West Hertfordshire Hospitals NHS
NHS Trust

Board Assurance Framework

April 2017

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	Trust Executive
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
April 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	April 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/September 2016 CQC visit. • Corporate and divisional risk registers and Risk Review Group •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 •Clinical policies & guidelines •Whistleblowing policy •Daily review of staffing/escalation •CQC compliance framework •Patient Experience & Carers strategy. •Clinical guidelines and policy ratification & review process **Gaps in controls:** • Gaps in evidence of action completion and embedded / shared learning from SIs and Complaints •Gaps in evidencing implementation of policies •Gaps in the process of complaints and quality of responses. •Adhering to the 'Duty of Candour' policy timeframes and thresholds for moderate and severe. •Patient experience performance report in development •Approximately 50% of clinical guidelines are in date.	**Key assurance in place:** •IPR quality and safety metrics •Mortality reports (Dr Foster) •Test Your Care & Ward dashboards & matron quality checks •Monthly QIP plan progress reports to IRGC and Oversight group. •Quality and Safety Group (QSG) meets monthly to review Q&S work programme •S&C sub committee meets bi-monthly •Clinical Outcomes & Effectiveness committee bi-monthly •Risk Review Group meets monthly to review all 15+ risks on CRR. • CCG contract and quality meetings •Safe staffing reports to Board in the IPR • Executive level 15 steps programme •Audit Committee to provide assurance on effectiveness of processes. •Quarterly audit/NICE reports •QS Performance report •QIP reports •Patient Experience Strategy progress updates •Safety & Quality IPR reviewed at Board subcommittees **Gaps in assurance:** • Analysis and triangulation of data across different sources needs to be strengthened and made more consistent • Gaps in assurance: Safe staffing data for medical staffing • Gaps in assurance re adherence to duty of candour for moderate harm incidents. • Gaps in assurance audit and NICE compliance KPIs • Embedding learning from Sis, complaints and incidences • Development of Trust Quality Strategy • MCA/Best interests consent

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

Action Plans for Gaps 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status
Principal Risk One: Failure to provide safe, effective, high quality care				
Continued implementation of QIP, milestones updated as required with monthly report to IRGC and Board on progress.	Chief Information Officer	Monthly reporting continues to IRGC with a number of projects completed . Due for completion in March 2017 Continue with QIP into Q1 to ensure actions completed whilst developing a quality strategy	Dec 16	Achieved. Carried forward
Implement actions arising from internal audit of complaints in Q4 2015/16	Chief Nurse	Audit report reviewed and actions incorporated into complaints improvement programme with the exception of training on recording actions	Nov 16	Partially achieved. Carried forward
Establish medical safe staffing assurance report	Medical Director/ Director of Human Resources	A steering group has been established to formulate an approach to the development of an establishment and vacancy strategic plan. The membership includes the Medical Director and representation from Human Resources and Medical Workforce	June 16	Partially achieved. Carried forward
Implement complaints review and 90 day improvement programme.	Chief Nurse	New complaints indicators report in the S&Q IPR and a new indicator added to the Trust Board IPR. Complaints adviser based in unscheduled care division after successful pilot. Complaints tracker reviewed and implemented. Continue to embed implementation of improved quality and performance across the divisions.	Dec 16	Partially completed. Carried forward
Develop Trust Quality Strategy	Chief Nurse	This is part of the 2017 – 18 workplan for S&Q committee and will succeed the QIP.	Sept 17	Not yet due. Carried forward

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

Action Plans for Gaps 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status
Principal Risk One: Failure to provide safe, effective, high quality care				
Embedding the learning from SI's + duty of candour understanding and thresholds for moderate and severe.	Chief Nurse	Develop process to track actions from SI's through divisional performance reviews. Continuing to develop Datix and thresholds for duty of candour. Duty of candour intranet page available for staff including a link to the duty of candour video. And policy	Dec 16	Partially achieved. Carried forward
Establish status of clinical guidelines and trajectory and agreed trajectory for compliance.	Medical Director/ Chief Nurse	Review underway of clinical guidelines. Purchase of Q-Pulse to manage and monitor clinical guidelines review process Mapping exercise for Trust guidelines was still in progress and being undertaken by the Assurance Team The trajectory for Clinical Guidelines was agreed at Policy Review Group Dec 16 and set to achieve a target of 90% in-date guidelines	March 17	Partially achieved. Carried forward

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status
Principal Risk One: Failure to provide safe, effective, high quality care				
Complaints quality & performance: Review KPI's for Board IPR Set trajectory for performance at Trust & divisional level and embed Review complaints management capacity & roles and responsibilities Implement investigation process and complaints response Internal audit implementation of actions.	Chief Nurse	KPI's to be further reviewed and consider a KPI for complex complaints. Audit of complaints responses with HWH planned to be repeated in the summer.	July 17	
Continued implementation of QIP. Refresh QIP post September CQC inspection and final report March 17.	Chief Nurse	Refresh being completed: Change requests submitted to TEC throughout April 17. Update to Trust Board in March/April on work to refresh and 'Must & Should' to be included in QIP from March 17 CQC inspection reports.	September 17 May 17	
To meet clinical guidelines in-date trajectory 0f 90%. Determining effectiveness of policies	Medical Director/ Chief Nurse	Reporting of compliance process underway. Included in work plan	June 17 December 17	

