TRUST BOARD IN PUBLIC	Date: 27th June 2013 Agenda Item:
REPORT TITLE:	Board Assurance Framework
EXECUTIVE SPONSOR:	Gillian Francis-Musanu Director of Corporate Affairs
REPORT AUTHOR:	Colin Pink Acting Head of Integrated Governance and Quality
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	

Purpose of the Report and Action Required:		**(√)**
The Board Assurance Framework (BAF) describes the principal risks that relate to the organisation's strategic objectives and priorities. It is intended to provide assurances to the Board in relation to the management of risks that threaten the ability of the organisation to achieve these objectives.	**Approval**	√
	Discussion	√
	Information/Assurance	√

Summary: (Key Issues)

The BAF highlights potential risks to the trusts strategic objectives and mitigating actions.

The Board is asked to note the current updated report and consider the following:

- Does the board agree with the existing controls and assurances
- Are the mitigating actions acceptable for the target risk score.

Relationship to Trust Corporate Objectives & Assurance Framework:

This report is the main document that reviews the Trust Corporate Objectives and is the Assurance Framework.

Corporate Impact Assessment:

Legal and regulatory implications	The report is a requirement for all NHS organisations.
Financial implications	As discussed in sections 4.1a – 4.1b (Income generation linked to activity referred to throughout the document)
Patient Experience/Engagement	Patient experience and engagement is one of the Trusts strategic objectives. .
Risk & Performance Management	These are highlighted throughout the report.
NHS Constitution/Equality & Diversity/Communication	Discussed throughout the report but with the greatest detail in objective 2.

Attachments:

Board Assurance Framework spreadsheet.

TRUST BOARD REPORT – 27th June 2013
BOARD ASSURANCE FRAMEWORK

1. Introduction

The Board Assurance Framework (BAF) describes the principal risks that relate to the organisation's strategic objectives and priorities. It is intended to provide assurances to the Board in relation to the management of risks that threaten the ability of the organisation to achieve these objectives.

The Trust has identified four main objectives:

1) Deliver safe, high quality, coordinated care
2) Ensure patients are cared for and cared about
3) Work in partnership with our community
4) Become a sustainable, effective organisation

These objectives are broken down into specific areas and the BAF details the key risks that the Trust faces to the delivery of these priorities, the controls that are in place, the sources and effects of assurance and mitigating actions to reduce the likelihood of the impact of the risk materialising. (Some priorities have more than one associated risk)

2. Current status

The BAF (attached) details a total of 24 significant risks to the four Trust objectives

Objective	Red (15-25)	Amber (8-12)	Green (1-6)
1. Deliver safe, high quality, coordinated care	1	13	0
2. Ensure patients are cared for and cared about	0	4	0
3. Work in partnership with our community	0	5	2
4. Become a sustainable, effective organisation	5	4	0
Total	**6**	**26**	**2**

2.1 Headline information by objective

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care	Initial Risk Rating: Severity x Likelihood	Current Risk Rating: Severity x Likelihood	Target Risk Score
1.1 Failure to maintain regulator expectations	S4 x L2 = 8	S4 x L2 = 8	S3 x L2 = 6
1.1a Failure to maintain improvement in mortality.	S4 x L2 = 8	S4 x L2 = 8. 8	S5 x L1 = 5
1.1b Failure to maintain improvements in patient safety	S4 x L3 = 12	S4 x L2 = 8	S3 x L2 = 6
1.1c Failure to maintain Emergency Department performance.	S5 x L3 = 20	S5 x L4 = 20	S3 x L4 = 8
1.1d Failure to maintain and improve Stroke outcomes	S3 x L4 = 12	S3 x L4 = 12	S3 x L3 =9
1.1e Failure to maintain and improve cancer performance	S4 x L2 = 8	S4 x L2 = 8	S3 x L2 = 6
1.1f Failure to maintain and improve 18 Week performance	S4 x L3 = 12	S4 x L3 = 12	S4 X L2 = 8
1.1g Failure to meet expected targets in Maternity Care	S4 X L2 = 8	S4 X L2 = 8	S4 x L1 = 4
1.1h Failure to maintain and improve fractured neck of femur.	S3 x L4 =12	S3 x L4 =12	S3 x L3 = 9
1.1i Failure to maintain and improve to readmission	S3 x L3 = 9	S3 x L3 = 9	S3 x L2 = 6
1.1j Failure to maintain systems to control rates of HCAI	S5 x L3 = 15	S5 x L2 = 10	S5 x L2 = 10
1.2 Achieve best practice in the use of quality & patient safety indicators. Adopt the National Quality Scorecard.	S4 X L2 = 8	S4 X L2 = 8	S4 x L1 = 4
1.3a Maintain and improve ability to allocate the right bed first time in terms of respect and dignity.	S4 x L2 = 8	S4 x L2 = 8	S3 x L2 = 6
1.4 Develop Clinical Partnerships which improve local clinical networks	S4 x L3 = 12	S4 x L3 = 12	S2 x L3 = 6

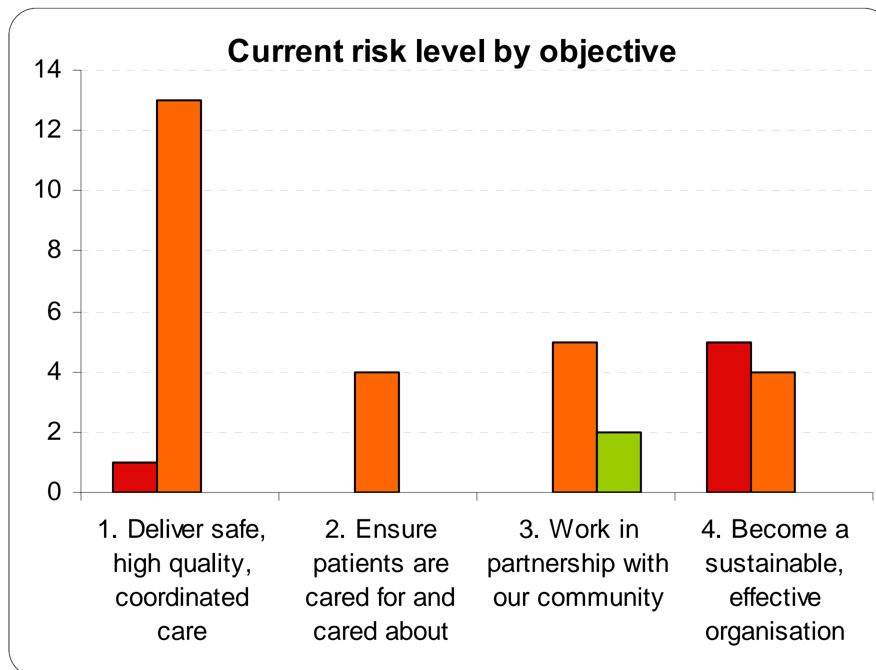
Objective 2 - Ensure Patients are cared for and cared about	Initial Risk Rating: Severity x Likelihood	Current Risk Rating: Severity x Likelihood	Target Risk Score
2.1 a Full implementation of "Your Care Matters" and use patient family to improve patient experience. "Friends and Family".	S4 x L2 = 8	S4 x L2 = 8	S4 x L1 = 4
2.1b Failure to maintain effective complaints management across the Trust.	S3 x L3 = 9	S3 x L3 = 9	S3 x L2 = 6
2,2a Ensuring that staff at all levels have the necessary knowledge, skills and attitudes related to caring for those at the end of their life to provide optimal care.	S4 x L3 = 12	S4 x L3 = 12	S4 x L1 = 4
2.2b Linked to Linked to Provide personalised care planning to assess, the needs and wishes of the individual included in a care those at the end of their life to provide optimal care	S4 x L2 = 8	S4 x L2 = 8	S2 x L3 = 6

