

BOARD OF DIRECTORS MEETING

Agenda Item	P1/109/18	Date: 31st October 2018
Subject /title	Enhanced Board Assurance Framework	
Author	Ann Highton,	
Responsible Director	Ann Farrar, Interim CEO	
Executive summary and key issues for discussion		
<p>The Board Assurance Framework has been reviewed.</p> <p>The Board Assurance Framework has been subject to a significant review for the period Quarter 2.</p> <p>The risks which appear on the framework have been reviewed by the individual Executive Directors having lead designated responsibility.</p> <p>The Board Assurance Framework has subsequently been reviewed collectively by the Governance and Compliance Sub Committee as well as the Audit Committee. The Quality Committee have reviewed the specific quality and safety strategic risks, assurances and mitigations.</p>		
Risk Ref	Risk description	Explanatory narrative
1.2	If we do not optimise 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.	<p>Risk is rated as being high due to the Trust Board having not yet signed off a detailed 2 year workforce and financial plan that gives the Trust Board assurance of significant control.</p> <p>It is expected that that the rating will reduce at the end of the financial year. The Trust will have a more detailed plan in place to close any potential gaps between income and capacity activity and workforce.</p>
2.4	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	This is rated as high as the workforce plan requires further work and development to establish a level which will confirm the required skills going forward.
2.5	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	This is rated as high due to the Organisational Development Strategy being signed off at the October

	and attract the right workforce	Trust Board; thereafter the implementation plan will be managed by the workforce subcommittee which is focussed on staff health and wellbeing and positive staff engagement.
3.6	If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	This risk is rated high due to the challenges relating to complex inter-operability and digital transformation presenting a risk to the delivery of optimal patient outcomes and operational effectiveness

1. Risks ref no 1.1 is running at its final risk target rate. Due to the continually changing nature of the risks they have been kept on the Quarter 2 BAF in order to maintain Board oversight. This has been discussed and approved at the relevant committees and sub-committees and noted on the chairs reports as appropriate.

2. The BAF has been scrutinised at the following committees/groups:
Audit Committee on 22nd October 2018
Governance and Compliance Subcommittee on 17th October 2018

The committees reviewed the details of the risk profile to determine the degree of assurance which can be provided to the Board; these committees have provided assurance to the Trust Board through their Chairs Reports and minutes of meetings.

3. The following changes have been made to the Quarter 2 BAF compared to Quarter 1.

- Risk ref 2.1: Action due date for action 4 changed from December to January 2018

4. There are no new risks on the BAF.

5. No risks have been removed from the BAF and placed on the Corporate risk register

6. No risks have increased in rating

7. No risks have reduced in rating.

8. A training session has been arranged for December 12th for the Trust Board to agree the organisational risk appetite. This session will be facilitated by an independent expert.

Strategic context and background papers (if relevant)								
It is good governance to have a Board Assurance Framework in order to assist the Board have oversight and manage risk.								
Recommended Resolution								
The Trust Board is asked to acknowledge the assurance provided through the Board committees and approve the risk profile identified on the Board Assurance Framework for Quarter 2.								
Risk Ref 1.2								
N/A								
Link to CQC Regulations								
Regulation 17: Good Governance.								
Resource Implications								
Not directly for this paper.								
Key communication points (internal and external)								
Ensure staff are aware of the main strategic risks for the organisation.								
Freedom of Information Status								
<p>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.</p> <p>Application Exemptions:</p> <ul style="list-style-type: none"> • Prejudice to effective conduct of public affairs • Personal Information • Info provided in confidence • Commercial interests • Info intended for future publication 	<p>Please tick the appropriate box below:</p> <table border="1" style="margin-left: 20px;"> <tr> <td style="text-align: center;">X</td> <td>A. This document is for full publication</td> </tr> <tr> <td style="text-align: center;"> </td> <td>B. This document includes FOI exempt information</td> </tr> <tr> <td style="text-align: center;"> </td> <td>C. This whole document is exempt under FOI</td> </tr> </table> <p>IMPORTANT:</p> <p>If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.</p> <p>Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.</p>		X	A. This document is for full publication		B. This document includes FOI exempt information		C. This whole document is exempt under FOI
X	A. This document is for full publication							
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Equality & Diversity impact assessment								
Are there concerns that the policy/service could have an adverse impact because of:	Yes	No						
Age		X						
Disability		X						
Sex (gender)		X						
Race		X						
Sexual Orientation		X						
Gender reassignment		X						
Religion / Belief		X						
Pregnancy and maternity		x						

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

Next steps

The BAF will be subject to a Quarter 3 review and the Trust Board will be kept updated on its status.

Appendices

Appendix 1 – BAF Dashboard

Strategic Objectives supported by this report

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

Link to the NHS Constitution

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

Appendix A. Directorate Risk Case Studies

A Risk Escalation Journey from Radiation Services, Chemotherapy, Integrated Care and Haemato-oncology Directorates.

