Kingston Hospital NHS
NHS Foundation Trust

Board Assurance Framework 2013/14

Name of meeting: Trust Board	**Item: 9.1**
Date of meeting: 26th March 2014	**Enclosure: J**
Purpose of the Report: To provide the Board with an outline of the key risks and changes within this year's Board Assurance Framework (BAF) since it was last presented to the Board in January 2014 and to ask the Board as the Scrutinising Committee to review in depth principal risks 4,5,6, and 9. The BAF will be considered by the Compliance and Risk Committee on Monday 24th March 2014. Any changes to the final year status of the report will be circulated following the meeting.	
For: Information ☐ Assurance ☒ Discussion and input ☒Decision/approval ☐	
Sponsor (Executive Lead):	Simon Milligan, Director of Finance
Author:	Lucy Carter, Assistant Company Secretary with input from Executive Directors
Author Contact Details:	lucy.carter@kingstonhospital.nhs.uk 020 8934 2145
Risk Implications - Link to Assurance Framework or Corporate Risk Register:	The report presents the 2013/14 BAF which highlights the controls and assurances on the management of the key risks to the delivery of the Principal Objectives
Legal/Regulatory/Reputation	
Link to Relevant Corporate Objective:	All
Document Previously Considered By:	Compliance and Risk Co-ordination Working Group – 13th March 2014 Executive Management – 17th March 2014 Quality Assurance Committee – 5th March 2014 Finance and Investment Committee – 27th February 2014 Audit Committee – 17th March 2014 Compliance and Risk Committee – 24th March 2014
Recommendations & Action required by the Trust Board: a) To review the 2013/14 BAF, and note the changes and areas of movement since the January 2014 Board meeting; b) Review in depth the four principal risks which are the responsibility of the Trust Board as the Scrutinising Committee; and c) Consider if the BAF provides assurance, in that it identifies the risks, controls and assurance that allows for the achievement of the Trust's principal objectives.	

1. Board Assurance Framework

1.1 Introduction

1.1.1 This report presents the Board Assurance Framework for review as a whole and for the scrutiny of four of the principal risks for which the Board has responsibility as nominated scrutinising committee.

1.1.2 There are two principal risks which have been scored at 12:
Principal Risk 1 - Failure to maintain and improve quality of care
Principal Risk 5 - Failure to ensure there are the right staff (numbers, skills and capability) in the right place

1.2 Changes in assurance and areas of movement in the BAF from last meeting on 29th January 2014

1.2.1 A summary of all new positive and negative assurances are included under appendix 1 along with the scores for each risk. There are no proposed changes to the scores of the principal risks.

1.2.2 An overview of the risks is included at appendix 2.

1.3 Delays in implementing of controls

There are no significant areas where controls have not taken place.

1.4 New Risks

No new risks have been identified

1.5 Review of the BAF by sub-committees

1.5.1 The risks have been reviewed by the responsible committees as outlined in appendix 3. Any requested changes have been documented in appendix 1.

1.6 Risks to be reviewed by the Board

1.6.1 The following risks are currently the responsibility of the Board to review as the scrutinising committee. The risks were also reviewed by the Executive Management Committee on 12th March 2014 as the responsible executive committee

1.6.2 In order for the Board, as the scrutinising committee, to be able to make decisions about the levels of assurance provided, further detail has been included on the sources of assurances on the pages following those four principal risks in appendix 4.

Principal Risk 4 - Scale of implementation and deployment of a number of new IT systems impacts negatively on the functioning of the Trust and on clinical care
Principal Risk 5 - Failure to ensure there are the right staff (numbers, skills and capability) in the right place
Principal Risk 6 - Failure to develop the organisation to support the delivery of the Trust's vision
Principal Risk 9 -Failure to respond appropriately to changes in the external environment

2. Recommendation

The Board is asked to:

a) To review the 2013/14 BAF, and note the changes and areas of movement since the January 2014 Board meeting;
b) Review in depth the four principal risks which are the responsibility of the Trust Board as the Scrutinising Committee; and
c) Consider if the BAF provides assurance, in that it identifies the risks, controls and assurance that allows for the achievement of the Trust's principal objectives.

