NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
9 MAY 2018

Title	Integrated Quality and Performance report
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Accountable Executive Director	Dr Navina Evans, Chief Executive

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 March 2018.

This version of the report focuses on a summary of performance over the year.

Summary of Key Issues:

This report provides a summary of year-end performance against regulatory and operational targets.

The Trust has finished the year in Segment 1 (best) of the NHS Improvement Single Oversight Framework.

Performance against national operational performance metrics, organisational health indicators, and other national and local targets continues to be good. There are plans in place to address areas of under-performance.

Workforce indicators are good compared to benchmarks, but performance against vacancy rates and mandatory training remain a priority going forward.

The Trust has The Trust has delivered an operating surplus (EBITDA) to end of March 2018 of £32.4m (8.3%) compared to plan of £28m (7.6%). There is a cash balance of £73.7m as at the end of March 2018.

The BAF is being refreshed in line with the new Trust strategy. The report sets out the new strategic risks, as well as the treatment of existing risks in the BAF (i.e. whether they will be incorporated into the new BAF, or included in the Corporate Risk Register). The review of the year-end BAF shows that 5 risks decreased in score during the year, and four increased in score. 8 risks are being maintained at their target score.

Supporting Documents and Research material:

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

Strategic priorities this paper supports (Please check box including brief statement)

Improved patient experience	☒	The report sets out a number of indicators relevant to patient experience, focusing on access to services and operational processes.
Improved health of the communities we serve	☐	
Improved staff experience	☒	The report sets out key workforce metrics which impact on staff experience, such as vacancy rates and sickness.
Improved value for money	☒	The report sets out the Trust's financial performance for the year.

Committees/Meetings where this item has been considered:

Date	**Committee and assurance coverage**
Various	This report is submitted to the Service Delivery and Trust Boards. Information is also submitted to commissioners and national systems.

Implications:

Impact	**Update/detail**
Equality Analysis	Some of the metrics in this report are designed to improve equalities by ensuring access to services and good outcomes. Analysis of the experience of different groups is undertaken as part of the Trust's equalities workstream.
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of March 2018 and provides data on key Compliance, NHS Improvement, 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.

This report focuses on providing a year-end review of performance across the Trust. A new integrated performance report is being introduced in line with the Trust strategy.

2. Regulatory compliance

NHS Improvement Single Oversight Framework
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'. NHS Trusts are placed on 1 of 4 "segments", with 1 being the lowest risk, and 4 being the highest risk.

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 has met the control total for 2017/18
Operational Performance		No Concerns
Strategic Performance		No Concerns
Leadership and Improvement Capability		No Concerns

Based on the above, the Trust finishes the year in Segment 1 of the framework.

Segment 1 is defined as "providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance".

Care Quality Commission
The Trust has no regulatory compliance issues outstanding. The Trust received unannounced visits in Luton & Bedfordshire in November 2017, and no compliance issues were identified.

The Trust was subject to a "well-led" review in April 2018. The draft report is expected in late May.

Commissioner contract compliance
The Trust reports approximately 1500 performance indicators per month to commissioners, with monthly meetings taking place. Breaches of contract targets can result in contract performance notices being issued, including fines. The Trust has not incurred any fines for the year and also expects to achieve the vast majority of CQUIN income (£6m).

3. Operational Performance Metrics

3.1 The Single Oversight Framework sets out national operational performance metrics for each sector. The metrics relating to mental health trusts are set out below. There are no metrics for community health services. Additional metrics are being developed for 2018/19.

Measure	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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%	100.0%	99.9%	100.0%	95.7%	99.9%	98.5%	98.2%	99.2%	99.1%	97.0%	99.5%
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	50%	84%	86%	87%	92%	89%	89%	98%	95%	91%	96%	93%	94%

Complete and valid submissions of metrics in the monthly Mental Health Services Data Set (MHSDS) submissions to NHS Digital:	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Identifier Metrics* (primary data)	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	TBC*
MHSDS Quarterly DQMI Scores	95%	96.4%			92.1%			National Data not yet published					

*March data published in May 2018

Improving Access to Psychological Therapies (IAPT)/talking therapies (Quarterly)	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Proportion of people completing treatment who move to recovery (from IAPT MDS)	50%	50.2%	50.2%	49.3%	49.3%	49.3%	50.0%	50.0%	50.0%	50.5%	50.5%	50.5%	50.1%
Waiting time to begin treatment within 6 weeks	75%	96.4%	96.4%	97.0%	97.0%	97.0%	97.5%	97.5%	97.5%	98.0%	98.0%	98.0%	98.1%
Waiting time to begin treatment within 18 weeks	95%	99.7%	99.7%	99.2%	99.2%	99.2%	99.5%	99.5%	99.5%	99.8%	99.8%	99.8%	99.9%

The Trust continues to perform well against operational metrics. The effective operation of crisis resolution and home treatment services ensures that patients are cared for in the right setting, and assists in the management of the Trust's inpatient bed capacity.

The data quality maturity index score dropped in quarter 2 due to a change from the Children's and Young People Services data set submission to the Community Services Data Set. CSDS submission will be in place from April 2018 and will include all Trust children's and adult's community data in Newham and Tower Hamlets. The Trust has liaised with NHS Digital regarding the changeover and the impact on performance.

The Trust continues to significantly exceed the national target for starting a NICE recommended package of care for patients with first episode of psychosis. As reported previously to the Board, the Trust also has significantly more patients in this cohort than other London mental health trusts.

Access and recovery rates for IAPT services also exceed targets. The Trust recovery rate was affected last summer due to capacity issues in Luton and Bedfordshire services. The Trust no longer provides the service in Luton, but the capacity issues in Bedfordshire have been resolved and the service is now functioning effectively.

3.1 Organisational Health Indicators

The Single Oversight Framework also tracks a number of other metrics, as part of an overall assessment of the Trust's organisational health. These are set out below.

Acute Indicators applicable to Mental Health	Standard*	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Mixed sex accommodation breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Patients occupying beds with delayed transfer of care - Adult & Older Adult (Only CAMHS excluded)	2.50%	2.2%	2.6%	3.3%	3.3%	3.2%	3.2%	2.2%	0.6%	0.9%	1.2%	1.1%	0.80%
MRSA bloodstream infections - reported instances	0	0	0	0	0	0	0	0	0	0	0	0	0
Reduction in Clostridium Difficile - reported instances	0	0	0	0	0	0	0	0	0	0	0	0	0

Mental Health Indicators	Standard*	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Admissions to adult facilities of patients who are under 16 years old	0	0	0	0	0	0	0	0	0	0	0	0	0
Care programme approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days*	95%	94.4%	94.2%	94.8%	95.1%	95.5%	95.4%	96.4%	66.7%	86.8%	85.7%	85.5%	87.1%
% clients in settled accommodation (CPA)	n/a	86.9%	87.2%	88.5%	87.0%	85.6%	85.1%	84.7%	87.7%	87.2%	87.6%	86.7%	86.5%
% clients in employment (CPA)	n/a	7.0%	7.2%	7.3%	7.3%	7.4%	7.6%	8.0%	9.1%	9.1%	9.3%	9.3%	9.6%

*target changed from 1 November 2017 to include all discharges

There have been two areas of major focus during the year.

The target for delayed transfers of care (DTOC) was reduced from 7.5% to 2.5% last summer. There has been strong partnership working between the Trust and local authorities to ensure discharge planning is effective and that patients are not stranded in a hospital setting when they don't need to be. As a result of this work, performance has been exceptional since November 2017.

The target for 7 day follow up following discharge from hospital also changed during the year. The target was extended to all inpatients, and services worked hard to put in place systems to ensure that all patients, and particularly those that were previously not known to services, are seen within 7 days. Performance in relation to CPA cases continues to meet the 95% target, with non-CPA cases at 81%. The performance gap is partly due to recording issues, and partly due to operational systems not yet being embedded. A new reporting system is now in place and the trajectory is to reach 95% compliance by the end of Quarter 1 2018/19.

3.2 Other national and local indicators

The tables below outline the Trust's performance against other indicators that are part of national, commissioner or Trust reporting. There are no red rated items.

Other Local Indicators Mental health - In patients	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient Bed Occupancy Rate – Adult 90% commissioner target / 85% Trust Target	90%	84.9%	86.7%	86.7%	85.0%	83.1%	82.9%	83.9%	85.2%	82.4%	86.4%	84.5%	84.2%
Inpatient Bed Occupancy Rate - Older Adult (Functional)	90%	69.2%	64.1%	61.7%	64.1%	72.9%	76.1%	71.0%	71.1%	81.7%	82.5%	66.5%	77.2%
Readmission rate (28 days) - Adult	7.5%	8.2%	6.8%	6.0%	5.9%	5.8%	5.6%	5.8%	5.6%	5.7%	5.6%	5.7%	5.7%
Readmission rate (28 days) - Older Adult	7.5%	11.1%	4.0%	3.6%	2.9%	2.3%	2.5%	2.1%	2.2%	2.0%	1.7%	1.6%	1.5%
Average Length of Stay - Adult	N/A	25.6	25.3	25.3	25.6	25.8	26.2	26.4	26.3	26.4	26.7	26.7	26.9
Average Length of Stay - Older Adult (Functional)	N/A	52.2	52.9	52.6	49.9	46.9	41.9	43.1	41.0	39.1	37.2	36.1	33.7

Other Local Indicators Mental Health - Community	Standard	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Assessment within 28 days of referral - Adult	95%	100.0%	99.1%	97.6%	97.8%	96.9%	95.8%	95.4%	95.2%	94.8%	93.8%	93.8%	88.2%
Assessment within 28 days of referral - MHCOP	95%	100.0%	100.0%	98.5%	98.5%	97.9%	97.2%	96.7%	96.3%	96.5%	95.8%	96.1%	95.9%
CPA patients - care plans in date (Documents 12 months old)	95%	91.1%	91.0%	91.6%	88.9%	88.3%	89.6%	89.7%	89.4%	87.6%	89.3%	89.3%	88.0%
CPA patients - care plans in date (Documents 6 months old)	n/a	78.4%	77.6%	83.1%	74.1%	71.4%	69.6%	71.9%	72.5%	68.0%	73.8%	73.8%	76.2%
% CPA patients seen in month - face to face only	85%	81.0%	83.7%	86.6%	86.0%	84.9%	83.0%	87.4%	88.0%	83.3%	87.2%	85.4%	85.4%
CAMHS Outcomes Percentage showing improvement	80%	87.0%	87.0%	84.0%	84.0%	84.0%	87.0%	87.0%	87.0%	87.7%	87.7%	87.7%	86.6%
Number of adult CPA patients meeting with care-coordinator in past 12 months	95%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%

The Trust continues to manage inpatient demand and capacity effectively, with inpatient bed occupancy remaining below 90% throughout the year. Benchmark information also shows that the Trust has relatively low lengths of stay and re-admission rates.