1. Radiation Services Directorate - ID851

Risk	2 Incident panels both had elements of incorrect patients being referred for Imaging examinations and the ease with which the incorrect patient can be chosen on Meditech has been described as a risk. There are no system controls in place on meditech to prompt user to double check they have the correct patient
Controls in place	<ul style="list-style-type: none"> • Application of the Trust patient ID policy • Reinforce importance of adherence to the Trust Patient ID policy. • Meditech training • Safe staffing levels • Audit of application of the policy • Justification process in Imaging and Radiotherapy
Actions Taken	<ul style="list-style-type: none"> • Incidents included in Team Brief • Incidents reported at MAC • Written confirmation obtained from each Clinical Oncologist that ID policy has been read and understood • Alert added to Meditech on all Diagnostic Imaging and Electronic Action Sheets to check patient demographics in line with Trust policy prior to submission. Displays ID of patient selected and states “PAUSE AND THINK – Is this the correct patient”. Does not allow submission until alert is acknowledged.
Initial Risk Grading	20
Current Risk Grading	12
How the risk was identified	Incidents
Who identified the risk	The Consultant in both cases realised that the referral for imaging investigation had been made in the incorrect patient record. Incident reports completed
How the risk was reported	Added to the Risk Register
How the risk was escalated	Escalated as a Corporate Risk
Risk open/closed	Open

2. Chemotherapy Directorate – ID 761

Risk	<p>Cause: Protocols for SACT treatment & leaflets are not developed and approved by the SRG in a timely manner, not updated onto key document sources such as the intranet and Meditech.</p> <p>Effect: Protocols are not available for other institutions to reference to from an AO perspective. Patient information leaflets not always available from Macmillan. Most importantly nursing staff do not always have access to the most up to date protocols.</p> <p>Impact: Potential patient harm by incorrect protocol being used. Delays to patient treatment.</p>
Controls in place	Pharmacist verification and pharmacists available 24/7 for pharmaceutical advice. Nursing staff utilise this service readily. SACT committee process mapping complete, group being set up & protocols uploaded to website
Actions Taken	A protocol project has been implemented to manage the process and ensure that consistent, timely and accessible. Whole systems approach to ensure adequate review. SACT Protocols pharmacist recruited.
Initial Risk Grading	12
Current Risk Grading	15
How the risk was identified	The risk was identified following a serious incident review which involved a review of the protocol process.
Who identified the risk	Chief Pharmacist
How the risk was reported	Initially by an incident and as an outcome of the serious incident review and then risk added to Risk Register.
How was the risk escalated	Escalated as a corporate risk when grading was increased to 15.
Risk open/closed	Open

3. Integrated Care Directorate – ID 885

Risk	There was an unpredictable, aggressive inpatient who had several episodes of becoming agitated and aggressive towards staff. This highlighted a security risk as no security attended or contacted the ward when they were called out of hours. Staff were informed that security does not cover CCC Wirral at weekends and therefore they would not respond to a 300 bleep call.
Controls in place	Extra staffing put in place
Actions Taken	Business case developed to provide additional security cover.
Initial Risk Grading	15
Current Risk Grading	12
How the risk was identified	Incident

Who identified the risk	Ward Staff
How the risk was reported	Risk added to Datix
How was the risk was escalated	Incidents reported and then risk added to risk register
Risk open/closed	Open

4. Haemato-oncology Directorate – ID 893

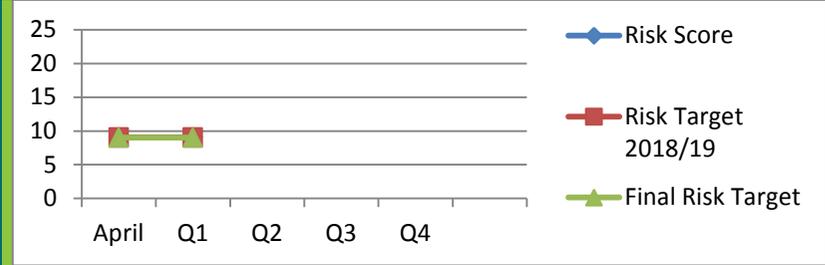
Risk	Temperatures in medicines storage areas are above recommended 25C. CCC HO Tem is storing medicines outside of recommended temperatures. This can result in degradation of the medications
Controls in place	Temp monitoring. QCNW algorithm to reduce expiry of products if stored above a certain temp for a specific time period.
Actions Taken	Options for cool down units explored. Risk assessment of fluid storage completed Review of expiry dates
Initial Risk Grading	15
Current Risk Grading	15
How the risk was identified	Spot check completed
Who identified the risk	Chief Pharmacist/Clinical Governance Manager
How the risk was reported	Reported as a risk on the risk register
How was the risk was escalated	Added as a corporate risk
Risk open/closed	Open

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 1: Deliver outstanding care as locally as possible	DIRECTOR LEAD: Medical Director	Datix Reference: 898
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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	2018/19 Risk Target	Final Risk Target 2022
	Moderate	Moderate	Moderate			Moderate	Moderate
	I3 x L3 = 9	I3 x L3 = 9	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
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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.	November 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-refreshed 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 March 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

