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

TRUST BOARD
25th July 2013

TITLE	**Board Assurance Framework**
EXECUTIVE SUMMARY	The Board Assurance Framework (BAF) is a key assurance tool that ensures the Board has been properly informed about the risks to achieving the Trust's Strategic Objectives. The BAF is aligned to the 4 Strategic Objectives as detailed in the Corporate Business Plan 2013-14.
ASSURANCE (Risk) / IMPLICATIONS	The Board assurance process ensures that risks to achieving the Trust's strategic objectives are actively identified and managed.
LINK TO STRATEGIC OBJECTIVE	The Framework links to all Strategic Objectives.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	The BAF incorporates risks and their impact to stakeholders, staff and patients.
EQUALITY AND DIVERSITY ISSUES	None known.
LEGAL ISSUES	The Board Assurance process supports the Chief Executive in signing the Annual Governance Statement which forms part of the Trust's statutory accounts.
The Trust Board is asked to:	Discuss, challenge and approve the Board Assurance Framework.
Submitted by:	Andrew Liles, Chief Executive.
Date:	July 2013
Decision:	For Approval

Board Assurance Framework (BAF)

1 Introduction

The BAF is an assurance tool to ensure that the Board is properly informed about the risks to achieving all of the Strategic Objectives as detailed in the Corporate Business Plan. The risks on the BAF are mapped to the risks on the Trust Risk Register.

2 Strategic Context

The BAF is aligned to achieving the four Strategic Objectives as documented in the Corporate Business Plan 2013-14. The BAF also supports the Annual Governance Statement, and has been cross referenced to the Trust Risk Register.

As a Foundation Trust it is important that the Board Assurance Framework works as a tool to support the Board's assurances in terms of self certification on compliance with the Trust's License.

3 Review

There was a detailed review of the risks which formed the BAF in April 2013 following the development of the new Business Plan for 2013/14. As such nine risks were closed at April 2013 with five additional risks added. At July one risk is proposed to be closed and no new risks are proposed to be added to the Framework.

4 Commentary on Risks

4.1 Closure of risks

Approval is requested to close risk 2.4 '*If levels of sickness increased, adversely affecting patient and team working, and organisational performance'* due to the target score being met and current levels of sickness being under the national target of 3%.

Staff sickness is not currently identified as a risk to the Trust meeting our Strategic Objective: *To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.*

4.2 Extreme risks

As with April there are five risks which are rated as extreme (red).

Risk	Rating
1.6 Poor capacity and flow in the emergency pathway this could result in a poor patient experience.	**20**
2.3 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	**16**
3.1 If the Trust does not fix the emergency pathway.	**16**
4.2 If ASPH fails to deliver the clinical quality incentives (CQUINS).	**16**
4.3 If ASPH fails to deliver 2013/14 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income.	**16**

Risk 1.6 and 3.1: Whilst the emergency department waiting time target was achieved in quarter one 2013/14 the hospital continue to remain under significant operational pressure at times in quarter two. This pressure hampers the ability to achieve capacity and flow and does at times result in poor patient experience. As such this risk has remained as 'extreme' at July 2013.

Risk 2.3: The 2012 staff survey published in February 2013 highlighted a lack of improvement in staff morale and satisfaction. A staff Experience action plan has been developed and approved by Board in April 2013 with progress tracked by the Workforce and OD Committee which met for the first time in July 2013. Quarterly surveys of staff will provide evidence of progress with the action plan. As staff have not yet been surveyed, and hence this evidence does not yet exist, the risk has remained as 'extreme' at July 2013.

Risk 4.2 and 4.3: Significant challenges exist to meet the CIP and CQUIN targets in 2013/14 despite the number of measures and plans in place. In quarter one the operational pressures on the hospital has impacted on the delivery of these plans and therefore their risk has not reduced at July 2013.

4.3 Top Five Risks

The Board has previously agreed that the key risks should be highlighted. At July 2013 these mirror the Trust's extreme risks and are:

1.6 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and outcome and potential failure of the Monitor Compliance Framework.

2.3 If individuals and teams were not values-driven or motivated, resulting in poor patient care experience and ineffective team working.

3.1 If the Trust does not fix the emergency pathway

4.2 If ASPH fails to deliver the clinical quality incentives (CQUINS).

4.3 If ASPH fails to deliver 2013/14 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income.

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

5 Recommendation

The Board is asked to discuss, challenge and approve the Board Assurance Framework including the closure of risk 2.4.

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

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

Board Assurance Framework - Summary
Version: July 2013

	Lead	July 12 Risk Score	Sept 12 Risk Score	Dec 12 Risk Score	April 13 Risk Score	July 13 Risk Score		In Quarter Risk Change
Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.								
Risks to Objective								
1.1 If there is a national publication at an organisational and/or clinician level of outcome data that is unknown, or unverified, to the Trust and is indicative of poor quality of care.	CN	n/a	n/a	n/a	12	**8**		↓
1.2 If the Trust provides poor quality care leading to a regulatory response by the CQC and/or Monitor.	CN	10	10	4	12	**12**		↔
1.3 If the quality governance and impact assessment processes fail during the design of CIPs this could lead to poor quality of care.	CN	9	9	9	8	**8**		↔
1.4 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.	CN	12	12	8	12	**12**		↔
1.5 If the Trust fails to secure a Friends and Family score that is within an acceptable and reassuring range when benchmarked with peers.	CN	n/a	n/a	n/a	8	**8**		↔
1.6 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and outcome and potential failure of the Monitor Compliance Framework.	DCE	12	12	16	20	**20**		↔

