North Cumbria University Hospitals NHS
NHS Trust

BOARD ASSURANCE FRAMEWORK 2013/14

REPORTING PERIOD: Q1 2013/14

SUMMARY OVERVIEW

Strategic Objective 1: We will deliver excellent clinical outcomes along closely integrated pathways	**Strategic Objective 2:** We will provide excellent patient centred care
Extreme risks (red): Gross: 7 Net: 4 Target: 1	**Extreme risks (red): Gross: 2 Net: 1 Target: 0**
High risks (amber): Gross: 2 Net: 5 Target: 4	**High risks (amber): Gross: 2 Net: 3 Target: 1**
Moderate risks (yellow): Gross: 0 Net: 0 Target: 4	**Moderate risks (yellow): Gross: 0 Net: 0 Target: 3**
Low risks (green): Gross: 0 Net: 0 Target: 0	**Low risks (green): Gross: 0 Net: 0 Target: 0**
Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance	**Strategic Objective 4:** We will deliver efficient care, work within budgets and deliver long-term financial strength
Extreme risks (red): Gross: 25 Net: 19 Target: 0	**Extreme risks (red): Gross: 6 Net: 6 Target: 1**
High risks (amber): Gross: 8 Net: 13 Target: 18	**High risks (amber): Gross: 3 Net: 3 Target: 5**
Moderate risks (yellow): Gross: 1 Net: 2 Target: 16	**Moderate risks (yellow): Gross: 2 Net: 2 Target: 3**
Low risks (green): Gross: 0 Net: 0 Target: 0	**Low risks (green): Gross: 0 Net: 0 Target: 2**

A fifth category of risks ("Corporate Enablers") contains 4 risks.

Corporate enablers
Extreme risks (red): Gross: 4 Net: 4 Target: 0
High risks (amber): Gross: 0 Net: 0 Target: 4
Moderate risks (yellow): Gross: 0 Net: 0 Target: 0
Low risks (green): Gross: 0 Net: 0 Target: 0
Low risks (green): Gross: - Net: - Target: -

Over-arching Risks:

During a risk workshop held with the executive management team on 3 July to discuss and update the content of the BAF, a number of over-arching themes became apparent.

These themes are reflected throughout the BAF but the view of the executive management team was that they should be clearly set out for the understanding of all readers of the BAF, and as an acknowledgement that actions taken to address these themes will implicitly drive better outcomes of the risks facing the Trust. The themes are:

- Compliance: greater focus is needed across the Trust on meeting all existing requirements, whether these originate internally or externally, and the executive management team appreciate that whilst there are many aspects of compliance to be met, colleagues need continuing support.

- Culture: the Trust is under-going significant cultural change as it becomes more open, supportive and seeks to improve lesson-learning, and whilst this change will improve longer term outcomes it is recognised by the executive management team that it currently this drives many risks in the BAF and that they have a continuing responsibility to support colleagues though this period of change.

- Capacity: the Trust faces challenges in terms of both quality and quantity of staff and management resources in all areas of operation and at all levels, and the executive management team recognise that, whilst there are no quick fixes in this area, there is a need to maintain focus on the critical capacity challenges as captured within the BAF.

A further and final over-arching theme, that binds together all the others, is that the overall pace of change across the Trust challenges the ability of all colleagues to meet their many requirements. Once again the executive management team recognise that this issue cannot be addressed overnight and that again the BAF provides insight into those areas requiring specific focus in the short term, whilst activities to deal with longer–term matters begin to take effect.

Strategic Objective 1: We will deliver excellent clinical outcomes along closely integrated pathways

Sub objectives:

(a) Reconfigure services and integrate care pathways spanning hospital, community and home
(b) Seek to understand best practice and the changing needs of our local communities
(c) Re-develop West Cumberland Hospital
(d) Complete the acquisition of the Trust by Northumbria Healthcare NHS FT

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
1.1 1d	The Trust does not become acquired by Northumbria Healthcare NHS FT	An alternative strategic solution will need to be identified with the NTDA.	2	5	10	Transaction oversight committee (TOC) in place to ensure milestones delivered in accordance with regulatory bodies. IMA in place.	Internal Monthly acquisition reports to Board and TOC reports. External TOC minutes.	2	5	10	Control None. Assurance Timescale for approval by Monitor not confirmed.	Monitor, TDA and NHFT reviewing process in line with Keogh review.	Dec 2013	1	5	5	A: CEO
1.2 1d	The acquisition is delayed beyond 1 October 2013	Less likelihood of developing a stable environment to deliver the Trust's strategic priorities, including increased management and staff turnover	4	4	16	Transaction oversight committee (TOC) in place to ensure milestones delivered in accordance with regulatory bodies. IMA in place.	Internal Monthly reports to Board and TOC reports. External TOC minutes	4	4	16	Control None. Assurance Timescale for approval by Monitor not confirmed.	Monitor, TDA and NHFT reviewing process in line with Keogh review	Dec 2013	2	3	6	A: CEO

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1.3	Trust does not have a sustainable acute and anaesthetic care medical model and is over reliant on trainees and locums, particularly at West Cumberland Hospital.	Over reliance on locums and potential loss of trainees by the Deanery. Risk to deliver of a safe and adequately staffed out of hours critical care and anaesthetic service at WCH.	4	4	16	New critical care and anaesthetic model agreed in principle by CPG. Needs developed into an operational workforce plan. Recruitment for additional consultants and nurse practitioners in progress. New ACP model approved for the Trust. Nurse practitioners for anaesthetics and acute medicine and hospital at night recruited as part of medium term workforce plan. Emergency care plan for doctors agreed and in place.	Internal Specific reports to Board. Reports from BU to Board on key service reviews Workforce report to Trust Board on monthly/ quarterly basis. Business case approval by EMT. External Trust returns to TDA, annually signed off by CEO DON and MD. Benchmarking can be undertaken by using Northwest e-win tool.	4	4	16	Control Locum staff in place in some specialties. In the interim, a 3rd on call senior doctor for WCH is being implemented before the end of August. Fully co-ordinated Trust workforce plan has not been approved by the Board. Recruitment in place. Assurance Revised medical rota not yet fully operational. Comprehensive Trust workforce plan has not been approved by the Board.	Risk is mitigated through moving to new ways of working with less reliance on trainees, consultant and specialists solely based at WCH and a new workforce of skilled nurse practitioners. Risk also mitigated through moving services that are high risk or non-resilient. Workforce assurance tool is currently being reviewed by DoHR, DoN and MD to agree how this can be reported to Board. Comprehensive workforce planning return for 2013/14 being completed and due for submission to TDA at end July 2013; requires sign off by CEO and MD. QIP and live action plan in place and very regularly reviewed.	**August 2014** and 2015	3	4	12	A: MD

