

Item 6.1a

Board Assurance Framework 2016/17

- Each area of the BAF is aligned to the delivery of the strategic goals set by the Board (i.e. achievement of 2016/17 milestones and in-year work to build capacity / capability for future milestones) and regulatory compliance (corporate governance statement)

- **Board Evaluation :**

An assessment of the likelihood and impact of each strategic risk will generate a RAG rating which the Board will assign to each BAF entry

5x5 matrix

| SAS matrix | | | | | | |
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| X | LIKELIHOOD | | | | | |
| IMPACT / CONSEQUENCE | | 1 Rare | 2 Unlikely | 3 Possible | 4 Likely | 5 Almost Certain |
| | 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| | 4 Major | 4 | 8 | 12 | 16 | 20 |
| | 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| | 2 Minor | 2 | 4 | 6 | 8 | 10 |
| | 1 Negligable | 1 | 2 | 3 | 4 | 5 |

- Refer to BAF Policy for operating guidance, roles and responsibilities and reporting template

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| | Never event reported 10.11.16 | <ul style="list-style-type: none"> ▪ ECS assessment process ▪ Audit programme ▪ RCA process ▪ <u>Comprehensive audit system in place to monitor the reliability and effectiveness of secure health messaging</u> | <ul style="list-style-type: none"> ▪ ECS compliance reports ▪ Weekly harms report (Exec team) | | <p>support medicines management, rationalise alerting system and improve functionality (s.t. contract re-negotiation and upgrade)</p> <ul style="list-style-type: none"> ▪ Baseline year for 2017/18 CQUiN on antimicrobial resistance to be agreed with commissioner s ▪ Identify and implement actions / organisational learning following RCA of never event ▪ Review and provide assurance on reliability and effectiveness of the secure health messaging system ▪ <u>Undertake comprehensive review of patient</u> | <p>MJ Q4</p> <p>MJ <u>Q4</u></p> <p><u>MJ Q4</u></p> <p><u>TW – Q4</u></p> | |
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| | | | | | <u>administration</u> <u>structures,</u> <u>systems and</u> <u>processes</u> <u>(PMO to</u> <u>recruit project</u> <u>manager)</u> | | |
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| 1.2 SP/RAP | <p>Unable to improve effectiveness of clinical care due to:</p> <ul style="list-style-type: none"> Failure to improve reliability in sepsis management and pathology testing bundles Operational pressures preventing timely discharge <p>This could lead to avoidable patient harm, financial penalties and poor patient experience.</p> <p>The maintenance of dementia case finding rates is very low risk as business as usual (this target is mandated for 2016/17)</p> | <ul style="list-style-type: none"> Care bundles and clinical management policies for sepsis management and pathology testing protocols Daily Safety Huddles ECS assessment process Audit programme Quality strategy Quality improvement policies and procedures (e.g discharge / 'home for lunch') Care Support Team Incident reporting & root cause analysis | <ul style="list-style-type: none"> Quality dashboard Divisional dashboards Clinical Audit Reports ECS compliance reports Weekly harms report (Exec team) | | Improvement plans to ensure 20% patients are 'home by lunch' by March 17 | SP – Q4 | 3 x 2 = 6 Unlikely |
| 1.3 SP | <p>Failure to deliver care with compassion due to:</p> <ul style="list-style-type: none"> Staff not consistently displaying trust values and behaviours Inability to meet the needs of patients with additional needs due to lack of resourcing and / or skills Lack of staff training and awareness of fasting policy Recruitment and retention of staff with the right skills and values | <ul style="list-style-type: none"> Patient and Family Experience Strategy PACT – staff values and behaviours Induction and mandatory training Individual performance review and PDP process Trust policy on fasting Policies and processes for ensuring safe | <ul style="list-style-type: none"> Safe staffing reports to Board Ward boards ECS compliance reports Workforce reports Recruitment strategy Complaints and Compliments | <ul style="list-style-type: none"> Patient Survey Staff survey CQC inspection report | <ul style="list-style-type: none"> Develop learning disabilities pathway | SP – Q4 | 3 x 2 = 6 Unlikely |