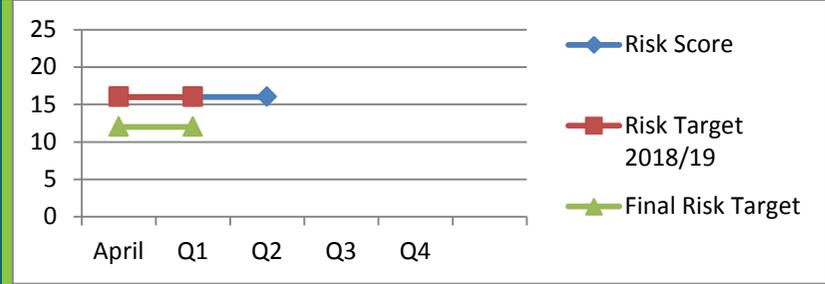
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
1.8	Staffing for Quality &. Safe staffing reported to Unify (external)	There are no gaps in assurance			
	Grant Thornton audits for finance and quality.				
	Workforce Review Group				
	Workforce and business plans				
	E-rostering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

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
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STRATEGIC RISK 2: If we do not optimise 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	2018/19 Risk Target	Final Risk Target 2022
	High 14 x L4 = 16	High 14 x L4 = 16	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 the Director of Finance who provides the long-term financial context, strategic financial implementation plan.	The permanent Director of Finance post is vacant.	To recruitment process for an Executive Director of Finance is on track. In the meantime, this role is covered by a Director of Strategic Finance and an Acting Director of Finance. This fits the capacity and skills of the DoF in the short term.	Dec.2018	ICEO
2.2	The senior leadership is the Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service and there is now a revised and better senior leaders forum effective from September, 2018.	No gaps in control.			ICEO 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 and this is described in the 3-year plan 18/19-20/21.	The scale of the clinically-led transformation opportunities is greater than the original business case for the new-build. Senior leaders are committed to maximising this potential hence a comprehensive and prioritised strategic implementation plan (2018-2022) is required.	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. 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.	Dec. 2018	DO&T MD
			The Trust Board and senior leaders to conclude the discussions about the potential strategic options for the short to medium-term (2018-2022). The initial deadline has been extended to January to ensure full compliance.	March 2019	DO&T DoF
			The strategic implementation plan has been implemented within the long-term resources and the trajectory over time has been met.	Jan. 2019	ICEO
2.4	The strategic direction includes headline strategic financial outcomes and KPIs and these are regularly reported to the Trust Board via the Finance & Business Development Committee and the Quality Committee.	No gaps in assurance.	Refresh process through the business planning round	March 2022	DO&T DoF
	Strategic and operational finance outcomes over a 3-year rolling programme are embedded floor to board.			October 2018	DO&T DoW&OD MD
2.5	The escalation of risk is defined with trigger points and enhanced	No gaps in assurance			

processes to address concerns in line with the 3-year rolling finance plan.

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
2.6	Trust Board approved Business Plan 2018/19 to 20/21 including 3-year Capital investment Plan.	Gaps in workforce plan aligned to finance and activity for 2019/20 and 2020/21 now clinical model has been further refined	3- year plan to Board, first draft by October and final draft by December.	October 2018	DoO&T
2.7	Senior Leaders Forum Agenda and outcomes: 17/18 and 18/19. Infrastructure Sub-committee Agenda and minutes 18/19 Finance Sub-committee Agenda and minutes 18/19 Operational Delivery & Business Development-committee Agenda and minutes 18/19 reporting to the FBDC Finance & Business Development Committee Agenda and minutes Strategic finance report to the Trust Board, October 2018	No gaps in assurance			ICEO DoF DoF DT&O DT&O DoF
2.7	Final Business Case for Transforming Cancer Care approved by Trust Board in 2016	A robust governance process regarding the e delivery of the TCC agenda required	Attain reviewing governance arrangements for PMO , report to board to be delivered.	Oct 2018	DoF
2.8	Business Cases approved by the Finance & Business Development Committee of the Board 18/19	Clinical model and business case for hospital at night required. Interventional Radiology BC requires further development.	Produce the business case for Board consideration by October and decide on implementation. Radiation Services Directorate developing IR BC	October 2018	DoO&T & DoF

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

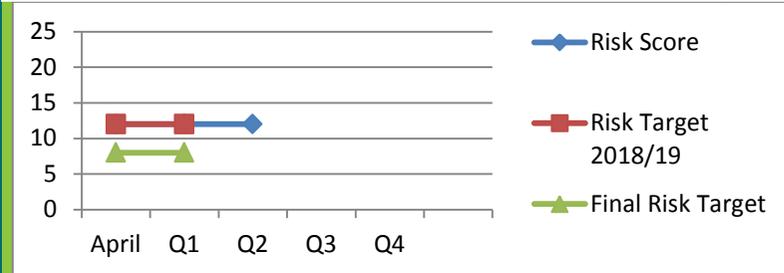
RISK RATING:

Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	2018/19 Risk Target	Final Risk Target 2022
Moderate	Moderate	Moderate			Moderate	Low
14 x L3 = 12	14 x L3 = 12	14xL3=12			14 x L3 = 12	14 x L2 = 8

CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led

ASSURANCE SUB-COMMITTEE TO REVIEW: Infrastructure Committee

ASSURANCE COMMITTEE TO REVIEW: Finance & Business Development Committee



RISK APPETITE RATIONALE: To be confirmed following the Board Development session during quarter 3.

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.

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.

