The point on a page – the Assurance Framework

The Board has three key roles in its leadership of AWP, as defined in the Foundation Trust Network's *The Foundations of Good Governance*:

- Formulating strategy;
- Shaping a positive culture for the Board and the organisation; and
- Ensuring accountability by holding the organisation to account for the delivery of strategy and **through seeking assurance that systems of control are robust and reliable**.

The Assurance Framework is a *dynamic* document which brings together three things:

- The Trust's purpose and priorities through its strategic objectives from its Integrated Business Plan (that includes Trust-wide strategies and Delivery Unit strategic priorities);
- A headline summary of all the issues (risks) that might get in the way of achieving those objectives;
- A headline summary of what we're doing about those issues, along with a concise description of how readers can be assured that what we're doing is working.

The Trust has defined its purpose as follows:

"We provide the highest quality mental healthcare to support recovery and hope".

To achieve this purpose the Trust has defined five priorities:

1. Deliver the best care
2. Support and develop staff
3. Continually improve what we do
4. Use our resources wisely
5. Be future focused

All NHS Trusts are required to use an Assurance Framework, not least because it's been proven good practice for many years in both healthcare and a whole range of complicated high-risk organisations. An Assurance Framework is a working document and you should be able to recognise in it all the principal risks you and your colleagues can see and are dealing with in helping to provide high-quality care for patients and service-users by identifying, removing, minimising and controlling all the things that can go wrong. In short, it is a list of the promises we've made and an assurance that we're going to deliver them despite all the problems we know we face on the way. It's a "live" document that changes over time, and in particular it picks up all the controls that we have in place to manage, minimise and/or remove the principal risks we've identified and points towards concise and comprehensive evidence that the controls are working.

The difference between "assurance" and "reassurance" is vital to make the Assurance Framework work:

- Reassurance is when someone tells you all's well;
- Assurance is when they tell you what's happening, show you the evidence, and you can judge for yourself if all's well – that's what the Assurance Framework is about.

The Assurance Framework and Risk Registers are complementary but not the same thing:

- The Assurance Framework identifies principal risks at quite a broad level over a full-year period – "what are the *sorts* of things that get in the way, what in general are we doing about it?" – the risks don't change much over a year, although the key controls and assurance elements probably will do;
- A Trust-wide, Directorate or local Risk Register identifies the precise day-to-day risks that make up those broad principal risks – "what *specifically is* getting in the way, what are we actually *doing* about it?", and those entries may stay relatively stable for the year or change day by day.

RAG Rating our Assurances

To provide the Board with an "at a glance" indication of how complete our assurances are against our strategic objectives a RAG rating is given. To RAG rate the objective the following guidance is given:

Green: Effective controls are definitely in place and the Board is satisfied that appropriate assurances are available.

Amber: Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient.

Red: Effective controls may not be in place and/or appropriate assurances are not available to the Board.

The Board must regularly review those RAG rated as green to ensure these remain current and satisfactory.

Further reading:

AWP Integrated Business Plan 2013/14 to 2017/18

"Board Assurance Frameworks: A *Simple Rules* Guide for the NHS, The Good Governance Institute, March 2009 and "Quality Governance: How does a board know that its organisation is working effectively to improve patient care? Guidance for NHS provider organisations", Monitor, April 2013

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust-wide Objectives and Assurances

