Surrey and Sussex NHS
Healthcare NHS Trust

Board Assurance Framework
March 2016

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An Associated University Hospital of Brighton and Sussex Medical School

Objective 1 - Safe –Deliver safe services and be in the top 20% against our peers

Priority ID and reference	1.A Consistently meet national patient safety standards in all specialties and across divisions	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L3 = 12
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	1.1 There is a risk that the Trust will not meet its objective to deliver continuous improvement in reducing avoidable harm, if all national and local standards are not embedded within divisions and specialties.	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	1009,1055

Controls in place (to manage the risk)	**Gaps in Control**
1. Clinical teams in place to implement patient safety plans in the Trust (falls, pressure ulcers and infection control) 2. Regular review of patient safety data including the Safety Thermometer at divisional, executive and board level 3. Groups/Committee established including SQC, ECQR and its subcommittees, N & M and Divisional Governance 4. Policies, procedures and guidelines provide the framework by which risks and incidents are managed. 5. Work undertaken to deliver '5 sign up to safety pledges' (Monitoring patients for early signs of deterioration, Pain management for Dementia, Duty of Candor, COPD EQ pilot and improve shared learning from incidents) 6. Matron on site 7 days a week to monitor nursing patient care and staffing 7. Clinical Site Matron established 24/7 with enhanced team (2xB7 and 1x B8a) 8. Nursing staffing levels monitored daily and issues managed **9.** Incident reporting policy in place and monitored **10.** Ward safety boards updated regularly and ward performance discussed at divisional level **11.** Serious incident review group established to monitor and evaluate investigation progress and progress against actions 12. Training undertaken for clinical staff in the assessment and management of patients at risk of falls 13. Patient falls strategic group meet monthly and report KPIs to the patient safety committee. 14. System developed to split Trust and Community acquired VTE events which are reviewed at Clinical Effectiveness, Patient Safety and ECQR.	1) Developing ward safety dashboards 2) Ward accreditation system under development as part of 15/16 CQUIN 3) Updating and planning RCA analysis training for new managers/leaders 4) Embedding DATIX incident review process within 14 day timeframe

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) External reports and visits to clinical areas both scheduled and unscheduled (e.g. 15 step challenge) 2) Ward Dashboards 3) Divisional and Trust Level Dashboards 4) VMI/SASH Plus Program	Positive (+) CQC Chief Inspector of Hospitals Report (+) CQC risk rating, lowest possible (+) CNST level 2 Maternity (+) Numbers of Hospital Acquired Pressure Ulcers reduced and sustained (+) MUST audit (+) QGAF assessment and action plan (+) New EWS trialed and audited (+) Meeting minutes and action plans, evidence of presentations and board discussion (+) Patient safety related KPI agreed and monitored at Board and Divisional Level (+) Datix incident reporting and analysis including increase in reporting (+) Monthly trust wide reporting using national benchmarking (+) Falls Training data

	(+) Annual Falls Report 14/15 (+) Clinical Nurse Consultant for Falls and Patient Safety commenced 4 December 2014 (+) 15 Steps quality program (+) Annual Falls report 2013/14 reduction in falls with harm in year (+) Resource focus on patient safety and falls (+) Strong evidence of improved SI investigation management and closures (+) Improved reporting of patient falls has enabled the Trust to understand fall profile and identify gaps in the falls management strategies available (+) Established links with falls team within community Negative (-) Never events incidence (-) NRLS reporting

Gaps in assurance	**Assurance Level gained: RAG**
Ability to benchmark in real time	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) VMI/SASH plus development program 2) 5 work streams identified in Trusts sign up to Safety Pledges (Monitoring patients for early signs of deterioration, Pain management for Dementia, Duty of Candor, COPD EQ pilot and improve shared learning from incidents)	1) Ongoing 2) Ongoing action plan

Update by	FA 23/03/16	**Date discussed at board**	To be discussed at March Board

Objective 1 - Safe –Deliver safe services and be in the top 20% against our peers

Priority ID and reference	1.A.1 Consistently meet national patient safety standards in all specialties and across divisions	**Director responsible**	Medical Director
		Initial Risk	S3 x L4 = 12
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	1.2 Failure to maintain systems to control rates of HCAI will affect patient safety and quality of care	**Current rating**	S3 x L4 = 12
		Target risk score	S3 x L3 = 9
		Linked to Risk	1049, 1050, 1401, 1514

Controls in place (to manage the risk)	**Gaps in Control**
1)IPCAS Team and Group in place, Weekly taskforce in place 2)Infection control manual in place and information resources available 3)Antibiotic policy and guidelines in place 4)Daily (Monday to Friday) Infection Prevention & Control Nurses (IPC), to facilitate assessment and advice for infection control issues. 5)MicroApp implemented for antimicrobial stewardship guidelines 6)Consultant led RCA and presentation of HCAI (MRSA, MSSA, C. *diff*). All cases C. diff joint review by CCGs and Trust. 7) Discussion group being setup to discuss any lapses of care in C. *diff* cases. 8) Prevalence studies and Enhanced surveillance of catheter-associated UTI part of annual programme. 9) 3 ICE-POD units in place – ED, HDU and Hazelwood. 10) Developed a system where site team and matrons during the weekend are responsible in checking wards that have received positive results (See 4 above) 11)Focus on risk and mitigation of VHF involving ED/Micro/ITU/PHE 12)Antibiotic Stewardship group revitalized 13)Decontamination group informing development of strategy for IPCAS 14)Policy on screening appropriate patients from abroad for CP Enterococci.	1)Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset 2)Variation in line care demonstrated by audit 3)High bed occupancy can cause infection control risk to increase (e.g. side room availability)

