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

**TRUST BOARD**
**29th March 2012**

| | |
|---|---|
| **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.<br><br>This iteration of the BAF was reviewed by IGAC on 21st March 2012. |
| **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 Annual Governance Statement. |
| **LEGAL ISSUES** | The Board Assurance process supports the Chief Executive in signing the Annual Governance Statement 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.<br>▪ The Board is consider and agree the proposed way forward in the major refresh of the BAF |
| **Submitted by:** | Jane Gear , Head of Corporate Affairs<br>For Andrew Liles, Chief Executive |
| **Date:** | 22nd March 2012 |
| **Decision:** | For Approval |

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

**TRUST BOARD**
**29th March 2012**
**Board Assurance Framework 2011/12 – 2015/16**
**March 2012 Version 12**

## 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 Annual Governance Statement, and has been cross referenced to the Corporate Risk Register.

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.

It has previously been agreed by IGAC and the Board that the time is now opportune for a further review of the BAF to ensure its remains Fit for Purpose.

## 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) meeting. This last place at IGAC on 21st March 2012.

## 4 Commentary on Risks

This section relates to the current BAF.

The risk rating on BAF risk 1.1 *If the Trust does not meet national priorities (and therefore Monitor's Compliance framework)* has been increased to reflect the challenges being experienced in meeting the A&E target.

BAF risk 3.3. *If the Trust did not succeed in reducing emergency admissions and redesigning the elective care pathways* has had its risk rating reduced to reflect that the emergency readmission rate is lower.

No new risks or deletions of risks are proposed.

## 5 Refreshing the BAF

5.1 On 8th December 2011 Board members participated in a seminar which was externally facilitated and resulted in a first draft of refreshed risks for the BAF:

This needs validating with the draft Business Plan for 2012/13 and then developing into a fuller draft BAF for Board agreement.

It has also been suggested that a revised format is appropriate and this will need to be agreed.

In terms of a way forward it was agreed at IGAC that further work is carried out with the management team, and that a small group including the chairs of IGAC and Audit meet to review it and consider a proposal on the structure of the BAF. The intention would be to have a draft populated BAF in a new format for the May Board.

## 6 Recommendation

- The Board comment on the current BAF; in particular any gaps in assurance and controls it would wish to see addressed.
- The Board AGREE the current BAF
- The Board agree the proposal for a sub group to develop the risk sand format for the refreshed BAF and for this to come to the May Board meeting

**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: March 2012

| | Lead | Sept Risk Score | Dec Risk Score | Feb 11 Risk Score | April 11 Risk Score | June 11 Risk Score | Sept 11 Risk Score | Jan 12 Risk Score | March 12 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 | 15 | 15 | 15 | 12 | 12 | 16 | ↑ |
| **2.** If the level of HCAI infection rose and monthly trajectory relating to the Quarter submission was not achieved | CN | 16 | 16 | 6 | 4 | 10 | 9 | 9 | 9 | ↔ |
| **3.** If there were pockets of poor quality services which were masked by top level performance | CN/MD | 10 | 10 | 10 | 10 | 10 | 15 | 15 | 15 | ↔ |
| **5.** If CQC registration requirements are not evidenced leading to qualification of Trust Registration and falling patient confidence | CN | 8 | 8 | 8 | 8 | 8 | 10 | 15 | 15 | ↑ |
| **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 | 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 | Sept Risk Score | Dec Risk Score | Feb 11 Risk Score | April 11 Risk Score | June 11 Risk Score | Sept 11 Risk Score | Dec 11 Risk Score | March 12 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 | 6 | 6 | 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 | 9 | 9 | ↔ |
| 9. If staff did not have up to date statutory and mandatory training competencies | DoW | | | | | 12 | 12 | 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 | 16 | 16 | 16 | 16 | 16 | 12 | ↓ |
| **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 | 8 | 8 | 8 | 8 | 8 | 8 | ↔ |

