TRUST BOARD IN PUBLIC	**Date: 26th September 2013** **Agenda Item: 4.1**
REPORT TITLE:	Board Assurance Framework
EXECUTIVE SPONSOR:	Gillian Francis-Musanu Director of Corporate Affairs
REPORT AUTHOR:	Colin Pink Corporate Governance Manager
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	AAC 2nd September 2013 Executive Team 11th & 18th September 2013

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 – 26th September 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

At the September Audit and Assurance Committee a new format for the BAF was proposed and agreed. The Executive Team was then asked to make other amendments (the wording of key risks, consistency of ratings, clarify significant risks e.g. winter capacity) and to consider whether some items are still required to be recorded the BAF at this point. As such through out September each risk owner has reviewed and updated their key lines. Following this process The Executive Team undertook a final level "face to face" moderation to ensure that the BAF reflected the Trusts current risks to its strategic objectives. As part of this process some risks have been merged or split. Each item is now described as a risk where possible.

The BAF (attached) details a total of 22 significant risks to the four Trust objectives

Objective	Red (15-25)	Amber (8-12)	Green (1-6)	Total
1. Deliver safe, high quality, coordinated care	3	5	0	**8**
2. Ensure patients are cared for and cared about	0	2	0	**2**
3. Work in partnership with our community	0	2	0	**2**
4. Become a sustainable, effective organisation	4	6	0	**10**
Total	**7**	**15**	**0**	**22**

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 If the Trust does not maintain expected regulatory standards this objective cannot be met	S4 x L2 = 8	S4 x L2 = 8	S3 x L2 = 6
1.1a Failure to continue to maintain and improve mortality indicators (Global HSMR or condition specific) will effect the Trusts ambition to achieve best outcomes for its patients	S4 x L2 = 8	S4 x L2 = 8	S5 x L1 = 5
1.1b Failure to maintain improvements in patient safety will effect the Trust's ability to achieve this objective	S4 x L3 = 12	S4 x L2 = 8	S3 x L2 = 6
1.1c Failure to maintain Emergency Department performance because of lack of capacity in health system to manage winter pressures has a significant impact on the Trust's ability to deliver high quality care	S5 x L4 = 20	S4 x L4 = 16	S3 x L4 = 12
1.1d Failure to maintain and improve performance within national expectations (i.e. Cancer, 18 Weeks, Maternity) will significantly effect the Trusts ability to achieve high quality care	S4 x L2 = 8	S4 x L2 = 8	S3 x L2 = 6
1.1e As readmission rates are an indicator of high quality care, failure to improve the Trust's rate poses a risk to this objective	S3 x L3 = 9	S3 x L3 = 9	S3 x L2 = 6
1.1f Failure to maintain systems to control rates of HCAI will effect patient safety and quality of care	S5 x L3 = 15	S5 x L3 = 15	S5 x L2 = 10
1.3a If the Trust does not maintain and improve ability to allocate the right bed first time there is an increased risk of receiving poor quality of our care (effectiveness, experience and safety)	S4 x L2 = 8	S4 x L4 = 16	S3 x L2 = 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
2,2 The Liverpool Care Pathway has been removed from use. Whilst an alternative management process is developed there is a probability that patients receiving palliative care will not receive the high quality care expected.	S4 x L3 = 12	S4 x L2 = 8	S4 x L1 = 4
2.1 The Trust's objective to ensure all patients are cared for and about, will be significantly hampered If the Trust does not embed a coordinated approach for learning from patient feedback such as "Your Care Matters", Complaints and PALS	S4 x L2 = 8	S3 x L3 = 9	S4 x L1 = 4

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 There is a risk that the Trust will fail to achieve a sufficient geographic and demographic representation of its membership to meet Foundation Trust requirements	S4 x L2 = 8	S4 x L2 = 8	S4 x L1 = 4
3.2a Failure to engage with local media has a significant effect on the Trust reputation	S4 x L2 = 8	S4 x L2 = 8	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 If the Trust does not progress and deliver its Foundation Trust plans it is unlikely to be able to successfully authorised. This could leave the Trust without local autonomy and could lead to an alternative organisational form being imposed on the Trust. Which could reduce choice and focus on local health provision	S4 x L2 = 8	S4 x L2 = 8	S4 x L2 = 8
4.4a There is a risk that the Trust does not fully realise the benefits available form well embedded IT systems	S5 x L3 = 15	S5 x L2 = 10	S5 x L1 = 5
4.4b There is a risk that the Trust isn’t able to deliver service in an effective timely manner due to the estate not fully supporting the clinical strategy	S5 x L3 = 15	S5 x L2 = 10	S5 x L1 = 5

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.

