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Whittington Health Trust Board

24 July 2013

Title:	**Board Assurance Framework 2013/14**		
Agenda item:	**13/111**	**Paper**	**11**
Action requested:	To note		
Executive Summary:	The Board Assurance Framework provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important annual objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls.		
Summary of recommendations:	The BAF was presented to the Audit and Risk Committee on 11th July 2013 and the following requirements were discussed and action agreed by the committee: • Additional controls and actions required to reduce the risk to under achievement of CIP delivery • Addition of action under 5.2 to include transferring of skills of interim staff into the organisation • Addition of action under 2.2 to include continued widespread community engagement • Board seminar on risks to potential service reconfigurations to be scheduled for October 2013 • Updates to 3.6 (SLM risk), 3.7 (tariff deflator) and 3.10 (risk management) required. Following the Audit and Risk Committee the following amendment has been made: • Downgrade of risk impact of Electronic Patient Record go-live following assurance from Director of IT at Audit and Risk Committee. The rationale for this is the ability for rapid and early revert to existing system in the event of adverse effects during launch.		
Fit with WH strategy:			
Reference to related / other documents:			
Date paper completed:	03/07/2013		
Author name and title:	**Louise Morgan Trust Secretary**	**Director name and title:**	**Yi Mien Koh Chief Executive**

Date paper seen by EC	**16/07 /2013**	**Equality Impact Assessment complete?**	**No**	**Risk assessment undertaken?**	**Yes**	**Legal advice received?**	**No**

Strategic Goal	Ref	Corporate/Principle Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Current risk rating: Impact	Likelihood	Risk Score	Movement from 16 May 2013	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)*	Target risk rating: Impact	Likelihood	Residual Risk Score	Gaps: 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
NHS Outcomes Framework 2013/14 Domain 2: Enhancing Quality of life for people with long term-conditions																
1. Integrate models of care and pathways to meet patient needs	1.1	If we fail to secure support for our IBP from our commissioners, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	YMK	4	4	16	⇨	1. Partnership Transformation Board meets monthly and includes senior leaders from Haringey and Islington CCGs. 2. CCGs actively involved in shaping the IBP. 3. Informal contacts with CCGs by exec and non-exec members of TB	1. New engagement arrangements to ensure CCG convergence with service developments, activity and income assumptions included in any revised LTFM and IBP. 2. Status of engagement with CCGs and leaders regularly reported to the TB by CEO, Director of Planning, DoF etc.	1. CCG Convergence letter signed by CCGs Feb 2013. 2. Two year block contract with commissioners extends through 2013/14 2. Visibility and governance of transformation board	4	2	8	1. Systematic engagement with CCGs in relation to next iteration of IBP to be finalised 2. Convergence letter from CCGs for new IBP 3. CCG engagement limited to Haringey and Islington which only accounts for 85% of activity	1. CCGs to attend FT Steering Committee 2. Appointment of a Contract and Business Development Director to build relations with other CCGs	Sep-13
	1.2	If we fail to maintain ongoing support from GPs as primary care providers and sources of referrals, then we will not be able to maintain (let alone grow) our market share or transform clinical services.	GB	4	3	12	⇨	1. Regular two way communication with GPs - led by Medical Director for Integrated Care (MDIC), who is himself a local GP. 2. Involvement of GPs in Integrated Care MDTs	1. Feedback from GP practice visits by CEO and MDIC. 2. Regular reporting of quality of services of particular concern to GPs (e.g. direct access acute services; and community services such as MSK, podiatry). 3. Audit Committee deep dive into GP engagement, Sep 2012	1. GP referral patterns 2. Feedback from CCGs	4	2	8	Capacity to develop and deliver formalised primary care engagement strategy	1. Closer working between GB and CG to support community engagement	Sep-13
