Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
26th August 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 11 August 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 are now also formal elements 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:	16th August 2010
Decision:	For Approval

Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
16th August 2010

Board Assurance Framework
2010/11 – 2015/16
August 2010 Version

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 also aligned to the Statement on Internal Control, the Corporate Business Plan 2010/11 and has been cross referenced to the Corporate Risk Register. The Board formally agreed the updated BAF at its June 2010 meeting.

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 11th August, and the review took place in tandem with the Corporate risk register.

There are two risks where the risk rating has reduced;

1.*9 If there was insufficient assurance to support Monitor assessment of Quality through Board Memorandum and external validation*. The work on reviewing the Trust's position in relation to the Monitor quality assessment criteria has progressed well.

4.9 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- review of the White Paper and subsequent Consultation documents against the Trust's strategy suggest there are strong areas of alignment currently.

Recommendations

- 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

Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
Board Assurance Framework - Summary
2010-2011
Version: August 2010

	Lead	June Risk score	Aug Risk Score	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							↔
2. If the level of HCAI infection rose and trajectory not achieved	CN	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							↔
4. If Data quality deteriorated leading to poor decision making	DoF	8	8							↔
5. If there were poor standards of information governance which then jeopardised patient confidence	DoF	8	8							↔
6. If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence	CN	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							↔
8. If Environmental standards, including Single Sex Accommodation (SSA), do not meet expectations/ standards	DCE	3	3							↔
9. If there was insufficient assurance to support Monitor assessment of Quality through Board Memorandum and external validation	CN/MD	10	8							↓

	Lead	June Risk score	Aug Risk Score	Oct 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							↔
2. If the Trust was unable to retain staff particularly in shortage specialties	DoW	6	6							↔
3. In ability to reduce management costs	DoW	9	9							↔
4. Medical appraisal and job planning do not underpin revalidation requirements	MD	6	6							↔
5. If there was failure to deploy a high performing workforce	DoW	8	8							↔
6. Increased turnover and sickness	DoW	6	6							↔
7. If there was reduced knowledge of junior Doctors	DoW	9	9							↔
8. Non compliance with Equality, Diversity and Human Rights legislation	DoW	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							↔
2. If the Trust was not the preferred provider (through a consortium) of renal services for Surrey	CE	6	6							↔
3. If the Trust was unable to provide increased services at Ashford Hospital and in community locations	DCE	6	6							↔
4. If the Trust lost significant market share including any current trends in specific localities or specialties	DCE	8	8							↔
5. If the Trust did not succeed in reducing emergency admissions and redesigning the elective care pathways.	DCE	12	12							↔
6. If the Trust developed a poor reputation	CE	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							↔

	Lead	June Risk Score	Aug Risk Score	Oct 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							↔
2. Insufficient attention to acuity of patient needs	CN	8	8							↔
3. Management of non elective cap fails, and emergency admissions rise	DCE	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							↔
5. Risk of CIP/productivity agendas inadvertently undermine the Trust's stated objective on improving quality	DCE	8	8							↔
6. Failure to secure benefits of service line management and the wider cultural benefits including clinical engagement	DoF	6	6							↔
7. EQUIP programme is not fully embedded with widespread and rising engagement throughout the Trust year on year	DCE	8	8							↔
8. National economic climate with focus on reducing public sector expenditure	DoF	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							↓
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							↔
11. If NHS Surrey's financial position causes negative impact on the Trust	DoF	12	12							↔

	Lead	June Risk score	Aug Risk Score	Oct 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							↔
2. Lack of Informatics strategy in a post NPfIT environment. (IT strategy needs to be driven by Trust overall strategy).	DoF	8	8							↔
3. Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy	DCE	6	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

BOARD ASSURANCE FRAMEWORK (BAF)