	Lead	July 12 Risk Score	Sept 12 Risk Score	Dec12 Risk Score	April 13 Risk Score	July 13 Risk Score		In Quarter Risk Change
Objective 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								
2.1 If the Trust workforce was not appropriately aligned to demand and acuity; particularly to meet reductions in WTE, agency usage and pay costs, resulting in overspends against agreed budgets.	DoW	9	9	9	12	**12**		↔
2.2. If the Trust was unable to retain high calibre staff through developing leadership potential.	DoW	n/a	n/a	n/a	12	**12**		↔
2.3. If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.	DoW	9	9	12	16	**16**		↔
2.4 If levels of sickness increased, adversely affecting patient and team working, and organisational performance.	DoW	4	4	4	8	**4**	*Closure Request*	↓
2.5 If roles and responsibilities for leadership and workforce development were unclear, thereby impeding individual, team and corporate performance.	DoW	6	6	6	6	**6**		↔
Objective 3: To deliver the Trust's clinical strategy of joined up healthcare								
Risks to Objective								
3.1 If the Trust does not fix the emergency pathway this will limit the Trust's ability to safely care for emergency patients, grow elective work and will damage the Trust's reputation and potentially impact on the Trust's strategic ambitions.	DCE	12	12	16	16	**16**		↔
3.2 If the Trust is unable to secure sufficient alignment and support from other key partners, it will not be possible to fully develop integrated out of hospital care in NW Surrey.	MD	n/a	n/a	n/a	12	**12**		↔
3.3 If the Trust is unable to secure sufficient support from Acute Partners and Commissioners, it will be not be able to develop the required scale for its specialist services.	MD	n/a	n/a	n/a	9	**12**		↑

Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.								
	Lead	**July 12 Risk Score**	**Sept 12 Risk Score**	**Dec 12 Risk Score**	**April 13 Risk Score**	**July 13 Risk Score**		**In Quarter Risk Change**
Risks to Objective								
4.1 If the Trust's clinical workforce is not aligned around the Trust's efficiency improvement programme.	DCE	12	12	12	12	**12**		↔
4.2 If ASPH fails to deliver the clinical quality incentives (CQUINS), fails to deliver the performance standards, or fails to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2013/14 contract and under recovers income.	CN/MD	16	16	16	16	**16**		↔
4.3 If ASPH fails to deliver 2013/14 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income.	DoF	16	12	9	16	**16**		↔
4.4 If the contribution from individual divisions and service lines is less than required to deliver the EBITDA margin for ASPH as a whole. If ASPH cross-subsidises uneconomic service lines with the financial contribution of unrelated service lines.	DoF	12	12	12	9	**9**		↔
4.5 If financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or leads to enforcement of contract levers more aggressively than expected.	DoF	12	16	16	12	**12**		↔

Key:

15-25	Extreme	↔	No change in risk score	CN	Chief Nurse
8 –12	High	↓	Risk score decreased	DCE	Deputy Chief Executive
4 – 6	Medium	↑	Risk score increased	DoW	Director of Workforce Transformation
1-3	low			MD	Medical Director
				DoF	Director of Finance & Information

Principle Risk:

1.1 If there is a national publication at an organisational and/or clinician level of outcome data that is unknown, or unverified, to the Trust and is indicative of poor quality of care.

Chief Nurse

Link to CRR: CRR 1214

	Initial	Current	Target
Likelihood	3	2	2
Consequence	4	4	4
Level	12	8	8

Strategic Objective Affected

Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Apr-13
Closed:

Controls

- Head of Clinical Effectiveness, HCE, monitors publication of national reports
- CEO and MD communicate information relating to new publications to HCE
- A Trust level annual, clinical audit forward plan is available and updated at least bimonthly
- HCE has strong network for communication e.g. SECEN, South East Coast Clinical Effectiveness Network, links to AHSN, Allied Health Sciences Network and is on the mailing list for a variety of national organisations e.g. RCP, NICE, HQIP, NCEPOD.
- Local clinical governance meetings discuss national audits, reports and actions
- Specialty performance review meetings (Clinical accountability for data)

Assurance

- Regular reports to CENARG, Clinical Effectiveness & National Audit Review Group and updates to the Clinical Outcomes Steering Group
- HCE communicates with relevant staff and includes DD, ADO, ADN and clinical governance managers and links with Head of Communications
- Trust forward plan approved and shared with CCG and monitored bimonthly at CENARG
- Support from HCE for clinicians to review data prior to publication e.g. surgical outcomes at consultant level.
-
- Implementation of actions following performance review meetings

Gaps in Controls

- Publication of national reports can come from variety of sources and HCE might not be kept informed, sometimes dependent on the individual who is a member of a national society
- Delay with communications sent directly to CEO, MD office.

Gaps in Assurance

- CENARG members not communicating within their areas
- Not all clinical staff share their data.

Closure Request?

