Whittington Health NHS

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Whittington Health Trust Board

24 April 2013

Title:	**Board Assurance Framework 2013/14**		
Agenda item:	**13/062**	**Paper**	**8**
Action requested:	***To receive***		
Executive Summary:	The BAF is a working document and as such is updated by WH Executives, monitored by the Audit Committee and reported to the Board on a monthly basis.		
Summary of recommendations:	The Executive reviewed all risks rated over 15 in their meeting of 15 April 2013 and agreed the risk management trajectory for Quarter 1. The trajectory will be included in the framework that will be reported to the Audit Committee on 22nd May. The Board is asked to note and approve the latest iteration of the BAF, with the following modifications: • An increase in the likelihood of Risk 1.3 materialising • A decrease in the likelihood of Risk 2.2 materialising. • An increase in the likelihood of Risk 3.2 materialising • A decrease in the likelihood of Risk 3.6 materialising		
Fit with WH strategy:	The BAF provides assurance to the board that the key risks to the achievement of the Trust's strategy are identified and effectively managed.		
Reference to related / other documents:	Corporate Risk Register, Risk Management Strategy		
Date paper completed:	16 April 2013		

Author name and title:		**Louise Morgan Trust Company Secretary**		**Director name and title:**		**Dr Yi Mien Koh Chief Executive**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**Yes**	**Legal advice received?**	**N/A**

Strategic Goal	Ref	Corporate/Principle Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Unmitigated risk rating - March 2013			Controls *The systems and processes in place that mitigate the risk*	Management Assurance *What are we doing to manage the risk and how this is evidenced - how and when this will be reported to the board?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Current risk rating			Gaps		Due Date
				Likelihood	Impact	Initial Risk Score				Likelihood	Impact	Residual Risk Score	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking and need improved reporting on assurances*	Action Plans *to address gaps in control/assurance*	
NHS Outcomes Framework 2013/14 Domain 2: Enhancing Quality of life for people with long term-conditions															
1. Integrate models of care and pathways to meet patient needs	1.1	If we fail to secure support for our IBP from our commissioners, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	YMK	4	4	16	1. Partnership Transformation Board meets monthly and includes senior leaders from Haringey and Islington CCGs. 2. CCGs actively involved in shaping the IBP. 3. Informal contacts with CCGs by exec and non-exec members of TB	1. New engagement arrangements to ensure CCG convergence with service developments, activity and income assumptions included in any revised LTFM and IBP. 2. Status of engagement with CCGs and leaders regularly reported to the TB by CEO, Director of Planning, DoF etc.	1. CCG Convergence letter signed by CCGs Feb 2013. 2. Two year block contract with commissioners extends through 2013/14 2. Visibility and governance of transformation board	4	4	16	Not yet established systematic engagement with CCGs in relation to next iteration of IBP	1. Proposal to come to FT steering group re engagement with CCGs 2. Negotiations with CCGs to commence in June once revised LTFM and IBP is complete.	May-13
	1.2	If we fail to maintain ongoing support from GPs as primary care providers and sources of referrals, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	GB	4	4	16	1. Regular two way communication with GPs - led by Medical Director for Integrated Care (MDIC), who is himself a local GP. 2. Involvement of GPs in Integrated Care MDTs	1. Feedback from GP practice visits by CEO and MDIC. 2. Regular reporting of quality of services of particular concern to GPs (e.g. direct access acute services; and community services such as MSK, podiatry). 3. Audit Committee deep dive into GP engagement, Sep 2012	1. Periodic monitoring of GP referral patterns	3	4	12	A comprehensive primary care engagement strategy that prioritises GP practices and sets more detailed objectives for each	1. Develop primary care strategy. 2. Recruit business development manager. 3. Complete GP directory of services. 4. Implementat GP electronic communication	Apr-13