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| | <p>This could lead to poor patient and family experience with adverse consequences for the Trust's strong reputation in this field</p> | <p>staffing</p> <ul style="list-style-type: none"> ▪ Safety huddle ▪ Speak out safely campaign ▪ Designated lead nurse for PFCC, dementia and safeguarding | <ul style="list-style-type: none"> ▪ Quality dashboard | | | | |
| 1.4 MJ | <p>Failure to implement and embed organisational learning due to :</p> <ul style="list-style-type: none"> ▪ Lack of cross-divisional communication ▪ Poor adoption of OL Policy ▪ Failings in governance processes to check on closure of actions <p>This could lead to avoidable patient harm, financial penalties and reputational issues.</p> | <ul style="list-style-type: none"> ▪ Organisational Learning Policy ▪ Operational Board business cycle ▪ Cross-divisional meetings ▪ Mortality Review Process ▪ Incident reporting & root cause analysis process | <ul style="list-style-type: none"> ▪ Audit reports ▪ Divisional Governance minutes ▪ Operational Board minutes ▪ RCA Investigation Reports | <ul style="list-style-type: none"> ▪ CQC Inspection Report ▪ Coroner inquest findings | <ul style="list-style-type: none"> ▪ Embed policy and conduct regular audits to provide assurance on actions taken (75% of audits to reveal significant assurance by March 17) | MJ – Q4 | <p>3 x 2 = 6 Unlikely</p> |

2 SERVICE AND INNOVATION

To develop our service portfolio and business by:

- Implementing the Cardiology Strategy
- Developing and implementing service line strategies informed by KPMG work
- Implementing world class cancer outcomes strategy
- Developing and implementing a genomics strategy
- Developing and implementing an integrated IM&T Strategy
- Implementing relevant clinical priority standards (TBC)
- Develop and implement a strategy for private patients
- Implementing new models of care – community respiratory service, ACHD, robotic surgery, 7 day ACS, capacity and flow (diagnostics and inpatients),
- Development and delivery of new innovations

| | Principal Risks preventing the Trust achieving strategic goals | Key controls | Board Assurance | | Gaps in Control / Assurance | Action Who? /When? | Board Evaluation (impact x likelihood) |
|---|---|---|--|---|--|---|--|
| | | | Internal | External | | | |
| 2.1 DH <u>CW</u> / TW | <p>Unable to develop and deliver key strategies due to :</p> <ul style="list-style-type: none"> ▪ Uncertainty in external environment ▪ Inability to influence commissioning intentions ▪ Inability to swiftly respond to national and local policy; ▪ Ineffective partnership arrangements leading to loss of management control; ▪ Inability to develop strategic alliances with other NHS providers ▪ Lack of clinical buy in / poor staff engagement ▪ Inability to secure the required resources – finance, capacity, expertise <p>If the Trust is unable to develop its service portfolio may lose strategic</p> | <ul style="list-style-type: none"> ▪ Stakeholder Management Strategy ▪ Clinical lead seconded to HLP ▪ R&I strategy and designated clinical lead ▪ Clinical leadership structure ▪ Dedicated BoD and Operational Board strategy days | <ul style="list-style-type: none"> ▪ Cardiology Strategy approved ▪ Updates on progress with stakeholder management plan ▪ <u>Management assurance report on mitigation of risk of cyber attack (Audit Committee Jan 17)</u> ▪ <u>Genomics Strategy (Ops Board</u> | <ul style="list-style-type: none"> ▪ KPMG Strategic Options Appraisal Report | <ul style="list-style-type: none"> ▪ Develop and implement service line strategies, building on Strategic options appraisal work ▪ <u>Produce internal annual planning document for 2017/18 that articulates new vision and strategic milestones</u> ▪ <u>Develop and</u> | <p>TW –Q4</p> <p><u>CW – Q4</u></p> | <p>3 x 3-2 = 96 PossibleUnlikely</p> |

