Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Trust Board
30 July 2015

TITLE	**Board Assurance Framework**
EXECUTIVE SUMMARY	The Board Assurance Framework (BAF) is a key assurance tool that ensures the Board has been properly informed about the risks to achieving the Trust's Strategic Objectives. The BAF is aligned to the four Strategic Objectives as detailed in the Corporate Business Plan 2015-16.
ASSURANCE (Risk) / IMPLICATIONS	The Board assurance process ensures that risks to achieving the Trust's strategic objectives are actively identified and managed.
LINK TO STRATEGIC OBJECTIVE	The Framework links to all Strategic Objectives.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	The BAF incorporates risks and their impact to stakeholders, staff and patients.
EQUALITY AND DIVERSITY ISSUES	None known.
LEGAL ISSUES	The Board Assurance process supports the Chief Executive in signing the Annual Governance Statement which forms part of the Trust's statutory accounts.
The Board is asked to:	Review, discuss and approve the Board Assurance Framework.
Submitted by:	Chief Executive
Date:	17 July 2015
Decision:	For Approval

Board Assurance Framework (BAF)

1 Introduction

The BAF is an assurance tool to ensure that the Board is properly informed about the risks to achieving all of the Strategic Objectives as detailed in the Corporate Business Plan.

2 Strategic Context

The BAF is aligned to achieving the four Strategic Objectives as documented in the Corporate Business Plan 2015-16. The BAF also supports the Annual Governance Statement, and has been cross referenced to the Trust Risk Register.

As a Foundation Trust it is important that the Board Assurance Framework works as a tool to support the Board's assurances in terms of self certification on compliance with the Trust's License.

3 Review

In accordance with the new business plan for 2015/16 and the revised strategic objectives an in-depth review of the BAF was undertaken in March 2015. A briefer review is undertaken quarterly.

The entire BAF has been submitted to IGAC for review.

4 Commentary on Risks

4.1 Closure and addition of risks

No risks have been removed or added from the Framework after this review.

4.2 Extreme risks

At July there remain nine extreme risks as reported in April (and ten at January).

Risk	Rating (Apr '15)	Rating (Jul '15)
1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.	20	16
1.3 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and quality of care outcomes.	20	20
1.4 If the Trust workforce was not appropriately aligned to meet safer staffing levels, approved WTE establishments, agency usage and pay costs, resulting in poor patient outcomes.	16	16
2.4 Administrative delays and cancellations to appointments leading to poor patient experience.	15	15

3.1 If the Trust was unable to recruit and retain high calibre staff.	**16**	**16**
3.2 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	**16**	**16**
4.1 Poor alignment of the clinical workforce around the Trust's efficiency improvement programme could lead to insufficient productivity.	**16**	**16**
4.3 A failure to deliver 2015/16 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction in productivity.	**16**	**16**
4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates.	**16**	**16**

Risk 1.2 There are significant "divergent and multiple" priorities at present due to the operational pressures in the hospital which is not expected to reduce greatly, and despite the CQC visit having now taken place there are still significant operational pressure on the hospital.

Risk 1.3 The Trust is still experiencing unprecedented demand and resultant capacity constraints. This risk remains extreme.

Risk 1.4 Operational pressures persist with the resultant impact on staffing through the use of agency staff.

Risk 2.4 The risk remains extreme. Following the outpatient workshop in November 2014 a plan has been developed, Project Manager appointed and a Programme Board has been set up. Booking team capacity to be assessed and review of management structure is underway.

Risk 3.1 It remains challenging to recruit and retain high calibre staff with a resultant reliance on temporary staff in some areas. Actions to mitigate are detailed within the appendix.

Risk 3.2 Despite improvement in the Q2 14/15 staff friends and family score (both versus Q1 and peer organisations) this risk remains extreme until the national staff survey results are published later in Q4.

Risk 4.1 Periods of severe operational pressure lead to poor alignment of the clinical workforce. This risk remains extreme.

Risk 4.3 £2.5m CIP risk at month 1. Mitigation schemes to be developed to bridge gap. Risk remains extreme.

Risk 4.5 Due to the likelihood and impact of increased demand this risk remains rated extreme.

4.3 Top Five Risks

The Board has previously agreed that the key risks should be highlighted. At July 2015 these are:

1.2 If divergent and multiple organisational priorities compete with and

undermine staff engagement leading to a distraction from the focus on high quality care.
1.3 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and quality of care outcomes.
3.1 If the Trust was unable to recruit and retain high calibre staff leading to lack of skilled and motivated teams.
3.2 If individuals and teams do not feel valued or motivated, resulting in poor patient care experience and ineffective team working.
4.3 A failure to deliver 2015/16 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction in productivity.

Actions to mitigate these risks are detailed within the individual tabs in the Appendix.

5 Recommendation

The Board is asked to discuss and approve the Board Assurance Framework.

