Whittington Health NHS

Board Secretary and Business Manager
Direct Line: 020 7288 3589
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

WHITTINGTON HEALTH TRUST BOARD

28 November 2012

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<tr><td>Title:</td><td colspan="7">Board Assurance Framework 2012/13</td></tr>
<tr><td>Agenda item:</td><td colspan="3">13</td><td colspan="2">Paper</td><td colspan="2">H</td></tr>
<tr><td>Action requested:</td><td colspan="7">For discussion and agreement</td></tr>
<tr><td>Executive Summary:</td><td colspan="7">The BAF has been updated following the Audit and Risk Committee meeting on 8 November 2012. The. The top five risk areas are now considered to be:
• Risks associated with Cost Improvement Programmes
• Risks associated with the FT application (New)
• Workforce issues
• Risks associated with delivering transformation and LEAN
• Meeting the A&E 4 hour target (New)

Further work is required to join up the BAF to the work of the Quality Committee and for the BAF to reflect the most important quality risks.</td></tr>
<tr><td>Summary of recommendations:</td><td colspan="7">The Board is asked to:
• Note the addition of two new key risks to the BAF
• Discuss and agree the top five risks for the Trust
• Confirm assurance on mitigating actions
• Ensure that the BAF provide the evidence that the Audit and Quality Committees are “joined up”.</td></tr>
<tr><td>Fit with WH strategy:</td><td colspan="7">The BAF provides assurance to the Board that key risks to the achievement of the Trust's strategy are identified and effectively managed.</td></tr>
<tr><td>Reference to related / other documents:</td><td colspan="7">Corporate Risk Register, Risk Management Strategy</td></tr>
<tr><td>Date paper completed:</td><td colspan="7">21 November 2012</td></tr>
<tr><td colspan="2">Author name and title:</td><td colspan="2">Dr Yi Mien Koh
Chief Executive</td><td colspan="2">Director name and title:</td><td colspan="2">Peter Freedman
Chair of Audit and Risk Committee</td></tr>
<tr><td>Date paper seen by Audit Committee</td><td>n/a</td><td>Equality Impact Assessment completed?</td><td>n/a</td><td>Risk assessment undertaken?</td><td>yes</td><td>Legal advice received?</td><td>n/a</td></tr>
</table>

Whittington Health Board Assurance Framework 2012/13

28 November 2012

1. Introduction

1.1. The Board Assurance Framework (BAF) forms part of Whittington Health's risk management systems and processes to assure the Board of Directors that the key risks that may threaten the delivery of the Trust's five strategic objectives are identified and being effectively managed.

1.2. The BAF brings together all of the key risks in a single management tool. The Audit and Risk Committee, informed by internal auditors, has oversight of Trust's risk management system and is responsible for reviewing the overall operation of the BAF.

1.3. The BAF is reviewed monthly at every Trust Board meeting to enable the Board of Directors to evaluate the assurance across all areas of key risks, to review the current risk scores in relation to each strategic objective, to track the actions being taken to close the gaps in controls, and to put in place plans for corrective actions where there are gaps in controls and/or assurance.

2. Areas in the BAF that have changed compared to the version reviewed by Audit and Risk Committee on 8/11/12 (highlighted in red)

2.1. Key risk 1.1 – Business development post and Trust marketing strategy

The Audit and Risk Committee was concerned to hear that this post is the subject of a Cost Improvement Programme (CIP) as its creation was regarded as a key control to mitigate this risk. Executives agreed to reinstate the post and will recruit to it in March 2013. Meanwhile, the trust will commission a competitor and market analysis for the purpose of informing the IBP and our growth strategy.

2.2. Key risk 1.2 – Quality and timeliness of performance reports

Under "Controls", the new Head of Performance started on 3/9/12. Deadline for implementation of new reporting format has been delayed by a month to 28/11/12. Historic Due Diligence stage 2 will provide independent assurance when it reports on 23/11/12.