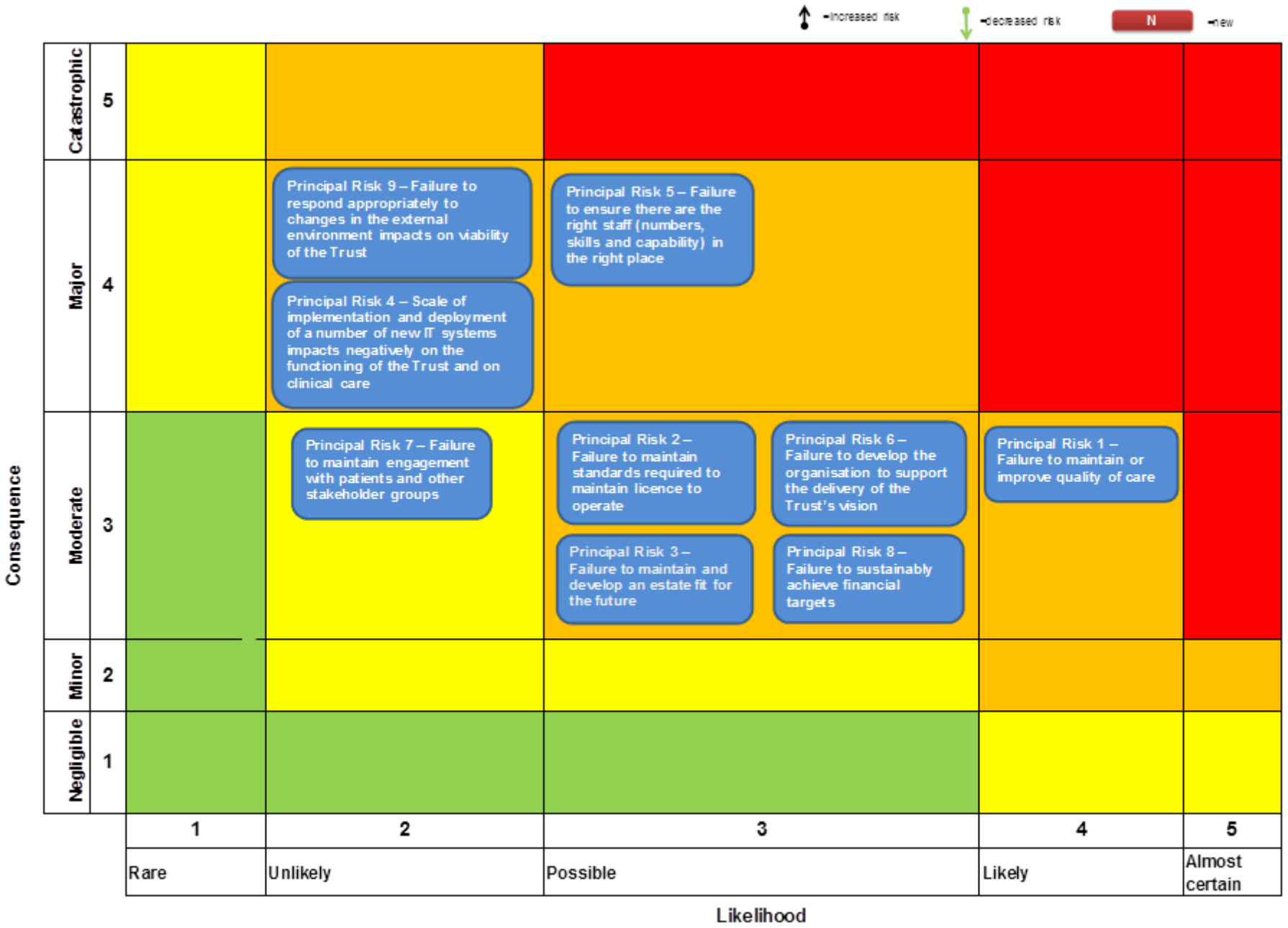
Appendix 1

Summary of changes in assurance and any proposed changes to risk ratings

Principal Risk	Current Risk Rating	Key Positive Assurances	Changes to Negative Assurances	New Risk Rating
Principal Risk 1 - Failure to maintain and improve quality of care	**12**	No new positive assurances	No new negative assurances	**No change**
Principal Risk 2 - Failure to maintain standards	**9**	No new positive assurances	No new negative assurances	**No change**
Principal Risk 3 - Failure to maintain and develop an estate fit for the future	**9**	No new positive assurances	No new negative assurances	**No change**
Principal Risk 4 - Scale of implementation and deployment of a number of new IT systems impacts negatively on the functioning of the Trust and on clinical care	**8**	No new positive assurances	No new negative assurances	**No change**
Principal Risk 5 - Failure to ensure there are the right staff (numbers, skills and capability) in the right place	**12**	No new positive assurances	• **Staff survey results for 2013 reports some poor people management**	**No change**
Principal Risk 6 - Failure to develop the organisation to support the delivery of the Trust's vision	**9**	• **Leadership programme starting.**	No new negative assurances	**No change**
Principal Risk 7 - Failure to maintain engagement with patients and other stakeholder groups	**6**	• **Volunteering Strategy approved by the Trust Board in January 2014**	No new negative assurances	**No change**
Principal Risk 8 - Failure to sustainably achieve financial targets	**9**	No new positive assurances	No new negative assurances	**No change**
Principal Risk 9 -Failure to respond appropriately to changes in the external environment	**8**	No new positive assurances	No new negative assurances	**No change**

Appendix 2

Current Ratings of Principal Risks in the Board Assurance Framework – March 2014



Principal Risk 1 – Failure to maintain and improve quality of care

Executive lead – Medical Director
Scrutinising committee – Quality Assurance Committee
Date last reviewed by Committee: 6th November 2013
Review by responsible committee – RMC – 14th October – will now report to the Clinical Quality Improvement Committee
Link to Corporate Risk Register: T_MAE003, T028, T018, T021, T016, T-MAE_AM016, T_WCH_PAE003, T_MAE_AM013, T_SCC_TCS007
Links to Corporate and Priority Objectives: 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 3.1, 5.2
Last Reviewed: Medical Director, 19th February 2014 – changes in red