Table 1: Current Risk Profile

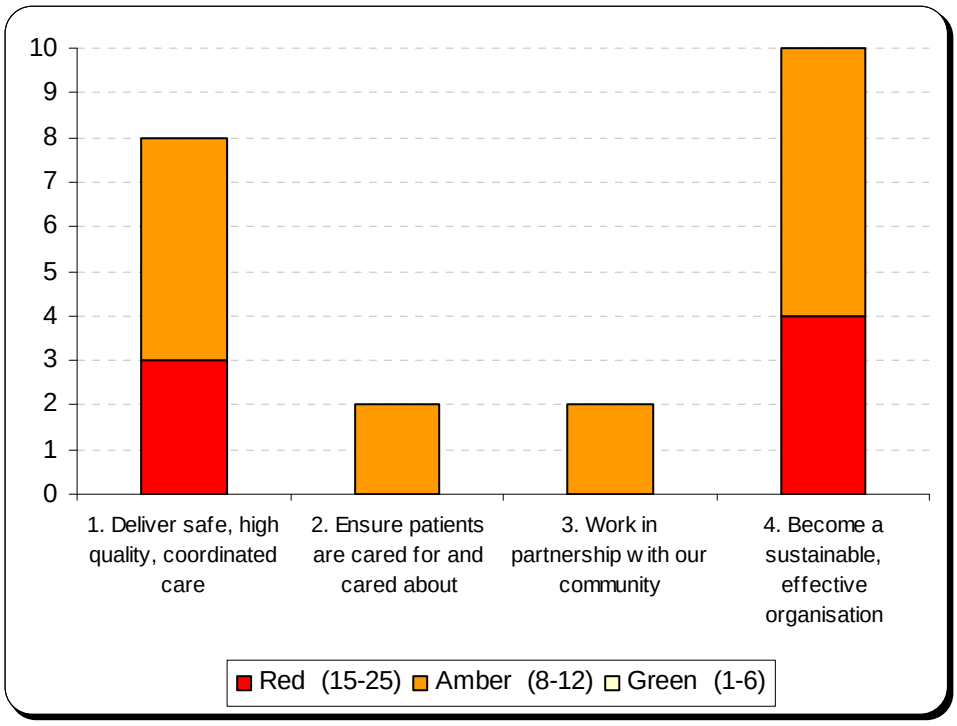
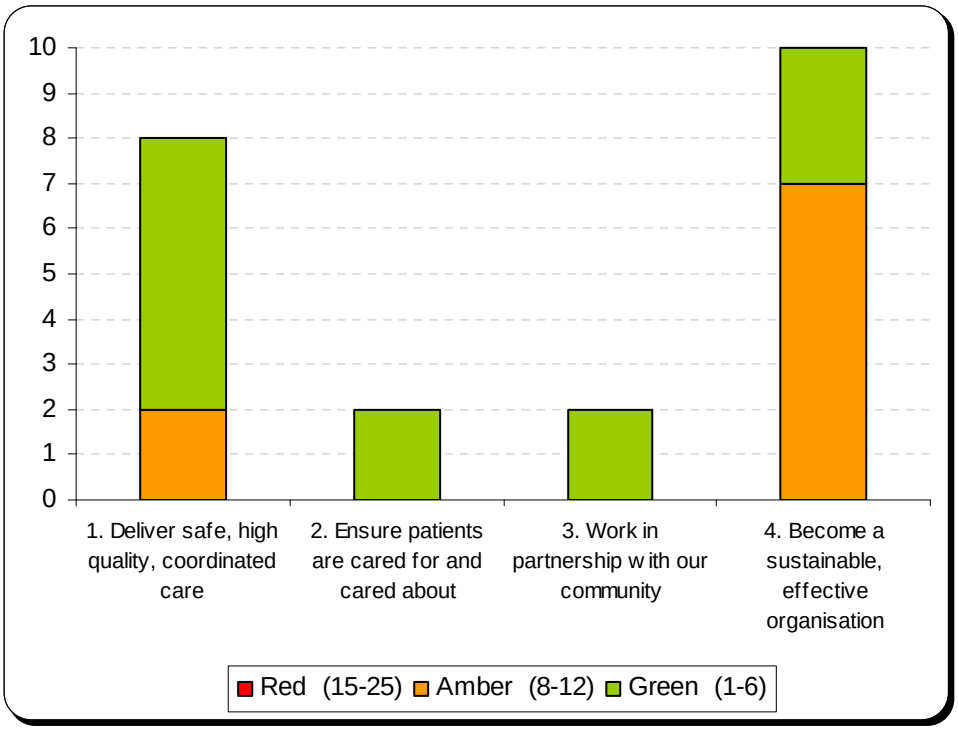


Table 2: Target Risk Profile



3. Key risks Identified

The BAF highlights the following 7 key red risks to the Trust objectives that have been identified at time of updating the framework. These are:

Risk description	Current rating	Target risk score	Page
1.1c Failure to maintain Emergency Department performance because of lack of capacity in health system to manage winter pressures has a significant impact on the Trust's ability to deliver high quality care	S4 x L4 = 16	S3 x L4 = 12	P4
1.1f Failure to maintain systems to control rates of HCAI will effect patient safety and quality of care	S5 x L3 = 15	S5 x L2 = 10	P7
1.3a If the Trust does not maintain and improve ability to allocate the right bed first time there is an increased risk of receiving poor quality of our care (effectiveness, experience and safety)	S4 x L4 = 16	S3 x L2 = 6	P8
4.1a Failure to deliver income plan	S5 x L3 = 15	S4 x L2 = 8	P13
4.1b Failure to stop divisional overspending against budget	S5 x L3 = 15	S3 x L2 = 6	P15
4.1c Unable to provide realistic medium term financial plan	S5 x L3 = 15	S4 x L2 = 8	P16
4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	S5 x L3 = 15	S4 x L3 = 12	P15

4. Recommendation/Discussion

The Board is asked to note the BAF as presented and consider the following discussion points:

4.1 Are the appropriate actions being taken to resolve the red risks to the corporate objectives?

4.2 Should the risks to sub objective 4.2, “Listen to, value and develop our workforce” 4.2 b and 4.2c (p20 and p21), be removed from the BAF as both are being recorded as reaching their target level of inherent risk?

