

Trust Board

TB2008.4

From: Mrs Elaine Strachan-Hall, Director of Nursing & Clinical Leadership
Date: January 2008
Subject: **Board Assurance Framework**
For: **Decision**

Synopsis

All Boards must have Assurance Frameworks in place that are regularly updated and reviewed. The Governance Committee has been charged by the Trust Board with the review and updating of the framework and with bringing together the controls and assurances that support risk mitigation and hence the achievement of the ORH's objectives.

Changes during the quarter to the end of December 2007 include the referencing of the objectives to the Strategic Goals, the inclusion of risks from the Trust's Risk Register and traffic lighting of the action plan so that the Board is immediately aware of the overall position.

The Governance Committee reviewed the BAF at its meeting on 21 December, paying particular attention to gaps in controls. The Board Assurance Framework is presented to the Board for its review and approval.

Financial, legal and risk impact

The BAF is a key tool in providing the Board with an oversight of the achievements of its objectives, the risks to those objectives and the controls and assurances in place. Regular updating through the Board's assurance committees, including the Governance Committee, the Commercial Committee and the HR Committee, are intended to support the Board's own review of the BAF.

Strategic Goals 2007/2008

1. **TO BE THE HOSPITAL OF CHOICE FOR PATIENTS** by providing an outstanding environment for clinical services with customer-focused patient care that will be valued by our partners and the communities we serve.
2. **TO BE A WORLD LEADING TEACHING HOSPITAL** and pre-eminent academic centre with an international reputation for advancements in medicine and biomedical research, able to offer specialist expertise and outstanding teaching and treatment facilities.
3. **TO ACHIEVE FINANCIAL SUSTAINABILITY AND LONG TERM GROWTH** by intelligent redesign of our hospital services based on improved leadership, productivity and efficiency.
4. **TO BE AN EXCELLENT EMPLOYER** with flexible and workable policies that will encourage the recruitment and retention of top quality staff.

Key

TB	Trust Board	EB	Executive Board
F&PC	Finance and Performance Committee	SHA	South Central Strategic Health Authority
AC	Audit Committee		Objective achieved
GovC	Governance Committee	TRR	Trust Risk Register
HRC	Human Resources Committee		Risk mitigation outstanding
CC	Commercial Committee		Work well underway on risk mitigation
			Mitigation puts risk at reasonable/acceptable/minimal level

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Lead and HCS	Risk and RR	Key controls	Potential sources of assurance	Assurance position	Gaps in controls	Gaps in assurance	Action plans for gaps	Action plan updates and status
Lead Director Standard for Better Health/Domain/target	What could prevent the objective being achieved?	What controls/systems are in place to secure the objective?	Where is evidence on effectiveness of controls & systems which we are relying on?	What does evidence tell us on effectiveness of controls and systems we rely on?	Where are we failing to put effective controls and systems in place?	Where is evidence lacking on effectiveness of the key controls and systems?	Plans to address the gaps in controls and or assurance (and indicative completion dates)	Progress made implementing action plans
ORH 1 To achieve the rating of good for quality in the Annual Health Check (SG1) ¹								
RR Ref: TRR028, TRR029, TRR30, TRR31, TRR32, TRR033, TRR 034, TRR041, TR062 ²								
Elaine Strachan-Hall All core standards Andrew Stevens/Andrew Murphy Existing and new national targets	Management focus slips and hence on-going compliance & assurance compromised for all elements: core standards, new and existing national targets (e.g. 4 hour wait, 18 week wait, delayed discharges) Given risk based	Weekly review by EB and lead directors of key targets. Governance, quality and risk framework in place with assurance committees in place.	Review by TB's Sub committees (including GovC, CC and HRC) Review by SHA - Board reports on clinical governance and infection	Performance to month 6 - Board and F&PC reports - satisfactory with improvements in some key targets, e.g. cancelled operations. Risk areas identified. Compliance with SfBH satisfactory to date as	Potential to use newly acquired Dr Foster software to improve analysis and understanding of ORH's position and activities.	AC has asked for further report on P&D in March 2008 Consideration of other sources of external assurances (e.g. HCC	Further work in hand with detailed action plan for privacy and dignity Full update to Trust Board at its January 2008 meeting on all standards. Areas for particular attention include	TB to consider full report in Jan 08. F&PC continues to review HCAI performance