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	The Trust does not have a fully cohesive and co-ordinated workforce plan for medical and nursing staff which is linked to the development of clinical services and associated models of care across the two hospital sites.					Business Units have developed priorities in accordance with service needs. Workforce profiling has commenced through LTFM. Nursing establishment work in progress with NHFT. Midwifery review being implemented. Medical records and contact centre consultation currently taking place. Senior manager/nursing re-structuring currently being implemented.											DoHR
1.4 3c	The Trust is unable to provide a consultant haematologist service at WCH due to inability	Clinical haematology support for patients and advice is lacking.	3	4	12	Locum cover in place for the short term. Longer term plan in place to recruit additional specialist nurses	Internal Progress reported to Board through service concerns reports. External	3	4	12	Control National shortage in consultant positions. Assurance	Remote support from networked haematologists in Newcastle and Northumbria review of haematology service by network.	December 2013	2	4	8	A: CBUD

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	to recruit.					or implement a larger 'pool' of haematologists with NHFT.	Quality Account				Longer term plan has not been approved by the Board.						
1.5 1a	Lack of robust middle grade tier and consultants, for obstetrics within North Cumbria.	Difficulty sustaining consultant delivered obstetric services at WCH.	4	4	16	Locum staff in place for short term plan. Plans for future service reconfiguration underway.	Internal Report to CPG External Deanery Report	4	4	16	Control Timescale for future reconfiguration not yet confirmed. Assurance Deanery action plan	Locums to cover gaps.	August 2013	3	4	12	A: MD

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1.6 1b	Lack of organisational development in the past hence no adoption of the national standard to provide the Trust Board with service reviews and benchmarked with peers.	Lack of assurance on the quality of services based on safer care, effective care and patient experience and benchmarked with peers.	4	4	16	Approach to quality approved by Trust Board in November 2012. Clinical audit plan for 13.14 confirms the plan to adopt the service review standard and consultant outcomes.	Internal Report to Board January 2013. Strategic plan 13/14 External External Audit of our Quality Account	3	4	12	Control Implementation programme for service reviews not defined. Board sub committee for quality to be redefined. Assurance External audit.	Programme for service reviews to be confirmed and presented to Board. Governance and Quality committee to be reviewed in accordance with Northumbria. Trust strategy documents to be updated with a specific quality strategy written.	Sept 2013	1	4	4	A: MD & DoN

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1.7 (see also 3.2)	Increased demand for acute medical beds and delays discharging patients to community hospitals and social care. **Capacity**	Poor patient flow leading to long delays in A&E, poor patient experience and impacts on ability to deliver excellent care and clinical outcomes.	5	4	20	Emergency care action plan in place. ACP model in place across both sites. EDD monitoring in place. Standardisation of ward rounds introduced. Executive/Clinical board rounds to expedite discharge. Augmented bed management team Integrated Emergency Floor operating.	<u>Internal</u> Board development session held. Action plans presented to Board in May 2013. Action plan monitored fortnightly by Director of Operations and monthly to Trust Board. Daily monitoring of A&E performance <u>External</u> Urgent Care Board report on strategic and operational changes.	4	3	12	<u>Control</u> Discharge and transfer policies out of date. Flow of patients to alternative settings. <u>Assurance</u> Nil	Policies updated – need approving at TPG Refresh of Clinical Leaders priorities to address.	**August 2013** **Sept 2013**	3	3	9	A: DoO DoO

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1.8 1a	The S&Q priority of improving care for the acute frail elderly is not embedded.	Increased LOS and dependency.	4	4	16	Elderly care vision developed. Business case approved.	Internal Board approved business case External Hip fragility bundle	3	4	12	Control Recruitment of posts. Assurance Nil	4 elderly, 1 orthopaedic geriatric consultant, vacancies advertised. Agreed to integrate with external agencies re discharge and admission prevention	March 2014	3	4	12	CBUD Medicine
1.9 1b	Inadequate control on clinical guidelines.	Care insufficiently standardised to deliver reliable outcomes	4	4	16	Process for updating NICE register approved by CPG in April 2013. BU governance meetings established. Agreement to adopt NHFT guidelines.	Internal Reports to Board. External Associate Medical Director leading on NICE review from NHFT.	3	4	12	Control Trust intranet and internal process for approval of guidelines is weak. Assurance Progress against NICE register and audit of high risk areas not yet confirmed.	Project lead to be identified to lead on updating Trust intranet for clinical guidelines in accordance with NHFT model. Reporting on progress against delivery of clinical audit plan to commence July 2013.	October 2013	1	4	4	A: MD

Strategic Objective 2: We will provide excellent patient centred care

Sub objectives:

(a) Engage with and listen to our local stakeholders, build relationships and work in partnership with others

(b) Encourage a culture of openness and duty of candour

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2.1 2b	Our culture is not open and transparent	Prevents the patient being at the centre of everything we do	4	5	20	Safety, Quality & Patient Experience report sets out the improvement plan. Organisational development plan in place. Patient safety walk rounds in place	Internal OD Plan approved by Board. Patient safety walk round reports. Culture survey Sept 12. External Keogh review. CQC outcomes.	3	5	15	Control BU clinical governance meetings in place but in their first year of development. Assurance Escalation of concerns continue to be raised with external sources such as local media.	Patient safety days established from June and will take a year for the teams develop. SUI training arranged for 2013. Evidence of rapid review of incidents and embedded practice	March 2014	3	4	12	A: CEO
2.2 2a	The trust does not learn from the Winterbourne review to protect patients with learning disabilities.	Trust does not meet the minimum NHS standards.	3	4	12	Policy of commitment to the Trust Board. Clinical audit to confirm standards are met.	Internal Monthly report to the Board External None	2	4	8	Control None Assurance None	None	n/a	2	4	8	A: DoN

