Paper 8.0

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

TRUST BOARD

27 October 2016

AGENDA ITEM NUMBER	5.4	
TITLE OF PAPER	Board Assurance Framework	
Confidential	**NO**	
Suitable for public access	**YES**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality and Performance Committee 20 October 2016		
STRATEGIC OBJECTIVE(S):		
Best outcomes	✓	
Excellent experience	✓	
Skilled & motivated teams	✓	
Top productivity	✓	
EXECUTIVE SUMMARY	.	
	The Board Assurance Framework (BAF) is aligned to the four Strategic Objectives as detailed in the Corporate Business Plan 16-17. The BAF is a key assurance tool that ensures the Board has been properly informed about the risks to achieving the Trust's Strategic Objectives. It is proposed a more in-depth review of the BAF will take place following the outcome of the Well Led Governance Review taking place this Autumn and to ensure alignment with the recent refresh of our strategic plan.	
RECOMMENDATION:	The Board is asked to discuss, challenge and approve the Board Assurance Framework	
SPECIFIC ISSUES CHECKLIST:		
Quality and safety	Poor quality governance can impact on quality of care	
Patient impact	Poor outcomes impact on patient experience	
Employee	Multiple organisational priorities could undermine staff engagement	
Other stakeholder	The BAF incorporates risks and their impact to stakeholders, staff and patients	

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

Equality & diversity		
Finance	Excess demand could increase financial pressure	
Legal	The Board Assurance process supports the Chief Executive in signing the Annual Governance Statement which forms part of the Trust's statutory accounts.	✓
Link to Board Assurance Framework Principle Risk		
AUTHOR NAME/ROLE	Executive leads Liz Davies, Acting Company Secretary	
PRESENTED BY DIRECTOR NAME/ROLE	Suzanne Rankin, Chief Executive	
DATE	14 October 2016	
BOARD ACTION	Approve	

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 current BAF has been reviewed and is aligned to achieving the four Strategic Objectives as documented in the Corporate Business Plan 2016-17. 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

The executive team met in June to cross reference the BAF with the Corporate Business Plan for 2016/17 and align with the Trust's four Strategic Objectives.

A briefer review is undertaken quarterly, and the entire BAF is submitted to the Quality & Performance Committee (QPC) for evaluation.

4 Commentary on Risks

4.1 Closure and addition of risks

At the executive meeting held in June to review the BAF, at the Chief Executive's request, it was agreed to amalgamate Risks 2.1 to 2.3 to form one Risk.

With reference to Risks 2.1, 2.2 and 2.3 the new Risk 2.1 has now been written and agreed. This new risk has been considered a major risk and is scored at 16.

4.2 Extreme risks

At October there are six extreme risks. There were six reported in July (and six in April).

Risk	Rating (Jul 16)	Rating (Oct16)
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.	**16**	**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 is not appropriately aligned to demand and acuity, resulting in high agency usage & pay costs, and poor patient	**16**	**16**

outcomes.		
2.1 If the Trust fails to adopt a culture of listening, kindness, and compassionate care then patients, including vulnerable groups, will have a poor experience of direct care, hospital services and facilities.	**n/a**	**16**
3.1 If the Trust was unable to recruit and retain high calibre staff would lead to lack of skilled and motivated teams.	**16**	**16**
4.6 The Trust in its existing configuration may not be clinically or financially viable in the long-term, and if the current organisational strategy to achieve sustainability fails, this presents a risk to the Trust.	**16**	**16**

4.3 Underlying issues to risk:

Risk 1.2 There are significant "divergent and multiple" priorities at present due to the operational pressures and work on achieving organisational sustainability which is not expected to reduce greatly.

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 2.1 Actions to mitigate are detailed within the appendix.

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.

4.6 The Trust in its existing configuration may not be clinically or financially viable in the long-term, and if the current organisational strategy to achieve sustainability fails, this presents a risk to the Trust

4.4 Top Five Risks

The Board has previously agreed that the key risks should be highlighted. At October 2016 these are as detailed above:

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.
1.4 Operational pressures persist with the resultant impact on staffing through the use of agency staff.
2.1 If the Trust fails to adopt a culture of listening, kindness, and compassionate care patients, including vulnerable groups, will have a poor experience of direct care, hospital services and facilities.
3.1 If the Trust was unable to recruit and retain high calibre staff leading to lack of skilled

and motivated teams.

