MEETING DATE:	13 September 2012	
AGENDA ITEM NUMBER:	Item 7.2	
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	John Pougher Assistant Senior Officer Quality & Assurance Quality & Assurance	**REPORT TO THE CLINICAL COMMISSIONING GROUP COMMITTEE**

BOARD ASSURANCE FRAMEWORK

PURPOSE/ACTION REQUIRED:	For Approval
CONSULTATION AND/OR INVOLVEMENT PROCESS:	Audit Group 30th August 2012
FREEDOM OF INFORMATION:	Public

1. PURPOSE OF THE REPORT:

To inform the CCGC of the highest rated risks identified for North Lincolnshire locality. The attached risk register previously constituted the Board Assurance Framework (BAF) for NHS North Lincolnshire. A further paper is attached that provides additional information on the management of some of the identified 'clinical' risks.

The register is reviewed regularly and each risk has a nominated 'director owner'. The register is supported by a corporate risk register and registers for each directorate that identify how lower rated risks are managed. The Cluster Trust Board has its own BAF that identifies the highest rated risks that threaten the delivery of its strategic objectives.

Following an exercise supported by Internal Audit, the Council of Members and CCGC have reviewed the risk profile of the organisation. A new risk register is now under the later stages of development and will be aligned to the newly agreed strategic objectives for the CCGC.

Public bodies must provide assurance that they appropriately manage and control resources that they are responsible for. HM Treasurer requires all public bodies to produce a statement regarding internal control that demonstrates how they manage their resources – the risk register is a key element of this process.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT: ***(will be populated following agreement with Council of Members)***

3. IMPACT ON RISK ASSURANCE FRAMEWORK:

Yes	x	No	

A risk register is a key element of a Trust's overall assurance framework.

4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:

Yes		No	x

5. LEGAL IMPLICATIONS:

Yes		No	x

6. RESOURCE IMPLICATIONS:

Yes		No	x

7. EQUALITY IMPACT ASSESSMENT:

Yes		No	x

8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:

Yes		No	x

9. RECOMMENDATIONS:

The CCG is asked to: -

- Approve the attached Risk Register in that it gives assurance that risks are being effectively managed.

LOCALITY RISK REGISTER

Risk ID	Link to Strategic Objective	Risk Description	Key Controls	Current Risk Score				Initial Risk Score	Movement	Assurance on Controls	Positive / External Assurance	Gaps in Control	Gaps in Assurance	Last Review Date	Lead
				Impact	Likelihood	Risk Score	Status								
CCG011	CCG	Due to staff leaving and moving to different/new organisations (ie CSS) and work not yet being picked up, there is increasing pressure on existing staff and a related risk to the ability of the organisation to achieve its strategic objectives.	Ongoing Humber cluster review of capacity and support across the cluster.	4	4	16	H	16	Same	Interim structure for CCS published; recruitment commenced. Interim CCG structure agreed and to be recruited to by June 2012.		Still agreeing exit plans for a number of NL staff.	Lack of clarity re functions going to NCB.	05/07/2012	CCG Chair/COO
CCG035	CCG	Tension between National and Cluster requirements and local needs.	Culture and values that places clinical decision making at the heart of the organisation - see OD Plan	4	4	16	H	20	Down	Framework as set out by Secretary of State 22/02/12 outlining CCG freedoms.				05/07/2012	CCG Chair
PH002	PH	Due to NHS and local government reforms there is a risk to the effectiveness of local partnerships that poses a threat to the health and wellbeing of the local population.	Focusing work with key strategic partners and building area based working. Cabinet accepted paper on Health & Wellbeing.	5	3	15	H	15	Same	Currently monitored via Transition Board Health and Wellbeing Board develops. Health & Wellbeing Board Reports and minutes, Performance Report. HWB adopts areas as methods to improve health inequalities, health inequalities top priority.	SHA response May 2011 acknowledging strength of Trust multi-agency working arrangements;		SHA transition plan assurance process	27/03/2012	DPH
PH004	PH	Failure to deliver key public health targets linked to Strategic Plan i.e. Cancer, Smoking in pregnancy, breastfeeding CHD & closing the gap in inequalities due to challenging targets and capacity during transition.	Key risks are identified under specific remit/targets with community based associated action plans for teenage conception rates, reducing smoking rates, improving Chlamydia screening rates and breast feeding rates. Risk register produced for key programme transfer to Local Authority. Full role out of Health Checks programme now in place.	4	4	16	H	16	Same	Some improvements seen in smoking in pregnancy but still not meeting all targets. Monitored via HWB Board / WHIP Board / SHA. Performance Report. CVD deaths still behind target, WHIP Board, SHA performance report.	SHA response May 2011 acknowledges improvements and work on all-age, all-cause, mortality. SHA performance monitoring. Evidence of some improvement.	Lack of PH outcome framework.		31/08/2012	DPH