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status
Principal Risk One: Failure to provide safe, effective, high quality care				
Embedding the learning from SI's	Chief Nurse/Medical Director	SI actions evidence of completion tracked through SI review group. Develop process to track actions from SI's through divisional performance reviews. RCA training development and forward programme under development.	June 17	
Establish medical safe staffing assurance report Develop metrics for reporting	Medical Director/ Director of Human Resources	NHSi Medical Director contacted to confirm metrics used.	May 17	
Duty of candour understanding and thresholds for moderate and severe harms.	Chief Nurse/Medical Director	Review of Datix to capture evidence for moderate harms for divisional incident reporting.	July 17	
Learning from deaths and implementation of NQB guidance.	Medical Director	New policy in development and presented to CAG Action plan in development to address recommendations set out within NQB guidance Review of Divisional M&M mtgs	April 17 May 17 July 17	

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status
Principal Risk One: Failure to provide safe, effective, high quality care				
Develop Trust Quality Strategy	Chief Nurse	This is part of the 2017 – 18 workplan for Clinical outcomes and effectiveness committee. Discussed at Strategy Delivery Board (SDB) TEC and quality priorities approved. Continued monitoring and discussion at SDB TEC as part of PMO workstreams.	October 17	
To set up a Trust wide consent framework linking MCA/Best interests.	Medical Director/ Chief Nurse	Training being developed on MCA/Best interests decisions with safeguarding and RAID teams. Audits to be undertaken in Q4	December 17	

Current Status	April 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 on going •On-going 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 **Gaps in controls:** •Further embedding of values which drive behaviours •Appraisal compliance falling •Lack of clear expectations of what we want from our leaders •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	April 2017	G	AG	A	AR	R	⟷	OWNER: Director of Human Resources and Organisational Development

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ Expected date of completion
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce				
Continued recruitment of nurses to ensure that the vacancy rate for our nursing workforce reaches 5%. In addition plan to recruit for junior/middle grade doctors to reach 5% vacancy rate	Director of Human Resources	Nurse vacancy rate stands at 14%, although actual staff in post is much higher than 12 months ago. There is a good pipeline of overseas nurses due to start later on in the year. Vacancies amongst consultant posts is less than 5% .There are still some very difficult to recruit to areas e.g. middle grades in ED, working group set up to manage.	March 17	Partially achieved. Carried forward.
Bullying and harassment strategy (has been drafted and is now being taken through governance processes)	Director of Human Resources	B&H strategy approved and a work plan is in place. There has been an increase in the number of B&H complaints which suggests that people are more willing to complain.	Sept 15	Achieved. BAU
Training and Development Strategy	Director of Human Resources	Development strategy approved and reorganisation of L&D function near completion. Improvements seen in external visits and compliance with mandatory training.	Jan 16 (Approval strategy)	Achieved.
Launch of 'pulse checking' on engagement	Director of Human Resources	First pulse check comprising of a basket of 11 questions completed and this will be repeated quarterly. Launch action now complete.	Jul 16	Achieved. BAU

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ Expected date of completion
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce				
Implementation of medical engagement programme	Medical Director	Changes to clinical leadership roles now implemented and DDs in place. On going activity to improve engagement MVDW blogs, clinical senate, etc.	Jun 16	Achieved. BAU
Roll out of values plan	Director of Human Resources	New values launched and activity underway to embed new values. On going work to embed will continue, but formal launch programme now complete.	Jun 16	Achieved. BAU

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ Expected date of completion
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce				
Having divisional staff survey action plans in place which are driving engagement	Director of Human Resources	Divisional staff survey action plans being developed. Implementation to be monitored via performance reviews. Quarterly temperature checks reviewed at PSEC	May 2017	
Complete current 'agency to permanent' recruitment campaign, with goal being to recruit 40 workers.	Director of Human Resources	All agency/locum workers being approached to encourage them to join the Trust permanently or bank	Sept 17	
90 new overseas nurses join the Trust	Director of Human Resources	These workers are from the recruitment campaign undertaken in India in Sept 16	Sept 17	
Launch of apprenticeship levy activity	Director of Human Resources	The Trust is working with STP partners on this work.	Oct 17	
Implementation of appraisal action plan to ensure compliance and improved quality of appraisals	Director of Human Resources	Goal is by September for Trust compliance to be at 90%	Sept 17	

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ Expected date of completion
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce				
Health and Wellbeing business case submitted d to Charitable Funds Committee	Director of Human Resources	This will help fund a range of intervention including stress management, H&WB 'MOT' checks, etc.	Aug 17	
Funding for CPD activity agreed and programmes being implemented	Director of Human Resources	Loss of external CPD means that the Trust must look at alternative options	Sept 17	
Publication of annual WRES Report and ensuring that associated activities are being implemented	Director of Human Resources	Goal is to address diversity issues within this year's staff survey	Dec 17	
Implementation of Trust's Workforce strategy	Director of Human Resources	Goal is for there to be clear structures and reporting in place to demonstrate implementation	Nov 17	
Launch of 'shared' Bank with STP partners	Director of Human Resources	This will encourage our workers to work through an STP bank as oppose to agencies.	Dec 17	

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ Expected date of completion
Principal Risk Two: Failure to recruit to full establishment, retain and engage our workforce				
Plan in place to address high level of agency use within Surgery and in particular anaesthetics	Director of Human Resources	There are very significant gaps in anaesthetics rotas which is demoralising and expensive.	Sept 17	
Relaunch of B&H advisors to challenge inappropriate behaviour	Director of Human Resources	These will be local points of contact in relation to B&H	Oct 17	
Suite of management programmes in place to assist development of our leaders	Director of Human Resources	This will help address issues around expectations of our managers	Oct 17	

