



Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	25 September 2019	
Agenda Item:	P1/192/19	
Title:	Board Assurance Framework	
Report prepared by:	Angela Wendzicha, Associate Director of Corporate Governance	
Executive Lead:	Liz Bishop, Chief Executive	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Audit Committee
Date & Decision:	11 September 2019. Initial draft discussed at the Audit Committee. Recognition that the BAF is in development.

Purpose of the Paper/Key Points for Discussion:	<p>The Trust's Strategic Priorities for 2019/2020 were presented and approved at Trust Board on 27 March 2019 as part of the Operational Business Plan submitted to NHS Improvement.</p> <p>The six Strategic Priorities summarise the Trust's vision to provide the best cancer care to our patients which equates to delivering compassionate, safe and effective care.</p> <p>The attached paper illustrates the first draft of the revised Board Assurance Framework.</p> <p>Additional training is being delivered to inform and support the development of the BAF.</p>
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Action Required:	Discuss	X
	Approve	
	For Information/Noting	X

Next steps required	Further training and discussions taking place with the Executive Team in relation to action planning linked to the BAF.
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The paper links to the following strategic priorities (please tick)

Deliver outstanding care locally	√	Collaborative system leadership to deliver better patient care	√
Retain and develop outstanding staff	√	Be enterprising	√
Invest in research & innovation to deliver excellent patient care in the future	√	Maintain excellent quality, operational and financial performance	√

The paper relates to the following Board Assurance Framework (BAF) Risks

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	√
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	√
3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home.	√
4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care.	√
5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce.	√
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	√
7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future.	√
8. If we do not retain system-wide leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	√
9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	√
10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services.	√

Equality & Diversity Impact Assessment		
Are there concerns that the policy/service could have an adverse impact on:	YES	NO
Age		X
Disability		X
Gender		X
Race		X
Sexual Orientation		X
Gender Reassignment		X
Religion/Belief		X
Pregnancy and Maternity		X

If YES to one or more of the above please add further detail and identify if a full impact assessment is required.

BOARD ASSURANCE FRAMEWORK 2019/2020

Strategic Priorities

- | | |
|-------------------|---|
| Priority 1 | Transforming Cancer Care Through our New Clinical Model |
| Priority 2 | Retaining and Developing our Outstanding Staff |
| Priority 3 | Investing in Patient Focused Research & Innovation |
| Priority 4 | Taking a Leadership Role in Collaboration with Regional Care Bodies and Research Centres |
| Priority 5 | Be Enterprising |
| Priority 6 | Maintaining Excellent Quality, Operational and Financial Performance |

BOARD ASSURANCE FRAMEWORK DASHBOARD 2019/2020

Strategic Priority	BAF Risk	Executive Lead	Current Risk	Target Risk	Risk Score Q 1	Risk Score Q 2	Risk Score Q 3	Risk Score Q 4	
1. Transforming cancer care through our new clinical model	1.1 Failure to deliver CCC-Liverpool on time & within budget	CEO	20	8	20				
	1.2 We do not improve access to cancer care within 45 minutes travel for 90% of patients by 2020	COO	4	1	4				
	1.3 We do not ensure patients have seamless access to all supporting acute services	COO	20	3	20				
	1.4 Failure to complete the integration of haemato-oncology	COO	20	12	20				
2. Retaining and developing our outstanding staff	2.1 We do not recruit new staff for CCC-Liverpool and retain our excellent workforce	DoW&OD	25	16	25				
	2.2 We do not increase our clinical academic workforce in partnership with the University of Liverpool	MD	16	12	16				
	2.3 Failure to build on the feedback from the 2018 staff survey re staff engagement	DoW&OD	16	4	16				
	2.4 Failure to develop inclusive leadership	DoW&OD	12	4	12				

Strategic Priority	BAF Risk	Executive Lead	Current Risk	Target Risk	Risk Score Q 1	Risk Score Q 2	Risk Score Q 3	Risk Score Q 4	
3. Investing in patient focused research and innovation	3.1 We do not meet our target to double the number of patients recruited into clinical trials from a baseline of 500 per year	MD	16	12	16				
	3.2 We do not maintain our status as an experimental cancer medicine centre (ECMC) leading world-class early phase clinical research	MD	20	12	20				
	3.3 We do not maintain our excellence in digital leadership expanding the use of technology to support digital systems	DoF/MD	20	12	20				
4. Taking a leadership role in collaboration with regional care bodies and research centres	4.1 We do not secure transformational funding to drive an ambitious work programme through the Cheshire and Merseyside Cancer Alliance	CEO & DoF	6	4	6				
	4.2 We do not support improvements in regional outcomes.	CEO	16	12	16				
	4.3 We do not contribute to the national cancer plan to improve ten year survival rates from 50% to 57% by 2022	MD	16	12	16				
5. Be enterprising	5.1 We do not develop our subsidiary companies and Joint Venture to reinvest back into the NHS	CEO & DoF	9	6	9				
	5.2 We do not generate the remaining £5million charitable income towards the new hospital	CEO & DoF	25	12	25				

