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Whittington Health Trust Board

3 September 2014

Title:	**Review of the Board Assurance Framework (BAF)**		
Agenda item:	**14/138**	**Paper**	**12**
Action requested:	***To discuss and agree***		
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. The Trust Board reviewed the BAF at its meeting of 2 July. The BAF has subsequently been discussed at Audit and Risk Committee on 23 July; the Trust Management Group on 26 August and will also have been revisited at the Audit & Risk Committee on 1 September.		
Summary of recommendations:	The Committee is asked to:- • Note the updated BAF • Agree the next steps		
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: 22 August 2014	**Version Number:**	**Version Date: 22 August 2014**	

Author name and title:		**Siobhan Harrington Director of Strategy/ Deputy CEO**		**Director name and title:**		**Siobhan Harrington Director of Strategy/ Deputy CEO**	
Date paper seen by EC	**28 Aug 2014**	**Equality Impact Assessment**	**N/A n/a**	**Quality Impact Assessment**	**N/A Yes**	**Financial Impact Assessment**	**N/A Yes**

Whittington Health Trust Board

Board Assurance Framework 2014/15

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 Trust Management Group. The BAF is reported to the Trust Board following its review by the Audit and Risk Committee which meets bi-monthly. The Committee 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. The cycle of meetings this month has been misaligned in terms of timing due to holidays.

3. This version of the BAF has been refreshed following discussion at Audit and Risk Committee and Trust Management Group however there will need to be a deeper review of the BAF and risk register over the coming months as we develop and evolve our strategy.

Changes to the BAF content since last reviewed at the Trust Board on 2 July 2014.

4. The following risks are showing an **improvement** in risk scores:

Risk ref number	Current risk score (previous)	Reason for decrease in risk
1.3	12 (16)	There has been significant work and focus to improve data quality and progress has been made which reduces the likelihood of this risk.
1.4	12 (16)	The improvement work completed in MSK and district nursing has been welcomed by local commissioners. This reduces the likelihood of the commissioners tendering for services but the risk does remain

5. The following risk is showing a **deterioration** (worse) in risk scores:

Risk ref number	Current risk score (previous)	Reason for increase in risk
3.2	25(20)	Financial sustainability. At month 4 the Trust is continuing to find the delivery of CIP of £15m very challenging. A combination of recurrent and non-recurrent mitigations are being identified and will be part of the recovery plan for the Trust. Income remains below plan with actions in place to recover this position.
3.8	20 (16)	Agency costs within the Trust remain high. Recruitment plans in place and these are expected to impact and decrease agency costs.

6. Risks below 12 will be removed from the BAF. No risks have been removed in this latest review

The top risks in the BAF

7. The top risk for the Trust is currently identified as the risk of delivering financial sustainability with risks in delivering the CIP and income plans for 2014/15. Mitigations are in place and longer term planning underway. This risk is currently scored as 25 (from 20).

8. The following have been identified as the next top five risks for the Trust.

Risk ref number	Current risk score	Reason for criticality
1.1	20	**Commissioner support** for our IBP and LTFM. At this time there is a process underway to develop the strategy for the Trust through the autumn and agree the alignment of commissioner 5 year plans with the Trust's 5 year planning.
3.8	20	**Payroll related costs** – Agency costs remain high and this remains a risk to our financial plans
4.1	20	**Operational performance** – Year to date, the Trust has achieved the A&E 4 hour target and waiting time targets for admitted and non admitted patients. We have also been put in band 6 (lowest risk) by the CQC in their latest intelligent monitoring tool.The achievements have required a great deal of effort. Going forward, there will be new commissioning standards while the CQC essential targets need to be maintained. 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 will both be at risk.
5.2	20	**Leadership** - There are significant leadership challenges in driving change and performance improvement in terms of capacity and capability. At the executive level, an interim CEO is in place. The CFO is an interim appointment. Medical Director and Director of Nursing recruited for one year.
5.3	20	**Comprehensive workforce planning** alongside an effective OD strategy is required to ensure we deliver the transformation needed in the organisation. These need to be completed following the review of the clinical and corporate strategy of the organisation this autumn.