¹ SG = Strategic Goal (1 to 4)

² All risks included within the Trust Risk Register are scored between 16 and 25 - red risks and hence are monitored regularly through the Executive Board, Governance Committee and Trust Board

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	inspection in 2006/07, increased likelihood of inspection in 2007/08	<p>Compliance part of regular governance meetings at all levels</p> <p>System for review of compliance with core standards in place with accountable director</p> <p>Accountability reviews from September 07 - cover Divisions and Corporate Directorates</p> <p>Performance Improvement</p>	<p>control</p> <p>Review by TB January 2008 - detailed paper on performance YTD and expected position at the year end.</p> <p>Accountability reviews</p> <p>CEAC reports</p>	<p>reviewed by Governance Committee</p> <p>Outcome of HCC inspection gave positive assurances on our processes for 06/07 to be carried forward into current year and built on.</p> <p>AC provided with assurances on progress continuing to be made on privacy and dignity.</p>		spot checks)	decontamination, delayed discharges and 4 hour wait.	

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		Team in place Validated KPIs and balanced scorecard reports to TB supported by robust data and information						
ORH2 To focus on improvements in patient safety and reducing harm (SG1)								
RR Ref: TRR001 to TRR020, TRR040, 41 and 42								
Elaine Strachan-Hall James Morris (DIPC) C1a, C1b, C2, C3, C4a, C4b, C4c, C4d and C4e C13a, C13b, C10a and C10b, C11a, C11b	Failure in policies, procedures and review result in patient harm: e.g. failure to act on SABs, NPSA Drug alerts, SUIs, infection control measures, decontamination. Spot check inspection	Accountable leads identified for all areas Increased focus on audit of practice and performance Updated	Divisional Quality Reports to quarterly GovC highlight performance and specific trends and issues.	TB and F&PC reports to Month 6. Further update report on all aspects of AHC and HCAI to TB December 2007	Gap analysis underway to inform plan to achieve NHSLA level 2 for ORH as a whole	Audits on performance to assure compliance and delivery against targets and standards	Detailed report on performance TB January 2008 Gap analysis process now underway for NHSLA Level 2 to be completed and business case	Good progress continuing to be made. Weekly reports to Exec Board covering range of areas linked to risk register reviewed in Nov

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and C11c C14a, b and c C20a	on Hygiene Code due between 1 Jan and 31 March 2008	incident reporting and SUI procedure and relevant training and robust investigative approach Weekly updates to EB on MRSA and C.diff. DIPC & Infection Control team in place. Robust understanding of duties under the Hygiene Code and policies and procedures in	Incidents, Comments and Complaints committee review of SUIs PCT/ORH monitoring meetings on Infection control Reports to TB, F&PC and GovC on HCAI SHA monitoring and Board reports. DH visits and action plans for both MRSA and C.Diff	CNST level 2 achieved for maternity services CNST Level 1 Achieved for ORH SABs process reviewed and response times improving Evidence submitted to HCC in preparation for Hygiene Code Inspection			for investment by end Jan 2008	07 Weekly Infection control team meetings

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		place	(Sept 07) Outcome of HCC inspection					
Risk to be removed as objective achieved	Failure to achieve NHSLA level 1	Robust process and engagement to support achievement of level 1	Report from NHSLA inspection on 26 September	Positive outcome achieved			Report to EB and GovC and TB Gap analysis and planning for NHSLA level 2 underway	NHSLA level 1 Achieved Report to Trust Board January 2008
	Failure to manage complaints results in damage to patient confidence and reputation	Updated complaints policy and procedure agreed. Annual report to TB. Quality reports include complaints	Balanced Scorecard reports to TB and F&PC Annual Report to TB in July 2007 Quality reports to	Performance in Month 7/8 shows 2 day target being achieved at 100% Additional information provided through Quality reports to	Additional scope to improve learning and quality of responses.	Ongoing review	Ongoing monitoring and management in place led by Director of Nursing and Clinical Leadership Actions plans to	Weekly reports to Chief Executive on all aspects Good performance being maintained on response times