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2.3 2b	The trust does not have robust patient feedback mechanisms to capture patient feedback.	Patient experience may not improve to be above the national norm.	4	4	16	Patient experience strategy approved. Infrastructure put in place and system implemented.	Internal Monthly reports to the Clinical Business Units and the Board. External National patient survey.	3	4	12	Control Regular reports to Consultants and the Clinical Business Unit Boards. Assurance None	Improvement plan to address the primary concerns in place with time out for clinical teams.	March 2014	3	3	9	A: DoN
2.4 2a	The Trust does not have an agreed approach for implementing the six C's	Patients do not receive the optimal care.	4	3	12	Policy commitment approved at the Board. Nursing standards and indicators/outcomes to be mapped to 6 Cs. 15 steps programme agreed by Board for implementation. Priority ward areas identified.	Internal Monthly patient experience report External National patient survey. CQC outcomes.	2	4	8	Control Governance Committee. Programme plan for commencement and training of staff not yet confirmed. Assurance Baseline of each ward	Action plan for CQC outcome 4 drafted. Roll out plan for 15 steps being developed.	March 2014	1	4	4	A: DoN

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

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3.1 3a	Mortality rate is higher than the expected norm due to a lack of strategic focus.	The trust does not reduce its mortality and harm rate	4	5	20	Review of 2011/12 deaths complete with improvement plan identified on four themes of work. Mortality framework updated in April 2013. Weekly trigger process implemented. Harm group in place and management of deteriorating patient group re-established.	Internal Monthly update included in Board S&Q report. External Dr Foster SHMI,CHKS and AQUA.	3	5	15	Control Some M&M meetings may require support and facilitation in certain specialties. Assurance Mortality review group has not met yet to monitor the implementation of the framework across the Trust.	Mortality review group meeting in June, key focus will be reviewing the BU M&M meetings and completion of weekly triggers.	July 2013	2	5	10	A: MD
3.2 3a	The Trust does not adequately communicate lessons learned from SIs and serious complaints to ensure the learning becomes embedded throughout	Learning from incidents is key to continually improve. The trust does not adequately communicate lessons learned from SUIs and serious complaints to ensure the lessons are	5	4	20	SIs shared and discussed with CPG. Safety Panels established from 12 June 2013. Serious complaints and SIs reported to Board with any immediate action	Internal Reports to Board and CPG. External Internal Audit report into SUIs July 2012.	3	4	12	Control New process for SIs and serious complaints not yet fully embedded. Assurance Internal audit report confirmed 'split' opinion.	New SUI and complaint process to be fully operational by 1 July 2013. Recommendations from internal audit to be complete by 1 September 2013.	Aug 2013	1	5	5	A: MD

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	the organisation.	learned and embedded throughout the organisation. Again the mitigated risk would already be lower than the gross risk				taken to mitigate against any risk. Training on SI commenced 28/06 for senior managers and clinicians A guide for staff on investigating incidents has been developed and is being implemented.											

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3.3 (see also 1.6) 3a	Increased demand for acute medical beds and delays discharging patients to community hospitals and social care. Consolidate A&E target.	Poor patient flow leading to long delays in A&E, poor patient experience and impacts on ability to deliver excellent care and clinical outcomes. Failure to achieve key national performance target of 95% of patients seen, treated and discharged or admitted from A&E in less than 4 hours or internal stretch target of 98%.	4	4	16	ACP model in place at both sites. Additional recruitment for A&E in progress. CD for emergency care appointed. Additional capacity on Maple C at CIC identified. Integrated discharge teams in place.	Internal Board development session held. Action plans presented to Board in May 2013. Action plan monitored fortnightly by Director of Operations and monthly to Trust Board. Daily monitoring of A&E performance External Urgent Care Board established by North Cumbria Clinical Leaders.	4	3	12	Control Failure to reduce length of stay in acute medicine Inadequate bed capacity to meet demand Assurance Performance still not achieving 98% as at May 2013.	• Winter planning commenced to provide additional bed capacity on both sites • Integrated plan to expedite community discharges • Continue to recruit to ACP model	Sept 2013	3	3	9	A: BUD/DoO
3.4 3a	Failure to provide sufficient capacity in Out-Patients and Elective Surgery to meet demand for elective	Failure to achieve key national standards for 18 week Pathways. Poor patient experience Impact on clinical	4	4	16	Trust and specialty level action plans in place for T&O, gynae, ophthalmology and general surgery. IST review complete.	Internal Reports to FIP and Board. Fortnightly meeting with CEO in place. External IST report and	4	3	12	Control Consultant performance. Assurance Progress not being made quick enough in some	New theatre schedules implemented Fortnightly monitoring of activity v capacity by consultant presented in Public Board papers	Sept 2013	3	4	12	DoO

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	care. Decline in productivity in elective surgical specialties.	outcomes Financial – loss of income and additional costs incurred due to private providers being required.				FIP meeting established.	Board development session March 2013.				specialties, further work required to understand reasons for variances in capacity and demand.	Continue to access private sector Demand and Capacity modelling received.					
3.5 3a	The Trust does not have adequate re-assurance arrangements in place for medical revalidation.	Puts medical workforce at risk, good quality appraisal necessary to reflect from feedback	2	4	8	Deputy Medical Director lead for revalidation. Draft policy in place. Training established for medical appraisers.	Internal Reports to governance committee. ORSA returns. External	2	4	8	Control Trust policy has not been ratified. Appraisals for staff / trust grade level doctors below 50%. Assurance Nil	Support from RO network and Northumbria. RO Group MD	March 2014	2	3	6	A: MD
3.6 3a	Excessive levels of change and external inspections	Detrimental impact on the delivery of high quality care	4	4	16	Action plans in place following external reviews. Plans to conclude nursing review in progress with NHFT & TDA. Escalation plans in place with BUs. Clear objectives for improving quality and safety agreed by the Board.	Internal Reports to Board on performance and delivery of safety and quality priorities. External Keogh Review CQC Review Deanery Review Quality Review	4	4	16	Control Publication of Keogh report will have further negative impact on staff morale and public confidence. Assurance Develop a consolidated improvement plan for the Board.	Action plan to address findings of Keogh, Deanery, Quality & CQC approved by the Board in June and to be implemented demonstrating substantial improvement.	Decemb er 2013	2	4	8	A: CEO