| | Lead | Sept Risk Score | Dec Risk Score | Feb 11 Risk Score | April 11 Risk Score | June 11 Risk Score | Sept 11 Risk Score | Dec 11 Risk Score | March 12 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 | 16 | 16 | 16 | 12 | 12 | 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 | 16 | 16 | 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 | 15 | 15 | 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 | 9 | 9 | 9 | 9 | 12 | 12 | 12 | 12 | ↔ |
| **10.** Financial pressures on other providers of health and | DCE | 12 | 12 | 16 | 16 | 16 | 16 | 16 | 16 | ↔ |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| social care cause operational difficulties at ASPH eg. increased DTOC, social services support | | | | | | | | 16 | | |
| **11.** If NHS Surrey's financial position causes negative impact on the Trust | DoF | 12 | 12 | 12 | 12 | 12 | 12 | 12 | | ↔ |

| | Lead | Sept Risk Score | Dec Risk Score | Feb 11 Risk Score | April 11 Risk Score | June 11 Risk Score | Sept 11 Risk Score | Dec 11 Risk Score | March 12 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 | 8 | 8 | 8 | 6 | 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 |

# BOARD ASSURANCE FRAMEWORK (BAF)

## 2010/2011 – 2015/16
## March 2012: version 12

**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<br>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.<br><br>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<br><br>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.<br><br>Clear ownership of each individual target/priority<br><br>Escalation process agreed<br><br>Daily performance reports<br><br>Daily A&E performance meetings<br><br>Additional Interim management support in place in A&E | Quarterly reporting to Monitor<br><br>Internal Trust monitoring systems with Board scorecard<br><br>Emergency care Intensive team have re visited and have agreed a programme of support | Governance rating now amber/red | | Unscheduled care is key project within PMO. Work streams, milestones and accountabilities have been confirmed<br><br>Action plan following revisit by Emergency care Intensive team to be implemented | **Deputy Chief Executive**<br><br>June 12 | 4 | 4 | 16 |
| IBP Risk 1.3<br><br>CRR 763<br><br>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<br><br>Framework on competency testing on aseptic techniques and IV site management in place<br><br>Training programmes including induction<br><br>Hand washing and audit of this | Mandatory reporting to the Health Protection Agency<br><br>Monitoring via Infection Control<br><br>Clinical/ward audits | On going embedding of best practice<br><br>Consistency of application of aseptic techniques and IV site mgt. | None known | Continued embedding , review and learning<br><br>Reinforcing of ICP messages especially around hand washing/Bare below the elbows/ zero tolerance | **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 |
| | | Rigorous RCA process for learning<br><br>Effective management of beds including occupancy levels<br><br>Designated team providing 24/7 phlebotomy service for blood cultures including night time arrangements.<br><br>C. Difficile Action plan Appropriate specimen taking for suspected C. Difficile and prompt isolation<br><br>Screening in place for all patients.<br><br>The competency framework is completed and is being adhered to | DoH visit 30/07/10<br><br>CQC spot checks on Hygiene Code compliance<br><br>Compliance with CQC Essential Standard 8 | | | | | | | |
| CBP 1.4<br><br>FT<br><br>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<br><br>Detailed quality metrics including scorecard and WQIs tracked over time. Divisional Quality dashboards presented to CGC<br><br>Senior clinical leadership and presence within clinical areas: Essential spot checks.<br><br>Best Care programme initiated<br><br>Patient comments/incidents and SUI review processes<br><br>Mortality Review Group | Trust Board reports built up from ward level detail.<br><br>Matrons' feedback to Directors<br><br>Patient complaints monitored via Complaints group.<br><br>CQC Compliance report dated Jan 12 | 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- to implement Datix web<br><br>Implement action plan in response to CQC Compliance report 2012<br><br>Implement local level judgment framework | **Chief Nurse**<br><br>June 12<br><br>December 2011<br><br>March 2012 onwards | 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 |
| | | Culture of openness, ultimately supported by Whistle blowing policy<br><br>Trust's internal monitoring of compliance with CQC standards triangulating against external evidence | Dr Foster data<br><br>LINk/OSC<br><br>CQC baseline assurance review of 16 essential Standards is complete | | | | April 2012 | | | |
| | | Maintaining agreed staffing levels with appropriate back-fill and monitoring compliance with processes<br>Ward sister development programme commenced in January 2011. Cohort 2 in planning.<br><br>Establishment review completed and implemented. Heads of Nursing in place with clear role and responsibilities for ensuring nursing is fit for purpose<br><br>Audit Commission review gave benchmark comparators | Audit Commission report on staffing levels | Complete establishment review with standardised methodology across Trust<br><br>Findings of CQC Compliance report | | Implement actions following the Audit Commission report. Nursing establishment review underway | Chief Nurse<br><br>April 2012 | | | |
| IBP Risk 1.4<br><br>CBP Priority 1.3<br><br>CRR 1037<br><br>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 | Currently strengthening ownership and accountability of tools in place. | None known | Continue with assessment process | **Chief Nurse** | 3 | 5 | 15 |
| | | Evidence is gathered on the Performance Accelerator allowing gap analysis with reporting to IGAC and Trust Board on the QRP framework | CQC Quality and Risk Profile<br><br>IGAC review ( June 2011) | | | | | | | |