Initial Risk Rating C X L: 3 x 3

Current Risk Rating C X L: 3 x 4

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
Monitor Quality Governance CQC Professional Regulator	• Governance Framework • Policies and Guidelines • Training and Education • Risk Management Strategy • CQC Controls – Challenge Sessions • Quality Account • Quality Strategy	**Internal Sources of Assurance (quality and level)** • Clinical Audits • Clinical Quality Reports • Ward Scorecards • CQC internal Challenge Sessions • Walkabouts	**Gaps in Control/Assurance** 1) Weak and incomplete information flows and data analysis 2) Benchmarking data not always available to allow comparisons with others 3) Limited correlation of information from SIs, incidents and complaints. 4) Ulysses system not yet working fully.	1) SLM Balanced Scorecards with quality performance indicators 2) Review of information set for Working Group and cross check with CQC data set 3) Align Quality Data in Q&S and QA 4) Improve exception reports in Q&S report to the Board.	October 2014 March 2014 Dec 2014 Complete
		External Sources of Assurance (have they been sought or are they planned) • CQC Quality and Risk Profiles • CNST/NHSLA • CQC Unannounced Visit compliant with all standards with exception of 1 on the medical wards. • Safety Thermometer benchmarking • Inpatient Surveys • Other benchmarking	**Negative Assurances** 1) Some issues of failings of care identified through serious incident investigations. 2) Falls 3) C-Difficile 4) Results of the Junior Doctor Survey 5) Unannounced CQC inspection resulted in non-compliance with one standard on the medical wards.	1) Align QAC workplan to areas of concern (JW) 2) New action plan to reduce falls has been developed and is being implemented 3) An action plan has to address concerns raised in the survey and hospital at night is being implemented. (JW) 4) Action plan developed to address issues raised by CQC(DB). 5) Following the Trust joining NHS Quest, work needs to be undertaken to ensure that the Trust is active in its membership.	Complete Complete May 2014 March 2014 Complete

Principal Risk 1 – Further information on assurances

Internal Sources of Assurance

Clinical Audits

Clinical Audit reports are published on the intranet. Audits include those for assurance such as the National audit of cardiac arrest and service improvement audits and re-audits, such as Dementia screening and referral. No new clinical audits have given cause for concern that would affect the rating.

Clinical Quality Reports

Reports are produced monthly and presented to every Board and QAC meeting. The key issue highlighted here is the c.difficile rate.

Divisional and Ward Scorecards

Scorecards are considered at divisional board and reported on an exception basis to RMC. Incident reporting and safety thermometer have been included on this report, no issues have been raised that would affect the scoring of the principal risk.

Walkabouts

The outcomes of walkabouts are reported to EMT and included in the Quality Report, these have not identified anything that we would want to bring to the Committee's attention.

Negative Assurances

1) **Some issues of failings of care identified through serious incident investigations.**
   A lack of recognition of deteriorating patients has been identified as a theme and actions have been identified to address this. The new National Early Warning Score (NEWS) has been implemented through the trust. A Quality Improvement Project has been developed on sepsis.
2) **Falls**
   The action plan to reduce falls throughout the Trust is being updated.
3) **C-Difficile**
   There have been 15 reported cases of c.difficile in the year to date.
4) **Junior Doctor Survey**
   The results of the recent Junior Doctor survey highlighted some safety concerns. An action plan has been developed to address this and initial actions have been implemented, a deep dive will be undertaken at QAC.
5) **CQC inspection**
   Unannounced CQC inspection resulted in non-compliance with one standard on the medical wards, an action plan has been developed and is underway to address the issues raised.

Update on action plans

Establishment of Clinical Quality Working Group – now completed
Serious Incident reporting to Board – Completed
Serious Incident Group – established to review SIs and the tracker and action plan tracker

The actions below have been incorporated into the work of the Quality Improvement Working Group and superseded

1) Improve data quality in Quality Performance review through scrutiny at Divisional Board Meetings and consider role of clinical analyst (JW)
2) Standardisation of Measures (JW)
3) Plan to use greater triangulation/correlation through the use of complaints information to create specific action plans (JW)
4) Task and finish group set up to address the issue.
5) Serious Incident and other action plans (JW)

Principal Risk 2 – Failure to maintain standards required to maintain licence to operate

Executive lead – Deputy Chief Executive
Scrutinising committee –**Quality Assurance Committee**
Date last reviewed by Committee: 8th January 2014
Review by responsible committee – RMC – 14th October – will now report to the Clinical Quality Improvement Committee
Link to Corporate Risk Register: T_MAE_AM017, T027, T031
Links to Corporate and Priority Objectives: 1.1, 1.2, 3.4, 3.5
Last Reviewed: Deputy Chief Executive 21st February 2014 – changes in red

Initial Risk Rating C X L: 3 x 3

Current Risk Rating C X L: 3 x 3

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
Monitor Quality Governance CQC	• Review GRR/secondary indicator quarterly submission • Monthly and quarterly performance meetings	**Internal Sources of Assurance (quality and level)** • Peer review • Reports on progress • Visits • Internal Audit on Self Certification • Monthly performance meetings	**Gaps in Control/Assurance** 1) Ensuring effective communication of the available information e.g.: - activity targets - Contract information 2) JAG accreditation	1) Speciality teams to review all relevant information at team meetings.(ST) 2) Contract information to the shared monthly (ST) 3) For assessment in autumn 2013 – Provisional meeting 15th January 2014 4) JAG Accreditation visit planned for 16th May 2014 5) Project support secured for 8 weeks commencing March 2014.	Complete Complete Complete May 2014 April 2014
		External Sources of Assurance (have they been sought or are they planned) • PLACE • Maintain NHSLA level as was • External Visits including: - CPA - HTA	**Negative Assurances** 1) Cancer performance ~~2) Cytology screening~~ 3) Number of C-difficile cases 4) Unannounced CQC inspection resulted in non-compliance with one standard on the medical ward	1) Cancer action plan monitored through Cancer Team (ST) 2) Cytology screening plan monitored through divisional board.(ST) 3) Pathway revision underway for tertiary referrals 4) HCAI action plan in place 5) Action plan developed to address issues raised by CQC(DB).	March 2014 Complete March 2014 Complete March 2014

Principal Risk 2 – Further information on assurances

Internal Sources of Assurance (quality and level)

- **Peer review**
  Now completed.
- **Visits**
  Regular walkabouts by NEDs and Executive Team, actions are captured at the EMT meetings.
- **Internal Audit on Self Certification**
  The internal audit on self-certification is planned for late summer 2013.
- **Monthly performance meetings**
  Divisional meetings underway, strong Divisional performance to date.

