NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
22 FEBRUARY 2018

Title	Integrated Quality and Performance report
Author	Sarah Gibbs, Assistant Director of Informatics Amar Shah, Associate Medical Director – Quality Matthew Hart, Deputy Director of Finance Sandra Drewett, Director of Human Resources & Organisational Development
Accountable Executive Directors	All

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 December 2017.

Summary of Key Issues:

This report, for the first time, integrates quality information. Quality metrics show special cause variation in relation to incidents, restraints and incidents of self-harm. Analysis is contained within the report.

The service provision infographic acknowledges and celebrates the work being done by Improving Access to Psychological Therapies services to help patients to improve and recover.

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.

Areas of performance where further work is being undertaken includes 7 day follow up for all discharges. Teams have been working hard to put operational and reporting systems in place to ensure that all patients discharged receive follow up. The December compliance figure is 86% and January figures are expected to reach 90%. Much work has also been done to reduce the number of patients whose transfer to community settings has been delayed, including close working with Local Authority colleagues.

The Trust vacancy rate has increased to 13%. Training compliance has increased by 1% in January, following previous dips, and is now 84%. Work continues to address the underlying issues affecting performance.

For finance, the Trust has delivered an operating surplus (EBITDA) to end of January 2018 of £17,143k (5.7%) compared to plan of £21,071k (6.9%). The net surplus is £4,188k (1.4%) compared to revised planned net surplus of £8,076k (2.75). The Trust is on target against revised forecast outturn of £6.29m surplus. Based on the above, the overall Risk rating is "2" to the end of January 2018.

The Board Assurance Framework is attached. All risks are being monitored regularly at Board committees. This will now be subject to a major revision as part of the development of the new Trust strategy.

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 February 2018 22nd February 2018 Various. Various dates in following month.	This report is submitted to the Service Delivery and Trust Boards. This report is based on December/YTD activity data received by the 5th January 2018. Final figures are considered at the Service Delivery Board, Quality and Directorate Performance review meetings with Service and Clinical Directors and Trust Executive Directors. This review process is supported via a central adverse variance action tracker and summaries prepared by DMTs. 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 December 2017 and provides data on key Compliance, NHS Improvement (Month 9), 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

Impact	Update/detail
	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 quality, performance and compliance matters.

The Trust is developing a more integrated approach to quality and performance management. This report now includes a section on quality.

Work continues to develop the presentation of information in line with Quality Improvement methodology, but also taking account of the regulatory requirements. Directorate performance reports now look at information over time, and utilise control charts. The work on the Trust strategy will further influence this work, with a new format of report coming to the next Board meeting.

2. Compliance Update

Trusts are 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		The Trust is not meeting the control total (financial surplus target of £12.4m) for 2017/18
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 overleaf 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.

This month's report shows activity across the Trust's Improving Access to Psychological Therapies (IAPT) services. All services are meeting demanding national targets for waiting times and recovery rates. Outcome data shows that many patients have entered employment or education by the end of their treatment.

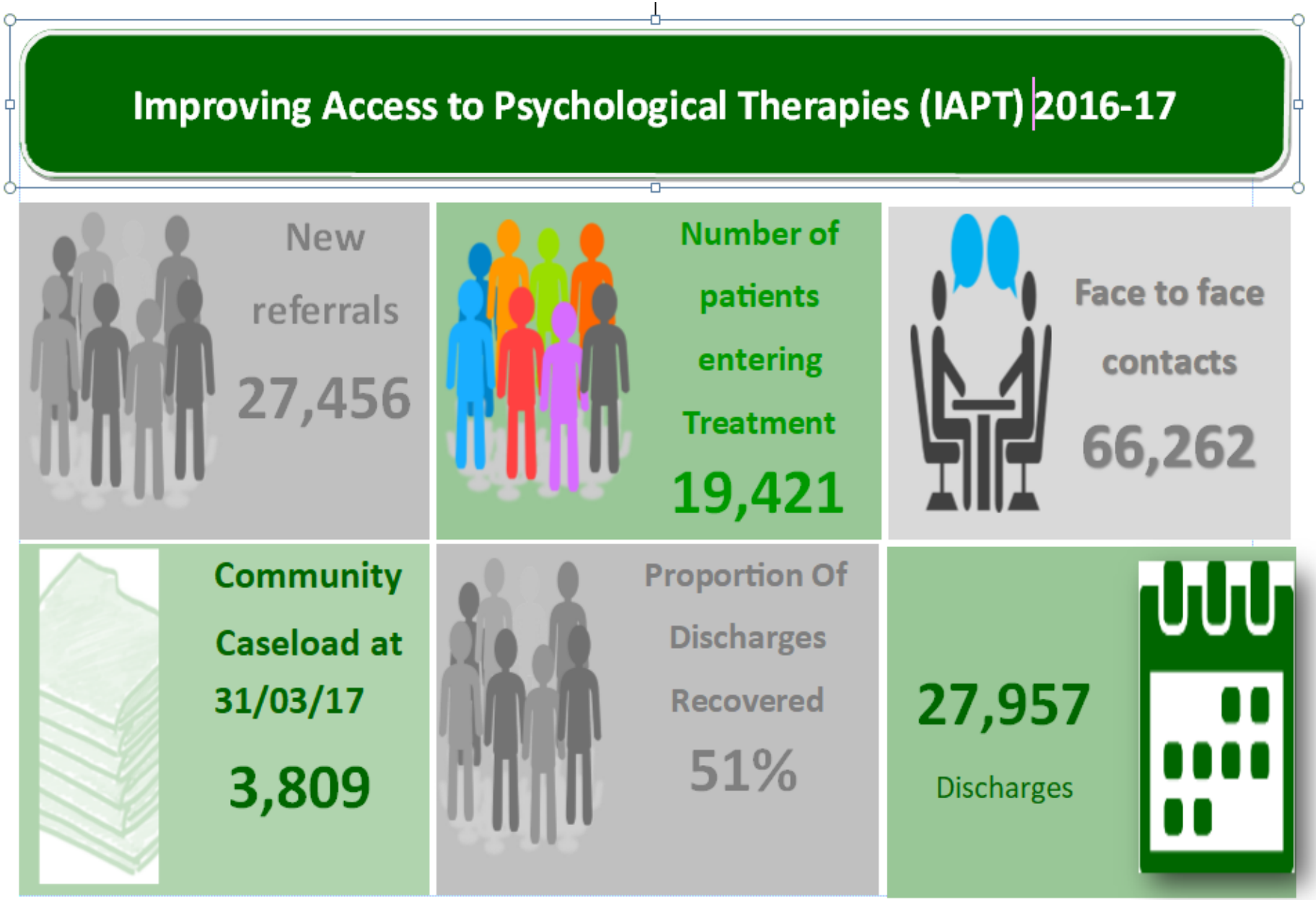
Services receive positive patient feedback. Some examples are as follows:

My therapist was incredibly helpful. I didn't anticipate just how much difference CBT would make. It has made such a change. Thank you for your excellent guidance!

Made me feel mentally stronger and able to address my relationship issues. Made me find my voice again.

I have found it really helpful, thank you for your support, felt listened to, feel more confident that can cope with everything more as I developed tools and techniques

Lovely and exceptional therapist. Thank you


Improving Access to Psychological Therapies (IAPT) 2016-17
New referrals
27,456
Number of patients entering Treatment
19,421
Face to face contacts
66,262
Community Caseload at 31/03/17
3,809
Proportion Of Discharges Recovered
51%
27,957
Discharges

4. Quality

The Quality Dashboard is attached as Appendix A.

From the measures presented within the quality dashboard, the number of reported incidents is showing special cause in the last two months. We have seen an unusually high number of incidents reported. Increased safety incident reporting is generally regarded as a sign of an improving safety culture, and this increased reporting mirrors the general increase we have seen in safety incident reporting since we commenced our large-scale quality improvement approach in 2014. Much of the safety improvement work within our QI programme raises awareness of key safety issues and encourages more open reporting, which may explain the progressive increase in incident reporting over the last four years.

Episodes of restraint have shown special cause variation in the last three months. A large proportion of these incidents have taken place on our psychiatric intensive care units. The number of restraints carried out in prone position has not shown any increase. Over the last two months, the Trust has launched a more visible campaign regarding restrictive practice, and lead nurses across every directorate are being encouraged to talk to inpatient teams about their practice regarding use of restraint. This increased awareness and openness may be contributing to increased, and possible more reliable, reporting of the use of restraint. The lead nurses across the Trust's inpatient services have commenced a project aimed at reducing the use of restrictive practice by 50% by December 2018. This work will be overseen within the violence reduction project board, as part of our QI governance structure.

Incidents of self-harm and attempted suicide show special cause variation for the last four months, with an unusually large number of incidents taking place. More detailed analysis of the 412 incidents that have been reported in the last three months demonstrates:

- 324 relate to incidents of self-harm, and 88 to attempted suicide
- Self-laceration occurred in 72 incidents, and attempted strangulation in 128 incidents
- 259 of the incidents are reported as resulting in no harm, whilst 142 are reported as having caused physical harm
- The most common locations were:
    - Bow ward (23 incidents)
    - Coborn ward (28 incidents)
    - Crystal ward Luton (83 incidents)
    - Keats ward (50 incidents)
    - Onyx ward (37 incidents)
    - Rosebank ward (23 incidents)

Following discussion with the clinical teams for Crystal, Keats and Onyx wards, it appears that Onyx ward occasionally does have peaks of self-harming behaviour, usually due to a single patient. Onyx is an 18-bedded female unit. The ward has begun a QI project to address this issue. Crystal ward's peak in self-harming is largely due to two patients who exhibited high levels of self-harming behaviour. One was also subsequently violence towards others, required long periods of seclusion and was then transferred to an intensive care unit.

Luton directorate has trained up staff to enable them to do dialectical behaviour therapy groups which will start in the next month (two groups in the community, and one group within inpatient services).

5. 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.

5.1 Operational Performance Metrics - Mental Health Providers

Measure	Standard	Dec-17	Q2
Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	95%	99.2%	99.9%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	91%	89%
Complete and valid submissions of metrics in the monthly Mental Health Services Data Set (MHSDS) submissions to NHS Digital:		Standard	Dec-17
Identifier Metrics (primary data)		95%	100.0%
Priority Metrics (primary data)		85%	93.0%
Improving Access to Psychological Therapies (IAPT)/talking therapies (Quarterly)		Standard	Q3
Proportion of people completing treatment who move to recovery (from IAPT MDS)		50%	50.5%
Waiting time to begin treatment within 6 weeks		75%	98%
Waiting time to begin treatment within 18 weeks		95%	99.8%

All national targets have been met for month 9.

5.2 Organisational Health Indicators

There is one red rated item for this month which relates to the 7 day follow up target for discharges from the inpatient unit. The trust will be submitting performance against all discharges in Q3. As reported to the December 2017 Board meeting, the Trust has previously reported against CPA cases only, and guidance has been received that reporting should take place against all cases.

Quarter 2 items were discussed in a previous month where the DTOC indicator was above target but recent performance shows a huge improvement following a focused area of work in all directorates.

Acute Indicators applicable to Mental Health	Standard	Dec-17	Q2
Mixed sex accommodation breaches	0	tbc	tbc
Mental Health Patients occupying beds with delayed transfer of care - Adult & Older Adult (Only CAMHS excluded)	2.50%	0.90%	3.2%
MRSA bloodstream infections - reported instances	0	0	0
Reduction in Clostridium Difficile - reported instances	0	0	0
Mental Health Indicators	**Standard**	**Dec-17**	**Q2**
Admissions to adult facilities of patients who are under 16 years old	0	0	0
Proportion of all discharges from hospital followed up within 7 days	95%	86.8%	n/a
% clients in settled accommodation	n/a	87.2%	85.1%
% clients in employment	n/a	9.1%	7.6%

The performance against the 95% target for all discharges to be seen within 7 days is 86.8% for month 9 (December 2017). Performance in January is expected to rise to 90% once figures are validated.

