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

TRUST BOARD
28th April 2011

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 2011-12. This iteration of the BAF was reviewed by IGAC on 6th April 2011.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Board assurance process ensures that risks to achieving the Trust's strategic objectives are actively identified and managed.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not assessed and views not taken
EQUALITY AND DIVERSITY ISSUES	None although a key risk relates to Equality and Diversity which is also a formal element of the Statement on Internal Control.
LEGAL ISSUES	The Board Assurance process supports the Chief Executive in signing the Statement on Internal Control which forms part of the Trust's statutory accounts.
The 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:	15th April 2011
Decision:	For Approval

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

TRUST BOARD
28th April 2011
Board Assurance Framework 2011/12 – 2015/16
April 2011 Version 7

1 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.

2 Strategic Context

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

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

Most recently the Corporate Business Plan 2011/12 has been produced and the risks identified within the Corporate Business Plan 2011/12 have been incorporated into the BAF so the two documents align.

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 Terms of Authorisation.

3 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 Integrated Governance Assurance Committee (IGAC) meetings. This took place at the last meeting of IGAC on 9th February, and the review took place in tandem with a review of the Corporate Risk Register.

4 Removal or addition of Risks

(i) The Director of Finance and Information recommended to IGAC the removal of the following BAF risks :

> Objective 1.4 on Data Quality. Following the Audit Commission outpatient report both inpatient and outpatient data quality are now much better than average.
>
> Objective 5.3. Lack of Informatics Strategy in a post NPfIT environment. This Strategy has now been approved by the Board.

The removal of these risks was supported by IGAC. During the discussion it was noted that any risks on implementation of the Strategy would initially be picked up via the Corporate Risk Register.

(ii) The draft Corporate Business Plan 2011/12 includes a new potential risk: If the

level and content of information provided to patients does not support patient choice and control. IGAC supported the recommendation that this is added to the BAF so the two documents are aligned.

(iii) IGAC also discussed the risk on Environmental Standards (1.9), which includes Single Sex Accommodation. This has tracked at a low level of risk rating over the last year. Despite this strong performance, IGAC agreed this risk should be maintained in the BAF and reviewed after quarter 1 as new standards had been introduced which were more demanding.

(iv) IGAC, and subsequently the Board, had previously considered whether a new risk on rationalisation of specialist services should be added. The Medical Director conformed that this was not necessary at the current time.

5 Recommendation

- The Board comment on the BAF; in particular the assurances and any gaps in assurance and controls it would wish to see addressed
- The Board agree the removal of the risk relating to the lack of an IT Strategy services and the risk on data quality
- The Board agree the addition of the risk on the level and content of information not supporting patient choice
- 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 Foundation Trust

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

	Lead	June Risk score	Aug Risk Score	Sept/Oct Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	Risk Score	Risk Score	In Month Risk Change
1. To achieve the highest possible quality standards for our patients, meeting and exceeding their expectations, in terms of outcome, safety and experience.										
Risks to Objective										
1. If the Trust does not meet national priorities (and therefore Monitor's Compliance framework)	DCE	10	10	10	10	15	15			↔
2. If the level of HCAI infection rose and trajectory not achieved	CN	16	16	16	16	6	4			↓
3. If there were pockets of poor quality services which were masked by top level performance (as apparent in Mid Staffs)	CN/MD	10	10	10	10	10	10			↔
~~**4.** If Data quality deteriorated leading to poor decision making~~	~~DoF~~	~~8~~	~~8~~	~~8~~	~~8~~	~~8~~	~~8~~			↔
5. If there were poor standards of information governance which then jeopardised patient confidence	DoF	8	8	8	8	8	8			↔
6. If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence	CN	8	8	8	8	8	8			↔
7. If the patient experience is poor due to the Trust not understanding the needs of our patients or the Trust is unable to respond in a timely and prompt fashion	CN	12	12	12	12	12	12			↔
8. If the level and content of information provided to patients does not support patient choice and control	CN						8			
9. If Environmental standards, including Single Sex Accommodation (SSA), do not meet expectations/ standards	DCE	3	3	3	3	3	2			↔

