Executive Office
Jenner Building
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

8 January 2014

Title:	**Review of the Board Assurance Framework (BAF)**		
Agenda item:	**14/011**	**Paper**	**6**
Action requested:	***To receive***		
Executive Summary:	The BAF sets out the key risks that may threaten the achievement of the Trust's strategic objectives and provides assurance to the Board that they are effectively managed. It is updated monthly by the Executive Team, monitored by the Audit and Risk Committee and reported to the Trust Board bi-monthly.		
Summary of recommendations:	The Board was asked to: • Note the updates in the BAF • Agree the top four risks in the BAF		
Fit with WH strategy:	The BAF provides assurance to the board that the key risks to the achievement of the Trust's strategy are identified and effectively managed.		
Reference to related / other documents:	Corporate Risk Register, Risk Management Strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Not applicable		
Date paper completed:	**Version Number: 5**	**Version Date: 17 December 2013**	

Author name and title:		**Dr Yi Mien Koh Chief Executive**		**Director name and title:**		**Dr Yi Mien Koh Chief Executive**	
Date paper seen by EC	**03/12**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**Yes**	**Legal advice received?**	**N/A**

Whittington Health Trust Board

8 January 2014

Board Assurance Framework 2013/14

Introduction

1. The Board Assurance Framework (BAF) forms part of Whittington Health's risk management systems and processes to assure the Board that the key risks that may threaten the delivery of the Trust's strategy are identified and being effectively managed. The Audit and Risk Committee, informed by internal auditors, is responsible for monitoring the overall operation of the BAF.

2. The BAF and the Corporate Risk Register are reviewed monthly by the Executive Team. The BAF is reported to the Trust Board following its review by the Audit and Risk Committee which meets bi-monthly, and last met on 5 December 2013. The Board is responsible for evaluating 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.

Changes to the BAF content since last reviewed at the Audit and Risk Committee on 5 December 2013

3. There has been no change to risk ratings since reviewed by the Audit and Risk Committee on 5 December. Updates were made in the following risk areas :

Risk ref no.	Current risk score	Updates in assurance
1.3	16	The trust is now able to generate waiting lists but still cannot produce financial and activity reports. McKesson expects to resolve the problems with a definitive fix on 8 January 2014.
5.1	10	To more accurately reflect the risks associated with the FT application process and to distinguish it from 5.2, the reference to the FT programme is now changed to "If the process to develop a robust IBP and LTFM is not well planned and managed, then our FT application could fail".
5.2	20	New chairman started on 1 January 2014.
5.5	16	McKesson has indicated that the community EPR will now not be ready until December 2014 due to the supplier's decision to use the acute EPR across the whole trust rather than develop it on Liquidlogic, the social care

		platform. This requires further development. To mitigate the risk, the Trust plans to proceed with upgrading the community system to RIO2 in 2014.

The top four risks in the BAF

4. The following have been identified as the top four risks for the Trust.

Risk ref no.	Current risk score	Reason for criticality
1.1	20	**Commissioner support** - If we fail to secure support from our core commissioners for our IBP and LTFM, then we will not be able to progress our FT application.
3.2	20	**Financial sustainability** - If we fail to identify sufficient CIPs and put in place processes to translate ideas and visions to practice going forward, the trust will not be able to deliver the planned productivity improvements. If we miss this year's CIP target of £15 m, we may fail to meet our overall financial targets for the year, our Monitor risk rating and FT application will be at risk. The amount of CIPs required in future years will also increase.
4.1	20	**Operational performance** – 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
5.2	20	**Leadership** - If the executive leadership is unable to transform the organisation at the required pace and scale, then trust will not be sustainable. If we are not able to successfully recruit and retain a management team that is capable of providing the leadership necessary to deliver the ICO transformation envisaged in the IBP, then the trust will not be sustainable.

