West Hertfordshire Hospitals NHS
NHS Trust

Board Assurance Framework

Updated 25 November 2015

Principal Objectives

Principal Objective 1 (PO1)	Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas
Principal Objective 2 (PO2)	Setting out our future clinical strategy through clinical leadership in partnership with whole system working
Principal Objective 3 (PO3)	Creating a clear and credible long term finance and estate strategy

Principal Aims

DOMAIN	PRINCIPAL AIMS	
Safe	PA1a	Ensure our services are safe and meet external compliance requirements.
	PA1b	Improve our estate infrastructure to meet statutory requirements and support service improvement
Effective	PA2a	Ensure our services are effective and deliver continuous improvement in quality and outcomes
	PA2b	Improve our IT infrastructure to support service improvement
Caring	PA3	Ensure our services are caring and deliver continuous improvement in patient experience
Responsive	PA4	Ensure our services are responsive and meet key national standards (emergency care, referral to treatment, diagnostics and cancer waiting times)
Well Led	PA5a	Support, develop and engage staff - continuous improvement in workforce satisfaction , improve retention and reduce vacancy rates.
	PA5b	Deliver agreed 2015/16 financial plan including delivery of efficiency programme.
	PA5c	Ensure we engage effectively with our patients, their families, local residents and partner organisations about the work we are doing to continuously improve our services
	PA5d	Develop a future clinical and organisational strategy in partnership with commissioners and partner organisations. (Clinically excellent, financially sustainable , fit for purpose estate)

Principal Risks

Principal Objective	Principal Aim	**Principal Risk**	**Description**	Executive Leads	Board assurance
PO1	1a, 2a, 3	**PR1**	**Failure to provide safe, effective, high quality care (insufficiently robust and embedded quality governance and risk management)**	HB, TC, MVDW	S&Q
PO1	1a, 2a, 3, 5a	**PR2**	**Failure to recruit to full establishments, retain and engage workforce**	PDG	WK
PO1	1b	**PR3**	**Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care**	KH	S&Q
PO1	2b	**PR4**	**Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care**	LE	F&P
PO1	4	**PR5**	**Inability to deliver and maintain performance standards**	LH, JS. CL	F&P
PO1	1a,2a,3, 4	**PR6**	**Failure to maintain business continuity**	LH, CL	S&Q
PO1, PO3	5b	**PR7**	**Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes**	DR	F&P
PO1, PO2, PO3	5a, 5b,5c,5d	**PR8**	**Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation**	HB, HR	Strategy
PO2, PO3	5d	**PR9**	**Failure to develop a sustainable long term clinical, financial and estates strategy**	HB	Strategy

Board Assurance Framework – current level of assurance December 2015

G AG A AR R

Principal Risk	Description	RAG	Trend
PR1	Failure to provide safe, effective, high quality care (insufficiently robust and embedded quality governance and risk management)	AR	↔
PR2	Failure to recruit to full establishments, retain and engage workforce	R	↔
PR3	Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care	AR	↔
PR4	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care	AR	↔
PR5	Inability to deliver and maintain performance standards	AG	↑
PR6	Failure to maintain business continuity	AR	↔
PR7	Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes	R	↓
PR8	Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation	AG	↔
PR9	Failure to develop a sustainable long term clinical, financial and estates strategy	AR	↔

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: HB/TC/MVDW

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk One: Failure to provide safe, effective, high quality care				
Potential cause: Quality governance (QG) and risk management processes not sufficiently understood or embedded within the organisation. **Potential impact:** Risks to quality and safety of care not identified and controlled leading to harm and / or sub optimal patient experience and outcomes.	•Quality Account and Annual Plan set out priorities. •QG team in place to develop and deliver support and assurance programme • Corporate and divisional risk registers •Incident reporting / datix & SI review group •M&M and service level governance meetings • Monthly mortality and clinical harm meetings •Audit and compliance programme • Appriasal and revalidation • QIA of all CIP plans • Divisiional and Trust wide Onion •Clinical policies •Whistleblowing policy • CCG contract and quality meetings •Risk Review Group •Daily review of staffing/escalation •Qulaity Improvement plan sets out key actions ref. April 2015 CQC visit.	• IPR quality and safety metrics •Test Your Care & Ward dashboards • Friends and Family Test • 1/4ly external assurance visits • Executive level 15 steps programme •Matron quality checks •Mortality reports • Safe staffing reports to Board •Dr Foster data •PSQ meeting meets monthly to review Q&S work programme and risks •Risk Review Group meets monthly to review all 15+ risks on CRR. •Integrated Governance and Risk Committee provides Board level oversight •Audit Committee to provide assurance on effetciveness of processes.	•Evidence that quality governance systems and risk management processes are not fully understood and embedded across the organisation. • Operational processes to review risks underdeveloped. • % Clinical Policies out of date •Insufficient evidence of learning from incidents and complaints.	•Insufficient visibility of risk and risk issues at Board level.

