# Board Assurance Framework
# October 2017

Presented by: **Gillian Francis-Musanu (Director of Corporate Affairs)**
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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 quartile 25% 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)<br>2) Regular review of patient safety data including incidents, HSMR, the Safety Thermometer at ward, divisional, executive and board level<br>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)<br>4) Nursing staffing levels monitored and related issues managed daily<br>5) National patient safety alerts NICE guidance and other safety related guidance reviewed and implemented where relevant and appropriate<br>6) Serious incident review group in place to monitor and evaluate investigation progress and demonstrate progress against agreed actions<br>7) IPCAS Team and Group in place, weekly taskforce meetings in place<br>8) Assurance process in place for C. diff / MRSA blood stream infection.<br>9) Variety of national audits contributed to and reviewed<br>10) Member of AHSN<br>11) STP member<br>12) GIRFT model hospital work within hospital<br>13) 7 day services audit benchmarked with STP | 1) Developing systems to support safety benchmarking<br>2) Electronic EWS with alert system likely to be more effective in ensuring clinical response to deteriorating patient / sepsis<br>3) Data quality and lag for use in improvement programmes |

| 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. genba walks / CQC /audit)<br>2) Divisional and Trust level dashboards<br>3) SASH + Program<br>4) Benchmark reporting<br>5) Compliance with NICE guidance<br>6) Improving data regarding new harm in safety thermometer at trust level<br>7) Model hospital reports<br>8) GIRFT reports<br>9) CQC inspection | Positive<br>(+) CQC Chief Inspector of Hospitals Report<br>(+) CNST level 2 Maternity<br>(+) Incidence of Hospital Acquired Pressure Damage reduced and sustained<br>(+) EWS audit, action plan in place including development of electronic systems<br>(+) Datix incident reporting and analysis including increase in reporting<br>(+) Datix linkages to audit and strengthening legal affairs systems<br>(+) Monthly trust wide reporting using national benchmarking<br>(+) Falls Training data<br>(+) 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<br>(+) Initiation of 'Stop, Access, Send' initiative for the management of loose stool<br>(+) Management of diarrhoea 'SASH+ Value Streams'<br>(+) Antimicrobial prescribing audit compliance<br>(+) NRLS reporting<br>(+) Feedback from CQC (periodic rather than formal report)<br><br>Negative<br>(-) Never events incidence<br>(-) Incidence of CDI 2016/17<br>(-) 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<br>2) 5 work streams identified in Trusts sign up to Safety Pledges<br>(Monitoring patients for early signs of deterioration, Pain management for Dementia, Duty of Candor, COPD EQ pilot and improve shared learning from incidents)<br>3) Actions described in the IPCAS strategy<br>4) Focused support regarding falls and pressure damage from Divisional Chief Nurse for Innovation & Improvement | 1) Ongoing<br>2) Ongoing action plan<br>3) Ongoing<br>4) Ongoing and monitored weekly |

| **Update by** | FA 09/10/17<br>DH 06/10/17 | **Date discussed at board** | October 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<br>2) Local Academic Board in place<br>3) CRN oversight of the research portfolio<br>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<br>2) KSS CRN worst performing nationally measured by cost each patient recruited to studies and patient recruitment per 1000 population. This is now improving. |
| **Potential Sources of Assurance (documented evidence of controls effectiveness)** | **Actual Assurances: Positive (+) or Negative (-)** |
| 1) GMC Survey trainees<br>2) Staff surveys (Qs relating to training/ doing job / appraisal)<br>3) NHSE 7 day service returns<br>4) Reporting on patient recruitment to studies / % achieved recruitment targets and % studies meeting recruitment of 1st patient from study initiation deadlines<br>5) Internal Audit review of BAF risk provides assurance<br>6) R+D and Chief of Education both agreed to reports / position statements for SQC per year<br>7) Feedback from physician associates<br>8) Strategy for clinical education to be presented at December 17 Public Board<br>(9) New COO appointed to KHS CNN with strong track record – opportunity for new leadership development as job share clinical director as stood down | Positive<br>(+) Significantly above target recruitment to research studies<br>(+) Good benchmark nationally for national metrics relating to the number days to recruit a patient to a study within 70 days of approval.<br>(+) GMC survey improving (for instance gateway 2 dark green flags and reducing red flags in pediatrics)<br>(+) funding received from KSS CRN continues (based on formula that rewards recruitment)<br>(+) HEKSS funding of school of Physicians Associates and Mouth Care Matters programs<br>(+) Frist draft of education strategy available for comment and review<br>(+) SASH have recruited more than 1,000 patients into NIHR adopted studies (10%) of total regional recruitment<br>(+) Research report taken at SQC<br>(+) Education report taken at SQC<br><br>Negative<br>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 06/10/2017 | **Date discussed at board** | October 2017 |
|---|---|---|---|