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Board Assurance Framework - Summary
Version: July 2015

	Lead	Mar 14 Risk Score	Jul 14 Risk Score	Oct 14 Risk Score	Jan 15 Risk Score	Apr15 Risk Score	Jul 15 Risk Score	In Quarter Risk Change
1.1 If the quality governance and impact assessment processes fail during the design of QIPP/CIPs, this could lead to a negative impact on quality of care	CN	8	8	8	8	4	8	↑
1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.	CN	12	12	20	20	20	**16**	↓
1.3 If there is poor capacity and flow in the emergency pathway and insufficient frequency in senior decision making this could result in poor outcomes and patient experience.	Interim COO	16	16	16	20	20	**20**	↔
1.4 If the Trust workforce was not appropriately aligned to demand and acuity, agency usage and pay costs, resulting in poor patient outcomes.	DoW/CN/ MD	12	12	12	16	16	**16**	↔
1.5 If delivery of CQC inspection action plan slips this risks quality of service delivery, reputation and further regulatory action	CN	n/a	n/a	n/a	n/a	9	**9**	↔

	Lead	Mar 14 Risk Score	Jul 14 Risk Score	Oct 14 Risk Score	Jan 15 Risk Score	Apr 15 Risk Score	Jul 15 Risk Score	In Quarter Risk Change
2.1 The Friends and Family Test (FFT) results and feedback are not used as a driver to achieve excellent patient experience.	CN	8	8	8	8	**8**	**8**	↔
2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patient experience.	CN	n/a	6	9	6	**6**	**6**	↔
2.3 If the Trust fails to adopt the culture of a listening, kind and compassionate organisation in dealing with complaints then our patients, within the course of their care and treatment, will have a poor experience.	CN	n/a	12	12	12	**12**	**9**	↓
2.4 Administrative delays and cancellations to appointments leading to poor patient experience.	DCE	n/a	9	9	15	**15**	**15**	↔

	Lead	Mar 14 Risk Score	Jul 14 Risk Score	Oct 14 Risk Score	Jan 15 Risk Score	Apr 15 Risk Score	Jul 15 Risk Score	In Quarter Risk Change
3.1. The inability to recruit and retain high calibre staff would lead to lack of skilled and motivated teams.	DoW	16	16	16	16	16	**16**	↔
3.2. If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	DoW	16	16	16	16	16	**16**	↔

	Lead	Mar 14 Risk Score	Jul 14 Risk Score	Oct 14 Risk Score	Jan 15 Risk Score	Apr 15 Risk Score	Jul 15 Risk Score	In Quarter Risk Change
4.1 Poor alignment of the clinical workforce around the Trust's efficiency improvement programme could lead to insufficient productivity.	DoFI	12	12	12	12	**16**	**16**	↔
4.2 A failure to deliver the clinical quality incentives (CQUINS), the performance standards or to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2015/16 contract leads to an under recovery of income and reduction in productivity.	DoFI	16	12	12	12	16	**8**	↓
4.3 A failure to deliver 2015/16 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction productivity.	DoFI	16	16	16	16	16	**16**	↔
4.4 Financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or to enforcement of contract levers more aggressively than expected leading to reduced income and inability to achieve top productivity.	DoFI	12	9	9	9	9	**9**	↔
4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates.	DoFI	n/a	n/a	n/a	16	16	**16**	↔

Key:

15-25	Extreme	↔	No change in risk score	CN	Chief Nurse
8 –12	High	↓	Risk score decreased	DCE	Deputy Chief Executive
4 – 6	Medium	↑	Risk score increased	DoW	Director of Workforce Transformation
1-3	low			MD	Medical Director
				DoFI	Director of Finance & Information

Principle Risk:

1.1 If the quality governance and impact assessment processes fail during the design of QIPP/CIPs, this could lead to a negative impact on quality of care

Chief Nurse

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	2	1	Objective 1: Best Outcomes
Consequence	3	4	4	
Level	9	8	4	

Opened 01-Apr-11
Closed

Controls

- Process control - procedural level - QIPP/CIP threshold for QSIA is determined in line with the ratified policy.
- Pre-implementation - process control - procedural level - there is a policy in place to govern this process.
- ***Post implementation - system overview control*** - QEWS dash board measures impact on quality.
- ***Post implementation - system overview control*** - The QEWS dashboard evaluates Quality, Experience, Workforce and Safety metrics across the Trust. This early predictor tool will indicate if quality is being compromised (a proxy for the quality:cost balance becoming unfavourable).
- QSIA reviews of QIPP/CIPS are presented to panel consisting of Medical Director, Chief Nurse, Chief of Patient Safety and Deputy Chief Nurse.

Assurance

- Monthly review at QIPP/CIP performance meetings.
- "Quality and Safety Impact Assessment" (Section 2) submitted to Quality and Transformation Review Panel for approval. Panel comprises Executive Sponsor, Medical Director, and Chief Nurse. For 2015/16 a threshold is to be implemented for this process, so that minor value / low risk QIPP/CIPS do not require panel approval.
- All Division Quality Leads have been trained in the QSIA process.

  QEWS monitored monthly by Integrated Governance and Assurance Committee (IGAC).
- Complaints and Incident data trends- reported to Board and Integrated Governance Assurance Committee (IGAC).