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

Board Assurance Framework – Summary

Version: October 2016

	Lead	Jul-15 Risk score	Oct-15 Risk score	Jan-16 Risk score	Apr-16 Risk score	Jul-16 Risk score	Oct-16 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**	**8**	**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	**20**	**16**	**16**	**16**	**16**	**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.	COO	**20**	**20**	**20**	**20**	**20**	**20**	↔
1.4 If the Trust workforce is not appropriately aligned to demand and acuity, resulting in high agency usage & pay costs, and poor patient outcomes.	DoWD	**16**	**16**	**16**	**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	**9**	**9**	**9**	**9**	**9**	**9**	↔

	Lead	Jul-15 Risk score	Oct-15 Risk score	Jan-16 Risk score	Apr-16 Risk score	Jul-16 Risk score	Oct-16 Risk score	In Quarter Risk Change
2.1 If the Trust fails to adopt a culture of listening, kindness, and compassionate care then patients, including vulnerable groups, will have a poor experience of direct care hospital services and facilities.	CN	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**16**	

	Lead	Jul-15 Risk score	Oct-15 Risk score	Jan-16 Risk score	Apr-16 Risk score	Jul-16 Risk score	Oct-16 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**	**12**	**12**	**12**	**12**	**12**	↔

	Lead	Jul-15 Risk score	Oct-15 Risk score	Jan-16 Risk score	Apr-16 Risk score	Jul-16 Risk score	Oct-16 Risk score	In Quarter Risk Change
4.1 Insufficient productivity driven by poor alignment of the clinical workforce, non-compliance with commissioner requirements or the inefficient use of resources (LOS, theatre utilisation, temporary staffing).	DoFI	**16**	**12**	**9**	**12**	**12**	**12**	↔
4.2 A failure to deliver the clinical quality incentives (CQUINS), demand management schemes and the performance standards or to respond to the admission thresholds/readmission caps/and required pathway changes for iMSK and Stroke leads to an under recovery of income and reduction in productivity.	DoFI	**9**	**9**	**9**	**12**	**12**	**12**	↔

4.3 A failure to deliver 2016/17 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.	DoFI	**16**	**16**	**9**	**16**	**16**	**12**	↓
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	**9**	**9**	**9**	**12**	**12**	**12**	↔
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	**16**	**16**	**12**	**12**	**12**	**12**	↔
4.6 The Trust in its existing configuration may not be clinically or financially viable in the long-term, and if the current organisational strategy to achieve sustainability fails, this presents a risk to the Trust.		**n/a**	**n/a**	**n/a**	**n/a**	**16**	**16**	↔

Key:

15-25	Extreme
8 –12	High
4 – 6	Medium
1-3	low

↔	No change in risk score
↓	Risk score decreased
↑	Risk score increased

CN	Chief Nurse
COO	Chief Operating Officer
DoW	Director of Workforce Transformation Development
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 - QSIA policy provides guidelines on assessment.
Post implementation - assessments outline monitoring controls for material plans.
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).
Annual training workshops for governance and operational teams.

Assurance

Monthly review of plans at QIPP/CIP performance meetings.
QSIA process annual training for divisional teams.
QEWS monitored monthly by Quality and Performance Committee (QPC).

High risk QSIA reviews of QIPP/CIPS are presented to panel consisting of Medical Director, Chief Nurse, Chief of Patient Safety and Deputy Chief Nurse.

Complaints and Incident data trends- reported to Board and Quality and Performance Committee (QPC).

Gaps in Controls

May 2016 spot check indicated completion and quality of QSIA documentation is significantly improving year on year, but timeliness, full completion and robustness of documentation requires further improvement. The training workshops will continue each business planning process to improve this.

Gaps in Assurance

Assurance on status of overall plan sign-off and completion, at divisional level, to be implemented as a review area for 2017/18 planning process.

Closure Request?

