Surrey and Sussex NHS
Healthcare NHS Trust

Board Assurance Framework
March 2017

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An Associated University Hospital of Brighton and Sussex Medical School

Objective 1 - Safe –Deliver safe services and be in the top 20% against our peers			
Priority ID and reference	1.A Consistently meet national patient safety standards in all specialties and across divisions	**Director responsible**	Chief Nurse / Medical Director
		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 be in the top 20% for safety and continue to improve beyond this benchmark 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, sepsis, AKI and infection control) 2) Regular review of patient safety data including incidents, HSMR, the Safety Thermometer at ward, divisional, executive and board level 3) 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) 4) Nursing staffing levels monitored and related issues managed daily 5) National patient safety alerts NICE guidance and other safety related guidance reviewed and implemented where relevant and appropriate 6) Serious incident review group in place to monitor and evaluate investigation progress and demonstrate progress against agreed actions 7) IPCAS Team and Group in place, Weekly taskforce meetings in place 8) Assurance process in place for C. diff / MRSA blood stream infection.	1) Developing systems to support safety benchmarking

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 / CQC /audit) 2) Divisional and Trust Level Dashboards 3) SASH + Program 4) Benchmark reporting 5) Compliance with NICE guidance	Positive (+) CQC Chief Inspector of Hospitals Report (+) CNST level 2 Maternity (+) Incidence of Hospital Acquired Pressure Damage reduced and sustained (+) EWS audit, action plan in place including development of electronic systems (+) Datix incident reporting and analysis including increase in reporting (+) Datix linkages to audit and strengthening legal affairs systems (+) 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 revised strategy and action plan in development (+) Initiation of 'Stop, Access, Send' initiative for the management of loose stool (+) Management of diarrhoea 'SASH+ Value Streams' (+) Antimicrobial prescribing audit compliance (+) NRLS reporting

	Negative (-) Never events incidence (-) Incidence of CDI 2016/17 (-) MRSA 3 x BSI

Gaps in assurance	**Assurance Level gained: RAG**
Ability to benchmark in real time and data quality of elements of reporting	

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	1) Ongoing 2) Ongoing action plan 3) Ongoing

Update by	VD 24/03/17 DH 22/03/17	**Date discussed at board**	March 2017

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 4) Practice development model in nursing	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 6) Internal Audit review of BAF risk provides assurance 7) R+D and Chief of Education both agreed to reports / position statements for SQC per year	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 (+) New COO appointed to KHS CNN with strong track record – opportunity for new leadership development as job share clinical director as stood down (+) Frist draft of education strategy available for comment and review (+) SaSH have recruited more than 300 patients into NIHR adopted studies (10%) of total regional recruitment (+) Research report taken at SQC (+) Education report taken at SQC 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. (-) NIHR have not renewed contracts for current CRN managing directors

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 2) Advertising for Clinical Professor of Disease of the Elderly and Professor of Nursing-Elderly Care	TBC 31/03/2017

Update by	DH 22/03/2017	**Date discussed at Board**	March 2017

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 4. Opening visiting in place 5. Engagement with the voluntary sector 6. Carers support network, involvement in John's campaign 7. Open visiting introduced in general ward areas	Hard to reach groups of patients Patient listening events

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 (including patient experience committee) 9. Patient feedback with SASH plus improvement work 10. Feedback from open visiting 11. PROMS rolling out to show we care about patients 12. Ward improvement linked to access and signage	Positive (+) Carers passport (+) Standards of behavior and feedback from staff (+) National cancer survey (+) National pediatric survey (+) Patient feedback (+) Place audit 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. Re-procuring the YCM service 3. Developing IT solution for Accessible Information Standard	1. Work at early stage – December 16 2. Underway – September 2016 3. TBC

Update by	FA 24/03/2017	**Date discussed at Board**	March 2017

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**	Proposed S4 x L3 = 12
		Target risk score	S4 x L2 = 8
		Linked to Risk	1220, 1491