Gaps in Controls

- None

Gaps in Assurance

- Quality impact assessment process to be run on the final QIPP initiatives.

Closure Request?

The QSIA review panel met on the 19 March 2015 to review the high risk CIPs for 2015/16 from a quality perspective. The Director of Finance has specified some further actions in relation to sign-off of the high risk CIPs; these were commenced in Q1 2015/16 and are still progressing. The QSIA CIP review process has been much strengthened this year as a result of embedding the process in the clinical divisions.

Action Plan

Due:	Action Description	Progress to Date	Date Completed
on-going	Familiarise business development managers with the quality governance and impact assessment processes.	Divisional quality leads leading on this familiarisation (completed in Q3 and Q4 14/15).	01-Apr-15
01-Sep-15	To quality impact assess the final QIPP initiatives/programmes	Ongoing	

Principle Risk:

1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.

Chief Nurse

Link to Trust Risk Register 764

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	5	2	Objective 1: Best Outcomes
Consequence	4	4	4	
Level	12	16	8	

Opened: 01-Apr-11
Closed:

Controls

- Clear vision of Quality of care as major driver for the trust
- Clear Strategic Objectives with two relating to quality
- PMO approach helps prioritise competing priorities
- Strong quality monitoring
- Strong clinical leadership at both Executive level , through Divisional Triumvirates.
- Achiement of full CQC Compliance. Compliance in Practice audits undertaken.
- PMO overview of change activity within the organization
- Merger PMO in place providing monitoring of merger budget and timescales

Assurance

- Scorecards including Best Care dashboards
- Self certification process by Trust board based on a structured assurance process
- Staff and patient Survey results (Improvements in 2015 National Staff Survey & Q1 Friends & Family Test)
- Corporate Objectives are monitored quarterly
- Clinical sounding board chaired by Medical Director and Chief Nurse established.
- Merger: Steering Group and Strategic Oversight Group in place
- CQC: Compliance in practice audits in 2014 identified high level of CQC compliance

Gaps in Controls

- None known

Gaps in Assurance

- Junior doctor GMC Survey improved in 2014 but not at level required yet.
- Merger: CMA submission result unknown.

Closure Request?

n/a

Action Plan

Due:		Action Description	Progress to Date	Date Completed
Ongoing		Test all new initiatives against two core SOs (Emergency pathway and financial balance)	On going	
On going		Monitor staff comments on The Wall, other forum of communication	On going	
1-Jan-15		Hold a Schwartz Round on related subject	CLOSED	01-Mar-15
Q1 14/15		PMO to train Divisions to deliver change projects	On-going	
		Strengthened business continuity prospective planning being commenced (to incorporate staffing levels, annual leave planning, safer staffing plan)	Ongoing progress with safer staffing plan, staffing levels and annual leave planning being incorporated at Divisional level.	

Principle Risk:

1.3 If there is poor capacity and flow in the emergency pathway this could result in poor outcomes and patient experience.

Interim Chief Operating Officer

Link to Trust Risk Register 764

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	5	2	Objective 1: Best Outcomes
Consequence	4	4	4	
Level	16	20	8	

Opened: 01-Apr-12
Closed:

Controls

- Weekly 4 hour performance meeting chaired by COO
- Bi-weekly NWS A&E Steering Group meeting with partners
-
- 4 hour recovery plan shared with CCG and Monitor & NHSE (including forecast trajectory)
- Whole-system action plan in place and monitored through Unscheduled Care Partnership Board
- Implementation of robust Frail Elderly pathway (OPAL)
- MAU Assessment area changes
- Development of 15/16 Winter Plan

Assurance

- Trust signed off by ECIST November 2012. Positive feedback from visits in Jul 13 and Jan 14.
- Compliance with trustwide 4 Hour standard (Q3 14/15) monitored and multi-disciplinary, multi-divisional review of breaches.
- Quality indicators are reported at divisional and corporate levels
- Recruitment of additional A&E Consultants
- Alamac whole sector support for urgent care pathway
- Tripartite review of recovery plan

Gaps in Controls

- Insufficient Consultant cover for 7 day working
- Urgent Care Strategy has a long term focus and multiple short term actions
- Securing Commissioner and Community engagement and desired results

Gaps in Assurance

- RealTime - full potential of system yet to be realised
  7 day working
- Performance in June 90.36% (A&E CCG contract standard)

Closure Request?

