TRUST BOARD IN PUBLIC	Date: 29th November 2012 Agenda Item: 5.1
REPORT TITLE:	Board Assurance Framework
EXECUTIVE SPONSOR:	Gillian Francis-Musanu Director of Corporate Affairs
REPORT AUTHOR:	Colin Pink Acting Head of Integrated Governance and Quality
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Audit and Assurance Committee (13/11/12)

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 eight risks to the trusts strategic objectives.

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

- Are the risks descriptions appropriate
- Does the board agree with the assurances; and
- 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 – 29TH NOVEMBER 2012
BOARD ASSURANCE FRAMEWORK

1. Introduction

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

The Trust has identified four main objectives:

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

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

2. Current status

The BAF (attached) details a total of 24 significant risks to the four Trust objectives (9 risks for objective 1 and objective 4; and 3 risks for objective 2 and objective 3).

Objective	Red (15-25)	Amber (8-12)	Green (1-6)
1. Deliver safe, high quality, coordinated care	2	5	2
2. Ensure patients are cared for and cared about	1	2	0
3. Work in partnership with our community	1	2	0
4. Become a sustainable, effective organisation	4	5	0
Total	**8**	**14**	**2**

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).

All risks have been reviewed by an appropriate member of the executive team. The BAF was reviewed at the November 2012 Audit and Assurance Committee. The risks identified in the BAF are being aligned with those on the Trust Risk Register.

3. Key risks Identified

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

I) 1.1b: Failure to reduce non-elective demand (risk to Objective 1).

II) 1.1f: Failure to meet national health care acquired infection reduction targets (risk to Objective 1).

III) 2.1a: Inability to improve patient perceptions of care (risk to Objective 2).

IV) 3.1a: Inability to develop and deliver cross organisational services and pathways (risk to Objective 3).

V) 4.1a: Failure to deliver income plan (risk to Objective 4).

VI) 4.1b: Failure to stop divisional overspend (risk to Objective 4).

VII) 4.1c: To produce realistic medium term financial plan (risk to objective 4).

VIII) 4.1d: Liquidity and subsequent payment issues (risk to Objective 4).

4. Changes since last iteration

Grading	August Board	November Board
Red	10	8
Amber	14	14
Green	0	2

Risk reduction to green: Two risks have been assessed and the current risk category changed to Green (1.1d Safety Thermometer Implementation and 1.3 Medical Workforce in the ED). The safety thermometer has been rolled out throughout the Trust and it is felt that this is no longer a key risk to the objective. All vacancies in the Medical Workforce in the Emergency Department have been resolved.

Risk reduction to amber: One risk has been assessed and the current risk category changed to amber. (1.4a Trauma unit accreditation).

There are further changes to the document which detail increase in the levels of controls or assurances. Of note **4** priorities have had significant work to reduce the risks identified but have been affected by events and new information namely:

- 1.1a - Failure to improve mortality: Affected by the hospital standard mortality ratio's (HSMR) data for chronic obstructive pulmonary disease (COPD). New mitigating actions are underway.

- 1.1f - HCAI target rates (MRSA BSI is still significant risk to this priority, CDI improved)

- 3.1a - Cross organisational pathways (4 plans developed with partners, all stalling externally)

- 4.1c - The Trust has developed a medium term financial plan. This risk was discussed at the Audit and Assurance Committee and it was felt that the risk should remain red because of the overall financial position

5. Recommendation

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

- Are these risks descriptions appropriate and does the Board agree with the assurances for each risk as presented?
- Are the mitigating actions acceptable for the target risk score?

The BAF will continue to be updated throughout the year and be presented to the Board at the March 2013 meeting.