Strategic Priority	BAF Risk	Executive Lead	Current Risk	Target Risk	Risk Score Q 1	Risk Score Q 2	Risk Score Q 3	Risk Score Q 4	
6. Maintaining excellent quality, operational and financial performace	6.1 We do not complete the implementation of our CQC action plan. We are not prepared for CQC inspections	DoN	8	4	8				
	6.2 Risk we exceed the thresholds for harm free care.	DoN	12	4	12				
	6.3 Risk we do not meet the 62 day target resulting in delays to patient care and potential adverse reputational impact.	DoO	12	4	12				
	6.4 Risks we do not achieve the quality outcomes for the 2019/2020 CQUINs indicators.	DoN	9	4	9				
	6.5 We do not continue to achieve top declile results for patient experience.	DoN	16	12	16				
	6.6 We do not enhance patient safety by ensuring all risks are identified and managed.	DoN	10	5	10				
	6.7 We do not have robust Business Continuity Plans	All Execs	20	4	20				
	6.8 Financial Performce target not achieved.	DoF	16	9	16				
	6.9 We do not deliver on our transformation Schemes (CIP)	All Execs	12	6	12				

BOARD ASSURANCE FRAMEWORK 2019/2020
Transforming Cancer Care Through our New Clinical Model

BAF ID	RISK REGISTER REF:	EXEC OWNER	RISK OWNER	RISK DESCRIPTION	CONTROLS IN PLACE	GAPS IN CONTROLS	ASSURANCE IN PLACE	GAPS IN ASSURANCE	ACTIONS	Deadline	IMPACT	LIKELIHOOD	RISK SCORE	PREVIOUS SCORE	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score
1.1		CEO/DoF/DoO/DoW OD		Failure to deliver CCC-Liverpool on time & within budget	• Monthly reports to Board from TCC Programme Director Monthly Directorate Performance Reviews in place. TCC Monthly updates to each Directorate meeting	• Uncertain completion date of the new RLBUHT. • No formalised agreed SLA with RLBUHT in place. • Retain and recruit workforce for CCC-L. • Communications engagement with staff in preparation for the expansion to Liverpool.	Monthly TCC Board meetings Chaired by CEO.ED meetings established with RLBUHT. SLA in draft form with advice from Hill Dickinson. Workforce planning and new recruitment underway. Monthly review of workforce/recruitment plans via Finance Committee and WOD Committee.	RLBUHT have not confirmed completion date	• RLBUHT to open new hospital site and install 3 connecting link corridors to CCC-L. • Agree and sign SLA with RLBUTH. • To have workforce in place to open May 2020	May-20	5	4	20	New	20				8
1.2		DoO		We do not improve access to cancer care within 45 minutes travel for 90% of patients by 2020	Executive leadership with Director of Operations. Senior leadership with Clinical Directors and Matrons. Reported to Board as part of the monthly IPR through R function	None, exceeding target of 90%	Reported to Board as part of the monthly IPR. Current reports suggest current target of 90% is being exceeded	None	Ongoing monitoring against the target. Hub model implemented to achieve target	Apr-20	4	1	4	New	4				1
1.3		DoO		We do not ensure patients have seamless access to all supporting acute services	SLA with WUTH in place. Triage line in place providing guidance on where to send patients for treatment. Acute oncology presence in partner organisations linking patient care.	Patients who require critical care services are transferred according to NWAS criteria. Lack of link bridges in CC-L to RUBUTH. Lack of agreed escalation pathway for CCC-L	SOPs and SLA's in place to manage the deteriorating patient and access to non cancer specialists.	None	• Open CCC-L. Maintain current SLA provision. • New SLA agreed and signed with RLBUHT. • Workforce recruited to new CCC-L and RLBUHT. Develop TCC Programme in preparation for expansion into Liverpool.	May-20	5	4	20	New	20				3
1.4		DoO/MD/DWOD/DoN/DoF		Failure to complete the integration of haemato-oncology	Executive to Executive meetings in place with RLBUTH & CCC. SLA currently in place. CCC Exec presence and site visits. Identified Business Partners on site. IT presence on site. Digital Board oversees the IT integration. Monthly 1:1 with GMS CDs. Maintenance contracts in place. Medicine Management Lead aligned to haemato-oncology. Royal College of Pathology attending to provide expert opinion on move.	Haemato-oncology in-patient move date to be determined. Lack of critical cre agreement in place.	Clinically led risk assessment commenced to assess the timing of the move of haemato-oncology in-patients. Issue around timeliness of data received from RLBUTH.	Clinically led risk assessment may not be able to make a recommendation about the timing of the move of haemato-oncology in-patients	Open CCC-L, haemto-oncology in-patients may remain in current RLBUHT or CCC-L with supporting arrangements in place for either option. TCC leading on delivery of robust SLA for future move to CCC systems. Appoint to approved Deputy General Manager role. Royal College of Pathologists provide expert opinion. Clinical Senate providing support.	May-20	5	4	20	New	20				12