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3.7 3c	Trust has individual clinicians and teams in difficulty, due to a lack of clinical leadership and failure to implement MHPS	Impacts on patient care and effective team working	4	3	12	Action plans in place for paediatrics, orthopaedics at WCH including overwater ward, gastroenterology and breast surgery.	Internal Progress reported to Board through service concerns reports. External n/a	3	3	9	Control Nil Assurance Action plans for individual and or teams not reviewed by Board.	Update on service concerns report required to explicitly confirm planned actions and end dates.	**July 2013**	2	3	6	A: MD
3.8 3a	Safety and quality priorities are not measured to ensure delivery and monitoring during 2013/14	Safety and quality is not delivered due to lack of measurement of an outcome	3	5	15	Board reporting on safety, quality and regulatory compliance changed from March 2013.	Internal Monthly reports to Board and FIP. External External audit of Quality Account	3	5	15	Control None Assurance Assurance required to confirm all priorities are included in reports to Board.	Clarity is required concerning objectives and priorities. Report required to confirm all 36 priorities can be evidence through reports to the Board.	**August 2013**	2	5	10	A: CEO

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3.9	National & local CQUINs (F&F, VTE, Dementia, & Safety Thermometer) are not achieved due to lack of capacity and capability	Affect on the delivery of excellent quality care and possible loss of income.	3	5	15	Contract signed with Commissioners and accountabilities clearly defined by the DoO and DoN	Internal Monthly report to the Trust Board External Commissioners quality payment	3	5	15	Control No information system to produce a timely summary Assurance No report to FIP	Produce report to FIP Update Service Performance Report quarterly Fortnightly monitoring at Divisional Performance Reviews	July 2013	3	4	12	A: DoO? / DoN?
3.10 3a	CQC Outcome 1 Respecting and involving people who use services Failure to comply with the Health and Social Care Act 2008	People do not understand the care and treatment being given, are not treated with dignity and respect and do not have their views taken into account about how a service is delivered. Could also lead to restrictions on service provision and/or financial penalty.	4	5	20	PCA updated and monitoring measures in place/ Range of Audits in place to capture patient experience, which has been extended during 13/14.	Internal Monthly S&Q report to the Board. External	3	5	15	Control Assurance	Process for ensuring alerts on AuditR are completed is required. BU evidence of ensuring outcomes of the surveys are acted on is required.	Sep 2013	2	5	10	A: DoN and BU Leads

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3.11 3a	CQC Outcome 2 Consent to care and treatment: Failure to comply with the Health and Social Care Act 2008	People to do not give valid consent for their examination / treatment or understand how to change any decisions. Human rights are not respected. Could also lead to restrictions on service provision and/or financial penalty.	3	5	15	Policy for consent in place. Audit completed 2012. Delegated consent register in place.	Internal External	2	5	10	Control Delegated consent register not up to date and does not have competency sign off in place for all staff on the register. Assurance PCAs require updating for each BU.	Delegated register to be updated with competency training completed. BU PCAs to be completed.	Sep 2013	1	5	5	A: MD and BU leads
3.12 3a	CQC Outcome 4 Care and welfare of people who use services: Failure to comply with the Health and Social Care Act 2008	People do not experience effective, safe and appropriate care, treatment or support that meets their needs. Could also lead to restrictions on service provision and/or financial penalty.	4	5	20	PCA and monitoring measures in place. Action plan in place following CIC and WCH inspections of this outcome in 2013. Internal inspection programme on 15 steps being implemented.	Internal CQC action plan for outcome 4. Reports to Board. Presentation to Board June 2013 External	3	5	15	Control Assurance	CQC action plan in place to address concerns identified from inspections.	Q4 13/14	1	5	5	A: DoN/MD and BU Leads

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			L	S	R			L	S	R				L	S	R	
3.13 3a	CQC Outcome 5: Meeting nutritional needs: Failure to comply with the Health and Social Care Act 2008	People are not supported to have adequate nutrition and hydration. Could also lead to restrictions on service provision and/or financial penalty.	3	5	15	PCA and monitoring measures in place.	Internal Nutrition steering group in place. External	1	5	5	Control Increased incident reporting on nutritional incidents involving NG tubes. Assurance Report to Board or subcommittee required on how nutritional needs are being met.	Nutrition steering group to review incidents involving delays in feeding on a monthly basis.	Sep 2013	1	5	5	A: DoN
3.14 3a	CQC Outcome 6: Cooperating with other providers: Failure to comply with the Health and Social Care Act 2008	People do not receive co-ordinated care, treatment or support between providers. Could lead to restrictions on service provision and/or financial penalty.	4	5	20	PCA in place. Discharge liaison in place with daily reviews of patient's. Communication with care homes in place/	Internal External	3	5	15	Control BU leads have been identified; however BU PCAs/ monitoring measures require completion. Assurance Report required on how this standard is being met in each BU and how this can be evidenced.	Trust and BU PCAs/, monitoring measures to be completed.	Oct 2013	2	5	10	A: DoN and BU Leads

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.15 3a	CQC Outcome 7: Safeguarding people who use services from abuse: Failure to comply with the Health and Social Care Act 2008	People are not protected from abuse, or the risk of abuse and their human rights are not respected. Could lead to restrictions on service provision and/or financial penalty.	3	5	15	PCA and monitoring measures in place. Trust level safeguarding board in place/	Internal Safeguarding report to Board. CPG presentation on children safeguarding. External	2	5	10	Control Training levels remain low in certain areas. Assurance	Training levels to be improved for both adult and children.	October 2013	1	5	5	A: DoN (Executive Lead for Safeguarding)
3.16 3a	CQC Outcome 8: Cleanliness and infection control: Failure to comply with the Health and Social Care Act 2008	People are not protected from healthcare associated infections. Could lead to restrictions on service provision and/or financial penalty.	4	5	20	PCA and monitoring measures in place. IPC steering group in place, chaired by CEO.	Internal Monthly report to Governance Committee and Board on performance. External	3	5	15	Control Monitoring measures require completion in all areas. SSI rate not reported monthly. Assurance	C-Difficile action plan in place.		1	5	5	A: DIPC