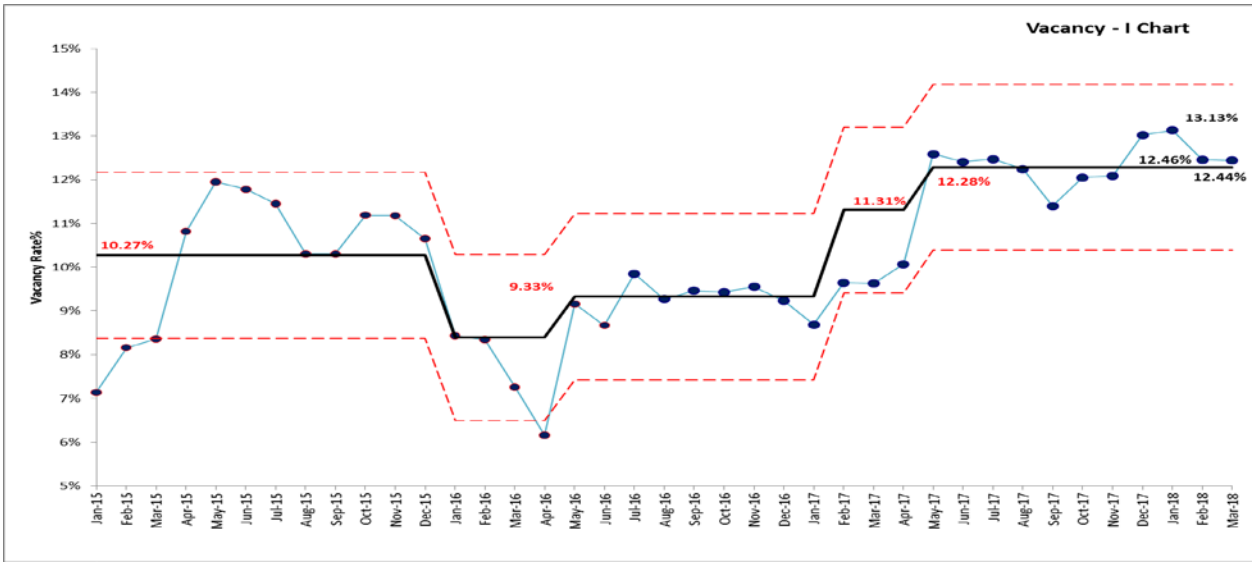
Some community metrics were affected by the redesign of community services in Luton & Bedfordshire that occurred during the year. Both services have shown good progress and performance should be achieved by the end of Quarter 1. Care planning metrics have also been affected by recording issues as the Trust implemented a new care plan document during the year, and again are lower in Luton and Bedfordshire.

Community Health Services in Newham and Tower Hamlets continue to perform well across a range of metrics, with 100% performance against urgent (24 hours) and routine referrals (72 hours) being seen within target time limits.

4.0 Workforce Indicators

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

VACANCIES

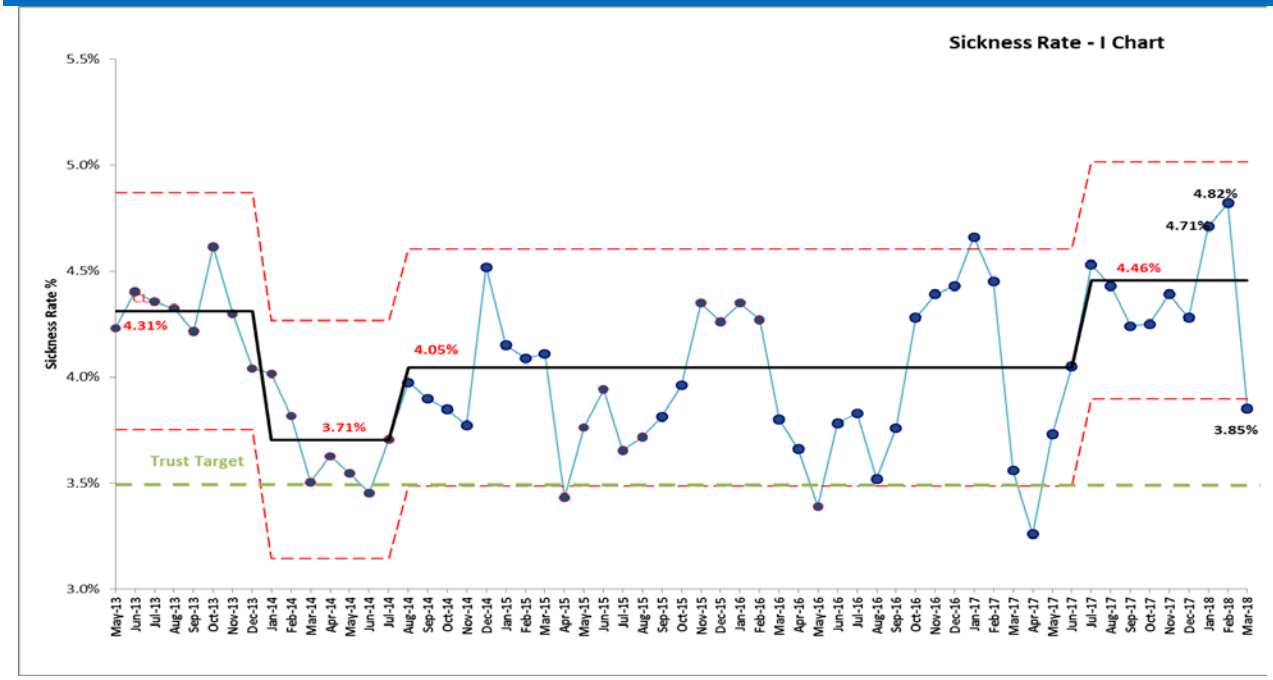


The vacancy rate is 12.44% as of 31 March. The London average is 17%. The vacancy rate increased at the start of 2017, primarily due to the acquisition of Tower Hamlets community health services. Hotspots include Luton, Bedfordshire, Specialist Services and Tower Hamlets community health services.

The focus remains on managing internal talent and building a recruitment pipeline for the medium and long term. We have delivered Regular open days for recruitment have been introduced where prospective candidates can find out more about working for ELFT.
Refer a Friend scheme has successfully enabled the recruitment of 4 roles since the last board report and we are looking at extending the scheme to community health staff

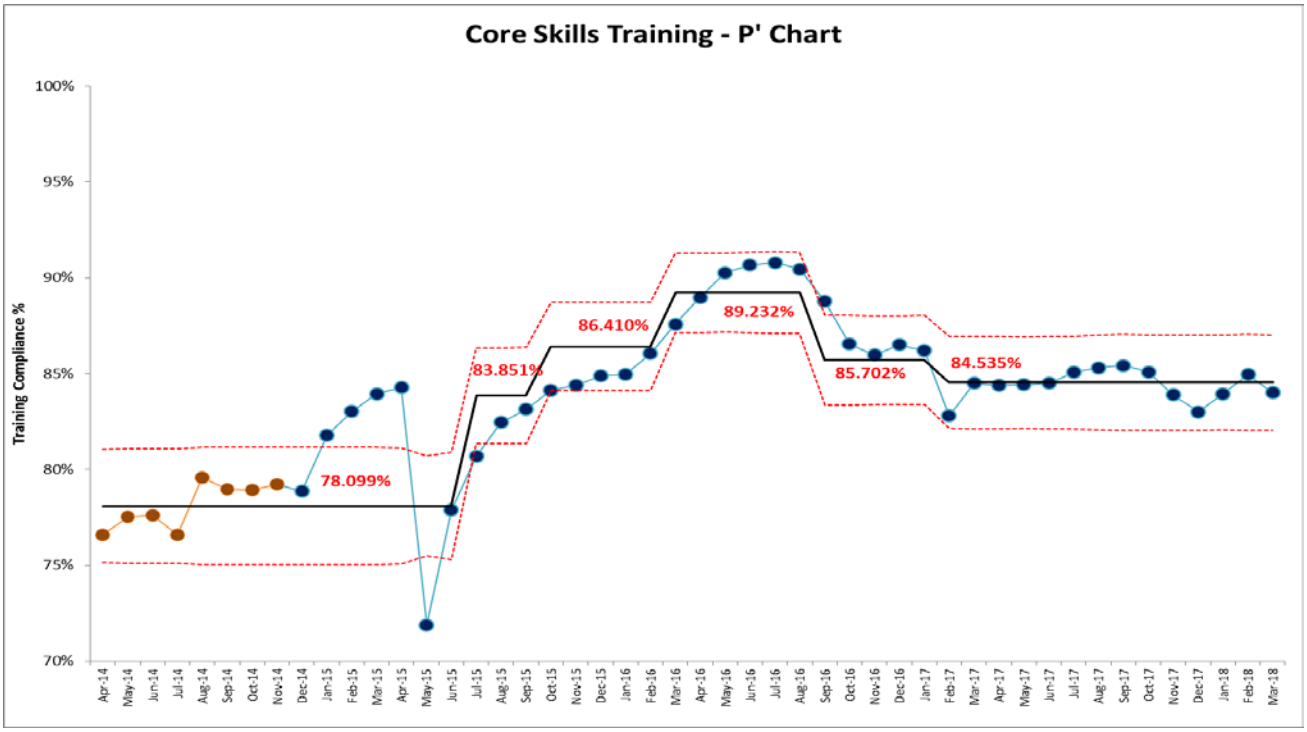
Pay has been reviewed for health care workers in Luton and Bedfordshire and a set of principles agreed with the unions to link bank pay to agenda for change rates which should make bank work more attractive. A social media campaign is being delivered to support recruitment in Luton and Bedfordshire which has resulted in 4 offers to qualified clinical staff so far. A careers and redeployment post has been introduced to support staff to look at internal opportunities for career progression.

ABSENCE



Absence has dropped to 3.85% in March. There continues to be focus on active management and support of staff on long term sickness. A health & wellbeing plan has been developed in conjunction with staff side and will be implemented during 2018/19.

MANDATORY TRAINING



Mandatory training figures are 84% as of 31 March. There is a working group set up to review this area. A set of principles have been agreed, as well as specific work to review the training requirements for staff and the systems issues. The group is chaired by the Chief Operating Officer and reports monthly to the Service Delivery Board on progress.