	Lead	June Risk score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	Risk Score	Risk Score	In Month Risk Change
2. To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.										
Risks to Objective										
1. If the Trust has difficulty recruiting to key positions	DoW	9	9	9	9	9	9			↔
2. If the Trust was unable to retain staff particularly in shortage specialties	DoW	6	6	6	6	6	6			↔
3. In ability to reduce management costs	DoW	9	9	9	9	9	9			↔
4. Medical appraisal and job planning do not underpin revalidation requirements	MD	6	6	6	6	6	6			↔
5. If there was failure to deploy a high performing workforce	DoW	8	8	8	8	8	8			↔
6. Increased turnover and sickness	DoW	6	6	6	6	6	6			↔
7. If there was reduced knowledge of junior Doctors	DoW	9	9	9	9	9	9			↔
8. Non compliance with Equality, Diversity and Human Rights legislation	DoW	6	6	6	6	6	6			↔
3. To deliver the Trust's clinical strategy; redefining our market position to better meet the needs of patients and commissioners, and increasing market penetration.										
Risks to Objective										
1. If the Trust was unable to provide increased services at Ashford Hospital and in community locations	DCE	6	6	6	6	6	6			↔
2.If the Trust lost significant market share including any current trends in specific localities or specialties	DCE	8	8	8	8	8	8			↔
3. If the Trust did not succeed in reducing emergency admissions and redesigning the elective care pathways.	DCE	12	12	12	12	16	16			↔
4. If the Trust developed a poor reputation	CE	8	8	8	8	8	8			↔
5. If the Trust was unable to engage with GPs individually and collectively as national policy enhances their role in commissioning	DCE	12	12	12	12	8	8			↔

	Lead	June Risk Score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	Risk Score	Risk Score	In Month Risk Change
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
Risks to Objective										
1. Unexpected changes in pattern of demand and admissions puts pressure on the bed complement and therefore patient care	DCE	12	12	12	12	16	16			↔
2. Insufficient attention to acuity of patient needs	CN	8	8	8	8	8	8			↔
3. National Contract changes putting risk onto providers- Non elective admissions and readmissions cap could lead to loss of income	DCE	12	12	12	12	16	16			↔
4. Delivering CIPs is handled ineffectively or in a piecemeal fashion. Insufficient long term planning of CIPs into future years	DCE/DoF	10	10	10	10	10	10			↔
5. Risk of CIP/productivity agendas inadvertently undermine the Trust's stated objective on improving quality	DCE	8	8	8	8	8	8			↔
6. Failure to secure benefits of service line management and the wider cultural benefits including clinical engagement	DoF	6	6	6	6	6	6			↔
7. EQUIP programme is not fully embedded with widespread and rising engagement throughout the Trust year on year	DCE	8	8	8	8	8	8			↔
8. National economic climate with focus on reducing public sector expenditure	DoF	12	12	12	12	12	12			↔
9. As the new Government develops its Policy for NHS this could impact adversely on the Trust strategy and the role and priorities or our key stakeholders	CE	12	9	9	9	9	9			↔
10. Financial pressures on other providers of health and social care cause operational difficulties at ASPH eg. increased DTOC, social services support	DCE	12	12	12	12	16	16			↔
11. If NHS Surrey's financial position causes negative impact on the Trust	DoF	12	12	12	12	12	12			↔

	Lead	June Risk score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	Risk Score	Risk Score	In Month Risk Change
5. Other (including Statement on Internal Control requirements)										
Risks to Objective										
1. Non compliance with Climate Change Adaptation reporting to meet the requirements under the Climate Change Act 2008	DCE	6	6	6	6	6	6			↔
~~**2.** Lack of Informatics strategy in a post NPfIT environment. (IT strategy needs to be driven by Trust overall strategy).~~	~~DoF~~	~~8~~	~~8~~	~~8~~	~~8~~	~~8~~	~~8~~			↔
3. Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy	DCE	6	8	8	8	6	6			↔

