East and North Hertfordshire NHS
NHS Trust

Agenda Item: 11b

BOARD – 23 October 2013
Board Assurance Framework 2013/14

PURPOSE	To present to the Committee the draft Board Assurance Framework 2013/14 with the quarter 2 updates for consideration.
PREVIOUSLY CONSIDERED BY	Executive Committee RAQC, October 2013.
Objective(s) to which issue relates *	☑ 1. To continuously improve the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services ☑ 2. To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction ☑ 3. To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services ☑ 4. To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable ☑ 5. To support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services ☑ 6. To improve our staff engagement and organisational culture to be amongst the best nationally
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Integral part of the Trust's Quality Governance & Risk Management Strategy As identified in the report
Healthcare/ National Policy (includes CQC/Monitor)	Key element of governance and risk management structures Healthcare Regulation through CQC , key component of NHSLA requirements and central to the Trust's FT application
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	Chief Executive
PRESENTED BY:	Company Secretary
AUTHOR:	Company Secretary
DATE:	October 2013

East and NorthHertfordshire NHS
NHS Trust

Board Assurance Framework 2013/14

TRUST BOARD: October 2013

Executive Summary:

The format of the Board Assurance framework (BAF) is reviewed and approved annually by the Board and Audit Committee. The format for 2013/14 now provides greater visibility of the measures for each of the annual objectives and where the full measures are listed and monitored. The BAF remains a live document with ongoing work to continue to ensure the strategic risks are appropriately identified, documented and mitigated. There is ongoing work to strengthen the controls, actions and links to known future sources of internal and independent assurance.

The BAF continues to be reviewed and updated with Executive Directors at least quarterly and then reported to RAQC and Board for scrutiny and assurance. The Company Secretary retains core oversight of the document.

The RAQC reviewed and discussed the BAF at is October meeting. The Committee endorsed the updates and requested minor amendments including that the risk relating to demand management and potential breach of performance targets is revised to 'amber' for year end to take into account the winter pressures and impact of the treatment centre.

In addition, further updates relating to the areas led by the Director of Strategic Development have been incorporated.

The Board are asked to review the latest version of the BAF and are particularly asked to note:

- The increase end of year risk position to 'amber' on pages 6 & 7 re the risk relating demand management and to potential breach of performance targets
- The red risk for c. difficle on page 9
- The objective summaries on pages 9, 10, 13, 17, 29, 32 and 36
- Page 27 & 28, the closure of the Risk 11 - Risk to the reputation of the Trust if Clinicenta performance is poor. As services transferred safely to the Trust on 14 September 2013. And the addition of the new risk - Risk that the transfer of the treatment centre services to the Trust adversely impacts on the overall performance and finance. This related to objectives 4.12 & 1.1.
- Page 17, the achievement of objectives 4.2 and 4.3 – approval of the Chemotherapy and Pathology Hot Lab FBCs

N.B. Changes are recorded in 'pink' text

Board Assurance Framework 2013/14

The Board Assurance Framework contains the principal risks associated to the achievement and delivery of the Trust Strategic Aims and Annual and. The Strategic Aims, from which the 2013/14 annual objectives have been framed, build on the previous work of the Trust and support the delivery of the Trust's vision: *To be amongst the best* and the Trust's values.

Strategic aims 2013-2018

1. To continuously improve the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services.
2. To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.
3. To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
4. To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable.
5. To support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services.
6. To improve our staff engagement and organisational culture to be amongst the best nationally.

The risk traffic light definitions are:

Red: A significant failure to mitigate a risk either through lack of controls identified (or poorly framed controls), with a high likelihood of the risk being realised in the short term.

Amber: On course to be mitigated, given the controls identified, but further work required in delivering the agreed actions.

Green: The risk has been mitigated as defined by the controls and actions identified. These risks will continue to be displayed on the framework so that assurances received can be kept up to date.

Trust Board Assurance Framework 2013/14

Trust Strategic Objective 1: To continuously improve the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services.				
Trust Annual Objectives 2013/14:		**Forecast RAG**	**Achieved**	**Measures**
1.1	To improve patient outcomes thereby achieving a governance risk rating of 'amber/green', or better.			**GRR/ CQC summary/ performance report & floodlight**
1.2	To reduce mortality and deliver HSMR and SHMI within the 'as expected' range or better *(Trust Improvement priority 1)*			**Floodlight/ mortality report**
1.3	To improve the safety and outcomes of patients by:			
	i) implementing the priorities set out in the Improving Clinical Outcomes strategy			**Floodlight/ mortality report/ MD report**
	ii) delivering the agreed pathways to improve patient outcomes and ensure the achievement of the agreed CQUIN targets			**Floodlight**
	iii) improving post operative outcomes for high risk patients (deteriorating patient, frail elderly, co-morbidities) *(Trust Improvement priority 3)*			**Floodlight/ mortality report/ MD report**
1.4	Have a zero tolerance approach to hospital acquired infection and comply with the hygiene code			**Floodlight/ IC report**
1.5	To deliver on the key priorities for 2013/14 agreed within the Quality Account Priorities *(improving safety, improving clinical outcomes, staff development /engagement, improving patient experiences)*			**Floodlight/ MD& DoN report/ QA/ Quality Indicators**