5.0 Finance report

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

The Trust has delivered an operating surplus (EBITDA) to end of March 2018 of £32.4m (8.3%) compared to plan of £28m (7.6%). This is subject to the audit of the Trust's accounts. The net surplus of £16.8m (4.3%) compared to revised planned net surplus of £12.4m (3.4%). Year to-date favourable net surplus variance of £4.4m. There is a cash balance of £73.7m as at the end of March 2018.

The Trust is reporting achievement exceeding the NHSI control total. As such, the Trust has achieved an overall risk rating of "1" to the end of March 2018.

The table below indicates the amount of STF funding that the Trust has achieved in the financial year as a result of the year end performance.

Total Indicative STF	Q1 to Q3 £000s	Q4 £000s	2017/18 Total £000s
Core STF Including paid Appeals	853	1,585	2,438
Outstanding Appeals at 31 March 18	0	0	0
Total Core	**853**	**1,585**	**2,438**
Incentive STF (finance)		1,087	1,087
Incentive STF (performance)		0	0
Incentive STF (general distribution)		784	784
Incentive STF (bonus)		1,688	1,688
2017/18 Indicative STF	**853**	**5,144**	**5,997**
2016/17 Post Accounts STF	0		0
Total Indicative STF	**853**	**5,144**	**5,997**

6.0 Board Assurance Framework

The BAF is submitted to the Trust Board on a bimonthly basis. The year-end version is attached as Appendix B.

The Trust Board have commenced a refresh of the Board Assurance Framework in line with the new Trust strategy. Areas of risk identified by the Board have been considered along with existing risks, in order to develop a new set of strategic risks. These are set out in the Strategy Development report and are repeated below. There is analysis in the BAF (pg2-3) that sets out the treatment of all the existing risks in the Board Assurance Framework. This has been done by analysing the rationale for the risk, the current scores, and the relevance of the content, in order to determine whether the risk will be incorporated into the new BAF, or included in the Corporate Risk Register.

Strategic risks 2018/19

Strategic risk 1: Lack of agreement across local health and care partnerships regarding major plans results in failure to achieve quality and financial objectives

Strategic risk 2: Failure to effectively engage with local agencies and communities prevents the development of services and the delivery of improvement initiatives

Strategic risk 3: Failure to effectively work with patients and local communities in the planning and delivery of care results in services that do not meet the needs of local communities

Strategic risk 4: Failure to maintain essential standards of quality and safety results in the provision of sub-optimal care and increases the risk of harm

Strategic risk 5: Failure to effectively plan for and attract the right numbers and skills of staff required will impact on the Trust's ability to deliver safe, high quality integrated care

Strategic risk 6: Failure to address issues affecting staff experience (i.e. health & wellbeing, equalities) results in staff burnout and high staff turnover

Strategic risk 7: Failure to identify and deliver CRES plans for 2018/19 adversely affects the Trust's financial sustainability, access to revenue streams and reputation

Strategic risk 8: Poor quality data and information systems affect the ability of staff to provide high quality care, and create duplication and waste

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 review of the year-end BAF shows that 5 risks decreased in score during the year, and four increased in score. 8 risks are being maintained at their target score.

7.0 Recommendations and Action Being Requested

The Board is asked to:

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

b) **NOTE** the year-end position.

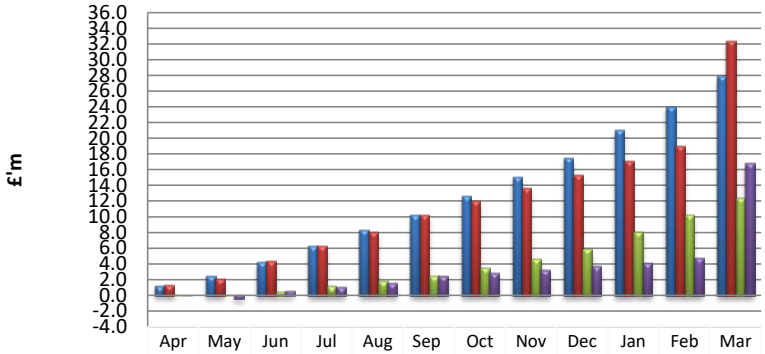
c) **NOTE** areas below performance and discuss action being taken to address performance issues across the Trust in order to maintain and improve performance.

Financial Overview to Period Ending 31st March 2018

EBITDA AND NET SURPLUS

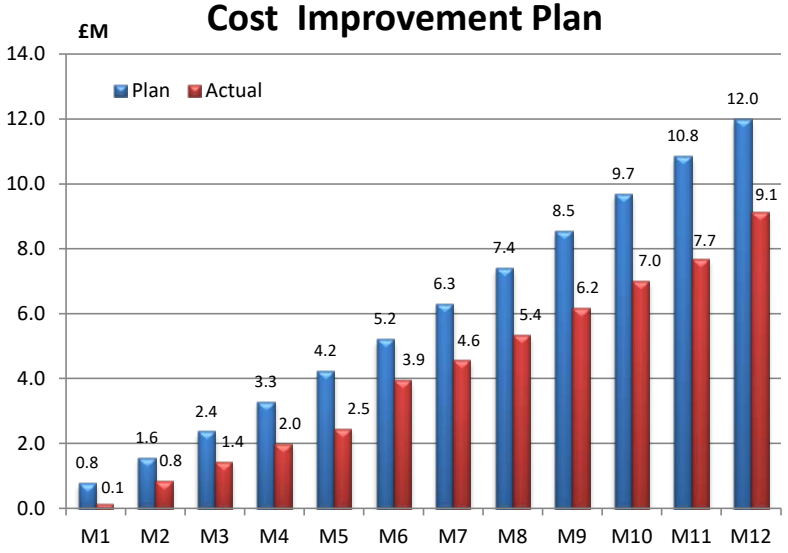
	To 31/03/18		Projection		Plan	
	£m	%	£m	%	£m	%
EBITDA	32.4	8.3	32.4	8.3	28.0	7.6
SURPLUS	16.8	4.3	16.8	4.3	12.4	3.4

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	28.0
EBITDA Actual	1.3	2.1	4.4	6.3	8.1	10.3	12.0	13.7	15.4	17.1	19.0	32.4
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	4.8	16.8

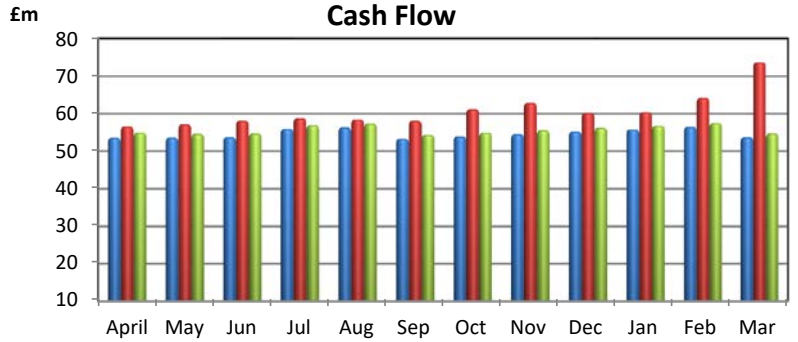
Cost Improvement Plan



WORKING CAPITAL

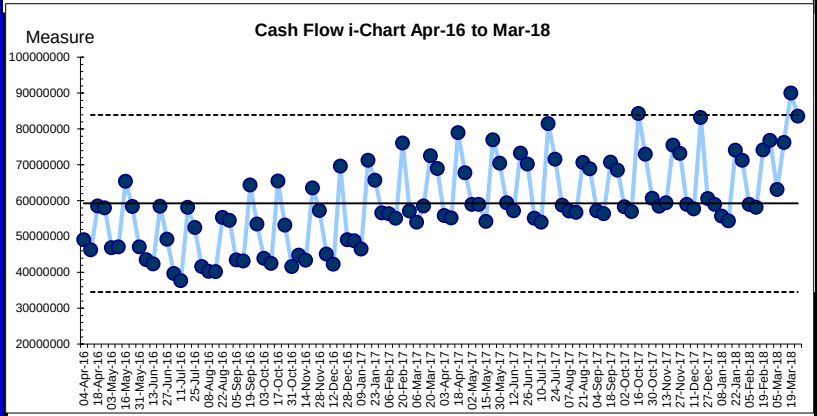
		£m	Risk
Cash	: at Bank	73.7	
	: Short term deposits	0.0	
Short term	: Assets	96.0	
	: Liabilities	66.2	

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	64	74
Forecast £M	55	55	55	57	57	54	55	56	56	57	57	55

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



	Q1	Q2	Q3	Q4
DEBTOR DAYS	20	16	17	16
CREDITOR DAYS	34	28	29	31

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	1	●
Agency rating	2	●
OVERALL RISK RATING	1	●

East London NHS Foundation Trust

Board Assurance Framework (BAF)

31 March 2018

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

Year end review

The Trust Board have commenced a refresh of the Board Assurance Framework in line with the new Trust strategy. Areas of risk identified by the Board have been considered along with existing risks, in order to develop a new set of strategic risks. These are set out in the Strategy Development report and are repeated below. The analysis below sets out the treatment of all the existing risks in the Board Assurance Framework. This has been done by analysing the rationale for the risk, the current scores, and the relevance of the content, in order to determine whether the risk is incorporated into the new BAF, or included in the Corporate Risk Register.

