TRUST BOARD PUBLIC - MAY 2016

Agenda Item Number: 65/16
Enclosure Number: (4)

Subject:	Board Assurance Framework (BAF)
Prepared by / Sponsored by / Presented by:	Peter Mellor, Director of Corporate Affairs
Purpose of paper	To provide the Trust Board with a monthly update of the Board Assurance Framework.
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Trust Board are asked to note • Risks greater than 15 on the BAF • Risks with an increased score • Risks to be removed • Risks with a target date change
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Review the Assurance Framework and consider requirement for further assurance on actions related to significant risks. • Determine any further assurance required on any aspect of the Framework
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Any decisions with regard to the severity and/or removal of the risks will be actioned as appropriate and presented at Trust Board.
Consideration of legal issues (including Equality Impact Assessment)?	None
Consideration of Public and Patient Involvement and Communications Implications?	None

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	All
BAF/Corporate Risk Register Reference (if applicable)	N/A
Risk Description	N/A
CQC Reference	S4,S5,E1,E2,E3,R1,R3,W1,W2,W5

Committees/Meetings at which paper has been approved:	**Date**

N/A	N/A

ASSURANCE FRAMEWORK REPORT

TRUST BOARD: APRIL2016

Purpose:

To provide the Trust Board with a monthly update on the BAF as at March 2016.

Top Risks

04-1415◄ ►(Red 20): Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing.

05-1516◄ ► (Red 16): The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED.

17-1415◄ ►(Red 16): Current and future workforce demand is outstripping supply leading to; national skill shortages in nursing, scientific and other professions..

22-1516◄ ► (Red 16): Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital.

01-1415 ▲ (Red 16): Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement Plan

New Risks

Nil

Risks with Increased Score

01-1415 ▲ (Red 16): Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement Plan

6-1516 ▲ (Orange 12): Failure to achieve cancer wait targets

Risks with Decreased Score

9-1516 ▼ (Green 8): Failure to successfully implement the Trust's IT Strategy eHospital Programme to deliver an enterprise clinical system that better supports delivery of high quality, more efficient and cost-efficient patient centred care.

15-1516 ▼ (Yellow 6): Insufficient engagement of workforce

19-1516 ▼ (Orange 12): Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned surplus on income and expenditure.

20-1516▼ (Green 3): The Trust does not achieve sufficient PbR income from commissioners to meet the income plan, or sufficient cash is not available within commissioners to pay activity based invoices.

21-1516 ▼ (Green 3): 2015/16 Savings plans are not identified & delivered, with subsequent impact on Trust financial position.

Risks to be Removed

15-1516 ▼ (Yellow 6): Insufficient engagement of workforce.

20-1516▼ (Green 3): The Trust does not achieve sufficient PbR income from commissioners to meet the income plan, or sufficient cash is not available within commissioners to pay activity based invoices.

21-1516 ▼ (Green 3): 2015/16 Savings plans are not identified & delivered, with subsequent impact on Trust financial position.

Target Date Changes

01-1415

02-1415

04-1415

05-1516

11-1516
14-1415
16-1516
17-1415
18-1415
19-1516
22-1516

Portsmouth Hospitals NHS Trust Strategic Aims

These aims inform the Trust's business objectives and vision for the future. The Board Assurance Framework identifies where there are risks to delivery of any of the objectives and provides assurance on risk mitigation and therefore delivery of objectives.

STRATEGIC AIM 1: DELIVER SAFE, HIGH QUALITY PATIENT CENTERED CARE

- Year on year improvement in national, local and quality account metrics
- Year on year reduction in avoidable harm
- Maintain compliance against Care Quality Commission outcomes
- Deliver good patient experience as measured by Friends and Family Test
- Consistently achieve all access standards in line with commissioning and regulatory requirements
- Partner with other organisations to deliver joined up emergency care

STRATEGIC AIM 2: DEVELOP A REPUTATION FOR EXCELLENCE IN INNOVATION, RESEARCH & DEVELOPMENT AND EDUCATION IN THE TOP 20% OF OUR PEERS.

- Year on year increase in patient recruitment to clinical trials
- Implementation of the academic/innovation centre within PHT
- Become a hospital of choice within Wessex for trainees to wish to work in

STRATEGIC AIM 3: BECOME THE HOSPITAL OF CHOICE FOR GENERAL, SPECIALIST AND SELECTED TERTIARY SERVICES.

- Maintain and grow referral practice from General Practitioner surgeries in the local catchment area and beyond
- Maintain and grow specialist services with local national and international reputation
- Maintain and grow Renal and Transplantation service to become centre of excellence in the UK

STRATEGIC AIM 4: BE A HOSPITAL WHOSE STAFF RECOMMEND THE TRUST AS A PLACE TO WORK AND A PLACE TO RECEIVE TREATMENT.

- Overall staff engagement, as measured through the National Staff Survey, will improve and score above average in the 2014 survey for the follow:
  - Staff ability to contribute towards improvements at work
  - Staff recommendation of the Trust as a place to work or receive treatment
  - Staff motivation at work

STRATEGIC AIM 5: DEVELOP SUFFICIENT FINANCIAL STRENGTHS TO ADAPT TO CHANGE AND INVEST IN THE FUTURE.

- Achieve a surplus in 2014/15 of at least £2m in 2014/15 and £4m in 2015/16.
- Develop and update annually a fully Integrated Business Plan underpinned by robust supporting strategies.
- Be in a position to make a credible application to Monitor to become a Foundation Trust in Q3 2014/15.
- Develop Clinical Service Centres as fully functioning developed business units with full profit and loss responsibility.
- Re-align corporate services to support all of the above
- Develop Clinical Service Centres as fully functioning developed business units with full profit and loss responsibility.
- Re-align corporate services to support all of the above

Trust Risk Profile - March 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)			20 Financial Income & Penalties ▼ 21 Delivery of savings ▼		
Unlikely (2)				2 Quality and Safety Standards ◄ ► 6 Cancer Wait Targets ▲ 9 IT Strategy ▼ 13 Growth in R&D ◄ ►	
Possible (3)		15 Staff engagement ▼	3 Patient Experience ◄ ► 14 Threat to specialist services ◄ ► 15 Staff engagement ◄ ► 16 Leader development ◄ ► 18 Foundation Trust status ◄ ►	6 Cancer Wait Targets ◄ ► 7 Data Quality ◄ ► 11 Prolonged LoS for MFDR patients ◄ ► 19 Failure of budgetary control ▼	
Likely (4)				5 RTT and Access targets ◄ ► 17 Workforce demand & key skill shortages ◄ ► 22 Mental Health Service Provision ◄ ► 1 CQC compliance ▲	
Highly Likely (5)				4 Failure to achieve Emergency Department Quality Standards ◄ ►	