	1.3	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. Ensure accurate data reporting for national data returns and commissioning data sets	LMa	4	4	16	⇨	A data governance review is underway, with systematic checks of the data inputs and outputs and will included the following. 1. Data Validation process 2. Escalation framework 2. Patient Access policies and procedures 3. Referral management administrative processes 4. Staffing capacity and competency in demand and capacity planning 5. Data Quality Review Group workplan	The data governance actions are reported to the audti and risk committee, and also updates are provided in the scorecard section of the board report the plan includes steering comitees for the review and management of; 1. RTT Action Plan 2. Cancer and RTT Steering Committee and Clinical Advisory Panel 3. Data Quality Group workplan 2. Establishment of a PMO to support delivery 3. Integration of Performance and Information functions 4. Weekly data report	1. Intensive Support Team working directly with the Trust 2. Performance meeting with TDA 3. Audit Commission annual review of clinical coding 4. Parkhill annual audit of RTT has been reviewed and essantial data sets have been included in the report 5. Audit Commission audit to support Quality Account	4	2	8	Weekly waiting list meetings have been established. A review of information and perfomrance unit is underway, including reporting schedules, validation program and data reports needed for meetings. The board report will start to change over the next three weeks to include more detailed specific information	A action plan is in place for referal pathway improvements for both the acute and community services. Assurance training and assurance rating will be included in the board report by the end of September.	End of Sept
	1.4	If commissioners choose to market test services in order to improve affordability of services, services may be priced at a lower level or decommissioned. This is especially related to outpatients and community services	RM	5	2	10	⇨	1. Two year block contract provides a control through 2013/14. 2. In the longer term, our strategy to be the low cost/high quality provider will enable us to provide competitive services. 3. Close engagement with local CCGs and GPs (see risk 1.1) enables us to be more responsive to their needs.	1. Periodic reports from CEO, MDIC etc following interactions with GPs and CCGs 2. Deep dive by finance and development committee in April 2013	Periodic tracking of referral patterns and market share	5	2	10	Take appropriate action to ensure that our services are competitive or better on quality and cost and evidence at Transformation Board and CQRG.	1. Recruitment of Contracts and Business Development Director	Sep-13
NHS Outcomes Framework 2013/14 Domain 4: Ensuring that people have a positive experience of care																
2. Ensuring "no decision about me without me"	2.1	If our patient experience is poor, our patients will suffer, our reputation will suffer, our CCG support and our FT application will be at risk	BS	5	2	10	⇨	1. Quality is top of TB agenda and at the heart of the business, with clear lines of accountability down to ward/community level. 2. Datix incident reporting system and integration with risk management processes. 3. Staff encouraged to raise concerns - e.g. through Partnership Board & Meet the CEO programme. 4. Special controls to ensure CIPs do not threaten quality - Clinical Advisory Panel meeting (6-12 weekly meeting)	1. Bimonthly Quality Committee meeting 2. Bimonthly Quality visits in each division 3. Clinical risk reports to QC from each division each meeting 4. Review of integrated performance dashboard at QC 5. Written reports - SIs, NHS LA, 6. Quarterly reports from feeder committees 7. Hotspot deep dives	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. NHS Staff survey identifies high management commitment to patient care compared to other trusts 7. Link/healthwatch audits 8. Governance reviews 9. CQC Reports	5	2	10	1. Patient experience surveys and results 2. Pressure ulcers (grade2 and above)	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2 Plan to achieve NHSLA Level 2 by February 2014 3. PET in each ward to achieve higher percentage scores in each of the CQIN areas of the pt survey 4. Specific improvement plans related to areas of poor performance in pt experience surveys.	Monthly review of KPIs by TB. Quarterly patient safety reports to quality committee
	2.2	If we do not engage our stakeholders in the development and decisions about our strategies, confidence in our strategic direction will be undermined and our clinical and organisational reputation will be damaged.	YMK	5	3	15	⇨	1. Communication and engagement plan 2. Regular meetings with key stakeholders 3. Partnership Board 4. Listening exercise 5. Whittington weekends	1. Regular status of engagement with stakeholders reported to the TB by Chairman and CEO etc. 2. Interim Director of Communications recruited 3. Review of communication function	1. Feedback from stakeholders, including TDA 2. Report to Trust Board in July on outcome of engagement activities 3. General media coverage	5	2	10	Widespread community engagement	1. Report to Trust Board regardig outcome of engagement activities 2. Continue to engage with all stakeholders	Jul-13
NHS Outcomes Framework 2013/14 Domain 3: Helping people to recover from episodes of ill health or following injury NHS Outcomes Framework 2013/14 Domain 5 Treating and caring for people in a safe enviroment; and protecting them from harm																