4.3 Is the risk rating appropriate for the risk to sub objective 4.3a “Delivery of agreed milestones to achieve Foundation Trust status” (p22)?

Colin Pink
Corporate Governance Manager
September 2013

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.1. Achievement of national best practice in clinical care.	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1 If the Trust does not maintain expected regulatory standards this objective cannot be met	**Current rating**	S4 x L2 = 8
		Target risk score	S3 x L2 = 6
		Linked to Risk	1170

Controls in place (to manage the risk)	**Gaps in Control**
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) Embedding Synbiotix 2) Review of compliance monitoring system in light of CQC consultation
Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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. 10)Nursing audit framework includes Essence of Care benchmarks	Positive (+) CQC formal feedback following two day inspection Feb 13, Compliant with outcomes 8 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) (-) SI themes in particular delayed diagnosis

Gaps in assurance	**Assurance Level gained: RAG**
1)Process of review for Provider Compliance Assessments 2)Triangulated reporting Complaints, Risks and Audits	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
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 6) Awaiting CQC guidance to influence CCG quality review	1)Nursing documentation reviewed updated and in place 2)Nursing documentation group functioning 3)PCA review commenced (9 of 16 in date) 4)Resolving final roll out issues 5)In development 6)Outstanding

Update by	AC 16/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.1. Achievement of national best practice in clinical care.	**Director responsible**	Medical Director
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1a Failure to continue to maintain and improve mortality indicators (Global HSMR or condition specific) will effect the Trusts ambition to achieve best outcomes for its patients	**Current rating**	S4 x L2 = 8
		Target risk score	S5 x L1 = 5
		Linked to Risk	1270

Controls in place (to manage the risk)	**Gaps in Control**
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 5)Stroke service 6)Fracture neck of Femur controls 7)Pathways to external providers in place	1) Data quality of primary diagnosis and co morbidities in palliative care 2) Real time data sets for benchmarking

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) HSMR 2) KPI internal pathways (e.g. stroke) 3) Discussions and actions taken at mortality review meetings 4)Full review of #NOF cases presented and monitored by MBQR 5)Clinical effectiveness Committee	Positive (+) HSMR below 100 and better than predicted (+) Falling HSMR (+) Within expected mortality rate for all Dr Foster mortality indicators (+) Report to SQC on Mortality (+) Performance for 4 hour target to get all #NOF cases to an orthopedic Negative (-) Access to specialist beds (-) Surgical sight wound infections (-) Numbers community rehab beds

Gaps in assurance	**Assurance Level gained: RAG**
Audit of data quality for mortality indicators	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Healthcare of the elderly strategy 2)Considering attaching orthogeriatrics to Surgery ward rounds 3)Increasing Jnr Dr and reviewing enhancing quality programs 4)Service reviews following changes in mortality for fractured neck of femur 5)Trust piloting whole system approach to management of COPD 6)Ring fencing of stroke and fracture neck of femur beds 7)Recruiting healthcare of the elderly to work across primary and acute care 8)Implementing 7 day specialist physician working 9)Continuing programs for improving data quality	1)Underway 2)Underway 3)Underway 4)Underway 5)Underway 6)Underway 7)Underway 8)Underway 9)Ongoing

Update by	DH 13/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.1. Achievement of national best practice in clinical care.	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L3 = 12
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1b Failure to maintain improvements in patient safety will effect the Trust's ability to achieve this objective	**Current rating**	**S4 x L2 = 8**
		Target risk score	**S3 x L2 = 6**
		Linked to Risk	1054,1055,1306,1447,1460

Controls in place (to manage the risk)	**Gaps in Control**
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. 5) Matron on site 7 days a week	1) Full implementation of Synbiotix 2) Incident reporting policy to be reviewed

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Synbiotix 2) KPI agreed and monitored at Board and Divisional Level 3) QGAF 4) External reports and visits	Positive (+) Never events incidence low (+) Pressure Ulcers reduction (+) Falls strategy Fall Teams (+) MUST 100% June 2013 Negative (-) Falls SI Cluster (-) Delayed diagnosis SI theme

Gaps in assurance	**Assurance Level gained: RAG**
Ability to benchmark in real time National Safety Dashboard to be implemented once produced	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Pressure damage board 2)Patient safety Post 3)Draft Maternity Strategy 4)Full implementation of Synbiotix 5)New EWS 6)Policy update for Incident reporting and management	1) In place re-embedding 2) Commenced early September 3) Due end of September 4) Implemented resolving initial hardware issues 5) Discussed at MBQR due to finalise in Q3 6)December 2013

