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

TRUST BOARD
16th December 2010

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 totality of risks to achieving the Trust's strategic objectives. The BAF is aligned to the 4 strategic objectives as detailed in the Integrated Business Plan and also the Corporate Business Plan 2010-11. This iteration of the BAF was reviewed by IGAC on 15th December 2010.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Board assurance process ensures that risks to achieving the Trust's strategic objectives are actively identified and managed.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not assessed and views not taken
EQUALITY AND DIVERSITY ISSUES	None although a key risk relates to Equality and Diversity which is also a formal element of the Statement on Internal Control.
LEGAL ISSUES	The Board Assurance process supports the Chief Executive in signing the Statement on Internal Control which forms part of the Trust's statutory accounts.
Trust board is asked to:	The Board is asked to discuss, challenge and review the Board Assurance Framework.
Submitted by:	Jane Gear , Head of Corporate Affairs For Andrew Liles, Chief Executive
Date:	3rd December 2010
Decision:	For Approval

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

Trust Board
16th December 2010
Board Assurance Framework 2010/11 – 2015/16
December 2010 Version 4

Introduction

The BAF is an assurance tool to ensure that the Board is properly informed about the totality of risks to achieving all of the strategic objectives as detailed in the Integrated Business Plan. The risks on the BAF are mapped to the risks on the Corporate Risk Register, as shown in the first column.

Strategic Context

The BAF is aligned to achieving the 4 Strategic Objectives as documented in the Integrated Business Plan (IBP).

The BAF has been subject to significant review at the beginning of 2010/11. Thus it is aligned to the Statement on Internal Control, the Corporate Business Plan 2010/11 and has been cross referenced to the Corporate Risk Register.

In July 2010 the White Paper: Liberating the NHS; a major document outlining the new government's strategy for health was been launched; the BAF review undertaken by the EDs has taken this into account as far as possible

Review

An Executive Director (ED) is allocated responsibility for each principal risk and progress against any related action plan is monitored and reported upon.

The full BAF is reviewed at the bi monthly Integrated Governance Assurance Committee (IGAC) meetings. This took place at the last meeting of IGAC on 15th December, and the review took place in tandem with the Corporate Risk Register. As the meeting of IGAC was immediately before the Board meeting, the Chair of IGAC will verbally apprise the Board of the content of the discussion.

Subject to the conclusions of IGAC the significant changes proposed to the BAF are :

<u>2 risks which it is proposed should be removed:</u>

1.9 If there was insufficient assurance to support Monitor assessment of Quality through Board Memorandum and external validation

3.1 If the Trust was unable to achieve FT status it is likely the Trust would be an outlier in the national programme and might need to consider future organisational configuration;

The reason for the recommendation is that the Trust has now been successful in achieving authorisation as a Foundation Trust.

<u>1 Risk proposed to be added:</u>

Under the Foundation Trust regime the Board will be required to self certify that all risks to its Authorisation have been identified and are being managed. During the preparation for FT status the Trust started to develop a risk log addressing this subject; it is recommended that this is adapted and a new risk of the potential failure to comply with the Terms of Authorisation is added to the BAF.

Recommendation

- The Board comment on the BAF in particular the assurances and any gaps in assurance and controls it would wish to see addressed
- The Board highlight any risks to the strategic objectives that they believe should be documented on the BAF, but are currently missing

Submitted by: Jane Gear , Head of Corporate Affairs
For Andrew Liles, Chief Executive

Board Assurance Framework - Summary
2010-2011
Version: December 2010

	Lead	June Risk score	Aug Risk Score	Sept/Oct Risk Score	Dec Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	In Month Risk Change
1. To achieve the highest possible quality standards for our patients, meeting and exceeding their expectations, in terms of outcome, safety and experience.										
Risks to Objective										
1. If the Trust does not meet national priorities (and therefore Monitor's Compliance framework)	DCE	10	10	10	10					↔
2. If the level of HCAI infection rose and trajectory not achieved	CN	16	16	16	16					↔
3. If there were pockets of substandard services which were masked by top level performance (as apparent in Mid Staffs)	CN/MD	10	10	10	10					↔
4. If Data quality deteriorated leading to poor decision making	DoF	8	8	8	8					↔
5. If there were poor standards of information governance which then jeopardised patient confidence	DoF	8	8	8	8					↔
6. If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence	CN	8	8	8	8					↔
7. If the patient experience is poor due to the Trust not understanding the needs of our patients or the Trust is unable to respond in a timely and prompt fashion	CN	12	12	12	12					↔
8. If Environmental standards, including Single Sex Accommodation (SSA), do not meet expectations/ standards	DCE	3	3	3	3					↔
9. If there was insufficient assurance to support Monitor assessment of Quality through Board Memorandum and external validation	CN/MD	10	8	8	Recommend risk deleted					✕

