Strategic Objective 1 – To ensure that all care is rated amongst the top 20% nationally for patient safety, clinical outcomes and patient experience			
Corporate objectives	**Owner**	**Status**	**Exception Report**
1.1 To comply with (a) Care Quality Commission and (b) Monitor requirements to maintain licence to practice	CE	**G**	The status box for this risk has been divided to differentiate between CQC (green) and Monitor (red) requirements. COSSR will reduce to 1 by the end of the year and the Trust declared the risk of breaching the A&E waits target and Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral). Monitor has opened an investigation. The financial recovery plan and 'faster flow, safer care' transformation plans in place will receive thorough scrutiny through EMC and Board Committees.
		R	
1.2 To ensure sustainable delivery of national standards and targets and CQUIN targets	DoNPE/DDs	**A**	One sub-objective is rated amber. For more information on the A & E target please see 1.1.
1.3 To implement year 2 of the dementia strategy	DoNPE	**G**	All sub objectives are green. It will not be possible to deliver simulation training staff in dementia, however, new proposals have been approved. A post to support improvements in dementia has now been recruited to and an earlier start date negotiated. The 2 other sub-objectives relating to the dementia strategy are on track.
1.4 To ensure an active quality improvement programme	DoNPE/MD	**A**	The model for quality improvement is being developed. The next steps are to finalise the model and to raise the profile across the organisation.
1.5 To review and restructure cancer services to ensure high quality care for our patients	MD	**G**	
1.6 To address quality of care issues associated with the environment through implementation of year one of the Trust Estates Strategy	DoF	**A**	One sub-objective is rated green but one is red and one is amber. The Outpatients works have experienced further delays since the last report. The effect of this is assessed as 18 weeks. The causes vary but currently 10 weeks is associated as being the Trust's responsibility with the remainder being the responsibility of the contractor. The programme is being re-prioritised so that completion of all ground floor works is achieved by Christmas 2015 and the first floor completed by mid-February 2016. Phase one of the pipe works have been slightly delayed and will be completed in October 2015.
1.7 To work towards paperlight using information technology and record management across the Trust	MD	**A**	The 80% target has been met for bands 5, 6 and 7 in many areas, however this has slipped due to staff turnover, the IST supporting clinical services and Junior Doctor assessments and sign off and a reduction in support from an external contractor which in turn has affected overall competency uptake. There has been some slippage in working to achieve these targets in Maternity and ED to achieve completion of the competencies with days commenced in early November in the ED, dates are being finalised for Maternity.
1.8 To transform administration across the hospital	COO	**A**	Four of six sub-objectives are rated amber; one is red and one is green. The administration project is behind schedule and urgent review of project resourcing is taking place with the Head of Patient Administration, and Deputy Director of Nursing to ensure that the programme regains momentum. Recruitment is underway and the COO is leading on a review of the structure.
1.9 To implement the Trusts plans to improve quality of care in line with the London Quality Standards	MD/DSD	**A**	Of two sub-objectives, one is green and the other red. As part of the recovery plan the Trust had agreed to not fund some of the planned investments. This has led to the non- delivery of some milestones.
1.10 To redesign the medical workforce and processes to ensure efficient patient flow through the organisation	COO	**A**	A Clinical Director for Emergency Medicine has now been appointed and will start in early January. The COO and Emergency Department are working on the correct workforce model and vacancies are being advertised and a Divisional Director is now in post leading the changes. A new rota and junior doctors are in place and active recruitment is underway.

Assurances and Controls			
Controls	**Positive Assurance**	**Negative Assurance**	**Gaps in Assurance/Control**
• Quality Strategy • CQC Preparation and Peer Reviews • QAC • QIC, QIWG • Clinical Audit Process • Revalidation • CNST • Dementia Strategy Delivery Group • Out of Hours Steering Group • Estates Steering Group • SLM Trios • Process to carry out Board Self Assessments • Unscheduled care improvement plan and monitoring • Quality Account • Roll out plan e-prescribing/clinical documentation • Cancer action plan • Meeting with CCG to discuss CQUIN performance • Administration Improvement Plan • Cancer Board • Cancer Lead • Quality Improvement – Projects process • Programme management system • Operational management group (national standards & targets) meeting to EMC • Quality Goals launched	• CQC Report • Maternity Survey • SHMI • Referral to Treatment targets • Data for pilot of e-prescribing and clinical documentation • CQUIN • Green Rated Clinical Audits • Quality Strategy refresh plan • Cancer performance/targets • Existing quality improvement projects and structures • Improving FFT results • Quality Improvement Seminar • Financial recovery plan • Faster flow/safer care programme	• Falls above reduction trajectory • Serious Incidents/Never Events • Red Rated Clinical Audit • Pressure ulcers • Monitor investigation • Trust at NHS England/Monitor tripartite re:A&E • Emergency Department performance target	• Quality Performance at Service Line • Inability for staff to describe Quality goals • Trust wide oversight and evidence process,database of morbidity and mortality data needs to be embedded

