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

TRUST BOARD
29th September 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 8th September 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. ▪ The Board is asked to agree the addition of the risk on statutory and mandatory training competencies
Submitted by:	Jane Gear , Head of Corporate Affairs For Andrew Liles, Chief Executive
Date:	15th September 2011
Decision:	For Approval

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

TRUST BOARD
29th September 2011
Board Assurance Framework 2011/12 – 2015/16
September 2011 Version 9

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 8th September, and the review took place in tandem with a review of the Corporate Risk Register.

4 Commentary on Risks

1. BAF Risk 1.4 relates to 'poor standards of information governance which then jeopardises patient confidence'. This risk was initially included as a result of the loss of data sticks two years ago and referral to the Information Commissioner. Recently the Trust has achieved 96% compliance with the IG toolkit requirement for all staff to receive training on Information Governance. Following discussion, IGAC agreed to recommend to the Board that the risk be removed from the BAF.

2. As stated above, the BAF relates to risks to the Trust's Strategic objectives. The Trust is currently considering a major transaction relating to the potential acquisition of Epsom hospital.

   IGAC considered whether to recommend to the Board the inclusion of a new risk relating to this transaction. It was agreed that the Director of Workforce

and OD (Epsom Project Sponsor) and the Head of Corporate Affairs would discuss this further in order to shape a firm proposal.

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 highlight any risks to the strategic objectives that they believe should be documented on the BAF, but are currently missing
- The Board agree the deletion of the risk on Information Governance

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
2011-2012
Version: September 2011

	Lead	June Risk score	Aug Risk Score	Sept/Oct Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	June 11 Risk Score	Sept 11 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	15	12	↓
2. If the level of HCAI infection rose and monthly trajectory relating to the Quarter submission was not achieved	CN	16	16	16	16	6	4	10	9	↓
3. If there were pockets of poor quality services which were masked by top level performance	CN/MD	10	10	10	10	10	10	10	15	↑
4. ~~If there were poor standards of information governance which then jeopardised patient confidence~~	DoF	8	8	8	8	8	8	8		
5. If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence	CN	8	8	8	8	8	8	8	10	↑
6. 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	12	12	↔
7. If the level and content of information provided to patients does not support patient choice and control	CN						8	8	8	↔
8. If Environmental standards, including Single Sex Accommodation (SSA), do not meet expectations/ standards	DCE	3	3	3	3	3	3	3	3	↔

	Lead	June Risk score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	June 11 Risk Score	Sept 11 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	6	6	↓
2. If the Trust was unable to retain staff particularly in shortage specialties	DoW	6	6	6	6	6	6	6	6	↔
3. In ability to achieve planned workforce cost reductions	DoW	9	9	9	9	9	9	9	9	↔
4. Medical appraisal and job planning do not underpin revalidation requirements	MD	6	6	6	6	6	6	6	6	↔
5. If there was failure to deploy a high performing workforce	DoW	8	8	8	8	8	8	8	8	↔
6. Increased turnover and sickness	DoW	6	6	6	6	6	6	6	6	↔
7. If there was reduced knowledge of junior Doctors	DoW	9	9	9	9	9	9	9	9	↔
8. Non compliance with Equality, Diversity and Human Rights legislation	DoW	6	6	6	6	6	6	6	6	↔
9. If staff did not have up to date statutory and mandatory training competencies	DoW							12	12	↔
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	MD	6	6	6	6	6	6	6	6	↔
2.If the Trust lost significant market share including any current trends in specific localities or specialties	MD	8	8	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	16	16	↔
4. If the Trust developed a poor reputation	CE	8	8	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	JH	12	12	12	12	8	8	8	8	↔

	Lead	June Risk Score	Aug Risk Score	Sept Risk Score	Dec Risk Score	Feb 11 Risk Score	April 11 Risk Score	June 11 Risk Score	Sept 11 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	16	12	↓
2. Insufficient attention to acuity of patient needs	CN	8	8	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	DoF	12	12	12	12	16	16	16	16	↔
4. Delivering CIPs is handled ineffectively or in a piecemeal fashion. Insufficient long term planning of CIPs into future years	DoF	10	10	10	10	10	10	15	15	↑
5. Risk of CIP/productivity agendas inadvertently undermine the Trust's stated objective on improving quality	DCE	8	8	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	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	8	↔
8. National economic climate with focus on reducing public sector expenditure	DoF	12	12	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	12	12	↔
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	16	16	↔
11. If NHS Surrey's financial position causes negative impact on the Trust	DoF	12	12	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	June 11 Risk Score	Sept 11 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	6	6	↔
2. Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy	DCE	6	8	8	8	6	6	6	6	↔