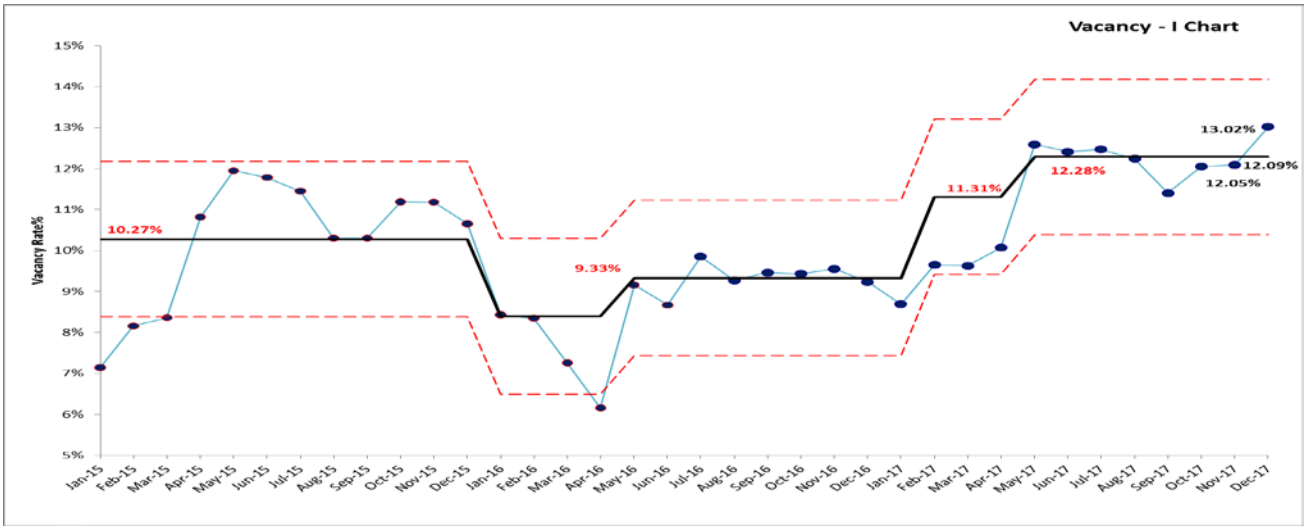
Directorates report that they were a number of engagement issues with some services users – in some cases mobile phone numbers did not work. The community teams needing to try several times to contact users and offering home visits. There is further work by teams to ensure communication around 7 day follow up plans between inpatient staff and community staff are documented on RIO and monitored on a daily basis to ensure there are no delays in taking actions forward once discharged.

5.3 Workforce Indicators

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

VACANCIES

Vacancies	July	August	September	October	November	December
Trust	12.47%	12.24%	11.40%	12.05%	12.09%	13.02%

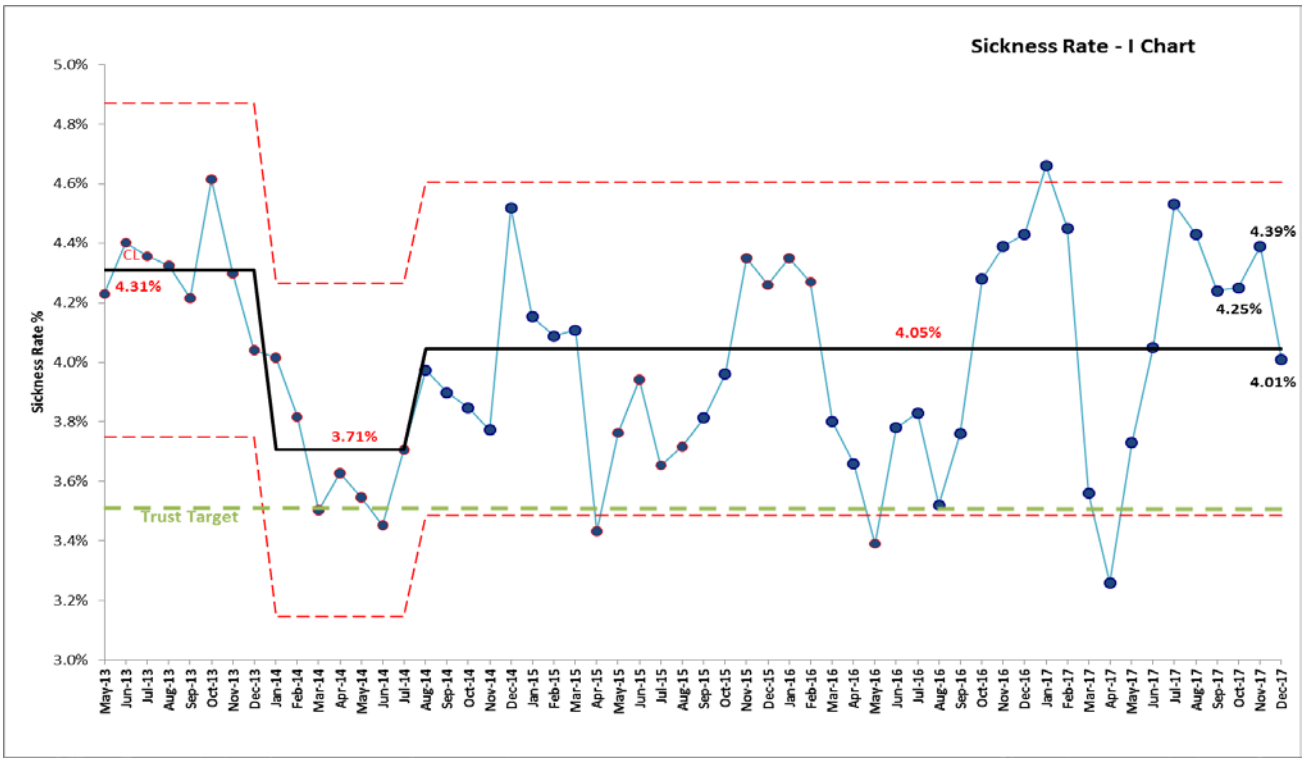


The vacancy rate increased to 13.02% in December 2017. This is thought to be partly attributable to a recruitment lag in December due to the holiday period. Recruitment plans are in place in each directorate. The Newham mental health directorate has had particular success in recruiting through using a rolling selection day, and this learning is being considered by other directorates.

ABSENCE: For last 3 Months

Sickness Absence Rate	Oct-17	Nov-17	Dec-17	Cumulative % Abs rate (FTE) - 3 months
Trust	4.25%	4.39%	4.01%	4.22%

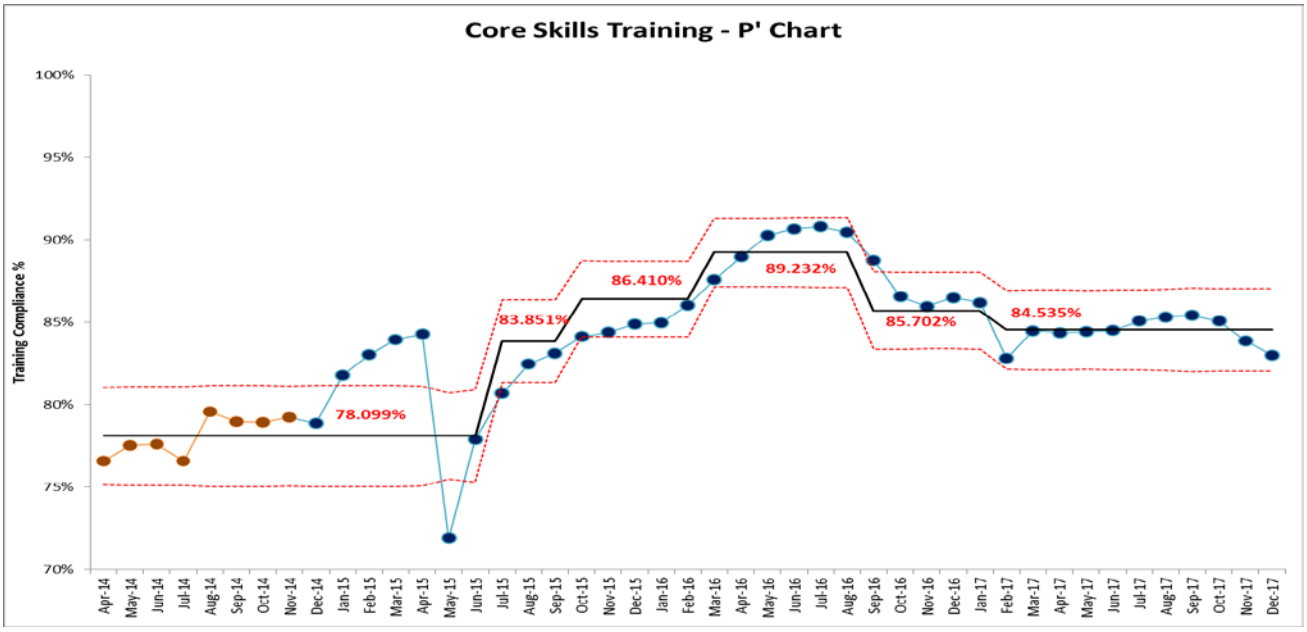
Indicators Amber > 3.5% & 4.5%



Absence has dropped to 4.01% in December. There continues to be focus on active management and support of staff on long term sickness.

MANDATORY TRAINING

Mandatory Training	July	August	Sept	Oct	Nov	Dec	Target
Trust	85.07%	85.31%	85.42%	85.08%	83.89%	83.00%	95%



Mandatory training figures for January are now available and show an increase of 1% to 83.9%. There has been an awareness campaign, including a Twitter “challenge” which has generated increased activity. Work continues to address the underlying issues affecting compliance, with monthly reports at the Service Delivery Board on progress.

6. Finance report

This section highlights financial performance for the period ended 31 January 2018 and projections to 31 March 2018. Performance is summarised in the dashboard attached as Appendix B. Key conclusions are summarised below.

The Trust has delivered an operating surplus (EBITDA) to end of January 2018 of £17,143k (5.7%) compared to plan of £21,071k (6.9%). The net surplus is £4,188k (1.4%) compared to revised planned net surplus of £8,076k (2.7%). Year to-date adverse net surplus variance is £3,887k.

There is a Cash balance of £60.4m as at the end of January 2018. The Trust is on target against revised forecast outturn of £6.29m surplus.

Based on the above, the overall Risk rating is “2” to the end of January 2018.

7. Board Assurance Framework

The Board Assurance Framework (BAF) incorporates a register of the highest risks faced by the Trust in meeting its principal objectives. It is in effect a ‘high level Risk Register’ which provides the Trust with a simple but comprehensive method of describing the organisation’s objectives, identifying the key risks to their achievement and the gaps in assurances on which the Board relies in agreeing action plans. The Audit Committee has overall responsibility for risk management and the BAF.

Each risk within the Board Assurance Framework has a designated Executive Lead or risk owner, who is responsible for routinely reviewing the details of the risk, before submitting it to the Trust Board and other relevant committees. The most recent version of the BAF is presented to each Trust Board meeting, for information only. A streamlined version of the BAF, containing only the relevant risks, is submitted to each of the Board sub-committees, assigned as the lead committee for particular risks. The role of each Board sub-committee to review its assigned risks at each meeting, focusing specifically upon:

a) The accuracy of the current risk score based on the available assurance and/or gaps in assurance
b) Progress against action plans or mitigating actions designed to reduce the risk,
c) Identifying any risks for addition/deletion.
d) Where it deems it necessary, conduct a more detailed review or ‘deep dive’ into specific risks

The BAF is submitted to the Trust Board on a bimonthly basis. The latest version of it is attached as Appendix 3.

8. Recommendations and Action Being Requested

The Board is asked to:

a) **RECEIVE** and **DISCUSS** the report.

b) **NOTE** areas below performance and discuss action being taken to address performance issues across the Trust in order to maintain and improve performance.

Quality dashboard

organisation-level view

Trust wide including Bedfordshire and Luton

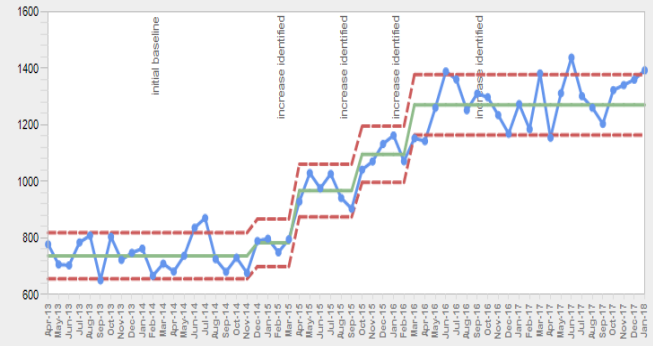
February 2018

NHS
East London
NHS Foundation Trust

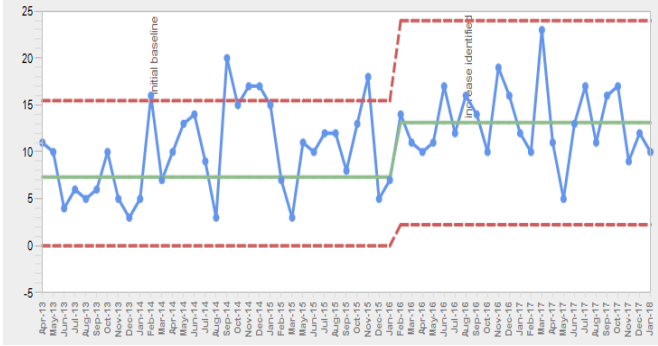
Safety

Trust wide including Bedfordshire and Luton

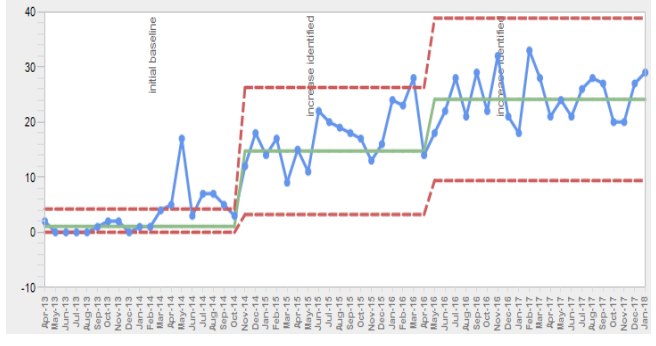
Number of Incidents Reported c Chart



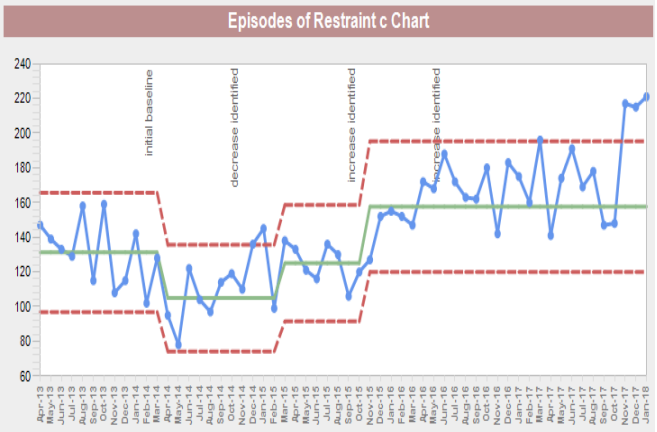
Number of Serious Incidents Reported c Chart



