Surrey and Sussex Healthcare NHS Trust Assurance Framework 2010/2011

Detailed Risks

No	Principal Risks	Lead	No Initial Risk	Existing Controls	Assurances on Controls	Positive Assurances	Gaps in Controls
	What could prevent the objective being achieved?			What controls/systems do we have in place to assist in securing delivery of this objective? (After controls have been considered)	Where can we gain evidence that our control systems on which we are placing reliance are effective?	We have evidence that shows we are reasonably managing our risks and objectives are being delivered.	Where are we failing to put controls/systems in place
Domain 1							
Objective							
1.1.1	Patients could experience avoidable harm due to lack of ownership of a coordinated approach to patient safety at specialty level	RH/ VC	S5, L5 = 25	1. Individualised patient risk assessments are completed routinely on admission and evaluated throughout to minimise each patients risk. 2. Trust wide groups in place focusing on reducing avoidable harm through implementation of best practice and learning from events e.g Falls group, Nutrition Group, Medcines Safety, infection control. 3. Clinical audit, observational audit, clinical areas inspections, nursing Quality Standards Framework measure and identify any areas of concern for action. 4. Trust policy and procedure for responding to external agencies, reports and inspections leads to action planning monitored for completion of actions. 5. External scrutiny and accountability meetings with the both PCT's involving senior clinicial staff.	1. Clinical audit of policies, record keeping standards alongside the Quality Standards Frame work and PCT clincial audit of SASH standrads. 2. Quality and Performance dashboard reports a wide range of safety, clinical effectiveness and patient experience measures to the board. There is exception reporting and action planning in place for any underperformance. 3. Action planning in response to identifying areas for improvement are part of the quality processes in place. 4. External inspections, reports and action plans are monitored by the Management Board and reported onwards to Trust Board 5. Monthly CQPM meetings with PCTs where action outcomes are followed up and only closed once performance meets required standards.	1. Quality Standards Framework audits evidence that risk assessments in place. CQC reactive review supported that risk assessment and care planning was in place. 2. Quality and Performance dashboard evidences infection control performance is exceeding expected targets, mortality rate is below 100, NICE compliance is >95%. 3. Improved performance with Venous Thromboprophylaxis, the WHO operative checklist. 4. CQC compliance review evidences that Trust is compliant with regulations inspected with minor concerns for improvement. MHRA inspection has signed Trust as compliant with the Blood Safety Quality Regulations. 5. CQPM meetings evidence areas of improvement.	1. Patients are not being routinely involved in their risk assessment and care planning. There is no nursing documentation policy in place currently. 2. Work plans and improvement targets are not set for all Trust groups focusing on reducing harm. Division clinical governance systems are still maturing. Deep Dive governance scrutiny process is embedding and focus needs to move to delivery of agreed improvement trajectories. 3. Coordination of various workstreams 4. Divisional governance systems are still maturing. 5. No gaps identified
Objective							

1.2.1	Lack of understanding of the breadth and depth of the hygiene code	RH/VC	C5,L4 = 20	1. Comprehensive training, education, audit, monitoring and reporting framework in place.	Outcome measures reported to the Trust Board for infection control clinical care, patients affected by specific organisms and patient feedback on cleanliness as part of the Quality and Performance Dashboard. Clinical audits and progress with work plans from IPCAS and Infection Control Taskorce reported monthly to the Management Board for Quality and Risk.	Trust is achieving all stretch targets for reducing infections. Audit of cleaning standards evidences improvements CQC compliance review February 2011 evidences staff able to discuss auditing at ward level	Escalation bays in a small number of wards reduce the bedspace below the stdnards set in guidance with the potential for increased risk of infection control issues.
Objective							