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	
Dec-15	Changes from Business Planning Workshop to be assessed by this process.	Business Plan 16/17 yet to commence.	
Jun-16	Divisions were asked to review for plans requiring presenting to Panel.	Panel not required for 2016/17 as no high or extreme risk plans currently.	30-Jun-16
Mar-17	Assurance over divisional sign-off of plans to be reviewed during 2017/18 planning	Business planning for 2017/18 is to commence in Q3.	

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	4	2	Objective 1: Best Outcomes
Consequence	4	4	4	
Level	12	16	8	

Opened: 01-Apr-11
Closed:

1

Clear vision of Quality of care as major driver for the trust

Quality Improvement initatives support continual frontline improvement
Strong quality monitoring
Strong clinical leadership at both Executive level and through Divisional Triumvirates.
CQC Compliance monitoring framework and assessment mechanism

Assurance

Scorecards including Best Care dashboards, Performance monitoring, monthly Board
Self certification process by Trust Board based on a structured assurance process
Staff and patient Survey results are monitored with action plans
Corporate objectives and actions monitored quarterly with update to Trust Board
Formal monitoring as above, ability to escalate via Sounding Board forums
Ongoing continual self-assessment regime implemented

Gaps in Controls

Significant gaps not identified

Gaps in Assurance

Junior doctor GMC Survey improved in some areas but not at level required yet. An action plan in conjunction with the Deanery is being progressed.

Closure Request?

n/a

Action Plan

Due:		Action Description	Progress to Date	Date Completed
Ongoing		Key new initiatives consider both strategic objectives, staff and patient impact, and financial impact via business cases.	On going	
Ongoing		PMO implentation of the Quality Improvement support framework.	On-going	
Ongoing		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. During doctors strike a robust continuity plan was developed, tested and reviewed afterwards.	
Ongoing		amalgamated in the current MSSU space and expanded to include an ambulatory care unit. The vacated ward will become the discharge lounge and a “medically fit for discharge area”. The current MSSU team will become a dedicated MAU/MSSU team and work coherently with the acute take team. The consultant rota has been adjusted so that continuity of care will be delivered in blocks of 3 – 4 days. The clarity of ownership of the patient will be achieved as the patients remain the responsibility of the MAU consultant until they leave the ward area.	The co-location of MAU and MSSU to form a single Acute Medical Unit took place on 19 December 2015, at the same time as the commencement of a new consultant rota across acute medicine ensuring continuity of patient care during stays on AMU. An ambulatory unit has also been created, although staffing challenges both in AMU and across Medicine continue to limit the opening hours of that facility. Separately the AMU team are working with NHS Elect as part of the Ambulatory Emergency Care network to maximise ambulatory care within the unit. Named Consultant progressing but not established throughout as at Sept 2016.	Mar-16
Ongoing		Task and finish group to review safeguarding reporting and committee structure within the Trust. This is to consider and question the merger of the childrens and adults committees into one Trust wide committee led by an Exec with NED presence and involvement.	Safeguarding lead has commenced the task and finish group and first meeting held. The County wide safeguarding boards have been notified of our review.	
Ongoing		2016/17 review of the Clinical and quality governance structure. The review providing emphasis on the requirement of each committee ands its reporting structure.	Several committees have had ToR re-written and current reviews on CENARG and the frequency of the QGC.	

Principle Risk:

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

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-14
Closed:

Controls

Bi-weekly Urgent Care Programme Board chaired by COO
Bi-weekly Clinical Forum
CCG and ASPH clinical and operational A&E visits
Alamac supported improvements in discharge.
Urgent Care recovery plan shared with CCG and Monitor & NHSE (including forecast
Whole-system action plan in place and monitored through the CCG Unscheduled Care

Local A&E Delivery Board Bi Weekly with System partners

Assurance

Deputy Divisional Directors in post to provide clinical leadership to the programme
ED Highlight Report with progress, KPIs and performance measures
Trust Performance Report monitors quality and performace indicators at divisional
Alamac whole sector support for urgent care pathway
Tripartite review of recovery plan
Workforce capacity Performance Indicators report to Trust Committees
Risk management report at the 4-hour performance meeting and Divisional
Divisional financial budget report monitored at the Divisional meeting

Gaps in Controls

Insufficient Consultant cover for 7 day working
Securing Commissioner and Community engagement and desired results
Securing out of hospital capacity through system partners
Gaps in junior doctor cover

Gaps in Assurance

RealTime - full potential of system yet to be realised
7 day working

Closure Request?

