

Trust Board in Public – 25th August 2016

Board Assurance Framework August 2016

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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 be within the top 20% benchmark for safety standards if opportunities to innovate and learn from benchmarked outcome data/peer review are not adopted and implemented	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
<ol style="list-style-type: none"> 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. 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) 5. Matron on site 7 days a week to monitor nursing patient care and staffing 6. Clinical Site Matron established 24/7 with enhanced team (2xB7 and 1x B8a) 7. Nursing staffing levels monitored daily and issues managed 8. Ward safety boards updated regularly and ward performance discussed at divisional level 9. Serious incident review group established to monitor and evaluate investigation progress and progress against actions 12. Patient falls strategic group meet monthly and report KPIs to the patient safety committee. 13. System developed to split Trust and Community acquired VTE events which are reviewed at Clinical Effectiveness, Patient Safety and ECQR. 14. IPCAS Team and Group in place, Weekly taskforce in place 15. Infection control manual in place and information resources available 16. Antibiotic policy and guidelines in place 17. Daily (Monday to Friday) Infection Prevention & Control Nurses (IPC), to facilitate assessment and advice for infection control issues. 	<ol style="list-style-type: none"> 1) Developing ward safety dashboards 2) Ward accreditation system under development 3) Updating and 4) Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset 5) 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 (-)		
<ol style="list-style-type: none"> 1) External reports and visits to clinical areas both scheduled and unscheduled (e.g. opportunity walks) 2) Ward Dashboards 	Positive (+) CQC Chief Inspector of Hospitals Report (+) CQC risk rating, lowest possible		

<p>3) Divisional and Trust Level Dashboards 4) VMI/SASH Plus Program</p>	<p>(+) CNST level 2 Maternity (+) Numbers of Hospital Acquired Pressure Ulcers reduced and sustained (+) MUST audit (+) QGAF assessment and action plan (+) EWS audit (+) Datix incident reporting and analysis including increase in reporting (+) Monthly trust wide reporting using national benchmarking (+) Falls Training data (+) 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 (+) Initiation of 'Stop, Access, Send' initiative for the management of loose stool (+) Management of diarrhoea 'SASH+ Value Streams' (+) Antimicrobial prescribing audit compliance</p> <p>Negative (-) Never events incidence (-) NRLS reporting (benchmarked position) (-) Incidence of CDI 2015/16 (-) MRSA 2 x BSI</p>		
<p>Gaps in assurance</p>			
<p>Ability to benchmark in real time</p>	<p>Assurance Level gained: RAG</p>		
<p>Mitigating actions underway</p>	<p>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</p>		
<p>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) 3) Actions described in the IPCAS strategy 4) Develop actions from the strategic falls group</p>	<p>1) Ongoing 2) Ongoing action plan 3) Ongoing 4) October 16</p>		
<p>Update by</p>	<p>FA 05/08/16</p>	<p>Date discussed at board</p>	<p>August 2016</p>

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
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	2.1 There is a risk that the Trust will not meet its objective of delivering effective and sustainable care if it does not embed relevant research and education programmes that support the development of local services with the best outcomes.	Initial Risk	S4 x L3 = 12
		Current rating	S3 x L3 = 9
		Target risk score	S3 x L2 = 6
		Linked to Risk	TBC
Controls in place (to manage the risk)		Gaps in Control	
1) Oversight training by GMC/RCN/ other professional bodies for AHPs 2) Local Academic Board in place 3) CRN oversight of the research portfolio		1) Educational bodies not yet forward looking enough to provide new staffing models. Therefore Education models not aligned with future needs 2) KSS CRN worst performing nationally measured by cost each patient recruited to studies and patient recruitment per 1000 population	
Potential Sources of Assurance (documented evidence of controls effectiveness)		Actual Assurances: Positive (+) or Negative (-)	
1) GMC Survey trainees 2) Staff surveys (Qs relating to training/ doing job / appraisal) 3) Benchmarked reports from Academic Health Science Network Enhancing Quality and Recovery Programme 4) NHSE 7 day service returns 5) Reporting on patient recruitment to studies / % achieved recruitment targets and % studies meeting recruitment of 1 st patient from study initiation deadlines		Positive (+) GMC survey improving (for instance gateway 2 dark green flags and reducing red flags in pediatrics) (+) funding received from KSS CRN continues (based on formula that rewards recruitment) (+) HEKSS funding of school of Physicians Associates and Mouth Care Matters programs Negative Narrative: Most of what is currently available relates to/supports traditional structure and expectations that needs to be challenged and changed (see 5YFV, STPs). Challenge needs to focus on smarter strategy and intelligence.	
Gaps in assurance			Assurance Level gained: RAG
Position is known, future state needs to be developed			
Mitigating actions underway		Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.	
1) Strategic actions being developed		TBC	
Update by	DH 08/08/2016	Date discussed at Board	August 2016