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| | <p>opportunities that help the Trust to remain clinically, operationally and financially viable.</p> <p>Increased risk of threat of cyber-attack following spate of IT security breaches reported across NHS</p> | | <u>Jan 17)</u> | | <p>implement a genomics strategy</p> <ul style="list-style-type: none"> Develop and implement an integrated IM&T strategy Cyber-attack risk analysis and assurance report to Audit Committee Develop and implement a strategy for private patients | <p>MJ – Q4</p> <p>MJ – Q4</p> <p>MJ – Q4</p> <p>TW – Q3 (ref Board paper Dec 16)</p> | |
| 2.2 TW | <p>Unable to implement new models of care due to:</p> <ul style="list-style-type: none"> Uncertainty in external environment Inability to influence commissioning intentions Inability to swiftly respond to national and local policy; Ineffective partnership arrangements leading to loss of management control; Inability to develop strategic alliances with other NHS providers Lack of clinical buy in / poor staff engagement Inability to secure the required resources – finance, capacity, expertise Lack of ideas / innovations <p>If the Trust is unable to develop its service portfolio may lose strategic opportunities that help the Trust to remain</p> | <ul style="list-style-type: none"> Investment policy Business case appraisal Regular meetings with key stakeholders Stakeholder Newsletter Partnership governance arrangements Contract management Research and Innovations Strategy | <ul style="list-style-type: none"> Integrated Performance committee papers & minutes BoD papers & minutes Plan in place for delivery of 7 day ACS service wef January 2017 | <ul style="list-style-type: none"> Stakeholder feedback / survey Announcement of commissioners decision to implement Liverpool partners model for provision of CHD wef 1.4.16 | <ul style="list-style-type: none"> Develop and agree an implementation plan to ensure smooth transition of Manchester service for implementation in 2018 Develop business case for robotics Achieve and maintain compliance with national access targets Develop and | <p>TW-Q4</p> <p>TW-Q3</p> <p>TW-Q1 onwards</p> | <p>3 x 3 = 9 Possible</p> |

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| | clinically, operationally and financially viable. Implementation of Liverpool Partners Model for CHD is delayed pending outcome of national consultation process | | | | deliver innovations | MJ-Q3 | |
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3 VALUE

To maintain financial viability, enhance service delivery, improve the health of our patients and safely reduce costs through our programme of transactional and transformational change by:

- Achieving income plans – activity plan
- Reducing expenditure – bank and agency (Monitor cap on agency); premium sessions
- Achieving CIP
- Improving Service Line Reporting – alignment with ledger, SLR self-service, improved adoption as reliable information source

| | Principal Risks preventing the Trust achieving strategic goals | Key controls | Board Assurance | | Gaps in Control / Assurance | Action Who? / When? | Board Evaluation (impact x likelihood) |
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| | | | Internal | External | | | |
| 3.1 CW/ TW | <p>Failure to improve the Trust's efficiency through the safe reduction of costs:</p> <ul style="list-style-type: none"> ▪ Non-delivery of the cost improvement target; ▪ Non-delivery of conditions attached to release of STF ▪ Competing quality and resource priority may lead to additional cost pressures; ▪ Inability to improve patient flow; ▪ Decommissioning and/or loss of services to competitors; and/or ▪ Commissioner contracts below forecast demand levels. ▪ Inability to reduce agency costs ▪ Continued increase in non-elective demand ▪ Growth in pay costs (NHSI Review) <p>If the Trust is becomes financially unstable this could lead to enforcement action from regulator. It may also have an impact on the quality of care provided due to inability to invest in service</p> | <ul style="list-style-type: none"> ▪ Annual Plan ▪ Robust operational planning process through new Divisional structures ▪ CIP steering Group ▪ Budgetary control ▪ Local counter fraud ▪ Core financial controls (e.g. payroll, cash, capital, credit control, etc) ▪ Business case appraisals ▪ Service line reporting ▪ Standing Financial Instructions, Standing Orders and Scheme of | <ul style="list-style-type: none"> ▪ Performance dashboard ▪ Integrated Performance papers & minutes ▪ Operational Board papers and minutes ▪ Monthly Board report on activity and income, agency trajectory, CIP delivery ▪ Revised Financial Plan 2016/17 to deliver control total ▪ Robust | <ul style="list-style-type: none"> ▪ Internal Audit – Combined Financial Systems ▪ External Audit opinion ▪ NCBC benchmarking ▪ Regulatory risk ratings ▪ Monitor review of Annual Plan ▪ Receipt of STF funding for Quarters 1 and 2 | <p>• Embedding of PMO</p> <ul style="list-style-type: none"> ▪ Action plan to align SLR with ledger and deliver self-serve to management ▪ Improve adoption of SLR – 50% consultants utilising output by March 17 | <p>CW – Q2</p> <p>CW – Q3</p> <p>CW – Q4</p> | <p>4 x 3 =12 Possible</p> |