Colin Pink
Acting Head of Integrated Governance and Quality
November 2012

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
Objective 1 - Deliver Safe, High Quality, Co-ordinated Care																
1.1. Achievement of national best practice in clinical care	1.1a Failure to improve mortality, particularly NOF	Medical Director	**S5 x L2 =10**	1) Regular review of Dr Foster alerts 2) Regular review mortality rates and COPD in clinical services 3) Standardised mortality review process 4)Mortality group established (see link with Risk 1192, 1055)	1) Limited numbers of pathways linking Trust to external services	1) HSMR 93% 2) KPI stroke monitored 3) Discussions and actions taken at mortality review meetings 4)Full review of #NOF cases presented and monitored by MBQR	Positive (+) HSMR below 100 (+) Falling standardised mortality (+) Within expected moratlity rate for stroke care Negative (-) Mortality alert for Fractured Neck of Femur. (-) Access to specialist beds (-) High HSMR for COPD		First report from Mortality group to SQC yet to be presented	**S5 x L2 =10**	1) Healthcare of the elderly strategy 2) Considering attaching orthogeriatrics to Surgery ward rounds 3) Increasing Jnr Dr Support 4)Implement system of alerting orthopaedic wards when at arrival at ED 5) Strengthening respiratory Team Consultant post 6) Agreeing COPD pathways and reviewing enhancing quality programs	1)Review and report on effectiveness for SQC 2)Healthcare of the Elderly Strategy underway	DH 05/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S5 x L1 =5**	November Board
	1.1b Failure to reduce non-elective demand	Chief Operating Officer	**S5 x L5 =25**	1)Revised ED arrivals process which provides senior decision making earlier in the attendance facilitating early streaming to correct specialty 2)Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed 3)Executive review and action arising from weekly ED dashboard review 4)Intentional Rounding in ED embedded to maintain safety 5)All escalation areas have identified Matron responsible and patients have nemed Consultant. All patients reviewed daily at clinical operations meeting 6)Daily 8:30management meeting in Ed to review previous 24 hrs and plan for day ahead a	1) Currentley running with 7 locum / agency middle grades and 1 consultant vacancy	1) Combined weekly Quality and Performance Dashboard for ED reporting on a combination of quality and safety standards and the ED national indicators reported to exec meeting weekly 2) Safety and Quality Committee dashboard 3) Performance Management Framework and reporting to Trust Board 4) RTM data on patient experience in all clinical areas 5) External stakeholder inspections 6) Daily 9am performance review meeting 7) Capacity sheets updated three times a day 8) Daily winter Sit Reps (Commenced November)	Positive (+) Sustained Medical outliers in SAU decreased since start of calander year (+) Sustained decrease in cancelled elective procedures (Dec 11) (+) Significant reduction in 12 hour breaches (sustained) (+) SHA external review provided positive assurance on safety and quality (+) Fewer medical patients in surgical beds (+) Below 3.5% target agreed with DTOC consistently (+) >95% Weekley ED performance since April 2012 Negative (-) Quality indicators for time to assessment and time to t		Continue to displace surgical beds (rate dropped to <20 beds daily)	**S5 x L3 = 15**	1)Demand management plans with local health economy agreed but delay in all 4 major schemes starting 2)Phase 2 of ambulatory care pathway commenced (further 11 pathways) 3)As part of a wider patient flow work stream look to develop a reduction in length of stay program 4)Winter plan agreed and being adopted, including new escalation processes (ICT), winter plans circulated	1)Reduction in demand/activity is not supported/indicated by data 2)Phase 2 pathways being implemented but yet to make significant impact on admissions, preventing creep but not reducing number	BE 07/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S5 x L2 = 10**	November Board
	1.1c Failure to comply with regulator expectations	Chief Nurse	**S4 x L4 = 16**	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 1167)	1) Staff understanding of their responsibilities under the Care Quality Commission regulatory framework remains poor	1)CQC and external stakeholder inspection reports 2)Patient Experience feedback all sources 3)Organisational Patient Safety Incident Reports from the National Patient Safety Agency benchmarking the reporting rates and types of incidents 4)Quarterly internal incident reports 5)Internal Audit reports 6)Audits of nursing assessment and care plan tool 7)Patient experience reporting to Trust Board and Safety and Quality Committee. 8) Nursing audit framework includes Essence of Care Benchmarks 9)Division action planning following mock CQC inspections, surveys and clinical Friday working. 10)Nursing audit framework includes Essence of Care Benchmarks	Positive (+) SHA clinical review (Jan 12) - no safety concerns (+) CQC feedback (Jun 12) no safety concerns positive comments (+) Registration status with CQC shows no concerns (+) CQC reactive inspection (Feb 2011) found Trust compliant with all standards inspected (related to Dispatches Investigation) (+) Facilities Cleaning Audit (+) Matrons infection control audit Negative (-) CQC Risk profile shows areas of concern		1)Process of review for Provider Compliance Assessments 2)Triangulated reporting Complaints, Risks and Audits	**S4 x L3 = 12**	1)implement PEAT action plan arising from most recent inspection 2)Continuing with the development and introduction of ED operational standards and the enhancing nursing skill mix and competency. 3)Review nursing documentation 4)Review provider compliance assessments 5)Review compliance monitoring system	1)Recent PEAT results very encouraging 2)Nursing documentation reviewed updated and in place 3)Nursing documentation group functioning 4)PCA review commenced 5)Policy for monitoring CQC compliance in draft, procedure agreed in principal	CP 08/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S4 x L2 = 8**	November Board
