Norfolk & Suffolk Foundation Trust Board Assurance Framework (BAF) - 11 November 2019

NSFT Strategic aim - Supporting people to live their hopes, dreams and aspirations

The Board Assurance Framework forms the key document for the Trust in ensuring all principal risks to the Trust's objectives are controlled, that there is sufficient assurance as to the effectiveness of these controls, which underpins the Trust's system of internal control. The Trust Risk Management Framework details how the Assurance Framework is populated and maintained.

Strategic Objectives	Risk Ref	Risk Description	Inherent Risk Rating (LxC)	Existing Controls *(measures in place to reduce likelihood)*	Assurances on controls	Nov 2019 Risk Rating LxC	Gaps in controls and/or assurance	Target Risk Rating	Progress with actions to address gaps	Date for Review	Lead Assurance Committee	Lead
1. Engage and inspire our staff	1.1	Lack of focus on staff engagement and development will adversely impact on leadership and staff morale, resulting in poor outcomes for patients and carers.	R 4 x 4 = 16	Culture change programme, led by People Participation team and overseen by NED-led Cultural Change Group. Medical Education Improvement Plan working closely with Health Education England. Nursing education programme. Quality Improvement projects on employee relations. increased focus on clinical supervision. Staff Governors. Equality & Diversity work	Annual Staff Survey Monthly Pulse Surveys Workforce reports to Board. Regular HR reports to executive Service Delivery Board and Quality Committee. Quality Assurance Committee and Appts & Remuneration Committee take assurance of effective staff engagement. Council of Governors - have set this as focus area. Medical Education Survey WRES data. FTSUG reports to BoD	A 3 x 4 = 12 ➡	Annual Staff Survey and WRES data highlights improvements needed. Internal audit report on consultant job planning - No assurance opinion staff vacancies	A 2 x 4 = 8 Mar 2020	1. Culture Change programme underway, monitored by Culture Change Group 'People Before Process'. Report to each Board. Diagnostic phase to be completed by end Jan 20 2. Trust's People Strategy implementation 3. Equality Diversity & Inclusion Strategy for approval by Nov BoD 4. Medical Director for workforce reviewing support for medical workforce and training places for junior doctors and addressing actions for consultant job planning. Working closely with HEE. and Associate Nurse Director and AHP lead focusing on nursing and AHP development and Preceptorship programme. 5. Care Groups implementing priority actions from Staff Survey results.	Dec-19	Service Delivery Board Appointments & Remuneration Committee	MG
	1.2	Lack of development and support for the new Care Group management structures, and their relationship with the executive and Board, impacts on the effectiveness of those leadership teams and results in poor clinical outcomes.	R 4 x 4 = 16	Programme of NED and exec visits to teams. Care Group Leadership induction programme. Regular comms bulletins. Breakfast meetings with teams. Care Group senior leadership now in place and comprehensive induction programme throughout September and on going. FTSUG	Quality Performance Meetings. Monthly Pulse Surveys. Executive walkabouts and breakfast meetings. Clinical outcome KPIs and performance reporting dashboards reviewed by BoD, Executive, FBIC	A 2 x 4 = 8 ⬇	Phase 2 of care group management re-structure underway	Y 1 x 4 = 4 March 2020	1. Leadership programme continues for Care Group - Trust Five-year leadership development strategy for all levels of staff. 2. People before Process culture change programme. 3. New governance framework of reporting and accountability co-produced with care group leadership 4. focused work on improving recruitment	Dec-19	Service Delivery Board Quality Assurance Committee	MG
nd partnerships	2.1	Poor engagement with service users and carers and other stakeholders will mean that their views are not heard and responded to, and result in services that do not meet the needs of local communities.	A 3 x 4 = 12	Appointment of People Participation Leads in each Care Group. newly established Patient Participation Committee reporting to BoD - overseeing PP Strategy. Triangle of Care. Working Together Hub. Carers Network. Service User Engagement Forum. Service Users, Carers and Governors trained in QI methodology as part of last cohort. and taking forward QI projects.	Reports to BoD and People Participation Committee. Progress with Quality Improvement projects involving SUs reviewed by Quality Committee. CQC inspection Reports. Progress reported In Quality Improvement Plan at Board. Council of Governors. Healthwatch. HOSC	A 3 x 4 = 12 ➡	Further develop people participation and carer involvement and true co-production	Y 1 x 4 = 4 Jul 2020	1. Making Families Count conferences 14th November 3. People Participation leads appointed for each of the care groups, developing clear objectives and workstreams, with infrastructure to support them.	Jan-20	People Participation Committee	DH

