SURREY AND SUSSEX HEALTHCARE NHS TRUST BOARD ASSURANCE FRAMEWORK 2011/12- NOVEMBER v1.3

No.	Principal Risks	Lead	Initial Risk Rating	Existing Controls	Potential Assurances on Controls	Actual Assurances	Gaps in Control	Gaps in Assurances	Current Risk Rating	Action Plan
	What could prevent the objective being achieved?			**What controls/systems do we have in place to assist in securing delivery of this objective?**	**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 we are failing to put controls/systems in place.**	**Where we are failing to gain evidence of our systems, on which we place reliance, are effective.**		**What are we doing to reduce the principal risks?**
Priority 1 - Deliver Safe, High Quality Care										
1.1.1	**Risk of staff not being engaged in the safety agenda due to pressure of work, *leading to poor risk assessment, incident (actual and near miss) identification, reporting, and investigating***	**JT**	**S4xL5 = 20**	1. Full recruitment and absence management 2. Patient Experience and Staff Engagement Group in place 3. Patient Safety Lead nurse working with front line staff 4. Job planning 5. Senior Clinicians trained in investigation, incident management bringing process learning and understanding closer to front line staff 6. Agency/locum Drs usage	1-4 National Staff Survey 1-4 Annual Staff Survey on Patient Safety 1-4 Patient Experience feedback ***Organisational Patient Safety Incident Reports from the National Patient Safety Agency.*** ***Quarterly internal incident reports.***	1. Nursing and Midwifery vacancy rate has decreased since April 2011 and there has been a decrease in turnover in the Women and Child Health Division 3. Intentional rounding in emergency department (ED) in place with the escalation component monitored weekly in the ED dashboard. 5. Senior clinicians trained and investigating incidents. ***(-) Latest data provided by the NPSA place the Trust in the lowest 25% of incident reporters when compared to 48 other similar organisations (medium size acutes).***	Sharing of learning across divisions is not robust. Increased absence rate since June 11. ***Electronic Datix Web for Incident Reporting not yet rolled out; paper based system currently used, which can lead to delays in reporting.***	Annual staff survey is only source of benchmarked staff feedback.	**S4 X L4 = 16**	1. Further qualified nursing staff (approx 40) ***are due to commence at SASH in November and January*** 2. Divisions implemented plans to manage absence development with ongoing monitoring and revision. Performance Management by exec team at Management Board 3. Quality Strategy and implementation plan for ***approved: implementation underway.*** 4. Review of internal skills to achieve maximum productivity from Consultant job planning underway.
1.1.2	**Risk of avoidable harm to patients due to staff not *fulfilling* their accountabilities in preventing potential harm**	**DH**	**S4xL5 = 20**	1. Policies and procedures clarify staff responsibilities 2. Professional Registration requirements 3. Implemented best practice tools which define each step. 4. Best Practice approaches adopted e.g. care bundles, EQ pathways which by design optimise outcome and minimise risk	Clinical audit reporting Benchmarked Key Performance indicators Benchmarked performance in EQ, Safer smarter nursing, care pathways SUI investigation and completion of action plans Patient experience reporting to Trust Board and Safety and Quality Committee. ***Agency/locum Dr usage*** ***Complaints/incidents/litigation*** ***HR disciplinary activity*** ***Appraisals*** ***Dr Foster data*** ***Feedback on agency/locum staff performance***	1. ***Assurance gained for specific patient group as*** SASH is highest performing Trust for Congestive Heart Failure Pathway (Enhancing Quality programme) in South East Coast Region (10/11) 2. HSMR remains below 100 decreasing numbers of alerts (Sept 11) 3. CQUIN monies paid for Enhancing Quality programme and Safety Survey (10/11)	Ineffective data capture processes in some specialties Compliance with completing the audit programme varies across the divisions. ***Lack of consistent evidence of Locum/temporary staff competency and reporting of performance during shift/s.*** ***PDPs as part of appraisal for doctors are optional currently.***	Divisions are not consistently reporting evidence of change from learning. ***Lack of audit or review of evidence of Locum/temporary staff competency and reporting of performance during shift/s.***	**S4 X L4 = 16**	1. VTE data collection methods are being revised in areas / specialties where there are difficulties. 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.*** 4. Deep dive executive performance management of quality of services ***continues with the Divisions.*** 5. Quality Management and Governance Policy for ***approved- roll out/ implementation .***