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Strategic risk 2: Failure to effectively engage with local agencies and communities prevents the development of services and the delivery of improvement initiatives

Strategic risk 3: Failure to effectively work with patients and local communities in the planning and delivery of care results in services that do not meet the needs of local communities

Strategic risk 4: Failure to maintain essential standards of quality and safety results in the provision of sub-optimal care and increases the risk of harm

Strategic risk 5: Failure to effectively plan for and attract the right numbers and skills of staff required will impact on the Trust's ability to deliver safe, high quality integrated care

Strategic risk 6: Failure to address issues affecting staff experience (i.e. health & wellbeing, equalities) results in staff burnout and high staff turnover

Strategic risk 7: Failure to identify and deliver CRES plans for 2018/19 adversely affects the Trust's financial sustainability, access to revenue streams and reputation

Strategic risk 8: Poor quality data and information systems affect the ability of staff to provide high quality care, and create duplication and waste

Principle Risks: *The Trust may not achieve its objectives if:*			**Scores**		**Treatment**
	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	To be incorporated into SR 3
	1.2	It fails to achieve agreed optimum levels of adult acute MH bed occupancy	9	9	To be incorporated into the Corporate Risk Register
	1.3	It fails to transform district nursing services in order to meet the needs of the local health services and wider community	12	9	To be incorporated into SR 5
	1.4	It fails to implement relevant NICE guidance	9	9	To be incorporated into the Corporate Risk Register
	1.5	It fails to innovate in the pursuit of quality improvement	6	3	Improvement and innovation inherent in all SRs. Risk regarding the QI programme to be created in the Corporate Risk Register
	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	To be incorporated into SR 4
	1.7	It fails to develop systems and processes to deliver safer and more	8	8	To be incorporated into the

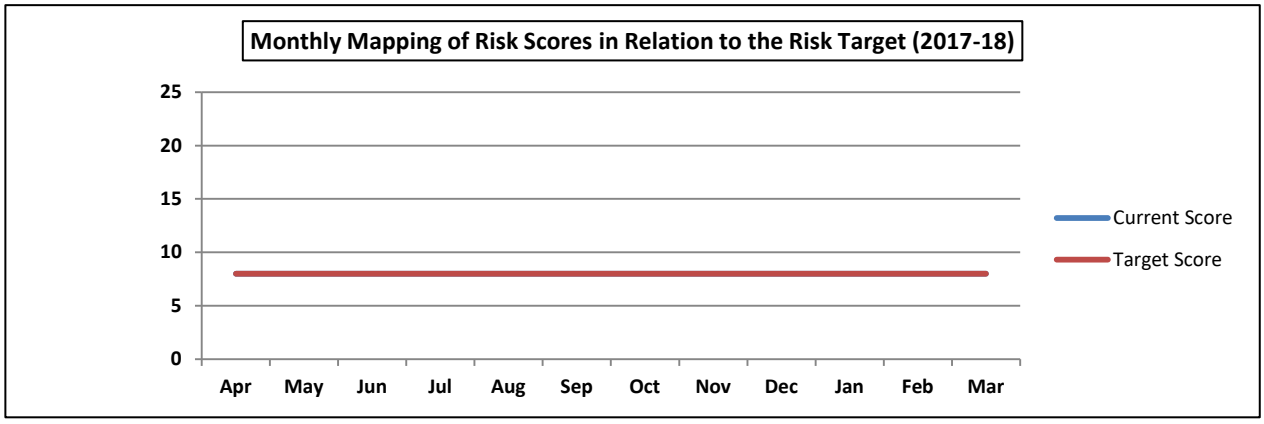
		effective physical health care to MH patients			Corporate Risk Register
	1.8	It fails to provide high quality services from premises that are secure, minimise risk, and are well maintained	12	9	To be incorporated into the Corporate Risk Register
	1.9	It fails to recognise and respond to the impact of CRES savings plans on the quality and safety of services already responding to increasing demand	9	6	To be incorporated into SR 4
	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	To be incorporated into SR 1
OBJECTIVE 2: Improve Staff Satisfaction	**2.1**	It fails to recruit and retain high quality staff	16	8	To be incorporated into SR 5
	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	8	To be incorporated into SR 5
	2.3	It fails to put in place succession plans for the Trust Board and senior management roles	9	9	To be incorporated into the Corporate Risk Register
	2.4	If it fails to maintain improvement in measures of staff engagement in the context of continued financial constraints and CRES plans	12	6	To be incorporated into SR 6
	2.5	If it fails to provide, and engage staff with, modern and effective IT infrastructure, both physical and systems	9	9	To be incorporated into SR 8
	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	To be incorporated into SR 6
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.	9	4	To be incorporated into SR 1
	3.2	It fails to plan properly for the introduction of new funding systems, potentially jeopardising income streams	8	8	To be incorporated into the Corporate Risk Register
	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	To be incorporated into SR 5
	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	To be incorporated into the Corporate Risk Register
	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	To be incorporated into SR 7
	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	To be incorporated into SR 7
	3.6	If services are not adequately incorporated into Sustainability and Transformation Plans (STPs), they risk becoming unsustainable over the next five years.	8	8	To be incorporated into the Corporate Risk Register
	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	To be incorporated into SR 1 & 2

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, 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**
None identified	CQC well-led and service level reports to be available in June 2018

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**

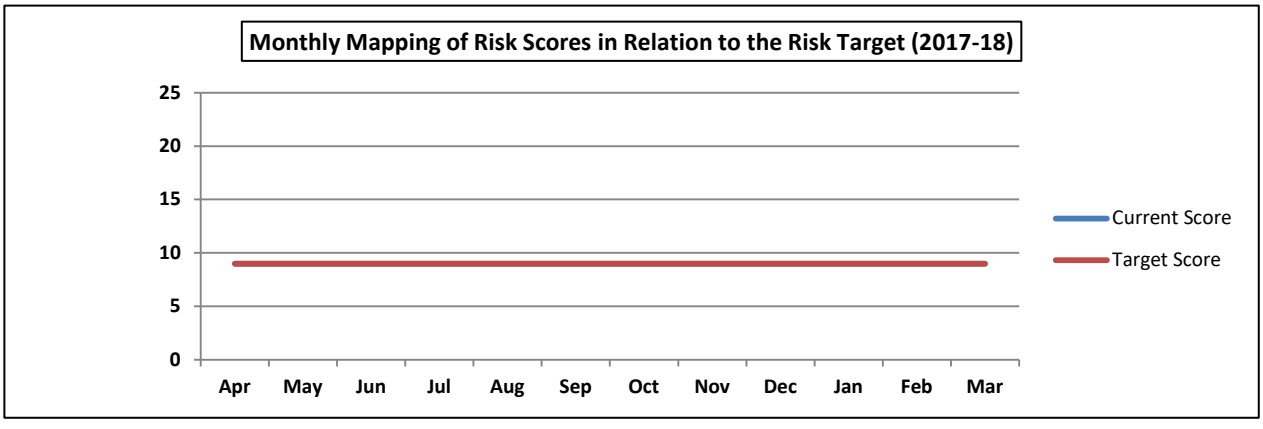
	N/A			

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 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 by 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**
None identified	Evidence of implementation of planned actions and impact

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
1	Introduce new huddles led by the medical directors	Paul Calaminus	May 2018	
2	Introduce a more focused approach to bed management processes by senior management.	Paul Calaminus	May 2018	

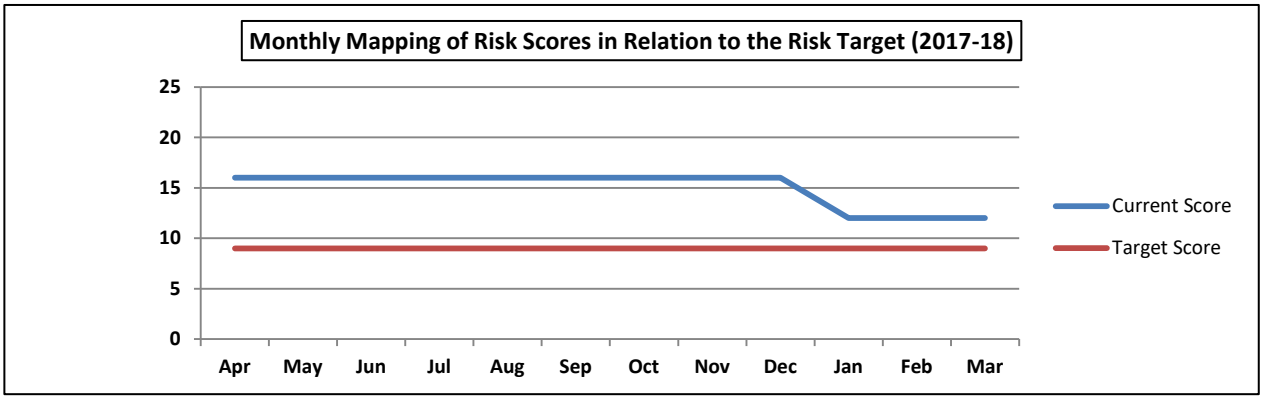
Risk No.	**1.3**
Objective	Improve service user satisfaction
Risk Description	It fails to transform district nursing services in order to meet the needs of the local health services and wider community
Executive Lead	Lorraine Sunduza, Interim Chief Nurse
Lead Committee	Quality Assurance Committee
Source	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**
Monthly integrated nursing workforce report capturing vacancy and turnover rates, hot spots and risk areas.	Evidence of progress against the areas in the report

Risk Scores

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



Action Required

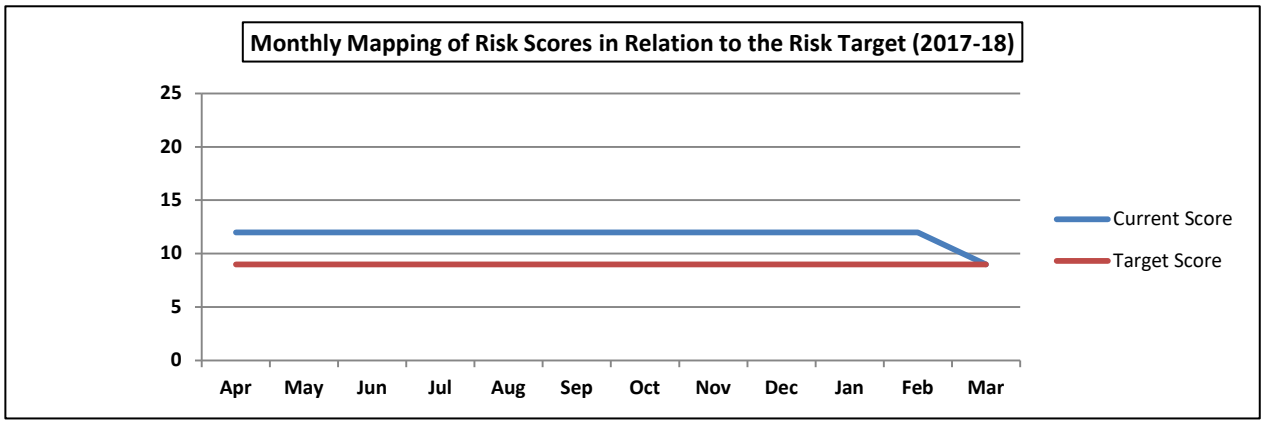
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Introduce the Monthly Integrated Nursing Workforce Report.	Lorraine Sunduza	Apr 2018	

Risk No.	**1.4**
Objective	Improve service user satisfaction
Risk Description	It fails to implement relevant NICE guidance
Executive Lead	Dr. Paul Gilluley, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Quality Assurance Committee – October 2015
Change since last review	Current consequence score has been reduced from 4 to 3 (risk score reduced from 12 to 9) as the action is now completed.

