East London NHS Foundation Trust

REPORT TO THE TRUST BOARD – PUBLIC

27 APRIL 2017

Title	Performance and Compliance Report: March 2017 - Month 12
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Purpose of the Report:

This report provides assurance to the Trust Board on Trust-wide performance and compliance matters, including CQUINS for the period 1st April 2016 to 31st March 2017.

Summary of Key Issues:

Data gathered for the reporting period indicates that Trust's third quarter 2016/2017 return for the Single Oversight Framework has been rated as **Segment 2.** See section 8 of this report for details.

All NHSI targets have been met for month 12

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
27th April 2017 12th April 2017 Various.	This report is submitted to the Trust Board. This report has been submitted to the Trust Executive and Service Directors at the March SDB meeting. This report is based on February/YTD activity data received by the 3rd April 2017. Contract Performance Information is based on March (M11) information. Final figures are also considered at Quality and Performance review meetings with Trust Executive Directors. This review process is supported via a central adverse variance action tracker and summaries prepared by DMTs.

Date	Committee and assurance coverage
Various dates in following month.	Metrics herein are reported in more depth to service commissioners at monthly Technical Support Group and Service Performance Review meetings. Where required, significant variance and recovery plans are prepared by DMTs and agreed with commissioners regarding contract compliance issues.

Implications:

Impact	Update/detail
Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of September 2016 and provides data on key Compliance, NHS Improvement (Month 6/Quarter 2), national and contractual targets.
Service User/Carer/Staff	This report summarises progress on delivery of national and local performance targets set for all services.
Financial	The NHSI return, CQUIN report and contract compliance summary will highlight the areas where targets have not been met or areas of noncompliance against the main contacts and could pose a financial risk to the Trust.
Quality	Metrics within this report are used to support delivery of the Trust's wider service and quality goals.

Supporting Documents and Research material:

	Description	Frequency
1.	**Performance Scorecard** *Including key targets, trend indicators and movement since the last reporting period.*	**Monthly – SDB** **Bi-monthly – Trust Board**
2.	**Performance Charts and supporting tables** *Graphs and Tables*	**Monthly – SDB** **Bi-monthly – Trust Board**
3.	**Contract Compliance Report (previous month)**	**Monthly - SDB** **Bi-monthly – Trust Board**
4.	**Board Assurance Framework**	**Bi - Monthly - SDB** **Bi-monthly – Trust Board**
5.	**Corporate Risk Register**	**Bi - Monthly - SDB** **Bi-monthly – Trust Board**
6.	**CQUIN Report**	**Monthly – SDB** **Bi-monthly – Trust Board**
7	**New Executive Scorecard**	

Glossary

Abbreviation	In Full
A&E	Accident and Emergency
APMS	Alternative Provider Medical Services
CCG	Clinical Commissioning Group
CHN	Community Health Newham
CDC	Child Development Centre (Community Health Newham)
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRES	Cash Releasing Efficiency Savings
DMT	Directorate Management Team
EPC	Enhanced Primary Care
IAPT	Improving Access to Psychological Therapies
KPI	Key Performance Indicator
MHLDDS	Mental Health and Learning Disabilities Data Set
MHT	Mental Health Tariff
NHSE	NHS England
RAID	Rapid Assessment, Interface and Discharge
RAG	Red, Amber, Green ratings
SDB	Service Delivery Board
SLT	Speech and Language Therapy
SOF	Single Oversight Framework
SUS	Secondary Uses Service *(the single, comprehensive repository for healthcare data in England)*

1. Background/Introduction

This report provides assurance to the Trust Board and Executive Directors on Trust-wide performance and compliance matters for the period 1st April 2016 to 31st March 2017.

2. Report Summary

2.1 Current performance against key national metrics is shown in the table below for Month 12 (March 2017) which will be the Q4 submission.

NHS Improvement Targets		
CPA inpatient discharges followed up within 7 days (face to face and telephone)	95%	96.4%
Mental Health Patients occupying beds with delayed transfer of care - Adult & Older Adult (Only CAMHS excluded)	7.5%	0.90%
Admissions made via Crisis Resolution Teams (end of period)	95%	99.7%
Number of adult CPA patients meeting with care-coordinator in past 12 months	95%	98%
Access to healthcare for people with a learning disability – report compliance to CQC (Completion of self-assessment and declaration)		19
Completeness of Mental Health and Learning Disabilities Data Set (MHLDDS) – PART ONE	97%	100.0%
Completeness of Mental Health and Learning Disabilities Data Set (MHLDDS) – PART TWO	50%	84%
Reduction in Clostridium Difficile - reported instances	0	0
Improving Access to Psychological Therapies - Proportion of people completing treatment who move to recovery	50%	50.2%
Improving Access to Psychological Therapies - Patients referred within 6 weeks	75%	96.4%
Improving Access to Psychological Therapies - Patients referred within 18 weeks	95%	99.7%
Meeting commitment to serve new psychosis cases by EI teams	50%	92%
Community Referral to treatment information	50%	100%
Referral information (Community Health)	50%	73.6%
Care Contact Activity information (Community Health)	50%	89.1%

2.2 The table above shows that the Trust has achieved all NHSI indicators for month 12.

3. Performance Summary

Commentary for this report focuses on red rated items only, being those metrics 5% or more adrift of agreed thresholds. Details of local or minor variances meriting attention are contained within the relevant Appendices at a directorate level.

3.1 National and partner targets

3.1.1 There was one red rated items this month which relates to the new KPI introduced as part of the single oversight framework in relation to cardiometablic assessment.

Although the Trust met the new monthly targets for both CPA and EIS cases, for the inpatient target the trust achieved 69.7% against the 90% target. Performance managers are investigating this further where the service recently met this target in relation to the quarter 3 CQUIN targets.

3.1.2 Workforce Performance Measures

All currently rated amber except for Statutory and Mandatory Training where performance is above target for M12.

Indicator	Target	Performance
Sickness and Absence Levels	3.5%	4.3%
Non-Medical Staff Supervision (Clinical) – compliance rate	90%	77.8%**
Medical Staff Supervision (Clinical)	90%	82.7%**
All Staff Supervision (Management)	90%	70.9 **

**Awaiting manual returns from Newham

3.1.3 Assurance Performance Measures

There is one red rated item this month:

% of complaint response rates within 25 days.

Current performance is showing as 43% for month 12, a significant improvement from the 27% performance in month 11.

A detailed action plan is in place within the assurance team to improve the performance of complaints reporting.

3.2 Information governance and data quality indicators

Appendix 1 includes performance against a range of agreed Data Quality targets. Individual Directorate performance is measured at DMT level.

The majority of areas show good compliance rates, but there are 4 Trust wide red rated items reported this month.

Indicator	Target	Performance
Primary diagnosis – Inpatient	95%	65.3%
Primary diagnosis – Community	95%	80.0%
Employment	95%	88.8%
Accommodation	95%	88.5%

3.3 Mental Health Tariff

Current performance for unexpired clusters (% in date) is 94.1% just below the 95% target this figure excludes Luton and Bedfordshire.

Directorate	Missing	Missing%	Expired	Expired %	Unexpired %	Total	Missing & Expired
CH	183	**6.5%**	118	**4.2%**	**95.8%**	2813	**10.7%**
MHCOP	47	**3.5%**	102	**7.6%**	**92.4%**	1347	**11.1%**
NH	159	**5.6%**	154	**5.4%**	**94.6%**	2859	**10.9%**
TH	142	**4.7%**	214	**7.1%**	**92.9%**	3029	**11.8%**
Trust Total	**531**	**5.3%**	**588**	**5.9%**	**94.1%**	**10048**	**11.1%**

3.3.1 Awaiting Cluster

Continuous monitoring is in place to meet the clustering targets for new patients who have been seen (twice) and for re-clustering as recommended by Department of Health National Tariff Clustering timescales.

Charts and Reports are available in reporting services by client, clinician, wards and teams for clustering information including missing and expired clusters – these are updated every weekday.

Teams need to focus on “re-clustering” patient records, where clinically relevant in order to:

- Meet national requirements
- Establish best available clinical evidence base for future internal use.
- Support Payment by Results shadow arrangements.

3.3.2 Expired Clusters

In order to support teams to address the numbers of expired clusters, charts and reports are available in reporting services for Wards and Teams for Expired Clusters – these are updated every weekday and can be drilled down by client or clinician.

Amendments have been made to the MH Tariff reports to help improve figures in advance of implementing shadow National Tariff to show those cases in clusters 14 and 15 in line with the new 3 week buffer period and the 6 week buffer period for all other clusters. Once out of the buffer period cases would have no payment associated with the case.

To support improvement, detailed National Tariff Cluster reports are available to all DMTs and are updated daily. The reports allow "drill down" to patient records, enabling prompt local investigation and action.

3.3.3 Clustering in Luton and Bedfordshire

Clustering continues to improve in Bedfordshire and Luton. Services are implementing comprehensive training plans and targets will be agreed with Commissioner but are working towards an internal target of 80% by the end of March 2017 in line with Trust requirements for the reference costs process.

Services are focusing on training staff to cluster, recording on RiO and addressing the cases where the clustering information is missing on RiO including reviewing legacy data from the SEPT system.

Current performance is shown in the table below.

Directorate	Missing	Missing%*	Expired	Expired %*	Unexpired %	Total	Missing & Expired
BEDFORDSHIRE	821	14.2%	841	14.5%	85.5%	5790	28.7%
LUTON	15	1.0%	34	2.2%	97.8%	1512	3.2%
Trust Total	**2235**	**30.6%**	**875**	**12.0%**	**88.0%**	**7302**	**42.6%**

4. Contract Compliance

Commentary for this section of the performance report focuses on areas of non-compliance for each of the main contracts where items are RAG rated. The table below lists the main contracts and the number of indicators where compliance was not achieved for the commissioner reports submitted to the CCGs for Month 11.

Contract	Areas of Non Compliance
Bedfordshire	2
Luton	16
East London Consortium	5

RAID	One delivery risk on one project
Community Health Newham	
· Adult Services	5
· Children Services	7
Newham Transitional Practice Service	2
Health E1 and Greenhouse APMS	2
Community Health Newham NHSE	0
Barnet SLT	7
IAPT	
· Bedfordshire	0
· Luton	0
· Newham	0
· Richmond	0
Specialist Addiction Services	Awaiting KPIs
NHSE Specialised Services (Q3)	2

5. CQUIN

The report confirms that all Quarter 3 CQUINs have been submitted, and the Trust has received a combination of verbal and written feedback from each commissioner detailing our achievement.

For Quarter 4 following the Trust's Self-Assessment the Trust has achieved all milestones except for the following two CQUINs.

1a (b) Introduction of health and wellbeing initiatives (Option B)

It is predicted that we will achieve this CQUIN in East London and it has been given a conservative estimate of an amber in Luton, pending further work to review each of the 20+ health and wellbeing initiatives.

In Bedfordshire there is concern that non-delivery on one or more initiative in the Health and Wellbeing Plan will result in us not achieving against the full plan. There are two initiatives that are at risk of non-delivery, a cycle-to-work scheme (due to the geography of the area, staff are not keen to cycle to work) and delivery of activities in partnership with the Bedford Borough Council.

1c Improving the uptake of flu vaccinations for frontline clinical staff

In Bedfordshire, 65% of staff were vaccinated, therefore it is expected the Trust will achieve 50% of the CQUIN payment £57,037 out of the total £114,075 payment (if 75% had been vaccinated we would have achieved the full CQUIN payment).

6. Executive Score Card

Following a review of the data presented in the performance, finance and workforce reports to the board, the Trust has been working with an external provider to design a bespoke application which focuses on key performance indicators.

The new executive score card will integrate clinical, assurance, workforce and financial information into a series of interactive dashboards. These will displaying the indicators the Trust needs to monitor in line with local and national targets. This programme of work enables us to present corporate information on a single screen at a Trust or Directorate level.

Please see Appendix 2.

7. Board Assurance Framework

The Board Assurance Framework (BAF) is currently being refreshed in line with the objectives in the Operational Plan for 2017-18. The executive team are conducting a fresh assessment of the risk environment and discussion will then be had at Board sub-committees in relation to the areas of risk that they oversee. A revised format is also being introduced which is expected to aid the clear tracking of actions and assurance.

Each risk within the current 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. 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 current version of it is attached as Appendix 3.

8. Compliance And Governance Update

The Single Oversight Framework has replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'.

Trusts are now segmented under the Single Oversight Framework (SOF) based on the level of support each provider needs which is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of ‘Good’ or ‘Outstanding’:

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

Theme	Current Rating	
Quality of Care		No Concerns
Financial and Use of Resources		Trust has not achieved financial surplus target for 2016/17
Operational Performance		No Concerns
Strategic Performance		No Concerns
Leadership and Improvement Capability		No Concerns

The Trust has been categorized in **Segment 2** (Target Segment 1). See table below for descriptions of each segment

Segment	Description
1	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.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.
4	Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures

9. Finance returns

Summary of financial performance figures returned are detailed within the Finance Report on the agenda.

10. Exception reports

Exception reports will be submitted to NHS Improvement in line with the Compliance Framework.

11. Recommendations and Action being requested

The Board/Committee is asked to:

a) **RECEIVE** and **NOTE** the report for information
b) **CONSIDER** whether appropriate assurance has been provided.