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Apr-13	Collaboration with Pharmacy and Head of DTC to publish Trust Formulary re NICE Technology Appraisals prior to deadline of April 2013 (mandatory).		Formulary published and updated in June	ongoing
01-Apr-13	Exception report containing details of potential issues submitted to April QGC		Exception report is updated for July QGC	01-Jul-13
30-Jun-13	Support for review of data for publication of surgical outcomes data at consultant level		Support provided included reviewing clinical data and contacting national societies for further information relating to which data being published. Linking with Head of Communications to ensure Trust website is updated with links to the published data (mandatory).	31-Jul-13
ongoing	Monitoring publication of national reports		Trust annual clinical audit forward plan is updated regularly and at least bimonthly	ongoing
ongoing	Support to clinical teams for review of recommendations and development of action plans		Ongoing action - gap analysis and review will support response should published data indicate poor quality care.	ongoing

Principle Risk:

1.2 If the Trust provides poor quality care leading to a regulatory response by the CQC and/or Monitor.

Chief Nurse

Link to CRR: CRR 1037/1072/763/1147/1130/1057/766

	Initial	Current	Target
Likelihood	2	3	2
Consequence	5	4	4
Level	10	12	8

Strategic Objective Affected

Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Apr-11
Closed:

Controls

- Corporate owners and Divisional owners of Essential Standards of Quality and Safety outcomes
- Policies, procedures and training programmes
- HealthAssure devolved to Clinical Divisions to upload evidence and review compliance with each outcome, including Divisional and Committee to Board reporting
- Awareness raised of essential standards through Corporate Induction and further communications
- Comprehensive clinical audit programme focussed on CQC Essential outcomes undertaken, across Wards monthly "Best Care" and 6 monthly " Compliance in Practice", reported into Sub-Board Committee.
- Monitoring of the CQC's Quality Risk Profile on ASPH
- Regular communications with the CQC and Monitor.

Assurance

- Registered with the CQC without conditions.
- 31/05/2013 CQC Quality Risk Profile (for ASPH) outcomes, 6 green, 9 yellow and 1 amber
- HealthAssure - 4 green, 10 yellow, 1 not assessed.
- Attach information to payslips
- Monthly "Best Care" audits showing overall no red ward areas. June 2013, "Compliance in Practice" audit to be presented at the 15th June, Intergrated Governance & Assurance Committee.
- Quarterly report to IGAC
- Park hill audit demonstrated full assurance regarding Outcome 9.

Gaps in Controls

- Clinical Divisons have recently moved from 6 to 4, which has been replicated on HealthAssure. Leads are currently updating evidence and standards accordingly.
- New users of HealthAssure need training within all Divisions.
- Reporting of HealthAssure within Clinical Divisions is still being finalised.
- Outcome 21: Work still progressing to improve documentation
- Lack of policy on Shared Decision Making (Outcome 1 CQC findings) Completion of mandatory training (Outcome 14 CQC findings)

Gaps in Assurance

- The Trust self-assessment of the evidence of compliance judged eight Outcomes to be fully compliant, seven Outcomes to be compliant with minor concerns and one Outcome to be non-compliant with moderate concerns: Outcome 17 – complaints.

Closure Request?

[Enter details of closure request]

Action Plan

Due:	Action Description	Progress to Date	Date Completed
01-Sep-13	Leads to update HealthAssure for the new Clinical Divisions	In-progress. Leads and shared users have been agreed by senior management within Divisions. Leads and shared users are currently uploading evidence.	
01-Sep-13	New users of HealthAssure to be trained	In-progress.	
01-Sep-13	Reporting of HealthAssure within Clincial Divisions is still being finalised.	Discussions in-progress.	
01-Sep-13	Outcome 21: Work still progressing to improve documentation.	Documentation Champions within all Wards, have been identifed. Training is planned for late July and early August. Regular forums will progress once training givin.	

Principle Risk:

1.3 If the quality governance and impact assessment processes fail during the design of CIPs, this could lead to a negative impact on quality

Chief Nurse

Link to CRR

	Initial	Current	Target	Strategic Objective Affected
Likelihood	3	2	1	Objective 1: To achieve the highest possible quality of care and treatment for our patients,
Consequence	3	4	4	in terms of outcome, safety and experience.
Level	9	8	4	

Opened: 01-Apr-11
Closed:

Controls

- ***Process control - procedural level*** - Consultation process undertaken where the CIP is more than a headcount reduction of one
- ***Pre-implementation*** - ***process control - procedural level*** - Change programmes, transformation schemes, and cost improvement programmes (CIPS) are supported by completion of the "Quality and Transformation Template and Quality Assessment." Initial review is by Associate Director of Quality.
- ***Post implementation - system overview control*** - QEWS dash board measures impact on quality.
- ***Post implementation - system overview control*** - The QEWS dashboard evaluates Quality, Experience, Workforce and Safety metrics across the Trust. This early predictor tool will indicate if quality is being compromised (a proxy for the quality:cost balance becoming unfarourable).
- ***High level monitoring control -*** monthly monitoring of complaints and incidents, which would detect serious failures of equipment due to quality issues.

Assurance

- Challenge process via CIP Quality review meetings at start of year
- "Quality and Safety Impact Assessment" (Section 2) submitted to Quality and Transformation Review Panel for approval. Panel comprises Executive Sponsor, Medical Director, and Chief Nurse.
- CIP monitoring meetings chaired by Assistant Director of Efficiency and Productivity.
- QEWS monitored monthly by Integrated Governance and Assurance Committee (IGAC).
- Complaints and Incident data trends- reported to Board and Integrated Governance Assurance Committee (IGAC).