Strategic Priority 1				*To deliver the best care*						
Lead director:				*Medical Director*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To achieve a rating of 'good' from the Inspector of Hospitals										
	Gaps in quality governance system relating to ability to check and test effectiveness of processes in place, and challenges in capturing issues broader than specific compliance criteria, such as clinical environmental issues	CE5	Integrated Assurance Framework – the framework through which the Trust maintains oversight at management and Board level of performance across all areas. Use of IQ to record and monitor performance through regular review of data at Quality Huddle, Quality and Standards Committee and Board. 2 weekly presentation to Ops SMT of mock CQC inspection outcomes and themes and associate actions developed. A review of the role of Professional Council is underway, with the aim of ensuring the group provides the required support and guidance within the Trust. The revised Supervision Policy supports staff to discuss quality of services delivered with management, supported with mechanisms for future review and feedback.	9	Positive trends in performance reported through IQ seen during 2013-14 Internal Audit report (Clinical Governance and Compliance) issued in Q3 of 2013/14 confirming accuracy of data recorded.		Clinical Audit will report on outcomes and issues throughout the year. Provision of Business Information, Data Quality and Incident Reporting Internal Audits to be undertaken in 2014/15	Comparison of Trust performance in relation to quality of services reported through IQ is limited in national comparators. IQ reporting requires further development to allow an “override” to apply a broader filter in areas of concern Clearer links to be established for communication between the Academy and localities	An extraordinary huddle is to be held at the end of April 2014 which will review additional data and will consider performance against national trends. This will help the Trust identify areas where it needs to focus on improvements in comparison to other providers. Further actions to be identified to close gaps	30 April 2014
	The Trust has been inspected by the Chief Inspector of Hospitals who has indicated a number of areas where improvement is required. Processes to sign off actions to provide assurance must be improved	IBP17	The action plan is owned and monitored by the CQC Inspection project team sponsored by the Medical Director. Monitoring of compliance with CQC standards via information reported through IQ system Quality and Standards Committee work plan to scrutinise quality issues and receive assurances over implementation of actions Targeted Quality Improvement	12	The project Board reports weekly to Executive Team and escalates issues. Continued monitoring of performance reported through IQ at Quality Huddle (fortnightly) and at Committees and Board (monthly) by the Executive Team and senior management		Patient Safety and Quality (Regularity Reviews) and Medicines Management Internal Audits to be undertaken in 2014/15, to focus on compliance with quality requirements and medicines management policies QGAF review of compliance to be completed by KPMG	QGAF guidance has been refreshed by Monitor therefore previous assessment is not aligned with current process Inability to manage compliance with Outcome 16 at locality level Template required to ensure Trust responses to actions	QGAF self-assessment to be refreshed in line with recently published MONITOR guidance IQ Self assessment tool being updated to assess the CQC 5 Domains rather than previous Quality and Safety Outcomes Redesign Action	30 August 2014

Strategic Priority 1				*To deliver the best care*						
Lead director:				*Medical Director*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
			visits by Executive Team and Non-Executive Directors, increased in frequency Locality Management Teams can respond to local standards through Care Quality Review Meetings etc. Targeted ongoing programme of mock CQC inspections and 15 Steps inspections Monthly monitoring of Staffing Levels through Quality and Performance report Procedures for responding to external and internal inspections have been approved and disseminated via Director of Nursing.		QGAF compliance reviewed by Trust Board regularly Progress against workplan is reported to Executive Team and escalated to Quality and Standards Committee The project board identifies the areas to be targeted for Quality Improvement Visits through review of the action plan.		in August 2014 Reports to Board Committee in safer staffing levels.	are outcome focused. New procedures need embedding to fully demonstrate improvement	Plan template for Trust wide use to have focus on Outcomes and assurance and less focus on describing process. Emma Adams to work with HoPPS to ensure new Procedures for inspection are embedded in to Governance practices for Localities There will be a weekly triangulation meeting to review actions and monitor progress.	
	Failure to create and maintain relationships with partners which leads to poor reputation.	IBP16	Quality and performance management, based on information captured in the IQ system Effective partnership relationship management Locality/Delivery Unit Business Plans Locality/CCG/partner meetings Chair/CEO quarterly CCG meetings CEO meetings with other stakeholders regularly, e.g. Las, Police and Crime Commissioner, Healthwatch	9	Continued monitoring of performance at Quality Huddle (fortnightly) and at Committees and Board (monthly) Relationships developed with LAs by Chair and CEO Relationships built through CQPM meetings		Staff and Stakeholder Engagement Internal Audit	Engagement leads across the Trust currently not in place.	Employed a DRE lead for the Trust who will engage and advise on the wider partnership agenda across AWP. Engagement leads being identified across the Trust in line with the Engagement Strategy which covers all stakeholders.	30 June 2014
	CQC CIH have identified risk in relation to ligatures as unacceptable (non-compliant)	CE4	Annual Risk Assessment Identified priority of works Internal Review External Review	15	Quality Improvement Visits		Patient Safety and Quality (Regularity Reviews) Internal Audit	Gap between identified works required and funds to rectify all risks	External Reviewer to identify immediate actions required to reduce risk in the Fromeside estate	August 2014