ASSURANCE FRAMEWORK 2016/17 PROGRESS SUMMARY

STRATEGIC AIMS REFERENCE	Risk Reference	Operational Leads	RESPONSIBLE COMMITTEE	PRINCIPAL RISK (Obstacle to achievement of strategic aim)	TRUST RISK REGISTER REF.	CQC KLOE REFENCE	PROGRESS MONTH ON MONTH												REVIEW DATE	TARGET DATE TO ACHIEVE RESIDUAL RISK SCORE
							JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1, 3, 5	1-1415	TS	G&Q	Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement Plan		All	12	12	16										Jun 16	Aug 16
1, 3, 5	2-1516	FMcN/CM	G&Q	Failure to comply with internally and externally set standards on quality and safety		S4, S5 W1	8	8	8										Jul 16	Mar 17
1,3, 5	3-1516	CD	G&Q	Failure to achieve internal and external standards around patient experience		S4, S5	9	9	9										Nov 15	Apr 16
1,3,4,5	4-1415	MP	OB	Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing		S4, S5 R3	20	20	20										Jul 16	July 16
1,3, 5	5-1516	MD	OB	The Trust fails to achieve referral to treatment (RTT) access targets excluding those specific to ED		S4, S5 R1 R3	16	16	16										May 16	Jun 16
1,3, 5	6-1516	MD	OB	Failure to achieve cancer wait targets		S4, S5 R1	8	8	12										Apr 16	Apr 16
1, 5	7-1516	MK	DQSG	Quality of data produced and provided for use in internal performance reporting and for external reporting is inaccurate		S4, S5	12	12	12										Jun 15	Jun 16
1,3, 5	9-1516	CT	ITSC	Failure to successfully implement the Trust's IT Strategy eHospital Programme to deliver an enterprise clinical system that better supports delivery of high quality, more efficient and cost-efficient patient centred care.		S4, S5	12	12	8										Jul 16	Oct 16
1,3,5	11-1516	GM	UCT	Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed		S4, S5	12	12	12										Jul 16	Jul 16
2,3,5	13-1415	AC/KG	OB	The Trust fails to secure growth in R&D as part of a wider Academic Health Science Network		S4, S5	8	8	8										Apr 16	Jun 16
1,3,5	14-1415	SH	OB	Threat to specialist services due to centralisation agenda		S4, S5	9	9	9										Apr 16	Jun 16
1,3,4	15-1516	LW	OB	Insufficient engagement of workforce		S4, S5 E4 W4	9	9	6										Remove	Apr 16

1,3,4	16-1516	RK	OB	Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to delivering change		S4, S5 W3	9	9	9										Jul 16	Oct 16
1,3,4,5	17-1415	RK	OB	Current and future workforce demand is outstripping supply		S4, S5 E3	16	16	16										Jul 16	Apr 17
3,5	18-1415	TB	TB	Inability to achieve Foundation Trust status within the agreed timetable		S4, S5	**TOLERATE**												Dec 16	Dec 16
5	19-1516	LWi	FC	Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned deficit of £9.7m (or better) on income and expenditure.- as required by the TDA		S4, S5	20	20	12										Jun 16	Jun 16
5	20-1516	LWi	FC	The Trust does not achieve sufficient PbR income from commissioners to meet the income plan, or sufficient cash is not available within commissioners to pay activity based invoices.		S4, S5	12	12	3										Remove	Mar 16
5	21-1516	LWi	FC	2015/16 Savings plans are not identified & delivered, with subsequent impact on Trust financial position		S4, S5	16	16	3										Remove	Mar 16
1	22-1516	FMcN	MHLD	Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital		S4,E1 E3,E4 R1,R2 R3	16	16	16										Jul 16	Sep 16

Ref Date opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk) On target Minor Obstacle to achieving target Inability to achieve predicted target	LINK TO CQC KLOEs AND TRUST RISK REGISTER
1-1516 **Apr 15**	**Inability to maintain on-going compliance with all CQC standards and implement the Quality Improvement plan**	• CSC and Trust risk registers • CQC Intelligent Monitoring Report indicators – process of review in place of data accuracy prior to publication • CSC Executive Performance Reviews monitoring quality and safety of services. • Quality Improvement Plan at Board, CSC, Corporate and Operational level to address compliance, 'must do' and 'should do' actions in place	• Quarterly compliance to TB and key committees + monthly exception reporting of key quality indicators (action plans in place for any identified compliance issues) • Clinical dashboards / quality metrics • CSC governance reports • Internal audit assurance • Quality Care Reviews commenced in August 2015.	**12 (4X3)**	**16 (4X4)**	**6 (3X2)**	i. Enforcement Notice from CQC relating to Unscheduled Care and safety within the Emergency Department	i. Implementation of the Urgent Care transformation plan revised to address CQC Enforcement Notice ii. Weekly reporting to CQC against Condition 4 iii. Monthly exception reporting to Trust Board against Conditions of Enforcement Notice. iv. Continue Care Quality Reviews to gain assurance of progress and compliance	1. Director of Nursing 2. Head of Governance and Quality 3. Governance & Quality Committee (G&Q)	June 16	Review August 16	CQC All RR 2-1415 3-1415 8-1415 9-1415 12-1415 13-1415 15-1415 17-1415 18-1415 19-1415 20-1415 21-1415 23-1415 26-1415 27-1415 30-1415 32-1415 33-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i. Implementation of the Urgent Care transformation plan revised to address CQC Enforcement Notice	M.Purse	Until further notice	
ii. Weekly reporting to CQC against Condition 4	T.Stenning/F.McNeight	Until further notice	
iii. Monthly exception reporting to Trust Board against Conditions of Enforcement Notice	T.Stenning/F.McNeight	Until further notice	
iv. Continue Care Quality Reviews to gain assurance of progress and compliance	A.Fitzsimons	On-going	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
2-1516 Apr 15	**Failure to comply with internally and externally set standards on quality and safety** **Implications:** • **Avoidable harm to patients** • **Reputational damage** • **Failure to satisfy quality contract** • **Fines associated with some quality metrics** • **Loss of CQUIN income**	• Governance Framework and monitoring • Quality Performance measures • CSC performance reviews • Clinical Audit programme • Gov & Quality Committee • Patient safety Steering Group and associated Safety work streams • Monthly and Quarterly Board and Governance and Quality Committee reporting • Quality Impact Assessments of CIP plans and transformation schemes • Clinical Effectiveness and Mortality Steering Group • CSC Governance meetings • Specialty M&M meetings • Quality Heatmap • Monthly meetings with Commissioners to review quality and performance.	• Quality heatmap and exception reports to Trust Board monthly • Quality report quarterly to Governance and Quality Committee	**8 (4x2)**	**8 (4x2)**	**8 (4x2)**	i. Finalising quality contract with Commissioners and any gaps in delivery will be highlighted throughout the year.		1. Director of Nursing 2. Associate Director of Quality & Governance 3. G&Q	July '15	March '17	CQC S4, S5 W1	RR 3-1415 8-1415 9-1415 13-1415 18-1415 19-1415 20-1415 21-1415 23-1415 24-1415 26-1415 30-1415 32-1415 33-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i. Once agreed in contract, quality heatmap to be updated with 2016/17 metrics	F.McNeight/T.Stenning	May '16	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
3-1516 Apr 15	**Failure to achieve internal and external standards around patient experience as measured through Friends and Family test and National Patient Surveys** **Implications:** • **Poor patient experience** • **Reputational damage** • **Loss of income if fail to achieve CQUIN associated with friends and Family Test**	• CSC targets set to achieve friends and family test returns with weekly reporting loop • Complaints and PALS process to capture patient feedback • Patient Experience Steering Group • Quality Improvement Framework • Governance and Quality reporting • Monthly and quarterly reporting to Trust Board • Patient stories at the Board • Monthly performance review with Heads of Nursing • Review of complaints process completed • Net promoter score replaced by % patient satisfaction score	• Positive feedback from the ombudsman regarding individual complaints and level of investigation • Positive patient survey results for cancer services and satisfactory for ED. • Maintained reduction in number of complaints • Response rates increased to 48%% of inpatients, 22% of Emergency Department attender but ED rates very variable.. % of patients who would recommend the Trust 96%, not recommend 1.5% • New Complaints and Experience Committee chaired by non executive to support greater organisational learning (July 15) • Patient experience priorities developed with each CSC using feedback • Draft Patient Engagement Strategy which aims to improve feedback methods and opportunities.	**9 (3x3)**	**9 (3x3)**	**6 (3x2)**		i. Evidence of improvement actions from negative Friends and Family response. Resolved but will need to be monitored to ensure sustained. ii. National in-patient survey reported satisfactory experience overall but improvements required in some elements. iii. CSC Quality improvement plans do not all include reference to FFT and/or surveys. iv. Lack of on going intelligence for in-patient survey v. Variable FFT response rate from ED.	1. Director of Nursing 2. Head of Patient Experience 3. G & Q	Nov 15	Apr 16	CQC S4, S5	RR 3-1415 7-1415 8-1415 9-1415 12-1415 13-1415 15-1415 17-1415 18-1415 19-1415 20-1415 21-1415 23-1415 30-1415 32-1415 33-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
I)/ii)/vi) Formal FFT performance management process will be implemented to include response and satisfaction rate, and action on written feedback from patients	SB	Jul 2015	June 2015
i)/ii)/iv) CQC report will be reviewed and action plan agreed and monitored by PESG	SB	Jun 2015	June2015
i)/iv)/vi) CSC s to review PE elements of QI plans and include actions required and monitoring processes.	CSCs	Jul 2015	June 2015
iv)/v)/vi) Develop and implement local survey with target response rates , agree, implement and monitor via PESG	CD	May 2015	NB Replaced with action below
iv) The new system enabling analysis of FFT comments in real time is used to assess current status against in patient survey questions.	CD/SB	July 2015	July 2015
iv) A detailed thematic analysis of all sources of patient experience feedback is to be undertaken	CD	October 2015	December 2015

