

BOARD OF DIRECTORS PART ONE

Agenda Item	P1-099-18	Date: 25th July 2018
Subject /title	An Enhanced Board Assurance Framework 2018/19	
Author	Ann Farrar, Interim CEO	
Responsible Director	Ann Farrar, Interim CEO	
Executive summary and key issues for discussion		
<p>The Board development review during 2017 recommended an enhanced Board Assurance Framework (BAF) to reflect best practice and this development was supported by internal audit when they reported in April 2018. The Board recognised that an efficient and effective Assurance Framework is a fundamental component of good governance, providing a tool for the Board to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to our organisational success. Given this context, the right time to enhance the BAF was in quarter one.</p> <p>Independent expert support was commissioned from a Trust with a solid track record of exceptional performance in governance. Time out with the Executive team and appropriate senior leaders took place during June and July. The key outcomes are:</p> <ul style="list-style-type: none">(a) A better understanding of the added value and critical importance of the BAF to the long-term success of the Trust.(b) An enhanced range of draft strategic risks co-produced by the Executive Directors reflecting the refreshed strategic objectives for 2018/19.(c) A better understanding of the range of effective control systems and assurance and actions to continually improve to mitigate the risks over time.(d) A review of the operational/clinical risks, graded 15 and above, better alignment with the strategic risks and appropriate mitigation via trust-wide quality improvement plans.(e) An outline of the BAF operating process so there is a consistent and better understanding by the Executive Team and senior leaders on the current process and how this is to be enhanced to reflect best practice. <p>The draft BAF (Appendix 1) and operating process has been considered by members of the Board at a Board development session prior to the recommendation for approval by the Trust Board on 25th July.</p> <p>The Board Assurance Framework Dashboard (Appendix 2) is an overview of all strategic risks including the proposed Sub-Committees identified to monitor progress.</p> <p>The Board is asked to review and approve the draft Board Assurance Framework 2018/19.</p>		
Strategic context and background papers (if relevant)		
Trust Strategy		

Recommended Resolution

The Board approves the draft Board Assurance Framework 2018/19 and delegates authority to the Sub Committees identified to monitor and provide progress reports.

Risk and assurance

As outlined in the BAF 2018/19

Link to CQC Regulations

Regulation 17: good governance

Resource Implications

Key communication points (internal and external)

Communication across the Trust to be issued following revision of the relevant Trust policies.

Freedom of Information Status

FOI exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.

Application Exemptions:

- **Prejudice to effective conduct of public affairs**
- **Personal Information**
- **Info provided in confidence**
- **Commercial interests**
- **Info intended for future publication**

Please tick the appropriate box below:

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A. This document is for full publication

B. This document includes FOI exempt information

C. This whole document is exempt under FOI

IMPORTANT:

If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.

Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

Equality & Diversity impact assessment

Are there concerns that the policy/service could have an adverse impact because of:	Yes	No
Age		✓
Disability		✓
Sex (gender)		✓
Race		✓
Sexual Orientation		✓
Gender reassignment		✓
Religion / Belief		✓
Pregnancy and maternity		✓

If YES to one or more of the above please add further detail and identify if full impact assessment is required.

Next steps

Appendices

Appendix 1 – BAF Improvement Plan
Appendix 2 – BAF Dashboard

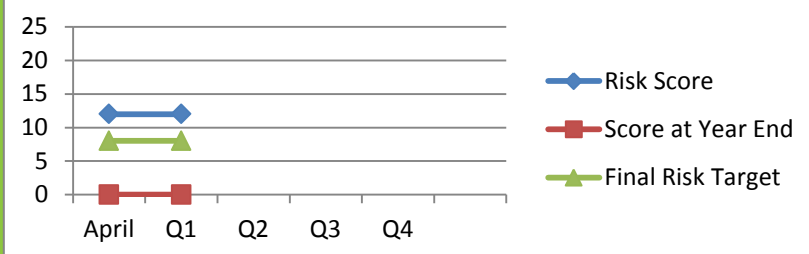
Corporate Objectives supported by this report

Improving Quality		Maintaining financial sustainability	✓
Transforming how cancer care is provided across the Network	✓	Continuous improvement and innovation	
Research		Generating Intelligence	

Link to the NHS Constitution

Patients		Staff	
Access to health care		<i>Working environment</i> Flexible opportunities, healthy and safe working conditions, staff support	
Quality of care and environment		<i>Being heard:</i>	
Nationally approved treatments, drugs and programmes		<ul style="list-style-type: none"> • Involved and represented • Able to raise grievances • Able to make suggestions • Able to raise concerns and complaints 	
Respect, consent and confidentiality			
Informed choice		Fair pay and contracts, clear roles and responsibilities	
Involvement in your healthcare and in the NHS		Personal and professional development	
Complaint and redress		Treated fairly and equally	

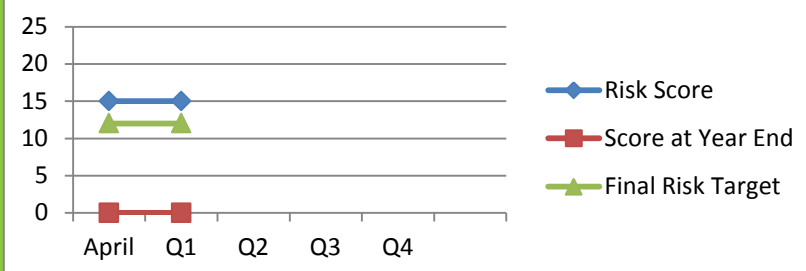
BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 1: Deliver outstanding care as locally as possible			DIRECTOR LEAD: Medical Director					Datix Reference: 898	
STRATEGIC RISK 1: If we do not the optimise quality outcomes we will not be able to provide outstanding care			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			Moderate	Moderate					Moderate
			I3 x L3 = 9	I3 x L3 = 9					I3 x L3 = 9
CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Quality & Safety						
			ASSURANCE COMMITTEE TO REVIEW: Quality						
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: Reflects Trust's commitment to provision of high quality care & recognises key outstanding challenges to delivery						
			RATIONALE FOR CURRENT RISK SCORE: Board to floor governance has been strengthened, however there are gaps in clinical workforce to ensure optimal improvements in delivery and growth of future clinical model and outcomes						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:				DEADLINE:	OWNER:	
1.1	Executive Leadership is the Medical Director for the clinical model and system of care and the Executive Director of Nursing for the Quality strategy and the clinical and corporate governance systems and processes.	There are no gaps in control.							
1.2	The senior leadership is the Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service.	There is a gap in the senior clinical capacity to support the MD role deliver this ambition in the longer-term. There is a need to review the capacity of the clinical and corporate teams to ensure the right capacity for the longer term ambition to be achieved.	The MD to determine the right capacity to support this role and the benefits realisation. The DoF to work together with the MD to determine the resource implications and source of funding for the executive team to determine and recommend to the FBD Committee.				October 2018	MD	
1.3	There is a quality strategy approved by the Board and key measurable outcomes reported in the annual quality account.	The quality strategy needs a re-refresh to align with the strategic direction for 2022. This would require a re-refresh of the success outcomes to ensure alignment from floor to Board.	The quality strategy will be re-freshed by the DoN and include the enhanced systems and processes to optimise top performing outcomes in the longer-term and a trajectory for improvement. The Medical Director will lead on the development of longer term clinical outcomes working in partnership with the Clinical Directors, SRG Leads and Director of Nursing. This will include a trajectory for improvement.				March 2019 October 2018	DoN MD	
1.4	The Trust delivers outstanding care as locally as possible for circa 65% of our population and has an ambition to deliver this standard to over 90% of the population.	Our current strategic outcome measures confirm there are more patients that could receive more appropriate care locally due to medical advances in recent years and the geographic location of our service provision.	A refreshed strategic direction and implementation plan for the period 2018-2022 to be finalised by the Board to transition from the current plan.				March 2022	MD DoN DoO&T	
1.5	The governance committee and flow of information is clear and there is regular reporting from floor to Board.	The frequency is not fit for the purpose of the enhanced strategic aim and needs reviewed.	The frequency of the reporting to the Quality Committee and Q&S Sub-Committee to be increased and reviewed after 12 months to ensure it remains fit for purpose.				June 2019	DoN	
1.6	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are in place however, these need to education and training to embed consistent and sustainable application.	The Quality Committee will receive assurance from the Q&S Committee of the work progressed on the education and training of staff by better results in faster and consistent initiation of escalation and appropriate and timely action.				March 2019	DoN	
1.7	CCC delivers a single service model for the whole of Cheshire & Merseyside enabling a consistent level of high quality care to be.	Isle of Man services are not commissioned to consistent standards and CCC is not sighted on outcomes and standards	Work with Isle of Man authorities to develop a commissioning specification for Oncology and Haemato-Oncology care for IoM residents				Dec 2018	DoO&T	