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				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
1.1	1. Risk of breach of CQC regulations and increase level of performance management & scrutiny by TDA, CCG and regulatory bodies. **(Risk carried forward from 2012/13 BAF)**	All regulations / FRR/ GRR	Governance Risk Rating & exception reports to Trust Boards Monthly Compliance & Governance Assurance Maps reports to RAQC, Monthly review of CQC QRP. Risk register Internal review process for all CQC Outcomes. Infection control action plans monitored weekly by DIPC/ Executive Comm Floodlight Scorecard – all areas Internal unannounced & announced ward visits /Pt Stories by various members of Board Reports to RAQC IG Steering	Registration without compliance conditions across all locations Evidence logs for all CQC outcomes; internal review of all outcomes – compliant; April 2013 NHSLA level 2 & CNST level 1 Positive CQC unannounced Inspection reports 2012/13 & September 2013. Positive QRP's 2012/13 & 2013/14 to date Quality Account 2012/13 Internal Audits – Governance/ Performance CSS & Cancer	Ensuring registration standards continue to be embedded across Divisions. Compliance with all infection control targets (MRSA screening/C diff) Monitoring of completion/outcomes of all mandatory Clinical Audits Meeting patient experience expectations CQC reviewing standards and regulatory process Access to winter pressure funding	Compliance with IC policy Implementation of Health & Safety Strategy Full completion of Clinical Audit Programme Areas in National Patient Survey Quality indicators at ward level – not all data sources available in timely manner. *Internal Audit (IA) - Risk & Assurance & IG in 23/24* Outcomes of IA Programme reports due inc Clinical Audit Outcome of external audit on treatment centre waiting list	Action plans in place for targets and standards at risk of not performing within the 'achieved' thresholds Implementation of infection control RCA's and C.Diff action plan Monthly review of QRP and other external & internal information to target areas at potential risk of non compliance IG Toolkit action plan Monitoring of NQD, Quality Matrix & Patient Experience at Performance Reviews Internal Audit programme 2013/14	All Executive Directors RAQC/FPC		

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			Group Annual review of statement of purpose (2013)	(positive) IG Toolkit submission 2012/13 – level 2 & satisfactory & Internal Audit MVCC Quality visit by CCG – positive Positive TDA ward visits & Infection Control inspection in Q2		No allocation of winter pressure funding to date	Clinical Audit Programme 2013/14 Review governance structure/processes in line with new CQC requirements when published. Treatment centre project group actions Implementation of the Winter Pressures Operational Plan			
1.2 1.3 1.5	2. Risk that service pathway changes and changes to the coding service model do not deliver the reductions in mortality set. **(Risk carried forward from 2012/13)**	Regulation 9, 10 (outcome 4 & 16)	Monitoring of mortality at Trust, Divisional and Consultant Level. Regular reports to RAQC & Board. Clinical Audit Programme. Care pathway reviews. Monthly Coding Mortality report & twice a month coding review meetings. SPC charts	Dr Foster reports. Service Pathway reviews. HSMR benchmarking reports. Mortality outlier investigation reports. Improvement in depth of coding. HSMR action plan agreed with SHA & PCT Regular coding	Ineffective implementation of the process to ensure data quality Leadership for the coding team/ward clerks	Mortality review/feedback from individual consultants incomplete at present. Coding model continues to be reviewed & strengthened Review of effectiveness of all CQUIN	Implement Improving patient outcome priorities & strategy SHMI/ HSMR Action plan & service pathway reviews Continued monitoring of mortality rates against benchmarks &	Medical Director/ RAQC, Clinical Governance Strategy Committee/ Coding Review Group	Risk reviewed & increased, July 2013	Risk reviewed & increased, July 2013

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			reviewed prior to submission to SUS. Floodlight scorecard report – Clinical Outcomes Report to Execs	and mortality meetings inc Herts Mortality review group. Improvements in HSMR predicted rebase 97 for 2012/13 (green), & SHMI now 111 (as expected). Favourable mortality on all reconfigured services. CQC Mortality Outlier alerts - #NOF & Septicaemia, Therapeutic; alerts closed Improving outcome report to RAQC/Board Dec 2012 No mortality alerts for 2012/13 New RHD programme Internal review against risk responsive reviews		pathway changes not yet known	implementation of specific Divisional action plans to reduce mortality Review of low risk conditions Weekly reports to DEC/Execs Implementation of findings from pathway reviews and outlier alerts #NOF action plan monitoring impact of service changes Implement coding review action plan Implement learning from national Risk Responsive reviews			
1.1	3. Risk that demand management does not reflect CCG commissioning	GRR / FRR	CCG/Trust commissioning/ contract monitoring	Significant clinical engagement from the Trust	The Trust is not the responsible organisation for delivery of	Limited history of sustained delivery on demand management	Work with CCG to deliver robust plans for activity reductions and	Director of Operations / Director of Finance		

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	intentions leading to insufficient capacity & delivery of performance targets (Short term risk) **(Risk carried forward from 2012/13)**		meetings. QIPP committee. Activity & demand reports to FPC New regional Urgent Care Board	regarding possible changes to the way we respond to the QIPP/Demand Management Challenge. Schemes developed by specialty. Negotiated revised contract with private sector providers at discounted rates. Activity is broadly in line with commissioning intentions	activity reductions/DTOCs- The Trust provide input & support through the CCG/Urgent Care Board to deliver the planned reductions Allocation of winter pressures monies is outside to the Trust's control	Increased acuity of patients attending A&E No allocation of winter pressure funding to date	monitor through QIPP steering group and contract meetings Capacity plan to allow scope for increasing capacity if demand management is unsuccessful Review of DTOCs C Diff action plan A&E action plan OCH Programme Review of bed configuration TIMP Implementation of the Winter Pressures Operational Plan Treatment centre project group actions			October 2013: Risk reviewed and increased
1.3	4. Risk that CQUIN **targets will not be delivered, leading to failure to achieve**	Regulation 9, 10 (outcome 4 & 16)	Details of CQUIN fully agreed between both parties.	Monthly reports and to FPC & RAQC	Baseline audits required for number of new pathway	Current information systems/ processes may	Continue to monitor delivery against each known individual	Director of Finance/ FPC/ RAQC		

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	financial payments		Trust Floodlight scorecard (CQUIN)/ CCG contract monitoring/ Quality Review meeting		measures & SHMI used an indicator VTE performance fell in Q1 21013/14 SMHI being used by CCG as measure for some mortality pathways	not support robust monitoring from Divisional to Board Level VTE performance *Clinical Audit Programme*	CQUIN element and strive to improve performance where necessary. FFT action plan & monitoring Dementia action plan Clinical Audit Programme	Director of Finance/ Medical Director/ Director of Operations/ Director of Nursing		
1.3 1.1	5. Risk that falls and pressure ulcer prevention policies are not consistently applied **(Risk carried forward from 2012/13)**	Outcomes 1,4,5,8	Policies Floodlight Score card Monitoring through Exec/DEC & RAQC NMEC TVN's Training Falls co-ordinator post holder has commenced, working within acute Trust and across into community – 18 month secondment TVS Team	Met trajectory for agreed reduction in 2012/13 Significant reduction in falls in Medicine	Consistency in application of policies	Evidence of consistency in application of policies	Monitor implementation of plan & quality matrix Implement & share learning from RCAs Implement recommendations from nursing establishment review	Director of Nursing/ RAQC		