	1.1d Failure to establish the nursing safety thermometer effectively	Chief Nurse	**S4 x L3 = 12**	1)Fully implemented Trust wide across ahead of target (see link with Risk 1055)	1)New inclusion criteria published 02/11/12 (Labour ward and Theatres Recovery)	1)Reports available	Positive (+)All ward areas collecting data and uploaded			**S4 x L1 = 4**	1)Ensure new areas are included in Novemeber data	1)New areas aware of requirement and will collect data for November submission	06/11/12 SB	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S4 x L1 = 4**	November Board
	1.1e Workforce not performing to required expectations at point of care	Chief Nurse	**S4 x L4 = 16**	1)RTM and other patient experience information with local action planning 2)Policies and procedures clarify staff responsibilities 3)Professional Registration requirements 4)Clinical effectiveness audit teams (Weekley audits) 5)Clear managerial and clinical structures in place with single point accountability through the Chiefs of Service 6)Divisional action plans in place addressing patient experience feedback (see link with Risk 1171 and 1170)	1)Multidisciplinary working practice on ward rounds and for discharge is not standardised and embedded across the Trust; 2)Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU 3)Compliance with completing the audit programme varies across the divisions.	1)National Staff Survey measures of staff engagement / opinion on fairness of reporting / incident management. 2)Observatory and Safer Smarter Care data 3)Patient Experience feedback all sources 4)Vacancy rates and workforce information reported to Trust Board 5)Audits of nursing assessment and care plan tool 6)Benchmarked performance in EQ, Safer smarter nursing, care pathways 7)Division action planning following mock CQC inspections, surveys and clinical Friday working. 8)Appraisal compliance rates 9)Dr Foster data 10)Clinical audit reporting	Positive (+) CQC verbal feedback (Jun 12) (+) CQC reactive inspection (Feb 2011) found Trust compliant with all standards inspected (related to Dispatches Investigation) (+) Appraisal rate improving across the Trust >70% (Dec 11) (+) 80 managers trained in appraisal (+) SHMI (+) Observatory and Safer Smarter Care data shows imp		1)Divisions are not consistently reporting evidence of change from learning. 2)Lack of audit or review of evidence of Locum/temporary staff competency and reporting of performance during shift/s.	**S4 x L3 = 12**	2)Ongoing implementation of a wide ranging action plan, as part of clinical effectiveness implementation plan for approval, to drive up compliance with clinical audit programme. Audit plan being monitored by the Safety and Quality Committee. 3)Education programme - Dementia 4)Recruitment Centre to assess level of competence 5)Irish recruitment - Wk commencing 05/11/12	1)Clinical effectiveness audits in place 2)Dementia programme commencing	06/11/12 SB	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S4 x L2 = 8**	November Board
	1.1f Failure to meet national targets to reduce HCAI	Medical Director	**S5 x L4 = 20**	1)IPCAS Group Team and group in place 2)Weekly taskforce in place 3)Infection control manual in place and information resources available 4)Antibiotic policy and guidelines in place 5) Infection control quality round implemented 6)Education for Jnr Doctors on induction 7)New cleaning products in use (Tristel, effective against C. diff spores) 8)Develop pocket size antimicrobial guide 9)Consultant led RCA and presentation of HCAI (see link with Risk 1054,1050,1049)	1)Antimicrobial prescribing compliance is low in areas 2)Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset 3)Variation in line care demonstrated by audit	1)KPI indicators 2)Reducing numbers of cases of C. diff year on year 3)No confirmed outbreaks of C. diff commenced during 2011/12 4)Recent PCT and SHA visits focusing on infection control 5)Recent CQC visit focusing on Nursing documentation and escalation	Positive (+)C. diff rate continues to drop year on year (+)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 (-) MRSA BSI rate higher than acceptable (-) C.diff rate higher than acceptable at start of FY		Extensive auditing and monitoring in place. Trust position known	**S5 x L4 = 20**	1) Launch diarrhoea risk assessment tool. 2) Review MRSA management policy 3)Consultants to lead on OSCE-based competency training for doctors on hand washing and insertion of invasive devices. 4) Further actions detailed in IPCAS annual plan 5)Update urinary catheter care policy carried out to be relaunched	1)Guides developed to be printed 2)MRSA policy review ratified at July MBQR to be launched 3)Extensive scrutiny of annual plan of work monitored by IPCAS Group	DH 05/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S5 x L2 =10**	November Board
1.2. Ensure patients are cared for in the right place at the right time	1.2a Lack of ability to allocate the right bed first time in terms of respect and dignity.	Chief Nurse	**S4 x L3 = 12**	1) Operational meeting three times a day chaired by Chief / Deputy Chief Operating Officer with clinical involvement from Matrons, Nurse Specialists and therapists 2) Daily Board rounds by clinical site team 3) Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed	1)Levels of temporary staff (agency) in key areas such as ED, AMU 2)Additional workload for medical teams having to cover significant numbers of patients outside their bed base 3)The external influences outside of SASH control e.g.) demand management and delayed discharges in care	1)Patient Experience feedback all sources 2)Patient experience and complaints 3)Mixed sex breach data	Positive (+) No mixed sex accomadation breaches since June 2012 (+) 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 reducded (Patient Experience Group Report) Negative (-) Patient Choices data (-) Complaints and incident data		SQC comparison of PT journeys indicated further development of process of right bed first time	**S4 x L3 = 12**	1)Ambulatory care pathways 2)Linked to 1.1b 3)Additional screens arivng to reduce chance of mixed sex accomadation breaches during winter pressures	See 1.1b	SB 06/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S4 x L2 = 8**	November Board

