Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
28th June 2012

TITLE	**Board Assurance Framework**
EXECUTIVE SUMMARY	The Board Assurance Framework (BAF) is a key assurance tool that ensures the Board has been properly informed about the totality of risks to achieving the Trust's strategic objectives. The Board has asked for a comprehensive review of the BAF both in terms of presentation and content to take place. IGAC considered a re write of the risks in the light of the refreshed Strategic Objectives and also a redesigned format at their meeting held on 20th June 2012.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Board assurance process ensures that risks to achieving the Trust's strategic objectives are actively identified and managed.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not assessed and views not taken.
EQUALITY AND DIVERSITY ISSUES	Non known
LEGAL ISSUES	The Board Assurance process supports the Chief Executive in signing the Annual Governance Statement which forms part of the Trust's statutory accounts.
The Board is asked to:	▪ To agree the risks for the 2012-13 BAF. ▪ Approve the format
Submitted by:	Jane Gear , Head of Corporate Affairs For Andrew Liles, Chief Executive
Date:	22nd June 2012
Decision:	For Approval

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
28th June 2012
Board Assurance Framework 2011/12 – 2015/16

1 Introduction

The BAF is an assurance tool to ensure that the Board is properly informed about the totality of risks to achieving all of the Strategic Objectives as detailed in the Integrated Business Plan.

2 Context

As a Foundation Trust it is important that the Board Assurance Framework works as a tool to support the Board's assurances in terms of self certification on compliance with the Terms of Authorisation.

The BAF was subject to significant review at the beginning of 2010/11. It was aligned to the Annual Governance Statement (SIC), and was cross referenced to the Corporate Risk Register.

It has previously been agreed by the Board that the time is now opportune for a further review of the BAF to ensure its remains Fit for Purpose.

A Board seminar took place in December 2011 looking at risk management and the role of the BAF. The Board seminar also agreed to refresh the presentation of the BAF and settled on the format used by a middle England PCT cluster. The review of the Strategic risks also needed to incorporate the creation of a fifth Strategic Objective on the Epsom transaction.

Discussions have now taken place and the Executive Directors have drafted strategic risks which they recommend for inclusion in the BAF. These were considered at IGAC on 20th June 2012.

3 Risks

IGAC agreed that the risks were generally appropriate but suggested the number were reduced if possible. Subsequent to the IGAC meeting some risks have therefore been changed in relation to Strategic Objective 2 *To recruit, retain and develop a high performing workforce* and Strategic Objective 4 *To improve the productivity and efficiency of the Trust in a financially sustainable manner*.

IGAC supported the revised template noting that a small change would be made to ensure the BAF could show how it aligned to risks in the Corporate Risk Register

4 BAF 2012-13

The revised draft risks are attached (Appendix 1)

The template for the revised BAF is attached and has been populated as an example for three risks. (Appendix 2)

The BAF, when presented to the Board in future, will be accompanied by the summary sheet showing changes in risk ratings, as used in previous years, but

supplemented with a by exception commentary . (Appendix 3)

5 Recommendation

The Board is asked to

- AGREE the risks
- AGREE the format.

Following which it will be fully populated

Submitted by: Jane Gear , Head of Corporate Affairs
For Andrew Liles, Chief Executive

Appendix 1

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)

2010/2011 – 2015/16
REVISED RISK DESCRIPTIONS

1. Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.	
1.1	A failure in quality and timeliness of information leading to false assurance, failure to intervene and deliver targeted improvement
1.2	If the Trust provides poor quality care leading to the loss of CQC Registration or significant conditions being attached.
1.3	ASPH fails to achieve appropriate compliance reports from any external regulator during 2012/13 or otherwise fails to recover adequately from any adverse findings
1.4	A failure of quality governance and impact assessment processes during the design of CIPs, leading to a negative impact on quality
1.5	A failure to align service resource to demand (24/7) leading to variability in service quality and clinical quality
1.6	Divergent and multiple organisational priorities compete with and distracts from the focus on high quality care
1.7	Poor capacity and flow in the emergency pathway results in a poor patient experience and outcome and potential failure of the Monitor Compliance Framework (VB)

2. Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.	
2.1	If the Trust workforce was not appropriately planned and managed particularly to meet reductions in WTE, agency usage and pay costs, resulting in overspends against agreed budgets
2.2	If the Trust was unable to recruit and retain a high calibre workforce, thereby adversely affecting quality and the organisation's reputation (particularly in delivery of front line care or where there are challenges with supply at regional/national level)
2.3	If individuals and teams were not values-driven or motivated, resulting in poor patient experience and ineffective team working
2.4	If the workforce was not appropriately developed and compliant with Mandatory Training, thereby risking non-compliance with CQC outcome 14
2.5	If levels of turnover and sickness increased, adversely affecting patient and team working, and organisational performance
2.6	If roles and responsibilities for leadership and workforce development were unclear, thereby impeding individual, team and corporate performance,

