NHS
West Hertfordshire Hospitals
NHS Trust

Board Assurance Framework

June 2017

Appendix 1

Our Aims

Aim One	To deliver the best quality care for our patients
Aim Two	To be a great place to work and learn
Aim Three	To improve our finances
Aim Four	To develop a strategy for the future

Our success will depend on the continued commitment of all of our staff to the delivery of quality care ~ we will support them in every way we can. We will also listen carefully to what our patients and local residents tell us about how we can improve care and learn from our mistakes. We will work in partnership with our commissioners (Herts Valley CCG and NHS England), with local councils and with other local NHS providers to make sure we deliver joined up care for our patients.

2017/18 objectives

AIM	OBJECTIVES	
AIM ONE: To deliver the best quality care for our patients	To sustain our ‘ better than expected’ performance on key mortality indicators (HSMR & SHMI).	CO1
	To meet all national standards.	CO2
	To improve patient experience.	CO3
	To further strengthen and embed quality improvement processes through the development of a quality strategy and delivery of quality priorities set out in the 2017/18 quality account.	CO4
	To agree and implement plans to improve our estate and IM&T . (To bid for additional capital funding to support urgent improvements to our estate.)	CO5
AIM TWO: To be a great place to work and learn	To improve staff satisfaction as measured by the national staff survey and local WHHT temperature checks.	CO6
	To reduce staff turnover rates, vacancies and use of agency staff.	CO7
	To ensure all staff have annual appraisals and personal development plans.	CO8
	To strengthen our clinical and managerial leadership.	CO9
AIM THREE: To improve our finances	To deliver our 2017/18 financial plan.	C10
	To deliver our efficiency savings programme, including opportunities highlighted in the Carter review.	C11
AIM FOUR: To develop a strategy for the future	To identify and implement priorities to support delivery of our strategy and further develop service line strategies.	C12
	To work with regulators to secure approval of our strategic outline case for the redevelopment of our hospitals and progress the development of the outline business case.	C13
	To work with STP partners and local stakeholders to deliver system wide transformation priorities; to agree a partnership strategy to support the long term clinical and financial sustainability of our services, including consideration of the benefits of closer collaboration with the Royal Free Hospital.	C14

Principal Risks

Principal Risk	Description	Executive Lead(s)	Board assurance
PR1	**Failure to provide safe, effective, high quality care**	Chief Nurse / Medical Director	Clinical Outcomes & Effectiveness / Safety & Compliance
PR2	**Failure to recruit to full establishments, retain and engage workforce**	Director of Human Resources and Organisational Development	Patient & Staff Experience
PR3	**Current estate and infrastructure compromises ability to deliver safe, responsive and efficient patient care**	Director of Environment	Safety & Compliance
PR4	**Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care** **4A) IM&T** **4B) information and information governance**	Chief Information Officer	Finance & Investment
PR5	**Inability to deliver and maintain performance standards** **5A) Emergency Care** **5B) Planned Care (including RTT, diagnostics and cancer)**	Chief Operating Officer	Trust Executive
** PR6	Failure to maintain business continuity	Chief Operating Officer	N/A
PR7	**7A) Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes** **7B) Failure to secure sufficient capital, delaying needed improvements in the patient environment, securing a healthy and safe infrastructure**	Chief Financial Officer	Finance & Investment
PR8	**Failure to engage effectively with our patients, their families, local residents and partner organisations compromises the organisation's strategic position and reputation**	Deputy Chief Executive / Communications Director	Patient & Staff Experience
PR9	**Failure to deliver a long term strategy for the delivery of high quality, sustainable care**	Deputy Chief Executive	Trust Executive
PR10	**System pressures adversely impact on the delivery of the Trust's aims and objectives**	Chief Executive	Trust Executive

*** PR6 – business continuity has been closed (incorporated into PR1)*

Board Assurance Framework – current level of assurance
June 2017

G AG A AR R

	Risk profile deteriorating	Risk profile improving
Trend	↓	↑

Principal Risk	Description	RAG	Trend
PR1	Failure to provide safe, effective, high quality care (insufficiently robust and embedded quality governance and risk management)	A	↔
PR2	Failure to recruit to full establishments, retain and engage workforce	A	↔
PR3	Current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care	AR	↔
PR4	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care	AR	↔
	4A) IM&T 4B) Information and information governance	AG	↔
PR5	Inability to deliver and maintain performance standards	R	↔
	5A) Unscheduled care 5B) Elective care (including RTT, diagnostics and cancer	A	↔
** PR6	Failure to maintain business continuity	G	↔
PR7	7A) Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes	AR	↔
	7B) Failure to secure sufficient capital, delaying needed improvements in the patient care environment, security and safe infrastructure	R	↔
PR8	Failure to sustain key external stakeholder relationships and communications compromises the organisation's strategic position and reputation	AG	↔
PR9	Failure to deliver a sustained long term clinical, financial and estates strategy	AR	↔
PR10	System pressures adversely impact on the delivery of the Trust's aims and objectives	R	↔