Strategic Objectives	Risk Ref	Risk Description	Inherent Risk Rating (LxC)	Existing Controls *(measures in place to reduce likelihood)*	Assurances on controls	Nov 2019 Risk Rating LxC	Gaps in controls and/or assurance	Target Risk Rating	Progress with actions to address gaps	Date for Review	Lead Assurance Committee	Lead
2. Co-production a	2.2	Not working in a collaborative way with STP colleagues and other system partners will prevent the transformation of services and result in risks to services and Trust sustainability.	A 3 x 4 = 12	Key member of STP/ICS groups Norfolk & Waveney and Suffolk & North East Essex. NSFT CEO is SRO for N&W STP MH Group. Working with partners to deliver the two adult MH and CYP strategies (Norfolk and Suffolk). New Models of Care Work in collaboration with regional MH Trusts.	Feedback from STP/ICS partners, including commissioners, primary care, Healthwatch, HOSC. OAG meetings open to all stakeholders. BoD and CoG receive regular updates on implementation of the strategies and implications for NSFT	A 3 x 4 = 12 →	Implementation of Mental Health strategies in partnership with Norfolk & Waveney and Suffolk & North East Essex STP/ICS - Alliance working	A 2 x 4 = 8 Mar 2020	1.Active partner in development of MH offer to Primary Care Networks (PCNs) 2. Suffolk Alliance - work underway to implement Suffolk MH & Emotional Wellbeing strategy; high level models agreed for workstreams 3. NSFT and NCH&C signed MoU to work together to deliver better integrated services 4. Working with both STP/ICS to develop local 5 Year plans 5. Working closely with all partners and agencies on EU Exit plans 6. Mapping and prioritisation of transformation work to be completed	Dec-19	Service Delivery Board	MF
3. Building quality improvement skills	3.1	Lack of support for the Trust's Quality Improvement programme will jeopardise the successful establishment of the programme and result in poor staff morale and patient outcomes.	R 4 x 4 = 16	Quality Improvement Team provide support and training to staff, service users, governors, stakeholders on QI methodology. Building capacity and capability. Individual coaching sessions for each project. Working with Care Group Leadership	Quality Improvement Report to BoD. Quality Assurance Committee scrutinises performance. Quality Performance Meetings with Care Groups	A 2 x 4 = 8 ↓	Address CQC recommendations on quality and safety and to be a learning organisation	Y 1 x 4 = 4 Mar 2020	1. Continuing to embed Quality Improvement (QI) methodology throughout the Trust - key tenet of Trust Strategy; advertising for more infrastructure support. 2. more staff and service users trained in QI methodology. Providing pocket introductory QI session in December. Board training on QI methodology in October. 3. Participating in National QI projects: Reducing Restrictive Intervention, Sexual safety 6. Quality& Safety reviews underway, learning from these and from incidents	Dec-19	Quality Assurance Committee	DH
	3.2	Not implementing learning from complaints, incidents, Coroner's recommendations and other information means that issues continue to occur and may result in harm to patients.	R 4 x 4 = 16	Serious Incident (SI) policy and process - RCAs, liaising closely with families for each incident. Duty of Candour. SI Scrutiny panel. newly appointed Family Liaison Officer. Suicide Prevention Lead. Patient Safety Manager. Patient Safety Alert process. Organised variety of learning events. Complaints and PALs process. Quality and safety reviews. E9	Quality Performance Meetings CQC inspections Quality Improvement Plan monitored by Quality Committee and Quality Assurance Committee. SI reports to BoD CCGs review performance at contract meetings. OAG and OSM with NHSI. Commissioner contract meetings	R 4 x 4 = 16 →	Address CQC recommendations on quality and safety, to be a learning organisation	Y 1 x 4 = 4 Mar 2020	1. Changes to Serious Incident process; involving families and carers in every review. New SI and Mortality Review Group. 2. Pop Up Learning events, Patient Safety Alert process, co-produced learning events 3. Care Group Lead Nurse and Clinical Director now responsible for leading complaints process to enusre learning and embedding of changes to practice 4. employing a Peer Support Worker to improve learning 5.Learning from Quality & Safety reviews 6. Continuing to roll out QI methodology with Care Groups to be learning organisation	Jan-20	Quality Assurance Committee	DH
	4.1	Not achieving compliance with CQC essential standards results in risks to patient and carers, as well as the Trust's sustainability and reputation.	R 4 x 4 = 16	"Buddy" arrangement with ELFT for Trust support. Quality Improvement Plan - QI methodology, Quality & safety reviews, learning organisation. Culture change programme New Governance architecture to improve assurance reporting and flow of information ward to board to ward. New clinically led Care groups established. MH Act compliance work. Recruitment of new NEDs and Executive Directors	Oversight & Assurance Group meetings and PRM with NHSI Quality Improvement Plan reported to each Board and scrutiny by Quality Assurance Committee; CQC Inspections; Contract meetings with commissioners	R 4 x 4 = 16 →	CQC report - Inadequate November 2018; awaiting report from October 2019 inspection	Y 1 x 4 = 4 January 2020	1. Quality Improvement Plan implementation to address quality and safety, restrictive interventions; monitored closely by NHSIE 2. New clinical leadership in Care Groups, with revised governance and Quality Performance Meetings to monitor performance and provide support. 3. improvements in ward to board flow of information and assurance, more work underway to develop clinical governance and sub-group meetings and workplans. 4. CQC inspection mid October 2019 and further table top review November; initial feedback, awaiting final report for publication in January 2020.	Jan-20	Board of Directors	JW