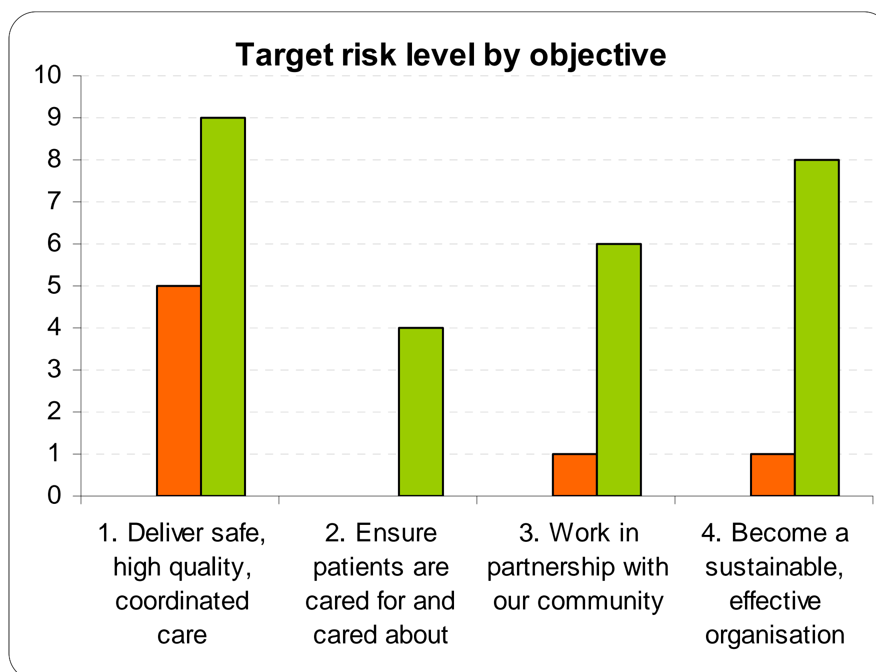
Objective 3 - Work in partnership with our community	Initial Risk Rating: Severity x Likelihood	Current Risk Rating: Severity x Likelihood	Target Risk Score
3.1a Develop and implement a Patient and Public Engagement (PPE) Plan	S4 x L3 = 12	S4 x L3 = 12	S2 x L3 = 6
3.1b Develop opportunities for Foundation Trust membership recruitment and engagement through Membership Strategy. Recruit FT members in line with plan	S4 x L2 = 8	S4 x L2 = 8	S4 x L1 = 4
3.1c Work with health and social care system to reduce emergency admissions.	S5 x L2 = 10	S5 x L2 = 10	S5 x L2 = 10
3.1d Onsite development with healthcare partners focussing on Chemotherapy services	S3 x L2 = 6	S3 x L2 = 6	S3 x L1 = 3
3.2a Use of patient feedback to improve the patient experience in services and across the Trust	S3 x L4 = 12	S3 x L4 = 12	S3 x L2 = 6
3.2b Development and implementation of communications & PR strategy	S4 x L2 = 8	S4 x L2 = 8	S3 x L2 = 6
3.2b Active partnership engagement	S4 x L2 = 8	S3 x L2 = 6	S3 x L2 = 6

Objective 4 - Become a Sustainable, Effective Organisation	Initial Risk Rating: Severity x Likelihood	Current Risk Rating: Severity x Likelihood	Target Risk Score
4.1a Failure to deliver income plan	S5 x L3 = 15	S5 x L3 = 15	S4 x L2 = 8
4.1b Failure to stop divisional overspending against budget	S5 x L3 = 15	S5 x L3 = 15	S3 x L2 = 6
4.1c Unable to provide realistic medium term financial plan	S5 x L3 = 15	S5 x L3 = 15	S4 x L2 = 8
4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	S5 x L5 = 25	S5 x L3 = 15	S4 x L3 = 12
4.2a Ineffective staff development means that the Trust does not have the skilled workforce to deliver current and future services	S4 x L3 = 12	S4 x L3 = 12	S4 x L2 = 8
4.2b Ineffective staff engagement and buy-in of staff to the Trusts objectives and direction delays or derails service and workforce redesign and ability to make financial savings	S4 x L3 = 12	S4 x L2 = 8	S4 x L2 = 8
4.2c Lack of leadership capacity and capability to engage with and develop staff delays or derails workforce redesign and ability to make financial savings	S3 x L3 = 9	S2 x L4 = 8	S2 x L4 = 8
4.3a Implement our plans to become a Foundation Trust by 2014	S4 x L2 = 8	S4 x L2 = 8	S4 x L2 = 8
4.3a Ensure the estate and infrastructure supports sustainability	S5 x L3 = 15	S5 x L3 = 15	S5 x L2 = 10

The objective of the BAF is to ensure that all risks are mitigated to an appropriate or acceptable level. It is expected that not all risks will be able to have mitigating controls that reduce the risk to green (low impact, low likelihood).

The tables below highlight the predicted swing in risk rating.





3. Key risks Identified

The BAF highlights the following 6 key risks to the Trust objectives that have been identified at time of updating the framework. These are:

i) 1.1c Failure to maintain Emergency Department performance.

ii) 4.1a Failure to deliver income plan
iii) 4.1b Failure to stop divisional overspending against budget
iv) 4.1c Unable to provide realistic medium term financial plan

v) 4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position
vi) 4.3a Ensure the estate and infrastructure supports sustainability

4. Recommendation

The Board is asked to note the BAF as presented and consider the following discussion point.

- Are these risks descriptions appropriate and does the Board agree with the assurances for each risk as presented?

The BAF will be updated continue to be updated throughout the year. The next iteration will link to all relevant audits.

