Surrey and Sussex Healthcare NHS Trust Assurance Framework 2012/13

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
Objective 1 - Deliver Safe, High Quality, Co-ordinated Care																
1.1. Achievement of national best practice in clinical care	1.1a Failure to improve mortality, particularly NOF	Medical Director	S5 x L2 =10	1) Regular review of Dr Foster alerts 2) Regular review mortality rates and death in clinical services 3) Standardised mortality review process 4)Mortality group established (see link with Risk 1192, 1055)	1) Limited numbers of pathways linking Trust to external services	1) HSMR 93% 2) KPI stroke monitored 3) Discussions and actions taken at mortality review meetings 4)Full review of #NOF cases presented and monitored by MBQR	Positive (+) HSMR above 100 . Negative (-) Mortality alert for Fractured Neck of Femur. (-) Performance for 4 hour target to get all #NOF cases to an orthopaedic ward within 4 hours		First report from Mortality group to SQC yet to be presented	S5 x L2 =10	1) Healthcare of the elderly strategy 2) Considering attaching orthogeriatrics to Surgery ward rounds 3) Increasing Jnr Dr Support 4)Implement system of alerting orthopaedic wards when at arrival at ED	1)Review and report on effectiveness for SQC 2)Healthcare of the Elderly Strategy underway	DH 17/07/12	01/09/2012	S5 x L1 =5	August Board
	1.1b Failure to reduce non-elective demand	Chief Operating Officer	S5 x L5 =25	1)Revised ED arrivals process which provides senior decision making earlier in the attendance facilitating early streaming to correct specialty 2)Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed 3)Executive review and action arising from weekly ED dashboard review 4)Intentional Rounding in ED embedded to maintain safety 5)All escalation areas have identified Matron responsible and patients have nemed Consultant. All patients reviewed daily at clinical operations meeting 6)Daily 8:30management meeting in Ed to review previous 24 hrs and plan for day ahead agreed 7)Two hourly board rounds to ensure patinet plans progress and delays are escalated 8)Rolling programme of implementation of 11 ambulatory care pathways- 5 complete; 3 due end of Dec, 3 end of March.	1)Currentley running with 7 locum / agency middle grades and 1 consultant vacancy	1) Combined weekly Quality and Performance Dashboard for ED reporting on a combination of quality and safety standards and the ED national indicators reported to exec meeting weekly 2) Safety and Quality Committee dashboard 3) Performance Management Framework and reporting to Trust Board 4) RTM data on patient experience in all clinical areas 5) External stakeholder inspections 6) Daily 9am performance review meeting 7) Capacity sheets updated three times a day	Positive (+) Sustained Medical outliers in SAU decreased since start of calander year (+) Sustained decrease in cancelled elective procedures (Dec 11) (+) Significant reduction in 12 hour breaches (sustained) (+) SHA external review provided positive assurance on safety and quality (+) Fewer medical patients in surgical beds Negative (-) Quality indicators for time to assessment and time to treatment not yet at acceptable threshold (-) Yet to achieve sustsained reduction to 3.5% target agreed with DTOC		Continue to displace surgical beds and by between 25 - 40 medical patients (daily)	S5 x L4 = 20	1)Demand management plans with local health economy to be set 2)Phase 2 of ambulatory care pathway commenced (further 11 pathways) 3)As part of a wider patient flow work stream look to develop a reduction in length of stay program	1)Reduction in demand/activity is not supported/indicated by data 2)Phase 2 pathways being implemented but yet to make significant impact on admissions, preventing creep but not reducing number	BE 16/07/12	01/09/2012	S5 x L2 = 10	August Board