Action Plan

Due:	Action Description		Progress to Date	Date Complete
Complete	Front Door Reconfiguration - delivery of Urgent Care Centre at SPH		Contract was awarded to Greenbrook in September. Detailed work has	01-Mar-16
Complete	Hospital Patient Flow - Implementing consistent agreed core processes (RAT, stream etc)		1.3	01-Sep-16
Complete	Reduce length of stay to improve bed availability - implementation of consultant-of-the-		Ongoing work and consultation with GIM Consultants and Junior Doctors to	21-Dec-16
Complete	Reduce delayed Transfer of Care (DTOC) - implement weekly reporting of DTOCs		Weekly reporting of DTOC and validation takes place on a Thursday.	01-Sep-16
Complete	The Trust is in the process of reviewing and agreeing a revised recovery trajectory.		New interim ADO for Emergency Medicine in place	01-Dec-16
Complete	Appoint Deputy Divisional Directors to provide clinical leadership to the programme		Deputy Divisional Directors to provide clinical leadership in place	01-Apr-16
Complete	Establish an ambulatory emergency care unit		Working with the CCG and clinicians to develop pathways. Clear challenge to	01-Apr-16
31 12 16	Develop the medical model of care including consultant continuity and Gastro/OPSSU ward		New OPSU model to commence 1/11/16. Consultant recruitment continuing. Bed	
31.10.16	Establish and embed a philosophy of care and core clinical standards		Core standards developed and due for launch 13th October.	
Complete	Establish new junior doctor continuity rota and process to fill gaps		Cross divisional work on staffing model implemented. Working with HR on process to improve fill rates for junior doctor gaps	04-Aug-16
31.12.16	System wide project underway to implement Discharge to Assess programme to improve patient flow		Dependent on reduction in length of stay in community hospitals and the effectivemness of the locality hu. D2A model started September 16	
29 02 16	Revise improvement plan and implement Rapid Implementation Guidance		Plan revised to include new improvement actions. Implementation underway but needs to secure support from PMO	

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

i. Annual business planning process confirms establishment

ii. Business Planning process and targets set for 2016/17

iii. Weekly vacancy Control panel & weekly rostering meeting

iv. Centralised medical staffing booking system (Asciepius)

v. Centralised change programmes led by an Executive Director

vi. Safer Staffing Templates

vii. Compliance with CQC Outcome 13

viii. Regular acuity establishment reviews

Assurance

Divisional budgets and establishments. Staff turnover rates monitored at PRM at divisional and speciality level, and at Trust Board level through Board scorecard.

Divisional Performance Review Meetings to review appointment to establishment & forward plan.

Trust wide processes for financial governance, decision making and control of use and expenditure in place. Workforce reports supplied to Divisions weekly and monthly.

Agency usage monitored at Finance Committee, WOD Committtee, weekly rostering meeting for nursing and Division Review meetings and actions agreed monthly.

Monthly monitoring at Finance Committee. Bimonthly monitoring of workforce metrics at Workforce and OD Sub Committees, weekly rostering meeting - attended by Exec & 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 every 6 months.