	1.3	If we do not improve the quality, completeness and timeliness of performance reports, then we may lose the support of commissioners who value more detailed data, we may be unable to correct performance issues in a timely manner and our FT application may fail.	MdS	4	4	16	1. Performance manager in post from 3/9/2012. 2. Performance Management framework agreed by TB January 2013	1. Monthly trust board and and divisional dashboards generally report one month in arrears.	1. Periodic internal and external audit reports on data quality are generall satisfactory. 2. Various external reports in 2012 - HDD1&2, BGAF 3. internal audit of 18 weeks and cancer targets	5	4	20		1. Intensive support team full evaluation - report due 18 April 2013. Action Plan in place 2. Employment of second performance manager (May '13) 3. Identification of extra capacity for validation 4. Access programme plan 5. Data quality workstream	May-13
	1.4	If commissioners choose to market test services in order to improve affordability of services, services may be priced at a lower level or decommissioned.	RM	4	5	20	1. Two year block contract provides a control through 2013/14. 2. In the longer term, our strategy to be the low cost/high quality provider will enable us to provide competitive services. 3. Close engagement with local CCGs and GPs (see risk 1.1) enables us to be more responsive to their needs	Periodic reports from CEO, MDIC etc following interactions with GPs and CCGs	Periodic tracking of referral patterns and market share	2	5	10	Evidence that our services are competitive or better on quality and cost	1. Recruitment of Business Development manager 2. Deep dive by Finance and Development Committee	May-13
NHS Outcomes Framework 2013/14 Domain 4: Ensuring that people have a positive experience of care															
2. Ensuring "no decision about me without me"	2.1	If we lose focus on safety and patient experience, then our main business of caring, patient safety and quality of care could be put at risk.	BS	3	5	15	1. Quality is top of TB agenda and at the heart of the business, with clear lines of accountability down to ward/community level. 2. Datix incident reporting system and integration with risk management processes. 3. Staff encouraged to raise concerns - e.g. through Partnership Board & Meet the CEO programme. 4. Special controls to ensure CIPs do not threaten quality - Clinical Advisory Panel meeting (6-12 weekly meeting)	1. Bimonthly Quality Committee meeting 2. Bimonthly Quality visits in each division 3. Clinical risk reports to QC from each division each meeting 4. Review of integrated performance dashboard at QC 5. Written reports - SIs, NHS LA, 6. Quarterly reports from feeder committees 7. Hotspot deep dives	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. NHS Staff survey identifies high management commitment to patient care compared to other trusts 7. Link/healthwatch audits 8. Governance reviews 9. CQC Reports	2	5	10	1. Patient experience surveys and results 2. Pressure ulcers (grade2 and above)	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2 Plan to achieve NHSLA Level 2 by February 2014 3. PET in each ward to achieve higher percentage scores in each of the CQIN areas of the pt survey 4. Specific improvement plans related to areas of poor performance in pt experience surveys.	Monthly review of KPIs by TB. Quarterly patient safety reports to quality committee
	2.2	If we do not engage our stakeholders in the development and decisions about our strategies, confidence in our strategic direction will be undermined and our clinical and organisational reputation will be damaged.	YMK	4	5	20	1. Communication and engagement plan 2. External support from SN 3. Monthly Partnership Board	1. Status of engagement with stakeholders regularly reported to the TB by Chairman and CEO etc. 3. Director of Communications in place	1. Feedback from stakeholders 2. TDA lead communications meeting 6.3.2013 3. Report to Trust Board in July on outcome of engagement activities	3	5	15	1. Refresh communication and engagement strategy based on 13/14 annual plan 2. Review of communications function 3. Lack of strategy for listening and response	1. Refresh under development 2. Reporting to FT committee	Apr-13
NHS Outcomes Framework 2013/14 Domain 3: Helping people to recover from episodes of ill health or following injury NHS Outcomes Framework 2013/14 Domain 5 Treating and caring for people in a safe enviroment; and protecting them from harm															
3. Delivering efficient and effective services	3.1	If we fail to maintain staff engagement then staff morale will decrease and the delivery of changes in services and patient pathways will not happen in line with the plan	JR	4	4	16	1. Staff engagement strategy includes communications, alignment meetings, visible leadership at all levels 2. Clear commitment to clinical leadership at service line level. 3. Strengthened processes forcompliance with mandatory training. 4. Partnership Group meetings	Deep dives into staff engagement at audit committee 7/3/12 and 13/9/12	NHS 2011 staff survey showed engagement levels are in top 20% of trusts nationally	3	4	12	1. More evidence of staff engagement and monitoring of progress. 2. Board site visits. 3.Lack of specific strategy for consultant engagement and metrics to demonstrate	Quality committee members undertaking visits to divisions bimonthly commencing in October 2012. Quality Committee will receive feedback reports from visits at each bimonthly meeting. Patient Safety Walkabout programme revised and approved by Quality Committee September 2012.	Monthly review of KPIs by TB. Quarterly patient safety reports to