	1.1c Failure to comply with regulator expectations	Chief Nurse	S4 x L4 = 16	1)Safety priorities approved, KPI's in place and reported to Safety and Quality Committee 2)Patient Experience Group in place 3)Mock CQC inspection programme 4) RTM and other patient experience information with local action planning 5) Divisional action plans in place addressing patient experience feedback (see link with Risk 1167)	1)Staff understanding of their responsibilities under the Care Quality Commission regulatory framework remains poor	1)Internal Trust Annual Staff Survey on Patient Safety using MAPSAF tool 2)Patient Experience feedback all sources 3)Organisational Patient Safety Incident Reports from the National Patient Safety Agency benchmarking the reporting rates and types of incidents 4)Quarterly internal incident reports; 5)CQC and external stakeholder inspection reports 6)Audits of nursing assessment and care plan tool 7)Patient experience reporting to Trust Board and Safety and Quality Committee. 8) Nursing audit framework includes Essence of Care Benchmarks 9)Division action planning following mock CQC inspections, surveys and clinical Friday working. 10)Nursing audit framework includes Essence of Care	Positive (+) SHA clinical review (Jan 12) verbal feedback - no safety concerns (+) CQC verbal feedback (Jun 12) no safety concerns positive comments (+) Trust Quality and Risk Profile from CQC evidences no red rated risks to non compliance with the regulations (Dec 11) (+) CQC reactive inspection (Feb 2011) found Trust compliant with all standards inspected (related to Dispatches Investigation) (+) Facilities Cleaning Audit (+)Matrons infection control audit		1)Patient stories at Trust Board	S4 x L3 = 12	1)implement PEAT action plan arising from most recent inspection 2)Continuing with the development and introduction of ED operational standards and the enhancing nursing skill mix and competency. 3)Review nursing documentation	1)Recent PEAT results very encouraging 2)Nursing documentation reviewed updated and in place	JT 16/07/12	01/09/2012	S4 x L2 = 8	August Board
	1.1d Failure to establish the nursing safety thermometer effectively	Chief Nurse	S4 x L3 = 12	1)Project leads identified and aware of approaching initial deadline 2)Process for data collection agreed with line management (see link with Risk 1055)	1)No administration support identified for large data entry requirements 2)System has not been tested	1)Process for establishing system in place 2)Local implementation exercise carried out to review other Trusts systems	Positive (+)Initial runs of safety thermometer successful		SASH data not included in initial reports despite delivery deadlines being met, should now be resolved	S4 x L2 = 8	System being developed to roll out data collection and recoding for all wards by the end of financial year	July audit doubled areas recorded from 7 to 14	17/07/12 SB	01/09/2012	S4 x L1 = 4	August Board
	1.1e Workforce not performing to required expectations at point of care	Chief Nurse	S4 x L4 = 16	1)Patient Safety Lead nurse working with front line staff 2)Policies and procedures clarify staff responsibilities 3)Professional Registration requirements 4)Mock CQC inspection programme 5)RTM and other patient experience information with local action planning 6)Divisional action plans in place addressing patient experience feedback 7)Clear managerial and clinical structures in place with single point accountability through the Chiefs of Service (see link with Risk 1171 and 1170)	1)Multidisciplinary working practice on ward rounds and for discharge is not standardised and embedded across the Trust; 2)Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU 3)Compliance with completing the audit programme varies across the divisions.	1)National Staff Survey measures of staff engagement / opinion on fairness of reporting / incident management. 2)Internal Trust Annual Staff Survey on Patient Safety using MAPSAF tool 3)Patient Experience feedback all sources 4)Vacancy rates and workforce information reported to Trust Board 5)Audits of nursing assessment and care plan tool 6)Benchmarked performance in EQ, Safer smarter nursing, care pathways 7)Division action planning following mock CQC inspections, surveys and clinical Friday working. 8)Appraisal compliance rates 9)Dr Foster data 10)Clinical audit reporting	Positive (+) CQC verbal feedback (Jun 12) (+) CQC reactive inspection (Feb 2011) found Trust compliant with all standards inspected (related to Dispatches Investigation) (+) Appraisal rate improving across the Trust >70% (Dec 11) (+) 80 managers trained in appraisal (+) SHMI Negative (-) Statutory and Mandatory training compliance - 65% (Dec 11)		1)Divisions are not consistently reporting evidence of change from learning. 