1.1.4	**Risk to patient safety due to key staff / individuals not working effectively as teams, *leading to poor patient experience***	**JT**	**S4xL5 = 20**	1. Policies and procedures set out staff roles and responsibilities 2. Nursing staff templates are based on national model for nursing establishment 3. Revised nursing assessment documentation implemented which standardises individual patient's risk assessment. ***4. Multidisciplinary Nutritional Steering Group established with Terms of Reference and meeting chaired by a clinician.*** ***Parenteral Nutrition Policy in place.***	1. Incident Reporting and investigation 2. Patient experience and complaints 3. KPI's reported to the Quality and Safety Committee 4. Vacancy rate and temporary staff monitoring at Trust Board 5. Length of stay and Readmission monitoring 6. Performance reporting	The composite care scores for all four pathways are exceeding the improvement target set for 2011/12 (August 2011). ***Minutes of the Nutritional Steering Group.***	Multidisciplinary working practice on ward rounds and for discharge is not standardised and embedded across the Trust Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU. Additional workload for medical teams having to cover significant numbers of patients outside their bed base. ***Multidisciplinary Food and Drink Group not yet established.***	No material gaps identified	**S4 X L4 = 16**	1. Emergency Department follow up clinics are being implemented 2. Actions arising from Dispatches investigation being implemented - including standardised protocols for ward rounds and multi disciplinary working. ***3. Formulation of a Nutrition Support Group with additional dietetic support to be taken to the Digestive Diseases Group.*** ***4. Multidisciplinary Food and Drink Group to be established.***
Objective 1.2 - Ensure Patients are cared for *and* cared about "no decision about me, without me"										
1.2.1	**Risk of poor quality care for patients due lack of engagement, inadequate capacity, inappropriate environment and a lack of staff belief that things can improve.**	**JT**	**S4xL5 = 20**	1. NHS Constitution, CQC Regulatory Framework and Trust Objectives promote patient involvement in their care 2. Safeguarding teams in place for vulnerable patients 3. Policies and Procedures in place 4. Patient Experience and Staff Engagement Group 5. Mock CQC inspection programme ***6. Use of transit area in Emergency Dept (ED) to reduce congestion in the dept.*** ***7. Intentional rounding in place in ED***	1. Division action planning following mock CQC inspections, surveys and clinical Friday working. 2. Nursing audit framework includes Essence of Care Benchmarks 3. KPI's reported to Quality and Safety Committee ***4. Reports internal and external e.g. Quality and Risk Profiles from the CQC***	***Decrease in the ED complaints in August.*** ***Latest Quality and Risk Profiles are showing Reds in relation to PEAT inspection (re choice of menus and cleaning standards in Out Patients).***	Consent training for medical staff not currently in place which includes Mental Capacity Act The external influences outside of SASH control e.g. demand management and delayed discharges in care.	Benchmarked staff engagement information is only available annually in the Staff Survey	**S4 X L4 = 16**	Productive ward programme aimed at releasing time to care and patient safety relaunched in July 11 with rolling programme in all inpatient wards. Peer review (ASPH) as part of SHA programme for Care and Compassion ***completed now awaiting formal report which will trigger Trust response and action (initial verbal feedback positive given constraints).*** ***Review in light of latest Quality and Risk Profiles in order to deliver improvements.***