1.3.1	Patient outcomes will not be improved due to limited local information being available to engage clinicians in quality improvements and a lack of embedded processes to manage delivery.	RH/VC	C2, L4 = 8	1. The Quality and Performance dashboard provides benchmarked comprehensive outcome measures alongside system measures for quality and operational performance and patient satisfaction feedback to report on progress in achieving the objectives for 2010/2011. 2. The exception reporting and action planning process informs on actions to address under performance to achieve the required standard. Follow up monitoring is achieved through the Quality and Performance Dashboard being a standing item at each Trust Board meeting. 3. Progress with achiveing the Quality Account Improvement priorities 2010/2011 is reported to all Trust Board meetings through outcome measures included in the Quality and Performance Dashboard. 4. The Quality and Performance dashboard, key performance indicators, scheduled and ad hoc reports, investigation, external reviews and inspections and patient feedback is reported at Management Board and Divisional levels within the organisation to identify actions to address areas of under performance. 5. There are Trust wide systems in place to ensure informati 6. The new Clinical Services organisational structures, roles	Quality and Performance dashboard against national, regional and contractual measures evidences that a number of measures are meeting or exceeding the required standard. 2 and 3. Monitoring of the effectiveness of the actions identified in Exception Reports is achieved through submission of an updated Quality and Performance Dashboard at each Trust Board meeting evidencing whether there has been any change in achiveing the required standard since the action was implemented. 4. Management Board decisions and actions taken in response information reviewed and issues reported are monitored to completion. Division processes for improving clinical governance are scrutinised at the Division Deep Dive meetings 5. Reports and external data produced contains includes the Trust's performance benchmarked against other providers for all quality indicators - safety, clinical effectiveness and patient experience. 6. Scrutiny of clinical governance performance through setting improvement trajectories for key quality measures.	1., 2 and 3. All green and blue quality and performance measures within the Quality and Performance Dashboard are achieving or exceeding the benchmarked standard. 4. Audit and Assurance Committee programme of Management Board scrutiny and internal audit programme provides independant evaluation of quality systems. 5. National reports evidences how the Trust is meeting quality standards compared to similar organisations and how quality has changed year of year 6. Division infrastructure in place including leadership and sernior roles, meeting structures and business planning leading to imrpovements.	1 and 2. Process for identifying new indicators and removing indicators is not in place 3. Process for identifying Quality Improvement priorities which involves the organisation and consulting on these with external stakeholders is not in place. 4. Standardised TOR for Divsion and specialty quality and risk forums are not approved.
Domain 2. Better Information, More Choice							
Objective 2.1 Increase efficiency and effectiveness by ensuring access to appropriate information systems							

2.1.1.	Risk of criminal charges / claims against staff and the Trust due to failure to obtain legally valid consent for patients with mental capcity issues due to limited embedding of updated consent requirements.	RH	C5, L5 = 25	1. Consent Policy. Consent Training. 2. Mental Capacity Act stautory and mandatory training all staff groups. IMCA referral processes and safeguarding alerts 3. Safeguarding procedures in Surrey and Sussex. Safeguarding and mental capacity training programmes in place. 4. Mental Capacity Training is a mandatory element in the annual Consultant appraisal process	1. Consent Audit. 2. Statutory and Mandatory training compliance figures. 3. Incident reporting, complaints and claims information. Safeguarding alerts. Staff awareness surveys 4. Compliance with Consulatnt appraisals	1. Consent Policy audit 2010 showed generally high levels of compliance . Core trainee medical staff (above Foundation level) receive consent training at core induction. FY1 medical staff are prohibited from obtaining consen. They have MCA exposure as part of their training programme. 2. High nursing staff attendance at Safeguarding training. 3. High number of referrals to IMCA's for best interests assessments. Low numbers of complaints and incidents reported raising concern.	1. Policy being implemented - audit planned for September 2011 2. There is variable compliance with Mental Capacity and consent training across staff groups. 3. No gaps 4. Consultant training to be scheduled into the audit half day programme.

2.1.2	A lack of organisational engagement will not allow the Trust to take advantage of the benefits that clinically focussed Information Systems can deliver	IM	C4, L3 = 12	1. SPfIT Programme Board in place and project plan being developed for Millennium Upgrade. 2. Formal Trust CRS Board, chaired by CE, and Project Team well established. PID signed-off and budget for 2010/11 established. 3. Director lead and Project Manager in place. 4. Trust is part of Southern Programme for IT (SPfIT) governance structures.	1.Formal Cerner Project Management includes Gateway sign-off by Trust, SHA and BT/Cerner. 2. Reporting to Project Board and Management Board and Board. 3. Directorate reporting and management. 4. External monitoring through SPfIT live-sites executive and SHA deployment Board.	1 and 4 Formal Gateway process monitors project delivery. 2. Budget monitored through Project Board and Directorate reporting. 3. Clinical Lead for IM&T Appointed and in Place. New Clinical Advisory Group in place	No Gaps as system now live
Domain 3: Easier Access and Shorter Waiting Times							
Objective 3.1 Consistently deliver all patient access and contractual targets							