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		performance and key issues. 'Red' complaints highlighted. Active involvement of directorate managers Customer care plan includes management of comments and complaints	Divisional Boards and GovC External review of resources and processes within complaints NAO survey on complaints	GovC and review by NEDs			be developed to ensure any issues/learning are identified and acted on - particularly for 2 nd stage reviews External review commissioned and underway at November 07 Customer Care plans in place to bring together all aspects and ensure improvements	despite slight drop in 25 day response rate (NB numbers below 25 days small) Outcome of Review in Jan 08
ORH3a To implement the action plan arising from the external review at the Horton General Hospital (Benjamin Geen).(SG1)								
Risk Ref: TRR001, N007								

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Elaine Strachan-Hall Patient Safety domain	Failure to implement agreed action plan results in reputational damage	Designated lead executive and manager Regular Monitoring meetings internally and with SHA	Report from SHA Regular updates to GovC	Monitoring is effective and plan delivery nearing completion	No areas for ORH	No areas for ORH	Action plan to be delivered by Mid-October 2007 Final sign off meeting 28 November 2007 And agreement reached on timings for final evidence to be made available (CDs and HEIs)	Outstanding actions now complete at end December 2007
ORH 3b To agree and implement an action plan arising from the Healthcare Commission investigation into adult cardiothoracic surgical services at the John Radcliffe (SG1)								
Risk Ref: TRR001, TRR060								
Elaine Strachan-Hall CNST	Failure to deliver and evidence agreed actions results in damage to reputation	Robust monitoring mechanism established for	Reports to GovC Half yearly update to TB	Action plan on target across most areas with a significant	None	Assurance being evidenced throughout	Full SHA review meeting to be held in January 2008.	As outlined in Action Plan and on target. To be updated post

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Patient Safety and governance domains	and potential damage to clinical activity	internal review. Monthly meetings held from September 2007 Quarterly reports to Divisional Board and GovC - reports to include analyses of outcome data throughout the year. Additional resource to support delivery in	due January 2008 Outcome of monitoring meetings with SHA Outcome of meetings and work with Vascular Network Evidence folder in support of action plan in place North Vascular Network report Peer review of	number already achieved and reported to SHA. Full report on clinical outcomes to TB in July 2007 GovC review of action plan and progress to date in Dec 07. Noted excellent progress with actions and provision of evidence.		life of action plan Further report in March 08 to TB and GovC	Plans agreed with Network for work on leadership development and for peer review on protocols (£25k allocated) - by end Feb 2008	meeting on 29 January 2008.

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		place Evidence submitted to SHA supports completion of actions	protocols for management of high risk patients					
ORH 4 To agree recruitment and retention plans that position the ORH as an employer of choice in all areas (SG4)								
Risk Ref: TRR043 to TRR047, TRR055								
Mark Gammage C2, C5b, C5c, C7b, C10a and C10b, C11a, C11b and C11c	Policies not adhered to resulting in poor recruitment and retention and poor practice across the ORH Continued performance improvement and cost reduction impacts on perception of ORH as	Reports with HR KPIs to TB and F&PC Accountability reviews cover HR indicators ESR in place from October 07 Updated HR	HRC review of policies and procedures and of compliance with core standards and relevant legislation HRC responsible for	At month 6 HR indicators show slight increase in employment of agency staff and increase in vacancy rate Agency project in place with regular monitoring and		AC to seek additional assurances on HR function across all areas	CEAC audits on mandatory training and consultant appraisals to be carried during 07/08 as part of agreed internal audit plan HR Director to ensure process in	Performance on HR KPIs reviewed at weekly performance meetings VCF measures in place to ensure delivery of financial plan impacting on all

