Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
25th February 2010

TITLE	**Board Assurance Framework** 209/10 – 2014/15 February 2010 Version 17
EXECUTIVE SUMMARY	The Board Assurance Framework (BAF) is an assurance tool that ensures the Board have been properly informed about the totality of risks to achieving all of the Trust's strategic objectives. The BAF (version 16) is aligned to the 4 strategic objectives as detailed in the Integrated Business Plan. The BAF is presented to the Board, detailing all the changes made as a result of reviewed undertaken by the individual Executive Leads review.
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
LEGAL ISSUES	The Board Assurance process will enable the Chief Executive to be able to sign a Statement on Internal Control which forms part of the Trust's statutory accounts.
The Trust Board is asked to:	The Board is asked to discuss, challenge and review the Board Assurance Framework (version 17).
Submitted by:	Jane Gear , Head of Corporate Affairs For Andrew Liles, Chief Executive
Date:	18th January 2010
Decision:	For Approving

Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
25th February 2010

Board Assurance Framework
209/10 – 2014/15
November Version 17

Introduction

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

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

Review

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

Due to the meeting cycle and completion of Version 17 of the BAF, this document has not been reviewed by IGAC. The current version of the BAF (version 17) is presented to the Board, detailing all changes made since the publication of version 16.

Developing the BAF

Considerable work took place in 2009 realigning the BAF to the Trust's strategic objectives. Further review will be need in 2010. Responsibility to coordinate the BAF has transferred to the Head of Corporate Affairs/Trust Board secretary and a meeting has taken place with the internal auditors to discuss further possible improvements in presentation and completeness. One intention for 2010/2011 is to make sure the BAF aligns to support the completion of the Statement on Internal Control.

Recommendations

- The Board comment on the BAF in particular the assurances and any gaps in assurance and controls it would wish to see addressed
- The Board highlight any risks to the strategic objectives that they believe should be documented on the BAF, but are currently missing

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

Date: 18th February 2010

Ashford and St. Peter's Hospitals NHS
NHS Trust

Board Assurance Framework
Summary v 17

January changes and summary commentary
(New/amended items are in italics and highlighted. Removed items are crossed out and highlighted, whilst the larger removed items are detailed at the end of the BAF)

Reference number	Previous Risk Score	Revised Risk Score	Commentary	Lead
1a	9	9	• 1 gap in control expended • 1 additional means of assurance	COO
1b	12	12	• Additional controls in place	CN/MD/DIPC
1c	9	9	• Additional assurance added	CN
1d	16	16	• Additional control added • Timescale and Milestone updated	CN/COO
1e	12	12	• Gap in control restated • Timescale and milestones updated	CN/DoS
1f	9	9	• Additional gap in control identified	MD
2a	12	9	• Actions updated	DoW&OD
2b	9	9	• Actions updated • Controls clarified	DoW&OD
3a	12	9	• Controls updated	DoS/COO
3b	8	15	• Severity of risk increased impacting on overall rating • Controls updated	DoS
3c	12	12	• Timescale and Milestone updated	DoS
3d	4	4	• Timescale and Milestone updated	CEO
3e	20	20	• Milestone updated	DoF&I& COO
3f	9	9	• No change	COO

4a	8	8	• No change	DoF&I
4b	12	12	• Milestone updated	DoS
4c	12	12	• Additional controls added. Milestones completed	DoF&I
4d	12	12	• Risk removed in January 2010	DoF&I
4e	12	12	• No change	DoF&I
4f	20	20	• Additional controls added. Milestones completed	DoF&I
4g	9	9	• Controls updated	MD/COO

Legend

15 – 25	Extreme
8 – 12	High
4 – 6	Medium
1 - 3	Low

CE	Chief Executive		CN	Chief Nurse
DOO	Chief Operating Officer		DoW&OD	Director of Workforce & Organisational
DoS	Director of Strategy		DoF&I	Director of Finance & Information
MD	Medical Director		DIPC	Director of Infection Prevention & Control

Ashford and St. Peter's Hospitals NHS
NHS Trust

Board Assurance Framework

BOARD ASSURANCE FRAMEWORK (BAF)

2009/2010 – 2014/15

February 2010 - Version 17

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: Standards for Better Health – (S4BH) Auditor Local Evaluation, Key Line of Enquiry (ALE KLOE) NHSLA Risk Management Standards (NHSLA) Corporate Risk Register (CRR)	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

Reference:

Department of Health (2006) Integrated Governance Handbook. A handbook for executives and non executives in healthcare organisations www.dh.gov.uk/governance
Health Care Commission - Standards for Better Health

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.										
S4BH C7f, C4a CRR 764 Previous 1a.a	**a)** Failure to meet targets: A&E, stroke 18 weeks	**1**) Monthly review of status re: Annual Health Check by Information Lead and S4BH lead **2**) Weekly breach meetings with CD's and BCM's **3**) Daily reports on breaches and 18 WTT **4)** Improved working with NW Surrey Urgent Care Network **5)** Monthly performance meetings with CD's and BCM's **6)** Business Centre scorecards in place and standardised performance reports for each directorate **7)** Shared drive contains all performance reports 8) Improvement Boards established Dec 09 9) Initial increased in investment agreed for psychiatry liaison 10) recovery plans now standard requirement for all targets not on track 11) New clinical and managerial leadership within emergency services	**1)** Performance Monitoring by **2)** SHA – STEIS reports. **3)** Internal Auditors **4)** External Auditors **5)** Standards for Better Health - Annual Health Check. **6)** Cancer Peer Review. **7)** HES data. **8)** National annual Patient Surveys. **9)** NHSLA Risk Mgt standards **10)** Registration with Care Quality Commission (from April 2009) **11)** Trust Board scrutiny and challenge 12) PCT unplanned care network	**1)** Better management of discharge required both within Trust and across community including better information on discharge flows **2)** Improved psychiatric liaison service required to avoid some 4 hour breaches		**1)** Work programmes in partnership with wider health community (including SHA SWP) with a particular focus on patient flow and discharge Regular programme of meetings under way and in place. Key actions agreed. **2)** Emergency access action plan. Initial plan delivered. **3)** Internal programme of work on improving discharge practice to be developed and implemented by COO and Chief Nurse. Programme of work on discharge within the Trust agreed and implementation under way. Forms part of LEAN process	**Chief Operating Officer** **1)** Implementation of community wide discharge task-group on going **3)** on going Next stages of this work programme to be agreed by CN and COO with respective teams Feb.10 ~~Recruitment under way for psychiatric liaison~~	3	3	9
CRR 763	**b)** Failure to meet targets:	**1)** Screening of specified patients on arrival at hospital	**1)** Standards for Better Health - Annual Health Check.	**1)** HCAI **2)** Employment of Temporary staff.	Not all the ward cleanliness inspections were	**1)** On going training and monitoring programmes **3)** DIPC and Senior	**Chief Nurse / Medical Director / Director of Infection Prevention &**	3	4	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
Previous 1a.b	to reduce rates of HAIs	~~**2)** Hand washing and high impact intervention (HII) audits monthly~~ **3)** Infection control policies including – isolation; precautions taken by staff and visitors; antibiotic policy **4)** Infection control Training & Education **5)** Infection control annual programme **6)** Hand washing / HII audit programme for each area to actively involve staff with monthly audits 7) RCA & Executive Debrief on all MRSA cases 8) Ad hoc visits with an HCAI focus from Chief Nurse (on going through out 2010) 9) Rapid response team for deep clean now fully in post (Feb 2010)	**2)** HAI monitoring & surveillance **3)** National annual Patient Surveys. **4)** HCC hygiene Code visits **5)** NHSLA Risk Mgt standards **6)** Unconditional Registration with Care Quality Commission (from April 2009) **7)** Housekeeping audits **8)** Trust Board scrutiny and challenge **9)** adherence with dress code and infection control policies **10)** CQC visit on 9th October with a positive outcome **11)** MRSA & C Diff Trajectory currently meeting SHA stretch target Feb2010	3) High occupancy rate of hospital wards during capacity challenge	carried out during January 2010.	Management Team walkabouts ***4***) MRSA targeted action plan signed off by CDs **5)** Trust "charter" on infection control and campaign on personal responsibility for infection control **6)** Chief Nurse assimilated visits with consultant nurse in Infection prevention & control to do check compliance with the Heath & Social Care Act 2008 **7)** Corporate learning from all root cause analysis of HAIs **8)** Publicity via CEO bulletin, infection bulletin, intranet information **9)** PEAT inspections & Higher percentage of ward cleanliness audits	**Control (DIPC)** Reviewed monthly Reported to SHA weekly Introduced June 2009 & ongoing. Feb 2010			
S4BH C1a NHSLA Previous 1d	**c)** Failure to deliver a consistently safe service which would jeopardise our registration with the CQC	**1)** Lead for Clinical Governance in each Directorate ~~Business Centre (BC)~~ **2)** Clinical Governance Managers in post in Directorates **3)**Training for risk, health and safety **4)** The clinical and non clinical risk committees ~~**5)** CNST Level 2 Maternity services~~	**1)** NHS LA Risk Mgt standards and CNST Maternity Standards **2)** HCC hygiene Code visits **3)** Health and Safety Visits **4)** Registration with Care Quality Commission (from April 2009) **5)** Datix reporting system bringing together complaints, incidents, risks,	**1)** No explicit goals or priorities for action set **2)** Safety performance measures not comprehensively presented to Trust board **3)** Cultural environment not always seen as respectful, fair and just	Lack of safety climate / culture survey feedback	**1)** Develop explicit priorities and goals to meet strategic safety priorities as identified through LIPS work **2)** Board to agree and regularly review a set of safety performance measures as part Board's balanced score card **3)** Complaints to have greater corporate follow-up 4) CNST preparation for level 3 visit for Maternity	**Chief Nurse** on going Commencing November 2009 ~~Gained CNST Level 2 Jan 2010~~	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