Legend

15 – 25	Extreme	↔	No change to the risk score	CE	Chief Executive
8 – 12	High	↓	Risk score decreased	CN	Chief Nurse
4 – 6	Medium	↑	Risk score increased	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
September 2011: version 9

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 Division. Clear ownership of each individual target/priority Escalation process agreed Daily performance reports Daily 18 week meetings Daily A&E performance meetings External support commissioned to develop and implement 18 week planning tool	Quarterly reporting to Monitor Internal Trust monitoring systems with Board scorecard	Currently green on Monitor risk rating but A&E remains a risk	Emergency care Intensive team have visited and will return in Autumn	Unscheduled care is key project within PMO. Work streams, milestones and accountabilities have been confirmed	**Deputy Chief Executive**	3	4	12
IBP Risk 1.3 CRR 763 FT	2. If the level of HCAI infection rose and monthly trajectory relating to the Quarter submission was 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	**Chief Nurse**	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
		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. C. Difficile Action plan Appropriate specimen taking for suspected C. Difficile and prompt isolation Screening in place for all patients. The competency framework is completed and is being adhered to	Compliance with CQC Essential Standard 8			Reinforcing Promoting Zero tolerance approach	Ongoing			
CBP 1.4 FT CRR 1112	3. If there were pockets of poor quality care which were masked by top level performance	Ward to Board approach including patients stories/Board visibility programme/MDT 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**	3	5	15
		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.			Paper to Sept. Board on ward to Board assurance including prototype dashboards				
		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. Trust	Late Sept 2011			
		Patient comments/incidents and SUI review processes								
		Mortality Review Group	Dr Foster data							

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
		Culture of openness, ultimately supported by Whistle blowing policy Trust's internal monitoring of compliance with CQC standards triangulating against external evidence	LINk/OSC CQC baseline assurance review of 16 essential Standards is complete			proto-type has been developed and is being tested. Awaiting national Directions on publication.. Develop action plan following assurance review on 16 essential Standards	Directions still awaited- Dec 2011 Oct 2011			
		Maintaining agreed staffing levels with appropriate back-fill and monitoring compliance with processes Ward sister development programme commenced in January 2011. Cohort 2 in planning. Establishment review completed and implemented. Heads of Nursing in place with clear role and responsibilities for ensuring nursing is fit for purpose		Complete establishment review with standardised methodology across Trust		participate in Audit Commission review- Process now agreed with AC	**Chief Nurse** Sept **2011** Dec 2011			
IBP Risk 1.4 CBP Priority 1.3 CRR 1037 FT	5. 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 Divisional reviews	Performance Accelerator CQC Quality and Risk Profile IGAC review (June 2011)	Currently strengthening ownership and accountability of tools in place. Not all standards have been allocated to a Governance committee	None known	Continue with assessment process Develop action plan following assurance review on 16 essential Standards	**Chief Nurse**	2	5	10
		Evidence is gathered on the Performance Accelerator allowing gap analysis with reporting to IGAC and Trust Board on the QRP framework and Trust's compliance with Essential standards. Improved guidance issued.								

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
		Programme of activity to embed ownership at service level Review process incorporated into committee/group TOR. All standards are allocated to a Committee for overview	Results of patient surveys				October 2011			
		Early warning indicators and triangulation of data ward to Board Improved reporting to IGAC on external inspections	Patient complaints/incidents/ KPIs							
		Proactive review and response to external advice on best practice e.g. NPSA alerts								
		Integrated governance and risk management infrastructure and oversight								
		Your Feedback means assessment can become more outcome focussed								
CBP Priority 1.1 IBP Risk 1.1 CRR 766	6. 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	National and local Patient surveys i.e. Picker, CQC and internal Patient Panel LINKs OSC Complaints data January 2011 local inpatients survey	Continue to improve on results in national surveys. Develop actions from January 2011 local survey	None known	Local and corporate action plans in response to patient survey results	**Chief Nurse**	3	4	12
		Strong feedback mechanisms e.g.Net promoter Scores National and local surveys,				Implement Patient Diaries- initial plan costly so alternative approaches are being scoped	November 2011			
		Programme of organisational change and cultural transformation- Living our Values					March 2012			
		Launched Care Standards (nursing)				Releasing Time to Care 100% completed				
		'Your feedback' introduced in all adult inpatient wards and rolled out to Outpatients				Trust has commissioned additional postal patient surveys including 2 surveys annually for A&E patients.	Results due September 2011. Fieldwork for next survey starts in September			