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives
(b) Provide excellent education, training and development
(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.17 ?	CQC Outcome 9: Management of Medicines: Failure to comply with the Health and Social Care Act 2008	People do not get their medicines when they need them in a safe way. Could also lead to restrictions on service provision and/or financial penalty.	4	5	20	PCA and monitoring measures in place. Safe medicines practice group in place. Audit programme in place.	Internal Notes from D&T and SMPG. External	3	5	15	Control Medicines audit programme not complete. Mandatory training levels significantly low (red). Assurance C2C medicines management group	Mandatory training being aligned with NHFT to ensure delivery during 13/14. Merged Pharmacy BU to advise on implementation of NHCT medicines management standards.	March 2014	1	5	5	A: Director of Pharmacy
3.18 ?	CQC Outcome 10 Safety and Suitability of premises: Failure to comply with the Health and Social Care Act 2008	People are not in safe, accessible surroundings that promote their wellbeing. Could also lead to restrictions on service provision and/or financial penalty.	3	5	15	PCA in place with supporting action plan. Fire alarm tests undertaken weekly. Additional recruitment for fire safety officer agreed. Estates and Facilities meeting established in accordance with Northumbria model.	Internal Reports to Board and FIP on position with outcome 10 via Estates Group. External	3	5	15	Control External concerns raised following Keogh review of theatres. Inadequate resource to achieve fire safety requirements. Gaps in departmental risk assessments for COSHH and Fire. Assurance Independent assessors appointed to produce gap analysis.	Independent assessment of PCA and supporting evidence to be undertaken in July 2013.	April 2014	1	5	5	A: DoE&F

Comment [j1]: Steven B to confirm

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.19 (a) 3.38	CQC Outcome 11: Safety, availability and suitability of equipment: Failure to comply with the Health and Social Care Act 2008 Failure to ensure medical equipment, ventilation & clean air systems etc are maintained with an approved planned preventative maintenance programme.	People are at risk of harm from unsafe or unsuitable equipment. Could also lead to restrictions on service provision and/or financial penalty.	2	5	10	PCA in place with supporting action plan. Backtrack system now fully operational for planned preventative maintenance. Trust policies have been revised. Medical Devices group revised. Estates and Facilities meeting established in accordance with Northumbria model. Additional technician employed. KPMG: There are actions and timescales in place – DoO could provide details.	Internal Reports to Board and FIP on position with outcome 11 and via medical devices group/governance. External	2	5	10	Control Training records for medical equipment training not reported formally. Meetings of medical devices committee and E&F meeting fully established. Resource to manage all PPM schedules inadequate. Assurance Independent assessors appointed to produce gap analysis.	Business case being prepared to identify resource requirements to close risk gap relating to maintenance trainers now approved recruitment to take place.	July 2013	1	5	5	A: DoE&F

Comment [j2]: Steven B to confirm

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.20 3a	CQC Outcome 12: Requirements relating to workers: Failure to comply with the Health and Social Care Act 2008.	Staff are not fit, appropriately qualified or physically/mentally able to do their job. Restrictions on service provision and therefore patient care, and/or financial penalty.	2	4	8	Adherence to/compliance with NHS Employers safer recruitment employment checks standards. (risk rating has reduced from amber to green due to commencement of electronic DBS checks now being undertaken (speedier process) and also review of pre-employment health screening arrangements in line with NHFT).	Internal Regular departmental (Recruitment and Medical Staffing) audits. Reports from above to Workforce Committee on quarterly basis, with verbal presentation by Recruitment Manager. Workforce Committee minutes provided to Trust Board External CQC	1	4	4	Control Fluctuating workload in both recruitment section and medical staffing. Assurance	Temporary additional staffing to be appointed in recruitment section to address increased workload over last 3-6 months.	Q2	1	4	4	A: DoHR
3.21 ?	CQC Outcome 13: Staffing: Failure to comply with the Health and Social Care Act 2008	Insufficient numbers of staff to meet the needs of patients. Could also lead to restrictions on service provision and/or financial penalty.	4	5	20	PCA and monitoring measures in place. Monthly Ward assurance report in place. Daily escalation plan in place. Recruitment plans in place where required.	Internal Monthly report to Board. External	3	5	15	Control Assurance	Action plan in place as part of CQC inspections in 2013.	Q3.	2	5	10	A: DoN and BU Leads

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.22 3a	CQC Outcome 14: Supporting Workers: Failure to comply with the Health and Social Care Act 2008	Could lead to restrictions on service provision and therefore patient care and/or financial penalty.	4	4	16	PCA and supporting action plan in place (rated yellow). TNA in place for all staff and majority of in-house training now available.. Performance monitoring in place within BU for uptake levels on training and staff appraisals. Board confirmed compliance in March 2013 with regard to the CQC visit earlier in year. Updated action plan to ensure compliance with the revised TNA being presented to Workforce Committee on 29.7.13. Business Units are presenting plans and trajectories for completion of	Internal Reports to business unit boards, workforce committee and Trust Board. Review by NHFT Governance representatives on 2.7.13. External CQC	3	4	12	Control Training levels are below standard in some areas. Some in house training provision relating to new TNA not yet available. Assurance	Workforce Committee to monitor and approve action plan and provide exception report on key milestones to Board. WFC to receive trajectories and compliance rates from Business Units on 29.7.13. First presentation of PCA for Q1 being presented to Workforce Committee on 29.7.13. Seeking temporary additional support to delivery mandatory training from MET. QIP action plan 'live' document and very regularly reviewed.	Q4	2	4	8	DoHR

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

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(a) Deliver key performance indicators for operational performance in line with strategic objectives

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(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
						appraisals and mandatory training to WFC on 29.7.13..											
3.23 3a	CQC Outcome 16: Assessing and Monitoring the quality of service provision: Failure to comply with the Health and Social Care Act 2008	People do not receive quality care, treatment or support due to ineffective decision making and management of risks to quality. Could lead to restrictions on service provision and/or financial penalty.	4	4	16	CAP in place NICE improvement plan in place Safety panels Established. Staff training on incident management training commenced. CAS monitoring in place. CPG established. Safety and quality priorities sin place and approved by the Board. BU governance Boards established.	Internal CAP report to Board. Clinical effectiveness report on performance in monthly S&Q report. BU & Board development session on clinical governance (June 2013). External	3	4	12	Control Audit and NICE results not at the required level of performance for Q1. Level of policies which are due for review is high. Escalation of risk against quality standards weak in certain areas. KPMG Quality Governance assessment score <2 Complaints performance still weak in certain areas. Limited assurance reports from	NICE progress to be reviewed by EMT. Delivery report on CAP being drafted to ensure CAP can be monitored each quarter. Plan in place to reduce number of outstanding policies. Session on escalation of risk being identified for July/Aug. Session with BU Governance Boards and MD/DoN and DoG in September to review their performance and help support teams. New internal audit tracking process in place	Q3	1	4	4	A: DoG