			litigation **6)** Dr Foster information utilised to help prioritorise and monitor safety **7)** compliance with CEQUINs **8**) Matrons now reporting to the Trust Board bi-monthly allows and facilitates scrutiny and challenge 4) CNST gained at level 2 in Jan 10			services				
S4BH C14c, C17 CRR 766 Previous 4a	**d)** Patient Survey results fail to consistently reach fiftieth centile of Trusts in England - Failure to listen and act on feedback from service users will undermine the image and reputation of the Trust	**1)** Seeking regular feedback from Patients via Patients comment cards in all inpatient areas. **2)** Patient survey action plan to address key areas **3)** Communication & Engagement Strategy now agreed **4)** Patient surveys. **5)** Patient involvement (Patient Panel). **6)**Patient and public engagement Group (PPEG) 7) Programme updates to TEC and Board ongoing	**1)** Healthcare Commission annual patient surveys. **2)** LINKS reports. **3)** PEAT inspections **4)** Clinical Tuesdays continue for Matrons with clinical report to EDs & Chair on visits 5) Launched Matron Role to have a greater sense of Patient focus, higher visibility and standard setter	**1)** Not comprehensively addressing recurring trends in surveys and complaints, e.g. communication and attitude. **2)** Lack of evidence of all actions taken and resulting outcomes **3)** Patient comment card – poor response **4)** Lack of Monitoring & challenge at Directorate and Board level.	**1)**Too much time between National Patient Surveys and results **2)** Complaints action plans overseen by Complaints Monitoring Group. 3) Patient stories to the Trust Board demonstrate we are not always getting the care right	**1)** Fully embed the patient comment card to increase patient feedback + introduce more local surveys to provide more timely feedback. Publicise results in areas. **2)** Develop action plan based on results of the recent patient survey undertaken summer 2009 – overall objectives for the Trust, individual plans for ~~Business Centres.~~ Directorates. Action plan in response to May Outpatient (Picker) survey being actioned **3)** Patient experience group has met twice with detailed action plan **4)** Embed review of action plans in monthly performance meetings. **5)** Pilot of Picker hand held audit tool on 3 wards to completed January 2010 5) Coordinated through Programme 1 on " Patient	**Chief Nurse / Chief Operating Officer** April 2009 – March 2010 ~~Outpatient survey conducted May 2009 reported on.~~ Inpatient July 2009 – waiting full results. Ongoing review of patient survey action plans and at six monthly performance reviews. Clear areas for action agreed with each directorate. Outpatient survey results- Picker presentation January 2010 completed. PDA picker results due in Mid February 2010	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
						experience"				
S4BH C13a, C20b CRR 767 Previous BAF 4b IBP 1.2	**e)** Failure to meet single-sex accommodation as standard by March 2010	**1)** Mix sex accommodation situation reviewed and actioned at 11.30 & 3.30 capacity daily **2)** Completion of incident forms in the event of mixed sex accommodation **3)** Clear guidance in place for staff around placing of patients, consent, information and Trust objective of no mixed sex accommodation **4)** Commitment by Trust that all future developments, including conversion of existing ward stock, will have single rooms **5)** On going work with Head of Capacity and Deputy COO and Director of Delivery to reduce capacity pressures **6)** Estates strategy & commitment to implement **7)** Single Sex Accommodation fortnightly meetings ~~**8)** Rigorous management of the capital control group~~	**1)** ~~Matrons and Sisters~~ Directorates performance monitoring meetings **2)** National Annual patient survey **3)** Rigorous management of project plan **4)** SHA / PCT visits with feedback 5) Regular weekly report of breaches produced and analysed	~~**1)** Impact of the pressure on beds due to Swine Flu and winter pressure~~ ~~**2)** Full dialogue with Children's Services~~ 1) Breach report requires further validation and refinement	**1)** Elimination of Single Sex breaches	~~**1)** Commence work following the successful bid and action plans around eliminating mixed sex accommodation to STHA / PCT~~ ~~**2)** Implement planned bed re-modelling programme~~ **1)** convert whole wards to single sex accommodation (Discussion with Medical Directorate has identified plan to resolve) 2) Revised escalation policy for Trust wide use 3) reduce length of stay to target rate of 85%	**Chief Operating Officer ~~/ Director of Strategy~~** March 2010 During 2010/2011	3	4	12
IBP 2.5	**f)** failure to achieve full CQIN funding 2 elements: 1) Reduction in income 2) Failure to achieve	**1)** Ensure the delivery of CQIN targets **2)** Performance (quality) management against KPIs (Trust and PCT) 3)Rapid assessment	**1)** Trusts quality /metric/quality report **2)** PCT quality report – monthly performance meetings **3)** Directorate reports	**1)** Not achieving 48hr target for ~ NoF ~~**2)** Not delivering 100% 24/7 Stroke thrombolysis~~ 2) Not achieving VTE prophylaxis			**Medical Director** Key indicator on Trust scorecard. Significant improvements	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
	quality/safety/performance targets impacting on: reputation; on-going commissioning; CQC registration	bay for #NOF Dec 09 4)Action plans on 48hr #NOF target and Thrombolysis in place	– Clinical Gov Comm **4**) Thrombolysis audit shows 73% achievement with an upward trajectory							