<table>
<tr><th colspan="4">Objective 2 - Effective –Deliver effective and sustainable clinical services within the local health economy</th></tr>
<tr><td rowspan="2">Priority ID and reference</td><td rowspan="2">2.A Achieve the best possible clinical outcomes for our patients</td><td>Director responsible</td><td>Chief Operating Officer</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">2.2 There is a risk that the Trust will not meet its annual priority to improve discharge planning if suitable plans are not developed and delivered within year.</td><td>Current rating</td><td>S3 x L3 = 9</td></tr>
<tr><td>Target risk score</td><td>S3 x L1 = 4</td></tr>
<tr><td>Linked to Risk</td><td>To be identified</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">National Driver<br>CQUINN Board - 'Safe and Timely Discharge<br>Identified funding to appoint project support worker for this CQUINN ( 1 year fixed term)<br><br>System wide<br>• Transformation Board<br>• SASH System A&E Delivery Board<br>• Integrated Discharge Team (IDT) Management Board<br>• Appointment of AD Integration<br><br>Trust wide<br>• Patient Focus Board<br>• Operational IDT<br>• 'Safe and timely Discharge' Internal review group<br>• SAFER programme<br>LOS Reviews</td><td colspan="2">Conflicting priorities and objectives between Trust and community providers<br>Social Care Funding and allocation of priorities<br>No resource allocated to support specific complex discharge pathways<br>Community Capacity does not match demand<br>Unable to reach agreement on Trusted Assessors role across all providers<br>No agreed funding for Discharge to assess in Sussex</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">Delivery of key milestones laid out in CQUINN Action Plan<br>Integrated performance Management Report to Board monthly<br>IDT Management Board KPI monthly report<br>Patient feedback</td><td colspan="2">Positive<br>+ Length of time on Discharge tracker reduced<br>+ LOS post MRD reduced<br>+Internal discharge team increased in size and levels of seniority<br><br>Negative<br>-MRD remains above tolerance in KPIs<br>-Community capacity does not match demand as per bed audit (Carnell Farrel)<br>-EDD not documented for all patients within 48 hours of admission<br>-Feedback from patients demonstrates poor levels of satisfaction with discharge process<br>-LOS for non-elective patients remains high<br>-Discharge Team currently under established due to staff movement.<br>Concerns re size of team in relation to workload to implement national improvements to discharge (i.e. High Impact Changes)</td></tr>
</table>

| Gaps in assurance | Assurance Level gained: RAG |
| --- | --- |
| Transparency of allocation of Social Care Funding<br>CCG commitment to fund Discharge to assess beds | |

| Mitigating actions underway | Progress against mitigation (including dates, notes on slippage or controls/ assurance failing. |
| --- | --- |
| 1) IDT Management Board using system wide KPIS to drive improvements<br>2) Delivery of internal actions relating to CQINN | 1)MRDs above agreed tolerance<br>2)Requirements for CQUINN delivered for Q 1<br>3)Requirements for CQUINN delivered for Q 2 |

| Update by | AS 18/10/2017 | Date discussed at Board | October 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 There is a risk that the Trust will not meet its annual priority to promote the conditions that create the best environment for patients if it 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<br>2. ECQR receives reports and provides feedback regarding patient experience<br>3. Engagement with the voluntary sector including dementia groups<br>4. Carers support network, involvement in John's campaign<br>5. Open visiting introduced in general ward areas in addition to existing areas<br>6. Patient listening events for discharge process to be arranged<br>7. New system procured and in place for YCM<br>8. Cerner solution for Accessible Information Standard in place | Groups and patients which are "seldom heard" |

| **Potential Sources of Assurance (documented evidence of controls effectiveness)** | **Actual Assurances: Positive (+) or Negative (-)** |
|---|---|
| 1. Your Care Matters (YCM) results (including free text comments)<br>2. FFT scores and free text responses<br>3. Staff survey<br>4. National patient surveys<br>5. Complaints<br>6. PALS concerns<br>7. Duty of Candour<br>8. Engagement with representatives from shadow Council of Governors (including patient experience committee)<br>9. Patient feedback with SASH plus improvement work<br>10. Feedback from open visiting<br>11. PROMS rolling out to show we care about patients<br>12. Ward improvement linked to access and signage | Positive<br>(+) Carers passport<br>(+) Standards of behavior and feedback from staff<br>(+) National cancer survey<br>(+) National pediatric survey<br>(+) Patient feedback<br>(+) Place audit<br><br>Negative<br>(-) No clear improvement in YCM or national results relating to discharge or communication around medication and danger signals<br>(-) Outpatient YCM comments<br>(-) National patient survey, not in top 50%<br>(-) Compliance with Accessible Information Standard<br>(-) 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 | 1. To be arranged |

| **Update by** | FA 09/10/17 | **Date discussed at Board** | October 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 2017/18 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 L3 = 12 |
| | | **Target risk score** | S4 x L2 = 8 |
| | | **Linked to Risk** | 1220, 1491 |