*** PR6 – business continuity has been closed (incorporated into PR1)*

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Nurse / Medical Director

Risk Description	Controls	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.	**Key controls in place:** • Quality Account and Annual Plan set out priorities. • QG team in place to develop and deliver support and assurance programme • Quality Improvement plan sets out key actions ref. April 2015 CQC visit. • Corporate and divisional risk registers and Risk Review Group • Incident reporting / datix & SI review group • Monthly mortality and clinical harm meetings • M&M and service level governance meetings • Audit and compliance programme • Appriasal and revalidation • QIA of all CIP plans • Clinical Policies & Guidelines – review and ratification process • Whistleblowing policy • Daily review of staffing/escalation • CQC compliance framework • Patient Experience & Carers Strategy **Gaps in controls:** • Gaps in evidence of action completion and embedded / shared learning from SIs and Complaints • Gaps in evidencing implementation of policies • Clinical Guidelines documentation current status not fully established & 50% of guidelines out of date • Complaints response times and inconsistent application of complaints policy. • Adhering to the 'Duty of Candour' policy timeframes and lack of shared understanding of thresholds for moderate and severe incidents. • Patient Experience Strategy performance report in development • Quality Strategy to be developed in 2017/18.	**Key assurance in place:** • IPR quality and safety metrics, including safe staffing • Bi-monthly Safety &Compliance (S&C) and Outcomes & Effectiveness (O&E) sub committee meetings – updates on work plan and cycle of reporting: audit / NICE / Pt Experience Strategy / Quality Account etc. • Safety & Quality IPR for S&C and O&E sub committees • Test Your Care & Ward dashboards & matron quality checks • Monthly QIP plan progress reports to IRGC and Oversight group. • Monthly Quality and Safety Group (QSG) to review work plan • Monthly Risk Review Group reviews all 15+ risks on CRR. • CCG contract and quality meetings • 1/4ly assurance visits with external stakeholders • 15 steps programme **Gaps in assurance:** • Analysis and triangulation of data across different sources needs to be strengthened and made more consistent • Safe staffing data for medical staffing • Adherence to duty of candour for moderate harm incidents. • NICE compliance KPIs

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Director of Human Resources and Organisational Development

Risk Description	Controls	Assurance
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce		
Potential cause: In some areas it is difficult to recruit to meet the need of increased service demand, which is creating additional pressure on our staff and impacting negatively upon engagement. Basic workforce processes e.g. appraisals are not always being met. **Potential effect:** People feel disengaged and retention may become an issue which results in higher vacancies and increased temporary staff costs **Potential impact:** The Trust may fail to provide the highest standards of patient care, increase staff costs and staff morale will be negatively effected	**Key controls in place:** • Workforce strategy now in place • Recruitment and retention strategy in place • New values in place • Clinical engagement programme • Implementation of B&H strategy • Divisional people engagement plans • Metrics for key workforce activities in place • Good development programmes in place for key staff groups • Health and wellbeing initiatives in place • Mechanisms for on-going monitoring of engagement in place • Improved induction processes including training for managers with new joiners • Improved exit data • Improved access to e-learning • Improved management of agency/locum usage • HR & OD team – business partner model • PMO support to implementation and tracking of strategy **Gaps in controls:** • Further embedding of values which drive behaviours • Appraisal compliance falling • Some leaders still rely upon command and control and this can lead to feelings of bullying • Lack of clear development pathways for staff • More work required to grow engagement amongst our medical workforce. • Staff facilities remain poor	**Key assurance in place:** •A work plan to support the implementation of workforce strategy •Robust exit interviewing data **Sources of Assurance:** Workforce KPIs and delivery against strategy implementation plans reviewed at Patient and Staff Experience sub-committee. Workforce Steering Group provides management oversight of the overall workplan. **Gaps in assurance** Lack of data relating to % of staff with PDPs in place and whether they are being released for development