	Lead	June Risk score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	In Month Risk Change
2. To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.										
Risks to Objective										
1. If the Trust has difficulty recruiting to key positions	DoW	9	9	9	9					↔
2. If the Trust was unable to retain staff particularly in shortage specialties	DoW	6	6	6	6					↔
3. In ability to reduce management costs	DoW	9	9	9	9					↔
4. Medical appraisal and job planning do not underpin revalidation requirements	MD	6	6	6	6					↔
5. If there was failure to deploy a high performing workforce	DoW	8	8	8	8					↔
6. Increased turnover and sickness	DoW	6	6	6	6					↔
7. If there was reduced knowledge of junior Doctors	DoW	9	9	9	9					↔
8. Non compliance with Equality, Diversity and Human Rights legislation	DoW	6	6	6	6					↔
3. To deliver the Trust's clinical strategy; redefining our market position to better meet the needs of patients and commissioners, and increasing market penetration.										
Risks to Objective										
1. If the Trust was unable to achieve FT status it is likely the Trust would be an outlier in the national programme and might need to consider future organisational configuration	DoW	8	8	8	Recommend risk deleted					✖
2. If the Trust was not the preferred provider (through a consortium) of renal services for Surrey	CE	6	6	6	6					↔
3. If the Trust was unable to provide increased services at Ashford Hospital and in community locations	DCE	6	6	6	6					↔
4. If the Trust lost significant market share including any current trends in specific localities or specialties	DCE	8	8	8	8					↔
5. If the Trust did not succeed in reducing emergency admissions and redesigning the elective care pathways.	DCE	12	12	12	12					↔
6. If the Trust developed a poor reputation	CE	8	8	8	8					↔
7. If the Trust was unable to engage with GPs individually and collectively as national policy enhances their role in commissioning	DCE	12	12	12	12					↔

	Lead	June Risk Score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	In Month Risk Change
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
Risks to Objective										
1. Unexpected changes in pattern of demand and admissions puts pressure on the bed complement and therefore patient care	DCE	12	12	12	12					↔
2. Insufficient attention to acuity of patient needs	CN	8	8	8	8					↔
3. Management of non elective cap fails, and emergency admissions rise	DCE	12	12	12	12					↔
4. Delivering CIPs is handled ineffectively or in a piecemeal fashion. Insufficient long term planning of CIPs into future years	DCE/DoF	10	10	10	10					↔
5. Risk of CIP/productivity agendas inadvertently undermine the Trust's stated objective on improving quality	DCE	8	8	8	8					↔
6. Failure to secure benefits of service line management and the wider cultural benefits including clinical engagement	DoF	6	6	6	6					↔
7. EQUIP programme is not fully embedded with widespread and rising engagement throughout the Trust year on year	DCE	8	8	8	8					↔
8. National economic climate with focus on reducing public sector expenditure	DoF	12	12	12	12					↔
9. As the new Government develops its Policy for NHS this could impact adversely on the Trust strategy and the role and priorities or our key stakeholders	CE	12	9	9	9					↔
10. Financial pressures on other providers of health and social care cause operational difficulties at ASPH eg. increased DTOC, social services support	DCE	12	12	12	12					↔
11. If NHS Surrey's financial position causes negative impact on the Trust	DoF	12	12	12	12					↔

	Lead	June Risk score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Risk Score	Risk Score	Risk Score	Risk Score	In Month Risk Change	
5. Other (including Statement on Internal Control requirements)											
Risks to Objective											
1. Non compliance with Climate Change Adaptation reporting to meet the requirements under the Climate Change Act 2008	DCE	6	6	6	6						↔
2. Lack of Informatics strategy in a post NPfIT environment. (IT strategy needs to be driven by Trust overall strategy).	DoF	8	8	8	8						↔
3. Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy	DCE	6	8	8	8						↔

Legend

15 – 25	Extreme
8 – 12	High
4 – 6	Medium

↔	No change to the risk score
↓	Risk score decreased
↑	Risk score increased

CE	Chief Executive
CN	Chief Nurse
DCE	Deputy Chief Executive
DoW	Director of Workforce & Organisational Development
DoF	Director of Finance & Information

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

BOARD ASSURANCE FRAMEWORK (BAF)

2010/2011 – 2015/16
December 2010 version 4

KEY:

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Risk Priority		
Which standard / aim / risk the objective relates to:	What could prevent this corporate objective being achieved	What controls / systems we have in place to assist securing delivery of our objectives	Where we can gain evidence that our controls / systems, on which we are placing reliance, are effective	Where we are failing to put controls/systems in place Where we are failing to make them effective	Where are we failing to gain evidence that our controls/systems on which we are placing reliance, are effective	What is required or in place to address the gaps. To be approved and monitored by the Board	Lead Executive Director	Obtained using Trust's risk matrix		
								Likelihood	Severity	Risk Score

Risk Score Legend; Green - Low risk Yellow -Moderate Risk **Orange** – High Risk Red – Extreme Risk

Cross references:

ALE	Auditors Local Evaluation	**IBP**	Integrated Business Plan
CRR	Corporate Risk Register	**CBP**	Corporate Business Plan
FT	Monitor Requirement	**CQC**	Registration

