Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Title:	Board Assurance Framework Report
Report to:	Trust Board
Date:	2 October 2017
Security Classification:	Public Board Meeting

Purpose of Report:

This report presents the Board Assurance Framework (BAF) which identifies the highest risks faced by the Trust in meeting its principal objectives.

The BAF contains 12 identified risks to achieving the Trust's objectives which were agreed at the Trust Board meeting held on 27 March 2017. Board Leads have been consulted and have confirmed the Initial Risk score, Tolerable Risk score and Current Risk score for each risk falling within their remit.

The Trust Board is asked to note the following updates to the BAF:

- Risk 1 – 'Regulatory Standards' – the risk score has decreased from 12 (Medium) to 9 (Medium) as a result of reduced variation in regulatory compliance.

- Risk 2 – 'CQC Compliance Actions' – the risk score has decreased from 12 (Medium) to 9 (Medium) as a result of evidence submitted to support the Quality Improvement Plan, with outstanding actions rolled over into the preparation plan for the CIH Inspection.

- Risk 3 – 'Learning from Serious Incidents' – the risk score has decreased from 12 (Medium) to 9 (Medium) as a result of the development of the Trust's response to the Learning From Deaths Guidance issued in April 2017 and associated actions.

- Three risks (4 – 'Recruit and Retain Staff', 7 – 'Budget Adherence', and 8 – 'Liquidity' remain rated as 'High', whilst all other risks are rated as 'Medium'.

- The following six risks have achieved or exceed their respective tolerable risk score.

  - Risk 1 - 'Regulatory Standards'
  - Risk 2 - 'CQC Compliance Actions'
  - Risk 3 - 'Learning from Serious Incidents'
  - Risk 9 - 'New IT Contract'
  - Risk 11 - 'Efficiencies through Enablement'
  - Risk 12 - 'Performance Information'

- Four risks require a risk score movement of 3 to achieve their respective tolerable risk score.

Sponsor:	Mary Sexton, Executive Director for Nursing, Quality and Governance

Comments / Views of the Report Sponsor:	The BAF sets out details of the 12 identified risks to meeting the Trust's organisational objectives and the progress being taken to mitigate these.
Report Author:	Name: Barry Ray Title: Trust Board Secretary Tel Number: 020 8702 4060 E-mail: barry.ray@beh-mht.nhs.uk
Report History:	Regular Report
Budgetary, Financial / Resource Implications:	The BAF contains risks which have a combination of resource and budgetary implications. All risks are mitigated and subject to regular review.
Equality and Diversity Implications:	None.
Links to the Trust's Objectives, Board Assurance Framework and / or Corporate Risk Register	This report presents the BAF outlining the key risks to achieving the Trust's organisational objectives.
List of Appendices: • Appendix 1 - Board Assurance Framework	

Report

1. Introduction

1.1 This report presents the Board Assurance Framework (BAF) for 2017 / 2018. The purpose of the BAF is to ensure that the Trust is monitoring and addressing the principal risks that would prevent the Trust achieving its organisational objectives, sets out the controls (or ways the risks are being mitigated) and the assurance the Board is receiving that these risks are being managed.

1.2 The BAF is a useful tool in ensuring that the Trust Board is focusing on the key risks that the Trust needs to mitigate. The BAF also forms a key part of the process used by Auditors to gain assurance that the Trust has adequate controls in place.

2. 2017 / 2018 BAF

2.1 Barnet, Enfield and Haringey Mental Health Trust agreed the following Objectives at the Trust Board meeting held on 27 March 2017:

1. Excellent care (coloured yellow)

1.1 Providing excellent care for our patients, evidenced in improving service user and carer feedback and meeting service and CQC requirements.

2. Happy staff (coloured purple)

2.1 Developing our staff to be the best they can be, to deliver excellent patient care

2.2 Increasing staff engagement, evidenced in improved Staff Survey results

3. Value for money services (coloured blue)

3.1 Providing the best outcomes for patients and meeting NHS requirements, within the resources available

2.2 Attached as Appendix 1 is the Trust's BAF for 2017 / 2018 outlining the key risks to achieving the above Objectives.

2.3 Each risk has been given a summary title, to make referencing each risk easier, whilst each risk has been described in line with best practice, which suggests that the risks should be structured along the lines of 'If X (being the risk) happens then Y (being the outcome) might occur'. The risk score is then a reflection of the probability multiplied by the severity of the risk occurring.

2.4 Each Board Lead has been consulted in the development of the 2017 / 2018 BAF, and has confirmed the Initial Risk score, Tolerable Risk score and Current Risk score for each risk falling within their remit.

2.5 Risk 7 – 'Budget Adherence' and Risk 8 – 'Liquidity' were reset as these relate specifically to the 2017 / 2018 financial year. The risk for Risk 9 – 'New IT Contract' was restated for 2017 / 2018 to reflect the status of the procurement process. All other Risks have been carried over from 2016 / 2017.

2.4 Summary of Risks

2.4.1 Set out below is a summary of the 12 risks contained in the BAF for 2017 / 2018. The table highlights the 'Initial Risk' score, the 'Current Risk' score as a result of mitigating actions, and the 'Tolerable Risk' score which indicates the level of risk that the Trust is willing to accept or retain.

Risk		Initial Risk	30 May 2017	18 July 2017	Current Risk (2 October 2017)	Tolerable Risk
1.	**Regulatory Standards**	12	12	12	9	9
2.	**CQC Compliance Actions**	12	12	12	9	9
3.	**Learning from Serious Incidents**	20	12	12	9	9
4.	**Recruit and Retain Staff**	16	16	16	16	12
5.	**Development of the Trust's Culture**	20	12	12	12	9
6.	**Staff Engagement**	20	12	12	12	9
7.	**Budget Adherence**	15	15	15	15	12
8.	**Liquidity**	16	16	16	16	12
9.	**New IT Contract**	12	12	12	12	12
10.	**Estates Management**	16	12	12	12	9
11.	**Efficiencies through Enablement**	12	12	9	9	12
12.	**Performance Information**	20	12	12	12	12

2.5 BAF Heat Map

2.5.1 Set out below is a heat map showing the relative position of each of the risks contained in the BAF, and the direction of travel for any risk where there has been a change in the risk score.

RISK RATING MATRIX

Impact / Likelihood	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)					
Likely (4)				4, 8	
Possible (3)			1, 2, 3 11	5, 6, 9 10, 12	7
Unlikely (2)					
Rare (1)					

Impact Score x Likelihood Score = Risk Rating:

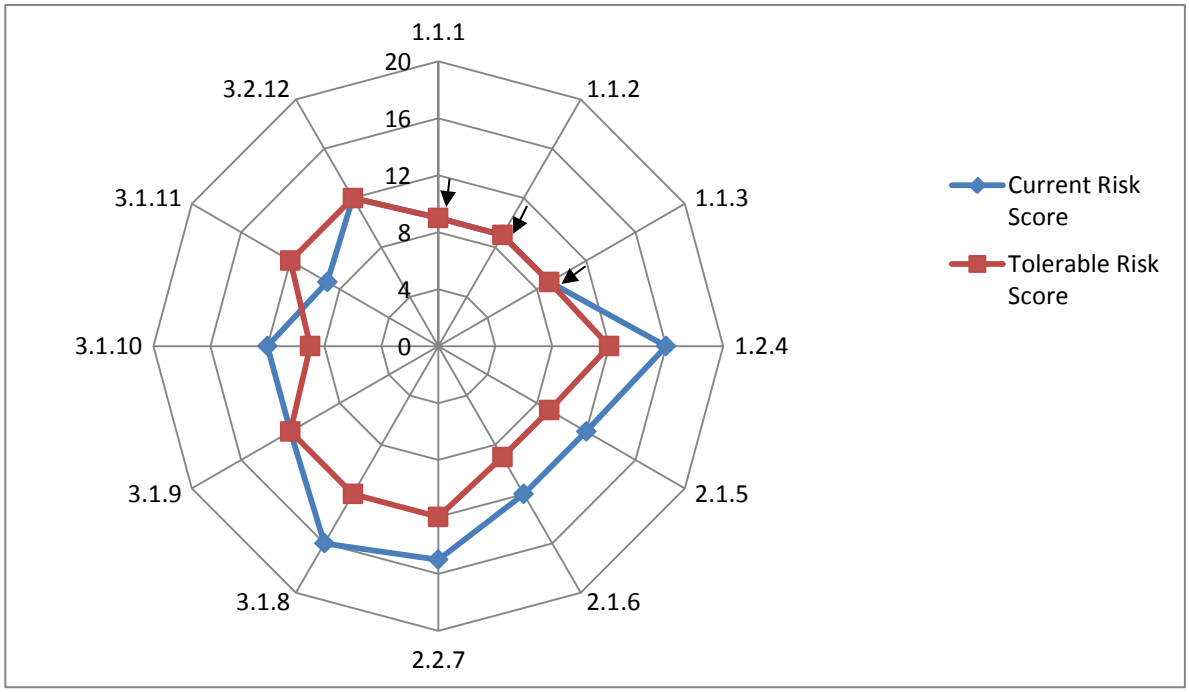
2.6 **Achievement of Tolerable Risk Score**

2.6.1 Tolerable risk scores have been set for each risk in order to determine the point at which risks become tolerable due to the mitigating actions and controls in place.

2.6.2 The difference between current risk score and tolerable risk score is demonstrated below.

2.6.3 The following five risks have achieved or exceeded their respective tolerable risk score.

- Risk 1 - 'Regulatory Standards'
- Risk 2 - 'CQC Compliance Actions'
- Risk 3 - 'Learning from Serious Incidents'
- Risk 9 - 'New IT Contract'
- Risk 11 - 'Efficiencies through Enablement'
- Risk 12 - 'Performance Information'



2.7 **'High Rated' Risks**

2.7.1 The Trust currently has three risks rated as high:

4. Recruit and Retain Staff
7. Budget Adherence
8. Liquidity

2.7.2 The relevant Board Leads will be available to provide a verbal update at the meeting on the steps being taken to mitigate these risks.

2.8 **Mitigating Actions**

2.8.1 Set out over the page is a table showing the mitigating actions being undertaken for each risk and an update on progress since the last meeting.

Risk	Action	Update since last reviewed by Trust Board	Board Lead	Deadline / Status
1.	~~Borough level plans in process of being agreed to support CIH preparation.~~	~~All plans in place and preparation programme commenced~~	~~Clinical Directors~~	~~25/09/17~~ Completed
	Skill Mix Review to be undertaken	New action	MS	Dec 2017
2.	Completion of 'Must Do' compliance actions and 'Should Do' actions contained in the Quality Improvement Plan (QIP) within the Trust's ability to deliver.	All outstanding action now form part of preparation plan for forthcoming CIH Inspection.	EMT	Dates set out in the QIP
3.	~~Appointment of a new Non Executive Director to the Trust wide 'Serious Incident Review Group'.~~	~~Paul Farrimond appointed to the Trust wide Serious Incident Review Group~~	~~JB~~	Completed
4.	~~Review of recruitment plans and Staff Survey plans by the Workforce Sub-Committee~~	~~Recruitment plans updated at 6 weekly Recruitment meetings and Workforce Sub-Committee~~	~~MV~~	Completed
5.	~~Communications campaign to highlight sources of support~~	~~Promoting Dignity at Work Advisors and employee assistance programme~~	~~MV~~	Completed
	Training for managers and staff in handling inappropriate behaviours	Piloted bullying and harassment training sessions in July 2017. Further programmes scheduled to align with Trust values	MV	~~Ongoing~~ November
6.	~~Management Development courses developed and being implemented at different levels across the Trust~~	~~Two programmes – New and Aspiring Manager and Experienced Middle Manager – were launched in 2016 and have received positive feedback. A strategic leadership programme is under development, in collaboration with Middlesex University~~	~~MV~~	Completed
	Development of communication channels across the Trust as well as introduction of staff networks e.g. Better Together, LGBT	Range of activities planned for diversity month in October 2017.	MV	~~Ongoing~~ Oct 2017
7.	The Trust is exploring other avenues to help reduce cost, for example closer collaboration with other London Mental Health Trusts regarding procurement.	The Trust's Procurement function is now led by NELFT with a joint Head of Procurement. CIPs are fully identified for 2017/18 and the PMO are closely monitoring delivery.	EMT	Ongoing
	The Trust is part of the pilot cohort for Lord Carter's review of productivity and efficiency and is optimistic that there will be early learning that will lead to savings.	Requested datasets have been submitted and a response is expected in late Summer.	SG	Ongoing
	A number of strategic work streams have been developed to deliver more transformational service changes and efficiency improvements; including Mobility and Workforce Strategy	Mobility Transformation project board established – Pilot planned for Q4 17/18 Scoping Work for new Workforce Strategy underway	AG MV	New action New action
8.	Financial management systems and processes rigorously applied.	Review of aged debtors and active escalation where debts remain unresolved, such as with the London Borough of Enfield on health visiting debt for which there is now a resolution.	DG	Ongoing

