ANNUAL OBJECTIVE			
AO1: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care			
Responsible Executive:	Chief Nurse and Director of Quality and Operations	**Responsible Committee:**	Quality Committee

SUB- OBJECTIVE
Improve Patient Experience by Putting Patients First - (1) Improving the care of clients who raise concerns or complaints and increase the number of compliments received. (2) Listening and Learning from patient experience; and (3) Improving the essential aspects of nursing care focussing on pain management, nutrition and hydration.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
AMBER	**AMBER**	**Yellow**

LINKS	
CRR	**CRR04**
SO	**SO1**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Achieving CQUINS	Improving the effectiveness of our services	Poor patient experience / less effective services

Initial risk score (CxL) *Jul 2009*	Quarter 1 score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	
4x4 = 16	**3x3 = 9**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Dedicated Programme Manager for CQUINs with clear objectives	Medium (2)
Working groups for the pathways within the CQUIN programme.	Low (1)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Reporting line to Associate Chief Nurse	Low (1)
Reporting structure for each group with the PMO as the safety net to pick up issues to CQUINs	Low (1)

Performance monitoring published monthly.	High (3)
Clinical Quality & Patient Safety Board report for external review	High (3)
Framework in place to achieve CQUINs	Medium (2)
Quarterly reporting to the Divisional Clinical Governance Groups, as well as engagement with other staff groups to increase staff awareness, with the objective of meeting each of the CQUINS targets	Low (1)

Data validated through Information Team and reported to CPMT / FIC / Board to show progress to achieving – actual performance figures / agreed standards	Medium (2)
Quarterly to CCG Quality Meeting – performance reporting	Medium (2)
Minutes from Working Groups	Low (1)
Performance reporting monthly to Finance Teams	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Increase the % of positive feedback received by the Complaints team by 10%	**GREEN**			
Meet the national net promoter scores for the Friends and Family Test	**YELLOW**			
Reduce the number of PHSO referrals upheld by 10% against 2013/14	**YELLOW**			
Maintain the 85% standard for responding to complaints	**YELLOW**			
Reduce the number of complaints in relation to pain management, nutrition and hydration by 10%; our inpatients experience of Pain should be over 85% across the Trust	**GREEN**			

COMMENTARY

Risk: The CQUIN risk, although not directly relevant to the performance measures, is relevant as it is about ensuring patients have a good experience and effective treatment. No other risks have yet been identified.
Assurance: Assurance around the CQUIN risk is Amber based on the number of assurances and the lack of positive actuals which is due to this being the first quarters report, this should improve over the next quarter.
Performance: "The Trust received 17,076 compliments in 2013-14 and 6,609 in Quarter 1 of 2014-15. The Trust is on target to achieve a significant increase in the % of compliments for 2014-15, well above the 10% target. The wards and Maternity are achieving the national average NPS score but the A+Es are below the national average. Improvements are forecast.

Only 20 of the 33 PHSO referrals made in 2013/14 are closed and 8 (40%) were upheld, The remaining 13 from 2013/14 remain open and including the 6 referrals made in Q1 a total of 22 remain open (3 from 2012/13 remain open)

The % of complaints responded to within the agreed timescale in 2013-14 was 88% (Target 85%). The % of complaints responded to within the agreed timescale in Quarter 1 of 2014-15 is 82%. This metric has not therefore been achieved in this quarter, though considerable work is being undertaken with the Divisions to reduce the response times. Efforts to respond very quickly to informal complaints, where a response can be provided within 10 working days, have improved.

"The Trust received a total of 60 complaints regarding either the lack of/inappropriate pain management or nutrition during 2013-14. The Trust received a total of 13 complaints regarding the same during Quarter 1 of 2014-15. The target is to reduce the number of complaints regarding pain management and nutrition by 10% in 2014-15. The Trust is on target to achieve a 10% reduction in 2014-15"

Forecast: Sustained improvement is forecast for the % positive feedback received.
Improvements are forecast around the net promotor scores.
Reduction of upheld PHSO referrals will be seen as a result of improvements in thoroughness and appropriateness of responses.
Considerable work is being undertaken with the Divisions to reduce the complaint response times. Efforts to respond very quickly to informal complaints, where a response can be provided within 10 working days, have improved.
Sustained improvement is forecast in the area around complaints relating to pain management, nutrition and hydration.

ANNUAL OBJECTIVE			
AO1: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care			
Responsible Executive:	Chief Nurse	**Responsible Committee:**	Quality Committee

SUB- OBJECTIVE
Improve patient safety and reduce harm

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
AMBER	**AMBER**	**RED**

LINKS	
CRR	
SO	

Risk to Annual Objective		
Cause (due to):	**Risk that:**	**Effect (resulting in):**
Ability to maintain continuous improvement in the reduction of HCAI's in the presence of existing low rates	The Trust will not be able to meet the target set by the Department of Health.	Reputational risk which may make patients unnecessarily anxious.

Initial risk score (CxL) *Sep 2008*	**Quarter 1 score (CxL)**	**Quarter [ ] score (CxL)**	**Target risk score (CxL)** *Apr 2015*	
4x4 = 16	**3x3 = 9**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Detailed annual program of infection prevention and control in place (Framework for delivery)	Medium (2)
Robust systems in place to enable the early identification and decolonisation of positive patients for MRSA	Medium (2)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Program approved by the Infection Control Committee / Clinical Management Board / Patient Safety Committee; Annual Report to the Trust Board, detailing work undertaken during the previous year	Low (1)
The Infection Prevention and Control Annual Programme and Annual Report	Low (1)

Full Post Infection Review (PIR) for all cases of MRSA bacteraemia within 14 working working days to ensure lessons are learned and improvements to practice made.	Medium (2)	All cases included in the monthly Infection Prevention and Control Report, the Clinical and Quality Patient Safety Report, and reported at the bi-monthly Infection Control Committee	Medium (2)
Full Root Cause Analysis (RCA) for all cases of post-72 hour C.difficile infection	Medium (2)	All cases included in the monthly Infection Prevention and Control Report, the Clinical and Quality Patient Safety Report, and reported at the bi-monthly Infection Control Committee	Medium (2)
Performance dashboard	High (3)	Clinical Management Board review performance against plan and action plans to address	Medium (2)
Anti-microbial pharmacists on all sites with specific duties	Low (1)	Antimicrobial Stewardship Committee	Low (1)
Enhanced surveillance for wards that do not meet the standards (IP&C "Special Measures").	High (3)	Monitored and escalated by Infection Prevention Control Committee to Clinical Management Board to take appropriate action	Medium (2)
Divisional IPC Key Performance Indicators / Divisional MRSA / C.difficile trajectories in place	Medium (2)	Clinical Quality and Patient Safety report to Clinical Management Board, Finance and Investment Committee and then Board – performance monitoring	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress
Auditing against anti-microbial policy	DIPC	Apr 2015	A	
6 month trial of hydrogen peroxide vapour	DIPC	Aug 2014	C	
RCA for all MSSA and e-Coli	DIPC	July 2014	A	
Implementation of HOUDINI	DIPC	July 2014	C	
Urinary Catheter Passport	DIPC	Tbc	C	