2.3. Key risks 2.1, 3.5 and 4.1 – Quality governance

The BAF dated 31/10/12 reviewed by the Audit and Risk Committee found gaps in controls and assurances under the main quality-related key risks (2.1, 3.5 and 4.1). The gaps have been reduced as follows:

Key risk 2.1 - Divisional risk registers not sufficiently focused on quality risks *have been replaced with* Divisions are implementing a standard Terms of Reference to ensure a robust governance structure that will give more focus to quality risks. More staffs are being trained in Root Cause Analysis to increase the numbers in the pool of trained investigators. This in turn should clear the backlog of Serious Incidents and Complaints awaiting investigations. The Transforming Patient Experience (TPE) project which sets out to improve outpatient processes is being led by Maria DaSilva.

Key risk 3.5 The risks are about the costs (efficiency), affordability and impact on quality of maternity services. The "key risk" of suboptimal care environment has been reworded to reflect the implications of doing nothing. Workforce planning of midwifery skill mix is based on adopting NHS London's standard of 1:30 midwife to birth ratio.

Key risk 4.1 This is a **NEW** key risk area, due to the trust's **inconsistent performance in meeting the critical A&E 4 hour target**. An interim ECIST programme manager started on 1/9/12. Progress has been slow due to organisational change and leadership issues in Emergency Department (ED). New clinical and managerial leaders are expected to drive improvement and compliance.

2.4. Key risks 3.2 and 3.4 – Change of due date from 30/9/12 to 31/3/13 due to CIPs performing behind run rate (3.2) and needing more time to close the efficiency gaps in future years with sufficiently robust CIPs (3.4).

2.5. Key risk 4.2 – Quality impact of CIPs

The narratives describing the key risk have been reworded. Our local Clinical Commissioning Groups (CCGs) were concerned about the quality impact of some of the CIPs and sought independent assurance from NHS London (which had been reviewing our submission). The SHA was able to provide the reassurance.

2.6. Key risk 5.1 – **Progress with FT application** (**NEW**)

Last week, the Trust Board took the decision to delay our FT application process by three months following a stock take by the Board on our readiness. The SHA Board to Board scheduled for 23/11/12 has now been postponed to 21/2/13. To strengthen our submission to the SHA by the new deadline of 26/1/13 and to help the board to prepare for the B2B, we have secured external support as a control assurance. The pause also gives us more time to hone our strategy and financial plans, engage with staff and stakeholders, and secure CCG support.

2.7. The Audit and Risk Committee asked the Executive Committee (EC) to consider having IT related risks included on the BAF, noting that the EPR project risk register had a number of risks rated 16 and above and therefore should be included as a risk in its own right. The EC has also been asked to review if the top three IT risks, including disaster recovery and community infrastructure, would merit inclusion.

The IT risk relating to disaster recovery was removed from the BAF in the September Board meeting following the Audit and Risk Committee meeting on 13/9/12 due to reassurance provided about our IT Disaster Recovery Policy.

3. The Top Five Risk Areas

The following areas have been identified as the top five risks for the Trust. The Board is asked to discuss and agree this list.

3.1. Cost Improvement Programmes (CIPs) risks

- If we miss this year's CIPs target of £13.1 million significantly (>10%), we may fail to meet our overall financial targets for the year, putting at risk our Monitor risk rating and FT application. The amount of CIPs required in future years will also increase. (Key Risk 3.1)

- The CIPs for 2013/14 and 2014/15 are now detailed down to Project Initiation Document level, thereby enabling the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) to be modelled. Medium to long term, consultants and other staff need to engage in the transformational work programme to drive down costs, or the CIPs will not be realised. (Key Risk 3.2)

3.2. Commissioner support for Integrated Business plan (IBP)

- If commissioners do not support our Integrated Business Plan (IBP), our FT application will fail. To achieve commissioner alignment, the Trust has agreed to flat activity growth in the IBP which increases the CIPs required. This means reducing costs to below average reference costs from 2014/15, a timescale which poses further risks. We are in the process of negotiating with commissioners for demographic growth (Key risk 1.1)

- If GPs and patients do not believe that all of our services are available and accessible, of high quality and good value, the Trust may lose market share through Patient Choice, Any Qualified Provider and market testing. (Key risk 4.3)

3.3. Workforce risk issues

- If consultants and other staff are not engaged in redesigning pathways, improving processes and changing the way they work, we will not be able to deliver our CIPs and make progress on all of our strategic objectives. (Key risk 3.1)
- Management capacity is stretched and unsustainable for longer than the short term. (Key risk 5.2)
- We need to have robust workforce plans that develop the organisation and translate the efficiencies in the CIPs into required workforce capacity and capability. (Key risk 5.2)

3.4. **FT application risks**

The Trust Board decided last week to delay our Foundation Trust (FT) application by three months to allow more time to strengthen a number of key aspects of our strategic and financial plans. We are working in a very difficult financial climate and have to have robust plans in place to demonstrate we are a financially sound organisation. We want to take the extra time to ensure our staffs, commissioners and stakeholders are fully engaged with the process.

