V1 FINAL JANUARY 2012

Risk ID	Risk Description	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 and decision to mitigate or tolerate	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	Top Five Priorities
							Objective 1.1										
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**	**Chief Nurse**	S4xL5 = 20	Safety priorities approved, KPI's in place and reported to Safety and Quality Committee. Proactive recruitment campaign in nursing and Midwifery in conjunction with HR to minimise reliance on agency staff. Patient Experience Group in place Patient Safety Lead nurse working with front line staff Incident Reporting Policy, monitoring and reporting of performance KPI's Job planning Senior Clinicians trained in investigation, incident management bringing process learning and understanding closer to front line staff Agency/locum Drs usage Risk Register Policy and guidelines - incident reporting and analysis identifies risks for register	Electronic Datix Web for Incident Reporting not yet rolled out; paper based system currently used, which can lead to delays in reporting. Sharing of lessons learned is not robust across the Trust. Information / dashboards are front line for presenting timely safety and quality information to enable teams to act.	National Staff Survey measures of staff engagement / opinion on fairness of reporting / incident management. Internal Trust Annual Staff Survey on Patient Safety using MAPSAF tool Patient Experience feedback all sources Organisational Patient Safety Incident Reports from the National Patient Safety Agency benchmarking the reporting rates and types of incidents Quarterly internal incident reports; Vacancy rates and workforce information reported to Trust Board Trend agency usage Monthly benchmarked KPI's at Division and Trust levels. CQC and external stakeholder inspection reports Audits of nursing assessment and care plan tool MBQR and SQC (Board reporting cycle) Risk Reports.	(+) Intentional rounding in emergency department (ED) in place with the escalation component monitored weekly in the ED dashboard at Execs (+) 35 Senior clinicians trained and investigating incidents (July 11) (-) 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) for period Oct 2010- Mar 2011. (=)Zero vacancies in Midwifery (+ Dec11) (+) SHA clinical review (Jan 12) verbal feedback - no safety concerns (+) CQC verbal feedback (Dec 11) no safety concerns although welfare concerns in POPPA (-) (-) Q2 Risk Dashboard indicates risk register management not embedded (Dec 11) (-) IA report on risk maturity 'risk defined' not managed or enabled (Jan 12)		No material gaps identified	S4 X L3 = 12 Mitigate	1. Further qualified nursing staff (approx 40) are due to commence at SASH in November and January 12 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.	Cohort of nurses from Ireland dropped out due to positions becoming vacant in Ireland. Recruitment to date 20 nearing completion of process, 20 further posts offered and ongoing recruitment in Jan 12. Implementation slipped due to secondment of HOIGQ.	JT	01/03/2012	S* X L*= **- an assessment of all target scores needs to be undertaken as a Board		
1.1.2	**Risk of avoidable harm to patients due to staff not fulfilling their accountabilities in preventing potential harm**	**Medical Director**	S4xL5 = 20	Policies and procedures clarify staff responsibilities Professional Registration requirements Implemented best practice tools which define each step. Best Practice approaches adopted e.g. care bundles, Enhancing Quality pathways which by design optimise outcome and minimise risk	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.	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	(+) 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 evaluation Nov 11) (-) HSMR above 100 . Mortality alert for Fractured Neck of Femur. (Jan 12) (+) SHMI is below 100 (Q3 2011) (+) VTE risk assessment compliance 90% (Dec 11) (+) 77% of clinical audits have an action plan (Jan 12) (+) 62% of clinical audit programme started (+) PCT have awarded finances associated with achieving Q1 and Q2 CQUINS milestones		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 Mitigate	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 approved- roll out/ implementation . 6. CQUIN Q3 performance to be submitted to PCT for evaluation of milestones being met	Completed all areas using electronic reporting Audit programme 62% commenced. Monthly monitoring continues. CSS executive scrutiny undertaken Jan 12 - SQC report TOR steering groups approved; Pt Safety and Experience meetings set up	DH DH DH DH JT	Complete 03/12	S* X L* = *		