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Reduction in HSMR of 2 against validated 2013/14 year end position.	**n/a**			
Increase compliance against the Royal College of Emergency Surgeons standards for septicaemia on all three sites to xxx (6 monthly audits)	**n/a**			
Reduce the recorded harm rate by having 10% less harm than in 2013/14 (year-end)	**n/a**			

Achieve the improvement trajectory for C-difficile and no more than 5 avoidable MRSA cases. Undertake RCA's for eColi to enable benchmarking and an action plan to reduce for 2015/16	**RED**			
Reduce the number of falls resulting in moderate or more harm by 25% from 2013/14 year end position	**GREEN**			
Reduce the number of avoidable hospital acquired Category 2,3 & 4 Pressure ulcers by 25%	**GREEN**			
Increase our achievement of openness and transparency, 'duty of candour' by contacting and discussing the incident with the patient / patient family where moderate+ harm has occurred	**GREEN**			

COMMENTARY

Risk: The Parliamentary and Health Service Ombudsman (PHSO) published a report into the wide national variations in the management of severe sepsis nationally. The report "Time to Act – severe sepsis: rapid diagnosis and treatment saves lives". The Trust has participated in the recent National Severe Sepsis and Septic Shock audit (A&E), the results of which are expected in May 2014. It is possible that the Trust will not be compliant fully with the standards for the treatment of severe sepsis published by the College of Emergency Medicine. A recommendation from the PHSO's report is that these increased risks should be reflected in the Trust's risk register.

The data collection for the National Confidential Enquiry into Patient Outcome and Death Sepsis Study also commences in May 2014. The study aims to identify and explore avoidable and remediable factors in the process of care for patients with known or suspected sepsis. The Trust will be participating in this study; the results are not however expected until autumn 2015. In the interim, the Trust is identifying professional activities (PA) time for a designated clinical lead for sepsis and is in the process of reviewing the RCAs undertaken over the past two year period as a thematic analysis to identify gaps in the clinical pathways of care. The clinical audit programme for the Trust for the 2014/15 financial year is being updated by the divisions to take account of this Report and the results of the thematic analysis, when this is complete. This risk was discussed at the RMGG in May and since this meeting, the inaugural meeting of the multi-disciplinary Trust Sepsis Collaborative has taken place. Planning and actions corporately and locally were identified and a date for the next meeting identified.

The HCAI risk is well controlled with high and medium controls in place.
Assurance: The risk has high level assurance and requires positive performance to ensure that this moves to "yellow".
Performance: 2013-14 Year End HSMR was 82.1 (Balanced Scorecard). So far only Additional April activity has been added (80.4 in month), lowering the 12 month rolling average to 81.8.
Sepsis Group is meeting. Standards Compliance Target is 80% within 4 Hours, 100% within A&E. Audit has not yet taken place in this year, so there is no measure in Q1.

There were 15 post 72hr cases of C. difficile for Quarter 1 against a trajectory of 11. An MRSA bacteraemia occurred in June and following the Post Infection Review (PIR) was assigned to EKHUFT and deemed to be avoidable. An additional case occurred in May and was provisionally assigned to

Thanet CCG. This case has been referred for arbitration on the grounds of the patient having an "intractable" infection. The result of the final assignation will be known later this month (July). This is likely to be either to a third party or Thanet CCG. With regard to E. coli bacteraemias, RCAs are now being completed for those occurring within 30 days of surgery (2014/15).

There were 3 falls with harm in Q1 against a trajectory of up to 24. The target 25% improvement in prevalence of falls with harm (NHS Safety Thermometer) in Q4 will require no more than 94 by Mth 12)

Incidence of avoidable category 2, 3 and 4 pressure ulcers is meeting improvement trajectory with 23 in Q1 against a year end maximum of 99. The target reduction of avoidable deep ulcers is being met with 3 in Q1 against a year end maximum of 28. However, the target reduction of avoidable category 2 ulcers is not being met with 20 in Q1 against a year end maximum of 71.

Regarding openness and transparency; for Q1, 112 informed / 206 applicable , 54%. Difficult to baseline as in the previous year the feedback field was not mandatory, however now staff has to answer whether the patient / family have been contacted. For Serious Incidents reported on STEIS (Severe harm, death and Never Events) the RCA template prompts the completion and documentation of actions taken to inform patients and relatives of the incident, offer them the opportunity to contribute to the investigation and feedback the findings of and actions taken as a result of the investigation.

Forecast: CDIFF/MRSA: A recovery plan is in place including the implementation of Hydrogen Peroxide vapour system (HPV) for high level disinfection of clinical areas Trust wide as appropriate. In addition, the IPCT are implementing the HOUDINI protocol to improve the management of urinary catheters with regard to strict criteria for insertion and removal which will be audited.

33 wards have returned action plans with an increased focus on improving evidence of repositioning to reduce avoidable category 2 heel ulcers. Further urgent actions are being undertaken by The Pressure Ulcer Steering group and Deep Ulcer Task and Finish Group. This includes the implementation of a new protocol for 'Intensive Investigations' for high risk areas to ensure clinical teams are supported to make the necessary improvements. This will be rolled out Trust wide in response to agreed triggers and monitored closely. The 'Think Heel' campaign actions are proving successful with a reduction in heel pressure ulcers by over 50% this quarter. Also being introduced next quarter is a dedicated Pressure Ulcer Panel of Senior Nurses. All deep pressure ulcer investigations will be presented to the Pressure Ulcer Panel, assuring a robust process of accountability and learning at the frontline. As these actions become further embedded in practice, we expect to see a greater reduction of avoidable pressure ulcers in subsequent quarters.