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)KPI indicators 2)Reducing numbers of cases of C. diff year on year 3)Divisional and departmental governance meeting minutes 4)Output of CCG and Trust meetings regarding lapses of care in C. *diff* cases	Positive (+)Antimicrobial prescribing audit compliance (+)Actions taken as part of annual program (updated July 2015) (+)1st TDA visit inspecting controls and procedures (+)2nd TDA visit comparison with other Trusts and brokered meeting with CCGs (+)PHE and NHSE walkthrough ED for VHF risk provides good assurance (+)Management of diarrhoea agreed as one of first 'VMI Value Streams' (+)Initiation of 'Stop, Access, Send' initiative for the management of Negative (-)Incidence of CDI 2015/16

Gaps in assurance	**Assurance Level gained: RAG**
Extensive auditing and monitoring in place. Trust position known	

<table>
<tr><th colspan="3">Mitigating actions underway</th><th>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</th></tr>
<tr><td colspan="3">1) Roll out of Urinary catheter Passport
2) Full list of actions in IPCAS Annual Programme of work (2015/16)
3) Ongoing discussion with commissioners about penalties applying only to cases with poor/inadequate care. This conversation is nationally mandated
4) Considering implementation of two low risk C. diff Antibiotics (Fidaxomicin and Chloramphenicol IV)</td><td>1) Embedding
2) 2015/16
3) Ongoing
4) Under review</td></tr>
<tr><td>Update by</td><td>DH 23/03/16</td><td>Date discussed at Board</td><td>To be discussed at March Board</td></tr>
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Objective 2 - Effective –Deliver effective and sustainable clinical services within the local health economy

Priority ID and reference	2.A Achieve the best possible clinical outcomes for our patients	**Director responsible**	Medical Director
		Initial Risk	S3 x L3 = 9
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	2.1 There is a risk that patient outcomes will not continue to improve if monitoring and benchmarking is not utilized to improve clinical outcomes across divisions and specialties	**Current rating**	S3 x L2 = 6
		Target risk score	S3 x L1 = 3
		Linked to Risk	1460

Controls in place (to manage the risk)	**Gaps in Control**
1) Safety thermometer data is reviewed by wards and specialties at regular meetings 2) HSMR/SHMI/Datix incidents are reviewed at divisional and trust level 3) Groups/committees established including SQC, ECQR, Effectiveness committee and its subcommittees 4) Specialty deep dive process identified areas of best practice and also areas for improvement, which have been actioned and monitored by relevant clinical leads	1) Evidence of learning from incidents/audit 2) Time lag with which some data sets are released

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1. PROMS 2. Minutes of divisional meetings including M & M 3. Minutes of Clinical Effectiveness and Patient Safety and Risk subcommittees 4. Patient tracking and analysis (whiteboard project) 5. Datix reporting and analysis 6. Clinical Nurse Consultant for Patient Safety and Falls commenced 02/12/14 7. Results from National Clinical Audit Programme 8. Benchmarked reports from Academic Health Science Network Enhancing Quality and Recovery Programme 9. Reviewing all deaths proactively where coding wish to apply diagnostic code 10. Working with the 4 other successful Trusts in the TDA/Virginia Mason development program	Positive (+) Sharing data through VM program with identified peers (+) CQC Chief Inspector of Hospitals Report (+) CQC risk rating, lowest possible (+) The latest HSMR data shows overall Trust mortality is lower than expected for our patient group (+) CNST level 2 Maternity (+) Numbers of Hospital Acquired Pressure Ulcers reduced and sustained (+) MUST 100% (+) New EWS implemented (+) Increase in reporting trends (+) National falls data benchmarks favorably (Trust desire to improve position) (+) HSMR for low risk procedure Negative (-) Never events incidence (-) NRLS reporting

Gaps in assurance	**Assurance Level gained: RAG**
Ability to benchmark in real time National Safety Dashboard to be implemented when available	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Development of ward based performance dashboards	1) Ongoing

Update by	DH 23/03/16	**Date discussed at Board**	To be discussed at March Board

Objective 2 - Effective –Deliver effective and sustainable clinical services within the local health economy

Priority ID and reference	2.B Deliver services differently to meet need of patients, the local health economy and the Trust	**Director responsible**	Chief Operating Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	2.2 There is a risk that if the Trust does not deliver the planned efficiencies it will be unable to create the capacity desired to deliver transformational changes.	**Current rating**	S5 x L3 = 15
		Target risk score	S5 x L2 = 10
		Linked to Risk	1221, 1480, 1601, 1405, 1547

Controls in place (to manage the risk)	**Gaps in Control**
1) Transformation Team in place 2) System Resilience Group 3) 3x3 meetings 4) CEO strategic meetings 5) Partnership boards 6) Trust part of national Virginia Mason transformation programme 7) Integrated Reablment Unit build complete	1) Pathway redesign needs to ensure its appropriate and fit for purpose 2) Repatriation of tertiary services effected and influenced by external factors 3) Clear action plans linked to root causes of efficiency issues and using service improvement methodologies not yet fully embedded