Principal Objectives	PO1	Principal aims	1a, 1b, 2a, 3

Current Status	November 2015	G	AG	A	AR	R	↔	OWNER: HB/TC/MVDW

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Actual / Expected date of completion
Principal Risk One: Failure to provide safe, effective, high quality care				
Establish Integrated Risk Management committee to oversee implementation and embed new risk management arrangements	HB	Committee in place and has met 3 times supported by risk review meeting.	August 15	Completed
Risk management handbook and training cascade	HB	Handbook completed in August 2015. leaflet developed and briefing sessions for senior leadership team. Training review in place and engagement with divisions to develop. All staff video training being developed. Full roll out trainign plan commenced November 2015.	August/ Sept 15	Mar 16
Implement recommendations from review of SI process	MVDW / TC	Recommendations agreed and CCG support to implement. Reduction in incidents categorized as SIs following application of national criteria. Improved compliance rates. Continued focus on evidencing learning.	31.10.15	Feb 16
Improvement plan for compliance and audit to be developed	HB	Developed as part of the Quality Improvement Plan (Theme 5) .	31.09.15	Completed
Develop 'MOU' setting out respective roles and responsibilities of QG team and divisions / directorate teams	HB	Completed.	31.09.15	Completed
Include audit of risk management processes in internal audit programme for 2015/16	HB	To be included in Q4 work programme.		March 16
Implement QIP Theme Five milestones as per plan,	HB	NEW ACTION – MONITORED VIA IRGC.		As per plan.

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: PDG

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance	Action Plans for Gaps (date)
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce					
Potential cause: The Trust has a very significant vacancy rate and is finding it difficult to recruit to existing and the future expanded staffing establishment. **Potential effect:** If Recruitment and Retention challenges are not resolved sufficient staff will not be available and will increase reliance on bank and agency staffing. **Potential impact:** The Trust may fail to provide the highest standards of patient care, increase staff costs and staff morale will be negatively effected.	•Recruitment and retention strategy in place which include ongoing plans for more overseas recruitment, streamlining our recruitment processes, growing our Bank, re-introduction of adaption programmes and enhanced focus and reporting on recruitment. •Divisional focus and plans upon R&R •Listening into Action Programme •Staff engagement programme to include improvements to working environment, staff discounts, social event, etc. •Central and Divisional staff survey action plans	Workforce Board sub committee Key workforce indicators: •turnover rates •Vacancy •Agency & Bank spend •Results from staff survey and action plan •Key HR indicators e.g. time taken to recruit •Friends and family staff survey – scores and verbatim •Overseas nurse recruitment action plan	• A workforce strategy which clearly sets out our approach to retention. • Organisational and divisional retention plans at divisional level •Assurance that issues around bullying and harassment have been adequately resolved. • Ensuring that we have the necessary staff facilities to drive engagement e.g. staff rooms. •A full understanding of how new English language requirements will impact upon our EU recruitment	A work plan to support the implementation of workforce strategy Robust exit interviewing data	Approval of workforce strategy (Jan 16) Divisional People plans (Mar 16) On-going implementation of B&H strategy action plan for full implementation by April 16 Implementation of LiA staff facilities (April 16)

Principal Objectives	PO1	Principal aims	1a, 2a, 3, 5a	Corporate Risk Register entries	

Current Status	November2015	G	AG	A	AR	R	↔	OWNER: PDG

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce				
Formal staff engagement strategy to be produced by Sept 15	PdG	Production of engagement strategy subsumed into workforce strategy. In the interim our key engagement activities have been undertaken under the auspices of Listening into Action and significant action undertaken.	Sept 15	Jan 16 (Approval of workforce strategy)
Bullying and harassment strategy (has been drafted and is now being taken through governance processes).	PdG	B&H strategy now approved and a work plan devised and action being taken in accordance with this plan		Completed
Training and Development Strategy (Dec 15)	PdG	Production of training and development strategy subsumed into workforce strategy.	Dec 15	Jan 16 (Approval of workforce strategy)
Approval of workforce strategy	PdG		Dec 15	Jan 16
Creation of Divisional People plans	HR BPs		Dec 15	(Mar 16)
On-going implementation of B&H strategy action plan for full implementation	PdG		Dec 15	April 16
Implementation of LiA staff facilities (April 16)	KH		Dec 15	April 16