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**
None identified	None

Risk Scores

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

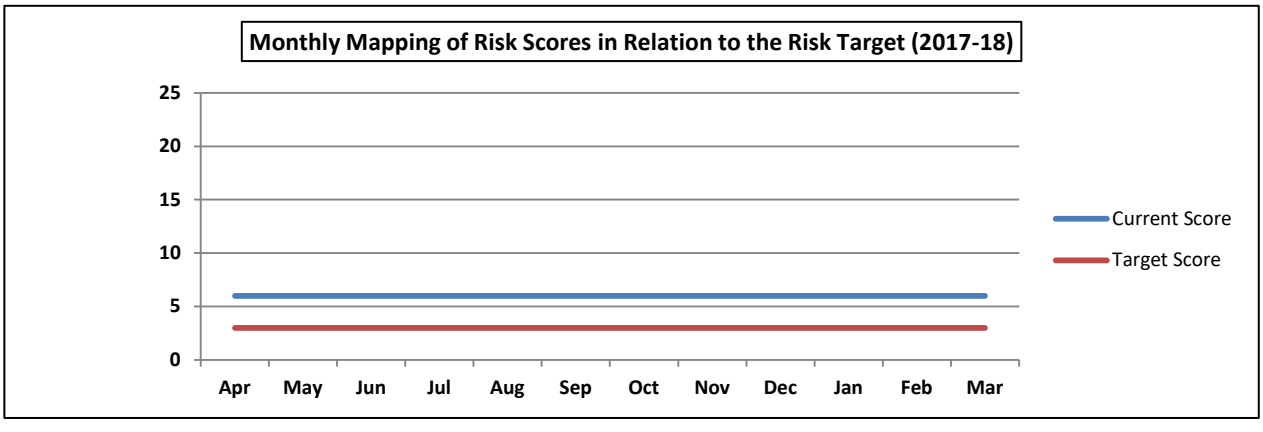
Risk No.	**1.5**
Objective	Improve service user satisfaction
Risk Description	It fails to innovate in the pursuit of quality improvement
Executive Lead	Dr Paul Gilluley, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Trust Board - April 2014
Change since last review	None

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**
TBC	TBC

Risk Scores

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



Action Required

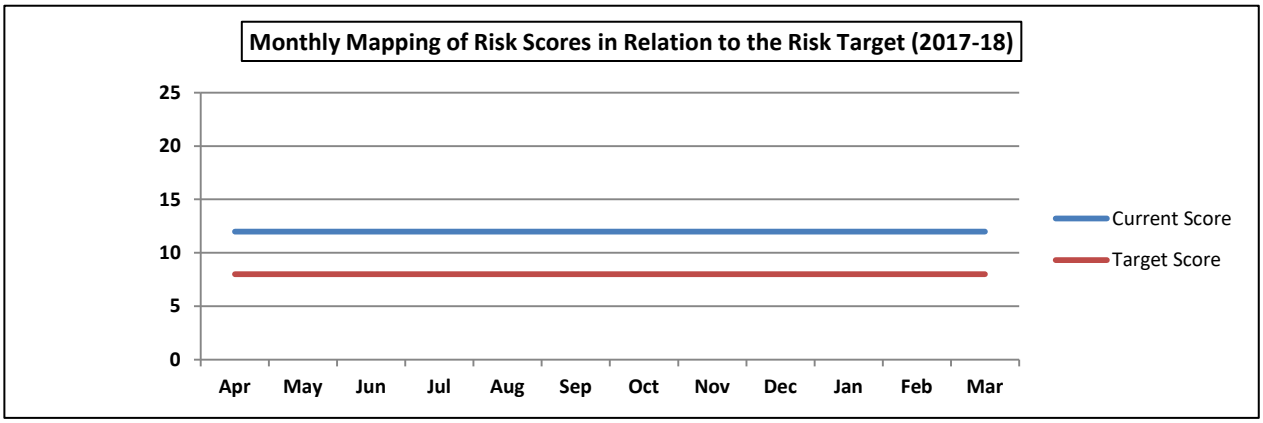
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
	TBC			

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**
	CQC well-led and service level reports to be available in June 2018

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	

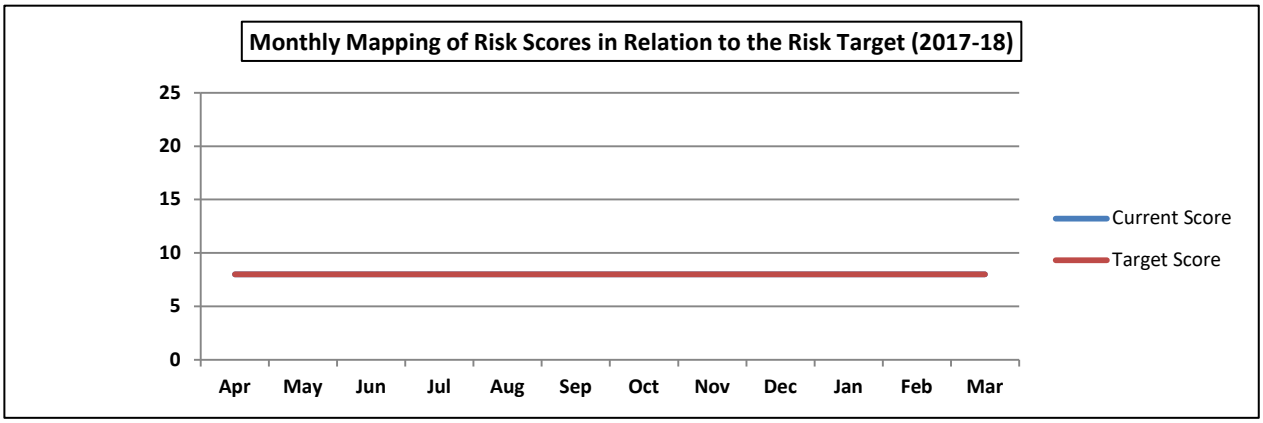
Risk No.	**1.7**
Objective	Improve service user satisfaction
Risk Description	It fails to develop systems and processes to deliver safer and more effective physical health care to MH patients
Executive Lead	Dr Paul Gilluley, Chief Medical Officer
Lead Committee	Quality Assurance Committee
Source	Serious 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**
None identified	Evidence of implementation of physical health strategy

Risk Scores

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



Action Required

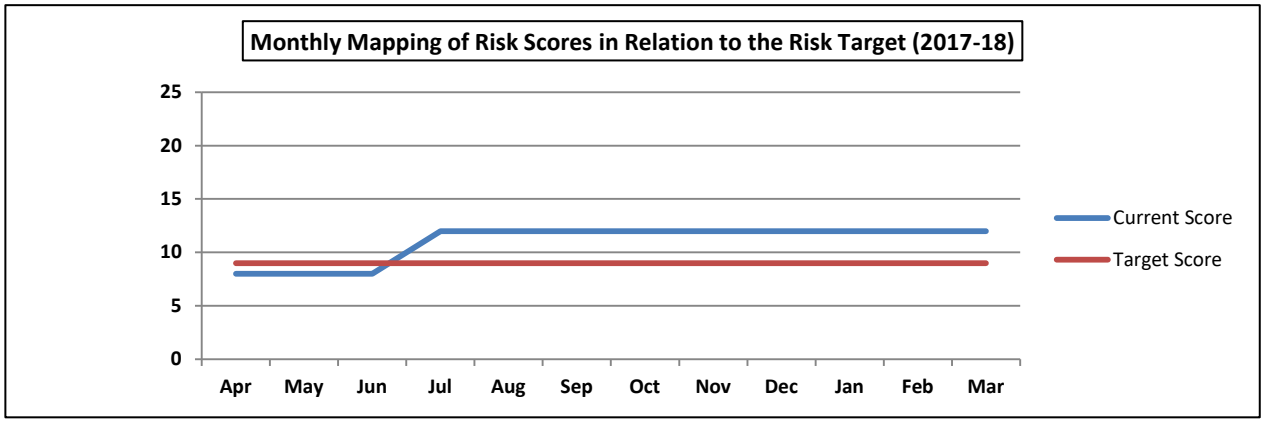
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
	N/A			

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
7. Monthly meeting between the executive lead for Estates and Facilities and the Director for Estates and Facilities to discuss exceptions to compliance.	➢ Quarterly PLACE assessments and annual fire risk assessments.
Gaps in Controls	**Gaps in Assurance**
None identified	Evidence of timely delivery of capital programme at FBIC during the year

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**

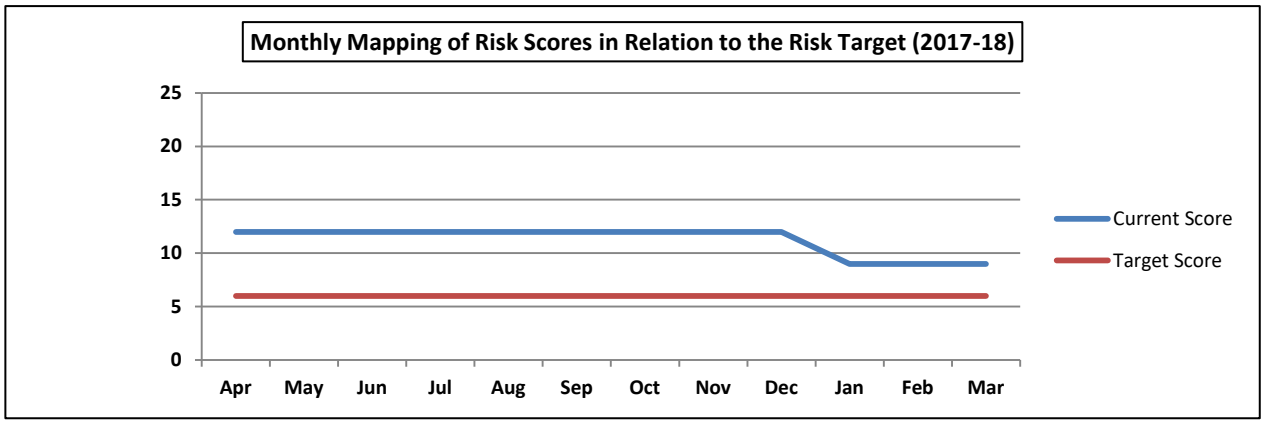
	Delivery of 2018/19 capital programme	John Hill	March 2019	Ongoing

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
7. Six monthly quality impact reviews	➢ Reports to the Quality Committee
Gaps in Controls	**Gaps in Assurance**
New Quality Impact Assessment format is not yet fully embedded	Evidence that new process is working effectively

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	3	3	3
Likelihood	5	3	2
Risk Scores	**15**	**9**	**6**