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1.4	6. Risk of not meeting C Difficile target **(Risk carried forward from 2012/13)**	Outcome 8	Policies Floodlight Score card ICT team Audit Programme Divisional IC Meetings Monitoring through Exec/DEC Timely information from MVCC/ HHT pathology – process agreed Weekly monitoring at Execs/DEC	Reports to IC, RAQC & Board RCAs Care Bundles Deep Clean Programme Sept 2013, TDA Infection Control inspection – positive	Trust wide consistency in application of Policies	Trust wide consistency in application of Policies	RCA's on all case Ensure deep clean programme Delivery of IC Audit Programme Communication Plan IC Committee workshop C Diff action plan	Director of Nursing/ RAQC		

QUARTERLY TRUST BOARD PROGRESS REPORTS (Executive Director Lead): *(include progress on meeting the objective and the management of the principle risk)*	
Quarter 1 Progress Report:	1.1: Quarterly GRR is Amber/green due to C Diff. Actions in place 1.2 Rebase HSMR predicted at 97. SHMI currently within the as expected range. Risk reviewed at RAQC & increased, July 2013: due to impact of the SHMI forecast not being in the as expected range on the next data releases prior to improvement. 1.3 i) strategy to RAQC for approval in July 13 1.4: Compliant with hygiene code. C. Diff 7 at end of June against target of 14. 2 x community acquired. RCA's completed. Escalation meetings and action plan in place. Deep clean programme.
Quarter 2 Progress Report:	1.1: Quarter 2 GRR is Amber/green due to C Diff. Actions in place. New Risk Assessment framework is being implemented in October and this will change the ratings going forward. 1.2 Rebased HSMR within as expected, 98. SHMI currently above the 'as expected range', However, this is expected to improve on the next data release in October. HSMR – April to June 2013 – is as expected at 89.8. NED training session on mortality delivered by Dr Foster in

	September with CCG representatives. 1. 3 i) Improving Outcomes Strategy approved by RAQC & Board in July 13 ii) Current risk to VTE CQUIN – actions reported to Board and its committees. 1.4: Compliant with hygiene code. C. Diff 11 at end of September against target of 14. RCA's completed. Escalation meetings and action plan in place. Deep clean programme. Positive TDA inspection in September 2013.
Quarter 3 Progress Report:	
Quarter 4 Progress Report:	

Trust Strategic Objective 2: To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.				
Trust Annual Objectives 2013/14:		**Forecast RAG**	**Achieved**	**Measures**
2.1	Achieve improved levels of GP satisfaction with Trust communication and services (measure clinical correspondence contract performance & GP survey/feedback)			**GP Survey**
2.2	To implement the Carer friendly hospital strategy			**Progress against milestones/ DoN report**
2.3	To implement the Patient and Carer Experience Strategy and review identified priorities *(Trust Improvement priority 5- Improving the experience of patients using our services)*			**Progress against milestones/ DoN report**
2.4	To improve the administration processes and patient experience in relation to Outpatients			**Complaints/Pat feedback/ reduce DNAs**

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2.1	1. Risk of delays to service change or adverse changes to commissioning pathways		CCG Quality meetings Primary Care Customer Relations Manager activities Clinical	Clinical involvement in pathway changes GP helpline GP update RHD reports Divisional	Proactive engagement at across all areas Data set not fully validated to enable accurate performance	Proactive engagement at across all areas New structures No clear system in place to	Engagement plan GP surveys Develop action plan to address data validation and improve	Director of Strategic Development /RAQC		

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			correspondence performance data Engagement with OSC, Healthwatch, Involvement Committee Attendance in Board Development Sessions	Marketing Reports Director of Ops attendance at Urgent Care Board	improvement/ monitoring	validate the data and to improve performance	performance			
2.2 2.3	2. Risk that we don't improve on the 5 national composite patient experience questions and net promoter (FFT) **(risk revised from BAF 2012/13)**	All core CQC outcomes	Patient Experience Committee ARC Steering group and programme Audit & Survey programme Patient & Carer Experience Strategy / Focus groups Nursing & Midwifery Strategy Weekly reporting in place by ward.	Carer survey – implemented Internal Audit report on Patient Experience Friends & Family test & meridian tracker results Positive improvement demonstrated for 2012/13 -	New national methodology for the net promoter score – rolled out to A&E	Consistent Net promoter score across all areas. Number of areas identified in National and Local patient experience survey as now performing in upper quartile	divisional performance is being monitored at PMR's Implementation of Patient and Carer strategies Implementation of Internal Audit recommendations Implementation of Care Friendly Hospital Plan	Director of Nursing / RAQC		
2.4	3.Risk of ability for current IM&T infrastructure to		IMIT strategy Patient Experience and			Negative Patient Experience & Compliant	Review of IM&T strategy with stakeholder	Director of Operations/ Director of		

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	fully support the technological changes required		Care feedback processes / reports to RAQC TIMP/TOMP			feedback DNA rates	involvement CSS to implement centralised call centre Review of administration processes & implementation of action plans by divisions Implementation of TIMP and TOMP action plans Develop bids to access national funding streams	Finance/ RAQC & FPC		

QUARTERLY TRUST BOARD PROGRESS REPORTS (Executive Director Lead): *(include progress on meeting the objective and the management of the principle risk)*	
Quarter 1 Progress Report:	2.2 & 2.3: Update on first year review of Patient and carer experience strategy to RAQC in July.
Quarter 2 Progress Report:	2.4: Transforming outpatient services project group launched. Clinical Support services are due to present to RAQC in October 13. Patient stories at Board highlighted areas for improvement.
Quarter 3 Progress Report:	
Quarter 4 Progress Report:	