	3.2	If we fail to deliver CIPs and planned productvity improvements, then our financial stability will reduce, our FT applcation will be jeopardised and local patient services may be put at risk.	MdS	4	5	20	1. CIP Board monitors CIP implementation. 2. Programme Management Office (PMO) provides operational support. 3. Contingency plans include vacancy scrutiny panel, substitution of alternative CIPs etc	1. Monthly Finance report to TB shows progress against plan. 2. Finance and Development Committee regularly reviews CIP plans for current and future years for deliverability	1. Internal Audit review of CIP programme management. 2. External review of CIPs through HDD2.	4	5	20	1. PMO arrangements for 2013/14 2. recruitment to permanent CIP programme manager 2. Need to review and ensure transformational element to ensure deliverability and support from consultants 3. Rephasing and reprofiluing of CIP delivery during 2013/14.	1. PMO arrangements to be established as part of new OD arrangements 2. Recruitment to permanent post underway 3.	May-13
	3.3	If potential future London-wide service reconfigurations (e.g. colorectal, interventional radiology & vascular surgery, pathology) are implemented, then a significant amount of our activity being decommissioned	MK	5	3	15	1. Active engagement with opinion leaders, local providers and other stakeholders by Medical Director and CEO.2. Contingency plans developed.	Report to Audit Committee Jan 2013	External service reviews e.g. cancer peer reviews, NHSL pathology reviews	4	3	12	Further detailing of contingency plans	Audit Committee Deep Dive schedule	Apr-13
	3.4	If we do not mitigate against potential quality impacts of cost reduction programmes, then patient experience may reduce, patients may choose other providers, the Trust will lose business and the Trust's viability will be put at risk.	Mk/BS	4	4	16	1. All CIP programmes must pass clinically-led Quality Impact Assessment before going forward. 2. Clinical Advisory Group (chaired by Medical Director and Director of Nursing) monitor and report on quality impact of CIPs.3. Divisional Boards are responsible for assessing all quality risks in the division and for implementing mitigating actions	1. Quality committee and TB regularly review measures of quality, including: Complaints, Incident reporting, Friends & Family scores, GP surveys, Readmission rates, Mortality etc 2. TB monitors staffing ratios (e.g. nursing & midwifery) against good practice standards. 3. Divisional Board scrutiny of impact	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts.	3	4	12	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2 3. Pressure ulcer incidence 4. C-diff/ MRSA incidence	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2 Plan to achieve NHSLA Level 2 by February 2014 3. PET in each ward to achieve higher percentage scores in each of the CQIN areas of the pt survey 4. Specific improvement plans related to areas of poor performance in pt experience surveys.	Monthly review
	3.5	If WH does not improve the environment and efficiency of the maternity department, then the service may not continue to be financially viable or clinically safe.	YMK	3	4	12	1. Quality of patient care and experience is monitored as in all departments through patient feedback, complaints, incident reports etc. 2. Funds now secured for substantial upgrade of maternity environment, through combination of Estates Strategy and NHS grant award.	1. Estates strategy was approved by TB In Jan 2013. 2. Performance of maternity is subject of regular reviews by Quality Committee 3. Maternity redevelopment plan in development 4. additional funding approved by DH		3	4	12			Jun-13
	3.6	If we do not fully implement Service Line Management (SLM), then consultants will not know where and how to improve efficiency, weakening their clinical leadership in the achievement of CIPs and financial trajectories	RM/MdS	3	5	15	Structured roll out of SLR to clinical leads, training provided by divisional directors, clinical directors and clinical leads on how to interpret reports. CLs and CDs use SLR data to reduce cost level pf RCI = 100 by 2014/15	1. Finance & Development committee remit includes monitoring of SLM implementation. 2. SLM reports reviewed monthly at TB, to include names of CLs. 3. Evidence of SLR data being being used to inform decision making. 4. Audit committee deep dive in SLM.	HDD2 in Nov 2012 noted that WH continues to implement SLM across the Trust	2	5	10	Additional SLM resources to divisions to be identified	Additional SLM resources to divisions to be included in organisational capapcity plan due for presentation at EC in March 2013	May-13

