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

TRUST BOARD
28 July 2016

AGENDA ITEM NUMBER	5.5	
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 21 July 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 executive team met in June to cross reference the BAF with the Corporate Business Plan 16-17 and align with the Trust's four Strategic Objectives. A more in-depth review of the BAF is planned following a strategy refresh and this was initiated at the Executive Team Away Day held on 22 June.	
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	

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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	21 July 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

In accordance with the business plan for 2016/17 and an anticipated refresh of the Trust's strategy an in-depth review of the BAF will be undertaken in due course.

A briefer review is undertaken quarterly, and the entire BAF is submitted to the Quality & Performance Committee (QPC) for evaluation. The evaluation at QPC did not take place this month.

4 Commentary on Risks

4.1 Closure and addition of risks

The Chief Operating Officer has requested to close Risk 2.4.

Closure of Risk 2.4

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

The Chief Operating Officer has requested to close this risk. It is judged no longer a risk as the Outpatient Improvement Project is now complete and incorporated in business as usual.

4.2 Extreme risks

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

Risk	Rating (Oct'15)	Rating (Jan'16)
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 outcomes.	**16**	**16**
2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patient experience.	**6**	**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**
4.3 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	**9**	**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 2.2 Actions to mitigate are detailed within the appendix, however it was deemed appropriate to increase the risk as staff awareness of the Mental Health Act and DOLs escalation criteria and process need to be more robust in relation to vulnerable groups.

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 4.3 £10.7m CIPs have been identified. Actions to underpin this are being pursued.

4.4 Top Five Risks

The Board has previously agreed that the key risks should be highlighted. At July 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.
2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patient experience
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.

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Board Assurance Framework - Summary
Version: July 2016

	Lead	Apr15 Risk Score	Jul 15 Risk Score	Oct 15 Risk Score	Jan 16 Risk Score	Apr 16 Risk Score	Jul 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	4	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	20	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	Apr15 Risk Score	Jul 15 Risk Score	Oct 15 Risk Score	Jan 16 Risk Score	Apr 16 Risk Score	Jul 16 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	CN	6	6	6	16	16	16	↔

experience.								
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	12	12	9	9	9	9	↔
2.4 Administrative delays and cancellations to appointments leading to poor patient experience. Request to close	COO	15	15	9	9	9	9	↔

	Lead	Apr15 Risk Score	Jul 15 Risk Score	Oct 15 Risk Score	Jan 16 Risk Score	Apr 16 Risk Score	Jul 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	16	12	12	12	12	↔

		Apr 15 Risk Score	Jul 15 Risk Score	Oct 15 Risk Score	Jan 16 Risk Score	Apr 16 Risk Score	Jul 16 Risk Score	
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	16	12	9	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	16	9	9	9	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	16	9	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	9	9	9	9	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	16	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	n/a	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
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 contro l - 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	Divisional quality leads leading on this familiarisation (completed in Q3 and Q4	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

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
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.
CQC Compliance monitoring framework and assessment mechanism
PMO overview of change activity within the organization

Assurance

Scorecards including Best Care dashboards
Self certification process by Trust board based on a structured assurance process
Staff and patient Survey results are monitored with action plans
Corporate Objectives are monitored quarterly
Clinical sounding board chaired by Chief Executive Officer.
Clinical and Quality Governance frameworks reviewed
Executive led CQC Quality Review Group forum for monitoring CQC framework action.

Gaps in Controls

None known

Gaps in Assurance

Junior doctor GMC Survey improved in 2014 but not at level required yet. Poor junior doctor feedback of MAU.

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	
Q1 14/15		PMO to train Divisions to deliver change projects	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.	
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.	
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 m,eeting 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:

1

Bi-weekly 4 hour performance meeting chaired by COO
Bi-weekly NWS A&E Steering Group meeting with partners
Bi-weekly Clinical Forum

CCG and ASPH clinical and operational A&E visits
Alamac supported improvements in discharge.