Objective 3 - Caring – Ensure patients are cared for and feel cared about			
Priority ID and reference	3. Ensure patients are cared for and feel cared about	Director responsible	Chief Nurse
		Initial Risk	S3 x L3 = 9
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	3.1 The Trust will not meet its priority of delivering high quality care which is wrapped around the individual needs of each patient if the organisation does not seek to shape patient centered clinical services and learn from all sources of patient feedback.	Current rating	S3 x L3 = 9
		Target risk score	S3 x L2 = 6
		Linked to Risk	TBC
Controls in place (to manage the risk)		Gaps in Control	
<ol style="list-style-type: none"> 1. Patient experience committee reviews performance and escalates areas of work and concerns to Executive Committee for Quality & Risk (ECQR) and Board 2. ECQR receives reports and provides feedback 3. Quarterly meetings with Surrey and Sussex Healthwatch 		Hard to reach groups of patients Patient listening events Engagement with the voluntary sector	
Potential Sources of Assurance (documented evidence of controls effectiveness)		Actual Assurances: Positive (+) or Negative (-)	
<ol style="list-style-type: none"> 1. Your Care Matters (YCM) results (including free text comments) 2. FFT scores and free text responses 3. Staff survey 4. National patient surveys 5. Complaints 6. PALS concerns 7. Duty of Candour 8. Engagement with representatives from shadow Council of Governors 9. Patient feedback with SASH plus improvement work 		Positive (+) Carers passport (+) Opening visiting (going live in September) (+) Standards of behavior and feedback from staff (+) Recent cancer survey results (+) National cancer survey (+) National pediatric survey Negative (-) No clear improvement in YCM or national results relating to discharge or communication around medication and danger signals (-) Outpatient YCM comments (-) National patient survey, not in top 50% (-) Compliance with Accessible Information Standard (-) Outpatient and Pediatric feedback via YCM	
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).	
<ol style="list-style-type: none"> 1. Focus groups among recently discharged inpatients 2. Open visiting 3. Re-procuring the YCM service 4. Developing IT solution for Accessible Information Standard 		<ol style="list-style-type: none"> 1. Work at early stage – December 2016 2. Underway – September 2016 3. Underway – September 2016 4. TBC 	
Update by	FA 05/08/2016	Date discussed at Board	August 2016

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
Key Action for 2015/16 objectives and description of any potential significant risk to this priority	4.1 There is a risk that the Trust will not meet its objective of becoming the secondary provider of choice for our catchment area if it does not deliver all national standards including seven day working.	Initial Risk	S4 x L4 = 16
		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	
<p>1) EDD Patient Pathway under review 2) Acute and Ambulatory Pathways under review 3) Clinical Site Team 4) Review of Integrated Discharge Team and complex discharge process 5) Plans for escalation areas agreed and management tools in place 6) Review of breaches and winter last year to identify areas for improvement. 7) Review of 7 day working 8) Implementation of SAFER and Urgent and Emergency Care Improvement Plan 9) Whiteboard implementation Project 10) Reviewing SaSH@Home pathways 11) IRU admission criteria under review 12) Reviewing booking process in TWR and RTT 13) Fortnightly Elective Care Board 14) Weekly divisional patient tracking list meetings 15) Top 20 weekly MRD meeting with community partners 16) Daily focus on Top 50 Longest stay patients *Owned by SASH System</p>		<p>1) Ambulatory pathways yet to imbed (New Consultant undertaking review) 2) Support of partners required to effectively reduce and sustain numbers of patients medically ready for discharge* 3) Demand and capacity alignment – Beds* 4) Delivery of internal actions relating to Urgent and Emergency care implementation plan* 5) Demand and Capacity alignment outpatients and theatres *Owned by SASH system</p>	
Potential Sources of Assurance (documented evidence of controls effectiveness)		Actual Assurances: Positive (+) or Negative (-)	
<p>1) NHSE and NHSI aware through formal monthly IDM 2) Combined weekly Quality and Performance Dashboard reporting on a combination of quality and safety standards, including the ED national indicators, reported to exec meeting weekly 3) Performance Management Framework reporting to Trust Board 4) Monthly Access and Responsiveness reporting to Trust board 4) External stakeholder and peer review inspections 5) Daily sit rep reporting to NHSI 6) SRG changed to monthly A&E Delivery Group 7) Whole system operational resilience plans signed off for 14/15 9) Clinical audit of clinical pathways which impact on reducing emergency re-admissions. 10) External company (Deloitte) appointed by C&HCCG to undertake whole system Demand and Capacity Review *Owned by SASH System</p>		<p>Positive (+ External company (Deloitte) appointed by C&HCCG to undertake whole system Demand and Capacity Review including MRD (+ ED trajectory delivered for Q1 and July (+ Cancer 62 day delivered since Feb 16 (+ RTT incompletes delivered consistently (+ 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 Jan to April 16 (- Cancer 2 week wait Access standard not delivered April to June 16 (- Adult Bed occupancy remains higher than plan due to increased activity (- Circa 110 medically fit for discharge patients (- Local availability of Nursing home beds / ability to start complex packages of care*</p>	

