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

TRUST BOARD
31st July 2014

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 2014-15.
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.
IGAC is asked to:	The Board is asked to approve the Board Assurance Framework.
Submitted by:	George Roe, Head of Corporate Affairs on behalf of Andrew Liles, Chief Executive.
Date:	24th July 2014
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 2014-15. 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 2014/15 and the revised strategic objectives an in-depth review of the BAF was undertaken in March 2014. A briefer review is undertaken quarterly.

The BAF in its entirety was reviewed at the meeting of the Integrated Governance and Assurance Committee on 22nd July. The risks under SO3 (skilled, motivated teams) and SO4 (top productivity) were reviewed at the Workforce and OD Committee and the Finance Committee at their respective meetings in July.

4 Commentary on Risks

4.1 Closure and addition of risks

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

Consideration has been made to the risks which the proposed merger with Royal Surrey County Hospital post for ASPH. Review of the merger programme risk register details, at this stage, no significant risks to the Trust's current strategic objectives as a result of the merger programme. Further review of these risks is being conducted by the programme team in August and any significant risks which arise will be incorporated into the BAF as appropriate.

4.2 Extreme risks

At July there are four extreme risks as there were in March.

Risk	Rating (Mar '14)	Rating (Jul '14)
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.	16	16
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
4.3 A failure to deliver 2014/15 CIPs to the level required and/or pay and non-pay expenditure exceed	16	16

budget without a compensating increase in income may lead to a reduction in productivity.		

Risk 1.3 The Trust have achieved the waiting time target for four of the last five quarters with failure of the target in Q3 13/14 being followed by achievement in Q4 13/14. Despite this the emergency departure continues to be under significant operational pressure which is not expected to reduce in the short to medium term. A significant number of actions and mitigations have been implemented in the last 12 months but this risk remains extreme.

Risk 3.1 The Trust's reliance on the usage of temporary staff, with the resultant financial implications, is linked to the ability to recruit and retain sufficient substantive staff. At May 2014 agency staff spend as a percentage of total pay was 7.6% against a target of 5%. Staff turnover rate remains over plan (14%) at 14.3% and therefore this risk has remained as extreme.

Risk 3.2: The 2013 staff survey published in February 2014 did not identify the desired improvement in staff morale and satisfaction and hence this risk remains as extreme. The new friends and family quarterly survey for staff has not yet been published for Q1 14/15.

Risk 4.3: Significant challenges exist to meet the CIP targets in 2014/15 despite the number of measures and plans in place. CIPs at May are off trajectory with slippage expected to impact on the year end achievement. Additional schemes identified but deliverability remains an extreme risk.

4.3 Top Five Risks

The Board has previously agreed that the key risks should be highlighted. At July 2014 these are:

1.6 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and quality of care outcomes.
3.2 If the Trust was unable to recruit and retain high calibre staff through developing leadership potential.
3.3 If individuals and teams were not values-driven or motivated, resulting in poor patient care experience and ineffective team working.
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 2014/15 contract leads to an under recovery of income and reduction in productivity.
4.3 A failure to deliver 2014/15 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.

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

4.4 Board focus

One of the purposes of the BAF is to provide the Board with 'reasonable assurance' that systems are in place to identify and control risk that may prevent the Trust from achieving its principal organisational objectives. As such the Board should use the BAF to develop the agenda for its meetings.

The table below summarises the risks detailed within the BAF and how and when the input of the Board is being sought or the Board are being appraised of current positions and plans to rectify:

BAF Risk (colour = risk level)	Board reports (items in bold = specific papers)	BAF Risk (colour = risk level)	Board reports (items in bold = specific papers)
Best Outcomes			
SO 1.1 – Quality Governance	Quality report (Monthly). IGAC minutes (monthly) **Clinical Quality Assurance (Sept '13)** **Responding to Francis (Nov '13)**	**SO 1.3 – Emergency Care**	Monthly performance report **Spring-to-Green report (May '14)** **IST feedback report (Jan '14)** **Winter Plan 2013/14 (Sept '13 and Oct '13)**
SO 1.2 – Organisational priorities	**Staff survey headlines (Jan '14)** **Staff Survey (Mar '14)** IGAC minutes (monthly) **Staff Experience and Culture Programme (Sept '13)**	**SO 1.4 – Alignment of Trust workforce**	Workforce & OD Committee minutes (bi-monthly) IGAC minutes (monthly) **Staff Experience and Culture Programme (Sept '13)** **GMC Survey Report (Oct '13)** **Safer Staffing Framework (Mar '14)**
Excellent Experience			
SO 2.1 – Friends and Family	Quality report (Monthly). IGAC minutes (monthly) **Annual Patient Experience Report (May '14)**	**SO 2.3 – Complaints**	Quality report (Monthly). **Complaints procedure (Jun '14).** IGAC minutes (monthly) **Responding to Francis (Nov '13).** **Annual Patient Experience Report (May '14)**
SO 2.2 – Safeguarding	Patient story (Bi-monthly). **Winterbourne View Hospital Report (Mar '14)** Safeguarding Annual Report due (Jul 14) IGAC minutes (monthly) **Child Safeguarding update (Nov '13)** **Responding to Francis (Nov '13).**	**SO 2.4 – Out-patients**	**RTT update presentation (Apr '14)** **Annual Patient Experience Report (May '14)**
Skilled, motivated teams			
SO 3.1 – Recruit/Retain	**Staff survey headlines (Jan '14)** **Staff Survey (Mar '14)** Balanced scorecard (Monthly). Workforce & OD Committee minutes (bi-monthly) **Staff Experience and Culture Programme (Sept '13)**	**SO 3.2 – Values/motivated teams**	**Staff survey headlines (Jan '14)** **Staff Survey (Mar '14)** Balanced scorecard (Monthly). Workforce & OD Committee minutes (bi-monthly) **Staff Experience and Culture Programme (Sept '13)**
Top productivity			
SO 4.1 – Clinical alignment/efficiency	Balanced scorecard (Monthly). **Ashford Hospital Elective Activity (Jan '14)**	**SO 4.3 – CIPs**	Balanced scorecard (Monthly). **Finance Forecast (Jun '14)** Finance Committee minutes (monthly) **Half Year Finance Report (Oct '13 and Nov '13).** **Revenue and Capital Budgets (Mar '14)**
SO 4.2 – CQUIN	Balanced scorecard (Monthly). Finance Committee minutes (monthly) **Half Year Finance Report (Nov '13)** **Revenue and Capital Budgets (Mar '14)**	**SO 4.4 – External financial pressures**	Strategy Committee papers Finance Committee minutes (monthly)

The table provides assurance to the Board that reports and updates on the key strategic risks are being provided to Board on a regular basis. In the autumn further assurance will be provided on the below risks which are due an update to Board:

- **SO3.1/3.2**: Skills, motivated teams – progress with the 2014/15 staff experience and culture programme;
- **SO1.3**: Emergency Care – winter plan 2014/15; and
- **SO 2.4**: Out-patients.

5 Recommendation

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

Submitted by: George Roe, Head of Corporate Affairs
For Andrew Liles, Chief Executive

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

Board Assurance Framework - Summary
Version: July 2014

	Lead	Dec 12 Risk Score	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	In Quarter Risk Change
Objective 1: Best Outcomes								
Risks to Objective								
1.1 If the quality governance and impact assessment processes fail during the design of CIPs this could lead to poor quality of care.	CN	9	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	8	12	12	12	12	**12**	↔
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.	DCE	16	20	20	16	16	**16**	↔
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	9	12	12	12	12	**12**	↔

	Lead	Dec 12 Risk Score	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	In Quarter Risk Change
Objective 2: Excellent Experience								
Risks to Objective								
2.1 The Friends and Family results are not used as a driver for improvement leading to persistently poor experience.	CN	n/a	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	n/a	n/a	n/a	6	**9**	↑
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	n/a	n/a	n/a	12	**12**	↔
2.4 Administrative delays and cancellations to appointments leading to poor patient experience.	DCE	n/a	n/a	n/a	n/a	9	**9**	↔

	Lead	Dec 12 Risk Score	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	In Quarter Risk Change
Objective 3: Skilled, motivated teams								
Risks to Objective								
3.1. The inability to recruit and retain high calibre staff would lead to lack of skilled and motivated teams.	DoW	n/a	12	12	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	12	16	16	16	16	**16**	↔