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
1. To achieve the highest possible quality standards for our patients, meeting and exceeding their expectations, in terms of outcome, safety and experience.										
FT CRR 988/769/ 764	1.If the Trust does not meet national priorities (and therefore Monitor's Compliance framework)	Monthly performance meetings with each CD. Clear ownership of each individual target/priority Escalation process agreed Elective MRSA screening programme now in place . Targeted improvement on pathways for elective patients to ensure 100% compliance have been introduced	SE Coast SHA monitoring via STEIS Internal Trust monitoring systems with Board scorecard	Elective MRSA screening target- but 100% achieved in October 2010	None known	Maintain existing actions- main focus is HCAI ~~Targeted improvement on pathways for elective patients to ensure 100% compliance are being introduced~~	**Deputy Chief Executive** ~~**November 2010**~~	2	5	10
IBP Risk 1.3 CRR 763	2. If the level of HCAI infection rose and trajectory not achieved	Infection Control Team , IC Policies and Antibiotic Policies Training programmes including induction Hand washing and audit of this Rigorous RCA process for learning Effective management of beds including occupancy levels	Mandatory reporting to the Health Protection Agency Monitoring via Infection Control Clinical/ward audits DoH visit 30/07/10 CQC spot checks on Hygiene Code compliance	On going embedding of best practice Consistency of application of aseptic techniques and IV site mgt.	None known	Continued embedding , review and learning Review and develop Framework to embed competency testing on aseptic techniques and IV site management commenced in August ~~.and completes in October inc. Jnr. Drs. Nurses and midwives~~ **Training completed end Nov 10**	**Chief Nurse** ~~**End October 2010**~~ **Report on findings December 2010. Implementation via NMC; monthly follow up.**	4	4	16

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
		Effective management of beds including occupancy levels								
		Designated team providing 24/7 phlebotomy service for blood cultures including night time arrangements				Non elective screening programme underway and monitored	Ongoing			
						Reinforcing Promoting Zero tolerance approach				
CBP 1.4 FT	3. If there were pockets of substandard services which were masked by top level performance (as apparent in Mid Staffs)	Ward to Board approach including patients stories/Board visibility programme/Matrons presentations	Trust Board reports built up from ward level detail.	Staff survey results indicate further focus on specific aspects e.g. incident reporting	None known	Complete actions from staff survey action plan E.g. incident reporting	**Chief Nurse/Medical Director**	2	5	10
		Detailed quality metrics including scorecard and WQIs tracked over time	Matrons' feedback to Directors			Divisional Quality dashboards ~~will be presented to CGC monthly~~ have been developed and presented to CGC. To commence regular review in Jan. 2011	~~**November 2010 onwards**~~ **Jan 2011 onwards**			
		Patient comments/incidents and SUI review processes	Patient complaints monitored via Complaints group.							
		Maintaining agreed staffing levels with appropriate back-fill and monitoring compliance with processes								
		Culture of openness, ultimately supported by Whistle blowing policy	Dr Foster data PPEG/LINk/OSC							
		Mortality Review Group		Complete establishment review with standardised methodology across Trust		~~Complete establishment review and then introduce systematic management controls on n/m establishment. For final discussion at TEC in October December.~~ Establishment review completed and	**Chief Nurse ~~October onwards~~**			

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
						consultation commenced November to complete 1st week December followed by implementation to complete April 2011. Introduce systematic management controls on n/m establishment. Ward sister development programme scheduled to commence in January 2011	**April 2011** **January 2011**			
FT CQC CRR 1088 CRR 1089	4.If Data quality deteriorated leading to poor decision making	Data Quality Manager in place	Audit Commission audit on PbR for SE Coast	Further work on detailed procedures.	None known	Review and update core procedures. Action plan to achieve this has been developed. Data Quality Policy has been ratified by the Safety and Risk Committee. Outpatient procedures to be piloted in Ophthalmology. Training using the new procedure guide is underway in Outpatients. Review outcomes of pilot after c 3 months prior to further roll out across the trust ~~Assurance – Internal Audit has commenced. PBR data assurance framework audit to be undertaken, initial meeting arranged for~~	**Director of Finance and Information**	2	4	8
		Training and staff awareness	Clinical Audit Team							
		Data quality audits (required as part of IG toolkit)	IG toolkit							
		Submission to external sources e.g. SUS (looks at completion rather than accuracy) or Dr Foster (allows benchmarking)	SUS/Dr Foster Internal Audit review							