1.2.2	**Risk of poor experience due to lack of staff *implementation of Trust Values when under pressure, leading to poor* behaviour and in-action affecting patients.**	**JT**	**S4xL5 = 20**	**1.** Policies and Procedures 2. Patient Experience and Staff Engagement Group 3. RTM and other patient experience information with local action planning 4. Divisional action plans in place addressing patient experience feedback ***5. Executive links with clinical areas in place***	1. Patient experience reporting 2. Appraisal compliance rates 3. Safety and Quality Committee dashboard includes patient experience measures monthly 4. Quality Management Implementation plan reporting to Safety and Quality Committee ***5. Staff Survey*** ***6. Safety Culture Survey***	Care Quality Commission Inspection reports provide evidence that the majority of patients state they are cared for and about Sustained reduction in complaints numbers in most areas.	Staff understanding of their responsibilities under the Care Quality Commission regulatory framework remains poor.	Patient stories at Trust Board Safety / Experience walk rounds by Trust Board members	**S4 X L4=16**	Executive performance management of divisional action planning in response to patient experience information at divisional Deep Dives. Patient Safety walk round programme in place Executive links with clinical areas relaunched

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Objective 1.3 - Right patient, in the right location at all times										
1.3.1	**Risk of serious adverse outcomes for patients due to overcrowding and patients being placed outside their specialty beds.**	**BB**	**S4xL5 = 20**	1. Operational meeting three times a day chaired by Chief / Deputy Chief Operating Officer with clinical involvement from Matrons, Nurse Specialists and therapists. 2. Additional capacity areas reviewed daily - high risk patients identified at this meeting. 3. Daily Board rounds by clinical site team 4. Established budgets for escalation areas to ensure own staff in these clinical environments. 5. Daily conference calls with PCT and social care to actively manage delayed transfer of care agenda. 6. Unscheduled care leads established in all specialties offering access to GP's all day Mon to Fri for advice / hot clinic alternatives to admission. 7. Revised ED arrivals process which provides senior decision making earlier in the attendance facilitating early streaming to correct specialty. 8. Live 'To come In' lists available to view in all specilaty wards to encoruage active pull of patients from AMU to the correct specialty bed. 9. Executive review and action arising from weekly ED dashboard review. ***10. Acute elderly assessment beds in operation.***	1. Various quality key performance indicators monitored including adverse event monitoring, SI investigations, complaints at divisional level. 2. 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. 3. Safety and Quality Committee dashboard	Stroke and Fractured neck of femur improvements Medical outliers in SAU decreased Decrease in cancelled elective procedures Improvements in time to treatment and initial assessment in ED	The external influences outside of SASH control e.g. demand management and delayed discharges in care. Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU. Additional workload for medical teams having to cover significant numbers of patients outside their bed base Loss of 8 beds to bed stock during capital works between Sept 5th and Mid October.	Live bed state would allow medical teams to track outliers more quickly and facilitate management of the 'in day' bed length of stay.	**S4 X L5 = 20**	1. Continuing with the development and introduction of ED operational standards and the enhancing nursing skill mix and competency. ***2. Revised recruitment of ED middle grade and Consultant posts substantively following initial failed recruitment process: posts revised to offer two fellow posts being two thirds clinical one thirs managerial (out to advery wk beg 7th Nov).*** ***3. Realignment of bed stock to match more closely the demand profile: Profiling complete; beds realignment starts end of November with project due to complete Feb/March.*** 4. Rolling programme of implementation of 11 ambulatory care pathways- ***5 complete; 3 due end of Dec, 3 end of March.*** ***5. Ongoing support of the Caterham Dene rapid assessment project to reduce attendance at ED to enable patients to be managed closer to home in order to deliver the predicted volume.*** ***6. Interim Winter Operational Framework should improve escalation and agreed- to be implemented.*** ***7. Agreement to support therapies discharge team which should lead to reduced length of stay and increased capacity- project ongoing.***
Priority 2 - Work with our Whole Community										
Objective 2.1 Improve experience and care for patients with dementia and at the end of life										