3.5. **CQC Essential KPIs - A&E 4 Hour Target** (Key risk 4.1)

Not meeting this target undermines our whole strategy as an integrated care organisation. New clinical and managerial leaders in the Emergency Department are expected to drive improvement and compliance.

3.6. The following **risks were removed** from the BAF following the Audit and Risk Committee meeting:

- Key risks 3.4 and 5.5 both relate to longer term CIPs in terms of crystallising and delivering transformational projects. Key risk 5.5 has been deleted.

3.7. The following **movements in residual risk scores** were made:

- The risk score for Key risk 4.1 was increased from 16 to 20 to reflect the risks to reputation and compliance should we not meet the A&E 4 hour target consistently every quarter.

4. Recommendations

4.1. The Board is asked to:

- Agree that the BAF reflects the current risks to Whittington Health
- Discuss and agree the top five risks for the Trust
- Confirm assurance on the mitigations underway to ensure risks are effectively managed
- Ensure that the BAF provide the evidence that the Audit and Quality Committees are “joined up”.

YI MIEN KOH **21 November 2012**

Five Year Strategic Goals	2012/13 Corporate Objectives	Ref	Key Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Likelihood	Impact	Initial Risk Score	Controls *The systems and processes in place that mitigate the risk*	Management Assurance *What are we doing to manage the risk and how this is evidenced - how and when this will be reported to the board?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Likelihood	Impact	Residual Risk Score	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking and need improved reporting on assurances*	Action Plans *to address gaps in control/assurance*	Due Date	Target Risk Score
1. Delivering integrated care models across Whittington Health	1a. Collaborating with GPs, social services and other NHS providers to deliver integrated care strategy 1b. Improving data quality and developing metrices to enable real time monitoring and reporting of performance 1c. Improving communication with GPs by having electronic communication as standard and using a GP portal	1.1	If we fail to secure the support for our IBP from GPs as commissioners and primary care providers, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	GB	4	4	16	Primary Care Engagement strategy Trust Marketing Strategy (to be developed) Membership of Haringey and Islington Integrated Care Programme boards (focus on transforming services through integrated care) Joint NCL/WH Transformation Board workingcollaboratively with CCGs to commission service transformations Two year block contract for 2012/14	Feedback from GP practice visits Head of Performance started 3/9/12 Appointing a Commercial and Business Development Manager Developing Primary Care Engagement and Trust Marketing Strategy Deep dive into GP engagement by Audit Committee 13/9/12	SHA B2B due 21/2/13	3	4	12	Primary Care Engagement and Trust Marketing Strategy Recruitment of Commercial and Business Development Manager Directory of services Implementation of GP electronic communications Actions delayed. Original due date 31/10/12	Primary care engagement strategy Trust to commission a rapid competitor and market analysis to inform the IBP and our growth strategy Primary Care engagement and Marketing Group to have first meeting on 10/12/12 Business Development Manager post to be appointed in March 13	31/03/2013	4
		1.2	If we do not improve the quality, completeness and timeliness of performance reports, then we may lose the support of commissioners who value more detailed data, we may be unable to correct performance issues in a timely manner and our FT application may fail.	MdS RM	3	3	9	Performance Manager Post responsible for dashboard development Monthly Trust Board and Divisional Dashboards EPR project information workstream Implementation of Qlikview reporting tool		Audit Commission's data quality audit MQGF RMS Tenon report HDD1 Deloittes report HDD2 Report due 23/11/12	3	3	9	Implementation plan to ensure commissioners receive timely and complete performance information Evidence that dashboards are fully compliant. Actions delayed. Original due date 31/10/12	Head of Performance started 3/9/2012 Performance Framework being developed and presented to Trust Board at November meeting.	28/11/2012	4
		1.3	If commissioners are unable to realise the benefits of having an ICO in the sector to control demand, our CCGs could become insolvent, then they will not be able to afford our services and the Trust will not be viable as an FT	RM	3	5	15	NCL Whittington Health Transformation Board Commissioner alignment with IBP	Performance monitoring of activity Contractual monitoring and Clinical Quality Review Group Convergence letter from NCL and CCGs		2	4	8	Influence on patient demand by GPs and provision of primary care services, and supply by other providers outside of WH control	Primary care development plans implemented by CCGs	31/12/2013	8