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	employer	<p>policies and procedures supported by active HRC</p> <p>Robust training for staff - focus on agreed mandatory training</p> <p>HR strategy in place regularly updated</p> <p>PIT weekly meetings focus on agency spend and recruitment.</p> <p>Robust process for agreement on agency and locum spend</p>	<p>reviewing strategy</p> <p>CEAC Audits on various HR functions, particularly since reductions during 2006/07</p> <p>AC and HRC review CEAC audits and action plans</p> <p>Staff Survey outcome (? Early 2008)</p>	<p>updates to Exec Board</p> <p>AC to review HR audits in March. Some concerns expressed on CEAC reviews. Director of HR to attend March 08 meeting.</p>			<p>place to ensure mandatory training in place for appropriate staff. Evidence of compliance with C11b now being sought. Update to HR and AC meetings in March 08</p> <p>Outcome of staff survey likely in indicate both positive and negative.</p> <p>Update to TB on HR standards in January 2008</p>	<p>areas.</p> <p>Update post FPC and TB during Jan 2008</p>

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		and controls updated in December 2007						
ORH 5 To agree and implement a customer care strategy (SG1)								
Risk Ref: TRR32, TRR033, TRR060								
Elaine Strachan-Hall C13a, C13b, C13c, C16, C18, C20a, C20b, C21, C22a, C22b and C22c	Failure to agree plan for 2007/08 impacts on reputation, stakeholder perceptions and engagement Resource constraints impact across all areas and reduce quality of care and environment	Agreed strategic direction by TB includes customer care Executive Lead identified and position paper agreed by EB Strong engagement with Patient Panel and PPIF	HCC confirmed compliance on C6 and C16. PALs and Complaints - reports. Outcome of external review of complaints Report on Spotcheck inspection in	Complaints information identifies need for action on customer care Action plan in place following HCC Spot Check and follow up visit in October 2007 Further assurances required on	Position paper to be followed by specific actions now being agreed for new customer care team Action plan to be completed on actions arising from HCC spot check visit and report November 2007	Outcome of HCC annual patient survey awaited Update required on Patient and public involvement and equality and diversity	Draft reports circulated to GovC. Full report on patient and public involvement and equality and diversity to GovC in March 2008	Full report to GovC March and TB March 2008

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		<p>Good relationships with HOSC and other 3rd parties</p> <p>Patient and public information group established (C16)</p> <p>FT focus on membership and stakeholder engagement</p> <p>NED leadership & engagement on equality, race and diversity</p>	<p>March 2007 and follow up visit October 2007</p>	<p>patient and public involvement and diversity</p>				

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ORH 6 To establish the Biomedical Research Centre working in partnership with the University of Oxford (SG2)								
Risk Ref: Med004								
James Morris C12, clinical and cost effectiveness and governance domains	Infrastructure and governance arrangements not in place to support BRC	Director of BMR in place and supporting staff appointed. BRC steering committee in place with identified plans for all themes Budgets in place for all themes and monitored through Board reporting processes with appropriate	Strategic Partnership Board between ORH and OU BRC Steering Committee Finance reports to TB cover BRC financial position Compliance with C12 reviewed November	Research Governance report to GovC indicates good progress in year following some staffing and other issues in 2006/07 Steering Committee has revised 14 themes and budgets in place for individual project (Div E) Audit Committee review initial	None - budgets and governance arrangements in place and being reported on to F&PC and TB (Division E)	CEAC to review finance and governance arrangements towards year end	Formal update to AC October 2007 Next update on research governance due March 2008 Strategic partnership board to receive update end November 2007 Update report to TB In January 2008	BRC established.

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		financial management arrangements	2007 CEAC Audits on research governance framework MHRA inspection reports	finance and governance arrangements.				
ORH 6 To establish the Biomedical Research Centre working in partnership with the University of Oxford (PIRCP). (SG3)								
Risk Ref: TRR021, TRR024, TRR025, TRR026, TRR027								
Chris Hurst C7d/ALE	Financial targets are not achieved, compromising AHC rating, reputation and FT application Funding/technical changes impact on 'bottom line'	Performance monitoring reports within directorates, divisions and the Trust as a whole Accountability	Reports to TB and F&PC highlight performance, forecast and risks across all areas of financial management	Month 6 position reviewed formally by F&PC and report to November TB ALE outcome for 06/07 improvement in		Monthly reporting to TB and F&PC to continue Further	Strengthening and reiteration of expenditure controls already in place e.g. VCFs and controls on locums and	Through weekly reporting and discussion at EB, F&PC and TB Position broadly on

