West Hertfordshire Hospitals NHS
NHS Trust

123/06(i)

Report From: Chief Executive

To: Trust Board

Subject: Updated Assurance Framework

Action: To Note Contents & Agree Recommendations

Date: 29th June 2006

Executive Summary

Introduction

This paper provides the Trust Board with a summary of the progress against the Assurance Framework to provide assurance of continual population; a review of recent developments relating to the Assurance Framework; and highlight most recent entries made (See attached Assurance Framework).

Recent Developments and Recommendations

During May 2006, the process of populating and managing the Assurance Framework was audited by the Trust's Internal Auditors. The Auditor was satisfied with the general appearance of the Framework and with the escalation process of strategic risks to the Board but made the following recommendations that will strengthen the content of the Framework in the future:

- Executive Directors should be encouraged to review the design and effectiveness of the identified controls in place to support the operation of the strategic objectives.
- Ensure that the descriptions of the supporting documentation are sufficient to fully identify where the assurances derive from to the support the controls in place.
- Whilst it is appreciated that Directors have their own specific actions plans relating to gaps identified in the objectives, these should also be included within the framework to demonstrate a complete audit trail. Directors should ensure that these action plans are regularly updated on the framework to demonstrate to the Board that actions identified are being addressed.
- The Trust should ensure that any specific lapse declared within the final declaration of the Standards for Better Health are clearly identified as gaps in control on the Framework.

New Risks Entries

During Quarter 1 (Apr - June '06) one new risk entry was made on to the Assurance Framework against Objective 4 (*Ensure there are joined up management and leadership*

responsibilities and ownership allocated appropriately at all levels of the organisation to ensure probity, quality assurance, quality improvement and patient safety (Ref: SFBH Domain 3)):

Risk	The organisation is unable to meet its statutory and mandatory responsibilities through ill-defined management accountability
Classification of Principal Risk and Executive Lead	Organisation wide Director of Human Resources
Key Controls	HR Committee Leadership strategy which will identify 150 key leaders in the organisation
Assurances on Controls	Development programmes developed
Board Reports/Positive Assurances	Not yet identified
Gaps in Control	Need to implement development programmes
Gaps in Assurance	Necessary to reach Trust Foundation Status. Governance paper in progress Chief Executive

Objectives Reviewed

During Quarter 4 (Jan - Mar '06) the following objectives were reviewed and updated:

Objective 5 (*To have high quality, well managed and trained staff, and to be an employer of choice*)

The Board is asked to note the contents of this report.

David Law
Chief Executive

June 2006

ASSURANCE FRAMEWORK 2006/7

The primary goal of the Trust is to create **a high performing organisation** with a focus on **service development**, within which there are **consistent of standards care delivery and appropriate staff behaviour.** The strategic objectives of the Trust are geared towards delivering these aims.

Principal objectives showing the link between Strategic & Divisional level objectives

Area	Strategic Objectives	Divisional Level Objective
1. Clinical Care	**To maintain high clinical standards, ensuring compliance with best practice**	To ensure that the Trust delivers the best standards of care that it can achieve, with due regard to the continuing professional development of its staff and the need to audit and improve practice on a continuing basis. To adhere to national guidance on the delivery of services
2. Patient Safety	**There is a strategic process in place that ensures Patient safety is enhanced by the use of health care process, working practices and systemic activities that prevent or reduce the risk of harm to patients (Ref: SFBH Domain 1)**	To ensure production and implementation of Divisional Risk Management Strategies To encourage, investigate and monitor incident reports To foster a culture of learning from incidents thereby reducing the risk of harm to patient