2010/2011 – 2015/16
Aug 2010 - Version 2.1

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

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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	SE Coast SHA monitoring via STEIS Internal Trust monitoring systems with Board scorecard	Elective MRSA screening target	None known	~~Completion of elective MRSA screening process~~ Maintain existing actions- main focus is HCAI	**Deputy Chief Executive** **~~1 September 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	**Chief Nurse** **August onwards**	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
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 Detailed quality metrics including scorecard and WQIs tracked over time Patient comments/incidents and SUI review processes Maintaining agreed staffing levels with appropriate back-fill Culture of openness, ultimately supported by Whistle blowing policy	Trust Board reports built up from ward level detail. Matrons' feedback to Directors Patient complaints monitored via Complaints group. Dr Foster data PPEG/LINk/OSC	~~None known~~ 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 Develop actions from Colin Norris and Airedale Inquiries	**Chief Nurse/Medical Director** **September 2010**	2	5	10
FT CQC	4.If Data quality deteriorated leading to poor decision making	Data Quality Manager in place Training and staff awareness Data quality audits (required as part of IG toolkit) Submission to external sources e.g. SUS (looks at completion rather than accuracy) or Dr Foster (allows benchmarking)	Audit Commission audit on PbR for SE Coast Clinical Audit Team IG toolkit SUS/Dr Foster	Further work on detailed procedures.	~~Consider for Internal Audit Programme~~	Review and update core procedures. Action plan to achieve this has been developed. Data Quality Policy drafted – to be approved by TEC Assurance – Internal Audit agreed for early Autumn. PBR data assurance framework audit to be undertaken. Date to be confirmed. Internal Audit on OP data quality to Oct Audit cttee	**Director of Finance and Information** Implement actions in OPD by end Sept. 2010	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
SIC CRR ~~866/~~887	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)	Uptake of mandatory training. IG toolkit requirement to achieve 95% of staff trained using the national on line IG training system Level of IGSG in committee structure means significant gap from Board	~~Review IGSG TOR , reporting arrangements and meeting efficacy~~	Continue with mandatory training. Target to achieve 100% IGSG ToR reviewed- membership changed to ensure relevant	**Director of Finance and Information**	2	4	8
IBP Risk 1.4 CBP Priority 1.3 CRR 1006	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 Evidence is gathered on the Performance Accelerator allowing gap analysis Programme of activity to embed ownership at service level Early warning indicators for many Regulations including ward metrics Proactive review and response to external advice on best practice e.g. NPSA alerts	Performance Accelerator CQC Quality and Risk Profile Results of patient surveys Patient complaints/incidents/ KPIs	None known	Ensure owned by Committees and groups internally	~~None identified~~ continue with Q1 assessment Incorporate review process into committee/group TOR	**Chief Nurse** **End August**	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
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 ~~Hand held devices~~ real time data mechanisms being reviewed. Patient comment cards	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 Launch Care Standards (nursing) Feedback Strategy to be approved by TEC	**Chief Nurse** **Continuous** ~~**July**~~ **August 2010** **August 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
IBP risk 1.2 CBP Priority 1.1 CRR 767	8. If Environmental standards, including Single Sex Accommodation (SSA), do not meet expectations/ standards	Self- assessment on SSA completed	Self assessed declaration on national template	None known	None known	Not required	**Deputy Chief Executive**	1	3	3
		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							
CBP Priority 1.2	9.If there was Insufficient assurance to support Monitor assessment of Quality through Board Memorandum and external validation	Project plan prepared. Gap analysis completed. Detailed evidence bank gathered to support self certification	Quality has been reviewed generally as part of SHA Medical Director assessment for FT application. Part of Monitor batching review process Integrated Governance and Risk department IGAC	Review of the clinical audit function	~~Consider use of Internal Audit to support elements of the Board assurance esp. data quality~~ (addressed above)	Address gap analysis : ~~o Develop Strategy~~ o Review Clinical Audit function o Confirm learning loop	**Medical Director/ Chief Nurse** ~~June 2010 for Board to agree Strategy~~ Self certification August 2010	2	~~5~~ 4	~~10~~ 8
		Quality Strategy agreed and launched								
		Existing governance/quality structures are in place and operating through out the Trust								
		Link to quality report and other best practice initiatives .Quality Account/CQUIN								