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
2. To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.										
S4BH C11a (Recruitment) C11b (Training) CRR 768 IBP 3.3	**a)** Failure to recruit and retain the right number of staff with the appropriate skills Trust wide, particular hot spots are: • NICU • Anaesthetics Emergency Services	**1)** Targeted recruitment to match national and international sources of workforce supply **2**) Recruitment and retention plans have been developed 3) Collaboration with neighbouring Trusts regarding agency fees 4) regular monitoring of vacancy levels- ~~at Dec 09= 8% one of lowest in region~~ At Jan 10 = 9.16%	**1)** Regular workforce reports to business centres and heads of professions **2)** Follow up performance review meetings **3)** ED Walkabouts **4)** Regular workforce reports against KWPIs	**1)** Targeted recruitment and retention plans **2)** Explore opportunities to create new roles to support experienced staff **3)** Consider recruitment and retention premia		**1)** Introduce new ways of working and new roles- being addressed through Programme 5 Workforce redesign 2) Develop a Trust wide Recruitment and Retention Plan for Nursing /Midwifery to address hot spots through the Recruitment and retention working group 3) develop similar plan to address medical staffing hot spots ,currently through weekly individual directorate Recruitment and retention meetings	**Director of Workforce & Organisational Development** Review in March 2010	3	3	9
S4BH domain 3 (Governance) S4BH C8b/11 Personal and Professional Development S4BH C7e, discrimination	**b)**Poor levels of staff engagement as demonstrated by Failure to improve Staff Survey response Results	**1)** SP1:Clear roles, responsibilities and rewarding jobs **2)** SP2:Personal development and access to appropriate training **3)** SP3: Health, safety and well being **4)** SP4:Enagage and empower staff to improve services (LEAN project) **5)** Staff recommend Trust as an employer **6)** Staff believe Trust is an equal opportunities employer 7) Appraisal matters campaign launched 8)E learning rolled	**1)** Results reflect positive trajectories (2007 to 2009) **2)** Corporate and business centre SAS delivery plans **3)** 2009 Survey response rates is one of the highest in the country for the acute sector	**1)** Implement initiatives to ensure staff feel valued **2)** All staff do not have updated JD, KSF, PDP objectives & appraisal **3)** Development and training not perceived to be accessible. **4)** Staff do not associate modular programme with Health and Safety **5)** Culture gap **6)** Applicants not asked: If Trust recommended as an employer **7)** No communication on how appointments or	1) benchmarked national survey results not available till March 2010	**3)** Promote Zero Tolerance **4)** Staff focus groups to develop Behaviours Charter **5)** TEC acknowledge staff who recommend Trust as an employer 6) Ongoing embedding of Trust Values including incorporations into Staff Awards Scheme	**Director of Workforce & Organisational Development** Results due March 2010 (may be embargoed)	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
		out 9)~~Staff~~ Trust values agreed 10) Aspire used to celebrate career progression and diversity in appointments		awards are made						