Gaps in Controls

- A prior assessment indicated CIP templates completed to draft status, and it was recommended that quality impact assessments needed to be routine.
- Impact assessment forms need to be completed as a matter of routine. PWC raised this point in Review of Quality Governance. Monitoring was needed for potential deterioration in quality using a clear set of quality indicators.

Gaps in Assurance

- Whilst quality impact assessments are now in place, rolling review on sample basis of CIP templates to ensure they are "final" rather than "draft" could improve assurance.
- This gap should be closed now that the above controls are in place.

Closure Request?

[Enter details of closure request]

Action Plan

Due:		Action Description		Progress to Date	Date Completed
12-Dec-12		Monitoring of potential deterioration in quality using set of quality indicators.		QEWS dashboard approved at March 2013 IGAC. Quality indicators being monitored at IGAC and Finance Committee.	on-going

Principle Risk:

1.4 If divergent and multiple organisational priorities compete with and undermine staff engagement leading to a distraction from the focus on high quality care.

Chief Nurse

Link to CRR: CRR 1057

	Initial	Current	Target
Likelihood	3	3	2
Consequence	4	4	4
Level	12	12	8

Strategic Objective Affected

Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Apr-11
Closed:

Controls

- Clear vision of Quality of care as major driver for the trust
- Clear Strategic Objectives with quality as first priority
- PMO approach helps prioritise competing priorities
- Strong quality monitoring
- Strong clinical leadership at both Executive level , through Divisional Triumvirates.
- Dedicated central Quality team
- Achiement of full CQC Compliance

Assurance

- Scorecards including Best Care dashboards
- External review inc CQC review Dec 11 and May 12 (Outcome 21 to be addressed)
- Self certification process by Trust board based on a structured assurance process- May 12 board sign off
- Staff and patient Survey results
- Annual Plan is monitored quarterly (July Board report on Q1)

Gaps in Controls

- None known

Gaps in Assurance

- None known

Closure Request?

[Enter details of closure request]

Action Plan

Due:		Action Description	Progress to Date	Date Completed
Ongoing		Test all new initiatives against two core SOs (Emergency pathway and financial balance)	On going	
01-May-13		Development of 'together we care' nursing stratgey.	Pride in Nursing Day held in May 2013.	
08-Oct-13		Pride in Therapies Day	To be held on 8 October 2013	

Principle Risk:

1.5 If the Trust fails to secure a Friends and Family Test score that is within an acceptable and reassuring range when benchmarked with peers.

Chief Nurse

Link to CRR:

	Initial	Current	Target	Strategic Objective Affected
Likelihood	2	2	2	Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.
Consequence	4	4	3	
Level	8	8	6	

Opened: 01-Apr-13
Closed:

Controls

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

Assurance

- The Trust achieved 100% assesment for state of readiness for implementing FFT.
- The Trust has launched and rolled out FFT to all Wards and A&E, including Communication
- Q1 2013/2014 response rate 18%, which is in excess of the 15% CQUIN target for Q1
- The Trust FFT score for March 2013 was 65, April 68 and May 67
- The Trust implemented a text response service in A&E - there was a significant improvement in A&E returns in June and the option of rolling this option Trust wide is being
- Preliminary bench mark data across the region has been received which ranks ASPH 3rd (2nd for Trusts with an A&E) for response rates. ASPH is also 3rd (2nd for Trusts with an A&E) for the Friends and Family Test score for May 2013 (Surrey and Sussex).

Gaps in Controls

- None known

Gaps in Assurance

- None known

Closure Request?

[Enter details of closure request]

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Apr-13		Agree Management responsibilities within Divisions for responding to issues raised where response rates are low or fluctuating		Initial project meetings held and Divisional leads agreed. Associate Directors of Nursing and theHead of Emergency Department worked with the project team to increase	01-Apr-13
31-Jul-13		Commence roll out of VFF project		Phase 1 with external partners complete. Phase 2 - in house workstream - initiation complete, early key milestones (e.g. design of PEN awards) met. VFF and FFT project plans incorporated.	04-Jul-13
31-Jul-13		Review VFF comms plan		Focus for phase 2 needs review and update	

Principle Risk:

1.6 If there is poor capacity and flow in the emergency pathway this could result in a poor patient experience and outcome and potential failure of the Monitor Compliance Framework

Deputy Chief Executive | **Link to CRR: CRR 1147/1215**

	Initial	Current	Target
Likelihood	4	5	2
Consequence	4	4	4
Level	16	20	8

Strategic Objective Affected

Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Apr-12
Closed:

Controls

- Weekly 4 hour performance meeting chaired by CEO
- Weekly NWS Capacity meeting with Partners
- Escalation Policy ratified and shared with Partners
- 4 hour recovery plan shared with CCG and Monitor (including forecast trajectory)
- Whole-system action plan in place and monitored through Unscheduled Care Partnership Board

Assurance

- Trust signed off by ECIST November 2012. Return assurance visit planned for July 2013.
- Compliance with 4 Hour Standard monitored and multi-disciplinary, multi-divisional review of
- Detailed progress update for Board as part of Compliance Framework
- Quality indicators are reported at divisional and corporate levels

Gaps in Controls

- Insufficient consultant cover in MAU/A&E/CoE
- Development of Ambulatory Unit
- Robust Frail Elderly pathway
- Securing Commissioner and Community engagement

Gaps in Assurance

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

Closure Request?

