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

TRUST BOARD
30th October 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.
The Board is asked to:	Review, discuss and approve the Board Assurance Framework.
Submitted by:	George Roe, Head of Corporate Affairs
Date:	23rd October 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 was reviewed and discussed at the Integrated Governance and Assurance Committee on 21st October. The risks under SO4 (Top Productivity) were also reviewed at the Finance Committee at its meeting on 23rd October.

4 Commentary on Risks

4.1 Closure and addition of risks

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

One new risk has been added; SO4.5:

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.

The risk of the proposed merger with RSCH and the impending CQC visit in December deflecting focus from day-to-day business has been incorporated within SO1.2 (*If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care*) with the resultant rating Increasing from 12 to 20 In this quarter.

4.2 Extreme risks

At October there are seven extreme risks compared to four at July.

Risk	Rating (Jul '14)	Rating (Oct '14)
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.	**12**	**20**
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**
2.4 Administrative delays and cancellations to appointments leading to poor patient experience.	**9**	**15**
3.1 If the Trust was unable to recruit and retain high calibre staff.	**16**	**16**
3.2 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	**16**	**16**
4.3 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 in productivity.	**16**	**16**
4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates.	**n/a**	**16**

Risk 1.2 There are significant "divergent and multiple" priorities at present due to the operational pressures in the hospital which is not expected to reduce greatly with the onset of winter, the impending CQC visit and the proposed merger with RSCH. As such this risk rating has been increased accordingly.

Risk 2.4 This risk has been increased as the likelihood factor of the rating has increased to '5' (almost certain) with a resultant overall rating of '15'.

Risk 4.5 New risk added following discussion at Finance Committee. Due to the likelihood and impact of increased demand this risk is rated extreme.

4.3 Top Five Risks

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

1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.
1.6 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and quality of care outcomes.
3.1 If the Trust was unable to recruit and retain high calibre staff through developing leadership potential.
3.2 If individuals and teams were not values-driven or motivated, resulting in poor patient care experience and ineffective team working.

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.

5 Recommendation

IGAC is asked to discuss and challenge the Board Assurance Framework prior to presentation at the Trust Board.

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

Board Assurance Framework - Summary
Version: October 2014

	Lead	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	Oct 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	8	8	8	8	8	**8**	↔
1.2 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.	CN	12	12	12	12	12	**20**	↑
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	20	20	16	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	12	12	12	12	12	**12**	↔

	Lead	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	Oct 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	8	8	8	8	8	**8**	↔
2.2 Lack of awareness of key issues relating to vulnerable groups may lead to compassionless care and poor patient experience.	CN	n/a	n/a	n/a	6	9	**6**	↓
2.3 If the Trust fails to adopt the culture of a listening, kind and compassionate organisation in dealing with complaints then our patients, within the course of their care and treatment, will have a poor experience.	CN	n/a	n/a	n/a	12	12	**12**	↔
2.4 Administrative delays and cancellations to appointments leading to poor patient experience.	DCE	n/a	n/a	n/a	9	9	**15**	↑

	Lead	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	Oct 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	12	12	16	16	16	**16**	↔
3.2. If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	DoW	16	16	16	16	16	**16**	↔

	Lead	April 13 Risk Score	July 13 Risk Score	Nov 13 Risk Score	Mar 14 Risk Score	Jul 14 Risk Score	Oct 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.	DoFI	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.	DoFI	16	16	16	12	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	16	16	16	16	16	**16**	↔
4.4 Financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or to enforcement of contract levers more aggressively than expected leading to reduced income and inability to achieve top productivity.	DoFI	12	12	12	9	9	**9**	↔
4.5 Excess demand could increase financial pressure due to emergency income on over-performance being received at marginal tariffs whilst additional staffing is paid at premium rates.	DoFI	n/a	n/a	n/a	n/a	n/a	**16**	*n/a*

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
DCE	Deputy Chief Executive
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 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

Gaps in Assurance

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 - in progress	

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	5	2	Objective 1: Best Outcomes
Consequence	4	4	4	
Level	12	20	8	

Opened: 01-Apr-11
Closed:

Controls

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

Assurance

- Scorecards including Best Care dashboards
- 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.
- Merger: Steering Group and Strategic Oversight Group in place
- CQC: Compliance in practice audits in 2014 identified high level of CQC compliance

Gaps in Controls

- None known

Gaps in Assurance

- Junior doctor GMC Survey improved in 2014 but not at level required yet.
- CQC: new inspection regime. Possible insufficient understanding of requirements
- Merger: CMA submission result unknown.