1.1.4 (1.1.3 and 1.1.4 consolidated)	**Risk to patient safety due to key staff / individuals not working effectively as teams, leading to poor patient experience**	**Chief Nurse**	S4xL5 = 20	Policies and procedures set out staff roles and responsibilities Revised nursing assessment documentation implemented which standardises individual patient's risk assessment. Multidisciplinary Nutritional Steering Group established with Terms of Reference and meeting chaired by a clinician. Parenteral Nutrition Policy in place. Standardised protocol for the management of internal referrals in place Patient streaming model based on MDT working and improved patient experience	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.	Incident Reporting and investigation; Patient experience and complaints; KPIs reported to the Quality and Safety Committee; Vacancy rate and temporary staff monitoring at Trust Board; Length of stay and Readmission monitoring; Performance reporting NRLS provides benchmarked incident reporting information	(+) The composite care scores for all four EQ pathways are exceeding the improvement target set for 2011/12 (Dec 11) (+) Independent Clinical Review (Jan 12) verbally reported observation of MDT using safety checks as part of their everyday practice (+) Independent Clinical Review verbal feedback (Jan 12) reported high level of clinical engagement and medical cover across the ED/ AMU pathway with good connectivity to patient care.		No material gaps identified	S4 X L4 = 16 Mitigate	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 Team with additional dietetic support to be taken to the Digestive Diseases Group. 4. Multidisciplinary Food and Drink Group to be established.	Implemented for 8 initial care pathways further pathways being developed. Resoruces agreed for SLT, Dieticians. Nutrition Support Group meeting - complete	BE JT JT	01/03/2012	S* X L* = *		
		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.**	**Chief Nurse**	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 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 and Medical wards 8.	Consent training for medical staff not currently in place which includes Mental Capacity Act, which is required for compliance with Outcome 2 for CQC ongoing registration. The external influences outside of SASH control e.g. demand management and delayed discharges in care. Mortality review processes are not standardised, aggregated and centrally reported. HSE Stress kit not implemented across Trust	1. Division action planning following mock CQC inspections, surveys and clinical Friday working. 2. Nursing audit framework includes Essence of Care Benchmarks 3. KPIs reported to Quality and Safety Committee 4. Reports internal and external e.g. Quality and Risk Profiles from the CQC 5. Patient experience Focus Groups feedback and completion of actions identified	(+) sustained reduction in ED complaint numbers monthly July - Dec 11when compared to Jan to Jun 11. (+) SHMI within normal limits (+) HSMR for Stroke (previous alert) is improved to (Jan 12) (+) CDU building works completed and unit operational providing compliance with regulations (Nov 11) (+) Trust Quality and Risk Profile from CQC evidences no red rated risks to non compliance with the regulations (Dec 11) (-) CQC inspection verbal feedback reported well being concerns in POPPA. (-) HSE Stress audits indicate poor compliance (Nov 11) (+) HSE Improvement Notices served in 2010 and 2011 are complied with (Dec 2011)		Staff feedback is benchmarked annually as part of staff survey.	S4 X L4 = 16 Mitigate	1. Roll out intentional rounding across all inpatient wards of the Trust 2. All modules of the Productive Ward initiatives rolled out in all inpatient areas 3. Completion of actions arising from CQC and other external inspections 4. Implement Quality Strategy work plan focused on delivering the Trust approved safety, clinical effectiveness and experience improvements. 5. Approve and introduce standardised mortality process in all clinical divisions. 6. Procure and implement E consent training for all Consultants and Registrars 7. Implement PEAT action plan arising from most recent inspection 8. Implement HSE Stress Toolkit	In ED and on Medical wards Productive ward being Relaunched focusing on one module Trust wide . Consent training for Drs overdue Slippage due to secondment - report to SQC Consulting on Template In progress	JT Jan12 JT Jan12 DH Jan 12 JT Jan 12 DHDec 11 DH Dec 11		S* x L* = *		

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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.**	**Chief Nurse**	**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	Staff understanding of their responsibilities under the Care Quality Commission regulatory framework remains poor.	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 DANI report (July 2011) evidences patients report they are cared for and about. (-) CQC inspection Dec 11 verbal feedback POPPA impacts on wellbeing (+) Complaints Report (Dec 11) evidences complaints numbers decreasing. (+) Independent clinical review (Jan 12) verbal feedback identified : good MDT working and confidence in the organisation of the Maternity Services Outreach neonatal service working very well		Patient stories at Trust Board Safety / Experience walk rounds by Trust Board members	**S4XL3= 12 Mitigate**	1. Revise the local action planning process arising from patient experience (complaints / PALS/ RTM / Clinical Fridays) to provide a standardised performance management framework. (Feb 2012) 2. Implement Patient Focus Groups feeding into the Patient Experience Steering Group (Dec 11) 3. Customer Care training programme for approx 1000 band 1 - 4 staff being launched (April 2011) 4. Patient Safety Walk rounds and Board Reporting (August 2011) 5.Implement actions arising from Care and Compassion Peer Review (May 2012)	**Currently all mitigating actions running to time**	JT Jan12	Mar-12			