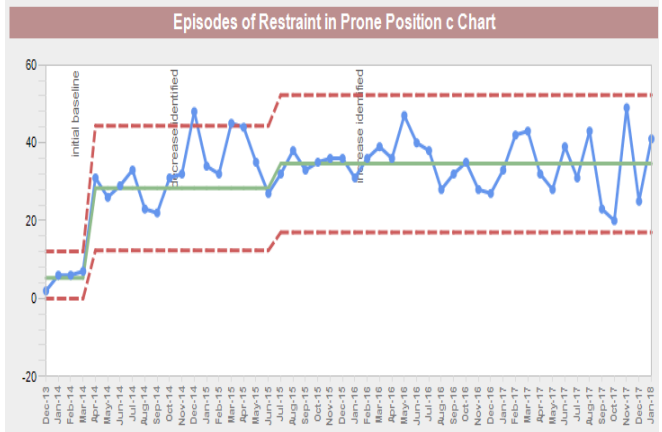
Number of Unexpected Deaths c Chart



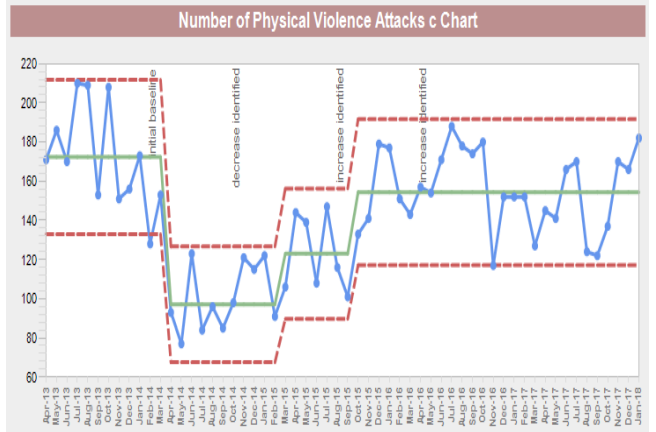
Episodes of Restraint c Chart



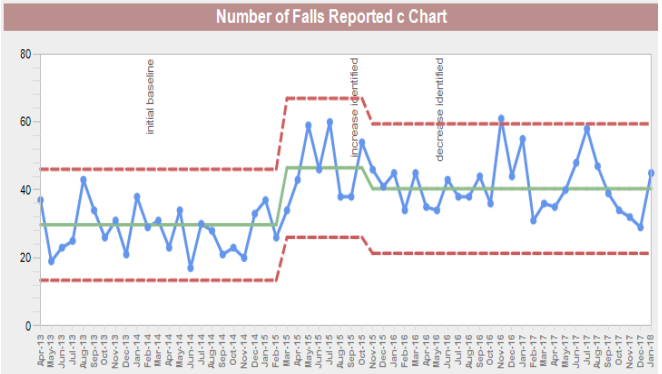
Episodes of Restraint in Prone Position c Chart



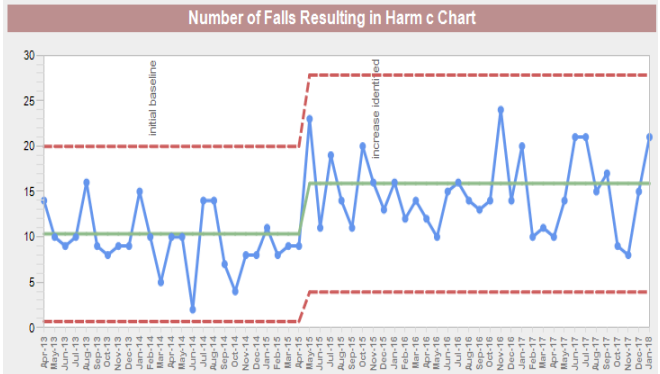
Number of Physical Violence Attacks c Chart



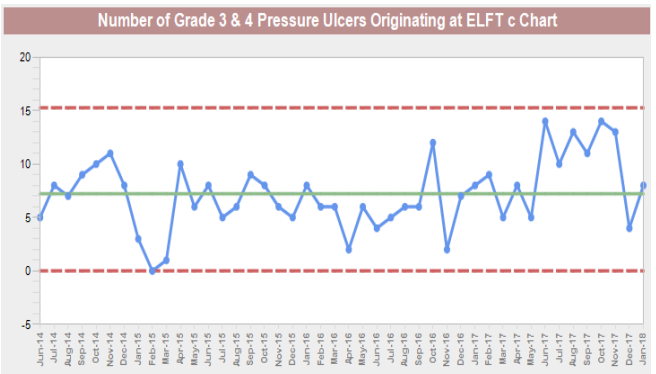
Number of Falls Reported c Chart



Number of Falls Resulting in Harm c Chart



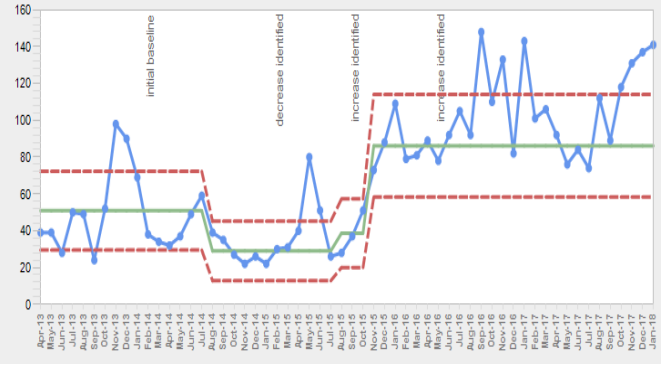
Number of Grade 3 & 4 Pressure Ulcers Originating at ELFT c Chart



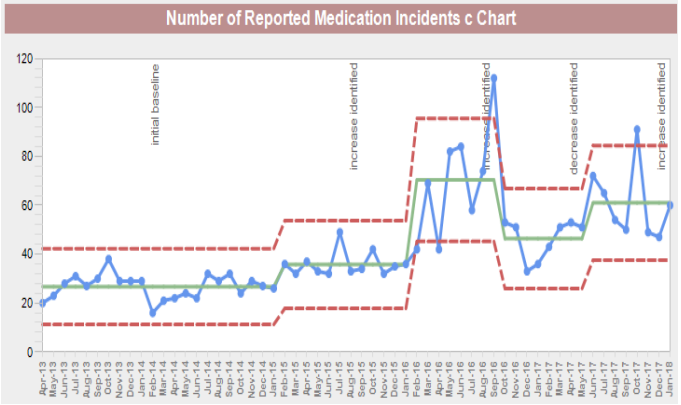
Safety

Trust wide including Bedfordshire and Luton

Number of Self Harm and Attempted Suicide c Chart

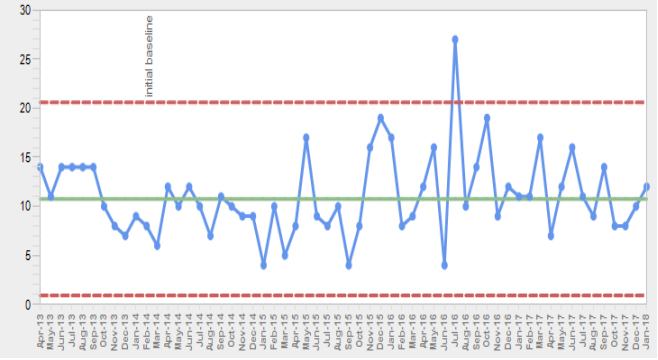


Number of Reported Medication Incidents c Chart

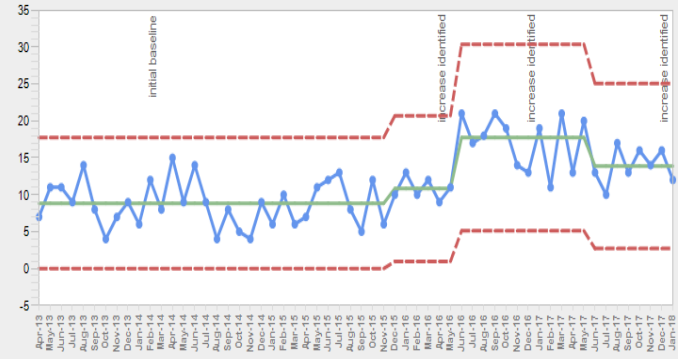


Number of Reported High Risk Medication Incidents c Chart

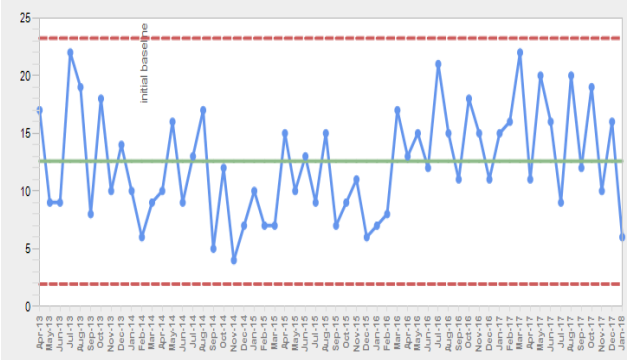
Number of Abscond from Ward c Chart



Number of Abscond from Escorted Leave c Chart

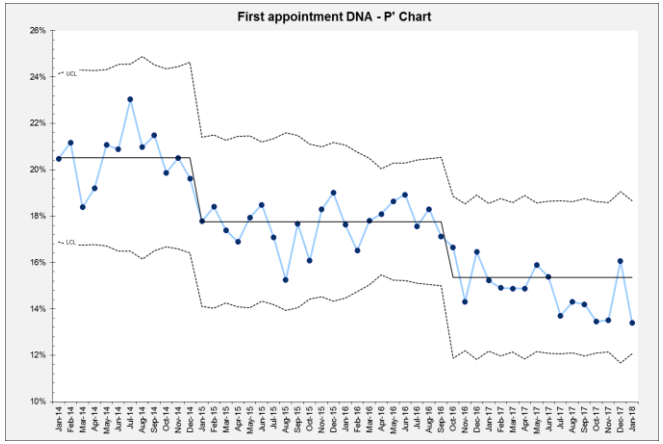


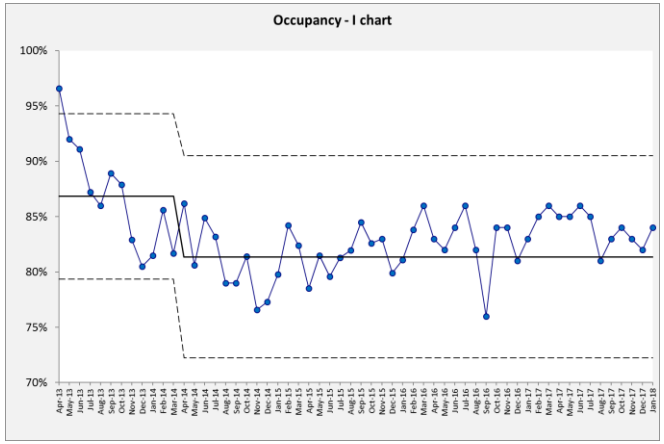
Number of Failure to Return from Leave c Chart