Area	Strategic Objectives	Divisional Level Objective
3. Governance	**Ensure visible Board ownership of Governance (Corporate and Clinical), Effectiveness and R&D Strategies to achieve effective clinical outcomes (Ref: SFBH Domain 2)**	To ensure best practice in the organisation of good governance within the Trust, for both clinical and non-clinical functions with clear leadership and accountability To establish an effective performance management system To cascade performance objectives throughout the Trust, using a universal appraisal system
4. Leadership	**Ensure there are joined up management and leadership responsibilities and ownership allocated appropriately at all levels of the organisation to ensure probity, quality assurance, quality improvement and patient safety (Ref: SFBH Domain 3)**	To understand the governance structure of the Trust and the levels of accountability To be capable of managing risk as it relates to quality assurance, quality improvement and patient safety To ensure that all managers are clear about their areas of accountability, and are sufficiently skilled to be able to undertake their management responsibilities To ensure that managers have access to the appropriate management development and leadership training so that they all improve their management capability
5. Workforce	**To have high quality, well managed and trained staff, and to be an employer of choice**	To increase flexible employment opportunities To encourage a sense of pride, taking responsibility and a sense of belonging thereby enhancing staff satisfaction To use training opportunities as a recruitment and retention tool To improve the working lives of its staff and create an environment in which staff feel respected, valued and well motivated. To increase recruitment and retention of staff with the appropriate skills to provide the range of services offered by the Trust To engage staff in improving the organisation and delivery of services

Area	Strategic Objectives	Divisional Level Objective
6. Environment	**Ensure that the Trust Modernisation Strategy includes all environmental aspects so they holistically meet patients' and staff needs (Ref: SFBH Domain 6)**	To provide a modern environment for the treatment of patients. To ensure that privacy and dignity of patients is maintained through a well-planned environment and good practice To maintain high standards of cleanliness in all areas To ensure that health and safety standards are maintained and improved To provide high quality catering and hotel services
7. Access	**To work in partnership with key stakeholders to achieve the Trust's objectives (Ref: SFBH Domain 5)**	To sustain local access to services, where this is consistent with a good patient experience and high standards of care To reflect the needs of local communities for access to services, working in conjunction with Pacts The Trust will provide a timely response to patients' needs, and will achieve the standards required on waiting times and access. To review the delivery of services to ensure that they are working efficiently and meet patients' needs To ensure the Trust has sufficient capacity (staff, beds, theatres, clinical support and infrastructure to meet its targets)
8. Finance	**To ensure the efficient use of resources and meet statutory financial duties**	To make efficient and effective use of the resources available to the Trust. To ensure statutory financial targets are met To use capital effectively to pursue the objectives of the Trust
9. IM&T	**To provide effective administrative and technological support for service delivery**	To ensure that best practice is adopted to deliver services in a timely way, including effective administrative systems To implement consistent administration systems across the Trust To use information technology to support the delivery of services, the patient pathway through the service and the production of effective management information

Area	Strategic Objectives	Divisional Level Objective
10. Patient Experience	**Ensure that patients, carers, relatives and volunteers are involved in the planning and delivery of health care, to ensure the Trust meets the needs of patients (Ref: SFBH Domain 4)**	To use various methods to obtain patient involvement in the planning and delivery of services to ensure that services are responsive to patients' needs To ensure implementation of action as a result of learning from comments and complaints To support and implement the work of the Patient Panel To maintain an effective Patient Advisory Liaison Service
11. Partnership working	**To work in partnership with key stakeholders to achieve the Trust's objectives**	The Trust will work closely with partner organisations (PCTs, local authorities) and with groups and individuals to achieve its strategic aims and its objectives To develop a communications strategy for internal and external stakeholders To respond to the needs of local GPs and assist them in delivering an excellent service to patients To agree new service models with partners To work with other Trusts in the provision of services where this benefits patient care