| Controls in place (to manage the risk) | Gaps in Control |
|---|---|
| **System wide**<br>• Performance Management & Clinical Quality Review Board with CCG's<br>• Transformation Board<br>• SASH System A&E Delivery Board<br>• SASH System Planned Care Board<br><br>**Emergency Care**<br>• ED Working Group<br>• Primary Care Streaming Project Build<br>• SASH (internal ) ED Delivery Board<br>• Clinical Pathway review using data<br><br>**Elective Care**<br>• Elective Care Board<br>• RTT Recovery Plan<br>• Productivity Board<br><br>**Medicine**<br>• Ambulatory pathways<br>• SAFER programme<br>• LOS review<br><br>**Surgery**<br>• Day case Unit<br>• SASH@Home<br>• SAFER programme<br>• LoS review<br><br>**Discharge**<br>• SASH System Integrated Discharge Board<br>• Patient Focus Board<br>• Integrated Discharge Review<br>• Review of Longest Stay patients | **System Wide**<br>• Social Services and CHC capability to effectively reduce and sustain target number of MRD patients<br>• Ineffective alternative pathways of care to ED<br>• Lack of appropriate capacity in the community to effectively manage discharge process<br><br>**Emergency care**<br>• Ongoing growth in emergency attendance and ambulance conveyance<br><br>**Elective Care**<br>• Increase in referrals particularly in Cancer TWR from south coast<br><br>**Medicine**<br>• GP limitations in supporting ambulatory pathways<br><br>**Seven Day Working**<br>• Incremental planned progress to deliver seven day working linked to long term financial plan |

**Emergency Planning**

- Business Planning Process
- Escalation Plan
- Business Continuity Planning

| Potential Sources of Assurance (documented evidence of controls effectiveness) | Actual Assurances: Positive (+) or Negative (-) |
|---|---|
| • Formal Integrated Delivery Meeting with NHSI<br>• Quality and Performance Dashboard reported to ECQR and EC weekly<br>• Integrated Performance reported to Board monthly<br>• Access and Responsiveness Committee<br>• NHSI Daily Sitrep<br>• Daily internal monitoring<br>• Clinical Audit<br>• Benchmarking Reporting<br>• Seven Day Services National Audit | Positive<br>+ ED good performer nationally<br>+ RTT Recovery Plan in place and plan to move to Cerner strategic solution in Q3<br>+ Strong Cancer performance throughout 16/17<br>+ Significant increase in referrals both for elective care and Cancer Care<br>Negative<br>+ MRD remains high driving LOS up<br>+ Community capacity does not match demand<br>+ Rehab capacity does not match demand<br>+ Adult bed occupancy remains high<br>+ Increase in ambulance conveyance |

| Gaps in assurance | Assurance Level gained: RAG |
|---|---|
| CCG commitment to increase capacity or alter capacity to meet demand | |

| Mitigating actions underway | Progress against mitigation (including dates, notes on slippage or controls/ assurance failing. |
|---|---|
| Systematic monitoring of actions and outputs described above and ensuring appropriate responsiveness when outputs not delivered. | Ongoing |

| Update by | AS 18/10/2017 | Date discussed at Board | October 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 elective care, 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 |
|---|---|
| • CSESA North Accountable Care Leadership Board<br>• Performance Management & Clinical Quality Review Board with CCG's<br>• Surrey and Sussex Transformation Boards<br>• System Wide A&E Delivery Board<br>• SASH ED Delivery Board<br>• Planned Care Board<br>• Productivity Board<br>• Deloitte Four Eyes Theatre and Productivity Diagnostic<br>• CQUIN Board<br>• Patient Flow Board<br>• GIRFT Reviews and Action Plans | • Ineffective alternative pathways to ED<br>• Community capacity does not match demand<br>• Rehab capacity does not match demand<br>• Adult bed occupancy remains high<br>• Sustained increase in ambulance conveyance |

| Potential Sources of Assurance (documented evidence of controls effectiveness) | Actual Assurances: Positive (+) or Negative (-) |
|---|---|
| Integrated Performance Report<br>Benchmarking Report<br>Productivity Report | Positive<br>+ Delivered surplus in 16/17<br>+ Strong elective performance in March 2017<br>+ Strong Cancer performance throughout 16/17<br>+ Evidence of positive management of performance alerts e.g. Diagnostics<br>+ Surgery Centre<br>Negative<br>– MRD remains high driving LOS up<br>– Community capacity does not match demand<br>– Rehab capacity does not match demand<br>– Adult bed occupancy remains high<br>– Increase in ambulance conveyance |

| Gaps in assurance | Assurance Level gained: RAG |
|---|---|
| CCG commitment to increase capacity or alter capacity to meet demand | |

| 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)<br>2) Delivery of internal actions relating to Urgent and Emergency Care Implementation Plan | 1) Ongoing<br>2) Ongoing |

| Update by | AS 18/10/2017 | Date discussed at Board | October 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];<br>2) National consultation rules, national publication and national leadership of STPs;<br>3) Very frequent reporting to Board, including Board seminar discussions every other month;<br>4) Trust strategy plans agreed by Board (part of existing Trust process); | 1) Financial position across the health system<br>2) Clinical group output not on line [group now established, and has met twice]<br>3) Commissioning reshape in progress but direction not agreed<br>4) BSUH forward plan (as a fixed point in STP – new management contract arrangement now in force with WSNHSFT, additional emergency care capacity needed, and capacity issue at RSCH site)<br>5) Infrastructure resourcing below benchmarked levels of other STPs<br>6) Formal linkage from Boards/Governing bodies into STP governance structure [new structure to be implemented shortly]<br>7) NHS England actions: locally NHS England is tasking CCGs with the submission of a revised financial plan and has grouped CCGs into categories according to financial risk – all local CCGs are in the worst risk category and are developing plans to restrict expenditure immediately. |