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Director of Environment

Risk Description	Controls	Assurance

Principal Risk Three: Current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care

Potential cause: The current estate and utilities infrastructure is fit for purpose for the delivery of safe, responsive and efficient patient care

Potential Effect:
Frequent failure of critical infrastructure creating a poor / inadequate / unsafe environment for delivery of healthcare services in beach of CQC Outcome 15

Potential Impact:
Disruption to service delivery (theatres /NICU/MRI all closed in last 12 months)

Patient safety impacted by lack of capacity (space & resources) to meets operational demands and mandated standards

Environment provides poor patient experience and increased infection Risk

Prosecution by statutory bodies

Key controls in place:

- Creation of Environment Division provides structure and staffing levels to deliver effective estates and facilities services
- All identified environment risks entered on Trust Risk Register. Reviewed monthly at Division's Risk & Governance meeting.
- Backlog Maintenance programme based on 6 Facet Condition Survey ensures highest identified risks are addressed first.
- 24/7 reactive maintenance capability across all sites
- Interim Estates Strategy prioritised investment & resources
- Monthly Site Management Meeting .
- Environment Help Desk provides single focal point for all reactive maintenance activity and works requests
- 2016/17 Authorising Engineers (AEs) engaged for all high risk areas (except confined spaces management), as required by HTM 00 for development of a safe system of work across the Trust estate

Gaps in controls :

- Capital funding insufficient to meet minimum requirement for backlog programme thereby increasing likelihood of infrastructure or equipment failure.
- No Authorising Engineer arrangement in place for confined spaces management (due July 2017)
- Process is underway to train / appoint WHHT staff to Authorised Person (AP) positions.
- Programme of audits by Authorising Engineers incomplete – some audits overdue (due to historic gaps in AE workforce now resolved)
- There is no Asset Register for critical infrastructure & major utilities. This limits development and effectiveness of planned maintenance programme and increases safety risk to on-call staff.
- Recruitment & retention challenges together with high sickness in Estates workforce undermine ability to keep controls in place.
- Development Control Plans required for each site to ensure investment is prioritized in accordance with Interim Estates Strategy

Key assurance in place:

- Implementation of Premises Assurance Model (PAM) Dashboard completed. Bi-monthly environment assurance reports through QSG to Safety & Compliance Committee..
- Operation of a Safe System of Work in accordance with HTM 00 including mandated Risk Assessments for high risk areas
- Monthly Divisional Risk & Governance meetings in place reporting to QSG.
- Engagement with HSE to provide external assurance regarding measures taken to manage asbestos containing materials (ACMs) and Legionella
- Mock PLACE visits underway at all sites with representatives from Trust, patients and Healthwatch

Gaps in assurance:

- The Trust's estate management system (ARCHIBUS) cannot currently provide required levels of assurance or 'live' task management / performance reports.
- PAM Action plan to close out highest risk gaps in assurance is underway but not fully complete.
- 6 Facet Survey out of date.
- Given complexity of challenges related to estates infrastructure, capital programme management and strategy, current governance arrangements do not provide sufficient assurance to Board level and need to be further strengthened.

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Information Officer

Risk Description	Controls	Assurance
Principal Risk Four A: Underdeveloped ICT 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 technical issues with supplier solutions, resource, funding, scope and physical estate constraints. Cyber attacks adversely impacts on system resilience. **Potential impact:** Unable to deliver 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	**Key controls in place:** • Five year contract to provide full managed CT service, negotiated with Herts Procurement, IT and Finance • Contract management structure in place for ICT holding supplier to account • Re-baselined programme plan and formal contractual change agreed with supplier • Enhanced resources to support delivery • Weekly exec to exec governance meetings to address issues as they arise • Member of NHSE cyber security programme. Full risk assessment undertaken and requirements placed on supplier to act. • Mitigated future risk of cyber attack by patching to latest NHS E recommended standards. • CCIO and CNIO in post to support and promote utilisation of technology. **Gaps in controls:** • High priority issues with migration of some applications to the supplier datacentre and end user devices means that some programme milestones are at risk • Dependency on the ICT infrastructure improvements has adversely affected delivery of other projects including medical records tracking • Risks to IT security as a result of delayed delivery of ICT infrastructure improvements • Clinical and Divisional representation at the ICT Transformation Group needs to be increased • Incomplete asset register • Some key clinical systems reaching end of life • lack of capital funding to implement strategy	**Sources of Assurance :** • ICT Transformation Group oversight of programme delivery and service management panels • ICT Transformation Group reports through to the Strategy Delivery Board (TEC) monthly • Detailed ICT infrastructure improvement programme update to Finance and Investment Committee monthly, with updates and escalations to Trust Board as required • Robust contract management with Commercial Executive meetings • External (CIO) review of programme governance and supplier management • Lead non –executive with subject matter expertise providing assurance on controls, mitigation and strategy. **Gaps in assurance:** • Insufficient assurance that Trust is adequately protected from future cyber attack.