Update by	AC 16/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	1.1. Achievement of national best practice in clinical care.	**Director responsible**	Chief Operating Officer
		Initial Risk	S5 x L4 = 20
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1c Failure to maintain Emergency Department performance because of lack of capacity in health system to manage winter pressures has a significant impact on the Trust's ability to deliver high quality care	**Current rating**	S4 x L4 = 16
		Target risk score	S3 x L4 = 12
		Linked to Risk	1491,824

Controls in place (to manage the risk)	**Gaps in Control**
1) EDD Patient Pathway 2) Discharge management 3) Plans for escalation areas agreed and management tools in place 4) Reviewing all breaches on weekly to implement lessons learnt	1)Identified on a rolling basis as part of weekly review 2)It is difficult for the Trust to influence the output of decision making across the local health economy 3)Ambulatory pathways yet to imbed

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) NHS England aware 2) 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 3) Performance Management Framework and reporting to Trust Board 4) External stakeholder inspections 5) Daily winter Sit Reps (Commenced November) Urgent Careboard Area Team.	Positive (+) Process improvement (+) Performance delivered since May 2013 (+) Reduction of 12 hour breaches (sustained) (+) SHA external review provided positive assurance on safety and quality (+) Below 3.5% target agreed with DTOC consistently (+)ED performance since (+) Working with partners commisioners/parteners to expedite flow through hospital (Medihome and community beds) Negative (-) Quality indicators for time to assessment / treatment. Surrey and Sussex local lead. (-) EDD Section 2 and section Patient tracking system (-) Bed modeling - 70 beds (-)Approximately 100 patients safe to discharge

Gaps in assurance	**Assurance Level gained: RAG**
Winter plans and local health economy position going into winter months	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Site management team 2) Reinstatement of Discharge Team 3) Resource Extra Beds. 4) Additional community beds being put in place 5) 7day medical consultant ward rounds planned	1)Target date September 2)Target date September 3)Target date September 4)Target date October 5)Target date November

Update by	PB 15/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care			
Priority ID and reference	1.1. Achievement of national best practice in clinical care.	**Director responsible**	Chief Operating Officer
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1d Failure to maintain and improve performance within national expectations (i.e. Cancer, 18 Weeks, Maternity) will significantly effect the Trusts ability to achieve high quality care	**Current rating**	S4 x L2 = 8
		Target risk score	S3 x L2 = 6
		Linked to Risk	1295

Controls in place (to manage the risk)	**Gaps in Control**
1) Cancer Tracking Team 2) 6 targets - well organised developed systems 3) Dedicated Monitoring 4) Patient tracking list	Identified on a rolling basis as part of monthly review. No significant gaps in control identified at present

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Commissioner reports 2) National report 3) Performance monitoring 4) Target focused performance systems.	Positive (+) Performance and monitoring (+) 18 week performance (+) Overall performance of Trust Negative (-) 62 day target cancer (-) Capacity issues

Gaps in assurance	**Assurance Level gained: RAG**
Link to 1.1c. Full plans for winter to be completed	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Virtual cover, division of leadership 2) Report trialing chemotherapy and Radiotherapy. 3) Surgery – Increase in activity report	1) October 2013 2) October 2013 3) December 2013

Update by	PB 15/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	Achievement of national best practice in clinical care.	**Director responsible**	Medical Director
		Initial Risk	S3 x L3 = 9
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1e As readmission rates are an indicator of high quality care, failure to improve the Trust's rate poses a risk to this objective	**Current rating**	S3 x L3 = 9
		Target risk score	S3 x L2 = 6
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1) Discharge processes in place 2) Work with CCG July 2013 to look at readmissions following on from initial work 2012/13	1) All coding processes not standardised to reflect true readmissions 2) Temporary notes makes clinical coding more difficult

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) KPIs 2) Dr Foster alerts	Positive (+) Readmission data work by local physicians (+) Internal audit of readmission figures provides positive assurance (+) Feedback following initial work on discharge process 2013/14 Negative (-) Readmission data quality

Gaps in assurance	**Assurance Level gained: RAG**
1)Re-admissions data quality paper to be submitted to MBQR or appropriate 2)Lack of agreement with CCG's over recent audit of readmission rates	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Data quality coding 2) OPAL Service linked to GP 3) Review storage of medical records to reduce need for temporary notes 4) Work to improve coding at ward level on clear signaling of planned readmission (TWOC)	1) Underway 2) Underway 3) Underway long term plans 4) Underway

Update by	DH 13/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care

Priority ID and reference	Achievement of national best practice in clinical care.	**Director responsible**	Medical Director
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.1f Failure to maintain systems to control rates of HCAI will effect patient safety and quality of care	**Current rating**	S5 x L3 = 15
		Target risk score	S5 x L2 = 10
		Linked to Risk	1050

Controls in place (to manage the risk)	**Gaps in Control**
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 (effective against C. diff spores) 8)Develop pocket size antimicrobial guide 9)Consultant led RCA and presentation of HCAI (MRSA, MSSA, CDI and hip and knee operation wound infection) 10)Reviewed MRSA management policy in year (see link with Risk 1054,1050,1049)	1)Risk assessment of patients with diarrhea is not consistent, in particular on admission and at first onset 2)Variation in line care demonstrated by audit