Trust Board Main Scorecard, Graphs and Tables - 2016/17

Current Month .... Prior periods

Mar-17

Summary Score Card	2016/17 Target	Mar-17	Feb-17	2016/2017 (Q3 Values) Actual	Trend since last Month	Comment	KPI Basis
NHS Improvement Targets							
CPA inpatient discharges followed up within 7 days (face to face and telephone)	95%	96.4%	98.0%	95.9%	↓	Trust wide figure excl CAMHS,FX,MHCOP	In Quarter
Mental Health Patients occupying beds with delayed transfer of care - Adult & Older Adult (Only CAMHS excluded)	7.5%	0.90%	0.80%	1.10%	→	Based on bed-days lost/total occupied bed-days. Does not include CHN figures (0.0%)	In Quarter
Admissions made via Crisis Resolution Teams (end of period)	95%	99.7%	99.8%	100.0%	↘		In Quarter
Number of adult CPA patients meeting with care-coordinator in past 12 months	95%	97.3%	97.0%	94.0%	→	Current Month percentage is March Primary	In Quarter
Access to healthcare for people with a learning disability – report compliance to CQC	Completion of self assessment and declaration	19	19	19	→	Current declaration is as will be reported to Trust Board 31st March 2014, LD Strategy and improvement plan led by Director of Operations.	In Quarter
Completeness of Mental Health and Learning Disabilities Data Set (MHLDDS) – PART ONE	97%	100.0%	100.0%	100.0%	→	Current Month percentage is March Primary	Monthly
Completeness of Mental Health and Learning Disabilities Data Set (MHLDDS) – PART TWO	50%	87.0%	82.0%	86.0%	↑	As above.	Monthly
Reduction in Clostridium Difficile - reported instances	0	0	0	0	→		In Quarter
Improving Access to Psychological Therapies - Proportion of people completing treatment who move to recovery	50%	50.2%	49.1%	49.1%	↗	New Single Oversight Framework KPI Sept 16. Q4 shown for this month and Q3 for last month	Quarterly
Improving Access to Psychological Therapies - Patients referred within 6 weeks	75%	96.4%	92.8%	92.8%	↑	Q4 shown for this month and last month	Quarterly
Improving Access to Psychological Therapies - Patients referred within 18 weeks	95%	99.7%	99.4%	99.4%	→	Q4 shown for this month and last month	Quarterly
Meeting commitment to serve new psychosis cases by EI teams	50%	92%	93%	90%	↓		In Quarter
NHS Improvement Targets - Community Information Data Set (CIDS - Data Completeness)						**Reported quarterly only**	
Community Referral to treatment information	50%	100.0%	100.0%	100.0%	→	In quarter reporting	In Quarter
Referral information	50%	73.6%	73.7%	72.1%	↘	March Q4 figures contain first attendance performance figures. Feb figures refreshed with actual performance data. In quarter reporting Jan _March MONITOR return.	In Quarter
Care Contact Activity information	50%	89.1%	86.6%	88.0%	↑	March Q4 figures contain first attendance performance figures. Feb figures refreshed with actual performance data. In quarter reporting to Jan_March MONITOR return.	In Quarter
Other National/CQC Targets - formerly used in CQC Annual Assessments						**Retained for continuity pending any further internal review of KPIs**	
Completeness of Ethnicity Coding – PART ONE (Inpatients in MHLDDS - Year to date)	85%	100.0%	96.0%	95.0%	↑	Current Month percentage is March Primary	Monthly
Completeness of Ethnicity Coding – PART TWO (Inpatient FCEs HES - Year to date)	85%	98.9%	98.9%	98.4%	→		YTD
Patterns of Care – assignment of Care Co-ordinator within Mental Health Minimum data set	95%	98.0%	97.0%	94.0%	↗	Current Month percentage is March Primary	Monthly
Drug Misusers in effective Treatment	85%					New KPIs from Oct 16	Monthly
Number of Learning Disabilities Inpatients with in date care plans	100%	100.0%	100.0%	100%	→		Monthly
Workforce Performance Measures							
Sickness and Absence Levels	3.5%	4.3%	4.3%	4.4%	↗	One month in arrears, data is for Feb 17	Monthly
Non-Medical Staff Supervision (Clinical) – compliance rate	90.0%	75.8%	82.9%	88.2%	↓	70% = Amber. Awaiting NH figures	Monthly
Medical Staff Supervision (Clinical) – compliance rate	90.0%	82.7%	82.1%	76.3%	→	70% = Amber. Awaiting NH figures	Monthly
All Staff Supervision (Management) - compliance rate	90.0%	70.9%	74.8%	80.3%	↓	70% = Amber. Awaiting NH figures	Monthly
Statutory and Mandatory Training						**NOTE - Over 80% Compliance = GREEN; Over 70% Compliance = AMBER**	
Compliance rate for all designated Statutory and Mandatory Training Courses	Over 80%		82.8%	86.5%		Delivery of 80% target led by the Director of Nursing and DMTs. Latest figures currently unavaliable	Monthly
CCG Contract and Mandatory Targets (NOT INCLUDED ABOVE)							
Exception reporting if a man and a woman share either a Bedroom or a Bed-bay	0	0	0	0	→		Monthly
Number of people under 18 admitted to adult inpatient wards	0	0	0	2	→		Monthly
Number of people under 16 admitted to adult inpatient wards	0	0	0	0	→	New Single Oversight Framework KPI - Sept 16	Monthly
Number of Service Users in employment (On CPA, 18-69)	N/A	7.3%	6.8%	4.4%	→	No target set	YTD
Number of Service Users in settled accommodation (On CPA, 18-69)	N/A	83.7%	82.7%	83.6%	→	No target set	YTD
Specialist Addiction Service - Proportion of new Service Users receiving General Healthcare Assessment	100%					Data as per National Drug Treatment Monitoring System. New KPIs from Oct 16	Monthly
Eating Disorder - Proportion of CYP that wait 1 week or less (Access)	N/A	88.0%	75.0%	75.0%		New National Quarterly KPI - Completed pathway metric. Urgent cases. Q4 shown for this month	Quarterly
Eating Disorder - Proportion of CYP that wait 4 weeks or less (Access)	N/A	93.5%	71.1%	71.1%		New National Quarterly KPI - Completed pathway metric. Routine cases. Q4 shown for this month	Quarterly
Patient Experience - Inpatient							
Inpatient Bed Occupancy Rate - Adult	90%	87.7%	89.9%	84.2%	↓	One Month Data. 90% is reported contract target (Trust aspiration is 85%).	Monthly
Inpatient Bed Occupancy Rate - Older Adult (Functional)	90%	66.0%	75.1%	78.1%	↑	One Month Data. 90% is the contract target (Trust aspiration is 85%).	Monthly
Readmission rate (28 days) - Adult	7.5%	6.2%	6.1%	6.1%	↗		YTD
Readmission rate (28 days) - Older Adult	7.5%	1.2%	1.4%	1.4%	↓	Targets agreed with the Commissioners	YTD
Average Length of Stay - Adult	N/A	25.9	25.7	25.9	↑	Rolling 12 months data	Rolling 12 months
Average Length of Stay - Older Adult (Functional)	N/A	52.3	50.9	51.1	↓	Rolling 12 months data. This measure is for Functional Older Adult beds ONLY.	Rolling 12 months
Patient Experience - Community/General							
Assessment within 28 days of referral - Adult	100%	96.3%	96.3%	96.6%	→		YTD
Assessment within 28 days of referral - MHCOP	Assumed N/A	97.8%	97.7%	97.7%	→		YTD
CPA patients - care plans in date (Documents 12 months old)	95%	91.4%	90.3%	86.6%	↗		Snapshot

Trust Board Main Scorecard, Graphs and Tables - 2016/17

Current Month .... Prior periods

Mar-17

Summary Score Card	2016/17 Target	Mar-17	Feb-17	2016/2017 (Q3 Values) Actual	Trend since last Month	Comment	KPI Basis
CPA patients - care plans in date (Documents 6 months old)	N/A	78.7%	75.5%	64.3%	↑		Snapshot
% CPA patients seen in month - face to face only	85%	83.8%	81.5%	82.8%	↑		Snapshot
CORC Percentage showing improvement	80%	87.0%	87.0%	87.0%	→	Q4 shown for this month as this is a quarterly return	Quarterly
MRSA bloodstream infections - reported instances	0	0	0	0	→	Removed from Monitor Risk Assessment Framework (Q3 2013-14)	In Quarter
Number of overdue incidents --- (Incidents are regarded as overdue if they have not been Finally Approved within seven days of the incident date)	N/A	0	0	0	→	From Datix. No targets/RAG rating required	Snapshot
Number of incidents exported to NRLS	N/A	310	460	259	↓	From Datix. No targets/RAG rating required. YTD figure = 5144	Monthly in month
Community Services Newham - National Targets							
Children's Services: Percentage of children in Reception with height and weight recorded.	90%	88.4%	88.4%	88.4%		Annually reported in August, current month is August 16 figures	Annual
Children's Services: Percentage of children in Year 6 with height and weight recorded.	90%	90.8%	90.8%	90.8%		As above.	Annual
Response to Complaints							
% Complaints Response Rates (within 25 working days or an extended timescale agreed with complainant)	85%	43.0%	27.0%	24.3%		MHCOP/CHN are combined as one	Monthly
Specialist Addictions - Key Contract Targets						**Q3 Position is shown**	
Summary of key Contract KPIs for Tower Hamlets (Red rated)		N/A	N/A	0		See Table E for details. There are 9 key indicators with targets for TH SAU based on local data. 1 under target ('new clients engaging in drug and alcohol treatment') for Q3 2015-16. NH SAU closed (July 14), CH SAU closed (Sept 15) New KPIs from Oct 16	Quarterly
Cardio Metabolic Assessment And Treatment							
Inpatients	90%	69.7%	87.3%	78.8%	↓	New Single Oversight Framework KPI - Sept 16. Q4 for this month, Q3 shown for previous month	Quarterly
EIS	90%	94.0%	99.0%	99.0%	↓	New Single Oversight Framework KPI - Sept 16. Q4 for this month, Q3 shown for previous month	Quarterly
CPA	60%	87.5%	90.2%	87.8%	↓	New Single Oversight Framework KPI - Sept 16. Q4 for this month, Q3 shown for previous month	Quarterly

Information Governance/Data Quality (Trust Target 95%) - East London Consortium/Bedfordshire and Luton	RiO - Mental Health Inpatient	Rio Community CAMHS	RiO - Mental Health Community	NEBULA SAU	RiO - Community Services Newham (NCHS)	Comment	KPI Basis
Date of Birth	✓ 100.0%	✓ 100.0%	✓ 100.0%		✓ 100.0%	MAISY and NEBULA (was ORION) are not part of the MHLDDS feed.	Monthly
Gender	✓ 100.0%	✓ 100.0%	✓ 100.0%		✓ 100.0%	MAISY and NEBULA (was ORION) are not part of the MHLDDS feed.	Monthly
Marital Status	! 93.6%	✓ 100.0%	! 92.0%			FCE (inpatients) . CPA clients only for Community (Community figure 90% for all open referrals).	Monthly
NHS Number	✓ 98.6%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 99.1%	NEBULA System. TH SAU only, CH & NH SAU closed. New KPIs from Oct 16	Monthly
Ethnic Group	✓ 98.6%	✓ 100.0%	✓ 99.0%	✓ 100.0%	✓ 96.5%	As above	Monthly
Postcode	✓ 98.1%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	As above	Monthly
GP Practice	! 94.5%	✓ 99.0%	✓ 98.0%	✓ 99.1%	! 84.3%	As above	Monthly
Commissioner Code	✓ 100.0%	✓ 100.0%	✓ 100.0%		✓ 99.5%		Monthly
Primary Diagnosis	✗ 65.3%		✗ 80.0%	✓ 100.0%		CPA clients only for Community. CAMHS/SAU not included in national targets. Awaiting SAU figures	Monthly
HoNOS			✓ 95.2%			CPA Patients Only - includes Inpatients on CPA (Provisional)	Monthly
Unexpired Clusters (% In Date)			! 94.1%			Cohort inclusion rules adjusted as agreed by PbR Steering Group/Commissioners. Exc. L&B	Monthly
Employment Status			✗ 88.8%			CPA Patients Only (18-69 years only). Includes Inpatients on CPA.	Monthly
Accommodation Status			✗ 88.5%			CPA Patients Only (18-69 years only). Includes Inpatients on CPA	Monthly

GENERAL NOTES

Luton and Befordshire figures included unless stated in comment box

Performance on certain indicators remains provisional and subject to central sign off via Commissioners.

Figures may thus vary from those subsequently reported to Trust Board and used in central returns. This reflects on-going internal/external validation and sign off activities.