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Information Officer

Risk Description	Controls	Assurance
Principal Risk Four B: Underdeveloped information/information governance 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 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	**Key controls in place:** • Director or Performance and Associate Director of Performance & Information supported by analytics team • Comprehensive suite of reports on iReporter • Comprehensive patient tracking lists and data quality reports developed to prospectively manage patient pathways and support operational management • Regular audits of information Governance compliance being undertaken • Regular audits of data quality being undertaken, DQ indicators including in IPR **Gaps in controls:** • Variable data quality (DQ) • Current Cancer Information System not fit for purpose *(business case approved for replacement in 2017/18)* • Variable understanding and utilisation of information available on iReporter.	**Sources of Assurance :** • Informatics group reporting through FIP to Trust Board • Integrated performance report (IPR), with enhanced exception reporting. • Data Quality reports – oversight by Director of Performance • Annual data quality audits (internal Audit) • CCG CQRM and contract schedules **Gaps in assurance:** • None identified

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Operating Officer

Risk Description	Controls	Assurance

Principal Risk Five A: Inability to deliver and maintain performance standards: unscheduled care.

Potential cause:

- Failure to maintain and improve system flow
- Failure to reduce DTOCs and system waits
- Failure to undertake robust demand & capacity modelling
- Failure of infrastructure/estate resulting in lost capacity
- Financial constraints limit the organisation's ability to respond to risk

Potential effect:

- Failure to meet agreed improvement trajectory

Potential impact:

- Adverse impact upon quality outcomes and patient experience
- Financial impact associated with performance fines and STF funding
- Reputational impact

Key controls in place:

- Bed management policy, escalation policy and surge plan in place and subject to regular review and evaluation
- 24/7 Ops team, senior manager and director on call
- 4 times daily bed meetings to review overall site position
- Bed state reporting on i-reporter
- Daily a.m. system call 365 days per year
- Fortnightly system wide Local ED Delivery Board (Chaired by WHHT CEO) monitors the delivery of system wide improvement
- Partnership wide System Resilience Improvement Plan in place
- Emergency care transformation plan in place with project support via PMO
- Fortnightly ED Transformation task force meeting chaired by Medical Director with strengthened clinical engagement, cross divisional representation
- Continued Emergency Care Improvement Team support
- ED turnaround programme director commissioned to provide intensive improvement support for a defined period (to commence June)

Gaps in controls:

- Insufficiently robust/consistent discharge processes and practice leading to delays and late discharges
- Bed state data not fully 'live' due to delays in entering data out of hours. Short term solution – additional bank admin out of hours pending long term redesign of ward administrative support.
- Workforce gaps/pressures - senior clinical workforce
- External factors outside span of control, e.g. social work capacity, DTOCs, stranded patients, ambulance traffic management
- Weak system wide escalation/responsiveness of partners at times of peak pressure
- ED environment/capacity constraints inhibits service efficiency

Sources of Assurance:

- Monthly integrated performance reports
- System wide urgent care dashboard
- TEC performance meeting & monthly update to part 2 of Trust Board
- Monthly 'day of care' audits
- Daily and weekly performance reports showing demand and performance data
- 4 hour standard breach report
- Monthly Divisional performance meetings

Gaps in assurance:

- None identified (Assurance mapping exercise for safety and quality of care in ED to be undertaken in June).