Assurance Framework

Objectives	Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
What the organization aims to deliver	*What could prevent this objective being achieved?*	*Which area within our organization this risk primarily relates to:*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/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 we are failing to put in controls/systems in place. /Where we are failing in making them effective*	*Where we are failing to gain evidence that our controls/systems, on which we place reliance are effective*
1. To maintain high clinical standards, ensuring compliance with best practice	(1.1) Failure to develop competencies of staff to provide high clinical standards (1.2) Not being able to fulfill Trusts National Audit Commitments (1.3) Not being able to provide mandatory help for Junior Doctors Audits	Clinical Care **Medical Director*/Director of Nursing**	(1.1) Clinical Governance Committee (1.1) Trust programme around 'Essence of Care' (1.1) Comprehensive Clinical Governance Programme (1.1) Multidisciplinary Team Meetings	(1.1) Positive Essence of Care Reporting (1.1) Clinical Audit Report (1.4) Clinical Divisions Quarterly Performance Review Reports (1.1) Central monitoring of consultant appraisal summaries and PDPs	(1.1) (1.2) CNST Level 1 compliance (1.1) Clinical Governance Report monitoring by (SHA) (1.1) Clinical Governance Quarterly Reports (1.1) Deanery and college reports	(1.1) Full compliance with National Service Framework standards (1.1) (1.4) Divisional monitoring of NICE compliance (1.1) (1.4) Lack of funding from PCT's to achieve NICE	(1.1) (1.2) Achievement of CNST level 2 and 3 (1.1) Across the board NICE compliance

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	(1.4) Not being able to achieve NICE compliance		(1.1) Clinical Audit programme	(1.1) (1.4) System to monitor NICE compliance (1.1) Consultant appraisal and personal development plans (1.1) Programme of post-graduate training for all junior medical staff including educational objective setting	(1.1) Deanery approved training posts	compliance	
2. There is a strategic process in place that ensures Patient safety is enhanced by	(2.1) Lack of capacity/financial resources to improve patient safety (2.2) (NM &	Director of Nursing, Midwifery, Quality and Risk Risk Committee Medical Devices	(2.1)(2.2) Trust Board (2.1) Risk Management Strategy/ Risk	(2.1) Datix (2.1) Incident Reporting System (2.1) Divisional	(2.1)(2.2)(2.5) CNST 1 – Acute Trust (2.1)(2.2) CNST 1 – Maternity	(2.2) Recruitment to unfilled posts underway (2.3)	(2.1)(2.2)(2.5) CNST 2 Acute Trust and Maternity (2.2) Audit report in 2004 identified areas of concern in regard to 3

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
the use of health care process, working practices and systemic activities that prevent or reduce the risk of harm to patients (Ref: SFBH Domain 1)	SVC) Insufficient staffing resource allocated to the management of medical devices (C4c) (2.3) Lack of availability of certain Medical Devices (SFBH Ref C4b)(RR Ref No. 18) (2.4) No funding in current budget to implement NICE recommendations (C3) (2.5) Failure to action all SABS Alerts by the given	Committee	Management Action Plan (2.1) Incident Reporting Policy (2.1) Risk Register with all high-level strategic and organisational risks sufficiently controlled. Risk escalation processes in place. (2.2) (2.3) Medical Devices Management Committee; Medical Devices Policy (2.3) (2.5) CG Committee (2.3) CG Strategy	Risk Leads Committee/minutes (2.1) Regular liaison with NPSA /Attendance at Regional Patient Safety Forum/minutes (2.1) Divisional Risk Management Strategies (2.1) Regular Risk Management Reports to Trust Board (2.1) Safety Alert Broadcasting Management (2.2) (2.3) Internal Audit of Medical	(2.1) Audit Commission – Report on Governance ???? (2.6) Quarterly performance monitoring tool for divisions.	Developing a capital replacement review to go to Capital Programme Group on 6/2/06 with a view to obtaining capital funding approval and replacement programme by 28/2/06 (2.4) Clinicians participate in regular clinical audit and reviews of clinical services (2.5) SABS Policy being drafted (2.5) No	of the 4 decontamination sites (2.3) Deficits relating to availability/repair of Medical Equipment; and availability of staff. (2.4) Insufficient Assurance that NICE appraisals are taken into account when planning and delivering care (2.5) Poor performance recorded on DoH linked SABS internet site in managing safety alerts within deadlines (2.6) Predicted failure to meet targets on reduction of MRSA set by DoH (2.6) Failure to comply with PEAT (2.9) Audit Report in 2004 identified areas of