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| | <p>improvement.</p> <p>NB The Trust's 2016/17 original financial plan yields a £4.3m deficit primarily due to national tariff – delay to implementation of HRG4+ and specialist service top ups. A revised financial plan reflecting STF funding and agreed control total with increased financial gap has been produced – this will need to be delivered each quarter in accordance with agreed profile in order to secure release of STF – there are penalties attached to failure to meet the conditions</p> | <ul style="list-style-type: none"> Delegation Robust contract negotiation and monitoring process Head of PMO appointed and in post Head of Nursing (corporate) leading on coordination of flow work LTFM developed for financial forecasting Business Transformation Steering Group established 2016/17 Control total agreed Introduction of HRG4+ 1.4.17 | <p>financial forecasting reports generated from LTFM</p> <ul style="list-style-type: none"> Achievement of agency trajectory | | | | |
| 3.2 LL | <p>Inability to meet the new requirements of the regulators – NHSI and CQC -</p> <p>could lead to the Trust being subject to enforcement action.</p> <p>FUTURE RISKS :</p> <p>i) The Trust has not yet reached agreement with NHSI on Control Totals set for 2017/18 and 2018/19; and has not yet agreed contractual terms with commissioners for 2017/18</p> <p>ii) <u>A number of Governors will reach their maximum tenures in 2017 resulting in vacant seats and loss of skills / experience on CoG</u></p> | <ul style="list-style-type: none"> Constitution Organisational structure Board committee Structure BAF Policy Risk management strategy Operational Plan Commissioner contracts New Board dashboard to monitor indicators set out in Single Oversight Framework | <ul style="list-style-type: none"> Annual Governance Statement Provider Licence checklist RTT Action Plan Operational Board papers and minutes Integrated Performance committee papers and minutes Quality | <ul style="list-style-type: none"> Internal Audit – BAF review External audit opinion NHSI Segment 1 (Shadow) CQC rating – Outstanding (Sept 16) | <ul style="list-style-type: none"> Complete and embed Data Quality Strategy MIAA Review Well Led Framework Deliver action plan to address CQC findings and work towards 'outstanding' across all key lines of enquiry | <p>MJ – Q3</p> <p>LL – Q3Q4</p> <p>SP – Q4</p> | <p>3x4 = 12 Possible</p> |

Comment [LL1]: Final Report to BoD March 17

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| | | | <p>Committee papers and minutes</p> <ul style="list-style-type: none"> Self assessment against Monitor's Well Led Framework Fit and Proper Persons requirements reviewed for directors Draft Operational Plan 2017-19 submitted (does not meet control totals set by NHSI for next 2 years) <u>Contracts 2017/18 agreed (except Wales)</u> <u>MIAA review of data quality – strategy – significant assurance (Jan 17)</u> | | <ul style="list-style-type: none"> Work to agree realistic ('Stretch') Control totals for 2017/18 and 2018/19 Agree contracts for 2017/18 <u>Succession plan and election campaign for new Governors</u> <u>Board Development Plan for 2017/18 – to reflect recommendations from Well Led Review and wider Board responsibilities for system leadership</u> Escalation process to ensure closure of MIAA follow up recommendations | <p>CW – Q3Q4</p> <p>CW – Q3</p> <p>LL – Q1 17/18</p> <p>LL – Q1 17/18</p> <p>LL – Q4</p> | |
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Comment [LL2]: NHSI focus is in current financial year, timeframe slipped to Q4