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
						~~12/10/10. Internal Audit on OP data quality to Oct Audit Committee~~ PBR data assurance framework audit to be undertaken. Initial meeting has taken place	January 2011			
SIC ~~CRR 887~~ CRR 1089 CRR 1088	5. If there were poor standards of information governance which then jeopardised patient confidence	Information Governance Steering Group Information Asset owners have been established with risk assessment process Mandatory IG training programme Policies and Procedures	Information Governance Toolkit Trust recording on mandatory training Chantrey Vellacott DFK (Audit on Mobile data 2010) Reviewed at IGAC October 2010	Uptake of mandatory training. IG toolkit requirement to achieve 95% of staff trained using the national on line IG training system	None known	Continue with on-line mandatory training to work towards annual target of 95%. Basic computer skills courses offered to staff where applicable in support of this initiative.	**Director of Finance and Information** **Ongoing**	2	4	8
IBP Risk 1.4 CBP Priority 1.3 CRR 1037	6. If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence	Approach to overseeing Registration has been agreed with Directors &TEC. Details included in Directorate reviews Evidence is gathered on the Performance Accelerator allowing gap analysis Programme of activity to embed ownership at service level Review process incorporated into committee/group TOR	Performance Accelerator CQC Quality and Risk Profile Results of patient surveys	None known	~~Ensure owned by Committees and groups internally~~ None known	Continue with ~~Q1~~ assessment process	**Chief Nurse**	2	4	8

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
		Early warning indicators for many Regulations including ward metrics Proactive review and response to external advice on best practice e.g. NPSA alerts *Your Feedback* means assessment can become more outcome focussed	Patient complaints/incidents/ KPIs							
CBP Priority 1.1 IBP Risk 1.1 CRR ~~769/~~766	7. If the Patient experience is poor due to the Trust not understanding the needs of our patients or the Trust is unable to respond in a timely and prompt fashion	Engagement and Communications Strategy with action plan agreed Good feedback mechanisms e.g. National and local surveys, Potential use of real time data mechanisms being reviewed. Patient comment cards Launched Care Standards (nursing)	National and local Patient surveys i.e. Picker, CQC and internal Patient Panel/PPEG LINKs OSC Complaints data	Poor results in national surveys	None known	Implement Programme 1 – Improving the patient experience Implement 10 point action plan for inpatient survey Feedback Strategy to be approved by TEC- further work on clarifying measureable outcomes to take place– agreed to continue with "Your Feedback" comment cards and embed that approach into the organisation. Review PPEG following authorisation for FT status. Merger of Quality and Customer Affairs Departments commenced consultation November to December followed by implementation December – March 2011.	**Chief Nurse** **Continuous** **Agreed in November 2010. Monthly reports to Divisions via Performance reviews on' Your Feedback'** **January 2011** **March 2011**	3	4	12
IBP risk 1.2	8. If Environmental standards,	Self- assessment on SSA completed	Self assessed declaration on	None known	None known	Not required	**Deputy Chief Executive**	1	3	3

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 1.1 CRR 767	including Single Sex Accommodation (SSA), do not meet expectations/ standards		national template							
		SSA delivery plan in place	PEAT inspections							
		Breach monitoring system in place	Trust Board reports							
		Funded programme of capital works to complete outstanding wards.	Funded Capital programme							
			Patient survey results							
			PCT assurance visit in December 2010							
~~CBP Priority 1.2~~	~~9.If there was Insufficient assurance to support Monitor assessment of Quality through Board Memorandum and external validation~~	~~Detailed evidence bank gathered to support self certification. Self certification agreed by Board with 3 elements amber/green~~	~~Quality has been reviewed generally as part of SHA Medical Director assessment for FT application.~~	~~Review of the clinical audit function~~	~~(addressed above)~~	~~Detailed action plan addressing 3 areas self - assessed by Board will be presented to September Board and then implemented.~~	~~**Medical Director/ Chief Nurse**~~	~~2~~	~~4~~	~~8~~
		~~Quality Strategy agreed and launched~~	~~Part of Monitor batching review process~~			~~Merge Quality, Risk Customer Affairs and R&D departments and realign to Divisional structures~~	~~September 2010~~			
		~~Existing governance/quality structures are in place and operating through out the Trust~~	~~Integrated Governance and Risk department~~				~~October onwards~~			
		~~Link to quality report and other best practice initiatives .Quality Account/CQUIN~~	~~IGAC~~							

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
2. To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.										
IBP Risk 3.2 CBP Priority 2.1 CRR 768	1. If the Trust has difficulty recruiting to key positions	Monthly vacancy reports at Corporate, Directorate, staff group level Weekly recruitment and retention meeting to design recruitment campaigns to fill vacancies in affected directorates Alternative roles and working patterns considered and proposed by Workforce Redesign Group	Board reports Performance Review meetings Workforce Redesign Group Workforce Strategy Steering Group	None known	Middle grade doctor vacancies in Emergency services, ~~ITU & Paediatrics~~ and qualified midwifery vacancies	Recruitment plans for nursing, midwifery and medical staffing in place to address issues in specific directorates e.g. international recruitment, Overseas Nursing Programme, newly qualified nurse recruitment fairs, development of new roles (e.g. Associate Consultant, ~~Associate Practitioner~~)	**Director of Workforce and OD** Ongoing programme of activities – review Feb 2011	3	3	9
IBP Risk 3.2 CBP Priority 2.1 CRR 768	2. If the Trust was unable to retain staff particularly in shortage specialties	Monthly staff turnover reports at Corporate and Directorate and staff group level Targeted plans for retention in shortage specialties e.g. Health and wellbeing, Training and development initiatives Talent management systems being developed, with work being undertaken to have at least 1 internal candidate for every vacancy by March 2011	Board report Performance Review meetings CG meetings Staff Attitude Survey (CQC and internal)	None known	1 key score did not improve and 3 scores remained below average in summer staff survey - % staff who believe there are equal opportunities for career progression, - % reporting availability of hand washing materials - % participating in health & safety training	Corporate action plans covering discrimination issues, availability of hand-washing materials and profile of health & safety training in place Directorate level targeted SAS action plans also in place Fieldwork for national survey ~~is due to commence in October 2010~~ closes in December 2010: results expected in March 2011	**Director of Workforce and OD** April 2011: revised action plan plans reflecting 2010 results	2	3	6