9.	~~Undertake due diligence checks on the Atos/UCLH contract~~	~~Set out in BAF entry~~	~~JD~~	Completed
	~~Finalise contract with new Managed Print provider~~	~~Set out in BAF entry~~	~~JD~~	Completed
	Finalise & agree Transition plan with all suppliers (inc. HP)	Set out in BAF entry	JD	~~31.07.17~~ 30.09.17
10.	Preparations for marketing of surplus land at St Ann's	CBRE, the Trust's agents, appointed and ready. Discussions with Haringey Council on process and next steps.	AW	~~Oct 2017~~ Nov 2017 – Mar 2018
	Design work on new MH facilities	IHP appointed as new design and build contractor and design work underway.	JM	Sep 2017 – Mar 2018
	Application for final Planning approval from Haringey Council	Planning application will be developed with IHP.	AW	Sep 2017 – Feb 2018
	Commencement of building works at St Ann's Hospital	Dependant on NHSI approval of OBC (Oct – 2017) and FBC (Feb - Mar 2018).	AW	~~Spring~~ Summer 2018 On hold
11.	Commissioners have met and will not invest in transformation during 2016/17 (31/10/15).	Being raised through the STP process.	AG	
12.	Activity recording will be queried at team level and teams where under-recording is an issue are supported to improve. Weekly activity reports are sent out to teams to flag any areas of concern.	New plans have been agreed with CCGs, so we expect recorded activity levels to come out closer to targets.	Katherine Wynne	Ongoing
	Having agreed the CCG planned activity trajectories for 2017/18, we will now be comparing the actual values each month against these figures and escalating underperformance greater than 3% across a borough	Whilst we are awaiting month 5 data activity continues to be monitored by the services on a weekly basis.	Katherine Wynne	For review in ~~August~~ October

Implications

3. Budgetary / Financial Implications

3.1 The BAF contains risks which have a combination of resource and budgetary implications. All risks are being mitigated and subject to regular review via the controls and assurances identified for each risk.

4. Risk Management

4.1 This report sets out details of the key risks faced by the Trust in meeting its organisational objectives which have been identified as part of a regular review process. A failure to operate a risk management system would expose the organisation to the risk of inadequate governance arrangements and inadequate management and mitigation of the key risks that may hinder the Trust from achieving the organisational objectives.

5. Equality and Diversity Implications

5.1 None.

Ends.

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Appendix 1

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

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Board Assurance Framework

2017 / 2018

Presented to Trust Board on 2 October 2017

1. Background

1.1 The Trust Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisational objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Trust Board achieves this, primarily through the work of its Committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. Strategic Aims and Organisational Objectives:

2.1 Barnet, Enfield and Haringey Mental Health Trust agreed the following Objectives for 2017 / 2018 at the Trust Board meeting held on 27 March 2017, as follows:

1. Excellent care (coloured yellow)

1.1 Providing excellent care for our patients, evidenced in improving service user and carer feedback and meeting service and CQC requirements.

2. Happy staff (coloured purple)

2.1 Developing our staff to be the best they can be, to deliver excellent patient care

2.2 Increasing staff engagement, evidenced in improved Staff Survey results

3. Value for money services (coloured blue)

3.1 Providing the best outcomes for patients and meeting NHS requirements, within the resources available

3. Definitions

Category	Definition
Objective	The organisational objective to which the risk refers to.
Risk	What could prevent the objective from being achieved?
Board Lead	The relevant Executive Director(s) with overall responsibility for mitigating the identified risk.
Lead Committee	The relevant Committee within the Trust with responsibility for overseeing the identified risk.
CQC Domains	The five domains of the Care Quality Commission's (CQC) inspection framework (safe; effective; caring; responsive; well-led)
CQC Outcomes	Links to the 28 Outcomes which the CQC checks for compliance in relation to essential standards of quality and safety.
Initial Risk Score	Initial consideration of the risk based on the Probability x Likelihood (5 x 5) matrix (see Risk Rating matrix below).
Current Risk Score	An assessment of the risk based on the Probability x Likelihood (5 x 5) matrix following consideration of the controls, assurances and progress to mitigate the risk.

Tolerable Risk	The level of risk that the Trust is willing to accept or retain.
Controls	The controls (or systems) in place to assist in addressing the risk.
Assurances	Sources of information (usually documented) which serve to assure the board that the controls are having an impact, are effective and comprehensive.
Gaps in Assurances	What further sources of assurance are required.
Mitigating Actions	Additional actions required to assist in mitigating the risk.
Current performance	An outline on the progress made to mitigate the risk.

The Controls and the assurances have been grouped together to indicate the relevant sources of assurances for the respective controls.

4. Risk Rating Matrix

4.1 The overall risk ratings below are calculated as the product of the Probability and the Severity Score.

IMPACT SCORE				
LEVEL	**INJURY / HARM**	**SERVICE DELIVERY**	**FINANCIAL / LITIGATION**	**REPUTATION / PUBLICITY**
5. CATASTROPHIC	Fatality, Multiple fatalities or large number injured or affected.	Complete breakdown of critical service/ 'Significant under-performance' against key targets.	Losses; claims/damages; criminal prosecution, over-spending; resourcing shortfall: >£1M.	International adverse publicity/reputation irreparably damaged.
4 Major (HIGH)	Fatality/multiple serious injuries/major permanent loss of function/increased length of stay or level of care >15 days.	Intermittent failures of a critical service/'under-performance against key targets'.	£501K - £1M	Adverse national publicity
3 Moderate (MEDIUM)	Semi-permanent harm (1 month-1 year). Increased length of stay / level of care 8-15 days, >1 month's absence from work.	Failure of support services/under-performance against other key targets'.	£51K - £500K	>3 days local media publicity
2 Minor (LOW)	Short-term injury (<1 month). Increased length of stay or level of care <7 days, 3 days-1 month absence for staff.	Service Disruption	£11K - £50K	<3 days local media publicity
1 (Insignificant)	No harm. Injury resulting in <3 days' absence from work for staff.	No service disruption	<£10K	

LIKELIHOOD SCORE		
Level		
5	Almost certain	Will occur frequently given existing controls
4	Likely	Will probably occur given existing controls
3	Possible	Could occur given existing controls
2	Unlikely	Not expected to occur given existing controls
1	Rare	Not expected to occur, except for in exceptional circumstances, given existing controls

RISK RATING MATRIX					
Impact / **Likelihood**	**1**	**2**	**3**	**4**	**5**
5	**5** (LOW)	**10** (MEDIUM)	**15** (HIGH)	**20** (CATASTROPHIC)	**25** (CATASTROPHIC)
4	**4** (LOW)	**8** (MEDIUM)	**12** (MEDIUM)	**16** (HIGH)	**20** (CATASTROPHIC)
3	**3** (LOW)	**6** (MEDIUM)	**9** (MEDIUM)	**12** (MEDIUM)	**15** (HIGH)
2	**2** (LOW)	**4** (LOW)	**6** (MEDIUM)	**8** (MEDIUM)	**10** (MEDIUM)
1	**1** (LOW)	**2** (LOW)	**3** (LOW\)	**4** (LOW)	**5** (LOW)
Impact Score x Likelihood Score = Risk Rating:					

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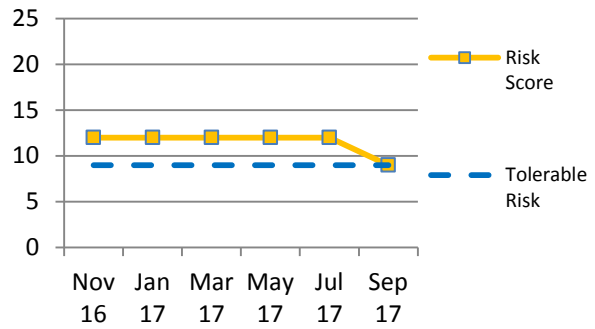
Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.1 - Providing excellent care for our patients, evidenced in improving service user and carer feedback and meeting service and CQC requirements.	**Board Lead:**	Mary Sexton	**Date of review:**	September 2017
				Lead Committee	Quality and Safety	**Date of next review:**	November 2017
Risk ID:	**1**	**Risk:**	**Regulatory Standards** - If services consistently do not meet regulatory core standards in respect of essential standards for quality and safety, this will impact on the quality of care given to patients.	**CQC Domain:**	Caring / Effective / Responsive / Safe / Well-led	**CQC Outcomes:**	4 - Care and welfare of people who use services

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	3 x 4 = **12**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 3 = **12**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⇩



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Indicator	Jun	Jul	Aug	17/18 Target
Number of Never Events	0	0	0	0
Formal Complaints received	19	15	21	
Overall Patient Satisfaction	89%	89%	90%	80%
Overall Carer Satisfaction	92%	93%	90%	80%
Nursing Vacancy Rate	16.7%	17.6%	16.6%	10%
Staff Turnover (total)	13.0%	13.9%	13.8%	15%
Proportion of staff compliant with individual mandatory training requirements	86.6%	86.6%	87.4%	90%

Rationale for current score:

~~The Risk Score remains the same as there remains a medium likelihood of a high impact on the risk as there remains variation in regulatory compliance due to environmental and affordability issues.~~ The Risk Score has reduced as variation in regulatory compliance has reduced though risk remains due to environmental and affordability issues. There is therefore a possible likelihood with a moderate impact that the risk will occur.

The Trust continues to implement a Quality Improvement Plan in response to the Chief Inspector of Hospital's inspection which identified 'Must Do' compliance actions for the Trust to address, and 'Should Do' actions for the Trust to consider, which resulted in the current risk score. Additional investment discussions have delivered some limited additional funding to address Child and Adolescent Mental Health Services (CAMHS). Wait to treatment. St Ann's development remains a risk.

