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Whittington Health Trust Board

25 September 2013

Title:	**Review of the Board Assurance Framework (BAF)**		
Agenda item:	**13/122**	**Paper**	**7**
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 is asked to: • Agree the changes in risk scores in the BAF • Approve the removal of risks with scores ≤ 8 • Agree to the addition of a new risk (Risk 5.6) • Agree the top three 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		
Date paper completed:	**Version Number: 2**	**Version Date: 19/09/13**	
19 September 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	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**Yes**	**Legal advice received?**	**N/A**

Whittington Health Trust Board

25 September 2013

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 (12.09.13). 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 on 11 July 2013

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

Risk ref no.	Current risk score (previous)	Reason for decrease in risk
1.1	15 (16)	This has been rephrased from the previous risk which was about securing commissioner support for the integrated business plan (IBP) and maintenance of market share. Action plans to close those gaps in controls have been completed. The risk is now about gaining clinical commission group (CCG) agreement for supporting radical transformation and to commission at a higher rate of activity from 2014/15.
1.3	12 (16)	Rapid actions taken to improve data quality and performance reporting, especially on waiting times, have resulted in timely and accurate reports.
1.4	8 (10)	Following two unsuccessful attempts to recruit to the post, an interim Director of Contracts with responsibility for business development started on 1 September.

2.2	10 (15)	Action plans completed. Following a three-month listening exercise, the revised clinical strategy received the support of local CCGs and overview and scrutiny committees (OSCs). It was approved by the Trust Board in July.
5.1	10 (15)	The Chief Finance Officer is responsible for the foundation trust (FT) programme and has developed a detailed timetable and action plan to manage the process for developing the IBP and long term financial model (LTFM). The Executive Team is meeting weekly to ensure steady progress on FT, with monthly oversight from the FT Steering Group and the NHS Trust Development Authority.

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

Risk ref no.	**Current risk score (previous)**	**Reason for increase in risk**
5.2	20 (12)	Two of the top team are interim appointments. Recruitment is underway to appoint a new chairman in November 2013. Many senior managers in operations are interims. Internal recruitment processes need significant improvement (based on feedback).

5. The following risk is **new** and has been added to the BAF:

Risk ref no.	**Current risk score**	Reason for adding the risk
5.6	20	There remains a significant gap between what the service development plans (SDPs) are projecting and the savings required for the LTFM. The challenge of driving performance improvement needs the right processes and inspirational leadership to engage staff. Initiatives that will deliver better care at lower cost are needed to meet the required efficiency targets for 2014/15 and 2015/16. Haringey and Islington CCGs are expecting to lose £10m/year in 2015/16 onwards to pooled budgets. This money is currently spent on health, so radical innovations are required. (nb. This risk is different from 3.2 which is about delivery in year.)

Proposal to remove the following risks from BAF

6. The following risks have risk scores ≤ 8. It is proposed that they are removed and where relevant, kept on the Corporate Risk Register.

Risk ref no.	Current risk score (previous)	Reason for decrease
1.2	8 (8)	Action plans to close the gaps in controls have been completed.
3.7	8 (8)	This was included in the BAF to align with the IBP. National policies on tariffs are under review. New CFO and interim Director of Contracts have started discussions with CCGs about 2014/15 contracts which are expected to include local tariffs.

The top three risks in the BAF

7. The following have been identified as the top three risks for the Trust.

Risk ref no.	Current risk score (previous)	Reason for criticality
3.2	20 (20)	If we miss this year's CIP target of £15 million, 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.
5.2	20 (12)	See 4 above. Management capacity is under significant pressure in part due to difficulty in recruiting to critical posts. Our internal policies and processes need to improve if we are to achieve our workforce strategy. If we do not fully implement our plans, we cannot improve staff productivity and take out costs, making the Trust unviable as an FT.
5.6	20 (new)	If the trust cannot come up with innovations that deliver better quality at lower costs, it will not be able to bridge the savings targets needed for a viable IBP and LTFM, without which our FT application will fail.

Recommendations

8. The board is asked to agree that the BAF reflects the current risks to Whittington Health

DR YI MIEN KOH **19 September 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: Impact	Current risk rating: Likelihood	Current risk rating: 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	Target risk rating: Likelihood	Target risk rating: 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*	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 to commission higher levels of activity and to support radical service transformations , then we will not be viable as an FT.	YMK	5	3	15	⇩	1. 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	Sept 2013 - actions completed.
	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	LMa	4	3	12	⇩	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 work plan	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 committees for the review and management of; 1. RTT Action Plan 2. Cancer and RTT Steering Committee and Clinical Advisory Panel 3. Data Quality Group work plan 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 essential 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	A action plan is in place for referral 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 on track to complete
	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 and 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. Whistle blowing 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 and HCA ratios versus similar Trusts. 5. NHSLA Level 1 completed Feb 2012. 6. CQC Reports 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 Family Test for AandE shows 4.6% response rate (bottom 5)	4	1	4	1. Patient experience surveys and results 2. Pressure ulcers (grade2 and above) 3. Full delivery of F&F action plan in areas where scores are low	1. Full roll out of Friends & Family Test 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. Net promoter 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 regarding 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 environment; 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 for compliance with mandatory training. 4. Partnership group meetings	Draft OD plan "Passionate about People" successfully delivered to TB seminar in 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 execs/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 coherent internal communications/engagement strategy present at this time.	1. Patient Safety Walkabout programme reignited and 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. October 2013 there will be a full engagement survey for all staff to complete from OCR International, an independent expert staff engagemen organisation. OD strategy currently subject to a business case for agreement on costings.	March 2014 Sept 2013
	3.2	If we fail to deliver CIPs and planned productivity improvements, then our financial stability will reduce, our FT application 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 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.	1. External review of CIPs through HDD2 - due December (moved from 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 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 EC and at Resources Committee