Strategic Priority 1				To deliver the best care						
Lead director:				*Medical Director*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
	Practice may not change and the use of restrictive practices does not reduce No national definition or guidance on recording of restraint including face down restraint A significant number of Bank staff are not trained						Anti-ligature work now under the suicide prevention group.		Master classes for WM and Matron on environmental risk assessment Risk Assessments to be updated by all Wards	July 2014 July 2014

Strategic Priority 2				To support our staff						
Lead director:				*Rachel Clark, Programme Director – Development*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To implement Friends and Family for staff	Survey fatigue for staff, resulting in limited responses	OD1	Bespoke information prepared for each delivery unit to encourage responses and to make information more locally relevant Locality/Delivery Unit leadership actively promoting staff engagement Localities to communicate local results, providing response to local issues and encouraging staff to engage in regular surveys Trust wide communication of overarching results and actions in response	9	Successful implementation of test across the Trust, measured through response rates Net promoter score reported to Senior management team and Board. Regular reporting to Senior Management Team and Executive team. Employee Strategy and Engagement Committee scrutinise the scores and plans to address improvement.		Reporting will evidence value of measure.	This is a new measure and reports have just been received by the Board Committees.	A range of quantitative (survey results, sickness absence rates) and qualitative measures (culture audit) will be utilised to measure the impact of controls. Progress will be mapped through ESEC.	31 July 2014
	Failure to respond to feedback received leading to a lack of confidence in staff in the value of completing the survey	OD2		9						

Strategic Priority 2				*To support our staff*						
Lead director:				*Rachel Clark, Programme Director – Development*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To enable every team to receive Team Development in the coming two years	Lack of ownership of Team Development by localities	OD3	Appointed Organisational Development Lead to implement Team Development programmes Access to specialist Team Development via "The Centre for Solutions Focus at Work". Collaboration with Quality Academy to enable rapid implementation	9			Stage gate reviews will take place throughout pilot and wider implementation, which will be reported on to ESEC	Implementation Plan will take account of LDU service development plans Pilot approach with 2/3 localities to test logistical plans	Implementation Plan to be developed. Delivery against implementation plan cannot be seen yet but will be over time	31 September 2014
	Logistical challenges of releasing staff, especially in inpatient services	OD4		9						
	Failure to relieve work related stress resulting from workload	OD5		9						
	Insufficient resources to support of Team Development (LDUs and central resource)	OD5		9						
To see 10% of questions on the annual staff survey improve on 2013 results	Failure to implement the Trust response to the 2013 staff survey. Failure to effectively communicate response to 2013 staff survey	OD7	Targeted programmes addressing issues highlighted in 2013 survey, e.g. bullying and harassment, health and wellbeing and appraisals Staff Experience and Engagement Strategy Workforce Planning and capacity management Enabling Excellence Programme Reinstated Learning and Development portfolio Bursary panel re-launch Effective working with Staffside to agree and implement changes in relation to NHS England pay increment changes	9	Staff Friends and Family test results Completion rates of appraisal and appraisal feedback Organisational Health Index		2014 Annual Staff Survey results Cultural Audit Compliance with Statutory and Mandatory training requirements	A detailed action plan is still being implemented.	An innovative communication and engagement plan is being developed to build a high degree of awareness with Trust purpose and priorities.	
	Continued low morale and lack of engagement across staff groups due to ongoing redesign and skill mix reviews, large scale change projects Trust-wide and work pressures.	OD8		9						