2)Lack of audit or review of evidence of Locum/temporary staff competency and reporting of performance during shift/s.	S4 x L3 = 12	1)Further qualified nursing staff (approx 40) are due to commence at SASH in November and January 12 2)Ongoing implementation of a wide ranging action plan, as part of clinical effectiveness implementation plan for approval, to drive up compliance with clinical audit programme. Audit plan being monitored by the Safety and Quality Committee.	Audit programme 75% commenced. Monthly monitoring continues.	27/07/12 JT	01/09/2012	S4 x L2 = 8	August Board
	1.1f Failure to meet national targets to reduce HCAI	Medical Director	S5 x L4 = 20	1)IPCAS Group Team and group in place 2)Weekly taskforce in place 3)Infection control manual in place and information resources available 4)Antibiotic policy and guidelines in place 5) Infection control quality round implemented 6)Education for Jnr Doctors on induction (see link with Risk 1054,1050,1049)	1)Antimicrobial prescribing compliance is low in areas 2)Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset	1)KPI indicators 2)Reducing numbers of cases of C. diff year on year 3)No confirmed outbreaks of C. diff commenced during 2011/12 4)Recent PCT and SHA visits focusing on infection control 5)Recent CQC visit focusing on Nursing documentation and escalation	Positive (+)C. diff rate continues to drop year on year (+)Antimicrobial prescribing compliance improving (+)Actions taken as part of annual program (+) Recent CQC inspection highlighted improvements in MRSA screening Negative (-) MRSA BSI rate higher than acceptable (-) C.diff rate higher than acceptable at start of financial year		Extensive auditing and monitoring in place. Trust position known	S5 x L4 = 20	1) Develop pocket size antimicrobial guide 2) Launch diarrhoea risk assessment tool. 3) Review MRSA management policy 4)Consultants to lead on OSCE-based competency training for doctors on hand washing and insertion of invasive devices. 5) Further actions detailed in IPCAS annual plan	1)Guides developed to be printed 2)MRSA policy review ratified at July MBQR to be launched 3)Extensive scrutiny of annual plan of work monitored by IPCAS Group	DH 17/07/12	01/09/2012	S5 x L2 =10	August Board
1.2. Ensure patients are cared for in the right place at the right time	1.2a Lack of ability to allocate the right bed first time in terms of respect and dignity.	Chief Nurse	S4 x L3 = 12	1) Operational meeting three times a day chaired by Chief / Deputy Chief Operating Officer with clinical involvement from Matrons, Nurse Specialists and therapists 2) Daily Board rounds by clinical site team 3) Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed	1)Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU 2)Additional workload for medical teams having to cover significant numbers of patients outside their bed base 3)The external influences outside of SASH control e.g.) demand management and delayed discharges in care	Patient Experience feedback all sources Patient experience and complaints;	Positive (+) Care Quality Commission DANI report (July 2011) evidences patients report they are cared for and about.		SQC comparison of PT journeys indicated further development of process of right bed first time	S4 x L3 = 12	1)Ambulatory care pathways 2)Linked to 1.1b	See 1.1b	JT 16/07/12	01/09/2012	S4 x L2 = 8	August Board

Surrey and Sussex Healthcare NHS Trust Assurance Framework 2012/13

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
1.3 Safety and Experience of Patients in ED	1.3 Failure to ensure substantive workforce in ED with experience and skill	Chief Operating officer	S5 x L5 =25	1)Clinical Lead appointed 2)Consultant in post 3)2 middle grades in minor injuries/aliments 4)Agreemnet with agency to proactively fill middle grade gaps one month in advance	1)Currentley running with 7 locum / agency middle grades 2)Consultant vacancy	1)Clinical rotas demonstrate planned medical cover in advance of date 2)Agreement with agency to proactively fill middle grade gaps one month in advance	Positive (+)Clinical lead in post (+) Consultant and mid grade interviews in July, potentially strong candidates Negative (-)Evidence demonstrates inability to consistently achieve time to treatment targets		Inability to process trauma unit status skill mix	S5 x L3 = 15	1) Recruitment agency unit engaged to support recruitment process 2) Review on site facility for primary care out of hours	Consultant and mid grade interviews in July, potentially strong candidates	BE 16/07/12	01/09/2012	S5 x L2 = 10	August Board