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
3. To deliver the Trust's clinical strategy; redefining our market position to better meet the needs of patients and commissioners, and increasing market penetration.										
S4BH C17,C18 ALE KLOE 5.2 CRR 832 Previous ref 7a and 1c	**a)** Trust loses market share due to; poor marketing & contracting, competitive health care market, & is not considered the "1st choice" provider for the local population (patient choice) and GPs (loss of commissioned services)	**1)** Definition of Trusts Clinical Strategy **2)** Raising the profile of the Trust's successes and strengths, with information provided to GPs and direct to members of the local public particularly. ~~through local media.~~ **3)** Undertake GP visits and increase focus on marketing our services to them **4)** Increase utilisation of choose and book and increase availability of booking slots. **5)** Contract and Marketing Team to undertake ~~**6)**~~ Regular visits to GP ~~by the marketing / contracting team~~ ~~**7) Contracting Team with PCT knowledge and experience**~~ **8)** Better market analysis in the business plan ~~and information to TEC~~ **9**) Each clinical Directorate is developing Business Plans to include market Share 10) delivery of Trust marketing grid	**1)** Weekly balance scorecard performance monitoring **2)** SLA activity and income **3)** Media analysis **4)** Monthly choose and book reports. 5) Referral analysis **6)** The establishment of a Trust Clinical Strategy Group	1) Marketing capacity **2**) Understanding GP's working relationship with us **3)** Clear process and objectives by Directorates to improve market share	**1)** Patient survey results	**1)** Patient survey action plans **2**) Complaints monitoring and action plans **3**) Improving car parking plan **4**) PEAT action plan **5**) FT branding and membership **6**) Improvement in availability of booking slots required (reduction from 10% to 5% unavailability) **7**) External support on Choose and Book secured to develop trust action plan **8**) Benchmark our patient waiting times with other Trusts. **9)** Working with PCT to improve data challenge process **10)** Agreement of actions to improve market share 11) GP spotlight evening planned	**Director of Strategy** March 2010 **Chief Operating Officer/** Improvement in slot availability required for September 2009. Initial review during July. Completed. Review of outpatient demand and capacity as part of business plan development for 10/11. 11) Jan 2010 and on going	3	3	9
Previous ref 1f	**b)** Not being licensed for FT status	**1)** Rigorously managed project to deliver F.T	**1)** Project Board **2)** Constant and open discussions with	**1)**PWC reported gaps **2)** Governors elections **3)** Board development	**1)** Final feedback on IBP from SHA **2)** Staff survey	**1)** Approval of IBP final **2)** Organisational transformation program	**Director of Strategy** February 2010	3	5	15