CONTROL SYSTEM

REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:	DEADLINE:	OWNER:
3.1	<p>Executive Leadership for the estates strategy and SIRO responsibilities is the permanent Director of Finance role.</p> <p>The Chief Information Officer is accountable for the IM&T strategy and reports to the DoF for the delivery of the SIRO duties.</p> <p>The Medical Director leads the development and implementation of the digital care strategy the in partnership with the Chief Information Officer.</p> <p>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.</p> <p>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.</p>	<p>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.</p> <p>None major medical equipment was not included in the review of the medical equipment required for the new hospital</p>	<p>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.</p> <p>A lead for medical equipment that is not capital (value of less than 5k) has been identified .The lead will produce a report to the major medical equipment (MME) group regarding " non – major" medical kit requirements for the new hospital. Terms of reference for the MME Group will be revised to include the monitoring of all medical equipment.</p>	<p>June 2019</p> <p>November 2018</p>	<p>CEO</p>
3.2	<p>There is an estates strategy that supports the transformation of cancer care in general and new build of the Cancer Centre in Liverpool in particular. .</p>	<p>The estates strategy does not fit our strategic direction for more care to be provided locally by local hospitals closer to home.</p> <p>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 opening date.</p>	<p>To refresh the estates strategy to respond to the Trust's clinical strategy for care closer to home over the timescale 2019- 2021. PropCare have been commissioned to draft the updated strategy. This is now expected to be completed by November 2018, with subsequent progression up through the Trust's governance structure.</p> <p>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 safe, effective and affordable services are provided in the new build despite the temporary absence of the planned adjacency to the Royal. Initial scoping work has commenced, with an update on</p>	<p>October 2018</p> <p>October 2018</p>	<p>DoSF</p> <p>PropCare Managing Director</p>

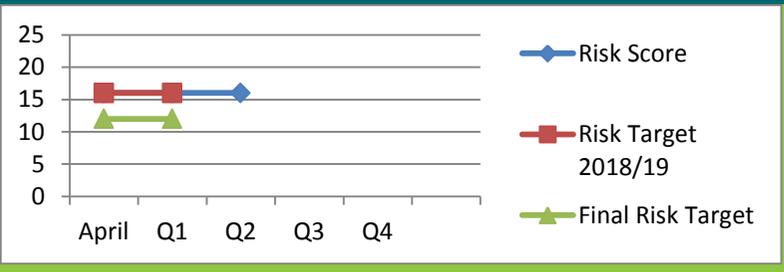
			progress to the October Infrastructure Committee. A detailed assessment will be taken through the Trust governance structure in January, 2019.		
		The office accommodation, car parking and travel and transport requirements to enable optimal delivery of the strategic care model and resources to be defined, resourced and implemented.	The operational requirements to be assessed, options considered, staff engaged and a recommendation to the Finance & Business Development Committee.	March 2019	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	October	EDoSF and PropCare
3.10		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 will go to Digital Board in November and will be shared via Infrastructure Committee and to Trust Board in January 19. Delay is in line with work required around business and clinical intelligence. Work commenced Oct18.	Q3	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	2018/19 Risk Target	Final Risk Target 2022
High		High	High	High			High	Moderate
14 x L4 = 16		14 x L4 = 16	14 x L4 = 16	14 x L4 = 16			14 x L4 = 16	14 x L3 = 12
		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) and a new Director of HR&OD commences in post 3 rd December 2018.	No gaps in control.			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.	Oct 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	Triple A reports now in use by the committee for reporting to Quality Committee and the Board		A Staff Engagement Steering group is established which reports into the Trusts Workforce Committee	September 2018	DoW&OD
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. On track for end October 2018.	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. On track for end October 2018.	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. On track for end October 2018.	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. On track for end October 2018.	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 Clinical Education strategy required to ensure skills development and growth to develop and retain current staff and attract the future workforce.	Workforce plan and narrative to be produced by Directorates Attain commissioned to support the full review and production of 3 year workforce plans. 3 year workforce plan to be approved at extraordinary Board in October 2018. Workforce plans will require at least annual review to take account of emerging plans e.g. Living with and beyond cancer. On track for end October 2018.	October 2018	DoW&OD
4.11	Directorate performance reviews to include workforce data				
4.12	PADR (appraisal) process in place	No Gaps in assurance	Development and delivery of E-PADR for roll out April 2019.	March 2019	DoW&OD
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. On track for end October 2018.	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	Cycle of business requires review	Reviewed and updated cycle of business to WOD Committee	December 2018	DoW&OD
4.18	Review of Workforce Sub-Committee Terms of Reference	No gaps in assurance	WOD Committee ToR to be reviewed Further review agreed at WOD committee in September 2018 to incorporate additional sub committees and review cycle of business	December 2018	DoW&OD
4.19	Reports from Workforce Sub-Committee, Quality Committee, Board	No gaps in assurance			
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	2018/19 Risk Target	Final Risk Target 2022
		High	High	High			Moderate	Low
		I4 x L4 = 16	I4 x L4 = 16	I4 x L4 = 16			I4 x L3 = 12	I4 x L2 = 8
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 &	No gaps in assurance						ICEO