[Enter details of closure request]

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Oct-13	Implement new emergency surgical model		Business case approved May 2013. Implementation plan in development	
01-Jul-12	Complete planned ward moves and rebalancing of bed base		Phase 1 complete. Business case for phase 2 due for approval by SD TEC July 2013.	
01-Feb-13	Widen the remit of RealTime		In-patient wards completed. IPL system to be migrated to Realtime. Phase 1 completed in March 13 with Phase 2 partially complete June 2013, for full completion September	
31-Jul-13	Workshop to build engagement with CCG/Virgin-care with project plan by the end of July.			
31-Aug-13	Implement Ambulatory unit		Business case being developed. To TEC in August.	
31-Jul-13	Implementation of Frail Elderly pathway		Business case being developed. To TEC in July.	
01-Oct-13	Development of multi-agency Programme Board			
01-Oct-13	Implement schemes to utilise reablement funds			

Principle Risk:

2.1 If the Trust workforce was not appropriately aligned to demand and acuity; particularly to meet reductions in WTE, agency usage and pay costs, resulting in overspends against agreed budgets.

Director of Workforce Transformation

Link to CRR

	Initial	Current	Target
Likelihood	3	3	2
Consequence	3	4	3
Level	9	12	6

Strategic Objective Affected

Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.

Opened: 01-Apr-11
Closed:

Controls

- Annual Workforce Plan
- Business Planning process and targets set for 2013/14
- Fortnightly vacancy Control panel
- Centralised change programmes led by an Executive Director
- Management of Change Policy
- Compliance with CQC Outcome 13

Assurance

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

Gaps in Controls

- Agency suppliers not reported (see below)

Gaps in Assurance

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Mar-13		Decision taken to bring temporary staffing in house to be confirmed		Completed	01-Jun-13
Aug-13		Streamlined resource for the supply of temporary staffing		In progress	
Oct-13		Renegotiate agency rates and identify shortlist of agencies		In progress	
01-Oct-13		Effective rostering and use of Heathroster to be established to maximise deployment of substantive nuring staff		In progress	
Mar-14		Embed trust wide processes for financial governance, decision making and control of use and expenditure		In progress	
01-Mar-14		Validate authorisation, booking and invoice approval processes for temporary staff		In progress	

Principle Risk:

2.2 If the Trust was unable to retain high calibre staff through developing leadership potential

Director of Workforce Transformation

Link to CRR

	Initial	Current	Target
Likelihood	4	4	2
Consequence	3	3	3
Level	12	12	6

Strategic Objective Affected

Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.

Opened: 01-Apr-13
Closed:

Controls

- All employment policies, including appraisal, structured in accordance with the 4Ps
- Corporate and divisional LED plans
- Leadership and management commitment framework
- Team ASPH launched and continuing
- Compliance with CQC Outcome 14

Assurance

- Staff turnover rates monitored at PMO at divisional and speciality level
- Employment policies available on Trustnet and reviewed with EPF & TEC
- Specific action plans in place to identify and address areas with retention difficulties
- Compliance with CQC Outcome 14 to be monitored by WOD Committee
- Leadership Programme in conjunction with Hay being developed in 2013
- Establishment of Workforce and OD Committee from July 2013.

Gaps in Controls

- Talent management/ succession strategy in place

Gaps in Assurance

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Sep-13		Appraisal policy to be reviewed in line with AfC		In progress	
Jun-13		Leadership Programme to be developed in conjunction with Hay		Completed	01-Jun-13
Aug-13		Development programme for first line managers to be piloted		In progress	
Oct-13		Comprehensive blended learing programme for leadership and management to be available to all staff as part of standard training programme		Pilot project due to complete in August. Further modules are in development.	
Dec-13		Create a talent management/ sucession plan for staff		Not yet started	
Mar-13		Complete roll out of team coaching to all speciality teams across the Trust		In progress - of 27 teams 14 are underway and 2 are complete	

Principle Risk:

2.3 If individuals and teams do not feel valued or motivated resulting in poor patient care and staff experience and ineffective team working.

Director of Workforce Transformation

Link to CRR: CRR 1244

	Initial	Current	Target
Likelihood	2	4	4
Consequence	4	4	2
Level	8	16	8

Strategic Objective Affected

Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.

Opened: 01-Apr-12
Closed:

Controls

- All employment policies, including appraisal, structured in accordance with the 4Ps
- Participation targets for Living our Values set 2013/14
- Implementation of Living our Values agreed 2013/14
- Individual and team diagnostics conducted
- Team ASPH launched and continuing

Assurance

- Employment policies on Trustnet and reviewed every three years
- Living our Values attendance monitored
- Living our Values plans displayed in ward areas
- Staff attitude survey and patient survey results reported to Trust Board, TEC (annually)
- Monitor improvements against 6 KPIs

Gaps in Controls

- Quality of appraisal not assessed systematically
- Individual and team recognition and Awards scheme

Gaps in Assurance

- Grandparent sign off

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Ongoing		Implement the WOW! Awards as ongoing staff recognition scheme		Launched 31st July 2013. Over 300 nominations received	
Apr-13		Implement Board development plan (incl Visibility and Assurance Prog) implemented		Plan developed. Implementation in progress	
Apr-13		Develop and get agreed 'enhancing staff experience' action plan.		Complete	Apr-13
Apr-13		Implement staff experience and culture programme		In progress - being managed as part of PMO	

Principle Risk:

2.4 If levels of sickness increased, adversely affecting patient and team working, and organisational performance.

Director of Workforce and OD

Link to CRR

	Initial	Current	Target
Likelihood	2	1	1
Consequence	4	4	4
Level	8	4	4

Strategic Objective Affected

Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.