Closure Request?

n/a

Action Plan

Due:		Action Description	Progress to Date	Date Completed
Ongoing		Test all new initiatives against two core SOs (Emergency pathway and financial balance)	On going	
On going		Monitor staff comments on The Wall, other forum of communication	On going	
1-Jan-15		Hold a Schwartz Round on related subject	Not yet arranged.	
Q1 14/15		PMO to train Divisions to deliver change projects	Planned for Q2 14/15	
Q2 14/15		CQC Inspection - establish delivery team	Completed. Interim AD of Regulatory Assurance in place plus Interim CQC Comms lead.	30/09/2014
Q2 14/15		ASPH/RSCH Merger - backfill arrangements for workstream leads	Backfill for Director of Workforce Transformation and Medical Director in place. PMO set up.	Q2 14/15

Principle Risk:

1.3 If there is poor capacity and flow in the emergency pathway 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 Gynae assessment unit, SAU changes
- Development of 14/15 Winter Plan

Assurance

- Trust signed off by ECIST November 2012. Positive feedback from visits in Jul 13 and Jan 14.
- Compliance with trustwide 4 Hour standard (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
- SIRI levels not increasing
- Discharge complaints decreasing

Gaps in Controls

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

Gaps in Assurance

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

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, full completion originally due Q1 2014. Now due December 2014.	
01-Jul-14	Develop 14/15 winter plan		Complete.	Q2 14/15
Mar-15	14/15 funding to increase Consultant cover at the weekends		In progress	
Mar-15	Development of Therapies Improvement Programme		Therapies Lead now appointed. Programme in progress	
Apr-14	Recruitment of middle grade doctors		Appointments made.	Q2 14/15
Jun-14	Recruit further two A&E Consultants		In progress	

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

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
- Safer Staffing Levels report presented to Board monthly.
- Nursing Acuity Tool developed.

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 use and expenditure		In progress	
01-Mar-14		Validate authorisation, booking and invoice approval processes for temporary staff		In progress	

Principle Risk:

2.1 The Friends and Family Test (FFT) 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

Gaps in Controls

- None known

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
- Inpatients FFT score was 80 in July and August above the target of 73. The response rate rose from 32% in July to 36% in August.
- August FFT score in A&E was 47 which is below the target of 55 but higher than the YTD average of 45 and the low of 38 in July. Response rate increased month on month in June, July and August to 18%.
- 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.
- QEWS dashboard in place highlighting F&F scores.
- Review at speciality performance meetings, Quality Governance Committee and IGAC.

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		Outpatient Department roll out completed in Oct '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 the Head of Patient Experience. Plan to roll out the text service in maternity shortly.	

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	2	1	Objective 2: Excellent Experience
Consequence	2	3	2	
Level	6	6	2	

Opened: 31-Mar-14
Closed:

Controls

- Policies have been reviewed, updated and ratified pertaining to all Adult Safeguarding.
- 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.
- Deputy Medical Director acting a Lead Safeguarding Adults Physician
- Safeguarding Lead Nurse appointment

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.
- Increased DOLs referrals
- Level 3 training commenced.

Gaps in Controls

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

Gaps in Assurance

- No evidence in-place to suggest Court of Protection to staff. No safeguarding competency framework in-place (however Trust will adopt Surrey Adult Board competencies and progress level 3 training for nominated individuals as part of strategic development when new safeguarding team is progressed). In regards to capacity assessments education and process in need of more robust management.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
20-Mar-14		Recruitment of a safeguarding team in-progress		Lead Nurse appointed.	Oct 14
20-Mar-14		Head of Nursing & Midwifery CPD will progress level 3 training and review competences in the next quarter.		Level 3 training prrogressed.	

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.
- Chief Nurse review estblished
- Patient Experience Manager in post, Divisional governance appointments made

Assurance

- Reduction in complaints in August (48 versus 63 in July)
- Timeliness of response is above 90%.

Gaps in Controls

- Sufficient substantive staff

Gaps in Assurance

- Not yet at 95% target level of complaint responses (August 90.7%)
- Number of complaints in 14/15 remains above 13/14 average.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
04-Aug-14		Substantive recruitment		Not yet at full establishments	
31-Mar-15		Systematic review of the behaviours, practices and processes around complaints		To be carried out by the Chief Nurse Project Lead supported by the PMO.	
31-Mar-15		Development of a complaints procedure guidance		Commenced. Connected to Chief Nurse Project.	
06-Jul-14		The creation of a Patient Involvement Centre		Completed.	01-Jul-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	5	1	Objective 2: Excellent Experience
Consequence	3	3	1	
Level	9	15	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 - Programme has been redefined in Q2 14/15	
2014/15		Improve pre-operative assessment process (recruit, expand facility, increase one stop shop clinics)		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.	
12-Nov-14		Outpatient workshop		Planned for 12th November	
2014/15		Reduction in cancellation of outpatient appointments with <6 weeks notice		Work progressing with the Divisional teams	

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
- ADN bi-weekly Recruitment and Retention Group
- Weekly review of temporary staff spend
- 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.

Gaps in Controls

- Control of rostering and planning

Gaps in Assurance

- Continuing inability to retain key staff.

