ASSURANCE FRAMEWORK 2010/11

Definitions
Risk Owner: The Executive lead responsible for delivering the objective
Relevant Care Quality Commission regulation: Number of the applicable regulation
Progress: Change in risk since previous version- ⇧ = increased risk, ⇩ = reduced risk
Inherent Risk Value: level of risk if no controls in place
Residual Risk Value: level of risk with current controls in place
Target Risk Value: level of risk once proposed improvements implemented
Hazard: what could prevent us from meeting the objective
Control Measures: Measures in place to control the risk
Assurances: Evidence that the controls are in place and are working
Actions: Proposals to address gaps in either controls or assurances
⇧ residual risk reduced, ⇨ no change in residual risk, ⇩ residual risk increased

Risk scoring system

Likelihood	**Severity**				
	1 Insignificant	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 certain	**5**	**10**	**15**	**20**	**25**
4- likely	**4**	**8**	**12**	**16**	**20**
3-Possible	**3**	**6**	**9**	**12**	**15**
2-Unlikely	**2**	**4**	**6**	**8**	**10**
1-Rare	**1**	**2**	**3**	**4**	**5**

CORE DIRECTION 1: High Quality Acute Hospital and specialist care for patients:

Risk Owner:	Medical & Nursing Directors, COO	**Relevant CQC Regulation:**	All	**Progress:**	⇨
Inherent Risk Value:	20	**Residual Risk Value:**	15	**Target Risk Value:**	12

Hazard:
1. Failure to deliver national and local performance targets
2. Key patient safety indicators do not improve.
3. CQUIN/QA objectives not achieved.
4. Infection levels do not reduce.
5. Delay in service improvements identified in IBP.
6. Target for reducing mortality not achieved.

Existing Control Measures

1. Balanced scorecard report showing target achievement Membership of Patient Safety First Campaign and adoption of its recommendations including WHO checklist, patients' stories, Leadership Patient Safety WalkRound.
2. Agreed major pandemic/major incidents/business continuity plans in place.
3. "Zero tolerance" approach to infection and pressure sores
4. Root Cause Analysis of MRSA/clostridium difficile cases
5. Root Cause Analysis of serious incidents
6. All hospital acquired pressure ulcers grade three and above being reported as serious incidents.
7. CQUIN indicator monitoring framework
8. Performance and planning framework
9. Contract monitoring framework for PCT and escalation process
10. Quarterly RAG monitoring of mortality
11. Medicines management processes - policy, ward pharmacy service, storage, administration.
12. 18 week action plan
13. SHA quarterly review of performance (on exception basis)
14. Monitored action plan in place for each development
15. VTE assessment policy introduced

Weaknesses in Existing Control Measures

1. Contractual A&E target not met Aug/Sept
2. Symptomatic breast cancer target breaches
3. Hand hygiene audits show less than 100% observance of policy
4. Breast feeding in pregnancy target not currently achieved.
5. VTE assessments not meeting target

Existing Assurances

1. Bench marking via CHKS reports and Quality Intelligence East data (although latter not as current as Trust monitoring)- show improving mortality
2. CHKS top 40 hospital 2010 and Dr Foster. Band 4 (5 best) 2009
3. CQC registration unconditional - clear unannounced visit.
4. PCT quarterly monitoring.
5. Internal Audit reports on performance management Sept 09/data quality March 10.
6. Governance return to Strategic Health Authority - monthly with action plan- last report green.
7. Deanery visit - (June 2010), PMET B visits to Anaesthetics and paediatrics
8. NHSLA accreditation 2009 Level 1 full score for both general and maternity.
9. Care Quality Commission Quality Risk Profile - mostly Green, 4 areas only highlighted for improvement.
10. Annual clinical audit programme linked to national imperatives (see annual quality report for details).
11. Performance monitoring of stroke and PCI developments by networks
12. Peer review of cancer and cardiac services by network
13. Weekly hand hygiene audit and monthly board report on hand hygiene, pressure sores, Sis
14. Sign off of quality aspect of FT application by Regional Medical Directors

Weaknesses in Existing Assurances 1. Colposcopy report 2 Process for ensuring ongoing CQC compliance not embedded i.