Controls in place (to manage the risk)	**Gaps in Control**
1) Introduction of Frailty Unit and Intermediate Care Ward 2) Implementation of Acute and Ambulatory Care Pathways 3) Clinical Site Team 4) Restructured Integrated Discharge Team 5) Plans for escalation areas agreed and management tools in place 6) Winter Plan, Christmas Plan and Escalation Plan updated to reflect lessons learned from last year. 7) Increased medical staff presence on weekends. 8) Implementation and ongoing monitoring of SAFER and Urgent and Emergency Care Improvement Plan 9) Establishment of Patient Focus Board Task Force 10) Reviewing SaSH@Home pathways to focus on elective work 11) New IRU admission criteria implemented 12) Reviewing booking process in TWR (complete), RTT and recovery plan in place 13) Weekly Elective Care Board 14) Weekly divisional patient tracking list meetings 15) Top 20 weekly MRD meeting with community partners, increased focus on CHC delay 16) Daily focus on Top 50 Longest stay patients 17) GP in ED until the end of March 18) Recovery Plan in place for Endoscopy	1) GP and Community ability to support Ambulatory Pathways of Care 2) Support of partners required to effectively reduce and sustain numbers of patients medically ready for discharge* 3) Demand and capacity alignment – Beds* and availability of appropriately skilled staff 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) Formal monthly IDM with NHSE/I 2) Combined weekly Quality and Performance Dashboard reporting on a combination of quality and safety standards, including the ED national indicators which is reported to Executive Committee weekly 3) Integrated Performance Management Framework reporting to Trust Board 4) Monthly Access and Responsiveness Committee reporting to Trust board 4) External stakeholder and peer review inspections 5) Daily sit rep reporting to NHSI 6) A&E Delivery Group monthly responsible for Resilience Planning	Positive (+)External company (Deloittes) appointed by C&HCCG to undertake whole system Demand and Capacity Review including MRD (+) ED trajectory delivered for Q1, Q2. Continues to be high performer nationally (+) All cancer standards delivered for 8 months (+) RTT recovery plan in progress (+) Top 20 patient delay weekly meetings (+) Monitoring and managing compliance #NOF, Stroke and medical outliers (+) Bed modelling refreshed including emergency demand increases (+) Elective referral drift from the south

through winter 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 complete *Owned by SASH System	Negative (-) ED standard not delivered in M10 (-) Adult Bed occupancy remains higher than plan (-) Circa 110 medically fit for discharge patients on average (-) Local availability of Nursing home beds / ability to start complex packages of care* (-) RTT access standard not met month 9-11 *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) Ongoing monitoring of actions and outputs described above and ensuring appropriate responsiveness when outputs not delivered.	1) Ongoing

Update by	AS 24/03/2017	**Date discussed at Board**	March 2017

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 Board* 3) CEO strategic meetings 4) Partnership boards 5) Trust part of national SASH+ transformation programme 6) Integrated Reablement Unit build complete and unit operational 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

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 2403/2017	**Date discussed at Board**	March 2017

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) STP structure and leadership [Exec Board, Programme Board, Finance Group]; 2) National consultation rules, national publication and national leadership of STPs; 3) Very frequent reporting to Board, including Board seminar discussions every other month; 4) Trust strategy plans agreed by Board (part of existing Trust process);	1) Deteriorating financial position across the health system (more CCGs moved into deficit at M10); 2) Clinical group output not on line [group now established, and has met twice] 3) Commissioning reshape in progress but direction not agreed 4) BSUH forward plan (as a fixed point in STP – new management contract arrangement due to come into force from 1 April, additional emergency care capacity needed, and capacity issue at RSCH site) 5) Infrastructure resourcing below benchmarked levels of other STPs 6) Formal linkage from Boards/Governing bodies into STP governance structure [new structure to be implemented shortly] 7) NHS England actions: locally NHS England is tasking CCGs with the submission of a revised financial plan (27 Feb) and has grouped CCGs into categories according to financial risk – all local CCGs are in the worst risk category and are being asked to develop plans to restrict expenditure immediately.