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
4-1415 Apr 14	**Repeated and prolonged overcrowding within ED results in poor patient experience, compromised safety and impacts on staff wellbeing Implications:** **1. Poor patient experience** **2. Poor staff morale and wellbeing** **3. Trust reputation** **4. Financial penalties related to Emergency care quality targets**	• CSC Strategy • PHT Unscheduled Care Improvement Plan ratified by SRG and PHT Trust Board • 12 Hour escalation process in place (standard: no patient to remain in ED for >12 hours)	• Reviewed at Operations Board Group and SRG Fortnightly • Trust Board • Plan monitored weekly by Urgent Care Improvement Board chaired by Dir of Ops – Unscheduled Care • All patient arrival and departure times monitored by ED Coordinator and DHM	**20 (4x5)**	**20 (4x5)**	**12 (4x3)**	i. Ability to control front door demand ii. CSCs not Sustaining agreed discharge targets on a daily basis iii. Inability of external partners to support increase in community capacity iv. Sustained high number of medically fit patients remaining in acute beds	v. Performance against 4hour wait target of 95% currently at 76.01% YTD	1 Chief Operating Officer 2. Director of Operations – Unscheduled Care 3. Operational Board	July 16	July 16	CQC S4, S5 R3	RR 15-1415
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									**By Whom**	**By When**	**Date Completed**		
i)/ii) Phase 2 (paperlite) and 3 (paperless) of ED IT system to be implemented									MP	Apr 15	Complete		
iii) 7 point action plan to be agreed with Commissioners and Community Providers to increase discharge I)/ii) Further WHE turnaround action plan being created, to be agreed – draft received and comments returned to F Wise									FW	May 14	Plan agreed by Accountable Officers 19th June 2014		
i)ii)iii) ECIST assurance visit recommendations received, incorporated into Urgent Care Taskforce Recovery Plan									CW/GP	Jun 14	Implemented and on track		
i)ii)iii) Key actions agreed Post TDA/NHS England Urgent Care Summit 3rd September, linked to whole system working to decrease medically fit/discharge ready patients to agreed target of 30.									WHE	Oct 14	Ongoing		
i)ii)iii ED Recovery Plan refined post TDA/NHS England Meeting 30/11/14									WHE	Nov 14	Ongoing		
i)ii)iii Consultant Early Senior Review in ED 1000-1800Hrs									SH	Dec 14	Ongoing		
i)ii)iii Operational Standards linked to Medical Model agreed									SJ	Dec 14	Ongoing		

i)ii)iii Perfect Week lessons learnt to be embedded	PH	Feb 15	Commenced and on-going
i)ii)iii PHT UC Improvement programme ratified	SJ	Feb 15	Commenced and on-going
i)ii)iii Additional Medical Consultant in ED/AMU 7/7 1700-2200	MR	March 15	Completed
i)ii)iii Plan to increase ACE spaces to increase admissions avoided	SH	March 15	Completed
i)ii)iii Create AMU Short Stay ward to decrease LoS	SH	May 15	Establishment commenced 11th May 2015
i)ii)iii Commence planned transfer from ED to MOPRS and Medicine Wards to decrease LoS	ED	March 15	Completed
i)ii)iii Create third General Medicine Ward	MR	March 15	Completed
i)ii)iii Recommence OPAS Frail Elderly model at Front door	ZH	May 15	Commenced 4th May 2015
i)ii)iii Review and enhance MDT Discharge Processes to increase daily discharge	SE	March 15	Commenced and on-going
i)/ii/iv)Internal Professional Standards to be ratified at Operational Board	AB	May 15	Completed
i)/iv)Frailty Intervention Team (FIT) commenced replacing OPAS	ED	June	Business care for approval end October 2015
i)/iv)Ambulatory Emergency Care moved to dedicated ring fenced area	ED	June	Completed
i)/ii)AUM Orange 22 beds re introduced to assessment bed stock allowing post taking to move from ED and off 4 hr clock	ED	June	Completed
ii)iv)Medical wards to review criteria for admission increasing availability of bed stock to ED/AMU	ED	June	Completed
i)ii)iii)iv)v) Mapping of frailty pathway commenced to agree WHE frailty strategy	DH	July	Underway
i)v) Enhanced role of ED Nurse in Charge to reduce 4o breaches	GMcD	July	Completed
i)ii)iii)iv)v) Auditing of internal professional standards	GMcD	July	On-going
i)ii)iii)iv)v) WHE KPIs to monitor performance against Phase II WHE plan	GMcD	July	Agreed – phase ii plan well underway

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
5-1516 **Apr 15**	**The Trust fails to achieve referral to treatment (RTT) access target in specialties:** ▪ **General Surgery** ▪ **Urology** ▪ **Gastroenterology** ▪ **Others (Hepatology)** **Implications:** • **Patient experience** • **Patient safety** • **Quality/clinical outcomes** • **Trust Reputation** • **Trust financial position**	• Weekly specialty PTL meetings led by CSC GM. • Weekly assurance meeting chaired by Director of Operations Scheduled Care//Head of Performance • Special measures support provided to key specialties failing standard • Performance team co-ordination of breach position at Trust aggregate level • RTT compliance plans and 35 week recovery plans for all “at risk” specialties – reviewed weekly • Weekend operating sessions programme in place	• Activity plans to meet GURROO 3 model. Including growth plans • Performance dashboard and weekly assurance meeting • Monthly review of performance dashboard at CSC performance reviews • Reports to TDA, Commissioners and Trust Board	**12 (4x3)**	**16 (4x4)**	**12 (4x3)**	i. Unscheduled care demands leading to lack of capacity ii. Reduction in inpatient bed base and associated risk to capacity iii. Required rolling programme of theatre upgrade reducing capacity iv. Diagnostic target at risk on monthly basis within Gastro speciality due to capacity gap v. Colorectal service vi. Pressures of cancer demand vii. Increase in backlog of patients due to cancellations associated with unscheduled care pressures and junior doctor industrial action in months 12 and 1.	• Capacity plans dependent on recruitment in urology, general surgery (colorectal and vascular) and dermatology • Theatre and OPD utilisation/ productivity improvements required • Additional theatre capacity required supported by investment and recruitment • Appropriate access to ISTC required • Additional endoscopy capacity required, supported by investment and recruitment	1. Chief Operating Officer 2. Director of Operations Scheduled Care 3. Operational Board	May 2016	Jun 16	CQC S4, S5 R1 R3	RR 13-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i Daily risk balance decision decided within Ops Centre to include identification of patients suitable for cancellation in adherence to Standard Operational Policy	MD/CSC Managers	Jan 15	Completed. Weekly monitoring
ii Improved working partnership with Harbour Suite to ensure optimisation of capacity to support NHS surgical specialties as able.	MD/PH	May 2016	

ii Exploration of alternative capacity provision and investment eg mobile ward (12 beds)	SJ/AB/BD	July 2016	
iii Scheduled Care Improvement plan reviewing elective pathways and efficiency opportunities in theatres and OPD	MM/MD	March 2017	1st year of projects due for completion March 2017, improvements commenced
iv Use of ISTC to support capacity	SB	April 2016	completed
iv Exploration and investment into alternative provider to use in house capacity in endoscopy at weekends to close gap for diagnostics	SB	May 2016	
v See Trust Risk Register for specific action	MD/SH	Sept 2016	

