# EKHU NHS FT BOARD ASSURANCE FRAMEWORK 2013-2014 SECOND EDITION Version 1 Dated 31 MARCH 2014

**Please note that the Assurance Framework should show the previous risk rating of each annual objective in order to inform the Board of the direction the risk mitigation process is going. This will inform management as to whether or not progress is being made in reducing the risk to an acceptable level.**

**Where a control to mitigate a risk is in the process of being put in place/formulated as opposed to it being actually in place, this fact should be clarified on the Assurance Framework so as not to lead users into thinking that the control is already in place. It may be instructive for dates when the control will be completed to be shown as well.**

**Where a gap in control or assurance has been noted, it should be succinctly explained and supported by an appropriate action with specific dates for completion of the actions.**

**Action Status: This relates to actions outstanding in terms of controls and assurances, the following explains the RAYG coding:**

- **Green: no actions outstanding for 2013/14 / actions outstanding but not due**
- **Yellow: actions outstanding for 2013/14 but none are more than 1 month overdue**
- **Amber: actions outstanding and are overdue between 1 – 2 months**
- **Red: actions outstanding and are more than 2 months overdue**

| **STRATEGIC OBJECTIVE: SO 1: Deliver excellence in the quality of care and experience of every person, every time they access our services.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 1: Implement the delivery plan in response to Francis Inquiry Recommendations.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (Lxl)** | **Mitigated Risk (Lxl)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Difficulty in managing sheer number of recommendations.<br>**Risk Effect:** Reduced chance of success of implementing individual recommendations<br><br>**Co-ordinating Director:** Trust Secretary. | 3x2 ↔ | 2x2 ↔ | 1. Action plan developed and split into three action plans:<br>(i) Business As Usual<br>(ii) Francis Specific and<br>(ii) We Care and Staff Survey (04/2013)<br><br>2. Regular monitoring of the implementation of Francis action plans.<br><br>3. Trust Secretary meets monthly with all Executive Leads to update the plan, from which reports are produced to measure performance.<br><br>4. Submitted Trust's progress on implementing the Francis recommendations to DoH and FTN (12/2013)<br><br>5. Action plan to be updated in light of the Government response on 19 November 2013. | **Positive:**<br>1. Apr BoD and CPMT approved v1 Francis Action Plan. (1) (2) (3)<br><br>2. May BoD content with progress of "We Care" project. (1) (2) (3)<br><br>3. Substantial Assurance provided by IA in Oct 13 in regards to management of response to Francis report. (1)<br><br>4. No issues raised at Mth 1-7 CPMTs with the action plan or progress against it. (2) (3)<br><br>5. We Care" project reports to CMB, CoG/BoD and BoD. Patient Safety action plans going to Divisional Boards. Patient Safety Board which reports to CMB (1) (3)<br><br>6. Positive response from FTN on the actions taken, especially in relation to the "We Care" programme.(4) (5)<br><br>7. Updated action plan approved by CPMT & BoD (February 2014) | | ~~1. Updated action plan to be approved by CPMT and BoD at their **February 2014** meetings.~~<br>1. Provide BoD with overview of the changes that have been made and the improvements as a result (May 2014) |

| **STRATEGIC OBJECTIVE: SO 1: Deliver excellence in the quality of care and experience of every person, every time they access our services.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 2: Implement the second part of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience/Person Centred Care.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** The national portal for UKTT reporting has closed and the number of trained reviewers is insufficient to complete the set number of reviews per site. This risk will increase in the next financial year with the number of staff in the corporate team being reduced.<br>**Risk Effect:** This results in an under reporting of the harm rate which will impact on the accurate assessment of performance against target and The lead organisation for Improvement is likely to fall to the National Quality Team but their role and remit remains unclear<br>(Helen Goodwin) | 3x2 ↔ | 2x2 ↔ | 1. Staff in maternity and paediatrics trained to undertake reviews (11/2013).<br><br>2. Specialty specific harm triggers have been developed in Obstetrics and for Geriatric Medicine (07/2013).<br><br>3. Harm events in corporate scorecard.<br><br>4. Clear outcome measures in place for the five-year Patient Safety Plan which include harm event rate and HSMR target.<br><br>5. Trust data extracted from portal and held locally.<br><br>6. Access database established and reporting criteria discussed with the Information team.<br><br>7.Training is being rolled out across all sites; in place 03/2014 | **Positive:**<br><br>1. Oct IAGC reported that reporting of low and medium risk incidents had improved (4) (7).<br><br>2. 6 monthly checks of those undertaking the reviews to ensure all are using the same methodology (1)<br><br>3. BoD and CPMT review scorecard and HSMR is nearing the target of 75. (4) (3)<br><br>4. Review of severity of harm events reported in Datix undertaken monthly using a 10% sample (4)<br><br>5. Weekly reviews of all death / severe and moderate harms reported by senior corporate team. (All),<br><br>6. Weekly reviews by corporate team of low / no harms | ~~1.Training is being rolled out across all sites; should be in place by 03/2014~~ | |