Colin Pink
Acting Head of Integrated Governance and Quality
June 2013

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2013/14

Prepared for July 2013 Board meeting

Priority ID	Key Action for 2013/14 objectives and description of any potential significant risk to this priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
Objective 1 - Deliver Safe, High Quality, Co-ordinated Care																
1.1. Achievement of national best practice in clinical care.	1.1 Failure to maintain regulator expectations	Chief Nurse	S4 x L2 = 8	1)Safety priorities approved, KPI's in place and reported to Safety and Quality Committee 2)Patient Experience Group in place 3)Mock CQC inspection programme 4)RTM and other patient experience information with local action planning 5)Divisional action plans in place addressing patient experience feedback (see link with Risk 844, 1167,1356,1366,1328)	1) Staff understanding of their responsibilities under the Care Quality Commission regulatory framework remains poor	1)CQC and external stakeholder inspection reports 2)Patient Experience feedback all sources 3)Organisational Patient Safety Incident Reports from the National Patient Safety Agency benchmarking the reporting rates and types of incidents 4)Quarterly internal incident reports 5)Internal Audit reports 6)Audits of nursing assessment and care plan tool 7)Patient experience reporting to Trust Board and Safety and Quality Committee. 8) Nursing audit framework includes Essence of Care Benchmarks 9)Division action planning following mock CQC inspections, surveys and clinical Friday working.	Positive (+) CQC formal feedback following two day inspection Feb 13, Compliant with outcomes 8 of the 16 outcomes reviewed (+) Registration status with CQC shows no concerns Negative (-) CQC Risk profile shows areas of concern (based on public information, anticipated that this will improve)		1)Process of review for Provider Compliance Assessments 2)Triangulated reporting Complaints, Risks and Audits	S4 x L2 = 8	1)Review nursing documentation 2)Review provider compliance assessments 3)Review compliance monitoring system 4)Synbiotix monitoring system to be rolled out which provides real time access to clinical quality indicators 5)Develop and monitor QGAF	1)Nursing documentation reviewed updated and in place 2)Nursing documentation group functioning 3)PCA review commenced (9 of 16 in date) 4)Policy for monitoring CQC compliance in draft, procedure agreed in principal 6)Initial implementation planned for April 2013	SB 12/06/13	29/08/2013	S3 x L2 = 6	Discussed at Mar Board
	1.1a Failure to maintain improvement in mortality.	Medical Director	S4 x L2 = 8	1)Regular review of Dr Foster alerts 2)Regular review mortality rates and COPD in clinical services 3)Standardised mortality review process 4)Mortality group established (see link with Risk 1192, 1055)	1) Limited numbers of pathways linking Trust to external services	1) HSMR 2) KPI internal pathways (eg stroke) 3) Discussions and actions taken at mortality review meetings 4)Full review of #NOF cases presented and monitored by MBQR	Positive (+) HSMR below 100 and better than predicted (+) Falling standardised mortality (+) Within expected mortality rate for stroke care Negative (-) Alert for Fractured Neck of Femur. (-) Access to specialist beds (-) Performance for 4 hour target to get all #NOF cases t		First report from Mortality group to SQC yet to be presented	S4 x L2 = 8	1)Healthcare of the elderly strategy 2)Considering attaching orthogeriatrics to Surgery ward rounds 3)Increasing Jnr Dr Support 4)Implement system of alerting orthopaedic wards when at arrival at ED 5)Strengthening respiratory Team Consultant post 6)Agreeing COPD pathways and reviewing enhancing quality programs	1)Review and report on effectiveness for SQC 2)Healthcare of the Elderly Strategy underway 3) Ring fencing Stroke beds. 4) Pilot site whole system project by Academic Health Service Network	DH 14/06/13	29/08/2013	S5 x L1 = 5	Discussed at Mar Board
	1.1b Failure to maintain improvements in patient safety	Chief Nurse	S4 x L3 = 12	1)Groups to implement Patient safety plans in the Trust 2)Synbiotx/Safety themes 3)Groups established including SQC and N & M and Divisional Governance. 4) Policies and procedures dictate management .	1) Data quality	1) Synbiotix 2) KPI 3) QGAF 4) External reports and visits	Positive (+) Never events incidence low (+) HCAI (+) Pressure Ulcers (+) Falls strategy Fall Teams (+) Must 100% June 2013 Negative (-) (-) Falls SI Cluster		Data Quality	S4 x L2 = 8	1)Pressure damage board 2)Patient safety Post 3)Draft Maternity Strategy 4)Full implementation of Synbiotic	1) Expected in place end of June 2) Fixed Term cover appointed awaiting notice period 3) September 4) Due end of July	SB 12/06/13	29/08/2013	S3 x L2 = 6	To be discussed at June Board
	1.1c Failure to maintain Emergency Department performance.	Chief Operating Officer	S5 x L4 = 20	1) EDD Patient Pathway 2) Discharge management 3) Extra Beds	To be identified	1) NHS England aware 2) Commissioner Action.	Positive (+) Process improvement Negative (-) EDD Section 2 and section Patient tracking system (-) Bed modelling - 70 beds (-) 100 beds safe to discharge		To be identified	S5 x L4 = 20	1) Site management team 2) Reinstatement of Discharge Team 3) Resource Extra Beds.	Target date September 2013	JT 13/06/13	29/08/2013	S3 x L4 = 8	To be discussed at June Board
	1.1d Failure to maintain and improve Stroke outcomes	Chief Operating Officer	S3 x L4 = 12	1) Stroke Service 2) Dedicated Ward 3) Ring fence bed every night 4) Medical Patients of Ward	Operational controls pathway performance not as desired	1) Performance monitoring - Weekly Exec.	Positive (+) Performance on KPI and outcomes Negative (-) Performance of KPI as detailed on performance report		To be identified	S3 x L4 = 12	1) Developing Benchmarking 2) Ring fencing medical patients of Ward.	Target date September 2013	JT 13/06/13	29/08/2013	S3 x L3 =9	To be discussed at June Board
	1.1e Failure to maintain and improve cancer performance	Chief Operating Officer	S4 x L2 = 8	1) Cancer Tracking Team 2) 6 targets - well organised developed systems 3) Dedicated Monitoring	To be identified	1)Performance good and good monitoring 2) Target focused.	Positive (+) Performance and monitoring Negative (-) 60 day target		To be identified	S4 x L2 = 8	1) Virtual cover, division of leadership 2) Report Trialling Chemotherapy and Radio Therapy.	Target date October 2013	JT 13/06/13	29/08/2013	S3 x L2 = 6	To be discussed at June Board