Action Required

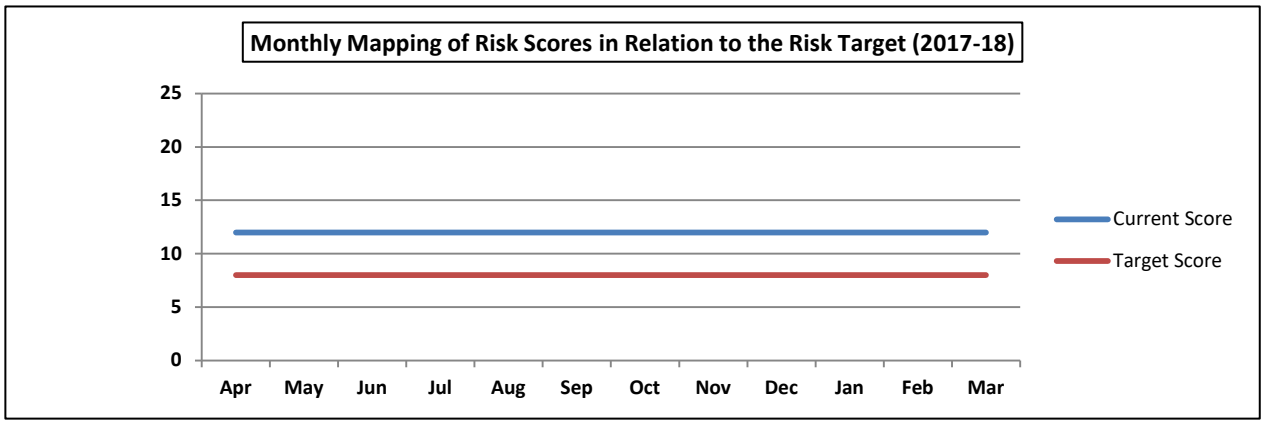
No.	Action	Responsible Person/s	Due date	Progress/Status
1	Embed and evaluate the effectiveness of the new Quality Impact Assessment format	Paul Calaminus/ Paul Gilluley	Mar 2018	
2	Develop directorate annual plans	Paul Calaminus	May 2018	

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. Assessments of anticipated and actual impact of new strategies and models of working.	
Gaps in Controls	**Gaps in Assurance**
None identified	➢ 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

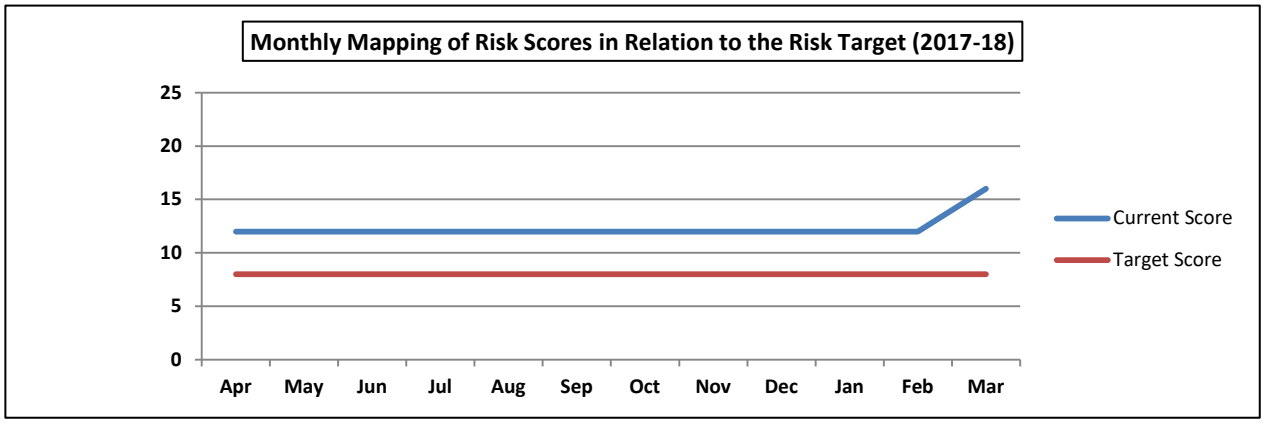
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1	Revised trust 5 year strategy to be approved by the Board	Mason Fitzgerald	~~Mar~~ May 2018	Requires more detailed work.

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	Current likelihood score has increased from 3 to 4 due increased vacancy rate both London-wide and in new trust services with high vacancy rates.

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**
None identified	Evidence that directorate plans are having an impact on vacancy rates

Risk Scores

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



Action Required

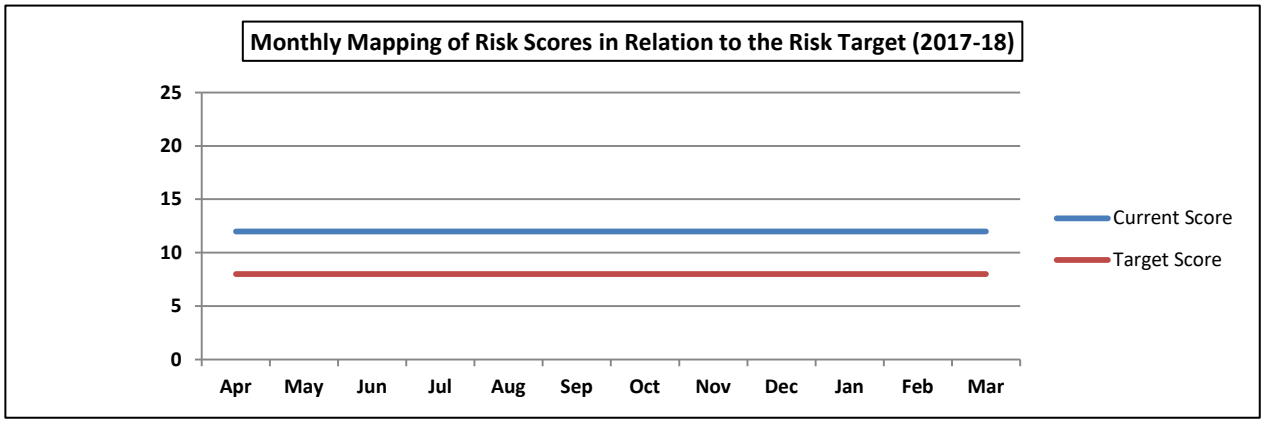
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Develop directorate workforce plans	Mason Fitzgerald/ Paul Calaminus	Nov 2017	**Complete**

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 2 has been changed from Dec 2017 to Mar 2018.

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

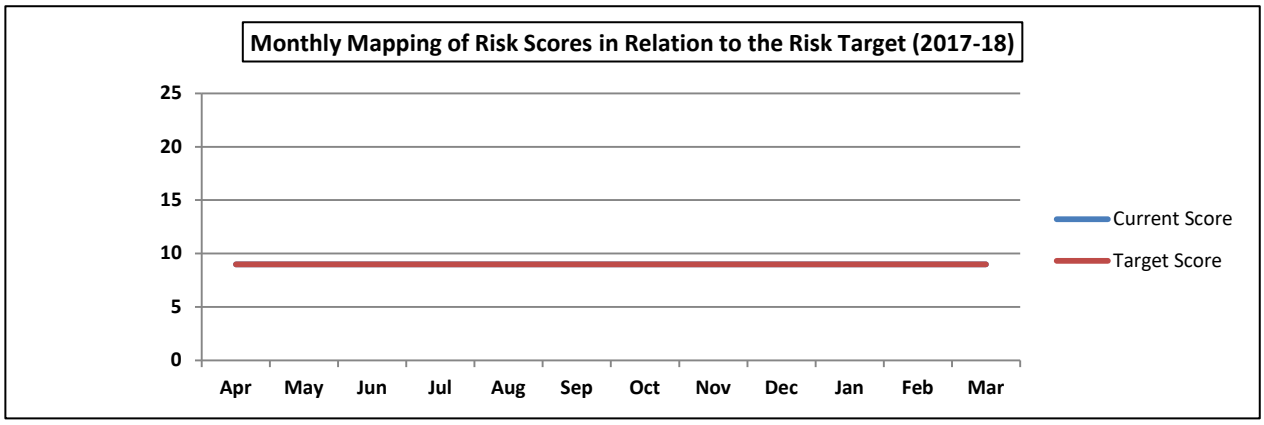
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Revise the Workforce Strategy	Mason Fitzgerald	~~Jan~~ May 2018	Due date amended
2	OD programme to report to the workforce committee	Mason Fitzgerald	~~Dec 2017~~ Mar 2018	Due date amended

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	Evidence of planned actions and outcomes

Risk Scores

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



Action Required

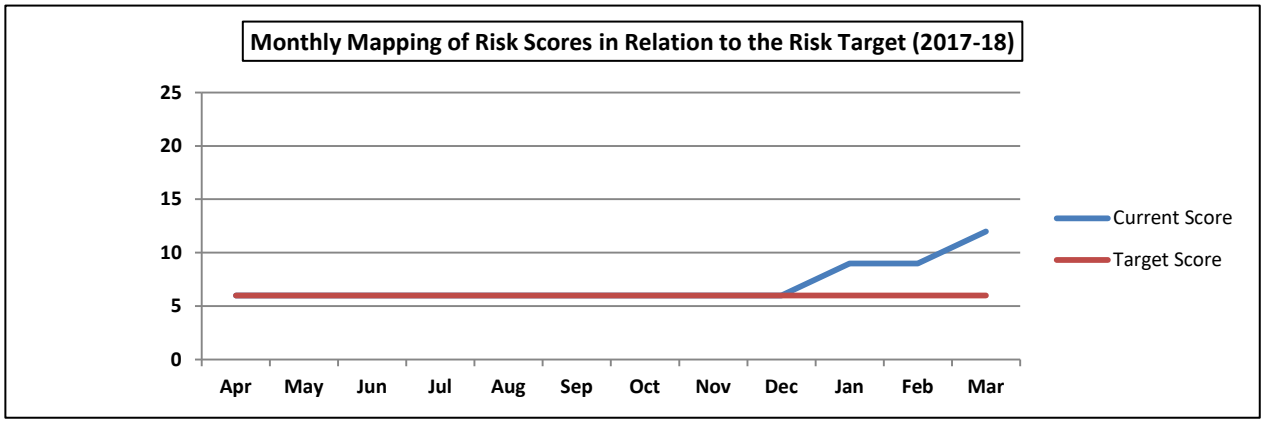
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Develop a formal succession plan	Mason Fitzgerald	Dec 2017	Complete
2	Introduce a system for monitoring succession planning outcomes	Mason Fitzgerald	~~Dec 2017~~ Apr 2018	

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	The likelihood score has increased from 3 to 4 as the recently published staff survey scores have indicated a drop in satisfaction levels from last year.