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Operating Officer

Risk Description	Controls	Assurance
Principal Risk Five B: Inability to deliver and maintain performance standards: Elective care		
Potential cause: •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 •Increased demand (referrals) beyond anticipated growth •Reduced demand as a result of referrers/patients choosing alternative providers •Inability to mitigate patient choice impact •Cancer data system requires upgrade/replacement	**Key controls in place:** • Access policy updated and in use • Weekly referral to treatment (RTT)Access meeting • GOO (patients with no outcome/booked to breach) Patient Tracking List (PTL) meetings • Daily RTT performance update email • Daily, weekly & monthly RTT pathway validation • Suite of iReporter data quality reports developed to safeguard accuracy of PTLs • RTT recovery trajectories by specialty • Director of Performance undertakes regular demand & capacity reviews • Outsourcing programme • Weekly Cancer Access meeting • Manual checks and processes to ensure accuracy and validity of cancer data to mitigate for system constraints • Cancer Improvement Plan • Cancer Action Group – CCG led • Diagnostic Performance meeting • Agreed activity plan with commissioners for 2017/18 **Gaps in controls:** • Variable adherence/application of Access Policy & OPD processes • Risk of loss of capacity associated with e.g. estate & theatre ventilation works • Limited uptake by patients of outsourcing options • Impact of unscheduled care demand / prioritisation of emergencies • Incomplete demand and capacity modelling • Some factors influencing patient choice outside span of control e.g. breast symptomatic 2ww	**Sources of Assurance :** • Monthly integrated performance reports • Comprehensive suite of data quality reports for RTT & Cancer • RTT Programme Board (Chaired by COO) • Divisional Performance meetings • Monthly Performance (RTT/Cancer/Diagnostics) TEC & exceptions reports to Part 2 of Trust Board • Internal audit of compliance with Access Policy and scheduling practices undertaken in August 2016 • Monthly Contract Quality Review Meeting (CQRM) reviews activity against agreed performance plan **Gaps in assurance:** • None identified

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Financial Officer

Risk Description	Controls	Assurance
Principal Risk Seven A: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes		
Potential causes: • Income less than planned due to variance in activity, paid for emergency activity at marginal rate, fines and/or penalties, additional risks from Commissioner financial position. • STP funding not secured due to not achieving conditions • Expenditure greater than planned due to spending to respond to emergency patient pressures. • Expenditure greater than planned due to cost benefit analysis not taking place and options appraised before any decision to overspend • Failure to achieve required levels of efficiency due to insufficient progress with establishment of internal PMO and competing operational pressures. **Potential effect:** • FY17 plan/target not achieved – reputational damage. • Insufficient cash to not disrupt services • Liability to demonstrate financial sustainability. **Potential Impact:** • External intervention • Deterioration to reputation • Capital funding delayed/ refused • Loss of market share • Financially unviable Trust	**Key controls in place:** • Finance team and PMO support to CIP programme • Budget setting and business planning process • Budget management process • Contract negotiation and monitoring process. • Contracts and other documented agreements • Standing Financial Instructions • Annual audit plan and local counter fraud plan • External audit of annual accounts and value for money assessment • Monitoring of efficiency programme • Monthly review with NHSI • Integrated delivery/ oversight meetings • Monthly performance divisional review meetings • NHSI funding application processes. **Gaps in controls:** • Limited use of benchmarking and SLR • Overspending occurs without prior approval and agreed recovery actions • Variable adherence to controls such as e-rostering • Need to rapidly identify additional CIP to bridge gap between target and identified schemes. • Clearer responsibility between health and social care partners for delivery of targets *(See also PR5a / b – significant tranche of STF funding dependent on meeting agreed improvement trajectories for emergency care and RTT standards).*	**Sources of Assurance:** • Monthly finance report + reconciliations • Monthly Finance & Performance Committee • Audit Committee reports • Internal Audit report on budgetary control • Internal Audit report on cost improvement programme • Internal Audit reports on financial controls • External Audit • Regular reviews of efficiency programme by Finance & Performance Committee • Review meetings with commissioners • Outcomes of monthly accountability meetings **Gaps in assurance:** • Benefits realisation assessment for approved business cases.