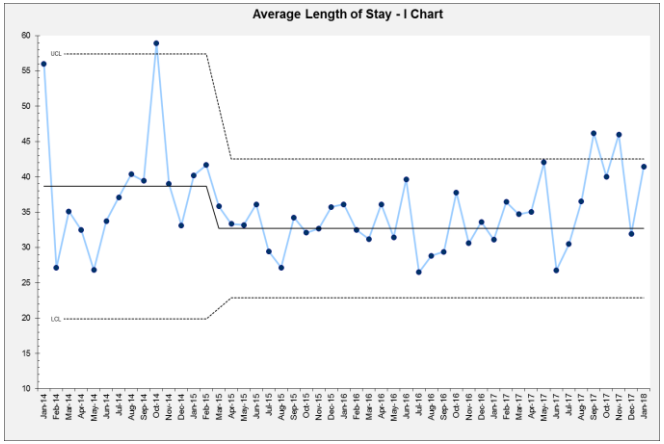


Clinical Effectiveness

Trust wide including Bedfordshire and Luton

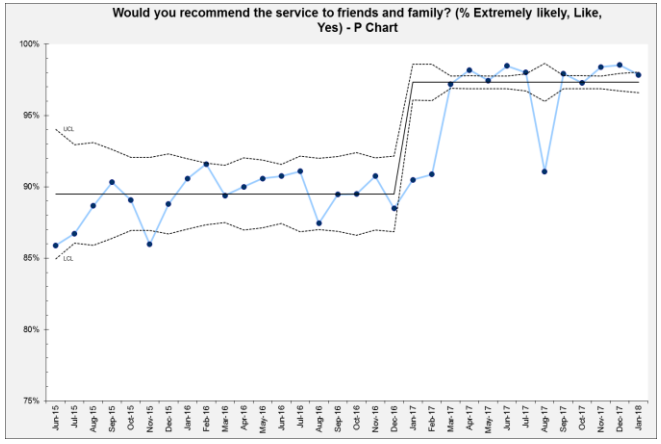


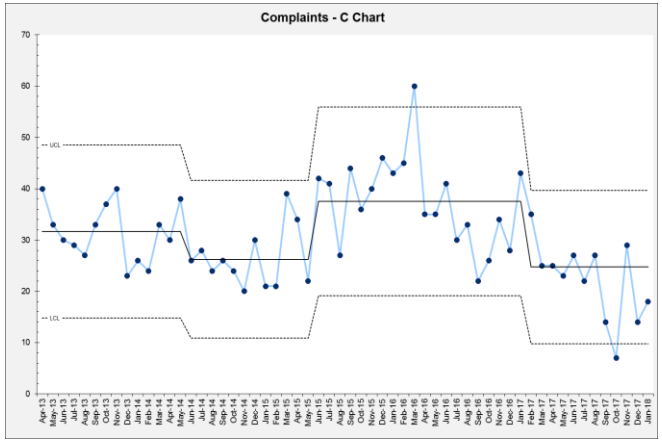


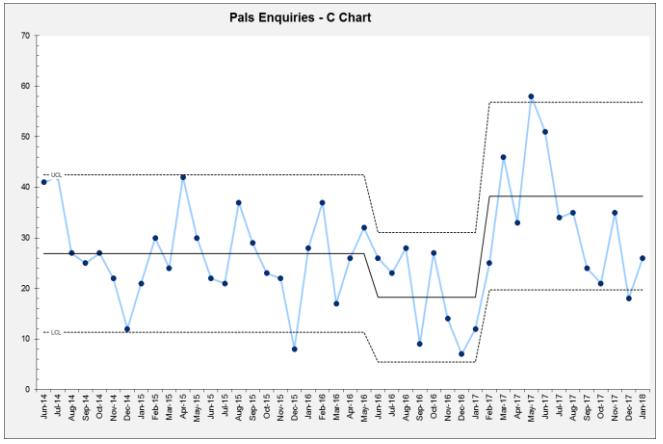


Patient Experience

Trust wide including Bedfordshire and Luton





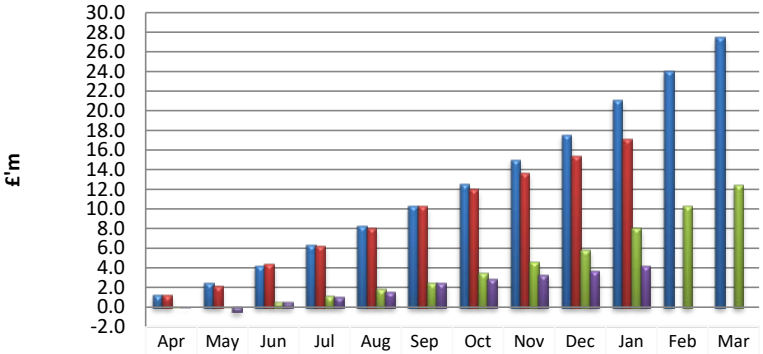


Financial Overview to Period Ending 31st January 2018

EBITDA AND NET SURPLUS

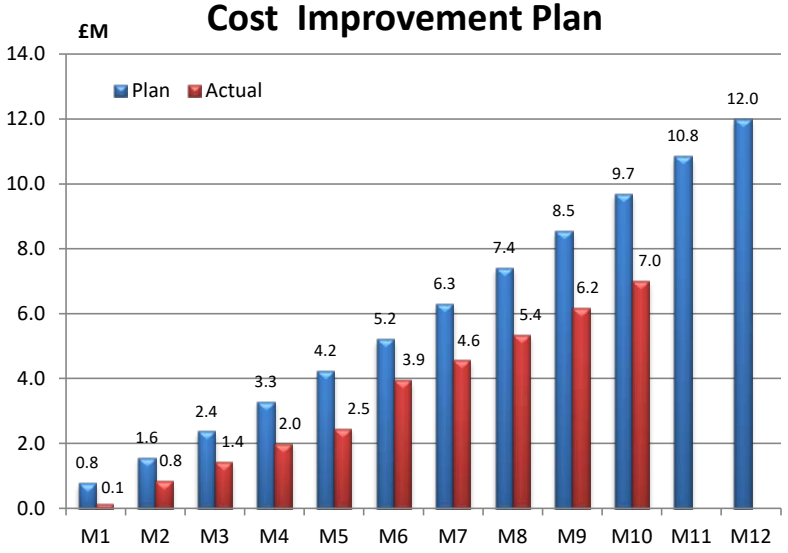
	To 31/01/18		Projection		Plan	
	£m	%	£m	%	£m	%
EBITDA	21.1	6.9	21.7	5.9	27.9	7.6
SURPLUS	4.2	1.4	6.3	1.7	12.4	3.4

EBITDA and Net Surplus



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EBITDA Plan	1.2	2.5	4.2	6.4	8.3	10.3	12.6	15.1	17.5	21.1	24.0	27.5
EBITDA Actual	1.3	2.1	4.4	6.3	8.1	10.3	12.0	13.7	15.4	17.1		
NS PLAN	0.0	0.0	0.5	1.2	1.8	2.5	3.5	4.7	5.9	8.1	10.3	12.4
NS Actual	0.0	-0.5	0.5	1.1	1.6	2.5	2.9	3.3	3.7	4.2		

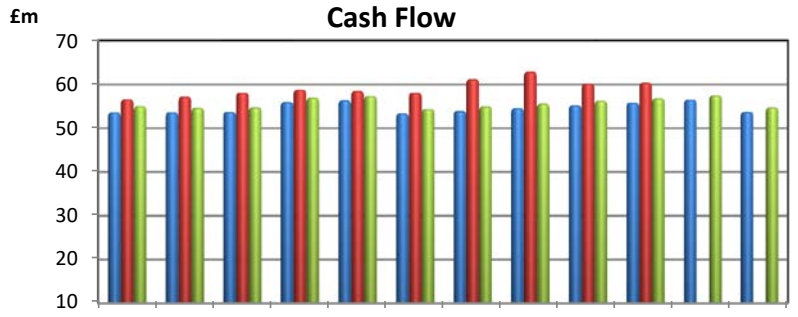
Cost Improvement Plan



WORKING CAPITAL

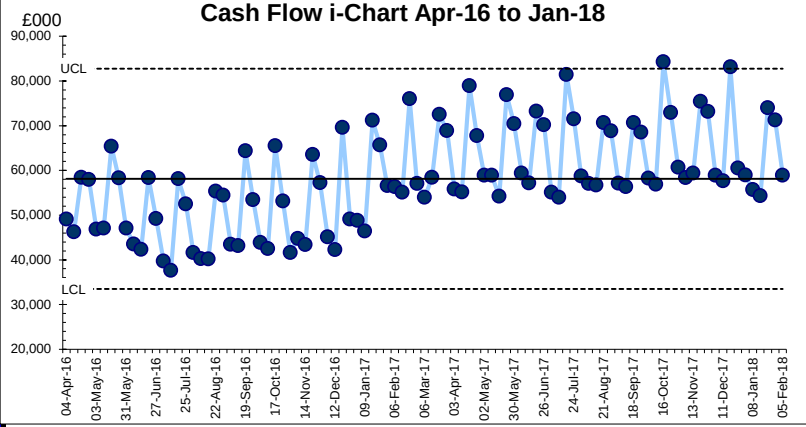
		£m	Risk
Cash	: at Bank	60.4	
	: Short term deposits	0.0	
Short term	: Assets	90.5	
	: Liabilities	69.1	

Cash Flow



	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan £M	54	54	54	56	56	53	54	55	55	56	56	54
Actual	57	57	58	59	58	58	61	63	60	60		
Forecast £M	55	55	55	57	57	54	55	56	56	57	57	55

Cash Flow i-Chart Apr-16 to Jan-18



	Q1	Q2	Q3	M10
DEBTOR DAYS	20	16	17	23
CREDITOR DAYS	34	28	29	27

RISKS AND RISK RATINGS

INCOME	£m
EBITDA Income	364.8
Signed / agreed	345.5
Non Contract	12.3
INCOME RISK	LOW

EXPENDITURE

Savings Programme	HIGH
Expenditure Risk	MEDIUM

METRICS (TBC)	RISK RATING	
Capital Service Cover	2	●
Liquidity	1	●
I&E Margin rating	1	●
Distance from plan	3	●
Agency rating	2	●
OVERALL RISK RATING	2	●

East London NHS Foundation Trust

Board Assurance Framework (BAF)

December 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. Paul Gilluley, Interim Chief Medical Officer	Quality Assurance Committee
1.4		Quality Assurance Committee
1.5		Quality Assurance Committee
1.7		Quality Assurance Committee
1.3	Lorraine Sunduza, Interim Chief Nurse	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
3.7		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
3.7		Steven Course, Chief Finance Officer
1.1	Quality Assurance Committee	Dr. Paul Gilluley, Interim Chief Medical Officer
1.2		Paul Calaminus Chief Operations Officer
1.3		Lorraine Sunduza, Interim Chief Nurse
1.4		Dr. Paul Gilluley, Interim Chief Medical Officer
1.5		Dr. Paul Gilluley, Interim Chief Medical Officer
1.6		Lorraine Sunduza, Interim Chief Nurse
1.7		Dr. Paul Gilluley, Interim 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	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.	12	6
	3.4	If the Trust fails to deliver the Year 3 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.	16	12
	3.6	If services are not adequately incorporated into Sustainability and Transformation Plans (STPs), they risk becoming unsustainable over the next five years.	12	8
	3.7	Agreement via consultation with commissioners, the public and other external stakeholders may not be granted in time to execute major plans, which should result in reduced expenditure and a more efficient delivery of service.	20	12