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										On target			
										Minor Obstacle to achieving target			
										Inability to achieve predicted target			
6-1516 Apr 15	**Failure to achieve core Cancer Waiting Time standards:** Implications: • Risk to patient safety, delays in treatment • Financial penalties may be applied by commissioner	• Weekly assurance meeting chaired by Director of Operations Scheduled Care/Head of Performance with forecast planning and triggers for escalation • Weekly PTL meetings with MDT Leads • Monthly Cancer steering group receives update on performance and key issues • CSC Executive Performance Reviews, monitor delivery of performance and quality standards • Increased national focus with weekly reporting of 62 day FDT performance	• Improved visibility and patient tracking • Improved ability to predict performance accurately • Weekly review between Director of Operations for Scheduled Care and TDA performance director • CSC Led Cancer improvement plan reviewed monthly and now including trajectories for delivery of at risk site e.g. urology • Collaborative working across Cancer Units to resolve late referrals', sharing RCA information	**12 (4x3)**	**12 (4x3)**	**8 (4x2)**	i. Ability to control referral rates ii. Impact of national campaigns iii. Patient choice rules means clock doesn't stop if patient defers anywhere on pathway iv. Impact of late inter Trust referrals v. Reduced Baseline Theatre Capacity due to essential works / limited Robotic capacity vi. Workforce Capacity identified across the CSC's & Cancer MDT Teams	i. Urology remains a key area of risk due to the adverse workforce capacity shortfall. ii. The team provide weekly updates to the DOSC iii. Tumour site specific actions plans being strengthened to support delivery using Cancer Improvement plan	1 Chief Operating Officer 2. General Manager - Cancer 3. Operational Board	April 16	Apr 16	CQC S4, S5 R1	RR 19-1415 20-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
Ability to control Referral rates:			
i) Review network 2WW standards received following NICE guidance [April 2016] ii) Issue new 2WW referral forms, with enhanced guidance on criteria for referral iii) Shared Implementation / Communication strategy with CCG / Network & PHT to re launch access process iv) Develop further opportunities for straight to test pathways with local CCG & Network	MDT / CSC LH/CCG/Network LH/CCG/Network MDT/ CSC	Complete Q116/17 Q116/17 Q116/17	April 2016
Impact of National Campaigns:			

Action	Lead	Status	Date
i) CSC Tumour sites to provide capacity plans to mitigate against BCOC schemes in conjunction with Clinical Support			
ii) Breast Cancer	MDT / CSC	Complete	Q1 15/16
iii) Blood in Pee Campaign	MDT / CSC	Complete	December 2016
iv) Respiratory Symptoms Awareness Campaign – July – September 2016	MDT / CSC	May 16	
Patient choice rules means clock doesn't stop if patient defers anywhere on pathway:			
i) Management of patient choice breaches in Breast symptomatic 2WW – review and secure regular capacity required to reduce risk of breach	AT / CSC	Complete	December 2015
ii) Increased Monitoring of individual patient pathways via PTL meetings	MDTC / CSC	Complete	November 2015
iii) Updated Joint Cancer Access & Operational policy supported by CCG	JL / CCG	Complete	January 2016
Impact of late inter Trust referrals:			
iv) Monitoring of individual patient pathways via PTL meetings, Weekly dial in from Partner Cancer Units	MDT / CSC Teams	Complete	November 2015
v) Implementation & sharing of RCA analysis, reviewed at Monthly Cancer Steering Group, shared at local trust Improvement Groups	MDT / CSC / Network	Q1 16/17	
vi) Development of shared timed pathways in line with 8 Key Priorities for Cancer	MDT / CSC / Network	Complete	April 2016
Reduced Baseline Theatre Capacity due to essential electrical works / limited Robotic capacity			
i) Weekend & Extended day operating in place across key specialities.	CSC / CHAT	Complete	Q3 15/16
ii) Robotic provision increased to support mitigation	CSC / CHAT	Complete	Q4 15/16
iii) Electrical works on track for completion to access Q2 16/17	CHAT	Q2 16/17	
Workforce capacity issues			
iv) Recruitment of X2 Urology Consultants – Posts currently advertised, backfilled by Locums.	AT	April 16	
v) CSC to produce options proposal for Board should recruitment be unsuccessful	AT	April 16	
vi) Recruitment of X2 Colorectal Consultants	AT	Q2 16/17	
vii) Review MDTC provision	LH	Complete	December 2015
Cancer Improvement Plan – Performance & Quality			
i) MDT / CSC teams to provide monthly updates via CSC governance & Cancer Steering Group structure	LH / CSC/ MDT	Q1 16/17	Live Operational Document
ii) Development of cancer recovery plan and trajectories of delivery to be presented to Trust Board, Commissioners and TDA	JL/MD	Complete	April 2016
iii) Work with Network to complete detailed demand & capacity modelling outlined as part of the 8 Key Priorities for Cancer via Steering group	LH / CSC / MDT	Q1 16/17	

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										On target Minor Obstacle to achieving target Inability to achieve predicted target			
7-1516 **Jun 15**	**Quality of data produced and provided for use in internal performance reporting and for external reporting may include inaccuracies (data entry and/or reporting)** **Implications** • **Reputation damage** • **Financial penalties** • **Incorrect business decisions made using incorrect data assumptions impacting on patient experience**	• Data validation processes in place in some areas but patchy • Data Quality Steering Group (DQSG) • Documentation now produced; Data Quality Steering Group TORs, Data Quality Strategy, Data Quality Policy • Data Quality Reporting Dashboard • All national returns signed-off by operational services & Head of Performance • 2 Access Data Quality Managers now in post	• Data Quality Steering Group meets monthly and all CSCs and Information Asset Managers report on their compliance with local and national standards annually. • Exceptional issues will be fed into SMT, including an annual DQ Report to Trust Board • Data Quality Reporting Dashboard provides a local replica of the national SUS Data Quality Dashboard at CSC and Specialty level.	**12** **(4X3)**	**12** **(4x3)**	**8** **(4X2)**	i. Significance of data quality is not recognised Trust wide ii. Lack of Standard Operating Procedures for internal report production	iii. Further development of data quality reporting required	1. Chief Operating Officer 2. Head of Information Services 3. Data Quality Steering Group	Jun 16	Jun 16	CQC S4, S5	RR 16-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Establish accountability for data quality at CSC and Executive level to promote a strong data quality culture throughout the Trust, ensuring engagement in Data Quality Steering Group from the appropriate level to effect organisational change.	MK / PM	Oct 15	Dec 15 – revised membership of DQSG in place from Aug-15 and now well established. PM provides Executive link.
ii) All new job descriptions to have personal responsibility for ensuring the quality of data included	RK	Nov 13	Ongoing
iii) Further development of the Data Quality Reporting Dashboard (referencing Information Governance toolkit where appropriate)	MK	Jun 16	Apr 16 - Data Quality Dashboard in place for >12 months. New reports added as issues identified and, us such, will be continually evolving.
iv) Standard Operating Procedures in place for routine internal reports, covering data quality checks and sign-off	MK	Jun 16	Currently being developed, due to the level of returns this will take until Jun-16 deadline.
v) Review effectiveness of data quality processes and structure put in place in improving Trust data quality and reducing inaccuracies in external and internal reporting.	MK	Oct 15	Review of effectiveness of DQSG in Aug-15 lead to revision of membership. Review and evaluation is a continual process, underpinned by an annual Data Quality Report. 15-16 report due for publication Jul-16.