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2012/13

Prepared for November Board meeting

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1.3 Safety and Experience of Patients in ED	1.3 Failure to ensure substantive workforce in ED with experience and skill	Chief Operating officer	S5 x L5 =25	1)Clinical Lead appointed 2)All consultant vacancies appointed 3)Middle grade rota filled	1)Further work required with SECAMB to improve hand over process 2)Embed "See and Treat" model and arrivals streaming 3)ED to Speciality referral pathways need to be adhered to	1)ED Medical Rota's 2)Breach analysis of senior decsion making	Positive (+)Clinical lead in post Negative (-)Evidence demonstrates inability to consistently achieve time to treatment targets		Inability to process trauma unit status skill mix	S5 x L1 = 5	1) Recruitment agency unit engaged to support recruitment process 2) Review on site facility for primary care out of hours	Consultant and mid grade interviews in July, potentially strong candidates Complete	BE 07/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S5 x L1 = 5	December Board
1.4. Develop clinical partnerships/Trust Status that provide safe and sustainable clinical services	1.4a Inability to comply with trauma unit accreditation	Medical Director	S5 x L3 = 15	1)Trauma steering group 2)Critical care network 3)Joint working with BSUH 4)Weekly project meetings		1) Minutes of Trauma steering group, MBQR and Critical Care Network	Positive (+)Recruited consultant with trauma leadership background (+)Mid grade vacancies being filled (+)Surgical lead for Trauma identified (+)TARN data now collected		Cancellation of meetings and gaps in essential data No independent mechanism for mapping/monitoring progress	S5 x L2 =10	1)MD progress reports to Board 2)Recruitment of vacancies 3)Commence systems for gathering and generating necessary evidence to support accreditation	1)Trauma steering group work 2)Vacancies filled and appropriate skill mix achieved 3)TARN data collection established	DH 05/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S1 x L1 =1	November Board
Objective 2 - Ensure Patients are cared for and cared about																
2.1. Be recommended on the basis of "customer care"	2.1a Inability to improve patients' perceptions of services, staff or hospital	Chief Executive	S4 x L4 =16	1)Patient experience group 2)Communication team and work plans 3)Communications strategy 4)Complaints team 5)PALS team 6)Newly opened "Boots" effecting delayed discharge and outpatients' experience (See link 1306)	Need to encourage patients to provide both negative and positive comment in order for Trust to learn from experience	1) NHS Choices 2)Complaints feed back 3)Links feedback 4)Patients Council 5)HASC minutes 6)RTM	Positive (+)Recent update of inpatient survey (+)DoH KPI indicate that Trust is performing (+)RTM data (+)Compliments (+)PALs annual report (+)Excellent July PEAT report (+)Recent reduction in numbers of recieved complaints per month Negative (-)NHS Choices		Aggregated pt feedback report including RTM, PALS, complaints etc	S4 x L4 =16	1)Preparation and Delivery of Customer Care Strategy 2)Senior leadership training and meetings 3)Extensive refurbishment of high pt flow areas	1)Customer Care training rolled out across Trust 3)Major refurbishment work completed, main entrance and ED, work to reduce escalation areas delivered on schedule 3)"Your care matters" pilot to commence	CP 08/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S4 x L2 = 8	November Board
	2.1b Failure to maintain effective complaints management across the Trust	Chief Nurse	S3 x L3 = 9	1)Trust wide monitoring system 2)Divisional responsibility for actioning complaints investigation	1)Delays in administration of complaints, including signature and final editing 2)Central function yet to embed following change in workforce	1) Quarterly complaints reports 2) Compliance with completion on time and numbers of case reopened	Positive (+) Number of new complaints significantly lower than last year Negative (-) Numbers of cases reopened (-) Performance in closing complaints (-) Supporting corporate function establishment		1)Performance data that details where a compliant is being held up in the system 2)Issues highlighted in Internal Audit regarding corporate reporting and analysis	S3 x L3 = 9	1)Reviewing supporting corporate function 2)Review working arrangements between Corporate body and Divisions to stream line the process 3)Review complaints policy to ensure all recomendations are considered	1)Corporate function review commenced, joint working with PALs in place 2)Initial meetings held and regular focussed communication planned 3)Review of policy commenced October 2012	CP 06/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S3 x L2 = 6	November Board