	Organisational Development (DHR&OD) and a new Director of HR&OD commences in post 3rd December 2018. The Trust Board is highly effective 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 recent changes to the Board, the new executive team has a range of highly experienced directors who are cohesive with clarity on the delivery of the strategic and operational objectives.	The Trust Board has a series of development sessions as part of the revised board planning cycle to support the continued successful delivery of the Board's objectives and values.	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 Draft OD strategy is to be presented to the Trust Board in October and reflects best practice and leading-edge approaches aligned to the highly transformational change in cancer services. This includes the first cut of the planned resources from 19/20 which require to be prioritised as part of the 3-year plan 19/20 -21/22. Staff engagement score remains steady at 3.96	March 2019	ICEO DoW&OD MD DoN
			Staff engagement score improves to at least 4	June 2019	DoW&OD
			Staff engagement score improves to at least 4.10	June 2020	DoW&OD
5.4	A Freedom to Speak Up Policy supports an open and honest culture that encourages staff to speak up about any concerns of patient care, quality or safety.	Audit required to test awareness of all staff and manager understand of Freedom to speak up	Freedom to Speak Up Policy (Jan 2018-2021)	September 2018	DoW&OD
5.5	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
5.6	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 meaningful staff communication and engagement measures that demonstrate the added value of the communication service contribution or OD measures.	There is commitment to shift The CCC from a regional trailblazer to a global brand recognising its substantial added value to cancer tertiary care and its major contribution to the Cheshire & Mersey system.	A new strategic communication strategy to match this need is commissioned to be developed.	January 2019	ADC&E
5.7	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
5.8	Focus staff survey action plan on stress. Stress task and finish group established				
5.9	Retention report to be monitored at the Workforce Sub-Committee on a bi-monthly basis to include 2 year leavers				
ASSURANCES					
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
5.7	Stress Policy Audit plan and progress reports to the Quality Committee.	Stress continues to be highest reason for absence	None identified		
5.8	Sickness absence deep dive report and improvement plan and progress reports to the Quality Committee.	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 to Workforce Committee	Gaps identified to understand leavers at 2 years	None identified		
5.10	Occupational Health SLA performance reports	No gaps in assurance	OH quarterly performance reports incorporated within the WOD Committee Cycle of Business	December 2018	DoW&OD
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

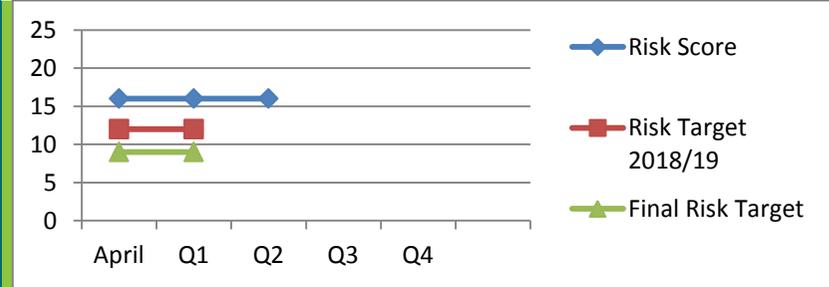
5.12	Introduction of Vivup – staff benefits system	Roll out of EAP, lease cars and financial support outstanding	Roll out of phase 1 Vivup in July 2018	December 2018	DOW&OD
5.13	Staff survey results – positive staff engagement – 3.96 (external assurance). Improvement Plan approved by the Board, July 2018 and regular update on progress to Quality Committee.	No gaps in assurance	Full and complete roll out of scheme Improvement Plan approved by the Board, July 2018. Regular update on progress included in WOD cycle of Business and updates to Quality Committee.	March 2019	DoW&OD
	Draft Trust Organisational Development strategy. Engagement sessions at Board level and senior leaders and Strategic Partnership to co-produce the draft strategy, 18/19	No gaps in assurance	Approval of OD strategy at October Trust Board	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
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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	2018/19 Risk Target	Final Risk Target 2022
	High 14 x L4 = 16	High 14 x L4 = 16	High 14 x L4 = 16			Moderate 14 x L3 = 12	Moderate 13 x L3 = 9

CQC DOMAIN: Safe, Effective, Caring, Responsive & 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: 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 Research Governance Committee 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	First assurance review in July 18. Assurance outcome	First assurance review to be fed through Digital Board	September 18	CIO

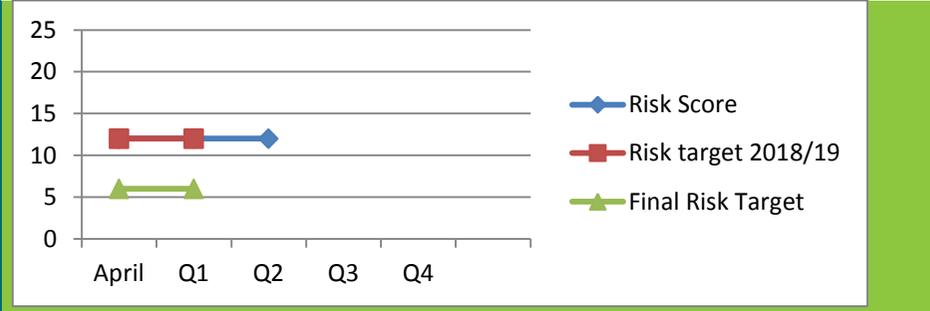
	Exemplar Fast Follower (GDE FF) programme	to be fed through Digital Board and Infrastructure Committee	and Infrastructure Committee. Completed		
	Digit@all digital strategy across Cheshire and Merseyside launched on 5/7/18 supports CCC way of working	Clear narrative to Feed through Infrastructure Committee	Report at Infrastructure Committee. To be reported at Infrastructure Committee in October. Formal reporting of digital reporting will continue to 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	MD
	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. Formal reporting is now in place with attendance in place from July and formal reporting to Quality and safety Sub Committee from October 18	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
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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	2018/19 Risk Target	Final Risk Target 2022
	Moderate I3 x L4 = 12	Moderate I3 x L4 = 12	Moderate I3 x L4 = 12			Moderate I3 x L4 = 12	Low I2 x L3 = 6