~~The CQC intelligent monitoring report, published in February 2016, identified seven out of 72 indicators which were rated as at risk.~~

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Quality Strategy 2016 – 2019 (agreed by the Trust Board on 25.01.16), which aims to address quality issues for patients	• Quality metrics reported to every meeting of the Quality and Safety Committee and Trust Board via the Integrated Performance Dashboard Report and the Clinical, Quality and Safety Report (I). • Patient feedback via complaints & claims, as reported in the KPIs reported to every Trust Board meeting (I). • Safety Thermometer data submitted and reviewed quarterly (I). • Safe Staffing Report to every meeting of the Trust Board (I). • Appraisal / revalidation in place across all Trust teams (I). • Trust Values have been reviewed and new Values agreed at the Quality and Safety Committee on 4.07.16 on behalf of the Trust Board. 'Living Our Values' workshops were rolled out across the Trust (I).
2. Quality Account, which details the quality priorities for the Trust:	• Quality Account priorities considered by Board members at the Board Workshop on 26.06.17 and published on 30.06.17 (I). • Six monthly update reports to the Quality and Safety Committee (I) and Joint Performance and Quality (E) meetings. • Quality metrics reported to every meeting of the Quality and Safety Committee and Trust Board via the Integrated

<table>
<tr><td></td><td>Performance Dashboard Report (I).
• External Audit review of the Quality Account, confirmed that it has been produced in line with national guidance and meets in full the statutory requirements for Quality Accounts, considered at the Quality and Safety Committee on 12.09.17 (E).</td></tr>
<tr><td>3. Statutory Committees in respect of Safeguarding, Health and Safety and Infection Control.</td><td>• Safeguarding Annual Report 2016 / 2017 considered at Quality and Safety Committee on 3.07.17 and ~~due to be considered~~ by the Trust Board on 18.07.17 (I).
• Infection Control Annual Report considered at Quality and Safety Committee on 3.07.17 and ~~due to be considered~~ by the Trust Board on 18.07.17 (I).
• Annual Health and Safety Report considered at Quality and Safety Committee on 8.05.17 and by the Trust Board on 30.05.17(I).</td></tr>
<tr><td>4. Skill Mix Review.</td><td>• Trust receives Safe Staffing report at each Trust Board meeting (I).
• SafeCare module implemented which will allow for real time acuity / dependency data. There remains ongoing issues with data reconciliation (I).
• Skill Mix Review in progress and due to report in December 2017.</td></tr>
<tr><td>5. CQUIN and Contract monitoring process.</td><td>• ~~Twice yearly CQUIN report considered by Quality and Safety Committee (last considered on 03.05.16) (I).~~
• CQUIN delivery monitored through meetings of the Integrated Performance Meeting - Partially met for Q1 (I).</td></tr>
<tr><td>6. Quality impact review process of all CIP plans.</td><td>• All CIPs have a Quality Impact Assessment in place and key milestones tracked through to delivery and monitored via the Integrated Performance Meeting (I).
• QIA process reviewed and refreshed (I).</td></tr>
<tr><td>7. Serious Incident Groups at Team / Borough Level</td><td>• All Serious Incidents scrutinised and action plans in place to address learning (I).</td></tr>
<tr><td>8. Borough Level Clinical Governance meetings.</td><td>• All key clinical governance indicators reviewed and actions agreed to address any variations (I).
• Heat Maps in place for teams (I).</td></tr>
<tr><td>9. Raising Concerns at Work Policy.</td><td>• Details of raising concerns issues reported to the Quality and Safety Committee and Trust Board (I).
• Two Independent Freedom to Speak Up Guardians commenced 3/4/17.
• Update from the Freedom to Speak UP Guardians presented to the Trust Board on 18.07.17 (I)</td></tr>
<tr><td>10. Patient Experience Committee.</td><td>• Regular feedback report on the work of the Patient Experience Committee reported to every meeting of the Quality and Safety Committee (I).
• Engagement and Involvement Strategy considered by Quality and Safety Committee on 03.05.16 and the Trust Board on 31.05.16. Borough level action plans in place to deliver strategy (I).
• Friends and Family Test and ‘You said, we did’ identifies actions taken (I).
• Patient Experience & Complaints Annual Report considered at Quality and Safety Committee (last considered on 12.9.17) (I).</td></tr>
<tr><td>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</td><td>Mitigating actions: (What more should we do?)</td></tr>
<tr><td>1. Preparation programme required for the CQC Inspection
2. Borough level plans to be completed to support the CIH</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>~~Borough level plans in process of being agreed to support CIH preparation.~~</td><td>~~All plans in place and preparation programme commenced~~</td><td>~~Clinical Directors~~</td><td>~~25/09/17~~ Completed</td></tr>
<tr><td>Skill Mix Review to be undertaken</td><td>New action</td><td>MS</td><td>Dec 2017</td></tr>
</table>
</td></tr>
<tr><td>Current performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
<tr><td></td><td>The CQC undertook an inspection of the Trust in the week commencing 25 September.

Linked to the Clinical, Quality and Safety Report presented to each meeting of the Trust Board.</td></tr>
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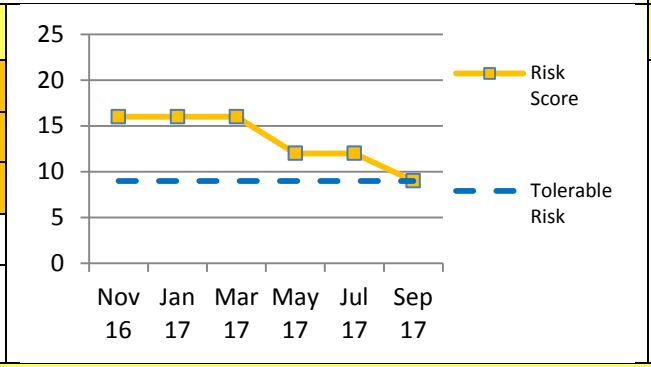
Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.1 - Providing excellent care for our patients, evidenced in improving service user and carer feedback and meeting service and CQC requirements.	**Board Lead:**	Mary Sexton	**Date of review:**	September 2017
				Lead Committee	Quality and Safety	**Date of next review:**	November 2017
Risk ID:	**2**	**Risk:**	**CQC Compliance Actions -** Failure to evidence progress against compliance actions against regulated activity may place people who use services at risk of unsafe care and will result in enforcement or other regulatory actions.	**CQC Domain:**	Caring / Effective / Responsive / Safe / Well-led	**CQC Outcomes:**	Regulations 9, 10, 15, and 18

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	3 x 4 = **12**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 3 = **9**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⇩



Performance Update

Type of Recommendation	Number of Actions	Current Status of Recommendations		
		Red	Amber	Green
Must Do	72	3	15	54
Should Do	208	2	39	167

Correct as at 7 September 2017. Several of the ambers are completed actions but remain amber until evidence of completion is received.

Rationale for current score:

The Risk Score has reduced reflecting evidence submitted to support the QIP, with outstanding actions rolled over into the preparation plan for forthcoming CIH Inspection. ~~There is therefore a medium likelihood with a high impact that the risk will occur.~~ There is therefore a possible likelihood with a moderate impact that the risk will occur.

The Trust developed a Quality Improvement Plan in response to the CQC's Chief Inspector of Hospital's inspection which took place 30 November – 4 December 2015. The inspection focussed on the Trust's 11 core services, giving each a rating; five were rated as 'good', with one 'outstanding'. The CQC have identified 'Must Do' compliance actions for the Trust to address, and further 'Should Do' actions for the Trust to consider, which resulted in the current risk score. The Trust continues to implement its Quality Improvement Plan ensuring that evidence of compliance is in place. Two must do actions remain outstanding in relation to St Ann's redevelopment and CAMHS waiting times to treatment.

The Trust's ability to deliver the Quality Improvement Plan, is in part, dependent on additional resources to address environmental and other service related issues. To date only partial funding has been agreed with commissioners to address psychology workforce in Enfield and the Psychiatric Intensive Care Unit. Outstanding are Child and Adolescent Mental Health Services (CAMHS) and returners from leave. Discussions are on-going with commissioners. The remaining 'must do' risk relates to the environment at St Ann's which is dependent on the St Ann's redevelopment. The Trust has submitted an OBC to NHS Improvement and is awaiting the outcome.

The Trust's Eating Disorders service (Phoenix Ward) was inspected in early March 2016. The CQC notified the Trust of a number of compliance actions that the Trust needs to address. A plan is in place and being robustly monitored. The Eating Disorders service was inspected by the CQC on 4/5 September ; the outcome of the inspection is awaited.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. The Quality Assurance programme to support the delivery of the Trust Quality Improvement Plan.	• Quality Improvement Plan reported to every meeting of the Quality and Safety Committee and Trust Board. Last reported to the Quality and Safety Committee on 3.07.17 (I). • Internal audit of the Quality Improvement Plan completed, and presented to the Quality and Safety Committee on 4.3.17 (I). • Designated monitoring Committees have been required to review those actions allocated and ensure these are included in their respective work plans (I). • Bi-monthly commissioner led Quality Review Group to review progress against the plan (E). Formal

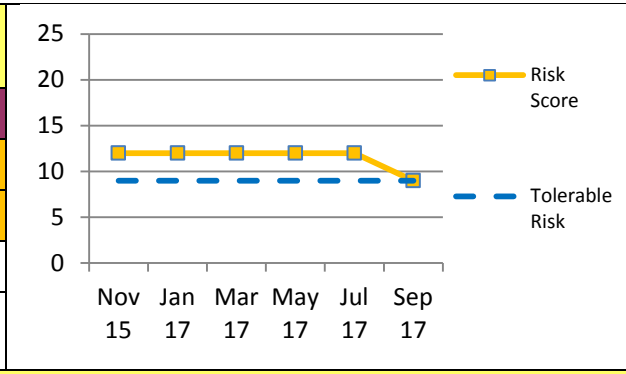
<table>
<tr><td></td><td>discussions have taken place with Commissioners regarding funding to deliver plan (E).</td></tr>
<tr><td>2. Internal Peer Assessment Programme which mirrors CQC inspections.</td><td>• ~~Twice yearly~~Annual Thematic Review of Service Peer Reviews considered by the Quality and Safety Committee (last considered on 7.11.16) (I).</td></tr>
<tr><td>3. Quality Review Week, to provide evidence of progress made and inform practice.</td><td>• Quality assurance monitoring in place and variations from standards are being actively addressed at team and Borough level (I).
• Quality Review Week held in the week commencing 23 January 2017 (I).
• Results of the Quality Review Week presented to the Quality and Safety Committee on 6.3.17 (I)
• Unannounced Quality Reviews ~~planned~~ undertaken in August / September as part of the Trust's preparation for the CQC inspection (I).</td></tr>
<tr><td>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</td><td>Mitigating actions: (What more should we do?)</td></tr>
<tr><td>• Internal Audit opinion on the Trust's Quality Improvement Plans.
• Successful achievement of 'Must Do' compliance actions and 'Should Do' actions contained in the Quality Improvement Plan (QIP)</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>Completion of 'Must Do' compliance actions and 'Should Do' actions contained in the Quality Improvement Plan (QIP) within the Trust's ability to deliver.</td><td>All outstanding action now form part of preparation plan for forthcoming CIH Inspection.</td><td>EMT</td><td>Dates set out in the QIP</td></tr>
</table>
</td></tr>
<tr><td>Current performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
<tr><td>An Analysis of the Quality Review Week has been undertaken and used to provide on areas of strengths and areas of weakness to be addressed in each ward / service visited.</td><td>The Trust's Quality Improvement Plan was submitted to the CQC on 29 April 2016 for consideration. Meetings have been held with the Director of Quality for each CCG and NHS England to discuss and agree the Commissioner's ownership of the Quality Improvement Plan. The Plan requires £2 million investment to implement in full.

Regular meetings are held with the CQC to provide an update on progress made. The CQC undertook an inspection of the Trust in the week commencing 25 September.</td></tr>
</table>

Board Assurance Framework – Provide Excellent Services for Patients

Objective:			1.1 - Providing excellent care for our patients, evidenced in improving service user and carer feedback and meeting service and CQC requirements.	**Board Lead:**	Jonathan Bindman	**Date of review:**	September 2017
				Lead Committee	Quality and Safety	**Date of next review:**	November 2017
Risk ID:	**3**	**Risk:**	**Learning from Serious Incidents -** Failure to ensure that the Trust learns from serious incidents, including Board Level Panel Inquiries and Independent Reviews, will impact on the quality of care given to patients.	**CQC Domain:**	Effective / Responsive / Safe	**CQC Outcomes:**	16 - Assessing and monitoring the quality of service provision. 20 - Notification of other incidents

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	4 x 5 = **20**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 3 = **9**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⇩



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Indicator	Jun	Jul	Aug	17/18 Target
Never events	0	0	0	0

Rationale for current score:

~~The Risk Score remains the same due to the fact that although current processes are now well embedded evidence of sharing learning is not evident in all areas. In addition, new requirements concerning the reporting of deaths come into effect on 1.4.17 and the Trust will require a further period to assure our response. This has a medium likelihood of having a high impact on the risk.~~
The Risk Score has been reduced as we have now developed our response to Learning From Deaths Guidance issued in April 2017, we have developed a Policy, reviewed it at the Quality and Safety Committee, implemented mortality reviews and discussed the implementation process at the Trust Wide Serious Incident Review Group (SIRG) and externally, and have collected data on deaths for reporting as required. There remains some risk that although current processes for learning from Serious Incidents are now well embedded, evidence of sharing learning is not evident in all areas. There is therefore a possible likelihood with a medium impact of the risk occurring.

