Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
27th May 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 currently aligned to the 4 strategic objectives as detailed in the Integrated Business Plan. The BAF is presented regularly to the Board, detailing all the changes made as a result of reviews undertaken by the individual Executive Leads. The Board has agreed an updated Corporate Business Plan for 2010-2011 and the BAF has been reviewed in the light of this and the Board seminar on risk.
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:	Discuss and agree the BAF.
Submitted by:	Jane Gear , Head of Corporate Affairs For Andrew Liles, Chief Executive
Date:	19th May 2010
Decision:	For Approval

Trust Board
27th May 2010

Board Assurance Framework
2010/11 – 2015/16

1 Introduction

The Board Assurance Framework (BAF) is a crucial element of the Trust's governance arrangements, and is fundamental to assuring the Board that key strategic risks are being managed effectively. The BAF also plays an important part in supporting the Statement on Internal Control and the Head of Internal Audit's opinion. The BAF, therefore, is an assurance tool to ensure that the Board has been properly informed about the totality of risks to achieving the strategic objectives. The BAF also maps to the Corporate Risk Register.

The BAF is aligned to the 4 strategic objectives as detailed in the Integrated Business Plan. This ensures that it is an intelligent and live document that provides the Board with the required assurance that the Trust will achieve its strategic objectives.

2 Current Position

An Executive Director is allocated responsibility for each principal risk and progress against any related action plan is monitored and reported upon at the Integrated Governance Assurance Committee (IGAC) meetings, when the full BAF is reviewed.

3 Developing the BAF

Considerable work took place in 2009 realigning the BAF to the Trust's strategic objectives. During the early part of 2010 it was agreed that further review would be needed in 2010-11.

3.1 Content

There are four main foci around which the revised BAF has been developed:

1. The Trust Board held a seminar in February 2010, supported by an external risk management consultant, and considered the implications which the Audit Commission's publication – *Taking it on Trust*, could have on the BAF.

2. The Board has recently agreed a Corporate Business Plan for 2010/2011 which is set in the context of the 5 year IBP but identifies specific priorities and actions to be achieved in 2010/2011. A review of the priorities has been undertaken to identify the potential major risks which should then be included within the BAF.

3. Guidance has been issued on the content of the Statement on Internal Control (SIC). As this is the annual statement whereby the Chief Executive as Accountable Officer confirms the adequacy of the organisation's risk management processes it is important that this is supported through the BAF. The SIC now includes formal statements on Climate Change Adaptation and Diversity and Human Rights legislation , so these , together with existing SIC obligations, have been identified in the proposals for the BAF.

4. The BAF is about strategic risk, and the 'bigger picture' issues which might seriously worry the Board. It is suggested that these could include issues which have challenged the NHS, particularly recently, where other organisations have been identified as having pockets of very sub standard care. Another potential major issue for the Trust which recurs not infrequently across the NHS relates to the reliability of data, and this is an issue in the Monitor Quality Governance process.

   These are only two suggestions which may or may not be appropriate, and there may be other bigger picture issues.

Having identified these suggested points for the next BAF to the April Board meeting, a revised set of strategic risks were submitted to the May IGAC meeting for discussion. Due to the timing of these meetings a verbal update will be given to the Board on IGAC's conclusions.

3.2 Changes from 2009/2010

As could be expected there are not huge differences between the draft BAF and the previous one operating across 2009/2010. This is because it reflects on strategic objectives and risk. Many of the risks map across the years relatively easily, but with changes in wording trying to focus-in more on the real risks. One example is the old BAF identified the risk of 'poor patient survey results'; the new BAF identifies 'poor patient experience' (which would be demonstrated by poor survey results)

(i) The significant changes are summarised below

Additions in 2010/2011
Pockets of sub standard care (BAF 1.3)
Data Quality (BAF 1.4)
Information Governance (BAF 1.5)
Medical revalidation (BAF 2.3)
Increased turnover and sickness linked to organisational change (BAF 2.3)
Implementation of MMC/EWTD (BAF 2.7)
Equality and diversity (BAF 2.8)

Removed from the BAF are

Failure to achieve CQUIN targets
Network resilience

(ii) It is also intended to focus on the really significant control and assurance rather than include minutiae.