BOARD ASSURANCE FRAMEWORK 2019/2020
Retaining and Developing Outstanding Staff

BAF ID	RISK REGISTER REF:	EXEC OWNER	RISK OWNER	RISK DESCRIPTION	CONTROLS IN PLACE	GAPS IN CONTROLS	ASSURANCE IN PLACE	GAPS IN ASSURANCE	ACTIONS	Deadline	IMPACT	LIKELIHOOD	RISK SCORE	PREVIOUS SCORE	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score
2.1		DoW&OD		We do not recruit staff required for CCC-Liverpool and retain our excellent workforce, for all sites within the affordable business plan.	Workforce, Education and OD Committee bi-monthly oversight of Workforce for the Future Programme. CCC Board approved OD Strategy in place. TCC Board Oversight	Ongoing OD programme to be completed Workforce models incomplete e.g. model rotas. Education Programme to be finalised.	E-PADR to confirm site of working near completion. Well co-ordinated timed recruitment plan underway.	National staff shortages across a number of professions within the NHS.	Workforce in place to open CCC-L	May-20	5	5	25	New	25				16
2.2		MD/DoW OD		We do not increase our clinical academic workforce in partnership with the University of Liverpool	Monthly R&D PRGs established. LHP bi-monthly oversight. Quarterly meetings with University.	Succession plan required. Joint recruitment process with UoL.	Business case approved to appoint lecturer in haemato-oncology.	No succession plan in place	Expansion of cadre of strong academic workforce. Complete succession planning workign jointly with university HR. Medical Oncology Chair interview October 2019. Encourage Consultatns to hold honorary contracts with university. Specialist Registrars carry out research projects.	Dec-20	4	4	16	New	16				12
2.3		DoW&OD		· Failure to build on the feedback from the 2018 staff survey and do not improve our staff engagement score.	· Workforce & Education and OD Committee bi-monthly oversight. · Staff focus groups to be completed end September. Staff engagement group in place. · Corporate and Directorate action plans and regular monitoring. OD and Workforce Strategies approved by Trust Board. Quarterly staff 'Friends and Family'.	There is no demonstrable evidence of a wider adoption of staff values and behaviours.	Staff communications and engagement programme commenced. Programme of ED/NED/COG walkarounds. Exec visibility walkabouts commenced. Internal Communications Plan approved and monitored by CCC Board.	Requirement for Leadership development. Trust wide 'holding to account'	Develop travel plans to support staff. Develop recruitemnt and retention package for staff. Improved engagement scores in the 2019 staff survey.	Mar-21	4	4	16	New	16				4
2.4		DoWOD		Failure to develop an inclusive leadership	Equality and Diversity Strategy in place	Equality and Diversity Straegy not yet embedded. Equality and Diversity workforce meeting not yet established.	None	Workforce equality and Diversity meeting not established.	Establish and embed Workforce Equality and Diversity meeting reporting to Workforce and Education OD Committee.	Nov-19	3	4	12	New	12				4