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4 WORKFORCE

To be the best NHS Employer by 2019 with a demonstrable track record of motivating our high performing workforce by:

- Developing workforce resourcing - attracting and retaining the best people and aligning staff resource to business objectives
- Promoting leadership – embedding leadership behaviours , management skills , PACT, implementing talent management and developing culture of innovation and improvement
- Educating and developing our people
- Ensuring engagement and wellbeing
- Promoting diversity and inclusion

| | Principal Risks preventing the Trust achieving strategic goals | Key controls | Board Assurance | | Gaps in Control / Assurance | Action Who?/ When? | Board Evaluation (impact x likelihood) |
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| | | | Internal | External | | | |
| 4.1 DHJTw | Inability to attract and retain the best staff and align people to business objectives due to: <ul style="list-style-type: none"> ▪ Pockets of poor staff engagement; ▪ Lack of clear roles and responsibilities leading to lack of accountability; ▪ Lack of resources to enable effective leadership development and talent management; ▪ Lack of effective education and training opportunities for junior doctors and reduced numbers ▪ Staff feeling unable to speak out openly and honestly about issues; and/or ▪ Lack of or ineffective performance appraisal ▪ Development needs of leadership teams ▪ Poor adoption of policies and delivery ▪ Failure to take advantage of roster efficiencies | <ul style="list-style-type: none"> ▪ Trust values & vision ▪ Code of Conduct ▪ HR policies and procedures ▪ People Committee ▪ Listening into Action ▪ Retention plan to mitigate reduction in F2 doctors and supply gaps for other staff groups ▪ Guardian for Safe Working (junior doctors) appointed and regular engagement forums in place ▪ New roster policy ▪ NHSI Agency Regulations ▪ Divisional Governance structures ▪ Divisional access to | <ul style="list-style-type: none"> ▪ People Committee papers and minutes - ▪ Trajectory for agency spend (on track) ▪ Recruitment Plan ▪ Board walk rounds ▪ Performance dashboard ▪ LiA pulse checks ▪ Culture survey / staff survey action plans ▪ Operational plan trajectory | <ul style="list-style-type: none"> ▪ CQC reports ▪ National staff survey ▪ ISAE 3402 report from payroll provider ▪ MIAA audits and reports ▪ Staff Survey ▪ HEE NW QI Report following Nov 16 visit | <ul style="list-style-type: none"> ▪ Deliver 2016/17 appraisals with focus on training and support ▪ Develop and deliver action plan from HEE Report received Jan 17 | <p>DH – Q2JTw – Q4</p> <p>RAP / JTw – Q4 (People Committee)</p> | <p>4 X 3 = 12 Possible</p> |