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| **Risk Cause:** The annual re-base of national measures of standardised mortality. Also the influence of mortality within 30 days of discharge on the SHMI is difficult to control.<br>**Risk Effect:** This makes the overall outcome measure difficult to monitor and maintain over each financial year. The overall SHMI figure for the Trust is higher than the HSMR.<br>(Helen Goodwin) | 4x4 ↔ | 2x4 ↔ | 1. Figures and trend data reported on all areas of mortality.<br><br>2. Patient Safety Plans in place corporately and at divisional level.<br><br>3. Local change registers in place to identify learning.<br><br>4. Patient Safety Meeting to look at coding with patient safety metrics to be aligned with mortality indicators.<br><br>5. Site variations to March 2014 have been assessed but this is an on-going process. | **Positive:**<br>1. BoD and CPMT reviewed trend data; as at month 8 the Trust remains one of the best performing organisations for HMSR with an improving SHMI. (1) (2)<br><br>2. Review of Coding shows that patient centre data richer than that through SUS; a further in depth review will take place. (4)<br><br>**Negative:**<br><br>A. As at month 4 high SHMI relative to HSMR in specific areas.(C1) (C2)<br><br>B. Report to Oct IAGC that HSMR had declined slightly since the previous year (C1) (C2) (C3) | C1. Review of specific triggers in clinical specialties (02/2014)<br><br>C2. site variations to be assessed (on-going)<br><br>C3 Development of organisational process to capture learning as a result of audit and mortality meetings | A1 Opinion from Discharge planning and readmission programme on patient deaths within 30 days of discharge (update by Q2 14/15).<br><br>~~A2 Review of coding (02/2014).~~ |
| **Risk Cause:** Due to a failure to listen and act on patient feedback there is a risk that the Trust will fail to make improvements in patient experience as measured by the CQC and the annual inpatient survey<br>**Risk Effect:** Loss of confidence from patients who expect high standards; negative impact on patient experience and loss of CQUIN income<br>(Sally Smith) | 4x2 ↔ | 2x2 ↔ | 1. Complaints and incidents monitored.<br><br>2. Quarterly updates of the Quality Strategy and action plan.<br><br>3. Friends and Family Test test.<br><br>4. External focus and review by the Patient and Staff Experience Governors Group.<br><br>5. Quality Improvement & CQUINs Programme Manager reporting progress to divisional governance groups quarterly.<br><br>6. Process for feeding back to patients on the actions taken as | **Positive:**<br>1. Clinical Quality and Patient Safety report to the BoD monthly which provides an overview of the Trust patient experience achievement. (1) (2) (5)<br><br>2. Strategic Group monitoring and discussion about the Quality Strategy updates as at month. Feedback to month 6 showed improvements in patient experience. (2) (5)<br><br>3. Feedback to Council of Governors has been positive (4).<br><br>4. Francis Theme on complaints to BoD in 01/2014 with resulting | ~~C1. Process for feeding back to patients on the actions taken as a result of their concern or compliment.~~ | |

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| | | | a result of their concern or compliment "you said, we did". | action plan. | | |
| **Risk Cause:** Due to the embryonic state of the new Health Economy there is a risk that there are varying levels of understanding of the focus on clinical outcomes for staff and how they may influence them.<br>**Risk Effect:** Lost opportunity to influence improved clinical outcomes for patients.<br>(Sally Smith) | 3x2 ↔ | 2x2 ↔ | 1. Quarterly updates of the Quality Strategy and action plan to the SG.<br><br>2. Mapping of current, planned and future activity against NHS England guidance in 'Everyone Counts: Planning for Patients 2013-14' and 'Putting Patients First: the NHS England business plan for 2013/14-2015/16 has been undertaken and will require publication of consultant level activity and outcomes for 8 medical and surgical specialties by September 2013. | **Positive:**<br>1. Clinical Strategy Update to BoD January 2014 (1) (2)<br><br>2. Quarterly Strategy Updates to Strategic Group to monitor performance against agreed metrics. (1) | | |
| **Risk Cause:** Due to patients on heart failure and pneumonia pathways not being managed in the same ward, there is a risk that clinicians are unable to ensure patients are managed in line with the agreed EQ pathway.<br>**Risk Effect:** sub-optimal patient care and fines in relation to Commissioning for Quality and Innovation metrics.<br>(Helen O'Keefe / Sarah Scott) | 4x3 ↔ | ~~3x3~~ 2x3 ↓ | 1. Electronic Discharge Notices in place to ensure good handover of care and appropriate follow-up<br><br>2. Quality Strategy and detailed annual plans detail the metrics to be achieved.<br><br>3. Quarterly Quality Report outlines progress against the plans;<br><br>4. Project Manager for Quality Improvement and CQUINs (PM) in place.<br><br>5. Regular meetings to discuss the pathways with all providers including community;<br><br>6. Electronic patient record | 1. Board Approved Quality Strategy and annual updates (2);<br><br>2. RMGG received quarterly updates on the annual objectives from the Quality Strategy to detail progress against plan. (2) (3)<br><br>3. Management of Project Manager to ensure achievement of objectives – currently meeting objectives (4)<br><br>4. At month 10 likely achievements of heart failure target and partial achievement of pneumonia target reported in. Clinical Quality and Patient Safety report to the BoD February (8) | C1 Consultant nurse practitioners in place and educating staff on pneumonia pathway (Q3 & Q4 13/14.)<br><br>C2 Improved working / pathway between acute and community (2014/15) | |