Link to the Corporate Risk Register: T_MAE003, T018, T028, T_EST008, T036, T021, T016, T_EST005, T031, T045

Corporate Risks relating to Strategic Objective 1 scoring 12 or over:

T031	Failure to meet Monitor requirements resulting in breach of licence	16
T_MAE003	Risk of falls resulting in harm for specific highly vulnerable patients Linked to ED012 and AM001	12
T038	Security measures including staff and patient safety may be breached due to the lack of policy, training and resources around restraint, conflict resolution, potential absconding patients, property theft and panic alarms.	12
T044	Risk of insufficient numbers of substantive nurses and/or with sufficient skills required to meet acuity/dependency and care needs of patients.	12
T040	Risks identified from the Frankham Consultancy Business Critical Review and the development of the Estates Strategy regarding the failure of engineering systems and buildings which are beyond their useful life may be realised.	12
T_RAD016	Risk of a potential CQC reportable radiation incident as a result of gamma counter camera breakdown.	12
T039	Old patient monitors may fail as they are approximately 12 years old, estimated capital cost of replacement is £2.0m phased over 4 years. The current support contractor reports that these machines are difficult to maintain due to availability of parts. Areas that require new monitors are ITU, HDU, AAU, A&E, NNU, Paeds HDU, DSU recovery, Main Theatre Recovery and monitored beds on the wards.	12

Strategic Objective 2 - To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients

Corporate objectives	Owner	Status	Exception Report
2.1 **To ensure all our staff are up to date with core (mandatory) training, have clear objectives, regular appraisal and a personal development plan reflecting our values**	DW/MD	**A**	Four of 6 sub-objectives are rated amber; 2 are green. At 13th November 2015 the percentage of appraisals completed had risen to 89% overall. Service line and departmental managers have received a list of staff with appraisal completion data for checking, and have been asked to schedule dates for completion and confirm to Divisional Director and HR Business Partners. If we continue to prioritise appraisal completion it is anticipated that 90% will be completed by November 2015. The doctors' appraisal management system is being updated and new approaches have been identified with a current rate of 75% completed. Appraisers have been identified and late appraisals for individuals are being chased up. Monthly reporting is provided to the Medical Director and Divisional Directors. New appraisers have been trained and 1:1 support provided to use e-portfolio.
2.2 **To increase staff retention by creating an environment where staff feel valued, supported and can develop, grow and thrive**	DW	**A**	Two of three sub-objectives are rated amber; one is green. Work is underway on areas including the positivity programme, staff retention action plan and training on a coaching approach to 1:1s and appraisals.

Assurances and Controls

Controls	Positive Assurance	Negative Assurance	Gaps in Assurance/Control
• Appraisal , PDP policies and procedures and monitoring • Reports to EMC • Registration and employment checks • Nursing Staffing Ratios • Leadership development and other training plans • Corporate staff development programmes • SLM • Introduction of mandatory training booklet • Manager staff feedback questionnaire • Staff appraisal questionnaire on effectiveness • Retention on effectiveness • Workforce committee • Programme of work on staff engagement • Nursing revalidation Group • Safer Staffing Group • Overseas recruitment plan • Vacancy control panel	• Staff survey • Vacancies • Objective rates • Appraisal rates • Agency spend controls • Nursing revalidation implementation plan • Agency reduction plan • Business Partners • Plans to reduce agency usage	• Staff Survey • Turnover • Agency usage • E-rostering capacity and reporting • Spend on bank and agency • Audit of appraisals • Vacancies • Nursing workforce projections-London • Delays in arrival of overseas nurses and national stopping of visas in hospitals	• E-rostering optimisation • Learning and development strategy and action plans (management development talent team) • Corporate and local induction and welcome to Trust

Link to the Corporate Risk Register: T009, T033, T038, T044, T025, T_HR009,		
Corporate Risks relating to Strategic Objective 2 scoring 12 or over:		
TO44	Risk of insufficient numbers of substantive nurses and/or with sufficient skills required to meet acuity/dependency and care needs of patients. This could also lead to the Safe Staffing guidance not being met which then has a potential for adverse local and national media coverage which could lead to harm to patients.	12
TO38	Security measures including staff and patient safety may be breached due to the lack of policy, training and resources around restraint, conflict resolution, potential absconding patients, property theft and panic alarms.	12

Strategic Objective 3 - To work creatively with our partners (NHS, Commercial and Community/Voluntary) to consolidate and develop sustainable high quality care as part of a thriving health economy for the future.

Corporate objectives	Owner	Status	Exception Report
3.1 To work closely with other providers in the local health economy, in SW London and beyond to deliver demonstrable benefits for our patients and to continually improve the health and wellbeing of the local population	CE	G	
3.2 To implement the commercial strategy	DSD	G	
3.3 To work with partners to improve the care of frail elderly across the local health economy	CE	G	All sub-objectives are green. A discharge to assess interim programme manager has been appointed. This is expected to accelerate progress with the programme.