| 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 Trust's compliance with Essential standards. Improved guidance issued. | CQC Compliance report dated Jan 12 | | | Implement action plan in response to CQC Compliance report 2012 | | | | |
| | | Programme of activity to embed ownership at service level<br><br>Review process incorporated into committee/group TOR. All standards are allocated to a Committee for overview | Results of patient surveys | | | | | | | |
| | | Early warning indicators and triangulation of data ward to Board<br>Improved reporting to IGAC on external inspections | Patient complaints/incidents/<br><br>KPIs | Findings of CQC Compliance review | | | | | | |
| | | Proactive review and response to external advice on best practice e.g. NPSA alerts | CQC Compliance report dated Jan 12 | | | | March 2012 onwards | | | |
| | | Integrated governance and risk management infrastructure and oversight | | | | | | | | |
| | | *Your Feedback* means assessment can become more outcome focussed | | | | | | | | |
| CBP Priority 1.1<br><br>IBP Risk 1.1<br><br>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<br><br>Patient Panel<br><br>LINKs<br><br>OSC<br>Complaints data January 2011 local inpatients survey | Continue to improve on results in national surveys.<br><br>Develop actions from January 2011 local survey | None known | Local and corporate action plans in response to patient survey results<br><br>Trial of implementation of Patient Diaries underway in Surgery and Medicine - Releasing Time to Care 100% completed – still ongoing<br><br>Trust has commissioned additional postal patient surveys including 2 | **Chief Nurse**<br><br>June 2012<br><br>March 2012 | 3 | 4 | 12 |
| | | Strong feedback mechanisms e.g.Net promoter Scores National and local surveys, | | | | | | | | |
| | | Programme of organisational change and cultural transformation- Living our Values | | | | | | | | |
| | | Launched Care Standards (nursing) | | | | | | | | |

| 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 |
| | | 'Your feedback' introduced in all adult inpatient wards and rolled out to Outpatients<br><br>Feedback strategy | | | | surveys annually for A&E patients.<br><br>Results of national OPD survey (Picker report) available- action plan to be implemented<br><br>Local inpatient survey completed – results due<br><br>Awaiting results of national inpatient survey- CQC benchmarked results<br><br>Patient experience newsletter being developed for distribution | May 2012<br><br>April 2012-03-15<br><br>May 2012<br><br>April 2012 | | | |
| 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.<br><br>Quality Account Publication<br><br>Monitoring of patient perception of choice and control to enable targeted intervention | Board<br><br>Complaints and Your feedback<br><br>National patient survey<br><br>Activity and Marketing data | Develop and enhance tools | Non known | Develop individualized consultant outcome data<br><br>External and internal benchmarking<br><br>Patient Experience programme being implemented (Choice and control/Best care ) | Chief Nurse<br><br>Ongoing | 2 | 4 | 8 |
| IBP risk 1.2<br><br>CBP Priority 1.1 | 8. If Environmental standards, including Single Sex Accommodation (SSA), do not meet | Self- assessment on SSA completed<br><br>SSA delivery plan in place | Self assessed declaration on national template<br><br>PEAT inspections | None known | None known | Not required<br><br>Further check re ITU to be completed | **Deputy Chief Executive**<br><br>April 12 | 1 | 3 | 3 |