4 Next Steps

The Board is asked to specifically consider the

1. Risks
2. Controls
3. Assurances

in the attached draft BAF.

Once these are approved the work on finalising the actions and actual risk ratings will be undertaken. The draft BAF submitted to the Board includes linkages to the IBP and Corporate Business Plan. It will also be cross referenced with the Corporate Risk Register to ensure consistency. It is suggested that this finalised BAF be presented to the Trust

Board in June, and then, if agreed (see para. 5 below), the presentations reverts to a sequence following IGAC scrutiny.

5 Timing of Board presentation

The current Board approved Integrated Risk Management Strategy requires the BAF to be presented no less than quarterly to the Trust Board. Over the last year, in part due to the move to monthly Board meetings, this has increased so the Board has been receiving the BAF monthly. It is suggest that it would be more useful if the BAF went to IGAC for scrutiny and challenge prior to presentation to the Board, and this implies a bi- monthly presentation to the Board. This would mean greater attention could be paid to ensuring gaps in controls and assurances were addressed rather than it becoming a more superficial process.

6 Conclusion

The BAF is a key document describing how the Board can be assured that risks to its Strategic Objectives are being managed effectively. This needs to be a live process and it is therefore not unexpected that the BAF needs to be refreshed periodically. The production of the Corporate Business Plan, which forms year one of the IBP is an essential trigger, and this is therefore a very appropriate point to refresh the BAF. Indeed many of the risks from the current BAF have transferred to the draft updated version.

7 Recommendation

1. The Board agrees the risks, controls and assurances in the draft BAF 2010/11

2. Discusses the frequency of presentation during 2010/2011

Jane Gear

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

Date: 19th May 2010

BOARD ASSURANCE FRAMEWORK (BAF)

2010/2011 – 2015/16
May 2010 - Version 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

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	1.If the Trust does not meet national priorities (and therefore Monitor's Compliance framework)	Monthly performance meetings with each CD. Escalation process agreed	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	**Chief Operating Officer**			
IBP Risk 1.3	2. If the level of HCAI infection rose and trajectory not achieved	Infection Control Team and IC Policies Hand washing and audit of this Rigorous RCA process for learning Antibiotic Policies	Mandatory reporting to the Health Protection Agency Monitoring via Infection Control Clinical/ward audits CQC spot checks on Hygiene Code compliance	On going embedding	None known	Continued embedding , review and learning	**Chief Nurse**			

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 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	None known	None known	**Chief Nurse/Medical Director**			
FT CQC	4.If Data quality deteriorated leading to poor decision making	Data Quality Manager in place Training and staff awareness 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 SUS/Dr Foster	Further work on detailed procedures.	Consider for Internal Audit Programme	Review and update core procedures	**Director of Finance and Information**			
SIC	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	Uptake of mandatory training Level of ISSG in committee structure means significant gap from Board	Review ISSG TOR , reporting arrangements and meeting efficacy	Continue with mandatory training. Target to achieve 100%	**Director of Finance and Information**			

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 1.4 CBP Priority 1.3	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	Performance Accelerator CQC Quality and Risk Profile Results of patient surveys Patient complaints/incidents/ KPIs	None known	None known	None identified	**Chief Nurse**			
CBP Priority 1.1 IBP Risk 1.1	7. If the Patient experience is poor due to the Trust not understanding the needs of our patients	Engagement and Communications Strategy with action plan agreed Good feedback mechanisms e.g. National and local surveys, Hand held devices collect information as do 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 Out patient action plan Target communications	**Chief Nurse** **July 2010**			