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
1.8	Staffing for Quality & Safety reported to Quality & Safety Sub-Committee. Safe staffing reported to Unify (external)	There are no gaps in assurance			
	Grant Thornton audits for finance and quality.				
	Workforce Review Group				
	Workforce and business plans				
	E-rostering assurance reports				
1.9	Quality & Performance reports and key indicators reported to Quality & Safety Sub-Committee	Activity module of e-roster system to be developed.	Consideration to this development during 18/19.	October 2018	AD Quality
	Medical workforce reviewed at Medical Advisory Committee (MAC)	There are no gaps in assurance			
	Medical workforce overview through Directorate integration				
	Quality Strategy approved at Quality & Safety Sub-Committee / Quality Committee / Board				
	Quality Strategy reported to Council of Governors and forms part of the Quality Accounts				
1.10	Quality risks standards against NHS Resolution standards	Directorate integration model not finalised Quality Strategy being refreshed	To be concluded and a date to be determined. Refreshed quality strategy to be led by the Director of Nursing.	October 2018 March 2019	AD Quality DoN.
	Quality contract meetings with Commissioners (external)				
	CCC Strategy sets direction, Board of Directors oversight				
	New clinical model in place				
	Transformation of Cancer Care plans aligned to Cancer Alliance and Cheshire & Merseyside Cancer Strategies				
1.11	Cancer Alliance hosted at CCC	Better assurance report by the sub-committee to the Quality Committee implemented.	Transforming cancer care programme assurance being strengthened	October 2018	Deputy CEO
	Quality & Safety Committee Chair's report				
	Quality Committee in place				
	Risk Committee Report to the Quality & Safety Sub-Committee				
	CQC Insight report to the Q&S Sub-Committee				
1.12	Floor to Board Governance review assurance	Need to be strengthened to reflect best practice and real-time.	New report on enhanced governance and assurance being strengthened.	January 2019	DoN MD AD Quality
1.12	Clinical audit programme reported to Quality & Safety Sub-Committee and Audit Committee	There are no gaps in assurance			
	Health and Safety audits				
	Quality surveillance reports				
	Datix system for incident and risk				
	Serious incident reporting framework				
	Serious incident reporting meeting with commissioners				

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 1: Deliver outstanding care as locally as possible			DIRECTOR LEAD: Director of Operations and Transformation					DATIX REF: 899	
STRATEGIC RISK 2: If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			High 14 x L4 = 16	High 14 x L4 = 16					Moderate 14 x L3= 12
CQC DOMAIN: Safe, effective, responsive and well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Operational Service Delivery ASSURANCE COMMITTEE TO REVIEW: Finance & Business Development						
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: The trust is committed to delivering high quality services as close as possible to patient's homes, however has not yet fully costed the future clinical model which will enable us to deliver this.						
			RATIONALE FOR CURRENT RISK SCORE: The risk will remain high until the Board are assured that the costs of the future clinical model can be contained within available funding envelopes through approval of a 2 year workforce plan at October Trust Board.						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:				DEADLINE:	OWNER:	
2.1	Executive Leadership is the Director of Operations & Transformation for the clinical model and system of care and need to work in partnership with the Director of Finance who provides the long-term financial context, strategic financial implementation plan together with the systems and processes for grip and control.	The permanent Director of Finance post is vacant and is temporarily covered by a Director of Strategic Finance (2 days per week) and an Acting Director of Finance (full-time). This fits the capacity and skills of the DoF in the short term.	To recruit a permanent DoF following the appointment of a permanent Chief Executive who would lead the determination of the skills assessment for this role and the Deputy CEO role.				December 2018	CEO	
2.2	The senior leadership is the Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service.	There is a recognised need for a single senior leaders' forum that ensures one message and process for effective leadership and engagement.	To consult on the options for a better senior leaders forum and conclude on the preferred option and implement.				September 2018	CEO DHR &OD	
2.3	The Board has approved a strategic direction based on the approved public consultation and an operational plan with appropriate resources. The Board has approved and resourced the Transforming Cancer Care programme through which the transformation of the care model will be delivered.	There is a need for a strategic implementation plan (2018-2022) that completes the definitive care model for in-patient care so the services are transformed through better integration with the Royal Liverpool Hospital where appropriate and are safe on day one. The definitive care model for care closer to home and better outcomes is described together with the potential patient numbers that would be appropriate to receive care closer to home together with the right infrastructure. This will determine the implementation timing.	The Director of Operations & Transformation to lead a senior leaders' event on 9 th July to produce a definitive care model and operating requirements (workforce, resources, estates, digital care), patient numbers and timetable. Whilst the principles and material requirements will be recommended this will require continuous refinement throughout 2018/19 until the business cases are fully developed and prioritised ready for a decision in the planning process.				July 2018	DO&T MD	
			The Finance & Business Development Committee to receive assurance that the resource implications fit the long-term financial strategy or highlight the risks should there not be a fit. The Board to determine the final determination as part of the operational planning process for the next three years.				March 2019	DO&T DoF	
			The Trust Board and senior leaders to conclude the discussions about the potential strategic options for the short to medium-term (2018-2022) and produce a draft strategic direction and implementation plan for system-wide leaders and staff to consider and feedback. Trust Board to take these views into account and approve the strategic direction and implementation plan.				October 2018	ICEO	
			The strategic implementation plan has been implemented within the long-term resources and the trajectory over time has been met.				March 2022	DO&T DoF	

2.4	The strategic direction includes headline strategic outcomes and KPIs and these are regularly reported to the Trust Board via the Finance & Business Development Committee and the Quality Committee.	The strategic outcomes and KPIs agreed by the Board in 2017 are not routinely reported and embedded floor to Board.	Implement the agreed strategic outcomes and KPI by reporting to the Committees of the Board.	July 2018	DO&T DoF MD DoW&OD
		Embed the reporting from floor to Board at the first level of reporting that is the clinical directorate meetings.	Continuously refresh throughout 2018/19 to ensure these fit with the outcomes of the re-freshed strategic direction.	October 2018	DO&T
2.5	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are gaps in this control measure and these needs to be addressed.	Implement reporting and accountability to deliver to these strategic milestones in the clinical directorate integrated performance reporting via the business intelligence system. The Finance & Business Development Committee will receive assurance from the Operational Services Sub-Committee and the Finance Sub-Committee on the additional assurances, skills and competencies required to be developed through an appropriate education and training programme. An independent expert resource is to be commissioned to support the Trust address this gap and build resilience going forward.	October 2019	DO&T

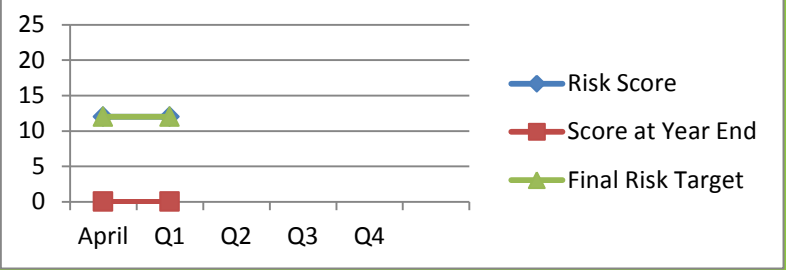
ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
2.6	Approved Business Plan 2017/18	Gaps in workforce plan aligned to finance and activity for 2019/20 and 2020/21 now clinical model has been further refined	2 year plan to Board	October 2018	DoO&T
2.7	Final Business Case for Transforming Cancer Care approved by Trust Board in 2016	All but clinical model not yet agreed for hospital at night	Agree staff model for new hospital	Sept 2018	DoO&T/MD
2.8	Business Cases for additional investments including interventional radiology	Commissioning intentions not yet fully known in some areas eg CAR-T therapy	Formal public consultation	October 2018	DoO&T

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 1: Deliver outstanding care as locally as possible	DIRECTOR LEAD: Director of Finance					DATIX REF: 900
STRATEGIC RISK 3: If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home	RISK RATING:					
	Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End
	Moderate	Moderate				
	14 x L3 = 12	14 x L3 = 12				
						Final Risk Target
						Moderate
						14 x L3 = 12

CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led	ASSURANCE SUB-COMMITTEE TO REVIEW: Infrastructure Committee
	ASSURANCE COMMITTEE TO REVIEW: Finance & Business Development Committee