External Sources of Assurance (have they been sought or are they planned)

- **PLACE**
  Recently undertaken, actions planned particularly regarding the breakfast provided for patients. Warm milk now available on wards for hot drinks.

- **Maintain NHSLA level as was**

The Trust achieved NHSLA level 1 in February 2013. We achieved CNST level 2 in January 2012 and are working towards level 3.

- **External Visits including:**
  - CPA – Expected in December 2013
  - HTA – No visit planned at this time

Negative Assurances

1) Cancer performance
   Cancer performance is now on track. Increased weekly monitoring and escalation of issues. Close working with Royal Marsden Hospital and St George's Hospital to develop pathways continues.
2) Number of C-diff cases
   The number of c-difficile cases stands at 18. HCAI action plan is in place. External Review undertaken, awaiting report.
3) CQC Inspection Report
   Action needed regarding the care and welfare of people who use our services. Action plan has been developed and being monitored through weekly meetings chaired by the Director of Nursing and Patient Experience.
4) JAG Accreditation visit planned for 16th May 2014. Project support secured to ensure all evidence is supplied as required by 4th April 2014. Building work will be completed on time.

Principal Risk 3 – Failure to maintain and develop an estate fit for the future **Executive lead** – Deputy Chief Executive Director of Strategic Development **Scrutinising committee** – Finance and Investment Committee **Date last reviewed by Committee: FIC 19th December** **Review by responsible committee - EMC 30th October 2013 and 8th January 2014** **Link to Corporate Risk Register:** T_EST005, T_EST002, T_EST004 **Links to Corporate and Priority Objectives: 1.6** **Last Reviewed: Deputy Chief Executive 21st February 2014 – changes in red**				**Initial Risk Rating C X L: 3 x 3**  **Current Risk Rating C X L: 3 x 3** 	
Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
CQC Health and Safety Executive Legionella Regulations Hazardous Equipment Planning Controls	Project Governance arrangements established to develop strategy (including, steering and working groups) Frankham's Report on business critical services Audits/reports committees Capital plan Risk Register	**Internal Sources of Assurance (quality and level)** PLACE Audits Legionella Audit L8 Guard. Internal Audit on Estates Procurement Health and safety audits Estates Director started Estates strategy approved by the Board	**Gaps in Control/Assurance** ~~1) Lack of Estates Director~~ ~~2) Lack of Strategy~~ 3) Estates procurement supervision and sign off	1) Estates Director started 5th August. (ST) 2) Estates steering group and operational group to develop strategy (RB) 3) Draft estates Strategy to be presented to the Board 4) Implementation of recommendations from audit of tendering and procurement processes when completed(ST) 5) Implementation of the Estates Strategy.	Completed Completed Completed Commenced July 2014
		External Sources of Assurance (have they been sought or are they planned) Frankham's Report Advanced environmental analytical reports on water quality	**Negative Assurances** 1) Outpatient Survey 2) Staff Survey	1) Outpatient Action plan (ST) 2) Staff/hand hygiene action plan (DB) 3) Outpatient action plan being addressed through Estates working group.	Completed March 2014 July 2014

Principal Risk 3 – Further information on assurances

Internal Sources of Assurance (quality and level)

- **PLACE Audits**
  Recently undertaken, actions planned particularly regarding the breakfast provided for patients.

- **Legionella Audit L8 Guard**
  Inhouse flushing regime monitored weekly, over 85% response currently.

- **Health and safety audits**
  Divisional health and safety audits undertaken in all areas. Action plans agreed and monitored through Performance Review Meetings and reported into the Health and Safety Committee. To be reviewed in 6 months.

External Sources of Assurance (have they been sought or are they planned)

- **Frankham's Report**
  A review of business critical services was undertaken, identifying highest risks to be addressed. Planning underway to commence replacing pipework in Esher Wing over 2013/14. All other works currently being scheduled for next five years.

- **Advanced environmental analytical reports on water quality**
  Regular monitoring of water quality on site.

Negative Assurances

1) Outpatient Survey
Outpatient redesign programme in place, including patient participation in redesign and will form part of the Estates Strategy..

2) Staff Survey
Particular issues identified in relation to hand hygiene and washing facilities. Action plan in place.

Principal Risk 4 – Scale of implementation and deployment of a number of new IT systems impacts negatively on the functioning of the Trust and on clinical care

Executive lead – Chief Executive
Scrutinising committee –**Trust Board**
Date last reviewed by Committee: 27th November 2013
Review by responsible committee – EMC 30th October 2013 and 8th January 2014
Link to Corporate Risk Register: T_IMT009, T_IMT013, T_IMT010, T_IMT011, T_IMT012, T_IMT014
Links to Corporate and Priority Objectives: PO1, 3.1, 5.2
Last Reviewed: Deputy Chief Executive 21st February 2014 – changes in red

Initial Risk Rating C X L: 4 x 4

Proposed Risk Rating C X L: 4 x 2

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative controls or assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
Monitor	Comprehensive pre-deployment Planning and resourcing Dedicated programme governance structure	**Internal Sources of Assurance (quality and level)** • Feedback from staff • KPI • Regular reports to the Board • Remedial action plan monitoring • Attendance at training • Reports received and validated • Recruitment programme achieved	**Gaps in Control/Assurance** 1) As an early adopter no reference site available 2) Not using real time bed management	1) Look to USA and others globally and work closely with Cerner (KG) 2) Action plan by using real time bed management (ST) 3) Nursing Recruitment Programme (DB)	March 2014 Complete Complete
		External Sources of Assurance (have they been sought or are they planned) No external sources of assurance at present	**Negative Assurances** No negative assurances		

Principal Risk 4 – Further information on assurances

Internal Sources of Assurance (quality and level)

- **Feedback from staff**
  Deployment approach for major systems (e.g. CRS upgrade) discussed at Operational group and resource model developed to minimise impact on ward areas.