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 based plans 7) Agreed implementation plans across the STP footprint 8) Engagement of relevant stakeholders 9) Feedback from NHSE/NHSI on initial submissions 10) Feedback from NHSE/NHI on October 2016 submissions 11) Publication of the STP 12) Feedback from NHSE/NHSI on current plans 13) Review and strengthening of governance processes	Positive: (+) STP Board and supporting infrastructure in place (+) 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 in [now] four "place based areas" (+) Publication of the STP plan Dec 2016 (+) Engagement and communication plan in place locally and with stakeholders 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
Continued development of next phase – Place Based Plans	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing
Development of next phase plans on track	Actions proceeding to plan.

Update by	PS 23/03/2017	Date discussed at Board	March 2017

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 to meet forecast (new forecast M09)	**Current rating**	S4 x L3 = 12
		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 2016. 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) A&E Delivery Board and Transformation meetings in place and operating. 6) NHSi/NHS England Performance Meetings: but solution to clash between organization actions difficult to see – Trust is planning to increase income, CCGs plan to reduce it – only one party can succeed. Risk rating adjustment discussed at AAC 18 January.	1) Activity demand continues to be a significant issue, with resultant capacity constraints. 2) Strategic management of activity (contract meetings, A&E Delivery & Transformation Boards) not fully effective - partners working to make it so. Cash has been received from East Surrey CCG and the previous gap in control is removed from the BAF report. **NOTE: Overall risk rating reduced (from 15) in January now that the risk has been realised and the forecast changed. Risk remains, however, to the forecast (but at a lower quantum). The forecast target has also been changed to that discussed in January after agreement with NHSi**

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.: A&E Delivery Board/Transformation Board) 5) Output of Contract Management Process .	Positive (+) STF milestones for first & 2nd quarter STF payment achieved – STF paid for Q1 and Q2. (+) East Surrey CCG have agreed MRET threshold increase and IRU is open…[nb: there is risk from new directions provided by NHS England and CCG actions that could see changes to previous agreements – but more positive action anticipated to reach resolution soon] (+) issues with Sussex over MRET resolved (although not full money value) Negative (-) The risk has been realised and the forecast changed - income value is below plan at M09 (-) Too much non elective activity, not enough elective – risk remains over emergency demand (-) disputes over 2015/16 income not yet resolved (but process has now started – this is the subject of discussion with CCGs)

Gaps in assurance	Assurance Level gained: RAG
Amber (as opposed to “red” at M08) because of realisation of risk. Risk, as stated above, does remain to the revised forecast and from transactional actions by CCGs.	

Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.
1) Revised plans to increase elective/outpatient activity implemented from M09; 2) Continue performance management of Divisions to increase income delivery (ongoing) 3) Embed the integrated reablement unit and the frailty unit (ongoing). 4) Robust contractual process operated and robust response to CCG challenge (ongoing).	Actions proceeding to timetable.

Update by	PS 22/03/2017	Date discussed at Board	March 2017

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 and not meet forecast (new forecast at M09)	**Current rating**	S4 x L3 = 12
		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 & budgets (activity & financial), CIP/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, 2nd in October, and in November now: internal PMOs based on last 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 and Radiology – however risk has now been transferred to the forecast **NOTE: Overall risk rating reduced (from 15) in January now that the risk has been realised and the forecast changed. Risk remains, however, to the forecast (but at a lower quantum). The forecast target has also been changed to that discussed in January after agreement with NHSi**

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 & 2nd quarter STF payment achieved – STF paid for Q1 and Q2. (+) Internal audit (IA) advises CIP process sound (but notes non-delivery, see below) – also Temporary Staffing audit positive (amber rated, noting delivery risk) Negative (-)The risk has been realised and the forecast changed – however there is still (at a lower value) risk to the revised forecast. STF for Q3 will not be paid; (-) IA advises effectiveness of savings delivery rated red/amber – risk to forecast. (-) Nurse & Medical agency and ADH CIPs being balanced by the contingency reserve (-) Emergency activity pressures have continued and several Divisions are overspending (-) Overall agency costs remain very high, with escalation still in use and significant costs across Divisions. However, spend appears flat rather than rising. Divisions are committing to delivering extant forecasts.