Gaps in Controls

Gaps in Assurance

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Aug-15		Implement new centralised medical staffing booking system to ensure control of booking and improved accuracy in pay rates and invoices.			Completed
May-15		Implement an HRMC-approved VAT savings scheme for medical agency bookings.		Scheme implemented in May 15 and savings achieved.	Completed
Mar-17				Detailed reports produced and regularly reviewed. Further work being completed to ensure content and commentary supports action planning particularly with respect to cost issues.	Ongoing
Mar-17		Daily reporting of nurse agency spend to support wards and departments to manage and control agency spend to meet Monitor cap.		Reporting in place since end October 2015	Ongoing
Mar-17		Negotiating with agencies for all staff groups to bring rates in line with Monitor capped rates		Weekly reporting to Monitor on any rates in excess of the caps, along with action plan to address. Benchmarking with neighbouring Trusts on the level of agency use above cap. Locums who exceed the cap have been given notice, some being employed directly to reduce costs. Further work being done in Surrey to harmonised rates and share intelligence.	Ongoing
Mar-17		HCA recruitment for existing non-clinical staff to train as HCA's to supplement bank workforce and open up career development opportunities		HCA recruitment well embedded. Now focusing on retention and potential to do more recruitment via apprenticeship roles.	Ongoing
Mar-17		Medical workforce strategy being developed in order to understand the medical workforce need, ensure that our current medical resource is fit for purpose, develop a strong recruitment strategy for medical staff and ensure we are developing clinical leadership and strong clinical culture.		Outline draft developed. Further work to understand priorities and develop action and resource plan	Ongoing

Principle Risk:

1.5 If demand is high then capacity issues could lead to failure of CQC requirements which would threaten the good CQC rating.

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

CQC monitoring

High level action plan for compliance actions with Senior Responsible Officer oversight
Detailed action plan for improvement actions and test of effectiveness: devolved setting, Regulations gap analysis (quarterly) and Domains in Clinical Practice Audit (6 monthly)
Divisional self-assessment using Health Assure Clinical Review Module

Demand-capacity pressures

Emergency care pathway improvement plan is an overarching programme to address capacity issues - this is being closely monitored by Performance Committee and Trust

Assurance

Formalised governance structure for monitoring

High level action plan on compliance actions is being reviewed monthly via Quality and
Detailed action plan on improvement actions is reviewed at CQC Quality Review Group
External scrutiny by CQC with monthly updates and quarterly face to face meetings.

Process assurance

Internal Audit review of CQC governance process in 2015 was favourable with no improvement actions identified.

NHS Improvement oversight of the emergency care pathway and improvement plan.

Gaps in Controls

Gaps in Assurance

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
30-Jun-15		Review risk in Oct 2015 - Assistant Director Regulation and Improvement		During July/August 2016 compliance action completion increased from 90% to 100% and should action completion rose from 77% to 81%. The key compliance action gap is increasing medicines management training in areas not subject to the compliance action, which is being tracked divisionally.	Action reviewed monthly in CQC Quality Review Group.
30-Jun-16		In Q1 2016/17 the risk was refreshed as a broader risk of overall CQC non-compliance owing to the potential impact of demand-capacity issues; the most		Monitoring for the revised risk has been outlined as above.	Complete June 2016
Ongoing		In Q2 2016/17 the Trust has rolled out the new Clinical Review Module of Health Assure which is being used to evaluate and evidence CQC compliance on a		Whilst self-assessment has commenced, and a high level gap analysis is in place and is being actionned, at the detailed 'key line of enquiry' level within Divisions,	Last reviewed 5 Oct 2016.

Principle Risk:

2.1 If the Trust fails to adopt a culture of listening, kindness, and compassionate care then patients, including vulnerable groups, will have a poor experience of direct care, hospital services and facilities.

Chief Nurse | **Link to Trust Risk Register**

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	4	1	Objective 2: Excellent Experience
Consequence	2	4	2	
Level	8	16	2	

Opened: 30-Sep-16
Closed:

Controls

- Direct feedback of patient experience to individual clinicians is being rolled out as part of the iWantGreatCare scheme. The national FFT data is reported in monthly Board reports and divisionally disseminated to drive excellent patient experience.
- National Inpatient Survey compares how our staff as a group perform in specific areas compared to other Trusts nationally.
- Regular review of safeguarding pathways occur. Most recently the Trust has linked-in with the new reporting system as part of the Surrey Multi-Agency Safeguarding Hub.
- Engagement and strategic planning for vulnerable groups is assessed as part of the Divisional Domains in Clinical Practice Audit (part of the CQC assurance audit).
- Disability Group considers needs of vulnerable patient groups.
- Complaints response and monitoring framework.
- Values-based behaviour scheme within appraisals, and other cultural initiatives led by the Workforce and Organisational Development Division.

