environment and SSI. Dress code relaunched . Assurance framework in place and monitored by IPCAS. Staff duties under the Hygiene Code infromation poster launched and in place in all areas.	1. Hygiene audit results improved. C diff rates low. IPCAS committee, quality dashboard, minutes of taskforce, regulatory review. MRSA BSI and C Diff below trajectory. 2. Surgical site infections monitored at IPCAS. 3. Failures in hygiene standards addressed with individuals concerned. 4. Mortality rates below national average 5. Surgical Site Infection Surveillance plan in place for Orthopaedics. 6. Medical Devices Group in place	1. Trust medical equipment and devices planned rolling replacement programme needs to extend to cover the entire definition of medical devices and equipment. Storage demand outreaches capacity within current arrangements. 3. Need to ensure all staff are committed to maintaining hygiene code standards. Governance arrangements at Directorate levels need embedding,	Variable compliance with Trust standards including uniform and hygiene policies	C4, L3 = 12	Testing of staff understanding of their duties as part of the planned clinical audit programme.	DH performance Framework, CQC Registration, ALE, PCT Contract
Objective 1.3 Improve Performance in Defined Quality Indicators											
1.3.1	Patient outcomes will not be improved due to limited local information being available to engage clinicians in quality improvements and a lack of embedded processes to manage delivery.	RH/MS	C2, L4 = 8	1. Wide range of information available internally and externally with local and national comparators	1. Information shared at management board which includes good clinical representation. 2. Increasing focus on quality at performance review meetings with plans for further improvements. Enhancing quality all milestones met.	1. Performance Committee dashboard contains some quality information which is also reported through to the Board. 2. External benchmarking through participation in Enhancing Quality programme. 3. Deep Dive governance meetings in place	1 +2 Information not reliably disseminated and focused at directorate, departmental and individual level to drive quality improvements.	Quality initiatives and results at departmental and individual level not consistently and reliably collected and acted upon	C2, L4 -= 8	Undertake Deep Dive governance scrutiny with all Divisions. Reviewing and standardising the information required in Divisional Dashboard for quality and performance. Consolidate the quality indicators into composite indicators. Implementing the complaince monitoring tool in stages. (* optimistic that at next review this risk should be mitigated)	DH performance Framework, CQC Registration, ALE, PCT Contract
Domain 2. Better Information, More Choice											
Objective 2.1 Increase efficiency and effectiveness by ensuring access to appropriate information systems											

2.1.1.	Risk of criminal charges / claims against staff and the Trust due to failure to obtain legally valid consent for patients with mental capcity issues due to limited embedding of updated consent requirements.	RH	C5, L5 = 25	1. Consent Policy. Consent Training. 2. Mental Capacity Act stautory and mandatory training. IMCA referral processes. 3. Safeguarding procedures in Surrey and Sussex. Safeguarding and mental capacity training programmes in place.	1. Consent Audit. 2. Statutory and Mandatory training compliance figures. 3. Incident reporting, complaints and claims information. Safeguarding alerts. Staff awareness surveys	2. High nursing staff attendance at Safeguarding training. 3. High number of referrals to IMCA's for best interests assessments. Low numbers of complaints and incidents reported raising concern. 4. Consent Policy approved Dec 2010	2. In depth training for medical staff is not in place. Training and paperwork to support medical staff to assess mental capacity is not n place. Out of hours support for junior staff is not clear.	Evidence from PMETB that current consent policy not followed consistently. Internal consent audit demonstrates poor compliance. Implementation of the consent policy	C3, L2 = 6	Launch consent Policy February 2011. Consent audit March 2011.	DH performance Framework, CQC Registration, ALE, PCT Contract