Recommendations

5. The board was asked to agree that the BAF reflects the current risks to Whittington Health and to
- Note the updates in the BAF
- Agree the top four risks in the BAF

Dr Yi Mien Koh **17 December 2013**

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			Movement from 23 October 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			Gaps		Due Date
				Impact	Likelihood	Risk Score					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*	
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 from our core commissioners for our IBP and LTFM, then we will not be able to progress our FT application.	YMK	5	4	20	⇧	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	Discussions are taking place at CEO and director levels to secure practical financial support for 2013/14 and to achieve realistic commissioning decisions for 2014/15. Negotiations have started with Islington and Haringey CCGs and North East London CSU for next year. The Islington CCG plans to use the integration pioneer status to pilot new payment mechanisms with a view to future sustainable funding from the Integration Transformational Fund from 2015/16.	Mar-14
	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	2	8	⇨	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 2. Borough based integrated Care Boards and Whittington Health Transformation Board in place	Sept 2013 - actions completed
	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	LM	4	4	16	⇧	A data governance review is underway, with systematic checks of the data inputs and outputs and will include 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 audit 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 meetings with TDA 3. Audit Commission annual review of clinical coding 4. Internal Auditors, 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 performance 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.	The action plan has been delayed due to EPR data issues. However, work has continued in other areas not affected. Manual data quality checks have been put in place. The supplier is engaging actively with the trust to put right the reporting systems and has provided additional resources to fix the problem. The current plan is for the fix on 8 January to be sustainable. In the meantime temporary fixes are enabling the trust to generate workable PTL to allow prioritisation.	Jan-14
	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	SW	4	2	8	⇩	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	4	2	8	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	Sept 2013 - Simon Currie in post. Action completed
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	4	3	12	⇨	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) 5. Ward conversations 6. Whistleblowing policy 7. Matron conversations	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 8. Friends and family test 9. Patient tracker 10. Ward dashboards 11. Performance report to the board	1. SHMI <70 over last 6 quarters. 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. CQC Reports demonstrating complaince 7. Cancer Patient survey published 30 Aug show poor results (8th from bottom , a drop from 33 place from bottom in 2012) 8. Friends and FamilyTest for A&E shows around 6% response rate (bottom 5)	4	1	4	1. Patient experience surveys and results not being published internally and externally 2. Pressure ulcers (grade 2 and above) incidents of harm in community continuing 3. Failing to deliver the F&F action plan in areas where scores are low	1. Full roll out of Friends & Family scores on inpatient wards and ED from April 2013, maternity October 2013 and community April 2014 2. Specific improvement plans related to areas of poo performance in pt experience surveys. 3. Deliver ED action plan (End of September) 4. Patient satisfaction boxes 5. Netpromoter scores	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	2	10	⇩	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 3. Revised strategy supported by local OSCs and CCGs and approved by TB in july.	July 2013 - complete
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. 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 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 to provide a full picture on how staff feel about working at WH. 2. November 2013 there will be a full engagement survey for all staff to complete from OCR International, an independent expert staff engagemen organisation.	March 2014 Jan 2013
	3.2	If we fail to identify sufficient CIPs and put in place processes to translate ideas and visions to practice going forward, the trust will not be able to deliver our CIPs and planned productivity improvements. If we miss this year's CIP target of £15 million, we may fail to meet our overall financial targets fo the year, our Monitor risk rating and FT application will be at risk. The amount of CIPs required in future years will also increase.	SW	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 5. Weekly performance updates at TOB	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 3. Review of in-year financial position by new CFO identified need to increase savings for rest of year due to significant under delivery of CIPs. 4. Additional targets set with Divisions to address original plan shortfalls, with further schemes underway. 5. Negotiations underway to replace cost reduction with new income from CCGs (to reflect overperformance against the contract)	Internal Audit of CIP process - November 2013	5	2	15	Mitigations for the CIPs which have been stopped due to possible quality issues and identification of alternative CIPs Important to balance the need to achieve cost reduction with the delivery of key targets and not create an adverse impact upon service and safety.	1. CIPs action plan in place 2. Executive Committee formed to action reduction in temporary staff 3. 8 point plan by DoF 4. Top down savings target set for each division/department for each month of the remainder of year by CFO 5. Acceleration of workforce plans in readiness for implementation in year 6. "Call for ideas" initiative launched by CEO on 6 Sept to encourage staff to come up with ideas	March 2014 with monthly review by ET and at Resources Committee