Recommendations

9. Trust Board is asked to:-

- Note the BAF
- Agree next steps including a seminar workshop in October to review the BAF including refresher training for Executives and Non-Executives.

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 2 July 2014	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: 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*	Gaps: 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 from our core commissioners for our IBP and LTFM, then we will not be able to progress our FT application.	SP	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. 4. Technical strategic sub group of Transformation Board meeting regularly.	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 Strategy, DoF etc. 3. 5 year plan and LTFM submittted to TDA 4. Engagement strategy approved by TB July 2014	1. 2014/15 Contract agreed. 2. Letter of support from CCGs for maternity OBC. 3. Visibility and governance of transformation board including minutes of meetings.	5	3	15	1. Systematic engagement with CCGs in relation to next iteration of IBP to be finalised 2. CCG engagement limited to Haringey and Islington which only accounts for 85% of activity 3. Agreeing workplan between September and December with CCGs on joint work to develop further iteration of IBP 4. Data quality issues following EPR upgrade completion being improved to assure CCGs	1. 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. 2. Engagement with stakeholders including staff and local people on developing vision and clinical strategy for next 5 years and inform integrated business plan. 3. Joint plan of work with CCGs September to December	Dec-14
	1.3	If we do not improve the quality, completeness and timeliness of performance data, then we may under recover income under a PBR contract and lose the support of commissioners who value more detailed data, we may be unable to correct performance issues in a timely manner. Ensure accurate data reporting for national data returns and commissioning data sets	LM	4	3	12	⇩	Data Quality Group in place and 'task and finish' PbR group.	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.	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. The Head of Data Quality and Training has now completed the validation process and is setting up sustainable training for frontline staff in data entry. A review of the data quality programme will be undertaken to align with the revised board report. Data submissions - WH is working with CCGs to audit submitted data sets. Discussion around definitions and data quality are underway	1. EPR upgrade completed in May. Validation of datasets and analysis of datasets underway. 2 An action plan has been implemented to check clinical data entry for OPd, Dc, IP, HDU and ICU patients. 3. A community data quality process is underway with each indicator being reviewed 4. Agreeing process and criteria with CCGs to assure of data set quality 5. A PbR working party has been set up to ensure that all processes are in place for capturing PbR data sets	Oct-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	SMH/UG	4	3	12	⇩	1. Contract agreed for 2014/15. 2. Close engagement with local CCGs and GPs (see risk 1.1) through Transformation Board enables us to be more responsive to their needs. 3) Development of a GP relationships through business development work. 4)Improvement plans in place to improve key community service lines over the next 6 months.	ongoing engagement of senior management in CCG and Trust both formal and informal	Periodic tracking of referral patterns and market share. Informal networking with CCG at Board level.	4	3	12	CCG and GP perception of the success of community and ICO performance requires improvement to support a long term contract.	1. Improvement plans on key community service lines being delivered. 2. Communication with clinical commissioners and GPs and alignment of expectations. 3. Business development strategy being completed. 4. review of contracts team and permanent capacity and capability	Oct-14
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	PD	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 Partnership Board & Meet the CEO programme. 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. 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 poor 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.	SP	5	3	15	⇨	1. Communication and engagement plan 2. Regular meetings with key stakeholders 3. Partnership Board 4. Listening exercise 5. Islington and Haringey Council Cabinet member are observe at Trust Board 6. Interim CEO stakeholder engagement	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 and Trust Engagement Strategy 3. General media coverage	5	2	10	Widespread community engagement	1. Report to Trust Board regarding outcome of engagement activities 2. Continue to engage with all stakeholders 3. Trust Engagement Strategy approved at July TB 4. Detailed engagement plan being developed linked to strategy development including engagement of governors and key stakeholders	Oct-14