	1.1f Failure to maintain and improve 18 Week performance	Chief Operating Officer	S4 x L3 = 12	1) Patient Tracking List 2) Demand and Capacity Modelling	To be identified	1) Performance Monitoring 2) 80% day case rates, 3) Commissioner National Reports.	Positive (+) 18 Performance (+) Patient Tracking List, Negative (-) Capacity issues (-) fluctuating demand (-) fluctuating Trauma and Elective Lists		To be identified	S4 x L3 = 12	1) Surgery - increase activity target.	Target date December 2013	JT 13/06/13	29/08/2013	S4 X L2 = 8	To be discussed at June Board
	1.1g Failure to meet expected targets in Maternity Care	Chief Nurse	S4 X L2 = 8	1) Hands on help 2) Audit policies 3) Birth Centre 4) Triage 5) 98hr Consultant presence.	Full establishment being recruited.	1) Local Audit 2) LSA Audit	Positive (+) Book before 12/40 (+) CNST Level 2 workstream (+) Birth Centre (+) Triage Negative (-) 1:1 Care in Labour not at desirde performance (-) Breast feeding Initiation		To be identified	S4 X L2 = 8	1) Recruitment of key staff 2) LSA Audit 3) CNST Working Party 4) Birth Centre open	Target date October 2013	SB 12/06/13	29/08/2013	S4 x L1 = 4	To be discussed at June Board
	1.1h Failure to maintain and improve fractured neck of femur.	Medical Director	S3 x L4 =12	1) 36 and 48 hour Orthopaedic Team 2) Rapid Theatre treatment 3) Anaesthetic Review, Ring fence Trauma beds.	To be identified	1)Outcomes of those patients who sustain a fractured neck of femur 2)KPIs	Positive (+) Mortality Reduction (appx 90) Negative (-) Admission to Newdigate		To be identified	S3 x L4 =12	1) Trauma Surgeon 2) Theatre capacity improving.	Target date December 2013	DH 14/06/13	29/08/2013	S3 x L3 = 9	To be discussed at June Board
	1.1i Failure to maintain and improve to readmission	Medical Director	S3 x L3 = 9	1) Discharge processes in place 2) Work last year with CCG to look at readmissions	To be identified	1) KPIs 2) Dr Foster alerts	Positive (+) Readmission data work (+) Internal audit of readmission figures provides positive assurance Negative (-) Readmission data quality (-) Colon Cancer Audits		To be identified	S3 x L3 = 9	1) Data quality coding 2) OPAL Service linked to GP	Data quality coding. OPAL Service linked to GP.	DH 14/06/13	29/08/2013	S3 x L2 = 6	To be discussed at June Board
	1.1j Failure to maintain systems to control rates of HCAI	Medical Director	S5 x L3 = 15	1)IPCAS Group Team and group in place 2)Weekly taskforce in place 3)Infection control manual in place and information resources available 4)Antibiotic policy and guidelines in place 5) Infection control quality round implemented 6)Education for Jnr Doctors on induction 7)New cleaning products in use (Tristel, effective against C. diff spores) 8)Develop pocket size antimicrobial guide	1)Antimicrobial prescribing compliance is low in areas 2)Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset 3)Variation in line care demonstrated by audit	1)KPI indicators 2)Reducing numbers of cases of C. diff year on year 3)No confirmed outbreaks of C. diff commenced during 2011/12 4)Recent PCT and SHA visits focusing on infection control 5)Recent CQC visit focusing on Nursing documentation and escalation	Positive (+)C. diff rate continues to drop year on year and on target (+)CQC visit Feb 2013 found no immediate concerns (+)Antimicrobial prescribing audit compliance (+)Actions taken as part of annual program (+) Recent CQC inspection highlighted improvements in MRSA screening (+)PCT visit inspecting controls and procedures Negative		Extensive auditing and monitoring in place. Trust position known	S5 x L2 = 10	1)Launch diarrhoea risk assessment tool. 2)Consultants to lead on OSCE-based competency training for doctors on hand washing and insertion of invasive devices. 3) Further actions detailed in IPCAS annual plan 4)Update urinary catheter care policy carried out to be re-launched	1)Guides developed to be printed 3)Extensive scrutiny of annual plan of work monitored by IPCAS Group 4)Urinary catheter care plan re-launched	DH 14/06/13	29/08/2013	S5 x L2 = 10	Discussed at Mar Board
1.2 Achieve best practice in the use of quality & patient safety indicators	1.2 Achieve best practice in the use of quality & patient safety indicators. Adopt the National Quality Scorecard.	Chief Nurse	S4 X L2 = 8	1)KPIs mirror draft scorecard 2)Multiple streams of information including Synbiotix	Awaiting final National quality Scorecard	1) KPI and Board reports	Positive (+)Divisional scorecard (+)Performance reports		To be identified	S4 X L2 = 8	1)Await realise of final quality scorecard	TBA once scorecard realised	CP 12/06/13	29/08/2013	S4 x L1 = 4	To be discussed at June Board
1.3. Ensure patients are cared for in the right place at the right time	1.3a Maintain and improve ability to allocate the right bed first time in terms of respect and dignity.	Chief Nurse	S4 x L2 = 8	1) Operational meeting three times a day chaired by Chief / Deputy Chief Operating Officer with clinical involvement from Matrons, Nurse Specialists and therapists 2) Daily Board rounds by clinical site team 3) Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed	1)Levels of temporary staff (agency) in key areas such as ED, AMU 2)Additional workload for medical teams having to cover significant numbers of patients outside their bed base 3)The external influences outside of SASH control e.g.) demand management and delayed discharges in care	1)Patient Experience feedback all sources 2)Patient experience and complaints 3)Mixed sex breach data	Positive (+) Improved In-patient Survey results (Time to wait to be allocated a bed, privacy, treated with respect and dignity all improved) (+) Numbers of formal complaints are now significantly reduced (Patient Experience Group Report) (+) Empathica "Your Care Matters" provides qualitative assurance (+) Improved patient opnion data Negative (-) Patient Choices data		SQC comparison of PT journeys indicated further development of process of right bed first time	S4 x L2 = 8	1)Ambulatory care pathways 2)Linked to 1.1b 3)Additional screens arriving to reduce chance of mixed sex accommodation breaches during winter pressures	See 1.1b	SB 12/06/13	29/08/2013	S3 x L2 = 6	Discussed at Mar Board
1.4 Work well within clinical networks and develop clinical partnerships.	1.4 Develop Clinical Partnerships which improve local clinical networks	Medical Director	S4 x L3 = 12	1)Internal controls and systems in place 2)Trust MD member of Clinical Senate	1)Systems supporting new Networks	1)KPIs 2)Information from the Academic Health Science Network	Positive (+)Networks supported by area team with relevant previous experience (+) CCG are have requested the new Networks support to describe quality		Developing Local Clinical Networks	S4 x L3 = 12	1)Working with all partners to develop fit for purpose services 2)Cancer strategy and JD for lead consultant	1)31/03/2014 2)01/10/2013	DH 14/06/13	29/08/2013	S2 x L3 = 6	To be discussed at June Board
Objective 2 - Ensure Patients are cared for and cared about																