| 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 767 | expectations/ standards | Breach monitoring system in place | Trust Board reports | | | Revised policy going to March TEC | March 12 | | | |
| | | Funded programme of capital works to complete outstanding wards.<br><br>Action Plan has been implemented | Funded Capital programme<br><br>Patient survey results<br><br>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<br><br>CBP Priority 2.1<br><br>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<br><br>Performance Review meetings<br><br>Recruitment meetings notes.<br><br>Workforce Strategy Steering Group | None known | Medical staff vacancies in Emergency services<br><br>Future supply of suitable midwifery candidates<br><br>Healthcare Assistant vacancies and turnover | Robust workforce plan for medical staffing in Emergency services:<br><br>▪ Conversion of agency doctors to Trust bank<br>▪ Continue Middle grade recruitment<br>▪ Consideration of workforce redesign and alternative roles<br><br>Monthly recruitment campaigns | **Director of Workforce and OD**<br><br>June-:onwards (Service Mgr A&E)<br><br>March 2012: (Spec. Lead A&E)<br><br>March 2012: (General Mgr A&E)<br><br>March 2012: (Head of Midwifery & Recruitment Manager) | 2 | 3 | 6 |
| | | Corporate Risk register reviewed at IGAC<br><br>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<br><br>Controls and systems put in 2010/11-have resolved vacancy hotspots in midwifery, ITU & paediatrics | | | | | | | |
| | | New roles and ways of working introduced as required | | | | | | | | |

| 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 |
| | | | | | | HCA workforce Plan in place, endorsed and monitored by senior Nurse leaders Committee | March 2012 | | | |
| IBP Risk 3.2<br><br>CBP Priority 2.1<br><br>CRR 768 | 2. If the Trust was unable to retain staff particularly in shortage specialties | Monthly corporate and divisional turnover reports. | Board TEC and EPF reports<br><br>Performance Review meetings | None known | Of the 8 below average scores from the 2010 National Staff Survey, 5 key findings have improved and 3 remain unchanged | Following a workshop of operational leads in August, the Corporate Action Plan which highlights areas for improvement is being updated. Has been published and is monitored by the WSSG<br><br>Results of the 2011 national Survey to be published with analysis, communication and actions thereafter | **Director of Workforce and OD**<br><br>Lead project manager is the Head of Organisational Development.<br><br>April 2012 | 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. | Staff Attitude Survey (CQC and internal)<br><br>Recruitment Audit | | | | | | | |
| CBP Priority 4.1 | 3. Inability to achieve planned workforce cost reductions | Annual Workforce Plan agreed and monitored monthly. | Board TEC and Finance Committee reports<br><br>Workforce Strategy Steering Group<br><br>Performance Review meetings | Tracking and deletion of established posts given up as CIPs | None Known | Corporate and Middle Admin Office (CMAO) review project established. Actions to be monitored by Strategic Delivery Board through CMAO Programme Board | **Director of Workforce and OD**<br><br>March 2013 | 3 | 3 | 9 |
| | | Business planning process and targets set for 2011/12 | Workforce Redesign Programme<br><br>CIP and Workforce Redesign Groups | | | | | | | |