Opened: 01-Apr-11
Closed:

Controls

- Sickness absence policy
- Sickness absence targets set 2013/14
- Occupational Health and Staff Physiotherapy Service (in-house)
- Employee Assistance Programme (independent)
- Health and Wellbeing Programmes

Assurance

- Policy available on Trustnet and reviewed every three years
- KPIs monitored at Board, Finance Committee, TEC, Employee Partnership Forum, Performance Review Meetings
- Occupational Health and staff Physiotherapy Service externally accredited, Health & Wellbeing Programme received national award (2011)
- EAP independent reports received by WSSG (annually)
- Corporate Plan 2013/14 (Strategic Objective 2)

Gaps in Controls

- None known

Gaps in Assurance

- None known

Closure Request?

Request to close risk. Target score met. Actions complete or in progress and not expected to significantly impact on the risk scoring. Trust sickness below 3% which is the national target.

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Jul-12		Develop Health & Wellbeing Strategy		Completed. Final Draft approved at July 2012 WSSG	31-Jul-12
Dec-12		Re-tender EAP contract		Completed. Tender issued	01-Dec-12
Mar-13		Review sickness absence policy		In progress	
Mar-12		Implement Health & Wellbeing Strategy		In progress	
Apr-13		Introduce EAP reporting		In progress	

Principle Risk:

2.5 If roles and responsibilities for leadership and workforce development were unclear, thereby impeding individual, team and corporate performance

Director of Workforce Transformation

Link to CRR

	Initial	Current	Target
Likelihood	2	2	1
Consequence	4	3	3
Level	8	6	3

Strategic Objective Affected

Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.

Opened: 01-Apr-12
Closed:

Controls

- Foundation Trust constitution
- Organisational structure
- Governance structure
- Employment policies clarify leadership and workforce roles and responsibilities
- Leadership and management commitment framework
- Key Workforce Performance Indicators set for 2013/14

Assurance

- Council of Governors meetings where Board is held to account
- Board structure reviewed by Council of Governors (NAC)
- Organisational structure reviewed by the Board (NAC)
- Governance and committee structure (Board, Sub-Comm, TEC, EPF)
- Employment policies available on Trustnet and reviewed with EPF & TEC (three yearly)
- Leadership Development Directory
- Balanced scorecard quadrant 2 presented by Director of Workforce & Organisational Development (Board) and Divisional management teams (Performance review meetings)

Gaps in Controls

- Lack of robust Clinical leaderhsip

Gaps in Assurance

- None known

Closure Request?

Action Plan

Due:		Action Description		Progress to Date	Date Completed
Mar-13		Implement new operational structure		Completed	Mar 13
Mar-13		Introduce accountability framework		Completed	Mar 13
Mar-14		Better Leaders, Better Care Programme' (facilitated by Hay)		Launched on 5th July. DD's programme to start in August and Specilaity leads in September. ED programme in progress	

Principle Risk:

3.1 If the Trust does not fix the emergency pathway this will limit the Trust's ability to safely care for emergency patients, grow elective work and will damage the Trust's reputation and potentially impact on the Trust's strategic ambitions

Deputy Chief Executive

Link to CRR: CRR 1072/1128

	Initial	Current	Target
Likelihood	4	4	2
Consequence	4	4	4
Level	16	16	8

Strategic Objective Affected

Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Apr-12
Closed:

Controls

- Escalation Policy and procedures in place
- New medical model for emergency care pathways in place
- Stage 1 of bed reprofiling is complete
- Daily capacity meetings
- Partial implementation of RealTime

Assurance

- Monthly Strategic Delivery TEC
- Demand and capacity project team
- Complaints and Incidents- trends tracked and reported
- Dashboards with clinical data showing trends
- ECIST
- Daily A&E reports

Gaps in Controls

- Inconsistency in service delivery due to partial implementation of bed remodelling
- Full implementation of RealTime

Gaps in Assurance

- ECIST reports identify work to be completed across the whole system
- RealTime- full potential of the system yet to be realised. Phase 2 implemented in part June 2013, to be completed September 2013

Closure Request?

[Enter details of closure request]

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Jul-12	Complete planned ward moves and rebalancing of bed base		Ward moves currently underway. Phase 1 complete	
01-Oct-12	Develop and implement 24/7 workforce plan		PMO project for 2013/14.	
01-Oct-12	Complete ECIST action plan and implement new medical model		Action plan developed. Consultation completed, move to implementation. Now complete, including 'hot clinics' and 'speciality in-reach'.	01-Jun-13
TBA	Develop and implement whole system action plan arising from ECIST review		Trust actions completed. Plan is CCG led. Action plan not now developed.	01-May-13
01-Feb-13	Widen the remit of RealTime		March 13 with Phase 2 implemented in part June 2013 to be implemented in full September 2013.	
01-Jun-13	Surgery Emergency Pathway - implementation of action plan		In progress - business case for redesign of SAU and increase in bed stock approved at May TEC. For implementation by winter 2013.	

Principle Risk:

3.2 If the Trust is unable to secure sufficient alignment and support from other key partners, it will not be possible to fully develop integrated out of hospital care in NW Surrey.