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	SP	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 for compliance 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. Workforce development plan successfully delivered to TB Seminar in March 2014, highlighting actions on culture, values, workforce planning and development initiatives. Workforce strategy group terms of reference being developed.	Recent CQC visit reported excellent staff engagement on the wards. NHS Staff Survey 2012 failed to give assurance due to low numbers of staff completing the survey. NHS Staff Survey 2013 results low results again. However, 1,600 staff completed a bespoke Staff Engagement Survey in 2014.	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. OD, coaching and mentoring being delivered for managers and leaders in nursing, medicine and management across the Trust. 3 Action planning underway in response to the results from the two staff surveys, completion by 1 September and progress review in Divisional performance meetings with COO and CEO.	1.Patient Safety Walkabouts are part of the culture of the Trust and working well. A series of innovative and focused management and leadership development initiatives are being rolled out. 2. Trust engagement strategy at TB July 3. Update on action planning to TB in September	Sep-14
	3.2	If we fail to deliver on CIPs and do not achieve the income as planned our financial sustainability will be at risk If we fail to identify and deliver 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.	UG	5	5	25	⇧	1. CIP Board in place 2. Service Improvement Team. 3. Revised processes for CIP management 4. Divisional performance management meetings, including CIP delivery 5. Weekly performance updates at TOB 6. Regular review and monitoring at Executive Committee and Trust Board	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. Project management documentation for all CIPs. 4. Improvement Board in place 5. CIP programme manager recruited and in place	1. Internal Audit of CIP process - November 2013 2. TIAA Internal Audit review Apr 2014 3. KPMG external audit May 2014 4. Ongoing scrutiny from TDA	5	3	15	£15m CIP identified for CIPs in 2014/15; planning gap remains for c£15m in 2015/16. Delivery of CIP for 14/15 behind plan. Discussion with CCGs on moving from block to pbr	1. Develop further improvement initiatives linked to benchmarking data. 2. Recovery plan being developed for September Trust Board 3. Recruitment of permanent FD underway 4. As part of recovery plan forecast on income in place and mitigations in place to maximise income opportunity	Sep-14
	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.	RJ	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	Self-assessment against new commissioning standards has been published. Comparison with other London Trusts awaited. Gap analysis being undertaken by operations to identify impact of achieving all unachieved standards. Trust will need to take risk assessed approach to full compliance, informed by position relative to other Trusts. Trust strategic planning group in place.	1. External clinical service reviews e.g. cancer peer reviews, NHSL pathology reviews 2. Configuration of other london healthcare organisations	3	4	12	1. Lack of detail in commissioner plans	1. Continued active engagement with UCLP. 2. Participation in Clinical Senates 3. Building a coalition with other DGHs 4. Involvement in NCL strategic planning group 5. 7 day working paper to September Trust Board	Oct-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.	RJ/PD	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. TB agreed investment in nurse establishment on acute adult wards June 2014 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 2. Prospective monitoring through Clinical Assurance Panel in place but ongoing monitoring of KPIs with regard to quality impact as part of routine CIP Board performance is being refreshed	1. identify tool and resource 2. Fully functioning clinical advisory panel 3. Quality report for each CIP to be considered within CIP Board 4. Further work on maternity and paediatric nursing ratios 5. E-rostering and dependency tool to be considered and report back to TB	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				Movement from 2 July 2014	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)*				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