- **KPI**
  Dashboard being developed to identify any adverse impact on operational performance at an early stage of IT deployments

- **Regular reports to the Board**
  CRS presentation to the board on the roll-out approach and a further report on Risks around the programme will be given in July. Quarterly IT performance reports to EMC, and half yearly to the Board
- **Remedial action plan monitoring**
- **Attendance at training**
  CRS deployment requires 80% training booking and attendance - 95% for key users.
- **Reports received and validated**
  CRS programme Board receives regular highlight reports from the project**.** IM&T Steering committee monitor progress/risks for IM&T schemes delivered through the business planning process**.**

External Sources of Assurance (have they been sought or are they planned)
No external sources of assurance at present

Negative Assurances
No negative assurances

Update on action plans
Clinical Documentation roll out planned for March 2014 in A and E. Plans currently being developed for clinical documentation and e-prescribing roll out across the in-patient areas for 2014/15.

Principal Risk 5 – Failure to ensure there are the right staff (numbers, skills and capability) in the right place

Executive lead – Director of Workforce and OD
Scrutinising committee –Trust Board
Date last reviewed by Committee: 27th November 2013
Review by responsible committee - EMC 30th October 2013 and 8th January 2014
Link to Corporate Risk Register: T_MAE_AM008, T025,
Links to Corporate and Priority Objectives: PO2, 1.3, PO3, 2.1, 2.2, 2.3, 2.4, 5.1, 5.2
Last reviewed: Director of Workforce and OD 19th February 2014 – changes in red

Initial Risk Rating C X L: 4 x 3

Current Risk Rating C X L: 4 x 3

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
CQC Standards 11, 12 and 13 Monitor Licence	• Establishment reviews • Performance against benchmarks • Implementation of our workforce strategy • Budget reviews • Proactive capacity planning • Recruitment and retention plans • Management Capability • Appraisals and PDPs • Job Plans • Temporary staffing controls • Pre-employment checks • Mandatory Training • Induction • Service Line Business Plans	**Internal Sources of Assurance (quality and level)** • People Management Feedback • Staff Survey • Budget/establishment review • Monitoring of staffing on shifts • PDR Reports • Mandatory Training and Induction Reports • HR Internal Audit	**Gaps in Control/Assurance** 1) Accessible data on actual shift fill rates and skill mix 2) Effective exit mechanisms to understand why people leave 3) Unit recruitment plans that account for turnover 4) Completed Service Line Business Plans for 2014/15	1) Staff Survey Action plan (DG) 2) Performance reporting tool on nursing deployment (roster perform) (DG) 3) Nurse recruitment exit interview programme (DB) 4) Nurse recruitment plan (DB) 5) E-roster optimisation work (DG) 6) Annual Business Planning Timetable	March 2014 Completed 31 July 2013 Completed 30th April 2014 31st March 2014
		External Sources of Assurance (have they been sought or are they planned) • Performance against benchmarks and national standards • CQC QRP reports • National Staff Survey	**Negative Assurances** 1) Local staff survey reports insufficient staffing as a key staff concern, 2) High turnover in medicine and corporate areas 3) Difficulty getting temporary backfill 4) Poor nursing leadership management on wards 5) Staff not being released for training 6) Lack of communication and team working 7) Shift patterns 8) Some poor people management reported (Staff Survey 2013)	1) Ward sister programme (DB) 2) Leadership Development (DG) 3) Shift pilot in medical ward evaluation awaited (DB) 4) Mandatory training action plan (updated at meeting on 4th October) 5) Team working action plan (DG)	30 March 2014 30 March 2014 February 2014 31st March 2014 30th April 2014

Principal Risk 5 – Further information on assurances

Internal Sources of Assurance (quality and level)

- **People Management Feedback**

  The Trust has collected feedback on every manager/supervisor during appraisal/PDR in 2013. The feedback has informed PDPs and trust wide interventions, process to be repeated in 2014.

  Staff Survey

  The results were positive in 2012 and have not changed significantly in 2013. In Q3 of 2013/14 the local survey results for engagement were average. Main issue raised by staff was staffing levels.

  Budget/establishment review

  Establishments and budgets agreed with managers for 2013/14, but plans for 2014/15 are still being completed.

  Monitoring of staffing on shifts

  New tools to monitor safe staffing being developed. Some issues with reliability/access. Re-training and set-up required with wards.
- **PDR Reports**

  Data on uptake reported. Discussions underway on system for 2014-15 linked to AFC changes/incremental progression.
- **Mandatory Training and Induction Reports**

  Data shows take-up had improved but then worsened. An action plan is being pursued and reviewed regularly. Reports now at service line level and improving uptake.
- **HR Internal Audit**

  The latest audit into recruitment and induction was adequate in 12/13 and recommendations following the audit were implemented.

External Sources of Assurance (have they been sought or are they planned)

- **Performance against benchmarks and national standards**

  An area of concern is turnover. Other indicators are comparable or favourable.
- **CQC QRP reports**

  No significant change.
- **National Staff Survey**

  2012 showed good relative performance. An action plan is in place at both a trust wide and divisional level. 2013 Survey rated performance overall as average, weaker scores in areas of people management by managers.