2. Ensuring "no decision about me without me"	2a. Improving the patient experience by one quartile as measured by national patient surveys 2b. To enable 50% of all communication with patients to be sent by electronic media in 2012/13 and 75% by 2013/14 2c. Achieving 100% of discharge letters to be sent to GPs and patients within 2 working days 2d. Clinical transformation projects to put patients at the centre of their own recovery	2.1	If we lose focus on safety and patient experience at the time of cutting costs, then our main business of caring, patient safety and quality of care could be put at risk. If we do not improve patient experience e.g. performance of outpatient survey in 2011/12 improved but was still poor, patients may choose other providers over us, we will lose business and the Trust's viability will be put at risk.	BS	3	4	12	All CIPs must pass quality impact assessment criteria to go forward Patient Experience strategy Transforming Patient Experience (TPE) project to improve patient administrative processes especially in outpatients Complaints and Serious Incident (SI) reports Implement Friends and family test from 1/4/2013 (Testing from December 2012) Nurse Rounding, Matrons Conversations	Quality Committee and feeder subcommittees	CQC reviews National Patient Surveys Hospital mortality indicators (SHMIs) LINKS and Healthwatch	3	3	9	Divisions are asked to adopt a standard Terms of Reference that will ensure a robust governance structure including a greater focus on quality risks. Additional staff are being trained in Root Cause Analysis from December so that more people are able to conduct reviews of complaints and SIs to clear the backlog. MDS is personally taking charge of implementing the TPE project	Quality Committee is requiring Divisions to present at each meeting their Clinical Risk Register along with actions being implemented to mitigate risks. Clinical risk registers being developed separately from divisional risk registers by 21/11/12. Timetable to roll out RCA training has been agreed. WCF and SCD have agreed timetable to clear backlog.	Bi-monthly review by Quality Committee	8
		2.2	If there is non compliance with information governance Toolkit requirements this would adversely affect CQC assessment, FT application requirements and we will be failing in our statutory obligations	RM	3	4	12	Information Governance (IG) improvement plan to meet level 2 IG toolkit compliance, by time of FT authorisation, monitored by Information Gov Committee (IGC)	IG Issues Log and Risk Register monitored at IGC Senior Information Risk Officer (SIRO) in post Caldicott Guardian in post Deep dives into IG at Audit Committee on quarterly basis	Audit Commission PbR annual review Parkhill annual IG toolkit review Decision by Information Commissioner about two SIs involving data loss 20/11/12	3	4	12	Information Asset Register with asset owners established Network Security policy EPR IG assurance Data Quality improvement system and process implemented Mandatory IG Training only 66% complaint – OCT 2012	Additional 1.4 wte IG resource from Sept / Oct 2012, includes: New Performance Manager to focus on achieving compliance of IG information asset owners system IT Director to develop IG toolkit compliant IT and Network Security policy, EPR IG compliance Data Quality group established Ongoing staff training and communications on IG - monitored weekly against 95% target	NHSLA Level 2 by Marc 2013	4
3. Delivering efficient and effective services	3a. Meeting key national performance indicators, targets and standards 3b. Achieving statutory financial duties including financial targets to maintain a Monitor Risk Rating >3 3c. Delivering £13.1 m Cost Improvement Programmes (CIPs) 3d. Full implementation of Service Line Management (SLM) 3e. Achieving productivity levels equal to the peer group average as measured by the Reference Cost Index (RCI)	3.1	If we fail to engage our consultants and other staff, then we will not be able to deliver the benefits of our strategy (including CIP programmes, pathway redesign, improvements in patient admin processes)	MDS BS MB	4	4	16	Staff engagement strategy includes communications, alignment meetings etc Divisional structure Implementation of SLM TPE programme board Visible leadership at all levels	Deep Dives into staff engagement by Audit Committee 7/3/12 & 13/9/12	Staff survey indicates engagement in top 20% of trusts	3	4	12	More evidence of staff engagement and monitoring of progress Board site visits	Quality Committee members undertaking visits to Divisions bi-monthly commencing October 2012. Quality Committee will receive feedback reports from visits at each bi-monthly meeting meeting Patient Safety Walkabout programme revised and approved by Quality Committee in September 2012. Safety walkabout programme shared with Trust Board and Executive Committee and Divisions in September. Reminders will be sent monthly and quarterly reports will be provided to Quality Committee	Monthly review of KPIs by TB, Quarterly Patient safety reports to Quality Committee	6
		3.2	If we miss our CIP targets significantly (>10%), then we may fail to meet our overall financial targets for the year, our Monitor risk rating and FT application are at risk, and we will lose the support of cour commissioners and partners	MDS	4	5	20	More robust management of CIPs CIP Programme Management Office CIP Programme Manager Improvement in accontability Board visibility through Finance and Development Committee	CIP Board monitors CIP implementation progress weekly, reporting to EC and F&D Committeee Monthly reporting to TB on CIPs Monthly Service Line reporting showing position compared to reference costs	Internal Audit reports into CIPs governance processes External review of CIPs' robustness as part of HDD2	4	4	16	Review and potential release of unallocated cost pressures budget Reinstatement of vacancy scrutiny panel Trust Board to have greater visibility over the risks associated with CIPs plans Project initiation documents (PIDs) required for every CIP	Develop a CIPs Risk Register that is reported monthly to the TB Overdue date 30/9/12 Update 2012/13 CIP programme with substitute schemes Fully identify CIP plans for 2013/14 and 2014/15 and PIDs completed. CIP programme agreed and implemented. Overdue date 30/9/12 CIP Board terms of reference amended to reflect accountability to Finance & Development Committee completed by due date 30/9/12	31/03/2013	9

