REPORT TO THE TRUST BOARD - PUBLIC
14 SEPTEMBER 2017

Title	Performance and Compliance Report: July 2017 - Month 4
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Purpose of the Report:

This report provides assurance to the Trust Board on Trust-wide performance and compliance matters for the period 1st April 2017 – 31st July 2017.

Summary of Key Issues:

Data gathered for the reporting period indicates that Trust's first quarter 2017/18 return for the Single Oversight Framework has been rated as **Segment 2.** See section 2 of this report for details.

Data gathered for month four is shown in section 4 of this report and at Directorate level in the SDB and Directorate reports. A summary of the areas of non-achievement against target is outlined in this report.

Supporting Documents and Research material:

	Description	Frequency
1.	**Board Assurance Framework**	**Bi - Monthly - SDB** **Bi-monthly – Trust Board**

Strategic priorities this paper supports:

Improving service user satisfaction	☒	Via reporting progress on national/local performance and contractual targets
Improving staff satisfaction	☒	Via reporting progress on delivery of national and local workforce targets
Maintaining financial viability	☒	Via confirming delivery of NHS Improvement Risk Assessment Framework requirements

Committees/Meetings where this item has been considered:

Date	Committee and assurance coverage
14th September 2017	This report is submitted to the Trust Board. This report is based on July/YTD activity data received by the 3rd July 2017.
Various.	Final figures will also considered at the Service Delivery Board, Quality and Performance review meetings with Trust Executive Directors. This review process is supported via a central adverse variance action tracker and summaries prepared by DMTs.
Various dates in following month.	Metrics herein are reported in more depth to service commissioners at monthly Technical Support Group and Service Performance Review meetings. Where required, significant variance and recovery plans are prepared by DMTs and agreed with commissioners regarding contract compliance issues.

Implications:

Impact	Update/detail
Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of July 2017 and provides data on key Compliance, NHS Improvement (Month 2), national and contractual targets.
Service User/Carer/Staff	This report summarises progress on delivery of national and local performance targets set for all services.
Financial	The NHSI return, CQUIN report and contract compliance summary will highlight the areas where targets have not been met or areas of noncompliance against the main contacts and could pose a financial risk to the Trust.
Quality	Metrics within this report are used to support delivery of the Trust's wider service and quality goals.

1. Introduction

This report provides assurance to the Trust Board and Executive Directors on Trust wide performance and compliance matters. The report shows compliance for the previous month.

In the last report we introduced a single page of infographic data, these reports will be included in the Board report showing 2 areas of service. Each report focuses upon a specific area of clinical service provision with the aim of illustrating key activity within each service area with an emphasis on the volume of work carried out, without reference to targets or benchmarking. For this month's board report the areas are Mental Health Inpatients and Child and Adolescent Mental Health Services – see Section 3.There are a number of developments underway in relation performance management and reporting:

- The development of an integrated reporting dashboard and system
- Moving towards an outcomes focus, including the development of patient reported outcome and experience measures
- A review of contractual KPIs and meetings with East London commissioners
- Internal audit review
- An overall review of the performance management framework

The integrated reporting dashboard is expected to be ready for the October 2017 Board meeting.

2. Compliance And Governance Update

The Single Oversight Framework has replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'. Trusts are now segmented under the Single Oversight Framework (SOF) based on the level of support each provider needs which is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding.

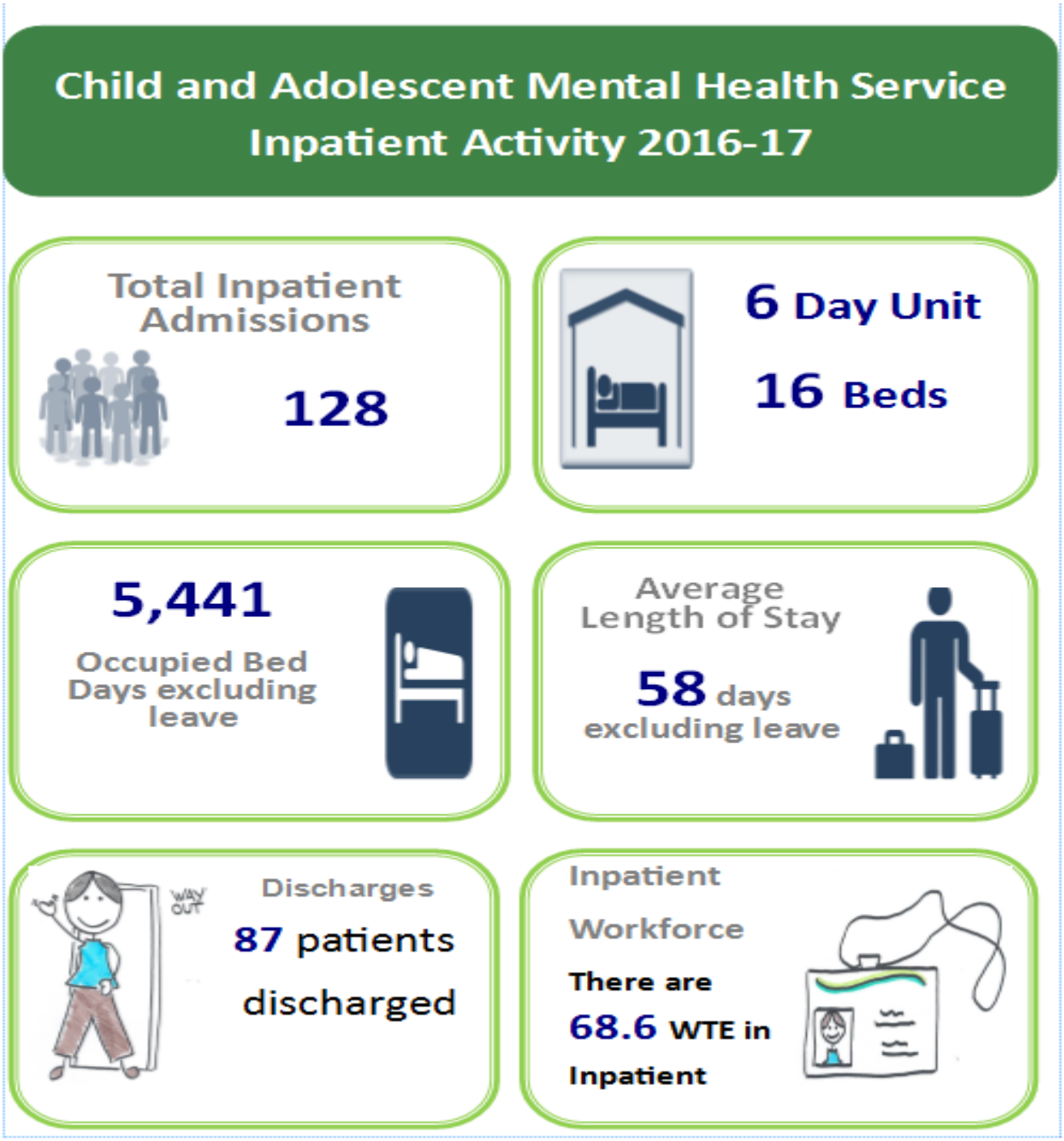
The Framework is divided into 5 themes. See table below for the Trust's current rating against each theme.

Theme	Current Rating	
Quality of Care		No Concerns
Financial and Use of Resources		Trust currently scores a 2 on the 1-4 rating scale. See Board Finance report for further details.
Operational Performance		No Concerns
Strategic Performance		No Concerns
Leadership and Improvement Capability		No Concerns

Based on the above, the Trust would remain in segment 2 (where targeted support is available, but not mandated).

3. Service Provision Infographic

The reports below highlight just how much work we deliver as a Trust and ensure that we acknowledge and celebrate it. The infographic page aims to address this.



Child and Adolescent Mental Health Community Activity 2016-17

6,224

Accepted Referrals

Community Caseload of

5,617

65,563

CAMHS Contacts

Community Workforce

292.59 WTE

CROM

3,878

paired outcome measures

PREM **98%**

of Children and Young People are happy with the service

Clinician Reported Outcome Measure (CROM) shows **87%** improvement

PROM

707 paired outcomes

77% Improvement reported by Children and Young People

4. Single Oversight Framework Summary

With the introduction of the Single Oversight Framework this report will show the Trust Performance against the Organisation Health Indicators and the Operational Performance Metrics not reported elsewhere. Other Indicators are reported as part of the Quality and Finance Reports.

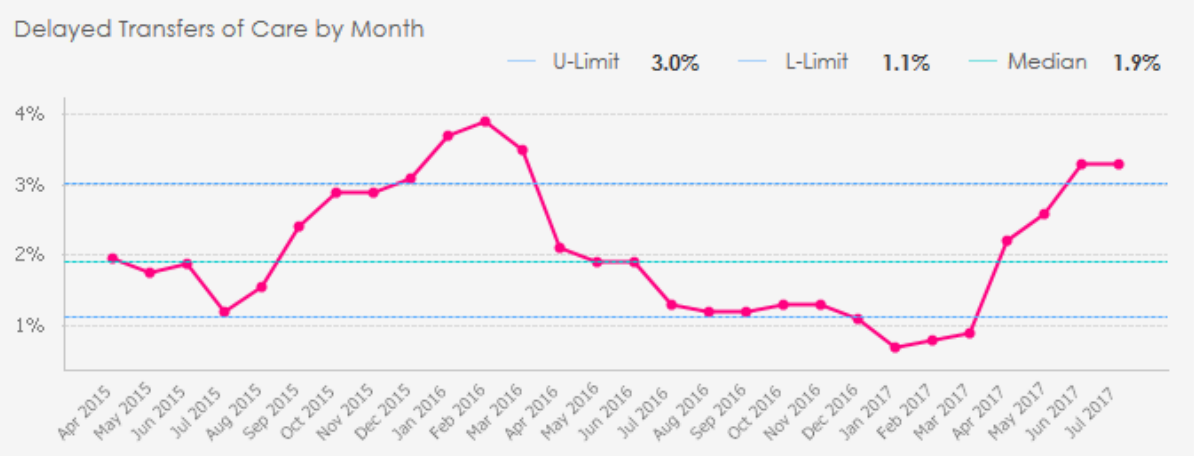
Current performance against monthly or quarterly indicators is shown in the tables below for Quarter one or Month 4.

The commentary for this report mainly focuses on red rated items only, being those metrics 5% or more adrift of agreed thresholds, plus amber items for NHSI indicators. Details of local or minor variances meriting attention are contained within Directorate level reports.

4.1 NHS Improvement Indicators

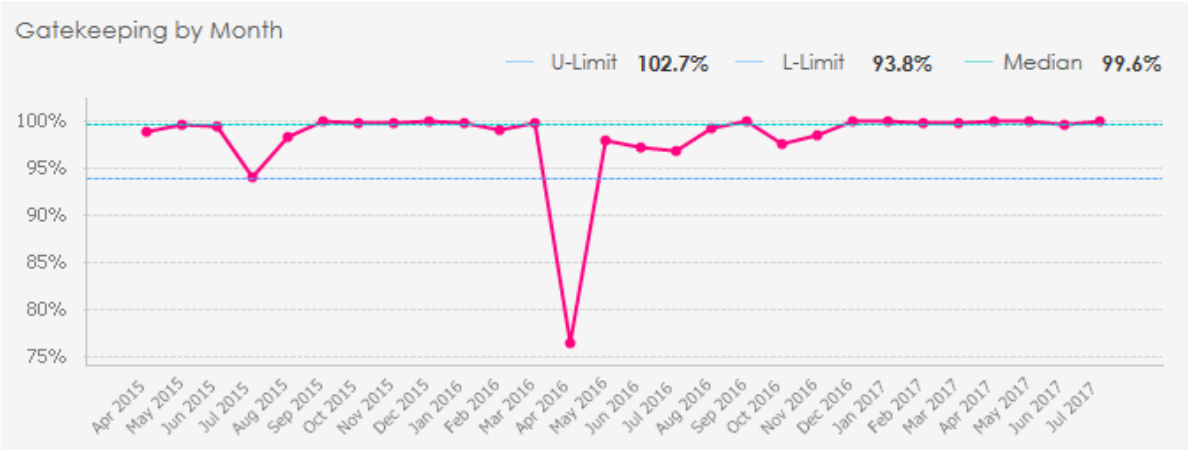
The charts below show the Trust's performance against the following NHSI targets/indicators. The charts are sample reports taken from the new Integrated Dashboard that is being developed.