Trust Strategic Objective 3: To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services				
Trust Annual Objectives 2013/14:		**Forecast RAG**	**Achieved**	**Measures**
3.1	To work with key partners and provide leadership to define and deliver year 3 of the Hertfordshire QIPP plan			**Floodlight Scorecard/**
3.2	To enhance quality of life by reducing emergency admissions for acute conditions and enabling patients to stay at home *(Trust Improvement Priority 2)*			**Set out in Improvement Priority**
3.3	To improve In-patient Care of Diabetes *(Trust Improvement Priority 4)*			**Set in Improvement Priority**
3.4	To implement and deliver the 2013/14 milestones within the Older Persons strategy			Milestones in strategy
3.5	To implement the dementia alliance framework			**Set out in strategy/**
3.6	To shape the AHSN workstreams, engage GP's in the pathways and work with the fellows of the higher education institutes to evaluate the improvements			

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3.1	1. Risk that whole systems QIPP plans that have an impact on demand, capacity & finance in this Organisation are not fully delivered. (cross ref to risk in objective 3 – short	GRR/FRR Various CQC outcomes	Monthly SLA contract meeting, OCH plans factor in some flexibility to increase capability to increase should plans not deliver reductions.	Jointly agreed Hertfordshire QIPP programme signed by all CEO's in March 2011. Financial close for New QEII	The Trust provide input & support through the CCG & CCGs/Community Trust to deliver the planned reductions.	Increased levels of non elective activity in 2012/13.	Continue to work with CCG to deliver robust plans for activity reductions and monitor through SLA meetings Review demand management	Director of Strategic Development / Director of Finance/FPC		

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	term) **(October 2013 – risk under review with Director of Finance)**		Market report to FPC reports activity against FBC assumptions. Trust established New QEII Programme Board to plan mobilisation and service delivery of New QEII Hospital New Urgent Care Board Delivery against QIPP plans monitored through contract meetings with CCG	achieved in March 2013	Non elective activity only paid at 30% tariff if above activity plan		delivery with a view to confirming capacity requirements Continue to work with the CCG to develop the operational policies and clinical pathways required			
3.2 3.3 3.4	**2. Risk to delays in service /improvement pathway reviews due to potential need for financial investment to enable changes & quality improvements**		CGSC/ Patient Safety Committee Reports to RAQC Agreed improvement priorities		Gaps analysis currently being undertaken	Outcome from gap analysis	Implementation of the Improvement Priorities 2 & 4 Implementation of the Older persons strategy	Medical Director/Director of Operations / RAQC		
3.5	**3. Risk of lack of specialist dementia knowledge across the workforce**	CQC outcomes	Dementia Strategy Training Program Adult	Lister Hospital CQC report – full compliance, Sept 2013			Implementation of the Dementia Strategy Action Plan	Director of Nursing/ RAQC		

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			Safeguarding Lead				Seek approval for recruitment of Dementia Nurse Specialist			
3.6	**4. Risk of failure to fully engage and maximise the benefits to the health system and beyond from the Eastern AHSN** **(new risk October 2013)**		Director of Strategic Development has bee appointed AO for the node and is core member of the EAHSN Executive team CEO alongside Professor of the Uni of Herts Co Chairs the Beds and Herts Node & represents the system on the EAHSN Board	Node meetings held monthly, TOR established. Excellent attendance from member organisations including Acute academic, MH , public health, CC, commissioners, clinicians – member continues to grow. Work programme established with focus on patient safety and clinical medicine clinical sturdy groups, for which the node has lead responsibility 8 project proposals fully developed and submitted for		Awaiting finding of EHSN project finding committee	Work underway to develop programme and project management structures to support delivery	Director of Strategic Development		

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				funding in Oct 2013.						

QUARTERLY TRUST BOARD PROGRESS REPORTS (Executive Director Lead): *(include progress on meeting the objective and the management of the principle risk)*	
Quarter 1 Progress Report:	
Quarter 2 Progress Report:	3.2, 3.3: In progress and reported through medical director reports to RAQC 3.5 In progress 3.6 Trust fully engaged with the AHSN workstreams.
Quarter 3 Progress Report:	
Quarter 4 Progress Report:	

Trust Strategic Objective 4: To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable.				
Trust Annual Objectives 2013/14:		**Forecast RAG**	**Achieved**	**Measures**
4.1	To ensure the delivery of safe services at the QEII during the final phase of the consolidation programme, ensuring the effective management of patient safety and clinical risks associated with the delays to the Phase 4 programme			**Floodlight**
4.2	To approve the Chemotherapy FBC			**Floodlight / OCH report**
4.3	To approve the Pathology Hot Lab FBC			**Floodlight / OCH report**
4.4	To approve the TPP Joint Venture and commence transformation of pathology services			**Floodlight / OCH report**
4.5	Deliver the health records project in line with the approved FBC			**Floodlight / OCH report**
4.6	To reach agreement with commissioners on pathways for services to be provided from the New QEII including children's services, local A&E and rapid assessment			**Agreements in place**
4.7	Ensure improvements in the stroke care pathway to deliver a Hyper Acute Stroke Unit			**Performance report/ floodlight**
4.8	To implement a 24/7 PPCI (Primary Percutaneous Coronary Intervention) service			**Service implementation**
4.9	Through targeted marketing ensure the maternity service is working to full capacity, 5250* births.			**Marketing report/ Divisional floodlight**
4.10	To work with partners to deliver requirements of vascular review and to maintain the quality of services			
4.11	Explore with Commissioners further opportunities for developing integrated care			**Reports**
4.12	To improve the financial efficiency of the Trust and deliver the financial forecast and the cost improvement programme across the Trust for 2013/14			**CIP delivery- floodlight**
4.13	To implement Service Line Reporting, ensuring that it is used to inform decision making at all levels within the organisation demonstrating service improvement contribution			**SLR project plan milestones**
4.14	To deliver on the milestones agreed with the Trust Development Authority to achieve authorisation as a NHS Foundation Trust			**TDA elf certification**