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Financial Officer

Risk Description	Controls	Assurance
Principal Risk Seven B: Failure to secure sufficient capital, delaying needed improvements in the patient care environment securing healthy and safe infrastructure		
Potential causes: • Insufficient funding for critical projects after capital loan repayment and completion of schemes in progress • Inadequate business cases and project management • Failure to access external funding as a sanction for failure to deliver I&E plan **Potential effect:** • Delay of needed improvements in the patient environment • Increased fire-fighting due to not undertaking backlog maintenance or replacement of worn out equipment **Potential impact:** • Failure to make infrastructure changes essential to deliver 2017/18 planned activity • Non compliance with health and safety or other standards • Unsustainable infrastructure	**Key controls in place:** • Capital Planning and Finance Group (CPFG) • Finance and Investment Committee. • Annual planning processes and Budget setting confirm and challenge process • Engagement with the NHSI capital and cash process • Priority one schemes for 2017/18 agreed from internal resources **Gaps in controls:** • Variable quality of business cases • Project management (spending profile, delivery risks, variance control) • Business case development process • ITFF application being developed – risk of delay to approval and / or not fully approved.	**Sources of Assurance:** • Monthly Board reporting • Progress updates to Finance and Investment Committee • Executive sign-off of CPFG recommendations • Monthly reporting to NHSI • Strong pipeline of Strategic Outline cases and Outline Business cases • NHSI review of capital programme provided assurance of robustness of 2016/17 process **Gaps in assurance:** • Lack of assurance that approvals for spending are always within delegated limit / cost overruns on capital projects. • Internal audit of capital controls being undertaken (to report in July 2017).

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Deputy Chief Executive / Director of Communications

Risk Description	Controls	Assurance

Principal Risk Eight: Failure to communicate and engage effectively both internally and externally compromises the organisation's strategic position and reputation

Potential causes:
- Competing priorities for the communications team
- Lack of clarity as to impact of STP
- Lack of clarity as to impact of RFH model
- Planned programme of engagement is still being built (and will be ongoing)
- Insufficient visibility of Board members and senior leadership team
- The intranet and website are unappealing and in need of an overhaul

Potential effect:
- WHHT position not well understood or misrepresented, opportunities for positive messaging missed

Potential impact:
- Reduced confidence of stakeholders and local residents in quality and safety of services

Key controls in place:
- Weekly meetings to discuss which issues have the highest strategic priority and to discuss workload
- Communications team working with divisional structures to source and disseminate positive news stories
- 24/7 communications support to respond to media enquiries and monitor media
- Quarterly Herts & Minds newsletters
- CEO briefings monthly on all 3 sites
- Close working with STP and HVCCG communications teams on STP and YCYF communications
- The MoU between RFH and WHHT has agreements re dissemination of key messages. This covers timings as well as content of key messages.
- Meetings with external stakeholders are regularly taking place (i.e. Communications colleagues at the CCG, Watford BC, RFH etc.)
- Communications plan devised for increased internal and external messaging re acute redevelopment strategic outline case.
- Regular meetings in place with Watford Borough Council to work on messaging and open meeting planned for late June to address this issue and to promote the benefits of having a shared approach to the site

Gaps in controls:
- Visible Leadership programme needs to be re-invigorated and particular focus on HHGH and SACH sites
- Website and intranet are based on old technology and content needs full refresh – this is subject to funding for the business case being secured
- Communications resource means that large scale projects like the SOC(s) and planning campaigns to counter local opposition will be a challenge
- Stakeholder strategy and action plan to be finalised

Sources of Assurance :
- Delivery against team's own action plan – monitored by the Deputy CEO
- Feedback from staff during engagement events in spring and summer of 2017 and the free text that is part of the new pulse check
- Media monitoring in help assess effectiveness of messaging
- Broadening our stakeholder base enables more feedback into planned external communications and an assurance that our messaging is clear
- Metrics on print and social media reported to Board in monthly CEO update
- Annual staff survey.

Gaps in assurance:
- Trend analysis of metrics needed to show progress in both media and staff communications.