IN044	CCG	Information Governance Toolkit scores and evidence Unable to attain min (level 2) scores in key areas for v9 with robust auditable evidence	Action plan to be reviewed and monitored monthly. Audit assurance will improve with available evidence. But scores will not all reach 2. Net reduction in impact. Int Audit to provide additional support through 12/13.	4	4	16	H	12	Up	NHS NL Quality Group		No gaps identified.	No gaps identified.	05/07/2012	ADIN
CE004	CCG	Risk to sustainable services review not being fully implemented on time resulting in failure to implement transitional changes required to meet strategic objectives.	Clinical Stakeholder Board established. Local tripartite approach agreed. Actions to be completed by end of year and fed into Contract negotiations. Longer term work being led locally by Management Group which will identify options.	4	4	16	H	16	Same	Monitored through DBM. QIPP plan in place. Cluster Board.	Independent Chair appointed.	Initial plans in place. External support being made available including facilitation for clinicians.	To identify external assurances. Lack of plans to deal with gaps.	05/07/2012	CCGC
EP026	CCG	Due to high level of Hospital Standardised Mortality Rate at NLAG there is a risk to patient safety.	Position monitored via Cluster BAF. Mortality Action plan in place. Supporting external reporting re. mortality. NLAG undertaking external review of stroke care. NLAG objective to reduce HSMR by 5 points. Commissioners undertaking external review of mortality.	4	5	20	H	20	Same	Revised action plans monitored & challenged by lead and associate commissioners. Commissioner deep dives into quality and performance, specific deep dive into stroke. Service review of Mortality Action Plan held on 05/07/11. Briefings provided to commissioners by NLAG. NLAG internal task group in place.	SHA review of mortality action plans. CQC reviews/ intelligence including review of NLaG stroke mortality performance. Building upon deep dive. Dr Foster monthly reviews of mortality rates. External mortality review underway. Stroke accreditation process underway.	No gaps identified	No gaps identified	05/07/2012	DQCC
EP030	CCG	Due to high level of Hospital Standardised Mortality Rate at HEY there is a risk to patient safety.	Position monitored by Cluster BAF. Mortality Action plan in place. External update review received. Consultancy report for HEY mortality. Additional actions identified to improve performance including appointment of Director of Patient Safety. HEY objective to reduce HSMR by 10 points. Workshop for Commissioners held Feb 2012 outlining progress and challenges.	4	5	20	H	20	Same	Revised action plans monitored & challenged by lead and associate commissioners. Trust deep dives into quality and performance - service review of HEY including review of Mortality Action Plan held on 05/07/11.	SHA review of mortality action plans. CQC reviews/ intelligence. Buidling upon deep dive. Dr Foster monthly reviews of mortality rates. Summary hospital mortality indicator publication.	No gaps identified	No gaps identified	05/07/2012	DQCC

