SURREY AND SUSSEX HEALTHCARE NHS TRUST BOARD ASSURANCE FRAMEWORK SEPTEMBER 2011

No	Principle Risks	Lead	Initial Risk Rating	Existing Controls	Assurances on Controls	Positive Assurances	Gaps in Control	Gaps in Assurances	Residual 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 principle 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**	**JT**	**S4xL5 = 20**	1. Full recruitment, absence management 2. Patient Experience and Staff Engagement Group 3. Patient Safety Lead nurse and Consultant 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	1-4 National Staff Survey 1-4 Annual Staff Survey on Patient Safety 1-4 Patient Experience feedback	1. Nursing and Midwifery vacancy rate has decreased since April 2011. 3. Intentional rounding in emergency department in place 5. Senior clinicians trained and investigating incidents 5. Incident reporting rate is comparable with middle 60% of trusts.	Sharing of learning across divisions is not robust Increased absence rate since June 11	Annual staff survey is only source of benchmarked staff feedback	**S4 X L4 = 16**	1. Commencement of 30 qualified nursing staff at SASH (Sept / Oct 11) 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 approval (Sept 2011) 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 understanding 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	1-4 Clinical audit reporting 1-4 Benchmarked Key Performance indicators 1-4 Benchmarked performance in EQ, Safer smarter nursing, care pathways 1-4 SUI investigation and completion of action plans 1-4 Patient experience reporting to Trust Board and Safety and Quality Committee.	1. SASH is highest performing Trust for Congestive Heart Failure Pathway (EQ programme) in South East Coast Region (10/11) 2. HSMR remains below 100 decreasing numbers of alerts (Sept 11) 3. CQUIN monies paid for EQ programme and Safety Survey (10/11)	Ineffective data capture processes in some specialties Compliance with completing the audit programme varies across the divisions.	Divisions are not consistently reporting evidence of change from learning	**S4 X L4 = 16**	1. VTE data collection methods are being revised in areas / specialties where there are difficulties. 2. Wide ranging action plan as part of clinical effectiveness implementation plan for approval to drive up compliance with clinical audit programme. 3. Divisional action plans for clinical audit commit to ensuring action plans are in place for all clinical audits on 10/11 audit programme (Oct 11). 4. Deep Dive executive performance management of quality of services in place. 5. Quality Management and Governance Policy for approval (Sept 11)
1.1.4	**Risk to patient safety due to key staff / individuals not working effectively as teams**	**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.	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)	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	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.
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	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	Increased rate of incident reporting - benchmarking in middle 60%	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**	1.Implementation of programme of mock CQC inspection checks through Clinical Friday working. 2. Intentional rounding in place in Emergency Department 3. Productive ward programme aimed at releasing time to care and patient safety relaunched in July 11 with rolling programme in all inpatient wards. 4. Peer review (ASPH) as part of SHA programme for Care and Compassion.
1.2.2	**Risk of poor experience due to lack of staff understanding of how their behaviour and in-action affects 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	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	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**	1. Revised Patient Experience Steering Group and reporting groups being implemented (post approval of the quality management and governance policy - Sept 11) 2. Executive performance management of divisional action planning in response to patient experience information at Deep Dives. 3. Patient Safety walk round programme in place 4. 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 specialty 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.	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. Recruitment of ED middle grade and Consultant posts substantively. 3. Realignment of bed stock to match more closely the demand profile. 4. Rolling programme of implementation of 11 ambulatory care pathways 5. Introduce acute elderly assessment beds 6. Supporting the Caterham Dene rapid assessment project (go live October 2011) to reduce attendance at ED to enable patients to be managed closer to home.
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 integration across the local health economy 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 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.	1. Project plan reflecting Trust acute actions to meet requirements of National Dementia Strategy reported to Trust Board 3. Funding has supported the development of an Older Adults team and Dementia Specialist Nurse / Champion - fixed term contract. 4 , Transformation programme reporting to Trust Board on each project	Funding allocated Project team meeting Recruitment underway for Dementia Nurse Specialist and Older Adults team	KPI's under development (Oct 11) Dementia strategy being consulted (Oct 11) Implementation Plan being consulted (Oct 11)	Dementia Nurse Specialist and Older Adults team due to be in place November 2011.	**S3 X L3 = 9**	1. Approval of Strategy and Implementation Plan 2. Change of Executive Leadership for implementation 3. Recruitment of Specialist nurse and Older Adults team.
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.
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.	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 = 20**	1. Building works to open up UTC to ambulance stretchers commences September 2011. 2. Continuing with the development and introduction of ED operational standards and the enhancing nursing skill mix and competency. 3. Recruitment of ED middle grade and Consultant posts substantively. 4. Rolling programme of implementation of 11 ambulatory care pathways to divert activity from ED 5. Introduce acute elderly assessment beds 6. Supporting the Caterham Dene rapid assessment project (go live October 2011) to reduce attendance at ED to enable patients to be managed closer to home. 7. Development of CDU and ED observation unit with nurse led protocols and admission criteria. 8 beds will be available Mid October following capital works.

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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		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) . 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.
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. required more defined leadership which we are addressing through the Health skills leadership programme and also the clinical leadership programme which commences In October In addition staff leadership training is identified locally by managers and supported centrally through the Bursary**	**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 8. Approved Booking of temporary agency medical staff Policy 9. Standardised performance management process of divisions bank and agency spend at the Management Board for performance.	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.	2. Appraisal rate improving across the Trust	Temporary staff booking policy focused on clinical staff groups (July 11) Proforma in use has been updated and policy needs to be revised to reflect this (proforma - IA June 2011)	KPI's for recruitment timescales to be developed an reported in HR dashboards. Weekly nursing budget meetings action points not widely shared	**S3 X L2 = 6**	1. All staff groups policy for booking bank and agency staff approved and implemented with monitoring and reporting (Oct 11) 2. Finalise and approve KPI's for improved monitoring of recruitment timescales. 3. TDG to receive action points from nursing meetings 4. Revised Policy update with vacancy approval process, exemptions and monitoring mechanisms (Oct 2011)
Objective 3.3 Demonstrate current and future viability										
3.3.1	**Financial sustainability:** **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)	1 Board & Investment & Workforce Committee reporting 2 Business planning assurance meetings and budget setting process	Business plan describing [favourable] recurrent financial position, clinical and operational viability.	1 Financial Model and outputs from that (not yet on line - being handed over in September) 2 2012/13 business plan	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.	**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 - to be signed end of Sept; b) PCT commissioning intentions - planning meetings are now beginning & Trust position being scoped for October (PS) c) The output of NHS Sussex's Project Endeavour (due Dec).
3.3.2	**Income, costs and savings** **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	3	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**	Awaiting feedback from SHA on allocation of operational PDC