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**
None identified	Reporting to take place at Workforce Committee

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	3	3	3
Likelihood	3	4	2
Risk Scores	**9**	**12**	**6**



Action Required

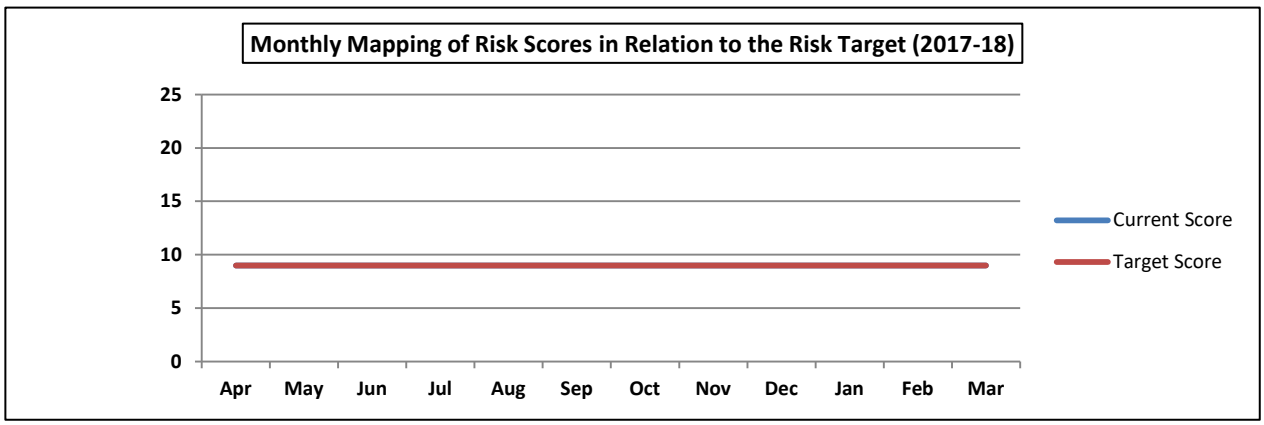
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Directorates to develop staff engagement plans in response to the Annual Staff Survey results for 2017.	Mason Fitzgerald	~~Feb~~ Apr 2018	Complete

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)	➢ Reports to the IM&T Task and Finish Group
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**
Non identified	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

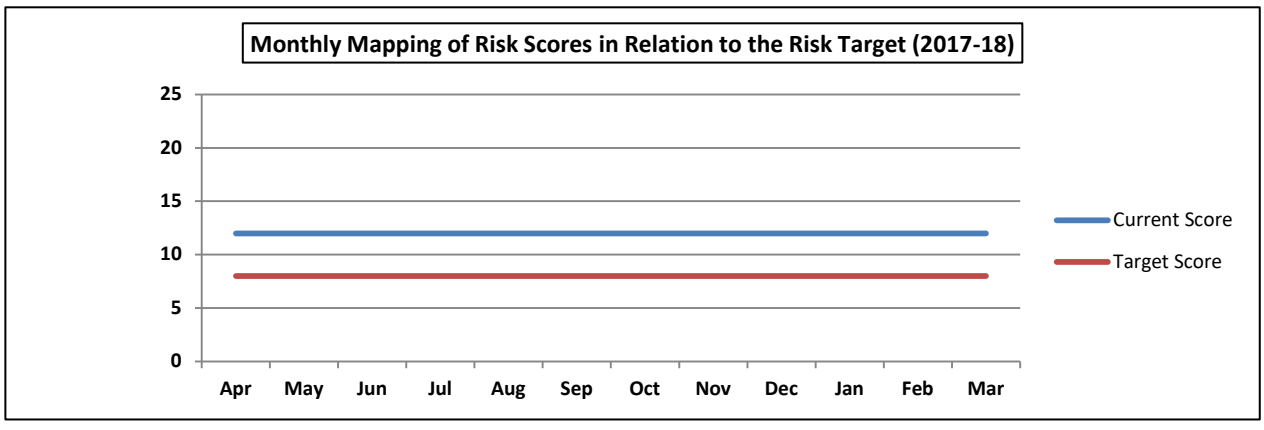
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/Status**
1	Roll-out of mobile working across all services. Implement plan agreed for the roll-out EMIS mobile and RiO mobile.	Steven Course	Mar 2019	Pilots start in Jan 2018
2	Migration of all staff to NHS Mail	Steven Course	Jan 2018	Complete
3	Implementation of EMIS in Tower Hamlets CHS	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	

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
Appointment of staff network leads	➢
Gaps in Controls	**Gaps in Assurance**
None identified	Evidence of implementation of plans to be submitted to Equalities Steering Group

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.~~ The equality strategy is being refreshed.	Lorraine Sunduza	~~Dec 2017~~ ~~Feb 2018~~ May	Consultation underway

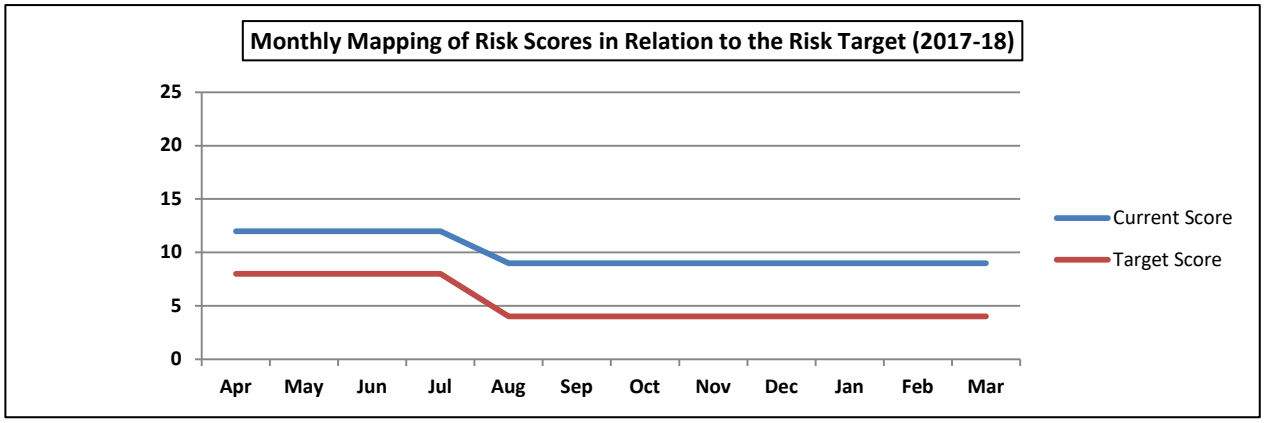
			2018	

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

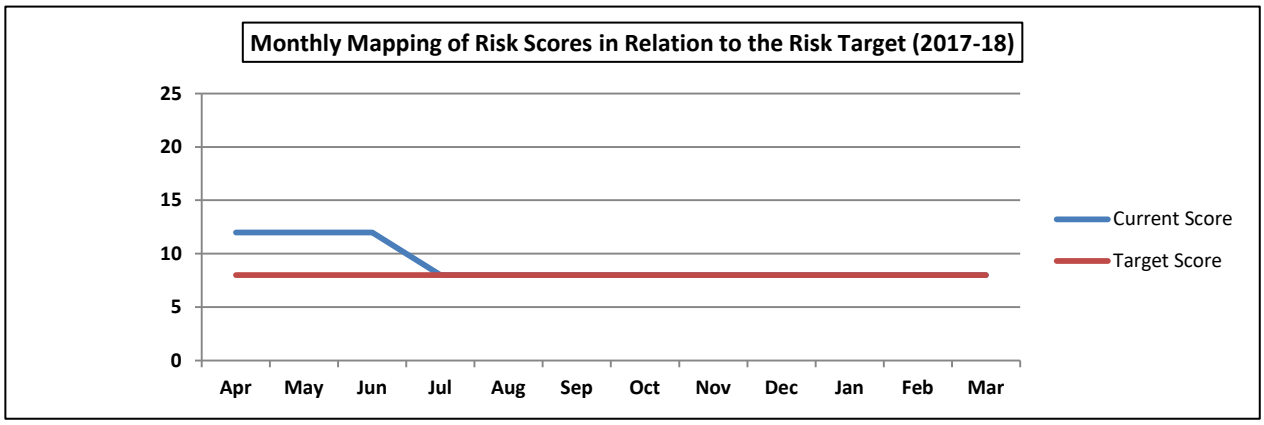
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Agree MoUs for Luton, Bedfordshire and Newham providers.	Mason Fitzgerald	Mar 2018	Complete
2	Implement the Business Strategy and review its impact	Mohit Venkataram	Sep 2018	

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**
None identified	TBC

Risk Scores

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



Action Required

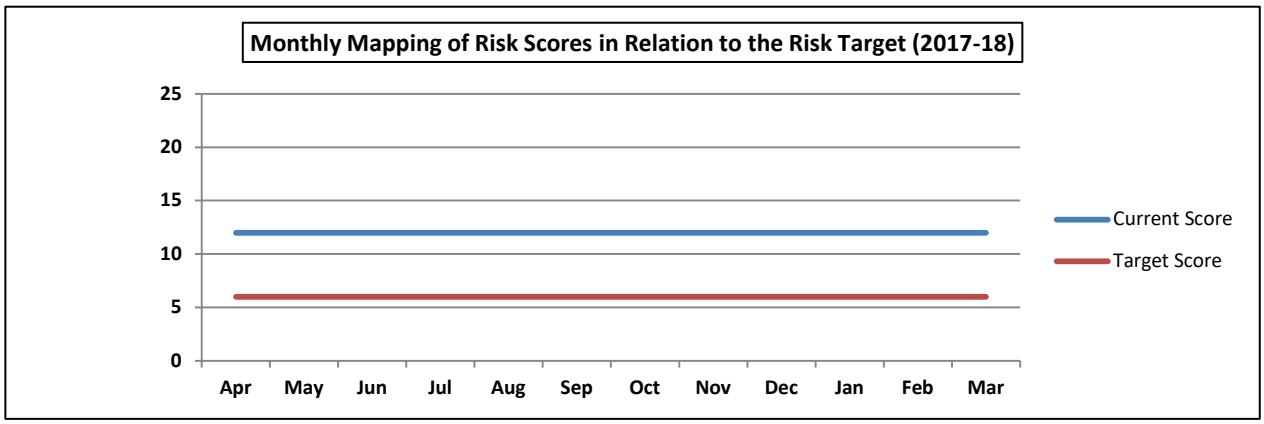
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/Status**
1	Analysis of the impact of the IAPT PbR approach	Steven Course	Sep 2017	Delayed nationally due lack of testing. Awaiting further information to dictate deadline.