3.1.1	Current capacity constraints to deliver planned levels of activity, potentially combined with increased demand above the indicative activity level, resulting in further demands on the current capacity, which could lead to an inability to deliver emergency or planned treatment of patients in a timely manner, impacting on patients care, inability to deliver access and contractual targets and impact on the Trusts reputation.	BB	C4, L5 = 20	1. Pro -active review and decision leading to action in all pathways; emergency, elective and cancer with appropriate and robust monitoring of outcomes through the Clinical Ops meeting dashboard. 2. Implementation fo the day case strategy delivering increased capacity at Crawley Hospital. 3. Chief Operating Officer forums with the Clinical Leads and Associate Divisional Director of Medicine. 4. Active external partnership working to improve delayed trasnefers and release capacity. 5. DH 18 week team working with the Chief Operating Officer.	Monthly performance reports evidencing compliance and areas requiring additional work. re the targets. Weekly review processes in place. Divisional meetings. Weekly Executive scrutiny meetings with the divisions.	Monthly performance reports and quality dashboard, which includes performance and quality indicators, e.g. re-admission rates, access targets. 18 week delivery. Have achieved cancer two week rule and two week symptomatic breast cancer for second month running.	Inability to flex capacity up toaccomodate surges in activity and variance in discharges and patient acuity. Inbalance between daily admission and discharge numbers. Discharge activity begins too late in the day to accomodate demand profile. Physicians resource available out of hours is not meeting patient demand. Significant ED medical staffing gaps.
Domain 4. Revitalising our Environment							
Objective 4.1 Ensure Best Possible Access to East Surrey Hospital							
4.1.1.	Risk of reputational damage as a result of poor access to site impacting negatively on patient and visitor experience.	IM	C2, L4 = 8	1. Over provision above minimum requirements for Blue Badge Parking. Site signage upgraded to meet Wayfinders standards. Improvements to road markings, safety lighting to meet requirements arising from HSE inspection. 2. Ongoing dialogue with the local authroity planning department - partnership working on options for green travel and increasing capacity. Existing strategy.	1. Daily inspection by car parking attendants of usage. Monitor patient complaints and feedback for thematice analysis of user experience related to access. Trust internal user group meetings and actions which addresses patient experience in a syatematic way. Board reporting through the Capital Investment Group reporting system. Green travel plan encourages car share, cycling and public transport use. 2. Active participation with stakeholders (local authority, social services etc) in North East Region Travel Group.	1. Low levels of complaints and PALS received from service users. HSE phase 1 recommendations are complete. Funding secured to implement phase 2. Partnership working with local authority and stakeholders evidences positive relationship and partnership in resolving access issues.	Capacity, resource and specialist skills requirement cannot be fully met within the Trust. Exisiting strategy needs revision to identify options needed to support Trust business and to take accoutn of people whose access to public transport from Crawley locality puts them at risk of a longer journey. Phase 2 has not currently commenced.
Objective 4.2 Provide services in modern, well equipped facilities							

4.2.1	Inability to progress capital projects in a timely manner due to competing operational demand, finance, internal stakeholder engagement and internal project management capacity to continuously improve the quality of the built environment.	IM	C4, L4 = 16	1. Capital Programme delivery monitoring and reporting through the Performance Committee. Capital spend priorities are predicated on a matrix which ensures risk, patient safety, patient experience and market forces are assessed during prioritisation. 2. Savings delivery programme and infrastructure in place. Estates strategy in place.	1. Capital Group, Internal Audit, SHA, Audit Commission, PEAT scores, Patient Surveys, Business cases include risk assessments. 2. External MAE Consultant commissioned to survey and prioritise all investment within the estate engineering infrastructure. Director of Clinical Services is a member of the Capital Investment group to inform operational impact.	1. Paradigm of 'internal client' for capital programme projects to ensure effective engagament and involvement at all stages PRINCE 2 methodolgy in place for capital programme projects. Board reporting. 2. Trust legal services engaged in optimising income in year from sale of assests. ALE assessment 2009/10.	1. Capital programme expenditure reliant on income from sales of assests which may deliver after March 2011. Risks and liabilities of the engineering infrastructure currently undefined. Financial climate provides insufiicient funding to progress all capital projects. Medical Device s replacement and purchase requests exceeded funding available. Clinical Directorates use of risk register to support business planning and requests for capital funding needs to be developed further. Increasing age of Estate leading to patient safety issues should major plant fail. 2. Estates strategy review reliant on agreed clinical strategy to support Trust services.
Objective 5.1 Ensure the Trust is highly regarded within its local community							
5.1.1	By not being well regrded within our local community there is a risk that we will not be able to understand the needs of our local community and ensure that they are met	FR	C3, L4 = 12	PPI Policy, Equality Policy, HR Strategy, Communication Strategy. Director of Communications appointed.	Patient surveys, staff surveys, community consultations, NHS Choices, complaints, compliments process, PALS, Real Time Monitoring, media coverage.	November patient surverys % of patients who would definetly or probably recommend SASH - chemo suite and Comet ward 100%, Crawley Day Surgery 100%. Community Survey June/July 2010 - % of people who rated ESH as good, very good or excellent; 63% Redhill, 93% Crawley.	The Trust reputation is closely aligned to performance so we need to ensure that we are consistently meeting our objectives and that we communicate this. No budget to do further surveys.
Domain 6 An Effective Organisation							
Objective 6.1 Develop a motivated, trained and developed workforce							