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 4.1	3. Inability to reduce management costs	Workforce Plan 2010/11 agreed and monitored monthly	Board reports Finance Committee Performance Review meetings	None known	None Known	Monitoring of Trust's Integrated Workforce Plan at WSSG CIP steering group established and meeting weekly to monitor progress against targets. Report held by Finance and HR to track progress against management CIPs. Business planning for 2011/12	**Director of Workforce and OD** By March 2011 have achieved additional management cost CIP	3	3	9
		Working Group progressing 2011/12 and 2012/13 plans to reduce management posts	Workforce Redesign Programme CIP and Workforce Redesign Groups							
		Corporate Directorate review meetings established wef July 2010								
		Vacancy Panel reviews every vacancy and all non clerical roles advertised and appointed to on a fixed 9 month term basis								
CBP Priority 2.1	4. Medical appraisal and job planning do not underpin revalidation requirements	Medical appraisal overseen by Medical Director	Board report Performance review meetings TEC MSC JLNC	Medical appraisal and Job Planning are not currently aligned	Removal of DoH appraisal toolkit	Systems & processes to support Medical appraisal and consultant job planning: - local appraisal system for medical staff to replace DOH toolkit being piloted - commission electronic job planning/appraisal software - Local job planning guidance agreed for 2011 round	**Medical Director** November 2010 Pilot concludes Feb.2011 Implement by March 2011 December 2010	3	2	6
		Consultant Job Plans are overseen by Deputy CEO								
		Medical appraisal reported at Corporate and Directorate levels monthly								
		Deputy Medical Director appointed and will lead on medical appraisal and revalidation								
		Centralised monitoring and recording of appraisal on ESR								

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score L	S	RS
CBP Priority 2.2	5. If there was failure to deploy a high performing workforce	Integrated performance reports at Corporate and Directorate level feeding into individual appraisals C600 staff participating in Leadership development programmes Succession planning being developed and implemented Values and behaviours driving improvement in motivation and productivity (honesty culture being fostered) Recognition of staff contribution through events, awards schemes, clear statement of values	Board report Performance Review meetings Delivery Programme 4 and Programme Board Appraisal rates	None known	~~None known~~ Attainment of 95% appraisal rate by 31/03/.11	~~Not applicable~~ - Weekly appraisals reporting - ESR self service training	**Director of Workforce and OD** March 2011	2	4	8
CBP Priority 2.3	6. Increased turnover and sickness	Turnover and sickness reports at Corporate, Directorate and staff group level reviewed at Board and Directorate performance review meetings SAS and Health and Well Being calendar in place (Occupational Health and Employee Assistance Programme) being more actively promoted	Board report Performance Review Meetings Health and Safety Committee EPF/JLNC WSSG CQC and internal staff surveys	Staff awareness of EAP,OH	None known	Promote EAP and OH services Calendar of Health and Well being events in place	**Director of Workforce and OD** **Review March 2011**	2	3	6
CBP Priority 2.1	7. If there was reduced knowledge of junior Doctors.	Close supervision by Clinical tutors and DME Replacing some roles with experienced doctors in A&E and MAU	Deanery Local Faculty Group Meetings (LFGs) Mid & end year	None known	Attendance at/participation in Local Faculty Groups for O&G	Ensure attendance at LFGs as identified at Centre Review	**Director of Workforce and OD** Review March 2011	3	3	9

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
		Junior Doctor survey Annual leave tracking in place to ensure adequate consultant cover during July/August	reviews for all Drs either in house or ARCP process. Speciality and LEP visits Centre Reviews that assess quality assurance of supervision and training and education in practice. PMETB/GMC Junior Doctor Survey							
		Consultant Cover strengthened ♦ Labour Ward 40 hrs week ♦ Physicians 13 hours/7 days a week ♦ Paediatrics and Neonates full Consultant attendance ♦ T & O Consultant delivered Service ♦ Acute Surgery Consultant delivered Service ♦ A & E Middle and Senior Grade cover 24/7	Induction includes competency-based training which ensures clinical skills are assessed							
		Junior Doctor presence at Directorate Meetings, Departmental and Trust Morbidity and Mortality Meetings								
SIC	8. Non compliance with Equality , Diversity and Human Rights	Single Equality Scheme and action plan	SHA review of SES	None known	None known	Not applicable	**Director of Workforce and OD**	2	3	6