 <p>RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.</p> <p>RATIONALE FOR RISK: This risk recognises that delivery of outstanding care requires effective supporting infrastructure to be in place. This includes the physical estates maintained to a high standard, and the supporting corporate services (e.g. comms, IM&T, finance, HR, etc) provide effective services to the clinical teams.</p> <p>RATIONALE FOR CURRENT RISK SCORE: The assessment of the current risk score takes into consideration that, although there are gaps in control identified, work is in progress to address those gaps, and the deadlines for doing so are October 2018 and beyond. Although greater integration is desirable, there are no major operational risks highlighted regarding current infrastructure.</p>	

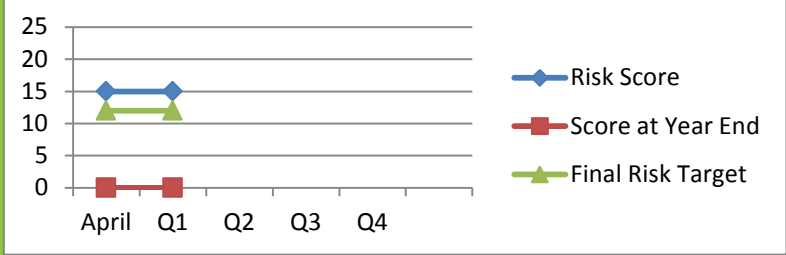
CONTROL SYSTEM					
REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:	DEADLINE:	OWNER:
3.1	Executive Leadership for the estates strategy and SIRO responsibilities is the permanent Director of Finance role. The Chief Information Officer is accountable for the IM&T strategy and reports to the DoF for the delivery of the SIRO duties. The Medical Director leads the development and implementation of the digital care strategy the in partnership with the Chief Information Officer. The Chief Executive is the executive lead for communications and engagement and this senior leadership is the responsibility of the Associate Director of Communications & Engagement. The Head of Physics is the senior leader responsible for the medical equipment system and investment and is accountable to the DoF for this system and process.	There are no gaps in control however, to deliver a shift of care closer to home there needs to be greater integration hence a cohesive integrated infrastructure strategy that reflects the oversight arrangements via the Infrastructure Committee and at the same time retains the highly professional leadership.	To review the executive and senior leadership arrangements as part of the refresh of the Organisational Development strategy and the executive team portfolio following the appointment of the permanent Chief Executive. In the meantime, ensure the right skills and capacities remain in place as approved by the Board.	June 2019	CEO
3.2	There is an estates strategy that focuses on the transformation of cancer care and primarily supports the new build of the Cancer Centre in Liverpool on time and to the right standard.	The estates strategy does not fit our strategic direction for more care to be provided locally by local hospitals closer to home.	To refresh the estates strategy to fit the strategic direction so it includes the requirements of care closer to home and the definitive care model requirements as recommended and approved following the senior clinical leaders forum.	October 2018	DoSF
		There are no gaps in control for the build of the new hospital led by PropCare however, there is an increasing risk with the integration of the new build with the new Royal Liverpool Hospital because of the delay in the confirmation of the opening date due to the need to confirm a new construction partner.	There continues to be positive and open strategic relationship networks with the construction company, CEO/Chair and Propcare and the new build remains on time and within budget. There is an agreement to produce a range of scenarios between executive partners to ensure the operational delivery of the new build remains on time and to a high standard.	October 2018	PropCare Managing Director
		The office accommodation, car parking and travel and transport requirements to enable optimal delivery of the strategic care model and resources to be defined, resourced and implemented.	The operational requirements to be assessed, options considered, staff engaged and a recommendation to the Finance & Business Development Committee via the Operational Services Sub-Committee.	October 2018	ADoO
			Implementation of requirements to ensure the new build in Liverpool is safe delivery on day one.	Spring 2020	ADoO

3.3	There is a capital investment strategy including digital care and a resource plan approved by the Board up-to 20121 to ensure there is an enabling infrastructure in place to deliver the strategic ambition.	This need to take into account the outcome of the senior leaders' forum which is determining the defined clinical model of care.	The Finance & Business Development Committee to receive a recommendation from the Infrastructure Committee on the preferred optimal option for capital investment for both major capital and medical equipment to fully implement the strategic direction (new build at Liverpool and care closer to home)	March 2022	DoF CIO MD DO&T
3.4	The strategic direction includes headline strategic outcomes and KPIs and these are regularly reported to the Trust Board via the Finance & Business Development Committee and the Infrastructure Committee.	The strategic outcomes and KPIs are not routinely reported and embedded floor to Board.	Implement the agreed strategic outcomes and KPI by reporting to the Floor to Board, that is, clinical directorates, to Infrastructure Sub-Committee and Finance & Business Development Committee. The Finance & Business Development Committee will receive assurance from the Operational Services Sub-Committee that the appropriate engagement with the operational team and Propcare is in place to ensure the continuation of quality outcomes following the recent changes to the executive team.	October 2018	DoSF
3.5	The escalation of risk is defined with trigger points and there are enhanced processes should performance need to be enhanced and regulatory standards are maintained.	There are no significant gaps in control there is a need for an integrated performance dashboard to ensure a comprehensive oversight and consistency.	Ensure there is a system and process developed and staff are made aware of this enhanced overview so it fits with their needs	October 2018	DoSF

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
3.6	Infrastructure Committee ToR, Board Minutes and Actions	Needs fixed agenda item reporting on capital programme (build and equipment)	Make fixed agenda item for ongoing meetings	September Meeting	DoF and MD PropCare
3.7	PropCare Board Minutes and Actions	There are no gaps in assurance			
3.8	PropCare Operational Meeting with CCC Ops team	Strengthen touch points between CCC and PropCare	Need to ensure reporting "touch points" are aligned as relevant between CCC and PropCare and well understood	August	EDoSF and PropCare
3.9	Estate Strategy and subsequent reporting	Estate Strategy in refresh and needs measureable action plan	Refresh of strategy underway	July	EDoSF and PropCare
3.10	Infrastructure Committee Terms of Reference, minutes and actions	There are no gaps in assurance			
3.11	Digital Board Terms of Reference, minutes and actions	There are no gaps in assurance			
3.12	IM&T Strategy – Trust Board Approved	Business intelligence is not part of the strategy	Refreshed Digital Strategy	Q2	CIO

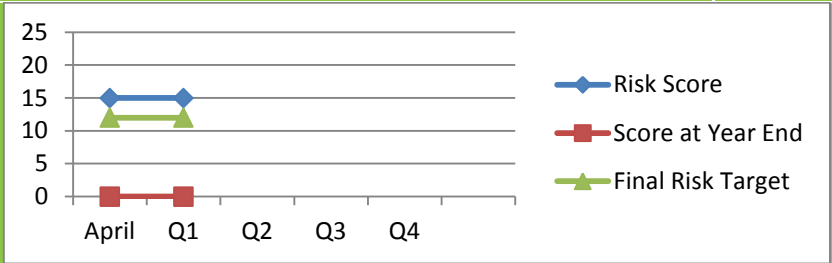
BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 2 : Retain and develop our outstanding staff			DIRECTOR LEAD: Director of Workforce & Organisational Development			DATIX REF: 895			
STRATEGIC RISK 4 : If we do not have the right innovative workforce solutions including education and development we will not have the right skills, in the right place, at the right time to deliver outstanding care			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			High 14 x L4 = 16	High 14 x L4 = 16					Moderate 14 x L3 = 12
CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Workforce, OD and Communication ASSURANCE COMMITTEE TO REVIEW: Quality						
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: Having the right workforce, with the right skills and competencies, available at the right time within the right place is essential to delivery of the new clinical model, which is key to delivering continued outstanding care to our patients.						
			RATIONALE FOR CURRENT RISK SCORE: The Workforce plans (including numbers of staff and skill mix) have been agreed for 2018/19, but are not locked down for years 2019 – 2022. Without confirmed ways of working within the new clinical model, this risk remains high as the lead in time for training and development of staff may exceed the timeline for changes in service provision.						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:			DEADLINE:	OWNER:		
4.1	Executive Leadership is the Director of Human Resource & Organisational Development (DHR&OD). The Director works in partnership with the executive team directors to produce and deliver a range of strategies for example, clinical workforce strategy and education and development strategy.	The long-standing DHR&OD has recently announced a successful promotion to an acute DGH Trust within C&M wider system.	To recruit a highly experienced individual in HR with a solid background in OD to lead this service through the period of transformation and beyond.			October 2018	ICEO		
4.2	The senior leadership is the senior HR leaders, Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service.	There are no gaps in this control.							
4.3	There are a range of strategies approved by the Board and these are (i) Trust has a workforce & OD strategy, (ii) Communication & engagement strategy, (iii) Education & training strategy and (iv) clinical workforce strategy.	These strategies were fit for purpose at the time but need a re-refresh to align with the next period of transformation (2018-2022) to ensure they fit with the ambition to deliver outstanding care and outstanding staff engagement. The strategic ambition needs to have succinct strategic measures of success including a trajectory over the transformation period.	Through engagement with staff , learning from the best and alignment with the work developed over the last 18 months on the clinical model of care for the future, refresh all the strategies and recommend to the Board. The strategies need to include high-level strategic measures and a broad trajectory for improvement.			October 2018	DoW&OD		
			Greater focus on a more quality driven appraisal process. Greater focus on a more effective local training needs analysis system. Continual improvement in the medical re-validation system.			March 2019	DoW&OD MD		
			The right workforce is in place with the right skills 3 months ahead of the opening of the new build in Liverpool.			March 2020	DoW&OD MD, DoN & DO&T		
			There is the right workforce in place for the planned shift of care closer to home for day and outpatient services.			March 2022			
			We are recognised in the staff survey as an outstanding Trust that invests in innovative workforce solutions, professional development and career progression			March 2022			
4.4	The governance structure is solid with a Workforce, OD and Communication Group with reporting systems below that enable the flow of information from floor to Board.	The strategic KPIs for each of the strategies need to form part of the report. There are no gaps in the operational KPIs.	Implement a dashboard to report progress on the strategic KPIs.			October 2018	DoW&OD		
4.5	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are in place, however, these need education and training to embed consistent and sustainable application.	To focus on the appropriate measures through the Workforce, OD & Engagement Committee and measure effectiveness for appraisal and training in the first instance. Embed this year through direction and education and training as the strategies are re-freshed.			July 2018	DoW&OD		
						October 2018			