Mitigation Actions from the BAF

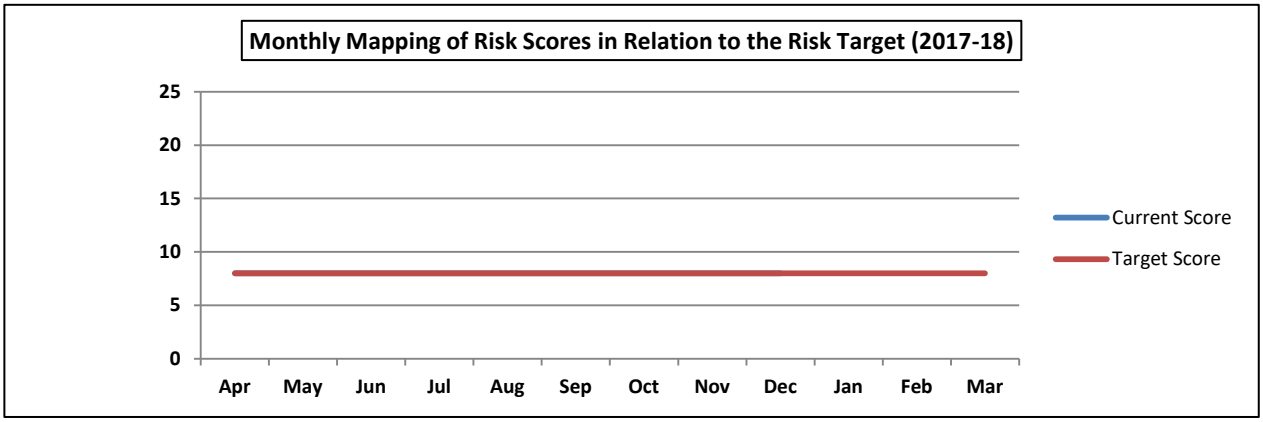
Risk No.	Risk Lead	Action	Responsible Person/s	Due date
3.2	Steven Course	Analysis of the impact of the IAPT PbR approach	Steven Course	Sep 2017
2.2	Mason Fitzgerald	OD programme to report to the workforce committee	Mason Fitzgerald	Oct 2017
1.9	Paul Calaminus	Ensure six monthly reviews are happening routinely	Paul Calaminus/ Paul Gilluley	Dec 2017
2.1	Mason Fitzgerald	Develop directorate workforce plans	Mason Fitzgerald/ Paul Calaminus	Nov 2017
2.6	Mason Fitzgerald	Introduce a high level oversight report to the Workforce Committee	Mason Fitzgerald	Dec 2017
2.3	Mason Fitzgerald	Develop a formal succession plan	Mason Fitzgerald	Dec 2017
2.3	Mason Fitzgerald	Introduce a system for monitoring succession planning outcomes	Mason Fitzgerald	Dec 2017
1.10	Mason Fitzgerald	Introduce measure for the anticipated and actual impact of new strategies and models of working.	Mason Fitzgerald	Dec 2017
2.5	Steven Course	Implementation of EMIS in Tower Hamlets CHS (December 2017)	Steven Course	Dec 2017
3.3	Mohit Venkataram	Establish assurance for the Luton and Bedfordshire Project Board and the Tower Hamlets Community Health Services Project Board	Mohit Venkataram	Dec 2017
1.8	Steven Course	Process and governance route to be established for reporting of estates and facilities issues from third party owned assets	Steven Course	Dec 2017
2.5	Steven Course	Establish the Data Visualisation Project Board	Steven Course	Dec 2017
3.7	Steven Course	Liaise with STP leaders to improve communication and seek improved documentation of decisions made and actions agreed at STP level which impact on the trust.	Steven Course/ Richard Fradgley	Dec 2107
2.2	Mason Fitzgerald	Revise the Workforce Strategy	Mason Fitzgerald	Jan 2018
1.4	Kevin Cleary	Implement and evaluate the trust's new process for implementing NICE guidance.	Kevin Cleary	Jan 2018
2.5	Steven Course	Migration of all staff to NHS Mail	Steven Course	Jan 2018
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
3.5 (b)	Paul Calaminus	Revise the trust's 5 year strategy	Mason Fitzgerald	Mar 2017
1.10	Mason Fitzgerald	Revised Trust 5 year strategy to be approved by the Board	Mason Fitzgerald	Mar 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	Lorraine Sunduza	Implement new trust process for monitoring and ensuring CQC compliance	Lorraine Sunduza	Jul 2018
3.1	Mohit Venkataram	Implement the Business Strategy and review its impact	Mason Fitzgerald	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 Paul Gilluley, Interim Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Annual plan/Board development day – April 2014
Change since last review	None

Controls	**Assurance**
1. Interim 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

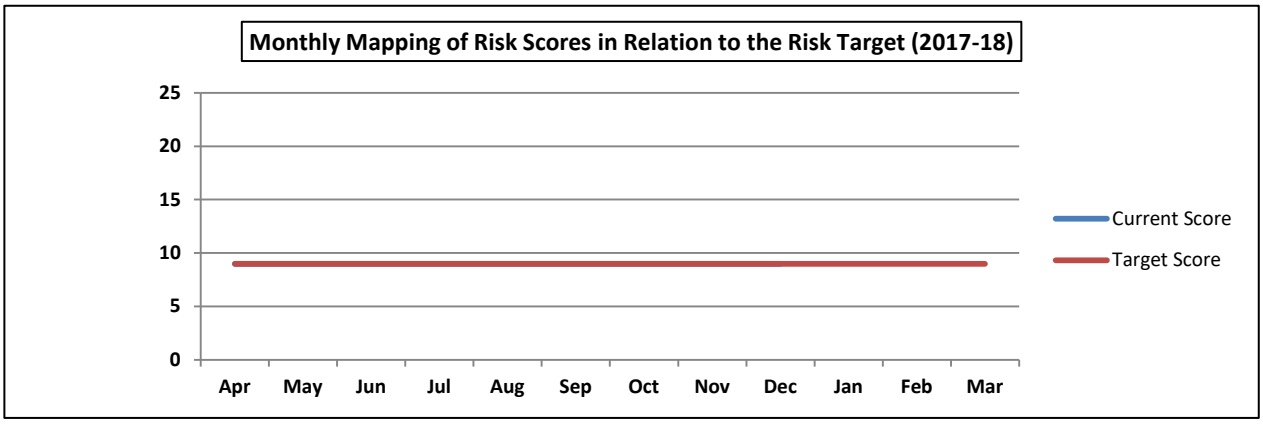
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

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

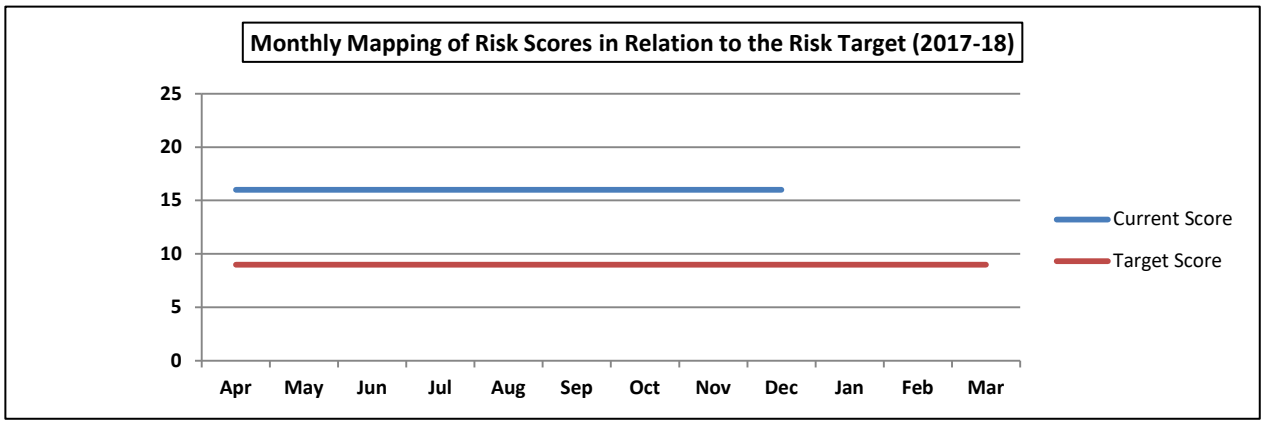
No.	Action	Responsible Person/s	Due date	Progress /Status

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	Lorraine Sunduza, Interim Chief Nurse
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

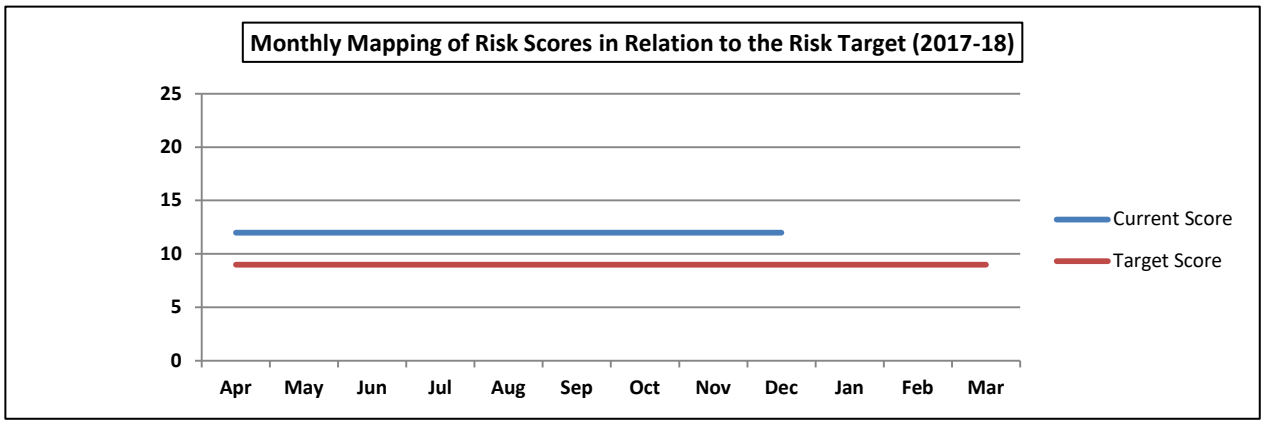
No.	Action	Responsible Person/s	Due date	Progress /Status

Risk No.	**1.4**
Objective	Improve service user satisfaction
Risk Description	It fails to implement relevant NICE guidance
Executive Lead	Dr. Paul Gilluley, Interim 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

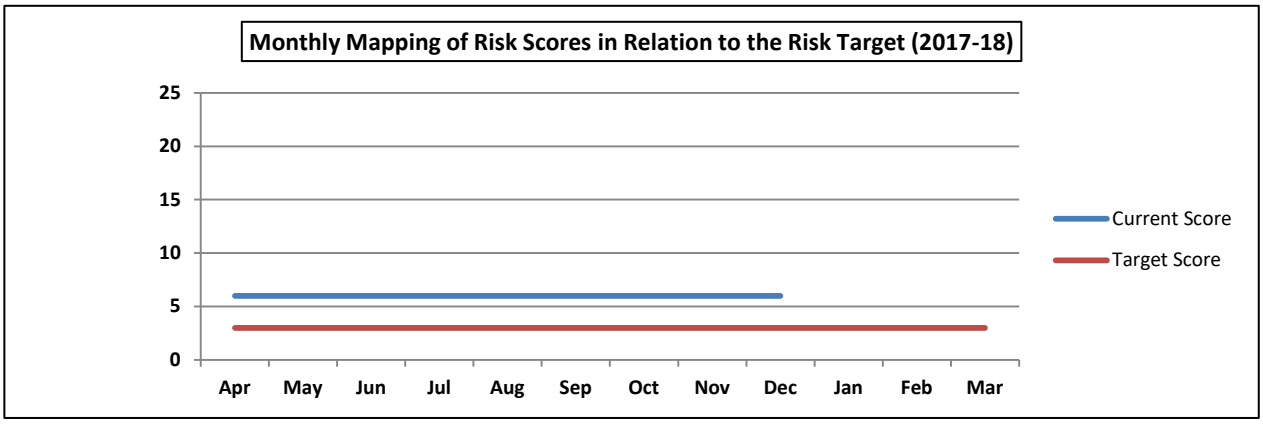
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implement and evaluate the trust's new process for implementing NICE guidance.	Paul Gilluley	January 2018	

Risk No.	**1.5**
Objective	Improve service user satisfaction
Risk Description	It fails to innovate in the pursuit of quality improvement
Executive Lead	Dr Paul Gilluley, Interim 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 Interim 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

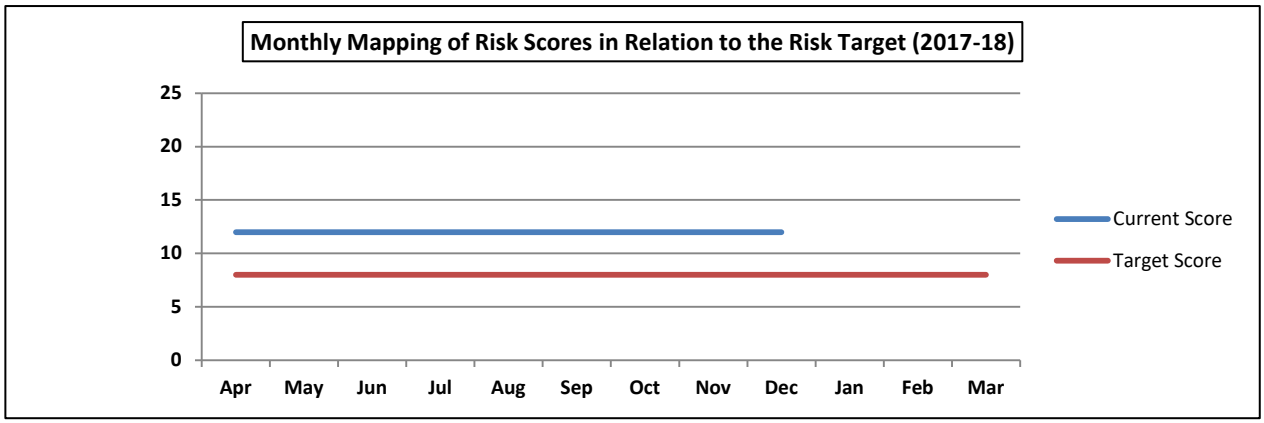
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

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	Lorraine Sunduza, Interim Chief Nurse
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	Lorraine Sunduza	July 2018	