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9-1415 **Sep 14**	**Failure to successfully implement the Trust's IT Strategy eHospital Programme to deliver an enterprise clinical system that better supports delivery of high quality, more efficient and cost-efficient patient centred care.** **Implications:** • **Increased fragmentation of clinical data flows leading to faulty processes and poor information** • **Worsening patient experience** • **Waste of staff time on manual processes** • **Failure to achieve clinical process improvements** • **Failure to meet national digital maturity requirements**	• Board approval for IT Strategy • IT Strategy Committee • Robust IT project and programme management processes • Robust IT procurement processes • Treasury Green Book 5 Case Model • TDA / Treasury business case approval process • eHospital Programme Delivery Board	• Bi-monthly reporting to IT Strategy Committee • Supplier engagement completed, providing an understanding of solution market • Strategic Outline Case approved by Trust Board • Trust Board approved production of Outline Business Case Sept 2015 • Bi-weekly reporting to eHospital Programme Delivery Board • eHospital Programme team established • Programme Plan for OBC / OBS production in place • Stakeholder engagement via IT Clinical Reference Group & CCGs IT-Enabling Change Board	**8** **4x2**	**8** **4x2**	**4** **4x1**	i. Lack of funding for eHospital Programme. ii. Lack of specialist procurement & contractual expertise iii. No defined specification of requirements to support procurement	iv. Current Trust focus on tactical developments rather than strategic	1. Director of Strategy 2. Head of IT 3. IT Strategy Committee	Jul 16	Oct 16	CQC S4, S5	RR 6-1415 22-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
1) Gain Trust Board approval for Outline Business Case (OBC)			
a) Produce work stream plans	Work Stream Leads	Apr 16	
b) Complete draft options appraisals for Economic & Procurement Case	Head of IT	May 16	

	c) Gain EMT decisions on preferred options for Economic & Procurement Cases	Head of IT / Dir.of Strategy	May 16	
	d) Gain indicative pricing from suppliers and draft Financial Case	Head of IT / Dep. DoF	Jun 16	
	e) Complete first draft OBC	Head of IT / WS Leads	Jun 16	
	e) Gain EMT sign-off of key OBC content	Head of IT / Dir.of Strategy	Jun 16	
	f) Submit OBC to Trust Board & gain approval	Head of IT / Dir.of Strategy	Jul 16	
	g) Submit OBC to NHS Improvement	Head of IT / Dir.of Strategy	Aug 16	
2)	Produce Output-Based Specification (OBS)			
	a) Produce project plan for OBS production	Head of IT	Apr 16	
	b) Arrange workshops for stakeholder consultation	Head of IT	Jun 16	
	c) Complete stakeholder consultation on draft OBS sections	Head of IT	Sep 16	

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11-1516 Apr 15	**Patients that are Medically Fit and Discharge Ready (MFDR) have a prolonged length of stay in an acute bed. This results in:** • **Poor patient experience of prolonged waiting and increased risk of patient de-compensation** • **Reduced daily capacity to meet acute demand.** • **Increased risk for patients being kept in an acute environment** • **Increased likelihood of patient moves and the need to outlie 'out of speciality'** • **Increased risk of breaching 4 hour ED target** • **Impact on elective programme** • **Increased cost of care due to prolonged LOS and ward moves**	• Discharge Planning Teams covering whole hospital • Daily review of patients discharge planning on Bedview by health and social care teams • Community Beds capacity available notified daily • CQUIN Community In-reach Team • QA@H (Hospital at Home) • Weekly SITREP report • 7 day availability of Discharge Planner (Trust-wide) • SAFERdischarge bundle roll out completed, with refresh commenced April 2016. • CHC assessor in house • Increased Hampshire discharge pathways • Development of QA@H social care business • Discharge targets agreed across CSCs and monitored daily	• Discharges reported via Operations Centre meetings x 4 daily • QA@H virtual ward trajectory (May 14 – April 16) • Implementation of the SAFER discharge bundle • Weekly length of stay report > 7/14 day • Metric reports • Outlier – trajectory • and performance reporting • Discharge numbers • Sitrep reporting • Length of stay reports • Working with the system to develop a whole system frailty service • Discharge to Assess implementation Plan lead byWHE supported by SRG • Single Point of Access commencing June 1st 2016 • WHE Fast Track/CHC Workstream commenced • Live Bedview reporting • Clinical Utilisation Review Tool purchased – pilot/rollout from May 2016 • Fraitly Interface Team commenced Dec 2016 with	**16** **4x4**	**12** **4x3**	**8** **4x2**	i. Demand from complex patients due to high volume ii. IDB still based across multiple venues, needs central base for MDT office' iii. Different IT systems across organisations iv. Unscheduled transformation v. System wide transformation vi. Recruitment issues in Adult Social Care vii. Challenges sourcing packages of care in Hampshire viii. Increased Nursing Home refusals	ix. CSC's failure to complete 123 Escalation updates x. Not performing against outlier trajectory xi. Discharge numbers fluctuate against target xii. Operational controls xiii. Bedview useage continuing to increase but not fully embedded as yet	1. Chief Operating Officer 2. Director of Operations for Unscheduled Care 3. Urgent Care Improvement Group	July 2016	July 2016	CQC S4, S5	RR 9-1415 13-1415 15-1415 17-1415

			increase in capacity and capability from April 2016										

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Increase focus on medically fit patients	CSCs	Nov 14	Complete and on-going
i) Executive focus to identify central base	Exec team	Mar 15	Complete and on-going
iii) Escalated discussions to be led by PHT IT to ensure systems are compatible	SE	Feb 15	Complete and on-going
ii) Implement IT access for all partners	SE	Jun 15	Acompleted
iii)Complete evaluation of IT system to ensure fit for purpose to support discharges	SE	Oct 15	Completed
iv) Recruitment by PHT and all partner organisations	SE	Apr 15	Ongoing
i-v)Additional Community bed capacity being commissioned (22 beds)	SE	Oct 14	Completed
i-v)IDB Action Plan implementation of MDT Board Rounds	MQ	Nov 14	Completed
i-x) Implement system transformation of internal discharge processes	SE	Aug 15	Ongoing
Ix i. Await new system to be agreed - IT working with DC Matron to agree new IT system to replace Newton	MP	Feb 16	Completed
Reviewed IDM meeting with partners and CSC clinical teams	SE	Jul 15	Complete and on-going
PHT Participation in the Systems transfer group hosted by the CCG	GMac	Aug 15	Ongoing

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13-1415 Apr 14	**The Trust fails to secure growth in Research and Innovation**	• Research & Innovation strategy launched May 2015 by Director of Research & Innovation • Medical Director participating in AHSN discussions with UHS • R&D income monitored by R&I and CEO • CEO now Executive sponsor • Director and Deputy Director to have oversight of the CTIMP studies and lead RQC following MHRA inspection • No further PHT sponsored CTIMPS until we have assurance to continue • Research & Quality Manager now recruited • Contracts management outsourced. • Data management outsourced.	• R&D income year on year increase • National NIHR and Guardian League tables shows good competitive performance by PHT • Local network performance reports received and reviewed by Director of research monthly • Improved reputation through winning HSJ research impact award • Increase in successful grant awards seen • Increase in successful innovation awards via AHSN • Increase in successful collaborative projects via Wessex CLARCH • Increase in clinical academics to build growth • Quarterly performance and finance reports submitted to Board • Research activity monthly reports to CSC Boards • R&I strategy	**10 (5x2)**	**8 (4x2)**	**3 (3x1)**	i. Low levels of portfolio recruitment recorded in 2014 ii. Lack of adequate monitoring identified by March 2015 MHRA inspection iii. Lack of research facilitator capacity to support CTIMPs in set-up (MHRA risk)	Iv Lack of adequate monitoring identified by March 2015 MHRA inspection	1. CEO 2. Director & Deputy Director of Research & Innovation 3. Trust Board	Apr 16	Jun 16	CQC S4, S5	RR 26-1415

			monitored quarterly by exec group										

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) LIA event for recruitment to be held with focus on research recruitment	GW	Oct 14	Completed
i) Embed actions and ideas from LiA event to increase recruitment	GW/CSCs	Mar 16	Completed
ii) CAPA plan implementation	AM	Mar 16	CAPA plan on track, final actions due for completion by end April 2016
iii) Identifying funding for RSO (R&I position) to release capacity of senior facilitators to support CTIMPs.	HM	Oct15	Complete
ii)/iii)iv) Recruit to vacant Research & Quality Manager post	GW	Oct 15	Complete