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
4.6	Workforce & Organisational Development (OD) Strategy	Strategy to be revised	Revised Strategy to be developed	October 2018	DoW&OD
4.7	Workforce & OD Annual report against Workforce & OD Strategy	Education and learning priority not on target to deliver outcomes	Review approach to Education & Learning and produce options paper	October 2018	DoW&OD
4.8	Monthly workforce performance report showing improvement against KPI's	Turnover above target of 12%	Develop Workforce Strategy / plan Bi-monthly report on turnover to be included on Workforce Sub-Committee	October 2018	DoW&OD
4.9	Recruitment policy with agreed KPI's (time to time)	Vacancy rates are high in nursing and medical workforce	Recruitment video to be developed – priority focus on nursing recruitment	October 2018	DoW&OD
4.10	One year workforce plan agreed at the Board	Years 2 and 3 workforce plan yet to be signed off	Workforce plan and narrative to be produced by Directorates	October 2018	DoW&OD
4.11	Directorate performance reviews to include workforce data				
4.12	PADR (appraisal) process in place				
4.13	Medical job planning cycle and job planning policy				
4.14	Review of medical job plans against new clinical model	Identified gaps in medical capacity per tumour site	Workforce plan to address shortfall and provide solution to deliver clinical model	October 2018	MD, DoO&T, DoN&Q
4.15	Mandatory training records	Low compliance in BLS	Directorate action plans in place	March 2019	DoN&Q
4.16	Leadership programme				
4.17	Workforce Sub-Committee cycle of business				
4.18	Review of Workforce Sub-Committee Terms of Reference				
4.19	Reports from Workforce Sub-Committee, Quality Committee, Board				
4.20	Restructure of Workforce & OD department	Medical workforce cover / support not fully embedded	Joint action plan with Clinical Directors / General Managers to address gaps in support and review policies and processes	December 2018	DoW&OD

BOARD ASSURANCE FRAMEWORK 2018/19

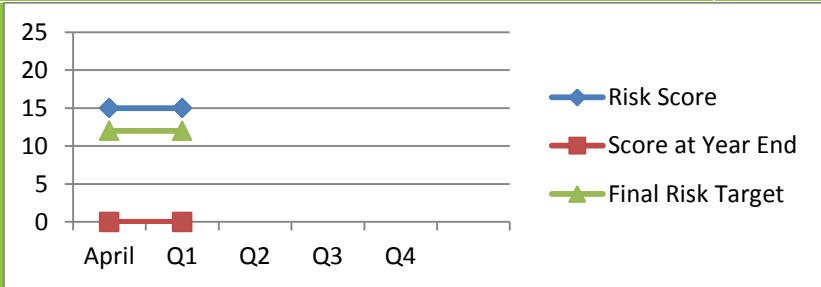
STRATEGIC PRIORITY 2 : Retain and develop our outstanding staff			DIRECTOR LEAD: Director of Workforce & Organisational Development				DATIX REF: 896			
STRATEGIC RISK 5 : If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce			RISK RATING:							
			Original score 1.4.18		Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			High I4 x L4 = 16		High I4 x L4 = 16					Moderate I4 x L3 = 12
CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Workforce, Organisational Development & Communication							
			ASSURANCE COMMITTEE TO REVIEW: Quality							
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.							
			RATIONALE FOR RISK: Staff engagement is a key indicator for positive health and well-being, which in turn indicates excellent patient care.							
			RATIONALE FOR CURRENT RISK SCORE: Staff engagement scores have reduced in the 2017 staff survey results, indicating that this is an area requiring significant focus over the next 12 months.							
CONTROL SYSTEM a										
REF:	CONTROL SYSTEM	GAP IN CONTROL:		ACTION PLAN:			DEADLINE:	OWNER:		
5.1	Executive Leadership is the Director of Human Resource & Organisational Development (DHR&OD). The Director works in partnership with the executive team directors to lead and direct on the organisational development strategy.	The long-standing DHR&OD has recently announced a successful promotion to an acute DGH Trust within C&M wider system.		To recruit a highly experienced individual in HR with a solid background in OD to lead this service through the period of transformation and beyond.			October 2018	ICEO		
	The Trust Board is stable and adds value by setting a strategic direction which sets out the values, aim, common purpose, strategic ambition, strategic goals and the behaviours that support the best outcomes from staff to continually delivery outstanding care.	Whilst there has been two planned executive retirements and a further two recent changes to the Board, the executive team has a range of highly experienced directors who are cohesive with clarity on strategic and operational objectives and a Board of directors with the right skills and capacity to inspire, lead and deliver the strategic objectives.		The Trust Board has approved a series of development sessions to develop as a cohesive team and transition through the change. The development plan acknowledges the highly experienced skill set of the executive team and expectations of the Board to implement the well-led development plan approved in September 2017.			March 2019	ICEO Chairman		
5.2	The senior leadership is the senior HR leaders, Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service.	There are no gaps in this control.								
5.3	An Organisational Development (OD) strategy that describes the values of the organisation and how they are delivered through our behaviours and our ways of working and governance. The OD strategy should be recognised as leading edge and support the Trust in the long-term aim of continuous quality improvement, best performing staff engagement and well-being and outstanding care and effectiveness.	The gap in control is the current HR&OD strategy is close to its renewal date and the emphasis on OD whilst acknowledged needs to be significantly emphasised recognising the ambition of the Trust to be an outstanding employer of choice and well-being.		The Trust Board committed in April to a stand-alone OD strategy based on best practice and leading-edge approaches to be aligned to the highly transformational change in cancer services over the next few years. Board development sessions are to be planned to set the context with contributions from recognised leading edge leaders together with contributions from the views of the senior leaders about their needs for the future to deliver the right care, right time, right place, and right behaviours.			October 2018	ICEO DoW&OD MD DoN		
				The strategy needs to include a strategic implementation plan including options and resources for each option so the optimal improvement approach is decided.			October 2018			
				Staff engagement score remains steady at 3.96			June 2019			
				Staff engagement score improves to at least 4			June 2020			
				Staff engagement score improves to at least 4.10			June 2022			