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
	legislation	Diversity champions	Monitoring of SES through Equality & Diversity Group and Board EDSG Patient and Staff Survey(CQC)				December 2010 review by Board			
3. To deliver the Trust's clinical strategy; redefining our market position to better meet the needs of patients and commissioners, and increasing market penetration.										
~~CRR 769~~	~~1. If the Trust was unable to achieve FT status it is likely the Trust would be an outlier in the national programme and might need to consider future organisational configuration~~	~~Foundation Trust Project plan~~ ~~Election process with external professional support~~ ~~LTFM reviewed and updated monthly~~ ~~New Quality Governance assessment prepared and submitted~~ ~~Board self certification (Quality, risk, performance, Board capacity and capability) completed~~	~~NHS Surrey support~~ ~~SHA assurance process~~ ~~DoH Applications Committee approval~~ ~~SoS approval~~ ~~Monitor initial risk assessment and process~~ ~~Programme of external check and validation via Board master classes~~ ~~FTA Project plan monitored by~~ ~~• Project manager~~ ~~• Overseen by Project Director~~ ~~• Reviewed~~	~~None known~~	~~Board to Board 4/11/10~~	~~Continue to implement project plan~~ ~~Continue to review and action Risk log~~	~~**Director of Workforce and OD**~~ ~~Monthly~~	~~2~~	~~4~~	~~8~~

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
			~~monthly by Project Board~~							
CBP Priority 3.3 IBP	2. If the Trust was not the preferred provider (through a consortium) of renal services for Surrey	Strong leadership and clinical engagement Stakeholder and external clinical independent advice are testing quality and robustness of consortium proposal Good strategic alliance between consortium partners One of the consortium is the existing provider	External professional advisors BDO Stoy Hayward Surrey and St Helier Kidney Patient's Association	Externally driven timetable and process via NHS Surrey	None known	Continue to develop submission with expected ITT ~~now October~~ January 2011	**Chief Executive** **~~October 2010~~** **January 2011**	2	3	6
CBP Priority 3.3	3.If the trust was unable to provide increased services at Ashford Hospital and in community locations	Market data available to support decision making Clinical strategy group Buy-in from Clinical directorates with Directorate specific marketing plans Market share information is monitored at performance meetings with Divisions Business development team has been aligned to operational divisional structure to ensure strong support	Clinical strategy Group TEC Marketing data	None Known but start preparing for 2011/12	None Known	Continue actively promoting Trust services and working with GPs. . Embed marketing goals within Business planning processes for 2011/12	**Deputy Chief Executive** October 2010 - February 2011	2	3	6

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 3.2 CRR 832	4. If the trust lost significant market share including any current trends in specific localities or specialties	Market data available to support decision making and monitored at performance review meetings Marketing manager Buy-in from Clinical directorates Programme of GP engagement Growth achieved in some key areas including Cobham	Clinical strategy group TEC Finance Committee	Sustain current levels of activity and grow Mid Surrey	None Known	Target activities to achieve growth in some key areas including Feltham and Bedfont	**Deputy Chief Executive** October- March 2011	2	4	8
CBP Priority 3.1 CRR 1070	5. If the Trust did not succeed in reducing emergency admissions and redesigning the elective care pathways. Involves collaborative working across organisations	Good collaborative working with NHS Surrey through Transformation Board- projects agreed and setup with Project leads Performance reviews in Emergency services and medicine Information tools being designed to enable Trust to anticipate and therefore pre-empt issues with delivery Regular contract management including the PCT MAU redesigned to provide non inpatient facilities Phase 1 of new MAU /A&E pathway has been implemented	NHS Surrey Trust Activity reports Programme Board Performance Review meetings (Performance still exceeds target)	NHS Surrey demand management systems need to be fully in place	None Known	~~Work with NHS Surrey as a whole systems project~~ ~~Internal redesign across emergency care and medicine~~ Implement ambulatory care pathways Work with NHS Surrey, and PBC clusters to support and develop and implement pathways that support admission and attendance avoidance in line with best practice	**Deputy Chief Executive** ~~EQUIP event planned October 2010~~ Implement phase 2 of MAU/A&E pathway- December 2010 Data analysis completed; now planning rollout. Review benefits realisation in March 2011	3	4	12