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14-1415 Apr 14	Threat to specialist services due to centralisation agenda Implications: • Potential loss of major vascular surgery at PHT due to centralisation to a tertiary unit • This carries longer term implications for the viability of other services such as interventional radiology and renal • Further services such as Stroke may be centralised in the future	• Outcome data • Vascular Society requirements for a service • Fully covered clinical rota with committed team • National audit results	• Positive outcome data for this group of patients • Fulfilment of vascular society recommendations for service delivery • Good clinical outcome data • Network vascular MDT with UHS has commenced • Providing some vascular service to Chichester • Recent confirmation from commissioners that arterial vascular surgery will continue in Portsmouth	**16 (4x4)**	**9 (3x3)**	**6 (3x2)**	i. Decision ultimately out with PHT control as specialist commissioner led ii. Currently no absolute and written assurances from specialist commissioning teams as to the medium and long term direction iii. NHS England have rejected two hub model and recommended another Vascular Service review iv. 2nd Vascular review recommends centralisation to UHS. v. Awaiting confirmation on details of arrangements from NHS England.	I. Lack of approved vascular service II. Service review recommends centralisation to UHS. III. Lack of Vascular workforce	1 Medical Director 2. Medical Director 3. Operational Board	Apr 16	Jun 16	CQC S4, S5	RR 30-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/ii) Continue to work closely with specialist commissioners and TDA on this issue	SH	Oct 13	Ongoing
i)/ii) Consultation scheduled for October 13 - View of Clinical Senate is awaited	SH	Oct 13	Completed/ongoing
i)/ii)/iii) New meetings of the Vascular Implementation Board to commence 07 May 2014 to agree a vascular service that meets the needs of Southampton, Portsmouth and specialist Commissioners	CEO	May 15	Ongoing
i)/ii)/iii) Establish joint MDT with UHS by end September 2014	SH	Sep 14	Completed and ongoing
i)/ii)/iii) Agreement to provide vascular outpatients in Chichester	SH	Nov 14	Completed and ongoing

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15-1516 **Apr 15**	**Insufficient engagement of workforce** **Implications:** • **Lack of understanding/ buy in, and therefore delivery of strategic priorities** • **Suboptimal delivery of patient care** • **Declined staff survey results**	• Listening into Action programme adopted. • Staff survey action plans developed across the organisations and within CSCs • Health and well-being programme established. • Employee recognition programmes in place. • Leadership development • Quarterly staff pulse survey • Development of appraisal quality framework linked to values • Full work plan introduced to address key issues of bullying & harassment	• Significantly Improved performance in 2014 national staff survey results. • Lower than average levels of sick absence and staff turnover when compared to other acute organisations. • Integrated performance report to Board including staff feedback • When compared to all acute trusts, movement from 7 key findings in the bottom 20% and only 2 in the top 20% in 2013 to 10 in the top 20% and none in the bottom in 2014 • Staff recommendation as a place to work or receive treatment has increased from 3.54 to 3.71 as measured in the 2014 NSS • Staff Friends and family quarterly pulse survey in 2014/15 Q4 demonstrates PHT as top in Wessex for recommendation as a place to work	**12 (4X3)**	**6 (3X2)**	**6 (3x2)**	i. Lack of engagement from clinical staff in delivering the change agenda ii. Unbalanced focus on operational delivery verse strategic planning	iii. Trust is positioned as above average for overall staff engagement when compared to other Trusts within the full 2015 staff opinion survey.	1. Director of Workforce and Organisational Development 2. Head of Organisational Development 3. Operational Board	N/A	Apr 16	CQC S4, S5 E4 W4	RR 24-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) CSCs continuing to adopt the LiA approach to address key findings and encourage new ideas for improvements	Chiefs/GMs/HoN	Jul 15	Completed but on-going to embed.
ii) Clinician pioneering LiA and forming part of the sponsor group to influence colleagues	UW/LR	Jul 15	Completed

iiii) Quarterly staff pulse survey with key questions linked to the priority areas from 2014 national staff survey	LR	May 15	Completed
iv) Specific medical engagement events set up to build relationships and partner in change programmes	UW/LR	Jul 15	Completed
OD interventions to be identified which enable delivery of CSCs 'well-led' quality improvement plan following CQC report	CSCs/LW	Dec 15	

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16-1516 Apr 15	**Leaders do not have the tools and/or development to deliver change management programmes and build staff commitment to delivering change**	• Leadership development programmes in place to support leaders at various levels. • 360 and self-assessment completed at Executive level • Trust wide leadership qualities and behaviours identified • Clinical Directors leadership programme in place • Performance appraisal process to assess behaviours and leadership performance in place.	• Utilisation of existing leadership development programmes • 360 completed for executive team and included for medical revalidation. Roll our to all senior managers as part of appraisal process • PHT representation on Thames Valley and Wessex Leadership Academy Board • Leadership Academy funded programmes launched and locally developed bite sized training on specific skills gaps • Performance management framework in place supporting talent development and succession planning • Bespoke leadership development roll out to CSC and corporate senior teams using MindGym	**12 (4x3)**	**9 (3X3)**	**6 (3x2)**	i. Programmes and framework for leadership development in place but needs to be embedded to ensure compliance. ii. Evidence of behavioural change and a culture shift in collective responsibility and holding to account iii. 'Optional' approach to leadership development influenced by operational demands	iv. There is insufficient training needs analysis at Trust and individual level to ensure that appropriate development interventions are delivered. v. Leaders setting clear direction and engaging the workforce in the vision of the organisation and how each role contributes to it	1. Director of Workforce and Organisational Development 2. Head of Organisational Development 3. Operational Board	July 16	Oct 16	CQC S4, S5 W3	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Audit the quality of appraisals defining expected behaviours with personal development plans outlining development needs – all aligned to organisational priorities	LW	Dec 15	Completed
ii)Increased utilisation of the national leadership academy resources from 2014 numbers	LW	Nov 15	Completed
iii)Successfully secure graduate management trainee placements	LW	Sep 15	Completed
iv)Ensure robust talent development plans and succession planning is undertaken for critical posts	CSCs	Nov 15	In progress

v)Create a performance management culture as measured by the NSS and workforce metrics	LW	July 16	
vi)All senior managers (band 8b+) to complete a 360 every 2 years as part of appraisal process	LW	Feb 16	Completed roll out and on-going
vii)Clear leadership development plan in place at a trust level aligned to critical skills gaps identified and cascaded to teams	LW	Feb 16	Completed

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17-1415 Apr 14	Current and future workforce demand is outstripping supply leading to: National skill shortages in nursing, scientific and other professions being reflected locally which is leading to an increasing expensive temporary workforce supply which may impact on patient care Adult nursing commissions have been increasing since 2013 but they have not kept pace with requirements due to the impact of increased demand post Francis. Workforce design has not kept pace with changing service delivery, for example, terms and conditions of service have not fundamentally changed for many years, but increasingly we need staff to work 24/7 on an ongoing basis	• Corporate CIP plan developed to reduce temporary staffing levels. • Speciality specific attraction strategies developed for CSCs in difficult to recruit areas • On-going recruitment of nursing staff from overseas. • E-Rostering deployed for all staff groups	• Business planning process has identified resource requirements for CSC service delivery. • Recruitment strategies have been successful with substantive staffing increasing and vacancies at about 200. But due to the pressure demands on the Trust the number of agency/bank staff have not decreased leading to increased costs	**16 (4x4)**	**16 (4x4)**	**12 (4x3)**	i) Temporary workforce spend remains high and is not sustainable. This is recognised as a national problem and the DH/Monitor are increasingly mandating actions to which the Trust is compliant. ii) Reduction in Junior Doctors and difficulty in recruiting ongoing in many specialities and is the major area of temporary spend. iii) The Trust has maintained many of its referral to treatment targets leading to an increased need for staff which resulted in a high level of premium payments including Waiting List Initiative payments for consultant medical staff and overtime in other staff groups. v) Temporary workforce is used to fill local and national shortages in some key skill areas which may result in some critical skill gaps in clinical rotas, specifically nursing, junior doctors and some other specialist	) High levels of substantive vacancies in Clinical Support specifically	1. Director of Workforce and Organisational Development 2. Deputy Director of Human Resources 3. Operational Board	Jul 16	Apr 17	CQC S4, S5 E3	RR

							areas.						