1.4. Develop clinical partnerships/Trust Status that provide safe and sustainable clinical services	1.4a Inability to comply with trauma unit accreditation	Medical Director	S5 x L3 = 15	1) Trauma steering group 2) Critical care network 3) Joint working with BSUH 4) Consultant Recruitment	1) Consultant vacancies 2)Use of locums 3)Gaps in essential skill mix	1) Minutes of Trauma steering group, MBQR and Critical Care Network	Positive (+) Recruited consultant with trauma leadership background (+)Mid grade vacancies being filled (+)Surgical lead for Trauma identified (+)TARN data now collected		Cancellation of meetings and gaps in essential data No independent mechanism for mapping/monitoring progress	S5 x L3 = 15	1)MD progress reports to Board 2)Recruitment of vacancies 3)Commence systems for gathering and generating necessary evidence to support accreditation	1)Trauma steering group work 2)Monitoring vacancies and recruitment 3)TARN data collection established	DH 17/07/12	01/09/2012	S1 x L1 =1	August Board
Objective 2 - Ensure Patients are cared for and cared about																
2.1. Be recommended on the basis of "customer care"	2.1a Inability to improve patients' perceptions of services, staff or hospital	Chief Executive	S4 x L4 =16	1)Patient experience group 2)Communication team and work plans 3)Communications strategy 4)Complaints team 5)PALS team (See link 1306)	Need to increase patients to provide both negative and positive comment in order for Trust to learn from experience	1) NHS Choices 2)Complaints feed back 3)Links feedback 4)Patients Council 5)HASC minutes 6)RTM	Positive (+)RTM data (+)Compliments (+)PALs annual report (+)Excellent July PEAT report Negative (-) NHS Choices (-)Static complaints trends		Aggregated pt feedback report including RTM, PALS, complaints etc	S4 x L4 =16	1)Preparation and Delivery of Customer Care Strategy 2)Senior leadership training and meetings 3)Extensive refurbishment of high pt flow areas	1) Complaints training rolled out across Trust 2)Major refurbishment work commenced, extra wards to increase bed stock and reduce escalation areas delivered on schedule	CP 17/07/12	01/09/2012	S4 x L2 = 8	August Board
	2.1b Failure to maintain effective complaints management across the Trust	Chief Nurse	S3 x L3 = 9	1) Trust wide monitoring system 2) Divisional responsibility for actioning complaints investigation	1) Delays in administration of complaints, including signature and final editing	1) Quarterly complaints reports 2) Compliance with completion on time and numbers of case reopened	Positive (+) Complaints performance in divisions Negative (-) Numbers of cases reopened (-) Performance in divisions (Surgical) (-) Supporting corporate function going through personnel change		Performance data that details where a compliant is being held up in the system	S3 x L3 = 9	1)Reviewing supporting corporate function 2)Review working arrangements between Corporate body and Divisions to stream line the process	1)Corporate function review commenced	JT 16/07/12	01/09/2012	S3 x L2 = 6	August Board
2.2. Treat all patients and their family/carers with Compassion, Courtesy and Privacy and Dignity	2.2a Failure to continually improve the patients perceptions of our staff	Chief Nurse	S4 x L3 = 12	1)Patient Experience Group in place 2)Patient Safety Lead nurse working with front line staff 3)Mock CQC inspection programme 4)RTM available at point of care 5)Divisional action plans in place addressing patient experience feedback 6) Leadership programmes in place at senior management level	1)The external influences outside of SASH control e.g. demand management and delayed discharges in care 2) Additional workload for medical teams having to cover significant numbers of patients outside their bed base	1)RTM data available and monitored by SQC and patient experience