- Delayed Transfers of Care – Target 7.5% (moving to 2.5%)

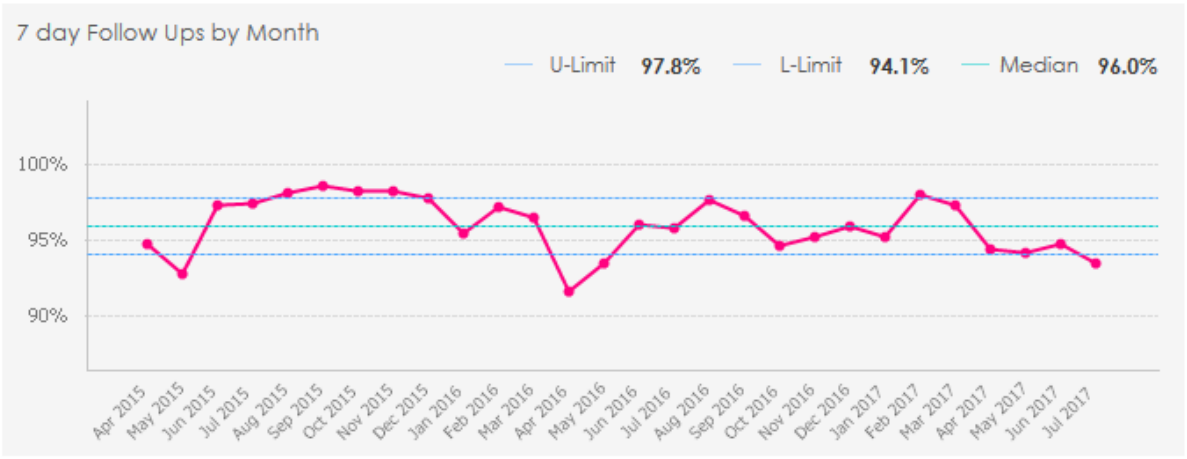


- Mental Health Community Team Activity

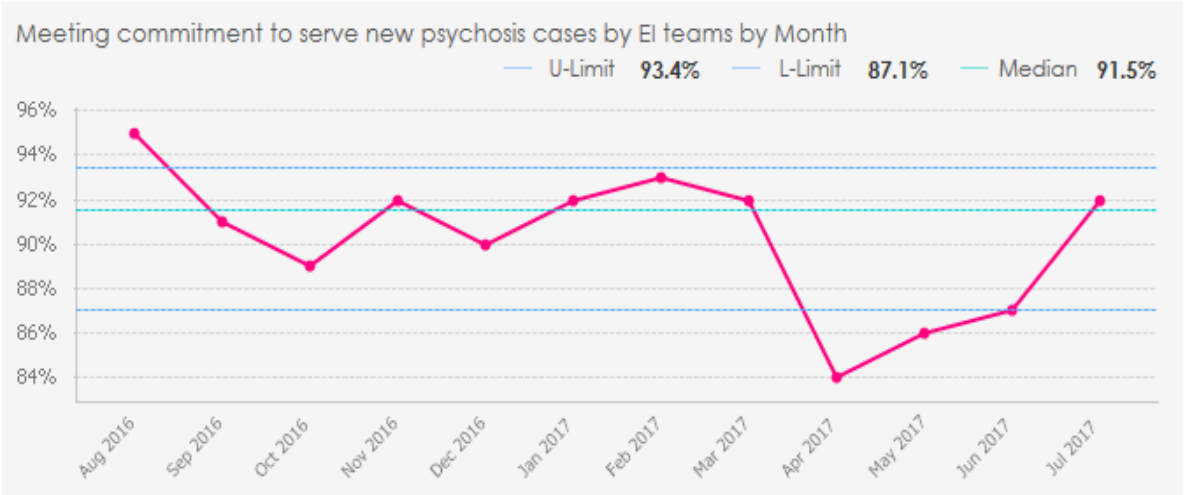
The number of admissions to the trust's acute wards that were gate kept by the Crisis Resolution Home Treatment Teams - Standard 95%



The number of people under adult mental illness specialties on CPA who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care. Standard 95%



People with a first episode of psychosis begin treatment with a NICE - recommended package of care within 2 weeks of referral – Standard 50%



4.2 Operational Performance Metrics - Mental Health Providers

Measure	Standard	Jul-17
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	95%	100.0%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	92.0%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas (Quarterly):	**Standard**	**Q1**
a) inpatient wards	90%	61.9%
b) early intervention in psychosis services	90%	94.0%
c) community mental health services (people on Care Programme Approach)	60%	84.4%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set (MHSDS) submissions to NHS Digital:	**Standard**	**Jul-17**
Identifier Metrics*	95%	100.0%
Priority Metrics	85%	92.0%
Improving Access to Psychological Therapies (IAPT)/talking therapies (Quarterly)	**Standard**	**Q1**
Proportion of people completing treatment who move to recovery (from IAPT MDS)	50%	49.3%
Waiting time to begin treatment within 6 weeks	75%	97.0%
Waiting time to begin treatment within 18 weeks	95%	99.2%

*identifier metrics are outlined in section 4.5

- The cardio-metabolic assessments in the inpatient services are below target at 61.9%. This target is reported quarterly as part of the National CQUINS, and is formally measured as part of an annual audit.

Performance managers and clinical leads continue to work with inpatient clinicians to ensure the CMA assessments are completed within 7 days. Actions also include the following:

- In East London Directorates have put a CQUIN operational group in place which meets on a fortnightly/monthly basis to review performance on wards. These meetings are attended by the inpatient leads, ward managers and admin staff.

- In addition, reminders are being sent out to wards on a daily basis by admin staff.

- Following the August change in junior doctors the services are in the process of ensuring they are trained and aware of the tasks that need to be completed. Further training and awareness sessions are being organised for all staff groups on the wards

4.3 Other National and Local Indicators

The tables below outline the Trust's performance against other national and local indicators.

National Indicators	Standard	Q1
Eating Disorder - Proportion of CYP that wait 1 week or less (Access)	N/A	100.0%
Eating Disorder - Proportion of CYP that wait 4 weeks or less (Access)	N/A	82.6%
Other Local Indicators Mental health - In patients	**Standard**	**Jul-17**
Inpatient Bed Occupancy Rate - Adult	90%	85.0%
Inpatient Bed Occupancy Rate - Older Adult (Functional)	90%	64.1%
Readmission rate (28 days) - Adult	7.5%	5.9%
Readmission rate (28 days) - Older Adult	7.5%	2.9%
Average Length of Stay - Adult	N/A	25.6
Average Length of Stay - Older Adult (Functional)	N/A	49.9
Number of Learning Disabilities Inpatients with in date care plans	100%	96.0%
Other Local Indicators Mental Health - Community	**Standard**	**Jul-17**
Assessment within 28 days of referral - Adult	95%	97.8%
Assessment within 28 days of referral - MHCOP	n/a	98.5%
CPA patients - care plans in date (Documents 12 months old)	95%	88.9%
CPA patients - care plans in date (Documents 6 months old)	n/a	74.1%
% CPA patients seen in month - face to face only	85%	86.0%
CAMHS Outcomes Percentage showing improvement	80%	84.0%
Number of adult CPA patients meeting with care-coordinator in past 12 months	95%	98.0%
Access to healthcare for people with a learning disability: CQC report compliance	Self-Assessment score	19
NHS Improvement Targets - Community Information Data Set (CIDS) - Data Completeness*		
Community Referral to treatment information	50%	data to follow
Referral Information	50%	data to follow
Care Contact Activity information	50%	data to follow

* To be replaced by CSDS from October 2017

CPA care plans performance is largely an issue in Luton & Bedfordshire, where significant changes are being made to community services. Most recent performance information shows that improvements are being made following the establishment of new teams and operational processes.

4.5 Data Quality Indicators

The table below show good compliance rates against the MHSDS Identifier Metrics, but there are 2 Trust wide red rated items in relation to recording of primary diagnosis reported this month.

MHSDS - Identifier Metrics /Data Quality (Trust Target 95%)	RiO - Mental Health Inpatient	Rio Community CAMHS	RiO - Mental Health Community	Community Services Newham (NCHS)
Date of Birth	100.0%	100.0%	100.0%	100.0%
Gender	100.0%	100.0%	100.0%	100.0%
Marital Status	93.9%	100.0%	94.0%	
NHS Number	98.8%	99.9%	99.8%	99.4%
Ethnic Group	98.1%	99.9%	99.4%	96.8%
Postcode	99.1%	100.0%	99.8%	100.0%
GP Practice	95.4%	99.4%	98.6%	85.5%
Commissioner Code	100.0%	100.0%	100.0%	99.5%
Primary Diagnosis	72.3%		81.0%	
HoNOS			97.0%	
Employment Status			91.9%	
Accommodation Status			91.9%	

Recording of primary diagnosis in inpatient and community settings continues to be a challenge. Practices from high performing areas are being shared with admin and clinical colleagues.

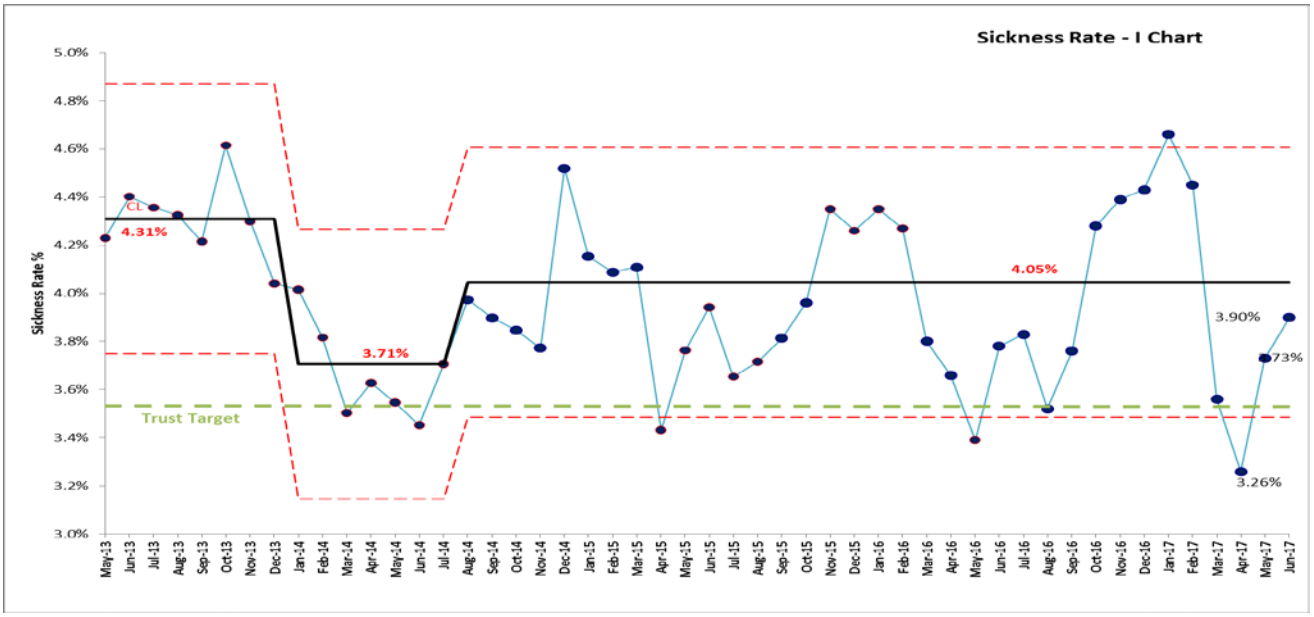
4.6 Workforce Indicators

The charts below show the Trust's performance in relation to Vacancy, Absence and Training compliance rates:

VACANCIES

Vacancies	Feb	March	April	May	June	July
Trust	9.65%	9.63%	10.07%	12.59%	12.41%	12.47%

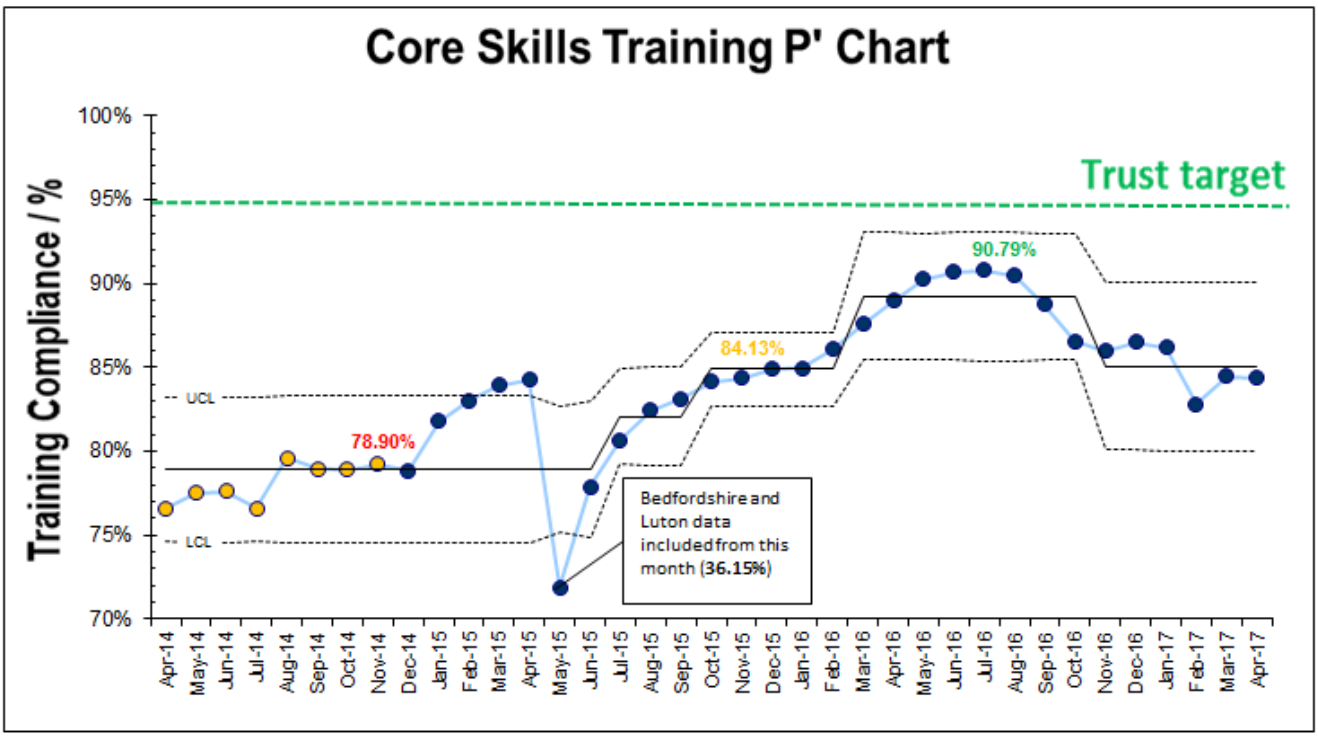
ABSENCE



MANDATORY TRAINING

Mandatory Training	May*	June *	July *	Trust target
Trust	84.43%	84.51%	85.07%	95.00%

* now includes data for L&B's



The increased vacancy rate is attributable to a 2% increase in Bedfordshire since April 2017 and the acquisition of Tower Hamlets Community Services which has a vacancy rate of 32%. A weekly action group is meeting to address recruitment in this service. There was an increase in specialist CHN as vacancies were held in children's services that transferred to London Borough of Newham under TUPE.