	Lead	Dec 12 Risk Score	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	In Quarter Risk Change
Objective 4: Top Productivity								
Risks to Objective								
4.1 Poor alignment of the clinical workforce around the Trust's efficiency improvement programme could lead to insufficient productivity.	DCE	12	12	12	12	12	**12**	↔
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 2014/15 contract leads to an under recovery of income and reduction in productivity.	CN/MD	16	16	16	16	12	**12**	↔
4.3 A failure to deliver 2014/15 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	9	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	16	12	12	12	9	**9**	↔

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 CIPs, this could lead to a negative impact on quality

Chief Nurse

	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 - 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 unfarourable).
- QSIA reviews of CIPS are presented to panel consisting of Medical Director, Chief Nurse, Chief of Patient Safety and Deputy Chief Nurse.

Assurance

- Monthly review at 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 2013/14 a threshold is to be implemented for this process, so that minor value / low risk 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

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Gaps in Assurance

- This will be remedied by training for divisional quality leads so that the process can be embedded for 2014/15

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. Internal Audit to audit process in Q2 14/15.	

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

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

Opened: 01-Apr-11
Closed:

Controls

- Clear vision of Quality of care as major driver for the trust
- Clear Strategic Objectives with two relatign 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
- PMO overview of change activity within the organization

Assurance

- Scorecards including Best Care dashboards
- External review inc CQC review Dec 11 and May 12 (Outcome 21 to be addressed)
- Self certification process by Trust board based on a structured assurance process
- Staff and patient Survey results
- Corporate Objectives are monitored quarterly
- Clinical sounding board chaired by Medical Director and Chief Nurse established.

Gaps in Controls

- None known

Gaps in Assurance

- Junior doctor GMC Survey improved in 2014 but not at level required yet.

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	Not yet arranged.	
Q1 14/15		PMO to train Divisions to deliver change projects	Planned for Q2 14/15	

Principle Risk:

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.

Deputy Chief Executive

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

Opened: 01-Apr-12
Closed:

Controls

- Weekly 4 hour performance meeting chaired by CEO
- Weekly NWS Capacity meeting with Partners (Urgent Care working group and Capacity and Resilience group)
- 4 hour recovery plan shared with CCG and Monitor (including forecast trajectory)
- Whole-system action plan in place and monitored through Unscheduled Care Partnership Board
- Implementation of robust Frail Elderly pathway (OPAL)
- Opening of Ambulatory Emergency Care Unit in late 2013
- Opening of Gynae assessment unit, SAU changes

Assurance

- Trust signed off by ECIST November 2012. Positive feedback from visits in Jul 13 and Jan 14.
- Compliance with trustwide 4 Hour standard (Q1 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

Gaps in Controls

- Insufficient Consultant cover for 7 day working
- Development of 14/15 Winter Plan
- Securing Commissioner and Community engagement and desired results
- Urgent Care Strategy has a long term focus with less short term actions

Gaps in Assurance

- RealTime - full potential of system yet to be realised
- A&E Patient Tracker System
- 7 day working

Closure Request?

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Feb-13	Widen the remit of RealTime		In-patient wards completed. IPL system to be migrated to Realtime. Phase 1 completed in March 13 with Phase 2 partially complete June 2013, for full completion Q1 2014	
01-Jul-14	Develop 14/15 winter plan		Discussions with commissioners and other stakeholders	
Mar-15	14/15 funding to increase Consultant cover at the weekends		In progress	
Apr-14	Spring to Green learnings		Learning Report completed. Presented to Trust Board in May 2014	29-May
Mar-15	Development of Therapies Improvement Programme		In progress	
Apr-14	Recruitment of middle grade doctors		Recruitment to fill vacancies sought from Europe - underway	
Jun-14	Recruit further two A&E Consultants		Underway	

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

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	3	2	Objective 1: Best Outcomes
Consequence	3	4	3	
Level	9	12	6	

Opened: 01-Apr-11
Closed:

Controls

- Annual Workforce Plan
- Business Planning process and targets set for 2014/15
- Fortnightly vacancy Control panel
- Centralised change programmes led by an Executive Director
- Management of Change Policy
- Compliance with CQC Outcome 13
- Establishment of the Temporary Workforce Programme Board in 2013 (includes 4 key workstreams: i. Medical workforce planning; ii. Supply; iii. Systems; iv. Governance and controls.