6.1.1	Risk to service users and the reputation of the organisation due to a failure to ensure appropriate support to the workforce to ensure delivery of the organisations business to the required standards.	YP	C5, L4 = 20	1. Staff wellbeing group delivering a work programme to improve staff satisfaction. 2. HR business partners are aligned to each directorate in relation to skill mix, vacancy rate and substantive establishments. 3. Annual Business planning cycle supports the Directorates in establishing the resources required to deliver their services. 4. First Care reporting to all line managers. Framework in place recording all training activity.	1. Reporting to the Management Board for Quality and Risk from the wellbeing group on progress with action pLan. Visions and Values staff engagement consultation. Education, training and development programme. 2. and 3. KPIs for vacancy rate, skill mix, use of temporary staff are key performance indicators monitored through the monthly Directorate Performance Review process and reported to the Trust Board at its Performance Committee. 4. Training KPIs in place for statutory and mandatory training and professional development which are reported to Performance Committee.	1. Staff survey 2010/11 demonstrates improvements in some areas of staff satisfaction. 3. Nursing business planning resoruce undertaken using a nationa tool to robustly identify resoruce requirments.	2, 3, 4. Organisational Development strategy not in place. 2,and 3 CQC Regulation 23 'supporting workers' is compliant with the understanding that the action plan will be achieved by March 2011. Directorate reporting of appraisal and PDP.
Objective 6.2 Achieve all financial targets							

6.2.1.	Income: Reduced levels of activity, increased levels of activity not paid for, lack of service agreements for non Contract activity or non achievement of Contract quality targets lead to failure to secure sufficient income.	PS	C4, L3 = 12	1. Business plans and budgets (activity & financial), financial, performance, quality and contractual reporting, signed PCT Contract, other service agreements. 2. Clear Director & senior manager responsibilities, SFI requirements on Trust staff (around actions that impact income), service line reporting. 3. Contract management (Contract Team) and data integrity (Information Team).	1. Financial, performance, quality & contractual reporting to Management Board, Perf Committee and Board. CQUIN reporting process including operation of EQ & CQUIN Group. 2. Performance Review process with Directorates. Monthly Contract cycle with PCTs (including clinical quality review where SaSH Directors account for performance). Service line reporting process. 3. Outputs and reporting from Contract & Information Teams.	a) Planned levels of activity, performance & quality achieved or exceeded b) Income exceeds budget c) Minimal loss of income from contract challenge or disputes	a) Lack or poor quality of service agreements for non Contract income (including in particular with community services) *Note: data quality risk removed: the Trust is now operating robust data quality processes that have impacted favourably on level of income challenge - reported to AAC in Sept.*
6.2.2	Costs & savings: Spending above budgeted levels from realisation of risk, impact of currently unknown factors or non delivery of budgeted savings plans leads to increased cost, failure to reduce cost base and restricts flexibility to manage quality investment.	PS	C4, L4 = 16	1. Performance reporting and related action planning within Directorates and at Perf Reviews. Business plans and budgets, PMO monitoring, 2. Clear Director & senior manager responsibilities, SFI requirements on budget managers and budget allocation processes (that can withhold or provide additional budget). 3.Procurement strategy . Exec sign off of robust recovery plan.	1. Directorate reporting and management. Financial & Performance reporting to Management Board, Perf Committee and Board. Performance Review process with Directorates with active development of action plans, monitoring at working level, with summary reporting. 2. Output and reporting from Finance Team. 3. Procurement reporting and processes.	a) Financial performance within budget (costs within cost budget or set off by income) and availability of contingency b) Financial savings delivered against plan and availability of contingency c) Operational & quality delivery maintained	a) Executive level recovery plan pulling together recovery actions from all sources b) PMO savings plan for 2010/11 and into future years