Principal Objectives	PO1	Principal aims	1a, 2a, 3, 5a	Corporate Risk Register entries	

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: KH

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Three: Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care				
Potential cause: the estate and utilities infrastructure is not fit for purpose for the delivery of safe, responsive and efficient patient care. **Potential Effect:** Frequent failure of critical infrastructure, a lack of resilience in essential services and a poor / inadequate / unsafe environment for delivery of healthcare services. **Potential Impact:** Disruption to service delivery (e.g. theatre closure, loss of water or power) impacting on patient safety, lack of capacity (space & resources) to meets operational demands and mandated standards, poor patient experience, suboptimal environment forinfection prevention and control.	•Creation of Environment Division provides structure and staffing levels to deliver effective estates and facilities services. •Identification and management of risk through Divisional risk register, elevating High-level risks to Corporate register. •Development of Backlog Maintenance programme based on 6 Facet Condition Survey ensures highest identified risks are addressed. •24/7 reactive maintenance capability provided across all sites •Development of Interim Estates Strategy (Draft) to direct investment and resources •Capital investment programme developed in consultation with Clinical Divisions and TLEC addresses Trust's greatest service development needs	•S&Q to receive quarterly updates •External gap analysis to identify non-compliance to statutory and mandated requirements •Operation of a Safe System of Work in accordance with HTM 00 and HSE requirement •Monthly Divisional Risk & Governance meeting with resultant Highlight report providing mechanism to alert Board of High level Risks. •Engagement with HSE to provide external assurance regarding measures taken to manage asbestos containing materials (ACMs) and Legionella •External validation on competency of workforce	•Lack of Long-Term Estates Strategy restricts ability to gain maximum benefit from Watford Health Campus project and ensure vfm in capital investment •Capital funding insufficient to address minimum requirements for backlog programme. •Very limited planned maintenance programme increases likelihood of failure •No funding allocated in 2015/16 to train staff to minimum Statutory requirements for delivery of a Safe System of Work •There is no Asset Register for critical infrastructure or engineering drawings for the major utilities, delaying ability to respond to failures and placing staff at risk	•The Trust's estate management system (ARCHIBUS) cannot currently provide required levels of assurance •Division's risk register not fully populated •Site level management meetings are not in place across Trust •Mock PLACE visits halted •Premises Assurance Model not yet adopted by Trust •Lack of Executive level visibility of progress on capital works programme

Principal Objectives	PO1	Principal aims	1b

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: KH

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Three: Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care				
Development of Interim Estates Strategy	KH	Interim strategy split into constituent parts compliance to Jan board. Capacity and configuration to Feb board. Interim Estates strategy March board		As per update
Request for additional capital funding submitted to TDA. Outcome awaited.	KH/DR	Submitted		Completed
Statutory training to be funded from estate maintenance funding (with resultant impact on estate condition)	PH	Funding identified in capital to replenish revenue used elsewhere		Ongoing
Estate Asset Register complete by 31 03 16	PH	Quotes returned. Start on site Dec 2015. Complete before April 2016		31/03/16
Programme to develop and populate ARCHIBUS underway.	TD	New version of Arhibus installed and being populated		Installation complete. Data entry underway ETC July 2016

Principal Objectives	PO1	Principal aims	1b

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: KH

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Three: Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care				
Division's Risk Register to be fully populated, with ongoing management in place	TD	Risk register updated - Monthly meetings set up in October and report through Environment Senior Mangers Group Meeting		Ongoing
Site Management meeting to take place monthly from Jul 15, supported by programme of mock PLACE visits	TD	Site meetings scheduled from October 2015. Monthly mock place visits underway		Ongoing
Capital works tracker to be presented monthly to Trust Executive Committee from Jul 15	KH	Final review of progress to be completed by end of Nov 2015		Completed