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Contracts 2) Plans 3) Referral activity 4) GP Support 5) Breaking the cycle 6) Divisional Performance Reviews 7) Productivity reporting	Positive (+) Contract 14/15 signed with BICS (+) Internal audit of readmission figures provides positive assurance (+) Feedback following initial work on discharge process 2013/14 (+) Joint working with Royal Surrey County (Chemo and Radiotherapy) (+) Pathology joint venture BSUH (+) Bowel screening (+) BOC respiratory unit (+) Extended theatre working days Crawley (20% increase capacity) (+) Second Cath Laboratory in place (+) VMI Guiding Team established, initial Value Streams agreed Negative (-) Medically ready for discharge (100 pts vs target 90) (-) Nationally an outlier on emergency length of stay by 1 day (-) Unplanned increase in >1 LOS emergency admission patients (10% vs 2% plan)

Gaps in assurance	**Assurance Level gained: RAG**
Agreed activity modelling across SEC National policy decisions and effective of general election	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Full action plan development for productivity programme (theatres, outpatients, VMI Value streams) 2) Breaking the cycle and reducing LOS action plan	1) End of quarter 4 2) Ongoing

Update by	AS 23/03/2016	**Date discussed at Board**	To be discussed at March Board

Objective 3 - Caring – Ensure patients are cared for and feel cared about			
Priority ID and reference	3.B Deliver high quality care around the individual needs of each patient	**Director responsible**	Chief Nurse and Medical Director
		Initial Risk	S3 x L4 = 12
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	3.1 The continuing challenge to recruit and retain clinical staff is impacting on the Trust's ability to maximize financial and quality benefits.	**Current rating**	S3 x L5 = 15
		Target risk score	S3 x L2 = 6
		Linked to Risk	770, 1295, 1580, 1652

Controls in place (to manage the risk)

1. Workforce KPIs including vacancy rates, turnover and temporary staffing monitored by Nursing agency PMO, Workforce subcommittee, Exec Committee and the Board
2. Monitoring of Safety Thermometer, patient experience and staff turnover, sickness at ward level and at associated subcommittee, Exec and the Board
3. Planned versus actual staffing levels monitored on a shift by shift basis, reported daily by Matrons and issues escalated to DCNs with evidence actions taken
4. PMO in place to monitor agency use and progress of the five related work streams
    a. E-roster- migration to v10 approved and project commenced
    b. Nursing recruitment plans developed by DCN and DCM in response to Right Staffing review and monitored by Agency PMO, Workforce subcommittee and divisional team meetings
    c. Recruitment process reviewed, KPIs in place to provide assurance
    d. Bank recruitment in progress to reduce use of agency nursing staff
    e. International recruitment undertaken but start date has been delayed. Further local and EU recruitment in progress. Monitored via temp staffing PMO
    f. Weekly reporting in place to TDA/Monitor in place on all agency use above cap or outside framework
    g. Monthly reporting of total agency spend against TDA/monitor agreed trajectory
5. SNCT/Birthrate Plus tool/NICE guidelines utilized to monitor patient acuity and dependency presented to relevant committees including Board to determine future staffing demand
6. Work underway to develop SASH recruitment brand and retention strategy including the development of new nursing roles
7. SASH funded by HEKSS to develop and lead on physician associate training and recruitment for SEC
8. Foundation doctors workloads re-modelled such that 95% of time is spent with no more than 14 patients.
9. Strong relationship with HEKSS who place junior doctors in the organisation
10. Practice development nurses recruited to support ward nursing teams improve retention.

Gaps in Control

1. E-Roster system is not updated out of hours
2. Unfilled shifts both nursing/midwifery and medical
3. The Trust still carries a volume of vacancies specifically in clinical areas and turnover in some areas is above Trust target
4. Imperfect induction for short notice, short term medical locums
5. Aiming for full nursing/midwifery and medical recruitment (influenced by HEKSS)
6. Medical trainees select a preference that affects the decision

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1. Ward staffing templates monitored daily by Matrons and escalated to the Divisional Chief Nurses to ensure safe levels to meet patient needs. 2. Staff absence reports and monitored in divisions 3. % of vacant shifts filled by Trust and agency staff 4. Revalidation (GMC) for locums 5. Monitoring agency utilisation and spend at PMO 6. Weekly & monthly reporting of agency use to TDA/Monitor	Positive (+)SNCT data (+) Recruitment plans developed by ward and reported monthly (+) Matron for workforce recruited (+) International recruitment for nurses undertaken (+) CQC Chief Inspector of Hospitals Report - Good rating (+) Daily ward staffing review (+) Reports regarding reducing vacancy rates, sickness, absence (+) Incident reporting via Datix (+) Patient experience data by ward or unit (+) Junior Doctors feedback regarding quality of experience and breadth of exposure (+) European recruitment undertaken Negative (-)Benchmarked high proportion of agency staff usage against other Trust's (-) Vacancy rates and turnover rates (-) Temporary staffing Internal Audit (-) Junior Doctors feedback relating to high workload

