



Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	24 April 2019	
Agenda Item:	P1-080-19	
Title:	Board Assurance Framework	
Report prepared by:	Angela Wendzicha, Associate Director of Corporate Governance	
Executive Lead:	Liz Bishop, Chief Executive	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	N/A
Date & Decision:	

Purpose of the Paper/Key Points for Discussion:	<p>The Board Assurance Framework has been updated to reflect 2018/19 Quarter 4 performance.</p> <p>The Quarter 3 BAF Dashboard reported 3 High risks, 6 Moderate and 1 Low risk. For Quarter 4 the position is the same with no change in ratings or risk scores.</p> <p>The approach to the format, scope and content of the BAF is being revised as part of the broader Corporate Governance review. Following consultation with the Executive team, the revised BAF (Quarter 1) will be presented to the Board in July 2019</p> <p>No new BAF risks have been raised or removed from the BAF.</p>
---	--

Action Required:	Discuss	X
	Approve	
	For Information/Noting	X

Next steps required	The format, scope and content of the BAF will be reviewed as part of the broader Governance review and recommendations provided to Board in due course.
---------------------	---

The paper links to the following strategic priorities (please tick)

Deliver outstanding care locally		Collaborative system leadership to deliver better patient care	
Retain and develop outstanding staff		Be enterprising	
Invest in research & innovation to deliver excellent patient care in the future		Maintain excellent quality, operational and financial performance	

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	√
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.	√
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.	√
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 the outstanding care.	√
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.	√
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	√
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.	√
8. If we do not retain system-side 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.	√
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.	√
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.	√

Equality & Diversity Impact Assessment		
Are there concerns that the policy/service could have an adverse impact on:	YES	NO
Age		X
Disability		X
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 a full impact assessment is required.

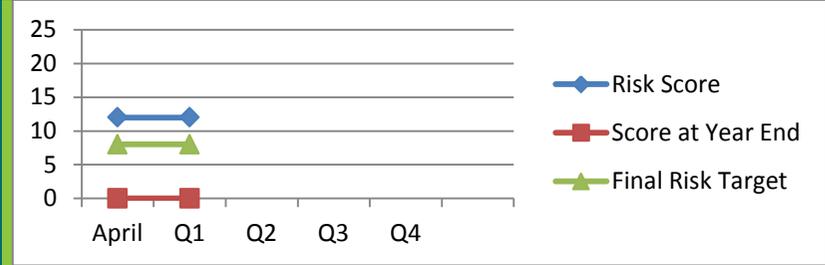
Strategic Priority	BAF Risk	Sub-Committee	Director Lead	Risk score 01.04.18	Risk Score Q1	Risk Score Q2	Risk Score Q3	Risk Score Q4	2018/19 Risk Target
SP 1 Deliver outstanding care	1. If we do not the optimise quality outcomes we will not be able to provide outstanding care	Integrated Governance Committee	MD	9 Moderate	9 Moderate	9 Moderate	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.	Performance Review Group	I DoO & MD PropCare	16 High	16 High	16 High	16 High	16 High	16 High
	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	Capital & Infrastructure Group	DoF	12 Moderate	12 Moderate	12 Moderate	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, Education & OD	DoW&OD	16 High	16 High	16 High	12 Moderate	12 Moderate	16 High
	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, Education & OD	DoW&OD	16 High	16 High	16 High	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.	Integrated Governance Committee	MD	16 High	16 High	16 High	12 Moderate	12 Moderate	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	Integrated Governance Committee	MD	12 Moderate	12 Moderate	12 Moderate	9 Moderate	9 Moderate	12 Moderate
SP 4 Collaborative system leadership	8. If we do not enhance our system-wide leadership and significantly contribute to 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 regeneration to improve health & well-being for the population of Cheshire & Merseyside.	Board Development	CEO	12 Moderate	12 Moderate	12 Moderate	6 Low	6 Low	12 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.	Capital & Infrastructure Group / Finance Committee	CEO	12 Moderate	12 Moderate	12 Moderate	12 Moderate	12 Moderate	12 Moderate
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	Performance Review Group	DoO&T	12 Moderate	12 Moderate	12 Moderate	16 High	16 High	12 Moderate