2.2. Treat all patients and their family/carers with Compassion, Courtesy and Privacy and Dignity	2.2a Failure to continually improve the patients perceptions of our staff	Chief Nurse	S4 x L3 = 12	1)Patient Experience Group in place 2)Leadership programmes in place at senior management level 3)Mock CQC inspection programme 4)RTM available at point of care 5)Divisional action plans in place addressing patient experience feedback 6)Nursing Clinical Effectiveness weekley 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	1)RTM data available and monitored by SQC and patient experience group 2)CEQUIN data 3)All sources of patient feedback, internal and external	Positive (+) Peat inspection July Privacy and Dignity (+) CEQUIN patient experience (+) CQC feedback for complaints system (+) NHS Choices positive feedback (+) Zero Mixed Sex Accomadation breaches since June 2012 (+) Improved inpatient survey results demonstrating improvments in treating patients with dignity (+) Improving numbers of patient complaints Negative) NHS Choices high ratio negative comments (-) Numbers of complaints recieved		1) Pro actively encourage patients to use NHS choices PALs and complaints systems to improve information resources	S4 x L3 = 12	1) Customer care training 2) Trust overall compliance monitoring of the appraisals system 3) Top down communication off need to focus on patient experience from Chief Exec down through Senior Leaders to front line staff 4) Roll out of Sit and See programme 5) Additional screens ordered to reduce likelihood of mixed sex accomadation breaches during winter pressures	1)Customer Care Training commenced 2)HR and Divisions monitoring appraisals	SB 06/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S2 x L3 = 6	November Board
Objective 3 - Work in partnership with our community																
3.1. Work with our patients and partners to develop services that meet the needs of our community	3.1a Inability to develop and deliver cross - organisational services/pathways that meet patients' needs	Chief Operating Officer	S4 x L5 = 20	1) Ambulatory path ways rolled out 2) Caterham Dene and Crawley Clinical Assessment services established 3)Twice weekly whole system conference calls to proactively manage patient discharge 4)Trust participating in Kings Fund Program	1)Gaps in assumptions made between PCT and CCGs 2)Whole system action needs more operational detail/time frames and deliverable outcomes	1)Internal activity data 2)Daily SIT reps 3)SECAMB activity data	Positive assurance (+): (+) System management unscheduled care dashboard improving cases (+) 4 work programmes agreed to reduce unscehduled admissions Negative assurance (-): (-) Dual handover data with SECAMB (-) All 4 work programmes delayed		1) Triangulation of data at sufficient level to demonstrate transfer of activity vs. new activity	S4 x L5 = 20	1) Planned work to identifygaps in provision 2) Re focus of System Management Team group to operational delivery group 3) Agreed workstream set of KPI's and dashboard to inform SMT	1) Recognition that current plan is not delivering, therefore refocusing on 3 key areas 2) Whole System Bed census planned for early 2013 3)Workstream to identify gaps in provision	BE 07/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S2 x L5 = 10	November Board
	3.1b Lack of strategic approach to identifying and developing opportunities	Chief Executive	S4 x L3 = 12	1)Transformation board in place, monitoring action plan 2)Clinical cabinet meeting between Trust Clinicians and CCGs 3)TFA Board	1)Rapid progress and changing in local care environment (Elective and Non elective activity) makes long term planning and forecast of activity difficult	1)Partcipationa with CCGS in developing new contracts and maintain activity 2)Kings Fund Work steam	Positive assurance: (+)Local commitment for extensive refurbishment of estate demonstrating key links with stakeholders (+)Repatriation of Chemotherapy services (+)High level conversations with other providers for maternity services (+)Positive feedback recieved for draft Clinical Strategy (+)Investment and Workforce committee discussion re partnership opportunities		1)Complexity of business model re chemotherapy (Funding)	S4 x L3 = 12	1)Clinical Strategy to be developed 2)Drafting Integrated Business Plan to be developed 3)Working with Sussex on proactive care model (Frail Elderly Strategy)	1)Clinical Clinical Strategy developed and shared with SHA and CCGs 2)Draft IBP developed and shared with SHA and CCGs	CP 08/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S4 x L2 = 8	November Board