2.1.2	A lack of organisational engagement will not allow the Trust to take advantage of the benefits that clinically focussed Information Systems can deliver	IM	C4, L3 = 12	1. SPfIT Programme Board in place and project plan being developed for Millennium Upgrade. 2. Formal Trust CRS Board, chaired by CE, and Project Team well established. PID signed-off and budget for 2010/11 established. 3. Director lead and Project Manager in place. 4. Trust is part of Southern Programme for IT (SPfIT) governance structures.	1.Formal Cerner Project Management includes Gateway sign-off by Trust, SHA and BT/Cerner. 2. Reporting to Project Board and Management Board and Board. 3. Directorate reporting and management. 4. External monitoring through SPfIT live-sites executive and SHA deployment Board.	1 and 4 Formal Gateway process monitors project delivery. 2. Budget monitored through Project Board and Directorate reporting. 3. Clinical Lead for IM&T Appointed and in Place. New Clinical Advisory Group in place	Whole Trust communictaion plan to be finalised and rolled-out in the next few weeks.	No material Gaps in assurance	C4. L3 = 12	Continued implementation of CERNER upgrade programme. Go llve 26th February.	DH performance Framework, CQC Registration, ALE, PCT Contract
Domain 3: Easier Access and Shorter Waiting Times											
Objective 3.1 Consistently deliver all patient access and contractual targets											
3.1.1	Current capacity constraints to deliver planned levels of activity, potentially combined with increased demand above the indicative activity level, resulting in further demands on the current capacity, which could lead to an inability to deliver emergency or planned treatment of patients in a timely manner, impacting on patients care, inability to deliver access and contractual targets and impact on the Trusts reputation.	BB	C4, L5 = 20	1. Systems and monitoring in place to manage all access targets, daily and weekly reporting, PTL, tracking systems for cancer and 18 weeks. 2. Escalation policies. 3 Established Divisional meetings addressing performance.	Monthly performance reports evidencing compliance and areas requiring additional work. re the targets. Weekly review processes in place. Divisional meetings. Weekly Executive scrutiny meetings with the divisions.	Monthly performance reports and quality dashboard, which includes performance and quality indicators, e.g. re-admission rates, access targets. 18 week delivery. Upward trends in stroke, fracturend neck of femur, cancer two week rule and two week symptomatic breast cancer evidences consistent improevement and nearing to target complaince performance.	Inability to flex capacity up to meet additional demand or variance in discharges, patient acuity. Reliable and accepted efficiency measures not consistently available at directorate, departmental and individual level. Significant medical staffing gaps in some specialities.	1 Performance in emergency care access and 18 week inpatient remain challenged.	C4, L5 = 20	Trust Transformation Programme, which includes - unschedlued care pathway and unschedlued care is launching. Orthogeriatirc service due to commence 1st ebruary. Medical job planning 80% complete continue to 100% Agreement to reallocate dedicated observation beds to ED. UTC relaigned to SASH management to support redesigned front of house pathways.	DH performance Framework, CQC Registration, ALE, PCT Contract
Domain 4. Revitalising our Environment											
Objective 4.1 Ensure Best Possible Access to East Surrey Hospital											

4.1.1.	Risk of reputational damage as a result of poor access to site impacting negatively on patient and visitor experience.	IM	C2, L4 = 8	1. Over provision above minimum requirements for Blue Badge Parking. Site signage upgraded to meet Wayfinders standards. Improvements to road markings, safety lighting to meet requirements arising from HSE inspection. 2. Ongoing dialogue with the local authroity planning department - partnership working on options for green travel and increasing capacity. Existing strategy.	1. Daily inspection by car parking attendants of usage. Monitor patient complaints and feedback for thematice analysis of user experience related to access. Trust internal user group meetings and actions which addresses patient experience in a syatematic way. Board reporting through the Capital Investmant Group reporting system. Green travel plan encourages car share, cycling and public transport use. 2. Active participation with stakeholders (local authority, social services etc) in North East Region Travel Group.	1. Low levels of complaints and PALS received from service users. HSE phase 1 recommendations are complete. Funding secured to implement phase 2. Partnership working with local authority and stakeholders evidences positive relationship and partnership in resolving access issues.	Capacity, resource and specialist skills requirement cannot be fully met within the Trust. Exisiting strategy needs revision to identify options needed to support Trust business and to take accoutn of people whose access to public transport from Crawley locality puts them at risk of a longer journey. Phase 2 has not currently commenced.	Communication management plan throughout the strategic review process and on implementation of the way forward.	C2,L4 = 8	Continue progressing agreed work programmes.	DH performance Framework, CQC Registration, ALE, PCT Contract