Strategic Objectives	Risk Ref	Risk Description	Inherent Risk Rating (LxC)	Existing Controls *(measures in place to reduce likelihood)*	Assurances on controls	Nov 2019 Risk Rating LxC	Gaps in controls and/or assurance	Target Risk Rating	Progress with actions to address gaps	Date for Review	Lead Assurance Committee	Lead
4. Align our governance and systems	4.2	Not making progress in reducing waiting times creates a risk to service users, as well as breaches of contractual and regulatory standards.	R 4 x 4 = 16	Clinical harm review process reviewed. Service User tracker in place. Quality & Safety Reviews. New Director appointed to address waiting times. Access Improvement Team in place reporting to COO. Service users' safety & experience is always maintained with visibility of those awaiting treatment & system for clinical review.	High level Performance Dashboard reports reviewed by Board include deep dives on waiting times and processes for keeping people safe; Quality Assurance Committee provides scrutiny. Access Improvement Task Force receives escalations from SUTL. CQC Inspections OAG and OSM monthly meetings with NHSI. Contract meetings with commissioners	R 4 x 4 = 16 →	Increasing demand leading to high waiting times Ensuring service user safety is maintained and visibility of those awaiting treatment	A 2 x 4 = 8 Nov 2020	1. Access Improvement Director to ensure SU Tracker List becomes BAU within Care Groups, with oversight by Trust Wide Access Improvement Group 2. Service Directors to provide RAPs to Access Improvement Team (AIT) for non compliant areas 3. Care Groups to implement Trust wide Access Policy from Jan 20 4. Access Improvement Director (AID) and Clinical Leads to conduct deep dives into ADHD, Autism and ED pathways by 29.02.20 and shared with key stakeholders by 31.03.20 5.Quality Summits to be held before March to include feedback from the Quality Safety Reviews and Clinical harm Audits. 6. AID and Deputy Director Contracts, Performance and Information to undertake a demand and capacity analysis for 2 PCNs in partnership with local Care Groups by march to determine the effect on access rates and compliance following proposed transformational changes and access to services via PCN's.	Dec 19 Dec 19 Jan 20 Feb 20 Mar 20 Mar 20 Mar 20	Service Delivery Board Quality Assurance Committee	SR
	4.3	Non-delivery of savings and income plans, including plans to reduce out of area placements, and investment required to deliver change programme, adversely impacts on the Trust's financial position and results in a risk of regulatory action and risks to long-term financial viability.	R 4 x 5 = 20	Agreed mitigation plan in Sept to achieve Control Total, Standing Financial Instructions, finance controls, monthly review with budget managers, Monthly scrutiny and challenge by Executive Group	Finance & Business Investment Committee scrutiny, Finance reports to Board, Internal and external audit reports, Annual Accounts approval OAG and PRM	R 4 x 5 = 20 →	Gap on delivery of mitigation plan of £1.4m, High reliance on non-recurrent schemes, Unknown cost pressures in response to Quality Improvement Plan, Poor budget management within operational teams, Delay in implementing and ongoing slippage OOT/SP reduction plans	Y 1 x 4 = 4 March 2020	1. Executive have committed to delivering mitigation plan, and confirmed appropriate and achievable 2. Ongoing executive discussions on cost pressures with individual Executive Director ownership and accountability 3. External placement recovery plan being reviewed and prioritised by COO 4. New Service Directors in place and undertaking leadership training to include financial management	Dec 19	Finance and Business Investment Committee	DC
	4.4	An imbalance between the pace of change required to address quality and safety issues, versus the need for long-term cultural change, undermines change efforts and results in disengaged staff, patients and stakeholders.	A 3 x 4 = 12	Cultural change programme overseen by Cultural Change Group led by NED. Regular reports to BoD. BoD reviews balance of financial sustainability and quality and safety requirements. FBIC provides deep dive scrutiny	BoD and committee oversight. Monthly Pulse reports Staff Survey Internal audit reports OAG and PRM Council of Governors CQC inspection NHSIE - exec to exec meetings, OAG/OSM	A 3 x 4 = 12 →	Balancing pace of change vs cultural programme with some parts of the organisation. Time and resource to adequately address quality and safety issues	Y 1 x 4 = 4 Oct 2020	1. Cultural Change programme cultural change work 2. Quality Impact Assessments for CIP and change projects, reviewed by Quality Committee 3. Phase 2 of Care Group management structure underway to provide capacity to address any outstanding issues 4. Quality Improvement approach to change projects	Dec-19	Quality Assurance Committee	JW