KPI calculations have been modified where required to match those published in the Monitor Compliance Framework

Where an indicator is reported quarterly the latest available data will be shown until next update. This mainly applies to central datasets that require external validation

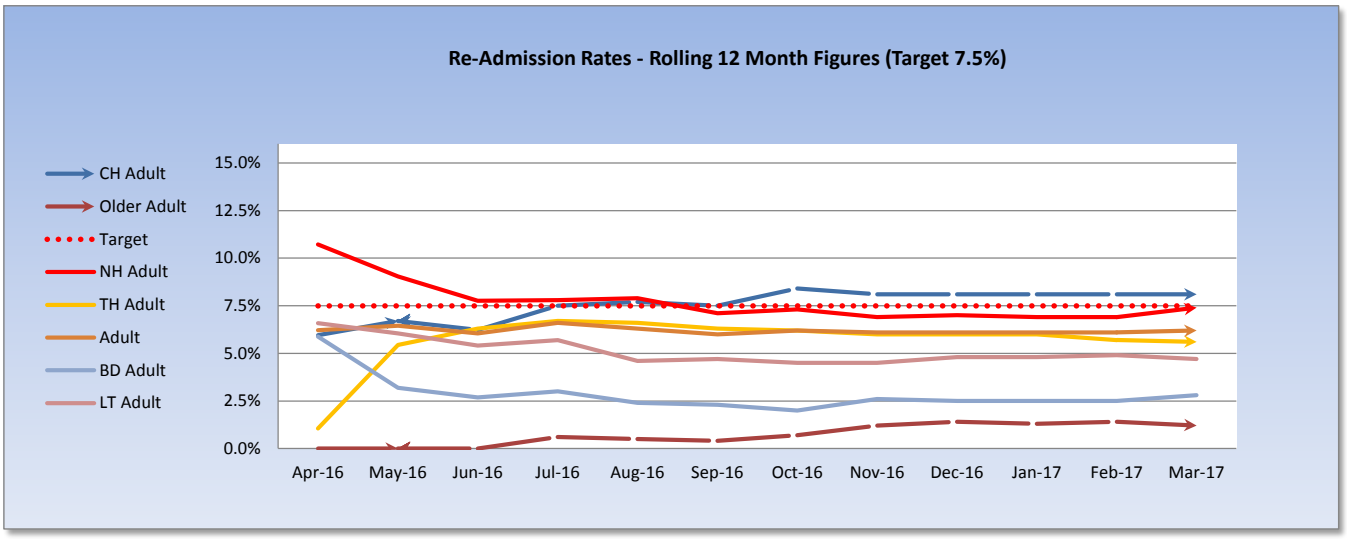
↑ = Improvement towards target/Positive variance

↓ = Movement away from target/Adverse variance

Trust Board Main Scorecard, Graphs and Tables - 2016/17

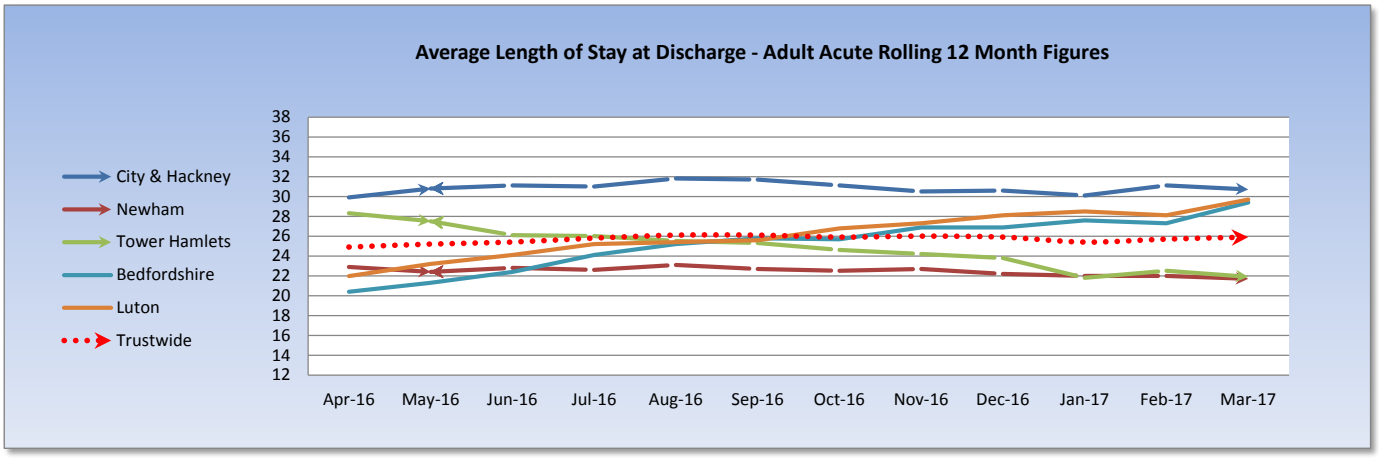
As at: Mar-17

Patient Experience - Inpatients



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Re-admission rate (28 days) - CH Adult	6.0%	6.7%	6.2%	7.5%	7.7%	7.5%	8.4%	8.1%	8.1%	8.1%	8.1%	8.1%
Re-admission rate (28 days) - NH Adult	10.7%	9.0%	7.8%	7.8%	7.9%	7.1%	7.3%	6.9%	7.0%	6.9%	6.9%	7.4%
Re-admission rate (28 days) - TH Adult	1.1%	5.4%	6.3%	6.7%	6.6%	6.3%	6.2%	6.0%	6.0%	6.0%	5.7%	5.6%
Re-admission rate (28 days) - BD Adult	5.9%	3.2%	2.7%	3.0%	2.4%	2.3%	2.0%	2.6%	2.5%	2.5%	2.5%	2.8%
Re-admission rate (28 days) - LT Adult	6.6%	6.0%	5.4%	5.7%	4.6%	4.7%	4.5%	4.5%	4.8%	4.8%	4.9%	4.7%
Re-admission rate (28 days) - Adult	6.2%	6.5%	6.1%	6.6%	6.3%	6.0%	6.2%	6.1%	6.1%	6.1%	6.1%	6.2%
Re-admission rate (28 days) - Older Adult	0.0%	0.0%	0.0%	0.6%	0.5%	0.4%	0.7%	1.2%	1.4%	1.3%	1.4%	1.2%
Target	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%

Demand, Capacity and Utilisation

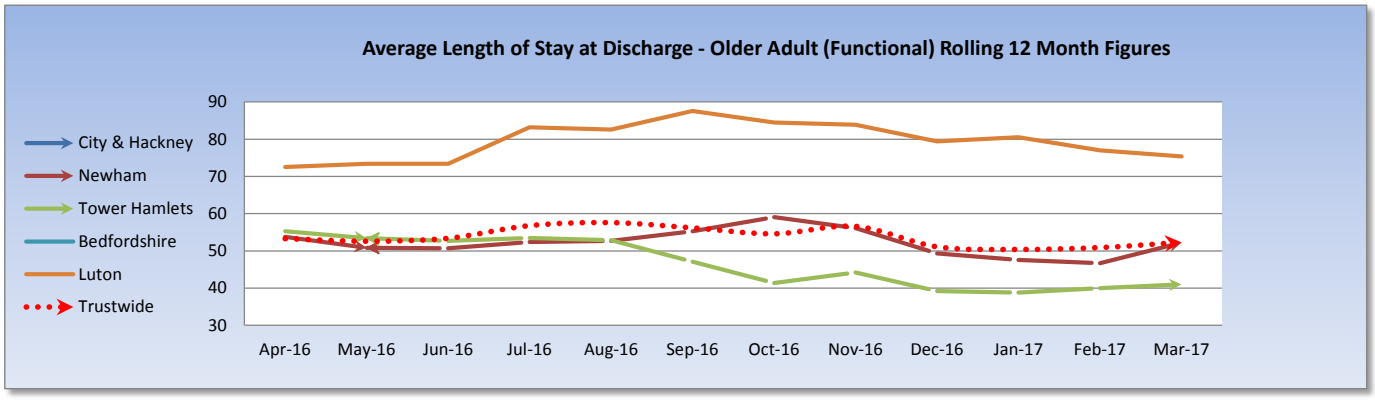


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
City & Hackney	29.9	30.8	31.1	31.0	31.8	31.7	31.1	30.5	30.6	30.1	31.1	30.7
Newham	22.9	22.4	22.8	22.6	23.1	22.7	22.5	22.7	22.2	22.0	22.0	21.7
Tower Hamlets	28.3	27.5	26.1	26.0	25.5	25.3	24.6	24.2	23.8	21.8	22.5	21.9
Bedfordshire	20.4	21.3	22.4	24.1	25.2	25.8	25.7	26.9	26.9	27.6	27.3	29.4
Luton	22.0	23.2	24.1	25.2	25.4	25.6	26.8	27.3	28.1	28.5	28.1	29.7
Trustwide	24.9	25.2	25.4	25.8	26.1	26.1	25.9	26.0	25.9	25.4	25.7	25.9

Definition: This measure is based on the entire Inpatient Spell from admission to discharge. Only patients discharged from Adult acute wards are considered but transfers between wards and specialties during their stay contribute to the stay length. Home Leave is EXCLUDED.

Trust Board Main Scorecard, Graphs and Tables - 2016/17

As at: Mar-17



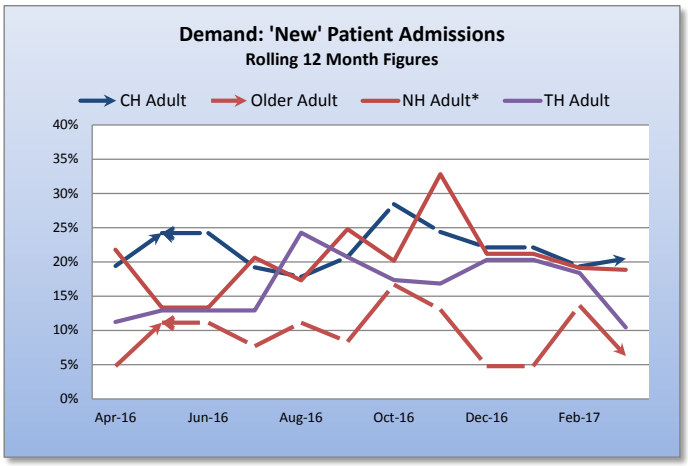
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
City & Hackney	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Newham	53.8	50.8	50.7	52.4	52.7	55.3	59.1	56.1	49.3	47.6	46.7	52.2
Tower Hamlets	55.3	53.4	52.7	53.5	52.9	47.1	41.4	44.2	39.2	38.8	40.0	41.0
Bedfordshire	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Luton	72.5	73.4	73.4	83.2	82.6	87.6	84.5	83.9	79.4	80.5	77.0	75.4
Trustwide	53.3	52.6	53.4	56.8	57.6	56.2	54.6	56.6	51.1	50.4	50.9	52.3

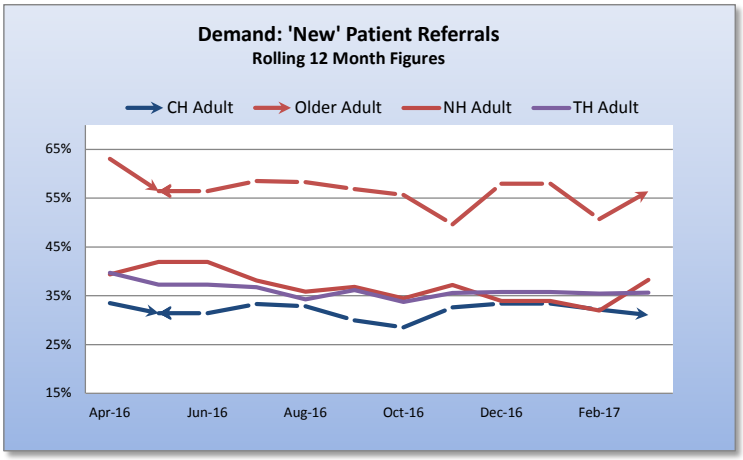
Definition: This measure is based on the entire Inpatient Spell from admission to discharge. Only patients discharged from Older Acute (Functional) wards are considered but transfers between wards & specialties during their stay contribute to the stay length. Home Leave is EXCLUDED.
NOTE: A '0' figure indicates no discharges from ward in time period.

Trust Board Main Scorecard, Graphs and Tables - 2016/17

As at: Mar-17

Demand, Capacity and Utilisation





ADMISSIONS: New Patient Demand (In Month figures and Year to Date Total)

Admissions		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16-17 YTD
CH Adult	New	13	23	23	19	13	18	25	19	19	19	17	17	225
	Known	54	72	72	80	60	69	63	59	67	67	71	66	800
	Total	67	95	95	99	73	87	88	78	86	86	88	83	1,025
	% New	**19%**	**24%**	**24%**	**19%**	**18%**	**21%**	**28%**	**24%**	**22%**	**22%**	**19%**	**20%**	**22%**
NH Adult*	New	27	12	12	26	18	31	24	43	25	25	22	29	294
	Known	97	78	78	100	86	94	95	88	93	93	93	125	1,120
	Total	124	90	90	126	104	125	119	131	118	118	115	154	1,414
	% New	**22%**	**13%**	**13%**	**21%**	**17%**	**25%**	**20%**	**33%**	**21%**	**21%**	**19%**	**19%**	**21%**
TH Adult	New	10	12	12	15	17	17	17	15	14	14	16	10	169
	Known	79	81	81	101	53	65	81	74	55	55	71	86	882
	Total	89	93	93	116	70	82	98	89	69	69	87	96	1,051
	% New	**11%**	**13%**	**13%**	**13%**	**24%**	**21%**	**17%**	**17%**	**20%**	**20%**	**18%**	**10%**	**16%**
TOTAL ADULT	New	50	47	47	60	48	66	66	77	58	58	55	56	688
	Known	230	231	231	281	199	228	239	221	215	215	235	277	2,802
	Total	280	278	278	341	247	294	305	298	273	273	290	333	3,490
	% New	**17.9%**	**16.9%**	**16.9%**	**17.6%**	**19.4%**	**22.5%**	**21.6%**	**25.8%**	**21.3%**	**21.3%**	**19.0%**	**16.8%**	**19.7%**
Older Adult	New	1	3	3	2	2	2	4	3	1	1	3	1	26
	Known	20	24	24	24	16	22	20	20	20	20	19	15	244
	Total	21	27	27	26	18	24	24	23	21	21	22	16	270
	% New	**5%**	**11%**	**11%**	**8%**	**11%**	**8%**	**17%**	**13%**	**5%**	**5%**	**14%**	**6%**	**10%**

** Newham calculation adjusted to exclude OT team referrals from contact checks, as agreed with Clinical Director*

REFERRALS: New Patient Demand (In Month figures and Year to Date Total)