2.1.1	**Risk of being unable to meet all the needs of patients with dementia due to insufficient *resource and specialist knowledge.***	**JCB**	**S4xL3 = 12**	1. Dementia steering group to deliver the acute elements of the National Dementia Strategy 2. Clinical and Managerial leads ***in place*** 3. Funding secured to implement an Older Adults liaison service within the Trust 4. Whole system Unscheduled care PMO - managing and monitoring implementation of older adults team. ***5. One of two specialist dementia nurses in post and existing 3PA medical input.***	1. Project ***workstreams and deliverables r***eflecting Trust acute actions to meet requirements of National Dementia Strategy ***developed (draft)*** 3. Funding has supported the development of an Older Adults team and Dementia Specialist Nurse / Champion - fixed term contract.	Funding allocated. Project team meeting. Recruitment ***completed*** for Dementia Nurse Specialist and Older Adults team. ***Project milestones are being met.***	***Dementia strategy, including KPIs and implementation plan, consulted (Oct 11) on now requiring Management Board sign off. Nov11 and to board for information Nov 11*** ***12 month external funding agreed with internal business case required demonstrating effectivenes for ongoing funding.*** ***2nd Dementia Nurse Specialist and Older Adults team due to be in place November 2011 and increase medical input (additional 3PAs) from 1 Dec***		**S3 X L3 = 9**	1. Approval of Strategy ***including Project Outline and Leads to Management Board and Trust Board in November*** ***2. 2nd Dementia Specialist Nurse due to start 17th November*** ***4. Increase Medical sessions for Dementia (externally funded for six months). Interviews in October.*** ***5. Dementia Specialist Nurse/champion to project manage key parts of the strategy*** ***6. Start monitoring KPIs from Nov 11***
2.1.2	**Risk of being unable to deliver adequate care for end of life patients (rather than failure to improve) due to inappropriately trained and skilled staff, insufficient capacity (and resource) and poor integration with the local health economy.**	**DH**	**S4xL3 = 12**	1. Policies and Liverpool Care Pathway - best practice tool in place across the Trust 2. Palliative Care Team in place to provide specialist advice 3. Multi faith facilities and chaplains available 24/7 4. Care of the Dying Policy in place	1. Clinical Audit local and National Care of the Dying Audit 2. Patient Experience feedback 3. Delivery of Implementation plan to timescale.		End of Life Care training is not consistently in place across the Trust National End of Life Care Strategy 'acute elements' are not robustly in place The external influences outside of SASH control e.g. demand management and delayed discharges in care impacting Trust's ability to provide a dignified death due to high occupancy rates / lack of side rooms. WTE Palliative Care consultant time reduced to 0,4 as 0.6 post not backfilled.	Liverpool Care Pathway has not been audited in the last year	**S4 X L3 = 12**	1. End of Life Care Strategy and implementation plan for approval (Sept 11) 2. End of Life training piloted in the Medical Division and being rolled out across the Trust.

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Objective 2.2. Work with our patients & partners to develop services that meet the needs of our community										
2.2.1	**Risk that patients will not be able to access the services they need locally due to the lack of agreed priorities and care pathways, poor communication and barriers to joint working with the PCTs.**	**BB**	**S2 X L4 = 8**	1. Whole Health Economy Programme Strategy Board in place 2. Specific Strategies e.g. dementia care being developed as a whole health economy approach 3. Daily conference calls with PCTs and Social Services to resolve delayed transfers of care 4. Information sharing with PCTs to enable performance management in primary care 5. Remodelling exercise undertaken 6. Working with LINKS - members of the Quality and Safety Committee	1. Trust Board reporting on overall and specific programmes via Transformation Programme 2. KPI reported to Trust Board and its committees 3. Remodelling report recommendations reports	Both PCT's and the SHA are working together with the Trust.	Lack of clarity in the working arrangements with Clinical Commissioning Groups and PCTs as the roles are under development		**S2 X L4 = 8**	1. Agreement of local commissioning strategy with stakeholders. Project Endeavour in Sussex progressing to shape local commissioning structure - reporting due Dec 2011.