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 the Executive Team and CEO.
Gaps in Controls	**Gaps in Assurance**
None identified	CQC well-led report to be available in June 2018

Risk Scores

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



Action Required

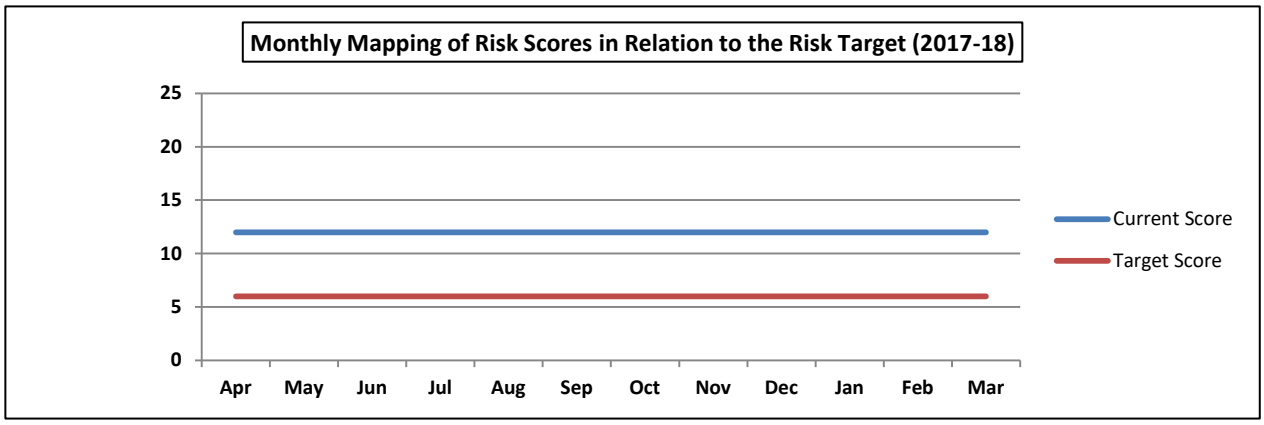
No.	Action	Responsible Person/s	Due date	Progress /Status

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	Evaluation of the impact of the plan

Risk Scores

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



Action Required

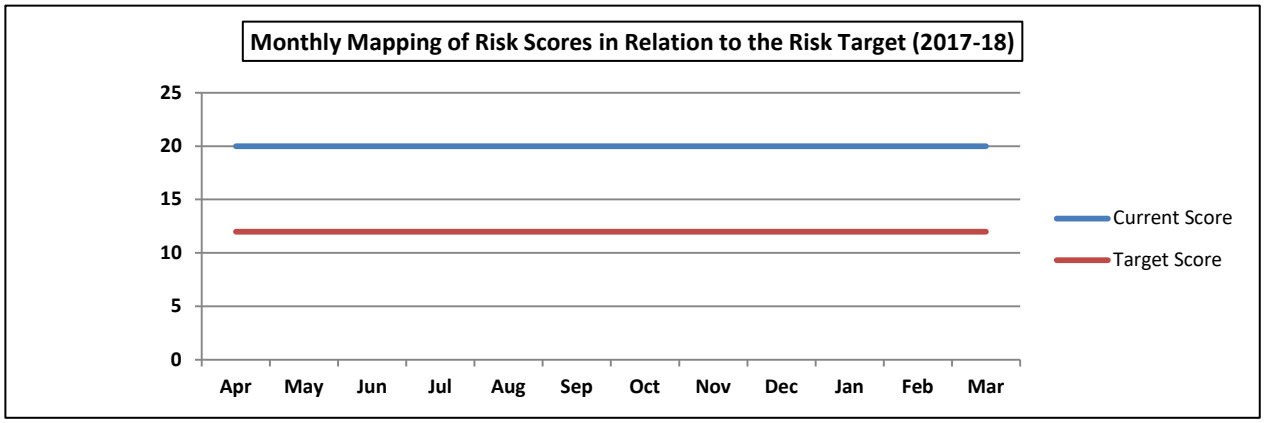
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Implementation of the Year 3 plan	Paul Calaminus	Mar 2018	Complete
2	Update the Year 3 plan for Year 4	Paul Calaminus	Mar 2018	

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**
None identified	Full CRES plan to be submitted to FBIC

Risk Scores

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



Action Required

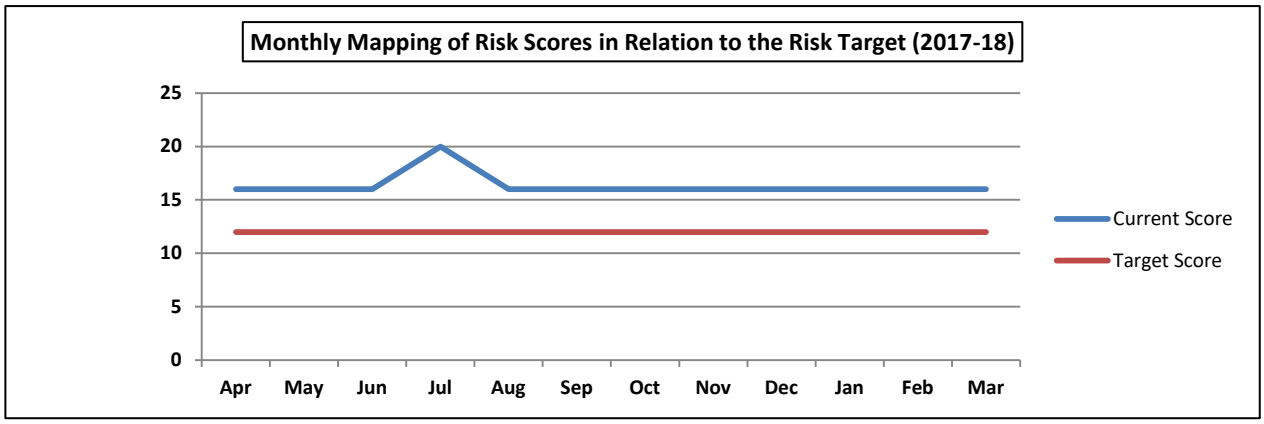
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress /Status**
1	Meetings in April with COO and Service Directors to formulate plans that address the 18/19 CRES gap	Steven Course/ Paul Calaminus	Apr 2018	

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
4. Current system for identification of CRES needs reviewing	➢ Reports to the FBIC
Gaps in Controls	**Gaps in Assurance**
None identified	Evidence of longer term financial planning to be submitted to FBIC

Risk Scores

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



Action Required

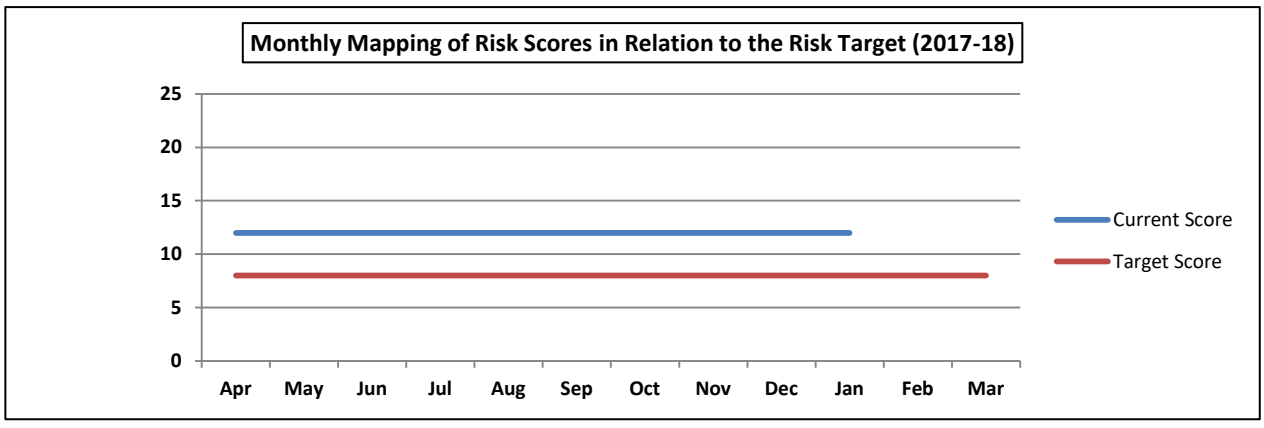
No.	Action	Responsible Person/s	Due date	Progress /Status
1	Revise the trust's 5 year strategy	Mason Fitzgerald	Mar 2018	Requires more detailed work

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	The likelihood score has been reduced from 3 to 2 as the trust plays an active part in both STPs and is working with each of them to deliver their long-term plans. Both have mental health delivery plans.

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**
None identified	None

Risk Scores

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



Action Required

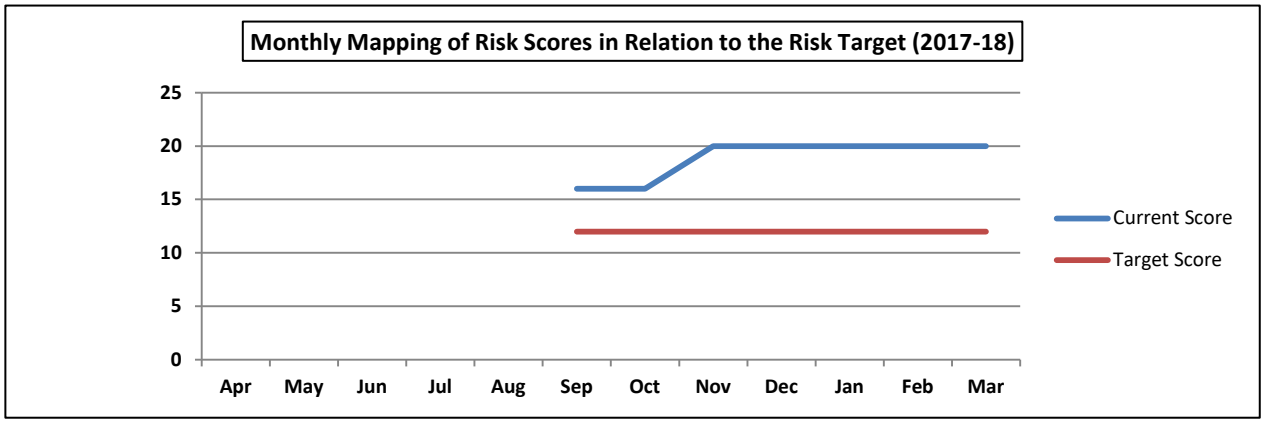
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/Status**

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	Evidence that major plans are being executed in the timely way

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~~ Mar 2018	