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: LE

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Four: Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care				
Potential cause: Unable to fully deliver improvements in information, communication and technology (ICT) and decision support due to resource, funding, scope and physical estate constraints. **Potential impact:** Unable to deliver the benefits of the 'digital hospital environment' laid out in the IM&T Strategy - to improve patient and staff experience through improved decision support, agile and paperless working, support for integrated models of care.	• Five year contract with CGI Group to provide full managed CT service, negotiated with Herts Procurement, IT and Finance • Governance structure in place for IM&T holding suppliers and directorate to account. • Patient tracking lists and data quality reports developed to prospectively manage patient pathways.	• Legal assurance of CGI contract by DLA Piper. • Informatics Group oversight of programme delivery and service management panels. • Informatics group reporting through Finance and Performance Committee to Trust Board. • Integrated performance report , with enhanced exception reporting. • Robust contract management.	• Variable data quality (DQ). • Provision of timely, automated performance information to support clinical decision making in some areas (OPD and Therapies). • Processes and resources for cancer information reporting (including Cancer Outcomes and Service Data set).	• Information Governance Steering Group meets monthly – actions to embed culture of IG in the organisation. • Medical records – project to implement electronic tracking underway. Due March 2016. • Detailed information dashboard to support Outpatient management. • Detailed information regarding Therapies referral times.

Principal Objectives	PO1	Principal aims	2b

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: LE

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Four: Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care				
Undertake regular DQ audits during 2015/16 – Quarterly updates to F&P		• BDO audit completed June 2015. Taken to Audit Committee • VTE audit completed July 2015 for Quality Account.	31/03/15	31/03/16
Additional funding agreed to deliver further development and automation for cancer, diagnostics, RTT and DQ during 2015/16. Quarterly updates to F&P		Improvements to RTT, cancer and diagnostics automated reports delivered and in operational use.	31/03/2015	Completed
Options appraisal for cancer system requirements to TLEC June 2015		Options appraisal approved by TLEC June 2015.	June 2015	Completed
Development of Outpatient information dashboard to support OPD performance management		Work commenced. Initial phase due December 2015.	March 2016	March 2016
Provide electronic system to monitor responsiveness times from referral to assessment within therapies		Work commenced.	November 2015	November 2015
Confirmation of compliance of Cancer submissions (Cancer Outcomes and Service Data set)		Work completed.	October 2015	Completed
Audit ward / departmental Information Governance compliance (documented spot check audits of clinical areas)		Work commenced.	January 2016	January 2016

Principal Objectives	PO1	Principal aims	2b

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: LH

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Five: Inability to deliver and maintain performance standards				
Potential cause: •Failure to maintain and improve reduction in DTOCs and system waits •Failure to undertake robust demand & capacity modelling •Failure of infrastructure/estate resulting in lost capacity •Inability to recruit staff to full establishments, and with right skills •Financial constraints limit the organisation's ability to respond to risk	• Development of Unscheduled Care programme. •Operational Recovery plan •Cancer Improvement Plan •Strengthened clinical engagement •Divisional Performance reviews •RTT Access meeting •Cancer Access meeting •Diagnostic Access meeting •Performance meeting •RTT trajectories •Review of access policy now complete	•Monthly integrated performance reports •Unscheduled care programme report •Referral to treatment programme report •System wide urgent care dashboard •F&P monthly review •Audit committee report	•Best practice RTT policy to be embedded •Development of GOO PTL •External factors outside span of control, eg social work capacity •Incomplete demand and capacity modelling •OPD processes are fragmented	•Further development of IPR •OPD metrics

Principal Objectives	PO1	Principal aims	4	Corporate Risk Register entries	

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: LH

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Five: Inability to deliver and maintain performance standards				
Divisional Management Boards				
ALTUROS supporting Trust with demand and capacity work for theatres (commenced 19th August 2015) –	Jane Shentall /Mary Richard son	Project scoping is 90% complete. Meetings with consultants underway. Project plan reviewed weekly at TUG	Forward work programme with dates by 30.09.15	31/03/16
SSG supporting Trust wide demand and capacity work	Mark Currie	Work on theatre model is ahead of plan. Outpatient model one week behind schedule. Potential issue with out of date clinic templates but this won't impact higher level plan. Weekly call in place with CCG. Some outputs expected by 31/12/15	31/01/16	
RTT: •Access Policy refresh and roll out •Implementation of GOO PTL and GOO management meetings within services, with exception reporting at weekly Access meeting	Jane Shentall	Updated policy to be presented at Policy Review Group 23/11/15. Service leads to be tasked with rolling out to teams across organisation. Rolling bi-monthly audit programme to be implemented to assess effectiveness and compliance	October 2015	31/12/15
Outpatient Improvement Programme – commenced November 2015	Lynn Hill	Programme Board will oversee delivery of improvement plan through working groups assigned to 3 key work streams. Meeting and reporting cycle in place	November 2016	November 2016