Medical Director

Link to CRR

	Initial	Current	Target	Core Aims Affected
Likelihood	3	4	2	Objective 3 : To deliver the Trust's clinical strategy of joined up healthcare
Consequence	3	3	3	
Level	9	12	6	

Opened: 01-Apr-13
Closed:

Controls

- NW Surrey Urgent Care Board
- Market intelligence information
- Community Services Project Team
-
- Business Planning Processes top down and bottom up
- 5 Year Business plan
- Exec to Exec CCG Forum

Assurance

- High level Programme progress tracker reviewed by Strategic Delivery Committee in November 2012.
- Regular reports to Strategic Delivery Committee

Gaps in Controls

- Documented specialty level strategies

Gaps in Assurance

- Outline project plans for full Programme of work
- Strategic alignment of Virgincare

Closure Request?

[Enter details of closure request]

Action Plan

Due:		Action Description		Progress to Date	Date Completed
31-Jul-13		Proposals to be developed to invest in community assessment and capacity		In progress	
30-Sep-13		Review of NW Surrey Transformation Board		In progress	
30-Sep-13		Review of NW Surrey Transformation Board		In progress	
30-Sep-13		The formalisation of the existing contractual arrangements with Virgincare through the development of KPIs and a clinical governance board		In progress	

Principle Risk:

3.3 If the Trust is unable to secure sufficient support from Acute Partners and Commissioners, it will be not be able to develop the required scale for its specialist services.

Medical Director

Link to CRR

	Initial	Current	Target	Core Aims Affected
Likelihood	4	4	2	Objective 3 : To deliver the Trust's clinical strategy of joined up healthcare
Consequence	4	3	3	
Level	16	12	6	

Opened: 01-Apr-13
Closed:

Controls

- Principle partnership in place with RSCH with monthly Partnership Board.
- Strategy Committee which is a sub group of the Board to develop and review plans
- Business Development team in place to support this work across the Trust
- Director of Strategic Development in post to support partnership working
- CEO working closely with Specialist Commissioners, LAT and Acute Partners in alliance with RSCH

Assurance

- Marketing report to TEC
- Partnership progress reported to Strategy Committee
- Reporting on progress of partnership with Virgin
- Quarterly reporting on achievement against core strategic objectives
- Board to Board in May 2013 (ASPH/RSCH)
- Vascular Services Business case approved by TEC, accredited in November 2012
- Joint clinical workshop held in June 2013.

Gaps in Controls

- Speciality level partnership planning
- Ability to get alignment with key partners and Specialist Commissioners over Vascular Services
- Trust strategy in process of being refreshed.
- Non hyper-acute specialist services may lack oversight

Gaps in Assurance

- Specialist Commissioning has an expanding role. Lack of clarity and influence at present.

Closure Request?

Action Plan

Due	Action Description	Progress to Date	Date Completed
May-13	Board-2-Board with RSCH	Held in May 2013.	May-13
Jun 13	Joint Clinical Strategy workshop with RSCH	Held in June 2013.	Jun-13
August 13	Joint Clinical Strategy workshop with RSCH	Scheduled for August 2013	
October 13	Board-2-Board with RSCH	Scheduled for 9 October 2013	
TBC	Stratgey for Stroke being developed with RSCH	In progress	
TBC	Stratgey for Renal being developed with RSCH	In progress	

Principle Risk:

4.1 If the Trust's clinical workforce is not aligned around the Trust's efficiency improvement programme.

Deputy Chief Executive

Link to CRR:CRR 1128/1215

	Initial	Current	Target
Likelihood	3	3	3
Consequence	4	4	3
Level	12	12	9

Strategic Objective Affected

Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.

Opened: 01-Apr-11
Closed:

Controls

- KPIs on LOS, admissions, discharges etc. weekly and monthly
- Clear demand and capacity plan
- Escalation Policy in place
- Monthly speciality performance reviews in place
- Daily Information Reporting and Intelligence systems
- Weekly Trust wide urgent care dashboard
-

Assurance

- Trust signed off by ECIST November 2012. Return assurance visit in July 2013.
- Monthly NWS Unscheduled Care Programme Board
- Board reporting of KPIs
- Patient survey results reported to Board annually highlighting areas for improvement
- Clinical Leadership Programme - 'better leaders, better care'.

Gaps in Controls

- Real Time Bed Management System phase 2 underway - this will support real time bed management before the winter
- Ward/consultant level urgent care dashboards to be delivered.
- Future demand and capacity plans to be reviewed.
- Theatre Utilisation

Gaps in Assurance

- Robust discharge meetings

Closure Request?

N/A

Action Plan

Due:	Action Description	Progress to Date	Date Completed
01-Jul-12	Complete planned ward moves and rebalancing of bed base	Ward moves currently underway. Phase 1 complete. Business case for phase 2 for approval by SD TEC July 2013	
01-Feb-13	Widen the remit of RealTime	In-patient wards completed. IPL system to be migrated to Realtime. Phase 1 completed in March 13 with Phase 2 completed in part June 2013. Full competition planned September 2013.	
01-Jun-13	Reduce length of stay across hospital.	In progress. Surgery emergency care pathway action plan commenced. Business case approved by SD TEC May 2013.	
31-Jul-13	Revision to discharge meeting to Executive led	in progress.	
01-Dec-13	Clinical Leasdership Programme	Events and coaching sessions through to December 2013.	