4 hour recovery plan shared with CCG and Monitor & NHSE (including forecast trajectory)
Whole-system action plan in place and monitored through the CCG Unscheduled Care

Assurance

Deputy Divisional Directors in post to provide clinical leadership to the programme of transformation
ED Highlight Report with progress, KPIs and performance measures
Trust Performance Report monitors quality and performace indicators at divisional and corporate levels
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 meetings
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

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 Completed
Complete	Front Door Reconfiguration - delivery of Urgent Care Centre at SPH		Contract was awarded to Greenbrook in September. Detailed work has commenced to model pathways with implemention planned for September 2016.	01-Mar-16
Complete	Hospital Patient Flow - Implementing consistent agreed core processes (RAT, stream etc)		RAT-ing is in place (2-9pm) with patients being assessed, referred to CT, given fluids/ antibiotics, and referred to the specialist teams more rapidly.	01-Sep-16
Complete	Reduce length of stay to improve bed availability - implementation of consultant-of-the-week model		Ongoing work and consultation with GIM Consultants and Junior Doctors to implement a Consultant continuity model with the Acute Physicians on MAU/MSSU	21-Dec-16
Complete	Reduce delayed Transfer of Care (DTOC) - implement weekly reporting of DTOCs (including % of occupied bed days (OBD)		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
30.4.16	Establish an ambulatory emergency care unit		Working with the CCG and clinicians to develop pathways. Clear challenge to support the unit with a sustainable workforce.	
30.9.16	Develop the medical model of care including consultant continuity and Gastro/OPSSU ward moves to ensure the most efficient use of bed base. Review hospital bed capacity.		Draft plans to provide continuity in some specialities in place with clear challenges to implementation. Plans to implement the in place with a view to complete ward moves end of April. Review fo hospital bed capacity in progress.	
30.5.16	Establish and embed a philosophy of care and core clinical standards		Working in partnership with clinicians across divisions to develop clinical standards	
30.8.16	Establish new junior doctor continuity rota and process to fill gaps		Cross divisional work on staffing model started. Dependency on co-location of HDU/ITU in December. Working with HR on process to improve fill rates for junior doctor gaps.	
31.12.16	System wide project underway to implement Discharge to Assess programme to improve patient flow		Scheduled to start in September. Dependent on reduction in length of stay in community hospitals and the effectivemness of the locality hub	

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		**Assurance**
i.	Annual business planning process confirms establishment	Divisional budgets and establishments. Staff turnover rates monitored at PRM at divisional and speciality level, and at Trust Board level through Board scorecard. Safer staffing Levels set and reviewed and nursing acuity tool developed.
ii.	Business Planning process and targets set for 2016/17	Divisional Performance Review Meetings to review appointment to establishment & forward plan
iii.	Weekly vacancy Control panel & weekly rostering meeting	Workforce reports supplied to Divisions weekly and monthly
iv.	Centralised medical staffing booking system (Asclepius)	Agency usage monitored at Finance Committee, WOD Committtee, weekly rostering meeting for nursing and Division Review meetings and actions agreed monthly
v.	Centralised change programmes led by an Executive Director	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
vi.	Safer Staffing Templates	Safer Staffing Levels report presented to Board monthly.
vii.	Compliance with CQC Outcome 13	Nursing Acuity Tools deployed . Safer staffing templates being used to validate staffing levels for other non nursing staff groups every 6 months.
viii.	Regular acuity establishment reviews	

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		Completed	15/16
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	
May-15		Implement an HRMC-approved VAT savings scheme for medical agency bookngs		Scheme implemented in May 15 and savings monitored monthly against target.	Completed
Mar-17		Monthly workforce assurance report to both Finance and WOD Committees to assess financial impact of workforce risks and action plans to address risks		Report developed which includes N&M, and Consultant medical staff, and being extended to other staff groups. Board Committees have noted the value of the reports	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	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		30 successful applicants, training commenced December 2015	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	
	1.5			

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, implementing and monitoring of the plans promotes local ownership.
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 Board.