		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.**	**Chief Operating Officer**	**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. 10. Acute elderly assessment beds in	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,. Additional workload for medical teams having to cover significant numbers of patients outside their bed base	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 4. Performance Management Framework and reporting to Trust Board 5. RTM data on patient experience in all clinical areas. 6. External stakeholder inspections.	(-) Stroke and FNOF performance declined (Dec 11) (+) Sustained Medical outliers in SAU decreased (Dec 11) (+) Sustained decrease in cancelled elective procedures (Dec 11) (+) Significant reduction in 12 hour breaches (Dec 11) sustained in Jan 12 (+) Nursing establishment on AMU meet template (Jan 12) (+) ED has access to its 8 bedded refurbished CDU (Dec 11) (+) SHA external review provided positive assurance on safety and quality	**S4 X L5 = 20**	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 Mitigate**	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. 8. 40 beds to open 20th Feb 2012	Two substantive Consultant posts offered Hazlewood ward realigned to medicine 11 additional beds 8 pathways complete Internal escalation plan implemented Weekend therapies team in ED and weekend therapies discharge team in place.	BE Jan12 BE Jan 12 BE Jan 12 BE Jan 12 BE Jan 12		**S*x L* = *****		
		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.**	**Director of Strategy & Transformation**	**S4xL3 = 12**	1. Board approved Dementia Strategy and work plan 2. Steering group to deliver the acute elements of the National Dementia Strategy 3. Clinical and Managerial leads in place 4. Older Adults liaison service in place (Dec 11)	Funding for Older Adults liaison service is 1year and is not recurrent. Approved funding for additional Dementia Specialist to lead on improvements not currently recruited to which is delaying implementation of the work plan.	Dementia Strategy KPIs and reporting to Dementia Steering Group and onto Management Board. Recruitment and vacancy information within the Older Adults Team and Dementia Specialist Action log from steering group / work plan monitoring .	(+) Older Adults team in place (Dec 11) (+) Funding approved for internal specialist role (-) Specialist to drive improvement is not recruited		Implementation at early stage and KPI's / information limited to assess progress.	**S3 X L3 = 9 Mitigate**	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 (liaison team) 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 7. Business planning includes bid for recurring funding for Older Adults liaison service. 8. Alternative recruitment strategy with mental health partner being explored to recruit best candidate.	Complete Complete Complete Unsuccessful recruitment Reports are limited in value at present. In progress In progress	action amended as at 8	04/12 03/12	**S* x L* = ***		
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.**	**Medical Director**	**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	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.	1. Clinical Audit local and National Care of the Dying Audit 2. Patient Experience feedback 3. Delivery of Implementation plan to timescale.	(-) Dispatches Investigation identified system failures which impacted on EOL care. (+) CQC reactive inspection (Feb 2011) found Trust compliant with all standards inspected (related to Dispatches Investigation) (-) Palliative Care Team resources reduced due to maternity leave		Liverpool Care Pathway has not been audited in the last year	**S4 X L3 = 12 Mitigate**	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.	Complete			**S* x L* = ***		
Objective 2.2. Work with our patients & partners to develop services that meet the needs of our community																	

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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.**	**Chief Operating Officer**	**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 7. Whole system Management team meetings for Unscheduled Care	Lack of clarity in the working arrangements with Clinical Commissioning Groups and PCTs as the roles are under development	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	(-) Plans for delivering community services have limited communication and engagement with acute Trusts during development.		Demonstration of a willingness to work in integrated way but the system and relationships are immature and this hampers implementation.	**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.	**Local strategy not shared with Trust at present. -- check with Paul**					