~~Proposed for removal~~ =	Proposed for removal
	Proposed new risk

Legend

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

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

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

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

BOARD ASSURANCE FRAMEWORK (BAF)

2010/2011 – 2015/16
April 2011: version 7

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	Terms of Authorisation	**CQC**	Registration

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
1. To achieve the highest possible quality standards for our patients, meeting and exceeding their expectations, in terms of outcome, safety and experience.										
FT CRR 988/769/ 764	1.If the Trust does not meet national priorities (and therefore Monitor's Compliance framework and Terms of Authorisation)	Monthly performance meetings with each DD. Clear ownership of each individual target/priority Escalation process agreed Elective MRSA screening programme now in place. Targeted improvement on pathways for elective patients to ensure 100% compliance have been introduced	Quarterly reporting to Monitor Internal Trust monitoring systems with Board scorecard	A&E target under pressure for Q4.	None known	Maintain existing actions- main focus is-A&E Daily review and escalation plan ▪ Continued senior medical staff recruitment ▪ Improvement of internal processes e.g. site meetings. ▪ Development of improved front door assessment	**Deputy Chief Executive** April 2011	3	5	15
IBP Risk 1.3 CRR 763 FT	2. If the level of HCAI infection rose and trajectory not achieved	Infection Control Team , IC Policies and Antibiotic Policies Framework on competency testing on aseptic techniques and IV site management in place Training programmes including induction Hand washing and audit of this Rigorous RCA process for learning	Mandatory reporting to the Health Protection Agency Monitoring via Infection Control Clinical/ward audits DoH visit 30/07/10	On going embedding of best practice Consistency of application of aseptic techniques and IV site mgt.	None known	Continued embedding , review and learning Develop and implement an audit programme for the Competency–framework when the competencies have been embedded	**Chief Nurse** August 2011	2	2	4

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
		Effective management of beds including occupancy levels	CQC spot checks on Hygiene Code compliance							
		Designated team providing 24/7 phlebotomy service for blood cultures including night time arrangements. Non elective screening in place				Reinforcing Promoting Zero tolerance approach	Ongoing			
CBP 1.4 FT CRR 1112	3. If there were pockets poor quality care which were masked by top level performance (as apparent in Mid Staffs)	Ward to Board approach including patients stories/Board visibility programme/Matrons presentations	Trust Board reports built up from ward level detail.	Staff survey results indicate further focus on specific aspects e.g. incident reporting	None known	Complete actions from staff survey action plan E.g. incident reporting	**Chief Nurse/Medical Director**	2	5	10
		Detailed quality metrics including scorecard and WQIs tracked over time. Divisional Quality dashboards presented to CGC	Matrons' feedback to Directors Patient complaints monitored via Complaints group.			Continue to develop triangulated ward indicators tracking patient experience/staff metrics/outcomes.	June 2011			
		Senior clinical leadership and presence within clinical areas: Essential spot checks. Best Care programme initiated				Continue to Integrate Outcomes framework and national metrics into a granular reporting structure throughout the trust which also informs the Board report	June 2011			
		Patient comments/incidents and SUI review processes								
		Mortality Review Group	Dr Foster data LINk/OSC							
		Culture of openness, ultimately supported by Whistle blowing policy								
		Maintaining agreed staffing levels with appropriate back-fill and monitoring compliance with processes		Complete establishment review with standardised		Establishment review completed and consultation commenced November to complete 1st	**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
		Ward sister development programme commenced in January 2011		methodology across Trust		week December followed by implementation to complete April 2011. Introduce systematic management controls on n/m establishment. Complete final stages of recruitment and implementation	May **2011**			
~~FT~~ ~~CQC CRR 1088~~ ~~CRR 1089~~	~~4.If Data quality deteriorated leading to poor decision making~~	~~Data Quality Manager in place~~		~~Further work on detailed procedures.~~	~~None known~~	~~Review and update core procedures. Action plan to achieve this has been developed.~~	~~**Director of Finance and Information**~~	~~2~~	~~4~~	~~8~~
		~~Training and staff awareness~~	~~Clinical Audit Team~~							
		~~Data quality audits (required as part of IG toolkit)~~	~~IG toolkit~~			~~Outpatient procedures to be piloted in Ophthalmology. Training using the new procedure guide is underway in Outpatients.~~				
		~~Submission to external sources e.g. SUS (looks at completion rather than accuracy) or Dr Foster (allows benchmarking)~~ ~~Data Quality Policy has been ratified by the Safety and Risk Committee.~~	~~SUS/Dr Foster~~ ~~Internal Audit review~~ ~~Good outcome from Audit Commission 2011 Outpatient Audit~~			~~Review outcomes of pilot after c 3 months prior to further roll out across the trust~~				