Current Status	April 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. And reviewed monthly at Division's Risk & Governance meeting. •Backlog Maintenance programme based on 6 Facet Condition Survey ensures highest identified risks are addressed first. 6 Facet Survey is currently being updated •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. •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 prioritised 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	April 2017	G	AG	A	AR	R	⟷	OWNER: Director of Environment

Action Plans for Gaps: 2016/17	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 the ability to consistently deliver safe, caring, responsive and efficient patient care				
Complete Interim Estates Strategy	Director of Environment	Interim Estates Strategy (2016-2020) ratified by Board on 2 Feb 17. All stakeholders fully engaged in development.	Sep 15	Achieved.
Provide a safe working environment in accordance with Statutory and DH Mandated obligations	Director of Environment	Safe system of work in place. 70% of authorised person (AP) positions now held by permanent staff. External specialists appointed to Authorising Engineer (AE) positions in highest risk areas.	31 Dec 15	Achieved.
Maintain the operational functionality of the hospital estate through a programme of planned and response maintenance	Director of Environment	Environment Division Help Desk operational. Estate Asset Database will not be completed until May 17, Full PPM programme will be rolled out in 2017/18, with first years full compliance on 31 Mar 18.	31 Mar 16	Partially achieved. Carried forward
Deliver programme to develop and populate ARCHIBUS	Director of Environment	New version of Archibus installed and being populated. Data entry underway. Full functionality not before October 2017.	Dec 15	Partially achieved. Carried forward
Review & strengthen governance of estates and facilities work programme reporting through Safety & Quality Committee.	Director of Environment	Monthly Divisional Risk & Governance meetings implemented. PAM implemented. Progress reports provided to S&Q.	30 Jun 16	Partially achieved. Carried forward

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

Action Plans for Gaps: 2016/17	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 the ability to consistently deliver safe, caring, responsive and efficient patient care				
Provide a 'safe' environment for delivery of clinical services (strengthen health and safety governance)	Director of Environment	H&S audit conducted across all areas of Trust. Risk Assessments in place and being refined. Safe system of work in place for high risk activities on estate.	31 Mar 16	Achieved.
Provide assurance across spectrum of Environment Division activities through operation of the Premises Assurance Model	Director of Environment	PAM Dashboard complete. Actions complete to address 90% of areas graded Inadequate. Estates Asset Database delayed by 2 months, ETC now July 2017. PAM reassessment scheduled for Sep 17.	Nov 16	Partially achieved. Carried forward
Provide assurance that estate is 'fit for purpose'	Director of Environment	Updated to 6 Facet (Condition) Survey commissioned. Report due mid 17. Will address compliance issues, identifying areas of high & significant risk. Derogations will be required for areas of non-compliance to standards.	Dec 16	Partially achieved. Carried forward
Deliver 2016/17 Capital Works Programme	Director of Environment	Programme was prioritised at CFPG in Apr 16, but was dependant funding. Delay in response to ITTF submission means full in-year programme was not delivered. Endoscopy & MRI/CT works will complete in Apr 17.	31 Mar 16	Partially achieved. Carried forward
Manage user expectations though delivery of agreed Environment Works Plan	Director of Environment	Works Plan agreed at QIP. Environment works plan completed.	30 Nov 16	Achieved.

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

Action Plans for Gaps 2017/18	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 the ability to consistently deliver safe, caring, responsive and efficient patient care				
Agree and deliver prioritised capital programme for 2017/18.	Director Of Environment	Priority programme to be agreed by CPFG on completion of confirm and challenge process. Priorities for ITFF application to be agreed. Agreed milestones and implementation timelines to be agreed via CPFG for first phase More robust mechanism to track and report delivery against milestones to be implemented.	June 2017 July 2017 July 2017	
Deliver 2017/18 medical devices life cycle replacement programme to meet statutory obligations and ensure compliance with CQC outcome 15.	Director Of Environment	Prioritised programme to be produced by 30 Apr 17. Implementation plan to be developed once capital allocation confirmed. Business cases to be developed in line with agreed milestones.	April 2017 July 2017	
Provide development control plans (DCPs) to direct investment in line with Trust and Estates strategy.	Director Of Environment	Project plan to be developed . Implementation milestones TBC once project plan complete.	June 2017 TBC	

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

Action Plans for Gaps 2017/18	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 the ability to consistently deliver safe, caring, responsive and efficient patient care				
Complete estate asset database and roll out full PPM programme for 2017/18.	Director of Environment	Estate Asset Database to be completed by end July 2017. PPM programme completed	July 17 March 2018	
Deliver programme to develop and populate ARCHIBUS to provide full functionality	Director of Environment	Archibus data entry underway. Full functionality to be achieved by end October 2017.	October 17	
Establish Estates Transformation Group with agreed set of deliverables for 2017/18, including development of estates and facilities KPI dashboard.	Director of Environment	First ESG meeting Draft dashboard / plan for rollout in place	May 17 July 17	
Provide assurance across spectrum of Environment Division activities through operation of the Premises Assurance Model	Director of Environment	Complete outstanding actions from 2016 PAM dashboard to address all areas assessed to be Inadequate by end August 2017. PAM reassessment scheduled for Sep 17.	Sept 17	
Provide assurance that estate is 'fit for purpose' – finalise 6 facet survey and develop recommendations / action plan to respond to findings.	Director of Environment	Updated to 6 Facet (Condition) Survey to be completed by end July Recommendations / actions to address highest level risks . Derogations will be required for areas of non-compliance to standards.	July 17 Sept 17 Sept 17	