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	deadline (SFBH Ref C1b) (2.6) Non-compliance of staff with Infection Policies and Procedures (2.7) (GE) Lack of pressure equipment (RR ID: 584) (2.8 Failure to achieve a year on year reduction in MRSA (SFBH Ref C4a) (2.9) Failure to ensure that all reusable devices are properly decontaminated prior to use		(2.5) Risk Management Department currently operationally managing SABS alerts. (2.6, 2.8) Director of Infection and Prevention and Control in place (2.6, 2.8) Infection Control Policies (2.6, 2.8) Infection Control Team and link persons (2.8 Annual Infection Control Programme	Devices Management and resultant Action Plan and progress report (See Datix RR Ref: 18 ; minutes of Medical Devices Management Committee; (2.5) SABS alert compliance currently at 85% (as per SABS Internet Report) (2.6) Infection Control Programme and Annual Report (2.6) Audit and surveillance Programmes (2.5) Training and education programme in place		operational performance monitoring on Trust's response to Safety Alerts other than that reported within RM Reports directly to the Board (2.5 No budget for the management of SABS) (2.6) Lack of clarity around defined roles and responsibilities for managing and reporting on infection control	concern in 3 out of 4 decontamination sites within the Trust.

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	(SFBH Ref C4c).		(2.9) Decontaminatio n Policy	(2.5) 'Clean your hands campaign'. (2.5) PEAT inspections (See Estates and Facilities Directorate Intranet site) (2.7) Business case for Pressure Relieving Equipment (2.8 Matron's Charter Action Plan; Divisional Infection Control Leads produce quarterly infection control reports; Monthly performance against the Trust trajectory performance			

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
				monitored by the Finance and Performance Committee and The Trust Board; Quick Fix initiatives implemented in all Divisions; Regular infection control audits undertaken; Regular walkabouts by Director of Nursing, Midwifery, Quality and Risk, Matrons and Medirest; Regular PEAT Visits (2.9) Routine external auditing systems are now in place to monitor compliance			

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
				(2.9) Discussions with SHA with regard to centralisation of services currently in train.			
3. Ensure visible Board ownership of Governance (Corporate and Clinical), Effectiveness and R&D Strategies to achieve effective clinical outcomes (Ref: SFBH Domain 2)	(3.1) Ability to identify inadequate resources (3.2) Failure in completing the process of Risk Management and Governance (C7a and c) (3.3) Gaps in the systematic and planned approach to the management	Organisation Wide **Director of Nursing, Midwifery, Quality and Risk*/Chief Executive Officer/Secretary to the Board**	(3.1) (3.2) Trust Board; Audit Committee; Risk Committee; Clinical Governance Committee; (3.1) (3.2) Risk Management Strategy (3.1) (3.2) Risk Register (3.1)(3.2) Assurance Framework (3.1)(3.2)	(3.1) (3.2) Principal objectives set and agreed at board level and communicated to staff. (3.1)(3.2) Report of Emergency Care Task Force to Board (3.1)(3.2) Implementation of plans which compensate for shortage of resources and	(3.1)(3.2) External Audit Reports (3.1)(3.2) CNST Level 1 (3.1)(3.2)(3.3)(3.4) (3.1)(3.2)(3.3)(3.4) RPST Level 1	(3.1)(3.2) Full compliance with the core Standards for Better Health (3.3) Gap identified within information governance around data quality, monitoring and recording (3.4)	Loss of Star Rating 03/04 (3.1)(3.2) Achievement of CNST Level 2 (3.1)(3.2)(3.3)(3.4) Achievement of CNST Level 2 (3.2) Areas of concern raised within Audit Report (3.3) Gaps identified within information governance with respect to data quality, monitoring and recording