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 1089 CRR 1088	5. If there were poor standards of information governance which then jeopardised patient confidence	Information Governance Steering Group Information Asset owners have been established with risk assessment process Mandatory IG training programme Policies and Procedures	Information Governance Toolkit Trust recording on mandatory training Chantrey Vellacott DFK (Audit on Mobile data 2010) Reviewed at IGAC October 2010	Uptake of mandatory training. IG toolkit requirement to achieve 95% of staff trained using the national on line IG training system	None known	Continue with on-line mandatory training to work towards annual target of 95%. Basic computer skills courses offered to staff where applicable in support of this initiative. New approach to training to be devised for 2011/12	**Director of Finance and Information** June 2011 (extended national deadline)	2	4	8
IBP Risk 1.4 CBP Priority 1.3 CRR 1037 FT	6. If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence	Approach to overseeing Registration has been agreed with Directors &TEC. Details included in Directorate reviews Evidence is gathered on the Performance Accelerator allowing gap analysis Programme of activity to embed ownership at service level Review process incorporated into committee/group TOR Early warning indicators and triangulation of data ward to Board Proactive review and response to external advice on best practice e.g. NPSA alerts Integrated governance and risk management infrastructure and	Performance Accelerator CQC Quality and Risk Profile Results of patient surveys Patient complaints/incidents/ KPIs	None known	None known	Continue with assessment process Develop guidance on use of the performance accelerator including roles and responsibilities	**Chief Nurse** June 2011	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
		oversight *Your Feedback* means assessment can become more outcome focussed								
CBP Priority 1.1 IBP Risk 1.1 CRR 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 Strong feedback mechanisms e.g.Net promoter Scores National and local surveys, Programme of organisational change and cultural transformation Patient comment cards Launched Care Standards (nursing) Net Promoter scores introduced Your feedback introduced in all adult inpatient wards and rolled out to Outpatients Feedback strategy Local inpatient survey completed	National and local Patient surveys i.e. Picker, CQC and internal Patient Panel LINKs OSC Complaints data	Poor results in national surveys	None known	Launch living our Values Programme Implement Patient Diaries Launch releasing Time to Care with 100% completed	**Chief Nurse** May 2011 Sept 2011 March 2012	3	4	12
CBP	8. If the level and content of information provided to patients does not support patient choice and control	Use of NHS Outcomes Framework data at clinical divisional and Board level that is published. Quality Account Publication Monitoring of patient perception of choice and control to enable	Board Complaints and Your feedback National patient survey Activity and Marketing	Develop and enhance tools	Non known	Develop divisional dashboards with national outcome Framework data Develop individualized consultant outcome data External and internal benchmarking	Chief Nurse December 2011	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
		targeted intervention	data							
IBP risk 1.2 CBP Priority 1.1 CRR 767	9. 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			Position re new guidance now assured and was reported to board in March Implement action plan	April 2011			
		Breach monitoring system in place	Trust Board reports							
		Funded programme of capital works to complete outstanding wards.	Funded Capital programme							
			Patient survey results PCT assurance visit in December 2010							
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	Robust internal information and management of vacancies, including monthly vacancy reports at Corporate, Directorate, staff group level	Board, TEC and EPF reports Performance Review meetings Recruitment meetings notes.	None known			**Director of Workforce and OD**	3	3	9
		Corporate Risk register reviewed at IGAC BAF reviewed at WSSG including Heads of Professions. Recruitment and retention meetings to design recruitment campaigns to fill campaigns in affected divisions								
		Targeted recruitment campaigns	Workforce Redesign Group		Middle grade doctor vacancies in	Robust recruitment plan for medical staffing in Emergency	Targets / timescales to be agreed following discussion with Speciality Lead,			