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2012/13

Prepared for November Board meeting

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3.2. Improve the way all other partners perceive and talk about SASH	3.2a Failure to effectively engage external stake holders	Chief Executive	S4 x L2 = 8	1)Stakeholder meetings and actions underway, such as HASC, LINKS, Patients Council and CQPM 2)GP Newsletter and GP forum	1)Evidence to demonstrate board to ward understanding of need to engage with stakeholders	1)HASC minutes 2)CQPM minutes 3)Patient focus groups 4)Peer review 5)RTM	Positive (+)Performing Trust on DoH KPI (+)Senior stakeholder acknowledgement that quality of care at SASH is improving (CEO of NHS SOE, CQC Inspector) (+)Attendance of stakeholders at focus groups and Trust committee meetings (+) Press and media coverage (+)Maternity services liason committee (MSLC) Negative (-) Press and media coverage			S4 x L2 = 8	1)Develop and implement PPI Plan 2)Plan to embed experience based design into service provision and development 3)Proactively seeking and promoting positive news stories	1)PPI plan under development 3)Plan to commence "Your Care Matters" Pilot	CP 08/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	S3 x L2 = 6	November Board
Objective 4 - Become a Sustainable, Effective Organisation																
4.1.Live within our means both in year and ensure sustainability into the future	4.1a Failure to deliver income plan	Chief Financial Officer	S5 x L3 = 15	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Signed contract with commissioners. 3) Contract management process in place	1) NHS Sussex activity plan not fully profiled and aligned with Trust plans at Oct 2012 2) Although recovery plans are being developed with Sussex, there is a lack of clear change plans available at October 2012 3) At M06 activity levels remain within the previous trend providing significant pressure. 4) Contract management meetings and process are not running as they should. 5) Substantial contractual challenges are being made by CCGs	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 PCTs (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 (but please note issues there)	Positive assurance (+): 1) M06 - income plan is being exceeded, providing good assurance - however there is a counter to this below. Negative assurance (-) 2) Exceeding the income plan indicates "overheating" which is adverse to health system plans, which provides a risk to our shared aims and the risk of non payment from NHS Sussex because of the capped contract 3) The "overheating" introduces an additional cost problem visible in Finance reports 4) CCG contractual challenges are onerous, time consuming and financial values are high - Trust processes are running OK but contract process with CCGs has issues (being addressed currently) Assurance RAG right is "red" because of these last three points.		A) Confirmation of health system action (of which the Trust has a part) to deal with "overheating" (recovery plans with Sussex being developed) B) Confirmation of CCG payment for activity (escalated discussions are going on but resolution not reached) C) Resolution of contract management process with CCGs	S5 x L3 =15	1) Recovery plan being developed jointly with Sussex (but not with Surrey) - Trust has shared forecast activity/income impacts with CCGs 2) Position with Sussex escalated through Single Performance Conversation and forms part of the escalated process overseen by SoE SHA. 3) Surrey resolution appears to be through financial contract challenge, which is being managed through other work. Surrey are on a full PbR contract, whereas Sussex have a capped contract. 4) Linking with the last two points Trust is driving improvements to the contract management process to ensure that is working as it should. Escalation meetings at senior level are now in process (including an Accountable Officers meeting with Surrey, with a set timetable for further escalation).	Actions proceeding to timetable	29 Oct - CFO	Post M06	S4 x L2 =8	Discussed at August Board - will be discussed at Nov Board
	4.1b Failure to stop divisional overspending against budget	Chief Financial Officer	S5 x L3 = 15	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Divisional activity plans agreed & signed off 3) Additional activity budget being allocated after agreement of specific pressures 4) Internal Performance Review process	1) Nursing spend and medical agency spend controls subject to review and action. 2) Activity driven spend, notably in theatres, is having an adverse impact [In both areas action is in place and there are signs of it being effective]	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 PCTs (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 (notably in the Surgical Division with 18 week driver)	Positive assurance (+): 1) Overall I&E position is balanced - income covers spend, but see negative assurance. 2) 2 Divisions are above overspend thresholds (more previously) with imnproving position, many cost centres are not overspent andall issues are . 3) Financial reporting describes improved performance OR links spend to activity (which is covered by income, noting contractual issues with CCGs) Negative assurance (-) 4) Overspending in nursing budgets (which is improving), and medical agency budgets. 5) Need to fully recruit to nursing vacancies (action in train) 6) Spend related to activity increasingly confirmed as unavoidable, issue is over CCG payment. Assurance rating right is "red" because of latter aspects.		A) Nursing spend and medical agency spend (although actions are proving effective) B) Linkage to contractual discussion with CCGs (see item above) - capped contract in Sussex and degree of financial challenge (non payment) from Surrey	S5 x L3 =15	1) Additional control structure remains in place (nursing in particular), with escalation to CEO as necessary (ongoing) 2) Performance Review process operating with all Divisions - - and improvement in risk mitigation visible 3) Please see contractual aspects in line above which are directly connected with management action.	Actions proceeding to timetable. Note: Timetable has lengthened because of contract management process issues with CCGs. Timelines have, however, now been revised and set.	29 Oct - CFO	Post M06	S3 x L2 =6	Discussed at August Board - will be discussed at Nov Board
	4.1c Unable to provide realistic medium term financial plan	Chief Financial Officer	S5 x L3 = 15	1) Items referred to in 4.1c above 2) FIRST draft long term financial model and integrated business plan completed (submitted to SHA on 18 October)	None	1. Delivery of current year financial plans 2. Delivery of long term financial model and integrated business plan	Positive assurance (+) 1) Long term financial model provides realistic plan and scenarios describe wider robustness against downsides Negative assurance (-): 1) Plan requires delivery of performance in 2012/13 - there are risks as described here 2) External approval is currently in principle only (meeting with SHA on 8 Nov) 3) Savings and income levels provide extremely challenging targets and the LTFM assumptions are subject to change dependent on CCG plans 4) Lack of clarity over commissioning plans for 2013/14 and future years Overall, on basis of current assumptions and delivery of LTFM, RAG improved to amber [but subject to review]		A) Performance in 2012/13 against first milestones B) Outcome of 8 Nov meeting with SHA	S5 x L3 =15	1) Trust actions to manage items listed above (delivery of 2012/13 plan) 2) As advised - Trust has delivered FIRST draft long term financial model (LTFM) and integrated business plan 3) Actions expected to move to more refined version of LTFM once commissioning plans for 2013/14 received and business planning complete (January 2013)	Actions proceeding to timetable	29 Oct - CFO	Post M06	S4 x L2 =8	Discussed at August Board - will be dicsused at Nov Board
	4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	Chief Financial Officer	S5 x L5 = 25	1. Bi weekly review of forward cash flow by finance team and CFO 2. Cash and working capital policy and strategy 3. Annual cash plan linked to business plan and capital plan	None	1. Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2. Monthly finance reporting to Management Board and Trust Board	Positive assurance a. Positive cash flow reported for every month in 2011/2012, and into 2012/13 b. Liquid ratio has folowed expectations c. Cash flow forecast for year is OK, but dependent on mitigation to I&E risks described above. Negative assurance 1: no confirmed additional cash to resolve underlying liquidity problem Assurance RAG "amber" - no current cash problem but underlying problem unresolved.		In terms of cash flow management to end year, no material gaps in assurance. In terms of resolving the actual risk (liquidity), there is no confirmation of additional cash to resolve SoFP weakness.	S5 x L3 =15	1) Risks around I&E above apply here too; 2) Trust received a cash injection at the end of 2011/12 - day to day cash control is main action currently 3) Long term financial model now provides additional validation of the level of cash injection required and the interaction from an improving financial position within the model	Actions proceeding to timetable	29 Oct - CFO	Post M06	S4xL3= 12	Discussed at August Board - will be dicsused at Nov Board