ANNUAL OBJECTIVE			
AO1: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care			
Responsible Executive:	Chief Nurse	**Responsible Committee:**	Quality Committee

SUB- OBJECTIVE
Improve clinical effectiveness and reliability of care by: (1) Delivering the CQUINS Programme (national / local and specialist) collaborating with the Service Improvement Team and KCHT (2) Ensuring staffing levels are in line with the agreed plan

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
AMBER	**AMBER**	**AMBER**

LINKS	
CRR	**CRR04**
SO	**SO1**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Achieving CQUINS	Improving the effectiveness of our services	Poor patient experience / less effective services

Initial risk score (CxL) *Jul 2009*	Quarter 1 score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	
4x4 = 16	**3x3 = 9**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Dedicated Programme Manager for CQUINs with clear objectives	Medium (2)
Working groups for the pathways within the CQUIN programme.	Low (1)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Reporting line to Associate Chief Nurse	Low (1)
Reporting structure for each group with the PMO as the safety net to pick up issues to CQUINs	Low (1)

Performance monitoring published monthly.	High (3)
Clinical Quality & Patient Safety Board report for external review	High (3)
Framework in place to achieve CQUINs	Medium (2)
Quarterly reporting to the Divisional Clinical Governance Groups, as well as engagement with other staff groups to increase staff awareness, with the objective of meeting each of the CQUINS targets	Low (1)
6 monthly staffing actuals against planned	High (3)

Data validated through Information Team and reported to CPMT / FIC / Board to show progress to achieving – actual performance figures / agreed standards	Medium (2)
Quarterly to CCG Quality Meeting – performance reporting	Medium (2)
Minutes from Working Groups	Low (1)
Performance reporting monthly to Finance Teams	Medium (2)
Staffing reviews reported to BoD (06/2014) with actions to address shortfalls	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress
COPD % improvement to be agreed with Commissioners	Commissioners /		C	
Clinical and administrative support to be agreed for the over 75s frailty CQUIN	Divisional Director for UCLTC		C	
Stronger risk assessment	CQUINs Project Manager		C	
Risk Register with prioritised actions			A	

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Monthly performance of CQUINS	**AMBER**			
Actual ward staffing levels: planned vs actual	**AMBER**			

COMMENTARY
Risk: The main risk to achieving the CQUIN's relates to the lack of resource in managing the Over 75 frailty CQUIN, the Divisional Director of UCLTC is currently reviewing the need and resource requirement. Additionally, "frailty" may not be recognised or resourced in terms of a clinical code. As such there may be a risk that we will identify patients at high risk of harm but not be appropriately reimbursed for the developed pathway of care. The other controls in place are strong and with the additional controls identified will provide adequate assurance that the risk is well managed **Assurance:** Amber assurance until performance provides positive results as well as the need for some external assurance which may be provided by Commissioners. **Performance:** RAG rating applied is indicative of the % of programme likely to be achieved by Qtr 4. Current key risks are: 1.FFT rollout to outpatient areas requires SIG approval for investment before implementation by October can be certain. 2. COPD measures require both some data collection and clinical process issues to be resolved. 3. Integrated Diabetes pathway implementation plan in progress. The Trust is achieving >90% fill rates. June performance was lower than May and is influenced by vacancies and sickness rates. **Forecast:** A recruitment plan is currently being implemented to address staffing levels.

ANNUAL OBJECTIVE			
AO2: Develop and agree a Transformation Redesign Service Improvement Strategy that supports frontline staff to identify ways of working that costs less whilst maintaining high quality patient care.			
Responsible Executive:	Chief Nurse and Director of Quality and Operations	**Responsible Committee:**	Quality Committee

SUB- OBJECTIVE
Redesign elective and emergency pathways to enhance patient care and quality whilst maximising efficiency

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
AMBER	**AMBER**	**RED**

LINKS	
CRR	**CRR03**
SO	**SO1**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Unplanned use of extra beds	(1) Un-resourced staffing (2) Patients outlying from their appropriate speciality	(1) Financial impacts (2) Patient safety

Initial risk score (CxL) *Jun 2010*	Quarter 1 score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Apr 2015*	
4x5 = 20	**4x3 = 12**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Daily Bed meetings to review bed status including outliers (risk assessment)	Medium (2)
Weekly operational meetings to review the trust-wide position	Low (1)
Performance dashboard includes indicators of additional beds and outliers	High (3)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Bed meeting sheets reviewed by GM's and Senior Site Matrons to make decisions about bed allocation	Medium (2)
Minutes of the operational meetings	Low (1)
Divisional Performance meeting to review and minute outcomes	Low (1)

Weekly high level board round to review patients	Low (1)
Monitoring length of stay through QlikView to reduce LOS and free up beds	High (3)
Ambulatory care pathways in place (12 in place so far)	Medium (2)
Diagnostic Overload Group – to review and reduce inappropriate use of diagnostics and to ensure patients do not remain in hospital due to waiting for a test	Low (1)

Clinical staff review	Low (1)
Internal wait audits undertaken which identified process delays for all specialities and categories and these will continue.	Medium (2)
Transformation dashboard looks at utilisation of those 12 pathways to monitor increase in use	Medium (2)
Minutes of meetings; report to Transformation Steering Group.	Low (1)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress
Provision of a surgical assessment unit	Marion Clayton	11/2014	C	Just in the planning stages
Reduction in length of stay project for surgery and urgent care to implement the internal waits outcomes	Marion Clayton / Giselle Broomes	10/2014	A	Surgery underway – Steering Group set up

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Deliver £3.5m savings by 31 March 2015 (phasing to be agreed for quarterly submissions) Meet the project plan milestones to time, quality and money	**RED**			

COMMENTARY
Risk: The risk around unplanned use of extra beds is well managed internally, further work has been identified but this also requires support and action from primary care and community care. **Assurance:** Although the assurance level is amber there are strong controls in place and once positive figures are received the level of assurance will increase. An internal or external audit would ensure the assurance level reaches green at an early stage. **Performance:** Project Timescales have been slightly delayed as more detailed analysis was required before key projects could be signed off by Divisional Directors (Internal Waits) Project Briefs completed & agreed - £1.8m efficiency confirmed, plus £834k awaiting approval (£2.6m to date). £3.5m target has increased to £5.5m as of 1/6/14, following the decision to include the £2m SLR target with Transformation Programme. Divisions have identified 7-9 SLR schemes for review; SLR project team approach being developed Quality Impact Assessments completed for all confirmed projects and underway for schemes 'in development'. **Forecast:** 3 of 4 Divisional working groups are now established (UCLTC being established), so progress expected to be on target, by next quarter Schemes to be identified for £5.5m (financial phasing agreed). Q2 contributions expected to be achieved.