	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.**	**Chief Operating Officer**	**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.	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 l 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	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	(+) Sustained Improvements in; ED re-attendance, (+) Activity shift from ED Majors into UTC evidencing better arrivals process (+) ED Consultant posts offered (Jan 12) (+) Refurbishment of CDU complete -full bed stock available to ED		No material gaps in assurance	**S4 X L5 = 25 Mitigate**	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. 40 additional Beds opening 20th Feb 2012 .	Phase 1 complete, phase 2 due for completion Jan 12 Two Consultant posts offered 8 care pathways complete	BE Jan12 BE Jan 12 BE Jan 12		**S* x L* = ***		
	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.**	**Chief Operating Officer**	**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.	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.	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 Complaints Report Dec 12 (-ive) Out Patients waiting times impacting on delivery of 18 weeks (Month 9 performance)		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. Validation of non admitted pathway and reporting at the weekly PTL. 3. Reviewing demand and capacity 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. Outpatient staff to attend trust Customer Care training for bands 1 - 4 9. Skill mix review	These actions form part of the Transformation Project for Outpatients - the monitoring and performance management of these actions will be through the Transformation Delivery Group.	BE Jan12		**S* x L* = ***		
	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.**	**Director of Human Resources**	**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	Second cohort of leadership trainees due to commence course Feb 12	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	(+) First co-hort of 150 staff completed leadership training (Oct 11) (+) Appraisal rate improving across the Trust >70% (Dec 11) (+) Medical Director has confirmed sufficient numbers of Consultants trained in Appraisal to support revalidation (Dec 11) (+) 80 managers trained in appraisal		Staff Survey embargoed until February 2012.	**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 5. Deliver second cohort of leadership programme 6. Develop Trust action plan in response to Staff Survey 2011 (when published)	1st Cohort complete On target Complete Complete - awaiting CQC publication	YP YP DH YP	05/ 2012 04/12	**S* x L* = ***		

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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**	**Director of Human Resources**	S3 x L4= 12	1. Statutory and mandatory training matrix. 2. Regular programme of training run throughout the year. 3. Performance monitoring of attendance through Management Board 4. Training split into clinical staff and non clinical staff days / sessions to tailor training.	Training space available restricts numbers of trainees.	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 and reports to Medical Devices Group	(+) Statutory and Mandatory training compliance increasing - 65% (Dec 11) (+) Content of Nursing Stat days has been revised and implemented focused on Trust objectives (Sept 2011)		No material gaps identified	S3 X L3= 12	1. Recruit additional trainers 2. Whole day Clinical and non clinical update training introduced 3. E learning packages being scoped 4. Risk management approach to be taken to non attendance during winter months particularly in clinical areas 5. Implement Customer Care programme for Bands 1 -4 (approx 1000 staff) 6. Additional Training space identified - capital process in progress	Training team complete Completed Fire complete others being designed DNA approach being enforced - monitoring continues NEW ACTION NEW ACTION	YP YP YP YP YP YP	11/11 09/11 05/11 04/11 05/11 03/11	S* x L* = *		
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**	**Director of Human Resources**	S3 X L3 = 9	1. Policy in place 2. Data collection linked to ESR 3.performance monitoring through Management Board and at Division level by HRBP 4. Appraisal training for Managers in place	No Material gaps identified	1. Monthly Trust Board Performance report 2. Annual Staff Survey responses to appraisal questions 3. Monthly Management Board Performance management of Division appraisal / stat and mand rates 4. HRBP in month reporting to Divisional meetings on compliance	(+) Appraisal rate 70% (Dec 11) (+) 80 managers attended Trust Appraisal training (+) Staff survey completion rate is 60% (approx 2000 staff) for 2011 survey - this places the Trust in the top quartile for Trusts using Capita.		Staff Survey 2011 not published by CQC to indicate effect of improved appraisal rates on staff.	S3 X L2 = 6	1. Policy revised , simplified and relaunched 2. Revise reporting mechanism to improve assurance 3. Additional appraisal refresher training 4. Proactive publicity to engage staff in completing staff survey	Complete Complete x staff completed to date Complete	YP YP YP YP	09/11 05/11	S* x L* = *		