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)KPI indicators 2)Reducing numbers of cases of C. diff year on year 3)No confirmed outbreaks of C. diff commenced during 2013/14 to date 4)PCT and SHA visits focusing on infection control 2012/13 5)Recent CQC visit focusing on Nursing documentation and escalation	Positive (+)No C. diff outbreaks declared in year (+)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 (-)1xMRSA BSI case in year (-) Rising incidence of C. diff against trajectory

Gaps in assurance	**Assurance Level gained: RAG**
Extensive auditing and monitoring in place. Trust position known	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Trial of 2 ICE-POD side rooms to commence in September 2013. 2)Full list of actions in IPCAS annual programme of work 3)Reviewing antibiotic prescribing policy for further improvements 4)Considering screening for C. diff for all adult emergency admissions	1)Commence September 2013 2) Ongoing 3) December 2013 4) December 2013

Update by	DH 13/09/13	**Date discussed at Board**	Discussed at July Board

Objective 1 - Deliver Safe, High Quality, Co-ordinated Care			
Priority ID and reference	1.3. Ensure patients are cared for in the right place at the right time	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	1.3a If the Trust does not maintain and improve ability to allocate the right bed first time there is an increased risk of receiving poor quality of our care (effectiveness, experience and safety)	**Current rating**	S4 x L4 = 16
		Target risk score	S3 x L2 = 6
		Linked to Risk	1501

Controls in place (to manage the risk)	**Gaps in Control**
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 4)Matrons walk round 5) Additional screens arriving to reduce chance of mixed sex accommodation breaches during winter pressures 6) Matron on site 7 days a week	1)Additional workload for medical teams having to cover significant numbers of patients outside their bed base 2)The external influences outside of SASH control e.g.) demand management and delayed discharges in care 3)Link to 1.1c
Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Patient Experience feedback all sources 2)Mixed sex breach data 3)Feedback from ward round project	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) (+)"Your Care Matters" provides qualitative assurance (+) Improved patient opinion data (+)Lack of breaches Negative (-) Internal reporting high against target bed occupancy levels (-) Complaints and incident data (-) Delayed discharge of medically fit patients

Gaps in assurance	**Assurance Level gained: RAG**
SQC comparison of PT journeys indicated further development of process of right bed first time	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Board round and ward round project and implementation of professional standards 2)Site team improvements 3)Reducing bed occupancy to 95%	1) Being implemented 2) December2013 3) Ongoing

Update by	AC 16/09/13	**Date discussed at Board**	Discussed at July Board

Objective 2 - Ensure Patients are cared for and cared about

Priority ID and reference	Be recommended on the basis of "customer care"	**Director responsible**	Director of Information and Facilities
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	2.1 The Trust's objective to ensure all patients are cared for and about, will be significantly hampered If the Trust does not embed a coordinated approach for learning from patient feedback such as "Your Care Matters", Complaints and PALS	**Current rating**	S3 x L3 = 9
		Target risk score	S4 x L1 = 4
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1)Friends and Family Test implemented in inpatient areas, ED and Maternity 2)Your care matters implemented in OP / Endoscopy/ DSU across all sites 3)Trust wide monitoring system developing for complaints and PALS 4)Divisional responsibility for actioning complaints investigation 5)Patient Experience Delivery Committee monitoring	1)Delays in administration of complaints, including signature and final editing

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
External Audit TDA - Confidence, Board Performance Information - Friends and Family	Positive (+)Plans developed to continue implementation (+) Presentation to CQPM (Commissioner Quality Meeting) (+) Implementation of ward dashboards (+) Number of new complaints significantly lower than last year (+) Low numbers of cases referred to the Ombudsman Negative (-) Numbers of complaints cases reopened (-) Performance in closing complaints (-) Supporting corporate function establishment (-) Friends and Family data

Gaps in assurance	**Assurance Level gained: RAG**
Effective function of the patient experience and delivery forum and the linkage of patient experience data and responses/actions	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Implement YCM in Maternity 2)Develop SQC Reports 3)Review complaints policy to ensure it is fit for purpose and is aligned with new structures	1)01/11/13 2)01/11/13 3)31/12/13

Update by	IM 16/09/13	**Date discussed at Board**	To be discussed at September Board

Objective 2 - Ensure Patients are cared for and cared about

Priority ID and reference	2.2. Always treat all patients and their families/carers with compassion, courtesy and privacy and dignity	**Director responsible**	Chief Nurse
		Initial Risk	S4 x L3 = 12
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	2.2 The Liverpool Care Pathway has been removed from use. Whilst an alternative management process is developed there is a probability that patients receiving palliative care will not receive the high quality care expected.	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1)Patient Experience Group in place 2)Leadership programmes in place at senior management level 3)Mock CQC inspection programme 5)Divisional action plans in place addressing patient experience feedback 6)Nursing Clinical Effectiveness weekly audits commenced	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 3) Withdrawal of LCP, replacement system for management of palliative care being trialed