3. Delivering efficient and effective services	3.1	If we fail to maintain staff engagement then staff morale will decrease and the delivery of changes in services and patient pathways will not happen in line with the plan	JR	4	3	12	⇨	1. Staff engagement strategy includes communications, alignment meetings, visible leadership at all levels 2. Clear commitment to clinical leadership at service line level. 3. Strengthened processes forcompliance with mandatory training. 4. Partnership Group meetings	Draft OD plan "Passionate about People" sucessfully delivered to TB Seminar June 2013. NEDs reported confidence in the messages and initiatives outlined	Recent CQC visit reported excellent staff engagement on the wards trhey visited. NHS Staff Survey 2011 failed to give assurance due to the low numbers of staff completing the survey.	4	2	8	1. Evidence should be sought on number of exec's/senior managers attending walkarounds across the Trust to check for greater visibility. 2. Currently there is little to no development for managers and leaders in nursing, medicine and management across the Trust. 3. There is a lack of a coherant internal communications/engagement strategy present at this time.	1. Patient Safety Walkabout programme has been reignited & execs/senior managers have been more visible over recent months. Trust has started "ward conversations", two have taken place already which the Dir of Nursing, Dir of OD and Med Dir (integrated care) have attended, more are planned. Comprehensive staff engagement survey for all staff to complete in the Autumn, for the first time this will give the Trust the full picture on how staff feel about working at WH. 2. October 2013 there will be a full engagement survey for all staff to complete from OCR International, an independent expert staff engagement organisation. Further details of costs to be presented to Trust Board in July	March 2014 July 2013
	3.2	If we fail to deliver CIPs and planned productvity improvements, then our financial stability will reduce, our FT applcation will be jeopardised and local patient services may be put at risk.	LMa	5	4	20	⇨	1. New PMO established 2. Revised processes for CIP management 3. Divisional performance management meetings, including CIP delivery 4. Reprofiling of CIPs based on CIP target for 2013/2014	1. Formal CIP Board review of all Red and Amber CIP schemes against a framework to ensure consistency and identification of issues 2. Monthly finance report presented to Trust Board	1. External review of CIPs through HDD2 - due October 2013	5	2	10	Mitigations for the CIPs which have been stopped due to possible quality issues and identification of alternative CIPs	1. CIPs action plan in place 2. Executive Committee formed to action reduction in temporary staff 3. 8 point plan by DoF	Mar-14
	3.3	If potential future London-wide service reconfigurations (e.g. colorectal, interventional radiology & vascular surgery, pathology) are implemented, then a significant amount of our activity being decommissioned	MK	3	4	12	⇨	1. Active engagement with opinion leaders, local providers and other stakeholders by Medical Director and CEO. 2. Contingency plans developed.	1. Report to Audit Committee Jan and March 2013	1. External clinical service reviews e.g. cancer peer reviews, NHSL pathology reviews 2. Configuration of other london healthcare organisations	3	4	12	Not knowing what strategic decisions about configuration will be taken in the near future	1. Continued active engagement with UCLP. 2. Participation in Clinical Senates 2. Building a coalition with other DGHs	Mar-14
	3.4	If we do not mitigate against potential quality impacts of cost reduction programmes, then patient experience may reduce, patients may choose other providers, the Trust will lose business and the Trust's viability will be put at risk.	Mk/BS	4	3	12	⇨	1. All CIP programmes must pass clinically-led Quality Impact Assessment before going forward. 2. Clinical Advisory Group (chaired by Medical Director and Director of Nursing) monitor and report on quality impact of CIPs.3. Divisional Boards are responsible for assessing all quality risks in the division and for implementing mitigating actions	1. Quality committee and TB regularly review measures of quality, including: Complaints, Incident reporting, Friends & Family scores, GP surveys, Readmission rates, Mortality etc 2. TB monitors staffing ratios (e.g. nursing & midwifery) against good practice standards. 3. Divisional Board scrutiny of impact	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts.	4	2	8	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2 3. Pressure ulcer incidence 4. C-diff/ MRSA incidence	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2 Plan to achieve NHSLA Level 2 by February 2014 3. PET in each ward to achieve higher percentage scores in each of the CQIN areas of the pt survey 4. Specific improvement plans related to areas of poor performance in pt experience surveys.	Monthly review