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| | | | system to alert staff of the need for a patient to follow a prescribed pathway. (02/2014);<br><br>7. Regular HF MDM meetings in place<br><br>8. Clinical Quality and Patient Safety report to the BoD monthly which provides an overview of the Trust performance<br><br>9 Consultant nurse practitioners in place and educating staff on pneumonia pathway (03/2014).) | | | |
| **Risk Cause:** Due to the four main CCGs that the Trust provides services to having differing priorities for health improvements in their populations there is a risk that the selection of CQUINs may be inappropriate with unachievable trajectories<br>**Risk Effect:** which means that focus may be on the wrong area resulting in a failure to improve clinical outcomes or maintain good practice and ultimately loss of the CQUIN payment.<br>(Helen O'Keefe / Sarah Scott) | 3x3 ↔ | 2x3 ↔ | 1. Meeting has taken place to start the process for agreeing CQUINs for 2014/15;<br><br>2. Weekly teleconferences to discuss CQUINs for 2014/15 and progress for 2013/14. This has now incorporated in the discussions in contract meetings.<br><br>3. Clinical involvement in all pathway discussions to ensure appropriate measures agreed. | 1. CMB received assurance at its February 2014 meeting ahead of the contract signing (1) (2). | C1. CQUIN schedule agreed (03/2014)<br><br>C2.Over 75's schedule: CCGs to confirm meeting to discuss this further and to seek agreement on this with KCHT (04/2014) | A1. Method for providing assurance to the BoD on progress of agreeing CQUINs for 2014/15 (2)<br><br>~~A2 CMB to receive assurance at its February 2014 meeting ahead of the contract signing.~~ |
| **Risk Cause:** Due to the lack of development for staff there is a risk that the culture change required to enable quality improvement will not develop or be sustained.<br>**Risk Effect:** resulting in failure to improve or maintain quality standards | 3x2 ↔ | 2x2 ↔ | 1. Listening events held as part of our We Care Programme for staff to share with each other what could improve the Trust as a better place to work and for patients to feed back on their experience.<br><br>2. Improvements to internal communications and a reward and recognition process implemented in order to foster | **Positive:**<br><br>1. BoD approval and involvement with the We Care Programme. (1) (2) (3) (4)<br><br>2. Uptake of clinical leadership course has increased with waiting lists to join.<br><br>3. Presentation to Chief Executive's Forum from a | C1. Continuous roll-out of the programmes.<br><br>C2. More facilitators to ensure the programme can be rolled out quickly enough.<br><br>C3. Those that have been through the programme need to lead bottom up culture | A1. Update to Clinical Management Board and BoD on progress and success of leadership programmes (April 2014).<br><br>A2. Report to confirm roll out of programme is managed and prioritised. |

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| | | | staff engagement.<br><br>3. Team development programme implemented across organisation to improve team effectiveness.<br><br>4. Clinical Leadership Programme (30 complete / 24 current / 24 starting Autumn 2014) / Enhancing Individual Effectiveness (50 going through the programme) / Aspiring Consultant Programme and Medical Appraisal Programme implemented to improve leadership skills in creating effective workplace cultures. MDT approach linked to Shared Purpose Framework and Trust shared values.<br><br>5. A network of programmes has been introduced to ensure more staff are able to receive relevant training. | number of participants from the first cohort of the Clinical Leadership Programme.<br><br>4. Medical Director has witnessed a change in culture in areas where the Clinical Leadership Programme has been implemented.<br><br>5. Strong data shows that participants have dramatically improved their confidence in being able to tackle culture issues and understand their roles as leaders. | change across the organisation.<br><br>C4. Accreditation of clinical leaders and facilitators and accreditation of wards / teams as effective workplace cultures. | |
| **Risk Cause:** Due to the process to carry out the Friends and Family Test not being embedded there is a risk that the Trust will fail to meet required response rates for Friends & Family Test ( FFT).<br>**Risk Effect:** Loss of confidence from patients who expect high standards and loss of CQUIN income Failure to achieve quality target of 90% recommendation to Friends & Family by our patients<br>(Sally Smith) | 4x3 ↔ | 2x3 ↔ | 1. Standard Operating procedure developed and in use.<br>2. Task and Finish Group steers improvements in responses from the response rates received.<br>3. Methods of collecting the information have been widened to include cards, email and texting.<br>4. Feedback to wards on lessons learned to enable action plans to be developed and implemented.<br>5. Process for feeding back to patients on the actions taken as a result of their concern or | **Positive:**<br>1. CQ&PS report provides the BoD with data on response rates. Since August the rates have been steadily improving. The national rates for maternity, inpatient and A&E were met for Nov / Dec 2013. Trust has consistently met 15% since November 2013.<br>(1) (2) (3) (4)<br>2. Improvements plans monitored through RMGG (2) (4)<br><br>**Negative:**<br>A. Concern expressed at Jun BoD Away day with low YTD | C1 Share and embed learning through the We Care Programme. | |

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| | | | compliment "you said, we did" and Wordalls.<br><br>6. Trustwide Market Place We Care Event held on 6 March to seek patient and staff feedback on their experience. The feedback has been typed up. | response rate.<br>B. Aug 13 Quality Surveillance Group put trust under enhanced surveillance for low FFT returns..<br>C. Oct RMGG considered including FFT on corporate risk register. Oct BoD heard that A&E was bringing compliance down. A&E rates have double since texting introduced. Target not met for Feb 2014. | | |
| **Risk Cause:** Due to the continuous improvement in the reduction of Health Care Acquired Infections there is a risk that the Trust may be unable to meet the revised targets for 2013/14 .<br>**Risk Effect:** Failure to meet the c.Diff target carries a financial penalty which increases with each case over the agreed target. In addition it results in patient experience below the standards accepted by the Trust.<br>(Sue Roberts) | 4x4 ↔ | 4x4 ↔ | 1. Detailed annual program of infection, prevention and control in place.<br><br>2. Robust systems to assist in the early identification and decolonisation of positive patients for MRSA bacteraemia (within 5 working days to ensure lessons are learned and improvements made).<br><br>3. Antimicrobial Pharmacists in post on all sites.<br><br>4. Enhanced surveillance of any new outbreaks plus additional control measures implemented through regular Outbreak Meetings in conjunction with Public Health England. | **Positive:**<br>1. CQ&PS report provides the BoD with data infection rates. (1)<br><br>2. Presentations to the BoD by the Director of Infection Prevention and Control on infections and the Trusts profile with additional benchmarking data.<br><br>3. Divisional performance dashboards look at details per ward. (2) (4)<br><br>4. Trustwide action plans in place to address findings through root cause analysis.(1) (2) (4)<br><br>**Negative:**<br>A. C.Diff cases over the threshold for Monitor in October 2013 with a total of 38 to December 2013<br><br>B. 7 MRSA cases reported to the end of January 2014. | C1. Action Plan arising from Public Health England visit. | A1. Assurance report from Public Health England from visit in January 2014 (03/14) |