NEW 6.2.3	Liquidity : Inability to pay creditors resulting in non delivery of essential services and goods due to poor liquidity ratio	PS	c5,I5= 25	1. Bi-weekly review of forward cash flow by finance team and FD 2. Monthly discussions with SHA on solution to cash pressures	1. Positive cash balance reported each month in Board report 2. Further cash injection secured	a. Positive cash flow reported for every month in 2010/2011 b. SHA emgagement in options for securing income c. no serious creditor on stop issues experienced	
Objective 6.3 Develop a long term clinical model for the Trust							
6.3.1	Current NHS agenda - FT legisltaion, network Trust working arrangements, care closer to home agenda etc - generating constant revision to clinical strategy	RH	C4, L4 = 16	1. Wide ranging review of clinical strategy continuing - led by CEO/MD/CN/COO with support from clinic Division Chiefs and Clinical Leads. 2. SHA scrutiny and assitance in place.	1. and 2. Working in partnership with community and partners to embed the clinical strategy around safety and quality. Consultant Job Plannng progressing to suppport strategy.	1. Regular reporting to Trust Board 2. Startegy is being preented to the Trust Board March 22nd	1. Detailed referece cost data for speciailities not yet avilable. 2. Programme Board and Clinical Reference Groups constantly reviewing 'fit' with wider health economy - lags behind
Objective 6.4 Move to a clinically led management structure.							

6.4.1	Risk of key decisions being made without sufficient clinician input due to lack of engagement of frontline clinicians.	BB / RH	C4, L3 = 12	1. Division infrastructure for clinical leadership supported by senior managerial expertise is in place. 2. Meeting structures and focus re-aligned to promote effective ward to Board reporting	50% clinical membership at every meeting of management board for decision making purposes. Clinical leads identified for all transormation work streams as approrpaite. Clinical involvement in review of clinical space and capital projects. Clinical Chiefs meeting weekly with Medical Director	Regular attendance at management board. Medical engagament in Medicine and Women and Child Health Divisions in governance. Monthly Division Deep Dive reporting and scrutiny which involves clicnicians, managers and senior nursing staff.	Divisional Boards operational policies currently being discussed with the divisions.

Gaps in Assurances	Residual Risk rating	Action Plan	Links to Regulators
Where we are failing to gain evidence of our systems, on which we place reliance, are effective		What are we doing to reduce the principal risks?	
1. Comprehensive audit of nursing assessment and care planning. 2 + 3 . Reporting on improvements from Divisions is variable - improvement trajectories not set in each division 4. No gaps 5. No gaps	S4,L4 = 16	1. Analyse and identify actions to support Patient Safety Strategy implementation following staff survey. 2. Approve the Patient Safety Strategy and work plan for implementation 3. Identify improvement trajectories for reducing avoidable harm for each Division to devlier. 4. Implement a Division infrastructure to support embedded clinical governance by developing a structured cohort, based on specilaties, of senior clinical staff who are trained and have skills to deliver quality and safety imrpovements - including RCA training (April 2011) and After Action Review training. 5. Submitting a business case to procure training for a cohort of clinical leaders in After Action Review process 6. Finalise and approve TOR for Divisional quality and risk meetings and consult on TOR for specilaty quality and risk forums. 7. Develop quality and performance dashboards, information and reporting at divisional and specialty levels to embed the new structures.	DH performance Framework, CQC Registration, ALE, PCT Contract

Very High Risk areas are not consistently achieving the 98% compliance with NPSA Cleaning Standards (current performance is 96-97%) New MRSA BSI bring total for year to date to 4.	C4, L2 = 8	1. Conduct Root Cause Analysis investigation for new MRSA BSI with actions to reduce risk 2. Risk assessments completefor all escalation areas to inform on relative risks associated with each area and revision of esclation policy to deliver need of service users and minimise risk. 3. Implementation of actions in each very high risk area to meet 98% cleaning standard and sustain improved performance.	DH performance Framework, CQC Registration, ALE, PCT Contract

Division clinical governance processes are not yet fully embedded at specialty level.	C2, L4 = 8	1. Identify improvement trajectories for reducing avoidable harm for each Division to devlier. 2. Finalise and approve TOR for Divisional quality and risk meetings and consult on TOR for specilaty quality and risk forums. 3. Develop quality and performance dashboards, information and reporting at divisional and specialty levels to embed the new structures 4. Approve TOR and repoting schedule for the new Quality and Safety sub committee of the Trust Board.	DH performance Framework, CQC Registration, ALE, PCT Contract