		(-) Unplanned increase in >1 LOS emergency admission patients (10% vs 2% plan)	
		*Owned by local health economy	
Gaps in assurance			Assurance Level gained: RAG
Winter plans and local system position going into winter months			
Mitigating actions underway		Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.	
<ul style="list-style-type: none"> 1) Refresh winter capacity plans based on assessment of Q1 activity 2) A&E Delivery Group winter planning 3) Review of pathways and winter plans 4) Delivery of internal actions relating to Urgent and Emergency care implementation plan 5) Ambulatory care unit delivery 6) Frailty unit 7) Developing SASH system escalation plan 		<ul style="list-style-type: none"> 1) Aug 16 2) Ongoing 3) Ongoing 4) Ongoing 5) Ongoing 6) September 16 7) October 16 	
Update by	AS 11/08/2016	Date discussed at Board	August 2016

Objective 4 - Responsive to people's needs – Become the secondary care provider of choice for the catchment population			
Priority ID and reference	4. Responsive to people's needs – Become the secondary care provider of choice for the catchment population	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	4.2 There is a risk that if the Trust does not deliver the planned efficiencies it will be unable to create the necessary capacity, which will have an adverse impact on income, expenditure and ultimately quality objectives.	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) SASH System A&E Delivery Group* 3) CEO strategic meetings 4) Partnership boards 5) Trust part of national SASH+ transformation programme 6) Integrated Reablement Unit build complete 7) Operational and Acute capacity 8) Systems developed to support winter 9) Safer Care Bundles and Toolkits 10) Transformational boards 12) Executive lead Internal Productivity Work streams 13) Carter actions and reviews *Owned by SASH System		1) Pathway redesign needs to ensure its appropriate and fit for purpose 2) Repatriation of tertiary services affected 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 4) Delivery of internal actions relating to Urgent and Emergency care implementation plan* *Owned by local health economy	
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) Review of Business Continuity Plan 6) Divisional Performance Reviews 7) Productivity reporting 8) Benchmark reporting		Positive (+) Internal audit of readmission figures provides positive assurance (+) 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	
Demand and Capacity Plans for SEC			
Mitigating actions underway		Progress against mitigation (including dates, notes)	

1) Full action plan development for productivity programme (theatres, outpatients, VMI Value streams, LOS) 2) Delivery of internal actions relating to Urgent and Emergency Care Implementation Plan		on slippage or controls/ assurance failing. 1) Ongoing 2) Ongoing
Update by	BE 11/08/2016	Date discussed at Board August 2016