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)RTM data available and monitored by SQC and patient experience group 2)CEQUIN data 3)All sources of patient feedback, internal and external 4)Compliments and PALS	Positive (+) Steering Group (+) "Your Care Matters" feedback (+) Care pathway material replaced EOL guidance (+) Low trend of complaints with EOL as main issue (+) Initial management process discussed and agreed at September MBQR Negative (-) Audit highlight gaps in delivery of care (-) Discharge issues (-) Training and release of staff to support wards (-) NHS Choices negative comments

Gaps in assurance	**Assurance Level gained: RAG**
1)Clinical audit of suggested process 2)Triangulation of training, appraisal and quality 3) Pro actively encourage patients to use NHS choices PALs and complaints systems to improve information resources	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Review all patient feedback systems for trends 2)New care plan for EOL care 3)Provide training of new care plan 4)Investment in Nurses and Palliative care team 5)CEO and Medical Director liaison with St Catherines	1)December 2013 2)September 2013 3)Initiate by November 2013 4)6 day service being implemented, recruiting to a 7 day service 5)Ongoing

Update by	AC 16/09/13	**Date discussed at Board**	Discussed at July Board

Objective 3 - Work in partnership with our community

Priority ID and reference	3.1. Work with patients, the public and partners to develop services that meet the needs of our community	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	3.1a There is a risk that the Trust will fail to achieve a sufficient geographic and demographic representation of its membership to meet Foundation Trust requirements	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L1 = 4
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1)FT Membership Strategy & Action Plan agreed by Trust Board July 2)WebPages live and online recruitment commenced	1)Delivery of controls

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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 5)Representative membership	Positive (+)FT Project Board engagement with draft FT membership plans (+)Initial proposals for Council of Governors (+)FT Program Manager in place (+)Corporate Governance Officer in place to manage membership Negative (-)FT membership forms in draft

Gaps in assurance	**Assurance Level gained: RAG**
Foundation Trust milestones have yet to be agreed with TDA and delivery of Action Plan	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Develop and implement roll out 2) Agree FT milestones with TDA	1) 30/09/13 2) 30/10/13

Update by	GFM 16/09/13	**Date discussed at Board**	To be discussed at September Board

Objective 3 - Work in partnership with our community

Priority ID and reference	Improve the way people see and talk about SaSH	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	3.2a Failure to engage with local media has a significant effect on the Trust reputation	**Current rating**	S4 x L2 = 8
		Target risk score	S3 x L2 = 6
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1)Board Approved Communications Strategy and action plan 2)Proactive and positive press and media coverage and relationships	Current Communications Strategy not entirely fit for purpose

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Implementation of Communications Strategy & Action Plan 2)Implement outcome of Communications Team re-organisation 3)Positive results of Staff Survey	Positive (+) Proactive national and local media coverage. (+) Positive feedback from Your Care Matters (+) Positive Feedback from Patient Opinion (+) Head of communications in post Negative (-) Minimal adverse media coverage

Gaps in assurance	**Assurance Level gained: RAG**
Communications strategy not yet finalised	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Development and implementation of communications & PR strategy (in draft) 2)Implement Outcome of communications team consultation 3)Communications Strategy to FWC	1)01/11/13 2)30/10/13 3)30/10/13

Update by	GFM 16/09/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.1.Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.1a Failure to deliver income plan	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1479

Controls in place (to manage the risk)	**Gaps in Control**
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) - now augmented (July 2013) with a Finance e sub-group which is discussing forecast outturn on the contract 6) M03 forecast scenarios presented to Board	1) CCG activity plans not fully profiled against their own plans at Jun 2013 - updated - still not done at August 2013 2) Activity in the first three months greater than plan but lack of robust CCG change plans available at August 2013 3) At M04 activity levels remain within the previous trend providing significant pressure on CCG plans.

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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 M04 aligns overall with Trust plan - shortfall in elective activities is noted (+) Overall forecast I&E position is balanced - income covers spend (+) Forecast shared transparently with CCGs - who recognise it, but differ in effectiveness of QIPP plans (+) M01 reconciliation completed - partially - over performance is being paid in cash terms (+) CCGs engaging over LTB community bed scheme - some thaw in dogmatic approach to demand management Negative: (-) Still early in the year to conclude on trends against new CCG initiatives - CCGs clear about delivery in Q2 onwards (-) 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.

Gaps in assurance	**Assurance Level gained: RAG**
(1) Output from M01 reconciliation process (partly completed) (2) Output from resolution of unscheduled care actions with CCG	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
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 M05]; ii) Range of actions on unscheduled care: internal U/S Care Board running, engagement with other providers now part of weekly business - but CCG actions to support unscheduled care actions not yet visible [to Trust] [COO: update at M05]. iii) Discussion with CCGs over adequate CHC assessment arrangements to get those in place in the	Actions proceeding to timetable - no suggestion currently that CCG actions on unscheduled care will resolve.

summer [COO: update at M05] and participation in LTB to expedite actions around unscheduled care. this has progressed since last BAF update and is very live currently iv) Escalation with TDA.			
Update by	PS 04/08/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.1b Failure to stop divisional overspending against budget	**Current rating**	S5 x L3 = 15
		Target risk score	S3 x L2 = 6
		Linked to Risk	1477,1365