Sickness absence rates remained stable at under 4% however long term sickness in Bedfordshire and Luton services is above 5%. Additional resources have been secured to work with managers in these areas.

Statutory and Mandatory Training figures are affected by lower compliance rates in Community Services Tower Hamlets at 63% and Specialist Services and City and Hackney at 81%. Action plans are being monitored at the monthly performance meetings.

5. Spotlight Report on Seven day Follow Up

Care programme approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days

Background

The 7 day follow up indicator was previously a national target for mental health trusts. With the introduction of the single oversight frame work this is now one of the quality indicators monitored monthly through the framework.

The guidance states that:

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team.

Exemption:

- Patients who die within 7 days of discharge may be excluded.
- Where legal precedence has forced the removal of a patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (child and adolescent mental health services) are not included.

Until recently the Trust only monitored Adults but this has been widened to include all cases on CPA.

Current Performance

The table below shows the Trusts performance for all cases on CPA for 2016/17

Table 1: 7 Day Follow up – CPA Cases (Target 95%)

Directorate	Discharges	Breach	Not Breach	% Not Breached
Bedfordshire	353	9	344	97.5%
City & Hackney	394	8	386	98.0%
Forensic	41	1	40	97.6%
Luton	416	20	396	95.2%
MHCOP	128	8	120	93.8%
Newham	346	10	336	97.1%
Tower Hamlets	323	7	316	97.8%
Grand Total	**2001**	**63**	**1938**	**96.9%**

The table shows that the Trust did achieve the target. Although MHCOP did not meet the target we are mindful that the small numbers of discharges do mean that meeting this target can be challenging.

New Guidance – All discharges

New guidance has been published stating that all cases admitted to a mental health in patient service should be categorised as a CPA case. The table below shows the Trust's performance against the target if all discharges need to be seen/contacted by phone within 7 days. The Trust will start measuring against the new target from 1 October 2017.

Table 2: 7 Day Follow up – All Cases

Directorate/Service	Discharges	Breach	Not Breach	% Not breach
Bedfordshire	708	171	537	75.8%
City & Hackney	1082	344	738	68.2%
Forensic	52	3	49	94.2%
Luton	750	183	567	75.6%
MHCOP	220	40	180	81.8%
Newham	1226	543	683	55.7%
Tower Hamlets	940	358	582	61.9%
Grand Total	**4978**	**1642**	**3336**	**67.0%**

The table shows that the Trust does not currently meet the 95% target of cases seen within 7 days for all discharges.

Action

In order to meet the 7 day follow up target there are a number of areas of focus in order to address this issue. These include:

- Local performance managers have been working with Inpatient and community services to put in place proactive discharge arrangements to ensure all CPA cases discharge are seen within 7 days. This will involve service users being given appointment times with their respective care coordinator prior to discharge to improve coordination and engagement.

- Accuracy and timeliness of data entry. Ensuring all activity in relation to seven day follow up appointments is accurately recorded on RiO and appointments are outcome within 24 hours. This will ensure that late data entry is no longer the reason for the Trust reporting breaches.

- Performance managers validating cases that have been identified as an actual number of breaches and ensuring that exceptions are recorded accurately.

- In relation to the widening of the indicator to include all discharges, services are putting in systems to ensure that all patients are allocated for follow-up.

- For CPA cases the community teams will be responsible for arranging the follow up appointment.

- Further work is needed in relation to recording of 7 day follow up for cases that are discharge from ELFT wards that are the responsibility of another provider.

Timeliness of Follow up Following Discharge

The Table and Chart inlcudes all discharges seen within 7 days and show when patients are seen following discharge.

The table show percentage of patients seen within the different time periods. There are discusisons at a national level about further changing this target so that all discharges are followed up within 48 hours.

Number of Days	0	1	2	3	4	5	6	7
Total as a Percentage	12%	27%	14%	12%	10%	9%	10%	6%

6. Board Assurance Framework

A new format for the BAF has been introduced with the aim of providing clearer summary information of all strategic risks and more precise and detailed information for individual risks. Key changes in the format are:

- Summary information regarding the risks aligned to the lead committees.
- Summary information regarding the risks aligned to each executive lead.
- Summary information of all BAF risk scores (current and target) on one page.
- Summary of mitigating actions
- Risk controls and assurance for each risk are clearly identified and linked.
- Gaps in control and/or assurance are clearly identified.
- Graphical illustration of current risk scores and progress towards target risk scores is linked to the business year and mapped monthly.
- Actions clearly link to gaps in controls and assurance, record identified executive leads, due dates and progress/status fields to encourage updates.

The latest version of the BAF is attached in Appendix 1.

7. Recommendations and Action Being Requested

The Board/Committee is asked to:

a) RECEIVE and DISCUSS the report
b) NOTE action taken to maintain and improve performance

NHS
East London
NHS Foundation Trust

Board Assurance Framework (BAF)

August 2017

Risk Scoring Matrix and Colour Codes					
	Likelihood (Probability)				
Consequence	1: Very Unlikely	2: Unlikely	3: Likely	4: Very Likely	5: Almost Certain
5: Catastrophic	5	10	15	20	25
4: Major	4	8	12	16	20
3: Moderate	3	6	9	12	15
2: Minor	2	4	6	8	10
1: Negligible	1	2	3	4	5

Responsible Leads and Committees

Filtered by Executive Lead

Risk No.	Executive Lead	Lead Committee
1.1	Dr. Kevin Cleary, Chief Medical Officer	Quality Assurance Committee
1.4		Quality Assurance Committee
1.5		Quality Assurance Committee
1.7		Quality Assurance Committee
1.3	Jonathan Warren, CN & Deputy Chief Executive	Quality Assurance Committee
1.6		Quality Assurance Committee
1.10	Mason Fitzgerald, Director of Corporate Affairs	Trust Board
2.1		Appointments and Remuneration Committee
2.2		Appointments and Remuneration Committee
2.3		Appointments and Remuneration Committee
2.4		Appointments and Remuneration Committee
2.6		Appointments and Remuneration Committee
3.6		Trust Board
3.1	Dr. Mohit Venkataram, Executive Director of Commercial Development and Performance	Trust Board
3.3		Trust Board
1.2	Paul Calaminus Chief Operations Officer	Quality Assurance Committee
1.9		Quality Assurance Committee
3.4		Quality Assurance Committee
3.5 (b)		Finance, Business and Investment Committee
1.8	Steven Course, Chief Finance Officer	Quality Assurance Committee
2.5		Audit Committee
3.2		Finance, Business and Investment Committee
3.5 (a)		Finance, Business and Investment Committee

Filtered by Lead Committee

Risk No.	Lead Committee	Executive Lead
2.1	Appointments and Remuneration Committee	Mason Fitzgerald, Director of Corporate Affairs
2.2		Mason Fitzgerald, Director of Corporate Affairs
2.3		Mason Fitzgerald, Director of Corporate Affairs
2.4		Mason Fitzgerald, Director of Corporate Affairs
2.6		Mason Fitzgerald, Director of Corporate Affairs
2.5	Audit Committee	Steven Course, Chief Finance Officer
3.2	Finance, Business and Investment Committee	Steven Course, Chief Finance Officer
3.5 (b)		Paul Calaminus Chief Operations Officer
3.5 (a)		Steven Course, Chief Finance Officer
1.1	Quality Assurance Committee	Dr. Kevin Cleary, Chief Medical Officer
1.2		Paul Calaminus Chief Operations Officer
1.3		Jonathan Warren, CN & Deputy Chief Executive
1.4		Dr. Kevin Cleary, Chief Medical Officer
1.5		Dr. Kevin Cleary, Chief Medical Officer
1.6		Jonathan Warren, CN & Deputy Chief Executive
1.7		Dr. Kevin Cleary, Chief Medical Officer
1.8		Steven Course, Chief Finance Officer
1.9		Paul Calaminus Chief Operations Officer
3.4		Paul Calaminus Chief Operations Officer
1.10	Trust Board	Mason Fitzgerald/Jonathan Warren
3.1		Mohit Venkataram, Executive Director of Commercial Development and Performance
3.3		Mohit Venkataram, Executive Director of Commercial Development and Performance
3.6		Mason Fitzgerald, Director of Corporate Affairs

Summary of Principle Risks

Principle Risks: *The Trust may not achieve its objectives if:*			**Scores**	
	Ref.	**Risk Description**	**Current**	**Target**
OBJECTIVE 1: Improve Service User Satisfaction	**1.1**	It fails to improve the overall quality of care provision	8	8
	1.2	It fails to achieve agreed optimum levels of adult acute MH bed occupancy	9	9
	1.3	It fails to transform district nursing services in order to meet the needs of the local health services and wider community	16	9
	1.4	It fails to implement relevant NICE guidance	12	9
	1.5	It fails to innovate in the pursuit of quality improvement	6	3
	1.6	It fails to meet standards for safety and quality as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process	12	6
	1.7	It fails to develop systems and processes to deliver safer and more effective physical health care to MH patients	12	8
	1.8	It fails to provide high quality services from premises that are secure, minimise risk, and are well maintained	12	9
	1.9	It fails to recognise and respond to the impact of CRES savings plans on the quality and safety of services already responding to increasing demand	8	6
	1.10	The impact of new strategies, models of care or organisational forms may adversely impact on the quality of care currently provided by the Trust	12	8
OBJECTIVE 2: Improve Staff Satisfaction	**2.1**	It fails to recruit and retain high quality staff	12	8
	2.2	It fails to ensure that workforce capability and capacity and ability to respond to change, including delivery of new strategies and models of care, is sufficient to continue to meet stated Trust objectives	12	6
	2.3	It fails to put in place succession plans for the Trust Board and Senior Management roles	9	9
	2.4	If it fails to maintain improvement in measures of staff engagement in the context of continued financial constraints and CRES plans	6	6
	2.5	If it fails to provide, and engage staff with, modern and effective IT infrastructure, both physical and systems	9	9
	2.6	If the Trust fails to address concerns regarding fair treatment, career progression and discrimination then the experience and outcomes for certain staff groups will not improve, and adversely impact on the quality of care provided	12	8
OBJECTIVE 3: Maintain Financial Viability	**3.1**	Changes to the commissioning landscape due to the development of accountable care systems could lead to loss of relationships with current commissioners and impact upon currently agreed contractual terms.	12	8
	3.2	It fails to plan properly for the introduction of new funding systems, potentially jeopardising income streams	8	8
	3.3	If it fails to effectively balance the investment of energy and resources between potential new and existing business the Trust may find the quality of care it provides compromised and its reputation affected, impacting on its ability to retain existing business, attract new business, and deliver new contracts and projects	12	6
	3.4	If the Trust fails to deliver the Year 1 plan of the Luton & Bedfordshire integration, then it may find that the quality of care is compromised, patient and staff satisfaction reduced, and its reputation affected	12	6
	3.5 (a)	The short-term impact and potential lack of achievability of CRES requirements, coupled with expenditure control and income generation, upon the overall financial sustainability of the Trust. Further risk implications concerning the impact on the reputation of the Trust and access to revenue streams such as STF funding.	20	12
	3.5 (b)	The long term impact and potential lack of achievability of CRES requirements over the next 5 years, threatens the overall financial sustainability of the Trust and adversely impacts on the pursuit of quality improvement.	16	12
	3.6	If services are not adequately incorporated into Sustainability and Transformation Plans (STPs), they risk becoming unsustainable over the next financial year.	12	8