group 2)CEQUIN data	Positive (+) Peat inspection July Privacy and Dignity (+) CEQUIN patient experience (+) CQC feedback for complaints system (+) NHS Choices positive feedback (+) Compliments PALs Q4 Negative (-) NHS Choices high ratio negative comments (-) Numbers of complaints recieved (-) Staff and patient survey trends		1) Pro actively encourage patients to use NHS choices PALs and complaints systems to improve information resources	S4 x L3 = 12	1) Customer care training 2) Trust overall compliance monitoring of the appraisals system 3) Top down communication off need to focus on patient experience from Chief Exec down through Senior Leaders to front line staff	1)Customer Care Training commenced 2)HR and Divisions monitoring appraisals	JT 27/06/12	Sep-12	S2 x L3 = 6	August Board
Objective 3 - Work in partnership with our community																
3.1. Work with our patients and partners to develop services that meet the needs of our community	3.1a Inability to develop and deliver cross - organisational services/pathways that meet patients' needs	Chief Operating Officer	S4 x L5 = 20	1) Ambulatory path ways rolled out 2) Caterham Dene and Crawley Clinical Assessment services established 3)Twice weekly whole system conference calls to proactively manage patient discharge 4)Trust participating in Kings Fund Program	1)Gaps in assumptions made between PCT and CCGs 2)Whole system action needs more operational detail/time frames and deliverable outcomes	1)Internal activity data 2)Daily SIT reps 3)SECAMB activity data	Positive assurance (+): (+) System management unscheduled care dashboard improving cases (+) SECAMB activity data		1) Triangulation of data at sufficient level to demonstrate transfer of activity vs. new activity	S4 x L5 = 20	1) Planned work to identify gaps in provision 2)Proposal to focus whole system approach on 3 major work streams	1) Recognition that current plan is not delivering, therefore refocusing on 3 key areas 2) Bed census planned for August 3)Workstream to identify gaps in provision	BE 16/07/12	01/09/2012	S2 x L5 = 10	August Board
	3.1b Lack of strategic approach to identifying and developing opportunities	Chief Executive	S4 x L3 = 12	1)Transformation board in place, monitoring action plan 2)Clinical cabinet meeting between Trust Clinicians and CCGs 3)TFA Board	1)Rapid progress and changing in local care environment (Elective and Non elective activity) makes long term planning and forecast of activity difficult	1)Partcipationa with CCGS in developing new contracts and maintain activity 2)Kings Fund Work steam	Positive assurance: (+)Local commitment for extensive refurbishment of estate demonstrating key links with stakeholders (+)Repatriation of Chemotherapy services (+)High level conversations with other providers fro maternity services		1)Complexity of business model re chemotherapy (Funding)	S4 x L3 = 12	1)Clinical Strategy to be developed 2)Drafting Integrated Business Plan to be developed 3)Working with Sussex on proactive care model (Frail Elderly Strategy)	1)All mitigating actions and plans in varying stages of draft format	CP 17/07/12	01/09/2012	S4 x L3 = 12	August Board
3.2. Improve the way all other partners perceive and talk about SASH	3.2a Failure to effectively engage external stake holders	Chief Executive	S4 x L2 = 8	1)Stakeholder meetings and actions underway, such as HASC, LINKS, Patients Council and CQPM 2)GP Newsletter and GP forum	1)Evidence to demonstrate board to ward understanding of need to engage with stakeholders	1)HASC minutes 2)CQPM minutes 3)Patient focus groups 4)Peer review 5)RTM	Positive (+)Senior stakeholder acknowledgement that quality of care at SASH is improving (CEO of NHS SOE, CQC Inspector) (+)Attendance of stakeholders at focus groups and Trust committee meetings (+) Press and media coverage (+)Maternity services liason committee (MSLC) Negative (-) Press and media coverage			S4 x L2 = 8	1)Develop and implement PPI Plan 2)Plan to embed experience based design into service provision and development	1)PPI plan under development	CP 17/07/12	01/09/2012	S4 x L2 = 8	August Board
Objective 4 - Become a Sustainable,																