Objective 4.2 Provide services in modern, well equipped facilities											

4.2.1	Inability to progress capital projects in a timely manner due to competing operational demand, finance, internal stakeholder engagement and internal project management capacity to continuously improve the quality of the built environment.	IM	C4, L4 = 16	1. Capital Programme delivery monitoring and reporting through the Performance Committee. Capital spend priorities are predicated on a matrix which ensures risk, patient safety, patient experience and market forces are assessed during prioritisation. 2. Savings delivery programme and infrastructure in place. Estates strategy in place.	1. Capital Group, Internal Audit, SHA, Audit Commission, PEAT scores, Patient Surveys, Business cases include risk assessments. 2. External MAE Consultant commissioned to survey and prioritise all investment within the estate engineering infrastructure. Director of Clinical Services is a member of the Capital Investment group to inform operational impact.	1. Paradigm of 'internal client' for capital programme projects to ensure effective engagament and involvement at all stages PRINCE 2 methodolgy in place for capital programme projects. Board reporting. 2. Trust legal services engaged in optimising income in year from sale of assests. ALE assessment 2009/10.	1. Capital programme expenditure reliant on income from sales of assests which may deliver after March 2011. Risks and liabilities of the engineering infrastructure currently undefined. Financial climate provides insufiicient funding to progress all capital projects. Medical Device s replacement and purchase requests exceeded funding available. Clinical Directorates use of risk register to support business planning and requests for capital funding needs to be developed further. Increasing age of Estate leading to patient safety issues should major plant fail. 2. Estates strategy review reliant on agreed clinical strategy to support Trust services.	Estates strategy review. PAMS not currently in place. Helpdesk system for accessing and reporting repairs (reactive) is not fit for purpose.	C3, L3 = 9	Deicated Head of Capital in place. Developing a long term financial model for capital expenditure.	DH performance Framework, CQC Registration, ALE, PCT Contract
Objective 5.1 Ensure the Trust is highly regarded within its local community											
5.1.1	By not being well regrded within our local community there is a risk that we will not be able to understand the needs of our local community and ensure that they are met	FR	C3, L4 = 12	PPI Policy, Equality Policy, HR Strategy, Communication Strategy. Director of Communications appointed.	Patient surveys, staff surveys, community consultations, NHS Choices, complaints, compliments process, PALS, Real Time Monitoring, media coverage.	November patient surverys % of patients who would definetly or probably recommend SASH - chemo suite and Comet ward 100%, Crawley Day Surgery 100%. Community Survey June/July 2010 - % of people who rated ESH as good, very good or excellent; 63% Redhill, 93% Crawley.	The Trust reputation is closely aligned to performance so we need to ensure that we are consistently meeting our objectives and that we communicate this. No budget to do further surveys.	November patient surveys: % of patients who would probably / definetly recommend SASH (target 95%) Discharge Lounge 92%, Inpatient Wards 86%, Outpatients 87%, NHS Choices 44%.	C3,L3 = 9	CEO active engagement with community including local media. Staff communication sessions in place alongside weekly reports to all staff.	DH performance Framework, CQC Registration, ALE, PCT Contract
Domain 6 An Effective Organisation											
Objective 6.1 Develop a motivated, trained and developed workforce											