Five Year Strategic Goals	2012/13 Corporate Objectives	Ref	Key Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Likelihood	Impact	Initial Risk Score	Controls *The systems and processes in place that mitigate the risk*	Management Assurance *What are we doing to manage the risk and how this is evidenced - how and when this will be reported to the board?*	Independent Assurance *External evidence that risks are being effectively managed (e.g. planned or received audit reviews)*	Likelihood	Impact	Residual Risk Score	Gaps in Controls or Assurance *Where an additional system or process is needed, or evidence of effective management of the risk is lacking and need improved reporting on assurances*	Action Plans *to address gaps in control/assurance*	Due Date	Target Risk Score
		3.3	If future London-wide service reconfigurations (e.g. cancer, pathology) result in a significant amount of our activity being decommissioned, then we may not be viable as an FT	MK	4	4	16	Benchmark our services to ensure we are as efficient as possible while maintaining high quality Ensure we meet service standards including patient experience Explore joining Pathology JV Partnership once preferred bidder is known		External service reviews e.g. cancer peer reviews, NHSL pathology reviews	3	4	12	This is an external strategic decision not within our control		ongoing	9
		3.4	If we are not able to identify sufficient detailed CIP schemes to meet our cost reduction targets from 2013/14 onwards, then we will not be viable as an FT.	MDS	4	5	20	Use of SLM and Reference Cost Indices as benchmarks to set CIP tagrets	CIP Board monitors CIP implementation progress weekly, reporting to EC and F&D Committeee Monthly reporting to TB on CIPs Monthly Service Line reporting	HDD2 and HDD3	4	4	16	SHA recommends modelling the downside risks of top five CIPs Top 5 risks must not exceed 12% of income (£33-35m)	CIPs Plan for 2013/14 onwards All CIPs have now detailed PIDs. IBP. Missed original due date of 30/9/12. New deadline set at submission date to SHA	31/03/2013	9
		3.5	If there is no coherent maternity strategy for NCL that gives confidence about the future of maternity services in the Whittington, then we will not be able to make the business case for additional investments in the maternity care environment. If we do not improve our care environment, women may choose to not come here, which further reduces the margin of our maternity services. If we do not increase the efficiency of our maternity services, it will impact on the financial viability of the service/Trust.	MK BS	3	4	12	Benchmarking the costs of our obstetric and midwifery services show the Trust to be more expensive than average and also have one of the lowest decile birth:midwifery ratio in the country	Sharing this information with staff to stimulate action to improve productivity	NHSL audit of maternity services CNST level 3 assesment. Annual Midwifery supervision audit. Independent review of womens experiences undertaken by Trust Governors	3	4	12	The workforce planning of effective staffing levels and practices is based on meeting the NHS London standards of 1:30 midwife to births ratio.	Review of Midwifery to birth levels to ensure staffing ratio remain within national guidelines. Midwives reviewing ways of working and roles of managers and staff.	30/12/2012	9
		3.6	If we do not fully implement Service Line Management (SLM), then consultants will not know where and how to cut costs, and both our CIP and overall financial targets will be at risk	RM	4	5	20	Structured roll out of Service Line Reporting (SLR) to clinical leads Training sessions provided for Divisional Directors, Clinical Directors and Clinical Leads on how to interpret SLR reports CLs and CDs use SLR data to reduce costs to level of RCI = 100 by 2014/15	Finance & Development Committee remit includes monitoring of SLM implementation SLM reports reviewed monthly at TB to include names of CLs Evidence of SLR data being used to inform decision making Audit Committee deep dives into SLM	Historic Due Dilligance (HDD) Stage 2 due started 22/11/2012	3	4	12	Evidence that adequate financial support is being provided to service line CLs to achieve ownership of service line performance	Audit Committee deep dive with evidence of project plan to roll out Patient Level Information Costing (PLIC) to every consultant	30/11/2012	6