Controls in place (to manage the risk)	**Gaps in Control**
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 6) M03 forecast scenarios presented to Board	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 has been replaced by alternative group but still outside PMO process. 3) Specific savings plans risky (Amenity beds, Pathology JV, Digital Dictation) - all subject to particular scrutiny.
Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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 M04 Negative (-) Three clinical divisions overspent at M04 (-) 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

Gaps in assurance	**Assurance Level gained: RAG**
(1) Savings delivery is not proven at M04 (2) Interim budget still in place and no resolution to non recurrent support	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
I) PMO structure will remain in place while savings bed in [PMO is proving effective] (CFO - update at M05]; 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 M05] iii) Decisions on further budget changes delayed (agreed at TDG 5 June, reinforced at Board 25 July) until evidence of corrected position. iv) Escalation to TDA over resolution of non recurrent funding issue - discussed are Board 25 July (CEO - update at M05)	Actions proceeding to timetable.

Update by	PS 04/08/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.1c Unable to provide realistic medium term financial plan	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L2 = 8
		Linked to Risk	1493

Controls in place (to manage the risk)	**Gaps in Control**
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 4) Timetable for refreshed IBP and LTFM is 26 August 2013	1) Decision over non recurrent support is still outstanding

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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 now 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. (+) LTFM submitted to Trust Development Authority 26/08/13 describing viable position Negative (-) Savings and income levels in future years provide extremely challenging targets and the LTFM assumptions are subject to change dependent on activity and income (-) 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 kept at amber [but subject to review]

Gaps in assurance	**Assurance Level gained: RAG**
Review of LTFM (long term financial model) and IBP (Integrated Business Plan) following submission to Trust Development Authority	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Review of LTFM (long term financial model) and IBP (Integrated Business Plan)	1) 30/10/13

Update by	PS 04/08/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	Live within our means both in year and ensure sustainability into the future	**Director responsible**	Chief Finance Officer
		Initial Risk	S5 x L5 = 25
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	**Current rating**	S5 x L3 = 15
		Target risk score	S4 x L3 = 12
		Linked to Risk	1459

Controls in place (to manage the risk)	**Gaps in Control**
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)	No significant gaps in control identified

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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 underlying problem unresolved.

Gaps in assurance	**Assurance Level gained: RAG**
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.	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Day to day cash control is main action currently, coupled with action stop 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

Update by	PS 04/08/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.2. Listen to, value and develop our workforce	**Director responsible**	Director of Human Resources
		Initial Risk	S4 x L3 = 12
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.2a Ineffective staff development means that the Trust does not have the skilled workforce to deliver current and future services	**Current rating**	S4 x L3 = 12
		Target risk score	S4 x L2 = 8
		Linked to Risk	910

Controls in place (to manage the risk)	**Gaps in Control**
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

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1) Implementation Plan report to Finance 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, HEEKSS allocations received and HEEKSS reporting quarterly (+) at least 20% mandatory and statutory training via e-learning (+) improvement in staff and patient survey results. (+) Performance Scorecards 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 Negative (-) e learning take-up hampered by IT and system network issues. (-)Quality of appraisals (-)Monthly reporting by division and staff feedback sessions.

Gaps in assurance	**Assurance Level gained: RAG**
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	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) ongoing review and monitoring of Statutory and mandatory training matrix 2) continued delivery of revised Statutory and mandatory Training programme	1) &2) Matrix being reviewed following UK Skills for Health consultation on delivery of Core mandatory

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			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.
Update by	31/07/2013 JM/SK	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.2. Listen to, value and develop our workforce	**Director responsible**	Director of Human Resources
		Initial Risk	S4 x L3 = 12
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	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	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L2 = 8
		Linked to Risk	910

Controls in place (to manage the risk)	**Gaps in Control**
1) 2012 Staff Survey engagement score improvement from 2011 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) 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 10) GE work with leaders on behaviours and culture	No significant gaps in control identified which are not covered by the action plans in place

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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"	(+)Attendance at team briefs and Senior Leaders Meeting (+) Board Report in June (+)Customer Care programme to be recommissioned (+)Assurance at Investment and Workforce Committee on internal comms strategy (+)Improved feedback from internal communications approach (+) All staff feedback sessions ESH

Gaps in assurance	**Assurance Level gained: RAG**
1) Engagement score improved in 2012 staff survey, now average for acute Trusts, requires long tem actions and commitment to sustain improvement	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
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

Update by	31/07/2013 JM/SK	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.2. Listen to, value and develop our workforce	**Director responsible**	Director of Human Resources
		Initial Risk	S3 x L3 = 9
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	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	**Current rating**	S2 x L4 = 8
		Target risk score	S2 x L4 = 8
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1) Investment and Workforce Committee oversight of Training Plan 2) Board development programme and work with 'Foresight' 3) Ward Managers leadership rolling programme 4) Leadership Strategy - in draft	No significant gaps in control identified which are not covered by the action plans in place

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
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	(+) 200 Senior Leaders trained under Healthskills with different work streams over 2 years (+)GE Clinical leaders programme (+) 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 Service (+) Regular Board seminars, recent Board meeting and observation by Foresight (+) LEAP leadership Programme by KSS Deanery for Medical teaching Faculty now an on-going programme (+) Chiefs and Clinical leads programme with GE programme established (+) Board Development programme commissioned by Dir of Corp Affairs commencing September 2013