Gaps in assurance	Assurance Level gained: RAG
Trust position known - no identified gaps in assurance	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1. Continue to monitor effectiveness of recruitment plans 2. 7 day working plans for medical staff under development across the Trust 3. Implement e-roster upgrade and utilize core functionality (bank and messaging) 4. Implement plans to manage staffing issues in Theatres 5. Increasing direct entry nursing students by 100% (40 to 80) from February 2016	1. Ongoing 2. Being implemented 3. Embedding and under review 4. Being implemented 5. Ongoing

Update by	FA 23/03/2016 and DH 23/03/2016	Date discussed at Board	To be discussed at March Board

4 - Responsive to people’s needs – Become the secondary care provider of choice for the catchment population

Priority ID and reference	4.A.1 Deliver access standards	**Director responsible**	Chief Operating Officer
		Initial Risk	**S4 x L4 = 16**
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	4.1 Failure to maintain Emergency Department performance because of lack of capacity in health system to manage pressures has a significant impact on the Trust's ability to deliver high quality care	**Current rating**	**S4 x L4 = 16**
		Target risk score	S4 x L2 = 8
		Linked to Risk	1220, 1491

Controls in place (to manage the risk)	**Gaps in Control**
1) EDD Patient Pathway 2) Site management team and Discharge management 3) Plans for escalation areas agreed and management tools in place 4) Reviewing all breaches weekly to implement lessons learnt 5) Site Management Team and Discharge Team 6) Circa 50 additional community beds made available 7) 7 day medical consultant ward rounds established 8) Additional community beds 9) Tilgate annex opened providing extra surgical capacity 10) 10th Theatre opened (May 15) 11) Increasing hospital at home capacity 12) Integrated Reablement Unit built	1)Identified on a rolling basis as part of weekly review 2)It is difficult for the Trust to influence the output of decision making across the local health economy 3)Ambulatory pathways yet to imbed (New Consultant undertaking review) 4)Support of partners required to effectively reduce and sustain numbers of patients medically ready for discharge

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) NHS England aware 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) Performance Management Framework and reporting to Trust Board 4) External stakeholder inspections 5) Daily sit rep reporting to the TDA 6) Daily winter Sit Reps (Commenced November) Urgent Careboard Area Team. 7) Whole system operational resilience plans signed off for 14/15 8) 2020 whole system review of discharge process, reviewing recommendations 9) Clinical audit of clinical pathways which impact on reducing emergency re-admissions.	Positive (+) MRD Summit June agreed map capacity available across Surrey and Sussex (+) ED Standard delivered April, May, Aug, Sept, Oct, Dec 2015 (+) Process improvement (+) Working with partners commissioners / partners to expedite flow through hospital (Medihome and community beds) (+) Top 20 patient delay weekly meetings (+) Monitoring and managing compliance #NOF, Stroke and medical outliers (+) Bed modelling refreshed including emergency demand increases Negative (-) ED standard not delivered June, July, Nov 2015, Jan and Feb 2016 (-) Quality indicators for time to assessment / treatment. Surrey and Sussex local lead. (-) EDD Section 2 and section Patient tracking system (-) Number of patients safe to discharge at any one time (-) Adult Bed occupancy remains higher than plan due to increased activity Circa 100 medically fit for discharge patients (-) Local availability of Nursing home beds / ability to start complex packages of care (-)Unplanned increase in >1 LOS emergency admission patients (10% vs 2% plan)

Gaps in assurance	Assurance Level gained: RAG
Winter plans and local health economy position going into winter months	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1) Comparison between 2014/15 Q1 vs on 2015/16 Q1 assumptions and activity to identify variance 2) Refresh winter capacity plans based on assessment of Q1 activity 3) Planned local health economy summit regarding emergency growth 4) Agreed breaking the cycle 2 encompassing internal and external bodies 5) Planned breaking the cycle throughout weeks throughout winter 6) Demand and Capacity plans for 16/17	1) Complete 2) Complete 3) Complete 4) Complete 5) Complete 6) March 2016

Update by	AS 23/03/16	Date discussed at Board	To be discussed at March Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5.1 Failure to deliver income plan	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1689

Controls in place (to manage the risk)	**Gaps in Control**
1) Business Plans and budgets (activity and financial) savings / transformation plans. 2) Agreed contracts in place with main sets of commissioners (NHSE and CCGs) – all Contracts were finally signed in August. 3) Contract management process in place (this operated effectively in 2014/15). 4) Financial reporting, including periodic forecast scenarios, is in place and effective – a detail forecast was provided to Board in July and internal PMOs are based on that forecast. 5) Chief Officer meeting (which includes coordination of has been in place since Nov 2014. Its structures are still embedding.	1) There are issues with Sussex over the under commissioning of activity and the transparency of investment to manage urgent care. 2) Winter demand has been a significant issue with the Health System declaring “black” status in January on two occasions, and with worse performance in recent weeks. This has triggered a risk summit and the completion of a serious incident review (nb: focus isn’t income, but planning) 3) The strategic management of activity is not currently effective, but the Trust is doing all it can to support making it so. Note: other gaps in previous reports mitigated by actions currently in train with CCGs.