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

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(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
											internal audit not acted on in a timely manner. Assurance Clinical Audit process requires strengthening						
3.24 3a	CQC Outcome 17: Complaints: Failure to comply with the Health and Social Care Act 2008	People who complain do not have their concerns listened to or acted on effectively. Could also lead to restrictions on service provision and/or financial penalty.	4	5	20	Complaints policy and process in place. Monthly reporting to Board on performance metrics in accordance with Complaints Regulations 2009. Serious complaints being reviewed by the Board in relation to immediate action required. Complaints surveys issued to all complainants.	Internal Monthly public and private reports to the Board. CQC monitoring measures in place and updated PCA. External	3	5	15	Control Response times overall remain high (length of time). Assurance Annual report on complaints required.	New process to be implemented to improve response times (agreed at complaints workshop June 2013). Trajectory for backlog of complaints and new complaints to be set to track performance during Q2.	Sept 2013	2	5	10	A: DoG

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.25 3a	CQC Outcome 21: Records: Failure to comply with the Health and Social Care Act 2008	Could lead to restrictions on service provision and/or financial penalty.	4	5	20	Health records user group established. Additional project resource being identified to lead on improvement plans.	Internal Report to Board as part of mortality theme 'documentation'. External	4	5	20	Control Monitoring measures and milestones not clearly defined. Assurance	Action plan to be formalised and monitored through healthcare user group.	Q4	2	5	10	A: MD
3.26 3a	The Trust fails to achieve C. difficile trajectory for 2013/14	Substandard patient care (increase length of stay, morbidity), financial penalties and adverse publicity	4	4	16	Improvement plan in place and approved by Board. Weekly C-Difficile meetings established to review RCA with clinician involved in patients' care.	Internal Monthly report to G&Q. Board approved plan in place. External TDA review of IPC.	4	4	16	Control Physical capacity to do deep clean. Cultural change. Assurance Weaknesses identified in TDA plan regarding management of CDifficile.	Action plan in place.	March 2014	2	4	8	A: DIPC
3.27 3a	The Trust fails to achieve zero MRSA bacteraemias for 2013/14	Substandard patient care (increase length of stay, morbidity), financial penalties and adverse publicity	3	4	12	Screening programme in place. IPC measures in place. Cleanliness and cannulation audits in place.	Internal Monthly report to G&Q. External TDA reporting	3	4	12	Control n/a Assurance n/a	n/a	n/a	2	4	8	A: DIPC
3.28 ?	The Trust fails to comply with rights and pledges of the NHS	Impact on patient safety, ability to deliver excellent clinical	4	4	16	Performance management framework in place. Monthly reports to Board	Internal Reports to Board. External TDA report	2	3	6	Control None Assurance Specific report on	Report on implementation and compliance with pledges to be presented to Board.	Sept 2013	1	4	4	A: DoO

Comment [j3]: Clive Graham to update

Comment [j4]: Clive Graham to confirm

Comment [j5]: Clive Graham to update

Comment [j6]: Clive Graham to confirm

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
	constitution.	outcomes and poor patient experience. Patients experience long delays for treatment.				on service performance and safety and quality.					NHS Constitution not received by Board in last 12 months.						
3.29 ?	Ability to sustain IG Level 2 due to competing priorities.	The trust may not meet the new enhanced standards for information governance.	3	4	12	Information governance steering group in place. IG policies and procedures in place.	Internal Reports to G&Q. External Internal Audit/External Audit.	3	4	12	Control None Assurance None	None	None	3	3	9	A: DoF
3.30 ?	Depth of Clinical coding may not be adequate due to lack of strategic focus.	Co-morbidities may not be recorded and income secured within required timeframes.	3	4	12	Additional coders recruited. Checking process in place for co-morbidities with consultants.	Internal Coding Audits in place External PbR Audit results 2012	3	4	12	Control None Assurance None	Head of Coding to target area for improvement through Data quality audits.	July 2013	2	4	8	A: DoF
3.31 ?	Cultural failure to ensure all patients are discharged with a discharge summary and TTO	Failure to discharge patients safely leads to reputation failure and financial penalty of £500k.	4	4	16	Standard set by Executive Team. Process redesigned. Weekly reporting.	Internal CPG, EMT, Trust Board. External CCG, Quality Group.	3	4	12	Control Enhanced processes and culture. Assurance None	Action plan approved and robust close monitoring.	Sep 2013	3	3	9	A: MD

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.32 3a	Failure to achieve CNST level three by February 2015 or revised national benchmarks (NHSLA standards currently under review	Risk management standards in maternity do not contribute to providing safe care.	3	5	15	Plan in place. Revised governance maternity meeting established. Quarterly reporting in place. CNST guidelines and audit programme in place.	Internal Quarterly reports to CBUB, Governance Committee & Trust Board. External Nil	3	5	15	Control Significant gaps. Assurance No independent assurance on proposed timeframe and action plan.	Independent assurance to be sought on current plan and scheduled milestones by August 2013.	August 2013	1	5	5	A: DoG
3.33 3a	Failure to put in place robust plan to ensure delivery of NHSLA level three by 2016 or revised national benchmarks (NHSLA standards currently under review)	Risk management standards do not contribute to providing safe care.	4	5	20	No adequate controls in place.	Internal External	4	5	20	Control No agreed project implementation plan in place. Project manager required. Changes to key RM policies and procedures happening as a result of acquisition thus impacting on ability to move to audit as procedures are changing. Assurance	Report to be prepared on how this will be taken forward across the organisation/group.	Sep 2013	1	5	5	A: DoG

Strategic Objective 3: We will deliver excellence in safety, quality and regulatory compliance

Sub objectives:

(a) Deliver key performance indicators for operational performance in line with strategic objectives

(b) Provide excellent education, training and development

(c) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
3.34 3a	Change in National, Regional and Local arrangement for managing Emergency Planning & Resilience.	Emergency preparedness plans are not adequate. Lack of robust business continuity arrangements in place across all clinical services.	3	3	9	Emergency Preparedness Committee meets monthly. Training programme in place for key staff Trust Executive presence on Local Health Resilience Partnership	Internal Regular mock training exercise Scrutiny of Business Continuity Plans at EPC External Reports to LHRP Participation in National Emergency Planning Exercises	2	3	6	Control Major Incident Policy in draft following recent re-organisation Assurance Updated Policy needs testing internally and externally Training programmes need updating and rolling out	Policy to TPG and Governance Committee for approval Training programme updated and rolled out Business Continuity Plans to be updated and presented in BU Quarterly Governance Review	October 2013	1	3	3	A: DoO