Gaps in assurance	**Assurance Level gained: RAG**
Amber (as opposed to "red" at M08) because of realisation of risk. Risk, as stated above, does remain to the revised forecast and from transactional actions by CCGs.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) PMO/Performance structure continues - Divisions are committing to delivery of forecasts in their recovery plans [all are on track to forecast at M11] 2) Additional PMOs in place for agency control (ongoing) 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 22/03/2017	**Date discussed at Board**	March 2017

<table>
<tr><th colspan="4">Objective 5 – Well Led - become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model</th></tr>
<tr><td>Priority ID and reference</td><td>5.A Live within our means to remain financially sustainable</td><td>Director responsible</td><td>Chief Finance Officer</td></tr>
<tr><td rowspan="4">Key Action for 2014/15 objectives and description of any potential significant risk to this priority</td><td rowspan="4">5. 3 Unable to deliver medium term financial plan</td><td>Initial Risk</td><td>S5 x L3 = 15</td></tr>
<tr><td>Current rating</td><td>S5 x L3 = 15</td></tr>
<tr><td>Target risk score</td><td>S4 x L2 = 8</td></tr>
<tr><td>Linked to Risk</td><td>1603</td></tr>
<tr><th colspan="2">Controls in place (to manage the risk)</th><th colspan="2">Gaps in Control</th></tr>
<tr><td colspan="2">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 [however new control total regime changes this approach]
3) NHSi Plan submitted in April 2015, 2016/17, resubmitted (minor cash changes) July 2016..and accepted
4) Cost improvement plan process in place (including PMO structure)
5) Contracts agreed with commissioners in 2016/17 (but risk to 2017/18)
6) 2017/18 planning shows recurrent surplus with gain from HRG4+ (tariff pricing change) – but risk in delivering control totals specified.
7) STP process is providing health system financial model</td><td colspan="2">1) Items listed above (5.A.1, and 5.A.2) are applicable here
2) Reliance on centrally determined rules for tariff & wider NHS finance regime.
3) Risk over capacity from other operational pressures
4) Overall health system financial view describes significant financial pressures (now being discussed through STP)
5) CCG control totals antagonistic to provider control totals (Trust must increase income, CCGs must reduce it), HRG4+ isn't fully funded for CCGs – net output, substantial unspecified QIPP schemes providing very large financial gap.
6) Central actions over NHS overspend may have an adverse impact on Trust because of manner of application (e.g. withholding capital and cash).
7) STP process identifies significant "do nothing" deficit [noting impact of actions reduces that considerably]
8) Need for additional actions to manage STP process and secure financial sustainability.</td></tr>
<tr><th colspan="2">Potential Sources of Assurance (documented evidence of controls effectiveness)</th><th colspan="2">Actual Assurances: Positive (+) or Negative (-)</th></tr>
<tr><td colspan="2">1) Production of 2017/18 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 2017/18 Plan, sustainability & transformation funding with NHS Improvement in 2016/17, and 2017/18</td><td colspan="2">Positive
(+) STF milestones for first and 2nd quarter STF payment achieved – STF paid Q1 and Q2.
(+) 2017/18 planning shows recurrent surplus with gain from HRG4+ (tariff pricing change). This surplus takes into account the underlying position behind the changed forecast.
(+) 2017/18 contracts signed (but significant health system risk behind the contract agreement)

Negative
(-) 2016/17 forecast OT has been revised - £10.2m adverse variance (leaving a £5.0m surplus) –however, as above 2017/18 budget based on this forecast delivers a recurrent surplus
(-) overall health system loss of resource in 2015/16 (to BCF and from CCG non recurrent recovery) and continued financial pressures (notably for CCGs locally) in 2016/17 – 2017/18 describes worsening position, reflected in substantial 2017/18 contract risk
(-) CCGs do not appear to be funded for HRG4+ (tariff) increase in 2017/18
(-) Health system STP footprint in overall deficit – increasing pressure in local health system (all CCGs are now reporting deficits).</td></tr>
<tr><th colspan="3">Gaps in assurance</th><th>Assurance Level gained: RAG</th></tr>
<tr><td colspan="3">Significant risk and unknown impact of central actions to manage NHS overspending.</td><td></td></tr>
<tr><th colspan="2">Mitigating actions underway</th><th colspan="2">Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</th></tr>
<tr><td colspan="2">Please see items above.</td><td colspan="2">Progress is on timetable</td></tr>
<tr><td>Update by</td><td>PS 22/03/2017</td><td>Date discussed at Board</td><td>March 2017</td></tr>
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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 (and met YTD) (+) Liquid ratio has followed expectations (+) Cash managed well in 2015/16 and to date; Green internal audit report on cash management (+) BPCC has improved month on month to better (but not compliant) levels at Q2, and into M09 (+) Adequate working capital facility sufficient to cover cash needs into 2016/17 has been agreed. Negative (-) revised forecast means cash pressure – working capital repayments need to be revised; (-) 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” with 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.	(red)