| Potential Sources of Assurance (documented evidence of controls effectiveness) | Actual Assurances: Positive (+) or Negative (-) |
|---|---|
| 1) Establishment of STP Board<br>2) Agreed leadership of STP Board<br>3) Meeting the deadlines for submission of plans to NHSE<br>4) SASH involvement in STP work streams<br>5) Board understanding and input into STP solutions<br>6) Place based plans<br>7) Agreed implementation plans across the STP footprint<br>8) Engagement of relevant stakeholders<br>9) Feedback from NHSE/NHSI on initial submissions<br>10) Feedback from NHSE/NHI on October 2016 submissions<br>11) Publication of the STP<br>12) Feedback from NHSE/NHSI on current plans<br>13) Review and strengthening of governance processes being considered by NHS & NHSI | Positive:<br>(+) STP Board and supporting infrastructure in place<br>(+) SASH CEO leader of STP in Sussex & East Surrey<br>(+) All current submission milestones met<br>(+) New models of care for population-based catchments being explored in [now] four "place based areas"<br>(+) Publication of the STP plan Dec 2016<br>(+) Engagement and communication plan in place locally and with stakeholders<br>(+) Specific work streams being developed in partnership with the STP and Carnall/Farrar<br>(+) Proposed governance and leadership model<br>(+) Clinical Board<br>(+) Recruitment of an Executive CEO to lead the STP<br>(+) Partners approve STP governance arrangements with MoU for agreement by Trust Boards across the STP<br>(+)Commissioners developing plans for closer joint working<br>(+) Framework established for development of place based plans<br>(+) Clinical Board is continuing to oversee work, through the Clinically Effective Commissioning programme and the Rightcare and Get it Right First Time initiatives |

| | |
|---|---|
| | (+) Mental health workstream research published<br>(+) Coordinated work to improve urgent and emergency care services is progressing across the partnership, in line with the NHS Five Year Forward View<br>(+) Let's Get You Home campaign supports prompt hospital discharge<br>(+) Enhancing GP access to specialist advice<br>(+) Development of joint clinical pathways with STP stakeholders<br>(+) Recruitment of a shared AD for integration to focus on system wide flow<br>(+) Appointment of new Executive Chair for the STP<br>(+) STP prioritises winter preparations and flu campaigns<br>(+)The STP mental health review has developed a strategic framework<br>(+) Central Sussex CCGs agree to establish single leadership<br><br>Negative:<br>(-) Financial gap across the STP footprint<br>(-) Vacancies in senior posts across the footprint<br>(-) National workforce issues in key disciplines<br>(-) 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** | GFM 17/10/17 | **Date discussed at Board** | October 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.A Live within our means to remain financially sustainable</td><td>Director responsible</td><td>Chief Finance Officer</td></tr>
<tr><td>Initial Risk</td><td>S5 x L3 = 15</td></tr>
<tr><td rowspan="3">Key Action for 2014/15 objectives and description of any potential significant risk to this priority</td><td rowspan="3">5.1 There is a risk to the Trust's short term financial stability if the annual income plan is not delivered.</td><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>1689</td></tr>
</table>

| Controls in place (to manage the risk) | Gaps in Control |
|---|---|
| 1) Business Plans & budgets (activity/ financial) savings & productivity plans.<br>2) Agreed contracts in place – all Contracts were signed in January 2017.<br>3) Contract management process in place.<br>4) Financial reporting, including periodic forecast scenarios, is in place and effective – the first detail forecast will go to Board in July (Q1).<br>5) A&E Delivery Board and Transformation meetings in place and operating.<br>6) NHSi/NHS England Performance Meetings:<br>7) COO has established "boards" to oversee productivity delivery, emergency care management & CQUIN | 1) CCGs are past deadline for agreement of refreshed contract baseline (to reflect actual OT in 2016/17) – [NB: this work has now reached a conclusion but is not currently subject to insertion in the Contract ];<br>2) Linked to #1, strategic management of activity (contract meetings, A&E Delivery & Transformation Boards) not fully effective<br>3) Activity demand continues to be a significant issue<br>4) No Regulator feedback on last CEP submission [and still the case]: CEP remains a planning item only.<br>5) CCGs are increasing the transactional burden on the Trust – this has worsened in September & October [subject of discussion with CCGs] |

| Potential Sources of Assurance (documented evidence of controls effectiveness) | Actual Assurances: Positive (+) or Negative (-) |
|---|---|
| 1) Financial performance and contractual reporting to Exec Committee, Finance & Workforce Committee and Trust Board (including CQUIN reporting process).<br>2) Performance Review (PMO) and Exec Quality and Risk process with Divisions, monthly contract cycle with CCGs. Service line reporting process<br>3) Outputs and reporting from contract and information teams<br>4) Output and reporting from health system management (e.g.: A&E Delivery Board/Transformation Board)<br>5) Output of Contract Management Process . | <u>Positive</u><br>(+) Trust delivered a surplus in 2016/17 – STF was paid for Q1 and Q2 in that year.<br>(+) Contract in place requires commissioners to make cash payments for work done prior to the formal reconciliation process<br>(+) 2017/18 Q2 plan achieved, and AE achievement resolved – we qualify for STF payment<br><u>Negative</u><br>(-) Income below plan at M06 (although improved since M05, still below Plan)<br>(-) Commissioners around the Trust have significant financial risk – deficits in 2016/17 and adverse positions now that may lead to more transactional measures being taken. This is also driving the delay to agreeing the baseline (Gaps in Control #1) and creating a planning issue around activity<br>(-) Too much non elective activity, not enough elective – risk remains over emergency demand<br>(-) disputes over 2016/17 income largely resolved, but not yet fully resolved. |