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	Middle grade doctor vacancies in Emergency services, ITU & Paediatrics	None known	Recruitment plans for nursing and medical staffing in place to address issues in specific directorates by end Q2 – 2010 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** **September 2010**	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 internal candidates for every vacancy by March 2011	Board report Performance Review meetings CG meetings Staff Attitude Survey (CQC and internal)	None known	4 key scores still within lowest 20% of acute hospitals: % reporting errors, impact of work on health & wellbeing, % experiencing physical violence from staff, % experiencing discrimination	Directorate level targeted SAS action plans corporate actions plans covering health & wellbeing and discrimination issues e.g. zero tolerance posters, publicising diversity of internal promotions, equality and diversity training programmes. Summer staff survey undertaken to understand areas for improvement in more detail	**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
CBP Priority 4.1	3. In ability to reduce management costs	Workforce Plan 2010/11 agreed and monitored monthly	Board reports Performance Review meetings		None Known	Monitoring of Trust's Integrated Workforce Plan ~~Corporate Directorate review meetings to be established wef July 2010~~	**Director of Workforce and OD**	3	3	9
		Working Group progressing 2011/12 and 2012/13 plans to reduce management posts	Workforce Redesign ~~Group~~ Programme CIP and Workforce Redesign Groups	~~Currently no Corporate Directorate review meetings to be established wef July 2010~~ ~~Directorate performance reviews~~						
		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 JLNC MSC	Medical appraisal and Job Planning are not currently aligned	None Known	Medical appraisal and Job Planning interim reviews planned ~~in~~ for September 2010	**Medical Director** **September 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								
		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	Not applicable	**Director of Workforce and OD**	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 Develop calendar of Health and Well being events	**Director of Workforce and OD** **Publicity during August onwards**	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**	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	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							
SIC	8. Non compliance with Equality , Diversity and Human Rights legislation	Single Equality Scheme and action plan Diversity champions	SHA review of SES Monitoring of SES through Equality & Diversity Group and Board EDSG Patient and Staff Survey (CQC)	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
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	Executive Project Lead supported by Project Manager, with Project Board Project plan LTFM reviewed and updated monthly	SHA assurance process DoH Applications Committee approval NHS Surrey support Programme of external check and validation via Board master classes	Complete all preparation for Monitor assessment including Trust wide briefings	Complete new Quality Assessment introduced in 2010 leading to Board self certification	Continue to implement project plan Conduct elections Board Self Certification to be completed	**Director of Workforce and OD** ~~July~~ August onwards 2010 August Board meeting	2	4	8
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 ~~and look at options~~ with expected start date for ITT end of August	**Chief Executive**	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 3.3	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	Clinical strategy Group TEC	None Known	None Known	Continue actively promoting Trust services and working with GPs. Fundamental review of the Trust's marketing strategy and account management systems for local GPs and Pbc clusters to align its ways of working to the White Paper.	**Deputy Chief Executive** **September 2010**	2	3	6
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 Marketing manager Buy-in from Clinical directorates Programme of GP engagement	Clinical strategy group TEC Finance Committee	~~Need to define 'right size' strategy~~ Sustain current levels of activity and grow Mid Surrey	None Known	~~Define 'right size' strategy~~ Targeted growth in some key areas including Cobham Feltham and Woking	**Deputy Chief Executive**	2	4	8
CBP Priority 3.1	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	NHS Surrey Trust Activity reports Programme Board Performance Review meetings	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 Redesign MAU to provide non inpatient facilities	**Deputy Chief Executive**) Sept 10 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
		Regular contract management including the PCT								
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 CQC Patients surveys Internally run surveys and feedback Feedback from major external stakeholders	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	Marketing Report LMC Feedback via LEC	Review in light of White Paper	None known	Fundamental review of the Trust's marketing strategy and account management systems for local GPs and Pbc clusters to align its ways of working to the White Paper.	**Deputy Chief Executive** **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	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	Benchmarking Programme Board Patient complaints and incidents. Staff feedback	None known	None known	Not applicable	**Deputy Chief Executive**	3	4	12
CBP Priority 1.1&2	2. Insufficient attention to acuity of patient needs	Acuity review completed and will be repeated. Resulted in some realignment of nursing establishments	Benchmarking ACUH Programme Board Patient complaints and incidents. Staff feedback	Acuity review did not consider activity	None known	Applied to SHA who are undertaking benchmarking on ACUH tool	**Chief Nurse** **Oct 2010**	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 Transformation Board work stream with NHS Surrey	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	**Deputy Chief Executive** 31 September review of progress (pre winter escalation)	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
IBP Risk 4.1 CBP Priority 4.1 CRR 847	4. Delivering CIPs is handled ineffectively or in a piecemeal fashion. Insufficient long term planning of CIPs into future years.	Strong Programme management approach with clear governance arrangements and tracking 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	External advisor Finance committee review Programme Board. Work stream 2 and sub group	None known	None known	~~None known~~ CIPs update to August Finance committee	**Deputy Chief Executive and Director of Finance**	2	5	10
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	TEC Board Programme Board Complaints and KPIs	Develop the Quality dashboard for CIPs	None known	Quality dashboard for CIPs is now available and to be fully embedded	**Deputy Chief Executive** ~~**July**~~ **August 2010**	**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
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	**Director of Finance** ~~September 2010~~ Finance cttee and Board update in August	3	2	6
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 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	Simpler TEC Programme Board CIP Programme Board	None known	None known	Not applicable	**Deputy Chief Executive**	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
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. Good recent track record of managing budgets and delivering a surplus. Robust approach to CIPs with target of over delivery, thus 'banking'.	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**	4	3	12
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	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	~~Review when White paper published in July~~ Review of 6 Programmes and Corporate Business plan priorities to be completed	**Chief Executive** July 2010	~~4~~ 3	3	~~12~~ 9
	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	KPIs OSC LINk	None known	None known	Review mid year	**Deputy Chief Executive** 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
CBP Priority 3.1	9. 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	None known	Improvements planned to financial monitoring supporting contracting monitoring	**Director of Finance**	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		Carbon emission strategy required New Associate Director of Estates and Facilities to develop Implementation plan Additional Technology will require capital investment	**Deputy Chief Executive** **October 2010**	2	3	6
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	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	External review of Informatics completed in 2009/10	Complete actions from Informatics review	None known	Develop Strategy Strengthen IGSG	**Director of Finance and Information** Discussion at September TEC on strategic direction , then Trust Board strategic direction for	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
	deliver services differently cannot be seized.	support developing the Strategy					discussion ~~at August Board and~~ for agreement in October/November			
	3.Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy	Capital programme agreed annually	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

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