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. Well Led - become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model	Director responsible	Chief Executive
		Initial Risk	S4 x L3 = 12
Key Action for 2014/15 objectives and description of any potential significant risk to this priority	5. There is a chance that the Trust may not meet its priority to benefit from the opportunities of strengthening partnerships, collaboration and developing high quality safe and sustainable systems that emerge from the solutions within the STP.	Current rating	S4 x L3 = 12
		Target risk score	S3 x L3 = 9
		Linked to Risk	N/A
Controls in place (to manage the risk)		Gaps in Control	
1) Development of a robust sustainability and transformation plan which is fully owned across the Sussex & East Surrey Foot Print			
Potential Sources of Assurance (documented evidence of controls effectiveness)		Actual Assurances: Positive (+) or Negative (-)	
1) Establishment of STP Board 2) Agreed leadership of STP Board 3) Meeting the deadlines for submission of plans to NHSE 4) SaSH involvement in STP work streams 5) Board understanding and input into STP solutions 6) Place base plans 7) Agreed implementation plans across the STP footprint 8) Engagement of relevant stakeholders		Positive: (+) STP Board actively engaged (+) SaSH CEO confirmed leader of STP in Sussex & East Surrey (+) All current submission milestones met (+) New models of care for population-based catchments being explored (+) 4 Executive Directors actively engaged in STP work streams (+) Board engagement and input into emerging solutions (+) All checkpoint submissions completed to time Negative: (-) Financial gap across the STP footprint (-) Vacancies in senior posts across the footprint (-) National workforce issues in key disciplines (-) Growing and ageing population leading to real underlying growth in demand	
Gaps in assurance			Assurance Level gained: RAG
Development of next phase plans			
Mitigating actions underway		Progress against mitigation (including dates, notes on slippage or controls/ assurance failing)	
Development of next phase plans due for submission 30/09/16		Actions proceeding to plan.	
Update by	GFM 08/08/2016	Date discussed at Board	August 2016

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.A Live within our means to remain financially sustainable	Director responsible	Chief Finance Officer
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	Initial Risk	S5 x L3 = 15
		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 / productivity plans 2) Divisional activity plans 3) Internal Performance Review (PMO) process and CEO review 4) Forecast scenarios presented to Board – first at Q1 in July and internal PMOs are based on that forecast. 5) Structure of roster and agency PMOs in place and NHSi agency reduction plan submitted, with weekly NHSi reporting on compliance		1) Cost improvement plan forecasts (CIPs delivering at M04) suggest adverse delivery on agency (medical and nursing). 2) There is overspending in specific areas – notably WaCH (less so in Radiology, Medicine and E&F – improvements in these areas at M04).	
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 and roster PMOs.		Positive (+) STF milestones for first quarter STF payment achieved – STF paid. (+) Budget changes made to match activity – overall spend is within tolerance (noting overspending areas and budget profile) at M04 (+) Internal audit (IA) advises CIP process sound (but notes non-delivery, see below) Negative (-) IA advises effectiveness of savings delivery rated red/amber – risk to forecast. (-) Nurse agency CIP reported to FWC shows use of contingency, but still means a c£1.0m shortfall without further action (-) Emergency activity pressures have continued and unplanned increase in elective referrals (-) Overall agency costs remain very high, with escalation still in use and significant costs across Divisions. However, spend appears flat rather than rising.	
Gaps in assurance			Assurance Level gained: RAG
Overspending and agency savings delivery are the main areas 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 2) Additional PMOs in place for agency control 3) Controls are being exercised in divisions and centrally – vacancy restriction and non-clinical procurement. The latter tightened again in February (and maintained since then) 4) Decisions on business cases taken in light of affordability and contribution.		Actions proceeding to timetable	
Update by	PS 12/08/2016	Date discussed at Board	August 2016

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

leadership model			
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
<ul style="list-style-type: none"> 1) Items referred to in 5.A.1 and 5.A.2 above 2) V8.0 long term financial model and integrated business plan completed (submitted to NHSi in June 2016) and supports 2016/17 budget 3) TDA Plan submitted in April 2015, 2016/17, resubmitted (minor cash changes) July 2016 4) Cost improvement plan process in place (including PMO structure) 5) Demand and capacity planning for 2016/17 is now largely complete 6) Contracts agreed with commissioners 		<ul style="list-style-type: none"> 1) Items listed above (5.A.1, and 5.A.2) are applicable here 2) Reliance on centrally determined rules for tariff and the wider NHS finance regime. 3) Risk over capacity from other operational pressures 4) Overall health system financial view describes significant loss of resource to BCF funding and recovery of non recurrent actions in CCGs in 2015/16- reduces resource available for health and social care overall. 5) Central actions over NHS overspend may have an adverse impact on Trust because of manner of application (e.g. withholding capital and cash). 6) STP process identifies significant “do nothing” deficit [noting impact of actions reduces that considerably] 	
Potential Sources of Assurance (documented evidence of controls effectiveness)		Actual Assurances: Positive (+) or Negative (-)	
<ul style="list-style-type: none"> 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 		<p>Positive (+) STF milestones for first quarter STF payment achieved – STF paid.</p> <p>Negative (-) overall health system loss of resource in 2015/16 (to BCF and from CCG non recurrent recovery) and likely continuation of seepage in 2016/17 (-) Health system STP footprint in overall deficit.</p>	
Gaps in assurance			Assurance Level gained: RAG
Significant risk and unknown impact of central actions to manage NHS overspending.			
Mitigating actions underway		Progress against mitigation (including dates, notes on slippage or controls/ assurance failing).	
Please see items above.		Progress is on timetable	
Update by	PS 12/08/2016	Date discussed at Board	August 2016