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Financial performance and contractual reporting to Exec Committee, Finance & Workforce Committee and Trust Board (including CQUIN reporting process). 2) Performance Review (PMO) and Exec Quality and Risk process with Divisions, monthly contract cycle with CCGs. Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output and reporting from health system management (e.g.: System Resilience Groups and Chief Officer Meetings) 5) Output of Contract Management Process .	Positive (+) The reconciliation process is seeing payment for over performance against CCG contract plans {although the process has seen delay in payments] (+) Internal action on income delivery in specific specialties has, generally, been effective – part year shortfall, but underlying issues have now been corrected (+) Agreement now reached with Sussex over MRET and handover fines – surrey not expected to be far behind [but not yet agreed] Negative (-) Risk over income growth assumptions, now materialized – risk in last few months is from balance of emergency activity and capacity. This is the single biggest issue in the Trust’s financial performance in the last 6 months of the year - adverse income variance at M11 (-) Monitor response to MRET complaint provided no useful application in 2015/16 (although a deal done with Sussex over the original increase in the threshold) (-) Too much non elective activity, not enough elective – risk over emergency demand (-) disputes now received from Surrey – only one from Sussex – escalation status implied but not confirmed by CCGs – waiting for CCGs to calrify position (-) Tripartite letter on 19 January provides conflicting advice to that from the TDA about levying of fines in Q4 (-) Issues still unresolved over the SRG allocation of resources prior to Q4 for readmissions and operational resilience.

Gaps in assurance	**Assurance Level gained: RAG**
Red because of level of risk, activity planning differences, issues with strategic health system management of urgent care activity and transactional processes with CCGs.	

Mitigating actions underway			Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1) Complete all contractual commitments according to timetable; 2) Revised forecast for elective activity completed, now being monitored – performance is not on plan; 3) The integrated reablement unit opened on 21 January. 4) Robust contractual processes being operated and action being taken over decisions in respect SRG funding.			Actions proceeding to timetable.
Update by	PS 09/03/16	**Date discussed at Board**	To be discussed at March Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	Director responsible	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5. 2 Failure to stop divisional overspending against budget	Current rating	S5 x L3 = 15
		Target risk score	S3 x L2 = 6
		Linked to Risk	1663,1688

Controls in place (to manage the risk)	Gaps in Control
1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Divisional activity plans 3) Internal Performance Review (PMO) process and CEO review 4) Forecast scenarios presented to Board – a detail forecast was provided to Board in July and internal PMOs are based on that forecast. 5) TDA agency reduction plan now submitted	1) Management of increased levels of emergency activity subject to review; 2) Cost improvement plans are not fully delivering with adverse performance on agency and escalation in particular. Red rated savings have been partially mitigated. The forecast assumes non delivery of the total savings target. 3) There is overspending in specific areas against agreed forecast control totals among the Divisions.

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1) Financial performance and contractual reporting to Exec Committee, Finance & Workforce Committee and Trust Board UIN reporting process). 2) Performance Review (PMO) and Exec Quality and Risk process with Divisions, monthly contract cycle with CCGs. Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output in financial reporting describes improvement and risk mitigation. 5) Agency PMO.	Positive (+) Budget changes made to match activity and main Divisions within forecast tolerance (bar 2 specific areas) (+) Internal audit advises CIP process is sound (but notes non-delivery, see below) Negative (-) Internal audit advises effectiveness of savings delivery rated red/amber. (-) Emergency activity pressures have continued to be greater than expected (-) Overall agency costs remain very high, with escalation still in use and significant costs across Divisions. (-) The forecast provides an adverse variance to plan.

Gaps in assurance	Assurance Level gained: RAG
Overspending is the main area of risk and the ability of the Trust to reduce the rate of spend while maintaining services adequately.	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing
1) PMO/Performance structure continues - Divisions have been required to produce recovery plans and PMO meetings have become more frequent for all Divisions. 2) Controls are being exercised in divisions and centrally – vacancy restriction and non-clinical procurement. The latter tightened again in February (spend to be put off even if urgent) 3) Decisions on business cases are now taken in light of affordability against forecast.	Actions proceeding to timetable

Update by	PS 09/03/16	Date discussed at Board	To be discussed at March Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	Director responsible	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5. 3 Unable to deliver medium term financial plan	Current rating	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1603

Controls in place (to manage the risk)	Gaps in Control
1) Items referred to in 5.A.1 and 5.A.2 above 2) V7.0 long term financial model and integrated business plan completed (submitted to Monitor in April 2015) – V8.0 completed in December 2015 and supports 2016/17 budget 3) TDA Plan submitted in April 2015, 2016/17 initial plan submitted February 2016 4) Cost improvement plan process in place (including PMO structure) 5) Demand and capacity planning for 2016/17 is ongoing but his hitting milestones 6) Contract process with commissioners is in train, but has aslow start	1) Items listed above (5.A.1, and 5.A.2) are applicable here 2) Lack of alignment between CCG activity plans and actual performance. 3) Reliance on centrally determined rules for PbR, Better Care Fund and the wider NHS finance regime. 4) Risk over capacity from other operational pressures 5) Overall health system financial view (Chief Officer's Finance Sub-Group) describes significant loss of resource to BCF funding – this reduces resource available for health and social care overall. 6) Central actions over NHS overspend may have an adverse impact on Trust because of manner of application (e.g. withholding capital and cash).

Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)
1) Production of 2016/7 budget, revised long term financial model and integrated business plan documentation, and delivery against them 2) Agreed contracts with commissioners describing realistic demand and acceptable financial values 3) Sign off of sustainability & transformation funding with NHS Improvement	Negative (-) alignment in 2015/16 with CCG plans was never completed with significant variances between actual performance on activity and CCG plans [CCGs are, in the main, paying over performance] (-) overall health system loss of resource in 2015/16 (to BCF and social care) (-) 2016/17 sustainability and transformation funding and the applicable control total are not yet agreed with NHSi. (-) 2016/17 planning still at a very early stage with partial progress against timetables for 2016/17 contracts Overall, on basis of current assumptions, RAG has turned red with the impact of urgent care activity, the level of risk to the forecast and the position on 2016/17 contracting. Assurance RAG red.

Gaps in assurance	Assurance Level gained: RAG
Central actions to manage costs across the NHS are not yet clearly described and there has been delay to the issue of the tariff and contract documentation (causing the NHS timetable to slip by one month). Plus cumulative impact of other finance risks here.	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
Please see items above. Tariff information is now available (11 February) but consultation not yet closed. The 2016/17 budget has been reported to Board and the 8 February plan submission made. The Board is aware of action in relation to control totals and S&T funding.	Progress is on timetable

Update by	PS 09/03/16	Date discussed at Board	To be discussed at March Board

Objective 5 – Well Led

Priority ID and reference	5.A Live within our means to remain financially sustainable	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5. 4 Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L3 = 12
		Linked to Risk	1604

Controls in place (to manage the risk)	**Gaps in Control**
1) Bi weekly review of forward cash flow by finance team and CFO 2) Cash and working capital management processes 3) Annual cash plan linked to business plan and capital plan (see link with Risk 1134) NOTE: This risk was reviewed at FWC 22 September and agreed to be maintained noting working capital facility. Additionally capital loan is now secure. An application for a £12.5m working capital facility has now been agreed and cash drawn down.	1) No agreement on medium term solution to liquidity – being pursued during 2015/16 – a loan application has been drafted and submitted – awaiting confirmation of agreement 2) Delay in receiving cash payments to match accrued income from CCGs, although main CCGs are providing cash advances 3) Threat of central cash controls in line with control totals. Confirmation has been received of an increased working capital facility but the risk of further central control remains (as it is a WCF not a loan).

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2) Monthly finance reporting to Executive Committee, Finance and Workforce Committee and Trust Board 3) Confirmation of working capital injection (either through a loan, working capital facility or, if available, PDC)	Positive (+) Cash targets met in 2014/15 (+) Liquid ratio has followed expectations (+) Cash has been managed well in 2015/16 to date, Green internal audit report on cash management (+) Adequate working capital facility sufficient to cover cash needs into 2016/17 has been agreed. Negative (-) no additional cash to resolve underlying liquidity problem – restrictions being applied by NHSi as described in “gaps in control”. (-) cash flow dependent on financial outturn described in 5.A.1 and 5.A.2 above. Overall rating “red” noting risk to forecast I&E. No current cash problem but underlying problem unresolved.

Gaps in assurance	**Assurance Level gained: RAG**
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. Assurance level “red” noting unresolved underlying cash issue.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Day to day cash control is main action, but coupled to action to maintain income and manage spend 2) Long term financial model, and TDA plan now provides additional validation of the level of cash injection required and the interaction from an improving financial position within the model 3) Discussion will continue with NHSi over the cash facility they are making available.	Actions proceeding to timetable

Update by	PS 09/03/16	**Date discussed at Board**	To be discussed at March Board

Objective 5 - Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model

Priority ID and reference	5.E We are an organisation that is clinically led and managerially enabled.	**Director responsible**	Director of Organisational Development & People
		Initial Risk	S3 x L3 = 9
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	5.5 There is a risk we will fail to realize the strategic benefits of having an Achievement Review Process that effectively monitors and influences behavior and performance.	**Current rating**	S3 x L3 = 9
		Target risk score	S3 x L2 = 6
		Linked to Risk	1740

Controls in place (to manage the risk)	**Gaps in Control**
1) 'Refreshed' Achievement Review Policy for 2016/17 with implementation / communication and training plan 2) Personal objectives are being linked to Trust/Divisional and team objectives and the SMART methodology is being used to assess performance 3) New AR process includes assessment of Behaviours against Trust values 4) For 2016/17, a 'cascade' approach has been agreed for the delivery of ARs with 90% of staff who have 12 months or more continuous service to complete their AR by end of October 2016 5) Personal Development Plans as part of AR identify development needs 6) Training Need's Analysis at Divisional level extrapolated to Trust level to inform strategic planning of development priorities 7) Scoping work to understand how medical staff can be included in the AR programme- focus around embedding values and behaviours	1) Operational activity levels in the Trust stated as reason by line managers for non-compliance with expected appraisal completion rates 2) Change to annual timetable with delivery in first part of financial year yet to embed. In year two (2016/17), AR completion period extended to end of October 2016 to try to ensure compliance is met. 3) Scoping work still to be undertaken to consider how medical staff utilise AR process – this is scheduled for June 2016