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
	1. Risk of sustainability of QEII as an acute site until final consolidation **(Risk carried forward from 2012/13 BAF)**	All Outcomes	OCH Programme Board Monthly OCH reports to Board and FBC Clinical Risk report to RAQC Quality Governance Risk Management strategy & escalation process for risks New staff contracts – organisational not site specific & rotation across sites Monitoring through Divisional Performance reviews Nursing Staffing establishment review March 2012 & 2013 Estates management PPM schedule	Wards and Theatres FBC approved by Trust Board, DH/HTM in January 2012 Treasury approved for ED FBC PCT achieved financial close for New QEII in March 2013. New QEII will open in Spring 2015.			Manage construction and development of operational plans to achieve the planned acute consolidation in October 2014 and to commence provision of service from the New QEII in Spring 2015. Monitoring of quality and performance indicators & actions. –including new nursing matrix, safety thermometer Implementation of recommendations from Nursing establishment review	Director of Nursing/ Medical Director/Director of Strategic Development		
4.2 4.3 4.4 4.5 4.6	2. Risk of lack of capacity & competing priorities to enable dedicated time to enable delivery		OCH programme board Project workstreams Monitoring	History of successful delivery against complex project plans		Level 10 FPC requires approval	Finalise and obtain approval of the final project business case as per the OCH	Director of Strategic Development/ FPC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
4.7 4.12	against plan **(Risk carried forward from 2012/13 BAF)**		through Board, FPC All FBC for phase 4 now approved with exception of level 10				programme			
4 All	3. Risk of non achievement of productivity and quality benefits **(Risk carried forward from 2012/13 BAF)**	Various CQC outcomes	As a key component of OCH & individual business cases mobilisation plans are in place - including clinical engagement, workforce development, and service changes. All business cases include outcome measures Monthly reporting through Project Boards, OCH Programme Board, OCH workforce management group, FPC and Trust Board – including progress against plan 2014/15 planning process, incorporating OCH and CIP	Progress to date on Phases 1 & 2 and elements of Phase 4 have demonstrated adherence to plan. Project Boards are responsible for delivery of Benefits Realisation Plan for individual projects. OCH workforce management group, chaired by Director of Workforce & OD, to coordinate & lead delivery of required workforce changes. Trust staff consultations to achieve OCH March 2013 OGC Gateway review	None identified	Divisions have been tasked with developing operational plans to reflect the new QEII and new Lister hospital configurations and to demonstrate delivery of the productivity and quality benefits in the planned financial envelop	Post project evaluations and implementation of learning Enhanced PMO process and resources are being put in place	Director of Strategic Development with Director of Finance and Director of Operations /FPC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			plan, has been launched by the Trust Executive. Gateway review management process introduced that will result in the Trust being in a position to commence staff consultation in early spring 2014.	concluded that the programme will be delivered to plan. Membership of the OCH Programme Board included all clinical Project Directors with a particular focus on the delivery of productivity and clinical benefits. Lister Hospital CQC report – full compliance, Sept 2013						
4 all	4. Risk of delay in the delivery programme to reconfiguration services due to the volume, pace, interdependence and complexity of the major change programme **(carried forward from BAF 2012/13)**	Various CQC Outcomes	Strong stable Board, Executive Team & Divisional Team with development support. OCH project Board and structure. Project Team. Succession planning. DQHH programme board & project boards	Operational Project Team with track record of delivering on time & on budget Robust risk register OD programme with key outcomes Q4 2012 Internal Audits on	Some areas of the programme are outside the direct control of the Trust Gaps in workforce/skill mix/service model service model inherited from Clinicenta	Limited assurance where areas of the programme are outside the direct control of the Trust Gaps in workforce/skill mix/service model inherited from Clinicenta under review	Reporting through OCH project Board and structure Reporting through DQHH project Board Meetings with key stakeholders Monitoring of interdependent service	Executive Team. Board/FPC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			reports to FPC & Trust Board. Monitoring by FPC/ Executive Committee CIP programme monitoring through divisional performance reviews OCH workforce management group, chaired by Director of Workforce & OD, to coordinate & lead delivery of required workforce changes.	Governance and Risk & Assurance – positive draft reports			reconfiguration plans and associated risks by RAQC/FPC/Board Establishment of PMO office to support delivery Treatment Centre Project			
	5. Risk that the delivery of the regional Pathology strategy impacts on the Phase 4 programme timetable **(Risk carried forward from 2012/13 BAF)**	.	Pathology Project Board in place led by Divisional Director of Clinical Support Services & Director of Business Development, OCH Programme Board Regular management reports are presented to	EoE procurement timetable has been confirmed and FBC produced. Trust selection of consortia was based on ability to meet Trust strategic and clinical needs. Strategic options paper	Delivery of EoE Strategy relies upon external organisations to deliver according to Trust timetable and for EoE procurement timetable to not be delayed.	FBC for Lister Lab from 2014 to be developed and approved Potential review under Monitors new guidance	Working with TPP and CPS Review workforce implications and HR programme management support Reflect agreement for transfer of services off the QEII site in the TPP joint venture agreement.	Director of Strategic Development / FPC /RAQC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			Executive Committee, OCH Programme Board and FPC. Executive and NED lead	considered by FPC in February 2012 with a particular focus on the delivery of the Pathology Strategy within Phase 4 programme timetable. Paper outlines a number of commercial negotiating principles to inform JV negotiations; most successfully negotiated. Investment Plan approved by FPC and Board in Sept 2012.			Identify preferred hot lab option and procure. Potential risk mitigations being developed Financial model to be reviewed at a suitable time in the TPP project timetable			
	6. Risk of access to Capital through Trust Capital Programme and of competing service delivery priorities **(carried forward from BAF 2012/13)** **October 2013 Risk reviewed and**	Outcome 10	Established process for development and approval of business cases though capital control group. Board prioritisation Weekly Execs Monthly capital	Strong Board with clear strategy and process for prioritisation. All large business cases have been developed and approved.		Availability of the level of finance available through the capital programme Programme & commitment of work outside of the Trust's control i.e. QEIII	Ensure each scheme has full business case and implementation monitored through project boards	Director of Strategic Development / Director of Operations / Director of Finance / Capital Control Group/FPC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
	revised as all consolidation monies now received		cash flow to FPC & Board List of approved schemes compiled for 2012/13 Capital Programme	Capital monies for OCH programme received.						
4.8 4.10	7 Risk to these services following consultation & Trust is not the preferred provider for Vascular or 24/7 Heart Attack Service		Track record of successfully winning new services – UCC & Renal Satellites Monitoring of BC development through Executive Committee/DEC.	Project Boards in place Vascular Services BC approved by Execs PPCI FBC approved by FPC & Board in July 2012 Provided response to Vascular services engagement exercise & assess potential impact on other Trust services. Engaged SCG in understanding commissioning process impact of vascular proposal on other key specialties i.e.	Consultation / Engagement process is outside of the control the Trust WHHT understood to be the preferred provider of vascular services	Ensure accurate & up to date benchmarked quality/outcome data is available	Continue to participate in Hertfordshire Clinical Engagement Group Implement the PPCI 24/7 plan.	Director of Strategic Development / FPC Medical Director		