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 and senior leadership is two Clinical Directors for Research and an Associate Director.	There are no gaps in control however there is an ask by the Trust Board to ask is the leadership configuration best fit for the delivery of the strategy in the longer-term.	The Medical Director to review with colleagues and recommend the best configuration to the Trust Board.	October 2018	MD
7.2	The executive director for Innovation is the Director of Operations & Transformation and senior leadership is the Associate Director of Strategy.	The Associate Director of Strategy role is part-time and there is need to enhance this contribution to best fit the needs of the scale and significance of the TCC.	To recommend and engage on a new role and operating system for TCC and recruit the right skills and capacity into the Trust.	March 2019	DT&O
7.3	The Trust Board approved a strategic direction and outcomes for Clinical Research and appropriate resources for 3-years, July 2018.	No gaps in assurance.			MD
7.4	The current OD strategy commits the Trust to a change management methodology for the Transforming Cancer Care Programme. The draft OD strategy, 2018-2022 recommends how best to roll-out the principle of the improvement methodology to be the norm for our quality improvements. This will enhance reliability and resilience in the implementation of improvements	The need for a Trust-wide quality improvement methodology that is the norm by all staff. Proactive promotion of innovation implementation and positive results including celebration of recognition.	Proposed approach and resources to be included in the draft OD strategy. This will involve an investment in an enhanced system with the appropriate resource and this will be included in the 2019-2022 3-year financial plan.	March 2019 March 2022	DoW&OD
7.5	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	No gaps in assurance for clinical research. Gaps in assurance for innovation	An external company is commissioned to produce an enhanced governance system for the TCC and the recommendations are being implemented to demonstrate in a highly visible process the reporting of the objectives and trigger points.		DT&O

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
7.6	Clinical research strategy approved by the Board, July 2018	No gaps in assurance			MD
7.7	ECMC status achieved and research strategy supports longer term ambition to retain status.	No gaps in assurance			
7.8	Strategic and operational objectives and their outcomes reported to the Quality Committee flowing from the Research Governance Committee to the Q&S sub-committee.	System further developing to embed floor to board clinical research at site tumour group and clinical directorate level.	Part of the site tumour group development plan 18/19 and the clinical research strategy. Dashboard on improvement measures for each STG.	January 2019	ADR
7.9	Academic Health Sciences Network: NWC Network reported outcomes to our Trust Board, 2018	Gap in assurance, performance of the NWC Network benchmarked against other NIHR Networks	Improvement plan that addresses long term success for the Network equal to middle to top	April 2021	CEO

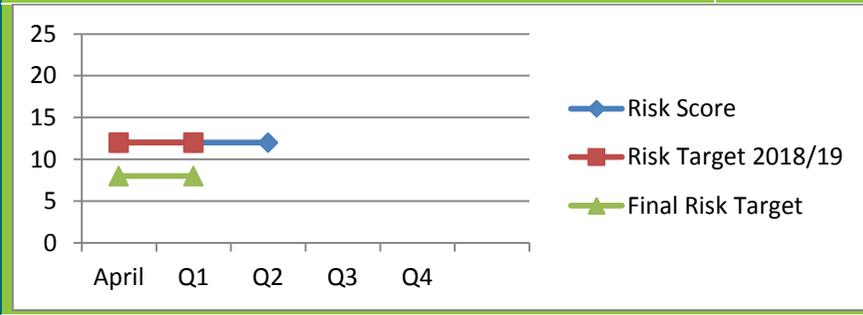
7.10	Proposed outstanding practice Trust-wide QI methodology to the Trust Board via Draft HR and OD Strategy	No gaps in assurance	Delivered as part of the OD Strategy.		DHR&OD DT&O
7.11	Evidence of promotion of services and recognition by local, regional and national in place in the chief executive reports to the Trust Board and inclusion in our Trust website.	To enhance from a strongly recognised regional brand to a global brand.	Determine measures of success through the co-production of the draft strategic communication & engagement strategy.	January 2019	ADC&E
7.12	Independent assurance of Innovation and TCC programme presented to our Trust Board, 2018	Gaps in assurance highlighted.	To be addressed during 2018/19 with an enhanced and more resilient system with greater capacity and capability to match the ambitious strategic direction 2018-2022.	March 2019	DT&O