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.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)	
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 2015 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, with a further draw down of £7.0m cash.		1) No agreement on medium term solution to liquidity – being pursued during 2016/17 (as it was last year) 2) Threat of central cash controls in line with control totals.	
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 2015/16 (+) Liquid ratio has followed expectations (+) Cash has been managed well in 2015/16 and 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		Actions proceeding to timetable	
Update by	PS 12/08/2016	Date discussed at Board	August 2016

Objective 5 - Well Led - become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model				
Priority ID and reference Key Action for 2015/16 objectives and description of any potential significant risk to this priority	5.E We are an organisation that is clinically led and managerially enabled.	Director responsible	Director of Organisational Development & People	
	5.5 There is a risk that the Trust will not meet its objective of becoming an 'employer of choice' if it does not deliver a workforce strategy that drives the recruitment and retention of talent and ensures a positive staff experience for all groups of staff through on-going education, development, engagement, inclusion and well-being.	Initial Risk	S3 x L3 = 9	
		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) Reviewed and 'refreshed' the Trust's Workforce Strategy ensuring relevant objectives in place 2) Trust-wide and Divisional resourcing plans being devised to ensure the Trust is able to identify and recruit 'talent' that compliments the current staff 3) Retention Strategy being developed collaboratively between Workforce and Nursing Directorates 4) Multi-disciplinary education and training strategy in development 5) New Achievement Review (ARs) process launched in April 2016 which will support the development of all staff and as well provide structure to Talent Management 6) Inclusion strategy being developed in conjunction with BRAP, (an independent equalities charity), which will link to national inclusion initiatives and regulatory requirements (e.g. EDS2, WRES, Public Sector Equality Duties) 7) SaSH Health & Well-being Strategy being developed as well as a programme to deliver the 2016/17 Healthy Workforce CQUIN		1) Operational activity levels in the Trust stated as reason by line managers for non-compliance with Corporate targets		
Potential Sources of Assurance (documented evidence of controls effectiveness)		Actual Assurances: Positive (+) or Negative (-)		
1) Progress towards Trust's Workforce Strategy objectives is reported monthly to the Finance & Workforce Committee. The quarterly Annual Plan report to the Board also includes Workforce Strategy updates 2) Key Workforce Indicators (e.g. recruitment, establishment, sickness, turnover, AR compliance, etc.), reported on a monthly basis to the Trust Board 3) Key Inclusion objectives are reported on a national basis (e.g. annual WRES report, National Staff Survey, etc.) 3) For 2016/17, Health & Well-being initiatives will be reviewed by CCGs as part of the national CQUIN		Positive (+) Accurate Workforce data being published on a monthly basis (+) Close collaborative working between key internal and external stakeholders (i.e. Workforce, Finance, Nursing, HR Business Partners, BRAP, etc.) (+) National frameworks in place to support local delivery (e.g. Health CQUIN, WRES, etc.) (+) Quality of appraisals in top 20% nationally in 2015 Staff Survey Negative (-) 2015 Staff Survey on appraisal completion in last 12 months is in lowest 20% nationally (-) 2015 Staff Survey on bullying and harassment in lowest 20% nationally (-) 2016/17 compliance rates for Achievement Review remains adverse to plan (-) Nursing recruitment challenging with negative effect on Bank and Agency usage		

Gaps in assurance		Assurance Level gained: RAG	
Some of the individual strategies / work-plans (i.e. Inclusion, Well-Being, Education & Training), which support the overarching Trust Workforce Strategy are still being developed			
Mitigating actions underway		Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.	
<ul style="list-style-type: none"> 1) Individual strategies with objectives and action plans being drafted for approval 2) 'It's Not Okay' campaign being developed to address issues of bullying and harassment 3) Promotion of 2016 AR cascade process on-going Trust-wide to support delivery of 90% compliance rate 4) Pro-active Recruitment planning in place including international campaigns 5) 2016/17 Q1 Actions for the Health CQUIN being delivered 			
Update by	MP 17/08/2016	Date discussed at Board	August 2016