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
CRR 894	Due to: **1.**Organisational transformation **2.** Lack of support from :- Local Community, PCT/SHA, DH/Monitor **3.** Worsening public sector economy	**2)** Robust project Plan and project management 3) Revised IBP submitted	other partners **3)** Convergence meeting with PCT/SHA **4)** Strong Foundation Office **5)** Feedback from SHA and PCT on IBP **6)** Feedback from PWC **7)** Board to Board with the SHA 8) letter of support from NHS Surrey	**4)** Organisational transformation ~~**5)** Revision of IBP (January 2010)~~	feedback on transformation	**3)** Board to Board with SHA **4)** Complete action plan from PWC review **5**) Project plan to deliver FT status	Department of Health 1st March 2010			
Previous ref 3c	**c)** Not securing the placement of the surrey renal service on the SPH site	**1)** Establishment of a project infrastructure **2)** High level collaborative working between 3 partners **3)** Expert project management support in place	**1)** ASPH now part of Surrey Renal Services with wide scale clinical support for application **2)** Business case discussed and will continue if approved by the Board **3)** ASPH short listed by the PCT (last 2) 4) letters of ~~praise~~ support from patients	**1)** The commercial model **2)** Agreement of final bid detail 3) As bid is commercial and process is still open the gaps will be discussed in more detail in the project report in Feb.2010	**1)** support from local community **2)** Final Board approval ~~December 2009~~ April 2010	**1)** To ensure robust bid is submitted 2) fully costed model of the service to be provided	**Director of strategy** PCT have delayed process. Review Feb ~~09~~ 10 Placement decision ~~Q4 2009/10~~ Q2 2010/2011	3	4	12
Previous ref 8a	**d)** Loss of confidence in and support from the local community	**1)** Delivery of clinical targets **2)** "Good news" communications in local press	**1)** Patient and staff survey **2)** S4BH **3)** Successful recruitment of 8,500 staff and public members. Recruitment will continue to be ongoing as we increase and develop our membership going forward.	**1)** Profile in local community **2)** Engagement of staff and public **3)** Lack of positive publicity	Establish ongoing working arrangements with LINKS	**1)** Develop communication and engagement strategy 2010-2013 update Currently in draft form, will shortly be going through the PPEG. **2)** Increase profile of organisation within the local community update Ongoing media programme, preparing Chairman's programme to continue the engagement work undertaken during the FT consultation campaign **4)** Robust stakeholder mapping for continued engagement update	**Chief Executive** Agreed by TEC in February 2010 ~~Final draft by 18th December~~, to be ratified by Board in ~~January~~ February 2010 Ongoing	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
						Initial stakeholder mapping completed, dynamic mapping document has been produced, will be ongoing work to keep updated and map our engagement programme	Ongoing			
IBP 2.2	**e)**NHS Surrey financial issues may impact on ASPH	**1)** Cross system working within the NW Surrey Locality. **2)** Iterative financial planning process via LTFM 3) Focussing on capping emergency admissions **3)** CIP's programme.	**1)** Monthly contract meetings with Surrey PCT. **2)** Surrey and SHA level CE and DoF meetings.	1) Further detail needed on non elective cap response		Action plan to be worked up and shared with Clinical directorates	**Director of Finance and Information and Chief Operating Officer** Feb 2010 TEC updated on activity/financial implications in Feb	5	4	20
IBP 2.3	**f**) Failure to provide services in the right locations	**1)** regular meetings with GP practices	**1)** IBP Delivery Group **2)** Provision of regular data on market share changes and movement from contracting team **3)** choose and book system feedback (eg TAL reports) **4)** national outpatient survey	**1)** As yet underdeveloped demand and capacity flow for out patients **2)** improvements in choose and book performance required	**1)** Slow feedback from national out patient survey **2)** Data provision to business centres relatively underdeveloped	**1)** Agree production of consistent data set to ~~business centres~~ Directorates **2)** Action Plan on choose and book and TAL performance improvement	**Chief Operating Officer** **1)** Regular market share data now available to directorates, and marketing group re-established with stronger clinical engagement.	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
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
CRR 815 816 Previous ref 1g	**a)** Vulnerable network resilience and inadequate infrastructure	**1)** Secure computer rooms (both sites) with appropriate environmental controls **2)** Documented backup procedures and controls in existence **3)** IT Systems Portfolio and IT Asset Inventory **4)** Agreed list of critical systems **5)** Rolling 4 year refresh program for desktop hardware **6)** Blade network servers in SPH Computer Room with attached SAN (Storage Area Network) **7)** 3 year IT Strategy/ IM&T Workplan 8) **)** Network Capacity Study completed Nov 09 providing 1st stage of DR plans for 10 systems 9) IT asset inventory/Systems register	**1)** South East Coast SHA External Audit review **2)** Internal Audit Review **3)** IG (Information Governance) Toolkit **4)** NIMM (network infrastructure maturity model) review	**1)** Absence of written Disaster Recovery Plans and Procedures **2)** Absence of fire suppression in ASH computer room **3)** Absence of order of priority for business critical systems **4)** Incomplete IT Asset inventory/Systems register **5)** Competing projects/insufficient resource to develop new technologies to maximise return on investment	**1)** NIMM reviews/audits not arranged 2) poor Internal Audit report	**1)** Implement Business Continuity plan **2)** Install appropriate fire suppression controls in the ASH computer room	**Director of Finance & Information** 1) March 2010 2)March 2010	2	4	8
S4BH C20, D21 Previous ref 2a	**b)** Lack of capital to investment in correct elements of the infrastructure	**1)** Capital Control Group **2)** Estates Strategy **3)** 3 year capital programme **4)** Service developments in Business Plan **5)** Robust business cases	**1)** Finance Committee **2)** Trust Board **3)** TEC	**1)** Approval of outline planning application for St Peter's site **2)** Developing and embedding the Estates strategy **3)** Changing national priorities **4)** Pressure on capital budget because of Renal submission	**1)** Authorized planning application for St Peter's site	**1)** Horizon scanning for changing national priorities **2)** Greater involvement of Trust Executive Committee in Capital Programme	**Director of Strategy** Quarterly 2009/10 -2010/11 outline planning application for St Peter's site submitted	3	4	12
S4BH C7d CRR 847	**c)** Failure to deliver full benefits of Cost Improvement	1) Early start to planning 2010/11 CIPs 2) Dedicated project office 3) Total CIPs of £12m to	**1)** Finance Committee. **2)** Business Centre	~~**1)** Lack of back up~~ ~~2) Support functions~~ ~~CIPs still to be agreed~~	~~Need to agree governance of corporate CIPs~~	~~1) Corporate CIP governance to be agreed at productivity workstream~~	**Director of Finance & Information / Chief Operating Officer**	3	4	12