ANNUAL OBJECTIVE			
AO3: Improve the overall score in the annual staff survey and embed engagement into everyday practice in the Trust			
Responsible Executive:	Director of Human Resources and Corporate Affairs	**Responsible Committee:**	Quality Committee

SUB- OBJECTIVE
Improve engagement internally and externally by with the public, patients and staff including in the first year implementation of the NHS Equality Delivery System

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**YELLOW**

LINKS	
CRR	
SO	**SO2**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL) *Insert date scored*	Quarter [ ] score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Membership Engagement Strategy	Medium (2)
Engagement Strategy	Medium (2)
Staff Surveys	Medium (2)
We Care Programme Board	Low (1)
Council of Governance Patient and Staff Experience Group	Low (1)
Individual Accountabilities for all aspects of engagement	Low (1)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Approved at Board of Directors meeting (08/2013)	Low (1)
Approved at BoD meeting (08/2013)	Low (1)
Staff Survey (with interim surveys) at least annually – negative results reviewed at BoD . CoG	Medium (2)
Ad Hoc reports to the Board	Low (1)
Reports on a bi-monthly basis to Council of Governors	Low (1)
Line management of those with responsibilities	Low (1)

Quality Strategy (incl We Care)	Medium (2)
Friend and Family Staff indicator surveys (quarterly)	Medium (2)
Equality and Diversity Objectives via the Equality Delivery System	Medium (2)
Trust Wide Equality, Diversity, Human Rights and Public Patient Engagement Steering group	

Key performance indicators reported on to Strategic Committee on a quarterly basis	Medium (2)
E&D Objectives approved by the BoD (08/2013)	Low (1)
Review of progress of E&D Objectives – reporting to Risk Management and Governance Group (6 monthly)	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress
Signed off business case for funding to support We Care	Head of Human Resources / Deputy Chief Nurse	Tbc	C	
Outputs from Friends and Family staff indicators to BoD with detailed actions for improvement	Head of Human Resources / Deputy Chief Nurse	Tbc	A	

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Increase the number of Healthwatch volunteers / public / patients involved in EKHUFT Groups (Q1 1: Q2 3: Q3 5 Q4 7 - rolling total)	**GREEN**			
Increase the number of Voluntary Community organisations represented at local events (Q1 3: Q2 6: Q3 6: Q4 12 - rolling total);	**GREEN**			
Engage staff, public and patients in the implementation of the NHS Equality Delivery System (Selection of outcome: Q1 2: Q2 0: Q3 2: Q4 0 - per quarter figures. Assessed outcome Q1 - 0: Q2 - 2: Q3 - 0: Q4 - 2 - per quarter figures);	**GREEN**			
Embedding of We Care Values by monitoring FFT patient feedback	**YELLOW**			
We Care: Delivery against milestone to time, quality and money	**GREEN**			
Improve the component scores that make up engagement in the Staff Survey against the 2013/14 performance	**AMBER**			
Improve the Friends and Family Test element in the staff survey in relation to working / being treated at the hospital.	**AMBER**			

COMMENTARY

Risk: There are two risks being assessed: one in relation to the engagement of staff in the normal business processes such as annual planning; the other in relation to having a signed-off business case to approve funding required to implement We Care.
Assurance: There is a good level of assurance but additional positive assurance is required to move this to "yellow" and confirmation that the action plan in place to address the staff survey results is also needed.
Performance:
1 new Public Member now sitting on Clinical Audit and Effectiveness Committee. 3 VCOs were represented at the Engagement Event on 22/5/14
3 VCOs involved in the selection of 2 Outcomes for EDS Goals 1 & 2
Friends and Family Test Net Promoter Score (FFT NPS) is achieving the national average in 2 of the three areas surveyed. Improvement work is in place for A&E where there are lower scores.

We Care delivery is on time with Tender document

Measure will be taken in October NHS staff survey with results for publishing in Jan 2015. Board has approved staff engagement as area for priority action and Chairman is leading on this work. Detailed plans yet to be agreed. FFT results for staff questions are not directly comparable to previous responses as the question has been amended, for example from
"I would recommend my organisation as a place to work" to "How likely are you to recommend this organisation to friends and family as a place to work" The question change is even more marked when describing treatment of patients moving from would you be happy with the care of friends and family to would you recommend services. Therefore as these are first results it is not possible to determine that there is a genuine improvement or

deteriorating position.

Current results show the Trust as below average, when compared to those Acute organisations that have used Picker to support the survey, with 79% of staff stating they are likely to recommend the organisation for care and treatment and 55% stating they are likely to recommend the organisation as a place to work.

Forecast:
New public/Healthwatch members planned for Equality & Engagement Governance Group, Clinical Support Division Patient User Group, We Care Steering Group & Way Finding Project Group. Next event planned for 11/9/14. At least three new VCOs expected. Event in September to Assess 2 Outcomes planned.

Staff Survey Engagement: Any work done in summer / autumn 2014 is unlikely to significantly impact the underlying culture of the organisation. It is hoped that some of the work initiated by the Board with the adoption of the We Care values in January 2014 may start to show some improvements however there is a high risk that there will be no statistically significant improvement in 2014 given the Trusts previous performance.

FFT will be clearer on this once the results are benchmarked by NHS England following uploading on UNIFY the deadline for which is 24th July.

ANNUAL OBJECTIVE			
AO4: Agree with Commissioners and consult with the public to implement a sustainable clinical strategy which will, in particular, meet the standards for emergency surgery; ensure the availability of an appropriately skilled workforce and provide safe sustainable services with consideration of access for patients and their families and visitors.			
Responsible Executive:	Director of Strategic Development and Capital Planning	**Responsible Committee:**	Quality Committee

SUB- OBJECTIVE
Develop and implementation plan based on the outcomes from the outpatient consultation and implement the elements in the 2014/15 plan.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**GREEN**

LINKS	
CRR	
SO	**SO1** **SO4**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL)	Quarter [ ] score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Outpatient Consultation outlining the strategy	Medium (2)
Project Initiation Document in place	Medium (2)
Dedicated Project Manager	Low (1)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Process evaluated by Kent University	High (3)
Progress checked by the Clinical Strategy Implementation Board reported to Board – currently on track	Medium (2)
Project Manager with signed off objectives measured by Line manager	Low (1)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Meet the milestones in the Outpatient implementation plan and deliver to time, quality and money	**GREEN**			

COMMENTARY

Risk: None currently identified but Strategic Development will be looking at the cultural changes risk as well as seeking clarity around the readiness of Buckland prior to March 2015.
Assurance: Good progress on the assurances with one external assurance already in place; work within Strategic Development to identify additional assurances.
Performance: Trust and CCG Boards have approved the OP consultation recommendation outcome to reduce to 6 Outpatient sites with a preferred option of Estuary View as the North Kent site. 6 months' notice has been given to W&T, Faversham and Herne Bay. Work has commenced to plan one stop clinics and adjust job plans to accommodate other OP changes.