| 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 |
| | | 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<br><br>Consultant Job Plans are overseen by Deputy CEO<br><br>Weekly corporate and divisional appraisal reports<br><br>Interim Medical director and Deputy Medical Director appointed and will lead on medical appraisal and revalidation<br><br>Centralised monitoring and recording of appraisal on ESR<br><br>Medical Appraisal Policy implemented in 2011<br><br>Medical Director has attended Responsible Officer training. | Board, TEC and EPF report<br><br>Performance review meetings<br><br>CRMS System<br><br>Participation in ORSA process – assessment of readiness for introduction of medical revalidation<br><br>Appraisal reports<br><br>Medical appraisals have increased to 84% with 37 doctors outstanding at end Jan 12 | Job plans that have been recently reviewed not in place for all consultants | Readiness for introduction of Revalidation in Autumn 2012 | Executive review of all divisional job plans<br><br>Complete final ORSA<br><br>Complete prioritised development plan and trajectory to show how we intend to achieve readiness by 31st March 2012 in order to commence recommendations for revalidation in December 2012 | **Medical Director**<br><br>March 2012<br><br>March 2012<br><br>March 2012<br><br>September 2012 | 3 | 2 | 6 |
| 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 | Board &TEC report<br><br>Performance Review meetings | None known | Improvement in Patient Survey scores | Living our Values' programme launched for all staff, based on real | **Director of Workforce and OD**<br>Implementation from April 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 | | |
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| | | | | | | | | L | S | RS |
| | | High levels of participation in leadership and team development programmes | Programme Board<br><br>Appraisal rates monitored weekly | | Attainment of 100% appraisal rate by 31/03/12 | patient stories<br><br>Leadership & Management Commitment Framework, with underpinning directory of training offerings to be monitored and evaluated following launch in Q1 | March 2012 (Director of Workforce & OD) | | | |
| | | Succession planning being developed and implemented.<br><br>Robust individual appraisal processes and systems | Patient outcomes and patient experience feedback | | | | | | | |
| | | 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 | | | | Divisions/directorates required to identify dates to hold outstanding appraisals | March 2012 (Director of Workforce & OD) | | | |
| CBP Priority 2.3 | 6. Increased turnover and sickness | Monthly corporate and divisions turnover and sickness reports | Board, TEC and EPF report<br><br>Performance Review Meetings<br><br>CQC and internal staff surveys<br>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<br><br>CQC and internal staff surveys<br><br>Staff Physiotherapy service | | | Calendar of Health and Well being events for 2011/12 in place | March 2012 (Director of Workforce & OD) | | | |