Strategic Priority 3				*To continually improve what we do*						
Lead director:				*Alan Metherall, Acting Director of Nursing*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To fully establish the Quality Academy	Delayed development and implementation of Academy due to non-release of agreed funding and recruitment of staff with the necessary skills and knowledge	QA2	A review of the scope and purpose of the Quality Academy commenced in 2014. The consultation process in underway and will report to Quality and Standards Committee in the third quarter of 2014.	8	Review is underway. Scope and nature of the review is underway. The Quality Academy is already delivering elements of its purpose relating to standard setting and promoting practice. Established networks and management groups		Consultation outcome paper (as appropriate)	Not all objectives have not been agreed. Academy is not yet fulfilling its role as staff have not been released from other posts. Significant resource has not been released from LDUs e.g. HoPPS , Trustwide leads	Identifying skills within team for development. Clinical Networks paper presented to SMT July 2014 Discussing potential opportunities with Other institutions. Clarifying objectives with SMT. Reviewing the role and function of the Heads of Profession and Practice and their contribution to the Quality Academy.	30 September 2014
To achieve a 20% reduction in the use of restrictive practices	Clinical practice does not change sufficiently to bring about a reduction in the use of restraint/ Lack of definition for reporting. Use of untrained Bank Staff.	Unassigned	Conflict Resolution Training PMVA Training amended to include a focus on the preventative interventions identified in Safewards Safer Staffing Numbers Violence Reduction Group leading the implementation of Safewards PERT Training. Training needs for bank staff being identified.	No rating	Wards to have access to incident data on restraint data. Work plan for Violence Reduction Group CIOG reviews incidents and cascades lessons learned with the Quality Academy Mental Health Legislation Group reviews practice and learning. Quality and Standards Committee reports. Lead Nurse for PMVA now based in N&Q Directorate.		Q4 Audit Monthly incident reporting (commence Aug 2014) Adoption of preferred model of physical interventions	National definitions of restraint recording are not available No nationally recognised model or 'Kite Mark' for models of PMVA Numbers of bank staff trained.	DN to liaise with other provides across the two area teams to agree consistent recording Options appraisal commencing July 2014 led by VRG Safer Staffing numbers will ensure appropriate staffing levels.	31 March 2015

Strategic Priority 4				*Use our resources wisely*						
Lead director:				*Sue Hall, Director of Resources*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To establish the Resources Directorate	Directorate has been established, but work is ongoing to ensure this directorate is able to meet the needs of the Trust.	Unassigned	Resources consultation underway to: – Consult with LDUs on what they need from the directorate and how LDUs see this being achieved – Identify of staff requirements to deliver what is required. – Define roles within directorate to deliver requirements Enabling Excellence programme, supporting cultural change and embedding Trust intentions, priorities and goals		Performance reported in relation to localities through IQ, as evidence of strong leadership through triumvirate management structure		Feedback will be gathered via the Staff Survey during the year A successful continuation of the FT journey tests the effectiveness of our support services as well as our care services, therefore this will be an assurance that the directorate is operating effectively Internal and External Audit reviews of finance and workforce management and controls	Directorate is partially established but consultation is not yet complete	Resources staff included in Ops SMT and attend, where required, locality meetings to understand their business Weekly Resources "huddle" to identify issues to be resolved and highlight any that cross functions.	30 September 2014
	Impact of changes to NHS England commissioner intentions for specialised services from 2015	TW3	Regular contract and performance meetings with specialist commissioners which demonstrate significant quality and performance improvements which are now sustained. Early discussions with NHSE regional team regarding the impact on the Trust of the potential funding gap in the commissioning of specialised services in NHSE Secure Services staffing redesign programme in place with consultation outcome published on 18th June CIPs identified and agreed for 2014/15 and in progress for 2015/16 Strong relationships in place with NHS England to develop new ways of working to reduce the risk of tenders.	12	Board and Committee oversight of CIP delivery Positive and proactive relationship with NHSE		Ongoing evidence of the delivery of good quality care from the Trust reducing the desire to re-commission from another provider	Understand our costs of delivering services	Understand our costs of delivering services to be achieved through resource mapping by the Finance and Information Group reporting to CQPM	1 September 2014