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Feb-13	Widen the remit of RealTime		Q2 2015/16 Remaining elements of Inpatient Lists (IPL) transfer to RealTime (RT) for Adult inpatient wards. Delayed Transfer of Care reporting will transfer to Radar, using data from RealTime and Patient Centre. Rehab reporting - awaiting input from Supplier.	
Mar-15	14/15 funding to increase Consultant cover at the weekends		Added to 15/16 Business Plan.	
Mar-15	Development of Therapies Improvement Programme		Therapies Lead now appointed. Programme in progress	
Jun-14	Recruit further two A&E Consultants		New recruitment plan developed with Dir of Workforce & OD for implementation.	
Jan-15	Development of the Urgent Care Programme ASPH/NWS CCG		Joint Urgent Care Recovery Programme in place	
Jan-15	Strengthening support to the hospital at weekends, with more physicians working. This includes the Trust's 'Enhanced Care for Older People' team and an additional discharge consultant for the		OPAL team on site at weekends. Additional discharge Registrar for medical wards and Registrar to support AECU service in place.	
Jul-15	Due to tender for supplier to trial urgent care centre at front door of A&E		Jul-15	Jan-15
Jul-15	Develop plans for Paediatric Assessment unit co-located with A&E		Commenced June 2015	
01/07/2015	Introduction SOP's, including point of care testing		In progress July 2015	

Principle Risk:

1.4 If the Trust workforce was not appropriately aligned to demand and acuity; particularly to meet reductions in WTE, agency usage and pay costs, resulting in poor patient outcomes.

Director of Workforce Transformation/Chief Nurse/Medical Director

Link to Trust Risk Register 1317

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	4	2	Objectives 1 & 3: Best Outcomes & Skilled Motivated Teams
Consequence	3	4	3	
Level	9	16	6	

Opened: 01-Apr-11
Closed:

Controls

- Annual Workforce Plan
- Business Planning process and targets set for 2015/16
- Weekly vacancy Control panel & weekly rostering meeting
- Centralised medical staffing booking system (Asciepius)
- Centralised change programmes led by an Executive Director
- Safer Staffing Templates
- Compliance with CQC Outcome 13
- 6 monthly acuity & describing review

Assurance

- Safer staffing Levels
- Divisional Performance Review Meetings to review appointment to establishment & forward plan
- Workforce reports supplied to Divisions weekly and monthly
- Agency usage monitored at ED Finance and Division Review meetings and actions agreed monthly
- Bimonthly monitoring of workforce metrics at Workforce and OD Sub Committees, weekly rostering meeting -
- attended by Exec Directors & Non Exec Directors
- Safer Staffing Levels report presented to Board monthly.
- Nursing Acuity Tools deployed . Safer staffing templates being used to validate staffing levels for other non nursing staff groups.

Gaps in Controls

Gaps in Assurance

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Mar-14		Embed trust wide processes for financial governance, decision making and control of use and expenditure		In progress	
01-Aug-15		Implement new centralised medical staffing booking system to ensure control of booking and improved accuracy in pay rates and invoices		In progress	
31-Jan-15		Safer Staffing plan being developed.		Complete	01-Jun-15

Principle Risk:

1.5 If delivery of CQC inspection action plan slips this risks quality of service delivery, reputation and further regulatory action

Chief Nurse

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	3	2	Objective 1 Best Outcomes
Consequence	3	3	3	
Level	9	9	6	

Opened: 17-Apr-15
Closed:

Controls

- High level action plan for compliance actions with Senior Responsible Officer oversight
- Detailed action plan for improvement actions
- Devolved setting, implementing, and monitoring of the plans promotes local ownership
- Clear link between action owner, deliverable, and timescale

Assurance

Formalised governance structure for monitoring

- High level action plan on compliance actions is being reviewed monthly via IGAC, with summary monthly update to Trust Board
- Detailed action plan on improvement actions to be formulated and reviewed at CQC Quality Review Group fortnightly
- External scrutiny by CQC (details to be agreed in meeting June 2015). Anticipate monthly written updates and quarterly face to face review.
- **Process assurance**
- Test of effectiveness to ensure than an action has been effectively resolved

Gaps in Controls

Gaps in Assurance

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
April 2015		Implement monthly monitoring to IGAC and Trust Board		First reports to be submitted for month of April 2015	
June 2015		Agree arrangements for monitoring of progress with CQC in meeting of June 2015		Meeting scheduled for 2nd week in June 2015	
TBC		Formulate detailed improvement action plan for non compliance actions		Commenced, will set timescale and progress via CQC Quality Review Group forums	
30-Jun-15		Review risk in June 2015 - Associate Director of Quality		The action plan continues to be monitored through the above assurance framework. At 19/7/2015 of the 53 should actions 76% were rated green to deliver on timescale. Of the 12 components of the compliance actions, 7 actions (58%) were rated green for on track. The slippage is contributed to by lack of capacity to progress actions owing to pressures of service across the Trust, and this has been notified to IGAC and Closed Trust Board in June 2015.	

Principle Risk:

2.1 The Friends and Family Test (FFT) results and feedback are not used as a driver to achieve excellent patient experience.

Chief Nurse

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	4	1	Objective 2: Excellent Experience
Consequence	2	2	2	
Level	8	8	2	

Opened: 01-Apr-13
Closed:

Controls

- New satisfaction targets to be set for 15/16 and reported on balanced scorecardwith new recommended % score replacing the NPS
- Monitor performance against similar trusts - agree target from Q2 15/16
- Monthly reporting - monitor response and satisfaction rates across all areas of hospital
- Improvement plans and initiatives, plus any concerns in feedback to be reviewed at PEMG on a quarterly basis
- Monthly performance review of FFT scores

Assurance

- The Trust has achieved roll out of FFT to all areas of the hospital

  The Trust has achieved the set response rate targets for Inpatients and A&E
- Recommended scores for Inpatients and maternity are above the target level for 15/16
- Review at speciality performance meetings, Quality Governance Committee and IGAC. QEWS dashboard in place highlighting FFT scores. National requirement to report Touchpoint 2 in Maternity.