Negative Assurances

1) **Staffing is the main issue raised in the local survey**

   Recruitment plan has been underway for nursing and vacancies are reduced.
2) **High turnover in medicine and corporate areas**

   Nurse leadership programme
3) **Difficulty getting temporary backfill**

   Bank improvement plan and proposals to change management arrangements pursued. New manager appointed to work with bookers and wards.
4) **Poor nursing leadership management on wards**

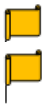
   Nurse leadership programme is underway.
5) **Inability to release staff for training**

   A mandatory training action plan is underway, on-line training is underway.
6) **Lack of communication and team working**

   Team development toolkit prepared.
7) **Shift patterns**

   A pilot of alternative shift patterns is underway.
8) **Some poor people management reported**

   Leadership development and feedback to managers from PDRs.

Principal Risk 6 – Failure to develop the organisation to support the delivery of the Trust's vision **Executive lead** – Chief Executive **Scrutinising committee** –Trust Board **Date last reviewed by Committee: 27th November 2013** **Review by responsible committee - EMC 30th October 2013 and 8th January 2014** **Link to Corporate Risk Register:** T009, T_HR009 **Links to Corporate and Priority Objectives: PO1, PO2, 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.12.3, 5.1, 5.2** **Last reviewed: Director of Workforce and OD 19th February 2014 – changes in red**				**Initial Risk Rating C X L: 3 x 3** **Current Risk Rating C X L: 3 x 3** 	
Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
All Monitor Regulations	• OD Plan and action plan • OD plan owned • Governance Structure to oversee implementation • External Support and input from Beech consultancy • Workforce strategy	**Internal Sources of Assurance (quality and level)** • KPI • Staff engagement • Staff Survey • OD Plan (agreed by the board in July 2013) • Management arrangements clarified • Leadership programme starting.	**Gaps in Control/Assurance** ~~1) Some management changes/vacancies creating uncertainty~~ ~~1) Leadership programme not yet commenced.~~	1) Plan to Board in July (KG) 2) Shared with the Board (KG) 3) Consultation implemented 4) Leadership programme tendered 5) Leadership programme to be finalised 6) Service line business and strategy planning (RB)	Complete Complete Complete Complete Complete 31st March 2014
		External Sources of Assurance (have they been sought or are they planned) • Beech management support • Annual Staff Survey	**Negative Assurances** No negative assurances		

Principal Risk 6 – Further information on assurances

Internal Sources of Assurance (quality and level) • KPIs • Staff engagement 2012/13 Quarter 4 score was comparable with the 2012 Staff Survey. • Staff Survey Good results in 2012. Action plan approved by the Board in March 2013. No evidence of deterioration in Quarter 4 of 2012/13.
External Sources of Assurance (have they been sought or are they planned) • Beech management support Tender for leadership and management development prepared. • Annual Staff Survey Good results in 2012, action plan approved by the Board in March 2013.
Negative Assurances No negative assurances

Principal Risk 7 – Failure to maintain engagement with patients and other stakeholder groups

Executive lead – Director of Nursing and Patient Experience
Scrutinising committee – Quality Assurance Committee
Date last reviewed by Committee: 6th November 2013
Review by responsible committee – RMC – 14th October – will now report to the Patient Experience Committee on 9th January.
Link to Corporate Risk Register: T012
Links to Corporate and Priority Objectives: 1.2, 1.6, PO3, 2.1, 3.4, 3.5, 5.2
Last Reviewed: Patient Experience Improvement Manager – 6 February 2014 – updates in red

Initial Risk Rating C X L: 3 x 2

Current Risk Rating C X L: 3 x 2

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
• CQC • Monitor • Healthwatch • OSC • Health and Wellbeing Board	• Quality Scrutiny & Improvement Group (QSIG) • Commercial Strategy • Patient Assembly • Clinical Quality Review Group • SSB • Governing Body • PPI strategy	**Internal Sources of Assurance (quality and level)** • Friends and family test and local patient surveys • Six monthly reports on Commercial Strategy • Proposed Internal Audits on patient experience and complaints • QSIG progress reports to QAC • PPI strategy approved by the Trust Board in July 2013 • Healthwatch meeting minutes • Patient Assembly minutes • Volunteering strategy approved by the Trust Board in January 2014	**Gaps in Control/Assurance** 1) Feedback mechanism for stakeholders not yet effective 2) Representativeness of stakeholder engagement in line with actual local population 3) Transition to new PPI arrangements could cause negative change in relationship with stakeholders if not fully supportive of the new strategy.	1) Review structure of patient involvement stakeholder groups as part of QSIG work (DB) 2) Review terms of reference for various groups and revise reporting mechanisms where appropriate. (DB) 3) Develop PPI strategy as part of QSIG review. For approval at Trust Board (DB) 4) Implementation of plans to address representativeness through PPI review(DB)	Complete Complete Complete June 2014
		External Sources of Assurance (have they been sought or are they planned) • Patient Survey • Healthwatch Reports • External CQRG reports • Active engagement with OSCs • NHS Choices comments • NHS Care Connect comments	**Negative Assurances** No negative assurances		

Principal Risk 7 – Further information on assurances

Internal Sources of Assurance (quality and level)

Friends and family test and local patient surveys

The overall Friends and Family Test score for the whole hospital (including inpatients, A&E, outpatients and maternity) for December is 64. This is based on 3060 responses. We are required to report the Inpatient and A&E scores which are 61and 58 respectively. We also report nationally on the FFT for Maternity Services and in December 2013 the overall FFT score for Maternity Services was 64.