Forecast: Work is progressing according to plan.

ANNUAL OBJECTIVE			
AO4: Agree with Commissioners and consult with the public to implement a sustainable clinical strategy which will, in particular, meet the standards for emergency surgery; ensure the availability of an appropriately skilled workforce and provide safe sustainable services with consideration of access for patients and their families and visitors.			
Responsible Executive:	Director of Strategic Development and Capital Planning	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Develop a consultation programme for Clinical Strategy reconfiguration to deliver safe, sustainable services for the next 5-10 years; and maintain stakeholder engagement as required for outputs from the long term clinical strategy.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**GREEN**

LINKS	
CRR	
SO	

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL) *Insert date scored*	Quarter [ ] score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Communications Workstream in place	Low (1)
Named individual with objectives to lead the communications strategy	Low (1)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Monitored by Clinical Strategy Implementation Board	Medium (2)
Individual managed at Executive Director level	Low (1)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**
Communications Strategy to be drafted	Director of Communication	August 2014	C	

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Meet the milestones for the Clinical Strategy reconfiguration implementation plan; deliver to time, quality and money	**GREEN**			
Meet the milestones in the communication and engagement plan; deliver to time, quality and money	**GREEN**			

COMMENTARY

Risk: no risks currently identified.
Assurance: Limited assurance at this stage but work on this, especially progress against plan, will increase the Board assurance through the dedicated workstream and individuals tasked with delivery.
Performance: Work is well underway with all divisions to design future pathways to facilitate a single emergency and high risk hospital. CEO has written to all clinicans describing the direction of travel and time scale. Internal engagement has now been planned with diary dates agreed. External stakeholder events planned for September and October.
Forecast: Across all three areas, work is progressing according to plan.

ANNUAL OBJECTIVE			
AO5: Identify and implement the commercial strategies that support the Trust to maximise its opportunities to increase revenue, grow its business in profit making areas and retain its market share.			
Responsible Executive:	Director of Strategic Development and Capital Planning	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Develop strategic plans to deliver new services in key markets.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**GREEN**

LINKS	
CRR	
SO	**SO4**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL) *Insert date scored*	**Quarter [ ] score (CxL)**	**Quarter [ ] score (CxL)**	**Target risk score (CxL)** *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Private Patients Strategy in place	Medium (2)
Private Patients Steering Group in place	Low (1)
Private Patients Strategy implementation plan in place	Medium (2)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Private Patients Strategy signed off by Board in April 2014	Low (1)
Steering Group reports to Finance and Investment Committee on progress	Low (1)
Progress on implementation monitored through Steering Group	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**
Teaching Nursing homes plan	Director of Strategic Development and Capital Planning	October 2014	C	In progress

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Meet milestones in the Private Patient Strategy implementation plan; deliver to time, quality and money	**GREEN**			
Meet the milestone to deliver the Teaching Nursing homes implementation plan; deliver to time, quality and money	**GREEN**			

COMMENTARY

Risk: No risks have been identified at this point
Assurance: Assurance level is amber due to the early stages of the project and no clarification on positive achievements. Strategic Development are looking at additional assurances to provide to the Board.
Performance: Work on this project is progressing to timelines and milestones are clearly defined.
Forecast:
Work is expected to continue to meet key milestones and progress over 14/15.

ANNUAL OBJECTIVE			
AO5: Identify and implement the commercial strategies that support the Trust to maximise its opportunities to increase revenue, grow its business in profit making areas and retain its market share.			
Responsible Executive:	Director of Strategic Development and Capital Planning	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Maintain market share for existing services and explore development opportunities for 2015/16.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**GREEN**

LINKS	
CRR	
SO	

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL) *Insert date scored*	Quarter [ ] score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Project plans in place to develop business cases for new services including timelines	Medium (2)
Detailed activity reports / performance against actual	High (3)
Project Managers for new services in place	Low (1)
External review and discussion about activity against actual	High (3)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Strategic Development Quarterly Meeting will review progress against timeline	Medium (2)
Activity monitored by Finance and Investment Committee on a monthly basis	Medium (2)
PM's managed with identified objectives monitored	Low (1)
External assurances through Commissioners	High (3)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**
Business Cases for new services to be approved at Strategic Investment Group	Director of Strategic Development	Dec 2014	A	

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Meet the planned activity in services for 2014/15	**GREEN**			
Signed off business cases for orthopaedics, ophthalmology and cardiology.	**GREEN**			

COMMENTARY

Risk: None identified at this time

Assurance: Assurances in relation to the activity are looking good for the time of year with assurance from internal and external reporting. Assurance around the sign-off of business plans is medium with external assurance from the Commissioners on the activity and as timelines and action plans for the new business progress further positive assurances will be provided.

Performance:

General EKHUFT performance against plan is monitored through CPMT. Currently reporting that EKHUFT is expected to achieve planned activity over 2014/15.

Business Cases: Working groups for each area are established and work is progressing to underline the cases for change and outline options for each specialty. Teams established for the 4 ophthalmology areas: Emergency care, AMD, Paediatric - strabismus, and cataracts - to determine service reconfiguration options to address capacity and quality issues

Forecast: EKHUFT is expected to hit internal plan over 2014/15. Work will continue with the goal of producing the cardiology business case to SIG Q3; and orthopaedic strategic outline proposal for board in Q3.