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 (Ongoing) 2) Detail of cash position issued to NHSi in September 2016 – awaiting feedback from NHSi on likelihood of a new loan agreement (November 2016)	Actions proceeding to timetable

Update by	PS 22/03/2017	**Date discussed at Board**	March 2017

<table>
<tr><th colspan="4">Objective 5 - Well Led - become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model</th></tr>
<tr><td rowspan="2">Priority ID and reference</td><td rowspan="2">5.E We are an organisation that is clinically led and managerially enabled.</td><td>Director responsible</td><td>Director of Organisational Development & People</td></tr>
<tr><td>Initial Risk</td><td>S3 x L3 = 9</td></tr>
<tr><td rowspan="3">Key Action for 2016/17 objectives and description of any potential significant risk to this priority</td><td rowspan="3">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.</td><td>Current rating</td><td>S3 x L3 = 9</td></tr>
<tr><td>Target risk score</td><td>S3 x L2 = 6</td></tr>
<tr><td>Linked to Risk</td><td>1740</td></tr>
<tr><th colspan="2">Controls in place (to manage the risk)</th><th colspan="2">Gaps in Control</th></tr>
<tr><td colspan="2">1) Reviewed and ‘refreshed’ the Trust’s Workforce Strategy ensuring relevant objectives in place
2) Trust-wide and Divisional resourcing plans being devised, implemented and reviewed to ensure the Trust is able to identify and recruit ‘talent’ that compliments the current staff
3) Retention Strategy agreed and now being implemented Trust
4) Multi-disciplinary education and training strategy in development
5) 2017 Achievement Review (ARs) process being promoted which will support the on-going development of all staff
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. WRES, Public Sector Equality Duties)
7) SaSH Health & Well-being Strategy being developed which will incorporate relevant Healthy Workforce CQUIN objectives</td><td colspan="2">1) Operational activity levels in the Trust stated as reason by line managers for non-compliance with Corporate targets</td></tr>
<tr><th colspan="2">Potential Sources of Assurance (documented evidence of controls effectiveness)</th><th colspan="2">Actual Assurances: Positive (+) or Negative (-)</th></tr>
<tr><td colspan="2">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.)

4) For 2016/17, Health & Well-being initiatives will be reviewed by CCGs as part of the national CQUIN</td><td colspan="2">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.)
(+) The Trust achieved its highest Staff Survey response rate – 66% - for the 2016 Survey
(+) SaSH scored in the top 20% nationally in the 2016 National Staff Survey for 22 of the 32 Key Findings
(+) Both staff engagement and staff recommending SaSH as a place to work and receive treatment were in the top 20% nationally
(+) Quality of appraisals was in the top 20% nationally in 2016 Staff Survey
(+) The Trust achieved a 97% completion rate for Achievement Reviews in the 2016/17 AR cycle</td></tr>
</table>