4.1.Live within our means both in year and ensure sustainability into the future	4.1a Failure to deliver income plan	Chief Financial Officer	S5 x L3 = 15	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Signed contract with commissioners.	1) PCT activity plans not profiled and aligned with Trust plans at July 2012 2) No validated change plans available at July 2012	1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, 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 and information teams 4) Output and reporting from health system management (e.g.: System Management Team meeting)	Positive assurance (+): 1) M03 - income plan is being exceeded, providing good assurance - however there is a counter to this below. Negative assurance (-) 2) Exceeding the income plan indicates "overheating" which is adverse to health system plans, which provides a risk to our shared aims and the risk of non payment from NHS Sussex because of the capped contract 3) The "overheating" introduces an additional cost problem visible in Finance reports Assurance RAG right is "red" because of these last two points.		A) Confirmation of health system action (of which the Trust has a part) to deal with "overheating" B) Confirmation of CCG payment for activity (M01 reconciliation process is behind schedule)	S5 x L3 =15	1) Activity plans being aligned by Trust - Trust has shared phased plans with CCGs and is supporting work to correctly set out the plans (output in July). 2) Position escalated through formal letter and recorded action at Single Performance Conversation.	Actions proceeding to timetable	12 Jul - CFO	Post M04	S4 x L2 =8	To be discussed at August Board

Surrey and Sussex Healthcare NHS Trust Assurance Framework 2012/13

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
	4.1b Failure to stop divisional overspending against budget	Chief Financial Officer	**S5 x L3 = 15**	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Divisional activity plans agreed & signed off 3) Additional activity budget being allocated after agreement of specific pressures	1) Nursing spend and medical agency spend controls subject to review and action.	1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, 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 and information teams 4) Output and reporting from PMO	Positive assurance (+): 1) Overall I&E position is balanced - income covers spend, but see negative assurance. 2) Although 3 Divisions are above overspend thresholds, many cost centres are not. Negative assurance (-) 3) Overspending in nursing budgets, and medical agency budgets. 4) Need to fully recruit to nursing vacancies, increasing complexity of achieving planned spend reductions with planned activity reductions. Assurance rating right is "red" because of latter aspects.		A) Nursing spend and medical agency spend	**S5 x L3 =15**	1) Additional control structure remains in place - and is being strengthened - weekly nursing meetings now with CEO, CFO/Deputy meetings with ADOs to manage other actions, with escalation to CEO (ongoing) 2) Performance Review process operating with all Divisions	Actions proceeding to timetable	12 Jul - CFO	Post M04	**S3 x L2 =6**	To be discussed at August Board
	4.1c Unable to provide realistic medium term financial plan	Chief Financial Officer	**S5 x L3 = 15**	1) Items referred to in 4.1c above	None	1. Delivery of current year financial plans	Negative assurance (-): 1) Plan is high level and requires delivery of performance in 2012/13 - there are significant risks as described here 2) External approval is currently in principle only 3) Savings and income levels provide extremely challenging targets		A) Performance in 2012/13 against first milestones	**S5 x L3 =15**	1) Trust actions to manage items listed above (delivery of 2012/13 plan) (Q1 - July) 2) Long term financial model being revised - resource taken off-line to complete July 2012	Actions proceeding to timetable	12 Jul - CFO	Post M04	**S4 x L2 =8**	To be discussed at August Board