4. Improve the health of local people	4a. Maintaining top decile safety record as measured by standarised Hospital Mortality indicator (SHMI) and other mortality indicators 4b. Operating a 7 day organisation 4c. Improving compliance with local targets including CQUINS as measured by step change in RAG ratings 4d. Meeting waiting times targets for community services, notably musculo skeletal, physiotherapy and podiatry services	4.1	If we fail to meet quality and safety standards including CQC essential targets (KPIs), ED and cancer waiting times and maintain or improve our performance in patient safety and patient experience, then our patients may be experiencing poor care, our reputation will suffer, and our CQC licence and FT application are both at risk. If our ED performance does not improve and we do not achieve the 95% A&E 4 hour standard, our reputation as an integrated care organisation is undermined, putting our FT application at risk.	MK BS MDS	4	4	16	Weekly monitoring of Serious Incidents by Executive Committee Patient Safety Thermometer Quality Committee and feeder subcommittees Weekly monitoring of all KPIs, action plans and trajectories by Operations Board with escalation to Executive Committee Quality Committee	Infection control audits and quarterly DIPC reports Patient surveys reported to Quality Committee Patient stories at TB Regular review & monitoring by Quality Committee, incl board walk-abouts Divisional Performance Dashboards Pe	CQC reviews ECIST review visit in May 2012 National patient surveys	4	3	12	Evidence that ECIST action plan is being implemented Interim ECIST Programme Manager started 1/9/12 Programme Manager Head of Performance started 2/10/12 New ED manager to be appointed in 12/12	Action plans for improvement to ED and outpatients ECIST action plan Performance report to TB Trust Performance Framework being developed and presented to November Trust Board	Quarterly reviews by Quality Committee Monthly review by TB	6
		4.2	Due to the minimal levels of revenue growth included within our financial plans, we have to generate higher levels of CIPs. The CCGs are concerned at the quality impact of the CIPs and seek assurance that quality will be maintained with the siginificant CIPs planned.	RM	4	4	16	Use of detailed planning templates to back up growth proposals Engagement of CCGs in developing growth plans		Written expressions of support from CCGs for growth plans HDD1 (completed) and HDD2 to be compled	4	4	16	Assurance provided to CCGs about the quality and safety aspects of the CIPs by NHS London (Mark Brice)	Convergence letter from CCGs agreeing to growth plans This was due 24/9/12.	7/12//12	8
		4.3	If GPs and patients do not believe that all our services are available and accesible (i.e. have short waiting times), of high quality and good value, then we may lose market share through Patient Choice	MDS BS MK	4	4	16	Focus must be to ensure that services meet the expectations of patients and commissioners notably waiting times Differentiate our services by offering care models of high quality and lower costs to become provider of choice Offer discounts to minimise loss as last resort GP Directory of services	Monitoring of market share indicates no significant losses to date	Feedback for Haringey CCG 31/10/12 of disatisfaction	4	4	16	Feedback from GPs indicates that WH is at risk of losing market share to neighbouring Trusts which have shorter waiting times and are developing more accessible services e.g. direct telephone calls to consultants	Pathway redesigns have to produce better quality services at lower costs, that will allow the Trust to be the preferred provider for local GPs. Provision of activity and waiting times data to GPs	Review by F&D committee	8