Priority ID	Key Action for 2013/14 objectives and description of any potential significant risk to this priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
2.1. Be recommended on the basis of "customer care"	2.1 a Full implementation of "Your Care Matters" and use patient family to improve patient experience. "Friends and Family".	Director of Information and Facilities	S4 x L2 = 8	1)Implemented in ED and ward areas.	To be identified	External Audit TDA - Confidence, Board Performance Information - Friends and Family	Positive (+)Plans developed to continue implementation		To be identified	S4 x L2 = 8	1)Implemnet in Maternity 2)Develop SQC Reports	1)01/11/13 2)01/11/13	IM 13/06/13	29/08/2013	S4 x L1 = 4	To be discussed at June Board
	2.1b Failure to maintain effective complaints management across the Trust.	Chief Nurse	S3 x L3 = 9	1)Trust wide monitoring system 2)Divisional responsibility for actioning complaints investigation	1)Delays in administration of complaints, including signature and final editing 2)Central function yet to embed following change in workforce	1) Quarterly complaints reports 2) Compliance with completion on time and numbers of case reopened	Positive (+) Number of new complaints significantly lower than last year (+) Low numbers of cases referred to the Ombudsman Negative (-) Numbers of cases reopened (-) Performance in closing complaints (-) Supporting corporate function establishment		1)Performance data that details where a compliant is being held up in the system 2)Issues highlighted in Internal Audit regarding corporate reporting and analysis	S3 x L3 = 9	1)Reviewing supporting corporate function 2)Review working arrangements between Corporate body and Divisions to stream line the process 3)Review complaints policy to ensure it is fit for purpose and is aligned with new structures	1)Corporate function review commenced, joint working with PALs in place, corporate team restructure underway 2)Initial meetings held and regular focussed communication planned 3)Review of policy	CP 12/06/13	29/08/2013	S3 x L2 = 6	Discussed at Mar Board
2.2. Always treat all patients and their families/carers with compassion, courtesy and privacy and dignity	2,2a Ensuring that staff at all levels have the necessary knowledge, skills and attitudes related to caring for those at the end of their life to provide optimal care.	Chief Nurse	S4 x L3 = 12	1)EOL care teams and systems in place 2)Policies in place	To be identified	1)KPI 2)Audit 3)Complaints and Incidents	Positive (+) Steering Group (+) Audit Negative (-) Audit highlight failures (-) Discharge issues (-) EOL Steering Group (-) working 1/1 Hospice/McMillan (-) training and release of staff to support wards		To be identified	S4 x L3 = 12	1)Review all patient feedback systems for trends	1)Due 01/09/13	SB 12/06/13	29/08/2013	S4 x L1 = 4	To be discussed at June Board
	2.2b Linked to Provide personalised care planning to assess, the needs and wishes of the individual included in a care those at the end of their life to provide optimal care	Chief Nurse and Medical Director	S4 x L2 = 8	1)Patient Experience Group in place 2)Leadership programmes in place at senior management level 3)Mock CQC inspection programme 4)RTM available at point of care 5)Divisional action plans in place addressing patient experience feedback 6)Nursing Clinical Effectiveness weekly audits commenced 7)Additional screens ordered to reduce likelihood of mixed sex accommodation breaches during winter pressures	1)The external influences outside of SASH control e.g. demand management and delayed discharges in care 2)Additional workload for medical teams having to cover significant numbers of patients outside their bed base	1)RTM data available and monitored by SQC and patient experience group 2)CEQUIN data 3)All sources of patient feedback, internal and external	Positive (+) CQC verbal feedback following two day inspection Feb 13, Compliant with outcomes 8 of the 16 outcomes reviewed (+) "Your Care Matters" feedback (+) CEQUIN patient experience (+) CQC feedback for complaints system (+) NHS Choices positive feedback (+) Improved inpatient survey results demonstrating improvments in treating patients with dignity (+) Improving numbers of patient complaints Negative		1) Pro actively encourage patients to use NHS choices PALs and complaints systems to improve information resources	S4 x L2 = 8	1) Customer care training 2) Trust overall compliance monitoring of the appraisals system 3) Roll out of Sit and See programme	1)Customer Care Training commenced 2)HR and Divisions monitoring appraisals 3)Early stages of "Sit and See" programme implemented	CP12/06/13	29/08/2013	S2 x L3 = 6	Discussed at Nov Board - will be discussed at Mar Board
Objective 3 - Work in partnership with our community																
3.1. Work with patients, the public and partners to develop services that meet the needs of our community	3.1a Develop and implement a Patient and Public Engagement (PPE) Plan	Chief Nurse & Director of Corporate Affairs	S4 x L3 = 12	1)Development & Implementation of PPE Plan	1)Lack of implementation plan	1)Board approved PPE Plan 2)Implementation of PPE Action Plan 3)Evidence of increase of PPE	Positive (+) Patient Delivery Committee (+) Active Support and development of Healthwatch in Surrey and Sussex		Gaps addressed my mitigating actions	S4 x L3 = 12	1) Develop patient and public engagement strategy 2)Develop and implement an action plan to meet strategy	1) Due September 2)March	GFM 14/06/13	29/08/2013	S2 x L3 = 6	To be discussed at June Board
	3.1b Develop opportunities for Foundation Trust membership recruitment and engagement through Membership Strategy. Recruit FT members in line with plan	Director of Corporate Affairs	S4 x L2 = 8	1)FT Membership Strategy & Action Plan	1)Current strategy is in draft	1)Achievement of FT membership recruitment milestones 2)Proposals for FT Shadow Governor's Council 3)Membership Engagement Plan 4) Elections to Shadow Governor's Council	Positive (+)FT Project Board engagement with draft FT membership plans (+) Initial proposals for Council of Governors		Gaps addressed my mitigating actions	S4 x L2 = 8	1) Finalise strategy	1)Due 01/08/13	GFM 14/06/13	29/08/2013	S4 x L1 = 4	To be discussed at June Board
	3.1c Work with health and social care system to reduce emergency admissions.	Chief Executive	S5 x L2 = 10	1)Revised ED arrivals process which provides senior decision making earlier in the attendance 2)Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed 3)Executive review and action arising from weekly ED dashboard review 4)Intentional Rounding in ED embedded to maintain safety 5)All patients reviewed daily at clinical operations meeting 6)Daily 8:30 management meeting in Ed to review previous 24 hrs and plan for day ahead agreed 7)Two hourly board rounds to ensure patient plans progress and delays are escalated 8)Rolling programme of implementation of 11 ambulatory care pathways- 5 complete; 3 due	1) Currently running with 7 locum / agency middle grades and 1 consultant vacancy	1) Combined weekly Quality and Performance Dashboard for ED reporting on a combination of quality and safety standards and the ED national indicators reported to exec meeting weekly 2) Safety and Quality Committee dashboard 3) Performance Management Framework and reporting to Trust Board 4) RTM data on patient experience in all clinical areas 5) External stakeholder inspections 6) Daily 9am performance review meeting 7) Capacity sheets updated three times a day 8) Daily winter Sit Reps (Commenced November) Urgent Careboard Area Team.	Positive (+) Sustained Medical outliers in SAU decreased since start of calender year (+) Sustained decrease in cancelled elective procedures (Dec 11) (+) Reduction of 12 hour breaches (sustained) (+) SHA external review provided positive assurance on safety and quality (+) Below 3.5% target agreed with DTOC consistently (+) >95% Weekly ED performance since April 2012 (+) Working with partners commisioners/parteners to expedite flow through hospital (Medihome and community beds) Negative (-) Quality indicators for time to assessment / treatment.		Continue to displace surgical beds (rate dropped to <20 beds daily)	S5 x L2 = 10	1)Demand management plans with local health economy agreed but delay in all 4 major schemes starting 2)Phase 2 of ambulatory care pathway commenced (further 11 pathways) 3)As part of a wider patient flow work stream look to develop a reduction in length of stay program 4)Winter plan agreed and being adopted, including new escalation processes (ICT), winter plans circulated 5)Discharge project team to be established to review long stay patients	1)Reduction in demand/activity is not supported/indicated by data 2)Phase 2 pathways being implemented but yet to make significant impact on admissions, preventing creep but not reducing number	CP13/06/13	29/08/2013	S5 x L2 = 10	To be discussed at June Board
	3.1d Onsite development with healthcare partners focussing on Chemotherapy services	Chief Operating Officer	S3 x L2 = 6	1)Agreements with Royal Surrey County over chemotherapy serives including legal arrangements to support radiotherapy work	None identified at this stage	1)Minutes of Board meetings and legal paperwork	Positive (+)Agreements in place an arrangements being made		None identified	S3 x L2 = 6	1)Agreeing financial aspects of new services	1)Due 01/08/13	CP13/06/13	29/08/2013	S3 x L1 = 3	To be discussed at June Board
3.2. Improve the way people see and talk about SaSH	3.2a Use of patient feedback to improve the patient experience in services and across the Trust	Director of Information and Facilities	S3 x L4 = 12	1)Patient Experience delivery 2)Responding to Patient Opinion Inpatient Survey Action Plan. 3)Your care matters system	To be identified	1)All streams of patient communication	Positive (+) Patient Opinion using SASH as case study (+) External Presentations. (+) Patient survey correlation patient feedback		None identified	S3 x L4 = 12	1) Monitor and develop action plans.	1)Due 01/08/13	IM 13/06/13	29/08/2013	S3 x L2 = 6	To be discussed at June Board
	3.2b Development and implementation of communications & PR strategy	Director of Corporate Affairs	S4 x L2 = 8	1)Board Approved Communications Strategy	Board Approved Communications Strategy not entirely fit for purpose	Implementation of Communications Strategy & Action Plan Implement outcome of Communications Team re-organisation Positive results of Staff Survey	Positive (+) Proactive national and local media coverage. (+) Positive feedback from Your Care Matters (+) Positive Feedback from Patient Opinion		None identified	S4 x L2 = 8	1)Development and implementation of communications & PR strategy	1)Due 01/10/13	GFM 14/06/13	29/08/2013	S3 x L2 = 6	To be discussed at June Board
	3.2b Active partnership engagement	Chief Executive	S4 x L2 = 8	1)Stakeholder meetings and actions underway, such as HASC, LINKS, Patients Council and CQPM 2)GP Newsletter and GP forum	1)Evidence to demonstrate board to ward understanding of need to engage with stakeholders	1)HASC minutes 2)CQPM minutes 3)Patient focus groups 4)Peer review 5)RTM	Positive (+)Performing Trust on DoH KPI (+)Senior stakeholder acknowledgement that quality of care at SASH is improving (CEO of NHS SOE, CQC Inspector) (+)Attendance of stakeholders at focus groups and Trust committee meetings (+) Press and media coverage (+)Maternity services liaison committee (MSLC) Negative		None identified	S3 x L2 = 6	1)Develop and implement PPI Plan 2)Plan to embed experience based design into service provision and development 3)Proactively seeking and promoting positive news stories	1)PPI plan under development 2) Implementation of "Your Care Matters" with extension across the Trust 3) Regular positive news stories in local media 4) FT Project board with good partnership & stakeholder representation	GFM 14/06/14	29/08/2013	S3 x L2 = 6	To be discussed at June Board
Objective 4 - Become a Sustainable, Effective Organisation																