Evidence from PMETB that current consent policy not followed consistently. Internal consent audit demonstrates poor compliance. Implementation of the consent policy	C4, L3 = 12	Consultant training scheduled into rolling half day audit programme.	DH performance Framework, CQC Registration, ALE, PCT Contract

No material Gaps in assurance	C2. L2 = 4	Cerner Millennium Upgrade went Live 28th January 2011.	DH performance Framework, CQC Registration, ALE, PCT Contract

No improvement in the ED 4 hours access standard.However we have seen a reduction in the number of escalation beds required.	C5,L5 = 25	1. Further develop the rapid access and treatment model . 2. Implement joint clinical board rounds to create early identification of capacity. 3. Complete a comprehensive capacity and demand review to idenfity any further gaps for action. 4. Implement the rapid access / a,bulatory model at Caterham Dene to decrease demand at SASH. 5. Implement the revised Urgent Treatment Centre and ED pathways to focus clinical activity in the most appropriate area. 6. Implement the 18 week action plan. 7. Develop the Trust Hospital at Night / Out of Hours team	DH performance Framework, CQC Registration, ALE, PCT Contract
Communication management plan throughout the strategic review process and on implementation of the way forward.	C2,L4 = 8	Continue progressing agreed work programmes.	DH performance Framework, CQC Registration, ALE, PCT Contract

Estates strategy review. PAMS not currently in place. Helpdesk system for accessing and reporting repairs (reactive) is not fit for purpose.	C3, L3 = 9	Deicated Head of Capital in place. Developing a long term financial model for capital expenditure. Dedicated capital project managers now being put-in-place. 2011/12 capital programme being signed-off in March 2011. New Business Case process being agreed and implemented	DH performance Framework, CQC Registration, ALE, PCT Contract
November patient surveys: % of patients who would probably / definetly recommend SASH (target 95%) Discharge Lounge 92%, Inpatient Wards 86%, Outpatients 87%, NHS Choices 44%.	C3, L3 = 9	CEO active engagement with community including local media. Staff communication sessions in place alongside weekly reports to all staff. Partnership working in place with stakeholders.	DH performance Framework, CQC Registration, ALE, PCT Contract

1. Annual staff satisfaction survey provides the Trust Board with minimal opportunity to measure the impact of actions and improvements need to be viewed over more than one business planning cycle. 3. Ownership at local level to deliver required compliance with appraisal and PDP. 4. Lack of space to deliver the statutory and Mandatory training programme will restrict capability of staff to achieve their required training to 60%.	C5, L4 = 20	Deliver Leadership programme to first cohort of senior managerial staff. Recruit to vacant Education and Training posts - following restructure Develop appraisal process to deliver timely information for managing compliance with Policy	DH performance Framework, CQC Registration, ALE, PCT Contract

a) Activity plans owned & operated at specialty level b) Directorate level accountability processes for activity & income	C4, L1 = 4	1. Community service agreements reviewed as part of recovery plan - completed October 2010 one risk of £0.2m identified and escalated to Financiaol Officer to resolve. 2. Agreement reached with PCT's to confirm income receivable in 2010/2011 in January 2011. Likelihood therefore reduced to 1. 3. Robust operation of challenge process with PCT's and internal process to minimise risk against delivery of contractual targets is a continuing ongoing action.	Audit Commission will check delivery, assurance on controls and assurance for ALE
No material gaps in assurances - reporting processes allow for judgements on evidence presented.	C4, L3 = 12	1. Risk of Trust not delivering forecast now mitigated significantly by agreement over income levels with PCT's. 2. However further overspending in Divisions requires continual control: a. Action plan process with refreshed forrecasrs due at M11 (20 Feb) b.Chief Financial Officer has written to overspent Divisions about accountability. c. Chief Financial Officer looking at contingency to cover overspends from accountancy measures	Audit Commission will check delivery, assurance on controls and assurance for ALE

No material gaps in assurances - reporting processes allow for judgements on evidence presented.	C5, L5 = 25	Awaiting feedback from SHA concerning a central solution to liquidity issue.	Audit Commission will check delivery, assurance on controls and assurance for ALE
Some speciality positions in context of wider agenda uncertain	C4, L2 = 8	Continue close working with Commissioners and SHA. Develop the revision process for the in house clinical model in response to wider NHS change.	DH performance Framework, CQC Registration, ALE, PCT Contract

Clinical engagement in surgical division governance meetings.	C2, L2 = 4	Continue to engage and embed the model.	DH performance Framework, CQC Registration, ALE, PCT Contract