Current Status	April 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 **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 •Governance structure in place for IM&T holding suppliers and directorate to account •Re-baselined programme plan agreed with supplier •Resources to support delivery •Detailed plan and weekly executive governance meetings **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	**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 **Gaps in assurance:** •Clinical and Divisional representation at the ICT Transformation Group needs to be increased •Chief Nurse Information Officer (CNIO) post to be created to increase clinical engagement with major user groups

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board (end of year update)	Original due date	Status / expected date of completion
Principal Risk Four A: Underdeveloped ICT infrastructure compromises ability to deliver safe, responsive and efficient patient care				
•Escalation with supplier to resolve datacentre and network issues •Implementation of plan to mitigate issues and assure delivery programme	Chief Information Officer	Datacentre application migration plan has recommenced Network remediation plan on track.	April 2016 April 2016	Achieved. Achieved.
•Agree actions to improve stakeholder communication and engagement	Chief Information Officer	Champions identified for clinical rollouts. Communications and engagement plan in place. Business engagement lead for programme in place.	April 2016	Achieved.
•Implement formal chief Clinical Information Officer (CCIO) role	Chief Information Officer	CCIO appointed.	April 2016	Achieved.
•Refresh terms of reference (TOR) of Informatics Group to create ICT Transformation Group and increase representation from divisions	Chief Information Officer	TOR refreshed and distributed. First meeting end January 2017.	December 2017	Achieved.

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Four A: Underdeveloped ICT infrastructure compromises ability to deliver safe, responsive and efficient patient care				
•Implement formal Chief Nursing Information Officer (CNIO) role	Chief Information Officer and Chief Nurse	New action	May 2017	
•Completion of ICT infrastructure improvement programme	Chief Information Officer	Ongoing programme as reported monthly through Finance and Investment Committee	April 2017	
•Completion of IM&T Strategy refresh	Chief Information Officer	On track for delivery	May/June 2017	
•Implementation of new PACS system	Chief Information Officer	Preferred system identified and implementation plan in place / underway. On track for delivery.	July 17	
•Revised TOR for ICT Transformation Group, Group to be chaired by CCIO	Chief Information Officer	Completed	March 2017	

Current Status	April 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:** •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) •Provision of additional performance information to support clinical decisions making in some areas •Processes and resources for cancer information reporting	**Sources of Assurance :** •Informatics group reporting through FIP to Trust Board •Integrated performance report (IPR), with enhanced exception reporting. •Detailed integrated performance report for Safety and Quality Committee **Gaps in assurance:** •Further actions required to embed culture of IG in the organisation. •Further work required regarding cancer information collection processes and systems

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board (end of year update)	Original due date	Status/ expected date of completion
Principal Risk Four B: Underdeveloped information/information governance infrastructure compromises ability to deliver safe, responsive and efficient patient care				
•Learning from Information Governance audits to be embedded by Divisional Managers	Chief Information Officer/ Director of Communications	Ongoing and included in CQC preparation	June 2016	Achieved.
•Outputs from IG audits to be used to inform and improve IG training	Chief Information Officer	Included in classroom based training	June 2016	Achieved.
•Procurement and implementation of new cancer information system following approval of business case	Chief Information Officer/ Director of Communications	Trust Executive Committee approved business case September 2016, but no funding in 2016/17	2017/18	Not achieved. Carried forward.
•Provision of the further performance information reports to support operational delivery (*ongoing through 16/17 as required)	Chief Information Officer	Ongoing	March 2017*	Achieved.

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Four B: Underdeveloped information/information governance infrastructure compromises ability to deliver safe, responsive and efficient patient care				
•Procurement and implementation of new cancer information system following approval of business case (*exact date to be confirmed in May 2017, subject to agreement of capital priorities for 2017/18)	Chief Information Officer/ Director of Communications	Trust Executive Committee approved business case September 2016	Date to be confirmed once funding achieved	
•Provision of the further performance information reports to support operational delivery (*ongoing through 17/18 as required)	Chief Information Officer	Ongoing	March 2018*	

Current Status	April 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 • 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 ECIP support **Gaps in controls:** •Insufficiently robust/consistent discharge processes and practice leading to delays and late discharges •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 •Lack of real time electronic bed state •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

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

Action Plans for Gaps 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Five A: Inability to deliver and maintain performance standards: unscheduled care				
Delivery of the Emergency Care Improvement plan – bi-monthly updates on progress to Trust Executive Committee to supplement IPR exception reporting commentary	Chief Operating Officer	Significant progress implementing improvement plan priorities which is subject to regular re-fresh Monthly updates to Finance, Investment and Performance Committee and Trust Board have been in place since October 2016	September 2016	Partially achieved. Carried forward
Achievement of the 95% standard via the delivery of the System Resilience Improvement Plan (system wide approach) to be monitored via the A& E Delivery Board meetings attended and chaired by organisational CEO	Chief Operating Officer	Performance below trajectory. Emergency care transformation plan in place. New trajectory submitted.	September 2016	Not achieved. BAU

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Five A: Inability to deliver and maintain performance standards: unscheduled care				
Develop and deliver ED workforce transformation plan	Divisional Director of Unscheduled Care	Plan/business case for TEC review Implementation milestones TBC	July 2017	
GP streaming – secure capital, work with CCG to implement new model	Chief Operating Officer	Bid submitted, but not successful Agree service model and contract variation with HVCCG Delivery capital improvements (subject to funding) and implement new model	April 2017 July 2017 October 2017	
Develop business case for further ED environment improvement aimed at improving flow and service adjacencies and secure capital	Deputy Chief Executive	Business case Implementation milestones TBC once capital secured	July 2017	
*** See also PR10 System pressures**				