Evidence of action plans is now collected by the Patient Safety Team and Boroughs. Serious Incidents (SIs) are not closed and filed until all evidence is available that actions have been completed. These are reported at Deep Dive meetings for each Borough. Reports detail how many SIs remain outstanding and timelines due. In the last month the Trust has met with the Commissioning Support Unit and resolved a number of outstanding Further Information Requests.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Management of Incidents Policy. 2. Updated processes to ensure reporting and investigation of all deaths.	• Regular Serious Incidents reports to the Quality and Safety Committee, Trust Board and, Deep Dive Meetings which includes moderate and serious incidents (I) and includes data on deaths. • Regular reports quarterly to the Commissioners Quality Review Group (CQRG) meeting with commissioners (E). • Monthly quality feedback from the North East London Commissioning Support Unit's (NELCSU)'s North Central London Serious Incident Panel Meeting, with additional meetings as required (E). • A Summary of SI data presented to the Quality and Safety Committee (reported on six-monthly basis, last reported on 12.09.17). • Internal Audit Report conducted by RSM into 'Incidents and Learning Lessons' in 2016, action plan developed and completed, ratified by Quality and Safety Committee on 4.6.16 (I) ~~concluded that there was partial assurance, but all recommendations now completed and final action, revision of Management of Incident Policy, ratified at the (I).~~ • Reporting of all deaths on Datix, and review by the Patient Safety Team of all reports.

	• Care and Mortality Review Group (CMRG), established from 1.4.17 and led by the Medical Director, reviews all deaths reported on the Datix system and agrees level of investigation required. • Review of existing procedures and reporting requirements to comply with the new requirements concerning the reporting of deaths came into effect on 1.4.17, reported to Quality and Safety Committee 8.5.17. • Amendment to the Managing Incidents Policy agreed at the Quality and Safety Committee on 3.07.17 (I).
3. Compliance with the statutory Duty of Candour.	• Regular Serious Incidents reports to the Quality and Safety Committee and Deep Dive meetings (I). • Duty of Candour issues reported to the Trust Board via the Clinical, Quality and Safety report (I). • ~~'Evidencing Compliance with the Duty of Candour' report considered at the Quality and Safety Committee on 6.7.15 (I).~~ • Duty of Candour incorporated into Serious Incident report submitted to the Quality and Safety Committee (last reported on 12.09.17) (I). • Regular report to the CQRG meeting with commissioners (E). • Part 1 compliance has been 100% and part 2 compliance 96% (I).
4. Serious Incident Review Groups	• Borough and Specialist Serious Incident Review Groups established and meeting monthly. • Trust wide Serious Incident Review Group established and meets quarterly, most recently 14.9.17 (I). • Paul Farrimond appointed to the Trust wide Serious Incident Review Group on 18.07.17 (I).
5. Datix system for the recording of all incidents.	• Datix reports considered by each Service Line at Deep Dive meetings (I). • Datix incidents reports reviewed by Borough Governance Facilitator at a minimum of weekly (I). • Datix reports re incident reporting to Quality and Safety Committee (I)

Gaps in controls and assurances: (What additional controls and assurances should we seek?)	**Mitigating actions:** (What more should we do?)
1. Requirements for structured judgement reviews in guidance but no agreed methodology for mental health. Policy states that we will use established RCA methodology and SI template for this purpose. ~~1.~~2. Guidance on Learning from Deaths advises 'avoidability' of deaths is reported but no agreed methodology for mental health; a method advised by CNWL is being piloted from 1.9.17. ~~2. Appointment of a new Non Executive Director to the Trust wide 'Serious Incident Review Group'.~~	

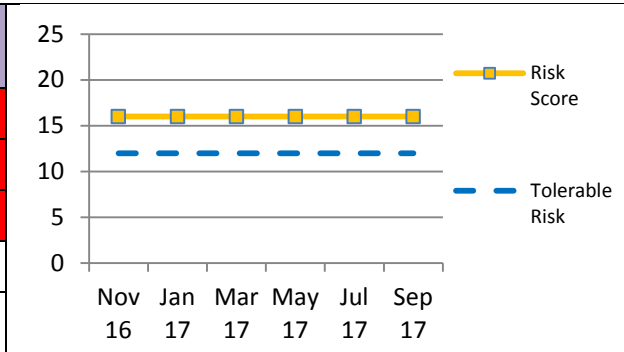
Action	Update since last reviewed by Trust Board	Lead	Deadline
~~Appointment of a new Non Executive Director to the Trust wide 'Serious Incident Review Group'.~~	~~Paul Farrimond appointed on 18.07.17~~	~~JB~~	~~1.4.17~~ Completed

Current performance: (With these actions taken, how serious is the problem?)	**Additional Comments:**
1. Borough Serious Incident Review Groups are established and governance structures are now established which these groups report to are reviewing SI reports and recommendations. Borough Governance structures have been reviewed at Trust Wide SI Assurance Group and are considered to be functioning well. However evidence of learning and consequent improvements in delivery of care remains difficult to quantify 2. A programme of Berwick Learning Events has been developed for 2017 / 2018, which reflects issues identified from Sis. ~~in the recent CQC inspection.~~ Events are also taking place at Borough and at Team level. ~~Wide programme of learning established trust wide~~ 3. The Trust has established a Trust Wide 'Serious Incident Review Group' which is having oversight of the Borough SI panels. Membership includes one Non Executive Director and representation from each Borough and Specialist Service and Patient Safety Team. ~~4. Trust has been ranked 127th out of 230 by NHS England March 2016 with a significant concern with regards openness and sharing lessons.~~ ~~5.~~4. A total of 7,595 incidents reported for Qs 1, 2 & 3 – a 49% increase in reporting. ~~6.~~5. The total number of 'serious' incidents reported and declared for 2016 / 2017 is 63 to year date.	A meeting has been held with NELSCU and the Trust is working with our commissioners to resolve identified issues including receiving late information requests from NELSCU which delay closure of SI's. It has been recognised by commissioners there has been improvements in both quality of reports and completion of reports on time. A 'never event', administration of insulin through a non-insulin syringe, took place in February 2017. The patient was not affected. A Board Level Panel Inquiry ~~is due to be considered by~~ was presented to the Trust Board on 18.07.17.

Board Assurance Framework – Develop our Staff

Objective:			2.1 - Developing our staff to be the best they can be, to deliver excellent patient care	**Board Lead:**	Mark Vaughan	**Date of review:**	September 2017
				Lead Committee	Workforce Sub-Committee	**Date of next review:**	November 2017
Risk ID:	**4**	**Risk:**	**Recruit and Retain Staff -** If the Trust is unable to recruit and retain sufficient levels of staff or staff with appropriate skills and capability to meet the needs of changing services, this will result in a continued dependency on the need for temporary staffing which impacts on the quality of care delivered and financial sustainability of the Trust.	**CQC Domain:**	Effective / Safe / Well-led	**CQC Outcomes:**	12 - Requirements relating to workers. 13 - Staffing

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	4 x 4 = **16**
Previous Risk Score:	4 x 4 = **16**
Current Risk Score:	4 x 4 = **16**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Indicator	Jun	Jul	Aug	17/18 Target
Agency as a % of Employee expenditure	7.1%	6.5%	7.2%	8%
Bank as a % of Employee expenditure	8.4%	9.0%	9.1%	10%
Total vacancy rate (% established posts without staff members in place)	11.5%	12.4%	11.8%	10%
Nursing Vacancy Rate	16.7%	17.6%	16.6%	10%
Medical Vacancy Rate	12.6%	12.5%	9.3%	10%
Staff Turnover (Total)	13.0%	13.9%	13.8%	15%

Rationale for current score:

The Risk Score remains the same as there remains a 'likely' likelihood of the risk occuring which may have a major impact.

After a steady decline in vacancies in the year 2016/17, there was an increase from April 2017 with increases in establishment. Increases to establishment continued in the first few months of the year. Vacancy levels have declined in August with increased appointment to vacant posts. This has been evidenced in medical vacancies which have returned to a position below the 10% threshold. Recruitment to vacancies continues at pace, with an intense focus on nursing roles. It is expected that the decline will be maintained overall as new appointments to nursing roles come to fruition in September and October. Recruitment to newly qualified nursing roles has been very successful with increased engagement with universities and over 50 nurses will start in the next two months.

~~Vacancy levels in the Trust have increased with increases to the establishment in April. Recruitment to vacancies continues at pace, with an intense focus on nursing roles. It is expected that the vacancy levels will decline again as new roles are recruited to. In addition, a further validation exercise is being carried out at the request of the boroughs to ensure that vacancies that are not being actively recruited to are removed from vacancy reporting.~~

There are a range of initiatives underway to support the recruitment campaigns. The Trust is running an active social media recruitment campaign, apart from actively participating in career fairs and open days. Interviews in the Philippines resulted in over 200 offers in various roles, including dis~~e~~trict and community nursing. A small cohort of 4 nurses will start in November and will undertake the OSCE programme. Further cohort dates are being planned for the following months. Rotation programmes for newly qualified nurses were introduced. Competency frameworks for Band 6 Care Coordinator roles have beenwere launched in Haringey and Enfield and have proved to be attractive providing Band 5 nurses and OTs the opportunity to progress in their careers. The campaign was highly successful and the new appointments will start in these roles in September and October. A dedicated onboarding programme has been designed to make sure that they are well-suported in this transition. . Apart from providing an opportunity for career development and therefore improve retention, recruitment to these roles will also have an impact on agency levels.

~~These candidates are now being followed up with the agency to ensure that all required checks and tests are being carried out in a timely manner. have been designed and advertised and are expected to attract more applicants. At the present time, the Trust is already expecting a cohort of 52 newly qualified nurses in September. Competency frameworks for Band 6 Care Coordinator roles have been launched in Haringey and Enfield and have proved to be attractive. Apart from providing an opportunity for career development and therefore improve retention, recruitment to these roles will also have an impact on agency levels.~~

A large number of process improvements have been made to improve the time taken to hire. Monitoring of these targets continues with managers and within workforce to ensure that improvements are sustained and that further progress is made.

Spend on agency has generally declined since June 2016 and was half its earlier level by April 2017. It reflects a trend for declining bookings since the second quarter of 2016. The trend is indicative of medical and non-medical bookings. The increase in bank spend was expected as an increasing number of agency bookings are being replaced with bank and substantive roles. There has been a recent reversal of the declining trend in agency bookings with new services (staffed primarily with interims) coming on stream in April/May. This increase has taken place despite very substantial declines in most areas through conversion of agency bookings to fixed term or bank assignments. Improvements in rostering practice in inpatient areas have also contributed to the decline in agency bookings, and will be replicated in community services. The Trust is participating in the NHSI led rapid improvement event. Lessons learnt from the programme will be cascaded over the next few months.