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
			Workforce Strategy Steering Group. Controls and systems put in place in April 2010 have resolved vacancies in midwifery, ITU & paediatrics		Emergency services	services	A&E			
		New roles and ways of working introduced as required								
IBP Risk 3.2 CBP Priority 2.1 CRR 768 Local risk 319 Maternity	2. If the Trust was unable to retain staff particularly in shortage specialties	Monthly corporate and divisional turnover reports.	Board TEC and EPF reports Performance Review meetings	None known	8 key scores remain below average in 2010 staff survey: % using flexible working options % participating in health & safety training % suffering work-related injury % saying hand washing materials not always available % reporting errors and near misses % reporting negative impact of health and well being on their work % staff who believe there are equal opportunities for career progression % experiencing discrimination at work	Corporate action plans to address 8 'below average' key scores Directorate level targeted SAS action plans	**Director of Workforce and OD** April 2011: revised action plan plans reflecting 2010 results	2	3	6
		Focussed plans for retention in shortage specialties e.g. Health and wellbeing, Training and development initiatives	CG meetings							
		Talent management systems being developed, with work being undertaken to have at least 1 internal candidate for every vacancy by March 2011	Staff Attitude Survey (CQC and internal) Recruitment Audit							

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
CBP Priority 4.1	3. Inability to reduce management costs	Workforce Plan 2010/11 agreed and monitored monthly. Report held by Finance and HR to track progress against management CIPS	Board TEC and Finance Committee reports Workforce Strategy Steering Group Performance Review meetings	Tracking and deletion of established posts given up as CIPs	None Known	Monitoring of Trust's Integrated Workforce Plan at WSSG Corporate and Middle Office Workshop held in March 2011. Actions to be monitored by Programme Board through Workforce Redesign Group	**Director of Workforce and OD**	3	3	9
		Business planning process and targets set for 2011/12	Workforce Redesign Programme CIP and Workforce Redesign Groups							
		Corporate Directorate review meetings established wef July 2010								
		Vacancy Panel reviews every vacancy and all non clerical roles advertised and appointed to on a fixed 9 month term basis								
CBP Priority 2.1	4. Medical appraisal and job planning do not underpin revalidation requirements	Medical appraisal overseen by Medical Director and local job planning guidance in place	Board , TEC and EPF report Performance review meetings CRMS System	Medical appraisal and Job Planning are not currently aligned	Removal of DoH appraisal toolkit	Medical appraisal Policy and Process developed at workshop in February for agreement at JLNC and TEC in April	**Medical Director** November 2010 Pilot concludes Feb.2011 Implementation March 2011 April 2011	3	2	6
		Consultant Job Plans are overseen by Deputy CEO								
		Weekly corporate and divisional appraisal reports								
		Deputy Medical Director appointed and will lead on medical appraisal and revalidation								
		Centralised monitoring and recording of appraisal on ESR	Appraisal reports							