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	of medical records (C9) (3.4) Failure to ensure all staff attend relevant mandatory training (C11b) (3.5) Failure to support staff through organisational and personal development programmes (C8b)		Corporate and Clinical Governance Strategy (3.1)(3.2) R&D Strategy (3.3) Information Governance Committee (3.4) H&S Committee;	achieve Performance (3.1)(3.2) Continued compliance with Controls Assurance Core Standards on Governance, Risk and Finance (3.1)(3.2) Internal Audit (3.3 Documentation Audits as part of CNST requirement; Data Quality and Coding monitored via CHKS returns. (3.4) Workforce Development Group		Monitoring attendance problematic (3.2) Implementation of outstanding Clinical Governance audit; paper to Trust Board setting out strengthening of internal arrangements to improve corporate governance	(3.4) Lack of assurance that all staff attends mandatory training. (3.5) Yet to implement Electronic Staff Record (will go live Oct ’06)

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
				Performance reports to H&S Committee			
4. Ensure there are joined up management and leadership responsibilities and ownership allocated appropriately at all levels of the organisation to ensure probity, quality assurance, quality improvement and patient safety (Ref: SFBH Domain 3)	(4.1) The organisation is unable to meet its statutory and mandatory responsibilities through ill-defined management accountability	Organisation wide **Director of Human Resources**	(4.1) HR Committee (4.1) Leadership strategy which will identify 150 key leaders in the organisation	(4.1) Development programmes developed		(4.1) Need to implement development programmes	(4.1) Necessary to reach Trust Foundation Status. Governance paper in progress/DL
5. To have high quality, well managed and trained	(5.1) Lack of appropriate training specifically for	Workforce **Director of Human**	(5.1, 5.2) Trust wide training strategy	(5.3, 5.4) Reduction in staff vacancy levels.	(5.1 – 5.5) Compliance with 'Improving	(5.2, 5.5) Trust-wide training needs	(5.1 – 5.5) Achievement of CNST Level 2 & 3 (5.1 – 5.5) Achievement

Objectives	Risks		Key Controls	Assurances on Controls	Board Reports		
	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
staff, and to be an employer of choice **(**	medical equipment (C4c) (5.2) Failure of some staff to meet statutory/ mandatory training requirements (5.3) Inability to recruit the right staff with the right skills (5.4) Failure to retain skilled staff (5.5) Time for staff to commit to CPD and update skills due to staff shortages and vacancies (5.6) Inadequate cover for in-	**Resources**	(5.3, 5.4) Trust Board to support recruitment plans and development of accommodation strategy (5.3) Recruitment/Policy/Strategy	(5.1, 5.2) Training opportunities in place (5.4) Increase in retention levels. (5.2, 5.5) Ensure all staff receives regular appraisals. (5.5) Put in place a programme to meet personal development plans (5.2) Training records for Trust and Local Induction (5.2 – 5.5) Improved results of staff surveys	Working Lives' Practice Plus (5.1 – 5.5) Royal College audits of Junior Doctor training (5.1 – 5.5) University accreditation (5.1 – 5.5) Internal audit	analysis (5.2) Gaps in linkage to staff appraisal (5.1, 5.2) Training plan costed/resourced and included in divisional business plans. Cover arrangements in place.	of RPST Level 2 & 3 (5.1 – 5.5) Achievement of IWL "Investors in People" (5.1 – 5.5) Achievement of IWL "Model Employer"

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
	house training. (5.7) Lack of resource to implement improvements (5.8) Shortage of affordable and appropriate accommodatio n			(5.3) Clear recruitment plan with proposals that attract staff to the Trust (5.2, 5.4, 5.5) Effective capacity planning and review of establishments to enable release of staff to attend training (5.1, 5.2, 5.5) Performance indicators for uptake of training (5.1 – 5.5) Compliance against CNST (Acute Trust and Maternity) and RPST Level 1 standards			