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	2018/19 Risk Target	Final Risk Target 2022
	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
	13 x L3 = 9	13 x L3 = 9	3x3=9	3x3=9	3x3=9	13 x L3 = 9	13 x L3 = 9

CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led **ASSURANCE SUB-COMMITTEE TO REVIEW:** Integrated Governance Committee
ASSURANCE COMMITTEE TO REVIEW: Quality



RISK APPETITE RATIONALE: To be reviewed by the Board.

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.	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 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 – Quality Strategy due to be presented to the Quality Committee in May 2019. 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
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 review.	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 – revised governance structure in shadow form has superseded this action.	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

			<ul style="list-style-type: none"> Overall process for risk escalation is being reviewed as part of the broader Governance review including new CEO Chaired Risk Management Committee 		
1.7	CCC delivers a single service model for the whole of Cheshire & Merseyside enabling a consistent level of high quality care.	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

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
1.8	Staffing for Quality & Safe staffing reported to Unify (external) Grant Thornton audits for finance and quality Workforce Review Group Workforce and business plans E-rostering assurance reports	There are no gaps in assurance			
	Quality & Performance reports and key indicators Medical workforce reviewed at Medical Advisory Committee (MAC)	Activity module of e-roster system to be developed. There are no gaps in assurance	Consideration to this development during 18/19.	October 2018	AD Quality
1.9	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 Quality risks standards against NHS Resolution standards Quality contract meetings with Commissioners (external) Safeguarding Sub Committee	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 – due for presentation to the Quality Committee in May 2019.	October 2018 March 2019	AD Quality DoN.
1.10	CCC Strategy sets direction, Board of Directors oversight New clinical model in place reported via the Operational Delivery and Services Improvement Sub-committee. Transformation of Cancer Care plans aligned to Cancer Alliance and Cheshire & Merseyside Cancer Strategies reported via the Operational Delivery and Services Improvement Sub-committee. Cancer Alliance hosted at CCC reported via the Operational Delivery and Services Improvement Sub-committee.	There are no gaps in assurance New model of care to be finalised.	Transforming cancer care programme assurance being strengthened	October 2018	Deputy CEO
1.11	Quality & Safety Committee Chair's report Quality Committee in place Risk Management Committee Report to the Quality & Safety Sub-Committee CQC Insight report	Better assurance report by the sub-committee to the Quality Committee implemented.	New report on enhanced governance and assurance being strengthened – <ul style="list-style-type: none"> Revised Governance Structure in shadow form in place and will supersede this action when review of governance approach has completed 	January 2019	DoN MD AD Quality
	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 – <ul style="list-style-type: none"> Revised Governance Structure in shadow form in place and will supersede this action when review of governance approach has completed 	October 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 Health and Safety audits reported via Health & Safety Committee Quality surveillance reports Datix system for incident and risk reported via Risk Management Committee Serious incident reporting framework reported via Risk	There are no gaps in assurance			

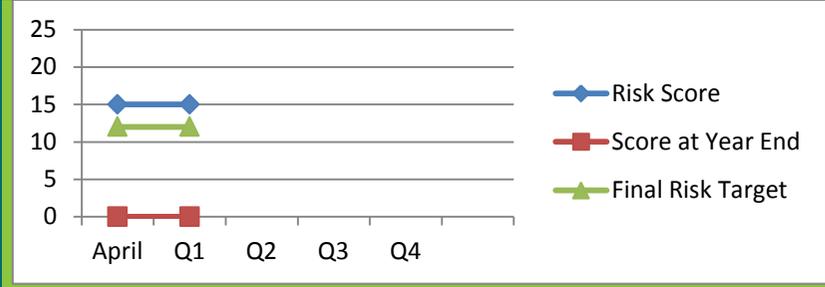
	Management Committee				
	Serious incident reporting meeting with commissioners reported via Risk Management Committee				
	CQUINN quality standards				

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 1: Deliver outstanding care as locally as possible	DIRECTOR LEAD: Interim Director of Operations	DATIX REF: 899
--	--	-----------------------

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 4x4=16	High 4x4=16	High 14 x L4= 16	Moderate 14 x L3 = 12

CQC DOMAIN: Safe, effective, responsive and well-led	ASSURANCE SUB-COMMITTEE TO REVIEW: Performance Review Group
ASSURANCE COMMITTEE TO REVIEW: Performance Committee	



RISK APPETITE RATIONALE: To be reviewed by the Board.