Assurance

- Assurance on responsiveness to individual feedback is an area under development. High level FFT data provides high level feedback overall.
- Action planning is ongoing.
- Detailed assurance framework internally via case reviews, and externally via multi-agency oversight through Surrey Safeguarding Boards.
- Divisional action plans, and summary audit results reported to Quality and Performance Committee.
- Minutes to evidence key decisions.
- Complaints Panel, Patient Experience Monitoring Group, Patient Experience Group with Governors, underpinned by action plans for learning and improvement.
- Have won national awards and significant nominations such HSJ, WOW, etc.

Gaps in Controls

- Mental Health Act (MHA) and Mental Capacity Act (MCA) training is being refined and effectiveness is audited. Restraint is an improvement area regarding knowledge. Application of the principles in clinical practice requires deeper embedding including patient identification and escalation.
- There have been temporary capacity gaps in resource for learning disability training and patient support.

Gaps in Assurance

- Some of these have been rectified by updated documentation and training plans implemented by the Professional Lead for Safeguarding. Regular audits are undertaken. Lasting Powers of Attorney and Courts of Protection related matters requires are being reviewed. The area overall still has scope for improvement.
- Learning disability audits and training requires improvement. A report on gaps is to be presented to Trust Board in Q3.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Completed
Per individual plans		Continuation of the MHA, MCA, Safeguarding and Learning Disability improvement work.		Commenced and ongoing.	

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

i	Annual business planning process confirms establishment
ii	Weekly vacancy control panel reviews and approves appointment to vacancies
iii	Weekly review of temporary staff spend & rostering for nurses with senior nursing
iv	Monthly Nursing & Midwifery Recruitment and Retention (NMRR) Group reviews progress
v	Clinical Cabinet formed in Medicine & Emergency Care as a forum for reviewing medical workforce gaps and risks
vi	Corporate and divisional LED plans developed as part of business planning to ensure appropriate investment in education and development
vii	Leadership, Management & Talent Management strategy developed & approved in April 2016. Leadership Steering Group established to enable implementation of strategy.
viii	All employment policies, including appraisal, structured in accordance with the 4Ps
ix	Compliance with CQC Outcome 14

Assurance

Divisional budgets and establishments. Staff turnover rates monitored at PRM at divisional and speciality level, and at Trust Board level through Board scorecard.
Vacancy fill rate reviewed at divisional and speciality level, and at Trust Board level through Board scorecard.
Specific action plans in place to identify and address areas with retention difficulties
Vacancy levels improved
Numbers of staff accessing education & development and in particular monitoring uptake via the Study Leave & Finance Committee.
Numbers of staff attending leadership & management training and in particular the new Manager's Toolkit training.
Employment policies available on Trustnet and reviewed with EPF & TEC
Compliance with CQC Outcome 14 - monitored by WOD Committee

Gaps in Controls

- Control of rostering and planning for medical workforce

Gaps in Assurance

- Continuing inability to retain key staff.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
2016/17		Divisional Business & workforce plan and development of new roles.		In progress - part of delivery of 2016/17 business plan	Ongoing
2016/17		Active forward looking recruitment plan for nurses (UK and overseas). Recently supplemented by skype interviewing to capture as many candidates as possible, with a target to recruit 200 Band 5 nurses in 2016/17.		In progress, continually updated and reported via workforce report at WOD & the NMRR Group & the Finance Committee. To support overseas nurses, the Trust has put in place extra induction support, NHS language and culture familiarisation to ensure the nurses are supported to make the transition to UK nursing, settle into their new wards and teams, and ensure good retention. Target of 200 being reviewed to consider if need to stretch to 250.	Ongoing
2016/17		Development of pay incentives for nurses in targeted areas.		Developed and implemented. Currently reviewing effectiveness and considering a number of additional incentives to use in difficult to recruit areas.	Ongoing
2016/17		Refreshed approach to employer branding and recruitment with 4 key workstreams: 1. Re-branding exercise – Trust video, template job packs, refreshed Join The Team page on website. 2. Positioning ourselves in the jobs market – conferences, social media, developing an alumni. 3. Recruitment Tactics – Advertorials in professional press, job stands in local shopping centre, recruitment days, refer a friend scheme. 4. Improved Staff Benefits offer – development of an app, annual staff benefits week		recruiting managers, nurse recruitment video and ITU recruitment videos completed 2. Developing social media toolkit for recruitment to enhance organisational profile, use of Linkedin for SM posts 3. Calendar of nursing events refreshed for 2016/17. Working with a number of recruitment agencies to support specific campaigns eg Australian recruitment for theatres, European recruitment. Now actively recruiting in Europe for medical staff 4. Trust Staff Benefits Officer established and detailed workplan being implemented. Successful staff benefits week in Sept. App due to be launched imminently. Assessing need/ desire to do big salary sacrafice promotion.	