Strategic Objective 4: We will deliver efficient care, work within budgets and deliver long-term financial strength

Sub objectives:
(a) Deliver a balanced budget
(b) Modernise and optimise our estate, infrastructure and equipment
(c) Reduce waste and improve efficiencies

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
4.1 (a)	Strategic support is not available	Impact on the Trust's ability to achieve its statutory financial duties and short term financial plan	5	4	20	£26.3m financial support reflected in financial plan for 2013/14.	Internal Financial plan for 2013/14 reported to Board and FIP. External NTDA signed off 2013/14 financial plan	4	4	20	Control None Assurance None	n/a	n/a	2	4	8	A: DoF
4.2 (a)	CIP not delivered due to lack of focus.	Plans in place to deliver £16.8m CIP in 2013/14 are not robust.	5	3	15	CIP process in place with CBU. Corporate monitoring in place. KPMG: DoF has provided some additions and corrections – CIP is £16.8m, reporting includes to Board via finance reports, BU presentations quarterly from now on, timescale should say EMT monthly.	Internal Monthly finance reports to FIP. CPG BU presentations May 2013 and quarterly thereafter. Board Finance reports. External TDA reports. External Auditors.	5	3	15	Control Actual monthly delivery below trajectory. Assurance	Additional CIP schemes if necessary.	Monitored monthly via EMT, FIP and Trust Board	4	2	8	A: DoF

Strategic Objective 4: We will deliver efficient care, work within budgets and deliver long-term financial strength

Sub objectives:

(a) Deliver a balanced budget
(b) Modernise and optimise our estate, infrastructure and equipment
(c) Reduce waste and improve efficiencies

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
4.3 4a	The Capital Resource Limit (CRL) means the Trust does not have adequate funds in the capital programme to deliver the necessary works	Impact on the safety and quality of care as well as compliance with essential estates and facilities regulations.	4	4	16	Prioritisation of PPM and capital replacement programme commenced.	Internal Budget report to Board for 2013/14. Monthly finance reports to FIP. External TDA report.	4	4	16	Control Capital investment group not yet established. Gaps in risk assessments for specific services and equipment. Assurance	Capital Investment Group to consider CBU priorities by July 2013. Seek greater freedoms and flexibility from NHS FT.	April 2015	4	3	12	A: DoF
4.4 (same as 3.13?)	Inability to deliver required quality standards including CQUIN.	Financial penalties incurred	3	4	12	Internal quarterly monitoring in place to ensure CQUIN delivery.	Internal Report to FIP External CCG, Quality Group.	3	3	12	Control Systems to be enhanced. Assurance	Action plan agreed.	**July 2013**	2	3	6	A: DoF & DoO

Strategic Objective 4: We will deliver efficient care, work within budgets and deliver long-term financial strength

Sub objectives:

(a) Deliver a balanced budget
(b) Modernise and optimise our estate, infrastructure and equipment
(c) Reduce waste and improve efficiencies

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
4.5 ?	Equal value claims in the system.	Equal value claims may be upheld.	2	4	8	All claims known. Cases being defended by the Trust in accordance with the NHSLA. Financial provision for current claims identified in accounts.	Internal Monthly return to the DoH. External	2	4	8	Control None Assurance None	KPMG: Per DoF, this should be allocated to him. Key control relates to current claims.	n/a	2	4	8	A: DOF
4.6 ?	Trust has insufficient cash.	Failure to meet legal obligations	3	5	15	Financial plans are in place. Strict management of payment runs via SBS system implemented.	Internal Monthly report to FIP and Trust Board on cash position. External	3	5	15	Control None Assurance None	n/a	n/a	1	5	5	A: DoF
4.7	No robust plan in place to reduce bed capacity at WCH and redesigned community hospitals and community services to compensate	Failure to meet closer to home assumptions	4	4	16	Clinical leaders forum established and liaison meetings with Cumbria Partnership NHS FT and Cumbria CCG. Solution agreed and being implemented.	Internal Monthly report to Board on new WCH. External CCG and CPFT report and agreement.	4	4	16	Control Monitored internally through WCH redevelopment clinical reference group through to board. Monitored across system though directors of operations group though to clinical leaders forum.	CCG has yet to sign off on the commissioning plan (a gap in assurance?).		3	4	12	A: Project Director

Comment [j7]: To be updated

Comment [j8]: To be updated

Comment [j9]: Les M to complete

Comment [j10]: Date?

Strategic Objective 4: We will deliver efficient care, work within budgets and deliver long-term financial strength

Sub objectives:

(a) Deliver a balanced budget
(b) Modernise and optimise our estate, infrastructure and equipment
(c) Reduce waste and improve efficiencies

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
											Assurance The CCG has yet to sign off on the commissioning plan. Letter received form Chief officer of Cumbria CCG confirming commissioner intentions re 30 contingency beds and 15 nursing home beds. First Surgical bed reduction on WCH site of 7 in July 13.						

Strategic Objective 4: We will deliver efficient care, work within budgets and deliver long-term financial strength

Sub objectives:
(a) Deliver a balanced budget
(b) Modernise and optimise our estate, infrastructure and equipment
(c) Reduce waste and improve efficiencies

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
4.8 ?	Lack of funding for phase 2 of WCH re-development due to strategic plan deficiencies.	Failure to ensure phase 2 of the necessary building works at WCH can be achieved.	5	3	15	Business case drafted for phase 2 works.	Internal Reports to private part of Board in April and May 2013. External	4	3		Control None Assurance None	n/a	n/a	1	3	3	A: DoF
4.9 4b	Failure to achieve carbon reduction targets of 20% by 2015.	Ability to deliver targets has a fiscal risk.	2	3	6	£300k released for 12/13 plan. Carbon management plan in place and approved by Board.	Internal Reports to Trust Board via Estates and Facilities Advisory Board. External	2	3	6	Control New carbon plans measured against sustainability objectives via sustainability group. Assurance Plans for 13/14 not reviewed by Board.	Carbon Plan to be redrafted to reflect 10% savings by 2015 based on 2007/08 baseline.	2015	1	3	3	A: DoE&F
4.10	Failure to achieve significant assurance in the key financial audits to support the financial systems of internal control.	Per DoF should be downgraded to a low risk as significant assurance verdicts have been achieved in last 2 years.	1	4	4	Significant assurance opinions received in both 2011/12 and 2012/13 audits.	Internal Internal Audit reports. External External Audit	1	4	4	Control None Assurance None	None	None	1	4	4	A: DoF