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.

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 Operations & Transformation left the Trust on 10 April 2019.	New Finance Director in post on 1 February 2019. Interim Director of Operations appointed and MD of PropCare will lead the TCC Programme.	Dec.2018	CEO
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 leader's forum effective from September, 2018.	No gaps in control.			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 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.	Trust Board to approve strategic direction and 3 Year Operational Plan –	Dec. 2018	DO&T MD
			<ul style="list-style-type: none"> Strategic Direction approved in Oct 2018 3 Year Operational Plan approved by the March 2019 Trust Board 	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). The strategic implementation plan has been implemented within the long-term resources and the trajectory over time has been met.	Dec 2018	ICEO
2.4	The strategic direction includes headline strategic financial outcomes and KPIs and these are regularly reported to the Trust Board via the Performance Committee and the Quality Committee.	No gaps in assurance.		October 2018	DoOT DoF DoW&OD MD
	Strategic and operational finance outcomes over a 3-year rolling programme are embedded floor to board.	This is work that needs to be implemented			
2.5	The escalation of risk is defined with trigger points and enhanced processes to address concerns in line with the 3-year rolling finance plan.	No gaps in assurance			

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	Trust Board to approve strategic direction and 3 Year Operational Plan –	October 2018	DoO&T
			<ul style="list-style-type: none"> Strategic Direction approved in Oct 2018 3 Year Operational Plan approved by the March 2019 Trust Board 		

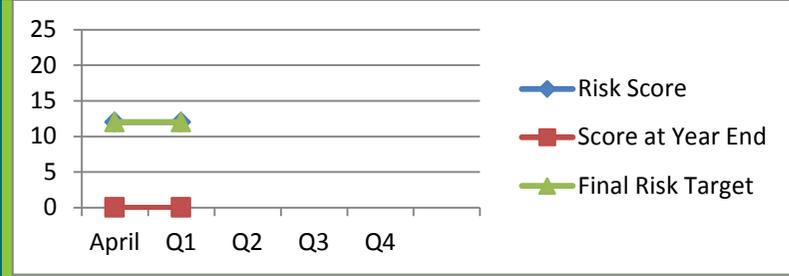
2.7	Senior Leaders Forum Agenda and outcomes: 17/18 and 18/19.	No gaps in assurance			ICEO
	Infrastructure Sub-committee Agenda and minutes 18/19				DoF
	Finance Sub-committee Agenda and minutes 18/19				DoF
	Operational Delivery & Business Development-committee Agenda and minutes 18/19 reporting to the FBDC				DoO
	Performance Committee Agenda and minutes				DoO
Strategic finance report to the Trust Board, October 2018					DoF
2.7	Final Business Case for Transforming Cancer Care approved by Trust Board in 2018	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. Trust Board to approve strategic direction and 3 Year Operational Plan – <ul style="list-style-type: none"> Strategic Direction approved in Oct 2018 3 Year Operational Plan approved by the March 2019 Trust Board 	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	Moderate	Moderate	Low
14 x L3 = 12	14 x L3 = 12	4x3=12	4x3=12	4x3=12	14 x L3 = 12	14 x L2 = 8	

CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led	ASSURANCE SUB-COMMITTEE TO REVIEW: Capital & Infrastructure Group
ASSURANCE COMMITTEE TO REVIEW: Performance Committee	



RISK APPETITE RATIONALE: To be reviewed by the Board.