	3.5	If WH does not improve the environment and efficiency of the maternity department, then the service may not continue to be financially viable or clinically safe.	LMa	4	3	12	⇨	1. Quality of patient care and experience is monitored as in all departments through patient feedback, complaints, incident reports etc. 2. Funds to improve the environment in terms of quality and patient safety are subject to a business case application to the TDA 3. Funds to improve the environment in terms of functional suitability and standard have been included in the trust 5-year capital investment plan as part of the Estate Strategy and a further £750k has been awarded by the DH	1. The estates strategy and investment plan were approved by the Trust Board in January 2013 2. Performance of maternity is subject of regular reviews by community committee 3. A maternity redevelopment plan is in preparation and reviewed by the Estates Strategy Delivery Board	1. CQC inspection reports	4	2	8	Commissioner support for growth	1. Secured CCG support for growth to 4700 births 2. developing outline business casefor £10m maternity investment 3. LTFM excludes estates sale to support maternity investment	Sep-14

Strategic Goal	Ref	Corporate/Principle Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead	Impact	Likelihood	Risk Score	Movement from 16 May 2013	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)*	Impact	Likelihood	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
	3.6	If we do not fully implement Service Line Management (SLM), then consultants will not know where and how to improve efficiency, weakening their clinical leadership in the achievement of CIPs and financial trajectories	RM/LMa	4	3	12	⇨	Structured roll out of SLR to clinical leads, training provided by divisional directors, clinical directors and clinical leads on how to interpret reports. CLs and CDs use SLR data to reduce cost level pf RCI = 100 by 2014/15	1. Finance & Development committee remit includes monitoring of SLM implementation. 2. SLM reports reviewed monthly at TB, to include names of CLs. 3. Evidence of SLR data being being used to inform decision making. 4. Audit committee deep dive in SLM.	HDD2 in Nov 2012 noted that WH continues to implement SLM across the Trust	4	2	8	Additional SLM resources to divisions to be identified	Additional SLM resources to divisions to be included in organisational capapcity plan due for presentation at EC in March 2013	May-13
	3.7	If a Tariff deflation proves to be greater than in our plans, then this will reduce WH income and may affect its financial viability	RM	4	2	10	⇨	1. Block contract provides security through 2013/14. 2. In the longer term, our strategy mitigates some of this risk through growth in additional services and with other commissioners.	LTFM assumptions and associated risks periodically reviewed by F&D Committee	EY review of LTFM provided assurance of viability	4	2	8			
	3.8	If payroll related costs including severance are higher than planned this will cause financial instability against financial plans	RM	4	3	12	⇨	1. Our plans are to take advantage of existing vacancies and natural staff turnover (which combined are substantially in excess of envisaged workforce reductions over the next 5 years) to minimise redundancies	LTFM assumptions and associated risks periodically reviewed by F&D Committee		4	2	8	1. Workforce planning	1. Severence to be controlled by workforce plans and performance management of staff	Monthly review through 13/14 financial
	3.9	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	4	3	12	⇨	1. IG improvement plan to meet Level 2 IG Toolkit compliance, by time of FT authorisation, monitored by Information Gov Committee (IGC) 2. IG policies	1. IG Toolkit submission and report 2. IG report to Audit committee bi annually 3. IG report to Trust Board annually	1. Parkhill internal audit review due July 2013	4	2	8	Outstanding issues in the following areas: 1. Records management 2. Mandatory training compliance 3. Longitudinal six month audit of data quality practice	IG action plan in place to complete outstanding issues in the following areas by Sept 2013.	Sep-13
	3.10	If integrated risk management is not embedded across the Trust, the Trust will not deliver safe and effective services	BS	4	4	16	⇨	1. Policies in place regarding risk management, incident reporting, and serious incident reporting. 2. Recruitment of new quality posts (2 posts) into central team and divisional structures 3. Training with individual specialities in place 4. Roll out of compliance programme to support CQC readiness	1. Progress reports at divisional and committee level 2. Increase in incident reporting across the Trust	1. Parkhill annual internal audit of governance arrangements 2. CQC inspection 3.CSU assurance reports 4. Quality visits with TDA	4	3	12	1. Achievement of NHSLA Level 2 pilot 2. Level of risk assessments being completed across the Trust to increase 3. Acceptance by division of risk 4. Capacity in operations to manage risk	1. Project in place to address and achieve by June 2013 2. NHSLA pilot assessment due for September. 3. Operations restructure	Jun-13