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	3	2	Objective 3: Skilled, motivated teams
Consequence	4	4	4	
Level	8	12	8	

Opened: #######
Closed:

Controls

i. All employment policies, including appraisal, structured in accordance with the 4Ps
ii. Results of annual staff survey
iii. Results of quarterly staff friends and family test
iv. Chief Executive Sounding Board
v Development of Values Based Behaviours
vi Staff award scheme in place
vii Managers adequately trained to support, develop and value teams

Assurance

i. Employment policies on Trustnet and reviewed every three years with EPF and
ii. Staff attitude survey and patient survey results reported to Trust Board, TEC
iii. Improvement results, favourable ranking in comparison with sector acute trusts.
iv. Feedback from CEO Sounding Board actively used to improve employment
v. Recruitment, appriasal and reward aligned with core values and associated
vi. Numbers of people being thanked and recognised via the WOW award scheme
vii. Number of people accessing management development and leadership

Gaps in Controls

Gaps in Assurance

Appraisal rates below 90% target
GMC survey results in 2016 identify improvements needed.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Mar-17		Deliver Health & Well Being programme to meet CQUIN requirements including a)		Detailed action plan in place and being implemented	Ongoing
Mar-17		Revise and roll out 360 appraisal		Review of current system in progress. New tool developed and currently being	Ongoing
Mar-17		Develop Team diagnostic and interventions toolkit and train HRBP to use with		Toolkit developed and currently being piloted	Ongoing
May-16		Refresh the Chief Executive's Sounding Board		Review completed and new format introduced	Ongoing
Jun-16		Roll out Unconcsious Bias mandatory training programme		Completed. Review on uptake and feedback in progress	Ongoing
Jul-16		Review communciation forums		Communications audit completed. Action plan developed.	Ongoing
Jul-16		Launch managers toolkit training		Manager's toolkit launched and getting high levels of take up and positive	Ongoing
Sep-16		Staff survey results and action plan		Complete a 'You said, We did' campaign locally within the divisions. Recent	Ongoing
Oct-16		Review and update recognition scheme, linked to VBBs, incentivises and		Review in progress. Achieved 2000 wow nomination milestone recently	Ongoing
Oct-16		Develop and promote ASPH leadership model with clear emphasis on		Model developed in draft format	Ongoing
Oct-16		Delivery of compassionate leadership programme at Team brief and reflection on how to improve staff experience			Completed
Oct-16		Improve Staff Benefits offer – development of an app, annual staff benefits week		Trust Staff Benefits Officer established and detailed workplan being implemented.	Ongoing
Oct-16		Significantly increase focus on both a quality improvement and leadership		Successful QI Summit with Trust Board, senior leaders and a faculty from the	Ongoing

Principle Risk:

4.1 Insufficient productivity driven by poor alignment of the clinical workforce, non-compliance with commissioner requirements or the inefficient use of resources. (LOS, theatre utilisation, temporary staffing

Director of Finance and Information

Link to Trust Risk Register N/A

	Initial	Current	Target
Likelihood	3	4	3
Consequence	4	3	3
Level	12	12	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
- Discharge planning "RADAR"
- Joint Delivery Plan Strategic and Delivery Boards

Assurance

- Balanced Scorecard
- Monthly Finance Committee
- Bi-monthly Workforce and OD Committee
- Joint Trust / CCG monthly CIP/QIIP delivery review board

Gaps in Controls

Gaps in Assurance

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

Closure Request?