ANNUAL OBJECTIVE			
AO6: Drive increased efficiency and effectiveness of Trust corporate led services and through the implementation of major infrastructure projects.			
Responsible Executive:	Director of Strategic Development and Capital Planning	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Deliver increased efficiency and effectiveness by Implementation of systems to support delivery of patient safety, targets and patient pathways

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**GREEN**

LINKS	
CRR	
SO	**SO5** **SO6**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL) *Insert date scored*	**Quarter [ ] score (CxL)**	**Quarter [ ] score (CxL)**	**Target risk score (CxL)** *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Project plans in place for all IT elements – progress reported	Medium (2)
Project Managers in place	Low (1)
Risk assessment undertaken for all projects	Medium (2)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Project Board monitors performance against project plans / Strategic Development quarterly meetings	Medium (2)
Project Managers line managed to achieve objectives	Low (1)
Risk registers reviewed internally at Project Board meetings	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Preferred bidder in place for implementation of maternity and patient administration system	**GREEN**			
18 week compliant patient administration system in place (monitor throughout the year by implementation plan to time, quality and money)	**GREEN**			
Implement baseline telecommunication infrastructure (monitor to plan; time, quality and money);	**GREEN**			
Implement Electronic Patient Record in inpatients; monitor against plan to time, quality and money;	**GREEN**			
Deliver Clinical Workstation Plan to time, quality and money.	**AMBER**			

COMMENTARY
Risk: no corporate level risks identified so far in the process. **Assurance:** assurance looks low but there are plans in place for all system implementations which timescales and budgets, monitoring will be through Project Boards and escalation through Strategic Group. **Performance:** Final moderation due 23rd July - FIC approval to follow for the implementation of maternity & PAS system. 18 Week compliant PAS Project is on plan for go live by end Jan-15 Telecoms Procurement process has been completed, finalised order for telephony system to be placed in July -14 Electronic Patient Records - Currently in the planning phase of this project - milestones in 2014-15 will be to develop & pilot IP EPR as a proof of concept on a surgical ward. Delivery of the Clinical Workstation: The current plan is to deliver a pilot in September. This is later than originally planned. Supplier has been challenged to demonstrate the final version of the product to our satisfaction. **Forecast:** Maternity / PAS contract to be negotiated after internal approval 18 week PAS Project is on plan for go live by end Jan-15 Next quarter will involve planning of the rollout of the telephony system. Currently in the planning phase of this project - milestones in 2014-15 will be to develop & pilot IP EPR as a proof of concept on a surgical ward. The pilot Clinical Workstation is well defined and will be evaluated.

ANNUAL OBJECTIVE			
AO6: Drive increased efficiency and effectiveness of Trust corporate led services and through the implementation of major infrastructure projects.			
Responsible Executive:	Director of Strategic Development and Capital Planning	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Deliver increased efficiency and effectiveness by improving the Trust infrastructure to ensure that the estate is fit for purpose now and in the future

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
SEE COMMENTARY	**AMBER**	**GREEN**

LINKS	
CRR	
SO	**SO5** **SO6**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**

Initial risk score (CxL) *Insert date scored*	Quarter [ ] score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *Insert target date*	

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Capital Plan with phasing in place	High (3)
Capital Plan monitored actuals against performance	High (3)
Back Office review – dedicated project manager in place with objectives to deliver plan	Medium (2)
Back Office Review – Implementation plan with milestones	Medium (2)
Project plan in place and monitored through Strategic Development for the estates redevelopment	Medium (2)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Capital Plan signed off as part of Annual Plan by Board	Low (1)
Capital plan monitored on a monthly basis by Finance and Investment Committee	Medium (2)
Line manager of Back Office PMO reviewing performance against objectives	Medium (2)
Project Board in place to review performance against milestones	Medium (2)
Progress monitored through Strategic Development and line management	Low (1)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**
Estates redevelopment and rationalisation strategy	Director of Estates	Mar 2015	A	Draft strategy has been written and will go to Strategic Property Group

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Monitor Capital plan - actuals against plan;	**GREEN**			
Estates redevelopment and rationalisation strategy signed off by the Board;	**GREEN**			
Deliver the back office review 2014/15 plan; deliver to time, quality and money.	**GREEN**			

COMMENTARY

Risk: None identified at present
Assurance: Controls are strong and so strong assurances should follow. Assurance is currently indicating Amber but this will increase as performance against objectives shows that the assurances in place are working. All areas have some form of assurance.
Performance:
Capital plan delivery is on target for Q1. Estates Strategy on target to present recommendations to the board in December 2014. First market open day with potential partner developers held 30-Jun.
All service area reviews are on schedule according to overall programme

Forecast:
Quarter 2,3,4 of the Capital Plan are re-profiled following decision to not centralise surgery in Q1
Work is progressing according to plan on Estates Redevelopment and Rationalisation Strategy.
Work is progressing according to programme plan as signed off by the back office review group.

ANNUAL OBJECTIVE			
AO7: Implementation of the Research and Innovation (R&I) Strategy to increase homegrown R&I whilst continuing to support other R&I by putting the right people, processes and facilities to support these goals and through effective engagements with R&I stakeholders			
Responsible Executive:	Medical Director	**Responsible Committee:**	CPMT / FIC

SUB- OBJECTIVE
Implement the R&I Strategy by 1. Meeting the agreed target from K&M CLRN / KSS for CRN Portfolio recruitment; 2. Increasing the level of research funding; 3. Increasing the level of peer-reviewed publications; and 4. Increased the level of research the Trust takes part in. 5. Increase internal innovation by increasing the number of Bright Ideas coming through for review and implementation.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
YELLOW	**AMBER**	**GREEN**

LINKS	
CRR	**CRR054 (related)**
SO	**SO3**

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Due to closure of the aseptic unit	Provision of sterile cancer treatment	Patient safety / experience / clinical trial activity

Initial risk score (CxL) *Apr 2014*	**Quarter [ ] score (CxL)**	**Quarter [ ] score (CxL)**	**Target risk score (CxL)** *Sep 2014*	
4 x 5 = 20	**4x2 = 8**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Routine reporting of agreed targets through Board reporting	Medium (2)
Divisional Scorecards	Medium (2)
R&D Annual Report which shows progress against the objectives	Medium (2)
Key performance indicators agreed with Collaborative Local Research Network	High (3)
Chair of R&D with specific responsibilities for achieving the R&D Objective	Low (1)
R&D Committee monitors progress against the objectives at its meetings (quarterly)	Low (1)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Board of Directors received information on the scorecard on a monthly basis / actuals against planned	Medium (2)
Divisions to report any variances and discuss at Corporate Performance Management Team (monthly)	Medium (2)
Board and Directors / Council of Governors; performance identified as good (09/2013)	Medium (2)
External review and conformation of performance	High (3)
Line management by Medical Director	Low (1)
R&D reports concerns to Clinical Management Board and these are raised to Board level if appropriate	Low (1)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**
R&D Risk Register	R&D Committee	Mar 2015	C/A	Not started as yet
Information to be published on website as per CLRN contract	R&D Committee	Mar 2015	A	In progress

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Baseline £1.53m - increase of £0.66m for 2014/15	N/A			
10% increase in peer-reviewed publications against 2013.14 achievement	**GREEN**			
Achievement of Trust target (agreed with K&M CLRN/KSS LCRN) for CRN Portfolio recruitment (Q1 = 450; Q2 = 900; Q3 = 1350; Q4 = 1800)	**AMBER**			
Achieve the 15 day target for NHS R&D Approval from submission of a valid application in >80% of CRN applications	**GREEN**			
New metrics available to all staff via Qlikview including an innovation score;	**GREEN**			
Increased the number of "Bright Ideas" by 20% from 2013/14.	**GREEN**			

COMMENTARY

Risk: There is a risk due to the closure of the aseptic unit on participation in cancer studies which has both a financial and reputational impact on clinical trials. Mitigation is shown on the CRR which has reduced the risk to “8”.