Comment [LL3]: Evaluate results of 2016 staff survey

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| | If the Trust cannot recruit and retain the best staff and the required numbers / skill –mix, this may inhibit the Trust's ability to provide excellent patient care. | <ul style="list-style-type: none"> Athena to monitor KPIs <u>Freedom to Speak Up Guardian and champions network</u> | | | | | |
| 4.2 <u>DHJTw</u> | <p>Inability to promote and ensure effective leadership due to:</p> <ul style="list-style-type: none"> Inability to develop and embed leadership behaviours and management skills Inability to embed PACT Lack of talent management and succession planning Poor culture of innovation and improvement Inability to release staff <p>If the Trust is unable to secure effective leadership this will impact of staff morale and may inhibit the Trust's ability to provide excellent patient care</p> | <ul style="list-style-type: none"> Leadership Development Programme Staff performance appraisals and PDPs linked to PACT Staff induction and training Staff communications | <ul style="list-style-type: none"> Workforce dashboard People Committee papers and minutes - | <ul style="list-style-type: none"> National staff survey | <ul style="list-style-type: none"> Deliver talent management and succession planning Develop and implement an improvement plan in response to <u>2015-2016</u> staff survey results | <p><u>DH – Q3JTw – Q4</u> and ongoing (People Committee)</p> <p><u>DH – Q4JTw Q4</u> and ongoing (People Committee)</p> | 3 x 3 = 9 Possible |
| 4.3 <u>DHJTw</u> | <p>Inability to educate and develop our people due to :</p> <ul style="list-style-type: none"> Lack of resources and skills to deliver education and training Inability to provide an excellent training experience – junior medical staff, other clinical staff and non-clinical staff Staff shortages <p>If the Trust is unable to provide excellent education, this could impact on its reputation as a tertiary centre of excellence and inhibit the Trust's ability</p> | <ul style="list-style-type: none"> Appointment of Deputy Director of Strategy and OD to provide leadership for education <u>New HR / Workforce structure in place with senior leaders for education and development</u> | <ul style="list-style-type: none"> People Committee papers and minutes - | <ul style="list-style-type: none"> HEE visit 23.11.16 – confirmation of strong progress on improving E&T provision for doctors in training (formal report to follow) <u>HEE Report</u> | <ul style="list-style-type: none"> Deliver CEO roadshows Deliver Education and Training Plan Demonstrate improvement in education | <p><u>DH – Q3</u></p> <p><u>DH-JTw – Q1</u> and ongoing (People Committee)</p> <p><u>(DHRAP / JTw – Q4</u></p> | 4 x 3 = 12 Possible |

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| | to recruit and retain the best staff. It could also impact upon patient safety if staff are not sufficiently skilled and competent to fulfil their roles. | <ul style="list-style-type: none"> and OD Education and Training plan People Committee | | received Jan 17 | experience via education scores for junior medical and other staff groups | | |
| 4.4 DHJTw | <p>Inability to ensure engagement and wellbeing due to :</p> <ul style="list-style-type: none"> Lack of staff involvement in LiA Absence of an effective health and wellbeing priorities Failure to recognise and reward appropriately Poor engagement in pockets of the organisation <p>If the Trust is unable to ensure staff engagement and wellbeing this will impact of staff morale and may inhibit the Trust's ability to provide excellent patient care. It could also have an adverse impact on recruitment and retention.</p> <p>Enhanced risk in relation to the extent and pace of organisational change, including consolidation of back and middle office functions</p> | <ul style="list-style-type: none"> LiA process embedded Health and Wellbeing Strategy Health and Wellbeing Group Staff recognition scheme and annual awards event F&F Quarterly survey | <ul style="list-style-type: none"> LiA pulse checks People Committee papers and minutes - Staff roadshows | <ul style="list-style-type: none"> Staff survey – engagement score F&F quarterly survey results | <ul style="list-style-type: none"> Monitor KPIs – no. staff involved in LiA; no. suggestions on ideas hub; LiA impact scores | DH-JTw – Q1 and ongoing (People Committee) | <p>3 x 3-2 = 96</p> <p>PossibleUnlikely</p> |

Comment [LL4]: Awaiting confirmation that enhanced monitoring can be lifted

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| 4.5 DH | <p>Inability to deliver Equality and Diversity Strategy due to :</p> <ul style="list-style-type: none"> ▪ Lack of awareness of strategy and requirements ▪ Inability to recruit and develop a diverse but representative workforce ▪ Operational pressures and priorities <p>If the Trust cannot demonstrate promotion of diversity and inclusion, this could impact upon the Trust's reputation as an excellent employer and may pose a threat to compliance with CQC regulations.</p> | <ul style="list-style-type: none"> ▪ E&I Strategy ▪ E&I Steering Group ▪ Board training session ▪ Improved E&I training programme ▪ Athena dashboard available to Divisions ▪ Board succession plan reflects potential gap around diversity ▪ <u>WRES data monitoring</u> | <ul style="list-style-type: none"> ▪ People Committee papers and minutes ▪ <u>Operational Board – Divisional Reviews- BoD papers and minutes</u> | <ul style="list-style-type: none"> ▪ External evaluation of compliance with regulations ▪ CQC Report | ▪ | | | <p>3 x 3 = 9 Possible</p> |
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5 WORKING TOGETHER