Priority ID	Key Action for 2013/14 objectives and description of any potential significant risk to this priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
4.1.Live within our means both in year and ensure sustainability into the future	4.1a Failure to deliver income plan	Chief Finance Officer	**S5 x L3 = 15**	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Signed contract with commissioners. 3) Contract management process in place - clearer and better structure than last year 4) Internal Unscheduled Care Board 5) Health system Local Transformation Board (LTB)	1) CCG activity plans not fully profiled against their own plans at Jun 2013 2) Activity in the first two months greater than plan but lack of robust CCG change plans available at June 2013 3) At M02 activity levels remain within the previous trend providing significant pressure on CCG plans.	1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, monthly contract cycle with CCGs (including clinical quality review where SASH Directors account for performance). Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output and reporting from health system management (e.g.: System Management Team meeting) 5) Output of Contract Management Process	Positive: (+) Activity at M01 and M02 aligns overall with Trust plan - shortfall in electives can be caught up later (+) Overall forecast I&E position is balanced - income covers spend Negative: (-) Very early in the year to decide on trends against new CCG initiatives (-) CCG Contract reconciliation process has not yet completed - this will define level of challenges - so position is an estimate until complete (-) Too much non elective activity, not enough elective...greater cost (the imbalance of n/e activity is blocking elective beds, causing elective lists to be cancelled, escalation areas required for it need staffing by agency nurses). The perfect storm. (-) CCGs dogmatic/unresponsive over actions to deal with unscheduled care - notably CHC assessment		(1) Output from M01 reconciliation process (2) Output from resolution of unscheduled care actions with CCG	**S5 x L3 = 15**	I) Regular Contract monitoring meetings now in place - action is to ensure they run properly and the hierarchy of meetings around them (CQPM and Chief Officer meetings) also run properly [CFO: update at M03]; ii) Range of actions on unscheduled care: internal U/S Care Board running, engagement with other providers now part of weekly business - but CCG actuions to support unscheduled care actions not yet visible [to Trust] [COO: update at M03]. iii) Discussion with CCGs over adequate CHC assessment arrangements to get those in place in the summer [COO: update at M03] and participation in LTB to expedite actions around unscheduled care.. iv) Escalation with TDA.	Actions proceeding to timetable - no suggestion currently that CCG actions on unscheduled care will resolve.	PS 10/06/13	29/08/2013	**S4 x L2 = 8**	Discussed at Mar Board
	4.1b Failure to stop divisional overspending against budget	Chief Finance Officer	**S5 x L3 = 15**	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Divisional activity plans agreed & signed off 3) Additional activity budget being allocated after agreement of specific pressures 4) Internal Performance Review process 5) Programme Management Office weekly CEO review	1) Trust still operating on interim budget because non recurrent funding decision not yet made 2)Nursing agency spend controls subject to review and action - Nursing Recruitment & Retention Group not yet provided information or results and outside PMO process. 3) Specific savings plans risky (Amenity beds, Pathology JV, Digital Dictation) - all subject to particular scrutiny.	1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, monthly contract cycle with CCGs (including clinical quality review where SASH Directors account for performance). Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output in financial reporting describes improvement and risk mitigation. Linkage between activity levels and spend is clear from 2012/13 5) PMO review process (weekly)	Positive (+) Overall forecast I&E position is balanced from profiled reserves - income covers spend at M01 Negative (-) Three clinical divisions overspent at M01 (-) Although savings on target, savings are not hitting the "contingency" level (mitigation ahead of the big profile jump ion savings at M4) (-) Nursing agency spend remains very high (-) Interim budget still in place without a date for resolution of non recurrent support		(1) Savings delivery is not proven at M01 (2) Interim budget still in place and no resolution to non recurrent support	**S5 x L3 = 15**	I) PMO structure will remain in place while savings bed in [PMO is proving effective] (CFO - update at M03]; ii) Controls are being exercised in divisions (NB: not centrally, reflecting autonomy of divisions) - non pay requisition management, agency booking, general tightening of control & ADO escalation (ongoing) (CFO - update at M03] iii) Decisions on further budget changes delayed (agreed at TDG 5 June) until evidence of corrected position. iv) Escalation to TDA over resolution of non recurrent funding issue (CEO - update at M03)	Actions proceeding to timetable.	PS 10/06/13	29/08/2013	**S3 x L2 = 6**	Discussed at Mar Board
	4.1c Unable to provide realistic medium term financial plan	Chief Finance Officer	**S5 x L3 = 15**	1) Items referred to in 4.1a and 4.1b above 2) FIRST draft long term financial model and integrated business plan completed (submitted to SHA on 18 October) 3) TDA Plan submitted end of May 2013	1) Decision over non recurrent support is still outstanding 2) Revised LTFM to be prepared based on 13/14 Contract and n/r settlement	1. Delivery of current year financial plans 2. Delivery of long term financial model and integrated business plan	Positive (+) Long term financial model provides realistic plan and scenarios describe wider robustness against downsides (+) Delivery of performance in 2012/13 notable - delivery no needed in 13/14 (+) The submitted LTFM (October 2012) passed muster with TDA/SHA high level review although it has not been subject to full challenge and scrutiny. Negative (-) Savings and income levels in future years provide extremely challenging targets and the LTFM assumptions are subject to change dependent on CCG plans (-) Delivery of stated CCG commissioning plans for 2013/14 and future years risky - potential change in shape of commissioning intentions Overall, on basis of current assumptions and delivery of LTFM, RAG improved to amber [but subject to review]		A) 2013/14 planning round not complete B) Revision of LTFM	**S5 x L3 = 15**	1) Revise LTFM (CFO: complete M06) 2) Review of actions from items above around actual outturn in 2013/14	Actions proceeding to timetable	PS 10/06/13	29/08/2013	**S4 x L2 = 8**	Discussed at Mar Board