	4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	Chief Financial Officer	**S5 x L5 = 25**	1. Bi weekly review of forward cash flow by finance team and CFO 2. Cash and working capital policy and strategy 3. Annual cash plan linked to business plan and capital plan	None	1. Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2. Monthly finance reporting to Management Board and Trust Board	Positive assurance a. Positive cash flow reported for every month in 2011/2012, and into 2012/13 b. Liquid ratio has not worsened in any month, and has improved with cash injection c. Cash flow forecast for year is OK, but dependent on I&E risks described above. Negative assurance		In terms of cash flow management to end year, no material gaps in assurance. In terms of resolving the actual risk (liquidity), there is no confirmation of additional cash to resolve SoFP weakness.	**S5 x L3 =15**	1) Risks around I&E above apply here too; 2) Trust received a cash injection at the end of 2011/12 - day to day cash control is main action currently	Actions proceeding to timeta	12 Jul - CFO	Post M04	**S4xL3= 12**	To be discussed at August Board
4.2. Delivery of TFA and Monitor standards	4.2a Failure to Implement a governance framework suitable for foundation trust status	Director of Corporate Affairs	**S4 x L3 = 12**	1)BGAF assessment carried and action plan developed 2)Corporate governance framework 3)Interim Director of Corporate Affairs in post, vacancy filled	1)Corporate Governance infrastructure and support not yet clearly identified	1)BGAF assessment	Detailed as part of BGAF action plan		Gasp in evidence of implementation	**S4 x L3 = 12**	Detailed BGAF action plan developed	BGAF has been discussed regularly and will be driven forward by Director of Corporate Affairs post	18/06/2012 HA	01/09/2012	**S4 x L2 =8**	To be discussed at August Board
	4.2b Unreliable information resulting in poor decision making	Director of Information and Facilities	**S4 x L3 = 12**	1) Data Quality Strategy written by Director of Information and Facilities and managed on everyday basis by Data Quality Manager reporting to Head of Information 2) Data Quality Report reviewed by Information Governance Meeting on a regular basis 3) Information used within wide range of Board and Management Reports 4) DQ Training key element of EPR/PAS Training	1) Insufficient DQ Resource to fully check all relevant KPIs	1) Monthly Data Quality Report as reviewed by Information Governance Group 2) Internal Audit Reports 3) External Audit Reports	Positive (+) Data quality report showing positive results (+) Internal audit report (+) Information Governance report		None	**S4 x L3 = 12**	1) Development of rolling data quality programme looking at each KPI in turn 2) Data Quality Mark to be added to Performance Report based on above 3) Work underway lead by Andy McGraw	Plan to be developed	16/06/12 IM	01/09/2012	**S4 x L2 =8**	To be discussed at August Board
4.3. Listen to, value and develop our workforce	4.3a Ineffective staff development means that the Trust does not have the skilled workforce to deliver current and future services	Director of Human Resources	**S4 x L3 = 12**	1) Ratified Workforce Strategy and Plan 2) Training plan aligned to national and regional requirements 3) Appraisal and PDP compliance monitoring and reporting to Board (see link with Risk 910) 4) Statutory and mandatory training matrix (see link with Risk 1170). 5) Data collection and monitoring linked to ESR , and exception reporting	1) Quality of appraisals and pdps 2)Matrix needs review 3) Limited availability of training rooms 4) Trainer capacity 5) Quality of data received	1) Implementation Plan report to Investment and Workforce Committee ????SHA assurance process 2) Delivery of plan and monitoring of external training budgets (CPD Delivery plan and reporting) 3) Monthly performance reports to Management Board. Annual Staff Survey responses to training questions 4) Monthly reports to Management Board on performance 5) Complementing current provision with robust e-learning programme	+) Implementing actions from Trust Workforce Strategy Plan 2012-2015 +) LDA signed, SHA allocations received and SHA reporting quarterly -) increase in appraisal compliance and quality of appraisal -)) Monthly reporting by division and staff feedback sessions,improvement in staff and patient survey -) New Performance Framework and increase in statutory and mandatory compliance +) at least 20% mandatory and statutory training via e-learning		1) Inability to deliver e-learning project on time 2) Insufficient resources to fund Training