Mitigation Actions from the BAF

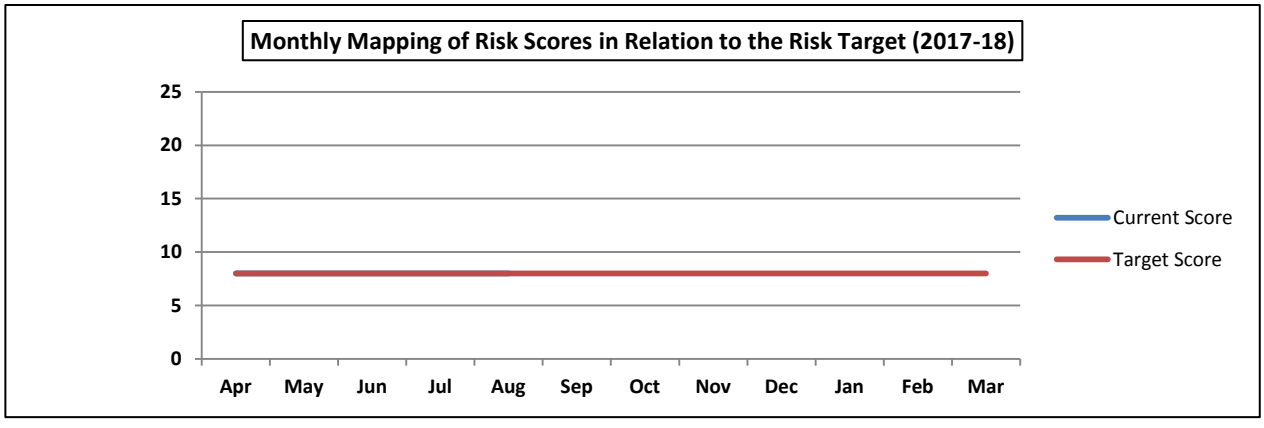
Risk No.	Risk Lead	Action	Responsible Person/s	Due date
2.4	Mason Fitzgerald	Implementation of staff survey action plans	Mason Fitzgerald	Jul 2017
1.8	Steven Course	The window security at The Green site to be upgraded.	Steven Course	Aug 2017
3.5(a)	Steven Course	Continued discussions with directorates and commissioners regarding further efficiency savings.	Steven Course/Paul Calaminus	Aug 2017
3.6	Mason Fitzgerald	Development of mental health and community health plans for BLMK	Mason Fitzgerald	Sep 2017
2.1	Mason Fitzgerald	Develop directorate workforce plans	Mason Fitzgerald/Paul Calaminus	Sep 2017
2.2	Mason Fitzgerald	Revise the Workforce Strategy	Mason Fitzgerald	Sep 2017
2.2	Mason Fitzgerald	OD programme to report to the workforce committee	Mason Fitzgerald	Sep 2017
2.6	Mason Fitzgerald	Introduce a high level oversight report to the Workforce Committee	Mason Fitzgerald	Sep 2017
3.2	Steven Course	Analysis of the impact of the IAPT PbR approach	Steven Course	Sep 2017
3.5 (b)	Paul Calaminus	Review current system for identification of CRES needs	Mohit Venkataram	Sep 2017
1.10	Mason Fitzgerald	Introduce measure for the anticipated and actual impact of new strategies and models of working.	Mason Fitzgerald	Oct 2017
2.3	Mason Fitzgerald	Develop a formal succession plan	Mason Fitzgerald	Oct 2017
2.3	Mason Fitzgerald	Introduce a system for monitoring succession planning outcomes	Mason Fitzgerald	Oct 2017
3.5 (b)	Paul Calaminus	Revise the trust's 5 year strategy	Mason Fitzgerald	Nov 2017
1.10	Mason Fitzgerald	Revised Trust 5 year strategy to be approved by the Board (November 2017)	Mason Fitzgerald	Nov 2017
2.5	Steven Course	Implementation of EMIS in Tower Hamlets CHS (December 2017)	Steven Course	Dec 2017
2.5	Steven Course	Roll-out of mobile working across all services	Steven Course	TBC
2.5	Steven Course	Delivery of inter-operability across all services	Steven Course	TBC
1.4	Kevin Cleary	Implement and evaluate the trust's new process for implementing NICE guidance.	Kevin Cleary	Jan 2018
1.9	Paul Calaminus	Embed and evaluate the effectiveness of the new Quality Impact Assessment format	Paul Calaminus/ Kevin Cleary	Mar 2018
3.1	Mohit Venkataram	Agree MoUs for Luton, Bedfordshire and Newham providers.	Mason Fitzgerald	Mar 2018
3.4	Paul Calaminus	Implementation of the Year 3 plan	Paul Calaminus	Mar 2018
3.6	Mason Fitzgerald	Implementation of NEL STP mental health delivery plan	Mason Fitzgerald	Apr 2018
1.6	Jonathan Warren	Implement new trust process for monitoring and ensuring CQC compliance	Jonathan Warren	Jul 2018
3.1	Mohit Venkataram	Implement the Business Strategy and review its impact	Mason	Sep 2018

Risk No.	**1.1**
Objective	Improve service user satisfaction
Risk Description	It fails to improve the overall quality of care provision
Executive Lead	Dr Kevin Cleary, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Annual plan/Board development day – April 2014
Change since last review	None

Controls	**Assurance**
1. Chief Medical Officer is the executive lead for quality	➢ CMO reports monthly to the QAC
2. Real time patient feedback system	➢ Quality and safety report to the SDB and Trust Board.
3. Quality Improvement Strategy and supporting strategies	➢ Bi-monthly reporting to the QAC
4. Integrated reporting around quality assurance, quality improvement and quality control.	➢ Regular reporting to the QAC and Trust Board via the Quality and Safety Dashboard. ➢ Annual Quality Accounts report to the Trust Board. ➢ CQC inspection report (August 2016)
5. Quality Improvement Team	➢ Progress reports on the QI work plan at the QI Programme Board
6. Participation in national audits and benchmarking exercises	➢ Feedback reports to the Quality Committee and QAC.
7. QI work plan	➢ Progress reports on the QI work plan at the QI Programme Board
8. CQC Compliance Framework	➢ Reporting to the Quality Committee ➢ Directorate quarterly CEO monitoring meetings
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	4	2	2
Risk Scores	**16**	**8**	**8**



Action Required

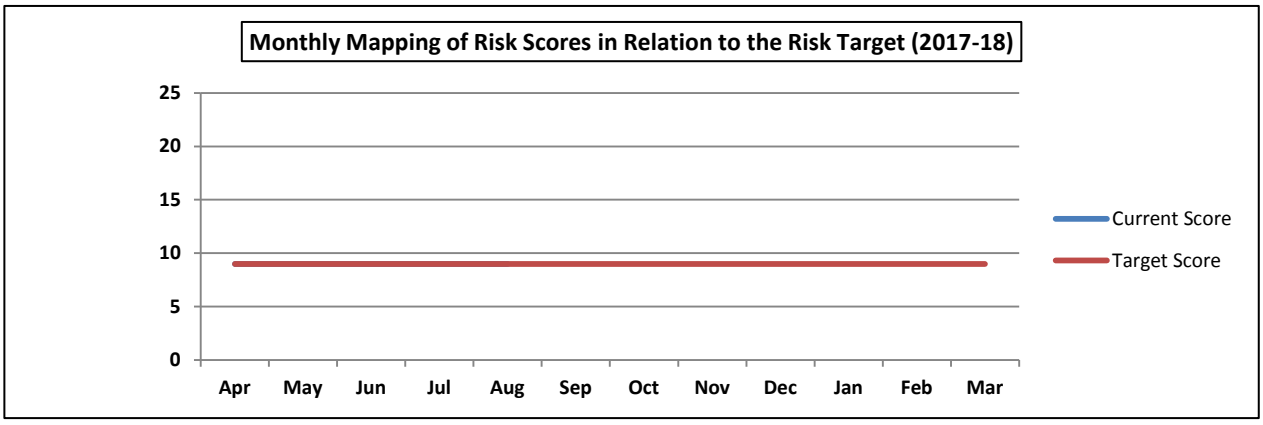
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

Risk No.	**1.2**
Objective	Improve service user satisfaction
Risk Description	It fails to achieve agreed optimum levels of adult acute MH bed occupancy
Executive Lead	Paul Calaminus, Chief Operating Officer
Lead Committee	Quality Assurance Committee
Source	Trust annual plan, directorate risk registers and serious incident reviews
Change since last review	None

Controls	**Assurance**
1. Monitoring of trustwide bed occupancy by the SDB	➢ Monthly performance report containing bed occupancy levels, length of stay and re-admission rate.
2. Weekly directorate safety huddles	➢ Bed numbers and occupancy levels reported to the Exec. Team.
3. Care pathways to ensure to appropriate admissions	➢ Monitoring of CMHT contact rates, seven day follow-up, numbers of admissions and A&E breaches, via the monthly performance report to the SDB.
4. Monitoring of formal admissions	➢ Quarterly MHA report to the Quality Committee
5. Team level dashboard data provided by Reporting Service update in real time.	➢ Monitoring and oversight the Chief Operating Officer.
6. Daily reports to the CNO and COO from directorates on inpatient activity.	➢ Data review by CNO and COO.
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	5	3	3
Likelihood	5	3	3
Risk Scores	**25**	**9**	**9**



Action Required

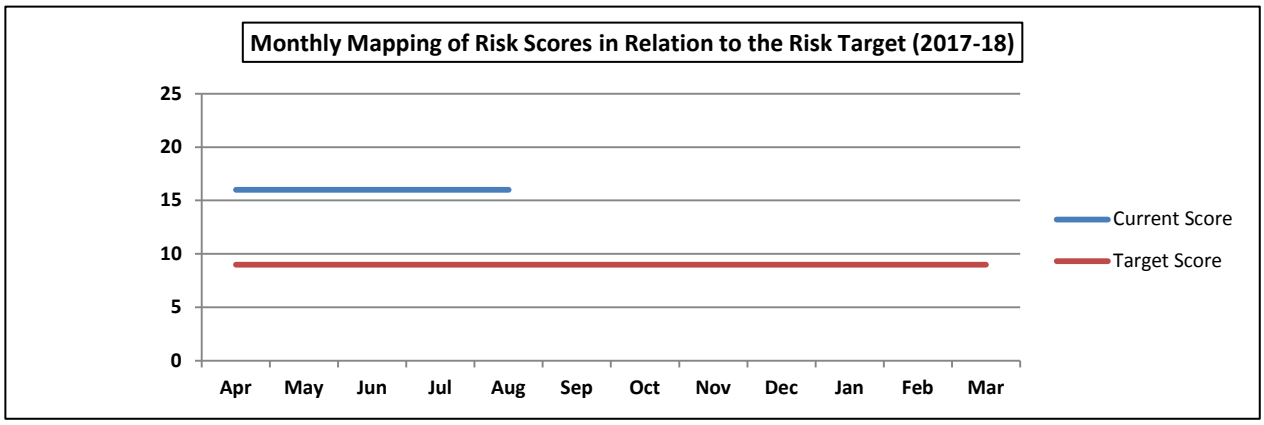
No.	Action	Responsible Person/s	Due date	Progress /Status

Risk No.	**1.3**
Objective	Improve service user satisfaction
Risk Description	It fails to transform district nursing services in order to meet the needs of the local health services and wider community
Executive Lead	Jonathan Warren, Chief Nurse and Deputy Chief Executive
Lead Committee	Quality Assurance Committee
Source	Trust annual plan, directorate risk register (CHN) and serious incident reviews
Change since last review	None

Controls	**Assurance**
1. Recruitment and retention strategy	➢ Reporting to the Directors' Weekly Safety Huddle ➢ Verbal reports to bimonthly QAC ➢ Monthly reports on the numbers of district nursing staff and vacancy rate.
2. Tower Hamlets Project Board	➢ Monitoring by the CEO
3. Piloting Tower Hamlets Neighbourhood Community Team	➢ Monthly reporting to the performance meetings and quarterly meetings with the CEO.
4. Collaboration and supporting the development of GP federations	➢ Monthly reporting to the performance meetings and quarterly meetings with the CEO.
5. Development of a training super hub in conjunction with HEE	➢ Monthly reporting to the performance meetings and quarterly meetings with the CEO.
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	4	4	3
Likelihood	4	4	3
Risk Scores	**16**	**16**	**9**



Action Required

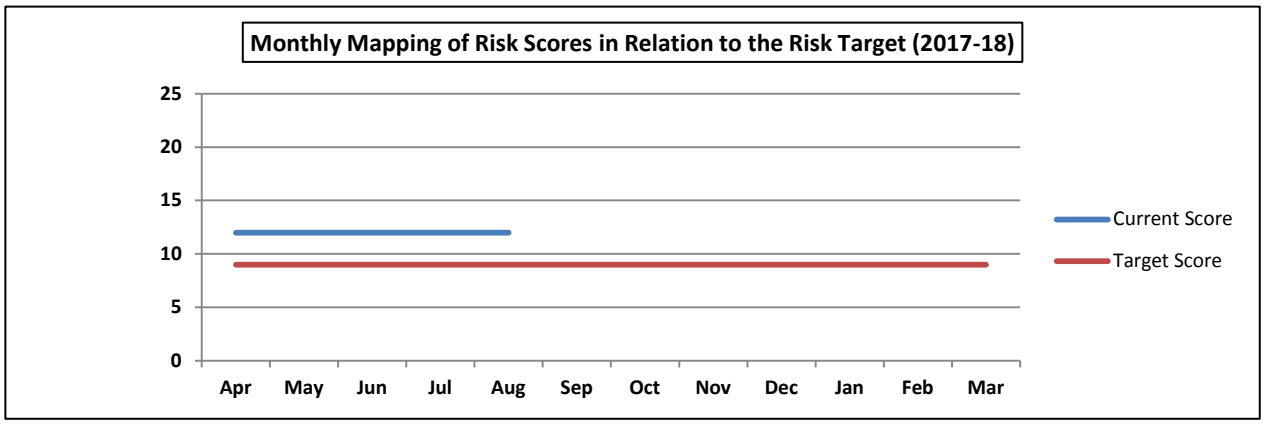
No.	Action	Responsible Person/s	Due date	Progress /Status

Risk No.	**1.4**
Objective	Improve service user satisfaction
Risk Description	It fails to implement relevant NICE guidance
Executive Lead	Dr. Kevin Cleary, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Quality Assurance Committee – October 2015
Change since last review	None

Controls	**Assurance**
1. 'NICE Guideline Process in ELFT'	➢ Monthly NICE briefing reports to the Mental Health Quality Committee and Physical Health Quality Assurance Group ➢ Annual report to the Quality Committee
2. The Associate Medical Directors for mental health and community health services are the designated leads for NICE guidance	➢ Monthly NICE briefing reports to the Mental Health Quality Committee and Physical Health Quality Assurance Group ➢ Reporting to the Quality Committee
3. NICE Guidance Policy: Dissemination, Implementation and Monitoring of NICE Guidance	➢ Monthly implementation monitoring at the Quality Committee ➢ Annual report to the Quality Committee
4. Clinical audit programme	➢ Clinical audit reports go to the Quality Committee
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	3
Likelihood	4	3	3
Risk Scores	**16**	**12**	**9**



Action Required

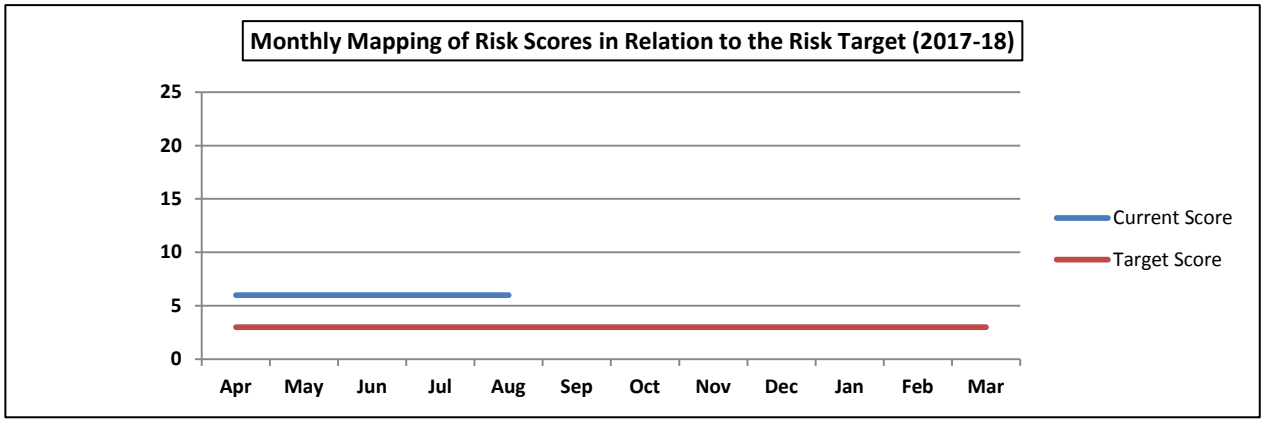
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implement and evaluate the trust's new process for implementing NICE guidance.	Kevin Cleary	January 2018	