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) AR review audits focusing on objective setting and linked to quality of services 2) National Staff Survey results (2015 results - Level of appraisal completion is in the lowest 20% nationally, but quality of appraisals is in highest 20% nationally) 3) Agreed that all staff at 8a and above will have an objective in their own AR that their team's must have met AR compliance by end of October 2016 4) Monthly reporting against AR completion timetable at Divisional and Trust level at ECQR&CC, Workforce Committee, and Finance Investment & Workforce Committee 5) Development of behavior based recruitment systems and introduction of a values workshop during induction, will increase familiarity of our values and behaviors, enabling staff to use them in a more effective way in the achievement review and performance ratings, in order to support the long term strategic implementation of achievement reviews	Positive (+) Development of toolkit and intranet resources refreshed to 2016 including FAQs and how to write SMART objectives (+) 2015 staff survey results for quality of appraisals puts SaSH in the top 20% of Trusts nationally (+) Culture champion led initiative on standards of behavior – 'One Team One Way' programme (+) 72% compliance achieved following significant focused effort Negative (-) 2015 staff survey on appraisal completion in last 12 months is in bottom 20% nationally (-) 2015/16 compliance rates for Achievement Review remains adverse to plan

Gaps in assurance	**Assurance Level gained: RAG**
New AR process is yet to provide assurance that all relevant staff are completing ARs within agreed timescale, and as such there is still a risk in relation to this.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Recovery plan for 2015/15 compliance in place – AR completion rate now at 72% for 2015/16 2) Series of training courses to support implementation commenced and will run throughout 2015/16 and up to end of June 2016/17	1) 31 March 2016 2) 30 June 2016

3) Scoping conversation to take place in June re doctor's use of AR process 'One Team, One Way- Launches April 2016 by the Trust's Culture Champions. Include significant focus on the Trust values and behavioural anchors and their links to ARs Establish process for annual performance review to identify and talent map all staff in the Trust with succession plans developed for the Executive Team and their deputies in 2016. 4) Launch of 2016/17 AR process with supporting communications plan	3) Launches April 2016 4) Launches April 2016

Update by	MP 16/03/2016	**Date discussed at Board**	To be discussed at March Board

Objective 5 - Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model			
Priority ID and reference	5.G.2 We are a well governed organisation	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	5.6 The Trust remains within the current FT pipeline and awaits national guidance on potential new organisational forms which could result in changes to the current timescale and associated requirements to the process. Due to the merger of the NHS TDA & Monitor and creation of NHS Improvement there is uncertainty over the longevity of the current FT model.	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	1531

Controls in place (to manage the risk)	**Gaps in Control**
1) Successful outcome from the formal Monitor assessment process 2) Achievement of FT project plan milestones 3) Formal approval by TDA Board to move to Monitor assessment phase target 4) Successful elections to the Council of Governors 5) FT Project Board 6) Implementation of Board development programme	No significant gaps in control identified

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) LTFM agreed by the Board 2) Submission of Integrated Business Plan to TDA & Monitor 3) Public Consultation completed with positive outcome 4) QGAF External assessment completed with implementation of action plan 5) TDA Formal approval to move to the Monitor stage 6) Chief Inspector of Hospitals Inspection – "Good" 7) Elections to Shadow Council of Governors 8) HDD to be completed as part of Monitor phase 9) Submission of all current Monitor information requests	Positive (+) Completion of Monitor pre-assessment phase (+) Election to the Council of Governors complete (+) FT membership over 10,000 (+) Monitor Exe to Exe Challenge took place on 1st June 2015 (+) External assessment of QGAF score 3.5 (+) Quality Governance Memorandum submitted to Monitor with score of 2.0 (+) Monitor confirmed QGAF score as 3.5 – Further actions being implemented (+) Successful elections - Shadow Council of Governors in place (+) Discussion in place with Monitor on final timescales & remainder milestones to re-start the process (+/-) Awaiting national guidance on future FT model and metrics (NHS Improvement)

Gaps in assurance	**Assurance Level gained: RAG**
Completion of Historical Due Diligence	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Shadow Council of Governors in place 2) Monitor formal assessment currently paused	1) Ongoing 2) Plans are on track

Update by	GFM 03/03/16	**Update by**	To be discussed at March Board

Objective 5 – Well Led- become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model

Priority ID and reference	5.F. Ensure IT support/optimise patient experience by improving patient interface, sharing and capture of patient information and patient communication	**Director responsible**	Director of Information and Facilities
		Initial Risk	**S5 x L3 = 15**
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	5.7. There is a risk that the Trust will not fully realise the benefits available from well embedded IT systems	**Current rating**	S4 x L3 = 12
		Target risk score	S3 x L3 = 9
		Linked to Risk	1428, 999, 1483

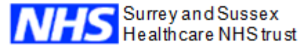
Controls in place (to manage the risk)	**Gaps in Control**
1) Move to direct contract with Cerner now happened and Trust has exited NPfIT well ahead of schedule 2) IT Strategy aligned with Clinical Strategy and IBP and reviewed Oct 14 3) Clinical Informatics Group 4) Clinical IT leads 5) Various project groups (EPMA etc.) 6) Project management controls (Descried in Internal Audit of project management) 7) EPR costs identified in LTM 8) CCIO and CNIO roles being implemented – greater clinical buy-in 9) Cerner Optimisation Group now in place 10) IT Road Map presented to FWC and Executive 11) EPR Roadmap signed-off by Executive November 2015 and Trust working on implementation plan and business case with EPR Provider	1) Insufficient focus on change benefits realization due to financial constraints 2) Lack of operational involvement in identifying and delivering benefits
Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
Efficiencies being delivered through IT enabled change	Positive (+) Improving infrastructure (e.g. Wi-Fi move to Windows 7) (+) Development of existing EPR platform (e.g. EPMA and move to Cerner) (+) EPR Contract signed and data center move finished (+) Trust moved to latest version of EPR software (+) Business Continuity System now in place (7/24)