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| **ANNUAL OBJECTIVE: AO 3: Deliver the CQUIN programmes commissioned by CCGs demonstrating improvements and financial benefit.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** The Trust cannot meet the needs of the CQUIN programmes because of the increased complexity of targets and the reduced ability to record partial success.<br>**Risk Effect:** Quality standards and income is compromised.<br>(Helen O'Keefe / Sarah Scott) | 3x2 ↔ | 2x2 ↔ | 1. Monthly BoD reports on performance against all elements of the CQUIN targets. Clinical Audits of CQUIN target areas.<br><br>2. Dedicated Programme Manager for CQUINS and Quality Improvement<br><br>3. Quarterly reporting to the Divisional Clinical Governance Groups, as well as engagement with other staff groups to increase staff awareness, with the objective of meeting each of the CQUINS targets. | **Positive:**<br>1. Mth 1-8 PS&QC BoD / CPMT reports had no reds for CQUIN targets. Since 10/11 the % value of CQUINS targets missed have improved from 20% of value, to 6.8% of value. (1) (2) (3)<br><br>2. Reported at Oct IAGC/FIC that the Trust is meeting Heart Failure CQUIN and good action plans for other elements are in place. (1) (2) (3)<br><br>3. Monthly risk profiles to Finance. (1) (2) (3)<br><br>4. Mth 10 risk profile shows value of CQUIN targets missed at 7.8% with likelihood of further reduction if the CAP, stroke and COPD elements of CQUIN are achieved. (1) (2) (3)<br><br>**Negative:**<br><br>A. Mth 4 CPMT expressed some concern over achievement of | | |

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| **Co-ordinating Director:** Chief Nurse and Director of Operation & Quality. | | | | HCAI CQUIN.<br><br>B. Sep CPMT expressed concern over the pressure ulcer, heart failure, pneumonia and stroke elements of CQUIN, though some assurance from the Divisional representation was provided that these would be achieved.<br><br>C. Oct IAGC/FIC it was reported that there were still difficulties in meeting the community acquired pneumonia CQUIN.<br><br>D. Month 10 CQ&PS report shows possibility of missing targets for CAP, stroke and COPD elements of CQUIN. | | |

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| **ANNUAL OBJECTIVE: AO 4: Plan and Implement PAS up-grade to enable more efficient and productive approach to managing 18 week pathway for elective care from referral to treatment and follow-up.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Insufficient Project oversight, staffing resource, including a dedicated project manager, to ensure robust project delivery. Varying levels of understanding about how patient pathways work and appreciation of the importance of 18 weeks amongst operational and management levels **Risk Effect:** The upgrade is not delivered to time or with maximum effect. Trust is ill prepared for the level of change required in using the system at all levels of staff. Poor prioritisation, perpetuated by inconsistent and inappropriate local processes resulting in Trust's inability to accurately report 18 week position .<br><br>**Co-ordinating Director:** Chief Nurse and Director of Operation & Quality. | 4x4 ↔ | ~~3x4~~<br>2x4 ↓ | 1. Robust validation processes are in place.<br><br>2. Intensive support in place for the T&O specialty via a dedicated external consultant and a team of key staff from within the Trust.<br><br>3. PTL and report training for Surgical Division staff completed for July 13 so PTLs used to maximum advantage<br><br>4. Project Team in place.<br><br>5. Project Board meetings.<br><br>6. Project Initiation Document in place (03/2014)<br><br>7. ToRs for Project Group signed off. (03/2014) | **Positive:**<br>1. No issues raised at Mth 1-8 BoDs with PAS or 18 weeks at Q1 EPRs and CPMTs. Improvement in admitted 18 week RTT reported to Oct BoD, as was advised that all 52 week waits would be eliminated by 12/2013. (1) (2) (3) (4)<br><br>2. Minutes from Project Board meeting (5)<br>3. Sign off of project Initiation Document (by Programme Board 01/2014) (6)<br><br>4. Sign off of ToRs of Project Group (by Programme Board 01/2014) (7)<br><br>**Negative:**<br>A. 08/2013 Trust placed on enhanced surveillance by Quality Surveillance Group because of 52 week waiters and the RIS problems.<br><br>B. Monitor Q1 feedback raised the risk of 52 week waiters. | .<br>C1. Training for band 2/3 (02/14)<br><br>~~C2 Project Initiation Document in place~~<br><br>~~C3 ToRs for Project Group~~ | A1. Process for reporting progress of project to appropriate BoD Committee (if required).<br><br>~~A2 Sign off of project Initiation Document (by Programme Board 01/2014) (C2)~~<br><br>~~A3 Sign off of ToRs of Project Group (by Programme Board 01/2014) (C3)~~ |