6.1.1	Risk to service users and the reputation of the organisation due to a failure to ensure appropriate support to the workforce to ensure delivery of the organisations business to the required standards.	YP	C5, L4 = 20	1. Staff wellbeing group delivering a work programme to improve staff satisfaction. 2. HR business partners are aligned to each directorate in relation to skill mix, vacancy rate and substantive establishments. 3. Annual Business planning cycle supports the Directorates in establishing the resources required to deliver their services. 4. First Care reporting to all line managers. Framework in place recording all training activity.	1. Reporting to the Management Board for Quality and Risk from the wellbeing group on progress with action p lan. Visions and Values staff engagement consultation. Education, training and development programme. 2. and 3. KPIs for vacancy rate, skill mix, use of temporary staff are key performance indicators monitored through the monthly Directorate Performance Review process and reported to the Trust Board at its Performance Committee. 4. Training KPIs in place for statutory and mandatory training and professional development which are reported to Performance Committee.	1. Staff survey 2009/10 demonstrates improvements in some areas of staff satisfaction. Care Quality Commission registered the Trust without condition for Supporting Workers and accepted the Trusts action plan. 4. Increased uptake of training and preceptorship. PDP and appraisal training in place.	2, 3, 4. Organisational Development strategy not in place. 2,and 3 CQC Regulation 23 'supporting workers' is compliant with the understanding that the action plan will be achieved by March 2011. Directorate reporting of appraisal and PDP.	1. Annual staff satisfaction survey provides the Trust Board with minimal opportunity to measure the impact of actions and improvements need to be viewed over more than one business planning cycle. 3. Ownership at local level to deliver required compliance with appraisal and PDP. 4. Lack of space to deliver the statutory and Mandatory training programme will restrict capability of staff to achieve their required training to 60%.	C5,L4 = 20	Staff survey - staff encouraged to complet, sample only this year due to financial constraints. KPIs and exception reports provided for Divisions. HR resturcturing with additional HRBP and Deputy Director post appointed, further work on embedding role required within the organisation. Restructuring of Training and Development to give a focus on development for service delivery and improvement completed. Change in Director accountabilities from 1st December 2010, however a number of posts will remain unfilled. Leadership programme developed for senior clinical and non clinical leaders will emphasies the link between staff engagement and performance.	DH performance Framework, CQC Registration, ALE, PCT Contract
Objective 6.2 Achieve all financial targets										

6.2.1.	<u>Income:</u> Reduced levels of activity, increased levels of activity not paid for, lack of service agreements for non Contract activity or non achievement of Contract quality targets lead to failure to secure sufficient income.	PS	C4, L3 = 12	1. Business plans and budgets (activity & financial), financial, performance, quality and contractual reporting, signed PCT Contract, other service agreements. 2. Clear Director & senior manager responsibilities, SFI requirements on Trust staff (around actions that impact income), service line reporting. 3. Contract management (Contract Team) and data integrity (Information Team).	1. Financial, performance, quality & contractual reporting to Management Board, Perf Committee and Board. CQUIN reporting process including operation of EQ & CQUIN Group. 2. Performance Review process with Directorates. Monthly Contract cycle with PCTs (including clinical quality review where SaSH Directors account for performance). Service line reporting process. 3. Outputs and reporting from Contract & Information Teams.	a) Planned levels of activity, performance & quality achieved or exceeded b) Income exceeds budget c) Minimal loss of income from contract challenge or disputes	a) Lack or poor quality of service agreements for non Contract income (including in particular with community services) *Note: data quality risk removed: the Trust is now operating robust data qulaity processes that have impacted favourably on level of income challenge - reported to AAC in Sept.*	a) Activity plans owned & operated at specialty level b) Directorate level accountability processes for activity & income	C4, L1 = 4	1. Community service agreements reviewed as part of recovery plan - completed October 2010 one small risk of £0.2m identified and being addressed. 2. Agreement reached with PCT's to confirm income receivable in 2010/2011 in January 2011. Likelihood therefore reduced to 1. 3. Robust operation of challenge process with PCT's and internal process to minimise risk against delivery of contractual targets is a continuing ongoing action.	Audit Commission will check delivery, assurance on controls and assurance for ALE