Principle Risk:

4.2 If ASPH fails to deliver the clinical quality incentives (CQUINS), fails to deliver the performance standards, or fails to respond to the admission thresholds/readmission caps/ambulance turnaround penalties within the 2013/14 contract and under recovers income.

Chief Nurse/Medical Director

Link to CRR:CRR 764/1129/832

	Initial	Current	Target
Likelihood	4	4	2
Consequence	4	4	3
Level	16	16	6

Strategic Objective Affected

Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.

Opened: 01-Apr-12
Closed:

Controls

- Service planning processes in place with clear targets
- Clear internal Performance Review Framework
- Clear articulation of internal programme of work via PMO.
- Monthly contract KPI monitoring
- CQUIN project managed through PMO with Executive Director leads

Assurance

- Balanced scorecard KPIs
- Divisional Performance Review Meetings.
- Monthly income reports to Finance Committee and Board
- CQUIN report to Strategic Delivery Committee
- Weekly Executive-led review of emergency care
- Monthly review of CQUIN/Contractual delivery reports at TEC

Gaps in Controls

- Monthly process for clinical review of clinical performance metrics to be strengthened.
- Evidence of clinical review impact.

Gaps in Assurance

- None

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Oct-12		Contract KPIs performance to be reported to Finance Committee quarterly.		To be reported from Q1 13/14.	
2013/14		Implementation of re-admissions action plan		In progress	
30-Sep-13		Implementation of Emergency Care action plan		In progress	

Principle Risk:

4.3 If ASPH fails to deliver 2012/13 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income.

Director of Finance and Information

Link to CRR: CRR 1208

	Initial	Current	Target
Likelihood	4	4	2
Consequence	4	4	4
Level	16	16	8

Strategic Objective Affected

Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.

Opened: 01-Apr-11
Closed:

Controls

- Monthly Directorate and Divisional performance reviews look at workforce, activity, finance and Trust's quality framework
- Planned programme of LOS reductions which is regularly reviewed with Directorates
- Other delivery metrics i.e. theatre utilisation, weekly bank and agency usage reports
- Major Productive schemes identify patients experience objectives as well as productivity objectives and monitor any adverse impacts during implementation.
- Monthly Divisional CIP meetings

Assurance

- TEC review of business cases and quality impact reports
- Board performance and PMO delivery / impact reports
- Strategic Delivery Committee
- Performance Review meetings
- Internal and external audit reports

Gaps in Controls

- Non-pay overspending
- Agency over-spending

Gaps in Assurance

- None

Closure Request?

N/A

Action Plan

Due:	Action Description		Progress to Date	Date Completed
8/2012	Review of vacancy / recruitment processes		Completed	01-Apr-13
31-Jul-13	Consolidating the in-house bank service		Notice given, full transfer by July 2013.	
01-Jul-13	Closure of Swift Ward		Completed. Full closure from 1/07/2013	01-Jul-13
01-Sep-13	Review of winter bed and staffing requirement		Review underway. Due by 1 September 2013.	

Principle Risk:

4.4 If the contribution from individual divisions and service lines is less than required to deliver the EBITDA margin for ASPH as a whole. If ASPH cross-subsidises uneconomic service lines with the financial contribution of unrelated service lines. If ASPH service delivery is inefficient when compared to similar services elsewhere.

Director of Finance and Information

Link to CRR: CRR 1208

	Initial	Current	Target
Likelihood	3	3	2
Consequence	4	3	3
Level	12	9	6

Strategic Objective Affected

Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.

Opened: 01-Apr-12
Closed:

Controls

- Programme management in place with Project lead
- Financial accountant to support development of financial benchmarking
- SLR information reported bi-monthly.
- Finance Committee review of finance delivery

Assurance

- SLR report to Finance committee and Closed Board (to Finance Comm)
- TEC reporting
- SLR divisional programme
- SLP report to Finance Committee

Gaps in Controls

- None

Gaps in Assurance

- Service line strategies covering all divisions for the next three years to be reviewed by Finance Committee.
- Potential impact of emergency activity at marginal tariff.

Closure Request?

N/A

Action Plan

Due:	Action Description		Progress to Date	Date Completed
01-Sep-13	Review of emergency activity levels, thresholds and marginal tariffs		In progress	

Principle Risk:

4.5 If financial or service pressures on third party providers of health and social care or commissioners cause operational difficulties or to enforcement of contract levers more aggressively than expected.

Director of Finance and Information

Link to CRR: CRR 832

	Initial	Current	Target
Likelihood	3	4	2
Consequence	4	3	4
Level	12	12	8

Strategic Objective Affected

Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.

Opened: 01-Apr-11
Closed:

Controls

- Focus on NW Surrey Locality relationships
- Signed contract in place with monitoring arrangements
- Activity profiled across year
- Demand management scheme monitoring.

Assurance

- Monthly contractual close down and agreement processes.
- Contractual escalation arrangements will be used as required.
- Activity reporting via Board and Finance Committee reports.
- PCT notification of issues or performance concerns are reported to the Board as required.

Gaps in Controls

- Confidence in PCT QIIP programmes to deliver fully the expected activity reductions
- Actions to reduce continued over performance

Gaps in Assurance

- None

Closure Request?

N/A

Action Plan

Due:		Action Description		Progress to Date	Date Completed
01-Oct-12		Corrective actions to be reviewed via contract monitoring meetings		Ongoing	
31-Jul-13		Sign off of enabling monies action plan and review of Q1 delivery		Expected by end of July	