Strategic Priority 3				*To continually improve what we do*						
Lead director:				*Alan Metherall, Acting Director of Nursing*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To achieve our CIP Programme	Failure to identify, agree and implement CIPs (Cost Improvement Plans).	IBP05	Business planning process in place, from which Cost Improvement Plans are identified, developed and agreed Programme Management Office is established and managing CIPs The Trust Information Quality (IQ) system and associated performance management through SMT, ET, Finance and Planning Committee and the Board is providing oversight of performance Quality and Standards Committee ensures CIPs do not adversely impact on quality Operational locality and corporate management structures effectively owning and implementing CIP's (note this risk is also covered by risk FIN 07). SMT provide additional oversight and action to ensure the implementation of the short term Cost Improvement Programme in 2013/14 and 2014/15.	9	Reporting on delivery to Finance and Planning Committee and Board on a monthly basis.		Monthly monitoring via PMO & Ops of CIP delivery against budgets Internal and External Audit reviews of financial management and controls IQ development to include financial performance Business Development – Contracting and Commissioning Response Internal Audit to be undertaken during 2014/15	Access to shared good practice to inform CIP development	The Trust Quality Academy which will identify effective clinical interventions along care pathways The resources restructure proposes a business intelligence team which will support streamlined reporting. Further development of the Trust's workforce strategy which will ensure the Trust's staff align to the needs of service users and carers in a sustainable way and Further development of the Trusts Organisational Development strategy which will include work-streams that ensure the Trust has the culture and tools to eliminate	30 September 2014

Strategic Priority 3				*To continually improve what we do*						
Lead director:				*Alan Metherall, Acting Director of Nursing*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
	Failure to plan and systematically deliver Cost Improvement Plans (CIPs) across localities.	IBP09	Leadership development programme in place for new Clinical Directors to enable them to support change and new working practice Corporate restructure to provide better support to front line services and review all practices to minimise bureaucracy Local ownership provides relevant opportunities to review working practices and develop new approaches IQ System provides an accessible focus on quality and drives continuous improvement Weekly CIP assurance process in place Business Planning process underway Weekly recruitment panel in place Coordinating CIP development process for 14/15 and 15/16 with detailed PIDs, QIAs and defined delivery plans & leads. Monthly monitoring via PMO & Ops of CIP delivery against budgets.						waste in the delivery of services.	

Strategic Priority 5				*Be future focused*						
Lead director:				*Executive Team*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To become authorised as a Foundation Trust	Failure to match demand with capacity would lead to pressure on existing resources and a requirement to use out-of-area beds for adult, PICU and older adults, potentially compromising patient care.	TW2	Trust wide escalation to red against current escalation policy Discussions held with commissioners Consideration given to black escalation discussed with commissioners On-going discussions with local authorities regarding DTOC both locally and Trust wide Bed management and occupancy project being established to take urgent action against a number of different issues relating to access, bed escalation, bed management, care coordination and discharge Consideration on whether to block purchase private beds Action plan developed and agreed	12	Progress to implement actions identified recorded and reported Review completed of all current DTOCs Register of all patients ready for discharge prepared		Patient Safety and Quality (Regularity Reviews) Internal Audit to be undertaken in July/August 2014 reviewing practice in selected operational teams	Currently the Trust is experiencing significant pressures and action needs to be taken before this is effectively controlled and assurance can be provided over this.	Repatriate out of locality patients back to home locality over a 4 week period	30 September 2014
	Failure to develop a corporate and locality infrastructure that enables the Trust to respond quickly, appropriately and effectively to changing market requirements.	IBP08	Locality Delivery Unit Management Teams (LDUs) now set up, coordinated by the Executive Director of Operations and proving effective. New infrastructure has been established for corporate departments and local delivery units. Effectiveness of arrangements are being managed by relevant executive directors Resources directorate established, with consultation underway Effective service delivery is being monitored through the Integrated Assurance Framework	6	Effectiveness of LDU Management Teams is being monitored by the Director of Operations Performance improvements measured through IQ and reported via Board and sub-Committees		Medical Staffing and Workforce Planning Internal Audits, to be undertaken in 2014/15	Clinical Strategy, underpinning the Business Development Strategy, is yet to be agreed Resources directorate not fully established	Clinical Strategy drafted, to be presented to Quality and Standards Committee and Trust Board during July 2014 Consultation underway with outcomes to inform establishment of remaining elements of directorate	31 July 2014