Work is also being carried out within the Trust and in collaboration with the NCL STP to review the Trust's employment offer, in terms of career development, talent management as well as pay and non-pay benefits.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Policies, including Learning and Development and Training Plan, Workforce Development and Study Leave Policy, including arrangements for Performance Development Framework. 2. Reviewing the Recruitment Policy in collaboration with NCL STP. 3. A Service Level Agreement for the recruitment service to improve accountability and transparency. 4. Rolling recruitment advertising for a range of posts including bank nurses and HCAs, RGNs and RMNs with standardised job descriptions and assessment processes has resulted in a regular recruitment cycle. 5. TRAC recruitment software package has been fully implemented including the OH functionality. This has resulted in improved tracking and monitoring of OH clearances. 6. Monitoring of time to hire data to ensure that appropriate pressure is maintained on the pace of recruitment 7. Training for first-line managers to improve their knowledge of workforce policies (including recruitment, disciplinary etc) has been launched and is expected to improve their skill in dealing with employee matters. 8. Vacancy Control Panel, led by Executive Directors, meeting weekly since July 2016 to review all recruitment and non-urgent temporary staffing requests. 9. Fortnightly recruitment project team meetings with representation from all the boroughs is allowing clear oversight of nursing recruitment as well as share good practice within the Trust. 10. There has been an increased level of engagement with universities to recruit newly qualified nurses and mental health workers and the launch of rotation programmes for newly qualified nurses. 11. Good practice e-rostering meetings are taking place regularly with each division and key performance indicators are reviewed with ward management teams. Particular focus has been placed on the management of leave and unused hours to ensure that rosters are appropriately managed. 12. Electronic exit interview monitoring and feedback is shared with boroughs for change and remedial action. 13. A career development framework (including rotational programmes) has been launched to help retain nurses within the organisation. A competency framework is due to be launched in the first quarter of the year. 14. The Haelo model for continuous improvement commenced in November and uses a collaborative improvement methodology to support a reduction in agency usage through improved recruitment, consolidation of leadership skills and improved retention. 15. Standardised pay rates for bank work were implemented in June (effective January 2016) and have made our bank work more competitive. The rates will remain under review to ensure that this remains the case. 16. The Trust is collaborating with the NCL STP on the recruitment and retention workstream. This includes the consideration of harmonising of pay rates for temporary staff, as well as standardised employment contracts which will increase the flexibility and scalability of the workforce across the region. 17. A "Buddy" scheme has been launched to support all new starters with their integration into the team and the Trust.	• Workforce KPIs and compliance, including appraisals, revalidation, compliance with mandatory training, staff turnover and vacancies reported to every meeting of the Quality and Safety Committee and Trust Board via the Integrated Performance Dashboard Report (I). • Regular reports to the Workforce Compliance Committee, which reports to each meeting of the Quality and Safety Committee (I). • Reporting on Time to Hire data on a monthly basis to the Integrated Performance Meetings and the Improvement and Delivery Board (I). • Recruitment plans updated (I). • Update on the Staff Survey 2016 Action Plan presented to the Quality and Safety Committee on 12.09.17 (I).

<table>
<tr><td>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</td><td>Mitigating actions: (What more should we do?)</td></tr>
<tr><td>1. Monitoring the effectiveness of HR policies may not give sufficient assurance.
2. Effective and timely management information available on vacancy rates.</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>~~Review of recruitment plans and Staff Survey plans by the Workforce Sub-Committee~~</td><td>~~Recruitment plans updated at 6 weekly Recruitment meetings and~~</td><td>~~MV~~</td><td>~~Ongoing~~
Completed</td></tr>
</table>
</td></tr>
<tr><td>Current performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
<tr><td>The Trust commenced a concerted effort to recruit to vacancies in early 2016. This has borne fruit with a heightened focus on the volume of recruitment as well as its quality and pace. Various administrative systems and processes have been standardised to ensure that the necessary pace is achieved and maintained. This has, in addition, been with support from the quality improvement team.</td><td>• The TRAC IT system was implemented in 2015.
• Staff Survey Action Plan presented to the Trust Board on 27.03.17 and communicated widely, supported with local borough plans.

Linked to Risk 1593 on the Corporate Risk Register.</td></tr>
</table>

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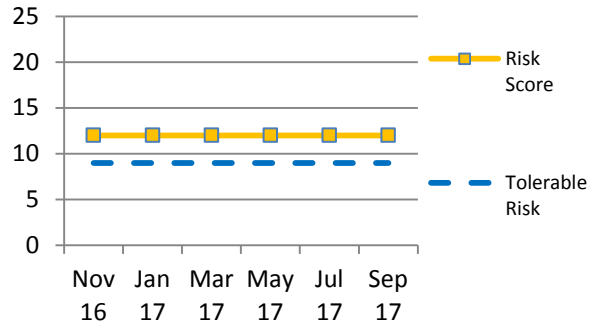
Board Assurance Framework – Increasing Staff Engagement

Objective:			2.2 - Increasing staff engagement, evidenced in improved Staff Survey results	**Board Lead:**	Mark Vaughan	**Date of review:**	September 2017
				Lead Committee:	Workforce Sub Committee	**Date of next review:**	November 2017
Risk ID:	**5**	**Risk:**	**Development of the Trust's Culture -** If the Trust fails to develop an open, people-focused and values-based organisational culture this will result in concerns not being effectively reported, inconsistent compliance with best practice, inability to attract / retain staff and deliver change programmes.	**CQC Domain:**	Well-led	**CQC Outcomes:**	14 - Supporting workers

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	4 x 5 = **20**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 4 = **12**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Indicator	2014	2015	2016	Average (MH)
Overall staff survey engagement indicator (score out of 5)	3.69	3.83	3.81	3.80
Ability to contribute to improvements at work	74%	74%	75%	74%
Recommend the Trust as a place to receive treatment or work	3.45	3.65	3.69	3.71
Motivated and engaged in work	3.89	4.01	3.94	3.04
Confidence and security in reporting unsafe practice	3.45	3.70	3.65	3.71

Rationale for current score:

The current risk score reflects the results in the 2016 Staff Survey. There remains a medium likelihood of a high impact on the risk.

The Trust is working with clinical divisions and corporate areas to develop an action plan to address the main issues of concern e.g. discrimination and bullying and harassment.

Following approval of refreshed values in 2016, we have run over 80 staff engagement sessions – Living our Values – to help bring the values to life. Feedback from the sessions is informing a behavioural framework which is in development.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Staff Survey Action Plan 2015, including actions to improve staff engagement. 2. Staff Concerns and the Disclosure of Information - "Whistleblowing" Policy, which supports staff in being able to raise concerns. 3. Whistleblowing Policy and Freedom to Speak Up Champion provides point of contact to raise concerns. 4. Recruitment of staff willing to be dignity at work advisors to support staff 5. Refreshing our wellbeing and equalities fora to increase staff engagement 6. Developing staff networks which give opportunities for shared learning, input to policy	• Regular reports to the Workforce Sub-Committee, which reports to the Quality and Safety Committee (I). • Update on the Staff Survey 2016 Action Plan presented to the Quality and Safety Committee on 12.09.17 (I). • Workforce KPIs, including appraisals, revalidation, compliance with mandatory training, staff turnover and vacancies (I). • Staff Survey results (E). • Friends and Family Test (I). • Freedom to Speak Up update to be considered at Trust Board on 18.07.17 (I). • Two Independent Freedom to Speak Up Guardians have been appointed (I). • 25 Dignity at Work Advisors have been trained to provide support to staff, now renamed as Dignity and Wellbeing Advisors (I). • Promotion of Dignity and Wellbeing Advisors and other sources of support via the intranet and posters (I).
Gaps in controls and assurances: (What additional controls and assurances should we seek?)	**Mitigating actions:** (What more should we do?)
1. Staff confidence in using sources of support for reporting concerns	

Action	Update since last reviewed by Trust Board	Lead	Deadline
~~Communications campaign to highlight sources of support~~	~~Promoting Dignity at Work Advisors and employee assistance programme~~	~~MV~~	~~Ongoing~~ Completed
Training for managers and staff in handling inappropriate behaviours	~~Programme of workshops is in development – will be a managers' session and one for staff~~ Piloted bullying and harassment training sessions in July 2017. Further programmes scheduled to align with Trust values	MV	~~Ongoing~~ November

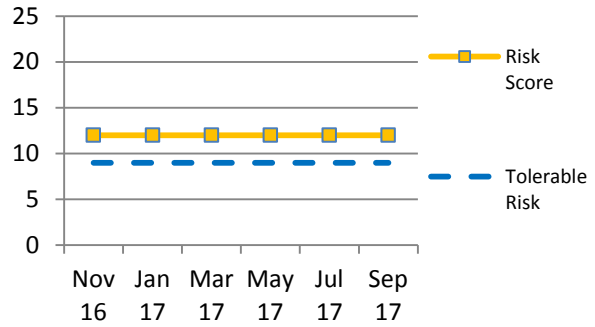
Current performance: (With these actions taken, how serious is the problem?)	**Additional Comments:**
The national staff survey results provide the year on year trend. In the meantime the work to engage staff and make them more aware of the overall quality and performance of the Trust continues, as does the work set out in the staff survey action plan to improve working life in the Trust. The Board will receive a presentation on the key findings of the 2016 survey at the March Board. The final "living our values" sessions ~~will take place in April~~took place in June 2017. Take-up ~~has been~~ was good (over ~~1,200 staff so far~~ 1,800 staff attending) and feedback very positive. Staff feedback from sessions is being developed into a new behavioural framework (currently with printing company), intended to illustrate positive, constructive behaviours and will be integrated to our workforce process from induction to performance management.	The Workforce Sub-Committee monitors the Staff Survey results and Values survey, and the agreed action plans.

Board Assurance Framework – Increasing Staff Engagement

Objective:			2.2 - Increasing staff engagement, evidenced in improved Staff Survey results	**Board Lead:**	Mark Vaughan	**Date of review:**	September 2017
				Lead Committee	Workforce Compliance Sub Committee	**Date of next review:**	November 2017
Risk ID:	**6**	**Risk:**	**Staff Engagement -** If the Trust fails to engage effectively with staff through robust communication, appraisals and the development of personal development plans, this will affect their ability to deliver excellent care and maintain professional standards.	**CQC Domain:**	Well-led	**CQC Outcomes:**	14 - Supporting workers

Risk Rating: (Likelihood x impact):

Initial Risk Score:	4 x 5 = **20**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 4 = **12**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Indicator	Jul	Aug	Sep	17/18 Target
% of staff who have completed mandatory training	86.6%	86.6%	87.4%	90%
% of staff who have received an appraisal	N/A	N/A	81%	90%

Rationale for current score:

The Risk Score remains the same as compliance with mandatory training remains slightly below the Trust's target. This has a medium likelihood of having a high impact on the risk.

Discussions at Deep Dive meetings in each of the clinical divisions ensures that mandatory training remains a priority for managers. The Learning and Development team has offered outreach sessions for teams, additional courses ~~are being scheduled and reminders are being issued to staff for some courses.~~ have been run and individual reminders were issued to staff who remain non-compliant.

The appraisal cycle for 2017 began in April with all appraisals to be completed by 30 June (with the exception of new starters, staff on maternity leave, career break, external secondment or suspension). It is too early to determine the final level of appraisal returns. ~~The current rate is 30% but over 600 appraisals arrived between 30 June and 05 July which have yet to be included in the return. The appraisal paperwork was refreshed in response to feedback and a number of appraisal training sessions were held for managers and staff.~~ The current rate is 81% and some paperwork has not been received yet. Individual reminders were sent to staff whose appraisal hadn't been returned. This has resulted in a small increase in returns this month.

Mandatory training compliance continues to improve, albeit slowly, with just over 2% more to reach the Trust target. The L&D team continues to promote options for achieving compliance ~~. We continue to provide a range of options to enable staff to become compliant~~ including face-to-face training, e-learning, quizzes and bespoke sessions where requested. There remains a risk that staff will not maintain compliance but controls in place will ensure that staff and their managers are aware when this occurs. There is online access for all staff to see their own and their team's compliance.

We ran over 80 Living our Values sessions between November and June – over 1,800 staff attended. The behavioural framework is now ~~in development, based on feedback from the sessions.~~ being printed and will be distributed in the coming month, as well as integrated into recruitment and learning and development activities.