Gaps in Controls

- None known

Gaps in Assurance

- Text service across A&E and outpatients but inpatients and maternity continue to use postcards. Two separate dashboards provide little strategic Board sight of FFT data across

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Completed
01-Sep-15		Plan for roll out of text services to all areas		Outpatient Department and Day surgery roll out completed in Oct '14. Inpatients and maternity 2015/16 roll out suspended due to decision on supplier of patient data gathering. CN & CEO to meet with supplier to explore this further. Other suppliers being met with by Patient Experience.	
TBA		The response rates in maternity FFT are insufficient to guide improvement actions at present, and therefore the response rate requires improvement.		Nationally the problem with accurate data gathering in maternity has been recognised and a decision has been taken to reduce to Touchpoint 2 only.	CLOSED
01-Jan		Interactive voice messaging service for FFT being put in place for A&E patients.		Roll out commenced.	COMPLETE

Principle Risk:

2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patients experience

Chief Nurse

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	2	1	Objective 2: Excellent Experience
Consequence	2	3	2	
Level	6	6	2	

Opened: 31-Mar-14
Closed:

Controls

- Policies have been reviewed, updated and ratified pertaining to all Adult Safeguarding, being reviewed again to reflect Care Act 2015.
- Prevent (Management of radicalisation of public service) being addressed.
- Health & Safety Manager is facilitator and Adult Safeguarding lead Nurse is nominated lead for Prevent.
- All policies and process reviewed recently.
- HealthAssure has been updated - Outcome 7.
- Trust Intranet Safeguarding section has been updated.
- Clinical pathway has been created for safeguarding and adult alerts. Safeguarding domestic abuse has been developed. Partnership with MARC . Winterbourne strategy achieved, working in partnership with the adult social care team.
- Deputy Medical Director interim Lead Safeguarding Adults Physician. Looking at substantive role.
- Safeguarding Lead Nurse appointment & Safeguarding Adult Nurse.

Assurance

- CQC compliant - as per inspection 13th and 14th Jan 2015 (Outcome 7 - Safeguarding people for abuse, Outcome 14 Supporting workers, Outcome 16)
- New package has been introduced with projection to have 85% compliance with training within 3 years. Reviewing training updates to address.
- Quarterly assessments take place at Divisional level and organisational level, reported into the Integrated Governance and Assurance Committee (IGAC).
- Safeguarding Adults at Risk - Self Assessment tool (Surrey Safeguarding Board) completed in July 15.
- Increased DOLS referrals.
- Level 3 training commenced.
- Administration support recruited.

Gaps in Controls

- Specialised audit pertaining to Safeguarding Adults focussing paticually in regards to capacity assessment and best interest decisions. The use of DoLs and application needs to be more robust.
- Need to identify who and how to PREVENT session can be provided

Gaps in Assurance

- No evidence in-place to suggest Court of Protection to staff. No safeguarding competency framework in-place (however Trust will adopt Surrey Adult Board competencies and progress level 3 training for nominated individuals as part of strategic development when new safeguarding team is progressed). In regards to capacity assessments education and process in need of more robust management. Compliance: Adult safeguarding 80.3%, DOLS 95.5% and Child safeguarding 85.1%.
- CQC finding re vulnerable groups re help with meal times.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
20-Mar-14		Head of Nursing & Midwifery CPD will progress level 3 training and review competences in the next quarter.		Level 3 training progressed.	
Jan-15		Training re physical disability and comunciation needs with vulnerable groups.		On-going. Communication study day being run, dementia study day introduced and running monthly. Physical and Learning disability training being planned for induction and mandatory update.	
Jul-15		PREVENT training & training for Controlled Holding for patients needs to be introduced. Need to agree funding and identify appropriate staff.			

Principle Risk:

2.3 If the Trust fails to adopt the culture of a listening, kind and compassionate organisation in dealing with complaints then our patients, within the course of their care and treatment, will have a poor experience.