	3.5	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. Performance of maternity is subject of regular reviews by community committee 2. A maternity redevelopment plan is in preparation and reviewed by the Estates Strategy Delivery Board 3. Minor improvement plan under way 4. OBC submitted to the TDA awaiting decision	1. CQC inspection reports 2. Patient feedback	4	2	8	Awaiting TDA response on Business case	1. Secured CCG support for growth to 4700 births 2. LTFM excludes estates sale to support maternity investment 3. Activity monitoring in place 4. Once OBC approval obtained then FBC to be completed 5. Estates strategy to be developed after further work on clinical strategy	Oct-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	UG	3	5	15	⇨	1. Costing and business intelligence systems purchased to support SLR.	1. Project to be established in finance with support from business intelligence team. 2) Quarterly update of SLR to include scorecards.	Clinical Champion identified to advise on project and progress (Rob Sherwin, O&G).	4	2	8	Additional SLM resources to divisions to be identified	1. New permanent Deputy Director of Finance in place June 2014 2 SLM plan to be developed and discussed at TMG and BFD committee	Sep-14
	3.8	If payroll related costs including severance are higher than planned this will cause financial instability against financial plans. If agency usage continues to be high, then we will not meet our financial targets	UG/LM	4	5	20	⇧	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. 2. Project to reduce agency costs in place. 3. Workforce strategy group terms of reference being developed	1. LTFM assumptions and associated risks periodically reviewed by F&BD Committee 2. Trust Management Group and Trust strategic planning group review	Severence for Executive posts & settlements above £100k require TDA sign off.	4	4	16	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 sustainability4. Impact of Agency reduction programme takes time to deliver as linked to recruitment	1. Severence to be controlled by workforce plans and performance management of staff. 2. Delivery of Agency reduction project. 3. Worforce strategy group to meet. 4. Benchmarking with other integrated care organisations to complete.	Sep-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	UG	4	3	12	⇨	1. IG improvement plan to meet Level 2 IG Toolkit compliance, by time of FT authorisation, monitored by Information Governance 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 Apr 2014 2. KPMG external audit May 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		Oct-14
	3.10	If integrated risk management is not embedded across the Trust, the Trust will not deliver safe and effective services	PD	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 4. Work completed in strengthening governance within divisional structure on risk and quality.Additional resource in place.	1. Parkhill annual internal audit of governance arrangements 2. CQC inspection compliance 3. CQRG meeting 4. Quality visits with TDA 5. KPMG external audit May 2014 6. Quality account published June 2014	4	3	12	1. Increase in the level of risk assessments being completed across the Trust	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 work completed and Quality and Risk management embedded in work of the Divisions.	Oct-14 Work in progress
	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 3. Improvement plans for all board indicators 4. Improvement committee formed	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. Further refinement is underway to align the board performance pack with the TDA national assurance guidance 14/15	1. Divisional performance dashboards to be issued in July 2. Revised Trust Board Performance Report to be issued in July 3. Operations restructure	Sep-14
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	PD/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 9. Divisional quality reviews completed 10. Quality standards established 11. New Quality Committees commenced in each division 12. Quality data packs established	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 poor 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