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 4: Collaborative system leadership to deliver better patient care	DIRECTOR LEAD: Interim Chief Executive	DATIX REF: 903
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STRATEGIC RISK 8: If we do not enhance our system-wide leadership and significantly contribute the Cheshire & Merseyside Health & Care Partnership we will not have the right influence on the strategic direction to deliver outstanding cancer services and wider economic re-generation to improve health and well-being 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	2018/19 Risk Target	Final Risk Target 2022
	Moderate	Moderate	Moderate			Moderate	Low
	14 x L3 = 12	14 x L3 = 12	14 x L3 = 12			14 x L3 = 12	14 x L2 = 8

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 Director of the Cancer Alliance reports to the SRO, Cancer Alliance.		The Chair and the interim CEO have the support of the C&M systems management board and are in the process of requesting regional and national support.	December 2018	Chair Interim CEO
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.	The Cancer Alliance is a national trailblazer however, there is more opportunity to enhance population outcomes across C&M with an ambition to reduce variation and deliver world class outcomes over the next 10 years.	The draft strategic ambition was considered by the Cancer Alliance and C&M Systems Management Board and approved subject to amendments to be recommended to the Trust Board.	October 2018	ICEO AD Strategy
			The C&M system management board agreed that the Cancer Alliance produce a 10-year cancer services strategy in line with the NHS Plan commitment.	October 2019	ICE AD Strategy DCA
8.5	Board members are externally focused and have a range of high priority system wide relationships and collaborations to significantly contribute to improved health and well-being and economic re-generation of the C&M system.	The Trust performs best in class in staff and public engagement. A similar assessment of the opinion of external stakeholders is required to ensure the Board members and senior clinicians influence and lead across the C&M system.	To seek the views of our external partners so the Trust has a baseline and responds with an action plan to build better positive and highly effective relationships contributions.	December 2018	ADCE&M
			External relationship engagement score has improved year on year from moderate to best in class.	October 2022	ICEO ADCE&M
8.5	To retain Trust status and maximise the benefits of greater collaboration to ensure the long-term success of our cancer services for our local population.	Trust strategy 2018-2022 approved by the Trust Board to set out not only the direction of travel but the added value the Trust contributes to the longer term success of the C&M system.	To work in partnership with the system leaders in C&M 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.	October 2019	Chair Interim CEO AD strategy
8.6	The Chief Executive report to the Trust Board confirms the operating system and escalation of risk.	No gaps in assurance			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	No gaps in assurance.			ICEO
8.8	Chief Executive overview of the effective collaboration of the Trust within the C&M system noted at the Trust Board, 2018.	No gaps in assurance			

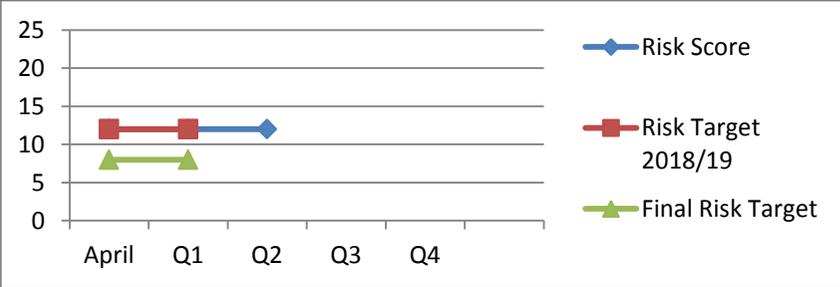
8.9	External stakeholder relationships regarding collaboration leadership on system wide outcomes	Building on the public consultation and public opinion outcome, determine a baseline and process of regular review	Assurance commissioned and report expected	Dec 2018	ICEO
8.10	Draft Strategic Direction Development approved by the Trust Board. Engagement programme on the draft strategy, feedback and the report to Trust Board.	No gaps in assurance			ICEO

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 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	2018/19 Risk Target	Final Risk Target 2022
	Moderate 14 x L3 = 12	Moderate 14 x L3 = 12	Moderate 14 x L3 = 12			Moderate 14 x L3 = 12	Low 14 x L2 = 8

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 Executive Director of Finance.	The permanent post is vacant.	The recruitment process is on track for interviews on 3 rd November.	January 2019	CEO DoSF
9.2	There are a range of senior leadership roles to support the enterprising system, e.g., MD (Propcare), Chief Pharmacist, AD Strategy, Acting Deputy Chief Executive, MD, Clinical Directors, and AD Clinical Research.	There is a vacancy in the Associate Director of Strategy. There is a potential for Pharmacy to expand.	A recruitment process started October and is on track for interviews by January. A business case is to be presented to the Trust Board.	January 2019 October 2018	CEO DT&O MD & Chair, Pharmca
9.3	The Trust can demonstrate it has a highly valued enterprising/investment culture with investment back into patient care.	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. 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 e CCC strategic objectives. Review of successful growth opportunities and income outcomes one year on.	January 2019 January 2019 March 2020	DoSF DoSF DoSF
9.4	Regular overview of potential changes to national cancer policy, market conditions, contributions on legislative changes and clinical horizon scanning reported to the Trust Board.	A six month report to the Trust Board would provide a strategic overview.	Aim for the start and end of the Trust business planning framework to provide an external consensus to approve the Plan.	March 2019	DoSF AD Strategy
9.5	Charitable Funds Committee in place to review and monitor progress against charity appeal to raise £20m to contribute towards the new capital build.	There is a risk to the delivery of the total sum.	Review of the major donor income stream to identify opportunities and restraints to achieving target otherwise there is a risk the strategic objective will not be achieved on time.	October 2018	DoF/ HoC