Risk No.	**1.5**
Objective	Improve service user satisfaction
Risk Description	It fails to innovate in the pursuit of quality improvement
Executive Lead	Dr Kevin Cleary, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Trust Board - April 2014
Change since last review	None

Controls	**Assurance**
1. Quality Improvement Programme Board	➢ Reports to the Trust Board
2. Quality Improvement Strategy and work plan	➢ Reports to the QI Programme Board ➢ Monitoring of QI projects at directorate QI meetings
3. Associate Medical Director for QI in post, supported by QI team	➢ Reporting to the QI Programme Board and Chief Medical Officer/Executive Lead for Quality
4. Central QI Team with structures to support directorates (Directorate QI Leads and QI meetings)	➢ Reporting to the QI Programme Board
5. Associate Medical Director for research and innovation in post	➢ Reporting to the Research Board
6. QI training delivery	➢ Reporting to the QI Programme Board
7. Strategic partnership with IHI	➢ Reporting to the QI Programme Board
8. Service User Steering Group	➢ Reporting to the QI Programme Board
9. People participation structure and PP Team	➢ Reporting to the Trustwide People Participation Committee
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	3	3	3
Likelihood	2	2	1
Risk Scores	**6**	**6**	**3**



Action Required

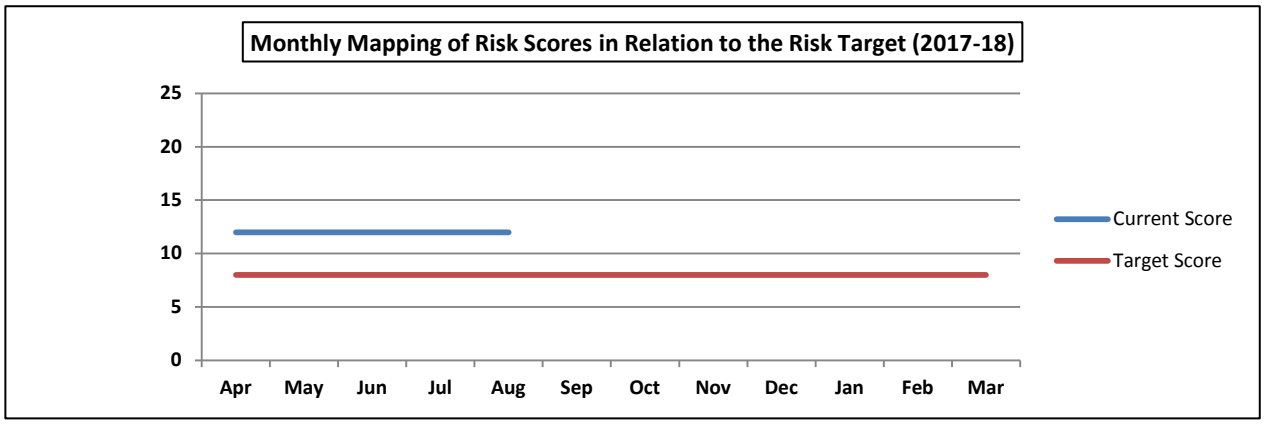
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

Risk No.	**1.6**
Objective	Improve service user satisfaction
Risk Description	It fails to meet standards for safety and quality as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process.
Executive Lead	Jonathan Warren, Chief Nurse and Deputy Chief Executive
Lead Committee	Quality Assurance Committee
Source	Mental Health Act Commissioner visit and CQC regulatory inspection reports
Change since last review	None

Controls	**Assurance**
1. Chief Nursing Officer is the Executive Lead for CQC compliance	➢ Reporting the Quality, and Quality Assurance Committees
2. Quality Assurance Strategy	➢ Monitoring reports to the Quality Committee
3. Local governance arrangements in place	➢ Quality and performance reports to the Executive Team
4. CQC action plan	➢ Monitored via the Quality Assurance Committee
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	5	4	4
Likelihood	4	3	2
Risk Scores	**20**	**12**	**6**



Action Required

No.	Action	Responsible Person/s	Due date	Progress /Status
1	Implement new trust process for monitoring and ensuring CQC compliance	Jonathan Warren	July 2018	

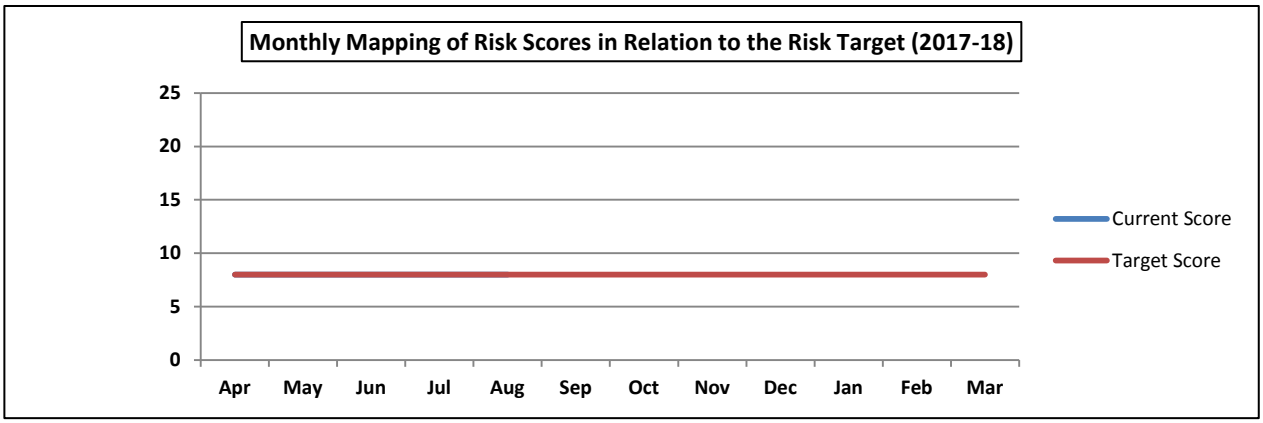
Risk No.	**1.7**
Objective	Improve service user satisfaction
Risk Description	It fails to develop systems and processes to deliver safer and more effective physical health care to MH patients
Executive Lead	Dr Kevin Cleary, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Serious Incident Reviews, City & Hackney Directorate Risk Register, Council of Governors feedback
Change since last review	None.

Controls	**Assurance**
1. Lead director for physical health	➢ Reports to the Quality Committee
2. Lead Nurse in post for control of infection and physical health	➢ Reports to the Quality Committee
3. GP service in place across the Trust	➢ Reports to the Quality Committee
4. Physical health strategy	➢ Progress reports to the Quality Committee ➢ Incident reporting
5. Physical health policy	➢ Audit of Physical Healthcare Assessments ➢ Incident reporting
6. Physical healthcare training programme	➢ Audit of Physical Healthcare Assessments ➢ Incident reporting ➢ Compliance figures for physical health training
7. National CQUIN standards	➢ Monthly CQUIN performance report
8. QI projects	➢ Reports to directorate QI meetings
9. Physical health care simulation exercises	➢ Reports to the Quality Committee
10. Physical health monitoring equipment including Pods, to community mental health teams	➢ Monthly CQUIN performance report

Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	4	3	2
Risk Scores	**16**	**8**	**8**



Action Required

No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

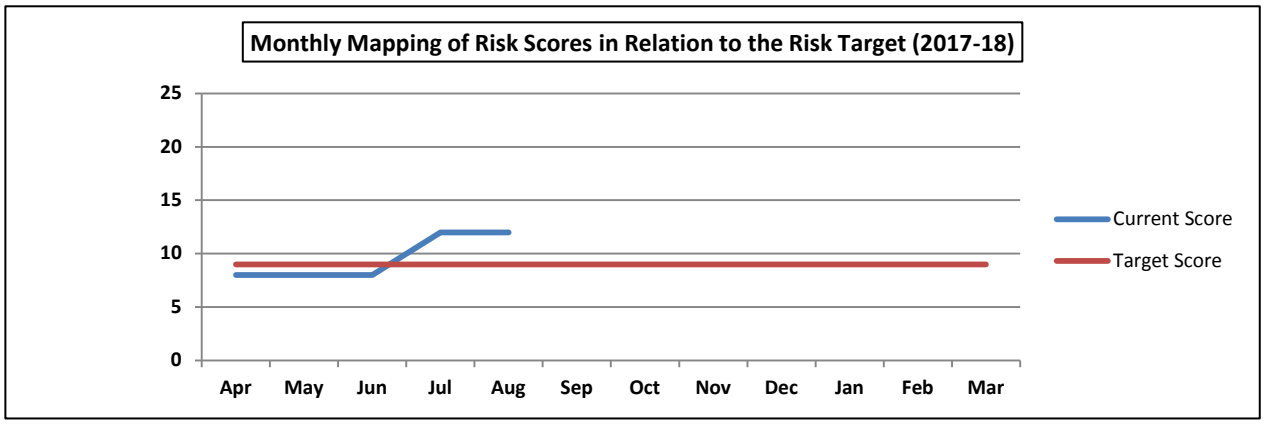
Risk No.	**1.8**
Objective	Improve service user satisfaction
Risk Description	It fails to provide high quality services from premises that are secure, minimise risk, and are well-maintained
Executive Lead	Steven Course, Chief Financial Officer
Lead Committee	Quality Assurance Committee
Source	Serious Incident Reviews, Directorate Risk Register, Board walkabout feedback - June 2015
Change since last review	Likelihood score has increased from 2 to 3 (Risk Score from 8 to 12) following a review of window security at The Green site

Controls	**Assurance**
1. Estates Strategy in place, and funded Capital Plan	➢ Reporting to the FBIC (from Sept 2017) ➢ Monitoring officers reporting monthly to the Director of Estates ➢ Incident reporting to the Quality Committee
2. Capital Projects Steering Group	➢ Reporting to the FBIC
3. QI Gold Standard Environments project	➢ Reporting to C&H QI meeting
4. CQC compliance programme	➢ Reporting to the Quality Committee ➢ CQC inspection reports
5. PLACE assessments	➢ Reporting to the FBIC, SDB and Trust Board as part of the annual update on the Estates Strategy

Gaps in Controls	**Gaps in Assurance**
Security at the Green site is not at the required level due to current window design.	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	3
Likelihood	4	3	3
Risk Scores	**16**	**12**	**9**



Action Required

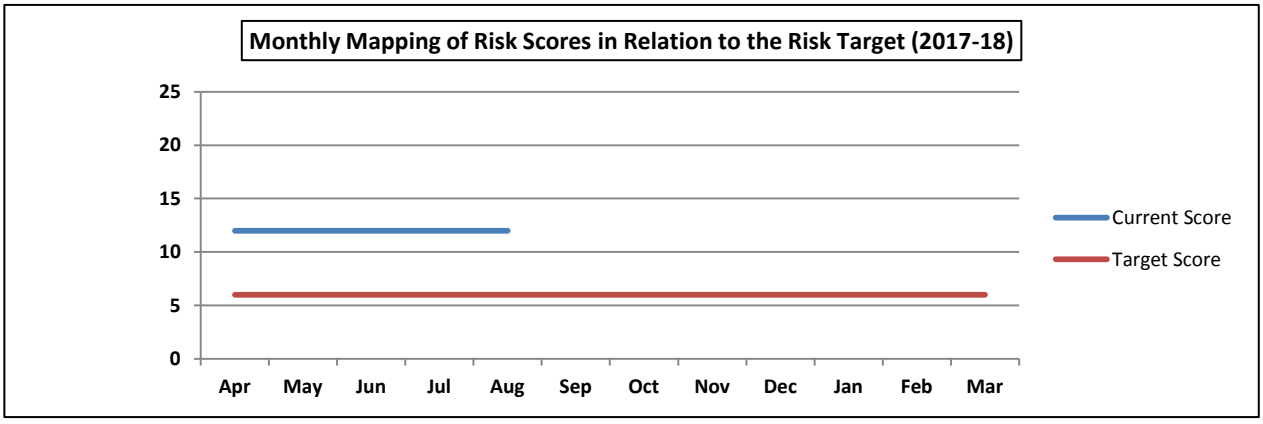
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	The window security at The Green site to be upgraded.	Steven Course	August 2017	

Risk No.	**1.9**
Objective	Improve service user satisfaction
Risk Description	It fails to recognise and respond to the impact of CRES savings plans on the quality and safety of services already responding to increasing demand
Executive Lead	Paul Calaminus, Chief Operating Officer
Lead Committee	Quality Assurance Committee
Source	Annual Plan – April 2014
Change since last review	The consequence rating has been increased from 3 to 4 (Risk Score from 8 to 12) following review by the new risk owner

Controls	**Assurance**
1. Integrated Business Strategy and Annual Plan	➢ Reporting to FBIC
2. Quality Impact Assessment (QIA) Group	➢ Reports to the QAC
3. Quality impact assessment (QIAs) for CRES plans twice yearly	➢ Reports to the QIA Group
4. Annual budget setting cycle	➢ Reports to the FBIC
5. Refreshed 5 year strategic and financial plan	➢ Reporting on implementation to the Trust Board
6. Quality Dashboard	➢ Reports to the Trust Board ➢ Patient feedback
Gaps in Controls	**Gaps in Assurance**
New Quality Impact Assessment format is not yet fully embedded	