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2012/13

Prepared for November Board meeting

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failure	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
4.2. Delivery of TFA and Monitor standards	4.2a Failure to Implement a governance framework suitable for foundation trust status	Director of Corporate Affairs	**S4 x L3 = 12**	1)BGAF assessment carried and action plan developed 2)Corporate governance framework 3)Interim Director of Corporate Affairs in post, vacancy filled	1)Corporate Governance infrastructure and support not yet clearly identified	1)BGAF assessment	Positive (+) Director of Coporate Affairs in post (+) Met current SHA TFA and majority of SOM milestones Outcome Escalation meeting with NHS TDA planned for November 2012		Gasp in evidence of implementation	**S4 x L3 = 12**	Detailed BGAF action plan developed and currentley under review	1) BGAF has been discussed regularly and will be driven forward by Director of Corporate Affairs post 2) TFA and SOM milestones being met	GFM 07/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S4 x L2 =8**	November Board
	4.2b Unreliable information resulting in poor decision making	Director of Information and Facilities	**S4 x L3 = 12**	1) Data Quality Strategy written by Director of Information and Facilities and managed on everyday basis by Data Quality Manager reporting to Head of Information 2) Data Quality Report reviewed by Information Governance Meeting on a regular basis 3) Information used within wide range of Board and Management Reports 4) DQ Training key element of EPR/PAS Training 5) Performance meetings provide scrutiny	1) Insufficient DQ Resource to fully check all relevant KPIs	1) Monthly Data Quality Report as reviewed by Information Governance Group 2) Internal Audit Reports 3) External Audit Reports	Positive (+) Data quality report showing positive results (+) Internal audit report (+) Information Governance report (+) Feedback from PCT challenges of readmission rates (+) Increased Trust income following improvmenets in data quality Negative (-) Quality of medical records effects quality of coding		None	**S4 x L3 = 12**	1) Development of rolling data quality programme looking at each KPI in turn (focussing on the BAF) 2) Data Quality Mark to be added to Performance Report based on above	1) Implementing a system for identifying data quality of KPI 2) Increase capacity of Data Quality team, interviewing DQ clerks x2	IM 08/11/12	TBA, (NB ensure presented at Audit and assurance committee prior to next board meeting)	**S4 x L2 =8**	November Board
4.3. Listen to, value and develop our workforce	4.3a Ineffective staff development means that the Trust does not have the skilled workforce to deliver current and future services	Director of Human Resources	**S4 x L3 = 12**	1) Ratified Workforce Strategy and Plan 2) Training plan aligned to national and regional requirements 3) Appraisal and PDP compliance monitoring and reporting to Board (see link with Risk 910) 4) Statutory and mandatory training matrix (see link with Risk 1170). 5) Data collection and monitoring linked to ESR , and exception reporting	1) Quality of appraisals and pdps 2)Matrix needs review 3) Limited availability of training rooms 4) Trainer capacity 5)Quality of data received	1) Implementation Plan report to Investment and Workforce Committee SHA assurance process 2) Delivery of plan and monitoring of external training budgets (CPD Delivery plan and reporting) 3) Monthly performance reports to Management Board. Annual Staff Survey responses to training questions 4) Monthly reports to Management Board on performance 5) Complementing current provision with e-learning programme	(+) Implementing actions from Trust Workforce Strategy Plan 2012-2015 (+) LDA signed, SHA allocations received and SHA reporting quarterly (+) at least 20% mandatory and statutory training via e-learning (-)e learning take-up hampered by IT and system network issues. (-) increase in appraisal compliance and quality of appraisal (-)Monthly reporting by division and staff feedback sessions,improvement in staff and patient survey (-) Monthly reporting by division and staff feedback sessions,improvement in staff and patient survey		1) Inability to deliver e-learning project on time 2) Insufficient resources to fund Training needs 3) Lack of staff engagement and low morale 4) poor appraisal compliance	**S4 x L3 =12**	1) review and monitoring of Statutory and mandatory training matrix 2) continued delivery of revised Statutory and mandatory Training programme 3) More local delivery of statutory and mandatory training 4) New method of collecting appraisal data just put in place 5) Regular monitoring of appraisals by division 6) IT and network system difficulties escalated to Ian Mackenzie and Yvonne Parker; resource implications.	