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>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>June 2019</p>	<p>CEO</p>
	<p>None major medical equipment was not included in the review of the medical equipment required for the new hospital</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>November 2018</p>	<p>None</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>To refresh the estates strategy to respond to the Trust’s clinical strategy for care closer to home over the timescale 2019- 2021</p>	<p>October 2018</p>	<p>DoSF</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>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.</p>	<p>October 2018</p>	<p>PropCare Managing Director</p>	
	<p>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</p>	<p>The operational requirements to be assessed, options considered, staff engaged and a recommendation to the Finance & Business Development Committee via the.</p>	<p>March 2019</p>	<p>ADoO</p>	
			<p>Implementation of requirements to ensure the new build in</p>	<p>Spring 2020</p>	<p>ADoO</p>

		implemented.	Liverpool is safe delivery on day one.		
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 DoO
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

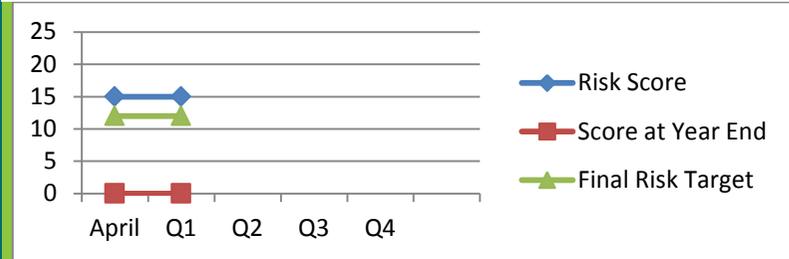
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
3.6	Infrastructure Committee ToR, Board Minutes and Actions	Needs fixed agenda item reporting on capital programme (build and equipment)	Make fixed agenda item for ongoing meetings – in 2019/20 this will fall under the new Capital & Infrastructure Group.	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 14 x L4 = 16	High 14 x L4 = 16	High 14 x L4 = 16	Moderate 3x4=12	Moderate 3x4=12	High 14 x L4 = 16	Moderate 14 x L3 = 12

High
14 x L4 = 16 **ASSURANCE SUB-COMMITTEE TO REVIEW:** Workforce, Education & OD Committee
ASSURANCE COMMITTEE TO REVIEW: Quality



RISK APPETITE RATIONALE: To be reviewed by the Trust Board.

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.
January 2019 – Following review by Director of HR overall risk score reduced.

CONTROL SYSTEM

REF:	CONTROL SYSTEM	GAP IN CONTROL:	ACTION PLAN:	DEADLINE:	OWNER:	
4.1	Executive Leadership is the Director of Workforce & Organisational Development – new Director started 10 Dec 2018. The Director works in partnership with the Exec Team to produce and deliver a range of strategies including clinical workforce and education strategy.	No gaps in control.				CEO
4.2	The senior leadership is the senior HR leaders, Clinical Directors, General Managers, Matrons, Associate Directors and Heads of Service.	No gaps in 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	
			<ul style="list-style-type: none"> Workforce & OD Strategy approved by Trust Board in Oct 2018, with implementation plans for both presented to the March 2019 Trust Board. Monitoring will be provided by the new Workforce & OD Committee with bi-annual progress reports to Trust Board. Education Strategy to be presented to the Trust Board in June 2019 for approval. 			
			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	March 2020	DoW&OD	

			months ahead of the opening of the new build in Liverpool. There is the right workforce in place for the planned shift of care closer to home for day and outpatient services. We are recognised in the staff survey as an outstanding Trust that invests in innovative workforce solutions, professional development and career progression	March 2022 March 2022	MD, DoN & DO&T
			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 – <ul style="list-style-type: none"> The Workforce and OD Strategies progress will be monitored through WEOD Committee and bi-annual reports to Trust Board. 	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, Education & OD 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 refreshed – <ul style="list-style-type: none"> Overall process for risk escalation is being reviewed as part of the broader Governance review including new CEO Chaired Risk Management Committee. 	July 2018 October 2018	DoW&OD