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
		Feedback strategy 10 point plan implemented prior to July 2011 national inpatient survey								
CBP	7. 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 targeted intervention	Board Complaints and Your feedback National patient survey Activity and Marketing data	Develop and enhance tools	Non known	Develop divisional dashboards with national Outcome Framework data Develop individualized consultant outcome data External and internal benchmarking Scoping a shared decision making process for Programme 1	Chief Nurse December 2011	2	4	8
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			Position re new guidance now assured and was reported to Board in March Implement action plan	Review Q2 performance - October 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 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 New roles and ways of working introduced as required	Board, TEC and EPF reports Performance Review meetings Recruitment meetings notes. Workforce Strategy Steering Group Workforce Redesign Group Controls and systems put in 2010/11-have resolved vacancy hotspots in midwifery, ITU & paediatrics	None known	Medical staff vacancies in Emergency services Future supply of suitable midwifery candidates	Robust workforce plan for medical staffing in Emergency services: ▪ Launch consultant recruitment campaign ▪ Conversion of agency doctors to Trust bank ▪ Middle grade recruitment ▪ Consideration of workforce redesign and alternative roles Monthly recruitment campaigns	**Director of Workforce and OD** Sept 2011: (Spec. Lead A&E) June- August 2011: (Service Mgr A&E) September 2011: (Spec. Lead A&E) September 2011: (General Mgr A&E) September 2011: (Head of Midwifery & Recruitment Manager)	2	3	6
IBP Risk 3.2 CBP Priority 2.1 CRR 768	2. If the Trust was unable to retain staff particularly in shortage specialties	Monthly corporate and divisional turnover reports. Focussed plans for retention in shortage specialties e.g. Health and wellbeing, Training and development initiatives Talent management systems being developed, with work being undertaken to have at least 1 internal candidate for every vacancy.	Board TEC and EPF reports Performance Review meetings CG meetings Staff Attitude Survey (CQC and internal) Recruitment Audit	None known	Of the 7 below average scores from the National Staff Survey, only one key finding has slightly improved and one has not changed. The other five have deteriorated	Following a workshop of operational leads in August, the Corporate Action Plan which highlights areas for improvement is being updated.	**Director of Workforce and OD** Lead project manager is the Head of Organisational Development. The National Staff Survey 2011 will be issued in late September.	2	3	6

CBP Priority 4.1	3. Inability to achieve planned workforce cost reductions	Annual Workforce Plan agreed and monitored monthly. Business planning process and targets set for 2011/12 Vacancy Panel reviews every vacancy and all non clerical roles advertised and appointed to on a fixed 9 month term basis	Board TEC and Finance Committee reports Workforce Strategy Steering Group Performance Review meetings Workforce Redesign Programme CIP and Workforce Redesign Groups	Tracking and deletion of established posts given up as CIPs	None Known	Corporate and Middle Office review to be conducted during Q2 with implementation thereafter. Actions to be monitored by Strategic Delivery Board through Workforce Redesign Group	**Director of Workforce and OD** October 2011 July 2011 (Director of Workforce & OD)	3	3	9
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 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 Medical Appraisal Policy developed and agreed in February 2011 Medical Director and Deputy Medical Director have attended Responsible Officer training. Appraisal process has been aligned with Clinical excellence	Board , TEC and EPF report Performance review meetings CRMS System Participation in ORSA process – assessment of readiness for introduction of medical revalidation Appraisal reports 95% medical appraisal compliance at end of 2010/11	Medical appraisal and Job Planning are not currently aligned	None known	ORSA reassessment 2012	**Medical Director**	3	2	6

		process								
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 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	Improvement in Patient Survey scores Attainment of 100% appraisal rate by 31/03/12 Regular, robust reporting of statutory and mandatory training compliance	Living our Values' programme launched for all staff, based on real patient stories Leadership & Management Commitment Framework, with underpinning directory of training offerings to be monitored and evaluated following launch in Q! Implementation of outcomes arising from review of statutory and Mandatory provision and reporting structures 1200 staff to participate in 360 feedback during 2011/12	**Director of Workforce and OD** Implementation from April 2011 March 2012 (Director of Workforce & OD) September 2011 (Director of Workforce & OD) March 2012 (Director of Workforce & OD)	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