Actions	**Target completion date**
1. Electronic link to GP prescribing history to improve medicines management.	March 2011
2. Adoption of single mortality measure.	DH dependent
3. New VTE policy implementation - ensure use of screening tool	July 2010
4. Closer working with PCT over clostridium difficile prevention.	March 11
5. Implement action plans- colposcopy - PMETB anaesthetics - PMETB paediatrics	Tbc Tbc tbc
6. Continue to refine Extended, integrated balanced scorecard	Ongoing
7. Home for lunch action plan	Dec10
8. Plan to achieve NHSLA level 2 accreditation, maternity and general	Mar 11, ongoing
9. Maternity service benchmarking	Dec10
10. Breast feeding/ smoking cessation action plan devised	Dec 10
11. Implement CQC monitoring process and data base	Mar 11

Q2 Current Key Risks rated 15+

1 Risk of hospital acquired, avoidable infection
2 Colposcopy – inability to demonstrate robust practice against national standards

CORE DIRECTION 2: Delivering Patient Focussed Care

Risk Owner:	COO, Director of Nursing and Patient Services	**Relevant CQC Regulation:**	9,10,17,19	**Progress:**	
Inherent Risk Value	20	**Residual Risk Value:**	15	**Target Risk Value:**	12

Hazard:

1. Cancelled operation target not met
2. Aim of morning discharges with TTO drugs and discharge letter complete not achieved.
3. Waiting times in outpatient department not reduced.
4. Patient survey scores not improved in 3 areas
5. Patients dissatisfied with care

Existing Control Measures

1. Improving Patient Experience strategy and committee in place
2. Review of each cancelled operation
3. Complaints and compliments reported and monitored
4. Commitment to Personal Best training programme
5. Productive ward project
6. Weekly report on morning discharge
7. Patient involvement in focus groups for LEAN reviews, plans for service development
8. PTL programme
9. Outpatient department waiting times reported daily
10. Capacity planning tool and escalation in place

Weaknesses in Existing Control Measures

1 increasing number of readmissions
2 Some discharge summaries not provided in timely manner

Existing Assurances

1. Internal patient surveys, reported monthly
2. EMG monitoring of completeness and timeliness of discharge summaries
3. PCT quarterly audit of discharge summaries
4. Performance monitoring report to Trust Board on cancelled operations.
5. Interim report on productive ward project (Trust Board May)
6. Regular audits of patient choice, experience, access

Weaknesses in Existing Assurances

1. Internal Audit report on discharge summaries
1Dip in scores on local patient surveys April-Jun and Aug
2Target satisfaction with cleaning/ catering not achieved

Actions	**Target completion date**

1. LEAN on outpatient department- short/medium/long term	3 years
2. OP booking review	Sept 10
3. Patient survey action plan	July 10
4. Personal Best training programme roll out	Dec 10
5. Completion of productive ward project	Dec 10
6. Extend use of internal patients survey and action planning on outcomes	Ongoing
7. Whole Health system approach to care of dying patient to be developed - implement end of life care action plan	March 2011
8. Implement action plan from Internal Audit report on discharge summaries	tbc
9. Home for lunch action plan	Dec 10
10 Vulnerable adult/ Learning disabled persons service improvement framework developed	July10-March11
11 Review complaints process/ style of responses	Nov 10
12 Review of readmissions	Dec 10
13 Implement You said we did strategy	Mar 11

Q2 Current Key Risks rated 15+

Poor patient survey response which has not improved since last year.

CORE DIRECTION 3: Transforming the way we work

Risk Owner:	Chief Executive, Director of OD, COO	**Relevant CQC Regulation:**	All	**Progress:**	⇧
Inherent Risk Value:	20	**Residual Risk Value:**	12	**Target Risk Value:**	12

Hazard:
1. Failure to achieve productivity improvements
2. Staff satisfaction survey results show no improvements
3. Delay on implementing business unit structure
4. Commercial skills not developed.
5. Improved relationship with NHS Bedfordshire not evident.
6. NHS constitution not embedded in communications and activities.
7. Insufficiently responsive to changing political/ consumer expectations

Existing Control Measures
1. Balanced scorecard report showing target achievement
2. Continuous improvement strategy and transformation board and trained staff/ champions in place. Each project has programme. Overall position reported to Trust Board monthly
3. NHS constitution reference on all Trust Board papers
4. Project plan for Service Level Management (SLM) monitored by management board and Finance Committee
5. Contract monitoring arrangements with PCT
6. Board to Board meetings with PCT
7. Divisional staff survey action plans
8. Participation in the local health economy healthier workforce group
9. Vacancy review
10. Signed SLA with NHS Bedfordshire