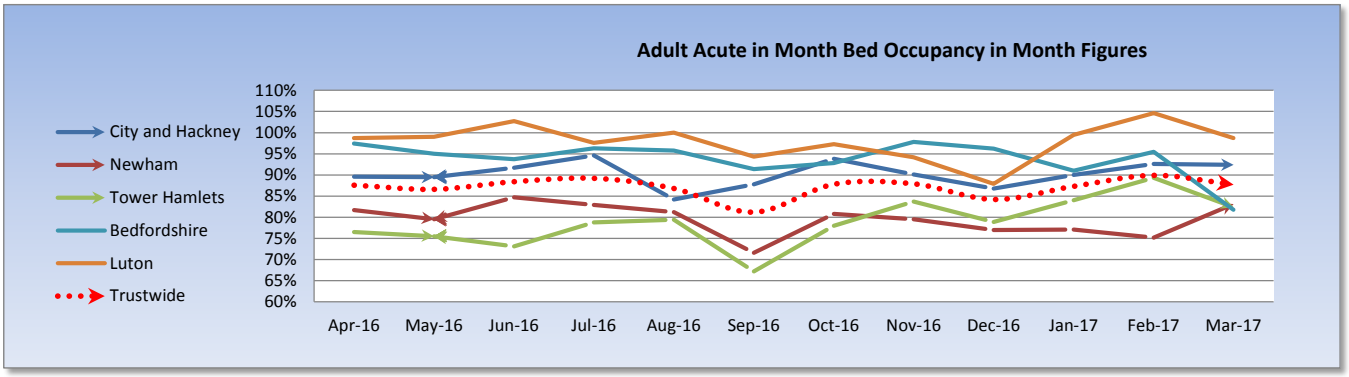
Referrals		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16-17 YTD
CH Adult	New	283	249	249	345	288	301	270	348	328	328	318	347	3,654
	Known	562	544	544	692	589	704	677	719	654	654	671	771	7,781
	Total	845	793	793	1,037	877	1,005	947	1,067	982	982	989	1,118	11,435
	% New	**33%**	**31%**	**31%**	**33%**	**33%**	**30%**	**29%**	**33%**	**33%**	**33%**	**32%**	**31%**	**32%**
NH Adult	New	442	475	475	437	424	422	365	445	384	384	313	403	4,969
	Known	681	657	657	709	759	725	694	751	748	748	665	650	8,444
	Total	1,123	1,132	1,132	1,146	1,183	1,147	1,059	1,196	1,132	1,132	978	1,053	13,413
	% New	**39%**	**42%**	**42%**	**38%**	**36%**	**37%**	**34%**	**37%**	**34%**	**34%**	**32%**	**38%**	**37%**
TH Adult	New	512	376	376	420	331	407	374	421	369	369	401	475	4,831
	Known	778	633	633	722	635	719	734	762	663	663	730	859	8,531
	Total	1,290	1,009	1,009	1,142	966	1,126	1,108	1,183	1,032	1,032	1,131	1,334	13,362
	% New	**40%**	**37%**	**37%**	**37%**	**34%**	**36%**	**34%**	**36%**	**36%**	**36%**	**35%**	**36%**	**36%**
TOTAL ADULT	New	1,237	1,100	1,100	1,202	1,043	1,130	1,009	1,214	1,081	1,081	1,032	1,225	13,454
	Known	2,021	1,834	1,834	2,123	1,983	2,148	2,105	2,232	2,065	2,065	2,066	2,280	24,756
	Total	3,258	2,934	2,934	3,325	3,026	3,278	3,114	3,446	3,146	3,146	3,098	3,505	38,210
	% New	**38.0%**	**37.5%**	**37.5%**	**36.2%**	**34.5%**	**34.5%**	**32.4%**	**35.2%**	**34.4%**	**34.4%**	**33.3%**	**35.0%**	**35.2%**
Older Adult	New	225	241	241	272	240	241	202	198	186	186	178	225	2,635
	Known	132	186	186	193	172	183	161	201	135	135	173	174	2,031
	Total	357	427	427	465	412	424	363	399	321	321	351	399	4,666
	% New	**63%**	**56%**	**56%**	**58%**	**58%**	**57%**	**56%**	**50%**	**58%**	**58%**	**51%**	**56%**	**56%**

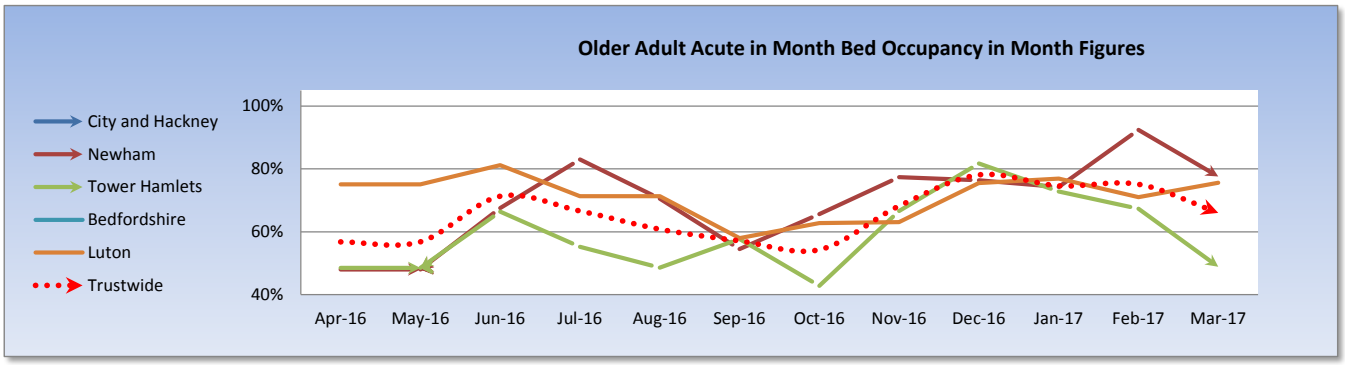
Definition:
An admission is deemed to be 'new' if in the past 24 months the patient has had no prior inpatient contact with the trust via an inpatient ward stay. This is a new definition (Provisional), currently udner discussion with clinicians. The prior definition included Community activity and has caused particular problems with Newham data due to proximity of contacts/referrals recorded in NH Occupational Therapy/NH Psychiatric liaison.
A referral is deemed to be 'new' if no prior referral exists within 24 months and including all teams.

Trust Board Main Scorecard, Graphs and Tables - 2016/17

As at: Mar-17

Demand, Capacity and Utilisation





Occupancy (excluding Leave) In Month figures 2013/2014 and 2014/2015 (Target 90%)

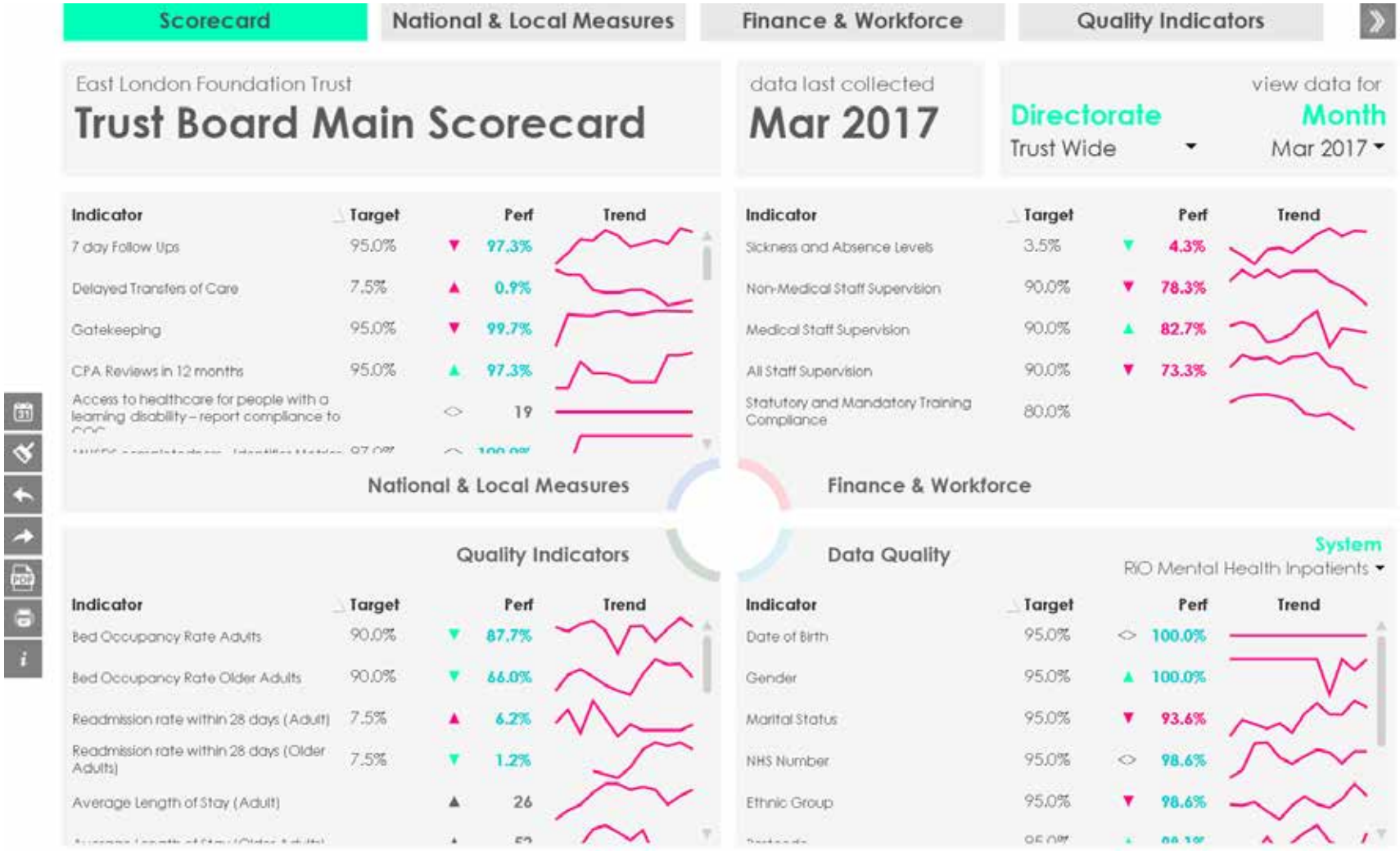
Occupancy		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16-17 YTD
Adult	City and Hackney	89.6%	89.5%	91.7%	94.6%	84.2%	87.8%	93.8%	90.1%	86.8%	90.0%	92.6%	92.4%	89.8%
	Newham	81.7%	79.5%	84.7%	82.9%	81.2%	71.6%	80.8%	79.5%	77.0%	77.1%	75.2%	83.1%	79.3%
	Tower Hamlets	76.5%	75.5%	73.1%	78.8%	79.4%	67.2%	78.0%	83.7%	78.9%	84.0%	89.3%	82.4%	78.2%
	Bedfordshire	97.4%	95.0%	93.7%	96.3%	95.8%	91.4%	92.8%	97.8%	96.2%	91.0%	95.5%	81.8%	93.5%
	Luton	98.7%	99.0%	102.7%	97.6%	100.0%	94.3%	97.3%	94.2%	87.9%	99.5%	104.6%	98.7%	96.1%
	Trustwide	**87.6%**	**86.6%**	**88.4%**	**89.2%**	**86.8%**	**81.2%**	**87.8%**	**87.9%**	**84.2%**	**87.3%**	**89.9%**	**87.7%**	**86.4%**
Older Adult (Functional)	City and Hackney	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Newham	48.0%	48.0%	67.5%	83.0%	70.5%	54.5%	65.6%	77.4%	76.4%	74.2%	92.4%	77.6%	70.2%
	Tower Hamlets	48.5%	48.5%	66.4%	55.2%	48.6%	57.7%	42.8%	66.6%	81.7%	72.8%	67.3%	48.9%	58.8%
	Bedfordshire	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Luton	75.1%	75.1%	81.2%	71.3%	71.3%	58.0%	62.8%	63.1%	75.5%	76.9%	71.0%	75.6%	72.4%
	Trustwide	**56.8%**	**56.8%**	**71.3%**	**66.6%**	**60.8%**	**57.1%**	**54.3%**	**68.2%**	**78.1%**	**74.6%**	**75.1%**	**66.0%**	**66.1%**

East London NHS Foundation Trust

East London NHS Foundation Trust
Executive Scorecard Indicator Report
March 2017

East London Foundation Trust

Executive Scorecard Overview



East London Foundation Trust

National and Local Measures

Scorecard | National & Local Measures | Finance & Workforce | Quality Indicators

East London Foundation Trust

Delayed Transfers of Care

data last collected
Mar 2017

viewing data for
Directorate
Trust Wide
Months
Apr 2015 - Mar 2017

Indicators

- 7 day Follow Ups
- Delayed Transfers of Care
- Gatekeeping
- CPA Reviews in 12 months
- Access to healthcare for people...
- MHSDS completedness - Identifi...
- MHSDS completedness - Priority...
- Reduction in Clostridium Difficile

Delayed Transfers of Care by Month

Indicator Detail

Scorecard Area
Monitor Targets

Direction of Travel

Feb 2017		Mar 2017
0.8%	▲ 0.1%	0.9%

Additional

Comments
In Development (TBC by ELFT)

Collected
In Quarter

East London Foundation Trust

Finance and Workforce Measures

Scorecard | National & Local Measures | Finance & Workforce | Quality Indicators

East London Foundation Trust

Sickness and Absence Levels

data last collected

Mar 2017

viewing data for

Directorate: Trust Wide

Months: Apr 2015 - Mar 2017

Indicators

- Sickness and Absence Levels
- Non-Medical Staff Supervision
- Medical Staff Supervision
- All Staff Supervision
- Statutory and Mandatory Trainin...
- Agency Spend
- Cash Balance
- Net Surplus

Sickness and Absence Levels by Month

Indicator Detail

Scorecard Area
Workforce Performance Measures

Direction of Travel

Feb 2017		Mar 2017
4.3%	▼ 0.0%	4.3%

Additional

Comments
In Development (TBC by ELFT)

Collected
Monthly

East London Foundation Trust

Quality Indicators

Scorecard | National & Local Measures | Finance & Workforce | Quality Indicators

East London Foundation Trust

Bed Occupancy Rate Older Adults

data last collected
Mar 2017

viewing data for
Directorate: Trust Wide
Months: Apr 2015 - Mar 2017

Indicators

- Bed Occupancy Rate Adults
- Bed Occupancy Rate Older Adults
- Readmission rate within 28 days...
- Readmission rate within 28 days...
- Average Length of Stay (Adult)
- Average Length of Stay (Older A...
- Assessment within 28 days Adult
- Assessment within 28 days (Olde...