| **STRATEGIC OBJECTIVE: SO 1: Deliver excellence in the quality of care and experience of every person, every time they access our services.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 5: Reduce the number of unplanned readmissions within 30 days of discharge following an elective and non-elective episode of care, where there is a direct link to the index admission.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Due to the maturity of the whole system economy and the ability of primary care and secondary care to work seamlessly together; there is a risk that the "system" does not support the Trust In reducing the unplanned readmission rate.<br>**Risk Effect:** Resulting in patient care being compromised and financial penalties being imposed.<br><br>**Co-ordinating Director:** Medical Director. | 3x3 ↔ | 2x3 ↔ | 1. Organisational Balanced Scorecard with re-admission rates against target - monthly;<br><br>~~2. Re-admissions Committee is in place to review the four workstreams performance against action plans.~~<br><br>3. Target for reduction was set by the Trust and agreed with Monitor as a reduction of 0.67%;<br><br>4. Routine reporting of the target and any outliers in performance identified and commentary provided on action to be taken CQPS report.<br><br>5. Associate Director of Operations has an annual objective lined to reducing the readmission rate.<br><br>6. Addition project support – Service Improvement Manager appointed; started in 01/2014. | **Positive:**<br>1. BoD, CPMT and EPR review and discuss the Organisational Balanced Scorecard and no concerns were raised about the re-admission rates Month 1-8. The Trust is currently showing a reduction in re-admissions of 1% (12/2013) (1) (3) (4)<br><br>~~2. Verbal updates from the Re-admissions Committee are provided by the Medical Director to Clinical Management Board (monthly) (2)~~<br><br>3. The Chief Nurse and Director of Quality and Operations performance managed the Associate Director of Operations to achieve the agreed re-admissions target. (5)<br><br>**Negative:** A. Concern expressed at Aug BoD meeting as target not being met and worry that faults in the recording of admissions were occurring. | C1 Review of programme to refresh and update to maintain and improve performance (Chief Nurse / Medical Director) 03/2014<br><br>C2 Set improvement trajectories for re-admissions at speciality level. (Medical Director) 03/2014<br><br>C3. Re-admissions Committee is in place to review the four workstreams performance against action plans. Following C1.<br><br>C4. Re-admissions programme to be moved into the Transformational Redesign Service as re-admissions impacts on | A1: possible data audit to be discussed 04/2014 (A). |

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| | | | 7. Review of programme to refresh and update to maintain and improve performance (Chief Nurse / Medical Director) 02/2014 | | trust-wide improvement plans (05/2014).<br><br>C5. Re-set plan following a review of the use of risk stratification, setting of trajectories and review of other similar trusts who are achieving well in relation to readmissions. | |

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| **ANNUAL OBJECTIVE: AO 6: Emergency Planning and Business Continuity achieve upper quartile performance against mandatory DH, EP&BC Indicators.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Lack of engagement from the Divisions in the understanding, development and implementation of effective and resilient Business Continuity plans.<br>**Risk Effect:** Poor resilience of the Trust to respond to Major Incidents or failure of critical business activities resulting in a detrimental effect on patient care and failure to deliver core business performance indicators.<br><br>**Co-ordinating Director:** Chief Nurse and Director of Operation & Quality. | 4x2 ↔ | ~~3x2~~ 2x2 ↓ | 1. Divisional Business Continuity plans in place.<br><br>2. Gap Analysis against two key Emergency Planning documents - 'Emergency Preparedness' and 'Everyone Counts: Planning for Patients 2013/14'<br><br>3. The 'After Action Review' from last winter has captured the lessons learned and underpins a detailed Action Plan that addresses a number of improvements that will be implemented during 2013/14. New organisational incident plan to ensure it meets the EPRR Framework published in Mar 13<br><br>4. Suite of policies in place; Seasonal Plan; Incident plan.<br><br>5. Risk Register in place. | **Positive: :**<br>1. Major Incident Plan was tested throughout Winter 2012/13 and during the Major Incident in April 2013 – no concerns. (1) (3)<br><br>2. Emergency Planning and Business Continuity Committee (EPBCC) approved and tested Divisional BCP's (07/2013) (1)<br><br>3. Lessons learned from the exercises, gap analysis and After Action Review were fed into updated plans. (2)(3)<br><br>4. External assessment by KMCS against the NHS indicators – found to be 97.6% compliant. (1) (2) (4)<br><br>5. EPBCC escalates risks as appropriate to RMGG. (5)<br><br>**Negative:**<br>A. KMCS identified the need for a Business Continuity Plan. | C1 Business Continuity Plan (03/2014) - response to "A"<br><br>C2 Trust-wide training programme 2014/15<br><br>C3 reviewing the approach to develop divisional plans to ensure engagement by frontline staff (03/2014)<br><br>C4 Develop dashboard to monitor compliance (03/2014)<br><br>C5 Increase the number of specialties covered by business continuity to 90% (03/2014) | A1 EP & BC Team to test the effectiveness of the Plans and report progress to EP&BC Committee for corrective action and the RMGG for oversight (03/2014) |

| **STRATEGIC OBJECTIVE: SO2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 7: Engage with the new local Healthwatch and Wellbeing Boards while further developing relationships with vulnerable patient groups and local and voluntary community organisations (VCOs), through a structured programme of meetings and other communication channels. The overall aim is to develop and strengthen relationships and understanding between the Trust and key stakeholders.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Inability to identify or engage with vulnerable patient groups.<br>**Risk Effect:** Services provided in a manner that do not cater for the needs of the whole population. | 3x3 ↔ | 2x3 ↔ | 1. MONITOR self-certification process for FY 13/14 Q1 and Q2 return in relation to the Learning Disability access governance indicator.<br><br>2. Corporate Governance Statement.<br><br>3. Equality and Diversity Objectives via the Equality Delivery System.<br><br>4. Annual BoD Equality Review of Service Delivery.<br><br>5. Trust Wide Equality, Diversity, Human Rights and Public Patient Engagement Steering group in place which reports to the Risk Management and Governance Group (RMGG).<br><br>6. BoD approved engagement strategy.<br><br>7. Review on service provision to Learning Disability patients.<br>~~8. Public Patient Advisory Forum~~ | **Positive:**<br>1. BoD approval of Q1 and Q2 Monitor Self-assessment.<br><br>2. No engagement issues raised BoD when signing the Monitor Corporate Governance Statement (05/2013).<br><br>3. E&D Objectives approved by the BoD (08/2013)<br><br>5. RMGG review of minutes from ED&HR & PPE Steering Group (quarterly).<br><br>6. Engagement Strategy approved at BoD (08/2013).<br><br>7. CMB approved service provision to Learning Disability patients (05/2013).<br><br>8. Minutes of Public and Patient Advisory Forum to CMB (quarterly).<br><br>9. No issues raised by BoD at Q1 or Q2 report on AO progress. | 1. Memorandum of Understanding between Trust and Local Healthwatch (2014/15) – this has been prepared and is to be signed off by the BoD in 04/2014.<br><br>~~2. Develop relationship and membership of KentCAN to provide a wider forum through which to engage the voluntary sector. (03/2014)~~ | |