Weaknesses in Existing Control Measures
1. Staff use cost exceeds budget
2. Extra staffing use increased, although vacancy levels reducing
3. Appraisal/ training targets not met

Existing Assurances
1. Staff survey outcomes
2. Top 100 Good employer award

Weaknesses in Existing Assurances

Action Plans	**Target completion date**
1. Implement SLM	March 11
2. Continue to Implement HR changes	Mar 11
3.	
4. Review of medical consultants' contracts	Nov 10
5. Buy in Business manager and commercial skills as required, business unit structure developed	Aug 10- March 11

6. Workforce plan developed and monitored to ensure costs kept within budget	Mar 11
7. Nursing workforce review	Sept 11
8. Introduction of further productive projects	Ongoing
9. Revised contract monitoring arrangements, with quarterly sign-off	March 11
10. Recruitment plans	Dec 10

Q2 Current Key Risks rated 15+

Inefficient use of resources through failure to discharge patients before 1200.

CORE DIRECTION 4: Becoming a Leading Hospital/Care Network and Campus

Risk Owner:	Chief Executive	**Relevant CQC Regulation:**	10,17,24	**Progress:**	➪
Inherent Risk Value:	15	**Residual Risk Value:**	9	**Target Risk Value:**	6

Hazard:

1. Reliance on single commissioner for 95% of business
2. Plans not in line with strategic direction
3. Renal services not developed locally
4. No progress with MK/SEM cluster
5. Failure to win tender for PCT provider arm
6. Foundation Trust status not achieved
7. Impact of regional transforming pathology project
8. Risk from external provider arm contractor

Existing Control Measures

1. Balanced scorecard report showing target achievement
2. Agreed strategy, refreshed May/June 2010, and consulted on
3. Integrated Business Plan based on strategy
4. Partnership arrangements proposed to strengthen bid for renal development
5. Approved capital programme includes agreed service developments e.g. theatre
6. Steering group established, programme director in post, case for change developed for MK SEM cluster
7. QIPP programme board established
8. FT project / staff engagement plans in place
9. Membership of QIPP programme board

Weaknesses in Existing Control Measures - none

Existing Assurances

1. Strategic Health Authority sign off of Foundation Trust application
2. PricewaterhouseCoopers due diligence report for FT bid
3. Microbiology relocation/new pathology computer systems being implemented

Weaknesses in Existing Assurances - none

Action Plans	**Target completion date**
1. Confirm arrangements with proposed renal partner	Nov 10
2. Foundation Trust governor elections	tbc
3. Revised Integrated Business Plan for Monitor assessment	Jan 11
4 MK SEM cluster project to identify options	Dec 10
5 Clinical service plans developed	Nov 10

Q1 Current Key Risks rated 15+

Risk	**Action**	**Completion date**
Performance issues identified by SoS	Achievement of CIPs	Dec10

CORE DIRECTION 5: Financial strength and accountability

Risk Owner:	Director of Finance	**Relevant CQC Regulation:**	-	**Progress:**	➪
Inherent Risk Issue:	20	**Residual Risk Value:**	15	**Target Risk Value:**	12

Hazard:
1. Impact of mid-year review/ overall pressure on public sector finance
2. Failure to achieve sufficient income in a competitive market to achieve financial targets
3. Capital programme exceeds budget
4. Integrated QIPP project not delivered
5. Delay in establishing business support function
6. CIPs not achieved
7. Forecast I&E surplus not achieved

Existing Control Measures
1. Balanced scorecard report showing target achievement
2. EMG/Finance Committee review of performance - monthly including Cost Improvement Programme
3. Reporting to Strategic Health Authority - governance
4. Financial Improvement Team
5. Robust contract monitoring in place
6. Monthly divisional review meetings
7. Downside plans in IBP

Weaknesses in Existing Control Measures
1. Previous year's contracting issue
2. Issues identified in KPMG and Grant Thornton reports
3. CIPs not being delivered per profile
4. Expenditure on additional staff above budget

Existing Assurances
1. Internal Audit reports on financial systems (payroll, income & debtors, clinical income, creditors, general ledger) and data quality (March 10)- strong
2. External Auditor opinion on accounts strong
3. External Auditor value for money opinion strong
4. External audit ALE scores