	4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	Chief Finance Officer	**S5 x L5 = 25**	1. Bi weekly review of forward cash flow by finance team and CFO 2. Cash and working capital policy and strategy 3. Annual cash plan linked to business plan and capital plan (see link with Risk 1134)	None	1. Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2. Monthly finance reporting to Management Board and Trust Board	Positive (+) Positive cash flow reported for every month in 2011/2012, and throughout 2012/13 - although borrowing required in 11/12, no such borrowing needed in 2013/14 (+) Liquid ratio has followed expectations Negative (-) no confirmed additional cash to resolve underlying liquidity problem - source of such funding questionable in current Govt spending position (-) cash flow dependent on financial outturn described in 4.1a and 4.1b above. Assurance RAG "amber" - no current cash problem but		In terms of cash flow management to end year, no material gaps in assurance. In terms of resolving the actual risk (liquidity), there is no confirmation of additional cash to resolve SoFP weakness.	**S5 x L3 = 15**	1) Day to day cash control is main action currently, coupled with action sto maintain service income and spend 2) Long term financial model, and TDA plan now provides additional validation of the level of cash injection required and the interaction from an improving financial position within the model 3) Discussion continues with the TDA	Actions proceeding to timetable	PS 10/06/13	29/08/2013	**S4 x L3 = 12**	Discussed at Mar Board
4.2. Listen to, value and develop our workforce	4.2a Ineffective staff development means that the Trust does not have the skilled workforce to deliver current and future services	Director of Human Resources	**S4 x L3 = 12**	1) Ratified Workforce Strategy and Plan 2) Training plan aligned to national and regional requirements 3) Appraisal and PDP compliance monitoring and reporting to Board (see link with Risk 910) 4) Statutory and mandatory training matrix (see link with Risk 1170). 5) Data collection and monitoring linked to ESR , and exception reporting	1) Quality of appraisals and personal development plans 2)Matrix requires ongoing review 3) Limited availability of training rooms 4) Trainer capacity 5)Quality of data received	1) Implementation Plan report to Investment and Workforce Committee SHA assurance process 2) Delivery of plan and monitoring of external training budgets (CPD Delivery plan and reporting) 3) Monthly performance reports to Management Board. 4) Annual Staff Survey responses to training questions. 5) Complementing current provision with e-learning programme. 6) Matrix reviewed and information governance included in programme from end October 12.	Positive (+) Implementing actions from Trust Workforce Strategy Plan 2012-2015 (+) LDA signed, SHA allocations received and SHA reporting quarterly (+) at least 20% mandatory and statutory training via e-learning (+) improvement in staff and patient survey results. (+) Performance Scorecared shows increase in statutory and mandatory compliance (+) Appraisal target of 90% achieved for 12/13 (+) Saving plans agreed (+) Improvement in levels of motivation shown in 2012 staff survey (-)Monthly reporting by division and staff feedback sessio		1) Inability to deliver e-learning project on time 2) Insufficient resources to fund Training needs 3) Timely measurement of staff engagement and morale 4) Timely measurement of quality of appraisal	**S4 x L3 = 12**	1) ongoing review and monitoring of Statutory and mandatory training matrix 2) continued delivery of revised Statutory and mandatory Training programme 3) More local delivery of statutory and mandatory training 4) New method of collecting appraisal data in place, monthly reports to Divisions on outstanding appraisals that month 5) Monitoring of appraisals by division at performance meetings 6) IT and network system difficulties escalated to Ian Mackenzie and Yvonne Parker; resource implications. 7)Healthskills Leadership program completed (2 cohorts) 8)Ward Managers Development program commenced 9) GE Board and Clinical Leaders development programme commissioned	1) &2) Matrix being reviewed following UK Skills for Health consultation on delivery of Core mandatory training. Streamline programme will reduce matrix to 10 core programmes with rest delivered locally. Staff coming from other NHS organisations will be able to 'passport' their training to SASH. 3) cascade training in place 6) capital bid made.	31/05/2013 BC/JM	29/08/2013	**S4 x L2 = 8**	Discussed at Mar Board
	4.2b Ineffective staff engagement and buy-in of staff to the Trusts objectives and direction delays or derails service and workforce redesign and ability to make financial savings	Director of Human Resources	**S4 x L3 = 12**	1) Staff Survey engagement score 2) NHS Employers Engagement Framework adopted 2012, Staff Engagement OD plan developed 2012, reporting directly to Trust Board (see link with Risk 1321) 3) Focus groups and in year temperature check on engagement 4) Team briefing mechanism for message cascade 5) Transformation Plans embedded in business planning cycle. 6) Sash Window magazine for staff, Health Focus magazine for community. 7) Star of the Month, Team awards and annual staff awards evening. 8)Wellbeing agenda and activities. 9) Staff suggestion box	To be identified	1) Annual Board report on staff survey results and action plan 2) Staff will be involved in its development - Engagement OD Strategy approved by Board in 2012. 3) Report to Executive Management Board on results 4) Number of briefings held during 13/14 and attendance sheets 5) PMO monitoring, monthly reports to Management Board 6) Improvements in feedback from "your care matters"	Positive (+)Attendance at team briefs and Senior Leaders Meeting (+) Board Report in May (+)Customer Care programme to be recommissioned (+)Assurance at Investment and Workforce Committee on internal comms strategy (+)Improved feedback from internal communications approach Negative (-) Feedback sessions ESH and Crawley Hospital		1) Engagement score improved in 2012 staff survey, now average for acute Trusts, requires long tem action and commitment to maintain improvements	**S4 x L2 = 8**	1) Equality and Diversity & HR Steering Group 2) Board Seminar engagement 3) Focus Groups for Engagement Strategy. 4) Engagement OD plan approved by Board 2012 and monitored six monthly	Actions agreed to progress	31/05/2013 SK/JM	29/08/2013	**S4 x L2 = 8**	Discussed at Mar Board