Objective 2.3 Delivering better emergency care pathways										
2.3.1	**Risk the emergency care patients will not receive better / safer care due to serious capacity restrictions, ability to manage external demand, delay to implement the whole system unscheduled care model combined with ED accommodation constraints.**	**BB**	**S5 x L5 = 25**	1. Comprehensive quality indicator weekly and 12 weekly dashboard 2. First four hour transformation project 3. Attendance at whole system unscheduled care board 4. Unscheduled care leads established in all specialties offering access to GP's all day Mon to Fri for advice / hot clinic alternatives to admission. 5. Senior experienced ED Matron recruited and in post 6. Safety and comfort rounds implemented in ED 7. Revised ED arrivals process which provides senior decision making earlier in the attendance facilitating early streaming to correct specialty. 8. Executive review and action arising from weekly ED dashboard review. ***9. CDU and ED observation unit with nurse led protocols and admission criteria.*** ***10. Acute elderly assessment beds in place.***	1. Comprehensive quality indicator weekly and 12 weekly dashboard 2. Patient experience feedback 3. Adverse event monitoring and investigation 4. Weekly ED dashboard 6. ED safety and comfort round audits / patient experience feedback	Improvements in; ED re-attendance, time to initial assessment and time to treatment. Activity shift from ED Majors into UTC evidencing better arrivals process	The external influences outside of SASH control e.g. demand management and delayed discharges in care. Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU. Additional workload for medical teams having to cover significant numbers of patients outside their bed base Inability to recruit to the vacant ED Consultant posts Failure to improve against the 95% compliance with the four hour standard The current configuration of the ED restricts the ability of the Trust to deliver care to the standard expected by patients Loss of 8 beds due to building works throughout September		***S4 X L5 = 25***	1. Building works to open up UTC to ambulance stretchers commenced September 2011; 2nd phase due December 2011. 2. Continuing with the development and introduction of ED operational standards and the enhancing nursing skill mix and competency. ***3. Revised recruitment of ED middle grade and Consultant posts substantively following initial failed recruitment process: posts revised to offer two fellow posts being two thirds clinical one thirs managerial (out to advery wk beg 7th Nov).*** 4. Rolling programme of implementation of 11 ambulatory care pathways to divert activity from ED***; 5 complete; 3 due end of Dec, 3 end of March.*** ***5. Ongoing support of the Caterham Dene rapid assessment project to reduce attendance at ED to enable patients to be managed closer to home in order to deliver the predicted volume.*** ***6. Implementation of phase two of 'First Four Hours'.*** ***7. Winter operational trial filtering with SECAMB.***
Priority 3 - Develop an Effective Organisation										
Objective 3.1 Improve ease of booking out-patient appointments and reduce cancellation rates										
3.1.1	**Risk of poor patient experience and patients choosing other providers due to current booking systems, outpatient capacity and inefficient clinic systems.**	**BB**	**S2 x L4 = 8**	1. Weekly specialty outpatient tracking meetings 2. Whole system Capacity Management Group managing the deficit between referral / demand and capacity 3. Sharing GP activity data to support Primary Care in managing its demand 4. Monthly update to GP informing of outpatient waiting time to enable demand management and better informed patient choice.	1. Weekly patient tracking reported through the Divisions through Management Board and Nationally 2. Patient experience feedback Clinical wait times (next available appointment) 3. 18 week National dashboard available	***(-ive) Increase in complaints about Out Patients*** ***(-ive) Out Patients waiting times impacting on delivery of 18 weeks***	The external influences outside of SASH control e.g. demand management Clinic outcome completion forms and clinic cashing up process Is not fully embedded - impacting on ability to code accurately and track where the patient is in their 18 week journey.	Unable to accurately report on non admitted pathway due to issues with clinic outcome forms and cashing up.	**S3 X L5 = 15**	1. Joint training and education exercise underway between the information team and Surgical Division and CSS. 2. Scrutiny of non admitted pathway and reporting at the weekly PTL. 3. Robust demand and capacity review of outpatient services underway to identify reconfiguration requirements to address areas of over / under supply and ensure adequate planned capacity is in place to meet demand within expected access times. 