BOARD ASSURANCE FRAMEWORK 2019/2020

Investing in Patient Focused Research

Investing in Patient Focused Research																			
BAF ID	RISK REGISTER REF:	EXEC OWNER	RISK OWNER	RISK DESCRIPTION	CONTROLS IN PLACE	GAPS IN CONTROLS	ASSURANCE IN PLACE	GAPS IN ASSURANCE	ACTIONS	Deadline	IMPACT	LIKELIHOOD	RISK SCORE	PREVIOUS SCORE	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score
3.1		MD	GHeap	We do not meet our target to double the number of patients recruited into clinical trials from a baseline of 500 per year	Monthly R&D PRG monitoring.	Insufficient research active clinicians with sufficient research PA's in job plans (target 80%). Shortage of radiologists. Reduction in allocated funding (£180K) from North West Coast Research Network for 2019/2020.	Consultant recruitment and job planning. Outsourcing routine scan reporting. Appointment of Site Reference Group leaders.	Inability to recruit academics or research active Consultants, national shortage of radiologists	Sufficient cadre of academics and research active clinicians and research delivery staff	Mar-21	4	4	16	New	16				12
3.2		MD	GHeap	We do not maintain our status as an experimental cancer medicine centre (ECMC) leading world-class early phase clinical research	Risk identified in draft Research Strategy . An Academic lead is in place.	Lack of approved overarching research CCC Research Strategy. ECMC bid writing group to be established	Focus groups underway to develop CCC Research Strategy. Professor Dan Palmer to lead the next ECMC bid	Links with risk relating to lack of support services (Radiologists).	Successful ECMC bid and retention of ECMC. Board discuss Research Strategy at Board Development day in October and sign off Research Strategy at November Board.	Mar-22	5	5	20	New	20				12
3.3		DoF/MD	S Barr	We do not maintain our excellence in digital leadership expanding the use of technology to support digital systems	Monthly Digital Board oversight	OD programme to support digital programme	CCC is part of the NHSE Global Digital Exemplar, securing funding and increased pace of change	CCC may not deliver the Digital Programme in full	Delivery of the Digital Programme	Apr-21	5	4	20	New	20				12

BOARD ASSURANCE FRAMEWORK 2019/2020

Taking a Leadership Role in Collaboration with Regional Care Bodies and Research Centres

BAF ID	RISK REGISTER REF:	EXEC OWNER	RISK OWNER	RISK DESCRIPTION	CONTROLS IN PLACE	GAPS IN CONTROLS	ASSURANCE IN PLACE	GAPS IN ASSURANCE	ACTIONS	Deadline	IMPACT	LIKELIHOOD	RISK SCORE	PREVIOUS SCORE	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score
4.1		CEO & DoF		We do not secure transformational funding to drive an ambitious work programme through the Cheshire and Merseyside Cancer Alliance (CMCA)	Bi-annual Board oversight of CMCA progress. CCC CEO is SRO for CMCA and chairs bi-monthly CMCA Board	Awaiting information about diagnostic capital programme for the region, and call for additional Innovation funds	NHSE has announced funding on fair share basis until 2024	CMCA are unsuccessful in securing additional funding	Successful bids for diagnostic kit and additional transformation programmes	Apr-24	3	2	6	New	6				4
4.2		CEO		We do not support improvement in regional outcomes.	CCC host to Cheshire and Mersey Cancer Alliance (CMCA). CMCA Programme oversight at bi-monthly CMCA Board. CCC has national leadership role in Rapid Diagnostics Service.	Closer alignment of surgical and non-surgical oncology	Two Lung Health Check programmes established. Screening programmes underway	System wide capacity and demand pressures e.g. radiology	CMCA can evidence improvement in early diagnosis	Mar-20	4	4	16	New	16				12
4.3		MD		We do not contribute to the national cancer plan to improve ten year survival rates from 50% to 57% by 2022	CMCA Programme oversight at bi-monthly CMCA Board	Closer alignment of primary care with secondary/tertiary care	Rapid Diagnostic Centre established. Two Lung Health Check programmes established. Screening programmes underway	System wide capacity and demand pressures	CMCA can evidence improvement in 10 year survival rates	Mar-22	4	4	16	New	16				12

BOARD ASSURANCE FRAMEWORK 2019/2020

Be Enterprising

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5.1		CEO & DoF		We do not develop our subsidiary companies and Joint Venture to reinvest back into the NHS	· Monthly Trust Board oversight. · Monthly JV and subsidiary Board oversight with ED and NED representation	None	· Five Year Strategy for CPL approved by Trust Board in January 2019.	Need Board approved strategy for ·· PropCare and Joint Venture	Strategies and plans for PropCare and JV to be approved by Board	Mar-20	3	3	9	New	9				6
5.2		CEO & DoF		We do not generate the remaining £5million charitable income towards the new hospital	Quarterly Charity Board oversight. Appeal Board in place	Small fundraising team. Challenge of fundraising in different geography prior to presence in Liverpool. Lack of Chair for Appeal Board	Increased CCC Charity team, with focus on donors and legacies. Increased marketing and PR in Liverpool geography. Current Trust Financial Plans include an element of contingency to cover any potential shortfall.	Lack of Chair for Appeal Board	£5m shortfall achieved	Mar-20	5	5	25	New	25				12