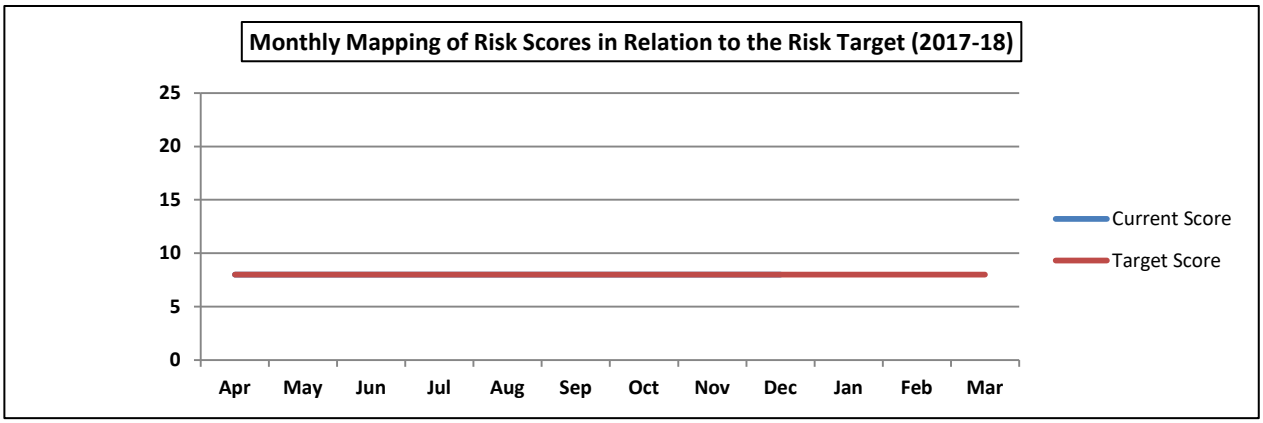
Risk No.	**1.7**
Objective	Improve service user satisfaction
Risk Description	It fails to develop systems and processes to deliver safer and more effective physical health care to MH patients
Executive Lead	Dr Paul Gilluley, Interim Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	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

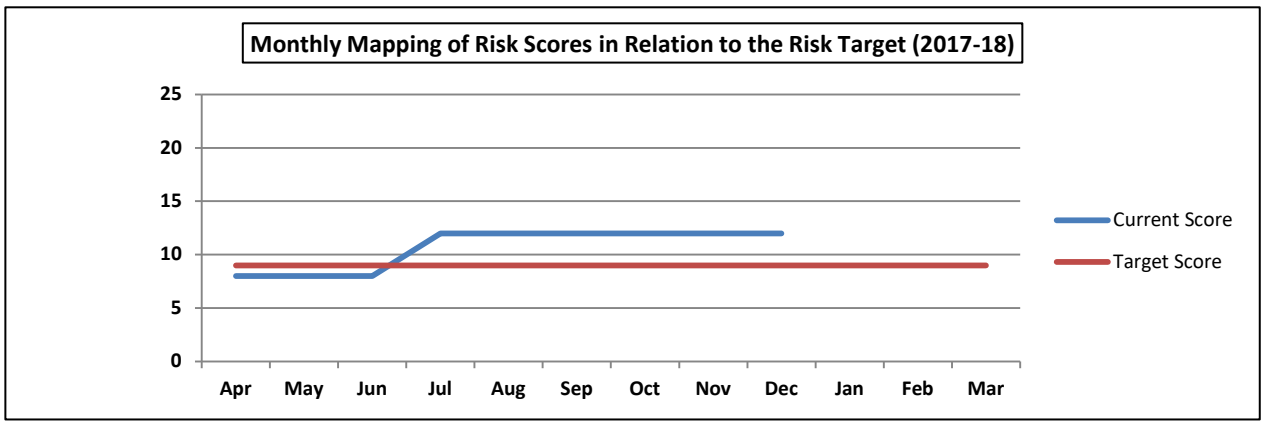
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

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	None

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
6. Compliance meetings and review with NHSPS and CHP landlords	➢ Currently only reported within Estates and Facilities directorate
Gaps in Controls	**Gaps in Assurance**
Lack of escalation process for NHSPS and CHP owned properties	No governance route for oversight or assurance on progress against issues raised

Risk Scores

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



Action Required

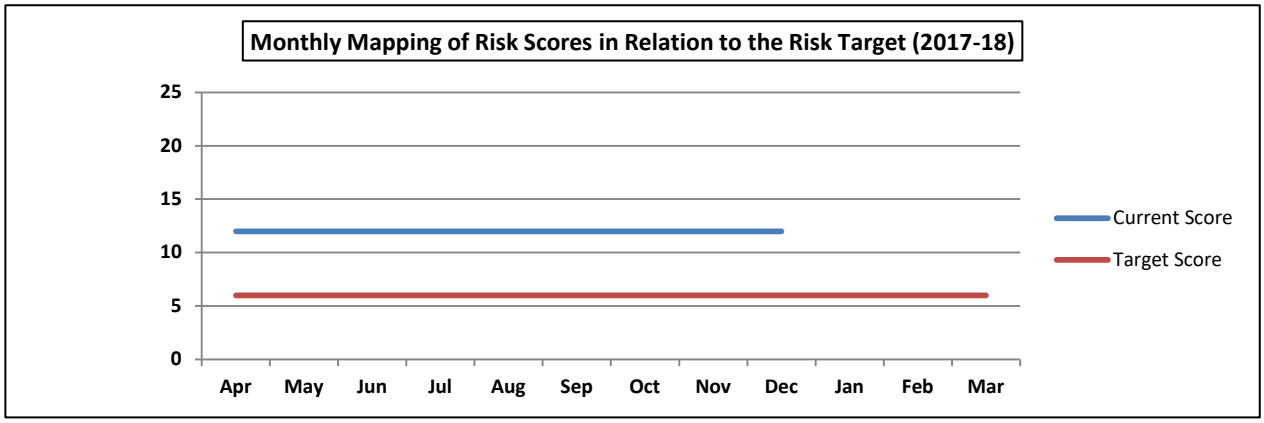
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1	Process and governance route to be established for reporting of estates and facilities issues from third party owned assets	Steven Course	Dec 2017	

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	None

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

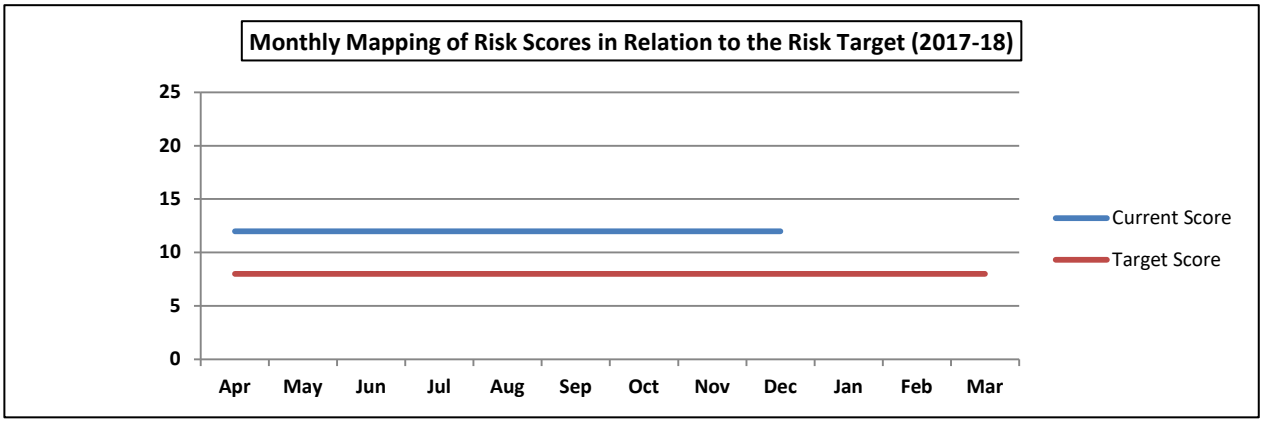
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Ensure six monthly reviews are happening routinely	Paul Calaminus/ Paul Gilluley	Dec 2017	
2	Embed and evaluate the effectiveness of the new Quality Impact Assessment format	Paul Calaminus/ Paul Gilluley	Mar 2018	

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
4.	
Gaps in Controls	**Gaps in Assurance**
	➢ Evidence of the use and effectiveness of the new template for Assessing the Impact of New Strategies or Models of Care

Risk Scores

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



Action Required

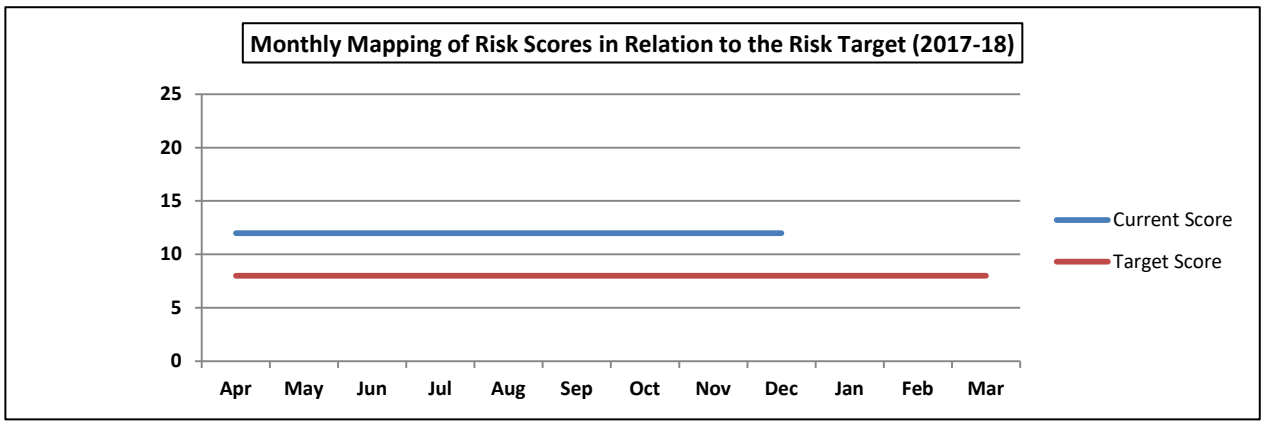
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1	Revised the trust's 5 year strategy to be approved by the Board (November 2017)	Mason Fitzgerald	End of Mar 2018	Requires more detailed work.
2	Introduce measure for the anticipated and actual impact of new strategies and models of working.	Mason Fitzgerald	Dec 2017	Template has been developed and is due to be rolled out.

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	Due date on action no. 1 changed from Sep 2017 to Nov 2017.

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

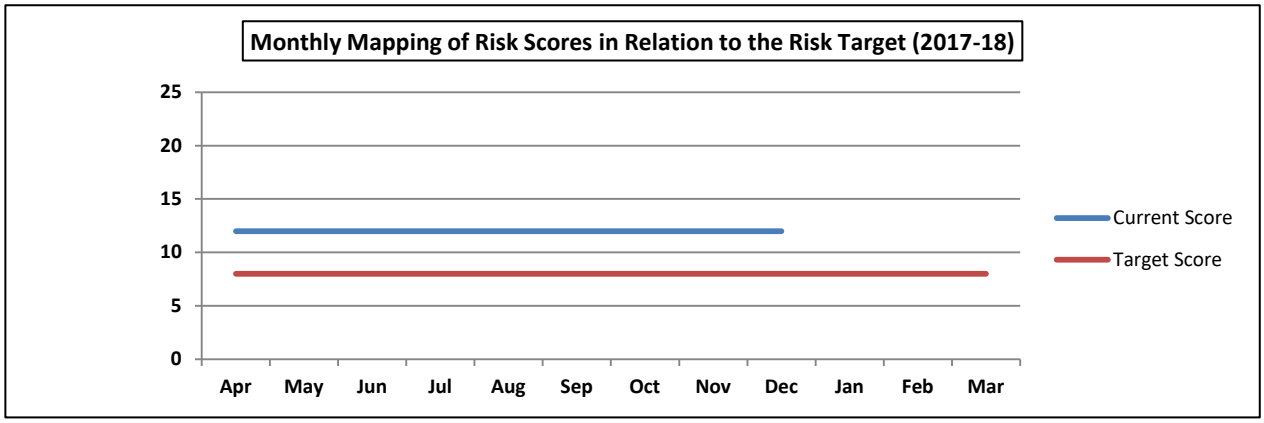
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Develop directorate workforce plans	Mason Fitzgerald/ Paul Calaminus	Nov 2017	Due date put back from Sep 2017.

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 due date for action point 1 has been changed from Sep 2017 to Jan 2018. The due date for action point 2 has been changed from Sep 2017 to Oct 2017.