N/A

Action Plan

Due:	Action Description	Progress to Date	Date Completed
01-Sep-16	Joint delivered demand managment schemes action plan under development.	Implementation being monitored.	
31-May-16	Consultant recruitment plan updated.	In progress. Various posts recruited to in hot-spot areas (i.e. Stroke physicians) but key posts remain unfilled.	
31-May-16	Agency reduction plan updated.	NHS wide initiatives under review. Implementation in stages from 1 April.	

Principle Risk:

4.2 A failure to deliver the clinical quality incentives (CQUINS), demand management schemes and the performance standards or to respond to the admission thresholds/readmission caps/and required pathway changes for iMSK and Stroke leads to an under recovery of income and reduction in productivity.

Director of Finance and Information | **Link to Trust Risk Register 1216 & 12(**

	Initial	Current	Target
Likelihood	4	4	2
Consequence	4	3	3
Level	16	12	6

Strategic Objective Affected

Objective 4: Top productivity

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

Gaps in Controls

Gaps in Assurance

- Current activity pressures impacting upon CQUIN measures.

Closure Request?

N/a

Action Plan

Due:		Action Description		Progress to Date	Date Completed
30-Jun-16		Implementation of Emergency Care action plan		In progress. Trajectory for compliance by December. Ongoing monitoring due to access target issues.	
2016/17		CQUIN delivery plan		Monitored monthly - in progress	
01.10.16		iMSK Delivery Plan		Monitored monthly - in progress	

Principle Risk:

4.3 A failure to deliver 2016/17 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.

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	3	4	
Level	16	12	8	

Opened: 01-Apr-11
Closed:

Controls

- Monthly Directorate and Divisional performance reviews look at workforce, activity, finance
- 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

- Commercial Group 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

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-16	Delivery of Divisional Recruitment plans		In progress	
16/17	Delivery of Cost Improvement Plans		In progress - £10.5m identified. Further actions to underpin this are being pursued.	

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	4	4	
Level	12	12	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

Gaps in Assurance

- Impact of 'discharge to assess' initiative and other commissioning changes, i.e. to 'hospital at home' contracts.
- Confidence in QIIP programmes to deliver fully the expected activity reductions

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
		Monthly contract monitoring		Ongoing	

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
Likelihood	4	3	3
Consequence	4	4	3
Level	16	12	9

Strategic Objective Affected

Objective 4: Top productivity

Opened: 30-Oct-14

Closed:

Controls

- Monthly monitoring on contract activity, QIIP, Joint Delivery Programme
- Planned programme of LOS reduction

Assurance

- Limited impact to date from health system on reducing demand

Gaps in Controls

Gaps in Assurance

- Referral and attendance rated significantly over plan.
- Confidence in existing whole system plan.
- Crowding out of elective activity

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
1.10.16		Joint Delivery Programme established to reduce demand.		Internal monitoring and delivery meetings held.	Ongoing

Principle Risk:

4.6 The Trust in its existing configuration may not be clinically or financially viable in the long-term, and if the current organisational strategy to achieve sustainability fails, this presents a risk to the Trust.

Director of Finance and Information

Link to Trust Risk Register N/A

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

Strategic Objective Affected

Objective 4: Top productivity

Opened: 30-Apr-16

Closed:

Controls

- Sustainability and Transformation Plan (STP) Programme

Assurance

- STP central review processes
- Board Strategy Meetings
- Revised Clinical Strategies
- Collaborative working approach
- ASPH CEO SRO leadership of STP Workforce Plan

Gaps in Controls

- Detailed underpinning financial model yet to be generated
- Service line impacts to be assessed
- Detailed delivery plans yet to be generated

Gaps in Assurance

- Fully consistent clincial strategy still to be generated
- Wider consultation still to be undertaken
- Final sign off in October yet to be achieved
- Consistency with wider cancer strategy and neighbouring STPS to be assured.

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
30.09.16		STP Implementation Plan, Joint Delivery Programme implementation plan		Ongoing	