Objective 3 : To deliver the Trust's clinical strategy of joined up healthcare	
3.1	Failure to fix the emergency pathway will limit the Trust's ability to grow elective work and will damage the Trust's reputation and potentially impact on the Trust's strategic ambitions
3.2	If the Trust does not have all clinical and managerial leaders in the organisation aligned in a way that supports the delivery of its strategic objectives. Particularly for the development of Epsom integration and for key acute specialities where competitors innovate, strategically position and undermine clinical services at ASPH.
3.3	If the Trust does not establish key relationships through an activate partnership strategy with GP commissioners, Specialist Commissioners, networks, provider organisations, social care etc, this could lead to significant loss of market share by not implementing joined up health care.
3.4	If the Trust does not provide high quality, innovative services that exploit modern technology and ideas, easy/fast to access services then GPs and specialist commissioners will potentially recommend alternative services.

3.5	If the Trust does not exploit the benefits of working with partners (e.g. Epsom partners, Virgin etc) at both financial and service levels, then there is the potential that the long term the Trust will be strategically out- manoeuvred by competitor organisations.

Objective 4: **To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.**	
4.1	If unexpected changes in the patterns of demand and particularly admissions put pressure on the bed complement / costs and crowd out other service developments. If the relationship between effective capacity, demand & efficiency is not aligned this may negatively impact on the patient experience and financial performance.
4.2	If ASPH fails to deliver the clinical quality incentives, fails to deliver the performance standards, or fails to respond to the admission thresholds and readmission caps within the 2012/13 contract and under recovers income
4.3	If the Trust's efficiency programme is insufficiently supported by process changes and fails to deliver, the Trust will be unable to achieve year on year savings and maintain its FRR of 3+ over the longer term.
4.4	If ASPH fails to deliver 2012/13 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income. If the productivity agenda inadvertently undermines quality objectives
4.5	If the contribution from individual divisions and service lines is less than required to deliver the EBITDA margin for ASPH as a whole. If ASPH cross-subsidises uneconomic service lines with the financial contribution of unrelated service lines. If ASPH service delivery is inefficient when compared to similar services elsewhere.
4.6	If insufficient focus on collaboration and competition means the Trust is unable to achieve the desired growth in a reducing market. If divisions fail to develop their opportunities to grow markets outside current catchment areas, to defend encroachment from competitors or to develop new service delivery methods
4.7	If financial pressures on third party providers of health and social care cause operational difficulties and increased costs at ASPH e.g. increased DTOC, social services support
4.8	If NHS Surrey suffers unexpected financial pressures and seeks to enforce the levers within the 2012/13 contract more aggressively than expected

Objective 5 :To achieve successful integration with Epsom General Hospital, as a Trust delivering care from three hospital sites	
5.1	Insufficient or delayed transitional funding due to ; • Delays in the regulatory and NHS approval processes (CCP, Monitor, Final Business Case, Transitional Funding) • Incorrect ASPH financial planning assumptions. • Source of funding not clarified and confirmed • Key stakeholders believe different planning numbers as sensible for basis of funding
5.2	Level of Epsom actual financial performance that means delivery of sustainable financial performance (i.e. without transitional funding support) • Stretches beyond 2017/18 so makes practicality of sustainable delivery too great • Requires funding support beyond DoH affordability.
5.3	Operational performance around quality of patient care across EASPH is compromised (compared to national and local standards) because the scale of the integration process, resources needed and relative executive and senior leadership focus required.
5.4	Operational performance at ASPH around the emergency pathway is not recovered and sustained by September 2012 i.e. well before the formal integration with Epsom concludes.
5.5	ASPH CQC concerns raised in December 2011 are not resolved sustainably and result in • the approvals process being delayed • Key resources required to deliver integration from being compromised though the need to focus on resolving on-going CQC concerns.
5.6	ASPH financial performance falls behind plan and requires recovery action that dilutes resource and focus from EASPH integration. This will also threaten the proposed level of funding to support a surplus from the new Trust to plan for an FRR of 4.
5.7	Failure to align major stakeholders and residents to the vision and execution plans for the new organisation resulting in; • a negative impact on the Epsom and ASPH's brand and reputation • delay in approval processes • weakened relationships with proposed clinical partners
5.8	Integration programme across ASPH/Epsom is not managed properly or resourced satisfactorily resulting in negative impact on ASPH.

