Surrey and Sussex Healthcare NHS Trust Assurance Framework 2011/12

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 provides a year on year measure of engagement in many aspects of the Trust's business including safety 1-4 Annual Staff Survey on Patient Safety 1-4 Patient Experience feedback in all forms provides an indication of staff engagement in the safety agenda	1. Incident reporting rate is benchmarking in the middle 60% of Trusts nationally - increased rate 2. Clinical Leads and Matrons trained and engaged in investigation of incidents 3. Increased medical reporting	Mechanisms for sharing learning are inconsistent across the Trust	Reliant on annual surveys to measure staff engagement	S4x L5 = 20	1. Patient Experience and Staff Engagement Group developing work plan
1.1.2	**Risk of avoidable harm to patients due to staff not understanding their accountabilities in preventing potential harm**	**JT**	S4xL5 = 20	1. Policies and procedures provide staff with their responsibilities within the task 2. Professional accountabilities and registration informs accountabilities 3. Number of best practice safety tools in place e.g. WHO, VTE that clarify 'by rote' accountabilities and responsibilities toward every patient 4. Best Practice approaches adopted e.g. care bundles, EQ pathways which by design optimise outcome and minimise risk	1-4 Clinical audit and discussion of results - reported to the Quality and Safety Committee 1-4 Key Performance Indicators reported to Quality and Safety Committee and Trust Board 1-4 EQ , Safer Smarter Nursing and other Region wide safety / clinical effectiveness presentations externally - provides benchmarked data on Trust performance 1-4 SUI investigation and completion of action plans	1. SASH is highest performing Trust for Congestive Heart Failure Pathway (EQ programme) in South East Coast Region 2. HSMR remains below 100 decreasing numbers of alerts 3. CQUIN monies paid for EQ programme and Safety Survey	No material gaps in controls	Evidence of embedded learning is not robustly in place	S4xL5 = 20	Quality Work stream focused on delivering the Quality Strategy to be approved.
1.1.3	**Risk of patients being cared for in unsafe environments**	**JT**	S4xL5 = 20	1. Decisions taken by senior clinicians and managers on daily basis for patient placement	1. Reports on progress with joint working with the whole health economy on unscheduled care 2. KPI in place monitoring relevant quality indicators e.g. delayed transfers of care, patients being nursed outside their specialty beds, number of inpatient transfers		The external influences outside of SASH control e.g. demand management and delayed discharges in care.		S4xL5 = 20	See actions related to 1.3.1
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. Job Planning complete for Consultants 3. Nursing staff templates for each area are in line with national models	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 Workforce and Investment Committee 5. Length of stay and Readmission monitoring	Pilot of Nursing Care Plans successful	Purpose and structure for ward rounds and MDT ward meetings is consistently robust across the Trust Nursing care planning which includes patients and promotes MDT working is not rolled out completely 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		S4 x L5 = 20	1. Nursing Care Plans being implemented July 2011 onwards across the whole Trust 2. Standards developed for MDT ward rounds sand piloted
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	**1.** Mock unannounced CQC inspections carried out by senior nursing staff 2. Nursing audit framework includes Essence of Care Benchmarks 3. KPI's reported to Quality and Safety Committee 4. Reports internal and external	Increase in patients recommending SASH in RTM survey	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.	Reliant on annual staff survey to measure engagemen**t**	S4 x L5 = 20	1. Finalise the extended nursing audit framework and implement 2. Implement new nursing care plans which involve patients in the process 3. Ward level information available to staff and public
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 feedback in all forms - including thematic analysis fed back to wards 2. Appraisals with specific objectives where there is an identified need 3. Reporting to Quality and Safety Committee from Divisional Chiefs on progress 4. Reporting to Quality and Safety Committee from Patient Experience and Staff Engagement Group	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 L5 = 20	1. Ward level action planning and sharing of patient experience feedback with staff and public as part of productive ward 2. Patient Stories being shared anonymously within Trust via Comms 3. Clarity of standards expected by CQC regulatory framework through ward based sessions
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.	1. Various quality key performance indicators monitored. Adverse event monitoring, SI investigations, complaints at divisional level.	Stroke and Fractured neck of femur improvements Medical outliers in SAU decreased Decrease in cancelled elective procedures Sussex delayed transfers of care are reducing	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	Delayed discharges in Surrey remain significantly higher than the agreed 3.5% threshold - assurance	S4 x L5 = 20	1. Continue supporting the whole system unscheduled care model 2. Continue to work with external partners on delayed discharge agenda and external management schemes 3. Actively encourage the development of a primary care strategy for unscheduled care through the unscheduled care group 4. Primary care activity data will be shared to allow PCT's to performance manage primary care 5. Continue to develop ambulatory care pathways 6. Continue to work to the 'First Four Hours' work stream action plan 7. Change the footprint on arrival to the ED and UTC to allow transfer of activity from Majors to Minors (Building) 8. Complete the Hazelwood project to increase bed capacity by 10 beds by Nov 2011. 9. Ten 'virtual' beds available to provide additional capacity in
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 identified 3. Funding secured to implement an Older Adults liaison service within the Trust 4. Key Performance indicators and reporting arrangements in place 5. Better, safer, closer regional initiative and work programme	1. Project plan reflecting Trust acute actions to meet requirements of National Dementia Strategy reported to Trust Board 4 , 5. Transformation programme reporting to Trust Board on each project	Transformation reporting on progress with project plan and outcome KPI's	None identified at present	None identified at present	S4 x L3 = 12	1. Baseline assessment of current work across the Trust to establish a single coordinated project plan to meet National requirements. (Sep 2011) 2. Implementing an Older Adults liaison team (Oct 2011) 3. Review antipsychotic prescribing to ensure it is managed in line with best practice (Oct 2011) 4. Recruit a dementia champion and train clinical teams to improve specialist knowledge in caring for patients with dementia.