Weakness in Existing Assurances
1. Financial reporting

Action Plans	**Target completion date**
1. SLM to be implemented	Dec10
2. 6 month soft close to be audited.	Nov10
3. Action plan from External review of Finance Dept capacity and capability	Dec10
4. Ensure achievement of CIPs by year end	Dec 10
5. Turnround approach to be adopted in surgery	Mar 11

CORE DIRECTION 6: Achieving Effective Stakeholder Relationships

Risk Owner:	Chief Executive, COO	**Relevant CQC Regulation:**	24	**Progress:**	
Inherent Risk Value:	15	**Residual Risk Value:**	15	**Target Risk Value:**	9

Hazard:

1. Government White paper impact with new role for local authorities/ creation of Healthwatch/ establishment of new commissioning consortia
1. Healthier Bedfordshire initiatives not delivered
2. Community engagement strategy not implemented
3. Corporate relationships with PCT not improved
4. Direct engagement with GPs not achieved
5. Patients choose to be treated elsewhere
6. FT membership not increased

Existing Control Measures

1. Balanced scorecard report showing target achievement
2. Marketing strategy in place
3. Communications processes - GP newsletter/Members Matters, web site with GP Gateway
4. Involvement of LINks/Overview and Scrutiny Committees in formal quality process
5. Joint working e.g. Safeguarding Board, transport plan, Maternity Services Liaison Committee
6. Planning and performance meetings with PCT
7. Engagement strategy agreed Jan 10
8. Board to Board meetings with PCT
9. CE member of Bedford Borough Strategic Partnership Board
10. Joint working with PCT on QIPP, lead for emergency /urgent care, involvement in repatriation.

Weaknesses in Existing Control Measures

1 Impact of change of Chief Executives
2 Undeveloped relations with voluntary/ pressure groups

Existing Assurances

1. PCT quality review strategy review
2. Internal Audit report on safeguarding
3. Strategic Health Authority supportive visit on safeguarding

Weaknesses in Existing Assurances

None

Action Plans	Target completion date
1. Implement Community Engagement strategy action plan	Ongoing
2. NHS Bedfordshire/Bedford Hospital Board development - buddying etc	Dec10
3. Implement recommendations in SHA safeguarding review	Dec 10
4. Improve relations with voluntary/ pressure groups	Ongoing
5. CE to visit GP surgeries	Ongoing
6. FT governor/ member recruitment campaign	Dec10

Q2 Current Key Risks rated 15+

Discharge Letters

- failure to deliver within 24 hours to GPs
- Unsatisfactory content

CORE DIRECTION 7: Development of Leading Edge Support Services

Risk Owner:	Directors of Nursing, Finance and OD	**Relevant CQC Regulation:**	**15, 20**	**Progress:**	
Inherent Risk Value:	15	**Residual Risk Value:**	9	**Target Risk Value:**	9

Hazard:

1. Issues with providing high quality Information and information governance
2. OD plan not delivered with impact on FT application and IBP
3. Carbon use not reduced
4. Untoward events impact on Trust's reputation

Existing Control Measures

1. Policy framework/strategy framework for procurement, estates, IM&T, marketing
2. Investment plans for IM&T infrastructure
3. Contract arrangement with GSTS for pathology computer system
4. Project management for decontamination to ensure remains on programme/budget
5. Contract with GSTS for pathology services

Weaknesses in Existing Control Measures

None

Existing Assurances

1. National "cleanest hospital" award
2. Good Corporate Citizen score- position maintained
3. Charter mark for hotel services
4. PEAT inspection scores- good/ excellent
5. Investors in People reaccreditation January 2010, ✓✓ May 2010
6. Heartbeat award
7. HTA registration
8. Positive Fire Service/Environmental health/HSSD audit reports
9. IG toolkit – score for 2009/10, 66 – amber
10. Carbon reduction league table
11. Achieving BREEM standard for decontamination unit

Weakness in Existing Assurances

1. Internal Audit report on IM&T infrastructure- recommendations now actioned
2. No IGT toolkit score under 2 required by 31.3.11

Action Plans	**Target completion date**
1. Action plans implemented for marketing, IM&T, sustainable development strategies/plans	Ongoing
2. Supporting strategies (estates, IM&T) updated	Jan 11
3. Pathology computer installation	Mar11
4. Compliant decontamination unit operational	End March 2011