Assurance

- Staffing routinely monitored by PMO at Divisional and speciality level
- Divisional Performance Review Meetings to review progress & agree forward plan (monthly)
- Vacancy panel outcomes published by the DoF and DWOD (monthly)
- Workforce reports supplied to Divisions (monthly)
- Agency usage monitored at ED Finance and Division Review meetings and actions agreed monthly
- Workforce and OD Sub Committee meetings are now taking place

Gaps in Controls

- Agency suppliers not reported (see below)

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		In progress - part of the work of the Temporary Workforce Programme Board	
01-Mar-14		Validate authorisation, booking and invoice approval processes for temporary staff		In progress - part of the work of the Temporary Workforce Programme Board	
Mar-14		Embed trust wide processes for financial governance, decision making and control of		New processes launched. On-going controls/monitoring	Mar-14
01-Mar-14		Validate authorisation, booking and invoice approval processes for temporary staff		Completed.	Mar-14

Principle Risk:

2.1 The Friends and Family results are not used as a driver for improvement leading to persistently poor experience

Chief Nurse

	Initial	Current	Target	Strategic Objective Affected
Likelihood	2	2	2	Objective 2: Excellent Experience
Consequence	4	4	3	
Level	8	8	6	

Opened: 01-Apr-13
Closed:

Controls

- Establish baseline metrics against previous ASPH NPS once FFT data set large enough est. July 2013
- Monitor performance against similar trusts - agree target from Q2 13/14
- Monthly reporting - monitor repsonse rates
- Monthly reporting - monitor ward level FFT score by Division and identify low scores compared with other Divisions
- Monthly reporting - monitor FFT score by Division and identify areas with fluctuating range of scores month on month
- Agreed management responsibilities within Divisions for responding to issues raised where scores are low/fluctuating
- Valuing Frontline Feedback(VFF) project, using the FFT score and feedback as a key metric for improvement activity in the Wards and A&E

Assurance

- The Trust achieved 100% assesment for state of readiness for implementing FFT.
- The Trust has launched and rolled out FFT to all Wards and A&E, including Communication materials
- Improving response rate. Inpatient: 43% in May (25% target). A&E reponse rate dropped to 15% in May but in line with CQUIN target of 15%. Maternity response rose from 12% in April to 14% in May.
- May FFT score of 71 (inpatient: target 73), 43 (A&E: target 55), 80 (maternity: target 73).
- In line with national guidance, the Trust has implemented the FFT in our Maternity Services and work is ongoing to ensure that mothers are asked for their feedback at all 4 feedback touchpoints in the maternity pathway.

Gaps in Controls

- None known

Gaps in Assurance

- Maternity denominator figure: pending availability of digipen data, manual returns relied upon from community midwifes.
- It has been identified that response rates in maternity are insufficient to guide improvement actions at present.
- Text service across the organisation.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Dec-14		Plan for roll out of text services to all areas		Option for Outpatient Department text pilot has been scoped; stakeholder event to be held in Sept '14.	
TBA		Because the response rates in maternity FFT are insufficient to guide improvement actions at present, the response rate requires improvement.		The complexity of capturing data at four points in maternity continues to be challenging - this is being addressed by the Women's Health Division with support from Information Services.	

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

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

Opened: 31-Mar-14
Closed:

Controls

- Policies have been reviewed, updated and ratified pertaining to all Adult Safeguarding.
- Prevent (Management of radicalisation of public service) in place.
- Health & Safety Manager is facilitator and Adult Safeguarding Lead Nurse is nominated lead for
- 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.

Assurance

- CQC compliant - as per inspection 13th and 14th Jan 2014 (outcome 7 - Safeguarding people for abuse, Outcome 14 Supporting workers, Outcome 16)
- Quarterly assessments take place at Divisional level and organisational level, reported into the Intergrated Governance & Assurance Committee (IGAC).
- Safeguarding Adults at Risk - Self Assessment tool (Surrey Safeguarding Board) completed in May '14.

Gaps in Controls

- No Safeguarding Adults Physician or team in-place. 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.