ASSURANCES

REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
4.6	Workforce & Organisational Development (OD) Strategy	No gaps – action complete	Revised Strategy to be developed – completed on time	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 and against KPIs to be included on Workforce, Education & OD Committee from April 2019	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 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. Education Strategy in development – to be presented to the June 2019 Trust Board	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	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 WEOD Committee to be discussed in April 2019	December 2018	DoW&OD
4.18	Review of Workforce Sub-Committee Terms of Reference	No gaps in assurance	WEOD Committee TOR under review – to be presented to April 2019 WEOD Committee	December 2018	DoW&OD
4.19	Reports from Workforce Sub-Committee, Quality Committee, Board	No gaps in assurance	Triple A reports now in use by the committee for reporting to Quality Committee and the Board	September 2018	DoW&OD

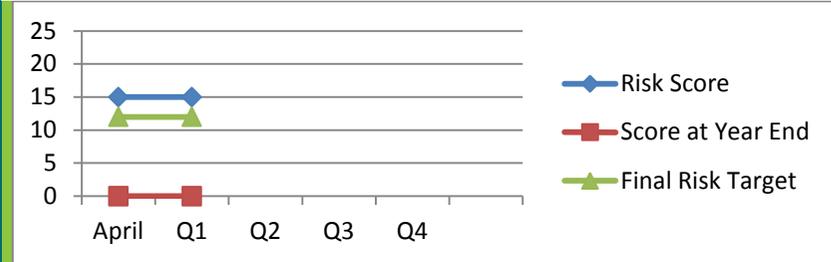
4.20	Restructure of Workforce & OD department	Medical workforce cover / support not fully embedded	Joint action plan with Clinical Directors / General Managers to address gaps in support and review policies and processes	December 2018	DoW&OD
------	--	--	---	---------------	--------

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 14 x L4 = 16	High 14 x L4 = 16	High 14 x L4 = 16	High 4x4=16	High 4x4=16	Moderate 14 x L3 = 12	Low 14 x L2 = 8

CQC DOMAIN: Safe, Effective, Caring, Responsive and Well-led	ASSURANCE SUB-COMMITTEE TO REVIEW: Workforce, Education & Organisational Development Committee		
	ASSURANCE COMMITTEE TO REVIEW: Quality		



RISK APPETITE RATIONALE: To be reviewed by the Trust Board.

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 score reduced slightly in 2018 staff survey, indicating that this is an area requiring continued focus.

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) and a new Director of Workforce, Education & OD commenced in post on 3 December 2018.	No gaps in assurance				CEO
	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 have 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 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 Exec Team and expectation of the Board.	March 2019	CEO 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 OD Strategy was approved by the Oct 2018 Trust Board and the implementation plan for the strategy was presented to the March 2019 Trust Board and noted. This will be monitored through the WEOD Committee with bi-annual progress reports provided to the Trust Board.	March 2019	ICEO DoW&OD MD DoN	
			Staff engagement score remains steady at 3.96	June 2019	DoW&OD	
			Staff engagement score improves to at least 4	June 2020	DoW&OD	
			Staff engagement score improves to at least 4.10	June 2022	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 Strategy discussed at a September 2019 Board Development Session and subsequently approved by the February 2019 Trust Board. The Policy is next due for review in Nov 2019. Re-launch of Freedom to Speak Up was delivered in early 2019 with confirmation of Lead Guardian and Guardians	September 2018	DoW&OD	

			across the Trust. Regular reports on concerns will be provided to the Quality Committee with an annual report provided to the Trust Board.		
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 - <ul style="list-style-type: none"> Overall process for risk escalation is being reviewed as part of the broader Governance review including new CEO Chaired Risk Management Committee. 	January 2019	DoW&OD ADCEM

