Surrey and Sussex NHS
Healthcare NHS Trust

Board Assurance Framework
September 2016

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An Associated University Hospital of
Brighton and Sussex Medical School

Putting people first
Delivering excellent, accessible healthcare

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 2016/17 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
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.	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 (-)
1) External reports and visits to clinical areas both scheduled and unscheduled (e.g. opportunity walks) 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 (+) 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 Negative (-) Never events incidence (-) NRLS reporting (benchmarked position) (-) Incidence of CDI 2015/16 (-) MRSA 2 x BSI

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) 3) Actions described in the IPCAS strategy 4) Develop actions from the strategic falls group	1) Ongoing 2) Ongoing action plan 3) Ongoing 4) October 16

Update by	FA 12/09/16	**Date discussed at board**	September 2016

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	S4 x L3 = 12
Key Action for 2016/17 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.	**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 1st 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 19/09/2016	Date discussed at Board	September 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 2016/17 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**
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 (-)**
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.**
1. Focus groups among recently discharged inpatients 2. Open visiting 3. Re-procuring the YCM service 4. Developing IT solution for Accessible Information Standard	1. Work at early stage – December 2016 2. Underway – September 2016 3. Underway – September 2016 4. TBC

Update by	FA 12/09/2016	**Date discussed at Board**	September 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
		Initial Risk	**S4 x L4 = 16**
Key Action for 2016/17 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.	**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 under review 2) Acute and Ambulatory Pathways under review 3) Clinical Site Team 4) Review of Integrated Discharge Team and complex discharge process complete, implementing actions 5) Plans for escalation areas agreed and management tools in place 6) Review of breaches and winter last year to identify areas for improvement complete 7) Review of 7 day working in progress 8) Implementation of SAFER and Urgent and Emergency Care Improvement Plan 9)Whiteboard implementation Project 10) Reviewing SaSH@Home pathways regularly 11) IRU admission criteria review complete 12) Reviewing booking process in TWR and RTT and recovery plan in place 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	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

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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 (Deloittes) appointed by C&HCCG to undertake whole system Demand and Capacity Review in progress *Owned by SASH System	Positive (+)External company (Deloittes) appointed by C&HCCG to undertake whole system Demand and Capacity Review including MRD (+) ED trajectory delivered for Q1 and July, Aug (+) 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*

	(-) 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.
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	1) Aug 16 2) Ongoing 3) Ongoing 4) Ongoing 5) Ongoing 6) September 16 7) October 16

Update by	AS 22/09/2016	Date discussed at Board	September 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 2016/17 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 Reablment 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 on slippage or controls/ assurance failing.**

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			1) Ongoing 2) Ongoing
Update by	AS 22/09/2016	**Date discussed at Board**	September 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 9) Feedback from NHSE/NHSI on initial submissions	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 (+) Executive Programme Board now in place (+) Regular progress updates to SaSH Board 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 16.09.16 & 21.10.16	Actions proceeding to plan.

Update by	GFM 20/09/16	**Date discussed at Board**	September 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	5.1 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/ financial) savings & productivity plans. 2) Agreed contracts in place with main sets of commissioners (NHSE and CCGs) – all Contracts were finally signed in May. 3) Contract management process in place (this operated effectively in 2015/16). 4) Financial reporting, including periodic forecast scenarios, is in place and effective – the first detail forecast went to Board in July. 5) SRG and Transformation meetings in place and operating – specific joint working with ESCCG and Surrey County Council.	1) There are issues with Sussex over MRET and the provision of services to manage urgent care (hence separate transformation meeting). 2) Winter demand has been a significant issue, and activity grew significantly in 2015/16. 3) The strategic management of activity (through SRG & Transformation Boards) is not fully effective, but partners are working support making it so. 4) Action at East Surrey CCG (reviewing approach and investments) may have an impact on income and/or plans to manage emergency activity.

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 (+) STF milestones for first quarter STF payment achieved – STF paid. (+) East Surrey CCG have agreed MRET threshold increase and IRU is open…[nb: there is risk from new directions provided by NHS England that could see changes to previous agreements] Negative (-) Risk over income growth assumptions, primarily because of capacity and the unplanned increase in elective referrals (and happening earlier than anticipated) (-) Dispute with Sussex over MRET changes [although potentially drawing to an agreed conclusion] (-) Too much non elective activity, not enough elective – risk over emergency demand (-) disputes over 2015/16 income not yet resolved (reconciliation process complete allowing negotiation to begin)

Gaps in assurance	**Assurance Level gained: RAG**
Red because of level of risk, 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) Revise forecast for elective activity; 3) Embed the integrated reablement unit and open the frailty unit (both joint working with ESCCG). 4) Robust contractual processes being operated.	Actions proceeding to timetable.

Update by	PS 19/09/2016	**Date discussed at Board**	September 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. 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 / 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 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 latter areas at M04 and M05).

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) – also Temporary Staffing audit positive (amber rated, noting delivery risk) 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 September. 4) Decisions on business cases taken in light of affordability and contribution.	Actions proceeding to timetable

Update by	PS 19/09/2016	**Date discussed at Board**	September 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. 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) 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	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 (-)**
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	Positive (+) STF milestones for first quarter STF payment achieved – STF paid. 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.

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 19/09/2016	**Date discussed at Board**	September 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)	**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 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 19/09/2016	**Date discussed at Board**	September 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.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 2016/17 objectives and description of any potential significant risk to this priority	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.	**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 over-arching Trust Workforce Strategy are still being developed	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
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 Q2 Actions for the Health CQUIN being delivered	1) Ongoing 2) Monthly completion reporting made at F&WC and Workforce Committee. Current completion rate as at end August was 55% 3) Ongoing: 105 posts offered following recent Skype interviews;12 internationally recruited nurses commencing between August and end of October;80 directly recruited nurses in pre-employment screening phase 4) Actions being reviewed and delivered

Update by	MP 12/09/2016	Date discussed at Board	September 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 2016/17 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
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 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	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 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	Positive (+)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. 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 plans to manage staffing issues in Theatres 4. Increasing direct entry nursing students by 100% (40 to 80) from February 2016	1. Ongoing 2. Being implemented 3. Being implemented 4. Being implemented

Update by	FA 12/09/2016 and DH 19/09/2016	Date discussed at Board	September 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/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 2016/17 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 (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 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 12/09/2016	**Date discussed at Board**	September 2016