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 3.3 &4	6. If the Trust developed a poor reputation	Continuous focus on maintaining high standards of care Positive media campaign-celebrating success Communications and Engagement strategy linking with stakeholders Active process of media hot spot analysis and preparation	Trust Board Successful FT application CQC Patients surveys Internally run surveys and feedback Feedback from major external stakeholders Results of summer staff survey	None known	None known	Not applicable	**Chief Executive**	2	4	8
CBP Priority 3.1	7. If the Trust was unable to engage with GPs individually and collectively as national policy enhances their role in commissioning	GP Liaison/Marketing Manager Choose and Book Manager CDs working with /visiting GPs Pathway work on referral management schemes Clinical Interface meeting chaired by medical director Engagement through NW Surrey Board Business development team aligned with divisions Medical director commenced an programme of engagement with GPs	Marketing Report LMC Feedback via LEC	Review in light of White Paper	None known	Develop the model of care with PBCs(clinically led with consultants and GPs around 6 themes) ~~Medical director commencing an programme of engagement with GPs~~	**Deputy Chief Executive** **March 2011** ~~**Commenced September 2010**~~	3	4	12

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score L	S	RS
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
CBP Priority 1.1&2 CRR 1070	1. Unexpected changes in pattern of demand and admissions puts pressure on the bed complement and therefore patient care	KPIs e.g. LOS Clear bed complement plan Escalation processes Winter plan agreed in principle by NW Transformation Board. Includes plans for additional capacity.	Benchmarking Programme Board Patient complaints and incidents. Staff feedback	None known	None known	~~Winter planning commencing looking internally and with NW Surrey~~ ~~To include plans for additional capacity~~	**Deputy Chief Executive** ~~**End October**~~ Regular review of capacity over winter period	3	4	12
CBP Priority 1.1&2	2. Insufficient attention to acuity of patient needs	Acuity review completed Resulted in review of nursing establishments. Bed ratios & AUKUH tool used to inform and review establishments	Benchmarking ACUH Programme Board Patient complaints and incidents. Staff feedback	Complete current review	None known	~~Complete current review~~ Nursing and Midwifery workforce review completed November 2010AUKUH tool found to be subjective and not of value. Professional judgement model used to determine workforce. 6 monthly review to commence June 2011 and as change in clinical areas occur.	**Chief Nurse** ~~**Oct 2010**~~ **March 2011 Follow up review June 20-11**	2	4	8
IBP Risk 2.4 CBP Priority 4.4	3. Management of non elective cap fails, and emergency admissions rise	Activity planning process with clear targets Clear approach to performance review	KPIs Performance Review Meetings Patient complaints and incidents. Staff feedback	~~Internal change plan in medicine and Surgery need to be implemented~~	None Known	~~Implement Internal change plan in medicine and Surgery~~ See actions in BAF 3.5	**Deputy Chief Executive** ~~31 September review of progress (pre winter escalation~~)	3	~~4~~	12
IBP Risk 4.1	4. Delivering CIPs is handled ineffectively or in a	Strong Programme management approach with clear governance arrangements and tracking	External advisor Finance committee	None known	None known	Not applicable	**Deputy Chief Executive and Director of Finance**	2	5	10

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 4.1 CRR 847	piecemeal fashion. Insufficient long term planning of CIPs into future years.	 Good track record of delivery in 2009-2010 External advisor has helped challenge and test robustness of proposals Plans for 2011/12-2012/13 are well advanced	review Programme Board. Work stream 2 and sub group				~~**Update to October Finance committee**~~			
CRR 847 CBP Priority 4.1 & 1.1	5. Risk if CIP/productivity agendas inadvertently undermine the Trust's stated objective on improving quality	Monthly Directorate performance reviews look at workforce/activity, finance and quality Trust's quality framework Planned programme of bed reductions which is regularly reviewed with Directorates Quality dashboards now implemented in Divisions	TEC Board Programme Board Complaints and KPIs	~~Develop the Quality dashboard for CIPs~~	None known	~~Standardised quality dashboards being developed for Divisions and review via CGC~~	**Deputy Chief Executive** ~~**November 2010**~~	**2**	4	8
IBP Risk 4.3 CBP Priority 4.3	6. Failure to secure benefits of service line management and the wider cultural benefits including clinical engagement	Programme management in place with Project lead Financial accountant to support development Good Clinical engagement Reports currently produced for 2nd six months of 2009/10. Moving to quarterly reporting in 2010/11	Delivery Programme TEC	Continual validation of data Continual clinical engagement Further staff training	None known	Continue to implement Programme 6 Continual validation of data Training needs analysis to be undertaken Engagement events and specialty lead training	**Director of Finance and Information** Ongoing monitoring through SLM workstream January 2011	3	2	6

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 4.2	7. EQUIP programme is not fully embedded with widespread and rising engagement throughout the Trust year on year	External support through Simpler	Simpler TEC Programme Board	Align EQUIP programme with 2011/12 priorities	None known	Not applicable Develop EQUIP priorities as Objectives for 2011/12 are agreed	**Deputy Chief Executive** March 2011	2	4	8
		Strong Project team/resource in place> new transformation lead appointed.								
		Good clinical engagement with clinical lead agreed								
		Active programme of rolling out training to Bronze level across organisation								
		Strong sign up from the Directorates- EQUIP programme full till December	CIP Programme Board							
CBP Priority 3.1	8. National economic climate with focus on reducing public sector expenditure.	Medium term financial planning though LTFM includes downside scenarios and mitigation.	Finance committee Internal and External audit DoH/SHA	Continuous review	None known	Continuous review through Finance Committee including review of o Trading o CIP o LTFM	**Director of Finance and information**	4	3	12
		Good recent track record of managing budgets and delivering a surplus.								
		Robust approach to CIPs with target of over delivery, thus 'banking'.								