ASSURANCES

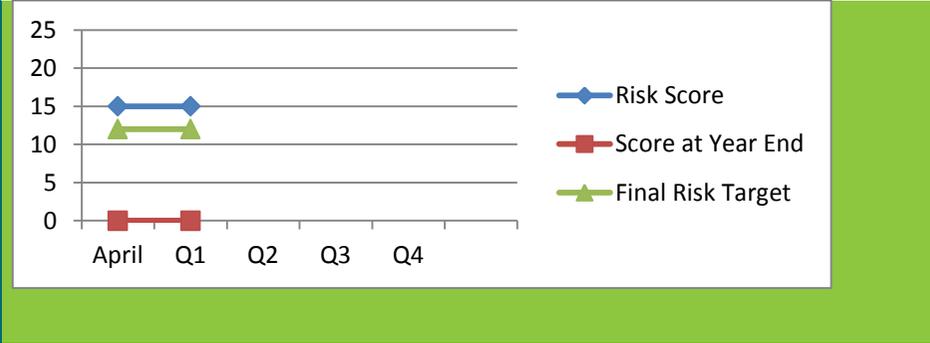
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
5.7	Stress Policy Audit plan and progress reports to the Quality Committee.	Stress continues to be highest reason for absence	Focus staff survey action plan on stress. Stress task and finish group established	October 2018	DoW&OD
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	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	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 – Employee Assistance Programme has been offered to staff on the waiting list for counselling.	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 Full and complete roll out of scheme	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	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 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
--	--	-----------------------

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 I4 x L4 = 16	High I4 x L4 = 16	High I4 x L4 = 16	Moderate 4x3=12	Moderate 4x3=12	Moderate I4 x L3 = 12	Moderate I3 x L3 = 9

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 reviewed and finalised at the March 2019 Board.

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. including new CEO Chaired Risk Management Committee	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				

ASSURANCES

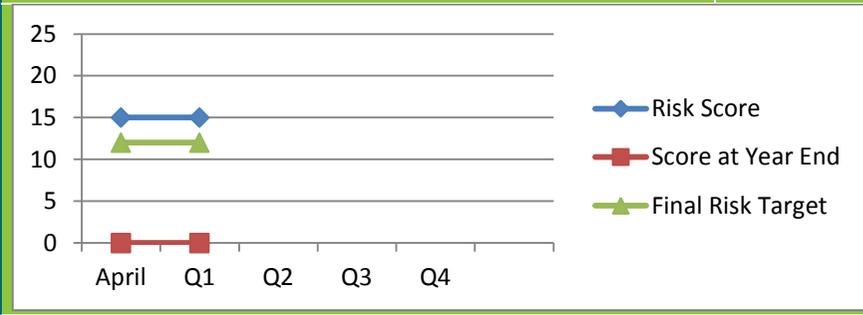
REF:	POSITIVE ASSURANCE:	GAP IN ASSURANCE:	ACTION PLAN:	DEADLINE:	OWNER:
7.6	Clinical research strategy approved by the Board, July 2018	No gaps in assurance			MD
7.7	ECMC status achieved and research strategy supports longer term ambition to retain status.	No gaps in assurance			
7.8	Strategic and operational 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: Chief Executive	DATIX REF: 903
---	---------------------------------------	-----------------------

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	Low	Low	Moderate	Low
	14 x L3 =12	14 x L3 = 12	14 x L3 = 12	3x2=6	3x2=6	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: Performance Committee



RISK APPETITE RATIONALE: To be reviewed by the Board.

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 original moderate risk score was because the C&M wider system did not have a 5-10 year cancer plan led co-produced with system-wide leaders. The new CEO has been appointed as the SRO for the Cancer Alliance and work to date, in discussion with the CEO, reduced the risk rating to Low from January 2019.