Bed Occupancy Rate Older Adults by Month

Indicator Detail

Scorecard Area
Patient Experience - Inpatient

Direction of Travel

Feb 2017		Mar 2017
75.1%	▼ 9.1%	66.0%

Additional

Comments
In Development (TBC by ELFT)

Collected
Monthly

Data Quality

Data Quality | Clusters

East London Foundation Trust

Marital Status

data last collected
Mar 2017

viewing data for
DQ System
RiO Mental Health Inpatients
Months
Apr 2015 - Mar 2017

Indicators
- Date of Birth
- Gender
- Marital Status
- NHS Number
- Ethnic Group
- Postcode
- GP Practice
- Commissioner Code

Marital Status by Month

Indicator Detail

Scorecard Area
Information Governance/Data Quality (Trust Target 95%)

Direction of Travel

Feb 2017		Mar 2017
96.1%	▼ 2.5%	93.6%

Additional

Comments
In Development (TBC by ELFT)

Collected
Monthly

Clusters

Data Quality | Clusters

East London Foundation Trust
Missing Clusters

data last collected
Mar 2017

viewing data for
Directorate: Trust Wide
Months: Apr 2015 - Mar 2017

Indicators
- Missing Clusters
- Missing % Clusters
- Expired Clusters
- Expired Clusters %
- Unexpired Clusters Perc
- Total Clusters
- Missing & Expired

Missing Clusters by Month

Indicator Detail

Scorecard Area
Clusters

Direction of Travel

Feb 2017		Mar 2017
528	▲ 3	531

Additional

Comments
In Development (TBC by ELFT)

Collected
Monthly

East London NHS
NHS Foundation Trust

ELFT Board Assurance Framework (BAF) – 1st April 2017

Risk Rating Matrix (Consequence x Likelihood)

See Appendix 6 of the Risk Management Strategy for detailed guidance on scoring.

Risk Scores and RAG Rating	Likelihood				
Consequence	**1: Rare**	**2: Unlikely**	**3: Possible**	**4: 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

SUMMARY SHEET

OBJECTIVE 1: Improve Service User Satisfaction

Potential Principle Risk *The Trust may not improve service user satisfaction, if:*	**Initial score**	**Current Score**	**Risk Appetite Score**
1.1 It fails to improve the overall quality of care provision	16	8	8
1.2 It fails to achieve agreed optimum levels of adult acute MH bed occupancy	25	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	16	12
1.4 It fails to implement relevant NICE guidance	16	12	9
1.5 It fails to innovate in the pursuit of quality improvement	6	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	20	12	6
1.7 It fails to develop systems and processes to deliver safer and more effective physical health care to MH patients	16	8	12
1.8 It fails to provide high quality services from premises that are secure, minimise risk, and are well maintained	16	8	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	15	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	12	8

OBJECTIVE 2: Improve Staff Satisfaction

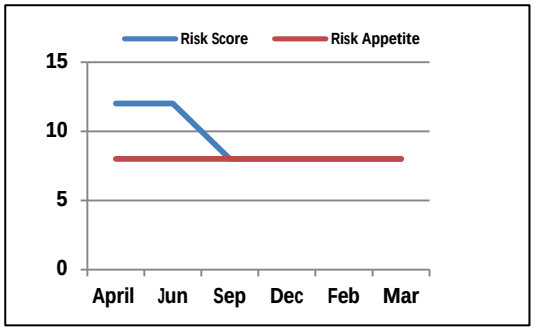
Potential Principle Risk *The Trust may not improve staff satisfaction, if:*	**Initial score**	**Current Score**	**Tolerance/Risk appetite Score**
2.1 It fails to recruit and retain high quality staff	16	12	8
2.2 It fails to ensure that workforce capability and capacity and ability to respond to change, including delivery of new strategies and models of care, is sufficient to continue to meet stated Trust objectives	16	12	6
2.3 It fails to put in place succession plans for the Trust Board and Senior Management roles	16	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	9	6	6
2.5 If it fails to provide, and engage staff with, modern and effective IT infrastructure, both physical and systems	15	12	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	12	8

OBJECTIVE 3: Maintain Financial Viability

Potential Principle Risk *The Trust may not maintain financial viability, if:*	**Initial score**	**Current Score**	**Tolerance/Risk appetite Score**
3.1 It fails to develop effective relationships with Commissioners and other stakeholders, and respond effectively to changes in the commissioning landscape, and recognise threats and opportunities they bring	20	12	8
3.2 It fails to plan properly for the introduction of new funding systems, potentially jeopardising income streams	16	12	8
3.3 If it fails to effectively balance the investment of energy and resources between potential new and existing business the Trust may find the quality of care it provides compromised and its reputation affected, impacting on its ability to retain existing business, attract new business, and deliver new contracts and projects	12	12	6
3.4 If the Trust fails to deliver the Year 2 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	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.	16	20	12
3.5 (b) The long term impact and potential lack of achievability of CRES requirements over the next 5 years, threatens the overall financial sustainability of the Trust and adversely impacts on the pursuit of quality improvement.	16	16	12
3.6 If services are not adequately incorporated into Sustainability and Transformation Plans (STPs), they risk becoming unsustainable over the next financial year.	12	12	8

RISK ANALYSIS

OBJECTIVE 1: Improve Service User Satisfaction - *The Trust may not improve service user satisfaction, if:*

<table>
<tr><td colspan="2">Risk: 1.1 - It fails to improve the overall quality of care provision</td><td>Executive Lead: Dr Kevin Cleary, Chief Medical Officer</td></tr>
<tr><td colspan="2">Source: Annual plan/Board development day – April 2014</td><td>Lead Committee: Quality Assurance Committee</td></tr>
<tr><td colspan="3">Change since last review: None.</td></tr>
<tr><td>
<table>
<tr><th>Risk rating</th><th>Consequence</th><th>Likelihood</th><th>Score</th></tr>
<tr><td>Initial</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Current</td><td>4</td><td>2</td><td>8</td></tr>
<tr><td>Appetite</td><td>4</td><td>2</td><td>8</td></tr>
</table>
</td><td> 
</td><td>Rationale for current risk scoring:
§ The Trust is performing well against national and local targets
§ The Trust has the 3rd best score in the country in the national community patient survey
§ The Trust has acquired services in Luton & Bedfordshire, and significant work is being done to improve the overall quality of service provision. The service is currently meeting all national targets.

Rationale for the level of risk appetite:
§ The Trust's vision is to provide the highest quality care in the country, and so has relatively low risk tolerance has been set</td></tr>
<tr><td colspan="2">Controls and Mitigating Actions (what are we currently doing about the risk?):
§ The Chief Medical Officer is executive lead for quality
§ Real time patient and staff feedback systems
§ Implementation of the Trust Quality Improvement Strategy and supporting strategies
§ Establishment of an integrated Quality Improvement and Quality Assurance Committee and reporting structure
§ Quality Improvement team in place
§ Participation in national audits and benchmarking exercises
§ Revised Quality Strategy approved by the Trust Board (April 2016)
§ QI work plan in place and monitored by the QI project Board (April 2016)
§ Improved patient feedback system to be implemented (April 2016 - largely completed)</td><td>Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):
§ Trust Quality Dashboard
§ Quality and safety report to SDB and Trust Board
§ Exception reporting to Assurance Committee
§ Quality Accounts report
§ Team Quality Improvement Plans
§ National audit results/benchmarking
§ CQC inspection report (August 2016)</td></tr>
<tr><td colspan="2">Gaps in controls/assurance (what additional controls are required or assurances should we seek?):
§ Consistent and timely feedback/action from patient feedback systems</td><td>Further actions required:
§ Implementation of CQC Compliance work plan (ongoing)</td></tr>
</table>

Risk: 1.2 - It fails to achieve agreed optimum levels of adult acute MH bed occupancy

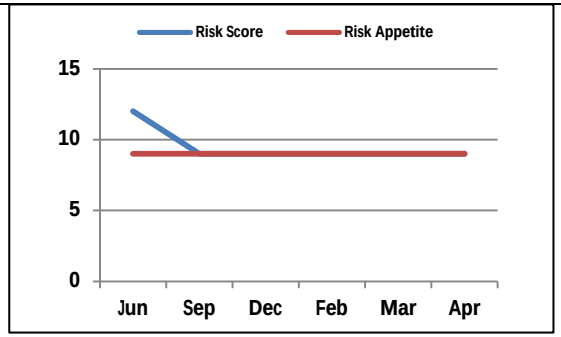
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Annual Plan, Directorate Risk Registers, Serious Incident Reviews

Lead Committee: Quality Assurance Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	5	5	**25**
Current	3	3	**9**
Appetite	3	3	**9**



Rationale for current risk scoring:

- The Trust's bed occupancy has been well managed for an extended period
- The Trust is able to sell spare bed capacity to other trusts in order to generate income
- Bed occupancy in Luton & Bedfordshire has been in excess of 100%, but is now less than 100%

Rationale for the level of risk appetite:

- In the context of increasing demand on services and the need for savings, there is a reasonable likelihood of experiencing difficulties in this area

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Adult service steering group addressing issues across the care pathway
- Monitoring of bed occupancy through DMTS/SDB and Trust Board
- Bed Management policy/systems in place
- Regular reporting to Commissioners
- Newham triage ward opened – evaluated and future plans to be confirmed
- Improved female PICU capacity in place
- Luton & Bedfordshire inpatient project boards in place, and additional capacity available
- Recurrent finding for Newham triage ward secured (April 2016)
- Luton & Bedfordshire inpatient project boards to continue, and review of community services and crisis pathway in order to ensure that admissions are avoided where possible (July 2016)

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Exception reporting to SDB and Trust Board
- (Absence of) Complaints/ Claims and SUIs
- Ongoing stability in bed availability/90% occupancy levels in each adult acute ward in East London
- CQC inspection report (August 2016)

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Bedfordshire & Luton occupancy levels current above Trust target of 85% (96%)

Further actions required:

- Continued monitoring of the bed occupancy implementation plan by the SDB

Risk: 1.3 - It fails to transform district nursing services in order to meet the needs of the local health services and wider community

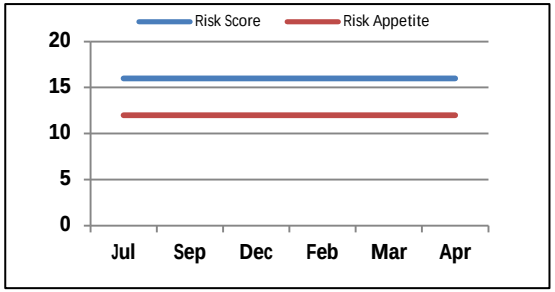
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Annual plan, Directorate Risk Register, Serious Incident Reviews

Lead Committee: Quality Assurance Committee

Change since last review: None

Risk rating	Consequence	Likelihood	Score
Initial	4	4	**16**
Current	4	4	**16**
Appetite	4	3	**12**



Rationale for current risk scoring:

- There is continued high use of agency staff to cover vacancies in the service, as recruitment is still proving to be difficult
- There is not yet evidence of sustained service improvement

Rationale for the level of risk appetite:

- There are national issues with district nursing services (i.e. recruitment) and therefore a reasonable likelihood that problems will persist

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Plan to recruit 15 agency community nurses (20 CV's received) and 10 staff with MH experience (training underway)
- Second Tissue Viability nurse from Columbia ward seconded for 6 months
- Second senior admin manager seconded for 6 months
- Additional support in place to investigate complaints/incidents in a timely fashion
- Project board to oversee and support implementation of change
- Routine allocation of patients with pressure ulcers (grade 2 upwards) to named nurse
- Review of capacity of continuing care team to carry out DSTs
- 2016/17 Contract discussions completed with commissioners. New contract specification agreed
- Visit to Holland to see the Buurtzorg model in action and acquired funding for a pilot team in Tower Hamlets, with a view to also piloting the model in Newham.

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Reports to Quality Assurance Committee
- 17 agency nurses appointed on medium term contracts covering vacancies.
- Reduction in Serious Incidents
- Reduction in complaints and claims
- Improved PROMs and PREMs scores for EPCT patients
- Improved team functioning and staff morale
- Recruitment of permanent staff improving

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Trajectory in pace to recruit to substantive posts however experiencing some difficulties in recruiting to senior posts.