5.4	A Communications, Engagement & Marketing strategy that describes the added value of this service to the ambition of the Trust. This strategy should be recognised as leading edge and support the Trust in the long-term aim of continuous quality improvement by proactively listening to its key external stakeholders and staff and respond its strategic care offer and behaviours to patients and the wider system leaders accordingly within available resources.	The gap in control is the current CE & M strategy is past its renewal date and whilst there is a current operational action plan the longer term prioritised activities need to fit with the strategic ambition of the Trust. The Trust aims to be recognised as best performing staff engagement and system wide leadership to ensure cancer services in C&M are on a journey to be best in class in the longer-term.	To commission an independent and highly experienced support to undertake a baseline of our relationships with wider system-wide leaders and our contribution to the wider-system quality improvements. To reflect on this feedback and respond accordingly to our strategic objectives for both our OD strategy and CE&M strategy. The strategy needs to include a strategic implementation plan including options and resources for each option so the optimal improvement approach is decided.	January 2019	ADC&E
5.5	The governance structure is solid with a Workforce, OD and Communication Group with reporting systems below that enable the flow of information from floor to Board.	There are no meaningful staff communication and enagement measures that demonstrate the added value of the communication service contribution or OD measures.	The formal name change of the Committee is to take place during quarter to incorporate the contribution from the communication team to staff engagement. Success measures and measurable outcomes to be determined by this Group and reported to the Quality Committee enabling a flow of information from the floor to Board and themes to be determined that influence priorities for development.	October 2018	ADC&E
5.6	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are in place, however, these need education and training to embed consistent and sustainable application.	The directors to lead this development to fit with the approval of the strategies by the Board.	January 2019	DoW&OD ADCEM

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
5.7	Stress Policy Audit	Stress continues to be highest reason for absence	Focus staff survey action plan on stress. Stress task and finish group established	October 2018	DoW&OD
5.8	Sickness absence deep dive report	Absence is high in lower banded roles and middle age bracket	Focus groups to be established to determine key reasons and propose solution	December 2018	DoW&OD
5.9	Retention audit / review paper	Gaps identified to understand leavers at 2 years	Retention report to be monitored at the Workforce Sub-Committee on a bi-monthly basis to include 2 year leavers	September 2018	DoW&OD
5.10	Occupational Health SLA performance reports				
5.11	Counselling service in place (CWP)	Currently over demand is exceeding capacity	Review service and alternative options to support staff mental health and wellbeing	December 2018	DoW&OD
5.12	Introduction of Vivup – staff benefits system				
5.13	Staff survey results – positive staff engagement – 3.96 (external assurance)	Slight decline in engagement scores	OD Strategy to focus on staff engagement	October 2018	DoW&OD

BOARD ASSURANCE FRAMEWORK 2018/19

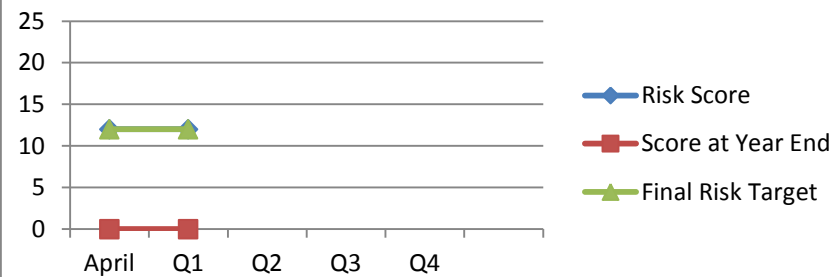
STRATEGIC PRIORITY 3: Invest in research and innovation to deliver excellent patient care in the future			DIRECTOR LEAD: Medical Director				DATIX REF: 901		
STRAGIC RISK 6: If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			High 14 x L4 = 16	High 14 x L4 = 16					Moderate 14 x L3 = 12
CQC DOMAIN: Safe, Effective, Caring, Responsive & Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Quality & Safety ASSURANCE COMMITTEE TO REVIEW: Quality						
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: The challenges relating to complex inter-operability and digital transformation present a risk to the delivery of optimal patient outcomes and operational effectiveness						
			RATIONALE FOR CURRENT RISK SCORE: The Trust is still to put in place systems and processes for effective Board assurance reporting, digitalisation of clinical pathways and inter-operability delivery						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM:		GAP IN CONTROL:		ACTION PLAN:		DEADLINE:	OWNER:	
6.1	Executive Leadership for digital care is the Medical Director and is proactively supported by the Chief Information Officer.		There are no gaps in control.						
6.2	The Trust Board approved a Digital Care strategy, implementation plan with appropriate resources, March 2018.		Effective inter-operability with partner clinical information systems that delivers optimal patient care. fits best in class.		To ensure a task and finish group is in place to design and implement effective inter-operability between the CCC and RLH no later than 3 months before the opening of the new CCC-Liverpool.		March 2019	CIO	
			The digital care transformation need to be patient centred. Transform pathways and then implement via Meditech.		To produce a prioritised programme of clinical pathways to be transformed prior to an e-adoption. Confirm the clinical engagement and capacity is in place to deliver. Communicate this ambition and the programme on a single page for all staff to be aware and contribute.		October 2018	CIO	
					Recognised as an exemplar in digital care.		March 2022	CIO	
6.3	The governance structure for Clinical Research & Development (Innovation) is solid, that is, the Clinical Research & Development Group which reports to the Quality & Safety Sub-committee which in turn provides assurance to the Quality Committee.		The gap in control is the need for an enhanced flow of information on the key measures of success from the clinical teams to the R&D committee and onto the Board.		The success measures to be defined developed and implemented at clinical team level, Trust clinical research level and at the Board. This would include reporting to the Board on the strategic objectives agreed with Liverpool Health Providers and Academic Health Care Alliance, CRN.		October 2018	AD, CR	
6.4	The governance structure for the development for digital care Board is the digital care board which reports to the Infrastructure committee reports and provides assurance to the Finance & Business Development Committee.		The gap in control is the need for an enhanced flow of information on the key measures of success for digital care and business intelligence from the floor to the Board.		The reporting of the key measures of success will be reported to the Board Committee from July and continued to be embedded from the floor to the Board by October.		October 2018	CIO	
6.5	The escalation of risk is defined with trigger points and enhanced processes to address concerns.		These are in place, however, these need education and training to embed consistent and sustainable application from floor to Board.		To embed this development during quarter two and three.		January 2019	ADoQ CIO	

ASSURANCES					
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
6.6	External Assurance from NHS Digital for Global Digital Exemplar Fast Follower (GDE FF) programme	First assurance review in July 18. Assurance outcome to be fed through Digital Board and Infrastructure Committee	First assurance review to be fed through Digital Board and Infrastructure Committee	September 18	CIO
	Digit@all digital strategy across Cheshire and Merseyside launched on 5/7/18 supports CCC way of working	Clear narrative to Feed through Infrastructure Committee	Report at Infrastructure Committee	September 18	CIO
	National Information Toolkit assurance	There are no gaps in assurance			
	Membership of Cheshire and Merseyside Digital Board as specialist Trust representative	There are no gaps in assurance			
	Membership of Clinical Informatics Advisory Group (CIAG) quarterly meeting across Cheshire and Merseyside	Formal feedback into Digital and Infrastructure Committee and Digital Board			
6.7	External reviews from Merseyside Internal Audit Agency	There are no gaps in assurance			
6.8	Clinical Research & Development reports into Quality & Safety Sub-Committee / Quality Committee	Board reporting on strategic objectives agreed, LHP and AHCA not in place, impact not understood	Discuss and agree with the Medical Director, Director for Academic Research and Lead for Clinical Research and address.	October 2018	CIO
	Aligned to Liverpool Health Providers and Academic Health Care Alliance				
6.9	Infrastructure Committee Terms of Reference, minutes and actions	There are no gaps in assurance			
	Digital Board Terms of Reference, minutes and actions	There are no gaps in assurance			
6.10	Digital Board report to the Quality & Safety Sub-Committee in place to confirm assurance on the optimal use of digital technology to deliver optimal patient outcomes and operational effectiveness.	Committee reporting on this measure to be strengthened.	Discuss and agree with the Medical Director, Director of Nursing and AD Quality and address.	October 2018	CIO
6.11	Floor to Board Governance review assurance	Need to be strengthened to reflect best practice and real-time.	Consistent standard implemented from June but needs embedded.	October 2018	ADoQ
			A real-time business intelligence system has been commissioned.	March 2019	ADoQ CIO
6.12	Quality & Safety Chairs report	There are no gaps in assurance			
	Risk Committee				
	CQC Insight report				
	Health & Safety audits				
	Clinical audit programme reported to Quality & Safety Sub-Committee and Audit Committee				
	Quality surveillance reports				
	Datix system for incident and risk				
	Serious incident reporting framework				
	Serious incident reporting meeting with commissioners				

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 3: Invest in research and innovation to deliver excellent patient care in the future	DIRECTOR LEAD: Medical Director					DATIX REF: 902	
STRATEGIC RISK 7: If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future	RISK RATING:						
	Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
	Moderate	Moderate					Moderate
	I3 x L4 = 12	I3 x L4 = 12					I3 x L4 = 12

CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led	ASSURANCE SUB-COMMITTEE TO REVIEW: Quality & Safety ASSURANCE COMMITTEE TO REVIEW: Quality
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RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.