Gaps in assurance	**Assurance Level gained: RAG**
1) How to measure leadership training - identifying link between leadership activities and programmes and organisational change	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
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. 5) Leadership Strategy in draft	1) Monitor through Management Board for Performance 2) New Performance Score card measuring quality, patient satisfaction, staff satisfaction and performance

Update by	31/07/2013 JM/SK	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation

Priority ID and reference	4.3. Delivery of agreed milestones to achieve Foundation Trust status	**Director responsible**	Director of Corporate Affairs
		Initial Risk	S4 x L2 = 8
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.3a If the Trust does not progress and deliver its Foundation Trust plans it is unlikely to be able to successfully authorised. This could leave the Trust without local autonomy and could lead to an alternative organisational form being imposed on the Trust. Which could reduce choice and focus on local health provision	**Current rating**	S4 x L2 = 8
		Target risk score	S4 x L2 = 8
		Linked to Risk	

Controls in place (to manage the risk)	**Gaps in Control**
1)BGAF assessment carried and action plan developed 2)Corporate governance framework 3)Foundation Trust project board 4)Timeline agreed with TDA 5)QGAF assessment carried out and action plan being developed	Foundation Trust Task and Finish group not yet embedded

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)BGAF action plan and self assessment 2)LTFM 3)FT Project board 4)FT Project plan 5)Integrated Business Plan 6)Public Consultation 7)QGAF Action Plan and self assessment	Positive (+) Active FT Project Board (+)Draft IBP (+)LTFM (+)Draft membership strategy (+)BGAF action plan (+)Initial QGAF action plan Negative (-)Timeline to be agreed with TDA

Gaps in assurance	**Assurance Level gained: RAG**
Yet to undertake external assessments	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Detailed BGAF action plan developed and currently under review 2) Board Development Programme 3) Membership Strategy 4) FT Programme Manager 5) Draft Foundation Trust timeline to be developed	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 3) Plans are being driven forward by Director of Corporate Affairs 4) FT Programme Manager post being recruited to

Update by	GFM 16/09/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation			
Priority ID and reference	4.4 Ensure that the estate and infrastructure supports our sustainability	**Director responsible**	Director of Information and Facilities
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.4a There is a risk that the Trust isn't able to deliver service in an effective timely manner due to the estate not fully supporting the clinical strategy	**Current rating**	S5 x L2 = 10
		Target risk score	S5 x L1 = 5
		Linked to Risk	969,1092,1431,1494

Controls in place (to manage the risk)	**Gaps in Control**
1) Capital program 2) Investment Workforce Committee 3) Weekly Capital Plan 4) Estates Strategy	Triangulation of all information to support decisions regarding capital spend

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)IT Strategy - Clinical Health Informatics Group 2)All sources of patient feedback 3)Your Care Matters	Positive (+) Front entrance (+)ED refurbishment and recent projects achieved and improvements demonstrated (+)Capital group (+)Theatres refurbishment Negative (-)Patient feedback involving estates issues

Gaps in assurance	**Assurance Level gained: RAG**
No significant gaps identified	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1) Theatres refurbishment 2) Radiotherapy capital work 3) Hospital infrastructure. 4) Electrical supply capacity upgrade	1) 2013/14 2) 2013/14 3) Ongoing 4) 31/03/14

Update by	IM 16/09/13	**Date discussed at Board**	To be discussed at September Board

Objective 4 - Become a Sustainable, Effective Organisation			
Priority ID and reference	4.4 Ensure that the estate and infrastructure supports our sustainability	**Director responsible**	Director of Information and Facilities
		Initial Risk	S5 x L3 = 15
Key Action for 2013/14 objectives and description of any potential significant risk to this priority	4.4b There is a risk that the Trust does not fully realise the benefits available from well embedded IT systems	**Current rating**	S5 x L2 = 10
		Target risk score	S5 x L1 = 5
		Linked to Risk	988,996,999,1502

Controls in place (to manage the risk)	**Gaps in Control**
1) IT Strategy 2) Clinical Informatics Group 3) EPR User Group 4) Various project group (EPMA etc) 5) Internal Audit	1)Investment in Infrastructure 2Insufficient focus on change benefits realization due to financial constraints

Potential Sources of Assurance (documented evidence of controls effectiveness)	**Actual Assurances: Positive (+) or Negative (-)**
1)Efficiencies being delivered through IT enabled change	Positive (+) Improving infrastructure (e.g. WiFi) (+) Development of existing EPR platform (e.g. EPMA)

Gaps in assurance	**Assurance Level gained: RAG**
1)IT strategy not yet fully aligned with overall Trust clinical strategies	

Mitigating actions underway	**Progress against mitigation (including dates, notes on slippage or controls/ assurance failing.**
1)Upgrades for Cerner applications 2)Hospital wide WiFi 3)E prescribing project	1) 31/03/14 2) 31/03/14 3) 31/03/14

Update by	IM 16/09/13	**Date discussed at Board**	To be discussed at September Board