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				renal and help inform revised model to ensure no future adverse impact on quality and safety Medical Division developed the 24/7 PPCI implementation plan in conjunction with Heart & Stroke network.						
4.9 4.1 1	8. Risk that market share is not maintained at planned level due to lack of clarity on GP Consortia & engagement. **(Risk carried forward from 2012/13 BAF)**		Established links with Commissioners, OSC, CCG leads, Clinical Engagement Forum. Market Report to FPC. GP engagement Report to DEC. Marketing meetings with divisions include GP engagement and satisfaction Paper to Trust Board in December 2011 regarding	GP commissioning leads now attend monthly contract meetings and engage with Dir of Finance and Dir of Operations. Discussion regarding replacement of Clinical Engagement Forum/establishment of Clinical Senate have reached agreement	Relationships require development. GPs wish to develop closer relationships with clinical directors/consultants. Reputational/referral risk due to previous poor performance from Clinicenta	Complete analysis of performance and future prediction in line with OCH FBC assumptions Re- establishment of referral patterns following transfer of services provided by Clinicenta to the Trust Awaiting outcome of external audits relating to treatment centre services	Medical Director and GP Consortia Chair to lead the replacement Clinical Forum to support achievement of Trust and GP consortia aims. Continue to further improve GP satisfaction with the trust – implement action plan (to be monitored by DEC). Continue to develop market	Director of Strategic Development/ Medical Director /RAQC		

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				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			engagement with CCG's	between Medical Director and GP leads. Trust now supporting some of the Children's services from Bedfordshire Lister Hospital CQC report – full compliance, Sept 2013		transferred to the trust – e.g. waiting lists scrutiny.	share analysis and monitor market share – with Divisional Workshops. Continue to establish relationships /engagement with new forums and emerging structures especially Bedfordshire CCG Treatment Centre Project Group			
4.13	9. Risk of lack of expertise and clinical engagement to deliver the SLR project	FRR	Regular reporting to Board and FPC Project plan Project support	Reports to Board and FBC Q2 2010/11 PLICs report published. Internal Audit	Ensuring all Clinical Director are involved in implementation & roll out of the programme	SLR system not yet available for use Internal Audit – SLR	Continue to roll out use of PLICs within Divisions. Quarterly updates to FPC. Regular and specific reverence to plics information in monthly Finance Report SLR project plan & implementation form April 2014	Director of Finance / FPC		

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				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
4.14 4.12	10. Risk that the Trust breeches the terms of the agreed FT timeline & doesn't achieve FT milestones	DH/TDA integrated delivery model	Monthly Monitoring by Executive, FPC, RAQC & Board Monthly performance meetings with TDA	Strong history on financial and governance performance	FT application process is under national review	Draft FT timeline has not yet been formally approved by Board and TDA	Agree new FT timeline with Board and TDA in July 2013 Ensure continued delivery of Finance & Performance targets Ensure organisational readiness for elections & Monitor assessment Review and implement actins from QGF & BGAF assessments	CEO/Company Secretary/ Director of Operations /Director of Finance		
4.10	11 Risk to the reputation of the Trust if Clinicenta performance is poor **(Risk closed - services transferred to the Trust 14 September 2013)**		Weekly meetings with CCG & Clinicenta Monitoring of SLA's Provision of waiting list expertise to Clinicenta as agreed with CCG	Whole systems approach being taken through Risk Summit MP's & the Media to date have made the distinction between the Trust and Clinicenta	Delivery of the service is outside of the control of the Trust Potential – poor CQC inspection reports.	Limited availability of information from Clinicenta Trust receive some of Clinicenta complaints	Maintain weekly meetings with CCG & Clinicenta Monitoring of impact on Trust	CEO/ Executive Team	**(Risk closed - services transferred to the Trust 14 September 2013)**	**(Risk closed - services transferred to the Trust 14 September 2013)**

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			Reports to Execs, Board, Board Comms Positive relationships with key stakeholders and media							
4.12 1.1	12. Risk that the transfer of the treatment centre services to the Trust adversely impacts on the overall performance and finance. **(new risk September 2013)**		Treatment Centre Project Group – with workstreams Daily/Weekly reporting to Execs Monthly reporting to Board and FPC	Reports to Board and FPC Actions implemented to address previous risk summit & CQC concerns Positive support by CCG, TDA, MP's, CQC Lister Hospital CQC report – Sept 2013	Limited data received prior to service transfer Gaps in workforce/skill mix/service model Not yet working to capacity Reputational/referral risk due to previous poor performance from Clinicenta	Gaps in assurance on inherited waiting list Gaps in workforce/skill mix/service model under review Not yet working to capacity Re- establishment of referral patterns following transfer of services provided by Clinicenta to the Trust Awaiting outcome of external audits relating to treatment centre services transferred to the trust – e.g. waiting	Treatment Centre Project plan – including external audits PMO structure Communication and marketing plan	Director of Operations/ Executive team. FPC, Board		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
						lists scrutiny.				