| Cross Reference | Principal Risk | Key Controls | Assurance | Gaps in control | Gaps in Assurance | Actions to address Gaps | Timescale / Milestone and Responsibility | Current Risk Score | | |
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| 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<br><br>Replacement of junior doctor roles with experienced doctors in A&E and MAU<br><br>Junior Doctor induction. Hand over protocols developed, used and enforced<br><br>Junior Doctor survey<br><br>Consultant Cover strengthened<br>• Labour Ward 60 hrs week<br>• Physicians 13 hours/7 days a week<br>• Paediatrics and Neonates full Consultant attendance<br>• T & O Consultant delivered Service<br>• Acute Surgery Consultant delivered Service<br>• A & E Middle and Senior Grade cover 24/7 | Deanery<br><br>Local Faculty Group Meetings (LFGs)<br><br>Mid & end year reviews for all Drs either in house or ARCP process.<br><br>Assessment of clinical skills during induction<br><br>Centre Reviews that assess quality assurance of supervision and training and education in practice.<br><br>Provision of local high quality clinical teaching<br><br>Induction includes competency-based training which ensures clinical skills are assessed | 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)<br><br>Divisional workforce meetings to review and plan24/7 service cover, particularly evenings and weekend out of hours senior presence<br><br>Review of medical workforce plans (across all grades) in each division | **Director of Workforce and OD**<br><br>March 2012<br><br>March 12<br><br>April 12 | 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 | | |
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| | | | | | | | | L | S | RS |
| | | 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.<br><br>Staff diversity champions.<br><br>Single Equality Scheme and action plan<br><br>Employment policies | Equality and Diversity Steering Group<br><br>Annual Equality & Diversity report to Trust Board. Quarterly reports to TEC.<br><br>Monitoring of SES through Equality & Diversity Group and Board<br><br>SHA review of SES<br><br>Patient and Staff Survey(CQC)<br><br>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<br><br>Lead Mandatory Trainers identified for each training strand<br><br>Mandatory Training Committee | Monthly reports to Mandatory Training Committee by Mandatory Leads<br><br>Staff's attendance recorded on electronic system | None Known | CQC Compliance action (December 2011) | Increased ability to access e-learning<br><br>Cascade through divisional representatives Monthly OLM reporting to divisions and directorates | **Director of Workforce & OD** | 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 | | |
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| | | | | | | | | L | S | RS |
| | | OLM system and ESR notifications to managers of mandatory training competencies due to expire<br><br>Inclusion of mandatory training compliance check within template appraisal documentation<br><br>Simplification of Mandatory Training matrix | (ESR/OLM)<br><br>Quarterly reports to WSSG (CQC outcome 14)<br><br>Divisional reports to Clinical Governance Committee<br><br>External Review of Trust's statutory and mandatory provision | | | Ongoing monthly OLM reporting to divisions and directorates | March 2012 | | | |
| **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<br><br>Clinical strategy group<br><br>Buy-in from Clinical directorates with Directorate specific marketing plans<br><br>Market share information is monitored at performance meetings with Divisions<br><br>Business development team has been aligned to operational divisional structure to ensure strong support | Clinical strategy Group<br><br>TEC<br><br>Marketing data | Due to operational pressures commitment to move all possible day Surgery to Ashford | None Known | (a)To redesign the rehabilitation / re-enablement pathways at Ashford Hospital with community services and social care. Redesign complete by July 2012. Implementation by December 2012.<br><br>b) Improving the care for the local community through one stop clinics<br><br>c) Improving the patient environment through redesign and refurbishment of the outpatient facilities (Works Stage 1&2 by March 2013)<br><br>d) Expanding the delivery of elective care which can be totally provided at Ashford Hospital | **Medical Director**<br><br>July 2012<br><br>Oct 2012<br><br>March 2013<br><br>October 2012 | 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 | | |
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| | | | | | | (urology, ophthalmology, general surgery, gynaecology) | | | | |
| CBP Priority 3.2<br><br>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<br><br>Marketing manager<br><br>Buy-in from Clinical Divisions<br><br>Programme of GP engagement<br><br>Growth achieved in some key areas including Cobham<br><br>Work with SECamb regarding patient flows | Clinical strategy group<br><br>TEC<br><br>Finance Committee | Sustain current levels of activity and grow Mid Surrey | None Known | (a) Develop the Trauma service at St Peter's Hospital for Mid Surrey patients<br><br>b) address the issues and developments identified in the recent Trauma Unit Assessment<br><br>c) Implement year 2 of the business plan for regional Bariatric services<br><br>d) Implement the Urology clinical strategy<br><br>e) Deliver the vascular strategy<br><br>f) Develop a Trustwide strategy for Colorectal surgery<br><br>g) Re-develop our Renal strategy with Epsom St Helier University Hospitals | **Medical Director**<br><br>Oct 12<br><br>May 2012-<br><br>March 2013<br><br>March 2013<br><br>Sept 12<br><br>Dec 2012<br><br>Dec 2012 | 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 | | |