BOARD ASSURANCE FRAMEWORK 2019/2020

Maintaining Excellent Quality, Operational and Financial Performance

BAF ID	RISK REGISTER REF:	EXEC OWNER	RISK OWNER	RISK DESCRIPTION	CONTROLS IN PLACE	GAPS IN CONTROLS	ASSURANCE IN PLACE	GAPS IN ASSURANCE	ACTIONS	Deadline	IMPACT	LIKELIHOOD	RISK SCORE	PREVIOUS SCORE	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score
6.1		DoN		We do not complete the implementation of our CQC action plan. We are not prepared for CQC Inspections	Monthly CQC action plan monitoring with Quality Committee and Trust Board oversight	Embedding new Committee structure. Complete Haemato-oncology transition of services	CQC Quarterly Engagement meetings		Receive an improved CQC report 2020	Mar-20	4	2	8	New	8				4
6.2		DoN		Risk we exceed the thresholds for harm free care indicators (sepsis/falls/VTE)	· Falls collaborative · VTE policy.		Monthly reporting through IPR to Integrated Governance Committee, Quality Committee and Trust Board.	None identified.	Continue monitoring via committee structure	Ongoing	4	3	12	New	12				4
6.3		DoO		Risk we do not meet the 62 day target resulting in delays to patient care and potential adverse reputational impact to the Trust.	Increase in capacity when required. Weekly patient treatment list meetings with all specialities. Implementation of new National Policy.	Gaps in guidance relating to the National Policy. Gaps in medical workforce results in capacity issues when additional clinics are required. Timely access to diagnostics by LC Labs.	Escalation process in place for any delays. Monthly reports to Performance Committee and Trust Board.	None identified.	Continue monitoring via committee structure	Ongoing	4	3	12	New	12				4
6.4		DoN/DoF		Risk we do not achieve the quality outcomes for the 2019/2020 CQUINs indicators	CQUIN working group in place. Reports to Performance Committee	None Identified	Monitoring via Performance Committee	None identified.	Continue monitoring via committee structure	Ongoing	3	3	9	New	9				4
6.5		DoN		We do not continue to achieve top decile results for patient experience	Patient Involvement & Experience Group established and COG PPI/E group oversight. · Patient Experience Strategy approved by Trust Board	Trust action plan to be developed	Consistent high scores (>95%) in outpatient and in-patient Friends and Family Tests	Time lag with national patient surveys	Embed Trust Patient Experience and Inclusion Group.Improved patient feedback as evidence by national patient survey and Patient Friends & Family Test. Sustain liaison with Governors re Patient Experience.	Mar-20	4	4	16	New	16				12
6.6		DoN		We do not enhance patient safety by ensuring all risks are identified and managed	Monthly Quality Committee and Board oversight	Embedding new governance framework. Complete Haemato-oncology transition of services	Daily incident review meeting established July 2019. Training in incident reporting September 2020 by AmberWing. Risk Management Committee chaired by the CEO	None identified	Enhanced patient safety as evidenced by KPI's e.g. zero never events, no increase in SUI's and complaints	Oct-19	5	2	10	New	10				5

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6.7		DoN/DoF/DoO/MD/DoWOD		We do not have robust Business Continuity Plans	Full scoping to be completed	No established process for review and monitoring of Business Continuity Plans	None identified	Reporting and escalation process needs to be agreed.	Agree process and escalation process and implement. Report through Risk Management Committee.	Nov-19	4	5	20	New	20					4
6.8		DoF		Financial performance target not achieved	· Monthly Directorate Review meetings in place · Agency cap monitored monthly · Agreement of control total for 2019/2020 with NHSI	None identified	Trust Board have sight of the Financial Planning and Capital Plan	Changing financial landscape may result in combined control totals	Continue monitoring through committee structure	Ongoing	4	4	16	New	16					9
6.9		All		We do not deliver on our transformation schemes (CIP)	Monthly Performance meetings with Exec oversight. Performance Committee and Board oversight. Monthly meetings with Finance Business Partners.	Transformation currently focused on new build and not financial delivery	Trust Board oversight on CIP delivery. Actual financial performance relative to planned forecast.	None	Continue with montly oversight meetings and escalation where target off plan	Mar-20	4	3	12	New	12					6