1) Draft review of matrix completed. Matrix will be reviewed following end of consultation with UK Core Skills for Health with input from Education and Governance Strategic Group. Streamline programme will reduce matrix to 10 core programmes with rest delivered locally. Addtionally it will enable staff coming from other NHS organisations to 'passport' their training to SASH 2) Revised programme being delivered 3) cascade training in place 4) New appraisal reporting method in place	9/11/2012 BC/JM	05/01/2013	**S4 x L2 =8**	Workforce & Investment Committee
	4.3b Ineffective staff engagement and buy-in of staff to the Trusts objectives and direction delays or derails service and workforce redesign and ability to make financial savings	Director of Human Resources	**S4 x L3 = 12**	1) Staff Survey engagement score 2) Engagement Strategy in development (see link with Risk 1321) 3) Focus groups and in year temperature check on engagement 4) Team briefing mechanism for message cascade 5) Transformation Plans embedded in business planning cycle	Lag between Staff survey completion and results - being addressed through in year temperature check and focus groups	1) Annual Board report on staff survey results and action plan 2) Staff will be involved in its development - Strategy will be approved by Board 3) Report to Executive Management Board on results 4) Number of briefings held during 12/13 and attendance sheets 5) PMO monitoring, monthly reports to Management Board	(+)Attendance at team briefs and Senior Leaders Meeting (+) Board Report in May (+)Customer Care Pilot launch in June. Frontline staff engaged in design and development (+)Assurance at Investment and Workforce Committee on internal comms strategy (+)Improved feedback from internal communications approach (-) Feedback sessions ESH and Crawley Hospital		1) Engagement still poor (in bottom 20% of acute Trusts) 2) Engagement Strategy not yet in place	**S4 x L3= 12**	1) Equality and Diversity & HR Steering Group 2) Board Seminar engagement 3) Focus Groups for Engagement Strategy	actions agreed to progress	5/11/2012 SK/JM	05/01/2013	**S4xL2=8**	Workforce & Investment Committee
	4.3c Lack of leadership capacity and capability to engage with and develop staff delays or derails workforce redesign and ability to make financial savings	Director of Human Resources	**S3 x L3 = 9**	1) Leadership programmes provides a cohort of 150 senior managers to effect change. Programmes of change focused on trust priorities. 2) Training needs analysis annually and funding of external training through the bursary 3) Clear managerial and clinical structures with single point accountability through the Chiefs of Service. 4) Investment and Workforce Committee oversight of Training Plan 5) Board development programme		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 workstreams over 2 years (+) 1st Cohort Leadership in Action programme has completed, 2nd cohort underway (+) Essentials of Management pilot completed, programme roll out from March 2013 following second evaluation (+) 2012-2013 Training Plan in place. (+) LDA signed and SHA allocations received and Bursary panels in session (+) New clinical structure in place with Chiefs of Staff (+) Regular Board seminars, recent Board meeting and observation by Healthskills (+) LEAP leadership Programme by KSS Deanery for Medical teaching Faculty, 2nd programme completed 9/11/12 (+) Chiefs and Clinical leads Development Sessions - rolling programme established (+) Board Development review in progress with Dir of Corp Affairs		1) How to measure leadership training - identifying link between leadership activities and programmes and organisational change 2) Lack of behavioural change	**S2xL4=8**	1) Establish framework to enable short-term change or KPI measures to show added value of programmes, new structures and processes in place 2) Attendance at Senior Leaders meeting and engagement with Transformation Plans 2) Prioritising TNA funding to Trust priorities	1) Monitor through Management Board for Performance 2) New Performance Score card measuring quality, patient satisfaction, staff satisfaction and performance	9/11/2012 BC/JM	05/01/2013	**S2xL4=8**	Workforce & Investment Committee