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	Jan 2018	Due date amended
2	OD programme to report to the workforce committee	Mason Fitzgerald	Dec 2017	Due date amended

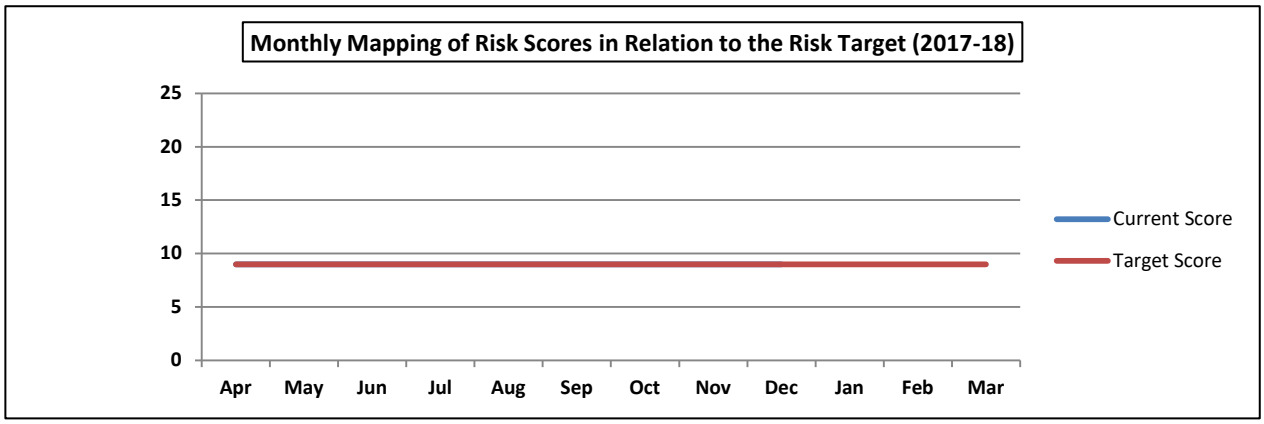
Risk No.	**2.3**
Objective 2	Improve staff satisfaction
Risk Description	It fails to put in place succession plans for the Trust Board and senior management roles
Executive Lead	Mason Fitzgerald, Director of Corporate Affairs
Lead Committee	Appointments & Remuneration Committee
Source	Board development 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

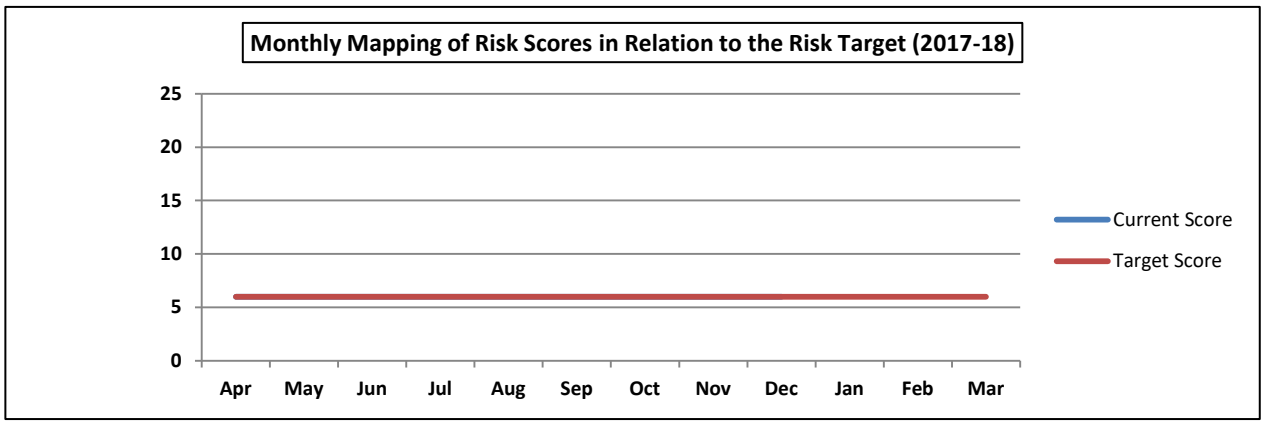
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Develop a formal succession plan	Mason Fitzgerald	Dec 2017	To be agreed at the REMCO in Dec 2017
2	Introduce a system for monitoring succession planning outcomes	Mason Fitzgerald	Dec 2017	

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

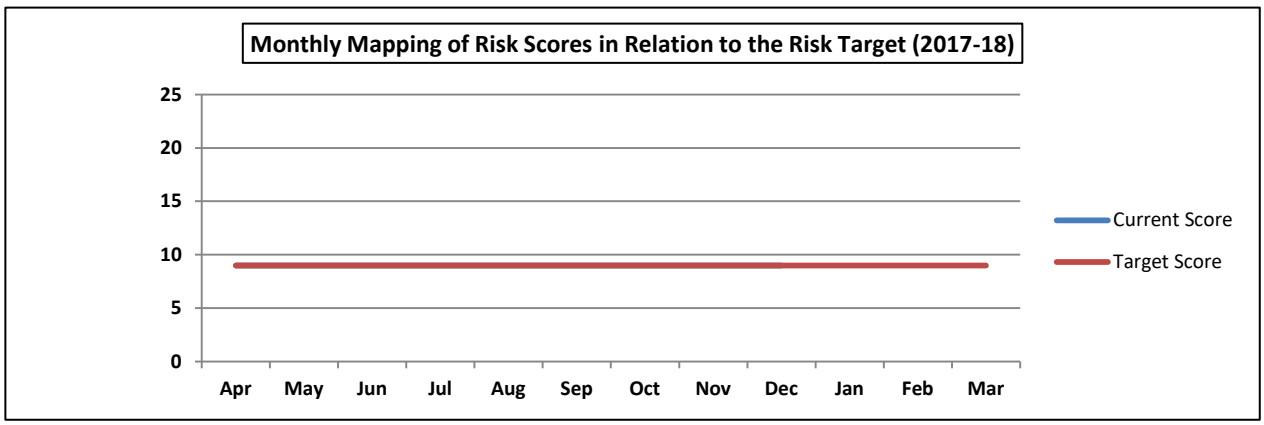
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

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	Roll-out of mobile working across all services. Implement plan agreed for the roll-out EMIS mobile and RiO mobile.	Steven Course	Mar 2019	Pilots start in Jan 2018
2	Delivery of inter-operability across all services in tandem with STP plans.	Steven Course	TBC	Shared records now across all east London CHS and

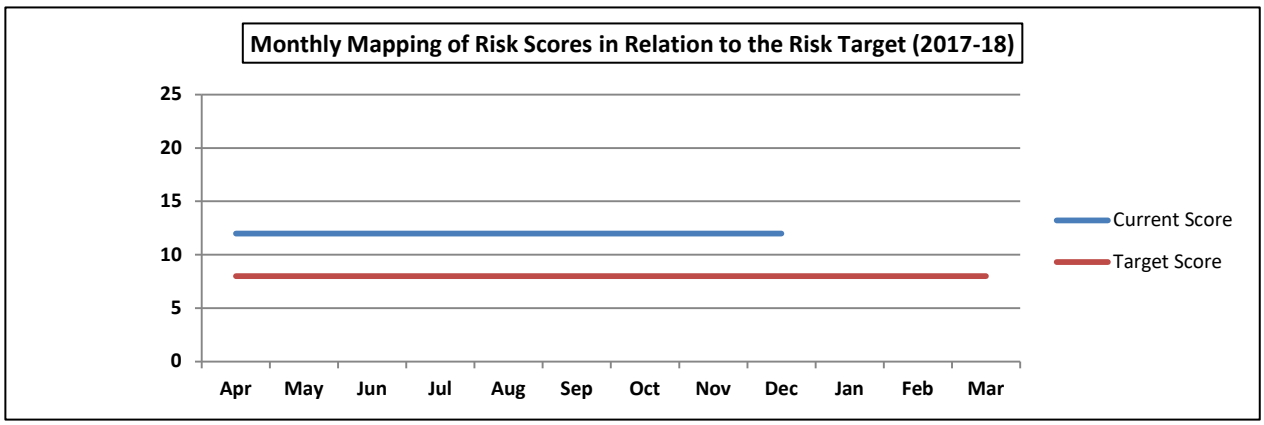
				MH Services
3	Migration of all staff to NHS Mail	Steven Course	Jan 2018	3,000 users now migrated.
4	Establish the Data Visualisation Project Board	Steven Course	Dec 2017	Completed.
5	Implementation of EMIS in Tower Hamlets CHS (December 2017)	Steven Course	~~Dec 2017~~ Mar 2018	Lease issue have caused delays.

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	None

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

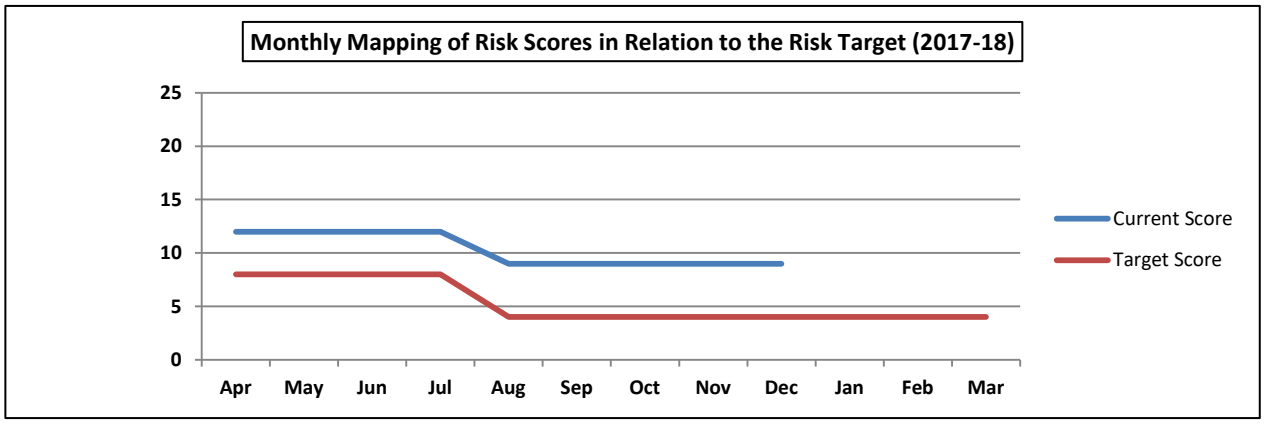
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Introduce a high level oversight report to the Workforce Committee	Mason Fitzgerald	Dec 2017	Due to be in place by Dec 2017

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	None

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

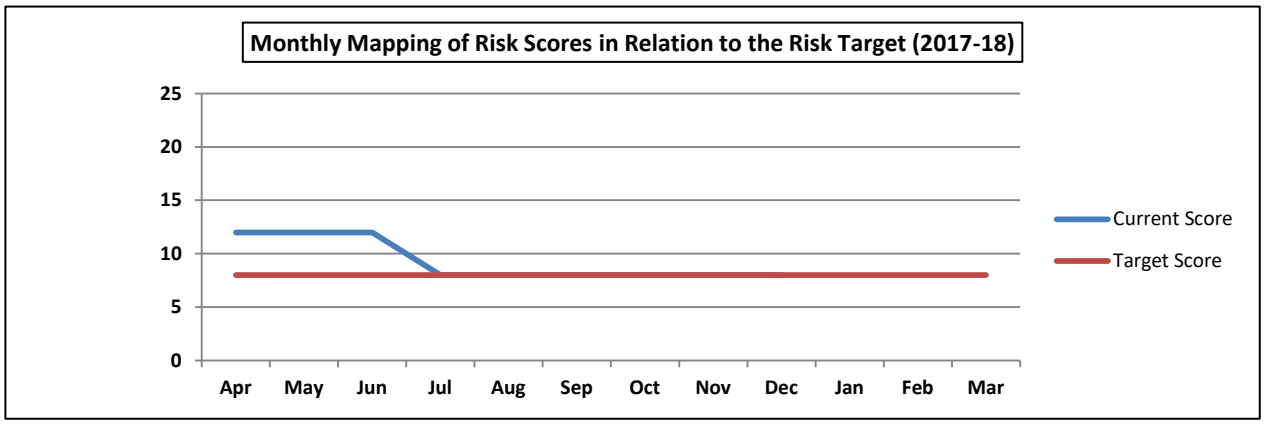
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Agree MoUs for Luton, Bedfordshire and Newham providers.	Mason	Mar 2018	
2	Implement the Business Strategy and review its impact	Mason	Sep 2018	

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	None

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)
4. Engagement with the STPs to develop new payment systems.	➢ 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

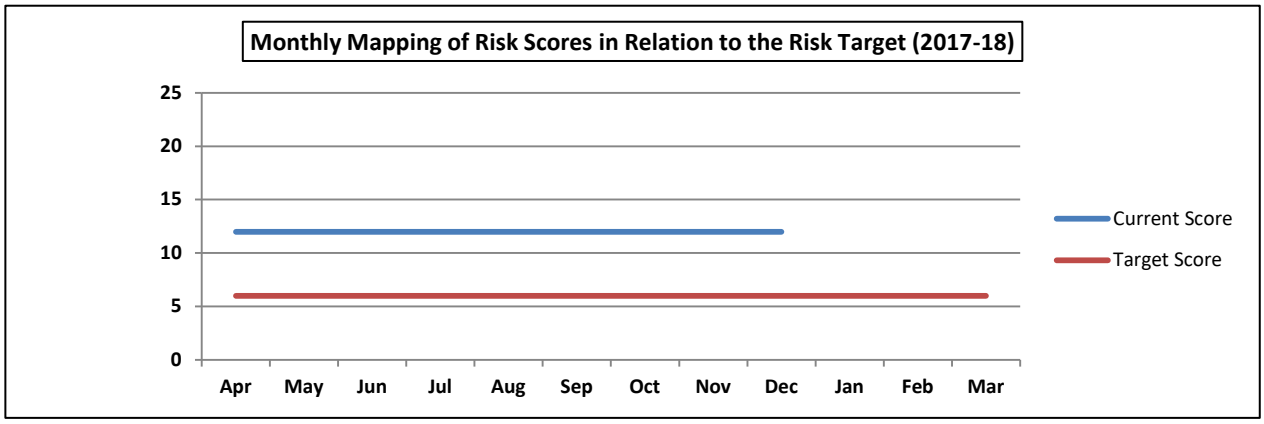
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/Status**
1	Analysis of the impact of the IAPT PbR approach	Steven Course	Sep 2017	Delayed nationally due lack of testing. Awaiting further information to dictate deadline.