Jonathan Warren	JW	Sustainability & Transformation Partnership	STP
Diane Hull	DH	Health Overview & Scrutiny Committee	HOSC
Stuart Richardson	SR	Clinical Commissioning group	CCG
Mark Gammage	MG	NHS England	NHSE
Bohdan Solomka	BS	NHS Improvement	NHSI
Daryl Chapman	DC	Cost Improvement Plans	CIP
		Business Continuity Plan	BCP
		East London Foundation Trust	ELFT
		Non executive Director	NED
		Care Quality Commission	CQC
		Likelihood x Consequence	LXC

Memorandum of Understanding	MoU
Integrated Care System	ICS
Primary Care Networks	PCN
Workforce Race Equality Scheme	WRES
Workforce Disability Equality Scheme	WDES
Freedom to speak up Guardian	FTSUG

Strategic Objectives	Risk Ref	Risk Description	Inherent Risk Rating (LxC)	Existing Controls *(measures in place to reduce likelihood)*	Assurances on controls	Nov 2019 Risk Rating LxC	Gaps in controls and/or assurance	Target Risk Rating	Progress with actions to address gaps	Date for Review	Lead Assurance Committee	Lead
					Primary Care Network	PCN						
					Oversight and Assurance Group	OAG						
					Performance Review Meeting	PRM						
					Children & Young People	CYP						
					Service Users	SU						
					Remedial Action Plan	RAP						
					Access Improvement Team	AIT						
					Quality Improvement Plan	QIP						