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 23 October 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
	3.3	If potential future London-wide service reconfigurations or impact of commissioning standards lead to loss of ability to meet standards due to financial constraints, a significant amount of activity may be 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. 3. Engagement with commissioners to agree implementation plans	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 Item for board seminar discussion in Feb 2014	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.	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 & patient safety committee 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. Identification of a quality predictor tool for emerging SDPs	1. identify tool and resource 2. Fully functioning clinical advisory panel	Mar 14
	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.	LM	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
	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	SW/LM	4	2	8	⇨	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 RCI	1. Resource & Planning committee remit includes monitoring of SLM implementation. 2. SLM reports reviewed quarterly at TB, to include names of CLs. 3. Evidence of SLR data 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	Revised SLR reporting to be implemented to support clinical engagement	Jan-14
	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	SW	4	2	8	⇨	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 reviewed by R&P Committee	EY review of LTFM provided assurance of viability	4	2	8	Director of Contracts started in September 2013 and will support CFO in negotiating 2014/15 contracts on the basis of out-turn activity levels. Discussions to be had with commissioners other than CCGs, who include NHS England, LAs and Public Health England.	Discusisons with CCGs on next year's contracting round have started, led by SW.	Mar 2014.
	3.8	If payroll related costs including severance are higher than planned this will cause financial instability against financial plans	SW/JR	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. Project to reduce agency costs established.	LTFM assumptions and associated risks periodically reviewed by R&P Committee	Severence for Exec posts & settlements above £100k require TDA sign off.	4	2	8	1. Workforce planning 2.Benchmarking with peer trusts e.g. Croydon, Ealing, Kingston and Homerton to identify areas for improving productivity 3. A review of all HR policies relating to staff pay terms and implement changes that are fair and realistic for financial sustainability	1. Severence to be controlled by workforce plans and performance management of staff	Feb-14
	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	SW	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. TIAA Internal Audit review due Feb 2014	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. Focus on training: on line training, timetabled sessions and bespoke training now available.	Mar-14
	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. Roll out of Health Assure and 3. RCA training for staff	1. Increase in incident reporting across the Trust 2. Good RCAs with action plans 3. SHMI	1. Parkhill annual internal audit of governance arrangements 2. CQC inspection compliance 3. CQRG meeting 4. Quality visits with TDA	4	3	12	1. Increase in the level of risk assessments being completed across the Trust 2.Accountability by divisions for risk management 3. Increase in capacity in risk management in divisions Item for board seminar discussion in Feb 2014	1. Project in place to address by June 2013 (Risk Register Roll out Commenced in September 2013 following testing in WCF) 2.Risk register implementation full roll out in progress, SCD Divisional Support implemented from Central Governance Team 25.11.2013.ICAM Defined Risk Manager in place, WCF Head of Quality in place. 3.Operations restructure 4.Governance workgroup to commence in January 2014 combination of Divisional and Central Governance leads now additional resources in place, work plan to be developed for integrated risk management and highlight priority areas. Intial discussions have commenced with support from Central and Divisional Resources on priority areas.	Mar-14 Work in progress
	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 3. Keogh review - National Inspector of hospitals	5	1	5	Impact of new CQC quality standards	New quality standard structure to be implemented	Mar-14
	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.	LM	4	4	16	⇨	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	4	2	8	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	Sept-13 complete
NHS Outcomes Framework 2013/14 Domain 1: Preventing people dying prematurely																