	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.**	**Chief Executive Officer**	S4 x L4 = 16	1 Independent financial review (KPMG modelling work) 2 Extant financial modelling and budgeting processes (see below) 3 Tripartite Formal Agreement 4 TFA Programme Board 5 Sussex Together programme	1 Financial Model and outputs from that (not yet on line - first new outputs February) 2 2012/13 business plan (first cut available, but still work in progress)	1 Board & Investment & Workforce Committee reporting 2 Business planning assurance meetings and budget setting process 3 [External] TFA Programme Board reporting (SHA monitoring TFA milestones)	Positive assurance (+): 1) TFA agreed and signed; 2) Full financial support agreed for 2011/12 3) 2012/13 deficit notified early to SHA, along with requirement for transitional funding 4) Financial modelling describes reducing deficit over 3 years (but see below) Negative assurance (-): 1) PCT activity plans not yet shared - so unable to see alignment and expected additional risk 2) Although financial modelling shows a reducing deficit, it is still a deficit - so the model does not yet deliver sustainability 3) Savings plan not yet fully scoped. 4) Business plans converting model into achievability not yet finalised.		A) The continuing recurrent deficit in modelled plans is the main gap in assurance B) Savings plan not fully scoped C) Completion of business planning D) Sharing of PCT activity plans	S4 x L4 = 16	a) Business planning process proceeding to time (next key milestone 17 Feb SoE return) b) Consultancy support is working on the Trust savings plan - work is proceeding to time (final output 27 Jan); c) PCT activity plans - planning meetings have been held, PCTs are aware of Trust strategy and vice versa. Timetable agreed for further engagement (sharing of activity data by PCTs 16 Jan). d) The output of Sussex Together (due mid Feb). e) TFA initial financial modelling outputs by 26 Feb	Currently all mitigation actions running to time	PS 12 Jan 2012		4x3=12		
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**	**Chief Financial Officer**	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).	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.	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 Trust budgetary position meeting Plan; 2) Analysis has been completed of overspends in CSS, nursing, E&F and other areas - with mitigating action agreed - assurance on controls received. 3) Revised end year control totals agreed with CSS, WaCH and Surgical Negative assurance (-): 1) NHS Surrey income challenges unresolved 2) Non elective displacement of elective work continues with non elective volumes - this drives overspending that cannot be avoided while the Trust must outsource elective work to deliver 18 weeks RTT targets 3) Some hot spot cost centres (eg ICU) not yet subject to agreed recovery plans		A) NHS Surrey contract challenge details and impact B) Completion of work on hot spot overspending areas C) Potential of additional income not explored	S3 x L3 = 9	I) Additional control structure in place - non pay requisitions, daily cost control group & CFO escalation (ongoing) ii) Divisional savings and performance delivery through ongoing monthly process (COO) - overspending cost centres subject to cost control group action (ongoing) iii) Contract performance reviewed monthly - financial challenge currently within tolerance (ongoing) iv) Escalation of activity with NHS Surrey over potential disputes (resolved 31 Jan) v) Strengthened financial controls around 18 weeks activity (ongoing) vi) Allocation of reserves to cover contingent risks - ongoing monthly process (Mgmt Board)	Currently all mitigation actions running to time	PS 12 Jan 2013		3x2=6		
3.3.3	**Liquidity: Inability to pay creditors / staff resulting from insufficient cash (bankruptcy) 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 b. Liquid ratio has not worsened in any month c. Cash flow forecast to March OK with draw down of additional cash provision Negative assurance 1: no confirmed additional cash to resolve underlying liquidity problem		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 L5 = 25 Mitigate	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 reviewed for M09 (PS - Jan)	Currently all mitigation actions running to time It is unlikely that the underlying issue will be resolved until the Trust can demonstrate its timeline to achieve FT status. Until that point is reached cash will need to be managed tightly with access to temporary cash support when required. That is risky.	PS 12 Jan 2014		4x3= 12		