		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 Staff Physiotherapy service			Calendar of Health and Well being events for 2011/12 in place	March 2012 (Director of Workforce & OD)			
CBP Priority 2.1	7. Reduced knowledge of junior Doctors.	Close supervision by Clinical tutors and DME. Clinical teams ensure clear instructions given with regards to clinical care	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. Provision of local high quality clinical teaching	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 (CRMS system) Action plan to increase training opportunities and provide senior support to staff particularly out of hours	**Director of Workforce and OD** March 2012	3	3	9
		Replacement of junior doctor roles with experienced doctors in A&E and MAU								
		Junior Doctor induction. Hand over protocols developed, used and enforced Junior Doctor survey								
		Consultant Cover strengthened • Labour Ward 60 hrs week • Physicians 13 hours/7 days a week • Paediatrics and Neonates full Consultant attendance • T & O Consultant delivered Service • Acute Surgery Consultant delivered Service	Induction includes competency-based training which ensures clinical skills are assessed							

		• 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
NHSLA CQC	9. If staff did not have up to date statutory and mandatory training competencies	Learning, Education and Development Policy Lead Mandatory Trainers identified for each training strand Mandatory Training Committee OLM system and ESR notifications to managers of mandatory training	Monthly reports to Mandatory Training Committee by Mandatory Leads Staff's attendance recorded on electronic system (ESR/OLM) Quarterly reports to	Specific mandatory training requirements for each staff group not mapped to ESR/OLM	ESR/OLM reporting templates not in place to provide regular robust assurance and input to Balanced Scorecard	Implementation of actions arising from External Review of Trust's statutory and mandatory provision Development of improved ESR/OLM reporting templates and capability	**Director of Workforce & OD** September 2011 August 2011 August 2011	3	4	12

		competencies due to expire Inclusion of mandatory training compliance check within template appraisal documentation	WSSG (CQC outcome 14) Divisional reports to Clinical Governance Committee External Review of Trust's statutory and mandatory provision			Inclusion in Balanced Scorecard Review of monthly	August – December 2011			
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 at Ashford Hospital and in community locations	Market data available to support decision making Clinical strategy group Buy-in from Clinical directorates with Directorate specific marketing plans Market share information is monitored at performance meetings with Divisions Business development team has been aligned to operational divisional structure to ensure strong support	Clinical strategy Group TEC Marketing data	Due to operational pressures commitment to move all possible day Surgery to Ashford	None Known	Continue actively promoting Trust services and working with GPs. Continuing to move as much day Surgery to Ashford as possible .	**Medical Director** Dec **2011**	2	3	6
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	Continue to strengthen active dialogue with West Middlesex hospital and SASH. Work with SECamb regarding patient flows	**Medical Director** **Review Oct 2011**	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- Weekly and Daily tracking of admissions and discharges Unscheduled care and discharge are included in the PMO and fully launched Monthly action meeting with Director of Social Services Weekly operational meeting with Divisional directors	NHS Surrey Trust Activity reports Strategic Delivery Board Performance Review meetings Weekly Executive Director/Divisional director performance meetings	NHS Surrey demand management systems need to be fully in place	None Known	Identified through PMO. Work with NHS Surrey, and PBC clusters to support and develop and implement pathways that support admission and attendance avoidance in line with best practice Early winter planning launched in August. Trust to be able to activate a clear and agreed plan	**Deputy Chief Executive** Oct 2011	4	4	16
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	NA	**Chief Executive**	2	4	8
CBP Priority 3.1	5. If the Trust was unable to engage with GPs	GP Liaison/Marketing Manager Choose and Book Manager	Marketing Report	Review in light of White Paper	None known	Agree next steps on implementing the model of care with	**Director of Finance and Information**	2	4	8