Further actions required:

- Director of Nursing is overseeing the implementation of an action plan and will report on progress to Quality Assurance Committee as a standing agenda item (ongoing)

Risk: 1.4 - It fails to implement relevant NICE guidance

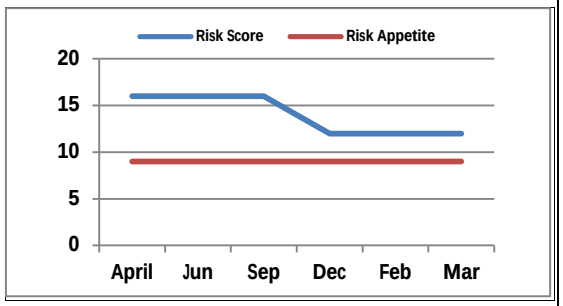
Executive Lead: Dr Kevin Cleary, Chief Medical Officer

Source: Quality Assurance Committee – October 2015

Lead Committee: Quality Assurance Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	3	12
Appetite	3	3	9



Rationale for current risk scoring:

- The Trust is not fully compliant with relevant NICE guidance

Rationale for the level of risk appetite:

- The Trust wishes to provide the highest quality evidence based care and must provide services that are compliant with relevant NICE guidance
- Provision of the highest quality of services for patients is central to the Trust's strategic objectives

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Associate Medical Director for Adult Services is the Trust lead
- Proposal for monitoring compliance with NICE guidance approved by the Service Delivery Board
- Work on the psychosis project is completed and we are awaiting a decision from the CCGs regarding the gap in the funding of systemic family therapists. Currently working on Depression guidance

Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Plans setting out how the Trust will address gaps in NICE compliance have been agreed
- DMTs are reporting results to any gap analysis that cannot be addressed locally to the Quality Assurance Committee
- Psychosis Project Board is addressing gaps and making recommendations about service design
- Amber green on recent Internal Audit report: 2017

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Action plans setting out how the Trust will address gaps in NICE compliance will be developed, but will require further time – anticipated by end of 2016
- Audits testing compliance with NICE guidance to be carried out and reported to the Quality Committee
- Programme of implementation needs more time in specialist and non-adult settings – anticipated by end of 2016

Further actions required:

- Implementation of DMT and Trust wide action plans to continue following gap analysis – ongoing, various timescales
- Further project boards and groups to be set up - as required
- Review of audit results (when completed)
- Further action planning and implementation to be completed

Risk: 1.5 - It fails to innovate in the pursuit of quality improvement

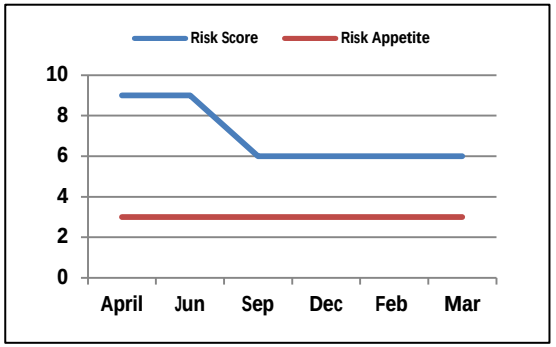
Executive Lead: Dr Kevin Cleary, Chief Medical Officer

Source: Trust Board - April 2014

Lead Committee: Quality Assurance Committee

Change since last review: No change to the risk score but two additional gaps in controls/assurance identified.

Risk rating	Consequence	Likelihood	Score
Initial	3	2	**6**
Current	3	2	**6**
Appetite	3	1	**3**



Rationale for current risk scoring:

- There is increasing evidence that individual QI programmes are delivering improved quality, and a number of programmes are now being scaled up and spread across the Trust
- The Trust has a very high score in terms of staff being engaged in making improvements at work
- A QI programme has just commenced in Luton & Bedfordshire

Rationale for the level of risk appetite:

- The Trust Board has set quality improvement at the core of its integrated business strategy, and the Trust wishes to be an internationally recognised leader in the field. As such, a very low risk tolerance has been set.

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Quality Improvement (QI) Strategy in place
- Associate Medical Director for QI in post, supported by QI team
- Associate Medical Director for research and innovation in post
- QI training delivery
- Strategic partnership with IHI
- Revised Quality Strategy approved by the Trust Board (April 2016)
- QI work plan in place and monitored by the QI project Board (April 2016)

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- QI strategy implementation reports to SDB and Trust Board
- Reputation and external recognition of the Trust for improvement and innovation
- Implementation of improvement projects
- Patient feedback
- Staff feedback
- IHI and internal evaluation of progress
- CQC inspection report (August 2016)

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Programme not yet fully established in Luton & Bedfordshire
- TH lack of robust system to oversee improvement work
- Lack of fit for purpose information system to support improvement

Further actions required:

- Implementation of the QI programme in Luton & Bedfordshire (commencing and ongoing)

Risk: 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.

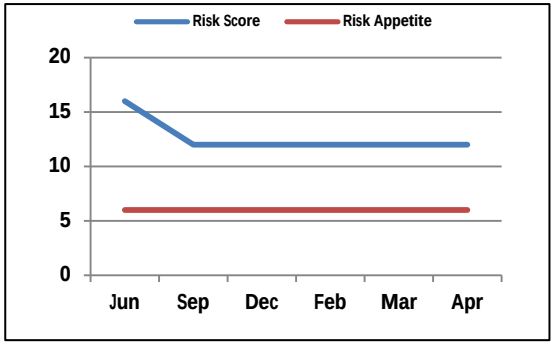
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Mental Health Act Commissioner visit, and CQC regulatory inspection reports

Lead Committee: Quality Assurance Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	5	4	**20**
Current	4	3	**12**
Appetite	3	2	**6**



Rationale for current risk scoring:

- The Trust has established structures and systems in place for ensuring compliance with CQC standards
- The Trust has been fully compliant with CQC standards (as a result of inspections) since 2011
- The Trust acquired services in Luton & Bedfordshire in April 2015, which have had CQC compliance issues in the past
- The CQC inspection report provided an "outstanding" rating, but also identifies a number of areas for further improvement

Rationale for the level of risk appetite:

- CQC standards are fundamental, minimum standards that must be met at all times
- The Trust faces severe penalties if it is non-compliant with standards
- As such, a low threshold for risk has been set

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Renewed Trust Governance Structure in place, geared towards ensuring CQC compliance
- Local Governance arrangements in place
- Horizon scanning and regular reporting the Quality, and Quality Assurance Committees
- Programme of internal inspections based on CQC standards and methodology
- Mental Health Act audit programme
- Review of directorate and Trust-wide action plans by an external assessor (May 2016)
- Completion of estates action plan (May 2016)
- CQC actions being monitored via performance meetings with the Directorates/departments and regular updates sent to the CQC

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- CQC risk rating of the Trust in their Intelligent Monitoring document
- CQC inspection outcomes – no areas of non-compliance currently identified
- Positive staff engagement feedback
- Service user feedback, including friends and family test
- Achievement of key performance and workforce metrics relevant to CQC standards
- CQC inspection report (August 2016)

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Assurance regarding the four areas rated as requiring improvement by the CQC inspection
- Assurance regarding the Trust's compliance with the Duty of Candour

Further actions required:

- Continue with the CQC project board and monitor the implementation of the action plan in response to the CQC report (ongoing)

Risk: 1.7 - It fails to develop systems and processes to deliver safer and more effective physical health care to MH patients

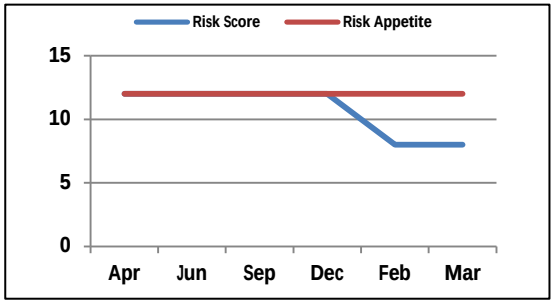
Executive Lead: Dr Kevin Cleary, Chief Medical Officer

Source: Serious Incident Reviews, City & Hackney Directorate Risk Register, Council of Governors feedback

Lead Committee: Quality Assurance Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	4	**16**
Current	4	2	**8**
Appetite	4	3	**12**



Rationale for current risk scoring:

- § Physical health problems can have a major impact on patients and service delivery
- § The recent review of the physical health strategy showed that there are a number of improvements that should be made to practice in the Trust

Rationale for the level of risk appetite:

- § There are inherent risks in service delivery, but these should be mitigated in order to reduce both the consequence and likelihood of risks occurring

Controls and Mitigating Actions (what are we currently doing about the risk?):

- § Lead Director for physical health
- § Lead Nurse in post for control of infection and physical health.
- § GP service in place across the Trust
- § Physical Health Strategy & Policy
- § Quality Committee oversight
- § Physical health care training programme.
- § Audit of Physical Healthcare Assessments
- § National CQUIN standard in place
- § QI projects in place
- § Physical health care simulation exercises
- § Integrated care programmes focusing on prevention and improved care for patients with mental and physical health problems

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- § Quarterly reports to Quality Committee
- § EPCT Project Board reports to Quality Assurance Committee
- § Incident reporting and reduction in serious incidents
- § Physical health care training compliance
- § Number of pressure ulcers have decreased
- § Introduction of physical health monitoring equipment including Pods, to community mental health teams
- § Compliance with CQUIN standards for physical health

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- § Need to further reduce occurrence of pressure ulcers
- § Improvement of resuscitation training and practice across the Trust

Further actions required:

- § Implementation of pressure ulcer improvement plan (ongoing – delivered through QI project)
- § Implementation of a resuscitation action plan, including improved training compliance (ongoing)
- § Implementation of revised Physical Health Strategy. Annual report to provide a quantifiable analysis of progress (April 2017)

Risk: 1.8 - It fails to provide high quality services from premises that are secure, minimise risk, and are well-maintained

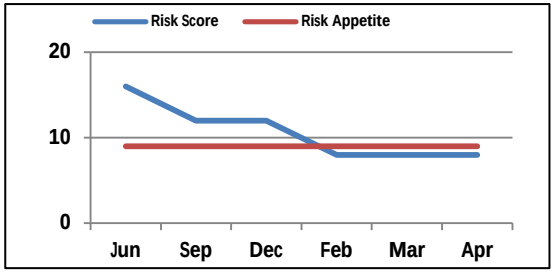
Executive Lead: Steven Course, Director of Finance

Source: Serious Incident Reviews, Directorate Risk Register, Board walkabout feedback - June 2015

Lead Committee: Quality Assurance Committee

Change since last review: Further action added: '' Review of estate transferring in from Barts for THCS (Q2 2017)''

Risk rating	Consequence	Likelihood	Score
Initial	4	4	**16**
Current	4	2	**8**
Tolerance	3	3	**9**



Rationale for current risk scoring:

- The general standard of premises has been highlighted as a concern in directorate risk registers, as well as Board walkabouts
- The latest Estates Strategy (December 2015) shows that the Trust performs very well in relation to other Trusts in relation to PLACE scores and other indicators
- The CQC inspection report provides external assurance regarding the quality of the Trust's estate

Rationale for the level of risk appetite:

- There is a low threshold for risks to patient safety arising from the estate

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Estates Strategy in place, and funded Capital Plan
- QI project in place
- Capital Projects Steering Group in place
- Assessment of compliance with CQC standards, and remedial action taken
- Monitoring officers reporting monthly on quality of the estate
- Outstanding jobs on the Estates Help Desk are followed-up monthly
- Improved fire procedures at the Homerton Hospital
- Regular reporting of estates issues, including completion of works orders

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Regular reports to FBIC that set out progress of major projects
- Incident reporting and reduction in serious incidents
- CQC inspection report (August 2016)

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Ensuring consistency of standards across all trust sites

Further actions required:

- Review of estate transferring in from Barts for THCS (Q2 2017)

Risk: 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

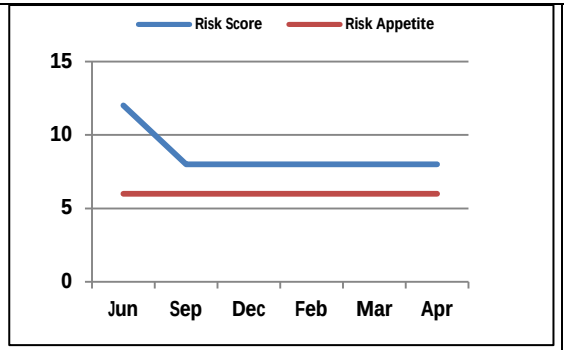
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Annual Plan – April 2014

Lead Committee: Quality Assurance Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	3	5	15
Current	2	4	8
Appetite	3	2	6



Rationale for current risk scoring:

- The Trust is currently performing well against quality standards and targets, but due to the year-on-year impact of CRES savings then this position could be susceptible to adverse change
- The Trust is required to plan for further years of CRES savings

Rationale for the level of risk appetite:

- Given the ongoing need to deliver CRES savings, then the Trust needs to ensure that it has the ability to quickly recognise and respond to the potential adverse impact

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Integrated Business Strategy and Annual Plan in place
- Annual Budget setting cycle
- Quality impact assessment (QIA) of CRES plans twice yearly
- (Virtual) QIA group formed
- 2016/17 quality impact assessments to be submitted to the June 2016 QAC

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Trust performance in relation to Monitor, CQC, Commissioner and internal targets and KPIs
- Quality Dashboard
- Commissioner review of QIAs
- Patient and staff feedback

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- 2016/17 CRES quality impact assessments have not yet been submitted to the QAC
- Further assurance required in relation to equalities impact and long-term impact on services

Further actions required:

- Review of quality impact process in order to identify equalities and long-term impact (May 2017)
- 5 year strategic and financial plan refreshed – ongoing reporting on implementation to Trust Board

Risk: 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

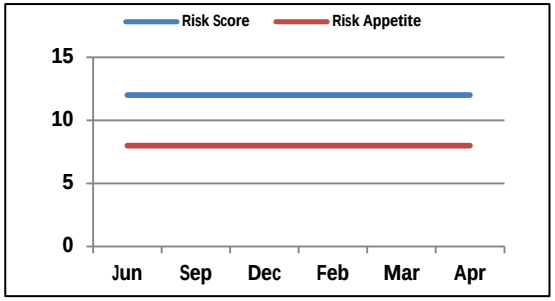
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Board development event