| Gaps in assurance | Assurance Level gained: RAG |
|---|---|
| Amber recognizing pressures visible at M06 and data describing income adverse to Plan. | |

| Mitigating actions underway | Progress against mitigation (including dates, notes on slippage or controls/ assurance failing. |
|---|---|
| 1) CCGs and Trust have now completed joint work on the activity plan to agree a 2017/18 demand and capacity plan. That was finalized on 19 October – the indicative activity plan at patient level needs to be completed and next steps agreed with CCGs [see Gaps in Control #1]<br>2) Revised plans to increase elective/outpatient activity to deliver RTT implemented and enhanced in 2017/18 – booking structure being streamlined and improved (ongoing – forecast includes revised output);<br>3) Continue performance management of Divisions to deal with activity backlog and meet demand (ongoing)<br>4) Embed the integrated reablement unit, frailty unit and other measures to manage non elective demand (ongoing).<br>5) Robust contractual process operated and robust response to CCG challenge (ongoing – notably so in October). | Actions proceeding to timetable,. |

| Update by | PS 19/10/2017 | Date discussed at Board | October 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.A Live within our means to remain financially sustainable</td><td>Director responsible</td><td>Chief Finance Officer</td></tr>
<tr><td>Initial Risk</td><td>S5 x L3 = 15</td></tr>
<tr><td rowspan="3">Key Action for 2014/15 objectives and description of any potential significant risk to this priority</td><td rowspan="3">5. 2 There is a risk to the Trust's short term financial stability if in-year divisional spending exceeds budget.</td><td>Current rating</td><td>S5 x L3 = 15</td></tr>
<tr><td>Target risk score</td><td>S3 x L2 = 6</td></tr>
<tr><td>Linked to Risk</td><td>1663,1688</td></tr>
</table>

<table>
<tr><th>Controls in place (to manage the risk)</th><th>Gaps in Control</th></tr>
<tr><td>1) Business Plans & budgets (activity & financial), CIP/productivity plans… Divisional activity plans<br>3) Divisional business cases to support correction for overspending areas in 2016/17 (e.g.: WaCH)<br>4) Internal Performance Review (PMO) process and CEO review<br>5) ) Financial reporting, including periodic forecast scenarios, is in place and effective – the first detail forecast will go to Board in July (Q1).<br>6) A&E Delivery Board and Transformation meetings in place and operating.<br>7) STP capped expenditure process (CEP): as part of the STP the Trust is engaging in work to meet CEP requirements<br>8) Structure of roster and agency PMOs in place and NHSi agency reduction plan submitted, with weekly NHSi reporting on compliance<br>9) COO led "boards" to oversee productivity delivery, emergency care management & CQUIN</td><td>1) There is continued overspending at M06 in specific areas<br>2) Productivity delivery is behind expectation</td></tr>
</table>

<table>
<tr><th>Potential Sources of Assurance (evidence of controls effectiveness)</th><th>Actual Assurances: Positive (+) or Negative (-)</th></tr>
<tr><td>1) Financial performance and contractual reporting to Exec Committee, Finance & Workforce Committee and Trust Board reporting process).<br>2) Performance Review (PMO) and Exec Quality and Risk process with Divisions, monthly contract cycle with CCGs. Service line reporting process<br>3) Outputs and reporting from contract and information teams<br>4) Output in financial reporting describes improvement and risk mitigation.<br>5) Agency and roster PMOs.</td><td><u>Positive</u><br>(+) Trust delivered a surplus in 2016/17 – STF paid for Q1 and Q2 in that year.<br>(+) 16/17 Internal audit (IA) advises CIP process sound (but notes non-delivery, see below) – also Temporary Staffing audit positive (amber rated, noting delivery risk)<br>(+) Agency spend reduced by £3.0m in 2016/17 compared to 2015/16) ..and up to M06 has been better than planned in 17/18 (Note: this differential will be lost soon & overall agency costs remain high).<br>(+) 2017/18 Q2 plan achieved, and AE achievement resolved – we qualify for STF payment<br><u>Negative</u><br>(-) IA advises effectiveness of savings delivery rated red/amber – risk to forecast.<br>(-) A sizeable amount of contingency is being used at M06 to balance the savings plan – there is risk here from the productivity line.<br>(-) Emergency activity pressures have continued and some Divisions are overspending</td></tr>
</table>

<table>
<tr><th>Gaps in assurance</th><th>Assurance Level gained: RAG</th></tr>
<tr><td>Amber recognizing pressures at M06 - although data describes overall spend in line with Plan there is reliance on reserves.</td><td></td></tr>
</table>