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| | | | ~~receives 6 monthly reports on progress against achievement of the AO and Public Patient Engagement Strategic Objectives~~.<br><br>9. Quarterly report to BoD on progress with AO.<br><br>10. Head of Equality & Engagement in post with objectives aligned to delivery of the annual objective.<br><br>11. Membership & Engagement Strategy.<br><br>12. Twice yearly events for external engagement. | 10. Report to Equality & Engagement Steering Group through to RMGG.<br><br>11. Membership & Engagement Strategy approved by BoD & CoG (08/2013)<br><br>External Auditors observed good CoG engagement at joint meeting with BoD<br><br>CQC inspections for Outcomes 1. CQC Quality Risk Profile for Outcomes 1.<br><br>**Negative:** | | |
| **Risk Cause:** Use of new communications media with the public leads to an unmanageable increase in the availability of patient and carer views.<br>**Risk Effect:** Data confidentiality issues, inappropriate views given credibility and damage to reputation by failure to respond in a timely manner.<br><br>**Co-ordinating Director:** Director of Human Resources and Corporate Services. | 3x2 ↔ | ~~2x2~~<br>1x2 ↓ | 1. Weekly monitoring summary of new media activity to Director of Communications, Chief Executive and Chairman.<br><br>2. Annual Communications Strategy approved by BoD.<br><br>3. Daily monitoring of new media channels in place with responses where appropriate and reported as part of the weekly summary.<br><br>4. Collation of nature of new media traffic and report provided to Strategic Group (SG) on a quarterly basis.<br><br>5. Social Media steering group in place.<br><br>6. New media Policy in place (Jan 2014) | **Positive:**<br>1. Governance structure in relation to monitoring of new media quarterly Social Media Steering Group; Strategic Group; CPMT and then where appropriate items go to BoD). No concerns raised. (3) (4) (5) (6).<br><br>2. Annual Communications Strategy monitored through Strategic Group (2)<br><br>3. Away Day presentation overview and external communications. Comms team presentation on way ahead to Aug BoD well received.<br><br>4. Strategic Group approved New Media Policy (6)<br><br>**Negative:** | | |

| **STRATEGIC OBJECTIVE: SO 3: Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects, and rapidly implementing best practice from across the world.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 8: Implement of the Research and Innovation (R&I) Strategy to increase "homegrown" R&I whilst continuing to support other R&I by putting in place the right people, processes and facilities to support these goals, and through effective engagement with R&I stakeholders.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Ineffective performance management of R&I.<br>**Risk Effect:** Non achievement of "homegrown" R&I. | 3x2 ↔ | 1x2 ↔ | 1. R&I Committee review of "homegrown" R&I.<br><br>2. Quarterly and annual CLRN reports. R&I on Balanced Scorecard discussed at CPMTs, BoDs.<br><br>3. Annual R&I BoD report. | **Positive:**<br>1. BoD reviewed and approved the Annual Research and Innovation Report (10/2013). (4)<br><br>2. CLRN minutes (1)<br><br>3. Periodic MHRA inspections and reviews – none recently.<br><br>**Negative:**<br>A. Review of scorecard metrics; currently failing target 71% in October 2013 (2) | | |
| **Risk Cause:** Continued bureaucratic burden for researchers.<br>**Risk Effect:** Delay in commencement of clinical trials and R&D projects.<br><br>**Co-ordinating Director:** Medical Director | 3x2 ↔ | 1x2 ↔ | 1. Quarterly and annual CLRN reports on achievements of targets.<br><br>2. R&I and innovation on Balanced Scorecard discussed at CPMTs, EPRs and BoDs.<br><br>3. Annual R&I BoD report.<br><br>4. Countrywide methodology in place which has speeded up the process | **Positive:**<br>1. BoD reviewed and approved the Annual Research and Innovation Report (10/2013). (4)<br><br>2. CLRN minutes (1)<br><br>3. Progress of trials monitored through R&D Committee (5)<br><br>4. Periodic MHRA inspections and reviews – none recently.<br><br>**Negative:**<br>A. Review of scorecard metrics; currently failing target 71% in October 2013 (2) | | |