Current Status	April 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 RTT Access meeting •GOO (patients with no outcome/booked to breach) 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 despite training •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 •Variable adherence in application of OPD processes •Insufficient visibility of commissioner demand management programme •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 CQRM review activity against agreed performance plan **Gaps in assurance:** •None identified

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Five B: Inability to deliver and maintain performance standards: Elective care				
External demand management	Chief Operating Officer Director of Performance	Discussed as standing agenda item with CCG colleagues at Quality Contract Review meeting.	July 2016	Partially achieved. BAU
CCG audit of referral trends	Director of Performance	Scope proposed by CCG extends beyond referral trends. To date no reply received to Trust response to CCG (sent Nov 16). **March 17** – audit undertaken by CCG without Trust involvement. Ongoing discussion with CCG at QCRM and QIPP board regarding referral trends and demand management.	October 2016	Partially achieved. BAU
ALTUROS supporting Trust with demand and capacity work for theatres (commenced 19 August 2015)	Chief Operating Officer	Review completed. New theatre schedule implemented 17/10/16. Surgical Division to provide benefits realisation and utilisation review Jan 2017 and will include monthly update at divisional performance reviews.	June 2016	Achieved. BAU

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Five B: Inability to deliver and maintain performance standards: Elective care				
Embedding Access policy into BAU, implementation of GOO PTL and GOO management meetings within services, with exception reporting at weekly Access meeting	Director of Performance	All agreed actions implemented within timeframe. Internal audit undertaken by RSM. Report being finalised.	June 2016 December 2016	Partially achieved. Carried forward.
Outpatient Programme Board – Commenced November 2015	Director of Performance Divisional Manager for Elective Medicine	Initial project milestones completed within anticipated timelines. Elective Medicine division to take ownership of future outpatient transformation projects.	November 2016	Achieved.
Outpatient Users Group established – December 2016	Divisional Manager for Elective Medicine	Users group established to manage day to day/BAU improvements and standardisation	December 2016 onwards	Achieved.

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Five B: Inability to deliver and maintain performance standards: Elective care				
RTT Programme Board to be re-established to ensure divisional recovery planning and sustained improvement.	Chief Operating Officer Director of Performance	First meeting took place on 6/10/16 Monthly meetings continue	October 2016	Achieved.
Demand & Capacity Modelling workshops to be organised for DMs & ADMs (Surgery)	Director of Performance Chief Information Officer	External support (IST) as envisaged was not achieved A capacity modelling tool has been developed by the Information team for use by the Surgical Division	December 2016	Achieved.
Divisional level RTT Access & Performance reviews to be reinstated and led by DM for Surgery	Director of Performance Chief Operating Officer	New DM in Surgery (in post Dec 16) has implemented weekly divisional level review of RTT performance against specialty action plans	October 2016	Achieved.
Outsourcing programme	Director of Performance Divisional Manager for Surgery	Outsourcing has commenced in ENT, Oral Surgery, Orthopaedics, Pain and General Surgery	October 2016	Partially achieved. BAU

Current Status	April 2017	G	AG	A	AR	R	↔	OWNER: Chief Operating Officer

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Five B: Inability to deliver and maintain performance standards: Elective care				
Develop an RTT delivery workplan to address gaps in controls and assurance and embed new processes implemented in 16/17 (including actions from audit recommendations)	Director of Performance	Work plan will address areas for improvement identified by the internal audit report and other priorities identified by the RTT programme board Audit report to be finalised Action plan	 May 2017 June 2017	
Improve theatre utilisation at WGH & SACH to 95% for elective surgery, building on 2016/17 realignment of theatre capacity and extension of working day	Divisional Manager for Surgery Divisional Director for Surgery Chief Operating Officer		March 2018	
Delivery of improved performance against Breast Symptomatic 2 week wait standard, develop a joint action plan with HVCCG	Director of Performance Chief Operating Officer Divisional Manager for Surgery Divisional Director for Surgery Cancer Programme Lead		May 2017	

Current Status	April 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:** •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:** •Restricted ability to influence CCG investment • Clearer responsibility between health and social care partners for delivery of targets •Limited use of benchmarking and SLR •Incomplete procedures •Limited planning to meet STP conditions •Spending occurs prior to securing funds •Overspending occurs without approval and agreed recovery actions •Ineffective use of controls such as e-rostering • Lack of ownership and need to rapidly identify savings initiatives	**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 • Supplier feedback regarding payments •Review meetings with commissioners •Outcomes of monthly accountability meetings **Gaps in assurance:** •Full Commissioner commitment to spirit and substance of financial agreements. •Full Executive sign-off of additional spending in response to extreme operational pressures. • Responsiveness of follow-up actions including but not limited to: delivery of contract conditions, CQUIN targets, internal audit report findings, benchmark conclusions. •Improved processes for identifying new CIPs • Benefits realisation assessment for approved business cases.

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Seven A: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes				
Minimise income risk through finalising agreements linking operational performance trajectories to Sustainability Funding	Chief Financial Officer	Operational target trajectories submitted. Written confirmation needed that Sustainability funding will be linked to recently submitted trajectories. Notification of outcome of appeals expected April 2017.	October 2016	Achieved.
Establish action teams to define, monitor and deliver targets CQUIN, Lord Carter, STP Conditions , Nurse agency cap. Also extend the Annual Plan CIP expectation from £14m to £18m	Chief Financial Officer	Teams established. CQUIN Executive, Efficiency Steering Group, Workforce efficiency theme group. 2016/17 CIP outturn £14.7m. 2017/18 CIP programme in development – covered under new principle risk.	June 16	Partially achieved. BAU
A programme of work supported by the Executive towards a cultural change where cost benefit analysis takes place and options appraised before any decision to overspend. Even where an over spend is approved action taken to recover the position	Chief Financial Officer	Executive agreed to only apply changes to meet operational pressures for a limited time. Any permanent request to be formally approved after cost benefit analysis. Policies / procedures updated to formalise requirements.	June 16	Achieved.