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Deputy Chief Executive

Risk Description	Controls	Assurance
Principal Risk Principal Risk Nine: Failure to deliver sustainable long term strategy for WHHT – clinical, financial, estates and digital		
Potential cause: Internal operational issues and capacity / capability constraints compromise ability to focus on progressing medium to long term strategic plans. System alignment via Strategy and Transformation Partnership. Note commissioner £ position increasingly challenging. **Potential effect:** Delays to strategy implementation, key sustainability issues not addressed, **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 poor infrastructure	**Key controls in place:** • CEO, Deputy CEO, CFO and CMO all actively engaged in STP governance and delivery processes. CEO leading Urgent and Emergency Care and IM&T work streams, Deputy CEO leading estates and capital work stream. • Deputy CEO has lead responsibility for development and delivery of Trust strategies, linking with other Executive Directors as applicable. • Director of Integrated Care in place to support delivery of strategy and system wide pathway transformation. • Director of Environment lead responsibility for interim estate strategy and expert advice to development of redevelopment OBC. Strategy and Compliance function within Environment team strengthened to provide capacity to deliver strategy. • Associate Director IM&T leading updating and delivery of IM&T / digital strategy. • Regular dialogue with NHS I finance team to progress business case approvals for SOC & OBC. NHS I have recognised the need for substantial funding to take forward the development of the acute transformation OBC (contingent on SOC approvals) • Agreement in principle to explore closer working with RFL via the group model. Lead executives scoping opportunities. Programme Board established. • Long Term Financial Model **Gaps in controls:** • Limited internal strategic planning / health planning capacity currently in place to support the detailed work required to progress acute transformation OBC. • Availability of capital severely constrained. This is likely to impact on delivery of IM&T and Estates strategies and potentially delay OBC development if funding not secured. • Strategy implementation plans to be developed – overarching Trust strategy, interim estate strategy and IM&T strategy (following refresh) – via PMO / QIP process. • Detailed work plan with RFH to be developed	**Sources of Assurance :** • Strategy / STP & Your Care, Your Future updates to Trust Board • Board strategy development sessions • Long Term Financial model quarterly updates to FIC Committee • IM&T strategy progress updates to ICT transformation group / TEC / FIC. • External review of CGI contract undertaken. **Gaps in assurance**: • Key elements of programme to be incorporated into PMO model and reporting arrangements. • Acute Transformation Programme Board to be established to provide assurance re delivery of the outline business case (OBC) and associated transformation work • Estates governance to be strengthened with establishment of Estates Steering Group (Strategy and Capital)

Current Status	June 2017	G	AG	A	AR	R	⟷	OWNER: Chief Executive Officer

Risk Description	Controls	Assurance
Principal Risk Ten: System pressures adversely impact on the delivery of the Trust's aims and objectives		
Potential Cause Insufficient alignment of demand, capacity and financial plans across the system; service gaps; insufficiently robust system plans to address key pressures and / or plans not delivered and / or plans do not have the anticipated impact on performance **Potential Effect**: Demand exceeds capacity – planned & emergency care pathways including delays discharging medically stable patients to alternative care settings **Potential Impact**: Significant adverse impact on quality, safety, responsiveness and efficiency of services including delivery of national standards and financial plans	**Key controls in place:** • STP / Your Care Your Future programme •Monthly clinical partnership meeting – WHHT & HVCCG clinical commissioning leads •Provider collaborative established , principles for collaboration agreed, shared work programme in place. "One Herts" GP federation established and providing mechanisms for increased work with GPs are providers. •A&E Local delivery Board (LDB)– WHHT CEO chair and EDs active participation •System support being provided by the National Emergency Care Improvement Programme (ECIP) / Emergency Care Improvement plan in place •EoE Ambulance Handover pilot site •System wide discharge improvement plan developed and submitted to NHS E. (HVCCG led) •WHHT COO meets weekly with system partners •Director of Integrated Care appointed – key role in building collaborative relationships , developing and implementing solutions. •Annual contractual negotiation and contract management mechanisms – joint QIPP Board •CEO / representative attends Hertfordshire Chief Executive's Forum **Gaps in controls:** •Significant gap between HVCCG and WHHT contract values. Joint QIPP Board not functioning optimally – needs review, increased clinical engagement & jointly agreed work programme to be developed. •HVCCG and HCC financial positions leading to the decommissioning of community and social care capacity to support people at home as alternative to admission / following admission. Persistent issues in relation to high levels of delayed transfers - system not meeting trajectory to reduce •Continuing care / End of Life care pathways not operating effectively – joint improvement plan to be developed. •Clinical relationships WHHT / primary care under developed in some specialities	**Sources of Assurance:** • Daily / weekly /monthly monitoring of KPIs and escalation to NHS E, NHS I and partners. CEO to CEO / system escalation as required • Fortnightly LDB meeting – reviews LDB dashboard and progress against system improvement plan • Monthly integrated Performance Report (IPR) reports key metrics and remedial actions • Monthly reports to TEC setting out performance, remedial actions and risks / issues. Monthly updates to Trust Board. • Monthly regional escalation meetings. • Finance reports. **Gaps in assurance:** • Insufficient assurance that all LDB resource (readmissions and marginal rate emergency tariff (MRET)) is delivering the maximum impact – particularly ref reducing acute pressures