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	3	3	3
Likelihood	5	4	2
Risk Scores	**15**	**12**	**6**



Action Required

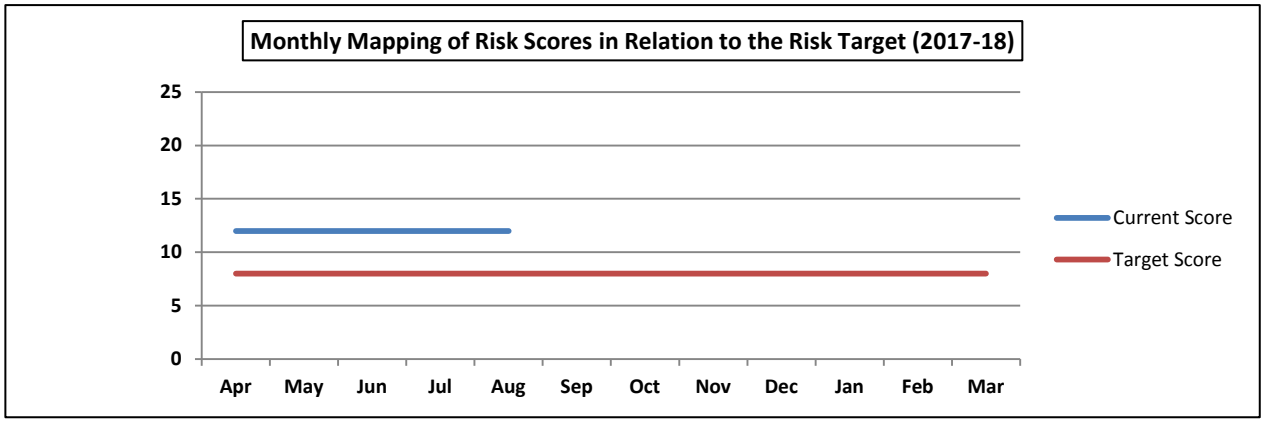
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Embed and evaluate the effectiveness of the new Quality Impact Assessment format	Paul Calaminus/ Kevin Cleary	Mar 2018	

Risk No.	**1.10**
Objective	Improve service user satisfaction
Risk Description	The impact of new strategies, models of care or organisational forms may adversely impact on the quality of care currently provided by the Trust
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Trust Board
Source	Board development event
Change since last review	None.

Controls	**Assurance**
1. Partnership arrangements in place	➢ Monthly Strategic Activity Update reports to the SDB and Trust Board
2. Representation in all relevant strategic forums	➢ Monthly Strategic Activity Update reports to the SDB and Trust Board
3. 5 year strategy and operational plan in place	➢ Monthly Strategic Activity Update reports to the SDB and Trust Board
Gaps in Controls	**Gaps in Assurance**
Measurement of the anticipated and actual impact of new strategies and models of working	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	3	3	2
Risk Scores	**12**	**12**	**8**



Action Required

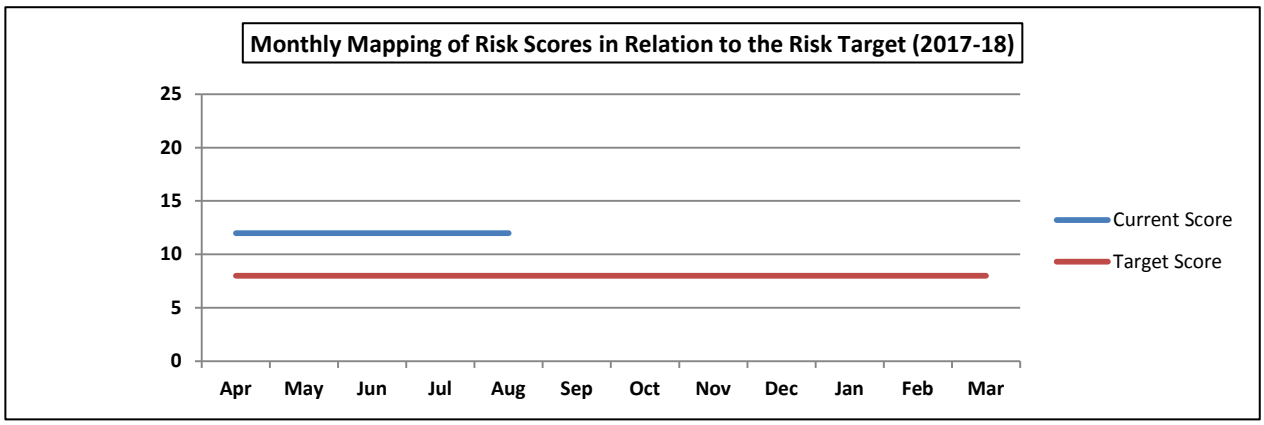
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Revised Trust 5 year strategy to be approved by the Board (November 2017)	Mason Fitzgerald	End of Nov 2017	
2	Introduce measure for the anticipated and actual impact of new strategies and models of working.	Mason Fitzgerald	Oct 2017	

Risk No.	**2.1**
Objective 2	Improve staff satisfaction
Risk Description	It fails to recruit and retain high quality staff
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Appointments & Remuneration Committee
Source	Board development event
Change since last review	None.

Controls	**Assurance**
1. QI recruitment project	➢ Reporting to the corporate services QI meeting
2. Workforce Committee	➢ Reporting to the Service Delivery Board
3. Close links with training institutions	➢ Reporting to the Trust Board
4. Retention project	➢ Reporting to the Workforce Committee
5. Training, supervision and appraisal compliance monitoring	➢ Monthly compliance reports to the Service Delivery Board
6. Annual staff survey	➢ Annual staff survey results
Gaps in Controls	**Gaps in Assurance**
Lack of directorate workforce plans	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	4	3	2
Risk Scores	**16**	**12**	**8**



Action Required

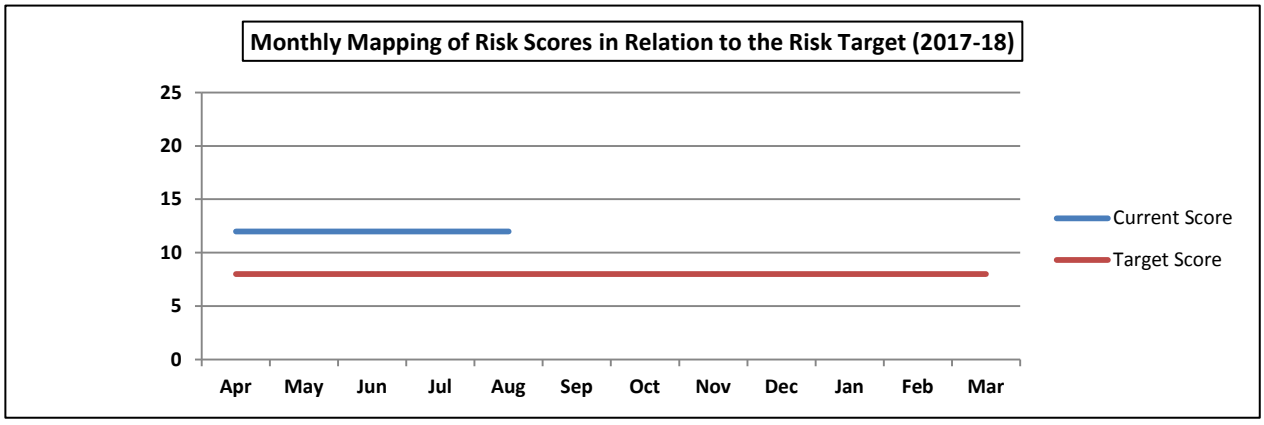
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Develop directorate workforce plans	Mason Fitzgerald/ Paul Calaminus	Sep 2017	

Risk No.	**2.2**
Objective 2	Improve staff satisfaction
Risk Description	It fails to ensure that workforce capability and capacity and ability to respond to change, including delivery of new strategies and models of care, is sufficient to continue to meet stated trust objectives
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Appointments & Remuneration Committee
Source	Trust annual plan
Change since last review	The consequence for the target score has increased from 3 to 4 (new Target Score 8 instead of 6) following the review of controls and assurance

Controls	**Assurance**
1. Management of Staff Affected by Change Policy and Procedure	➢ Reporting to Joint Staff Committee ➢ Reporting on grievances relating to change ➢ Feedback from staff on change consultations
2. Organisational development programme	➢
3. Workforce Committee	➢ Reports to the Service Delivery Board
Gaps in Controls	**Gaps in Assurance**
Lack of an up to date workforce strategy	Reporting on the organisational development programme

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	4	3	2
Risk Scores	**16**	**12**	**8**



Action Required

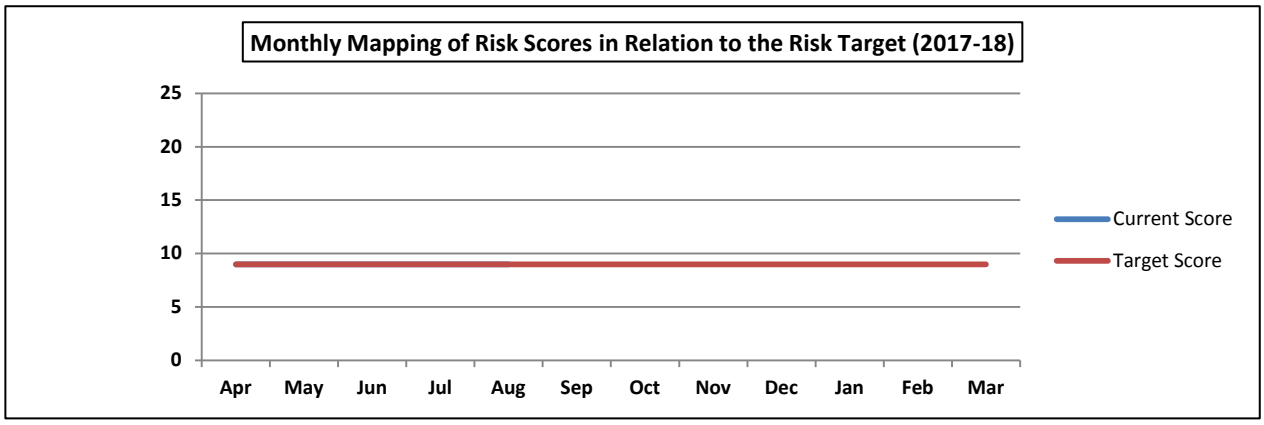
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Revise the Workforce Strategy	Mason Fitzgerald	Sep 2017	
2	OD programme to report to the workforce committee	Mason Fitzgerald	Sep 2017	

Risk No.	**2.3**
Objective 2	Improve staff satisfaction
Risk Description	It fails to put in place succession plans for the Trust Board and senior management roles
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Appointments & Remuneration Committee
Source	Board development event
Change since last review	None

Controls	**Assurance**
1. Appointments and Remuneration Committee	➢ Reports to the Trust Board
2. Council of Governors Nomination Committee	➢ Reports to the Council of Governors
3. Board skills audit	➢ Reports to the Trust Board
4. Formal succession planning process in place	➢ Reports to the Appointments and Remuneration Committee
Gaps in Controls	**Gaps in Assurance**
➢ No formal succession plan in place ➢ No formal monitoring of succession planning outcomes	

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	4	3	3
Likelihood	4	3	3
Risk Scores	**16**	**9**	**9**



Action Required

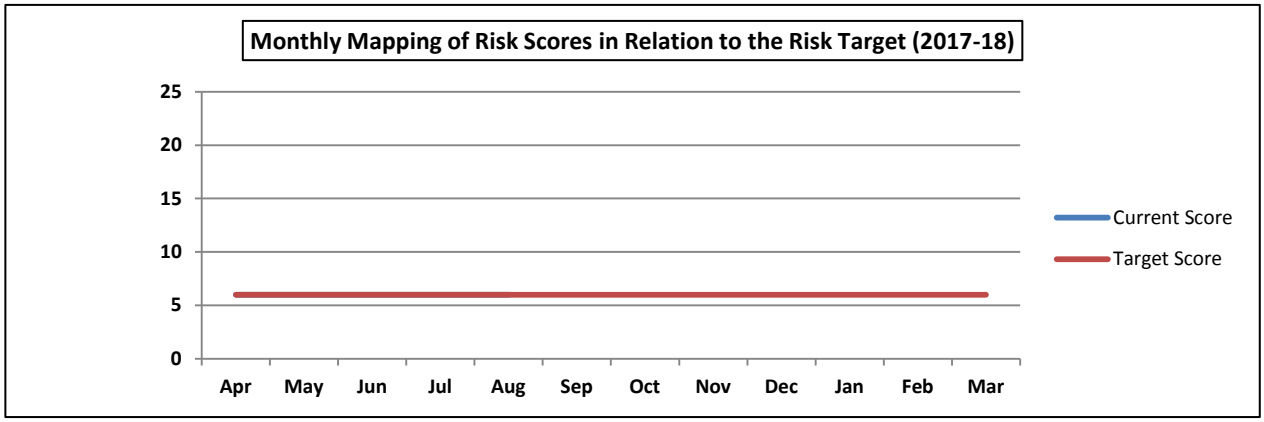
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Develop a formal succession plan	Mason Fitzgerald	Oct 2017	
2	Introduce a system for monitoring succession planning outcomes	Mason Fitzgerald	Oct 2017	

Risk No.	**2.4**
Objective 2	Improve staff satisfaction
Risk Description	If it fails to maintain improvement in measures of staff engagement in the context of continued financial constraints and CRES plans
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Appointments & Remuneration Committee
Source	Board development event & annual staff survey
Change since last review	None