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: LH

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Six: Failure To Maintain Business Continuity				
Potential cause: Internal lack of knowledge about business continuity issues and time constraints re: producing sustainable business continuity plans. **Potential effect:** Failure to provide assurance at service and trust level re: maintaining resilience **Potential Impact:** Reduced resilience and ability to respond to business critical system threats.	•Head of EPRR appointed and commenced in post. Qualified EPRR professional. •Director of Operations – Unscheduled Care appointed in July 2014. Experienced in delivering first line resilience to Acute Trusts •Participation by CEO and executive leads in system resilience group •Participation by Director of Operations – Unscheduled Care in monthly and quarterly executive LHRP •Participation by Head of EPRR in monthly EO LHRP •BCP template, database and identified metrics in place •Internal EPRR meeting now established with robust divisional representation. •First draft BCP's for all divisions in place .	• Monthly update to S&Q •Monthly update to LHRP •Quarterly update to TLEC •Annual update to NHSE (EPRR submission) •Annual update to Trust Board (EPRR submission)	•BCP knowledge not embedded across the organisation. •Draft BCP plans are embryonic and need further work	•Lack of full assurance re divisional competencies and knowledge

Principal Objectives	PO1	Principal aims	1a, 2a,3,4	Corporate Risk Register entries	

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: LH

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Training timetable being constructed with divisions (commenced July 15)	KH	complete	July 2015	Completed
Head of EPRR to link with Head of O&D re developing robust training processes. (Re timetabled to September 2015)	KH	In place and live	September 2015	Training programme in place
Annual audit programme	KH	In planning		31/03/2016

Principal Objectives	PO1	Principal aims	1a, 2a,3,4	Corporate Risk Register entries	

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: DR

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Seven: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes				
Potential cause: •Insufficient funding for emergency activity •Lack of effective financial controls •Failure to achieve required levels of efficiency •Delayed outcome of Your Care, Your Future and development of clinical strategy **Potential effect:** •FY15 plan/target not achieved. •Liability to demonstrate financial sustainability **Potential Impact:** •External intervention •Loss of market share •Extended timetable for delivery of a sustainable, financially viable Trust •Deterioration to reputation. •Reduced ability to • improve quality & services	•Budget setting and business planning process •Budget management process •Contract negotiation and monitoring process •Standing Financial Instructions •Annual audit plan and local counter fraud plan •Monitoring of efficiency programme •Monthly review with Trust Development Authority (TDA) •Integrated delivery meetings •Monthly performance divisional review meetings •TDA funding application process • Capital Finance Planning Group	•Monthly finance report + reconciliations •Monthly Finance & Performance Committee •Audit Committee reports •Internal Audits •External Audit •Regular reviews of efficiency programme by Finance & Performance Committee •Review meetings with commissioners •Outcomes of monthly ITDA accountability meetings	•Establish an estates strategy group •Establish a capital finance planning and control group •Review and establish escalation processes •Agree executive sponsors for the efficiency programme •Establish efficiency programme delivery group •Establish two year rolling efficiency programme •Develop consequences for poor financial management and incentive for excellence. •No advisory support for efficiency programme after September 2015	•Monitoring of adherence, escalation and action •Engagement and ownership of efficiency programme •Embedded governance system and processes •On-going identification of efficiencies •Skilled workforce

Principal Objectives	PO1	Principal aims	4

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: DR

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Seven: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes				
Develop incentive and consequences regime.	CFO	Requires full engagement of Exec Team recommendations to form part of financial planning process. Timetable discussed at November 2015 Finance Committee.	01/11/2015	31/3/2016
Secure support for efficiency programme.	CFO	Complete.	01/10/2015	Completed
Establish estates strategy group	CFO	Complete. CFO commissioned Interim Estate Strategy and chaired two meetings of Estate Strategy Group. Leadership of the strategy transferred to Director of Environment.	01/06/2015	Completed
Establish efficiency steering group	CFO	Complete. Meetings happening regularly.	01/06/2015	Completed