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)Eliminate premium work and repatriate outsourced work to improve productivity to ensure maximum optimisation of the workforce to realise increased income opportunities and minimise the need for further investment.	CSC	Ongoing	Agreements made to continue to pay WLIs. No agreed rate is paid.
i)Reduce the cost of the temporary workforce by investing where necessary to create capacity for patient care; this includes recruitment from overseas to fill critical vacancies, abolition of WSC and a deft recruitment process including: NHS jobs website, NHS Jobs 2, Linked-in, Careers Fairs, local Universities, Job Centre Plus and introduced a Sector Based Working Academy. We have actively recruited overseas nursing and medical staff to address vacancies and lack of supply of staff in the national labour market.	RK	Ongoing	Significant successful overseas recruitment used for nursing and this is now actively being approached for other staff groups.
iii)Establish new ways of working and new roles to maximise skills to ensure the workforce is equipped with the required skills to deliver patient care in the most efficient and effective manner. This is being implemented but tends to be slow due to the need to ensure appropriate new staff are in place with the appropriate skills and training e.g. Clinicians Associates, Associate Practitioners, Advanced Clinical Practitioners in Histopathology, Critical care Practitioners who are designed to replace junior doctors, First Assist etc.	BH	Ongoing	
iv) CSCs to comply with capped rates	CSC	April 2016	
v)Where agency/bank spend is being used over and above budgeted establishment look to either make substantive via appropriate business case or remove resource	CSC	May 2016	
vI0 Implementation of new junior doctors contract as well as creating discontent amongst juniors will cost the Trust more in terms of basic pay and pension contributions. New rotas being written to moth comply with the new rules and minimise cost where possible	CD	Aug 2016	

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										On target / Minor Obstacle to achieving target / Inability to achieve predicted target			
18-1415 Apr 14	**Inability to achieve Foundation Trust status within the agreed timetable**	• Trust Board development • Well led organisation development • CSC development • TDA monthly assurance programme • Clear trajectories for improvement in key national standards and financial sustainability • LTFM and 5 year strategy refreshed as at 30 Sep 14 • Continuity of service risk ratings	• TDA monthly assurance programme • Significant improvement in many key performance targets/metrics. However unscheduled care performance continues not to achieve the national standard and therefore remains a key area of focus	**12 (4x3)**	**9 (3x3)**	**8 (4x2)**	i. 15/16 Financial Plan shows circa £16m deficit ii. Performance against key targets **TOLERATE**	iii. Unscheduled care pressures across the Trust iv. Pace of delivery of savings programme v. Impact of fines, penalties and contractual payments vi. Not achieving required Continuity of Services Risk Ratings (3 or above)	1. Interim Director of Finance 2. Interim Deputy Director of Finance 3. Trust Board	Dec 16	Dec 16	CQC S4, S5	RR

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Ii), iii), iv), v) Revised performance review process in place from May 2015 to monitor performance and drive change	Interim DoF	May 15	Ongoing
iii) System wide working party on emergency care pathway	Chief Executive	?	
v) Contract performance meetings with commissioners	Interim DoF	Jun 15	Ongoing
vi) Working Capital Group established May 2015	Interim DoF	May 15	Ongoing

Update: 13.4.16

Priorities in the new financial year will be working with our healthcare system partners to establish a sustainable, timely and patient focussed unscheduled care pathway and to achieve sustainable financial balance for the organisation, whilst maintaining all quality, safety and access targets. Foundation Trust status will follow as a consequence of achieving these priorities.

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19-1516 **Apr 15**	**Failure of budgetary control: The Trust doesn't deliver its target financial position for the year 2015/16 of a planned deficit of £9.7m (or better) on income and expenditure, as required by the TDA.** **(In November 2015 the Trust revised its forecast outturn to £23.6m deficit)**	• Finance reporting and monitoring mechanisms at CSC to Board level • Updates on Financial position provided to Board, SMT Finance Committee • Delegated budgetary control framework • Trust wide savings and transformation programme • Income and contract monitoring • Bottom up forecasting in place • Pre-performance review meetings • Agency and no-pay corporate controls	• Draft Outturn position for 2015/16 is £23.5m Deficit and is current subject to external audit • Final Income position has been agreed with Local Commissioners	**16 (4x4)**	**12 (4x3)**	**9 (3x3)**	None	i) Outcome of External Audit	1.Director of Finance 2. Finance & Performance Committee	Jun-16	Jun 16	CQC S4, S5	RR 26-1415 27-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Reinforced, focussed performance review arrangements supported with accurate, detailed financial information	DoF	Nov-15	Nov-15
ii) Focused EMT response to financial challenges and detailed presentation to Finance and Performance Committee/Trust Board	EMT	Dec-15	Mar-16
iii) Comprehensive demand and capacity planning process as part of annual planning, linked to Transformation Programme, supported by enhanced costing systems	DoF/DoS	Apr-16	Mar-16
iv) Review of internal controls and reinforcement/application of standards	DoF	On-going	
v) External Audit opinion due to be presented to Audit Committee 23rd May 2016 and submitted to Dept of Health 2nd June	DOf	Jun-16	

Ref Date Opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target Minor Obstacle to achieving target Inability to achieve predicted target			
20-1516	**The Trust does not achieve sufficient PbR income from commissioners to meet the income plan required to achieve the original plan, or sufficient cash is not available within commissioners to pay activity based invoices.**	• Monthly contract monitoring reports • Monthly contract review meetings (CRM) • Forecast and capacity reviews corporately on working day 1 and during performance reviews (monthly) • CQUIN monitored through the TSO function • Contract issues unable to resolve escalated to Execs via ECRM	• Final Income Position agreed with Local Commissioners	**12 (4x3)**	**3 (3x1)**	**3 (3x1)**	None	i. None	1. Director of Finance 2. Head of Financial Planning and Information and Assistant Director of Commissioning 3. Finance and Performance Committee 4. Operational Board	N/A	Mar 16	CQC S4, S5	RR 8-1516 9-1415 13-1516 19-1516 20-1415 26-1415 27-1415

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i)/iv) Finalise and agreed contracts with commissioners including CQUIN schemes	ET/IH	Aug 15	Mar 16
ii)/iii) Maintain intensive CSC performance meetings which cover contract performance review – performance assurance framework agreed and implemented	EMT	Ongoing	Mar-16
i) Continue negotiations with commissioners over the full re-investment of fines and penalties	DoF	Ongoing	Mar-16
v) Assurance given to Audit Committee that the Costing Team is now fully staffed allowing complete focus on costing and income to occur. Recent resignation of one member of the team means a case will be going to the back office work stream group to recruit	IH	Nov 15	Nov-15
vi) Build relationships with CCG's based on aligned plans and sustainability principles.	DoF	Ongoing	Mar 16