4. Specific patient pathway issues being addressed (including implementation of electronic referral grading / approval, electronic check in kiosks and reception staff uniforms) . Mapping Central Booking Office processes to identify issues and agree solutions 5. Full pathway mapping to be carried out to identify other areas for action. Options for customer care programme (initially on outpatients) also being investigated. ***6. Mapping Central Booking Office processes to identify issues and agree solutions.*** ***7. Develop 18 wk and Out Patient 'Rule Book' laying out operational expectations.*** ***8. Observations around patient experience to take steps to improvements to customer care training.*** ***9. Skill mix review*** ***10. 20 page action plan implementation: one project with two sub projects (1) Out Patient Management (2) Capacity and Demand.***
Objective 3.2 Developing Our Workforce										
3.2.1	***Risk that the delivery of the Trust's agenda will be limited by staffs current level of leadership skills impacting on Trust progress.***	**YP**	**S3 x L3 = 9**	1. Leadership programmes in place at senior management level. 2. Training needs analysis annually and funding of external training through the bursary 3. Clear managerial and clinical structures in place with single point accountability through the Chiefs of Service. 4. Investment and Workforce Committee at Trust Board level 5. Board development programme for all Board members 6. Ratified training plan aligned to national and regional requirements. 7. Appraisal and Development Policy ratified	1. Attendance at leadership training provides a cohort of 150 senior manager to effect change. Programmes of change focused on trust priorities. 2. Training programme is approved annually and informed by training needs - appraisals and local knowledge e.g. risks, incidents etc 3. Performance management processes from ward to board 4. Wide range of KPI and reports being received at Investment and Workforce committee 5. Annual Staff Survey - focused work programme in Patient Experience and Staff engagement group.	1. First co-hort of 150 staff completed 19/10/11 2. Appraisal rate improving across the Trust	No material gaps identified	No material gaps identified	**S3 X L2 = 6**	1.Run further leadership programmes 2. Continued implementation of appraisal programme in all areas of the Trust. 3.Training of senior medical staff to facilitate Consultant appraisal for revalidation. 4. Undertake census NHS Staff Survey to enable service specific actions in support of leadership capacity and capability

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3.2.2	***Risk that the delivery of the Trust's agenda will be limited because staff are not attending statutory and mandatory training or updating on medical devices resulting in reduced capability of Trust staff***	***YP***	***S3 x L4= 12***	***1. Statutory and mandatory training matrix.*** ***2. Regular programme of training run througout the year.*** ***3. Performance monitoring of attendance through Management Board***	***1. Training plan presented to Workforce & Investment Committee*** ***2. Monthly Trust Board Performance report*** ***3. Annual Staff Survey responses to training questions*** ***4. Medical devices trainer appointed***	***2. Attendance is improving*** ***3. 2010 results confirm improvement***	***2. operational pressures may lead to cancellation***	***No material gaps identified***	***S3 X L34= 12***	***Additional trainers now recruited*** ***Whole day Clinical and non clinical update training introduced*** ***e learning packages being scoped*** ***risk management approach to be taken to non attendance during winter months particularly in clinical areas***
3.2.3	***Risk of not being able to identify the current and future education and training needs of staff to deliver the Trust agenda due to the low appraisal compliance across the Trust***	***YP***	***S3 x L3 = 9***	***1. Policy in place*** ***2. data collection linked to ESR*** ***3.performance monitoring through Management Board***	***1. Monthly Trust Board Performance report*** ***2. Annual Staff Survey responses to appraisal questions***	***1. Compliance now improving***	***1. operational pressures may lead to cancellation***	***No material gaps identified***	***S3 X L3 = 9***	***1. Policy revised , simplified and relaunched*** ***2. Monitoring and reporting mechanism improved through direct intervention of ETD manager and HRBP's*** ***3. Additional appraisal refresher training being run through 2010/11***
Objective 3.3 Demonstrate current and future viability										