6.2.2	<u>Costs & savings:</u> Spending above budgeted levels from realisation of risk, impact of currently unknown factors or non delivery of budgeted savings plans leads to increased cost, failure to reduce cost base and restricts flexibility to manage quality investment.	PS	C4, L4 = 16	1. Performance reporting and related action planning within Directorates and at Perf Reviews. Business plans and budgets, PMO monitoring, 2. Clear Director & senior manager responsibilities, SFI requirements on budget managers and budget allocation processes (that can withhold or provide additional budget). 3.Procurement strategy . Exec sign off of robust recovery plan.	1. Directorate reporting and management. Financial & Performance reporting to Management Board, Perf Committee and Board. Performance Review process with Directorates with active development of action plans, monitoring at working level, with summary reporting. 2. Output and reporting from Finance Team. 3. Procurement reporting and processes.	a) Financial performance within budget (costs within cost budget or set off by income) and availability of contingency b) Financial savings delivered against plan and availability of contingency c) Operational & quality delivery maintained	a) Executive level recovery plan pulling together recovery actions from all sources b) PMO savings plan for 2010/11 and into future years	No material gaps in assurances - reporting processes allow for judgements on evidence presented.	C4, L3 = 12	1. Risk of Trust not delivering forecast now mitigated significantly by agreement over income levels with PCT's. 2. However further overspending in Divisions requires continual control: a. Action plan process with refreshed forrecasrs due at Mon 9 (21 jan) and again at MO 10 (20 Feb) b. Personla invitation by CEO with ADD to affirm their accountability.	Audit Commission will check delivery, assurance on controls and assurance for ALE

NEW 6.2.3	Liquidity : Inability to pay creditors resulting in non delivery of essential services and goods due to poor liquidity ratio	PS	c5,l5= 25	1. Bi-weekly review of forward cash flow by finance team and FD 2. Monthly discussions with SHA on solution to cash pressures	1. Positive cash balance reported each month in Board report 2. Further cash injection secured	a. Positive cash flow reported for every month in 2010/2011 b. SHA emgagement in options for securing income c. no serious creditor on stop issues experienced		No material gaps in assurances - reporting processes allow for judgements on evidence presented.	C5,L5 = 25	1. SHA advised explicitly of issue (completed) 2. Discussion with SHA at 2nd Dec FT trajectory meeting delayed - meeting is now on 21st Jan.	Audit Commission will check delivery, assurance on controls and assurance for ALE
Objective 6.3 Develop a long term clinical model for the Trust											
6.3.1	Current NHS agenda - FT legisltaion, network Trust working arrangements, care closer to home agenda etc - generating constant revision to clinical strategy	RH	C4, L4 = 16	Wide ranging review of clinical strategy continuing - led by CEO/MD/CN/COO with support from clinical staff. External benchmarking undertaken - final report imminent. SHA scrutiny and assitance in place	Clinical input within trust increasing with establishment of 'modern' divisional structures. Partner agencies informing clinical strategic development via scheduled meetings . Job planning in place.	Regular reporting to the management board and Trust Board will be enhanced as the clinical input increases.	1. Detailed referece cost data for specialilities not yet avilable. 2. Programme Board and Clinical Reference Groups constantly reviewing 'fit' with wider health economy - lags behind	Some speciality positions in context of wider agenda uncertain	C3, L2 = 6	Continue to develop a robust and appropriately networked / integrated long term clincial strategy.	DH performance Framework, CQC Registration, ALE, PCT Contract
Objective 6.4 Move to a clinically led management structure.											
6.4.1	Risk of key decisions being made without sufficient clinician input due to lack of engagement of frontline clinicians.	BB / RH	C4, L3 = 12	Appointment of clinical chiefs in divisions with dedicated management time. Appointments to supporting lead clinician roles. Appointments to interim associate director posts. Permenant roles out to advert.	50% clinical membership at every meeting of management board for decision making purposes.	Regular attendance at management board. Medical engagament in Medicine and Women and Child Health Divisions in governance.	Divisional Boards operational policies currently being discussed with the divisions.	Clinical engagement in surgical division governance meetings.	C 4,L2 = 8	Clinical structures are in place and beginning to demonstrate effective governance and operational delivery.	DH performance Framework, CQC Registration, ALE, PCT Contract