To maintain and improve productive relationships and alliances with key stakeholders as effective and responsive partners in order to enhance the Trust's profile and reputation and thus secure LHCH clinical sustainability by:

- Delivering the Stakeholder Management Plan
- Engaging in the production of the 2016-2021 Sustainability and Transformation Plan
- Implementing Year 1 of fundraising strategy (£425k)

| | Principal Risks preventing the Trust achieving strategic goals | Key controls | Board Assurance | | Gaps in Control / Assurance | Action Who?/When? | Board Evaluation (impact x likelihood) |
|---------------|---|--|---|---|---|---|---|
| | | | Internal | External | | | |
| 5.1 DH | <p>Inability to deliver stakeholder plan and engage effectively in health economy-wide STP 2016-2021 due to:</p> <ul style="list-style-type: none"> ▪ Inability to influence commissioners and engage key stakeholders strategy; ▪ Uncertainty around configuration of other providers ▪ Impact of external factors eg Healthy Liverpool Programme ▪ Impact of wider STF footprint ▪ Inability to recruit sufficient clinical expertise to support management of wider cardiology network. <p>As a result, the Trust may be unable to maintain and enhance its reputation as high quality provider of cardiothoracic healthcare services which in turn could lead to a loss of market share.</p> | <ul style="list-style-type: none"> ▪ Regular meetings with stakeholders, including commissioners ▪ Robust governance arrangements to support new models of care ▪ Annual plan ▪ Strategy for Cardiology ▪ Engagement at CEO level in Healthy Liverpool Programme and STP ▪ June 16 STP submission completed ▪ CVD Programme Board established | <ul style="list-style-type: none"> ▪ Output from board strategy days ▪ CEO report on partnership updates ▪ Chair and CEO involvement in Liverpool Provider Groups ▪ Update on stakeholder engagement plan to BoD Dec 16 | <ul style="list-style-type: none"> ▪ KPMG strategic options appraisal report | <ul style="list-style-type: none"> ▪ Achieve milestones in stakeholder plan and demonstrate reduced service variation and improved outcomes ▪ Timeframes to be established for delivery of early CVD projects | <p>DH-Q2</p> <p>TW – Q3Q4</p> | <p>3 x 3-2 = 96 PossibleUnlikely</p> |

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Comment [LL5]: Work in progress

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| 5.2 LL | <p>Inability to deliver the first year of the new Fundraising Strategy due to :</p> <ul style="list-style-type: none"> Failure to effectively promote the Charity and engage existing and new donors Reputational damage through poor application of policies and control processes <p>If the Trust is unable to deliver the first year of its strategy the benefits in relation to increased charitable funding and enhanced profile of the Trust will not be realised.</p> | <ul style="list-style-type: none"> Experienced Head of Fundraising in post New donor database with significantly improved functionality Policies, procedures and guidelines in place to govern fundraising activities Review of Etherington findings undertaken Charitable Funds Committee with strengthened membership Engagement in work of / best practice from Association of NHS Charities | <ul style="list-style-type: none"> Charitable funds committee papers and minutes Reports to Board (/Corporate Trustee) Fundraising Strategy Clear Brand Suite of literature aligned to brand Spotlight Newsletter New website | <ul style="list-style-type: none"> External Audit | <ul style="list-style-type: none"> Limited opportunity to enhance presence of charity in public areas due to accommodation constraints – possible solution being explored | <p>LL to keep under review</p> | <p>3 x 2 = 6 Unlikely</p> |
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