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: HR

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Eight: Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation				
Potential cause: Internal operational issues and capacity constraints compromise ability to maintain effective stakeholder relationships and communications. **Potential effect:** Adverse publicity and reputational damage to the organisation. **Potential impact:** Reduced confidence of stakeholders and local residents in quality and safety of services. Adverse impact on staff morale, recruitment and retention. Loss of market share.	•Director of Communications (experienced interim currently in place) and team. •Chief Executive maintains relationships with CCG and Herts County Council and other partner organisations. •Active participation by CEO and executive leads in system resilience group and Your Care, Your Future. •Regular Chair and CEO meetings with local MPs, OSC and lead members / officers. •Regular attendance at local engagement meetings. •Proactive positive communications campaign.	•Updates to Transformation / Strategy committee. •Healthwatch chair and members attend key board sub committees. •Annual stakeholder review.	•4 out of 5 posts in communications team currently vacant (filled by interims). •Lack of documented stakeholder map and communications strategy / plan. •*Lack of identified metrics to track performance.*	• Transformation committee stood down and first meeting of Strategy Committee postponed to December 2015.

Principal Objectives	PO1	Principal aims	1a, 1b, 2a, 3

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: HR

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original due date	Expected date of completion
Principal Risk Eight: Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation				
Recruit substantive Director of Communications	HB / PDG	Search process for substantive Director of Communications has been initiated. Timeline to be confirmed asap.	February 2016	Offer: January 2016.
Recruit full communications team	HB	Recruitment process for Head of Communications, GP liaison and Fundraising posts held but unsuccessful for all 3 posts. To be readvertised asap.	Autumn 2016	Autumn 2016
Stakeholder map and communications and engagement strategy / plan to be developed	HB	To be presented to Strategy Committee in December 2015.	30/09/15	Jan 2016.
Quarterly updates to Strategy Committee	HB	September meeting cancelled. First meeting scheduled December 2015.	Sept 15	Dec 15
Stakeholder review scheduled for Q4 2015/16	HB	Given gaps in communications team and recent leadership changes at the Trust consideration to be given to postpioing this to Q1 / Q2 2016/17.	March 2016	TBC
Agree and implement small number of metrics to track performance	HB	As part of communications strategy.	October 2015	Jan 2016.

Principal Objectives	PO1	Principal aims	1a, 1b, 2a, 3

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: HR

Risk Description	Key controls in place	Sources of Assurance	Gaps in controls	Gaps in assurance
Principal Risk Nine:Failure to develop a sustainable long term clinical, financial and estates strategy				
Potential cause: Internal operational issues and capacity constraints compromise ability to focus on progressing the medium to long term strategic plan **Potential effect:** Delays to strategy development **Potential impact:** Reduced confidence of stakeholders and regulators in the leadership of the trust. Continued adverse impact on quality, safety and efficiency of services due to sub optimal clinical configuration and infrastructure.	•Director of Stragey and Corporate services and planning team in place •First phase of clincial strategy work undertaken to establish clear baseline and model scenarios. •Active participation in and alignment of WHHT clinical strategy work with whole system review (YCYF) •Estate strategy group developing interim / tactical estate strategy	•Quarterly reports to Strategy committee. •Board strategy development sessions. •YCYF updates to Board	•In context of CQC / special measures Corporate Services portfolio is absorbing majority of the capacity of the the team, leaving limited time to progress strategy work. •Lack of clear project plan / timeline to deliver clinical strategy and overall alignment of clinical / financial and estate strategies into a long term sustainabilty strategy. •Insufficient alignment between long term financial model and clinical strategy / YCYF •Vacancy within estates and facilities team – senior health planning lead.	• First meeting of Strategy Committee postponed to December 15.

Principal Objectives	PO2 / PO3	Principal aims	5d

Current Status	November 2015	G	AG	A	AR	R	⟷	OWNER: HR

Action Plans for Gaps (date)	Owner of action	Update since list review by Committee/Board	Original date	Expected date of completion
Principal Risk Nine: Failure to develop a sustainable long term clinical, financial and estates strategy				
Develop high level project plan / timeline for clinical strategy and redevelopment	HB	Preliminary paper on timeline and resourcing to be presented to strategy committee in December 2015.	31/10/15	January 2016.
Establish 'exec' Strategy steering group to ensure better alignment across all strands of work	HB	Delayed due to other priorities. 1:1 meetings held with key Directors.	30/09/15	Dec 2016.

Principal Objectives	PO2 / PO3	Principal aims	5d