	3.11	If our services are unsafe, our patients will suffer, our reputation will suffer, and our CQC licence and FT application will be at risk	MK	5	2	10	⇨	1. Clinical policies, procedures and guidelines 2. Professional registration, appraisals, PDPs,	1. Clinical outcome measures, SHMI 2. Clinical audit 2. Incident reporting	1. External service reviews 2. National benchmarking	5	2	10			
	3.12	If WH is not operationally excellent, patients will not be seen and treated in line with national guidelines and the organisations reputation will suffer.	LMa	4	4	16	New risk	1. Divisional performance assurance meetings 2.Performance plan agreed with TDA	1. Weekly ET review of performance 2. Monthly TB review of performance review meetings	1. Weekly TDA meetings	5	2	10	1. Restructured performance dashboard at division and TB level.	1. Divisional performance dashboards to be issued in July 2. Revised Trust Board Performance Report to be issued in July 3. Operations restructure	Jul-13
NHS Outcomes Framework 2013/14 Domain 1: Preventing people dying prematurely																
4. Improve the health of local people	4.1	4.1 If we fail to meet quality standards (eg CQC essential targets, waiting times for ED, Cancer, and therapy services) then our patients may be experiencing poor care, our reputation will suffer, and our CQC licence and FT application are both at risk	BS/LMa	5	2	10	⇨	1. Quality is top of TB agenda and at the heart of the business, with clear lines of accountability down to ward/community level. 2. Datix incident reporting system and integration with risk management processes. 3. Staff encouraged to raise concerns e.g. through Partnership Board & Meet the CEO programme. 4. Special controls to ensure CIPs do not threaten quality (see above).	1. Monthly performance report to trust Board 2. Bimonthly Quality Committee meeting 3. Bimonthly Quality visits in each division 4. Clinical risk reports to QC from each division each meeting 5. Review of integrated performance dashboard at QC 6. Written reports - SIs, NHS LA, 7. Quarterly reports from feeder committees 8. Hotspot deep dives	1. SHMI <70 over last 6 quarters. 2. CQC inspection reports 2. MQGF assessment 2012. 3. Ongoing complaints and negligence claims data. 4. Comparison of nursing, midwifery & HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. NHS Staff survey identifies high management commitment to patient care compared to other trusts	5	2	10	1. Full roll out of Friends & Family scores. 2. NHSLA Level 2	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2 Plan to achieve NHSLA Level 2 by February 2014 3. PET in each ward to achieve higher percentage scores in each of the CQIN areas of the pt survey 4. Specific improvement plans related to areas of poor performance in pt experience surveys.	Monthly review
5. Fostering a culture of innovation and improvement	5.1	If the FT programme is not well planned and managed, then we may miss our deadlines and fail our FT application	YMK	5	3	15	⇨	1. Refreshed and stronger Board now in place, with capabilities and governance processes to lead an FT. 2. Integrated care organisation now in place, well placed to deliver its strategic vision. 3. Partnerships with Commissioners and other healthcare providers provide support for the implementation of our strategic vision. 4. Team in place for programme management of FT application.	1. FT Board provides scrutiny of programme management. 2. Status of FT application is standing item on TB agenda 3. Review of Board capacity 4. Board Development programme	1.Internal audit on FT programme. 2. MQGF report by RMS Tenon 3. BGAF by E&Y. 4. HDD2 repeat by Deloitte. 5. Working capital by KPMG 6. B2B Feedback	5	2	10	1. FT timeline 2. FT Programme Manager	1. FT timeline 2. Establishment of FT Executive	Mar-14
	5.2	If management capacity for change leadership is too stretched, transformation in the way services are provided and managed will not be achieved	JR	4	3	12	⇨	1. Ongoing commitment to increase capacity by delegating leadership to lower levels in the organisation - e.g. creation of 3 Divisions, appointment of Service Line Clinical Leads etc.2. Regular monitoring of management capacity & capability through appraisals, 360° feedback, Board development programme, and external feedback via FT process. 3. Selective strengthening of management capacity from external sources - e.g. Interim OD Director; E&Y support to IBP development.	1. Change leadership capacity discussed in Board Seminars. 2. Informal NED discussions on leadership capbility & capacity	1. BGAF report. 2. Informal discussions with other external stakeholders who know us well (e.g. NCL, NHSL, CCGs)	4	3	12	1. Recruitment of top team to be completed	Procure Board development programme, executive development programme and OD plan	TB BGAF Sept 2013