RATIONALE FOR RISK: Risk reflects the refreshed Clinical Research Strategy to be presented to Board in July 2018; additionally the requirement to engage with all staff to embed improvement methodology and innovation, supported by OD Strategy

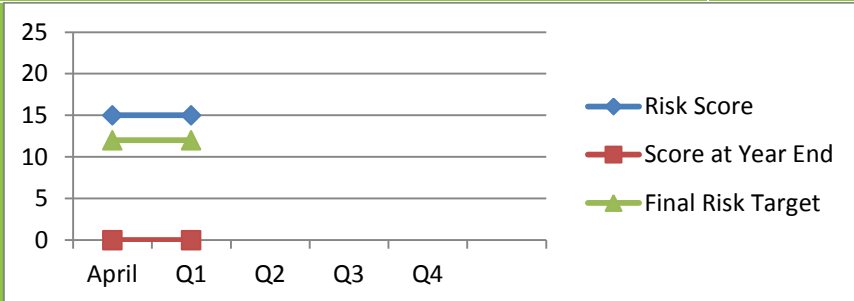
RATIONALE FOR CURRENT RISK SCORE: Clinical Research Strategy is to be approved and the Trust continues as an active research partner, however there is a need to lead and support innovative research opportunities for quality improvement in future patient care

CONTROL SYSTEM

REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:	DEADLINE:	OWNER:
7.1	Executive Leadership for clinical research and clinical innovation is the Medical Director. The executive director for business transformation systems is the Director of Operations & Transformation.	There are no gaps in control.			
7.2	The senior leadership dedicated to research are the Director for Academic Research and Lead for Clinical Research, and innovation is the Associate Director, Strategy.	The gap in control is a single system and forum for the executive team and senior leaders to explore innovation as a business opportunity opportunities and threats and ensure this is regularly reported to the Trust Board as part of its strategic planning process.	Consult on the smarter use of the various senior leaders forums and decide on a preferred option and implement. The agenda for these forums would include innovation/horizon scanning. This system and process needs to be integrated and reported to the Board.	September 2018	ICEO ADStrategy
7.3	The Trust Board approved a strategic direction for Clinical Research and appropriate resources, March 2018.	Whilst the Trust Board approved in principle a strategic direction for research and funding, a detailed strategy is required which will improve research capability delivering best in class.	The MD to present the Research Strategy and describe how the resources will be utilised. The Board will be asked to approve the Research Strategy	July 2018	MD
7.4	The current OD strategy commits the Trust to a change management methodology for the Transforming Cancer Care Programme.	The need for a Trust-wide improvement methodology as business as usual.	The re-freshed OD strategy will recommend how best to roll-out the principle of the current improvement methodology from TCC to be the norm for our quality improvements. This will enhance reliability and resilience in the implementation of improvements.	October 2018	DoW&OD .
		Proactive promotion of innovation implementation and positive results including celebration of recognition	Trust-wide improvement methodology used to affect 100% of the quality improvements	March 2022	
7.5	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are in place, however, these need education and training to embed consistent and sustainable application from floor to Board.	The awareness via performance reporting has commenced and the improvement is being tracked from quarters one.	March 2019	ADCR

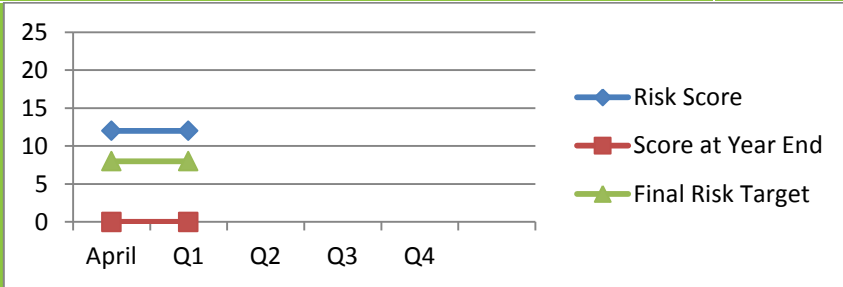
ASSURANCES					
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
7.6	Research Strategy in draft	Research Strategy to be considered by Board of Directors in July 2018.			
7.7	ECMC status				
7.8	Strategic and operational objectives and their outcomes reported to the Quality & Safety Sub-Committee.	System emerging but needs further developing.	Embed and strengthen.	January 2019	AD Research
	Floor to Board Governance review	Governance co-ordinators in Directorates to be approved and recruited			
7.9	Governance structure and oversight All research studies are reviewed through each SRG and then to the Resource Committee. The Research Governance Committee (RGC) oversees and manages all governance through R&I for research. The RGC oversees portfolio, recruitment, safety, audit reports and implementation milestones against the research strategy. ECMC, Biobank, Gene Therapy, Sponsorship reports through the RGC. The RGC reports to the Research Committee and Board providing strategic oversight. The RGC reports also to the Quality and Safety Sub Committee for Trust oversight and assurance. Portfolio and activity reporting are produced quarterly through the RGC. Performance in Initiating and Delivery of Research is reported nationally to the NIHR each quarter. CCC R&I is on a statutory external inspection cycle (4-5 yearly) from the MHRA as participating site and Sponsor and the Biobank through the Human Tissue Authority and annual reports to the NHSE Research Ethics Committee.	There are no gaps in assurance			
7.10	Quality & Safety Chairs report	There are no gaps in assurance			
	Risk Committee				
	CQC Insight report				
	Health & Safety audits				
	Clinical audit programme reported to Quality & Safety Sub-Committee and Audit Committee				
	Quality surveillance reports				
	Datix system for incident and risk				
	Serious incident reporting framework				
	Serious incident reporting meeting with commissioners				

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 4: Collaborative system leadership to deliver better patient care			DIRECTOR LEAD: Interim Chief Executive			DATIX REF: 903			
STRATEGIC RISK 8: If we do not retain system-wide leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			Moderate 14 x L3 =12	Moderate 14 x L3 = 12					Moderate 13 x L3 = 9
CQC DOMAIN: Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Trust Board Development Sessions (2-3 p.a.) ASSURANCE COMMITTEE TO REVIEW: Finance & Business Development						
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: The strategic ambition is deliver outstanding cancer services and a whole system approach can only be achieved by highly effective collective leadership amongst system-wide partners.						
			RATIONALE FOR CURRENT RISK SCORE: The primary rationale for the high risk score is the because the C&M wider system does not have a 5-10 year cancer plan led and co-produced with system-wide leaders. The permanent CEO is due to take up appointment later in 18/19, however, the interim CEO will start the process of gaining support from the C&M wider system leaders.						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM:	GAP IN CONTROL:	ACTION PLAN:			DEADLINE:	OWNER:		
8.1	The permanent CEO is recognised in the C&M system as the Cancer Alliance SRO and the Cancer Alliance is hosted by the Trust. The SRO for the Cancer Alliance requires the approval of the National Cancer Lead.	The Trust is in the process of recruiting a permanent CEO and it is expected that the new CEO would be the SRO for the Cancer Alliance.	The Chair and the interim CEO engage with the system-wide leaders' to ensure continued support for the permanent CEO to be recognised as the SRO for the Cancer Alliance.			December 2018	Chair Interim CEO		
8.2	The Director of the Cancer Alliance reports to the SRO, Cancer Alliance.	No gaps in control.					DCA		
8.3	The Cancer Alliance Plan 18/19 was approved by the Trust Board and the Trust influenced this Plan.	No gaps in control.					DCA		
8.4	The Trust's strategic ambition is to deliver the principles of the longer term national cancer plan that is to deliver world class outcomes for the local population of C&M in the next 10 years.	An effective Cancer Alliance, well represented by partner organisations, however, there is more opportunity to lead a major transformation in cancer services reflecting the ambition of the national cancer plan to reduce variation and deliver world class outcomes over the next 10 years.	The re-freshed strategic ambition has formally engaged the Cancer Alliance. The draft needs to be shared with system-wide leaders and the Cancer Alliance to seek their feedback and sign off commitment and full support for implementation over the next 3 years.			October 2018	ICEO AD Strategy		
			Ensure the right governance and flows of information on the full range of innovation and transformation are in place reflecting best in class project management.			October 2018	ICEO		
			To lead the request to the C&M system management board to produce a 10-year cancer services strategy via the Cancer Alliance system leaders to set out a major transformation from a whole system perspective (public health to specialist services).			October 2019	ICE AD Strategy DCA		
		The Trust performs best in class in staff and public engagement however a similar assessment of the opinion of external stakeholders is required to ensure the Board members and senior clinicians influence and lead appropriately to produce and implement the 10-year strategy.	The executive directors and Chair have been recruited with the right skills and competencies to be more externally focused and to build highly effective relationships with system leaders within the C&M system. High level engagement with major external networks will have been made by July and arrangements put in place for this to be sustained in the longer term.			July 2018	ICEO ADCE&M		
			The plan is to seek the views of our external partners so the Trust has a baseline and will produce an action plan to build better positive and highly effective relationships over time. External relationship engagement score has improved year on year from moderate to best in class.			October 2018	ADCE&M		
						October 2022	ICEO ADCE&M		