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		reviews from September 07 ALE project team in place Controls on expenditure across ORH incorporated into SFIs	and standing Accountability reviews SHA/DH monitoring returns AC review	scores for Use of Resources Improved performances across all 13 KLOEs anticipated at year end		information required on elements of ALE, e.g. financial standing and value for money	agency ALE to be included in Annual Health Check report to January 2008 Trust Board	targets with further actions on both income and expenditure to maintain surplus F&PC to review forecasts
Chris Hurst Andrew Stevens	Unplanned/unforeseen changes in commissioner income impact on delivery of financial balance PP and other income streams do not perform to plan	Income reporting procedures improved and strengthened to include indicators. Production of accurate income/activity	Performance and activity reports to TB and F&PC Weekly meetings with Oxon PCT Key Commissioner	Board report at month 7 identify steps needing to be taken to achieve year end targets. Income issues identified Income audit by CEAC	Leading indicators being developed. Development of leading indicators/warning signs. Strengthened Directorate / Divisional sign-off	Income forecasting processes to be audited.		Further update post FPC and TB in January 2008

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		information to show targets for activity and related income Agreements with PCT in support of financial plan	meetings Weekly performance meetings and monthly formal performance reviews		of income forecasts.			
ORH 8 To complete the Strategic Review and gain TB approval for plans for clinical and corporate services (SG2)								
Risk Ref: TRR061								
Andrew Stevens Clinical and cost effectiveness domain	Failure to gain approval and take forward strategy compromises internal and external credibility Failure to integrate (agreed) strategy into business planning and	Agreed strategies for clinical and other services in place Effective business planning process and	ORH Objectives and goals are based on work of SR and feed into FT IBP TB Final SR	TB approved strategy Strategic review findings and principles incorporated into BP and objectives for 2007/08 and into IBP work for	Plans to be put in place to support delivery of corporate strategies (e.g. customer focused care (see ORH5)	Tbc through FT process	Formal document to be prepared by end Jan 2008 TB to review strategic aims, objectives and direction annually - due March 2008	Further review through IBP - TB reviewed 20 Dec 07

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	into FT application process compromises success	integrated within the FT IBP project structure	document published January 2008	FT			(dates to be agreed)	
ORH 9a To deliver an agreed Capital Programme (SG3)								
Risk Ref: TRR052 and TRR053, TRR054								
Ian Humphries C20a, C20b, C21 Patient safety, patient focus, and care environment and amenities domains	Late agreement of plan compromises delivery and failure to meet statutory duty Objectives fail to drive investment decisions and compliance with core standards could be compromised Failure to deliver	Physical Resources group (PRG) (reports to EB) to prepare capital plan and lead debate on priorities Divisions and corporate areas engaged in the	CC (TB sub committee) CEAC audits on capital projects Reports to TB and F&PC on financial aspects of capital programme	Capital programme agreed by TB and further work being done on longer term financial model			Review as part of LTFM work and update provided. Updates through PRG, CC, EB and TB	Capital programme in place and slippage being managed. Programme covers broad range of areas including health and safety, medical equipment,

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	resources for backlog maintenance compromises patient, public and staff environment	debate CC with remit to oversee and manage estates and capital issues, including relocation projects	and asset management Internal monitoring, review and audit processes					environment and capital projects, e.g. Geratology scheme
ORH 9b To reach agreement on the Cardiac Services extension (SG1)								
Risk Ref:								
Moira Logie	Failure to achieve DH sign off for project	Approved business case agreed with all stakeholders	Approval of Business Case	Business case approved and work underway.	n/a	n/a	Building work underway and on target (CC Sept 07)	Underway and on programme
ORH 9c To deliver PFI projects to agreed timetables (Cancer Centre) (SG1)								