QUARTERLY TRUST BOARD PROGRESS REPORTS (Executive Director Lead): *(include progress on meeting the objective and the management of the principle risk)*	
Quarter 1 Progress Report:	
Quarter 2 Progress Report:	4.2: Chemotherapy Business case approved by FPC and Board. 4.3: Pathology Hot lab business case approved by FPC and Board in September 2013 4.4: Joint venture agreement signed. Risk due to further project delay are monitored through Board ad its Committees. 4.14: National review of FT application process. 4.12: Month 5 finance report to FPC and Board showed revised surplus forecast to reflect the impact of the transfer of the Treatment Centre Services. CIP behind plan and mitigations in place/being taken, including the establishment of a PMO office. 4.12 & 1.1: Risk 11 - Risk to the reputation of the Trust if Clinicenta performance is poor – now **closed - services transferred to the Trust 14 September 2013. Services transferred safely and Treatment centre project group in place. New risk added -** Risk that the transfer of the treatment centre services to the Trust adversely impacts on the overall performance and finance.
Quarter 3 Progress Report:	
Quarter 4 Progress Report:	

Trust Strategic Objective 5: To support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services.				
Trust Annual Objectives 2013/14:		**RAG**	**Achieved**	**Outcome /measure**
5.1	Agree a Memorandum of Understanding with Hillingdon Hospital NHSFT regarding the Mount Vernon site development plan which will enable the development of a business case to address the cancer centre infrastructure including re-provision of the wards and clinical areas.			**MoU Agreed**
5.2	Assess services provided by the Cancer Centre against the new cancer commissioning specification. Develop, agree and progress delivery of an action plan to support delivery of the specification.			**Action plan & delivery against milestones**
5.3	Work collaboratively with clinical commissioners and cancer systems to support the development of the Cancer Centre.			**Agree plan**

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
5.1	1. Risk that agreement is not reached or funded for preferred site for MVCC redevelopment **(Risk carried forward from 2012/13 BAF)**	All core outcomes	Quarterly CEO meetings between the Trusts. Mini Board to Boards in May & Sept 2013. Commitment to work together secured. Current arrangements cause significant problems for both Trusts. The release of surplus land could enable the necessary infrastructure	Joint project team established by Trust and Hillingdon Hospital NHSFT Representations have been made to the planning authority in respect of their local development framework High level vision and proposed redevelopment	Site is owned by Hillingdon Hospital NHSFT. Significant future developments by the Trust will be precluded if the Trust does not have a legal interest in the site. Planning may also be a problem	The Trust requires securing a leasehold interest in a section of the site sufficient to support future plans for cancer services. Progress will be restricted by complicated service arrangements and the need to fully engage with a range of stakeholders.	Both Trust Boards to commit to the programme at there October 2013 Board meeting s detailed plan to be presented to their November Board meetings Established Programme Board to coordinate site development as per Trust Board decision. CEO & Chairs	Chief Executive/ Director of Strategic Development		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			developments.	of site proposals shared with HHT in Sept 2013 and positively received.			meeting			
5.1	**2.** Risks to business continuity due to specific estate risks		Mini Board to Boards established in 2013. Joint MV Governance Board Reports to RAQC/FPC MV 2015 Project Board in place	Assurance received from HHFT that electrical cable fixed following incident in April 13		SLA'a not reviewed HHFT not yet implemented all learning following the external electrical infrastructure assessment Gaps identified in business continuity	Liaise with HHFT to ensure all action taken forward following failure to electrical infrastructure Review and agree SLA's with HHFT Review joint Major Incident Plan with HHFT fir the MV stie Review Trust MV business continuity plans	Director of Operations / RAQC/FPC		
5.2 5.3	3. Risk of not winning tender processes for future commissioning intentions (Long term risk) **(carried forward and amended from BAF 2012/13)** **Risk reviewed and reduced – Oct 2013**		Trust has contributed significantly to development of PCT feasibility study. Trust has MVCC clinical leadership & expertise to distinguish itself from competitors. Project structure in place to respond to	Standing item on OCH programme board and Cancer Division Performance Review Cancer Satellite project board in place. Trust submitted interim response to PCT in April	Availability of capital funds.	Implications of the new cancer commissioning specification not yet known.	Cancer divisional project board continuing to complete & explore options for delivery service at tariff. To confirm commissioning intentions and develop & agree and implement action plan	Director of Strategic Development		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / SHA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			commissioning intentions. Academic Partnership & AHSN	2011. Implications of emergence of integrated cancer systems in London are being confirmed by Cancer Divisions – report to Trust Board May 2011.						

QUARTERLY TRUST BOARD PROGRESS REPORTS (Executive Director Lead):
(include progress on meeting the objective and the management of the principle risk)

Quarter 1 Progress Report:	
Quarter 2 Progress Report:	5.1: High level proposal of site redevelopment considered by RAQC and part II Board in September 2013. Mini Board to Boards held with Hillingdon Hospital NHS FT.
Quarter 3 Progress Report:	
Quarter 4 Progress Report:	

Trust Strategic Objective 6: To improve our staff engagement and organisational culture to be amongst the best nationally.				
Trust Annual Objectives 2013/14:		**RAG**	**Achieved**	**Outcome /measure**
6.1	Develop the detailed workforce strategy and delivery plan required to manage and deliver the Phase 4 workforce skill mix changes and planned workforce reductions and pay savings in line with Phase 4, the Trust FT application and the Hertfordshire QIPP plan			**Workforce Report / LTFM**
6.2	To implement a workforce recruitment strategy and reduce ward nurse vacancy rates to below 6.0%			**Vacancy rate 6%/ Floodlight scorecard**
6.3	Increase the level of customer service and patient experience within the Trust, ensuring 90% of staff attend customer service training and focus on priority areas			**Culture Indicator/ Floodlight scorecard**
6.4	Ensure mechanisms and processes for staff to raise concerns are firmly established and a clear understanding of the issues in order to reduce bullying and harassment			**National Staff Survey**