Chief Nurse

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	2	3	1	Objective 2: Excellent Experience
Consequence	3	3	2	
Level	6	9	2	

Opened: 31-Mar-14
Closed:

Controls

- Trust forums in place to monitor and scrutinise complaints and the actions undertaken to improve: Patient Experience Monitoring Group, Patient Experience Group (Governors), Patient Panel (Patients Representatives).
- Board oversight. Complaints data within monthly quality report.
- Complaints policy.
- Target set of 10% or less follow up complaints per month
- Chief Nurse review established
- Weekly Trust Complaints Panel - chaired by Chief Nurse.
- New datix web system for managing complaints from 20.4.15

Assurance

- Achievement of less than 10% in follow up complaints ongoing
-
- New datix web system to ensure better understanding of themes and trends and further breakdown of data

Gaps in Controls

- Timeliness is now a quantitative target of 25 days and 35 days

Gaps in Assurance

Timeliness has dropped for Q1. Expectation for improvement from Q3. Q1 status at 89% for complaints received before 1st April 2015, 78% for Grade 1&2 complaints received post 1st April 2015, 71% for Grade 3&4 complaints received post 1st April 2015

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-May-15		Substantive band 6 recruitment		Recruited Band 5 from August 2015	Closed
31-Mar-15		Systematic review of the behaviours, practices and processes around complaints handling		To be carried out by the Chief Nurse Project Lead supported by the PMO.	Closed
31-Mar-15		Development of a complaints procedure guidance		Commenced. Connected to Chief Nurse Project.	Closed
Q2 14/15		Develop training and development programmes		Training delivered, ongoing program in progress	01-Dec-14
Q2 14/15		Focus session on medical engagement		Incorporate Patient Experience as part of annual consultant leadership programme	
Jan-15		Complaint response improvement plan being developed		Developed. Being implemented.	

Principle Risk:

2.4 Administrative delays and cancellations to appointments leading to poor patient experience.

Deputy Chief Executive

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	5	1	Objective 2: Excellent Experience
Consequence	3	3	1	
Level	9	15	1	

Opened: 31-Mar-14
Closed:

Controls

- Outpatient Improvement Board
- Patient Experience Monitoring Group
- Divisional level review
- Improving Outpatient Experience Programme (Customer Service strategy, Out-patient promise)
- Weekly Trust wide performance meetings (Cancer, A&E, RTT)

Assurance

- Complaints (marginal decrease year on year)
- Outpatient Friends & Family (live from October 2014)
- Reports to Trust Board & Divisional Performance reviews. Council of Governors

Gaps in Controls

- Embedding Divisional review processes
- Pre-operative assessments

Gaps in Assurance

- Out-patient cancellation report reviewed in every Division
- Full suite of O.P. performance meetings

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
2015/16		Improve pre-operative assessment process (recruit, expand facility, increase one stop shop clinics)		One stop clinics to be rolled out across all specialties.	
2015/16		Trust wide performance meetings		Q2 15/16 - strengthen review of cancellation process (in and out-patients)	
01-Sep-14		Review of booking pathway		Review of Management structure & process underway	Complete
12-Nov-14		Outpatient workshop		Took place on 12th November with over 50 attendees	12/11/2014
2014/15		Reduction in cancellation of outpatient appointments with <6 weeks notice		Work progressing with the Divisional teams	
End March 2015		Improving Outpatient Experience Programme (run by PMO)		In progress - Programme has been redefined in Q2 14/15. Following outpatient workshop the output have been collated with a plan developed. Project manager appointed and Programme Board set up.	31-Mar-16
		Develop a measurement of KPIs to measure improvement		In progress. To be agreed at Outpatients Improvement Board.	
		Use 15 steps improvement plan in outpatient departments.		Head of Patient Experience to implement with patient representatives.	

Principle Risk:

3.1 The inability to recruit and retain high calibre staff would lead to lack of skilled and motivated teams.

Director of Workforce Transformation

Link to Trust Risk Register 1317

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	4	2	Objective 3: Skilled, motivated teams
Consequence	3	4	3	
Level	12	16	6	

Opened: 01-Apr-13
Closed:

Controls

- All employment policies, including appraisal, structured in accordance with the 4Ps
- Corporate and divisional LED plans
- Weekly vacancy Control panel
- Compliance with CQC Outcome 14
- ADN bi-weekly Recruitment and Retention Group
- Weekly review of temporary staff spend
- Health Roster User Group for Nursing (Chaired by an ADN)

Assurance

- Staff turnover rates monitored at PMO at divisional and speciality level
- Employment policies available on Trustnet and reviewed with EPF & TEC
- Specific action plans in place to identify and address areas with retention difficulties
- Compliance with CQC Outcome 14 - monitored by WOD Committee
- Leadership Programme in conjunction with Hay in progress
- Establishment of Workforce and OD Committee from July 2013.
- Institute Leadership Management programme in place for Band 5 and above, in addition to external leadership academy programmes