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| CBP Priority 3.1<br><br>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-<br><br>Weekly and Daily tracking of admissions and discharges<br><br>Unscheduled care and discharge are included in the PMO and fully launched<br><br>Monthly action meeting with Director of Social Services<br><br>Weekly operational meeting with Divisional directors | NHS Surrey<br><br>Trust Activity reports<br><br>Strategic Delivery Board<br><br>Performance Review meetings<br><br>Weekly Executive Director/Divisional director performance meetings | NHS Surrey demand management systems need to be fully in place | None Known | Identified through PMO.<br><br>Weekly capacity meeting with key partners. These have focused on increasing the number of ambulance journeys to walk in centres. Nurse navigator implemented in A&E.<br>Direct access to OPD slots by A&E being introduced | **Deputy Chief Executive**<br><br>May 2012 | 3 | 4 | 12 |
| CBP Priority 3.3 &4<br><br>CRR 1112 | 4. If the Trust developed a poor reputation | Continuous focus on maintaining high standards of care<br><br>Positive media campaign-celebrating success<br><br>Communications and Engagement strategy linking with stakeholders<br><br>Enhanced system of media monitoring and analysis in place | Trust Board<br><br>Successful FT application<br><br>CQC Patients surveys<br><br>Internally run surveys and feedback<br><br>Feedback from major external stakeholders<br><br>Results of summer staff survey and excellent response rate to national winter survey | None known | CQC Report 2012 | NA<br><br>Branding initiative underway. involves feedback from members' groups<br><br>CQC action plan and communications strategy in place | **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 | | |
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| 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<br><br>Choose and Book Manager<br><br>DDs working with /visiting GPs<br><br>Pathway work on referral management schemes<br><br>Engagement through NW Surrey Board<br><br>Business development team aligned with divisions<br><br>Medical director commenced an programme of engagement with GPs<br><br>Participation in tenders to provide acute services in a community setting | Marketing Report<br><br>LMC<br><br>Feedback via LEC | | None known | Strengthen contacts with Clinical Commissioning Groups in NW Surrey and Hounslow | **Director of Finance and Information**<br><br>March 2012 onwards | 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<br><br>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<br><br>Clear bed complement plan<br><br>Weekly length of stay meetings in place<br><br>Escalation processes<br><br>Daily Information Reporting and intelligence System in place<br><br>Weekly Trust wide urgent care dashboard | Benchmarking<br><br>Programme Board<br><br>Patient complaints and incidents.<br><br>Staff feedback | See BAF 3.5 on reducing emergency admissions | None known | See BAF Risk 3.3 Unscheduled care<br><br>.<br><br>Refurbishment of escalation areas to improve the patients' experience- out to contract<br><br>Real Time Bed Management System to go fully live- this will enable real time bed management | **Deputy Chief Executive**<br><br>Regular review of capacity over winter period<br><br>March 2012 | 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 | | |
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| | | | | | | LoS is one of next projects in PMO to be embedded<br><br>Move to by ward/by consultant urgent care dashboard<br><br>Demand and Capacity plan to be implemented | June 12<br><br>2012/13 | | | |
| 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<br><br>New Nursing establishments have been implemented.<br><br>Heads of Nursing to undertake a monthly reconciliation of establishments/budgets/current healthroster | Benchmarking ACUH<br><br>Programme Board<br><br>Patient complaints and incidents.<br><br>Staff feedback | On going review process needed | None known | Acuity review now completed and forms part of establishment review aligned to bed modelling work | **Chief Nurse**<br><br>May 2012 | 2 | 4 | 8 |
| IBP Risk 2.4<br><br>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<br><br>Clear internal Performance Review Framework.<br><br>Good recent track record of managing budgets and delivering a surplus.<br><br>Future Models of Care work streams with locality commissioners.<br><br>Clear articulation of internal programme of work as unscheduled care via PMO | KPIs<br><br>Performance Review Meetings<br><br>Patient complaints and incidents.<br><br>Staff feedback | None known | None Known | Monthly process for clinical review of readmissions | **Director of Finance**<br><br>On going | 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 | | |
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| IBP Risk 4.1<br><br>CBP Priority 4.1<br><br>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<br><br>Programme Management Office (PMO) launched | External advisor<br><br>Finance committee review<br><br>Programme Board. Work stream 2 and sub group | None known | Current forecast £10.9m | Continue with programme management approach<br><br>2012/13 CIP put to Finance Committee and Trust Board | **Director of Finance**<br><br>March 12 | 2 | 5 | 15 |
| | | 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<br><br>Additional resource to strengthen CIP project office | | | | | | | | |
| CRR 847<br><br>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<br><br>Board<br><br>Strategic Delivery Board<br><br>Performance Review meetings | None known | None known | Major Productive schemes will identify patients experience objectives as well as productivity objectives | **Deputy Chief Executive**<br><br>ongoing | **2** | 4 | 8 |
| | | Trust's quality framework | Complaints Monitoring Group<br><br>Clinical Governance Committee<br><br>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 | | | | | | | | |