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
				(5.3, 5.4) Success in hard to recruit areas			
6. Ensure that the Trust Modernisation Strategy includes all environmental aspects so they holistically meet patients' and staff needs (Ref: SFBH Domain 6)	(6.1) (SVC) Failure to provide environments, which are well maintained and clean. (SFBH C21) (Datix RR Ref: 612) (6.2) (SVC & SS) Poor capital stock and inadequacy of capital fund (6.3) (SVC) Poorly designed patient areas (SFBH Ref: C20b) (Datix RR Ref: 613) (6.4) (SVC &	Organisation wide **Director of Estates & Facilities** Organisation wide **Director of Planning** **Director of HR** **Director of Nursing, Midwifery, Quality and Risk**	(6.1) Monthly Soft Services contract monitoring at Contract Partnership Board; Monthly internal PEAT inspections and monitoring at monthly Contract Partnership Board; New 'soft' services contracts; appropriate capital investment in the patient environment; monthly performance monitoring by the Finance and Performance	(6.1) Achievement of targets / standards: PEAT Inspections results; PEAT capital investment provision; programme for IP inspections and contract monitoring together with specific actions from visits within the Trust (evidence from Head of Facilities); (6.2) Capital Programme management within	(6.1) One Star Rating Achievement (6.2) Project Progress Reports and Finance Capital reports; ERIC returns (6.3) Board Design Champion; Major scheme business case inclusion of AEDET score & NEAT score Gateway 0	(6.1) Programme of strategic measures to address and achieve cleanliness issues monitored fortnightly (See action plan attached to Risk No. on Datix RR Ref: 612) (6.3) No programme currently in place to address M.V Burns and Plastics Service	(6.2) Areas of concern raised within both internal and external PEAT visits (6.3) Burns and Plastics Service on MV Site beyond economic repair and maintenance. Discussions underway for Health Economy Reprovision; Current services provided within the constraints of the building stock. Trust will not be totally compliant until 2012 when the agreed redevelopment of the Trust will take place.

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
	RR) HSE criminal prosecution/civil litigation. (6.5) (SVC & RR) Potential loss of training accreditation (linked to 6.3)		Committee (6.2) Clear process for design and construction of new projects; strategic capital business case process to identify and obtain appropriate strategic capital funding; Capital Programme prioritisation (6.3) Compliance with NHSE Guidance including Health Building Notes; CABE review on major new schemes; Investing in your Health (WGH Redevelopment	performance standards set (6.3) Success in: NHSE Design Review Panels for major schemes; AEDET (achieving excellence design evaluation toolkit); NEAT (NHS Environmental Assessment Tool); (6.4) Reduction in Health & Safety Risk; Ad Hoc Health & Safety Visits	Design Review (WGH OBC) (Report awaited)		

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			and HHGH Surgicentre development); Bi annual audit undertaken using Essence of Care Benchmark; Analysis of themes identified by PALS and Complaints. Action plans arising from national and local Patient Surveys. (6.4) Health & Safety Action Plan; Proactive Risk Assessment/ Management of Risk Register through established risk sub-committees Increased				

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
			resource agreed with PCTs 'Essence of Care' Programme				
7. Ensure patients receive prompt, efficient and effective care and have choice in access to appropriate services and treatments (Ref: SFBH Domain 5)	(7.1) Failure to achieve emergency care targets (ID: 585) (7.2) Lack of access to level two HDU service (RR ID: 401)	Organisation wide **Chief Operating Officer (TBC)**	(7.1) Temporary appointment of interim Director of Operations from 21/11/05 (7.1) Establishment of Emergency Care Task Force from 19/12/05 **(7.2) This risk is currently being assessed**	(7.1) Introduction of site lead role and responsibility for daily capacity management and hourly emergency care target performance from 19/12/05 (7.1) Department of Health Emergency Care Support Team working with Trust on	(7.1) Weekly report to CEO (7.1) Weekly report to Emergency Care Network (7.1) Weekly report to SHA (7.1) Performance Reports to the Board	(7.1) Change management programme not yet fully implemented	(7.1) Improvements being made but target not yet fully met