<table>
<tr><th>Controls: (What are we currently doing about the risk?)</th><th>Assurances: (How do we know if the things we are doing are having an impact?)
(Key: I = Internal / E = External)</th></tr>
<tr><td>1. Workforce Development and Study Leave Policy, including arrangements for Performance Development Framework and appraisals.
2. Training Panel processes for the agreement of training.
3. Recording appraisals on Electronic Staff Record
4. Booking and recording course attendance on Electronic Staff Record
5. Regular updates on training opportunities through Trust communication channels</td><td>• Workforce KPIs, including appraisals, revalidation, compliance with mandatory training, staff turnover and vacancies (I).
• Regular reports to the Workforce Compliance Sub Committee, which reports to the Quality and Safety Committee (I).
• Staff survey 2016 results show small improvements in some areas though there are some areas (particularly around behaviours) that remain a concern. The Board will receive a presentation on the key results at the March Board (E).
• Workforce Information Reporting Engine Database (WIRED) IT system which shows levels of compliance from Trust-wide to individual level (I).
• A strategic leadership programme, in collaboration with Middlesex University, was launched in July 2017 (E).
• Leadership and management development portfolio has been produced (I).
• Better Together Network established (I).</td></tr>
<tr><td>6. Mandatory training validation and compliance plan.
7. Mandatory Training Policy</td><td>• Mandatory training report considered at Quality and Safety Committee on 7.3.16, and the Workforce Sub-Committee; also reviewed at Joint Staff Committee (I).
• Mandatory training matrix reviewed in line with national best practice reported to the Quality and Safety Committee on 4.07.16 (I).
• Annual Workforce report considered at Trust Board (I).
• Monthly data quality checks (I).
• Monthly DNA reports submitted to managers for remedial action (I).</td></tr>
<tr><td>8. Medical Revalidation Plan.</td><td>• Annual Organisational Audit submitted to NHS England (I).
• Quarterly reports submitted to NHS England (I).
• Annual Report to Trust Board on 26.09.16 (I).
• Higher Level Responsible Officer’s Inspection Report (E).</td></tr>
<tr><td>9. Nursing Revalidation.</td><td>• Registered nurses revalidation readiness report considered at Quality and Safety Committee 6.07.15 (I).
• Nurse revalidation audit undertaken in May 2016 (I).</td></tr>
<tr><th>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</th><th>Mitigating actions: (What more should we do?)</th></tr>
<tr><td>1. ~~Lack of management skills and knowledge~~
2. Lack of effective communications across the Trust</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>~~Management Development courses developed and being implemented at different levels across the Trust~~</td><td>~~Two programmes – New and Aspiring Manager and Experienced Middle Manager – were launched in 2016 and have received positive feedback. A strategic leadership programme is under development, in collaboration with Middlesex University~~</td><td>~~MV~~</td><td>~~Ongoing~~ Completed</td></tr>
<tr><td>Development of communication channels across the Trust as well as introduction of staff networks e.g. Better Together, LGBT</td><td>~~Successful launch of work around improving LGBT staff and service user experience within the Trust. Better Together Network has launched a series of “listening lunches” which enable staff to hear from senior colleagues about their career pathways and how they took opportunities to progress~~ Range of activities planned for diversity month in October 2017</td><td>MV</td><td>~~Ongoing~~ Oct 2017</td></tr>
</table>
</td></tr>
</table>

Current performance: (With these actions taken, how serious is the problem?)	**Additional Comments:**
The 2016 annual national Staff Survey closed in December. The Trust achieved a response rate of 53% which was a significant increase on the 2015 rate (38%). The results were published on 7.03.17.	Due to legislative changes affecting mandatory training, the Trust reviewed the mandatory training matrix to ensure that there is a robust training needs analysis and that refresher training periods are in line with national best practice. This was reported to and agreed by the Quality and Safety Committee on 4.07.16. This resulted in staff being required to undertake additional elements of mandatory training, which has had a negative effect on mandatory training compliance.

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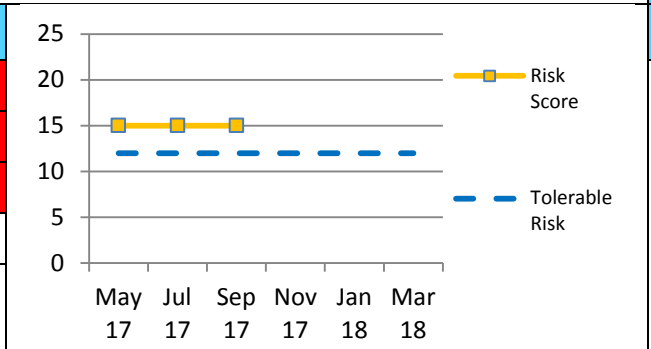
Board Assurance Framework – Meeting NHS requirements within the resources available

Objective:			3.1 - Providing the best outcomes for patients and meeting NHS requirements, within the resources available	**Board Lead:**	David Griffiths	**Date of review:**	September 2017
				Lead Committee:	Finance and Investment	**Date of next review:**	November 2017
Risk ID:	**7**	**Risk:**	**Budget Adherence -** If the Trust fails to deliver the Budget for 2017 / 2018 the Trust will not be able to meet its Control Total or be financially sustainable going forward.	**CQC Domain:**	Well-led	**CQC Outcomes:**	26 - Financial position

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	3 x 5 = **15**
Previous Risk Score:	3 x 5 = **15**
Current Risk Score:	3 x 5 = **15**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Financial Performance Report)

Indicator	Jun	Jul	Aug	17/18 YTD £000's	17/18 Forecast £000's
Budget – surplus / (deficit)	(880)	(863)	(926)	(4,443)	(4,616)
Actual performance – surplus / (deficit)	(761)	(808)	(918)	(4,164)	(4,616)
Variance to budget – Favourable / (adverse)	119	55	8	279	0

Rationale for current score:

The Risk Score remains at 15 (a possible likelihood with a potentially catastrophic impact). The Trust has a Budgeted Deficit for 2017 / 2018 of £4.6m. This is equal to the Control Total agreed with NHS Improvement.

The budgeted deficit includes unidentified income of £4.5m in Q4; this is intended to be met through increased funding from Commissioners and is our most significant financial risk. To secure this the Trust has undertaken ~~is engaged in~~ a Pricing Review of its contracts with the CCGs. The report was finalised in September, draws similar conclusions with earlier reports, and is being discussed with Clinical Commissioning Groups. ~~(concluding July) who are raising affordability concerns regardless as to what the review concludes.~~

This and other financial risks are articulated in the monthly Financial Performance Report.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Standing Financial Instructions (SFI) providing framework of financial controls. 2. Reservation of Powers to the Board and Delegation of Powers. 3. Full suite of financial policies and procedures, in line with best NHS practice. 4. Controls for approving bank and agency staff usage to reduce costs associated with the use of temporary staffing.	• SFI and Reservation of Powers considered annually by the Audit Committee and approved by the Trust Board (Last considered by the Audit Committee on 14.11.16 and approved by the Trust Board on 28.11.16) (I).
5. Efficiency plan in place to achieve c. £8.3m of savings, overseen by a Programme Management Office. 6. Monthly Integrated Performance Meetings to review Service Line performance, risks and opportunities. 7. Monthly review of financial performance of each Service Line. 8. Fortnightly meetings of the Improvement and Delivery Board which includes CIP delivery 9. Service Line Recovery Plans to address top 3 over spending areas	• Financial Performance Report considered at all meetings of the Trust Board and Finance and Investment Committee (I). • Current financial position and actions taken to deliver cost control and CIP savings discussed fortnightly and Improvement and Delivery Board

<table>
<tr><td>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</td><td>Mitigating actions: (What more should we do?)</td></tr>
<tr><td>No significant gaps in controls and assurances identified, as evidenced by extant Internal Audit reports and the Statement of Internal Control.</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>The Trust is exploring other avenues to help reduce cost, for example closer collaboration with other London Mental Health Trusts regarding procurement. ~~The Trust is currently involved in the NHS Improvement's Financial Improvement Programme, and an interim Turnaround Director has been appointed and substantive appointments have been made to the PMO, and are in discussions with other Trusts about the possibility of other services being provided on the St Ann's Hospital site.~~</td><td>The Trust's Procurement function is now led by NELFT with a joint Head of Procurement. CIPs are fully identified for 2017/18 and the PMO are closely monitoring delivery.</td><td>EMT</td><td>Ongoing</td></tr>
<tr><td>The Trust is part of the pilot cohort for Lord Carter's review of productivity and efficiency and is optimistic that there will be early learning that will lead to savings.</td><td>Requested datasets have been submitted and a response is expected in late Summer.</td><td>DG</td><td>On-going</td></tr>
<tr><td>A number of strategic work streams have been developed to deliver more transformational service changes and efficiency improvements; including Mobility and Workforce Strategy</td><td>Mobility Transformation project board established – Pilot planned for Q4 17/18

Scoping Work for new Workforce Strategy underway</td><td>AG

MV</td><td>On-going

On-going</td></tr>
</table>
</td></tr>
<tr><td>Current performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
<tr><td>There is a substantial gap between income and expenditure for 2017 / 2018 and beyond. The Trust has submitted a two year plan to achieve the control total set by NHS Improvement, but this is dependent on additional income of £12m over 2 years, from commissioners.

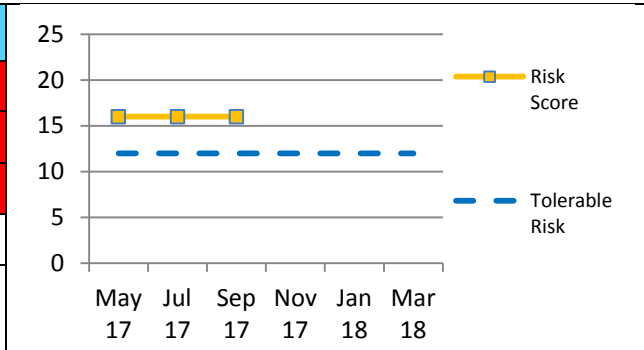
The main emphasis, as set out in the Carnall Farrar report, commissioned by the CCGs, is around system wide working and better alignment of income with expectations around service provision. This has now moved on to include a pricing review as part of the STP and 17/19 contracting round.

The Trust is actively participating in the sector wide 5 year Sustainability and Transformation Plan.</td><td>Linked to the Financial Performance Report.</td></tr>
</table>

Board Assurance Framework – Meeting NHS requirements within the resources available

Objective:			3.1 - Provide the best possible outcomes for patients, meeting national and local NHS requirements within the resources available - evidenced by meeting agreed targets	**Board Lead:**	David Griffiths	**Date of review:**	September 2017
				Lead Committee:	Finance and Investment	**Date of next review:**	November 2017
Risk ID:	**8**	**Risk:**	**Liquidity -** If the Trust does not manage its Liquidity position then the Trust will be unable to pay its creditors and staff.	**CQC Domain:**	Well-led	**CQC Outcomes:**	26 - Financial position

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	4 x 4 = **16**
Previous Risk Score:	4 x 4 = **16**
Current Risk Score:	4 x 4 = **16**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Financial Performance Report)

Indicator	**Jun**	**Jul**	**Aug**
Liquidity Ratio (Days)	-21	-22	-23
Net Cash Flow - surplus / (deficit) (£000's)	-548	2,040	2,210
Current Cash Balance - surplus / (deficit) (£000's)	3,073	5,113	7,323

Rationale for current score:

The Risk Score remains the same (a 'likely' likelihood of the risk occurring causing a major impact) as the Trust is now reliant on cash support from the Department of Health. The Trust has received cash support since quarter 4 in 2016/17 and the process to apply for and access cash is now in place and working well. The Trust has access to £9.5m of cash support in 2017/18 and this figure was calculated taking into account that £4.5m of the Trust's income target is currently not cash backed.

Controls: (What are we currently doing about the risk?)

1. Standing Financial Instructions (SFI) providing framework of financial controls.
2. Reservation of Powers to the Board and Delegation of Powers.
3. All financial policies and procedures.
4. Monthly cash flow monitoring.
5. Monthly review of financial performance of each Service Line.
6. Monthly Integrated Performance Meeting to review Service Line performance, risks and opportunities.
7. Monthly reports to service lines on outstanding debt
8. Ongoing discussions with NHS Improvement.
9. Process in place for receipt of cash support and to date £10m has been requested and received.