Gaps in Controls

- Control of rostering and planning

Gaps in Assurance

- Continuing inability to retain key staff.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
2014		New Consultant Development Programme		Implemented - 3rd cohort of Consultants started programme in Jan '15	2015
31-Mar-15		Medical Workforce Planning: Assessment of future Divisional workforce model.		In progress - on-going, part of 2015/16 business plan	
2015/16		Recruitment plan for nurses (UK and overseas)		In progress, continually updated and reported via workforce report at WOD	
2015/16		Nurse rotational programme for Band 5/6		In progress	
Nov-14		Development of Corporate Framework for hard to recruit to areas		Completed, microsite for A&E live	May-15
Nov-14		Development of pay incentives for nurses in targeted areas.		Developed.	Nov-14
Mar-15		Refreshed approach to employer branding and recruitment with 4 key workstreams:		In progress	
Mar-15		Defining our corporate identity and our recruitment needs – why do people work here, what sets us apart from others.		Scoping USP with CEO Sounding Board and other forums, developing organisation story, developing benefits package, developing a *working in surrey* brochure.	
Mar-15		Describing this through a re-branding exercise – Trust video, template job packs, *Join The Team* page on website.		Corporate branding and recruitment material drafted, toolkit being developed for recruiting managers, corporate video filming in progress, developing microsites for	
Mar-15		Positioning ourselves in the jobs market – conferences, social media, developing an alumni.		Developing social media toolkit for recruitment to enhance organisational profile, use of Linkedin for SM posts	
Mar-15		Recruitment Tactics – Advertorials in professional press, job stands in local shopping centre, recruitment days, refer a friend scheme.		Advertorial in HSJ for SM posts in June. Microsites for medical staffing campaigns to be launched in Aug/Sept onwards. Calendar of nursing events developed for 2015/16.	

Principle Risk:

3.2 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.

Director of Workforce Transformation

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	2		4	Objective 3: Skilled, motivated teams
Consequence	4		2	
Level	8	12	8	

Opened: 01-Apr-12
Closed:

Controls

- All employment policies, including appraisal, structured in accordance with the 4Ps
- Team ASPH continuing
- Chief Executive Sounding Board
- Development of Values Based Behaviours
- Junior doctor activities
- Development of new appraisal policy with inclusion of values based behaviours

Assurance

- Employment policies on Trustnet and reviewed every three years
- Staff attitude survey and patient survey results reported to Trust Board, TEC (annually)
- Monitor improvements against KPIs
- Staff Social Committee
- Exit interviews
- Open Communication channels (ideas wall)
- WOD Committee meets bi-monthly
- Improved NSS staff survey results 2014, Staff FFT on going improvement including latest results in Q4
- 800 managers and staff trained on new appraisal policy.

Gaps in Controls

Gaps in Assurance

- Appraisal rates now well below 90% target
- GMC survey results in 2015 identify improvements needed.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
2014		Improve career development and training and development opportunities		New leadership portal, ongoing In Their Shoes career shadowing events	
Sep-14		CEO Chat Room launched		Commenced - on-going	
Sep-14		CEO Consultant one on one meetings initiated		Commenced - on-going	
Jan-15		Additional communciation forums being developed		CEO weekly messages videoed once a month. Weekly operational update from Deputy CEO.	
Mar-15		In Their Shoes career shadowing established		4th cohort Sept 2015	
Apr-15		Annual staff appreciation & recognition awards		Held on 16th April 2015	
Jun-15		Hold Staff Benefits Week, showcasing local and national discounts		Complete	
Jul-15		Trust recognised in national WOW scheme for 2015/16 - finalist in 5 categories		Event to be held in Nov 2015	
Jul-15		Launch Consultants' on line forum, and link to MSC		In progress	
Jul-15		Create interactive webpage to describe Employee Promise and components		In progress	
Jul-15		Refresh local induction checklist		In progress	

Principle Risk:

4.1 Poor alignment of the clinical workforce around the Trust's and Commissioner efficiency programmes could lead to insufficient productivity.

Director of Finance and Information

Link to Trust Risk Register N/A

	Initial	Current	Target
Likelihood	3	4	3
Consequence	4	4	3
Level	12	16	9

Strategic Objective Affected

Objective 4: Top productivity

Opened: 01-Apr-11
Closed:

Controls

- KPIs on LOS, admissions, discharges etc. weekly and monthly
- Clear demand and capacity plan
- Escalation Policy in place
- Monthly speciality performance reviews in place
- Daily Information Reporting and Intelligence systems
- Weekly Trust wide dashboards
- Theatre Utilisation Monitoring
- Realtime inpatient system
- Bed Management Radar

Assurance

- Balanced Scorecard
- Monthly Finance Committee
- Bi-monthly Workforce and OD Committee
- Joint Trust / CCG fortnightly CIP/QIIP delivery review board (starts May 15)

Gaps in Controls

Gaps in Assurance

- Evidence of delivery around business plans
- Evidence of delivery over planned care demand management programme
- Emergency Capacity Plan and crowding out of elective workload.

Closure Request?

N/A

Action Plan

Due:	Action Description	Progress to Date	Date Completed
01-Sep-15	Theatre Utilisation action plan	In progress. 18 week capacity issues still requiring weekend elective activity levels.	
01-Dec-15	Length of Stay action plan	New 15/16 plan currently in sign off processes.	
30-Jun-15	Rehab reprovided across the community. Reduction in Trust provided rehab beds.	43 beds closed. Impacts and system support under review.	
31.4.15	Trust delivered demand managment schemes for A&E, MSK, Cardiology, ENT, Urology, Dermatology, Opthalmology, Neurology and Diabetes under development	Implementation commencing.	
01-Sep-15	Consultant recruitment plan	In progress. Various posts recruited to in hot-spot areas (i.e. Care of the Elderly, Acute physicians) but key posts remain unfilled.	
31-Oct-15	Agency reduction plan	NHS wide initiatives under review	

Principle Risk:

4.2 A failure to deliver the clinical quality incentives (CQUINS), the performance standards or to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2015/16 contract leads to an under recovery of income and reduction in productivity.