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / TDA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
6.1	1. Risk of lack of engagement, capacity & capability to deliver the workforce plans **(carried forward form 2012/13)**	CQC outcomes	Workforce Management Group Reports to OCH Programme Board & FPC	Reports to FPC/RAQC & Board Workforce workbooks at Divisional/Directorate level	Currently limited information across the Trust on future workforce needs/ skill mix Vacancy rate high and shifts unfilled by NHSP	Detailed future workforce assessments not fully established Current vacancy rate & unfilled shifts (medical & nursing)	Review data & develop future workforce plans across all divisions - Challenge 600 workstreams Recruitment strategy Establishment of PMO office to support delivery	Director of Strategic Development/ Director of Workforce & OD /FPC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / TDA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
6.2	2. Risk of not being able to recruit sufficient staff with required expertise due to national shortage	CQC outcomes 12,13,14	New recruitment strategy 2013 Monitoring of progress & vacancy rate at Board & its committees, Division PMRs.	Reports to FPC/RAQC & Board CQC Inspection report – Lister Sept 2013	Vacancy rate currently over 10% in some areas	Lengthy recruitment process	Implement recruitment strategy Continue to streamline recruitment process	Director of Strategic Development/ Director of Workforce & OD /FPC		
6.3	3. Risk of failure to engage the workforce and leadership in Our Changing Organisation (ARC) & customer care Programmes therefore impacting on quality, targets and cost of service delivery **(Updated & Risk carried forward from 2012/13 BAF)** **(Longer term risk)**	Regulation 22 & 23 (outcomes 13 & 14)	Monthly reports to Board committees on floodlight score card (workforce & cultural indicators) and exception reports October 2010 Organisational Development Strategy & ARC steering group reporting to RAQC & Board. People & Workforce Development Strategy approved by Board March 2012 Workforce Management Group	Workforce efficiency data reported monthly to Board Committees with exception reports. Health & Wellbeing Strategy approved by RAQC, Dec 2012. Positive staff survey 2013- +engagement scores Customer care training in place Internal Staff survey CQC Inspection report – Lister	Not meeting all workforce targets	Cultural indicators established for 1/4 ly monitoring Consistently implementing ARC sessions across the organisation *Internal Audits - workforce* **People & Workforce Development Strategy currently under review.** Staff perception of gaps following the on Francis Staff survey results show need for improvement	Continue to monitor & implement ARC programme Monitor implementation of action plan from Annual Staff Survey as part of ARC programme Performance monitor appraisal rates, mandatory training & workforce indicators Quarterly internal audit of staff cultural indicators Review of cultural indicators Review of Workforce	Director of Strategic Development/ Workforce & OD / RAQC		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / TDA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
			Board development session culture held in March 2013 and further Board session on culture in Q3. E&D steering group	Sept 2013 ARC sessions for Treatment Centre Staff		to reduce bullying & harassment	Strategy 2013 ARC programme & Customer care Training Action plan following Francis Inquiry focus groups			
6.1 6.2 6.3 6.4	4. Failure to achieve workforce targets and risk of failure to engage with the workforce to support service redesign **(Risk carried forward from 2012/13 BAF)**	Regulation 22 & 23 (outcomes 13 & 14)	Workforce plans within OCH & support IBP. Trust & Divisional workforce action plans. HR & Staff side representative on each project board. Workforce leads resourced & group report to OCH Weekly Mandatory Training to Execs Monthly workforce reports to Board and its Committees	Maternity Services workforce plan. Regular reports to Divisional Performance reviews. Vacancy management processes OCH Progress Board Internal Audit 2012/13: sickness management Amber /Green- actions completed	Workforce planning currently at a high level Sickness and Mandatory Training floodlight indictors amber Vacancy rate high and shifts unfilled by NHSP	Service level implementation of the workforce plans Data systems do not currently support robust monitoring Current vacancy rate & unfilled shifts (medical & nursing) Internal Audit Employments Check (risk) *Workforce planning IA*	Work with the Divisions to further develop and implement workforce plans at an operational level to ensure changes in skill mix in line with OCH & other service developments Review People & Workforce Strategy Implement use of workforce assurance tool /divisional workbooks ESR project plan	Director of Strategic Development / Director of Workforce and OD - FPC/ OCH Project Board		

Obj No.	Principal Risk /Current Risk Score (*what should prevent this objective being achieved)* * Risk score – Likelihood v Consequence and Trust's risk scoring matrix = RAG rating	CQC / TDA Performance Framework Reference	**Key Controls** *(what controls/systems do we have in place to ensure we deliver our objectives)*	**Assurance Obtained on Controls**			**Board Action Plan**			
				Positive Assurance *(what evidence shows the risks are being managed and objectives are being delivered)*	**Gaps in Controls** *(where are we failing to put controls in place? Where are we failing to make them effective)*	**Gaps in Assurance** *(where are we failing to gain evidence that our controls/systems are effective)*	Action Plan	Responsible Director / Key Assurance Committee	6 Month (Sept 13) Forecast	Year End Forecast
							Statutory & Mandatory Training plan & trajectory Recruitment strategy Establishment of PMO office to support delivery IA Employments Checks action plan			

QUARTERLY TRUST BOARD PROGRESS REPORTS (Executive Director Lead): *(include progress on meeting the objective and the management of the principle risk)*	
Quarter 1 Progress Report:	
Quarter 2 Progress Report:	6.1: Comprehensive workforce data workbooks now available at Divisional level to support future workforce planning 6.2: Current vacancy rate for the Trust is 10.45%. Challenge 600 implemented and vacancy control process for any non clinical post and specialist posts above band 7. 6.3: 1750 attendances at ARC session and Customer Care training. 6.4: ARC workstream in progress.
Quarter 3 Progress Report:	
Quarter 4 Progress Report:	