| **STRATEGIC OBJECTIVE: SO 4: Identify and exploit opportunities to optimise and, where appropriate, extend the scope and range of service provision.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 9: Implement the marketing strategy to meet repatriation and market share targets for inpatient and day case procedures** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Due to patient choice, new market entrants and own workforce able to work for competitors; there is a risk that the Trust may not be able to maintain its current market share in specific areas<br>**Risk Effect:** resulting in a loss of income of between 5-10%.<br><br>**Co-ordinating Director:** Director of Strategic Development & Capital Planning | 5x2 ↔ | 5x2 ↔ | 1 Marketing Assessment.<br><br>2.Income plans;<br><br>3. Income targets;<br><br>4. Marketing approach developed.<br><br>5. Process agreed for review of tender opportunities.<br><br>6. Monthly reports to the FIC on income, CIPs and tender opportunities.<br><br>7.Summary reports to ET on tender opportunities.<br><br>8. Private Patient Strategy (03/2014) | **Positive:**<br>1. Board reviewed and assessed the Marketing Assessment and Marketing approach prior to approval. (1) (4)<br><br>2. Tenders assessed at ET and FIC where an assessment of how the opportunities fit into the repatriation strategy takes place. (5)<br><br>3. FIC / BoD monitor actuals against plan in terms of income plans. (2) (3)<br><br>**Negative:** Income below plan in Mths 4-6. FIC concerned with lack of income given levels of expenditure during Q3. | C1 Detailed service review to be undertaken to inform marketing strategy (02/2014 – on-going)<br><br>~~C2. Development of Private Patient Strategy (01/2014)~~ | |

| **STRATEGIC OBJECTIVE: SO 5: Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 10: Support increased efficiency and effectiveness across the Trust via the implementation of major infrastructure projects.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Due to failure to plan projects to upgrade and develop the Trust's infrastructure effectively there is a risk that upgrade and development work will impact on service<br>**Risk Effect:** resulting in service interruption leading to unacceptable impact on patient care.<br><br>**Co-ordinating Director:**<br>Director of Strategic Development & Capital Planning | 3x3 ↔ | 3x2 ↔ | 1. CQC inspections for Outcomes 10.<br><br>2. BoD approved Estates Strategy and 5 year capital plan – although the Clinical Strategy is now the main driver.<br><br>3. Five year condition survey of Trusts infrastructure completed (2013/14)<br><br>4. Backlog maintenance categorised into high, medium and low risk<br><br>5. Annual maintenance plan aligned to risk profile.<br><br>6. Annual ERIC return and Patient Led Assessment in Care Environment (PLACE) inspections.<br><br>7. Reprioritisation of 5 year capital programme to support immediate infrastructure issue and supporting emerging priorities from clinical strategy. | **Positive:**<br>1. BoD approved Estates Strategy, 5 year plan and Clinical Strategy (2) (7)<br><br>2. Bi-monthly report on progress against capital plan to FIC with monthly report to SG - Mth 3 report to BoD that capital plan was on target and Monitor Q1 report shows £0.1 below plan with a forecast of on plan, Q2 report shows £0.3m ahead of plan with same forecast. (2) (3)<br><br>3.Oct IAGC received an IA report that gave a "green" rating for capital planning and management in the FT. (2)<br><br>4. Backlog maintenance monitored at SG (4)<br><br>5. Annual maintenance plan agreed at PEIC and reported to SG (5)<br><br>**Negative:**<br>1. Monitor Q1 feedback raised the issue of over activity leading to financial pressures and risks to CIPs.<br><br>2. PLACE results in September 2013 showed that the Trust in the lower quartile in two out of the four areas (Cleanliness, and Condition, Appearance and Maintenance. (6) | 1. Review of Estates Strategy following the implementation of the Clinical Strategy. | |

| **STRATEGIC OBJECTIVE: SO 5 and SO 6: Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust and Deliver efficiency in service provision that generates funding to sustain future investment in the Trust.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 11: Drive increased efficiency and effectiveness of Trust corporate led services and activities.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Restrictions on income driven by increased competition for patients and NHS efficiency targets **Risk Effect:** Inefficient use of existing resources affecting the Trusts ability to deliver patient services, and deliver a safe environment for staff<br><br>**Co-ordinating Director:** Director of Strategic Development and Capital Planning | 2x2 ↔ | 2x1 ↔ | MONITOR self-certification process for FY 13/14. BoD and MONITOR approved Annual Plan. BoD approved Financial Strategy. Plan that includes achievement of financial efficiency targets. Monthly CPMT, EPR, BoD and FIC reports on progress with efficiency plans. Back office steering group with NED oversight. H&S reports to RMGG and Q2 and Q4 IAGC. Quarterly and Annual Monitor declarations. Corporate H&S Committee. Quarterly BoD review of achievement of this AO. | **Positive:** No issues on this subject raised at May BoD when signing the Monitor Corporate Governance Statement. BoD approval of annual plan and financial strategy. No issues raised at Mth 1-7 CPMTs or at Q1 EPRs and FIC. No issues raised by BoD at Q1 and Q2 report on AO progress **Negative:** | | |

| **STRATEGIC OBJECTIVE: SO 1 and SO 4: Deliver excellence in the quality of care and experience of every person, every time they access our services and Identify and exploit opportunities to optimise and, where appropriate, extend the scope and range of service provision.** | | | | | | **Action Status** |
|---|---|---|---|---|---|---|
| **ANNUAL OBJECTIVE: AO 12: Agree with commissioners and consult with the public to implement a sustainable clinical strategy which will in particular meet the standards of emergency surgery; ensure the availability of an appropriately skilled workforce; provide safe sustainable services with consideration of access for patients and their families and visitors.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Due to acceptability of service reconfiguration with stakeholders there is a risk to implementing the clinical strategy on time and on budget to deliver the vision to provider a larger range of services more locally<br>**Risk Effect:** resulting in failure to provide excellent patient experience; failure to drive the required level of efficiencies and reputational risk.<br><br>**Co-ordinating Director:** Director of Strategic Development & Capital Planning | 5x3 ↔ | 5x3 ↔ | 1. Prolonged period of engagement with Health Economy stakeholders before commencement of formal consultation.<br><br>2. Programme Board in place to deliver the Clinical Strategy with six workstreams.<br><br>3. Communications / Engagement plan with Steering Group to implement.<br><br>4. Consultation started 9/12/2013 | **Positive:**<br>1. CE of Local Area Team supported principles of the Clinical Strategy (1)<br><br>2. Strategic group receives regular performance reports from the programme board (2).<br><br>3. Strategic Group receives regular performance reports on the implementation of the communication and engagement plan (3)<br><br>4. BoD approved the consultation document with Canterbury CCG as a partner in the consultation (11/2013)<br><br>**Negative:** Aug IAGC expressed some concern that this AO may not be met in year. | | A1 The outcome of the consultation will be evaluated externally by Kent University (05/2014) (4) |