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
IBP	9. As the new Government develops its Policy for NHS this could impact adversely on the trust strategy and the role and priorities of our key stakeholders	Continue to review Trust strategy alongside new Policy. Initial review shows strong degree of alignment between Trust strategy and The White Paper Maintain a very strong focus and relationship with local GPs and other stakeholders Corporate Plan reviewed in the light of the White Paper- additional actions identified and agreed	Trust Board	Review Corporate Business plan and 6 Programmes when White paper published in July Priority is likely to be a focus Information to be patients	None known	To be reviewed as part of Business Planning Processes commencing in October. New objectives will be identified in Corporate and Divisional plans	**Chief Executive** March 2011	3	3	9
CRR 1070	10. Financial pressures on other providers of health and social care cause operational difficulties at ASPH e.g. increased DTOC, social services support	Continuous review through KPIs Local engagement with key stakeholders Reviewed through Transformation Board. Joint winter planning with NW Surrey Transformation group Weekly interagency discharge review established. Initial discussions on winter planning have secured some additional community support. Formal winter plan agreed Additional in house support secured by trust to maintain pace on discharge arrangements	KPIs OSC LINk	None known	None known	~~Daily interagency discharge review established.~~ ~~Initial discussions on winter planning have secured some additional community support.~~ ~~Formal winter planning to be addressed via NW Surrey Transformation Board.~~ ~~Additional in house support secured by trust to maintain pace on discharge arrangements~~	**Deputy Chief Executive** Monthly review	3	4	12

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 3.1	11. If NHS Surrey's / LHE financial position causes negative impact on the Trust	Focus on NW Surrey Locality relationships Signed Contract in place with monitoring arrangements Activity profiled across year	NHS Surrey Contract Monitoring Group Finance Committee TEC	External factors to the Trust	External factors to the Trust	~~Regular Executive level meetings with NHS Surrey have been requested~~ Capped contract under negotiation Trust response to "Fast, Steady, Stop" is being developed	**Director of Finance and Information** Dec 10	4	3	12
5. Other (Including Statement on Internal Control requirements)										
SIC	1. Non compliance with Climate Change Adaptation reporting to meet the requirements under the Climate Change Act 2008	Participation in Carbon 10:10 programme Closer integration of estates and hotel services	PWC audit	Carbon emission strategy required with action plan	Baseline of current position required- external advice required	1. Develop a sustainable action plan to meet DoH targets 2. Establish baseline of current position Review ways of working that reduce carbon e.g. light use/PCs Review energy technologies to reduce carbon emissions Internal Audit are to undertake a review on Carbon reduction as part of their annual plan	**Deputy Chief Executive** January 2011 February 2011 January 2011 onwards March 2011 onwards Quarter 4	3	2	6

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
~~CRR 816~~	2. Lack of Informatics strategy in a post NPfIT environment. (IT strategy needs to be driven by Trust overall strategy.) Lack of capacity so opportunities to deliver services differently cannot be seized.	Interim Associate Director of Informatics appointed to help develop the strategy and seize opportunities to use existing infrastructure better. Permanent post to be recruited to. Consultants appointed to support developing the Strategy	External review of Informatics completed in 2009/10	Complete actions from Informatics review	None known	Develop Strategy Strengthen IGSG Following discussion at TEC development session, strategy to be brought to ~~TEC and~~ Board	**Director of Finance and Information** ~~November 2010~~ February 2011	2	4	8
	3.Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy	Capital programme agreed annually Monthly Capital Review Group Regular report to Finance committee	Capital Control Group Finance Committee	None known	Develop Strategy with outline capital plans	None known	**Deputy Chief Executive**	2	3	6

Audit Trail

Version 1	BAF Amended to reflect revised Corporate Objectives in the Corporate Business Plan 2010/2011
Version 2	July/August updates via EDs
Version 3	September review by EDs/ Review by October IGAC and then further refresh by Executives
Version 4	December refresh by Execs prior to review by IGAC

Reference:

Department of Health (2006) Integrated Governance Handbook. A handbook for executives and non executives in healthcare organisations www.dh.gov.uk/governance
Audit Commission – Taking it on Trust

Risk Scoring Matrix –

Risk Matrix - Severity x Likelihood

			Likelihood				
			Rare	Unlikely	Possible	Likely	Almost Certain
Severity	Descriptor		1	2	3	4	5
	Negligible	1	1	2	3	4	5
	Minor	2	2	4	6	8	10
	Moderate	3	3	6	9	12	15
	Major	4	4	8	12	16	20
	Catastrophic	5	5	10	15	20	25

Risk Rating
Extreme
High
Medium
Low