Assurance

Formalised governance structure for monitoring

High level action plan on compliance actions is being reviewed monthly via Quality and Performance Committee (QPC), with summary monthly update to Trust Board

Detailed action plan on improvement actions is reviewed at CQC Quality Review Group monthly
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
April 2015		Implement monthly monitoring to IGAC and Trust Board		First reports to be submitted for month of April 2015	Complete Apr 2015
June 2015		Agree arrangements for monitoring of progress with CQC in meeting of June 2015		Meeting scheduled for 2nd week in June 2015	Complete Jun 2015
TBC		Formulate detailed improvement action plan for non compliance actions		Commenced, will set timescale and progress via CQC Quality Review Group	
30-Jun-15		Review risk in Oct 2015 - Assistant Director Regulation and Improvement		As at March 2016 there were 8 of 10 compliance actions green rated, with a firm plan for the 1 amber and 1 red action. The should actions are being progressed also, but priority has been given to the mandatory commpliance actions.	Action reviewed March 2016
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 significant area for this is the Emergency Care Pathway. The controls and assurance mechnanisms above have been refresed to account for this changed focus of the risk.		Monitoring for the revised risk has been outlined as above.	Complete June 2016

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

- Direct feedback being implemented for clinicians with ability to respond to comments Monthly review to take place of clinical uptake
- Performance is monitored against the national average for acute trusts
- Monthly reporting - monitor response and satisfaction rates across all areas of hospital
- Improvement plans and initiatives, plus any concerns in feedback are 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 consistent and high remended scores for Inpatients, Outpatients, and Maternity.
- Review at speciality performance meetings, Quality Governance Committee and QPAC. QEWS dashboard in place highlighting FFT scores.

Gaps in Controls

- Link between operational pressures, untoward incidents, complaints and patient feedback.

Gaps in Assurance

- ED recommended score is not below national average

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Completed
01-Apr-16		Roll out of new provider to encompass direct clinical feedback		A staggered roll out has commenced beginning with inpatents. Outpatients and A&E to follow in May 16.	
Feb-16		Use patient feedback as a unifying operational & quality indicator. Purchase "I want great care" services		New provider contract secured from 1 April 2016	

Principle Risk:

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

Chief Nurse

Link to Trust Risk Register N/A

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	4	1	Objective 2: Excellent Experience
Consequence	2	4	2	
Level	6	16	2	

Opened: 31-Mar-14
Closed:

Controls

- Mental Health Act policies, processes and staff awareness of these is to be reviewed following the TIAA audit findings in October 2015 which identified that only limited assurance could be placed in the area of Safeguarding - Mental Health overall.
-
- Health & Safety Manager is facilitator and Adult Safeguarding lead Nurse is nominated lead for Prevent.
- Inclusion of patients vulnerability factors in business planning was included in the Compliance in Practice Audit from July 2015.
-
- 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 Inspection in March 2015 - action plan in place and progressing. Internal Audit Report from TIAA on Safeguarding - Mental Health was issued in October 2015 with recommendations to be progressed.
-
  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
- Increased DOLS referrals.
- Level 3 training commenced.
- Administration support recruited.
-

Gaps in Controls

- Specialised audit pertaining to Safeguarding Adults focussing particularly in regard to capacity assessment and best interest decisions. The use of DoLs and application needs to be more robust.

Gaps in Assurance

- Training package under review to flag to staff about lasting power of attorney and court of protection. Specific session being planned on MCA and legal aspects being planned. Safeguarding training strategy for adults and children being reviewed to reflect Surrey Adult Board competencies and progress level 3 training for nominated individuals as part of strategic development when new safeguarding team is progressed. Action plan in place to address DOLS and MCA issues. Compliance: Adult safeguarding 76.6%, MCA and DOLS 95.2% and Child safeguarding 79.0%.