| **STRATEGIC OBJECTIVE: SO 1, SO 4 and SO 6: Deliver excellence in the quality of care and experience of every person, every time they access our services and Identify and exploit opportunities to optimise and, where appropriate, extend the scope and range of service provision and Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust.** | | | | | | **Action Status** |
|---|---|---|---|---|---|---|
| **ANNUAL OBJECTIVE: AO 13: Develop and deploy analytical approaches to support strategic and evidence based decision making and provide clinicians with real time business intelligence.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Service Line Reporting (SLR) and other approaches not developed to the required level of sophistication<br>**Risk Effect:** Less than optimal decision making and lack of credible results in poor use of the information.<br><br>**Co-ordinating Director:** Director of Finance | 4x4 ↔ | 4x3 ↔ | 1. Project Management approach to reporting of SLR. to Finance Senior Team monthly and to the FIC quarterly.<br><br>2. Budgets agreed by service line at the beginning of the year.<br><br>3. Robust systems in place to monitor SLR / financial control / coding and income.<br><br>4. Divisions identify three priorities to action – rolling basis. All Divisions have concluded one round and a second round has begun.<br><br>5. Training for clinicians included in consultant training programme.<br><br>6. A proposal is in place for non profitable service lines to be presented clinically to the Medical Director at first instance and then to CPMT for discussions about the viability. | **Positive:**<br>1.Reports on SLR to Finance Senior Team monthly to check performance against budget (1) (2) (4);<br><br>2. Reports on SLR to Finance and Investment Committee on a quarterly basis to check performance against budget (1) (2)<br><br>3. No issues raised by audit on the systems of control in place at the beginning of the year (3).<br><br>4. No issues raised at Mth 1-7 CPMT or at Q1 EPRs (1) (2).<br><br>5. The Oct IAGC received a report from IA that reasonable assurance could be taken that controls were in place around the quality of clinical coding (3).<br><br>6. A more sophisticated dialogue with clinicians is taking place about the robustness of the information<br>**Negative:** | 1. Each division has been asked to agree three areas of priority – to focus their actions – on-going.<br><br>2. Engagement with clinicians to be supported through training – on-going.<br><br>3. Linking SLR information with the balanced scorecard to ensure a holistic view of performance (2014/15 objective) | |

| **STRATEGIC OBJECTIVE: SO 6: Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust.** | | | | | | **Action Status** |
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| **ANNUAL OBJECTIVE: AO 14: Ensure strong financial governance, agree contracts with commissioners that deliver sufficient activity and finance and support a comprehensive internal cost improvement programme where all Divisions deliver cash releasing savings schemes to deliver Trust QIPP targets.** | | | | | | |
| **Principal Risks Descriptors with Co-ordinating Director** | **Current Risk (LxI)** | **Mitigated Risk (LxI)** | **Controls Already in Place** | **Assurance (Evidence that Controls are Working)** | **Control Gaps with Significant Actions and Timescales** | **Assurance Gaps with Significant Actions and Timescales** |
| **Risk Cause:** Financial plans not achieved due to lack of external (health economy cannot afford activity delivered) and internal delivery<br>**Risk Effect:** Funds not available to invest in infrastructure.<br><br>**Co-ordinating Director:** Director of Finance | 5x4 ↔ | 4x4 ↔ | 1. Annual Plan includes detailed financial plans.<br><br>2. Monthly Finance reports on income, expenditure and CIPs.<br><br>3. Monthly reports to divisions that includes progress against income and expenditure plan.<br><br>4. BoD Q1 to Q4 reports to MONITOR that includes progress against financial targets.<br><br>5. Fortnightly technical meetings with CCGs where any over performance is discussed.<br><br>6. Revised financial plan and CIPs<br><br>7. Budgets in place for 2014/15 pending outcome of contract negotiations with CCGs. | **Positive:**<br>1. EPR / CPMT / BoD assured through reporting that the Trust is achieving against plan. Mth 1-5. Mth 11 breakeven for the month(1) (3) Achieved against revised plan (04/2014)<br><br>3. Jun FIC content with approach being taken to try to manage demand. (2) (5)<br><br>4. Oct IAGC received a report from IA that gave a "green" rating to FT CIPs, financial accounting, reporting and budgetary control.(1) (2) (3). Met revised CIP position – working on 2014/15 (04/2014)<br><br>5. No outstanding contract issues with the CCGs (5)<br><br>**Negative:**<br>A. FIC understand the issues and are concerned that CCG does not have the finances to pay for current forecast levels of activity.(5)<br><br>B. Month 6 – 10 CPMT and FIC expressed concerns that the underlying financial run rate was in deficit and that CIP plans were behind plan.<br><br>C. BoD expressed concern at levels of agency spend, delivery of CIPs and TYD loss of contingency (Oct & Nov) (1) (2)<br><br>D. December BoD advised that the Trust would not meet the planned surplus. | C1 Action Plan arising from Baker Tilly report (05/2014) | A1. Baker Tilly review of Financial Governance in Surgery (actions for 14/15 will come out of this) 04/2014 |