<table>
<tr><th>Mitigating actions underway</th><th>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</th></tr>
<tr><td>1) PMO/Performance structure continues (ongoing)<br>2) Additional PMOs in place for agency control (ongoing )<br>3) Controls are being exercised in divisions and centrally – vacancy restriction and non-clinical procurement (ongoing).</td><td>Actions proceeding to timetable</td></tr>
</table>

| Update by | PS 19/10/2017 | Date discussed at Board | October 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. 3 There is a risk to the Trust's longer term financial stability if it is unable to deliver its 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 5.1 and 5.2 above<br>2) NHSi Plan submitted in December 2016, resubmitted (minor cash changes) March 2017..and accepted<br>3) Cost improvement plan process in place (including PMO structure)<br>4) Contracts agreed with commissioners in 2017/18<br>5) 2017/18 planning shows recurrent surplus with gain from HRG4+ (tariff pricing change) – but risk in delivering control totals specified.<br>6) STP capped expenditure process (CEP): as part of the STP the Trust is engaging in work to meet CEP requirements | 1) Items listed above (5.1, and 5.2) are applicable here<br>2) Reliance on centrally determined rules for tariff & wider NHS finance regime.<br>3) Risk over capacity from other operational pressures<br>4) Overall health system financial view describes significant financial pressures (now being discussed through STP and capped expenditure process CEP) – no CEP response from regulators – this remains a planning initiative only<br>5) CCG control totals antagonistic to provider control totals (Trust must increase income, CCGs must reduce it), HRG4+ isn't fully funded for CCGs – this is driving a large part of CCG financial problem.<br>6) Central actions over NHS spend may have an adverse impact on Trust because of manner of application (e.g. withholding capital and cash).<br>7) STP process identifies significant "do nothing" deficit [noting impact of actions reduces that considerably] – action required to correct, and not yet fully scoped. |

| **Potential Sources of Assurance (documented evidence of controls effectiveness)** | **Actual Assurances: Positive (+) or Negative (-)** |
|---|---|
| 1) Production of 2017/18 budget, revised two year financial model, business plan documentation, and delivery against them<br>2) Agreed contracts with commissioners describing realistic demand and acceptable financial values<br>3) Sign off of 2017/18 Plan, sustainability & transformation funding with NHS Improvement in 2017/18 | Positive<br>(+)Trust delivered a surplus in 2016/17 (now affirmed by audit) – STF was paid for Q1 and Q2.<br>(+) 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.<br>(+) 2017/18 contracts signed (but significant health system risk behind the contract agreement)<br>(+) 2017/18 Q2 plan achieved, and AE achievement resolved – we qualify for STF payment<br>Negative<br>(-) 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 operating plan risk and adverse STP planning position against control totals<br>(-) CCGs do not appear to be fully funded for HRG4+ (tariff) increase or change to specialized commissioning attribution of activity (moved to CCGs) in 2017/18.<br>(-) Health system STP footprint in overall deficit – increasing pressure in local health system (all CCGs are now reporting deficits locally, and majority doing so across STP). |

| **Gaps in assurance** | **Assurance Level gained: RAG** |
|---|---|
| Amber recognizing pressures at M06. | |

| **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 19/10/2017 | **Date discussed at Board** | October 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** | 5.4 There is a risk to the Trust's ability to operate if its historic liquidity position restricts its ability to physically pay for expenditure. | **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<br>2) Cash and working capital management processes<br>3) Annual cash plan linked to business plan and capital plan (see link with Risk 1134)<br><br>*NOTE: This risk was reviewed at Board in June 2017 and has been discussed intermittently at Boards since. The risk agreed to be maintained, noting continued current need of working capital facility and issues with CCG payments. That remains the case at M05. A working capital facility was agreed in 2016/17 and cash drawn down, and partial repayment made against that. Delivery of surplus in year would mean a much reduced need for this facility (likely to be visible in last quarter of 17/18, subject to CCG cash payments). This risk will continue to be reviewed and discussed.* | 1) No agreement on medium term solution to liquidity – however planned surplus will address (depending on its size)<br>2) Threat of central cash controls in line with control totals.<br>3) CCG transactional behaviour over cash payments and issues over CCG deficits (see 5.1 above). |

| **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<br>2) Monthly finance reporting to Executive Committee, Finance and Workforce Committee and Trust Board<br>3) Smooth operation (i.e.: no restriction) on working capital arrangement | Positive<br>(+) Cash targets met in 2016/17 and liquid ratio has followed expectations - cash managed well in 2017/18; Green internal audit report on cash management. BPCC has improved month on month to better levels in 2017/18<br>(+) Adequate working capital facility sufficient to cover cash needs into 2017/18 has been agreed<br>(+) Have reduced working capital facility by repayment at end of 2016/17 [but repayment plan ceased because of current cash flow].<br>(+) Planned surplus will improve liquidity position if achieved, at the end of the year<br>Negative<br>(-) No additional cash to resolve underlying liquidity problem – restrictions being applied by NHSi as described in "gaps in control".<br>(-) Cash flow dependent on regular CCG payments – problematic in 2016/17..and in 2017/18.<br>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. Rated amber, and changed from red, although main i*I calculation unchanged. This reflects improved current cash position – to be reviewed monthly. | |