| Cross Reference | Principal Risk | Key Controls | Assurance | Gaps in control | Gaps in Assurance | Actions to address Gaps | Timescale / Milestone and Responsibility | Current Risk Score | | |
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| IBP Risk 4.3<br><br>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<br><br>Financial accountant to support development<br><br>Good Clinical engagement<br><br>SLR now supported by patient level costing<br><br>New Programme Lead in place | Delivery Programme<br><br>TEC | Continual validation of data<br><br>Continual clinical engagement<br><br>Further staff training | None known | QLIKVIEW implementation | **Director of Finance**<br><br>Ongoing monitoring through SLM workstream<br><br>April 2012 | 3 | 2 | 6 |
| CBP Priority 4.2 | 7. EQUIP programme is not fully embedded with widespread and rising engagement throughout the Trust year on year | EQUIP now formally part of PMO<br><br>Project team/resource in place<br><br>Active programme of rolling out training to Bronze level across organisation | Simpler<br><br>TEC<br><br>Programme Board<br><br>CIP Programme Board | None known | Increased Executive level scrutiny and support required | PMO and Equip projects will be completely aligned to business plan priorities<br><br>Implement revised structure for PMO/EQUIP team | **Deputy Chief Executive**<br><br>April 2012 onwards<br><br>June 2012 | 2 | 4 | 8 |
| 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.<br><br>Good recent track record of managing budgets and delivering a surplus. | Finance committee<br><br>Internal and External audit | Continuous review | None known | Continuous review through Finance Committee including review of<br>o Trading<br>o CIP | **Director of Finance and information** | 4 | 3 | 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 | | |
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| | | | | | | | | L | S | RS |
| | | 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 of our key stakeholders | Continue to review Trust strategy alongside new Policy.<br><br>Continued review shows strong degree of alignment between Trust strategy and The Bill | Trust Board | Bill now in House of Lords. Act expected c March 2012 | None known | Develop the future model of care strategy with NW Surrey<br>Maintain focus on joint work with GPs<br>Improve commercial expertise of the organisation<br><br>Bill now expected to receive Royal assent in May 2012 | **Chief Executive**<br><br>ongoing | 4 | 3 | 12 |
| | | Maintain a very strong focus and relationship with local GPs and other stakeholders | | Limited ability to Influence development of GP commissioning in our catchment | | | | | | |
| | | Health informatics strategy agreed<br><br>Business Plan 2011/12 agreed. 12/13 in preparation<br><br>Board seminar on acquisitions<br><br>Governors and Board seminar held Nov 11 | | | | | | | | |
| 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<br><br>Daily teleconference on delayed discharges.<br><br>Weekly capacity meetings | KPIs<br><br>OSC<br><br>LINk | None known | None known | Initial meeting between EDs and Assura has resulted in agreed list of early priorities | **Deputy Chief Executive**<br><br>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 | | |
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| | | | | | | | | L | S | RS |
| CBP Priority 3.1 | 11. If NHS Surrey's / LHE financial position causes negative impact on the Trust | Focus on NW Surrey Locality relationships<br><br>Signed Contract in place with monitoring arrangements<br><br>Activity profiled across year<br><br>Capped contract in place for 2011/12; signed | NHS Surrey<br><br>Contract Monitoring Group<br>Finance Committee<br><br>TEC<br><br>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<br><br>Contract negotiations for 2012/13 | **Director of Finance and Information**<br><br>End March 2012 | 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<br><br>All building upgrades comply with sustainability requirements where practical and funding allows.<br><br>Participation in Carbon Reduction Commitment Scheme (CRC) with formal reporting requirements which will allow benchmarking | PWC audit<br><br>Internal Audit review 2011<br><br>Benchmarking energy sustainability through CRC.<br><br>Display energy certificates (DECs) now available) | Sustainable Development Action Plan<br><br>Lack of designated lead at implementation level | Baseline of current position Drafted for March Board approval<br><br>Action Plan from Internal Audit | 1. establish baseline of current position- Consultants appointed and currently completing assessment of carbon baseline<br><br>Develop coherent plan to impact on ways of working that reduce carbon e.g. light use/PCs<br><br>Review opportunities for energy technologies to reduce carbon emissions e.g. CHP Report completed | **Deputy Chief Executive**<br><br>March 2012<br><br>March 2012 | 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 | | |
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| | | | | | | Sustainable action plan drafted for March Board approval<br><br>Implement action plan from Internal Audit Initial actions complete. Action plan spans a year<br><br>Head of Estates & Infrastructure appointed. To be in post May 2012<br><br>. | March 2012<br><br>June 2012<br><br>May 2012 | | | |
| | 2 Insufficient capital available to support improvements to the environment, equipment replacement or support IT Strategy | Capital programme agreed annually<br><br>Monthly Capital Review Group<br><br>Regular report to Finance committee | Capital Control Group<br><br>Finance Committee | None known | Develop Strategy with prioritised outline capital plans from divisions | None known | **Deputy Chief Executive** | 2 | 3 | 6 |

**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 |