Cross Reference	Principal Risk	Key Controls	Assurance	Gaps in control	Gaps in Assurance	Actions to address Gaps	Timescale / Milestone and Responsibility	Current Risk Score		
								L	S	RS
Previous ref 6b	Programmes (CIPS)	cover £9m target 4) Programme 2 includes CIPs; governance framework agreed 5) Corporate CIPs agreed	Directorate performance meetings 3) Productivity workstream steering group				~~Feb 2010~~			
S4BH C7d Previous ref 6j	**e)** The Trust may not obtain the benefits of Service Line Management rapidly enough, and may not obtain clinical buy-in.	**1)** Project management as one of 6 Programmes	Finance Committee Service Line Management Steering Group	1)Project plan and 2010/2011 deliverables still to be agreed 2)SLR accountant on a temporary contract		**1** 1)Agree action plan and deliverables 2) Permanent recruitment	**Director of Finance & Information** Feb 2010	3	4	12
IBP 2.1	**f)** 2010/2011 Operating Framework- zero tariff growth and non elective cap	1) Cross system working within the NW Surrey Locality 2)Iterative financial planning process via LTFM 3) focus on capping emergency admissions 4) CIP programme 5) impact of emergency cap now fully assessed. Requires reduction of 5 admissions per day 6) Internal performance management systems established to manage the cap in 10/11	TEC Finance Committee	~~1) further detail need on non elective cap response~~		~~Action plan to be worked up and shared with Clinical Directorates~~	**Director of Finance & Information and Chief Operating Officer** ~~**2)** Feb 2010~~	5	4	20
IBP 4.2	**g)** Non achievement of benefits of Lean efficient processes and a productive environment	**1)** Used of 'Simpler' – provider with a record of Lean delivery in Health Care setting **2)** Appointment of Trust staff to create Service Improvement Department and work programme underway ~~**3)** Service improvement steering group established~~ **4**) Engagement of staff in pilot projects and	**1)** 1st phase projects with defined objectives/targets/ key metrics – Achievement to be rewarded **2)** Data collection underway	**1)** Need to ensure full staff engagement **2)** Need Senior Management commitment to on going process **3)** trust information systems may not be able to source data for this process **4)** productive ward programme has not yet identified clear improvement - metrics	**1)** Need to see delivery on the initial pilot projects ~~**2)** Overview of productive ward work not included in Service Improvement Steering group~~	**1)** High profile publicity **2)** Open staff invitation to attend **3)** Management commitment to free time and fund development of Lean **4)** Clear objectives set for Simpler **5)** Incorporate assurance on productive ward programme into overall steering group **6)** Ensure regular and	**Medical Director/ Chief Operating Officer** First two pathways ~~successfully launched~~ nearly complete Strong internal programme of engagement and training on lean awareness. Next projects chosen ~~.~~ February 2010	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
		subsequent role out ~~**5)** Careful choice of 3 projects~~ **6)** Lean process of review and audit – embedding ongoing programme of service improvement 7) next phase of projects has been selected 8) increase bronze training for Lean				accurate reporting of delivery against improvement metrics to steering group **7)** Agree improvement metrics for productive ward 8) productive ward incorporated in EQUIP	Metrics for each project clearly defined and tracked routinely February 2010			