Lead Committee: Trust Board

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	3	**12**
Current	4	3	**12**
Appetite	4	2	**8**



Rationale for current risk scoring:

- The Trust is currently providing high quality services from a sustainable provider base
- Significant changes to the commissioning, payment and operation of services, particularly through new organisational forms, may place this at risk
- The Trust is well engaged in strategic forums in order to manage this risk

Rationale for the level of risk appetite:

- The development of the Trust's 5 year strategy should reduce the likelihood of this risk occurring

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Partnership arrangements in place
- Representation in all relevant strategic forums
- Trust 5 year strategy and operational plan in place
- Initial analysis completed of recent national publications (mental health 5 year forward view, STP etc.)
-

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Ongoing good performance of Trust services

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Further analysis of recent national publications
- Further analysis of potential outcomes of STPs, vanguards and devolution pilots relevant to the Trust

Further actions required:

- Revised Trust 5 year strategy to be approved by the Board (November 2017)
- Ongoing analysis of risk/opportunity in relation to national publications and potential outcomes of STPs, vanguards and devolution pilots relevant to the Trust

OBJECTIVE 2: Improve Staff Satisfaction

Risk: 2.1 - It fails to recruit and retain high quality staff

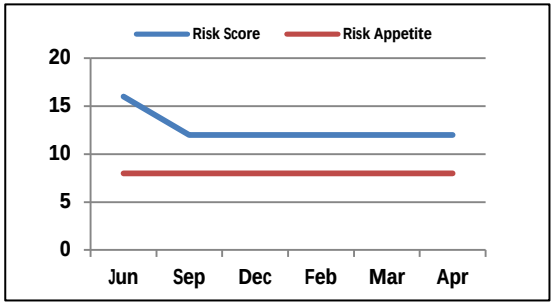
Executive Lead: Mason Fitzgerald, Director of Corporate Affairs

Source: Board development event

Lead Committee: Appointments & Remuneration Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	3	12
Appetite	4	2	8



Rationale for current risk scoring:

- The Trust is in a highly competitive recruitment environment in London, but the overall vacancy rate is low compared to peers
- There have been historical recruitment problems in Luton & Bedfordshire
- Having sufficient numbers of high quality permanent staff is critical to providing high quality care
- CQC inspection report provided positive assurance about vacancy levels, the recruitment process and the quality of Trust staff

Rationale for level of risk appetite:

- Having high quality permanent staff in post is increasingly recognised as being crucial to the delivery of high quality care

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Recruitment Project in place
- Consultant recruitment programme
- Relationships with training institutions
- QI project in place to reduce time to hire
- Regular reporting to HR performance meeting, DMTs, Workforce Committee, SDB and Trust Board
- Establishment of Institute of Nursing in Bedfordshire (March 2016)
- Work is being commissioned across the STP looking at recruitment and retention

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Trust vacancy rate currently 8%, with significant progress made in Luton & Bedfordshire
- Reduction in time to hire
- Training and appraisal compliance improving
- Positive staff engagement and patient feedback scores
- CQC inspection report (August 2016
- Implementation of action plans in response to internal audit report (March 2017)

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Limited assurance from internal audit report on recruitment controls
- High vacancy levels and turnover in some services and staff groups

Further actions required:

- Formal Recruitment and Retention project established and proposing solutions to vacancy and retention issues (ongoing)
- Risks to be reviewed in light of the acquisition of Tower Hamlets Community Health Services

Risk: 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

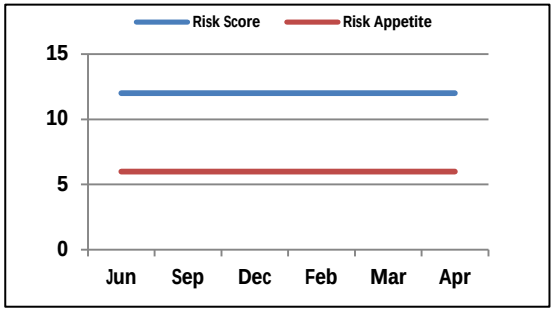
Executive Lead: Mason Fitzgerald, Director of Corporate Affairs

Source: Annual Plan

Lead Committee: Appointments & Remuneration Committee

Change since last review: None

Risk rating	Consequence	Likelihood	Score
Initial	4	4	**16**
Current	4	3	**12**
Appetite	3	2	**6**



Rationale for current risk scoring:

- The Trust has experienced four years of large scale organisational change
- Due to future CRES requirements, the need for organisational change will continue, and will likely involve wider service configuration
- Staff morale and engagement is adversely affected through periods of organisational change, which has a knock-on effect on the quality of care provided
- The Trust has, however, managed to develop services and improve staff engagement during this time

Rationale for the level of risk appetite:

- Due to the ongoing need for large scale organisational change then the Trust must further improve its workforce planning in order to meet the demands

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Policy for Management of Change
- Organisational Development Programme
- Talent Management and Succession Planning policies in place
- Workforce Committee oversight
- Executive walk-arounds and listening exercises
- Financial / Service change implemented according to individual plans

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Successful implementation of change
- Number of grievances relating to change & feedback from staff side re change process
- Sustained performance and stability of service provision
- Successful implementation of service developments
- Review of QIA is in progress, as is development of the workforce strategy, which is dependent on the Trust's vision, which is currently being reviewed.

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Workforce capabilities to deliver new strategies/models of care in relation to the 5 Year Froward view, STPs and specific transformation initiatives
- Measurement of long-term impact of change on staff

Further actions required:

- Revised workforce strategy to be developed (June 2017)
- Review of quality impact process in order to identify equalities and long-term impact (May 2017)

Risk: 2.3 - It fails to put in place succession plans for the Trust Board and Senior Management roles

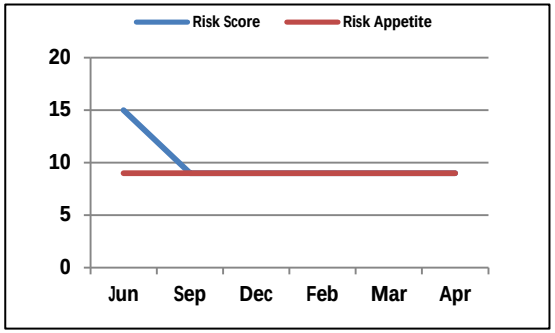
Executive Lead: Mason Fitzgerald, Director of Corporate Affairs

Source: Board Development event

Lead Committee: Appointments & Remuneration Committee

Change since last review: None

Risk rating	Consequence	Likelihood	Score
Initial	4	4	**16**
Current	3	3	**9**
Appetite	3	3	**9**



Rationale for current risk scoring:

- The stability of senior leadership in the Trust has been a feature of our success
- Changes at Trust Board have and will be made due to retirements and succession planning
- Changes at directorate level are being made due to the Luton & Bedfordshire transaction, as well as other service changes
- New CEO appointed and commenced in post 1 August. One executive and one non-executive director appointed.

Rationale for the level of risk appetite:

- There are inherent risks in relation to succession planning given the market in which the Trust operates, the workforce profile, and competition

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Appointments and Remuneration Committee
- Council of Governors Nomination Committee
- Board skills audit
- Formal succession planning process in place

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Successful recruitment and induction of new executive and non-executive directors
- Sustained performance of the Trust and individual clinical directorates
- Paper on succession planning presented to the March Appointments and Remuneration Committee

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- No formal succession planning process in place
- No formal monitoring of succession planning outcomes

Further actions required:

- Develop a formal succession plan (October 2017)

Risk: 2.4 - If it fails to maintain improvement in measures of staff engagement in the context of continued financial constraints and CRES plans

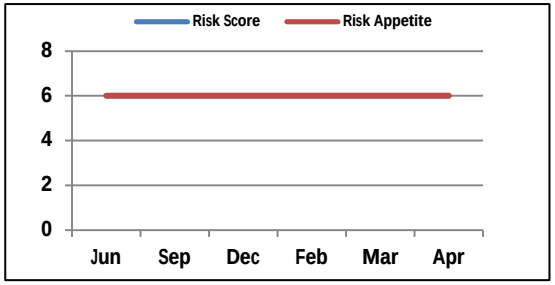
Executive Lead: Mason Fitzgerald, Director of Corporate Affairs

Source: Board development event. Staff survey

Lead Committee: Appointments & Remuneration Committee

Change since last review: Inclusion of 2016 staff survey results

Risk rating	Consequence	Likelihood	Score
Initial	3	3	**9**
Current	3	2	**6**
Appetite	3	2	**6**



Rationale for current risk scoring:

- § The Trust recognises the importance of staff engagement and the link to patient experience
- § The Trust is currently ranked 4th= in the country for staff engagement scores, and has made significant improvements over the last two years
- § Staff engagement levels have been historically lower in Luton & Bedfordshire
- § CQC inspection report provides positive assurance regarding staff morale and engagement
- § 2016 staff survey results shows that improvements have been sustained

Rationale for the level of risk appetite:

- § The Trust recognises the link between staff and engagement and patient experience, and therefore places huge importance in the need to sustain performance in this area

Controls and Mitigating Actions (what are we currently doing about the risk?):

- § Staff engagement strategy in place
- § Quarterly internal staff survey
- § Annual national staff survey
- § QI programme
- § Trust wide, directorate and professional group action plans in place

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- § Strong and improving staff engagement survey scores
- § Sustained high performance in the staff survey over the last three years
- § CQC inspection report (August 2016)
- § 2016 staff survey results shows that improvements have been sustained

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- § Staff experience measures specific to change programmes

Further actions required:

- § Implementation of staff survey action plans (July 2017)

Risk: 2.5 - If it fails to provide, and engage staff with, modern and effective IT infrastructure, both physical and systems.

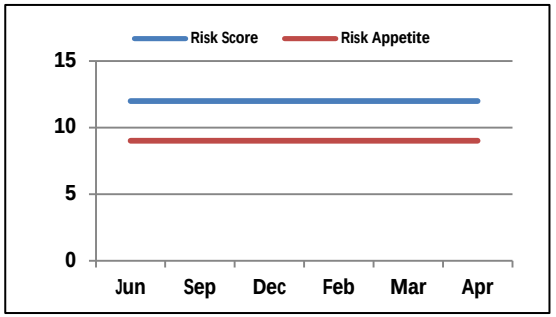
Executive Lead: Steven Course, Director of Finance

Source: Directorate risk registers, Staff feedback

Lead Committee: Audit Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	3	5	15
Current	3	4	12
Appetite	3	3	9



Rationale for current risk scoring:

- The Trust has successfully transferred to open Rio
- There are ongoing programmes to upgrade IT equipment and roll out mobile working solutions

Rationale for the level of risk appetite:

- There are complex issues regarding inter-operability of clinical systems
- There is significant work required to get Luton & Bedfordshire in line with the rest of the Trust

Controls and Mitigating Actions (what are we currently doing about the risk?):

- IT Strategy
- Electronic Clinical Records Programme
- RiO 2015 Project Board
- Associate Medical Director for Clinical Information in post
- Roll out of open Rio in Luton & Bedfordshire
- IT Strategy includes delivery of interoperability, related to improved staff experience

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Board reports on strategy implementation
- Performance reporting
- Mobile working - implementation rolled out to many services - process ongoing

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Inter-operability not currently delivered across all services
- Variable reports from staff about quality of IT hardware and systems

Further actions required:

- Continued implementation of RIO 2015

Risk: 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

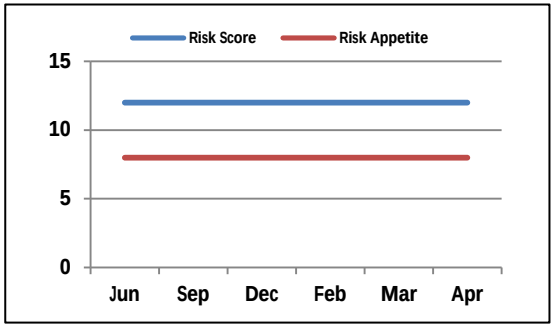
Executive Lead: Mason Fitzgerald, Director of Corporate Affairs

Source: Board development event

Lead Committee: Appointments & Remuneration Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	3	**12**
Current	4	3	**12**
Appetite	4	2	**8**



Rationale for current risk scoring:

- § Overall staff engagement scores for all staff groups are high compared to national averages
- § The Trust has a very diverse workforce and compares well against similar Trusts in equalities analysis
- § There are, however, a number of areas of concerns for certain staff groups in relation to fair treatment, career progression and discrimination
- § Positive feedback on plans from CQC inspection report (August 2016)

Rationale for the level of risk appetite:

- § The Trust wants all staff to have a positive experience of working in the organisation, and wishes to be an exemplar in relation to equalities and diversity in order to improve the quality of care provided to our local communities

Controls and Mitigating Actions (what are we currently doing about the risk?):

- § Equality & Diversity Strategy
- § Equality & Diversity steering group
- § Staff networks led by Executive Directors
- § Workforce Race Equality Standards (WRES) action plan in place
- § Reporting to Workforce Committee, Remuneration Committee and Trust Board
- § WRES action plan refreshed and approved by the Trust Board (September 2016)
- § Board session on equalities to review current strategies and action plans (November 2016)

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- § Positive staff survey scores for individual staff groups
- § Reduction in levels of violence & aggression, harassment and discrimination experienced by BME staff
- § Favourable results for BME staff in a number of areas
- § CQC inspection report (August 2016)
- § Recent staff survey results for different equalities groups analysed and feeding into action plans

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- § Evidence of action and progress against all areas of concern
- § Variable outcomes from staff networks

Further actions required:

- § Refreshed inclusion action plan to be developed following Board development session (May 2017)