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5. Fostering a culture of innovation and improvement	5a. Adoption of an innovation Strategy 5b. Achieving Foundation Trust Accountability Agreement milestones 5c. Delivering service transformation as set out in QIPP programme 5d. Adoption of LEAN across the Trust and meeting Unipart project milestones 5e. Implementation of workforce and staff engag	5.1	If the FT programme is not well planned and managed, then we may miss our TFA deadlines and fail our FT application	RM	4	4	16	FT programme plan Monitoring of progress by FT Programme Steering Group	FT Programme reports Self assessments Progress update on action plan	Internal Audit report on FT programme External Audit report MQGF report by RMS Tenon BGAF by E&Y Working capital by KPMG	3	4	12	FT programme manager to maintain an FT Risk Register that is presented monthly to the TB TB to ensure the risks within the IBP map to the BAF or Corporate Risk Register with an escalation process Integrated risk management system (Datix) installed in October 2012. Training to be rolled out in batches over next six months. Support of Edward Lavelle in preparing the FT submissionto the SHA on 26/1/13 amd SHA B2B on 21/2/13	Action plans developed in response to all external review reports All risks identifed within the IBP to be modelled in full and FT Risk Register to be presented to the TB monthly	Monthly review by TB	8
		5.2	If we are unable to fully implement our workforce strategies (e.g. for efficiency, engagement, skill mix), then we will not be able to deliver cost savings or service transformation and will not be viable as an FT. Management capacity is stretched and unsustainable for longer than the short term.	MDS MK BS	4	5	20	Workforce strategies including Nursing, Midwifery and AHP strategy Staff engagement strategies Benchmarking and use of RCI to set productivity targets by service lines raise financial awareness among staff Participation in NHSL productivity improvem	Monitoring of workforce statistics	Annual staff survey	4	5	20	Evidence of staff engagement strategies being implemented Additional management capacity required especially to support implementation Independent assurance that workforce plans are fit for purpose Feedback from staff consultations on organisational change	External support on workforce and organisational development plans procured and to start 26/11/12 Review of management capacity	Quarterly Review by Audit & Risk Committee	12
		5.3	If the quality of teaching is not excellent, then commissioners (UCL, Middlesex and LETB) may not renew their teaching contracts. This will not only lead to a loss in income, it may lead to loss of trainees who are a critical part of service delivery.	MK	3	3	9	Prograduate Medical Education Board chaired by Director of Education oversees the quality of training Feedback to consultants on teaching quality	Ensure that consultants' job plans include teaching	External reviews by the Deanery and Royal Colleages Annual GMC survey of trainees	3	3	9	Transition from Deanery to LETB		Annual report to TB	6
		5.4	If we do not continue to improve the uptake of mandatory training, then we are in breach of our corporate responsibility as an employer, we are at risk of litigation should accidents happen, our patient care may suffer and our FT application may fail. If we do not improve the quality of ESR which makes it hard to assess the extent of training and appraisals, we will be under-recording and under-reporting our performance.	MK	5	3	15	Personalised e-mail reminders are sent to staff on outstanding training requirements Message to all staff that individual performance on mandatory training will be included in appraisal discussion Divisional Directors to agree to not pay thresholds if mandatory training not completed and no clear reason given Monitoring of uptake by TOB			4	4	16	Mandatory Training Policy to be implemented consistently and implementation to be monitored Data quality from ESR is unreliable and needs improving.	Individual and peer comparison feedback to staff in leadership roles. Move to weekly updates of mandatory training compliance on intranet.	Monthly report to TB in performance dashboard	9