	5.3	If we do not implement an effective OD strategy, we will fail to evolve / employ / train our work-force to deliver service changes and productivity improvements and therefore CIP will not be delivered, services will not be transformed safely and our FT application will be significantly jeopardised.	JR	5	3	15	⇨	1. Continued development of integrated training & education programme, focused on skills relevant to the Trust's strategy. 2. Processes to maximise compliance with mandatory training. 3. Ongoing Board and other leadership development programmes. 4. Continued reinforcement of a culture that encourages mentoring, continuous improvement, and innovation. 5. Appointment of Interim Director of OD, Feb 2013	1. TB regularly reviews workforce statistics, incl training, appraisals, sick leave, vacancies etc. 2. OD Executive Director in post 3. Changes already underway in HR with improvements being made in HR data quality and reporting. Changes to how appraisal and MT is conducted and reported upon leading to improved compliance and quality. 3. Recruitment to key new posts in OD, Deputy Director of Leadership & Talent, Director of Communications and Deputy Director of HR Operations. 4. Review and improvements in train to streamline recruitment processes and policies so that the right recruitment decisions are made. 5. New OD strategy received praise by NEDs at June Trust Board Seminar, further work being delivered to July TB on timing of programmed initiatives with costs. Focus of OD strategy is engagement and improvements in managerial and leadership capability and confidence.	Via results of staff engagement survey, feedback on SDP and CIP success from TDA, quality of staff to give excellent care via CQC, ability for NHS Trust to become FT, via TDA, Monitor. Reduced number of complaints from patients, family, improvement in media story coverage in local press via local journalists and relationships with key stakeholders such as commissioners, regulators, local politicians and the public.	5	2	10	1. An OD team not yet functioning as an expert leadership team enabling the organisation to move from Good to Great. 2. Limited development interventions for exec team, NEDs and whole unitary trust board. 3. A group of managers and leaders across the organisation with patchy skill and will in a range of managerial and leadership activities. 4. Inconsistent processes and practices across all areas leading to poor messaging and low levels of engagement. 5. A pervading culture of "cosy", with not enough staff/managers/leaders feeling "restless" for improvement. 6. Very weak internal workforce planning expertise.	Interim support currently in place for workforce planning to reach an IBP position of good workforce forecasting by September. Newly appointed Dir of Comms, Deputy Dir of HR Ops and Deputy Dir of Leadership & Talent to suppport the need to strengthen OD as a means to help the organisation grow and develop. Deep dive review within recruitment to reduce complaints and improve turnover from advert to start date, due to complete by end of July 2013. OD programme plans to commence with staff engagement survey in Sept/Oct 2013 with results by Dec 2013.	September 2013 July 2013 Sept 2013/Oct 2013
	5.4	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/BS	3	2	6	⇨	1. Post graduate medical education board chaired by Director of Education oversees quality of training. 2. Director of UCL Medical School is a NED on the Trust Board. 3.Commitment to maintain/enhance training infrastructure evidenced by TB 3. Approval of capital expenditure for e.g. Library, Cinical Skills Centre	1. Education Strategy Group developing education strategy	1. Medical education audit annually, NMC audit of education standards, NMC audit of mentorship, 2. GMC annual trainee survey	3	2	6		1. Clinical Education Strategy Group convened for 20/03/2013 (re reconfiguration of LETB and educational funding for individual professional groups). Met in May and next meeting July/Aug 2013.	Mar-14
	5.5	If delivery of the Electronic Patient Record Project fails, patient care may suffer and transformation of the organisation and delivery of the IT strategy will be delayed.	RM	4	3	12	⇩	1. EPR Management Board in place, with associated programme management arrangements in place 2. Stakeholder workshops with operational services 3. Joint weekly project meetings for functional workstreams 4. Weekly dashboards 5. Current systems are review only and ability to revert to old systems - ability to know very early if there is a problem	1.EPR Project Phase 1 - Project Board Dashboard 2.Community Requirements Analysis Review Meeting Schedule (Phase 1) 3. Quarterly report to F&D committee 4. Risks issues and action logs 5. Site visits undertaken	1. Go live date for maternity complete. 2. Mckesson proven deployment methodology 3. Parkhill quality assurance process	4	2	8	Lack of integration of EPR programme management into new operational management team	EPR project team and ops to meet weekly to discuss EPR go live.	Jul-13