	individually and collectively as national policy enhances their role in commissioning	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	LMC Feedback via LEC			PBCs(clinically led with consultants and GPs around 6 themes) now incorporated into NW Surrey QIPP	October 2011 onwards			
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 Weekly length of stay meetings in place Escalation processes Daily Information Reporting and intelligence System in place	Benchmarking Programme Board Patient complaints and incidents. Staff feedback	See BAF 3.5 on reducing emergency admissions	None known	See BAF Risk 3.3 Unscheduled care . Refurbishment of escalation areas to improve the patients' experience- out to contract Implement Real Time Bed Management System LoS is one of next projects in PMO	**Deputy Chief Executive** Regular review of capacity over winter period Oct 2011 Oct 2011	3	4	12
CBP Priority 1.1&2	2. Insufficient attention to acuity of patient needs	Acuity review completed Resulted in review of nursing establishments. Bed ratios & AUKUH tool used to inform and	Benchmarking ACUH Programme Board	On going review process needed	None known	Further skill mix review to include all clinical nursing specialists and Audit	**Chief Nurse**	2	4	8

		review establishments New Nursing establishments have been implemented. Heads of Nursing to undertake a monthly reconciliation of establishments/budgets/current healthroster	Patient complaints and incidents. Staff feedback			Commission benchmarking Introduce safer nursing tool run by AUKUH	Dec 2011			
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 Detailed review of 30 day readmissions after an elective episode to identify any inappropriate coding or pathways See actions in BAF 3.5	**Director of Finance** DoF&I and MD October 2011	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 Programme Management Office (PMO) launched Good track record of delivery in 2009-2010 and 2010/11 External advisor has helped challenge and test robustness of proposals Plans for 2011/12-2012/13 are well advanced Additional resource to strengthen CIP project office	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	Continue with programme management approach	**Director of Finance** October 2011	2	5	15

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 and Divisional performance reviews look at workforce/activity, finance and quality	TEC Board Strategic Delivery Board Performance Review meetings	None known	None known	Major Productive schemes will identify patients experience objectives as well as productivity objectives	**Deputy Chief Executive** ongoing	**2**	4	8
		Trust's quality framework	Complaints Monitoring Group Clinical Governance Committee SHA Workforce Plan: Assurance Process							
		Planned programme of bed reductions which is regularly reviewed with Directorates								
		Quality dashboards now implemented in Divisions and monthly clinical governance meetings								
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** Ongoing monitoring through SLM workstream September 2011	3	2	6
		Financial accountant to support development								
		Good Clinical engagement								
		SLR now supported by patient level costing New Programme Lead in place								
CBP Priority 4.2	7. EQUIP programme is not fully embedded with widespread and rising engagement throughout the Trust year on year		Simpler TEC Programme Board External review completed.	Align EQUIP programme with 2011/12 priorities	Increased Executive level scrutiny and support required	EQUIP to be embedded in PMO	**Deputy Chief Executive** October 2011	2	4	8
		Project team/resource in place								
		Divisions and Directorates identified Affiliates to strengthen clinical engagement								
		Active programme of rolling out training to Bronze level across								

		organisation	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. 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	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
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 Health informatics strategy agreed Business Plan 2011/12 agreed Board seminar on acquisitions	Trust Board	Health and Social care Bill paused by parliament- Government response just issued but will cause delay Limited ability to Influence development of GP commissioning in our catchment	None known	Develop the future model of care strategy with NW Surrey Maintain focus on joint work with GPs Improve commercial expertise of the organisation Increase understanding of legal implications of the Bill e.g. Joint Ventures and partnership arrangements	**Chief Executive** ongoing	4	3	12

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	NW Surrey Transformation Board Daily reports on delayed discharges. Monthly meeting with Director of Social Services underpinned by action plans	KPIs OSC LINk	Poor information on utilisation of community services	None known	Early engagement with new community services provider once agreed	**Deputy Chief Executive** Monthly review	4	4	16
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 for 2011/12; signed	NHS Surrey Contract Monitoring Group Finance Committee TEC Quarterly director level meeting with NHS Surrey	External factors to the Trust	External factors to the Trust	Weekly executive director meetings to monitor financial position	**Director of Finance and Information**	3	4	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	Sustainable Steering group established and developing action plan All building upgrades comply with sustainability requirements. Participation in Carbon Reduction Commitment Scheme (CRC) with formal reporting requirements which will allow	PWC audit Internal Audit review 2011 Benchmarking energy sustainability through CRC	Sustainable Development Action Plan Lack of designated lead at implementation level	Baseline of current position required- external advice required Action Plan from Internal	1. establish baseline of current position Develop coherent plan to impact on ways of working that reduce carbon e.g. light use/PCs Review opportunities for	**Deputy Chief Executive** December 2011	2	3	6

		benchmarking			Audit	energy technologies to reduce carbon emissions e.g. CHP Implement action plan from Internal Audit .	September 2011 onwards By end December 2011			
	2 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