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	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	**Chief Operating Officer**			
		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 underway.	Quality has been reviewed generally as part of SHA Medical Director assessment for FT application Integrated Governance and Risk department	Complete the self assessment and gap analysis	Consider use of Internal Audit to support elements of the Board assurance esp. data quality	Complete gap analysis and address	**Medical Director/ Chief Nurse** June 2010			
		Existing governance/quality structures are in place and operating through out the Trust								
		Link to 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 3.1 CBP Priority 2.4	1. If the Trust was to loose its reputation as an attractive employer and did not focus on staff experience	Action plan to address the findings of the national staff survey thus improving staff experience Recognition of staff contribution through events, award schemes, clear statement of values Active Employee Partnership Forum and positive staff engagement. Maximising opportunities to listen and respond to staff	National staff survey results (CQC) Workforce metrics Internal staff survey EPF/EDSG/H&S cttee	Complete specific actions from national staff survey	None known	Complete specific action plans around corporate themes on health, safety & wellbeing and discrimination at work issues	**Director of Workforce and OD**			
IBP Risk 3.2 CBP Priority 2.1	2. If the Trust was not able to recruit and retain people in shortage specialties	Establishment control Active Recruitment bureau Targeted recruitment campaigns	Directorate and Board reports on establishment and workforce metrics. National staff survey	Focus on middle grade Doctors in Emergency Medicine, Paediatrics and ITU	None known	Implement Recruitment and Retention Strategy	**Director of Workforce and OD**			
CBP Priority 2.1	3. Medical appraisal and job planning do not support medical revalidation	Trust's approach to medical appraisal is being refined National guidance on revalidation is available and also being developed National pathfinder Trusts are being selected and will share learning	National coordination including GMC Workforce strategy Group/MSC/LNC	Further detailed National Guidance awaited	Ensure appraisal process is fully robust and embedded	Continue to implement and monitor medical appraisals Board to formally appoint Responsible Officer in due course	**Medical Director**			

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 2.3	4. If Appraisal design, coverage and experience (for all staff) was ineffective	Simplification of design of appraisal in order to increase uptake and focus on quality of	KPIs	Achieve target completion of 95% for appraisals	None known	Continue to action Appraisal Matters	**Director of Workforce and OD**			
		Improved recording and monitoring systems	Trust monitoring systems via ESR			Consider development of a 360° feedback tool				
		Linkage with Values and delivery of annual plan has been strengthened in 2010	CQC Staff Survey							
CBP Priority 2.2	5. Leadership is insufficiently developed throughout the Trust to support organisational transformation	Talent management system being developed. Programme 4 Leadership development	Staff Survey Workforce Strategy Group Delivery Programme 4	None known	None known	Progress the Leadership programme – from Good to Great achieving 100 participants in Year 1	**Director of Workforce and OD**			
		Leadership Development programme commenced 2010. Metrics included in scorecard for Board								
CBP Priority 2.3	6. Increased turnover and sickness occurs as a result of moving to a more performance orientated and challenging economic climate	Monthly forums with staff representatives (EPF)	Workforce trends/metrics to Board and Directorates	Lack of staff awareness of EAP	None known	Re launch EAP Continue to develop and Implement Programme 5 Workforce redesign	**Director of Workforce and OD**			
		Clear , new Organisation Change Policy agreed with EPF to recognise importance of consultation during change programme	Staff Survey			Programme of health and well being events				
		Continued investment in Employee Assistance Programme (EAP)								

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 2.1	7. Implementation of MMC/ EWTD leads to junior staff having less knowledge and experience.	Robust rotas	Deanery	MMC is a national approach	None known	Consideration is being given to developing a junior consultant model	**Director of Workforce and OD/Medical Director**			
		Consultant led service	Local Academic Board							
		Education supervision	Local Faculty Groups							
		Induction								
SIC	8. Non compliance with Equality , diversity and human rights legislation	Single Equality Scheme and action plan Diversity champions	SHA review of SES Assessment of provision for people with a Learning Disability Monitoring of SES through Diversity Group and Board EDSG	None known	None known	Not applicable	**Director of Workforce and OD**			
		Training programmes e.g. Customer care	Observational audits							
		Linkage to job descriptions, appraisal and conduct management	Patient and Staff Survey (CQC)							