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Seven A: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes				
Establish internal PMO team to support the efficiency programme	Chief Information Officer/Chief Financial Officer	Establishment of PMO in progress. Two short term posts still filled with interim appointments and work programme being firmed up. EY handed over programme management materials.	May 16	Achieved.
Develop SLR , benchmarking and capacity models to ensure that Trust is paid for work carried out at the right price, costs removed and efficient use of resources	Chief Information Officer/Chief Financial Officer	IT server improvements complete. Schedule for more definitive feeder system and Albatross development to be advised.	September 16	Partially achieved. Carried forward.
Complete revenue deficit and working capital funding application	Chief Financial Officer	Draft application discussed at June FIPC. NHSI review of capital programme complete. Further iteration of ITFF application submitted to NHS Improvement (NHSI). Funding received.	June 16	Achieved.

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Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Seven A: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes				
Develop cost improvement plan for 2017/18 supported by suite of project support documents within project management systems.	Chief Information Officer/Chief Financial Officer	Confirm and Challenge meetings with Divisions complete. As at end of April report to FIC showed £7m CIPs fully identified vs £13.7m required to meet 4% expectation and £21.9m required to meet £15m Control Total.	April 2017	
Develop applications for loan finance to cover revenue deficit and capital expenditure plans	Chief Financial Officer	Confirm and Challenge meetings have identified top Divisional priorities. Cross Divisional prioritisation exercise in progress. Application structure being developed, capital priorities to support detailed appendices.	June 2017	
Commission third party expertise to strengthen contractual risk assessment, mediation and arbitration processes.	Chief Financial Officer	Invitations to tender issued.	April 2017	

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

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Seven A: Failure to achieve financial targets, maintain financial control and realise and sustain benefits from CIP and Efficiency Programmes				
Develop SLR and cost benchmarking capability to support efficient use of resources and identification of opportunities for CIP.	Chief Information Officer/Chief Financial Officer	Develop implementation / roll out plan for review by TEC. Implementation milestones TBC	June 2017 TBC	
Commission third party review of staffing establishment levels to respond to efficiency challenge and NHSI challenge to Trust's high staff costs.	Chief Financial Officer/Chief medical Officer/ Chief Nurse	Chief Medical Officer and Chief Nurse finalising brief and consulting with NHSI professional leads for list of suitable organisations/ candidates to conduct the review. Review reporting timelines TBC	May 2017 TBC	
Commission independent review of cost of back office function metrics (eg IT) to support more targeted interventions.	Chief Financial Officer	Work commenced. Interim report in May 2017	May 2017	
Ensure the two year CIP programme has at its core re-tendering of Trust's FM services, radical change to back office services, new pathology service, benefits from radical reduction to DToCs, agency cost reduction from £27m to £17m.	Chief Financial Officer	Develop 2 year CIP plan with clear implementation milestones Quarterly exception reports to FIC on progress.	July 2017 October 17 January 18	

Current Status	April 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 **Gaps in controls:** • Variable quality of business cases • Project management (spending profile, delivery risks, variance control) • Business case development process • Capital accountant	**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:** • Approvals for spending at levels in excess of delegated limit. • Success with borrowing applications

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

Action Plans for Gaps: 2016/17	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Seven B: Failure to secure sufficient capital, delaying needed improvements in the patient care environment securing healthy and safe infrastructure				
Instigate training programme to support business cases and ensure a quality review prior to relevant consideration for approval	Chief Financial Officer	General Finance training programmes initiated for middle and junior members of staff Business case training for senior managers completed in July Business case training for Board members arranged as part of the Board Development Programme in December 2016	September 2016	Achieved.
Complete the application for national funding	Chief Financial Officer	Completed and ITFF loan secured February 2017. Delays due to national approvals process but all internal milestones met.	June 2016	Achieved.

Current Status	April 2017	G	AG	A	AR	R	↔	OWNER: Chief Financial Officer

Action Plans for Gaps 2017/18	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Seven B: Failure to secure sufficient capital, delaying needed improvements in the patient care environment securing healthy and safe infrastructure				
Develop applications for loan finance to cover revenue deficit and capital expenditure plans	Chief Financial Officer	Confirm and Challenge meetings have identified top Divisional priorities. Cross Divisional prioritisation exercise in progress. Application structure being developed, capital priorities to support detailed appendices.	June 2017	
Capital programme manager for estates project management + re-procure call off contract for additional support for major projects as required.	Director of Environment		September 2017	
Internal audit of costing, tendering and control of estates capital projects	Director of Environment	Audit commenced report, due July. Actions to be implemented as agreed from audit outcome – TBC	July 2017	

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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:

1. Competing priorities for the communications team
2. Lack of clarity as to impact of STP
3. Lack of clarity as to impact of RFH model
4. Planned programme of engagement is still being built (and will be ongoing)
5. Active campaigning for a greenfield hospital is making more of an impact than our own comms
6. Visibility of directors and NEDs needs to be higher within the trust
7. The intranet and website are unappealing and in need of an overhaul
8. Fears expressed in the media, among local communities and campaigners that the health campus is 'more important' than the hospital – flats being built before new NHS buildings

Potential effect:

Uncertainty among staff and stakeholders on how WHHT may be affected by the plans of others

Potential impact:

Reduced confidence of stakeholders and local residents in quality and safety of services

Key controls in place:

1. Weekly meetings to discuss which issues have the highest strategic priority and to discuss workload
2. Your Care, Your Future is the filter through which staff understand changes to service provision. The impact of the STP is a layer added on to explain the expanded geography – the principles remain the same
3. The MoU between RFH and WHHT has agreements re dissemination of key messages. This covers timings as well as content of key messages.
4. Meetings with external stakeholders are regularly taking place (ie comms colleagues at the CCG, Watford BC, RFH etc)
5. Comms plan devised for increased internal and external messaging re the rationale for pursuing funding for a radical redevelopment at Watford and further work at SACH as well as SOC plans re Hemel Hempstead
6. Capital business case has been agreed for the intranet (but subject to securing ITFF funding)
7. 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:

- Website and intranet are based on old technology and content needs full refresh – this is subject to funding for the business case being secured
- Comms resource means that large scale projects like the SOC(s) and planning campaigns to counter local opposition will be a challenge
- Purdah will impact on comms activity until June 9.
- 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 comms 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 comms.

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

Action Plans for Gaps	Owner of action	Update since last review by Committee/Board	Original due date	Status/ expected date of completion
Principal Risk Eight: Failure to communicate and engage effectively both internally and externally compromises the organisation's strategic position and reputation				
Business case successful for intranet update	Director of Communications/ Chief Information Officer	Delayed due to resourcing and focus on improved face to face / print communication in run up to CQC re-inspection. Business case developed - approved but not funded during 2016/17	Major work completed by Sep 2016	Not achieved. Carried forward
Over reliance on email communication (staff) – new staff newsletter to be launched, will be bi-monthly	Director of Communications	Bi-monthly newsletter now published and feedback is very positive. Shift of focus to print (staff newsletter) and good attendance at team brief has demonstrated an appetite for non e-comms.	July 2016	Achieved
Confirm planned approach for stakeholder management in 2016/17 including board development session	Deputy Chief Executive/ Director of Communications	Plan agreed for NED buddying and board development session held December 2016. Follow-up to board session moved off agenda due to other priorities – to be rescheduled in 2017.	Oct 2016	Partially achieved. Carried forward
Agree metrics to track delivery/performance of communications and stakeholder engagement activity	Deputy Chief Executive/ Director of Communications	Partially completed, media and engagement metrics are now part of Board papers but require analysis to show trends/success. This will form part of stakeholder strategy.	Oct 2016	Partially achieved. Carried forward

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

Action Plans for Gaps 2017/18	Owner of action		Original due date	Status/ expected date of completion
Principal Risk Eight: Failure to communicate and engage effectively both internally and externally compromises the organisation's strategic position and reputation				
Establish 'visible leadership' programme	Director of Communications	New Programme to be finalised and approved via TEC. Implementation milestones TBC	May 2017	
Comprehensive comms plans for four major strategic issues:- 1. Acute SOC 2. Hemel SOC 3. STP 4. RFH	Director of Communications	Brief discussion about items 1 and 4 at April Trust Board. Planning underway for stakeholder event at the end of June with NED involvement on the planning group.	June 2017	
Stakeholder strategy and action plan	Director of Communications	Finalise strategy and action plan for approval by TEC and Trust Board. Implementation milestones TBC	May / June 2017	
Intranet update	Director of Communications/ Chief Information Officer	To be included in ITFF funding application. Business case to be reviewed and updated.	June 2017 July 2017	
Trend analysis of communications KPIs	Director of Communications	Bi-annual updates to Trust Board.	Sept 2017 March 2018	

Current Status	April 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 workstreams, Deputy CEO leading estates and capital workstream. •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 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. **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. Is likely to impact on delivery of IM&T and Estates strategies and potential 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). •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) • Partnership Board with RFL to be established to explore opportunities for closer working and potential for WHHT to join the RFL group membership model.

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

Action Plans for Gaps: 2016/17	Owner of action	Update since list review by Committee/Board (end of year update)	Original date	Status/ expected date of completion
Principal Risk Nine: Failure to deliver sustainable long term clinical, workforce, financial, and estates / IM&T strategies				
Trust Strategy – implementation plan / 2016/17 priorities to be developed.	Deputy Chief Executive	Trust wide Transformation priorities for 2017/18 set out at high level in Operating Plan. Transformation Groups established and initial draft priorities agreed – in process of being finalised (NB – expect to evolve further over time). Includes 2017/18 priorities from strategy.	September 16 & March 17	Partially achieved. Carried forward.
Estates Strategy	Deputy Chief Executive/ Director of Environment	Estate strategy approved by Trust Board in February 2017. Implementation plan in development. Year one priorities to be confirmed and ITFF submission prepared.	June 2016	Partially achieved. Carried Forward.
IM&T strategy – implementation of new PACs	Chief Information Officer	Preferred system identified and implementation plan in place / underway. On track for delivery.	July 17	Partially achieved. Carried forward into PR4.