Gaps in Assurance

- No evidence in-place to suggest Court of Protection to staff. No appointed Physician lead for Adult Safeguarding (however Q2 2013/14, funding agreed for Safeguarding team). 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.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
20-Mar-14		Recruitment of a safeguarding team in-progress		Due Sept '14. Joint appointment with RSCH.	
20-Mar-14		Head of Nursing & Midwifery CPD will progress level 3 training and review competences in the next quarter.		In progress.	

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

	Initial	Current	Target	Strategic Objective Affected
Likelihood	2	3	1	Objective 2: Excellent Experience
Consequence	3	4	2	
Level	6	12	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.
- Training programme in place.

Assurance

- Marginal drop in the number of complaints vs prior year.
- Timeliness fo response is above 90%.

Gaps in Controls

- Sufficient substantive staff

Gaps in Assurance

- Not yet at 95% target level of complaint responses.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
04-Aug-14		Substantive recruitment		From 4th August the central team will be fully staffed with substantive appointments.	
01-Jul-14		Systematic review of the behaviours, practices and processes around complaints		To be carried out by the Chief Nurse Project Lead supported by the PMO.	
Q2 14/15		Development of a complaints procedure guidance		Started in April 2014	
06-Jul-05		The creation of a Patient Involvement Centre		In progress	
01-Jun-14		Role-play session on the complaints procedure with central and Divisional teams		Completed.	01-Jun-14
Q2 14/15		Develop training and development programmes		In progress	
Q2 14/15		Focus session on medical engagement		In progress	

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	3	1	Objective 2: Excellent Experience
Consequence	3	3	1	
Level	9	9	1	

Opened: 31-Mar-14
Closed:

Controls

- 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

Gaps in Controls

- Embedding Divisional review processes
- Pre-operative assessments

Gaps in Assurance

- Out-patient cancellation report reviewed in every Division

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
2014/15		Improving Outpatient Experience Programme (run by PMO)		In progress.	
2014/15		Improve pre-operative assessment process (recruit, expand facility, increase one stop shop		In progress.	
2014/15		Trust wide performance meetings		Q2 - strengthen review of cancellation process (in and out-patients)	
01-Sep-14		Review of booking pathway		Review of capacity of booking team to be conducted.	

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

	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
- Team ASPH continuing
- Compliance with CQC Outcome 14
- Establishment of the Temporary Workforce Programme Board in 2013 (includes 4 key workstreams:
- i. Medical workforce planning; ii. Supply; iii. Systems; iv. Governance and controls.
- Establishment of the 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.
- Consultant Conference in June 2014. Joint conference with RSCH planned.

Gaps in Controls

- Control of rostering and planning

Gaps in Assurance

- Monitoring of effectiveness of Temporary Workforce Programme Board.
- Continuing inability to retain key staff.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Oct-13		Comprehensive blended learing programme for leadership and management to be available to all staff as part of standard training programme		First modules completed in November 13. Band 5/6 commenced. Band 7/8 to commence in Oct '14	
Dec-13		Create a talent management/ sucession plan for staff		Hay work complete. Talent management as part of transition programme.	
on-going		Complete roll out of team coaching to all speciality teams across the Trust		In progress - of 32 teams, 14 are complete, and 12 are on-going.	
01-Apr-14		Consideration of establishment of other Roster user groups for Doctors.		Review and decision needed.	
2014		New Consultant Development Programme		In progress	
31-Mar-14		Medical Workforce Planning: Assessment of future Divisional workforce model.		In progress	
2014		Implementation of the Employee Promise.		Launched	Mar-14
Jul-14		Appraisal policy to be reviewed in line with AfC		Completed. To be presented for approval at TEC on 1.08.14	
Mar-14		Embed trust wide processes for financial governance, decision making and control of use and expenditure		New processes launched. On-going controls/monitoring	Mar-14
01-Mar-14		Validate authorisation, booking and invoice approval processes for temporary staff		Completed.	Mar-14

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				**2**
	Initial	**Current**	**Target**	**Strategic Objective Affected**
Likelihood	2	4	4	Objective 3: Skilled, motivated teams
Consequence	4	4	2	
Level	8	16	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 sounding board
- 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 6 KPIs
- Staff Wellness Group
- Pulse Survey (Aug '13)
- Open Communication channels (ideas wall)
- Establishment of Workforce and OD Committee from July 2013.
- Exit interviews