Assurances: (How do we know if the things we are doing are having an impact?)
(Key: I = Internal / E = External)

- Financial Performance Report considered at meetings of the Trust Board and Finance and Investment Committee (I).
- SFI and Reservation of Powers considered annually by the Audit Committee and approved by the Trust Board (Last considered by the Audit Committee on 14.11.16 and approved by the Trust Board on 28.11.16) (I).
- Regular report to the Finance and Investment Committee on the Trust's cash flow position.

<table>
<tr><td>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</td><td>Mitigating actions: (What more should we do?)</td></tr>
<tr><td>1. Delegated expenditure budgets currently exceed expected income which is unsustainable.
2. Commissioning income doesn't adequately reflect activity risk.
3. Lack of a joined up plan for Mental Health and Community Health across the North Central London Sector.</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>Financial management systems and processes rigorously applied.</td><td><s>Ongoing</s>Review of aged debtors and active escalation where debts remain unresolved, such as with the London Borough of Enfield on health visiting debt for which there is now a resolution.</td><td>DG</td><td>Ongoing</td></tr>
</table>
</td></tr>
<tr><td>Current performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
<tr><td>The Trust is applying the recently approved national controls re agency nursing. These are not expected to have a significant impact on the cost base, but will help to an extent.

The main emphasis, as set out in the Carnall Farrar report, commissioned by the CCGs, is around system wide working and better alignment of income with expectations around services.

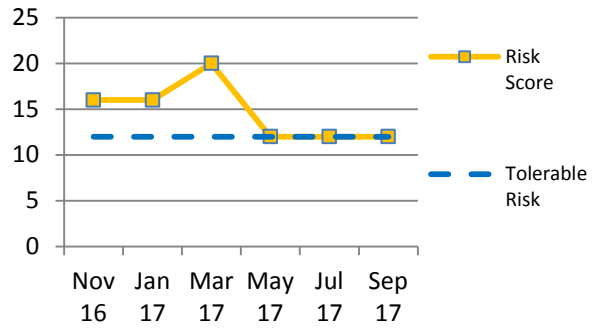
Whilst the Sustainability and Transformation Plan (STP) process is expected to resolve individual Trusts' sustainability issues over the medium term, the Trust has a short to medium term cash requirement which needs to be resolved.

The Trust has received advance payments from commissioners to delay the need for cash support and therefore interest payments. Debt collection processes are being improved and creditor payments reviewed. However, with these actions the Trust will still need cash support.</td><td>Linked to the Financial Performance Report.</td></tr>
</table>

Board Assurance Framework – Meeting NHS requirements within the resources available

Objective:			3.1 - Providing the best outcomes for patients and meeting NHS requirements, within the resources available	**Board Lead:**	Maria Kane (John Davidson)	**Date of review:**	September 2017
				Lead Committee:	Trust Board	**Date of next review:**	November 2017
Risk ID:	**9**	**Risk:**	**New IT Contract -** Failure to procure and implement a new IT systems supplier from January 2018 will impact on staff workload and effectiveness, and will have a detrimental impact on the activity recording, quality and safety of services.	**CQC Domain:**	Well-led	**CQC Outcomes:**	21 - Records

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	3 x 4 = **12**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 4 = **12**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⇔



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

No relevant Key Performance Indicators identified.

Rationale for current score:

The Trust has signed an extension to the contract with DXC (previously known as HPE) until 31st January 2018. This negates the original risk as stated. The risk has been restated to reflect this new date and consequently the risk score has been reduced.

We signed the contract paperwork with Atos on 7th Aug 2017 and the Ricoh contract on 31st Aug. We have now embarked on the Transition Programme relating to moving our IT services from DXC. The current plan is for the printers to be migrated to Ricoh by the end of November. The Atos Operational Service Commencement date is currently planned to be 6th March 2018 and the conclusion of the roll-out of new devices/PC configs to be 10th May 2018.

Governance and reporting arrangements have been established for the Transition Programme. An extension to the current DXC contract (currently due to expire 31/01/18) will be required aligned to the Ricoh/Atos transition. This is anticipated to be negotiated and concluded before the end of October 2017.

~~Bids have been received for the Managed Print Service and a preferred partner selected and notified. Bids have also been received for the Hosting, End-user compute & Network (HEN) tower and the Managed Security tower. A single bid was received for the out-of-hours service desk; however this was declared invalid as it was outside the stipulated cost envelope.~~

~~The Trust is in discussion with University College London Hospital (UCLH) and Atos regarding the viability of using their contract for the provision of the Trust's IT services. On 10 March 2017 the Trust signed a 'Letter of Intent' with Atos to enable a further period of due diligence to be undertaken with them. This due diligence included ensuring that the Trust's IT service and mobility requirements were clearly stated as well as providing sufficient information to Atos for them to provide a final proposal to us.~~

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Use of a third party consultancy company to advise and support the Trust in the ~~procurement and~~ transition process. ~~2. Invitation to Tender (ITT) and evaluation of bid responses.~~ ~~3.~~2. Engaging with DXC to discuss details of an extension to their contract for extended exit support	• Programme and project milestones in place (I). • Quality of project deliverables should be adequate (I). • Specific project risks and issues are being mitigated (I). • Internal Audit report (Partial Assurance) into the Programme and Project Governance

3. Ensuring escalation routes are in place both within DXC and Atos 4. ~~Discussion of alternative opportunities for the provision of IT Services using UCLH's contract with Atos.~~	presented to the Audit Committee on 5.09.16. Actions arising completed (I). • ~~Business Case presented to the Trust Board 26.09.16 (I).~~ • Regular updates to the Finance and Investment Committee. • Discussions with DXC are being held to provide extended exit support after the end of January 2018 • ~~External advice has been obtained from the trust's legal advisors (Bevans)~~

Gaps in assurance: (What additional assurances should we seek?)	**Mitigating actions:** (What more should we do?)
1. Validate the Transition programme plan with new suppliers and DXC ~~once they have been appointed.~~	

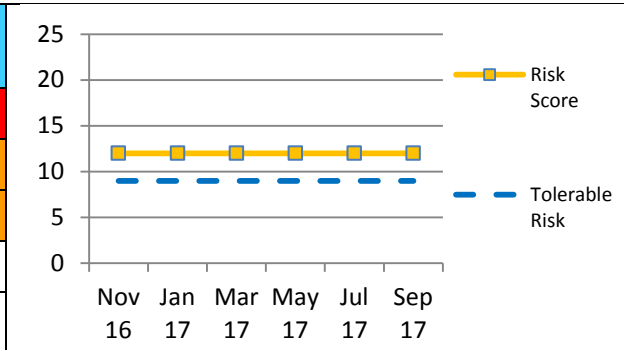
Action	**Update since last reviewed by Trust Board**	**Lead**	**Deadline**
~~Undertake due diligence checks on the Atos/UCLH contract~~	~~See current performance below~~	~~JD~~	~~14.07.17~~ Complete
~~Finalise contract with new Managed Print provider~~	~~See current performance below~~	~~JD~~	~~31.07.17~~ Complete
Finalise & agree Transition plan with all suppliers (inc. DXC)	See current performance below	JD	~~31.07.17~~ 30.09.17

Current performance: (With these actions taken, how serious is the problem?)	**Additional Comments:**
Update 22 Sept 2017 As noted above, we have now commenced the Transition programme with Atos who have been working on achieving their early contractual milestones. These milestones comprised the delivery of a draft detailed plan, high-level design documents for the data centre and networks as well as a detailed knowledge transfer plan. Atos have been engaging with the trust and DXC on exit and transition plans and their proposed approach.	

Board Assurance Framework – Meeting NHS requirements within the resources available

Objective:			3.1 - Providing the best outcomes for patients and meeting NHS requirements, within the resources available	**Board Lead:**	David Griffiths / Maria Kane (John Mills / Andrew Wright)	**Date of review:**	September 2017
				Lead Committee:	Estates Sub Committee	**Date of next review:**	November 2017
Risk ID:	**10**	**Risk:**	**Estates Management -** Failure to modernise the Trust's estate may result in a failure to realise the potential estate cost reductions and detrimentally impact on the quality and safety of services, poor patient outcomes and affect the patient experience.	**CQC Domain:**	Safe / Well-led	**CQC Outcomes:**	10 - Safety and suitability of premises.

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	4 x 4 = **16**
Previous Risk Score:	3 x 4 = **12**
Current Risk Score:	3 x 4 = **12**
Tolerable Risk:	3 x 3 = **9**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Annual PLACE Inspection (undertaken between February and June)**:**	**National Average 2015**	**BEH 2015**	**National Average 2016**	**BEH 2016**
Cleanliness	97.57%	98.75%	98.10%	99.20%
Food	88.49%	92.51%	88.20%	92.80%
Privacy, Dignity and Wellbeing	86.03%	89.11%	84.20%	85.71%
Condition, Appearance and Maintenance	90.11%	93.93%	93.40%	96.31%
Dementia	74.51%	83.19%	75.30%	87.34%

Rationale for current score:

The Risk Score remains the same as there remains a medium likelihood of a high impact on the risk as there remain environmental which are dependent on the redevelopment of the St Ann's Hospital site.

- Work continues to take place to improve the environment for service users of wards at St Ann's, and the implementation of the Trust Wide prioritised ligature mitigation plan.
- Planned maintenance work continues to take place in line with the Estates Strategy and maintenance programmes.
- The Trust's Strategic Outline Case (SOC) for the redevelopment of St Ann's Hospital has been approved by NHS Improvement and it is now moving to the next stage.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Estates Strategy, which sets out how the Trust will achieve the desired facilities that best accommodate the services provided in the most cost effective way.	• Confirmation from the CQC that the Estates actions in the Quality Improvement Plan have been delivered (E). • HealthWatch Enfield's Patient Led Assessments of the Care Environment (PLACE) - Summary report of 2016 inspection. Annual PLACE Survey reported to the Trust Board on 30.05.17 as part of the Clinical, Quality and Safety Report (E). • Asbestos Register and Management Action plan reported to the Health and Safety Committee (I). • Compliance with the Legionella Water Management Policy, reported to the Health and Safety Committee (I). • Estates and Facilities KPIs (I). • Services provided at Baytree House relocated to Somerset Villa. Baytree House has been marketed; decision to sell Baytree House is with the Trust Board (I).

2. Adherence to the Estates and Facilities work programme. 3. Delivery of agreed NCL Estates Strategy.	• Estates and Facilities KPIs (I).
4. Implementation of the re-development of the St Ann's Hospital site to provide new mental health inpatient facilities.	• ~~Following a competitive process, Integrated Health Projects (IHP) have been appointed as the new design and build contractor for the new mental health facilities, following Wilmott Dixon's decision to withdraw. Work is now underway on developing the detailed clinical design for the new inpatient facilities, obtaining final Planning approval, developing the surplus land sale strategy and developing the OBC, all due by September 2017.~~ • The Trust submitted its Outline Business Case to NHS Improvement on 1 September and it is due to be considered at the NHSI Improvement Committee on 16 October. • Design work on the new mental health facilities with the Trust's design and build partner, IHP, continues with patients and staff and work with Haringey Council on the Planning issues is progressing to plan. • Work on developing the Full Business Case has started, this is due to be completed by February / March 2018 and following NHSI approval of the FBC, construction of the new mental health facilities is due to commence by early summer 2018, with completion by early 2020.
5. Ligature Mitigation Work Plan.	• Summary of Highest, Medium and Low Risk areas following Review of In-Patient Ligature Risk Assessments considered by the Quality and Safety Committee on 5.05.15 (I). • Update report presented to the Quality and Safety Committee on 3.07.17(I). • Report on the Clinical Management of Ligature Risks presented to the Trust Board on 18.07.17 (I).

Gaps in controls and assurances: (What additional controls and assurances should we seek?)

1. Approval of St Ann's redevelopment business case by NHS Improvement by October 2017.
2. Approval of Application for final Planning approval from Haringey Council.