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. LD awareness day planned for June.	
Jul-15		PREVENT training - Controlled Holding for patients needs to be introduced. Need to agree funding and identify appropriate staff.		Still awaiting response from training department about the introduction of PREVENT training on mandatory update sessions. Restraint policy has been completed and awaiting ratification, training will be introduced after this has been ratified, plan to do joint training with RSCH no longer an option.	
Dec-15		DOLs/MCA - monitor the actions from the external review of the service.		Still awaiting response from training department about the introduction of separate session on MCA, DOLS and MHA training on mandatory update sessions.	
Feb-16		Attempt to secure funding from CCG to appoint 0.4 WTE Learning Disability Nurse		In progress. LD liaison nurse has returned from sick leave.	
Jan-16		Increase awareness of Mental Health Act and DOLs escalation criteria and process		In progress. Still awaiting response from training department about the introduction of separate session on MCA, DOLS and MHA training on mandatory update sessions.	
Feb-16		Reviewing TOR & membership for Safeguarding Adult Committee		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

Link to Trust Risk Register N/A

	Initial	Current	Target
Likelihood	2	3	1
Consequence	3	3	2
Level	6	9	2

Strategic Objective Affected

Objective 2: Excellent Experience

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.
- Updated complaints policy.
- Target set of 10% or less follow up complaints per month
- Chief Nurse review established
- Regular Trust Complaints Panel - chaired by Chief Nurse or Divisional Chief Nurse
- New datix web system for managing complaints from 20.4.15
- Quarterly complaint reviews of investigation and actions undertaken and shared with CCG by Head of Patient Experience

Assurance

Achievement of less than 10% in follow up complaints ongoing

- Duty of candour and identification of possible SIRI is discussed at Chief Nurse Complaints Review Panel.
- New datix web system to ensure better understanding of themes and trends and further breakdown of data
- Timeliness measured as successfully achieving an agreed date with complainant. Monitored monthly and reported in quality report. Move to assurance column

Gaps in Controls

Gaps in Assurance

- Continuation of certain themes e.g issues at discharge. Requires further steps in root cause analysis, action and test of effectiveness to be undertaken.
- A robust complaints action tracker.
- Irregular thematic review of complaints using Datix system.

Closure Request?

Action Plan

Due:		2		Progress to Date	Date Completed
Q3 16/17		Roll out of root cause analysis methodology in complex complaint handling, with test of effectiveness in place		Project initiated to pilot methodology in complaints specific to discharge	

Principle Risk:

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

Chief Operating Officer

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

Open 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
Reports to Trust Board & Divisional Performance reviews. Council of Governors

Gaps in Controls

Gaps in Assurance

Clashing priorities with e-MR project

Closure Request? It is judged the Outpatient Improvement Project is now complete and incorporated in business as usual.

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Mar-16		Workstream 1 - Referral Management Process: Working towards electronic referrals from GP's to App Centre only.		83% objectives achieved to date. Ongoing. Working with CCG and GP liaison manager. Number of email referrals increased to circa 600/week from 400 in February.	Ongoing.
31-Mar-16		Workstream 2 - Appointment Booking Processes: Implement changes to scanning and referral tracking system.		80% of objectives achieved to date. Ongoing.	Completed 14.4.16
31-Mar-16		Workstream 3 - Clinic Capacity: Implement a transparent clinic room booking system		Demos undertaken. Business case written - needs to be transferred onto IT template. Further demo to IT project lead scheduled for February. Paper spreadsheet system being used, as requested by Director of Finance.	Completed 11.4.16
31-Mar-16		Workstream 4 -Patient Experience: Continuing with late clinic audits.		53% of objectives achieved to date. Ongoing. Percentage of clinics 0-15 mins late up to 56% in March from 38% in July across both sites.	Ongoing.
Feb-16		Workstream 5 - Training: Set up bi-annual refresher training schedules		90% of obectives achieved to date. Ongoing.	RTT on line training package being created by Julian Ruse/Julie Morland/Jason Lane
01-Jan-16		Workstream 6 - Clinic cancellations - avoidable cancellations work progressing for ADO's sign off.		Ongoing. No improvement to date.	
Mar-16		Workstream 7 - Information: Service Managers working with Business Development to update Directory of Services. GP Education.		50% of objectives achieved to date. Ongoing.	
Mar-16		Workstream 8 - Appointment/clinic outcome letters: Moving towards all Services using Synertec to issue appointment letters.		75% of objectives achieved to date. Progress was unfortunately delayed due to early retirement of appointment centre manager. Due to complete by end of March 2016.	Completed 15.4.16
Mar-16		Wait from referral to first booking and referral to first appointment not progressing as well as desired, although subject to specialty engagement, improvements and resilience to referral surge.		Ongoing but showing improvement, subject to capacity in some areas and time taken to triage referrals by clinicians.	
Apr-16		The scope of the OPD Project is being reviewed to align more closley to Better Care Better Health.		Ongoing	For 2016/2017 programme