Gaps in Controls

Gaps in Assurance

- Appraisal rates below 95% target

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Apr-13		Implement staff experience and culture programme		Year 1 complete. Year 2 in progress	
Oct-13		Comprehensive blended learing programme for leadership and management to be available to all staff as part of standard training programme		First modules completed in November 13. Band 5/6 commenced. Band 7/8 to commence in Oct '14	
Dec '13		Junior doctors engagement		Sounding Board in place.	01-Apr-14
Jul-14		Appraisal policy to be reviewed in line with AfC		Developed. To be presented to TEC on 01.08.14 for approval.	
2014		Implementation of the Employee Promise.		In the early stages of implementation	Mar-14
2014		Implementation of Values Based Behaviours matrix		In progress	
2014		Culture Integration Programme		Director of Workforce and OD time split with 2.5 days per week dedicated to programme	
2014		Improve career development and trainign and development opportunities		In progress	
2014		Executive Directors to sponsor hot-spot areas from staff survey		In progress	

Principle Risk:

4.1 Poor alignment of the clinical workforce around the Trust's efficiency improvement programme could lead to insufficient productivity.

Director of Finance and Information

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

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

Gaps in Controls

Gaps in Assurance

- Evidence of delivery around business plans

Closure Request?

N/A

Action Plan

Due:	Action Description	Progress to Date	Date Completed
01-Dec-14	Theatre Utilisation action plan	In progress. Urology transferred to SPH. Utilisation improvement noted in Jul '14.	
01-Dec-14	Length of Stay action plan	In progress. Not yet seeing significant improvement. Hampered by capacity constraints in Q1.	
30-Jun-14	Rehab into the community. Reduction in acute rehab beds.	In progress. 20:20 report received in Jun '14. Discussions with CCG on-going.	
01-Sep-14	Consultant recruitment plan	In progress. Various posts recruited to in hot-spot areas (i.ew. Care of the Elderly, Acute physician)	

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 2014/15 contract leads to an under recovery of income and reduction in productivity.

Director of Finance and Information

	Initial	Current	Target	Strategic Objective Affected
Likelihood	4	3	2	Objective 4: Top productivity
Consequence	4	4	3	
Level	16	12	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
- 2014/15 CQUINs agreed.

Gaps in Controls

Gaps in Assurance

Closure Request?

N/a

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Jul-14		Implementation of RTT action plan		In progress. Non-admitted, incompletes, diagnostics - on trajectory and target. Admitted - off trajectory. Main issues in general surgery and T&O.	
01-Jun-14		Implementation of re-admissions action plan (clinical change programmes)		In progress. Focus on follow up calls and departmental procedures	
01-Jun-14		Implementation of Emergency Care action plan		In progress. Q1 Trust wide target achieved.	
Q2 14/15		Audit of RTT systems by Internal Audit		Included within Internal Audit Plan for Q2. Audit Committee will receive the report.	

Principle Risk:

4.3 A failure to deliver 2014/15 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

	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.
- Temporary Staffing Board
- 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
- CIP short fall at month 2. Mitiagtion schemes developed.

Gaps in Controls

Gaps in Assurance

- Delivery of recruitment plans to reduce agency spend.
- Complete medicine recovery plan.

Closure Request?

N/a

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Apr-14	Delivery of Divisional Recruitment plans		In progress	
01-Mar-15	Delivery of Cost Improvement Plans		In progress	
01-Jul-14	Complete Medicine recovery plan		In progress	

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

	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

- Confidence in CCG QIIP programmes to deliver fully the expected activity reductions
- Detail underpinning Better Care Fund

Gaps in Assurance

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
on-going		Corrective actions to be reviewed via contract monitoring meetings		Ongoing	
on-going		Sign off of enabling monies action plan and review of delivery		Sign off complete. Review - on-going.	
31-Mar-14		Sign 14/15 contract		Completed.	Apr '14
Q1 14/15		Joint work to review future financial and activity plans		In progress - 20:20 stage 1 and stage 2 report complete. Discussions over alignment continue.	
01-Jul-14		Awaiting sign off of additional 18 week backlog funding scheme proposals.		In progress. With CCG for sign off.	