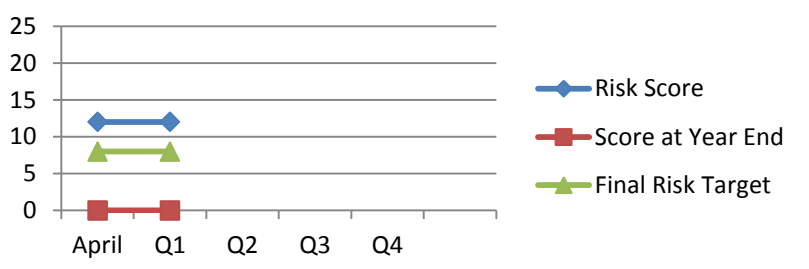
8.5	To retain our cancer specialist Trust status and maximise the benefits of greater collaboration to ensure the longer – term success of our cancer services for our local population.	Trust strategy 2018-2022 approved by the Trust Board needs to set out not only the direction of travel but the added value of autonomous specialist Trust status by comparing our best in class outcomes with comparable peers and major teaching hospitals.	To work in partnership with the system leaders in C&M, the Specialist Hospitals Network and leading national policy units to produce a comparative benchmark of best in class outcomes to derive the added value of greater collaboration with the right partners to contribute to a longer-term strategy for the CCC. Greater collaboration potential to be agreed and work-in-progress by system-wide leaders.	October 2019	Chair Interim CEO AD strategy
8.6	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are in place, 2-3, however, these need to be formalised into planned Trust Board development sessions in the Board planning cycle.	To recommend an amendment to the Board planning cycle by July and implement	July 2018	Chair ICEO
ASSURANCES					
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:&P	DEADLINE:	OWNER:
8.7	Chief Executive Report to Board of Directors provides national, regional and local overview of strategic and operational business and risks	SRO report on Cancer Alliance	Progress discussions with the Cheshire & Merseyside Executive Lead and Interim SRO Cancer Alliance to seek approval for the CEO to be SRO and start date	Dec 2018	Chair
8.8	External stakeholder relationships regarding collaboration leadership on system wide outcomes	Building on the public consultation and public opinion outcome, determine a baseline and process of regular review	Assurance commissioned and report expected	Oct 2018	ICEO
8.9	Draft Strategic Direction Development sessions to engage and develop a longer term direction	Completed first draft	First draft for feedback by staff and external partners	Aug 2018	ICEO
8.10	Planning and Performance Framework	In place but to be refreshed	Refreshed in line with enhanced planning and operational performance arrangements	Sept 2018	HoP&P
	Workforce & OD Strategy in place				
	External assurance – staff survey engagement score 3.96				
	PMO programme structure and reporting framework				
	External assurance – 'Attain' assessment of TCC programme management and function				

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 5: Be Enterprising			DIRECTOR LEAD: Interim Chief Executive				DATIX REF: 904		
STRATEGIC RISK 9: If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			Moderate	Moderate					Low
			I3 x L3 = 12	I3 x L3 = 12					I2 x L3 = 6
CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Infrastructure and Finance						
			ASSURANCE COMMITTEE TO REVIEW: Finance & Business Development						
			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: The strategic ambition is to enterprising and forward thinking in order to remain best in class this requires the right entrepreneurial spirit and risk appetite at Board and senior leaders level and the right infrastructure to maximise impact.						
			RATIONALE FOR CURRENT RISK SCORE: The Board and senior leaders have demonstrated a high value impact in recent years hence this is a moderate risk score with the need for continual strategic support balanced against other competing priorities. The gaps in control and assurance can be reasonably addressed by a highly experienced executive director and the strategic ambition realised over time.						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM:	GAP IN CONTROL		ACTION PLAN:			DEADLINE:	OWNER:	
9.1	Executive Leadership for the enterprising strategy is the Deputy Chief Executive/Director of Finance.	The permanent post is vacant.		The Board has recruited a temporary Executive Director of Strategic Finance to fulfil this role with the right skills and experience. A process to recruit a permanent executive director to fulfil this objective will commence following the appointment of a permanent Chief Executive.			January 2019	CEO DoSF	
9.2	There is a range of senior leadership at the CCC which fulfil this role, e.g., MD (Propcare), Chief Pharmacist, AD Strategy, Acting Deputy Chief Executive, MD, Clinical Directors, and AD Clinical Research & Innovation.	There are no gaps in assurance.							
9.3	An enterprising strategy approved by the Board including key market opportunities, risk appetite assessment, prioritised implementation plan and timescales	There are a number of strategic business cases but no single enterprising strategy reflecting on successful outcomes to date and potential growth areas. These need to be prioritised along with the potential increased income as a contribution to continually invest in better patient care and experiences.		To produce an enterprising strategy and determine implementation effective from 2019/20 following agreement with the Cheshire & Mersey system leaders group.			January 2019	DoSF	
				Review the business cases for major service development initiated by the clinical and non-clinical teams and prioritise over the next five years the risk appetite and added value to the delivery of the CCC strategic objectives.			January 2019	DoSF	
				Review of successful growth opportunities and income outcomes one year on.			March 2020	DoSF	
9.4	Regular strategic overview of potential changes to national cancer policy and market conditions reported to the Finance & Business Development Committee. The strategic overview to include contributions on legislative changes informed by the external auditors (via Audit Committee) clinical horizon scanning via senior leaders forum and networks with NHSI and NHS England.	This needs to be a regular report.		To the frequency of reporting to the Board is to be formalised to 2-3 times a year and included in the Trust Boars planning cycle.			October 2018	DoSF AD Strategy	
9.5	Charitable Funds Committee in place to review and monitor progress against charity appeal.	The Charity does not provide the £20m capital required for the capital build		Substantial review of the major donor income stream in place to identify opportunities and restraints to achieving target otherwise there is little confidence the strategic objective will be achieved on time. This review will be led by Executive Director of Strategic Finance and be concluded by the end of quarter two.			October 2018	DoF/ HoC	
9.6	Same note as 8.5.								

ASSURANCES					
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
9.10	PPU JV Board and Actions	There are not gaps in assurance.			
9.11	PPUJV Action Plan	Currently developed and to be agreed before implementation	To be agreed in July and action plan implemented thereafter -	July and ongoing	EDoSF and PPU Business Manager
9.12	PropCare Board Minutes and Actions	There are no gaps in assurance.			
9.13	PropCare Estate Strategy	In development	Under development and will reflect measureable actions to assess future performance	July	EDoSF and MD PropCare
9.14	CPL Board Minutes and Actions	There are no gaps in assurance.			
9.15	CPL Strategy	Refresh strategy and business plan under development	To be completed by CPL and CCC to demonstrate future growth ambitions across the STP	September	EDoSF and Chief Pharmacist
9.16	Charitable Funds Committee minutes and actions	Major donor engagement	Charitable Funds Committee to monitor progress against appeal target, escalate risk of non achievement to Board of Directors	October and ongoing	DoF / HoC