OBJECTIVE 3: Maintain Financial Viability

<table>
<tr><td colspan="2">Risk: 3.1 - It fails to develop effective relationships with Commissioners and other stakeholders, and respond effectively to changes in the commissioning landscape, and recognise threats and opportunities they bring</td><td>Executive Lead: Navina Evans, Chief Executive</td></tr>
<tr><td colspan="2">Source: Board development event</td><td>Lead Committee: Trust Board</td></tr>
<tr><td colspan="3">Change since last review: None.</td></tr>
<tr><td>
<table>
<tr><th>Risk rating</th><th>Consequence</th><th>Likelihood</th><th>Score</th></tr>
<tr><td>Initial</td><td>5</td><td>4</td><td>20</td></tr>
<tr><td>Current</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td>Appetite</td><td>4</td><td>2</td><td>8</td></tr>
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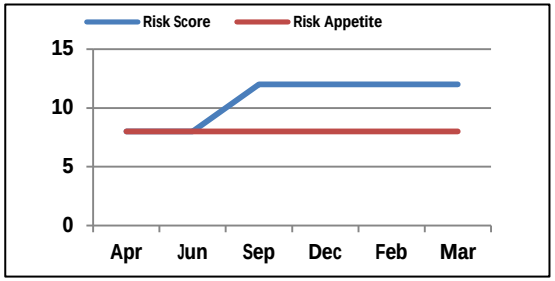
</td><td> 
</td><td>Rationale for current risk scoring:
§ The Trust is active in integrated care and other transformation programmes in the local health economy
§ The Trust has attracted new business, most notably the integration of services in Luton & Bedfordshire
§ The Trust has lost substances misuse contracts in Newham and Hackney
§ Commissioners' intention to tender community children's and adult services

Rationale for the level of risk appetite:
§ As the commissioning landscape is complex and changing, the Trust must continue to develop effective relationships with commissioners and other stakeholders in order to reduce risks to sustainability of the Trust</td></tr>
<tr><td colspan="2">Controls and Mitigating Actions (what are we currently doing about the risk?):
§ Business Development Unit in place
§ Business Strategy approved by the Trust Board
§ Specialist commercial expertise recruited to the Trust
§ Formal horizon scanning and business development reporting</td><td>Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):
§ Acquisition of new business
§ Reporting to the Trust Board
§ Strategy implementation reporting</td></tr>
<tr><td colspan="2">Gaps in controls/assurance (what additional controls are required or assurances should we seek?):
§ Uncertainty due to changes to the partnership working arrangements in Newham mental health services
§ Formal tendering to take place in Newham for aspects of community services</td><td>Further actions required:
§ Strengthen partnership arrangements in Newham through integrated care and other forums (ongoing)
§ Ongoing implementation of Business Strategy</td></tr>
</table>

Risk: 3.2 - It fails to plan properly for the introduction of new funding systems, potentially jeopardising income streams

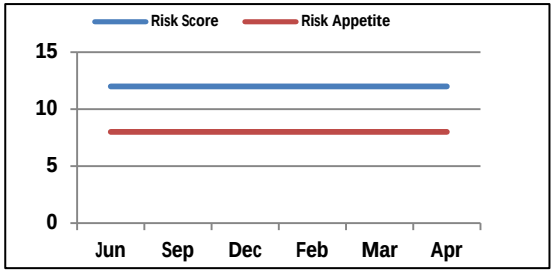
Executive Lead: Steven Course, Director of Finance

Source: Annual Plan

Lead Committee: Finance, Business and Investment Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	3	12
Appetite	4	2	8



Rationale for current risk scoring:

- The Trust is well-positioned in preparations for payment by results, but the commissioning intention to implement it is not clear. Recent guidance published by Monitor suggests a move to a capitated budget or outcomes approach
- New IAPT payment models to be introduced in 2017/18

Rationale for the level of risk appetite:

- Risk to the Trust's income streams places the viability of the Trust at risk

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Joint Tariff Implementation Board (Co-chaired with CCGs)
- Trust involvement in London-wide PBR group
- Agreement with commissioners on payment systems as part of 2017/18 contracting round (December 2016)

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Reports to Trust Board and Financial, Business and Investment Committee (FBIC)
- Analysis of long-term risks and benefits to the trust

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Uncertainty in approach for 2016/17 and beyond
- Uncertainty of risks and benefits of moving to an outcomes based, capitated payment system

Further actions required:

- Analysis of the impact of the IAPT PbR approach

Risk: 3.3 - If it fails to effectively balance the investment of energy and resources between potential new and existing business the Trust may find the quality of care it provides compromised and its reputation affected, impacting on its ability to retain existing business, attract new business, and deliver new contracts and projects

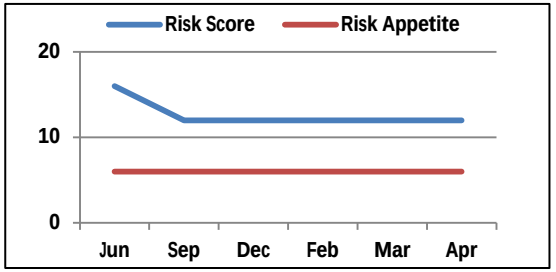
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Quality Assurance Committee, Luton and Bedfordshire transaction risk register

Lead Committee: Trust Board

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	3	**12**
Current	4	3	**12**
Appetite	2	3	**6**



Rationale for current risk scoring:

- The Trust has successfully managed the mobilisation of services in Luton & Bedfordshire whilst maintaining performance across the rest of the Trust
- The Trust is involved in a number of major projects (Luton & Bedfordshire, THIPP, Hackney devolution, STPs)

Rationale for the level of risk appetite:

- The continued need for the Trust to bid for services in a competitive market poses a reasonable likelihood of further risks in this area, and the consequence of these risks emerging must therefore be effectively mitigated

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Luton and Bedfordshire Project Board in place
- Enhanced Directorate structure to be put in place for the management of Luton and Bedfordshire Services
- Quality dashboard
- BDU team and support structures
- Established governance and quality improvement structures
- Revised executive and senior leadership structure

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Quality and safety reports to the Trust Board
- Staff and patient feedback
- CQC report indicates that the Luton and Bedfordshire implementation plan has been well executed and the large-scale secondment of east London staff to these directorates' services has not had a negative impact upon the east London services.

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- No up to date formal assessment of capacity required to deliver 2016/17 projects

Further actions required:

- Implementation of mitigation and mobilisation plans (ongoing)
- Monitoring of key quality metrics across Trust services (ongoing)

Risk: 3.4 - If the Trust fails to deliver the Year 2 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.

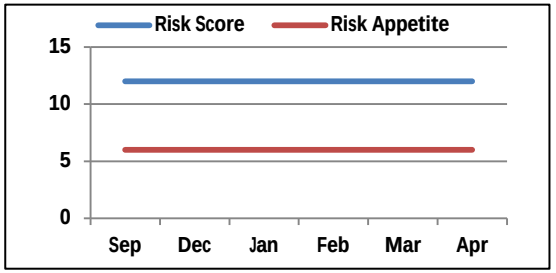
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Trust Board

Lead Committee: Quality Assurance Committee

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	3	**12**
Current	4	3	**12**
Appetite	3	2	**6**



Rationale for current risk scoring:

- The Trust has successfully managed the mobilisation of services in Luton & Bedfordshire whilst maintaining performance across the rest of the Trust
- Significant work remains to deliver the year 2 plan

Rationale for the level of risk appetite:

- The integration is a major undertaking for the Trust and its success will impact on the Trust's reputation

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Project Board meets monthly
- Ongoing Corporate and Directorate governance arrangements
- Executive walkarounds
- Implementation of the Year 1 plan (April 2016)
- Formal evaluation of the transaction (April 2016)

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Regular transaction reports to the Trust Board
- Ongoing performance and quality monitoring
- Quality and Safety report to the Trust Board
- Improved staff survey scores and good stakeholder feedback

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

Further actions required:

- Implementation of the Year 2 plan (April 2017)

Risk: 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.

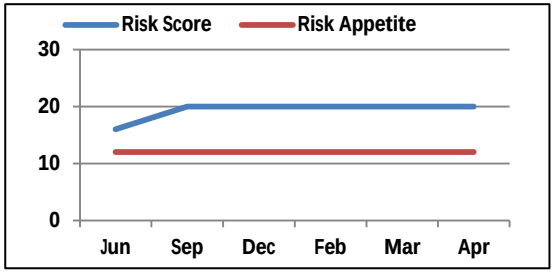
Executive Lead: Steven Course, Director of Finance

Source: Board development event

Lead Committee: FBIC

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	5	20
Appetite	4	3	12



Rationale for current risk scoring:

- The current Trust CRES programme is behind plan and the ability to achieve the control total surplus is hindered.
- The Trust is no longer receiving a risk rating of 4 but is rated 2 instead.
- Experience form other Trusts shows that a deterioration in financial position puts quality priorities at significant risk
- Against the 5 financial metrics in the Single Oversight Framework, the Trust scores a 4 (on a scale of 1-4, with 4 being the worst) on "distance from financial plan". This results in the Trust being placed in segment 2.

Rationale for the level of risk appetite:

- Given the CRES requirements over the last 5 years, and the future requirements, there will always be a relatively high level of residual risk in this area

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Quality Impact Assessment of CRES plans
- Financial planning process with clinical leadership and engagement
- In year financial monitoring meetings with directorates
- Directorate management review
- Agency expenditure reviews
- Financial reports to the Board detail the ongoing actions of the operational teams in managing services within budget

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Continued good performance of the Trust against quality targets

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Implementation and effectiveness of financial recovery plans

Further actions required:

- Continued scrutiny of in year financial position at FBIC
- Joint work with CCGs to allow progress on CRES schemes requiring their approval.

Risk: 3.5(b) The long term impact and potential lack of achievability of CRES requirements over the next 5 years, threatens the overall financial sustainability of the Trust and adversely impacts on the pursuit of quality improvement.

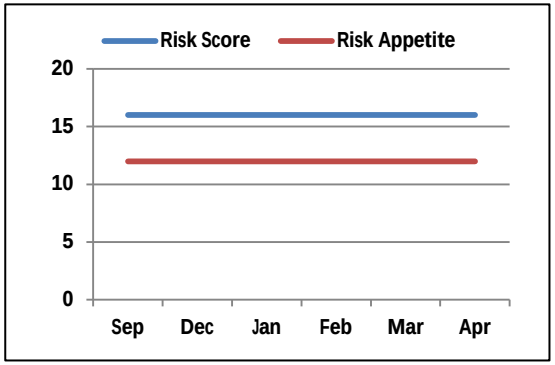
Executive Lead: Jonathan Warren, Chief Nurse & Deputy Chief Executive

Source: Board development event

Lead Committee: FBIC

Change since last review: None.

Risk rating	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Appetite	4	3	12



Rationale for current risk scoring:

- The Trust has been required to make significant CRES over the last 5 years, and is required to continue to do so for the next 5 years
- The Trust is currently maintaining a financial risk rating of 4 (best)
- Experience form other Trusts shows that a deterioration in financial position put quality priorities at significant risk
- Currently rated as 2 on single oversight framework
- Increased oversight from NHSI around financial performance may mean less attention on quality issues.

Rationale for the level of risk appetite:

- Given the CRES requirements over the last 5 years, and the future requirements, there will always be a relatively high level of residual risk in this area

Controls and Mitigating Actions (what are we currently doing about the risk?):

- Quality Impact Assessment of CRES plans
- Financial planning process with clinical leadership and engagement
- Business Strategy approved by the Board (May 2016)

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- Continued good performance of the Trust against quality targets

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- Long term business strategy and financial plan required as part of the Trust's refreshed 5 year strategy

Further actions required:

- Revised Trust 5 year strategy to be approved by the Board (November 2017)

Risk: 3.6 If services are not adequately incorporated into Sustainability and Transformation Plans (STPs), they risk becoming unsustainable over the next five years.

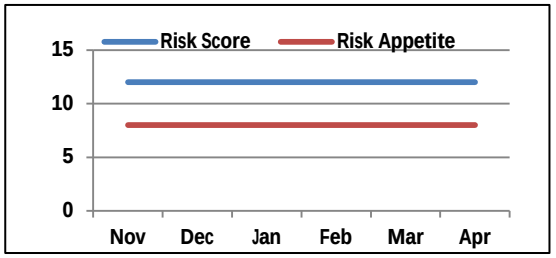
Executive Lead: Mason Fitzgerald, Director of Corporate Affairs

Source: Trust Board discussion

Lead Committee: Trust Board

Change since last review: Addition assurance: NEL STP mental health content rated "good", BLMK STP rated "inadequate"

Risk rating	Consequence	Likelihood	Score
Initial	4	3	12
Current	4	3	12
Tolerance	4	2	8



Rationale for current risk scoring:

- § STPs set out plans for the local health economy for the next 5 years, and will influence commissioning intentions
- § Focus so far has centred on acute services

Rationale for the level of risk appetite:

- § The Trust needs to ensure that mental health and community services are sustainable

Controls and Mitigating Actions (what are we currently doing about the risk?):

- § Involvement in STP planning groups
- § Mental health/community workstreams in North East London
- § Mental health/community workstream in Luton & Bedfordshire
- § Action plan in response to NELSTP mental health review

Positive Assurance/Evidence (How do we know if things we are doing are having the desired effect?):

- § 2017/18 contracting round completed in line with timescales
- § NEL STP mental health content rated "good", BLMK STP rated "inadequate"
- § Delivery plan for North East London STP mental health workstream developed. The mental health and community workstream is commencing for the BLMK STP.

Gaps in controls/assurance (what additional controls are required or assurances should we seek?):

- § No mental health/community workstream in Luton & Bedfordshire

Further actions required:

- §