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.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	5.6 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)		Gaps in Control	
<ol style="list-style-type: none"> 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. CHPPD reported monthly to NHSI. 4. PMO in place to monitor agency use and progress of work streams <ol style="list-style-type: none"> a. E-roster- migration to v10 implemented 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 in place, monitored and via divisional agency PMO f. Weekly reporting in place to NHSI in place on all agency use g. Monthly reporting of total agency spend against NHSI 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. Triangulated with safety and workforce metrics. 6. SASH recruitment brand and retention strategy in place 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. 11. Care certificate implemented 		<ol style="list-style-type: none"> 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 (-)	
<ol style="list-style-type: none"> 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 monitored in divisions 3. % of vacant shifts filled by Trust and agency staff 4. Revalidation GMC and NMC 5. Monitoring agency utilisation and spend at PMO 6. Weekly & monthly reporting of agency use to NHSI 		<p>Positive</p> <ul style="list-style-type: none"> (+)SNCT/CHPPD data (+) Recruitment plans developed by ward and reported fortnightly (+) 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 (+) Initial feedback from nursing revalidation. <p>Negative</p> <ul style="list-style-type: none"> (-)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.	
<ol style="list-style-type: none"> 1. Continue to monitor effectiveness of recruitment plans 2. 7 day working plans for medical staff under development across the Trust 3. Implement plans to manage staffing issues in Theatres 4. Increasing direct entry nursing students by 100% (40 to 80) from February 2016 		<ol style="list-style-type: none"> 1. Ongoing 2. Being implemented 3. Being implemented 4. Being implemented 	
Update by	FA 05/08/2016 and DH 20/07/2016	Date discussed at Board	August 2016

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/optimize 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 Feb 16 3) Clinical Informatics Group 4) Clinical IT leads 5) Various project groups (EPMA etc.) 6) Project management controls (Described 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 12) EPR OBC Agreed by FWC and Executive		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. EPR Digitise Business Case now approved 7. 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 17/08/2016	Date discussed at Board	August 2016

RISK QUANTIFICATION MATRIX

Likelihood	Consequence				
	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	<ul style="list-style-type: none"> No obvious injury / harm 	<ul style="list-style-type: none"> Non-permanent avoidable injury / harm requiring only first aid / minor treatment 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Long-term (>1 month) / permanent avoidable injury / harm / illness or any of the following: <ul style="list-style-type: none"> Infant abduction Infant discharged to wrong family Rape or serious assault Moderate harm event involving >5 patients 	<ul style="list-style-type: none"> Avoidable death Major harm incident involving >5 patients
Patient 'Experience' & Care Pathways and Involvement of Service Users	<ul style="list-style-type: none"> No significant impact on patient experience No complaints / concerns raised Care pathway problems resulting in short-term treatment / care delay <3 hours 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No harm injury 	<ul style="list-style-type: none"> Short term / non-permanent injury / ill health. Injury / ill health resulting in 0-7 days absence from work. 	<ul style="list-style-type: none"> Medical treatment required Injury / ill health resulting in >7 days absence from work or restricted duties for >7 days (RIDDOR reportable) 	<ul style="list-style-type: none"> Permanent or extensive injury / ill health / permanent disability or loss of limb (RIDDOR reportable) 	<ul style="list-style-type: none"> Death (RIDDOR reportable)
Financial Management	<ul style="list-style-type: none"> Small loss <£1K 	<ul style="list-style-type: none"> Minor loss £2K to £100k 	<ul style="list-style-type: none"> Moderate loss, £100k - £1M 	<ul style="list-style-type: none"> Major loss, £1M-£10M 	<ul style="list-style-type: none"> Loss > £10M
Governance Arrangements	<ul style="list-style-type: none"> Concern raised by internal or external systems that can be resolved through normal governance processes in < 3 months (e.g. one financial quarter) 	<ul style="list-style-type: none"> Concern raised by internal or external systems that will take > 3 months to resolve but does not fulfil the criteria of moderate consequence 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Insignificant interruption of service(s) which does not impact on the delivery of patient care or the ability to continue to provide service 	<ul style="list-style-type: none"> Short term disruption to service(s) with minor impact on patient care 	<ul style="list-style-type: none"> Some disruption to service(s) provision with unacceptable short-term impact on patient care. Temporary loss of ability to provide service(s) 	<ul style="list-style-type: none"> Sustained loss of service which has serious impact on patient care resulting in major contingency plans being involved 	<ul style="list-style-type: none"> Permanent loss of core service or facility