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.**	**JT**	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 2. Patient Experience feedback		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.	Liverpool Care Pathway has not been audited in the last year	S4 x L3 = 12	1. Clinical audit of Liverpool Care Pathway compliance 2. Staff Survey of understanding of End of Life Care 3. Develop for approval at Quality and Safety Committee the Trust End of Life Care Strategy
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.**	**JT**	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 received by	Both PCT's and SHA engaged in whole system working approach	Lack of clarity in the working arrangements with Clinical Commissioning Groups and PCTs as the roles are under development		S2 xL4 = 8	1. Agreement of the local commissioning strategy with stakeholders.
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	1. Comprehensive quality indicator weekly and 12 weekly dashboard 2. Patient experience feedback 3. Adverse event monitoring and investigation	Improvement in ED re-attendance, time to initial assessment and time to treatment.	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	Mapping daily discharges to predicted demand - reliant on clinical information.	S5 x L5 = 25	1. Continue supporting the whole system unscheduled care model 2. Continue to work with external partners on delayed discharge agenda and external management schemes 3. Actively encourage the development of a primary care strategy for unscheduled care through the unscheduled care group 4. Primary care activity data will be shared to allow PCT's to performance manage primary care 5. Continue to develop ambulatory care pathways 6. Continue to work to the 'First Four Hours' work stream action plan 7. Change the footprint on arrival to the ED and UTC to allow transfer of activity from Majors to Minors (Building) 8. Complete the Hazelwood project to increase bed capacity by 10 beds by Nov 2011. 9. Ten 'virtual' beds available to provide additional capacity in conjunction with external provider.
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 patient tracking meetings in place where all outpatient activity by specialty clinics are reviewed 2. Newly formed whole system capacity management group aimed to review referral patterns from pirmary care into the Trust and actively manage the deficit between referral / demand and capacity 3.Sharing GP activity data to support Primary Care in managing its demand	1. Weekly patient tracking reported through the Divisions through Management Board and Nationally 2. Patient experience feedback		The external influences outside of SASH control e.g. demand management	Unable to currently populate the National 18 week dashboard due to inaccurate data capture in outpatients	S2 x L4 = 8	1. All aspects of clinic operational processes and staffing being reviewed under the transformation work streams programme.
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	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	No material gaps identified	No material gaps identified	S3 x L3 = 9	1. Complete the leadership training and Board development programme. 2. Continued implementation of appraisal programme in all areas of the Trust. 3. Training of senior medical staff to facilitate Consultant appraisal for revalidation.
Objective 3.3 Demonstrate current and future viability										
3.3.1.	**<u>Financial sustainability:</u> Non recurrent financial support is not provided because strategic modelling inconclusive or health system is unsupportive**	**MW**		This risk is being revised following the re-submission of the Trust financial plan on Monday 18th July.						
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	a. Savings plan not complete gap remaining at end of MO3 = £1.0M b. Savings in Divisions not adequately planned AND/OR contingency plans not in place c. SLR (income and activity) reporting and follow up prior to Performance Review not embedded	No material gaps in assurance - reporting arrangements allow for judgements on evidence presented	S4 x I4 = 16	1. Gap in savings plan to be filled through I) Additional external support to develop operational efficiency plans for longer term including for 2011/2012 (CFO Aug) ii) Identification of 'economic' and capacity benefits from transformation work streams (Aug Dir Strat & Trans) 2. Divisional savings and performance delivery through ongoing monthly process (COO) 3. Allocation of reserves to cover contingency risks - ongoing monthly process (Mgt Bd) 4. SLR (income and activity) process in place and functioning by July (CFO) 5. Robust challenge process minimises risk against delivery of contractual targets - ongoing action (CFO)
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 concerning a central solution to liquidity issue.