Assurances and Controls

Controls	Positive Assurance	Negative Assurance	Gaps in Assurance/Control
• SWL Acute Providers Collaborative MOU • EOC Partnership Board (commercial documents) • Arrangements with BMI • Board strategy committee • Market Share Reports • WSTB • Richmond Outcome Based Commissioning Most Capable Providers MOU	• SWL Acute Providers Collaborative functioning with programme Director appointed, Governance arrangements & project plan developed and meetings taking place • Regular meetings of EOC partnership board in diaries, information circulated, more routinely and independent chair appointed. • Stakeholder Engagement strategy signed off by the Board and operational plan in place with quarterly reports to strategy committee • Q market share data shows stability and in specific areas market share is rising • Trust Chair, is Chair of WSTB with successes including roll out of 'discharge to assess' • Patient Involvement strategy principles signed off by the Board • Governance qualification achieved for Richmond Outcome Based Commissioning Most Capable Providers MOU following CCG review.		• Further work required to move EOC arrangements to a formal Joint Venture with strategic and commercial arrangements. • Agreement to be reached on timeline and resources for submission of detailed proposals to support Richmond OBC.

Link to the Corporate Risk Register: T007, T008, T_AC_PAT0019, T006, T012, T_MAE_AM016, T003

Corporate Risks relating to Strategic Objective 3 scoring 12 or over:

Strategic Objective 4 – To deliver sustainable, well managed, value for money services			
Corporate objectives	**Owner**	**Status**	**Exception Report**
4.1 To deliver the 2015/16 financial plan	**DDs**	**G**	Two sub-objectives of 3 are amber; 1 is green. As at the end of M5 the trust reported 85% of CIPs delivered in month and 90% year to date. The main areas of non-achievement relate to emergency services and trauma and orthopaedics in specialist services due to schemes identified at the planning stage in these areas that are no longer considered deliverable. Recovery plans have been requested in each of these areas and further action is being taken centrally to identify further schemes to help mitigate the impact.
4.2 To develop a clear recovery plan	**DF**	**G**	
4.3 To embed and further strengthen the effective functioning of service line management across the organisation	**DCE/DF**	**G**	Two sub-objectives of 5 are amber; 3 are green. We have a monthly performance management meeting for each Clinical Division, supported by key members of their teams and service lines, and members of the executive team to review performance. The first of these meetings took place on 12th August 2015; the second took place on 23rd September. We will also establish a programme of performance review meetings for each of the corporate areas. We have assigned this area an amber rating while we develop the approach further. We are in the process of enhancing performance management arrangements across all areas of the trust, both clinical and corporate. These arrangements will be refined and embedded during the early part of Q3.

Assurances and Controls			
Controls	**Positive Assurance**	**Negative Assurance**	**Gaps in Assurance/Control**
• Development of financial recovery plan focussed on ensuring that the Trust is taking all action within its control to mitigate financial risks and challenges and mapping out long-term route to financial sustainability. • Production of robust SLR information to enable service portfolio analysis to inform development of recovery and sustainability plan • Tracking of financial and operational performance against recovery plan. • Appropriate intervention to ensure that	• Reliable and timely information provided to FIC and the Board • Demonstrable understanding of position on a monthly basis including variations to plan and mitigations for any gaps • Development and sharing of appropriate balanced scorecards • Service Lines achieve accreditation according to plan. • PMO in place all CIPS have QEIAs, cross-cutting and income CIPS monitored through Project Monitoring	• Unforeseen and unexplained departures from plan • Any audit reports of a limited assurance • Activity significantly above or below plan • Non-pay costs higher than plan • Formal intervention by Monitor	• Unexplained variations in performance compared with the plan / recovery plan • Lack of robust Service Level analysis compromising ability to make longer-term investment/disinvestment decisions

performance is maintained and improved. • Regular reviews of financial forecasts to ensure they remain current and realistic. • Regular management accounts worked up in association with Service Lines that feed a cycle of reporting through sub-committees to FIC/Trust Board • Financial information crosschecked with performance information. • Robust management of the recovery programme, feeding into a regular reporting cycle to the Trust Board	Group. • Submission of credible plans and returns to FTFF and Monitor in a timely fashion. • All internal audits are rated 'adequate' or better. • Establishment of robust monthly performance management meetings.		

Link to the Corporate Risk Register:
T037, T002, T032, T_IG005,T035, T_EST026

Corporate Risks relating to Strategic Objective 4 scoring 12 or over:

T002	Failure to deliver the Trusts long term productivity programme Linked to GS004	16
T037	Implementation of the 'Better Care Fund' agenda results in a significant net financial deficit to the Trust and/or inability to meet quality targets e.g. waiting times	12
T032	Transition to SLM: Establishing Devolved Structure Transition to SLM could lead to reduction in control (e.g. performance / finance) and other priorities getting pushed back. This is exacerbated by the fast pace Link to SLM009,SLM011, SLM010 and SLM012	12
T_IG005	Risk of ICO fines through data breaches e.g. handover sheets not being properly disposed of, emails being sent to incorrect destinations	12