Strategic Goal	Ref	Corporate/Principle Risks *Should be high level potential risks which if happened will prevent the objective from being achieved*	Executive Lead				Movement from 2 July 2014	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)*				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
	4.2	If we fail to deliver the agreed CQUINs we will fail to make desired improvements and fail to achieve financial targets. There is also a risk of non alignement of CQUINs with internal and external QIPP programmes which could fail to maximise achievement of health improvement	LM	4	3	12	⇨	A CQUIN Steering committee has been established to monitor and assure delivery of CQUIN standards, this is chaired by the Deputy COO Carol Gillen. Monthly reporting is in place and action plans to ensure delivery.	Monthly Monitoring reports to TOB, TMG and reported within the present performance Dashboard	CQUINs are monitored via the Contracts meeting and also the CQRG meeting each month	4	2	8	Progress has been made with the improvements implemented, however the Alcohol CQUIN is being closely monitored to ensure delivery	Action plans in place, Monitoring and reports in place	Delivery standards have been set for each month and annual performance
5. Fostering a culture of innovation and improvement	5.1	If the planning processes across the Trust are not consistent and robust, then our business will be inefficient and ineffective, our IBP and LTFM will not be delivered, and our FT application could fail. This includes the continued development and implementation of the ICO strategy and SDF development to ensure service change supports FT application once the formal application process is resumed.	SMH/UG	4	3	12	⇨	1.Timetable and planning documentation set up to deliver planning requirements. 2. Executive planning group in place 3. Business planning cycle agreed at Trust Management Group	1.Executive responsible for planning and strategy in place. 2. Outputs from planning to be reported to Trust Board	1. TDA planning process to Sept 14. 2. HDD at the appropriate time.	5	2	10	Board and executive team in a state of transistion, including vacant CEO and CFO posts. Further work required to translate ICO vision into long term strategy.	1.Recruitment process for key posts underway. 2. Planning guidance for Divisions developed and business cycle underway 3. Templates issued to divisions	Sep-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.	SP	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.	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	Odgers Bernstein conducting recruitment process. Medical Director post and Director of Nursing posts recruited to.	Discussions to restart CEO recruitment with TDA in September. FD recruitment continues.	Sep-14
	5.3	If we do not develop comprehensive workforce planning supported by 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 the trust long term future will be compromised.	SP	5	4	20	⇨	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.	1. Integrated performance reporting agreed with the Trust Board includes workforce monitoring as a key component. 2. Trust Operational Board recieves monthly reviews of workforce statistics, including training, appraisals, sick leave vacancies etc. 3. Improvement being made in HR data quality and reporting. Changes to how appraisal and mandatory training is conducted and reported upon leading to improved compliance and quality. 4.Improvements made in streamlining recruitment processes and policies so that the right recruitment decisions are made. 5. Focus of OD strategy is engagement and improvements in managerial and leadership capability and confidence. 6. TB Seminar received the Workforce Development Plan 2014-16 in March 2014 and circulated to Finance and Business development Committee in July 2014.	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. Managers and leaders across the organisation developing skills as part of the Leadership and programme. 2. Inconsistent processes and practices across the Trust.	1. New leadership and management developmnent programme in place and roll out commnced on coaching and mentoring. 2. LETB funded projects being rolled out. 3. Strategic Workforce monitoring report produced for Audit and Risk Committee. 4. Scorecard - HR key metrics now being reported to the new quarterly Divisional performance meetings and monthly to the Operational board meetings. This will show month on month comparisons and RAG rated so that Directors will be able to identify areas of risk that need further focus and development.	Mar-15
	5.4	If the quality of teaching is not excellent, then commissioners (UCL, Middlesex and LETB) may not renew their teaching contracts. Alongside this there are changes in the structure and funding of medical education from 2015. This will not only lead to a loss in income, it may lead to loss of trainees who ar a critical part of service delivery.	RJ	4	3	12	⇨	1. Post graduate medical education board chaired by Director of Education oversees quality of training. 2.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	3	12	2. Inconsistent processes and practices across the Trust..	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. Work to consider impact and opportunity of medical education changes underway 3. Recruitment to integrated care and primary care education roles - manager post to be advertised	Sep-14
	5.5	If delivery of the Electronic Patient Record Project fails, transformation of the organisation and delivery of an integrate patient record will be delayed i.e. delay in improvements to patient safety, outcomes and experience as well as operationa efficiency.	UG	4	3	12	⇨	1. EPR Project Board in place, with associated programme management arrangements in place 2. Joint Trust/McKesson fortnightly project team meetings to review workpackages 3. On-going stakeholder workshops with clinical services	1. Joint Trust/McKesson fortnightly project team meetings to review progress 2. Joint Trust/McKesson workshops to review functional specifications 3. Quarterly report to Executive Committee 4. Bi Annual report to Trust Board 5. Risk register and issue log	1. Successful go-lives for EPR PAS, ED, Maternity, and GP portal 2. McKesson proven deployment methodology 3. HSCIC-BT process to manage migration off RIO by October 2015	4	2	8	EPR Steering group terms of reference being revisited	TIAA to be re-engaged for EPR Community deployment to provide external assurance. Community EPR group to be reinstated.	EPR and BI upgrade - 03/05/14 Community EPR go-live - 30/10/15