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 Local risk 319 Maternity	5. If there was failure to deploy a high performing workforce	Integrated performance reports at Corporate and Directorate level feeding into individual appraisals High levels of participation in leadership and team development programmes Succession planning being developed and implemented. Robust individual appraisal processes and systems 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 &Tec report Performance Review meetings Delivery Programme 4 and Programme Board Appraisal rates monitored weekly Patient outcomes and patient experience feedback	None known	Attainment of 95% appraisal rate by 31/03/.11	'Living our Values' programme to be launched for all staff, based on real patient stories	**Director of Workforce and OD** April 2011	2	4	8
CBP Priority 2.3	6. Increased turnover and sickness	Monthly corporate and divisions turnover and sickness reports	Board, TEC and EPF report Performance Review Meetings CQC and internal staff surveys EAP reports	Staff awareness of EAP,OH	None known		**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
		SAS and Health and Well Being calendar in place (Occupational Health and Employee Assistance Programme) being more actively promoted	WSSG CQC and internal staff surveys			Calendar of Health and Well being events for 2011/12 in place	April 2011			
CBP Priority 2.1	7. Reduced knowledge of junior Doctors.	Close supervision by Clinical tutors and DME Replacement of junior doctor roles with experienced doctors in A&E and MAU Junior Doctor induction Junior Doctor survey	Deanery Local Faculty Group Meetings (LFGs) Mid & end year reviews for all Drs either in house or ARCP process. Assessment of clinical skills during induction Centre Reviews that assess quality assurance of supervision and training and education in practice.	Reduction in opportunities for learning for Doctors in Training posts	Sufficient consultant cover during junior doctor change over periods	Annual leave tracking to ensure adequate consultant cover during holiday periods Action plan to increase training opportunities and provide senior support to staff particularly out of hours	**Director of Workforce and OD** April 2011	3	3	9
		Consultant Cover strengthened • Labour Ward 40 hrs week • Physicians 13 hours/7 days a week • Paediatrics and Neonates full Consultant attendance • T & O Consultant delivered Service	Induction includes competency-based training which ensures clinical skills are assessed							