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	None

Controls	**Assurance**
1. The trust's business strategy	➢ Six monthly reporting to the Trust Board
2. Workforce strategy, capacity and planning	➢ Annual reporting to the Trust Board and reporting to the Workforce Committee
3. Programme of training to prepare trust leaders for new and evolving leadership roles within accountable care systems	➢ Reporting to the Workforce Committee
4. Quality and safety dashboard	➢ Quality and safety reports to the Trust Board
5. BDU team and support structures	➢ Report to the Executive Team fortnightly
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	➢ CQC annual Well-led Domain
9. Mobilisation plan and TH CHS Project Board	➢ Monitoring of mobilisation plans by
Gaps in Controls	**Gaps in Assurance**
	➢ Internal monitoring of the functioning of the Luton and Bedfordshire Project Board
	➢ Internal monitoring of the functioning of the Tower Hamlets CHS Project Board

Risk Scores

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



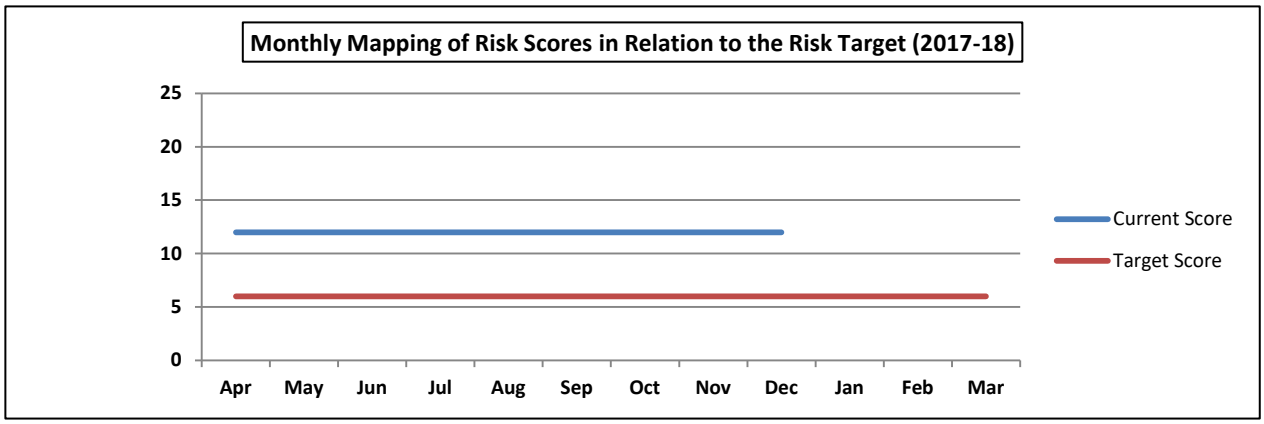
Action Required				
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Establish assurance for the Luton and Bedfordshire Project Board and the Tower Hamlets Community Health Services Project Board	Mohit Venkataram	Dec 2017	Complete

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

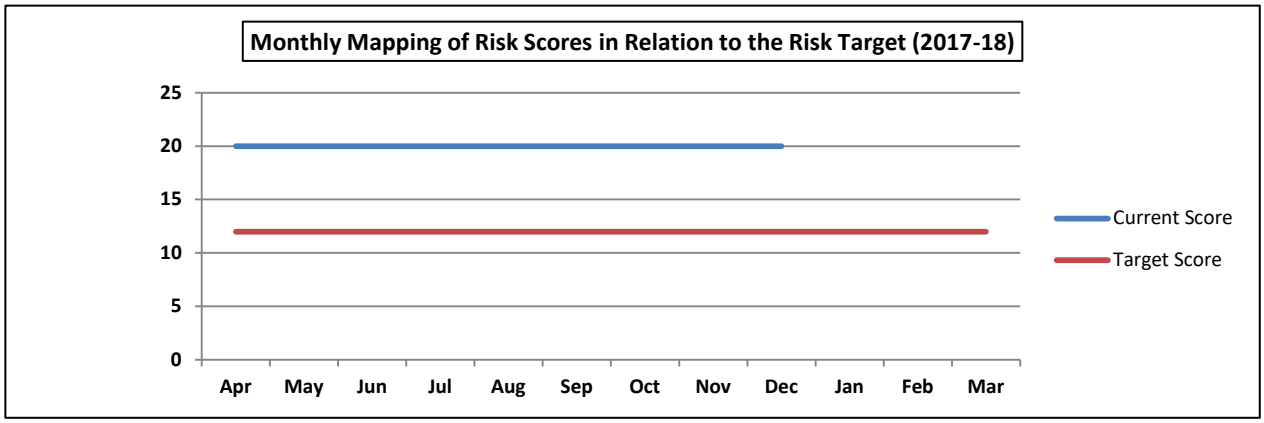
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implementation of the Year 3 plan	Paul Calaminus	Mar 2018	

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 Interim 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**

Risk Scores

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



Action Required

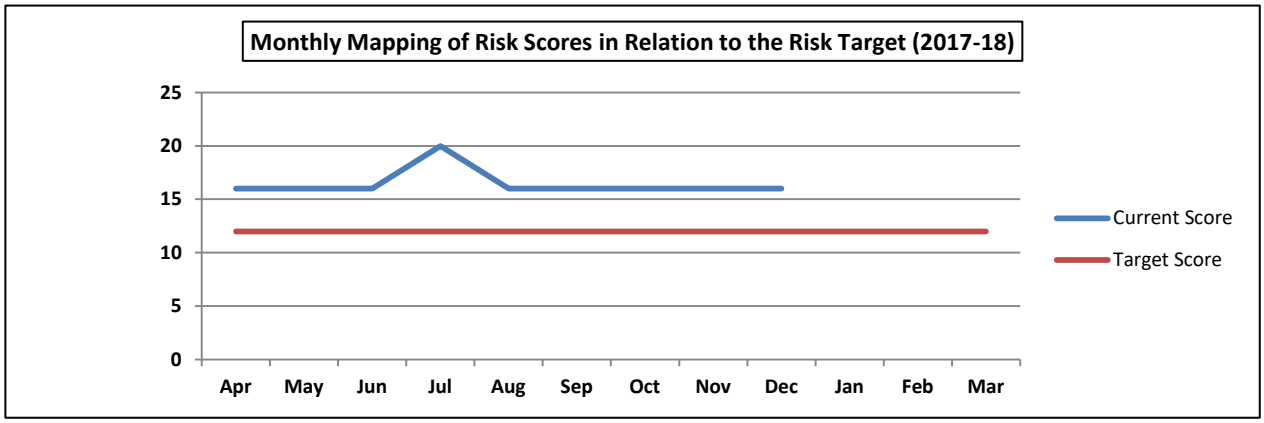
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**

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	None

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

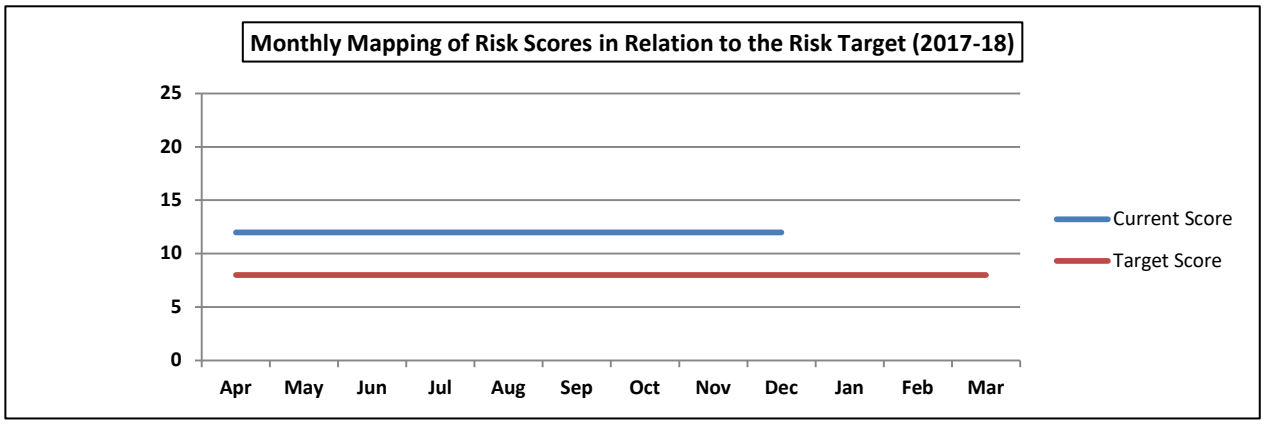
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Revise the trust's 5 year strategy	Mason Fitzgerald	Mar 2018	Requires more detailed work

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

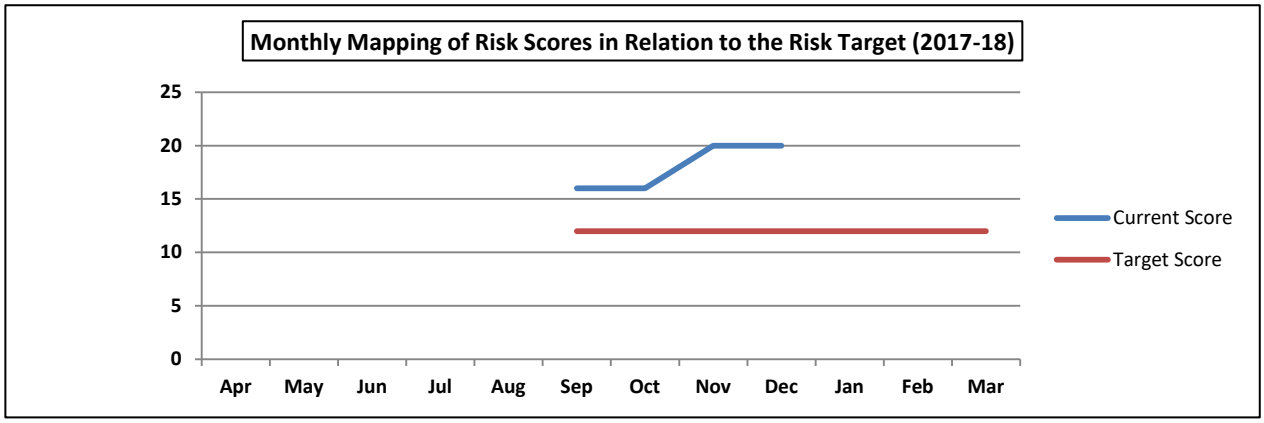
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/Status**
1	Implementation of NEL STP mental health delivery plan	Mason Fitzgerald	Apr 2018	In progress

Risk No.	**3.7**
Objective	Maintain Financial Viability
Risk Description	Agreement via consultation with commissioners, the public and other external stakeholders may not be granted in time to execute major plans, which should result in reduced expenditure and a more efficient delivery of service.
Executive Lead	Steven Course, Chief Financial Officer
Lead Committee	Finance, Business and Investment Committee (FBIC)
Source	FBIC meeting on 23rd May 2017
Change since last review	Current likelihood has increased from 4 to 5 in response to NHSI being notified that the forecast outturn is 6.3 million not 12.4m control total as a result of STP plans not being achievable within the timeframes.

Controls	**Assurance**
1. Development of reconfiguration plans in collaboration with key external stakeholders	➢ Quarterly reporting to the FBIC
2. Membership of the Waltham Forest and East London Collaborative System Delivery Board	➢ Reporting to the Trust Board
Gaps in Controls	**Gaps in Assurance**
Lack of minutes from the STP Board meetings	

Risk Scores

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



Action Required

No.	Action	Responsible Person/s	Due date	Progress/Status
2	Liaise with STP leaders to improve communication and seek improved documentation of decisions made and actions agreed at STP level which impact on the trust.	Steven Course/ Richard Fradgley	Dec 2107	