Assurance: The introduction of a risk register and achievement against plans would enable the assurance level to move from “amber” to “green”.

Performance: Increase of research inputs **r**eporting annually. YTD publications target is 12.75; Q1 publications = 31. April & May recruitment target = 264 vs. target 300 = 88%. Recruitment data will always be >30 days in arrears. 17/21 studies (81%) approved within 15 days, exceeding the 80% target. R&D, Bright Ideas and innovation metrics already implemented on Qlikview. Based on comparison with last year the Bright Ideas improvement performance is currently on track

Forecast: Publications target already achieved target for Q2 as well so will be 'green'. Recruitment likely to remain >90% so will be 'yellow'. 15 day target is likely to be achieved again, so will be 'green'. On-going work on improving engagement with Divisions on innovation scoring. Work continuing on developing corporate innovation metrics. Difficult to predict but no reason to assume the current level of bright ideas should drop.

ANNUAL OBJECTIVE			
AO8: Engage with the Divisions to develop and provide clinical information to support strategic decision making.			
Responsible Executive:	Director of Finance	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Continue to develop the Information Strategy / Approach by: 1. Developing a method for presenting, predicting and pushing outcomes to clinicians; 2. Introducing clinical performance measurement for the purposes of consultant appraisal to support revalidation; and 3. Opening the Innovation Centre for Information in conjunction with the Academic Health Science Network.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
YELLOW	**GREEN**	**GREEN**

LINKS	
CRR	
SO	**SO1 / SO4 / SO6**

Risk to Annual Objective:		**Risk Owner:**
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Lack of agreement about structure of innovation centre funding with AHSN. Lack of engagement with the publishing of clinical outcomes. Key informatics staff leaving because of lack of resources and incentives	Innovation centre opening. Development of informatics services to help clinicians and managers	Lack of insight into how future care might be delivered following breakthroughs in technology. Lack of reputational benefit from not opening the centre. Less opportunity for clinical improvement by addressing key areas for concern. Slow down in pace and quality of informatics service to improve patient care

Initial risk score (CxL) *July 14*	**Quarter 1 score (CxL)**	**Quarter [ ] score (CxL)**	**Target risk score (CxL)** *Insert target date*	
1. 2 x 1 = 2 **2. 2 x 2 = 4** **3. 4 x 2 = 8**	**1. 2 x 1 = 2** **2. 2 x 2 = 4** **3. 4 x 2 = 8**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Regular ET briefing from Dir of Inf/Dir of Fin.	Low (1)
Options appraisals being taken through relevant governance structure ie CPMT-FIC-board.	High (3)
Approval for approach through Medical Director and through CMB	High (3)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Divisional governance structures and through CMB.	High (3)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*				
What is required	**Who needs to take action**	**Due by**	**A or C**	**Progress**

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Technology in place for distributing messages. Statistical processes in place for robust modelling - demonstrated working in at least one speciality	**Green**			
Launch Pilot version of 'Real-time Consultant Appraisal'.	**Green**			
Opening the Innovation Centre for Information in conjunction with Academic Health Science Network	**Green**			

COMMENTARY
Risk: Opening an innovation centre in this way, though supported in principle by the Trust and by the AHSN, is new in terms of organisational structure. It implies potentially complex financial and governance arrangements which will need to be worked through. This is an exciting development for the trust and will bring significant reputational benefit but because it does not refer to a burning platform there is a risk that it simply does not happen. **Assurance**: The work of the Informatics team is assured through a number of routes. Strategically it is managed via the IM&T board which, it is proposed, would directly oversee the development of the innovation centre. The FIC receives the activity-related analysis that this team produces. CMB would be asked to assure the development of a consultant appraisal tool. **Performance:** Distributing Messages:Framework in place, simply needs time to write up. Has been presented widely through the AHSN and a number of national conferences. The objectives that then flow from the strategy need project plans associated with them. Real-Time Consultant Appraisal: Significant clinical engagement will be needed to achieve this with sign off via Medical Director and through CMB. Aim to 'start low' with improvements to data quality made by giving clinicians access to their electronic records more easily. Innovation Centre for Information: Papers likely to go to boards of AHSN and EKHUFT which both require investment. **Forecast**: Distributing Messages: Framework Draft document produced ready for taking to IM&T board. Real-Time Consultant Appraisal: Timing will depend on EPR strategy. Innovation Centre: Next quarter will be crucial in getting decision from boards on both sides.

ANNUAL OBJECTIVE			
AO9: Ensure strong financial governance, agree contracts with commissioners that deliver sufficient activity and finance and support a comprehensive internal cost improvement programme where all Divisions deliver cash releasing savings schemes to deliver Trust CIP targets.			
Responsible Executive:	Director of Finance	**Responsible Committee:**	Finance and Investment Committee

SUB- OBJECTIVE
Ensure the Trust has a strong financial position by: 1. Meeting the financial statutory duties and delivering the Monitor Plan; and 2. Delivering the Trusts Cost Improvement Programme.

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
RED	**AMBER**	**RED**

LINKS	
CRR	**CRR0027**
SO	**SO1** **SO4**

Risk to Annual Objective:		**Risk Owner:**
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Cost control, performance management systems fail to prevent avoidable cost increases	Divisions are unable to make the agreed savings	Failure to meet the CIP target but also possible impact on patient safety / experience.