| **Mitigating actions underway** | **Progress against mitigation** (including dates, notes on slippage or controls/ assurance failing. |
|---|---|
| 1) Please see actions in 5.1 around CCG contractual arrangements.<br>2) Day to day cash control is main action, coupled to action to maintain income and manage spend (Ongoing)<br>3) Watching brief: issues remain with CCG payments, and the contract baseline hasn't yet been adjusted to reflect 2016/17 OT | Actions proceeding to timetable |

| **Update by** | PS 19/10/2017 | **Date discussed at Board** | October 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 and Chief Nurse</td></tr>
<tr><td>Initial Risk</td><td>S5 x L3 = 15</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, provides the relevant skill-mix for operational delivery and supports on-going professional education, training and development across all staff groups</td><td>Current rating</td><td>S5 x L3 = 15</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><td colspan="2">Controls in place (to manage the risk)</td><td colspan="2">Gaps in Control</td></tr>
<tr><td colspan="2">1) Following Board ‘Away Day’ on 7th July, plan to reviewed and ‘refresh’ the Trust’s Workforce Strategy ensuring relevant objectives in place<br>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<br>3) Retention Strategy updated for review by NHSi as part of their ‘Retention Support Programme’<br>4) Multi-disciplinary education and training strategy in development – sent to key stakeholders, including Trust Board members, for initial review<br>5) 2017 Achievement Review (ARs) process on-going<br>6) Divisional HRBPs continue to develop local Workforce Plans<br>7) Formal Succession Planning process being devised to support the retention of ‘top talent’ at SASH</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><td colspan="2">Potential Sources of Assurance (documented evidence of controls effectiveness)</td><td colspan="2">Actual Assurances: Positive (+) or Negative (-)</td></tr>
<tr><td colspan="2">1) Progress towards Trust’s Workforce Strategy objectives is reported monthly to the Finance & Workforce Committee<br><br>2) The quarterly Annual Plan report to the Board also includes Workforce Strategy updates<br><br>2) Key Workforce Indicators (e.g. recruitment, establishment, sickness, turnover, AR compliance, etc.), reported on a monthly basis to the Trust Board and Finance & Workforce Committee</td><td colspan="2">Positive<br>(+) 2017/18 Staff Friends & Family Q2 scores published show staff recommending SASH as a place to work has increased by 5.4% to 86.8%<br>(+) Accurate Workforce data being published on a monthly basis<br>(+) Close collaborative working between key internal and external stakeholders (i.e. Workforce, Finance, Nursing, HR Business Partners, BRAP, etc.)<br>(+) National frameworks in place to support local delivery (e.g. NSS, NHSi Retention Programme, etc.)<br>(+) 2017 National Staff Survey was launched on 5th October<br>(+) SASH scored in the top 20% nationally in the 2016 National Staff Survey for 22 of the 32 Key Findings<br>(+) 2017 AR cycle is well under way and the Trust is aiming to reach at least the 90% completion rate KPI by the end of October<br>(+) The multi-professional Education and Development strategy has been issued for</td></tr>
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|---|---|
| | initial review by key stakeholder groups, including Trust Board<br>(+) SASH invited to be part of the NHSi Retention Support Programme<br>(+) Deputy Director of Workforce attended the NHS Employers Retention Masterclass sessions<br>(+) We have 35 (bands 5/6) registered midwives or nurses due to start with the Trust in the next 6 weeks on a direct recruitment basis. We have 11 international nurses due to commence employment in October<br>(+) Further Skype recruitment events for international nurses are planned for late October 2017<br>(+) There are 28 nursing assistants and 7 registered nurses being processed to join the temporary staff bank<br>(+) There remain 12 Continental Travel nurses that are eligible to transfer into direct SASH employment - work is on-going to support the transfer process for these nurses should they wish to transfer.<br><br>**Negative**<br>(-) 2016 Staff Survey on appraisal completion in last 12 months was scored as 'Average' nationally<br>(-) Nursing recruitment challenging, (including international recruitment issues with Provider organisation), with negative effect on Bank and Agency usage |

| **Gaps in assurance** | **Assurance Level gained: RAG** |
|---|---|
| Some of the individual strategies / work-plans (i.e. 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<br>2) 2017 AR cascade process commenced to support delivery of 90% compliance rate<br>3) Pro-active recruitment planning in place including international campaigns | 1) Delivery of the Retention Strategy is on-going<br>2) The AR completion rate is reported on a monthly basis to F&WC and Workforce Committee, as well as the Executive meetings<br>3) Recruitment & Retention Group set up to support overall R&R in the Trust |

| **Update by** | MP 17/10/2017<br>FA 18/10/2017 | **Date discussed at Board** | October 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.E We are an organisation that is clinically led and managerially enabled. | **Director responsible** | Director of Organisational Development & People and Chief Nurse |
| | | **Initial Risk** | S5 x L3 = 15 |
| **Key Action for 2016/17 objectives and description of any potential significant risk to this priority** | 5.6 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 seeks to prioritise staff health, safety, well-being, engagement and inclusion. | **Current rating** | S5 x L3 = 15 |
| | | **Target risk score** | S3 x L2 = 6 |
| | | **Linked to Risk** | 1740 |