needs 3) Lack of staff engagement and low morale 4) poor appraisal compliance	**S4 x L3 =12**	1) review and monitoring of Statutory and mandatory training matrix 2) continued delivery of revised Statutory and mandatory Training programme 3) More local delivery of statutory and mandatory training 4) New method of collecting appraisal data just put in place 5) Regular monitoring of appraisals by division	1) Draft review of matrix completed and meeting with Medical Director and Chief Nurse planned 2) Revised programme being delivered 3) cascade training in place 4) New appraisal reporting method in place	8/6/2012 BC/JM	01/09/2012	**S4 x L3 =12**	To be discussed at August Board
	4.3b Ineffective staff engagement and buy-in of staff to the Trusts objectives and direction delays or derails service and workforce redesign and ability to make financial savings	Director of Human Resources	**S4 x L3 = 12**	1) Staff Survey engagement score 2) Engagement Strategy in development (see link with Risk 1321) 3) Focus groups and in year temperature check on engagement 4) Team briefing mechanism for message cascade 5) Transformation Plans embedded in business planning cycle	2) Lag between Staff survey completion and results - being addressed through in year temperature check and focus groups	1) Annual Board report on staff survey results and action plan 2) Staff will be involved in its development - Strategy will be approved by Board 3) Report to Executive Management Board on results 4) Number of briefings held during 12/13 and attendance sheets 5) PMO monitoring, monthly reports to Management Board	-) Feedback sessions ESH and Crawley Hospital +) Attendance at team briefs and Senior Leaders Meeting 3) Board Report in May +) Customer Care Pilot launch in June. Frontline staff engaged in design and development		1) Engagement still poor (in bottom 20% of acute Trusts) 2) Engagement Strategy not yet in place	**S4 x L3= 12**	1) Equality and Diversity & HR Steering Group 2) Board Seminar engagement 3) Focus Groups for Engagement Strategy	actions agreed to progress	8/6/2012 BC/JM	01/09/2012	**S4xL3=12**	To be discussed at August Board
	4.3c Lack of leadership capacity and capability to engage with and develop staff delays or derails workforce redesign and ability to make financial savings	Director of Human Resources	**S3 x L3 = 9**	1) Leadership programmes provides a cohort of 150 senior managers to effect change. Programmes of change focused on trust priorities. 2) Training needs analysis annually and funding of external training through the bursary 3) Clear managerial and clinical structures with single point accountability through the Chiefs of Service. 4) Investment and Workforce Committee oversight of Training Plan 5) Board development programme		1) Attendance at leadership training and output of change project 2) Delivery of plan and monitoring of external training budgets 3) Performance management processes from ward to board, vacancies in management structures 4) Reports being received at Investment and Workforce committee 5) Completion of programme	+) 200 Senior Leaders trained under Healthskills with different workstreams over 2 years +) 1st Cohort Leadership in Action programme has completed +) Pilot Essentials of Management ongoing -) 2012-2013 Training Plan in place. +) LDA signed and SHA allocations received and Bursary panels in session +) New clinical structure in place with Chiefs of Staff +) Regular Board seminars, recent Board meeting and observation by Healthskills +) LEAP leadership Programme by KSS Deanery for Medical teaching Faculty		1) How to measure leadership training - identifying link between leadership activities and programmes and organisational change 2) Lack of behavioural change	**S2xL4=8**	1) Establish framework to enable short-term change or KPI measures to show added value of programmes, new structures and processes in place 2) Attendance at Senior Leaders meeting and engagement with Transformation Plans 2) Prioritising TNA funding to Trust priorities	1) Monitor through Management Board for Performance 2) New Performance Score card measuring quality, patient satisfaction, staff satisfaction and performance	8/6/2012 BC/JM	01/09/2012	**S2xL4=8**	To be discussed at August Board