Priority ID	Key Action for 2013/14 objectives and description of any potential significant risk to this priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
	4.2c Lack of leadership capacity and capability to engage with and develop staff delays or derails workforce redesign and ability to make financial savings	Director of Human Resources	S3 x L3 = 9	1) Leadership programmes provides a cohort of 150 senior managers to effect change. Programmes of change focused on trust priorities. 2) Training needs analysis annually and funding of external training through the bursary 3) Clear managerial and clinical structures with single point accountability through the Chiefs of Service. 4) Investment and Workforce Committee oversight of Training Plan 5) Board development programme	To be identified	1) Attendance at leadership training and output of change project 2) Delivery of plan and monitoring of external training budgets 3) Performance management processes from ward to board, vacancies in management structures 4) Reports being received at Investment and Workforce committee 5) Completion of programme	Positvve (+) 200 Senior Leaders trained under Healthskills with different work streams over 2 years (+) 2 Cohorts of Leadership in Action programme completed - this is now an on-going programme (+) Essentials of Management pilot completed, programme roll out from September 2013 following second evaluation (+) 2012-2013 Training Plan in place. (+) LDA signed and allocations received and Bursary panels in session (+) New clinical structure in place with Chiefs of Staff (+) Regular Board seminars, recent Board meeting and observation by Healthskills (+) LEAP leadership Programme by KSS Deanery for Medical teaching Faculty now an on-going programme (+) Chiefs and Clinical leads Development Sessions -		1) How to measure leadership training - identifying link between leadership activities and programmes and organisational change	S2 x L4 = 8	1) Establish framework to enable short-term change or KPI measures to show added value of programmes, new structures and processes in place. 2) Attendance at Senior Leaders meeting and engagement with Transformation Plans 3) Prioritising TNA funding to Trust priorities. 4) Development of behavioural competencies to support Trust Values.	1) Monitor through Management Board for Performance 2) New Performance Score card measuring quality, patient satisfaction, staff satisfaction and performance	31/05/2013 BC/JM	29/08/2013	S2 x L4 = 8	Discussed at Mar Board
4.3. Delivery of TFA and Monitor standards	4.3a Implement our plans to become a Foundation Trust by 2014	Director of Corporate Affairs	S4 x L2 = 8	1)BGAF assessment carried and action plan developed 2)Corporate governance framework 3)Interim Director of Corporate Affairs in post, vacancy filled 4)Foundation Trust project board 5)Timeline	1)Corporate Governance infrastructure not fully embedded	1)BGAFaction plan 2)LTFM 3)FT Project board 4)FT Project plan 5)Integrated Business Plan 6)FT Project Board	Positive (+) Active FT Project Board (+)Draft IBP (+)LTFM (+)Draft membership strategy (+)BGAF action plan (+)Initial QGAF action plan		1) Gaps in evidence of implementation	S4 x L2 = 8	1) Detailed BGAF action plan developed and currently under review 2) Board Development Programme 3) Draft Membership Strategy 4) FT Programme Manager post being recruited to	1) BGAF action plan has been discussed regularly at TB Seminars and progress against action plan monitored 2) Plans are being driven forward by Director of Corporate Affairs 4) FT Programme Manager	GFM 14/06/13	29/08/2013	S4 x L2 = 8	Discussed at Mar Board
4.4 Ensure that the estate and infrastructure supports our sustainability	4.3a Ensure the estate and infrastructure supports sustainability	Director of Information and Facilities	S5 x L3 = 15	1) Capital 2) Investment Workforce 3) Weekly Capital Plan 4) Capital Plan 5) Estates Strategy	To be identified	1) IT Strategy - Clinical Health Informatics Group 2) All sources of patient feedback	Positive (+) Front entrance (+)ED refurbishment and recent projects achieved and improvements demonstrated (+)Capital group		To be identified	S5 x L3 = 15	1) Theatres refurbishment 2) Radiotherapy capital work 3) PACS RIS Upgrade. 4) Hospital infrastructure.	1) 2013/14 2) 2013/14 3) Implement June 2013 4) Ongoing	IM 13/06/13	29/08/2013	S5 x L2 = 10	Discussed at Mar Board