Director of Finance and Information

Link to Trust Risk Register 1216 & 1268

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	3	2	Objective 4: Top productivity
Consequence	4	3	3	
Level	16	8	6	

Opened: 01-Apr-12
Closed:

Controls

- Service planning processes in place with clear targets
- Clear internal Performance Review Framework
- Clear articulation of internal programme of work.
- Monthly contract KPI monitoring
- CQUIN project managed through PMO with Executive Director leads

Assurance

- Balanced scorecard KPIs
- Divisional Performance Review Meetings (monthly)
- Monthly income reports to Finance Committee and Board
- CQUIN report to Strategic Delivery Committee
- 2015/16 CQUINs to be finalised.

Gaps in Controls

Gaps in Assurance

- Current activity pressures now impacting upon most CQUIN measures.

Closure Request?

N/a

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Jun-15		Implementation of Emergency Care action plan		In progress. Trajectory for compliance by December. On track.	
2015/16		CQUIN delivery plan		Monitored monthly - in progress	

Principle Risk:

4.3 A failure to deliver 2015/16 CIPs to the level required and/or pay and non-pay expenditure exceed budget without a compensating increase in income may lead to a reduction productivity.

Director of Finance and Information

Link to Trust Risk Register 1266

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	4	2	Objective 4: Top productivity
Consequence	4	4	4	
Level	16	16	8	

Opened: 01-Apr-11
Closed:

Controls

- Monthly Directorate and Divisional performance reviews look at workforce, activity, finance and
- Trust's quality framework
- Planned programme of LOS reductions which is regularly reviewed with Directorates
- Other delivery metrics i.e. theatre utilisation, weekly bank and agency usage reports
- Major Productive schemes identify patients experience objectives as well as productivity objectives and monitor any adverse impacts during implementation.
- Monthly Divisional CIP meetings

Assurance

- TEC review of business cases and quality impact reports
- Board performance and PMO delivery / impact reports
- Strategic Delivery Committee
- Performance Review meetings
- Internal and external audit reports
- £2.5m CIP risk at month 1. Mitiagtion schemes to be developed to bridge gap.

Gaps in Controls

Gaps in Assurance

- Delivery of recruitment plans to reduce agency spend.
- CIP mitigation schemes continue to be developed.

Closure Request?

N/a

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Sep-15	Delivery of Divisional Recruitment plans		In progress	
31-Mar-16	Delivery of Cost Improvement Plans		In progress - £13.5m identified. Actions to underpin this are being pursued. Currently on track.	
01-Jul-14	Deliver Medicine recovery plan		In progress - challenging due to on-going demand, capacity and temporary staffing requirement.	
31-Oct-14	Deliver TASCC recovery plan		In progress.	
31-Jul-15	Finance Committee to undertake deep dive on Q1 performance		Done.	

Principle Risk:

4.4 Financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or to enforcement of contract levers more aggressively than expected leading to reduced income and inability to achieve top productivity.

Director of Finance and Information

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	3	2	Objective 4: Top productivity
Consequence	4	3	4	
Level	12	9	8	

Opened: 01-Apr-11
Closed:

Controls

- Focus on NW Surrey Locality and specialist commissioner relationships
- Regular Board-to-Board with the CCG.
- Activity profiled across year
- Demand management scheme monitoring.

Assurance

- Monthly contractual close down and agreement processes.
- Contractual escalation arrangements will be used as required.
- Activity reporting via Board and Finance Committee reports.
- CCG notification of issues or performance concerns are reported to the Board as required.

Gaps in Controls

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Gaps in Assurance

- Confidence in CCG QIIP programmes to deliver fully the expected activity reductions
- Confidence in the impact of the Better Care Fund.
- Confidence in the Trust QIIP programmes to deliver fully the expected activity reduction

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
15/16		Joint strateegic work to allign future financial and activity plans		Underway.	
15/16		Better Care Fund / QIIP impacts in 2015/16 to be activily monitored.		No material impacts yet noted.	

Principle Risk:

4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates.

Director of Finance and Information

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	4	3	Objective 4: Top productivity
Consequence	4	4	3	
Level	16	16	9	

Opened: 30-Oct-14
Closed:

Controls

- Monthly monitoring on contract activity, QIIP
- Planned programme of LOS reduction
- Funding of escalation beds from April 15.
- Health economy winter plan
- Rehab action plan to transfer Trust beded provision to the community

Assurance

- Limited impact from health system on reducing demand

Gaps in Controls

Gaps in Assurance

- Confidence in existing whole system plan.
- Potential crowding out of elective activity

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
15/16		System wide provider response discussions being co-ordinated by Trust and CCG CEOs and the Local Area Team.		Plan developed to achieve four hour compliance by Q3 2015.	