EP033	CCG	111 Project - lack of continuity and capacity threatening mobilisation and implementation of unplanned care.	Staff transition process. Concerns raised with CSS management team.	5	3	15	H	0	Up	Interim structure		HR processes; potential lack of understanding by support staff; monitored by 111 Programme Board; Lack of representation on Programme Board.		05/07/2012	DQCC
EP034	CCG	Lack of robust clinical governance arrangements threatening 111 accreditation and development of unplanned care agenda.	Cluster Clinical Governance Group.	5	3	15	H	0	Up	Cluster 111 Clinical Governance Group; CCG Quality Group.	National 111 project team.	Lack of project lead for clinical governance; DOH mobilisation project support August 2012.		05/07/2012	DQCC

STRATEGIC OBJECTIVES 2011-12 ONWARDS

1	**To maximise the health and well being of all residents of North Lincolnshire and minimise the health gap whilst :-**
1A	improving quality of commissioned services as measured through patient safety, clinical excellence and patient experience;
1B	delivering a balanced PCT budget.
2	**During the transition work efficiently and effectively to support the migration of our staff and appropriate PCT functions to the new organisations, also ensuring a safe legacy transfer.**

Risk update for CCGC 13th September 2012

This paper provides some additional information to that provided in the locality risk register and focuses on clinical risks. This report will be developed further in light of feedback.

EP026
Due to high level of hospital standardised mortality rate at NLaG there is a risk to patient safety.

A mortality action plan approved by the SHA is reported on monthly.

The latest SHMI report (July 12) gives NLaG a score of 116.37 and is the 7th highest in the country.

NLaG has an established Task Group to promote a range of improvements in mortality performance.

Commissioners have commissioned an external review of mortality at NLaG and across the whole health care community to better understand issues and improve performance. The first phase of the review has now been completed and the results considered by North Lincolnshire and North East Lincolnshire CCGs. Recommendations for improvements are currently being drawn up along with an executive summary and are due for publication in September.

According to the Risk Adjusted Mortality Index (RAMI) scores (the measure of choice used by NLaG to monitor performance and report to their Board) mortality performance continues to improve steadily. In the latest Quality report (June 12) RAMI was stated at 111 for the 12 months to May 2012 compared to 147 for the 12 months to May 2011.

Quality contract meetings continue to monitor and challenge progress. A number of Key Performance Indicators (KPIs) and CQUINS support improved performance.

More detailed reports are now available to commissioners on a regular basis to highlight work and progress in clinical specialities supporting the identification of good practice and potential 'hot spots'. These reports break down into clinical specialities in addition to providing trend and benchmarking data.

Key priority areas have been identified and continue to be addressed and monitored with clinical leaders in place to support improved performance. These include respiratory systems, digestive systems, haematology, stroke and cardio-vascular care. A number of new initiatives are being reported on including; use of the heart failure care bundles to assess compliance with NICE guidance, random reviews of mortality and a weekend mortality review.

Progress is monitored and challenged at the monthly quality contract meetings and the Contract Board. The deep dive review conducted by NHS North Lincolnshire which has also reviewed mortality and performance will be reviewed on a regular basis.

EP30

Due to high level of hospital standardised mortality rate at HEY there is a risk to patient safety.

The latest SHMI (July 12) gives HEY a score of 116.06 and this score is rated as the 8th highest in the country.

In the 2011 Dr Foster Good Hospital HEY was identified as one of only two Trusts that were higher than expected in 3 of the 4 mortality measures. HEY also had the highest national score for deaths after surgery at 160.

A mortality action plan approved by the SHA is in place and updated on a regular basis.

A workshop was held on the 10th of February at which HEY updated commissioners on progress and challenges. The workshop explored potential reasons for the performance including poor clinical care, coding issues and care across the whole health care community.

The Trust has identified 3 key priority areas

1 Recognising, preventing and rescuing deteriorating patients
2 Implementation of care bundles
3 Reducing HCAI's

An established Mortality Reduction Committee oversees a range of work streams under the leadership of the trust's Medical Director.

In the absence of quality contract meetings more detailed and updated information on performance is being requested through NHS Hull - the lead commissioners.

JP 31/8/12