Initial risk score (CxL) *April 2011*	**Quarter 1 score (CxL)**	**Quarter [ ] score (CxL)**	**Target risk score (CxL)** *Apr 2015*	
5x5 = 25	**5x4 = 20**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Executive Director identified to lead on CIP delivery to work with Divisional Directors	Low (1)
CIP targets agreed and programmes identified to make up a substantial part of the value	High (3)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Reports to Executive Management Team	Low (1)
a) Actuals against planned to Corporate Performance and Management Team / Finance and Investment Committee and Board of Directors; b) internal reports	Medium (2) Medium (2)

Corporate meetings discuss and interrogate the data	Low (1)
Accountability Framework – Performance Management in place	Medium (2)

Minutes of Corporate Performance and Management Team / Finance and Investment Committee and Board of Directors to show breadth of discussions	Low (1)
Performance Management Framework signed off by Finance and Investment Committee	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Achievement against CIP profile	**Red**			
Meeting the planned CoSR	**Green**			

COMMENTARY

Risk: There is likely to be a change to the financial risks affecting Trust as a consequence of the block contract for 2014/15. The divisional leadership teams have articulated the issues this poses for them and for the Trust overall. UC&LTC has seen a 5.8% increase in A&E activity since the start of the financial year; this is also reflected in, Trauma and Orthopaedics, Rheumatology, and Neurology. An associated risk is the middle grade rota, which is essential to support current activity. There are a large number of vacancies which are being covered with agency staff. This has driven a corresponding increase in agency costs. This risk is being mitigated by a recruitment plan and the divisions have appointed some overseas personnel. The current immigration processes will result in a delay of three to four months.

Both the Surgical and Clinical Support Divisions highlight and increased risk of the pattern of increased referrals not being managed by the CCGs. This will have a significant impact on the divisions if they are unable to income generate to off-set these additional operational costs. The impact of the “Any Qualified Provider” also considerably increases demand.

Assurance: There are strong controls which will ensure that the level of assurance throughout the year will continue to increase by providing actuals against performance. It would benefit from external / internal assurance.

Performance: CoSRR has been maintained due to the positive cashflow held (green for performance); as reported at the June FIC, CIP’s are significantly behind plan this is due to slow delivery of procurement savings, bed closures and process redesign. As a result the Board have appointed Liz Shutler to review and support the CIP delivery in 2014/15 it may take until Q3 to turn the position around (red for performance).

Forecast: CoSRR is expected to continue at 4 rating due to a positive cashflow position; although progress to close the gap for CIPs in the next quarter it is unlikely to close within 15% of the target at this point.

ANNUAL OBJECTIVE			
AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.			
Responsible Executive:	All	**Responsible Committee:**	Integrated Audit and Governance Committee

SUB- OBJECTIVE
Ensure strong governance structures are in place to meet statutory duties:

OVERVIEW OF RISK, ASSURANCE AND PERFORMANCE		
RISK STATUS	**ASSURANCE STATUS**	**PERFORMANCE STATUS**
AMBER	**AMBER**	**GREEN**

LINKS	
CRR	**CRR34** **CRR15** **CRR55**
SO	

Risk to Annual Objective		
Cause (due to):	**Risk to:**	**Effect (resulting in):**
Ability to meet the Monitor governance targets, especially in relation to HCAI's, cancer standards and A&E 4 hour wait	Maintaining a governance rating of Green	Monitor review of the Trust's governance.

Initial risk score (CxL) *various*	Quarter 1 score (CxL)	Quarter [ ] score (CxL)	Target risk score (CxL) *various*	
4x4 = 16	**3x3= 9**			

The risk is CONTROLLED by: *(include the date in place, why it controls the risk and where this approved etc)*	**Strength (RAG)**
Performance scorecard which shows progress against internal and national targets	Medium (2)
Performance meetings with Divisional leadership team to review performance against metrics	Medium (2)
Health and Safety Annual training programme	Low (1)
Health and Safety Toolkit Audit	Medium (2)
Senior Health and Safety Manager in place with network of H&S staff across all sites	Low (1)
See HCAI risk on AO1	High (3)
A&E Action Plan in place to recover position – monitored monthly	High (3)

The Board receives ASSURANCE through: *(include the date of the assurance and where this is scrutinised)*	**Strength (RAG)**
Performance against actuals: Corporate Performance Management Team (monthly) Finance and Investment Committee (monthly) Board of Directors' (monthly)	Medium (2)
Action notes from meetings with exception reporting to Corporate Performance Management Team (as required)	Low (1)
Matrix of completion discussed at Divisional level	Low (1)
Concerns / issues reported to Divisional Board for action	Low (1)
Reporting structure against objectives	Low (1)
Assurance for HCAI risk see AO1	Medium (2)
Review of performance against action plan undertaken by Divisional Board and risks escalated to Corporate Performance Management Team (monthly)	Medium (2)

Cancer Action plan following RCA on 62 day screening – monitored monthly	High (23)

Review of performance against action plan undertaken by Divisional Board and risks escalated to Corporate Performance Management Team (monthly)	Medium (2)

Gaps in CONTROL and additional ASSURANCES required: *(where the assurance level is amber or red additional actions are required to address this: A = Assurance required: C = Control required):*

What is required	Who needs to take action	Due by	A or C	Progress

PERFORMANCE				
Performance Measure	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Maintain a governance risk rating of Green	**GREEN**			
Deliver improvements as identified in external reports in line with the relevant action plans	**GREEN**			
No HSE Improvement notices	**GREEN**			
Health and Safety training strategy programme to be in place	**GREEN**			

COMMENTARY
Risk: The risks around Monitor governance rating in relation to the four hour wait; HCAI's and Cancer standards are well controlled with no gaps in assurance, a number of initiatives are on-going in infection control for MRSA and C.Diff. There are no reported risk in relation to Health and Safety, nor any in relation to completing external action plans, such as Francis. **Assurance:** The level of assurance is good but requires a couple more "medium" level assurances or an external / internal audit to improve the situation. **Performance:** Monitor rated Trust Governance Green in Q1. The Francis Action Plan is on target for completion as agreed. Some dates have been changed to accommodate the level of work required; this was agreed with the Board. The CQC action plan is being drafted and is on target to be presented at the Quality Summit on 10 July 2014. There is no associated budget with the Francis Action Plan. The budget for the CQC action plan is currently being reviewed and agreed. No HSE notices received in Q1, and scoping exercise is being undertaken with H&S team. **Forecast**: Continue to expect Monitor to rate Trust Green in Q2. The main bulk of actions have been completed for the Francis Action Plan and therefore it is likely that this element will continue to be met. No concerns have been identified for the second quarter. Delivery of a plan to the Corporate H&S committee and RMGG for September meeting