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 23 October 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
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/LM	5	4	20	⇧	SAFETY, EFFECTIVENESS EXPERIENCE 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.	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 (NHSLA program has ceased, exit program in place including development of organisational wide document control processes and assurance committee agreed at EC in October 2013 and approval of Terms of Reference in 26.11.2013 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 poo performance in pt experience surveys. 5. Roll out care connect 6. Monthly mock inspections being completed for Services by Central Governance Team based on CQC Standards commenced October 2013, 1 Community 1 Hospital, additional reviews being completed based on intelligence from Incidents, Complaints, feedback. 7. Health Assure (compliance system roll out plan approved in October Exec. Staff Forums developed for ongoing support and feedback and rolling program of service compliance visits support and training.	Monthly review
5. Fostering a culture of innovation and improvement	5.1	If the process to develop a robust IBP and LTFM is not well planned and managed, then our FT application could fail. This includes the continued development and implementation of the ICO strategy and SDP development to ensure service change supports FT application once the formal application process is resumed.	SW	5	2	10	⇩	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. 3 SDP implementation plan linked to 2014/15 onwards planning	1. FT timeline 2. Establishment of FT Executive 3. CFO taking lead role for FT programme and has refreshed timetable with detailed milestones. 4. FT Executive meet weekly to review progress with FT application. 5. Plan for 2014/15	Mar-14
	5.2	If the executive leadership is unable to transform the organisation at the required pace and scale, then trust will not be sustainable. If we are not able to successfully recruit and retain a management team that is capable of providing the leadership necessary to deliver the ICO transformation envisaged in the IBP, then the trust will not be sustainable.	JR	5	4	20	⇧	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 capability & capacity	1. BGAF report. 2. Informal discussions with other external stakeholders who know us well (e.g. NCL, NHSL, CCGs)	4	3	12	1. The new trust chairman has been appointed and started in post on 1 January 2014. 2. The Audit chair (NED) resigned and leaves the Trust in Dec 2013. Recruitment is underway for a replacement. 3. The Resources Committee received a plan on successions for key temporary staff in the Trust. As a result the following posts will be advertised in December - Director of OD, CFO, Director of Communications, Director of Corporate Affairs	1. Feedback from the NHS Leadership Academy's Board development programme disgnostic completed in December 2013. Board development programme have started in Dec 2013. 2. Development of a Recruitment and Retention Plan for delivery in January 2014 3. Executive development with an external facilitator commenced in November 2013	BGAF planned for Sept 2013 to be delayed until Chair and Director of Corporate Affairs in post. Expected new date: April -14.
	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. A group of managers and leaders across the organisation with patchy skill and will in a range of managerial and leadership activities. 3. Inconsistent processes and practices across all areas leading to poor messaging and low levels of engagement. 4. A pervading culture of "cosy", with not enough staff/managers/leaders feeling "restless" for improvement. 5. Very weak internal workforce planning expertise.	1. Deputy Director of HR Ops in post from October 2013. 2. New top OD team in place. 3. Full work programme and roll out commnced on leadership development and management development, coaching and mentoring	Nov 2013 and ongoing
	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	4	2	8	⇨	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	4	1	4	Integrated care and primary care education roles to maintain quality and negotiate opportunities	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. 2. Recruitment to integrated care and primary care education roles	suggest removal

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 23 October 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
	5.5	If delivery of the Electronic Patient Record Project fails, transformation of the organisation and delivery of an integrated patient record will be delayed i.e. delay in improvements to patient safety, outcomes and experience as well as operational efficiency.	SW	4	3	12	⇨	1. EPR Management Board in place, with associated programme management arrangements in place 2. Stakeholder workshops with operational services 3. Joint Trust/McKesson weekly project meetings to review and sign off weekly dashboard reports and issues log 4. Weekly EPR and Operations meetings 5. If EPR fails to go-live, the Trust will roll back to the current systems.	1.EPR Project Phase 1 - Project Board Dashboard 2.Community Requirements Analysis Review Meeting Schedule (Phase 1) 3. Quarterly report to R&P committee 4. Risks issues and action logs 5. Site visits undertaken	1. Go live date for maternity complete. 2. Mckesson proven deployment methodology 3. TIAA quality assurance process	4	2	8	Implementation of the new Electronic Patient Record in late September 2013 has gone relatively smoothly other than data reporting. Mc Kesson has inidicated that the community EPR would not be ready until December 2014. In the meantime, the Trust will progress with upgrade to RIO 2.	An action plan /log of outstanding issues needing to be resolved are reviewed and monitored daily. Hot fixed in place for PTL (waiting list reporting) and trust able to generate wiaitng lists. Permanent fix for SLAM and CDS data expected 8 january 2013.	Sept-14 EPR implemented but remaining data quality issues to be fixed Jan 2014