	(+) The Trust exceeded its 2016/17 CQUIN Flu Vaccination target – 77% vaccinated against a target of 75% (+) The Well-Being strategy is under development and will link with key CQUIN objectives. Sickness rates reduced for a second month running in February 2017 (+) The multi-professional Education strategy is being worked up and meetings are currently being held with key stakeholders to support the development of this. (+) The SaSH BAME Network is being launched on 23rd March (+) 7 international nurses commenced work in February 2017 with a further 33 offers made to international candidates. There are skype interviews planned in March and it is expected that this will include 50 candidates predominately from the Philippines. A total of 8 Continental Travel (CT) agency nurses have successfully transferred to direct employment with SaSH in February (+) 16 directly recruited registered nurses and 3 qualified midwives joined the Trust in February and 8 directly recruited registered nurses are scheduled to commence employment in March. 40 Bank Nursing Assistants have also been recruited (+) Trust Retention strategy approved by the Executive Committee and actions plans are now being developed to support the delivery of this **Negative** (-) 2016 Staff Survey on appraisal completion in last 12 months was scored as 'Average' nationally (-) SaSH was in the lowest 20% nationally in the 2016 Staff Survey for staff experiencing physical violence from patients, relatives or the public (-) 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 2017 AR cascade process commenced to support delivery of 90% compliance rate 4) Pro-active Recruitment planning in place including international campaigns 5) 2016/17 Q4 actions for the Health CQUIN being delivered 6) Head of Education, Training & OD appointed to – postholder to commence 15th May	1) The Inclusion Strategy is being developed in conjunction with BRAP 2) The 'It's not Okay' campaign is being developed and is planned to launch in May 2017 3) The AR completion rate is reported on a monthly basis to F&WC and Workforce Committee, as well as the Executive meetings 4) Recruitment & retention Group set up to support overall R&R in the Trust 5) HWB CQUIN report being drafted to highlight achievements against CQUIN objectives for 16/17

Update by	MP 15/03/2017	**Date discussed at Board**	March 2017

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, including module which allows for real time monitoring of activity and staffing 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. Unfilled shifts both nursing/midwifery and medical 2. The Trust still carries a volume of vacancies specifically in clinical areas and turnover in some areas is above Trust target 3. Imperfect induction for short notice, short term medical locums 4. Aiming for full nursing/midwifery and medical recruitment (influenced by HEKSS) 5. Medical trainees select a preference that affects the decision

<table>
<tr><td colspan="3">12. Scoping work to inform service efficacy and workforce needs in relation to patients struggling with addition</td><td colspan="2"></td></tr>
<tr><td colspan="3">Potential Sources of Assurance (documented evidence of controls effectiveness)</td><td colspan="2">Actual Assurances: Positive (+) or Negative (-)</td></tr>
<tr><td colspan="3">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</td><td colspan="2">Positive
(+)SNCT/CHPPD data
(+) Ability to recruit to Consultant post
(+) International recruitment for nurses undertaken
(+) CQC Chief Inspector of Hospitals Report - Good rating
(+) Daily ward staffing review
(+) PMO reports regarding reducing agency, 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.
(+) Staff survey
(+) Nursing sickness rates now at less than 3.5%
(+) Increasing direct entry nursing students by 100% (40 to 80) from February 2016

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</td></tr>
<tr><td colspan="4">Gaps in assurance</td><td>Assurance Level gained: RAG</td></tr>
<tr><td colspan="4">Trust position known - no identified gaps in assurance</td><td></td></tr>
<tr><td colspan="3">Mitigating actions underway</td><td colspan="2">Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</td></tr>
<tr><td colspan="3">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</td><td colspan="2">1. Ongoing
2. Being implemented
3. Being implemented</td></tr>
<tr><td>Update by</td><td>VD 24/03/2017 and DH 22/03/2017</td><td>Date discussed at Board</td><td colspan="2">March 2017</td></tr>
</table>

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, IBP and updated Jan 173) Executive Informatics Board now established 4) Clinical IT leads 5) Various project groups (EPR etc.) 6) Project management controls (Described in Internal Audit of project management) 7) EPR costs identified in capital programme 8) CCIO and CNIO now implemented – greater clinical buy-in 9) New IT Governance structure agreed 10) EPR Road Map approved by 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 FBC approved by FWC and Executive and external loan being sort	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) and well established

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. New IT governance structure agreed 4. Greater focus on IT in Capital Plan for 2016/17 and future years 5. EPR Roadmap now approved by Executive and approval to proceed agreed 6. EPR Digitise Outline Business Case now approved 7. Move to latest version of Cerner software now taken place 8. Loan being sought to fund EPR Digitise Business Case	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 5. EPR Digitise FBC Approved 6. EPR roadmap approved

Update by	IM 06/03/2017	Date discussed at Board	March 2017