Six monthly reports on Commercial Strategy

Trends in new Outpatient Activity, Referrals, Waiting Times and Market Share was considered by the EMC in December 2013.

Proposed Internal Audit on patient experience and complaints

This has now taken place and no major issues were identified**.**

QSIG progress reports to QAC

QAC members have been involved in the work of QSIG and reports have been presented on the progress at meetings.

External Sources of Assurance (have they been sought or are they planned)

Patient Survey

The Board received the results of the Adult In-Patient survey for 2012 in May 2013. Overall, the Trust has made significant progress in improving the experience of inpatients at Kingston Hospital and an action plan has been put in place to address issues highlighted. The Maternity Survey published in December 2013 shows the Trust is the highest rated in London.

Healthwatch Reports

Healthwatch have provided responses for inclusion to the Quality Account 2011/12 and the Healthwatch Forum has now commenced.

External CQRG reports

CCG has provided responses for inclusion to the Quality Account 2011/12.

Active engagement with OSCs

A member of the EMC attends OSC meetings on a regular basis.

NHS Choices comments

The trust has a protocol for handling comments posted on NHS Choices, divisions are expected to respond within three working days. The Trust is taking part in NHS Care Connect pilot.

Updates on action plans

1) Review structure of patient involvement stakeholder groups as part of QSIG work (DB) – Proposed structure drafted and to be included in PPI strategy - completed
2) Review terms of reference for various groups and revise reporting mechanisms where appropriate. (DB) Drafting of revised terms of reference underway – completed
3) Develop PPI strategy as part of QSIG review. For approval at Trust Board (DB) On target to be presented to July 2013 Trust Board - completed
4) Develop & implement plans to address representativeness through QSIG PPI review(DB) Component of strategy – strategy approved in July 2013 - progressing

Principal Risk 8 – Failure to sustainably achieve financial targets

Executive lead – Deputy Chief Executive with support from Director of Finance and Productivity Director
Scrutinising committee – FIC
Date last reviewed by Committee: Reviewed by FIC 19th December
Review by responsible committee - EMC 30th October 2013 and 8th January 2014
Link to Corporate Risk Register: T002, T_WCH_MAT009, T016, T029, T037, T029,
Links to Corporate and Priority Objectives: PO2, 4.1, 5.1, 5.2
Last reviewed: Director of Finance, 25th February 2014, no changes identified.

Initial Risk Rating C X L: 3 x 3

Current Risk Rating C X L: 3 x 3

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
Monitor	Maintain Five year planning cycle Engagement with divisions on SLA Signed Contract Engagement with commissioners on operational and strategy matters Budget setting process with clear and rigorous rules Ownership of budgets and functioning performance framework Clear plan to move to SLM Upgraded financial and procurement systems	**Internal Sources of Assurance (quality and level)** • Regular reporting to the Board on finance, CIP and SLA • Proper functioning of FIC • Signed Budgets • Signed Contract • Monthly performance	**Gaps in Control/Assurance** 1) Proposed Trust approach to SLM has been devised 2) Need close partnership working with whole system transformation board to be sustained and developed 3) Formalised budget holder training	1) Develop Trust plan for SLM and implement (NH/SM) 2) Need to strengthen partnership working via whole system transformation board and CQRG (ST/SM) 3) Recraft Trust plan for SLR and PLICs (SM) 4) Ensure benefits of new ledger and procurement system fully realised (SM) 5) Formalise budget holder training (SM) 6) Review how CQRG is managed.	Complete Complete March 2014 March 2014 March 2014 March 2014
		External Sources of Assurance (have they been sought or are they planned) • Scrutiny of 5 year plan by Monitor/TDA	**Negative Assurances** 4) Insufficient use of SLR/PLICS data 5) Deployment of CRS has been delayed	7) Demonstrate links from SLM information in ledger to SLR/PLICS (SM) 8) Source support from BT and Department of Health to cover costs of CRS delay	March 2014 [Now not applicable as only limited update]

Principal Risk 8 – Further information on assurances

Internal Sources of Assurance (quality and level)

- **Regular reporting to the Board on finance, CIP and SLA**
  Comprehensive Finance Report prepared for month 1 to month 5. Trust on plan.

- **Proper functioning of FIC**
  FIC meets regularly; Director of Finance and Senior Independent Director meet to set agenda; action list maintained.

- **Signed Budgets**
  Budgets signed for virtually all cost centres.

- **Signed Contract**
  Heads of agreement in place since 28th March 2013. Trust has signed and contract is with CCG for signature.

External Sources of Assurance (have they been sought or are they planned)

- **Scrutiny of 5 year plan by Monitor/TDA**
  FT licence granted based on 5 year plan in the IBP. 3 year plan submitted to Monitor, no issues reported. Q1 submission made to Monitor. Very few issues raised by Monitor in Q1 telephone catch up.

Negative Assurances

- **Insufficient use of SLR/PLICS data**
  Emphasis being placed on moving to SLM. This move will drive service lines to use SLR/PLICs data further.
- Deployment of CRS has been delayed
  Source support from BT and Department of Health to cover costs of delay.

Update on action plans

1) Develop Trust plan for SLM and implement (NH/SM)
   Trust engagement with McKinsey/NHS London Together to Improve Value (TTIV), two specialities taken through the programme. Trust plans for implementation of service line management developed. Finance component will be developed. Plan for SLM developed and being implemented ('SLM 1b' commenced with month 6 reporting)
2) Need to strengthen partnership working via SSB and CQRG (ST/SM)
3) Recraft Trust plan for SLR and PLICs following introduction of SLM(SM)
   See 6 below.
4) Ensure benefits of new ledger and procurement system fully realised (SM)
   System optimisation process being implemented.
5) Formalise budget holder training (SM)
   A training programme related to SLM is being developed and rolled out. Contract for OD (leadership, management, SLM) about to be let.
6) Reinvigorate SLR/PLICS (SM)
   Emphasis being placed on moving to SLM will re-engage with SLR/PLICs for Q3 (reporting in Q4). This move will drive service lines to use SLR/PLICs data further.