ASSURANCES

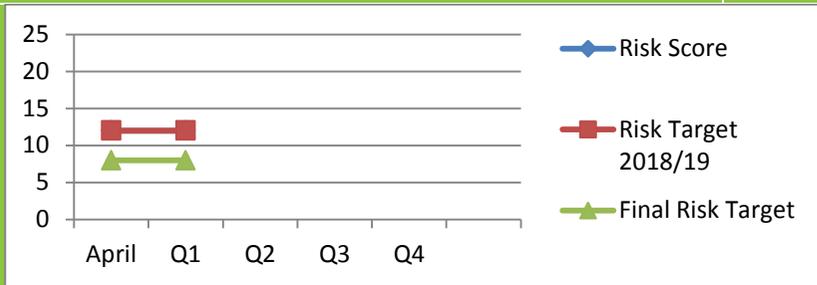
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
9.10	PPU JV Board meetings reported to the Trust Board	There are no gaps in assurance.			MD, The Mater.
9.12	PropCare Board meetings reported to the Trust Board	There are no gaps in assurance.			
9.13	Trust Estate Strategy	In development	Under development and will reflect measureable actions to assess future performance	Oct 2018	EDoSf and MD PropCare
9.14	CPL Board meetings reported to the Trust Board including strategic objectives.	Refresh strategy and business plan under development	To be completed by CPL and CCC to demonstrate future growth ambitions across the STP	Sep 2018	EDoSf and Chief Pharmacist
9.16	Charitable Funds Committee meetings reported to the Trust	Major donor engagement	Charitable Funds Committee to monitor progress against appeal	March 2019	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
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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 to an outstanding standard.	RISK RATING:						
	Original score 1.4.18	Score at Q1	Score at Q2	Score at Q3	Score at Q4	2018/19 Risk Target	Final Risk Target 2022fc
	Moderate	Moderate	Moderate			Moderate	Low
	I4 xL3 = 12	I4 xL3 = 12	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
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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 is the Director of Operations and Transformation. The senior leadership is the Associate Directors Clinical Directors, General Managers, Matrons, and Heads of Service.	The permanent Executive Director of Finance role is vacant but appropriate capacity and skills are in place in interim roles.	The recruitment of the Executive Director of Finance is on track.	January 2019	CEO
10.2	The strategic direction and operational plan to deliver an outstanding performance outcome was approved by the Trust Board, March 2018. To make substantial progress to implement the well-led improvement plan agreed by the Board, September 2017.	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. No gaps in assurance	Fully developed IPR led by DOT and in collective leadership with the Associate Directors for Quality, Finance and Chief Information Officer.	January 2019	DOT&O ICEO
10.5	The Trust Board receives assurance via the Finance & Business Development Committee by the Operations Service Development Sub-Committee. Floor to Board flow of information is in place.	The floor to board flow of information to be enhanced to reflect best practice.	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&O
10.6	The escalation of risk is defined with trigger points and enhanced processes to address concerns.	The corporate risk register and BAF to be enhanced and formally reported via the first line sub-committees of the Trust Board.	The directors to lead this development with appropriate training to the directorates.	March 2019	DOT&O ADO
10.7	Directorates to implement a separate Safety & Quality meeting to provide enhanced focus. Chemo / Radiotherapy / HO services utilise daily safety huddle / team meeting to standardise information. This is on track. Data included in IPR.	None identified	None identified		

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
10.7	Trust operational group outcomes, actions and minutes reported to Operational Services Sub-committee.	Timeliness and data quality regarding Haemato-oncology performance	Review of plan with RLUHT regarding Haemato-oncology data. This is on track for end October 2018	October 2018	CIO ADoO
10.8	Monthly cancer waiting times reported to the Trust Board. MIAA report – Significant Assurance.	There are no gaps in assurance			
10.9	Monthly Directorate meetings that includes reports on Finance, Clinical Governance Team, Activity, Workforce & OD re sickness, absence and mandatory training compliance.	Enhance data quality		Oct 2018	DoO&T
		Format of Integrated Care Dept Directorate meetings not aligned to standard format of other	Revised version of the IPR will shape and inform all Directorate Agendas. This is in place.	Complete	ADoO

		directorates			
10.10	Integrated Performance Report to the Trust Board	No gaps in assurance			ADoO
10.11	Quality and safety meeting for the clinical directorates. Quality & Safety Sub-Committee reports to Trust Board.	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
10.12	F&BD Committee report demonstrates Directorates control and grip of the financial plan.	Need to enhance the process to demonstrate benefits realisation for the investment in the workforce.	Process established but needs strengthening.	October 2018	DT&O ADoO DoF
10.13	Corporate risk register highlights the operational high risks that require the support of the Trust Board.	As part of the development plan embed within the subcommittee reports to the Trust Board.		October 2018	