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
		• Acute Surgery Consultant delivered Service • A & E Middle and Senior Grade cover 24/7								
		Junior Doctor presence at Directorate Meetings, Departmental and Trust Morbidity and Mortality Meetings								
SIC	8. Non compliance with Equality , Diversity and Human Rights legislation	Implementation of Equality Act 2010 and impact of new Public Sector Equality Duty. Staff diversity champions. Single Equality Scheme and action plan Employment policies	Equality and Diversity Steering Group Annual Equality & Diversity report to trust Board. Quarterly reports to TEC. Monitoring of SES through Equality & Diversity Group and Board SHA review of SES Patient and Staff Survey(CQC) Up to date suite of employment policies	None known	None known	Not applicable	**Director of Workforce and OD**	2	3	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.										
CBP Priority 3.3	1.If the trust was unable to provide increased services	Market data available to support decision making	Clinical strategy Group	None Known but start preparing for	None Known	Continue actively promoting Trust services and working with GPs.	**Deputy 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
	at Ashford Hospital and in community locations	Clinical strategy group Buy-in from Clinical directorates with Directorate specific marketing plans Market share information is monitored at performance meetings with Divisions Business development team has been aligned to operational divisional structure to ensure strong support	TEC Marketing data	2011/12		.				
CBP Priority 3.2 CRR 832	2. If the trust lost significant market share including any current trends in specific localities or specialties	Market data available to support decision making and monitored at performance review meetings Marketing manager Buy-in from Clinical Divisions Programme of GP engagement Growth achieved in some key areas including Cobham	Clinical strategy group TEC Finance Committee	Sustain current levels of activity and grow Mid Surrey	None Known		**Deputy Chief Executive**	2	4	8
CBP Priority 3.1 CRR 1070	3. 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	NHS Surrey Trust Activity reports Programme Board Performance Review meetings (Performance still exceeds target)	NHS Surrey demand management systems need to be fully in place Severe and early winter and swine flu	None Known	Implement ambulatory care pathways Work with NHS Surrey, and PBC clusters to support and develop and implement pathways that support admission and	**Deputy Chief Executive** Data analysis completed; now planning rollout. Review benefits realisation in March	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
		Information tools being designed to enable Trust to anticipate and therefore pre-empt issues with delivery Regular contract management including the PCT MAU redesigned to provide non inpatient facilities Phase 1 and Phase 2 of new MAU /A&E pathway has been implemented Meet and Greet implemented New winter pressure schemes implemented- nursing homes and virtual ward				attendance avoidance in line with best practice Escalation plans activated re flu	2011			
CBP Priority 3.3 &4 CRR 1112	4. 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 Enhanced system of media monitoring and analysis in place	Trust Board Successful FT application CQC Patients surveys Internally run surveys and feedback Feedback from major external stakeholders Results of summer staff survey and excellent response rate to national winter survey	None known	None known		**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	5. 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 DDs working with /visiting GPs Pathway work on referral management schemes Clinical Interface meeting chaired by medical director Engagement through NW Surrey Board Business development team aligned with divisions Medical director commenced an programme of engagement with GPs Model of care strategy groups working collaboratively across organisations	Marketing Report LMC Feedback via LEC	Review in light of White Paper	None known	Agree next steps on implementing the model of care with PBCs(clinically led with consultants and GPs around 6 themes)	**Deputy Chief Executive** May 2011	2	4	8
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
CBP Priority 1.1&2 CRR 1070	1. Unexpected changes in pattern of demand and admissions puts pressure on the bed complement and therefore patient care	KPIs e.g. LOS Clear bed complement plan Escalation processes Winter plan agreed in principle by NW Transformation Board. Includes plans for additional capacity.	Benchmarking Programme Board Patient complaints and incidents. Staff feedback	See BAF 3.5 on reducing emergency admissions	None known	Business plans for 2011/12 to review bed base for acute medicine. Refurbishment of escalation areas to improve the patients' experience- out to contract	**Deputy Chief Executive** April 2011 Regular review of capacity over winter period	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
		Additional winter schemes implemented (see3.5)								
CBP Priority 1.1&2	2. Insufficient attention to acuity of patient needs	Acuity review completed Resulted in review of nursing establishments. Bed ratios & AUKUH tool used to inform and review establishments	Benchmarking ACUH Programme Board Patient complaints and incidents. Staff feedback	Complete current review	None known	Nursing and Midwifery workforce review completed November 2010AUKUH tool found to be subjective and not of value. Professional judgement model used to determine workforce. 6 monthly review to commence June 2011 and as change in clinical areas occur.	**Chief Nurse** **Follow up review June 20-11**	2	4	8
IBP Risk 2.4 CBP Priority 4.4	3. National Contract changes putting risk onto providers- Non elective admissions and readmissions cap could lead to loss of income	Activity planning process with clear targets Clear internal Performance Review Framework. Good recent track record of managing budgets and delivering a surplus. Future Models of Care work streams with locality commissioners.	KPIs Performance Review Meetings Patient complaints and incidents. Staff feedback	Programme management office to be launched	None Known	Clear articulation of internal programme of work as unscheduled care via PMO See actions in BAF 3.5	**Deputy Chief Executive**	4	4	16
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 and 2010/11 External advisor has helped challenge and test robustness of proposals	External advisor Finance committee review Programme Board. Work stream 2 and sub group	None known	Further work needed to assure delivery of £`12m target for 2011/12	Programme Management Office (PMO) to launched	**Deputy Chief Executive and Director of Finance** April 2011	2	5	10