Strategic Priority 5				*Be future focused*						
Lead director:				*Executive Team*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
			Local performance meetings with commissioners in place to improve relationships and knowledge of the health system in the local areas Organisational Development Programme will support Corporate Departments as they refocus their support to ensure maximum responsivity to Local Delivery Units. The programme has a specific emphasis on alignment and shared purpose and considers the effectiveness of partnership working of Senior Management Team and Professional Council. Engagement and Involvement Strategy Enabling Excellence programme Leadership Development							

It is recognised that the following risks also directly relate to the achievement of this objective as they have the potential to impact directly upon quality of services provided. These have been captured above and therefore not reiterated in full here.

- **TW2 –** Failure to match demand with capacity would lead to pressure on existing resources and a requirement to use out-of-area beds for adult, PICU and older adults, potentially compromising patient care
- **CE4 –** CQC CIH have identified risk as unacceptable (non-compliant)
- **CE5 –** Gaps in quality governance system relating to ability to check and test effectiveness of processes in place, and challenges in capturing issues broader than specific compliance criteria, such as clinical environmental issues mean the Trust is not able to fully assure itself in all areas

Strategic Priority 5				*Be future focused*						
Lead director:				*Executive Team*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To implement the Bristol Tender and provide Mental Health Services as part of Mental Health Bristol	Failure to establish effective and responsive working relationships with CCGs to understand their commissioning intentions and timeframes.	IBP02	The key control is to inspire confidence in AWP as the existing contract holder, by ensuring that our services are responsive, locally-focussed, effective, and demonstrate value for money, and so establishing AWP as a provider that CCGs need to engage with. Controls already in place to meet those objectives include: – AWP's revised management structure prioritises clinical leadership – Locality structure enables services to be matched to local priorities, to experiment and innovate, and to respond quickly to changing needs – An open and transparent culture encourages dialogue with CCGs and between AWP staff – The "Back to the Floor" programme and Quality Improvement Visits allow Executive Directors to be aware of issues and opportunities apparent at localities. – Sharing of IQ information with commissioners – Service User and Carer involvement at all levels of the organisation Greater transparency of financial positions and costs. Integrated Business Plan for 2014/15 – 2018/19	9	Effective service delivery is being monitored through the contract performance framework All localities have regular performance meetings with CCGs Regular reporting to the Executive Team Robust programme management infrastructure and governance. Exception reporting to Board.		Additional streamlined reporting when Business Intelligence Team is configured.	Appropriate skills and capacity to support the transition process. The capacity of the Trust for cultural change may still limit the progression of the Trust's bid as historic issues could still be affecting current delivery of services.	Work is ongoing to positively shape culture. CEO/Chair to have regular meetings with CCGs 360 degree feedback being set up from CCGs Organisational Development programme to address the gaps in staff skills to ensure the Trust is fit for purpose Clinical Engagement being harnessed through Professional Council and development of Health Partnerships Creation of Business Development and Information function to support localities Learning from tender experience in other areas Skilled and experienced programme management support.	30 September 2014
	Failure to create and maintain a commercial culture, literacy and infrastructure within the Trust that ensures the Trust is fully aware of the short-term, medium-term and long-term commercial risks of all tenders and contracts.	IBP04		6						