Controls	**Assurance**
1. Staff engagement strategy in place	➢ Quarterly internal staff survey ➢ Annual national staff survey
2. QI programme	➢ No. of staff trained in QI methodology ➢ No. of staff involved in QI projects
3. Trustwide directorate and professional group action plans	➢ Reporting to the Workforce Committee
Gaps in Controls	**Gaps in Assurance**
Staff experience measures specific to change programmes	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	3	3	3
Likelihood	3	2	2
Risk Scores	**9**	**6**	**6**



Action Required

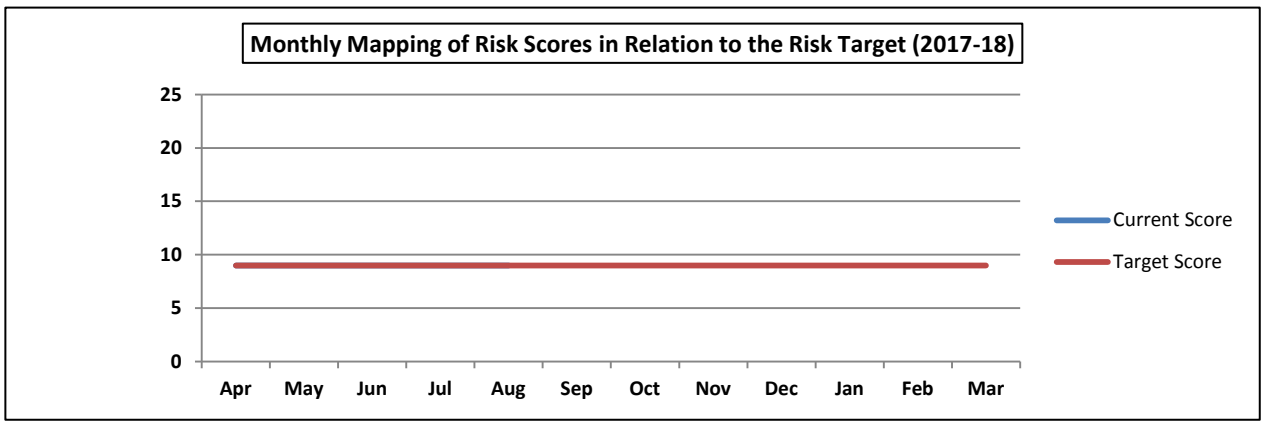
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implementation of staff survey action plans	Mason Fitzgerald	Jul 2017	Plans are now in place.

Risk No.	**2.5**
Objective 2	Improve staff satisfaction
Risk Description	If it fails to provide, and engage staff with, modern and effective IT infrastructure, both physical and systems.
Executive Lead	Steven Course, Chief Financial Officer
Lead Committee	Audit Committee
Source	Directorate risk registers and staff feedback
Change since last review	None

Controls	**Assurance**
1. IT strategy	➢ Reporting to the Trust Board on strategy implementation ➢ Reporting to the FBIC on the quality of IT hardware and systems
2. Electronic Clinical Systems Board (ECSB)	➢
3. RiO Project Board	➢ Reporting to the ECSB
4. Associate Medical Director for Clinical Information	➢ Reports to the Chief Financial Officer and the ECSB
5. Roll-out of Open RiO in Luton and Bedfordshire	➢ Performance reporting
Gaps in Controls	**Gaps in Assurance**
➢ Inter-operability is not currently delivered across all trust services.	Reporting on the effectiveness and work of the Electronic Clinical Systems Board

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	3	3	3
Likelihood	5	3	3
Risk Scores	**15**	**9**	**9**



Action Required

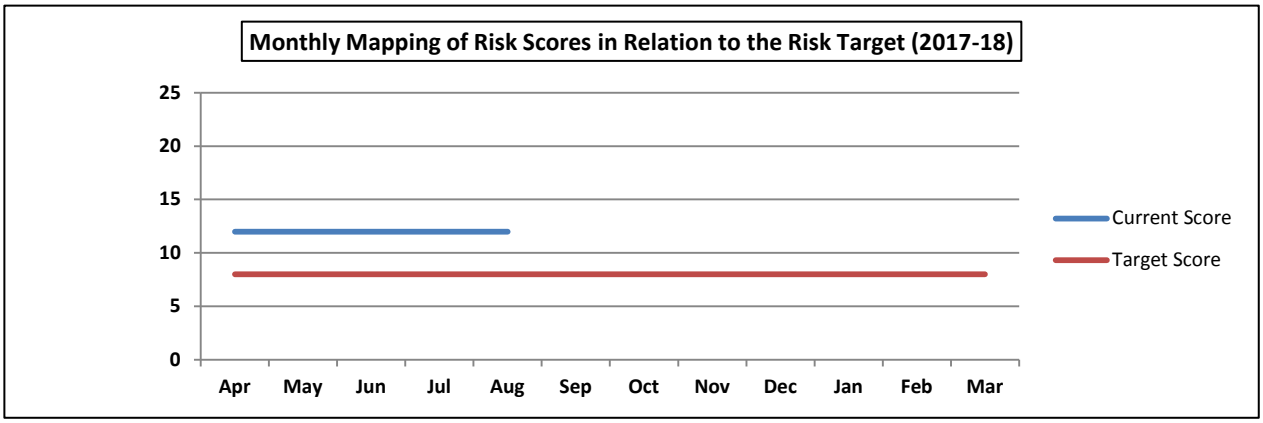
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implementation of EMIS in Tower Hamlets CHS (December 2017)	Steven Course	Dec 2017	
2	Roll-out of mobile working across all services	Steven Course	TBC	
3	Delivery of inter-operability across all services	Steven Course	TBC	

Risk No.	**2.6**
Objective 2	Improve staff satisfaction
Risk Description	If the Trust fails to address concerns regarding fair treatment, career progression and discrimination then the experience and outcomes for certain staff groups will not improve, and adversely impact on the quality of care provided
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Appointments & Remuneration Committee
Source	Board development event
Change since last review	

Controls	**Assurance**
Equality & Diversity Strategy	➢ Reporting to the Workforce Committee, ➢ Reporting to the Remuneration Committee and Trust Board
Equality & Diversity Steering Group	➢ Staff survey results broken down by staff groups ➢ Levels of violence & aggression, harassment and discrimination experienced by BME staff
Staff networks led by executive directors	➢ Reports to the Workforce Committee
Workforce Race Equality Standards (WRES) action plan	➢ Monitoring and review by the trust Board
Strategy and action plan reviews by the Board	➢ Monitoring and review by the trust Board
Gaps in Controls	**Gaps in Assurance**
Lack of high level oversight of all workstreams	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	3	3	2
Risk Scores	**12**	**12**	**8**



Action Required

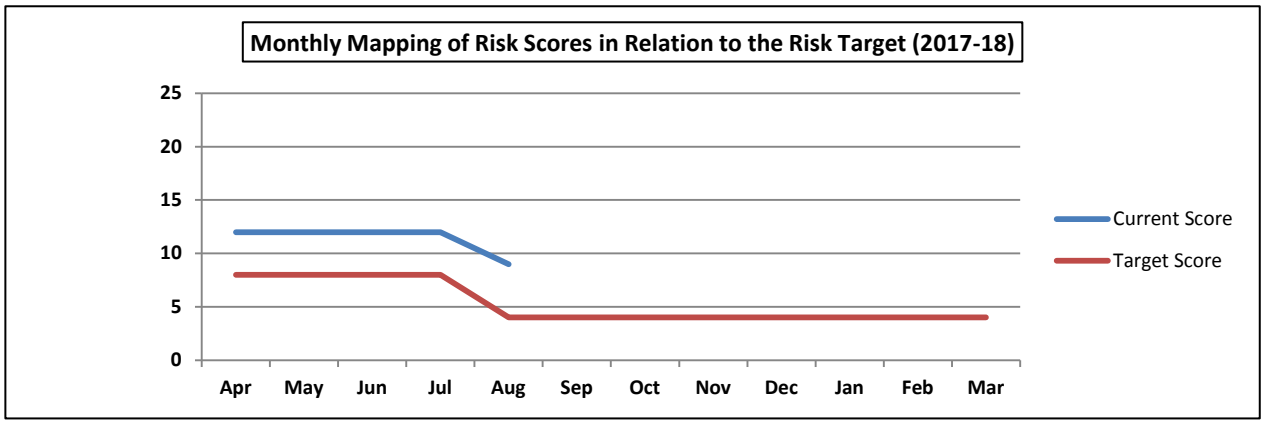
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Introduce a high level oversight report to the Workforce Committee	Mason Fitzgerald	Sep 2017	

Risk No.	**3.1**
Objective	Maintain financial viability
Risk Description	Changes to the commissioning landscape due to the development of accountable care systems could lead to loss of relationships with current commissioners and impact upon currently agreed contractual terms.
Executive Lead	Mohit Venkataram, Director of Commercial Development and Performance
Lead Committee	Trust Board
Source	Board development event
Change since last review	Risk description has been rewritten and controls amended. The target score has been reduced to from 8 to 4 and the current score from 12 to 9. Action 2 has been added.

Controls	**Assurance**
Leadership and representation at STP	➢ CEO's report at Board Part II
Business Strategy approved by the Trust Board	➢ Monitored at Trust Board and Board development events
MoU between providers in Tower Hamlets and Hackney	➢ Monthly Strategic Activity Update Report
Current relationship with NHSI and NHSE	➢ CEO's report at Board Part II
Gaps in Controls	**Gaps in Assurance**
MoUs for some providers	
Information about the who the new commissioners will be	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	5	3	2
Likelihood	4	3	2
Risk Scores	**20**	**9**	**4**



Action Required

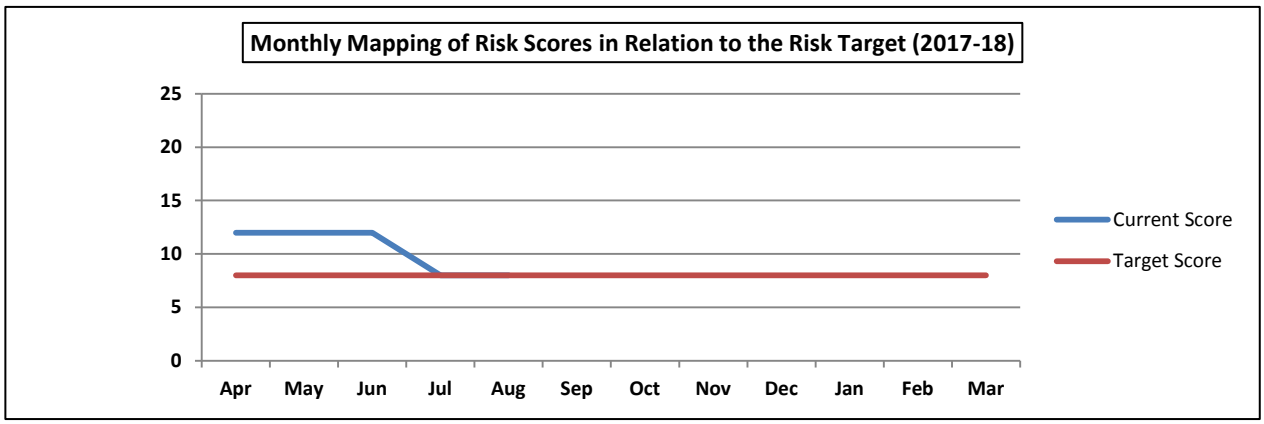
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implement the Business Strategy and review its impact	Mason	Sep 2018	
2	Agree MoUs for Luton, Bedfordshire and Newham providers.	Mason	Mar 2018	

Risk No.	**3.2**
Objective	Maintain financial viability
Risk Description	It fails to plan properly for the introduction of new funding systems, potentially jeopardising income streams
Executive Lead	Steven Course, Chief Financial Officer
Lead Committee	Finance, Business and Investment Committee
Source	Trust annual plan
Change since last review	The likelihood has reduced from 3 to 2 (Current Score is now 8)

Controls	**Assurance**
1. Joint Tariff Implementation Board (Co-chaired with CCGs)	➢ Reports to Trust Board and Financial, Business and Investment Committee (FBIC)
2. Trust involvement in London-wide PBR group	➢ Reports to Trust Board and Financial, Business and Investment Committee (FBIC)
3. Agreement with commissioners on payment systems as part of 2017/18 contracting round (December 2016)	➢ Reports to Trust Board and Financial, Business and Investment Committee (FBIC)
Gaps on Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	4	4	4
Likelihood	4	2	2
Risk Scores	**16**	**8**	**8**



Action Required

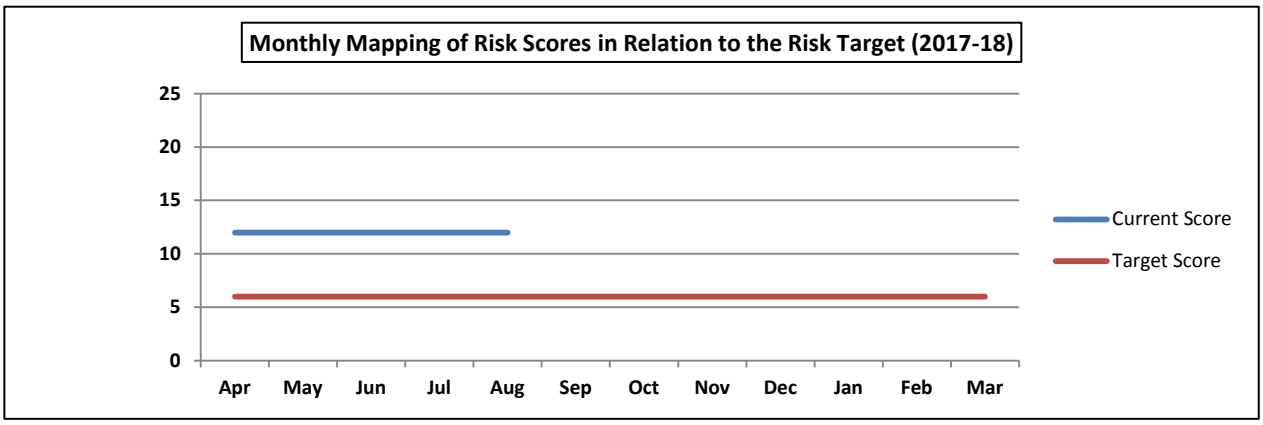
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Analysis of the impact of the IAPT PbR approach	Steven Course	Sep 2017	

Risk No.	**3.3**
Objective	Maintain financial viability
Risk Description	Pressure to meet the trust's Control Total could lead to the pursuit of service acquisitions beyond the trust's agreed geographical footprint, placing additional demands upon existing leadership and management resources which could impact upon the quality of existing service provision. This in turn, could have a detrimental effect upon the trust's reputation for providing high quality care and its competitive edge within the commissioning arena.
Executive Lead	Mohit Venkataram, Executive Director of Commercial Development and Performance
Lead Committee	Trust Board
Source	Quality Assurance Committee, Luton and Bedfordshire transaction risk register
Change since last review	Risk description has been rewritten and new controls (2&3) added.