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
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 May 2014. Band 5/6 commenced. Band 7/8 commenced in Oct '14	Oct 14
Dec-13		Create a talent management/ sucession plan for Medical staff		Hay work complete. Talent management as part of transition programme.	Q2 14/15
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 not to pursue on cost benefit analysis. Other modules being considered.	Jul 14
2014		New Consultant Development Programme		Implemented	2014
31-Mar-14		Medical Workforce Planning: Assessment of future Divisional workforce model.		In progress - on-going, part of 2015/16 business plan	
Jul-14		Appraisal policy to be reviewed in line with AfC		Developed and approved at TEC.	Aug 14
2014/15		Recruitment plan for nurses (UK and overseas)		In progress. Open days taken place with success. Recruitment for nurses in Portugal has also been successful.	
2014/15		Nurse rotational programme for Band 5/6 to be developed		In progress	
Nov-14		Development of Corproate Framework for hard to recruit to areas		In progress	
Nov-14		Development of pay incentives for nurses in targeted areas.		In progress	

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
- Exit interviews
- Open Communication channels (ideas wall)
- Establishment of Workforce and OD Committee from July 2013.
- Preliminary results for Staff Friends and Family highlight improvement

Gaps in Controls

-

Gaps in Assurance

- Appraisal rates now well below 95% target
- Staff Friends and Family results for "place to work" require improvement.
- GMC survey results in 2014 identify improvements needed.

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	Q2 14/15
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 May 14. Band 5/6 commenced. Band 7/8 commenced in Oct '14.	Oct 14
Jul-14		Appraisal policy to be reviewed in line with AfC		Developed and approved at TEC.	Aug 14
2014		Implementation of the Employee Promise.		Implemented	Mar-14
2014		Implementation of Values Based Behaviours matrix		Implemented	Q2 14/15
2014		Culture Integration Programme		Director of Workforce and OD time split with 2.5 days per week dedicated to programme	Q2 14/15
2014		Improve career development and training and development opportunities		In progress (aided through new Appraisal Policy)	
2014		Executive Directors to sponsor hot-spot areas from staff survey		Progressed through Speciality and Divisional action plans.	Q2 14/15
Sep-14		Culture diagnostic launched in September 2014		In progress	
Sep-14		CEO Chat Room launched		Commenced	
Sep-14		CEO Consultant one on one meetings initiated		Commenced	

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. Utilisation improvement noted from Jul '14. End of September Urology transferred to SPH. All other day surgery transferred to AH. Some deterioation expected whilst moves are embedded.	
01-Dec-14	Length of Stay action plan	In progress. Not yet seeing significant improvement. Hampered by capacity constraints in Q1 and Q2. Escalation areas now fully open.	
30-Jun-14	Rehab into the community. Reduction in acute rehab beds.	In progress. 20:20 report received in Jun '14. Discussions with CCG have resulted in plan to transfer patients by the end of December. However, plan remains high risk given activity pressures across the system.	
01-Sep-14	Consultant recruitment plan	In progress. Various posts recruited to in hot-spot areas (i.e. Care of the Elderly, Acute physicians) but key posts still unfilled.	

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, admitted target achieved in September '14.	
01-Jun-14		Implementation of re-admissions action plan (clinical change programmes)		In progress. Focus on follow up calls and departmental procedures with improvements noted.	
01-Jun-14		Implementation of Emergency Care action plan		In progress. Q1 and Q2 Trust wide target achieved however Q3 remains challenging.	
Q2 14/15		Audit of RTT systems by Internal Audit		Included within Internal Audit Plan for Q2. Audit Committee will receive the report in due course.	
2014/15		CQUIN delivery plan		Monitored monthly - in progress	

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.
- 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 to bridge gap.

Gaps in Controls

Gaps in Assurance

- Delivery of recruitment plans to reduce agency spend.
- CIP mitigation schemes not delivering as required
- Complete Medicine and TASCC 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 - workforce plan for quarters three and four to be updated.	
01-Mar-15	Delivery of Cost Improvement Plans		In progress - £13.7m identified. Actions to further increase this are being pursued.	
01-Jul-14	Complete Medicine recovery plan		In progress - challenging due to on-going demand, capacity and temporary staffing requirement.	
31-Oct-14	Complete TASCC recovery plan		In progress	
31-Oct-14	Finance Recovery Task Force to be established		In progress	
23-Oct-14	Finance Committee to undertake deep dive on Q2 performance		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 - Q1 expected to be signed off in Oct.	
on-going		Sign off of enabling monies action plan and review of delivery		Winter funding discussions on-going.	
Q1 14/15		Joint work to review future financial and activity plans		Completed - 20:20 stage 1 and stage 2 report complete. Discussions over alignment will be finalsied at month six.	
01-Jul-14		Awaiting sign off of additional 18 week backlog funding scheme proposals.		Signed off.	30-Sep-14
15/16		Better Care Fund impacts in 2015/16 and 2016/17 to be determined.		Financial appraisal completed. Impact being factored into the Long Term Financial Model (Nov '14)	

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

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

Opened: 30-Oct-14
Closed:

Controls

- Monthly monitoring on contract activity, QIIP
- Planned programme of LOS reduction
- Opening of escalation beds in Sept '14
- Health economy winter plan
- Embryonic Rehab action plan to transfer Ashford beds to the community

Assurance

- Limited impact from health system on reducing demand

Gaps in Controls

Gaps in Assurance

- Lack of confidence in existing whole system plan.

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
14/15		System wide provider response discussions being co-ordinated by Trust and CCG CEOs		In progress.	