3.3.1.	**<u>Financial sustainability:</u> Recurrent financial position weakens due to critical mass and income mix restrictions, and demand/capacity mismatch.**	**MW**	**S4 x L4 = 16**	1 Independent financial review (KPMG modelling work) 2 Extant financial modelling and budgeting processes (see below) 3 Tripartite Formal Agreement (in draft) ***4 Strategic Change Board*** ***5 Sussex Together programme***	1 Board & Investment & Workforce Committee reporting 2 Business planning assurance meetings and budget setting process ***3 [External] Strategic Change Board reporting (monitoring TFA milestones)***	Business plan describing [favourable] recurrent financial position, clinical and operational viability. ***This positive assurnace is not currently provided, the Trust carries a sizeable recurrent deficit.***	1 Financial Model and outputs from that (not yet on line - being handed over in September) 2 2012/13 business plan ***3 Strategic Change Board structures and terms of reference (to be agreed 18 Nov)***	Business planning process, responsibility & timetable confirmed at I&W Committee. That process has not yet started but will provide assurance over the Trust's clinical/operational and financial planning. ***Strategic Change Board is now being set up.***	**S4 x L4 = 16**	KPMG Report completed and signed off in August. To allow the Trust business plan to be finalised a positional analysis needs to be completed based on the output from: a) The Tripartite Formal agreement ***- now signed;*** b) PCT commissioning intentions - planning meetings are now beginning & Trust position being scoped for October ***(initial report to Board -further detail work now starting- PS review Nov)*** c) The output of NHS Sussex's Project Endeavour (due Dec). ***The Strategic Change Board meets for the first time on 18 Nov. This will provide the core of the evidenced assurance (nb: this is a process issue and is not describing the authority of the SCB, the Trust Board has tehd ecision making authority).***
3.3.2	**<u>Income, costs and savings</u> Reduced activity or financial challenges reduce income, spending above budget or non delivery of budgeted savings plans leads to a financial problem, financial inefficiency and restricts flexibility to manage quality investment**	**PS**	**S4 x L4 = 16**	1. Business Plans and budgets (activity and financial) savings / transformation plans 2. Performance reporting and related action planning within Divisions at Performance Reviews, savings and PMO monitoring 3. Clear Director and Divisional Responsibilities, SFI requirements on budget managers and budget allocation processes (that can withhold or provide additional budget).	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	a. Planned levels of activity, performance and quality achieved or exceeded b. Income exceeds budget c. Minimal loss of income from contract challenge or dispute d. Financial performance within budget (costs within cost budget or off set by income) and availability of contingency e. Financial savings delivered against plan and availability of contingency f. Operational and quality delivery maintained	***No material gaps identified, and controls have been increased with the Cost Control Group and Procurement control for non clinical non pay. All staff recruitment remains subject to TDG approval..*** ***However, there sre some areas in Divisions where assurnace on controls are variable (notably CSS, E&F and nursing budgets). each of these aresa is subject to scrutiny following M06.***	No material gaps in assurance - reporting arrangements allow for judgements on evidence presented	**S3 x L3 = 9**	I) Additional control structure in place - non pay requisitions, daily cost control group & nursing budget oversight by CEO ii) Divisional savings and performance delivery through ongoing monthly process (COO) - overspending cost centres subject to cost control group action iii) Contract performance reviewed monthly - financial challenge currently within tolerance iv) Strengthened financial controls around 18 weeks activity (Sept - PS) v) Gap in savings plan is now filled with additional planned items vi) Allocation of reserves to cover contingent risks - ongoing monthly process (Mgmt Board)
3.3.3	**Liquidity: Inability to pay creditors / staff resulting from insufficient cash (bankruptcy) due to poor liquid position**	**PS**	**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	1. Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2. Monthly finance reporting to Management Board and Trust Board	a. Positive cash flow reported for every month in 2011/2012 b. Liquid ratio reported improve to a positive number (and ultimately to plus 15 days)	None	No material gaps in assurance - reporting processes allow for judgements of evidence presented	**S5 X L5 = 25**	***Operational PDC has now been partially signed off for 2011/12 and the Trust is drawing down cash when it needs to from the control total. However, full formal sign off has not yet been done .*** ***The Trust's cash & liquidity position will be reveiwed for M08 (PS - Dec)***