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.										
	1. If the Trust was unable to achieve FT status it means the Trust would be an outlier in the national programme and need to consider future service configuration	Executive Project Lead supported by Project Manager 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	Preparation for Monitor stage	Complete Quality Assessment leading to Board assurance	Detailed project plan to be developed and implemented	**Director of Strategy**			
CBP Priority 3.3 IBP	2. If the Trust was not the preferred provider (through a consortium) of renal services for Surrey	Strong project management 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	**Director of Strategy**			

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		**Director of Strategy**			
CBP Priority 3.2	4. If the trust lost significant market share	Market data available to support decision making Marketing manager Buy-in from Clinical directorates Programme of GP engagement	Clinical strategy group TEC Finance Committee	None Known	None Known	Not aplicable	**Director of Strategy**			
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 Information tools being designed to enable Trust to anticipate and therefore pre-empt issues with delivery Regular contract management including the PCT	NHS Surrey Trust Activity reports	NHS Surrey demand management systems	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	**Chief Operating Officer**			

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	6. 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	**Director of Finance**			
CBP Priority 3.1	7. If NHS Surrey's 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 Strategy**			
CBP Priority 3.3 &4	8. Trust develops 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**			

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 improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
CBP Priority 1.1&2	1. Focus on productivity impacts negatively on patient care. Insufficient attention to acuity of patient needs	Acuity review completed and will be repeated. Results in realignment of nursing establishments Robust approach to Clinical Governance Formal documented approach to assessing impact of CIPs on quality of care	Benchmarking Programme Board Patient complaints and incidents. Staff feedback	None known	None known	Not applicable	**Chief Operating Officer**			
IBP Risk 2.4 CBP Priority 4.4	2. 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	Activity Reports NHS Surrey		None known	See BAF 3.5 above	**Chief Operating Officer**			
IBP Risk 4.1 CBP Priority 4.1	3. 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	**Chief Operating Officer and Director of Finance**			

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	4. 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	None known	Continue to implement Programme 6 Continual validation of data Training needs analysis to be undertaken	**Chief Operating Officer/ Director of Finance**			
CBP Priority 4.2	5. 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 and plans to enhance in 2010 Good clinical engagement with clinical lead agreed Active programme of rolling out training to Bronze level across organisation	Simpler TEC Programme Board	None known	None known	Not applicable	**Chief Operating Officer**			
IBP Risk 4.1 CBP Priority 4.1	Achieving workforce reductions (particularly management cost reductions)	Establishment controls including recruitment panel process Specific work streams of CIP programme dedicated to the reduction of management costs and support functions	TEC Programme 5 Workforce Redesign CIP Programme Board	Continue to develop granularity of plans	None known	Continue to implement Programme 5	**Director of Workforce and OD**			

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
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	PWC audit	Carbon emission strategy required with action plan		Carbon emission strategy required Implantation plan	**Director of Strategy**			
		Closer integration of estates and hotel services				Additional Technology will require capital investment				
	2. Lack of Informatics strategy in a post NPfIT environment. Lack of capacity so opportunities to deliver services differently cannot be seized	Interim Associate Director of Informatics appointed to help develop the strategy and seize opportunities to use existing infrastructure better. Permanent post to be recruited to. Consultants appointed to support developing the Strategy	External review of Informatics completed in 2009/10	Complete actions from Informatics review	None known	Develop Strategy Strengthen ISSG	**Director of Finance and Information** Strategic direction for discussion at July 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	**Director of Finance and Information**			

Audit Trail

Version 1 BAF Amended to reflect revised Corporate Objectives in the Corporate Business Plan 2010/2011

Version 2

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