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	3.7	If a Tariff deflation proves to be greater than in our plans, then this will reduce WH income and may affect its financial viability	RM	4	5	20	1. Block contract provides security through 2013/14. 2. In the longer term, our strategy mitigates some of this risk through growth in additional services and with other commissioners.	LTFM assumptions and associated risks periodically reviewed by F&D Committee		2	5	10	External review of LTFM	1. E&Y review of LTFM commissioned Feb 2013.	Monthly review through 13/14 financial
	3.8	If payroll related costs including severance are higher than planned this will cause financial instability against financial plans	RM	4	4	16	1. Our plans are to take advantage of existing vacancies and natural staff turnover (which combined are substantially in excess of envisaged workforce reductions over the next 5 years) to minimise redundancies	LTFM assumptions and associated risks periodically reviewed by F&D Committee		3	4	12	External review of LTFM	1. E&Y review of LTFM commissioned Feb 2013.	Monthly review through 13/14 financial
	3.9	If there is non compliance with information governance Toolkit requirements this would adversely affect CQC assessment, FT application requirements and we will be failing in our statutory obligations	RM	4	4	16	1. IG Steering Group in place since Nov 2011. 2. Clear responsibilities flowing from SIRO and Caldicott Guardian. 3. IG issues log and risk register monitored regularly 4. IG Management framework, suite of IG policies and procedures	1.IG Steering Group reports to Audit and Risk Committee quarterly and also conducted a deep dive on IG risks in 2012.	1. Parkhill review of IG gave substantial assurance on IG governance systems and processes and limited assurance on the Trust acheiving level 2 compliance by March 2013. 2.External Audit report on reliability of PbR data in 2011/12 indicated improvement in coding accuracy since prior year. 3. Decision by Information Commissioner about two SIs involving data loss on 20.11.2012 that no further action required	4	4	16	1.Review of IG compliance in M12 indicated the Trust will not achieve level 2 compliance until May 2013. 2.Records management - outstanding actions on the action plan that will not complete before end of March 3. The Trust will not achieve 95% IG mandatory training complicance by end of March 4. Longitudinal six month audit of data quality practice will not complete within this financial year	1. Records management project established. New storage facility to come on line 2013. 2. IG issues log and subsequent actoin plan in place and monitored through the IG Steering Committee on a monthly basis to achieve compliance by June 2013 3. Data quality group established meeting weekly and reporting to IG steering committee, audit to be completed by June 2013. 4. Organisational change Information Team	Jun-13
NHS Outcomes Framework 2013/14 Domain 1: Preventing people dying prematurely															
4. Improve the health of local people	4.1	If we fail to meet quality and safety standards including CQC essential targets, along with waiting times for ED, cancer, MSK and podiatry, then our patients may be experiencing poor care, our reputation will suffer, and our CQC licence and FT application are both at risk.	MK/BS/MdS	3	5	15	1. Quality is top of TB agenda and at the heart of the business, with clear lines of accountability down to ward/community level. 2. Datix incident reporting system and integration with risk management processes. 3. Staff encouraged to raise concerns - e.g. through Partnership Board & Meet the CEO programme. 4. Special controls to ensure CIPs do not threaten quality (see above).	1. Bimonthly Quality Committee meeting 2. Bimonthly Quality visits in each division 3. Clinical risk reports to QC from each division each meeting 4. Review of integrated performance dashboard at QC 5. Written reports - SIs, NHS LA, 6. Quarterly reports from feeder committees 7. Hotspot deep dives	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. NHS Staff survey identifies high management commitment to patient care compared to other trusts	2	5	10	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2 Plan to achieve NHSLA Level 2 by February 2014 3. PET in each ward to achieve higher percentage scores in each of the CQIN areas of the pt survey 4. Specific improvement plans related to areas of poor performance in pt experience surveys.	Monthly review