Ref Date Opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER	
										On target / Minor Obstacle to achieving target / Inability to achieve predicted target			
21-1516 Apr 15	**2015/16 Savings and recovery plans are not identified & delivered, with subsequent impact on Trust financial position**	• Review of savings performance at Finance Committee and Operational Board • Monthly CSC performance meetings • Tracker providing clear information on which initiatives are 'off-track' • Defined CSC reporting arrangements • CSCs submitted initial savings plans • Transformation Board • Risks and opportunities tracked monthly • TSO function in place	• Monthly reporting to Finance Committee • Programme Management Office in place • Monthly refresh of year end forecast • Clear lead against all recovery programme workstreams • Closer Financial Monitoring • EMT bi-weekly review	**16 (4x3)**	**3 (3x1)**	**3 (3x1)**	i.	i)	1. Director of Finance 2. Finance and Performance Committee	N/A	Mar 16	CQC 26	RR 5.1

ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE	By Whom	By When	Date Completed
i) Reinforced CSC performance meetings to be held monthly with significant financial focus and enhanced financial information	DoF	Nov-15	Nov-15
i0 Finance and the TSO are developing a linked tracking system (to monitor financial and non-financial performance)	Head of Finance Business Partners/TSO	Aug-15	Aug-15
ii) Focused EMT response to financial challenges and detailed presentation to Finance and Performance Committee/Trust Board	EMT	Dec-15	Mar -16
iii) EMT to consider the most effective mechanism for development and delivery of 3-5 year efficiency programmes	EMT	Dec-15	Mar-16

Ref Date Opened	RISK DESCRIPTION	KEY CONTROLS	POSITIVE ASSURANCE	INITIAL RATING (CXL)	CURRENT RATING (CXL)	PREDICTED (RESIDUAL RISK)	GAPS IN CONTROL	GAPS IN ASSURANCE	1. Exec Owner 2. Manager 3. Responsible Committee	REVIEW DATE	TARGET DATE (for mitigation of risk)	LINK TO CQC STANDARDS AND RISK REGISTER
										On target / Minor Obstacle to achieving target / Inability to achieve predicted target		
22-1516 Jun 15	**Lack of urgent access to specialist mental health clinical assessment and advice for patients who are having an acute episode in general hospital** • Current service can result in a complex and fragmented provision based on age and locality with gaps in inpatient psychiatry provision for adults of a working age • No SLA with Solent for Responsible Clinician (RC) provision results in gap in service and risk to compliance with the Mental Health Act requirements • OPMH service constrained by resources (Solent funding withdrawn) • Lack of consistent provision of mental health advice regarding young persons Impacts • Patient and staff safety • Organisational reputation	• Mental Health Team liaison presence in ED for patients who present having self-harmed or for whom ED medics consider a mental health assessment is required. • Mental health in acute setting on junior doctors rolling educational programme • Alcohol liaison service team MAU/ED • Mental Health operational Group up and running – led by Lead Liaison nurse • Mental Health Lead identified within DHMs reviewing completion of Section papers and follow up. • MH and LD committee reinstated • SLA with Southern Health to provide mental health administration function – to commence 01 August 15 • Mental Health Act policy	• Complaints and incidents – monthly exception report and quarterly quality performance report. • Reports to MH & LD Committee • Reports to G&Q Committee	**12 4x3**	**16 4x4**	**12 4x3**	i. Service specification for Trust to provide Mental Health support for inpatients to be agreed ii. No agreement between Southern and Solent to provide RC provision iii. Limited staff training programme	iv. Lack of full compliance with Mental Health Act requirements	1. Medical Director 2. Head of Quality 3. MH & LD Committee	Jul 16	Sep 16	S4,E1, E3, E4, R1, R2, R3,
ACTIONS AGAINST GAPS IN CONTROL/ASSURANCE									**By Whom**	**By**	**Date Completed**	

			When	
i.	Meeting arranged with Commissioners 29th May 15 to review service specification. Further actions will come out of initial meeting	S.Holmes	May 15	Meeting held and draft service specification circulated. The Trust has sent back comments. Further meeting to be arranged
ii.	Will form part of overall service specification once agreed	S.Holmes /F.McNeight	Sept 15	
iii.	Policy to be finalised and ratified	F.McNeight	July 15	Completed
iv.	Establish training programme	D.Knight / F.McNeight	July 15	Training established. Basic awareness training sessions commissioned through Southern Health. Further training funded through charitable funds to commence delivered by Solent MH Lead
v.	Specific training required for Duty Hospital Managers arranged for May 15	F.McNeight	May 15	Completed – additional training also received from Southern Health aligned to new SLA and section paper administration

Update: 13.4.16

Progress has been made with the Commissioners in respect of the liaison service specification. Southern Health have agreed to provide the whole service. Solent and Southern are now working up a plan to transition the service over to Southern Health (Solent currently provide the ED liaison service). We do not have a definitive date of commencement so I would not reduce the risk rating.

We have been providing mental health training sessions through an external provider funded through charitable funds but that money has run out now so training will cease. Once the new liaison service is up and running this will be resolved as training will be incorporated within the service spec.

I am hoping that this risk will be mitigated hopefully in the next 6 months (earlier hopefully but dependant on factors outwith the Trust control).

Care Quality Commission – Key Lines of Enquiry

Safe
S1 What is the **track record** on safety?
S2 Are **lessons learned and improvements made** when things go wrong?
S3 Are there **reliable systems, processes and practices** in place to keep people safe and safeguarded from abuse?
S4 How are **risks to people who use services** assessed, and their safety monitored and maintained?
S5 How well are potential risks to the service **anticipated** and **planned** for in advance?

Effective
E1 Are people's needs assessed and care and treatment delivered in line with legislation, standards and **evidence-based guidance**?
E2 How are people's care and treatment **outcomes monitored** and how do they **compare** with other services?
E3 Do **staff** have the **skills, knowledge and experience** to deliver effective care and treatment?
E4 How well do **staff, teams and services work together** to deliver effective care and treatment?
E5 Do staff have all the **information they need** to deliver effective care and treatment to people who use services?
E6 Is people's **consent** to care and treatment always sought in line with legislation and guidance?

Caring
C1 Are people treated with kindness, **dignity**, **respect** and **compassion** while they receive care and treatment?
C2 Are people who use services and those close to them **involved as partners** in their care?
C3 Do people who use services and those close to them receive the support they need to **cope emotionally** with their care, treatment or condition?

Responsive
R1 Are **services planned** and delivered to meet the needs of people?
R2 Do services take account of the **needs of different people**, including those in vulnerable circumstances?
R3 Can people access care and treatment in a **timely** way?
R4 How are people's **concerns and complaints** listened and responded to and used to improve the quality of care?

Well Led
W1 Is there a clear **vision** and a credible **strategy** to deliver good quality?
W2 Does the **governance** framework ensure that **responsibilities** are clear and that **quality, performance and risks** are understood and managed?
W3 How does the **leadership** and **culture** reflect the vision and values, encourage openness and transparency and promote good quality care?
W4 How are **people** who use the service, the **public** and **staff engaged** and **involved?**
W5 How are services **continuously improved** and **sustainability** ensured?

LEADS			COMMITTEE/GROUP ABBREVIATIONS			OTHER ABBREVIATIONS	
AC	Anoop Chauhan		EMT	Executive Management Team		CQC	Care Quality Commission
CD	Claire Dyson		G&Q	Governance & Quality Committee		CSC	Clinical Service Centre
MD	Michelle Dixon		FC	Finance Committee		DoH	Department of Health
SH	Simon Holmes		OB	Operational Board		KPI	Key Performance Indicator
MK	Michael Kellagher		SEC	Strategic Education Committee			
RK	Rebecca Kopecek		TB	Trust Board			
FMcN	Fiona McNeight						
TP	Tim Powell						
MQ	Mike Quinn						
LR	Lucy Wiltshire						
PS	Paul Sadler						
TS	Tracey Stenning						
LW	Lee Williams						