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	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	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 Test scores, GP surveys, readmission rates, mortality etc 2. TB monitors staffing ratios (e.g. nursing and midwifery) against good practice standards. 3. Divisional Board and 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 and 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.	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 case for £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/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 and 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 capacity plan due for presentation at EC in March 2013	May 2013 incomplete
	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 periodically reviewed by F&D 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.	Discussions with CCGs on next year's contracting round have started, led by SW.	Mar 2014. suggest remove
	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	LTFM assumptions and associated risks periodically reviewed by F&D Committee		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. Severance to be controlled by workforce plans and performance management of staff	Sept 13 for workforce plan Dec 13 for policy review
	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. 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. 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 3. CQRG meeting 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 3. Keogh review - National Inspector of hospitals	5	1	5	Roll out of quality standards	New quality standards to be rolled out.	Mar 2013 - suggest remove
	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	⇨	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	Sept 2013 - 1 and 2 complete. 3 to be completed
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 Test 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 poo performance in pt experience surveys. 5. Roll out care connect	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	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
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	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	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.	Mar-14
	5.2	If we do not recruit and retain a management team that can deliver the transformation at the required pace and scale, 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 and 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. Half of the top team are interim appointments. The three interim posts (CFO, Director of OD, Director of Communications) will be advertised in January 2014. 2. Two attempts to recruit a permanent CFO failed and an interim (SW) has been in post from August 2013. 3. The two most senior finance managers in the trust have resigned in September. The Deputy DoF will need to be replaced. 4. The trust chairman has resigned and recruitment is underway, to appoint a new chairman in Nov 2013. 5. The trust secretray (LM) left the trust on 30 August. The post will be advertised in September. 6. The majority of senior managers in Operations are interim appointments. The posts need to be reviewed and permanent appointments made. 7. Internal recruitment processes need significant imp	1. The Trust has been selected by the TDA to participate in the NHS Leadership Academy's Board development programme to take place Sept-Dec 2013. 2. Executive development programme and OD plan. Subject to a business case to be presented to EC in September. 3. Development of a Recruitment and Retention Plan.	TB BGAF planned for Sept 2013 to be delayed until Chair and trust secretary in post. Expected new date: Nov/Dec 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 and 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, including 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 and 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 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.	1. Interim support currently in place for workforce planning to reach an IBP position of good workforce forecasting by September. 2. Newly appointed Deputy Dir of Leadership & Talent (Aug) to support organisational growth and development. 3. Deep dive review within recruitment completed. Plans with Dir of OD for implementation. 4. OD programme plans to commence with staff engagement survey in Oct 2013 with initial results in Dec 2013. 5. Advert place (end August) for deputy director of Hr operations to lead improvements in operational and transactional HR performance. Anticipated appointment by Dec 2013.	Oct 2013 Aug 2013 complete Oct 2013/Nov 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	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, Cynical 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	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
	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 operational efficiency.	LMa	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 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	Dress rehearsal in first week of August went well other than issues with reporting and RTT data. ET reviewed progress and decided to delay go-live scheduled for 30 August until outstanding items resolved. Correct expected new go-live date in 14/15 or 21/22 Sept.	An action plan /log of outstanding issues needing to be resolved are reviewed and monitored daily.	August 2013 - missed deadline. New date in mid to late Sept
	5.6	NEW. If the trust does not have the right processes in place and the inspirational leadership that engage staff, we will not be able to improve at the required pace and scale. If we are unable to deliver better care at lower cost, we will not be able to meet the required efficiency targets for 2014/15 and 2015/16. The IBP and LTFM will then not be viable, in which case our FT application will fail. Haringey and Islington CCGs are due to lose (top sliced) £10m/year from 2015/16 to pooled budgets so radical innovations are required. nb. This risk is different from 3.2 which is about delivery in year.	SW	5	4	20	NEW	FT Executive meeting weekly to maintain progress on IBP and LTFM. Service Development Plans (SDPs) to be refined and modelled, Call (to staff) for new ideas to achieve better quality lower costs. Review of PMO arrangements and management capacity and capability.	Monthly report to FT Steering Group	Transformation Board feedback Support from Commissioners HDD 2 due Dec 13/Jan 14 Health and Wellbeing Boards and OSCs	5	2	10	More engagement of staff, especially clinicians, in SDP development More strategic discussions with CCGs about service innovations and affordability at a time when seeking to be commissioned on out-turn (activity) basis.	Robust IBP and LTFM	Mar-14