Gaps in assurance	**Assurance Level gained: RAG**
Trust position known, no identified gaps in assurance	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1. Procurement and implementation of replacement EPR - complete 2. Establishment of Chief clinical Information Officer role - complete 3. Clinical Cerner Optimisation Group now in place with strong leadership 4. Greater focus on IT in Capital Plan for 2015/16 and future years 5. EPR Roadmap now approved by Executive and approval to proceed agreed 6. Move to latest version of Cerner software now taken place	1. Completed 2. 724 Go-live November 2014. 3. PC Upgrade plan now complete 4. Network review first draft now complete and approval to proceed approved

Update by	IM 17/03/16	**Date discussed at Board**	To be discussed at March Board

Appendix 1



RISK QUANTIFICATION MATRIX

Consequence

Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Almost certain - 5	5	10	15	20	25
Likely - 4	4	8	12	16	20
Possible - 3	3	6	9	12	15
Unlikely - 2	2	4	6	8	10
Remote - 1	1	2	3	4	5

RISK Low (1-6) Medium (8-12) High (15-25)

	LIKELIHOOD		
	Actual frequency	**Will occur:**	**Probability**
Almost certain	Will occur given existing controls	Daily	> 90%
Likely	Will probably occur given existing controls	Weekly	50% - 90%
Possible	Could occur given existing controls	Monthly	10% - 50%
Unlikely	Not expected to occur, except for in exceptional circumstances, given existing controls	Once a year	1% - 10%
Remote	Not expected to occur given existing controls	Once in >2 years	> 1%

Abridged consequence table taken from Trust guidance

Risk Type	Insignificant	Minor	Moderate	Major	Extreme
Patient Safety	• No obvious injury / harm	• Non-permanent avoidable injury / harm requiring only first aid / minor treatment	• Short-term avoidable injury / harm with recovery / treatment up to 1 month • Injury / illness requiring more complex treatment, e.g. stitching, plaster, medication course, minor theatre operation etc. • Minor harm event involving >5 patients	• Long-term (>1 month) / permanent avoidable injury / harm / illness or any of the following: ▪ Infant abduction ▪ Infant discharged to wrong family ▪ Rape or serious assault • Moderate harm event involving >5 patients	• Avoidable death • Major harm incident involving >5 patients
Patient 'Experience' & Care Pathways and Involvement of Service Users	• No significant impact on patient experience • No complaints / concerns raised • Care pathway problems resulting in short-term treatment / care delay <3 hours	• Minor unsatisfactory patient experience related to treatment / care given • Informal complaints raised / PALS contacted • Care pathway problems resulting in short-term treatment / care delays (3 hours – 1 day)	• Unacceptable patient experience related to poor treatment / care • Formal complaints raised and/or MP / independent advice / advocacy contacted • Care pathway problems resulting in medium term delays (up to 1 month) or 5-10 patients affected	• Major unsatisfactory patient experience related to poor treatment / care • Legal action against the Trust initiated / local media involvement • Care pathway problems resulting in medium term delays (1-6 months) or 10-20 patients affected	• Upheld complaints regarding death in the Trust • National media coverage / political action against the Trust • Care pathway problems resulting in long term delays (>6 months) or >20 patients affected
Health & Safety	• No harm injury	• Short term / non-permanent injury / ill health. • Injury / ill health resulting in 0-7 days absence from work.	• Medical treatment required • Injury / ill health resulting in >7 days absence from work or restricted duties for >7 days (RIDDOR reportable)	• Permanent or extensive injury / ill health / permanent disability or loss of limb (RIDDOR reportable)	• Death (RIDDOR reportable)
Financial Management	• Small loss <£1K	• Minor loss £2K to £100k	• Moderate loss, £100k - £1M	• Major loss, £1M-£10M	• Loss > £10M
Governance Arrangements	• Concern raised by internal or external systems that can be resolved through normal governance processes in < 3 months (e.g. one financial quarter)	• Concern raised by internal or external systems that will take > 3 months to resolve but does not fulfil the criteria of moderate consequence	• Concern raised in external inspection report or raised in single performance conversation with commissioners / TDA (or equivalent) due to a failure to provide "well led" services as described by the CQC • Adverse Monitor continuity of service rating <1 month	• Suspension of services provided due to a failure to provide "well led" services as described by the CQC • Any issue that would have to be recorded in annual governance statement or annual report (e.g. significant issue "red risk" audit produced by Internal Audit) • Adverse Monitor continuity of service rating > 1 month	• Permanent removal of services and / or prosecution due to a failure to provide "well led" services as described by the CQC • Act or omission that could led to removal of the Board • A breach of Monitor Terms of authorisation
Quality of Service	• Insignificant interruption of service(s) which does not impact on the delivery of patient care or the ability to continue to provide service	• Short term disruption to service(s) with minor impact on patient care	• Some disruption to service(s) provision with unacceptable short-term impact on patient care. Temporary loss of ability to provide service(s)	• Sustained loss of service which has serious impact on patient care resulting in major contingency plans being involved	• Permanent loss of core service or facility