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
				Emergency Care Change Management Programme to be completed by March '06 Emergency Care Action Plan			
8. To ensure the efficient use of resources and meet statutory financial duties	(8.1) Failure to meet financial targets (8.2) Inability to deliver agreed services with available resources (8.3) Inability to plan for future services across health economies (8.4) Failure in probity and	Organisation wide **Director of Finance**	(8.1, 8.2, 8.4) Capital Planning Group (8.2, 8.3) Benchmarking costs against other Trusts, including reference costs and national tariff (8.1, 8.2) Green and Kassab review of Trust costs (8.1, 8.2) Strong	(8.1 - 8.5) Trust Recovery Plan (8.1) Balanced budget (8.1, 8.2) Cost against tariff (8.1) Financial targets are met (8.4) Audit Reports (8.2) Comparative data from external	(8.4) Internal Audit (8.1, 8.2, 8.3, 8.5) External Audit (8.4) Counter Fraud Services Reports	(8.1 – 8.5) Lack of reliable systems for monitoring and for effective communicati on both internally and externally	(8.1) Inability to achieve financial balance (8.1 – 8.5) Lack of integration of finance activity and manpower information.

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
	good governance (8.5) The Board not fully engaged in financial planning		budgetary control (8.5) Finance and Performance Committee (Board sub-committee) (8.3) Trust Internal Business Planning Group (8.5) Participation in the Quadrant Commissioning Group (8.4) Internal Audit, External Audit, Audit Committee Counter Fraud Services (8.4) Standing orders; schemes of	organisations (8.4) Financial reports to the Board (8.2, 8.3) Cost Comparisons by Healthcare Commission. (8.1- 8.5) Minutes of: Audit Committee Finance & Performance Committee Capital Planning Group Partnership Board			

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
			Delegation; Standing Financial Instructions				
9. To provide effective administrative and technological support for service delivery and management	9. Knowledge of the national programme and willingness to change practice	Organisation wide **Director of Finance**	(9.1) Costed plan for NpfIT implementation locally	(9.1) Compliance with Information Governance Framework	(9.1) Plan yet to be fully agreed		
10. Ensure that patients, carers, relatives and volunteers are involved in the planning and delivery of health care, to ensure the Trust meets the needs of patients (Ref: SFBH Domain 4)	10. 1 Organisational commitment to Public and Patient Involvement	Patient Experience **Chief Executive Officer**	(10.1) Functioning Patients Panel (10.1) Plan for Public and Patient Involvement	(10.1) Improved audit of patient opinion (incl. NAO patient surveys) (10.1) Work programme of the Panel reviewed by the Board (10.1) Representation of independent lay person to sit on key committees/foru	(10.1) NAO patient surveys	(10.1) Reporting system to be established (10.1)Work programme to be produced and reviewed (10.1) Implementati on of plan for PPI Plan to be agreed by	

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	Principal Risk	**Classification of Principal Risk and Executive Lead**			**Positive Assurances**	**Gaps in Control**	**Gaps in Assurance**
				m in the Trust		the Board	
11. To work in partnership with key stakeholders to achieve the Trust's objectives	(11.1) Lack of common objectives between Trusts and clinical staff (11.2) Time to manage relationships effectively	Organisation wide **Chief Executive Officer**	(11.1, 11.2) Forums for joint working with other organisations	(11.1, 11.2) Agreed service strategies between Trusts Audit of Partnership working (11.1, 11.2) Audit of communications with key stakeholders (11.1) Progress against strategic aims and objectives Clear statement of patient benefits	(11.1, 11.2) Sign off of agreement around service model, management and financial arrangement s	(11.1, 11.2) Need to establish working forums with other organisations .	

Abbreviations: RR – Risk Register

dl/ge/nm September 04

Developed and ratified by the Trust Board on 14 October 2004
Updated 25 November 2004
Updated 9 December 2004

Updated 14 February 2005
Updated 16 March 2005
Updated 18 March 2005
Updated 22 June 2005
Review and updated in line with SFBH 25 October 2005
Updated 28 November 2005
Updated 9 January 2006
Updated 10 January 2006
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