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.	No gaps in control.		December 2018	Chair 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	CEO 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	CEO 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	CEO 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 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			CEO

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.			CEO
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			

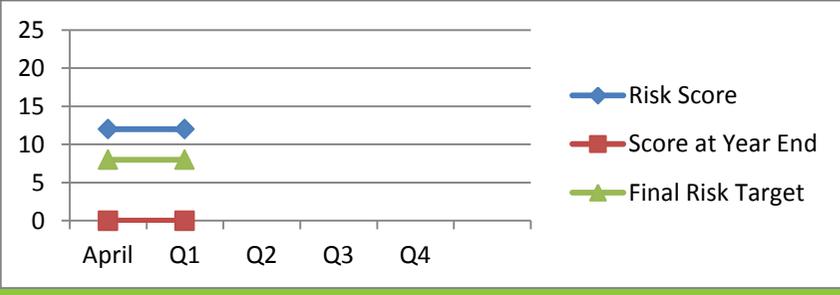
8.9	External stakeholder relationships regarding collaboration leadership on system wide outcomes	Building on the public consultation and public opinion outcome, determine a baseline and process of regular review	Assurance commissioned and report expected	Dec 2018	ICEO
8.10	Draft Strategic Direction 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: 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 4x3=12	Moderate 4x3=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: Capital & Infrastructure Group and Finance Committee
ASSURANCE COMMITTEE TO REVIEW: Performance Committee



RISK APPETITE RATIONALE: To be reviewed by the Board.

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.	No gaps in control – DoF in post 1 Feb 2019		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.	No gaps in control – all key roles appointed including support for Chief Pharmacist		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 CCC strategic objectives. Review of successful growth opportunities and income outcomes one year on.	January 2019 January 2019 March 2020	DoF DoF DoF
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 – the frequency of reporting to the Board is to be formalised to 2-3 times a year and included in the Trust Boards planning cycle.	March 2019	DoF 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.	Substantial review of the major donor income stream in place to identify opportunities and restraints to achieving target otherwise there is a risk the strategic objective will not be achieved on time. The review will be led by the Exec Director.	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 Matar.
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	DoF and MD PropCare
9.14	CPL Board meetings reported to the Trust Board including		To be completed by CPL and CCC to demonstrate future growth	Sep 2018	DoF and

	strategic objectives.		ambitions across the STP – the strategic direction was presented to the Trust Board on 1 March 2019 and approved by the Board.		Chief Pharmacist
9.16	Charitable Funds Committee meetings reported to the Trust Board.	Major donor engagement	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 – On going risk – Committee in 2019 requested a review of the major donor strategy.	March 2019	DoF / HoC

BOARD ASSURANCE FRAMEWORK 2018/19

STRATEGIC PRIORITY 6: Maintain excellent quality, operational and financial performance

DIRECTOR LEAD: Interim Director of Operations

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 to an outstanding standard.

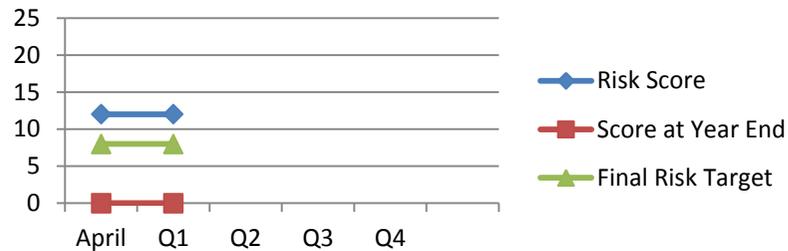
RISK RATING:

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	High	High	Moderate	Low
I4 xL3 = 12	I4 xL3 = 12	4x3=12	4x4=16	4x4=16	I4 xL3 = 12	I4 x L2=8

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

ASSURANCE SUB-COMMITTEE TO REVIEW: Performance Review Group

ASSURANCE COMMITTEE TO REVIEW: Performance Committee



RISK APPETITE RATIONALE: To be reviewed by the Board.

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. January 2019 – This risk has increased to High

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.	No gaps in control		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 DoO&T and in collective leadership with the Associate Directors for Quality, Finance and Chief Information Officer. Revised IPR in development with progress made. Further work to do to enhance further.	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 – revised governance approach in place from March 2019 – to be approved by the Board in early 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 <ul style="list-style-type: none"> Overall process for risk escalation is being reviewed as part of the broader Governance review – includes a new CEO Chaired Risk Management Committee 	March 2019	DOT&O ADO

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	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	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.	Oct 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. This is in place.	Sept 2018	ADoO
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	