Controls	**Assurance**
1. The trust's business strategy	➢
2. Workforce strategy, capacity and planning	➢
3. Programme of training to prepare trust leaders for new and evolving leadership roles within accountable care systems	➢
4. Quality and safety dashboard	➢ Quality and safety reports to the Trust Board
5. BDU team and support structures	➢
6. Luton and Bedfordshire Project Board	➢ CQC report
7. Governance and quality improvement structures	➢ Key quality metrics across trust services
8. Revised executive and senior leadership structure	➢ Staff and patient feedback
9. Mobilisation plan and project board for TH CHS	➢ Monitoring of mobilisation plans
Gaps in Controls	**Gaps in Assurance**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	2
Likelihood	3	3	3
Risk Scores	**12**	**12**	**6**



Action Required

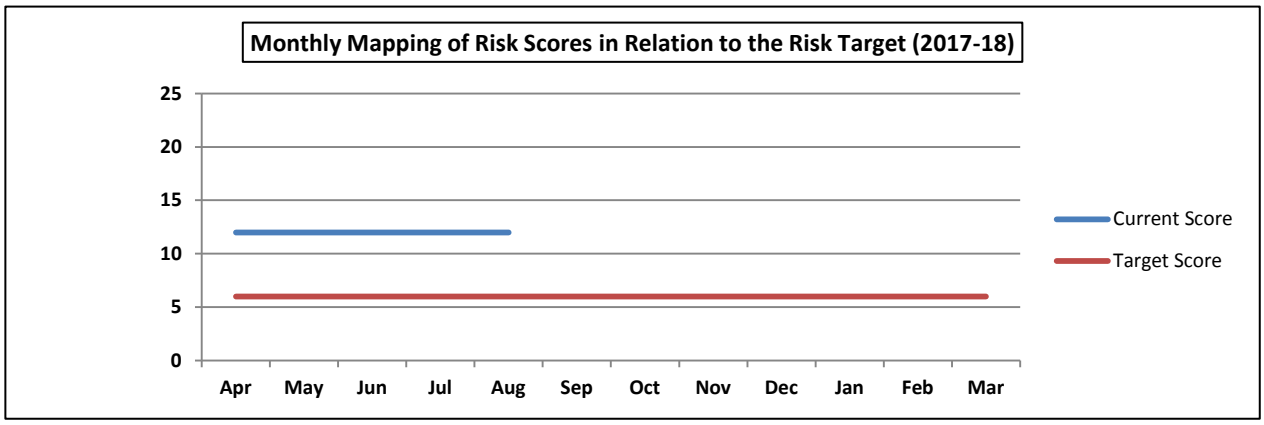
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

Risk No.	**3.4**
Objective	Maintain financial viability
Risk Description	If the trust fails to deliver the Year 3 plan of the Luton & Bedfordshire integration, then it may find the quality of care it provides compromised, patient and staff satisfaction reduced, and its reputation affected.
Executive Lead	Paul Calaminus, Chief Operating Officer
Lead Committee	Quality Assurance Committee
Source	Trust Board
Change since last review	None

Controls	**Assurance**
1. Luton and Bedfordshire Project Board	➢ Regular transaction reports to the Quality Assurance Meeting ➢ Quality and Safety report to the Trust Board
2. Corporate and directorate governance arrangements	➢ Ongoing performance and quality monitoring
3. Executive walkarounds	➢ Improved staff survey scores and good stakeholder feedback
4. Monitoring implementation of the Year 3 plan	➢ Reports to the Quality Assurance Committee
Gaps in Controls	**Gaps in Assurance**
Implementation of the Year 3 plan	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	3
Likelihood	3	3	2
Risk Scores	**12**	**12**	**6**



Action Required

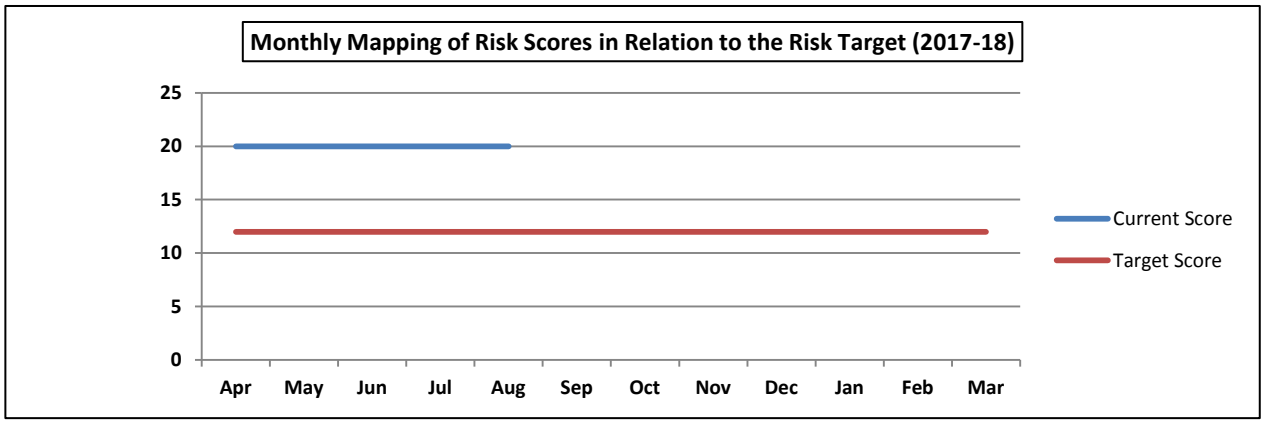
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implementation of the Year 3 plan	Paul Calaminus	Mar 2018	

Risk No.	**3.5 (a)**
Objective	Maintain financial viability
Risk Description	The short-term impact and potential lack of achievability of CRES requirements, coupled with expenditure control and income generation, upon the overall financial sustainability of the trust. Further risk implications concerning the impact on the reputation of the trust and access to revenue streams such as STF funding.
Executive Lead	Steven Course, Chief Financial Officer
Lead Committee	Finance, Business and Investment Committee
Source	Board development event
Change since last review	None

Controls	**Assurance**
1. Quality Impact Assessment of CRES plans	➢ Monitored by the Chief Medical Officer
2. Financial planning process with clinical leadership and engagement	➢ Reporting to the FBIC ➢ Financial reports to the Board detail the ongoing actions of the operational teams in managing services within budget
3. In year financial monitoring meetings with directorates and the Chief Operating Officer	➢ Reporting to the FBIC ➢ Reporting to the Board
4. Agency expenditure reviews	➢ Reporting to the FBIC
5. Scrutiny of in-year financial position at FBIC	➢ Reporting to the FBIC
6. Joint work with CCGs to allow progress on CRES schemes requiring their approval	➢ Reporting to the FBIC
Gaps in Controls	**Gaps in Assurance**
Inability to identify sufficient levels of efficiency savings to meet our Control Total, without detriment to patient care	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	4	5	3
Risk Scores	**16**	**20**	**12**



Action Required

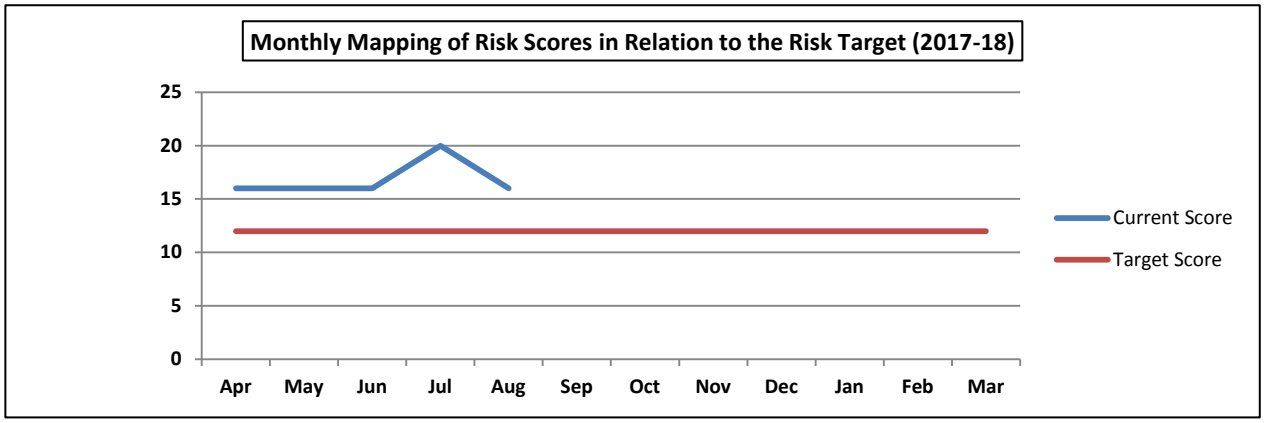
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Continued discussions with directorates and commissioners regarding further efficiency savings.	Steven Course/ Paul Calaminus	End of August 2017	

Risk No.	**3.5 (b)**
Objective	Maintain financial viability
Risk Description	The long term impact and potential lack of achievability of CRES requirements over the next 5 years threatens the overall financial sustainability of the Trust
Executive Lead	Paul Calaminus, Chief Operating Officer
Lead Committee	Finance, Business and Investment Committee (FBIC)
Source	Board development event
Change since last review	Likelihood has decreased from 5 to 4 (Current Score is now 16) in response to financial planning undertaken.

Controls	**Assurance**
1. Quality Impact Assessment of CRES plans	➢ Reports to the Quality Impact Assessment Group ➢ Reports to the CCGs
2. Financial planning process with clinical leadership and engagement	➢ Reporting to the Service Delivery Board and the FBIC
3. Business Strategy	➢ Reports to the FBIC
Gaps in Controls	**Gaps in Assurance**
Current system for identification of CRES needs reviewing	

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	4	4	4
Likelihood	4	4	3
Risk Scores	**16**	**16**	**12**



Action Required

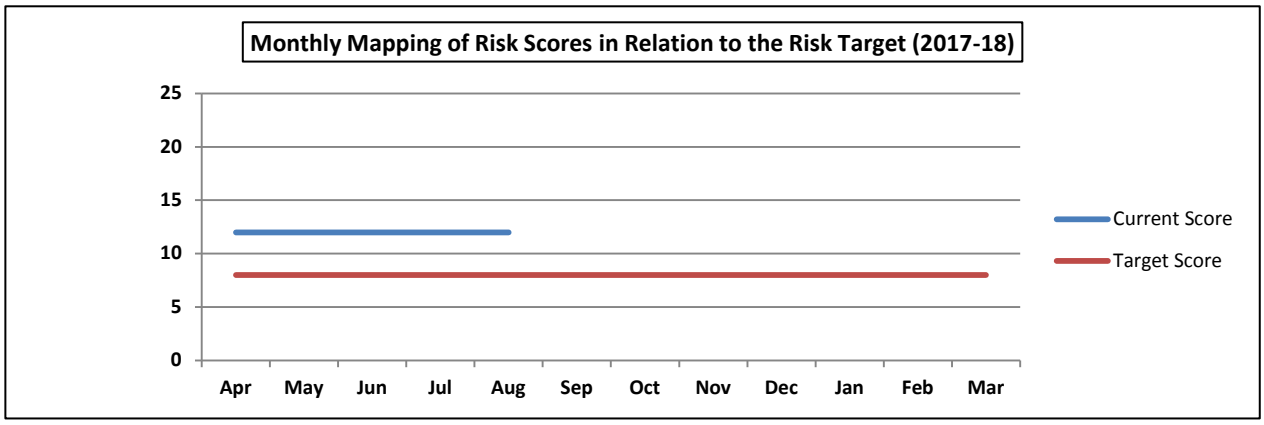
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Revise the trust's 5 year strategy	Mason Fitzgerald	Nov 2017	
2	Review current system for identification of CRES needs	Mohit Venkataram	Sep 2017	

Risk No.	**3.6**
Objective	Maintain financial viability
Risk Description	If services are not adequately incorporated into Sustainability and Transformation Plans (STPs), they risk becoming unsustainable over the next five years.
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Trust Board
Source	Trust Board discussion
Change since last review	None

Controls	**Assurance**
1. Involvement in STP planning groups	Reports to Service Delivery Board
2. Mental health/community workstreams in North East London	Reports to Service Delivery Board
3. Mental health/community workstream in Luton & Bedfordshire	Reports to Service Delivery Board
4. Action plan in response to NELSTP mental health review	Reports to Service Delivery Board
5. Mental health and community health workstreams now commenced in BLMK (April 2017)	Reports to Service Delivery Board
Gaps in Controls	**Gaps in Assurance**
➢ Implementation of NEL STP mental health delivery plan ➢ Development of mental health and community health plans for BLMK	

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	3	3	2
Risk Scores	**12**	**12**	**8**



Action Required

No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implementation of NEL STP mental health delivery plan	Mason Fitzgerald	Apr 2018	
2	Development of mental health and community health plans for BLMK	Mason Fitzgerald	Sep 2017	