5. Fostering a culture of innovation and improvement	5.1	If the FT programme is not well planned and managed, then we may miss our deadlines and fail our FT application	YMK	4	5	20	1. Refreshed and stronger Board now in place, with capabilities and governance processes to lead an FT. 2. Integrated care organisation now in place, well placed to deliver its strategic vision. 3. Partnerships with Commissioners and other healthcare providers provide support for the implementation of our strategic vision. 4. Team in place for programme management of FT application.	1. FT Board provides scrutiny of programme management. 2. Status of FT application is standing item on TB agenda 3. Review of Board capacity 4. Board Development programme	1.Internal audit on FT programme. 2. MQGF report by RMS Tenon 3. BGAF by E&Y. 4. HDD2 repeat by Deloitte. 5. Working capital by KPMG 6. B2B Feedback	3	5	15	1. Action Plan following B2B incl Board strengthening of IBP strategy 2. FT Programme Manager	1. Review of executive capacity and capability 2. Action plan and revised timetable for discussion at B2B seminar 3. EY support 4. Succession plan regarding departure of Director of Programmes and Planning	Monthly review by TB
	5.2	If management capacity for change leadership is too stretched, transformation in the way services are provided and managed will not be achieved	YMK/MdS	4	4	16	1. Ongoing commitment to increase capacity by delegating leadership to lower levels in the organisation - e.g. creation of 3 Divisions, appointment of Service Line Clinical Leads etc.2. Regular monitoring of management capacity & capability through appraisals, 360° feedback, Board development programme, and external feedback via FT process. 3. Selective strengthening of management capacity from external sources - e.g. Interim OD Director; E&Y support to IBP development	1. Change leadership capacity discussed in Board Seminars. 2. Informal NED discussions on leadership capbility & capacity	1. BGAF report. 2. Informal discussions with other external stakeholders who know us well (e.g. NCL, NHSL, CCGs)	3	4	12	1. Ongoing objective to raise capability of Board members and other senior leaders. 2. Additional management capacity still required in selected areas	Monthly board development programme	TB BGAF Annual review June 2013
	5.3	If we do not implement an effective OD strategy, we will fail to evolve / employ / train our work-force to deliver service changes and productivity improvements and therefore CIP will not be delivered, services will not be transformed safely and our FT application will be significantly jeopardised.	BS/MdS/MK	4	5	20	1. Continued development of integrated training & education programme, focused on skills relevant to the Trust's strategy. 2. Processes to maximise compliance with mandatory training. 3. Ongoing Board and other leadership development programmes. 4. Continued reinforcement of a culture that encourages mentoring, continuous improvement, and innovation. 5. Appointment of Interim Director of OD, Feb 2013	1. TB regularly reviews workforce statistics, incl training, appraisals, sick leave, vacancies etc. Interim OD Director hired Feb 2013	1. NHS 2011 workforce survey shows WH in top 20% of trusts nationally for: training, engagement, teamwork	3	5	15	1. Refinement of OD strategy and associated programmes. 2. Appraisals and job planning. 3. Leadership development - e.g. for clinicians to become effective service line leaders	1. External support on workforce and organisational development plans from Nov '12. 2. Interim OD Director hired Feb 2013 3. OD report due for presentation to the Finance and Development Committee in April 2013.	Review by Finance and Developme nt Committee April 2013
	5.4	If the quality of teaching is not excellent, then commissioners (UCL, Middlesex and LETB) may not renew their teaching contracts. This will not only lead to a loss in income, it may lead to loss of trainees who are a critical part of service delivery.	MK/BS	3	3	9	1. Post graduate medical education board chaired by Director of Education oversees quality of training. 2. Director of UCL Medical School is a NED on the Trust Board. 3.Commitment to maintain/enhance training infrastructure evidenced by TB 3. approval of capital expenditure for e.g. Library, Cinical Skills Centre	1. Education Strategy Group developing education strategy	1. Medical education audit annually, NMC audit of education standards, NMC audit of mentorship,	2	3	6		1. Clinical Education Strategy Group convened for 20/03/2013 (re reconfiguration of LETB and educational funding for individual professional groups). Next meeting May 2013.	Mar-13
	5.5	Electronic Patient Record					Details not available at time of publishing								