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Risk Ref: TRR055, 056, 057, 058 and 059								
Vickie Holcroft Ian Humphries Kathleen Simcock Andrew Stevens	Failure to meet 'sign off' dates with consortium increases revenue liability for ORH Failure to agree funding with commissioners with potential impact on I&E and requirement for additional performance Failure to agree service models e.g. in emergency/specialist surgery, HDU/ITU, gynaecology etc	Robust project management structure and governance Project Director in place Risk Register in place Robust arrangements for agreements on income and activity Marketing plan agreed to secure additional new	CC oversight of Cancer Centre PFI Project Steering Group Key Commissioners meeting CEAC Audit due on business planning for PFIs Business Plan Review process undertaken	EB has overseen work of Cancer Centre Business Planning Group and agreed approach. Financial parameters set for income, including PPs Monthly reports provided Internal audit reviewing commissioning arrangements			Action plan in place with update to EB Jan 2008 Review of plans for PPs - through CC. Advert placed for Business Director for PPs Marketing Plan for Private Patients being developed	Further update in Jan/Feb 2008

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		income (including pps) Arrangements in place to agree service models Business Director for PPs in place						
ORH 10 To decide on the configuration of services at the Horton General Hospital, including ED, Surgical, Paediatric and Maternity services.(SG1, SG3)								
Risk Ref:TRR002, TRR003, TRR004, TRR060, TRR061								
Andrew Stevens C17 Patient safety domain Clinical and cost effectiveness	ORH options are not acceptable to the local community; political pressures cause implementation delays with impact of patient service and quality of care	Robust plans in place for a) consultation process and b) implementation Robust engagement	HOSC and PPIF review TB review and agreement on proposals (Jul 07) Horton	IRP process now underway HOSC commended process of further work and engagement			IRP Process now underway and ORH supporting process Actions underway to ensure safety and quality of	IRP Process to report to SoS February 2008 Actions underway to ensure safety and quality of

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domain	Proposals referred to SoS/IRP for review	with stakeholders able to stand up to scrutiny Plans in place to manage service and financial implications of delays in implementing agreed proposals	Steering Group review at appropriate points Outcome of IRP process				services at the Horton General Hospital	services at the Horton General Hospital
ORH 11 To reach agreed milestones for implementation of IT systems including Care Records Service (CRS) and Picture Archiving and Communications System (PACS) (SG3)								
Risk Ref: TRR019, TRR049, TRR050								
Andrew Stevens C9, Governance domain	Programme at cluster level is delayed further Proposals do not	Proper governance and project management	GovC review of risk register and Information	Risks identified and plans in place to mitigate External		Continued review of arrangements through CC	Regular updates to CC and GovC through reviews of risk register -	Go live date amended to Feb 09. New SRO appointed and

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	meeting ORH requirements Failure to engage clinical and other staff compromises success for ORH	arrangements in place Risk register in place Oversight of governance and progress through TB assurance systems Information Governance Group in place	Governance Group in place SHA and TB approval of governance arrangements CEAC audit and other CEAC IT audits reported through AC. AC review CEAC audit reports December 2007 External review of governance arrangements and	consultant providing input to and assurance on processes in place internally Recommendations now being implemented. New governance arrangements in place approved by TB Nov 07		and ??	ongoing Further update March 2008 post contract finalisation	Oxfordshire Change Board established

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			programme management framework.					
ORH 12 To make a successful application for Foundation Status (SG3)								
Risk Ref: TRR021, TRR026, TRR027, TRR061								
Andrew Stevens/Jane Dudley Governance domain	Failure to engage within the Trust as a whole compromises application Project management resource and infrastructure is not agreed or put in place Governance transition arrangements (esp. in	Robust project structure and internal and external communication plan in place Board development programme in place	Assurance committee structure SHA and DH phases and sign off TB SHA DH	Timetable agreed with TB and SHA informed Project plan updated to reflect revised timetable for application Work planned with OU	Further work needed on resourcing and infrastructure in longer term FT Secretary not yet appointed Transitional governance arrangements	Audit Commission review of committee structure - timetable to be confirmed	Reviews at fortnightly steering group and regular updates to TB Programme of communications internal meetings in place Recruitment of	SHA and ORH updating programme and timetable Further update in January 2008

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	relation to member recruitment) FT Secretary not in post Timetable is not agreed or slips	Documents (e.g. consultation document) agreed with internal and external stakeholders TB sign up to timetable and approach.	Monitor				FT Secretary planned Plans being developed to address actions highlighted by SHA following meeting on 29 November	