Mitigating actions: (What more should we do?)

Action	Update since last reviewed by Trust Board	Lead	Deadline
Preparations for marketing of surplus land at St Ann's	CBRE, the Trust's agents, appointed and ready. Discussions with Haringey Council on process and next steps.	AW	November ~~October~~ 2017 – March 2018
Design work on new MH facilities	IHP appointed as new design and build contractor and design work underway.	JM	~~September~~ September 2017- March 2018~~7~~
Application for final Planning approval from Haringey Council	Planning application will be developed with IHP~~..~~	AW	September 2017 – February 2018
Commencement of building works at St Ann's Hospital	Dependant on NHSI approval of OBC (Oct –2017) and FBC (Feb - Mar 2018).	AW	Early summer ~~Spring~~ 2018

Current performance: (With these actions taken, how serious is the problem?)

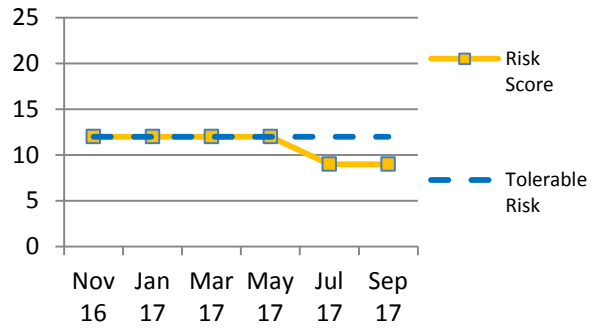
A five year programme (2015 – 2020) for mitigating ligature risks is in the process of being implemented. Approximately £700k was programmed in year one and two, with a further expenditure of £1.2M over the following three years.

Additional Comments:

Board Assurance Framework – Meeting NHS requirements within the resources available

Objective:			3.1 - Providing the best outcomes for patients and meeting NHS requirements, within the resources available	**Board Lead:**	Andy Graham	**Date of review:**	September 2017
				Lead Committee	Improvement	**Date of next review:**	November 2017
Risk ID:	**11**	**Risk:**	**Efficiencies through Enablement -** If the Trust fails to deliver operational and financial efficiencies through Enablement this will affect the sustainability of the Trust.	**CQC Domain:**	Effective / Safe / Well-led	**CQC Outcomes:**	1 – Respecting and involving people. 4 - Care and welfare of people. 26 - Financial position

Risk Rating: (Likelihood x impact):	
Initial Risk Score:	3 x 4 = **12**
Previous Risk Score:	3 x 3 = **9**
Current Risk Score:	3 x 3 = **9**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⟺



Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

Indicator	Jun	Jul	Aug	17/18 Target
Percentage of people in receipt of Community Mental Health services who are in settled accommodation	75%	77%	75%	70%
Percentage of people in receipt of Community Mental Health services who are engaged in structured occupations, including actively seeking work, parenting and running a home	24%	25%	25%	20%

Rationale for current score:

The Risk Score has reduced as funding has been secured to open new rehabilitation ward, an agreement is in place with a housing provider to increase the number of people in secure tenancies and pre-market intelligence on the future tender of enablement demonstrated an acceptable level of interest.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Enablement Board re-established. 2. Consultation with staff undertaken.	• Regular reports providing an update to the Trust Board (I). • Regular reports to the Improvement and Delivery Board (I). • Enablement project communications campaign (I). • Regular meetings of the Enablement Board (I).
3. Rehabilitation inpatient project established- due to open ~~January~~ March 2018.	• Funding secured. • Memorandum of Understanding signed with housing partner
4. Adult Mental Health Pathway changes delivered in Barnet and in progress in Enfield and Haringey.	• Project plans in place for adult pathway review in each borough and rehabilitation project. • New Adult pathway being implemented in Barnet. • Consultation on proposed adult pathway in Enfield and Haringey has concluded.
5. Involvement of Third Sector partners to secure the benefits of Enablement. 6. Enablement Specification developed and anticipated tender during October 2017 ~~5.~~7. Senior enablement post agreed and will be advertised during October 2017	• Proposals developed. • Pre-market engagement event held on 3 July with potential providers

<table>
<tr><td>Gaps in controls and assurances: (What additional controls and assurances should we seek?)</td><td>Mitigating actions: (What more should we do?)</td></tr>
<tr><td>1. Approval of transformation funding by Clinical Commissioning Groups.</td><td>
<table>
<tr><th>Action</th><th>Update since last reviewed by Trust Board</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>Commissioners have met and will not invest in transformation during 2016/17 (31/10/15).</td><td>Being raised through the STP process.</td><td>AG</td><td>On hold</td></tr>
</table>
</td></tr>
<tr><td>Current performance: (With these actions taken, how serious is the problem?)</td><td>Additional Comments:</td></tr>
<tr><td>~~The Trust is currently implementing and monitoring a number of Enablement pilot projects. The Enablement programme is being independently evaluated, the outcome of which will be reported to the Trust Board in due course.~~

~~Service Line Enablement Managers and Project managers have been appointed.~~

Enablement Outcome measures on housing and employment are being delivered as set out in this report.

The Trust has recruited eight Community Engagement workers in place with lived experience.</td><td>The Trust is developing an ambitious change programme to ensure that all clinical services are delivering Enablement based care to patients. This is supported by commissioners, local authorities and other stakeholders although funding has not been agreed. The initial proposals have been widely communicated with stakeholders and feedback has been positive.</td></tr>
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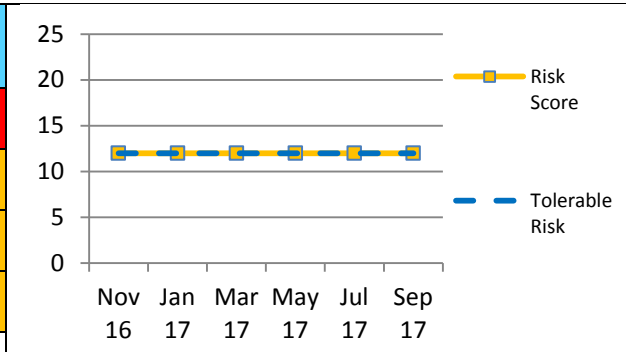
Board Assurance Framework – Meeting NHS requirements within the resources available

Objective:			3.1 - Providing the best outcomes for patients and meeting NHS requirements, within the resources available	**Board Lead:**	Andy Graham (Katherine Wynne)	**Date of review:**	September 2017
				Lead Committee:	Performance Improvement	**Date of next review:**	November 2017
Risk ID:	**12**	**Risk:**	**Performance Information -** If the Trust fails to ensure reliable, accurate, timely or complete clinical or management information this may impair decision-making, the optimal use of resources to deliver safe patient care efficiently, and the Trust's ability to evidence this to commissioners in line with contractual requirements.	**CQC Domain:**	Well-led	**CQC Outcomes:**	16 - Assessing and monitoring the quality of service provision. 21 - Records

Risk Rating: (Likelihood x severity):

Initial Risk Score:	4 x 5 = **20**
Previous Risk Score	3 x 4 = **12**
Current Risk Score:	3 x 4 = **12**
Tolerable Risk:	3 x 4 = **12**
Direction of travel:	⟺



Top Relevant Key Performance Indicators: (taken from the Performance and Quality Dashboard Report)

	Qtr 1			Qtr 2		
	Apr	**May**	**Jun**	**Jul**	**Aug**	Sep
Activity Recording - Percentage variance from contracted activity plan (CCG Contracted Activity)	-0.2%	4%	-3%	-9%	TBC	
Patient FFT - Mental Health Response Rate	10%	8%	9%	7%	8%	

Rationale for current score:

The Risk Score remains the same. The likelihood of information being incomplete has reduced through the new controls which continue to prove effective via the assurances described. However, the expectation of Commissioners is now based on this increased recording, the maintenance of which has been a challenge in the past. Under recording of contacts will also have a more direct impact on funding from April, so potential severity remains the same despite the baselines having been reset.

While CCG plans have been reset according to previous years, the Adult MH Pathway Reviews and associated changes are likely to present some variation this year. Most of the work will remain the same, despite being delivered by a restructured service, and should not impact activity levels. There will however be some areas in which the nature of the work itself has changed, and the number of contacts will change as a result. This will require regular review throughout the year to ensure expectations for the activity levels of teams such as the Barnet Primary Care Link Workers are adjusted to reflect the new approach.

The existing controls focus on manual validation and scrutiny. While these are adequate to reduce the risk, we are planning their phased replacement and augmentation with more efficient, automated validation checks as part of the database redesign project.

Controls: (What are we currently doing about the risk?)	**Assurances:** (How do we know if the things we are doing are having an impact?) (Key: I = Internal / E = External)
1. Performance Improvement Committee meets on a bi-monthly basis to review the Integrated Performance and Quality & Safety Dashboard Report and the Corporate Risk Register prior to consideration by the Quality and Safety Committee and Trust Board. 2. Integrated Performance and Quality Dashboard Report which presents performance information across a number of KPIs. 3. Validity and completeness of information is being monitored as part of Borough level performance reporting. 4. Further controls include scrutiny at the new Performance Improvement Committee and the Integrated Performance Meetings. 5. Productivity information is being produced weekly. Some evidence that IT is impacting negatively on recording is being addressed through Open Rio functionality and a 12-month project to improve information reporting. 6. Funding for a data warehouse, improved database infrastructure and reporting has been secured through CAMHS Future in Mind transformation. We have started the project, in collaboration with NELFT, which will provide a repository of validated, replicable data for use in all retrospective reporting. 7. We have a dedicated 'Activity Improvement Coordinator' whose role it is to offer dedicated validation and support to teams throughout the trust. Any apparent under recording is now cross referenced with ESR staffing data and discrepancies are queried within the month, prior to reporting.	• Regular feedback report on the work of the Performance Improvement Committee presented to every meeting of the Quality and Safety Committee (I). • Increased activity recording is now more in line with expectations, based on the team-level delivery plans and analyses scrutinised at the activity recording working group (I). • Integrated Performance and Quality & Safety Dashboard Report presented to every meeting of the Quality and Safety Committee and Trust Board (I). • Bi-Monthly Data Quality Improvement Meetings (I). • Data Quality (validity) is part of 16/17 and 17/18 contracts. Data is scrutinised by the CCGs via the NELCSU (E). • Integrated Performance Meeting with each Borough and Specialist Team (I).

Gaps in controls and assurances: (What additional controls and assurances should we seek?)	**Mitigating actions:** (What more should we do?)
1. The replicability of performance information (i.e. the ability to reproduce the same, validated information from a source that integrates all of our key systems) is jeopardised by the absence of a static reporting data warehouse.	

Action	**Update since last reviewed by Trust Board**	**Lead**	**Deadline**
Activity recording will be queried at team level and teams where under-recording is an issue are supported to improve. Weekly activity reports are sent out to teams to flag any areas of concern.	New plans have been agreed with CCGs, so we expect recorded activity levels to come out closer to targets.	Katherine Wynne	Ongoing
Having agreed the CCG planned activity trajectories for 2017/18, we will now be comparing the actual values each month against these figures and escalating underperformance greater than 3% across a borough	Whilst we are awaiting month 5 data activity continues to be monitored by the services on a weekly basis.	Katherine Wynne	For review in ~~August~~ October

Current performance: (With these actions taken, how serious is the problem?)	**Additional Comments:**
The information presented to our board is increasingly complete and reliable, and the likelihood of misleading information being reported is low. With routine, operational validation and multiple points of scrutiny, the impact of minor data inaccuracies would be minimal. The Board and Committee level performance report for 2016/17 calculates key indicators directly from RiO data extracts. This applies to the borough-level reports as well as the Trust Board view, so performance is unavoidably reflective of the information recorded in our clinical systems.	The 'live' nature of the reporting database is less of a problem for board-level decision making than it is for retrospective analyses and CCG assurance. In17/18 we plan to implement a read-only database, providing access to reports that will remain static.

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