| Controls in place (to manage the risk) | Gaps in Control |
|---|---|
| 1) Following Board 'Away Day' on 7th July, plan to reviewed and 'refresh' the Trust's Workforce Strategy ensuring relevant objectives in place<br>2) 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)<br>3) SASH Health & Well-being Strategy being developed which will incorporate relevant Healthy Workforce CQUIN objectives | 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<br><br>2) Key Workforce Indicators (e.g. sickness, etc.), are reported on a monthly basis to the Trust Board<br><br>3) Key Inclusion objectives are reported on a national basis (e.g. annual WRES report, National Staff Survey, etc.)<br><br>4) As with 2016/17,for 2017/18, Health & Well-being initiatives will be reviewed by CCGs as part of the national CQUIN | **Positive**<br>(+) 2017/18 Staff Friends & Family Q2 scores published show staff recommending SASH as a place to work has increased by 5.4% to 86.8%<br>(+) Accurate Workforce data being published on a monthly basis<br>(+) Close collaborative working between key internal and external stakeholders (i.e. Workforce, Finance, Nursing, HR Business Partners, BRAP, etc.)<br>(+) National frameworks in place to support local delivery (e.g. Health CQUIN, WRES, etc.)<br>(+) The 2017 Flu Vaccination campaign has been launched (1045 staff vaccinated in Week 1 of the campaign)<br>(+) The Well-being strategy is under development and will link with key CQUIN objectives<br>(+) Overall average monthly sickness rates reduced for 2016/17 compared to 2015/16<br>(+) The 2017 National Staff Survey has been launched on 5th October<br>(+) Mental Health Awareness Impact Assessments, in conjunction with SLaM, being undertaken<br>(+) Mental Health Awareness training for staff and line managers being delivered<br>(+) Staff health & Well-being day held on 12th September with over 500 SASH staff attending<br>(+) SASH supporting national smoking cessation campaign, Stoptober<br>(+) SASH moving towards smokefree on the ESH site from 1st April 2018<br><br>**Negative**<br>(-) SASH was in the lowest 20% nationally in the 2016 Staff Survey for staff |

| | |
|---|---|
| | experiencing physical violence from patients, relatives or the public |

| Gaps in assurance | Assurance Level gained: RAG |
|---|---|
| Some of the individual strategies / work-plans (i.e. 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<br>2) 2017/18 HWB CQUIN actions and objectives being finalised<br>3) Collaborative working with South London & the Maudsley being undertaken to support mental health awareness for staff and managers | 1) SASH Inclusion Strategy is being developed in conjunction with BRAP for launch early in 2018<br>2) 2017/18 CQUIN objectives developed and submitted for approval<br>3) SLaM delivering mental health awareness interventions |

| Update by | MP 17/10/2017<br>FA 18/10/2017 | Date discussed at Board | October 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.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<br>2) IT Strategy aligned with Clinical Strategy, IBP and updated Jan 173) Executive Informatics Board now established<br>4) Clinical IT leads<br>5) Various project groups (EPR etc.)<br>6) Project management controls (Described in Internal Audit of project management)<br>7) EPR costs identified in capital programme<br>8) CCIO and CNIO now implemented – greater clinical buy-in<br>9) New IT Governance structure agreed<br>10) EPR Road Map approved by FWC and Executive<br>11) EPR Roadmap signed-off by Executive November 2015 and Trust working on implementation plan and business case with EPR Provider<br>12) EPR FBC approved by FWC and Executive and external loan being sort<br>13) EPR loan approved in principle – now awaiting release of cash | 1) Insufficient focus on change benefits realization due to financial constraints<br>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<br>(+) Improving infrastructure (e.g. Wi-Fi move to Windows 7)<br>(+) Development of existing EPR platform (e.g. EPMA and move to Cerner)<br>(+) EPR Contract signed and data center move finished<br>(+) Trust moved to latest version of EPR software<br>(+) 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 | |

<table>
<tr><th colspan="3">Mitigating actions underway</th><th>Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.</th></tr>
<tr><td colspan="3">1. Procurement and implementation of replacement EPR - complete<br>2. Establishment of Chief clinical Information Officer role - complete<br>3. New IT governance structure agreed<br>4. Greater focus on IT in Capital Plan for 2016/17 and future years<br>5. EPR Roadmap now approved by Executive and approval to proceed agreed<br>6. EPR Digitise Outline Business Case now approved<br>7. Move to latest version of Cerner software now taken place<br>8. Loan being sought to fund EPR Digitise Business Case – approved in principle and awaiting release of cash</td><td>1. Completed<br>2. 724 Go-live November 2014.<br>3. PC Upgrade plan now complete<br>4. Network review first draft now complete and approval to proceed approved<br>5. EPR Digitise FBC Approved<br>6. EPR roadmap approved</td></tr>
<tr><td>Update by</td><td>IM 03/10/2017</td><td>Date discussed at Board</td><td>October 2017</td></tr>
</table>