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
		Plans for 2011/12-2012/13 are well advanced								
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	TEC Board Programme Board Performance Review meetings	None known	None known	Major Productive schemes will identify patients experience objectives as well as productivity objectives	**Deputy Chief Executive** March 2011 onwards	**2**	4	8
		Trust's quality framework	Complaints and KPIs							
		Planned programme of bed reductions which is regularly reviewed with Directorates								
		Quality dashboards now implemented in Divisions								
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	Delivery Programme TEC	Continual validation of data Continual clinical engagement Further staff training	None known	Continue to implement Programme 6 Continual validation of data Training needs analysis to be undertaken Engagement events and specialty lead training Timetable to move to monthly SLR data	**Director of Finance and Information** Ongoing monitoring through SLM workstream April 2011	3	2	6
		Financial accountant to support development								
		Good Clinical engagement								
		SLR now supported by patient level costing								
CBP Priority 4.2	7. EQUIP programme is not fully embedded with widespread	External support through Simpler	Simpler TEC	Align EQUIP programme with 2011/12 priorities	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
	and rising engagement throughout the Trust year on year	Strong Project team/resource in place> new transformation lead appointed.	Programme Board							
		Divisions and Directorates identifed Affiliates to strengthen clinical engagement								
		Active programme of rolling out training to Bronze level across organisation								
		Strong sign up from the Divisions Work programme for 11/12 developed	CIP Programme Board							
CBP Priority 3.1	8. National economic climate with focus on reducing public sector expenditure.	Medium term financial planning though LTFM includes downside scenarios and mitigation.	Finance committee Internal and External audit	Continuous review	None known	Continuous review through Finance Committee including review of o Trading o CIP o LTFM	**Director of Finance and information**	4	3	12
		Good recent track record of managing budgets and delivering a surplus.								
		Robust approach to CIPs with target of over delivery, thus 'banking'.								
IBP	9. As the new Government develops its Policy for NHS this could impact adversely on the trust strategy and the role and priorities	Continue to review Trust strategy alongside new Policy. Initial review shows strong degree of alignment between Trust strategy and The White Paper	Trust Board		None known		**Chief Executive**	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
	of our key stakeholders	Maintain a very strong focus and relationship with local GPs and other stakeholders Health informatics strategy agreed		2011/12 Corporate and divisional business plans to clearly set out activity and implications from the Health and Social Care Bill 2011 Limited ability to Influence development of GP commissioning in our catchment		Develop the future model of care strategy with NW Surrey Maintain focus on joint work with GPs Improve commercial expertise of the organisation Complete Business planning 2011/12 Increase understanding of legal implications of the Bill e.g. Joint Ventures and partnership arrangements	May 2011 and ongoing April 2011			
CRR 1070	10. Financial pressures on other providers of health and social care cause operational difficulties at ASPH e.g. increased DTOC, social services support	Continuous review through KPIs Local engagement with key stakeholders Reviewed through Transformation Board. Joint winter planning with NW Surrey Transformation group Weekly interagency discharge review established. Initial discussions on winter planning have secured some additional community support. Formal winter plan agreed Additional in house support secured by trust to maintain pace on discharge arrangements	KPIs OSC LINk	None known	None known		**Deputy Chief Executive** Monthly review	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
		Trust is monitoring the flow of patients to community hospitals on a monthly basis Additional central funding has been made available for social care support during the winter								
CBP Priority 3.1	11. If NHS Surrey's / LHE financial position causes negative impact on the Trust	Focus on NW Surrey Locality relationships Signed Contract in place with monitoring arrangements Activity profiled across year Capped contract in place	NHS Surrey Contract Monitoring Group Finance Committee TEC	External factors to the Trust	External factors to the Trust	Fortnightly executive director meetings to monitor financial position	**Director of Finance and Information**			
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 High level action plan and Sustainable Group agreed and established Closer integration of estates and hotel services	PWC audit Internal Audit review 2011	Carbon emission strategy required with action plan	Baseline of current position required- external advice required Action Plan	1. establish baseline of current position Develop coherent plan to impact on ways of working that reduce carbon e.g.	**Deputy Chief Executive** October 2011 April 2011 onwards	3	2	6

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

Audit Trail

Version 1	BAF Amended to reflect revised Corporate Objectives in the Corporate Business Plan 2010/2011
Version 2	July/August updates via EDs
Version 3	September review by EDs/ Review by October IGAC and then further refresh by Executives
Version 4	December refresh by Execs prior to review by IGAC
Version 5	January 2011 refresh by Execs prior to review by IGAC
Version 6	March 2011 refresh by Execs prior to review by IGAC
Version 7	incorporates outcome of IGAC

Reference:

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

Risk Scoring Matrix –

Risk Matrix - Severity x Likelihood

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

Risk Rating
Extreme
High
Medium
Low