Principle Risk:

1.1 A failure in quality and timeliness of information leading to false assurance, failure to intervene and failure to deliver targeted improvement

Chief Nurse

	Initial	Current	Target
Likelihood	3	3	2
Consequence	4	4	4
Level	12	12	8

Strategic Objective Affected

Strategic Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Mar-11
Closed:

Controls

- Automated and manually fed clinical information systems/databases
- Guidelines/protocols for data collection
- Clinical outcome steering group
- Clinical Coding team

Assurance

- External (e.g. Dr Foster) and internal benchmarking
- External Auditor report on Quality Account data- identified an issue with falls data
- Clinical Governance Committee- last met 17 May 2012
- Audit Commission out patient PbR report issued 2011- showed improvement in data
- IG Toolkit Audit on selected aspects of clinical record

Gaps in Controls

- Clinical ownership of information and data collection
- Too many manual systems
- Inadequate correction loops

Gaps in Assurance

- Comprehensive audit of all data supporting dashboards

Closure Request?

[Enter details of closure request]

Action Plan

Due:	Action Description	Progress to Date	Date Completed
	Include audits in Internal Audit Plan	Need to discuss at Audit committee	
	Develop individualised consultant level data via Qlikview		

Principle Risk:

1.3 If the Trust provides poor quality care leading to the loss of CQC registration or significant conditions being attached

Chief Nurse

	Initial	Current	Target
Likelihood	2	3	2
Consequence	5	5	5
Level	10	15	10

Strategic Objective Affected

Strategic Objective 1: To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.

Opened: 01-Mar-10
Closed:

Controls

- Standard owners and Executive leads
- Policies, procedures and training programmes
- Process review via Health Assure
- Compliance in Practice review audits undertaken by matrons
- Best Care dashboard

Assurance

- Health Assure currently shows xxx
- Mandatory Training registers shows 82% compliance as at 8 June
- CQC QRP report dated 31/05/12 shows slightly increased risk but nothing of high amber or above
- CQC Compliance Report dated January 2012 showed areas of non compliance
- Best Care Dashboard highlights need to improve patient documentation

Gaps in Controls

- Divisional level standard owners are needed together with ownership of divisional level compliance
- Front line ownership and accountability for Essential standards
- Escalation process are not aligned to clinical ownership of patients (outcome 4 CQC finding on use of day surgery for escalation)
- Lack of policy on Shared Decision Making (Outcome 1 CQC findings)
- Completion of mandatory training (Outcome 14 CQC findings)

Gaps in Assurance

- CQC re- inspected 23 May 2012- report awaited

Closure Request?

[Enter details of closure request]

Action Plan

Due:	Action Description	Progress to Date	Date Completed
31-Jul-12	Complete implementation of the CQC action plan	Day Surgery Unit has not been used as an escalation area for inpatients	16-Jan-12
		82% compliance on mandatory training	08-Jun-12
01-Aug-12	Improve patient documentation	Workshop on documentation led by Chief Nurse	08-Jun-12
TBC	Implement Shared Decision making		

Principle Risk:

4.1 If unexpected changes in the patterns of demand and particularly admissions put pressure on the bed complement / costs and crowd out other service developments. If the relationship between effective capacity, demand & efficiency is not aligned this may negatively impact on the patient experience and financial performance

Deputy Chief Executive

	Initial	Current	Target	Strategic Objective Affected
Likelihood	2	3	2	Strategic Objective 4: To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework
Consequence	5	5	5	
Level	10	15	10	

Opened: 01-Mar-10
Closed:

Controls

- KPIs e.g. on LOS, admissions discharges etc.
- Clear bed complement plan
- Weekly length of stay meetings in place
- Escalation processes
- Weekly Trust wide urgent care dashboard
- Daily Information Reporting and Intelligence System in place

Assurance

- ECIST working with the Trust
- Benchmarked data
- Patient survey results show areas for improvement

Gaps in Controls

- To be completed
-
-
-

Gaps in Assurance

- Non known
-

Closure Request?

[Enter details of closure request]

Action Plan

Due:	Action Description	Progress to Date	Date Completed
	To be completed		

Appendix 3

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Board Assurance Framework - SUMMARY
2011-2012
Version: June 2012

NB Abridged risk descriptions

	Lead	June 12 Risk Score	July 12 Risk Score	Oct 12 Risk Score	Jan 13 Risk Score	April 13 Risk Score	July 13 Risk Score	In Month Risk Change
1. To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience.								
Risks to Objective								
1 A failure in quality and timeliness of information	DCE							
2 If the Trust provides poor quality care leading to the loss of CQC Registration or significant conditions being attached.	CN							
3 ASPH fails to achieve appropriate compliance reports from any external regulator during 2012/13	CN/MD							
4 A failure of quality governance and impact assessment processes during the design of CIPs,	CN							
5 A failure to align service resource to demand (24/7) leading to variability in service quality and clinical quality	DCE							
6 Divergent and multiple organisational priorities compete with, and distracts from, the focus on high quality care	CN							