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

i	Divisional budgets and establishments. Staff turnover rates monitored at PRM at divisional and speciality level, and at Trust Board level through Board scorecard.
ii	Vacancy fill rate reviewed at isional and speciality level, and at Trust Board level through Board scorecard.
iii	
iv	Specific action plans in place to identify and address areas with retention difficulties
v	
vi	Numbers of staff accessing education & development and in particular monitoring uptake via the Study Leave & Finance Committee.
vii	Numbers of staff attending leadership & management training and in particular the new Manager's Toolkit training.
viii	Employment policies available on Trustnet and reviewed with EPF & TEC
ix	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.	Ongoing
2016/17		Development of pay incentives for nurses in targeted areas.		Developed and implemented.	Ongoing review
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 planned for Sept 16		1. Corporate branding and recruitment material drafted, toolkit being developed for 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. 4. Trust Staff Benefits Officer appointed and commenced with first few months detailed workplan in place.	

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: 01-Apr-12
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 TEC
ii. Staff attitude survey and patient survey results reported to Trust Board, TEC (annually). Improved NSS staff survey results 2014
iii. On-going improvement including latest results in Q1 2016/17. Favourable ranking in comparison with sector acute trusts.
iv. Feedback from CEO Sounding Board actively used to improve employment aspects and promote retention.
v. Recruitment, appriasal and reward aligned with core values and associated behaviour.
vi. Numbers of people being thanked and recognised via the WOW award scheme
vii. Number of people accessing management development and leadership programmes.

Gaps in Controls

Gaps in Assurance

Appraisal rates below 90% target
GMC survey results in 2015 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) introduction of a range of physical activities for staff, b) Improving access to physiotherapy services for staff, c) Introducing a range of mental health initiatives for staff.		Detailed action plan in place and submitted to CCG	Ongoing
Mar-17		Revise and roll out 360 appraisal		Review of current system in progress. New tool developed and currently being piloted	Ongoing
Mar-17		Develop Team diagnostic and interventions toolkit and train HRBP to use with teams in difficulty		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		Piloted core people management skills training and officially launch programme in July 16	Ongoing
Sep-16		Staff survey results and action plan		Complete a 'You said, We did' campaign locally within the divisions	Ongoing
Oct-16		Review and update recognition scheme, linked to VBBs, incentivises and highlighting role models. Review and update "thank you" scheme which serves as a mechanism for conveying thanks.		Review in progress	Ongoing
Oct-16		Develop and promote ASPH leadership model with clear emphasis on expectations on leaders in relation to recognition and motivation		Model developed in draft format	Ongoing
Oct-16		Improve Staff Benefits offer – development of an app, annual staff benefits week planned for Sept 16, showcasing local and national discounts		Trust Staff Benefits Officer appointed and commenced with first few months detailed workplan in place	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	Trust 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. Care of the Elderly, Acute physicians) but key posts remain unfilled.	
31-May-16	Agency reduction plan updated.	NHS wide initiatives under review. Implementation in stages from 1 Oct.	

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
- 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
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		MSK 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	4	4	
Level	16	16	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

- 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

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. 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	4	2	Objective 4: Top productivity
Consequence	4	3	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

- Contract affordability to commissioner's contract sign-off/arbitration processes.
- Confidence in QIIP programmes to deliver fully the expected activity reductions

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
30-Jul-16		Contracts to be signed off		Specialist Commissioners	Complete
				Local CCG's detailed contract still being finalised.	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

- Confidence in existing whole system plan.
- Potential crowding out of elective activity
- Service disinvestments
- Rehab action plan to transfer Trust bedded provision to the community

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 monetary and delivery meetings held.	

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			
Consequence			
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 September 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	