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

Action Plans for Gaps 2017/18	Owner of action	Update since list review by Committee/Board	Original date	Status/ expected date of completion
Principal Risk Nine: Failure to deliver sustainable long term clinical, workforce, financial, and estates / IM&T strategies				
Mobilise Acute Transformation Programme Board & additional internal programme delivery capacity to support development of outline business case and associated service transformation. SOC Approvals process (HVCCG, STP, NHSI, DH &Treasury)	Deputy Chief Executive	Proposal for additional internal programme delivery capacity approved in principle by TEC April 2017. To mobilise over next 3 months. In process. HVCCG Board June, NHS I investment committee in July. DH and Treasury targeted for Sept. Subject to confirmation and NHS I approval.	July 17 Oct 17	
Digital / IM&T Transformation strategy to be developed. Bids for capital via STP and ITFF.	Chief Information Officer Chief Information Officer Chief Financial Officer	Digital Transformation Strategy to be developed for Trust Board approval STP capital applications ITFF loan application	July 2017 April / May 2017 June 2017	
Establish Partnership Board with RFL Scope potential opportunities and agree work plan. (see also PR7 re financial sustainability CIP & back office programme)	Deputy Chief Executive Deputy Chief Executive	TOR agreed and meeting schedule in place. First meeting due May 17. Executive Directors have started to scope opportunities in a number of areas – agreed work plan to be confirmed.	May 17 July 2017	
Estate strategy implementation – prioritised capital programme for 2017/18 & development control plans	Deputy Chief Executive/ Director of Environment	Estates Steering Group established Prioritised capital plan Development control plans	May 207 June 2017 Oct 2017	

Current Status	April 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 / developing mature and productive relationships. •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. Needs to link clearly to STP governance. •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

Current Status	April 2017	G	AG	A	AR	R	↔	OWNER: Chief Executive Officer

Action Plans for Gaps: 2016/17	Owner of action	Update since list review by Committee/Board	Original date	Status/ expected date of completion
Principal Risk Ten: System pressures adversely impact on the delivery of the Trust's aims and objectives				
Local Delivery Board Plan to be developed in partnership with the Your Care Your Future (YCYF) Programme Executive	Chief Executive	Mapping previous SRG plans and 5 mandated areas across into updated Local delivery board plan for 2016/17	July 2016	Achieved.
Sustainability and Transformation Plan (STP) to be developed with partners	Deputy Chief Executive	Hertfordshire and West Essex STP submitted to NHS E November 2016. Published December 2016. External advisory support commissioned to advise on strengthening governance and delivery arrangements.	July 2016	Achieved.
Aligned demand, capacity and financial assumptions to be agreed as part of the development of the main redevelopment Strategic Outline Case (SOC)	Deputy Chief Executive/ Chief Financial Officer	Modelling assumptions for SOC agreed with HVCCG (aligned to YCYF / STP). Further detail and stress testing required at specialty level. Joint working group being established to support west Hertfordshire STP delivery and development of more detailed assumptions for the OBC.	July 2016	Achieved.
Appoint project manager to develop plan to facilitate stronger clinical partnership work and ensure clearer more streamlined approach to care pathway improvements	Medical Director/ Deputy Chief Executive	Project manager appointed and in post 05/09. Director of Integrated Care appointed – in post 30/01/17. Programme of care pathway improvement work underway.	Sept 2016 (complete) & new action added	Achieved. BAU

Current Status	April 2017	G	AG	A	AR	R	↔	OWNER: Chief Executive Officer

Action Plans for Gaps: 2016/17	Owner of action	Update since list review by Committee/Board	Original date	Status/ expected date of completion
Principal Risk Ten: System pressures adversely impact on the delivery of the Trust's aims and objectives				
Joint review of risks to RTT and cancer delivery to be undertaken between WHHT and HVCCG and mitigations identified. Formalise escalation where delivery at risk due to system issues.	Director of Operational Development and Elective Care Performance	RTT oversight via monthly CQRM meetings. Risks escalated via this process.	Aug 2016.	Achieved. BAU
Strengthen relationships with senior public sector leaders – WHHT CEO to attend public sector chief executive forum.	Chief Executive Officer	First meeting 5th October.	October 2016	Achieved.
Child and Adolescent Mental Health Service (CAMHS) – work with HPFT to agree approach to managing care and treatment of C&YP with mental health needs presenting to WHHT emergency care services.	Divisional Director for Women's and Children's Services	Ongoing operational dialogue in place – no further actions currently identified as required.	September 2016	Achieved. BAU

Current Status	April 2017	G	AG	A	AR	R	↔	OWNER: Chief Executive Officer

Action Plans for Gaps 2017/18	Owner of action	Update since list review by Committee/Board	Original date	Status/ expected date of completion
Principal Risk Ten: System pressures adversely impact on the delivery of the Trust's aims and objectives				
New STP governance arrangements being put in place with strengthened PMO to support delivery. Visible leadership contribution from WHHT to STP work streams.	STP Programme Director Chair / Chief Executive	WHHT CEO SRO for urgent and emergency care and IM&T, Deputy CEO SRO for estates and capital work stream. WHHT Chair attends STP Oversight Committee. Active input from CMO and CFO and other Execs to relevant work streams. Clinical representatives to be confirmed.	May 2017	
Agree 'West Herts' STP governance including joint HVCCG and WHHT QIPP Board with clear TOR and increased clinical engagement.	Trust Chief Executive/ Herts Valleys Clinical Commissioning Group Accountable Officer	Agree revised terms of reference for HV STP delivery group and WHHT/HVCCG QIPP Board. Develop joint QIPP work programme and implement.	May 2017 July 2017 (with agreed delivery milestones TBC)	
Implement new 'discharge to assess' pathways	Director of Integrated Care	Pathway one (discharge home) – pilot started in March. Due for review to inform long term sub contract by July 2017. Pathway three (patients expected to need a long term placement). Transition hub to be developed / implemented by June 2017. Pathway two (further assessment and / or rehabilitation prior to decision re long term care) – plan to be developed by July 2017. Implementation milestones TBC	July 2017 June 2017 July 2017	