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 6: Maintain excellent quality, operational and financial performance			DIRECTOR LEAD: Director of Operations & Transformation				DATIX REF: 905		
STRATEGIC RISK 10: If we do not continually support, lead and prioritise improved quality, operational and financial performance we will not provide safe, efficient and effective cancer services			RISK RATING:						
			Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	Score at Year End	Final Risk Target
			Moderate	Moderate					Low
			I4 xL3 = 12	I4 xL3 = 12					I4 x L2=8
CQC DOMAIN: Safe, Effective, Caring , Responsive and Well-led			ASSURANCE SUB-COMMITTEE TO REVIEW: Operational Services Development ASSURANCE COMMITTEE TO REVIEW: Finance & Business Development						
 <p>Legend: Risk Score Score at Year End Final Risk Target</p>			RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.						
			RATIONALE FOR RISK: The risk recognises the critical importance of delivering high levels of quality, operational and financial performance and the potential for these to be impacted during a period of significant transformational change.						
			RATIONALE FOR CURRENT RISK SCORE: This risk is not currently materialising and CCC is delivering against quality, operational and financial metrics. However the potential for future disruption as we move further into the TCC programme remains, therefore this risk is scored as medium.						
CONTROL SYSTEM									
REF:	CONTROL SYSTEM:		GAP IN CONTROL:		ACTION PLAN:		DEADLINE:		OWNER:
10.1	Executive Leadership to maintain operational, financial and quality leadership and delivery is the Director of Operations and Transformation. This Directors of Nursing, Finance and the Medical Director lead on the professional strategy and standards and there is therefore a collective leadership and accountability for the success of this objective.		The permanent Executive Director of Finance role is vacant.		The Board has recruited a temporary Executive Director of Strategic Finance and an Acting Director of Finance is also in place to fulfil this role with the right skills and experience. A process to recruit a permanent executive director to fulfil this objective will commence following the appointment of a permanent Chief Executive.		January 2019		CEO
10.2	The senior leadership is the Associate Director of Operations, Associate Director, Quality, and the acting Deputy Director of Finance, Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service.		The Deputy Director of Finance role is acting DoF.		A temporary acting Deputy Director of Finance is in place until the above is implemented.		January 2019		CEO
10.3	The strategic direction approved by the Trust Board confirms the ambition and plan to be and retain best performing ranking at Trust level and deliver best outcomes throughout its services.		The IPR need to be more forward-looking and comprehensive to provide the necessary assurance that the Trust remains on track to delivery its strategic objective of best in class.		Develop the IPR to provide a forward-looking and comprehensive assurance report to confirm to the Board that best performance is on track and the risks to delivery including the necessary strategic and operational action to take to mitigate the risks.		July 2019		DOT
					Fully developed IPR led by DOT and in collective leadership with the Associate Directors for Quality, Finance and Chief Information Officer.		January 2019		DOT ADO ADQ ADF
					Floor to Board reporting of information enhanced and a plan in place to further enhance in all service lines for 19/20		January 2019		DOT CIO ADO
10.4	The Operational Plan approved by Trust Board confirms the ambition and operational deliverables to achieve the requirements of top performing organisation.		To make substantial progress to implement the well-led improvement plan agreed by the Board, September 2017.		A task and finish group led by the ICEO to make substantial progress to implement the well- led improvement plan. This is to include a Board development session on the latest well-led requirement and a Board self-assessment using the evidence and PIR. The resource implications to ensure the right infrastructure to respond to the challenges and gaps is approved and implemented.		October 2018		ICEO
10.5	The governance structure is clear; the assurance is to the Finance & Business Development Committee by the Operations Service Development Sub-Committee. The floor to Board flow from floor to Board is from the operational, quality and finance departments.		The floor to board flow of information is in place but needs to be enhanced to reflect best practice and be integrated so a comprehensive overview of all standards are consistently communicated and a balanced scorecard operates at floor to board.		Action is as described in 10.3				

10.6	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	These are in place, however, these need education and training to embed consistent and sustainable application. The directors to lead this development to fit with the approval of the strategies by the Board. January 2019	The Finance & Business Development Committee will receive assurance from the Operational Services Sub- Committee of the work progressed on the education and training of staff by better results in faster and consistent initiation of escalation and appropriate and timely action.		DOT ADO
ASSURANCES					
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
10.7	Weekly Trust operational group outcomes, actions and minutes:	Timeliness and data quality regarding Haemato-oncology performance	Review of plan with RLUHT regarding Haemato-oncology data	October 2018	CIO ADoO
10.8	Monthly trend analysis regarding cancer waiting times (CWT) Monthly CWT Performance Improvement Plan Weekly PTL review MIAA report – Significant Assurance (re CWT)	There are no gaps in assurance			
10.9	Monthly Directorate meetings that includes monthly performance reports from: <ul style="list-style-type: none"> Finance, Clinical Governance Team, Activity, Workforce & OD re sickness, absence and mandatory training compliance 	Enhance data quality	Directorates to implement a separate Safety & Quality meeting (monthly) Review rotas to ensure staff can attend meeting. Chemo / Radiotherapy / HO services utilise daily safety huddle / team meeting to standardise information.	Oct 2018 July 2018	DoO&T
		Format of Integrated Care Dept Directorate meetings not aligned to standard format of other directorates	Revised version of the IPR will shape and inform all Directorate Agendas	Sept 2018	ADoO
10.10	Revised and refresh of Integrated Performance Report (monthly)	Enhance content of the IPR to improve flow of information from Floor to Board	Substantial progress at July, fully completed by Sept	Sept 2018	ADoO
10.11	Quality and safety meeting across all clinical directorates	Need to embed new meeting structure and flow of information and items that require escalation	All Directorates have meeting dates in diary – GM's and CD's	July 2018	ADoO
10.12	Daily Safety Huddles: Wards, Chemotherapy, Clinics and OPD	There are no gaps in assurance			
10.13	Monthly Operational Delivery and Business Development Committee – minutes / actions	Functions of this meeting and Terms of Reference require review to improve assurance process	Director of Operations & Transformation to review and agree with senior operations team	August 2018	DoO&T
10.14	F&BD Committee – supporting Directorate ability to deliver financial plan	Need to enhance the process to demonstrate benefits realisation for the investment in the workforce.	Process established but needs strengthening.	October 2018	DoO&T / ADoO DoF
10.15	Quality & Safety Sub-Committee in place	Increased frequency of reporting required.	Training to support the Quality & Safety governance process to be finalised and increase the frequency of reporting.	October 2018	DDoO
10.16	Patient feedback via FFT, national in patient survey, local departmental surveys	Patient feedback very positive, however, volume of completed FFT low	FFT to be completed via hand held electronic device to enable immediate feedback and areas of poor uptake	July 2018	ADO/ADQ
10.17	Quality & Safety Sub Committee in place	Increased frequency of reporting not in place	Frequency of Quality Committee currently under review and revised schedule to be implemented 2019.	January 2019	HoCG
	Quality Committee in place	Training to support the Quality & Safety governance process to be finalised	Risk management training for all senior level staff currently being implemented to ensure consistency of approach	September 2018	ADoQ
		Deputy Director of Nursing & Education to be appointed	Recruitment process currently underway, interviews planned by September	September 2018	DoN
	Frequency of reporting reviewed				
	Floor to Board Governance review	Governance co-ordinators in Directorates to be approved and recruited	Revised structure currently being reviewed and options to be considered by Executive Team	December 2018	ADoQ
	Quality & Safety Chairs report				
	Risk Committee				
	CQC Insight report (external)				

BOARD ASSURANCE FRAMEWORK DASHBOARD 2018/19

Strategic Priority	BAF Risk	Sub-Committee	Director Lead	Risk score 01.04.18	Risk Score Q1	Risk Score Q2	Risk Score Q3	Risk Score Q4	2018/19 Risk Target	2018/19 Risk Target Gap	Final Risk Target	Final Risk Target Gap
SP 1 Deliver outstanding care	1. If we do not the optimise quality outcomes we will not be able to provide outstanding care	Quality & Safety	MD	9 Moderate	9 Moderate						9 Moderate	
	2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	Ops Del & Service Imp	DoO&T	16 High	16 High						12 Moderate	
	3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home	Infrastructure	DoF	12 Moderate	12 Moderate						12 Moderate	
SP2 Retain and develop our outstanding staff	4. If we do not have the right innovative workforce solutions including education and development we will not have the right skills, in the right place, at the right time to deliver outstanding care	Workforce	DoW&OD	16 High	16 High						12 Moderate	
	5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce	Workforce	DoW&OD	16 High	16 High						12 Moderate	
SP 3 Invest in research and innovation	6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	Quality & Safety	MD	16 High	16 High						12 Moderate	
	7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future	Quality & Safety	MD	12 Moderate	12 Moderate						12 Moderate	
SP 4 Collaborative system leadership	8. If we do not retain system-wide leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	Board Development	ICEO	12 Moderate	12 Moderate						9 Moderate	
SP5 Be enterprising	9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	Infrastructure / Finance	ICEO	12 Moderate	12 Moderate						6 Low	
SP5 Maintain excellent performance	10. If we do not continually support, lead and prioritise improved quality, operational and financial performance we will not provide safe, efficient and effective cancer services	Ops Del & Service Imp	DoO&T	12 Moderate	12 Moderate						8 Low	