Comment [j11]: Steven Bannister to complete

Strategic Objective 4: We will deliver efficient care, work within budgets and deliver long-term financial strength

Sub objectives:
(a) Deliver a balanced budget
(b) Modernise and optimise our estate, infrastructure and equipment
(c) Reduce waste and improve efficiencies

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
4.11 ?	Trust does not have clear plans in place in relation to IM&T strategic priorities which have been approved by the Board.	Impact on delivery of clinical care and possible loss of income	3	4	12	There is an IM&T workstream with Northumbria to develop an integrated strategy.	Internal Workstream reports External	3	4	12	Control None Assurance None	None	None	3	4	12	A: DoF

Corporate Enablers 5 to support achievement of the strategic objectives

Sub objectives:

(a) Create integrated health information and optimise health informatics
(b) Excellent staff experience by supporting staff through a time of change
(c) Provide excellent education, training and development
(d) Attract, recruit and nurture talent

Ref	Risk Cause	Risk Effect	Gross rating			Key controls	Sources of assurance	Net rating			Gaps in control or assurance	Action planned to address gaps	Time scale	Target rating			Accountable Responsible
			L	S	R			L	S	R				L	S	R	
5.1 5c	Risk of non-compliance with EWTD, particularly non medical staff.	Renders the Trust liable to prosecution and a fine for non-compliance	3	5	15	DRS system/software package in place to ensure compliant rotas for training grade medical staff. Rota co-ordinator in place. Doctors in training hours monitored twice annually. BMBS system used for bank workers. Compensatory rest agreement in place in NCUH.	Internal Audit report on bank workers undertaken and recommendation being pursued. EWTD is specific work stream in liaison with NHFT, and work has commenced on this to identify optimum route to capture working time effectively. Action plan being developed. External	3	5	15	Control Locum staff in place to ensure compliant rotas, however this leads to quality issues. Lack of meal breaks is an issue, particularly for nursing staff on night duty. Assurance Work stream tasks are just beginning to be identified and action plan developed.	Report to be produced for workforce committee through the work stream confirming current position and proposed action plan to address. Recruitment of additional nursing staff to ensure rest breaks can be achieved.	March 2014	3	4	12	A: DoHR

Corporate Enablers 5 to support achievement of the strategic objectives

Sub objectives:

(a) Create integrated health information and optimise health informatics
(b) Excellent staff experience by supporting staff through a time of change
(c) Provide excellent education, training and development
(d) Attract, recruit and nurture talent

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			L	S	R			L	S	R				L	S	R	
5.2 5d	Long term vacancies in operational management team. Inability to recruit to junior and senior management posts. Inability to recruit to senior and middle grade medical staff posts. Doctors in training posts in North Cumbria unattractive to Newcastle Deanery students. Therefore gaps on rota as all posts never filled.	Impact on the organisation's ability to achieve the short to medium term objectives. Lack of continuity in patient care, delayed decision making adversely affects reputation of the hospitals. Increased cost to Trust. Business Unit re-structure process may put further posts at risk.	4	4	16	BU model in place. CDs in place. Review of Senior Managers and senior nurses commenced. Midwifery review being implemented. Additional support sourced from NHFT for some key areas OD plan presented to Trust Board in March 2013 and has now commenced. QIPP action plan.	<u>Internal</u> BU present Operational plans and Governance arrangements to CPG Fortnightly Performance Reviews QIPP action plan. <u>External</u> CQC outcome Deanery	3	4	12	<u>Control</u> Failure to recruit /attract /retain senior managers Lengthy recruitment processes, consultants, middle grade doctors and doctors in training. <u>Assurance</u>	Joint advertising with Northumbria to ensure most attractive offer to potential candidates. Additional management post investment to ensure adequate capacity and capability. Management Development and OD programme implemented for junior and senior staff. BU structures fit for purpose to ensure adequate leadership and support. Corporate support for performance management. Appraisal mechanisms/job planning for long term locums. QIPP action plan. Robust job planning being implemented.	March 2014	3	4	12	A: DoHR

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5.3	Medical Education Quality Assurance – due diligence reports identified a number of significant areas of concern surrounding governance of medical education and the availability of clinical supervision. Also concerns expressed by Deanery and poor Self Assessment Report (SAR).	Poor SAR could affect the training posts the Trust currently has; the Deanery may withdraw training posts in some areas, plus the Trust is not viewed as attractive by potential trainees leading to difficulty to recruit and therefore potential gaps in patient care.	4	4	16	Appointment of Interim Director of Education. Review of E&T structure including medical education. Process and forum established for QIP and SAR review and submissions. Review of appraisal and format for educational supervisors to ensure consistency. Robust QIP developed and monitored regularly.	Internal Medical Education Committee. Workforce Committee Medical Education work stream established External Regular Deanery visits and reviews. Some positive feedback from Deanery from last visit.	3	3	9	Control Lack of current robust system in place re clinical supervision/education. Assurance No current established link between Medical Education Committee and workforce committee.	Quarterly reporting to Workforce Committee from September 2013. Educational supe4rvisors development days commencing. QIP is a 'live' document which is very regularly reviewed and updated. Close links with Deanery representatives.	March 2014	3	3	9	DME/DHR

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			L	S	R			L	S	R				L	S	R	
5.4	Staff Survey/Staff engagement/staff experience	Impact on the ability to recruit, retain and develop staff in the organisation and provide the patient care the Trust aspires to achieve.	4	4	16	Staff Survey Action plans in each business unit and corporate area. Consultation/communication with staff commenced via chief executive road shows and BUD/Deputy BUD visits to their areas.	Internal Business Unit Boards. Workforce Committee. Trust Board. Survey Monkeys External National staff survey results	4	4	16	Control Capacity of Business Units to undertake robust and consistent monitoring of action plans. Inability to recruit to key positions due to reputation of organisation. Assurance Culture within NCUH.	Monitoring at Business Unit Boards. Quarterly monitoring at Workforce Committee. Regular service monkeys with results reported to Trust Board.	March 2015	3	3	9	

NOTES:

Risk assessment is used using the NPSA matrix

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5