	Lead	June 12 Risk Score	July 12 Risk Score	Oct 12 Risk Score	Jan 13 Risk Score	April 13 Risk Score	July 13 Risk Score	In Month Risk Change
Objective 2: To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.								
Risks to Objective								
1.If the Trust workforce was not appropriately planned and managed particularly to meet reductions in WTE, agency usage and pay costs,	DoW							
2. If the Trust was unable to recruit and retain a high calibre workforce,	DoW							
3. If individuals and teams were not values-driven or motivated,	DoW							
4. If the workforce was not appropriately developed and compliant with Mandatory Training,	DoW							
5. If levels of turnover and sickness increased, adversely affecting patient and team working , and organisational performance	DoW							
6. If roles and responsibilities for leadership and workforce development were unclear, thereby impeding individual, team and corporate performance,	DoW							
7. If the Trust workforce was not appropriately planned and managed particularly to meet reductions in WTE, agency usage and pay costs	DoW							

	Lead	June 12 Risk Score	July 12 Risk Score	Oct 12 Risk Score	Jan 13 Risk Score	April 13 Risk Score	July 13 Risk Score	In Month Risk Change
Objective 3 : To deliver the Trust's clinical strategy of joined up healthcare								
Risks to Objective								
1. Failure to fix the emergency pathway will limit the Trust's ability to grow elective work and will damage the Trust's reputation and potentially impact on the Trust's strategic ambitions	DCE							
2. If the Trust does not have all clinical and managerial leaders in the organisation aligned in a way that supports the delivery of its strategic objectives.	MD							
3.If the Trust does not establish key relationships through an activate partnership strategy with GP commissioners, Specialist Commissioners, networks, provider organisations, social care etc,	MD/DoF							
4. If the Trust does not provide high quality, innovative services that exploit modern technology and ideas, easy/fast to access services	MD							
5. If the Trust does not exploit the benefits of working with partners (e.g. Epsom partners, Virgin etc) at both financial and service levels.	MD/DCE							
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.								
Risks to Objective								
1. If unexpected changes in the patterns of demand and particularly admissions put pressure on the bed complement / costs and crowd out other service developments. If the relationship between effective capacity, demand & efficiency is not aligned	DCE							

2. If ASPH fails to deliver the clinical quality incentives, fails to deliver the performance standards, or fails to respond to the admission thresholds and readmission caps within the 2012/13 contract and under recovers income	CN/MD							
3. If the Trust's efficiency programme is insufficiently supported by process changes and fails to deliver, the Trust will be unable to achieve year on year savings and maintain its FRR of 3+ over the longer term	DoF							
4. If ASPH fails to deliver 2012/13 CIPs to the level required and/or allows pay and non-pay expenditure to exceed budget without a compensating increase in income. If the productivity agenda inadvertently undermines quality objectives	DoF							
5. If the contribution from individual divisions and service lines is less than required to deliver the EBITDA margin for ASPH as a whole. If ASPH cross-subsidises uneconomic service lines with the financial contribution of unrelated service lines.	DCE							
6. If insufficient focus on collaboration and competition means the Trust is unable to achieve the desired growth in a reducing market.	DoF							
7. If financial pressures on third party providers of health and social care cause operational difficulties and increased costs at ASPH	DCE							
8. If NHS Surrey suffers unexpected financial pressures and seeks to enforce the levers within the 2012/13 contract more aggressively than expected	DoF							

Objective 5 :To achieve successful integration with Epsom General Hospital, as a Trust delivering care from three hospital sites

Risks to Objective

	Lead	June 12 Risk Score	July 12 Risk Score	Oct 12 Risk Score	Jan 13 Risk Score	April 13 Risk Score	July 13 Risk Score	In Month Risk Change
1. Insufficient or delayed transitional funding	ID							↔
2. Level of Epsom actual financial performance	ID							
3. Operational performance around quality of patient care across EASPH is compromised.	ID							
4. Operational performance at ASPH around the emergency pathway is not recovered and sustained by September 2012	ID							
5. ASPH CQC concerns raised in December 2011 are not resolved sustainably	ID							
6. ASPH financial performance falls behind plan and requires recovery action that dilutes resource and focus from EASPH integration.	ID							
7. Failure to align major stakeholders and residents to the vision and execution plans for the new organisation	ID							
8. Integration programme across ASPH/Epsom not managed properly or resourced satisfactorily	ID							↔

Legend

15 – 25	Extreme
8 – 12	High
4 – 6	Medium

↔	No change to the risk score
↓	Risk score decreased
↑	Risk score increased

CE	Chief Executive
CN	Chief Nurse
DCE	Deputy Chief Executive
DoW	Director of Workforce & Organisational Development
ID	Integration Director
DoF	Director of Finance & Information
MD	Medical Director