Principal Risk 9 – Failure to respond appropriately to changes in the external environment impacts on viability of the Trust

Executive lead – Director of Strategic Development
Scrutinising committee –Trust Board
Date last reviewed by Committee: Reviewed by Trust Board 27th November 2013
Review by responsible committee - EMC 30th October 2013 and 15th January 2014
Link to Corporate Risk Register: T006, T003, T005, T007, T008, T_AC_PAT0019
Links to Corporate and Priority Objectives: 3.1, 3.2, 3.3, 4.1, 4.2
Last Reviewed: Director of Strategic Development**, 14th February – changes in red**

Initial Risk Rating C X L: 4 x 2

Current Risk Rating C X L: 4 x 2

Links to primary regulatory frameworks Identify links to other primary regulatory frameworks such as Monitor's Quality Governance Framework	**Key controls to manage risks** Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed.	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
Health and Social Care Act Risk Assessment Framework	• Downside/Upside review sessions with Board • Horizon Scanning sessions with Board • Stakeholder engagement strategy • Robust five year plan • Commercial team in place with capability for leading bid process • Partnerships e.g. SGH, SAP, Merton CCG, , WSTB, SWL Pathology, Elective Orthopaedic Centre. • Commercial Strategy/Action plan • Criteria/Systems in place to assess: - Merger and acquisition opportunities - Tendering opportunities • Engagement with neighbouring CCGs and local providers to support development of BCF plans	**Internal Sources of Assurance (quality and level)** • Board Review of Commercial Strategy, Stakeholder Engagement Strategy • WSTB minutes and project plans • Stakeholder Survey	**Gaps in Control/Assurance** 1) Transaction plans less developed than competitors 2) Ownership of commercial strategy/action plan at business unit level could be strengthened 3) Arrangements for sector wide planning unclear post BSBV	1) Development of transaction plans (RB) 2a) OD strategy development (KG) 2b) Develop Programme to develop strategies for each service line (RB) 3)Close liaison with CCG leads to understand future planning assumptions that could impact on the Trust (RB/SM)	**Complete** **Complete** **Complete** **March 2014**
		External Sources of Assurance (have they been sought or are they planned) • Five year plan reviewed by NHS London, DH, Monitor, Alvarez and Marsal • Successfully influenced BSBV proposals for consultation (although programme no longer proceeding) • Merton and Kingston CCGs working collaboratively with the Trust on the development of outreach facilities.	**Negative Assurances** No negative assurances		

Principal Risk 9 – Further information on assurances

Internal Sources of Assurance (quality and level)

- **Board Review of Commercial Strategy, Stakeholder Engagement Strategy**
  Commercial Strategy reviewed February 2013 and Stakeholder Engagement Strategy reviewed November 2013. Further board reports planned. January 2014 – Stakeholder Engagement Strategy, March 2014 – Commercial Strategy

- **WSTB minutes and project plans**
  WST

- **Stakeholder Survey**
  A Stakeholder Survey was undertaken in summer 2012 and the results were generally positive. Plans to understand stakeholder views will be included in the refreshed stakeholder engagement strategy going to the Board in January 2014.

External Sources of Assurance (have they been sought or are they planned)

- **Five year plan reviewed by NHS London, DH, Monitor, Alvarez and Marsal**
  The Trust's plan was sufficiently robust to enable FT authorisation.

- **Successfully influenced BSBV – confirmed as 1:3 sites**
  Next steps to be confirmed following the withdrawal of support from Surrey Downs CCG.

- **Merton and Kingston CCGs working collaboratively with the Trust on the development of outreach facilities.**
  Trust services opened at Raynes Park Health Centre in April 2013. Further Trust services opened at Surbiton Hospital in January 2014.

Negative Assurances

No negative assurances have been identified

Update on action plans

1) Transaction plan (RB)
Approach developed July 2013 and discussed at the Board Development Forum in September 2013.

2a) OD strategy development (KG)
The final plan was presented to the Board in July 2013.

2b) Service Lines Strategies (RB)
Process discussed and agreed at EMC in October 2013. Development of Strategies underway for agreed service lines.

3)Close liaison with CCG leads to understand future planning assumptions that could impact on the Trust (RB/SM)
Discussions underway to inform development of 2 year operational plan and 5 year strategic plan for submissions to Monitor

Abbreviation used in risk register links	Explanation
T	**Corporate**
EST	Estates
FIN	Finance
HR	Human Resources
IMT	Information Management & Technology
IG	Information Governance
INF	Information Services
MAE	**Medicine and A&E**
ED	A&E
AM	Acute Medicine
SP	Specialities
TH	Therapies
AC	**Ambulatory Care**
CPC	Cancer and Palliative Care
REC	Health Records
OPD	Outpatients Department
PAT	Pathology
PHA	Pharmacy
RAD	Radiology
SCC	**Surgery & Critical Care**
ENT	Ear, Nose & Throat/Oral
GS	General Surgery
REU	Royal Eye Unit
TCS	Theatres/Critical Care/Sterile Services Department
TO	Trauma & Orthopaedics
W&CH	**Women & Children's Services**
ACU	Assisted Conception Unit
GYN	Gynaecology
MAT	Maternity
NNU	Neonatal Unit
PAE	Paediatrics