Audit Trail

Version 4	BAF Amended to reflect revised Corporate Objectives in the IBP November 2008
Version 5	Updated at IGAC December 2008
Version 6	Updated following IGAC meeting February 2009
Version 7	Individually reviewed by Executive Director Leads March 2009
Version 8	Reviewed by Executive Director Leads and updated following IGAC Meeting 8th April 2009
Version 9	Individually reviewed by Executive Director Leads May 2009
Version 10	Reviewed by Executive Director Leads and updated following IGAC Meeting 3rd June 2009
Version 11	Individually reviewed by Executive Director Leads July 2009
Version 12	Reviewed by Executive Director Leads as a group and re-aligned to the four Strategic objectives, discussed at IGAC
Version 13	Individually reviewed by Executive Director Leads September 2009 and discussed at IGAC Meeting 7th October
Version 14	Individually reviewed by Executive Director Leads October 2009
Version 15	Individually reviewed by Executive Director Leads November 2009
Version 16	Individually reviewed by Executive Director Leads January 2010
Version 17	Individually reviewed by Executive Director Leads February 2010

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

Trust Board
Board Assurance Framework - Summary
February 2010
Version 17

	Lead	Sept Risk score	Oct Risk Score	Nov Risk Score	Jan Risk Score	Feb Risk Score	March Risk score	April Risk score	May 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										
a. Failure to meet targets: A&E	COO	9	9	9	9	9				↔
b. Failure to meet targets: to reduce to a minimum rates of HAIs	CN/ MD/ DIPC	12	12	12	12	12				↔
c. Failure to deliver a consistently safe service which would jeopardise our registration with the CQC	CN	9	9	9	9	9				↔
d. Patient Survey results fail to consistently reach fiftieth centile of Trusts in England - Failure to listen and act on feedback from service users will undermine the image and reputation of the Trust	CB / COO	16	16	16	16	16				↔
e. Failure to meet single-sex accommodation as standard by March 2010	CN / DS	12	12	12	12	12				↔
f. failure to achieve full CQIN funding	MD	9	9	9	9	9				↔
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										
a. Failure to recruit and retain the right number of staff with the appropriate skills	DW&O D	12	12	9	**9**	**9**				↔
b. Poor levels of staff engagement as demonstrated by failure to improve Staff Survey Results	DW& OD	9	9	9	9	9				↔
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										
a. Trust loses market share due to; poor marketing & contracting, competitive health care market, & is not considered the "1st choice" provider for the local population (patient choice) and GPs (loss of commissioned services)	DS /COO	12	12	9	9	9				↔
b. Not being licensed-for FT status	DS	8	8	12	12	15				↑

	Lead	Sept Risk score	Oct Risk Score	Nov Risk Score	Jan Risk Score	Feb Risk Score	March Risk score	April Risk score	May Risk Score	In Month Risk Change
c. Not securing the placement of the surrey renal service on the SPH site	DS	12	12	12	12	12				↔
d. Loss of confidence in and support from the local community	CE	4	4	4	4	4				↔
e. NHS Surrey financial issues may impact on ASPH	DF&I	20	20	20	20	20				↔
f. Failure to provide services in the right locations	COO	9	9	9	9	9				↔
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.										
Risks to objective										
a. Vulnerable network resilience and inadequate infrastructure	DF&I	8	8	8	8	8				↔
b. Lack of capital to investment in correct elements of the infrastructure	DS	12	12	12	12	12				↔
c. Failure to deliver full benefits of Cost Improvement Programmes (CIPS)	DF&I / COO	12	12	12	12	12				↔
d. Quality of commercial analysis and decision making may not reach the more rigorous standards needed for Foundation Trust environment.	DF&I	12	12	12	Removed					**X**
e. The Trust may not obtain the benefits of Service Line Management rapidly enough, and may not obtain clinical buy-in.	DF&I	12	12	12	12	12				↔
f. 2010/11 Operating Framework has zero tariff growth and non elective cap	DF&I	20	20	20	20	20				↔
g. Non achievement of benefits of Lean efficient processes and a productive environment	MD / COO	9	9	9	9	9				↔

Legend

15 – 25	Extreme
8 – 12	High
4 – 6	Medium
1 - 3	Low

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

CE	Chief Executive
CN	Chief Nurse
COO	Chief Operating Officer
DS	Director of Strategy
DW&OD	Director of Workforce & Organisational Development
DF&I	Director of Finance & Information